International Journal of Translational Medical Research and Public Health (2021), Volume 5, Issue 2, 125-134

IJTMRPH

Available online at www.ijtmrph.org

INTERNATIONAL JOURNAL OF TRANSLATIONAL MEDICAL RESEARCH AND PUBLIC HEALTH
ISSN 2576-9499 (Online)
ISSN 2576-9502 (Print)
DOI: 10.21106/ijtmrph.234

ORIGINAL ARTICLE | VIOLENCE

Accessibility to Gender-based Violence Health Services for Adolescent Girls and Young Women in Tanzania

Caroline Mtaita, MD, MPH;[1,2]✉ **Samuel Likindikoki,** MD, MMED;[3] **Shishira Mnjokava,** MSc;[4] **Gaspar Mbita,** MSc;[5] **Elvis Safary,** MPH;[1] **Dawud Hilliard,** DHS, MPM, HTL (ASCP) QIHC;[6] **Albrecht Jahn,** MD, PhD, MSc[1]

[1]Heidelberg Institute of Global Health, Heidelberg, Germany; [2]Christian Social Service Commission, Tanzania; [3]Muhimbili University of Health and Allied Sciences, Tanzania; [4]Health Education and Livelihood Empowerment, Tanzania; [5]Jhpiego Tanzania – An Affiliate of John Hopkins University, Tanzania; [6]An Affiliate of Nova Southeastern University, Florida, USA

✉Corresponding author email: caroline.mtaita@uni-heidelberg.de

ABSTRACT

Background and Objective: Gender-based violence (GBV) health services can offer lifesaving prevention and treatment, particularly for GBV survivors among adolescent girls and young women (AGYW), which includes post-exposure prophylaxis (PEP) provisions, counseling, and referrals to other GBV programs. Although there are many benefits to GBV services, such as HIV prevention, sexual and reproductive health rights, and mental well-being, the number remains small for GBV survivors who access these services following the violence. This study was focused on identifying and describing the perceived barriers and facilitators of accessing GBV health services among AGYW in Tanzania.

Methods: This was a qualitative study in which a structured and in-depth interview process was used for AGYW (N = 20) aged between 15 - 24 years old in two districts of Dar es Salaam: Temeke and Kinondoni. The interviewer explored the participants' perspectives on barriers and facilitators relating to GBV health-service access. Audiotapes from the participants' responses were transcribed and later translated. Thematic areas were identified using the Social-Ecological Model. Transcripts were analyzed using inductive content analysis.

Results: The study findings were divided into barriers and facilitators. Key barriers included lack of knowledge on available GBV health services, stigma, low self-esteem, negative attitude, fear of HIV testing, fear of disclosing perpetrator(s), and lack of parental support. Key facilitators included community and parental support, positive-prior experiences, and peer support.

Conclusion and Implication for Translation: It is paramount to strengthen existing interventions to address community and GBV health facility stigma and to empower survivors in the overcoming of fear- and esteem-related issues. Additionally, it is necessary to increase GBV survivors' access to related GBV health services through strengthening facilitators' abilities and influences.

Keywords: • Gender-Based Violence • Adolescent Girls • Health Care Workers • Barriers • Facilitators • Health Services • Survivors • Tanzania

1. Introduction

1.1. Background of the Study

Gender-based violence (GBV) against adolescent girls and young women (AGYW) is persistent in Sub-Saharan Africa (SSA), including Tanzania, where one in three females have experienced violence of some kind[1] compared to the global statistic of GBV where at least one in five women have experienced physical or sexual abuse at some point in their lives.[2] GBV is associated with many negative health consequences for AGYW and impedes their holistic development and exacerbates gender inequalities.[3] Gender plays a role in the access and usage of GBV health services on several levels. Gender norms are always determined by culture and the societies in which people live and vary significantly across and within cultures.[3] Norms also govern differences in roles, rights, and opportunities for men and women in society.[3]

There are multiple studies on sexual violence's prevalence and its sequelae among AGYW.[4,5] These studies draw attention to GBV's mental health impact among AGYW as a result of sexual violence and the group's elaborated measures to overcome adversity while seeking access. It is broadly recognized that AGYW are at an increased risk of GBV.[6,7] GBV among AGYW has both physical and psychological consequences that greatly vary across different contexts, for example, increased rates of sexually transmitted diseases, such as HIV/AIDS, syphilis,[8] and unwanted pregnancies.[9] Additionally, there are negative social and economic impacts of GBV on survivors and their families.[10]

Globally, underreporting and failure to seek help occur with barriers, such as shame, stigma, financial barriers, lack of service-ability awareness, and fear of reporting the offender(s), are cited in various studies.[11-13] According to the last Tanzania Demographic Health Survey (TDHS; 2015 – 2016), the percentage of women who accessed health services following GBV was low (1.1%),[14] despite governmental efforts in GBV prevention and responses, such as the provision of GBV management guidelines at all health facility access points, staff training and development, the establishment of one-stop centers, and establishment of a national recording system for GBV cases.[14]

Access to GBV health services can simply be referred to as accessibility, availability, acceptability, affordability, and timely use of health services to achieve desired outcomes.[15,16] However, AGYW continue to face significant inequalities in accessing and using health care, particularly in low-and-middle-income countries.[17] Other barriers to seeking health care included fear of retaliation,[20] distrust of health care workers, the belief that violence was normal, and stereotypical attitudes.[20] The timely uptake of appropriate health care services can be important for maximizing performance, participation, and quality-of-life improvement. Despite international and local commitment for universal health coverage, there is evidence to suggest that AGYW face a range of physical, financial, and attitudinal barriers, which limit their access to GBV health care.[18] Several studies in Tanzania focused on obstacles and facilitating elements related to health service access in specific populations, such as pregnant women, the physically challenged, and the elderly.[19]

Additionally, studies conducted by Kirby (2010) revealed that the vast majority of AGYW in Tanzanian experienced violence in their homes by someone they knew, making it difficult to report to authorities and health providers.[17] However, little is known regarding accessibility to GBV health services in Tanzania and the barriers AGYW experience (individually, socially, or institutionally) to meet their needs for GBV services. Based on these gaps, we aimed to identify barriers and opportunities for AGYW's access to GBV health services. Findings will contribute to the design and implementation of health care programs for AGYW. The present study was performed to explore perceived barriers and facilitators that influence access to GBV health services in Tanzania. We sought to explore perceived accessibility barriers and facilitators to GBV health services among AGYW in Tanzania.

2. Methods

2.1. Study Area

The study was conducted in multiple locations within the Temeke and Kinondoni districts of Dar es Salaam

Region in Tanzania. These locations were selected because they had the highest reported cases of GBV in Dar es Salaam.[20]

2.2. Study Design and Population

The study employed a qualitative-based descriptive design to explore AGYW perception. We adopted the Social-Ecological Model by Dahlberg and Krug,[21] which is designed to understand the influence of violence as well as potential prevention strategies. For the study's purposes, we adjusted the model to understand barriers and facilitators that hinder and encourage AGYW from accessing GBV health services.

2.3. Sampling

Different views and perceptions of barriers and facilitators were collected from the participants using an interview protocol. The participants were part of a Sauti project, a comprehensive community outreach program implemented by the Ministry of Health and John Hopkins Program for International Education in Gynecology and Obstetrics (JHPIEGO) in 14 regions of Tanzania. A purposive selection of 10 AGYW from each district was used for the study's qualitative part, totaling 20 AGYW. All interviews were conducted in a quiet and private area by two local and experienced research assistants (one from each district). The interviews were conducted in Swahili. The research assistants received a one-day research training delivered by an experienced expert. AGYW over the age of 18 years were asked to read and sign informed consent forms for the study. Consent from guardians/parents was sought for AGYW under the age of 18 years. Each in-depth interview (IDI) took approximately 20 to 30 minutes to complete. During the interviews, participant probing was applied whenever necessary to ensure the results' quality and to minimize data loss.[22]

2.4. Data Collection

We used a face-to-face in-depth interviews protocol to collect qualitative data. The interview began with broad questions relating to the participants and their opinion of the GBV health services; we then moved to questions about barriers and facilitators relating to GBV health services.

2.5. Analysis

We undertook the qualitative data's content analysis using the Social-Ecological Model,[21] with the aim to inductively gain the barriers and facilitators' descriptive overview. We performed a tape-based and note-based analysis of the data. Content analysis was manually performed to identify themes regarding AGYW's assessment of barriers and facilitators to GBV health services. The data went through a stepwise process of inductive coding performed by the researcher including grouping themes from identified categories.

2.6. Ethical Approval

The study was granted ethical approval by the Medical Research Coordinating Committee (MRCC) of the National Institute for Medical Research (NIMR) in Tanzania (NIMR/HQ/R.8a/Vol.IX/2986) and the Ethics Committee of the Medical Faculty of Heidelberg University (S-737/2018). Approval to work in the study wards was obtained through official permission from respective central and local government authorities and leaders. Permission to access the AGYW groups was granted by the JHPIEGO Country Director. All participants provided written informed consent for participation in the study. Confidentiality was maintained for the participants as their names nor identification were used in this study.

3. Results

3.1. Demographic Characteristic of the Study Participants

According to the demographic characteristics, the participants predominantly were between the age of 19 to 22 years old, single (60%), and the majority (60%) had attained a primary level education. Details are summarized in Table 1.

3.2. Barriers in Accessing GBV Health Services Among the Study Participants

According to the participants, several barriers influenced the ability of AGYW to access GBV health services. These factors have been divided into individual/personal, interpersonal, and institutional factors as summarized in Table 2.

Table 1. Demographic Characteristics of Adolescent Girls and Young Women in the Study

Characteristic	Number (%)	
Age (Years)		
15-18	6	30%
19-22	10	50%
23-24	4	20%
Education level		
No formal education	1	5%
Primary education	12	60%
Secondary education	7	35%
Marital status		
Single	12	60%
Married	4	20%
Divorced/Separated	4	20%
Having children		
No	13	65%
Yes	7	35%
Occupation		
*Sex work	7	35%
Petty business/trader	9	45%
Unemployed	4	20%

*Received payment for sex in the last 6 months

Table 2: Barriers and Facilitators that Hinder and Encourage Adolescent Girls and Young Women from Accessing Gender-Based Violence Health Services

Characteristics	Barriers	Facilitators
Individual/ Personal factors	Lack of knowledge on accessibility to GBV services offered at health facilities	Awareness of services at health facility
	Stigma from health care workers and the community	
	Low self-esteem and a negative attitude towards accessing GBV services	
	Lack of parental support	
	Fear of disclosing perpetrator Fear of HIV testing	
Social/ Interpersonal factors	Fear of being judged by healthcare workers	Peer support
	Fear of being judged by parents & the community	Supportive family and community
	Denied permission to leave the house	A positive-prior experience with health workers
	Parents or guardians silenced by perpetrators	
Institutional factors	Bad experience with health care providers	Posters with GBV messages
	Cost of GBV treatment	Media/GBV messages from radio and IEC materials such as leaflets
	Health facility barriers, such as lack of sufficient space for privacy & confidentiality	NGO's working on community outreach programs, such as *Huduma rafiki*

The most common barriers that were expressed by the participants during the interviews were individual barriers. All 20 participants shared that lack of knowledge on GBV-service availability was most prominent. Nineteen out of 20 participants expressed fear of stigma from health care workers, parents, and community, and 18 out of 20 participants feared HIV testing. Fourteen out of 20 participants expressed low self-esteem and a negative attitude towards accessing GBV health services. Eleven out of 20 participants cited fear of disclosing perpetrators, and 5 out of 20 reported a lack of parental support.

3.3. Lack of Knowledge on the Availability of GBV Health Services

All 20 participants indicated a lack of awareness of available GBV health services offered at the health facility. The services were not sufficiently advertised for AGYW to know of their existence.

> *I think many girls do not know if dispensaries offer services for girls who have experienced violence. Before I heard of such services, I used to go to pharmacies and buy myself pain killers or pen V if I had vaginal itching or discharge.* Participant #20
>
> *Women do not know of such services; I knew of the police but not dispensaries. As for me, I only got to know of PEP when I joined this group [SBCC Sauti groups] and at that time it was too late as I had already contracted HIV.* Participant #13

3.4. Fear of Stigma from Health Care Workers, Parents, and the Community

Nineteen out of 20 participants noted that they encountered labeling, stereotyping, and separation, especially for those who experienced sexual violence. They were labeled as being promiscuous and feared the stigmas associated with tests outcome. Some health care workers insulted them with negative names, leading some participants to avoid mentioning that they experienced violence.

> *After my form four graduation, we went clubbing with my friend to celebrate. I was then raped by 4 different strangers. I was scared of how people would think of me. Following treatment, my mother decided we move from Kinondoni to Temeke as people were already talking.* Participant #12

Sixteen out of 20 participants (accompanied by their parents at the health facility) hesitated to ask for advice since they were in the company of their parents or guardians; the participants were concerned with openly disclosing the GBV occurrence to both the parents and health provider. Discussing GBV encounters are taboo; parents and the community are more ashamed to talk about violence.

> *We are afraid of discussing the issue with anyone. Our parents and people around are even ashamed to discuss the topic of violence, especially sexual violence. They do not want anyone to know that their daughter or sister was raped.* Participant #10

3.5. Fear of HIV Testing

For 18 out of 20 participants, fear of testing was a dominant theme that emerged from the data. This fear was realized through the negative interactions between the participants and the environment with behavior relating to their sexual activities. Participants who experienced sexual violence mentioned that they avoided health facilities for fear of being tested for HIV.

> *I am a sex worker, so I am at risk of getting AIDS, so why should I go and get embarrassed and end up being discriminated by people? I would rather not go. Eventually, everyone dies, I would rather not know.* Participant #17

> *Sometimes when you sleep with these men, they tend to break their condoms on purpose. That way, I am at risk of contracting HIV. I am scared of getting tested.* Participant #5

The quote below points to the participants' inability to cope and manage the consequences of a positive-HIV result; hence, they have testing fears and consequently avoid accessing GBV health services.

> *I know if one is taking HIV drugs, they need to eat well and take good care of themselves; otherwise, the drug kills you before the disease; I have seen this happening to some girls. As it is, I don't have the money to eat sometimes; I have to rely on my friends and roommates for food. Trust me; it is not easy to go and get tested after rape knowing all this.* Participant #17

3.6. Low Self-esteem and a Negative Attitude Towards Accessing GBV Health Services

Fourteen out of 20 participants identified that they already had low self-esteem and a negative attitude towards GBV health services, which consequently, has a significant impact on accessing GBV health services. Additionally, life frustrations influenced the negative attitude they had towards service accessibility. Participants also indicated that they received discouraging advice and remarks from their peers, health facility staff, parents, and the community.

> *I know I am a sex worker and am at risk of being raped, but that does not give the health care workers opportunity to call me names and blame me for being a victim… I am not worthy enough to receive any care…. I am not even sure if the services will be of help anyway…. I would rather walk to a pharmacy and explain myself and get medication rather than go to a hospital.* Participant #16

Seventeen out of 20 participants refused help because they somehow assumed responsibility for the perpetrator's violence and blamed themselves (for the violence) and health care workers, believing that the abuse was their fault even if it was not.

> *I know the work that I am doing* (prostitution) *causes men to rape me. My life is already stressful enough and on top of it, when I go to the hospital,*

the doctors and nurses will blame me; thus, there is no need to go and get myself embarrassed. It is not that I want to get raped or sell my body. But what can I do, it is what it is… Participant #15

3.7. Fear of Disclosing the Perpetrator

Eleven out of 20 participants indicated that many of them do not access health facilities for fear of disclosing the perpetrator, especially if the perpetrator was a spouse, boyfriend, or someone well known to them. This is because most participants reported that disclosing the perpetrator's identity would trigger more violence upon them. Some participants also mentioned that the perpetrators were their major breadwinners and reporting them meant the perpetrators would stop providing for them financially; hence, they would lose everything. Some participants also experienced the resounding shame of disclosing the perpetrator, since there was a social expectation that women should remain with their male partners at all costs.

I fear... I fear going to the facility, because I will end up being asked a lot of questions that will put him (boyfriend) in trouble, and he might beat me up or chase me out of the house… and I do not have anywhere to go. Participant #9

My sister and I used to live with our uncle, who used to rape us. We both contracted HIV from him. We were afraid to tell anyone as he was paying for our school fees and other things. Participant #12

3.8. Lack of Parental Support

Preventive health services are important for child development, and parents play a key role in facilitating access to services. Five out of 20 participants reported general discomfort and worry about their parent's reaction because they felt like they were not getting any parental support. Sometimes parents/guardians were themselves the perpetrators or the participants were paid off by the perpetrator to keep the issue silent.

I told my parents once I experienced violence, and they did not do anything to help…. Instead, they told me not to talk about it with anyone ever again…I felt so sad because I thought they would help me get treatment. Participant #2

I reported my uncle to my mother for raping me, and instead, I was told to stay quiet, this is because my uncle is the one providing money to my family. Participant #3

Seventeen out of 20 participants also mentioned they were not getting any support after they experienced violence because their parents were embarrassed that their daughter experienced violence, particularly sexual violence.

I was raped when I was 12 years old, I was still living in the village. I was so scared of telling my mother and grandmother as I knew they would have not helped me and seen me as an embarrassment. They still do not know this happened to me. Participant #15

4. Facilitators of Access to GBV Health Services Among AGYW

According to the participants, several facilitators influenced the ability of AGYW to access GBV health services. These factors have been divided into individual/personal, interpersonal, and institutional factors as summarized in Table 2.

The most common facilitators that were expressed by our participants during the interview were social/interpersonal facilitators. Thirteen of the 20 participants shared that they had supportive family and community members, and 7 out of 20 participants expressed that they had a positive prior experience with professional health workers. For 9 out of 20 participants, peer support was reported as a facilitator to access GBV health services.

4.1. Supportive Family and Community

Thirteen of the 20 participants consistently described the immediate family as the first source of support when they experienced GBV. The family offered advice, emotional support, and in most cases, they escorted the survivor to the hospital and police. Additionally, some participants mentioned that their families paid for their hospital bills. Participants also mentioned that if an issue could not be solved by the family, family members immediately sought help from community leaders.

When I got raped and told my mother, she took me to the hospital where I got treated. My mother is closely working with the social worker in following

up on the one who raped me. My father is not cooperative at all, but that has not stopped my mother. Participant #11

I was working as a housemaid for a family. The man of the house used to rape me. Once the wife found out, she put all the blame on me, even cut my hair, and started beating me badly. The neighbors heard the commotion and came to my rescue. A few neighbors took me to the hospital, where I got help. Participant #5

4.2. Positive-prior Experiences with Professional Health Workers

Seven out of 20 participants mentioned that they had positive experiences with health care workers (HCWs) to the extent of being linked to other GBV services such as social workers.

Through this project (Sauti), I was referred to the hospital. The HCW was so friendly to me and advised me to use medicine (PrEP). I would advise girls like me not to be afraid to seek health services. Participant #5

I went to the hospital for a burn wound injury but did not mention any violence as I was scared. The nurse called me aside after dressing my wound and pleaded with me that I can open up and tell her the truth; she was kind. I eventually told her that I was burnt by my partner. She advised me to go and talk to a social worker and seek counseling. Participant #3

4.3. Peer Support

Nine out of 20 participants mentioned that knowing other GBV survivors who previously received GBV health services was important in terms of advice and encouragement. Through this relationship type, GBV survivors can better understand the nature of services offered at the health facilities. Additionally, linkage to support groups, such as Social behavior change and communication (SBCC) groups and other small community groups, was critical.

If an adolescent girl experiences violence, then she goes to the facility to seek help and if they are assisted, it motivates others (GBV survivors) if they hear of such stories. Participant #9

One of my neighbors was raped and got help. Through her, I got to know that hospitals offer GBV health services. She even encouraged me to join the group. Participant #2

5. Discussion

This study fills a gap by providing rich descriptions of AGYW's perceived barriers and facilitators that hinder or encourage them from accessing GBV health services; thereby, augmenting the existing literature on reproductive health and GBV relating to adolescent girls in Tanzania.

In identifying these barriers and facilitators, the participants were a key information source for understanding the challenges of GBV health services. This is because the participants were the study's main subjects who received care. The participants highlighted barriers, such as lack of GBV knowledge and the availability of GBV health services in health facilities.

5.1 Access Barriers to GBV Health Services Among the Participants

Stigma was a key barrier emphasized in our study. Stigma undermines treatment and successful health outcomes. Addressing stigma is fundamental to delivering quality GBV health care and achieving optimal health for AGYW. Stigma perpetuated by health care providers, parents, and the community has been shown to be primary barriers among AGYW in accessing GBV health services. This was similar to a study among HIV-uninfected adolescents seeking reproductive health services in resource-limited countries.[23] Our study has gone further to indicate that the stigma AGYW face is due to them being labeled as promiscuous. This negative response is based on institutional perception and community norms of when adolescents should be engaged in sexual activities. School-based interventions in resource-limited settings have been critical in changing norms among adolescent girls and leading to behavior change.[24] Some participants in this study also highlighted that some health care providers had already visited their schools to promote adolescent knowledge about GBV services.

Fear of HIV testing was also predominantly highlighted by the participants. A fundamental issue mounting the fear of HIV testing was an individual disclosing her own sexual behavior. Adolescent participants working as sex workers were very

reluctant to seek GBV services due to fear of being tested for HIV. This fear can be due to a lack of knowledge in coping mechanisms once a positive result has been confirmed. Existing literature highlights some of the barriers that exist, such as personal factors, and include personal behavior and how it can negatively affect testing intentions and consequently, create fear for HIV testing.[25,26] The fear of HIV-related stigma is well acknowledged in existing literature [27] and is supported in this study; this fear acts as a robust barrier to testing for AGYW.

Some participants had issues with social support from parents and their communities in our study. Parental involvement, particularly in seeking GBV health services, may be instrumental in decision-making and creating a responsive environment. The participants' perception about lack of a support network, such as limited (if any) safe spaces or environment for young women, created a number of other barriers, such as fear of stigma, which may not exist if the perceived stigma were diminished. There is considerable literature on the challenges and potential benefits of parental involvement in care.[28]

Low self-esteem and a negative attitude to accessing GBV health services was a specific barrier expressed by the participants. Self-esteem and a positive attitude have been shown to enhance an individual's ability to cope with a situation and/or disease.[29] Some participants showed a lack of self-love or happiness in their deserving of any health services, a lack of reliance on health care providers, and that their particular responses would compromise their confidentiality and how they were viewed in the community. These factors are potential problems; they require designing strategies that encourage and support adolescent girls in the improvement of their self-esteem and accessibility to GBV health services.

5.2. Facilitators of Access to GBV Health Services Among the Participants

Participants noted that knowing other GBV survivors who previously received GBV health survivors was helpful. These other survivors could narrate their experiences regarding the GBV health services they received, the service type, and how they were treated by the health providers. Peer-to-peer interaction is one strategy that has been used to motivate and encourage adolescents to be interactive in any activity. They can also be used to improve access to health services.

Participants reported that they found effective help from supportive parents and the GBV-survivor community. Local community leaders are featured as key gatekeepers and are the second intermediary for GBV survivors. Local community leaders were referred to as "ten cell leaders," despite that these leaders rarely had any GBV training. However, the majority of GBV survivors first seek assistance from family or other members of their social network.

A positive-prior experience with professional health providers meant that providers delivered outcomes that positively impacted participants. Positive-prior experiences with health workers are essential parameters to measure outcomes guiding quality improvement in health care settings. Adolescent girls preferred health care workers who listened to them and showed compassion; hence, effective communication and high-quality information from patient arrival to discharge positively influences AGYW engagement in clinical decision-making. This was contradictory in other studies that indicated prior-positive experiences with health providers indicated different levels of satisfaction with different people (young women).[30]

Our study has several strengths, including sampling participants from different wards within the Temeke and Kinondoni districts. The open-ended questions allowed for participants to voice different barriers and facilitators.

5.3. Limitations

Nonetheless, our study has a few limitations. The study interviewed participants who were already part of a country-wide AGYW project being implemented by the Ministry of Health and JHPIEGO. However, the project implemented a community-based method to recruit the study participants.

6. Conclusion and Implication for Translation

Our study identified individual barriers and institutional facilitators that hindered and encouraged AGYW access to GBV health services. Given the high prevalence of gender-based violence among AGYW in

Tanzania, it is imperative that AGYW access to GBV health services be improved. This should be considered as a loss for AGYW in their access to GBV services. Improved strategies should be aimed to increase this population's access to these services. However, these recommendations are from the targeted population's perspective (demand side); it would also be important to examine the health system/providers' perspective (supply-side) and receive their insight.

Compliance with Ethical Standards

Conflict of interest: *The authors declare that they have no competing interests.* ***Financial disclosure:*** *None.* ***Funding/Support:*** *Caroline Mtaita (CM) received doctoral funding for fieldwork from Brot für die Welt. The sponsor was not involved in the study design, the collection, analysis, the data interpretation, and the manuscript composition.* ***Ethical approval:*** *The study was granted ethical approval by the Medical Research Coordinating Committee (MRCC) of the National Institute for Medical Research (NIMR) in Tanzania (NIMR/HQ/R.8a/Vol.IX/2986) and the Ethics Committee of the Medical Faculty of Heidelberg University (S-737/2018). Approval to work in the study wards was obtained through official permission from respective central and local government authorities and leaders. Permission to access the AGYW groups was granted by the JHPIEGO Country Director.* ***Consent for publication:*** *The participants were told (orally) that the findings would be published in scientific journals and that the findings would be presented in the form of examples/quotes provided by the participants.* ***Acknowledgment:*** *The authors gratefully acknowledge the support of the District Medical Officer's office (both Temeke and Kinondoni districts) for granting support to conduct the research. We also appreciate JHPIEGO and civil society organizations for providing access to AGYW who participated in the study.* ***Disclaimer:*** *None.*

Received: July 30, 2020
Accepted: May 16, 2021

Key Messages

- Gender-Based Violence (GBV) survivors experience fear and esteem-related issues. More emphasis on empowering GBV survivors at both health facilities and the community is needed.
- Specific attention should be given to health programs that provide GBV health services to adolescent girls and young women.
- Strengthening existing interventions to improve GBV survivors' accessibility to GBV health services is critical

References

1. Don M. The United Nations Convention on the rights of persons with disabilities. *Syracuse J Int'l L & Com.* 2007;34:323.
2. Venis S, Horton R. Violence against women: a global burden. *Lancet.* 2002;359(9313):1172. doi: 1110.1016/S0140-6736(1102)08251-X
3. Kishor S. The heavy burden of a silent scourge: domestic violence. *Rev Panam Salud Publica.* 2005;17(2):77-78. doi: 10.1590s1020-49892005000200002
4. Zraly M, Rubin-Smith J, Betancourt T. Primary mental health care for survivors of collective sexual violence in Rwanda. *Glob Public Health.* 2011;6(3):257-270. doi:210.1080/17441692.17442010.17493165
5. Zraly M, Nyirazinyoye L. Don't let the suffering make you fade away: an ethnographic study of resilience among survivors of genocide-rape in southern Rwanda. *Soc Sci Med.* 2010;70(10):1656-1664. doi: 1610.1016/j.socscimed.2010.1601.1017
6. Austin J, Guy S, Lee-Jones L, McGinn T, Schlecht J. Reproductive health: a right for refugees and internally displaced persons. *Reprod Health Matters.* 2008;16(31):10-21. 10.1016/S0968-8080(1008)31351-31352
7. Asgary R, Emery E, Wong M. Systematic review of prevention and management strategies for the consequences of gender-based violence in refugee settings. *Int Health.* 2013;5(2):85-91. doi: 10.1093/inthealth/iht1009
8. Kim AA, Malele F, Kaiser R, et al. HIV infection among internally displaced women and women residing in river populations along the Congo River, Democratic Republic of Congo. *AIDS Behavior.* 2009;13(5):914-920. doi: 910.1007/s10461-10009-19536-z
9. Lehmann A. Safe abortion: a right for refugees? *Reprod Health Matters.* 2002;10(19):151-155. doi: 110.1016/s0968-8080(1002)00026-00025
10. Kelly J, VanRooyen M, Kabanga J, Maclin B, Mullin C. *Hope for the Future Again: Tracing the Effects of Sexual Violence and Conflict on Families and Communities in Eastern Democratic Republic of the Congo*. Cambridge, MA, USA: Harvard Humanitarian Initiative; 2011.
11. Du Mont J, Forte T, Cohen MM, Hyman I, Romans S. Changing help-seeking rates for intimate partner violence in Canada. *Women Health.* 2005;41(1):1-19. doi: 10.1300/J013v1341n1301_1301
12. UNICEF. *Violence Against Children in Tanzania: Findings from a National Survey, 2009*. Dar es Salaam: UNICEF Tanzania. Centers for Disease Control Prevention and Muhimbili University of Health Allied Sciences; 2011.
13. Casey SE, Gallagher MC, Makanda BR, Meyers JL, Vinas MC, Austin J. Care-seeking behavior by survivors of sexual assault in the Democratic Republic of the Congo. *Am*

J Public Health. 2011;101(6):1054-1055. doi: 1010.2105/AJPH.2010.300045

14. National Bureau of Statistics. *Tanzania Demographic and Health Survey 2010*. National Bureau of Statistics *and ICF Macro*; 2011.
15. Dutton D. Financial, organizational and professional factors affecting health care utilization. *Soc Sci Med.* 1986;23(7):721-735. doi: 710.1016/0277-9536(1086)90121-90128
16. O'Donnell O. Access to health care in developing countries: breaking down demand side barriers. *Cad Saude Publica.* 2007;23(12):2820-2834. doi: 2810.1590/s0102-2311x2007001200003
17. Kirby N. Access to healthcare services as a human right. *Med Law.* 2010;29(4):487-496.
18. Odetola TD. Health care utilization among rural women of child-bearing age: a Nigerian experience. *Pan Afr Med J.* 2015;20. doi: 10.11604/pamj.2015.20.151.5845
19. McCleary-Sills J, Namy S, Nyoni J, Rweyemamu D, Salvatory A, Steven E. Stigma, shame and women's limited agency in help-seeking for intimate partner violence. *Glob Public Health.* 2016;11(1-2):224-235. doi: 210.1080/17441692.17442015.11047391
20. National Bureau of Statistics. *The 2012 Population and Housing Census: Basic Demographic and Socio-economic Profile.* National Bureau of Statistics Mininstry of Finance and Office of Chief Government Statistician; 2014.
21. Krugg E, Dahlberg L, Mercy J, Zwi A, Lozano R. *Violence—A Global Public Health Approach. World Report on Violence Health.* World Health Organization; 2002.
22. Price B. Laddered questions and qualitative data research interviews. *J Adv Nurs.* 2002;37(3):273-281. doi:10.1046/j.1365-2648.2002.02086.x
23. Tylee A, Haller DM, Graham T, Churchill R, Sanci LA. Youth-friendly primary-care services: how are we doing and what more needs to be done? *Lancet.* 2007;369(9572):1565-1573. doi: 1510.1016/S0140-6736(1507)60371-60377
24. Hindin MJ, Fatusi AO. Adolescent sexual and reproductive health in developing countries: an overview of trends and interventions. *Int Perspect Sex Reprod Health.* 2009;35(2):58-62. doi: 10.1363/ipsrh.1335.1058.1309
25. Njagi F, Maharaj P. Access to voluntary counselling and testing services: perspectives of young people. *South African Review of Sociology.* 2006;37(2):113-127. doi: 10.1080/21528586.2006.10419150
26. Ikechebelu I, Udigwe G, Ikechebelu N, Imoh L. The knowledge, attitude and practice of voluntary counselling and testing (VCT) for HIV/AIDS among undergraduates in a polytechnic in southeast, Nigeria. *Niger J Med.* 2006;15(3):245-249. doi: 210.4314/njm.v4315i4313.37222
27. Young SD, Hlavka Z, Modiba P, et al. HIV-related stigma, social norms and HIV testing in Soweto and Vulindlela, South Africa: NIMH Project Accept (HPTN 043). *J Acquir Immune Defic Syndr.* 2010;55(5):620-624. doi: 610.1097/QAI.1090b1013e3181fc6429
28. UNAIDS. *The Gap Report 2014: Adolescent Girls and Young Women*. UNAIDS; 2014.
29. Mann MM, Hosman CM, Schaalma HP, De Vries NK. Self-esteem in a broad-spectrum approach for mental health promotion. *Health Educ Res.* 2004;19(4):357-372. doi: 310.1093/her/cyg1041
30. Williams B. Patient satisfaction: a valid concept? *Soc Sci Med.* 1994;38(4):509-516. doi: 510.1016/0277-9536(1094)90247-x