East African Journal of Education and Social Sciences
EAJESS January –February 2024, Vol. 5, No. 1, pp. 167-176.
ISSN: 2714-2132 (Online), 2714-2183 (Print). Published by G-Card
DOI: https://doi.org/10.46606/eajess2024v05i01.0360.

Gender-Based Violence Cases and Response at One-Stop Centers in Shinyanga Region, Tanzania

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Abstract
This study sought to establish the perceptions of female survivors regarding the effectiveness of One Stop Centers (OSCs) in responding to Gender-Based Violence (GBV) in Shinyanga, Tanzania. Employing a cross-sectional design and mixed research method, the study surveyed 96 female GBV survivors through a questionnaire and key informant interviews. Quantitative data was analyzed using the SPSS software while thematic analysis analyzed the qualitative data. The findings reveal that sexual and physical violence are the common forms of GBV reported at the OSCs. In response, different services are offered at OSCs but the kinds of services offered at each center depend on the availability of staff, accessibility to OSCs, funding from partners and availability of testing equipment. Female survivors reported barriers to OSCs utilization, including low awareness, fear and stigma, protecting perpetrators and insufficient privacy. Shortages in staff, budget constraints and inadequate transportation emerged as significant challenges for OSCs. Increased government funding for OSCs and collaborative efforts among stakeholders are essential steps to fortify these canters and ensure they can adequately respond to the complex and sensitive nature of GBV.

Keywords: One Stop Centers; effectiveness; Gender-based violence; GBV survivors.

How to cite: Mntambo, B. D. and Bwikizo, S. S. (2024). Gender-Based Violence Cases and Response at One-Stop Centers in Shinyanga Region, Tanzania. East African Journal of Education and Social Sciences 5(1)167-176. **Doi:** https://doi.org/10.46606/eajess2024v05i01.0360.

Introduction

Gender-based violence (GBV) is a violation against human rights winch affects millions of women are affected such that it has become a major global public health issue. While GBV can take many different forms, this study is limited to violence against women (VAW). The rate of physical and/or sexual violence by an intimate partner is 27% of women aged 15-49 worldwide and is greater in sub-Saharan Africa (World Health Organization, 2021; Sardinha et al., 2022). The perception that males are worth more than females and the unequal allocation of power and resources between men and women are possible causes of VAW (UN Women, 2015).

GBV has persisted as one of the main reasons for human rights violations in Tanzania (Mikongoti et al., 2017; Mtaita et al., 2021). Research findings show that 40% of women between the ages of 15 and 49 have experienced physical abuse, and 17% have experienced sexual violence (Munisi et al., 2021). In addition, according to OECD (2020), 48% of women have experienced intimate partner violence at least once in their lifetime. As a result, women's physical, emotional, social and economic wellbeing are significantly impacted by gender-based violence.

Furthermore, GBV survivors are more prone to experience sadness, anxiety and other mental health concerns. They might experience discrimination and humiliation from their family, neighbors and society at large. GBV limits women's employment opportunities and ability to contribute to the economy. In this context, addressing GBV is critical.

Tanzania has ratified a number of international agreements, including the Convention of Elimination of All Forms of Discrimination against Women (CEDAW), the Beijing Declaration and Platform for Action (1995), the Sustainable Development Goal 5 (gender equality and the empowerment of all women and girls) and others. As a result, the Tanzanian government has launched a number of initiatives to fight GBV. For instance, the National Plan of Action to End Violence against Women and Children (NPA-VAWC) was created with a five-year timeline from 2017–2022 (URT, 2016).

One Stop Centers (OSCs) refers to a specific building or set of rooms set aside within the hospital or close by to offer GBV survivors all-inclusive services in one place. A variety of professionals, including doctors, social workers, police officers and lawyers collaborate to provide comprehensive post-GBV care services to survivors (World Health Organization, 2017; Olson et al., 2020). In Tanzania, the establishment of OSCs and Police Gender and Children Desks (PGCDs) was done in order to offer counselling, psychological support, legal assistance and medical care. The establishment of OSCs and PGCDs attempted to raise the number of survivors who reported acts of violence provide care and support for survivors and result in the conviction of perpetrators.

Yet Tanzania still has a small number of GBV victims that seek medical attention. For instance, according to Ministry of Health, Community Development, Gender, Elderly, and Children et al. (2016), less than 1.1% of women aged 15 to 49 who had experienced physical and sexual violence sought out GBV health care services. Contrarily, women who had been the victims of violence asked a family member, a partner's relatives, a friend or a neighbor for help. Shame, stigma and financial constraints are some of the reasons why GBV cases in health care services are underreported (Mtaita et al., 2021).

Shinyanga is one of top regions in Tanzania with high rates of violence against women. According to Ministry of Health, Community Development, Gender, Elderly, and Children et al. (2016), 78% of women in the region experience violence. In addition, there were 105 child pregnancy cases and 164 rape charges in 2018. Prevalence of GBV in Shinyanga is influenced by socio-cultural norms. For instance, while men own land and property, women are not permitted to make decisions and domestic work is seen as their responsibility (URT, 2020). To combat gender-based violence, the Shinyanga Region took several steps, including setting up GBV committees, establishing 14 Protection and Gender Child Desks (PGCDs) and developing a regional plan aimed at eliminating violence against women and children. The purpose of this study was to establish Gender-Based Violence cases and response at One Stop Centers in Shinyanga, Tanzania.

Literature Review

This section presents what is going on in the body of knowledge regarding the implementation of One-Stop Centers' responding to gender-based violence.

One Stop Centers

One Stop Centers (OSCs) seek to reduce challenges that survivors of GBV encounter when seeking assistance. One-stop centers alleviate the stress endured by survivors of GBV by simplifying procedures and offering immediate access to a comprehensive range of support services. This streamlined process reduces the burden on survivors, enabling them to swiftly access the assistance they need, thereby minimizing the duration of their distressing experiences and facilitating their recovery journey. Given the relevance of OSCs, some countries, including Tanzania, have constructed OSCs, which offer complete assistance and treatment to victims of gender-based violence. These facilities offer a range of services, including access to housing and other resources, counselling, medical attention and legal support. The purpose of OSCs is to offer a safe and encouraging environment where victims of gender-based violence can get the help they need to escape violent situations. By offering a variety of services under one roof, OSCs make it simpler for victims to access the services they need to recover from the trauma of GBV. By providing a coordinated and thorough response to GBV, OSCs seek to break the cycle of abuse, fostering healing and rehabilitation for victims (World Health Organization, 2017; Olson et al., 2020; Munisi et al., 2021) examined the enablers and challenges to the implementation and efficacy of the OSC modality for intimate partner

and sexual violence in Kenya, Malawi, South Africa, Zambia, Congo, DRC and Rwanda and in 15 Asian counties. The study identified a number of enablers that encourage OSCs to operate efficiently. The enablers include current standard operating procedures and rules that dictate what must be done and how, regular interagency meetings to facilitate collaboration and a reinforced referral system and free services that contribute to greater accessibility. On the other side, the study found that OSCs face difficulties with inter-professional coordination and weak links between legal and policy systems. Obstacles that prevented OSC from achieving its goals included lack of staff, lack of funding and lack of political will. Mulambia et al. (2018) conducted a study in Malawi with the aim of determining the kind of initial and follow-up care the survivors received from OSCs in Malawi. The findings show that 107 survivors had their first physical examination and HIV testing, 84% had counselling and 95% had their first police report. Even though survivors such got services, just 27% of GBV cases resulted in convictions. This suggests that extremely few cases go to court even if survivors might obtain help at OSCs.

Some OSCs in Tanzania have made a range of progress by providing survivors with long-lasting, high-quality care. For instance, Munisi et al. (2021) mention the OSC's success in the Arusha Region. Success stories include more knowledge of GBV and VAC services, conviction of suspects, some of whom being sentenced to 30 years in prison and 4 to life and improved coordination between the centers and community support services. Additionally, through comprehensive, integrated healthcare, HIV and STDs were identified. These results show that OSCs have a good impact on survivors and communities, which eventually helps the government's efforts to end GBV.

Theoretical Framework

This study followed the Ecological Framework, developed by Heise (1998). The framework shows evidence that no single factor can explain why some people or groups are at higher risk of interpersonal violence. The framework acknowledges that rather than being caused by a single element, gender-based violence results from several factors at various levels, which are interconnected and influence each other. The framework emphasizes the importance of addressing the factors at each level to prevent violence. Because it emphasizes the complex interplay of individuals, relationship, community and societal factors that contribute to violence perpetration, the framework is relevant for proper understanding and addressing GBV. The framework further acknowledges that GBV is not just the result of individual acts or decisions, but it is influenced by social, cultural, economic and political influences at many levels.

At the individual level, for instance, gender norms, trauma or abuse histories and attitudes toward violence are the primary characteristics and experiences that affect behavior (Bronfenbrenner, 1979). At the interpersonal level, intervention targets individual dynamics such as power dynamics, communication styles and conflict resolution strategies. At the community level, intervention addresses broader social and cultural norms, including gender roles, perspectives on violence, and access to education and employment. Finally, the emphasis at the societal level is on the larger systems and structures that shape the social and economic circumstances that lead to violence.

Methodology

Design

The study used the cross-sectional design whereby data collection took place at a single point in time. The cross-sectional design provided a comprehensive snapshot of the perceptions of female survivors, offering valuable insights to enhance the effectiveness of OSCs and improve the response to GBV.

Population and Sampling

The study was conducted in Shinyanga Region, which comprises six districts: Ushetu, Kahama, Msalala, Kishapu, Shinyanga and Shinyanga Municipal. The study selected three districts as sample: Shinyanga Municipal, Shinyanga District and Kahama District. To select the One Stop Centres, three were chosen randomly, including Shinyanga Referral Hospital (Shinyanga OSC) in Shinyanga Municipality, Nindo Health Centre (Nindo OSC) in rural Shinyanga and Kahama District Hospital (Kahama OSC). The researcher selected these OSC because they were the only ones available in the region and the centers were functioning according to required standard. Through the purposive sampling method, the researcher selected 96 female GBV survivors: 31 from the Shinyanga OSC, 11 from the Nindo OSC and 54 from the Kahama OSC. Additionally, the researchers purposely selected key informants, including staff at the OSCs such as medical doctors, social workers and police officers.

Instruments

The study used an interviews and a questionnaire as instruments for data collection. The questionnaire collected information such as socio-demographic information, gender-based violence cases, services offered by OSCs and perception of female survivors on accessibility to OSCs. Interviews took place with key informants to gather insights on various aspects related to GBV response, service provision and challenges faced.

Validity and Reliability

The questionnaire underwent a thorough review process to ensure it accurately captured relevant information regarding the perceptions from female survivors and staff regarding One-Stop Centers' response to gender-based violence. Additionally, a pilot test took place to assess the clarity and comprehensiveness of the questionnaire items. The pre-testing allowed the researchers to identify and address several weaknesses in the data collection tools. The researchers made adjustments to address issues like the wording of questions and some minor problems with questions about the respondents' demographic characteristics. The interview guide with key informants and female GBV survivors covered key aspects related to GBV response, service provision, and challenges faced by OSCs.

Statistical Treatment of Data

The analysis of descriptive quantitative data used the SPSS (Statistical Package for Social Science) software. The quantitative analysis calculated frequencies and percentages on the socio-demographic information, types of gender based violence cases reported at the One Stop Centers, the services offered by OSCs, and perception of female survivors on accessibility to OSCs. The researchers translated and transcribed the audio recordings from the interviews after listening to such for common themes. Access to OSCs, service availability, female GBV survivors, and OSC challenges were the key themes explored for qualitative analysis

Ethical Considerations

The researchers made sure to get verbal consent from respondents. The researchers also made the participants aware of the confidentiality of their data and the subsequent dissemination of the findings

Results and Discussion

This section presents the results of the study. It begins with the presentation of demographic factors and the analysis of research questions follow.

Table 1: Socio-demographics of Female GBV Survivors

Socio-demographics	Category	Frequency	Percentage
Age	0-15	1	1
	16 - 20	26	27
	21 - 25	24	25
	26 - 30	23	24
	31 - 36	12	12.5
	37 - 41	5	5
	52 - 56	1	1
	62 - 67	2	2
	78+	2	2
	Total	96	100
Marital status	Married	47	49
	Single	37	38.5
	Widow	11	11.5
	Separated	1	1
	Total	96	100
Education	None	23	24
	Primary	44	45.8
	Secondary	24	25
	College	4	4.2
	University	1	1
	Total	96	100

Socio-Demographics of Respondents

The socio-demographic characteristics of GBV survivors appear in Table 1. The table shows that 49% of female survivors were married. This is consistent with a study by Ministry of Health, Community Development, Gender, Elderly, and Children et al., 2016) which found that married women, particularly those who are formally married, are more likely to experience physical and sexual abuse, with their partners.

Table 1 provides socio-demographic data categorized by age, marital status and education level, along with corresponding frequencies and percentages. The majority of respondents fall within the age groups of 21-25 and 26-30. Among the respondents, 49% were married, 38.5% were single, 11.5% are widowed and 1% separated. Bigger portion of respondents (45.8%) had primary level of education, followed by those with secondary education (25%), college education (4.2%) and university education (1%). Furthermore, 24% of respondents had no formal education. The educational background of female survivors can significantly influence their understanding of GBV, help-seeking behaviors' and interactions with support services. A moderate level of educational attainment suggests that while many survivors may have some level of literacy to access to information, others may face barriers in comprehending or navigating the services provided by OSCs.

Research question 1: What are the types of gender based violence cases reported at the One Stop centers?

Table 2 presents data on the types of GBV cases reported at OSCs. The most commonly reported type of GBV is physical violence accounting for 38.5% of the reported cases. This category includes acts such as hitting, punching, and beating, resulting in physical harm or injury. Sexual violence accounts for 35.4% of the cases. Sexual violence encompasses a range of abusive behaviors, including rape, sexual assault and harassment. A significant portion of cases (13.5%) involves both sexual and physical violence, indicating instances where survivors experienced multiple forms of abuse simultaneously. This highlights the complex and intersecting nature of GBV. While comparatively less frequent, neglect still accounted for 7.4% of reported cases. Neglect refers to the failure to provide necessary care, support, or protection, often leading to harm or deprivation. Psychological/Emotional comprises 4.2% of the reported cases, which involves behaviors such as intimidation, threats and manipulation, aimed at exerting control and causing distress to the survivor. Verbal. Abusive Language is the least reported type of GBV, representing only 1% of the cases. Verbal abuse includes insults, humiliation, and derogatory language, which can have significant psychological impacts on survivors.

Table 2: Types of Cases Reported at the One-Stop centers

Types of cases reported	N	%
Physical violence	37	38.5
Sexual violence	34	35.4
Both sexual and physical violence	13	13.5
Neglect	7	7.4
Psychological/emotional	4	4.2
Verbal (abusive language)	1	1.0
Total	96	100

Table 2 indicates that women reported experiencing higher sexual and physical violence. The findings support the claims made by URT (2020), Munisi et al, (2021) and World Health Organization (2021) that the majority of women endure physical and sexual abuse at the hands of their spouses. The findings underscores the need for comprehensive support services and interventions to address the diverse needs of survivors. It also highlights the importance of OSCs in providing a safe and accessible space for survivors to seek help and support. Overall, the findings suggest that GBV

remains a significant issue, requiring concerted efforts from policymakers, service providers and communities to prevent violence, support survivors and promote gender equality and human rights.

Research question 2: What services do survivors receive at the One-Stop centers?

Table 3 highlights different types of services survivors received at the OSCs. In the table, some of respondents received more than one service at the OSC. The table shows that counselling is the most commonly received service with 52 survivors (32.7%) receiving it.

Table 3: Service received by female GBV survivors at the One Stop centers

Service Received	N	N%
Counselling	52	32.7
General health testing and treatment	36	22.6
Pregnancy test	23	14.4
HIV test	22	13.8
Police Statement	17	10.7
Legal aid	10	6.3
Prevention education	10	6.3
Police Form No 3 (PF3)	6	3.8
Contraceptive	6	3.8
Protection education	6	3.8
Case opening	3	1.9
Temporary stay at OSC	3	1.9
Linked to child support	3	1.9
Seeing the doctor	4	2.5
Post-Exposure-Prophylaxis (PEP)	2	1.3
First aid	1	0.6
Multiple services (escort, food)	1	0.6

This indicates the importance of psychological support for survivors of various traumatic experiences. Thirty-six survivors (22.6%) received general health testing and treatment, suggesting a significant need for medical assistance among survivors. Pregnancy and HIV test were received by only 23 (14.4%) and 22 (13.8%) survivors respectively, highlighting concerns about reproductive health and HIV/AIDS transmission knowledge among survivors. Female survivors 17 (10.7%) received assistance with providing a police statement and 10 (6.3%) received legal aid. Other services such as legal aid and prevention education were received by a smaller percentage of survivors (6.3% each), suggesting efforts to educate survivors on prevention methods and provide them with contraceptive options. There are various other services received by smaller percentages of survivors, such as Police Form No 3 (PF3), case opening, temporary stay at OSC, linkage to child support, seeing the doctor, Post-Exposure-Prophylaxis (PEP), first aid and multiple services (eg. escort, food). Overall, the findings highlight the diverse range of services provided by One-Stop Centres to survivors, addressing their medical, psychological, legal, and educational needs.

The findings indicate that One Stop centers offer a range of services for survivors of GBV including health screening, counselling, testing for pregnancy and HIV, and education on prevention. Some OSCs also provided assistance with legal procedures, first aid, and filling out necessary forms. Despite efforts by OSCs, there are limitations in their capacity, including disparities in staffing, accessibility, funding and equipment availability. For instance URT, (2020) reported that in the Shinyanga Region, 470 GBV cases were recorded in 2019 but only 159 of those cases were filed in court and 314 were under police investigation. Overall, OSCs play a crucial role in providing medical, legal, counselling, and psychosocial support to GBV survivors.

The study also found that OSCs provided referrals for legal assistance, medical care, and connecting survivors to stakeholders. The following is what one female victims had to say about referrals:

> I was directed to AGAPE by a social worker who assured me that the organization would provide me with capital, which they did. I was placed in a group with other victims, and they taught us how to operate a small business. They handed us capital so we could start a business. My business

> is now improving (Kahama OSC, female GBV survivor).

Another respondent reported, "I had excellent support at the center with the bleeding and medication, and I did not pay. However, they advised me to visit another hospital in order to get an HIV and pregnancy test done as there was no electricity" (Female GBV survivor, Nindo OSC).

The first statement suggests that OSC has the ability to connect female victims with other organization that can financially empower women. As one of the risk factors for GBV occurrences is financial dependence, giving a woman financial independence increases her agency and decision-making, which lowers the likelihood of GBV occurrence. Offering a range of services under one roof makes it easier for a victim to receive the care and support they require to recover from trauma (Munisi et al., 2021).

Research Question 3: How do female survivors perceive the accessibility to One Stop centers in responding to gender based violence?

Table 4 presents data on perceptions of female survivors regarding accessibility to OSCs. It is worth noting that some female survivors offered varied perceptions, outlining a range of issues influencing the accessibility to OSCs. A significant proportion of female GBV survivors (36.8%) gad limited awareness services provided by OSCs. This suggests that the government's attempts to end violence against women are hindered by limited awareness of OSC service availability.

Closer to a half of respondents reported fear of shame and stigma as factors that hinder access. The table further shows that reluctance to report cases, insufficient privacy and trained staff, distance and lack of knowledge about OSCs existed. Through the qualitative data, female survivors stated that some of them were not aware of OSCs when they faced violence. They first learned about OSCs through peer support. This is comparable to the observation of Mtaita et al. (2021) that peer support is one way to provide information and use legal and medical services.

Table 4: Perceptions of female GBV survivors on the accessibility to One Stop centers

Women's Perception	Frequency	Percentage
Limited awareness of OSCs availability and services	50	36.8%
Fear of shame and stigma hindering access	48	35.3%
Reluctance to report to OSCs to protect a family member (perpetrator)	20	14.7%
Insufficient privacy and trained staff at OSCs	10	7.4%
Distance as a barrier to access OSCs	4	2.9%
Lack of knowledge about OSCs	4	2.9%
Total	**136**	**100.0%**

Some women reported deficiencies in services provided. For instance, a female survivor spoke about her OSC experience:

> Concerns about privacy at OSC need to be improved, and when a victim arrives there, they should pay attention to her and offer assistance. I believe it is wise to start speaking with one member of staff, such as a doctor, social worker, or police officer. You feel depressed when all of them are asking questions at the same time. A separate space for each member of staff would be preferable to having everyone in one room at once (Female GBV Survivor, Shinyanga OSC).

The statement suggests the OSC's lack of privacy and unskilled staff about GBV. For example, Shinyanga OSC has only one room implying lack of privacy. As a result, victims will not feel comfortable discussing the details of the violence faced in a setting that lacks privacy. This aligns with the study findings of Olson et al. (2020) study in 15 low and middle-income countries from Asia and Africa who reported that the primary challenges that OSCs encounter in providing services to GBV survivors include lack of private consultation spaces and shortage of skilled staff. According to the above statement, a female victim who received low quality care is very likely to discourage other victims from using the OSCs' services. In the end, this will have an impact on the government's efforts to combat GBV.

Research Question 4: What are factors that hinder the ability of One Stop Centers' staff to respond to survivors of Gender-Based Violence effectively?

This question reports factors that hindered the ability of One Stop Centers' staff to respond to

female survivors of Gender-Based Violence effectively. The study identified the following factors:

Budget Issues

The study established budget issues as a factor that hindered the effective functioning of OSCs. One key informant reported, "At times, we rely on funds from various partners to carry out OSC activities. However, accessing these funds involves going through numerous bureaucratic steps, often resulting in delays in receiving the funds (Social worker, Kahama OSC).

Another respondent reported, "In municipal budget, there is no specific allocation designated for OSC. Occasionally, when a victim arrives with a hungry child or requires medication, they cannot afford. As a result, we offer assistance using our personal income" (Social worker, Shinyanga OSC). These statements shed light on how budgetary constraints can significantly impede the timely delivery of services at One Stop centers (OSCs). In response to this challenge, Columbini et al. (2012) suggests that it is necessary to secure sustainable funds for acquisition of testing equipment, transportation, legal case follow-ups and outreach efforts to promote OSC services. This finding aligns with the URT's (2020) discovery that budgetary limitations restrict OSCs' ability to address GBV cases effectively.

Shortage of Staff and Training

The study established that limited number of staff is a key challenge. Shinyanga OSC had two social workers, one police officer and one medical Doctor. On the other hand, Nindo had one social worker and one medical doctor. Kahama had three social officers, one medical doctor and three part-time police officers. Additionally, OSCs were not open for 24 hours but they operated during working hours. One of respondents reported, "With only four social workers available, we are responsible for covering 20 wards, 77 villages and streets while fulfilling other duties at the district hospital. Due to other commitments, police officers and doctors work in shifts (Social worker, Kahama OSC).

The statements highlight how the shortage of staff can significantly hinder the timely delivery of services at One Stop Centres (OSCs) as the workload is overwhelming, making it challenging to provide timely and comprehensive services to survivors. The fact that police officers and doctors work in shifts due to other commitments underscores the strain caused by staffing shortages. The statements from respondents suggest that operating during regular working hours is insufficient to meet the needs of clients, resulting in clients missing crucial services. The findings are consistent with URT (2020) that OSCs are short-staffed with personnel capable of handling GBV cases. In addition, low staff motivation affects the operation as revealed by one police officer:

> Our main incentive at the center is watching survivors improve; aside, there is nothing else. There are no additional duty allowances until you switch to work to another department. You go to court with your own money and occasionally escort a victim with your own money, which is why many employees do not want to work here.

One Social Worker reported, "I have not received an invitation to a workshop or training on GBV since I have been working at OSC. I only went to the training during COVID-19 because we were asked to offer psychosocial counselling."

Limited Transport

The study revealed that OSCs had no designated transport. However, some of the services, like transporting a victim to OSC are urgent and demanded a transport. The following statements indicate the limited transportation: "We have many emergency cases that need to be handled quickly, yet it sometimes takes us up to three days to response. We are expected to provide emergency services, but how can you do so without a reliable transport?" (Social worker, Shinyanga OSC).

> You might get a call telling you the location of a perpetrator, and I need to go there, arrest the perpetrator, go over the crime scene and gather evidence, but without a transport, I cannot. Due to insufficient evidence, the case cannot be brought before the court (Police officer, OSC Shinyanga).

This limitation increase the risk of more GBV incidences and pending cases in court. For example, in the Shinyanga region, the police (URT, 2020) are still investigating 314 out of 470 recorded cases in 2019. As a result, female GBV victims continue to experience trauma because they are unable to receive immediate support, care, health services and justice. Similar to the current findings, Ranchod

and Boezak (2013) discovered that several survivors were unable to access OSC services because the centres failed to send an emergence vehicle or ambulance in Pretoria and Vryburg. Additionally, Keesbury et al. (2012) reported that survivors in Zambia had to cover all transportation charges to the centre due to lack of transportation. This suggests that transportation issues in dealing with GBV are common even in other African countries.

Conclusions and Recommendations

Based on the findings, the prevalence of physical and sexual violence reported at One Stop Centres highlight the importance for targeted interventions and comprehensive support services to address the multifaceted needs of survivors and promote a safer and more equitable society. One Stop Centres did their best in providing various services including counselling, health testing and treatment, legal aid and case opening to empower survivors of gender-based violence and facilitate their recovery. However, accessibility to One Stop Centres was hindered by limited awareness, fear of shame and stigma, reluctance to report cases and insufficient privacy and trained staff. This highlights critical areas for improvement. Factors such as budget constraints, staff shortage, inadequate training and limited transportation hindered the ability of One Stop Centres' staff to effectively respond to survivors, which hindered timely delivery of services and justice.

Therefore, there is a need to launch comprehensive awareness campaigns to educate communities about the existence and services offered by One Stop Centres. Furthermore, there is a need to address misconceptions and reduce stigma surrounding help-seeking behaviours for survivors of GBV. There is also a need to prioritize staff training initiatives and enhance skills in trauma-informed care and GBV response protocols while advocating for increased staffing levels to alleviate workload burdens and ensure timely service delivery. Finally, dedicated budget is essential for effective running of the One Stop Centres.

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