

Healthcare Workers' Experiences and Challenges in Managing Gender-Based Violence Among HIV-Positive Women Living in Southern, Tanzania: A Qualitative Study

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Introduction: Healthcare workers (HCW) play an important role in managing women living with HIV (WLHIV) with gender-based violence (GBV) experience, but little is known about their experience in screening and managing GBV among WLHIV. This study explored the perceptions and experience of the HCWs on screening and managing GBV cases among WLHIV.

Patients and Methods: We performed a descriptive phenomenological qualitative study to elicit the views and experience of HCW on GBV screening and management for WLHIV. The study was conducted in the semi-urban setting in Morogoro Region, Tanzania. Ten in-depth interviews (IDIs) were administered to HCW selected purposefully based on their roles at an HIV care and treatment center. Data were transcribed using patterns matching study aim and then merged into relevant themes for analysis and interpretation. NVIVO software version 12 was used for data coding and analysis.

Results: We found that HCW experienced multiple challenges in GBV screening and management, including limited capacity for GBV screening and management; inadequate training on assessment and handling GBV cases, limited resources (time, GBV guidelines and screening tools), inadequate GBV referral and monitoring systems; referral forms for GBV survivors to social support centers and follow-up mechanisms to trace survivors, mental aspects; HCWs' fear of being stressed by listening to women's' GBV traumatic experiences, HCWs' fear of causing problems to the women's families and HCW biased notions on women disclosure of GBV; the believes that women will not report their GBV experiences.

Conclusion: We identified context-specific challenges preventing HCW to deliver optimal services of GBV to WLHIV, stressing the necessity to strengthen HCW capacity and resources for GBV services and to integrate psychosocial services into HIV care. Policy and programs should be developed to support GBV screening and management for WLHIV.

Keywords: healthcare provider, intimate partner violence, women living with HIV, gender-based violence

Introduction

Gender-based violence (GBV) remains an impediment to health, social and economic development across all regions of the world.¹ It is known as violation of human rights and a discrimination resulting in physical, sexual, psychological, or economic harm; these acts may occur both in public or in private life.^{1,2}

Globally, an estimated 736 million women are subjected to GBV, including intimate partner violence and non-partner violence at least once in their lifetime.¹ The World Health Organization (WHO) report from 2021 reported that in sub-Saharan Africa (SSA), the lifetime prevalence of GBV was 33% and 20% in the past 12 months.¹ In

Tanzania, the prevalence of physical and sexual violence among women aged 15–49 is reported to be 44%, and it is even higher among ever-married women (50%). The prevalence increases to 58% when assessed for the past 12 months.^{2,3} The prevalence of GBV varies in the country, with the highest percentage in Tabora and Shinyanga Regions (78%), and lower in Kaskazini ya Pemba regions (8%).^{2,4,5} Studies have shown that rural areas are more affected with GBV (52%), compared to urban areas, where prevalence is 45%.²

Studies have reported that the incidence of anxiety disorders, sexually transmitted infections, and HIV are higher in women who have experienced violence compared to women who have not, as well as many other long-term health problems like psychological trauma that can last even after the violence has ended.^{1,6,7} Survey data from Tanzania in 2015 reported that 15% of women who experienced violence from their partner had serious injuries like deep wounds or broken bones or teeth.²

Furthermore, studies have shown that GBV is more prevalent among people living with HIV (PLHIV).^{8–10} The odds of women living with HIV (WLHIV) who experience intimate partner violence are 10 times more than those who are HIV-negative.¹¹ Similar studies from Uganda, and Kenya also show a higher GBV prevalence among WLHIV compared to HIV-negative women.^{9,12,13} In WLHIV, GBV is significantly associated with poor clinical, immunological and virological outcomes.^{14–16} A study conducted in semi-rural Cameroon and Malawi showed that physical intimate partner violence is associated with the interruption of antiretroviral therapy among PLHIV.^{16,17}

In Tanzania, the Ministry of Health and Social Welfare (MoHSW) has recognized that addressing GBV is crucial in improving the health and social wellbeing of women and their families. Thus, the MoHSW has developed guidelines for GBV service provision to be integrated into existing health services.¹⁸ In year 2009 MoHSW adapted the validated abuse assessment screening tool which have five questions asking about emotional, physical and sexual violence and one question that assesses the safety of the survivor.^{18,19} In addition, through the establishment of gender desks at the Ministry of Home Affairs Police Departments and civil organization, the MoHSW provides advocacy, legal aid, and GBV shelters and addresses gender equality.²⁰ Equally, the National Plans of Action to end violence against women and children were adopted.²¹

Healthcare workers (HCWs) play a crucial role in responding to GBV-related injuries and directing survivors to the treatment and support needed. Despite the assigned responsibility, implementation of GBV screening is poor.²² Known challenges are the service providers' attitudes, perceptions, and lack of knowledge about GBV.^{10,22,23} GBV screening is also impacted by the absence of GBV-specific training in national medical curricula, awareness of the scope of the GBV problem, and not knowing what to do when women disclose GBV impact HCWs level of confidence in asking question.^{10,24–26}

In addition, a poor referral system between different support services, and a lack of specific GBV clinics to support integrated services has been reported as a barrier to GBV screening.^{10,22,25} GBV-supporting networks are reported to be ineffective and uncoordinated, which may discourage GBV survivors from seeking solutions.^{10,27}

Furthermore, GBV screening by HCWs is hindered by the shortage of time to help women disclose GBV,^{4,25} and survivors' unwillingness to reveal their experiences of violence.^{22,28} It has been reported that GBV survivors need time to feel emotionally ready, safe, and comfortable to disclose their experiences and most women do not disclose on the first encounter.^{24,25} HCWs have also reported a lack of sufficient time to conduct detailed assessments or safety planning and assist women in navigating other services.²⁵ Also, lack of time makes HCW feel unsupported in their roles when screening for GBV, leading to them not asking the GBV questions effectively or perhaps not at all,²⁴ adding to the feeling of being pressured to support women who disclose GBV.²⁴

It has also been reported that HCWs lack resources such as an independent record-keeping system, medical equipment to diagnose GBV, and reporting systems, making routine assessments and follow-up difficult due to poor record-keeping.^{10,26}

Evidence remains scarce concerning healthcare workers' perceptions of screening for GBV and their challenges in managing GBV cases among women living with HIV in rural settings. Therefore, the objective of this study was to we explored the perceptions and experience of the HCWs experiences on screening and management of GBV cases among WLHIV attending HIV care in semi-rural Tanzania.

Materials and Methods

Study Area

This study was conducted at the Chronic Diseases Clinic of Ifakara (CDCI), which was established in 2005 as the government Care and Treatment Center for people living with HIV (PLHIV) at Saint Francis Referral Hospital (SFRH) at Ifakara, Morogoro, Tanzania.²⁹ The CDCI cares for a large rural catchment area, namely the Kilombero, Ulanga and Malinyi districts and delivers services based on Tanzania National Control Program. Currently, at the CDCI 56 HCWs provide services for more than 3688 PLHIV on active follow-up.²⁹ PLHIV enrolled in the Kilombero and Ulanga antiretroviral cohort (KIULARCO) receive medical service, laboratory testing and drug refill as per guidelines and as documented elsewhere.^{30,31} In addition, a counselling team takes care of pre and posttest counselling and adherence counselling. The Kilombero and Ulanga Antiretroviral Cohort (KIULARCO) is a collaborative project between the Saint Francis Referral Hospital (SFRH), the Ifakara Health Institute (IHI), the Swiss Tropical and Public Health Institute, and the University Hospital Basel, Switzerland.

Design

This study adapted the descriptive-phenomenological qualitative research design, which brings out what is hidden in HCWs experience, relations and aims to understand how they make sense of their experience on screening and managing GBV cases among WLHIV. The study participants were actively engaged in interpreting the events, objects and people in their lives using in-depth interviews (IDIs). The in-depth interview assisted in the understanding of their personal experiences and the different meanings attached to them.³²

Sample and Recruitment

From a list of 56 HCWs working at the CDCI, 31 HCWs were excluded as they did not work close to the patient and those who were not present during the implementation of the study. The excluded groups were those who work in laboratory, pharmacy, data team, and medical doctor who were on training. While 25 participants were purposively identified based on their professional qualifications, roles, and working units. This study included healthcare workers who had close interactions with PLHIV, whom were over 18 years old, had at least six months of working experience, and signed the informed consent. The included participants were medical doctors, nurses, counselors, and nutritionists who closely interact with clients at the CDCI adult clinic, one-stop clinic, tuberculosis clinic, and the CoArtha study. The CoArtha study was a randomized control trial focused on finding the best strategy to treat arterial hypertension in sub-Saharan Africa.³³ HCWs in these units have the responsibility of screening for gender-based violence (GBV) using the abuse assessment tool for GBV survivors in healthcare settings. They also provide information on how GBV affects survivors' health and offer counseling, treatment, prophylaxis, and support based on the national GBV guidelines.^{18,19}

In this study, HCWs were selected to participate in an in-depth interview using the following procedures: 25 identified HCWs were deemed eligible and assigned a unique number. Separate boxes were designated for nurses and doctors in each unit, resulting in a total of four boxes across the four units. One paper was picked-up from each box to ensure representation of participants from each unit. Additionally, two counselors and one nutritionist were included. Thus, a total of 11 participants were recruited, consisting of one doctor and one nurse from each unit, two counselors, and one nutritionist [Figure 1](#). However, despite providing a thorough description of the study, one participant declined to participate, resulting in only 10 HCWs agreeing to take part in this study.

Data Collection and Procedures

A total of 10 IDIs with HCWs were conducted by one trained and experienced master's student from April to August 2022. Researcher carefully explained the purpose of the study to the participant before signing the informed consent. An interview guide was developed in English and translated into Swahili language; which is the National language of Tanzania, and then the Swahili version was translated back into English to ensure it had the same meaning. The tool was tested among HCWs to explore their experiences on the screening for GBV, and the challenges they face when managing GBV cases. All interviews were conducted at the clinic by the first author, using Swahili language.

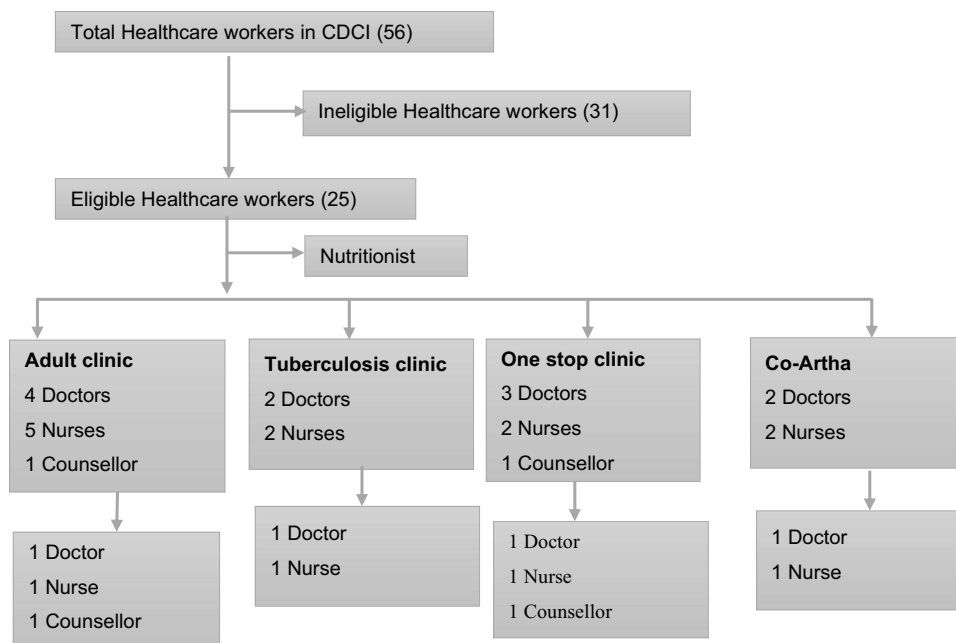


Figure 1 Healthcare worker's recruitment framework.

Interviews' durations lasted between 30 and 90 minutes, and they were digitally recorded and supplemented by the written notes.

Data Analysis

All recorded interviews were verbatim transcribed by the study investigator (LS). LS also verified the transcripts by listening to the recordings. All transcripts were reviewed repeatedly line by line by the study investigator to familiarize with the data. Transcripts were thematically coded using both deductive and inductive approaches. Relevant themes that respond to the study objectives were identified and categorized into major themes and sub-themes. The NVIVO software version 12. 2020 assisted in data management and categorization.³⁴ Data were analyzed in Kiswahili language and selected quotes were translated into English. To ensure validity of themes, the investigator used member checking approach.³⁵ During member check, the study investigator shared all themes with few study participants for verification of the investigator's data interpretation.

Ethical Consideration

Ethical clearance to conduct this study was obtained from the Ifakara Health Institute – Review Board (IHI/IRB/No:21–2022) and the National Institute for Medical Research (Ref. NIMR/HQ/R.8a/Vol IX/620) prior to the beginning of the study. Written informed consent was provided by every participant. Participants consented to the publication of anonymized responses, and to the recording of IDI audio. They were also informed of their right to interrupt or withdraw their consent at any time during the interview. To ensure confidentiality, participants were assigned identification numbers that were used throughout the study period.

Results

Social Demographic Characteristics of the Healthcare Workers

We interviewed ten HCWs at the CDCI; nine of them were women. Most of the study participants were graduates with a bachelor's degree (six), and the majority had five to nine years of experience working. The average age of HCWs was 38 years, with ages ranging from 27 to 57 years [Table 1](#).

Table 1 Sociodemographic Characteristics of the Healthcare Providers

Variables	Categories	Frequency (n)
Gender	Males	1
	Females	9
Age	25–35	7
	36–45	1
	46–59	2
Level of education	Certificate	2
	Diploma	2
	Degree	6
Work experience per years	1 to 4	3
	5 to 9	5
	10 and above	2

HCWs Perception and Experience on GBV Screening and Management Among WLHIV

This study shows that HCWs face numerous challenges in screening for GBV which include lack of training, resources and supportive system. We categorized HCWs narratives into four major themes as follows; (i) capacity for GBV screening, (ii) GBV referral and monitoring system, (iii) Mental aspect and (iv) HCWs biased notions on women disclosure of GBV. Sub-themes which emerged from the participant narratives are provided under the major themes in Table 2. Sub-themes are supported with sample quotes from participants.

GBV Screening and Management Status at the Facility

Most of CDCI HCWs reported that they had been screening for GBV cases, and they saw two to three GBV cases each week on average. HCW interest and workload both influenced the number of GBV cases identified each week. Furthermore, HCWs reported that most of the women at the facility experienced either physical, sexual, psychological, or economic violence at the hands of their partners.

Table 2 Themes Related to Challenges Experienced by HCW in Screening and Managing GBV

Major theme	Sub-Theme
Capacity for GBV	<ul style="list-style-type: none"> • Inadequate training on how to assess and handle GBV cases • Limited resources (time, GBV guidelines and GBV screening tools)
GBV referral and monitoring system	<ul style="list-style-type: none"> • Lack of referral forms to refer GBV survivors to social support centers • Lack of follow-up mechanisms to trace the referred GBV survivors
Mental aspect	<ul style="list-style-type: none"> • HCWs' fear of being stressed after listening to women's GBV traumatic experiences • HCWs' fear of causing problems to women's family
HCWs biased notions on women disclosure of GBV	<ul style="list-style-type: none"> • Acceptability of GBV in the society

HCW Reporting on GBV Screening Experience

It depends on the clients who came that week. If my job had been to screen, I might have identified a lot of GBV cases. However, if you are not screening, you may not get a client with GBV experience because some people cannot disclose their experiences by themselves without asking; hence, you may only get three or four GBV cases. (HCW, 32)

HCWs Affirming on the Various Types of GBV Reported by Women at the Clinic

I once came across a case of a mother who was beaten by her husband to the point where it led to a hearing impairment of one ear and she couldn't hear well because of it. (HCW,32)

A lot of cases are about sexual violence, children or young people who are in school, they are brought in having been subjected to sexual violence by people, which leads to childhood pregnancies and later being unable to continue their studies. (HCW, 33)

Capacity for GBV Screening, Management and Support Services

HCWs reported that they did not screen for GBV routinely despite being recommended in the GBV national guideline. The GBV screening is done upon suspicion that a woman had experienced GBV. Reasons for poor screening were lack of training and resources, such as time, guidelines, and screening tools, as well as the need for registration and documentation of GBV survivors, which are crucial for effectively screening and managing GBV cases. All these reasons lead to poor adherence to GBV screening recommendations.

Lack of Training

Despite the fact that GBV screening is recommended at the health facility by the government, HCWs express as a main concern the lack of comprehensive training that provides them with the knowledge and skills needed to successfully screen and manage GBV cases. This makes identification of GBV cases and provision of adequate support to survivors difficult. They further stated that the facility lacked designated staff members in charge for GBV cases.

Our understanding is limited. So, what exactly is GBV? How to deal with it? Where to go to? Even if you get GBV cases where do you direct them? Will it end to me without any support? Will you just counsel them and then they go home? (HCW, 32)

Sometimes we miss people who are experiencing GBV because service providers do not have the right knowledge on how to identify people who are subjected to GBV, especially those who do not have the ability to open up easily about the fact that they are subjected to violence. (HCW, 33)

Few HCWs stated that they have never screened for GBV and were not motivated to do so because they are not emotionally prepared to handle the cases, mainly because they were not trained.

I have never. I've never screened and don't intend to. I don't really want to because, as you know, there are many things to do if you really want to help someone. You may be confused. (HCW, 29)

Inadequate Time and HCWs Workload for GBV Screening

The HCWs also reported inadequate time to carefully pay attention to GBV screening. They reported being overwhelmed with their regular workload of attending PLHIV, let alone conducting additional screening for GBV. HCWs mentioned that GBV screening significantly hinders their primary responsibility of providing HIV treatment and follow-up care. Thorough GBV screening is time-consuming, and HCWs lack this time due to other work obligations and responsibilities. The HCW perception that screening for GBV is an "additional" task, that could be performed at one's convenience and when time allows, leads to selective screening of GBV cases.

As I said, there are times when you find that a mother has brought a child (exposed child) to be tested, and there is a queue outside. You test the child, give them their results, and she leaves. You have no time to talk to her in detail to disclose the GBV. (HCW, 32)

Lack of Screening Tools

The HCWs reported that lack of appropriate screening tools, documenting registers for tracking, and guidelines for identifying cases of GBV accurately as factors that complicate their work and limit their ability to manage GBV cases effectively.

There is only one guideline and the hospital is big with many registration points (entry points) for patients. So we may be missing some patients with GBV cases because other units do not have them or do not know what needs to be done. It could be helpful if guidelines were available at each registration point. We frequently get information about continuing to screen all the patients we meet, sometimes screening tools are unavailable, faint and difficult to read. (HCW,33)

GBV Referral and Monitoring System

GBV-Specific Referral Systems

Based on the report from HCWs, the facility offers various services to GBV survivors, including psychological counseling, health investigations such as HIV testing, and treatment of injuries and other sexually transmitted diseases. In addition, HIV-negative survivors can receive pre-exposure prophylaxis (PrEP) or post-exposure prophylaxis (PEP) for HIV prevention. HCWs mentioned that in cases requiring additional assistance, they refer patients to either social welfare or to the police.

If the patient is a victim of rape or any other sexual abuse, the doctor will examine them and perform other tests to determine whether or not this person was involved in abuse. This includes physical observation, checking for any remaining sperm, then providing evidence that this happened to her and offering services such as PEP. (HCW, 27)

The majority of HCWs were satisfied with the quality of GBV services provided at their clinics but highlighted the need for improvements in the referral system. They stated that some GBV cases require further assistance. Although they refer patients to other departments or organizations, such as the police or social welfare, they rarely receive feedback on whether the patient received the necessary services. Few HCWs were uncertain about what to do when they identified GBV and where to refer survivors for appropriate support and services. This was due to the lack of a clear and well-defined referral system.

Exactly, the place to take them. Even if someone has come to me and told me that she has been experiencing GBV, where do I take them? Where exactly should I go with the women? I don't know; I really don't have the capacity to counsel a patient at that level (HCW, 32)

As far as I can see, the quality is there, but I also think we need to make more improvements in the sense of continuing to monitor. You know, sometimes you can find people who report a case; simply linking that patient is not enough; you must follow up to ensure that she has arrived at the correct location and that appropriate steps have been taken (HCW, 32)

Follow-Up for GBV Survivors

Healthcare workers stated that GBV cases require time and follow-up, but the clinic structure does not allow that. Some said that they receive cases from the police for further investigation, others from routine clinical visits, but they usually do not follow up with the GBV survivors. This makes them unsure if survivors have received the appropriate services. They also reported a lack of coordination hospital department that would assist in dealing with the survivors at the facility. Further, poor coordination with organization and facility that offer GBV services hinders proper GBV service delivery.

Now you find that sometimes we will link the mother with social welfare, but it is not enough just to make a link; I think the improvements are to do follow-up and know that the person has received the right help (HCW, 32)

HCWs Biased Notions on Women Disclosure

Acceptability of GBV in the Society

HCWs expressed that preconceptions regarding patients' disclosure of GBV impeded their likelihood of screening. Healthcare workers believe that women are usually not willing to disclose their GBV experiences due to the culture and norms in the sense that the society perceives GBV acts as normal incidences. For instance, the act of men beating their wives does not need much attention, as long as the signs of physical harm cannot be publicly observed. This makes women select what to disclose when HCW inquire on the GBV experiences. Moreover, HCWs believe that women will not disclose abuse histories, as they do not know that what is happening to them, or what should not happen; therefore, even if HCWs ask, patients will not report GBV because they see it as a normal aspect of their lives and the problem that cannot be solved by HCWs. They also believe that HCWs are not trained to solve the root causes of GBV, but rather only to treat the outcomes of the violence. The preconception that survivors will not open up regarding GBV hinders HCWs from even asking about it.

We rarely screen for GBV and frequently deal with cases that are severe and cannot be missed, but identifying those small cases still appears to be a challenge because, women report GBV as very normal situation, and the service provider sees it as a very normal situation because of our culture. Other healthcare workers perceive GBV as normal. (HCW, 32)

There are things that, in our society, for example, if you are a married woman, getting beaten by a man is considered normal. It's not normal if the beating she received would result in body injuries. But there is no bleeding, there is nothing; two, one slap is like a normal thing for us (HCW, 47)

Mental Aspects

HCWs' Fear of Being Stressed After Listening to Women's GBV Traumatic Experience

HCWs expressed discomfort regarding GBV screening and an avoidance of having conversations related to GBV with their patients. HCWs experience an emotional burden associated with the identification of GBV cases, yet they do not fully assist survivors to disclose GBV or ensure that they receive adequate support due to fear and lack of resources.

I don't want to screen because I get too emotional and I don't want to be in her shoes while explain because at the end of the day I will start crying. I have other patients waiting for me, how will I start presenting myself? (HCW, 32)

HCWs' fear of causing problems to women's family.

Healthcare workers also reported fearing to incite problems among survivors' families because when a GBV case is discovered, it needs to be reported to the authorities for a solution. They believe that it is better not to solve the case if that will lead to further family conflicts. HCWs also fail to treat GBV cases due to fear of being attacked by the respective GBV perpetrators.

When you dig deeper into those cases, you can cause problems for people. So you say no, let me not cause problems in people's families; you stop even when you have a clue that this is violence; you treat what is in front of you and let it go because you don't want to cause problems in people's families. Because these are things that need follow-up, you may involve other people, for example, the police or a person in the community, but you will not have time to do that and put your safety at risk. (HCW, 29)

Discussion

This study aimed to explore the perceptions and experiences of HCWs in the screening and managing of GBV cases among WLHIV in semi-rural Tanzania. This study sheds light on the challenges faced by HCWs in semi-rural Tanzania when it comes to screening and managing GBV cases among WLHIV. Notably, HCWs lack sufficient training, face obstacles related to workload and resource constraints, and encounter difficulties in establishing a clear referral system. The study's findings, categorized into capacity for GBV screening, referral systems, mental aspects, and HCWs' biased notions, underscore the critical need for targeted interventions.

Our study reveals that HCWs lack training in the screening and management of GBV making them feel confused on when to report that women have experienced violence and how to handle GBV cases. Lack of adequate training has been

reported in other studies as a barrier to GBV screening and management as providers were often unsure of how to screen and respond to GBV.^{10,22,27}

This study reveals a lack of resources at the facility level such as time, staff, the GBV guideline, and the absence of effective interventions for GBV cases. HCW reported having limited time with the patients they attend, which makes it difficult for them to screen for GBV, provide proper support to GBV survivors, and then provide normal HIV treatment due to the long queue of patients waiting outside. This is consistent with other studies from Ethiopia, Uganda, United States, United Kingdom and other parts of the world which show that HCWs' lack of resources was a barrier to GBV inquiries.^{10,15,22,23,25,36,37}

The study also found that although screening tools and guidelines are available, they are insufficient to meet the demand of the facility, which has several departments. The facility has a single guideline, and the screening tools are of such poor quality, that they make HCWs tasks difficult. In addition to that other HCWs were unaware of these tools until recently and had no idea how to use them. This finding is consistent with other studies that found that HCWs were unaware of screening tools, to whom they should use them, and how to document them.^{22,37} Capacity building is thus required to equip HCWs with the tools, skills and motivation to adequately counsel and assess their clients in order for them to disclose the extent of their abuse. The same result was documented in other studies with numerous challenges HCW face, including a lack of a GBV register and of guidelines for GBV to assist HCWs on GBV screening and management.^{10,22,23}

A clear referral system makes it easier for HCWs to maintain their commitment to GBV screening.^{10,22} Our findings, however, show a lack of a clear referral system (no suitable referral channel, referral forms, or feedback from the place to which the survivors have been referred) and well-defined support mechanisms available for GBV survivors which hampers HCWs' ability to provide better help to GBV survivors after disclosure and makes them feel helpless. Furthermore, HCWs were unaware of the GBV service available at their hospital, from which patients could benefit. This has been reported from other studies and has been linked to HCWs decreased interest in or commitment to screening, creating a missed opportunity to detect GBV among women.^{10,23,25} These obstacles reduce GBV screening and can give the false impression that GBV is not a major public health issue, lowering the chances that patients will receive help. These show a need of improving referral system and feedback channel within the facility and inter-agency referral system to will allow sufficient support to survivors.

Another issue raised by our findings that needs to be addressed is the lack of GBV patient follow-up. Although Tanzania GBV guideline indicates that HCW to should plan follow-up for psychological therapies and assess survivors' needs beyond treatment,¹⁸ this study demonstrates a lack of follow-up to the GBV survivor. This difficulty has been identified in other studies as undermining efforts to implement GBV screening.^{10,23} Patient follow-up has been reported to be important in assisting women in discussing their experiences with others, making them feel safe and as though they have someone to talk to.²³ The Ministry of Health and its partners should provide specialized staff training and start follow-up care for GBV survivors. It is also necessary to train them on how to assist women in developing safe plans as a means of preventing violence. GBV survivors are likely to be concerned about their safety, but they do not anticipate further violence. Training HCWs will enable them to better serve women.

Furthermore, our study found that HCW are convinced that women perceive violence as normal and that there is nothing they can do about it because they have witnessed their parents and relatives being abused since they were children. Society, parents and relative expect married women to tolerate beating, few slaps and abusive words from their partners as long as they have no major physical impact. Similar findings were reported by other studies from Uganda and Palestine that GBV is perceived normal and women are expected to tolerate.^{22,38} Also, women's fear of family separation and their partner's refusal to support the family and their feeling of shame to speak about violence create barriers for women to come forward for support after GBV experience. This finding corresponds to data from Tanzania demographic survey 2015 which illustrated that 34% of women who have experienced violence have never sought help or told anyone, with only those who were employed for cash and currently married were those who would seek support.² Similar findings have been documented in the literature that women do not report or seek support to keep their families together, protect their privacy, fear of the stigma and trying to fulfil the societal expectation.^{10,25,27,38-40} HCWs also illustrate that women fear losing material things like money by reporting the perpetrator, so they continue tolerating the abuse. Existing

literature shows that women's fear of losing material such as loss of housing and family separation to be a barrier to GBV disclosure.^{25,41} These results indicate the necessity of empowering women with knowledge about GBV, available support services in the community and GBV impact to them, children and community as well as economic empowerment.

Moreover, HCWs reported that women do not disclose their GBV experiences in the absence of direct inquiry as they feel uneasy to talk about GBV and believe that family matter should be solved within the family. Other studies reported the same findings that women were uncomfortable talking about GBV due to its private nature and the belief that only women with specific signs of abuse should be screened.^{22,25,42} This indicates that the prevalence of GBV may be underreported based on women's self-reports and may be a barrier to getting proper support. The Tanzanian government has played a big role in the implementation of different GBV interventions such as the establishment of GBV guidelines and training to HCWs, but there is a need for a designated HCW responsible for GBV services. This is because HCWs are overwhelmed with other responsibilities and have a minimum amount of time to deal with GBV cases, making universal screening difficult. This result concurs with studies showing that HCWs do not screen for GBV for different reasons, such as a lack of resources, time, and HCW bias.^{22,38,42}

In this study, HCWs reported that women are afraid to disclose their experiences of GBV due to fear of social and economic consequences, feelings of shame, and stigma. However, women may disclose their experiences over time and when they feel ready and comfortable with their HCW's. Yet, HCWs do not have enough time as they are over loaded with other responsibilities at the clinic. Similarly, other research has found that women conceal their experiences of violence due to fear of the consequences of disclosing GBV and a lack of awareness of available support.^{25,27,37,43} HCWs can facilitate disclosure by investing time in developing rapport and trust with their clients, providing appropriate services such as emotional counseling and treatment support, and educating women about available support. Women may only disclose if they believe there will be a beneficial follow-up discussion with their HCW or referral to related services.^{24,25,27,43} Other studies pointed out that women may feel ashamed and fear judgment from HCWs when asked about their experiences of GBV.^{10,27,36–38,43}

Moreover, HCWs in this study expressed concern about discussing GBV with their clients due to negative perceptions about women disclosing GBV, fearing of hurting theirs and those of clients' emotions. Furthermore, the lack of clear guidance on GBV management makes HCW feel worried, anxious, and uncomfortable. This hinders routinely screening for GBV cases due to fear of an emotional breakdown from listening to the women's traumatic stories, the fear of not properly assisting the survivor and inciting conflict in the client's family. These findings were similar to other studies where HCWs tend to avoid screening for GBV to protect their mental health.^{10,22,25,27} This finding corresponds with other studies that HCWs are not interested in screening for GBV.^{10,36,37,43} The main causes for this could be a lack of knowledge, skills, and training in identifying violence and appropriate interventions. This underlines the need for specific education about GBV service provisions among HCWs to increase available services, providing them proper skills to build trust among women and facilitate disclosure.

Interestingly, HCWs reported being satisfied with the facility's GBV services, despite the hurdles they confront when providing those services. They report that what they provide to GBV survivors is adequate and acceptable in their perspective. This can be explained by the knowledge required for the GBV survivor's services. However, when women confessed their experiences with GBV, the majority of HCWs were unsure what to do or how to assist. This highlights the need for training to equip HCW with the necessary health, legal, and psychosocial services for GBV survivors based on national guidelines.

Strengths

This study generated important insights that HCWs experience in screening and managing GBV among women living with HIV in semi-rural Tanzania. By delving into multiple facets, such as training, resources, referral systems, and societal perceptions, the study provides a nuanced understanding of the challenges faced by HCWs. Second, the study demonstrates strength in organizing its findings into distinct thematic categories. This structured approach enhances the clarity of presentation and allows for a systematic analysis of the challenges encountered by HCWs. The identification of categories like capacity for GBV screening, referral systems, mental aspects, and biased notions contributes to a robust exploration of the topic with direct quotations from the participants to help readers judge reality for themselves. Third,

the study not only highlights challenges but also proposes practical recommendations for improvement. The emphasis on the need for training, adequate screening tools, clear referral systems, and designated healthcare workers underscores the study's intention to contribute to actionable solutions for enhancing GBV screening and management in healthcare settings.

Limitations

This study had several limitations, first, the study was conducted on one site; St. Francis referral hospital, which may potentially introduce the risk of single-site bias. The experiences and perceptions of HCWs with managing GBV for WLHIV in this particular setting may not be fully representative of the broader semi-rural Tanzanian context, limiting the generalizability of the findings. Second, the presence of various research and clinical trials at the chosen site could lead to saturation, influencing the attitudes and experiences of HCWs and participants. This saturation may affect the transferability of the study's findings to healthcare settings with fewer research activities. Third, the study acknowledges the potential for selection bias as it gathered data from specific HCWs and WLHIV seeking services at the hospital. Those who participate in research or clinical trials might have different perspectives than those who do not, introducing bias and limiting the study's ability to capture a comprehensive understanding of GBV screening and management in the broader semi-rural Tanzanian context. Fourth, the study may have limitations related to the diversity of its participants. If the sample primarily includes individuals with similar demographic characteristics or those who have similar experiences with GBV, the study may not fully capture the range of perspectives within the target population.

Conclusions

This study demonstrates that HCWs lack training, resources and clear referral system in screening and management GBV cases which hinder GBV survivors getting quality health services. This indicates the need for improved training, an adequate resources such screening tool, registration books, updated guidelines, and a clear support system like referral system. There is also a need of designated HCWs at clinics to manage and refer cases for women identified as GBV survivors by the HCW. Further research is needed in various health facilities with limited research activities to understand HCW perception and experiences in screening and managing GBV cases. It is necessary to understand the available GBV services with health facilities and communities for proper implantation.

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Author Contributions

All authors made a significant contribution to the work reported, in the conception, study design, execution, acquisition of data, analysis and interpretation. They critically reviewed the article; gave final approval of the version to be published; have agreed on the journal to which the article has been submitted; and agree to be accountable for all aspects of the work.

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