SASA!

Preventing Violence Against Women and HIV

Baseline Study Results in Tanzania

Dafrosa Itemba (TAWREF)
Anton Popic (FOKUS)

TAWREF
TANZANIA WOMEN RESEARCH FOUNDATION

20 1995 2015
FOKUS
FORUM FOR KVINNER OG UTVIKLINGSSPØRSMÅL

For information related to this study, please contact:

Tanzania Women Research Foundation
Dafrosa Itema
J.K. Nyerere Road, P.O. Box 8598 Moshi, Tanzania
Web*: www.tanzaniawomenressearchfoundation.org*
E-mail:*dafrosakoku@gmail.com*

Forum for Women and Development
Anton Popic
Storgata 11, 0155 Oslo, Norway
Web:*www.fokuskvinner.no*
E-mail*: ap@fokuskvinner.no*

SASA! was developed by Raising Voices, Uganda

Financial support for this study provided by NoVo Foundation

Acknowledgments

We would like to thank SASA-implementing organizations Kivulini Women's Rights Organization of Mwanza and Women's Promotion Centre of Kigoma for their cooperation on this baseline study. Without their logistical support, it would not have been possible to carry out the research.

Special appreciation goes to the following surveyors who worked tirelessly to collect household information: Suniva Busiga, Christian Noah, Dotto Makona, Eva William, Steven Andrew, and Theresia Michael, Elinaquinity Mushi, Dotto Dulla, Festo Nemes, Zabibu Said, Jenita Luhasha, Selemani Moshi, Jonathan Nicholaus, and Jerome Mamba.

We are also grateful to the ward leaders of the eight participating study wards (Jinjimili, Sukuma, Bukandwe and Kitongosima wards of Magu district, Mwanza region and Katubuka, Mwanga, Kaskazini, Gungu and Bangwe wards of Kigoma/Ujiji district, Kigoma region) and the District Executive Directors of the two districts.

We also appreciate the good work done by TAWREF data entry assistants and analysts Stephen Sikumbili, Wendy Ricky, Anthony Jonas, and Joseph Banula.

The study was made possible by the generous support of NoVo Foundation, to which we are grateful.

Most of all, we owe our gratitude to the 1,653 women and men who were willing to share their thoughts and experiences on matters that too often tend to be veiled in silence.

We hope that this study will contribute to the growing body of knowledge on violence against women and that it will inform the intervention to prevent this violence.

Table of contents

List of Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
CA	Community Activist
FGD	Focus Group Discussion
GBV	Gender Based Violence
HIV	Human Immunodeficiency Virus
IPV	Intimate Partner Violence
NIMR	National Institute of Medical Research
PSU	Primary Sampling Unit
SASA!	A community mobilization method for preventing intimate partner violence developed by Raising Voices in Uganda (Start -Awareness -Support –Action)
SPSS	Statistical Package for Social Sciences
TAWREF	Tanzania Women Research Foundation
WHO	World Health Organization

List of tables

List of figures

Introduction

This baseline study sought to map community knowledge, perceptions, and practice of intimate partner violence (IPV) in two districts in Tanzania, Magu and Kigoma/Ujiji. The primary goal was to establish a baseline prior to a community-level intervention (SASA!) to reduce the prevalence of Intimate Partner Violence (IPV) against women and HIV-related behavior drivers.

The study methodology was based on mixed methods by combining a cross-sectional population survey and focus group discussions. Two wards per district were sampled as intervention areas and two as control areas.

The primary outcomes studied were: acceptability of intimate partner violence; acceptability that a woman can refuse to have sex; past year experience of physical violence from a partner; past year experience of sexual violence from a partner; appropriate community response to women experiencing physical and/or sexual IPV in past year; and past year concurrent sexual partners among men.

Questions on the acceptability of violence were adapted from those used in the WHO multi-country study on women's health and domestic violence. Each of the questions was asked in relation to 'in the last 12 months.'

The study findings reflect inadequate safety experienced by women in both the intervention and control communities due to the general acceptability of the violence imposed upon them. There is very little consciousness on the hazards posed by this prevailing acceptability of the violent attitudes women face from their intimate partners. The communities themselves appear to take no responsibility for the unfortunate situation women live in. Consequently, very little is done to make the community environment safer for women.

Part I Background

Intimate partner violence and HIV

Intimate partner violence (IPV) against women is widely recognized as a major global public health problem, with the World Health Organization (WHO) multi-country study on women's health and domestic violence highlighting the scale and extent of the problem in 10 countries around the world [1]. The gendered nature of the HIV and AIDS epidemic has also received increased attention in recent years [2], with women now constituting 60% of adults living with HIV in sub-Saharan Africa [3]. Evidence points to important links between these two epidemics. In particular, recent analyses have found IPV to be an independent risk factor for HIV [4, 5].

The IPV/HIV association occurs through multiple posited mechanisms. Underpinning many of these mechanisms is inequality of power and relations. Economic and social gender inequities, together with norms and expectations about how women and men should behave, influence risk of IPV and HIV in several ways. Prevalent notions of masculinity condone or attach status to men who exhibit dominance over women, engage in sexual conquests, and take risks. It is then not surprising that men who endorse more traditional views about masculine roles and behaviors are likely than other men to perpetrate IPV and to engage in higher risk sexual behaviors [8,9]. Both these behaviors are manifestations of the same model of masculinity. Similarly, inequality of power assumes women's subservience to men, especially in sexual relations. This inequality often condones violence against women and can increase vulnerability to HIV [10] - for example if a woman's power to negotiate condom use is limited through fear of implying promiscuity, transgressing gender norms and incurring violent repercussions [7,11].

Research has shown that women who believe that there are circumstances where a man can be violent towards their partner are more likely to experience IPV [12], and there is evidence that women in less equitable relationships are at increased risk of HIV. Some studies found that inequity of power within a relationship was an independent risk factor for incident HIV infection among women, even after controlling for partnership duration and other indicators of risk behavior [4].

Against a backdrop of gender inequity, an HIV diagnosis and/or its disclosure may also put a woman at increased risk of IPV [6]. In turn, fears of violent repercussions may prevent women from taking up HIV testing or disclosing their HIV status [13-15].

Intimate partner violence and HIV in Tanzania

In Tanzania, more than one-third of all women (39%) have suffered from physical violence at some point since age 15. One-third (33%) of women suffered from acts of violence during the previous 12 months. This proportion is substantially higher for divorced, separated or widowed women (46%) than single women (21%). More than four-fifths of women who have ever experienced physical violence report that the perpetrator of the violence was a current or former husband/partner. Ten percent (10%) of women had their first sexual intercourse forced against their will. [16]

Data on HIV-related behavioral drivers in Tanzania shows that, on average, women have 2.3 sexual partners over their lifetimes and men have 6.6. Four percent of women and 21% of men reported having sex with two or more partners in the 12 months preceding the survey. Regarding multiple sexual partners, the proportion of men with multiple sexual partners in the past twelve months was exceptionally high among those in polygamous unions (83%). [17]

Several other drivers are identified as having a strong correlation between the spread of HIV and intimate partner violence. Among them are commercial sex, men having sex with men, discordant couples, non condom use, alcoholism, forced sex, low level of knowledge of risks, widow inheritance, and sharing of syringes [18]

The intervention studied—SASA!

The intervention, for which this baseline was conducted, uses a community mobilization approach to try to change the community attitudes, norms, and behaviors that underlie power imbalances between men and women and support both HIV risk behaviors and the perpetration of violence against women. The intervention takes a holistic approach that explicitly recognizes that IPV is the result of a complex interplay of factors operating at the individual, relationship, community and societal levels [19] – therefore interventions to prevent it must engage with and achieve change at each of these levels. SASA! also draws heavily upon a social-level adaptation of the Stages of Change Theory [20], explicitly taking communities through a four-phase process of change. Indeed, the name SASA! is an acronym for this four-phase process:

Start– Start thinking about violence against women and HIV and AIDS as interconnected issues and foster power within yourself to address these issues.

Awareness – Raise awareness about communities' acceptance of men's use of power over women, which fuels HIV and AIDS and violence against women.

Support– Support women and men directly affected by or involved in these issues to change.

Action– Take action to prevent HIV/AIDS and violence against women.

The intervention supports communities through these four phases of change by ensuring that community members are exposed to regular and ongoing mutually reinforcing messages from a variety of formal and informal sources.

Figure 1 Map of Tanzania with Kigoma and Mwanza regions, where SASA! is being implemented and where this baseline study was conducted

During the first phase of SASA!, Start, the SASA! team starts to foster power within the team to address violence against women and its connections with HIV and AIDS. During this phase, the team gains improved knowledge and awareness, and engages in critical thinking and discussion about: what constitutes violence; the causes and consequences of violence; the underlying links between violence, gender inequality and the misuse of power, and the implications of violence for individuals, families and communities. Gender inequality and social norms about sexual behavior for men and women are also discussed and opened up to analysis. Time is also spent understanding the community's perceptions of violence against women, gender and HIV and building relationships with leaders who will support and enable the community mobilization in the subsequent phases.

During the second phase, Awareness, the team engages the community to become aware of men's power over women, and the ways in which this power imbalance (manifested at both the relationship and societal level) perpetuates violence against women and HIV and AIDS risk. This and subsequent phases involve the implementation of a wide range of one-on-one and group-based activities that seek to achieve widespread community participation. The intention of the awareness phase is to spark critical thinking among community members to question the legitimacy of violence against women and gender inequality. The third phase, Support, involves the SASA! team engaging with the community to promote and facilitate individuals joining their power with others to confront the dual pandemic of violence against women and HIV and AIDS. This involves fostering supportive networks in which people feel able to seek help and support from others in the community, and where community members work together to support those in need,

those trying to change and those speaking out. Community members are supported to feel that they themselves, along with others in their community, can take actions to address gender inequality and violence. Activities focus upon helping people to develop appropriate skills to reduce inequities in their relationships, and to challenge and respond appropriately to violence in their communities. These activities seek to encourage recognition of the ways in which different individuals can address the misuse of power, gender inequality and violence, and the strength that can be generated when they join together with a common aim - as part of this, CAs, leaders and professionals are supported to work more closely together to address violence.

During the final phase, Action, the team engages the community in using their power to take action, with the aim of normalizing shared power and non-violence, demonstrating its benefits, and as a result, preventing violence against women and reducing HIV and AIDS risk. During this phase, the process of change is consolidated, individual and collective action to address violence strengthened, and change institutionalized within local leadership and normative structures.

The comprehensive SASA! intervention is expected to have multiple community-level impacts at the end of these four phases. These are presented in the last column of the logic model: reduced social acceptance of gender inequality and IPV; decreased experience/perpetration of IPV; improved response to women experiencing violence; decreased sexual risk behaviors associated with HIV. These hypothesized long-term impacts have formed the basis for our selection of primary outcomes in this study.

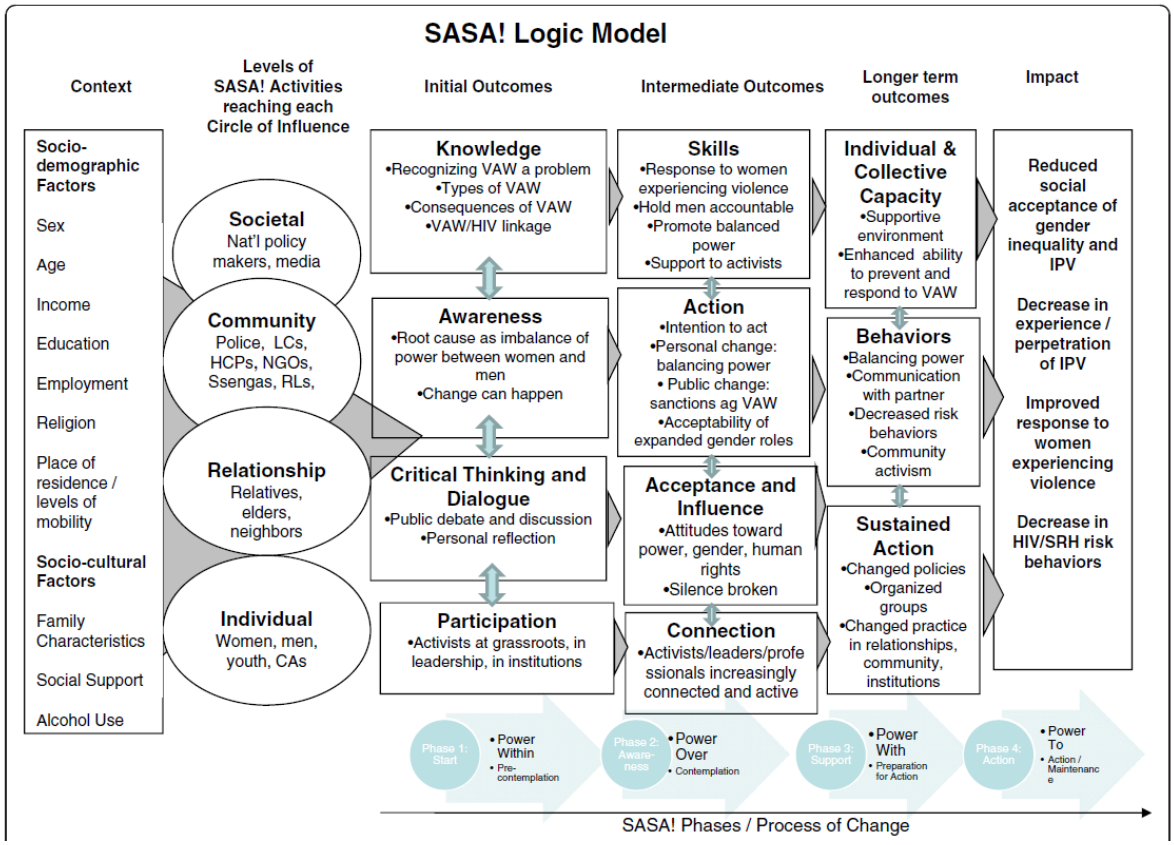

Figure 2 SASA! Logic Model

Study design

Sample size

The eight study communities (4 interventions and 4 controls) ranged in size from 10,167 to 25,224. At the 95% confidence level and a confidence interval of 6.88, the number of study respondents per community was to be 200. In the end, 1629 people were surveyed (792 women and 837 men).

Recruitment methods and selection criteria

The primary sampling unit was a simple random sample of households within each of the eight sites. As a list of households was not available to the researchers, a mapping exercise was undertaken prior to study start to divide each community into clusters of socio-economic areas (such as "around the market," "fishermen's areas," "affluent areas," "Muslim area," "Christian area," etc.). Surveyors then received instructions by the principal investigator on how many surveys needed to be completed in each community subunit in order to ensure representativity. Within each subunit, surveyors sampled every third households geographically. Care was taken to avoid that female and male researchers sample the same "street."

A maximum of one person per household was selected to complete the survey. A person was eligible for inclusion if he/she was between the ages of 18 and 49 years, had lived in the village for at least a year, and was the same sex as the surveyor. Separate sampling by sex was chosen for reasons of safety (to reduce the chance that men in the immediate locality are aware of the nature of the questions in the survey and the potential disclosures that may occur). Where more than one eligible household member was identified, one was randomly chosen for interview (with no substitutions made for refusals or failure to subsequently contact this person).

Informed consenting

All research subjects underwent an informed consenting procedure. The guiding principle was that a person's decision to participate in research was to be voluntary, and based on adequate information and adequate understanding of both the proposed research and the implications of participation in it.

To make sure they have fully comprehended the risks and benefits involved by their participation, the researchers asked them more questions to trigger their comprehension, stimulate further discussion and prompt the subject to think more carefully about the study.

Some of these questions were:

> "I would like to make sure that you truly understand what we would like to do today. Would you, please, explain to me what you think we're going to ask you to do?" "What did you understand is the purpose of the study? "What do you think you could gain from participating in this study? What problems do you think might arise if you participate? What more would you like to know?"

Quantitative data collection and analysis

Survey tools developed by the Ugandan NGO Raising Voices were used to collect data on research variables. The surveys were translated and administered in Kiswahili. There were separate surveys for males and females (see appendix 2 and 3). All completed questionnaires were checked by field supervisors upon completion, and where problems were identified with a questionnaire, it was returned to the interviewer for corrections or for information to be completed. Once a supervisor checked a questionnaire and cleared it as complete and satisfactory, it was sent to the TAWREF offices. There a fieldwork coordinator or data manager rechecked it. Data was double entered and stored in SPSS.

Where discrepancies were noted between twin-entries, reference to the original questionnaire was made to determine the correct entry. Data is stored, password-protected, on a secure central drive at TAWREF. All electronic data are anonymous. The questionnaires are stored in locked filing cabinets in a locked office.

Qualitative data collection

Quantitative data was complemented by a qualitative method known as Focus Group Discussions (FGD). This method used a set of interview questions as a guide to the discussion. It gave the researchers an opportunity to observe group dynamics and clarify and/or confirm the quantitative data. A non-random sample was used since participants were selected depending on selected general characteristics. One Focus Group Discussion was organized with community members at one site per study area to explore attitudes and norms around violence, gender roles and relationship power. It explored cultural frameworks, and meanings of gender – related concepts in the study communities. Focus group discussions were conducted with 13 male and 11 female participants.

Training of interviewers

A two-day training of interviewers took place on June 23-24, 2014 in Mwanza and on July 6-7, 2014 in Kigoma. The interviewers received specialized training that included a basic introduction to domestic violence issues and an overall orientation to the concepts of gender, and gender discrimination and inequality. Other topics included research standards ethical procedures, protocols and ensuring common understanding of questions. The training provided a mechanism for interviewers to confront and overcome their own biases, fears, and stereotypes regarding abused women. It also equipped the surveyors with the skills to deal with difficult situations, including the use of a dummy survey with women in case the interview was interrupted by anyone. It also included practice on how to terminate an interview if the impact of the questions on the respondent became too negative. All interviewers were trained to provide referrals to women requesting assistance to available local services and sources of support.

Ethical clearance

Ethical clearance was obtained from the National Institute for Medical Research (NIMR) Lake Zone in respect to scientific content and compliance with all applicable research and human subjects' regulations. The respective District Executive Directors and the Regional Administrative Secretaries were also informed and they consented.

Part II Results

Demographic characteristics of study respondents

In total, 1,629 people aged 18 to 49 were surveyed. The demographic information for survey participants is presented in Table 1, organized by type of community (intervention or control) and by sex.

Focus group discussions were conducted with 13 male and 11 female participants.

Table 1 Demographic data, presented y sex and trial arm

	Intervention communities		Control communities	
	Women n=378 % (N)	Men n=486 % (N)	Women n=414 % (N)	Men n=351 % (N)
Age				
18-28	153 (40.5%)	205 (42.2%)	179 (43.1%)	142 (40.5%)
29-39	150 (39.7%)	165 (34%)	171 (41.2%)	111 (31.6%)
40-50	75 (19.8%)	112 (23%)	65 (15.7%)	97 (27.6%)
Marital status				
Single	48 (12.7%)	132 (27.2%)	28 (6.7%)	70 (19.9%)
Married	275 (72.8%)	317 (65.2%)	308 (74.2%)	238 (67.8%)
Cohabiting	17 (4.5%)	27 (5.6%)	50 (12%)	37 (10.5%)
Widow	19 (5%)	0	17 (4.1%)	1 (0.3%)
Divorced	19 (5%)	8 (1.6%)	12 (2.9%)	4 (1.1%)
Religion				
Catholic	102 (27%)	155 (31.9%)	134 (32.3%)	99 (28.2%)
Muslim	113 (29.9%)	142 (29.2%)	75 (18.1%)	98 (27.9%)
Born again	44 (11.6%)	37 (7.6%)	54 (13%)	28 (28.2%)
Sabbath	19 (5%)	22 (4.5%)	26 (6.3%)	22 (6.3%)
Lutheran	18 (4.8%)	14 (2.9%)	14 (3.4%)	20 (5.7%)
Other	63 (16.7%)	76 (15.6%)	85 (20.5%)	61 (17.4%)
No religion	18 (4.8%)	39 (8%)	25 (6%)	20 (5.7%)
Education				
No formal educ.	75 (19.8%)	41 (8.4%)	63 (15.2%)	15 (4.3%)
Partial primary	56 (14.8%)	28 (5.8%)	55 (13.3%)	32 (9.1%)
Completed primary	201 (53.2%)	287 (59.1%)	242 (58.3%)	156 (44.4%)
Partial secondary	16 (4.2%)	32 (6.6%)	24 (5.8%)	32 (9.1%)
Completed second.	27 (7.1%)	92 (18.9%)	30 (7.2%)	107 (30.4%)
University	1 (0.3%)	6 (1.2%)	1 (0.2%)	9 (2.6%)
Worked for money in the past 3 months	210 (55.6%)	397 (81.7%)	198 (47.7%)	295 (84.5%)

Two in five respondents belonged to the 18-28 age group and another two in five to the 29-39 age group. The least numerous respondent population was of the 40-50 age group. This age breakdown is more or less comparable with the Tanzania Population Pyramid (2014).

Regarding marital status, the vast majority of the respondents were married. Single respondents were the next most numerous group, while other types of marital status had a much lower number of respondents each.

Approximately half the respondents adhered to a Christian denomination, while slightly under a third were Muslims. Catholics made up the decidedly largest group among Christian respondents.

The overall educational level of the respondents was low. Half of all respondents had primary-level education. When seen as one group, the respondents with no formal education, partial primary and completed primary education made up the decidedly largest group. Though educational level differences

between men and women exist at all levels, the difference becomes statistically significant at the secondary school and university levels, with women being significantly less likely to have completed secondary school or university education.

Regarding working for money, there is a significant difference between women and men in both types of communities, whereby men were much more likely to have earned money in the past three months than women.

In general, intervention and control communities are comparable in regards to demographic characteristics, which allows us to compare them on research variables.

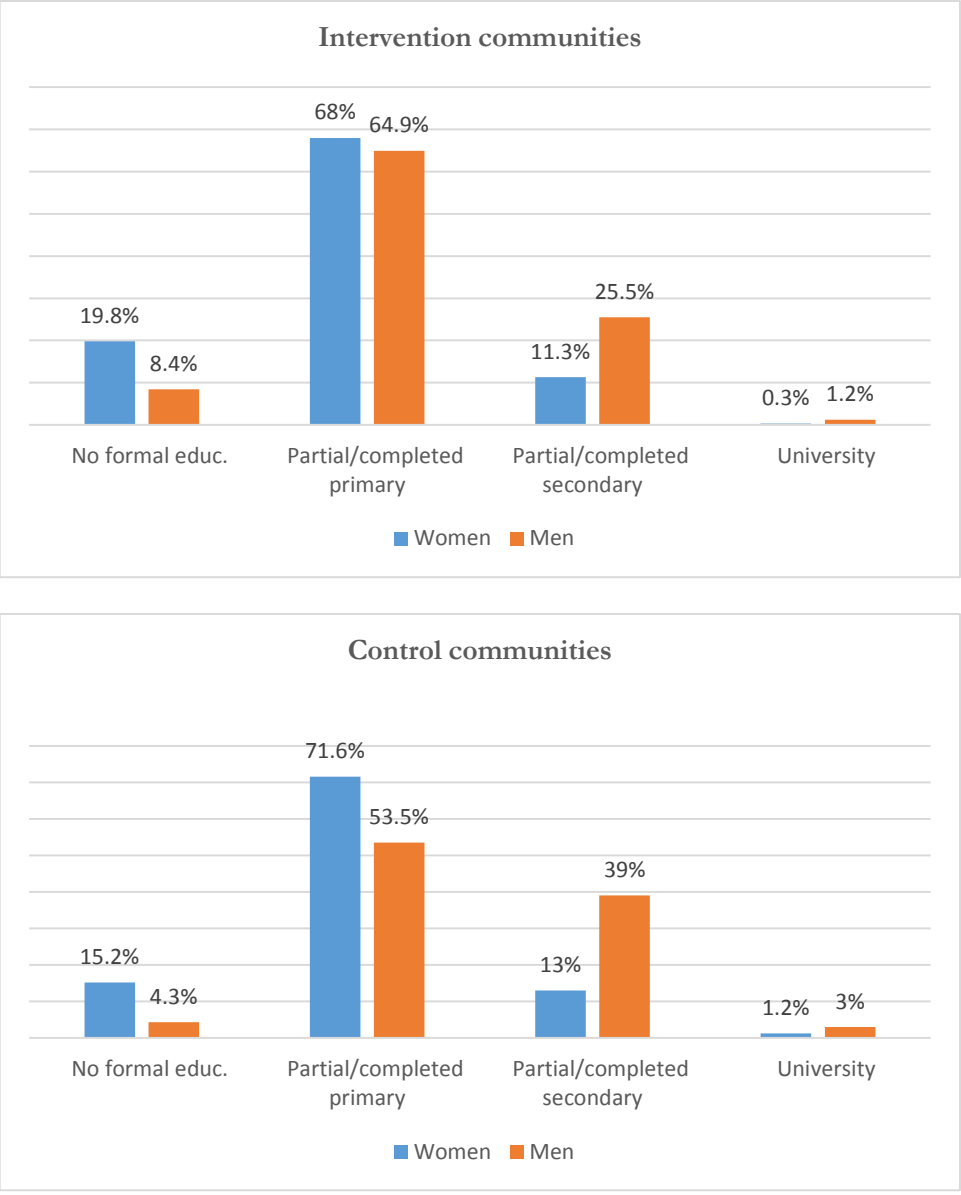

Figure 3 Educational level of survey respondents, by sex and type of community

Knowledge on intimate partner violence against women

The study aimed to establish the level of knowledge of intimate partner violence in the communities. We wanted to see what people considered violence and what they thought might trigger it. The measures of knowledge chosen are by no means exhaustive, but they do give an indication of the level of knowledge of this type of violence.

The results are presented in Table 2.

Table 2 Level of knowledge on IPV

Agreement with the following statements:	**Intervention communities**		**Control communities**	
	Women n=378 % (N)	Men n=482 % (N)	Women n=415 % (N)	Men n=351 % (N)
Husband controlling finances is violence	182 (48.1%)	196 (40.7%)	249 (60%)	146 (41.6%)
IPV also affects children who witness it	240 (63.7%)*	240 (50.6%)*	244 (59.5%)	209 (60.2%)
Disclosure of HIV by women leads to violence	245 (65.3%)	316 (65.2%)	264 (64.5%)	230 (65.9%)
Violence increases risk of HIV	265 (70.5%)	310 (65.3%)	269 (65.1%)	239 (69.5%)
Alcohol increases risk of violence	324 (87.1%)	390 (80.6%)	347 (84.8%)	297 (84.9%)
Agrees with all of the above statements	**57 (15.1%)**	**53 (10.9%)**	**62 (14.9%)**	**66 (18.8%)**

* differences between women and men in the same type of community significant at the $p<0.05$ level

A high proportion of all respondents indicated that violence increased the risk of HIV, that children are also affected by IPV, and that disclosure of positive HIV status increased the chance of violence against the woman. Importantly, more than 80% of all respondents considered alcohol to be a risk factor for violence against women, indicating this to be an important topic to be discussed during the intervention.

The lowest level of knowledge was present on the issues of financial control by husbands as a manifestation of violence. Women in control communities stand out as seeing financial control as violence to a greater extent than the other groups, though the difference is not statistically significant.

A composite measure of the knowledge of IPV was created to identify the proportion of those who answered 'correctly' to all the questions in this section. Only approximately 15% of all women respondents and 10.9%-18.8% of male respondents fell into this category. Taking into consideration the reletively high level of knowledge on individual items compared to the low levels on the composite measure, we can conclude that the knowledge on IPV is fragmented and not integrated into a comprehensive understanding of the phenoemenon.

One-way ANOVA analysis was conducted to explore level of knowledge among the respondents of various educational levels in regards to the composite measure of "good knowledge." The differences were significant for the control communities only, though not unidirectionally skewed towards better knowledge among the higher educated. The dispersed nature of significant variation among the educational levels makes it difficult to conclude that formal education increases a person's knowledge of violence against women.

Focus group discussion results

Focus group discussants identified various types of violence against women. One of the categories was physical violence, such as "*cruelty, wife battering, and kicking.*"

Other types of violent actions mentioned by the discussants included forced sex through marital rape and other forms of rape. Also mentioned were early marriages whereby men brought younger wives without seeking consent from the first wife. They did this because the first wife "looked tired."

Sometimes the senior wife is asked to move out of the matrimonial bed into another room. Male discussants said that such practice was in violation of the Islamic faith, which required the first wife to consent. Men fail to ask for permission, claimed the discussants, because they know that "*the wife not consent."*

Women reportedly faced psychological torture through rude remarks like a husband telling his wife,

> *"Don't ask me where I have been."*

Some discussants reported cases of 'bewitching.' This action of gaining control over someone through magic was specifically reported in a community where there is high superstition on witchcraft due to belief in supernatural powers. Sometimes the wife "*suspects that her husband has extramarital relations and she could go to a magician and ask for medicine which will harm him."* The belief is that men bewitched in that way can be made impotent whenever they visited other women.

The most extreme type of violence mentioned by the discussants was *cutting her with a machete."* In other words, violence can result in femicide.

Some discussants blamed community members for prompting conflict between husbands and wives. In addition, many discussants identified "hatred towards women married into the family" by the husband's relatives. Discussants told of relatives or in laws criticizing the wife and creating conflict between husband and wife.

Women remarked,

> "*Our husbands' relatives are usually blaming us for being arrogant to our husbands, looking down upon them, not respecting them and misusing their son's or brother's resources. It is as if we are not contributing or we are married to all relatives."*

Like the survey respondents, focus group discussant identified alcohol as an important factor in IPV. They explained that men who tend to misuse family resources through drinking often cause problems in family life.

Attitudes towards intimate partner violence against women

In addition to determining the level of knowledge of IPV, the survey ascertained the respondents' attitudes to this type of violence. A series of questions regarding "good" reasons for men hitting women was asked in order to unpack the respondents' deep-seated attitudes. Furthermore, the respondents were probed on their views of women being able to negotiate sex, demand the use of condoms, and on the acceptability of outsiders intervening in IPV. The results are presented in Table 3.

Table 3 Attitudes towards IPV

	Intervention communities		Control communities	
	Women n=378 % (N)	Men n=486 % (N)	Women n=414 % (N)	Men n=351 % (N)
A husband has a good reason to hit his wife if:				
She disobeys him	246 (65.6%)*	206 (42.6%)*	241 (58.5%)	145 (41.4%)
She answers back to him	181 (48.3%)*	126 (26.1%)*	226 (54.9%)*	95 (27.1%)*
She disrespects his relatives	190 (50.7%)*	160 (33.1%)*	239 (58.2%)*	99 (28.3%)*
He suspects that she is unfaithful	160 (42.8%)*	144 (29.8%)*	182 (44.6%)*	95 (27.1%)*
He finds out that she has been unfaithful	240 (64.5%)*	183 (37.7%)*	271 (66.6%)*	103 (29.6%)*
She spends her time gossiping with neighbors	178 (47.7%)*	140 (29%)*	212 (52.1%)*	89 (25.4%)*
She neglects taking care of the children	209 (56%)*	145 (30.1%)*	238 (58.6%)*	120 (34.4%)*
She does not complete her household work to his satisfaction	129 (34.6%)*	94 (19.4%)*	168 (41.3%)*	72 (20.6%)*
A married woman can refuse to have sex with her husband if she doesn't feel like it	160 (42.9%)*	303 (62.9%)*	204 (49.9%)*	258 (73.7%)*
A woman should tolerate violence from her partner to keep her family together	225 (60.3%)	266 (57.2%)	229 (56%)	177 (52.5%)
Women are to blame for the violence their partners use against them	95 (25.4%)	80 (17.2%)	79 (19.2%)	86 (25.1%)
It is okay for her to tell others if she has been beaten by her husband	81 (21.6%)	110 (22.8%)	112 (27.3%)*	119 (34.4%)*
It is acceptable for a married woman to ask her husband to use a condom	128 (34.9%)	137 (28.4%)	139 (34.2%)*	151 (43.3%)*
If a husband beats his wife, others outside the couple should intervene	103 (27.5%)	183 (38%)	141 (34.3%)	141 (40.2%)

* differences between women and men in the same type of community significant at the $p<0.05$ level

In both types of communities, women were much more likely blame women for the violence. We found significant differences ($p < 0.05$) between men and women in both intervention and control

communities on what constitutes a good reason for hitting (with the only exception being the item "if she disobeys him" in control communities). However, when asked directly if women are to blame, very few women indicated that they agreed. The discrepancy, among women, between the explicit and implicit blaming of women for IPV is something that should be explored during the intervention.

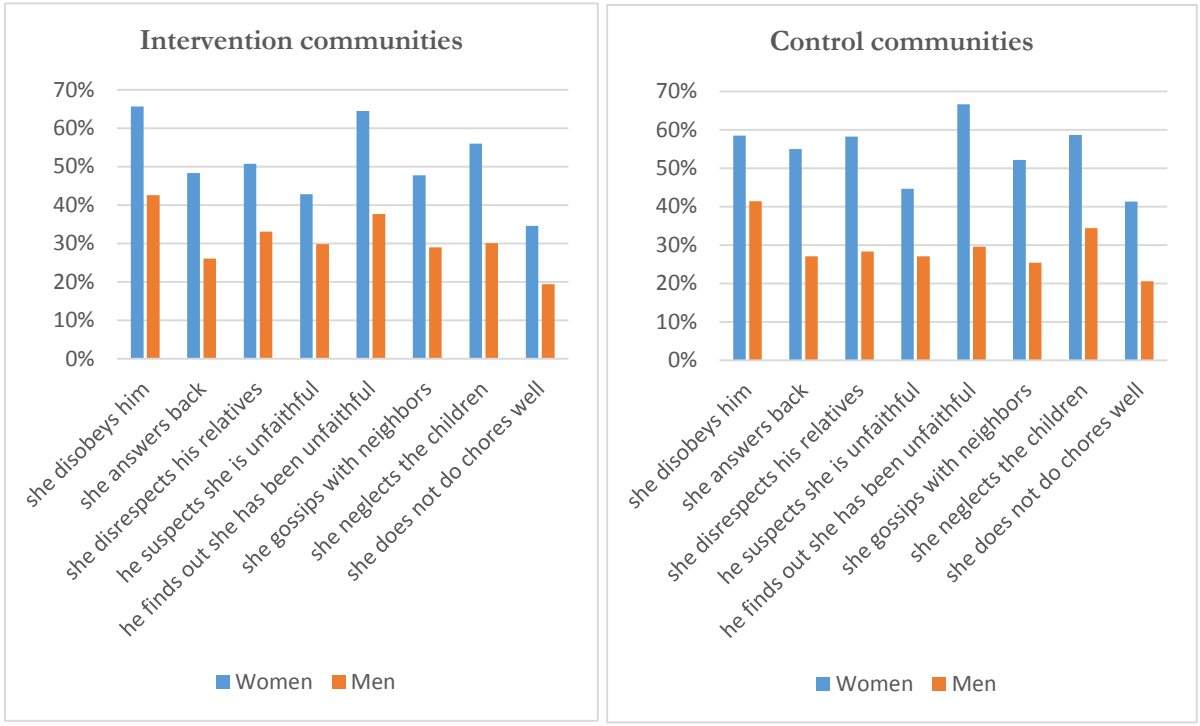

Figure 4 Proportion of women and men who think that a husband has a good reason to hit his wife, by type of behavior

Several other attitudinal questions also revealed significant differences between the sexes, with men exhibiting attitudes that are more progressive. This includes the question on the women's ability to refuse to have sex with her husband (in both intervention and control communities), the question about the acceptability of the women revealing her experience of IPV to others (significant only for control communities), and the question on the acceptability of the women asking her husband to use a condom (significant only for control communities).

The agreement with the question about the acceptability of outsiders intervening in IPV ranged from 27.5% for women in intervention communities to 40.2% for men in control communities.

Focus group discussion results

The discussants expressed some tolerance for intimate partner violence in certain situations. Some discussants regarded women selling family food to meet other needs as a somewhat legitimate reason for violence. Many also regarded women stopping to value their relationship and having extramarital affairs as a good reason. A few discussants in Kigoma said that some of the misunderstandings cropped up when husbands and wives stopped consuming their marriage due to fear of HIV infection, which leaves the family in a hopeless situation.

These attitudes towards "good reasons" for violence went hand in hand with the discussants view of gender roles. Many regarded men as "*a head and a woman as an organ in the family*." According to some discussants, "once they earn they own income, women start oppressing their husbands, forgetting their roles and looking down upon men to an extent that some women convert their men into house workers thus lowering their status to *bushoke*.[1]"

[1]A Kiswahili term for men who are looked down upon by their 'rich' wives.

Experience of intimate partner violence by women

Female respondents were asked about their experience of intimate partner violence during the preceding 12 months. Based on WHO guidelines and methodology, IPV was broken down into many different types of specific acts in order to measure all its manifestations and not be dependent on the respondents' understanding the label "intimate partner violence." Table 4 displays the results of this crucial part of the survey.

Table 4 Actos of physical and sexual IPV experienced by women in the past 12 months

	Intervention communities	**Control communities**
	Women n=378 % (N)	Women n=415 % (N)
He slapped her or threw something that could hurt her	99 (26.2%)	119 (28.7%)
He pushed her, shoved her or pulled her hair	65 (17.2%)	77 (18.6%)
He hit her with fist or with something else that could hurt her	69 (18.3%)	76 (18.3%)
He kicked, dragged or beat her	62 (16.4%)*	88 (21.3%)*
He choked or burnt her intentionally	27 (7.1%)*	47 (11.3%)*
He threatened to use or used a gun, knife or any other weapon on her	16 (4.2%)	16 (3.9%)
He forced her to have sex with him by holding her	50 (13.2%)	61 (14.7%)
She had sex with him because she felt threatened or scared that he might hurt her	52 (14.1%)	62 (15.4%)
One or more acts of physical violence	**120 (31.7%)**	**147 (35.4%)**
One or more acts of sexual violence	**66 (17.5%)**	**80 (19.3%)**
One or more acts of physical and/or sexual violence	**138 (36.5%)**	**178 (42.9%)**

* differences between intervention and control communities significant at the $p<0.05$ level

In intervention communities, 36.5% of all surveyed women admitted to having experienced one or more acts of intimate partner violence in the past year. In control communities, the prevalence was at 42.9%. The difference in prevalence is not statistically significant ($p = 0.067$).

These prevalence rates are only slightly above the national average in Tanzania (at 33%), according to the 2010 DHS survey (see figure 5). Here, it is important to note that DHS data is not directly comparable to our findings. The DHS asked only ever-married women about their experiences of violence. In contrast, all women in the Sasa! survey who had been in an intimate partnership in the past 12 months were asked about their experiences of violence, including women who had a regular partner with whom they were not living.

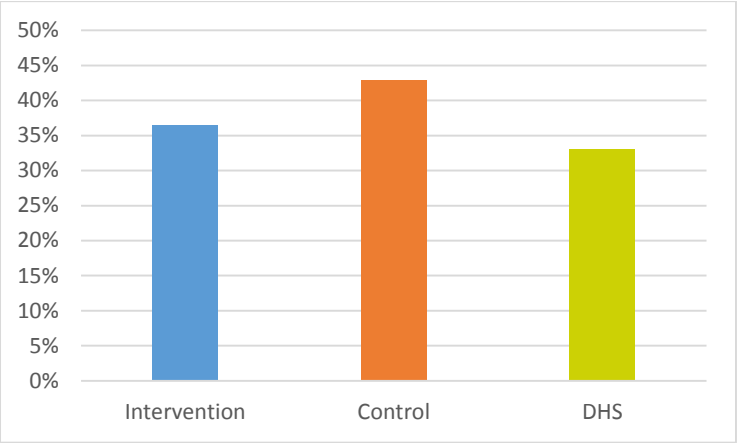

Figure 5 Proportion of women who have experienced IPV during the past 12 months (in comparison with DHS)

The prevalence rates for physical IPV only were 31.7% and 35.4% for intervention and control communities respectively, while the prevalence of sexual IPV was at 17.5% and 19.3%. Evidently, physical violence was more commonly reported than sexual violence, with the moderate acts reported more frequently than the more severe acts. The leading IPV experiences of physical violence in both types of communities was being slapped or having something thrown at (26.2% intervention and 28.7% control). The use of a gun, knife or another weapon or the threat thereof was the least prevalent type of physical IPV experienced (4.2% and 3.9%).

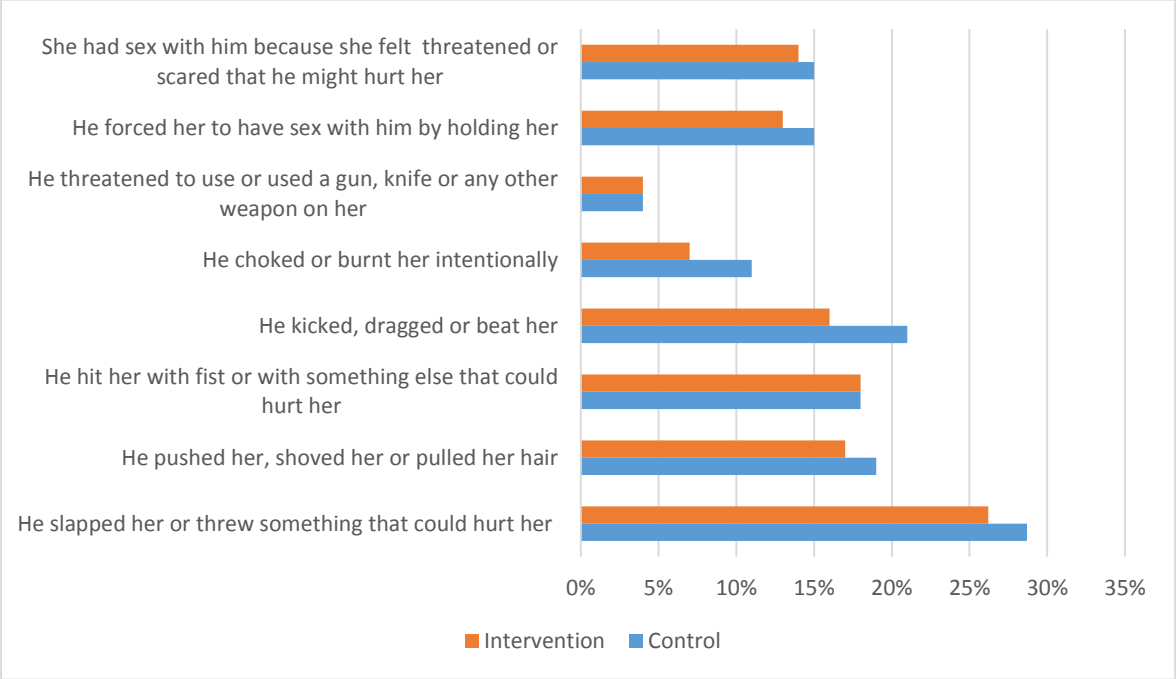

Figure 6 Proportion of women who experienced IPV in the past 12 months, by type of act

For sexual IPV, the most prevalent experience was of having had sex because she was afraid of being hurt if she refused (14.1% and 15.4%), closely followed by being physically forced to have sex (13.2% and 14.7%).

The levels of violence reported in the intervention and control communities are very similar, suggesting that the communities are highly comparable. As concerns discrete act of violence, control communities exhibited higher levels of violence on all of them, though the difference was statistically significant ($p < 0.05$) only in two categories: being kicked, dragged or beat; and being choked or burned intentionally.

Community response to women experiencing intimate partner violence

The study tested if the women who had experienced IPV also received help from someone in the community, and if so, what kind of help it was. The findings are displayed in Table 5.

Table 5 Community response to victims of IPV, in the past 12 months

	Intervention communities	Control communities
	Women n= max 101 % (N)	Women n=max 128 % (N)
Received help from someone in the community	**38 (37.6%)**	**41 (32%)**
Someone gathered others in the community to help	24 (42.9%)	22 (28.2%)
Someone knocked on the door and stopped the fight	25 (46.3%)	31 (41.3%)
Someone separated the victimizer and the women during the violent episode	26 (48.1%)	32 (42.7%)
Someone informed the police or other law enforcement institution	15 (26.8%)	10 (12.8%)
Someone asked her if she needed assistance.	25 (42.4%)	27 (31.8%)

Approximately 38% a the women in intervention communities who had experienced IPV in the preceding 12 months received help from someone in the community following the violence. In control communities, the rate was 32%. Informal types of help were much more frequent than informing law enforcement in all communities. Control communities displayed lower levels of help giving in general and in each category, though the differences are not statistically significant.

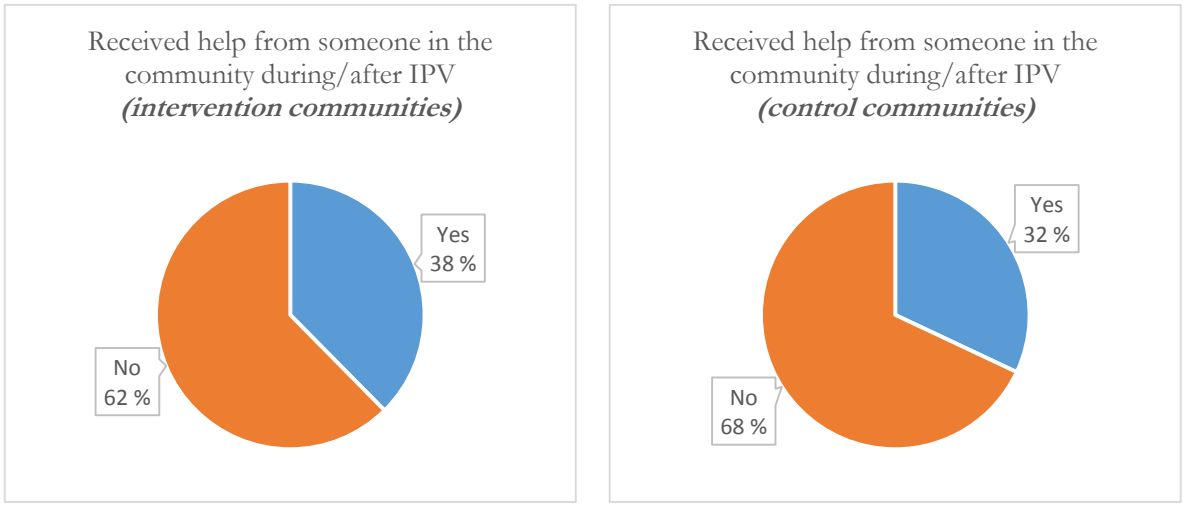

Figure 7 Proportion of women who received help from someone in the community during/after IPV

Skills and behavior

In this section of the survey, the respondents were asked about their experience with offering help to victims of intimate partner violence and of their 'compliance' with a range of gender-specific stereotypes. Being a culture-specific construct, gender portrays significant differences in what women and men can or cannot do. Table 6 displays the results on skills and gender-specific behavior.

Table 6 Help giving to victims of IPV and gender-specific behavior among women and men, in the past 12 months

	Intervention communities		Control communities	
	Women n=378 % (N)	Men n=486 % (N)	Women n=414 % (N)	Men n=351 % (N)
Helped a woman who was experiencing violence at home	153 (40.5%)*	147 (30.5%)*	113 (27.6%)	124 (35.5%)
Told a local leader about domestic violence in a home nearby	38 (21.9%)	106 (21.9%)	52 (12.6%)*	74 (21.1%)*
Spoken out about violence against women to others in my community	94 (24.9%)	170 (35.9%)	105 (25.4%)*	120 (34.3%)*
Done things that are typically thought of as the other sex's role	157 (41.6%)	231 (48%)	167 (40.3%)*	187 (54.5%)*
Regularly helped (men) or received help from men (women) with washing dishes in the home	64 (16.9%)*	232 (48.3%)*	115 (27.8%)*	218 (62.1%)*
Gotten her/his way most of the time during arguments with partner	125 (33.2%)	162 (33.8%)	141 (34.1%)	117 (33.3%)
Had her/his partner make most of the decisions about when they could visit your family/relatives	210 (55.6%)*	136 (28.2%)*	258 (62.5%)*	130 (37.4%)*
Usually felt respected by your partner	235 (62.3%)	356 (74.8%)	288 (69.7%)	254 (72.4%)

* differences between women and men in the same type of community significant at the $p<0.05$ level

In intervention communities, women were more likely than men to have helped someone who had experienced IPV (statistically significant), while men were more likely to have given help in control communities. In control communities, there were significant differences between the sexes in regards to having told a local leader about IPV experienced by someone else, with men being more likely to have done so. Also in control communities, women sensitized others in the community about domestic violence at higher rates than men (statistically significant).

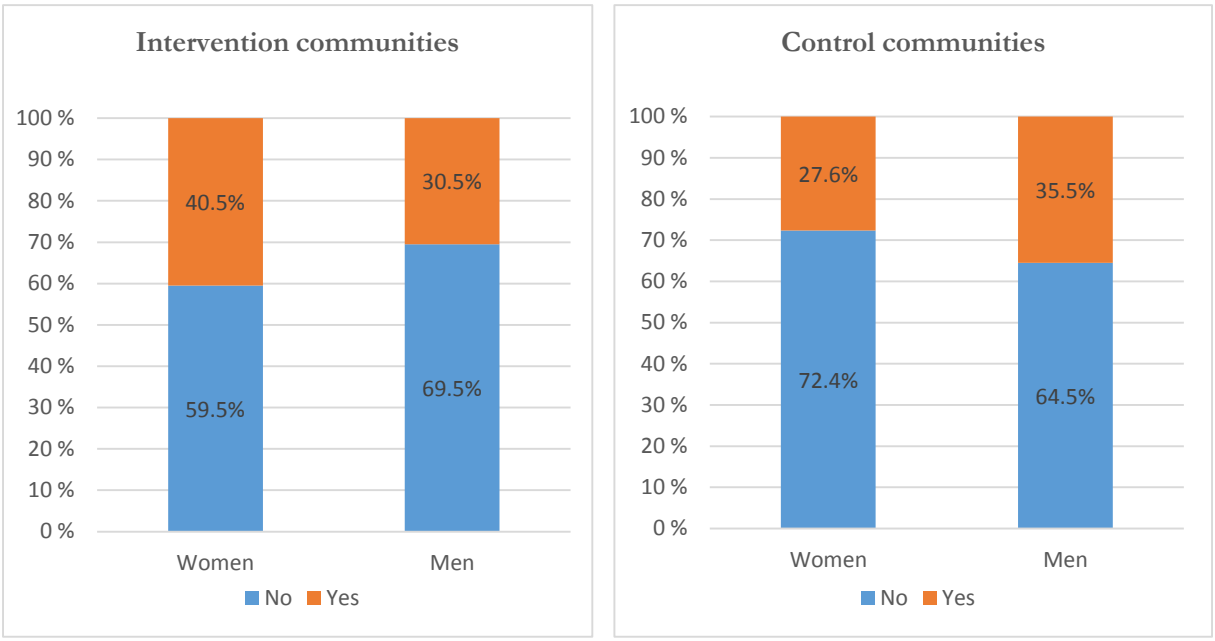

Figure 8 Proportion of women and men who helped a woman experiencing IPV in the past 12 months

Results of the questions on gender roles and decision-making power in the past 12 months indicate that, in control communities, more men say that they had done things that are typically regarded the women's role than women say they had done something considered the men's role. The difference here is statistically significant. When asked about whether men helped with dishwashing, more men than women (in both types of communities) responded affirmatively. Men being aware of the social desirability of sharing household chores and their reluctance to provide an honest answer could explain the discord between women and men's responses to this question.

Not surprisingly, many more women than men reported having their partner make most of decisions on when to visit family or relatives.

Focus group discussion results

The discussants shared their opinions towards gender roles and norms in a relationship. Many identified the expected roles of women in a relationship such as domestic roles including cooking washing, clothes, taking care of the sick children and husband, knowing how to care for the children and the environment. Two men who helped with domestic chores boasted to be living happily.

Others labelled the woman as the backbone of the family, but in need of protection, while some said that she was the minister for internal affairs while the man was the minister for foreign affairs. In addition, a woman was expected to be a planning officer for the family.

Most discussants saw men as the head of the household and a person who identified and attended family issues such as buying food, caring for his wife, paying for children's education, feeding them and ensuring they had behaved well. Others added that he was responsible for house construction; he was the main overseer of the planned activities, family counsellor and chief administrator. One discussant added that it was a man's role to identify which seeds needed to be planted. Men were expected to be careful, to know the behavior of each family member including his wife, and not to keep quiet if a child misbehaves. In the words of one male discussant,

> *"For us men, our roles are clear, we are the bread winners, if a woman does so, she is just topping up."*

However, some women discussants observed that a man ought to be kind, not to use force but wisdom. Two women made the following remarks,

" A man is regarded as a head and a woman as an organ in the family, but if a child fails at school, it is the woman who struggles; this has happened to me." "Fathers are always happier than mothers; indeed this has happened to many of us."

The topic of men who performed domestic chores created a lot of interest. The views on this matter were divided. Some discussants thought that this was good,

"It is a role model to children so they can imitate it when they grow up."

One male discussant in Kigoma proudly remarked,

"This is the regulation at my home [that the man does some household chores]. The challenge is reaction based on community ethics. They say 'he has been hijacked or even bewitched by the wife, he is washing dishes, he is washing clothes.' Even my religion preaches that men have to work and leave women to rest."

However, many men thought that not all sorts of domestic work are suitable for men. One man noted that "*men should not have to wake up and clean the environment, wash dishes, etc.*"

HIV risk behavior by men

As indicated in the background section, there are important interlinks between HIV and IPV. Research conducted worldwide shows that power imbalance between women and men expands male sexual freedom. This also increases women's and men's risk and vulnerability to HIV. Men in the study were asked if they had had a sexual relationship with someone else than their primary partner/spouse during the preceding 12 months. See Table 7 below.

Table 7 Concurrent sexual partners among married/partnered men, in the past 12 months

	Intervention communities	Control communities
	Men n=351 % (N)	Men n=69 % (N)
Has had a sexual relationship with someone else than spouse/primary partner during the past 12 months	74 (21.1%)	11 (15.9%)

Extremely few surveyed men in control communities (n=69) opted to respond to this question, making it impossible to make inferences about this study variable in those communities. In intervention communities, on the other hand, the response rate was satisfactory. The results there reveal that 1 in 5 men had had an extramarital sexual affair during the past year.

Polygamous men were to be excluded from this survey question in order to avoid the conflation of sexual concurrency within and outside marriage. However, it is highly possible that not all surveyors followed the protocol on this point, thus contaminating the results. Nevertheless, the prevalence found by this study is at the level of national data on multiple concurrent sexual partners among men (also 21%), which indicates reliability.

Focus group discussion results

Female discussants said that their men looked for 'small (concubines') houses,' meaning a different house from the matrimonial one, especially if that woman had money.

> *"They get better food and treatment. As poor wives, we cannot afford this type of maintenance. They move to those other houses and leave us with vegetables and sardines. We are indeed oppressed."*

Some focus group discussants viewed multiple wives among Muslim men as a type of sexual infidelity, and as violence in its own right:

> *"In Kigoma, most Moslem husbands would marry more wives even if they already had 2 or 3 wives. They do everything secretly and the elder wife will know later. This is violence and it is humiliating."*

> *"I have experienced that the majority do not seek consent from earlier wives. This type of violence is common here."*

It is worth noting here that the survey results do not indicate significant differences among the various religious affiliations when it comes to men having extramarital sexual relations.

Exposure to violence prevention messaging

To help SASA-implementing organizations prepare for their intervention in the chosen communities, the survey examined the extent to which other actors had already exposed the communities to violence prevention initiatives.

Table 8 Exposure to violence prevention messages, in the past 12 months

	Intervention communities		Control communities	
	Women n= 301 % (N)	Men n=484 % (N)	Women n=396 % (N)	Men n=350 % (N)
Has seen people in the community working to prevent violence against women	66 (18%)	116 (24%)	84 (21.2%)	122 (34.9%)
Has participated in activities on healthy and safe relationships	135 (36.3%)[a]	202 (42.2%)[a]	159 (39.9%)[b]	184 (52.6%)[b]
Once	57 (15.4%)	72 (17.2%)	38 (9.5%)	42 (12.8%)
Twice	21 (5.7%)	60 (14.3%)	35 (8.8%)	51 (12.8%)
More than twice	59 (15.9%)	72 (17.2%)	76 (19.1%)	198 (32.8%)

[a,b] differences between intervention and control communities for combined sexes significant at the $p<0.05$ level

Approximately 1 in 4 respondents say they have seen others in the community working to prevent violence against women. More respondents in control communities (27%) than in intervention communities (24%) responded affirmatively to that question, though the difference is not statistically significant. A higher proportion of respondents in control communities also say they have participated in activities on healthy and safe relationships. Surprisingly, more men than women report having participated in such activities in both types of communities.

Part III Discussion

This baseline survey sought to investigate and report on the community perceptions, attitudes and practices of Intimate Partner Violence (IPV) in four intervention and four control wards in Magu and Kigoma/Ujiji districts

The communities were found to be comparable in demographic characteristics and most research variables.

The prevalence of intimate partner violence found in the research communities is in line with the national level in Tanzania. Prevalence (both physical and sexual) was comparable between the community types, as were the levels of knowledge, attitudes, help giving, gender roles, and previous exposure to violence prevention. As regards sexual concurrency by men, control communities exhibited lower levels of promiscuity. However, we are not able to compare the communities on this variable with enough statistical power due to the extremely low number of respondents in control communities.

To a large extent, focus group discussions validated the findings of the survey.

Importantly, the study revealed that men had generally more progressive attitudes to intimate partner violence than women. Women seem to have generally accepted violence as part of their daily lives' expectations. Focus group discussions, however, do not confirm the progressiveness of men found by the survey.

The study also uncovered a discord between espoused and actual attitudes among women. This discrepancy should be used as an entry point for changing attitudes during the intervention.

Three years after the start of the implementation of the Sasa! intervention in Tanzania, a follow-up survey will be conducted in these same communities. The same sampling methods will be used for both the baseline and follow-up surveys. The follow-up data will be used to compare outcomes between intervention and comparison communities to assess what changes have occurred as a result of the intervention activities.

References

1. Garcia-Moreno C, Jansen HA, Ellsberg M, Heise L, Watts CH: Prevalence of intimate partner violence: findings from the WHO multi-country study on women's health and domestic violence. Lancet 2006, 368:1260–1269.

2. Greig A, Peacock D, Jewkes R, Msimang S: Gender and AIDS: time to act. AIDS 2008, 22 (Suppl):S35–S43.

3. UN Joint Programme on HIV/AIDS: Global Report: UNAIDS Report On The Global AIDS Epidemic 2010. Geneva: UNAIDS; 2010.

4. Jewkes RK, Dunkle K, Nduna M, Shai N: Intimate partner violence, relationship power inequity, and incidence of HIV infection in young women in South Africa: a cohort study. Lancet 2010, 376:41–48.

5. Zablotska IB, Gray RH, Koenig MA, Serwadda D, Nalugoda F, Kigozi G, Sewankambo N, Lutalo T, Wabwire Mangen F, Wawer M: Alcohol use, intimate partner violence, sexual coercion and HIV among women aged 15–24 in Rakai, Uganda. AIDS Behav 2009, 13:225–233.

6. Maman S, Campbell J, Sweat MD, Gielen AC: The intersections of HIV and violence: directions for future research and interventions. SocSci Med 2000, 50:459–478.

7. Wingood GM, DiClemente RJ: The effects of an abusive primary partner on the condom use and sexual negotiation practices of African-American women. Am J Public Health 1997, 87:1016–1018.

8. Santana MC, Raj A, Decker MR, La Marche A, Silverman JG: Masculine gender roles associated with increased sexual risk and intimate partner violence perpetration among young adult men. J Urban Health 2006, 83:575–585.

9. Noar SM, Morokoff PJ: The relationship between masculinity ideology, condom attitudes, and condom use stage of change: a structural equation modeling approach. Int J Men's Health 2001, 1:43–58.

10. Gupta GR: Gender, sexuality, and HIV/AIDS: the what, the why, and the how. Can HIV AIDS Policy Law Rev 2000, 5:86–93.

11. El-Bassel N, Gilbert L, Rajah V, Foleno A, Frye V: Fear and violence: raising the HIV stakes. AIDS EducPrev 2000, 12:154–170.

12. Abramsky T, Watts CH, Garcia-Moreno C, Devries K, Kiss L, Ellsberg M, Jansen HA, Heise L: What factors are associated with recent intimate partner violence? Findings from the WHO multi-country study on women's health and domestic violence. BMC Publ Health 2011, 11:109.

13. Maman S, Mbwambo J, Hogan NM, Kilonzo GP, Sweat M: Women's barriers to HIV-1 testing and disclosure: challenges for HIV-1 voluntary counselling and testing. AIDS Care 2001, 13:595–603.

14. Medley A, Garcia-Moreno C, McGill S, Maman S: Rates, barriers and outcomes of HIV serostatus disclosure among women in developing countries: implications for prevention of mother-to-child transmission programmes. Bull World Health Organ 2004, 82:299–307.

15. WHO: Violence Against Women and HIV/AIDS: Setting the Research Agenda, Meeting Report. Geneva: WHO; 2000.

16. National Bureau of Statistics (NBS). Tanzania Demographic and Health Survey 2010. Dar es Salaam, Tanzania: NBS and ICF Macro: 2011.

17. Tanzania Commission for AIDS (TACAIDS) Tanzania HIV/AIDS and Malaria Indicator Survey 2011-12. Dar es Salaam, Tanzania: TACAIDS, ZAC, NBS, OCGS, and ICF International. TACAIDS: 2013

18. Mawsanya et al. Drivers of HIV/AIDS Epidemic in Tanzania mainland: Case Study. TACAIDS /UNAIDS: (2010)

19. Heise LL: Violence against women: an integrated, ecological framework. Violence Against Women 1998, 4:262–290.

20. Prochaska JO, Diclemente CC, Norcross JC: In search of how people change - applications to addictive behaviors. Am Psychol 1992, 47:1102–1114.

Appendix 1:Baseline Rapid Assessment Survey for Women

1	*Record the respondent's sex*	FEMALE ..... 1 MALE 0
2	*Record the date of the interview*	DAY ..... [ ][ ] MONTH ..... [ ][ ] YEAR ..... [ ][ ][ ][ ]
3	*Record the location of the interview*	DISTRICT..... COMMUNITY/VILLAGE.....
4	Do you live in this community/village?	YES.....1 NO.....0 (IF NO, THANK AND SAMPLE SOMEONELSE)
5	Have you lived in this community/village for at least one year?	YES.....1 NO.....0 (IF NO, THANK AND SAMPLE SOMEONE ELSE)
6	How old are you?	[ ][ ] (IF LESS THAN 18, THANK AND SAMPLE SOMEONE ELSE)
7	What is your marital status?	SINGLE..... 0 MARRIED ..... 1 CO-HABITING ..... 2 WIDOWED ..... 3 DIVORCED ..... 4 REFUSE TO ANSWER.....9
8	What is your level of education?	NO FORMAL EDUCATION..... 0 SOME PRIMARY EDUCATION..... 1 COMPLETED PRIMARY EDUCATION..... 2 SOME SECONDARY EDUCATION ..... 3 COMPLETED SECONDARY EDUCATION... 4 TECHNICAL COURSE..... 5 UNIVERSITY DEGREE..... 6 OTHER..... 7 REFUSE TO ANSWER.....9
9	What is your religious affiliation?	NO RELIGIOUS AFFILIATION..... 0 CATHOLIC..... 1 BORN AGAIN..... 2 PROTESTANT..... 3 MUSLIM..... 4 TRADITIONAL/ANIMIST..... 5 OTHER..... 6 REFUSE TO ANSWER.....9
10	Have you been involved in any income generating activities in the last 3 months?	NO.....0 YES.....1 REFUSE TO ANSWER...9

In this community and elsewhere, people have different ideas about families and what is acceptable behavior for men and women in the home. In these questions, we'd like to learn from you what you think about some of these issues. I am going to read some statements, can you please tell me if you agree or disagree with them? There are no right or wrong answers, please answer honestly.

Knowledge		
11	A man controlling the family finances is a kind of violence.	AGREE ……..0 DISAGREE …….. 1 REFUSE TO ANSWER..9
12	If a man/husband is violent toward his wife it does not affect the children.	AGREE ……..0 DISAGREE …….. 1 REFUSE TO ANSWER..9
13	If a husband is violent toward his wife, she is at higher risk for getting infected by HIV.	AGREE ……..0 DISAGREE …….. 1 REFUSE TO ANSWER..9
14	Women often experience violence from their partner after sharing their HIV positive status.	AGREE ……..0 DISAGREE …….. 1 REFUSE TO ANSWER..9
15	If a man drinks alcohol regularly, he is more likely to use violence against his wife.	AGREE ……..0 DISAGREE …….. 1 REFUSE TO ANSWER..9

Thank you very much. This next section is about what you think about common issues that come up in relationships between women and men as we are interesting in learning your opinion. Please answer yes or no and remember, there are no right or wrong answers.

In your opinion, does a man have a good reason to hit his wife if:

Attitudes		
16 a	She disobeys him	YES..... 0 NO ..... 1 REFUSE TO ANSWER..9
16 b	She answers back to him	YES..... 0 NO ..... 1 REFUSE TO ANSWER..9
16 c	She disrespects his relatives	YES..... 0 NO ..... 1 REFUSE TO ANSWER..9
16 d	He suspects that she is unfaithful	YES..... 0 NO ..... 1 REFUSE TO ANSWER..9
16 e	He finds out that she has been unfaithful	YES..... 0 NO ..... 1 REFUSE TO ANSWER..9
16 f	She spends her time gossiping with neighbours	YES..... 0 NO ..... 1 REFUSE TO ANSWER..9
16 g	She neglects taking care of the children	YES..... 0 NO ..... 1 REFUSE TO ANSWER..9
16 h	She does not complete her household work to his satisfaction	YES..... 0 NO ..... 1 REFUSE TO ANSWER..9
16 i	She disobeys him	YES..... 0 NO 1

		REFUSE TO ANSWER..9
17	In your opinion, can a married woman refuse to have sex with her husband if she doesn't feel like it?	YES..... 0 NO ..... 1 REFUSE TO ANSWER..9
18	Do you think that a woman should tolerate violence from her partner to keep her family together?	YES..... 0 NO ..... 1 REFUSE TO ANSWER..9
19	Do you think that women are to blame for the violence their partners use against them?	YES..... 0 NO ..... 1 REFUSE TO ANSWER..9
20	If a married woman has been beaten by her husband, is it okay for her to tell others?	YES..... 0 NO ..... 1 REFUSE TO ANSWER..9
21	Do you think it is strange for a married man if his friends see him regularly washing dishes at home?	YES..... 0 NO ..... 1 REFUSE TO ANSWER..9
22	Do you think women are mostly to blame for bringing HIV to the household?	YES..... 0 NO ..... 1 REFUSE TO ANSWER..9
23	Is it acceptable for a married woman to ask her husband to use a condom?	YES..... 0 NO ..... 1 REFUSE TO ANSWER..9
24	If a husband beats his wife, do you think others outside the couple should intervene?	YES..... 0 NO ..... 1 REFUSE TO ANSWER..9

Thank you very much. I am now going to ask you about some situations that happen to many women. I assure you that your answers will be kept secret and that you do not have to answer any questions that you do not want to*. Please remember, there is no right or wrong answer.*

Has your partner done any of the following things to you IN THE PAST YEAR (12 MONTHS?)?

Experience of violence		
25 a	Slapped you or thrown something at you that could hurt you?	YES..... 0 NO ..... 1 REFUSE TO ANSWER..9
25 b	Pushed you or shoved you or pulled your hair?	YES..... 0 NO ..... 1 REFUSE TO ANSWER..9
25 c	Hit you with his fist or with something else that could hurt you?	YES..... 0 NO ..... 1 REFUSE TO ANSWER..9
25 d	Kicked you, dragged you or beat you up?	YES..... 0 NO ..... 1 REFUSE TO ANSWER..9
25 e	Choked you or burnt you on purpose?	YES..... 0 NO ..... 1 REFUSE TO ANSWER..9
25 f	Threatened to use or actually used a gun, knife or other weapon against you?	YES..... 0 NO ..... 1 REFUSE TO ANSWER..9

25 g	Forced you to have sexual intercourse by physically threatening you, holding you down or hurting you in some way?	YES..... 0 NO ..... 1 REFUSE TO ANSWER..9
25 h	Did you ever have sexual intercourse because you were intimidated by him or afraid he would hurt you?	YES..... 0 NO ..... 1 REFUSE TO ANSWER..9

[If the woman answers YES to any of the above question, go to question 26. If not, skip to 28].

Community response		
26	When the experiences you have told me about were happening or afterwards, did anyone in your community try to help you?'	YES..... 0 NO ..... 1 REFUSE TO ANSWER..9

If YES, proceed to 27. If NO, skip to 28.

Community response		
27 a	Did they gather other people from the community to help?	YES..... 0 NO ..... 1 REFUSE TO ANSWER..9
27 b	Did they knock on the door to stop the fighting?	YES..... 0 NO ..... 1 REFUSE TO ANSWER..9
27 c	Did they separate you and your partner during fighting?	YES..... 0 NO ..... 1 REFUSE TO ANSWER..9
27 d	Did they inform police or other authority?	YES..... 0 NO ..... 1 REFUSE TO ANSWER..9
27 e	Did they talk to you and ask you if you want them to help you?	YES..... 0 NO ..... 1 REFUSE TO ANSWER..9

In the next few questions, I am going to ask you about some common situations that happen in communities. We would like to know what you think about them. Please answer yes or no, there are no wrong answers, please be honest.

Skills and Behavior		
28	In the last 12 months, have you helped a woman who was experiencing violence at home?	YES .....0 NO .....1 DOESN'T APPLY.....8 REFUSE TO ANSWER....9
29	In the last 12 months, have you told a local leader about domestic violence in a home nearby?	YES .....0 NO .....1 DOESN'T APPLY.....8 REFUSE TO ANSWER.....9
30	In the last 12 months, have you spoken out about violence against women to others in my community?	YES .....0 NO 1

		REFUSE OR N/A 9
31	**If talking to a woman ask:**Do you regularly do things that are typically thought of as men'srole?	YES .....0 NO .....1 REFUSE TO ANSWER.....9
32	**If talking to a woman ask:** Does your partner regularly help with washing dishes in the home?	YES .....0 NO .....1 REFUSE TO ANSWER.....9
33	In the last 12 months, has your partner had more say than you do about important decisions that affect your relationship/family?	YES .....0 NO .....1 DOESN'T APPLY.....3 REFUSE TO ANSWER.....9
34	During the last 12 months, has your partner made most of the decisions about your own health care?	YES .....0 NO .....1 DOESN'T APPLY.....3 REFUSE TO ANSWER.....9
35	During the last 12 months, when your partner and you disagree, do you get your way most of the time?	YES .....0 NO .....1 DOESN'T APPLY.....3 REFUSE TO ANSWER.....9
36	During the last 12 months, did your partner made most of the decisions about when you could visit your family/relatives?	YES .....0 NO .....1 DOESN'T APPLY.....3 REFUSE TO ANSWER....9
37	During the last 12 months, have you usually felt respected by your partner?	YES .....0 NO .....1 DOESN'T APPLY.....3 REFUSE TO ANSWER.....9

Thank you so much, we are almost finished. These last questions are about what you see in your community about violence prevention. Please answer yes or no.

Exposure to violence prevention		
39	In the last 12 months, have you seen people in your community doing something to prevent violence against women?	YES .....0 NO .....1 REFUSE TO ANSWER..9
40	In the last 12 months, have you participated in any activity about safe and healthy relationship?	YES .....0 NO .....1 REFUSE TO ANSWER..9
41	How many times have you participated in one of these activities?	NONE.....0 ONCE.....1 TWICE.....2 MORE THAN TWICE....3 REFUSE TO ANSWER..9

Thank you for your time. I really appreciate you talking with me and sharing your thoughts. Would you like a list of organizations/people who you could talk confidentially with about any of these issues? (IF YES, GIVE REFERRAL LIST. IF NO, THANK AGAIN AND REMIND THEM OF THE NAME OF YOUR ORGANIZATION IN CASE THEY ARE INTERESTED IN FOLLOW UP.)

Appendix 2: Baseline Rapid Assessment Survey for Men

1	*Record the respondent's sex*	FEMALE ..... 1 MALE 0
2	*Record the date of the interview*	DAY ..... [ ][ ] MONTH ..... [ ][ ] YEAR ..... [ ][ ][ ][ ]
3	*Record the location of the interview*	DISTRICT..... COMMUNITY/VILLAGE.....
4	Do you live in this community/village?	YES.....1 NO.....0 (IF NO, THANK AND SAMPLE SOMEONELSE)
5	Have you lived in this community/village for at least one year?	YES.....1 NO.....0 (IF NO, THANK AND SAMPLE SOMEONE ELSE)
6	How old are you?	[ ][ ] (IF LESS THAN 18, THANK AND SAMPLE SOMEONE ELSE)
7	What is your marital status?	SINGLE..... 0 MARRIED ..... 1 CO-HABITING ..... 2 WIDOWED ..... 3 DIVORCED ..... 4 REFUSE TO ANSWER.....9
8	What is your level of education?	NO FORMAL EDUCATION..... 0 SOME PRIMARY EDUCATION..... 1 COMPLETED PRIMARY EDUCATION..... 2 SOME SECONDARY EDUCATION ..... 3 COMPLETED SECONDARY EDUCATION... 4 TECHNICAL COURSE..... 5 UNIVERSITY DEGREE..... 6 OTHER..... 7 REFUSE TO ANSWER.....9
9	What is your religious affiliation?	NO RELIGIOUS AFFILIATION..... 0 CATHOLIC..... 1 BORN AGAIN..... 2 PROTESTANT..... 3 MUSLIM..... 4 TRADITIONAL/ANIMIST..... 5 OTHER..... 6 REFUSE TO ANSWER.....9
10	Have you been involved in any income generating activities in the last 3 months?	NO.....0 YES.....1 REFUSE TO ANSWER...9

In this community and elsewhere, people have different ideas about families and what is acceptable behavior for men and women in the home. In these questions, we'd like to learn from you what you think about some of these issues. I am going to read some statements, can you please tell me if you agree or disagree with them? There are no right or wrong answers, please answer honestly.

Knowledge		
11	A man controlling the family finances is a kind of violence.	AGREE ……..0 DISAGREE …….. 1 REFUSE TO ANSWER..9
12	If a man/husband is violent toward his wife it does not affect the children.	AGREE ……..0 DISAGREE …….. 1 REFUSE TO ANSWER..9
13	If a husband is violent toward his wife, she is at higher risk for getting infected by HIV.	AGREE ……..0 DISAGREE …….. 1 REFUSE TO ANSWER..9
14	Women often experience violence from their partner after sharing their HIV positive status.	AGREE ……..0 DISAGREE …….. 1 REFUSE TO ANSWER..9
15	If a man drinks alcohol regularly, he is more likely to use violence against his wife.	AGREE ……..0 DISAGREE …….. 1 REFUSE TO ANSWER..9

Thank you very much. This next section is about what you think about common issues that come up in relationships between women and men as we are interesting in learning your opinion. Please answer yes or no and remember, there are no right or wrong answers.

In your opinion, does a man have a good reason to hit his wife if:

Attitudes		
16 a	She disobeys him	YES..... 0 NO ..... 1 REFUSE TO ANSWER..9
16 b	She answers back to him	YES..... 0 NO ..... 1 REFUSE TO ANSWER..9
16 c	She disrespects his relatives	YES..... 0 NO ..... 1 REFUSE TO ANSWER..9
16 d	He suspects that she is unfaithful	YES..... 0 NO ..... 1 REFUSE TO ANSWER..9
16 e	He finds out that she has been unfaithful	YES..... 0 NO ..... 1 REFUSE TO ANSWER..9
16 f	She spends her time gossiping with neighbours	YES..... 0 NO ..... 1 REFUSE TO ANSWER..9
16 g	She neglects taking care of the children	YES..... 0 NO ..... 1 REFUSE TO ANSWER..9
16 h	She does not complete her household work to his satisfaction	YES..... 0 NO ..... 1 REFUSE TO ANSWER..9
16 i	She disobeys him	YES..... 0 NO 1

		REFUSE TO ANSWER..9
17	In your opinion, can a married woman refuse to have sex with her husband if she doesn't feel like it?	YES..... 0 NO ..... 1 REFUSE TO ANSWER..9
18	Do you think that a woman should tolerate violence from her partner to keep her family together?	YES..... 0 NO ..... 1 REFUSE TO ANSWER..9
19	Do you think that women are to blame for the violence their partners use against them?	YES..... 0 NO ..... 1 REFUSE TO ANSWER..9
20	If a married woman has been beaten by her husband, is it okay for her to tell others?	YES..... 0 NO ..... 1 REFUSE TO ANSWER..9
21	Do you think it is strange for a married man if his friends see him regularly washing dishes at home?	YES..... 0 NO ..... 1 REFUSE TO ANSWER..9
22	Do you think women are mostly to blame for bringing HIV to the household?	YES..... 0 NO ..... 1 REFUSE TO ANSWER..9
23	Is it acceptable for a married woman to ask her husband to use a condom?	YES..... 0 NO ..... 1 REFUSE TO ANSWER..9
24	If a husband beats his wife, do you think others outside the couple should intervene?	YES..... 0 NO ..... 1 REFUSE TO ANSWER..9

In the next few questions, I am going to ask you about some common situations that happen in communities. We would like to know what you think about them. Please answer yes or no, there are no wrong answers, please be honest.

Skills and Behavior		
28	In the last 12 months, have you helped a woman who was experiencing violence at home?	YES .....0 NO .....1 DOESN'T APPLY.....8 REFUSE TO ANSWER....9
29	In the last 12 months, have you told a local leader about domestic violence in a home nearby?	YES .....0 NO .....1 DOESN'T APPLY.....8 REFUSE TO ANSWER.....9
30	In the last 12 months, have you spoken out about violence against women to others in my community?	YES .....0 NO .....1 REFUSE OR N/A 9
31	**If talking to a man ask:** Do you regularly do things that are typically thought of as a woman's role?	YES .....0 NO .....1 REFUSE TO ANSWER.....9
32	**If talking to a man ask:** Do you regularly help with washing dishes at your home?	YES .....0 NO .....1 REFUSE TO ANSWER.....9
33	In the last 12 months, has your partner had more say than you do about important decisions that affect your relationship/family?	YES .....0 NO .....1 DOESN'T APPLY.....3

		REFUSE TO ANSWER.....9
34	During the last 12 months, has your partner made most of the decisions about your own health care?	YES .....0 NO .....1 DOESN'T APPLY.....3 REFUSE TO ANSWER.....9
35	During the last 12 months, when your partner and you disagree, do you get your way most of the time?	YES .....0 NO .....1 DOESN'T APPLY.....3 REFUSE TO ANSWER.....9
36	During the last 12 months, did your partner made most of the decisions about when you could visit your family/relatives?	YES .....0 NO .....1 DOESN'T APPLY.....3 REFUSE TO ANSWER....9
37	During the last 12 months, have you usually felt respected by your partner?	YES .....0 NO .....1 DOESN'T APPLY.....3 REFUSE TO ANSWER.....9

I am now going to ask you a very personal question. I assure you that your answer will be kept secret and that you do not have to answer.

Concurrent sexual behavior		
38	*Have you had a sexual relationship with anyone else in the last 12 months, while being with your wife/partner/most recent partner?*	YES .....0 NO .....1 REFUSE TO ANSWER..9

Thank you so much, we are almost finished. These last questions are about what you see in your community about violence prevention. Please answer yes or no.

Exposure to violence prevention		
39	In the last 12 months, have you seen people in your community doing something to prevent violence against women?	YES .....0 NO .....1 REFUSE TO ANSWER..9
40	In the last 12 months, have you participated in any activity about safe and healthy relationship?	YES .....0 NO .....1 REFUSE TO ANSWER..9
41	How many times have you participated in one of these activities?	NONE.....0 ONCE.....1 TWICE.....2 MORE THAN TWICE....3 REFUSE TO ANSWER..9

Thank you for your time. I really appreciate you talking with me and sharing your thoughts.
Would you like a list of organizations/people who you could talk confidentially with about any of these issues?

Appendix 3: Focus Group Discussion Guide

Notes for facilitator:

- Every person in the group should answer the opening question. The sooner people talk in the focus group, the more comfortable they feel and the more likely they will be to answer subsequent questions.
- The follow-up questions in the boxes should only be used if participants are having a difficult time answering the main question.
- The focus group discussion should last around 1.5 hours and no more than 2 hours.
- Not everyone in the group has to answer each question.

Opening and Introduction

Welcome. Thank you all for sparing time to come to this discussion. Today we are getting information about the relationships between men and women in this community. The information and opinions you share today will be kept confidential. You may choose to not answer any of these questions if you do not want to. You may choose to leave the discussion at any point.

1. **Would everyone please share your name, how long you have lived in this community.**

Transition Questions

1. **What do you think the role of a woman is in a relationship? What do you think the role of a man is in a relationship?**

a. What do you think about a man who does work around like house like cooking, cleaning, washing clothes or looking after the children? b. What do you think about a woman who works to earn money?

2. **What are some of the challenges that men and women have in their relationships?**

Key Questions

3. **As we know, violence against women can happen anywhere, in any community, I would just like to ask you a few questions about any violence in your community. How common is violence against women in your community?**
4.

a. What sort of violence are you aware of? b. What do you think is the cause of this violence?

5. **Who do you think should work to prevent or respond to violence against women in your community?**
6.

a. Why do you think that they should work to prevent and respond to violence against women? b. What do you think they should do? c. Is there anyone else that you think has a role in preventing or responding to violence against women in your community?

7. **What is the experience in this community regarding violence towards women living with disability?**

8. **Please think of the last time you saw or heard about a woman in your community that was experiencing violence? Is there anything that you did?**

a. At the time?
b. After the event?
c. Do you think you should have done less?
d. Do you think that you should have done more?

Ending Questions

The facilitator should now give a short summary (around two or three minutes) about what was discussed in the focus group. Then ask participants:

9. **How well did I summarize what we talked about?**

10. **Is there anything that we should have talked about, but didn't?**

Thank the participants for their time.