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On the frontlines of support: Tanzanian service providers' experiences delivering services to survivors of violence against women and girls- A qualitative study

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Abstract

Background

Violence against women and girls (VAWG) remains a major public health and human rights concern globally and in Tanzania. In response to this, Tanzania, through its National Action Plan to End Violence Against Women and Children (NPA-VAWC), has stipulated strategies aimed at ending violence against women and girls. Among other implementation approaches stipulated in the Tanzanian NPA-VAWC, it is to strengthen coordinated multisectoral services for survivors of VAWG. Although these policies and national frameworks have been developed to improve service delivery for survivors of VAWG, the effectiveness of service delivery largely depends on frontline service providers' experiences, capacities, and working environments. Therefore, exploring their experiences, the facilitators, barriers, and the strategies to address them is essential for strengthening the effectiveness of multisectoral services for survivors of VAWG in Tanzania.

Method

A qualitative research design was employed. Participants included multisectoral key service providers who deliver care and support to survivors of VAWG across five regions in Tanzania. We conducted (n=25) individual semi-structured interviews. Thematic analysis was conducted.

Results

Participants shared individual clients' outcomes and organizational factors that facilitated their service provision to survivors of VAWG. These include knowledge and skills in handling survivors, as well as improvements in survivors' physical and psychosocial well-being following service provision. Likewise, participants reported perceived challenge factors at the individual, family, community, and structural levels. These include survivors' delayed seeking of services, particularly for time-bound services, such as post-exposure prophylaxis care and financial and resource support for service provision. Nevertheless, participants proposed strategies to address perceived challenges in providing services to survivors of VAWG. These include continuing to raise community awareness on VAWG and improving infrastructure and budget for the provision of services for survivors of VAWG.

Conclusion

These findings indicate both the promise and the complexity of service providers' experience in delivering services to survivors of VAWG. While service providers reported facilitators such as survivors' physical and psychosocial well-being outcomes and their capacity in handling survivors of VAWG, survivors delayed in seeking services, and financial and resource needs for support services continued hindering their effectiveness in service provision. Nevertheless, they proposed strategies to enhance certain facilitators and overcome certain challenges. Therefore, there is a need to address the facilitators, barriers, and strategies of these service providers to strengthen frontline services for

survivors of VAWG in response to the Tanzania NPA-VAWC, which calls for multi-sector engagement in the prevention and response to VAWG.

Introduction

Violence against women is one of the most widespread human rights violations[1]. Approximately one in three experiences physical and/or sexual intimate partner abuse, non-partner sexual violence, or both[1]. Speaking of intimate partner violence, over one quarter of women aged 15–49 years who have been in a relationship have experienced physical or sexual violence by a partner[3]. Also, violence by non-partners is remarkable, with around 263 million women(8%) having experienced sexual violence from someone other than a partner since age 15.

According to the Tanzania health demographic survey of 2022, one in four women(26%) and one in ten(12%) of women aged 15–49 have faced physical and sexual violence, respectively, in their lifetime[4]. Adolescents and young women are also vulnerable; evidence shows that about 30% of girls experience sexual violence before the age of 18[5]. Moreover, Reports indicate that approximately 28% of girls and women in Tanzania experienced sexual abuse during childhood, reflecting persistent gender-based violence throughout the life course[5].

Violence against women is associated with health, social and economic consequences not only to the victim/survivor but also to the family, community and society at large[6], including physical injuries, disability, mental health conditions, unintended pregnancy, and sexually transmitted diseases such as HIV.

Despite advancements in women's rights, one of the most pervasive abuses of human rights across social and cultural groups continues to be VAWG. In response to this, Tanzania, through its National Action Plan to End Violence Against Women and Children (NPA-VAWC), has stipulated strategies aimed at ending violence against women and children [7]. Among other implementation approaches stipulated in the Tanzanian NPA-VAWC, it is to strengthen coordinated multisectoral services involved in care for survivors of VAWG. These include, but are not limited to, the following sectors: health, police, justice, local government authority, and social welfare [7]. Health and social welfare service providers are often the first point of professional contact for survivors and play a key role in linking them to multisectoral support systems[6]. Hence, to ensure the comprehensiveness of survivors' services, these multisectoral agencies are the frontline key providers in identifying, managing, providing linkage and referral to survivors of VAWG[6]. Therefore, exploring service providers' experiences, the facilitators and barriers, and the strategies to address them is essential for strengthening survivors-centred prevention and response services and improving the effectiveness of VAWG multisectoral service response systems in Tanzania.

Methods

Study design

The study employed a **qualitative research design** to explore the experiences of Tanzanian service providers who deliver care and support to survivors of VAWG. A method was appropriate because it allows for an in-depth understanding of participants' perspectives, experiences, and the contextual factors influencing service provision [8].

Study settings

Tanzania's mainland is located in the Eastern part of the African continent. It has a total administrative area of 26 regions[9]. The survey was conducted in five of 26 regions: Arusha, Singida, Mara, Geita, and Simiyu. These regions were selected based on one or more of the following criteria: a higher incidence of physical and/or sexual violence by intimate partners in the past 12 months compared to the national average (29.6%), and elevated Social Institutions and Gender Index (SIGI) scores. All five regions reported violence against women incidence rates above the national average, with Mara and Geita recording rates of 56.8% and 37.5%, respectively. SIGI scores for all selected regions exceeded the national average of 35, except for Geita, which had a score of 32 [10-11].

Study participants and recruitment

The study participants were service providers' representatives working on gender based violence and violence against children services. These included social welfare, justice, local government, health, and police. The study participants were selected purposively based on their roles in gender based violence and violence against women and children. Our approach was consistent with practices in qualitative methods [8,12], as the focus was not on obtaining a representative sample but on identifying individuals with defined roles who could provide an in-depth understanding of the topics of interest. Involving participants from different sectors involved in the care of VAWG survivors helped maximize the variation in the qualitative information [8].

Data collection

The study team conducted semi-structured interviews using a locally developed interview guide(***Appendix A***). The development of the interview guide enhanced credibility because it contained questions aligned with the study objective and was used by all interviewers [13]. The questions explored service providers' experiences when attending to VAWG survivors, including the perceived benefits and challenges of this work. Probes allowed for flexibility and were used to encourage participants to propose strategies to enhance reported facilitators and overcome reported barriers; moreover, they clarified responses and obtained detailed descriptions[13]. The study team ensured documentation throughout the research process to facilitate transparency and consistency, thereby enhancing the study's reliability [13]. We conducted 25 interviews with service providers, lasting 60-90 minutes each. Interviews were conducted in Swahili and audio-recorded by the data collectors with experience in qualitative data collection.

Qualitative data analysis

The interview narratives were transcribed verbatim and then translated into English. The translated transcripts were imported into NVivo 12 for coding to support data analysis. Thematic analysis was conducted [14]. The study team ensured that the analysis was based on the participants' findings narrative. The research team regularly discussed emerging themes to minimize individual bias and ensure that interpretations reflected participants' perspectives. The study context, participants, and research procedures were clearly documented by the study team, enabling users to assess the applicability of the findings to similar settings and thereby enhancing transferability[13].

Ethical approval

Ethical approval for this study was obtained from the Muhimbili University of Health and Allied Sciences Institutional Review Board (IRB). Permission to conduct the study was also obtained from the relevant regional and district authorities. Written informed consent was obtained from all participants before participation in the study. All procedures performed in this study involving human participants were conducted in accordance with the ethical standards of the institutional research committee and the 1964 Declaration of Helsinki and its later amendments, or with comparable ethical standards.

Results

A total of 25 key informant interviews with service providers were conducted in all five regions. **(Table 1)**

Perceived facilitators for providing services to survivors of the VAWG

Service providers reported that perceived facilitators were categorized into individual, client, and service organization factors.

Service providers' individual factors

Service providers reported having knowledge and skills for assessing and providing needed interventions to survivors/victims of VAWG. They continued to facilitate the provision of services to survivors/victims of violence. They are aware that the on-the-job training in the response and prevention of GBV/VAC enhanced their knowledge and skills in handling survivors /victims of violence. Training was coordinated by the Tanzanian Ministry of Health, in collaboration with other government authorities and the implementing partner organizations working on GBV/VAC.

Service providers reported that the training builds their capacity to provide services for survivors of VAWG, including survivor/victim assessment, provision of necessary interventions based on the assessment, and linkage to other services. This includes screening/identification of women and girls experiencing various forms of violence, conducting physical and mental state assessments for survivors, providing management according to the assessment and linking to other multisectoral services or /referral to care and follow-up. In general, service providers express positive attitudes while handling survivors/victims of violence.

*"Here at the hospital, we provide medical services. For example, if a victim arrives with injuries, they will be treated for them. Also, they (survivors)get test services such as pregnancy tests, laboratory services to test for HIV, and testing for sexually transmitted diseases. We healthcare providers) also provide treatment for them by protecting them from pregnancy and treatment to protect them from HIV infection." Also provide counselling services to survivor(**Participant 1, HCP**)*

*"We provide social welfare services. First of all, the main service that we offer is counselling because we want them(survivors) to return to a normal mental state, i.e. psychological support. We also link them (survivors) to other services, including referrals for medical treatment. Police and other non-governmental services**. (Participant 6, SWO)***

Service providers also highlighted the need for connecting survivors with legal services.

*"Another service is to link them with legal services. Because we know you may be needed to go to court, for example, in our region, there is an office for the Human Rights Commission. They help us." **(Participant 2, SWO)***

Clients outcomes factors

Service providers reported the following as client outcomes among the facilitators for providing services to survivors of VAWG. Include the victim's /survivor's improvement in physical and psychosocial well-being following the provision of services. For example, clients reported satisfaction with strengthened social support, with being equipped with coping mechanisms and important life skills for managing their basic needs and handling encountered experiences. Also, service providers were satisfied with increased community/society awareness of VAWG and with people seeking services.

*"Previously, a person(survivor) could not talk to her husband to explain their family plans, but now (following a life skills session) they can explain to him(husband/partner) that they need to plan family matters together. So I(service provider), I feel satisfied with the services that we are offering".(**Participant 3, SWO)***

*"There are benefits. Because some have begun to understand and see the consequences of sexual violence. For example, when it comes to the period of female genital mutilation, some children run to the safe house. Some parents voluntarily send their children to the safe house so other community members do not influence them. But also, citizens report incidents of sexual violence. Therefore, there are benefits". **(Participant 6, HCP).***

*"Another benefit is that the children themselves want to go to school. A parent comes and tells you, "I don't want my children to be mutilated, but the community will not understand me. How can you help me? Did you get me? So for me, it is a benefit. And they also see the importance of giving birth at our healthcare centres. It is also beneficial for them due to the education we provide." **(Participant 3, HCP)**.*

"I feel comfortable helping them because you see a person(survivor) change. A person grew up not thinking they could do income-generating activities. Through the services that we do offer them, you see, they

*started thinking they could do a small business****".(Participant 4, HCP)***

*"The benefit is saving people's lives psychologically, and solving the problem that has been bothering them for a long time, which is already a benefit. The society continues to be educated, that if the society is educated, cruelty decreases****".(Participant 1, HCP****).*

Services organization

Service providers reported things that would facilitate the provision of services to survivors/victims. Including the provision of services that address survivors' multisectoral needs at one centre (one-stop centre), continuing to raise community awareness of VAWG, and improving infrastructure and budgets for the provision of VAWG services.

Perceived challenges for providing services to survivors of the VAWG

Participants reported experiencing multiple challenges while providing services to survivors/victims, including individual, family, community and structural level challenges. These included delayed seeking of services, unavailability of safehouses/shelters for victims/survivors, providers' and victims/survivors' safety, family negotiation with the perpetrator, and limited infrastructure and budget for service provision.

Individual-level challenges

Survivors' delays in seeking services (particularly for services whose effectiveness is time-bound, i.e., post-exposure prophylaxis care) and loss to follow-up for care were expressed by service providers as among the factors which may affect survivors/victims' health outcomes.

*"The challenge is that they(survivors/victims) arrive late at the centre to get health services now. They are missing other services. For example, if someone is late for five days, you cannot give them medication to prevent unexpected pregnancies, HIV, and other sexually transmitted infections****."(Participant 1, HCP).***

Family and community-related challenges

Service providers reported challenges in obtaining family and community support while helping survivors of VAWG. Include family negotiation in handling perpetrators and the lack of Community support.

"The challenge is when you give information, maybe the victim suffered from a certain violent act, and its effect is shown. Still, when the case comes to court, they have the habit of sitting together (the criminal and the victim), talking, and paying each other to end the case before the court even knows. They sometimes advise the victim to escape to avoid leaving evidence. This has a negative impact when you are called to give information as a witness; then the victim is not there, and the case will be closed, but not reach an end, because they have already agreed with each other and paid the victim."(***Participant 4, HCP).***

"They want to solve this, and they have taken it at the family level. They will say, "How do you report something like this against your husband?" You want to humiliate him? At the end of the day, the community, especially those who do not understand, talk to her and blame her. How do you report an incident where you are the first to be beaten? Have you seen it?" ***(Participant 1, SWO).***

*"The biggest challenge is when they meet at home and agree with each other on how to finish the case; they end the case without involving the police. Parents also cause problems, but tomorrow they will move together, and they will repeat fighting for the same problems again and return to the police station. I also think that community awareness is limited****".(Participant 4, Police gender desk)****.*

"Community members themselves fail to cooperate with the security agencies because they are hiding criminals in their society by not reporting violent acts" ***(Participant 2, local government)***

Providers safety

Service providers shared their experiences of how their safety is at risk when providing services to survivors of VAWG.

"The perpetrator has threatened me. I was helping a woman who was experiencing violence from her husband. She opened a case in court because her husband took their children from home without informing her. Therefore, I had to go back to the police, and they arrested him". ***(Participant 1, HCP).***

Structurally related factors

Financial and resource constraints, such as medical equipment and supplies, basic needs, available and accessible safe houses/shelters, transport cost, safety environment /infrastructure for survivors/victims and service providers, are perceived as contributing challenges to the provision of services to survivors/victims of violence.

"Resources are also a problem. When compared to the needs, the available budget is small. The social welfare services budget is not like the others(compared to other services) in the council's internal revenue offices," ***(Participant 4, SWO).***

"We can prevent many children from being forced to marry because they are still young by taking them(young girls who are forced to be married) to the safe house. She will call me (a service provider) over a hundred kilometres away from where she (a young girl who is forced to be married) is. Do you see! How will you help her? As the social welfare officer, you don't have a fuel budget or a car to pick her up and bring her to safe houses/shelters. If you tell her, I will give you bus fare so you can catch those very early morning buses to places with transport. But you start to think what time she will leave? What if the family and community members) might catch her on the way, and you will have put her at more risk?"(***Participant 5, SWO****).*

"Another challenge is that our systems for providing these services are sometimes not friendly and are cumbersome. You know, you must go to the court, then the police. That is, you should take the child to the police, or take the mother to the police. Take the police form number three and go to the hospital ***(Participant 5, SWO)****.*

*"There are challenges, including transportation challenges, insufficient budget and human resources for providing services to survivors of VAWG. (****Participant 1, SWO)***

Proposed strategies to address challenges for the survivors of violence services

Participants also proposed strategies to address perceived challenges in providing services to survivors of VAWG. These include continuing to raise community awareness on VAWG and improving infrastructure and budget.

*In addressing challenges, we continue to provide education/ community outreach and awareness-raising (****Participant 5****, ****legal services****).*

*What I could say is that development stakeholders should continue to collaborate with the government in combating gender-based violence. In particular, we should continue to provide education to community members so that they can stop gender-based violence. But it is also good that issues of gender-based violence are included in the educational system, from primary to secondary education. But in parallel with that, education on development and upbringing is also important and provided to parents and guardians, so that everyone can understand a child's developmental stages. At each stage of development, parents/guardian can know their role and what is needed for a child****. (Participant 2, HCP****).*

*Regarding threats, we report them to the police. In terms of financial resources, if we encounter challenges, we contact the director so he can make changes to the provisions or pay us through another financial provision. For example, there are times when a child may be brought here; maybe he has been kidnapped, so you have to take him to a children's home in Mwanza. That is, things like that happen. But we also collaborate with various development stakeholders when we encounter challenges; let's say, maybe with equipment. So we can contact stakeholders. We have a problem, maybe with a car. Maybe we want to go somewhere. So they can help us, maybe with transportation. So we collaborate with various stakeholders****. (Participant 5, SWO).***

Discussion

The study reports Tanzanian service providers' experience in managing survivors of VAWG. Service providers reported their perceived facilitators, barriers and proposed strategies for addressing them. Reported multilevel factors that facilitate them in providing services for women and girls who experienced VAWG. This included on-the-job training that will continue to improve their capacity to provide services to survivors of VAWG; clients received service outcomes and a one-stop center multidisciplinary system of care.

Service providers reported that the training they received helped them build knowledge and skills in providing services to survivors of VAWG; they noted that this knowledge supported screening/identification, assessment, management, linkage/referral to care, and follow-up. Examples of these services are (i)providing physical medical care, psychological, counselling services and social services, (ii) assisting with a safety plan, (iii) police gender desk, (iv) women's help group, safe home/shelter, (v)legal aid and justice (vi) spiritual and family counselling (vii)referral and linkage to other multidisplinary services. The findings highlighted the importance of continued capacity building for service providers to enhance the effectiveness of comprehensive services for survivors of VAWG [15-17]. Moreover, continuous professional development has been shown to improve provider confidence, attitudes, and adherence to guidelines in responding to VAWG[18-19].

The service provider's perceived satisfaction with the survivor's outcome may reflect a positive attitude, which may play a key role in the survivor's physical and psychosocial outcomes [18-19]. It has been shown that respectful, empathetic, and non-judgmental care is consistently linked to increased service uptake [18,20]. This suggests that, beyond technical competence, the interpersonal dimension of care is central to the effective provision of services to survivors of VAWG [18,21-22]. Recognition of positive client outcomes as a facilitator suggests a reciprocal relationship between provider motivation and perceived impact [21,23-24], in which witnessing survivor recovery reinforces provider commitment. However, this needs structured monitoring to enhance clients' continuity of care, as one of the barriers reported by service providers was clients' loss to follow-up. Therefore, this underscores the importance of integrated facilities and community services for survivors of VAWG.

Service providers reported that a comprehensive, multisectoral, integrated one-stop center facilitated their provision of services to survivors of VAWG. This may be because one-stop centres are recognized as effective in reducing care fragmentation and improving access to coordinated medical, legal, and psychosocial support services[25-26]. These approaches not only streamline service delivery but also reduce the burden on survivors, who might otherwise need to navigate multiple, disconnected systems[25-26]. Therefore, having all services under one roof facilitated the coordination of multisectoral services needed by survivors of VAWG [25-26]. The findings mirror the World Health Organization's global plan of action, which emphasizes providing quality, comprehensive health services and programming that facilitate access to multisectoral services [27]. Likewise, they reflect the United Nations framework for essential services packages, which emphasizes a survivor-centred, rights-based, and coordinated approach across sectors [28]. Moreover, the reported services aligned with the guiding principles and thematic implementation areas of Tanzania's response and prevention of the National Plan of Action on ending violence against women and children, which insists on the multisectoral response to addressing VAWC[7].

Besides service providers' knowledge, outcomes, and multidisciplinary care as facilitating factors in handling survivors of VAWG, service providers in the study also reported experiencing individual and structural barriers that hindered the effectiveness of VAWG service provision. Such as survivor' delays in seeking services (particularly for services that effectiveness bounded, example post-exposure

prophylaxis care), loss to care/services, refusing medical-legal and court proceedings services, family negotiation in handling perpetrators, unavailability of safehouses/ shelters for the victim/survivors, providers' and survivors/victim's safety, compared to the need limited infrastructure and budget for the provision of services.

The reported individual and structural barriers in the study are consistent with global evidence highlighting the complex multilevel barriers that hinder access to and delivery of comprehensive care for survivors of violence [28-30]

Reflecting on these findings, the reported individual and systemic barriers may indicate a gap between existing policy frameworks and real-world implementation [18,21,23-24]. It has been documented that delays in VAWG survivors' care-seeking and refusal of legal services may reflect sociocultural dynamics, including stigma, fear of retaliation, economic dependency, and limited trust in formal systems[31]. This suggests that improving service uptake requires not only strengthening health system responsiveness but also addressing broader social determinants and community norms that influence survivors' seeking, accessing, and managing the services they need [21,32].

Structural constraints, such as inadequate infrastructure, insufficient shelters, and limited funding, indicate systemic challenges that can undermine the effectiveness of VAWG service delivery [23,31]. These limitations may also contribute to provider burnout and reduced quality of care, particularly in resource-constrained settings[33-34]. Furthermore, safety concerns for both providers and survivors emphasized the need for organized protections and clear protocols to manage risk[35-36]. Overall, these findings emphasize that addressing VAWG requires a holistic approach that goes beyond individual-level interventions to include increased investment in systems that provide care to survivors, intersectoral coordination, legal enforcement, and community engagement. Without addressing these interconnected barriers, efforts to improve service delivery and survivor outcomes are likely to remain constrained despite the presence of supportive policies and trained personnel[37-38].

Nonetheless, service providers proposed strategies for enhancing factors that facilitate service delivery, as well as for addressing hindering factors in providing services to women and girls experiencing VAWG. Including (i) continued raising awareness in the community on preventing VAWG and support services to survivors/victims of VAWG. (ii)Inclusion of Gender based violence and Violence Against Children in the primary and secondary training curriculum. (iii)Multisectoral stakeholders' engagement and coordination. (iv)Strengthen the budget for the provision of VAWG services. (v) Training service providers and continue building their capacity on providing services to survivors of VAWG.

Reflecting on these findings, the emphasis on both preventive and system-strengthening strategies illustrates a comprehensive understanding among providers that VAWG needs to be addressed across multiple levels[34,37,39]. Community awareness initiatives and curriculum integration underscore the importance of early prevention and of shifting harmful social norms, which are widely recognized as critical components in reducing violence over time [23,34,40]. At the same time, strengthening

multisectoral coordination and financing underscores the necessity of robust institutional frameworks to support effective service delivery [23,34,37,41].

The focus on continuous training further reinforces the dynamic nature of the VAWG response, where providers require up-to-date skills to deliver trauma-informed, survivor-centred care [23,35]. Importantly, these recommendations also indicate providers' awareness of gaps within the current system and their willingness to contribute to service improvement.

Alignment with the Tanzania National Plan of Action to End Violence Against Women and Children further underscores the contextual relevance of these strategies, particularly in advancing a comprehensive, integrated protection system capable of delivering coordinated, timely, and high-quality support to survivors [7]. Therefore, to translate these strategies into practice, there is a call for strengthening multisectoral engagement, resource allocation, and monitoring and evaluation. Overall, these findings highlight that meaningful progress in addressing VAWG requires not only evidence-based strategies but also strong implementation frameworks tailored to the local context 23,34,41].

Implications

The study examined the experiences of multi-sector service providers, the facilitators and barriers to providing services to survivors of VAWG, and strategies for addressing them. It is anticipated that these findings will inform the comprehensiveness of care for survivors of VAWG. Therefore, it responded to the Tanzania National Plan of Action for Ending VAWG[7] and to the United Nations agencies' call for multisectoral engagement to enhance comprehensive care for survivors of VAWG[16].

Strength and Limitations

The study will enhance context-specific evidence from Tanzania; therefore, it will help inform policy and programming not only in Tanzania but also in similar contexts. Moreover, by examining providers' experiences across sectors, the study highlights coordination challenges and opportunities that are often underexplored; therefore, it may strengthen the effectiveness of integrated service provision for survivors of VAWG.

However, the study's findings should be interpreted with the following limitations in mind. The study was conducted in five regions of Tanzania, mostly in the upcountry. Therefore, the generalizability of the study findings could be limited to other parts of Tanzania due to variations in sociocultural norms, practices, and attitudes, as sociocultural factors are among the determinants of risk and protective factors for VAWG. We did not interview administrators/managers responsible for coordinating and planning VAWG services; we acknowledged that they may have their own experiences regarding the provision of services for victims/survivors of VAWG that could add further insight.

Conclusion

These findings indicate both the promise and the complexity of service providers' experience in delivering services to survivors of VAWG. While service providers reported facilitators such as survivors' physical and psychosocial well-being outcomes and their capacity in handling survivors of VAWG, survivors delayed in seeking services, and financial and resource needs for support services continued hindering their effectiveness in service provision. Nevertheless, they proposed strategies for enhancing some facilitators and for overcoming some of the challenges. Therefore, there is a need to address the facilitators, barriers, and strategies of these service providers to strengthen frontline services for survivors of VAWG in response to the Tanzania NPA-VAWC, which calls for multi-sector engagement in the prevention and response to VAWG.

Declarations

Ethical approval and consent to participate

The Muhimbili University of Health and Allied Sciences Institutional Review Board reviewed and approved the study. Participants provided written informed consent.

Consent for publication

Not applicable

Availability of data and materials

The article summarizes all the data used to write this paper. If the study's narrative data is needed, don't hesitate to contact the corresponding author.

Competing interests

The authors declare that they have no competing interests.

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Authors' contributions

All authors contributed to the study's design. DM wrote the first draft. All authors contributed to the interpretation of the findings and reviewed the final draft of the paper. All authors read and approved the final manuscript for submission.

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Tables

Table 1
Participants' demographic characteristics

1	Representative category	Female	Male
	Police	**2**	**2**
2	Healthcare provider(HCP)	4	3
3	Social welfare(SWO)	3	5
4	Legal protection/justice	1	2
5	Local government	1	2
	Total	11	14

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