Improving Health-seeking Behavior and Care among Sexual Violence Survivors in Rural Tanzania

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Abstract

The aim of this thesis was to assess the effects of providing community education and training to healthcare workers to improve community response, healthcare and support for rape survivors in the Kilombero district of Tanzania. The overall design of the project was to begin with an exploratory study (Paper I) to establish the community’s perceptions towards sexual violence and their perceived recommendations to address this issue. Using a structured questionnaire, the community’s knowledge and attitudes towards sexual violence were determined along with their associations with demographic factors (Paper II). Papers III and IV assessed the effect of healthcare workers’ training and a community information package, respectively, using a controlled quasi-experimental design. The findings highlighted the social norms and variety of barriers that impacted negatively on the survivors’ care-seeking from support services and health outcomes. Increasing age and higher education were associated with better knowledge and less accepting attitudes towards sexual violence. Training on the management of sexual violence was effective in improving healthcare workers’ knowledge and practice but not attitude. Knowledge on sexual violence among the communities in the intervention and comparison areas increased significantly over the study period; from 57.3% to 80.6% in the intervention area and from 55.5% to 71.9% in the comparison area. In the intervention area, women had significantly less knowledge than men at baseline (53% Vs 64%, p<.001). There was a reduction, though not significantly, in acceptance attitudes from 28.1% to 21.8% in favor of women. In conclusion, the current intervention provides evidence that healthcare workers’ training and community education is effective in improving knowledge but not attitudes towards sexual violence. The findings have potential implications for interventions aimed at preventing and responding to violence. The broader societal norms that hinder rape disclosure need to be re-addressed.

Keywords: healthcare worker, community, sexual violence, rape, intervention, quasi-experimental, qualitative, rural, Tanzania

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urn:nbn:se:uu:diva-261902 (http://urn.kb.se/resolve?urn=urn:nbn:se:uu:diva-261902)
To my husband Rashad, and my children Danah and Manal
List of Papers

This thesis is based on the following papers, which are referred to in the text by their Roman numerals.


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Acronyms and Abbreviations

AIDS  Acquired Immunodeficiency Syndrome
CSA  Child Sexual Abuse
EC  Emergency Contraception
FGD  Focus Group Discussions
GBV  Gender-Based Violence
HCWs  Health-Care Workers
HIV  Human Immunodeficiency Virus
IPV  Intimate Partner Violence
IEC  Information, Education, Communication
MDGs  Millennium Development Goals
MCDGC  Ministry of Community Development, Gender and Children
MEWATA  Medical Women Association of Tanzania
MOHSW  Ministry of Health and Social Welfare
MUHAS  Muhimbili University of Health and Allied Science
NGO  Non-Government Organization
NSGD  National Strategy on Gender and Development
PEP  Post Exposure Prophylaxis
PF3  Police Form number 3
SOSPA  Sexual Offences Special Provisions Act
STIs  Sexual Transmitted Infections
VAW  Violence Against Women
VCT  Voluntary Counseling and Testing
WHO  World Health Organization
Definitions

*Rape*, in legal terms in Tanzania, is defined as any person who has unlawful carnal knowledge of a woman or girl without her consent or with her consent if the consent is obtained by false or by means of threats or intimidation of any kind or by fear of bodily harm by means of false representation as to the nature of the act or in the case of a married woman by personating her husband is guilty of an offence termed rape\(^1\) (National penal code).

*Child Sexual Abuse (CSA)* is defined as any activity with a child who is under the age of legal consent that is for sexual gratification of an adult or a substantially older child. The perpetrators take advantage of, violate or deceive children or young people who have less power over elders.\(^2\)

*Intimate partner violence (IPV)* includes violence between people in intimate relationships who do not necessarily live in the same household, including ex-spouses, boyfriends/girlfriends, ex-boyfriends/ex-girlfriends, or those in same-sex relationships. It includes sexual, physical and emotional violence.\(^3\)

*Perceptions* are defined as beliefs, opinions or the insider’s views of a condition/situation, often held by many people and based on appearance and previous experiences.\(^4\)

*Healthcare workers*, for the purposes of this study, refers to all levels (certificate, diploma and degree) of professional nurses, doctors, clinical officers and medical attendants working at the dispensaries, health centers and hospitals in the study area.

*Gender*, according to Connell, refers to the culturally and socially constructed roles and responsibilities of men and women that vary from place to place and over time.
Preface

I am an obstetrician/gynaecologist, and throughout my practice I often come across rape survivors. This is a frustrating experience because one has to deal with such clients without any formal training and/or guidelines relating to their particular situation. In the past, I often consulted senior colleagues on how they managed rape cases and searched for information from published works on the Internet.

In 2009, I was fortunate to get an opportunity through the Medical Women Association of Tanzania (MEWATA) to visit and learn from several hospitals in Nairobi, Kenya, particularly within their gender-based violence (GBV) sections. It was really fascinating to see the advancement made in the care of GBV survivors by our Kenyan colleagues. They have a functional GBV system with guidelines in place.

It was this particular trip that generated my interest in issues concerning violence against women. I strongly felt the need for action to ensure that GBV is well understood by fellow doctors at work and especially the junior doctors directly under my supervision. My immediate step after the study tour was to infuse GBV-related information into the continuous medical education (CME) program at my hospital. Gradually I noticed a surge in doctors’ interest to learn more. They appreciated the effort and expressed their views that GBV knowledge added value to their work.

I also participated in MEWATA’s awareness-raising activities at a community level that always gained momentum in November every year during the 16 days of activism against gender-based violence. However, I still felt the need to do more in this area to further enrich GBV approaches in the country. Hence, an opportunity to pursue a PhD in this area was hard to turn down, although I knew that such an endeavor would be demanding, challenging and at times frustrating as I would have to strike a balance between work, family and travel.

I am blessed with two daughters, and the realities and horrific experiences of rape survivors evoke strong feelings in me to remain committed to the cause – to minimize and eventually eliminate sexual abuse and other related gender-based violence, while working towards the prevention of the adverse
health consequences of sexual violence. The emphasis in this piece of work is on strengthening community knowledge in order to increase the reporting of rape cases, as well as ensuring immediate healthcare response. There is a need to sustain collaborative efforts to combat these social ills.

It is my sincere hope that the reader will find this thesis interesting, academically stimulating, and a platform for initiating action to combat sexual and GBV and ensure a safety environment, especially for women and girls in Tanzania.
Introduction

Despite increasing acknowledgment that sexual violence is a violation of human rights and a major threat to public health, the evidence shows that violence against women is a pervasive problem in almost every society. The statement below is just one indicator of how sexual violence in sub-Saharan Africa impacts lives in such negative and persistent ways:

To be honest with you, people – even women – don’t take rape seriously [in Sierra Leone]. To them, it is a way of life but they don’t know how it is affecting them. Even when the victims try to speak out they don’t get justice. If they go to the police station, the rapist will go and pay money to police and the victims will remain suffering. So some resort to silence but suffer from trauma forever. Marie Jalloh, a Parliament member in Sierra Leone.

The World Health Organization (WHO) estimates that, globally, 35% of women have experienced physical or sexual violence at some point in their lives. Tanzania is no exception; sexual violence against women and children is a serious public health, human rights and development issue; at least 20% of women are reported to have experienced sexual violence in their lifetime, and children under the age of eighteen, 28% of girls, and 13% of boys, are reported to have experienced sexual violence.

The term “gender-based violence” (GBV) is sometimes used interchangeably with “violence against women” (VAW) and recognizes that violence is overwhelmingly directed towards girls and women as the subordinate gender characterized by power imbalances. GBV occurs on a vast scale and takes different forms throughout women’s and children’s lives, ranging from Child Sexual Abuse (CSA), early marriage, female genital mutilation, rape, forced prostitution, and domestic abuse, to the abuse of elderly women. This thesis focuses on rape against women and children, for which we used the term “sexual violence”. Rape was defined as sexual contact that occurs without the victim’s consent, involves the use of force, threat of force, intimidation, or when the victim was of unsound mind due to illness or intoxication and involves sexual penetration of the victim’s vagina, mouth or, rectum. The legal definition of rape in Tanzania excludes marital rape therefore this definition was preferred.
The WHO study emphasizes the urgent need for a multi-sectoral response to eliminate the tolerance of violence, increased investment in prevention efforts, and strengthened services for survivors. Furthermore, the WHO recommends that interventions should be developed at “macro-level” in order to provide the infrastructures that aim to support gender equality at both community and individual levels while improving community resources to reduce the incidence of sexual violence and providing adequate non-stigmatizing services for survivors. The present thesis was built on previous PhD studies that were undertaken in Tanzania and which identified various barriers that hinder help-seeking and the provision of proper care to survivors of sexual violence. Studies on service providers revealed that healthcare workers (HCWs) lack knowledge, skills and appropriate resources in managing sexual violence survivors. Furthermore, the consequences of rape and CSA are not well understood in communities.

The fact that violence is a predictable and preventable health problem, as illustrated in the WHO world report on violence, indicates that there is a need to have violence prevention programs focusing on changing individual as well as community factors. This thesis is an attempt to respond to that WHO call by providing such a program which focused on training HCWs and delivering community information campaigns and conducting an assessment of their effectiveness.

Health and social consequences of sexual and GBV

Violence against women is associated with potential deleterious health and social consequences. Some of these consequences are direct, such as acute injuries, sexually transmitted infections (STIs) including HIV, and unwanted pregnancies. Sexual violence has been specifically linked to an increased risk of HIV and AIDS for exposed women/girls. Emotionally, the problem is associated with chronic somatic disorders, anxiety, depression, high-risk sexual behavior, chronic illnesses and socio-economic consequences that generally impact negatively on the survivor’s quality of life. Table 1 below summarizes the health and social consequences of sexual violence.
Table 1: Health and social consequences of sexual violence

<table>
<thead>
<tr>
<th>PHYSICAL</th>
<th>REPRODUCTIVE</th>
<th>PSYCHOLOGICAL, SOCIAL AND ECONOMIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fatal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Homicide</td>
<td>Miscarriage</td>
<td>Post-traumatic stress</td>
</tr>
<tr>
<td>Suicide</td>
<td>Unwanted pregnancy</td>
<td>Depression</td>
</tr>
<tr>
<td>Maternal mortality</td>
<td>Unsafe abortion</td>
<td>Anxiety, fear</td>
</tr>
<tr>
<td>Infant mortality</td>
<td>Sexually transmitted infections</td>
<td>Anger</td>
</tr>
<tr>
<td>AIDS-related mortality</td>
<td>(STIs), including HIV/AIDS</td>
<td>Shame, insecurity, self-hate, self-blame</td>
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<tr>
<td>Acute</td>
<td></td>
<td></td>
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<tr>
<td>Injury</td>
<td>Menstrual disorders</td>
<td>Shaming</td>
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<tr>
<td>Shock</td>
<td>Pregnancy complications</td>
<td>Mental illness</td>
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<tr>
<td>Infection</td>
<td></td>
<td></td>
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<tr>
<td>Chronic</td>
<td></td>
<td></td>
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<tr>
<td>Disability, Scars</td>
<td>Infertility</td>
<td>Suicidal thoughts, behavior, attempts</td>
</tr>
<tr>
<td>Somatic complaints</td>
<td>Gynecological disorders</td>
<td>Difficulty concentrating</td>
</tr>
<tr>
<td>Infections</td>
<td>Sexual disorders</td>
<td>Social rejection, isolation</td>
</tr>
<tr>
<td>Pain</td>
<td>Increased “risk” behaviors such as sex with many partners, unprotected sex</td>
<td>Loss of ability to function in the community, e.g., earn income</td>
</tr>
<tr>
<td>Gastrointestinal problems</td>
<td>Younger age at first intercourse</td>
<td>Low productivity</td>
</tr>
<tr>
<td>Eating disorders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sleep disorders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol/drug abuse</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Adapted from Bott S, Morrison A, Ellsberg M, 2005

Socio-cultural norms related to sexuality

In the last few decades, there has been a major social change in Tanzania which has had an impact on the expression of sexuality for the youths. Previously, the only legal way that young women could engage in sex was through marriage, and this was dependent on the wealth of the bride’s family. Today, in contemporary societies, marriage is delayed because of schooling engagements and income generation. Poverty is an important risk factor that puts women and girls at risk of early sexual debut, transactional sex and unwanted pregnancies. Studies in Northern Tanzania demonstrate that a majority of young girls and women engage in transactional sex and see it as a “normal” part of sexual relationships, motivated by a desire to acquire modern commodities. In actual practice, young women’s sexuality is even used by their mothers for economic benefit. This means that young survivors are likely to have reduced economic and social potential, or increased dependency.

The initiation rituals for defining womanhood (unyago) and manhood (jando) facilitates the process of conveying community-held attitudes, beliefs and practices to young people. This cultural practice furthermore reinforces
women’s submissiveness to men. Sexual education within these initiation rites is based upon an ancient matricentric foundation. However, this socialization process which is conducted in a number of communities in sub-Saharan Africa is rapidly losing ground. The original messages of the rituals are no longer relevant to adolescents in the present society. Today young people acquire information from their peers and social media. Women’s sexual behavior allows extensive sexual networking, exacerbating their vulnerability to HIV infection.

United Republic of Tanzania

The first part of Figure 1 shows the location of Tanzania on the African continent. Important landmarks of Tanzania include Mount Kilimanjaro, the highest mountain in Africa, the Ngorongoro Crater and the Great Rift Valley, dotted with several lakes including Lake Tanganyika, the world’s second-deepest lake. The 2010 population of Tanzania was 43 million, of which 75% reside in rural areas. The population is sparsely distributed in some geographical locations, hence making some social services inaccessible. The country has 26 administrative regions with 130 administrative districts. The economy of Tanzania is based mainly on agriculture, which accounts for 44.4% of the gross domestic product. However, about 33.4% of the population lives below the national poverty line, their expenditure each being less than US $0.50 per day. In 2010 the per capita income was US $509 and the total per capita expenditure on health was US $31.

**Figure 1:** Map showing Tanzania, Kilombero and Ulanga Districts and the Ifakara Demographic surveillance site (IC-DSS), Tanzania. Source: (Ifakara HDSS TANZANIA, 2009) reproduced with permission.
In Tanzania, women are disadvantaged compared to men in terms of both education and earnings. The literacy rate is estimated to be 73%, of which 72% are women and 82% are men. Overall, 19% of Tanzanian women aged 15–49 have received no formal education, almost twice the proportion of men (10%).

Tanzania has more than 120 ethnic groups with diverse cultures and traditions. Most Tanzanian communities follow the patriarchal kinship pattern whereby the inheritance rights and decision-making power are vested in the husband’s clan. Women lack decision-making power in various matters, including how, when and where to have sex. Many ethnic groups are polygamous and condone the practice of multiple sexual partners. On average, women have 2.3 sexual partners versus 6.7 partners for men. Patriarchal structures benefit men more than women, where women are culturally considered to have a subordinate status and minimum influence on decision-making, even in regards to their own health.

Legal and justice sector in relation to sexual and GBV

Tanzania has a decentralized, multi-sectorial governance system which extends from the village to the regional level. The legal providers primarily include Ward Reconciliation Councils (WRC), Primary and District Courts, police officers, and legal aid services. The WRC is a dispute resolution body and is considered to be the most locally accessible tier in Tanzania’s court system. The WRC mandate is, among other things, to provide marital reconciliation and mediation. Matters unresolved in the WRC can be referred to Primary Courts. Primary Courts are mostly concerned with the application of criminal and customary laws. Divorce can be granted by Primary Courts and these courts also have the right of appeal. District Courts offer similar services to those provided in Primary Courts and their mandate includes arbitrating cases of sexual and physical violence. Because the country has no separate court for family matters, GBV cases are tried in general courtrooms alongside other criminal cases. Police posts and police stations are also central to the legal system. With respect to sexual violence services, police stations are responsible for issuing a Police Form number 3 (PF3) when an act of violence or a criminal offence has occurred. This form is required if the victim of a crime intends to take legal action against the alleged perpetrator/s, for example, through detention, mandating an individual to appear in front of the court, or arrest. For sexual violence, a survivor who files a PF3 will be asked to describe and document the incident at the police station and this form will be used as the basis of her case against the perpetrator.
The police department piloted Gender and Children’s Desks at police stations in 2008 in Dar es Salaam in an attempt to offer more “woman-friendly” services. Gender and Children’s Desks, staffed by male and female police officers, provide private locations for discussing sensitive matters — including sexual violence — and officers frequently offer escort services, for example, to the hospital, or to represent survivors in court, and they may also provide temporary shelter at the police station or at a female police residence. Between 1990 and 2004, the number of rape incidents reported annually to the Ministry of Home Affairs increased from less than 1,000 to 4,500 with very few cases reaching hearings at the court. However, the program has only recently expanded to districts beyond Dar es Salaam. Access to these services for rural women remains limited.

Health sector’s response to sexual and GBV

The public health system, administered by the Ministry of Health and Social Welfare (MOHSW) of Tanzania, is also decentralized. According to the WHO, the primary objective of a health system is to ensure the quality of care and the safety of the people it serves. The healthcare system is currently operating with a 40% shortage of the required skilled workforce which impacts greatly on quality of care. Health dispensaries provide the most basic level of care, and can assist a survivor with first aid for minor injuries. Most often they will refer sexual violence cases to a higher-level health facility with more comprehensive services. Health centers offer the next level of care and can treat a wider range of injuries. While District Hospitals offer both inpatient and outpatient care and some basic laboratory testing, comprehensive services for sexual violence survivors are available only at selected health centers, District Designated Hospitals (DDH), District Hospitals, and referral hospitals. Depending on the capacity of the facility and the availability of supplies, these services can include post-exposure prophylaxis (PEP), HIV and STI screening and treatment, collection of forensic evidence, and counseling. Survivors who report sexual violence will be required to obtain a PF3 during or after they receive this care. However, a woman can choose not to report that her injuries were due to sexual violence and she will still be able to receive the necessary services. The ability to pay for healthcare depends a great deal on the contributions from their social network. Before this study commenced there were no guidelines on the care of rape survivors to suggest that it should include PEP, emergency contraception (EC), and forensic evidence gathering at the health facilities. In addition, the healthcare workers had not received any formal training on the management of care for people affected by sexual violence.
Private health facilities, in contrast to government-supported health facilities, are not authorized or mandated to complete PF3 forms. As a result, their capacity to respond to cases of sexual violence is very limited. This is a serious constraint, given that an estimated one-third of health services in Tanzania are provided outside of the public system. The range of services provided by non-governmental organizations (NGOs), faith-based organizations (FBOs), and other private organizations that operate health facilities, varies according to the mandate of each organization and the specific center. In addition, Tanzania also has several Voluntary Counseling and Testing (VCT) centers that provide services for sexual violence survivors. However, to date, GBV has not yet been systematically integrated into these facilities.

Legal and policy framework for GBV in Tanzania

The Government of Tanzania has enacted various laws in support of women’s economic and social rights and well-being. The passing of the following two key policies in 2011 represents important milestones and indicates that the Government of Tanzania is increasingly placing its attention on GBV:

1. The National Policy Guidelines for the Health Sector Prevention of and Response to Gender-based Violence,\(^\text{53}\) which outline the roles and responsibilities of the MOHSW and other stakeholders in the planning and implementation of comprehensive GBV services.

2. The National Management Guidelines for the Health Sector Response to and Prevention of Gender-based Violence (GBV),\(^\text{54}\) which provides a framework for standardized medical management of GBV cases and aims to strengthen referral linkages between the community and service providers. In addition, a national clinical training curriculum has also been developed for HCWs and social welfare officers, which includes GBV screening protocols.

However, while the principle of gender equality is enshrined in the Tanzanian constitution (1977) and more recent legislation upholds this commitment (e.g., the Land Act and Village Land Act, 1999, which permits women to inherit land), legal protections against GBV are limited. The Sexual Offences Special Provisions Act, 1998 (SOSPA)\(^\text{55}\) criminalizes various forms of GBV, including rape, sexual assault and harassment, female genital cutting (for girls aged 18 years and younger), and sex trafficking. However, marital rape is not recognized as an illegal act. The Law of Marriage Act, 1971 (revised 2002), prohibits “corporal punishment” against a wife, but this Act fails to recognize marital rape and does not provide legal protection for un-
married women against bodily harm by their partner.\textsuperscript{56} The Law of Marriage Act further allows for child marriage at 15 years of age with parental consent, which is another common form of GBV perpetrated against women in Tanzania.\textsuperscript{57}

Gender equality situation in Tanzania

Gender equality and women’s empowerment are essential to the health, social and economic development of all nations. The promotion of gender equality and empowerment of women is one of the eight Millennium Development Goals (MDGs), which underscores the importance of women’s empowerment as essential to international development efforts.\textsuperscript{58} The World Development Report (WDR) on Gender Equality and Development identified several key dimensions of gender equality which include women’s voice, agency, and participation, alongside endowments and opportunities. The WDR 2012 recognizes freedom from the risk of violence as being among the key aspects of ensuring that women and girls have the ability to make meaningful choices in their lives and to act on those choices.\textsuperscript{59}

The Government of Tanzania has made considerable achievements in the implementation of the critical areas of concern of the Beijing Platform for Action and the Outcomes of the 23\textsuperscript{rd} Special Session of the General Assembly.\textsuperscript{60} These areas are: enhancement of women’s legal capacity; economic empowerment of women and poverty eradication; women’s political empowerment and decision making, and women’s access to education and employment. Tanzania is committed to gender equality as indicated in the Constitution and in the signing and ratification of major international instruments that promote gender equality and human rights. Such instruments include the MDGs (2000), the United Nations Security Council, Resolution 1325 (2000), and Conventions on maternity protection (2000), among others. Through the National Strategy on Gender and Development (NSGD 2005) the government has laid down gender mainstreaming approaches towards building the foundation to promote gender equality and equity in the country. The Ministry of Community Development, Gender and Children (MCDGC) have the mandate to coordinate the implementation of the national policy on gender equality and are also custodians of the NSGD.\textsuperscript{61}

The participation of women in public decision-making is one of the areas in which progress has been made in Tanzania. About 60\% of women report making decisions regarding their own healthcare alone or jointly with their partners.\textsuperscript{41} However, participation in decision-making varies dramatically by regions; just 8\% of women in Mara region participate in making household
decisions, compared to 64% of women in Kilimanjaro region. The ongoing Constitutional review offers an opportunity for promoting gender equality. The women’s movement has advocated for gender parity in parliament, and the current draft, if passed, would establish a 50:50 representation ratio between women and men in the parliament, political leadership and in decision-making entities. The draft constitution addresses women’s rights and includes such rights as: respect of women as human beings; freedom from violence; participation in election without discrimination; equal opportunities in employment where they are competent; protection from discrimination, or harmful discriminative laws; employment protection during pregnancy; and delivery provided by quality health services. Moreover, the number of women ministers has increased from 15% in 2004 to 27% in 2009, and 31% in 2013.

Attainment of gender equality also requires a change in people’s perceptions and attitudes. The SOSPA, enacted in 1998, stipulates stiff sentences of up to 30 years’ imprisonment for people found guilty of rape. However, despite stiff sentences, rape is still commonplace in many communities. Inequalities still persist between rural and urban areas in regards to capacity, as they do for the access to education, physical assets including land, and political and economic opportunities for girls and women. In this regard, lasting progress cannot be made in improving the health and wellbeing of individuals and nations while gender inequalities exist in society.

Previous interventions on violence

Given that sexual violence is an important risk factor for a range of health problems, there has been increasing international attention given to the potential role that the health sector can play in identifying and supporting women who experience abuse. Despite the scarcity of empirical evidence, in 2014, the Lancet presented a scientific evaluation of a series of interventions to reduce the prevalence and incidence of violence against women and girls. Several types of interventions, such as the Tostan model, Stepping Stone and SASA!, were revealed to be effective approaches with significant positive effects in reducing or preventing violence against women and girls.

Many countries are actively seeking to develop a health sector response to intimate partner violence (IPV) and sexual violence, which are integrated into different health service entry points, such as family planning clinics, antenatal clinics, and emergency services. Alongside these initiatives there has been greater focus placed on the formal evaluation of interventions
in healthcare settings designed to ameliorate the harmful effects of violence against women. The greatest number of trials in this area that took place in high-income countries have focused on two types of secondary prevention approaches – violent partner interventions and survivor services. A large number of screening evaluations took place in the context of health services, and involve pregnant women who are screened for violence during pre-natal care. Healthcare providers are uniquely positioned to identify and assist individuals in situations of violence by caring for their physical needs and referring them to shelters, counseling or legal services. Evaluations of screening programs have found statistically-significant positive results for identifying survivors of IPV, and recurrent screening throughout the pregnancy has further increased identification rates. The few studies in Africa that have looked at the impact of training programs have reported a positive impact on the support given by health workers. Little is known on what constitute the most promising services to provide to survivors of intimate partner violence such as sexual violence, although one-stop crisis centers are drawing increasing interest.

In low- and middle-income countries, there is a much greater focus on primary prevention of violence. The interventions focusing on primary prevention of IPV use a wide range of approaches, including: group training; social communication, such as radio and television spots; billboards; theater, and so forth; community mobilization; and livelihood strategies. A number of community-level interventions focusing on changing the community’s attitudes and norms surrounding violence using public information and campaigns have been undertaken. The SASA! Study was successful in bringing IPV out of the private realm into the public eye by using community networks, identifying change agents, and applying innovative media with stimulating messages. Income-generating schemes such as the IMAGE intervention in South Africa, a program that combined microfinance and gender training, has been shown to reduce the level of violence among program participants to half, and highlights the benefit of facilitating economic empowerment of women, indicating that the establishment of gender norms is necessary to ending violence. Other successful interventions that have influenced men’s and boys’ perceptions of masculinity and gender norms include the Stepping Stone program in South Africa and the Champion Project in Tanzania.

Sexual violence is a global issue, and sub-Saharan Africa is generally a place where it is concentrated, goes largely without punishment, and goes hand-in-hand with political instability and gender inequality. There is a need of significant organization for change and response by health and human rights professionals at the community and international levels. Despite all these developmental efforts and growing awareness of the links between sexual
and GBV, and health, human rights and national development, interventions are still scarce and most are not evaluated using a strong research design, either experimental or quasi-experimental, with evidence of a significant preventive effect. Knowledge of what works to prevent violence has been limited by number of factors: a poor understanding of which contributing factors are amenable to change and can lead to significant reductions in violence; an overemphasis on single-factor solutions; limited consistency, rigor, and quality of evaluation approaches, measures, and methodologies; and a lack of experimental and quasi-experimental evaluations in research, monitoring, and evaluation efforts. Rigorous evaluation of any such intervention is limited, particularly in low- and middle-income countries. Responses at present are being implemented separately by the NGO and public sectors, and by separate line ministries within the national government.
Rationale for the study

Improved survival, health and well-being of all children, women and special vulnerable groups and the elimination of sexual violence are important goals of the WHO MDGs and the newly sustainable development goals as well as for the national poverty reduction strategies in Tanzania. This thesis addressed two questions: does training of HCWs on rape management and the introduction of rape kits at health facilities improve care among rape survivors? Does providing community education on sexual violence and its consequences improve reporting of the events?

The development of GBV policy and management guidelines by the MOHSW is a first step towards the prevention of and responding to GBV. However, to provide effective and comprehensive, high-quality GBV services, some key gaps within the health sectors must be addressed. Previous studies directed towards survivors of violence have been undertaken in an urban setting in Dar es Salaam, 15-17 however, it is important to understand the strengths and limitations in the existing support services, as well as the community needs and potential barriers to care in rural settings in order to develop interventions relevant for the entire country.

Because rape and CSA occur in the community, it is important to target the health facilities and HCWs who may be the first or only point of contact outside the home for sexual violence survivors for emergency care of the acute cases. HCWs are strategically placed to provide information and assistance, as well raise society’s awareness to GBV as a public health problem. HCWs that are uninformed or unprepared may inadvertently put survivors at further risk of misdiagnosis or may offer inappropriate treatment. Therefore, training of HCWs and adopting the Tanzanian MOHSW GBV management guidelines will support healthcare workers in providing high-quality and comprehensive services to sexual violence survivors and the community.

It is consistently reported in previous studies that many victims of GBV decline referrals made at health facilities and that they are generally not satisfied with the services offered at referral hospitals. 19,20,82 Creating community awareness of the consequences of sexual violence may improve health-seeking behavior and increase reporting.
The interventions in this thesis are aimed at complementing efforts of the government, and other NGOs, to prevent and respond to sexual violence and GBV. Lessons learned from the project will form the basis for advocating expansion to other districts, and will also create opportunities for policy makers to address identified key policy challenges in the health sector.
Aims and objectives

The aim of this thesis was to determine whether community education, the training of HCWs and the introduction of rape kits will improve community response, healthcare and support for rape survivors at the community and health facilities in Kilombero district, Tanzania.

The specific objectives were:

1. To explore community perceptions of the rape of women and child sexual abuse (*Paper I*)
2. To assess associations between knowledge and attitudes towards sexual violence and socio-demographic characteristics (*Paper II*)
3. To compare knowledge, attitudes and practice towards the care of sexual violence survivors before and after the HCW training program (*Paper III*)
4. To compare knowledge and attitudes towards sexual violence survivors before and after a community intervention (*Paper IV*)
Theoretical framework

The study’s theoretical frames are the Socio-Ecological Model by Heise and Connell’s Relational Theory of Gender. Their concepts, constructs and ideas were used as lenses in implementing the interventions and also when reflecting on the results as well as in the discussion of the results.

Socio-Ecological Model

This study intervention takes a holistic approach that explicitly recognizes that sexual violence against women and children is the result of a complex interplay of factors operating at the individual, interpersonal, community and societal levels. The socio-ecological model helps to understand factors affecting behavior and also provides guidance for developing successful programs across social environments. The socio-ecological model emphasizes multiple levels of influence, such as those at individual, interpersonal, organizational, community and public policy levels. The principles of this model are consistent with social cognitive theory concepts, which suggest that creating an environment conducive to change is important to facilitate the adoption of positive health behaviors. Application of this model in our study will help to understand why people are not ready to adopt health-promotion behaviors to eventually improve the effectiveness of medical interventions. Interventions to prevent sexual violence against women and children must engage with and achieve change at each of these levels; individual, interpersonal, community and societal levels. A conceptual framework for this study intervention is presented in Figure 2. This framework maps out the key contextual socio-demographic variables that may influence the impact of the intervention; the levels of activities that were conducted in different spheres of influence; the expected outcomes of the intervention; and the long-term sustained impact the intervention was designed to have on the community.
Connell’s Relational Theory of Gender

Because gender permeates across all levels of the ecological model, it is therefore important to take into consideration the gender aspect so as to be able assess the impact that violence has on those not directly exposed.

Violence against women and girls is highly gendered, and Connell describes gender as relational social practices within our daily lives, which are constructed dependent on cultural context, and constantly changing. Femininity and masculinity are norms and expectations attributed to ‘womanhood’ and ‘manhood’ respectively in a specific social environment. Connell places at the top hegemonic masculinities, that is to say, practices of masculinities that are more socially idealized and associated with social powers and are maintained by cultural consent and sustained by the subordinate status of women. In many sub-Saharan societies, men tend to dominate and control the economic and social environment. They are decision-makers in all matters of life. Women are not expected to discuss or report any IPV with outsiders or the police. Any maltreatment within intimate relationships is often settled at family level. Similar gendered expectations are described elsewhere.

Figure 2: Conceptual Framework of the thesis
dominance in families facilitate violence against women,\textsuperscript{92} which has a great impact on children.

The relational theory of gender by Connell,\textsuperscript{87,88} as also applied in this thesis, describes gender as being multidimensional; encompassing, at the same time, economic, power, emotional and symbolic dimensions that operate simultaneously at intrapersonal, interpersonal, institutional and society-wide levels. The dynamics of sexual violence and gender relations in this study context were illuminated by applying Connell’s relational theory of gender\textsuperscript{88} using these four dimensions of gender. Furthermore, gender relations cannot be separated from other social structures such as ethnicity, class and sexuality.\textsuperscript{84} These structures of gender relations drive us to examine gender relations and how they affect individuals and societies in more complex ways.

In Tanzania, gender as a concept is still often understood as women and men, and not the systems and structures of inequalities that exclude and discriminate against certain groups. Our perception of gender greatly influences how we perceive the sex of the survivor and perpetrator. Male perpetrators are usually taken more seriously compared to female perpetrators, even though some men are subjected to serious violence by women.\textsuperscript{92-95}
Methodology

Study design

This intervention study involved two arms: the Kilombero district (intervention site) and the Ulanga district (comparison site). We applied mixed methods; including both qualitative and quantitative research methods. The study had three phases: the pre-intervention phase (2012), where baseline studies (*Papers I and II*) were conducted; the intervention phase (2013) where the health facility and community-based interventions were delivered; and the post-intervention phase (2014), in which the evaluation studies (*Papers III and IV*) were conducted (Table 2).

Table 2: Overview of design, participants and methods in Papers I–IV

<table>
<thead>
<tr>
<th></th>
<th>Paper I</th>
<th>Paper II</th>
<th>Paper III</th>
<th>Paper IV</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Design</strong></td>
<td>Qualitative</td>
<td>Cross-sectional</td>
<td>Quasi-experimental</td>
<td>Quasi-experimental</td>
</tr>
<tr>
<td><strong>Participants</strong></td>
<td>54 participants: 27 men and 27 women aged 18 to 58</td>
<td>1,568: 653 men and 915 women aged 18 to 49</td>
<td>HCWs 151 baseline: 61 men and 90 women 169 endline: 58 men and 111 women</td>
<td>1,568 (baseline): 1,551 endline: 680 men and 871 women aged 18 to 49</td>
</tr>
<tr>
<td><strong>Data collection</strong></td>
<td>Six focus group discussions</td>
<td>Structured questionnaires</td>
<td>Structured questionnaires</td>
<td>Structured questionnaires</td>
</tr>
<tr>
<td><strong>Data analysis</strong></td>
<td>Qualitative content analysis</td>
<td>Descriptive statistics, Bivariate and multivariate analyses, SPSS</td>
<td>Comparative statistics, SPSS, difference in difference (DID) SAS</td>
<td>Comparative statistics, SPSS, difference in difference (DID) SAS</td>
</tr>
</tbody>
</table>
Study setting

The research studies were conducted in a rural district called Kilombero, which is in the southeastern part of Tanzania. Kilombero is one of the six districts in the Morogoro region in Tanzania, as shown in the second part of Figure 1. The literacy rate for the Morogoro region is 24%. The area is predominantly rural with the semi-urban district headquarters, Ifakara, being located about 420 kilometres southwest of Dar es Salaam, the biggest commercial city of Tanzania. The major features found in the Kilombero district are the Kilombero River and Udzungwa Mountain. The river separates the Kilombero district from the Ulanga district (the comparison district) while forming the vast Kilombero valley floodplain. Large parts of this valley are flooded during the rainy season, usually between November and May. Kilombero district, which has an area of 14,915 km², is divided into 5 divisions, 19 wards, 81 villages and 365 hamlets. The district has a total population of 416,401 with an annual growth rate of 3.9%. It has an organized health system, with one designated district hospital, one private hospital, 5 health centers (one in each division) and 38 dispensaries. There is a tarmac road which connects the Kilombero district to other regions of Tanzania and a railway line (TAZARA) which goes as far as Zambia. However, in some rural areas, the roads are in very poor condition, so that during the rainy season they may be impassable, leaving some areas disconnected from the rest of the district. The Kilombero people are mostly engaged in such economic activities as subsistence farming, fishing, animal husbandry, and petty trade. This district is unique in that it has large commercial sugar cane farms that are owned by the biggest sugar factories in Tanzania. These factories are also situated in the district and employ laborers who are recruited from different parts of the country.

Ulanga district, the comparison district (Figure 1), has a total population of 234,219, with 7 divisions, 31 wards, 91 villages and 40 health facilities with two hospitals (one is a district hospital). The economic activities are similar to those of the Kilombero district. The study involved two administrative divisions, one from the Kilombero district (Mngeta division) and one from the Ulanga district (Mwaya division); only one village from each division was included for the studies, both together encompassing approximately 12,000 inhabitants. The rationale for choosing the Kilombero district in which to conduct the interventions was because there were no existing sexual violence interventions ongoing there, but also because the district has a well-organized health system.
Participants and Procedure

This section gives a brief description of the material, method and procedure used to generate and analyze the data. More detailed descriptions are covered in each article.

Selection of participants and data collection

**Paper I:** The aim of this study was to explore and understand perceptions of the rape of women and children at the community level. A purposive sampling technique was used to recruit participants. To allow for maximum variations of perceptions, participants were recruited from different ages and social groups. The participants included professionals, religious leaders, and other community members (farmers, housewives, village/ward executive officers). Sexual violence survivors were not actively recruited in this study.

Data were collected using focus group discussions (FGD), which is a data collection process that gathers people of similar backgrounds to discuss a research topic. FGD was chosen for its potential to utilize group interactions that enable identification and exploration of contextualized community perceptions. A total of six FGD (four of single gender and two of mixed gender) were conducted. The FGD were tape-recorded with the participants’ consent.

**Paper III:** The aim was to evaluate the changes in knowledge and attitudes towards sexual violence, including their management, in a selected population of health professionals at primary healthcare level. The participants included HCWs (medical officer (MD), assistant medical officers (AMO), clinical officers (CO), nurses and medical attendants working at the health centers and hospitals in the two areas. In the intervention area, participants were randomly selected from the departments of paediatric, gynaecology, outpatient departments and laboratory. The selection of participants from the comparison area was purposive with priority given to doctors and nurses who were available and willing to participate in the survey. A sample of 151 HCWs at baseline and 169 at final assessment participated in the self-administered surveys.

A structured questionnaire was used, adapted from a study done in Vietnam that evaluated the responses of HCWs to GBV. The attitude questions in this study were adapted from the WHO multi-country study. The questionnaire comprised three sections: respondent’s profile, actual knowledge, attitude and practice towards sexual violence and recommendations for future improvement in responding to sexual violence survivors. The
same questionnaire was used at baseline, from December 2012 to January 2013, and after the training program for HCWs from February to March 2014.

**Papers II & IV:** The aim was to determine community knowledge of and attitudes towards sexual violence and their association with demographic factors (*Paper II*), and evaluate the impact of a community information package (*Paper IV*). Participants were made up of both men and women who were eligible for inclusion if they were between the ages of 18 and 49 years, had lived in the village for at least a year, and if they usually shared meals with others in the household. A negative attitude towards gender violence was rated at 70% and higher, and confidence limits of 5%, a design effect for cluster survey of 2.0, and a sample size of 1,082 was assumed to obtain a 95% confidence level so the results could be generalized to the wider population.

Through a multi-staged random sampling technique where only one village in each district was included, a household survey of community members using a structured questionnaire was conducted in the intervention and comparison areas (*n*=1,568) before the intervention started. Using a ballot technique, one eligible member was selected to complete the survey. The questionnaire was adapted using the WHO multi-country study and the rape victim scale. It included information on the communities’ knowledge and attitudes toward sexual violence, and socio-demographic factors. A follow-up cross-sectional survey (*n*=1,551) using the same questionnaire took place after eight months of implementing the intervention. Ten research assistants were selected and trained in the use of the questionnaire, the nature of the study, ethical issues related to this study and techniques to conduct such sensitive interviews.

**Measures**

The main outcome measures were the number of reported rape events at the health facilities, and the communities’ and HCWs’ knowledge and attitude towards sexual violence. A binary outcome variable was created for knowledge and attitude towards sexual violence. The knowledge and attitude scores were dichotomized using the two-third rule to categorize respondents with a score of between 0–66% as having incorrect knowledge on sexual violence, and all those who score 67–100% as having correct knowledge on sexual violence. The program’s effect was assessed by comparing the pre-intervention score with the post-intervention scores within and between districts.
Data management

All questionnaires were reviewed by the field supervisor, MA, checked for missing data and inconsistencies, and returned to the research assistant for correction whenever necessary. Data were entered by trained personnel and continuous checked by the principal researcher, MA.

Analyses

Qualitative

Qualitative content analysis (QCA) was used to analyze qualitative data (Paper I). QCA enables systematic organization and analysis of data collected qualitatively. Prior to analysis the audiotaped discussions were transcribed in Swahili and translated to English. The transcripts were checked against the recordings for accuracy. Minor discrepancies were corrected. The initial step in the analysis was to read the transcripts several times to get an overall understanding of the messages. Meaning units were identified and condensed to retain the core meaning. These condensations were further shortened to codes or labels which were sorted into sub-categories and categories with shared commonalities.

Quantitative

Quantitative data were double-entered using Epidata 3.0 and analyzed using SPSS version 21 and SAS version 9.4. Multiple logistic regression analyses were performed (Paper II). Adjusted Odds Ratios and 95% Confidence Intervals were obtained to determine variables that independently predicted knowledge and attitude towards sexual violence (Paper II). The Chi-square test was used and a p-value of <0.05 was considered statistically significant. The effects of the interventions were estimated as the net intervention effect (NIE) and also by comparing post- intervention differences (Papers III & IV). This effect is a linear combination of four independent estimates. P-values from a Z-test and 95% confidence intervals for the intervention effect were calculated based on a normal distribution assumption.
Interventions

The interventions were implemented at the health facility and at community level in the intervention district (Kilombero) as described below.

Training of healthcare workers

The health facility intervention included training of HCWs on the management of rape and CSA and the introduction of a rape kit. The training took place between February and April 2013. The objective of this training was to improve knowledge of sexual violence and its clinical management and provide prompt medical support to rape survivors. A total of 100 HCWs from the five health centers and the district hospital in the intervention district participated in the training in three batches. This was a five-day training program which was conducted using the WHO/UNHCR guidelines and the National GBV Management Guidelines. The first author, MA, the co-supervisor, PM, and the local gynaecologist from the district hospital facilitated the training. Participatory learning methods, including lectures, discussions, group work, and case studies/scenarios, were utilized. A warm-up session on ‘building awareness on gender’ preceded the actual training which covered the basic concepts of gender and commonly accepted norms. The topics covered for the training included: introduction to GBV; responsibilities of HCWs; obtaining consent from survivor; introduction to survivor-centered medical history; introduction to examination and collection of forensic evidence; treatment for consequences of rape; psychological support for survivors; and medical care of the child survivor. After the training of HCWs, all of the five health centers and the district hospital in the intervention area were provided with the National GBV Management Guidelines and pre-packed rape kits, which included supplies for forensic evidence collection, medications for prevention of STI, pregnancy tests and EC and HIV testing reagents. On-site services included medical care, documentation of injuries, and external referral for police investigations and legal support or higher-level hospital. Rape registry books were provided to the health facilities in both the intervention and comparison areas for the documentation of all rape cases before the intervention and throughout the whole study period. In the facilities located in the comparison area, services were provided as per the normal routine.
Community-based information package

In the community-based intervention, various strategies were used to create awareness, and these included radio programs, information, education and communication (IEC) materials and advocacy meetings with local leaders, including religious leaders. This intervention program commenced in May and ended in December 2013 after providing capacity-building training to healthcare workers employed at local health facilities. This awareness-creation program aimed to improve the community’s knowledge and attitude towards gender-based violence, specifically sexual violence. The radio program was broadcast in the intervention area through the local radio station, Pambazuko FM. This station reaches more than five million people who are inhabitants of the Kilombero district and areas of the Ulanga district along its borders, and the Iringa region. The radio sessions covered the following topics: the magnitude of violence against women and children; the laws that convict the perpetrators; the health and social consequences of violence; the importance of seeking care; the type of care to expect at health facilities and from police; and the role of the community in supporting sexual violence survivors. A total of four educative sessions were pre-recorded by the PhD
candidate, MA. Each session was an hour in length and these were broadcast in rotation, once a week for a month, over a period of eight months. Once every two months there was a live radio program where community members had the opportunity to call in or send text messages and ask questions. All of the live radio programs were also facilitated by the PhD candidate, MA. The radio programs ended by urging the community to refer the survivors to the local health facilities for further care and support during and after the end of the intervention.

Similar topics were also developed into fliers and posters and distributed to the community. A total of 10,000 copies of fliers and posters were produced and disseminated. Periodical meetings (every two months) were also conducted with religious and community leaders to sensitize their unique role in influencing the community’s behavior. These leaders also received fliers and posters for them to distribute in the community.

![Figure 4: Flier prepared by M. Abeid for providing education on health consequences and importance of seeking care](image)

**Ethical consideration**

The procedures for the studies closely followed the ethical guidelines of research on violence against women approved by the WHO\textsuperscript{108} and the WHO/CIOMS\textsuperscript{109} ethical guidelines for biomedical research involving human subjects.
The WHO guidelines emphasize the importance of ensuring confidentiality and privacy, both as a means to protect the safety of the participants interviewed and the fieldworkers performing the study. The research assistants received special training and support. The investigations were presented as a “study on women’s health”. Appropriate actions were included to minimize any distress caused by the research. Data were kept with strict confidentiality, accessible only to the research team. The identification of the participants was not used in study reports or papers. Because of the sensitivity of the topic, regular debriefings were held with the research assistants.

- **Ethical clearance**: Ethical clearance to conduct this study was obtained from the Ethical Committee of Muhimbili University of Health and Allied Sciences (MUHAS-IRB). Ref. No. MU/DRP/AEC/Vol.XIII.

- **Local authority’s permission**: Permission to conduct this study in the area was sought from Kilombero and Ulanga municipal authorities.

- **Participants’ consent**: The study topic of sexual violence is of a sensitive nature. To ensure informed voluntary participation, the study participants received a verbal explanation of the objectives and procedures of the study. They were told how confidentiality would be safeguarded and were also fully informed of the potential risks and benefits of their participation.
Results

The main findings across the four papers are summarized in this section. The findings highlight the community’s perceptions towards the rape of women and children, and the effectiveness of training healthcare workers and the community information package in improving knowledge and attitude towards sexual violence. Detailed results can be found in the individual papers.

Characteristics of the participants

All the participants in the four papers were adults (above 18 years old). More than 1,500 participants were interviewed and about 80% were women. The majority (80%) of the participants had completed primary education. Most participants were married or cohabiting. Farming was the dominant occupation in the two districts. About 70% possessed a radio. The healthcare workers who participated in the intervention and comparison areas were similar in terms of age, gender, marital status and their working experience. However, the intervention area had a significantly higher proportion of physicians than the comparison area at baseline as well as at final assessment.

Perceptions of rape of women and children (Paper I)

The rape of women and children was regarded as a common, serious and hidden problem. Due to several barriers, rape was perceived to be seldom reported. Fear of being blamed for reporting rape and stigmatization of women for their experience was perceived as a powerful hindrance for rape disclosure. The rape of a child perpetrated by a known person or relative was not disclosed to legal authorities as this was perceived to put the family’s honor at stake. On the contrary, the rape of a child by a stranger was described as an unacceptable form of violence and was immediately reported. However, the rape of children older than 10 years was often not reported and was regarded as normal behavior within the social and cultural norms of their communities. A number of factors were attributed to the increase in rape events, such as replacement of the traditional social norm, poverty, poor
parental care, alcohol/drug abuse and the influence of globalization (internet, social media) that has promoted the acquisition of foreign Western cultures. The parents’ poor economic status might force girls to engage in risky sexual activities such as prostitution in order to solicit financial support. The police posts and health facilities are scarce and have to cover a wide geographical area and this was perceived to be a major hindrance to obtaining care at an appropriate time.
Association of knowledge and attitudes towards sexual violence and socio-demographic characteristics (Paper II)

All the socio-demographic variables were associated with knowledge on sexual violence. The older age group were more likely to have adequate knowledge on sexual violence \[\text{AOR} = 1.4 \ (95\% \text{ CI: } 1.0–1.8)\] compared to younger age groups. The higher the education level, the more likely the participant was to have adequate knowledge on sexual violence \[\text{AOR} = 3.1(95\% \text{ CI: } 1.8–5.3)\]. Those who were single, divorced or separated were significantly less likely to have adequate knowledge on sexual violence compared to the married/cohabiting group. All the independent variables except for age showed a significant association with accepting/non-accepting attitude towards sexual violence. Men were more likely \[\text{AOR}=1.7 \ (95\%\text{CI: } 1.4–2.1)\] than women to express a non-accepting attitude towards sexual violence.

Effects of intervention on the outcomes (Papers III & IV)

Reported rape cases

The number of rape cases that were reported at the health facilities increased from 20 to 55 cases in the intervention area but not in the comparison area. All the 55 cases that reached the health facilities for care were females under the age of eighteen, and only 20 cases managed to reach the health facility within 72 hours and received appropriate treatment. The rest arrived after 72 hours due to various reasons, such as far distance or lack of money for transport.

Knowledge on sexual violence

Overall there was improved knowledge of HCWs on sexual violence in the intervention district, from 55% at baseline to 86%, and a decreased knowledge, from 58.5% to 36.2%, in the comparison area with a net intervention effect (NIE) of 53.7% \(95\% \text{ CI: } 32.2–75.1, p <.001\) as shown in Table 3.

The community’s knowledge on sexual violence increased significantly in both areas over the study period, from 57.3% to 80.6% in the intervention area and from 55.5% to 71.9% in the comparison area. The NIE between the
intervention and comparison areas was statistically significant 6.9% (95% CI 0.2–13.5, \( p = 0.03 \)) as shown in Table 4.
Table 3: Effects of training HCWs in the intervention and comparison areas at baseline and endline

<table>
<thead>
<tr>
<th></th>
<th>Intervention Estimates of change %</th>
<th>Comparison Estimates of change %</th>
<th>NIE</th>
<th>95%CI Lower</th>
<th>Upper</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Care of rape survivors:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HCWs suspicious of rape are obliged to interrogate the victim</td>
<td>-16.9</td>
<td>-54.3</td>
<td>37.4</td>
<td>16.8</td>
<td>57.9</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Rape of women and children should be treated as an emergency</td>
<td>13.5</td>
<td>-24.3</td>
<td>37.8</td>
<td>20.8</td>
<td>54.7</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>HCWs have a legal obligation to give forensic evidence in court</td>
<td>33.7</td>
<td>-1</td>
<td>34.7</td>
<td>13.8</td>
<td>55.6</td>
<td>&lt;.001</td>
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<tr>
<td><strong>Causes leading to sexual violence:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Influence of sex movies</td>
<td>1.5</td>
<td>-4.2</td>
<td>5.8</td>
<td>-12.9</td>
<td>24.4</td>
<td>0.54</td>
</tr>
<tr>
<td>Influence of alcohol, drugs</td>
<td>-0.4</td>
<td>-0.6</td>
<td>0.2</td>
<td>-10.1</td>
<td>10.5</td>
<td>0.97</td>
</tr>
<tr>
<td>Traditional values have been changed</td>
<td>8.6</td>
<td>12.7</td>
<td>-4.1</td>
<td>-23.7</td>
<td>15.4</td>
<td>0.67</td>
</tr>
<tr>
<td><strong>Health consequences:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Impact on the women’s health</td>
<td>7.1</td>
<td>-15</td>
<td>22.1</td>
<td>9</td>
<td>35.2</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Impact on the women’s mental health and psychology</td>
<td>-4.1</td>
<td>-15</td>
<td>10.9</td>
<td>-3.8</td>
<td>25.5</td>
<td>0.14</td>
</tr>
<tr>
<td>Impact on the women’s reproductive health</td>
<td>-0.2</td>
<td>-18.7</td>
<td>18.5</td>
<td>2.6</td>
<td>34.4</td>
<td>0.02</td>
</tr>
<tr>
<td>Impact on long-term development</td>
<td>17.5</td>
<td>-16.1</td>
<td>33.7</td>
<td>13.6</td>
<td>53.7</td>
<td>&lt;.001</td>
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<tr>
<td><strong>Perpetrators of sexual violence:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acquaintances</td>
<td>54.5</td>
<td>-15.9</td>
<td>70.4</td>
<td>49.6</td>
<td>91.3</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Close relatives</td>
<td>64.9</td>
<td>12.3</td>
<td>52.6</td>
<td>32.3</td>
<td>73</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Awareness of National GBV Management Guidelines</td>
<td>46.6</td>
<td>-3.4</td>
<td>50</td>
<td>29.5</td>
<td>70.5</td>
<td>&lt;.001</td>
</tr>
<tr>
<td><strong>Agencies/organization that provides support to the victims of violence:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Police</td>
<td>18.5</td>
<td>-12.2</td>
<td>30.7</td>
<td>9.7</td>
<td>51.6</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Judicial offices</td>
<td>25.3</td>
<td>-4</td>
<td>29.3</td>
<td>7.3</td>
<td>51.2</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Government authorities</td>
<td>22.3</td>
<td>1.1</td>
<td>21.2</td>
<td>0.9</td>
<td>41.5</td>
<td>0.04</td>
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<tr>
<td><strong>Composite Scores:</strong></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Correct Knowledge</td>
<td>31.4</td>
<td>-22.3</td>
<td>53.7</td>
<td>32.2</td>
<td>75.1</td>
<td>&lt;.001</td>
</tr>
</tbody>
</table>

Abbreviations: CI, confidence interval; NIE, net intervention effect (difference in intervention area from baseline to endline minus difference in comparison area from baseline to endline)
Table 4: Effects of community education in the intervention and comparison areas at baseline and endline

<table>
<thead>
<tr>
<th>Contributing factors of sexual violence:</th>
<th>Intervention</th>
<th>Comparison</th>
<th>NIE</th>
<th>95% CI Lower-upper</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effects of alcohol/illicit drugs</td>
<td>6.7</td>
<td>5.8</td>
<td>0.9</td>
<td>-5 – 6.9</td>
<td>0.75</td>
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<tr>
<td>Effects of pornographic films</td>
<td>12</td>
<td>1.2</td>
<td>10.8</td>
<td>4.4 – 17.1</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Changes in our culture</td>
<td>6.4</td>
<td>2.5</td>
<td>3.9</td>
<td>-2.7 – 10.5</td>
<td>0.23</td>
</tr>
<tr>
<td>Consequences of sexual violence:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health and physical effects</td>
<td>6.5</td>
<td>9.3</td>
<td>-2.8</td>
<td>-7.2 – 1.6</td>
<td>0.20</td>
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<tr>
<td>Mental and psychological effects</td>
<td>9.5</td>
<td>7.5</td>
<td>2</td>
<td>-3.3 – 7.3</td>
<td>0.45</td>
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<tr>
<td>Reproductive health effects</td>
<td>8.5</td>
<td>7</td>
<td>1.5</td>
<td>-3.4 – 6.4</td>
<td>0.54</td>
</tr>
<tr>
<td>Long-term effect on the victim’s develop-</td>
<td>15.9</td>
<td>6.5</td>
<td>9.3</td>
<td>3.9 – 14.7</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>ment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perpetrators of sexual violence:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Close friends</td>
<td>0.5</td>
<td>-13.8</td>
<td>14.2</td>
<td>7.8 – 20.7</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Close relatives</td>
<td>10.4</td>
<td>-4.9</td>
<td>15.3</td>
<td>8.2 – 22.4</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Sexual offence Special Provision Act (SOSPA) for Tanzania:</td>
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<tr>
<td>Number of years of imprisonment for perpetrators</td>
<td>1.4</td>
<td>0.8</td>
<td>0.6</td>
<td>-4.3 – 5.7</td>
<td>0.78</td>
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<td>Expected services at the health facility:</td>
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<tr>
<td>Contraception</td>
<td>45.5</td>
<td>15.7</td>
<td>29.7</td>
<td>23.9 – 35.5</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>HIV/AIDS prophylaxis</td>
<td>38.8</td>
<td>9.3</td>
<td>29.5</td>
<td>23.1 – 35.9</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>STI treatment</td>
<td>35.7</td>
<td>29.5</td>
<td>6.3</td>
<td>-0.4 – 13</td>
<td>0.06</td>
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<tr>
<td>Wound care</td>
<td>2.7</td>
<td>0</td>
<td>2.7</td>
<td>-0.9 – 6.4</td>
<td>0.13</td>
</tr>
<tr>
<td>Psychotherapy</td>
<td>2.7</td>
<td>4.7</td>
<td>-2</td>
<td>-8 – 4</td>
<td>0.50</td>
</tr>
<tr>
<td>Legal verification</td>
<td>4.5</td>
<td>2.5</td>
<td>2.1</td>
<td>-2 – 6.1</td>
<td>0.31</td>
</tr>
<tr>
<td>Composite scores:</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Correct knowledge</td>
<td>23.3</td>
<td>16.4</td>
<td>6.9</td>
<td>0.2 – 13.5</td>
<td>0.03</td>
</tr>
</tbody>
</table>

Abbreviations: CI, confidence interval; NIE, net intervention effect (difference in intervention area from baseline to endline minus difference in comparison area from baseline to endline)
Attitudes towards sexual violence

The proportion of HCWs who exhibited an accepting attitude towards violence declined from 15.3% to 11.2% in the intervention area but increased from 13.2% to 20.0% in the comparison area. Marked decline in accepting attitudes among HCWs was noted in the items that were related to justifying men beating their partners for whatever reason. However, the observed overall changes in the intervention and comparison areas were not statistically significantly with a NIE of -10.9% (95% CI: -27.2–5.5, \( p=0.18 \)).

Likewise, there was a significant reduction in most of the attitude indicators favoring male dominance, justification of men beating their partners, as well as rape myths, among the community members in the intervention area, but not in the comparison area. However, the intervention had no effect in the final assessment when comparing the two areas, NIE of -2.4% (95% CI: -8.4–3.6, \( p=0.42 \)).

Gender analysis on knowledge and attitudes towards sexual violence

Comparing men and women’s knowledge, a significant difference between men and women at baseline (53% vs 64%, \( p <.001 \)) but no significant difference at endline (78% vs 84%, \( p=0.06 \)) in the intervention area was revealed. Women were less knowledgeable on the consequences of sexual violence and the law that convicts the perpetrators; SOSPA. Men, on the other hand, were not aware of the services available at the health facilities.

There was a reduction, although not significantly, in acceptance attitudes, from 28.1% to 21.8% in favor of women. Women were more likely to believe that men were justified in beating their wives for the majority of reasons, and they were also likely to endorse the rape myths, specifically the notion that women or girls are raped because of the way they dress or act.
Discussion

Main results

This thesis provides an understanding of the community’s perceptions, knowledge and attitudes towards rape and CSA, and the effects of training HCWs and providing a community information package. Poverty and gendered norms were described as contributing, both to the occurrence and acceptance of sexual violence. Knowledge and attitudes towards sexual violence differed significantly with demographic factors. Significant improvement in HCWs’ knowledge and clinical practice towards sexual violence after the training program was revealed. The community information package enhanced improvement in the community’s knowledge and reporting of rape cases.

The use of Connell’s relational theory of gender enhanced the illumination of the dynamics of gender and sexual violence. The economic dimension of gender relations was described as contributing to sexual violence at societal, institutional and individual levels. Poverty emerged to be the major constraint in accessing care and meeting the expenses of care and rendered women and children to be the most common victims of sexual violence. Corruption could prevent a woman from accessing justice if the perpetrator had the means to “pay off” the police or local government officials. This finding contributed to the low rate of help-seeking observed among women and children, as also demonstrated in other parts of Tanzania.19,20 Economic power, as seen in a partner’s alcohol abuse and extramarital affairs, was linked to intimate partner violence, including rape, as also observed in other parts of Sub-Saharan Africa.110,111

Knowledge and attitudes towards sexual violence differed significantly by demographic factors. The higher the level of education the more likely the participants were to have good knowledge and a non-accepting attitude towards sexual violence. A high illiteracy rate in this rural community was observed to be a major hindrance to justice. The majority of participants had only completed primary education, and this factor could have contributed to their poor knowledge on sexual violence and accepting attitude towards sexual violence. Evidence suggests that educational reforms can prevent gender-
based violence by empowering women through education, increasing school safety, and by promoting better attitudes and practices among students with regard to women’s human rights.29

Most men tended to be less supportive of gender stereotypes and rape myths than did women. Women who may be potential victims of violence justified it and endorsed the rape myths. This significant difference in men’s and women’s acceptability of violence may be attributed to contextual factors such as women’s disempowerment, low educational and occupational status, poverty and rural residency,112-114 as demonstrated in studies in Zambia and East Africa. After the intervention there was a significant reduction in some indicators of violence acceptance, such as attitudes favoring male dominance, justification of men beating their partners, and rape myths among both men and women. Similar findings have been revealed in the evaluation of the Stepping Stone intervention study.79 Although the overall net effect in the current study was not significant, this indicates a positive shift in perceived social norms, taking into account the short period of the intervention. Additionally, the attitudes reported by men in this study may have been influenced by the Champion project, which focuses on involving men as partners in addressing gender roles.80

Research has consistently found that the training of health professionals on violence against women improves awareness and increases the detection of survivors,74,75,115,116 although evaluation designs and differences in length, content and settings have hindered clear comparisons between training programs. The availability of support services enabled the survivors to address their short- and long-term health needs. The training program appeared to increase knowledge on sexual violence management. This is in line with other training interventions which report significant improvements in immediate post-training measures as well as at 6–10-month follow-ups.117-119 There was a trend towards a reduction of accepting attitudes among HCWs, though insignificantly. Attitudinal changes after training often end up with inconclusive results partly because they require a long intervention and follow-up period and the lack of validated scales. Salmon et al.’s evaluation of a midwifery routine enquiry program on domestic violence found significant lasting increments in favorable attitudes still remaining at 6 months or later,120 while other studies have found no significant changes immediately after training or at 6-month follow-ups.121

Changes in HCWs’ practices were enhanced by a supportive environment, which included factors such as access to guidelines or protocols as well as adequate material resources. Existing literature has focused more on whether women should be ‘screened’ for violence, and the impact of an intervention on the number of cases detected.122-124 The majority of studies found that
health providers who received training were more likely to enquire about domestic abuse compared to pre-training conditions,74,75,125-129 or to control groups with no training.118,121 In the current study, the number of rape cases that were reported to the community leaders and later referred to the health facilities in the same study area increased by more than 50% after the community intervention as noted in the rape registries.

The intervention effects on the community not only increased the awareness of the health consequences of sexual violence and services available in the health facilities, but there were also some indications that the social acceptability of violence against women norms was reduced. Significant positive effects of the intervention were noted on the knowledge of health consequences and the treatments available at the health facilities, with no differential effect found for gender. However, during the study period, similar improvements were also noted in the comparison area. Although the comparison area was not exposed directly to the intervention, a possible contamination could have occurred due to exogenous factors or greater mobility of people across the region. Nonetheless, increased knowledge in the community relating to sexual violence was not sufficient enough to increase the reporting of rape events to the health facilities in the comparison area. On the other hand, in the intervention area, where the healthcare workers received training and were provided with material resources and guidelines, thus assuring adequate medical services for survivors, there was an increase in the number of rape survivors who reported and sought care at the health facilities. The fact that all reported rape cases were under 18 years of age confirms what was previously found in a qualitative study that for an adult survivor, besides financial, structural and infrastructural barriers, social barriers play an important role in care-seeking.18-20,130 Therefore, it is important for any health development program that responds to sexual and GBV to incorporate approaches to tackle social barriers that hinder care-seeking and justice to survivors.

The intervention used a gender-neutral approach, but differential effects of intervention on gender were demonstrated. There was a reduction of violence acceptance attitudes with significant difference found between men and women, unlike in previous studies which did not show any differential effect of gender using the same approach.131 Nevertheless, gender analysis based on the participants’ gender in surveys does not reflect the complexities between violence and gender. A power imbalance in a context where gender norms support male dominance in families facilitates violence against women.92 The SASA! Study observed change at the community level by engaging with both men and women at all levels, and by explicitly focusing on power rather than gender,77 but this requires sustained effort and a commitment to a human rights perspective.
Overall, in this rural context, given the closed and tight community networks, it is unlikely for rape survivors to report or seek care due to fear of community and family reactions.\textsuperscript{18-20,132-134} Poverty is characterized by poor access to education and health services, and this might contribute to the normalization of gender roles in which legitimacy for GBV is increased. Focused interventions directed on educating the community, training HCWs and coordinating service systems, and changing norms and attitudes to be supportive of rape survivors may be the way forward. In order to achieve the sustainability of improvements generated by the training and community information package, regular training workshops should be offered to health professionals and adequate medical services for survivors should be available. Qualitative research is needed to explore what the survivors want from the interventions and what outcomes they find beneficial, and to obtain measures of their physical and psychological well-being.

Methodological consideration

This thesis employed both qualitative and quantitative research methods. The overall design of the project was to begin with an exploratory study to establish the community’s perceptions towards sexual violence and their perceived recommendations to address such issue. The basis for choosing this research paradigm was to gain an insiders’ viewpoint, a unique feature in qualitative research. Although such perceptions were previously reported in an urban setting,\textsuperscript{18-20,132-133} such perceptions could be socio-culturally influenced even within the same country.\textsuperscript{135} In this first step, the identified barriers or challenges to care-seeking were then used to make contextually meaningful interpretations in the subsequent studies. The two approaches complimented each other and enriched the interpretations of the research findings.

Strengths

Qualitative data

The use of FGDs may have given an overly positive view of the community’s perceptions towards rape and child sexual abuse. Variation in experience was enhanced by having a diverse and representative sample of participants. Our interpretation is that the discussions were free and reflected an increasing awareness about the seriousness of sexual and gender-based violence.
Trustworthiness in qualitative research can be measured through four criteria which include credibility, transferability, dependability and conformability.\textsuperscript{98} The use of a checklist to enhance trustworthiness is considered an important step that confers respectability to qualitative research.\textsuperscript{136}

Credibility refers to how well the data have captured the research question. Credibility of the qualitative study was enhanced and reflected in the details provided in the purposive selection of participants and in the data collection and analysis, and through citing quotations from the data. These details allow assessment of the appropriateness of the study design, research methodologies and quality of the findings. Prolonged engagement (over a period of one year) in the field by the researcher helped to familiarize her with the setting and community members. All fieldwork logistics, including the recruitment of FGD participants, was the responsibility of the researcher. The research team consisted of insiders to the Tanzanian context, and outsiders based in Sweden. Continuous peer-debriefing sessions within the research team and checks with some community members and health professionals further increased the validity of the data and its analysis.

Transferability refers to the extent to which research findings can be transferred to other settings or groups.\textsuperscript{136,137} The study is context-based and cannot be directly transferred to other settings. Hence, efforts were made to provide detailed descriptions of participants and context, process of data collection and analysis to facilitate the reader’s judgment of the interpretations and thus the transferability of the results to other context.

Dependability refers to the ability of the researcher to assess changes in the research process over time. The use of a flexible topic guide and the same moderator for all FGDs allowed for consistency in focusing discussions while at the same time being open to new insights while probing.

The qualitative approach involved the researcher as an instrument which has implications in the data collection and analysis. A flexible guide, emergent design, verbatim transcription and following a structured analytical procedure all aimed to promote the conformability of the study results. This strategy serves to assure readers that our findings are grounded in data and not as a result of our pre-understanding.
Quantitative data

The use of a quasi-experimental study design for Papers III and IV that included a comparison area and two time period assessments (pre- and post-intervention) to estimate the intervention’s true effect is what we considered an important strength. The cross-sectional design also suited our objective to measure the impact of a community- rather than individual-level intervention.

External validity

The findings from Papers II, III, and IV are of general interest, as violence against women and children is widespread and causes health consequences for the survivors. Papers II and IV were population-based studies and efforts ensured that the samples were representative for the population studied. The study areas manifested the typical characteristics of rural Tanzania. The intervention and comparison areas were similar despite the huge geographical buffer. The communities matched, especially in their education level and radio ownership, which would have implications on the reliability of the results relating to knowledge.

The study was conducted in rural settings; although we do not know how representative the findings are in an urban setting, research shows that rural service providers have poorer access to relevant training and report a lack of adequate resources within their locality.\textsuperscript{138} Staff training and on-site integration of services for survivors may have resulted in a better coverage than interventions implemented at tertiary level, as primary and secondary level facilities are closer to the community.

The findings, in general, were consistent between the ethnically and culturally different study populations in Tanzania and thus increased external validity.

Internal validity and reliability

Although the nature of this topic was sensitive, several features are likely to have increased the validity of such reporting, including the training of interviewers on how to introduce the study and build rapport with respondents, the close interaction between interviewers and respondents, and efforts undertaken to ensure the privacy and confidentiality of responses. Validated instruments\textsuperscript{23,100,102} were used with minor modifications to adapt the questions to the cultural context. All questionnaires were pre-tested in pilot studies in the study areas.
Most studies have measured attitudes to rape by the acceptance of rape myths, societal gender stereotypes and interpersonal violence. Our measure of attitudes towards rape and acceptability of violence using validated cross-cultural scales ensured that findings are comparable with other studies because such interpretations of rape have been demonstrated to relate to acceptance of gender stereotypes and rape myths.

To minimize selection bias and provide a random sample representative for the population, a multistage sampling technique was used. Response rates were maximized: at least three repeat visits were made to households where respondents were not available at the time of the first visit. Confounders in the statistical analysis were accounted for by multivariate modelling (Paper II).

Limitations

Qualitative data

Because the topic was sensitive in nature, group discussions are unlikely to allow the expression of viewpoints that counter the dominant public norms, and so we suggest that individual interviews or gender-homogenous FGDs could provide a space in which more pluralistic views can emerge. Having conducted mixed-gender group discussions, it was difficult to analyze the participants’ responses in view of gender differences. Perhaps it would have been easier for women to argue that rape should be recognized within marriage if the groups were structured by gender. Future studies should take this into account to allow gender analysis.

Quantitative data

A direct measure of attitude for both community and HCWs survey was taken with a shortened Likert scale due to the participants failing to respond in Swahili using a wider Likert scale. Furthermore, dichotomization of the attitude scores might have affected the strengths of the attitudes expressed.

The higher number of doctors in the intervention than in the comparison area could be attributed to the geographical location of the Ulanga district, which is more remote, where doctors would be less likely to want to go and work. This limitation may have resulted in an overestimation of knowledge and good practice among healthcare workers in those localities. The HCWs’ practices were examined by the use of self-reported rape registry books, as
direct observations were not feasible due to the large geographical distribution of HCWs and poor road conditions.

The study design was unable to determine the route that increased rape reporting: knowledge increased in both groups, but the intervention did not significantly change attitudes. Was the increased rape reporting due to increased knowledge or changed attitudes in healthcare providers? Or to other contextual factors influencing the behavior of the intervention group not related to the intervention? It is therefore difficult to attribute the increase in rape reports purely to the intervention. Further research is needed to understand the promising results of this intervention before the program can be replicated in other settings.
Conclusions

Several conclusions emerged from this thesis:

- The study sheds light on the contextualized norms, especially related to the acceptability of wife beating, masculinity and gender relations that influence and reinforce sexual violence against women and children. Prominent socio-cultural and structural barriers were identified, such as fear of blame and shame for rape disclosure, and an insufficient, costly and corrupt support service, each of which frequently serve as obstacles to both seeking and receiving care for sexual violence survivors.

- The highest levels of sexual violence acceptance attitudes were found among women. This finding highlights the challenges associated with changing attitudes towards sexual violence, considering that most survivors of sexual violence are women or girls. Increasing age and higher education were associated with better knowledge and less accepting attitudes towards sexual violence.

- The study has shown promising results by including multiple components and intervening at different levels. The study interventions in the community and among HCWs were able to change knowledge and practice but were not as effective for changing attitudes.
Implication and Recommendations

The study findings have potentially important implications for interventions aimed at preventing and responding to violence. The existence of broader societal norms and traditions that hinder rape disclosure must be re-addressed, especially when formal networks rely on increased reporting of rape events.

The training of HCWs has generated significant improvement; however, the sustainability of this training in the long run is a common challenge because of the high staff turnover. Moreover, a number of interventions have shown significant changes in attitudes among communities and HCWs. There is a need for a longer follow-up period to determine the long-term and fade-out effects and to identify changes in attitudes and how they translate into behavioral changes.

The study showed that the community information package, through radio programs, IEC materials and at meetings with local leaders, enhanced the improvement of knowledge and attitudes towards sexual violence. This finding informs the public health practitioners of the importance of promoting wider community involvement that engages both men and women and implementing combined strategies in achieving change.

In order to see long-term promise while acknowledging the ecological scope of the issue, below are recommendations for prioritizing sexual and GBV in health development models and integrating sexual and GBV response in health services:

National/Policy Level

- At the macro level, legislative reforms, as well as broad investment in strengthening the law enforcement response to GBV, are needed to make the laws work more effectively.

- There is a need to review the SOSPA and the marital law to enhance full protection of children.
• Incorporating education programs in schools and universities that focus on violence against women and children, and also channeling them through appropriate social institution and gatekeepers to suit the particular context, might be an effective strategy for changing attitudes about rape and rape victims and promoting a better response to rape survivors.

• To address the challenge of high staff turnover, the relevant ministries should develop a pre-service curriculum that would facilitate the training of all those who graduate through different programs.

Institutional level

• Broad institutional reform to improve healthcare response to GBV is critically important. For example, support for the training of HCWs, protocols, alliances with referral services, and ensuring adequate supplies for caring rape survivors, promise to be an effective approach.

• Facilitate the coordination of first and secondary responders to sexual violence, including medical professionals, police, criminal justice workers, and others through the establishment of local task forces or groups, modeled after SART (Sexual Assault Response Team).

• Multi-sector collaboration is important for most GBV initiatives, especially those that aim to improve women’s lives through social services, economic empowerment and infrastructure improvement. There is a need to create partnerships between government and non-governmental agencies, as both have a role to play and are unlikely to change the levels of violence by working alone.

Community/Individual level

• Community-based campaigns and mass media “entertainment-education” programs, such as soap operas that address GBV, as well as economic empowerment interventions, can aid in reducing the occurrence of and tolerance for violence against women and girls.

It is important therefore for any health development program that wishes to successfully respond to sexual violence to incorporate approaches to gender
equity, universal prevention, and criminal justice for survivors in addition to comprehensive and integrative health services and care.


Kutokana kwamba unyanyasaji wa kijinsia unaambatana na madhara mengi ya kiafya kama vile, kupata majeraha, magonjwa ya zinaa pamoja na ukimwi, matatizo kwenyewe mfumo wa uzazi, ulemavu na hata kifo, ni vyema jamii kuelewa ipasavyo madhara hayo ili kuwahisanya kufanya na kupata tiba au kinga muda muafaka. Wahudumu wa afya wanakutana na wahanga wa unyanyasaji wa kijinsia kila siku hivyo wana nafasi nzuri ya kuweza kugundua unyanyasaji wa kijinsia na kutoa kinga au tiba sahihi ili kuzuia madhara yatokanayo na unyanyasaji huo.
Kitabu hiki cha shahada ya uzamifu kinatoa muhtasari wa utafiti ambao ulifanyika wilaya ya Kilombero mkoa wa Morogoro. Miongoni mwa mbinu zilizotumika katika utafiti huo ni kuelimisha jamii juu ya unyanyasaji wa kijinsia na madhara yake kupitia redio, vipeperushi na, mikutano na viongozi wa vijiji na dini. Vilevile, ilitoa mafunzo kwa wahudumu wa afya jinsi ya kuwahudumia wahanga wa unyanyasaji wa kijinsia pamoja na kutoa ushauri wa kisaikolojia. Vituo vya afya vilipatiwa dawa kwa ajili ya tiba au kinga ya madhara yatokanayo na unyanyasaji wa kingono, pamoja na vifaa vya kukusanya vinasaba kwa ajili ya ushahidi mahakamani.

Baada ya uelimishaji huo kwa jamii na wahudumu wa afya juu ya unyanyasaji wa kijinsia na kingono, ulewawa wa jamii umaonekana kuongezea juu ya madhara yatokanayo na unyanyasaji huo. Wahudumu wa afya umaonekana kuja jamii sasa na utafiti uliokoa mafunzo kwa wahudumu wa afya jinsi ya kuwahudumia wahanga wa unyanyasaji na kingono. Wahudumu wa afya umaonekana kuja jamii sasa na utafiti uliokoa mafunzo kwa wahudumu wa afya jinsi ya kuwahudumia wahanga wa unyanyasaji na kingono. Kesi za ubakaji zilizofuata huduma katika vituo vya afya ziliongezeka, hii inaonyesha uwezo wa jamii uwezo wa unyanyasaji na kingono. Pamoja na mafanikio haya, jamii bado umaonekana kung’ang’ania mila potofu na kanuni zinazosozia mwanamke. Hivyo basi kuna haja ya kubuni mbinu mbadala ya kuweza kukabili na mila na desturi potofu zinazozua usawa katika jamii. Juhudi za pamoja katika kutokomeza unyanyasaji wa kijinsia zinahitajika ili kuwa na mazingira salama kwa wanawake na watoto nechini Tanzania.
Våld mot kvinnor är utbrett över hela världen och ger uttalade negativa hälsokonsekvenser för de drabbade. Världshälsoorganisationen WHO beräknar att 35% av världens kvinnor under sin livstid har utsatts för fysiskt eller sexuellt våld. Övergrepp mot kvinnor tar sig olika former, fysiskt, sexuellt och psykologiskt våld.

I Tanzania utgör sexuellt våld mot kvinnor och barn ett alvarligt häls- och människorättsproblem. Enligt nationell statistik från 2011 anges att 20 % av kvinnor i Tanzania under sin livstid har utsatts för sexuellt våld. Senare statistik visar att av barn under 18 år har 28% av flickorna och 13 % av pojkar blivit utsatta för sexuellt våld.

Avhandlingens syfte var att utvärdera effekten av ett informationsprogram riktat ut i samhället samt utbildning av sjukvårdspersonal för att de skall kunna ge korrekt vård och omhändertagande av de våldsutsatta. Studien har utförts i ett ruralt område Morogoro bestående av två distrikt, Kilombera och Ulanga i Tanzania.

Studie I var en explorativ studie där vi ville få en bild av hur samhällsinnevånarna uppfattade sexuellt våld, och vilka de ansåg var de tänkbara orsakerna samt vilka åtgärder de föreslog för att minska våldet. Sex fokusgruppdiskussioner genomfördes med både manliga och kvinnliga deltagare, representerande olika yrkes- och samhällsgrupper.

I Studie II tillfrågades innevånare(totalt1568) i ett interventionsdistrikt, Kilombero samt i ett kontrolldistrikt, Ulanga om kunskap om och attityd gentemot sexuellt våld.

I Studie III utvärderades ett utbildningsprogram för sjukvårdspersonal genomfört i interventionsdistriktet. I utbildningen ingick hur våldsdrabbade skall vårdas, vilka prover som skall tas, hur bevismaterial skall säkras, hur landets lagar kring våld ser ut samt hälsoeffekter för de drabbade och attitydfrågor. Ett frågeformulär distribuerades före utbildningen samt åtta månader efter utbildningens slut till sjukvårdspersonal i interventionsdistriktet samt i kontrolldistriktet. I Studie IV utvärderades effekten av ett informationsprogram bland innevånarna i interventionsdistriktet och jämfördes
med kontrolldistriktet med avseende på kunskap och attityd i frågor rörande sexuellt våld. Interventionen bestod av radioprogram som sändes regelbundet under 8 månader över en lokalradiostation, information till lokala ledare samt religiösa ledare samt distribution av pamfletter och posters, allt för att öka kunskapen om sexuellt våld i samhället.

Resultaten visade att sexuellt våld var vanligt förekommande och ett dolt problem i samhället. De flesta drabbade sökte sällan sjukvård eller legala instanser utan problemet löstes lokalt av förtroendevalda medborgare. En mängd faktorer ansågs bidra till den, som man ansåg, ökade förekomsten av våld nämligen fattigdom, uppluckring av det traditionella normsystemet, svagt föraldraskap, alkohol och droganvändning samt inflytande från västerländska medier.


Sammanfattning Interventionen visar att utbildning av sjukvårdspersonal samt ett omfattande upplysningsprogram riktat till samhällsmedborgarna vad gäller frågor kring sexuellt våld ökar kunskapsläget och förbättrar omhändertagandet av de våldsdrabbade.

Attitydförändringar i relation till sexuellt våld kunde på denna korta tid inte påverkas mer än marginellt.

Avhandlingen påvisar även de socio-kulturella och strukturella normer som accepterar våld mot kvinnor, samt de strikta genderrollerna som påverkar och förstärker våld mot kvinnor och barn.

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