LESSONS FROM THE GENDER-BASED VIOLENCE INITIATIVE IN TANZANIA

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ACRONYMS

CDC	U.S. Centers for Disease Control and Prevention
DOD	Department of Defense
GBV	gender-based violence
GBVI	Gender-based Violence Initiative
HMIS	health management information system
M&E	monitoring and evaluation
MCDGC	Ministry of Community Development, Gender and Children
MER	monitoring, evaluation, and reporting [PEPFAR]
MOHA	Ministry of Home Affairs
MOHSW	Ministry of Health and Social Welfare
NGO	nongovernmental organization
OCGS	Office of the Chief Government Statistician
PEP	post-exposure prophylaxis
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PF3	Police Form Number 3
SASA!	Start, Awareness, Support, Action
TACAIDS	Tanzania Commission on AIDS
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VAC	violence against children
WHO	World Health Organization
ZAC	Zanzibar AIDS Commission

INTRODUCTION

In 2011, the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) launched the $55 million, three-year, interagency Gender-based Violence Initiative (GBVI) in the Democratic Republic of Congo, Mozambique, and Tanzania. The GBVI aimed to integrate gender-based violence (GBV) prevention and response into the existing HIV prevention, care, and treatment programs at health facility, community, and policy levels. See Box 1 for a definition of GBV.

The GBVI focused on multiplying the effects of PEPFAR investments to integrate GBV prevention and response into existing HIV programs. This included developing national guidelines, strengthening coordination across sectors, and building the capacity of and linkages between clinic- and community-based services in GBV prevention, as well as response, within the context of the existing HIV prevention, care, and treatment.

There are important lessons to learn about the potential for synergy created by various models for GBV prevention and response interventions, such as addressing GBV prevention and response simultaneously; taking a selected set of approaches or a multicomponent GBV program model across the PEPFAR platform of services; and building linkages between facility-, and community-based GBV interventions. The PEPFAR Gender and Adolescent Girls Technical Working Group asked AIDSFree to conduct a review of the GBVI in all three countries to inform programming, specifically the integration of GBV prevention and response into the context of the HIV cascade of services. These lessons, in turn, can inform PEPFAR and other donor initiatives in designing future investments in GBV prevention and response.

In Tanzania, the AIDSFree team reviewed 65 documents and gathered information in Dar es Salaam and Iringa regions from more than 50 global and in-country stakeholders (implementing partners, community-based and nongovernmental organizations [NGOs], government officials, U.S. Government agencies, United Nations organizations, and Tanzanian service providers) through semi-structured interviews, focus group discussions, and a two-week country visit.

This report describes lessons learned from the GBVI in Tanzania.

GBV and HIV Prevalence in Tanzania

Tanzania, despite its economic progress as a country, continues to be marred by health disparities that particularly affect women and girls. In the most recent HIV and Malaria Indicator Survey (2011–2012), 5.1 percent of Tanzanians age 15–49 were HIV positive. HIV prevalence in Tanzania is almost twice as high in women (6.2 percent) as among men (3.8 percent) (Tanzania Commission for AIDS et al. 2013). The 2010 Tanzania Demographic and Health Survey found that 44 percent of ever-married women had experienced physical and/or sexual violence from a partner, and 37 percent of ever-married women had experienced spousal violence in the prior 12 months (National Bureau of Statistics et al. 2013). Linkages between intimate partner violence

and higher risks of HIV infection are well documented in the literature and are seen throughout Tanzania's HIV and GBV crisis (World Health Organization [WHO] and Joint United Nations Programme on HIV/AIDS [UNAIDS] 2013).

Tanzania also has among the highest prevalence of child marriage in the world. On average, four of every ten girls will be married before their eighteenth birthdays (National Bureau of Statistics Tanzania and ICF Macro 2011). Tanzania has a Law of Marriage Act that allows girls to marry at 15, significantly impeding reduction of the practice. In addition, a 2009 Violence against Children (VAC) Survey found that almost three of 10 females and one of seven males had experienced sexual violence before the age of 18. It also found that nearly three-quarters of females and males had experienced physical violence by an adult or intimate partner by age 18 (United Nations Children's Fund [UNICEF] et al. 2011). The survey also reported links between violence and HIV and found that those who had experienced sexual violence before the age of 18 also engaged in behavioral practices that increased HIV risk, including having multiple partners, using condoms less frequently, and being more engaged in sexual exploitation or prostitution.

Box 1. United States Government Definition of GBV

Violence that is directed at an individual based on biological sex, gender identity, or perceived adherence to socially defined norms of masculinity and femininity. It includes physical, sexual, and psychological abuse; threats; coercion; arbitrary deprivation of liberty; and economic deprivation, whether occurring in public or private life.

Gender-based violence takes on many forms and can occur throughout the life cycle. Types of gender-based violence can include female infanticide; child sexual abuse; sex trafficking and forced labor; sexual coercion and abuse; neglect; domestic violence; elder abuse; and harmful traditional practices such as early and forced marriage, "honor" killings, and female genital mutilation/cutting.

Women and girls are the most at risk and most affected by gender-based violence. Consequently, the terms "violence against women" and "gender-based violence" are often used interchangeably. However, boys and men can also experience gender-based violence, as can sexual and gender minorities. Regardless of the target, gender-based violence is rooted in structural inequalities between men and women and is characterized by the use and abuse of physical, emotional, or financial power and control.

(U.S. Government 2012)

OVERVIEW

Box 2. GBVI Tanzania Five Strategic Pillars

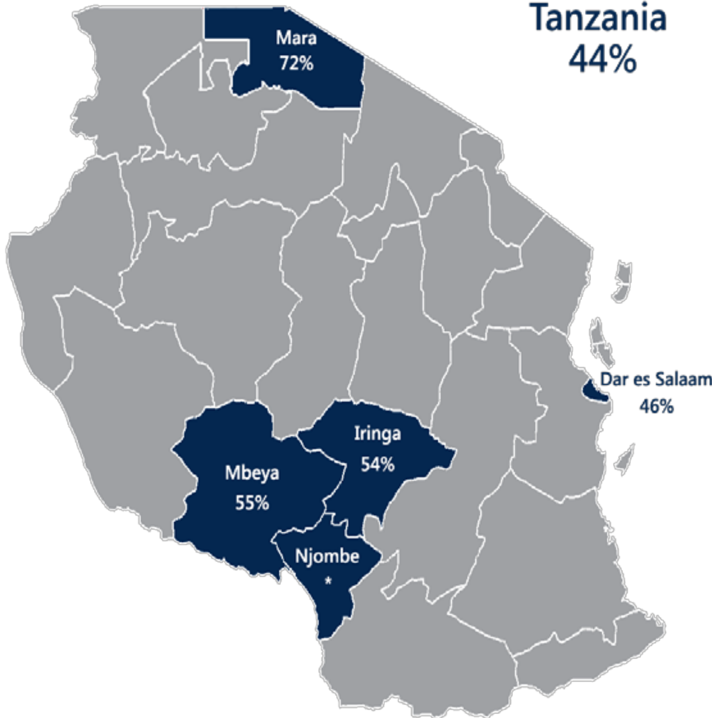
1. Services
2. Prevention and Community Protection
3. Enabling/Policy Environment
4. Coordination
5. Research and Evaluation

The overall goal of the GBVI was to reduce HIV transmission and barriers to HIV services directly and indirectly attributable to GBV. The immediate goal was to reduce and respond to GBV in Tanzania by leveraging the PEPFAR platform through five pillars presented in Box 2.

The GBVI in Tanzania

In Tanzania, the $24 million, three-year GBVI aimed to prevent and reduce GBV prevalence by addressing the sociocultural norms that condone it and by offering comprehensive post-GBV care services for survivors. GBVI funding was divided into two parts. For the first part, PEPFAR allocated $21 million to three U.S. Government agencies—the U.S. Agency for International Development (USAID), the Centers for Disease Control and Prevention (CDC), and the Department of Defense (DOD)—to implement GBV activities focused on the five key pillars listed in Box 2, implemented by 19 partners listed in Annex 1. For the second part, separate from this primary funding, PEPFAR allocated an additional $3 million to evaluate the GBVI program in Mbeya region. This evaluation, named Tathmini ("evaluation" in Swahili) GBV, was conducted to inform scale-up of GBV programs and services in Mbeya and throughout Tanzania.

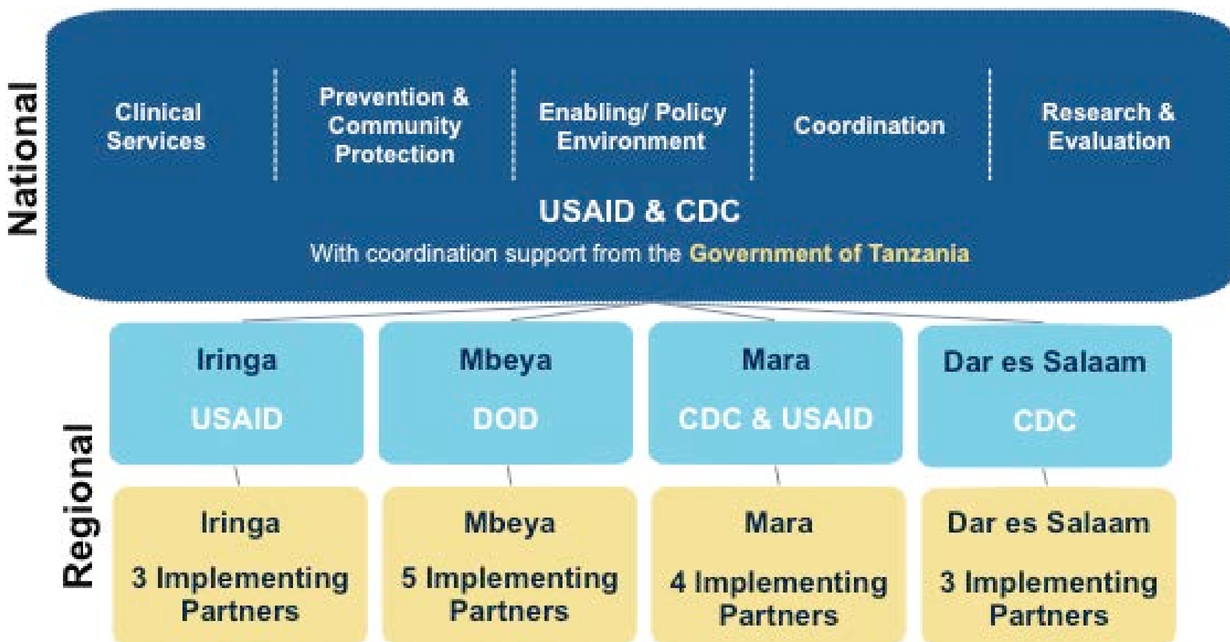
Figure 1. GBVI Regions of Tanzania with GBV Prevalence



Tanzania is an expansive country, and rather than focusing on a broad, national scale, the GBVI focused on four geographic areas with some of the nation's highest rates of GBV (Demographic Health Survey 2010) illustrated in Figure 1. The four

regions—Dar es Salaam, Iringa/Njombe,[1] Mara, and Mbeya—were chosen based on reported GBV prevalence among women and girls, U.S. Government presence, and current U.S. Government HIV activities that could be expanded to include GBV prevention and response. As presented in Figure 2, to ensure coordination and avoid duplication of efforts, the GBVI in Tanzania aligned with the existing PEPFAR structure, which designated different U.S. Government agencies to lead the majority of work in specific regions, by having U.S. Government agency leads in each of the four regions. At the national level, USAID and CDC coordinated with the Government of Tanzania to manage, plan, and implement activities across the five pillars of the GBVI. At the regional level, Iringa/Njombe was managed by USAID, Mbeya by the DOD, Dar es Salaam by CDC, and Mara by CDC and USAID. The agencies in charge of those regions coordinated with clinical and community Implementing partners within their regions, and reported back to the national level any successes or challenges occurring in their regions.

Figure 2. GBVI Tanzania Structure[2]

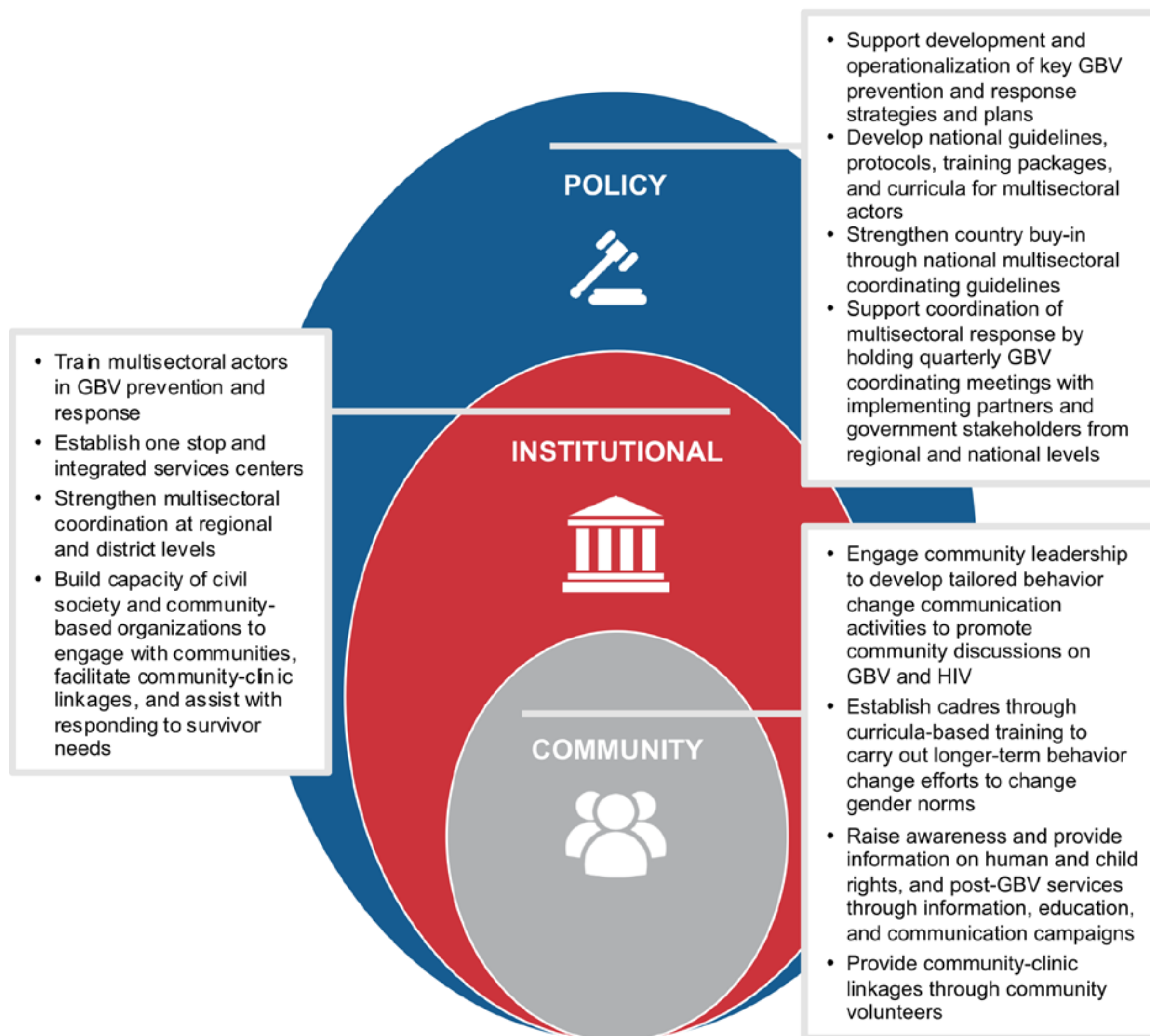


[1] Iringa and Njombe were one region when the GBVI started. Therefore, the GBVI focused on Iringa (which included Njombe). Halfway through the initiative, the region separated into two. The latest Demographic Health Survey data are only for Iringa/Njombe, as one single region.

[2] Implementing partners listed in Figure 2 represent the number of implementing partners working in each region. Some of these implementing partners operate in more than one region and are represented twice. This list does not include implementing partners operating at national level. For a full list of implementing partners operating in the country, see Annex 1.

The GBVI in Tanzania integrated GBV prevention and response into HIV programs by using a multisectoral, multilevel approach that involved health and social services, and legal and law enforcement at community, institutional/facility, and policy levels. Figure 3 uses the socioecological model to illustrate the major GBVI activities in Tanzania and the interdependent relationship between the three levels. Every level in which the GBVI operated was closely connected and influenced by the levels above and below it. Each activity required the engagement of the different sectors and staff at all levels.

Figure 3. GBVI Multisectoral Approach to GBV Prevention and Response



The outermost level shows the legal and policy environment that guided the multisectoral GBV prevention and response activities conducted at the lower institutional levels. The GBVI supported the Government of Tanzania by working with the Ministry of Health and Social Welfare (MOHSW), Ministry of Community Development, Gender and Children (MCDGC),[3] Ministry of Home Affairs (MOHA), Tanzania Commission on AIDS (TACAIDS; under the Prime Minister's Office), and local government authorities to lead the GBVI response. Later, the Ministry of Justice was engaged to a more limited extent. Prior to the GBVI, there were no guidelines or frameworks for the national GBV response, which was identified as a major constraint to moving GBV programming forward in the country (Fleischman 2012). The GBVI supported the government to create and disseminate numerous policy guidelines, strategic planning tools and training materials, and service delivery tools for GBV prevention and response. These national guidelines and tools led the way in ensuring standardization and quality assurance in GBV training, service provision, and response at the regional level.

The GBVI also supported the MOHSW, MOHA, TACAIDS, and MCDCG to develop GBV prevention and response pre-service curricula and modules, and conduct mass media campaigns and broader GBV and HIV awareness-raising efforts at all levels.

At the institutional level, the GBVI supported activities to integrate GBV prevention and response within the existing HIV clinical services, build clinical and medico-legal capacity to deliver GBV services, and establish comprehensive post-GBV care services. A main activity was capacity building of clinical and non-clinical providers at health facilities, police at Gender and Children Desks, social welfare officers in all regions, and some lab technicians to integrate GBV prevention and response into their work. In alignment with MOHSW priorities and following national guidelines approval, one-stop centers and drop-in centers for GBV survivors were established in two regions (Iringa and Mbeya), and local government authorities were trained on quality assurance and supportive supervision.

The GBVI supported community-level prevention activities by building on existing HIV prevention interventions and using existing community groups. The GBVI used participatory and gender-transformative approaches to increase community awareness and reduce social acceptance of GBV and VAC. Community partners worked through local radio spots, community leaders, and peer-to-peer education. Activities included creating and disseminating information, education, and communication materials; using social and behavior change trainings; community engagement; and community–clinic linking activities.

[3] After data collection, the Ministry of Health and Social Welfare and the Ministry of Community Development, Gender and Children (MCDGC) combined into the Ministry of Health, Community Development, Gender, Elderly and Children (MOHCDGEC).

The Government of Tanzania's Response to GBV

The Government of Tanzania has been a leader in gender equality in East Africa and continues to increase its commitment to ending GBV. Tanzania achieved the Millennium Development Goal 3 indicator that focused on gender equality and women's empowerment, and has policies and strategies to promote gender equality, and women's empowerment and to reduce GBV. Freedom from GBV is part of the Tanzania Development Vision 2025, which has broad objectives of creating a strong economy and quality of life. This vision is operationalized through the National Strategy for Growth and Reduction of Poverty–II (2010–2014), also known by its acronym in Kiswahili, MKUKUTA. This incorporates a framework of indicators, targets, and strategies for child protection, gender equality, and women's empowerment as key to sustainable development (Economic Commission for Africa 2012).

Although the government has recently focused on policies and strategies to fight GBV and VAC, prior to the GBVI there were no laws specifically addressing these issues. The Penal Code, Cap. 16 (1945), contained provisions prohibiting different types of violence including "cruelty to children," but those provisions were vague, overarching, and unknown to most service providers. Prior to 1998, when the government added the amendment of the Sexual Offences Special Provisions Act that incorporated crimes of sexual offenses into the law, GBV had not been defined and outlined in the country. The Sexual Offences Special Provisions Act provides a stiff punishment, 30 years, for perpetrators of rape, and the right of compensation to for GBV victims. However, a review in 2012 showed the law had not been reviewed in more than a decade and that prosecution had been limited (Kipobata 2012). In 2011, the government passed the Female Genital Mutilation Act aimed at protecting women and girls from GBV. This 2011 law has helped reduce female genital mutilation nationally however some regions continue to have high prevalence rates. A 2012 review reported prevalence rates over 50 percent in Arusha, Dodoma, Manyara, and Mara (Kipobata 2012). Implementation of both laws has been constrained by cultural norms encouraging limited reporting by GBV survivors; weak linkages among the police, health facilities, and judicial system; lack of funding to promote the trickle down from the national policy to the courts; and limited forensic capabilities at all levels of the system. The government also enacted the Law of Marriage Act, which mandates equality in marriage. However, marital rape as a form of GBV is not included within this law and is still legal in Tanzania. This act also allows a girl to be married at the age of 15 (or 14 with special permission), while the permissible marriage age for a boy is 18. Reforming the Law of Marriage Act is a priority for many GBV advocates in Tanzania, as marital rape is still seen as a "family problem" among many Tanzanians and is just beginning to be discussed at the highest level of government.

GBVI SUCCESSES AND CONTRIBUTIONS

National/Policy-level Contributions

"We didn't have the committee and now we do, we didn't have the gender desks at police stations and now we do, we didn't have much documentation and tools, but now we have a lot of tools on GBV." (National government)

"Initially these guidelines were not there, the trainings were not there. Seeing these different units and different stakeholders working together, it was a good thing." (U.S. Government agency)

"It [GBV] was starting over with a whole new health area. It has a whole new infrastructure. For HIV, malaria, maternal and newborn health, they have been there for years, but GBV was a whole new health area to be addressed." (U.S. Government agency)

The GBVI engaged and supported the Government of Tanzania from the beginning of the initiative to lead the development of a national GBV platform. Prior to the GBVI, the Government of Tanzania had limited national-level policy and guidelines for implementation of GBV activities. During this time, activities implemented occurred with limited coordination among partners, mostly multilateral agencies such as the United Nations Population Fund, UN Women, and UNICEF. When the GBVI began, one of its first priorities was to support the MOHSW to work with the MCDGC, TACAIDS, and MOHA to integrate GBV into national policies, guidelines, tools, and curricula.

Two of the most significant achievements supported by the GBVI were supporting the MOHSW and MCDGC in the creation and dissemination of the National Policy Guideline for Health Sector Prevention and Response of GBV and the National Management Guidelines for Prevention and Response to GBV (Box 3).

These guidance documents have ensured integration and operationalization of GBV services into the health facility, targeting HIV service delivery points while engaging social welfare and police officers. The GBVI also worked with the MOHSW to integrate GBV into pre-service curricula for clinicians and nurses, ensuring that GBV training was mainstreamed into every level of the health sector.

Box 3. National Guidelines

National Policy Guideline for Prevention and Response to GBV

The Policy Guideline provides a framework for the delivery of health services to all in need, including GBV survivors. The objectives of the Policy Guideline are to strengthen efforts of the MOHSW to prevent and respond to GBV and to direct the health sector to establish effective linkages with the community and multisectoral actors. It outlines the roles and responsibilities of the MOHSW and key partners in the provision of quality services to GBV survivors by integrating them into the existing national health delivery infrastructure—guided by principles of respect for human rights, professional ethics, and compassion. This Guideline was instrumental to the development of the National Management Guidelines for the Health Sector Prevention and Response to GBV.

National Management Guidelines for the Health Sector Prevention and Response to GBV

The National Management Guidelines for the Health Sector Prevention and Response to GBV are based on the National Policy Guideline for Prevention and Response to GBV. The guidelines provide a framework for medical management, referral for psychosocial care, advice for integrating GBV services into existing health services, linkage between health facilities and local communities, and support and linkages to social and legal protection systems. The guidelines also provide guidance on GBV monitoring and evaluation and quality assurance; consent and GBV medical forms; Police Form Three (PF3); GBV Register; laboratory investigation for GBV and preventive treatments; and GBV indicators.

The GBVI supported the MCDGC to create a One-Year Plan from Commitments to Action in June 2012–2013 that led to the formation of a National Multi-Sector Task Force to address VAC. The task force was led by UNICEF as secretariat, with support from the GBVI, and helped engage local governments and NGOs across key sectors: police, justice, education, health and social welfare, HIV. In addition, the GBVI supported the MCDGC to draft and disseminate the multisectoral GBV coordination guidelines that lay the groundwork for sustained coordination of GBV partners across ministries after GBVI funding ends. The GBVI also supported the MOHA to establish Gender and Children Desks, and standard operating procedures on prevention and response to GBV and VAC, and to create additional guidelines, curricula, and training materials that incorporated GBV response. The MOHA reported there are now Gender and Children Desks, in various stages of operationalization, in all 417 police stations countrywide. Most notably, the GBVI worked with police to draft a three-year action plan to operationalize Gender and Children Desks in six priority regions, four of them overlapping with GBVI regions. Gender and Children Desks are designated offices within police stations where GBV survivors can report and be assisted by a trained police officer who can provide emergency legal services as well as referrals to necessary health and psychosocial services. Box 4 summarizes GBVI-supported policy-level achievements in Tanzania.

Box 4. GBVI-supported Policy-level Achievements

Ministry of Health and Social Welfare

- **Development of the following policies, guidelines, and legal documents for GBV**
  - National Guidelines for Integration of One-Stop Centers (2013)
  - Tanzania National Health Policy (2012)
  - National Policy Guidelines for the Health Sector Prevention of and Response to Gender-Based Violence (GBV) (2011)
  - National Management Guidelines for the Health Sector Response to and Prevention of Gender-Based Violence (GBV) (2011)
- **Creation of the following strategic and planning tools**
  - National M&E Plan and Facility Data Collection Tools
  - National Plan of Action to Prevent and Eradicate Violence against Women and Children (2001–2015)
  - National GBV and VAC Clinical Monitoring and Evaluation Plan
  - National Costed Plan of Action for Most Vulnerable Children 2011
- **Creation and dissemination of the following training and service delivery tools**
  - National orientation package for local government authorities, Regional Health Management Teams (RHMTs) and Community Health Management Teams (CHMTs) and Facility Managers
  - GBV and VAC Competency-based Training Curriculum (2013)
  - GBV and VAC Training of Trainers Training Manual for Health Care Providers and Social Welfare Officers (2013)
  - GBV and VAC Trainers Manual for Health Care Providers and Social Welfare Officers (2013)
  - GBV and VAC Participants Manual for Health Care Providers and Social Welfare (2013)
- **Inclusion of GBV modules in pre-service curricula** for clinical and non-clinical staff
- **Standardization of supportive supervision** tools already in use to ensure harmonization across partners
- **Establishment of a national recording system for GBV cases,** including a data collection sheet and register book for GBV at regional and community levels
- **Harmonization of GBV indicators** into the National Health Management Information System (HMIS) and the District Health Information System (DHIS)

Ministry of Community Development, Gender and Children

- **Development of a parenting educational manual** for training Community Development Officers at district and ward levels on how to conduct community dialogue to generate community-led actions for preventing VAC
- **Development of National Multisectoral Coordination Guidelines**
- **Mapping of GBV activities** across regions

Ministry of Home Affairs

- Creation of Gender and Children Desks as a dedicated space with a trained provider to respond to post-GBV care
- **Inclusion of GBV modules in pre-service curriculum** for the Police Academy
- **Creation of police coordination** group to manage GBV activities across all police activities and to engage other sectors

Legal Medicine

- **Development of an official data collection form** linking GBV survivors to the legal system
- **Development of GBV Chain of Custody Training Manual,** which describes the process of collecting and reporting GBV evidence
- **Development and dissemination of locally assembled sexual assault kits**

Leadership by Government

> *"Seeing the way MOHSW was organizing all of these and taking the lead for most of the activities that were happening, you can see the ownership of the government. Even guidelines, training, they were coordinated by the partners, but the MOH was the lead to all of these."* (Regional government)

> *"Before, there was no involvement of the Regional Administrative Secretary, Regional Health Management Team—they were involved, but didn't own it. But now it is them who calls the meeting."* (Implementing partner)

A significant contribution of the GBVI was the increased leadership taken on by the Government of Tanzania at national and regional levels. At the national level, coordination was led by the MOHSW and supported by the GBVI. The GBVI supported the MOHSW GBV National Coordinator to ensure that ministries and partners across sectors were working together to continuously share successes, challenges, and lessons learned. A majority of stakeholders identified the GBV National Coordinator as a champion of GBV and her leadership as a key contribution to the success of the initiative. The GBV National Coordinator succeeded in bringing together ministries and implementing partners across sectors to establish a new standard for how different stakeholders could be involved when working across sectors on GBV prevention and response.

Leadership at the national level encouraged greater GBV leadership among regional and community partners. The MOHSW conducted a 14-day training of trainers at the national level with health care providers and social welfare officers who had a background in GBV and VAC. Following the training of trainers, they identified the most qualified trainers and assigned them to be national facilitators in GBV who were responsible for traveling from region to region to train service providers, government officials, local community leaders, and police on GBV and VAC prevention and response. The MCDGC and MOHSW also coordinated to establish gender focal persons in each ministry and at the regional, district, and community levels in order to mainstream gender into policies and activities at all levels.

Raising Awareness and Visibility

> *"Even the past President was the guest of honor at the GBV meeting/launch, and said we have zero tolerance for GBV."* (National government)

> *MOHSW GBV has been incorporated—One plan for the Regional Health Care Plan—[that] was not there before. A very good health sector strategic plan has incorporated GBV and one-stop centers and plans to improve on the GBVI…The Strategic Plan goes down from national, regional to the district, which can plan for GBV and get a budget."*
> (National government)

Stakeholders acknowledged increased awareness and visibility of GBV prevention and response as an overarching contribution of the GBVI. This contribution trickled down from the national level to institutional and community levels. At the national level, government stakeholders spoke

of a greater awareness of GBV among their counterparts within the ministries and within government leadership. For example, in April 2014 during Most Vulnerable Children Week, the Vice President, officiating at a keynote event, spoke of the importance of GBV and VAC in Tanzania. Additionally, GBVI partners at the regional level mentioned standardized guidelines and policies for GBV at the national level as an advocacy tool they used to incorporate GBV into regional budgets. Some regional governments have incorporated GBV activities into their regional Comprehensive Council and Health Plans while elsewhere, regional governments have allocated land and resources to GBV multicomponent models.

The GBVI contributed to increased awareness at the national level by engaging new stakeholders, such as the MOHA and police officers. Through the Police Gender and Children Desk trainings and police sensitization, stakeholders reported an increased awareness among police officers of the connection between GBV and HIV and of the importance of addressing GBV to prevent HIV within the police system as well as within their communities.

Setting the Stage for Other Partners

> *"We just finished a two-year project rolling out child protection system, and the only way you can roll it out in two years and to have some sort of a system going is because it has been guided by existing tools and regulations that have been developed (by MOHSW/GBVI)."* (Multilateral agency)
>
> *"They told me in the past when other organizations came, they used to struggle, they took six months to come and they could not penetrate our system, so for you, you just come and you move on with implementation right away. It was not that easy before."* (International nongovernmental organization)

The close collaboration among the three ministries (MCDGC, MOHA, and MOHSW) and TACAIDS in creating and implementing GBV policy and management guidelines contributed to advancing the work of other multilateral and implementing agencies. For example, one multilateral agency mentioned the importance of using GBV clinical management guidelines, Police Gender and Children Desk guidelines, and one-stop center guidelines when designing the child protection system with the Tanzanian government. In addition, the stakeholder attributed the quick pace of the child protection system in part to the existing guidelines and systems established during the GBVI. The new relationship between the MOHA and MOHSW, facilitated by the GBVI, created a greater willingness among other NGOs to work with the MOHA. One GBVI implementing partner that recently began working with the police to strengthen the ability of police and prison facilities to implement HIV and GBV services, spoke of the increased willingness of this historically bureaucratic agency to work with them. Although some GBVI partners still described frustrations with sometimes lengthy, bureaucratic systems in the MOHA, the incremental progress that external partners noted is a significant accomplishment of the GBVI.

Institutional-level Contributions

GBVI contributions at the institutional level focused on capacity building for health, police, and social welfare service providers. Capacity building included training providers on user-friendly GBV service prevention and response; on understanding and filling out revised Police Form Number 3 (PF3) to link survivors to services; on data collection; and on integrating GBV guidance and services into existing HIV services. The PF3 is used to record evidence that may be required to testify in court. The form is completed by a medical doctor, but is available at police stations; survivors must report to the police before seeking health care if they want to press charges. Challenges with regards to the PF3 are discussed below; Box 5 summarizes GBVI-supported institutional-level achievements in Tanzania.

Box 5. GBVI-supported Institutional-level Achievements

Ministry of Health and Social Welfare/Ministry of Community Development, Gender and Children

- **Training clinical and non-clinical staff** to provide integrated care to GBV survivors based on newly formed GBV Ministry of Health protocols
- **Training to increase awareness of GBV** among health clinic staff, police officers, social welfare officers, and community leaders
- **Support for multisectoral meetings** at national and regional levels, including technical support and support for information sharing
- **Development of a training package** for clinical and non-clinical workers on GBV prevention, screening, and response
- **Inclusion of a GBV registry** within HIV, outpatient, and inpatient clinics, and reporting of GBV indicators to district and national data collection systems
- **Training on data collection** for GBV indicators and harmonization with Government of Tanzania indicators
- **Support for two one-stop centers** providing post-GBV care.

Ministry of Home Affairs

- **Training of police** to provide GBV-friendly services at Gender and Children Desks
- **Joint training on the revised PF3 form** for health providers, police officers, and social welfare officers in order to improve linkages.

Legal Medicine

- **Provision of forensics training** for health care providers, forensic lab scientists, prosecutors, lawyers, social welfare officers, and police officers.

Other Activities

- **Training provided to civil society** and community-based organizations on the integration of GBV into behavior change strategies and HIV-related activities
- **Development of communications materials**, radio spots and billboards.

Multisectoral Training

> *"Now [the] situation has improved. People can access services. Health care providers' attitudes have also been changed. Compared to where we started with government health facilities, the situation was very bad, but now someone has attended the training and you can access the services in a timely manner."* (Local NGO)

> *"Providers have been trained and have been mentored and provided with tools to help them. All these have strengthened the system to respond to GBV."* (National government)

A key contribution of the GBVI at the institutional level was the diverse and comprehensive capacity building of stakeholders within health, social welfare, police, and judicial systems. Capacity building differed slightly depending on the sector, service provider, and level of services (community, regional, or national).

The GBVI supported the MOHSW to implement a tiered training approach for health care providers and social welfare officers. The partners began by disseminating the National Clinical Training Package in the four GBVI regions. This clinical training package gave health providers a national protocol for clinical management of GBV. National trainers then conducted a training of trainers with national, zonal, and regional staff, who then facilitated training of health and social welfare officers at their respective government levels. The training included clinical and non-clinical providers in order to ensure that all first-line responders, throughout the health system, were trained on GBV prevention and response.

Police Form Number 3

> *"Working closely with them [health providers], initially we had issues. Doctors would refuse to sign the PF3 forms, because they don't want to be witnesses in the court. But engaging in them [health providers] now, they [health providers] see the importance and they treat it well compared to previously."* (Implementing partner)

> *"One challenge, staff at lower level [facility] hesitate to go to court sessions to testify because they don't qualify to testify. I just told [GBV] coordinator maybe the district medical officer should go to court to testify on their behalf, since he is a doctor and can testify on his behalf. The judge will say, 'What is your qualification?' and they won't believe him if he is just an attendant. We need to fix this problem."* (Regional government)

The GBVI also contributed to capacity building within the MOHA. GBVI partners worked with the MOHA and MOHSW to revise the PF3, a police form filled out by doctors after a survivor is referred to the health facility in order to document the crime so as to be able to present medical evidence in court. The MOHA trained doctors, nurses, and police on the revised PF3 at the regional and national levels, but there is still work to be done.

Challenges involving the PF3 center on three main issues. First is the fact that the PF3 is a police form and therefore stays at the police station. GBV survivors who go directly to a health facility

without the form cannot take their cases to court or must return to the police station to obtain the form and then go back to the doctor to have it filled out. Second, many health providers held the misconception that a completed PF3 form was required before they could provide services to survivors. To remedy this situation, the GBVI sent out an advocacy document clarifying the procedure and informing health providers that the PF3 was not required to treat a GBV survivor. Nonetheless, the misconception remains. Third, respondents reported that doctors were often reluctant to fill out the PF3s out of a fear of testifying in court. This fear comes from two places: First, sometimes the lower-level health staff fill out the form and may not believe that they have the technical knowledge to testify in court about medical issues; and second, doctors are in high demand in Tanzania and do not want to spend their time outside the hospital testifying in court. These challenges are known by the MOHA, MOHSW, and GBVI implementing partners working with the police. Among doctors and the police, GBVI partners have begun to address this challenge by raising awareness among doctors and police about the importance of the PF3. These partners are also continuing to work with the police to identify a solution to address situations where getting the PF3 filled and completed is challenging or complicated.

Training on the PF3, conducted by the MOHA and MOHSW with multisectoral stakeholders, included professionals from health, social welfare, police, and justice systems. However, within the police department, the PF3 training included only police officers working at the Gender and Children Desks. Stakeholders mentioned the lack of training of other police officers within the police station as an area to improve in future trainings. Stakeholders suggested using the model of training clinical and non-clinical health care workers for future training of the police. The lack of comprehensive training of the police resulted in a gap in user-friendly services within the police station because many GBV survivors reported to administrative desks prior to reporting to the Gender and Children Desks. In addition, high turnover of trained Gender and Children Desk officers created a need to train more staff at all positions within the police station.

Integration within the Existing Services

> *"One of the very successful entry points was the care and treatment where we have to integrate HIV and GBV clinics services."* (Implementing partner)

> *"For us it was also very successful approach, in all 43 sites we were working we have care and treatment clinics, and those who are HIV positive are accessing HIV services. We use that opportunity to screen for GBV. It also becomes very fruitful for women and children and young girl[s]."* (Implementing partner)

The GBVI has also contributed to the support of comprehensive and integrated GBV care for survivors within the existing HIV care and treatment programs, a core goal of the initiative. The GBVI in Tanzania operationalized this goal by working with the MOHSW to integrate standardized GBV guidance into the existing HIV protocols at national and regional levels. Aside from the national policies and guidelines addressing GBV within the health sector, the MOHSW

also integrated GBV into the existing protocols for HIV testing and counseling, and key populations.

At the service delivery level, GBVI partners used existing HIV platforms to screen, treat, and refer GBV survivors to the appropriate services. GBVI clinical partners also conducted needs assessments and facility audits at service entry points to assess the availability of HIV post-exposure prophylaxis (PEP) and other emergency services. To ensure availability at all sites, GBVI partners provided GBV starter packs funded by the United Nations Population Fund (UNFPA) and the Global Fund to Fight AIDS, Tuberculosis and Malaria, that included emergency provisions such as emergency contraceptives and PEP at outpatient and inpatient departments. Service providers used entry points such as maternity wards, outpatient and inpatient departments, and care and treatment clinics to screen for GBV and provide post-GBV services, including emergency contraception and PEP for survivors of sexual violence. Out of all entry points at health facilities, providers mentioned HIV care and treatment units as the most common entry point for identifying GBV survivors. This could be due to the alignment of PEPFAR funding with care and treatment partners or because of PEPFAR partners' large presence in these units. Service providers also linked survivors to psychosocial support through referrals to social welfare officers and police stations when necessary.

Data Collection Registries

The GBVI increased the capacity of health facilities to collect data on GBV survivors. Prior to the GBVI, there were no registries documenting GBV occurrences and services in Tanzania. Through the GBVI, implementing partners worked with TACAIDS to create a GBV registry for use in hospitals, health centers, and health dispensaries. As part of this effort, the GBVI provided training to service providers on how to collect and report data properly, on the importance of data quality, and on data use. These trainings are still being rolled out, and service providers' comfort level with the registries and the frequency with which they are used varies. Some partners reported challenges convincing nurses not only to report when GBV services are provided, but also to specify the type of GBV reported. According to respondents, convincing nurses to specify the type of GBV was challenging due to nurses' limited capacity and the need for overall behavior change to add this additional step. However, the same partners also acknowledged the important contribution of the registries to collecting, reporting, and advocating for GBV support at both regional and national levels.

Forensics

> *"On lab side, we are able to train all regions, and [with] people trained in evidence collection and, evidence is secure and admissible in court. If they want to take their cases to court they have correct evidence present."* (U.S. Government agency)

> *"Also support to national lab, forensic lab. That has been on the slow side and a chunk of the remaining funds are geared to supporting that one. We don't have a central lab to be able to process evidence for GBV cases."* (U.S. Government agency)

The GBVI has also contributed to strengthening forensic management and laboratory systems within Tanzania. Although still nascent, the attention given to forensic management was seen as an important step in strengthening overall GBV response in Tanzania. The GBVI worked with the MOHSW and Ministry of Justice to create GBV and VAC forensic evidence chain of custody guidelines. These guidelines provided health care providers, police officers, and social welfare officers with guidance regarding each stage of evidence collection, transfer, and processing. The GBVI trained service providers within these sectors including healthcare providers, police, social workers, prosecutors, and forensic sampling officers who work in the Government Chemist Laboratory Agency. The training covered how to collect, pack, and transport samples to the lab and what evidence can come from the lab to be presented in court procedures.

Partners recognized the initial progress in forensic capacity building as a significant contribution by the GBVI to GBV response in Tanzania. Many stakeholders mentioned this area as a key to future initiatives in providing comprehensive care for and response to GBV survivors. Specifically, partners spoke of the rollout of a forensic kit that is in development and will be introduced to clinics in the near future to assist in collection and transfer of forensic evidence. Additionally, partners spoke of a need to increase the capacity of the national lab to process and present evidence in court on behalf of survivors.

Successful Institution-level Approach: One-stop Models

> *"I think the drop-in center approach is one of the good models because it includes referral, linkage, and services."* (U.S. Government agency)

> *"'For me it would be the one-stop center is a microcosm of multisectoral approach—you have them all there where you get all the service providers."* (Multilateral organization)

> *"The most successful approach that we have been using is the one-stop center, where now the survivors have been able to get clinical and non-clinical services. They get tested, they get counseled, they get PEP, HIV prevention, emergency contraceptives, and medical attention…So, many people can access GBV services…"* (Implementing partner)

Stakeholders across government, donors, and implementing partners identified multidimensional approaches as the most successful used by the GBVI in Tanzania. These multidimensional approaches included one-stop centers and drop-in centers (two of them

established by the GBVI) to provide post-GBV care and support; these were implemented in coordination with the MOHA and MOHSW. These integrated models were seen as the most important models supporting Tanzania's future work in GBV.

Each one-stop center meets, in a single location, the medical, social, and legal needs of GBV survivors who have experienced physical, sexual, or psychological violence or abuse. In 2013, the GBVI supported the MOHA and MOHSW to establish guidelines for integrating one-stop centers into the standard operating procedures for health care services and facilities. In the national guidelines, there are two models for one-stop centers: public hospital-based and police-based.

The GBVI used both models to establish one-stop centers in four regions. In Dar es Salaam and Mwanza, one-stop centers were established in public hospitals; in Iringa and Mbeya, one-stop centers were established in police dispensaries. Partners discussed the positive and negative aspects of each model. Most saw the health facility as the ideal one-stop center location because of the availability of more advanced health services there. Others saw the police dispensaries as the more desirable choice, because that is where most GBV survivors first report. Police dispensaries also typically had more space available, which partners implementing the model saw as a key contributing factor.

A successful approach woven into the rollout of the one-stop centers was the way partners implementing one-stop centers used existing funding mechanisms to support this GBV work. This was seen specifically at two of the four one-stop centers. Although the one-stop centers in Iringa and Mbeya were established with direct support from the GBVI, the two one-stop centers in Dar es Salaam and Mwanza used Country Operational Plan funding and other donor funding, not specifically allocated for the GBVI, for establishment and rollout. GBVI partners' advocacy for the establishment of these two one-stop centers and the subsequent mainstreaming of GBV funding outside the GBVI is an important accomplishment of the GBVI.

The drop-in centers are an additional multicomponent model facilitated by the GBVI. In 2011, in Iringa, the GBVI supported the launch of a drop-in center that provides life skills training and medical, legal, and psychosocial services for survivors. The drop-in center also provides shelter, immediate post-GBV services and linkages, and referrals to other health, social, and legal facilities. The drop-in center used community volunteers to conduct GBV prevention outreach in the community and provided information about the drop-in centers to facilitate linkages with the community. The drop-in center also worked closely with Police Gender and Children Desks, social welfare officers, and health facilities in referring patients to needed support.

The establishment of one-stop and drop-in centers was seen by respondents as an example of the multisectoral collaboration that should be replicated in future GBV activities. The establishment of these centers required collaboration between the health providers, social welfare officers, and police at regional and community levels. Multisectoral GBV meetings at national and regional levels and collaboration on referrals and communication across partners at the regional and community levels allowed the centers to be successful at this initial stage.

Obtaining government buy-in and achieving sustainability will be the most important challenges facing these models in the future. However, there are preliminary signs that the government is starting to recognize the importance of these models. In Iringa, the government assigned a plot of land to construct a stand-alone drop-in center to help the organization avoid paying rent. The local government also included a budget line item for the drop-in center in the proposed 2016 budget. Although the budget was not approved, partners were enthusiastic about the drop-in center and that GBV survivor needs were, for the first time, recognized as an important investment within the local health system.

Community-level Contributions

The GBVI contributed to establishing of systems and increasing of community capacity to respond to GBV while simultaneously focusing on preventing GBV from happening in the first place. The GBVI used community volunteers, community-based organizations, and religious and political leaders in prevention, linkage, and data collection activities. The GBVI's approach to engage community leaders from the beginning and in all aspects of the program—from awareness raising to referrals and service provision—made the approach community-based and owned. GBVI-supported community-level achievements are summarized in Box 6.

Awareness Raising in Communities

> *"I remember when we started it was very hard for people to report, because a lot of perpetrators are family members. But now they are reporting, and we see, for example, for rape cases, we receive them in very early days—we used to receive them maybe three or five months ago and it was hard to support her with PEP, but now we receive them earlier than compared to the last time."* (Local NGO)

> *"GBVI has helped a lot…People are now aware, are speaking out, and go to report—before they used to say the victims were at fault. So it has helped a lot and has raised awareness that GBV is not right, it is a violation of human rights."* (National government)

> *"So, this approach has been successful. The community has been sensitized, and more cases are being reported to the responsible authorities for support. More cases are being reported, and this means people are aware of the GBV and VAC. People now fear doing GBV/VAC because they would be reported."* (Implementing partner)

> *"You will help a woman to get PEP, but also the community goes further to link that woman with someone in the community who can have psychological support."* (Implementing partner)

Box 6. Community-level Achievements

Sample Activities

- **Workshops to stimulate open discussions about masculinity and gender norms,** using the Men as Partners curriculum to facilitate open dialogue and discussion
- **Workshops to support couples at the community level** through CouplesConnect
- **Conducting training using the Family Matters Program curriculum** and integrating VAC and GBV into family counseling programs
- **Community-based HIV testing and counseling** and referrals to clinic-based testing for survivors
- **Engaging existing HIV community groups** to discuss GBV and refer patients to needed services
- **Engaging village and ward executives,** who are part of the existing political structure, to act as promoters of linkages between community and clinic
- **Establishment of men's and women's groups** by some community and clinical partners as part of their HIV and GBV prevention strategy, which provides safe spaces for discussing a number of issues
- **Establishment of male peer educators** as a follow-on to the Men as Partners program, where former perpetrators discuss GBV in their communities
- **Training local data collectors** to collect community-level GBV data.

Training Manuals

- **Creation and dissemination of community data collection manuals** to collect GBV indicators at the community level
- **Men as Partners and CouplesConnect training manuals** were used to train and disseminate GBV gender-transformative trainings throughout communities
- **Family Matters Program** integrated a GBV and VAC module into its curriculum.

Information, Education, and Communication Materials

- **Billboards and pamphlets** about GBV and gender norms in all four regions
- **Communications packages to facilitate discussion**, with audiovisual materials, including pamphlets, posters, radio, and TV spots
- **"Be a Role Model Campaign,"** which included mass media, community engagement, and interpersonal communications.

GBVI partners' most reported contributions at the community level included awareness raising and sensitization. Community partners created information, education, and communication materials; placed them at GBV service delivery points and public gathering places; and used local radio, peer education, drama groups, and billboards to reach a broad range of community members. Partners also used social marketing campaigns aimed at changing harmful male gender norms related to GBV. Community partners spoke of their appreciation for the GBVI contribution in standardizing messaging through Government of Tanzania guidelines and curricula. The standardized tools assisted partners in disseminating clear messaging across regions. Partners also used national guidelines in deciding which curricula were most appropriate for training, depending on their local community context and familiarity with each program, such as CouplesConnect or the SASA! (Start, Awareness, Support, Action) partners curriculum.

When training providers at the community level, the GBVI focused on sustainability. This led to a strategy of some implementing partners using the existing community structures and influential community leaders, while other implementing partners established Community Action Teams made up of many existing volunteers in the community. Volunteer training differed by region, but included community leaders such as local government Village Executive Officers and Ward Executive Officers, HIV committee members, and frontline workers, such as GBV focal persons, social workers, and home-based care providers. The GBVI implemented a comprehensive training covering GBV laws, rights, and norms as well as more technical issues of referrals to post-GBV services available at the regional, district, and ward levels; assistance in filling out PF3s; psychosocial and HIV counseling; and awareness raising in the community. Partners also used gender-transformative approaches to training fathers, husbands, and other male partners, which brought together couples and families to address harmful gender norms. The community action teams in Iringa have continued to work on gender norm transformation under another activity, not funded by the GBVI but approved by USAID Tanzania, illustrating the ability of other actors within USAID to recognize and successfully transition the capacity built under GBVI.

Referrals

> *"While we have coordinated, it is very hard with the current system we have to track the outcomes for our clients. If in the health sector, they stay within the health sector. But if you link them to legal, there is no way to track that…There is no way for us to have a systemic response to this individual and [see] how did it [the system)] work."* (Implementing partner)

> *"I think the spirit of this initiative earlier on was to come up with a central database, which has not been realized but we shouldn't lose focus on that. Even though it is difficult to come up with a mechanism for sharing across sectors is a little shaky. It is something we need to take up and see in the near future."* (Implementing partner)

Key contributions of the GBVI's community activities included increased awareness, referrals, and reporting of GBV. Partners and donors highlighted increased reporting of GBV and an increase in the type and timing of GBV reported. For example, partners spoke of an increase in reporting and a decrease in acceptance of intimate partner violence, a practice that has traditionally been viewed as a "family issue" in Tanzania and has rarely been reported (Fleischman 2012). In addition, partners reported a reduction in the time between a GBV incident and a report on it to a health facility or clinic. The change in reporting time is crucial, because many post-GBV services, such as emergency contraceptives and PEP, must be administered soon after an incident of sexual violence.

Referrals and linkages between communities and clinics have improved, but there is still a lot of work to be done. Partners struggled to accomplish their goals in increasing referrals between communities and clinics and between clinics and police stations. Partners reported difficulty in tracking survivors across the continuum of care, from their communities though the justice

system, and recommended a more systematic response to better track and support GBV survivors throughout the process. This will be an area for future initiatives to concentrate on and strengthen.

Data Collectors

> *"Successful approaches include training on data collecting tools to volunteers at the ward level."* (Implementing partner)

The GBVI also contributed to capacity building for data collectors at the community level. Previously, the government and implementing partners collected GBVI data at district and regional levels. GBVI partners, in collaboration with MOHSW and TACAIDS, created and are currently finishing training on community-level data collection tools. Trainings were rolled out in three of the four regions, with Dar es Salaam scheduled to complete training by the end of 2015. The data at the community level will assist the Government of Tanzania in tracking GBV cases and referrals more consistently in the future.

Successful Community-level Approach: Participatory and Gender-transformative Approaches

Stakeholders within and outside the GBVI mentioned the importance of gender-transformative approaches to changing harmful social norms at the community level. One GBVI partner with expertise in gender-transformative approaches served as a lead prevention partner and trained other partners across the four regions; these newly trained partners then trained men, women, youth, families, and couples. The GBVI used following three curricula most frequently to change behavior and harmful social norms around HIV and GBV, with an emphasis on engaging men in GBV prevention:

- **Men as Partners:** This group education intervention was created by EngenderHealth and modified and implemented based on consultations with Raising Voices' SASA! methodology. SASA! uses a comprehensive tool for addressing violence against women and preventing HIV by fostering critical reflection on gender and power and instigating local activities (Faramand, Mihyo, and Ezekiel 2013). This tool was incorporated into gender-transformative workshops spanning 12 weeks, which gathered groups of men and women two to three times per week, for 26 days total. These interactive, skills-building workshops confronted harmful gender norms and practices in Tanzania, including a focus on intimate partner violence, the most common form of GBV in Tanzania. The workshops discussed consequences of these and other harmful norms on couples and families. The goal of Men as Partners is to reduce HIV and adverse reproductive health outcomes through behavior change, thus also reducing GBV.
- **CouplesConnect:** This interactive, skills-based group education was created in 2012 by EngenderHealth through the USAID-funded CHAMPION Project and also incorporated the SASA! methodology. This gender-transformative curriculum was implemented through a

three-day, 15-session group education workshop focusing on providing married and cohabitating couples the information and skills they need to communicate better and change harmful gender norms, both determinants of reproductive and sexual health. This curriculum included a GBV module in which participants learned about various forms of GBV, how it can be prevented, and how to intervene with friends or family to try to stop violence from recurring.

- **Family Matters Program:** This evidence-based, parent-focused intervention was adapted from CDC's U.S. evidence-based intervention, the Parents Matter! Program. First adapted and tested in Kenya, it has been adapted and implemented throughout sub-Saharan Africa. Family Matters Program was implemented in Tanzania over six consecutive weekly group sessions lasting approximately three hours each. The intervention was designed to promote positive parenting and effective parent–child communication about sexuality and sexual risk reduction, including risk for child sexual abuse and VAC for parents or caregivers of children aged nine to 12.

GBVI partners reported changes in social norms and attitudes as a result of these trainings. In some cases, former perpetrators who had gone through the training formed community education groups to spread GBV awareness to others in their communities. Some of these past-perpetrator community groups then created income-generating activities and used savings and lending models to raise money for transportation and educational materials to conduct GBV and social norm change education programs in other regions.

Multisectoral and Partner Synergies

> *"GBVI was very key in bringing us together. Before GBVI, each ministry had their own gender focal point. GBVI brought everyone together on what each needs to do."*
> (National government)

The GBVI prioritized communication and coordination across sectors from early on. It engaged ministry officials working on GBV within each sector and across all levels of government to coordinate and complement one another's activities. Although certain synergies could have been further strengthened, particularly with the Ministry of Justice, the GBVI was successful in coordinating across the MCDGC, MOHA, TACAIDS, and MOHSW. The GBVI used the same approach to create synergies among implementing partners by engaging and coordinating civil society organizations, local and international NGOs, and academic institutions with the government and other partners around GBV prevention and response.

Multisectoral Synergies

The GBVI engaged outside PEPFAR's traditional partner, the MOHSW, to create relationships within the MCDGC, TACAIDS, and MOHA in order to successfully deliver comprehensive GBV prevention and response services. Beginning in its early stages, the GBVI collaborated closely within established structures across ministries at the national, regional, district, ward, and village

levels. The GBVI built on expertise within each ministry to implement policies and programs at the national level, while simultaneously ensuring coordination and communication across ministries at all levels of government. For example, the Department of Social Welfare (within the MOHSW) provides psychosocial support to GBV survivors. At the national level, the Department of Social Welfare worked with MOHA and MOHSW to draft national guidelines for GBV and VAC response, guidelines that incorporated psychosocial support protocols for health care professionals who were already providing HIV care and treatment. At the regional level, regional social welfare officers coordinated with health facilities and police to ensure that survivors received assistance from the police and were linked to health facilities for post-GBV care. GBV trainings at regional and national levels were also cross-sectoral, engaging police, health care providers, prosecutors, and social welfare officers within the same training program.

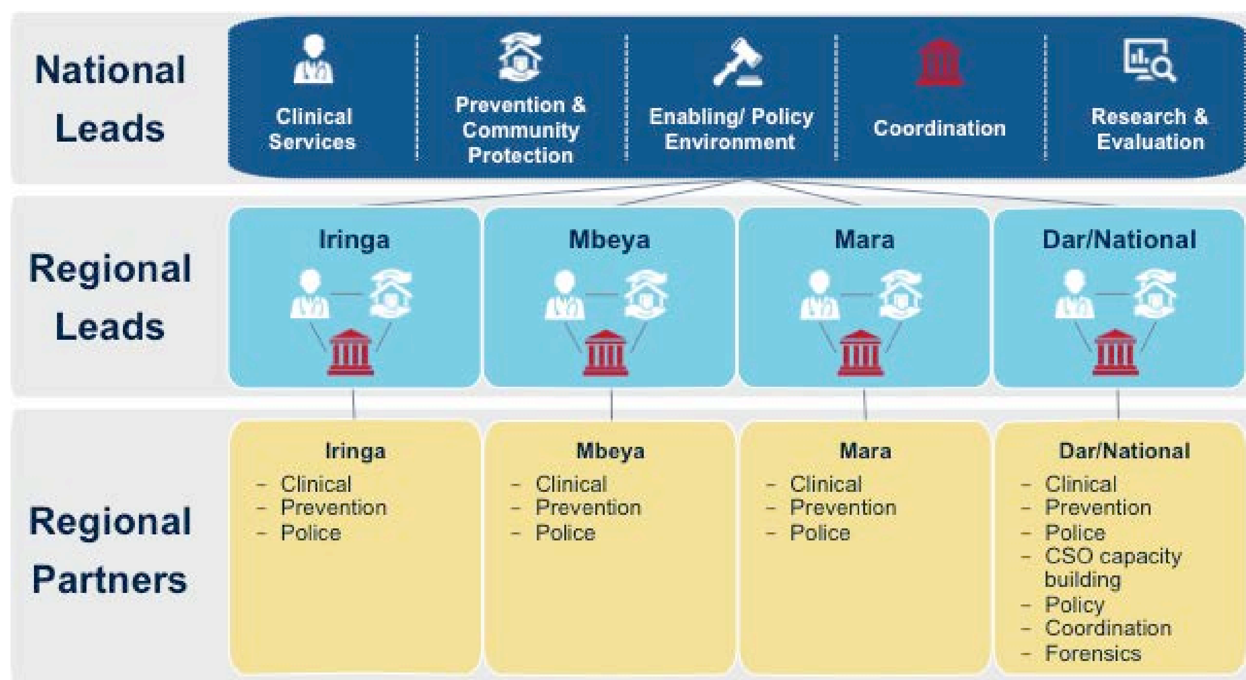
Another area of strong multisectoral synergies was the establishment of GBV and VAC multisectoral coordination committees at various levels. The MCDGC is nationally mandated to coordinate and provide guidance for mainstreaming gender and hence for addressing GBV. Part of the requirement of the GBV policy and management guidelines is the establishment of a GBV technical working group and provision of technical assistance to this group. In 2012, the MCDGC, in collaboration with the GBVI and the MOHSW, created policy guidelines to help it effectively coordinate GBV activities of multisectoral actors at both national and local levels.

Partner Synergies

> *"The great model in Tanzania was the implementing partner became the lead for other partners in GBV prevention to help convene, coordinate, and organize, which needs funding. But that is the kind of model that is needed."* (Multilateral agency)

Multisectoral coordination at the national level led to stronger coordination across partners both at national and regional level throughout the initiative. Following feedback from a national quarterly GBV meeting that reported a need for more leadership and coordination among partners at the regional levels, the GBVI created a model depicted in Figure 4 to ensure collaboration and avoid duplication across implementing partners. The GBVI comprised 19 implementing partners working across four regions and at the national level. One national lead implementing partner was assigned to each of the five GBVI pillars (clinical services, community prevention, enabling/policy environment, coordination, and research and evaluation) to work closely with host-country counterparts at the national level to harmonize guidelines and provide technical assistance to government and implementing partners at all levels. Each icon on the following page represents one lead implementing partner at the national level.

Figure 4. GBVI Partner Synergy Structure



The GBVI also assigned regional lead partners within each of the four regions. These lead partners' responsibilities were to identify main government counterparts within their regions and work closely with them and the implementing partners within their regions to ensure activities at clinical and community levels were as complementary as possible. These partners would also coordinate with the clinical and prevention leads at the national level for technical assistance and with other regions implementing similar activities. For example, in Iringa, the regional implementing partner leads worked with the regional social welfare officer to organize quarterly GBVI meetings and ensure effective communication and coordination across the region's four implementing partners. These regional leads then reported back to their national-level counterparts, who would share successes, challenges, and lessons learned at quarterly national GBV coordination meetings.

Program Synergies

> *"The quarterly and annual meetings organized by MOHSW that enabled facility and non-facility stakeholders come together to share experiences, challenges, and find the way forward together."* (Implementing partner)

Successful coordination across partners and ministries was overwhelmingly credited to quarterly GBVI meetings held at the regional and national levels.

At the regional level, GBV meetings were held with implementing partners, ministry officials, and other relevant stakeholders in the region. Partners spoke of the quarterly meetings as a space to create a multisectoral platform where synergies were further strengthened by sharing experiences and progress reports on GBV interventions. These meetings also provided a forum for partners to identify the most relevant needs and opportunities for response to GBV, to

brainstorm strategies for overcoming challenges, and to share successes to mimic in future GBV prevention and response activities. In Iringa, efforts were made to ensure that the regional government invited UNICEF child protection and other local partners not funded by the GBVI to these meetings so that VAC was included as part of the larger GBV prevention and response effort.

At the national level, the GBVI supported the MOHSW in collaboration with the MCDGC to organize quarterly meetings with the MOHA and implementing partners from all regions. Regional leads would present activities, successes, and challenges from all implementing partners within their regions. National leads would present the newest guidelines, policies, and innovations occurring at the national level. These meetings provided a forum for national and regional partners to come together and ensure synergy across programs at all levels.

The Tanzanian Police Female Network created its own police partners coordination group to better coordinate across all partners working on GBV within the police sector. GBVI partners participated in this group and supported revision of the PF3 and provided feedback on the Gender and Children Desk protocols.

Although partners and ministry officials mentioned quarterly meetings as key to the GBVI's success, their sustainability after GBVI funding ends will be a challenge. Partners reported concern for dependency on PEPFAR support for the meetings. The meetings were organized by GBVI-supported partners and, although extended to partners outside the GBVI in many regions, stakeholders were doubtful that post-GBVI momentum would continue. Some stakeholders reported an initial slowing of meetings towards the end of GBVI funding, while others speculated that meetings might continue on a biannual basis. The level of commitment for future GBV coordination meetings will vary based on regional government and national commitment. Additional challenges mentioned by partners included work stalled due to police bureaucracy, cases of missed communication and duplication of efforts within a region when new partners arrived, and the difficulty of coordinating facility and community interventions with 19 implementing partners.

Future Program Synergies

> *"More synergies could be created. Judiciary is part of the coordination meetings. When they refer to us, it is not referral."* (Implementing partner)
>
> *"We try to ensure the people trained on child protection are those being trained on GBV to ensure that it cuts across. At the district level, it is the same people. But it is not systematically—that is an area that we still need to work on."* (Multilateral agency)

Collaboration between the Ministry of Justice and stakeholders working on VAC is an area for improvement going forward. The GBVI worked to collaborate with those working on VAC in government ministries and U.S. Government agencies, but this is a recent partnership that occurred as a GBVI add-on program rather than as a systematic collaboration between the two.

Nonetheless, the GBVI was committed to future integration of GBV and VAC and allocated funding to UNICEF to develop and disseminate training on a VAC communication toolkit and to strengthen district-level child protection teams, as well as to improve collaboration with the Ministry of Justice. Ministry of Justice staff, such as prosecutors and attorney generals, were trained in GBV forensics and the PF3s. However, beyond this training, their engagement on the national level was limited. Ministry of Justice officials were not engaged in PEPFAR quarterly meetings and were cited by numerous stakeholders as the "missing piece" in the country's programming for GBV.

Quality and Scale-up

Quality Improvement

> *"We had some internal strategies to make sure that our services are being delivered at the quality that is minimum package that is acceptable by the government. So we involved quality improvement teams that were already there, developed by Health Council teams and add up component of GBV services to these people."* (Implementing partner)

> *"The gender desk is under the tree. Which means they are not [a private space]."*
> (Regional government)

> *"I wouldn't say that we had a very strong quality improvement from the start, because the focus really was to get the program to expand into different areas."*
> (Implementing partner)

The GBVI's work in quality of care and quality improvement continuously increased throughout the initiative. At the beginning, the initiative's focus was on laying the groundwork for policy implementation, coordination, and capacity building throughout the four regions. Once these systems were in place and functioning, the focus shifted to quality improvement activities. Given that the GBVI was a three-year initiative, the time necessary to create, roll out, and implement activities was time-consuming and partners spoke of the need for more time to focus on quality of care.

During the last year of the initiative, GBVI partners began to work with Regional Health Management Team, Community Health Management Team, MOHSW, and GBV prevention partners to integrate gender equality, GBV, and VAC into the existing Reproductive and Child Health Integrated Supportive Supervision Tool. This tool guarantees that providers trained within the reproductive and child health divisions will continue to be monitored to ensure they are screening and providing quality services to GBV survivors. Prior to rollout of the tool, clinical partners conducted facility audits and took inventory of equipment, staffing, and services available. Partners began using the tool recently to conduct site visits and check on quality of GBV, reproductive health, HIV, and overall health services on a quarterly basis.

Partners explained that, prior to the implementation of this tool, quality improvement took place in a more ad hoc fashion. GBVI clinical partners used the existing quality improvement systems within their organizations, such as supportive supervision and mentoring, to ensure the quality of services. Some ministry officials reported using checklists to assess the types of services offered and to identify gaps where necessary, as well as conducting joint monitoring with the ministries, departments, and agencies implementing the programs. These systems were already in place and being rolled out internally, but there was no systematic approach to quality of care within the GBVI.

Implementing partners and government stakeholders credited the newest GBVI guidelines, curricula, and tools as a way to ensure quality of services. During the creation of standard operating procedures, such as the National Clinical Training Package and the National Management Guidelines for Health Sector Response to and Prevention of Gender-Based Violence, partners ensured that quality of care was integrated into the documents. Partners used the same approved government documents in training and program design, and attributed the standardization and improved quality of services to following these guidelines.

The GBVI's challenges relating to quality of care arose mostly within those services that did not have previous standards of care. The Police Gender and Children Desks have standardized curricula for training police in GBV, but approval for standard operating procedures for the establishment the Gender and Children Desks is still in process. Partners reported that many Gender and Children Desks lacked a private room to see patients, limiting confidentiality and ultimately safety for the patients.

Scale-up

> *"It seems training is the most scaled-up intervention…It was a lot of training. That was the most scaled-up of anything that happened."* (U.S. Government agency)

Due to the design and short time span of the GBVI in Tanzania, scale-up occurred in different ways for different initiative pillars. For clinical and prevention services, scale-up occurred within regional territories to expand the type and number of health facilities and to deliver training to a broad range of stakeholders. Post-GBV services are now provided at health dispensaries, health centers, hospitals, police Gender and Children Desks, and one-stop centers. Training has also expanded to a wide cadre of health care providers, police, magistrates, and social welfare officers, many of whom were not engaged in GBV and HIV prevention and response prior to the GBVI.

Stakeholders cited institutionalization and data collection as two of the most successful areas of scale-up in the country. Institutionalization of national policies and guidelines was the main success in expanding within the GBVI. Guidelines, tools, and curricula are now institutionalized within 10 regions, while training and supervision continue to roll out throughout the country.

Data collection tools have now been created and disseminated beyond the four GBVI regions and are in five additional regions: Geita, Katavi, Mwanza, Ruvuma, and Shinyanga.

Other new programs, such as forensic lab management, reported a focus on scale-up over quality of care. The forensic infrastructure in Tanzania is limited, and only one lab in Dar es Salaam is able to process evidence. Lab partners had to build a system from the ground up to roll out GBVI activities— including creating guidelines, procuring equipment, and training service providers in every sector. For this reason, the majority of activities by lab partners focused on laying the groundwork for these programs. Recently, lab partners have formed supervision teams and plan to conduct supervision visits to ensure quality of evidence. Partners suggested that future initiatives should build more quality improvement mechanisms within the systems from the beginning, rather than expanding throughout the country without knowing whether the data is of good quality and whether the chain of evidence is working correctly.

Challenges to scale-up included the limited timeframe of the GBVI, the need to establish standards in data quality prior to scale-up, and the need for government ownership prior to scale-up beyond priority regions. Overall, the majority of stakeholders did not focus on the need to expand clinical and prevention activities, and instead suggested that continued capacity building of health, social welfare and police personnel within the priority regions as well as a continued focus on data quality including supportive supervision and quality improvement methods within facilities should be prioritized before expanding to the rest of the country.

Building the Evidence Base

> *"I think this is one of the greater legacies of the GBVI. Now these indicators are in place and it is possible if there isn't specific GBVI funding you can still use those indicators and if you are asking people to use HIV money or continue to support GBVI you have indicators in place to track that."* (U.S. Government agency)

> *"Strengths is that we know how our facilities are utilized and the numbers of clients and patients who have attended our facilities. The kind of services that they have received. Now we can see increase in the facility using these services and now help NGOs to support facilities. If you know percent of facilities [with GBV services], you can increase and the number of facilities."* (Regional government)

One of the five pillars of the GBVI Tanzania was to build the GBV evidence base. Before the GBVI, documentation of GBV services was extremely limited, health registries did not track GBV incidence in a standardized format, and only those at clinical levels had registries in place. The GBVI assigned one implementing partner to provide technical assistance in monitoring and evaluation (M&E) to the government, and other implementing partners to ensure harmonization and rollout of GBV data collection tools at the national, regional, and community levels. Although there are still challenges in terms of scale-up, quality, and data collection, the close working relationship that the GBVI established with the Government of Tanzania and the vast

amount of resources that are now in place to collect data present a model for future initiatives. For a full list of current data collection sources and frequency, see the References section of this document.

Harmonizing Indicators

> *"The biggest successful approach has been working with the MOHSW Reproductive Child Health Section in developing the national monitoring and evaluation data tools using PEPFAR GBVI Indicators (as a starting point); aligning them to the national GBV indicators; and entering the indicators [PEPFAR and national] into the national electronic database (i.e., the district health information system)."* (Implementing partner)

> *"The GBVI was instrumental in creating indicators that are tracked by facilities, but again they aren't rolled out nationally—they are only in five regions. So that is something to see how ministry moves forward with that."* (Implementing partner)

> *"Theoretically they are aligned. But in practice they are not. The national monitoring and evaluation system for GBV has yet to be rolled out to the regions. The system was established in 2012…The MOHSW printed only a few tools to a few regions. But majority of regions have not reached."* (Implementing partner)

The collaboration between the GBVI and Government of Tanzania began by laying a foundation for evidence collection and reporting. GBVI partners provided technical assistance to the MOHSW Reproductive and Child Health Section to draft the National GBV and VAC Clinical Monitoring and Evaluation Plan. This plan outlined protocols and standards for collecting, reporting, and using data for GBV and VAC throughout Tanzania. A GBVI partner also collaborated with TACAIDS and the MOHSW to draft and harmonize GBV and VAC indicators into the Tanzanian national health monitoring information system. This included using the existing clinical registries and aligning Government of Tanzania indicators with PEPFAR GBV indicators. This was an arduous process, because PEPFAR GBV indicators changed midway through the GBVI. After one round of harmonization had been completed, a new process began to incorporate the two newest PEPFAR monitoring, evaluation, and reporting (MER) indicators, GEND_GBV and GEND_NORM, which were added in early 2015 (Box 7).

Box 7. 2015 GBV Monitoring, Evaluation, and Reporting Indicators

GEND_GBV: Number of people receiving post-GBV care

GEND_NORM: Number of people completing an intervention pertaining to gender norms that meets the minimum 10-hour criteria

The two newest indicators are still being harmonized throughout the country. Following harmonization of the initial indicators, M&E leads worked with GBVI implementing partners to conduct M&E training in four GBVI regions for health service provider on collecting, inputting, and using GBV data.

Once national indicators were harmonized, a gap in community-level data collection remained. Prevention partners reported challenges resulting from a lack of standardized data collection tools for GBV community data and the inability of their data to feed into the national system because of this lack of standardization. GBVI M&E leads created, piloted, and are disseminating a community-level data collection tool. GBVI M&E leads worked through regional prevention partners to identify community volunteers who could be trained in this new tool. The GBVI, MOHSW, and TACAIDS conducted trainings in Iringa/Njombe, Mara, and Mbeya for community volunteers, peer educators, and health providers on how to collect community-level data. Rollout of the training in Dar es Salaam was planned for December 2015.

The PEPFAR and Government of Tanzania GBVI indicators are now harmonized and incorporated into the district health information system and the national health monitoring information system. However, the scale of the rollout of this harmonization is unclear. Many partners suggested that, although the indicators are harmonized at the national level, implementation of this harmonization at regional levels remains incomplete. Rollout of harmonization is tiered, and harmonization takes time to introduce to all regions, so many regions do not yet see the harmonization. In addition, partners suggested that not all indicators are harmonized within the district health information system, and prevention partners have continued to raise concerns about a lack of any GBV community-level data collection indicators.

PEPFAR Indicators

> *"Strengths of the first old indicator: was an eye opener that on negative effect of GBV and impact; it also provided an opportunity for people to know where to report."*
> (Implementing partner)
>
> *"One of the challenges of PEPFAR has been the constant change of indicators over the life of the project. It was crazy. Our indicators changed almost every year. It was so hard on how to get a handle of what are the achievements of the project, as they kept changing."*
> (Implementing partner)

PEPFAR introduced three new program indicators to monitor and report on GBV in Tanzania through the GBVI. The three new indicators were:

1. Number of people reached by an individual small group or community-level intervention
2. Number of GBV-related service encounters at a health facility
3. Percentage of health facilities with GBV services available.

Before these indicators were introduced, the Government of Tanzania or implementing partners had not previously systematically reported on GBV in Tanzania. For that reason, implementing partners and government officials reported that the indicators were useful in encouraging GBV data collection. Halfway through the GBVI, PEPFAR introduced two new MER indicators to replace the initial three, based in part on feedback from GBVI partners on the successes and challenges of the pilot indicators. During interviews, GBVI partners focused on the challenges of

incorporating the new indicators over the successes associated with the original ones. Implementing partners struggled to quickly change their reporting and activities to match the newest indicators, and expressed frustration at the abrupt change in reporting.

GEND_NORM

> *"This is almost impossible—we need more training for prevention implementing partners on this indicator."* (Implementing partner)

> *"Sometimes we would do a massive sensitization and do the ICT [information and communication technology] criteria, but now it isn't just 10 hours, it is the dialogue and participatory nature."* (Implementing partner)

GBVI partners had the most to say regarding the GEND_NORM indicator in reference to meeting the 10-hour criteria. The 10-hour criteria requires one person to participate in a minimum of 10 hours of total intervention time (in an individual, small group, or community setting) to count under this indicator The science and reasoning for putting a 10-hour criteria in the GEND_NORM indicator had been explained to partners; however, they found implementation difficult. Partners reported that the 10-hour criteria did not align with most of their existing programming structure, and partners found themselves having to adjust their programs to meet the indicator, rather than the other way around.

This indicator did suit implementing partners that were already implementing curriculum-based trainings where a cohort was brought to a training on a continuous, consistent basis. However, the partners with more nuanced approaches to address gender norms, such as information communication technology programs, text messaging, radio and television spots, peer-to-peer education, and community awareness events, felt that their programs were unable to meet this criteria while still being a critical part of changing gender norms. Additionally, partners felt that they needed more support and training from the U.S. Government around how to adapt their programs to meet this indicator.

Some partners began adapting their programs and testing innovative ways to meet the 10-hour criteria. For example, a few partners mentioned integrating GBV into their existing family planning or school-based trainings. In other words, they would integrate GBV into the curriculum of a program that was already meeting the 10-hour criteria in order to utilize their resources most efficiently. Other partners mentioned collaborating with community volunteers to spread more consistent messaging on GBV outside their organized programming. However, overall, partners remained challenged and frustrated by the new indicator, feeling that it was a weak standard that did not indicate the quality of the program.

GEND_GBV

> *"For me, I like the post-GBV care because that is where you see if the intervention is working or not."* (Implementing partner)
>
> *"…[The] post-GBV care disaggregate need[s] to be harmonized with [the] national age group."* (Implementing partner)
>
> *"Number of people reached with GBV services—here we need to have identification for the people/survivors to avoid double counting."* (Implementing partner)
>
> *"We need to harmonize the age groups and challenging in reporting the 15–19 age group. I think we still have a challenge there."* (Implementing partner)

The GEND_GBV indicator was meant to move away from reporting of screening numbers and to obtain more specific data on the types of services being provided. Partners did not have any issues with the GEND_GBV indicator in its purpose and thought that capturing post-GBV care was a step forward in data collection. The issues that arose were in regard to disaggregation by age and type and the potential for double counting.

The GEND_GBV indicator disaggregates age groups from 15–17 and 18–24, while the government disaggregates data from 15–19. Partners are unable to report the proper age disaggregation that PEPFAR calls for in this newest indicator because data are captured differently at the facility level. In addition, the type of GBV care is disaggregated in two categories: emotional/physical and sexual. This disaggregation does not differentiate between physical and emotional, providing the government and service providers with limited information. As MER indicators continue to be reviewed, these issues should be taken into consideration, because they affect data quality and the ability to harmonize indicators across the Government of Tanzania and PEPFAR.

Partners also mentioned the double counting that arose with the GEND_GBV indicator. The multisectoral nature of the GBV response means that survivors come into contact with multiple service providers, and even within a single health facility, because of the lack of identifications associated with each patient, there is potential for double counting. Currently, the registries record data based on service rather than on the individual, so one patient can be recorded for post-GBV care and then go to another part of the health facility and be counted again for post-GBV care. Other partners reported double counting between community- and facility-level partners. Community-level partners were reporting GBV patients referred and receiving post-GBV care, while facility-level partners were reporting the same patient for post-GBV care.

Implementing partners recommended addressing the issue of double counting by taking a more holistic approach to post-GBV services. Partners suggested giving patients identification codes that could be tracked throughout the health facility as well as along the continuum of care of post-GBV services. In this way, one patient could be tracked from the police to the health facility to social welfare and finally through the judicial system. Double counting among service

providers could also be reduced. Clinical and community implementing partners used relationships formed through the GBVI to meet and discuss the issue of double counting. The issue is still being discussed and strategized for the future; the dialogue is open and moving forward.

Tathmini GBV

The *Tathmini* ("evaluation" in Swahili) GBV was unique to Tanzania. Tanzania was the only GBVI country that had an external evaluation of the initiative. GBVI stakeholders remarked on the important contribution the Tathmini GBV made by providing evidence and a direction for future GBV programming in Tanzania and globally.

The Tathmini GBV, conducted in Mbeya region and funded with additional monies set aside by USAID/Washington, was originally designed as an 18-month matched-pair cluster randomized trial. Due to the tight time frame for completing the evaluation and a delay in the start of the program, the 18 months was reduced to 16. This impacted the ability to conduct endline household surveys, which ultimately led to a randomized controlled trial on the facility side but not on the community side. Even with the modifications, the evaluation yielded important results that were used for learning.

The evaluation examined the outcomes of a combination of the following GBVI-supported GBV prevention and response interventions:

1. Health facility-based services for GBV survivors
2. Health facility-based GBV screening and referral in clinical settings
3. Clinic and community outreach
4. Community-based GBV prevention activities
5. Referrals to psychosocial support, legal services, and safe houses.

The Tathmini GBV found that the GBVI activities in Mbeya region increased the overall use of GBV services, based on results showing a larger number of GBV client visits at the intervention health facilities than at control health facilities. Findings were that GBVI activities led to more delivery of certain GBV services, including psychosocial counseling, family planning counseling among female clients, and HIV testing and counseling services in health facilities. The Tathmini GBV revealed that GBVI activities also increased referrals to legal services, safe houses, and higher clinical care. The evaluation also found that GBVI activities led to less delivery of other services than at control sites; further data analysis failed to conclusively identify reasons for these differences. Services that were reduced compared to control sites included assessment of patients' physical injuries, medical treatment for injuries, police reports and forensics, and pregnancy tests. Evaluation results also demonstrated benefits from the design of the GBVI, including integration of the GBV program within the HIV program, effective engagement of the health sector and community leadership, and strong local ownership of the program (Settergren et al. 2015).

The Tathmini GBV evaluation results and interviews with Mbeya regional partners highlighted an increased awareness of GBV as an unanticipated outcome of the Tathmini GBV. The evaluation itself brought more visibility to GBV prevention and response activities in the region through interviews, focus group discussions, research, and documentation. The evaluation found increased understanding of GBV, less tolerance for GBV, and greater responsiveness on the part of community leaders. Mbeya regional partners reported that since the evaluation, their region, once recognized for having some of the highest rates of GBV in the country, was being recognized for making some of the largest strides in combatting GBV.

Data Implementation and Quality

> *"Tanzania is ahead of the game reporting indicators through the district health information system, but the quality of the data—is anyone really looking at that? We know there are a lot of challenges."* (Implementing partner)

> *"We do know from our look at those data—providers don't fill forms out, services being integrated throughout health facility is programmed—we placed GBV registers for all departments and at the end of the day, we'll link the folks together. No facilities have patient identification for doing that. That's why they say service encounters, not clients or visits."* (Implementing partner)

Data quality of indicators was reported as unknown at this point and a work in progress. Due to the lack of data on GBV prior to the GBVI, the focus has been on creating guidelines, harmonizing data, and rolling out training. Trainings highlight the importance of data quality. However, beyond this, data quality is still unclear.

Partners reported that nurses and clinicians did not want to fill out the entire GBV registry or would fill out only parts of the registry due to their exhausting workloads and long hours. In addition, with the recent training of community volunteers, there was little information regarding the quality of data collected at the community level. Data quality checks should be implemented as tools continue to roll out.

> *"People served at the facility level, but after that then what? You need to follow up—which is the challenge for that one."* (Implementing partner)

> *"The referral—on health management information systems you need to put a tick if a client came and you refer you put a tick, but the data doesn't show where the data was referred to (to legal, police, social welfare, etc.). You just put a tick, but you don't have any additional information, like follow-up. If they were referred to the police, did they get the information that they needed?"* (Implementing partner)

Partners also expressed a need to improve data and indicators on follow-up and referrals. Currently, most PEPFAR indicators are quantitative; partners expressed a desire to collect information not only on whether a patient received post-GBV care, but also on the kind of care received, both quantitatively and qualitatively. For quantitative indicators, partners

recommended collecting information on where a patient was referred—the police, social welfare office, judicial system, or the like. As qualitative indicators, partners suggested collecting more information on the quality of care and whether services met patient needs.

Country Ownership/Sustainability

> *"We did our curriculum in police training schools. The GBV/VAC since 2012, the curriculum is now in all police training schools."* (National government)
>
> *"Integrating GBV into clinical services will continue. No activities will stop because we used the model of integrating services using same hospitals and same facilities."* (Implementing partner)
>
> *"Some of the activities were expanding throughout the DREAMS[4] initiative, started in GBVI and expanded out in DREAMS initiative."* (U.S. Government agency)

Sustainability of the GBVI is dependent on multiple factors within Tanzania. The GBVI focused on sustainability throughout the initiative. However, there is still work to be done to ensure sustainability of the Government of Tanzania's programs, and among bilateral and multilateral organizations.

The GBVI succeeded in increasing the capacity of many stakeholders in GBV prevention and response. According to many stakeholders, GBVI clinical services are most likely to be sustained because they are now institutionalized within the existing government service structures. Nurses and doctors have been trained, police Gender and Children Desks are staffed, and social welfare officers are trained on GBV support. In addition, having national GBV trainers situated at regional offices provides a gender focal point to continue coordinating and providing technical expertise to those working on GBV in the regions.

In terms of financial sustainability and country ownership, Government of Tanzania officials are beginning to discuss how to integrate GBV prevention and response into their own planning, budgeting, and programming within existing HIV, family planning, and health budgets. Although funding is currently very limited, there has been progress in advocating for GBV programming in government budgets. Some local governments have also begun to discuss and incorporate GBV prevention and response activities into their local health plans. District councils, both within and outside of GBVI regions—including Ilala Municipal Council (Dar es Salaam), Iringa Municipal Council (Iringa), Magu District Council (Mwanza), and Temeke Municipal Council (Dar es Salaam)—have started incorporating both GBV and VAC into their budgets for the first time.

With regards to continuing activities through U.S. Government funding, discussion focused on how to integrate these activities into Country Operational Plans and other U.S. Government initiatives. The DREAMS initiative (Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe), a new, centrally funded, $210 million, 10-country PEPFAR initiative targeted at reducing

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[4] DREAMS is a PEPFAR initiative that stands for Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe.

rates of HIV infections among adolescent girls and young women, is currently beginning in Tanzania. Stakeholders suggested that certain GBV activities should be sustained under this new initiative, although during data collection, it was unclear to many exactly what those activities will be. One U.S. Government agency had already begun incorporating GBVI indicators into all of its partners' reporting. Another agency was integrating GBV interventions into new bilateral awards via social norms strengthening or health service delivery platforms.

GBVI partners most often reported that institutionalization of GBV training curricula, guidelines, and policies is the most sustainable impact of the initiative. GBV training is now part of pre-service curricula for health care providers and police, and GBV and VAC care and treatment will continue to be taught to the rising cohorts of service providers entering the field. This remains to be done in pre-service curricula for community development and for social welfare workers.

Other aspects of the GBVI that will be sustained include the team of volunteers trained under the Regional Psychosocial Care and Support Initiative providing home-based care and social–psychosocial support. These volunteers will be sustained because of the support of the MOHSW Social Welfare Department, with support of funding from outside the U.S. Government. Likewise, community resource persons (who are more or less volunteers) will be also be trained in specific areas using the Savings and Internal Lending Communities Model.

Volunteers will be sustained through other initiatives, funding mechanisms, and government programs and are embedded within the local communities where they live and work. According to stakeholders, these volunteers will continue to provide training for other volunteers on social–psychosocial support, using the same manuals and guidelines on home-based care and psychosocial support developed by the MOHSW, supported by the Regional Psychological Care and Support Initiative. The volunteers will also continue paying visits, managing children's clubs, and addressing issues of vulnerable groups.

Another model that will continue to be sustained is the Savings and Internal Lending Communities Model. Although this model was not directly funded by the GBVI, GBVI partners utilized these groups in their community outreach. The friendly savings and lending model for vulnerable and marginalized groups aimed at facilitating economic independence, based on traditional models of savings and credit systems. Participants who have gone through GBV trainings have used the model to organize and raise funds for GBV programming in their communities. It is increasingly being seen as a sustainable model to use for community-level prevention and awareness raising.

Challenges in sustainability include a commitment by all levels of the Government of Tanzania to make GBV a priority within the national agenda. This includes committing to financial and human resources, changing laws and policies and social norms, and increasing awareness and in regards to GBV. Stakeholders expressed hesitancy as to the national government's commitment to continue this support after GBVI funding ends. GBV programming, awareness, and sensitization have increased dramatically over the last three years. Nonetheless, the government emphasizes other health priorities over GBV. In addition, laws such as the Domestic Violence Act, which legalizes marital rape, marriage laws that allow girls to marry at age 14, and others must be amended, implemented, and enforced at national and regional levels.

CONCLUSIONS

The GBVI in Tanzania accomplished a significant amount within its three-year time frame. This report has outlined multiple successes and contributions to GBV prevention and response in the context of HIV programming, as well as opportunities for improvement in future initiatives. The GBVI Tanzania successes are summarized below, followed by opportunities.

- **Gender-transformative approaches:**[5] Gender-transformative curricula were used successfully to train national, regional, and community service providers on GBV prevention and response. The majority of programs were limited in their reach, and scale-up was focused within peri-urban communities.[6]
- **Multicomponent models:** One-stop centers and drop-in centers where patients could receive comprehensive services in one place were established and rolled out. Government buy-in to provide financial and human resources towards these centers remains unknown, because only selected local governments have provided resources, leaving sustainability of these models questionable.
- **Multisectoral coordination and collaboration:** Quarterly and annual meetings with the MCDGC, MOHA, and MOHSW have enhanced relationships and collaboration among ministries and between partners and those ministries. Engagement of the Ministry of Justice and Ministry of Education was limited.
- **Leadership by government:** The MOHSW provided leadership in coordinating across sectors. However, at regional level, there remained confusion about the responsibility for coordination, because it was meant to be under the MCDGC gender focal person. Partners suggested that future initiatives engage a prime minister level agency to lead coordination across ministries.
- **Raising awareness and visibility:** Guidelines, policies, curricula, community education, and media campaigns have all led to increased visibility of GBV in Tanzania. Harmful gender norms persist throughout the country, and national government advocacy campaigns are limited.
- **Setting the stage for other partners:** Policy and guidelines created by GBVI partners eased work for other partners in country. However, the U.S. Government and PEPFAR could have used a more systematic approach to engaging other donors outside of the U.S. Government system.

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[5] *Transformative gender programming* includes policies and programs that seek to transform gender relations to promote equality and achieve program objectives. This approach attempts to promote gender equality by: 1) fostering critical examination of inequalities and gender roles, norms, and dynamics; 2) recognizing and strengthening positive norms that support equality and an enabling environment; 3) promoting the relative position of women, girls, and marginalized groups, and transforming the underlying social structures, policies, and broadly held social norms that perpetuate gender inequalities (USAID and Interagency Gender Technical Working Group n.d.).
[6] Mbeya Region focused in peri-urban and rural communities.

- **Multisectoral training:** Training done by the MOHA and MOHSW with police, social welfare officers, health care providers, and justices enhanced cross-sectoral collaboration. However, training delivery was limited to police serving Gender and Children Desks and, therefore, clients were not guaranteed consistent survivor-friendly services.
- **Tathmini GBV**: First rigorous evaluation of GBV programming done in Tanzania. Informed future GBV programming in Mbeya and throughout Tanzania.
- **Integration within the existing HIV services:** Using the existing HIV service points for screening and services. There should be a stronger focus on integration of GBV into other health care entry points, such as family planning units and outpatient departments.
- **PF3 training:** Training police officers, health care providers, and social welfare officers increased likelihood of filling out forms. Challenges remain in getting clinicians to testify in court.
- **Indicators:** Harmonization of PEPFAR indicators within government M&E systems made large strides. There is still a discrepancy with age disaggregation between PEPFAR and the Government of Tanzania in regards to the GEND_GBV indicator. In addition, implementing partners continue to struggle to adapt their programs to fit the 10-hour training criteria. Rollout of community-level data collection and regional data management is still ongoing.
- **Forensics:** Creation of forensic tool kit and beginning of training rollout was seen as a preliminary success. However, there was limited scale-up of the training, greater capacity in labs throughout the country is needed and use of forensic kits was unclear.
- **Quality improvement:** Quality improvement was seen as a later part of the program that needs to continue to be improved upon in rollout of training, supervision, mentoring, and guidelines.
- **Community–clinic referrals:** Use of existing community volunteers for community–clinic referrals. These linkages are not systematic and were reported as one of the weaker aspects of the initiative.

LESSONS LEARNED

The purpose of this report is to document what was learned from the GBVI in Tanzania in order to inform others who want to invest in integrating GBV prevention and response into existing HIV programs and services. The lessons that stem from the GBVI in Tanzania are presented below and illustrate the importance of U.S. Government funding of GBV interventions. Allocating more funds to countries directly, rather than via centrally funded initiatives, can increase alignment of programs with government priorities and allow agencies, donors, and government counterparts to be more adaptable to changing country contexts.

Programming and Service Delivery

1. **Strengthen referrals and linkages between community and clinic and across sectors**. The GBVI in Tanzania illustrated the importance of investing financial and human resources from the beginning to strengthen referrals between communities and clinics. Designating community volunteers, health care or social welfare workers as points of contact for referral and follow-up is critical to a comprehensive GBV response. Ensuring that the liaison is properly trained in GBV-friendly services and the appropriate referral mechanisms and that referral data is entered into community-level monitoring tools stimulates greater ownership and awareness of these referral mechanisms within the community. Referrals among facility-level providers can be achieved by working with doctors and clinical providers to change their attitudes toward PF3s and by working to ensure consistent and correct use of forms as well as completing correct and thorough reporting to the court when necessary. Mapping GBV services, linkages, and referrals in communities can increase awareness among partners and community members as to where GBV services can be accessed within communities, increasing the potential for collaboration.
2. **Strengthen and expand multicomponent models.** One-stop and drop-in centers in Tanzania proved to be successful in providing GBV survivors with comprehensive services in one location. Monitoring one-stop centers for quality and impact based on number of patients, services provided, and referrals completed allows for greater documentation and the data to support greater advocacy for these centers in the future. Having a clear picture of the financial and human resources needed to establish a one-stop center will enhance partners' ability to advocate for these centers within existing government and donor budgets.
3. **Expand GBV capacity building at all levels of government.** By prioritizing training resources to cadres beyond direct service providers within the health system, the GBVI was able to ensure that both non-clinical and clinical providers had the capacity to offer services at each stage of care. This training approach, used within the MOHSW, could also be modeled within the police and justice systems, so that every level of the organization, from administration to leadership, understands and can provide GBV-friendly services. Training

police officers, as the GBVI did through the Gender and Children Desks, is an important first step in the process of ensuring that GBV survivors receive high-quality services at all stages of their referral. GBV training of prosecutors and magistrates within the justice system was limited in the GBVI, and in future initiatives, this sector should be engaged earlier in order to increase collaboration and engagement among the police, justice, and health and social welfare sectors. Training in forensic management, referrals, and GBV services within the highest levels of the police and justice system can ensure buy-in and institutionalization of GBV policies and can increase momentum in changing harmful norms at the all levels of government.

4. **Increase focus on community sensitization and awareness raising.** Evidence-based behavior change communication programming and awareness-raising activities allowed the GBVI to shift harmful gender norms. By focusing on community-level interventions and using existing community structures and volunteers to carry out awareness-raising and sensitization activities, programs can simultaneously increase community volunteer capacity and reach a wider range of individuals at the community level. By giving awareness-raising and sensitization activities importance equal to that of clinical and facility-level activities from the beginning, initiatives can ensure that the capacity built at the facility level is being utilized as a result of the demand driven by awareness-raising activities at the community level. Using schools in the community as platforms for sensitization allows for shaping of positive gender norms at critical socialization points early in children's lives. Greater attention to national-level media campaigns using radio, television, and billboards should be a focus from the beginning of the initiative in order to shift norms, particularly around the most harmful and most prevalent issues. In Tanzania, the focus was on intimate partner violence and marital rape. Complementarily, community-based interpersonal communication at the local level should be expanded to ensure that those without access to other media forums are receiving messaging on gender norms. Indicators to monitor the effectiveness of awareness-raising activities should reflect a variety of innovative approaches, such as social media and text messaging campaigns. Under the current GEND_NORM indicator, these campaigns are not counted, and innovative approaches to this important activity are therefore not well documented.
5. **Integrate GBV and VAC programming.** Systematically integrating GBV and VAC programming as cross-cutting issues can increase the impacts of all stakeholders working on these sectors. Coordinating with multisectoral agencies and other government agencies working within these fields can ensure collaboration in messaging, activities, and advocacy at all levels and can help maximize the effectiveness and efficiency of resources. This approach achieves the largest and most efficient impact given available resources.
6. **Focus on quality.** Focusing on quality of care, training, data, and forensics by incorporating quality improvement measures and metrics into every step of implementation will ensure that program quality is high from the outset. Using supportive supervision and mentoring as quality improvement methods can ensure that health care providers, social welfare officers,

lab technicians, and police officers are employing quality standards in every part of their service provision. Increasing training in forensic quality throughout the health care system ensures that evidence is usable throughout the judicial processes.

Coordination and Collaboration

1. **Strengthen and expand multisectoral synergies.** Building strong multisectoral synergies from the beginning and working frequently and consistently on coordination and collaboration improves the potential for increased GBV integration in future government programming. In Tanzania, the GBVI was able to increase engagement with new sectors and to ensure consistent contact with government counterparts by putting particular focus on the relationship between the MOHA, MOHSW, MCDGC, Ministry of Education and Vocational Training, and the Ministry of Justice. For example, the GBVI used the Police Coordination Group, organized by MOHA, to include partners and ministries from across sectors. Strengthening collaboration and coordination with the justice system by engaging the Ministry of Justice in planning, multisectoral meetings, and coordination among implementing partners can increase the likelihood that survivors will receive comprehensive care down the line.
2. **Engage broader range of stakeholders within GBV programming.** Expanding training, outreach, and sensitization to engage youth and men can ensure that a broader group of key stakeholders is trained in GBV prevention and response. Engaging the Ministry of Education and Vocational Training to incorporate GBV training and sensitization into national school curricula sets the stage for greater involvement of teachers, principals, and other school staff; enables them to become trainers on GBV sensitization within their classrooms; and helps community-based school councils create safer schools. Engaging orphans and other vulnerable children and community organizations in reaching these children outside school allows for more sensitization and awareness raising in informal settings. Expanding men's involvement in GBV training and sensitization by using curricula such as CouplesConnect, Men as Partners, and Family Matters Program can increase the shifting of harmful norms around gender inequality and GBV within communities. Encouraging participants to form community groups to continue education and outreach within their communities enhances possibility that these programs will be sustained in the future.
3. **Harmonization of monitoring and evaluation.** Working closely with the government to continuously harmonize indicators at national, regional, and community levels ensures that indicators are clear and straightforward and that they will be implemented by partners and used by government and donors in future planning, monitoring, and evaluation. Piloting and asking for feedback on indicators prior to national-level rollout mitigates challenges and the potential impact of changing indicators on implementing partner activities. Ensuring that every indicator change is providing useful and necessary information will reduce duplication and increase indicators' usability. Training community- and facility-level providers in data

collection and data quality can ensure that stakeholders are aware of the impacts of poor data quality and of the importance of avoiding double counting. Strengthening the rollout of training on the electronic database for M&E allows for partners, donors, and government employees to input data in the easiest, most standardized fashion.

Country Ownership and Sustainability

1. **Integrate GBV into the standard health package.** Use the model of the GBVI to integrate GBV guidelines, screening, and curricula into the standard package of health services across the broader health and social welfare sector. This will help ensure that GBV care is seen in the same light as other health services, and providers will become more comfortable providing post-GBV care and treatment. Integrating health services most likely to be in contact with GBV survivors, such as family planning, maternal and child health care, and outpatient departments, allows for a greater number of survivors to be screened, identified, and linked to services. This can be accomplished by working with key stakeholders overseeing these health services at the regional and national levels. For example, in Tanzania, the GBVI worked closely with the MOHSW Reproductive and Child Health Section to integrate GBV into the standard health package, which included reproductive and child health services. By using every entry point within facilities with the minimum line of services available to screen and provide emergency services to patients, a greater number of patients can be reached and a greater awareness of available GBV services can be achieved. Ensuring clinical and non-clinical providers are trained at each entry point allows for a greater awareness of post-GBV care and services among all providers and allows for greater sensitivity within the health care system overall.
2. **Raise responsibility for gender and GBV to highest levels.** Coordinating across ministries and partners can be more efficient if the Prime Minister's level takes on the lead role. Partners, including the MOHSW who led the coordination throughout the GBVI, recommended using TACAIDS as a model for what needs to happen with GBV leadership. Raising GBV above the ministry-level and creating a Tanzania Commission for Gender allows for a higher-level government agency to coordinate across ministries for GBV initiatives and raises the profile of gender through the country's highest levels of leadership.
3. **Sustainability and country ownership.** Engaging government counterparts from the beginning in planning, design, and implementation allows for greater likelihood that country programs will be relevant and sustainable. In Tanzania, putting the government (i.e., MOHSW) in the leading coordination role across sectors and partners resulted in institutionalization of guidelines, policies, and curricula into national-, regional-, and community-level protocols over a short period of time. Taking a systematic approach to engaging government stakeholders during the process allows for greater ownership and can increase the likelihood that they advocate within their ministries to get a budget line into national and regional budgets.

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ANNEX 1. LIST OF IMPLEMENTING PARTNERS BY REGION

Dar es Salaam—CDC is the main U.S. Government agency	
Implementing Partner (Project name)	**GBVI Focus**
Management and Development for Health	Regional lead, clinical
Pathfinder	Linking community and facility
Muhimbili University of Health and Allied Sciences	Key populations and police
Tanzania AIDS Prevention Programme	
Tanzania Youth Alliance	Phone hotline/referrals

FHI 360* not getting GBVI funds but working on OSC with orphan and other vulnerable children funds.

Iringa/Njombe—USAID is the main U.S. Government agency	
Implementing Partner (Project name)	**GBVI Focus**
EngenderHealth (***CHAMPION*** and ***RESPOND***)	Regional lead, clinical and prevention
Marie Stopes Tanzania	Clinical and police
Africare (***PAMOJA TUWALEE***)	Community

Mara—CDC and USAID are both the main U.S. Government agencies	
Implementing Partner (Project name)	**GBVI Focus**
Africare	Regional lead, linking community and facility
Intrahealth	Clinical
Pact (***PAMOJA TUWALEE***)	Community and police
Evangelical Lutheran Church in Tanzania	Faith-based organizations/community
Anglican Church of Tanzania	Faith-based organizations/community

Mbeya—DOD is the main U.S. Government agency	
Implementing Partner (Project name)	**GBVI Focus**
Henry M. Jackson Foundation Walter Reed Project	Regional lead, clinical and community
Mbeya Regional Medical Officer	Clinical
Kihumbe (Kikundi cha Huduma Majumbani Mbeya)	Community
Youth Empowerment through Sport Tanzania	Community
Marie Stopes (USAID)	Clinical and police

National partners—CDC and USAID are the main U.S. Government agencies	
Implementing Partner	**GBVI Focus**
American International Health Alliance	Pre-service training
International Training and Education Center for Health	Pre-service training
Child Health Section	Coordination and standards
Tanzania Commission for AIDS	Coordination
Women in Law and Development in Africa Tanzania	Policy lead partner
Futures Group *Health Policy Project*	Policy and Iringa Drop-In Centre
Deloitte BOCAR (Building Organizational Capacity for Results)	Small grants program
University of California, San Francisco	M&E lead partner
Management and Development for Health Lab	Forensics, processing of specimens
EngenderHealth (***CHAMPION*** and ***RESPOND***)	Clinical and prevention lead partner
UNICEF	VAC integration

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