Prevention and Mitigation of Intimate-Partner Violence: The Role of Community Leaders in Tanzania

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Abstract
Intimate-partner violence (IPV) is a major public health issue that disproportionately affects women, especially in Tanzania where 40% of women report experiencing IPV. While IPV research has focused on IPV victims and perpetrators, community leaders can provide valuable insight on IPV at the community level. We conducted 50 key informant interviews with community leaders in nine villages in the Karatu district. These leaders identified common themes regarding IPV causes and consequences, reporting methods, and future recommendations. This information can help mitigate IPV at the community level in future interventions and shows community leaders themselves could be powerful tools in future IPV programming.

Keywords
intimate-partner violence, community leaders, Tanzania

Introduction
Intimate-partner violence (IPV) is a major public health problem and human rights violation. IPV is defined as physical, sexual, emotional or economic violence within a
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relationship and has been described as both “spousal violence” and “domestic violence” in the literature (Krantz & Garcia-Moreno, 2005). While IPV can be perpetrated by both men and women, women are disproportionately victims of violence (Betron, 2008). Globally, 30% of women aged 15 years and older have experienced physical and/or sexual violence from an intimate partner during their lifetime (Devries et al., 2013). The negative mental and physical health consequences of IPV include increased risk of poor health, depression, substance use, chronic disease, chronic mental illness, and injury (Coker et al., 2002; Devries et al., 2013). Recent studies have shown a causal relationship between experiencing IPV and incidence of HIV in women (Fleischman, 2012; Kouyoumdjian et al., 2013; UNAIDS, 2016). Decreasing the prevalence of violence against women is a critical aspect of Millennium Development Goal #3, promoting gender equality and empowering women (United Nations, 2015).

IPV is especially prevalent in societies where gender norms lead to accepting violence as normative (Jewkes, 2002). One of these societies is Tanzania where IPV is seen as normative by both men and women (Betron, 2008). Prevalence of women who have ever experienced IPV in Tanzania is higher than the global average at 40% (Tanzania Bureau of Statistics, 2016). Despite this high prevalence, almost 30% of women who have ever experienced physical violence did not report the abuse to any source (García Moreno, Jansen, Ellsberg, Heise, & Watts, 2005). According to the 2016 Tanzanian Demographic and Health Survey, most of the women who have ever experienced physical or sexual violence and did seek help reported to their families (56%), in-laws (42%), or friends and neighbors (14%), people outside the formal government structures. Only 12% of women in Tanzania who have suffered from physical or sexual abuse reported to formal government structures, such as medical personnel, police, or lawyers (Tanzania Bureau of Statistics, 2016).

To respond to the high prevalence of IPV in Tanzania, there have been some recent improvements in programs and policies. In 2011, the government developed the National Policy Guidelines for the Health Sector Prevention of and Response to Gender-based Violence (GBV) to define the roles and responsibilities of the Ministry of Health and Social Welfare (MOHSW) and its partners in preventing types of GBV, including IPV. While there are penalties for perpetrators of violence, gaps in the legal system prevail (Betron, 2008). The Law of Marriage Act, revised in 2002, prohibits corporal punishment against a wife, but does not recognize marital rape as a punishable offense (McCleary-Sills et al., 2016).

The lack of promising interventions to prevent and mitigate IPV in low-income countries is concerning (Taft & Small, 2014). To inform intervention design, a greater understanding of mechanisms of IPV in specific communities is necessary (Jewkes, 2002). Community leaders are an often untapped resource to gain information on these community-specific interventions. Community leaders have valuable insight on IPV in their communities, and they can be the unofficial resources to whom women report experiences of violence (Odero et al., 2014). While most IPV research focuses on the experiences of the victims and abusers, an examination of the broader context in which IPV occurs is necessary to inform future interventions.
To better understand the context in which IPV occurs in Tanzania and to inform the design and implementation of a planned IPV prevention intervention, we conducted in-depth qualitative interviews with community leaders in nine villages in the Karatu District of Tanzania. Key informant interviews (KIIs) have been used in other studies to gain insight about patterns of behavior and to give an overall perspective on important community issues (Lewis, West, Bautista, Greenberg, & Done-Perez, 2005). We explored community definitions and attitudes of IPV, community responses to IPV, and community attitudes and knowledge of IPV prevention strategies. The perspectives of these community leaders have important implications for the future of IPV interventions in Tanzania.

**Method**

KIIs were conducted in the formative phase of a larger study investigating the effect of World Education Inc/Bantwana’s (WEI/B) Together to End Violence Against Women (TEVAW) program to prevent IPV in the Karatu District described elsewhere (Messersmith et al., 2017). Karatu is one of seven districts in the Arusha region of Tanzania. Our selection of this region and district was based on the high prevalence (>1 in 3) and acceptance (1 in 3) of IPV in Arusha (Tanzania Bureau of Statistics, 2016), as well as the implementation of ongoing savings groups (known as LIMCA [Livelihood Improvement for Most Vulnerable Children Care]) with women implemented by our partner, WEI/B. These groups aimed to empower women participants through savings and credit activities to increase their economic independence and expand social networks. The groups also aimed to improve women’s knowledge about the physical, mental, and emotional harms of IPV on women, men and children. KIIs were conducted at baseline to ascertain information about IPV in the communities to inform the planning of the intervention.

Four to five community leaders in each of the nine study villages were purposively selected to participate in KIIs. A total of 50 key informants were interviewed. This sample size was sufficient to reach saturation of themes related to IPV. Community leaders were chosen from a list of district government officials including village headmen and women, chiefs, religious leaders, and heads of market, labor, and farmers’ associations. These key informants were selected based on their position at the district or village level and included sources both within and outside of formal government structures. For the purposes of this study, those community leaders defined as being within a formal government structure include medical personnel, government officials, police officers, and social welfare officers. In this study, all other community leaders were considered outside of formal government structures. All participants were aged 18 years or older, living in one of the nine study villages in the Karatu District, were willing to participate, and provided informed consent. Informed consent was obtained in English and Swahili. The background of key informants is shown in Table 1.
Table 1. Background Characteristics of Key Community Leaders.

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<thead>
<tr>
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<th>Male Key Informants (n = 35)</th>
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Theoretical Framework

Our study was informed by the use of Socio-Ecological and Social-Cognitive Theories. Guided by the Social-Ecological Model, we conceptualized IPV as a consequence of male-female power imbalances created by gender inequities at the relationship, community, and structural levels. These gender inequities allow men to use violence to set and enforce gender norms and to control access to economic and social capital at the individual, community, and structural levels. Using key constructs from the Social-Cognitive Theory, our interviews with community leaders explored community norms and values regarding IPV and their influence on individual behavior.

Procedures

KIIIs were conducted with the community leaders at baseline prior to the initiation of intervention activities. Qualitative researchers were trained in the study objectives, interview techniques, and protection of human subjects procedures. After eligibility was determined, potential participants underwent informed consent procedures. Researchers conducted these KIIIs in KiSwahili using a semistructured interview guide in private locations convenient to the key informants. These interviews were recorded to ensure the accuracy of the interview transcripts. Transcripts were translated into English for analysis. Interview guides included questions about community definitions and attitudes about IPV, the determinants of IPV, community responses to IPV perpetration against women, and community attitudes and knowledge about IPV prevention methods.

Data Analysis

Interviews with key informants were audio recorded and then translated and transcribed into English. Interview transcripts were then uploaded to QSR NVivo 10. Two researchers independently constructed and applied codes to the transcripts. Deductive coding was used to code constructs of the Social-Cognitive Theory and the Socio-Ecological Model, specifically on the perspectives of community leaders regarding social norms at the community and structural levels. Inductive coding was employed to code for additional themes emerging from the data that we would explore in the larger study. The researchers coded 10% of the transcripts and compared the accuracy of their coding. The researchers then reviewed and resolved the discrepancies in their coding. Finally, each of the researchers coded 50% of remaining transcripts, identifying overarching themes, patterns, and relationships between themes.

Ethical Approval

Approval of the study was obtained by the institutional review boards of the Tanzania National Institute for Medical Research, Medical Research Coordinating Committee, National Health Research Ethics Review Committee, and the Boston University Medical Center.
Results

Analysis of the KII data revealed several major themes regarding IPV causes and consequences, reporting methods, and future recommendations.

IPV Causes and Consequences

Alcohol. The two significant causes of IPV that were identified in these communities were alcohol abuse and economic inequality within relationships. According to community leaders, alcohol abuse is highly prevalent in these communities and is one of the leading causes of IPV:

The main cause is uncontrolled alcohol consumption. This causes fighting. (Female, Farmer’s Association, age 38, Baray Ward)

Alcohol use occurs mostly among men, but women are also known to drink alcohol excessively. Fighting as a result of drunkenness on the part of either men or women is seen as normative in these communities by the community leaders:

When males and females fight because one of them is drunk, this is perceived as a normal thing. (Male, Farmer’s Association, age 77, Karatu Ward)

Community leaders indicated that locally made alcohol is cheap and widely available. Accessing alcohol is easy for community members and is a major cause of financial difficulty in the home, which also leads to fighting among partners:

The main cause [of IPV] is alcohol drinking. Sometimes partners do not have a source of income, so they sell grains stored for food in order to buy alcohol. This creates conflicts. (Female, Police Officer, age 25, Qurus Ward)

When delving into the mechanism through which alcohol use leads to IPV, community leaders described changes in the personalities of those drinking alcohol, which in turn lead to IPV. Men often become suspicious of their wives’ faithfulness or forget their family responsibilities while drinking, leading to arguments and eventually perpetration of violence against women. Women often lose their inhibitions while drinking and may act or speak in a way that is perceived as disrespecting their husbands, again leading to fighting and eventual IPV:

Alcohol addiction is an acceptable reason that leads to intimate partner violence; some women drink to the point of losing their respect. Men also get drunk and forget their family responsibilities. (Male, Laborer Association, age 32, Karatu Ward)

Economic inequality. The second major cause of IPV according to leaders in these communities is economic inequality in relationships. While there is a consensus that both partners are involved in family business, this involvement is not equal. Often, it is the
job of both the man and woman to cultivate the family crops. However, when it is time to sell the crops, the man generally sees it as his right to make these decisions without consulting his wife:¹

Many IPV incidents happen during harvest season. It is because at this time a man gets the crops that have been cultivated together. He sells them without involving his wife.

(Female, Social Welfare Officer, age 58, Karatu Ward)

When the woman questions her husband’s decision making or asks for a portion of the funds received from selling the crops, violent conflicts can erupt between couples. This questioning of the man’s decisions is seen as disrespectful and a challenge to socially acceptable gender norms:

You may find a man going elsewhere and using the money and may not report to the woman how the money was used. So the women usually tend to ask. When they do, it is at such time they receive the beating.

(Male, District Medical Officer, age 45, Karatu Ward)

A community savings intervention targeting women and implemented by WEI/B existed before the start of this study. The findings from the KIIIs indicated that these loans had mixed results. In some cases, provision of these loans to women had the intended effect of improving the lives of all those living within the household. However, there were indications from community leaders that these loans did not always have a positive effect:

I have been told that vikoba [savings and loan program²] have broken many homes instead of building. However, there are some exceptions where vikoba have been instrumental in building homes. Maybe it is 50/50.

(Female, Farmer’s Association, age 38, Baray Ward)

While no negative incidents as a direct result from the provision of microfinance loans in this study were reported, microfinance loans were mentioned by some community leaders as being a source of arguments for couples. While these loans are intended to make couples more economically secure and equivalent, in some cases the men felt that it was their duty to control all household finances, even those brought in by their female partners. These men expected that this money be given to them, even if they wanted to use the money for an unintended use:

The money from vikoba is sometimes not a source of blessings. Women could either be boastful to their husbands. Or husbands may need that money for unintended use. If the money isn’t given, then war breaks out.

(Female, Small Business Owner, age 59, Karatu Ward)

Microfinance loans also induced feelings of jealousy in some men who felt that they should have the opportunity to get a similar loan:
There is another type of microfinance groups called vikoba. Many women in Karatu are members. So when women get those mini-loans, the men in such families want such money as well. It is here conflict may begin. This may lead women to be beaten and finally expelled. (Male, Village Executive Officer, age 57, Karatu Ward)

**The relationship between HIV and IPV.** Key informants indicated that a positive HIV status is both a cause and a consequence of IPV. A confirmation of a partner’s positive HIV status often causes fighting and IPV in the relationship. Key informants said that IPV is especially severe for women, who are often blamed for HIV transmission, even when it is the man who infected his partner:

[A woman or man being HIV positive] will bring some fights. Woman may be especially condemned. However, it could be the man is the one who infected her. It is too bad, you infect her with disease and at the same time you beat her. (Male, Business Owner, age 66, Karatu Ward)

Blaming women for bringing HIV into the relationship is often due to the fact that women are generally diagnosed when they attend clinic visits while pregnant. There is no such method to get men into the clinic for regular testing:

And on HIV, women are often the first to know that they are infected, because they are normally tested when attending clinic. Once a man is informed, he feels that his wife is the cause of all menace and that becomes a problem. (Female, Karatu Ward)

Key informants said that the woman is usually blamed for HIV transmission in the relationship, although it is often the man’s infidelity that actually led to HIV infection. While men are drinking in town, they are often tempted to engage in extramarital affairs. When these men return home, they see it as their right to have sexual relations with their wives. If these men have HIV, the disease is transmitted to their partners:

Yes, men are most likely to contract HIV/AIDS than women. This is because when they travel to town they can be tempted to engage in sexual relationships with other women. And their wives produce children almost every year. Once a man gets the disease, he may also infect his wife. A woman has no control over that circumstance. (Female, Market Association, age 43, Karatu Ward)

**Impact of IPV on children.** A major consequence of IPV was the negative impact on children affected by violence. Often, children of parents in conflict are neglected and lack basic needs such as food, hygiene, and school supplies:

When parents are drunkards, the children lack basic needs for their studies, like school uniforms, pens, exercise books, etc. Also school attendance is hampered when a marriage is in trouble. So in this way children lack their basic rights as a result of parents who constantly fight. (Female, Farmer’s Association, age 50, Qurus Ward)
This lack of basic needs can lead children to drop out of school and leave their houses to become “street children”:

Even if they get someone to help them, they cannot concentrate on their studies because they are affected psychologically. Such children may later become street children. (Male, Business Owner, age 42, Karatu Ward)

The insecurity created by both IPV in a household and living on the streets can lead female children to early sexual initiation. These life choices often mean that female children do not finish school:

Children, especially females, may start early sex or get married at a young age and sometimes they may fail to continue with their studies. (Male, Farmer’s Association, age 77, Karatu Ward)

Another negative outcome of witnessing IPV in the household is that children will learn these negative behaviors from their parents, and possibly act on these behaviors later in life, perpetuating a life cycle of IPV between generations:

If children witness parents fighting, they will learn from us. So the children will be asking themselves questions such as “why is our mother frequently beaten?” As a result, children will begin losing respect for their mother. They will rationalize that they belong into the same category as their mother, since they can all be beaten. (Female, Farmer’s Association, age 42, Karatu Ward)

**Reporting of IPV**

Key informants described different levels and stages of reporting of IPV in their communities. In the first level of reporting described by community leaders, the violence is kept secret from the community and addressed within the family. If the couple cannot resolve the issue themselves, they will turn to their parents or village elders for help. The ultimate goal is reconciliation of the couple. Women often choose this type of informal reporting method because they fear how the community will perceive them if they report IPV. The women feel that they need to first make an attempt to reconcile with their partner or the community will perceive that she wants to destroy her husband’s reputation:

Apart from going to parents, the beaten woman in these days tends to go to village leadership. The case will be referred to the police if all other approaches of reconciliation have failed. So if the injured person goes straight to the police, the community will perceive that person in a wrong way. They will perceive that she wants to destroy her husband completely. (Male, Farmer’s Association, age 52, Qurus Ward)

If close family members or village elders are unable to resolve the problems causing IPV, some women will then turn to religious leaders for counsel. Key informants
explained that women who use this layer of reporting tend to be married. Similar to women who report to their family members or village leaders, women reporting to religious leaders are also seeking to reconcile with their partner:

The next level after parents are religious leaders, especially Muslim [leaders]. The religious leaders play a great role in deciding on such issues; it is very rare to take the issue to government leaders. (Female, Karatu Ward)

The final and more formal level of reporting as explained by community leaders is to the police. This type of reporting usually happens if other methods have failed and women are no longer willing to tolerate violence in the relationship. These cases are usually extreme as reporting their partners to the police carries severe stigma from the surrounding community:

This means complicated cases can be reported to police but the normal ones like insulting each other or denying one’s right to sex they are reported at village offices. (Female, Farmer’s Association, age 33, Ganako Ward)

Throughout all levels of reporting, there was a preference for reconciliation over divorce according to these community leaders. Although divorce and separation are common in these communities, women are usually advised to stay with their partners due to concerns for their children, inability to remarry, and concerns about living arrangements:

Yes, because the woman was seeking to divorce but we advised her and [she] decided to stay put for the sake of children. The woman had five children. We told her if you get divorced what do you think will happen to your children? The male partner alone will not be able to take good care of them. (Male, Social Welfare Officer, age 35, Karatu Ward)

**Barriers to Reporting**

*Police corruption.* Key informants also described common barriers to reporting IPV. The first of these barriers is police corruption, which prevents many women from reporting IPV through formal means. There is a cost associated with reporting to police, including the cost of the official form that women need to take to the hospital and the bribe to convince police to arrest the perpetrator:

I am told that sometimes police are very problematic; they say you enter police station free of charge but you must pay to exit. (Female, Police Officer, age 25, Qurus Ward)

Key informants stated that this barrier in reporting to police is exacerbated for rural women. These women not only face economic hardship to pay for bribes and official forms but also bear the cost of transportation to the police stations:

If the matter is reported to the police, it may be demanded that the perpetrator be arrested. Imagine if the incident happened 50 kilometers away, and the victim has to bear transport expenses . . . that is a challenge. (Male, Magistrate, age 37, Karatu Ward)
**Self-blame.** Even if women are comfortable seeking support from and able to access formal government officials, community leaders, or family members, they usually do not report violence when they feel at fault for the IPV perpetrated against them. Women often feel at fault when violence occurs when they are drinking alcohol:

Sometimes the woman knows that she is the source of the conflict; she cannot report because of fearing to expose her problem; and she may be beaten while drinking alcohol. This also makes her uncomfortable to report the incident. (Female, Farmer’s Association, age 40, Karatu Ward)

Community leaders described another reason for self-blame: women also feel at fault for IPV perpetrated against them when they falsely accuse their husbands of infidelity:

Sometimes women are afraid to report violence because they are the source of problems. Women in this place prefer hearing words which lack evidence. Then when the husband comes in the evening, she will begin asking, “My husband, I heard that today you were with a certain woman?” If the information was false, the husband would begin beating the wife. Now under such circumstances it is hard to be the first to report violence. (Female, Farmer’s Association, age 43, Karatu Ward)

**Stigma as a barrier to reporting IPV.** A final barrier to reporting IPV according to community leaders is perceived stigma of reporting a perpetrator from the community. Women often feel that their community will be unsupportive if they report their partners:

Generally some women do not seek services due to fear of stigma or other related issues. Questions like this are normally asked, how will I go back? How will the community define me? These are some issues which prevail in the community. (Male, District Medical Officer, age 45, Karatu Ward)

Community leaders admit that while the community is sometimes opposed to reporting of IPV, it is often supportive of women reporting violence when their situation becomes unbearable:

The willingness to report is usually small. People are forced to report when it becomes unbearable. When that is done, the community is usually supportive. (Male, Retired, age 72, Ganako Ward)

**Recommendations for Preventing IPV**

As leaders in their respective communities, key informants were asked to identify ways that IPV could be prevented. The majority of respondents identified further education as an important measure to prevent IPV. Key informants thought that while IPV will not be completely eliminated, educating the community will reduce incidence of IPV and increase the reporting of IPV:
If the community was given education in regard to IPV, I suppose we would have been able to avoid many things which would have brought consequences. We need education as our first priority. (Female, Farmer’s Association, age 37, Karatu Ward)

Informants also suggested including education on IPV types, causes, and consequences in primary and secondary education. These children will eventually grow into adults and represent the future of these communities. Community leaders suggested that educating them on IPV at a young age could help to decrease the prevalence of IPV:

It can be prevented, but not at 100% level. If we would give education, IPV could be reduced at least to reach 80%. This kind of education is about the manner of how couples should live. It could be given to youth, because they are the ones who are starting life. I would propose that education be given based on age groups. If we would give this education to primary and secondary school pupils, that would be great. (Female, Farmer’s Association, age 50, Qurus Ward)

Community leaders indicated it is important for women to be educated on their rights, as many women do not understand what is and is not acceptable behavior by their partners. However, informants indicated that it is essential that this education be started with community leaders and men. These leaders must be prepared to guide community members in reporting and resolving conflicts between partners; thus, they must first understand IPV causes and consequences themselves. Men must be taught that it is not their right to be violent toward their partner:

It is possible to prevent IPV. The first thing should be education. It needs to begin with leaders and men. Because some men believe that it is okay to be violent, it is their right. They believe it’s okay for the women to sustain the family in everything. For a man to be attended as a child, it is a responsibility of a woman. All these ideas are not true. This indicates that men need to get education. For women too, they need to know when they are mistreated, they need to find out about their rights. For example, if a woman does not feel to have sex, she is forced into it, because of a wrong perception that she has no rights. (Female, Department of Social Welfare, age 32, Karatu Ward)

Discussion

This study sought to understand the perspectives of community leaders on definitions and attitudes about IPV, community responses to IPV, and knowledge and attitudes about IPV prevention. Through these discussions, some common themes were identified on IPV causes and consequences, reporting methods, and recommendations for IPV prevention in the future.

The key informants in this study identified alcohol use as a major contributor to IPV in their communities. This finding is supported in the literature, as an association between alcohol consumption and increased prevalence of IPV has been previously established on a global scale (Jewkes, 2002). The association between alcohol consumption and perpetration of violence has been found within the Tanzanian context as
well (Mulawa et al., 2016). Alcohol consumption by both men and women in these communities is common and normative. Community members rarely intervene in IPV instances that are a result of drunken behavior. Often IPV that results from alcohol abuse is verbal in nature and not viewed as severe enough for third parties to intervene. In addition, community members also appear to blame the woman for the IPV if she has been drinking and are therefore not likely to intervene.

There were several mechanisms described by key informants through which alcohol consumption contributed to IPV in this study. The first is through a loss of inhibitions, making it more acceptable for men and women to use damaging language and actions against their partners. After consuming alcohol, women often speak or act in a way contrary to gender norms and are then seen as being disrespectful to their husbands. This perceived loss of respect contributes to acts of IPV. A study in Vietnam also found that IPV perpetration increases when alcohol is consumed and when women act contrary to acceptable gender norms (Jonzon, Vung, Ringsberg, & Krantz, 2007). Men can become suspicious of their partners’ loyalty and may accuse their partners of infidelity or become violent toward their partners. Men may also forget their familial responsibilities, either by spending their family’s funds on alcohol or by neglecting responsibilities while drinking. As alcohol is inexpensive and easily accessible in these communities, purchasing alcohol is often a reason for financial difficulty in the home, which in turn can lead to IPV.

Community leaders also identified economic inequality in relationships as a cause of IPV. This economic inequality had previously been identified as a contributor to IPV in Tanzania, where key informants identified economic dependence on a partner as a contributor to increased vulnerability to violence (Betron, 2008). Because women are financially dependent upon their partner, they are often unable or unwilling to leave violent situations. Community leaders in this study indicated that men in these communities view themselves as the economic decision makers of their families. Even when women are involved in household economic activities, their involvement usually ends when it comes time to sell the product. Any disagreements the female partners may have on economic decisions often leads to an increase in IPV.

While microfinance groups in these communities sometimes helped to relieve the economic inequality between partners and to better the lives of all who live in a beneficiary’s home, many community leaders reported that these loans incited feelings of jealousy from men. Men felt either that their right as a man to be the economic decision maker of the home was being challenged or they felt resentful that they were not given the same opportunity. The contradictory results of increasing the financial independence of women as a protector against IPV have been cited elsewhere in the literature (Jewkes, 2002). A study in Vietnam found that having a woman as the main income earner in a family challenges acceptable gender norms making husbands feel inferior and more likely to perpetrate violence (Jonzon et al., 2007). A study in Bangladesh indicated that involvement in microfinance programs actually increased IPV incidence for women of higher education and wealth statuses (Dalal, Dahlström, & Timpka, 2013). A second study supports this finding, indicating that microfinance programs actually increased IPV against women with higher economic status, but not
for those in the lowest wealth quintiles (Murshid, Akincigil, & Zippay, 2016). The results in this article are purely qualitative, so we do not have information on the relationship between economic status and experiences of IPV. However, the findings of these studies in Bangladesh combined with contradictory findings of the success of microfinance groups in our study in Tanzania indicate that these programs must be considered with caution and fully evaluated to determine the effects.

A study in South Africa testing a combination of microfinance programs and training on HIV, gender norms, domestic violence, and sexuality showed an overwhelmingly positive impact on decreasing IPV prevalence (Kim et al., 2007). Qualitative results indicated that women in this study attributed reductions in violence to their ability to challenge the acceptability of such violence and to leave violent situations (Kim et al., 2007). The contradictory findings of the impacts of microfinance programs are concerning and the implications of these programs on IPV should be considered for future programming. While increasing the financial independence of women may help to alleviate one of the pathways to IPV, these programs might not help to change the root cause of IPV, the social norms that contribute to its acceptability. The contrasting findings of the success of microfinance programs in our study in Tanzania indicate that further assessments of microfinance programs in the Tanzanian context are necessary.

Community leaders identified three levels of reporting methods in this district. For less severe violence, women generally turned to family or village elders and religious leaders. In Tanzania, a World Health Organization (WHO) multicountry study on IPV identified family as the primary resource or support system to which women report violence and again stated that the decision about where to report depends on the severity of violence (García Moreno et al., 2005). In the case of more extreme violence, reports were generally taken to formal government officials, such as the police. These layers have been described in other studies. One study in Kenya found a similar division between reporting minor violent acts to informal support systems (e.g., family and friends) and severe violence to more formal officials, with greater reliance on the use of informal support systems (Odero et al., 2014). The reliance on community leaders as sources of support for reporting violence has implications for future interventions to mitigate IPV. Community leaders can provide invaluable information on reporting methods within their own communities as many women turn to them for counsel. Training community leaders on mitigation methods and educating them on available resources for reporting IPV are also potential methods to decrease violence against women.

Despite the high prevalence of IPV in Tanzania, the 2016 Demographic and Health Survey found that only 54% of IPV victims sought help from any source (Tanzania Bureau of Statistics, 2016). This lack of reporting despite high levels of IPV was also reported in a study in Kenya (Odero et al., 2014). One study on reporting of GBV prevalence and reporting methods in 24 developing countries noted low reporting levels, especially to formal sources (only 7% of study participants; Palermo, Bleck, & Peterman, 2014). Community leaders in our study identified perceived stigma from the community as a major barrier that prevents women from reporting violence. The
fear of stigma from the community was echoed by female health care volunteers in a study in Honduras (Sukhera, Cerulli, Gawinski, & Morse, 2012). While the community is normally supportive of women reporting unbearable violence, women often worry about how they will be perceived after reporting the perpetrator. No clear definition on what constitutes unbearable violence existed among the community leaders interviewed.

Community leaders in our study indicated that women will not report violence if they feel to blame for its perpetration. Often, women feel at fault if they were drinking alcohol or falsely accused their husbands of being unfaithful. A comparative analysis of 17 sub-Saharan African countries indicates that women are more likely than men to justify IPV perpetrated against women (Uthman, Lawoko, & Moradi, 2009). In one qualitative study in Tanzania, key informants identified the shame felt by IPV survivors as a major barrier in reporting violence (McCleary-Sills et al., 2016). These informants indicated that there was more shame in reporting violence than in the perpetration of violence itself. Women felt shame and self-blame not only for reporting violence but also for being victims of IPV. Data from another study in urban Tanzania indicated that this shame extends beyond the victims themselves to their friends, families, and neighbors (Laisser, Nyström, Lugina, & Emmelin, 2011). These results echo those found in our study and indicate that self-blame and shame experienced by survivors of IPV is a major barrier to reporting.

When asked about recommendations to decrease the prevalence of IPV, community leaders in this district overwhelmingly mentioned the need to provide more education on IPV causes, consequences, and preventive measures. These leaders also made suggestions about how to provide this education. Some indicated that education should start in primary and secondary school, as these children are the future of Tanzania and educating them on preventive methods could help to decrease future incidence of IPV. The importance of education from an early age was reflected in a study in Honduras where female health care volunteers emphasized the influence of education on young boys and girls (Sukhera et al., 2012). While community leaders in our study in Tanzania emphasized the importance of educating women on their rights, they also highlighted the importance of educating men, as men are overwhelmingly the perpetrators of IPV. The need for multilevel education methods was echoed in one study in Ethiopia. This study indicated there was a need to educate women on their rights, as well as the community as a whole, suggesting religious and municipal institutions provide this education (Abeya et al., 2012). In our study, key informants felt that it was their job as community leaders to educate their communities on ways to mitigate IPV. The use of these leaders in future studies and programming should be considered as mechanisms through which both men and women can become educated about IPV.

**Strengths and Limitations**

A network of community leaders is woven into Tanzanian society and represents potential resources to mitigate IPV in the future. Findings from this study are some of the first to discuss the attitudes of community leaders on IPV causes, consequences, and
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preventive methods in Tanzania. The findings of this study have important implications on the design of future interventions to prevent and mitigate IPV in these communities.

This study has some limitations. First, the sample was not representative of all community leaders, nor of all people living in these communities and, therefore, the findings cannot be generalized outside of this local context. As with any study on self-reported behavior, there could have been a social desirability bias as key informants may have reported what they thought the interviewers wanted to hear.

Recommendations

Previous studies have identified limited community referral networks for reporting violence in Tanzania (Fleischman, 2012). However, the findings from this study indicate that community leaders are a potential resource to augment these types of referral networks. According to the informants interviewed here, women typically report to government officials, such as police officers, only when the violence they are experiencing becomes “unbearable.” Women are more likely to report to family members and other sources of support, including community leaders, prior to this stage. Educating and training these community leaders, many of whom may already be involved in informal IPV referral networks, on appropriate intervention methods could be an important step in making these referral networks more efficient and effective. The involvement of these leaders in future efforts to support reporting of IPV, either as part of referral networks or as informants on IPV within individual communities, is crucial.

Although not an intended finding of this study, key informants identified the widespread access and use of alcohol use as a major contributor to IPV in these communities. While there were some indications that bylaws exist to limit alcohol consumption, there was no indication of measures to enforce these laws. More research is needed on existing measures to limit alcohol consumption and the effects of alcohol use on IPV within these communities. Based on the interviews in this study, education on alcohol use and its consequences should be included in future IPV programming efforts.

Other suggestions by community leaders in this study included emphasizing the need to expand future education on IPV. They suggested integrating this education in multiple community sectors, including schools, religious institutions, and community meetings. It is important to tailor this education to its audience. For example, women must claim their rights and determine what are and are not acceptable behaviors of their partners. Men must understand the causes and consequences of IPV and their role in preventing and mitigating IPV in their communities and their homes. Community leaders must learn to help change community norms and values as well as employ mitigation techniques, including the development and use of referral systems for women and families in need.

Conclusion

IPV is a major public health problem and human rights violation in Tanzania. Considering the strong associations between IPV and mental and physical health consequences,
efforts should focus on development of safe and appropriate interventions. This study indicates that community leaders are a critical, untapped resource for preventing and mitigating the effects of IPV at the local level. The experience and involvement of community leaders enable a more thorough understanding of the determinants of IPV and are critical in the development of comprehensive interventions to address IPV at the community level in Tanzania. However, further evidence is needed on how best to involve community leaders in IPV prevention programs and activities. The impact of community-based prevention interventions (e.g., antidomestic violence campaign; antistigma campaign) in relation to that of community-monitored and -enforced prevention interventions remains unknown. Findings from this line of research may also inform maternal and child health programs and policies in Tanzania and beyond.

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Notes
1. In rural Tanzania, although both men and women participate in agricultural activities, women tend to spend more hours than men, and make fewer decisions (Blackden, Rwebangira, & Ramin, 2004). For Tanzanian men, primary responsibilities include cash crop farming and income generation. Tanzanian women are largely responsible for food crop farming, and help with cash crops. Women bear the primary responsibility of tending cash crops while men are away for off-farm employment. Men control income from cash crops, and make production and labor allocation decisions (Mbilinyi, 1972).
2. Vikoba refers to a community banking program that has similar objectives to the World Education Inc/Bantwana (WEI/B) community savings group intervention (LIMCA).

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