Stigma, shame, and women's limited agency in help-seeking for intimate partner violence.

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In Tanzania, 44% of women experience intimate partner violence (IPV) in their lifetime, but the majority never seeks help, and many never tell anyone about their experience. Even among the minority of women who seek support, only 10% access formal services. Our research explored the social and structural barriers that render Tanzanian women unable to exercise agency in this critical domain of their lives. We collected qualitative data in three regions of Tanzania through 104 key informant interviews with duty bearers and participatory focus groups with 96 male and female community members. The findings revealed numerous sociocultural barriers to help-seeking, including gendered social norms that accept IPV and impose stigma and shame upon survivors. Because IPV is highly normalized, survivors are silenced by their fear of social consequences, a fear reinforced by the belief that it is women's reporting of IPV that brings shame, rather than the perpetration of violence itself. Barriers to help-seeking curtail women's agency. Even women who reject IPV as a "normal" practice are blocked from action by powerful

social norms. These constraints deny survivors the support, services, and justice they deserve, and also perpetuate low reporting and inaccurate estimates of IPV prevalence.

Keywords: intimate partner violence; help-seeking; stigma; social norms

Background

Intimate Partner Violence: Global Context

Violence against women (VAW) is a pervasive problem and a violation of human rights that crosses geographic, cultural, religious, and economic lines, affecting millions of women every year (Klugman et al., 2014). Globally, the most commonly experienced form of VAW is intimate partner violence (IPV), which nearly one in every three women experiences at some point in her life (Heise, Ellsberg, & Gottmoeller, 2002; WHO, 2013). Such violence has profound consequences on the wellbeing of women by negatively affecting physical and mental health, curtailing mobility, and decreasing productivity (Campbell, 2002; Taft & Watson, 2008; Beydoun, Beydoun, Kaufman, Lo & Zonderman, 2012). In addition, IPV often has harmful, long-term effects on social cohesion and the healthy functioning of families and communities.

For women who experience IPV, the ability to seek help—from both formal and informal sources—is associated with improved mental health, physical safety, and a willingness to seek needed medical and legal assistance (Liang, Goodman, Tummala-Narra, & Weintraub, 2005). Informal channels of help-seeking include family, friends, and other sources of social support, such as trusted elders and religious leaders. Formal support is provided by trained professionals or other individuals within the criminal justice, health, or social service sectors. Yet despite the high global prevalence of VAW, the majority of survivors around the world do not seek help for responding to or escaping violence, and more than a third never tell anyone about their experience. Recent analyses of Demographic and Health Survey (DHS) data show that across 30 countries, on average only 4 in 10 women exposed to IPV sought any support, and only 6 percent approached formal services such as police, healthcare professionals, lawyers, and/or social service organizations (Klugman et al., 2014). Similarly the largest published in-depth comparison to date showed substantial regional variation in formal reporting. Only 2 percent of women

in India and East Asia, 6 percent in Africa, 10 percent in Central Asia, and 14 percent in Latin America and the Caribbean made any formal disclosure of their experience of violence (Palermo, Bleck, & Peterman, 2014).

Studies in Bangladesh, Turkey, and the United States have found that women are more likely to seek help from formal sources as IPV becomes more severe and they fear for their lives or their children's safety (Ergöçmen, Yüksel-Kaptanoğlu, & Jansen, 2013; Naved, Azim, Bhuiya, & Persson, 2006; Fugate, Landis, Riordan, Naureckas, & Engel, 2005). In other words, if help is sought at all, this is often as a last-resort rather than an informed response to a human rights abuse.

The numerous barriers to women's help-seeking and reporting illustrate the ways that women's agency is stifled by social norms and systems that are not responsive to their needs. Some administrations of the DHS ask the reasons women do not seek help, and among these the most common reasons include: believing that there is no utility in doing so; seeing IPV as a part of life; not knowing where to go for help; fearing consequences (divorce, being beaten, or getting their partner in trouble); and being embarrassed to tell anyone about the violence (Kishor & Johnson, 2004). A study in Mexico found that the most common reasons included a perception that the violence was insignificant (29 percent), concern for their children (18 percent), embarrassment (14 percent), and fear of retaliation by their partners (14 percent) (Frías, 2013). Only 8 percent of women cited not knowing they could press charges.

These reasons illustrate the powerful impact of social barriers in preventing women from seeking help and exercising agency in this important domain of their lives. Agency refers to the "power within," and the "ability to define one's goals and act upon them" (Kabeer, 1999). In other words, agency is a measure of the degree of control individuals can exert in their own decision-making. Across all countries, men and women differ in their ability to make effective choices in a range of spheres, with women typically at a disadvantage. Experiencing violence, coupled with being barred from seeking necessary care, illustrates some of the overlapping agency deprivations women face (Klugman et al., 2014). For survivors of violence, this loss of agency corresponds to an inability to obtain the support that is often

critical for their personal recovery and safety as well as the wellbeing of their families. Moreover, the inability to disclose incidents of violence enables perpetrators to act with impunity and compromises the reliability of prevalence data used to inform policy and programming. As such, barriers to help-seeking violate survivor's fundamental rights and act as an impediment to social progress.

Tanzanian Context

In Tanzania, the prevalence of violence against women is higher than the global average; 44% of ever-married women have experienced physical and/or sexual IPV (National Bureau of Statistics (NBS), 2011). According to the 2010 Tanzanian Demographic and Health Survey (TDHS), while nearly half of survivors of physical or sexual violence sought help, the majority did so from their own family (47%) or religious leaders (33%). As with women around the globe, Tanzanian women reported that they seldom sought help from the police, lawyers, or medical personnel (6%, 1%, and 1% respectively). Further multivariate analysis using TDHS data suggests that after experiencing any sexual or physical violence, Tanzanian women who were previously married and in the bottom 40% wealth profile were more likely to seek help from formal sources, whereas women with secondary or higher education were less likely to do so (as compared to women with no education) (Palermo et al., 2014).

Societal acceptance of violence is widespread in Tanzania; a recent study found that several forms of violence, IPV and rape, are “seen as normal” and “met with acceptance” by both men and women (US Agency for International Development (USAID), 2008). Similarly, the 2010 TDHS found that more than half (53.5%) of women and more than a third (38.1%) of men agree with at least one justification for wife beating (NBS, 2011). Such trends are also confirmed by more recent qualitative evidence; evidence from 27 focus group discussions in Arumeru and Kigoma-Vijijini districts found that gender norms legitimate the use of a “good beating” as a way to enforce and demonstrate adherence to the “head of the house” masculine ideal (Jakobsen, 2014). Another qualitative study from an urban district in Dar es Salaam found

that women and men across age groups and professions frequently condoned IPV as a “measure to correct women in specific situations” (Laisser, Nyström, Luginia, & Emmelin, 2011).

Both civil society and government actors have made efforts to address these norms that serve to perpetuate violence. For example, the Channeling Men’s Positive Involvement in the National HIV/AIDS Response (CHAMPION) Project works to promote and implement research, programs, and policies that engage men to address violence and other pressing public health problems (The CHAMPION Project, 2014). Funded by the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR), the project implemented prevention and community protection projects in the three PEPFAR priority regions: Dar es Salaam, Iringa, and Mbeya.

An important milestone and clear indication that the government is increasing its attention on this issue was the development and passage of two key policies in 2011. The National Policy Guidelines for the Health Sector Prevention of and Response to Gender-based Violence (GBV) outline the roles and responsibilities of the Ministry of Health and Social Welfare and other stakeholders in the planning and implementation of comprehensive GBV services. The National Management Guidelines for the Health Sector Response to and Prevention of Gender-based Violence provide a framework for standardized medical management of cases and aim to strengthen referral linkages between the community and providers.

The principle of gender equality is enshrined in the Tanzanian constitution (1977) and more recent legislation upholds this commitment (e.g., the Land Act and Village Land Act, 1999), however legal protections against IPV are limited. The Law of Marriage Act (revised 2002) prohibits “corporal punishment” against a wife, however fails to recognize marital rape as a punishable offense (Human Development Trust, 2011). Although there is a growing awareness of violence and increased efforts at a policy level to address the issue, survivors’ access to health, psychosocial, and legal services remains limited. For example, there are few known shelters for survivors in Tanzania, and these are predominantly located in Dar es Salaam (USAID, 2008). Moreover, an overall shortage of trained professionals in the

country has implications for the availability of appropriate physical and mental health care for survivors of VAW.

The limited availability of services helps to shed light on the structural barriers to providing IPV survivors with appropriate care. However various individual, interpersonal, and socio-cultural factors operate throughout the help-seeking process and play an important role in determining whether or not a woman experiencing violence feels she can seek support. While both theoretical and empirical research has explored help-seeking behaviors among survivors of violence, the majority of such studies are from high-income settings. A notable exception is the Muganyizi et al. (2011) study on barriers to appropriate response for rape survivors within the Tanzanian policy and health care system. As such, we know much less about the potential barriers to help-seeking within low-income countries, where social, economic and cultural dynamics interact in diverse ways to limit women's agency. Our study addresses this gap by contextualizing low levels of help-seeking in three regions of Tanzania. We explore the social and cultural barriers that curtail women's agency in exercising their rights to social support, health, and justice after experiencing violence from an intimate partner.

Methods

This study was motivated by three core objectives: 1) to understand community perceptions of VAW and related patterns of and barriers to help-seeking; 2) to profile the range of services that currently exist for survivors of VAW in select districts; and 3) to identify current gaps and opportunities in the provision of violence-related services in the target regions. This paper presents findings related to the first objective, focusing on the socio-cultural barriers that limit women's agency in seeking support after experiencing violence. While the overall study addressed diverse forms of violence against women, the analysis below concentrates on intimate partner violence as the most prevalent and frequently discussed form of violence in the study sites.

Data collection was carried out in one urban and one rural district in each of the three targeted regions: Dar es Salaam, Iringa, and Mbeya. Each key informant interviews (KII) entailed approximately one hour of conversation structured around an interview guide developed for this study. Recruitment of duty bearers, stakeholders, and service providers for the KIIs began with directories of civil society organizations and health providers furnished to the research team. From this starting point, the team carried out a structured snowball sample to achieve a final sample of 104 KIIs conducted with a wide array of stakeholders, service providers and duty bearers at the national, district, and ward level. These respondents included: public and private health care providers, Ward Reconciliation Council members, police gender desk officers, civil society representatives, ward/local leaders, and representatives of relevant national Ministries.

Participatory focus groups (PFG) were conducted as same-sex and age groups (women 18-24, women 25+, men 18-24, men 25+) in each of the three study sites. These sessions employed a range of participatory methods, and lasted an average of 2 hours per session. This format is based on the traditional focus group discussion but strategically incorporates participatory techniques such as community mapping, incomplete stories, and interactive ranking exercises to make these sessions more accessible to and enjoyable for respondents. A total of 96 individuals (48 men and 48 women) participated in 12 PFGs. Recruitment of these participants was conducted by the team of trained researchers from the University of Dar es Salaam in close consultation with local leaders once site selection was complete. Potential respondents were invited by the field research team to participate in a discussion about violence in their communities. Neither IPV survivors nor perpetrators were actively recruited for these discussions. However, given the prevalence of violence in the country, it is likely that individuals with personal experiences of violence participated in the sessions.

Collecting and analyzing data from both PFGs and KIIs provides a holistic understanding of the perceived norms and barriers from the perspective of community members, service providers, and other duty bearers. Notes from all sessions were recorded by Research Assistants using a standardized data

summary form to ensure consistency across KIIs and among the PFGs. The research team then compared these summary forms at the end of each day to assess the extent to which key themes had been addressed. If gaps in responses among KIIs or PFGs were identified, this domain was prioritized for subsequent interviews. KIIs and PFGs were audio recorded and transcribed into Kiswahili then translated into English. Once all the data had been collected, the research team carried out field-based analysis workshops to identify patterns and points of disagreement, related to the key findings. This layered analysis allowed for iterative validation of the data within and across the sessions as well as the three target sites.

The research protocol was approved by the Institutional Review Board of the International Center for Research on Women and the Directorate of Research and Publications of the University of Dar es Salaam. The field work was carried out by a team of trained researchers and research assistants from the University of Dar es Salaam Department of Sociology and Anthropology, who strictly adhered to the WHO Safety and Ethical Guidelines for Researching Violence against Women (World Health Organization, 2001). Informed consent was obtained prior to beginning the discussion, and the voluntary nature of participation was emphasized throughout each interview/focus group. All safeguards were taken to ensure the protection of research participants. Confidentiality, anonymity and the avoidance of re-traumatization related to experiences of violence were emphasized in the protocol development, training of the research team, and over the course of data collection and analysis.

It is important to note that the selection of study sites was guided by PEPFAR prioritization of Dar es Salaam, Mbeya and Iringa. As such, the resulting sample was not intended to be representative of all of Tanzania, but was a purposive sampling of the highest priority areas for intervention for CHAMPION and other PEPFAR partners. Only one ward per each priority district was included in this sample, and

these were intentionally those wards with evidence of higher reporting of GBV and/or a higher concentration of existing services for survivors of GBV.¹

Results

The KIIs and PFGs revealed a wide array of key structural and socio-cultural influences that prevent women who experience IPV from seeking help through both informal and formal channels. Socio-cultural barriers are those that are imposed upon survivors by the values, attitudes, and norms that are prevalent in a cultural context. These barriers may be due to survivors' perceptions of the gendered roles and expectations that govern their identity as Tanzanian women, or may be due to a fear of the social consequences of reporting IPV through official channels or divulging it within their familial and social networks. Structural barriers are determined by the systems, processes, and legal frameworks that govern how and where services are provided and to whom. Together, these barriers curtail women's agency and contribute substantially to the low rate of help-seeking observed among women who experience IPV.

Gender inequality is perhaps the most pervasive and persistent and overarching barrier, which affects Tanzanian women across multiple domains of their lives. Our research also identified specific structural barriers to women's help-seeking, including cost of transport and services, corruption, limited or inaccessible services, and lack of quality care, particularly with respect to the availability of psycho-social support. These findings are consistent with other research from Dar es Salaam indicating that survivors of sexual violence are frequently deprived of critical services due to high costs, corruption, and lack of coordination, resources, and information within the health care and criminal justice systems (Muganyizi et al., 2011).

¹ This determination was made in consultation with the District Community Development Officers and the District Social Welfare Officers.

Models for help-seeking behavior articulate three-stages: problem identification; the decision to seek help; and selection of a care provider/source of support (Liang et al., 2005). Following this generalized framework, it is important to note that structural barriers come into play relatively late in the process—only once a survivor has decided to seek help. Prior to this stage, however, women are faced with a host of socio-cultural factors that dictate normative expectations around experiencing and responding to violence, thereby affecting how they define violent incidents and, subsequently, whether or not they pursue support. Three overarching themes emerged in discussing the specific ways in which socio-cultural factors limit women’s agency to seek help for IPV: gender norms that legitimize and normalize violence within intimate relationships; stigma, shame, and fear; and limited trust in the existing system. Below we present key findings related to each theme.

Theme 1: Gender norms

Numerous studies from around the world emphasize the highly prevalent attitudes and norms that tolerate VAW and the Tanzanian communities included in our study are no exception. While overall respondents had a relatively high awareness of what constitutes VAW and were able to list a range of violent behaviors, male and female participants across age groups and sites indicated that many acts of IPV are considered socially acceptable. As a result, women may not define violence as a problem—but rather as a “normal” part of their relationship, thus preventing them from moving forward in the help-seeking process.

Findings suggest that the normalization of violence is closely linked to Tanzanian norms around ideal masculinity, which emphasize male dominance and control. Respondents expressed a common set of expectations for men as providers and decision makers who exercised violence as a legitimate use of their power in the household. For example, both male and female participants raised the issue of provocation and blame in domestic abuse. Across gender and age groups there was a shared idea that any time a woman goes against her husband (disobeys him), she risks being beaten. At issue is the man’s degree of

“tolerance” for her behavior, and at the core of this is a sense that women are at fault for any violence they experience because they have somehow provoked their partners into beating them, as illustrated in the second excerpt below:

It is very common. If you refuse his orders you will be beaten, when he denies to start a business and you do it anyway, you will be beaten, and if you give birth and defend yourself it wasn't your plan but God's, you will be beaten. Whatever you do that seems to be wrong to him will lead into you being beaten up. (Female PFG participant, 18-24 years old, Dar es Salaam)

It depends how angry I am. You can control her by simply slapping because she has gone against your former routines and how you live. You start by yelling at her, and if she reacts then you change the style and slap her a bit. (Male PFG participant, 25+ years old, Mbeya).

Sexual IPV is also condoned by gender norms emphasizing men’s ability to demand sex from their partners, and further complicated by the dowry system that exists throughout Tanzania.

Our traditions come from in the past women, were like the oppressed ...they were instructed or advised that if a man harass you in any kind you do not go anywhere because he is your husband, he paid dowry for you. (Service Provider, Mbeya)

Marital rape is not recognized within Tanzania’s legal framework, and this omission was reflected by the study, with only one female participant defining forced sex in a relationship as rape. All the other respondents drew a sharp distinction between rape and forced sex, with the former referring only to non-partner sexual violence, as illustrated by the quote below:

Rape is for someone who you are not related to but being forced to have sex is for your sex partner. He can decide to have sex with you without your consent. When it is done by someone who is strange to you it becomes a big issue but if it is your sex partner you have to tolerate because marital issues should remain inside. (Female PFG participant, 25+ years old, Iringa)

This normalization of physical and sexual violence as a common and largely accepted behavior for men also carries implications for norms around femininity. For instance, participants commonly described expectations around women's need to *tolerate* and *withstand* the violence they experience. Moreover a women's ability to take her husband to court or even exercise customary forms of justice is often limited by the normative context, which considers a wife confronting her husband to be outside the bounds of appropriate behavior:

*Yes, it's normal, being beaten, yelled at. If you tell (anyone), your peers will ask you, 'is this your first time to be beaten?' Some of us are used to it, just like the way we are used to eating ugali.*² (Female PFG participant, 25+ years old, Mbeya)

The African community feels that it is not right for a woman to take a husband to court even if he abused her. They are not aware that everyone has equal rights. (Service Provider, Mbeya)

While these findings do not necessarily imply that *individuals* condone these acts, they underscore the ways in which gender norms act as a barrier to women's agency in help-seeking after experiencing IPV. It is important, however, to acknowledge that expressed tolerance of IPV was often moderated by the severity and nature of the violence, with certain acts clearly transcending "acceptable" boundaries. For

² Ugali is a ground maize meal, a traditional staple food in Tanzanian culture.

example, respondents across sex and age groups described a common set of violent behaviors regarded as “extreme” within the community and meriting a formal response, such as reporting to the police or other help-seeking channels. These included rape by a stranger, being threatened with or experiencing the use of a weapon, severe physical abuse by a husband or partner, and physical violence against a partner in public spaces. Additionally, in contrast to forced vaginal sex, forced anal sex was viewed as completely unacceptable, even within a relationship. This is due in large part to societal norms that make anal sex, even if consensual, a taboo. The degree to which it is considered unacceptable is underscored by the quote below, which explains that in this extreme case a woman’s family would encourage and support her decision to leave a relationship in which forced anal sex occurs:

If you are forced to have anal sex that is not ok. Even your parents will tell you to ask for a divorce immediately and go back home. And they will stand by you all the way through.

Female PFG participant (25+ years old), Dar es Salaam

Although the argument that gender norms both underlie and perpetuate IPV is well established in the literature, less discussion has explored how such norms further circumscribe women’s agency after violence has occurred. If violence is regarded as “normal,” women are unlikely to define these incidents as a problem, and subsequently are barred from the first step in the help seeking process. Further PFG and KII discussions underscored how even women who might recognize IPV as a violation of their rights are unlikely to have social support for a decision to leave an abusive relationship.

Theme 2: Stigma, shame, and fear

Another common theme emerged that provides insight on the gap between a woman experiencing IPV and her agency to disclose the abuse-- the fear of bringing stigma and shame to herself and/or to her family. Respondents explained that survivors are commonly made to feel ashamed for *talking* about their

experiences with others, given that what happens within marriage is considered to be something private that should not be shared outside the home. These expectations are closely linked to the patriarchal gender norms discussed above, as illustrated by these quotes:

The man will say 'why have you gone to announce what happened in bed?' They (the women) feel ashamed. (Duty bearer, Dar es Salaam)

She is a just a human being and she feels talking about it will degrade her humanity. She better keep it her secret. (Duty Bearer, Mbeya)

They are hiding because of the patriarchal system. Some of the women think in marriage you have to tolerate everything. A parent is telling her daughter that she had also experienced abuse from her husband and whatever happens has to be kept a secret you cannot tell other people about your husband's behavior. (Service Provider, Iringa)

In addition to the shame which surrounds *discussing* IPV, there is also a high degree of shame associated with *experiencing* violence, whether it is disclosed to authorities or not. For instance, women in PFGs listed insults, name calling, yelling, and threats as normal and widely accepted forms of violence when carried out within in the home. However, *public* perpetration of these same acts was described as crossing a threshold into unacceptable behavior because they are a form of humiliation for the woman. The idea that women are frequently blamed for the violence they experience was noted several times during the KIIs and FGDs:

You know the problem is...that there is a concept of shame upon the victim, and not shame upon the perpetrator. There is a need of changing the society. (Service provider, Mbeya)

A related barrier that was commonly expressed by respondents is a fear of the social consequences that result from reporting spousal abuse to formal channels. In particular, women fear that reporting abuse will cause divorce or abandonment, which would leave them without any source of material support and/or render them undesirable for other prospective husbands. Structural factors—such as poverty and patrilineal inheritance patterns—contribute to women’s economic dependence on men and thus exacerbate related barriers to reporting.

That is a challenge because when women experience violence they are afraid to report their husbands to the police because doing that will break off marriage totally and sometime you might find that a woman has no income so they think of where they will go after the marriage breaks up.
(Service provider, Iringa)

Women’s agency to seek help for violence is also curtailed by fear of an escalation of violence. Participants consistently described how women were unlikely to seek help—or even speak about the violence they suffer—because this could trigger emotional, and physical retaliation:

He (the husband) will be called and warned, but he will feel like you have humiliated him and when you go back home things will get worse by shouting at you because he thinks you are stupid.
(Female PFG participant, 18-24 years old, Dar es Salaam).

Theme 3: Limited Trust in Response Systems

Even women who challenge the status quo by reporting IPV to duty bearers are likely to experience other obstacles. Many of these are structural barriers (e.g., costs, gaps in services, unskilled providers, etc.),

which, in the context of the gendered norms and fears discussed above, culminate in expectations around insensitive and discriminatory treatment from service providers and duty bearers. Overall these barriers produce a lack of trust in the response system. At worst, the interaction with the formal systems may re-traumatize survivors. Thus, for the minority of women who effectively pass through the first two stages of help seeking (i.e., identifying violence as a problem and deciding to seek assistance), either direct or indirect experience of a non-responsive system can be another formidable deterrent to seeking help.

This limited trust in the systems was particularly prominent among younger women, who reported that they and their peers do, in fact, recognize that IPV is a violation of their rights. While they may be willing to seek help, these young women expressed discouragement at the lack of adequate support structures and pervasive culture of impunity:

...they are already used to the habit of being beaten. Even if they report them and nothing is done, she will just keep quiet because he isn't changing...she will just continue with her business while her wounds heal. (Female PFG participant, 18-24 years old, Iringa)

It is important to note that the fear of stigma mentioned above also extends to healthcare providers and duty bearers within the criminal justice system. Respondents described that many women believe they will be blamed and further traumatized if they report IPV (and this fear is even more acute in the case of non-partner violence). These findings are consistent with another study on barriers to responding to rape within the police and health care system in Dar es Salaam. Muganyizi et al. (2011) describe that rape survivors who report to authorities are forced to “walk a path of anger and humiliation” throughout their engagement with healthcare professionals and police. Similarly, women in our study describe how stigma is folded into the blame placed on women; even if a woman is sexually assaulted, it is her *report* of this rape that brings dishonor and shame. This sense of deep humiliation is a significant barrier to help-seeking of any kind, which explains why so many rapes go unreported.

Some girls will not report because they feel humiliated. It's not like there aren't girls who are raped, there are so many but they just don't report to the authorities. (Female PFG participant, 18-24 years old, Iringa)

Discussion

This study underscores a stark reality: that the vast majority of survivors of violence in Tanzania never receive the services or justice they deserve. Most survivors do not seek emotional support, help for their physical safety and recovery, or assistance to hold the perpetrator accountable and prevent further violence. These low levels of help-seeking are partially explained by structural barriers at all levels of society—corruption, direct costs, gaps in services, and lack of quality care within many existing health centers. Beyond these constraints, however, this study revealed numerous socio-cultural barriers that directly impede women's ability to seek support from formal and informal providers. The most instrumental barriers to help-seeking that emerged can be grouped under three broad categories: gender norms that accept IPV as a “normal” part of intimate relationships; stigma, shame, and fear; and lack of trust in existing response systems. The specific barriers noted by respondents are overlapping and often mutually reinforcing. For example, gendered norms that accept IPV simultaneously impose stigma and shame upon women who speak out against the violence they experience. Because IPV is highly normalized in this context—like “eating ugali”—survivors often maintain a culture of silence, fearing social consequences such as humiliation, divorce and rejection by family and friends. Such fear is upheld by the belief that it is women's reporting of IPV that shames the family, rather than the violent act itself. Our results are consistent with other studies in Tanzania that draw attention to the gender norms that frequently legitimate IPV, in particular expectations for men's roles as the head of the household and women's roles as subordinate and submissive to her partner (Laisser et al., 2011; Jakobsen, 2014).

Findings from this study further delineate how a woman's agency—her ability to make a decision to seek help and her sense of empowerment to act on this decision—is largely conscribed by socio-cultural barriers to help-seeking. The initial hurdle experienced by many survivors is whether or not the violence she has experienced crosses the threshold of what is deemed “normal” or “tolerable” within her community. The widespread acceptance of “wife beating” in many situations means that survivors often face powerful obstacles to disclosing the violence they experience, thus jeopardizing their mental health, safety, physical recovery, and ability to take criminal action to hold the perpetrator accountable. While the argument that gender norms both underlie and perpetuate VAW is well established in the literature, less discussion has explored how such norms further curtail women's agency *after* violence has occurred. If violence is regarded as “normal,” women are unlikely to define these incidents as a problem, and subsequently are barred from the first step in the help seeking process. Further PFG and KII discussions underscored how even women who might recognize IPV as a violation of their rights are unlikely to progress in the help-seeking process, because they have insufficient social support for a decision to report the violence through formal channels or to leave a dangerous relationship. Finally, women who successfully navigate these initial barriers may still choose to keep silent because of their distrust that service providers will fairly and adequately address their needs.

Conclusion

Intimate partner violence undermines women's fundamental rights. Barriers to help-seeking, such as those identified through this research, further curtail women's agency through the threat of marginalization and related social consequences. Such restraints on women's agency deny IPV survivors the support, services, and justice they deserve, and also perpetuate low levels of reporting and, subsequently, inaccurate estimates of IPV prevalence. Overcoming these barriers and creating more responsive systems for survivors who do seek help requires a multi-faceted approach that engages women

and men at the family, community, and national level. Removing these barriers will contribute to stemming the tide of violence, promoting women's agency, and ultimately, achieving gender equality.

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