Prevention of intimate partner violence - Community and healthcare workers’ perceptions in urban Tanzania

Rose Mjawa Laisser
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Community and healthcare workers’ perceptions in urban Tanzania

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2011
"Thank you for the attempts to create awareness about the problem of intimate partner violence in Tanzania. Thank you for the attempts to create awareness about the problem of intimate partner violence in Tanzania."
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ABSTRACT

Background: Intimate partner violence (IPV) against women is a public health and human rights concern. The studies forming this thesis seek to understand healthcare worker and community attitudes and perceptions about IPV; their role in support, care and prevention of IPV, and the feasibility of introducing routine screening for IPV among women attending healthcare.

Methods: Four interrelated studies were conducted in Temeke District, Dar es Salaam, Tanzania: 1) a content analysis of 16 in-depth interviews with healthcare workers about their experiences of meeting IPV clients, 2) a grounded theory analysis of seven focus group discussions that explore community perceptions, 3) a cross-sectional study of 657 healthcare workers and students to understand their attitudes and perceptions about IPV and future roles in care and support, and 4) evaluation of a pilot intervention that introduces routine screening in an outpatient department. The pilot intervention included screening of 102 women, ten observations of healthcare worker interactions with women clients, three focus group discussions, and five narratives written by healthcare workers about their experiences with the screening tools.

Results: Gender inequalities, attitudes, and poverty intersect in the explanation of IPV. Healthcare workers view low economic status among women, rigid gender norms, and stigma that influence women to stay in violent relationships. Alcohol abuse, multiple sexual partners and low levels of income among men were cited as triggers for IPV episodes. Between 20-67% of healthcare workers and students report meeting IPV clients at work. More than 90% observed clients with unexplained feelings of sadness and/or loss of confidence. Resource and training limitations, heavy workloads and low salaries constrain services. A strong desire to make a difference in the care and support of IPV clients was present, but violence as a hidden agenda with a client resistance to disclosure was a challenge. The community study shows a transition in gender norms is making violence against women less acceptable.

Conclusions and suggestions: Healthcare workers and the community strongly wish and are committed to support IPV prevention. Both groups understood the meaning, provocative factors and some IPV effects. This awareness contributes to their desire to be part of a change. At the central level, prevention of IPV should be on the governments’ policy agenda and should be prioritised. Education about gender-based violence must be incorporated into the curricula of healthcare workers. At community level, advocacy is necessary for changing harmful gender norms and measures to combat women’s poverty. Men should be engaged at all levels. Provision of information on the human rights perspectives of IPV should be strengthened and related to other types of violence.

Key words: Intimate partner violence, healthcare workers, perceptions, gender norms, social support, prevention, Tanzania.
ORIGINAL PAPERS

This thesis is based on the following papers:


III. Laisser RM, Emmelin M, Nyström L. Health care workers’ attitudes and perceptions on intimate partner violence and their views in care and prevention: a cross-sectional survey from Tanzania (Manuscript).


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ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>In plain text</th>
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<tbody>
<tr>
<td>CDC</td>
<td>Centres for Disease Control and Prevention</td>
</tr>
<tr>
<td>FGD</td>
<td>Focus group discussion</td>
</tr>
<tr>
<td>GDP</td>
<td>Gross domestic product</td>
</tr>
<tr>
<td>HCWs</td>
<td>Healthcare workers</td>
</tr>
<tr>
<td>HIV</td>
<td>Human immunodeficiency virus</td>
</tr>
<tr>
<td>HRW</td>
<td>Human rights watch</td>
</tr>
<tr>
<td>ICRW</td>
<td>International Centre for Research on Women</td>
</tr>
<tr>
<td>IPV</td>
<td>Intimate partner violence</td>
</tr>
<tr>
<td>MoCDGC</td>
<td>Ministry of Community Development Gender and Children</td>
</tr>
<tr>
<td>MUHAS</td>
<td>Muhimbili University of Health and Allied sciences</td>
</tr>
<tr>
<td>NACTE</td>
<td>National Council for Technical Education</td>
</tr>
<tr>
<td>POA</td>
<td>Plan of action</td>
</tr>
<tr>
<td>SADC</td>
<td>Southern African Development Community</td>
</tr>
<tr>
<td>TDH</td>
<td>Tanzania Demographic Health Survey</td>
</tr>
<tr>
<td>TGNP</td>
<td>Tanzania Gender Networking Project</td>
</tr>
<tr>
<td>UN</td>
<td>United Nations</td>
</tr>
<tr>
<td>UNFPA</td>
<td>United Nations Population Fund Agency</td>
</tr>
<tr>
<td>USAID</td>
<td>United States of America Aid Development</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
BACKGROUND

Intimate partner violence (IPV) against women is a worldwide public health and human rights concern. There are societies where IPV is reported to be almost absent, but they are few (Krug et al, 2002). The determinants of IPV against women occur at the individual, relational, community and societal levels (Heise et al, 1999; Jewkes, 2002; Krug et al, 2002; Koenig et al, 2006; WHO, 2010) with known health, social and economic consequences (Campbell, 2002; Krug et al, 2002; Plichta, 2004; Garcia-Moreno et al, 2006; Ellsberg et al, 2008). A major concern is how the health sector and the community can contribute to change by involvement in social support, care and prevention of IPV. This thesis addresses these concerns in the context of Tanzania.

Definitions and types of violence

There is no globally accepted definition of violence. This thesis adopts the WHO definition that “Violence is the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development or deprivation” (WHO, 2002). The words “intentional use of” are an important element that distinguishes IPV from other, unintended injuries and harm (Rutherford et al, 2007a).

The WHO definition elaborates on three categories of violence. The first is self-directed violence that includes “self harm, suicidal thoughts and other related actions which may cause self harm”. The second includes interpersonal violence which explains “the acts of violence and intimidation that occur between family members”; and the third category is collective violence, defined as an “instrumental use of violence by people who identify themselves as members of the group against the other group or set of individuals” (Waters et al, 2004). These types of violence are further illustrated in Figure 1.

Violence against women (VAW) is one of a common form of violence that refers to types of harmful behaviours directed at women and girls. According to United Nations (UN) (1994), VAW is defined as “any act of gender-based violence that results in, or is likely to result in, sexual or mental harm or suffering of women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private”. The term gender-based violence is sometimes used interchangeably with VAW and recognises that violence is often directed towards girls and women as the subordinate gender (Rutherford et al, 2007b). The most common type of VAW is IPV by men toward female partners (WHO, 2002).
Intimate partner violence is part of interpersonal violence and defined as “an actual or threatened physical or sexual violence or psychological/emotional abuse directed towards a current or former spouse, boyfriend or girlfriend or a dating partner”. IPV includes physical, sexual, and psychological abuse within a relationship in which one person in that relationship uses it to harm and take power and control over the other (Krantz & Garcia-Moreno, 2005). The Center for Disease Control and Prevention (CDC) further specifies the physical, sexual and psychological harm caused by a current or former partner/spouse that occurs in heterosexual or transgender relationships and emphasises its continuum of episodes, ranging from minor to severe battering (Saltzman et al, 2002).

**Figure 1.** Types of violence. Source: Adapted from the World Health Report on Violence and Health (2002).

The term domestic violence is often used interchangeably with IPV and includes physical, verbal, economic and social abuse (Hergarty et al, 2000). These three forms of IPV usually overlap with physical violence and are often intertwined with emotional/psychological and sexual abuse (Ellsberg et al, 2000; Ellsberg & Heise, 2005).
*IPV against women* refers to IPV exerted towards women by a male partner. This does not mean that IPV does not occur to men by women perpetrators or within same sex intimate relationships (Kelly & Johnson, 2008). This thesis focuses on interpersonal violence by men towards women since the magnitude of this type of violence is highest. The intimate relations referred apply to heterosexual intimate relationships since little is known about transgender intimate relationships in the study area.

**Types of abuse**

There are three common types of abuse: physical, sexual and psychological/emotional violence (Saltzman et al, 2002). In this thesis, we refer to abusive acts exerted by a man towards a woman partner, spouse or girlfriend.

*Physical abuse* refers to intentional use of physical force with the potential to cause death, disability, injury, or harm. Acts such as scratching, pushing, shoving, throwing, grabbing, biting, choking, shaking, slapping, punching, burning, and use of a weapon, restraints, or one’s body size or strength against another person are included.

*Sexual abuse* refers to the use of physical force to compel a person to engage in a sexual act against her will, attempted or completed sex acts without her will or understanding, or abusive sexual contact.

*Psychological/emotional abuse* involves trauma to the individual caused by acts, threats of acts, or coercive tactics. Psychological/emotional abuse can include, but is not limited to, humiliation, control, withholding of information, deliberately making someone feel diminished or embarrassed, isolation from contacts, and denying access to money or other basic resources.

**Magnitude of IPV against women**

Over the past two decades, more than 30 surveys in over 50 countries on IPV against women indicate that 20-60% of women have experienced abuse from their partners (Heise, 1994). Table 1 summarises the results from studies in Sub-Saharan Africa and four other developing countries from 1990-1993.
Table 1. Prevalence of IPV against women from eight studies published 1990-1993.

<table>
<thead>
<tr>
<th>Country</th>
<th>Year</th>
<th>Study area</th>
<th>Sample size</th>
<th>Age group</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kenya</td>
<td>1990</td>
<td>Kissi district</td>
<td>733 women</td>
<td>Reproductive age</td>
<td>42% beaten regularly by a partner.</td>
</tr>
<tr>
<td>Tanzania</td>
<td>1990</td>
<td>Dar es Salaam</td>
<td>Convenience sample of 300 women</td>
<td>Reproductive age</td>
<td>60% physically abused by a partner.</td>
</tr>
<tr>
<td>Uganda</td>
<td>1991</td>
<td>5 Kampala divisions</td>
<td>159 women</td>
<td>Reproductive age</td>
<td>46% of women (n=73) physically abused by a partner.</td>
</tr>
<tr>
<td>Zambia</td>
<td>1992</td>
<td>Lusaka and Kafue rural</td>
<td>Convenience sample of 171 women</td>
<td>20-40</td>
<td>40% beaten by a partner and 40% emotionally abused.</td>
</tr>
<tr>
<td>Colombia</td>
<td>1992</td>
<td>National survey</td>
<td>3272 urban and 2118 rural women</td>
<td>Reproductive age</td>
<td>20% physically and 33% psychologically abused. 10% raped by husbands.</td>
</tr>
<tr>
<td>Barbados</td>
<td>1993</td>
<td>Island-wide</td>
<td>264 women and 243 men</td>
<td>20-45</td>
<td>30% of women abused and 50% of the men had witnessed their mothers’ are abused.</td>
</tr>
<tr>
<td>Antigua</td>
<td>1993</td>
<td>National survey</td>
<td>Probability sample; 97 women</td>
<td>20-45</td>
<td>30% of women abused and 50% of men and women had witnessed their mothers’ being beaten</td>
</tr>
<tr>
<td>Chile</td>
<td>1993</td>
<td>Santiago</td>
<td>1000 women with relationships not ≥2 years</td>
<td>22-55</td>
<td>60% abused by a male intimate partner, 26% physically abused and 70% of those abused were beaten more than once</td>
</tr>
</tbody>
</table>

Source: Adapted from Heise (1994)
The world report on violence and health by WHO showed that in 48 population-based studies, 10%-69% of all women had been physically abused by a male partner (Krug et al, 2002). One in three women had been beaten, coerced into sex or abused at least once in her lifetime (Heise & Garcia Moreno, 2002). The variation in prevalence might be due to methodological or contextual differences (Watts & Zimmerman, 2002).

The WHO developed standardized tools that were used in the 2002 multi-country study on women’s health and domestic violence conducted in 15 sites in 10 countries. The countries include Bangladesh, Brazil, Ethiopia, Japan, Namibia, Peru, Samoa, Serbia and Montenegro, Thailand, and the United Republic of Tanzania. This study confirmed the variation in lifetime prevalence of 15-71% for physical, sexual or both forms of violence in participating countries (Garcia-Moreno, 2006). In urban Tanzania, the lifetime prevalence of physical and/or sexual violence was 41% while figures from the rural site were 56% for physical and/or sexual violence (WHO, 2005b) (Figure 2).

**Figure 2.** Prevalence of physical and/or sexual violence among ever-partnered women, by study sites. Source: WHO (2005c).
Determinants of IPV against women
IPV against women has no single or direct cause but is a product of interrelated factors occurring within a particular social context. Persistent discrimination and power imbalance between men and women within the society is known to influence the occurrence of IPV (Jewkes, 2002; Obeid et al, 2010). A common understanding of these determinants is important for effective responses of care and primary prevention of IPV. In the following theoretical framework, some important theories are explained that may help the reader understand the causes and determinants of IPV against women that are relevant to this thesis.

Theoretical framework

Culture of violence theory
This theory focuses on socially constructed gender norms that permit the use of violence by a dominant group against others. IPV is high in societies with traditional ideologies of male dominance (Levinson, 1998). Male dominance influences all levels of women’s autonomy and academic lives. At the political level, male dominance determines economic allocations. This dominance also includes medical, legal and criminal justice systems (Wamala & Lynch, 2002). In some societies, violence is so common that it is integrated into the culture. Where a ‘culture of violence’ persists, preventing IPV against women is more challenging (Jewkes, 2002; Kaye et al, 2002).

Power theory
Power theory goes further to explain the influence of violence within relationships. Cross-cultural studies on domestic violence determinants (Levinson, 1989) identified four areas of women’s subordination that influence IPV: 1) economic inequality between men and women; 2) the use of IPV to reprimand women and children; 3) men’s authority and decision-making power; and 4) bureaucracy in divorce processes. All these characteristics are observed in patriarchal societies where male dominance persists.

Bograd (1988) has a feminist perspective on wife abuse and relates IPV to the power men have as the dominant class. This allows men more access to symbolic resources and materials than women have. IPV against women is often given less importance because male dominance influences all aspects of life. The power imbalance and societal structural factors do not allow equal participation of women in social, economic and political systems. This imbalance becomes internalised by the population and is reproduced at community and family levels, thereby giving men the opportunity to control their partners. If the power balance is threatened
by changes in gender norms, and women have more influence in decision-making, IPV may increase. Men’s internal conflict and loss of identity may cause anger. IPV is used to reduce anxiety and to control women (Dutton & Strachan, 1987).

In societies where a woman’s status is either very high or very low, levels of IPV are often low because violence has no value (Counts et al, 1999). Similarly violence has no value in societies where IPV is controlled legally or culturally. Raising IPV as a human rights concern that requires prevention is therefore seen as important to change harmful gender norms (Ellsberg et al, 1997; Jewkes, 2002; WHO, 2007; WHO, 2010).

*Social learning theory*

The proponent of this theory (Bandura, 1986; 1997) explained social learning as a combination of psychological, social, and environmental factors that influence behaviours. Learning demands attention, retention, reproduction and motivation. When a person observes behaviour, that behaviour will be remembered, produced (modelling) and adopted (imitation). Social learning theory describes how children are influenced by observing the behaviours of important others. The children learn behaviours that seem to them to achieve desired results. These behaviours are modelled and patterned in social interactions with peers, through media, or at home. They become rooted and replicated in future social interactions. Social learning theory may be used to understand why observing IPV in the family of origin is a strong risk factor for men being perpetrators of IPV in adult life (Mihalic et al, 1997; Ormond, 1999). Many studies show higher rates of abuse against women whose partners experienced or witnessed violence against their mothers during their childhood (Parish et al, 2004; Dibaba, 2008; Vung & Krantz, 2009).

*The ecological model*

The ecological model was introduced in the late 1970s to examine child abuse. Later it was applied to youth violence (Kostelny & Garbarino, 1994). The ecological model puts IPV into a broad perspective and describes its determinants at the individual (intrapersonal), relational (interpersonal), community (organizational), and societal (organizational) levels (Figure 3). The ecological model helps explain how social relations need to be changed and framed in order to decrease the IPV in specific contexts (Ellsberg & Heise, 2005; WHO, 2007).
Figure 3. The ecological model of IPV. Source: Ellsberg & Heise (2005) p 26.

The individual level comprises biological and personal characteristics such as being male or female and other individual experiences related to gender norms and expectations. These factors are predictors of how an individual is at higher risk of being an IPV perpetrator or victim. In some societies, women are more likely than men to justify IPV. Women who accept IPV are more likely to experience it (Uthman et al, 2009), and men who believe it is acceptable to reprimand their wives are at greater risk of being perpetrators than others (Abrahams et al, 2004). Use of alcohol, low economic status, low education and unemployment are other individual attributes that increase the risk of being a perpetrator (Heise, 1998; Lawoko, 2006; Boyle et al, 2009; Dalal et al, 2009). Witnessing violence or being abused as a child or as an adolescent are also individual risks factors (Mihalic et al, 1997; Parish et al, 2004; Koenig et al, 2006; Dibaba, 2008).

The family/relational level focuses on close relationships such as family and friends, and refers to the context in which abuse may occur. Gender relations and how these shape the life circumstances of men and women are important. Men’s controlling behaviours, as well as control over family resources and decision-making, are known risk factors (WHO, 2005c; Krantz & Nguyen, 2009). Men
with multiple sexual partners also are at higher risk of perpetrating violence because they are isolated from emotional bonding with their spouses or permanent partners (Jewkes et al, 2006a).

The community level extends to family, neighbours, colleagues, work environment, and other social networks. IPV risk factors include restrictive marriage norms (Obeid, 2010), honour killings (Kulwicki, 2002), poverty (Jewkes, 2002) and lack of social support due to silence associated with violence (Deyessa et al, 2009). At this level, family bonding may contribute to hesitation of women to leave an abusive relationship for fear of leaving their children (Kaye, 2004).

The societal level explains how dominant societal norms, laws, socio-economic policies, and income inequalities contribute to IPV. Societal leadership may influence sanction mechanisms in cases of violence. Lack of workable policies and laws that protect women exposed to violence, as well as inadequate sanction mechanisms for perpetrators, are important societal challenges (Jewkes, 2002). Certain religious groups may also influence IPV by norms and conditions that justify IPV (Obeid et al, 2010).

**Consequences of IPV and the health sector response**

IPV against women imposes health problems, negative social effects and unnecessary economic costs. Women who experience IPV have diminished ability to participate in public life and this causes loss of productivity (ICRW & UNFPA, 2009). Women exposed to severe IPV are estimated to lose 5.6 days per week of household productivity (CDC, 2003). IPV raises the costs of healthcare resources and services, treatments, care of women and children, as well as bringing perpetrators to justice. IPV accounts for GDP losses of 1.6% in Nicaragua and 2% in Chile (Waters et al, 2004).

IPV is the cause of 40-70% of female murders in Australia, Canada, Israel, South Africa and the United States (Krug et al, 2002). Among affected women, IPV is associated with an elevated risk of memory loss, pain or discomfort, suicidal thoughts and injuries (Vung et al, 2009). In the WHO multi-country study, 25% of women exposed to IPV experienced severe injuries, fractures, broken teeth, or other serious health problems (Ellsberg et al, 2008). Mental health problems (Valladares, 2005; Crofford, 2007; Deyessa et al, 2009), chronic diseases, gastrointestinal, gynaecological, and immune disorders (Leserman, 2007, Gass et al, 2010), negative pregnancy outcomes, maternal mortality (Campbell, 2002) and HIV (Jewkes, 2006b) are associated with IPV. Women exposed to IPV are three times more likely to report health problems than non-abused women (Ellsberg et al, 2008).
The role of health care workers (HCWs) is important since they have more contact with affected women than any other professional group (Cann et al, 2001; Campbell, 2002; Fawole, 2010). The enormous negative health effects make HCWs responsible to assure that relevant services are made available (Krug et al, 2002).

Social effects of IPV include isolation from society and strained relationships, even with HCWs and employers (Plitcher, 2004). The complexity and social stigma that surrounds IPV may result in ineffective use of available health services or inability to seek help (Taket, 2003). Health professionals are not always ready to inquire about IPV and therefore the problem may continue to be unrecognised (Mezey et al, 2003; Ahmed et al, 2003; Fawole, 2010).

IPV consequences demand that the health care sector take an active role, but there is a need to understand further how HCWs and the community can best be involved in care and prevention of IPV. This thesis contributes with knowledge about how both HCWs and the community view IPV, and their perceived roles in care and prevention. The results are expected to foster policy changes and practices that reduce men’s violence against women in Tanzania.
AIMS
The aims of this thesis are to explore the possibilities and barriers for community and healthcare worker involvement in care and prevention of IPV, and to understand how these are influenced by the social context of violence.

Specific aims are to:

• Understand healthcare worker and community perceptions about IPV (Paper I-III)

• Explore healthcare worker and community views on care and prevention of IPV (Paper I-IV)

• Study the feasibility, benefits and challenges of introducing routine inquiry/screening for IPV among women who attend healthcare (Paper IV)
STUDY CONTEXT

This thesis is part of a long-term bilateral collaborative project on reproductive health between Muhimbili University of Health and Allied Sciences (MUHAS) in Tanzania, and Umeå and Uppsala Universities in Sweden, and is funded by Sida.

Violence Against Women and Children Project

The plans to investigate issues related to gender-based violence started in 2005 with an objective to build research capacity at MUHAS. The project on violence against women and children emerged from the fact that gender-based health problems had been increasingly recognized as a global public health and human rights issue.

The overall aims of the planned projects were to contribute to a better understanding of the socio-cultural factors that influence violence against women and children in the Tanzanian setting and to explore possible preventive intervention measures within the healthcare systems as well as in the community. The project involved studies on child sexual abuse, rape against women and IPV (Table 2). To be able to achieve in-depth knowledge and to allow the different studies to mutually benefit each other the projects were planned to be performed in the same geographical setting (Temeke district) and to use a combination of qualitative and quantitative approaches. Three PhD proposals were developed and it was envisaged that the principal investigators would work closely together to facilitate the planning and data collection phases and to enrich the analysis. Dissemination of results was planned to be a joint effort with emphasis to give feedback to the community and the healthcare system.

Table 2. Study designs, study areas, training institutions and PhD students involved in the Violence Against Women and Children Project.

<table>
<thead>
<tr>
<th>Project</th>
<th>Study design</th>
<th>Study area</th>
<th>University</th>
<th>PhD</th>
</tr>
</thead>
<tbody>
<tr>
<td>IPV against women</td>
<td>Qualitative and quantitative</td>
<td>Temeke District</td>
<td>Umeå</td>
<td>Rose Laisser</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(Midwife)</td>
</tr>
<tr>
<td>Child sexual abuse</td>
<td>Qualitative and quantitative</td>
<td>Temeke District</td>
<td>Umeå</td>
<td>Felix Kisanga</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(MD)</td>
</tr>
<tr>
<td>Rape against women</td>
<td>Qualitative and quantitative</td>
<td>Temeke District</td>
<td>Uppsala</td>
<td>Projestine Muganyizi</td>
</tr>
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<td></td>
<td></td>
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<td></td>
<td>(MD)</td>
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</tbody>
</table>

IPV in Tanzania

IPV against women is common in Tanzania even though prevalence figures vary depending on source and geographical area (Figure 4). The lifetime prevalences for physical and/or sexual violence was 41% for the urban site (Dar es Salaam)
and 56% for the rural site (Mbeya). The figures for current physical and/or sexual violence (within the past 12 months) are 21% for the urban and 29% rural sites (WHO, 2005a). These figures are higher than findings from a population-based study conducted in northern Tanzania where the lifetime prevalence of physical and/or sexual violence was 26% (McCloskey et al, 2005). On the other hand, the 2010 Tanzania Demographic and Health Survey (TDHS) indicated higher prevalence figures for physical and/or sexual violence of 54% in the eastern zone (where Dar es Salaam is located) and 59% for the southern highlands (where Mbeya is located).

![Figure 4: Prevalence of physical, sexual, and physical and/or sexual lifetime and current violence to ever partnered women 15-49 years in urban Dar es Salaam and rural Mbeya, Tanzania. Source: WHO (2005a).](image)

The seriousness of violence against women is recognized today in Tanzania. Several treaties aiming to prevent violence against women have been signed. An addendum to the 1997 gender and development declaration entitled “A National Plan of Action for the Prevention and Eradication of Violence against Women and Children 2001-2015” has been written (MoCDGC, 2001). The addendum relates to legal, social, economic, cultural and political areas. Training and awareness-building on legal issues is underscored. Unfortunately, the document does not explicitly include components related to health. However, an assessment of gender-based violence policies, services and interventions performed by USAID...
(2008) reported that Tanzania had shown some political will. The President publicly stated that gender-based violence should be included in the indicators of Millennium Development Goals (in an interview with UNIFEM representative Salome Onyote, September 18, 2008). A gender-focused person is also assigned for each government ministry.

**IPV and women’s health in Tanzania**

According to the WHO multi-country study (2005a), ever-partnered women with lifetime experiences of violence in both urban and rural Tanzania encounter difficulties in carrying out daily activities, problems with walking, pain, memory problems, dizziness, and vaginal discharge to a significantly higher degree than women who never experienced violence. These women have more visits for antenatal and postnatal services during their most recent live births (Ellsberg et al, 2008). Over 50% of ever-injured women need healthcare services. Seven per cent of urban and 12% of rural Tanzanian women experience abuse during pregnancy. For more than 90%, abuse was by the child’s father. For more than 30% of women who were physically abused during pregnancy, the violence started during pregnancy and was associated with marked negative maternal health outcomes, including death of the child (Stöckl et al, 2010).

Sixty per cent of urban and 50% of rural women is open about the violence with their families. However, 30% of the women told no one about their experiences. Among those who are experiencing severe abuse, 42% of urban and 21% of rural women report fighting back (WHO, 2005a).

**Attitudes towards IPV against women in Tanzania**

An attitude is a hypothetical construct that represents an individual’s degree of like or dislike towards something. Attitude is defined as “a predisposition to experience, to be motivated by, and to act toward a class of objects in a predictable manner” (Smith et al, 1956). Attitudes towards violence are therefore constructions of what people believe and judge from their experiences and their social context.

The WHO multi-country study found higher rates of IPV against women in settings where traditional gender norms normalize IPV. Women in Tanzania, like those in many other African countries (Koenig et al, 2003; Fawole et al, 2005), believe a man has the right to beat his wife under certain circumstances (eg, if she does not complete household work, refuses sex, disobeys her husband, or is unfaithful). Twenty-four per cent of the women at the urban site believe that all of these circumstances justify violence. Women believe that at least one of the circumstances justifies physical violence among 63% of the urban and 68% of the
rural participants (WHO, 2005). Attitudes towards violence are therefore shown to be part of women’s internalised norms. This is reported from several other countries (Garcia-Moreno et al, 2006; Antai & Antai, 2008; Deyessa et al, 2010).

**Rationale for the studies**

Elimination of IPV is an important element in meeting the Millennium Development Goals (WHO, 2005b; Ellsberg, 2006). This thesis is an effort to contribute evidence about ways to improve women’s survival, health and well-being.

HCWs receive clients at their workplaces who have problems related to IPV. The major challenge is recognition, provision of support, and involvement in IPV prevention. Due to the complexity of IPV, HCWs may find it difficult to provide healthcare to perpetrators while also giving care to the women (Leander, 2002).

The WHO multi-country (2005a) study provides evidence of the severity of IPV in Tanzania. The study also documents that there is resistance to disclose violent incidences to HCWs during medical care visits. IPV against women is a sensitive issue. People, including HCWs, may avoid being open and willing to even ask about such experiences.

The WHO multi-country study identified different types of IPV against women, including violence during pregnancy. However, HCWs and community perceptions were not studied. The HCWs live and work within the same social context as their clients; hence there is a need to understand the social contexts that influence community perceptions as well as the healthcare response to IPV.

This thesis aims to understand the factors that perpetuate IPV against women within the study context, and to suggest improvements for support and care of affected women. We provide suggestions for IPV prevention strategies at individual, family/relationship, community/local government, and societal/central government levels in Tanzania.
METHODS

This thesis is based on four interrelated studies conducted in an interactive process, employing a multi-method approach with both qualitative and quantitative components. The studies were conducted between the year 2006 and 2010 and the process and characteristics of the studies are given in Figure 5.

Figure 5. Overview of the process, problem analysed, data sources and analytical approaches of the thesis.

Multi-method design

Using a combination of qualitative and quantitative methods is increasing popular in public health research. This is based on Gadamer’s philosophical assumption that a research process is interactive, descriptive and explorative. He states that “coming to an understanding involves mediation, integration, and assimilation” (Gadamer, 2004 cited in James et al, 2010). By the time we assimilate the unknown, we have gained new knowledge. None of the methods are subordinate to the other. The research question guides the choice of methodology and the two may complement each other (White, 2002). Sanderlowski (2002) underscored that choosing between different qualitative approaches should be based on the research question, and no method should be ranked lower than the other. Similarly, Mayer (2000) assumes that a research approach is not based solely on ‘naturalistic’ or ‘positivistic’ ideas but is based on the researcher’s assessment of the research question.

Others argue that the best research design is the one that uses a multi-method approach (Pearce et al, 2009; Farrag et al, 2010). In public health, this may imply starting with quantitative methodologies to measure the magnitude or
determinants of a disease or a health state. This may later be followed by a qualitative study to understand the given phenomenon in depth. Quantitative measures may be used to evaluate a public health intervention in terms of quantifiable outcomes, while qualitative methodologies would focus on perceptions of how and why the intervention has or has not worked. Qualitative studies are most suitable to understand the broader sociocultural context of a public health problem or intervention. As a researcher, it is important to know how to appropriately design and analyse the different components (Lieber, 2009).

In this thesis, qualitative methods help explore community and HCWs perceptions about IPV. Qualitative methods are regarded as suitable to explore views on their roles in social support, care and prevention (Papers I-II). However, to compare HCWs and student views, we chose a quantitative approach (Paper III). In the mixed methods study (Paper IV), qualitative methods were useful to capture the challenges faced by HCWs when testing a tool for routine screening within the healthcare setting. The quantitative component was beneficial for determining feasibility of identifying IPV and other types of violence.

**Study setting**

**History and characteristics**

Tanzania, previously known as Tanganyika, became independent in 1961 when British colonial rule ceased. The United Republic of Tanzania was formed in 1964 from the union of two sovereign states, Tanganyika (Tanzania mainland) and Zanzibar (Tanzania islands).

The country is located in East Africa and borders Kenya and Uganda to the north, Rwanda, Burundi and the Democratic Republic of Congo to the west, Zambia, Malawi and Mozambique to the south, and the Indian ocean to the east. Tanzania is divided into 21 administrative regions (Figure 6) and has a total area of 945,087 km². The total population was recorded at 34 million by the 2002 national census, and by 2011 it is estimated to be about 37 million with a growth rate of 2%. Women of reproductive age (15-49 years) represent 24% of the population.

Governmental administration is central and local. At the central level are the Ministries which are divided according to functional roles. The local governments include 21 regions that are divided into 127 districts. Each district is divided into wards (“kata”), which are further sub-divided into helmets (“vitongoji”). The smallest level is villages (“vijiji”) in non-urban settings and streets (“serikali za mitaa”) in urban settings.
Health indicators

Life expectancy at birth in Tanzania is 50 years (49 years for men and 51 years for women). The total fertility rate is 5.4 per woman, but is higher among rural (6.1 births) than urban (3.7 births) women (NBS, 2010). Median age at first delivery is 19.4 years, and ranges from 18.7 years for women with no education to 23.8 years among women with secondary education and above. Modern contraceptive method use among married women is 29%, with 5% using traditional methods of contraception.
Mortality rates for infants are 51 per 1000 live births and 58 per 1000 live births for those under five. Seventy five per cent of children aged 12-23 months are immunised against six preventable childhood illnesses in accordance with the national recommendations. While 99% of pregnant women in urban and 95% in rural settings attend antenatal care services, fewer women (82% of urban and 42% of rural) deliver in a health facility (NBS, 2010).

The 2010 maternal mortality ratio was estimated at 454 per 100,000 live births while the neonatal mortality ratio was 26 per 1,000 live births. Sixteen per cent of children are underweight (too thin for their height) and 42% are stunted (too short for their age). Among those who have ever had sex, the mean number of lifetime sexual partners is 2.3 for women and 6.7 for men (NBS, 2010).

Twenty per cent of women and 10% of men never attended school, while 50% of women aged 15-49 years completed primary school education. Fewer women (16%) than men (23%) completed secondary education (NBS, 2010). Thirty six per cent of the population lives below the poverty line. In 2009, the gross domestic product (GDP) per capita was US$ 1,400 and mean wages were US$ 0.52 per man hour (CIA, 2010).

**Organization of the healthcare system**

The government, faith-based and religious organisations, private organisations, and other non-governmental organisations provide health services in the country. A referral system starts at the community level. The lowest level of healthcare provides preventive services in homes. Each village usually has a health post and two village health workers chosen by the village government. The village health workers are given a short training before they start providing services.

At the second level, dispensaries care for 6,000 to 10,000 people and supervise all the village health posts in their wards. The third level is the health centre where approximately 50,000 people receive care. The health centre is a referral point for the district hospital (one in each administrative district).

Regional hospitals receive patients for specialized services and refer to the tertiary level hospitals which are commonly termed consultant or referral hospitals. The regional medical officer is manager of the health services within the region. In each district, the district medical officer holds leadership.
Healthcare worker training

The largest public centre for HCWs training (doctors, nurses, midwives, dentists, pharmacists, radiographers, laboratory technologists and ophthalmologists) is the Muhimbili University of Health and Allied Sciences (MUHAS). Recently faith-based and private universities have provided HCW training. Non-university tertiary health institutions offer paramedical training and nursing with standardized curricula under the National Council for Technical Education (NACTE). Training takes 5 years for medical doctors and 2-3 years for nurses. At the time of this thesis, Tanzania has 107 registered tertiary health training institutions (NACTE, 2011). Most of the institutions are located near or within a district, or close to a faith-based hospital.

Study population

Studies for this thesis were conducted in the Dar es Salaam region, with a population of about 2.5 million (NBS, 2002). The population estimate by 2011 projections is about 5.8 million with an annual growth rate of 2%. Women of reproductive age (15-49 years) represent 24% of the population (NBS, 2010). The Dar es Salaam region (Figure 7) has three administrative districts, Temeke in the south, Kinondoni in the north and Ilala in the east. The main data collection took place in Temeke District, and was selected on the basis of other studies on violence against women and children that were being conducted in the area (Muganyizi et al, 2004; Kisanga et al, 2010).

Temeke District has a total population of 800,000. Women aged 15-49 years constitute 18% of the population. The district has three administrative regions (Changombe, Mbagala and Kigamboni) that are further divided into 24 wards. There was one district hospital, two health centres and 26 dispensaries in Temeke at the time of the study. The district hospital consisted of about 255 HCWs (2006-2010). Ninety per cent of the population lives within five kilometres of a health facility.

The studies were primarily conducted in peri-urban and urban areas of Temeke District. Adult men and women community members, 15 years and above, were the main source population for study II. HCWs employed at the Temeke District hospital and its catchment area were the source population for the studies that resulted in Papers I, III and IV. In addition, students at the MUHAS healthcare training institutions were part of the source population for Paper III.
Study informants
In this thesis, HCWs refer to all levels of awards given after training (ie certificate, diploma and degree levels). These include nurses, doctors, clinical officers and medical attendants employed at the clinics, dispensaries, health centres and hospitals. The community groups refer to selected groups such as religious leaders, teachers, lawyers, agricultural officers, and women’s and men’s associations who were expected to handle and give advice in cases of IPV as well as ordinary men and women in the community. Students HCWs were final year medical students, nurses, midwives, and dentists.

Sampling strategies
Qualitative studies
Qualitative methodology is suitable for uncovering the meaning of experiences (Dahlgren et al, 2007). Creswell (1998, page 15) asserts that in qualitative research “the researcher builds a complex, holistic picture, analyses words, reports detailed views of informants and conducts the study in a natural setting”. The qualitative sampling approach in this thesis aimed at capturing the actual experiences of HCWs and the community.

For the in-depth interviews (Paper I) and focus group discussions (FGDs) (Paper II), we used purposive snowball sampling. Informants were selected after support from hospital management (Paper I) and local leaders. These leaders were approached on the basis that they were more familiar with the surroundings and were able to approach informants who could capture the demographic and sociocultural variation of the area with our age specifications (15-59 years) and those who were likely to have met with people affected by IPV at work or in their community (Paper II). From the list of names given by the hospital management and community leaders, informants were selected by first approaching a few, who then suggested subsequent informants (Dahlgren et al, 2007). This process continued until saturation was reached and no new information emerged. For Paper I, saturation was reached after 16 interviews, while seven FGDs were regarded as sufficient for Paper II.

Quantitative study
We compared HCWs and students’ attitudes and perceptions of IPV and their views on care and prevention in Paper III. All staff and students from the source population were invited to participate except for staff on sick leave. Questionnaires were distributed to 382 HCWs and 320 students. Of these, 359 HCWs and 312 students returned questionnaires with response rates of 90% for the HCWs and 98% for students.
Mixed methods study

Qualitative and quantitative components were used in Paper IV. Purposive sampling was used to select participants for training and for the FGDs. Forty HCWs were selected, two from each ward or department when they were off duty during the training days. Training on basic IPV issues and screening tools was conducted prior to routine IPV inquiry/screening. Among HCWs who were trained, four clinical officers, one medical officer and two nursing officers (5 women and 2 men) from the outpatient department were selected for screening, observation, and write narratives as part of the evaluation of the training and screening components. They were selected since they were expected to meet all women who enter the hospital. The FGDs participants were selected because they either participated in training or the actual screening test.

A simple random sampling method was used for routine IPV inquiry/screening. The first three women each day were eligible and approached if they attended the outpatient department and were in a health condition that allowed them to respond to screening questions during the intervention period.

Data collection

Qualitative studies

The author of this thesis spent more hours in the field. She was well-oriented to the informants’ natural setting. She conducted all of the interviews and FGDs, sometimes in collaboration with co-researchers. Data collection took place within the informant’s work or home environment.

For Paper I, in-depth interviews were conducted using a thematic guide but with flexibility when needed. Interviews were in the Kiswahili language (the author’s national language) in an effort to accurately capture HCWs perceptions and experiences. Interview proceeded after a brief explanation and consent. They were audiotaped and each lasted between 50-90 minutes. The interview guide covered demographic and employment characteristics, perceptions about IPV, causes, consequences and their personal experiences of meeting IPV clients. Reflections on their actions, challenges, dilemmas, and opinions on IPV prevention were solicited. The interviews were later translated into English for analysis.

For Paper II, two researchers – (me and a man who were both working with violence studies) moderated the FGDs. After our introduction and obtaining consent, we informed informants about audio taping and confidentiality issues. The discussions were opened by showing a drawing of a woman who looked sad,
and they were asked to reflect on the reasons for that state without mentioning IPV. Later, they were shown more specific newspaper headlines regarding violence to initiate further discussion on IPV and its consequences. After each FGD, we reviewed and discussed the collected information so that any new insights could guide subsequent discussions (emergent design). Each focus group consisted of 8-12 informants and lasted 65-90 minutes. Saturation was reached after the seventh FGD. The FGDs were conducted in a quiet venue in the informants’ neighbourhood. During FGDs, I put my pre-understanding aside as much as possible and tried to be open for information from the informants.

The guide we used was developed based on a general understanding of IPV and consisted of general and specific items. The general items included sociocultural factors, policy environment, risks, help-seeking behaviours, and future expectations of care, support and IPV prevention by the informants. The specific items included informants’ awareness and experiences of IPV, gender norms, attitudes towards marriage, IPV consequences, family, social, medical and legal support, elder and local governmental leader roles and informants’ suggestions for prevention. Similar to the interviews, FGDs were later translated into English for analysis.
**Quantitative study**

A structured self-administered questionnaire consisting of 120 questions was used for Paper III. With the support of hospital management and class representatives, questionnaires were distributed to all eligible respondents by the author (RML). The questionnaire had a section with attitude questions that were based on the WHO multi-county study questionnaire (WHO, 2000). The second section had questions constructed to elicit respondent experiences of meeting clients, and included their views on policies, guidelines and routines for IPV care, support, education and training. The last section had questions related to HCWs views on their role in care and primary prevention. The student questionnaires were distributed in the classroom or at their practice sites. Data from 345 HCWs and 312 students were analysed.

**Mixed methods study**

To test the feasibility of introducing IPV inquiry/screening, data were collected with a simple tool that had five questions relating to women’s experiences of physical, sexual or emotional abuse. If they had been exposed to violence, they were also asked about the frequency and the relationship they had with the perpetrator. The researcher (RML) checked and collected the completed forms twice a week from HCWs who conducted the intervention. Data from 102 questionnaires were used for the analyses.

For the screening evaluation, the HCWs were observed using a checklist for their interactions with clients. The checklist involved checking action(s) taken during the inquiry. The average time spent with a client was documented and the list summarised for analysis. Three FGDs with 21 HCWs were conducted. Five narratives were written that explored HCW perceptions of the benefits and challenges of introducing routine screening for IPV.

**Data analyses**

**Qualitative data**

The premise underlying qualitative studies is that “realities are multiple and socially constructed and that knowledge is produced in interaction with others”. In this regard, the researcher is a human instrument and inseparable from the informants (Kvale, 1996). The qualitative studies in this thesis followed this line of thinking and used qualitative content analysis (Graneheim & Lundman, 2004) for Papers I and IV, and grounded theory analysis (Dahlgren et al, 2007) for Paper II.
Content analysis
Content analysis is suitable for describing the understanding of people’s actual experiences of a given phenomenon, embedded within a particular context (White & Marsh, 2006).

According to Graneheim and Lundman (2004), the interpretation process starts by the researcher reading the whole interview/FGD or narrative several times. At this stage, the researcher gets a sense of the whole, and obtains a preliminary understanding of the study phenomenon, including the context of what informants say. The whole interview, FGD, narrative, or parts are regarded as the unit of analysis. Later, selected texts are summarised into meaning units (statements or words with related ideas) and then these are condensed without losing the core meaning of what is said. The condensed meaning units help to construct categories and sub-categories that guide the researchers’ decisions to develop themes. Graneheim and Lundman (2004) asserted that the outcome of a content analysis can be manifest (content nearer to the text) and presented as categories and sub-categories. The outcome can also be latent by aiming to capture the underlying meaning of the informants experiences, formulated as themes or sub-themes. In Paper I, the analysis focused on both manifest and latent HCWs experiences. In Paper IV, the analysis was on the manifest level. A common feature is that in each step, from text to categories or themes, the researcher constantly moves between text and interpretation, and involves peers and research colleagues in the interpretation process, in order to increase the study credibility (Parvicky et al, 2005; Dahlgren et al, 2007).

Grounded theory
Grounded theory is a qualitative research approach used to explore social processes and human interaction. The approach is rooted in symbolic interactionism and involves “systematic techniques and procedures of analysis that enable a researcher to develop a substantive theory that meets the criteria for doing good science: significance, theory observation, compatibility, generalisability, reproducibility, precision, rigor and verification” (Straus & Corbin, 1990). Recent grounded theory scholars assert that rather than developing a substantive or formal theory as an end result, it is possible to put emphasis on ‘grounded theorizing’ where theoretical integration is viewed as an on going analytical process (Clarke, 2005; Bryant, 2009). Classical grounded theory follows a step-by-step processing of information into a more abstract form that can be described as a theory or model grounded in data. These steps include open coding: selective coding, theoretical coding, and integration with theory (Dahlgren et al, 2007).
In paper II, we followed the grounded theory approach to analyse community group perceptions on IPV and their role in social support of abused women and prevention. The process of analysis started by reading the transcripts then performed open coding of the transcribed text line-by-line. The software OpenCode was used to facilitate the coding process by comparing open codes within and between the FGD transcripts. The grounded theory process was extended to selective coding and theoretical coding; the steps where relevant areas of codes were conceptualized led to development of main categories and sub-categories relevant to the research aim. This is what Creswell (1998) identified as ‘discriminant sampling’. On the basis of these categories and sub-categories, a core-category that captured all the data categories was constructed. The findings were then compared with findings from other studies in the literature. At this stage, we noted that our findings related to the levels of determinants of IPV as described in the ecological model by Heise (1998). We then integrated our findings into this theoretical framework.

Data from the FGDs and the HCWs for paper I were analysed using qualitative content analysis (Graneheim and Lundman, 2004).

**Quantitative data**
The cross-sectional study was analysed using SPSS. To determine whether the differences between HCWs and students and between women and men were due to random variation or not we applied Chi-square test for categorical variables and Student’s t-test for numerical variables.

In paper IV, data from the screening forms and observation checklists were computerised using Microsoft Excel and analysed in SPSS. Women’s experiences of emotional, physical and sexual violence and their relationships with the perpetrators were analyzed on the basis of responses to the screening tool.

**Data confidentiality**
Data were kept with strict confidentiality by the author (RML) while the other members of the research team had access when needed.

**Ethical considerations**
Procedures for the studies closely followed the WHO-approved ethical guidelines on research on violence against women (2001). The WHO/CIOMS (2002) ethical guidelines for biomedical research involving human subjects’ conditions were also followed. Prior to data collection, written permission for conducting the studies was obtained from Temeke District Council and ethical approval from Muhimbili
University of Health and Allied Sciences (MUHAS). Ethical clearance at MUHAS is normally given for a period of one year and is renewable. The purpose of the study, benefits, and the right to refuse participation were clarified to the study informants.
MAIN FINDINGS

Summary of main findings

Figure 7 summarise of the main findings in relation to the ecological model described previously. Results are further illustrated in the text under the headings of the main research questions.

Main findings in relation to the ecological model

- **Determinants:** Alcohol abuse, Women’s poverty, Patriarchal structures, Unequal gender power relations, Multiple partners, Rigid gender norms
- **Attitudes:** Community questioning existing norms, IPV still normative and hidden
  - Papers I-III
- **HCWs roles:** Ability to counsel and guide clients, Obligation to provide good quality care, A desire to engage in prevention
- **Promoting factors:** Commitment and need to stop IPV, Confidence and readiness to engage in support, care and prevention
- **Barriers:** Disclosure difficulties, Low staff motivation, Lack of resources and capacity
  - Papers I-IV
- **Feasibility of screening:** Possible to identify types of violence (from partners, from relatives and from work mates)
- **Benefits:** A stepping stone for other services
- **Challenges:** Negative attitudes, Ethical dilemma, Lack of resources and capacity
  - Paper IV

**Figure 7.** Main findings in relation to levels of the ecological model indicated by blue (individual level), purple (relational or family level), green (community level) and dark brown (societal level).

Attitudes and perceptions about IPV

At the societal level the existence of IPV is influenced by gender norms, poverty and a patriarchal structure that gives men the right to control women. At the community level, HCWs and the community acknowledge IPV to be a problem regardless of sex or profession. At the relational or family level, men’s authority
and power in decision-making put women at risk of violence. Multiple sexual partners increase the risk of IPV. At the individual level, alcohol abuse was reported to play an important role in IPV episodes.

In the content analysis for Paper I (Figure 8), HCWs “internalize (d) women’s suffering and powerlessness”. This theme indicates that HCWs recognize that women suffer as “a result of subordination” or just by “being a woman”. The norm is that women depend on men for their daily living and have granted men power in terms of resources, and permit them to use IPV as a tool to reprimand women and to ensure that women accept their subordinate position. This male power extends to institutions such as the police when women report abuse. According to the HCWs, their clients were often mistreated by the police, who demanded bribes from them but gave favours to the perpetrators.

Grounded theory analysis of the FGDs (Paper II) indicated that the community has started to question the existing gender norms because of the effects they exert on IPV within their community. However, the constructed notion that men were born to be more powerful and that power is part of their masculinity is seen in the sub-category “men have different blood”. The “influence of the power of money” is also emphasized. Violence is seen as “justified as part of male prestige” (Figure 8). Men are said to be proud of being violent to their partners when they are annoyed; they saw wife-beating as a normal measure of family control.

**Community groups**

- Justified as part of male prestige
- Men have different blood
- Influenced by the power of money

**Health care workers**

- Internalizing women’s suffering and powerlessness
- A result of subordination
- Suffer by being a woman

*Figure 8.* Community groups’ and healthcare workers’ attitudes towards violence.

In the cross-sectional survey of HCWs and students, it is clear that both groups are aware of the meaning of physical, sexual and emotional abuse, and that, men and women differ in awareness of some aspects of violence. More female (43%)
than male students (6.4%) recognized acts described as controlling behaviours. More women agreed to statements justifying physical violence while more men failed to recognize a woman’s right to refuse sex. Table 4 indicates a similar pattern and provides the mean number of statements supported that recognize controlling behaviours and justifying physical or sexual violence. Table 4 also shows the support for traditional gender norms, which was lower among students than HCWs.

**Table 4.** Mean number of statements supported by healthcare workers and students for controlling behaviours, physical and sexual violence, and traditional gender norms (*p-values for comparisons between healthcare workers and students).

<table>
<thead>
<tr>
<th>Statements (range)</th>
<th>Healthcare workers</th>
<th>Students</th>
<th>*p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Men</td>
<td>Women</td>
<td>p-value</td>
</tr>
<tr>
<td>Recognition of controlling behaviours (0-7)</td>
<td>4.6</td>
<td>4.2</td>
<td>0.20</td>
</tr>
<tr>
<td>Justification of physical violence (0-6)</td>
<td>1.0</td>
<td>1.5</td>
<td>0.02</td>
</tr>
<tr>
<td>Justification of sexual violence (0-4)</td>
<td>2.7</td>
<td>2.0</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Support of traditional gender norms (0-5)</td>
<td>2.8</td>
<td>2.6</td>
<td>0.12</td>
</tr>
</tbody>
</table>

**Involvement in support, care and prevention**

**Roles of the community**

The social context of IPV in the study area is described in Paper II. Analysis of the FGDs clearly illustrated a community in transition, where violence was obviously regarded as a part of daily life. There was also recognition about the need for change. There was awareness of the influence of a patriarchal system on violence. That the social and psychological consequences of violence lead to difficulties in openness in relation to family, friends, the healthcare and legal systems were also acknowledged. At the individual level, women were still urged to speak about their experiences of violence so they could be supported. At the relationship level, neighbours were encouraged to help those affected. At the community level, responsibility to protect affected families was felt, but there was also a strong sense of a need for normative and structural changes. In one of the male FGDs, a justification for change was given.

D1: “IPV should stop: you know the women we beat are other people’s sisters and mothers” (Paper II: FGD 5).

Similarly, one of the female discussants expressed her wish to end passivity.

D2: “We need to change, show that women don’t accept violence any longer” (Paper II: FGD 4).
Roles of healthcare workers

From the qualitative interview study (Paper I), HCWs clearly experienced that abused women had difficulty with openness about their situations. The shame and stigma associated with IPV often result in women failing to disclose the actual causes of their injuries and suffering. HCWs struggled to get the information necessary for treatment, and often felt they did not have the right tools. However, they were committed to taking care of the women despite the pressures of work. They saw that the IPV clients increased their workloads. Nevertheless, HCWs acknowledged their capabilities in counselling and were ready to engage with IPV prevention activities in collaboration with others. They were “striving to make a difference”.

The common experience of meeting women with experience of violence was confirmed in the quantitative survey among HCWs and students (Paper III). Most of the clients were seen in the orthopedics, outpatient departments, and surgical indicating that IPV results in more physical and gynaecological problems than other types of health problems (Figure 9).

![Figure 9. Healthcare departments (%) where healthcare workers (HCWs) and students met IPV clients.](image-url)
Almost all HCWs and students (91%-100%) observed clients with unexplained feelings of sadness, loss of confidence, or women with physical injuries who were escorted by their husbands (Paper III, Table 4). HCW and student willingness to have a role in support and care was confirmed in the cross-sectional survey. The majority indicated to have had the courage to inquire about IPV and inform clients where to get help when they suspected exposure to violence. Over 50% stated they would always collect information surrounding the incident, but the figure was lower for male students. More students than HCWs would encourage women to report IPV to their families. More students than HCWs would also always encourage women to report to the police and find out about the relationship between the woman and her perpetrator (Paper III, Table 4).

Trust in the healthcare system was shown by a majority of HCWs and students thinking a woman would prefer to turn to the hospital or HCWs for help if they experienced IPV. More men in both groups agreed to this statement. HCWs and students regarded the police as resource, but women suggested this as an alternative less often. (Paper III, Table 5).

**Barriers to involvement in care**

The interviewed HCWs (Paper I) had difficulty eliciting information from women with suspected IPV experiences. There was a strong sense of the community taboo for married women to tell others about home secrets, thus making violence a “hidden agenda”.

“A woman may present to the hospital after a fight with her husband but would not tell the truth. Instead, she would say she has fallen down. Rarely [would she] tell you directly. (Paper I, Log 4)

Disclosure difficulties were coupled with frustration about lack of guidelines, inadequate leadership, low salaries, lack of resources and generally poor work environments (Figure 10). The category “Why bother? Struggling to manage with limited resources” captured these barriers.
The cross-sectional data (Paper III) also showed that lack of disclosure may be an important issue for HCWs who want to support abused women. More than 10% of HCWs and students report they think a woman exposed to IPV will not disclose this to anyone, with more male than female students (40% vs. 11%; p<0.001) indicating this (Paper III, Table 5). The majority of them indicated lack of policies, guidelines and routines related to IPV as problems.

During the testing of routine screening (Paper IV), HCWs expressed a need to improve the physical setting and the number of consultation rooms. A situation where two clients are usually cared for in the same room is not acceptable for confidential discussions about violence experience. In this study, analysis of FGDs indicated that some HCWs do not feel comfortable handling abused women without adequate knowledge and skills. The theme “What’s next?” showed how these HCWs identified the ethical dilemma of doing harm if capacity and structures were inadequate (Paper IV, Table 1).

The evaluation of routine inquiry/screening also found that some HCWs have attitudes of blame towards abused women and believe that conducting a routine inquiry is a waste of their time. They claim that women are already privileged compared to men, and putting more resources into women will result in “neglecting other types of violence”.

Figure 10. Issues HCWs and students wanted to be trained on.
D2 “We may have skills for counselling but we have no time with such clients because of the pressure of work. Some of these patients are themselves to be blamed. Some women don’t want to be polite to their husbands and adhere to marriage norms.” 
(Paper IV, FGD3 male nurse).

Feasibility of routine Inquiry/screening
Routine IPV inquiry/screening is feasible and HCWs were generally able to interact well with their clients. However, a few failed to follow the counselling guidelines available to them during the training. As seen in Figure 11, alarming numbers of different types of violence experiences were identified with the screening tool.

**Figure 11.** Percentages of women who had ever been exposed to violence by a partner, a relative or a workmate.

**Benefits and challenges**
The FGDs revealed benefits and challenges for HCWs who conduct routine screening for IPV (Figure 12).
The category “just asking feels good” indicates an overall positive position towards routine screening. This is seen as a sign of hope and giving work satisfaction. “What’s next?” illustrate a frustration and the ethical dilemma of not having enough resources for proper support and referral. A risk of screening is that it might cause emotional reactions that may be hard to handle, or even increase the risk of violence exposure. The category “Fear of becoming a women’s hospital only” shows a concern that to focus only on men’s violence against women in intimate relationships may mean neglecting other types of violence.
A dissemination workshop with healthcare workers, judiciary and NGO personnel in 2010.
METHODOLOGICAL CONSIDERATIONS

Strengths
The strength of this thesis lies in its use of a combination of qualitative and quantitative approaches. The qualitative components contribute to an understanding of the norm systems that form attitudes and perceptions of IPV against women, the experiences of HCWs in meeting women exposed to violence, as well as their evaluation of participating in routine screening for IPV (Papers I, II, IV). The distribution of HCW and student attitudes towards IPV, their assessment of future training needs (Paper III), and the feasibility of routine IPV inquiry (Paper IV) were determined through quantitative measures. The two approaches complement each other and enrich interpretations of the collected information.

Trustworthiness of qualitative studies is assessed through four criteria: credibility, transferability, dependability and confirmability (Dahlgren et al, 2007). Efforts to achieve “credibility” (ie, how well the data capture the research questions) included frequent field site visits. The purpose was to become familiarized with the setting and people, and to learn more about local ideas for talking about IPV. This was facilitated by the responsible researcher who originated from the region and had work experiences in different healthcare facilities. Triangulation of methods using in-depth interviews, FGDs, observations and written narratives also increased the thesis credibility. Continuous peer-debriefing meetings within the research team and checks with healthcare personnel further increased the truth value. “Dependability” refers to the ability of the researcher to assess changes in the research process over time. The use of a flexible guide for both the interviews and FGDs allowed for consistency in focussing the discussions while being open to new insights while probing and sharing. Keeping good records and notes on decisions made during the course of the study were measures taken to increase transparency and allow others to assess the data quality. Quotes and codes are included in the presentation of findings (Papers I, II and IV) to enhance “confirmability”. The aim is to assure readers that our findings are grounded in data and not a result of our pre-existing understandings, wishes or motivations. The studies are context-based and cannot automatically be transferred to other settings. Through the emergent design, multi-method approach and a clear description of the analytical processes, it is possible to judge the fitness of the interpretations to similar settings, and contributes to an analytical generalisation of the findings.

The questionnaire for HCWs and students (Paper III) was partly based on the WHO questionnaire with validated questions on attitudes and perceptions about violence against women. To assess the other questions, 20 HCWs and students
from outside the study setting answered the questionnaire. The questionnaire was constructed to be self-administered, but during pilot testing the researcher was available for questions and clarifications. This exercise resulted in minor changes of word formulations and contributes to the validity of the research instrument. All staff and students from the defined study population were invited to participate and the response rate was high. When studying the feasibility of routine inquiry (Paper IV), we invited the first three women who attended the outpatient department (OPD) during the screening period to take part. The aim was to increase the likelihood of reaching a random sample of women attending the OPD.

**Limitations**

The qualitative studies involved the researcher as an instrument. Being an insider, living in a similar community with norm systems similar to the informants, may have influenced interpretations of the data. However, as much as possible, I tried to put my pre-understanding “within brackets” and be open to learn from the informants, probing to understand the meaning of what they said. Constant peer-debriefing sessions and checks opened my mind to seeing new things.

The use of FGDs for the study of community perceptions (Paper II) may have resulted in an overly positive view of the current transition in gender norms if participants avoided expression of deviant views that justify violence. However, since we allowed for an open and free discussion, and continued until saturation, we hope to have captured the complexity of the situation.

We are aware that the sample of women for the routine screening study (Paper IV) is not representative of the population since the study is hospital-based. The sample size is small and only included women reporting to the hospital for healthcare services in the morning. Therefore it is limited to those health conditions that allowed response to the questions. These factors may have biased our results. Since only women seeking care were screened, this may have resulted in an overestimation of the prevalence of violence, whereas selection procedures may have caused an underestimation of the prevalence compared to the general population. However, the aim was not to estimate the prevalence of IPV, but to investigate whether the screening tool could indentify different types of violence.
DISCUSSION

The studies in this thesis provide an understanding of the attitudes and perceptions of HCWs and the community regarding IPV against women. They also capture views on involvement in care and prevention. Most findings can be related to levels of the ecological framework for understanding the determinants of IPV and to the different domains for change, i.e., individual, relational, community and societal levels (Heise, 1998). These levels will be referred to when relevant.

Traditional gender norms in Tanzania permit the use of IPV by men to reprimand women. Women’s sub-ordination, low socioeconomic status, and a patriarchal system characterized by male dominance determine IPV at both community and societal levels (Papers I-IV). These norms also allow for weak sanctions against perpetrators and unfair treatment of women by the legal sector (Papers I, II). At the individual level, alcohol abuse and low or lack of income among men trigger IPV episodes (Papers I, II). At the relational level, family disputes are often related to multiple sexual partners, unfair distribution of household expenditures, and an inability of men to care for their families. (Papers I, II). Men have the final say on financial and other important family matters, while women were expected to obey their decisions. These norms influence HCWs attitudes and actions towards women with IPV experiences (Papers II, III and IV). At the societal level, poverty (2009 GDP per capita US$ 1,400), burden of disease, and a human resource crisis challenge the HCWs ability to perform their duties. The impact is seen as a direct lack of available resources, inadequate staff capacity, and low work motivation that creates barriers to quality services (Papers I, III and IV). In spite of these factors, both HCWs and the community indicate a strong desire to reduce the burden of IPV situation if they have adequate support from policy makers at central and local levels.

Traditional gender norms and IPV

The norms of any society prescribe or regulate the behaviours of its people. The studied community is gendered and the expectation is that men will provide for household resources and women will do the household work. This influences men’s control over women. The culture of violence theory explains how violence may become normalized in such male dominant societies. Controlling behaviours and physical and sexual abuse by men become part of the culture (Jewkes, 2002; Kaye et al, 2002; Krantz et al, 2009; Deyessa et al, 2010).

Changes in gender norms are expected in the current era of societal transition, increased urbanization, and development of communication technologies. More
independence, freedom and openness towards gender roles are observed but changes in behaviour remain a major challenge in societies characterized by a culture of violence (Jewkes, 2002; Kaye et al, 2002; Parish et al, 2004; McClosey, 2005, Deyessa et al, 2010). The theory of power (Levinson, 1989) illustrates how such gender inequalities may allow men to be violent towards their female partners.

Financial autonomy among women is protective against IPV. In a cluster randomised study in South Africa, Pronyk et al (2006) found a 55% reduction in IPV among women who receive microfinance loans with a gender sensitizing intervention. However, others have found that the risk of IPV may increase when women are empowered to support their families since it threatens the gender norms of femininity and masculinity (Jewkes, 2002).

This thesis shows that women themselves internalise norms that justify physical and sexual violence (Paper I, II, and IV). This is consistent with findings from the WHO multi-country study as well as studies from Nigeria and Lebanon (Okenywa, 2009; Uthman et al, 2009; Obeid et al, 2010). A socioecological analysis of data from 17 countries in Sub Saharan Africa, including Tanzania, shows that women are more likely to justify physical violence than men (Uthman et al, 2009).

This thesis also shows that extra-marital relationships trigger IPV. For men, multiple partners evoke ideals of masculinity. For women, extra-marital relationships reduce the stress that results from a violent relationship or is source of extra money (Papers I, IV). The 2010 Tanzania Demographic Health Survey (TDHS) indicates that 33% of ever-married men aged 15-24 years had more than two sexual partners in the past 12 months. In Tanzania, with its high (6%) prevalence of HIV (TACAIDS, 2008), women who experience violence may become more vulnerable. A cross-sectional study from Uganda found a strong association between men having multiple partners and IPV (Karamagi et al, 2006).

All of our studies found the belief that married women should keep their home situation within the family and that it is a shame to admit to violence. HCWs and the community groups viewed IPV as an internal affair (Paper I, II). Between 11-40% of HCWs and students thought women would not IPV to anyone (Paper III, Table 5). This is consistent with the TDHS (2010) that found 30% of women had experienced physical and/or sexual violence but did not tell anyone. Disclosure difficulties are reported in many settings. In a US crime survey, Stohr and Vazquez (2003) found that few people with IPV experiences disclosed them to the police. The consequences of not having anyone to tell about violence experiences are long term stress and behavioural problems. Crofford (2007) showed that violence
experiences are a long term stressor and create vulnerability to other types of ill-health among those affected.

Community members “viewed IPV as discreditable and unfair “and a threat to women’s human dignity (Paper II, Figure 2). Viewing IPV as a human rights violation may be a good way to justify the need for change and to target the legal system (Senyonjo 2007; USAID, 2008). Today, IPV against women is not explicit addressed in Tanzanian laws (SOSPA, 1998; UN OCHA, 2002). In other countries, targeting harmful gender norms through social movements that involve mass media campaigns has allowed eventual changes to laws regulating IPV (Ellsberg, 2006; Solozarno et al, 2008).

**Alcohol and IPV**

At the individual level, alcohol abuse by men triggers IPV episodes by impairing the men’s judgement (Krug et al, 2002). Alcohol may also be used as a strategy to mount the courage to beat partners (Abrahams et al, 1999). In a South African cross-sectional study on sexual violence, the likelihood of IPV is 2.8- 3.8 times higher among men who abuse alcohol compared to those who do not abuse alcohol (Abrahams et al, 2004). A study from Bangladesh (Dalal et al, 2009) also reports alcohol as one of the main risk factors for IPV against women.

**The roles of healthcare workers and the community**

There is twofold justification for involving HCWs and the community in care and prevention of IPV. The first is their role in alleviation of the massive effects that IPV creates in the health and socioeconomic situations of women (Krug et al, 2002; Taket et al, 2003; Plitcher, 2004; Jewkes et al, 2006b; Ellsberg et al, 2008; Deyessa et al, 2009; Gass et al, 2010; Stökl et al, 2010; TDHS, 2010). The second is the possibility of influencing the persistent and harmful gender norms that allow IPV and blame the women (USAID, 2008).

This thesis confirms that clients who experience IPV need services from both HCWs and the community. The WHO multi-country study shows that more than 50% of women who were injured needed healthcare services in urban and rural Tanzania (Ellsberg et al, 2008). The TDHS (2010) indicates that 63% of women who experience physical violence within the past 12 months had cuts, bruises and aches, and 12% had deep wounds, broken bones, broken teeth or other serious injuries. Other studies found that women who experience IPV have reduced physical functioning compared to other women. They experience more ill-health and spend a greater number of days in the hospital (WHO, 2002; Vos et al, 2006; Ellsberg et al, 2008). This situation calls for both IPV care and
prevention. The WHO multi-country study suggests an urgent, comprehensive health sector response and that primary prevention take a multisectoral position (WHO, 2005c). Similarly, Guderson (2002) advocated for primary prevention since victim shelters, counselling services, on-the-job training, and legal assistance rarely exist in developing countries.

Garcia-Moreno (2002) argued that the role of HCWs in IPV prevention is related more to secondary and tertiary prevention than primary prevention. She claims that for primary prevention, HCWs should join efforts in a multisectoral approach. However, the community’s role lies in primary prevention even if there is an important role for tertiary prevention that involves activities such as home-based care programs or organized shelters.

Primary prevention is a public health approach that addresses causal factors at the exposure level and/or counter measures. It aims to stop the occurrence of a health problem, which in this context is IPV. Measures may address harmful gender norms or involve school-based violence prevention programs that address social and emotional skills development and substance abuse.

Secondary prevention refers to preventing harmful consequences. In the case of IPV, this may mean emergency care of IPV victims. Tertiary prevention aims to prevent complications resulting from the consequences and means offering long-term care to the affected person (Cooker, 2004; WHO, 2007; WHO, 2010).

Routine IPV screening is an effort to ensure that women will be supported as part of secondary prevention. IPV screening and training of HCWs on gender based violence is well-documented but also debated (Ramsey et al, 2002; MacMillan et al, 2009). In Nigeria, Fawole et al (2010) conducted a cross-sectional study on knowledge, attitudes and screening practices. HCWs with training were three times more likely to screen than those without. John et al (2010) looked at readiness to screen in Nigeria and found that HCWs with blaming attitudes towards women exposed to IPV were less likely to screen. This highlights the importance of targeting gender norms during training of HCWs who are responsible for screening or care of women with IPV experiences (Kim & Motsei, 2002).

In this thesis, the women themselves were not asked about their experience of being routinely asked about violence experiences. However, Chang et al (2005) showed that women who experienced IPV appreciated being asked. Even if it does not result in their taking immediate actions, asking may make some move from a stage of denial to thinking about acting. Women in this study were hesitant
about having healthcare workers report IPV to the police. Individual counselling and interventions that go beyond intervention for the violence, such as providing treatment for depression or substance abuse are preferred.

**Recommendations**

Intimate partner violence against women is a significant public health problem in Tanzania and is associated with severe health risks to women as well as an increased work burden for scarce HCWs. The high acceptability of IPV also acts as a deterrent to the legal sector to redress IPV. This thesis suggests that strategies for IPV prevention should include public awareness campaigns and community-based support to affected women. The government should provide appropriate support in healthcare and legal settings so that they can provide quality services. Simple, coordinated intervention models including training on gender issues, and identifying victims and perpetrators of IPV for treatment. These can be replicated in Tanzania. Routine screening may not be an intervention, but it can pave the way for proper referral and support. However, it is crucial that it is performed in a professional manner that fulfills requirements for privacy so that the safety of exposed women is secured.

Figure 13 shows barriers and challenges for care and prevention of IPV in Tanzania and indicates the measures that are needed for the healthcare sector and the community to be able to “make a difference”.

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Challenges</th>
<th>Measures</th>
</tr>
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<tbody>
<tr>
<td>Gender norms that support IPV against women</td>
<td>Changing gender norms takes a long time</td>
<td>Health sector and the community to lead advocacy for change of rigid gender norms</td>
</tr>
<tr>
<td>Lack of disclosure</td>
<td>Women fear further abuse if they disclose IPV</td>
<td>HCWs to inform policy makers and the community about health effects of IPV</td>
</tr>
<tr>
<td>Lack of knowledge on human rights</td>
<td>Women have limited access to resources and knowledge of rights</td>
<td>The legal sector and the Ministry of Womens’ affairs to advocate on women’s rights.</td>
</tr>
<tr>
<td>Lack of capacity to handle women with IPV problems</td>
<td>Training is costly</td>
<td>Researchers and educationists to train on gender based violence</td>
</tr>
<tr>
<td>Uncondusive healthcare work environment</td>
<td>Conflicting interests with IPV being less prioritised</td>
<td>The government to support for infrastructure and resources to the healthcare and legal sectors</td>
</tr>
</tbody>
</table>

**Figure 13.** Barriers, challenges and suggested measures to improve care and prevention of IPV against women in Tanzania.
THE RESEARCHER

The situation of IPV against women, highlighted by the WHO multi-county study on domestic violence, raised my interest in PhD training. As a midwifery tutor, I had come across women who seemed afraid to go back to their homes after having delivered their babies at the hospital. For many years I had no idea that this misery was related to their being in a violent relationship. I recall my first job in northern Tanzania in 1977. I found a young woman with deep, septic wounds in her buttocks—a result of her being beaten by her husband. I was shocked when she told me she would go back to the man after she was discharged from the hospital. I had no understanding of the psychological consequences of being abused or the social context that can justify this type of violence.

I started to see my own role in IPV as a HCW, a midwife, and a woman. I wished to make other HCWs aware of IPV and the role they could play. This vision kept growing in my mind as I reviewed the literature about IPV against women. The development of study plans with colleagues within the Violence Against Women and Children Project helped me organize and distance myself from my role as a midwifery teacher. Then I was able to start to understand how research may make a difference. During the process of data collection, when I listened to the community focus group discussions and interviews with HCWs, I also felt their wish to change and fight situations where women are seen as subordinate and violence is part of daily life. Sharing experiences with fellow PhD students helped me improve my knowledge, skills and understanding of data collection procedures, and of the rigor needed for interpretation of research findings.

My dreams are to continue to work for Tanzania to be an IPV-free nation where women and children will no longer suffer, and for my country to enjoy the productivity of healthier women.
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