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Gender-Based Violence in Zimbabwe: A Critical Analysis of Institutional Responses

**Submitted in fulfilment of the requirements of the degree of Doctor of
Philosophy in Sociology**

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Declaration

I declare that *Gender-Based Violence in Zimbabwe: A Critical Analysis of Institutional Responses* is my own work and that all sources that I have used have been shown and acknowledged using complete references.

A handwritten signature in dark ink, appearing to read 'Emmanuel Siziba', is written over a horizontal line.

Emmanuel Siziba

Ethics Statement

I, Emmanuel Siziba, have obtained research ethical approval to conduct the research *Gender-Based Violence in Zimbabwe: A Critical Analysis of Institutional Responses*, reference number 17383863(GW20180224 HS). I declare that have observed the ethical standards required in terms of University of Pretoria's code of ethics for researchers and policy guidelines for responsible research.

Abstract

This study sought to analyse institutional responses to gender-based violence (GBV) in the health, justice (police) and education sectors in Zimbabwe against the background of limited research, particularly in developing countries, on the role of multisectoral institutions in addressing GBV.

Guided by the Heise's ecological model the study aimed to do the following:

- Identify the risk factors of GBV in Zimbabwe;
- Review institutional responses to GBV in the three sectors, with particular focus on laws and policies, institutional reforms and community mobilisation efforts;
- Explore service providers' and other key stakeholders' perceptions of the strengths and weaknesses of institutional responses aimed at addressing GBV; and
- Propose a model for a multisectoral response to GBV in Zimbabwe and other similar Global South contexts.

The mixed methods approach was adopted and specifically the sequential explanatory approach where a quantitative component was followed by a qualitative phase was undertaken. Secondary quantitative data from the 2015 Zimbabwe Demographic Health Survey was used to attain the first specific objective, and qualitative data collected in Mt Darwin and Shamva districts was used to achieve the second and third objectives. The data was obtained through key informant interviews and focus group discussions with stakeholders in the three sectors as well as through in-depth interviews with GBV survivors. The results from the quantitative and qualitative components were triangulated and informed the overall conclusion of the study and the last specific objective.

The study results show that women and girls in Zimbabwe continue to be exposed to GBV (especially physical, emotional and sexual violence) despite the country having enacted legislation and policies to curb this type of violence. The findings of this research strengthen the established point that the mere existence of legislation does not protect women and girls from GBV. The study established that there is a gap between legislation/policy availability and implementation because of the mediating effects of cultural and religious norms as well as lack of resources. Risk factors for experiencing GBV are alcohol abuse by partner, low levels of education for the survivor, cultural norms, normative use of violence, use of mobile devices and marital status. Institutional response by the three sectors is largely reactive, lack a clearly

defined long-term programme to curb GBV and is characterised by a weak coordination between the three sectors. Premised on the biomedical approach, the health sector offers medical treatment to GBV survivors while the police treat GBV as a crime. The education sector take disciplinary measures to those found guilty of perpetrating GBV. These reactive measures do not address the underlying causes of GBV, chief of which are gender discriminatory norms and an unequal balance of power between girls and women and boys and men. The results show that responses to GBV by the three sectors is a function of institutional capacity (availability of resources), officers' capacity (level of training in GBV issues) and social context (cultural and religious norms that condone violence).

The study makes a number of recommendations to strengthen institutional responses by the three sectors, empower women and improve the implementation of existing laws and policies. These include:

- Strengthen the operations of the police stations, schools and primary health care centres through in-service training of personnel;
- Ensure that at least one member of the victim-friendly unit is at the front office of any police station since all visitors, including GBV victims, report to this office before being directed to specific offices;
- Move from a biomedical approach to a gender sensitive approach to health in the health sector and include GBV issues in public health concerns like HIV/AIDS, sexual, reproductive and mental health; and
- In the educational sector, build more classrooms and provide furniture to minimise seating arrangements that expose girls to sexual harassment. Schools must work with communities to warrant the safety of children on their way to and from school.

In addition, the study proposes a three sector model (health, police and education) based on the common understanding of GBV, the use of a common module in the pre- and in-service training and a thrust to prevent GBV before it happens by using community-based strategies and violence prevention committees in schools and primary health centres.

Key words: Institutional response, gender-based violence, police, health education sectors

Dedication

This thesis is dedicated to Vivian Chiyanike, my young sister-in-law who was killed by her husband in Dubai on 8 January 2020 after a domestic dispute. May her soul rest in peace.

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List of Abbreviations and Acronyms

CBP	Community-Based Police
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CI	Confidence Interval
CSC	Client Service Charter
CSO	Civil Society Organisations
DVA	Domestic Violence Act
EA	Enumeration Areas
EC	Emergency Contraception
FGD	Focus Group Discussion
GBV	Gender-based Violence
ICF	Inner City Fund
IPV	Intimate Partner Violence
LCT	Leonard Cheshire Trust
LMICs	Low- to Middle-income Countries
NGO	Non-governmental Organisation
NHS	National Health Strategy
OR	Odds Ratios
OSC	One-stop Centres
PEP	Post Exposure Prophylaxis
SADC	Southern African Development Community
SDC	School Development Committee
SRGBV	School-related Gender-based Violence
UN	United Nations
UNESCO	United Nations Educational, Scientific and Cultural Organisation

US	United States
VFU	Victim-Friendly Unit
VHW	Village Health Workers
WHO	World Health Organisation
ZDHS	Zimbabwe Demographic Health Survey
ZIMSTAT	Zimbabwe National Statistics Agency
ZPC	Zimbabwe Patient Charter

Chapter 1: Background to the study

1.1 Introduction

Broadly construed as violence against a person because of their gender (EIGE 2021), gender-based violence (GBV) continues to be one of the most notable and grave social and human rights violations that occurs in all societies (Centre for the Study of Violence and Reconciliation 2016; EIGE 2021; UN 2015). Although people of all genders experience GBV, most victims are women and girls. Therefore, GBV is often used interchangeably with violence against women. However, using the ‘gender-based’ aspect is important as it highlights the fact that many forms of violence against women are rooted in power and gender inequalities between women and men (EIGE 2021).

GBV takes place in both public and private spheres, including homes, colleges, schools and workplaces and in the community at large. This type of violence includes, but is not limited to, the following: Physical violence, such as slapping, kicking, hitting with a fist and other weapons; emotional violence, such as systematic humiliation, degrading treatment and controlling behaviour; sexual violence, such as forcible sexual intercourse and coercive sex by intimidation or threat; and economic violence, such as restricting access to financial and other resources for the purpose of controlling a person) (Fife & Schrager 2012). Dowry related violence, marital rape, female genital mutilation, rape, trafficking in women and forced prostitution are also forms of GBV (Gangoli & Martin 2011).

GBV can thus be seen as a complex phenomenon shaped by forces that operate at individual, relationship, community and societal levels (Morrison et al. 2004). Research into individual-level factors indicates that violence is a learned behaviour. The social learning theory maintains that individuals are socialised by observing the experiences of others and then imitate and model the observed behaviour. Thus, the development approach states that early exposure to domestic violence results in children, especially boys, mimicking that behaviour in their own intimate relationships, creating a cycle of violence. The social learning theory suggests that behaviour becomes engrained through observation, internalisation of attitudes supportive of violence, imitation and reinforcement through rewards and sanctioning (Akers 2017). As a result, when children experience GBV, they learn that violence is acceptable and may later use it in their lives (Gomez 2011; Hamby et al. 2012). Sustained evidence in low- to middle-income countries (LMICs) reveal that many perpetrators of violence are more likely to have witnessed

parental violence in childhood (Fleming et al. 2015; Tharp et al. 2012). This is because children learn behaviour from the experiences and observation of social interactions. These observations have an impact if the modellers have authority, such as parents or caregivers. The intergenerational transmission of violence has been found to be a risk factor for both engaging in GBV and for victimisation (Barret et al. 2012).

Furthermore, childhood maltreatment is a consistently documented risk factor for GBV perpetration and for experiencing GBV (Calkins et al. 2015; Miller 2010). For example, male children with a history of abuse have been shown to have a higher likelihood of developing hostile masculinity (antagonistic and domineering attitudes over women) and a non-intimacy-based approach to sex, which in turn can lead to multiple partners and sexually aggressive behaviour (Jennings et al. 2014). Similarly, women who experienced childhood sexual abuse involving penetration often report more sexual partners than those with no history of childhood sexual abuse (WHO 2013). Girls who have been sexually abused are more likely to have early sexual debuts, engage in substance abuse, have multiple sexual partners, drop out of school, and have unwanted pregnancies compelling them to stop their education or to have unsafe abortions (Jennings et al. 2014; Sambisa et al. 2010). Having multiple partners is often associated with the risk of experiencing GBV as males compete for intimate space.

Furthermore, research shows that experiencing violence in childhood impacts brain development and personality, which affect the way one handles relationships. Anda et al. (2006) shows that experiencing violence and neglect in childhood lead to the suppression of the gene for Monoamine Oxidase A, which negatively affects personality and predisposing individuals to general anti-social behaviour and heightened propensity to violence. In addition, exposure to trauma in childhood impacts the development of brain circuits and systems (Gibbs et al. 2020). These changes in the brain structure increase the likelihood of poor mental health and substance abuse. Sustained evidence in both high- and low-income countries shows that alcohol abuse is a risk factor for experiencing and perpetrating GBV (Devries et al. 2014, Hatcher et al. 2019). As such, the maltreatment of children has far reaching consequences that include the initiation of multiple pathways of GBV perpetration.

In many settings, especially poor communities, children are subjected to multiple forms of maltreatment, and this is called polytrauma (Casey et al 2017). Being subjected to multiple forms of maltreatment (exposure to violence, being beaten, name-calling and denial of access to food) has been found to be a risk factor for the perpetration of GBV (Abbey et al. 2011; Sutton et al. 2015). While experiencing sexual and physical abuse increases the risk for

perpetration, polytrauma exacerbates the risk. Casey et al. (2017) found that 4% of men who have committed rape have no history of childhood abuse, 8.9% of men who have committed rape have a history of childhood sexual abuse, and 36.8% of men who have committed rape have a history of childhood polytrauma (physical and sexual abuse) and exposure to various forms of GBV.

This shows that multiple forms of child maltreatment heighten the risk for sexual and physical aggression later in life and that interventions need to target abused youth.

Still at individual level, younger women are at risk of experiencing violence (Abramsky et al. 2011; Jesmin 2015), demonstrating that there is a relationship between age and violence. Owing to their age, young women find it harder to manage crises. Eisikovits Band-Winterstein (2015) shows that young women experience a life of contradictions, paradoxes and ambivalence. Their mobility and helplessly being aware that their rights are being abused often creates a sense of agitation, which in turn creates a “wish to distance oneself without the ability to do so” (Eisikovits & Band-Winterstein 2015). Overall these young women remind men that women’s rights are human rights. This conflict with the deep-rooted hegemonic masculinity, which seek to subordinate women at all costs, results in a heightened risk of GBV. Older women benefit from the wisdom they gain through trial and error as they try to find ways to end or to protect themselves from GBV. This enables them to make decisions that facilitate coping strategies (Eisikovits & Band-Winterstein 2015). As women grow older, their ability to turn this wisdom into resilience and empowerment increases (Eisikovits & Band-Winterstein 2015). However, Izugbara 2018) and Adebawale (2018) show that age does not make much difference in women’s experience of GBV. This demonstrates that these measurable constructs are not key drivers of GBV but are linked to major drivers like masculinity. Overall, studies in LMICs show that those who have witnessed parental violence when young are more likely to be perpetrators of GBV, to hold permissive attitudes towards the use of violence against women, and to consider women to be of less value (Fleming et al. 2015; Speizer 2010). Studies also show that other individual factors such as lower educational and socioeconomic status, supportive attitudes of wife beating and alcohol abuse by partners are risk factors for both sexual and physical violence (Abrahamsky et al. 2011; Heise & Kotsadam 2015; Jesmin 2015). This shows that individual risk factors are conceptualised throughout the life cycle of an individual for both perpetrators and victims.

At the relationship level, family dysfunction, poor parenting practices, and associating with peers who commit intimate partner violence (IPV) or who promote male dominance over

women have been found to increase the likelihood of GBV being committed by individuals who are otherwise nonviolent (Heise 2011). Conversely, parenting characterised by emotional availability, sensitivity and responsiveness promotes secure attachment, thus reducing the odds for later GBV perpetration or victimisation (Zeanah et al. 2011). Tharp et al. (2013) show that family characteristics, such as parental mental health, exposure to family violence, and family relationships, for example, parental conflicts and negative attitudes and behaviour, are risk factors for experiencing and perpetrating GBV that can be measured at relationship level. In the Eastern and Mediterranean Region, a history of exposure to domestic violence and acceptance of male dominance were identified as risk factors for GBV at relationship level (Fageeh 2014). Evidence of an association between interpersonal violence and GBV victimisation has been found in the African countries of Uganda (Speiz 2010), Malawi, Rwanda and Zimbabwe (Hindin et al. 2008). Mathews (2011) conclude that children who experience violence in their formative years tend to have deep mistrust, are insecure, lack of empathy, feel guilty and have low self-esteem, which negatively impact relationships. These experiences cause these men to develop a deep mistrust of women. Since the intergenerational transmission of violence has been found to be a risk factor for both engaging in GBV and victimisation (Barret et al. 2012), it can be concluded that the family as an institution may facilitate the transmission of violence.

Male control of wealth and decision-making in the family has also been found to put women at risk of GBV (Heise & Kotsadam 2015). According to Fife and Schrager (2012), there is a relationship between economic resources and GBV. The resource theory indicates that the individual who has more resources (more income, education and employment) is the one who has control and power over the other individual, especially in spousal or intimate relationships (Fife & Schrager 2012). African societies socialise men to be breadwinners and those who fail to fit into the gender role face decreased masculinity, resulting in the discharge of violent emotions because of the pressure to fulfil the expectations of a 'real man'. Men who try to fulfil gender role expectations but fail face 'gender role discrepancy' (Pleck 1995). Vandello and Boson (2013) state that men may experience low self-esteem or other psychological effects and may resort to violence as a means of reclaiming their masculine status. In patriarchal societies, accessing workplace or employment opportunities and being the sole provider for the family show men's masculinity. During economic hardships many men fail to gain the physical signifiers of masculinity and resort to other constructed masculinities, such as aggression, force and physical violence. Globally, the economic situation is made worse by the Covid-19

pandemic, and many men find it difficult to fulfil the breadwinner role. Sustained evidence shows that when men lack resources (money, education and economic opportunities) they use force and engage in substance abuse, thereby increasing the risk of GBV perpetration (Mandal & Hindin; Yount et al. 2018).

The relationship between women's economic status and GBV is complicated and context specific, and there are mixed results concerning this relationship in the research (Terrazas-Carrillo & McWhirten 2015). Women employment in LMICs has mixed results as a risk factor for IPV. Five studies found employment to be a protective factor while six studies found a risk association (Eldoseri & Sharps 2017), demonstrating that the relationship between IPV and women employment is context specific. Essentially employment violates traditional gender roles by challenging male superiority.

Targeting women living in the poorest households in rural areas the Intervention with Microfinance for AIDS and Gender Equity (IMAGE) was developed in South Africa and tested in Limpopo province. An evaluation of the program by Pronyk et al (2006) showed that the participants experience a 55 % reduction in the past year of experience of physical and sexual violence by an intimate partner.

The intervention of Micro Finance for AIDS and Gender Equity (IMAGE) which was adapted and conducted in India was shown to protect women (Bhattacharyya et al. 2011). The programme used micro finance to empower women, and the evaluation results show this significantly lowered the risk of IPV (well over half) from the high of 71.3% prevalence (Bhattacharyya et al. 2011). However, studies in India show that GBV is high among working women (Dalal 2011; Rahman et al. 2011). Dalal (2011) shows that women with a lower income or the same income as their spouses are at a lesser risk of experiencing GBV than those who earn more than their husbands. The study concludes that women with a high education and gainful employment are at higher risk of experiencing GBV than unemployed women in India. Earning more than the husband can affect the traditional provider role of the man, causing stress, frustration, disagreement and marital conflict. Consequently, violence against women becomes a means for resolving male-identity crises because it allows the expression of power (Jewkes 2002). Therefore, programmes to empower women should run concurrently with primary prevention interventions strategies that target rigid cultural norms that condone violence against women.

At community level, the negative portrayal of women in the media, weak community sanctions against GBV perpetrators and low social capital are some of the factors associated with high levels of GBV perpetration and victimisation (Fleming et al. 2015; Heise 2011; Krug et al. 2002). Many people believe what is reflected in the media, and the way GBV issues are projected influences how the community react. The social disorganisation theory posits that the socioeconomic and political characteristics of a community have a bearing on the likelihood of GBV perpetration and victimisation (Flood 2010). A long, distinguished line of research shows that disadvantaged communities or neighbourhoods are associated with high levels of GBV (Fleming et al 2015; Medie 2015). Communities with low socioeconomic status, high rates of residential mobility and high population density tend to be plagued by high rates of GBV (Barker et al. 2011). As such, the economic challenges currently being faced in Zimbabwe are potentially a breeding ground for GBV perpetration and experience. Violence results from weak informal and formal community social control (Fattah & Camellia 2017). Flood (2010) shows that men who reside in these areas are not constrained by strong normative expectations against violence and are free to commit GBV without fear of social disapproval. In socially fragmented areas, victims who want to exit abusive relationships may fail to access financial resources and friends. Furthermore, official forms of social control, like law enforcement, are weak in disorganised areas as police view these communities as problematic (Medie 2015). As a result, extensive social disorganisation creates pervasive and persistent forms of GBV. This affirms the need to improve the socioeconomic environments of communities as a step to deal with GBV.

GBV rates are also found to be high in communities where schools and workplaces do not take deliberate initiatives to address it (Fergus & Van't Rood 2013). Poor safety in public spaces, blaming the victim for the violence, and violation of the victim's confidentiality have been identified as other risk factors of GBV at community level (Heise & García-Moreno 2002; Krug et al. 2002). Evidence shows that people who condone violence supportive norms and attitudes are less likely to intervene, support the victim or report the violence but are more likely to add fire by blaming the victim (Fattah & Camellia 2017; Flood & Pease 2009). Bystander attitudes towards GBV are not only a manifestation of weak community sanctions against GBV but also an area to target during prevention. The diversity and pervasiveness of factors at community level suggest that understanding GBV requires an understanding of micro contexts with respect to specific types of GBV, their association with gender dynamics, overall attitudes about violence and socioeconomic changes.

At the structural or societal level, research shows that the risk of GBV is high in societies characterised by poverty, gender inequality, masculinity linked to aggression, weak legal and criminal justice, and economic and social inequalities (Lazarus et al. 2011; Sethi et al. 2010). In patriarchal societies, GBV is rooted in women's lack of power in relationships and in society (Morrison et al. 2004), and it is essentially a manifestation of structural inequalities between men and women, which emanate from the way men and women are socialised. The overarching root causes are often socially constructed gender roles; social and cultural norms that support violence as a way of resolving conflict or support male dominance over women; low educational levels of men and women; and policies and laws that discriminate against women (Bhargava et al. 2014; Devries et al. 2014; Tenkorang et al 2013; Parkes et al 2017). According to Usta et al. (2016), society settings and the media further shape the societal justified norms associated with masculinity and female subordination. As a result, female behaviour, particularly in Africa, is constructed around conformity to men's claim of superiority and their subordination, even if there is risk of violence against women (Fidan & Bui 2016; Roller 2013). Equally, boys are socialised to conform to traditional gender norms, such as being the provider of the family. This may result in a masculinity crisis if they fail to provide, and they may turn to physical and sexual abuse to assert power (Saffitz 2010). In low- and high-income settings, GBV is also fuelled by social and cultural norms, such as the acceptance of wife beating as a normative spousal role or an 'appropriate correctional mechanism' in family settings (Barnett et al. 2016; Izugbara 2018; Mashiri 2013).

According to Fulu et al. (2013) and Fleming et al. (2015), one of the key causes of GBV is the socially constructed gender norms that socialise men to put a price on hierarchy, aggression, power, respect and emotional suppression. The socialisation of children into hegemonic masculinities and femininities often result in power inequalities between individuals, gender groups and institutions. Although challenging dominant masculinities has been given priority in the prevention domain, it is equally important to recognise that passive femininities or patterns that maintain the subordination of females facilitate GBV perpetration as the passiveness often results in negative effects on girls' self-esteem, body image and capacity to affirm themselves in relationships (Amin & Chandra-Mouli, 2014). Skovdal et al. (2011) maintain that hegemonic assumptions of masculinity usually characterise 'real men' as strong, in control, sexually promiscuous, disease free, emotionally independent, tough, and fearless and breadwinners. The dominance of hegemonic masculinity over others is not forced. Through socialisation both men and women internalise it as a norm and deviation is corrected using

violence. As a result, a number of studies maintain that men who act in accordance with hegemonic masculinities are likely to commit violence against women, girls and other men (Leone et al. 2016; McCarry 2010), suggesting that adherence to hegemonic masculinities is an important driver of GBV that must be prioritised in prevention efforts.

Jewkes et al. (2015) show that social and cultural norms, gender inequality and violence are intricately related. Sociocultural norms are embedded in the culture of a particular society, and an understanding of cultural values and traditions of both men and women who perpetrate and experience violence is key in understanding GBV (Karugahe 2016). According to Griswold (2012), culture is an aggregate that includes norms, values, beliefs, attitudes or symbols that determine the way people behave in a given community. In the context of GBV, social cultural norms justify the use of violence, blame the victim for the assault and can influence the way in which institutions respond to this type of violence. Cultural explanations of the causes of violence are frequently used in LMICs in Africa, Asia and the Middle East, but it is not the focus when unpacking the cause of GBV in high-income countries (Griswold 2012).

Different cultural contexts in sub-Saharan Africa have one thing in common: They determine the nature of GBV. In typical Zimbabwean culture, men are traditionally viewed as possessing power, entitlement and autonomy (Mashiri 2013). A study conducted in Kenya shows that there are normative spousal roles for women, like subservience, keeping the family together, child bearing (boys are a preference) and not refusing sex, that women have to adhere to (Barnett et al 2016). When women fail to fulfil these roles, they give a reason for physical, sexual or emotional spousal violence. This is because wife beating is accepted as an appropriate response or correctional mechanism when a wife fails to walk the ‘social line’. These social norms and beliefs are so intense in many parts of Africa that women can be victimised for bearing girl children, even though it is biologically the man’s sperm that determines the sex of the child.

In LMICs residence in rural areas was found to be associated with GBV (Eisikovits & Band-Winterstein 2018; Izugbara 2018). Due to structural disadvantages (e.g. lack of access to legal services), rural women lack capacity-building opportunities and access to economic resources and are usually dependent on men for their day-to-day subsistence (Kaddu 2011). Patriarchal norms and tendencies of hegemonic masculinities are stronger in rural areas than in urban areas (Izugbara 2018), increasing the risk of women and girls experiencing GBV if they deviate from socially prescribed gender roles. Additionally, societal acceptance of GBV appears relatively high in rural areas, especially in cases when women are disobedient, suspected of adultery or show disrespect to her husband and in-laws (Chaudhuri et al. 2014). As a result of the social

acceptance of violence, males in rural areas have a childhood history of physical abuse and exposure to violence. In adulthood they are likely to use violence as a conflict resolution strategy in their families, thus perpetuating violence. However, Ruiz-Pérez et al. (2015) found a lower frequency of violence against women in rural areas, demonstrating the importance of context as a latent construct influencing GBV.

Also at societal level, poverty has been identified as a key factor that influences men's violence perpetration and women's options to leave when exposed to GBV. The debate on the role of poverty is centred on the fact that women from different social classes experience GBV and that higher levels reported among the poor was driven by a greater willingness to report this type of violence (Gibbs et al. 2020). Peterman et al. (2017) and Vyas and Watts (2009) fail to show a clear association between markers of poverty (assets & employment) and GBV. However, there is increasing evidence demonstrating the multiple ways in which poverty is a direct and indirect driver of GBV.

As an indirect driver of GBV, poverty increases the chances of experiencing other recognised risk factors for this type of violence. According to Jewkes et al. (2017), growing up in poverty is associated with poor educational outcomes. Less education limits women's access to information, their exposure to diverse social norms and their willingness to challenge social norms that condone violence. Studies in South Africa, Asia-Pacific and Afghanistan demonstrate that poverty leads to less gender equitable attitudes (Gibbs et al. 2020; Jewkes et al. 2017). Furthermore, less education can lead to greater poverty later in life as less education limits options for individuals to access economic opportunities. Therefore, poverty eradication strategies are key in the elimination of GBV, yet these can be constrained in low- to middle-income settings because of economic challenges and poor prioritisation.

Jewkes et al. (2017) and Fulu et al. (2017) demonstrate how poverty increases the chances of experiencing childhood physical abuse and sexual or emotional abuse because of the challenges associated with lacking necessities. This demonstrates the challenges of raising children in poverty. In informal settlements in South Africa, Hatcher et al. (2019) found that men who grew up in poverty are more likely to experience childhood abuse and experienced increased depressive symptoms later in life, even after controlling for other childhood traumas. Other studies demonstrate the growing link between childhood poverty and later alcohol and drug abuse (Abbey et al 2011; Muluneh et al 2020). Thus experiencing childhood abuse, exposure to family violence and abuse of alcohol are established risk factors for GBV perpetration by men. Poverty eradication should be prioritised in primary prevention strategies.

Poverty as a latent construct can be a direct driver of GBV, especially IPV. Sustained evidence demonstrates that women's food insecurity (an indicator of absolute poverty) is associated with experiencing IPV in both high- and low-income settings (Fulu et al. 2013; Gibbs et al. 2018; Jewkes et al. 2017; Ricks et al. 2016). In acutely food insecure households there are likely to be more stress about the distribution of and search for food, leading to fights. Lack of food psychologically impacts individuals, leading to less ability to regulate emotions, and thus, contributing to the use of violence.

The lack of a clear association between poverty and IPV in some studies may be because samples lack sufficient variation in socioeconomic status to effectively measure the effect. This is inherent in self-selecting samples or samples from the same area. In Gibbs et al.'s (2020) assessment, many studies measure multiple indicators of poverty and treat them as separate constructs rather than as one latent construct, leading to measured indicators of poverty not being significant in the models. These methodological and conceptualisation challenges are not only misleading but prevent crafting primary prevention strategies that deal effectively with GBV.

According to True (2012), globalisation has worsened gender inequalities in many societies and has put women at more risk of experiencing GBV. Globalisation has led and continues to lead to the loss of male supremacy through neo-liberal policies, which have increased opportunities for women through access into the labour markets. The socioeconomic changes in the 20th century and the inevitable disempowerment of men have increased the risk of violence against women. The rising levels of unemployment in LMICs have incapacitated many men from fulfilling their social roles and expectations as breadwinners. Panda and Agarwal (2005) show that when men perceive their authority and economic ability challenged, they use power over women to establish their authority. The use of force is illustrated through the actions of men who perform more exaggerated masculinities or hyper masculinity (Gibbs et al. 2020). This type of masculinity cause men to physically and sexually abuse women. Masculinity as a latent construct cuts across all causes of violence perpetration, and there is inadequate attention given to it in violence prevention (Gibbs et al. 2020). The realisation that measured variables (e.g. age and women's employment) are just strongly associated with the actual drivers of GBV is key in the development of more effective GBV prevention strategies.

Research in both low- and high-income countries provide evidence that GBV emanates from gender inequality and community norms that discriminate against women and girls and these often overlooked by laws and institutions (Eldoseri & Sharp 2014; Fulu et al 2013), leading to

the normalisation of violence. Marhja (2013) concludes that normalisation and its normalisation functions are inextricably bound up with its subjectifying effects, which is to (re)inscribe norms at the same time as it produce particular kind of people who may police themselves in accordance with the norms. This creates a fertile ground for GBV.

Given the multifaceted structural and sociocultural factors that underlie and reinforce GBV, there has been calls for strong multisectoral and ecological responses to address the phenomenon (WHO 2013; UN Women, UNICEF & UNFPA 2015; UNFPA & EEIRH 2015). To this end, it is argued that traditional models of addressing GBV tend to deal with isolated providers that allocate a set of uncomprehensive services and are often unable to meet the complex needs of the GBV victims and survivors. Multisectoral responses, on the other hand, represent a holistic and coordinated approach aimed at harmonising and correlating programmes and actions developed and implemented by a variety of institutions that include, but are not limited to, psychosocial welfare, law enforcement (police, prosecutors and justice departments) and health (UNFPA & EEIRH 2015). Overall, multisectoral approaches can contribute to the prevention of GBV and the minimisation of harm through interventions at all levels (primary, secondary and tertiary) of the GBV prevention framework (Klugman 2017). According to Klugman (2017), the primary prevention levels entail stopping the problem of GBV before it occurs; the secondary prevention levels refer to responses immediately after violence; and the tertiary prevention levels entail long-term responses after violence have occurred.

Justice systems have been shown, for example, to contribute to the prevention of GBV through legislation that criminalises GBV and creating a statutory environment for survivors to access support services (Klugman 2017). To this end, it has been shown that people who live in countries with explicit GBV laws have lower odds of experiencing such violence compared to those living in countries without such laws (Klugman et al 2014). Legal reforms in many countries have also resulted in increased reporting levels, increased numbers of convictions and improving the quality of police and judicial responses to GBV (Abeyratne & Jain 2013; Dyamba & Kimuna 2015). Overall, it has been shown that the justice sector can contribute to the prevention of GBV by penalising those who perpetrate GBV; increasing societal awareness that GBV is a crime; strengthening women's rights; increasing women's access to the legal system; increasing the range of interventions to protect GBV victims; improving procedural and evidentiary problems in criminal prosecutions; and improving the treatment of GBV victims by law enforcement institutions (Klugman et al 2014; Morrison et al. 2004).

The health sector is similarly critical in the prevention of GBV as it is often the first point of contact with public service professionals for victims of GBV who are in need to services such as medical care; documentation of the violent event and its health consequences; counselling; and referrals to a network of service providers for further treatment, care and support. The sector also often provides screening for abuse and risk assessments as well as collect forensic evidence that may be needed to secure a prosecution and sentence for perpetrators (Ansara & Hindin 2010; García-Moreno et al 2014; Morrison et al. 2004; Olayanju et al. 2013).

A growing body of research evidence suggests that school-related gender-based violence (SRGBV), particularly sexual harassment, is widespread in many educational settings (Leach et al. 2014; Parkes et al. 2013; UNESCO 2012). The educational sector, specifically the school setting, is therefore another potentially important stakeholder in efforts to prevent GBV. For example, through sex education, school counselling programmes, improving teachers' conflict resolution skills, and helping learners who may be victims or perpetrators of violence, schools have the potential to send the message that GBV is wrong and can be prevented (UNESCO 2012). Furthermore, by increasing women's employment opportunities and socioeconomic status, education can reduce the unequal power relations between men and women, which has been shown to be among the root causes of GBV (Sida 2015). It can be argued, for example, that achieving gender equality in many patriarchal societies depends a great deal on how teachers construct their own gendered identities in relation to GBV. If female teachers subscribe to dominant cultural norms and values that promote rigid notions of masculinities and a patriarchal social order in which men continue to justify violence against women, they cannot act as agents of change. Likewise, male teachers in such societies will not automatically enact new discourses of gender equality that threaten their traditional position of superiority and privilege, thereby perpetuating cases of GBV; furthermore,

Schools can normalize a violent environment both in the classroom and outside it by using authoritarian pedagogy that strengthens the unequal power balance between teachers and students, by allowing corporal punishment, and by not properly addressing sexualised bullying. Schools and higher education institutions can reinforce traditional gender norms when men and boys are expected to be strong and respond with violence, or when encouraging men to apply to male dominated sectors and women to female dominated sectors (Sida 2015:2).

Against the foregoing and as Fergus and Van't Rood (2013) assert, the education sector, through all levels of schooling, can be an important site for normative change that can contribute to addressing GBV by raising awareness about its ills as well as by building the skills of students and staff to create equitable and respectful relationships. The basic thesis in

this regard is that education can modify social norms that promote GBV and empower young people to be agents of change. With school-based GBV programmes where teacher-pupil interaction is emphasised, students can be empowered to report when abused and teachers can have the skills to respond in a manner that mitigates the effects and/or perpetration of the violence. Indeed, a positive correlation between the number of years a person spends in school and a decrease in both future victimisation and preparation of physical and sexual violence is now an established fact (Plan International 2013). Against this background, the thrust of this study is to assess multisectoral responses to GBV in Zimbabwe with a focus on institutional responses in the justice, health and education sectors. Much of the current literature on GBV in Zimbabwe (see for example Makahamadze et al. 2012; Mashiri 2013; Mukanangana et al 2014) focus on GBV risk factors at the individual and relations levels, and therefore this study expands the current knowledge by exploring selected community and societal factors.

1.2 Research question

The study's main research question was: What is the extent and nature of institutional responses of the justice, health and education sectors and how effective are they in addressing GBV?

1.3 Objectives of the study

The broad objective of this study was to examine the risk factors that precipitate GBV in Zimbabwe and the effectiveness of the institutional responses to GBV by the justice, health and education sectors in the country. This study had the following specific objectives:

1. To identify risk factors of GBV in Zimbabwe within the ecological framework;
2. To assess the effectiveness of the institutional responses to GBV in the justice, health and education sectors;
3. To explore service providers' and other key stakeholders' perceptions of the strengths and weakness of institutional responses aimed at addressing GBV; and
4. To propose a model for multisectoral responses to GBV in Zimbabwe and other similar Global South contexts.

1.4 Rationale for the study

Zimbabwe provides an ideal context for this study because despite its comprehensive multisectoral legal and policy framework (see Appendix A) that mandates institutions in various sectors to develop and implement interventions and strategies to prevent and effectively

mitigate the impact of GBV, available evidence suggests GBV remains high in the country and exhibits an upward trend. For example, according to the 2015 Zimbabwe Demographic Health Survey (ZDHS), the experience of physical violence among women of reproductive age (i.e. those aged 15–49 years) increased from 30% in 2010/11 to 35% in 2015. In 2015, 14% of the women reported that they had experienced sexual violence at least once in their lifetime. Therefore, the question must be asked whether the persistent and increasing prevalence of GBV shows that Zimbabwe’s institutional responses to GBV are based on inadequate, inappropriate strategies or use outdated strategies that need reorientation. Indeed, a knowledge, attitudes and practice study aimed at enhancing “current and future GBV transformative prevention and response programmes in Zimbabwe” (UNFPA 2018) called for the following, among other key recommendations:

- Enhancement of information sharing for GBV multisectoral services to improve service accessibility;
- Strengthening community-based efforts towards knowledge and demand generation for GBV multisectoral quality services; and
- Enhancing the availability and accessibility of evidence-based and quality multisectoral survivor-centred service delivery models.

This study’s focus on the justice, health and education sectors to address GBV was highlighted in Section 1.1. It is, nonetheless, important to further add that the focus on the justice sector hinges on the call by the UN in Zimbabwe for more accountability and transparency in persecuting perpetrators in order to re-build the trust and enhance access to available services (UNFPA 2018). “This is particularly important given previous research findings that much remains to be done to protect [GBV] victims” (Zimbabwe National Statistics Agency [ZIMSTAT] & ICF 2016:315) given that the discriminatory attitudes and practices of authorities are barriers to Zimbabwe’s GBV victims’, especially women’s, access to justice (Home Office 2018). Similarly, in its final report on Zimbabwe in 2012, the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) Committee (UN 2012) expresses concern that proper funds and resources had not been allocated by the state to effectively support the implementation of the Domestic Violence Act (Chapter 5.06) of 2007 (hereafter called the DVA; see Appendix A for more details) and to address the GBV problem more broadly.

In addition to its critical role in addressing GBV, as discussed earlier, the education sector is also deemed important for this study against the call by UNFPA (2018) for efforts in Zimbabwe

“to ensure a greater focus on behavioural change programmes towards young boys and girls especially through interventions in schools”. The health sector, on the other hand, is deemed worthy of study given that health care workers’ perception of violence is also constructed in the course of their profession and personal life, and this can interfere directly in the care given to victims of GBV. For example, a study in South Africa (Rees et al. 2014) found that both male and female nurses perceive GBV as an acceptable form of ‘discipline’ invited by the actions of the abused. Thus, health care workers who view GBV as a social rather than a health issue may fail to provide holistic care. They may also fail to recognise women in danger, especially rape victims who need lifesaving care. This study therefore contribute to the knowledge of the factors that can influence service providers’ changes in attitude and behaviour regarding the institutional violence they witness and often take part in.

Overall, improving coordination between sector-specific approaches as well as between civil society initiatives and government institutions have been widely underscored as a critical component of an effective strategy for addressing GBV (Morison et al., 2004:v). However, in Zimbabwe, research mainly focus on individual and relationship factors that account for the levels and consequences of GBV in the country. Thus, this study not only contributes to filling this major research gap but also provides important pointers for policy and practice. In doing this, the study resonates with the global discourse on multisectoral responses to GBV. The basic thesis in this regard is that a well-designed and well-thought-out multisectoral response to GBV leads to increased safety and support for victims through an effective, immediate and consistent service network supported by common operations procedures. When implemented properly, the multisectoral response to GBV brings durable and sustainable changes in the lives of victims and helps to create an institutional and community culture that GBV is not acceptable (UNFPA & EEIRH 2015).

Finally the study makes a significant contribution by addressing another widely noted limitation of studies of GBV: The wide use of small-scale ethnographic studies. While these studies have undoubtedly advanced knowledge of the causes of GBV and its negative consequences for individuals and sectors, calls have been made for more studies based on wider scales using statistical evidence from large comparative surveys (UNESCO 2014). Using data from the ZDHS heeds this call. The Demographic and Health Survey is a global programme initiated and funded by the United States Agency for International Development to provide nationally representative and internationally comparative household- and individual-level data or a wide range of monitoring and impact evaluation indicators in the areas of population,

health and nutrition. Demographic and Health Surveys have large sample sizes (usually between 5 000 and 30 000 households) and are typically conducted for approximately five years to allow comparisons over time. In this study, data from the Demographic and Health Survey is used to partly achieve the first specific objective (identifying risk factors of GBV in Zimbabwe within the ecological framework). The quantitative component of the study is important given that the development of an effective GBV prevention interventions must be premised on the importance of understanding how drivers of this type of violence operate for vulnerable groups (Gibbs et al. 2020; Kerr-Wilson et al. 2019).

Dealing with the drivers of GBV (social and cultural norms, male superiority, and normalisation of violence; Gibbs et al. 2020) requires a detailed understanding of GBV. The study used document analysis to appreciate the legal and policy environment with regards to GBV mitigation and prevention. The other components of qualitative data collected through focus groups and interviews was used to understand the stakeholders' perceptions of GBV prevention and mitigation. The use of quantitative data enabled the research to establish the nature and trends of GBV in Zimbabwe. The use of an interdisciplinary approach took into account the cultural and contextual processes shaping the survivors' and stakeholders' experiences and perceptions (Priya 2012). The use of multiple methods facilitated tapping multiple traits of the phenomenon (in this case GBV) being studied (Denscombe 2010).

1.5 Conceptual framework

This study is theoretically grounded in the integrated ecological framework for understanding the origins of GBV proposed by Heise (1998). An ecological approach to abuse conceptualises violence as a multifaceted phenomenon grounded in an interplay among individual/personal, relationship/family, community and societal factors. Figure 1.1 shows that individual factors are related to one's personal history and biological makeup and that they influence how individuals behave and increase their likelihood of becoming a victim or a perpetrator of violence. Among these factors are victimhood to child maltreatment, psychological or personality disorders, alcohol and/or substance abuse and a history of behaving aggressively or having experienced abuse. At the second level, family dynamics or personal relations such as friends, intimate partners and peers may influence the risks of becoming a victim or perpetrator of violence where, for example, having violent friends may influence whether a young person engages in or becomes a victim of violence. Community factors, on the other hand, relate to contexts in which social relationships occur and that influences violence, for

example, in schools, neighbourhoods and workplaces. Finally, societal factors influence whether violence is encouraged or inhibited and include economic and social policies that maintain socioeconomic inequalities between people, sociocultural norms such as those around male dominance over women, and cultural norms that endorse violence as an acceptable method to resolve conflicts.

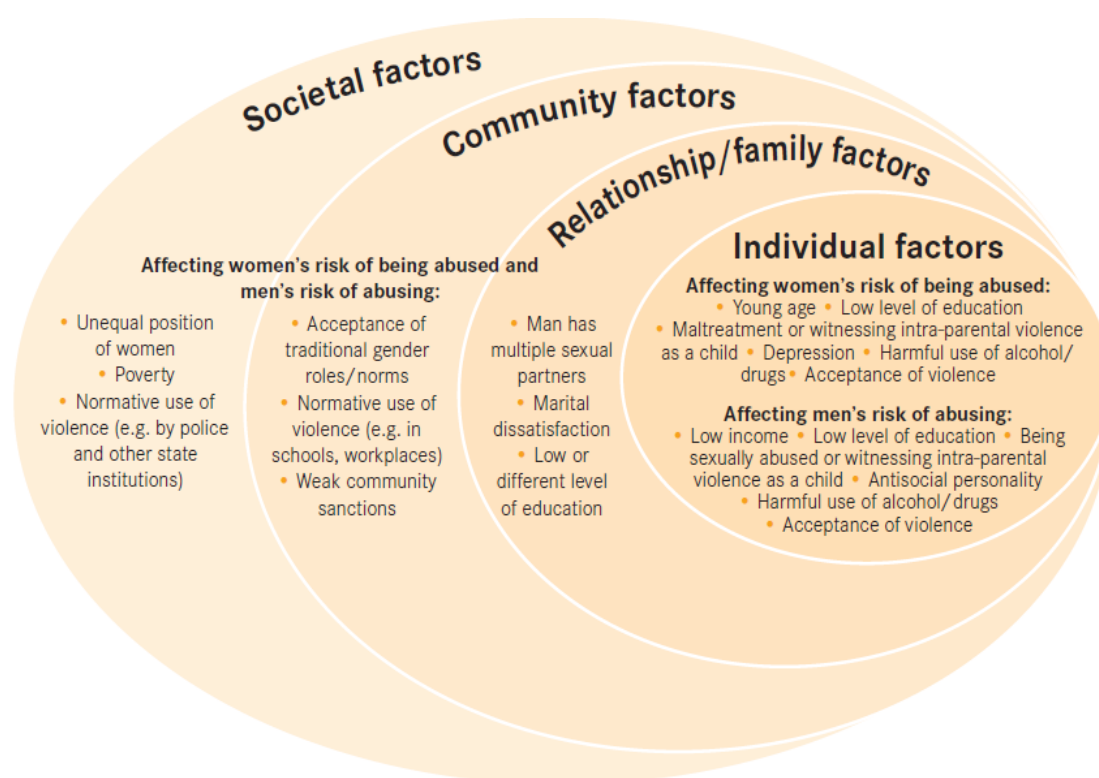


Figure 1.1: Ecological framework for understanding GBV

Source: Heise (1998)

As discussed earlier, much of the current literature on GBV in Zimbabwe and much of the developing world focus on factors at individual and relations levels. Very little has been done to illuminate risks and protective factors at the community and social levels. This study attempted to close this research gap, and to set the stage for the rest of the study, this thesis starts by drawing on current literature to discuss the key factors that may underlie the persistent levels of GBV in Zimbabwe. Drawing on this literature review and on previous research findings on individual and relationship levels, the study explored the extent to which laws, policies, institutional reforms, and community mobilisation efforts in Zimbabwe's justice, health and education sectors are effectively targeting the key risk factors for GBV and/or capitalising on the protective factors.

The ecological framework was deemed appropriate for this study because it highlights the interaction between some of the key risk factors at the different levels, contributing to the

study's first objective. An understanding of these key factors helped achieve the second specific objective by assessing the extent to which institutional responses target some of the key factors underlying GBV in the country. To this end, the undertaking makes useful recommendations of appropriate intervention strategies and a model for multisectoral response (specific objective 4).

As already stated, the study focused on the extent to which multisectoral interventions in Zimbabwe's justice, health and education sectors are effectively targeting the key risk factors for GBV. For the purpose of the study, the justice sector refers to the country's police system. This is because as the frontline of any justice system, the police facilitate legal protection of GBV victims through the courts system by providing forensic and other evidence (Goodman-Delahunt & Crehan 2015). The health sector refers specifically to the primary health care service facilities and were also targeted because it is the frontline of any health system (Ansara & Hindin 2010). The education sector in this study refers to primary and secondary schools as these are the sites of education during children's formative years (Sida 2015). These schools therefore have the potential to prevent GBV by diluting rigid traditional gender norms that condone GBV. The focus was on SRGBV, which is defined as acts or threats of physical or psychological violence occurring in and around schools and perpetrated as a result of gender norms and stereotypes and enforced by unequal power dynamics (UNESCO 2015). It includes different manifestation of physical, sexual and psychological abuse, such as verbal abuse, bullying, sexual abuse, corporal punishment, harassment, coercion, assault and rape (Greene et al. 2013). The placing of NGOs like Musasa under police LCT under education was motivated by the nature of programmes they have to curb GBV. To ensure GBV cases are formally recorded, Musasa usually accepts victims via police or they inform the police if victims do not report to police. LCT pay school fees to abused and other vulnerable children.

For the three sectors (justice, health and education) and organizations that work with them, the understanding of the workers' perceptions on strength and weaknesses of the institutional responses is key in appreciating the challenges the institutions face. The human resource factor is important in shaping the institutional response by the three sectors as well as measuring their effectiveness. The service providers are people on the ground who have the ability to give an objective assessment on the extent and nature of institutional response.

To this end institutional responses refer to the efforts of each of the three sectors, individually or when cooperating as a unit in a multisectoral collaboration, to offer a variety of sector-specific services to address GBV. Each sector's efforts were explored in terms of laws and

policies; protection, care and support services; political will; and multisectoral approach (see Section 3.7 for more details). The effectiveness of these efforts was assessed in terms of their perceived ability to produce desired results, which is to reduce the level of GBV and/or mitigate the impact of the violence on the sector's clients.

1.6 Organisation of the thesis

This thesis has eight chapters and these chapter are organised as follows:

- Chapter 1 introduces the thesis by outlining the background to the subject of the study, the study objectives as well as the conceptual framework that guided the study.
- Chapter 2 presents the literature review and focuses on categories of violence prevention, utility of multisectoral interventions, how laws and policies can address GBV; protection, care and support of victims; political will; and the importance of multisectoral collaboration in GBV prevention.
- Chapter 3 presents the methodology, which includes the research design, data sources, data analysis, and the ethical considerations.
- Chapter 4 sets the stage for the rest of the thesis by giving a brief overview of GBV dimensions in Zimbabwe and exploring its risk and protective factors at community and societal levels.
- The institutional responses to GBV in Zimbabwe are examined in Chapter 5 (justice sector), Chapter 6 (health sector) and Chapter 7 (education sector). For each sector, laws and policies; protection, care and support; human and financial resources; and multisectoral and collaborative approaches are covered.
- Finally, Chapter 8 presents the summary and conclusions as well as the proposed multisectoral model to curb GBV in low-income settings.

Chapter 2: Institutional responses to gender-based violence: A literature review

2.1 Introduction

This chapter provides a literature review on institutional responses to GBV. The chapter comprehensively discusses the categories of violence prevention (primary, secondary and tertiary). This is followed by the utility of multisectoral interventions; how laws and policies can address GBV; the protection, care and support of victims; political will; and how multisectoral collaboration contribute to GBV prevention and response. Because this study focused on community and societal factors in the ecological model, the chapter discusses the role of community mobilisation as a tool in primary prevention.

2.2 Existing models to prevent GBV

Violence prevention generally falls into three categories, namely primary, secondary and tertiary. Primary prevention of violence includes programmes that aim to prevent violence before someone is harmed and often entails efforts to transform gender related attitudes at all levels of the ecological model. According to De Gue et al. (2014), violence prevention practitioners must be aware of existing practices in order to select and implement ‘good’ practices that yield positive results. Evidence points to the changing of social norms and beliefs related to gender and family privacy as one of the sustainable ways of preventing GBV (Paluck et al 2010). Among the most common primary prevention strategies are awareness campaigns; peer training and community workshops; gender transformative interventions; social marketing and edutainment; parenting programmes; and school-based programmes (Maphosa 2018). These have the effect of changing social norms, which are important in shaping the contours of acceptable behaviour. Social norms, which are specific individuals’ or groups’ expectations of how people should behave, act as strong indicators for or against individual attitudes and behaviour. As such, individuals who deviate from group expectations are subjected to shaming, ridicule and disapproval by those important to them.

Secondary prevention aims to detect GBV early and prevent its progression or recourse (García-Moreno et al. 2015). By working with high risk groups or perpetrators, secondary prevention is premised on the need to meet the needs of victims and to prevent the occurrence of GBV. Screening programmes, data collection, addressing risk factors such as alcohol and

substance abuse disorders, protecting victims, and referrals to legal services are some secondary prevention strategies (García-Moreno et al 2015). Secondary prevention strategies are highly institutionalised as these services are offered by police for the protection of victims; by health care service as screening programmes; by law firms as legal services and by one-stop centres (OSCs), which provide comprehensive multidisciplinary services that address the needs across medical, psychological and legal services. As such, secondary prevention aims to provide supportive care that contributes to preventing violence recurring, mitigating consequences, addressing associated problems such as substance abuse, and providing immediate care. This level of prevention seeks to identify the factors and first events early on and to promote actions to prevent such events from becoming broad phenomena or pandemics. Studies in LMICs show that secondary intervention strategies depend on the availability of financial resources, personnel skilled in GBV issues, and political will (Devries et al. 2014; Kirk et al. 2017; WHO 2013). Service provision, which is the hallmark of secondary prevention, can also be constrained by social and cultural norms that inhibit victims from accessing services even when they are available.

Tertiary prevention encompasses actions that are promoted once violence has started to try and minimise the negative effects that favour their reproduction (WHO 2014). Tertiary prevention primarily focusses on people who have been perpetrators or victims and tries to rehabilitate and reintegrate them into the society. While other institutions can offer tertiary prevention, the health sector is well positioned to offer health care interventions that are supported by evidence, such as advocacy, safety planning, motivational interviewing and cognitive behavioural techniques and other trauma informed mental health interventions (Hegarty et al. 2013; Rosenberg 2011; Saftlas et al. 2014; Tirado-Munoz et al. 2014). Trials of advocacy or support interventions for women facing GBV in high-income countries report some reduction in violence and improvements in mental health outcomes (Jewkes et al. 2015). Advocacy intervention aims to help abused women directly by providing them with information and support to help them to access community resources (García-Moreno et al 2015). However, in LMICs, dependency on men, rigid gender roles and cultural norms may prevent women from linking with legal, police, housing and financial services. Access to financial services contributes to the economic empowerment of women, which reduces dependency on men.

2.3 Limitations of individual sector response to GBV

Notwithstanding the individual strengths of primary, secondary and tertiary prevention strategies, the traditional approach where services are provided in isolation is characterised by a number of challenges. When starting the healing process, victims often have to make multiple and repeated visits to service providers following an unclear interinstitutional itinerary (UNFPA & EEIRH 2015). The end result is the victims feeling frustrated and they may or may not delay seeking help. Separate institutions are involved in an uncoordinated response and conceptualise GBV differently, resulting in the collection of different data or indicators of GBV (Olson et al. 2020). Therefore, the different procedures of different institutions (e.g. health, police, and social welfare) for identifying, registering and reporting GBV cases mask this public health challenge. In any country or setting effective prevention should be based on accurate data about GBV.

In many settings the stand-alone service providers are located in different places and the cost of moving from one service provider to another discourage victims from seeking help (Mukanangana et al 2014; Olson et al. 2020). Victims may not go beyond seeking treatment for physical wounds, yet psychological trauma can lead to suicidal thoughts that can be fatal. The situation is exacerbated in the rural areas in many LMICs where transport connectivity is poor. In addition to visiting service providers scattered in different locations, victims need to retell their stories of trauma each time they engage with a different sector, which contributes to secondary victimisation (Olson et al. 2020). While case building is important for designing proper help, doing it in different settings put pressure on the victim, who may have trouble answering certain questions because of trauma.

Stand-alone sectors like health and police institutions are guided by operating procedures and ethics that relate to their profession. The health sector is guided by the biomedical approach, which is not compatible with handling sensitive GBV issues (Colombini et al 2013). On the other hand, the police is guided by the criminal justice approach, which tend to be authoritarian. These ethics together with a lack of training in GBV issues make it difficult for victims to get comprehensive services. Lack of training in these sectors is consistently identified as a barrier to the provision of effective services (Colombini et al 2013; Goodman-Delahunty & Crehan 2015; Medie 2015). In situations where victims perceive violence to be normal and fear consequences, such as another attack or losing their children, visiting stand-alone sectors for help becomes a daunting task (Fanslow & Robinson 2011; Miller 2010). The risk of being seen

or reported to the perpetrator is high. Thus, the absence of an integrated approach is fraught with challenges, which hinders GBV interventions through lack of accurate information and the offering of fragmented services.

2.4 Multisectoral response for addressing GBV

Given the foregoing, a multisectoral response to GBV are seen as a more holistic and coordinated approach that aims to harmonise and correlate programmes and actions developed or implemented by a variety of institutions in the area of health, law enforcement (police and justice department) and psychological welfare (UNFPA & EEIRH 2015). The need for a multisectoral response to GBV is motivated by responses to numerous issues raised by survivors and their advocates in LMICs when seeking services in traditional (non-integrated) health care, police or legal systems (Olson et al. 2020). Survivors of GBV need multidisciplinary services like treatment (health sector), legal protection (police), counselling (social welfare) and temporary shelter (shelter providers).

Women who experience violence have safety, social support, economic, security, housing and legal protection needs that can be met by a multisectoral approach (García-Moreno et al 2015). A multisectoral response to GBV leads to increased levels of safety and support for GBV victims through an effective and consistent service network provided in one location. Coordinated activities between relevant sectors improve the quality of services provided to GBV victims by facilitating the access to fulfil immediate needs, such as treatment, protection and access to training of multisectoral team members. A network of well-trained service providers with the necessary skills are likely to offer gender sensitive, efficient support adapted to victims' needs, leading to reduced risks of revictimisation (García-Moreno et al 2015; UNFPA & EEIRH 2015). Effective and quality services offered under one roof increase victims' trust in the capabilities and the addressability of mandated institutions (UNFPA & EEIRH 2015). Lack of trust in informal institutions has been identified as a barrier to GBV victims seeking help (Ansara & Hindi 2010). A multisectoral response to GBV brings durable and sustainable changes to the fight against this type of violence, creating an institutional and community culture that GBV is unacceptable. However, the effectiveness of a multisectoral response depends on how languages, goals and institutional cultures are addressed and aligned to a common goal (Kiss et al 2013). In line with this, some countries like the Philippines, Malaysia and Malawi have developed specific guidelines to support a multisectoral response to GBV (UNFPA 2010).

An increasingly popular strategy for addressing GBV from a multisectoral approach is the establishment of OSCs, which provide integrated, multidisciplinary services in a single physical location. The OSC model is defined as an inter-professional health-system-based centre that provides survivor-centred health services alongside a combination of social, legal, police and shelter services to survivors of GBV (Olson et al. 2020). The original OSC was established in 1994 in Malaysia, and the model has been replicated throughout South East Asia and the Western Pacific regions (Grisuranpong 2002; UNFPA 2010). In several African countries, the OSC model has been implemented with donor support (Jordaan et al. 2016; Keesbury et al. 2012). For African countries this creates another avenue for dependency on high-income countries and the associated strings attached to donor assistance. The situation is compounded by Covid-19, which is threatening the economic fortunes of high-income countries. Most OSCs are hospital based, although some are stand-alone centres that provide health services on site (Keesbury & Askew 2010). The strengths and weaknesses for this multisectoral model to prevent GBV in LMICs are documented.

OSCs are essentially designed to increase accessibility, acceptability, quality and multisectoral coordination of care to reduce survivor traumatisation when seeking care (Colombini et al. 2012; Mukwege & Berg 2016). The basic services of the OSC model in low resource settings in East and Southern Africa compromise health care (including psychological support), police and justice sector responses and ongoing social support (Keesbury & Askew 2010). This means that at the core of this approach is a system of integrated medico-legal and counselling services. While the integration or the provision of services in one location helps prevent secondary revictimisation, OSCs may fail to address socioeconomic, cultural and other contexts that make women and girls vulnerable to various types of GBV. This is because OSCs are largely modelled to be reactive.

The growing popularity of OSCs in LMICs is occurring in an environment characterised by barriers to the implementation of such models to meet the needs of women GBV survivors. OSCs, like any organisation, operate efficiently or optimally with standard operating procedures. Sustained evidence in LMICs shows that in many settings standard operating procedures are not available in the OSCs (Colombini et al. 2011; UNFPA 2013). In an environment where there is staff from different sectors, clear roles are critical as it avoids duplication of roles as well as negating critical roles. Conversely, studies by Buard et al. (2013) and Khorloo (2018) show that OSCs with standard operating procedures have clear staff roles, smooth patient flows and clear referral pathways. Referring victims to other service providers

is key as OSCs may not provide all the services needed by the victims. Referrals depend not only on specific standard operating procedures but also on the availability of an efficient transport system.

Lack of staff and high staff turnover are identified as barriers across all models of OSCs in meeting the needs of survivors (Colombini et al. 2015; Mukwege & Berg 2016). Lack of diversity in age and marital status and lack of female doctors and police officers create challenges for victims (mainly women and girls) to use OSCs services optimally (UNFPA 2016). Being attended by a male police officer or doctor ignite traumatic memories for female victims in the case of sexual abuse. In other settings, female modesty prevents women from visiting institutions where they are likely to be examined by male doctors, demonstrating the need for cultural sensitive arrangements in the establishment of OSCs. At a hospital-based OSC in India, responsibilities at the centre were taken as a burden, resulting in increased staff constraints and bad service delivery at both the centre and the main hospital (Ravindran & Undurti 2010). Staff availability is a function of political will demonstrated by the constant training, in-service training and maintaining of practical staff-patient ratios that do not burden existing staff.

Furthermore the OSCs in LMICs face governance challenges. Evidence shows that in well-established OSCs management hold regular intersectoral meetings to identify challenges and coordinate responses (Tien et al. 2017; UNFPA 2013). Governance issues are a challenge in many low-income settings, and these tend to compromise service delivery not only in OSCs but also in other institutions and sectors. This means that the availability of nicely constituted models to prevent or respond to GBV are rendered ineffective by poor governance. In two hospital-based OSCs in South East Asia and one in South Africa, reviews show that facility level advisory committees are ineffective, as demonstrated by sporadic meetings, leading to oversight and delayed services (UNFPA 2013). In the context of GBV response, some services, like emergency contraception (EC) and post exposure prophylaxis (PEP), are time sensitive.

Since a number of OSCs in low-income settings are located at hospitals, a review shows that there is lack of resources (Jordaan et al 2016), poor documentation and data management (Chew et al. 2015; More-Seytoux et al. 2010) and a number of OSCs face high operational costs (Vetten 2015). Lack of basic comfort items like clean clothes and sanitary pads reported in some OSCs means that the treatment of sexual GBV becomes tricky. Literature shows that poor documentation and data management are common across different contexts in LMICs (Bernath & Gahongayire 2013; Chew et al. 2015; Vetten 2015). Sustained evidence shows that

there is staff shortages, lack of knowledge on how to document violence, outdated information systems, different record-keeping procedures and ethical and logistical challenges in tracking victims (Ranchod & Boezak 2013; Ravindran & Undurti 2010). Challenges of recording violence results not only in narrow conceptualisation of GBV as some cases may not be recorded but also in the underestimation of this type of violence in different contexts.

One of the greatest challenges faced by OSCs in LMICs is the cost of operating these centres, and this is seen at hospital-based, stand-alone as well as government-run and non-governmental organisation (NGO) run centres (More-Seytoux et al. 2010). High operating costs mean that some OSCs are forced to weaken or forego services through decreased operation hours or heavy reliance on volunteers (Khorloo 2018; Ranney et al. 2011). Reducing the hours of an operation may adversely affect survivors who need time sensitive health services like EC and PEP and a reliance on volunteers may lead to compromises in services delivery. Psychosocial support given by untrained volunteers has a negative ripple effect as this is a highly specialised area that should be handled by trained personnel (CARE 2013). Essentially, high setting and operating costs suggest that it is difficult to establish these centres in other areas, especially rural areas, thus marginalising victims in these settings from accessing the much needed services. Many LMICs may just be establishing OSCs to be in line with global trends to establish a multisectoral response to GBV, yet these centres are grossly underfunded and underequipped.

In terms of service delivery at OSCs, many centres compromise service delivery because they lack private consultation rooms (Mukwege & Berg 2016; Pun 2016) and child-friendly environments (Khorloo 2018; More-Seytoux et al. 2010). GBV is a sensitive health issue in which secondary victimisation can be minimised in the way survivors are handled by staff. Lack of private consultation rooms in many settings often violate survivor confidentiality and privacy. These challenges can be traced back to operating costs because centres may not have the resources to build enough rooms. Lack of child-friendly units negatively affects children and adolescents, especially since violence against children is increasing (Sida 2015). This exposes a major weakness of OSCs, namely that they are ill equipped to deal with diverse vulnerable groups.

Studies in low-income settings show that the use of the services is influenced by the user fee paid by survivors, perceptions about OSCs in the community (UNFPA 2013), awareness of OSC services (Bernath & Gahongayire 2013; Colombini et al. 2013), and the physical location of the OSC (More-Seytoux et al. 2010). While free services at the OSCs facilitated access to

services, the payment of a user fee is meant to offset the high operational costs and often limits the number of survivors use such centres. The user fee together with high transport costs, especially for rural survivors, makes it difficult to visit the centres. Other negative perceptions that lead to the low use of OSC services are communities that feel OSCs are temporary and that OSCs seek to advance donor driven priorities. Usually these negative perceptions by the community arise when the community is not involved setting up the centres.

Hospital-based OSCs were found to be better equipped with the necessary infrastructure to provide comprehensive services (Khorloo 2018; More-Seytoux et al. 2010). Health-based OSCs have guaranteed medical personnel, operate 24 hours a day, have easy access for examinations and the treatment of sexual abuse related illnesses and easy access to critical services like EC, PEP and antiretrovirals (Vetten 2015). In addition to reducing the establishment costs, these advantages explain why many OSCs in low-income settings are hospital based. However, studies in Kenya and Zambia showed that sexual violence survivors shun hospital settings because of stigma related fears (Munalula & Kanyengo 2011; Undie et al. 2012), demonstrating that the existence of a OSC does not mean survivors use them. In reality, survivors have to overcome structural and cultural stigmatisation as well as economic challenges in order to benefit from these centres.

Overall, the most common weakness cited in a number of studies is poor multisectoral collaboration (Bernath & Gahongayire 2013; CARE 2013; Colombini et al. 2011; UNFPA 2010). Evidence shows that in many low-income settings there is a weak partnership with police sectors (UNFPA 2013), legal and justice services (Colombini et al. 2012) and shelter providers (Colombini et al 2017). While OSCs are designed to provide all or most of the services, studies show that in LMICs many are fragmented and the facilities are not truly one-stop (Human Rights Watch 2017; UNFPA 2013). This is because the implementation of OSCs in low-income settings face several barriers such as staff shortages, lack of basic equipment and high operating costs. With these constraints it becomes difficult for many OSCs to produce high level changes, such as improving multisectoral coordination and accessibility of services to become truly OSCs. Given the cost associated with this model in low-income settings, it is necessary to invest in models of care for survivors that are in tandem with resource constraint settings. This should be different to the Global North that have specialised staff and structures, such as sexual assault nurse examiners, which increases the cost (Colombini et al. 2017).

Concerns have been raised that investments in the OSC model with its associated establishing and operations costs may drive attention and efforts away from a broader health system-based

or traditional (non-integrated) models that do not require substantial amounts of financial resources to operate. In LMICs, OSCs may be a poor investment unless they are associated with broader efforts of system strengthening (Colombini et al. 2017). System strengthening can be a problem given the economic challenges in low-income settings and is worsened by Covid-19 and the sporadic donor disbursement of funds, which have dire consequences for continuity and sustainability (Ranchod Boezak 2013; Vetten 2015).

2.5 Laws and policies for GBV prevention

Legislation that criminalise GBV codifies the right of victims to live free from violence (Klugman 2017). The associated sanctions serve as deterrent and legislation is responsive to victims by providing protection and access to support services. The strength of national legal protection against GBV depends on how they adopt international standards in international law. Richards and Haglund (2015) show that countries that ratified the CEDAW are 23% more likely to adopt full legal protection against GBV. At the same time, countries that placed reservations on Article 2 of the CEDAW (embodying the principle of the equality of men and women) in their national constitutions, legislation or policies have weaker GBV and rape laws (Richards & Haglund 2015). As a result of the influence of international laws, Richards & Haglund (2015) conclude that there is a marked diffusion of international norms, the existence of effective policy machineries, and the presence of feminist movements to prevent GBV. This shows that the international law guides the enactment of national laws, which in turn guide the establishment of sector-specific policies to curb GBV.

Klugman (2017) analysed countries with and without domestic violence laws and concludes that the average rates of violence are lower in countries with legislation prohibiting violence (10.8% versus 16.7%). However, the relationship is not linear, and some countries with domestic violence legislation recorded high rates of violence (Batliwala 2013). Women's own attitudes towards violence, their childhood exposure to violence and the circumstances of their own marriage (early or polygamous) are not responsive to legislation and may take time to change.

In both high- and low-income settings, GBV laws vary in degree of comprehensiveness, depending on the timing of its adoption and the national dynamics of violence (Htun & Jensenius. 2020). While most comprehensive laws specify that GBV is a crime, create mechanisms to investigate and punish the perpetrators and offer resources and protection to victims, such as restraining orders, shelters, hotlines and legal assistance (Htun & Jensenius.

2020), the implementation of such laws is fraught with challenges and practice gaps, especially in LMICs. In many settings the existence of laws that criminalise GBV does not mean that people comply or that state authorities enforce them without facing challenges (Htun & Jensenius 2020; Klugman 2017). The challenge of curbing GBV is the lack of behaviour alignment with formal laws given that the letter of the law in many settings is far more progressive than the social norms and individual attitudes that condone violence.

Studies show that the problem of GBV persists across social groups and contexts, even in countries with laws to curb it (Frias 2010; Klugman 2017). An analysis of Demographic and Health Surveys in 24 countries showed that 7% of victims reported GBV to public institutions like police compared to 40% who spoke to family or friends about their experiences (Frias 2010). Underreporting of GBV to public institutions is attributed to attitudes that see violence as normal, common or as a private matter (Alaggia et al 2012), or it may be strategic as women choose to avoid emotional, financial and personal risks associated with police intervention and legal proceedings (Dobbin & Kalev 2016). In many settings women who report may incur costs, including disbelief, demeaning treatment by the authorities, retaliation, and ostracism by family members. In high-income countries, reporting have increased but the conviction rates have gone down and these high attrition rates demonstrate the reporting risks faced by women (Frias 2010).

In many patriarchal societies there are two legal system of justice, the formal and the traditional justice system. In the context of GBV prevention, the traditional justice system is respected, accessible and emphasise mediation for addressing violence, even when the life of the victim is at risk (Jayachandran 2014). The formal justice system emphasises the need to protect human rights and is based on the criminal justice paradigm; however, while the formal justice system offers redress in case of violence, many women face barriers accessing it (Jayachandran 2014). Bannister (2014) shows that while South Africa has enacted numerous pieces of legislation to provide health care services to abused women, the legislative framework is plagued by implementation challenges and gaps. Despite the DVA 116 of 1998 recognising that victims of GBV are the most vulnerable members in the community, it is silent on the role of the Department of Health. This omission is problematic as health workers are often ideally situated to help victims first (Montero et al. 2012). According to Bannister (2014), training police and health workers to handle GBV issues and introducing a system of accountability in the two sectors are key to enable victims to access services and to bridge the gap between policy implementation and practice.

Even elaborate legislation cannot engineer social change. Curbing GBV requires attention to beliefs and norms as well as power asymmetries that render women vulnerable to abuse. Access to resources, land, jobs, and social support to contest and exit from violence and harassment constitute a strong structural foundation for empowering GBV victims and GBV prevention (Htun & Jensenius 2020). Women empowerment through socioeconomic policies that improve their livelihoods and enable them to combine mothering and wage work are key to ending violence (Htun & Jensenius 2020). Reforming discriminatory traditional laws that subordinate women in many settings creates a conducive environment for the effective implementation of existing laws. Strategies that are proactive should be prioritised to compliment the challenges of emphasising using the legislation and promoting human rights. A number of countries now have laws and policies to curb GBV. Major obstacles to effectiveness include lack of awareness, low probability of conviction of perpetrators, and in some countries, the coexistence of customary and religious laws that are not compatible with legislative prohibitions (Htun & Jensenius 2020; Klugman 2017).

2.6 Protection, care and support

Despite the growing acceptance of the notion that GBV can be prevented in LMICs, this type of violence has been largely addressed through responsive interventions such as crisis services, law enforcement interventions and judiciary sanctions (KPMG 2016). The protection, care and support level of services enable victims to regain self-reliance and optimal social functioning by integrating them with family and community life after separation (KPMG 2016). This include, but are not limited to, medical services, counselling, provision of temporary accommodation, isolation of the perpetrator, income generating projects and skills acquisition to better livelihoods.

Despite the weaknesses inherent in stand-alone institutions like the police and health sectors in providing services, these sectors continue to be at the centre of care and support services (Bernath & Gahongayire 2013). Studies in Zambia, Zimbabwe and Kenya show that the health sector through primary health centres provide medication services like PEP and EC to prevent HIV transmission and pregnancy (Chireshe 2015; Keesbury et al. 2012). On the other hand, the police provide legal services through victim-friendly units (VFUs) as a means to protect victims from further abuse. Evidence shows that in LMICs the police use gender desks or VFUs to effectively provide support and care services to GBV victims, leading to increased reporting and disclosure (Keesbury et al. 2012). In South Africa, a study shows that victim-friendly

services are essential to ensuring that victims of GBV are informed of their rights, their role in the criminal justice process and are able to heal and recover (Thorpe et al 2015). However, shortages of victim-friendly rooms at police stations and poor referral mechanisms between government departments are some of the challenges that constrain service delivery (Thorpe et al. 2015).

Previous research shows that police stations are often the first and only point of contact for victims of rape in LMICs (Medie 2015). In response to this, a model involving the provision of EC by police to survivors of rape followed by a referral to a health facility for comprehensive care proved to be effective in Malawi (Population Council 2014). In Zambia, police providing PEP showed that with training police are able to administer a three day starter pack before referring the victim to the health facility for comprehensive care for sexual violence (Population Council 2014). The innovation proved handy as EC and PEP are time sensitive remedies.

Acknowledging that schools, from primary to higher educational institutions, are sites for normative change, school-based programmes in LMICs are designed to prevent SRGBV as well as provide relevant care and support to victims (Kennedy 2021; Sida 2015). In Jamaica, specific interventions like violence prevention programmes, a national safe school programme and a behavioural modification programme are geared towards achieving gender equity and resocialisation of student to enable boys and girls to coexist in a peaceful and non-threatening environment (Kennedy 2021). Stop Violence Against Girls in Schools (SVAGS) was implemented in Kenya, Ghana and Mozambique from 2008 to 2013, and the results showed that it was effective in reducing violence against girls (Parkes & Heslop 2011). A study in South Africa show that the Department of Basic Education provides programmes (e.g. PREPARE) that contribute to gender empowerment, prevention of rape and child assault, bullying and child pornography, among others (Medical Research Council 2013; Nagia-Luddy & Mathews 2011). Collectively the programmes aim to break the cycle of violence in schools through the provision of culturally relevant programmes and services. Breaking the cycle of violence creates an environment that is safe and supportive for learning.

In schools, the reporting of various forms of SRGBV opens up avenues for victims to receive vital services. Furthermore, reporting mechanisms are critical for holding perpetrators accountable for their actions and ensuring they cannot do more harm to students (UNESCO 2014). In Kenya, students use the national child line (116) to report teachers who abuse them, and happiness and sadness boxes have improved child reporting of violence. In the Democratic

Republic of Congo, male and female teachers are trained to be focal points and the reporting of SRGBV increased significantly (Alinane Consulting 2010; UNICEF 2014). However, another study in Africa found that girls in particular rarely report violence because of social and cultural norms that condone violence, not trusting the reporting mechanism, victimisation and ridicule, among others (Parkes & Heslop 2011; Leach et al 2014). This contributes to the invisibility of the problem.

Giving advice and emotional support to victims of SRGBV help them to overcome psychological problems. In LMICs, strategies for providing counselling and victim support range from training teachers as guardians or mentors to provide advice, and in Tanzania and Jamaica, training teachers as counsellors. In Ghana and Malawi, the Doorways training programme trains volunteer village leaders, school staff and individuals from the parent-teacher associations in basic listening skills, children's rights and responsibilities and methods to prevent, respond to and report SRGBV incidents (UNESCO & UN Women 2016). In situations where schools cannot provide services, students are referred to appropriate services. In the Democratic Republic of Congo, focal teachers are trained as first respondents to help students experiencing SRGBV, and then they refer them to institutions that provide legal, health and psychosocial services (Leach et al. 2013). Counselling and emotional support contribute to efforts to address violence-related trauma. Long-term therapeutic services for children are critical for the prevention of experiencing and perpetrating GBV, and evidence shows that this is in its infancy in LMICs (Nagia-Luddy & Mathews 2011).

In essence, school-based programmes target and modify social norms and gender role attitudes before they are internalised by young people. Both boys and girls are prone to subscribe to rigid gender roles, which put them at risk of being victims and perpetrators of GBV (Reyes et al. 2016). Thus, targeting young people is important to discontinue patterns of gender inequality and violence since it can be transmitted from one generation to another.

In the continuum of protection and support of victims of GBV, victim empowerment programmes demonstrate a shift from the response focused model to a prevention focused model. In South Africa, victim empowerment programmes seek to enhance service delivery and training through shelter provision, court preparation services, awareness and education programmes, psychosocial services and life skills programmes (KPMG 2016). Studies in Pakistan and Sierra Leone show that economic interventions improve the socioeconomic conditions of GBV victims (Hiran et al. 2010; Kohli et al. 2013). Economic independence is identified as a protective factor for experiencing GBV (Eldoseri & Sharp 2017).

Prior to Covid-19, African countries faced a well-documented epidemic of GBV and the situation was dire for sub-Saharan Africa (Fleming et al. 2015; Muluneh et al. 2020). Cognizant of lockdowns' potential exacerbation of the existing GBV crisis, many countries moved quickly to adopt GBV resources to better serve victims of GBV during the unprecedented times. In South Africa, measures to mobilise virtual resources like 24 hour hotlines for domestic violence and rape, the provision of virtual support via Skype, Please Call Me SMS message services, telephone counselling and shelter referrals for victims were vital to the response (Adonis & Lopez 2020). Thuthuzela Care Centres and GBV shelters were classified as essential services to allow for the continued provision of care and support services (Nicolson 2020). Thuthuzela Care Centres in South Africa are one-stop sexual assault centres that aim to both aid in the conviction of sexual offenders and to expand physical, psychological and social care to victims of GBV (Bougard & Booyens 2015). Overall, the results show that victims faced barriers to access the services due to Covid-19 challenges as well as existing pre-Covid-19 deficiencies in South Africa's GBV service delivery.

2.7 Political will

Political will, defined as the degree to which political leaders actively give attention to an issue (in this case GBV) and back up that attention with financial, technical and human resources, is critical for an effective response to GBV (Makoe et al. 2012). Adequate provision and efficient use of funds are critical to effectively address GBV, especially in the context of competing demands for limited government funds (KPMG 2016). Financial resources aid GBV responses by making it possible to purchase medical consumables like PEP and EC drugs, establish infrastructure, sustain institutional governance and implement new legislation. In South Africa, research by IMC (2013) note that there are inadequate financial resources to ensure the full implementation of GBV laws and policies and to monitor their enforcement. Furthermore, GBV Acts, policies and plans are not costed, resulting in inadequate funding for prevention and response services. In many settings in LMICs limited funds are not used effectively to ensure adequate coverage of essential services because of corruption and deviation of funds (Budlender et al. 2011; Chirenje 2015). The situation is dire in rural areas.

Within the context of limited financial resources, the optimisation of funding allocation at programme level relies on a comparison of the known impacts of different interventions (KPMG 2016). The limited evaluations of many programmes in LMICs means there is little evidence of their impact to facilitate limited funds prioritisation (UN Women 2013b). As a

result, many governments in LMICs fail to recognise the saving potential and return of investment that can be achieved by investing in prevention programmes. A sustained body of evidence suggests that preventing and reducing incidences of GBV reduce the cost of health care, criminal justice and public services (Fergus 2013; WHO 2010). For example, the cost involved in prevention and early intervention services are less than those required for investigation cases of violence, the treatment of victims and removing victims from their homes in the short to medium terms. Overall a lack of investment in prevention initiatives misses a crucial opportunity to reduce the required funds for response services.

Another key component of political will that is vital for GBV prevention and response is human capacity. This is defined as the skills, expertise, training and dedicated roles to the response to GBV across all levels, including those of service delivery, management and governance (KPMG 2016). Victims of GBV have special needs that require special services that can only be rendered by specialists in the field. For effective service delivery, the optimum number of workers together with their expertise in sectors that deal with GBV is vital. However, sustained evidence in LMICs shows that institutions dealing with GBV are characterised by a shortage of qualified, skilled staff, that there are limited education centres providing specialist training, and that there is a lack of in-house training courses, overall staff shortages and high attrition rates (Chirenje 2015; KPMG 2016; Makoae et al. 2012).

In South Africa, the Department of Health reported shortages of forensic medical practitioners, which leads to delays in dealing with sexual offences. In Zimbabwe, high attrition rates of staff in the health sector is due to the persistent economic challenges that contribute to low morale and the eventual decision to leave for greener pastures (Chirenje 2015). Shortages in the work force impact heavily on the provision of prevention and early intervention services, creating a vicious cycle of increased demand for care and support services. In South Africa, Martin (2010) observe that lack of human resources force social workers to prioritise the most urgent cases, neglecting prevention and early intervention and leading to increased numbers of children requiring protection, and thus, further reducing capacity. The challenge for many countries in the Global South is that increasing human capacity in sectors dealing with GBV requires a similar increase in the budget. In LMICs strategies to address workforce supply gaps are critical to break the vicious cycle of increasing demand as staff prioritises urgent cases and deprioritises prevention, which ultimately increases the number of victims. Psychological support to workers are necessary to create professional sectors that deal with GBV because dealing with sexual violence cases is traumatic (Bhaskaran & Seshadri 2016).

2.8 Multisectoral collaboration

GBV is rooted in complex structural and sociocultural factors such as social and cultural norms, gender inequalities and power dynamics (Sida 2015). As such, efforts to prevent and respond to this type of violence require a comprehensive, multisectoral approach in which sectors such as health services, social services, law enforcement, security forces, gender ministries and child protection institutions collaborate. Such an inter-institutional framework has the ability to cover an extensive list of the primary and immediate needs of GBV victims (UNFPA 2015). The needs that arise as a result of GBV require social reaction, whose legitimate and qualified promoters are government, institutions and civil society (UNFPA 2015). To this end, any strategy meant to design an effective mechanism to respond to GBV should be based on interinstitutional cooperation and partnership. Addressing GBV through a multisectoral collaboration involves coordinating various sectors over multiple timeframes and at multiple levels. For example, in Côte d'Ivoire the Ministries of National Education and Technical Education established a framework for the coordination and monitoring of child protection strategies (UNESCO 2015); and in Guatemala, a ministerial accord between the Ministries of Health and Education aim to facilitate the designing and implementation of sex education (Hunt et al. 2014). These collaborations are meant to meet the diverse needs of GBV victims.

Outsourcing services to civil society organisations (CSOs) is a model consistent with the strategy many governments are taking across the world since CSOs have unique knowledge bases in the specific areas they are engaged in (KPMG 2016; Thorpe et al. 2015). In LMICs, the non-profit sector plays a major role in providing support to victims of violence as well as for wider advocacy and raising awareness. In South Africa, it is estimated that 60% of social services for victims (girls and women) are provided via civil society (Bhana et al. 2012). Social services such as shelter are key in isolating the victim from the perpetrator while counselling address the traumatic experiences of victims. Many CSOs are located within the community and those that work directly with victims have valuable experiences and add important dimensions to the development and implementation of policy programmes (Thorpe et al. 2015). In addition, CSOs contribute to the development of context-specific interventions as their work can be highly localised.

For victims to benefit fully from the collaboration of different sectors, many governments in the world are using network integration, resource sharing and reform arrangements to create a more coordinated and stable service delivery system (KPMG International 2013). However,

these innovations are still facing challenges in LMICs. In South Africa, as in many LMICs, collaboration with the non-profit sector remains fragmented, uncoordinated and in need of reform (KPMG 2016). While the DVA in South Africa provides for the establishment of shelters for victims of GBV, it does not provide clarity on who is responsible for the establishment of the shelters. In LMICs, many departmental plans discuss civil society consultation and participation with a view to coordinate service delivery but these strategies face implementation challenges (Thorpe et al. 2015). In Zimbabwe, there is mistrust between government and the CSOs as these are perceived to project the political agendas of the opposition political parties (Chirenje 2015). In the end, GBV victims are faced with poor service delivery.

In addition to collaboration efforts, community mobilisation is a strategy that has proved to be effective in curbing GBV (Abramsky et al. 2014; Michau et al. 2015; Nair et al. 2020; Shai & Sikweyiya 2015). Community mobilisation is a participatory and holistic process in which communities challenge the broader social and institutional structures that undermine collective efforts to prevent GBV (Mannell & Dadswell 2017). Community members are mobilised to use their knowledge of social inequalities and vulnerability to construct a community identity, recognise structural reasons for GBV and take control of their life (Campbell et al. 2010; Campbell & Cornish 2010). Community-based interventions fall into two categories: The training to enable the victims and perpetrators to prevent violence or stop it; and wider community mobilisation to challenge norms and practices that perpetuate gender inequalities and abet GBV (Minckas et al. 2020). Using diverse strategies such as group-based dialogue, problem-solving and advocacy campaigns, some community-based interventions have succeeded in reducing violence (Abramsky et al. 2014; Wagman et al. 2015). These interventions include SASA!, developed by Raising Voices (Uganda) and Stepping Stone (South Africa) that were designed to improve sexual health through participatory learning and enforcing critical reflections on issues discussed (Abramsky et al. 2014).

Given the complex and deeply rooted risk factors of GBV in cultural norms, community participation in group activities is said to help promote critical thinking about the underlying inequalities between men and women; thereby encouraging community members to transform gender norms and prevent GBV (Michau et al. 2015). However, the frequency of engaging the community is key in transforming social norms. Once off or ad hoc community activities may not have the desired results because it takes time to change rigid social norms. Cook (2012) distinguishes between authentic participation and mere involvement in community

mobilisation. Authentic participation, which is the ownership that comes with shared responsibility in the production of knowledge and improvement (Cook 2012), is key to changing social norms and reducing GBV. Authentic participation facilitates the development of collaborative partnerships between different groups to foster empowerment and build people's capacity to exercise greater agency over their wellbeing (Minckas et al. 2020). However, a number of community mobilisation strategies are characterised by mere involvement of the community to disguise the top-down implementation of externally designed programmes (Cook 2012; Cornwall & Brock 2005; Minckas et al. 2020). According to Vijayakumar (2018), the mere involvement of the community by fitting the parameters of a predetermined intervention results in reinforcing hegemonic sources of information and decreases the ownership of the programme. Therefore, it is important to have a clear conceptual understanding of the nature of the participation, especially the community's involvement in the creation of the intervention.

2.9 Conclusion

GBV remains one of the most prevalent and persistent issues facing women and girls globally. At the centre of GBV pervasiveness are gender roles and sociocultural norms. Although the causes of GBV are complex and multiple, socially constructed gender roles and social and cultural norms are the overarching root causes (Bhargava et al. 2014; Devries et al. 2014; Parkes et al 2017). Furthermore, in the context of GBV prevention, the persistence of rigid gender roles and sociocultural norms constrains GBV interventions in multiple ways. Sustained evidence shows that if traditional community support systems are not an integral component of any intervention, whether primary, secondary or tertiary, the intervention will likely not achieve the desired results (Robbers & Morgan 2017; Wirtz et al. 2016). Even if institutions like health centres and police stations that offer a variety of services are well resourced, negative perceptions about them result in many victims not visiting them for help (Colombini et al. 2012; Goodman-Delahunty 2010; Vetten 2015).

In addition, social norms interact with GBV laws, especially in settings where customary and religious laws coexist with legislation that prohibit GBV. There are marked examples where laws on the book did not significantly affect behaviour; for example, the prohibition of child marriage in Bangladesh and dowry payments in India (Klugman 2017). These practices persist alongside legislation that criminalise GBV. Social norms affect male beliefs and behaviour (e.g. whether it is acceptable to beat wives) and female beliefs and behaviour (e.g. whether it

is acceptable to be beaten) as well as police, health and education workers' attitudes about GBV. These social norms normalise GBV and negatively affect the effectiveness of intervention programmes. As a result, legal and institutional reforms without strategies to address the root cause of GBV fail to curb GBV.

Despite the pervasiveness of GBV in terms of the cause and prevention, this social challenge must be curbed. While secondary and tertiary prevention strategies are useful when institutionalised, for example, treatment at health care centres, primary prevention is the least common in terms of institutionalisation yet may hold the most potential for impacting GBV prevalence (Heise 2011). Localised prevention strategies that are owned by the community are likely to contribute significantly to reduced rates of GBV prevalence. However, in many settings community mobilisation is not defined by authentic participation, which guarantee ownership of prevention programmes (Cook 2012).

Collectively, the evidence suggests that programmes that cut across and collaborate with multiple sectors, involve multiple stakeholders, and challenge the acceptability of violence in the community are promising for curbing GBV. While best practices and innovation exist, the overall response of the GBV sector would benefit from improved collaboration and integration to have a greater impact (KPMG 2016). This is true for strategic level collaboration and service level integration between government departments and civil society, who provide most of the services for victims of GBV in many settings. A lack of multisectoral collaboration can put victims of GBV at risk.

LMICs have adopted OSCs, and the discussion showed that there are challenges implementing the model, which include lack of collaboration between sectors, lack of standard operating procedures, high operating costs, negative perception about the OSCs, inadequate service provision, a bias in location (most are in urban areas), and staff shortages. Without a framework to strengthen service delivery within OSCs, it may be a poor investment for low-income settings that may drive efforts away from the traditional set-up that deal with GBV (Colombini et al. 2017). A cost-benefit analysis multisectoral approach to the prevention of GBV is better positioned to curb this type of violence than the traditional model where isolated providers deliver different sets of services. However, the OSC model is still in its infancy in LMICs, and stand-alone sectors are responsible for most of the care and support services.

Many governments in LMICs have made significant efforts to keep GBV services available during Covid-19 lockdowns when those at risk had more challenges to access services and

escape violence. However, many victims failed to access online services due to pre-Covid-19 deficiencies in the delivery systems. Being in the same environment with the perpetrators, the victims needed to overcome social, cultural and economic barriers to access online services and secure safety. The global pattern is that lockdowns are easing and Covid-19-related food insecurity and economic instability, both of which are risk factors of GBV, remain prevalent (Hatcher et al. 2019).

Political will to address GBV is critical to ensure this type of violence is prioritised as a departmental, provincial and national concern. It can be measured by sufficient power, status, knowledge and influence to champion the GBV agenda. This is done by availing financial resources to build infrastructure, buy medical equipment and build human capacity. However, in many LMICs there is a perception of political reluctance and weaknesses to drive responses to GBV. Studies show that political leaders are often unwilling to invest beyond their political term in long-term prevention programmes that normally yield results in GBV prevention (Makoae et al. 2012). Political leaders are at the centre of GBV prevention and response services as they are responsible for creating a conducive environment through legislation, implementation, facilitating collaboration as well as by engaging civil society, which have both the resources and the expertise to deal with GBV.

Chapter 3: Methodology

3.1 Introduction

This chapter presents the study's methodology and focuses on the philosophical underpinnings of researching GBV, the research design, the data sources, the data analysis methods as well as the justification of these choices. The validity and reliability of the data and the ethical considerations are also discussed.

3.2 Philosophical underpinnings of researching GBV

Easterby-Smith et al. (2012) define ontology as philosophical assumptions about the nature of reality. It has to do with the way things really are and how they work, such as how to understand and respond to GBV, which has multiple causes and dimensions. Ontology refers to “the way the social world and social phenomena or entities that make it up are viewed” (Matthews & Ross 2010:24). This means that people who experience it best understand the reality of GBV, and that those researching GBV may have a subjective way of interpreting the realities that constitute this type of violence, its meaning and its causes.

The critical emancipatory paradigm is premised on the fact that women who experience GBV are capable of informing researchers about their experiences and that research on this type of violence may help to promote concrete improvements for GBV survivors in terms of policies and practices (Denzin & Lincoln 2005; Katz 2015). These assumptions posit that the critical emancipatory paradigm has a materialist-realist ontology, which means that there is one single reality and that reality is shaped by economic, social, and political inequalities that make a material difference to people's lives. The material differences culminate in unequal power relations between men and women, which precipitates GBV. The material, realist ontology of the critical, emancipatory paradigm is suitable to research GBV issues as it promotes the premise that participants' narratives of GBV are real. Based on this, the researcher's role was to objectively represent material from the document analysis, and during interviews and focus group discussions (FGDs), the researcher facilitated the discussions without influencing the outcomes (Bowen 2006).

3.3 Research design

The study adopted the mixed methods research design, which is defined as “ the collection or analysis of both quantitative and qualitative data in a single study in which the data are collected concurrently or sequentially, are given a priority and involve the integration of data at one or more stages in the process of research” (Creswell 2003:12). Quantitative research entails “the collection of numerical data, a deductive view of relationship between theory and research, a preference for a natural science approach and for positivism in particular and an objectivist conception of social reality” (Bryman 2015:149). A quantitative design provides knowledge for practice in a way that is measurable and can be replicated, and this provides the basis for validity. The positivist approach on which this design is grounded emphasises predicting empirical relationships (Creswell 2009). Qualitative research, on the other hand, is concerned with understanding the processes and the social and cultural contexts that shape various behavioural patterns (Almeida 2018). It does this by allowing the researcher to delve deeper into discovering what people think and feel and how they cope with particular experiences (Almalki 2016).

The use of both quantitative and qualitative research techniques in this study was motivated by the following factors: Increased recognition of using mixed methods research in social sciences; understanding that validity can be increased by incorporating multiple methods; tapping multiple traits of the phenomenon being studied; the strength of the mixed methods research design that lies in its diversity and the triangulation strategies that are used; and the notion that mixed methods research provides better inferences and minimises uni-method bias (Creswell 2013; Denscombe 2010). The study specifically undertook the sequential explanatory approach where a quantitative component is followed by a qualitative phase (Creswell 2013). In so doing, qualitative data was used to explain, expand and complement the patterns that emerged from the quantitative analysis.

3.4 Data sources

3.4.1 Quantitative data

The quantitative component of the study aimed to achieve the study’s first specific objective, which was to identify the risk factors of GBV in Zimbabwe within the ecological framework. To do this, the study drew on secondary data from the 2015 ZDHS, which was the most recent at the time of the study. As already discussed in Section 1.4, Demographic Health Surveys

provide nationally representative and internationally comparative household- and individual-level data on a wide range population health and nutrition issues, with a specific focus on women of reproductive age (15–49 years). Thus, a limitation of this study is that it was not possible to do an analysis on women beyond this age bracket as their data is unavailable.

Sampling frame

The sampling frame used for the 2015 ZDHS was based on the 2012 Zimbabwe Population Census, which was demarcated into enumeration areas (EAs) (ZIMSTAT & ICF 2016). The focus was on the distribution of households whose distribution is the same as that of the population. In Zimbabwe, population distribution is 33.1% urban and 66.9% rural. In terms of households, 35.9% live in urban areas and 64.1% live in rural areas (ZIMSTAT & ICF 2016). In both urban and rural areas the average size of each EA was about 101 households. This is deemed an adequate size for the primary sampling unit.

Sample size determination

The sample for the 2015 ZDHS was stratified and selected in two stages from the sampling frame. To achieve stratification, each of the ten provinces in Zimbabwe were divided into urban and rural areas to generate 19 sampling strata (ZIMSTAT & ICF 2016). There were 19 sampling strata instead of 20 because Bulawayo, the country's second major city, does not have a rural component. A two stage selection process was employed to select the sample. Using a probability proportional to size selection procedure, 400 EAs were selected and the size was the number of households. A household listing operation was conducted that consisted of visiting each of the 400 selected EAs and recording on the household listing form all the details of the household (ZIMSTAT & ICF 2016). The listing of households served as the sampling frame that ensured the selection of households in the second stage. For EAs with more than 200 households, a segment was selected for the survey using a proportion. Thus, a 2015 ZDHS cluster was either an EA or a segment of an EA.

For the second stage, households were systematically selected for participation in the survey so that sample members for the large population of the households were selected using a random starting point and a fixed period interval (Oladepo et al. 2011). Twenty eight households were selected from every EA by an equal probability systematic sampling based on the household listing. Probability sampling is defined as sampling in which units are selected with known and unknown probabilities (Izugbara 2018). A sample of 28 households per EA

that have an average of 101 households constitute more than 10% of the households, which is the minimum required to generate validity (Izugbara 2018). Table 3.1 shows that a total of 11 200 households were selected.

Table 3.1: Sample allocation of clusters and households by province and residence, ZDHS 2015

Province	Allocation of clusters			Allocation of households		
	Urban	Rural	Total	Urban	Rural	Total
Manicaland	14	30	44	392	840	1,232
Mashonaland Central	9	31	40	252	868	1,120
Mashonaland East	12	29	41	336	812	1,148
Mashonaland West	15	26	41	420	728	1,148
Matabeleland North	10	26	36	280	728	1,008
Matabeleland South	11	25	36	308	700	1,008
Midlands	16	25	41	448	700	1,148
Masvingo	12	30	42	336	840	1,176
Harare	32	12	44	896	336	1,232
Bulawayo	35	0	35	980	0	980
Zimbabwe	166	234	400	4,648	6,552	11,200

Source: ZIMSTAT & ICF 2016:355

Data were gathered from the pre-selected household members. Only one member aged 15–49 was interviewed per household. The women’s response rates were 90.3% in urban areas and 95.2% in rural areas.

Measurement tools

The 2015 ZDHS questionnaire included a domestic violence module to collect GBV data, and it asked a series of questions on the following aspects of domestic and interpersonal violence:

- i. Women’s experiences of acts of physical and sexual violence;
- ii. Spousal violence or IPV;
- iii. Violence by other family members or unrelated individuals;
- iv. Experiences of ever-married women (widowed, separated, divorced) with regards to spousal emotional, physical, and sexual violence at any time in their lives and in the past 12 months;
- v. The physical consequences of the violence;
- vi. When the violence first began in relationships; and
- vii. Women’s perpetration of spousal violence.

For its purpose, this study used questions of aspects (i)–(iv) to explore GBV, which is the outcome variable, the predicted or the dependent variable (Izugbara 2018). The questionnaire solicited information on age, education, media exposure, marriage and sexual activity, women’s work, husbands’ characteristics, poverty and place of residence, which interact to

expose women to GBV. In line with the ecological model, these variables can be grouped into individual level (age, employment, education), relationship level (marital status, husband's characteristics), and community level (place of residence). These variables are also called background variables or predictor variables (Izugbara 2018). Selected risk factors at the individual, relationship, community and societal levels are shown in Table 3.2. The selection of the variables in the table was based on their availability in the ZDHS.

Table 3.2: Risk factor variables examined from the 2015 ZDHS

Level	Variable
Individual	Woman's age; woman's employment status; woman's educational attainment; whether woman's father beat her mother; husband/partner's educational attainment; husband/ partner's alcohol consumption
Relationship	Marital status; spousal age difference; spousal educational difference
Community	Place of residence (rural/urban); religion; number of reasons for which wife beating is justified
Society	Wealth quintile; number of marital control behaviours displayed by husband/partner; number of decisions in which woman participates

It is noteworthy that the 2015 ZDHS was preceded by similar surveys in 2005/2006 and 2010/2011. To contextualise the findings of this study, published data from the previous surveys' domestic violence modules were used to briefly present the levels and trends of GBV in Zimbabwe since 2005.

3.4.2 Qualitative data

The qualitative component of the study aimed to achieve the study's second and third specific objectives. The second objective was to review institutional responses to GBV in the justice, health and education sectors, and the third objective was to explore service providers' and other key stakeholders' perceptions of the strengths and weaknesses of institutional responses aimed at addressing GBV. Data for the qualitative component of the study were derived from a document review and through primary data collection.

Document review

This entailed a brief review of the key tenets of relevant international, regional and national legislative instruments and policy documents related to GBV. The aim of the review was to obtain an understanding of the current frameworks for commitment, policy, and implementation of interventions aimed at addressing GBV in Zimbabwe in general and the

three sectors of focus in particular. A list of the reviewed instruments and documents is presented in Table 3.3 and a brief overview of their key tenets is presented in Appendix A.

Table 3.3: Legislative and policy documents reviewed

International The United Nations Universal Declaration of Human Rights (1948) The United Nations Convention on the Rights of the Child (1990) The Beijing Declaration and Platform of Action The Agenda 2030 for Sustainable Development CEDAW 1979 CEDAW General Recommendation 24, 33 and 36
Regional The African Charter on Human Rights (ACHR 1981) The Maputo Protocol (2003)
Sub-regional The SADC Regional Strategy and Framework of Action for Addressing Gender Based Violence (2018–2030) The SADC Protocol on Gender and Development (2008) The SADC Gender Policy (2007)
National Constitution of the Republic of Zimbabwe (Amendment No. 20), 2013 The Domestic Violence Act, 2007 (DVA Chapter 5:16) The Sexual offenses Act 2002 Legal Age of Majority Act 1982 Marriage Act (Chapter 5:11) 1987 The Maintenance Act 1989 Children’s Act 2001 The Zimbabwe National Gender Strategy (2012–2015) The Protocol on the Multi Sectoral Management of Sexual Abuse in Zimbabwe (2012)

Primary data collection

Primary data were collected between April and September 2018 in Mt Darwin and Shamva districts in Zimbabwe’s Mashonaland Central province (see Figure 3.1).

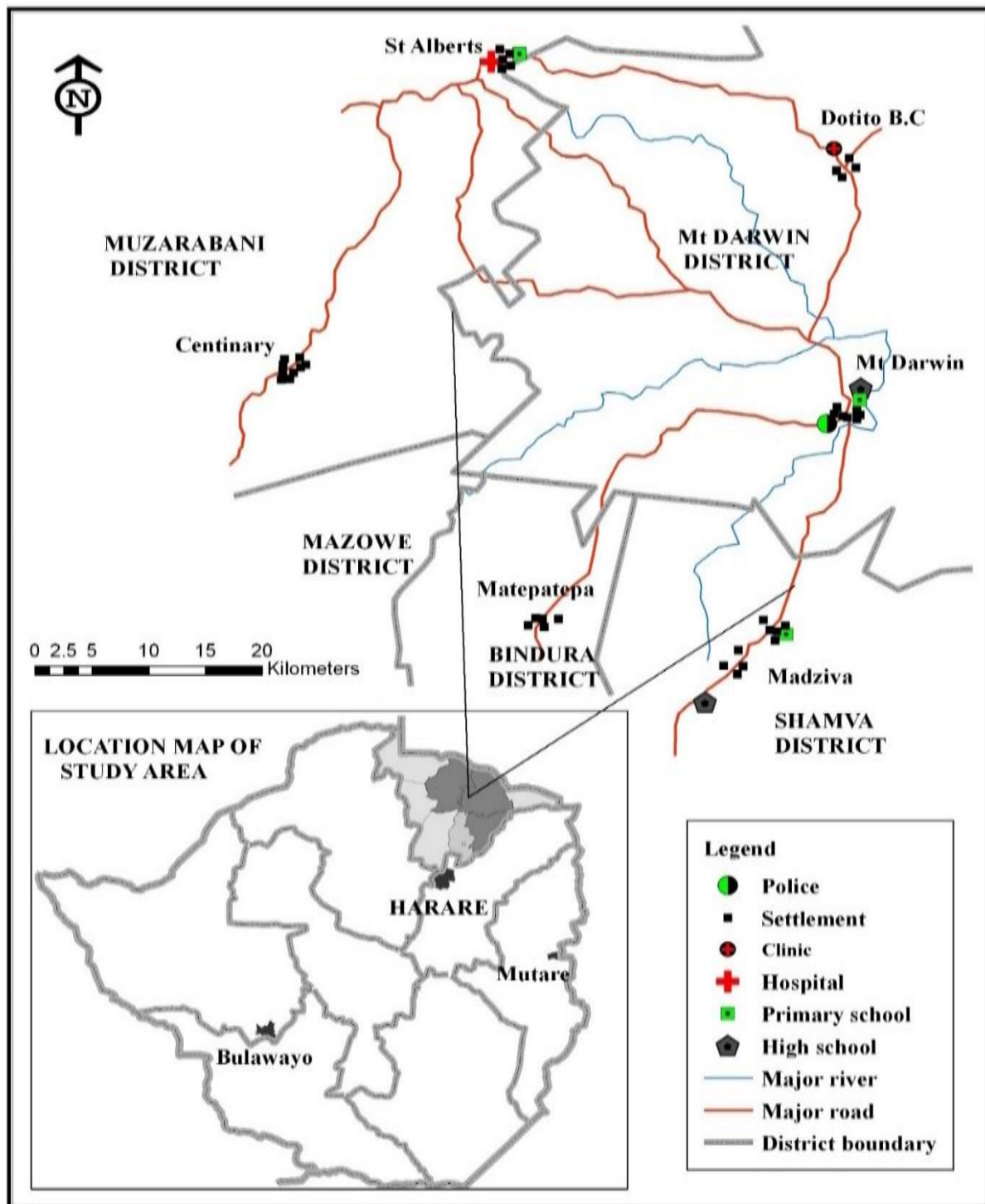


Figure 3.1: Location of study area

Source: Primary data

More details on the study areas, the study participants, and the data collection methods are presented in the following subsections.

Study areas

Located about 60 km east of Bindura (the provincial capital city of Mashonaland Central province), Mt Darwin is a rural area with a population of just over 210 000 people. Shamva is located 27 km north east of Bindura. It is also a rural district with a population of approximately 120 000 (ZIMSTAT & ICF 2012b). The choice of these two districts as research sites for the study hinged on the reportedly high prevalence of GBV in the province. According to the ZDHS (2015), the percentage of women who reported having experienced physical and sexual violence in their lifetime increased from 29.9% to 34.8% between 2010 and 2015 in the Mashonaland Central province, making it the highest provincial increase during that period. These two locations also have characteristics that are often associated with high prevalence of GBV, such as that it is predominantly (94%) rural (ZIMSTAT & ICF 2012b) and are mainly inhabited by the Doma, the only traditional hunter-gatherers indigenous to Zimbabwe, and the Korekore people, Shona speaking people, living in the northern part of Zimbabwe, who continue to practice entrenched traditional patriarchal sociocultural norms. Patriarchal communities are often characterised by the subordination of women and children, rigid cultural norms and values as well as hegemonic masculinity, all of which has the potential to precipitate GBV (Heise 2011; Leatherman 2011; Mootz et al. 2017).

The study areas were also selected based on the following existing interventions implemented by a number of organisations to address GBV in the province:

- **The Campaign for Female Education (CAMFED):** An international non-profit organisation tackling poverty and inequality by supporting girl children to go to school and empowering young women to step up as agents of change. This organisation is located in Mt Darwin where they offer, among other things, counselling services to GBV victims; treatment for sexually transmitted infections to young people (including those in school); and programmes promoting drug-free and sexually responsible lives among the youth.
- **ChildLine:** An international organisation with the mission to protect abused and neglected children in society. This organisation has offices at St Albert's rural health institution, a Roman Catholic referral hospital in Mt Darwin District, and at Madziva business centre in Shamva District. It offers a safe home to victims of GBV, especially children.

- **Mavambo:** An NGO that pays school fees for disadvantaged children as well as provide loans to young mothers is also found in both Mt Darwin and Shamva districts.
- **The Zimbabwe Catholic Bishops Conference (ZCBC):** It has a programme to protect children from abuse in the province. Running under the theme ‘Lets promote safety for children and avoid ABUSE’, the ZCBC has taken steps to empower teachers and nurses in Catholic institutions to protect children’s rights and reduce all forms of violence, including GBV. ZCBC trains teachers and nurses in the Catholic schools and hospitals respectively to identify GBV, to offer counselling services and to do referrals when necessary. The ZCBC is based in Mt Darwin at St Alberts Mission Hospital and it operates in the whole province.
- **Musasa Project:** A NGO that assists women who have experienced GBV. The organisation was included in the study to factor in the role of the ‘missing middle’ (Unterhalter 2013) in aiding the translation of policy into action in the three sectors. The ‘missing middle’ relates to NGOs whose role is to advocate for policy formulation and implementation in a manner that benefit the people who may be abused by government. The Musasa Project specifically promotes the safety of women after they experienced GBV and empowers them to reduce their vulnerability to this type of violence. All this is done in a number of ways, such as providing support through psychosocial counselling, legal advice and temporary shelter to women who have been banished from home by their partners or whose lives are in danger from violent perpetrators. Furthermore, the NGO promotes the dissemination of GBV information to the community and advocates for policy change to create a GBV-free environment in both rural and urban communities. Ultimately, their goal is to enable women to be economically independent as this has been found to reduce GBV in many communities. The number of women seeking support from the project is evidently on the increase. For example, the organisation used to counsel 150 women per month in 2008, and in 2018 this had increased to more than 350 women (Musasa Project 2018). Their head office is in Harare, and the organisation has officers based in every province in Zimbabwe, and for the purpose of this study, the Mt Darwin office was a research site.

With regards to the different sectors under study, the following were the specific research sites in the two districts.

Health sector

Two study sites were selected to carry out the primary data collection for the health sector. These were Dotito clinic and St Albert's rural hospital in Mt Darwin District. The latter is run by the Roman Catholic Church, and Dotito clinic is a government-run health centre. The purpose of having these two differently run health centres was to compare the ways in which they address GBV, given that private and church-run institutions are typically better resourced than government institutions, and this has a bearing on the implementation of laws and policies governing GBV. Although there is a health facility in Shamva District (Madziva Clinic), this was not included as a study site as it is located in a peri-urban area and thus does not fall under the scope of the study.

Justice sector

With regard to the justice sector, the Mt Darwin police and Dotito police stations were chosen as the study sites because they have operational VFUs. VFUs (discussed in detail in Chapter 4) is a special department at a police station that deals with GBV cases and offers a safe environment for survivors and witnesses in cases involving GBV. Police officers in VFUs are trained to handle GBV victims as well as to refer them to relevant service providers for further assistance and protection.

Education sector

Four schools (two primary and two secondary) were selected as study sites for the education sector. The primary school in Shamva was the government-run Madziva Primary school, and the secondary school was Bradley Institute run by the Salvation Army, a Christian church and an international charitable organisation¹. In Mt Darwin, the government-run Mt Darwin high school was the secondary school, and the primary school was St Albert's primary school run by the Roman Catholic school. As in the health sector, the purpose of including two sets of differently run schools was to compare their effectiveness in addressing GBV, given that church-run schools in Zimbabwe are generally better resourced.

¹ <https://www.salvationarmy.org.za/mission/>

Study participants

Purposive sampling, the intentional selection of informants based on their ability to elucidate a specific theme, concept or phenomenon (Robinson 2014), was used to select members who participated in both key informant interviews and FGDs in the justice, education and health sectors. Therefore, all the participants in the interviews and discussions were knowledgeable about GBV as either key informants or people who have experienced this type of violence. Purposive sampling is a type of non-probability sampling in which in most cases is not backed up by the statistical theory of inference as it is in probability sampling. The study employed purposive sampling based on Schutt's (2006) suggestion that in a qualitative approach purposive sampling involves an interactive process of selecting research subjects instead of starting with a predetermined sampling frame.

Methods of data collection

Two methods of data collection were used in the qualitative component of the study, namely key informant interviews and FGDs. All interviews and discussions were conducted in Shona, the vernacular in the study areas and/or English, especially among the key informants. With the consent of the respondents, all the interviews and discussions were audio recorded. Each data collection methods is discussed in detail in the following subsections.

Key informant interviews

Key informants can be described as people who have in-depth knowledge and understanding and can provide insights about the operations of the broader system (UCLA Centre For Health Policy Research, n.d.). Table 3.4 shows the 19 key informants who were interviewed for this study.

Table 3.4: Key informants interviewed

Justice sector	Health sector	Education sector	Community
• District police officer, Mt Darwin Police (1) • Head of VFU, Mt Darwin Police (1) • Member in charge, Dotito Police Station (1) • Head of VFU, Dotito Police Station (1)	• Nurse in charge, Dotito clinic (1) • Nurse in charge, St Alberts (1)	• Head teachers, Madziva and St Alberts primary schools (2) • Head teachers, Mt Darwin and Bradley secondary schools (2) • Life skills (or equivalent) teachers, Madziva and St Alberts primary schools (2)	• Manager, Musasa Project (1) • Gender officer, Musasa Project (1) • Programme officers, Mavambo, Leonard Cheshire Trust, ZCBC (3)

Justice sector	Health sector	Education sector	Community
		Life skills (or equivalent) teachers, Mt Darwin and Bradley secondary schools (2)	
Total: 4	Total: 2	Total: 8	Total: 5

The key informants were purposively selected and recruited based on their job description, length of time in the position, and where possible, training in GBV issues. Upon arrival at each institution shown in Table 3.4, the researcher was introduced to the head who later introduced the participants to the researcher. For example, at the two police stations, members in charge introduced the heads of the VFUs, and at the four schools, the head teachers helped identify the life skills teachers to facilitate the interviews. Purposive sampling involves an iterative process of selecting research subjects rather than starting with a predetermined sampling frame (Schutt 2006). Owing to the need to get expert knowledge about institutional responses, a purposive sampling strategy was employed. Purposive sampling facilitates the identification of the right people to give not only relevant information about the study but also to propose solutions.

The aim of the key informant interviews was to contribute to the achievement of specific objective 3 of the study, which was to explore service providers' and key stakeholders' perceptions of the strengths and weaknesses of institutional responses aimed at addressing GBV. The interviews were conducted using a semi-structured interview guide (see Appendix B) designed to solicit key informants' views on the adequacy and effectiveness of current GBV laws and policies in their specific sectors as well as on the key strengths and weaknesses of their institutional responses in terms of institutional reforms and community mobilisation. The key informants' recommendations for addressing critical gaps in the current responses to GBV at the policy and practice levels were also sought.

Focus group discussions

FGDs are defined as “a group interview centred on a specific topic ... and facilitated and coordinated by a moderator or facilitator which seeks to generate primarily qualitative data capitalising on the interaction that occurs within the group settings” (Sims 1998:346). FGDs are used to explore locally held views, opinions or beliefs as well as the general attitudes of population sub-groups about a specific topic (Nyumba et al. 2017). Table 3.5 shows that this study conducted a total of 13 FGDs with an average of eight participants with five categories of stakeholders.

Table 3.5: Basic characteristics of FGDs conducted

Locality and group	Number in group	Gender distribution
Mt Darwin		
Community-based police officers (Mt Darwin police station)	10	6 men; 4 women
Nurses at St Albert's Hospital	9	3 men; 6 women
St Albert's primary school	11	7 men; 4 women
Mt Darwin high school	12	7 men; 5 women
Parent-teacher association, St Albert's primary school	6	4 men; 2 women
Parent-teacher association, Mt Darwin high school	7	4 men; 3 women
Clients of Musasa Project	8	8 women
Shamva		
Community police officers (Dotito police station)	8	5 men; 3 women.
Nurses at Dotito Clinic	10	4 men; 6 women
Madziva primary school	10	6 men; 4 women
Bradley Institute	10	6 men; 4 women
Parent-teacher association, Madziva primary school	6	5 men; 1 woman
Parent-teacher association, Bradley Institute	7	4 men; 3 women

The overall aim of the FGDs was to provide a forum for selected stakeholders to discuss their experiences and views regarding institutional responses to GBV as well as to explore ideas for the improvement of the responses. The specific reasons for conducting discussions with each category of stakeholders are as follows:

- Community-based police officers:** As members of the local community who receive basic training in policing, these stakeholders are mandated to receive reports of GBV, to do preliminary investigations on such cases, and to take suspects to the police station. They were thus deemed relevant for this study as they have first-hand information of GBV cases in their communities. The issues discussed (see Appendix C) included the most common types of GBV in their communities; views on the effectiveness of national GBV laws and policies; training that community-based police (CBP) receive; challenges they face in their efforts to curb GBV; how they link the sector with the community; and their views on what can be done to improve the justice sector's responses to GBV. CBP officers were divided into two groups (strata) based on gender. Random sampling was used to identify those in the two groups to participate in the discussion. The final number of males and females was determined by the male-female ratio at the stations.

- **Nurses:** These are often the first point of call by victims of GBV, and therefore, the way they handle victims greatly determines the health sector's response to this type of violence. For example, based on the training received, nurses can identify victims of GBV when they come for treatment, even when victims do not report the violence. The issues discussed included the common types of GBV in the communities; perceived adequacy of the GBV laws and policies in the health sector; the adequacy of training nurses received on GBV interventions; services that most GBV victims need; challenges face in service provision; and recommended ways to improve services in the health sector (see Appendix D). Nurses were divided into two strata based on gender. Random sampling was then used to identify the participants, and more female nurses in the focus groups reflect the male-female ratios at the hospital and clinic.
- **Teachers:** The views and perceptions of teachers were deemed key to this study as they brought light to the difference between what is documented in education-related GBV legislation and policies and what is actually going on in schools. As shown in Appendix E, the issues discussed with teachers covered the types and prevalence of GBV in schools; teachers' knowledge of GBV laws and policies to curb GBV in schools and the challenges faced in implementing them; the nature of training teachers received to curb GBV in schools; teachers' perceptions of corporal punishment, among other issues; and perceived ways to improve the education sector's response to GBV. Using names, teachers were put into two groups (strata) based on gender. Names were picked randomly without replacement from the two strata, and the male-female ratios determined the final gender composition at the four schools.
- **Members of parent-teacher associations:** These stakeholders typically link communities with schools, and to the extent that GBV interventions are context specific, it was envisaged that the members would likely know the appropriate services and context-specific interventions needed in their areas. The issues discussed are shown in Appendix F and included common types of GBV in the area; their knowledge about government laws and policies to curb GBV; the nature of GBV services at their schools; and how schools can improve their response to this type of violence. Owing to their low numbers, all members of the parent-teacher associations at the four schools participated in FGDs. At all the schools the members consented to participate.
- **Clients of Musasa Project:** As victims of GBV, the women's experiences when dealing with service providers were key to understanding the nature of GBV prevention

in Zimbabwe. Their perceptions about the adequacy of services and institutional responses and the types and prevalence of GBV were also key to this study. The key issues discussed included the women's experiences with service providers and strategies to escape violent situations; perceived adequacy and quality of service provision in the justice and health sectors; challenges in accessing services; and recommended ways in which service provision can be improved (Appendix G). Women who took part in the FGDs were survivors of GBV sheltered at the time at the Musasa Project. The Musasa Project offers temporary shelter to abused women and also empowers them through training and self-help projects. At any given time, the Musasa Project have different categories of abused women that include the traumatised and those who have received counselling, are undergoing training and have reached a certain level of emotional stability. Among the emotionally stable survivors, those who participated in the FGDs and in-depth interviews were purposively identified by the Musasa Project by a qualified counsellor and consented to participate. An information sheet containing the information about the research was read to the abused women in Shona, first by the Musasa counsellor and later by the researcher after he was introduced to them by the counsellor. Armed with the purpose of the research, the abused women were assured that the information gathered was for academic purposes and that they were free to leave during the discussion. The discussion centred mainly on general issues that pertain to GBV prevention and their perceptions of institutional responses. It is important to emphasise that after the FGDs, two women consented to share their personal experiences and this was done individually.

3.5 Data analysis

Since the study used the sequential explanatory approach where the quantitative component is followed by a qualitative component (Creswell 2013), data analysis was done in stages.

3.5.1 Quantitative data analysis

Data from the quantitative stage was analysed using SPSS version 16 and multivariate analysis techniques, which yielded adjusted odds ratios (ORs) and 95% confidence interval (CI). In line with the characteristics (risk factors) that are established in the literature as related to GBV in low-income settings, adjustments were made to facilitate the analysis. These included women's educational attainment categorised as (a) none, (b) primary (c) secondary and a wealth index

to reflect wealth quintiles. Religious affiliation was dropped as it was found not to be statistically significant. The binary regression model was used in this study because the outcome variable (domestic violence) was binary coded as 0 (No) and 1 (Yes).

Using the unconditional multivariate logistic regression (Berkhemer et al. 2015), the ORs and 95% CIs were calculated for women's age groups with 15–19 used as the reference group in the analysis. Using the same method, the ORs and CIs for other variables were calculated and the reference group decided. ORs and 95% CIs were presented for the risk factors at individual and relationship levels. ORs are an indicator of the change in odds resulting from a unit change in the predictor. For example, it measures the probability of GBV occurring owing to the extent of alcohol intake by the perpetrator. It is interpreted in terms of change in odds: If the value is greater than 1, it indicates that as the predictor increases, the probability of the outcome occurring increases. A value of less than 1 indicates that as the predictor increases, the chance of the outcome occurring decreases (Field 2014).

The goodness of fit of binary logistic regression was assessed using the Homer Lemeshow test. This test is a goodness of fit statistics that is used to assess how well the chosen model fit the data (Field 2014). In this study, the binary logistic was most appropriate. The binary logistic regression was used to predict the presence or observed set of characteristics of the outcome based on values of a set of predictor variables. For example, it is used to statistically test the relationship between abuse of alcohol (predictor variable) and being beaten by a partner (outcome variable). After the logistic regression, the study anticipated revealing that some independent variables are more significant than others in influencing the experience or perpetration of violence.

Univariate and bivariate analyses were not performed as part of this study as these were done by the 2015 ZDHS. Thus, where necessary, relevant tables from the 2015 ZDHS were adopted and adapted for this study (see Chapter 4).

3.5.2 Qualitative data analysis

Inductive thematic analysis was used to analyse data from the FGDs and key informant interviews. According to Braun & Clarke (2006:79), thematic analysis is “a method for identifying, analysing and reporting patterns (themes) within data”. Inductive thematic analysis means that the themes were data driven (Braun & Clarke 2006). Figure 3.2 illustrates Braun & Clarke's (2006) thematic data analysis process that was used.

THEMATIC ANALYSIS

Familiarising with data

Transcribing data, reading and re-reading the data, noting down initial ideas.

Generating initial codes

Coding interesting features of the data systematically across the entire data set, collating data relevant to each code.

Searching for themes

Collating codes into potential themes, gathering all data relevant to each potential theme.

Reviewing themes

Checking if the themes work in relation to the coded extracts and the entire data set, generating a thematic map.

Defining and naming themes

Ongoing analysis for refining the specifics of each theme and the overall story that the analysis tells, generating clear definitions and names for each theme.

Producing the report

The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a report of the analysis.

Figure 3.2: Summary of qualitative data analysis for the study

Source: Braun & Clarke (2006:87)

According to Fereday and Muir-Cochrane (2006), thematic analysis is a way of recognising patterns in the data, with emerging themes becoming categories for content analysis. Pattern recognition was used in the analysis since the study used legal instruments at various levels (global, regional and national) and the emphasis on a number of issues was common. After a more focused reading, coding and category construction was done to uncover themes pertinent to GBV prevention, especially the gap between wording in legislation and practice. Care was taken during the analysis of document material to represent material fairly (objectivity) and respond to subtle cues to meaning (sensitivity) (Bowen 2006).

Data analysis for the key informant interviews and FGDs started with the transcription and appropriate translation of all interviews and discussions from Shona to English. This was after all the interviews and discussions were audio recorded with the participants' consent. The exact words of the participants were used to produce the transcripts of the interviews and discussions. The transcripts were coded based on important themes that arose from the FGDs and key informant interviews. These themes were analysed using the QRS NVivo software. A number of categories was identified during the coding process in response to the objectives of the study. The first was the prevalence and cause of GBV in Zimbabwe, the second looked at the perceptions about the effectiveness of institutional response to GBV, and the third focused on what could be done to improve institutional responses to this type of violence. Core themes

across different the sources of data (legislative and policy review, key informant interviews and FGDs) were synthesised. Finally, to understand the effectiveness of institutional responses, the quantitative component was triangulated with the qualitative component of data to give a critical analysis of institutional responses to GBV in Zimbabwe. In addition to the identification of themes from the data set, quotations were used in the thesis to provide insights into participants' perspectives about GBV issues. From the quotations, types of GBV emerge. In addition, the quotations illustrate the basis of the researcher's interpretation, enable the reader to judge the accuracy of the analysis of the researcher as well as represent the participants' experiences and feelings (Katz 2015).

“Data from the legislative and document review were analysed using content analysis, which is an analytical method that explores relationship aspects and involves an interpretation of the underlying meaning of text” (Shorideh et al. 2012:12). The research closely focused on how the education, health and justice sectors' responses to GBV are articulated in the country's legislative and policy framework. Content analysis is the process of organising information into categories related to the research question (Bowen 2006). It entails a first document review during which meaningful and relevant passages of texts are identified. In this study, content analysis involves organising information from legislative documents that guide or set operation procedures to curb GBV in the police, health and education sectors. In content analysis it is important to identify pertinent information that contribute to the overall integrity of the research. Throughout the process of data analysis, Creswell's (2009) six step procedure, which emphasises an inductive approach (see Figure 3.3), guided the analysis.

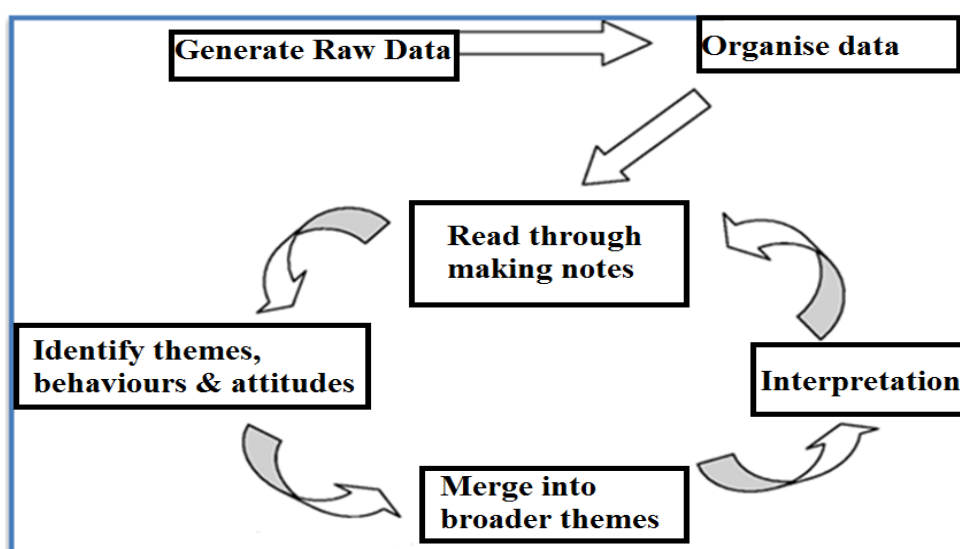


Figure 3.3: Steps for analysing qualitative data
Source: Creswell (2009)

After the analysis of qualitative data (second stage) quantitative and qualitative data were integrated in order to explain the findings of the research thereby producing a comprehensive findings of the study. While the quantitative help to illustrate what is being responded to the qualitative data from documents and the service providers helped to explain the nature of the response.

3.6 Validity and reliability

The validity and reliability of quantitative data depends on the way the data was collected, and in qualitative research, these issues are naturalistic (Ghani 2014). This means that the use of different methods, the steps taken to collect data and the data analysis ensure reliability and validity. These are covered during the qualitative research process. According to Creswell and Plano Clark (2011), validity is used to assess the quality of the research conclusions. Reliability, on the other hand, deals with measuring the consistency of the data with the research background and the suitability of the data for analysis (Saunders et al. 2009). The quality of the research conclusions (validity) and the consistency of the data with the research background and its suitability for analysis (reliability) are achieved by adhering to specific methodological requirements. The success of the two is further enhanced by choosing appropriate methodology. Key informant interviews and FGDs were appropriate to investigate the participants' perceptions on the effectiveness of the identified institutions' responses to GBV. Using multiple data collection methods from varied sources enhanced validity and reliability (Zohrabi 2013).

To evaluate the effectiveness of institutional responses to GBV, the qualitative study was conducted to represent the researcher's reflectivity and interpretation of key informants' and abused women's experiences and perceptions. As such, the central concern of validity and reliability lay in the nature and the ways in which questions were designed in the research instruments. The key informants' questions were standardised to increase the reliability of the data. The officer in charge (police), head teacher (education) and Health Administrator (health) were asked the same set of questions, and the operational staff, nurse in charge, teacher responsible for discipline and officer in charge of the VFU also received the same questions. In a number of cases, similar responses were captured from the interviews. To cater for construct validity issues, the research used different ways to collect data (key informant interviews and FGDs to facilitate triangulation. The use of different methods meant that the

methods complemented each other, and using them together compensated for the weaknesses inherent in some methods.

Furthermore, face-to-face interviews and FGDs added the additional advantage of observation. The researcher's reflections on the nature of the study were recorded soon after the interviews or discussions. The notes included the researcher's interpretation of the participants' non-verbal cues, facial expression and general body language. This aided the validation of the research process as it contributed to the richness of the qualitative data. In qualitative research, it is difficult for a researcher to be a neutral instrument of analysis. The researcher's understanding and views of the participants' situations can influence the conceptualisation of the (transcribed) data (Miller et al. 2012). However, guided by the critical emancipatory paradigm, the researcher attempted to base his understanding of the material on what participants said in both the key informant interviews and the FGDs. This contributed to the overall validity of the data collected.

3.7 Assessing institutional responses

To assess the effectiveness of the institutional responses, the key findings from the quantitative and qualitative components were used to explore the extent to which the different sectors' responses are aligned to the guiding principles of the Southern African Development Community (SADC) *Regional Strategy and Framework of Action for Addressing Gender Based Violence 2018–2030* (2012; hereafter called the SADC Framework). Appendix A provides more details on the strategy. The framework has the following guiding principles:

- a) The response to GBV will be guided by international and regional *human rights principles* that identify GBV as a development problem and a violation of human rights.
- b) The response to GBV will be based on understanding the roots of violence in a system of gender inequality and women's subordination.
- c) All GBV programmes and interventions must put the *safety and security of victims and survivors first*, which must be guaranteed to victims and survivors.
- d) Priority attention must be given to *confidentiality, privacy, disclosure and informed consent* in all responses to GBV. Care must be taken at all times not to re-victimise the survivor.
- e) The response to GBV will be *multisectoral and decentralised in approach* to accommodate the diverse stakeholders and population groups and to allow for reach of different communities.

- f) *Direct and meaningful engagement of CSOs* will be emphasised for their role in community-based actions and in advocating for changes in public sector policies and services and in sociocultural practices that reinforces GBV.
- g) Culturally sensitive, appropriate and transformative actions will be implemented at all levels of the GBV response.
- h) *Community involvement, ownership and participation* in the GBV response will be promoted for the success and sustainability of the response.
- i) *Comprehensive and integrated GBV services* will be provided to best address the root causes of violence and its consequences.
- j) The *political will* by governments to take action to address GBV will be demonstrated. This will include commitments to provide the necessary *human and financial resources as well as a conducive environment* for an effective response.

For the purpose of this study, these principles were broadly categorised into the following five principles:

1. Laws and policies: The extent to which national sectoral laws and policies are guided by and take into consideration human rights principles of relevant international and regional instruments.
2. Protection, care and support services: Taking into consideration principles (c), (d), and to some extent, (g), this category assessed the extent to which the sectoral responses protected and supported victims of GBV in a caring manner.
3. Political will: In line with principle (j), this explored the extent to which each sector has adequate human, financial and other resources to effectively undertake its GBV mandate.
4. Multisectoral and collaborative approach: This category takes into consideration the principles outlined in (e), (f) and (h).
5. Principles (b) and (i) were used as cross-cutting lenses in the assessment of sectoral effectiveness.

3.8 Ethical considerations

The study was designed and undertaken in line with the World Health Organisation's code of ethics for research on violence against women (WHO 2013). These guidelines are premised on the need to respect human subjects in research. Particular focus is placed on respect for person; the need to minimise harm (maleficence) and maximising benefits (beneficence) and justice

(Ellsburg & Heise 2005). The guidelines also stress issues such as protection of informants' confidentiality and measures to reduce real or perceived distress. Furthermore, the guidelines aim to guarantee that researchers have an obligation to ensure that findings are properly interpreted and used to advance policy and intervention development.

To adhere to these guidelines, the study proposal and data collection instruments were submitted to the Research Ethics Committee of the Faculty of Humanities at the University of Pretoria for ethical clearance. This was granted as per the approval letter in Appendix H.

The secondary data from the ZDHS (2015) is publicly available online, and therefore, no permission was needed to access the data. On the other hand, informed consent from individuals and institutions was sought for the key informant interviews and FGDs. This entailed providing all potential respondents with detailed information on the purpose of the study, the modalities of carrying out the data collection, how the gathered information would be used and stored, and the conditions for participation. They were informed, for example, that their participation in the study was voluntary, that their input would be kept confidential, and that their names would remain anonymous. They were further informed of their right to withdraw at any point and that this would not have any negative consequences. In addition, each participant was asked for permission to audio-record the interviews and FGDs.

All this information was clearly stated in the information sheet and consent form, which was given to participants after they confirmed that they had understood the requirements of the research and agreed to take part (see Appendix I for the English version and Appendix J for the Shona version). The Shona version of the information sheet and consent form enabled abused women to fully understand the research process in their own language. To indicate that they understood their role and agreed to participate in the study, participants were kindly asked to provide their signatures after a debriefing in which the aim and objectives of the study were spelt out. To guard against deception in the study, the true nature of the questions in the interview were described in simple language to the participants.

A reference number was assigned for each interview with staff from the justice, health and education sectors as well as NGOs to ensure complete confidentiality of data. The names of individuals, institutions and other identities were not used in any documentation as a way to guarantee confidentiality. Data was stored in a form that could not be linked to any official or organisation by using reference numbers instead of names of institutions or individuals.

The participants' privacy and safety was of paramount importance during data collection. Key informant interviews were held in their offices on mutually agreed dates and times between the researcher and the participants. FGDs with teachers were conducted in the staff rooms and those with members of the parent-teacher associations were conducted in the school halls with the consent of the participants. Finally, the FGDs with abused women were conducted in the counselling rooms at the Musasa Project.

To mitigate any distress during FGDs or interviews, the researcher made arrangements with professional counsellors to be available if needed. However, no such requests were made by the respondents, and hence, no professional counsellor was engaged. With regards to FGDs or interviews, permission was granted to gather data from the schools, police stations and primary health care in the study area. The permission given and other ethical considerations culminated in the granting of ethical clearance (Appendix H). No permission was needed for the document review as these documents are available online for free.

Chapter 4: Risk factors of gender-based violence in Zimbabwe

4.1 Introduction

This chapter explores the various factors that have been theoretically linked to increased risk of GBV among women aged 15–49 years. The chapter draws largely on the secondary data from the ZDHS 2015 as published by ZIMSTAT and ICF International (2016) to explore the factors at the four ecological levels. Where available and relevant, data from the qualitative component of the study are used to complement the secondary data. The chapter begins with an overview of the common types of GBV as revealed by the ZDHS data in the ten years between 2005 and 2015, and to some extent, the qualitative data obtained in this study. Thereafter, the risk factors at the four ecological levels are explored. As stated in the Chapter 3, the variables examined were selected based on their availability in the 2015 ZDHS.

4.2 Common types of GBV in Zimbabwe: Levels and trends

Table 4.1 shows that the proportion of women aged 15–49 years who have since the age of 15 years ever experienced GBV in the form of physical or sexual violence has hovered around 40%. When the two types of violence are assessed separately, physical violence has over the years been more common than sexual violence.

Table 4.1: Percentage of women aged 15–49 years with experience of physical and sexual violence, Zimbabwe 2005–2015

ZDHS	Physical violence only	Sexual violence only	Both physical and sexual violence	Both physical and/or sexual violence	Total number of women
2015	25.8	4.5	9.0	39.4	7 223
2010/11	16.2	13.5	13.7	43.4	6 542
2005/06	21.7	10.6	14.4	46.7	6 293

Source: Adapted from ZIMSTAT & ICF 2012a, 2012b and 2016

The pattern shown in Table 4.1 was affirmed by a number of key informants in the qualitative component of the study. For example, a police officer at the VFU at Mt Darwin Police Station said the following:

Physical violence, which we record as common assault, is the most common form of abuse in the area, if not the country, and hardly a day passes without a case being recorded. In many cases, perpetrators are cautioned or are made to pay an assault fine. Six to eight women for every ten women are victim of violence. Some come here with swollen eyes, bruises and some will be crying.

Similarly, a VFU officer at the Police Station in Shamva District had this to say:

Majority of cases that are reported are physical assaults. Some of which the victim pleads with us not to arrest the perpetrator but to warn him. Sexual abuses are rampant but are rarely reported.

Insights from the qualitative component of the study suggest that the prevalence of sexual violence are not necessarily uncommon but rather, that this type of violence is often under-reported because of power relations between men and women and the cultural expectation that young people must respect their elders. The following excerpts from key informants illustrate this:

Children are abused in the name of culture and because of their trust and economic dependency on adults. In the Shona and Ndebele cultures, it is allowed for married men to fondle the breasts of their wives' younger sisters, and through trusting adults, many children are sexually molested. Children depend on adults on a number of issues and when abused may not report. (High school teacher, Mt Darwin District).

Sexual abuse has attained unprecedented and epidemic levels in this country. While there are isolated cases of rape, many victims of sexual abuse are groomed before being abused. Sexual grooming is a process where a person creates trust with the child or an adult with the intention of initiating a sexual relationship. A sexually groomed person may not disclose the offence. However, through coercion, intimidation, economic dependency and the need to keep family ties accounts for low reported cases of sexual abuse. On the ground sexual abuse is rampant. (VFU officer, Mt Darwin Police Station)

Sexual abuse takes many forms. Women are raped by strangers, relatives or people of high positions, and this is taken as a criminal offence. Women who go to work can be asked to be intimate with their superiors while others can be booed for wearing miniskirts. In churches, children are forced to marry older men. In marriage, women can be raped, but this is difficult to prove. All these dimensions constitute sexual abuse, but some, like fondling of breasts of girls by the husband of the sister, is culturally condoned. (Secondary head teacher, Shamva District)

The practice known as *chiramu*, which gives older brothers-in-law the 'right' to 'playfully' fondle the breasts of their younger sisters-in-law (wife's sister) or to touch other erotic areas of these young women and girls was reported as still prevalent in some communities. This practice often takes places in conditions where the abuser and the victim can be in a secluded place, like a room, while other members of the household do not suspecting anything. As stated in the following quote by a police officer, such abuse also normally takes place when young girls visit their older sisters and the latter is away from home:

Through this cultural practice, the man and the unsuspecting young girl can be alone in a room. She can be asked to bring food to the bed room, asked to make the bed when the sister is away and sexual abuse takes place when the sister is away. (VFU police officer, police Station, Mt Darwin District)

The following comments give similar information:

It is still widespread that a man is culturally allowed to refer to the young sister of his wife as 'wife'. He can ask her to cook, wash clothes and can also touch her. This is called chiramvu ... Young girls may not resist as it is done in the name of culture. (FGD participant, high school, Shamva District)

For generations this has been our practice. The young sisters of my wife are the first people besides my wife that I get used to. When I visit my in-laws, I am given a room where I take meals, and the sisters of my wife bring food and other needs to the room. In our culture we don't eat in the same room with the in-laws, especially mother in law. (FGD participant, school development committee, Primary school, Shamva District)

In many cases such acts are not reported as families consider family cohesion more important than abuses such as the fondling of breasts and coerced sexual acts. In many cases, the abuse occur under contexts where the young women or girls have no options to protect themselves, such as in poverty or due to financial dependence on the perpetrator. For example, the girl or young woman may be staying with the brother-in-law who are paying her school fees and supporting his in-laws financially. This emerged from the FGDs.

The qualitative component of the study also revealed that another common type of GBV in Zimbabwe is emotional violence, which includes verbal insults, threats and denial of access to goods, friends or family members. The qualitative results show that emotional violence usually emanates from excessive jealousy, known in Shona as *kuchengerera*, and often entails men restricting their partners from visiting their relatives, deciding the types of friends the partners keep, going through their partners' mobile phones to check the history of chats and calls, and accusing partners of offences they did not commit. For example, during FGDs with victims of GBV one said the following:

My husband often asks me to account for footsteps in our yard and shouts at me when I ask for money to buy mealie meal or vegetables... it is painful. In many cases this is done in the presence of children or other members of the family. (GBV survivor, Musasa Project, Harare)

Similarly, another said the following:

Harsh words and name-calling are often more bitter than being beaten. My husband tells me words which feel as if he has stabbed me with a knife ... its painful. (GBV survivor, Musasa Project, Harare)

In the ZDHS, emotional violence is only assessed for ever-married women only (those who are divorced, separated or widowed at the time of the survey). Drawing on this data, Figure 4.1 shows that emotional violence is indeed prevalent in Zimbabwe. In the first two surveys, it was the most common violence after physical violence, while in the 2015 ZDHS, it was the most

commonly cited form of violence reported by ever-married women across all three categories of assessment (ever, often or sometimes experienced).

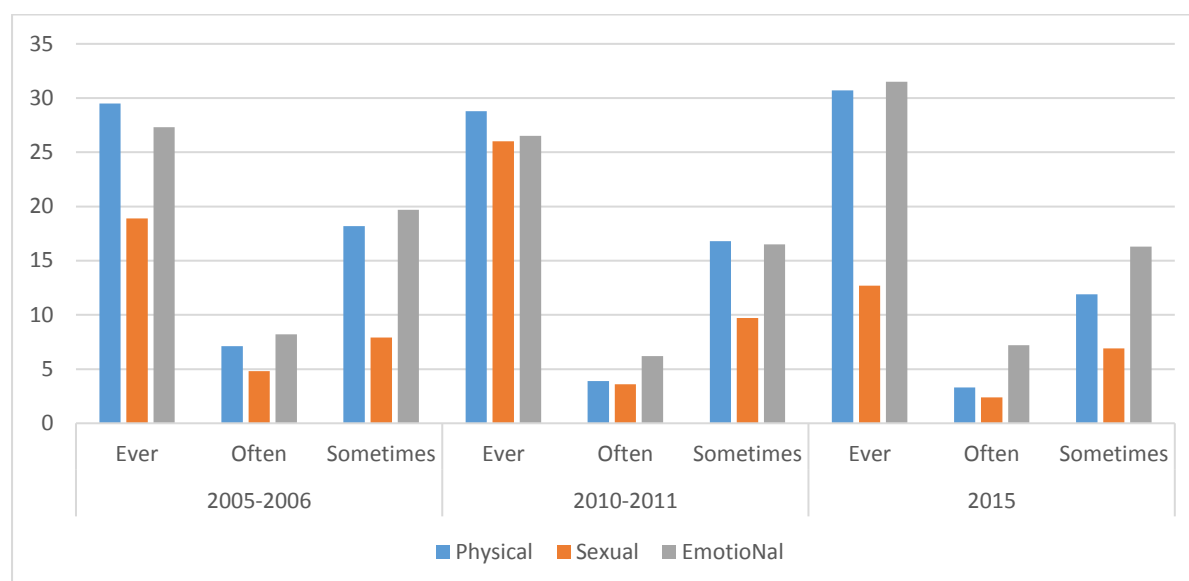


Figure 4.1: Percentage of ever-married women aged 15–49 years who have experienced various forms of violence ever or in the 12 months preceding the survey committed by their husbands or partners, Zimbabwe 2005–2015
Source: ZIMSTATS & ICF 2016

4.3 Risk factors for GBV in Zimbabwe: An ecological analysis

This section presents the various risk factors for GBV in Zimbabwe with a focus on ever-married women aged 15–49 years who at the time of the 2015 ZDHS reported that they had experienced emotional, physical or sexual violence committed by their husband/partner in the 12 months prior to the survey. The specific focus on spousal violence (where the husband or male intimate partner is the perpetrator) was determined by data availability in the 2015 ZDHS as well as the fact that intimate male partners tend to be the main perpetrators of GBV in Zimbabwe as per ZDHS results over the years.

4.3.1 Individual factors

Table 4.2 shows that there is not much difference in Zimbabwean women's experience of the different types of GBV by age. What is evident, however, is that younger women (15–19 years) are relatively more likely to experience sexual violence, while older women aged 45–49 years are less likely to experience any type of violence. This suggests that women can be subjected to a specific type of GBV during different stages in their lives. In terms of employment status, the table shows that relative to their unemployed counterparts, employed Zimbabwean are more

likely to report experiences of GBV, with those employed for cash more likely to do so with regards to sexual violence. The table further shows that the experience of GBV in Zimbabwe decreases with educational attainment, and women with post-secondary education are much less likely to have experienced GBV. Women who report that they have in their life witnessed their fathers beating their mothers are much more likely to report having experienced GBV than those who have not witnessed this.

Table 4.2: Percentage of ever-married women aged 15–49 who often/sometimes experienced emotional, physical or sexual violence committed by their husband/partner in the last 12 months, according to individual-level factors, Zimbabwe 2015

Background characteristics	Emotional violence	Physical violence	Sexual violence	Physical, sexual, or emotional	Number of ever-married women
Woman's age					
15–19	31.9	31.1	18.4	45.2	350
20–24	31.1	32.5	13.2	45.9	890
25–29	35.5	35.9	12.3	50.9	1 082
30–39	32.5	30.6	13.4	45.7	2032
40–49	26.4	24.5	9.6	37.5	1 140
Woman's employment status					
Employed for cash	×	39.5	15.9	×	3 458
Employed not for cash	×	39.6	11.9	×	253
Not employed	×	29.9	11.4	×	3 512
Woman's educational attainment					
No education	36.0	31.7	10.8	49.8	90
Primary	33.3	34.3	14.0	48.4	1 644
Secondary	31.6	30.4	12.5	45.0	3 359
More than secondary	22.5	18.2	9.6	29.9	401
Woman's father beat her mother					
Yes	38.2	38.0	17.7	54.4	1919
No	27.5	26.0	9.8	38.7	3 117
Husband/partner's educational attainment					
No education	27.3	31.3	18.4	42.8	71
Primary	35.7	33.6	13.3	49.2	977
Secondary	29.6	29.4	11.4	43.9	2 991
More than secondary	20.6	18.6	7.4	32.5	482
Husband/partner's alcohol consumption					
Does not drink	26.3	24.9	10.3	37.9	3 299

Background characteristics	Emotional violence	Physical violence	Sexual violence	Physical, sexual, or emotional	Number of ever-married women
Drinks but is never drunk	22.1	19.6	5.6	35.2	86
Is drunk sometimes	34.4	36.3	13.3	52.0	1 687
Is drunk very often	63.0	55.9	30.5	74.6	422

Source: Adapted from ZIMSTAT & ICF 2016

In terms of husbands' or partners' individual factors, Table 4.2 shows that women whose partners have attained post-secondary education are less likely to report experiences of GBV. Husbands' or partners' alcohol consumption also play a notable role, and women whose partners are often drunk are much more likely to experience GBV. The role of alcohol abuse in heightening the risk of GBV in Zimbabwe was affirmed during key informant interviews and FGDs. For example, one VFU officer at the police station in Mt Darwin revealed the following:

Majority of women who come here are in their 20s and 30s. Normally they indicate that after disagreeing on a number of issues, including finances, arguments set in and the men end up beating their partners. Drunkenness exacerbates the situation

Similarly, during a FGD with CBP officers, a female participant stated the following:

Some men when drunk argue, fight and abuse household monies and behave in a manner that they deny the following day. The wife usually is the target of all these. Beer tends to poison many men. (Female FGD participant, police station, Shamva District)

It also emerged that men sometimes manipulate women by putting alcohol in soft drinks in order to abuse them when they are drunk, as the following excerpt illustrates:

Young women and girls are often abused when drunk. At parties, especially at night, unsuspecting women are drugged when alcohol is put in their soft drinks or food. When they are under the influence of these drugs, these women are abused sexually. At times, they report, but it will be difficult to apportion the blame on a specific individual in terms of who put the alcohol in the drink or who sexually abused the complainant. (VFU officer, police station, Shamva District)

4.3.2 Relationship factors

In terms of relationship factors, Table 4.3 shows that women who were in a union (married or living together/cohabiting) at the time of the survey were less likely to report experiences of GBV compared with those who were formerly married. The table suggest that the risk of GBV tends to be lower when there is no spousal age difference and higher when the wife is younger or older. This is also true for spousal educational difference.

Table 4.3: Percentage of ever-married women aged 15–49 who often/sometimes experienced emotional, physical or sexual violence committed by their husband/partner in the last 12 months, according to relationship level factors, Zimbabwe 2015

Background characteristics	Emotional violence	Physical violence	Sexual violence	Physical, sexual, or emotional	Number of ever-married women
Marital status					
Married or living together	29.9	29.2	11.5	43.7	4 593
Divorced/separated/widowed	39.8	38.5	18.9	51.4	902
Spousal age difference					
Wife is older	31.3	30.4	13.2	45.2	148
Wife is same age	27.0	30.2	8.4	41.9	186
Wife is 1–4 years younger	30.1	32.0	12.1	45.2	1 621
Wife is 5–9 years younger	30.6	29.3	12.3	44.5	1 678
Wife is 10 or more years younger	28.6	24.0	9.3	40.2	958
Spousal educational difference					
Husband/partner has more education	30.9	30.7	10.6	45.2	2 152
Wife has more education	32.6	30.5	13.3	44.4	960
Both have equal education	26.5	25.9	11.4	41.3	1 395

Source: Adapted from ZIMSTAT & ICF 2016

4.3.3 Community factors

Table 4.4 shows that place of residence, defined by urban or rural areas, has no effect on the prevalence of GBV in Zimbabwe. Similarly, the table shows that while women who identify as traditionalists and Catholic reported relatively lower experiences of GBV, religion seems to play a role in the country. Overall, the results show that the experience of GBV is not only high among women of different Christian denominations but that women under the Apostolic sect are more vulnerable to GBV. Acceptance of traditional gender roles, which according to the ecological framework is a community-level factor for GBV, can be reflected in the justification of wife beating by men. Table 4.4 shows that the more reasons for which wife beating is justified by a woman the more likely the woman is to report having experienced GBV.

Table 4.4: Percentage of ever-married women aged 15–49 who often/sometimes experienced emotional, physical or sexual violence committed by their husband/partner in the last 12 months, according to community-level factors, Zimbabwe 2015

Background characteristics	Emotional violence	Physical violence	Sexual violence	Physical, sexual, or emotional	Number of ever-married women
Residence					
Urban	32.0	30.0	12.1	45.0	1956
Rural	31.3	31.1	13.0	45.0	3 538
Religion					
Traditional	(15.0)	(23.4)	(9.3)	(30.3)	31
Roman Catholic	22.5	24.9	12.4	36.9	336
Protestant	30.6	27.5	10.7	41.5	776
Pentecostal	29.6	29.2	12.1	43.4	1 293
Apostolic sect	33.1	32.0	14.1	46.9	2 485
Other Christians	33.8	31.0	9.6	43.5	224
None	37.7	41.5	12.4	45.6	323
Number of reasons for which wife beating is justified					
0	29.5	27.8	10.5	41.3	3 506
1–2	34.6	34.1	15.2	50.3	1 312
3–4	35.2	37.4	19.9	53.1	524
5	40.4	46.8	16.9	56.8	153

Source: Adapted from ZIMSTAT & ICF 2016

4.3.4 Societal factors

At societal level the unequal position of women is a major risk factor, and this is reflected in Table 4.5 in the number of marital control behaviours displayed by husband/partner and in the number of decisions in which women participate. In terms of the former, the more the reported number of marital control behaviours, the higher the risk for the woman to experience GBV. In terms of decision-making, women who are involved in more decision-making are less likely to report experiences of GBV. Therefore, the table suggests that at societal level GBV in Zimbabwe is a manifestation of structural inequalities between men and women. Using wealth quintile as a proxy for poverty, Table 4.5 also shows that the proportion of women who reported having experienced GBV tends to decrease with an increase in wealth levels.

Table 4.5: Percentage of ever-married women aged 15–49 who often/sometimes experienced emotional, physical or sexual violence committed by their husband/partner in the last 12 months, according to societal level factors, Zimbabwe 2015

Background characteristics	Emotional violence	Physical violence	Sexual violence	Physical, sexual, or emotional	Number of ever-married women
Wealth quintile					
Lowest	33.1	31.6	14.2	46.3	1 050
Second	30.7	32.8	14.0	45.3	993
Middle	31.9	32.2	11.8	47.2	964
Fourth	33.8	32.8	14.0	46.7	1 313
Highest	27.9	24.7	9.5	39.8	1 175
Number of marital control behaviours displayed by husband/partner					
0	12.0	15.3	3.8	22.2	1 848
1–2	27.4	26.9	10.6	43.8	2 332
3–4	60.7	55.7	24.8	74.8	1 036
5	86.9	72.4	44.5	95.2	278
Number of decisions in which women participate					
0	37.2	31.3	17.5	54.6	144
1–2	36.4	36.2	13.0	52.0	1 128
3	27.4	26.7	10.7	40.5	3 320

Source: Adapted from ZIMSTAT & ICF 2016

Although the use of technology, specifically social media, was not explored in the ZDHS, FGDs with victims of GBV suggested that this was an increasingly important risk factor at societal level. Essentially, in line with this global trend, the use of digital technologies (especially mobile devices) is increasing in Zimbabwe and often exposes extra marital affairs, which in turn can lead to incidences of GBV. The following statements illustrate this:

When he is home, he is always on his phone chatting with different people. One day he left his phone on the table when he was bathing. I discovered that some contacts have male names as a disguise. (GBV victim, Musasa Project, Harare)

The violence is increasing because of cell phones. Many men do not want their cell phones to be touched. When it rings, they go outside to answer, and at times there is a password. When women complain, they are threatened or beaten. There is a lot in men's cell phones. (FGD participant, Musasa Project, Harare)

4.3.5 Risk factors for GBV in Zimbabwe: A multivariate analysis

As per the ecological framework described in Chapter 1, GBV is a multifaceted phenomenon grounded in an interplay between various factors operating at different levels. Hence, the factors shown in the section 4.3 may well reflect a combination of various factors and not just those examined. It is thus important to examine all the factors within a multivariate framework to establish the net effect of each individual and relationship factor for which data was available in the 2015 ZDHS. Multiple regression analysis was used to this because it explains the relationship between multiple independent or predictor variables (in this case the background variables) and one dependent or criterion variable (in this case experience of GBV). The dependent variable is modelled as a function of the independent variables with corresponding coefficients along with the constant term. The results confirm the patterns in Tables 4.2 and 4.3:

- **Age:** There is a reduction in the experience of the three types of violence in the age group 40–49; however, the relationship between age and violence is not statistically significant (OR = 1.4, 95% CI 1.2–3.78, $p = 0.03$).
- **Religion:** This contributes to the high prevalence of GBV. Table 4.4 confirms this as it shows that women in the Apostolic faith are three times more likely to experience spousal violence and that the relationship between this type of violence and religion is statistically significant (OR = 3.2, 95% CI: 1.70–4.24, $p = 0.001$).
- **Employment status:** Being employed increases the risk of experiencing GBV as women employed for cash are 1.7 times more likely to experience this type of violence. This relationship is statistically significant (OR = 1.7, 95% CI: 1.10–4.31, $p = 0.002$).
- **Education:** The relationship between women's level of education and their experience of GBV has an inverse relationship and is statistically significant (OR = 1.12, 95% CI: 1.64–1.99, $p = 0.003$).
- **Wealth:** The relationship between wealth quintile and experience of GBV shows that a decrease in the experience of violence by women occurs at a stage where the women have economic opportunities that are not only sustainable but also make the women independent if she decides to leave the relationship. This relationship is statistically significant (OR = 1.1, 0.518–4.35, $p = 0.002$).

- **Marital status:** Women currently in an union are less likely to report GBV than those who are formerly married, and the latter are twice as likely to report GBV (OR = 2.2, 95% CI: 1.20–3.8, $p < 0.001$).
- **Husband's/partner's alcohol consumption.** There is a strong association between the male partner being drunk often and experience of GBV (OR = 2.16, 95% CI: 1.50–4.22, $p < 0.001$).

Overall, the factors that are statistical significant are religion, employment status, level of education, husband's/partner's use of alcohol, marital status. Age and wealth quintiles are not statistically significant.

Table 4.6: Logistic regression of spousal violence against women aged 15–49, Zimbabwe 2015

Variable	Odds ratio	Standard error	95% CI	p value
Age				
15–19	1.04	0.433	0.93–1.22	0.625
20–24	1.2	0.30	0.8–3.80	0.09
25–29	1.5	0.342	1.1–6.24	0.02
30–39	1.4	0.431	1.2–3.78	0.03
40–49*	1			
Religion				
Traditional*	1			
Roman Catholic	1.2	0.411	0.94–3.30	0.176
Protestant	1.7	0.33	1.10–4.35	0.008
Pentecostal	2.1	0.450	1.11–2.31	0.002
Apostolic sect	3.2	0.6	1.70–4.24	0.001
Other Christians	2.0	0.45	1.24–2.71	0.02
Employment status				
Employed for cash	1.7	0.671	1.10–4.31	0.002
Employed not for cash	1.6	0.405	1.12–5.56	0.012
Not employed*	1			
Educational Attainment				
No education	1			
Primary	1.1	0.223	0.91–2.11	0.722
Secondary	1.4	0.18	1.01–1.40	0.670
More than tertiary	1.12	0.29	1.64–1.99	0.003
Wealth quintiles				
Lowest*	1			

Variable	Odds ratio	Standard error	95% CI	p value
Second	1.43	0.51	0.265–1.45	0.155
Middle	1.30	0.781	0.370–1.470	0.781
Fourth	1.4	0.410	0.72–3.81	0.301
Highest	1.1	0.672	0.518–4.35	0.002
Marital status				
Married or living together	1.3	0.32	0.9–1.45	0.008
Sep/div/wid	2.2	0.25	1.20–3.8	p < 0.001
Single*	1			
Husband/Partner use of alcohol				
Does not drink*	1			
Drinks but never drunk	1.1	0.239	0.213–2.198	0.176
Is drunk sometimes	1.5	1.183	1.11–2.084	0.009
Is drunk always	2.16	0.45	1.50–4.22	p < 0.001

Sep/Div/Wid = Separated/Divorced/Widowed

*** Reference category**

4.4 Discussion

Drawing on the secondary ZDHS data and the qualitative data, this chapter revealed that the most common types of GBV in Zimbabwe are physical, emotional and sexual violence, in that order. That the latter is the relatively less common form of violence reflects, in a way, self-reported levels of sexual abuses in which reporting this type of violence is constrained by coercion, intimidation, economic dependency on men by women as well as the need to keep family ties when the perpetrator is a family member (Garcia-Moreno & Avni 2016; Palermo et al. 2014). In Zimbabwe, sexual abuse is a particularly complex, pervasive and multifaceted phenomenon understood in a context that is influenced by cultural norms. A specific cultural practice, *chiramu*, can lead to situations where sexual abuse is a planned criminal action and the abuser can create conditions that facilitate non-reporting by the victim. Physical violence is the most visible and common of the three types of violence. The results show that male dominance, female economic dependence on men and increased use of technology (e.g. mobile phones) contribute to the pervasiveness of physical violence. Sustained evidence shows that the prevalence of gender inequality, acceptance of violence as normal and limited law enforcement are contributing factors to the high levels of physical violence (Beyene et al. 2019; Decker et al. 2015; WHO 2013; Uthman et al. 2011). Physical violence takes many forms (pushing, choking, slapping, punching, burning, etc.) of physical harm (ZIMSTATS & ICF

2016). This broad definition of physical GBV together with Zimbabwean society's acceptance of the use of physical violence as a disciplinary measure makes this form of GBV common (Damba et al. 2013).

Using Heise's (1998) ecological model, this study established a number of risk factors that precipitate GBV in Zimbabwe. At individual level, it showed, in line with previous research (Adebowale 2018; Izugbara 2018), that age does not make much difference in the number of women experiencing GBV. The results do show, however, that women's employment, particularly wage employment, is a risk factor for experiencing GBV. It can be argued that the women's employment tends to challenge the traditional male provider role that males are socialised to conform to. A number of Zimbabwean men are failing to support their families financially due to the current harsh economic conditions in the country. Failure to support families can result in a masculinity crisis and as compensatory behaviour, men may turn to GBV perpetration to assert their power (Saffitz 2010). Although economically empowered women have reservation utility, which is the social and financial usefulness perceived by men, as a loss in the event that the women decide to leave (Kiss et al. 2012), in patriarchal societies like Zimbabwe, women's economic empowerment through employment can ignite waves of violence. In line with the sociological theory of 'male backlash' (McMillan & Gartner 1999) this may suggest that women's participation in the labour market improved economic opportunities for women outside the relationship and challenges the socially prescribed male dominance, triggering male backlash (Lukc & Munshi 2011). Similarly, Allonso-Borrego and Carrasco (2016) report that according to the 'extractive theory', men may commit acts of violence on a woman with more economic resources to get money. This weakens her bargaining position in the relationship. This is common in Zimbabwe where resources are limited due to harsh economic conditions that peaked in the early 2000s and continue today. Commenting on a similar situation brought about by high unemployment among men in South Africa, the Centre for the Study of Violence and Reconciliation (2016:12) stated the following:

Some men feel that women have usurped the roles that were previously allocated to men, resulting in uncertainty, insecurity and anxiety ... In this context, GBV becomes a prominent mechanism through which to reinforce male power and authority... In the crisis of male identity, violence is sometimes used as a tool to try to maintain patriarchal power. Some men become frustrated and angry when they can no longer live up to traditional forms of masculinity, such as providing materially and financially, which often leads to them reacting violently to their economically independent female partners

Education is found to increase women's employment opportunities and socioeconomic status, and the resultant empowerment typically reduces the unequal power relationship between men and women, which has been identified as a root cause of GBV (Sida 2015). The 2015 ZDHS results are consistent with the findings of Kiss et al. (2012) that educated women are less likely to experience GBV, presumably because they are more confident about leaving or reporting abuse to authorities.

While education can offer a potential shield to women against experiencing GBV, their husbands' educational status can expose women to this type of violence. Sustained evidence shows that lower education levels of women's partners is a predictor of GBV (Babu & Kar 2010; Gupta & Gupta 2012; Rapp et al. 2012). Low education levels of men may result in unemployment and poverty, which affect the traditional role of men as provider in the family, causing stress, frustration, disagreement and relationship conflict. The perpetration of GBV becomes a means for resolving men's male-identity crisis as it allows the expression of power (Fulu et al 2013). On the other hand, high education levels of men tend to dilute cultural narratives that justify male dominance and the use of violence to maintain unequal power relations (Fulu et al 2013). The positive association with education levels with more equitable gender attitudes and beliefs may be a result of the liberalisation influence of the educational environment reinforced by the critical thinking abilities developed by education (Bryant 2003; Fattah & Camellia 2017). However, this association cannot be generalised as complex dynamics of power and hegemonic masculine control may offset the influence of higher education of men and GBV perpetration. A study in India found that women with higher education than their husbands are more likely to experience GBV, even when their husbands have high educational attainment (Ackerson et al. 2008). This further substantiates men's use of violence against women as a means to maintain the hierarchy of hegemonic masculinity when their logic of authority over women is challenged.

However, Ola (2018) and Abramsky et al. (2011) show that in men who are alcoholic and have high education beyond secondary level, the likelihood of GBV perpetration decreases despite the use of alcohol. This relationship was consistent even after taking into account other variables such as household wealth, age and place of residence. The Zimbabwean government must invest more in education that promotes gender equality given the impact on education by the current economic challenges.

The results of this study show that women who witness their mothers being beaten by their fathers are at higher risk of experiencing GBV. Childhood experiences are proved to be one of

the most consistent factors in predicting the likelihood of GBV across a range of countries. Women who witness their mothers being beaten by their intimate partners are more likely than others to grow up to be victims of violence (Abramsky et al. 2011; Chokkanathan 2012; Deb & Walsh 2012). Witnessing their fathers beating their mothers is a form of childhood abuse that is associated with negative physical and mental health outcomes, not only in childhood but also in adulthood (Herrenkohl et al. 2013). A key pathway through which childhood violence (witnessing and experiencing) leads to subsequent GBV is social learning. The social learning theory suggests the following four mechanism through which behaviour becomes engrained: Observation of others, internalisation of attitudes supportive of that behaviour, imitation of role models, and reinforcement of behaviour through reward and sanctioning (Akers 2017). Through social learning violence is accepted as normal by women, and this constrains reporting, especially of sexual violence. In patriarchal societies like Zimbabwe, patriarchal attitudes in family contexts infantilise women and children, enabling the use of violence against both groups (Namy et al. 2017). It is therefore important that childhood abuse and IPV should be examined together to better understand the nature of GBV experienced by women.

The use of alcohol by the partner is found to be a key determinant of GBV in Zimbabwe. Under the influence of alcohol men are more likely to sexually objectify women and girls (Gervais et al. 2014). By sexually objectifying women, drunken men may erroneously assume that women's social cues indicate sexual interest. The qualitative results of this study show that drunkenness increases men's propensity to perpetrate GBV. There are multiple potential ways through which alcohol abuse leads to increased physical and emotional violence. Consuming harmful levels of alcohol can lead to more frequent quarrelling about finances and household responsibilities as money and time are spent on drinking (Gibbs et al. 2020). Alcohol related diminishment of cognitive function increases the likelihood of not only arguments but also physical violence. For women who are economically dependent on men, abuse of financial resources on drinking sprees contributes to emotional abuse (Abbey et al 2014). Excessive drinking in Zimbabwe is common as men use alcohol as a coping mechanism for a number of economic challenges currently experienced in the country. In Zimbabwe, a combination of alcohol abuse, hostile hegemonic masculinity and the perceived approval of the use of violence as a conflict resolution strategy increase the risk of GBV perpetration (Jewkes et al. 2015).

At the relationship level, women who were in a union at the time of the survey are less likely to report experiences of GBV compared to those who were formerly married. In addition to measuring the prevalence of GBV among these groups, the results show that the reporting

patterns of women in a union (married or cohabitation) is different from those who were formerly married. Women in union have challenges reporting any form of GBV due to economic dependency on men and the value attached to marriage (Mukanangana et al. 2014; Palermo et al. 2014). In Zimbabwe, a cultural norm called *chakafukidza dzimba matenga*, meaning what happens in the family is private, constrains women from reporting. Reporting not only makes the perpetrator accountable for his action but also highlights the magnitude of the problem in families or relationships. However, reporting GBV is risky, and in a family or a relationship many variables, including cultural norms, make reporting a daunting task (Alaggia et al. 2012).

This study's results show that spousal age difference does not play a major role in determining the risk of experiencing GBV by women in Zimbabwe. This is in contrast with evidence from other LMICs that shows increased odds of reporting GBV among young women (Adebowale 2018; Izugbara 2018). Women with an age difference greater than 15 years between them and their spouses are more likely to report having experienced GBV (Izugbara 2018). Owing to their age, young women have challenges managing crises. Eisikovits & Band-Winterstein (2015) shows that young women experience a life of contradictions, paradoxes and ambivalence. Their mobility, bad timing and exposure to human rights often create a sense of agitation, which creates a "wish to distance oneself without the ability to do so" (Eisikovits & Band-Winterstein 2015). The result is that young women tend to react strongly by reminding men that women have rights. This conflict with the deep-rooted hegemonic masculinity, which seek to subordinate women at all costs, result in heightened risk of GBV. Being aware of human rights without mechanisms to enforce them exposes women in general and young women in particular to GBV. Because of their lack of experience and wisdom, they may not have the ability to approach a violent situation with a systematic approach. Furthermore, older men tend to take advantage of young women's economic dependence as well as lack of self-reflection, which increases with age.

In the context of marriage, a combination of high education levels and age can be a resource that shield women from physical and economic abuse. McClendon et al (2014) and Lafortune (2013) show that high school attainment and premarital employment encourage women to marry at an older age, which increases a woman's post-marital agency. Post-marital agency include the possession of economic power, level of decision-making and the ability to foresee unfolding violent behaviour or scenario. Women married at a young age may possess little

post-marital agency and tend to have increased odds of experiencing physical and economic abuse (Samari & Pebley 2015).

Concerning educational difference between spouses, the findings indicate that educational difference has no bearing on the prevalence of GBV, especially IPV. However, in societies where violence is normalised, power imbalances, such as one partner having a higher level of education than the other, are more likely to be met with IPV (Abrahams et al. 2006). Educational attainment by women and their partners emerges in studies across the world as an important factor in reducing the likelihood of GBV. The level at which this becomes significant varies from primary education in some countries to secondary in others (Abramsky et al. 2011). According to Choi and Ting (2008), there are four potential explanations for how power imbalances may lead to IPV: The dependence hypothesis, the submission hypothesis, the compensation hypothesis and the transgression hypothesis.

The dependence hypothesis suggests that when men have higher levels of education, bring in more resources and dominate decision-making in the home, women are more likely to be emotionally abused because of their dependency (Yount 2005). The same research suggests that if women have more education and bring in more resources, they are less likely to be abused. This means that economically independent women are more likely to have more decision-making power in the home. Basing this argument on the link between masculinity, gender expectations and violence, researchers found that women with more education than their husbands are more likely to experience IPV in countries such as India, Kenya and Egypt (Gevers et al. 2013; Lawoko et al. 2017; Yount & Li 2010). When men have few educational and occupational opportunities, they may attempt to prove their masculinity by using violence against their women partners, particularly if those partners have greater education or occupational attainment than they (Duvury et al 2013). Choi and Ting (2008) state that this is the compensation hypothesis where men will compensate with violence for their inability to fulfil their role as the provider of the household. Similarly, women with higher education than their partners are more likely to be assertive and reject subordination in marriage. It is this increased assertiveness and their rejection of an inferior status that lead some men to feel that their power is threatened, increasing the likelihood of GBV (Bonnes 2016). This is the transgression hypothesis, which means that when gender norms are transgressed by women, GBV is viewed as an acceptable response.

However, other researchers in Africa have mixed results when examining educational differences between spouses and the likelihood of abuse. Research on IPV in Egypt and South

Africa found that both men with more education than their wives and men with less education than their wives are likely to use violence against them (Abrahams et al. 2006; Yount & Li 2010). In Malawi, it is found that although women having more education than their husbands is a protective factor against IPV, education and income differences between married couples are not associated with IPV in either direction (Bazargan-Hejazi et al. 2013; Conroy 2014). As such, more research is needed on education differences between spouses and the likelihood of IPV (Bazargan-Hejazi et al. 2013). This is crucial in Zimbabwe where the literacy rate is high among both men and women and there is a high chance of people with different educational status getting married or dating.

At community-level, place of residence expressed in terms of rural and urban residence, was found to have no bearing on the levels of GBV in the country. Places of residence are characterised by different social realities that are shaped by cultural differences in these areas (Antai 2011; Balogun et al. 2012; Eisikovits & Band-Winterstein 2015). In Zimbabwe, the social realities of urban and rural areas are the same as the poverty levels induced by economic challenges blurred the distinctions between rural and urban areas. Furthermore, people in Zimbabwe have two homes in urban and rural areas between which they constantly migrate, resulting in the ‘trading’ of cultural norms that condone violence between the two areas.

Traditional gender roles is a community-level factor that is found to be a major risk factor for GBV. GBV is an outcome of gender inequality, which arises from the differences in socially constructed gender roles (Wood 2012). In essence, gender attitudes assimilated by men and women are a product of many institutions and tend to justify norms associated with masculinity and female subordination. In Zimbabwe, the role of men as providers are being challenged because of the harsh economic environment, and this leads to men resorting to the use violence to regain power. Increasingly women are providing for their families, adding another dimension that affects the male provider role. Ultimately, it shows that GBV is a learned behaviour, a product of frustration that reflects challenges in the wider socioeconomic environment in the country.

By teaching girls that there is nothing wrong with being beaten by a partner (Mashiri 2013), beliefs in *chakafukidza dzimba matenga* (what happens in the family is private) and the Zimbabwean proverb ‘plates in a basket will rattle’, the Zimbabwean society not only normalises or justifies violence but also does not actively take steps to curb GBV. The normalisation of GBV means that disclosure becomes problematic. The culture entitles men to abuse women and legitimises their actions. Traditional sociocultural beliefs are why most

interventions to curb GBV fail (Bishwajit et al. 2016). It is therefore crucial that interventions focus on transforming context-specific sociocultural norms that pervasively fuel GBV and create ethically acceptable norms that do not discriminate against any individual.

Thus, despite the country's enabling legislative and policy framework in sectors such as education and gender equality, Zimbabwean Shona and Ndebele cultures continue to be influenced by traditional gender role paradigms, and this contributes to rigid harmful practices, beliefs and behaviours that expose women and girls to GBV. Bemoaning a deviation from the traditional rules, a member of the school development committee (SDC) at one of the primary schools in this study noted the following:

We believe that women are supposed to be quiet when men are talking, but things are changing. Their duty is to look after children at home. These days' women go to work and their exposure to media causes them to disobey their husbands. In our culture we have structures in the family, church and society to deal with violence.

In Zimbabwe, as in many African societies, traditional gender roles and socialisation patterns implicitly dictate what men and women do and how they behave. A deviation from traditional gender roles is often perceived as challenging male privilege, and in such cases, men often resort to violence as a form of resistance (Conroy 2014). For example, when women participate in paid employment while men lack resources, violence is often used to express the men's frustration because their breadwinner role is challenged. This is essentially because Zimbabwean society socialises men to be breadwinners, and when this is not achieved, many men resort to violence to reclaim their manhood. Therefore, it should be a priority to target rigid gender roles in the prevention of GBV.

Weak community sanctions are also identified as a major community level risk factor in relation to GBV. To the extent that religious teachings and communities will never be neutral in the in the context of GBV (Fortune & Enger 2005:1), the role of religious affiliation was explored at community level and were found to play a role in precipitating GBV.

In addition to traditional gender roles, cultural norms are significant in fuelling GBV in Zimbabwe. Cultural norms are embedded in the culture of a particular society and cultural norms sustain gender inequality and violence (Jewkes et al. 2015). A cultural practice called *chiramu*, which entails older brothers-in-law having the 'right' to fondle the breasts of their young sisters-in-law (wife's sister) or to touch other erotic areas of these young women fuel GBV in Zimbabwe, especially sexual abuse. This study's results show that the wife's sister can be treated as a wife (expected to make beds, cook and do laundry), which can lead to coerced

sexual acts. Sexual abuse associated with *chiramu* are often not reported because of economic dependency, fear, culture, stigma and the need to keep the family intact. Men as gatekeepers of power defend *chiramu* as they are direct illicit beneficiaries of this practice. As a result, cultural practices like *chiramu* and traditional gender roles (breadwinner mentality) must be targeted if interventions to curb GBV are to be effective.

Finally, at society level gender inequality is shown to be a major risk factor. Research shows that GBV occurs when there are gender and power inequalities within relationships or within the social and political environments in which these relationships exist (Gulliver & Fanslow 2016; Heise 2011). This means that GBV is rooted in women's lack of power in relationships, societal tolerance of violence and hostile masculinity by men. The qualitative results of this study show that spousal violence in Zimbabwe is a manifestation of structural inequalities between men and women and the nature of the institutional response. The following excerpt illustrates how many Zimbabwean men tend to maintain control over women and use force and threats to achieve their wishes:

In our society women are supposed to be under men, and even those who believe in the bible say so. Now these people from overseas came with the issue of human rights and women now complain about their rights. This is causing problems in our society ... Human rights should have boundaries and not in the family. (FGD participant, high school, Mt Darwin District)

Among other things, this shows the internalised rigid patriarchal norms and the pervasiveness of institutional responses to GBV. Indeed, the Human Development Report (2019) reveals that the gender inequality index for Zimbabwe, which reflects gender-based inequalities in three areas (reproductive health, empowerment and economic activities), is high at 0.62. Ranging between 0 and 1, the gender inequality index shows loss in potential human development due to disparities in the three areas. A gender inequality index value of 0.62 indicates high inequalities between males and females and a subsequent high loss in human development.

Another societal level factor can be described as the individual poverty levels, shown in this chapter using wealth quintiles. In Zimbabwe, sustained economic challenges coupled with mass unemployment, cash shortages and political uncertainty continue to diminish economic opportunities for many men who vent their frustration on women and girls, both in private settings like the home and in public like workplace and schools. In these situations, violence is used both to obscure men's misbehaviour (Saigol 2011) and to restate their authority to fulfil patriarchal norms (Izugbara 2018). On the other hand, economic dependence on men by women, culture (tolerance of violence by the society) and community service as penalty for

physical offences contribute to the rise of physical violence despite the presence of the DVA, which seek to protect women and girls from GBV.

The economic disempowerment of men through unemployment and underemployment resulted in male depression, anxiety and other psychosomatic symptoms in Zimbabwe. Research shows that men who commit acts of violence against women and girls score higher than the norm on depression and anxiety scales and are at increased risk of perpetrating GBV (Mngoma et al. 2016; Shorey et al. 2012). Mental health problems cause difficulties with emotional regulation and some men use GBV perpetration as a way to cope with emotional pain. The economic disempowerment of men resulted in many having low self-esteem, which interact with depression and anxiety to increase the risk of GBV perpetration (Mngoma et al. 2016).

It also emerged from the qualitative component of the study that the increased use of technology contributes to high levels of GBV in Zimbabwe at societal level. Similar to previous research, this study shows that jealous male partners typically use physical and virtual stalking to access victims' devices, monitor victims' contacts on social networks and track victims' devices (Diamond et al. 2011; Levy 2014; Freed et al. 2017; Shimizu 2013). Overall, extra marital affairs, which used to be covert, are increasingly becoming 'public' because of cell phone use, increasing the risk of perpetrating or experiencing GBV.

4.5 Conclusion

The existence of risk factors at all levels of the ecological model suggest that while it is good to design interventions to curb GBV at specific levels, interventions that incorporate all four levels are not only sustainable but may mitigate the interaction of factors that are at the centre of GBV perpetration and experiencing. This shows that there is no single factor for GBV that if modified will eliminate this type of violence from occurring. Rather, the likelihood of violence being perpetrated or experienced is influenced by a constellation of factors working at different levels of the ecological model, from historical and macro social factors to factors unique to the individual. The study's results show that wage employment for women, use of alcohol by partner (individual); traditional gender roles (community level); and poverty, cultural norms and gender inequality (societal level) are the major risk factors for GBV, while age and level of education (individual level) and place of residence (community level) are the least important risk factors. In patriarchal societies like Zimbabwe, masculinity and gender expectations mean that improving women's status through wage employment and education exposes them to violence (Yount & Li 2010). This put into context the importance of

community and societal level factors in fuelling GBV. The dilemma is centred on the fact that globalisation, the advent of human rights and modernisation have the potential to improve women's status in terms of education and access to resources, while at the same time, rigid cultural norms tend to be immune to these global changes. Poverty and economic inequalities can be exacerbated by globalisation, and in Zimbabwe, the current economic challenges the country is facing expose women to violence. The development of a systematic coordinated way of working and the widespread implementation of interventions designed to reduce the likelihood of GBV and to mitigate its effects have the potential to have wide ranging positive benefits, including creating a more egalitarian society and reducing the barriers that prevent Zimbabwean women from reaching their full potential. It is to this end that the next three chapters explore the extent to which the justice, health and education sectors in Zimbabwe effectively address the risk factors in their interventions.

Chapter 5: Institutional response to GBV in Zimbabwe: The justice sector

5.1 Introduction

This chapter assesses the institutional response to GBV in the Zimbabwean justice sector. It particularly focuses on the Zimbabwe Republic Police, which has the overall mandate to prevent, combat and investigate crime and to protect and secure the lives and property of people as well as maintaining law and order (Constitution of the Republic of Zimbabwe, 2013, Section 219). Therefore, the Zimbabwe Republic Police is the frontline of the justice system in Zimbabwe in terms of GBV. This chapter assesses the police's response against the four categories discussed in Section 3.7: (i) Laws and policies; (ii) protection, care and support services; (iii) political will; and (iv) multisectoral and collaborative approach.

5.2 Laws and policies

In the context of GBV, the duties of the Zimbabwe Republic Police are primarily governed by the DVA of 2007, which, as shown in Appendix A, clearly sets out the duties and powers of the police with respect to domestic violence. Furthermore, Article 5(1) of the DVA calls for every police station in the country to have a section “which shall, where practically possible, be staffed by at least one police officer with relevant expertise in domestic violence, victim-friendly or other family-related matters”. This provision led to the establishment of a VFU in every police station since 1995. These units were set up to “proactively and reactively police crimes of sexual nature committed against women and children in a manner sensitive to the victim” (Zimbabwe Republic Police Client Service Charter [CSC] 2016). The VFU is a component of the victim-friendly system. The victim-friendly system represents a confluence of multisectoral professional interventions that seek to help victims of GBV that include social workers, medical doctors, nurses, police, magistrates, prosecutors and psychologists (Muridzo et al. 2018). As a special arm of the police, the role of the VFU is to offer protection services to GBV victims by isolating them from the perpetrator and initiating prosecuting process. VFUs also refer GBV victims to other service providers like the social welfare and medical institutions. It emerged during the study that VFUs collect and record cases of violence on a monthly basis. This is evidenced by the following remarks:

As a unit we are mandated to maintain statistics on sexual crimes and domestic violence. These statistics are recorded as they manifest and on monthly basis we

display the information in form of charts. This help us to disseminate crime information, including sexual abuse and domestic violence, to all stakeholders. Our records show that common assaults (physical violence) is the most common. (VFU officer, police station, Mt Darwin)

We keep records of domestic violence in addition to sexual crimes.... The majority if not all cases show that women and girls are the victims. On monthly basis we analyse the results to illuminate on the patterns and trends of domestic violence and sexual crimes. (Officer in charge, police station, Shamva)

This is a potentially useful practice as it can illuminate the nature and extent of the problem in the country as a whole as well as the different policing areas. Essentially, unlike surveys, like the ZDHS, that produces GBV data after extended periods of time, the monthly data means the police can not only produce up-to-date statistics but can also produce data specific to a given area, and hence, assist in developing context-specific mechanisms to curb GBV. Key informants in the sector further reported that the police stations use these statistics and reports to, among other things, raise awareness about GBV in their areas, as noted in the following comments:

The trends and patterns that emerge from the analysed data form the basis of our awareness raining campaigns in our area. The data is also used by researchers and the government to buttress and influence other strategies to combat GBV like policy formulation. (Officer in charge, police station, Shamva)

Our awareness programmes, both in terms of content and frequency, are largely influenced by the nature and level of GBV in our area. We also incorporate new emerging issues in domestic violence as part of our awareness package. (VFU officer, police station, Mt Darwin)

Understanding the context under which GBV occurs in each policing area is not only in line with the SADC Framework (2012) but can also help the police apply appropriate protocols and standards to ensure the safety and protection of victims. It was, however, noted at the two stations studied that the record keeping is done manually and stored in physical files and as there are no computers in the VFU offices. This creates challenges for storing and retrieving the often large volumes of data. Furthermore, going through large volumes of paper can be time consuming, especially given that VFUs are understaffed, as discussed below.

In terms of policies, the *Protocol on the Multi Sectoral Management of Sexual Abuse and Violence in Zimbabwe* (2012; hereafter ‘the Protocol’) is an important instruments in the police’s efforts to address GBV. For example, it implores VFUs to treat “sexual violence or abuse or domestic violence” as a priority crime that is be attended to in accordance with the minimum standard outlined in the CSC. According to the Judicial Services Commission (2012:33), this entails, among other things, prompt attendance to reports of the specified forms

of GBV, whether the report is made telephonically or physically at a police station. The Protocol also specifies that soon after reporting, investigation of the matter should start immediately and that the identity of the victim and the details of the matter should be protected. It further underscores the need for sensitivity in interviewing victims by providing private, safe, and friendly spaces. Where a victim appears reluctant to open up, the officer should ensure that the victim is referred to a counsellor, social worker or psychologist. A child should be interviewed in the presence of a trusted adult. It also emphasises providing victim support when it is necessary to refer victims for medical care and/or throughout the justice process, if the case goes that far.

The CSC is the key operational policy document that has a mission to “maintain law and order, protect and secure the lives and property of the people and to institute dynamic policing practices that engender effective prevention, investigation and detection of crime”. The CSC sheds light on the required organisational structures and culture, human resources, accountability mechanisms and complaint procedures in the context of crime, including sexual crimes. Although the CSC does not explicitly specify GBV, its guidelines on human resources and accountability measures cover violence.

It can be argued from the foregoing that the legislative and policy framework in the justice sector implicitly treats GBV as a human rights issue and a priority crime in Zimbabwe. It is noteworthy, however, that despite the evidence in Chapter 4 showing that in addition to sexual and physical violence, emotional violence is prevalent in Zimbabwe, the latter is not explicitly mentioned by the framework. Emotional violence is not legally recognised as a crime in Zimbabwe. The non-recognition of emotional abuse as a crime emanates from the fact that it is difficult to prove in a court of law that a victim has been emotionally abused. In most cases, physical and sexual violence have tangible and irrefutable evidence that can be used in courts. In reality, however, women who experience physical or sexual violence are also emotionally abused in the process. While it may be clear to an observer that the victim have been physically abused, it is the victim who feel the emotional abuse, which can be exacerbated by the way the case is handled, demonstrating that emotional abuse has different layers and sources.

5.3 Protection, care and support services

In the police sector, the main institutional set-up designed to ensure the safety and protection of victims of GBV is the VFU. The study revealed that despite their importance in the police’s response to GBV, many VFUs are poorly resourced. It emerged from the key informant

interviews that VFUs often lack adequate infrastructure to ensure that victims of GBV are attended to in private, safe and friendly spaces, as underscored by the Protocol and the SADC Framework (2012). The following statements illustrate this:

We are interested in the protection and safety of the victims. However, we have only one room used as an office, interview room, and we do not have an extra room to be used by GBV victims as they wait for their turn to be attended to. This greatly compromise their privacy. (VFU officer, police station, Mt Darwin)

Considering the sensitivity of GBV cases that we deal with in this unit, lack of ceiling and enough rooms compromise the privacy of the victims. Nevertheless, we interview under these conditions. (VFU officer, police station, Dotito)

Lack of adequate rooms means that VFU officers share rooms used as an office and interview room. Under these conditions the officers not interviewing the victim may be interpreted (by the victim) to be listening to the conversation and this makes the victim to be uneasy. She may not disclose all the details. (Member in charge, police station, Shamva)

These comments suggest that the availability of policies does not necessarily mean that victims are protected from violence. The environment in which GBV cases are, for example, discussed in rooms without ceilings and in rooms used as offices does not only compromise privacy but can also lead to secondary victimisation when confidential information is leaked.

5.4 Political will

The political will in relation to the police is reflected in Section 6.3 of the CSC, which underscores the need to strengthen the capacity of the police as a means to effectively respond to GBV and other crimes. To this end, the study revealed that officers in VFU are generally equipped with skills to gather appropriate evidence to facilitate the prosecution of GBV perpetrators and do regular training programmes that address providing victim assistance, handling evidence, management of crime scenes and interviewing witnesses, including children. The following statements confirm this:

Before one is assigned to VFU, training is mandatory. We are trained to deal with sexually, emotionally and physically abused women. We are trained to be good listeners as all detail is important. We have counselling skills and that rape victims need to be taken to hospital within 72 hours for PEP and EC. We are not supposed to show that we have been affected by the narration. It's a balancing game. (VFU officer, police station, Shamva)

Every province have a Police Updating Centre where police officers undergo refresher courses. VFU officers receive refresher courses that are in line with their duties of helping GBV victims. Workshops are usually done in collaboration with civic societies. (Member in charge, police station in Mt Darwin).

Notwithstanding these comment, the study also revealed that there is a general shortage of staff in VFUs, as the member in charge at Mt Darwin police station noted:

Ideally we would want to have a VFU officer in every department, but we don't have enough trained personnel. Members of the police force retire after 20 years of service, and this has implication on the training and in-service training.

The shortage of skilled, qualified personnel is a significant challenge to the police's effective response to GBV because victims have special needs that require specialist attention, as per the Protocol. This is particularly important in the set-up in Zimbabwe where every visitor to a police station is required to first report to a charge office, which is typically the front office of any police station. Without at least a member of the VFU in this office, victims are forced to explain the purpose of their visit the station to an officer in the charge office who does not have gender sensitive training and who can re-victimise the victim with inappropriate communication and actions. In essence, police officers in the charge office who have not received sensitivity training in GBV do not always attend to victims with the level of empathy required to help the victim.

It emerged that lack of transport is another major barrier for the police's effective response to GBV. In Zimbabwe, it is common for police officers to use public transport when taking GBV victims to hospitals or courts as police stations have shortages of transport. For example, in Mt Darwin, it was reported that the police often spent hours at bus stops to connect with Mt Darwin hospital or Karanda hospital in the district. To get to courts, police officers often have to find their way to Bindura, the provincial capital where courts are located, which is 60 km from Mt Darwin. Transport issues become particularly challenging when victims, who are expected to pay their own bus fares, are unable to pay or raise the bus fares. The challenge of transport within the VFU is evident from the following comments by the key informants:

Transport is a major constraint at the station. We used to have two vehicles here and at the moment one is grounded. The only running vehicle cover the VFU activities as well as other department's needs. At times police officers use public transport to execute their duties. (Member in charge, police station, Dotito)

The VFU vehicle that was donated [Name of NGO withheld] has since broken down. We now rely on the two that serve the whole station. This tend to affect our operations as transport is needed for investigation and escorting the GBV victims to other service providers like the clinics and courts. (VFU officer, police station, Mt Darwin)

Taking sexual abuse victims to health centres is mandatory life saving activity and should be done within a stipulated time. In case where police transport is not available, VFU officers use public transport. We may not like it, but it is the situation on the ground. (VFU officer, police station, Dotito)

Police officers are part of the Zimbabwean civil service whose members are generally poorly remunerated (Mugumbate 2016). Poor remuneration can sometimes lead to de-prioritisation of some crimes, including GBV, as perpetrators can bribe police officers to not investigate their cases. This is suggested by the following comments from key informants:

The police are part of the civil servants that are reportedly poorly remunerated. The situation is compounded by the fact that some people in the private sector are given United States dollars and government workers are paid in the weak Zimbabwean currency. In the context of crime, including GBV perpetrators, can bribe police officers and judges ... we read about the bribes in the media. (Officer, Musasa Project)

When approached with US dollar, the investigating officer can compromise on his/her duties to bring the perpetrator to book. While we do not condone corruption, it may be difficult to rule it out under the present economic challenges our country is currently facing. (Officer in charge, police station, Mt Darwin)

5.5 Multisectoral and collaborative approach

In line with the key tenets of the Protocol, SADC Framework and the CSC's call for the reinvigoration of a multisectoral approach to the prevention of GBV, the justice sector has partnerships and collaborations with other services providers, the community, and CSOs. There is, for example, a clear-cut referral system, especially for medical services. Mt Darwin police refers victims to Mt Darwin hospital and Dotito police refer victims to Karanda hospital, also in the Mt Darwin District. In all cases, the police require the hospital to complete medical examinations and complete a form called P231, which, in addition to giving evidence in court, is used by the police to check people on the wanted list. Between the police and the hospital there is a two way referral system where the police produces a report for the victim to be attended to at the hospital and the hospital provides expert knowledge on the physical harm as well as forensic evidence. These are typically used as evidence in court to prosecute perpetrators.

There is also close collaboration with the CBP. This is an organisational strategy within the justice sector that allows the police and the community to work together to solve crime and safety issues in the community. Community police officers are members of the community who have no criminal record and who have been provided with basic policing skills. In their area of jurisdiction, CBP officers are expected to do patrols during the day and night as a way to prevent crime by increasing police visibility in the area. This gives people, including survivors of GBV, opportunities to make reports. CBP officers also participate in community-level initiatives to curb GBV by participating in crime consultative committee meetings.

Various stakeholders (business people, officials from the Ministry of Gender and Community Development, police, health personnel, chiefs, counsellors and Members of Parliament) regularly attend the monthly crime consultative committee meetings that find ways to prevent crime in communities. In addition to general citizen security issues, GBV issues now feature prominently at these meetings and ways to prevent rape and other forms of GBV are discussed. The key informants highlighted the role of CBP as follows:

In the context of GBV and other crimes we work with community-based police who provide day and night patrols in their areas. As locals these men and women are culturally accepted in their areas and people are comfortable reporting to them. (Officer in charge, police station, Mt Darwin)

Together with officers from the station, CBP participate in crime consultative committee meetings that seek to prevent crime, including GBV, in the area. As locals they are heard when they talk against GBV to their fellow community members. (VFU officer, police station, Dotito)

To discuss GBV issues from an informed position, the CBP officers provide monthly statistics of GBV cases in their specific areas. While the VFU rely on the reported cases, the CBP can rely on context to document various abuses that communities condone. This has the effect of broadening the nature of GBV and complement the statistics collected by the VFU. A key informant indicated that the statistics showed the members the diverse nature of GBV and motivated them to collectively and individually raise awareness about this type of violence. This claim is evident from the following observation by a key informant:

In the crime consultative committee meetings, the CBP are given an opportunity to present the state of the community in the context of GBV. Normally they have recorded, reasons for abuse and the contexts under which many abuses occur... in many case cultural and social norms as well as economic challenges are to blame for the abuses. (Member in charge, police station, Mt Darwin)

Armed with GBV statistics in their areas from the CBPs, the crime consultative committee meetings help promote widespread community education about the availability of GBV services, nature and types of GBV and can kick start community mobilisation activities to change norms about GBV in the area. Key informant made the following comments:

These meetings (crime consultative meetings) are very important as they bring together various stakeholders to discuss crime in the area, including GBV. The presence of community leaders like chiefs and headmen is a key starting point for community involvement. Changing social and cultural norms is vital in curbing GBV. (Head, secondary school, Mt Darwin)

The CBP bring to the meetings data that reflect the situation in their community as far as GBV is concerned. Of importance are the causes which borders on cultural and religious norms. (Officer in charge, police station, Shamva)

As part of citizen security, the CBP officers also patrol their assigned areas at night and during the day, targeting common drivers of crime, such as alcohol abuse and gold panning (illegal gold mining done on river banks and hilltops). Gold panners degrade the environment by using mercury to process the product, and it is a criminal offence under the Environmental Management Act (2002). The presence of the CBP has proved to be an important deterrent of crime, including some forms of GBV. It also provides a channel through which reports are made, as one key informant puts it:

The presence of the police officers acts as a deterrent to crime. When crime occurs, the officers report the case to the station or bring the culprit for questioning. As members of the community, they use both the power bestowed on them as police officers as well as kinship relationships to arrest the culprits or to resolve potentially explosive situations. A woman can become a victim of violence at any time and it is not possible for members from the station to rush to the scene. Community police is like first aid. (Officer in charge, police station, Mt Darwin)

Another key informant noted the following:

Because of their presence [community police], victims report violence at any time. From the data brought to the station it is clear that in our area violence is decreasing. (VFU officer, police station, Shamva)

This study also revealed that the police work in close collaboration with NGOs. A major partner in this regard is the Musasa Project, established in 1988 and currently operating from four regional offices in Harare, Bulawayo, Gweru and Masvingo. Through these offices, the NGO provides an array of services² that include psychosocial support and counselling to women and girls; a 24-hour helpline for survivors of GBV that is accessible from anywhere in Zimbabwe to subscribers of the country's largest telecommunications service provider (ECONET), and access to expeditious medical treatment for women and girls who experienced GBV. The Musasa Project also provides the following: Temporary safe shelters to GBV survivors to keep the survivor and at times her children from further harm; legal aid through resident lawyers and paralegals who offer legal advice and assist survivors in GBV related cases; and advocacy by engaging policymakers on issues of conflict resolution and peacebuilding initiatives that positively impact women and girls. Equipped with a unique knowledge base and experience, the project works with the police to protect and offer services to GBV victims. For example, one VFU officer at Mt Darwin police station stated the following:

² <https://musasa.co.zw/>

Normally victims come here and we refer them to Musasa Project via the hospital or clinic. Some go straight to Musasa, who also refer them to us to facilitate investigations of GBV cases. We assist victims to get treated, including PEP and EC, but Musasa offers accommodation and rehabilitation.

An officer from the Musasa Project related how the shelter provides a haven for victims, some of whom have nowhere else to go:

Some women come here with blood and bruises all over. Some will be so shocked to relate what will have happened. Some will have been raped and it pains me to imagine society allowing a rapist to marry the victim to avoid the legal system from taking its course. We have cases of women escaping from marriages, which started when they were raped. (Officer, Harare, Musasa Project)

Premised on the idea that GBV is rooted in gender inequality, the NGO also trains women in self-sustenance projects such as candle making, sewing, poultry, cake making, polish making and commercial gardening. According to the key informant, the skills help women not to have to return to abusive relationships for economic reasons but to return to their families and communities as productive members. The project equally focuses on the prevention of GBV through service provision and awareness campaigns, such as distributing pamphlets, conducting workshops with various stakeholders, and holding public demonstrations to conscientise general citizens about security issues and the community about the causes of GBV, what actions survivors can take, and the legal resources available. The organisation works in constant consultation with the Ministry of Gender, the police, Members of Parliament, the Senate and religious organisations in its quest to shape policies that deal with GBV. It obtains funding from a number of bilateral and multilateral organisations. When asked about the strength and weaknesses of police response to GBV, a VFU officer and an officer from Musasa Project said the following:

As a sector, we are contributing to a reduction of GBV in the country. By arresting perpetrators, making people aware that GBV is a crime, police help to reduce cases of GBV. Our challenge, however, is lack of financial and human resources (VFU officer, police station, Mt Darwin)

As law enforcement unit the police help victims by referring them either to health centres or to our institution. Rehabilitation of victims help to reduce secondary victimisation. Armed with DVA, the police are generally doing a good job. However, our clients often indicate the police take time to react. (Officer, Musasa Project)

In addition to the CBP and NGOs, the police also collaborate with multiple services providers such as shelters, health facilities and the social welfare department, to ensure the safety and security of victims. Referrals are based on the principle that GBV victims have multiple, complex needs that cannot be addressed by one organisation. In Zimbabwe, the referral system

that involves the police, the health sector, social welfare and CSOs like Musasa Project is based on legislation and standard protocols that define the roles and responsibilities of the organisations involved. According to the police, the referral system has a number of challenges. It was noted, for example, that the social welfare can take long to respond to requests to take survivors to safe homes. This is evident from the following observations:

The other challenge we face is that upon notifying the social welfare to take the victims to safe homes, they often delay in doing so. When they come they cite transport challenges. (VFU officer, police station, Shamva)

At the police station we do not have shelter for victims save for temporary facilities to hold them while we wait for social welfare. In many case they take time, up to four or more days, before they respond. In spousal abuse the partner may show up and mediation results in reconciliation. By the time the social welfare show up the victim will have gone home. (VFU officer, police station, Mt Darwin)

The economic challenges currently faced by the country is crippling government services, including social welfare services. Faced with the situation where the social welfare does not respond on time, the police have no option but to try mediation between the survivor and the perpetrator, allowing the survivor to go back home. Going back to a location where violence has occurred is traumatic if necessary measures are not taken to prevent further abuse. This is evident from the following comments by the key informants:

As police we do not have food to give the victim. When social welfare officers take time to respond, we often contact the spouse after consulting the victim and in many cases of physical abuse reconciliation is achieved. Yes, there are dangers that revictimisation can occur, but we strongly warn the perpetrator. If the victim does not come back it does not necessary mean all is well. It's a complex situation. (VFU officer, police station, Mt Darwin)

At times the social welfare may not show up at all and we engage the perpetrator through the community police in consultation with the victim. After warning the perpetrator, the victim goes back to her home. In most cases it is working as victims do not come back to report violence, but its trick. (Officer in charge, police station, Mt Darwin)

5.6 Conclusion

This chapter focused on the police to explore the justice sector's response to GBV in Zimbabwe. It revealed that the police's responses are guided by three key national legislative and policies instruments: The DVA, the CSC and the Protocol. Together these instruments are aligned to the international and regional instruments the country has ratified (Appendix A). The legal and policy instruments are comprehensive and create an enabling environment to address GBV. The results show that every police station has a VFU and all police officers in

these units are trained to handle GBV. The VFU increased the police's capacity to investigate cases of GBV, offer counselling and increase public awareness about GBV. Through a coordinated referral system, the police work with social welfare and the Musasa Project to protect and provide care to GBV victims. The police connect with the community through the CBP, and this contributed to reduced levels of GBV and an increased propensity to report. However, the results show that lack of resources is weakening the sector's response to GBV.

The legal and policy framework in the police sector treat GBV as a human rights issue. Crafted in gender neutral terms, the DVA acknowledges multiple forms of GBV, which is critical to address this type of violence. The DVA encourages GBV victims to report and the Act sets the platform for awareness campaigns as the police base some of the awareness content on the provisions of the Act. On paper the DVA is a comprehensive piece of legislation and as result show that when known it instils fear into perpetrators and would-be perpetrators. Fear of criminal justice sanctions, such as arrest, reduces physical violence (Fattah & Kabir 2013), but threats and coercion, which contribute to emotional violence, may continue.

The CSC is a comprehensive policy document that sheds light on the internal operations of the police sector. It guides the police to fulfil law requirements for addressing GBV. In addition to guiding the police on human resources needs, the police are trained to deal with GBV victims in a sensitive way. The increased reporting levels is a sign that members of the police in the study area are responsive to GBV issues and adhere to established procedures. Research shows that fair procedures, measured by trustworthiness, respect, treatment, neutrality and voice (awareness campaigns), are key to address GBV (Elliot et al 2011; Goodman-Delahunty 2010). Although not explicitly stated, the CSC's thrust to improve police-citizen interaction (including victims of GBV) is informed by the procedural justice theory. The theory states that the citizen perception of fair treatment by the police increases the sector's legitimacy, which leads to increased likelihood of legal compliance (Das, Frank & Sun 2011).

Despite being comprehensive and enabling, these instruments focus mainly on addressing sexual and physical violence. Emotional violence, which the 2015 ZDHS showed to have been experienced by about 32% of women of reproductive age, is not a visible focus of the sector's response. The view of GBV from a solely criminal justice perspective constitutes a serious strategic limitation on the capacity of the police to fully address this type of violence as it misses the multifaceted nature of GBV and the fact that women rarely experience only one form of violence.

The chapter revealed that VFUs is an institutional set-up designed to protect, care and support victims of GBV in Zimbabwe. They offer a variety of services that are meant to ensure that victims are safe from further abuse and to address the after effects of sexual violence. The safety of GBV victims is very importance and evidence showed that the police plays a unique role in providing victims of GBV protection and access to justice (Goodman-Delahunty & Crehan 2015). The collection and recording of GBV cases on monthly basis is a good practice that helps reveal the nature and extent of the problem in the country. The collection of GBV statistics and the subsequent use of this data in awareness campaigns demonstrate that the police in Zimbabwe contribute to mechanisms to prevent GBV before it occurs. As separate entities within the police station, VFUs help ensure privacy and confidentiality, which are important when dealing with sensitive issues like GBV.

It emerged that the police officers in VFUs are trained to handle GBV issues. The availability of trained officers create an environment that reflects a measure of political will. Political will represents a broader context accountability to women and in the context of GBV, the status of women (measured by the prevalence of GBV) reflects weak or strong political will in a country. The government is the organising body that facilitates skills acquisition, raise the morale of staff through remuneration and the overall improvement of their work conditions. Programmes that contribute to staff development contribute to high staff morale and help retain staff. Senior workers has the potential to contribute to organisational culture, which guarantees continuity in terms of service delivery and policy implementation.

However, the chapter also revealed that in Zimbabwe only police officers in VFUs are trained to handle GBV issues, and most police stations have more police officers than VFU officers. This has implications for the protection, care and support services provided to victims of GBV because the police charge office is the first point of call for all those reporting to police stations. Thus, on arrival victims interact first with police officers at the charge office who do not have any gender- and GBV sensitive training and who can potentially expose victims to secondary victimisation through inappropriate actions and communications. The absence of VFU officers at the charge office is an institutional oversight that can weaken the police efforts to deal with GBV issues. This is a major gap given the wide body of evidence (Alaggia et al. 2012; Ansara & Hindin 2010) that consistently shows that ensuring privacy and confidentiality when dealing with GBV cases facilitates the process of disclosure and can help the victim to seek safe refuge, access services and obtain legal protection.

It also emerged that in addition to police officers' training and capacity, the justice sector's response to GBV in Zimbabwe is a function of institutional capacity, for example, available infrastructure such as cars and private rooms for interviewing victims of GBV. These determine the effectiveness of the actions taken by police officers when attending to victims of GBV, investigating GBV, enforcing national legislation, adhering to sector-specific policies, and developing sustainable intervention programmes to curb GBV at station level. Indeed, the scenario in Mt Darwin District where VFU officers use public transport to accompany GBV victims to court is typical for all areas in Zimbabwe and the situation can be dire for rural communities (Muridzo et al. 2018). The centralisation of the courts system and the inadequate allocation of resources, such as transport, to the police may bring into question the sector's political will to prioritise GBV issues and ensuring the safety and security of GBV victims.

The multisectoral response to GBV is based on good cooperation and coordination between different organisation and the recognition that GBV as a crime cannot be solved unless there is a collaborative response from many players (Holtmann 2011). The police use the crime consultative committee meetings to create links with relevant stakeholders, like health care workers, the education sector, chiefs, counsellors and politicians, to challenge local attitudes and social norms that condone violence. Furthermore, the police connect with the community through the CBP, who understand the norms of the local community. Therefore, the police together with the relevant stakeholders have the potential to challenge the acceptability of violence in their communities by creating culturally sensitive dialogues as well as gender and culturally sensitive packaged awareness campaigns. The results in this chapter suggest that the presence of the CBP in the community resulted in the reduced prevalence of GBV in the study areas as well as an increased propensity to report. Overall, by interacting with people in the community, the CBP respond to GBV at the individual, relationship and community levels of the ecological model. As members of the community, CBP officers understand the local social and cultural norms and are more likely to be in a position to diffuse potentially explosive GBV cases before they reach the police stations or before the victims are harmed. Furthermore, although not formally trained to handle GBV issues, the CBP help alleviate staff shortages in the formal police structures.

The CBP as an organisation, however, faces a number of challenges. The officers are not paid, and like their counterparts in the VFUs, the CBP officers lack transport to help patrols and take suspects to the nearest station. In the community, some people do not respect CBP officers and they are mocked and labelled *ndini ndamubata*, which means 'it is I who apprehended them'.

As community police officers they do not produce dockets and members of the community are aware that they do voluntary work, which is often rewarded when they bring culprits to the station. The non-remuneration of this section of the police may demonstrate a lack of political will and often leads the officers to engage in various economic activities to make a living. In many cases, policing duties suffer when these officers engage in their economic activities.

Collaborating with CSOs is a model consistent with the strategy that many governments are taking across the world since CSOs have unique a knowledge base in the specific areas they engaged in (KPMG International 2013; Thorpe et al. 2015). Musasa Project's efforts to provide shelter, counselling services and strategies to empower women economically are critical steps in the process to heal and rehabilitate the survivor. By providing shelter, counselling, and economic empowerment to abused women, Musasa Project responds to GBV by addressing risks factors acting at the individual level of the ecological model.

It should be noted that Musasa Project and the police in Zimbabwe are operating in an environment where there are a shortage of resources. For example, the police face transport challenges to timeously transfer victims to the Musasa Project. The latter, on the other hand, depends on donors for funding and the current political challenges in Zimbabwe has led to massive donor fatigue and flight. This is preventing the NGO from increasing its intake, despite an increased demand. Furthermore, although the Musasa Project has offices in all the provinces, shelter is provided only in Harare, Bulawayo and Gweru (Midlands Province). Survivors from other places in Zimbabwe have to find their way to these shelters, and due to financial challenges, many survivors cannot afford to do this.

NGOs that provide shelter, like Musasa Project, are public places known by both men and women as there is sustained publicity about them. While abused women in Zimbabwe are aware of these organisation, visiting them may lead to further violence. To keep the family issues 'secret', the Shona and Ndebele culture advocate for the abused women to seek refuge at her parents, the parents of the partner or any relative. As such, the referral of women to Musasa Project is not only considered culturally subversive but may add fodder to potentially explosive incidences of further violence. In many cases it is a facility that is used by women who have made up their minds to leave the abusive partner. A study by the World Bank Group (2016) shows that culturally sensitive responses have a higher chance of success by encouraging the involvement and buy-in of members of the target population.

Overall, the justice sector's multiple stakeholder response has both cultural sensitive and non-sensitive elements. In the context of GBV, a culturally sensitive response takes into account specific cultural norms and values that permeate individual beliefs, behaviour, communication patterns and perceptions and the way these interact with broader structures and institutions (Okamoto et al. 2014). The way these beliefs, behaviours and norms are handled determines not only the acceptance of the response but may trigger further violence.

The referral of women to institutionalised shelter providers can be seen as culturally insensitive because the Zimbabwean culture encourages abused women to seek help from relatives and not from 'foreigners'. The cultural practice called *chakafukidza dzimba matenga*, which literally means 'what happens in the family is private', creates challenges for women to accept an offer for temporary accommodation at these formal institutions. Robbers and Morgan (2017) show that community-based responses that involve negotiations with community leaders and relatives are preferred to services provided by humanitarian staff. There is a basic mistrust in the services provided by international agencies as they are believed to act only in favour of women and against the interests of the involved families (Robbers & Morgan 2017). However, other studies show that community measures do not necessarily result in the protection of abused women and can also support revictimisation by blaming the victim (Horn 2010; William & Aldred 2013). This shows that the nature and cause of GBV are largely context specific and that culturally sensitive strategies are likely to impact the levels of this type of violence.

It can be concluded that the police response to GBV in Zimbabwe is a function of institutional capacity (availability of cars, furniture, and private rooms); officers' capacity (level of training and motivation) and social context (cultural and religious norms that condone use of violence). These determine the actions taken by police officers when attending to victims of GBV, investigating GBV cases, enforcing national legislation, adhering to sector-specific policies and developing sustainable intervention programmes to curb GBV at station level.

Although the institutional capacity of the police is constrained by a lack of resources due economic challenges the country is currently facing, the VFUs are staffed with trained officers trained to deal with GBV in a sensitive manner. The police work with Musasa Project, health the sector and social welfare to provide support and care services to GBV victims using the available transport and infrastructure at police stations. The police's preventive strategy of awareness campaigns helps raise awareness about GBV issues at individual level and transform harmful gender norms at community and society levels of the ecological model. These awareness campaigns target social and cultural norms, which are the overarching root causes

of GBV (Sida 2015; Van Baak 2016). It also emerged that these campaigns focus on making women and girls aware of existing laws and policies to protect them from GBV and of where to report when abused as well as making the general public aware of the effects of this type of violence. Furthermore, the campaigns focus on social and cultural norms like *chiramu* and how this practice exposes young women to sexual abuse. It can be concluded that the reactive component of the response (e.g. investigating cases and service provision) and the proactive component of the response (e.g. awareness raising) meet the minimum requirements to deal with GBV issues in Zimbabwe. However, lack of resources constrain the police to fully prevent this type of violence before it occurs.

Chapter 6: Institutional response to GBV in Zimbabwe: The health sector

6.1 Introduction

This chapter assesses the institutional response to GBV by focusing on the Zimbabwean health sector. The health sector is important in meeting the needs of GBV victims through its five levels of service provision. These are clinic (level 5); polyclinic (level 4); referral rural hospital (level 3); provincial hospital (level 2) and central hospital (level 1). Levels 5 and 4 are primary health care centres staffed by nurses, and doctors, nurses and other health specialists are found at level 3 to 1. The complexity of services offered increases from level 5 to level 1. The primary health facilities (clinics and outpatient departments) at hospitals are the frontline of any health system and their role is to initiate the treatment process by diagnosing and gathering the case history of the affected person. GBV survivors, physical and sexual, come in contact with nurses before being referred to other sections for further examination and treatment. As in the justice sector, this chapter assesses the health sector's responses in accordance with the categories explained in Section 3.7

6.2 Laws and policies

The health sector is generally guided by Section 76 of the Constitution of the Republic of Zimbabwe (2013), which provides for the right to health care for all citizens and permanent residents. In the context of GBV, the DVA implores the health sector to facilitate the application for protection orders when an act of GBV has been or is being committed by providing medical evidence, which should be supported by a police report (Section 8.b). A protection order is a written undertaking that legally bars the perpetrator from interacting with victim.

In terms of policies, in the context of GBV the health sector is mandated by the *National Health Strategy for Zimbabwe 2016–2020* (NHS) to treat victims of injuries sustained as a result of GBV as well as to prevent unwanted pregnancy and the contraction of HIV in the case of rape. This shows that the NHS only focuses on physical and sexual violence. Developed by the Ministry of Health and Child Care, the vision of the strategy is to have the highest possible level of health quality of life for all its citizens. To achieve its stated health commitments in the context of GBV, the NHS focuses on the provision of comprehensive preventive, diagnostic

and treatment services at all primary health centres as well as to empower health workers with tools for effective community engagement. The NHS also calls for the creation of multi-channels and opportunities for community participation and the strengthening of referral systems. Activities are encouraged that promote a reduction in substance abuse (a key risk factor in GBV) through a multisectoral approach that include schools, the police, and faith-based organisation.

In addition to the NHS, the health sector's response to GBV draws largely from the Zimbabwe Patient Charter (ZPC), which was developed by the Ministry of Health and Child Care (MoHCC) to protect patient consumer rights and to improve health service delivery in the country (MoHCC 2010). The ZPC spells out client rights in relation to access of health services and treatment. Premised on the ideal of ensuring the dignity of patients, the ZPC is designed to accord right on hospitality, confidentiality, consent, privacy, humane treatment choices and redress of grievances. The ZPC underscores *every* patient's right to be treated and attended to. In the event of an accident or emergency, patients should be attended by a health worker immediately upon arrival; in Zimbabwe, GBV is treated as an emergency as per the country's constitution.

As in the justice sector, the Protocol sets out roles and responsibilities of individual and professionals in the health sector and describes the sectoral response to sexual abuse and violence. The Protocol provides for the Ministry of Health and Child Care to ensure that all victims of sexual abuse and violence receive immediate, prioritised medical care and the necessary support to mitigate the negative health effects that result from the abuse and violence. This includes the provision of emergency medical examinations and enabling survivors to secure medical affidavits to enable them to pursue the legal route. In the case of a child victim, the medical officer is obliged to direct parents to consent to medical treatment according to Section 9 of the Children's Act (2001). At all primary health care centres, the health worker in charge should ensure the availability of medical supplies such as PEP and EC at *all* times as these are vital in cases of GBV. However, this depends on the availability of these drugs at provincial centres and transport to move them when needed by primary health centres.

6.3 Protection, care and support services

The ZPC upholds patients' rights to privacy during consultations, examinations and treatment. In line with this, the study results revealed that health workers treat privacy and confidentiality

as integral components of the safety and security of GBV victims and consider these non-negotiable issues (WHO 2013). As one key informant noted:

In addition to ensuring privacy during consultation and treatment, the case history of a victim is an important dimension of privacy and confidentiality. Information related to the victim is not disclosed to anyone. It is a closely guarded secret that can break the victim or patient. (Nurse in charge, primary health care centre, Mt Darwin)

Overall, based on the principle of ‘do no harm’, the health sector efforts in Zimbabwe are mainly focused on secondary prevention. This mainly entails protecting the victim from the effects of abuse-treatment of injuries and the provision of post-rape care that include clinical interventions like PEP and EC to prevent HIV infection and pregnancy. For example, one participant said the following:

Our primary aim is to save life by stopping bleeding as well as to prevent secondary effects like unwanted pregnancy and contracting HIV. So patients cannot wait for longer, we prepare them to receive EC and PEP, which should be administered within 72 hours. (Nurse in charge, clinic, Shamva District)

Despite the foregoing, the results also showed that despite the health workers’ good intentions, their efforts to ensure victims, safety and protection are often hampered by the fact that health facilities in the country are generally ill equipped in terms of infrastructure and staff. To this end, the number of patients often overwhelm outpatients departments, particularly in rural hospitals and primary health care units (clinics), making the issue of privacy secondary. The following statements illustrate this:

Women come to the clinic for various services like reproductive issues, natal services, treatment and sexual abuse related services. However, we do not have enough rooms and manpower to ensure that consultations are done privately due to large number of patients at the clinic. (Nurse in charge, clinic, Shamva)

At the hospital we have enough rooms to facilitate the private consultations when dealing with GBV victims. However, our challenges are rooted in staff shortages. Due to economic challenges staff are leaving for greener pastures. (Nurse in charge, St Albert’s Mission primary health care centre)

6.4 Political will

The skills, expertise and experience of personnel in the primary health care are key in enabling the sector to fulfil its mandate of treating and offering other services to GBV victims. It is to this end that the NHS underscores the need to create an integral plan for pre-service training, especially in curative medical culture. Outlining the nature of training nurses receive, a senior manager in the health sector said the following:

Depending on their level of health workers receive training that enable them to diagnose, treat ailments, stop bleeding as well as administer post exposure prophylaxis and emergency contraception in the event of rape.

In Zimbabwe, as in many parts of the world, health systems are biomedicalised. This means that health systems are grounded in the understanding of diseases, biological processes and medical care (Colombini et al. 2013). Key informants indicated that training in GBV issues is often voluntary and done as refresher courses. This means that because of medical training, providers apply a biomedical approach when dealing with GBV cases (Colombini et al. 2013), focusing on the treatment of physical complaints and not giving due diligence to the causes of the problem. One of the reasons given during interviews was that they are afraid to turn away survivors who may be in need of treatment of physical complaints. One key informant noted the following:

Training in GBV issues is not an integral component of the medical training health workers receive. Plans are underway to include it [GBV training]. At the moment, it is often voluntary and done as a refresher course, thanks to the funding from the donor community. (Nurse in charge, public health centre, Mt Darwin)

A FGD participant observed the following:

Asking questions about the cause of GBV may scare many victims who may not be willing to open up. Even if they do not open up we are still mandated to treat their physical ailments. Many present themselves for this reason (treatment). (FDG participant, Dotito Clinic, Shamva)

In the context of GBV, this means that psychological and emotional aspects are often systematically ignored when bio medical approaches take precedence. As shown in Chapter 4, emotional violence is one of the most common types of violence in the country. In the context of this aspect of GBV, a nurse in one of the FGDs said the following:

Training of GBV issues is voluntary. I attended a workshop in which we were taught how to identify and handle GBV cases. It needs a lot of patience. Due to pressure of work you end up concentrating on the treatment aspect [physical violence].

The study participants also painted a grim picture of the health sector fraught with acute shortages of medical supplies. The supply side of the health sector in Zimbabwe is facing a number of challenges in the wake of shrinking economy and political uncertainty. The high levels of physical, emotional and sexual violence (Chapter 4) mean that many seek medical help when injured. Shortages of medical equipment, drugs and the rising cost of private medication is causing people (including GBV survivors) to resort to buying medication on the streets, with dire side effects. This was confirmed during key informant interviews and discussions:

We are currently experiencing medical equipment and drug shortages due to economic challenges the country is going through. When victims come for treatment, we often refer them to private pharmacies to buy medication. This does not only cause inconveniences but may be too costly for many who resort to buying medication on the street. We do not recommend it but people do it. (Nurse in charge, public health centre, Mt Darwin)

In addition to medical consumable like drugs, the health sector need financial resources to service medical equipment, to cater for training needs as well as to remunerate staff, all of which is done at ministry level. Some of us are contemplating leaving as salaries are low. The budget is done at ministry level and I am not sure if it specify how much should be spent on issues like GBV. (FGD participant, Dotito Clinic)

Allocating resources to prevent GBV makes a lot of sense for a country that is facing economic challenge. While this is a noble idea the greatest threat is corruption. Resources may end up being diverted. This cannot be ruled out in this country. (FGD participant, St Albert Mission Public Health Centre, Mt Darwin)

The health care response to GBV incurs costs, such as the purchase and servicing of medical equipment, infrastructure, training of health personnel, and competitive salaries to motivate staff. For more than two decades, however, the economy of Zimbabwe has been on a downward trend (Ministry of Health and Child Care 2015). Lack of vehicles, fuel and electricity and ageing medical technology has had debilitating effects on all health facilities in the country. Most health facilities lack basic medical drugs, and where they are available, usually at private health centres, service providers demand payment in US dollars. Apart from this, the supply side of the health delivery system is riddled with corruption. These structural barriers linked to the way the Zimbabwean health sector should operate hinder efforts to effectively implement the NHS.

While the government of Zimbabwe allocates a budget to the Ministry of Health, the budget does not specify the exact amount to be spent on GBV management. In America, for example, legislation and policies on GBV include specific provisions on the amount of government funds that are to be administered to implement the Act or strategy (UN 2014). This is crucial as previous research shows that the costs involved in prevention and early intervention services are less than those required for investigating cases and meeting the needs of abused women and girls (UN 2014). For a country with limited resources like Zimbabwe, the potential long-term economic savings after investing in the prevention of GBV are phenomenal given the lifelong adverse health, social and economic consequences of GBV (Jamieson et al. 2014).

The results from this study show that medical personnel need formal training to identify and handle GBV victims in a sensitive manner. The sensitisation training must be part of their

medical training and not to be voluntary. During discussions and interviews, it came out that nurse training programmes involve studying basic sociology that features gender issues. Yet, the results show that nurses need trauma debriefing since they can be victims of GBV in addition to suffering emotionally when dealing with GBV issues. Here is another example from a nurse's testimony to this:

As nurses, we are human beings. When a woman comes telling me that I was beaten because of we had a misunderstanding with my husband over his girlfriend, emotions can rise in me if I am in the same position. (Nurse, FGD participant, Shamva)

Another participant noted:

We need in-house support training during staff debriefing meetings. This psychological support creates platforms for us to pour out our feelings and experiences that we go through that often traumatise us. (FGD participant, Dotito Clinic)

The psychological support constitutes professional support that is key to enhance professionals' social and mental wellbeing. Working with sex abuse victims is stressful for professionals, evoking feelings of uncertainty, frustration and emotional turmoil (Bhaskaran & Seshadri 2016).

In addition to training that is biased towards the biomedical approach, the primary health sector is characterised by shortage of staff. A nurse at a local clinic said the following:

We are only seven at this clinic, and at any given time, three will be on duty since there are shifts. We have to attend to nursing and expecting mothers. At times numbers are overwhelming and we prioritise cases, including GBV issues.

GBV has both clinical conditions (e.g. unexplained chronic pain and sexual dysfunction) and behaviours (frequently missing appointments, women trying to hide injuries, frightened women, and poor or non-attendance at antenatal clinic; WHO 2013). While nurses can identify both conditions, staff shortages at the clinics constrain them from pursuing the behavioural component that can be pursued by village health workers (VHWs). The following comments illustrate this:

The treatment of physical ailments, the administering of PEP and EC help to reduce the spread HIV and unwanted pregnancy. These can have long-term effects if not addressed. In this regard, our response to GBV is satisfactory but it can be constrained by lack of resources, including staff. (Nurse in charge, clinic, Shamva)

Clinics and hospitals help a lot. They provide medication and counselling to abused women. However, at times at any given time, there are few nurses at the clinic and patients wait for long time before being attended to. At times they end up ill-treating the patients. (GBV survivor, Musasa Project, Harare)

Staff shortages can undermine the health centres' responses in a number of ways. Staff shortages may result in victims being attended to at a health facility outside the 72-hour window period for the administering EC and PEP. Furthermore, staff shortages can lead to delays in evidence collection and evidence presentation of evidence before the courts. Overworking staff may have knock on effects, such as demoralisation, poor job satisfaction and weak staff retention.

6.5 Multisectoral and collaborative approach

The health sector response in Zimbabwe takes place within a multisectoral framework that includes the police, NGOs and government departments. This forms a large part of the health sector's referral system. Thus, for treatment and evidence gathering, victims are referred from clinics to hospitals in the event of serious cases. Normally these procedures are done at the clinic or facilities that provide primary health care. As per the DVA, the health sector is not allowed to treat any person without a police report detailing the cause of the injury. Thus, the health sector and the police work closely together. The referral to the police is meant to facilitate evidence gathering for the prosecution of the perpetrator. Upon arrival at the primary health facility, medical forensic examinations are done to gather evidence for prosecution and treatment and PEP and EC are administered in a confidential environment. The confidential environment is created by offering treatment in a separate room, and where possible, by a health worker of the same sex as the victim. A survivor of sexual abuse accompanied by the police is given preference at the clinic and the outpatient department at the health facility. It was reported that the health workers have trained the police that an officer accompanying a survivor should be in plain clothes to minimise stigma. Police officers attached to the VFU are normally trained by health workers on what should be done to preserve DNA evidence in the case of sexual assault. New recruits receive trainings. The participants described it as follows:

As health providers we work with the police on sexual and physical assaults. Evidence gathering is a specific procedure that need care and expertise. So the health workers train the police officers on how to 'handle' the environment under which assaults (sexual) occurs for forensic evidence. (Nurse in charge, clinic, Shamva District)

As a standard procedure, sexual abused victims are accompanied by police to health centres. This is done to ensure that anything that may provide evidence is carried. Furthermore some questions are asked from the police officer to avoid repeating the same questions to victim who will have been asked by the police. Officers accompanying the victim normally do not put on uniforms. Upon arrival,

the officer produce identity card as proof that he/she is a police officer and the victim is assisted promptly. (Nurse in charge, primary health centre, Mt Darwin)

In addition to the police, health centres can also refer victims to the social welfare. The Social Welfare Department is in the Ministry of Labour and Social Welfare. This department offers safety services to victims of GBV as well as pre-trial and post-trial counselling and social services. Social services offered include moving victims from unsafe environment into places of safety, such as children's homes and shelter providers like Musasa Project.

The study showed that stakeholders in the referral system have a clear understanding of their roles and responsibilities. For example, the clinics are aware of what to do, when to refer a patient to the hospital in case of major injuries, burns, and other forms of physical abuse. The hospital usually refers the patient back to the clinic for the management of wounds. The following comments substantiate these claims:

Major cases of injuries are normally referred to hospitals, which are in major towns and cities. After the victim has stabilise, the management of wounds can be reassigned to the primary health centres. This is done to cut the costs of keeping the patient in hospital. Victims can easily walk to the nearest clinic for change of bandages and other simple wounds management issues. (Nurse in charge, clinic, Shamva District)

Victims who had severe injuries and are showing signs of recovery are often discharged to reduce the costs of keeping them in hospital. The management of injures can be managed at a local primary health facility with an option of refereeing them back to the hospital if necessary. (Nurse in charge, primary health facility, Mt Darwin)

However, according to key informants in the health sector, the referral system has no follow ups. For example, if a person is referred from the clinic to a hospital for treatment, there is no mechanism to ensure that the survivor visited the hospital. Some survivors report violence late, and according to key informants, it is agonising to tell the survivor that there is no evidence to be gathered because of the time factor. The institutional oversight and delay in reporting are evident from the following comments by the key informant participants:

Save for victims transferred from clinic to hospitals by ambulances, other victims are given documents to show that they have been transferred hospitals. However, there is no mechanism to check whether the victim later goes to the hospital. Nurse in Charge, St Alberts primary health centre)

Due to cultural, social norms as well family pressure victims may delay in reporting. This creates challenge for gathering evidence thus weakening our response to GBV. So you see the effects of GBV can be exacerbated by late reporting. (Nurse in charge, clinic, Shamva District)

In rural areas, the health sector engages communities mainly through VHWs, who are volunteers recruited from the community, are mainly women and tend to understand the sociocultural norms of their communities. The VHWs' activities fall into two categories: Firstly, they encourage GBV victims to seek medical care and to offer counselling; and secondly, VHWs take part in joint awareness campaigns jointly with the police and other stakeholders in the crime consultative committee. This shows that the community mobilisation component (active participation by the community) is absent and raising community awareness about GBV constitutes community outreach. Community mobilisation does not only have the potential to address the root causes of GBV but also to create a sense of programme ownership, which can increase the sustainability of the programme. However, as noted by a nurse in charge at one of the primary health centre this is not the case:

As volunteers they are supposed to be paid tokens of appreciation, which rarely come. They face transport challenges and instead of making systematic rounds in the community this can be interrupted as they go to work in their fields. They have families to feed.

Working directly with the victims of GBV, these volunteers provide supportive care to abused women in a number of ways according to key informants. Overall, VHWs encourage survivors of GBV to seek medication, provide an initial supportive response to aid disclosure as well as offer mediation services between the survivor and the perpetrator. A nurse in charge at a clinic in Shamva District, for example, said:

As people in the community, they can discuss GBV issues whenever an opportunity arises ... at a funeral, wedding, food for work programmes or at church. In our society there is a tendency for people to seek spiritual help for ailments that require medical attention. So the health workers help to encourage women to seek medical help

The study also revealed that the health sector is often involved in awareness campaigns with the local leaders, councillors and faith-based organisations. During joint addresses with these stakeholders, health workers often raise awareness of the health, social and economic consequences of GBV for the victims, their family and society. Asked what they normally include in their address to the community, informant nurse in charge at primary health centre in Mt Darwin said:

We tell them that GBV results in injuries, death, and this is a cost to the families. We also tell them about the consequences of the perpetrator being arrested, the disruption of the family together with the medical costs when the victim visit the health centres for treatment ... we also tell them about the need to visit the health centres on time, basically we tell them about the importance of restoring health after the abuse.

The results of the study show that the health sector collaborates with CSOs at a higher level of the health system (provincial and central hospital) to establish OSCs for GBV victims. In Zimbabwe, OSCs are hospital based and are currently found in major cities of the country like Harare, Gweru, Gwanda, Chinhoyi and Bindura. Services offered at these centres include medical care, counselling, police and legal services. The health care in Zimbabwe is conceptualised at the five levels discussed earlier. The collaboration of the health sector and the civil society is evident from the following comments made by the participants:

Yes, our ministry (of health) work with non-governmental organisations to establish one-stop centres at major hospitals. I know one at Parirenyatwa hospital in Harare. These centres [OSCs] offer services provided jointly by the health, police and social welfare. (Nurse in charge, primary health centre, Mt Darwin)

At this level [primary health centre] we work with village health workers. However at higher levels [provincial and central hospitals], the ministry work with non-governmental organisations to facilitate the provision of services by the health workers, police and counsellors through the establishment of one-stop centres. Victims from rural areas have challenges from benefiting from these centres [OSCs] as they are absent in rural areas. (Nurse in charge, clinic, Shamva)

The establishment of OSCs is in line with global thinking of a multisectoral approach to curb GBV. The strategy is aimed at reducing secondary victimisation by offering essential services at the same place.

6.6 Conclusion

This chapter explored the health sector's response to GBV in Zimbabwe. The results revealed that the health sector's response is guided by the DVA, the NHS, the ZPC and the Protocol. Taken together these instruments are aligned to the international and regional instruments and have an overall mandate of promoting human rights in the area of health. To this end it emerged that the health sector in Zimbabwe focuses mainly on treatment and counselling as a response to GBV. Although the sector offers an array of medical services, the results show that the sector is characterised by staff and medical equipment challenges, which impact its response to GBV. The training of the staff in the biomedical approach positions the staff to treat GBV victims, but a lack of GBV sensitive training compromises their effective handling of the social aspects of this type of violence, like depression. The results showed that the health sector collaborate with NGOs and other governments departments to establish OSCs as referral hospitals and work with VHWs at primary health centres. At the primary health centres, the VHWs add much needed cultural sensitivity, which is key in dealing with GBV issues. Working with the police,

the health sector is responsible for gathering medical evidence that is vital in the prosecution of perpetrators of sexual violence.

As in the justice sector, the legal and policy frameworks for the health sector seek to protect victims of GBV by treating this type of violence as a human rights issue. By imploring the health sector to provide forensic evidence to be used in courts, the DVA treat GBV as a criminal issue in which justice needs to be pursued. Legislation that criminalises violence codifies the right of women and girls to live free of violence (Klugman 2017). The medical evidence culminates in the issuing of protection orders, which are key to provide protection and access to support services. The NHS's thrust is on treatment; the Protocol (2012) emphasises the mitigation of sexual offences; and the ZPC seeks to address the rights of patients (including GBV victims). GBV is both a human rights issue and a public health crisis, with enduring health and economic consequences. To this end, the treatment of victims reduces the morbidity burden and helps to release women into society as socially and economically active people.

However, emphasising the treatment and mitigation of sexual abuse means that the instruments are focused on dealing with physical and sexual violence, which constitute a biological component of health. GBV is both a biological (e.g. the treatment of wounds) and a social phenomenon (e.g. emotional abuse), and in the context of this type of violence, the emphasis on the treatment and administering of EC and PEP means that the health sector in Zimbabwe does not fully address the social aspects of GBV. The study revealed that nearly a third (32%) of women in the 2015 ZDHS has experienced emotional violence. In addition to PEP and EC, sexual violence victims require psychological healthcare for severe depression and post-traumatic stress disorders as well as screening programmes to identify victims.

Furthermore, the provisions of the ZPC protect the rights of the patient, but its efficacy depends on the personal integrity of the health worker, the availability of appropriate infrastructure for private counselling, the availability of resources to fund a second medical opinion and legal fees in the event of suing a negligent health worker. According to the ZPC, the victim has the right to sue the medical staff in case of medical negligence. Proving medical negligence can be a daunting task for victims who may not have enough financial resources to hire a lawyer. Furthermore, the requirement for evidence by an 'expert witness', defined as a medical doctor, is problematic because it is nurses and clinical officers who provide firstline treatment and care in a context where medical doctors are few, especially in primary health care centres.

It emerged that the health sector in Zimbabwe focuses on treatment and counselling as a response to GBV. This is necessitated by the fact that physical violence is the most common form of GBV in Zimbabwe and it manifest as burns, bruises, swollen faces, and much more, which naturally become the immediate concern of the health care workers. In addition, the sector offers post-rape care that includes clinical intervention like PEP and EC to prevent HIV and pregnancy. These are highly protocolised and specialised services that can only be offered by the sector, and the Zimbabwean health sector regularly offer these services. As mentioned earlier, the treatment of victims reduces the morbidity burden and its associated costs, which do not fall on women alone but on their children, families and the wider society, constituting major barrier to achieving equitable sustainable human development.

By focusing on the treatment of GBV victims, including administering of EC and PEP, the health sector is not only responding to this type of violence at individual level of the ecological model but also reducing this type of violence to a physical and sexual phenomenon. The focus on the treatment of GBV victims is part of a traditional biomedical approach, which has been found to be inadequate and inappropriate to address GBV (García-Moreno et al. 2014). A number of countries are changing their approach because of this weakness (Bacchus et al. 2012). The results of this study show that emotional violence is increasing in Zimbabwe. An analysis of individual-level factors shows that the economic status of women and their level of education contribute significantly to levels of GBV in Zimbabwe. To provide a comprehensive health care response to GBV, health care workers should take into account women's multiple needs that go beyond physical and sexual aspects (Briones-Vozmediano et al. 2015; WHO 2013). The sector's participation in awareness raising means that the sector is operating at the community and societal level of the ecological model where cultural and gender norms were found to precipitate GBV.

The chapter revealed that the health sector also takes steps to gather evidence for the prosecution. As a result, the health sector aligns its response to make the perpetrator accountable for their actions as well as initiate conditions to create harmony in families. In the Zimbabwean culture, the family is an important institution. A greater percentage of GBV occurs in the home and the main perpetrators are partners. The facilitation of the legal process by gathering of evidence, for example, forensic evidence after rape, reduces GBV to a physical and judiciary phenomenon. GBV is a complex issue that touches on legal, ethical, and human rights and social aspects, and therefore it should not be protocolised as is the case with clinical issues such as high blood pressure (Goicolea et al. 2015). The health sector's response is not

only shaped by the causes and the context under which GBV occurs but also by the biomedical paradigm of physical health and illness. The latter tends to take precedence.

The chapter revealed that all forms of physical abuse are recorded as assaults at clinics and hospitals. This has observable signs (burns, bruises, swollen faces), which naturally become the immediate concern of the health workers. The sector's investigation aims to treat the survivor for these symptoms and signs. However, survivors are likely to suffer more from depression, post-traumatic stress disorder and suicidality than the general population (Dillon et al. 2013; Lagdon et al. 2014; Ottisov et al. 2016). By focusing on the need to treat the survivor and take steps to gather evidence for prosecution, the health sector reduces GBV to a physical and clinical phenomenon. Yet GBV is a complex issue that touches on legal, ethical, and social aspects as well as awareness that this type of violence is a public health problem that is not protocolised like other clinical issues such as cholera (Giocolea et al. 2016). In many protocolised clinical problems such as cholera, one can deduce the cause from the symptoms but with GBV it is not that obvious.

The health sector is characterised by staff shortages, poorly remunerated health workers, lack of formal gender sensitive training and providing services as responses to problems rather than long-term prevention strategies. GBV issues have not been prioritised because of the sustained economic problems currently being experienced by the country as well as the growing needs of the community. The results show that health workers are failing to fully meet the needs of GBV victims because of lack of gender sensitive training coupled with the protocolised nature of the health discipline. As members of the community their own attitudes, which should have been neutralised by gender sensitive training (pre- and in-service), worsen the situation because of how they handle women at health centres.

The shortage of staff in primary health care tends to create a vicious circle of increasing demands as staff prioritises new cases and deprioritises prevention. It is possible that Zimbabwe is experiencing an increased demand for health services by GBV victims because the results show that nearly half the respondents (45%) reported having experienced physical, emotional or sexual violence. As such, the lack of human resources undermines the ability of the health ministry to shift from its current position, which is largely based on response services, to one that considers the underlying risk factors of GBV and implements preventive interventions to stop GBV before it occurs (KPMG 2016). International health standards in the field of GBV prevention emphasise the need for training on the prevention and response ends of the care

continuum as well as training on the root causes and preventive causes of GBV (Jewkes 2014; Thorpe et al. 2015; UN Women 2012).

In addition to showing that there is a staff shortage, the study revealed that the health workers do not receive formal gender sensitive training. Instead they receive training that enables them to do clinical inquiries in order to establish a history of the condition, and to examine patients (WHO 2013). This biomedical training is essential to meet the physical needs of patients (or survivors), but may not meet the emotional and psychological needs of abused women and girls. As stated earlier, emotional violence is increasing in Zimbabwe, calling for urgent intervention on the part of medical personnel. The training health workers receive does not teach them to understand the nature and patterns of GBV, and therefore, gender sensitive training is crucial to increase the knowledge and confidence of health workers on how to interview survivors and how to intervene. The sensitivity displayed by health professionals during inquiry can increase the chances of disclosure (Feder et al. 2011). Facilitating GBV disclosure is an important starting point for any health care strategy to curb this type of human rights violation. Asking about GBV in a professional and non-judgemental way can help remove the feelings of isolation, guilt and shame that GBV survivors experience (Feder et al. 2011). This helps to convey the message that not only is there help available but there is also hope.

The chapter revealed that the health sector is experience medical equipment and technology shortages. This prevents the sector from fully implementing the NHS and ZPC. Research also shows that health workers experience obstacles to effectively implement their strategies and responses to GBV (Beynon et al. 2012; Kirst et al. 2012, Ramsay et al. 2012). The success of the NHS hinges not only on the excellent wording of the strategy but also on the availability of resources, staff with relevant skills and experience, the socioeconomic and cultural realities of the health workers, the modification of the protocolised care. Lack of financial resources has affected the implementation of the excellent provisions of the NHS, which include in-service training of health personnel, community awareness programmes on drug abuse, and the consistent supply of medication for the treatment of different ailments, including injuries caused by GBV.

Many of the problems the Zimbabwean health care sector faces are due to lack of political will. Political will is critical for an effective response to GBV (KPMG 2016). Political leaders represent a broader context accountability to women, and in the context of GBV, the status of women (measured by the prevalence of GBV) reflects how weak or strong the political will is

in the country. In the context of public health issues like GBV, political will determines the availability of staff, the alignment of training needs of health workers to deal with GBV issues, the motivation of staff through effective remuneration, and the provision of resources at health facilities.

It emerged that the health sector collaborates with NGOs and government departments to establish and run OSCs at referral hospitals and to work with VHWs at primary health centres. OSCs in Zimbabwe are hospital based, and while hospital-based OSCs are better equipped than independent OSCs (Colombini et al. 2011; UNFPA 2010), the hospitals in Zimbabwe that house OSCs are in urban areas, creating accessibility challenges for rural victims. The 2015 ZDHS showed that GBV prevalence in urban and rural area is the same with 45% of women in both rural and urban reporting that they experienced physical, sexual or emotional violence (ZIMSTAT & ICF 2016). OSCs in Zimbabwe were established after the realisation that police stations and hospitals as stand-alone institutions do not provide an appropriate atmosphere to report GBV. The disclosure of GBV is an essential step to ensure that victims can seek safe refuge, access services intended to assist them and obtain legal protection (Alaggia et al 2012). However, the problem may not be the police and health centres as institutions but the patriarchal norms entrenched in the society, even at the individual level of policy implementation like police or health workers that have attitudes and perceptions about GBV. Sociocultural norms and religion viewed through the lens of power (Tamale 2014) created a legacy of domination, coercion and discrimination, resulting in astounding levels of physical, emotional and sexual violence in Zimbabwe. According to Tamale (2014), the connection between power and discrimination is that hegemonic powers sway both men and women to conform to social norms and values that are innately exploitative, putting women and girls at high risk of experiencing violence. The situation is dire for women in intimate relationships as violence occurs in private and reporting is risky.

In the study area, which only included primary health centres, the health sector works with VHWs as part of their community engagement. VHWs has the potential to reduce incidences of GBV if they speak against cultural norms (e.g. *chiramu*) or to amplify it if they condone cultural practices that precipitate this type of violence. Cultural norms and unequal power relations between men and women emerged as risk factors of GBV at community level in Zimbabwe. The rigid protocols in the medical field and the rigid cultural norms in the community constitute a barrier to access medical services and to designing and implementing a proactive strategy to stop GBV. Targeting the rigid protocols in the medical field and the

rigid cultural norms will likely reduce GBV levels, which remain high despite excellently worded policies.

However, as members of the community, VHWs (men and women) might share the predominant social cultural norms that promote male domination and the acceptability of violence (Kim 2011; Meneghel et al. 2011). This scenario will shape the counselling and mediation strategies to the women and girls who are GBV victims. In the Zimbabwean traditional culture, older women often advise young women before marriage that they need to remain resolute in the face of challenges in marriage, which include beatings, extramarital affairs and many other challenges. These damaging beliefs have also been internalised by VHWs. As such, even if there is a mechanism to stop GBV, social beliefs manifest through individual like VHWs who are supposed to help survivors escape violent situations. Instead, they trap the victim in the violence and help the perpetrator ‘escape’ and continue with their dominance. In the quest to justify male violence against women, the women are often blamed for inciting the violence (Fattah & Camella 2017). This persistent victim blaming results in women not disclosing GBV and not seeking medication. The impunity with which many societies handle GBV is a key supportive factor for the continued existence of this menace and creates an excuse and escape for many perpetrators. GBV is public health problem that can be addressed through multisectoral strategies that target sociocultural norms that condone violence, including the use of violence as a disciplinary act (Yount & Li 2010).

Despite the challenges of pervasive social norms, women are benefiting from the primary care GBV interventions at community level. Without going to the clinic, women benefit from face-to-face counselling in an environment where men do not suspect anything, as ‘two women who may be neighbours will be talking’. During face-to-face talking, women (survivors and VHWs) usually strengthen one another; this is called empowerment counselling. Empowerment counselling strategies help women discuss safety issues and coping strategies, and this reduces depressive symptoms (Saftlas et al. 2014). By resolving the explosive situation and being encouraged to visit the clinic for treatment, survivors can have more time and sound health to engage in economic activities.

The government of Zimbabwe through the Ministry of Health is missing an opportunity to fully use the engagement of VHWs as a community-based strategy to respond to GBV. Creating a conducive environment by remunerating VHWs is necessary as they are likely to support normative change at all levels of the ecological model. As they visit survivors in the community, these volunteers are likely to view GBV as a social problem when they offer

counselling and mediation services to survivors. Their counterparts in primary health care, like clinics, often view GBV as a clinical health issue (García-Moreno et al 2014). As such, they fail to appreciate social inequalities as social determinants of health and GBV. This study's results showed that unequal power relations between men and women, traditional gender roles and cultural norms (e.g. *chiramu*) are the risk factors of GBV in Zimbabwe.

It is impossible for a single organisation to provide for the multiple, complex needs of GBV survivors, which, include medical care, safe accommodation, counselling, police protection and legal advice. As such, the health sector response in Zimbabwe takes place within a multisectoral framework that includes the police, NGOs and government departments. External referrals (the communication between the health sector and other sectors aiming to help GBV survivors) depend on efficient lines of communications and clearly outlined procedures (UNFPA 2010). Moving survivors from one hospital to another and to or from the police can be hindered by the gravel roads in rural areas that are inaccessible during the rainy season and by exorbitant transport fees. In many cases, the police use public transport to accompany rape survivors. This shows that such a referral system relies on the contribution of committed individuals. The effectiveness of a referral system depends on its alignment to the legislation or standard protocol that defines the roles and responsibilities of all organisations (UNFPA & WAVE 2014). Although there is formal cooperation between the police, social welfare and the health sector, the referral system is affected by a lack of resources and monitoring. The health sector is the first point contact for many survivors of GBV, and as such, it is well positioned to meet the multiple, complex needs of survivors through internal and external referral networks. In the study area, these networks face a number of challenges, which include demoralised staff, deep-seated cultural norms, shortage of medicines, inaccessible roads, and lack of monitoring, especially in the external referral network.

The mandatory procedure of producing a police report before one is treated may deter injured survivors from seeking treatment. Traumatized survivors may find it difficult to give a full report of their experiences as their emotional numbness may make it difficult to answer questions (UN 2014). Some survivors may simply want treatment because a police report tends to 'expose' an issue they would rather deal with privately. In Zimbabwe many women subscribe to a cultural norm called *chakafukidza dzimba matenga* which literally means 'what happens in a family should not be exposed'. The results of this study shows that this cultural practice fuels spousal violence and curtails reporting.

Treatment, counselling, referral to other service providers and awareness raising constitute the health sector's response to GBV. Taken together, the components of the response have cultural aspects. A health care response that show understanding of the culture and values that allow individuals to construct their identities within it is not only relevant but has the potential to meet the needs of the target community. In the context of the health sector's response to GBV, there is much evidence that shows the importance of a culturally sensitive integrated response to GBV (UNFPA & WAVE 2014; Vu et al. 2016; Wirtz et al. 2016). A culturally sensitive integrated response takes into account the community's social norms as well as the relationships between victims, perpetrators, service providers and the wider socioeconomic environment.

The chapter showed that at the primary health care centres women are treated and examined by female health workers. The results also showed that care is taken to promote the victims' bodily integrity during examinations, and according to WAVE (2011), this is critical to avoid secondary victimisation and to respect the dignity of the victim. In Zimbabwean culture it is considered taboo for a male health worker to examine and see the private parts of a woman. This is not only considered culturally incompatible, but may discourage women from seeking help. Being examined by a male after being abused by another male is potentially traumatic. However, due to a shortage of health workers in the country, there is not always the option of being examined by a female health worker, especially in rural areas. This calls for an intervention that is culturally sensitive and increases the involvement and participation of the target community (World Bank Group 2016). Spangaro et al. (2015) showed that community engagement strategies help raise awareness about GBV and also have the potential to transform traditional harmful gender norms that precipitate this type of violence.

Although most primary prevention occurs outside the scope of the health sector (García-Moreno et al 2014), the health sector in Zimbabwe is actively involved in awareness campaigns in which people are made aware of the dangers and costs of GBV. The health sector works with youth groups, the police, education officials, chiefs, religious leaders, women organisations and politicians to challenge local attitudes and social mechanisms that condone violence. These collaborations add to the richness and diverse nature of the awareness campaign, and the presence of traditional leaders means that the campaigns are done in a manner that does not lead to cultural antagonism, which is when local people become defensive and reject the messages. The involvement of VHWs adds a much needed cultural dimension to the sector's response as VHWs are likely to understand GBV as a social phenomenon.

Overall, the response by the sector is governed by the biomedical approach because health workers are experts in medical care. Victims present themselves to experts in search of solutions to their predicament since GBV often results in an immediate need for medical care. The curative medical structure views the provider as the main decision maker (Lupton 2012). However, dealing with GBV means that health workers do not take a directive role and should be prepared to deal with unpredictable scenarios. This tends to frustrate many health workers (Guruge et al 2015), leading to resistance by the health workers to integrate or implement GBV interventions in the traditional biomedical approach to health (Colombini et al. 2013). In addition, as members of society, health workers also experience GBV, are perpetrators of GBV and have internalised cultural norms that condone violence. As a result, the protocolised medical field and the pervasiveness of cultural and gender norms constrain the health sector to holistically respond to GBV in Zimbabwe. Overall, the reactive component of the response (treatment) is fairly effective, while the proactive component is weakened by the traditional biomedical approach.

Chapter 7: Institutional response to GBV in Zimbabwe: The Education sector

7.1 Introduction

This chapter assesses the education sector's response to GBV against the four categories in Section 3.7. It should be noted that SRGBV often presents in the form physical violence (physical and corporal punishment), sexual violence (rape, love affairs between teachers and female students, and discrimination), psychological violence (emotional violence, and verbal abuse), and bullying, which can physical or psychological. SRGBV is multi-dimensional and includes physical, sexual and psychological acts of violence in and around schools that have their roots in inequalities, norms, exclusion and stigma in daily interactions, institutions and structures of the community.

7.2 Laws and policies

Section 75 of the Constitution of Zimbabwe (2013) guarantees the provision of state-funded education to all citizens. The Education Act (Chapter 25:04, 1987) is part of Zimbabwe's legislation that seeks to meet the country's international educational needs to protect, empower and fulfil human rights for children. The Act requires the state to provide free primary education for every child and requires parents to ensure their children attend school. Key informants indicated that the Act is not used directly by schools but guides the ministry to create administrative structures. In the context of SRGBV, the Act facilitates the creation of codes of conduct for both teachers and pupils; teaching methodologies; the curriculum, referral structures and reporting mechanisms. The following comment supports these claims:

In terms of legislation, the education sector is governed by the Education Act. However, the Act is not used directly by the schools. Through the Act codes of conduct for pupils and teachers are created together with the curriculum and other administrative guidelines. (Deputy head, high school, Shamva District)

Furthermore, the Act empowers the Ministry of Education to make regulations that guide school governance. In the context of GBV, the minister makes regulations that govern discipline in schools and the exercise of disciplinary powers of teachers. Occasionally regulations come to schools from the Ministry of Education in form of circulars. For example, *Circular Minute P35* (1999) seeks to protect pupils from sexual abuse and bullying as well as ensure that girls who fall pregnant continue with their education after delivery by enrolling at

another school. The circular penalises teachers who sexually abuse pupils, and since the introduction of the circular with its provision for punishing teachers, the rate of sexual abuse by teachers have gone down. Proven cases of sexual relationships with pupils result in immediate dismissal from the teaching profession. This is evident from the following comments by key informant participants:

Since the introduction of the circular, we have witnessed a reduction of cases involving teachers and pupils. However, pupils continue to be abused in the community and at home. These case are rarely reported unless in some cases they surface when we witness a change in the child's performance. (Teacher responsible for discipline, secondary school, Mt Darwin)

When there is evidence of improper association (sexual relationship between a teacher and a pupil), the member is dismissed by the ministry. The case is not referred to the courts of law, although the member can appeal to the courts of law. (Head, Primary school, Shamva District)

Following the abolition of corporal punishment, Section 10 of the circular implored schools to pursue other forms of discipline as follows:

Every head should strive to cultivate a school climate where pupils will/can develop internal discipline, which is not initiated by fear of punishment. A school ethos, which promotes self-discipline among pupils supported by positive remedial disciplinary and proactive measures, where necessary, is preferred to situation where pupils avoid misdemeanours because the alternative could inflict physical pain by the head... corporal punishment is comparable to a fight except in this case the pupil is not allowed to fight back. He has to endure the agony, the pain and the deprivation of human dignity. It is an admission that the school and the head have failed to 'correct' the child.

The circular emphasises the importance of counselling sessions at school and the involvement of parents to manage student discipline. The instrument, as part of the school-based administrative justice system, has the effect of regulating the behaviour of both teachers and students, the classroom environment, and the overall school environment. The circular thus acts as a deterrent to offenders, as one key informant indicated:

Teachers are afraid of this circular, and some teachers have committed suicide when caught in compromising positions with students. It is the last thing any teacher would want to hear applied in his/her teaching career. They try by all means to avoid it. (Deputy head, secondary school, Shamva District)

Overall, *Circular Minute P35* (1999) seeks to enforce discipline in schools by protecting pupils from harmful behaviour, such as discrimination, intimidation and harassment, by highlighting issues of misconduct for both teachers and pupils and emphasising the social responsibility and public accountability of teachers towards pupils. The section on improper association seeks to protect pupils from sexual harassment from teachers. The interviews and discussions made it

clear that teachers are afraid of this policy as it results in immediate dismissal if proven that there was improper association, especially of a sexual nature. The nature of improper association between teachers and pupils is elaborate, as detailed in the following comment:

When marking a book of a pupil, leaning over her or him and patting the pupil over the shoulder for doing well is considered improper association. The patting can put the teacher in hot soup if the pupil report that... that's how serious the issue of improper association is. (Teacher, primary school, Shamva District)

It should be noted that perpetrators of SRGBV can also be fellow pupils, and in accordance with national law, the code of conduct spells out the procedures for suspension, exclusion and expulsion. Exclusion is the removal of a pupil from a particular school for reasons that are in the best interest of the child, parent or school. For example, a girl child can be excluded from the school where she was learning when she gets pregnant; this is meant to protect her from further abuse in the form of ridicule. Expulsion is the removal of a pupil from the education system because of misconduct of a serious nature, like rape or drug abuse. From a legal and a human rights perspective, the circular, informed by Statutory Instrument 3 of 1998, banned corporal punishment in schools. The Statutory Instrument lists types of punishment that are deemed inhuman. Banning corporal punishment has contributed to challenges in class management.

As with the justice and health sectors, the Protocol sets out roles and responsibilities of individual and professionals in the education sector and describes the principles that guide primary and secondary schools' responses to sexual abuse and violence. The Protocol implores the school head to formulate an effective child protection policy, establish clear communication channels for reporting abuses and to report criminal sexual abuses to the police. In addition to taking disciplinary measures on staff and learners who perpetrate child sexual abuse and harassment, the head is implored to participate in child protection, welfare and survivor friendly initiatives in the community. The Protocol also specifies that the class teacher should identify cases of child abuse, educate children on measures to protect themselves from violence within and outside the school, report cases to the head, offer psychological support to abused children and embrace gender equitable norms. It further underscores the need for parents to cooperate and assist the school in the best interest of the child and to seek professional advice for handling child abuse cases.

From the foregoing it can be argued that the legislative and policy framework in the education sector is elaborative enough to protect learners from various forms of abuse. By clearly stating sexual abuses, corporal punishment, bullying and the need to offer psychological support to

victims, the framework covers physical, sexual, and to a greater extent, emotional violence. Curbing SRGBV is a step in the right direction to deal with this type of violence in the community.

7.3 Protection, care and support

The complex, pervasive and multifaceted nature of SRGBV has contributed to a growing need for the education sector to respond to this type of violence through a conducive learning environment. Tapping national laws and policies, the Ministry of Education developed strategies to prevent SRGBV and to protect survivors of this type of violence. These strategies include the development of codes of conduct, pedagogy and teacher training, and gender sensitive curricula. This is evident in the following comment:

To facilitate effective learning and the prevention of various forms of abuse, we are mindful of what happens in the classroom, toilets and playgrounds. We tape from the experiences of the teachers various codes of conduct, clear reporting mechanisms and the curriculum to create safe schools that prevent bullying and other forms of abuses. However, we face a number of challenges like large class sizes, indiscipline and cultural norms, among others. (Deputy head, high school, Mt Darwin)

Motivated by the government's desire to promote human rights, the FGDs revealed that police and other organisations with awareness campaigns visit schools to tell pupils about their rights, especially the right not to be beaten at school. One participant made the following observation:

Police come telling children about their rights, but they do not tell them where they should end ... At [name of school withheld] secondary, students misbehave openly and they tell teachers that they are not supposed to be beaten. ... When teachers come for lessons, girls are seen doing their makeup, and the teacher at times cannot stop them ... some of the laws that the government approves create challenges for class management. It is a challenge for us. (Teacher, primary school, Shamva)

Lack of effective class control is a breeding ground for a number of types of SRGBV. In all schools, key informants concurred that pupils bully others or abuse others when they are aware that corporal punishment cannot be administered. During interviews it came out that Zimbabwean rural children are hardened against beating when they make mistakes at home. It became clear during the interviews that corporal punishment gave instant results while other forms of punishment, such as giving a child work to do, is delayed and needs time and monitoring. The following comment describes this:

In our Zimbabwean culture children are beaten or threatened with beating if they make mistakes, and removing it (corporal punishment) creates problems for the teacher to effectively manage the class. Yes, there are other methods of punishing

the misbehaving child, but they need time to implement. (FGD participant, Madziva Primary School)

It became clear that children are left alone during tea and lunch breaks and that this is the norm in Zimbabwean schools. Students are vulnerable to bullying and sexual harassment during these times when most of the children are out and perpetrators pounce on those who remain in classrooms. The lack of teacher supervision during these times exposes children to various forms of abuse. Participants observed the following:

During breaks teachers normally go to their places of residence, leaving children alone. Tea break is 30 minutes and lunch is one hour. We have observed that a lot of bullying occurs during these times. (Teacher responsible for discipline, primary school, Mt Darwin)

Bullying occurs any time but most of it occurs during tea and lunch break times. During lessons boys place view mirrors under the girls' skirts to see their undergarments. This can be embarrassing, and we teachers should always be alert. (Deputy head, primary school, Shamva District)

Classrooms in government-run schools are overcrowded and genders are mixed in the classrooms, increasing children's exposure to sexual abuse. This arrangement does not only expose children to sexual abuse but overwhelms teachers' capacity to control and enforce discipline. The following comments discuss the large class sizes:

Due to shortages of class rooms, our classes range between 50 and 60. This creates challenges of class management and seating arrangement as we mix boys and girls. Girls are usually sexually harassed as leaners are packed on limited benches. (Teacher responsible for discipline, high school, Shamva)

We have acute shortage of classrooms due to the fact we have exceeded our teacher-pupil ration which is normally 1:30. It is government policy that every child should be enrolled in their area [where they can walk to school], so we cannot turn away pupils even if we reach the threshold for each class. Large class sizes expose children, especially girls, to sexual abuse and harassment. (Deputy head, primary school, Mt Darwin)

While many schools in Zimbabwe are built on locations perceived to be safe (for example, away from bars), one school in the study is built next to number of shops, increasing the vulnerability of children to abuse on their way to and from school. Safety audits of the school infrastructure and access routes are a key component in the fight of SRGBV. There was no evidence that this was done in the study area. The schools' physical infrastructure is important as SRGBV can take place on the school premises and on the way to and from school. For non-boarding schools, teachers are only responsible for children between the time they start school (confirmed by signing the register) and the time they dismiss them. Once dismissed and on their way home, teachers are no longer accountable. This means that children are vulnerable

on their way to and from school. The lack of child protection mechanisms is evident in the following comments:

As a school we take care of children within the school premises. After dismissal we do not have any mechanism to monitor them. It is true children can be abused on their way to and from school but we can assist those who report that they have been abused either at home or on their way to school (Head, primary school, Shamva)

It is true that children can be abused on their way to and from school but practically it is impossible for us as a school to monitor them as they move to and from school. Children come here from different directions, and some cover long distances to school. Maybe the local community can come up with such measures to protect their children. (Deputy head, high school, Mt Darwin)

The Zimbabwean primary and secondary education system demonstrates a major omission in the fight against SRGBV without mechanisms to protect children on their way to and from school. In the context of SRGBV, safe schools have appropriate physical infrastructure that protect children from this type of violence. The schools visited had gender specific toilets that were not locked. Flowers at the schools were maintained at heights that allow students to be seen as they move from one class room block to another. It was also observed that at all schools big windows ensure visibility, but this can be problematic, as one key informant observed:

During summer we cut grass within the school yard to reduce mischief by learners who may take advantage of long grass. Flowers are maintained at heights that learners are seen at all time as they move from one point to another. However we have problems with bullies who often enter classrooms through windows to pounce on unsuspecting girls. This happens when most students are out. (Teacher responsible for discipline, primary school)

Toilets, empty classrooms, corridors, paths with high flowers, dormitories and school playgrounds can be hot spots for violence if measures are not taken to prevent it. The learning environment in schools is also defined by what pupils do outside the classroom during break time, performing given outdoor tasks and on their way to and from school. The qualitative results show that in some of these environments pupils can be vulnerable to abuse, for example:

We are investigating a case of a child who left school late after performing her punishment. On her way home, she was raped at the shops and did not tell anyone. After a number of days and suspecting that something was wrong with the girl, a lady teacher approached her and she confided that she was raped. The case was reported to the police, which has since launched a manhunt for the perpetrator. (Deputy head, primary school, Shamva District)

A male teacher was tasked to supervise four male students serving a punishment in the form of planting trees in the orchard. No one suspected anything, as males (teacher and four boys) were involved. The teacher befriended the boys and started sleeping with them. The issue came to light when a certain organisation, during awareness campaigns, mentioned forms of abuse and one pupil reported, leading

to the arrest and dismissal of the teacher. (Teacher responsible for discipline, secondary school, Mt Darwin)

The two quotations demonstrate that pupils can be vulnerable both at school and on their way home. A male adult sleeping with boys is a rare form of SRGBV, both in terms of reports and occurrence. The critical aspect in the fight against SRGBV in particular and GBV in general is awareness. Raising awareness is a form of empowerment as knowledge is an increasingly critical resource. Armed with knowledge, survivors of any forms of violence are likely to report, which is a critical step in the response to GBV.

Reporting SRGBV is an important strategy to protect the victims of violence. Students are encouraged to report bullying, unsolicited touching and other forms of abuse to the senior master or women. They are also encouraged to confide their cases to any teacher they trust who are mandated to report to the senior master or woman. However, as the following quotation from a FGD participant shows, reporting to the senior master or woman has its own stigma:

To students being seen going to the office of the senior master or woman is a sign that something has happened to the student... they would rather approach other teachers and report their cases ... or not report at all. (Teacher, primary school, Shamva)

While there are clear reporting mechanisms in schools, victims and witnesses are afraid to report cases of SRGBV because of perceived or real victimisation from the perpetrators. Reprisals normally occur when students are on their way home as some students in rural areas walk up to 15 km to reach their homes. Victims may equally face ridicule and stigma on the school premises. The cultural norms were raised as a challenge in reporting SRGBV. One participant in the FGD observed the following:

In our culture there is a practice called 'chiramu', where the sister's husband can play with the younger sisters of his wife touching them or patting them on the back. In rural societies, this is a norm, and when touched here at school or on their way home, young girls may have challenges recognising it as sexual harassment. To them it may be normal, even if it is not the sister's husband doing it. (Teacher, primary school, Mt Darwin)

The discussions and interviews made it clear that reporting SRGBV exposes both the witness and victim to further reprisal and other forms of victimisation. In reporting, the most important consideration is continuity.

The results show that cases of serious sexual abuses become known when teachers notice unusual behaviour in the child or when witnesses come forward. Upon realising that the case has been reported to police by the school, witnesses withdraw from the case or deny having heard about it. Key informants reported that people do not want to bear witness against fellow

members for fear of creating enmity between families or to protect the perpetrator. This demonstrates the culture's emphasis on societal cohesion at the expense of individual rights. In cases where the abusers are relatives, they often 'force' the victim to withdraw statements from the police, and this frustrates teachers who have done a lot to investigate the case and have created enemies along the way. A teacher said the following:

In my class I had a case of a child who was abused at home. First, I noticed that her performance was going down and she would not participate in class as usual. I alerted a female teacher and the girl confided that she was abused by her uncle, a well-known person in the community. The case was reported to the police and after three days the girl said she was not abused. (Teacher, primary school, Shamva District)

The interference of family can constrain efforts by teachers and the police to identify potential victims and investigate perpetrators. To police, teachers, and even researchers, it is interference when family members, including the abuser, 'talk' to the survivor to withdraw cases of abuse. From a family perspective, it may not be regarded as interference but a strategy to keep family cohesion, which matters when court cases are over. This points to the fact that interventions need to consider all these dimensions to be effective in curbing GBV.

Giving advice and emotional support to victims, witnesses or perpetrators is of paramount importance in the case of SRGBV. This is counselling, which is a type of talking and listening therapy that allows a person to discuss and disclose their problems and feelings in a confidential environment. All the teachers responsible for student discipline concurred that they offer counselling services to both perpetrators and victims of abuse in cases that do not involve law enforcement. These cases include verbal abuse, unsolicited touching of girls' breasts, mocking girls who unexpectedly have their period, and laughing at young female teachers (usually at secondary level). It was reported that teacher training includes counselling skills. It was evident that seniority is considered when choosing teachers responsible for student discipline. To cater for boys and girls, each school has a senior master and senior woman who often work together during counselling, depending on the sensitivity of issues. During interviews, the senior masters and women concur that the obstacle to effective counselling is that they are supposed to teach in addition to their roles as teachers responsible for student discipline. These claims are substantiated in the following comments:

Children suffer emotionally through a number of abuse, which include verbal, touching of breasts and mocking. However, as senior teachers we have a challenge of balancing teaching and counselling. Counselling needs a lot of time. (Teacher responsible for discipline, secondary school, Mt Darwin)

At the school we have the senior master and senior woman to cater for needs for both boys and girls. While these two teachers are responsible for discipline, they can also work with other senior teachers in the school. Seniority is important for student discipline as well as for understanding the community in which they teach.
(Head, primary school, Shamva)

The learning environment is also defined by what pupils learn in schools. Section 4.2.6 of the new curriculum implores primary schools to ensure that learners explore concepts such as family, relationships, gender, culture, beliefs, values, morals and being responsible to others, oneself and the environment. It is premised on the idea of school democracy where students participate in decision-making. Using participatory teaching methods, the curriculum has cross-cutting themes (human rights, child protection and gender) and these are taught during guidance and counselling as well as during mainstream subjects. However, teachers are struggling to implement the new curriculum because of lack of adequate training and an examination centred principle in the education sector. Guidance and counselling, a non-examinable subject, is given fewer periods per week compared to traditional subjects like Mathematics and English. The following comments capture these claims:

The new curriculum put emphasis on the teaching of gender and family issues at primary level. This is important in changing the attitudes of children at a younger age. However, teachers face challenges in implementing the curriculum due to lack of training in gender issues. (Teacher responsible for discipline, primary school, Shamva)

Yes, the curriculum put emphasis on gender issues. However, the issues are covered in guidance and counselling, which is not an examinable subject. In most cases non-examinable subjects are not taken seriously by both teachers and pupils.
(head, primary school, Mt Darwin District)

Co-curriculum activities (activities and learning experiences that complement what students learn in school) are term specific. During first term, schools in the area are involved in athletics, second term is soccer, and during the third term, students engage in drama, public speaking and clubs. A key informant had this to say:

Co-curriculum activities complement what pupils learn in class. The main aim is keep the pupils physically and mentally fit. Pupils are organised into various clubs that include cooking, debate and drama. GBV issues do not feature in these clubs.
(FGD participant, primary school, Shamva District)

In the primary sector, third term is reserved for traditional dances. The traditional dances are community specific cultural dances and the idea is to keep them physically and mentally fit.

In Zimbabwe the responsibility for overseeing the management of a school is entrusted to a SDC. The SDC work with teachers and have the overall responsibility for creating safe schools by ensuring that there are adequate furniture and appropriate buildings that protect children,

especially girls, from SRGBV. As a link between the school and the community, the SDC work against traditional religious and societal context that affect both teachers and SDC members in their efforts to curb SRGBV. The following comment discussed this:

Teachers and members of SDC are part of the community. Their approach to GBV intervention can be influenced by social and cultural norms. For long, violence against women has been a norm and many people still hold this belief. (SDC member, secondary school, Mt Darwin District)

This shows that schools are not isolated from traditional, cultural and customary laws that exist in the community. Therefore, the results show that schools can reinforce traditional gender norms where boys are expected to be strong and girls are considered weak. During a visit at a primary school, girls were seen cleaning classrooms while boys were digging holes to establish an orchard. This type of stereotype reinforces masculine and feminine tendencies in both boys and girls. Acting in a manner that prevents a positive image of boys and girls in all areas in a school set-up goes a long way in demystifying the myth that boys are stronger than girls.

7.4 Political will

Training teachers in content delivery (pedagogy) is central to any initiative to prevent or respond to SRGBV. Teacher training in pedagogy is provided through pre-service training at teacher colleges and universities as well as through in-service training at workshops or seminars. The qualitative results show that more than 90% of the staff of the selected schools had had gone through teacher content delivery (Table 7.1). This is true for many primary and secondary schools in Zimbabwe.

Table 7.1: Qualified teachers in participating schools

School	Qualified (degree or diploma)	Student teachers	Total	% qualified
Bradley	48	2	50	96
Mt Darwin	46	2	48	95.8
Madziva	35	3	38	92
St Alberts	40	2	42	95

It came out that Madziva Primary and Mt Darwin high schools had a teacher each who have received training in gender issues. However, the training was not part of the teacher training but part of the individuals furthering their studies. Despite this, it was reported that teachers

have enough pedagogical skills to help them tackle SRGBV in and around schools. During FGDs, teachers acknowledged that they use experience to deal with SRGBV issues. One participant had this to say:

We are able to identify potential victims of GBV... usually if there is change of behaviour, performance in class or when student becomes restless or jittery when her/his name is called. Usually the child will be alone even during break time when others are playing... We investigate. (Teacher, local high school, Shamva)

Despite the impressive rates of trained teachers in schools, the training of teachers in both colleges and universities does not include GBV issues. More important, as the results show, teachers are members of the community who can also be victims of GBV and they are not exposed to trauma debriefing and emotional support. A deputy head at a secondary school in Mt Darwin had this to say:

Teachers ideally are supposed to help children who experience GBV at home or in the community. However, as members of the community teachers' efforts can be constrained by being victims or perpetrators themselves. GBV is a complex issue.

Another participant highlighted the lack of gender sensitive training and professional support as follows:

Children are abused at home, and we need skills not only to identify but to help victims, especially sexually abuse victims. Gender sensitive training is needed as a capacity-building programme. We need psychological support as dealing with GBV is equally traumatic. (Teacher responsible for discipline, high school, Shamva District)

In this context, professional support refers to professional counselling that prevents burnout, stress and trauma as well as in-house support training.

According to participants, the Ministry of Education takes long to replace teachers who have transferred or resigned. Due to the current economic challenges, teachers are leaving for greener pastures by going to neighbouring Botswana, South Africa and overseas. The resignation of a teacher move the load of maintaining discipline onto the remaining teachers. This heightens the risk of bullying and sexual harassment. One participant painted the following grim picture:

When a teacher resigns or transfers to another school [the common trend being from rural to an urban school] remaining teachers bear the brunt of teaching and managing large classes. During this temporary staff shortage phase, bullying and sexual harassment increase and as teachers are overwhelmed. The situation is compounded by the banning of corporal punishment. (Teacher responsible for discipline, high school, Mt Darwin)

In addition to the number of teachers and their skills their attitudes, perceptions and awareness of GBV and legislation designed to curb GBV influences the levels of this public health challenge. During a FGD, the teachers in both primary and secondary schools showed that they are aware of what constitutes GBV of some of the legislation designed to prevent it. A teacher at a primary school said the following:

Gender-based violence involves the violence between men and women, usually those in intimate relationships. Women usually suffer at the hands of men. (Female teacher, primary school, Mt Darwin District)

Asked about legislation designed to curb GBV, a deputy head at a local secondary school had this to say:

The Domestic Violence Act is used not to curb GBV, but as a divorce settlement. It's difficult for people to reconcile after taking each other to courts. (Deputy head, secondary school, Shamva District)

Traditionally, in Zimbabwe issues of discipline and classroom management centred on the use of corporal punishment. The results show that teachers are used to using corporal punishment as a means to manage classes. For example one teacher pointed out:

The abolishing of corporal punishment has resulted in challenges of class management. On average we have 60 pupils in a class. Students now bring alcohol to school knowing very well that they are not supposed to be beaten. This includes boys and girls. (Teacher responsible for discipline, secondary school, Mt Darwin District)

During a FGD at another school a teacher at a secondary school in Mt Darwin District influenced by the deep-seated belief about the need to enforce discipline using corporal punishment, indicated that banning of the corporal punishment was “*a foreign idea popularised by the human rights approach*”. The thrust of the Zimbabwean education system is centred on academic results and this tend to influence the attitudes of teachers and the overall response to GBV. During a FGD a teacher noted the following:

Our education system acknowledges a good teacher by the results at the end of the year. With good results, it is possible to transfer to good schools that pay appreciation in foreign currency. So as teachers we thrive to produce good results in order to position ourselves either for promotion or transfer to good schools. This has the effect of ignoring other challenges pupils may face in schools, thereby reducing the effectiveness of the education sector in curbing GBV. (Teacher, secondary school, Shamva District)

By emphasising results, teachers and the education sector fail to embrace a child-friendly school based on child-centredness, democratic participation by pupils and inclusiveness

(UNESCO-IBE 2015). In such an environment, pupils would be able to identify abuse, and more importantly, report it to a trusted teacher.

The practice of defining a good teacher by their academic results is not only narrow but shows that the education system does not embrace a holistic approach to education, and this tends to weaken their overall response to GBV. The whole school approach seeks to make school safe and friendlier by engaging various stakeholders at school, the local community and government in different programmes to protect children from abuse (Fulu et al. 2014). Schools cannot be safe if SRGBV is not contained. In an environment where the school management sends strong messages that SRGBV is not acceptable, teachers are likely to produce better products: Pupils with equitable gender norms and good academic results.

Overall, sustained economic problems is creating challenges for leaders to avail resources for gender sensitive training, to build more classrooms and to pay decent salaries to motivate staff. Political will is measured by ongoing support and reinforcement, not only to develop and maintain the competency of staff but also to create a conducive environment, such as smaller class sizes for effective management and the overall protection of children from abuse.

In Zimbabwean schools the referral system has formal and informal aspects. The formal referral channels are networks to direct students to services such as medical treatment, PEP, law enforcement, child protection, emotional support and other relevant services not provided by schools. In the case of rape or other serious cases of sexual abuse, schools refer victims to the police, which further refer victims to the hospital/clinic for treatment and the administering of PEP and to social welfare, which has the mandate to place children in safe homes, either in the community or in children's homes. This formal referral system is often augmented by the informal referral system where victims can report to the school via a trusted teacher. The school then summons the parent or guardian for counselling and this normally happens in the case of economic and physical abuse of children. Furthermore, informal referral systems in schools use suggestion boxes as well as confiding in any teacher the victim is comfortable with. In addition to this, church-run institutions refer victims to pastors based at the schools (St Alberts and Bradley High Schools). Informal referral systems are required for counselling and spiritual and psychological support.

The temporary shortage of staff at the school and lack of professional support are significant challenges to the education sector's effective response to SRGBV, given that the Protocol uniquely positions heads and class teachers to ensure children's awareness of the right to

protection from sexual violence and abuse and to identify children who may have had this right violated. The head at any school together with an optimum number of teachers creates a conducive environment for the protection of children from abuse.

7.5 Multisectoral and collaborative approaches

Armed with the knowledge that children learn harmful gendered attitudes and beliefs at home and in the community, the education sector works with a number of community-based organisations to prevent GBV and help survivors to cope with it. The qualitative results show that in the study areas, the sector works the following NGOs: Mavambo, an NGO that works with boys and girls aged 10–19; a theatre group called *Torangaridzana* (literally meaning ‘let’s remind one another’); the Leonard Cheshire Trust (LCT), an NGO that pays fees for vulnerable children; and the ZCBC. Mavambo and LCT operate nationwide, and Torangaridzana operates in the Mashonaland provinces. The ZCBC is a national organisation that works with Catholic institutions (schools and health centres). The following subsections discuss these NGO’s

7.5.1 Mavambo

Mavambo is an NGO that seeks to promote sound reproductive health for school-going children aged 10–19 years throughout the country. Through sports and other activities, these children are supported to realise their rights and to challenge negative gender norms that promote GBV. The girls are taught skills to protect themselves against violence, and the boys are taught to respect both themselves and others. Girls are taught to be vigilant when a male person asks them to join them in a room or to accompany them to the garden or when a teacher invites them into their office at odd hours when others have been dismissed.

Mavambo also has a component that teaches boys and girls about the reproductive health challenges they face. Dubbed *Auntie Stella*, the national programme aids disclosure of adolescent problems, including GBV, through a card system. A key informant noted the following:

After some teachings, children are given refreshments as well as cards where they are asked not to write their names but the problems they are facing. Pseudonyms are used to link the problem to a specific child for further assistance. The system has helped us to identify children with sexually transmitted infections, those that have chronic illness, and those whose relatives are trying to sexually abuse them, and single case where a girl was raped. (Programme officer, regional Mavambo office)

The content under *Aunty Stella* is structured around the following three core areas: Identify, speak out and take action. After deliberations, discussions and quizzes, the children are challenged to identify problems that affect them as a group or as individuals. Speaking about the problem helps to demystify it and also helps others understand that they are not alone in the challenges they face. Finally taking action means that adolescents emotionally and practically take steps to ‘solve’ the problem. The key informant indicated that after all is done, the children are given papers so that they can privately record the real problems they are facing. The officers issues papers with pseudonyms in order to identify children if further help is needed. A group of officers go through the messages and reply. Both the messages by the children and the replies are printed on cards, which are used as resource material during teachings.

7.5.2 Torangaridzana

This is a regional (Mashonaland Central province) theatre group that operates within the education sector in Zimbabwe to raise awareness about GBV and other social ills in the society. The group is often invited to schools’ prize giving ceremonies to provide entertainment to parents and children as well as the usual guests, such as religious leaders, chiefs and councillors.

The theatre group aims to raise awareness about the benefits of a GBV-free society through instructional messages like ‘stop GBV’,. The group’s messages also seek to start a process of sensitising men, women, school children and the community at large. It came out during interviews with school authorities that the group’s messages are centred on various aspects of unequal power relations between men and women, healthy relationships and respect, all of which have bearing on the prevalence of GBV. The following substantiate these claims:

Drama is an important component of awareness raising of a number of issues including GBV. In this area we work with Torangaridzana theatre group. Through entertainment the group seeks to promote gender equality, denounce GBV, encourage reporting, healthy living and harmony in families. We normally invite them at prize giving days. (Head, primary school, Shamva District)

Through drama, the theatre group helps raise awareness and break the silence about GBV in the area. Members of the community are invited to schools where they are made aware of the various forms of GBV, its effects, where to get help when affected and the benefits of creating a GBV-free society and healthy relationships. The theatre group uses drama to provide

entertainment and information about GBV. School authorities indicated that pupils are now opening up about GBV issues in schools.

7.5.3 Leonard Cheshire Trust

LCT is a community-based organisation that seeks to empower children through education in Zimbabwe. The qualitative results show that LCT pays fees for the orphans and vulnerable children. LCT work with schools to identify potential recipients of their services as described next:

Normally we approach schools, both primary and secondary, for them to identify potential recipients of our services. We pay school fees for the disadvantaged pupils as well as academically gifted ones. We also build or renovate classrooms so that they are accessible by all pupils, including the physically handicapped. We believe that young people are more open to change their views about violence and other socially condoned social ills than adults. (Officer, LCT, Shamva)

Although their school fees are paid, for a number of reasons some children still fail to come to school. For example, one school head had this to say:

Leonard Cheshire pays fees for 40 pupils in various grades, as this is a poor community. The empowerment of children, especially the poor, helps to break the vicious cycle of poverty and early marriage in girls. However, there some pupils who fail to come to school even if their fees have been paid. Reasons range from religion, distance to and from school and conditions at home where children stay alone or with grandparents. (Deputy head, primary school, Shamva District)

In addition to paying school fees, the LCT contributes to schools' infrastructural needs. For example, at Madziva primary school, they renovated classroom blocks to give disabled, wheelchair-bound children access to the classrooms. Before the renovations, the classrooms had steps, which made it difficult for physically challenged pupils to enter the classrooms. In schools that have electricity, the LCT installed internet services, computers and computer laboratories. St Alberts is a beneficiary of 20 computers from the trust.

7.5.4 Zimbabwe Catholic Bishops Conference

The ZCBC is a Roman Catholic Church initiative that calls on every person in the Catholic Church community to work towards the prevention of child abuse. The initiative's component operating under the theme '*Lets promote safety for children and avoid abuse*' works with Catholic schools in Zimbabwe to ensure abused children have access to food and shelter before being referred to formal institutions that provide shelter or the police. In St Albert parish in Mt Darwin District (which include a hospital, secondary school and primary school), the ZCBC

has a child protection committee that includes church officials, the teachers responsible for discipline in two schools and a nurse from the outpatient department. The child protection committee deals with cases of child abuse from the two schools and helps to design training material for teachers. Depending on the nature of abuse, the committee engages the relevant people to protect the child. The following comment describes their approach

If the child is neglected at home we engage the parents or guardian. Children from poor families are given food, clothes and have their fees paid. Cases of severe physical abuse are referred to the clinic for treatment and to the police for the purpose of arresting the perpetrator. (ZCBC officer, local Catholic office)

In an effort to prevent SRGBV, the ZCBC provide in-service training to primary and secondary school teachers to enable them to handle GBV issues in schools. The in-service training is done in Chinhoyi town, which houses the headquarters of Chinhoyi Diocese. Catholic Dioceses are large administrative areas that have many parishes and are not aligned with political boundaries. Chinhoyi is a town in Mashonaland West, a province that is adjacent to Mashonaland Central and is 150 km away from Mt Darwin. The Chinhoyi Diocese covers Mt Darwin and Shamva districts. It emerged that teachers are trained to identify survivors of GBV that happens at home or school, with counselling skills and how to administer alternative punishments. The schools in the study area are under the Chinhoyi Diocese, some 150 km away. Due to limited resources and the need for teachers to be at school, a teacher from each school is trained and they train their colleagues. The training has increased the teachers' sensitivity to GBV issues leading to increased reporting by children who are not only aware of the nature of SRGBV but are encouraged when their cases are treated with the urgency they deserve. These claims are substantiated in the following comment:

The ZCBC has a programme to train teachers to identify GBV victims as well as to empower them with skills to use alternative punishing deviant pupils now that corporal punishment was banned ... the training is beneficial as reporting has increased in our school. (Head, primary school, Shamva District)

7.6 Conclusion

This chapter focused on primary and secondary education to explore the education sector's response to GBV in Zimbabwe. The chapter revealed that the sector's efforts to curb SRGBV are guided by the Education Act, the *Circular Minute P35* (1999) and the Protocol. Collectively these instruments seek to promote the right to education for children as well as to protect them from various forms of GBV, including SRGBV. Taken together these instruments are aligned to the international and regional instruments that Zimbabwe has ratified (Appendix A). The

promotion of the right to education is done through the provision of school infrastructure (which was found to be inadequate), the training of teachers in pedagogical issues, and the use of a curriculum to guide content delivery. It emerged from the results that children are protected from various forms of SRGBV by banning corporal punishment, punishing those that bully others and dismissing teachers who sexually abuse children. However, large class sizes and mixed gender seating arrangements constrain efforts to fully protect children from SRGBV. To facilitate reporting SRGBV, schools have a gender sensitive arrangements that allow girls to report to the senior woman while boys report to the senior master. Cases of sexual violence are referred to the police, who take the victim to the health centre for medical treatment to prevent pregnancy and HIV transmission. While nearly all teachers were trained, it emerged that they did not receive gender sensitive training. The chapter revealed that efforts to provide education to all children is complimented by NGOs that pay fees for orphans and vulnerable children. Finally, the schools link with the community through the SDC members who work with families to promote the principle of gender equality.

The legal and policy frameworks in the education sector seek to ensure human rights for children by meeting their educational needs as well as protecting them from various forms of SRGBV. The Education Act is an elaborate piece of legislation that promotes literacy for every child by advocating for free primary education. Acknowledging that experiencing SRGBV prevents children from benefiting from the education system, the Act facilitated the creation of *Circular Minute P35* (1999), a code of conduct for both teachers and children. By protecting pupils from various types of SRGBV, it emerged that the circular promotes public trust in the education system. Since the introduction of the circular with its provisions of punishing teachers with sexual relationships with schools girls, the rate of student sexual abuse by teachers has drastically gone down. Furthermore, the Protocol's thrust on the prevention of sexual violence in schools is crucial because children who experience this type of violence have trouble disclosing it (Alaggia et al 2012). Children can also be sexually abused at home where poverty, cultural norms and religion constrain reporting (Sida 2015).

While the legal and policy frameworks are anchored on the prevention of GBV, protection, care and support services, and capacity development of service providers, the *Circular Minute P35* (1999) that is used by schools directly is reactive. The chapter revealed that it is applied when SRGBV has occurred in schools. The circular does not mention emotional violence directly, but implies it by punishing students who bully others. The circular were drafted in 1999 and needs to be overhauled to take a more holistic approach to SRGBV. Necessary

changes include adequate and appropriate school infrastructure, gender training needs of teachers, curriculum issues that deal with SRGBV, working with the community against GBV, reporting mechanisms. With such a thrust, the circular creates schools that are safer, more child friendly and gender sensitive and foster a positive learning environment (UNESCO & UN Women 2016). However, the current version of the circular creates challenges when dealing with SRGBV because there are now the added dimension of cyber bullying.

By punishing those who bully others and focusing on sexual abuse, these instruments focus on addressing physical, emotional and sexual violence. These are the three most common types of GBV in Zimbabwe. These policies are implemented in a socioeconomic environment characterised by limited resources due to sustained economic challenges and pervasive GBV caused by unequal power relations, patriarchal practices, and social norms and values that promote gender inequality (Mashiri 2013; Magezi & Manzanga 2019). This tends to weaken the prevention efforts of these instruments and prevents them from adequately meeting the needs of SRGBV victims.

The chapter revealed that the education sector's response to SRGBV is based on clear, safe and accessible procedures and mechanisms that ensure the protection of children from violence by banning corporal punishment, reporting incidences of violence, assisting victims, and referring them victims to other service providers to ensure their safety and security. Following the abolition of corporal punishment, the ministry opted for a shift from this form of discipline to counselling. This move is resisted by many teachers because they were trained in authoritarian education practices, both as students and as teachers. The deep-seated belief about the necessity of physical punishment to foster orderly learning (Parkes 2016) contributes to the rigidity of teachers. Counselling requires that those responsible for the counselling should have lighter teaching loads and an appropriate space to discuss SRGBV in a confidential manner. However, currently schools concentrate on pedagogics that promote academic achievement at the expense of the other dimensions of child development, like tolerance, which can be cultivated through counselling. Teachers are often rewarded for the academic performance of students and counselling bullies is perceived as time-wasting that is not worth the effort. SRGBV is embedded in everyday interactions at school, which define school culture, and this is influenced by the broader political, sociocultural, and economic contexts (Parkes et al. 2013).

The chapter showed that schools in Zimbabwe have designated roles for teachers responsible for student discipline; they are the senior master and senior woman and have separate offices. This gender sensitive arrangement allows female students to report to the senior woman, while

boys can report to the senior master. In these offices, identified and reported cases of SRGBV are treated in a confidential and private matter for the safety and security of victims. Studies shows that clear, safe and accessible procedures are critical to prevent the revictimisation of students (UNICEF 2013a).

In addition to designated roles of teachers, schools use suggestion boxes for children to anonymously report cases of SRGBV. A study by UNGEI (2013) show that suggestion boxes work if they are checked regularly for reports that are followed up on with visible actions. This promotes an accessible, child-friendly and anonymous reporting mechanisms. In a study in Malawi, suggestion boxes was found to be an innovative and effective way to expose SRGBV and to protect both the victim and the witness who report it (Alinane Consulting 2010). Reporting can be voluntary or mandatory, but the latter is fraught with problems and the incentives to do it and the sanctions for not doing it must be carefully considered (UNICEF & UN Women 2016). In the context of mandatory reporting and handling of the reports, the interest of the child is of paramount importance. Therefore, it cannot be overemphasised how important it is to include reporting techniques in staff training. Gender sensitive training is likely to enable teachers to build trusting and healthy relationships with students.

The chapter revealed that rape cases are referred to the police, who take the victim to a health centre for medical treatment to prevent HIV and pregnancy. Effective referrals depend on schools being aware of laws that protect children, how existing codes of conduct protect children and of the availability of services and organisations that victims can be referred to for additional support (UNICEF & UN Women 2016). School authorities are aware that clinical interventions like PEP and EC are time sensitive, and therefore, teachers can be a valuable first point of contact for disclosure of abuse because they can link the victims timeously to health care and psychosocial support (UNESCO & UN Women 2016). In addition to the formal referral structures, the safety of victims can be strengthened through informal referral structures that communities can use (Dunne 2011).

The reaction to SRGBV by the education sector occurs in an environment where nearly all teachers have received pre-training in content delivery but where there is a critical shortage of teachers trained in GBV issues. Teacher training is a key element in the fight against SRGBV as teachers and other support staff are at the frontline of SRGBV prevention (Roman & Murillo 2011). A growing body of evidence shows that trained teachers can recognise and address different types of GBV, reflect on their own experiences and their possible contribution towards SRGBV, and feel more equipped to take the risk of delivering sensitive SRGBV

content (Ollis 2011; UNGEI 2017). While their training in sociology, psychology and philosophy help them deal with GBV issues, mandatory training in GBV issues help teachers change their attitudes about addressing violence in schools. Despite the impressive record of trained teachers, nearly one fifth (18%) of girls reported that teachers are the perpetrators of GBV (ZIMSTAT & ICF 2016). This shows that while teachers are trained in the use of various methodologies that help different children engage with educational content, the methodologies are not gender sensitive.

The chapter revealed that gender sensitive training is not a component of teacher training in Zimbabwe. Gender sensitive training of both in-service and pre-service teacher will equip them with skills to reflect on their deeply held beliefs and practices through which they knowingly and unknowingly condone GBV. Overcoming these capacity constraints are critical to achieve the necessary change. This confirms other research that initiatives to specifically address violence in schools are less common (Leach et al. 2014). Without gender sensitive training teachers may not use positive discipline (rewarding good behaviour) or may not see it as a useful technique for managing large class sizes. The results of this study show that the primary and secondary sector is characterised by large class sizes. Cahill and Beadle (2013) show that including participatory methods fused with gender sensitive issues in pre-training can help to increase teachers' skills to encourage girls and boys equally, can change their mindset about the use of corporal punishment and can motivate them to use positive discipline techniques.

Gender issues is one of the dynamics in the classroom that teachers need to be aware of in order to tackle GBV in and around the school. Being aware of gender dynamics enables teachers to ensure that boys and girls receive the same treatment and attention and that they use teaching methods that are free of stereotypes and gender bias (UN Women 2016). In-service training is key for teachers to be aware of the various dynamics in their own bias and behaviour. Teacher training, especially in-service training, should explore teachers' own gendered lives and the way they approach their work and relationships (UN Women 2016). In-service training can be based on current issues in GBV and can equip teachers with skills to manage diverse classroom dynamics. This reduces bullying, which results of this study indicate is widespread in schools. Bullying contributes to emotional abuse, which is increasing in Zimbabwe. However, this is not feasible due to shortage of resources for in-service training.

Pre- and in-service training teacher training depend on the level of political will of leaders. Zimbabwean leaders should not only incorporate SRGBV into national laws but should also show commitment to prevention and responses by availing resources for training. Currently,

Zimbabwe does not have a national policy to specifically address SRGBV. While the legal environment in Zimbabwe is adequate to curb GBV, it must be translated into a policy to address SRGBV. In many settings the limited translation of legislation into policies that govern SRGBV is a key challenge in the fight against this type of violence (Leach, Dunne Salvi 2014).

The results of this study show that the attitudes of teachers can contribute to weak implementation of policies. The banning of corporal punishment in Zimbabwe was not welcomed by many teachers who had deep-seated beliefs about the importance of physical punishment to enforce orderly learning. While banning of corporal punishment was in line with the international campaign to end all forms of corporal punishment of children (UN 2011), banning it without looking at school and community cultural norms and inequalities contributed to an increase in the prevalence of SRGBV as students take advantage of not being beaten. The results of this study show that banning corporal punishment in schools where children are used to being beaten at home creates the ideal conditions for misbehaviour by students. Many teachers experienced, perpetrated or witnessed some form of violence in their lifetime, and these experiences influence behaviour and teaching techniques. Outlawing corporal punishment on its own does not appear to be effective to eradicate this form of SRGBV (Parkes et al. 2017).

The chapter revealed that the learning environment is not conducive to the effective prevention of SRGBV in schools. For example, lack of furniture and large class sizes of up to 60 students create challenges with seating arrangements, resulting in increased bullying. The situation is made worse by mixed gender seating arrangements. Fancy and McAslan Fraser (2014) show that the propensity for violence and harassment among students are high in classrooms with inadequate lighting, overcrowding or mixed seating arrangements. In large classes banning corporal punishment becomes problematic even when teachers are aware and accept the ban (Parkes et al. 2017).

The learning environment defined by what transpires in the classroom constitute a space for student to understand how gender inequality and unequal power dynamics affect individual attitudes and behaviours towards SRGBV. The type of language teachers use, peer culture, curriculum content and school messages reinforce harmful gender attitudes and beliefs. The classroom is therefore an important place to encourage students to challenge traditional notions of masculinity and femininity and can be used as a tool to raise awareness of SRGBV (UNESCO 2017). Ideally, what transpires in the classroom (e.g. challenging gender roles and power dynamics) means that the education sector is operating at the societal level of the

ecological model where this study's results show that cultural norms precipitate GBV in Zimbabwe and identified as the main cause of GBV (Sida 2015).

Addressing issues such as what pupils of different ages should learn is a crucial component of any education system (UNESCO 2015). The chapter revealed that pupils in primary schools explore concepts such as family, relationships, gender, culture, beliefs, values, morals and being responsible to others, oneself and the environment; all of which has a bearing on experiencing GBV. Furthermore, co-curricular activities such as drama and clubs can promote gender equality through carefully selected content. However, this is not done and the primary and secondary education sector is missing an opportunity to use clubs as a vehicle to promote gender equality by emphasising equal relations and examining social norms. UN Women (2014) report that clubs are used to promote gender equality in Mumbai schools, India, and that the results show that participating students (12–14 years) grew more supportive of girls pursuing higher education and marry later in life, and that participating students believed that boys and men should contribute to household work. Addressing issues of gender equality in the early stages of life is likely to reduce future prevalence of spousal violence, which is currently a compelling issue for the current generation of married people and those in intimate relationships in Zimbabwe.

The chapter revealed that children can be abused at school and on their way to and from school. It is important to conduct safety audits of the school infrastructure and access routes to and from school, and involving children in this task has been found to be effective. In participatory mapping students are given maps of the school and mark areas where they think are hotspots for SRGBV; this is becoming an increasingly popular method to conduct safety audits in schools (UNESCO & UN Women 2016). The technique was applied in schools in the Democratic Republic of Congo, and the results showed that the problems highlighted by students in the mapping informed school authorities of where to prioritise funding (UNESCO & UN Women 2016). This technique involves boys and girls separately to empower them by directly involving them in the fight against SRGBV.

It emerged that the SDC members work with the schools to create safe schools that protect children from various forms of SRGBV. As part of the school management structures, the SDC can build a culture of governance against SRGBV by working with school heads to develop and implement positive forms of discipline in schools. SDC members can further work with families and communities to promote principles of gender equality and non-violence and to establish community-based child protection committees. This is crucial as many children move

to and from school covering distances of as much as 10 km one way. However, as members of the community, SDC members may subscribe to collectivism instead of individualism. Collectivism is the extent to which a society puts more importance on the social cohesion of the society than on individual rights and personal achievement (Hofstede et al. 2010). While the results of this study show that cultural norms precipitate GBV, SDC members may fail to denounce negative cultural norms in the name of societal cohesion.

The chapter revealed that the sector works with Mavambo and LCT, local NGOs that pay school fees for orphans and vulnerable in Zimbabwe. Paying school fees enables disadvantaged girls to continue their education; a variable that was found to be a protective factor for GBV (Chapter 4). Education increases options for women in a number of fronts, including increased prospects of paid employment, making them aware of their rights, and teaching them where to get help and how to leave abusive relationships. More importantly, education has the potential to neutralise rigid cultural norms that condone violence (Sida 2015). This study established that cultural norms are risk factors for experiencing GBV.

In the study area, Mashonaland-based drama group Torangaridzana help raise awareness about GBV issues. The drama group's efforts have impacted positively on reporting GBV issues in schools. A WHO (2010) study shows that drama is a powerful tool that can be used to shift cultural norms and shift behaviour through its ability to draw large audiences and to move people to empathise with characters. By targeting cultural norms that condone violence, the Torangaridzana's efforts operate at community and societal levels of the ecological model. This study show that cultural norms and gender inequality precipitate GBV in Zimbabwe in spite of a favourable legal and policy environment to curb it. Addressing a complex issue, such as SRGBV, requires a comprehensive and context-sensitive response that involves diverse stakeholders (UNESCO & UN Women 2016). As a result, working with communities on SRGBV helps to raise awareness and provide an important mobilisation platform for advocacy initiatives (UNESCO & UN Women 2016.) The global pattern of how schools work with communities involves a number of areas of cooperation that include awareness raising (Leach et al. 2013); placing community members at 'referral points' (Antonowicz 2010); using community members as escorts to and from school (UNICEF 2010); SMS alert systems (Souktel 2012), and working with religious groups (Antonowicz 2010).

The sector's community engagement is complemented by ZCBC, a Catholic Church initiative that empowers teachers to handle SRGBV through in-service training. In-service training teachers can make teachers aware of various dynamics in their classrooms, including gender

and power dynamics that fuel SRGBV and it can also make them aware of their own biases and behaviour. Roman and Murillo (2011) concluded that tackling SRGBV requires the ability to identify elements of the education system that cause violence between students. Training in GBV issues can allow teachers to consistently enforce codes of conduct that influence SRGBV.

The root causes and reinforcing factors of SRGBV are social norms, patriarchal practices and gender discriminatory tendencies (UNESCO & UN Women 2016); all of which reflect the culture of a community. To address the root causes of SRGBV in particular and GBV in general, a culture-sensitive response is critical. To encourage students to report their experiences of violence, schools have two teachers responsible for discipline, a male and a female. This has the potential to encourage girls to open up to a women. While students can talk to any teacher, talking about sexual issues is possible when girls can talk to a female teacher. In the Zimbabwean culture, girls are socialised not to talk to men about sexual issues.

Banning corporal punishment in schools is in line with global trend that this form of punishment constitute a violation of children's rights (UNESCO & UN Women 2016). However, in Zimbabwean cultures children are beaten or threatened with a beating if they act outside the norm, for example, if they fail to do household chores. In a culture where children used to being beaten at home, banning corporal punishment is not only culturally insensitive but also created class management challenges because of the large class sizes. The multi-dimensional nature SRGBV warrants a mix of strategies that address the individual, structural and institutional drivers within the school environment and the wider community that take into account the cultural values and norms of the target community.

Despite the capacity constraints in the education sector, teaching strategies to cope with conflict without using violence and imparting general education has a key role to play in curbing SRGBV. The education sector in Zimbabwe is characterised by teachers trained in content delivery. However, specialist training for nonviolent or gender sensitive pedagogies place teachers in a position to produce and sustain safe and gender equitable learning environments. The sector has elaborate professional codes of conduct in schools and the schools based reporting systems are in place. By working with NGOs that pay school fees for orphans and vulnerable children, the sector ensures that all children attend school. Engaging the community through the SDC and drama groups means that cultural norms that precipitate SRGBV are targeted. These strategies ensure that children receive an education and the skills to reflect and develop gender equitable norms, thus reducing violence in schools and ultimately in the wider community. In can be conclude that the sector's response is reactive, proactive and effective.

Chapter 8: Summary, conclusions and recommendations

8.1 Introduction

The thesis set out to examine the effectiveness of the institutional response to GBV by the justice, health and education sectors in Zimbabwe. Specifically the study aimed to do the following in various chapters of the thesis:

1. To identify risk factors of GBV in Zimbabwe within the ecological framework;
2. To assess the effectiveness of the institutional responses to GBV in the justice, health and education sectors;
3. To explore service providers' and other key stakeholders' perceptions of the strengths and weakness of institutional responses aimed at addressing GBV; and
4. To propose a model for multisectoral responses to GBV in Zimbabwe and other similar Global South contexts.

This final chapter consolidates the major findings and implications of the study. The chapter is composed on three main sections. The first presents the main findings and the second and last sections present recommendations for policy, practice and future research, respectively.

8.2 Summary of the main findings

Across all the sectors the main finding is that there is a robust legal and policy framework to prevent and respond to GBV. In Zimbabwe, GBV legislation has both criminal sanctions and mediating and conciliation aspects. That there has been major progress in establishing the right of women to live free of violence in both international and national laws, with the civil society movement at local and global levels playing a pivotal role (Klugman 2017). However, as the results show, there is lack of resources to fully implement the existing laws and policies. The study established that the challenges of enforcement emanate not only from lack of resources but also from the mediating effects of social and cultural norms that are institutionalised in the three sectors. In all the sectors, some degree of protection exist on paper (laws and sector-specific policies), yet violence remain pervasive and enforcement weak. The social and cultural norms are contextual and this finding contribute to existing literature locally and globally. Batliwala (2013) shows that laws and policies alone cannot eliminate GBV. According to Klugman (2017), it is difficult to use legal approaches to change traditions, beliefs, values, attitudes, norms and practices that are often deeply embedded in culture.

8.2.1 Objective 1: To identify risk factors of GBV in Zimbabwe within the ecological framework

The Zimbabwean context under which GBV occurs was found to be similar to other parts of the world where this type of violence is widespread irrespective of all measures to curb and condemn it. The study found that the risk factors of GBV in Zimbabwe are chiefly unequal power relations between men and women and cultural and religious norms that are internalised by individuals and operate through other variables at individual, relationship, community and societal levels. The study confirms the utility of the Heise's (1998) social ecology to understand the risk factors at the four levels of the ecological model and the way these risk factors interact.

To appreciate the risk factors of GBV in Zimbabwe, the study analysed the 2015 ZDHS data to understand the nature and levels of this type of violence and concluded that GBV is a compelling issue for women and girls. The results showed that physical, emotional and sexual violence, in that order, are the most common forms of GBV in Zimbabwe. Physical violence was found to be the most common and visible of the three, confirming previous studies done in the country (Damba et al. 2013; Mukanangana et al. 2014). A major theme that emerged from the content and thematic analyses was that GBV is a human rights issue, and a number of studies have documented that this type of violence is an abuse of human rights in both low- and high-income countries, regardless of culture, socioeconomic status, class or religion (Abrahams et al. 2015; Palermo et al. 2014).

Another significant feature of the nature of GBV in Zimbabwe revealed by the analysis of the 2015 ZDHS data is that the main perpetrators are people known to the women and girls (husbands/partners, former husband/partner and family members), suggesting that women and girls are not safe, even in their own homes. GBV has gone up by 35% since 2005. The qualitative component of the study confirmed that the main perpetrators are people not only known to the victims but who are supposed to protect them. The homes of many women in Zimbabwe is not the shelter and safe haven filled with warmth and love it is supposed to be but a place of harm, danger and fear. It is often considered a silent epidemic as victims face challenges reporting this violence that occurs behind doors (Palermo et al. 2014). The reporting dynamics, which is not covered in this study, could give a clearer picture of the levels of GBV in the country.

In line with the Heise's (1998) ecological model, the study established a number of risk factors of GBV at individual, relationship, community and societal levels. The specific focus on

spousal violence was determined by the data availability in the 2015 ZDHS as well as the fact that partners tend to be the main perpetrators). At individual level the study analysed age, religion, employment status of women, educational attainment of women and wealth quintiles. The results show that age and religion do not make much difference in the number of women and girls who experience GBV. With regards to age, the data analysis showed that young women (15–19) are relatively more likely to experience sexual violence than older women (45–49), who are less likely to experience any type of violence. That the age has no bearing on the experience of GBV is consistent with literature (Adebowale 2018; Izugbara 2018). Religious texts and teachings can be used to cope with GBV, while at the same they can be misused to condone violence. This study established that there is a weak causative link between religion and the experience of GBV in Zimbabwe. This type of violence was found to be widespread irrespective of religious affiliation.

The results show that Zimbabwean women employed either for cash or not were at a greater risk of experiencing GBV than their unemployed counterparts. In patriarchal societies like Zimbabwe, the improved economic status for women tends to challenge the socially prescribed male dominance, triggering male backlash (Lukc & Munshi, 2011). By the same token, Allonso-Borrego and Carrasco (2016) reported that according to the extractive theory, men commit acts of violence on women with resources to get money. The acts of violence tend to weaken her bargaining position in a relationship. With regards to education, the experience of GBV by women decreases with increased educational attainment. Education increases women's employment opportunities, and as Kiss et al. (2012) found, educated, economically independent women are less likely to be abused because they are more confident about leaving or reporting abuses to authorities. At the same time, poverty increases the economic and social vulnerability of women and girls to GBV (Heise & Kotsadam 2015), and in line with this, the results show that the proportion of women who reported having experienced spousal violence decrease with an increase in wealth quintiles. Poverty is high in Zimbabwe due to the sustained economic challenges the country has been facing since 2000.

At relationship level, marital status and husband's use of alcohol were analysed to ascertain their relationship with the experience of GBV by women and girls. Women in a union at the time of the survey were less likely to report experiences of GBV compared to those who were formerly married. This pattern may suggest that GBV can lead to union termination, with over 50% of women in the widowed/separated/divorced group reporting having experienced some form of GBV. The relatively low levels of sexual violence are in line with previous

Zimbabwean research by Mukanangana et al (2014), which showed that married women find it difficult to report spousal rape.

Consistent with global research that consistently reveal an association between GBV violence and alcohol abuse (Adamczyk 2010; Barret et al. 2012; Messersmith et al. 2017; Schafer & Koyiet 2018), the results show that alcohol abuse, measured by the frequency of being drunk, exposes women whose partners drink and get drunk to GBV. Under the influence of alcohol men are likely to sexually objectify women and girls, and alcohol generally diminishes the ability to read social cues (Abbey et al. 2011; Gervais et al. 2014). The qualitative results of this study confirmed that alcohol abuse by men heightens the risk of experiencing GBV by women.

A multi-regression analysis of individual and relationship factors showed that employment status, education and husband/partner's use of alcohol are significant in precipitating spousal violence, either in a direct or inverse relationship. The results emphasise that factors associated with GBV are multifaceted and that the contexts in which women live are related to the odds of experiencing GBV. Despite the fact that employed women were at a higher risk of experiencing GBV, empowered women are likely to report this type of violence and to have economic independence to help them leave abusive relationships (Izugbara 2018). Economic interventions, such as micro credit programmes, have the potential to enhance decision-making abilities and address the structural pathways that result in women experiencing poverty (Izugbara 2018). In domestic violence research, women's age, income, education level, and occupational status are often measures of 'power' because these resources may reduce economic or social dependency and improve women's ability to resist violence or escape an abusive situation.

At community level, rural-urban residence, province of residence, traditional gender roles, and cultural norms were analysed to establish their role in influencing women's experience of GBV. Place of residence, defined by rural or urban, and geographical location, defined by province, were found to have no effect on the prevalence of GBV in Zimbabwe. This is in contrast to literature that shows that this type of violence is higher in rural areas where cultural and traditional norms are more prevalent (Antai 2011; Balogun et al. 2012; Eisikovits & Band-Winterstein 2015; Oyedirani 2016). The same prevalence of GBV in urban and rural areas is a result of sustained economic challenges that cause the sociocultural differences between rural and urban areas in Zimbabwe to be blurred and show that factors influencing GBV are highly

contextual. In line with the same argument, results show that GBV is widespread in all the country's provinces, with nearly half of the women reporting to have experienced GBV.

Despite the country's enabling legislative and policy environment, traditional gender roles and cultural norms and values contribute to high levels of GBV in Zimbabwe. The results show that a deviation from traditional gender roles, such as women being employed outside home instead of looking after children, expose women to the risk of experiencing GBV. A deviation from the traditional gender role is often perceived as challenging male privilege, and in many cases, men resort to violence as a form of resistance or to confirm authority (Conroy 2014). Women's participation in paid employment challenges men's breadwinner role and they vent their frustration and anger on women. The pervasiveness of gender roles means that women are not only exposed to the risk of experiencing GBV but that they may find it challenging to report this type of violence.

In Zimbabwe, the sociocultural norms practised for many generations determine the nature and prevalence of GBV (Mukanangana et al. 2014). The persistence of *chiramu* in the wake of the combative measures against GBV (initiated by globalisation in other spheres of life) means that the abuse of the rights of women and girls continues unabated. The acts of violence associated with this practice consists of a series of abuses ranging from the fondling of breasts to coerced sexual acts. Poverty and financial dependency exacerbate the situation as reporting is often curtailed. Consistent with these findings, studies in a number of countries show that context-specific cultural factors influence GBV in different ways (Jewkes et al 2015; Karugahe 2016).

Finally, at societal level, gender inequality, national poverty levels, normative use of force and increased use of technology were considered to establish their relationship with the experience of GBV by women and girls. The qualitative results of this study show that spousal violence is a manifestation of structural inequalities between men and women, which is reflected by the gender inequality index, which is high (0.62). Confirming the high gender inequality index, more than a third (33%) of women marry before the age of 18, and there is a higher prevalence of HIV among women (16.7%) than men (10.5%), creating conditions that heighten the risk women and girls' experiencing violence. Besides being abuse in its own right, marriage before the age of 18 is child marriage and means there is an age differences between partners, resulting in an array of abuses (Izugbara 2018). Mandatory HIV testing for pregnant women means that the women may be blamed for bringing HIV into the relationship, resulting in violence. Sustained and established evidence show that GBV occurs where there are gender and power

inequalities within relationships or within the social and political environment in which these relationships exist (Heise 2011; Kotsadam 2015; Gulliver & Fanslow 2016).

Sustained economic challenges continue to diminish economic opportunities for many men who are socialised to be breadwinners. In these situations, violence is used both to obscure male misbehaviour (Saigol 2011) and to restate their authority to fulfil patriarchal norms (Izugbara 2018). High levels of poverty in the country mean that increased economic dependency for many women heighten women's risk of experiencing GBV.

Normative use of violence in Zimbabwe can also be attributed to cultural norms and the actions of members in the security sector (police and army). GBV is culturally acceptable in Zimbabwe, as explained by the proverb 'plates in a basket rattle', which means that people who live together will clash. The police and the army often use force to maintain peace and order during demonstrations. The use of force by the police is often shown on television and the practice is now a norm in the country. Institutional use of force as a way to maintain peace and order and the cultural acceptance of violence increase the risk of women experiencing violence.

The increased use of technology, especially mobile devices, is fuelling GBV in Zimbabwe. A number of studies in the West show that men use physical and virtual stalking to access victim's devices, monitor victim's contacts and track victim's devices (Diamond et al. 2011; Freed et al. 2017; Levy 2014; Shimizu 2013). In Zimbabwe, mobile devices often expose extra marital affairs, igniting spousal violence. The qualitative results show that men are always on their mobile devices, and in many cases, use pseudonyms to hide the identities of those they have an extra marital relationship with. This not only contributes to emotional abuse but may also fuel physical abuse if their behaviour is challenged. The increased use of mobile devices contributes to the diverse range of risk factors that increase women's vulnerability to GBV. However, more research is needed to determine how mobile devices can be a protective factor.

Overall, patterns shown by the risk factors demonstrate that GBV in Zimbabwe remains a threat to the empowerment of women and girls. While paid employment shields women from GBV in Zimbabwe, it also exposes them to abuse. This shows the pervasiveness of GBV and that one-size-fits prevention may not work. GBV is widespread in Zimbabwe, prevalent in all spheres of the lives of women, and can manifest through physical, emotional and sexual violence. An important theme that emerged from the thematic analysis was that social and cultural norms do not only precipitate GBV but also make it difficult victims to report this type of violence. Izugbara (2018) found that an important step towards reducing or eliminating GBV

is for societies to create social environments that are intolerant of GBV, making it more difficult for perpetrators to persist in their violent behaviour and making it less difficult for victims to report GBV.

8.2.2 Objective 2: To assess the effectiveness of the institutional responses to GBV in the justice, health and education sectors

Content and thematic analyses showed that Zimbabwe has adequate legislation and policies that seek to prevent GBV, yet GBV incidences remain high. Zimbabwe has adhered to global policies, such as CEDAW 1979, and regional instruments, like the Maputo Protocol and the SADC gender policy which have influenced the enactment of the DVA with provisions to protect women and girls from GBV and the Sexual Offenses Act. These provide for the prosecution of all forms of rape, sexual violence and wilful transmission of HIV. The enacted pieces of legislation comply with the country's international obligation to protect women and girls from violence. The qualitative results showed that despite such efforts, the country still faces challenges in the implementation of the existing legislation and policy provisions due to lack of resources and the mediating effects of cultural and religious norms. From the results it was clear that the laws and policies are important to establish the public unacceptability of GBV. The laws, especially the DVA and the Sexual Offenses Act, serve as practical methods of legal responses for women and girls. However, they are insufficient as prevention mechanisms. The study established that there is a gap between policy and legislation availability and implementation, which accounts for a rise in GBV cases in Zimbabwe. A number of policy and legislative provisions are not compatible with cultural and religious norms, creating a barrier for their implementation. The results show that although the legal route is not the best way to deal with GBV, it does offer alternatives to victims of GBV.

The laws that protect women in Zimbabwe are a product of the country ratifying international instruments like CEDAW. The ratification triggered collective action around GBV issues and the rise of women and civic organisations that sought to promote gender equality. Richards and Haglund (2015) show that CEDAW ratification is associated with the strengthening of domestic gender violence laws overtime. While civic organisations motivated by human rights discourse promoted by CEDAW can advocate for policy makers to enact laws that protect women from GBV, they cannot do the same for the implementation of these laws. While the legislative environment is conducive to curbing GBV, the implementation challenges mean

that women continue to experience GBV. In Zimbabwe the impressive legislation only covers physical and sexual violence and not emotional violence, which is common (Chapter 4).

In addition to national instruments to curb GBV, the study established that there are sector-specific policies and strategies used by the justice (police), education and health sectors. The NHS, the CSC and *Circular Minute P35* (1999; education) are sector-specific strategies in place to curb GBV. On paper these strategies are detailed enough to guide the sectors to fulfil their mandate, which is dealing with crime (police) and the treatment of patients (health) and creating a conducive environment for learning (education). *Circular Minute P35* (1999) mentions some forms of SRGBV, like sexual harassment and rape, and is elaborate on how to deal with these. The CSC calls GBV a crime against women, and the NHS is silent on GBV issues. The results show that in its totality, GBV is not part of the three sectors' core business. The core business of the education sector is to teach children and the emphasis is on examinable subjects. The health sector exists to treat people, and the treatment of GBV wounds is not enough to prevent this type of violence. While the police exists to prevent crime, it is sometimes difficult to categorise GBV as a crime because of its diversity and complexity. Rape, for example, is not universally considered a crime in same way that murder is, which is evidenced by the non-reporting of rape cases.

Police response

From a criminology point of view, the results show that the police treat GBV as a crime and react to this type of violence by arresting perpetrators, investigating reported cases, offering counselling services, documenting cases, and referring victims to other service providers such as the health sector and institutions that offer temporary shelter to victims. The compilation of GBV statistics at police stations shows that this type of violence is a compelling issue for women and girls. This is supported by a number of studies carried out in Zimbabwe (Makahamadze 2012; Mashiri 2013; ZIMSTAT & ICF 2016). GBV occurrences are increasing, especially emotional and physical violence. Armed with the GBV statistics, the police still fail to come up with an effective primary prevention strategy to stop the violence from occurring. Instead, the police use repetitive awareness campaigns that can be erratic due to lack of resources. The results show that members of the VFU receive training in GBV issues but they are not present at the charge office, the first port of call for all visitors (including GBV victims) to the police station. In many cases, officers trained in GBV issues are of lower ranks. Although there are provisions that they report directly to the provincial VFU, the local head of the police

station interferes with the unit's activities indirectly by not offering adequate resources like vehicles.

The police respond to GBV in two ways: By dealing with reported cases, and creating awareness campaigns to prevent this type of violence. In the former, the police has a critical role to provide victims of GBV with protection and access to justice. In the latter, the role of the police is to promote peace. The results show that the police seek to address GBV through the VFU, which is done through the legal and the non-legal route. The legal route involves arresting the perpetrator after investigating and producing evidence in court for prosecution. The non-legal route involves summoning the perpetrator for counselling and cautioning.

As part of the efforts to prevent GBV in the community, police stations run awareness campaigns in conjunction with NGOs, chiefs and counsellors. This institutional set-up in the stations is meant to make the community aware of the dangers of GBV. The police attack GBV from a legal and human rights perspective while the chief attacks GBV from a cultural point of view. In a community where gender equality is opposed, NGOs promoting the latter are viewed as bringing in foreign culture, while counsellors representing politics may take a populist stance to gain votes. The faces of the law (police), culture (chief) and politician (counsellor) jointly denouncing GBV has improved reporting levels. However, the importance of marriage in Zimbabwe and the economic dependency on the perpetrator by the victims have resulted in a reporting pattern where the victim insists that the perpetrator should not be arrested. All these bring in the cultural context, which is important when the police decided how to deal with perpetrators.

The police participate in the crime consultative committee meetings with other stakeholders like the ministry of women affairs, teachers, farmers, local business people and politicians. The purpose of the meetings is to assess patterns of crime in the area. While the key informants acknowledge that GBV issues feature at the meetings, conceptualising GBV as a crime narrows it to serious life threatening abuses like fights, which the police classify as grievously body harm and rape. This practice omits other forms of abuse that affect women emotionally and psychologically. From the meetings, awareness campaigns are planned based on the pattern of crime in the area. The reliance on short-term activities like awareness campaigns demonstrates the absence of a long-term and effective strategic response to GBV. As a result, GBV increases despite awareness campaigns, which are done in an ad hoc manner. Awareness campaigns not informed by broad and clearly defined strategic framework to deal with GBV and its underlying causes have little impact in curbing this type of violence. It was clear from the findings that

there is no arrangement to provide post incident care to victims as part of the proactive approach to prevent further abuse.

The police link with the community through the CBP and the results show that they take crime suspects to the police station, reducing the reaction time by the police when called to assist as they stay in the community. Local people are more comfortable to report to CBP personnel than to go to the police station, which in addition to being very far may be manned by people from other regions. The results show that the CBP's presence in the community act as deterrent to crime and perpetration of GBV.

Based on the findings of this research, the police has a formal referral system that involves the health sector for treatment and evidence gathering and social welfare for placement in safe homes. Victims are referred to the hospital for PEP and EC and for treatment of physical wounds. Between the police and the hospital is a two way referral system where the police produce a report for the victim to be attended to at the hospital and the hospital provide expert knowledge on the degree of injury as well as forensic evidence in the case of rape. The forensic evidence and the degree of damage are used as evidence in the court to prosecute perpetrators. Credible forensic evidence is possible only if the victim is observed within 72 hours. The social, economic, religious and cultural realities of the victim may prevent her from getting to the hospital. In the study area, a victim can be constrained by distance from reporting the police, who may not have transport to pick the victim up. While the referral system is elaborate on paper, it is fraught with institutional challenges and challenges faced by the victims.

Thematic analysis showed that the police are aware of the laws that deal with GBV in the country as well as how and when to implement them. However, the interviews with police officers in the VFU revealed the complexity of the decision-making processes, especially when dealing with women with a swollen face who is pleading that the police should not arrest the perpetrator but caution him. The recognition of the complexity of decision-making dynamics is important the explanation for police response in low-income settings was largely limited to patriarchy and corruption (Medie 2015).

Health sector response

The Zimbabwean health sector reacts to GBV (identification, medical examination, treatment, administering PEP and EC) more than it takes a proactive role in responding to the needs of women and girls vulnerable to this type of violence. Based on the results, health care providers fail to register GBV due to the narrow clinical practices that focus on the direct symptoms of

physical violence. GBV survivors sometimes come to the health centres to seek treatment and not necessarily to report. All forms of physical abuse are recorded as assaults at the clinic and hospitals and have observable signs, which naturally become the immediate concern of health workers. The sector's investigations aim to treat survivors for these symptoms and signs. The health system in Zimbabwe relies on the biomedical paradigm of physical health and illness. As a result, health service providers focus on the treatment of physical complaints and often ignore not only the causes of GBV but also its secondary effects like depression and stress, which may not be visible but can have long lasting effects even after the abuse had stopped.

The NHS is silent on how to deal specifically with GBV but stresses the need to treat ailments, including those caused by GBV. This means that GBV survivors can pass through the health sector as people with physical complaints. The results show that GBV training is not part of the health sector-training programme but is optionally offered as part of in-service training. This shows that the screening of GBV victims depends on individual health workers and not on the sector. However, there is evidence in the clinics and outpatient departments that the health sector is ready to offer medical attention to rape victims by administering EC and PEP. The medication was readily available and the procedures clearly displayed.

Although most of the primary prevention occurs outside the scope of the health sector (García-Moreno et al 2014), the health sector in Zimbabwe is involved in awareness campaigns. At hospitals and clinics there are billboards with messages to remind people of the 365 days of activism against GBV as well as others that remind survivors to report to VFUs when abused. On the other hand, the results show that the training of health workers on GBV issues is optional. This means that in hospitals and clinics, the effectiveness on the health sector's response depends on individuals, which creates continuity challenges when the individuals are transferred or promoted. As a result, GBV continues to rise despite the health sector's biomedical efforts and awareness campaigns.

The health sector work with VHWs, who act as conduits for the distribution and dissemination of family planning material and information and HIV and AIDS mitigation and connect with the health sector for other medical related services. In the context of GBV, VHWs encourage abused women to visit the nearest clinic for medication. As the results show, the VHWs play a mediation role between the perpetrator and the victim. Largely the health sector's community efforts are reactive.

The results show that the referral system in the Zimbabwean health sector can be internal or external. Internal referrals involves referring survivors seeking help at a clinic to a hospital when necessary. It also means that survivors who present themselves at the outpatient department may be referred to other departments within the same hospital. Between clinics and hospitals and between departments in the hospital, survivors with serious injuries or those who have been raped are transferred immediately. The referral between and within health centres is motivated by the need to treat the survivor, gather evidence for the prosecution of the perpetrator as well as for counselling. While it is good clinical practice to refer a survivor with prior consent, in cases where their life is at risk (severe injuries and rape) this is done with or without the survivor's consent. The external referral system is the communication between the health sector and other sectors that aim to help GBV survivors, and it depends on efficient lines of communications and clearly outlined procedures (UNFPA 2010). The results show that this can be problematic when there are gravel roads that are inaccessible during the rainy season or moving the survivor from one hospital and police or the vice versa is curtailed by exorbitant transport fees. In many cases, rape survivors are accompanied by police who use public transport. This shows that this referral system relies on the contribution of committed individuals. The effectiveness of a referral system depends on the alignment to the legislation or standard protocols that define the roles and responsibilities of all organisations (UNICEF 2013a). Although there is formal cooperation among the police, social welfare and the health sector in Zimbabwe, the referral system is affected by a lack of resources and monitoring. The health sector is often the first point contact for survivors of GBV, and as such the sector is well positioned to meet the multiple, complex needs of survivors through internal and external referral networks. In the study area, these networks face a number of challenges, which include demoralised staff, deep-seated cultural norms, shortage of medicines, inaccessible roads and lack of monitoring, especially the external referral network.

Overall, at the level of the primary health facilities, the thematic analysis showed that health workers are more focused on the secondary prevention of GBV. The study focused on the health workers' knowledge of GBV laws and their perception about the sectors' response. Exploring their attitudes is key to understanding the effectiveness of the health sector's intervention strategies (Colombini et al. 2018). Since the primary health centres offer different health services, like family planning, maternal health care and emergence services, integrating GBV into these services is an important scaling-up strategy to deal with GBV, which was not

explored by this study. However, such an effort requires efficient top-down management support, including financial support, to ensure the long-term sustainability (WHO 2013).

Education sector response

The results show that schools suspend, exclude and expel pupils who perpetrate various types of SRGBV and terminate teachers' contracts of employment if found guilty of sexual abuse that involve school children. The results show that in all schools more than 90% of the teachers are qualified. However, the key informants alluded that teachers are trained to be specialists in their subjects but not specialists in dealing with SRGBV issues. In spite of this, teacher training incorporates philosophy, psychology and sociology modules that enable teachers to deal with the numerous social and psychological challenges that hinder learning. But without specific training it becomes futile to try to deal with SRGBV. The ban on corporal punishment in schools actually exacerbated SRGBV instead of alleviating it because of the increased indiscipline.

Schools work with Mavambo and LCT, local NGOs that pay schools for disadvantaged girls as well as offer loans to young mothers who dropped out of school because of early marriage. The schools also work with drama groups to raise awareness about various forms of GBV in the society. For example, in the study area, schools work with a drama group called Torangaridzana to raise awareness about GBV.

While all schools are built in locations perceived to be safe, in the study area one school is built next to a number of shops, increasing the vulnerability of children to abuse on their way to and from school. It is critical to conduct safety audits of the school infrastructure and access routes to identify unsafe areas. There was no evidence that this is done in the study area. However, the children are left alone during tea and lunch breaks, leaving children vulnerable to bullying and sexual harassment during these times when most of the children are outside and perpetrators pounce on those who remain in classrooms. Lack of teacher supervision during these times exposes children to various forms of abuse. The results show that in order to protect the girl child, schools allow pregnant girls to continue with schooling until she is about to deliver. This oversimplifies reality because pregnant girls are the subject of ridicule from both peers, the school and the community.

The results show that schools have adequate referral systems, which can be divided into formal and informal. The formal referral system involves the police in cases when serious sexual abuse is reported to the law enforcement agents, who usually investigate cases to prosecute the

perpetrator. Referral systems open avenues for perpetrators to account for their actions and aid in the provision of life saving services like PEP and EC. In many cases, perpetrators are not punished, making it worse for the victims. The informal referral system in schools use suggestion boxes and confiding in any teacher the victim is comfortable with. In addition to this, the church-run institutions refer victims to pastors based at the schools. Informal referral systems are required for counselling and spiritual and psychological support. The success of any referral system depends on the skills of the teachers to handle SRGBV cases. Referral procedures that are readily accessible to both teachers and students results in swift, appropriate responses and act as a catalyst for reporting any form of SRGBV. However, a cross-country research study in Africa found that girls in particular rarely report violence; in Mozambique, only 6% of girls who experienced violence reported it, and the figures are only slightly higher in Ghana (15%) and Kenya (35%) (Parkes & Heslop 2011).

The growing awareness about violence in schools has helped bring SRGBV onto the international and national policy agenda. However, a recent review carried out by UNESCO found that initiatives that specifically address violence in schools are uncommon (Leach et al. 2014). In Zimbabwe, *Circular Minute P35* (1999) deals with SRGBV and disapproves of violence in schools. Thematic analysis showed that social and cultural norms precipitate GBV. As such, witnessing violence in the home is linked to experiencing or perpetrating violence in schools (UNESCO 2014). It is evident from this study that banning corporal punishment in a context where children witness GBV may not solve the problem of violence. The top-down nature of policies resulted in teachers blaming the banning of corporal punishment and labelling it as a foreign idea. Dealing with SRGBV should extend beyond the school as this type of violence is embedded in everyday interactions, school cultures and broader sociocultural and economic contexts (Parkes et al. 2013).

The response by the three sectors is influenced by the traditional GBV interventions that focus on the survivors of this type of violence (for example, medical support, documenting GBV cases, police, dismissing teachers who sexually abuse school girls, and education). Operating within the traditional GBV intervention framework, the three sectors face organisational and personnel related challenges in responding to GBV. Schools, police stations and clinics lack resources like cars, space, and furniture to deal with this type of violence. Personnel in these sectors are members of the community, who, the results show, subscribe to the patriarchal norms and values that promote violence. Thus, organisational poverty and patriarchal norms affect the implementation of sector-specific strategies to respond to GBV. It was evident from

the results that the three sectors lack processes that engage all staff in exploring concepts of power and cultural and social norms and how they manifest in their own identity and work life. Effective institutional responses should be both reactive and proactive. Within the three sectors, the proactive approach is not implicitly implied and it is safe to conclude that the three sectors' responses to GBV is inadequate.

Community mobilisation

Community mobilisation efforts by the three sectors are done through awareness campaigns. The results show that the three sectors work with stakeholders like community leaders, politicians and churches to raise awareness about GBV issues. However, there is no evidence of an explicit programme to prevent GBV, save for cited awareness campaigns, which the discussions showed get stuck in repetitive cycles of general awareness activities. While these are good to maintain, focusing on GBV issues is not enough to support changes in the attitudes, norms and behaviour that help to perpetuate GBV. The non-systematic approach to awareness raising is evident despite it having the most potential to impact GBV rates (Heise 2011). The health sector works with VHWs, who act as conduits for distribution and dissemination of family planning material and information, HIV and AIDS mitigation and to connect with the health sector for other medical related services. In the context of GBV, the VHWs encourage abused women to visit the nearest clinic for medication. As shown in Chapter 5, the VHWs play a mediation role between the perpetrator and the victim. The health sector's community efforts are mostly reactive.

The police link with the community through the CBP, and the results show that they take crime suspects to the police station, reducing the reaction time by the police when called to assist. The local people are more comfortable to report to the CBP personnel than go to the police station, which in addition to being very far may be manned by people from other regions. As a sector, the police routinely holds crime awareness campaigns, which do not include GBV issues. Furthermore, the police refer victims of GBV to Musasa, an organisation that offers shelter and other services to abused women. Like the health sector, the police's community GBV efforts are largely reactive.

Education is the only sector whose community efforts aim to prevent GBV. The results show that schools in the sector work with a Mashonaland Central-based drama group called Torangaridzana. Through edutainment (Heise 2011) the drama group helps raise awareness about GBV issues and offer entertainment during functions. Edutainment is a primary

prevention strategy that has the potential to reduce cases of GBV (Heise 2011). Furthermore, the education sector work with Mavambo and LCT CSOs that pay school fees for needy children and offer loans to young mothers who dropped out of school due to early marriage or sexual abuse. Higher levels of education and a higher economic status of women have consistently been shown as a means to prevent GBV against women (Goicolea et al. 2015; Heise 2011; Sida 2015).

Community mobilisation is a complex and strategic intertwining of awareness raising, small group work and edutainment that work together to enable community members to take the lead in changing entrenched social norms, the overarching cause of GBV. An analysis of community mobilisation initiatives by the three sectors showed that they include public health and social justice elements. Campaigns that target cultural norms show the public health's focus on the process of behaviour change. GBV is also about injustice, striving for equality, and the rights and dignity of the victim (Michau et al 2015). Community mobilisation is a primary prevention strategy, and increasingly, efforts aimed at social level factors such as social norms that uphold gender inequality are emerging by using mass media edutainment (Michau et al 2015). However, lack of resources in Zimbabwe's three sectors make community mobilisation an ad hoc sporadic activity that lack the clear direction of systematic and long-term programming.

8.2.3 Objective 3: To explore service providers' and other key stakeholders' perceptions of the strengths and weakness of institutional responses aimed at addressing GBV

The research sought views on the strengths and weaknesses of institutional responses based on existing laws, policies and organisational work ethics. Officials in the three sectors were of the view that when the DVA is known, it is very effective. The findings show that the instrument encourages reporting and has provisions that women can explore to make perpetrators accountable. While laws may encourage reporting, increased reporting was found to strain the capacity of the police, courts and support services (Klugman 2017). When the police are overwhelmed, it can lead to high attrition rates. The results show that the DVA instils fear in potential perpetrators, and thus, contributes to primary prevention of GBV. The participants described the DVA as a divorce settlement tool, especially when the legal route is chosen. However, from a legal point of view, challenges arise when the perpetrator is sentenced to a jail term and then come home to their partner. The DVA also allows the police to counsel the warring parties, and this has proved to be effective as most abused women opt for this non-legal route. The non-legal route is compatible with the culture as it preserves marriages, to

which many women attach a lot of importance. However, research shows that when legislation prohibitions are enacted alongside customary laws that promote male dominance, the potential of legislative reform is curtailed (Michau et al. 2015). The findings of this research show that victims opt for the non-legal route. The interplay of formal and customary laws is important in Zimbabwe. Although the CSC guides the operations of the police (investigating crime and documenting GBV cases), the institutional efforts are constrained by lack of vehicles and office space, and poor remuneration.

Guided by the NHS, the health sector succeeded in mitigating the effects of sexual abuse by timeously administering EC and PEP. The results showed that the working relationship between the health sector and the police has contributed to a reversal of some of the negative effects of rape like unwanted pregnancy and HIV infection. Like the police, the health sector's efforts are constrained by lack of electricity, lack of vehicles, staff shortages and poor working conditions. With regards to other types of GBV, staff training is needed to enable them to identify victims. Privacy, which is a function of infrastructure and availability of staff, is crucial along with changes in care structures, which means shifting from a biomedical approach (Colombini et al. 2012).

From the education sector, the provisions of *Circular Minute P35* (1999) in the Ministry of Education has contributed to a reduction of sexual abuse of school children by teachers. The success of the instrument is attributed to the fact that it is administered within the ministry and not across ministries as the DVA. Despite this, the abolition of corporal punishment has instigated a wave of indiscipline among students. The findings show that teachers face a number of challenges dealing with indiscipline in the absence of corporal punishment, such as large class sizes; lack of furniture, which compromise the seating arrangement of students; and the way human rights were introduced by the police. Students were openly told that it is now against the law for them to be beaten at school and if beaten they should report to the police. Most teachers in the study felt that corporal punishment should be reinstated in schools. This is because most of them went through the school system when corporal punishment was used and have also used it as teachers.

In all three sectors, the results showed that there is a gap between laws/policies and practice. It was revealed that laws and policies that aim to curb GBV have improved over time in Zimbabwe while the attitudes and behaviours that condone violence against women have stayed the same. It is the perception of stakeholders in the three sectors that institutions face implementation challenges because of lack of resources, insufficient legal knowledge, legal

resources and societal attitudes of GBV tolerance. Key informants indicated that due to economic challenges, the Zimbabwean government is failing to adequately provide resources to the three sectors, and the budgetary constraints have negatively affected the operations of the three sectors. Implementation challenges that are associated with lack of resources are common in many low-income countries (Michau et al. 2015). Community tolerance of violence creates barriers for abused women to fully benefit from GBV services and the legal system. The results show that community tolerance of violence comes in many forms, including time taken to respond to reported cases at police stations, the way victims are treated at primary health centres, blaming the victims, and the nature of jail terms, especially for physical violence.

8.2.4 Objective 4: To propose a model for multisectoral responses to GBV in Zimbabwe and other similar Global South contexts

In the fight against GBV, primary prevention and secondary prevention strategies help to reduce new cases and to offer remedy to victims. Tertiary prevention involves long-term treatment and support for victims. From the public health perspective, violence prevention is multisectoral and involves private and public sectors like the health sector, the education sector, the criminal justice sector, social services and civil organisations (Butchart & Mikton 2014). Violence has traditionally been the purview of the criminal justice sector, but its deterrent approaches has failed to prevent violence. The public health approach uses behavioural, biomedical and environmental interventions (Akers et al. 2012) and has been successful in reducing a range of non-communicable diseases. (Callinan et al. 2010). The public health approach posits that the first step in designing a prevention programme is understanding the magnitude of the problem in the target population. It is necessary to understand the risk factors for experiencing an outcome (in this case GBV) (Wagman et al. 2013). To this end, the study used Heise's (1998) ecological model to understand the risk factors of GBV.

The public health approach to GBV needs a plurality of disciplines and a host of experts (e.g. from health, education and law enforcement) at its centre (WHO 2011), but a number of factors make it difficult to forge this primordial dynamic. These disciplines often lack a common understanding of GBV and approach GBV issues from different perspectives. For example, law enforcement, like the police, treat GBV as a crime, while the health sector views GBV as a morbidity issue. As such, this study proposes that a multisectoral approach from a public

health perspective is possible if there is a change in the way the public sectors are integrated to fight GBV.

The proposed model is based on the assumption that the field of violence prevention is still in a period of innovation, learning and refinement (Jewkes et al 2020) and the need to broaden the evidence base on what works to prevent violence reflecting on contextual appropriateness. Furthermore the proposed model is based on the assumption that any prevention work should be evidence and best practice informed and should support women's rights and equality. It assumes that a local political dynamics creates a conducive environment to address structural challenges that may impede the implementation of the model.

The study established that spousal violence (physical, emotional and sexual) is the most common form of GBV in Zimbabwe, and that the main risk factors are at all four levels of the ecological model. The main risk factors are the employment status of women (individual), alcohol abuse by partner (relationship), cultural norms and traditional gender roles (community), and normative use of violence, use of mobile devices and gender inequality (society). GBV is a product of the interaction of factors at different levels of the ecological model (Heise 1998; Saffitz 2010), and risk factors at individual and relationship levels provide an avenue through which risk factors at community and society levels manifest. For example, the employment of women challenges the provider or breadwinner identity in the home, which may result in men using violence to reaffirm dominance (True 2012). In essence, the proposed model is influenced by the risk factors of GBV in Zimbabwe and is centred on the community and societal levels of the ecological model. This is in line with the pronouncement by the SADC Framework (2012) that efforts to prevent GBV should entail strategies for transforming stereotypical culture, attitudes and behaviours that condone violence. Discriminatory cultural norms and stereotypes continue to keep women and girls in subordinate positions and place them at the risk of experiencing GBV and also constrain their ability to disclose this type of violence.

Furthermore, the proposed model intends to fill gaps in the response by the three sectors. Based on the results, the three sectors react to GBV more than they initiate programmes to prevent it. Teachers concentrate on the teaching of traditional subjects, and this is demonstrated by giving more time to mathematics than to guidance and counselling that feature gender issues. The health sector concentrates on the treatment and examination of GBV survivors. The core business of the police is to prevent crime, and perpetrators of rape and other sexual offences and child marriage face arrest. All three sectors are characterised by skills shortages due to lack

of consistent in-service training and resignation induced by sustained economic challenges in the country.

The proposed model is informed by the SADC Framework (2012), which in Section 4.1.3 identified the police, the health and education sectors and CSOs as key service providers in the mitigation of GBV. The framework has five thematic areas, namely prevention of GBV; protection, care and support services; capacity development; information and knowledge management; and networking and partnerships. In line with the multisectoral approach, the framework calls for the provision of standardised and comprehensive pre- and in-service training on issues surrounding GBV for all relevant professional skills across sectors (in this case health, police and education sectors).

Given the multifaceted causes of GBV and its widespread and complex nature in patriarchal societies in LMICs, a multisectoral approach using locally available expertise is required to address the issue. The study proposes a three sector primary and secondary prevention model comprising the justice (police), health and education sectors. The rationale for designing an intervention model based on the three sectors is the way these sectors interact with the public. The education sector interacts with children while in school, and this formative stage is critical as children can act as agents of change, especially of the social and cultural norms that condone violence. The health sector interacts with women when they come for other health services, and its frontline workers may be the first to meet a GBV survivor when they come for treatment. Firstline response (listening, validation of the survivor's experience and support) is a major step in the path of recovery and possible escape from violent situations. The police interact with the general population when maintaining peace and order and when helping GBV survivors. The three sectors are the most visible components of the government with hospitals, schools and police stations dotted throughout Zimbabwe.

Cognizant of the fact that Zimbabwe is experiencing economic challenges, the proposed model is accommodated within the sectors' budgets. These sectors are conducting pre-training of their workers and an additional cost is the introduction of a compulsory course. In rural areas, establishing community-based shelters for GBV victims is possible without requiring substantial amounts of financial resources. At chiefs' homesteads, the concept of *zunde raMambo*, which seek to ensure food security for vulnerable people, often have extra rooms to accommodate people in transit. The violence prevention committees at clinics and schools use the staff that is already available. The government can mobilise the donor community to fund the implementation as the thrust of the proposal is to help the realisation of women rights.

Table 8.1 and Figure 8.1 summarise the proposed three sector intervention model to address GBV. It is based on the transformation of the police, health and education sectors by having a common definition and understanding of GBV. It is informed by the change theory and the SADC Framework (2012). Rogers (2014) states that the change theory is based on how activities are understood to produce a series of results that contribute to a product or impact. For example, making people aware of the causes and effects of GBV and the provisions of the DVA that protect victims in order to reduce the levels of this type of violence.

The common definition and understanding of GBV should include the following:

- All forms of GBV (physical, emotional, sexual, and psychological)
- GBV is a violation of human rights
- It is a legal, social and economic issue
- Causes and effects of GBV
- Cultural practices that have the potential to expose women and girls to GBV
- All forms of coercion, threats and male control
- Mediating effects of cultural, social and religious norms in fuelling GBV and their role in non-disclosure
- That women and girls are the ‘scenes’ of violence, and trauma may affect their statements
- Most violence occurs in private, and the main perpetrators are people trusted by women and girls
- GBV perpetration is intentional
- Withdrawal of cases from police or change of statement by women and girls does not mean that they like what happened to them
- Prevention of GBV before it occurs is cost effective
- Treatment of GBV should go beyond the physical ailments to include trauma mitigation

Building a common understanding of GBV by the three sectors determines not only the skills needed to make a meaningful and practical change but also help to change their attitudes and perceptions towards this type of violence through joint training sessions. The results of this study showed that sexual abuse border on the deferent definitions of GBV.

Table 8.1: Three sector intervention model to curb GBV

Organisational Transformation		Intervention Strategy		Outcome
Organisational Culture	Capacity Development	Reactive Approach	Proactive Approach	
Standardised definition and understanding of GBV in the health, police and education sectors. Align sector-specific policies and strategies to the common definition and understanding of GBV. Establish violence prevention committees at every clinic and school. Demonstrate political will by availing financial and technical support. Ensure access to coordinated multisectoral services. Set national benchmarks and timelines for in-service delivery and referral systems.	Combine the introductory training curriculum for teachers, nurses and police officers to produce a compulsory module on GBV issues. Provide standardised and comprehensive pre-service and in-service training on GBV for health, education and police personnel. Ensure financial and technical support. Build capacity within communities to facilitate non-formal responses to GBV aligned to the principles of the multisectoral approach. Strengthen resource mobilisation for the national implementation of national laws. Provide bicycles for VHWs and CBP.	Set up referral networks and collaborate with community, traditional and religious leaders. Establish community-based safe shelters and services for the protection of victims. Establish community-based counselling services to deal with the emotional needs of victims. Strengthen psychosocial support to help GBV victims overcome trauma.	Promote multidisciplinary (health, education and police) research and analysis on the underlying causes of GBV. Harmonise and use data from the police, health and education sectors on incidents of GBV. Transform stereotypical culture, attitudes and behaviour through: -evidence-based awareness campaigns; -community mobilisation efforts; -engaging men and boys in finding innovative non-traditional ways to prevent GBV; and -standardised GBV prevention messages at the back of clinic cards, exercise books and tickets issued by police.	Levels of GBV

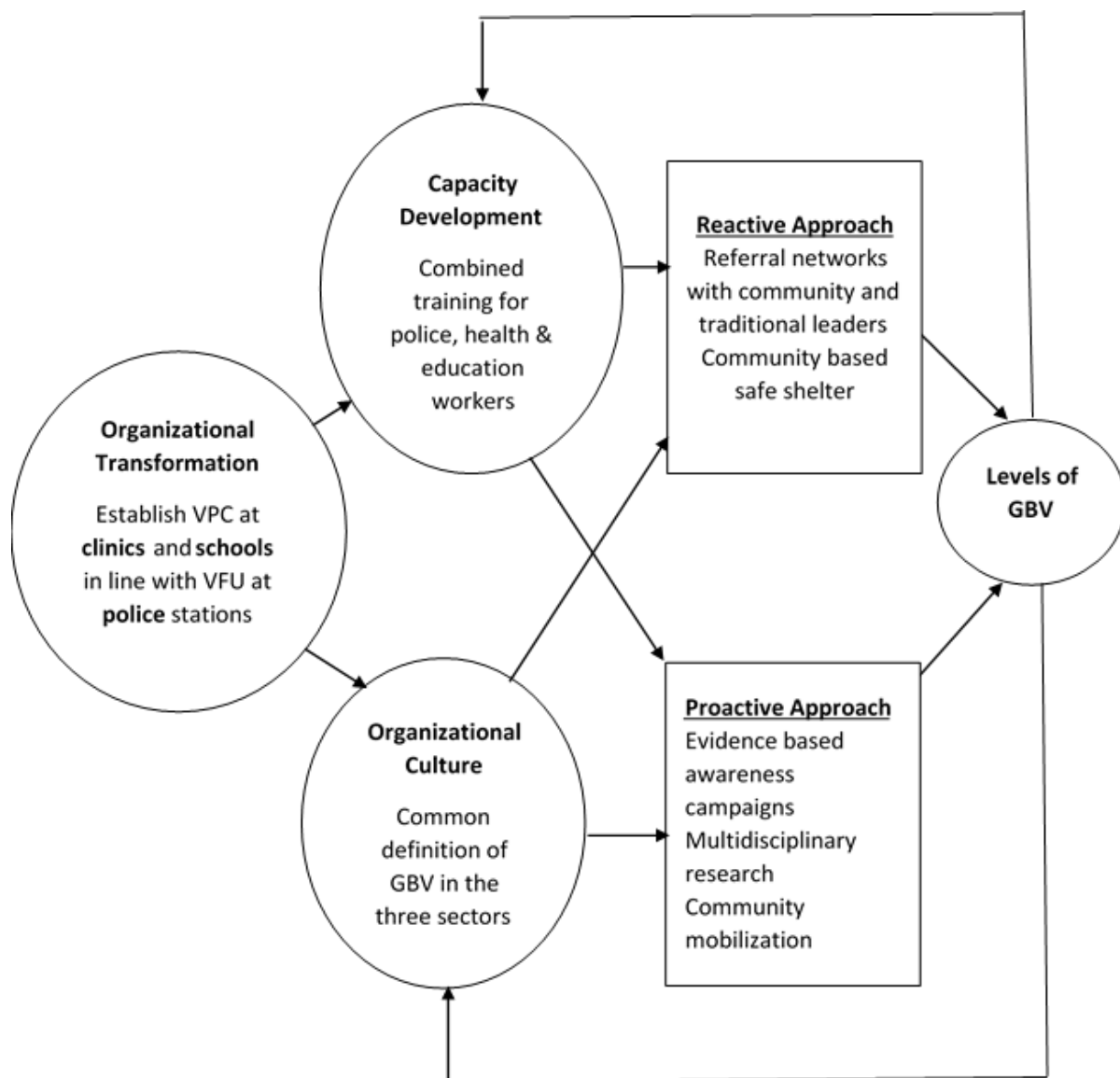


Figure 8.1: Three sector intervention model

With a broad, common definition of GBV that includes cultural norms that expose women and girls to this type of violence, the common understanding should form the basis of joint training session by the three sectors. Organisations like schools, hospitals and police are special institutions that have criteria to establish their boundaries and distinguish their members from non-members, principles of sovereignty concerning who is in charge, and chains of command delineating responsibility in their organisation. With regards to GBV, all these should incorporate the common concept of this type of violence. The three sectors react to GBV and a proactive strategy is glaringly missing.

The SADC Framework (2012) indicates that for GBV prevention strategies to be effective, they need to address the underlying cause of GBV to stop it before it occurs as well as reinforce the strategy across a range of settings such as schools and work places. The proposed model is

a proactive strategy that seeks to transform gender discriminatory norms that are conceptualised at the community and society levels of the ecological model. For this study, the proposed model is designed to be reinforced across the education, health and police sectors.

The curriculum to train the police officers, nurses and teachers should be combined to produce a common module that is compulsory for police officers, nurses and teachers and infused with GBV issues. This is possible as the minimum level of education required for these courses is 'O' level. The common module should be designed to reflect a common understanding of GBV, including prevention strategies. GBV prevention is a key theme of the SADC Framework (2012). The compulsory module together with sector-specific modules will produce police officers, teachers and nurses with a common understanding of GBV. The current organisational cultures of the three sectors necessitate the integration of the training curriculum. In the context of GBV, the health sector relies on a narrow clinical practice that focuses on direct symptoms of physical health and illness that is grounded in the doctrine of aetiology of diseases, biomedical processes and medical care (Colombini et al. 2013). While it is important to deal with protocolised clinical problems like cholera, frontline health workers need to be aware that GBV cannot be treated as such. The police in Zimbabwe, and in many parts of the world, depends on a constructed identity moulded on patriarchal masculine dominance. This tends to dilute the sensitivity required to investigate GBV. The education sector take GBV as a disciplinary issue, yet well behaved girls can be abused. GBV is a pervasive social phenomenon that must be addressed by fusing GBV issues with different pockets of knowledge (policing, nursing and teaching techniques) to broaden how the health and the education sectors conceptualise GBV and to neutralise the masculine nature of the police.

In line with the establishment of the VFU at every police station, a violence prevention committee (VPC) should be established at every clinic and school. In a defined area (e.g. a district) members of the VFU and violence prevention committee should meet regularly to discuss ways to prevent GBV in their area. The government should demonstrate its commitment to fight GBV by capacitating these committees by giving them human and financial resources. The VFU in the police should be realigned to increase the prevention component in its activities. As the name implies, its current activities are more inclined to meeting the needs of victims.

As part of the in-service training using the mandatory module and evidence from research, a joint team from the three sectors should conduct the sessions and participants should be police officers, teachers and nurses who are already in service. The SADC Framework (2012) calls

for standardised in-service training for professionals in the health and police sectors. Peers training peers is ideal because of their practical experience in each of the sectors and because training by peers gets more respect and is taken seriously. Where possible, experts from NGOs and other stakeholders should train the facilitators but not the frontline workers. After training, certificates issued should be considered for promotion. In-service training should be mandatory and systematic, and participants should include seniors members in the sectors, especially those to whom frontline officers report. This will facilitate ownership of the training within the three sectors.

Combining the parts of the curriculum of the three sectors should constitute internal multisector intervention. This is in contrast to the traditional external multisector intervention strategies where stand-alone sectors with different organisational cultures collaborate to address GBV. Internal multisector intervention strategies are based on the transformation of organisational culture in a number of sectors through combined training and the establishment of a common understanding of GBV. As shown in Table 8.1, the intervention model identifies a number of reactive and proactive strategies to reduce the effects and levels of GBV and to prevent it from happening. This determines the level of GBV in the society.

At the core of the proactive approach is the premise to address the underlying causes of GBV by transforming gender discriminatory norms, attitudes and behaviour that condone violence at community and society levels of the ecological model. This is done through joint, sustained evidence-based awareness campaigns by the three sectors. By working together the three sectors strengthen coordination, communication and monitoring of activities aligned to GBV prevention. Currently the three sectors work together in reacting to GBV by providing the necessary services and needs of abused women.

In line with the recommendation by the SADC Framework (2012), the involvement of men and boys in finding ways to prevent GBV addresses social norms that condone violence because men and boys are the centres of power that is often abused in the name of culture, putting women at risk of experiencing GBV. The proposed model seeks to ensure that changing men and boys' attitudes are placed within the remit of public health promotion through local activism.

With regards to the reactive approach, the proposed model seeks to facilitate the setting up of referral networks and collaboration with the community, traditional and religious leaders to complement the formal referral system that involves the police, health and education sectors,

social welfare and CSOs. The establishment of community-based safe shelters seek to complement efforts by CSOs like Musasa Project that offer formal shelter to abused women. Community-based counselling services are critical as part of the psychosocial support to mitigate the effects of emotional abuse that is increasing in Zimbabwe (32% of women reported having experienced this type of violence).

8.3 Recommendations

Chapter 4 established the levels, trends, types and context-specific risk factors of GBV in Zimbabwe. The legal and policy review contained in Appendix A shows that while Zimbabwe has a plethora of legal and policy frameworks to curb GBV, their implementation is constrained by a number of factors, chief of which are lack of organisational resources and the mediating effects of cultural and religious norms that condone violence. As shown in Chapters 5, 6 and 7, the GBV response by the justice, health and education sectors is largely reactive as they respond to this type of violence after it has occurred. The police treat it solely as a crime, while the health sector considers it a morbidity issue. The response by the education sector is centred on discipline, yet well-disciplined girls can be sexually abused. While these sectors have sector-specific policies and protocols that guide their operations, these policies lack gender sensitive components. In addition to this essential omission, the laws and policies on which the responses are based do not reflect the social and cultural norms of Zimbabwean society.

Recognizing this the need to prevent violence against women and girls cannot be over emphasised. As such recommendations were made taking into account the state of GBV in Zimbabwe as well as technical packages designed to translate evidence into more effective violence prevention and response such as INSPIRE and RESPECT. INSPIRE focuses on violence against children and adolescents while RESPECT seeks to prevent violence against women through the emphasis on women empowerment, investing in women organizations and an emphasis on gender equality (WHO 2018). Furthermore the recommendations were informed by the What works to prevent violence against women and girls (*What Works*) interventions that are groups into four areas namely community activism to shift harmful gender attitudes, roles and social norms; gender transformative and economic empowerment approaches; interventions that target couples and programmes designed to prevent violence against children (Jewkes et al 2020). Taking into account local drivers and context of violence, culture and local political will the *What Works* interventions has proved to be effective in

preventing GBV in LMICs (Jewkes et al 2020). It is against the findings of the study and the current best practices in GBV prevention that the study make the following recommendations:

8.3.1 Recommendations for the justice sector

The following recommendations need to be put in place to combat GBV:

1. The preventive component of the sector's response to GBV must be strengthened by increasing the frequency of awareness campaigns, which should target social and cultural norms that precipitate GBV. Dealing with GBV before it occurs reduces the cost of the sector's intervention efforts.
2. The operations of the police stations must be strengthened. The police are the frontline of the justice system in Zimbabwe and any legal proceedings depends on the quality of investigation in terms of promptness, nature of evidence gathered and docket processing. Police stations need to be capacitated by ensuring that VFUs have functional and enabling infrastructure to respond to the needs of abused women. Where the VFU have vehicles, these need to be used largely to help GBV victims. Some rooms used by the VFUs need renovations to ensure privacy, which is likely to stimulate disclosure. In addition, police operations can be strengthened by creating 'call me back' and toll free lines; these numbers should be made public through a number of initiatives and be displayed in public places, in clinics and on products frequently used by women. To buttress this, the CBP should have bicycles to enable them to patrol all areas, including remote rural areas. Currently, GBV victims report at the general inquiry desk in police stations, especially those reporting for the first time, before being directed to the VFU section. The study recommends that as part of capacitating the police station to effectively respond to GBV, there should be a VFU officer at the general inquiry desk who will likely be able to identify victims before they report their case. This arrangement will also help when one victim comes while another is being helped.
3. All police officers must be trained on GBV issues. Currently only officers in the VFU are trained to handle GBV issues. Training on GBV issues should extend to the CBP, who in most cases are first contacted by GBV victims. The CBP officers should be trained to identify victims even when they do not report. Cultural norms, the power differential between men and women, women's economic dependency on men and religion may lead to GBV not being reported (Fattah & Camella 2017; WHO 2013). In addition to incorporating GBV issues in police training, in-service training is necessary

to conscientise members on emerging issues from GBV research and to close the gap that can be caused by promotions, death or retirement. In-service training ensures that those in police stations have sufficient GBV knowledge to handle GBV cases sensitively. Furthermore, frequent in-service training ensures that officials who implement laws respond to requests for assistance in a way that reflects the legal and policy position and not their own values and norms.

4. The results show that the legal route is not the best way to deal with GBV in Zimbabwe. Because the victim is the scene of the crime, the study recommends that the police promote the non-legal route through a number of initiatives that include mediation, counselling and warning perpetrators. Traditional, customary and tribal systems have been used to resolve domestic disputes, but their major weakness is that they blame the victims, especially women, and justify the actions of men. As centres of authority in society, the police should caution, warn and record a statement by the perpetrator. This is likely to preserve community and family harmony. The non-legal route is time consuming for the police and the study recommends that the government increase the number of police officers in VFUs. Furthermore, the police can work with the traditional systems and their role should be to neutralise the patriarchal norms and project gender equality values. Ultimately, the police should strike a balance between making perpetrators account for their actions and preserving family harmony. However, in the case of rape, the perpetrators should be jailed, and if they are the breadwinners, the children's needs should be met by the state.
5. There is need to provide gender responsive policing by supporting equitable participation of both men and women police officers as well as enhancing the position of women within the police force. In the presence of female officers women and girls may not abstain from seeking police assistance.

8.3.2 Recommendations for the health sector

This study makes the following recommendations for the health sector:

1. The sector must move from a biomedical approach to a gender sensitive approach to health. The biomedical approach is premised on the dissemination of the dangers of various illness-causing organisms and the treatment of illnesses and is also highly protocolised. The partial dependency of the biomedical approach on technology-based diagnostic techniques means that the patient may not disclose much information. A

gender sensitive approach to health ensures that there is a dialogue between the patient and the health worker, and disclosure is an important step to facilitate the healing of GBV victims, which goes beyond physical pain and signs. Therefore, to achieve complete healing, the patient may need medication for physical wounds and counselling for emotional wounds. The move from a biomedical approach to a gender sensitive approach should be facilitated by realigning laws and policies to include GBV issues in the training curricular of health personnel.

2. Health personnel should be trained to identify GBV victims. Building on their knowledge to identify symptoms and therapeutic methods, health workers should be trained in basic knowledge of GBV, recognition of GBV, talking to GBV victims, working with survivors, and collaborating with the community to support victims and to prevent it before it happens. Specifically, health care should develop and adopt a simple screening tool to ask clients whether they have experienced physical, emotional or sexual violence. Health care providers are often the first point of contact with non-relatives for women and girls experiencing GBV (Heise 2011). In most cases their aim is to have their wounds treated and not necessarily to report. Training health workers, including those that prepare patients' documents, is handy to identify victims of GBV. The isolation of potential victims at this stage not only facilitates disclosure but also expedites the discovery of other issues the victim may not be willing to disclose. For example, married women who are on contraception may not report rape, knowing that she may incite further violence from a jealous husband. While she may not get pregnant, she is at great risk of contracting HIV. Pre- and in-service training should be designed to provide knowledge about GBV and existing GBV laws and should equip health workers with knowledge to tackle deep-seated norms, prejudices and inequalities surrounding GBV perpetration and experience.
3. The health sector must be strengthened by supplying bicycles to VHWs, making sure there is a constant supply of power at clinics, and increasing the number of health personnel, especially nurses and doctors in rural health centres. The study results showed that there is an acute shortage of health workers in rural health centres. The government needs to curb the health brain drain by improving the condition of service of medical personnel, especially their remuneration. Furthermore, the health sector can be strengthened by establishing survivor-counselling centres. This means that more spaces that guarantees confidentiality and privacy will be available. For continuity, the

counsellor should give victims her number so that they victims can seek further clarity when needed.

4. The health sector should include GBV in public health concerns like HIV/AIDS and sexual, reproductive and mental health in its quest to promote public health. Strategies by the health sector that focus on the prevention of HIV have been successful (Ministry of Health and Child Care 2015). Women coming for HIV testing, prevention of mother to child HIV transmission services and antiretroviral therapy should be screened for GBV. All these avenues will help to identify GBV survivors who do not report violence. This should be done at primary health care centres.

8.3.3 Recommendations for the education sector

While research show that schools and other educational institutions are important sites for normative change and to address GBV (Fergus & Van't Rood 2013; Sida 2015), they do not have a universal positive impact or reduce this type of violence. The schools' contribution to reducing GBV depends on what happens in the classrooms, the nature of the school environment (including policy development and implementation) and the attitudes of teachers. The results of this study showed that SRGBV is caused by the wrong interpretation of human rights by school children, large class sizes and the banning of corporal punishment. As such, the research can contribute to the prevention of GBV in schools and the community by the following recommendations:

1. Students must be taught subjects that encourage them to work on their own rather than for an employer; subjects like dressmaking and agriculture are hands on. In adulthood students are likely to apply for micro credit to finance their livelihoods leading to economic empowerment.
2. Teachers must teach schoolchildren about their human rights. Currently this is done by the police. Teachers have the training to teach children in a manner that they understand and lessen the chances of them abusing their knowledge. Children's lack of maturity means that they may not differentiate between absolute and relative rights if they are not taught properly. Teachers can incorporate the issue of human rights in the school curriculum. This is in contrast with the police who announces issues without elaboration because of time constraints.
3. Teachers need in-service training on how to use gender responsive teaching methodologies in the classroom and on techniques to manage large classes. While

teacher training covers basic pedagogics, gender responsive pedagogics are essential to address GBV. In-service training should focus on raising awareness of gender stereotypes in the education process, the types and causes of GBV, the identification of GBV victims, and the ability to conduct lessons from a gender perspective. Teachers should be trained to reflect on their deeply held beliefs and practices, which can constrain the sector's response to GBV. In a nutshell, mainstream gender issues in teacher training, in-service training and the school curriculum must be addressed. Awareness of gender stereotypes contributes to the reduction of GBV in the community.

4. Traditionally teacher training was done at teachers colleges but now most universities also offer teacher training programmes. As such, it is important to harmonise teacher training as it relates to GBV issues. This ensures that all personnel employed as teachers are likely to use gender sensitive pedagogy and have the skills to deal with emerging SRGBV issues in and around schools. Due to the shortage of qualified teachers, Zimbabwe often employs people with other qualifications, especially degrees, even if it is not a teaching qualification. These people need in-service training on GBV issues before assuming duty. Additionally, private learning institutions in the primary and secondary sector are increasing in Zimbabwe. These institutions register with the Ministry of Primary and Secondary Education, but the ministry has little or no control over the training of their teachers, including training on GBV issues. The study recommends that these teachers should undergo in-service training on GBV.
5. Schools' capacity to deal with SRGBV must be strengthened by reducing class sizes from the current average of 60 pupils per class to 40. Schools must be capacitated to build more classrooms to cater for the reduced class sizes. Furthermore, schools should buy more furniture to ease the seating arrangements that expose girls to various forms of SRGBV. To foster safe and non-discriminatory schools, the issue of extra lessons and the grading systems must be examined because it can expose girls to sexual harassment. In addition, schools must work with the community to ensure the safety of children on their way to and from school. As part of strengthening schools, the government needs to review the service conditions of teachers, including their remuneration. There is a positive correlation between policy implementation and staff motivation.
6. Sex education, HIV prevention and GBV issues should be integrated in the school curriculum for primary and secondary education. This results in gender sensitive

education, which can increase the potential of young people to act as agents of change to achieve the social transformation necessary to end GBV. Equally, a gender sensitive counselling system must be established to give effective support to GBV victims. This can be achieved through specialist training for teachers who should be patient listeners and treat any reported case seriously.

7. Acknowledging the role of entertainment as an information dissemination tool, schools are encouraged to introduce edutainment programmes. These programmes should be tailor-made to project what is desired to end GBV and not what is happening to perpetuate it. For example, the drama should portray a man being arrested and a women being supported. Drama series that always portray women being beaten may not curb GBV but may promote it. Edutainment programmes should be designed to modify norms and values that condone violence against women and girls.
8. There is need for schools to forge partnerships with communities by establishing and implementing child friendly centres in neighbourhoods. Working with community leaders, these centres should challenge the cultural and social norms that promote GBV. The partnership with the community facilitates the engagement with men boys in their multiple roles (fathers, teachers and community and religious leaders) to engineer the shifting of social norms around masculinity and challenge harmful gender norms that lead to discrimination, inequality and violence.

8.3.4 *Recommendations for a coordinated multisectoral response*

The government, the three sectors (health, education and police) and other stakeholders need to be committed to the principle of effective GBV prevention through awareness programmes and economic empowerment programmes. This principle emanates from years of practice and are increasingly confirmed by general and context-specific research, and it needs to be embraced by the government to empower these sectors to respond effectively to curb GBV. Furthermore, the government needs to support collective profeminist movements based activism in spite of their radicalism in some cases and their perceived influence on the voting patterns in Zimbabwe. The government of Zimbabwe is critical of NGOs as it perceived them to be sympathetic to opposition parties. Historically profeminist movements based in activism have helped to challenge unjust gendered discrimination, shape policies and inform government interventions models in various fields (Heise 2011).

A paradigm shift is necessary in the management of GBV. The government should focus on GBV prevention and not only on the provision of services to survivors of this type of violence. While it is morally desirable to provide services to GBV victims, prevention initiatives that avoid the occurrence of GBV are cost effective. Such initiatives reduce hospital bills, the disability adjusted life years, and the time spent by police investigating cases of GBV; and they help give women power in productive activities of the Zimbabwean society.

The Zimbabwean government should consider establishing OSCs for GBV victims at selected primary health care centres. Currently the OSCs are at provincial and central hospitals, which are in urban areas, a norm that is common in both high and low-income settings (Oslon et al. 2020). Rural communities face challenges accessing them. The OSCs should include health, police, shelter and social services. This arrangement ensures that victims report their cases and at the same time receive treatment and shelter if needed. Such a move ensures that cases of GBV are refereed to OSCs, bypassing the police stations. Socially, going to the police station may be interpreted as sign that something terrible has happened but visiting a clinic or hospital is socially acceptable as women and girls routinely visit health centres for natal and other health services. As a result, the OSCs removes the stigma associated with visiting stand-alone police stations. Members of the OSC (police, health and social workers) need regular in-service training as a group so that they treat GBV with the same sensitivity it requires. Training personnel with policing and nursing skills results in people who are ideal to work at OSCs. This is done by combing the police and nursing curriculum, and this dilutes the traditional notion of grouping knowledge into silos when different professionals are trained in their respective disciplines. Putting knowledge into silos creates professionals like health personnel, who when confronted with complex issues of GBV tend to ignore other aspects and concentrate on the treatment of physical wounds. For effective GBV intervention, people with multiple skills are needed to respond to it.

8.3.5 *Heise's social ecology model implications*

The results of the study confirmed that gender discriminatory norms and unequal balance of power between men and women intersect with sources of vulnerability such as age, lack of education, marital status, poverty, religion and place of residence to increase the probability of women and girls experiencing GBV. As a result, GBV interventions require anticipating, contextualising and addressing factors at the four levels of the Heise's (1998) social ecology model. Although factors identified by this model are illustrative, Chapter 3 identified risk

factors that intersect with gender discriminatory norms and unequal balance of power between men and woman in Zimbabwe. As such, in Table 8.2 the study suggests a number of recommendations at each level.

Table 8.2: Recommendation at each level of the Heise’s (1998) social ecology model

Level	Recommendations
Individual	• Empower school girls through education. • Create age specific intervention, for example, to protect old women from emotional violence and young women from physical violence. • Reinforce the protective factors that can support women and girls’ resilience against violence, for example vocational training and increased access to economic resources. • Encourage sober drinking habits (avoiding excessive drinking) through awareness campaigns by men’s forums.
Relationship	• Empower women economically through business training and loans. • Ensure proper parenting, for example, not exposing children to acts of GBV, sending them to school, and showing them affection. • Promote equitable gender attitudes and norms between men and women.
Community	• Ensure that girls continue with education up to tertiary or vocational level. • Involve communities in all activities meant to curb GBV. • Ensure that GBV issues and awareness of laws are raised whenever people are gathered, for example, churches, celebrations, Independence Day, funerals and parliament sessions. • Conduct community needs assessments to collect context-specific data to develop evidence-based GBV prevention interventions.
Society	• Target cultural and religious norms through awareness campaigns and drama. • Use community dialogues to challenge norms regarding violence or the socialisation of children that predispose boys and men to use violence. • Eradicate economic and moral poverty. Economic poverty makes women dependent on men, and moral poverty makes married men date and abuse young women. • Eliminate the use of force by police to maintain law and order. • Initiate poverty reduction programmes that benefit both men and women. • Strengthen social norms that promote gender equality.

8.3.6 Recommendations for policy and practise

Chapters 5, 6 and 7 showed that sector-specific policies guide the justice, health and education sectors' responses to GBV. The challenges they face emanate from policy implementation, which is constrained by cultural and social norms and non-disclosure of GBV. The findings of this study have a number of important implications for government and other stakeholders who work with GBV victims. Policy formulation is generally a theoretical exercise, despite it being informed by research. On the other hand, policy implementation is a practical exercise and may face challenges on the ground because of complex environments created by the interaction of political, social, economic and religious factors. To close the gap between policy availability and implementation, the study recommends that the government give financial and technical support to facilitate the effective and efficient implementation of policies. For example, the government should improve working conditions for health, justice and education personnel as they are at the heart of the implementation process. In the context of existing policies in the three sectors, it is necessary to identify additional resources, ensure further training of implementors, and modify or overhaul existing policies. However, this is only possible when the political and economic environments are conducive. In the meantime, the training of workers in the three sectors and the involvement of the community will help to close the gap between policy availability and implementation in a country that is facing economic challenges and lack of political will. The training can be based on existing resources, and the involvement of the community can be based on existing community structures for arbitration of cases and crime prevention, thus reducing operational costs.

8.4 Limitation of the study

The qualitative component of the study was conducted in a rural set-up, and the urban component is missing. As such, the results from this study cannot be generalised, but they do offer valuable insight into GBV dynamics in a rural set-up. Contextual studies of GBV are key to unlocking context-specific factors that are useful to design context-specific interventions. In all three sectors, the effectiveness of responses relate to the interviews, which gathered self-reported attitudes and the views of workers in the three sectors and not the actual practice. These provider related perceptions could overestimate or underestimate the measures of effectiveness. However, it is a valuable technique to understand staff attitudes (Colombini et al. 2012). Furthermore, the study did not include the courts in the justice sector. While this was necessary to narrow the scope of the research, the inclusion of the courts could have contributed

to how reported cases are handled. The study did not conduct a detailed analysis of legal and policy frameworks. To determine the effectiveness of these instruments, the study concentrated on the review of these instruments as well as the implementation dynamics revealed by key informants.

8.5 Recommendations for future research

GBV in Zimbabwe is precipitated by cultural, religious and social practices that condone violence. Furthermore, the three sectors' (police, education and health) institutional responses are constrained by lack of resources and adherence by both men and women to hegemonic gender norms and attitudes that justify, promote and perpetuate this type of violence. In the context of these challenges, the study proposes the following as part of efforts to enhance institutional responses to GBV and to curb GBV:

- Further research is needed to explore the dimensions of emotional violence (a type of GBV that is increasing in Zimbabwe), its effects and how the three sectors can effectively respond to it.
- Further research can explore the ways in which institutional responses (especially prevention) to GBV can be enhanced in low resourced countries. Many developing countries, including Zimbabwe, face challenges of availing resources for social protection, including the prevention of GBV, due to corruption, political uncertainty and unrest, disasters, economic challenges and neo-colonialism. Waiting for a time when resources are available is tantamount to condemning women and girls to permanent abuse.
- Further research is needed on why there are high attrition rates in the justice system when cases brought before the courts are dropped because of the way courts interpret and apply the laws.
- The experiences of personnel in the health, police and education sectors need to be studied. Such research is useful in understanding the issues and challenges faced by these professionals so as to improve institutional response to GBV. Institutions rely on their workers for the implementation of laws and policies.
- Further research can find ways in which researchers, policy makers and policy implementors can combine their knowledge to tackle the deep-seated norms, prejudices and inequalities surrounding GBV. The coordination between the three sets of people can reduce GBV.

- Further research can build an in-depth understanding of the underlying issues that drive men's resistance to changing their beliefs and attitudes that drive GBV. Furthermore, research can also determine whether the men and women in institutions that respond to GBV and are aware of cultural norms that perpetuate this type of violence and of the laws and policies that protect women choose to align themselves with cultural norms.
- Chapter 4 of this study revealed that in the 2015 ZDHS more than 50% of women formerly married reported having experienced some form of GBV. Further research is needed to determine whether GBV is causing termination of unions or whether being divorced, separated or widowed expose women to GBV.
- Further research can do a detailed analysis of the legal and policy frameworks.
- Further research is needed on how courts handle GBV cases and also include institutions of higher learning, like colleges and universities, in the education sector.

8.6 Overall conclusion

GBV, especially physical and emotional, are increasing in Zimbabwe despite concerted efforts by the three sectors to curb it. The study established that the root causes of GBV are gender discriminatory norms and an unequal balance of power between men and women, which acts through risk factors such as lack of education, alcohol abuse, marital status, employment status of women, increased use of technology, normative use of violence, cultural norms (*chiramu*), gender inequality and poverty. In schools the way human rights are promoted precipitate SRGBV. Thus, being born a girl in a patriarchal society is a fundamental risk factor for various types of GBV, and for some it persists for life. Being born a girl is a risk factor compounded by cultural norms, marital status, social norms and socioeconomic status, which affect both exposure to violence and access to responses.

The responses by the health, education and the police sectors are largely reactive (reacting to GBV that has occurred) and this does not address the root causes of this type of violence. The biomedical approach on which the health sector is centred means that clinics and hospitals concentrate on the treatment of GBV victims and the administering of EC and PEP in rape victims. From a criminology point of view, the police who treat GBV as a crime are mandated to arrest perpetrators and to refer victims to the health sector for evidence gathering for the purpose of prosecution. In the case of rape and other sexual offences, the education sector refer both the victim and the perpetrator to the police, who either arrest or caution the perpetrator and refer the victim to the health sector. Although the three sectors work with other

stakeholders to raise awareness about GBV, the results showed that these have been uncoordinated, are misaligned in terms of content, and are given little time as they are often done at national events, celebrations or other occasions that take centre stage. The use of drama by the education sector often depicts what happens to victims (for example a woman being beaten), and this tends to reinforce the practice rather than discourage it. The absence of an elaborate preventive mechanism means that GBV is often considered a silent epidemic (Palermo et al. 2014) as victims are hesitant to reveal their experiences because of a number of barriers.

The legal and policy frameworks in Zimbabwe guide the institutional responses. While laws and policies are important to establish public unacceptability of GBV and serve as practical methods of legal recourse for women, they are insufficient as prevention and response mechanisms. In Zimbabwe, the legal and policy frameworks are accompanied by non-legal measures, such as awareness campaigns and workshops, which are stuck in repetitive activities, often designed to meet organisational objectives to please donors and not necessarily to curb GBV. While these are good to maintain focus on GBV, the non-legal measures are not designed to support changes in attitudes, norms and behaviours that help sustain GBV. The complexity and scale of GBV demand that Zimbabwe's institutional response be aligned to efforts that leverage long-term changes in attitudes, norms and practices that perpetuate this type of violence. Investing in community-based prevention strategies not only results in changes of social norms at all levels of Heise's (1998) ecological model but also fosters a culture of tolerance and gender equality for the benefit of all members of the community in Zimbabwe. Equally important is the mobilisation of all levels of society (international donors, police, health, education, national government, women organisation, and grassroots women), which presents the best hope for reducing levels of GBV in Zimbabwe if these organisations find common ground to change the cultural, religious and social practices that condone violence. The cultural sensitivity of the responses by the three sectors need to improve. The challenge is to maintain a sustained commitment by all the actors to address GBV, which is an impediment to development, a public health problem and an egregious violation of human rights.

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Zimbabwe Republic Police Client Service Charter (2016).

Appendices

Appendix A: Legislation and Policy framework to curb GBV in Zimbabwe

Policy	Key tenets
International Instruments	
Universal Declaration of Human Rights (1948)	Calls for the respect of all persons based on the rule of law Underscores the protection of women and girls Urges states to facilitate education that lead to the development of human personality Calls for the right of standards of living adequate for health for humanity
International Convention on the Elimination of All forms of Discrimination Against Women (CEDAW 1979)	Provides a legal binding framework for states to take measures to curb GBV in all spheres of life Urges states to: - embrace the principle of equality of men and women in National constitutions and other legislation that seek to prevent discrimination against women - establish competent tribunal and other public institutions to protect the rights of women. States to take appropriate measures to modify or abolish existing laws, regulations, customs and practices which constitute discrimination against women and girls. Culminated in the establishment of general regulation 24, 33 and 36 to guide the justice, health and education sectors respectively to respond to GBV.
The United Nations Convention on the Right of the Child (1989)	Calls for the total protection of all children (i.e. those below the age of 18) Urges states to: take legislative, administrative, social and educational measures to protect children from all forms of physical, mental, sexual and other forms of maltreatment or exploitation ensure that children enjoy the highest standards of health and to abolish traditional practices prejudicial to health of children like child marriage and female genital cutting ensure that school discipline is administered in a manner that does not compromise the dignity of children.
The Beijing Declaration and Platform for Action 1995	Underscores the empowerment of women in all spheres of life Urges states to: - adopt, implement and review legislation to ensure its effectiveness in preventing GBV. - take measures to ensure the protection of women subjected to violence, making sure they access justice and essential services. - ensure that curricula and teaching material are non-gender bias as well as increasing access to education by girls.
The Sustainable Development Goals (2015)	Promotes the elimination of GBV through inclusive education in educational environment that is child, disability, gender sensitive, safe and nonviolent.

	Promotes of gender equality Underscores the elimination of all forms of violence against women and girls in the public and private spheres of life as well as the elimination of harmful practices like child marriage Urges states to end all forms of discrimination and violence against women and girls. Calls for the development of effective, accountable, and transparent institutions at all levels.
Regional Instruments	
The Protocol to the African Charter on Human and People's Rights and the Rights of Women (Maputo Protocol 2003).	States to promote gender equality. States to enact and effectively implement appropriate legislation prohibiting all forms of discrimination (social norms and harmful practices like child marriage) Stats to take appropriate measures to protect women and girls from all forms of abuse including sexual harassment in schools. The elimination of all stereotypes in textbooks, syllabi and media that perpetuate discrimination against women and girls.
The SADC Protocol on Gender and Development (2008–2015)	Focused on constitutional legal rights, governance, education, training and productive resources as a way to protect women and girls from GBV The elimination of discrimination of women by promoting gender responsive legislation, policies and programmes.
SADC Regional Strategy and Framework of Action for Addressing Gender Based Violence 2018–2030	Serves to stimulate regional intervention for harmonisation of GBV response efforts by all SADC member states. The need to strengthen effective GBV prevention and mitigation programmes which include : -role of the community -repeal and change of harmful cultural norms and practices perpetuating GBV -forging a strong partnership between governments and CSOs Strategy anchored on five main thematic areas: -prevention of GBV -Protection, Care and Support Services -Capacity Development -Information and knowledge management Coordination, Networking and Partnership
National Instruments	
Constitution of the Republic of Zimbabwe (Amendment No. 20) Act 2013	Zimbabwe founded on the principle of respect for gender equality, good governance, and the recognition of women and children's rights. Implores the state to protect women and children from any form of abuse and that children including the youth are protected from harmful cultural practices.
The Maintenance Act (1989)	Compels the neglecting spouse to contribute to the welfare of both children and the neglected spouse.
Criminal Law Codification and Reform– Sexual Offences Act Chapter 9:23) (2001)	Protects women from sexual abuse.

	Criminalises marital rape and wilful transmission of HIV and AIDS. Prohibits trafficking of persons for the purpose of prostitution.
Domestic Violence Act Chapter 5:16 (2007)	Provides for the protection of victims of GBV and the criminalisation of acts of abuse Provides for the broad and inclusive definition of GBV and is crafted in gender neutral terms While acknowledging multiple forms of GBV, Section 4 stipulates that emotional, psychological and economic abuse do not constitute an offence.
National Policies	
The Protocol on the Multisectoral Management of sexual abuse in Zimbabwe 2012	Promotes the protection of women and girls from sexual abuse the adoption of victim-friendly services. Its sets guidelines followed by the health, police and education sectors in the fight against GBV: The health sector is legally obliged to carry out medical examinations including forensic examination for the purpose of prosecution The police is responsible for investigating arresting the offender and making referral to other service providers Schools should create conditions ideal for children to continue with education.
The Zimbabwe National Gender Policy (2013–2017)	Curbs gender discrimination and inequalities in all spheres of life Ensures that constitutional and legislative provisions on GBV are implemented Aims to eliminate laws, cultural and traditional practices that infringe on women and girls’ rights Promotes the integration of GBV in the curricula at all levels. Underscores the provision of health services to GBV victims Calls for equal access to education for boys and girls as well as their retention at all levels.

Appendix B: Key informant interview guide

INSTITUTIONAL DETAILS

1.1. What is your designation in this facility? *How long have you been in this position?*

LAWS AND POLICIES

- Please tell me about any GBV laws and policies in Zimbabwe that you are aware. *Probe for key national legislation and policies.*
- Of these, which mandate ____ (sector) to provide GBV services:

Probe for sexual harassment (all sectors)

Probe for: corporal punishment, sexual violence, bullying and other non-sexual forms of abuse (education sector);

- To what extent would you say the current laws and policies enhance your (institution's) effort to address GBV? *Please explain*

INSTITUTIONAL REFORMS

Responses to GBV cases

- Based on your experience as _____ (designation) how common would you say GBV is in Zimbabwe; in your community? Why do you say so?
- What types of GBV do you usually deal with in this institution? Please explain more: Why do you think this is the case; what would you say are the typical characteristics of victims; of perpetrators.

Training and sensitisation of staff

- To what extent would you say you are well skilled to enforce current laws and policies? *Why do you say so?*

Service provision and referral systems

- What types of services or support are provided to victims of GBV in this institution? Explain more.
- Are there any services or support provided to perpetrators? Explain more: if yes, what are they? If No why?
- Do your clients/learners sometime need services or which you do not provide? If so, which ones?

- Are referrals made for services that you do not offer here?

Probes:

Which specific services?

Where do you make referrals to? Other institutions? Why specifically these?

Is there a formal referral system (including tracking and follow-up)?

How well do other partners cooperate with you in doing this?

What challenges do you face?

- Please comment on your infrastructure in terms of providing settings to enable privacy, confidentiality and safety of victims.

COMMUNITY MOBILISATION

- Do you have linkages with any other community organisation for provision of GBV services and support? *Please explain.*
- What other community initiatives is your institution involved in?

VIEWS OF STRENGTHS AND WEAKNESSES

- In your opinion what have been the major successes of your institution in the provision of GBV? *What contributed to the success?*
- What are your major barriers/challenges undermining response to GBV? Why do you say so? *How do you deal with these challenges?*
- What, in your view, are the primary strengths in government's policy to provide GBV services?
- What are the major weaknesses in the national GBV legislation and policy and implementation?
- We wish to hear your views on how the provision of GBV services in government institutions in general and your sector in particular can be improved. *Probes, types of services provided; budget, links to other services.*

Is there anything else you would like to add on this issue that we have not talked about?

Thank you for your time and participation in this study

Appendix C: Focus group discussion guide: Community-based police

- 1 How common is GBV in your community? Why do you say so?
- 2 What types of GBV are common in your area? Explain further. Why is this so?
- 3 We wish to find out what you know about the justice sector's laws and policies to address GBV. How effective are these laws?
- 4 We wish to know your role as community-based police (CBP) with regards to reducing GBV in your community. Probe: *dealing with victims and perpetrators*
- 5 To what extent were GBV issues incorporated in your training? Probe: handling of GBV cases, evidence collection. How does the training help to reduce GBV?
- 6 Do you face any challenges when dealing with GBV cases in your area? Explain further. Probe: *victim-reporting mechanism*.
- 7 We wish to know how you work with other community-based organisations in reducing GBV. Probe: *referrals to other service providers*.
- 8 We wish to know how the justice sector response can be improved.
- 9 Is there anything else you would like to add on this issue that we have not covered?

Thank you for your time and participation in this study

Appendix D: Focus group discussion guide: Nurses

- 1 How common would you say GBV is in Zimbabwe, in your community? Explain further.
- 2 What types of GBV are common in your area? Please explain more. What would you say are the characteristics of the victims, perpetrators?
- 3 We wish to find out what you know about the health sector's laws and policies to address GBV. Comment on the strengths and weaknesses of these laws and policies.
- 4 Do you face any challenges in implementing these laws and policies? Explain further.
Probe: *cultural challenges.*
- 5 We wish to know how you identify victims in your clinic, services offered. Probe: treatment of physical complaints, emotional needs, protection from further victimisation.
- 6 What service do you think GBV victims need most? Why? Are there any services, which you do not offer here? How do you address such situations?
- 7 With reference to GBV we wish to know how well skilled you are in dealing with this type of violence. **Probe:** *counselling, dealing with rape cases, trauma.*
- 8 What do you think about the adequacy and quality of current health services provided to GBV victims at your institution? Why do you say so?
- 9 We wish to know your views on how GBV services can be improved at your institution in particular and in the health sector in general.
- 10 . Is there anything else you would like to add on this issue that we have not talked about?

Thank you for your time and participation in this study

Appendix E: Focus group discussion guide: Teachers

- 1 How common would you say GBV is in Zimbabwe, in your community, at your school?
Why do you say so?
- 2 What type of GBV is common at your school? Elaborate. Why do you think this is so?
- 3 We wish to find out what you know about government's laws and policies to address GBV in schools. What would you say are the strengths and weaknesses of these laws and policies?
- 4 Do you face challenges in implementing these laws and policies? Explain further.
- 5 We wish to know the GBV services you offer to learners at your school. How effective do you think these are? Why?
- 6 We wish to know how well skilled you are in dealing with GBV issues at your school.
Probe: counselling, use of gender sensitive teaching methodologies.
- 7 In many settings, corporal punishment is condoned by both parents and teachers who believe children need discipline. Do you have any comment on this? **Probe:** culture, *deep-seated beliefs*.
- 8 How do you work with parents and other organisations to improve the safety of boys and girls as they move to and from school?
- 9 We wish to hear your views on how the education sector can improve their services in respond to GBV. Probe: type of services, training of teachers, links to other benefits and services.
- 10 Is there anything else you would like to add on this issue that we have not talked about?

Thank you for your time and participation in this study

Appendix F: Focus group discussion guide: Parents-teachers association

1. How common would you say GBV is in Zimbabwe; in your community? Why do you say so?
2. What types of GBV are most common in your community? Please explain more: Why do you think this is the case; what would you say are the typical characteristics of victims; of perpetrators.
3. I wish to find out what you know about the government's laws and policies to address GBV.
4. Do you face any challenges in implementing these laws and policies? Probe: Corporal punishment.
5. What do you know about GBV services that learners can receive from schools? *How effective do you think these are? Why do you say so?*
6. What do you think about the adequacy and quality of current education services provided to adolescents and youth by government? *Why do you say this?*
7. What GBV services do you think learners are most in need of? *Why do you say so?*
8. Are there any services that are not offered at your children's school that you wish were offered? *If yes, which one? Why?*
9. We wish to hear your views on how government GBV service provision for learners can be improved.

Probes: Requirements; types of services; links to other benefits and services.

10. Is there anything else you would like to add on this issue that we have not talked about?

Thank you for your time and participation in this study

Appendix G: Focus group discussion guide: Abused women

- 1 How common is GBV in your community? Why do you say so? What do you think are the causes?
- 2 Can you share with us your story of dealing with GBV? **Probe:** your experiences, strategies used to escape violent situations, the current situation.
- 3 What do you think about the adequacy and quality of the current justice and health services provided to victims of GBV? Why do you say so? **Probe:** *your experiences.*
- 4 We wish to know the services you received or are currently receiving from other organisations other than the justice and the health sectors. How has this help you to cope with GBV?
- 5 What GBV services do you think victims need most? Why do you say so? **Probe:** *those that address emotional, physical needs.*
- 6 Do you face any challenges in accessing services from various stakeholders that provide GBV related services? Probe: factors that inhibit use of justice, health and other sectors.
- 7 Comment on the ways employed by organisations that deal with GBV to ensure privacy, confidentiality and protection of victims. Probe: Adequacy, strategies used, needs assessments.
- 8 We wish to know if you are member of any support group. If yes, how has this helped you to cope with GBV?
- 9 We wish to hear your views on how government GBV service provision for victims can be improved.
- 10 Is there anything else you would like to add on this issue that we have not talked about?

Thank you for your time and participation in this study

Appendix H: Ethical clearance (University of Pretoria)



Faculty of Humanities
Research Ethics Committee

29 June 2018

Dear Mr Siziba

Project: Gender based violence in Zimbabwe: A critical analysis of institutional responses
Researcher: E Siziba
Supervisors: Prof ZS Mokomane and Prof DR Bonnin
Department: Sociology
Reference number: 17383863 (GW20180224HS)

Thank you for your response to the Committee's correspondence.

I have pleasure in informing you that the Research Ethics Committee formally **approved** the above study at an *ad hoc* meeting held on 29 June 2018. Data collection may therefore commence.

Please note that this approval is based on the assumption that the research will be carried out along the lines laid out in the proposal. Should your actual research depart significantly from the proposed research, it will be necessary to apply for a new research approval and ethical clearance.

We wish you success with the project.

Sincerely

A handwritten signature in black ink, appearing to be 'MS' followed by a long horizontal stroke.

Prof Maxi Schoeman
Deputy Dean: Postgraduate and Research Ethics
Faculty of Humanities
UNIVERSITY OF PRETORIA
e-mail: PGHumanities@up.ac.za

cc: Prof ZS Mokomane (Supervisor)
Prof DR Bonnin (Co-Supervisor and HoD)

Fakulteit Geesteswetenskappe
Lefapha la Bomotho

Research Ethics Committee Members: Prof MME Schoeman (Deputy Dean); Prof KL Harris; Mr A Bizos; Dr L Blokland; Dr K Booyens; Dr A-M de Beer; Ms A dos Santos; Dr R Fasselt; Ms KT Govinder Andrew; Dr E Johnson; Dr W Kelleher; Mr A Mohamed; Dr C Puttergill; Dr D Reyburn; Dr M Soer; Prof E Taljard; Prof V Thebe; Ms B Tsebe; Ms D Mokalapa

Appendix I: Information sheet and consent form (key informants)

My name is Emmanuel Siziba (student number 17383863) and I am a doctoral student in the Department of Sociology at the University of Pretoria. I am conducting a research on gender-based violence (GBV) in Zimbabwe focusing on institutional responses by the justice, health and education sectors. The research project is titled: *Gender Based Violence in Zimbabwe: A critical Analysis of Institutional Responses*. The study seeks to review institutional responses to GBV in the justice, health and education sectors. In these sectors, the focus is on the laws and policies, institutional reforms and community mobilisation efforts. The study seeks to understand service providers and other key stakeholders' perceptions on the strength and weaknesses on institutional responses that aim to reduce GBV.

As part of the study, I am kindly requesting your permission to participate in the study. This will involve an individual interview that will take approximately one hour and will be conducted at a place and time convenient to you. In addition can I request that the interviews be audio recorded in order to maintain the accuracy of the shared information as well as to facilitate analysis of the information. It should be noted that your participation in the study is voluntary and you are free to withdraw at any time during the interview. During the interview, if you feel uncomfortable about a question asked you are free not to answer it and you will not be affected in anyway.

All the information collected will be treated confidentially. Throughout the study, all the transcripts will be coded in such a way that your identity cannot be linked to the transcripts. As a result, the details of your identity will remain confidential throughout the study. Pseudonyms will be used to protect your identity in reports and publications on the research. The Department of Sociology at the University of Pretoria will be in custody of all information collected from you for a maximum of 15 years.

Your participation in this study will add knowledge on institutional responses to GBV in Zimbabwe with regards to the justice, health and education sectors. No direct benefits will accrue to you by virtue of your participation in the study. There are no anticipated risks associated with the participation in this study. However, if by any chance you feel distressed in any way during or after the interview, kindly let me know and I will share with you details of Helpline Zimbabwe and Msasa Project. These organisations will offer counselling services at no cost.

All this information is given to ensure that you fully comprehend what is involved and from an informed position, you either agree or disagree to participate. If you are to participate in the study, please sign the consent form available.

If you have any questions before or after the study please contact me on:

Cell : +263772288404

Email: ersamaita@gmail.com

CONSENT

I have read and understood the accompanying sheet on the research study, which seeks to explore institutional responses on GBV by the justice, health and education sectors. I agree to participate in this research whose conditions are as follows:

- The information I give will be used solely for academic purposes.
- At any time, I can refuse to answer certain questions or cease to participate in the interview.
- The information will be coded to protect my identity and will remain confidential.
- My participation is voluntary.

.....

Signature of participant Date

CONSENT

I hereby give my consent that the interview proceedings be recorded.

.....

Signature of participant Date

Interviewer's signature.....

Date.....

INFORMATION SHEET AND CONSENT FORM (Focus Group Discussions)

My name is Emmanuel Siziba (student number 17383863) and I am a doctoral student in the Department of Sociology at the University of Pretoria. I am conducting a research on gender-based violence (GBV) in Zimbabwe focusing on institutional responses by the justice, health and education sectors. The research project is titled: *Gender Based Violence in Zimbabwe: A critical Analysis of Institutional Responses*. The study seeks to review institutional responses to GBV in the justice, health and education sectors. In these sectors, the focus will be on the laws and policies, institutional reforms and community mobilisation efforts. The study seeks to understand service providers and other key stakeholders' perceptions on the strength and weaknesses on institutional responses that aim to reduce GBV.

As part of the study, I am kindly requesting your permission to participate in the study. This will involve focus group discussions that will take up to two hours and will be conducted at a place and time convenient to you. In addition can I request that the group discussions be audio recorded in order to maintain the accuracy of the shared information as well as to facilitate analysis of the information. It should be noted that your participation in the study is voluntary and you are free to withdraw at any time during the discussions. During the focus group discussions, if you feel uncomfortable about the session you are free to withdraw and you will not be affected in anyway.

All the information collected will be treated confidentially. Throughout the study, all the transcripts will be coded in such a way that your identity cannot be linked to the transcripts. As a result, the details of your identity will remain confidential throughout the study. Pseudonyms will be used to protect your identity in reports and publications on the research. The Department of Sociology at the University of Pretoria will be in custody of all information collected from you for a maximum of 15 years.

Your participation in this study will add knowledge on institutional responses to GBV in Zimbabwe with regards to the justice, health and education sectors. No direct benefits will accrue to you by virtue of your participation in the study. There are no anticipated risks associated with the participation in this study. However if by any chance you feel distressed in any way during or after the focus group discussion, kindly let me know and I will share with you details of Helpline Zimbabwe and Msasa Project. These organisations will offer counselling services at no cost.

All this information is given to ensure that you fully comprehend what is involved and from an informed position, you either agree or disagree to participate. If you are to participate in the study, please sign the consent form available.

If you have any questions before or after the study please contact me on:

Cell : +263772288404

Email: ersamaita@gmail.com

CONSENT

I have read and understood the accompanying sheet on the research study, which seeks to explore institutional responses on GBV by the justice, health and education sectors. I agree to participate in this research whose conditions are as follows:

- The information I give will be used solely for academic purposes.
- At any time, I can refuse to answer certain questions or cease to participate in focus group discussion.
- The information will be coded to protect my identity and will remain confidential.
- My participation is voluntary.

.....

Signature of participant Date

CONSENT

I hereby give my consent that the focus group discussion proceedings be recorded.

.....

Signature of participant Date

Interviewer's signature.....

Date.....

Appendix J: Information sheet and consent form (Shona version)

GWARO RINOJEKESA ZVICHAITWA MUTSVAKURUDZO UYE RINOTSVAKA MVUMO KUNE VAKASANGA NEDAMBUDZIKO IRI (INTERVIEW WITH ABUSED WOMEN)

Zita rangu ndinonzi Emmanuel Siziba (student number 17383863) uye ndirikuita zvidzidzo zvekuzova muzvina fundo muchikamu che Sociology pachikoro chikuru che University of Pretoria chiri munyika ye South Africa. Ndirikuita tsvakurudzo yakanangana ne mhirizhonga pakati pevarume ne vanhukadzi munyika ye Zimbabwe. Donzvo retsvakurudzo iyi nderekuda kuziva kuti mapazi ehurumende anoti redzidzo, rehutano ne re mapurisa arikuiteyi nedambudziko iri. Imi sevanhu vakasangana ne dambumbudziko remhirizhonga inoitika pakati pevanhurume ne vanhukadzi uye makambotsvaka kana kuedza kutsvaka rubatsiro kumapazi anoti remapurisa, redzidzo nere hutano, tsvakurudzo ino inodakuziva pfungwa dzenyu maererano nokugona kana kukundikana kwavo pakuedza kupedza dambudziko iri. Musoro we tsvakurudzo unoti:

Mhirizhonga pakati pevarume ne vanhukadzi mu Zimbabwe: Ongororo yezvirikuitwa nemapazi akasiyana siyana kepedza dambudziko iri.

Ndakanangana nemapazi matatu anoti redzidzo, rehutano uye remapurisa, tsvakurudzo inoda kuziva pfungwa dzevanoshandamo uye nedzenyu kuti mapazi aya arikugona here kana kuti ari kukundikana muzvirongwa zvavo zvekupedza dambudziko remhirizhonga pakati pevarume ne vanhukadzi. Nokudaro ndinokukumbirai kuti mupinde munhaurirano pakati pangu nemi inogona kutora ahwa imwe chete kana zvisoma. Nhaurirano iyi inoitwa ne nguva uye pazvimbo yamakasungunuka imi. Ndinokumbirawo kuti ndi rekodhe zvachataura kuitira kuti ndinyatsotora zvamunenge mataura. Kupinda kwenyu munhaurirano iyi zvinobva pakuda kwenyu uye hamumanikidzwe. Ikodzero yenyu kurega kupindura imwe mibvunzo uye izvi hazvina pazvinokukanganisai.

Zvichabuda mutsvakurudzo ndichazvichetedza. Ndichashandisa mazita ekunypera kuitira kuti mazita enyu chaiwo asabuda kana toshambadza zvatininge tawana. Boka re sociology pachikoro chikuru che University of Pretoria richachengeta zvichabuda munhaurirano yedu kwemakore gumi ne mashanu.

Kupinda kwenyu muchidzidzo ichi hakuna chouviri chinobuda. Kupinda kwenyu kunobetsera chete kujekesa mashandiro arikuita mapazi anoti redzidzo, rehutano nere mapurisa mukuenda kupedza dambudziko remhirizhonga pakati pevarume ne vakadzi mu Zimbabwe. Patinenge

tichikurukura munogona kudzimbikana. Kana zvadado ndiudzeyi ndikokuudzayi kwamunowana rubatsiro pachena. Masangano atoti Msasa Project nere Helpline Zimbabwe anobatsira vanenge vakanganisika zvikuru mupfungwa. Vanotaura nemi nedonzvo rekupedza mifungo ingadero yamuka.

Izvi zvose ndirikukupai kuti multe sarudzo yakakwana. Kana mukaita mubvunzo patinenge tichikurukura kana kuti ndaenda ndibateyi panhare mbozha ne tsamba mbozha ndinotevera

Cell: +263 772 288404

Email: ersamaita@gmail.com

Gwaro reMvumo

Ndaverenga ndikanzvisisa zvirimugwaro iri. Ndinobvuma kupinda mutsvakurudzo iyi ndokunge izvi zviripo:

- Kuti zvamuchawana mutsvakurudzo iyi zvinoshanda mune zvedzidzo chete.
- Chero nguvai ndinogona kubuda mutsvakurudzo iyi.
- Zita rangu haribudiswi.
- Hapana andimanikidza kupinda mutsvakurudzo iyi.

.....

Runyoro zuva

Gwaro Re Mvumo (Kuti zvinotaurwa zvitapwe)

Ndinotenda kuti mutape zvandinotaura

.....

Runyoro zuva

.....

Runyoro rwemutsvaki

.....

zuva

Appendix K: Language editor's letter



WORDPLAY EDITING
Copy Editor and Proofreader
Email: karien.hurter@gmail.com
Tel: 071 104 9484
Website: <http://wordplayediting.net/>

21 October 2021

To Whom It May Concern:

This letter is to confirm that *Gender-Based Violence in Zimbabwe: A Critical Analysis of Institutional Responses* by Emmanuel Siziba was edited by a professional language practitioner. It requires further work by the author in response to my suggested edits. I cannot be held responsible for what the author does from this point onward.

Regards,

A handwritten signature in black ink, appearing to be 'KH' or similar initials, enclosed within a circular flourish.

Karien Hurter