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Private Health Sector Engagement in Gender-Based Violence Service Delivery

Lessons from Tanzania

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Summary

Private sector health providers often see clients who are survivors of gender-based violence, yet the majority of providers do not have access to the training, equipment, and support they need to provide survivors with appropriate screening, care, and referral services. The Sustaining Health Outcomes through the Private Sector (SHOPS) Plus project, in coordination with the Tanzanian government, engaged private sector health providers in training and informal networking to support their provision of gender-based violence services, offering the providers a valuable opportunity to enhance their skills to address a major contributing factor to poor health. SHOPS Plus conducted a learning assessment 15 months after the training program and found that providers feel motivated to offer gender-based violence services, but they face obstacles as private providers in a public sector-dominated health system. This brief summarizes the pilot project, shows how global lessons in gender-based violence service delivery relate to those learned in the private sector in Tanzania, and provides recommendations to facilitate the integration of gender-based violence services into the private sector in Tanzania and globally.

Keywords: Africa, family planning, gender-based violence, private providers, reproductive coercion, quality, training, violence against women

Photo: Erick Gibson for JSI Research & Training Institute, Inc.

Recommended citation: Hastings, Mary Beth, Anne K. Eckman, Lauren Rosapep, and Micah Sorum. 2021. *Private Health Sector Engagement in Gender-Based Violence Service Delivery: Lessons from Tanzania*. Brief. Rockville, MD: Sustaining Health Outcomes through the Private Sector Plus Project, Abt Associates.

This brief is made possible by the support of the American people through the United States Agency for International Development. The contents of the brief are the sole responsibility of Abt Associates and do not necessarily reflect the views of USAID or the United States government.

SHOPSPLUS
Public-private engagement for better health

December 2021

Acknowledgments

The authors extend their sincere thanks to the many people who made this endeavor possible. Festo Komba and Maureen Ogada-Ndekana of Abt Associates provided extensive guidance and support for the pilot and assessment. Saiqa Panjsheri of Abt Associates provided technical and management support during the pilot implementation. The DAMAX Solutions team helped safely capture provider perspectives during our learning assessment. We are also grateful for the sage advice, keen expertise, and dedicated partnership provided by the staff of Women in Law and Development in Africa. This initiative would not have been possible without the enthusiastic participation of the private sector providers, nor the invaluable support of Tanzania's Ministry of Health, Community Development, Gender, Elderly, and Children, in particular, its national gender-based violence coordinator, Gerald Kihwele, and its training facilitators.


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Private Health Sector Engagement in Gender-Based Violence Service Delivery: Lessons from Tanzania

Private sector health providers see clients every day who are survivors of gender-based violence (GBV), yet the vast majority of them do not have access to the training, equipment, and support they need to provide survivors with appropriate screening, care, and referrals. One in three women worldwide has experienced physical or sexual violence, most often at the hands of an intimate partner (WHO 2019a).

Recognizing the significant negative impact GBV has on family planning use, HIV prevalence, and other health indicators, governments are increasingly adopting national policies and programs to integrate GBV services into existing public sector health services. Although private health providers are preferred by many family planning clients for their accessibility, quality, and privacy, the private health sector has fewer mechanisms to launch, standardize, and monitor a GBV response. The United States Agency for International Development's flagship initiative in private sector health, the Sustaining Health Outcomes through the Private Sector (SHOPS) Plus project, seeks to provide insights on how to enable a more systematic engagement of the private sector. An important part of the project's work includes exploring ways that engaging the private sector can improve the quality and range of services, such as through GBV service delivery.

In 2019 and 2020, SHOPS Plus, in coordination with the Tanzanian government, engaged private sector health providers in training and informal networking opportunities to support the provision of quality GBV services.

Photo: UN Women/Stephanie Raison

These interventions improved the quality of care they provided and their knowledge and skills to address a major contributing factor to poor health. The pilot was designed to understand whether and under what conditions private sector providers trained in GBV service delivery could become part of a GBV continuum of care.

Gender–based violence (GBV) is directed at individuals based on their biological sex, gender identity, or perceived adherence to culturally defined expectations of what it means to be a woman, man, girl, or boy. GBV is a human rights violation, affecting men, women, and children. Violence against women and girls is most prevalent. GBV cases are often unreported or underreported, undermining the health, dignity, and security of survivors. Victims of violence, especially of intimate partner violence, can suffer sexual and reproductive health consequences, including forced and unwanted pregnancies, unsafe abortions, traumatic fistulas, sexually transmitted infections including HIV, and death.

This brief summarizes the pilot and post-pilot learning activities, shares findings, shows how global lessons in GBV service delivery relate to those learned in the private sector in Tanzania, and provides recommendations to facilitate the integration of GBV services in the private sector in Tanzania and globally.

Background

Tanzania has a critical need to expand GBV services. Violence and abuse within relationships are common, affecting 4 in 10 women. Rates are higher regionally, reaching heights of 85 percent of women in the Dodoma region, who report having experienced emotional, physical, or sexual violence at the hands of their husband or partner (Tanzania DHS 2010). Accounting for 37 percent of family planning services, private sector providers represent a critical entry point to identify, treat, and refer GBV survivors.

Tanzania has a robust GBV response infrastructure, but it has operated exclusively through the public sector. This infrastructure includes a comprehensive national policy and implementation guidelines for a GBV response and prevention by the health system, along with standardized curricula and training for public sector health workers and police. Tanzania was one of three countries in the U.S. President's Emergency Plan for AIDS Relief's Gender-Based Violence Initiative launched in 2011, and its government

developed policy guidelines, clinical protocols based on WHO guidelines, and one-stop centers, which are public regional hospitals where GBV survivors can access medical care, make a police report, and engage with a social welfare officer in a single visit. The government's response emphasizes active engagement and preparation of health facilities at various levels to ensure an appropriate facility-level response.

Tanzania's public sector GBV approach, implemented in selected regions of the country, includes:

- A three-day orientation for health facility managers and local government officials to support the GBV response
- A six-day curriculum for clinical in-service training
- A set of expert facilitators experienced in using the curriculum
- Supportive supervision and post-training follow-up by a regional health team
- Protocols and policies governing GBV response and referral
- Social welfare officers who serve as case managers for GBV survivors
- Data reporting processes for capturing GBV cases

Prior to the start of the pilot in 2019, the public sector health response to GBV in Tanzania did not systematically include private providers and facilities, missing an important opportunity for these providers to serve as an entry point to a GBV continuum of care, in which providers appropriately identify GBV survivors from among their clients and connect them to the legal, psychosocial, and the other medical services they need.

Scope

In November 2019, facilitators from the Tanzanian Ministry of Health, Community Development, Gender, Elderly, and Children (MoHCDGEC) held a six-day training on GBV and violence against children to private sector family planning providers from various facility types and levels (including referral hospitals, health centers, and dispensaries) representing for-profit and faith-based organizations. The workshop, which the MoHCDGEC typically only offers to public sector providers, was the culmination of a collaboration among SHOPS Plus, the MOHCDGEC, and Women in Law and Development in Africa, Tanzania (WiLDAF).[1] SHOPS Plus selected 36 providers from 29 private facilities, including 17 for-profit facilities and 12 faith-based organizations.

[1] Women in Law and Development Africa has extensive experience implementing GBV activities in Tanzania.

The facilities were located in Dar es Salaam, Dodoma, and Arusha—areas where SHOPS Plus had established relationships with private family planning providers[2]—as well as the ministry's priority regions of Ruvuma and Katavi. Five public sector social welfare officers from the target regions also attended the training to facilitate their role as GBV case managers. The social welfare officers are part of the teams responsible for providing supportive supervision, and they also play a key role in linking survivors to non-medical referral resources (e.g., legal, psychosocial, and economic support). Just before the training workshop, SHOPS Plus and WiLDAF conducted a one-day orientation for managerial staff in the selected facilities and local government officials in the targeted areas. Its aim was to orient health facility leadership to GBV and the Ministry's GBV policies and operational guidelines. The annex provides more details on the health care providers trained.

The MoHCDGEC curriculum is the same for public and private providers and focuses on GBV and violence against children. It includes:

- Definitions, causes, and forms of GBV
- Reproductive health rights and policies related to GBV
- GBV's relationship with HIV
- Communication skills related to GBV
- Physical examination, evidence collection protocols, and case management—including safety plans and referral pathways
- The role of health providers in GBV prevention
- Data collection and reporting; how to use data to make decisions about service delivery
- Field visits to trained providers

To keep the participants connected, the project created a WhatsApp chat group so the providers could consult with each other and share implementation experiences. In the three months following the training, all participants received remote and in-person supportive supervision visits from a team composed of MoHCDGEC facilitators, WiLDAF, and SHOPS Plus to monitor implementation, encourage data reporting, and resolve any questions about service delivery. The supportive supervision visits were designed with the MoHCDGEC as a follow-up activity to the private sector GBV training, falling outside routine supervision visits. During each visit, the team used checklists developed by the Ministry to determine the retention of skills

[2] SHOPS Plus trained these providers in administering long-acting reversible contraceptive methods.

and the availability of key documents such as medical history forms, GBV data registrars, and forensic evidence forms. These materials are standard documents developed and administered by the MoHCDGEC.

To gather lessons from the pilot, SHOPS Plus conducted two assessments: an initial learning visit, completed in February 2020 (three months after the training) and a more comprehensive, mixed-method process assessment a year later. The scope of the process assessment was limited to the private sector facilities that participated in the pilot and were still offering GBV services a year after the training. The following table provides details on the approaches used by the team for each assessment.

Due to practical limitations and the ongoing COVID-19 pandemic, capturing the perspectives of survivors who received GBV services in private facilities was not part of this assessment. The findings draw solely from providers and implementing partners, and not from survivors themselves, who may have had different perceptions of the services delivered through this pilot.

SHOPS Plus GBV pilot learning assessment activities

Activity	Purpose	Data sources

Learning visit (February 2020)	Explore providers' initial experiences with GBV service provision	• Interviews with:
		  • SHOPS Plus staff
		  • WiLDAF staff
		  • MoHCDGEC representatives
		• Site visits and interviews with 7 trained providers in Dar es Salaam

Process assessment (February—March 2021)	Understand the experience of the providers in the year following their training	• Qualitative analysis of in-depth interviews:
		  • 24 trained providers from 22 pilot facilities*
		  • 10 pilot facility owners or managers
		  • 5 social welfare officers
		  • 1 SHOPS Plus staff
		  • 1 MoHCDGEC GBV coordinator
		• Descriptive analysis of quantitative service delivery data:
		  • 19 of the pilot's private sector facilities provided data on 7 GBV-related indicators from Dec 2019—2020
		• All data collection occurred with in-county IRB approval and was collected remotely via phone due to COVID-19
		  • Interviews were conducted in Kiswahili, transcribed, and professionally translated into English for analysis
		• SHOPS Plus researchers used NVivo 12 to analyze in-depth interview transcripts using both deductive and inductive analysis approaches

*SHOPS Plus staff conducted interviews in all facilities where there was at least one trained provider (n=22) still actively providing GBV services; facilities that discontinued GBV services (n=7) were not included in the assessment. (See the annex for a description of the cadres of health providers trained.)

Key findings

This section describes four key findings that emerged from the SHOPS Plus learning activities:

1. Private providers and facilities are motivated to offer GBV services.
2. Training, supervision, and community education efforts bolster private sector service delivery.
3. Private facilities face barriers to sustainably offering survivor-focused services.
4. Reproductive coercion is common, and private providers do not typically have a protocol to address it.

> "There are many who were experiencing GBV. There are children and adults who were hiding because they saw if they come and talk in front of people or the community or service providers about the violence that they might be shamed."
>
> — Provider, faith-based dispensary Ruvuma

Private providers and facilities are motivated to offer gender-based violence services

Participating private sector providers demonstrated a high degree of commitment to learning about and providing GBV services throughout the training process and in the year following. Participants were highly motivated to attend despite having to complete an off-site, week-long training, which would remove them from their facilities and their clients for an extended period. One participant from Ruvuma traveled three days to get to the training, telling the facilitators it was worth it because she wanted to be better able to respond to and prevent the violence she regularly observed in her practice.

The learning assessment found that in pilot facilities that provided ongoing GBV services a year after the initial training, providers, managers, and owners were eager to continue serving GBV clients. They understood GBV service provision as meeting an unmet need for their clients and a social good, rather than as an opportunity to generate additional business. Most facility managers interviewed in the assessment also recognized the importance of GBV service delivery as a social obligation, with just two of 10 managers referencing a business case for GBV services.

Photo: DDC/Sama Jahanpour

Participating providers and managers used this motivation to incorporate GBV services into their daily work, albeit in varied ways. The assessment found that providers used different approaches to identify GBV cases. Half of the providers described a more proactive approach of creating an environment that let clients know that GBV services were available, conducting community education activities, giving talks in waiting rooms, or placing posters in their facilities. In line with the training they received, the majority reported that they engaged in selective screening for GBV whereby they waited until they observed indications that a client might be experiencing GBV, at which point they asked questions.

The assessment found that most providers (15 of 24) perceived that their managers actively supported the integration of GBV services primarily by giving them additional time to attend to GBV cases, often through shifting tasks to others in the facility when GBV survivors were identified. Managers also encouraged facility-level GBV awareness building through client education sessions or regular GBV updates in staff meetings. However, five providers said the support they received from management was inadequate, in that they could not spend enough time with GBV clients or perform client or community outreach. Some providers noted that they paid out of pocket to support a client's transport expenses, or to call social welfare officers.

Training, supervision, and community education efforts bolster private sector GBV service delivery

To effectively deliver GBV services, private sector providers need training to develop the appropriate clinical skills, supervision to ensure that they continue to provide quality services, and support for community education efforts so survivors know where they can obtain compassionate care. The Tanzania pilot offered training and limited supervision, while community education was at the providers' discretion. Based on insights from pilot participants, all three components were and will continue to be critical for launching and sustaining GBV service delivery and referrals in private health facilities.

Training: The Tanzanian MoHCDGEC training appears to have prepared providers sufficiently for clinical GBV service delivery. At the start of the training, observers noted that participants showed only rudimentary knowledge of GBV definitions, forms, and causes. The assessment found that a year after the training, providers reported having an improved understanding of GBV and existing public sector resources for referral. Providers emphasized their improved ability to recognize violence among patients and directly help and appropriately refer GBV survivors to additional services.[3]

Supervision: Because some providers received in-person supervision while others received remote supervision, the pilot and the subsequent assessment provided an opportunity to examine provider reactions to these differentiated modes of supervision. The assessment findings show that providers received scant GBV-focused supervision from anyone not directly related to the pilot. Providers emphasized that any type of supervisory visit has the potential to reinforce their service delivery, and they are eager for more opportunities to receive feedback. Among the 11 providers who commented positively on their supervision experience, 7 mentioned in-person visits. Some providers equated the learning visit by SHOPS Plus in February 2020 with a supervisory visit, showing that it served some of the same purposes. Although not a substitute for supervision, almost all providers who were interviewed identified benefits from participating in the WhatsApp group, as it reduced isolation, and their peers helped them problem-solve.

> "Training has helped me to understand and realize the problems of people who are being abused for both children and adults. At my facility, a lot of things were hidden; we learned a lot after putting up a poster showing that we offer services here . . . Now I have learned a lot from the training, and I have unveiled many who were staying at home."
>
> — Provider, private hospital, Dar es Salaam

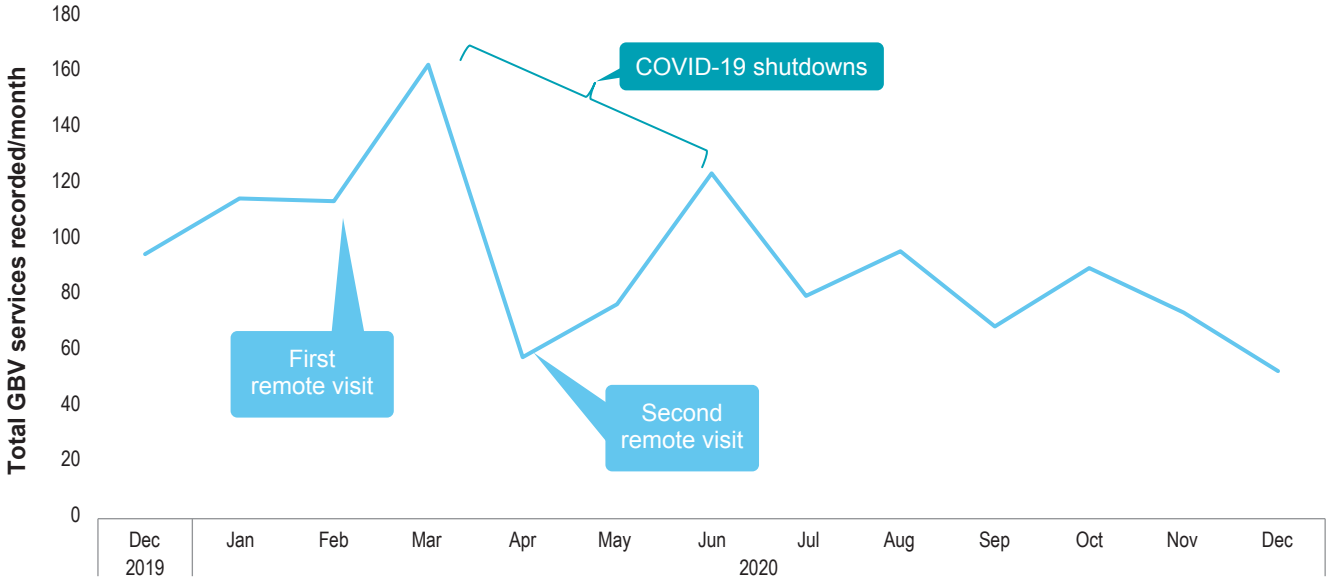
Community education: Soon after training, many participating providers realized that a lack of community awareness and stigma surrounding GBV would affect their ability to deliver GBV services. As a result, several providers were personally motivated to educate the community, either by putting up posters in the clinic or conducting educational sessions in the waiting room. One provider worked with an educator in the community to bring GBV education into a school setting. Interviewed managers understood this need as well, but most of them saw GBV awareness raising as falling outside their scope of practice.

Analysis of facility records (see figure) shows that GBV services spiked after SHOPS Plus conducted supportive supervision visits. This may indicate that providers were better at screening after these visits, or that they were reminded of the government's reporting requirements and took more accurate records. In June 2020, however, there was a decline in the total GBV services reported. While the assessment could not determine a definitive reason for this decline, potential explanations include pent-up demand for GBV services at the start of the pilot among a static client base, or a lack of motivation to continue to complete the forms for reporting GBV cases over time. Although COVID-19 related shutdowns were short-lived, the pandemic was likely an additional factor in the observed declines.

> "It is very good to be visited [in person] because when you are not visited you may forget. When you are visited if there are shortcomings, they will tell you and if you have shortages, you tell them."
>
> — Provider, private health center Dar es Salaam

[3] The assessment was not designed to measure the impact of the training on providers' quality of care.

Monthly reporting of GBV services increases after supportive supervision visits, but declines over time



Private facilities face barriers to sustainably offering survivor-focused services

Private sector facilities in the pilot reported some persistent challenges in offering GBV services, some of which may be shared by the public sector, and others likely specific to the private sector. In Tanzania, a GBV response has been developed by and for the public sector, and its health sector systems for GBV referrals, cost recovery, supplies, and data collection reflect this. The high attrition rates for health workers in Tanzania[4] also created challenges in the continuity of GBV service provision. It should be noted that the barriers documented in this section are from the perspectives of providers, managers, and MoHCDGEC officials, and not from survivors themselves, who may perceive different obstacles.

Referral processes: The assessment found that almost all private providers understood the triage and referral processes they were trained to follow when identifying GBV survivors in need of legal, psychosocial, and medical services beyond the scope or capacity of the pilot facility. First, they treat any immediate medical needs. If the facility does not have the capacity to address the need or the client cannot pay for the treatment, they will refer the survivor to a public

[4] See, for example, Tabatabai et al. 2013.

facility—in most cases to the public regional referral hospital. Then, providers assess the need to involve other government GBV response stakeholders, specifically the police or social welfare officers. Almost all (20 of 24) providers noted that they encountered clients who needed referrals in the year following their training. Five providers referenced making referrals to one-stop centers. Since the centers are not always conveniently located to clients, 15 providers described making separate referrals to the local police precinct for legal matters or to the social welfare officer assigned to their district for psychosocial support. None of the providers reported that they ever received an incoming GBV referral from another facility or GBV stakeholder, and no provider ever referred a survivor to another private facility, as this was not what they were trained to do. Outside of government GBV stakeholders, private providers in this pilot did not make any other types of referrals, although two providers noted that they were aware that social welfare officers could connect survivors to other kinds of important support services for GBV survivors such as safe houses.

> "Most people do not want to hear about the referral. They just want to get help at the same facility. If you force the referral, they might not even go."
> — Provider, private health center, Arusha

Although the providers demonstrated they were very familiar with the Tanzanian government's preferred referral procedures, providers' experiences with referrals were not universally positive. Half of the providers reported that communicating with government entities was challenging. While providers understand the importance of social welfare officers for linking the survivor to the government's GBV services, they also perceive social welfare officers to be in high demand, thinly spread, and not always available to help. Referrals are particularly challenging when there is a lack of a relationship between a facility and the social welfare officer or referral body. Some providers did not follow up with the referral destination or with patients to ensure referrals were completed. As noted previously, distance to referral facilities, particularly one-stops centers, was an issue because survivors were often unwilling or unable to travel out of their way to obtain services.

While more than half of the providers identified survivor reluctance to access referrals as a key challenge, many also recognized that their clients may choose the private sector in part to avoid reporting GBV to the government. Across public and private settings, it is not uncommon for GBV survivors to express reluctance to visit multiple facilities or involve police due to valid concerns about their safety (Podana 2010).

With some exceptions, only public sector medical doctors can fill out the medical examination report used in court cases in Tanzania. Collecting evidence and filling out the proper paperwork is covered extensively in the MoHCDGEC training curriculum and presented as a key aspect of providing proper care to GBV survivors. Providers who were interviewed reported frustration that the police would not respect their signature on the evidentiary form, despite providers having the requisite training. Although providers are encouraged to refer patients to government one-stop centers, not all regions have one. Several providers and social welfare officers expressed concern that referrals create an obstacle for survivors who want to pursue a case in the justice system. While this finding is applicable only to the Tanzanian context, there may be similar obstacles to private sector GBV services in other countries.

> "I see as a setback is their [private providers'] ability to fill PF3 [the police reporting form], which I consider as a limitation that would leave them unable to attend the [to the] client well."
> — Social welfare officer, Arusha

Cost recovery for the time and expense of GBV services: Cost recovery is an issue specific to the private sector in Tanzania. Private facilities offering GBV services do not incur substantial extra costs outside of staff time, and those that do incur costs—such as for printing, consumables, and commodities—can recoup through client fees. However, some providers mentioned that their GBV-related duties do not exempt them from their existing work, and the hours they put in with paperwork, outreach, education, and patient follow-up can be significant. The providers said that they bear this cost, not the facilities.

> "If I spend extra time offering such service, I cannot demand for overtime payment because this has become part and parcel of my responsibilities."
> — Provider, private dispensary, Arusha

All but three facilities reported charging clients a fee for GBV services. If a survivor cannot pay, the 20 remaining facilities either provide a free service (8 facilities) or refer the patient to a public facility (12 facilities). All social welfare officers who were interviewed and some providers said they were concerned that client fees could discourage GBV service access. As demand for GBV services rises with increased community awareness, some of those interviewed worried that more survivors would be turned away due to an inability to pay.

> "The only setback on management support is when there is a GBV client who is not well financially . . . they may leave unattended."
> — Provider, faith-based hospital, Arusha

Provider turnover: Attrition among private sector health providers is another constraint to providing continuous GBV care in their health facilities, particularly since most of the pilot facilities opted to send just one provider to the training. Over the 15 months between training and the assessment, nine facilities stopped providing GBV services due to the loss of a trained provider, a 30 percent loss of service delivery

capacity. Even after losing a trained provider, some facilities were able to continue to provide services by having trained providers teach other facility providers. Even though this sort of GBV training is not condoned by the MoHCDGEC, facilities have no other way of sustaining services without more frequent access to formal training.

> "One day I will leave, I tell [the facility management] this every day, so we have to make sure this expertise remains here . . . So, I usually try to use my personal time to do [stepdown training]. You [have to] make sure you train each new person on GBV so at least they know some things like screening."
> — Provider, faith-based health center Katavi

Reproductive coercion is common, and private providers do not typically have a protocol to address it

Reproductive coercion includes behaviors that directly or indirectly interfere with and seek to control a woman's or girl's efforts to prevent pregnancy. It is a distinct form of GBV, but it often occurs alongside other forms of emotional, physical, and sexual intimate partner violence. However, it is not currently part of the MoHCDGEC GBV curriculum. To assess the potential need and opportunity to address reproductive coercion in private sector facilities in Tanzania, we used the assessment to explore providers' intuitive understanding and observations of reproductive coercion. While many providers were unfamiliar with the specific terms (such as reproductive coercion, contraceptive sabotage, or pregnancy coercion), they clearly understood the concept, and most could name specific examples of reproductive coercion among their clients.

> "In our surrounding area the tendency to force women to have children is common because some women who come for family planning, most do it secretly."
> — Provider, private health center, Arusha

Providers cited examples of conflict between married couples rooted in a disagreement on family planning, which in some cases ended with the male partner insisting on the removal of the contraceptive method, even accompanying the female client to the clinic to demand its removal. In at least one case discussed by providers, the male partner himself attempted to remove an implant from his partner's arm. Some of the providers interviewed estimated that half of their clients are subjected to reproductive coercion.

> "Sometimes the woman needs to get contraception, but the husband does not allow. For example, there was a lady who came in with her husband. She had an implant inserted but her husband said we should remove it and I had to."
> — Provider, private dispensary, Dodoma

While they have no training or protocols specific to reproductive coercion, many of the providers who were interviewed attempt to tailor their contraceptive guidance to clients who report reproductive coercion by recommending less-detectable methods and meeting with women independently of their male partners. Some providers also talked about engaging male partners as a strategy to avoid reproductive coercion, but it was not clear how they

> "[It would be useful to have] guidelines on how I can provide services to reproductive coercion clients, as well as being able to educate them on the side effects they may experience."
>
> — Provider, faith-based health center Ruvuma

assessed the success or safety of these efforts. Several providers mentioned that they faced barriers to providing appropriate care to women experiencing reproductive coercion, whether due to threats or pressure from spouses, community norms that pressure women to submit to their husband's wishes on childbearing, or the high cost or unavailability of less-detectable contraceptive methods in their facility. One provider explicitly requested guidelines on how she could provide services to clients who experience reproductive coercion; such resources could help additional providers address reproductive coercion barriers and further integrate GBV into the facility's family planning service offerings.

A trained GBV provider (left) and a nurse administrator from Miracolo Hospital in Dar es Salaam

Photo: Festo Komba

Discussion

In this section, we will discuss how the findings from the Tanzania pilot relate to established best practices in GBV service delivery, offering lessons for leveraging the private health sector for expanded access to GBV care.

Equipping private sector health providers with the tools to screen, address, and refer for GBV is an urgent global need. With one in three women experiencing GBV, private sector providers very likely have survivors as clients, whether they are trained to give them GBV care or not. As pointed out by IPPFWHR, leaving health providers untrained on GBV is not only a missed opportunity to offer support and care, but also can pose a grave risk to clients:

> Health professionals who breach patient confidentiality, who respond poorly to a disclosure of violence, who blame victims, or who fail to offer crisis intervention can put women's safety, well-being, and even their lives at risk (Bott et al. 2010).

As emphasized by global bodies, efforts to expand access to compassionate GBV services within the health sector must be based on a "do no harm" approach that centers on survivor preferences and needs (UNFPA 2019). The Tanzania pilot provides important lessons related to these global best practices on GBV, both in terms of how to avoid harm and in how private sector providers can best fit into a systemic, survivor-centered GBV response.

Global Best Practice 1: Health providers can serve their clients by affirming their right to live free from violence. As respected authority figures in their communities, health providers can play an important role in validating survivors' experience and disrupting the social norms that sustain GBV (Bott et al. 2010).

> **Lesson from Tanzania:** Acknowledging GBV as a rights violation and a public health problem—instead of a private, family matter—can reframe the issue in a powerful way for a survivor. In Tanzania, providers spoke about "hidden" violence becoming "unveiled" because of their facilities' posters addressing GBV. Family planning providers are well placed to help women understand voluntary contraceptive use as their right and reproductive coercion as a form of violence.

Global Best Practice 2: Health providers can and should offer survivor-centered medical and emotional support to minimize costs to the survivor. Aside from delegitimizing violence, health providers should address survivors' immediate wounds and health care needs, while offering respect and compassion for their experiences (Bott et al. 2010).

> **Lesson from Tanzania:** This pilot showed that counseling and treatment (including wound care and administering post–exposure prophylaxis and emergency contraception) were among the commonly cited services provided to survivors. At an individual and facility level, providers and managers understood the need to stock necessary supplies and accommodate the time necessary for medical and emotional support. To address contraceptive needs, family planning providers should understand and screen for reproductive coercion and understand that stocking and offering less–detectable family planning methods can protect their clients. For the private sector, program implementers and policy makers should ensure private sector facilities can provide this kind of routine compassionate care at a limited cost or free of charge to the survivor.

Global Best Practice 3: Respect survivors' assessments of their own safety. While reporting GBV to authorities may be a step that some survivors want to take, a global best practice for survivor-centered care is to prioritize the survivor's own judgment about the safety and wisdom of reporting.

> **Lesson from Tanzania:** Survivors may seek the private sector to avoid reporting their abuse to the government, and may not want to report to other facilities, or to the police. As learned in this pilot (as elsewhere), providers found many survivors reluctant to visit outside facilities. While several providers expressed frustration at clients' reluctance to accept referral, others understood the vital need to respect the survivors' decisions. Providers need to continue to be supported to respect the decisions of survivors who do not wish to report GBV. When survivors do wish to report, providers need to be able to refer seamlessly and without policy barriers.

Lesson from Tanzania: Survivor safety needs to be prioritized in male engagement strategies. When discussing reproductive coercion, several Tanzania providers said they were eager to include men, but providers' male engagement efforts need to be very conscious of survivors' expressed desires related to informing or involving male partners. Providers—and others staffing their facilities—must understand the critical (and potentially life–saving) importance of confidentiality.

Global Best Practice 4: Health providers should be able to share referral resources, even if the survivor is not ready to access them. Survivors typically need much more than medical care and the health sector can be a good entry point to access other services, such as legal, psychological, and social support. In its recent curriculum for training health care providers, WHO notes that providers should not be expected to solve all violence-related issues (WHO 2019b). Rather, stakeholders in the health system should play appropriate roles based on their resources, capacity, and expertise.

Lesson from Tanzania: Outside of the social welfare officers, private sector providers in this pilot did not have the community connections to facilitate access to other services for survivors. Some of these providers tried to overcome these barriers themselves or take on roles that they were not best positioned to play. Even if providers do have information on other resources, they may not refer effectively if they pressure survivors to overcome their resistance. Private sector providers should have access to updated service directories, relationships with community organizations, and communication with local social workers and other GBV coordinating networks that may exist to facilitate referrals—and the training to respect survivors' decisions on whether and when to seek additional help.

Global recommendations

As shown by this pilot, the private health sector can be an enthusiastic and essential partner for ensuring widespread access to GBV services. While there are challenges in integrating private providers into the health system's GBV response, there are also promising benefits in terms of client health and rights. Future projects—wherever they are implemented—should consider the following recommendations as they prepare for implementation:

Consult with survivors to develop survivor-centered approaches to GBV service delivery, including on reproductive coercion. Placing survivors at the center of the health system's response is crucial when creating training curricula and protocols for GBV services. This pilot suggests that providers need clear guidance on how to respect client decision making related to referrals, when and whether to engage male partners in family planning discussions, and how to address reproductive coercion consistently and professionally. Consulting directly with survivors, or organizations that work directly with them, should lay the groundwork for such guidance and protocols.

Assess the level of government-led response prior to implementation. An engaged ministry of health with protocols and training curricula for health providers is a tremendous advantage in crafting a private sector response. The availability of legal, social, and psychological resources for GBV survivors is essential to sustaining the health system's response. Projects should assess the national and local GBV response during the planning process and coordinate with the public sector and NGOs where possible.

Provide robust supportive supervision. In-person supervision can boost providers' confidence in delivering GBV services, improve the quality of their care, and ensure national protocols are followed. This assessment suggests that supervisory visits remind providers to conduct screening and record their cases.

Photo: DDC/Sama Jahanpour

The supervisory process also provides an opportunity to monitor providers' feedback on how well they are supported by their facilities, and on their interactions with the public sector on GBV cases. Acting on such feedback may help providers avoid burnout and deal with the particular challenges of serving GBV survivors.

Develop a solution on cost and supplies. To sustain GBV services in the private health sector, private providers should have a way to recoup the costs of extra time in counseling and recordkeeping, extra materials for community education, and extra commodities and supplies to meet survivors' needs. At the same time, survivors should not bear the costs of their abusers' actions. Vouchers or another reimbursement system can help ensure private providers are able to sustain GBV services.

In 2019, SHOPS Plus supported the Ministry of Health's GBV training for private providers.

Photo: Festo Komba

Encourage public-private collaboration at the local, regional, and national levels. Private providers will be most effective if they are recognized by the public sector as partners in GBV prevention and response. Private sector representatives should have access to information and decision making bodies to achieve a coordinated approach. Including private sector voices at all levels will help ensure that they are able to contribute meaningfully and respond in areas of greatest need.

Invest in GBV resource mapping. Private providers must be able to seamlessly refer clients to appropriate services. This is more challenging where there is a lack of information about existing organizations that serve GBV survivors. Mapping GBV resources is a significant undertaking and requires ongoing updates, but it is essential to identifying service gaps and connecting survivors to the support they need.

Include policy advocacy as needed to facilitate the private sector response. National and local GBV policies are not always designed with the private sector in mind. Projects that engage the private health sector should analyze and address any policy-based obstacles to integrating GBV services and addressing the needs of GBV survivors.

Ease providers' burden through ensuring the strength of critical pathways. Survivors of GBV need services and support above and beyond compassionate medical care, yet the sustainability of the private sector GBV response depends on providers being able to stay within their domain of expertise. Health providers should only be expected to provide compassionate medical care and to help connect survivors to other points on the GBV response pathway. Public sector processes and systems that fill gaps in this response pathway and support community-based responses (legal, psychosocial, prevention education, etc.) are essential to private sector providers' integration of GBV services.

Support anti-GBV civil society organizations. Civil society groups can channel the needs of survivors, advocate for an improved policy response, and educate communities on GBV in creative and appropriate ways. This groundwork is essential for helping private providers serve survivors effectively. Funding for anti-GBV work, however, tends to be limited, leaving enormous gaps in the medical, social, and legal systems that should be addressing GBV.

Conclusion

If GBV were a potentially fatal medical disease affecting one in three women, the private health sector would be an active part of the solution, with private health facilities equipped to prevent, screen for, diagnose, and respond to the illness. This pilot project was a preliminary exploration of the complexities and dynamics related to integrating the private sector into a public sector GBV response. The results show that the private sector can be an important partner in a public sector response, given requisite training, preparation, and follow-up. Most importantly, with additional investment, private health facilities can close this gap in their provision of quality care and better respond to the epidemic of violence that affects such a large proportion of their clients.

Hilda Muarabu, a social welfare officer, holds a copy of Tanzania's National Plan of Action to End Violence against Women and Children.

Photo: Erick Gibson for JSI Research & Training Institute, Inc.

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Annex:
Gender-based violence training details

Table 1. Health care professionals trained, by cadre

Health asst.	Enrolled nurse	Asst nurse officer	Nurse officer	Nurse midwife	Clinical officer	Asst medical officer	Social welfare officer	Total
1	6	9	2	7	10	1	5	**41**

Table 2. Private sector heath providers and facilities trained, by location and previous SHOPS Plus training status

Region	Dar	Arusha	Dodoma	Ruvuma	Katavi	Total
Providers (facilities)	10 (10)	9 (8)	5 (5)	6 (3)	6 (3)	**36** providers (29 facilities)
Of participants, number rural	0	0	0	2 (1)	4 (2)	**6** providers (3 facilities)
Of participants, number with previous SHOPS Plus training	10 (10)	9 (8)	5 (5)	0	0	**24** providers (23 facilities)

Table 3. Private sector heath providers and facilities trained, by facility level

	Total participants (facilities)	Average number of facility patients per day
Faith–based organization/ private referral regional hospital	5 providers (2 Arusha, 3 Dar = 5 regional referral hospitals)	200
Faith–based referral district hospital	2 providers (1 Arusha = 1 district referral hospital)	100
Private health center (24–hour care)	22 providers (6 Dar, 3 Arusha, 3 Dodoma, 3 Katavi, 2 Ruvuma = 7 health centers)	70
Dispensary (outpatient only)	7 providers (2 Arusha, 2 Dodoma, 1 Ruvuma, 1 Dar = 6 dispensaries)	55

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Sustaining Health Outcomes through the Private Sector (SHOPS) Plus is a five-year cooperative agreement (AID-OAA-A-15-00067) funded by the United States Agency for International Development. The project strategically engages the private sector to improve health outcomes in family planning, HIV, maternal and child health, and other health areas. Abt Associates implements SHOPS Plus in collaboration with the American College of Nurse-Midwives, Avenir Health, Broad Branch Associates, Banyan Global, Insight Health Advisors, Iris Group, Population Services International, and the William Davidson Institute at the University of Michigan.

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