DSPACE

https://dspace.org/

Narratives of women residing in a rural area on intimate partner violence: a case of Chimanimani District, Eastern Highlands (Zimbabwe)

Chadambuka, Cyndirela

2021
https://hdl.handle.net/10539/32127

Downloaded from a DSpace repository. https://dspace.org/

Narratives of women residing in a rural area on intimate partner violence: A case of Chimanimani District, Eastern Highlands (Zimbabwe)

A thesis submitted in fulfilment of the requirements for the degree of Doctor of Philosophy in the Department of Social Work, Faculty of Humanities at the University of the Witwatersrand

A PhD including publications

By

Cyndirela Chadambuka

Student No. 890270

Supervisor: Dr Ajwang' Warria

June 2021

DECLARATION

I declare that this thesis is my own, unaided work. It is being submitted for the Degree of Doctor of Philosophy in Social Work at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at another university.

Signed: Cyndirela Chadambuka



Date: 02 June 2021

DEDICATION

This thesis is dedicated to my late mother Norah Chadambuka (nee Nemaisa-Gomo) and all the women and girls.

ACKNOWLEDGEMENTS

I give all the glory to God for his unfailing love and grace that is sufficient! Thank you Almighty God for giving me the means, ability and good health to conduct this study.

To my supervisor Dr Ajwang' Warria, your support, wisdom and mostly your patience with me transformed me into this researcher that I am today. I am forever grateful to you.

I would like to thank the Ministry of Women Affairs, Community and Medium Enterprise Development in Zimbabwe and Chimanimani Rural District Council for granting me permission to conduct this study. I would also like to thank all the women and the key informants who took part in this study. Your contribution is greatly valued.

To my husband Tatenda Brian Gwangwava, I am forever grateful for your patience, prayers and support during the course of this study. You made this journey bearable.

My gratitude also goes to my family and siblings for their support. I would like to thank my sister Rumbidzai for her support. I am forever indebted to you.

To my spiritual family who prayed for me and encouraged me during difficult times, I am thankful and privileged to have you in my life.

To my aunt and uncle, Mr and Mrs Tsinakwadi, who provided me with food and a comfortable place to stay during my data collection in Chimanimani district, I am forever thankful for the support.

To Professor Victor Chikadzi who supported and mentored me, I appreciate you.

To my friends, I am grateful for your support during the course of this study. Your support kept me going.

Lastly, I would like to thank the Department of Social Work at the University of Witwatersrand for the support and encouragement. Thank you very much.

ABSTRACT

This study explored the phenomenon of intimate partner violence (IPV) in rural areas in Zimbabwe. Similar to other countries, IPV remains a serious social problem in Zimbabwe that affects the psychosocial wellbeing of women. Regardless of its detrimental effects, IPV is largely unexplored in rural areas and this makes it difficult to establish its extent and interventions required. In addition, the IPV interventions that are crafted do not effectively respond to the needs of women in rural communities. Thus, this study explored the IPV experiences of women residing in a rural area in Zimbabwe.

This study utilised a qualitative research approach. Document analysis was used when reviewing literature. Narrative research design guided the study. Purposive sampling was utilised to recruit participants from one ward in Chimanimani Rural District in Zimbabwe. The participants in this study were categorized into two groups. The first group consisted of women who had experienced IPV in their previous intimate relationships, had exited abusive relationships and were not facing on-going IPV. These women were also chosen on the grounds of their residency in Chimanimani Rural district and their ages (between 19 and 49 years). The second group consisted of key informants who were key IPV service providers in Chimanimani Rural District. In-depth interviews using a narrative approach were adopted as the main method of data collection. The in-depth interviews were guided by semi-structured interview schedules with open- ended questions. The interviews were audio-recorded with participants' permission. Thematic analysis was used to analyse data.

Together with previous literature reviewed, the findings from this study revealed that women living in rural areas experience frequent and severe IPV, which is largely unreported due to social norms. It was evident in the findings that social norms play a central role in the perpetration and response to IPV. Viewed from the intersectional feminism perspective, the study findings show that to better understand the experiences of women in rural areas about IPV, the interconnectedness of different social variables such as geographical location, gender and social norms that facilitate the abuse ought to be considered.

It emerged in this study that women living in rural areas resort to context-specific coping strategies in responding to IPV. IPV victims in rural areas choose coping strategies that are aligned with social norms (i.e. acceptance and placating) to avoid community rejection and

stigma. The study findings further reveal that when these context-specific coping strategies fail, victims of IPV in rural areas resort to informal support systems for support. These informal support networks are family, traditional leaders, church and informal self-help groups (ISGHs) which are readily available and are culturally approved. However, in the case of life-threatening IPV, formal support systems play an important role in the provision of the needed support and intervention. The study findings revealed the barriers that IPV victims in rural areas face in seeking help from formal support systems and these barriers include lack of confidentiality and strained intervention resources. Notable in this study are the challenges that IPV service providers in rural areas face such as lack of intervention resources and limited male participation and conflicting identities. These challenges affected service providers' ability to intervene effectively in IPV situations in rural areas.

Utilizing the findings from this research, this study proposes culture-informed practice guidelines for social workers working within IPV contexts in rural areas. These guidelines look at intervention from the lens of intersectional feminism arguing that intervention efforts should be sensitive to the unique experiences of women residing in rural areas and prevention efforts should take into consideration the intersection of social norms, geographical location and gender in drafting intervention strategies.

The conclusions reached in this study are that, firstly, social norms are central to IPV perpetration and the responses to it in rural areas. Secondly, culture and religion commonly determine the coping strategies that women living in rural areas employ in managing and responding to IPV. Thirdly, IPV victims in rural areas are reliant on informal support networks because they are readily available and are deemed culturally appropriate in resolving marital conflicts. Fourthly, service provision in rural areas is tied to cultural norms and this affects the effectiveness of intervention efforts. Understanding the scope of IPV and the role of social norms in its perpetration and response is crucial in social work practice as it allows practitioners to contribute to the development of IPV and gender policies and implement programmes that are culturally sensitive and which respond to the unique needs of IPV victims in rural areas.

Key words: Intersectionality; Intimate Partner Violence; Narratives; Rural Areas; Social Work; Women; Zimbabwe

LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
AIC	African Independent Church
CEDAW	Convention on the Elimination of all forms of Discrimination Against Women
FAO	Food and Agriculture Organization
FDG	Focus Group Discussion
HIV	Human Immunodeficiency Virus
GBV	Gender based violence
ISHG	Informal Self-Help Groups
IPV	Intimate Partner Violence
LGBTIQ	Lesbian, Gay, Bisexual, Transgender, Intersex and Queer
NGO	Non-governmental organisation
PIS	Participant Information Sheet
PTSD	Post-Traumatic Stress Disorder
SADC	Southern African Development Community
SDG	Sustainable Development Goals
SAFAIDS	Southern Africa AIDS information Dissemination
SGBV	Sexual and gender based violence
USA	United States of America
WHO	World Health Organisation
ZNDHS	Zimbabwe National Demographic and Health Survey
ZNGBVS	Zimbabwe National Gender Based Violence Strategy
ZNPC	Zimbabwe National Population Census

TABLE OF CONTENTS

DECLARATION ..... **I**

DEDICATION ..... **II**

ACKNOWLEDGEMENTS ..... **III**

ABSTRACT ..... **IV**

TABLE OF CONTENTS ..... **VII**

PHD INCLUDING PUBLICATIONS ..... **XII**

LIST OF PUBLICATIONS ..... **XIII**

CHAPTER 1: OVERVIEW OF THE STUDY **1**

1.1 INTRODUCTION TO THE STUDY 1

1.2 BACKGROUND OF THE STUDY 1

1.3 STATEMENT OF THE PROBLEM AND RATIONALE OF THE STUDY 4

1.5 RESEARCH AIM AND OBJECTIVES 7

1.6 RESEARCH QUESTIONS 8

1.7 CONCEPTUALISATION OF KEY CONCEPTS 8

1.8 STRUCTURE OF THE THESIS 9

1.9 ROLES AND RESPONSIBILITIES 11

1.10 CONCLUSION 12

CHAPTER 2: THEORETICAL FRAMEWORK **13**

2.1 INTRODUCTION 13

2.2 INTERSECTIONAL FEMINISM 13

2.2.1 History of Feminism 13

2.2.2 Historical background of Intersectional Feminism 14

2.3 INTERSECTIONAL FEMINISM AS A PARADIGM 15

2.4 UNDERSTANDING IPV THROUGH THE LENS OF INTERSECTIONAL FEMINISM 17

2.5 JUSTIFICATION FOR ADOPTION OF INTERSECTIONAL FEMINISM FOR THIS STUDY 19

2.6 CONCLUSION 21

CHAPTER 3: LITERATURE REVIEW.....23

3.1 INTRODUCTION.....23
3.2 DOCUMENT ANALYSIS AS A RESEARCH METHODOLOGY 23
3.3 SCOPE AND NATURE OF IPV.....24
3.3.1 Conceptualisation of IPV……24
3.3.2 Understanding IPV prevalence…… ..26
3.3.2.1 A global overview of IPV 27
3.3.2.2 African context.....27
3.3.2.3 IPV in the Zimbabwean context.....28
3.4 FACTORS CONTRIBUTING TO IPV.....31
3.4.1. Micro Level…… ..32
3.4.2 Meso Level Factors…….34
3.4.3 Macro Level Factors……. ..36
3.5 IPV AND THE CYCLE OF VIOLENCE.....37
3.6 CONSEQUENCES OF IPV 39
3.6.1 Psychological effects…… ..39
3.6.3 Developmental effects on children…….. ..41
3.6.4 Reproductive health effects…….....42
3.6.5 Economic consequences of IPV…….....44
3.6.6 HIV/AIDS…….. ..44
3.7 IPV AND COVID-19 46
3.8 INTRODUCTION TO ARTICLE……..…...48
3.8.1 PRESENTATION OF ARTICLE 1……....48
3.8.2 CONCLUSION……...60
3.9 INTRODUCTION TO ARTICLE ..…….60
3.9.1 PRESENTATION OF ARTICLE 2……...60
3.9.2 CONCLUSION……..91

CHAPTER 4: RESEARCH METHODOLOGY 92

4.1 INTRODUCTION.....92
4.2 RESEARCH APPROACH.....92
4.3 RESEARCH DESIGN 93
4.4 RESEARCH INSTRUMENT 93

4.4.1 Pre-testing the research instrument…… ..94
4.6 RESEARCH POPULATION AND SAMPLING 96
4.7 DATA COLLECTION……100
4.7.1 Data collection with women participants……..……101
4.7.2 Data collection with key informants…….104
4.8.1 Steps in thematic data analysis……. 106
4.9 DEVELOPMENT OF PRACTICE GUIDELINES.....110
4.10 TRUSTWORTHINESS OF THE STUDY.....111
4.10.3 Confirmability……113
4.10.4 Transferability……114
4.11.1 Confidentiality…… 115
4.11.2 Informed Consent……116
4.11.3 Voluntary participation……... 116
4.11.4 Avoidance of harm……..117
4.12 ETHICS OF CARE 118
4.13 REFLEXIVITY.....120
4.14 CONCLUSION.....123

CHAPTER 5: FINDINGS AND DISCUSSION: COPING STRATEGIES AND IPV..124

5.1 INTRODUCTION.....124
5.2 PRESENTATION OF ARTICLE 3.....124
5.3 CONCLUSION.....150

CHAPTER 6: FINDINGS AND DISCUSSION: SUPPORT SYSTEMS AND IPV 151

6.1 INTRODUCTION.....151
6.2 PRESENTATION OF ARTICLE 4.....151
6.3 CONCLUSION.....172
6.4 INTRODUCTION.....173
6.5 PRESENTATION OF ARTICLE 5…….....173
6.6 CONCLUSION……..186

CHAPTER 7: FINDINGS AND DISCUSSION: KEY INFORMANTS' PERSPECTIVES 187

7. 1 INTRODUCTION.....187

7.2 PRESENTATION OF ARTICLE 6……187
7.3 CONCLUSION 208

CHAPTER 8: FINDINGS AND DISCUSSION: PRACTICE GUIDELINES 209

8.1 INTRODUCTION 209
8.2 PRESENTATION OF ARTICLE 7 209
8.3 CONCLUSION 231

CHAPTER 9: CONCLUSIONS AND RECOMMENDATIONS 232

9.1 INTRODUCTION 232
9.2 FINDINGS AND CONCLUSIONS OF THE STUDY 232
9.2.1 To explore how women residing in rural areas experience IPV……..……. 233
9.2.2 To explore the role of culture in women's experiences of IPV in rural areas……..234
9.2.3 To explore context-specific coping strategies adopted by IPV victims in rural areas..235
9.2.4 To explore the available formal and informal support mechanisms for IPV victims in rural areas……..…….236
9.2.5 To explore key informants' perspectives on IPV in rural areas……238
9.3 LIMITATIONS OF THE STUDY 239
9.4 RECOMMENDATIONS……240
9.4.1 Social work practice……..240
9.4.2 Social Work Curriculum……... 241
9.4.3 Social Policy……. 242
9.4.4 Recommendation to theory……243
9.4.5 Future Research on IPV……244
9.5 CONCLUDING REMARKS 245
APPENDICES 275
APPENDIX A1: PARTICIPANT INFORMATION SHEET (WOMEN RESIDING IN RURAL AREAS)..275
APPENDIX A2: PARTICIPANT INFORMATION SHEET (SHONA VERSION) 277
APPENDIX B1: INTERVIEW SCHEDULE (WOMEN RESIDING IN RURAL AREAS)..... 279
APPENDIX B2: INTERVIEW SCHEDULE (VAKADZI VEMUMARUWA) SHONA VERSION....281
APPENDIX C: INTERVIEW SCHEDULE (KEY INFORMANTS: GOVERNMENT OFFICIALS) 283
APPENDIX D: INTERVIEW SCHEDULE (KEY INFORMANT-NURSE) 284
APPENDIX E INTERVIEW SCHEDULE (KEY INFORMANT-POLICE OFFICER) 285
APPENDIX F: INTERVIEW SCHEDULE (KEY INFORMANT-HEADMAN SABHUKU) 286

APPENDIX G: OBSERVATION SHEET (SELF -HELP GROUPS OF WOMEN RESIDING IN RURAL AREAS).....287
APPENDIX H: CONSENT FORM FOR PARTICIPATION IN THE STUDY 288
APPENDIX I: CONSENT FORM FOR AUDIO-TAPING OF THE INTERVIEW FOR THE STUDY.....289
APPENDIX J: CONFIDENTIALITY AGREEMENT FORM WITH INDEPENDENT QUALITATIVE ANALYST.....290
APPENDIX K: PARTICIPANTS' DEMOGRAPHIC INFORMATION (WOMEN).....291
APPENDIX L: PARTICIPANTS' DEMOGRAPHIC INFORMATION (KEY INFORMANTS).....293
APPRENDIX M: TRANSCRIBED INTERVIEW WITH WOMAN PARTICIPANT…….294
APPENDIX N: ETHICS CLEARANCE CERTIFICATE.....311
APPENDIX O: PERMISSION LETTER FROM CHIMANIMANI RURAL DISTRICT COUNCIL.....312
APPENDIX P: PERMISSION LETTER FROM MINISTRY OF WOMEN AFFAIRS, COMMUNITY & MEDIUM ENTERPRISE DEVELOPMENT.....313
APPENDIX Q: STANDING ORDERS FOR PHD INCLUDING PUBLICATIONS 314
APPENDIX R: PROOF OF EDITING 317

LIST OF TABLES

Table 1: Summary of steps in thematic analysis…….....110
Table 2: Steps taken in ensuring trustworthiness ……..115

LIST OF FIGURES

Figure 1: Factors contributing to IPV……..32
Figure 2: The cycle of violence……39
Figure 3: Map of Zimbabwe showing Chimanimani Rural District…….....97

PhD Including Publications

According to Senate Standing Orders S2011/2148 (Appendix Q), a PhD including publications should have a minimum of four interrelated manuscripts that constitute the four chapters that form the central body of the thesis. Of the four articles, one should be published, one in press and two accepted for publication in peer-reviewed journals that are recognized by the University. One article should be published in an internationally recognized journal and one accepted or published article should include the candidate's name as the sole author. The Senate Standing Orders further suggest that the candidate should be the first author in all the articles and each article should be preceded by a brief explanatory section, which presents the aim of the manuscript, links it to the previous chapter and locates it within the overall study.

This PhD thesis incorporates seven articles with three published, two in press, one under review and one submitted. The candidate is the first author of all the seven articles – included in this thesis. The candidate is also the sole author of two out of the seven publications. These articles make a significant contribution to the knowledge within the field of social work, particularly psychosocial practice in rural areas and with female victims of IPV. In accordance with the Standing Orders, each article has an introduction, which outlines the aim of the article, its link to the previous article and the overall thesis. A conclusion is presented at the end which summaries the article.

List of Publications emanating from this research as submitted for PhD Including Publications

1. **Chadambuka, C.,** & Warria, W. (2019). Hurt or help? Understanding intimate partner violence in the context of social norms as practiced in rural areas. *Social Work/ Maatskaplike Werk*, 55(3),301-310. http://dx.doi.org/10.15270/52-2-741

2. **Chadambuka, C.** (2019). Intimate partner violence in rural areas: Examining the legislative measures in Zimbabwe. *Journal of Social Development in Africa*, 34(1), 115-140.

3. **Chadambuka, C.,** & Warria, A. (2020). Examining Support Systems Available for Victims of Intimate Partner Violence in Rural Areas in Zimbabwe. *Practice: Social Work in Action*, *32*(5), 381-399. https://doi.org/10.1080/09503153.2020.175057.

4. **Chadambuka, C.** (2020). Coping strategies adopted by women who experienced intimate partner violence in the context of social norms in rural areas in Zimbabwe. *Journal of InterpersonalViolence*,1-25. https://doi.org/10.1177%2F0886260520943734

5. **Chadambuka, C.,** & Warria, A. (2021). Intimate Partner Violence: Understanding Barriers in Seeking Formal Support Services in a Rural Area in Zimbabwe. *Journal of Family Violence*, 1-12. https://doi.org/10.1007/s10896-021-00275-4

6. **Chadambuka, C.,** & Warria, A. (Under Review). Understanding intimate partner violence in rural areas: Engaging service providers intervening in Chimanimani (Zimbabwe). *Journal of Progressive Human Services*

7. **Chadambuka, C.,** & Warria, A. (Submitted). Intimate partner violence in rural areas: Proposed cultural-relevant practice guidelines for social workers. *Journal of Social Development in Africa.*

CHAPTER 1
OVERVIEW OF THE STUDY

1.1 INTRODUCTION TO THE STUDY

Violence against women is a grave violation of human rights and a significant socio-cultural and public health problem globally. Forms of violence against women could include those perpetrated by an intimate partner (e.g. sexual and physical violence) or perpetrated by a non-partner (e.g. female genital mutilation, honour killing and human trafficking) (McCloskey et al., 2016; Panda & Agarwal, 2005). It is important to note that the examples provided in the previous statement could also be perpetrated or facilitated by the women's family members. Many women worldwide are victims of intimate partner violence (IPV) (Dim, 2020; Panda & Agarwal, 2005; World Health Organisation (WHO), 2013). IPV is harm mostly perpetrated by a current or ex-intimate partner or would-be rejected lover (Bikinesi et al., 2017). IPV impacts women's well-being and it threatens their survival and development. The 1979 Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) remains in force and stipulates that combating discrimination against women should focus on the legal and socio-economic contexts and their influence on inequalities. Understanding these legal and socio-economic contexts (through research) is important in order to intervene effectively in IPV cases in rural areas. Regardless of this emphasis on the importance of understanding contexts in IPV intervention, there are limited empirical studies conducted on IPV as experienced by victims in rural areas and its effects on women and children. Therefore, this study aimed to explore and understand the IPV experiences of women residing in rural areas in Zimbabwe with a focus on the Chimanimani Rural District.

1.2 BACKGROUND OF THE STUDY

There has been a rapid escalation in the rate of violence globally in the most recent decades. This rapid increase could be due to a number of factors such as poverty and Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) (Fidan & Bui, 2016; Goodman et al., 2009; Mascarenhas et al., 2020; Mahenge et al., 2020; McCloskey et al., 2016; Shamu et al., 2016). Most recently, an increase in IPV cases has been largely attributed to the coronavirus pandemic due to quarantine and lockdown as safety measures (Mazza et al., 2020) and based on the vulnerabilities that are exacerbated by a pandemic (Warria, 2020).

Different perspectives have been put forward, with violence also seen as a problem contributing to human trafficking (Solla, 2009; Klugman et al., 2014; Silva de Alwis & Klugman, 2015; Warria & Chikadzi, 2018) and arising from human rights violations (CEDAW, 1979; Klugman, 2017) and gender inequalities (Moono et al., 2020; Shamu et al., 2018; Sikweyiya et al., 2020). Violence is also a public health concern (Ambikile et al., 2020; Shamu et al., 2013; WHO, 2010, 2013), a development challenge (McCloskey et al., 2016; Klugman, 2017), a concern to religion (Chireshe, 2015; Dim, 2020) and a cultural issue (Mashiri, 2013; Mukanangana et al., 2014; Sikweyiya et al., 2020; Warria, 2018; WHO, 2012). These different perspectives showing that violence cuts across different contexts and cultures are significant in understanding the manifestation, management and prevention of violence against women.

There has been increased coverage of IPV against women in recent decades, which suggests that one in three women experience IPV in their lifetime (Giddens & Sutton 2017; Mahenge & Stockle, 2020). Studies on Arab countries indicate a high prevalence of IPV with sexual IPV ranging from 11% to 40% while physical IPV ranges from 26% to 50% (Elghossain et al., 2019). More than 35% of women globally have been reported to experience either physical or sexual IPV (Klugman et al., 2014). For example, 50% of women in Bangladesh and 71% of women in rural areas in Ethiopia have experienced IPV (Mukanangana et al., 2014). In South Asia, national studies indicate that up to 70% of women have experienced IPV (Klugman, 2017; Ler et al., 2020). A study by Coll et al. (2020) on IPV in low and middle-income countries (such as Uganda, South Africa, Mozambique and Afghanistan) reported IPV prevalence to range from 5% to 50%. In the same study by Coll et al. (2020), high prevalence of physical and/or sexual IPV was reported in Zambia, Angola, Tanzania, Mozambique and Kenya.

More women in Africa are susceptible to partner violence (45.6%) and sexual assault (11.9%) as compared to women globally (McCloskey et al., 2016). Longstanding patriarchal traditions, social and cultural norms surrounding violence and socio-economic status in sub-Saharan Africa promote IPV (Henderson et al., 2017; Izugbara et al., 2020; Mukanangana et al., 2014). IPV is viewed as chastisement and the right way to correct a straying wife (Heisse et al., 2002; Sikweyiya et al., 2020). Thus, in most parts of sub-Saharan Africa, IPV is normalised in intimate relationships as women mostly view it as normal occurrence in that setting (Chireshe, 2015; Izugbara et al., 2020; Mukamana et al., 2020).

Sub-Saharan Africa has been singled out as one of the regions with high rates of IPV (Wadji et al., 2020). Recent studies on IPV in sub-Saharan Africa reported that 36% of women experience at least one form of IPV with 40% of ever-partnered women experiencing physical and/or sexual IPV (Izugbara et al., 2020; Klugman, 2017; McCloskey et al., 2016). A study conducted in Tanzania reported lifetime prevalence of IPV against women as 41% (Ambikile et al., 2020). In South Africa IPV is regarded as a silent public health and social problem and its effects are argued to be visible amongst women (Gordon, 2016; Rees et al., 2014). Sprague et al. (2020) argues that 25% to 35% of pregnant women in South Africa experience IPV and this presents long-term reproductive health problems.

Gordon (2016) and Gottert et al. (2020) argue that in South Africa IPV is the second highest public health burden after HIV/AIDS. Amusa et al (2020) further argue that 26% of South African women have experienced some form of IPV in their lives. Their study revealed that in South Africa the fear of the husband or intimate partner was the strongest predictor of IPV. Furthermore, a study in 15 rural communities in South Africa reports that 80% of women are victims of IPV, which subsequently increased HIV/AIDS prevalence and reproductive health problems (Abrahams et al., 2009; McCloskey et al., 2005). Similarly, a study conducted by Mashaphu et al. (2018) in Durban, South Africa revealed that the prevalence of IPV is high in HIV-serodiscordant couples and gender differences in mental health problems, particularly in cases where the woman is HIV-positive. All these studies reveal the high prevalence of IPV in South Africa and the influence of patriarchal norms in its perpetration.

At the international level, limited consideration has been given to IPV and its detrimental effects on the welfare of women in rural areas. The limited studies report that the absence of police, geographic isolation, patriarchal family structures and fundamental religiosity lead to a higher prevalence of IPV in rural areas (Dudgeon & Evanson, 2014; Edwards, 2015; Klugman, 2017; Sandberg, 2013; Schafer & Giblin, 2010). There is little research on abused women living in rural areas in the United States of America (USA), and the few available studies have received scant attention and applied generalisability of results, thus making it challenging to determine the scope of the problem (Dudgeon & Evanson, 2014). Additionally, the prevalence of IPV is twice as high in rural areas in comparison to urban areas in countries like Nigeria, South Africa and Tanzania (Balogun & Olufunmiyo, 2012; Edwards, 2015; Hoque et al., 2009; McCloskey et al., 2016). This could be because the urban population is mainly prioritised and much of the human and financial resources are allocated to them (Lipton, 1977; McCloskey et

al., 2016). However, more than forty years after Lipton (1977) reported on urban bias, researchers still argue that rural areas are lagging behind in relation to service provision and that IPV problems in rural areas remain the same (Dim, 2020; Morris-Praxton et al., 2020; Mukamana et al., 2020). This in turn reflects the severe imbalance between rural and urban services that shows the extent to which IPV service provision is less prioritised in rural areas.

In Zimbabwe IPV remains a serious public health, economic and psychosocial problem despite the enactment of legislation that seeks to prevent gender-based violence (Mukamana et al., 2020; Zimbabwe National Population Census (ZNPC), 2012). Studies conducted on IPV in urban areas in Zimbabwe revealed the extent to which social norms around the subservient position of women in rural areas reinforces IPV perpetration (Mukanangana et al., 2014; Shamu et al., 2018). Regardless of the extent of the abuse, studies have shown that urban areas in Zimbabwe are at an advantage in terms of response relative to rural areas as IPV victims have access to crucial intervention services and facilities which are scarce in rural areas (Fidan & Bui., 2016; Henderson et al., 2017; Mukamana et al., 2020; Shamu et al., 2013).

The vulnerability to IPV of women living in rural areas is exacerbated by geographical isolation as well as social norms that condone male dominance and cultural beliefs that promote the subordinate position of women (Sikweyiya et al., 2020). These social norms support the hidden nature of IPV in a manner such that victims in rural areas are mostly 'invisible' and such cases are rarely reported. A further problem of IPV in rural areas is the implementation of interventions that are based on IPV studies conducted in urban and peri-urban areas. (Fidan & Bui, 2015; Mashiri, 2013; Shamu et al., 2013). For practitioners seeking to effectively intervene in rural areas and end IPV against women, it is important to gain a deeper understanding of IPV as experienced by women residing in these communities. Thus, the study explored IPV experiences of women residing in Chimanimani Rural District in the Eastern Highlands of Zimbabwe in a bid to develop culturally informed practice guidelines for successful social work intervention in rural areas.

1.3 STATEMENT OF THE PROBLEM AND RATIONALE OF THE STUDY

There is a high degree of concurrence on IPV being a serious threat in developing countries (McCloskey 2016; Shamu et al., 2018; Sikweyiya et al., 2020; Wadji et al., 2020). Zimbabwe as a developing country is not an exception to the grave effects of IPV on women and children.

Research has been done on IPV and its effects on women in Zimbabwe (Chireshe, 2015; Mashiri, 2013; McCloskey et al., 2016; Mukamana et al., 2020; Shamu et al., 2013; Shamu et al., 2018), yet little attention has been given to women residing in rural areas and how they experience it. Women are a heterogeneous group, and although similarities might exist, it is inaccurate to equate the experiences of IPV amongst urban women with those of rural women. Regardless of the gravity of this social challenge, knowledge about IPV in Zimbabwe, especially in the rural areas, remains very limited and most of the existing empirical studies are based on the urban population (Fidan & Bui, 2016; Mashiri, 2013; Mukanangana et al., 2014; Shamu et al., 2013). Studies (Chireshe, 2015; Fidan & Bui, 2016; Mukamana et al.,2020; Shamu et al., 2018) on IPV in the Zimbabwean context provides valuable contributions in relation to the scope of IPV and enhances knowledge and understanding of the phenomenon, gaps are evident as they do not provide deeper understanding of IPV in the rural areas. This literature predominantly focuses on IPV in urban areas in Zimbabwe and has tended to neglect the experiences of women residing in rural areas. Given that social justice and advocacy are at the centre of social work practice within IPV contexts, it is necessary that practitioners understand programmes and policies and how they affect women in rural areas, how these women access services, and the barriers they might face in attempting to seek help. Thus, the focus of this study on the experiences of women residing in rural areas, with regard to IPV, contributes a unique lens to the body of IPV literature.

Furthermore, the urban bias hypothesis argues that resources in developing countries are systematically allocated to urban populations (Sechele, 2016). Systematic discrimination is evident in the limited resources allocated to rural areas and projects (Lipton, 1977; Sechele, 2016). Policy-makers, funders and advisers in non-governmental organisations (NGOs) that deal with IPV conduct brief visits to the rural areas and what they see for a few hours is what they generalise without considering that IPV in rural areas is hidden and shrouded in the ‘code of silence’ (Edwards, 2015). The brevity of these contacts means that developing and implementing sustainable solutions to these challenges is compromised (Mago et al., 2015). Furthermore, the victims of IPV are often excluded from programmes and intervention development due to rigid social norms, geographical disadvantages such as poor infrastructure and the inaccessibility of their households (Sandberg, 2013).

Services in Zimbabwe are centralised, which means that the majority of the country’s population that resides in rural areas does not benefit from them (Fidan & Bui. 2016; Mashiri

2013; Mukanangana et al., 2014; Shamu et al., 2013). Failure to address IPV in rural areas perpetuates the acceptance of violence and violence-linked social norms and undermines gender equality in Zimbabwe. In addition, social development programmes that seek to ameliorate violence against women in rural areas in Zimbabwe become ineffective, as poor mental and physical health status is compromised by IPV and subsequently negatively impacts on the productive, reproductive and community contributions that these women can make. Thus, the loss of income in a household and the potential that economies in rural areas hold are reduced drastically and this further drains the national budgets (Duvvury et al., 2013).

Research on the IPV narratives of women living in rural areas in Zimbabwe is lacking in the literature that was reviewed. In addition, the intervention strategies identified were found to be scarce and mismatched for the rural context. When practitioners, researchers and policy-makers do not listen to the voices of abused women in rural areas, this contributes to further marginalization and oppression. Based on the rights-based approach, which highlights human dignity and equality, there is a need to focus more on the victims of IPV and allow for the development of solutions that keep the experiences of victims at the forefront. The lack of adequate, context-specific and cultural-appropriate victim and survivor intervention support strategies in rural areas exacerbates the violent social norms and scripts and impedes the achievement of Sustainable Development Goals (SDGs) and gender equity. The research gap was also informed by the researcher's professional experience as a student social worker during her fieldwork practice in rural areas. The researcher did her fieldwork practice (from January to September 2012) at Kunzwana Women's Association. This is an NGO that is actively involved in addressing gender-based violence (GBV) related issues by economically empowering women residing in rural areas in Zimbabwe through skills training. The various skills training projects are implemented in many rural areas in Zimbabwe. As part of this project, the researcher observed the extent to which IPV was normalised in rural areas and how most of the victims were not aware that it is a violation of their human rights. Furthermore, she also observed how IPV interventions were overlooked in rural areas and much attention was given to economic empowerment of women regardless of the extent to which IPV economically disempowers women in rural areas. The silenced voices of women in rural areas are a cause for concern based on the legal frameworks ratified and developed by the government of Zimbabwe. It is in this context of limited literature and lacunae in intervention that this study explored the experiences of women residing in the Chimanimani Rural District in the Eastern

Highlands of Zimbabwe in order to develop culture-informed practice guidelines for social workers working within IPV contexts in rural areas.

1.4 SIGNIFICANCE OF THE STUDY

The intention of this study was to add to the current literature by developing culture-informed practice guidelines for practitioners working with IPV-affected women in rural communities in Zimbabwe. Thus in addition to making an original contribution to the scholarship on IPV against women, the study findings may contribute to the knowledge base regarding the development of interventions that are culturally appropriate and minimise the occurrence of IPV. This may assist practitioners, especially those working in rural areas, in developing improved and strengthened psychosocial interventions with IPV victims. These findings are not only applicable to social work practitioners in rural areas but have links and could be beneficial in other disciplines (e.g. psychology, sociology, public health) and to those interested in the prevention and management of IPV.

This study focused on IPV against rural women who are located at the intersection of patriarchy and poverty and are also marginalised. This served to illuminate the inequalities that exist among rural Zimbabwean women that are important to consider when designing intervention programmes. The study findings may further assist policy makers and practitioners in the development and implementation of context-specific policies and programmes that respond to the varied and unique needs of IPV victims in rural areas. In addition, the significance of exploring the experiences of IPV of women in rural areas is apparent in the drive to achieve SDG Goal 5 that calls for gender equality.

1.5 RESEARCH AIM AND OBJECTIVES

The aim of the study is to explore rural women's narratives of IPV in order to develop culture-informed practice guidelines for social workers working in rural areas. In order to achieve the above research aim, the following research objectives were formulated:

i. To explore IPV experiences of women residing in Chimanimani District;
ii. To explore the role of culture in women's experiences of IPV in Chimanimani District;

iii. To explore the context-specific coping strategies that IPV women victims/survivors in Chimanimani District use;
iv. To investigate the available formal and informal support mechanisms for IPV victims/survivors in Chimanimani District;
v. To explore key informants' perceptions regarding IPV in Chimanimani District; and
vi. To develop culture-informed IPV guidelines for social work practice in rural areas.

1.6 RESEARCH QUESTIONS

The following are the research questions guided the study:

i. How do women who reside in rural areas experience and understand IPV?
ii. What components provided by the data can be used to develop culture-informed practice guidelines to address IPV against women residing in rural areas?

1.7 CONCEPTUALISATION OF KEY CONCEPTS

Intimate partner violence: This is a form of GBV that includes physical abuse, psychological abuse, economic abuse and sexual coercion within an intimate relationship that results in physical, sexual, psychological and other harm (Fidan & Bui, 2015; Klugman, 2017; Zimbabwe National Gender Based Violence Strategy (ZNGBVS) 2012-2015). In this study, IPV refers to physical, sexual, controlling behaviour, economic and psychological abuse and/or violence perpetuated by men against women that occurred in heterosexual marriages or intimate relationships.

Rural areas: A rural area is a countryside area and the major economic activity in this particular area is agriculture (Conyer, 2001); 67% of the total population of Zimbabwe is located in rural areas (ZNPC, 2012). In this study, a rural area is a sparsely populated countryside area in Zimbabwe where the majority of the population resides, and the main economic activity is subsistence farming. This is the case in Chimanimani District where the study was conducted.

Women in rural areas: Women are defined as a group of adult human beings who are biologically female (Giddens & Sutton, 2017). In this study, women in rural areas are women above the age of 19 years residing in Chimanimani Rural District.

Narratives: Butina (2015) highlights that narratives refer to stories from individuals and groups that are often collected through interviews. In this study, narratives refer to individual stories shared by participants with regard to their experiences of IPV in a rural setting.

Practice guidelines: Practice guidelines are statements that set the foundation to improve service provision and are used in health care as well as social work practice (Woolf et al., 2012). In this study, practice guidelines refer to statements that are systematically developed to assist practitioners in selecting the most appropriate social work intervention strategy for each unique IPV case (Howard & Jenson, 1999).

Intersectional feminism: This refers to the theory that guides the research process. This theory provides the researcher with the perspective to examine the phenomenon under study and help in focusing attention on specific aspects of the study (Korstjens & Moser, 2018). In this study, intersectional feminism is the lens of approach adopted.

1.8 STRUCTURE OF THE THESIS

The thesis of PhD Including Publications (Appendix Q) requires one to submit a minimum of four published and/or submitted articles to peer-review journals. Each article is expected to have a literature review section, methodology and discussion section. The chapters presented are aligned to the objectives that informed this study as well as the structure of PhD with publications.

Chapter One of the thesis introduces the study and provides an outline of the study aims, research objectives and the research questions. The statement of the problem and the rationale of the study are presented.

Chapter Two of the thesis focuses on intersectional feminism as the theoretical framework that informed this study. Although intersectional feminism has been discussed in the articles, this chapter will present an overview of intersectional feminism and further explore how the theoretical framework makes visible the multiple vulnerabilities and disadvantages that rural women have that exposes them to IPV.

Chapter Three of the thesis is a review of the literature pertaining to IPV. Two published articles are based on the review of literature. The article *Hurt or help? Understanding intimate partner violence in the context of social norms as practiced in rural areas* was published in 2019 in the journal *Social Work/Maatskaplike Werk*. The paper sought to explore the role of culture and social norms in relation to IPV perpetration and interventions in rural areas in accordance with objective two of this study which sought to explore the role of culture in IPV experiences in rural areas. The other paper titled, '*Intimate partner violence in rural areas: Examining the legislative measures in Zimbabwe'* was published in 2019 in the *Journal of Social Development in Africa*. This paper examined the legislative measures in Zimbabwe and their efficacy in responding to IPV in rural areas. In this article, the Zimbabwean legislative measures are analysed in relation to traditional systems that govern everyday life in rural areas. These two articles were incorporated in the Literature Review chapter. This chapter will also include discussion on the factors contributing to IPV, the conceptualization of IPV as a social problem, the consequences of IPV on the well-being of women and a section focused on IPV and the COVID-19 pandemic.

Chapter Four will provide an overview of the methodological approach that was adopted in this study.

Chapter Five focuses on the '*Coping strategies adopted by women who experienced intimate partner violence in the context of social norms in rural areas in Zimbabwe'* thereby addressing objective three which was aimed at exploring the context-specific coping mechanisms that IPV victims in rural areas utilise in managing the abuse. This article explores context-specific coping mechanisms that women experiencing IPV in rural areas utilise in minimising the abuse in their intimate relationships as informed by social norms.

Chapter Six focuses on the support mechanisms utilised by IPV victims in line with objective four which was aimed at exploring informal and formal IPV support mechanisms utilised by victims in rural areas. This objective was split into two articles. The first article in this chapter focuses on '*Examining Support Systems Available for Victims of Intimate Partner Violence in Rural Areas in Zimbabwe'*. This article was published in the journal *Practice: Social Work in Action.* The paper presents a discussion on the support mechanisms that are available for women residing in rural areas who are exposed to IPV. The second article is titled '*Intimate partner violence: Understanding barriers in seeking formal support services in a rural area in*

Zimbabwe". This paper is in press in the Journal of Family Violence. It focuses on the barriers that exist in the help-seeking process of IPV victims residing in rural areas.

Chapter Seven presents an article that seeks to answer objective five on key informants' perspectives regarding IPV in rural areas. The paper is titled *'Understanding intimate partner violence in rural areas: Engaging service providers intervening in Chimanimani (Zimbabwe).* This paper is under review in the *Journal of Progressive Human Services.* The perspectives of service providers with regard to IPV experiences and interventions in rural areas are explored through interviewing different service providers at different levels in this paper.

Chapter Eight presents culture-informed practice guidelines for social work practice in rural areas. This paper is titled *Intimate partner violence in rural areas: Proposed cultural-relevant practice guidelines for social workers* and is linked to objective six, which focuses on the formulation of practice guidelines for social work practice that respond to the unique needs of IPV victims in rural areas. This paper was submitted to the *Journal of Social Development in Africa*

Chapter Nine concludes the thesis by discussing the study strengths and limitations. An outline of the recommendations and issues to consider in future research, policy and practice is also presented.

1.9 ROLES AND RESPONSIBILITIES

As presented previously in the List of Publications, the candidate was the first author in all the scholarly articles and made a fundamental contribution to the study. The candidate formulated the research title and design of the research, which was a three-way process (data collection, data analysis and writing of the manuscripts and the thesis). The candidate transcribed all the audio-recorded interviews. It was her responsibility to search for suitable accredited peer-reviewed journals for potential submission. This included checking the scope of the journal in relation to the PhD study, word limit and referencing style and turnaround period. It was the responsibility of the candidate to ensure that the manuscripts conformed to the journal scope, writing and referencing styles. All the manuscripts were submitted to a professional language editor before submission to the respective journals. The candidate ensured that the manuscripts were submitted to the supervisor for review before submission to the journal. In addition, the

supervisor guided the candidate in formatting, content alignment and responding to the journal reviewer's feedback. However, it was the responsibility of the candidate to ensure that all the feedback from the journal reviewers was addressed in a timely manner. In addition, the candidate was the main contact person for all submissions. The PhD supervisor served in an advisory, mentoring and guiding role in the PhD process.

1.10 CONCLUSION

This chapter presented an overview of the study. The background of the study, the statement problem and the objectives of the study are explained, as well as the structure of the thesis. The next chapter will examine the theoretical framework that informed this study.

CHAPTER 2
THEORETICAL FRAMEWORK

2.1 INTRODUCTION

This chapter presents the theoretical framework adopted for this study. This study adopted intersectional feminism to better understand and explain IPV in rural areas. The articles presented in the subsequent chapters have presented sections on intersectional feminism; hence this chapter provides deeper discussions on information that was not presented in the articles.

2.2 INTERSECTIONAL FEMINISM

2.2.1 History of Feminism

The historical development of feminism takes into account different periods/ 'waves' whereby diverse women's issues were addressed, different questions were posed and women's roles (in the public and/or private realms) were challenged. The first wave of feminism in the 19th century to the early 20th century was centralised on the legal inequalities and addressing issues related to the suffering of women (Enyew & Mihrete, 2018). The goal was to open up opportunities and this first wave has been credited for forging a new path for women to gain agency and autonomy (Enyew & Mihrete, 2018). The second wave (1960s-1980s) broadened the feminism debate to include cultural and gender inequalities. It concerned itself with the issues related to the workplace and with crediting equality to domestic issues related to marriages and sexual liberation (Zeitz, 2008). Snyder (2008) argues that in simpler terms, second wave feminists were of the view that in patriarchal societies women tend to have common experiences and when they share these experiences, they are able to identify potential solutions to their problems. The increasing professional and economic power and status that was achieved by women from the second wave paved the way for the third wave (Vukoicic, 2013). The second wave feminist theories tended to assume the universalisation of their experiences as women's experiences of oppression (Mack-Canty, 2004). The third wave feminism emerged with new emphasis on the recognition of diversity and the differing and often interrelated oppressions of women. This feminist thinking also paved the way for further discussions with recent works being reported on 'womanism' (Bhagyathara, 2015) and

'ecofeminism' (recognising the similarities between the domination of women by men in relation to how people dominate the environment and the dismantling of the dominating oppressive structures) (Mukherjee, 2013) and 'African feminism' (Kabore, 2017).

The different periods of feminist waves were categorised to include various types of feminism such as gender reform feminisms (e.g. liberal feminism, Marxist and socialist feminism), gender resistant feminisms (e.g. radical feminism, lesbian feminism, psychoanalytical feminism) and gender revolution feminisms (e.g. multi-ethnic feminism, postmodern feminism). Liberal feminism is argued to be the most dominant and the groundwork for other feminist groups (Enyew & Mihrete, 2018). Liberal feminists believe that gender inequality is created by reducing access to civil rights and allocation of social resources like education of girls (Enyew & Mihrete, 2018). Gender resistant feminisms, such as radical feminism, emerged from the adverse reaction of the 1960s on liberal feminism (Vukoicic, 2013). Radical feminism focuses on male oppression of women and during the 1970s, radical feminism went further to argue against the biological predisposition of rape and indicated that rape was based on the socialisation of men that condoned the objectification of women (Vukoicic, 2013). Overall, radical feminism focuses on denouncing patriarchal ideologies, which result in women being victimised through rape and domestic violence (Diamond, 2009; Vukoicic, 2013). This has paved the way for current debates that focus on questions on sexuality, gender and on discussions on politics of identity.

2.2.2 Historical background of Intersectional Feminism

The origins of intersectionality emerged with feminist and womanist scholars of colour who argued that feminist scholarship at that time was focused more on middle class white women than on a comprehensive view of women's position that recognises the interconnectedness of gender with other significant identities (Rice et al., 2019; Shields, 2008). The concept of intersecting categories of oppression and discrimination was introduced and later expanded by Black Feminist legal scholar Kimberele Williams Crenshaw in 1989, when she studied migrant women who were survivors of rape. In 1991, Crenshaw further elaborated on intersectionality to demonstrate the shortcomings of approaches which tend to separate system of oppression and only focus on one while occluding the others (Carastathisis, 2014). In her widely read essay *Mapping the Margin*, Crenshaw offers a three-fold positive definition of intersections as comprising structural intersectionality, representative intersectionality and political

intersectionality. She explained that structural intersectionality comprises the ways in which the location of women of colour and the intersection of gender and race makes their experience of domestic violence different from white women. In political and representative intersectionality, she argues that the production of women of colour that is drawn on sexist and racist narratives can marginalise or reproduce the objectification of women (Carastathisis, 2014). This was significant in this study as it provided pathways in understanding the politics of location and how it intersects with gender in making the IPV experiences of women residing in rural areas unique and different to those of women residing in urban areas.

In feminist theory, intersectionality has become the significant way of conceptualising relations between different systems of oppression that conduct women's multiple identities (Barrios et al., 2020; Carastathisis, 2014). Since critics have argued that feminism claims to speak universally for all women, feminists have been aware of the limitation of gender as a single analytical category that explains the oppression of women (Joy, 2019; McCall, 2005). Therefore, since the 1980s feminist critics growingly utilised intersectionality to better understand the interconnectedness of gender to other social variables (e.g. ethnicity, race, and sexual orientation) (Shields, 2008). In feminist theory, it has become common cause that women's lives are built upon multiple intersecting systems of oppression. Intersectional feminism has thus been embraced by feminists because of its contribution to women's studies.

2.3 INTERSECTIONAL FEMINISM AS A PARADIGM

The intersectionality perspective highlights the extent to which individuals' social identity influences their beliefs and experiences of gender (Sandberg, 2013). From a feminist perspective, researchers understand that the individual's social location in relation to the interlinked identities must be at the forefront in any examination of oppression of women (Sandberg; 2013; Shields, 2008). Shields (2008) further dissects the concept of intersectionality by explaining 'identities' in this regard. Identities are conceptualised as social categories where individuals claim membership and personal meaning associated with the categories (Shields, 2008). The definition of intersectionality varies depending on context and situations but a consistent thread in various definitions is that social identities mutually constitute and reinforce one another (Barrios et al., 2020; Carastathis, 2014; Crenshaw, 1991; Kulkarni, 2019; Shields, 2008). This implies that no single social variable can fully explain the gender inequality and oppression of women; rather the different social categories influence one another in facilitating

inequality. Shields (2008) further argues that an intersectional position may be a disadvantage to one group but an advantage to another group. For example, women in urban areas in Zimbabwe may be disadvantaged as compared to their male counterparts considering the subservient position of women but might be advantaged when compared to rural women in terms of resource allocation and awareness of IPV interventions.

Human lives are complex and multi-dimensional and individual lived experiences cannot be understood and analysed by single explanations (e.g. gender or socio-economic status) because they are impacted by the simultaneous operation of micro and macro structures and dynamics (Barrios et al., 2020; Etherington & Baker, 2018; Joy, 2019). Intersectionality feminism is against placing individuals in fixed categories and emphasises the inclusion of all identities in trying to understand their lived experiences. It further rejects the notion that individuals are the same and places greater emphasis on understanding the experiences of women through their individual experiences (Etherington & Baker, 2018; Shields, 2008). An intersectional approach to any social phenomenon centres on these interdependencies and interconnectedness in accepting that different social identities and categories are constitutive and reinforcing.

On a global level, various studies have adopted intersectional feminism to better understand the interconnectedness of different social and economic factors that play a significant role in furthering the oppression of women. Nadan et al. (2015) adopted intersectional feminism in their study on child maltreatment. The focus was on analysing the extent to which intersecting social variables such as gender, race and ethnicity contribute to child maltreatment especially within the family setting. They further argued that there is the need for increased attention being given to the role of culture by examining cultural factors that contribute to child maltreatment especially within the family setting. In a study by Few-Demo (2020), intersectional feminism was utilised to analyse the transformation of family scholarships and this study further revealed the need for refinement and advanced theorising of family dynamics.

Baird et al. (2019) utilised intersectional feminism in their study in order to analyse and conceptualise IPV-related trauma. This study emphasised the importance of an intersectional lens in understanding trauma within IPV literature as experienced by women in different contexts. Etherington and Baker (2018) applied intersectional feminism in their study on children exposed to IPV. Their findings suggested a child-centred approach that recognises the heterogeneity of children exposed to IPV and challenges the existing ‘one-size-fits-all’

intervention strategies. Although this list is not exhaustive of all the studies that utilised intersectional feminism, their main thrust was to reveal the extent to which various socio-economic factors play a significant role in shaping the experiences of oppressed women as well as the children living with them. The adoption of intersectional feminism in this study will further this debate by focusing on women residing in rural areas who are marginalised as compared to their urban counterparts (Sandberg, 2013). It will further the debate that challenges the universalisation of intervention strategies and advocates that experiences of IPV victims in rural areas be at the forefront in the formulation and implementation of intervention programmes and policies.

2.4 UNDERSTANDING IPV THROUGH THE LENS OF INTERSECTIONAL FEMINISM

Intersectionality has been applied to studies on IPV (Barrios et al., 2020; Cramer & Plummer, 2009; Etherington & Baker., 2018; Kulkani, 2019; Sandberg, 2013, Walter & Chung, 2020) and findings from these studies revealed the extent to which the interlocking social variables (e.g. religion, gender and socio-economic status) contribute to the perpetuation of IPV against women. The findings further challenge uniformity of intervention strategies across diverse population groups and recommend that service provision should be centred on how IPV victims (i.e. women or children) experience the abuse in different situations. Intersectionality suggests that women's experiences of violence can be shaped by aspects of their identity that include religion and ethnicity. Etherington and Baker (2018) argue that intersectionality is a necessary component in studying IPV and has been recognised as a crucial theoretical and empirical framework. Researchers have further argued that it is inadequate to understand IPV based on one dimension, such as gender, but important to analyse the intersection of various social variables that facilitate the perpetration of IPV and ultimately the response to it (Cramer & Plummer, 2009; Joy, 2019). They further argue that what explains IPV is not only gender, race or other social variables but also who holds power and can define the social context. For example, in analysing IPV in rural areas, gender and race are not the only aspects that explain IPV perpetuation but that social norms also regulate the social behaviours that reinforce the acceptance and normalisation of IPV (Clark et al., 2018; Riddell et al., 2009).

There is a broad range of factors that explains IPV perpetration in rural areas. Literature highlights that the peculiarities of rural life socially, economically and geographically create a

conducive environment for the perpetration of IPV (Walter & Chung, 2020). When these peculiarities intersect with social norms and gender, the impact on IPV perpetration is amplified. In studies on IPV such as Etherington and Baker (2018) and Kulkarni (2019), intersectional feminism plays a crucial role in identifying the multiple disadvantages that intersect in heightening the risk of women to this form of abuse. While rural areas are also credited for being socially cohesive (Bosch & Bergen, 2006; Riddell et al., 2009), it has been argued that the disadvantages associated with these areas provide a conducive environment for the perpetration of IPV (Wendt, 2009). Gender intersects with other social variables and they tend to influence each other (Giddens & Sutton, 2017). In many instances, these social variables impact on women's identities, experiences and struggles and are linked to the marginalisation and oppression of poor women (Davis, 2008; Hill-Collin & Bilge, 2016). For each minority status there is an accumulation of disadvantages such that women residing in rural areas are thrice disadvantaged compared to their male counterparts. Hence, intersectional feminism highlights the differences among intersectional positions in different categories (Shields, 2008). According to Sandberg (2013), intersectional feminism is not only a gender-race-class theory but also focuses on other social variables, which, if attention is not given, can increase women's vulnerability to IPV. The influence of social norms is significant in intersectional studies on rural IPV. Most of these studies have focused on the interconnectedness of gender and other social variables and it is less evident how rural/urban geographies are also linked to IPV (Etherington & Baker, 2018; Kulkani, 2019; Sandberg, 2013).

The 'politics of location' become significant in understanding varied gender and life experiences. Borsa (1990) noted that feminism conceptualised the 'politics of location' as referring to places and spaces that people inherit and occupy which frame their lives and experiences and these can be geographical or physical spaces. In this study, the politics of location refers to how rural geography as social location impacts on IPV experiences of women residing in rural communities. Rural communities are characterised by advantages such as social cohesiveness (Riddell et al., 2009) which is the foundation of collective efficacy. Collective efficacy is when community members are able to control the behaviour of individuals or groups in order to restore social order in the community (Hipp, 2016). Edwards (2015) argues that the advantages of rural areas is that collective efficacy may function to prevent other social problems (e.g. crime) but might not work in addressing IPV. Based on the nature of rural areas, Edward (2015) suggests that this collective effort may overlook IPV and discourage victims from disclosing the abuse.

Research has revealed that geographical isolation intersects with other marginalising social variables in increasing the vulnerabilities of IPV victims/survivors residing in rural areas (Sandberg, 2013). Geographical location exacerbates various levels of isolation (emotional, economic, formal social support) which places women residing in rural areas in vulnerable positions (Shields, 2008). Sandberg (2013) argues that the difference between urbanity and rurality reveals how the privilege in relation to being situated at the centre or the periphery exposes women to IPV. She further argues that the 'voiceless' characteristic of women in rural areas shows that they are at the periphery and are more susceptible to IPV. The social norms that women in rural areas in Zimbabwe subscribe to condone the hidden nature of IPV (Chireshe, 2015) and studies that do not strive to unravel these intersections between locality and cultural norms may misrepresent the experiences of IPV victims residing in rural areas. Thus, intersectional feminism strives to reveal how rurality imposes IPV vulnerability on women residing in rural areas.

Black feminist scholarship argues that women of colour cannot share the same life experience with white women and no accurate representation can be derived from such an analysis (McCall, 2005). This also applies to IPV victims in rural areas as they do not share the same experiences with women residing in urban areas. Intersectional feminism further argues that uniform intervention is not the best approach and that diverse needs require different interventions and resource allocations (Crenshaw, 1991). It is difficult to translate intervention frameworks across differing geographic and socio-economic contexts, as this can result in challenges in enforcing the interventions, limits to opportunities and meaningful interventions and causes frustration to those that attempt to meet the needs of the population (Carastathis, 2014; Crenshaw, 1991; Hill-Collins & Bilge, 2016; McCloskey et al., 2016; Walby et al., 2012). Kulkani (2019) therefore proposes intersectional feminism as more appropriate in responding to IPV against marginalised women because these women tend to experience the abuse differently as compared to women who are advantaged socio-economically.

2.5 JUSTIFICATION FOR ADOPTION OF INTERSECTIONAL FEMINISM FOR THIS STUDY

IPV studies in Zimbabwe commonly focus on prevalence, determinants, the demographic variables in urban areas and the consequences of IPV (Henderson et al., 2017; Mukamana et

al., 2020; Mukanangana et al., 2014; Shamu et al., 2016, Shamu et al., 2018). There is not much focus on IPV in rural areas and this lack of discussion on rural IPV and the relevance of place in IPV research in Zimbabwe might be a reflection of an urban norm that prioritises the urban outlook on IPV. Considering the complexity of rural culture and the multiple disadvantages associated with rural areas, understanding IPV not only entails exploring how different social variables contribute to its perpetuation. Joy (2019) argues that intersectional feminism helps researchers and practitioners in understanding and explaining the social problems facing marginalised women. Intersectional feminism further enables IPV researchers to explore how macro-level and micro-level factors intersect with gender and location in increasing the risk of women to IPV in rural areas (Barrios et al., 2020). Just as intersectionality helps to explain IPV in other contexts (Etherington & Baker, 2018; Kulkarni, 2019; Sandberg, 2013) it can also assist in understanding the experiences of women residing in rural areas in Zimbabwe with regard to IPV. Rice et al. (2019) further suggest that intersectional feminism cannot be used only by a particular social group but rather advocate that intersectionality be directed at a particular purpose of social justice. Social justice is central to social work practice and from an intersectional lens, this implies social transformation which focuses on eradicating inequality. This in turn makes intersectional feminism applicable to social work research with marginalised women.

In light of this, this study applied an intersectional feminist framework to attempt to understand the interweaving of the diverse and complex social inequalities that shape the lives of IPV-affected women in rural areas (Giddens & Sutton, 2017; Rice et al., 2020; Walter & Chung, 2020). Individuals occupy multiple demographic categories, and research that does not acknowledge these complexities misrepresents people's experiences (Bright et al., 2015). Intersectional feminism has been used in social work research (Joy, 2019; Sandberg 2013) and in IPV studies (Barrios et al., 2020; Carastathisis, 2014; Crenshaw, 1991; Hankivisky et al., 2010, Sandberg, 2013; Walter & Chung, 2020) to explain how marginalised women experience oppression which facilitates IPV. Joy (2019) argues that the preservation of human rights is key to social work practice and intersectional feminism allows social workers to understand the connectedness of different social variables and their contribution to IPV perpetration. The application of intersectional feminism to this study was helpful in understanding the uniqueness of rural IPV, how women experience and respond to it and how different systems of domination and oppression converge in increasing their vulnerability to it.

The intersectional feminism framework was important in this study as it took into consideration the values, experiences and lives of IPV-affected women in rural areas. By bringing in different intersecting social variables (rural geographical location, patriarchy, femininity) it enabled the researcher to examine how place, in this context a rural area, intersects with other social variables (such as being uneducated, unemployed and female) in increasing the vulnerability of survivors/victims of IPV (McCall, 2005; Sandberg, 2013; Hill-Collin & Bilge, 2016; Giddens & Sutton, 2017).

The different makers of identity (such as gender, religion, social norms and ability) are not independent separate systems of oppression; rather, they constitute one another. Therefore, in this study intersectional feminism revealed the multiple identities exposing the different types of discrimination and addressing the manner in which gender, patriarchy and other systems of oppression create inequalities that structure the relative position of women in rural areas (Adhena et al., 2020; Barrios et al., 2020; Masson, 2008; Giddens & Sutton, 2017; Etherington & Baker, 2018).

Etherington and Baker (2018) challenge uniform intervention and suggest that interventions should prioritise the lived experiences of IPV victims. Intersectional feminism was thus central to the study as it took into consideration the voice of the IPV victims in rural areas who are mainly excluded from mainstream interventions (Conroy, 2014; Edwards, 2015) and valuing their voice is important for effective intervention. Given that this study was aimed at developing culture-informed practice guidelines for social workers practicing within IPV contexts in rural areas, intersectional feminism was useful as it provided the lens through which context-specific and culture-informed intervention guidelines were developed. Consistent with Kulkarni (2019) and Sandberg (2013), these guidelines were developed in a way that puts the unique experiences of IPV by women living in rural areas at the forefront and considers the multiple disadvantages and interlocking systems of oppression that impacted their experiences.

2.6 CONCLUSION

This chapter presented a discussion on the theoretical framework that was adopted for this study. The discussion presented the historical background of intersectionality and feminism and an explanation on IPV and intersectional framework was presented. The reasons for

adopting this framework in relation to IPV in rural areas were explained. The following chapter will focus on the review of literature pertinent to IPV.

CHAPTER 3
LITERATURE REVIEW

3.1 INTRODUCTION

This chapter focuses on reviewing relevant literature on IPV and situates this study in alignment with the findings and gaps in literature. It focuses on the conceptualisation of IPV, its different forms and distinguishes it from other forms of violence against women. The chapter further discusses the prevalence of IPV from a global and regional context, narrowing it down to a local context where IPV will be discussed in the Zimbabwean context. As an addition and part of the literature review section, two published manuscripts are presented to further understand the influence of culture on IPV perpetration and the Zimbabwean legislative measures that are in place to minimise and prevent the occurrence of IPV in rural areas.

3.2 DOCUMENT ANALYSIS AS A RESEARCH METHODOLOGY

Conducting a literature review indicates the researcher's knowledge regarding a particular phenomenon under study (Randolph, 2009; Snyder, 2019). With proper methods used, literature reviews can stand as legitimate and publishable scholarly documents (Torraco, 2005). Researchers have argued that when conducting literature review, researchers are expected to follow the convention on how the literature review was conducted (Randolph, 2009; Snyder, 2019). In achieving the objective of the literature review, this study adopted document analysis. Bowen (2009) defines document analysis as a structured method of assessing documents (electronic and printed) and requires that data be analysed and interpreted to elicit meaning. Document analysis is appropriate for qualitative studies that are aimed at exploring common issues and contributing to the body of knowledge on a specific research discipline, hence its application to this study (Bowen, 2009). Similar to conducting primary research, document analysis is guided by research questions (Randolph, 2009). In this study, the overall objectives and the research questions of the study guided the review research questions. For example, under objective two, the review research question was developed; "*What is the relationship between social norms and IPV in rural areas?"* In the search for literature, the researcher used academic platforms such as PubMed, Google Scholar and Science Direct. The literature search was defined by the following parameters: (i) publication date: articles published within the last 16 years (2005-2021), (ii) language i.e., published in English (iii) and

focus: namely IPV and/or GBV, domestic violence, culture and rurality. Key terms used for searching the relevant articles included, but were not limited to, "IPV AND Rural areas", "Social norms and IPV", "Domestic violence, Family violence and Service provision AND Rural areas". Studies that did not focus on or included IPV, GBV or violence against women were not included. The articles were not restricted to IPV against women in Zimbabwe or South Africa only but also included studies from other countries. Similar to recommendations by researchers, the researcher utilised references from retrieved literature to further search for literature about this study (Randolph, 2009; Snyder, 2019). This process was repeated until data saturation. Relevant data relating to a particular research question were grouped together.

Document analysis in qualitative research is not without limitations. Bowen (2009) argues that documents can serve purposes other than research and do not usually provide adequate information to answer specific research questions. Yin (1994) further argues that documents are sometimes difficult to retrieve or are not accessible and this is a potential limitation when conducting qualitative analysis. These are potential flaws, although not major drawbacks, and considering the efficiency and cost-effectiveness of document analysis, its advantages override the disadvantages, hence its use in this study.

3.3 SCOPE AND NATURE OF IPV

IPV is context-specific and women experience it differently depending on their geographical, cultural and socio-economic background amongst other factors. Understanding the nature and scope of IPV is necessary as it provides a comprehensive overview of IPV and ultimately provides pathways for increasing knowledge that can assist in the prevention and minimisation of this phenomenon.

3.3.1 Conceptualisation of IPV

There are many alternative terms that have been used in the literature to refer to IPV against women: family violence, intimate partner violence, domestic violence, battered women and gender-based violence (Campbell & Mannel, 2016; Duvvury et al., 2013; Edwards, 2015; Giddens & Sutton, 2017; Hill-Collins & Bilge, 2016). Although most researchers (Dudgeon & Evanson, 2014; Edwards, 2015; Klugman et al., 2014; Klugman, 2017; McCloksey et al., 2016; Shamu et al., 2013) agree that the common forms of IPV are sexual, psychological and physical

abuse, there is less agreement on the specific acts and attitudes that constitute it (O'Campo et al., 2014; O'Campo et al., 2017). Moreover, there have been numerous debates regarding how to gauge the extent of IPV and also the exclusion of lesbians, gay, bisexual, transgender, inter-sex, queer (LGBTIQ+) and other non-heterosexual identifying persons from most IPV research (Edwards, 2015). Although such debates are beyond the scope of this study, as the focus here is on male-perpetrated violence in intimate heterosexual relationships, the way in which IPV is conceptualised in the studies of LGBTIQ+ populations (Callan et al., 2020; Rolle et al., 2018) is important in the overall conceptualisation of acts and attitudes constituting it and its subsequent management.

Although this study focuses on IPV perpetrated against females by males, it is important to recognise that women can also be perpetrators of IPV against men (Douglas & Hines, 2009). Contrary to the societal narratives that typically portray males as perpetrators and females as victims, researchers have reported on the prevalence of female-perpetrated IPV and its risk factors (Houry et al., 2008; Mackay, 2018; Sikweyiya et al., 2020; Walker et al., 2019). Arguably, male-perpetrated IPV is considered more rampant than female-perpetrated abuse (Dim, 2020; McCloskey et al., 2016). The prevalence of IPV by women in sub-Saharan Africa is considered low as compared to men. For example, 25% of women in a national study in South Africa reported having perpetrated some form of IPV as compared to the 27% of reports by men (Gass et al., 2011).

Based on the literature reviewed, there are three major forms of IPV (i.e. sexual, physical and emotional abuse). Miller (2006) identifies physical abuse as one of the frequent forms of IPV which includes kicking, punching, hitting and pushing. Researchers have argued that different forms of IPV are usually co-occurring and female IPV victims can experience them at the same time (Chireshe, 2015; Mukamana et al., 2020; Yoshihama et al., 2009). For example, emotional abuse is often accompanied by sexual and physical abuse (Fidan & Bui, 2016; Yoshihama et al., 2009). Shamu et al. (2018) concluded that emotional violence occurs simultaneously with other forms of IPV and is an important measure of the abuse in both rural and urban areas.

Considerable attention has been shifted to economic/financial abuse as researchers acknowledge that deprivation of basic needs (especially for women residing in low-income communities where poverty is rife) can also be classified as abuse (Adhena et al., 2020; Chireshe, 2015; Mashiri, 2013). Ahmadabadi et al. (2017) argues that deprivation of financial

means to secure basic needs can be classified as financial abuse. They further argue that a household with a lower source of income is associated with higher risk of IPV. Given the patriarchal nature of most societies where men are regarded as providers, when they fail to fulfil this role they transmit their frustrations to their female partners (Dim, 2020). This is also common in rural areas where unemployment is high and women mostly remain dependent on men for survival. Chireshe (2015) reports that financial abuse can be triggered when a woman asks for money from the husband who might not be able to provide it.

While sexual abuse is identified as a form of IPV, it is a debatable matter as some societies regard sex as a conjugal right in intimate relationships. In rural areas in Zimbabwe where there is strong adherence to social norms surrounding marriages and conjugal rights (Venganai, 2016), sexual violence might not be considered a form of abuse since it is regarded as a husband's right. Researchers have argued that in most societies, women are underprivileged in making decisions pertaining to their sexual needs and this has lasting implications on their reproductive health (Ali et al., 2009; Shamu et al., 2018). They further argue that this form of IPV reduces the ability of women to have a healthy sex life and heightens their risk of reproductive health complications and depression.

McCloskey et al. (2016) points out that the long-standing patriarchal ideologies and cultural norms in Africa facilitate the perpetuation of IPV. While it is acknowledged that cultural norms were developed to ensure cohesiveness and social order, researchers have also revealed that these same ideologies and social norms are being used to justify the abuse of women in intimate relationships (Matavire, 2012). For example, the payment of *lobola* (bride-price/wealth) is a cultural practice that is intended to show appreciation to the bride's family. However, Chireshe (2015) and Moono et al. (2020) argue that this practice has created pathways for the commodification of women who end up being treated as 'sex objects'. It tends to strip women of their right to sexual freedom and the safety of their bodies since denial of these conjugal rights to a male partner can result in sexual violence.

3.3.2 Understanding IPV prevalence

Research on IPV has increased and existing literature reveals how research on IPV against women residing in rural areas has been conducted in different settings using different research methods (i.e. different sampling techniques, data collection instruments and methods and data

analysis). These differences make it difficult to compare IPV prevalence and rates considering that it is context and situation-specific. It is therefore necessary to discuss IPV prevalence from a global perspective before narrowing it to a Zimbabwean context.

3.3.2.1 A global overview of IPV

IPV is prevalent around the world and past research conducted has revealed that one in three women experience IPV in their lifetime (Klugman, 2017; Ler et al., 2020; USAID, 2010). Male perpetrated IPV against their female partners remains the second most common type of sexual and gender-based violence globally (Ambikile et al., 2020; Giddens & Sutton, 2017). Although the focus of IPV against women is largely linked to developing countries, studies have indicated that it is a social problem affecting all countries in varying degrees (Duvvury et al., 2013; Klugman et al., 2014; Fidan & Bui, 2016; Klugman, 2017; Adhena et al., 2020). According to the WHO, 35% of women globally have experienced either IPV or non-sexual partner violence and 38% of the homicides of women in America result from the actions of an intimate partner (Violence against Women and Girls Resource Guide, 2014). Giddens and Sutton (2017) further report that in the United Kingdom, on average two women are killed weekly by their intimate partners while 10% of women experience domestic violence. Klugman et al. (2014) project various rates of IPV worldwide, with South Asia having the highest rate of 43%, followed by Africa and the Middle East with 40% respectively. North America has the lowest at 21%, followed by Europe and Australia at 28% and 29% respectively. Additionally, a study conducted in Brazil indicated that 30% to 37% of women reported having suffered IPV and of the total number of notified cases of violence against women, the proportion for IPV was 67% (Mascarenhas et al., 2020). The high prevalence of IPV globally has largely been attributed to underreporting coupled with beliefs and attitudes that tend to promote the subordination of women to their intimate partners (McCloskey et al., 2016). India is among the countries where reporting rates are very low, with less than 5% of the victims seeking help from police, social workers and lawyers, and the majority seeking help from the nuclear family and extended family whenever there is conflict with an intimate partner (Klugman, 2017).

3.3.2.2 African context

North Africa and sub-Saharan Africa's rate of intimate partner violence sits at 40% (Klugman et al., 2014). Women in Africa are subjected to higher rates of IPV in comparison to other

women globally (McCloskey, et al., 2016; Moono et al., 2020; Shamu et al., 2018). Violence against intimate partners is very common in many countries in Africa; Zambia has the highest rate of 90%, followed by Ethiopia with 71% (Adhena et al., 2020; Klugman et al., 2014; McCloskey et al., 2016; Moono, et al., 2020). In Tanzania, almost two in five women between the ages of 15 and 49 years have experienced physical and sexual IPV in their lifetime, with 44% of married women having experienced IPV by their current or most recent husband (Kapiga et al., 2017). Further studies reveal that four out of ten women in Tanzania experience physical IPV and three out of 10 women experience physical and/or sexual IPV (Mahenge & Stockl, 2020). Furthermore, findings from a meta-analysis indicate that the highest prevalence of violent victimisation of young women aged between 20 and 24 years was recorded in South Africa and Botswana (Decker et al., 2015 as cited in McCloskey et al., 2016). The prevalence data taken from the Southern African Development Community (SADC) Gender Protocol Barometer (2014) showed the prevalence of IPV in specific countries, with Zambia and Zimbabwe ranking the highest at 90% and 69% respectively. Recent studies reveal that these high rates of IPV in Africa are largely attributed to socio-cultural factors like wife-beating, and geographical location, amongst others (Adhena et al., 2020; Ambikile et al., 2020; Moono et al., 2020)

South Africa, a country neighbouring Zimbabwe, is one of the countries in sub-Saharan Africa with the highest prevalence of IPV where research indicates that South African women at high risk of IPV are those residing in rural areas where resources are limited (Rees et al., 2014). Pregnant women are also at a higher risk with research showing that 21% of pregnant women in South Africa experience IPV (Groves et al., 2015). Although the prevalence of intimate-partner femicide has reduced in the period 1999–2009, the rate of IPV in South Africa remains high in comparison with other countries (Abrahams et al., 2013). A study conducted on the prevalence of intimate femicide indicated that in South Africa it is the leading cause of female homicide and occurs at more than double the global rate (Matthews et al., 2014).

3.3.2.3 IPV in the Zimbabwean context

The history of IPV against women in Zimbabwe is linked to the traditional values of manhood, with women being viewed as property and being expected to be submissive to their male counterparts (Henderson et al., 2017; Mashiri, 2013). Spousal physical and sexual violence has

been singled out as the most common forms of GBV, with Mashonaland West province and Manicaland province having the highest rates at 56% and 49% respectively (ZNGBVS 2012-2015; Zimbabwe Demographic and Health Survey (ZDHS) 2010-2011). Matebeleland North rated lowest with 17%, followed by Bulawayo 29%, Matebeleland South 36%, Midlands 39%, Masvingo 40%, Harare 40%, Mashonaland East 42% and Mashonaland West 47% (ZNGBVS 2010-2015). Pursuant to that, research shows that in the age group 15-49 in Zimbabwe, 64% were abused by current husbands or partners and 27% by former husbands or partners, and this in turn makes IPV the most common form of GBV in Zimbabwe (Zimbabwe National Demographic Health Survey (ZNDHS), 2015). The year 2015 saw an increase in the rate of sexual violence against women, with 35% of women in rural areas and 34% of women in urban areas having experienced IPV often since they were 15 years old (ZNDHS, 2015). A study conducted by Shamu et al. (2018) reported high prevalence of IPV perpetration against pregnant women in Zimbabwe with more than one in five of the participating women having experienced sexual/emotional and physical IPV. Recently, a study conducted by Mukamana et al. (2020) on IPV and nutritional status of women in Zimbabwe has revealed that 43% of women reported to have experienced IPV and these statistics include women residing in both rural and urban areas although the experiences of IPV in Zimbabwe vary according to background characteristics and locality (Shamu et al., 2016).

IPV takes place within the privacy of women's homes and this has contributed significantly to the code of silence, particularly in rural areas where spousal abuse is highly privatised. Researchers have argued that in African countries, rural dwellers experience frequent and severe abuse and the prevalence is higher in rural areas than in urban areas (Adhena et al., 2020; Ambikile et al., 2020). Consistent with this assertion, Mukamana et al. (2020) reports that in Zimbabwe rural residence is one of the causes of the high and increasing prevalence of IPV against women. Given that 67% of the total population in Zimbabwe resides in rural areas with the majority being women (ZNDHS, 2015), this shows the extent to which IPV is a social problem that requires urgent intervention. The perception of IPV in Zimbabwe is that it is a domestic issue that is dealt with within the household confines, with family and relatives being the mediators (Chireshe, 2015; Fidan & Bui, 2016; Henderson et al., 2017) hence it is difficult to determine its extent in rural areas. Mashiri (2013) further argues that it is difficult to ascertain the actual extent of violence against women in Zimbabwe given the various inconsistencies in terms of definitions and the paucity of comparable studies that are required in determining the scope and prevalence of IPV in different contexts in the country. There is limited IPV literature

on Zimbabwe and most of the studies conducted are concentrated in the urban areas (Fidan & Bui, 2016; Mukanangana et al., 2014; Shamu et al., 2013). The lack of empirical studies in rural areas makes it difficult to compare trends and extent of IPV in rural Zimbabwe.

Another difficulty that Mashiri (2013) highlighted is the underreporting of IPV incidents to relevant service providers. Underreporting is more common in rural areas where there is a strong adherence to social norms that encourage the privatisation of IPV (Klugman, 2017; Riddell, et al., 2009). As Klugman (2017) argues, underreporting makes it difficult to record IPV data that is essential to policy making and drafting context-specific intervention programmes that respond to the needs of the victims. Despite the gains made by the government of Zimbabwe to develop interventions, victims of IPV still find it difficult to report. Research indicates that 51% of victims in rural areas have never sought help and 12% confided in someone. Here the family appears to play a critical role, as approximately 61% indicated that they reported either sexual or physical violence to their own family while 1% reported to doctors and 11% reported to the police (ZNDHS 2010-2011). This aligns with research by Matavire (2012), who argues that family and community play a pivotal role in the arbitration of family conflict, and as a result, women who become victims of IPV believe that the family and in-laws are the only sources of help whenever there is a need. This may in part explain why underreporting remains a problem.

Zimbabwe is a patriarchal society and women occupy the lowest positions in the household. Gender traditionalism puts women in Zimbabwe in a subordinate position that makes them more susceptible to IPV (Fidan & Bui, 2016; Shamu et al., 2018). In the Shona culture, morality is determined by social norms and in rural areas, the chiefs and the village heads are the custodians of these norms (Chigwata, 2016). Morality is centred on the principle of *unhu* (personhood) (Matavire, 2012). One way of expressing *unhu* requires women to display unquestionable respect to their husbands. On the other hand, in the natal family men are regarded as the ultimate decision-makers and are allowed to discipline an errant wife as a form of love and care towards her (Chireshe, 2015; Matavire, 2012). Moreover, rural areas in Zimbabwe are largely characterised by remoteness, social cohesion, public visibility and strong adherence to social norms and patriarchal ideologies that obscure IPV (Riddell et al., 2009). All these factors play a significant role in heightening women's risk of IPV. These long-standing patriarchal ideologies and social norms have perpetuated unequal gender relations, which places women at an increased risk of IPV.

3.4 FACTORS CONTRIBUTING TO IPV

IPV can be experienced by women residing in both rural and urban areas and understanding the factors behind its perpetration is necessary in order to determine the extent thereof. Efforts to minimise and prevent IPV may be futile if there is no adequate understanding of the underlying factors contributing to the high perpetuation of IPV. For effective social work, intervention in IPV dominated contexts, it is imperative to understand the factors contributing to IPV perpetration and its increasing prevalence. Understanding these factors is important in designing appropriate social work intervention programmes for IPV victims in rural areas.

Previous research conducted on IPV has revealed the interconnectedness of different risk factors and different levels that heighten the risk of women to IPV (Heise & Kotsadam, 2015; Montesanti & Thurston, 2015). This section explains the main factors contributing to IPV that will be systematically discussed in three levels i.e. macro, meso and micro levels. An ecological model by Thurston and Vissandjee (2005) (Figure 1) is useful in understanding the interconnectedness of different micro, meso and macro levels that shape IPV against women. Although this multilevel model is based on the health and migration contexts, it also focuses on known determinants of health that can influence IPV perpetration and it is, thus, applicable in this study.

Figure 1

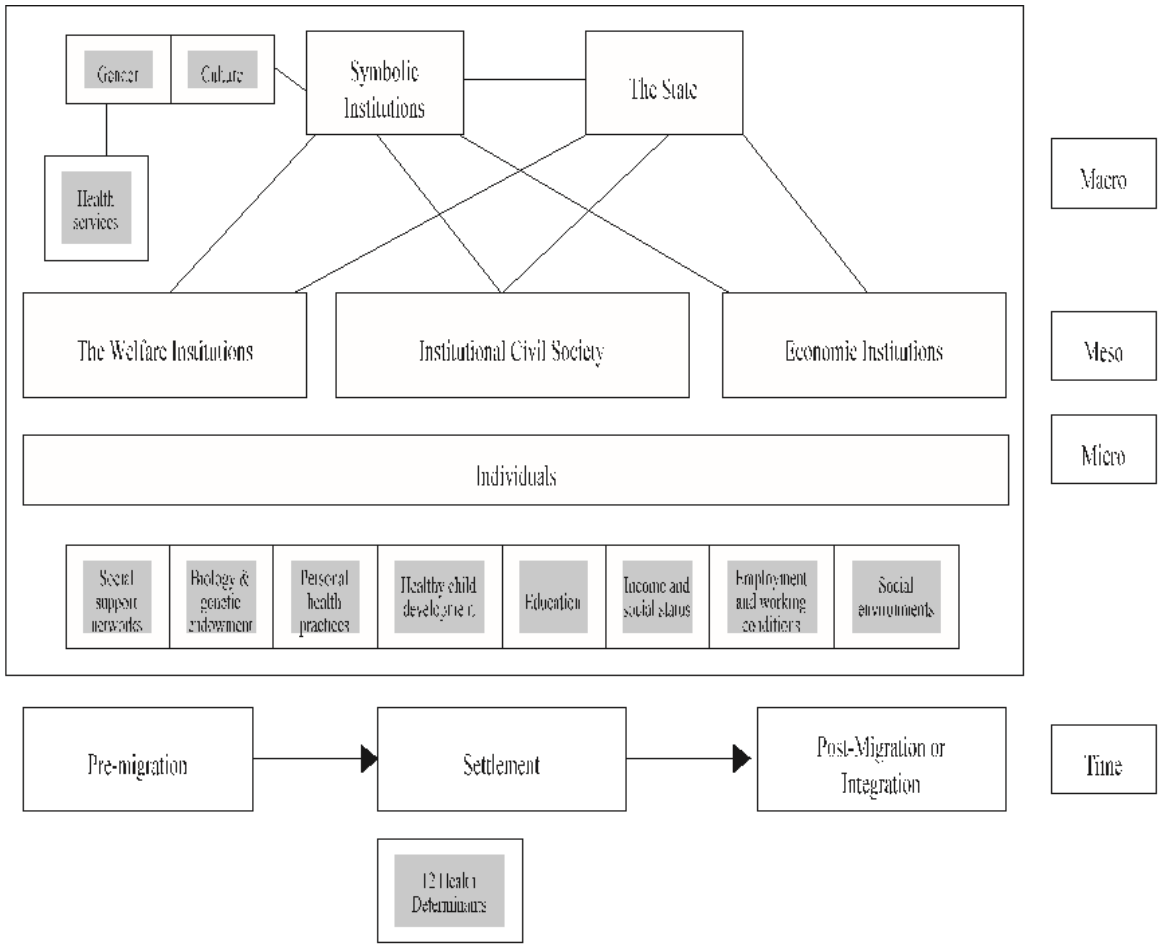


Figure 1. Ecological model of migration, gender and health.

Source: Thurston and Vissandjee (2005)

3.4.1. Micro Level

There are different micro level factors (i.e. individual relationships of victims and age) that are linked to IPV. However, in this section, the discussion will focus on two common factors namely excessive consumption of alcohol and past childhood experiences of abuse.

Alcohol and substance abuse have been identified as one of the major forces behind the perpetuation of IPV against women. Researchers have argued that excessive alcohol intake and dependence are regarded as catalysts in IPV perpetration as it is linked with loss of self-control

and judgement (Gass et al., 2011). On the contrary, when women consume alcohol excessively they defy gender norms and this often attracts 'punishment' from the husband (McCloskey et al., 2016). This implies that, whether women drink alcohol or not, they are still at a high risk of IPV if their partners consume alcohol. Studies conducted in rural areas in Nigeria have shown a strong link between alcohol and IPV perpetration (Brisibe et al., 2012). In addition, Eckhardt et al. (2015) reported that alcohol intoxication increases negative and aggressive behaviour which facilitates IPV perpetration. Although past research indicates that victims of IPV often resort to excessive consumption of alcohol in dealing with IPV, women in rural areas in Zimbabwe rarely resort to alcohol consumption in dealing with the abuse and a woman who is seen drunk is regarded as 'loose', where in most cases the behaviour warrants social sanctioning (Chireshe, 2015; Matavire, 2012). The influence of social norms around patriarchy is visible and alcohol consumption by men is condoned while females who drink alcohol are regarded as errant wives. Recent studies on IPV have indicated how alcohol consumption raises conflicts, heightens aggression and increases the women's risk of IPV (Dim, 2020; Ler et al., 2020). Consequently, disagreements or different opinions under the influence of alcohol may lead to violent behaviours and this in turn increases women's risk of IPV.

There have been considerable studies conducted on how childhood experiences of abuse can lead to IPV perpetration at a later stage (Abramsky et al., 2011). The intergenerational cycle of IPV has been extensively documented in different settings. Gass et al. (2011) argue that childhood experiences coupled with exposure to IPV in the family environment predicted IPV in both men and women. Women who were exposed to IPV also tend to normalise abuse and regard it as acceptable behaviour. Furthermore, victims and perpetrators of IPV in a South African and Ugandan study reported that they were exposed to IPV in their childhood (McCloskey et al., 2016; Roman & Frantz, 2013). Webberman et al., (2014) reports that there are significant associations between IPV and child maltreatment as evidenced by the high rates of IPV among child maltreatment patients. Fulu et al. (2017) reports that children who witness IPV in the home environment are at a greater risk of either experiencing or perpetrating IPV in their adult life. As a result, women who grew up in IPV-dominated households tend to normalise IPV and ultimately regard it as the best way to resolve conflicts and misunderstandings in the home. A study in Cameroon reveals the association between physical abuse experienced by mothers and IPV experiences in adult life (Wadji et al., 2020). Similarly, a study in Nigeria revealed how witnessing IPV as a child can inform a subconscious normalisation and acceptance of IPV as the right way of resolving conflicts (Dim, 2020).

Eriksson and Mazerolle (2015) augments the argument and notes that the social learning theory by Albert Bandura provides a clear explanation on how past experiences of IPV influence IPV perpetration. They further argue that the exposure of children to IPV in the home predicts IPV in their adult life. IPV is transmitted through direct experiences and vicarious observations such that female children are likely to model their behaviour on that of their mothers (i.e. placating and accepting violence) and male children will model the behaviour of their fathers (i.e. being aggressive in solving conflicts.) Overall, early experiences and exposure of children to IPV stand out as salient predictors of IPV in adult life (Eriksson & Mazorelle, 2015).

3.4.2 Meso Level Factors

Meso level factors that contribute to IPV perpetration are essential in understanding the IPV experiences of women residing in rural areas. These factors highlight how interpersonal relationships, networks and beliefs influence the perpetration of IPV against women. The discussion below will focus on the common meso level factors that were identified which are traditional gender roles, poverty and family.

Traditional gender roles and attitudes in this context refer to beliefs pertaining to the way men and women are supposed to think and behave in heterosexual relationships. This entails how community norms play a role in influencing their behaviour and decision-making in intimate relationships. Shamu et al. (2018) reports that from a gender norms perspective, IPV is viewed as a result of how women are socialised into accepting and justifying the abuse and being sexually passive. Gender norms can also perpetuate toxic hyper-masculinities and male controlling behaviours against female intimate partners. Researchers have argued that men with most traditional masculine gender beliefs and ideologies are more likely to perpetrate and rationalise IPV (McCloskey et al., 2016; Sikweyiya et al., 2020). Hegemonic masculinity supports male domination where men are regarded as heads of households and their decisions are not questioned. Sikweyiya et al. (2020) reports that traditional masculinity displayed by men is embedded in patriarchal power relations where men are positioned as controlling and dominant over women. They further argue that women are not only expected to be submissive but also to demonstrate unquestioning respect. A study in the Luhya community in Kenya and also among the Tiv-speaking people in Nigeria revealed that the beating of wives in marriages is regarded as an indication of love and affection which women in these societies have been socialised to accept (Oyediran & Feyisetan, 2017). Similarly, a study conducted by Antai and

Antai (2009) has shown that wife-beating is widely accepted and justified amongst women who subscribe to patriarchy. Rural areas are found to be at a greater risk of IPV tolerance and justification given the influence of social norms that promote the subjugation of women in intimate relationships (Adhena et al., 2020; Antai & Antai, 2009; Dim, 2020; Riddell, et al., 2009; Fidan & Bui, 2016).

Poverty escalates the risk of IPV (Goodman et al., 2009). Heise and Garcia-Moreno (2002) report that across various global contexts, most women living in poverty are affected by IPV. Financial strain tends to decrease women's capacity to make choices and decisions about their well-being in abusive relationships. A study conducted in Zimbabwe indicates that poverty is a strong factor contributing to IPV as poor women in rural areas are heavily dependent on their partners which tends to limit their bargaining power (Mukamana et al., 2020). Considering the nature of rural areas where poverty is widespread and the unemployment rate is high, women residing in these areas are more prone to IPV. The stress of unemployment and lack of stable income tend to trigger discord and frustration that ultimately result in partner abuse (McCloskey et al., 2016). Within a dysfunctional family setting, poverty can be either a cause or a consequence of IPV (Ahmadabadi et al., 2017). A recent study on IPV in Ghana revealed that the vulnerability of women to IPV is heightened by their limited access to resources that tend to create over-reliance on male partners (Modie-Moroka, 2010; Sikweyiya et al., 2020). Furthering this argument, Dim (2020) reports that the fact that the economic resources of women in rural areas revolve around agriculture result in the husband assuming authority over the economic affairs of the wife's input and output. This is similar in India where low socio-economic status is regarded as a stressor that can lead to IPV (Ler et al., 2020). Such economic disempowerment makes women in rural areas highly reliant on their partner and vulnerable to IPV. This is in part one factor that influences the high rates of IPV in rural areas.

In the same vein, Ahmadabadi et al. (2017) explains that poverty causes financial stress and insecurity, which contribute to the frustrations and powerlessness that ultimately encourage men to display violent behaviour towards their intimate partners. Jewkes (2002) argues that the link between poverty and violence in intimate relationships can be mediated through masculine identity. Men living in poverty normally find it difficult to live up to their ideas of success and manhood and as a consequence vent their frustrations on women. Poverty tends to strip men of their self-esteem and dignity and IPV against women becomes a norm especially in situations where they fail to support them financially. In this regard, IPV is not seen because of male

dominance and control only but is also rooted in male vulnerability that emerges from societal expectations that are unachievable because of poverty (Goodman et al., 2009; Jewkes, 2002). Similarly, male identity is usually associated with power and dominance and when this identity is threatened by poverty, it triggers a crisis of male identity. Consequently, IPV becomes a way of resolving these issues because it allows men to express power, control and dominance that is denied elsewhere (Jewkes, 2002).

Researchers have identified the natal family as one of the common factors that contribute to IPV perpetration (Bosch & Bergen, 2006; Capaldi et al., 2012). The family plays a significant role in furthering the status quo of male dominance in intimate relationships. Culturally the natal family (particularly that of the female partner) is mandated with the task to maintain and preserve marriages (Matavire, 2012). Marital conflicts are believed to be best solved within the family thus in the Shona culture whenever a woman is facing abuse from the husband, the expectation is that the natal family (where she is likely to get support) tries to de-escalate the conflicts by ensuring that the woman unquestionably respects the husband and submit to him. Although the family might not directly cause IPV, the level of support that IPV victims get from their families plays a pivotal role on how they respond and react to IPV. Thus, Chireshe (2015) and Riddell et al. (2009) argue that IPV victims, particularly in rural areas where there is strong adherence to social norms, end up accepting and normalising IPV.

3.4.3 Macro Level Factors

Understanding macro level factors that contribute to IPV perpetration is crucial in its amelioration. There are several macro-level factors that play a significant role in IPV perpetration. However, the following discussion will focus on the common factors that were identified which are weak legal provisions and religion.

Religion has been identified as one of the main macro-level factors that contribute to IPV perpetration (Al-Tawil, 2012; Kovacs, 2018). Generally, religion is viewed as a coping strategy that is utilised by IPV victims (Zakar et al., 2012). However, researchers have argued that although religion can provide healing and support to IPV victims, religious institutions and leaders perpetuate silence about abuse that ultimately exposes victims to further abuse (Katerndahl et al., 2015; Kovacs, 2018). Kovacs (2018) highlights the significant role that religion plays in IPV perpetration and reports on the experiences of Muslim and Christian

women with the former reporting low levels of IPV disclosure. Sikweyiya et al. (2020) argues that men use religion in substantiating their positions as heads of households and use the authority of God's law to defend the subjection of women, which ultimately results in IPV. In rural areas where there is strong adherence to cultural norms (Chigwata, 2016), divine decrees are used to further the dominance of these cultural norms that condone IPV. Sikweyiya et al. (2020) further argue that men may believe that their God-given role being head of household should not be challenged and women are expected to demonstrate unquestionable respect towards them. This increases the risk of women to IPV. Chisale (2018) furthers the argument and reveals that religious churches discourage women from leaving abusive husbands as it is against God's will as stipulated in Malachi 2:16, Matthew 19:6 and 1 Corinthians 7:10. Religion is, therefore, used to uphold IPV through naïve Bible interpretations, for example Proverbs 21:9 which condemns a quarrelsome wife, and which provide justification for the abuse, as well as Colossians 3:18 that encourages women to be submissive to their husbands.

Kovacs (2018) identified weak legal provisions on IPV as one of the main factors contributing to IPV perpetration. In the study it was revealed that women residing in countries with legal provision on IPV are at a lower risk of experiencing abuse as compared to women residing in countries where such legal frameworks do not exist (Kovacs, 2018). Legislative frameworks contain norms that can be formalised in legal controls and ultimately reinforce patriarchy (Chigwata, 2016; Montesanti & Thurston, 2015; Sikweyiya et al., 2020). The interplay of micro level factors and macro level factors is clear, as there is a link between the laws on IPV and the characteristics of women and their partners. Kovacs et al. (2013) argues that uneducated and marginalised women in rural areas might simply not be aware of IPV legislation given the geographical isolation of rural areas that makes service provision difficult (Bosch & Bergen, 2006). They further argue that even if these women are aware of the legal provisions, they might fail to follow through with the legal proceedings as they lack adequate resources.

3.5 IPV AND THE CYCLE OF VIOLENCE

One of the main challenges in relation to IPV is that victims are blamed for the perpetration of IPV and judged for staying or leaving abusive relationships (Davhana-Maselese, 2011). Questions pertaining to the reasons why victims of IPV stay in abusive relationships are often asked and this brings to the fore the discussion on the cycle of violence as a framework that better explains the reasons why women tend to stay in abusive relationships. The process of

leaving or staying in an abusive relationship has been considerably researched (Barrios et al., 2020; Davhana-Maselesa, 2011) and conclusions from these studies suggest that the reasons why women leave or stay in abusive relationships varies depending on context and circumstances. In this study, the stay/leave phenomenon is best understood in accordance with the cycle of violence theory proposed by Lenore Walker.

Walker (1984) states that they are three distinct phases in all abusive relationships. These phases are the tension-building stage, the acute stage and the honeymoon stage. The tension stage is when the tension builds up in the relationships and it reaches a point where the perpetrator becomes violent and aggressive (acute phase). In the acute phase, the perpetrator abuses the victim physically, either emotionally or sexually. When the violent episodes pass the perpetrator might apologise and vows to never abuse the victim again (honeymoon phase). Davhana-Maselese (2011) argues that when the honeymoon phase fades, usually the victim is left with a cycle of tension building that can lead to emotional and medical problems such as depression and injuries.

Women are caught up in the abusive cycle with their partners and these phases of the cycle of violence describe how women are trapped in abusive relationships. IPV is rarely a single isolated incident but rather an ongoing process of abuse as indicated by studies (Conroy, 2014; Fidan & Bui, 2016; Goodman et al., 2009). This ongoing process is not only detrimental to women but also to children living in the home. The three phases of abuse tend to keep IPV in motion and compels women to endure the abuse. When a perpetrator apologises for the abusive behaviour, victims often hope for positive change in the relationship. Researchers have argued that in most cases this abuse will not stop regardless of the 'apologies' from the perpetrator and the abuse becomes more intense when the victim attempts to leave the perpetrator (Chireshe, 2015; Davhana-Maselesa, 2011). This is worse in rural areas where victims of IPV are expected to adhere to the code of silence (Riddell et al., 2009). Thus, for those victims who attempt to exit the IPV-dominated relationship and seek assistance, there is a higher risk of frequent and severe IPV (Bosch & Bergen, 2006; Matavire, 2012; Mashiri, 2013).

Barrios et al. (2020) further examined the stay/leave phenomenon and concluded that socio-cultural factors, individual factors and access to formal services tend to keep the cycle of IPV in motion and influence the decision to leave or stay in abusive relationships. The intersection of these factors creates unique circumstances that influence decision-making amongst IPV

victims. Considering the nature of rural areas, the socio-cultural factors and limited access to formal resources tend to play a significant role in the IPV victims' decision to stay in an abusive relationship. Various studies conducted on IPV (Bosch & Bergen, 2006; Conroy, 2014; Sandberg, 2013; Mukamana et al., 2020) note the influence of inadequate intervention resources and social norms on IPV perpetration and ultimately the response to it. In rural areas women resort to staying in abusive relationships considering the influence of social norms as well as the inadequate intervention resources that are critical in responding to the needs of IPV victims.

Figure 2: The cycle of violence



Source: http://www.center4research.org/the-cycle-of-domestic-violence/

3.6 CONSEQUENCES OF IPV

IPV as a widespread social problem and violation of human rights has grave consequences on the welfare of women and children. Understanding the effects of IPV is critical in developing context-specific and culture-informed interventions that respond to the needs of IPV victims in rural areas. In this section, the broad consequences of IPV will be presented as follows: psychological effects, social effects, developmental effects on exposed children, reproductive health effects and HIV/AIDS.

3.6.1 Psychological effects

IPV is typically viewed as a public health problem with grave consequences for the mental health of its victims. One of the most common mental health consequences of IPV has been reported as mood disorders (Delara, 2016). Researchers have further argued that post-traumatic

stress disorder (PTSD) and suicidal ideation are often identified as the psychological effects of IPV on individuals, particularly victims (Blodgett & Lanigan, 2018; Delara, 2016; Duvvury et al., 2013; Karakurt et al., 2014; McCloskey et al., 2016). The severity and frequency of IPV play a significant role on the mental health consequences of IPV. The situation is exacerbated in rural areas where mental health in general is overlooked and mental health services are scarce (Verngust, 2018). Findings from a study by Esie et al. (2019) on IPV in rural Bangladesh indicate that the most elevated risk of depression is mostly pronounced for physical and injurious IPV and increased severity of the abuse corresponded to an increased risk of depressive episodes. Furthermore, Shamu et al. (2016) in their study on IPV amongst pregnant women in Zimbabwe, indicate that when emotional violence co-occurs alongside physical and/or sexual violence, the relationship between IPV depression and suicidality also strengthens. They further report that IPV during pregnancy was associated with high post-natal depression and suicide ideation. Similarly, a study conducted in Rwanda revealed that women who are exposed to IPV met the criteria of psychiatric disorders and depression was the most common diagnosis (McCloskey et al., 2016).

Chronic psychological stress emanating from the abuse also indirectly affects the psychological well-being of women, hence they have trouble in performing their daily activities and in worst-case scenarios, they can resort to substance abuse as a way of de-stressing (Coker et al., 2004; Delara, 2016). This is of significance considering that women in rural areas rely on subsistence farming, and the inability to perform their daily work due to chronic stress compromises their ability to provide food for their family. Woollet and Hatcher (2016) argue that for IPV victims living with HIV/AIDS, the psychological consequences of IPV are catastrophic. Chronic traumatic stress associated with IPV tends to accelerate disease progression by suppressing the immune system that ultimately causes ill-health amongst IPV victims. In worst-case scenarios, this can also affect the uptake of medication such as antiretroviral drugs.

3.6.2 Social effects

Researchers have argued that IPV is a pervasive social problem that has detrimental effects on the social functioning of women and children (Lanier & Maume, 2009; Sandberg, 2013). They further argued that IPV can often lead to poor social functioning, social isolation and marginalisation (Riddell et al., 2009). Women who have been abused tend to withdraw from their families and peers and this often leads to subsequent problems in their social functioning

and well-being. Lanier and Maume (2009) argue that not only does IPV affect the social functioning of victims but it also affects the family. They singled out social isolation as one of the significant social effects of IPV the same way it dramatically increases vulnerability to the abuse (Goodman & Epstein, 2009). Social isolation in this context refers to loneliness and rejection by others (Lanier & Maume, 2009). Netto et al. (2017) argues that social isolation of IPV victims can also occur as a restriction of freedom imposed by the perpetrator so as to weaken their support systems and pull them away from their social life. This subsequently led to further abuse. Women who cannot identify other people that they can talk to or share their problems with after the abuse besides the abusive partner are more susceptible to frequent IPV. Researchers have argued that the COVID-19 pandemic has intensified social isolation and loneliness and this creates a vicious cycle of IPV (Goodman & Epstein, 2020). The pandemic has disrupted social ties and ultimately produced increased isolation from friends, family and the community at large that can provide support to the victims. The situation worsens in rural areas where there is geographical isolation and a strong adherence to social norms that condone the hidden nature of IPV (Edwards, 2015; Riddell et al., 2009). This strong adherence to social norms causes most IPV victims to shy away from disclosing their IPV experiences to friends and families for fear of stigma and shame.

3.6.3 Developmental effects on children

Anderson and van Ee (2018) point out that children in an IPV dominated home are equal victims of the neglect and physical/emotional abuse from their parents. Children are exposed differently to IPV, by virtually or audibly witnessing the violence as well as seeing its effects on their parents (e.g. bruises and wounds) (Carpenter & Stacks, 2009). This suggests that children living in IPV dominated homes in rural areas are exposed differently and given the nature of rural areas, they are at a higher risk of experiencing IPV as secondary victims (Callaghan et al., 2018). They may also witness violence in the home environment through disarray, evidence of blood or damage to the dwelling. Peterson et al. (2018) suggests that IPV affects the ability of abused women to effectively parent their children. They further argue that female victims of IPV display higher parenting stress and use and ineffective parenting behaviour (e.g. beating and kicking) as well as reduced use of effective parenting (e.g. parental affection). Bowen (2015) indicated that children exposed to IPV were more likely to have a mother who reported higher levels of depression that adversely affected her parenting. Carpenter and Stacks (2009) pointed out that children who hear or witness unresolved conflict

between parents may show symptoms of PTSD that includes eating problems and sleep disturbances. Furthermore, the continual exposure to IPV can affect emotion regulation, which also affects the psychological well-being of children. Hyper-arousal symptoms that reflect emotion regulation include excessive crying and frequent temper tantrums (Carpenter & Stacks, 2009).

IPV has been linked with delayed language development amongst children who are exposed to the abuse. Peterson et al. (2018) studied the impact of IPV on language development amongst children, reporting that exposure to IPV in the first year of life in a home is associated with language development at three years of age. They further argued that early exposure to IPV has direct effects on children's expressive language development even if the home environment is of high quality and the child's basic needs are being met. This can be linked to children's inability to express themselves in a hostile and violent environment. The fear of the perpetrator parent also contributes to the child's ability to express themselves even outside the home environment. Mueller and Tronick (2019) suggests that exposure to IPV over the first five years of life can have lasting effects on cognitive development with exposed children reported to have lower Intelligence Quotient (IQ) levels. These consequences of IPV on children coupled with the disorder and attention deficit have been reported to contribute to the perpetration and normalisation of IPV in adult life (Barrios et al., 2020; Delara, 2016; Deories et al., 2016; Etherington & Baker, 2018; Giddens & Sutton, 2017; Karakurt et al., 2014; Kimball, 2016; Meekers et al., 2013; Roman & Frantz, 2013).

3.6.4 Reproductive health effects

Studies consistently demonstrate the association between IPV and reproductive health. IPV against women during pregnancy increases the risk of miscarriages, infant low birth weight and obstetric complications, and this is largely exacerbated by controlling behaviours in intimate relationships (disapproval of birth control, inability to negotiate condom use, sabotaging birth control measures) (Blodgett & Lanigan, 2018; Duvvury et al., 2013; McCloskey et al., 2016; Mukanangana et al., 2014; Shamu et al., 2016; WHO, 2013). Silverman and Raj (2014) and Chamberlain and Levenson (2012) also indicate that IPV is associated with adverse reproductive outcomes amongst women and girls, and where women with abusive partners are most likely to have induced abortions. A study conducted in urban Zimbabwe reported that women who get pregnant against their husband's wishes are likely to

experience IPV (Shamu et al., 2013). Whilst they argue that pregnancy can also be protection against abuse since perpetrators might not want to harm the foetus, a high number of pregnant women experience IPV regardless of the health complications.

Researchers have reported that birth control sabotage is used as a control mechanism by perpetrators in abusive partnerships and they pose risks of unintended pregnancies (Chamberlain & Levenson, 2012; Miller et al., 2010). They further argued that women who would want to keep the pregnancy might not be allowed to do so and their abusive partner coerces them into aborting, with a significant number of women seeking abortion having a history of IPV. As regards unintended pregnancies in intimate relationships, studies in Cameroon and Zimbabwe highlighted that the prevalence of unsafe abortions due to IPV is high, and the belief that pregnancy can be a protection against physical and sexual spousal abuse is false (Alio et al.,2011; McCloskey et al., 2016; Mukanangana et al., 2014; Shamu et al., 2013). In rural areas in some parts of Africa (Zimbabwe included), women tend to seek abortion from outside the medical sphere and this may explain in part the high mortality rate in Africa due to unsafe abortions (Shamu et al., 2013).

In addition, de Sousa et al. (2014) reported that physical IPV against pregnant women is one of the chief causes of spontaneous miscarriages and abortions. They further postulate that economic abuse against pregnant women can have dire consequences on their well-being. Pregnant women require specialised care for themselves and their unborn children and lack of these adequate resources (including proper healthcare) and proper diet can also have adverse effects on both the mother and the unborn child. The situation is dire in rural areas where the majority of the women live in poverty, are unemployed, and reliant on the abuser for socio-economic support (Dim, 2020). This in turn can negatively affect the well-being of pregnant women in rural areas who experience IPV. Similarly, emotional abuse can trigger chronic psychological stress that may contribute to miscarriages. Additionally, Sakar (2008) argues that abused pregnant women are twice as likely to experience antenatal hospitalisation not associated with childbirth but rather associated with stressful events emanating from IPV. This often complicates the health of the unborn baby and the pregnant women. To this end, Martinez-Torteya et al. (2017) argue that prenatal IPV is associated with increased levels of externalising behaviours at 12 months of age.

3.6.5 Economic consequences of IPV

The economic costs of IPV are high and can be categorised into three distinct groups, namely indirect or tangible costs, opportunity costs and direct or tangible costs (Lopez-Sanchez et al., 2019). Direct costs are costs associated with the supply of services and resources to IPV victims and these costs are borne by the government (Duvvury et al., 2013; Lopez-Sanchez et al., 2019). This is a burden to some developing countries with strained financial capacity to provide adequate facilities, resources and services to IPV victims. This possibly explains why rural areas are characterised by inadequate intervention services for IPV victims (Bosch & Bergen, 2006; Riddell et al., 2009). Indirect or intangible costs refer to the pain and suffering endured by IPV victims. Lopez-Sanchez et al. (2019) argues that these costs are often termed indirect psychological or social costs and include costs that are incurred when women leave an IPV dominated relationship (e.g. costs with changing schools for children and buying household items).

Ford-Gilboe et al. (2005) suggests that the mental and physical consequences of IPV tend to reduce the capacity and ability of women to fend for themselves and their children. Similarly, Duvvury et al. (2013) argues that absenteeism from work or a reduction in production due to the abuse affects not only the victims but also their family. This is severe in rural areas where women are unemployed and reliant on subsistence farming and income generating projects to feed their families. Thus, failure to work in the fields or garden may result in failure to feed their children. Furthermore, considering that women in rural areas are involved in income generating projects, IPV has the potential of undermining independent financial decision-making as they may be compelled to surrender their profits to their partners. For some women, particularly those residing in urban areas, financial costs of legal bills, medication and therapy sessions can result in financial stress, which affects women's health (Lopez-Sanchez et al., 2019). Lopez-Sanchez et al. (2019) identify opportunity costs as costs which women lose as a result of being in IPV dominated relationships and these are included under direct costs.

3.6.6 HIV/AIDS

HIV/AIDS is widespread and has affected nearly every corner of the world with sub-Saharan Africa recording one of the highest rates. Infidelity and multiple sexual partners have been identified as one of the common pathways in the transmission of HIV in sub-Saharan Africa

(Chireshe, 2015; Conroy, 2014; McCloskey et al., 2016). It has been argued that there is a close connection between IPV and HIV/AIDS. A review of the 12-country demographic survey in sub-Saharan Africa shows that abusive men are more likely to have contracted HIV, and its prevalence is not because of violence or sexual coercion in marriage but because of excessive controlling behaviours, which have been referred to as 'patriarchal terrorism' (Blodgett & Lanigan, 2018; McCloskey et al., 2016). Durevall and Lindskog (2015) further point out that significant associations between IPV and HIV are recorded in regions where HIV prevalence is high. For example, in Zimbabwe where the IPV rate is high, 20% of married women are HIV-positive (Fidan & Bui, 2016).

To this end, Siemieniuk et al. (2013) suggests that the link between IPV and HIV can be direct or indirect with the most obvious direct sexual transmission being forced or coerced sex. Researchers have argued that forced sex causes micro- and macro-laceration in the genital mucosa that facilitates and creates avenues for the transmission of HIV (Kouyoumdjian et al., 2013; Siemieniuk et al., 2013; Mukanangana et al., 2014). While one sexual encounter has minor chances of transmission, frequent sexual encounters imply an increase in sexual transmission (Siemieniuk et al., 2013). Likewise, a study conducted on IPV and HIV/AIDS in rural areas in South Africa indicated that sex is more regular in IPV-dominated relationships that ultimately increases women's risk to HIV infections in IPV dominated relationships (Jewkes et al., 2006). Sexual IPV can also create indirect pathways for HIV transmission. IPV generally undermines a woman's agency in her sexual life such that she fails to negotiate safe sex (McCloskey et al., 2016). This low sexual assertiveness amongst IPV victims is largely exacerbated by social norms that condone male controlling behaviours and increase women's risk to HIV infection in intimate relationships, especially in rural areas where there is a strong adherence to such norms (Chireshe, 2015; Kouyoumdjian et al., 2013; Siemieniuk, et al., 2013; Rigby & Johnson, 2017).

IPV has negative effects on HIV management and care given that IPV victims living with HIV/AIDS are in increased contact with the health care system. Siemieniuk et al. (2013) argues that effective management of HIV requires a lifelong commitment by the patient to therapy and regular medical check-ups. IPV dominated relationships tend to impede adequate adherence considering that victims can be injured and be deprived of financial resources that are necessary for HIV treatment. The situation is exacerbated in rural areas where most women are unemployed and rely on their partners for income and food. Given the high prevalence of

economic abuse (Chireshe. 2015), IPV victims are mostly unable to adhere to HIV treatment and in some cases fail to attend essential regular medical check-ups.

3.7 IPV AND COVID-19

IPV is largely experienced in the home environment and both mothers and children living in these homes are at a heightened risk of frequent abuse. The outbreak of the coronavirus pandemic disease (COVID-19) affected men, women and children. This disease was reported to affect mostly the elderly and those with underlying conditions (Gebrewahd et al., 2020). Research has revealed gender gaps that exist in deaths from COVID-19 with more men dying from the pandemic as compared to women (Jin et al., 2020). Bwire (2020) argues that this gender gap can also be attributed to gender behaviour such as higher dependency on smoking and alcohol consumption as compared to women. Regardless of these gender gaps, Barbara et al. (2020) argues that women are at an increased risk of IPV as there has been a significant increase in cases of abuse against women globally during the COVID-19 emergency.

COVID-19 has drastically changed the lives of many people around the world and the stringent measures put in place have subjected families to critical issues and tensions. While quarantines have proven to be effective measures in controlling the spread of the virus, they can lead to significant socio-economic and mental health problems for women (van Gelder et al., 2020). During quarantine, homes have often become the most dangerous places for IPV victims as most women are at home always and this limits their contact with support systems that can assist them (e.g. families and friends) (Mazza et al., 2020). It appears that during the time of mandatory quarantine there is a higher risk of intense and frequent IPV. Gebrewahd et al. (2020) studied the frequency of IPV against women during the COVID-19 pandemic in Ethiopia that revealed that women are at an increased risk of abuse with 24.6% of the 682 participants reported to have suffered all forms of IPV during this period.

IPV against women who may have experienced IPV even before COVID-19 may have increased as a result of quarantine bringing with it socio-economic and psychological stressors as well as an increase in negative coping mechanisms (e.g. excessive alcohol intake) (Bogwell-Gray & Bartholmey, 2020; Buttell & Ferreira, 2020). The financial strain resulting from COVID-19 as people lose their jobs and sources of income due to quarantine also plays a major role in the perpetration of IPV. This is consistent with past research conducted on IPV that

highlighted how financial strain can exacerbate IPV against women (Chireshe, 2015; Goodman et al., 2009). Some researchers have argued that COVID-19 is being used as a control mechanism in IPV dominated intimate relationships as perpetrators exert control through fear and threats of contagion (Buttell & Ferreira, 2020; Mazza et al., 2020; van Gelder et al., 2020). These threats of contagion prevent women from seeking either formal or informal support systems, as they may be afraid of contracting COVID-19.

COVID-19 in rural areas in Zimbabwe signifies a collision of crises. The intersection of poverty, IPV and COVID-19 threaten the well-being of women in rural areas. On top of geographical isolation associated with rural areas and social isolation (from friends and family), mandatory quarantine can trigger an unprecedented wave of IPV in rural areas in Zimbabwe (van Gelder et al., 2020). Women in rural areas are often afraid to be alone with the abusive partners and they experience higher levels of social isolation as they are not at liberty of disclosing their IPV experiences to families (Buttell & Ferreira, 2020). This can be both out of shame and anticipated stigma associated with revealing IPV to outsiders and also fear of further infuriating the perpetrator (Sandberg, 2013; Riddell et al., 2009). Given the importance of family intervention and the role that elderly family members play in resolving marital conflicts in rural areas in Zimbabwe (Chigwata, 2016; Chireshe, 2015; Matavire, 2012; Venganai, 2016), the quarantine measures of COVID-19 which warn about keeping the elderly at home and minimising contact with them has reduced the access to traditional family assistance in rural areas. This means that IPV victims in rural areas may not be able to access these support networks and this in turn can increase their risk of intense IPV.

The preceding sections in this chapter have revealed the significant role of culture and social norms in the perpetration of IPV. Even during the period of the COVID-19 pandemic, the influence of social norms is visible as men continue to exercise controlling behaviour towards women in homes. This in turn reflects the heightened risk of women to IPV even during this period of COVID-19 pandemic. Based on this increased risk, it is also important to examine the extent to which gender legislative frameworks in Zimbabwe protect women in rural areas from IPV. Thus two articles will be presented in this chapter relating to social norms and gender legislation in Zimbabwe. An article on social norms in relation to IPV perpetration in rural areas will be presented first followed by an article focusing on examining the legislative frameworks in Zimbabwe relating to IPV in rural areas. Each article will have an introduction and a conclusion.

3.8 INTRODUCTION TO ARTICLE

Culture plays a critical role in understanding the experiences of women residing in rural areas in relation to IPV. This article links with objective two that sought to explore the role of culture on IPV experiences of women residing in rural areas. Culture in rural areas includes patriarchal views of the family, social norms that govern daily life, economic stress and public visibility (Riddell et al., 2009). Social norms are put in place to regulate social behaviour and maintain social order. Hornost and Doherty (2003) argue that rural areas are socially cohesive, share consensus in values, and their lower tolerance for diversity plays a significant role in maintaining social order. Consequently, women residing in rural areas share these beliefs and values. Regardless of the 'functional' roles of social norms in rural areas, they inadvertently conceal IPV against women and inhibit prevention efforts. For example, it promotes the privatisation of violence against women and in those societies where it is not approved; women are blamed for provoking men to engage in it (Giddens & Sutton, 2017; Morrel et al., 2012; Oyideran & Feyisetan, 2017). Social norms surrounding the privatisation of IPV heighten the desire to protect one's private matters; hence women in rural areas are reluctant to open up and seek help from formal service providers for fear of further abuse and community rejection. In order to have a nuanced understanding of the experiences of women residing in rural areas regarding intimate partner violence, it is important to understand the role that culture plays in the perpetuation of IPV. Given the nature of rural areas where there is a strong adherence to social norms that govern everyday life, IPV cannot be de-linked with culture. It is in this context that this article sought to explore the role of culture in IPV experiences of women in rural areas. The article discusses social norms in the context of rural areas and how they may enable or hinder the prevention of IPV interventions.

3.8.1 PRESENTATION OF ARTICLE 1

Chadambuka, C. & Warria, A. (2019). Hurt or help? Understanding intimate partner violence in the context of social norms as practised in rural areas. *Social Work/ Maatskaplike Werk, 55*(3), 301-310. http://dx.doi.org/10.15270/52-2-741

Social Work/Maatskaplike Werk Vol 55 No 3; Issue 5
http://socialwork.journals.ac.za/pub doi:http://dx.doi.org/10.15270/55-3-741

HURT OR HELP? UNDERSTANDING INTIMATE PARTNER VIOLENCE IN THE CONTEXT OF SOCIAL NORMS AS PRACTISED IN RURAL AREAS 301

Cyndirela Chadambuka ORCiD id: 0000-0002-1300-8760

Ajwang' Warria ORCiD id: 0000-0002-4658-7324

Ms Cyndirela Chadambuka, Postgraduate student, Department of Social Work, University of the Witwatersrand, Johannesburg, South Africa.

Dr Ajwang' Warria, Department of Social Work, University of the Witwatersrand, Johannesburg, South Africa.

890270@students.wits.ac.za

Ajwang.Warria@wits.ac.za

KEYWORDS: intimate partner violence, social norms, rural areas, women;victims, social work

Cyndirela Chadambuka, Ajwang' Warria

Intimate partner violence (IPV) poses a serious threat to the welfare of women. IPV against women has aroused intense interest amongst policymakers, practitioners and researchers. Despite this development, IPV against women remains rife but there is still a dearth of research on the linkages between IPV and social norms. This study is a critical review of the literature on IPV and social norms as well as its impact on social work practice and policy. The authors argue that social norms can either promote or prevent IPV intervention and therefore propose an integrated approach to addressing IPV against women.

HURT OR HELP? UNDERSTANDING INTIMATE PARTNER VIOLENCE IN THE CONTEXT OF SOCIAL NORMS AS PRACTISED IN RURAL AREAS

Cyndirela Chadambuka, Ajwang' Warria

Cyndirela Chadambuka ORCiD id: 0000-0002-1300-8760

Ajwang' Warria ORCiD id: 0000-0002-4658-7324

Ms Cyndirela Chadambuka, Postgraduate student, Department of Social Work, University of the Witwatersrand, Johannesburg, South Africa.

Dr Ajwang' Warria, Department of Social Work, University of the Witwatersrand, Johannesburg, South Africa.

890270@students.wits.ac.za

Ajwang.Warria@wits.ac.za

KEYWORDS: intimate partner violence, social norms, rural areas, women;victims, social work

INTRODUCTION

Globally, violence against women has been a serious threat to their wellbeing, with gender-based violence (GBV) being one of the most common forms of such violence. IPV, which has been singled out as the most pervasive form of GBV, has become a global socio-economic and socio-cultural crisis. IPV is physical aggression, sexual coercion, emotional and psychological oppression, economic abuse and controlling behaviour in relation to an individual by a current or past intimate partner (Edwards, 2015; Klugman, 2017; Ogundipe, Woollet, Ogunbanjo, Olashore & Thsitenge, 2018). This results in physical, sexual and psychological harm. Research has indicated that 30% of women aged 15 or older are experiencing lifetime physical and/or sexual violence (Klugman, Hanmer, Twigg, Hasan, McCleary-Sill & Santa-Mary, 2014; Clark, Ferguson, Shreshtha, Shreshtha, Oakes, Gupta, McGhee, Cheong & Yount, 2018). To put it another way, IPV is experienced by one in three women in their lifetimes (Giddens & Sutton, 2017). More women in Africa are subjected to IPV (46%) and sexual violence (12%) than women anywhere in the world (McCloskey, Boonzaier, Steinbrenner & Hunter, 2016). This is mainly because more women in Africa reside in rural areas and are more vulnerable to IPV, as traditional norms that condone such violence are strongly recognised and regarded with high esteem in rural communities (Chigwata, 2016; McCloskey *et al*., 2016). The prevalence of IPV ranks higher in sub-Saharan Africa than in other regions, with the rate of 40%, and with 36% of the total population being affected by it (McCloskey *et al*., 2016; Klugman, 2017).

Although various studies have attempted to unravel the influence of social norms on violence against women (Linos, Slopen, Subramanian, Berkman & Kawachi, 2013; Baldry & Pagliaro, 2014; Edwards, 2015; Strauss Gelles & Steinmetz, 2017; Clark *et al*., 2018; Cislaghi & Heise, 2018), there has not been much clarity on the association between IPV and social norms and how this promotes or hinders IPV prevention, particularly in rural areas. The few studies conducted (Roberto, Brossole, McPherson, Pulsifier & Brow, 2013; Hatcher, Colvin, Ndlovu & Dworkin, 2015; McCloskey *et al*., 2016) do not adequately focus on the influence of social norms in the perpetuation of IPV against women residing in rural areas. Furthermore, absent from the social work literature are studies that seek to elucidate the linkages between IPV and social norms and their consequences for social work practice and policy. Understanding social norms and their influence on the perpetuation of IPV is critical for social workers working with victims/survivors, particularly those residing in rural areas. Globally, much attention has been drawn to the need for better intervention strategies in ameliorating IPV. Most countries in Africa have ratified international legislation prescribing punitive measures for the perpetrators of IPV. However, the efficacy of this legislation in terms of tackling IPV remains doubtful (Ogundipe *et al*., 2018). Although formal written norms (i.e. laws, policies and frameworks) prohibiting violence against

women have been in existence for many centuries, IPV remains a serious problem. This is mainly because IPV is viewed as a 'private tragedy' in different societies, especially in rural areas (Baldry & Pagliaro, 2014; Strauss *et al.*, 2017). Thus it is critical to also consider the role that social norms can play in informing intervention strategies against IPV, especially in rural areas.

Therefore, the aim of this article is to examine the linkages between social norms and IPV, particularly in rural areas, and how social norms can promote or prevent intervention strategies. The article also examines the implications of these linkages for social work practice and policy. The first section of the paper focuses on conceptualising IPV and social norms. The second section discusses social norms through the ecological and intersectional theoretical perspectives and examines how these norms facilitate IPV perpetuation and hinder IPV intervention. The last section focuses on the implications of social norms and IPV for social work practice and policy, with a focus on how social norms can also facilitate IPV prevention.

CONCEPTUALISING SOCIAL NORMS

Social norms are informal/unwritten rules and shared preferences derived from social systems that dictate the behaviour expected, allowed or sanctioned in particular situations (World Health Organisation (WHO), 2009; Baldry & Pagliaro, 2014; Guala, 2017; Clark *et al.*, 2018). People follow these prescribed rules because they i) perceive that other people are following and conforming to the rules, ii) perceive that other members of society expect the rules to be followed, and iii) recognise that failure to conform to the social norms results in social disapproval and punishment (Baldry & Pagliaro, 2014; Guala, 2017; Strauss *et al.*, 2017; Clark *et al.*, 2018). Similarly, an individual's perception of the expected behaviour also matters for adherence to the social norms of a particular society. In this regard, researchers have grouped social norms into two broad categories: descriptive norms and injunctive norms. Firstly, descriptive norms refer to perceptions about what members of social groups ought to do (e.g. in certain communities it is accepted practice for husbands to beat their wives). Injunctive norms refer to consensus about a prescribed or prohibited behaviour (e.g. in our community it is acceptable for men to beat their wives when they are deemed to have done wrong) (Linos *et al.*, 2013; Lilleston Goldmann & McCleary-Sills, 2017; Clark *et al.*, 2018). In addition to the issue of understanding social norms, Cislaghi and Heise (2018) provide four main compliance mechanisms that people use to conform to social norms. These are, firstly, coordination: to achieve a goal in a society, there is need for coordination; hence people comply with the rules of the society. Secondly, there is social pressure: anticipation of rewards or social punishment can force to people to comply with social norms even when they don't feel like doing so. The third compliance mechanism is signalling and symbolism, which entail showing membership of a society, or group that people belong to, and adhering to the rules/norms specific to it. Fourthly, there are reference points: people internalise norms that are considered normal so that they comply automatically. Research has indicated that in sub-Saharan Africa social norms are mostly acknowledged in rural areas, where they are regarded as mechanisms for maintaining social order and social coordination, as they reflect beliefs, attitudes, behaviours and moral judgements about what is right and wrong (Matavire, 2012; Conroy, 2014; McCloskey *et al.*, 2016; Chigwata, 2016). For example, they ensure social coherence, consensus regarding values and beliefs and less tolerance of diversity, which ultimately results in social order (Riddell, Ford-Gilboe & Leipert, 2009). In line with this, a study conducted in Muzarabani, a rural area in Zimbabwe, reported that among the Shona tribe social norms are premised on the principle of *unhu* (personhood and morality), and the community defines an individual as a person who adheres to the prescribed traditional values and ethics in order to maintain society's dignity and integrity (Matavire, 2012).

Personal attitudes, beliefs and moral judgements stem from a person's positive or negative evaluation of something (Linos *et al.*, 2013). Even when personal attitudes are not congruent with social norms, social norms can exert a great influence on how an individual behaves in particular circumstances and situations (Linos *et al.*, 2013; Baldry & Pagliaro, 2014; Lilleston *et al.*, 2017; Ogundipe *et al.*, 2018).

Therefore, for a social norm to be perpetuated, the majority of people do not have to believe it is true or not; rather, they simply perceive that society believes it to be right (Lilleston *et al*., 2017).

Social norms do not operate in isolation: they are influenced by other social forces such as culture and religion. In Malawi and South Asia social norms that relate to child marriages and the sexual abuse of young girls are reinforced by entrenched beliefs in the system of patriarchy that minimises women's and girls' rights to their own body (Malhotra, Warner, McGonagle, Lee-Rife, Powell, Cantrell. & Trasi, 2011; Mwambene & Mawodza, 2017). Similarly, in countries like Sierra Leone and Senegal, social norms that are related to female genital mutilation are deeply rooted in rural cultural and religious beliefs that view this practice as proof of female decency and fertility (Kandala & Komba, 2015; Lillestone *et al*., 2017). In Zimbabwe, virginity testing is highly valued in rural areas and regarded as a sign of honour to the husband, families and the community. A study conducted by Matswetu and Bhana (2018) in Shamva, a rural area in Mashonaland Central in Zimbabwe, indicated that women who get married as non-virgins are not respected and are often humiliated by their husbands, as they are regarded as incomplete This increases their vulnerability to IPV. Additionally, a study conducted in Mashonaland Central in Zimbabwe indicated that women in rural areas are regarded as carriers of culture and are tasked with the responsibility of ensuring that young girls and women adhere to the traditional norms of *kudhonza matinji* (labia elongation) (Venganai, 2016). As such women in urban areas rely on them for guidance on labia elongation. This is done to ensure that men get maximum pleasure during sexual intercourse and also to curb promiscuity. Thus, women who get married without undergoing the labia elongation process are regarded as incomplete and become vulnerable to IPV (Venganai, 2016).

SOCIAL NORMS AND IPV

Among the many possible explanations of the high prevalence of IPV globally, particularly in sub-Saharan Africa, are social norms that perpetuate and justify male dominance within families and societies. A number of social norms have been identified that singly or jointly increase the risk of women experiencing IPV. These include cultural and religious practices such as female genital mutilation (Kandala & Komba, 2015); male dominance and superiority over women within families and society (McCloskey *et al*., 2016); acceptance of wife-beating as a way of 'correcting a stray wife' and a sign of love (Oyediran & Feyisetan, 2017); family privacy and stigma associated with divorce or being unmarried (Matavire, 2012); women's responsibility to maintain a marriage and their reproductive role (Shamu, Abrahams, Zarowsky, Shefer & Temmerman, 2013); social norms surrounding *lobola* (bride-price) payment, which acts as a compromising factor in IPV tolerance (Mesatywa, 2014); and men's entitlement to sex (Mukanangana, Moyo, Zvoushe & Rusinga, 2014). These social norms have been ingrained in some women in rural areas to such an extent that there is a tolerance of abuse and thus a heightened vulnerability to IPV. Also, because their rights are violated, women's productivity diminishes and in some instances such violation can cause premature death, which has dire consequences for both the family and the welfare of children. In situations where they become unproductive, there is over-reliance on the partner because of the fear of being left destitute without a source of income. Thus, for women experiencing IPV, it becomes very difficult to leave abusive relationships, as they feel they will not be able to provide for their children.

Furthermore, attributes of masculinity are associated with dominance and aggression, with men holding the decision-making power in marriages (Mesatywa, 2014; Clark *et al*., 2018). Traditionally *lobola* (bride-price), referred to as *roora* in Zimbabwe, has always been regarded as a noble practice that gives status to both men and women. A study conducted in Zimbabwe on Christian women's experiences of IPV indicates that *lobola* has become the basis of oppression, which ultimately results in IPV (Chireshe, 2015). The social norms around *lobola* (such as entitlement to sex as a conjugal right and submission to the husband even when he is wrong) has a silencing effect on women and give males power over them. Consequently, women are forced to accept violence in their marriages, as they feel

that by virtue of the *lobola* payment IPV is normal and should not be questioned (Matavire, 2012; Chireshe, 2015).

Male dominance had been recorded as higher in rural than in urban areas because of the nature of rural communities and their strong adherence to social norms (Riddell *et al.*, 2009). Accordingly, women who reside in rural areas are at a higher risk of IPV than their urban counterparts are. Patriarchal views and social norms are strongly upheld in rural communities, and this rural culture (common understandings, values, ideas and practices in a rural location) reinforces adherence to these norms and evinces less tolerance for non-conforming behaviour (Riddell *et al.*, 2009; Conroy, 2014). Consequently, the fear of social sanctions and disapproval causes people to condone and accept violent behaviour (Lilleston *et al.*, 2017). Hence, a population of both men and women still regard IPV perpetrated by the husband as a normal occurrence in marriages (Linos *et al.*, 2013). A study conducted in 17 African countries revealed that more than half of the women surveyed justified and accepted IPV scenarios in their marriages and families (Linos *et al.*, 2013; McCloskey et al., 2017).

In the same vein, social norms do influence the responses of informal support systems and bystanders (neighbours, friends, community members) to IPV. These are important people, for they provide immediate informal support to victims of IPV. Their reaction to IPV cases is strongly influenced by the extent of the violation and the behavioural social scripts (patterns of behaviour learned and motivated by social norms that prescribe how a person should react in a particular situation) (Banyard, Edwards, Moschella & Seavey, 2018). In her study of a rural area in Zimbabwe Matavire (2012) argues that social norms do not allow disclosure of family matters to the public, as this destroys the dignity and integrity of the family – hence victims/survivors consign IPV to the private realm. Thus, moral judgements and beliefs are overridden by social norms (privacy concerns) and consequently individuals comply and do not intervene or offer help to IPV victims (Baldry & Pagliaro. 2014; Clark et al., 2018). Additionally, the police, who are often the first outside formal point of intervention for victims of IPV, often avoid dealing with such cases because of intrapersonal factors (beliefs and attitudes) and contextual factors (behavioural social scripts, characteristics of the situation) that are influenced by social norms that determine the decision to help or not (Baldry & Pagliaro, 2014). Most of the time police leniency to perpetrators and blaming victims for disobedience is are so ingrained in the social norms that they conform in a way that condones male dominance (Baldry & Pagliaro, 2014). A study conducted in the Western Cape in South Africa indicated that police officers also resort to victim blaming and upholding the patriarchal views and beliefs of the communities that they serve (Retief & Green, 2015). This then supports the patriarchal assumption that the women who are often victims of IPV must have provoked the perpetrator and they deserve the treatment they received (McCloskey *et al.*, 2016). Therefore, help is limited, as the behavioural social scripts regard IPV as an acceptable way of dealing with conflicts in an intimate relationship (Riddell *et al.*, 2009; Banyard *et al.*, 2018).

The above discussion makes it clear that the acceptability of IPV and its perpetuation are not reliant only on social norms: different factors also come into play. No single social variable causes IPV: the phenomenon is a consequence of different factors operating at different levels of the social ecology that tend to influence each other. The ecology of factors contributing to IPV goes beyond one driver. Social norms have not been clearly examined jointly with other social variables (i.e. education, geographical location, class, patriarchy) that also influence the perpetuation of IPV, particularly in rural areas, although research on IPV prevalence and its consequences is growing. Understanding how social norms intersect with other factors is fundamental to unearthing the different pathways that cause people to conform to certain practices, IPV included.

Theoretical underpinnings

The scholarship on intersectional feminism examines the multiplicity and interactivity of different social variables and how they influence the realities and lived experiences of different population groups (Gopaldas, 2013; Hill-Collins & Bilge, 2016). Intersectionality gained currency when women of colour and feminists began to explain their experiences and struggles in society and movements for

change in the late 1980s and early 1990s. Crenshaw is credited for coining the term to explain how various systems of oppression converge to marginalise women of colour. According to Gopaldas, (2013) the concept of intersectionality has been expanded and moves beyond specific social identity structures (i.e. race, gender and class) to include other social variables such as age, ethnicity, religion, education, physical ability to mention but a few depending on the context. Thus, intersectionality has become applicable in different contexts and population groups and now integrates other marginalised groups of society (such as women residing in rural areas). Additionally, intersectionality brings to the fore the debate on homogeneity with regard to the perpetuation of IPV. There are differences in population groups that are often deemed homogeneous (in terms of their lived experiences) such as women and men. For instance, women residing in urban areas may find difficulties in reporting cases of IPV because of their gender and attitudes and the beliefs of police officers who condone the consigning of IPV cases to the realm of privacy within the family institution (Retief & Green, 2015). These urban women will have a relative advantage over women residing in a rural setting, where police stations and health services are not available and women are mostly unemployed, which makes escaping the abusive relationship difficult. In the same vein, a study conducted on IPV in Zimbabwe showed that women in rural areas experience IPV more than their urban counterparts because of their low employment status, weak access to resources, their geographical location and lower levels of education, which all constrain their decision-making powers in intimate relationships (Fidan & Bui, 2015). This makes it clear that the perpetration of IPV varies according to the politics of location.

The intersection of social norms with other social variables impacts on the struggles and experiences that are linked to the marginalisation of poor women, particularly those residing in rural areas. A study conducted in South Africa with Xhosa women residing in rural areas revealed that the intersection of social norms relating to *lobola* payment, their poor family background, unemployment because of lack of education and their geographical location means that they have limited access to opportunities and resources contributed to their vulnerability to IPV and limited their ability to escape violent relationships (Mesatywa, 2014). Similarly, a study conducted in Zimbabwe indicated that social norms relating to patriarchy and a husband's conjugal rights following payment of *lobola*, limited access to knowledge and adherence to a religion that promotes forced marriage heightened women's risk of IPV and limited their chances of leaving abusive relationships (Mukanangana *et al.*, 2014). Thus focusing on social norms alone is inadequate in as far as IPV against women, especially those residing in rural areas, is concerned.

Similarly, Bronfenbrenner's (1979) ecological model also explains the various social systems in which human beings live as a series of layers. The ecological model posits that throughout the development of humans there is a reciprocal interaction of objects, humans and their environment (Salihu, Wilson, King, Marty & Whiteman, 2015). The interactions of different factors on the four levels (individual, relationship, political and societal) of social ecology could contribute to IPV. This interaction determines the behaviour of a person, including perpetrators' and victims' reactions to IPV. Hence the environment and the norms associated with it play a significant role in the perpetuation of IPV. A recent study by Eriksson and Mazerolle (2015) on child abuse, which observed IPV by male perpetrators, indicates how the influence of the environment can explain the transmission of violence across groups and generations through children learning from the family and the society at large. The results of the study indicate that violence is also transmitted through the acquisition of beliefs, norms and attitudes that individuals conform to that are considered as appropriate behaviour in society (Eriksson & Mazerolle, 2015). This speaks to the internalisation of social norms that condone the abuse of women, which in turn reinforces the acceptability of IPV against women.

The systems theory further explains the interaction of social norms and other elements in perpetuating IPV. According to systems theory, any system consists of subordinate subsystems that are interrelated to make up a whole. It focuses on social homeostasis (the system maintaining a relatively stable state of balance) which, when disturbed, can readjust itself and regain social stability (Zastrow-Kirst Ashman, 2010). This then means that through social norms the 'system' maintains its stability and, if disturbed,

in readjusting itself it applies 'social sanctions and social rejection' to those who do not comply with the social norms of the system. Therefore, the subsystems (families, individuals) feel compelled to conform to rules that keep the system (society) together through adhering to social norms. Hence, male perpetrators of IPV are deemed right by society for exercising their masculine authority over women, particularly in rural areas where patriarchy is strongly recognised and regarded as a sign of power and dominance, which in turn maintains order and stability (McCloskey et al., 2016).

IMPLICATIONS FOR SOCIAL WORK PRACTICE AND POLICY

The existence of IPV and its consequences for the wellbeing of women, especially those residing in rural communities, cannot be ignored. Individuals are part of the ecosystem of society; hence the ability to solve social problems, IPV included, also enhances their wellbeing and functioning. IPV is deeply rooted in traditional social norms and ideologies. The role of these social norms and traditional values and beliefs cannot be ignored. It has been argued that social work practice in Africa fails to tackle social problems because it deploys skills and strategies that are deeply rooted in European standards and principles. Baffoe and Dako-Gyeke (2013) argue that social work education that also incorporates gender studies in Africa is largely embedded in the dictates and principles of the European community. Thus, it fails to have the desired impact in addressing social problems such as poverty and IPV. For example, social work practice in Zimbabwe dates back to the colonial era, and the fact that present-day social work still uses the dictates and principles of the Global North tends to make communities unreceptive of the social work skills and intervention strategies (Baffoe & Dako-Gyeke 2013; Dziro, 2013). This is largely due to the incongruence of the social workers' ethical principles and the social norms of the clients or communities. Yan (2008) argues that social work ethical principles (such as self-determination and respect for an individual) are incompatible with various social norms that prescribe male domination and put much emphasis on the subordination of women. Thus, social work practice in rural areas becomes a mammoth task, given the nature and extent of the influence of social norms on behaviour and limited access to resources (Chiwara & Lombard, 2017).

It is important then for social workers to ensure that their skills and intervention strategies address the foundation of IPV, which is the traditional belief system that prevails in different contexts. As social workers strive to ensure sustainable intervention strategies in dealing with IPV, it is critical that they understand the social norms that can perpetuate or change attitudes relating to IPV. Additionally, social workers are encouraged to establish a close and engaging relationship with victims/survivors of IPV. In creating rapport, they will be able to identify the problems emanating from different social norms and provide the necessary professional assistance. Research conducted by Keeling and Van Wormer (2012) revealed that women affected by IPV are usually scared of social workers, because to them social workers do not consider their plight but are instead more concerned with the removal of the child(ren) from the abusive environment. These women indicated that they are in conflict with the system that is meant to help them and regard social work as a professional way of abusing them and taking away their children. Thus, instead of helping the victims/survivors of IPV, the social workers actually hurt them by taking away their children, which is traumatising and painful for them.

Changing attitudes, beliefs and behaviour influenced by social norms is critical in IPV intervention. Social norms can either emphasise continuity of beliefs and attitudes, or they can actively promote change (Giddens & Sutton, 2017). Marx and Delport (2017) argue that sustainable change implies transformation in attitudes and the self, which points to behavioural changes. Such shifts in attitude and beliefs can best be informed by health behaviour change models such as the Health Belief Model (HBM). HBM is a psychological model which explains health behaviours by focusing on individuals' attitudes and beliefs (Jones, Jensen, Scherr, Brown, Christy & Weaver, 2015). Such an intervention model can assist in changing injunctive norms that support IPV (Lilleston *et al*., 2017). Moreover, Clark et al. (2018) and Ogundipe *et al*. (2018) argue that if a large number of people shift their attitudes and beliefs and change their behaviour, injunctive norms become less effective. A good example is the SASA! (KiSwahili word meaning 'now') programme in Uganda which seeks to reassess the norms

around the acceptability of violence and gender inequality (McCloskey et al., 2016). Lilleston *et al.* (2017) further argue that shifting social norms also entails directly challenging descriptive norms and injunctive norms. It is critical for social workers practising within IPV-tolerant spaces, especially those who work in rural communities, to engage not only with victims, but also with different stakeholders (such as chiefs, headmen) who are responsible for ensuring that social norms are being adhered to in their communities (Ogundipe *et al.*, 2018). Hence a comprehensive approach to social work practice within the IPV space should address the co-existing adversities and the way that they interconnect in perpetuating IPV (Etherington & Baker, 2018).

Behaviour change in shifting norms that condone IPV also requires structural changes. Therefore, policy formulation on violence against women, IPV included, should incorporate an intersectional approach that seeks to address the way different groups of society experience inequality and oppression. Policies that target a single aspect of identity (e.g. gender or class) fail to respond to the multifaceted problems that shape women's experiences of IPV. Etherington and Baker (2018) concur and argue that policies that do not adequately address the different levels of inequalities and how they intersect in perpetuating IPV become ineffective. For instance, a policy that addresses gender issues in relation to IPV without taking into consideration the influence of class, literacy, ethnicity, religion and geographical location becomes ineffective. Thus, social workers who work within different IPV spaces and consult such policies face difficulties in serving the communities, as the policies fail to speak to the actual practical situations. Hence, policy analysts can use the notion of intersectionality to identify disparities in the existing policies and programmes, and thus determine how they can eliminate the unwanted consequences (Etherington & Baker, 2018). Additionally, formal laws and policies may be less desirable than the social sanctions imposed on individuals who violate social norms (Lilleston *et al.*, 2017). Such a move has been witnessed in Zimbabwe through the enactment of the Domestic Violence Act (2007), which criminalises violence against women.

CONCLUSION

This article provided an overview of the linkages between IPV and social norms. A detailed conceptualisation of social norms was presented and the key elements of these norms were discussed. The discussion went on to provide linkages between IPV and social norms and considered how these facilitate IPV and hinder IPV prevention. The article also focused on the implications of these linkages on social work practice and how social norms can be adapted to also facilitate the prevention of IPV against women. Based on the discussion it is recommended that social workers working within IPV spaces, especially in rural areas, ensure that the intervention strategies that they use to deal with IPV also take into consideration the role that social norms play. Also, further research on the intervention strategies that social workers working in rural areas use and their efficacy in ameliorating IPV should be undertaken. This could also include the influence of bystanders and how social workers can actually empower them, as they are often the first point of contact for IPV victims.

REFERENCES

BAFFOE, M. & DAKO-GYEKE, M. 2013. Social problems and social work in Ghana: Implications for sustainable development. **International Journal of Development and Sustainability,** 2(1):347-363.

BALDRY, A.C. & PAGLIARO, S.C. 2014. Helping victims of intimate partner violence: The influence of group norms among lay people and the police. **Psychology of Violence,** 4(3):334-347. DOI: 10.1037/a0034844.

BANYARD, V.L., PLANTE, E.G. & MOYNIHAN, M.M. 2004. Bystander Education: Bringing a broader community perspective to sexual violence prevention. **Journal of Community Psychology,** 23(1):61-79.

BANYARD, V.L., EDWARDS, K.M., MOSCHELLA, E.A. & SEAVY, K.M. 2018. 'Everybody is really close knit': Disconnections between helping victims of IPV and more general helping in rural communities. **Violence against women,** 1-22.

BRONFENBRENNER, U. 1979. **The Ecology of Human Development.** Cambridge, MA: Harvard University Press.

CHIRESHE, E. 2015. Christian women's experiences of domestic violence in Zimbabwe. **Journal of Women and Social Work,** 30(3):380-394.

CHIGWATA, T. 2016. The role of traditional leaders in Zimbabwe: Are they still relevant? **Law Democracy and Development,** 69-90. http://dx.doi.org/10.4314/ldd.v20i1.4

CHIWARA, P. & LOMBARD, A. 2017. The challenge to promote social and economic equality in Namibia through social work. **Social Work/ Maatskaplike Werk,** 53(4):563-578.

CISGLAHI, B. & HEISE, L. 2018.Theory and practice of social norms interventions: eight common pitfalls. **Globalisation and Health,** 14 (83):1-10. doi: 10.1093/heapro/day017.

CLARK, C.J., FERGUSON, G., SHRESTHA, B., SHRESTHA, P.N., OAKES, J.M., GUPTA, J., MCGHEE, S., CHEONG, Y.F. & YOUNT, K.M. 2018. Social norms and women's risk of intimate partner violence in Nepal. **Social science and Medicine,** 202:162-169. https://doi.org/10.1016/j.socscimed.2018.02.017

CONROY, A.A. 2014. Gender, power and Intimate partner violence: A study on couples from rural Malawi. **Journal of Interpersonal Violence,** 29 (5):866-888.

DZIRO, C. 2013. Trends in social work education and training: The case of Zimbabwe. [Online] Available: **International Journal of Development and Sustainability** 2(2):1423-1435. https://isdsnet.com/ijds-v2n2-74.pdf [Accessed 14/12/2018].

EDWARDS, K.M. 2015. Intimate partner violence and the rural-urban suburban divide: Myth or reality? A critical review of the Literature. **Trauma, Violence and Abuse,** 16(3):359-373.

ETHERINGTON, N. & BAKER, L. 2018. From 'buzzword' to best practise: Applying intersectionality to children exposed to intimate partner violence. **Trauma, Violence & Abuse,** 19(1):58-75.

ERIKSSON, L. & MAZEROLLE, P. 2015. A cycle of violence? Examining family-of-origin violence, attitudes and intimate partner violence perpetration. **Journal of Interpersonal Violence,** 30(6):945-964.

FIDAN, A. & BUI, H.N. 2015. Intimate partner violence against women in Zimbabwe. **Violence against women,** 22 (9):1075-1096.

GIDDENS, A & SUTTON P.W. 2017. **Sociology** (8th ed). Cambridge: Polity press.

GOPALDAS, A. 2013. Intersectionality 101**. Journal of Public Policy & Marketing**, 32, 90-94.

GUALA, F. 2017. Review of Cristina Bicchieri's Norms in the wild: how to diagnose, measure, and change social norms. **Erasmus Journal of Philosophy and Economics**, 10(1):101-111. https://doi.org/10.23941/ejpe.v10i1.282.

HATCHER, A.M., COLVIN, C.J., NDLOVU, N. & DWORKIN, S.L. 2015. Intimate partner violence among rural South Africa men: Alcohol use, sexual decision making power and communication. **Culture Health Sex,** 16(9):1023-1039. doi:10.1080/13691058.2014.924558

HILL-COLLIN, P. & BILGE, S. 2016. **Intersectionality.** Malden: Polity Press.

JONES, C.L., JENSEN, J.D., SCHERR, C.L., BROWN, N.R, CHRISTY, K. & WEAVER, J. 2015. The Health Belief Model as an exploratory framework in communication research: Exploring parallel, serial and moderated mediation. **Health Communication,** 30(6):566-576.

KANDALA, N.B & KOMBA, P.N. 2015. Geographic variation of female genital mutilation and legal enforcement in sub-Saharan Africa: A case study of Senegal. **American Journal of Tropical Medicine and Hygiene,** 92(4):838-847.

KEELING, J. & VAN WORMER, K. 2012. Social worker interventions in situations of domestic violence: What can we learn from survivors' narratives? **British Journal of Social Work,** 142:1354-1370.

KLUGMAN, J. 2017. **Gender-based violence and the law.** World Development Report Background Paper. Washington: World Bank.

KLUGMAN, J., HANMER, L., TWIGG, S., HASAN, T., MCCLEARY-SILLS, J., & SANTA-MARY, J. 2014 **Voice and agency; Empowering women and girls for shared prosperity**. Washington DC: World.

LILLESTON, P.S., GOLDMANN, L., VERMA, R.K. & MCCLEARY-SILLS, J. 2017. Understanding social norms and violence in childhood: Theoretical underpinnings and strategies for intervention. **Psychology, Health & Medicine,** 22:122-134 doi:10.1080/13548506.2016.1271954.

LINOS, N., SLOPEN, N., SUBRAMAMIAN, S.V., BERKMAN, L. & KAWACHI, I. 2013). Influence of community social norms on spousal violence: A population based mulitilevel study of Nigerian women. **American Journal of Public Health,** 103 (1), 148-155.

MALHOTRA, A., WARNER, A., MCGONAGLE, A., LEE-RIFE, S., POWELL, C., CANTRELL, E.V. & TRASI, R. 2011. **Solutions to end child marriage: What the evidence shows.** Washington DC: International Centre for Research on Women.

MARX, M. & DELPORT, A. 2017. 'I am because we are'. Dancing for social change! **Educational Research for Social Change,** 6(1):57-71.

MATAVIRE, M. 2012. Interrogating the Zimbabwean traditional jurisprudence and the position of women in conflict resolution. A case of Shona tribes in Muzarabani district. **International Journal of Humanities and Social Sciences,** 2(3):218-223.

McCLOSKEY, L.A., BOONZAIER, F., STEINBRENNER, S.Y, & HUNTER, T. 2016. Determinants of intimate partner violence in sub Saharan Africa: A review of prevention and intervention programs. **Partner Abuse,** 7 (3):277-315. http://dx.doi.org/10.1891/1946-6560.7.3.277

MESATYWA, N.J. 2014. Validating the evidence of violence in partner relationship with regard to Xhosa women. **Social Work/Maatskaplike Werk,** 50(2):235-257.

http://dx.doi.org/10.15270/50-2-397

MUKANANGANA, F., MOYO, S., ZVOUSHE, A. & RUSINGA, O. 2014. Gender based violence and its effects on women's reproductive health: The case of Hatcliffe, Harare, Zimbabwe. **African Journal of Reproductive Health,** 18 (1):110-122.

MWAMBENE, L. & MAWODZA, O. 2017. Children's rights standards and child marriage in Malawi. **African Studies Quarterly,** 17(3):21-44.

MATSWETU, V.S. & BHANA, D. 2018. Humhandara and hujaya. Virginity, culture and gender inequalities among adolescents in Zimbabwe. **Special collection: Reproductive Health in sub-Saharan Africa,** 1-11. https://doi.org/10.1177/2158244018779107

OGUNDIPE, R.M., WOOLETT, N., OGUNBANJO, G., OLASHORE, A.A. & TSHITENGE, S. 2018. Intimate partner violence: The need for an alternative primary preventive approach in Botswana. **African Journal Primary Health Care Fam Med**, 10(1):1-6. https:// doi.org/10.4102/phcfm. v10i1.1699.

OYEDIRAN, K.A. & FEYISETAN, B. 2017. Prevalence and contextual determinants of intimate partner violence in Nigeria. **African Population studies,** 23(1):3464-3477.

RETIEF, R. & GREEN, S. 2015. Some challenges of policing domestic violence. **Social Work/ Maatskaplike Werk,** 51(1):135-147. doi:http://dx.doi.org/51-1-432.

RIDDELL, T., FORD-GIBOE, M. & LEIPERT, B. 2009. Strategies used by rural women to stop, avoid or escape from IPV. **Healthcare for Women International**, 30, 134-159.

ROBERTO, K.A., BROSSOLE,N., McCPHERSON, M.C., PULSIFIER, M.B. & BROW, P.N. 2013. Violence against rural older women: Promoting community awareness and action. **Australasian Journal of Ageing,** 321:2-7. doi:10.1111/j.1741-6612.2012.00649.x.

SALIHU, H.M., WILSON, R.E., KING, L.M., MARTY P.J. & WHITEMAN, V.E. 2015. Socio-ecological model as a framework for overcoming barriers and challenges in randomized control trials in minority and undeserved communities. **International Journal of MCH and AIDS**, 3(1):85-95.

SHAMU, S., ABRAHAMS, N., ZAROWSKY, C., SHEFER, T. & TEMMERMAN, M. 2013. Intimate Partner violence during pregnancy in Zimbabwe: A cross-sectional study of prevalence, predictors, and associations with HIV. **Tropical Medicine & International Health**, 18: 696–711.

STRAUSS, M.A., GELLES, R.J. & STEINMETZ, S.K. 2017. **Behind closed doors: Violence in the American family.** New York: Routledge.

VENGANAI, H. 2016. Negotiating identities through the 'cultural practice' of labia elongation among urban women Shona women in Zimbabwe. **Culture unbound: Journal of current cultural research,** 8(3):306-324. http://www.cultureunbound.ep.liu.se/

YAN, M.C. 2008. Exploring cultural tensions in cross-cultural social work practice. **Social Work,** 53(4):317-328.

ZASTROW, C.H. & KIRST-ASHMAN, K. (2010). **Understanding human behaviour and the social environment** (8th ed). California: Brooks/Cole.

3.8.2 CONCLUSION

The findings in this paper reveal the significant role that culture plays in IPV perpetration. While considerable efforts that are being done to prevent and minimise IPV are acknowledged, women residing in rural areas are at a higher risk of frequent and chronic abuse. The influence of social norms around marriage tend to reinforce tolerant attitudes of IPV in women residing in rural areas. Notably, the influence of culture also affects service provision in rural areas. Evidence from the preceding discussion is how social norms have a strong influence on service delivery in rural areas as service providers within these settings are also mandated to adhere to the social norms of the communities they serve. Thus, it is crucial for service providers to take into cognisance the effect that social norms have on IPV perpetration in designing interventions.

3.9 INTRODUCTION TO ARTICLE

Understanding only the role that social norms play in IPV perpetration in rural areas is not sufficient in exploring IPV experiences of women residing in rural areas. Considering that rural areas in Zimbabwe have a strong adherence to cultural norms that condone IPV, it is important for government and civil society to ensure that measures are put in place to minimise and prevent the occurrence of IPV against women. Hence in accordance with objective two of this study which seeks to explore the role of culture, this article presents a critical analysis of the legislative frameworks in Zimbabwe regarding IPV. The enactment of the Domestic Violence Act is a clear indication of the gravity of IPV. There has been minimal coverage and concentration on how to eradicate the code of silence among rural women who have been exposed to IPV regardless of its consequences on women and children. It is therefore important to examine the extent to which the legislative frameworks in Zimbabwe are playing a role in the minimisation and prevention of IPV. The following article is a policy analysis of the legislative frameworks in Zimbabwe that are aimed at preventing and dealing with violence when it occurs. The legislation will be analysed with special reference to women victims of IPV who are residing in rural areas. These legislative frameworks range from international legislative frameworks that Zimbabwe has ratified and adopted, narrowing down to regional frameworks and lastly the Zimbabwean legislative frameworks.

3.9.1 PRESENTATION OF ARTICLE 2

Chadambuka, C. (2019). Intimate partner violence in rural areas: Examining the legislative measures in Zimbabwe. *Journal of Social Development in Africa, 34*(1), 115-140.

Intimate Partner Violence In Rural Areas: Examining The Legislative Measures In Zimbabwe

CYNDIRELA CHADAMBUKA[1]

Abstract

Women have the right to freedom and decision-making to ensure their well-being and realise their full potential. Intimate partner violence (IPV) threatens their well-being and violates their rights. The protection of women is fundamental to ensuring their welfare. This requires the government to acknowledge that IPV is a serious social problem. This article analyses Zimbabwe's legislative frameworks enacted and advances made in a bid to address IPV against women. The legislative frameworks will be examined alongside international and regional instruments that also address IPV against women. The government of Zimbabwe has acknowledged the gravity of IPV through the inclusion of IPV-related provisions in various legislative frameworks and policies. However, despite these efforts IPV continues to be a common occurrence, and this compromises the welfare of women in Zimbabwe.

Key Words: Women; intimate partner violence; rural areas; legislation; Zimbabwe

[1] PhD Candidate, University of the Witwatersrand, 890270@students.wits.ac.za

Introduction

The phenomenon of IPV remains a global social problem and a violation of human rights. The Sustainable Development Goals (SDGs) acknowledge that violation of human rights is a serious problem, and Goal 5 is aimed at eradicating all forms of violence against women and girls in both private and public spaces. Most IPV cases report men as perpetrators, which makes IPV against women more common. IPV is defined as "acts of physical aggression, sexual coercion, psychological abuse and controlling behaviour in the context of marriage or other intimate relationship" (Zimbabwe National Gender Based Violence Strategy 2012-2015, 1). It is regarded as the second most common type of domestic violence globally (Giddens and Sutton, 2017). Research conducted indicates that one in three women experience violence in their lifetime (Klugman, 2017). Global estimates suggest that 35% of all women will experience IPV in their lifetime (Alangea, Addo-Lartey, Sikweyiya, Chirwa, Coker-Appiah, Jewkes and Adanu, 2018). The worst IPV-affected regions are South East Asia with 38%, Eastern Mediterranean with 37% and Africa with 36% (Alangea et al. 2018). Sub-Saharan Africa has been ranked as one of the regions with the highest IPV prevalence, with Zimbabwe among the countries with the highest IPV rate (McCloskey, Boonzaier, Steinbrenner and Hunter 2016). Women, who make about 50% of the Zimbabwean population (ZimStats 2012), constitute a large portion of vulnerable groups in Zimbabwean society. One of the major social problems affecting women in Zimbabwe is IPV (ZNGBVS, 2012-2015). The eradication of IPV against women remains a priority for the international community.

IPV has serious implications for the social justice system. Social justice is at the core of social work practice with its values placing concern on dignity, worth and respect of all people (Cournoyer,

2011). Social work practice is mainly concerned with improving the lives of vulnerable and oppressed groups of society (Sesane and

Geyer, 2015). Despite its dire consequences on the welfare of women, there is scant literature on IPV and legislation in Zimbabwe, and the few studies conducted (Fidan and Bui 2015; Mukanangana, Moyo, Zvoushe and Rusinga 2014; Shamu, Abrahams, Zarowsky, Shefer and Temmerman, 2013; Shamu, Zarowsky, Roelens, Temmerman and Abrahams 2016) rarely focus on the contribution of legislative measures to the welfare of victims/survivors. Legislation plays a significant role by making IPV a criminal offence, and the sanctions associated with it provides a deterrent function (Klugman. 2017). Regardless of its important role, the legal route is often considered the last resort for victims/survivors, as IPV is mainly shrouded in a culture of silence. This secrecy is connected to culture and tradition of the victims and perpetrators, which urges them to keep family issues private (McCloskey et al. 2016; Nkomo 2014). In rural areas, traditional jurisdiction is also biased against the victims of IPV, as it condones social norms that support the subordination of women (Chigwata, 2016). As such women are left vulnerable and the only safety net that is available to them is the legal system.

This article seeks to examine the extent to which Zimbabwean legislative frameworks protect the victims/survivors of IPV. The first section of the article focuses on the prevalence of IPV from a global perspective, narrowing down to the Zimbabwean context. The second section focuses on international legislative instruments that speak against IPV that Zimbabwe has ratified. Thirdly, an examination of Zimbabwe's legislative frameworks that focus on the eradication of IPV will be presented. The last section will focus on the implication of these legislative measures on social work practice in Zimbabwe.

Global Overview of IPV

IPV remains a global problem and a threat to the well-being of women (Duvvury, Callan, Carney and Roghavendra 2013; Fidan

and Bui, 2015; Klugman, Hanmer, Twigg, Hasan, McCleary-Sills and Santa-Mary, 2014; Klugman 2017). It is estimated that globally 30% of women may experience sexual and/or physical violence in their lifetimes, and 35% of women worldwide have experienced physical and/or sexual partner violence (Kapiga, Harvey, Muhammad, Stock, Hashim, Harven, Lees and Watts, 2017; Klugman et al. 2014). In Asia, the rate of IPV has been recorded as 43%, with countries' statistics in that region indicating that 70% of women experienced IPV (Klugman 2017). Similarly, research has also indicated that the Eastern part of Asia has the highest prevalence of IPV against women (Kapiga et al. 2017). In the UK an average of two women per week are killed or abused by males and 10% have experienced domestic violence (Giddens and Sutton 2017). This high prevalence has been attributed mostly to under-reporting, attitudes that promote the subordination of women and the privatisation of violence. Similarly, in India it is reported that less than 5% of victims seek help from the police and social workers (Klugman, 2017; McCloskey et al. 2016).

The dimensions of IPV in Africa are embedded in patriarchy and social norms that condone the abuse of women in intimate relationships. More women in Africa are subjected to IPV (46 %) than women anywhere in the world, with sub-Saharan Africa countries ranking among the highest globally (McCloskey et al. 2016). A study conducted in Tanzania indicated that 44% of married women experience IPV perpetrated by either their current or most recent husband/partner (Kapiga et al. 2017). Pregnant women are not immune to IPV: research has indicated that in Namibia over a third reported physical and sexual abuse from an intimate partner, with 90% of these being assaults of pregnant

women linked to their intimate partners (Bikinesi, Mash and Joyner, 2017). In the same vein, a study conducted in South Africa reported that 20% of pregnant women experience IPV (Groves,

Moodley, McNaughton-Reyes, Martin, Foshee and Maman, 2015). The high rates of IPV in Africa, particularly sub-Saharan Africa, are largely attributed to longstanding patriarchal attitudes and social norms that promote men's hierarchical role in sexual relationships, particularly in marriages (McCloskey et al. 2016). Given that marriage is regarded as a private institution in which women are discouraged from disclosing or reporting any form of abuse, the violence continues unabated. This in turn increases the vulnerability of women to IPV and at the same time reduces the chances of effective intervention.

Prevalence of IPV in Zimbabwe

In Zimbabwe IPV has proven to be one of the most prevalent forms of GBV because of its patriarchal nature where exertion of male dominance and control over women is justified. According to the Zimbabwe Demographic Health Survey 2015, IPV prevalence in Zimbabwe varies depending on locality and other factors (i.e. education level, duration of marriage, resources). Matebeleland North, with 17%, has the lowest rate of IPV, while Mashonaland province, with 56%, recorded the highest. Interestingly, duration of marriage has been singled out as one of the main factors that determine the prevalence of IPV in marriage (ZDHS, 2010-11; ZDHS 2015). As reported in the findings, 1% indicated that IPV started before marriage, 15% reported that IPV started within two years of marriage, while 24% reported that it started after five years of marriage (ZDHS 2015). As the numbers of years in marriage progressed, vulnerability to IPV also increased. This clearly indicates that length of marriage tends to increase women's vulnerability to IPV, as they become more dependent on the husband and lose their control and power.

Furthermore, the trend of IPV prevalence in Zimbabwe is not linear, but tends to fluctuate. For example, IPV against women during pregnancy declined slightly, with the ZDHS 2005-06 recording a decrease from 8%, while a further 5% decline was

recorded in the 2010-11 survey. However, the prevalence increased again by 1% in the ZDHS 2015, which recorded an overall 6% incidence of IPV. By contrast, a study conducted during the 12 months preceding 2010-2011 indicated that 29% of women residing in urban areas had experienced IPV and 31% of those in rural areas had also experienced IPV (ZDHS 2010-2011). In 2015, 20% had experienced IPV in the preceding 12 months (ZDHS 2015). Due to these fluctuations in the rates of IPV, it is very difficult to determine the efficacy of proposed policies and legislative frameworks in combating IPV.

INTERNATIONAL LEGAL FRAMEWORKS

The abuse of women is strongly discouraged in international legal frameworks. IPV issues are widely recognised in international legal frameworks, which will be discussed below.

Universal Declaration of Human Rights (1948)

This Convention seeks to ensure that all human rights are respected. Article 3 states that all individuals have the right to liberty, life and security. The Declaration further states that no human being is to be subjected to inhumane treatment. It has become the cornerstone of international human rights legislation, and its contents have been articulated in various international conventions such as the Convention on the Elimination of all Discrimination against Women (CEDAW) (Kondo, 2017). This has also set the parameters within which the legislative measures against IPV in Zimbabwe are formulated. Zimbabwe is a member of the United Nations General Assembly and has ratified CEDAW, a convention that was birthed from the UDHR which condemns IPV.

International Covenant on Economic, Social and Cultural Rights (1966)

The International Covenant on Social, Economic and Cultural Rights (ICESCR) was adopted to acknowledge the social, economic and cultural rights of individuals. Article 10 of the Covenant recognises the importance of the protection of families and their members, with Article 11 recognising the importance of adequate standards of living and improvement of living conditions. The ICESCR is regarded as the most relevant treaty in protecting the socio-economic rights of individuals, IPV victims and survivors included. Zimbabwe ratified the ICESCR, and the contents of the Zimbabwean Constitution evince the influence of ICESCR on socio-economic rights (Kondo, 2017).

Convention on the Elimination of All Discrimination against Women (CEDAW) (1979*)*

CEDAW recognises that the abuse of women affects their social well-being, violates their human rights, their worth and dignity, and hampers their potential. Thus, it acknowledges explicitly in its preamble that despite the enactment of various instruments, discrimination against women remains rife. Article 1 of the CEDAW refers to discrimination asany distinction, exclusion, restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the politics, economic, social, cultural, civil or any other field.

Although this definition does not capture IPV or GBV explicitly, it touches on important aspects and drivers of IPV and calls for freedom in social and cultural spaces where IPV cases mostly occur. McCloskey et al. (2016) argue that the high prevalence of IPV particularly in African countries can be attributed to traditional norms and practices that condone the subordination of women in intimate relationships. Thus, Article 5

addresses the modification of cultural and social practices that eliminate prejudices based on the idea of superiority or inferiority and stereotyped roles for everyone. In Article 16 the Convention goes on to stipulate measures to eliminate discrimination in marriage. It stipulates that every woman shall have the right to choose a spouse and enter into marriage "with full and free consent". Furthermore, a study conducted in Zimbabwe on the prevalence of IPV among pregnant women indicated that the decision to fall pregnant lies with the partner and as such falling pregnant with the husband's consent is a way of protecting oneself from IPV (Shamu et al. 2013). Article 16 (e), however, recognises women's reproductive rights and explains the right of women to decide freely on the number of children they can have and when to have them, child spacing as well as access to information that will enable them to exercise these rights.

Discrimination against women is experienced differently depending on various factors such as locality and resource availability. Article 14 recognises the needs and rights of rural women as a distinct population group that experiences discrimination differently from their urban counterparts. Article 14 (b) and 14 (e) stipulates that women residing in rural areas should have access to "health care facilities, including information, counselling and services in family planning" and be able to "organise self-help groups and cooperatives" so that they will have equal access to opportunities. The lack of health facilities and psychosocial support services to IPV victims and

survivors is a major problem in rural areas in as far as responding to IPV cases in rural areas is concerned. Although the Convention recognises the need to decentralise such resources to the rural population, a lot still has to be done, as most women residing in rural areas do not have access to these facilities and services. Commendable in this Convention is its ability to address the

needs of various groups of women that are affected by IPV, and in this case, women residing in rural areas. It recognises the fact that discrimination is experienced differently by different groups; hence intervention measures should be different and specific to each group depending on how they are affected. Zimbabwe has ratified this Convention and has enacted various gender legislative instruments and policies. These include the Domestic Violence Act (2007), which is a response to CEDAW General Recommendations No. 19, which encourages states to prioritise the adequate protection of women and support services for victims and survivors of family violence (IPV included).

Beijing Declaration and Platform for Action (1995)

The Beijing Declaration and Platform for Action (1995) came about as a result of the Fourth World Conference on Women that was held in September 1995 in Beijing. This conference was built upon agreements that were reached at the previous three conferences: the World Conference of the International Women's Year held in Mexico in 1975, the World Conference of the United Nations Decade for Women held in Copenhagen in 1980 and the World Conference to Review and Appraise the Achievements of the United Nations Decade for Women, which was held in Nairobi in 1985. The Nairobi Conference was mainly focused on the equality and development of women, which is a critical issue in the empowerment of women residing in rural areas.

The Beijing Declaration and Platform for Action (1995) recognises the inherent dignity and worth of women. It recognises violence against women as a serious threat to the well-being of women and fundamental freedoms. Section 113 of Strategic Objective D defines violence against women as "any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including

threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life". It further recognises IPV by identifying marital rape and battering as one of the common forms of violence against women. Sections 114 and 116 take note of the reproductive rights of women and girls as well acknowledging that violence against women occurs across different groups of marginalised women; hence intervention should be best suited to these groups' particular needs.

The Beijing Declaration and Platform for Action recognises the contribution of patriarchy and social norms in the perpetuation of violence against women. Section 118 speaks against social norms and cultural practices that heighten the vulnerability of women and condone their abuse. It further provides specific measures to counter violence against women in Sections 124 and 125. It is critical to note that the Beijing Declaration does not assume uniformity in terms of how women experience violence: rather, it looks at violence from an intersectional perspective in Section 112, where it acknowledges how gender converges with other social variables (i.e. level of income, class, culture, economic status) in increasing women's vulnerability. This in turn has made it suitable for different contexts, such that Zimbabwe ratified the Convention and adopted it in formulating legislative frameworks on GBV.

AFRICAN LEGAL FRAMEWORKS

The following discussion will focus on the African legal frameworks that are aimed at ameliorating IPV.

The African Charter on Human and People's Rights

The African Charter on Human and People's Rights is an international instrument that seeks to protect and promote the rights of individuals on the African continent. Article 3 of the

Charter specifically states that everyone has equal protection under the law and shall be equal before the law. Article 18 recognises the family as the custodian of morals and tradition and calls for the elimination of discrimination of women as outlined in international declarations like CEDAW. The Charter draws its contents from international conventions like the ICESCR as it seeks to promote the fundamental rights and socio-economic rights of individuals. Although Zimbabwe has not yet domesticated the Charter, much of its contents are visible in the Zimbabwean Constitution, which is also centred on the promotion of socio-economic rights and the protection of women against social ills like IPV (Kondo, 2017).

Protocol to the African Charter on Human and People's rights on the rights of Women in Africa (adopted in 2003 and enacted in 2005).

This protocol was built upon Article 66 of the African Charter on Human and People's Rights, which acknowledged the need for special protocols and agreements that can supplement the provisions of the Charter. The Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa is a regional framework drafted to address socio-economic problems that are peculiar to Africa. Unlike CEDAW, the protocol touches on realities in Africa such as child marriages and harmful cultural practices. Zimbabwe has ratified this protocol. In its preamble it acknowledges that despite efforts made, women in Africa still suffer from lack of development. It also argues that advancement in terms of women empowerment in Africa is slow. It further acknowledges the existence of violence and discrimination against women. Article 2 recognises that discrimination against women hinders them from enjoying freedoms that come with their rights. As such, the protocol proposes measures that state parties are to follow in addressing discrimination. The protocol proposes an

inclusive approach in Articles 2 and 8, where it proposes the inclusion of the opinions of women from different geographical locations, rural areas included, and their access to justice systems. Additionally, Article 3 specifically touches on issues to do with IPV. Article 3(1) and 3(2) acknowledges the right of women dignity and respect for their personality. This means that women have a right to their bodies and cannot be attacked or injured. Hence, women cannot be subjected to harmful cultural practices or be abused by their intimate partners. It also recognises the freedom of women and acknowledges their reproductive rights in Article 14.

COMESA Gender Policy, 2002

The Common Market for Eastern and Southern Africa (COMESA) Gender Policy was drafted in support of gender equality and gender mainstreaming. It looks at the challenges women face and how these inhibit them from accessing opportunities that can transform their social and economic well-being. In its guiding principles the policy acknowledges women and girls as minority group that require protection. Additionally, it recognises the reproductive rights of women and acknowledges the need to protect these rights. Although this policy does not explicitly indicate IPV as a barrier to women's economic development, it does acknowledge the violation of women's rights as a major barrier to their well-being. As such it encourages policy implementation that safeguards these rights so as to ensure women's well-being.

SADC Protocol on Gender and Development, 2008

The SADC Protocol on Gender and Development speaks to issues pertinent in Africa, particularly in sub-Saharan Africa. Research

has indicated that countries in sub-Saharan Africa rank among the highest in the world with regard to IPV prevalence (McCloskey et al. 2016). It also acknowledges the effects of harmful cultural practices on the welfare of women and girls. Article 21(1) addresses the influence of social norms that exacerbate the perpetuation and tolerance of GBV, including IPV. Article 20 sets out the legal measures to be taken in dealing with victims and survivors of IPV. What is commendable in the SADC protocol is that it offers a comprehensive approach that touches on the drivers of GBV such as traditional norms and practices. However, the protocol does not take into consideration the differences in terms of women's experiences of GBV and the also the different intervention strategies that they might require in dealing with it. There are elements of uniformity in terms of how the protocol proposes measures to combat GBV, IPV included. It does not consider that interventions cannot be transferred from one geographical location to another. It is evident that the SADC Protocol on Gender and Development was crafted using a human rights-based approach, as it is more statutory and less focused on traditional systems regardless of their significant role in the perpetuation of IPV in rural areas. This in turn compromises the effective implementation of the protocol. Despite its shortcomings, the Protocol provides statutory measures that are critical in addressing IPV. Accordingly, Zimbabwe has ratified this protocol in an attempt to address IPV issues.

ZIMBABWEAN LEGAL FRAMEWORKS

Zimbabwe has made strides in dealing with IPV. Various legislative measures have been put in place to tackle IPV. Nonetheless, IPV remains a challenge in Zimbabwe; hence the government is obligated to protect the victims/survivors. Thus, the discussion below will show the legislative measures that Zimbabwe has enacted to ensure the protection of victims/survivors of IPV. The legislation measures that will be

discussed are: The Zimbabwean Constitution, Zimbabwe Gender Commission Act, Domestic Violence Act, Traditional Leaders Act, Sexual Offences Act, Zimbabwe National Gender Based Violence Strategy 2012-2015, Protocol on the Multi-Sectorial Management of Sexual Abuse and Violence in Zimbabwe and the Zimbabwe National Gender Policy 2013-2017.

The Zimbabwean Constitution (2013)

The Constitution of Zimbabwe, which is the supreme law in the country, recognises gender equality, human rights and freedoms as fundamental principles in ensuring the well-being of people. In acknowledging this, Chapter 2 (34) proposes that all treaties and convention that Zimbabwe is party to be incorporated in the domestic law. The Constitution does not make explicit reference to IPV; rather, it sets parameters within which legislation on IPV can operate. In its bid to recognise the sociocultural factors that promote the discrimination and abuse of women in different spaces, Chapter 34 (56) (3) the Constitution stipulates that,

> every person has the right not to be treated in an unfairly discriminatory manner on such grounds as their nationality, race, colour, tribe, place of birth, ethnic or social origin, language, class, religious belief, political affiliation, opinion, custom, culture, sex, gender, marital status, age, pregnancy, disability or economic or social status, or whether they were born in or out of wedlock.

It is laudable that the Constitutionhas a provision in Chapter 12 for the establishment of the Zimbabwe Gender Commission, which is mandated to promote equality, monitor violation of rights relating to gender and secure appropriate redress for this violation.

Zimbabwe Gender Commission Act (CAP 10:31)

The Zimbabwe Gender Commission (ZGC) was established under Chapter 12 of the Constitution of Zimbabwe Act No.20 of

2013 and operationalised through the Zimbabwe Gender Commission Act (CAP 10:31). It is a government entity that seeks to eradicate gender oppression and inequality. Its main role is to advocate for laws and policies and practices that promote gender equality, and it also oversees the implementation of the international and regional legislative frameworks such as CEDAW. The establishment of the ZGC is in line with Article 2(c) of CEDAW, which mandates states to "establish legal protection of the rights of women on an equal basis with men and to ensure through competent national tribunals and other public institutions the effective protection of women against any act of discrimination". In the Act, the ZGC is mandated to conduct investigations in a manner outlined such that the rights of victims and perpetrators cannot be violated.

However, the ZGC is argued to be not fully operational due to the staffing budget restrictions (International Federation of Red Cross & Red Crescent Societies, 2017). Although it was established for the purpose of better governance, it appears the Commission imposes heavy budget constraints which the government cannot bear. Thus in the 2018 National Budget the Gender Commission was the second least funded government commission and was allocated a total of USD 1.8 million for all its operational and employment costs. This in turn hascompromised the safety and well-being of IPV survivors and victims residing in rural areas, as service delivery is hamperedby limited funding. Hence, the government should empower, capacitate and regulate the ZGC, lest it become a defunct entity.

The Domestic Violence Act, 2007 (Chapter 5:16)

The Domestic Violence Act 2007 provides protection and relief to victims and survivors of domestic violence. Section 3(1) defines domestic violence (DV) as "any unlawful act, omission or behaviour which results in death or the direct infliction of physical, sexual or mental injury to any complainant by a respondent". Mugomba-Chirawu (2016) states that the greatest strength of the Act is that its comprehensive definition of DV has

not limited it to visible physical acts of violence, but covers all aspects that were previously silent but very harmful to the well-being of women, such as controlling behaviour. Section 3 (c), (i), (ii), (iii), (iv), (v), (vi) and (vii) also acknowledges abuse that is perpetrated by cultural practices and customary rites that violate the rights of women. Thus in ensuring protection of victims, Section 5 (1) stipulates that every police station shall be staffed with at least one officer who will be experienced in "domestic violence, victim friendly and other family-related matters". Similarly, Section 15(2) (a), (b), (c), (d), (e) and (f) stipulates the importance of anti-domestic counsellors whose roles include counselling, medical referrals, investigation as well as arrangements for places of safety – although these services are mostly absent in rural areas.

Section 15(3) allows the counsellor to seek assistance from any police officer in carrying out their duties. However, the Act does not specify social workers as counsellors but rather Section 15(1) (a), (b), (c) identifies social welfare officers or officers involved in community work, employees of private voluntary organisations concerned with welfare of victims of DV and chiefs and headmen as capable of carrying anti-domestic violence counselling. It is worth noting that the Act allows traditional leaders to provide counselling to victims of DV and ultimately IPV. Considering that IPV in rural areas is largely shrouded in social norms and formal services are not readily available, village heads and chiefs do play a significant role in the provision of basic counselling to victims.However, although this is crucial for victims, social work intervention remains critical in IPV intervention, as social workers are trained to provide psychosocial support to them. As such, therole of social workers should be acknowledged, as they play a significant role in the provision of psycho-social support to victims and survivors of IPV in rural areas.

Furthermore, although the Act criminalises DV, Section 4(2) (a) and (b) stipulates that emotional, verbal, psychological and

economic abuse do not constitute an offence yet are equally harmful, especially for women residing in rural areas who do not have access to formal counselling services and are unemployed. Research conducted in Zimbabwe indicates that IPV suicidal ideation and depression are associated with emotional and physical abuse, with emotional abuse recording a prevalence rate of 47% among pregnant women (Shamu et al. 2016). Thus, incomplete suicidal thoughts can result in full suicide if the problems that the women are facing are not addressed. Again, Section 18(a) and (b) stipulates that the local courts (community courts) can issue protection orders for issues relating to emotional, verbal, psychological and economic abuse without charging the perpetrators unless the conditions of the peace order are not adhered to. This compromises the efficacy of the Act and facilitatesIPV in rural areas by promoting non-disclosure of cases of spousal abuse, as perpetrators go uncharged and unpunished (Chigwata, 2016).

On a progressive note, the Act is credited for empowering informal support systems such as complainants' representatives (neighbours, religious leaders) for victims/survivors of DV, given that DV,especially in rural areas, is unvoiced and legal intervention is usually a last resort. Furthermore, Section 16 authorises the operation of the Anti-Domestic Violence Council, which a body is created to be a watchdog on DV issues as well as monitor the implementation of the Act. What is commendable about the Anti-Domestic Violence Council is its inclusive nature: it recognises the contribution of other support systems of victims/survivors of DV (such as churches). The contribution of these support systems is very helpful, as they are usually the first point of contact for victims/survivors of DV and IPV.

ZIMBABWEAN LEGAL FRAMEWORKS

Traditional Leaders Act 1998 (Chapter 29:17)

The government has attempted to fuse traditional law and judicial law through the enactment of the Traditional Leaders Act (Chapter 29:17), which recognises the importance of traditional leadership in upholding social norms and traditional laws that are critical in maintaining order and stability. In rural areas traditional leaders are highly respected and treated with considerable esteem (Chigwata 2016). The Act requires traditional leaders to be appointed in accordance with social norms and traditional practices, and this has in turn has compromised the position and plight of women in rural areas. The traditional law system is largely driven by patriarchal norms, as traditional jurisprudence itself regards women as weak, and the *dare* (traditional court) is regarded as a men's council (Matavire, 2012).

Furthermore, Section 12 of the Act tasks traditional leaders, as custodians of culture and social norms, with dispute-resolution roles (Chigwata, 2016). Their major role is to bring equilibrium to disequilibrated relationships (Matavire, 2012). Despite this, the jurisdiction of traditional courts is limited to civil cases, as chiefs and headmen do not have the authority and power to adjudicate complex matters such as spousal rape and abuse that results in physical injuries, as these are expected to be handled by the police. However, considering the geographical location of rural areas, where there is inadequate resources and infrastructure, traditional courts become more accessible and cheaper for victims of IPV than the magistrate courts, which are located mostly in towns and cities. Given these constraints, chiefs and headmen end up trying cases that are beyond their jurisdiction, which puts victims/survivors of IPV at a greater risk and increases their vulnerability. There is no confidentiality and

security in traditional courts, and there are no psychosocial or medical services for the victims. Normally the traditional court process for victims of IPV becomes embarrassing for them, as the court is structured on a system that conforms to social norms and traditional practices that condone IPV.

The Sexual Offences Act 2001 (Chapter 9:21)

The Sexual Offences Act 2001 (Chapter 9:21) criminalises sexual violence. Section 8 (1) acknowledges the existence of spousal abuse (non-consensual sex) and regards it as an offence liable to penalties provided by law for the perpetrators of sexual violence. This Act challenges the social norms regarding conjugal rights, which are one of the main drivers of IPV in rural areas (Matavire, 2012).

Zimbabwe National Gender Based Violence Strategy 2012-2015

The Zimbabwe National Gender Based Violence Strategy (ZNGBVS) 2012-2015 is a strategy adopted by the government to eradicate GBV and improve the response to such cases. The strategy came after the realisation that despite the enactment and

ratification of various international and regional frameworks, GBV against women remained high. Accordingly, the Strategy sought to reduce GBV by 20% by 2015. The ZNGBVS 2012-2015 is anchored in four key result areas: prevention, service provision, coordination and research, documentation and monitoring and evaluation. Commendable in this strategy is its attempt to provide a holistic package in GBV response by also taking into consideration the impact of IPV in rural areas. The four key result areas enable the collective efforts from various stakeholders (e.g. academics, civil

society organisations, communities and the government), and this is imperative in creating an enabling environment for zero tolerance of IPV.

Protocol on the multi-sectoral management of sexual abuse and violence in Zimbabwe 2012

The purpose of the protocol is to safeguard victims of sexual violence regardless of their marital status and age. It also provides a blueprint for service providers on how they should deal with survivors/victims of sexual violence. As such, the protocol provides a holistic package with timeframes in service provision to victims/survivors of sexual violence from medical services to psychosocial support and case reporting. Similarly, it provides referral pathways to be followed in dealing with survivors of sexual violence, be it in rural areas or urban areas. Creditable in this protocol are its guiding principles, which are embedded in social work ethical principles (such as confidentiality, self-determination, respect and dignity) that acknowledge and safeguard the rights and best interests of the victims/survivors. Moreover, the major strength of this protocol is the establishment of Victim Friendly Units (VFUs) located in police stations. These are a brainchild of the Judicial Services Commission which is provided for in Section 189 of the Constitution and its functions espoused in Section 190. The VFUs also include other stakeholders, such as social workers, in ensuring the protection and participation of IPV victims/survivors in the justice system.

Zimbabwe National Gender Policy (2013-2017)

In its executive summary the Zimbabwe National Gender Policy (ZNGP) 2013-2017 indicates that it sought to replace the ZNGP 2004 and address its shortcomings. The ZNGP 2013-2017 identified GBV as one of its eight priority areas. It is founded on, i)

2005 Beijing Global Review, ii) 2008 SADC Protocol on Gender and Development, which provides targets for achieving gender equality by 2015, iii) CEDAW Report, and iv) the 2011 Broad Based Women's Economic Empowerment (BBWEEF), a tool for women's economic empowerment across all levels of society. The policy recognises that one of the biggest obstacles to women's empowerment and their participation in social activities is GBV. The policy's objective is to reduce all forms of GBV in Zimbabwe by creating a supportive policy and programmatic environment for non-tolerance of GBV as well as strengthening institutional coordination mechanisms for addressing GBV. The main strength of this policy is that it seeks to provide a policy environment that is supportive of initiatives that are critical in addressing GBV and ultimately IPV. It acknowledges that despite numerous efforts to curb GBV, they continue to yield limited results, and this is mainly due to "inadequate services and weak institutions for addressing GBV, poor information communication systems and patriarchal attitudes that restrain men from reporting incidences of abuse". Thus, it seeks to strengthen institutions and communications systems as well as shift attitudes and beliefs on GBV as stipulated in the Optional Protocol to CEDAW.

However, the policy does not dwell much on the traditional institutions that play a major role in fuelling GBV; rather, it proposes strengthening the multi-sectoral stakeholders, who include community leaders and community structures. Traditional institutions, which include the family, the extended family and the religious leaders, are very critical in addressing GBV, particularly IPV, as they are regarded as the immediate source of support for victims. IPV in rural areas is unvoiced, which makes it very difficult to determine its extent. Furthermore, the National Policy prefers to use a generic approach, rather than directly acknowledge that the abuse of women residing in rural

areas is rife. Hence women residing in rural areas remain disadvantaged and vulnerable to IPV. A study conducted by the United Nations Fund for Population Activities (UNFPA) (2018) indicated that 78% of the GBV cases reported from the period of June 2017 to March 2018 consisted of female victims, with 41% of the cases stemming from IPV.

IMPLICATIONS FOR SOCIAL WORK PRACTICE

Legislation is the cornerstone of ensuring the safety of IPV victims/survivors. For its part, social work practice is governed and regulated by different policies and legislative frameworks. Social workers are agents of social change and advocates for the rights of vulnerable groups of society. According to Cournoyer (2011), social workers are mandated to advance human rights and engage in social policy and practice so as to ensure the social and economic well-being of individuals and groups. IPV in rural areas differs significantly from that in urban areas; hence there is need for social workers who are trained to analyse and understand complex social problems facing women residing in rural areas. As such social workers can play a significant role in the implementation of legislation relating to IPV in rural areas by conscientising women on the consequences of IPV and on how various legislative frameworks can protect them. It is very important that the formulation and implementation of IPV legislation explicitly outlines the role of social workers, as they are regarded as the agents of change and are trained to work with such a client base.

Additionally, there is also the risk of adopting a uniform and generalised approach in formulating and executing these legislative frameworks. Policies are often formulated targeting single social variables and barely recognise the intersectionality

of various factors that shape the experiences of women. Failure to take such realities into consideration may render the dissemination of legal information and intervention less useful, given the distinctive character of rural areas (Tsanga, 2003). The implementation of legislative frameworks in rural areas thus becomes a mammoth task, and this hampers effective social work intervention on IPV cases in rural areas in Zimbabwe.

In the same vein, dealing with sensitive social problems such as IPV requires special skills: Counoyer (2011) argues that engaging with people from different backgrounds with different perspectives and beliefs requires special professional expertise and considerable sensitivity. Social workers are trained to embrace diversity, which makes them more appropriate in dealing with IPV victims/survivors. Similarly, legal messages that challenge social norms in rural areas present difficulties in terms of their reception by community members. As a result there is need for social workers to intervene, as they are trained to work with such diverse groups of society.

Furthermore, economic empowerment remains the most important intervention strategy for changing the status of women and ameliorating any existing inequalities in Zimbabwe. IPV on its own remains a barrier that cannot be solved only by economically empowering women. Existing legal frameworks focus more on strategies that seek to economically empower women and give them decision-making powers. Considering that social work practice on IPV-related issues is also governed by these legislative frameworks, the intervention strategies that social workers employ in eradicating IPV might not be responsive to the actual experiences of the women. Thus, IPV victims/survivors residing in rural areas are still at risk regardless of the 'services available' to them. The starting point should be aimed at shifting patriarchal attitudes and beliefs that often lead to

IPV. It is therefore imperative that legislative frameworks be crafted in a way that they tackle the foundational barriers, IPV included, that inhibit the empowerment of women. Continual use of legislative frameworks that do not address these barriers will render social work practice in IPV spaces ineffective as the victims/ survivors of IPV will not be receptive of these services.

Additionally, research is crucial, as it informs policy formulation and implementation. Zimbabwe has limited research on IPV and how it is experienced by women, particularly those residing in rural areas; hence it is very difficult to determine its scope and extent. As such the intervention strategies that are formulated might not adequately represent the experiences of the women residing in rural areas. Implementing these intervention strategies against IPV in rural areas become difficult. As a result, social workers working in rural areas encounter challenges in implementing these policies and intervention strategies. Consequently, few social workers work in rural areas because of the complexities in dealing with IPV cases, and this has heightened the plight of survivors/victims of IPV. In this regard, Dziro (2013) argues that social work training in Zimbabwe should encourage rural placements and promote research on rural areas and the social problems that are prevalent there.

Furthermore, chiefs and headmen as traditional leaders have been given legislative powers to deal with such cases; however, by virtue of being custodians of archaic cultural practices, they conform to social norms that condone IPV. There is thus a danger of conflict arising between social workers and the chiefs, since the principles that the respective parties adhere to are

in conflict. As such, rendering social work services in to IPV victims/ survivors residing in rural areas become difficult considering that traditional leaders are the 'port of entry' for any interventions directed to IPV victims.

CONCLUSION

The protection of women against IPV is vital in changing their socio-economic status as well as ensuring their well-being. IPV is a violation of women's rights, and Zimbabwe accordingly recognises IPV as a threat to the well-being of women. It is evident from this article that there has been a remarkable shift from an era where IPV was regarded as an acceptable norm to the present, where it is regarded as a criminal offence. Regardless of legislative efforts in curbing the phenomenon, a lot still has to be done. Zimbabwean society is still largely patriarchal in nature, and formal laws, while commendable, remain creatures of statute. As a consequence, IPV remains pervasive and the enforcement of these laws is weak. It is important that lawmakers and social workers honour their obligation and duties towards protecting the rights of women by ensuring a form of integrated intervention that also incorporates customary laws so as to ensure an effective response to IPV in Zimbabwe, particularly in rural areas. It is also critical for the government to ensure that institutions aimed at fighting GBV and IPV are operationalised, as they are largely invisible.

Acknowledgements

The author would like to acknowledge the assistance she received from her PhD supervisor Dr Warria.

References

Alangea, D.O., Addo-Lartey, A.A., Sikweyiya, Y., Chirwa, E.D., Coker-Appiah,D ., Jewkes, R. & Adanu,R.M.F. 2018. Prevalence and risk factors of intimate partner violence among women in four districts of the central region of Ghana: Baseline findings from a cluster randomised controlled trial. PLoS ONE.13(7):1-19 https://doi.org/10.1371/journal.pone.020087

Bikinesi, L. T., Mash, R., & Joyner, K. 2017. "Prevalence of intimate partner violence and associated factors amongst women attending antenatal care at Outapi clinic, Namibia: A descriptive survey." *African Journal Primary Health Care Fam Med* 9(1):1512. https://doi.org/10.4102/phcfm.v9i1.1512

Cournoyer, B. R. 2011. The social work skills workbook (6th ed). California: Brooks/Cole.

Duvvury, N., Callan, A., Carney, P., & Roghavendra S. 2013. Gender and equality development, Intimate partner violence: Economic roots and Implications for Growth and development. Washington: World Bank Group.

Dziro, C. 2013. Trends in social work education and training: The case of Zimbabwe. *International Journal of Development and sustainability* 2(2): 1423-1435. https://isdsnet.com/ijds-v2n2-74.pdf (accessed December 14, 2018).

Fidan, A. & Bui, H. N. 2015. Intimate partner violence against women in Zimbabwe. Violence against women, 22 (9), 1075-

1096. DOI: 10.1177/1077801215617551

Giddens, A. & Sutton P. W. 2017. Sociology (8th ed). Cambridge: Polity Press.

Groves, A.K., Moodley, D., McNaughton-Reyes, L., Martin, S.L., Foshee, V. & Maman, S. 2015. Prevalence and rates of IPV among South African women during pregnancy and the postpartum period. *Maternal Child Health Journal* 19(3):487-49 https://dx.doi.org/10.1007%2Fs10995-014-1528-65

International Federation of Red Cross and Red Crescent Societies .2017. Zimbabwe country case study: Effective law and policy on gender equality and protection from sexual and gender based violence in disasters. Geneva: International Federation of Red Cross. https://redcross.eu/uploads/files/Positions/Humanitarian%20aid/SGBV%20in%20disasters/Gender%20SGBV%20Report_%20Zimbabwe%20HR.pdf (accessed January 15, 2019)

Kapiga, S., Harvey, S., Muhammad A.K., Stock, I.H., Hashim, R., Harven, C., Lees, S. & Watts, C. 2017. Prevalence of intimate partner violence and abuse associated and associated factors among women enrolled into a cluster randomised trial in North Western Tanzania. *BMC Public Health* 17 (190). DOI: 10.1186/s12889-017-4119-9

Klugman, J., Hanmer, L., Twigg, S., Hasan, T., McCleary-Sills, J., & Santa-Mary, J. 2014 Voice and agency; Empowering women and girls for shared prosperity. Washington DC: World Bank. http://hdl.handle.net/10986/19036 (accessed January 15, 2019)

Klugman, J. G. 2017. Gender based violence and the law. World

Development Report Background paper. Washington: World Bank.

Kondo, T. 2017. Socio-economic rights in Zimbabwe: Trends and emerging jurisprudence

African Human Rights Law Journal, 17, 163-193. http://dx.doi.org/10.17159/1996-2096/2017/v17n1a8

Kurevakwesu, W. 2017. The Social work profession in Zimbabwe: A critical approach on the position of social work on Zimbabwe's development. *Afro-Asian Journal of Social Sciences* 8 (1): 1-19. http://www.onlineresearchjournals.com/aajoss/art/232.pdf (accessed January 15, 2019)

Matavire, M. 2012. Interrogating the Zimbabwean traditional jurisprudence and the position of women in conflict resolution. A case of Shona tribes in Muzarabani district. *International Journal of humanities and social sciences* 2 (3): 218-223. http://www.ijhssnet.com/journals/Vol_2_No_3_February_2012/29.pdf (accessed January 15, 2019)

McCloskey, L.A., Boonzaier, F., Steinbrenner, S.Y, & Hunter, T. 2016. Determinants of intimate partner violence in sub Saharan Africa: A review of prevention and intervention programs. *Partner Abuse* 7 (3): 277-315.

Mugomba-Chirawu, Sylvia. 2016. A reflection on the Domestic violence Act (Chapter 5:16) and harmful cultural practices in Zimbabwe. The Zimbabwe Electronic Law Journal, 1, 4-12. http://ir.uz.ac.zw/bitstream/handle/10646/3341/Chirawu_Mugomba_A_Reflection_on_the_Domestic_Violence_Act%20%5bChapter%205-

16%5d.pdf?sequence=1&isAllowed=y (accessed January 14, 2019)

Mukanangana, F., Moyo, S., Zvoushe, A. & Rusinga, O. 2014). Gender based violence and its effects on women's reproductive health: The case of Hatcliffe, Harare, Zimbabwe. *African Journal of reproductive health, 18* (1): 110-122. http://bioline.org.br/pdf?rh14012 (accessed January 15, 2018).

Nkomo, S.N. 2014. A critical analysis of Zimbabwe's legal response to traditional cultural practices and gender-based violence. Master's dissertation, University of Western Cape.

Sesane, M. & Geyer, S. (2015). The perceptions of community members regarding the role of social workers in enhancing social capital in Metropolitan areas to manage HIV and AIDS. *Social Work/ Maatskaplike Werk,* 53 (1): 1-25. doi:http://dx.doi.org/10.15270/52-2-543

Shamu, S., Abrahams, N., Zarowsky, C., Shefer, T. & Temmerman, M. 2013. Intimate Partner violence during pregnancy in Zimbabwe: A cross-sectional study of prevalence, predictors, and associations with HIV. *Tropical Medicine & International Health* 18: 696–711. doi:10.1111/tmi.12078

Shamu, S., Zarowsky, C., Roelens, K., Temmerman, M. & Abrahams, N. 2016. High frequency intimate partner violence during pregnancy, postnatal depression and suicidal tendencies in Harare, Zimbabwe. *General Hospital Psychiatry* 38: 109-114. http://dx.doi.org/10.1016/j.genhosppsych.2015.10.005

Tsanga, A.S. 2003. Taking law to the people: gender, law reform and community legal education in Zimbabwe. Harare: Weaver Press

UNFPA 2018. Community-based BV surveillance system. June 1st- March 31st. Harare: UNFPA. https://zimbabwe.unfpa.org/en/publications (accessed January 14, 2019)

Zimbabwe Demographic and Health Survey 2010-2011. Harare: Zimbabwe National Statistics Agency

ZimStats 2012. Zimbabwe National Population Census. Harare: Zimbabwe National Statistics Agency.

Zimbabwe Demographic and Health Survey. 2015. Key findings on Gender-based Violence. Harare: ZIMSTATS.

Zimbabwe National Gender Based Violence Strategy 2012-2015. Ministry of Women Affairs, Gender and Community Development.

3.9.2 CONCLUSION

Laws are meant to protect people from any violation of their human rights and are necessary for maintaining order. Legislative frameworks in this regard are necessary in the protection of victims of IPV in both urban and rural areas. In urban areas, strides have been made in implementing the legislation as a consequence of the advantages of urban areas in terms of locality and allocation of resources. However, rural areas are still lagging behind in implementing the legislation due to scarce resources, lack of political will and lack of awareness of IPV as a criminal offence. Nevertheless, strides have been made to ensure the criminalisation of IPV, which is important in minimising, managing and preventing the occurrence of IPV.

CHAPTER 4
RESEARCH METHODOLOGY

4.1 INTRODUCTION

This chapter explains the methods used in this study. Research methodology entails the manner in which researchers conduct their studies and this includes the path to formulation of research questions, objectives and data collection methods (Nowell et al., 2017). The articles presented in the following chapters have included sections of methodology; therefore, this chapter will present an in-depth discussion on those sections that were not fully discussed in the articles. This chapter begins with a description of the qualitative approach and the research design utilized in this study in relation to IPV. An account of the sampling techniques and the research instrument used is provided. Data collection and data analysis processes are presented, followed by ethical considerations and ethics of care that guided the study. Lastly, a discussion on reflexivity will be presented.

4.2 RESEARCH APPROACH

This study adopted a qualitative approach. Researchers have identified the main characteristics of qualitative research as relating to the understanding of different aspects of social life and the methods that are used to generate words for the analysis of data, hence the research method is best suited to examine complex social issues (Devlin, 2006; Marshall & Rossman, 2011; Monette et al., 2005; Rotchford et al., 2002). This in turn offers new ways to better understand the complexities of society. It allows the researcher to obtain detailed data in its natural setting and due to its interpretive nature; it gives the researcher an opportunity to interpret the data collected. Given its focus on capturing the ideas and experiences of participants, the qualitative approach was best suited for this study as it allowed for the exploration of the participants' views, experiences and their multiple narratives of IPV. The selection of this research approach for the current study was influenced by its previous application to several other IPV studies (Dekel & Andipatin, 2016; Mashiri, 2013; Kelmendi, 2013; Fidan & Bui, 2016; Dodzo & Mhloyi, 2017; Shams et al., 2020; Moono et al., 2020) that adopted it because of its flexibility in exploring diverse views and interpretations of particular situations.

4.3 RESEARCH DESIGN

A narrative research design was adopted for this study. Narrative research design entails research that works with material of a narrative nature such as stories (Creswell et al., 2007). It provides both the researcher and the participants with a foundation to engage and develop connections that are critical for the development of a broader understanding of the phenomenon (Haydon et al., 2017). The main advantage of narrative research design is its ability to provide in-depth evidence about the everyday lives of research participants and give meaning to their experiences (Elliot, 2005). Furthermore, the inclusion of social, cultural and environmental influences on experiences makes narrative research design particularly suitable for qualitative studies as it incorporates dimensions that impact on people's experiences (Haydone et al., 2017). Although narrative research is hailed for being appropriate for qualitative studies, Bell (2002) argues that narrative research is not suitable for all inquiries as the time commitment required is not suitable for a larger sample. Also, the exchange of stories and personal experiences with participants can make it difficult for researchers to disengage after the research project. Regardless of these disadvantages, narrative research was found to be the most suitable for this study. In this study, narrative research was focused on the lived experiences of women residing in rural areas who experienced IPV in their previous intimate relationships. Participants' narratives explained their experiences of IPV, the causes as well as the impact on their psychosocial well-being. Bruce et al. (2016) argue that narrative enquiry focuses on understanding the outcomes of interpretation by gathering data from real life experiences. This is evident in past research conducted on IPV using narrative research design (Boonzaier & van Schalkwyk, 2011; Jarnkvist, 2018). Thus, in this study narrative research strategy was applied as it enabled the researcher to collect in-depth stories that were crucial in understanding rural women's experiences of IPV in Zimbabwe.

4.4 RESEARCH INSTRUMENT

A semi-structured interview schedule was used for the study. A semi-structured interview schedule is an interview script that structures and guides the direction of the interview and gives an outline of the topics to be covered with suggested open-ended questions (Kvale & Brinkmann, 2009). A semi-structured interview schedule was used in this study due to its flexibility in asking further questions in response to the significant replies provided by the participants (Bryman, 2008). The questions were all open-ended and sought to explore the

personal IPV experiences of participants. The researcher grouped the questions according to the objectives of the study to maintain flow of information from one topic to another. This allowed for further probing about specific issues that the participants may highlight. Sensitive issues were addressed only once rapport was established.

There were two different semi-structured interview schedules for the interviews with the women and these were in both English and Shona. Upon review of the ethics application for this study, the committee recommended that the schedules be translated into Shona as well in case there were participants who wanted to be interviewed in their home language. The researcher developed both the English and Shona versions of the interview schedule and requested a Shona-speaking person to assess the questions to ensure correct translation.

The use of open-ended questions was to ensure consistency and structure in the interview process as well as ensuring flexibility in probing. In line with Butin's (2015) suggestions, the open-ended questions were framed in everyday Shona language that was easy to understand and allowed participants to provide detailed information regarding their experiences of IPV. The semi-structured interview schedule consisted of 15 broad open-ended questions with multiple probing categories under each main question.

There were separate semi-structured interview schedules developed for each key informant that asked for information in line with their work specialisation and with further application to IPV intervention in rural areas. Different interview schedules were developed for the different sources (see appendices C, D, E and F). However, it should be noted that while some of the questions were similar, others were quite different.

4.4.1 Pre-testing the research instrument

When pre-testing the research instrument, a small study is conducted to test the study procedures and the validity of the tools (Arain et al., 2010). Chenail (2011) argues that the advantages of pre-testing the research instrument are that it warns the researcher about the areas that can negatively affect the research process and where research procedures cannot be followed. Before the beginning of the data collection process the researcher pre-tested the semi-structured interview schedule to ensure that it was able to generate the desired information from the participants. As suggested by researchers, pre-testing the research instrument is important

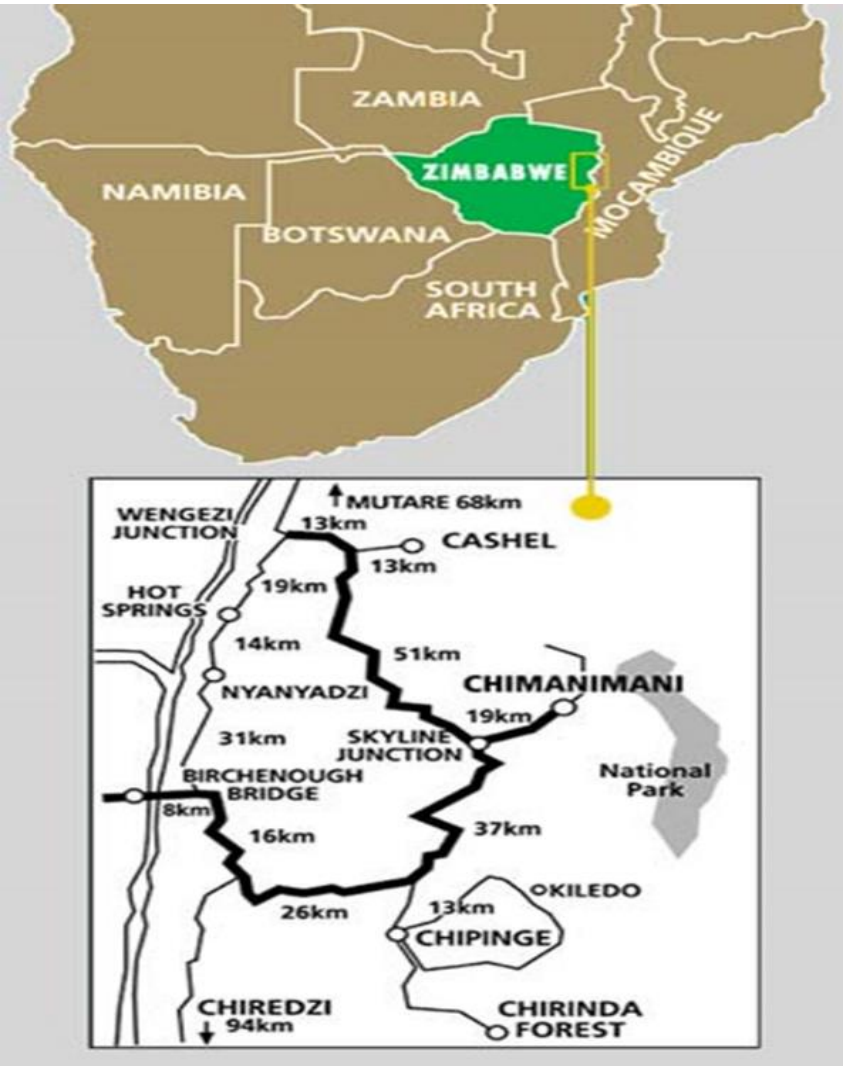
as it allows the researcher to refine the research instrument and adjust the questions where necessary (Sarantako, 1998; Marshall & Rossman, 2011). The researcher pre-tested the research instrument with one participant who had similar characteristics with those of the participants. The interviews with the participants were conducted in one session and lasted an average 53 minutes. In pre-testing the research instrument, the researcher was more concerned with scheduling of the questions, ease of comprehension, flow of questions and the questioning techniques. Amendments were made to the interview schedule regarding questions surrounding support mechanisms as well as the role of culture in the perpetuation of IPV. For example, in the revision, the researcher included follow-up question(s) relating to the appropriateness of formal and informal support systems in rural areas. Given the rich data obtained from the pilot study, the participant was included as a study participant (Malmqvist et al., 2019).

4.5 CONTEXT OF THE STUDY

Rural areas in Zimbabwe are home to two-thirds of the total population, with 79% being considered poor and 92% of the extreme poor (World Bank Macro-poverty Outlook, 2015). Additionally, males in rural areas make up 67%, while 33% reside in urban areas, whereas 62% of females reside in rural areas, while 38% are based in urban areas (ZIMSTAT, 2016). The rural economy in Zimbabwe is largely reliant on subsistence farming. Despite being home to more than 67% of the total population in Zimbabwe, the rural economy continues to be marginalised and is not integrated into the mainstream economy (ZNPC, 2012). This in turn explains why rural areas in Zimbabwe are poor and disadvantaged in terms of distribution of resources and provision of socio-economic services that are critical in addressing social and economic problems. Chimanimani District in the Eastern Highlands (in Manicaland Province) is mainly rural and one of the poorest districts in Zimbabwe. It is 155 kilometres southeast of the provincial capital, Mutare and borders Mozambique to the east. It is mountainous with rugged terrain that makes access to some of its remote villages challenging. The district is divided into 23 wards and the population mostly consist of the Ndau people, a Shona ethnic group. The population in Chimanimani District relies on subsistence farming, and communities like Chaseyama, Chakohwa, Hotsprings, Nenohwe, Nyanyadzi are situated 5 kilometres across the Odzi River, which borders the Marange and Chiadzwa diamond mines (Gomo & Munyati, 2005). The disruption of social lives due to both illegal and legal mining activities in both Chimanimani and in the neighbouring districts has left many households vulnerable. Part of the vulnerability reported is the increased exposure of women and girls to violence (including

IPV) (Centre for Research and Development, 2013; Gomo & Munyati, 2005) as well as HIV/AIDS prevalence. An increase in internally displaced persons due to legal and illegal mining, child marriages due to poverty, and the destruction of the family fabric facilitates the abuse of women. Given that in rural areas, the family structure influences marital relationships; its destruction can provide a conducive environment for the perpetuation of IPV.

Figure 3: Map of Zimbabwe showing the location of Chimanimani Rural District.



Source: http://www.chimanimani.com/about/

4.6 RESEARCH POPULATION AND SAMPLING

A research population has been defined as all possible cases of what the researcher is interested in studying and it often comprises people who have certain common characteristics (Butin, 2015). According to the last population census carried out in 2012 in Zimbabwe, the total

number of women residing in rural areas was 4 535 779. Based on the results of this census, the population of Chimanimani Rural District is 133 810 with 69 478 females and 64 332 males (Zimbabwe National Statistics Agency, 2012). In the identification of the research population, the population of this study consisted of women residing in rural areas in Zimbabwe, with a focus on one ward from Chimanimani District, Eastern Highlands, Manicaland Province, in Zimbabwe. A ward is made up of six to eight villages and each village has a minimum of 35 households (Madzudzo, 1997).

This study adopted non-probability sampling, which is used for exploratory and qualitative analysis and purposive sampling was used in selecting the sample for the study. Purposive sampling is when a researcher deliberately chooses a participant due to the qualities that the participant possesses in line with the phenomenon of interest (Etikan, Musa & Alkassim, 2016). The inclusion criteria were (a) participants' availability and willingness to take part in the study; (b) previous IPV experiences in former intimate relationship(s); (c) should be between 19 and 49 years of age; (d) reside in Chimanimani Rural District; and (e) female identifying persons. The sample of this study consisted of 25 participants drawn from one ward in Chimanimani Rural District. Initially the researcher intended to interview women from eight villages in the ward as the ward consisted of eight villages and the Ministry had given the permission to interview participants in the whole ward. Unfortunately, the researcher only managed to interview women from six villages due to Cyclone Idai that affected the district in March 2019 and made accessibility to some villages impossible due to the floods and landslides. Out of the six villages, at least two participants per village were interviewed.

The selection of women whose age range was between 19 and 49 years was because women in this age group are actively involved in intimate relationships and are considered able to participate in a research study voluntarily (Zimbabwe Demographic & Health Survey, 2015; Zimbabwe National Family Planning Strategy, 2016-2020). As the research was conducted in Chimanimani district, all participants in this study were drawn from the villages within the district. All the women in this study reported no current involvement in any intimate relationship. Girls aged 18 and under and women in intimate relationships that were characterised by IPV (during data collection) and who did not have intervention remedies were excluded from the study although this is a population that warrants inclusion in future IPV research.

In selecting participants, informal self-help groups (ISHGS) (in different villages) in one ward in Chimanimani District were approached. The groups meet once every week to discuss a range of issues including microfinance initiatives, challenges on the home environment as well as to debrief. The researcher took advantage of *zuva rechisi* (cultural resting day) to approach the women in their ISHGs. These groups would meet on *zuva rechisi* as it was the day they were free to rest and not do any hard labour such as farming. *Zuva rechisi* varied between villages and thus in a week, the researcher could cover a maximum of two villages.

During the meet-and-greet meetings, the researcher verbally explained the focus of the study and invited group members who fit the research criteria to be part of the study. In ensuring confidentiality, participant information sheets (PISs) (see appendix A) were distributed to all women in the gathering, requesting them to indicate their willingness to be part of the study. Women who were willing to participate in the study were requested to provide their contact details on the PISs for follow-ups. All women in the group then submitted the forms (after indicating their preference i.e. whether they want to be interviewed or not and contact details) in an A4-size envelope that was provided. This approach was used because of the sensitive nature of IPV and to maintain confidentiality (Shenton & Hayter, 2004). The researcher was available in case the women had questions regarding the study. However, no one in the groups requested further clarity regarding the study. As part of building rapport, the researcher attended the rest of the weekly meetings as an observer. This happened over several weeks and the observation provided rich information especially with regard to the context of the study and interactions amongst the women.

Once all the PISs were collected, the researcher read them through and made individual follow-ups with the participants who had agreed to participate in the study. Some women who had indicated their unwillingness to participate in the study later approached the researcher outside the group and expressed their interest in sharing their stories. This could be as a result of lack of anonymity and mistrust associated with engaging with 'outsiders' in rural areas that resulted in the women being hesitant to indicate their willingness to participate on the PISs provided (Riddell et al., 2009). The women who participated in the study were all unemployed and mainly reliant on subsistence farming and small income generating projects for survival.

Triangulation of sources, i.e. the collection of data from multiple sources to develop a comprehensive understanding of the phenomena, was applied (Nowell et al., 2017; Shenton,

2004). In ensuring data triangulation, seven key informants who have vast and varied experience of IPV in rural areas were included in the study. The key informants were drawn from community level to national level as aligned to IPV intervention in rural areas. The researcher selected the key informants on the basis that they (i) had experience in managing IPV issues in rural areas; (ii) had worked in Chimanimani District for at least three years; (iii) were willing to be part of the study; and (iv) were available during data collection. Seven key informants were identified for the study and of these, six were from Chimanimani Rural District and one was from the Ministry of Women Affairs, Community, Small and Medium Enterprise Development which oversees the implementation of gender policies that address IPV in rural areas. The gender officer from the Ministry was included in the study although not primarily based in Chimanimani Rural District. The key informants were the following:

(a) **Two traditional leaders**/ *masabhuku* (village heads) who manage the village. Traditional leaders in rural communities are mainly men. They are regarded as the custodians of culture and social norms that are at the centre of IPV perpetration in rural areas. Thus, village heads are legally mandated to deal with family disputes (marital conflicts included), social issues and challenges that are reported to them for (informal) intervention in rural areas (Chigwata, 2016). In most rural areas, this could be the only form of justice or intervention available. Further to that, these traditional leaders play a crucial role in the successful implementation of IPV intervention programmes as entrusted by the government and they act as the bridge between community members and service providers. The two traditional leaders were instrumental in the study because they are always in close interaction with IPV victims as they are trusted and seen to have wisdom to solve disputes and make fair judgements.

(b) **One medical practitioner**, a nurse from the nearest clinic: The role of the nurse is to provide health care services to community members. In IPV intervention, the nurse plays a critical role in the provision of medical care to IPV victims in the community especially when injuries are involved. The nurse also reinforces mandatory reporting of IPV cases to the police and refers victims to the police. The nurse was important for the study, because, depending on the severity of injuries from IPV, the victims seek medical assistance from the health facility.

(c) **One police officer** from the local police post: In IPV intervention, the police play a critical role in ensuring that IPV victims in rural areas are protected and perpetrators are brought to justice. The police officer works closely with the health care officials in terms of referrals for medical assistance if cases are first reported to them. It was

important to include this person in the study because in seeking formal (protection) remedies, IPV cases are reported to their office.

(d) **Two gender officers:** Of the two gender officers included in the study**,** one was from the Chimanimani District Office and the other one from the Ministry of Women Affairs, Gender and Community Development. Gender officers are critical in the formulation of policies and implementation of programmes that are aimed at preventing and minimising the occurrence of IPV against women in rural areas. They were included in the study because they are instrumental in gender policy development and implementation in the area under study.

(e) **One social worker:** The role of the social worker is to provide psychosocial assistance and support to IPV victims and make referrals for further assistance where necessary. In this study, the social worker was recruited because she is instrumental in the provision of psychosocial intervention to IPV victims in Chimanimani district. Unfortunately, the social worker eventually withdrew from the study due to Cyclone Idai. The social worker was assigned to a team that was sent off to assist people that were affected by the cyclone in some remote villages in the district. Due to communication challenges brought about by the cyclone, the social worker had to withdraw from the study. It was difficult to conduct a telephonic interview as the connectivity was bad due to damaged infrastructure.

The key informants in this study were six male service providers who had training and experience in dealing with IPV issues in rural areas. The key informants preferred their titles (e.g. nurse) to be used instead of the actual names. In retrospect, it is interesting to note that all the key informants who participated in this study were male. These service providers were selected by the management of the organisations as they were deemed experienced and knowledgeable in IPV interventions. In as much as they fitted the inclusion criteria, there was a possibility of bias in the way they perceived IPV and assisted female victims in rural areas considering that they also conformed to patriarchy and Shona cultural norms that condone IPV against women.

4.7 DATA COLLECTION

Data collection with the women and key informants was conducted using face-to-face in-depth interviews. Qualitative interviewing is an interaction between a researcher/interviewer and the

participant where the researcher sets up the general direction of the interview sessions and interrogates specific topics that are raised by the participant as the interview progresses (Babbie, 2001). The interview covers both a factual and a meaning level as it seeks qualitative knowledge as expressed (Kvale & Brinkmann, 2009). In this study, in-depth interviews were selected because participants' perspectives on the topic are sought in a way that encourages active engagements and changes of direction to pursue issues that emerge (Simon, 2009). In addition, they provided a platform for the researcher to understand the meanings of the everyday experiences of the participants through attentive listening combined with observing (Marshall & Rossman, 2011).

4.7.1 Data collection with women participants

The consent process has been explained under ethical considerations. Before the interview, the researcher ensured that she obtained written consent from the participants. Establishing positive relationships is necessary as they help stories to emerge that are difficult to tell (Swartz, 2011). To ensure this, the researcher spent three weeks attending the weekly meetings of the informal self-help groups to create rapport with the group members before the commencement of the interviews. During this period, the researcher sat in as an observer and requested permission from the group members to document conversations and behavioural patterns that might be relevant to the study. An observation schedule was developed for this purpose (see Appendix G). The documentation process entailed taking down notes and no recordings were made of these sessions. The researcher noticed that the women were more free to share their personal issues with each other. However, in the presence of the researcher the women did not discuss any issues related to IPV. Perhaps this was because the researcher was new to them and they did not feel comfortable in divulging their personal IPV experiences so soon in the process. Another observation was how women in the groups addressed each other as either *taita* (sister), *mai* (mother) or *mazvarira* (mother-in-law). In their explanations, the women indicated that they were related according to the totems they shared hence they treated each other like family. This also demonstrated the supportiveness of these ISHGs in supporting women in rural areas.

Butin (2015) argues that conducting interviews in two separate sessions in qualitative research is beneficial to the researcher as it allows them to reflect upon the first interview conducted and build upon and explore the participants' responses in the second session of the interviews.

In this study, the initial plan was for data collection to happen over two interviews. The objective of the first interview was to create rapport and explore some of the questions in the schedule while the second interview was aimed at completion of the questions in the semi-structured interview guide and to seek clarification of follow-up questions. However, most participants opted for one session, as they felt comfortable in sharing their IPV experiences in a single session. Given the importance of family life especially childcare duties, subsistence farming (Kaur, 2018) and other competing responsibilities, some participants indicated lack of time for multiple interviews hence their decision to opt for one session of the interview. Kvale and Brinkmann (2009) suggest that a researcher in qualitative research should be knowledgeable about the phenomenon under study to ensure that rich and detailed information is elicited from participants. The researcher's previous work experience with working with women in rural areas in Zimbabwe coupled with her experience and training in social work was helpful as she is skilled in handling conversations in a manner that allows people to openly share their life experiences.

The shortest interview was 30 minutes long whereas the longest one was 90 minutes long. On average, the interviews lasted 50 minutes. Although the interviews could not be covered in two sessions, the one session interview managed to adequately cover the questions and key areas of exploration during the interview session. Overall, 25 women were interviewed. Given the hidden nature of IPV particularly in rural areas (Riddell et al., 2009), participants were informed before the commencement of the interview that if the study affected them either psychologically or emotionally, referral services would be made available for free. These referrals were to be done with the consent of the participants. The researcher had made arrangements with the district office and a social worker was made available in case participants required social work intervention. In cases where the participant was not comfortable with resorting to social work intervention, arrangements were to be made (with the consent of the participants) for them to seek support from her immediate support network (e.g. family, churches and friends). However, no participant requested either social work intervention or for support from family, family or their churches. They were nonetheless sensitised by the researcher about the availability of these services.

The interviews were conducted in a dialogic, conversational and respectful manner to ensure that participants felt comfortable enough to share detailed information regarding their IPV experiences. The researcher asked the participants to share their life experiences in relation to

living in rural areas and IPV experiences. This was important in understanding how rural culture shaped the way women perceive IPV in rural areas (Chireshe, 2015; Riddell et al., 2009). The interviews were audio-recorded with permission from the participants, to avoid data loss, to capture participants' voices authentically (Nowell et al., 2017) and to gain a holistic account of the data collected. Indeed, audio recording "ensures accuracy of reportage and adds to the veracity of reporting" (Simon, 2009, p. 53). Audio recording was necessary as it freed the researcher from detailed note-taking, hence she could concentrate more on the interview, observe non-verbal expressions and probe where necessary (Kvale & Brinkmann, 2009). The researcher used a digital recorder and ensured that after every interview session, the audio-recorded interview was transferred to her personal password-protected computer.

Due to the nature of rural environments, safety issues, culture and the decorum that is expected, the researcher conducted the interviews at places and times convenient to the participants (WHO, 2001). Some participants chose to have the interviews at the researcher's place of residence as they considered it to be private and safe from nosy neighbours. Few participants opted to have the interviews in their homes because they had younger children and lived far from the researcher's place of residence. Shenton and Hayter (2004) further suggest that a researcher might have to immerse herself in the daily activities of the community in which they are conducting their fieldwork so as to obtain quality data from the participants. Some of the interviews were conducted while the participants were going about their daily work. Interviewing the participants when they were going about their daily chores such as collecting firewood, fetching water and sitting with them by the roadside while they were selling honey to passing motorists was essential to the study. This was because it made the participants feel at ease minimising the power dynamics between the researcher and the researched and participants were more comfortable to open up to the researcher whilst in their own 'natural habitat'. The researcher was also cautious to not put the participants in any harmful situation by discussing their experiences where and when there were other people. For example, the researcher would stop the interview if a customer was approaching and came by to purchase something. She would only continue if it was deemed safe to do so and when she received cues from the study participant.

English and Shona were used to communicate with the participants during the data collection phase. The Zimbabwe literacy rate was reported to be 98% as of 2014 (Pasara et al., 2020) and despite a majority of the women participants having a high school education and thus being

able to express themselves in basic English language, they opted to use Shona (Gomo & Munyati, 2006). The reason behind this could be that they felt more comfortable in expressing themselves fully in Shona and being able to share their experiences of IPV considering its sensitive nature. Furthermore, the use of the Shona language was important as it also allowed the participants to fully express their inner emotions as they narrated their experiences of IPV (DeJonckheere & Vaughn, 2019). The researcher could observe non-verbal cues of the participants as they shared their stories. These cues came in the form of body language, gestures and facial expressions that supplement the verbal responses in the interview sessions. The researcher did not have difficulty in communicating with the women since she is fluent in the Shona-Ndau dialect and had spent 16 years of her childhood amongst the Ndau people. The researcher conducted all the interviews over a period of nine weeks (March to May 2019) which excluded the observation period.

4.7.2 Data collection with key informants

With regard to key informants, both English and Shona were used in the interviews, as some of them preferred using the two languages interchangeably in the clarification of points. However, the interviews with the village heads, the police and the nurse were predominantly conducted using the Shona language. The village heads specifically opted for the use of Shona language, as the interview sessions were conducted *padare* (at the traditional court) where traditional norms (including language of communication) were to be observed. Interviews with the gender officers, the nurse and the police were conducted at their place of work in their offices. Their decision to conduct interviews at their workplaces and offices was to ensure privacy. The interviews with the village heads were conducted at their homesteads under the tree where the traditional court proceedings are held. These interviews with the key informants were conducted after the interviews with the women participants were concluded.

Formal permission to conduct the research was granted by the Ministry of Women Affairs, Community, Small and Medium Enterprise Development and Chimanimani Rural District Council (See Appendix L & M). Permission from the Ministry of Women Affairs, Small and Medium Enterprise Development was granted telephonically in January 2019 and the permission letter was collected on 8 March 2019. Permission from the Chimanimani Rural District Council was obtained in August 2018. Ethics Clearance (No. H18/11/04) was granted by the Human Research Ethics Committee (HREC) (non-medical) at the University of the

Witwatersrand. Informal permission was obtained from the women's groups before the beginning of data collection. Given the nature of rural areas where village heads are important gatekeepers and regarded as custodians of culture and communities, the researcher had to seek permission from each one of them before the commencement of data collection.

In accordance with the cultural norms in Zimbabwe, one is expected to go before the village head with a gift. The researcher had to buy gifts in the form of small food parcels to present to the village heads at the meeting to introduce herself, the study and to request for permission. Of note is the importance of the village heads in the daily activities of the communities as well as the positioning of women. Usually, community members feel comfortable with interacting with outsiders if the village heads have approved it. These are part of the norms and it was important for the researcher to meet the village head and inform him of the commencement of data collection to avoid difficulties in interacting with the women. An older male person accompanied the researcher to the village head's homestead where she was instructed to sit on the ground. She did not communicate directly with the village head but rather via a male elder who was present to convey the message and hand over the gifts to the village head. Sitting on the dusty ground while men sit on chairs and not being allowed to speak without the permission of the village head was disempowering and highlighted the subservient position of women in rural areas. Upon reflection, the researcher could clearly see patriarchy and male dominance at play and it provided a valuable insight into likely proceedings at the traditional court when women report IPV cases.

4.8 DATA ANALYSIS

Data collected was analysed using thematic analysis (Braun & Clark, 2006; Braun et al., 2018). Prior to the analysis process, it was important to prepare the data accordingly, which involved several data processing steps (Nowell et al., 2017). After every interview, the audio-recorded interviews were transferred to a password-protected mobile device and later transferred to a folder in a password-protected computer accessible only to the researcher. The raw data was only accessible to the researcher, the independent qualitative analyst and the academic supervisor. However, data shared with the qualitative analyst was de-identified in line with the ethics surrounding confidentiality and a confidentiality form was completed prior to the data being shared (see Appendix K). In addition to thematic analysis, the researcher also borrowed some tenets of phenomenological analysis to ensure in-depth analysis of data collected.

Phenomenological analysis was useful in this study as it strives to provide deeper understanding of social and psychological phenomena based on the personal experiences of the people involved (Groenewald, 2004).

Thematic analysis is defined as the identification and reporting of different patterns within the data (Braun et al., 2018; Braun & Clarke, 2006). Given that this doctoral study was done through publications, anonymous reviewers of various peer-reviewed journals contributed to the analysis of this data through their feedback on submitted manuscripts. Triangulation of data analysis took place and permission was further sought in April 2020 from the HREC (non-medical) before engaging the independent qualitative analyst. Triangulation of data analysis is the use of multiple researchers in the data analysis stage of a single study (Archibald, 2016). It has been argued that data triangulation is essential in addressing researcher bias in qualitative studies (Nowell et al., 2017; Saldana, 2009).

The researcher first analysed the data and sent the de-identified data to the independent qualitative researcher for further analysis. The objective was to address researchers' bias and ensure reliability. In analysing data, the researcher utilised the six-step process of thematic analysis involving the following steps: familiarisation with data, generating initial codes, searching for themes, defining and reviewing themes; and producing the final report. These different steps in thematic analysis will be explained further next.

4.8.1 Steps in thematic data analysis

Step 1: Familiarisation with data collected

Researchers have argued that one of the effective ways of familiarising oneself with data collected is through transcribing raw data (Braun & Clarke, 2006; Castleberry & Nolen, 2018; Creswell, 1998). Immersion with data involves repeated reading of data in a very active way and in some cases repeated listening of the audio-recorded interviews. Castleberry and Nolen (2018) further argue that the closeness to the data that a researcher achieves through the transcription of recorded interviews can catalyse the data analysis process. The close attention that is required in transcribing data facilitates the close reading and interpretative skills that are required for analysing data (Bird, 2005; Braun & Clarke, 2006; Bryman, 2008). In familiarising herself with the data, the researcher transcribed the recorded interviews. Although

the process is time-consuming (Castleberry & Nolen, 2018), it gave her an opportunity to intimately familiarise herself with the data and record interesting aspects arising from the interviews that were important in the analysis process.

Step 2: Generating initial codes

Castleberry and Nolen (2018) define the coding stage in thematic analysis as simply involving the identification of similarities and differences in the data. It involves the grouping of the transcribed data into meaningful categories and codes, identifying features of the data that answer the research questions and appear interesting to the analyst (Braun & Clarke, 2006). Creswell (1998) argues that at this stage, codes are identified by developing coding categories and winnowing useful data from less useful data. The codes that are generated act as tags that are used to retrieve and categorise similar data. When coding manually, the researcher can write notes on the texts that are being analysed to indicate potential patterns (Nowell, et al., 2017). Saldana (2009) suggested that coding manually tends to give researchers greater control over and ownership of the work. In this study, data was coded manually using highlighters to identify similar categories.

Researchers have argued that the use of multiple coders is essential in addressing researcher bias and validity of the data collected (Cassol et al., 2018; Castleberry & Nolen, 2018; Saldana, 2009). Therefore, de-identified data was shared with an independent qualitative analyst to establish whether there were similarities and/or differences in identification of themes. Nowell et al (2017) place more emphasis on the importance of regular meetings during the coding process to ensure that any discrepancies arising from the coding process are addressed. Thus, regular discussions were held with the independent qualitative researcher to address any discrepancies arising from the coding process. Furthermore, regular meetings were held with the supervisor to obtain guidance and to discuss the analysis process. Reviews from both the qualitative researcher and the supervisor were taken into consideration. The generated codes such as *transference of blame* and *reframing the abuse* influenced the development of the themes in the next phase such as *self-blame* as a coping mechanism in dealing with IPV (see article in Chapter 5).

Step 3: Searching for themes

This phase focuses on the analysis at the broader level of themes rather than codes extracted within identified themes. At this stage, the researcher is expected to gather all relevant data into each potential theme and continuously review the themes in order to determine if they relate to the data set and the overarching research question (Castleberry & Nolen, 2018). Furthermore, the development of themes involves the identification of relationships between the code categories and their significance in their theoretical conceptions and statements relevant to the study (Bazeley & Jackson, 2013). Emerging themes with the same meanings were combined into sub-themes. For example, under support mechanisms, the sub-themes *mistrust in the system* and *lack of confidentiality* were collated into one theme: lack *of confidentiality* under barriers to access and use of formal support systems (see article in Chapter 6).

Step 4: Reviewing themes

At this stage, the themes were refined. According to Braun and Clarke (2006), this stage entails assessing and analysing the transcriptions and ascertaining whether the themes accurately represent the data. Reviewing of themes involves interpretative work given that each theme has to be detailed enough, be specific and relate to one idea (Attride-Stirling, 2001). The themes should be interpreted in relation to the overarching research question and the overall objectives of the study (Castleberry & Nolen, 2018). Nowell et al. (2017) argues that at this stage it can become evident that some themes might have inadequate data to support them. For example, in this study under the objective of support mechanisms, the theme *support from friends* did not have enough data support while other themes needed to be broken down into separate themes. The developed themes were interrogated to determine the relevance to the study's goals and objectives. In ensuring that the themes reflected the views of the participants, the researcher continually returned to the raw data to assess credibility. This she did through thorough reading of the transcripts and listening to audio-recorded interviews multiple times (Braun & Clarke, 2006).

Step 5: Defining and reviewing themes

The naming of themes involves further refinement and redefining of themes through the analysis of interesting ideas emanating from the data collected. According to Braun and Clarke (2006), in naming the theme, it is important to ensure that there is a close link between the theme and the overall research question(s) of the study. Cassel and Symon (2004) further argue

that the theme names should be clear and concise so that readers can have a clear understanding of what the theme entails. If one fails to define the scope and the content of the theme, further refinement is required. At this stage the themes are given working titles, and the names should be focused so that the reader can immediately understand what the theme addresses (Nowell et al., 2017). Regular meetings with the supervisor and the independent qualitative analyst were helpful in ensuring consistency of the themes. The themes were revisited after reviews from the supervisor and the qualitative researcher. Walsh et al. (2019) suggest that verbatim quotations should always be congruent with overarching themes. In this light, some of the themes that emerged in this study were extracts from the verbatim quotations and reflected the participants' own words. For example, the theme, *"I want my marriage": Preserving marriage by limiting the involvement of others* (see article on barriers to help seeking in Chapter 6).

Step 6: Producing the final report

The final phase commences when themes are finalised and the researcher is ready to start writing up the research. This stage involved writing of the manuscripts and the final report with detailed descriptions of findings. King (2004) as cited in Nowell et al. (2017) suggests that direct quotations from participants are an important part of the final report and should be included to aid in understanding and interpreting specific points. In building valid arguments, researchers are expected to also refer back to the literature pertaining to the study. Given that this doctoral study is by publications, submission of publishable manuscripts in peer reviewed journals was part of the requirements. The manuscripts were developed in accordance with the overarching objectives of the study and the research questions. Each manuscript was in response to a research objective. The manuscripts were written in a concise, coherent, logical and non-repetitive manner (Braun & Clarke, 2006). The researcher used short and long quotes and these were accompanied by identifiers to demonstrate that various views of participants were integrated into the results. In developing the final thesis to be submitted for examination, the manuscripts were integrated in the thesis in a way that ensured a flow of the arguments raised in the study. This final write-up includes the research methodology, the review of literature and the analysis of data. Both the manuscripts and the final write-up also made use of theoretical literature to support arguments.

Table 1: A summary of thematic analysis

Step	Description	Summary of the process
1	Familiarisation with data	Data Transcription Reading and rereading the data Noting down initial ideas
2	Generating initial codes	Coding interesting features of data across data sets Collating data relevant to each set
3	Searching for themes	Collating codes with similar meanings into potential themes. Gathering all data relevant to each potential theme.
4	Reviewing themes	Checking in the themes in relation to the coded extracts and the entire data set.
5	Defining and naming themes:	Analysis of developed themes and refining each theme. Generating clear definitions and names for each theme.
6	Producing the report	Selection of compelling extract examples/ verbatim quotations Conducting final analysis of selected extracts and linking them to the research question and literature, Producing a research report based on the analysis of findings

Source: Braun and Clarke (2006)

4.9 DEVELOPMENT OF PRACTICE GUIDELINES

Practice guidelines inform users and practitioners about what ought to be expected from interventions and practitioners. They build a bridge between practice and science and inform practitioners about conclusions from research in a useful way considering that many practitioners fail to use findings of research to inform their practice (Beauchamp & Drapeau, 2015). The overall aim of this study was to develop culture-informed practice guidelines for social work practice in IPV contexts in rural areas. The practice guidelines developed in this study are informed by the findings of this study.

This study utilised Rothman and Thomas' Design and Development (D&D) model in intervention research to develop practice guidelines for social workers working in rural areas. This model has been previously utilised in research that sought to formulate frameworks for effective intervention in social work (Strydom et al., 2007). This model has six phases; however, this study focuses on phase 3 that is the design stage. The D&D model was selected due to its ability to take 'as its original departure a given real-world problem and practical goal,

rather than a hypothesis to be tested or a theory to be explored' (Rothman & Thomas, 1994, p. 12).

Phase 3 of the D&D model entails designing observational constructs and specifying procedural elements (Rothman & Thomas, 1994). The main activity in this phase was qualitative data synthesis. One of the objectives of the doctoral study was to develop culture-informed practice guidelines for social workers working within IPV contexts in rural areas. According to Rothman and Thomas (1994), the design requirement at this stage is the process of establishing the conditions that interventions will need to satisfy. The design requirements that were developed highlighted that the practice guidelines should a) build the capacity of social workers working within IPV contexts in rural areas; b) should inform IPV policies; and c) inform screening, assessment, referrals and service provision to IPV victims residing in rural areas by social workers. The process of specifying the procedural elements entails conversion of data collected and the design process. As these processes are information-based, creativity is imperative for the successful development of the practice guidelines. Fraser and Galinsky (2010) argue that the process of designing an intervention also requires blending and evaluating existing literature.

The knowledge from both the literature and the primary research findings should be adapted to the local contexts. Janzen et al. (2016) argue that adapting knowledge in the local context is critical and knowing the audience and assessing the appropriateness of the research knowledge is important in uptake and sustained use of these practice guidelines by practitioners working in these settings. Furthermore, the guidelines should be tailored to the local contexts and take into consideration the barriers that may exist in their implementation. In this study, the research ensured that the practice guidelines that were developed were tailored to suit the rural context and barriers that might exist in their implementation were taken into consideration. The proposed culture-informed practice guidelines are presented in detail in Chapter 8.

4.10 TRUSTWORTHINESS OF THE STUDY

Repetition of thematic analysis methods can be difficult in qualitative research, considering that many research articles do not provide a comprehensive overview of the qualitative research process (Roberts et al., 2019. Research is aimed at establishing the link between knowledge and practice through demonstrating rigor and this is important in ensuring the trustworthiness

of a research paper (Roberts et al., 2019). Trustworthiness is one way that researchers can assess the quality of the qualitative research (Bryman, 2008, Loh, 2013; Nowell et al., 2017). Lincoln and Guba (1985) expanded the concept of trustworthiness by bringing in stringent criteria of credibility, reliability, confirmability and transferability to ensure parallel reliability and validity in quantitative studies. In this study, the researcher chose the widely accepted and easily recognised criteria by Lincoln and Guba (1985) to demonstrate trustworthiness in this study, and complemented this with other studies. It should be noted that some activities overlap between the strategies identified, such as, for example, dependability and credibility.

4.10.1 Credibility

Bryman (2008) argues that credibility points to the extent the research is significant in different contexts of social reality. Lincoln and Guba (1985) suggest various ways in which credibility can be achieved in a qualitative study. This includes prolonged engagement, peer debriefing to provide an external check on the qualitative process, data triangulation and researcher triangulation. Korstjens and Moser (2018) suggest that prolonged engagement in increasing credibility involves long-lasting engagement with the participants, investing time to become familiar with participants and building trust to obtain rich data. In a bid to familiarise herself with the participants and their surroundings before conducting the interviews, the researcher spent the first three weeks of field work meeting women in their various ISHGs, taking part in their daily activities (e.g. gardening) and engaging in general conversations around the weather and farming or anything that was happening in this context or in the country in general. However, the researcher avoided talking about political issues as discussing these issues in an unstable political environment (Chipere, 2020) such as Zimbabwe could raise suspicions and potentially stall the whole data collection process. In addition, it might have posed a security risk for the researcher.

Data source triangulation (i.e. collection of data from multiple sources) was adopted as a way of increasing credibility in obtaining diverse views of the phenomenon under study (Forero et al., 2018). Data source triangulation in this study was achieved by including both the women and the service providers performing different roles in preventing and minimising IPV in the district and the ward. This triangulation offered varied sources that were necessary in gaining a holistic understanding of IPV and its impact on women residing in rural areas. Furthermore, an independent qualitative analyst was recruited in the data analysis process to address

researcher bias and ensure credibility of the findings. On the other hand, ensuring voluntary participation among the participants was used to enhance credibility given that participants are most likely to provide honest accounts when speaking without coercion. Each person approached was given an opportunity to accept or refuse to participate, and the data collection involved participants who were genuinely willing to participate and prepared to offer information freely (Shenton, 2004). Furthermore, the use of reflexivity in this study was crucial as it also enhanced credibility. This was done through examining implicit and explicit assumptions, researcher's experiences and values and how these affected the qualitative study (Korstjens & Moser, 2018). Further discussion on reflexivity is presented at the end of this chapter.

4.10.2 Dependability

Dependability refers to the extent to which the same work can be repeated with the same participants and generate the same result (Cassell & Symon, 2004). There is a close link between dependability and credibility and demonstration of the former influence the latter (Shenton, 2004). The process within the study should be explained in detail thereby enabling future researchers to repeat the study and perhaps gain the same results (Elo et al., 2014; Shenton, 2004). The research design can be viewed as a prototype model that provides readers with an opportunity to determine whether the appropriate research practices and methodologies have been followed (Shenton, 2004). In ensuring dependability in this study, the research design and its implementation were presented in detail. The data collection phase was presented addressing all the details of what was done in the field from the commencement to completion of collection of data. All the data collection methods and records of the different phases in the research process were presented in a manner that enables the readers to evaluate how the researcher will have adhered to the research procedures outlined (Shenton, 2004).

4.10.3 Confirmability

The concept of confirmability is comparable to the qualitative researcher's concern with objectivity. It implies that data should accurately represent the information that participants provide and findings should reflect the voice of the participants and not the researcher's motivations and biases (Elo et al., 2014; Nowell et al., 2017). Consistent with the suggestions of Elo et al. (2014) on presenting findings, representative verbatim quotations were used to

show the connections between the data and the results. Each concept is linked to the data by a quotation as evidenced in the manuscripts in the following chapters. The researcher used quotations from different participants to assist in confirming the richness of the data collected and the link between the data and the results. Elo et al. (2014) argue that there is a danger of overusing quotations that may negatively affect analysis and interpretation of the results. Thus, the researcher ensured that the quotations used are widely representative of the sample of the study and are not from only a few participants. Furthermore, the use of data triangulation was important in ensuring confirmability, as it reduced researcher bias (Shenton, 2004). Furthermore, the reasons underpinning decisions made by the researcher and research methods adopted were acknowledged in the research report and the reason for choosing one approach over others and any limitations arising were presented (Bryman, 2008).

4.10.4 Transferability

Transferability is referred to as the ability to transfer the findings generated from the study to other contexts of a social problem or phenomena (Attride-Stirling, 2001; Nowell et al., 2017). It demonstrates that the results at hand can be transferred to another study and that the study will be confined to a specific situation or context under study (Bryman, 2008; Shenton, 2004). It is the responsibility of the researcher to provide 'thick description' of the participants and the research process so that readers can establish if the findings can be transferred to their own settings (Kostjens & Moser, 2018; Nowell et al., 2017; Shenton 2004). This means that the readers are the ones who make transferability judgements. In this study, the researcher provided a thick account on the context of the study; the sample size, demographic and socio-economic characteristics of participants, the inclusion and exclusion criteria, interview procedures, interview questions and the steps taken in analysing the data. The detailed description of the research process was already included in the published peer-reviewed articles (see Chapters 5, 6, 7 and 8).

Table 2: Steps taken in ensuring trustworthiness in the study

Step	**Description of process.**
Credibility	Data source triangulation Triangulation of data analysts. Pretesting the research instrument

Dependability	Detailed description of methodologies utilised throughout the study
Confirmability	Data triangulation Use of verbatim quotations to report findings
Transferability	Thick description of context Report on reasons for theoretical, methodological and analytical choices

4.11 ETHICAL CONSIDERATIONS

Ethics are defined as the standards, principles and guidelines that the researcher ought to follow when carrying out a research study (Vanclay et al., 2013). Researchers are mandated to safeguard the privacy of participants and disguise research material so that participants will not be identified by others. It is important to inform participants prior to data collection that the researcher will do everything possible to ensure that all the information that is shared by participants remains confidential. In this regard, this study adhered to research ethics such as: confidentiality, informed consent, voluntary participation and avoidance of harm. These are discussed in detail below.

4.11.1 Confidentiality

Offering confidentiality is a common principle in research, and it is important in gaining trust, and encourages participants to speak freely and honestly. It assures participants that any information that they reveal that is sensitive, personal and that they wish to keep private will be respected and they will not be exposed or their information disclosed to anyone (Simon, 2009). In upholding confidentiality, pseudonyms were used instead of the actual names of the participants. Given that during interviews participants referred to names of places they visited, their relatives, their villages and neighbours' names that could be identified by someone who comes across or read the published information, it was necessary to exclude such identifying information when sharing or reporting on such data. Participants were also assured that all the information gathered will be accessible only to the researcher and the supervisor. The data that was gathered is kept in a folder in a personal password-locked computer.

4.11.2 Informed Consent

Informed consent is central to ethical qualitative research. Informed consent requires the researcher to communicate the purpose of the study including the risks and benefits that are associated with participating in the study (Nussbaum et al., 2017). Flory (2004) argues that in seeking informed consent from potential participants, disclosure of information regarding the purpose of this study needs to be more appropriate for individuals, particularly those who are not well educated, to understand what the study entails. Given that this study focused on women living in rural areas in Zimbabwe who are not highly literate (Fidan & Bui, 2016), the researcher ensured that the participants had a full explanation of what the study is all about (verbally and written in a language of their choice) expressing their willingness to participate in the study. Nusbaum et al. (2017) suggest that reading aloud the consent form in addition to written consent is necessary in ensuring that participants have a full understanding of what the study entails. In order to avoid passive listeners, the researcher allowed participants to ask questions or seek clarity after reading out each statement on the consent form. Furthermore, they were provided with ample time to familiarise themselves with the PIS in either English or Shona (see Appendix A) before being requested to sign a statement (see Appendices H and I), which would indicate that they were fully aware of the purpose and procedures of the study and had agreed to participate.

4.11.3 Voluntary participation

Voluntary participation is defined as the ability to make one's own decisions coupled with absence of coercion in research (Marshall et al., 2014). It is important as it ensures that participants will genuinely and willingly offer information that is relevant to the study. An important aspect in voluntary participation is the ability to withdraw from an ongoing study at any given time (Marshall et al., 2014; Vanclay et al., 2013). Participation in this study was voluntary and participants were allowed to withdraw at any time with no negative repercussions. This was emphasised to the participants verbally and in writing through the PIS prior to signing the consent form. The objective was to ensure that the participants would not feel coerced to participate in the study. Vanclay et al. (2013) suggest that if a participant withdraws from the study, data already collected should be removed from the analysis where necessary. Hence, if a participant withdraws from the study, the researcher was mandated to check with them if the data that had already been collected could be used. Should the

participant refuse, that data was to be destroyed and not used for the study. No such incidents occurred during the study; however, some participants withdrew from the study before the researcher conducted interviews with them due to the challenges presented by Cyclone Idai.

4.11.4 Avoidance of harm

Babbie (2001) suggests that another way of guarding against harm is to ensure that participants in the study are aware of the full understanding of the risks involved in the study. Similarly, a report by the WHO (2001) indicates that when conducting research on violence against women it is necessary to conduct the interview in a private setting, preferably outside the home environment, to minimise risks. The researcher prioritised the safety of the participants by ensuring that the interviews were conducted at a safe and convenient place for them. If the participants felt uneasy at any point in the study, they could reschedule and postpone the interview to another time. Based on prior agreement with the participant, the researcher was expected to terminate the interview or change the subject if the interview was interrupted by anyone (WHO, 2001).

The majority of participants opted to have interviews at the residence of the researcher, citing concerns surrounding security and privacy during the interviews as in some instances the interviews were to be conducted outside the house. Few participants preferred to have the interviews at their place of residence. Participants who opted to have interviews at the residence of the researcher shared the same characteristics, namely that they lived some distance away and they stayed with their children only. Although it was advantageous in observing women in their homes and the way they related to their children, there were also disadvantages. Due to the high temperatures, the researcher and the participant(s) were forced to sit outside during the interview. Bearing in mind the importance of social coherence in rural areas, interviews were interrupted regularly by passers-by who would regularly greet them although the road was not close to the house (Riddell et al., 2009). In some instances, the greetings would take longer as is the norm in the community where greetings are prioritised. This meant that the whole interview lasted longer though the actual interview was an average of 50 minutes. Furthermore, the usual child-care duties of women in rural areas meant that children would continually interrupt the interviews requesting food, amongst other things. In addition, the geographic location of the villages might have impacted on this process as well because some

participants had to walk since they preferred to have the interviews where the researcher was being accommodated (Bosch & Bergen, 2006).

The welfare and safety of the researcher are often overlooked in research (Sikweya & Jewkes, 2011). Conducting research on sensitive topics like IPV is emotionally taxing. The traumatic stories that will be narrated by the participants can also affect the researcher. Therefore, in guarding against secondary trauma the researcher resorted to debriefing with the supervisor and peers. A more detailed discussion on the welfare and safety of the researcher will be presented under the section on reflexivity.

4.12 ETHICS OF CARE

Ethics of care speaks to moral reasoning in conducting research. Researchers are encouraged to take due care when entering communities and create relationships that are essential in the research study (Brannelly & Bouton, 2017). Shenton and Hayter (2004) explain that a researcher should not be incongruous within the world of the participants and should immerse themselves in the culture of the participants and take part in their daily activities. This is necessary in creating rapport with the participants that will ultimately enable the researcher to obtain quality data. Considering that this study was based in one of the disadvantaged districts in Zimbabwe where adherence to cultural Shona norms is strong, it was important for the researcher to develop a trusting relationship with the participants. As Shenton and Hayter (2004) suggests, the researcher participated in their group activities which included gardening and assisting the women by the roadside while they were selling their honey. Moreover, the researcher wore culturally appropriate clothing (e.g. *doek* (headscarf) and loose clothing, avoiding wearing trousers or tight-fitting or revealing clothes), used the language of the area (Shona-Ndau dialect) while with the women, listened and engaged in their general conversations about their everyday life in the rural community.

Researchers have argued that social research should not endanger the home life, friendships and family relations of the participants, and where there is a probability of psychological harm, the researcher should guard against such (Bryman 2008; Babbie, 2001). Vanclay et al. (2013) further indicate that participation in sensitive social research implies that there may be triggering of emotional distress. They further indicate that the obligation of the researcher in this regard is to ensure that a resolution of the emotional distress that has arisen is reached and

there is recourse for follow-ups and counselling. No physical harm was experienced by the study participants. Participants were informed prior to the study that if the study affected them either psychologically or emotionally, referral services were available to them free of charge. Should they require assistance and intervention, referrals were to be made to the Chimanimani Rural District Council's social worker with their consent. The contact details of the social worker were provided in the PIS for referral purposes. In addition to social work intervention, the researcher was to seek permission from the participants with regard to liaising with close family members, or community and religious leaders for support.

Wendler et al. (2002) distinguishes four types of 'gifts' that are related to participation in a research study. These are a) reimbursements for expenses incurred like transport fare; (b) compensation for the time taken to participate in the study and the inconvenience involved in research participation; (c) appreciation gifts which include non-monetary gifts and small amounts of money; and (d) incentive payments that offer a certain amount of money for participating in the study. Morrow (2009) further argues that researchers conducting studies in low-income communities should focus on the cultural context about the value of time, the reality of poverty and not having to miss a day's wage/income to attend a research interview. Considering that this study was conducted in one of the poorest districts in Zimbabwe and that most of the women depended on subsistence farming and selling honey and baobab fruit by the roadside, it was necessary to show appreciation to the women who participated in the study. This aspect had been raised by the ethics committee when the ethics application was submitted to the Wits HREC.

The researcher intended to provide participants with culturally appropriate gifts (i.e. non-monetary at the end of the interview) as tokens of appreciation and compensation for the time taken to participate in the study. However, considering the high prices of basic commodities (e.g. mealie meal, cooking oil and sugar) in Zimbabwe at the time of data collection, the decision was made to offer cash instead. This decision was reached after consultation with the research supervisor upon realising that the women had varied needs that ranged from basic foods, transport money to the clinic, money for milling maize at the community miller and stationery for their school-going children. The researcher also consulted the women at the end of each interview to establish whether they preferred a small gift or money and all the participants chose to receive the money. The participants received R100; this South African currency was acceptable in Zimbabwe during the period of data collection. Based on the

responses from the women who had participated and the researcher's observations during the weekly meetings, this amount of money, though it might seem little, was almost equivalent to what they earned in a week selling honey or vegetables from their gardens.

Wendler et al. (2002) and Shenton and Hayter (2004) suggest that the decision to participate in the study should not be distorted by the offer of any form of appreciation. In this regard, they proposed safeguards in ensuring that participants are not 'coerced' by 'gifts' to participate in the study. They proposed that a researcher should be wary of any cases where there is a concern about people consenting because of payment and not because they are willing to participate and also justify the compensation being made. In abiding by these safeguards, the researcher clearly stated in the PIS that no payment was to be given for participation in the study. Women were therefore given gifts only after the completion of the interview. Giving them an appreciation gift was important, as some participants had to come to where the researcher was staying and had left their roadside honey business to take part in the study.

4.13 REFLEXIVITY

Reflexivity is a central element in undertaking sensitive research. It is defined as the process by which a researcher examines and observes his or her own experiences, positionality, emotions and reflections during the research process (Sherry, 2013). Self-awareness is a fundamental element to the researcher in positioning herself in the research process. Patnaik (2013) suggests that reflexivity recognises the role of the researcher as a participant and not only as an outsider during the research process. As such, introspective reflexivity acknowledges that the experiences of the researcher can affect the management of the data and ultimately its analysis (Patnaik, 2013; Turnbull, 2019). Considering the experiences of the researcher working with women in rural areas and the experiences working with victims of domestic violence in South Africa, the researcher was obliged to continue addressing various questions at different stages of the study. Questions included, but were not limited to, "How does my personal history and values influence the way I engage with participants and the data?" "How does my professional and cultural background affect my position in this research and how I engage with the data?" Coming from a different Shona ethnic group despite having stayed amongst the Ndau people for 16 years of childhood, the researcher was not entirely familiar with the cultural beliefs and this could have had a negative bearing on how data were engaged with. Continually addressing these questions was critical in self-reflection especially

in the data analysis stage. Considering the researcher's position as a single woman, coming from a different Shona sub-ethnic group as compared to that of the participants, there were incidents where urban bias crept in during data collection and this was addressed through debriefing with the supervisor. As argued by Patnaik (2013), in this study reflexivity was integral in maintaining research focus by bracketing the biases and attitudes (e.g. biases based on childhood observations of IPV in rural areas as well as urban bias in the way the stories of the participants were analysed) that could have negatively affected the management and analysis of the data.

Researchers have discussed subtle power imbalances that exist between the researcher and the participants. Considering the sensitive nature of IPV and the age difference between the researcher and some of the participants, conducting interviews with older participants presented some difficulties. In the Shona culture older women are respected and are considered as advisers to young women, both married and unmarried (Chireshe, 2015; Venganai, 2016). The data collection of this study challenged these norms as the older women were expected to discuss their marital issues and challenges with a younger person. Being a young single woman interviewing women in their forties proved to be challenging when sharing IPV experiences especially those of a sexual nature. In addressing these power imbalances, rapport and trust between the researcher and the older women had to be promoted through participating in their daily activities (Shenton & Hayter, 2004). Joining in these daily activities created trust and rapport but also provided an understanding of rural life as experienced by the women. During the interviews, all older participants were addressed with respect using Shona prefixes (e.g. *mu* and *ma*) that show respect for an older person.

The researcher's status as a PhD student based in South Africa created barriers between researcher and participants given the educational levels of most women generally, but specifically women residing in rural areas in Zimbabwe (Riddell et al., 2009). This meant that power dynamics might exist that would predispose them to be submissive to the researcher as a university graduate The researcher may have been perceived by the women as being a person of privilege, being educated and living in South Africa which may be viewed as offering better economic opportunities than Zimbabwe. For that reason, it was important that the researcher adopted a stance that would minimise power imbalances and barriers, and humbled herself, reminded the women of their important role, placed herself in a position of vulnerability and of being open to learning from them and their experiences.

Sherry (2013) suggests that qualitative research provides researchers with an opportunity to listen to participants' stories and these stories provide the researcher with information about lives that are different from their own. As a single young woman with no personal experience of IPV, listening to the stories of the participants was interesting for the study but often emotionally draining as the life circumstances of the women were characterised by poverty and numerous hardships. Some were disabled which brought additional challenges in rural areas. Some were HIV positive, which is considered a taboo in many societies as HIV/AIDS is considered to be a result of prostitution and promiscuous behaviour in most cultures. Some even walked barefooted in the scorching heat and the researcher could see the cracks of dryness on their feet. There were many stories of hardship but also of resilience. According to Naturale (2007), social workers working with vulnerable groups are at risk of secondary traumatic stress, and support for a social work researcher studying traumatic life events such as IPV was necessary. In this regard, the academic supervisor was supportive during the research period and visited Zimbabwe during the data collection period, as well as being available for regular communication. Journaling was helpful in dealing with stress as well as physical activities and general conversations (e.g. discussion on farming, the economy and life in South Africa) with the elderly randomly from the community. The elderly people are regarded as advisors with wisdom and young people listen to their stories and advice about life generally.

Furthermore, one of the challenges that researchers encounter in rural areas is geographical distance that can make accessibility of participants difficult. Mugurunyana (2011) explains that underdeveloped infrastructure in rural areas in Zimbabwe makes access to remote areas challenging. Not all participants opted to have the interviews conducted at the researcher's residence, and this required travel to their homes in order to conduct the interviews. This required walking long distances in high temperatures, up to 10 kms walking in 35C°. However, the researcher experienced the residents as helpful, kind and protective towards a visitor. Directions to some of the participants' homes implied passing through bushes, and along the way the researcher would usually meet other people using ox-drawn carts and this made the journey less scary. She was once offered a 'lift' in an ox-drawn cart on her way to a participant's home – a gesture she accepted in line with the kindness often exhibited in rural areas. Some of the participants would request their children to escort her home lest she gets lost. Through this, the researcher was also able to experience directly the challenges that women experiencing IPV might encounter should they attempt to seek formal help. Cheema

et al. (2018) argue that walking long distances in hot weather can cause fatigue for the researcher and ultimately negatively affect data quality. This was the experience of the researcher who experienced great discomfort in the process of data collection. Due to walking long distances in very hot weather, she suffered from severe headaches, blisters and rash on her feet and legs.

Cyclone Idai, which made landfall in Chimanimani District, also presented a threat to the data collection process. Infrastructure in 22 villages in the district was destroyed and this made accessibility difficult (International Organisation for Migration (IOM) Tracking Matrix, 2019). The weather conditions (storm and subsequent floods and landslides) were life threatening and the researcher returned to Harare to complete administrative tasks in relation to the data collection. Moreover, the social worker who was supposed to participate in the study had to withdraw, as she was part of the team deployed to some of the villages that had been severely affected by the cyclone. This was a setback in the data collection process as the input from the social worker was essential in the discussion of social work intervention in place to assist IPV victims in Chimanimani District.

4.14 CONCLUSION

This chapter has provided an overview of the research methods adopted for this study, including the rationale for the methods chosen in undertaking this study. Ethical considerations that were followed in this study are also presented. The following chapter presents and discusses the findings of the third objective of the study. The findings under this objective are presented in the form of a manuscript.

CHAPTER 5
FINDINGS AND DISCUSSION: COPING STRATEGIES AND IPV

5.1 INTRODUCTION

The article presented in this chapter is linked to objective three of this study, which seeks to explore the context-specific coping mechanisms available to IPV victims residing in rural areas. The previous articles in Chapter three presented a discussion on the role of culture in IPV experiences of women residing in rural areas as well as an analysis on the IPV legislative frameworks in Zimbabwe. Given the significant role that social norms play in IPV experiences, it is crucial to understand the coping mechanisms that women in rural areas adopt in dealing with IPV. Women residing in rural areas experience IPV differently taking into consideration the multiplicity of disadvantages that converge in increasing their vulnerability to IPV. This implies that women also respond and cope with IPV differently though there are similarities. Given the complexities of rural areas and the uniqueness of IPV in rural areas (Ridell et al., 2009; Sandberg, 2013), it is important to understand how women in rural areas respond and cope with the abuse. While there are legislative measures that have been put in place to protect IPV victims, it is crucial to understand how women deal with the abuse in their own way given the hidden nature of IPV in rural areas. This paper revealed how different contextual factors (e.g. socioeconomic status, prevalent cultural norms and ethnicity) influence the coping mechanisms that women in rural areas adopt in dealing with IPV. Emotion-focused coping mechanisms appeared to be more prevalent amongst the participants with culture-based and religion-based coping strategies being the dominant forms of coping strategies for IPV victims in rural areas. Understanding the unique coping strategies that women in rural areas use is important in ensuring that intervention programs and services are crafted to respond to their specific needs. The following article focuses on the coping strategies adopted by women residing in a rural area who experienced IPV in their former intimate relationships.

5.2 PRESENTATION OF ARTICLE 3

Chadambuka, C. (In press). Coping strategies adopted by women who experienced intimate partner violence in the context of social norms in rural areas in Zimbabwe. *Journal of Interpersonal Violence,* 1-20. https://doi.org/10.1177/0886260520943734

Check for updates

Original Research

Journal of Interpersonal Violence
1–25
© The Author(s) 2020
Article reuse guidelines:
sagepub.com/journals-permissions
DOI: 10.1177/0886260520943734
journals.sagepub.com/home/jiv
SAGE

Coping Strategies Adopted by Women Who Experienced Intimate Partner Violence in the Context of Social Norms in Rural Areas in Zimbabwe

Cyndirela Chadambuka, MA[1]

Abstract

Intimate partner violence (IPV) has detrimental effects on the welfare of women. Research on the coping strategies employed by rural women in Zimbabwe is notably lacking, despite the fact that the majority of Zimbabwean women reside in rural areas. Therefore, this study sought to explore the strategies that women in rural areas used to manage and cope with IPV. The study adopted a qualitative research approach, and participants were recruited through the purposive sampling method in Chimanimani Rural District, Eastern Highlands, Zimbabwe. Face-to-face interviews using a narrative approach were conducted with 25 women between 19 and 49 years and seven key informants. The 25 women consisted of women who had left abusive relationships and were selected on the basis that they should have experienced IPV in their former relationships. Current IPV victims were excluded from the study. All the interviews were recorded, with participants' consent, to avoid loss of data. Data was analyzed by the author and an additional independent data analyst using thematic analysis.

[1]University of the Witwatersrand, Johannesburg, South Africa

Corresponding Author:
Cyndirela Chadambuka, Doctoral Student, Department of Social Work, University of the Witwatersrand, Johannesburg, 1 Jan Smuts Avenue, Johannesburg 2050, South Africa.
Email: 890270@students.wits.ac.za

Findings from this study revealed that social norms influenced participants' covert coping behavior, which include acceptance of abuse and prayer. There is need to strengthen the existing coping strategies that are utilized by women as these could be the starting point for intervention efforts. This is important as it enables practitioners to develop context-specific and context-driven intervention strategies that will effectively serve the victims in their distinctive situation(s).

Keywords
coping strategies, intimate partner violence, rural areas, social norms, women

Introduction

Intimate partner violence (IPV) remains one of the most common stressors that challenge the well-being of women globally. The consequences of IPV reverberate through communities and nations. IPV is a challenging phenomenon to empirically measure and define. In this study, IPV is defined as a form of violence involving people in intimate relationships that can cause psychological, physical and sexual harm (Itimi et al., 2014). Thus, IPV can also happen in same sex relationships. This article however concentrates on violence perpetrated by males against females in heterosexual relationships. Several instruments have been used in measuring the prevalence of IPV and compare it over time across nations (Lindhorst & Tajima, 2008; Waltermaurer, 2005). While instruments like the Conflict Tactic Scales are valuable in measuring the frequency of IPV, there is a shift to using populations-based surveys in measuring IPV prevalence. For example, Klugman (2017) reports that current rates of IPV are usually estimated from population-based surveys based on questions that interrogate the experiences of violence in the preceding year(s). These surveys have been instrumental, for example, in reporting that one in three women have experienced IPV in her lifetime on a global level (Wood et al., 2019). Studies conducted in Europe and Eastern Asia reveal that these regions have low rates (29%) while South Asia is one of the regions with high rates of IPV (43%) (Klugman, 2017). Notably, the prevalence of IPV ranges from 15% to 71% among women in marriages or current intimate relationships, with developed countries having a smaller percentage range of 2% to 11% as compared with developing countries (Bhandari et al., 2011; Itimi et al., 2014).

In Africa, 36% of women are subject to IPV. This is higher than the IPV experienced by women elsewhere in the world due to the long-standing patriarchal norms that condone the subordination of women (McCloskey et al., 2016). In Kenya, 47% of women reported lifetime experience of IPV by their

partners (Hatcher et al., 2013), while in sub-Saharan Africa, IPV is recorded as high, with the overall prevalence pegged at 36%, exceeding the global average of 30% (Ahinkorah et al., 2018). In addition, a study conducted in South Africa indicated that IPV accounts for 63% of all acts of violence, with most men reporting perpetrating IPV on their partners (Rees et al., 2014).

Zimbabwe has been recorded as one of the countries with highest rates of IPV (McCloskey et al., 2016). Research conducted reported that IPV prevalence is high in Zimbabwe, with 63% of women indicating that they experienced IPV during pregnancy (Shamu et al., 2013). However, this prevalence does not adequately reveal the actual extent of IPV because of underreporting and social norms consigning IPV to the private realm. The Zimbabwean society is largely characterized by patriarchy, which supports the subjection of women (Matavire, 2012). This belief system is more upheld and respected in rural areas, where 68% of the total population resides ("Zimbabwe Inter-Censal Demographic Survey," 2017). One distinctive feature of rural areas is its adherence to social norms that shape the prevalence of IPV and consequently its invisibility, which leaves victims hopeless and helpless (Little, 2017). Regardless of the grave effects of IPV in rural areas, critical gaps exist in the literature on coping strategies used by women residing in rural areas in dealing with IPV. The available literature on IPV in Zimbabwe (Chireshe, 2015; Machisa & Shamu, 2018; Mukanangana et al., 2014; Shamu et al., 2013, 2018) is centralized on urban areas, with minimal coverage on rural areas and how victims cope with it. As a result, it is important to understand how previous victims of IPV residing in rural areas coped with this phenomenon in their unique situations and belief systems. It is envisaged that this study will increase the awareness of practitioners and researchers about the plight of IPV-affected women residing in rural areas.

This article is aimed at exploring the coping strategies in the context of social norms that previous victims of IPV residing in rural areas used in dealing with the abuse. The article will first focus on the overview of IPV and the conceptualization of coping strategies. Second, an outline of the methodology utilized in this study will be explained in the following section. This will be followed by a presentation of findings section. Third, the article will present a section on discussion of findings. Finally, the implications for practitioners will be presented.

An Overview of Coping Mechanisms in the Context of IPV

Coping can be defined as an individual's attempt to manage a problem through the constant change of cognitive and behavioral efforts (Mitchell

et al., 2006; Waldrop & Resick, 2004; Zakar et al., 2012). In IPV situations, coping mechanisms refer to resistance and resilience strategies that victims employ in an attempt to minimize harm and gain control over the situation (Wood et al., 2019). Coping behavior in IPV situations is dynamic, complex, and multidimensional, as it is largely influenced by contextual factors and the severity of the situation (Mitchell et al., 2006; Zakar et al., 2012). The select available literature on IPV (Goodman et al., 2009; Makongoza & Nduna, 2017; Schaefer et al., 2019; Zakar et al., 2012) shows the diverse experiences of IPV victims and the intersecting social variables (i.e., locality, income level, literacy level, gender) that make women susceptible to IPV and consequently reinforce its acceptance and normalization in intimate relationships. Intersectional feminism rejects the notion that women face the same experiences of IPV and respond the same way (Etherington & Baker, 2018); hence, IPV experiences of women in rural areas cannot be equated to the experiences of women in urban areas. The intersectionality of multiple forms of marginalization against rural women shape their experiences and impacts on the choices they make in terms of the coping mechanisms to use. Although there are no recorded studies on coping strategies in the context of social norms employed by victims of IPV residing in rural areas in Zimbabwe, findings from the few studies on IPV in Zimbabwe (Chireshe, 2015; Fidan & Bui, 2016; Nyamukoho et al., 2019; Shamu et al., 2013) show that the response is highly dependent on contextual factors and the availability of resources. Given the importance of context in the perpetration of IPV, coping strategies are conceptualized differently depending on the circumstances.

Various studies have attempted to categorize coping strategies in the context of IPV (Lokhmatkina et al., 2015; Mitchell et al., 2006; Riddell et al., 2009; Waldrop & Resick, 2004; Wood et al., 2019), but only two distinct categories repeatedly feature across different studies. The two main forms of coping strategies in IPV situations that have been identified are (a) problem-focused coping and (b) emotion-focused coping (Bauman et al., 2008; Zakar et al., 2012). Emotion-focused coping refers to coping using one's emotions and cognitions and is mainly focused on changing one's way of thinking (Waldrop & Resick, 2004; Zakar et al., 2012). Research conducted has revealed that emotion-focused coping strategies are largely influenced by traditional social norms that promote male supremacy in intimate relationships (Laisser et al., 2011). Furthermore, the use of emotion-focused coping is premised on the need to maintain reticence within the family for fear of being shamed or humiliated (Bhandari et al., 2011). This is closely knit with social norms that promote the preservation of family integrity by consigning IPV to the private realm and making its disclosure to non-family members unacceptable (Matavire, 2012).

Problem-focused coping in IPV is focused on overt techniques that victims use to deal with the abusive situation such as seeking help from external support systems (Waldrop & Resick, 2004; Zakar et al., 2012). Problem-focused coping mechanisms are recorded to be significant in reducing mental health problems (Wong et al., 2016). However, it is argued that problem-focused coping mechanisms are scarce in rural areas and risky to the safety of the victims, as they deviate from the social norms that condone nondisclosure of IPV (Riddell et al., 2009; Wong et al., 2016). Publicizing IPV challenges the status quo of cultural norms and values and can precipitate further victimization (Conroy, 2014).

A binary classification (i.e., emotion-focused coping and problem-focused coping) of coping strategies in IPV situation is not useful, as IPV is largely dependent on context (Foster et al., 2015; Waldrop & Resick, 2004; Zakar et al., 2012). Accordingly, a third type of coping mechanism is proposed: "survival-focused coping." Survival-focused coping is distinct from the other two coping mechanisms as it is aimed at meeting the basic needs (e.g., shelter and food) and keeping oneself and loved ones, particularly children, safe (Goodman et al., 2009). However, other researchers have argued that coping strategies that IPV victims residing in rural areas adopt fall in a continuum of emotion-focused coping, survival-focused coping to problem-focused coping with a higher emphasis placed on emotion-focused coping (Bhandari et al., 2011; Kanagaratnam et al., 2012). In low-income communities where poverty is rife, victims of IPV tend to suppress their own needs and safety and resort to emotion-focused coping strategies that ensure survival of their families including children (Laisser et al., 2011). Hence, one can argue that emotion-focused coping and survival-focused coping are interconnected in influencing the coping behavior of IPV victims residing in rural areas.

Evident from studies conducted on coping behavior in IPV, particularly in low-income communities, is the influence of social norms in the selection of coping mechanisms that victims utilize in response to IPV (Mitchell et al., 2006; Schaefer et al., 2019). Bearing in mind that social norms promoting the subordinate position of women are highly respected in rural areas, victims of IPV are much more likely to employ emotion-focused coping strategies (Conroy, 2014). Although they are highly ineffective in dealing with IPV, especially when survival is at stake, emotion-focused coping mechanisms are regarded as the best option. This is because these are culturally validated methods of coping which are safe as they do not enrage the perpetrator, lead to more economic hardships and further victimization (Bauman et al., 2008; Mitchell et al., 2006). Furthermore, the abuse that is inflicted on victims in rural areas has a psychological and physical impact on them, yet some women fail to

escape the abusive relationship (Machisa & Shamu, 2018). This suggests the need to investigate the coping strategies utilized by victims of IPV in rural areas that minimize the patterns of abuse and preserve their psychological and physical well-being.

Method

Research Paradigm

The qualitative research approach was used in this study due to its exploratory approach to the phenomenon under study (Shenton, 2004). A narrative research design was utilized in this study. Narrative research design involves story-telling which focuses on narratives of individual life experiences (Moen, 2006). This research design was selected due to its ability to capture real-life experiences, which cannot be identical from one person to another, and its ability to enable participants to freely express their feelings on IPV. This was advantageous to the researcher, as it enabled her to probe further where applicable.

Study Site

Chimanimani Rural District is situated in the southern part of Manicaland Province in the Eastern Highlands in Zimbabwe. It is predominantly rural and lies 155 km southeast of the provincial capital, Mutare, and borders Mozambique to the east. The population mostly consists of the Ndau people, who are a Shona sub-ethnic group. Based on the last census held in 2012, the population of Chimanimani District was 133 810 (Zimbabwe National Statistics Agency, 2012). Of this population 69 478 were females and 64 332 were males. The district consists of 23 wards with each ward having an average of six to eight villages. Each village in the district consists of an average of 35 households. It is one of the poorest rural districts in Zimbabwe, with only six wards incorporating commercial farming, while the rest are heavily reliant on peasant farming. Chimanimani District is mountainous and the terrain is rugged with most areas rocky, which contributes to the lack of socioeconomic infrastructure critical to ensuring the well-being of people residing in these areas. Furthermore, various wards in Chimanimani accommodate formal and informal mining activities, which contribute to the high levels of child marriages, prostitution, and infidelity, which ultimately cause rifts in marriages and disrupts the family fabric (Chatiza et al., 2015). This is a cause of concern, as these shortfalls provide a fertile ground for the perpetration and nurturing of IPV.

Sampling

Purposive sampling was utilized to recruit participants for this study due to its flexibility in selecting participants who are well informed about the area of study (Ames et al., 2019). A total of 25 participants and seven key informants participated in this study. The key informants consisted of service providers directly linked with IPV victims in Chimanimani District. These were the nurse, police officer, two village heads, one gender officer and one social worker from Chimanimani Rural District Council, one gender officer from the Ministry of Women Affairs, Community, Small and Medium Enterprise Development. Unfortunately, the social worker withdrew from the study due to Cyclone Idai which made a landfall in Zimbabwe in March 2019 and affected the district. The social worker was part of the team that was dispatched to assist victims of the cyclone. The women were drawn from one ward in Chimanimani District. Each ward consists of approximately six to eight villages. The women were selected on the basis that they had experienced IPV in their former intimate relationships, left the abusive relationship, and were currently not in an abusive relationship. In this study, 23 participants were divorced and reported no involvement in intimate relationships and the other two participants were widows. Severity and frequency of the abuse coupled with its negative impact on children were reported as the core factors that forced them to leave the abusive relationships. The 25 participants were drawn from six villages in one ward through informal self-help groups, where women gather to discuss issues relating to their marriages, children as well as income-generating projects. All the participants in this study were unemployed and relied on subsistence farming for family consumption. The researcher approached each informal self-help group in each village and explained the purpose of the study. As a way of ensuring confidentiality, each member of the group received participant information sheets (PISs) and indicated their preference (agree or disagree to participate), and the PIS forms were kept in a sealed A4 envelope. Participants who agreed to participate provided their contact details and the researcher made follow-ups on them. From each village, two or more participants were recruited for the study. The exclusion of current IPV victims from participating in the study was to avoid further victimization and ensuring the safety of the researcher (World Health Organization, 2001).

Data Collection

Face-to-face interviews were conducted using a narrative approach. The narrative approach was utilized due to its flexibility in stimulating participants into sharing their sensitive life experiences in a manner that leads to new

knowledge on the phenomenon under study (Moen, 2006). A semi-structured interview schedule was used to guide the interview. The interview guide was prepared in both Shona and English since the researcher is fluent in both languages and as per instructions from the University of the Witwatersrand's Human Ethics Research Committee (Non-Medical). All participants chose to use Shona throughout the interviews. The interviews were conducted in a conversational and dialogic manner to obtain rich information. As the semi-structured interview schedule guides the interview and ensures its flow, the questions are expected to allow participants to share their experiences in their own terms while allowing relevant themes to develop (Rubin & Rubin, 2005). All the questions were open-ended and sought to inquire about participants' personal experiences in their former abusive intimate relationships, the available sources of support, and the coping strategies they adopted to deal with IPV. Questions on their experiences and the coping styles adopted were asked in the following manner: "Can you tell me your experiences of IPV in your former relationship/marriage? How did you deal with the abuse in your former relationship/marriage? Could you share with me the support you received from your family/friends/community?" All the questions were asked in a polite, nonjudgmental, and supportive manner.

Initially, the researcher intended to cover the interviews in two sessions; however, some participants refused, indicating their unwillingness to narrate their traumatic experiences twice. The interviews were between 40 and 90 minutes. Before the start of each interview, the researcher obtained written consent from each participant. Participants were asked to give accounts of their social life in relation to living in rural areas as well as their experiences of IPV. The safety of the participants is important given the sensitive nature of IPV issues in rural areas, and the researcher wanted to avoid secondary victimization (Esie et al., 2019). To ensure the safety of participants, interviews were conducted at a place and time convenient for them. The majority of the participants preferred having the interviews at the researcher's place of residence, as it was safe and private for them, with a few opting for their homes and gardens. Given the importance of time in agricultural activities in rural areas, the participants received ZAR100 (approximately US$7) as compensation for their time and participation in the study.

Considering that the district mostly consists of the Ndau people, the researcher conducted the interviews in Shona using the Ndau dialect, which was also the participants' preferred and common dialect. None of the participants requested to have the interviews in English. The researcher audio-recorded the interview with the consent of the participants so as to avoid loss of data, and the recordings were transcribed verbatim. The purpose of the

study was explained fully to the participants, including issues around voluntary participation, consent, and confidentiality. Pseudonyms were used to identify the participants. As part of the ethics procedures, permission to conduct the study was obtained from the Ministry of Women Affairs, Community, Small and Medium Enterprise Development and Chimanimani Rural District Council. Ethics Clearance (No. H18/11/04) was granted by the Human Research Ethics Committee (HREC) (Non-Medical) at the University of the Witwatersrand. Given the nature of rural areas, further context-specific permission was sought from the village headmen, as is the cultural norm and expectation in this rural area.

Data Analysis

Upon completion of data collection, the audio-recorded interviews were transferred from the recorder to a password-protected folder on the author's personal computer. The audios and transcripts were matched by pseudonyms and names of village for easy identification. The author was responsible for transcribing the data. All the interviews were transcribed in Shona and further translated to English for wider audience sharing.

The data collected were coded by two data analysts using thematic analysis. This method was used for its flexibility in the identification and analysis of themes (Braun & Clarke, 2006). The researcher used the six steps, which are familiarization with data, generating initial codes, searching for themes, reviewing themes, defining themes, and writing the final report. The author transcribed the data herself and through reading the transcripts and listening to the interviews she managed to familiarize herself with the data. Each transcript was coded separately and manually through hard-copies of the transcripts using highlighters and pens. Each transcript was initially reviewed line-by-line by the author and an examination of the similarities between the views of the participants was carried out to identify the themes. The author then shared de-identified data with an independent qualitative data analyst for further analysis and to increase reliability of results and reduce author's expectation effects (Church et al., 2019). Categories were developed after multiple readings of the transcripts (e.g., silence, normalization of IPV, placating, ignoring the perpetrator). The generated codes were modified and analyzed to develop themes. Codes with similar meanings were collated into one theme (e.g., silence, placating and ignoring and normalization were merged to create one theme). To ensure coherence and accuracy, discussions regarding the coding process were held between the author and the independent data analyst. The discrepancies that occurred during the coding process were mainly due to the

varied interpretations of some categories, and this was resolved through discussions about the code meanings and interpretations. The results of the coding process were also discussed with the author's doctoral project supervisor. These multiple data analysis engagement processes provided corrections to errors and further theme and subtheme clarification.

Subsequently, emerging themes with similar meanings were combined to form one theme (e.g., ignoring, silence and placating formed the theme "acceptance and placating"). In this phase, themes and subthemes were developed. For example, the theme *culture-based coping strategies* was developed as the theme and *acceptance and placating* as subtheme. The author ensured that the themes and subthemes were clear, concise, and understandable (Braun & Clarke, 2006). The final report is the last step in the data analysis process and also includes writing up of this article as part of the doctoral project.

Findings

This study reveals how women in rural areas coped with IPV and how social norms played a significant role in the coping mechanisms that they utilized considering the victims' vulnerabilities and structural limitations. Based on the data collected, it was revealed that women's understanding of IPV in rural areas is varied. Given the economic hardships that are evident in rural areas, deprivation of financial assistance was provided as the main form of IPV. Furthermore, the data collected indicated that previous victims of IPV residing in rural areas adopt various mechanisms to avoid and minimize the occurrence of IPV. Most participants could not openly challenge the abusive partners or report the incident to the police. Instead, they had to cautiously establish strategies that ensured relief from abuse and its consequences, by trying not to infuriate the perpetrator and risk further victimization. Based on the findings, women residing in rural areas reported higher rates of emotion-focused coping, which shows how social norms cannot be discounted as plausible explanations for the response of women residing in rural areas to IPV situations. Although their understanding of IPV was based on financial abuse, participants reported a greater reliance on emotion-focused coping mechanisms than problem-focused coping mechanisms. Notable in their responses was the interconnectedness of emotion-focused coping and survival-focused coping in influencing the decision to deal with IPV regardless of their distinctive nature. Two major themes emerged from this study, namely, culture-based coping mechanisms (e.g., acceptance) and religious-based coping mechanisms (e.g., prayers), which will be discussed in detail in the following section.

Culture-Based Coping Strategies

Acceptance and placating. Social norms that encourage subordination of women drive victims into accepting abuse in intimate relationships. Acceptance of violence and placating was endorsed by all participants as one of the best ways of minimizing the recurrence of abuse in intimate relationships. Participants indicated that they had been socialized that marriage is not a smooth road and therefore being slapped, insulted, and other forms of abuse were to be expected. They also indicated that placating was the best way of keeping peace in the house, as it minimized physical violence and emotional abuse. The participants' narrations on their reasons for accepting violence and resorting to placating were interwoven with feelings of pain and vulnerability. With tears in her eyes one participant said,

> People were shocked why I kept the abuse from them but I told them marriage is like that, it is what it is and you have to be strong. The two of us were in love and I was hopeful it will be better because that is how marriage is like. People got to know about the abuse after I had told them. (Charmaine is a 24-year-old mother of two children who is unemployed and stays with her mother)

Another participant highlighted that she had devised strategies of making sure that she does not enrage her abusive husband. She had this to say:

> What I would do when he comes back in the evening is that I would make sure that I maintain silence and do not provoke him. If he provokes me I would make sure that I remain calm and do not answer back. That way it minimised abuse a lot. (Chipo is 28 years old, divorced, unemployed and a mother to one child)

The above verbatim quotations highlight the influence of social norms on coping decisions in IPV-dominated relationships. As noted by Machisa and Shamu (2018) in their study on the perpetration of IPV in Zimbabwe, patriarchal norms supporting male dominance and conjugal rights are major contributors to the perpetration of IPV, and victims are forced to accept them. Consistent with the Shona proverb *chakafukidza dzimba matenga* (meaning secrets of the home should remain undisclosed), disclosure of IPV is highly discouraged in rural areas, as it is against the social norms surrounding marriage and intimacy. Although the decision to resort to this emotion-focused coping is based on the adherence to social norms, the need to ensure survival is also evident. Thus, adopting acceptance and placating emanates from the socioeconomic disadvantages associated with rural areas that intersect with high unemployment in heightening the vulnerability of women to IPV. As

most women in rural areas rely on their husbands, challenging the abuser implies losing socioeconomic benefits associated with the relationship. For these reasons, the study participants resorted to acceptance and placating in dealing with IPV. Although acceptance as an emotion-focused coping strategy provides short-term protection against abuse, it does encourage further victimization.

Self-blame. Self-blame was adopted as an emotion-focused strategy in a bid to minimize and prevent the occurrence of IPV. The majority of the participants interviewed indicated that the abuse they endured was as a result of their "misbehaving" and not the perpetrator's fault. One participant admitted to insulting her husband back every time they had an argument. As expected, the insults would attract severe beating coupled with withdrawal of "privileges," such as money to buy necessities such as food. She believed that if she changes her behavior the abuse would stop:

> I get angry easily and sometimes I would just be rude to him and he would beat me because he felt disrespected. At times he would beat me and punish me by not giving me money to buy food. You know us women we talk too much sometimes and when you insult him back and hit a nerve what would you expect. Going back home was not an option because my parents take his side knowing very well that I have anger issues. (Rose is a 38-year-old divorced unemployed mother of three children)

Another participant also said,

> I blamed myself for the abuse. I would tell myself that if I was not rude and followed his instructions he would not have beaten me. I spend most of my time focusing on changing my character thinking I was to blame. I actually felt sorry for him. (Lydia is a 32-year-old divorced and unemployed mother of two children)

There is a clear interconnectedness of emotion-focused coping and survival-focused coping in the above quotations. Challenging the perpetrator implies limited access to basic needs for the women. Thus, to ensure access to basic needs crucial for survival, participants resorted to self-blame in an effort to avoid infuriating the perpetrator and avoid "the punishment." Self-blame as a coping mechanism is adaptive to victims as it reduces anxiety and has a "consoling effect" on the victims. As evidenced in the above quotations, when IPV victims resort to self-blame, they view IPV as something that they can control and prevent since it is caused by their actions. Such thinking would imply that the perpetrator was not at fault but her actions pushed him and

these women regard IPV as a way of "correcting" them when they go astray. Accordingly, the assumption will be that if one stops "misbehaving" there will not be any abuse in the marriage.

Defiance. Contrary to what the majority of participants indicated regarding acceptance and placating, few of them indicated that they used retaliation and resistance as emotion-focused coping strategies. Although it was futile at the end, participants mentioned that on a short-term basis, they succeeded in controlling the pattern of abuse in their intimate relationships. One of the participants indicated that she would also hit back at her husband even if he would physically overpower her. She indicated that after hitting back she would be assured that for several weeks to come, there would not be any abuse:

> We would fight, I ended up fighting back. Every time I would fight back things would get better in terms of the frequency of abuse. It was like if I fight back he would stop abusing me for a while. (Fadzai is a 47-year-old divorced and unemployed mother of one child)

Another woman also indicated that she was unfazed by her former husband's threats or gigantic body and would make sure that he did not overpower her. She always left him with an injury so that he would "rest" from beating her for a few weeks. She said,

> I ended up refusing to have sex with him because of his infidelity. I think the last time I had sex with him was when my last pregnancy was two months. So he would beat me because I was refusing to sleep with him (laughs). I ended up refusing to be beaten without fighting back. I would make sure that I give him an injury so that he can rest for about three days to a week from beating me. I did not allow him to just beat me (laughs). (Sara is 34 years old, divorced and unemployed with two children)

Based on the above quotations, victims of IPV in rural areas resorted to defiance as a way of coping with IPV. Defiance can be viewed as an emotion-focused coping strategy where participants respond to IPV by virtue of retaliation in an effort to reduce the abuse. Culturally and globally, women are considered to be gentle, caring, and compassionate and thus these women were defying this widely practiced norm by fighting back. In this study, defiance was based on physical resistance of abuse as well as deprivation of conjugal rights, which is a clear deviation from the social norms surrounding marriages. All the participants indicated that they grew up in families with patriarchal attitudes that condone female subordination. Interestingly, the participants used these patriarchal attitudes and norms to their own advantage. The idea behind this

was that no man would openly disclose being beaten or challenged by a woman, as this is considered weak and humiliating in Shona culture and does not fit into the hegemonic masculinity script. Resisting "correction" from one's husband is widely regarded as unacceptable behavior in Shona culture to the extent that in such circumstances the husband is allowed to return the wife to her parents as an indication of improper upbringing. Victims therefore use that to protect themselves and to cope, knowing fully well that their retaliation would minimize abuse and would not be publicized to their family or to their in-laws.

Religion and Spirituality-Based Coping Strategies

Faith and prayer. Participants spoke openly about the influence of faith and prayer in coping with IPV. Prayer and faith are regarded as important in giving hope to women in violent relationships. All the participants believed in God and their religious beliefs were based on Christianity. Participants mentioned that their belief in God and his ability to change a person gave them hope that one day things will change for the better. They also indicated that they had Bible verses that they meditated on. One participant was teary and visibly hurting when she mentioned this:

> I got a verse from the church that was full of hope. That verse managed to protect my marriage and helped me deal with the challenges that I was facing in it. Prayer helped me a lot because every time after prayer I would feel better and I had hope that God was going to intervene in my marriage and make things better. (Mucha is a 43-year-old mother of six children who is unemployed and stays alone with her children)

Another participant also mentioned that prayers kept her sane and lessened the burden, as she believed in the power of divine intervention in her marriage:

> At church, the prophets told me that my marriage was not destined to last. It was painful. For the seven years since my first pregnancy, I would tell myself that things were going to be fine and I would pray to God that things will get better. God answers prayers and I had faith that surely my husband will change and I will enjoy my marriage like any other woman. The prayer gave me hope and strength to endure. (Charmaine is a 24-year-old mother of two children who is unemployed and stays with her mother)

Notable in these quotations is the important role that religion plays in coping behavior in IPV situations. Faith and prayer in coping with IPV are strongly associated with optimistic feelings in taxing situations that fuel

hope and endurance. The women's faith in God and his benevolence provided psychological consolation and gave them hope to endure the abuse. Similarly, faith and prayer were also premised on the belief that God would change the abusive husband someday. As a result, the influence of their religious beliefs, in this regard Christianity, plays a significant role in their response to IPV situations. From the above, it can be seen that women's descriptions of their experiences of IPV reflected the importance of their religious beliefs and their influence in making choices of coping in the abusive relationship.

Pastoral mediation and prayers. Participants endorsed pastoral mediation as one of the significant ways of coping with IPV in rural areas. Participants indicated that when they felt like the burden was becoming too heavy, they resorted to mediation from their church pastors. This is when the pastor, often referred to as *muporofita* (church pastor), tries to resolve the conflicts and in some instances would summon the abusive partner. Participants also indicated that the pastors would pray for them and give them *muteuro* (anointed stones or holy water) to use in order for things to take a turn for the better. One of the participants indicated that she used the holy water and it worked for several weeks, but her former partner became abusive again. She mentioned that the holy water and the spiritual counseling she received were helpful and gave her hope. She said,

> The church I went to was an Apostolic church and I was given prayer materials to use for things to stabilise in my marriage. The church leader would tell me that the prayer materials will help in strengthening my marriage for some time and to be honest things would change and I would find strength from that, but the abuse would always resurface again after some period of time. (Tendai is 40 years old, divorced, unemployed and the mother of four children)

Another participant also highlighted that whenever she went with her former husband to the pastor for mediation, things would turn better. She also indicated that the pastor would give them holy water for them to bath with and to drink and things would be better for a while:

> At church they helped us to solve our differences and they encouraged me to stay, highlighting that things would get better. The pastor would give us holy water and we would bath with it and some of it we would drink. Surely things would get better for a while and the abuse would stop. He did not have a problem with going to the pastor for mediation despite the fact that he was not a church-goer. (Rose)

There is a clear indication from the above sentiments that religion in rural areas plays an important role in marriages. However, this should be understood in the context of the cycle of violence. Although, pastoral mediation can be categorized as problem-focused coping, their purpose was aimed at preserving the marriage and encouraging the woman to be submissive. As pastors/church leaders in rural communities are believed to have the gift of vision and revelation from God, women believed and trusted them. Accordingly, women tend to resort to pastoral mediation, as they believe that the words of the pastor symbolize the word of God. However, it should be noted that the decision to opt for pastoral mediation is not always the best option, as it would imply the need to bring in the family or the abusive husband. In rural areas, participants would resort to pastoral mediation and prayers after failing to handle the situation on their own or if the abuse becomes life-threatening. In general, participants regarded pastoral mediation as an effective way of dealing with IPV situations in rural areas.

Discussion

This study sought to examine the coping strategies adopted by women in rural areas of Zimbabwe in dealing with IPV. The women who participated in this study had left abusive relationships. The coping strategies that they adopted can be different from the coping strategies that current victims of IPV adopt. Examining the coping strategies adopted by victims of IPV in rural areas provides a clearer understanding of why there is a high prevalence of IPV in rural areas in Zimbabwe, yet there are few reported cases. Findings from this study resonate with intersectional feminism which challenges the assumption that women have similar experiences of IPV. The findings reveal how converging social variables (e.g., gender, religion, socioeconomic status and geographical location) shape the way IPV victims in rural areas react and respond to IPV and influences the choice of coping strategies that they use. Consistent with a study conducted by Bhandari et al. (2011), findings from this study also indicated that there is a correlation between survival-focused coping and emotion-focused coping strategies. Although participants reported higher reliance on emotion-focused coping as compared with problem-focused coping, it was observed that women suppressed their individual needs and safety and resorted to coping strategies that do not infuriate the perpetrator for fear of loss of basic needs (i.e., shelter and food obtained from the land of the husband) that ensure survival.

In line with studies conducted by Zakar et al. (2012) and Wong et al. (2016), participants who reported reliance on emotion-focused coping identified placating and accepting IPV as effective coping mechanisms that

minimized violence. Similar to previous studies, the reliance on placating and acceptance emanates from social norms that condone male dominance and prohibit disclosure of IPV (Conroy, 2014; Fidan & Bui, 2016; Little, 2017). Goodman et al. (2009) argues that in low-income communities the desire to meet basic needs such as shelter and food takes precedence when selecting coping strategies. This resonates with findings in this study where most women indicated that the need to ensure that the basic needs of their families are met was of paramount importance. It is therefore evident that emotion-focused and survival-focused coping intersect in influencing the coping strategies that IPV victims adopt.

Consistent with studies conducted by Koss et al. (2002) and Startup et al. (2007), participants in this study identified self-blame as an emotion-focused coping strategy in dealing with IPV. Similar to a study by Worthington and Scherer (2004), findings from this study revealed the link between self-blame and forgiveness where participants replaced the negative emotions (e.g., anger, hate) associated with IPV with positive emotions (e.g., sympathy, compassion and love) that seem to shift the blame from the perpetrator to them. Self-blame tends to give participants hope for the betterment of the abusive relationship as they feel they have control over actions that caused the abuse. Participants in this study created a new narrative which justified the abuse. Such thinking emanates from a point of vulnerability and was common among participants who were completely dependent on their husbands and did not have a strong socioeconomic support system. Based on studies conducted on self-blame, it is possible that women residing in rural areas are likely to suffer from posttraumatic stress disorder (PTSD) emanating from self-blame as higher levels of self-blame are associated with higher levels of PTSD (Flicker et al., 2012; Reich et al., 2015). This could be that turning to self-blame does not prevent abuse, but rather places the victims at a higher risk of further victimization and depression.

Worthington and Scherer (2004) argue that women seek to "restore justice," reduce stress, and minimize abuse in their relationships through retaliation, revenge, and seeking legal justice. Findings from this study resonate with the argument although participants did not engage in legal justice bearing in mind the influence of social norms that places more emphasis on family preservation. Consistent with a study conducted by Crann and Barata (2016), findings from this study indicate that women utilized defiance as a way of coping and controlling the pattern and occurrence of IPV. Contrary to a study by Matavire (2012) on women's subordinate position, women in this study resisted IPV by physically fighting back the perpetrator and depriving them of their conjugal rights. Although this is contrary to the social norms governing marriages in rural areas, participants reported

defiance as an effective short-term coping mechanism. However, in the Shona culture, depriving a man of his conjugal rights is a "punishable offence" that attracts "correction" and reinforces further abuse (Venganai, 2016). The frequent and severe abuse and the desire to preserve family honor and dignity in the community could have forced the participants to rely on defiance as a coping mechanism. Similar to previous studies (Foster et al., 2015), defiance did not provide long-term solution, but rather it reinforced further perpetration of IPV hence participants eventually opted to leave the abusive relationships.

Participants endorsed prayers as a form of emotion-focused coping strategy they adopted in dealing with IPV. These findings are in line with studies which revealed that women who experience IPV resort to their relationship with God for strength so as to enable them to deal with stressful situations (Mitchell et al., 2006; Zakar et al., 2012). When prayers fail, participants opt for pastoral mediation that focuses more on praying and removing the "evil spirits" than counseling. Rural areas in Zimbabwe are largely dominated by African Independent Churches (AICs) which promote the subordination of women. Similar to the study by Zakar et al. (2012), participants in this study sought assistance from the AICs' pastors who offered holy remedies to solve the problem through *muteuro* (e.g., holy stones or water). However, some participants revealed that some of the remedies came at a cost. Some women revealed that some of the prayers from the church leaders involved buying certain foods (e.g., eggs and milk) that they could not afford to cleanse them from evil spirits that wanted to destroy their marriages. These pastors and prophets were also male. Although pastoral mediation is deemed effective, pastors of these churches tend to reinforce the patriarchal norms that have a silencing effect on women as the interconnectedness of culture and religion cannot be overlooked (Chireshe, 2015; Chisale, 2018; Dim, 2019). This is in line with the findings of this study as pastors did not encourage women to seek external formal help but rather resorted to preserving the abusive relationship and further maintaining patriarchy. However, considering the geographical location of rural areas, it is possible that the lack of knowledge on the available formal coping services could have prevented them from assisting these women in seeking professional help. Arguably, the role that religion plays in coping with IPV cannot be regarded as uniform due to its complexity (Zakar et al., 2012). As a result, coping strategies that relate to religion and faith cannot be placed in binary categorization (i.e., effective or ineffective), because their usage is dependent on the context, type of religion, and the extent to which the victim adheres to the principles of that religion (Zakar et al., 2012).

Limitations

This study had its limitations. The sample participants were from the Shona ethnic group and might not be representative of the population of other rural women living within IPV situations. Different ethnic groups in Zimbabwe have different social norms that govern their way of living (Matavire, 2012). Thus, the coping strategies that Shona women residing in other rural areas use could be different from the way Ndebele and Shangaan women residing in rural areas in Zimbabwe cope with IPV. Moreover, participants in this study were recruited from informal self-help groups and had left the abusive relationships. Hence, the coping mechanisms that these women adopt can be different from those of women who are still in the abusive relationships. As such, women who participated in this study may not be representative of the majority of women experiencing IPV in Zimbabwe given that coping strategies that women adopt are based on context, norms, and other unique circumstances.

Implications for Practitioners

The need to strengthen the response system of women residing in rural areas to IPV cannot be overlooked by practitioners. Based on the findings, it is evident that the coping strategies that IPV victims residing in rural areas utilize are rooted in social norms that vary depending on context and determine the victims' ability to respond to the abuse. The importance of considering context in the choices of coping mechanisms to use when confronted with IPV is crucial (Bauman et al., 2008). Practitioners such as social workers, community workers, and psychologists therefore require a deep understanding of social norms and cultural values and how these influence victims' patterns of response. The idea behind this is to ensure that victims of IPV in rural areas are receptive to the intervention services that are provided to address their problems.

The findings in this study also call for professionals to reflect on work with IPV male perpetrators. This could be in form of developing social support for culturally appropriate alternative masculinities as a way of targeting behavior change of abusive men (Warria, 2017). Within this, it becomes essential to develop the skills of professionals engaging with IPV perpetrators and capacitate them to understand and apply gendered sociocultural-specific perspectives in their interactions with these men.

In addition, the findings also show the complexity of social norms and how they influence the victims' patterns of responding to IPV. Practitioners in rural areas face challenges in terms of blending in with complex social

norms that are different from their own cultural norms (Schenk, 2004). The training should therefore prepare them to accept the different social norms that come with the different rural areas in which they operate. When practitioners blend in with the culture, it is easier to bring change to the community (Schenk, 2004) and a sense of ownership can be adopted by the service users.

Furthermore, the ethical principle of self-determination speaks to the right of people to make choices and decisions in their situations (Zastrow & Kirst-Ashman, 2010). It is vital for practitioners working within IPV situations in rural areas to have an appreciation of the coping mechanisms that rural women use in dealing with the abuse (Bhandari et al., 2011; Foster et al., 2015; Sayem & Khan, 2012). It is important to recognize these mechanisms, and practitioners should not "discard" such strategies, but rather work towards empowering women on how best to utilize the available resources within their own belief systems and situations. Thus, context-specific intervention strategies that empower women to make the right decisions should be implemented. This can be done through raising awareness on the detrimental effects of social norms that condone IPV as well as imparting skills (e.g., basic culture-appropriate counseling skills) for family elders, pastors/church leaders, and traditional leaders.

From this study, it was evident that women can use culture to their advantage. Thus, cultural norms can be valuable and be a vehicle that can safeguard women. Women should also be encouraged and supported to have a voice and stand up for themselves in ways that lead to further prevention of violence. A further study, beyond the scope of this doctoral project could look at women's positive interpretation of cultural norms and practice and how they have applied it in their lives in rural contexts and in silent or unconscious defiance of patriarchy. This could be the start of amplifying women's cultural voices.

The lack of adequate literature and statistics on the prevalence of IPV in rural areas and the coping strategies women use makes it challenging to determine its scope and extent and subsequently intervention strategies applied. As such, there is likely to be a generalization of intervention strategies, which means that addressing the psychosocial needs of these women will ultimately fail. Practitioners should therefore promote more intervention research in rural areas, particularly on the influence of social norms in the perpetration of IPV and how they hinder or facilitate the intervention response system of IPV victims. The resulting themes could be subsequently used to improve and guide implementation of policy and practice.

Conclusion

The article provided an overview of IPV and the coping mechanisms that rural Zimbabwean women use in minimizing, avoiding, and escaping it. The

article conceptualized and categorized coping strategies in the context of IPV. The findings explained coping strategies used by women residing in rural areas who had exited the abusive relationships—with the majority opting for emotion-focused coping strategies. The findings indicate that the women's choice of coping strategies is premised on the prevailing social norms and the personal situations that a victim find themselves in. Given the dearth of research on the subject, it is recommended that further studies be conducted on the available coping and support systems for IPV victims in rural areas.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

ORCID iD

Cyndirela Chadambuka https://orcid.org/0000-0002-1300-8760

References

Ahinkorah, B. O., Dickson, K. S., & Seidu, A. A. (2018). Women decision-making capacity and intimate partner violence among women in sub-Saharan Africa. *Archives of Public Health*, *76*, Article 5. https://dx.doi.org/10.1186/s13690-018-0253-9

Ames, H., Glenton, C., & Lewin, S. (2019). Purposive sampling in a qualitative evidence synthesis: A worked example from a synthesis on parental perceptions of vaccination communication. *BMC Medical Research Methodology*, *19*, Article 26. https://doi.org/10.1186/s12874-019-0665-4

Bauman, E. M., Haaga, D. A. F., & Dutton, M. A. (2008). Coping with intimate partner violence: Battered women's use and perceived helpfulness of emotion-focused coping strategies. *Journal of Aggression, Maltreatment & Trauma*, *17*(1), 23–41. https://doi.org/10.1080/10926770802250942

Bhandari, S., Bullock, L. F., Anderson, K. M., Danis, F. S., & Sharps, P. W. (2011). Pregnancy and intimate partner violence: How do rural, low-income women cope? *Health Care for Women International*, *32*(9), 833–854. https://dx.doi.org/10.1080/07399332.2011.585532

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. http://dx.doi.org/10.1191/1478088706qp063oa

Chatiza, K., Muchadenyika, D., Makaza, D., Nyaunga, F., Murungu, R. J., & Matsika, L. (2015). When extractives come home: An action research on the impact of the extractives sector on women in selected mining communities in Zimbabwe. *OIDA International Journal of Sustainable Development*, *8*(12), 45–72.

Chireshe, E. (2015). Christian women's experiences of domestic violence in Zimbabwe. *Affilia*, *30*(3), 380–394.

Chisale, S. S. (2018). Domestic abuse in marriage and self-silencing: Pastoral care in a context of self-silencing. *HTS Teologiese Studies/Theological Studies*, *74*(2), 4784. https://doi.org/10.4102/hts.v74i2.4784

Church, S. P., Dunn, M., & Prokopy, L. S. (2019). Benefits to qualitative data quality with multiple coders: Two case studies in multi-coder data analysis. *Journal of Rural Social Sciences*, *34*(1), 1–16.

Conroy, A. (2014). Gender, power, and intimate partner violence: A study on couples from rural Malawi. *Journal of Interpersonal Violence*, *29*(5), 866–888. https://doi.org/10.1177/0886260513505907

Crann, S. E., & Barata, P. C. (2016). The experience of resilience for adult female survivors of intimate partner violence: A phenomenological enquiry. *Violence Against Women*, *22*(7), 853–875.

Dim, E. E. (2019). Differentials and predictors of IPV against Nigerian women in rural and urban areas. *Journal of Aggression, Maltreatment & Trauma*. Advance online publication. https://doi.org/10.1080/10926771.2019.1603178

Esie, P., Osypuk, T. L., Schuler, S. R., & Bates, L. M. (2019). Intimate partner violence and depression in rural Bangladesh: Accounting for violence severity in a high prevalence setting. *SSM: Population Health*, *7*, 100368. https://dx.doi.org/10.1016/j.ssmph.2019.100368

Etherington, N., & Baker, L. C. (2018). From "buzzword" to best practice: Applying intersectionality to children exposed to intimate partner violence. *Trauma, Violence, & Abuse*, *19*(1), 58–75. https://doi.org/10.1177/1524838016631128

Fidan, A., & Bui, H. N. (2016). Intimate partner violence against women in Zimbabwe. *Violence Against Women*, *22*(9), 1075–1096.

Flicker, S. M., Cerulli, C., Swogger, M. T., & Talbot, N. L. (2012). Depressive and posttraumatic symptoms among women seeking protection orders against intimate partners: Relations to coping strategies and perceived responses to abuse disclosure. *Violence Against Women*, *18*(4), 420–436. https://doi.org/10.1177/1077801212448897

Foster, E. L., Becho, J., Burge, S. K., Talamantes, M. A., Ferrer, R. L., Wood, R. C., & Katerndahl, D. A. (2015). Coping with intimate partner violence: Qualitative findings from the study of dynamics of husband to wife abuse. *Families, Systems, & Health*, *33*(3), 285–294. http://dx.doi.org/10.1037/fsh0000130

Goodman, L. A., Smyth, K. F., Borges, A. M., & Singer, R. (2009). When crises collide: How intimate partner violence and poverty intersect to shape women's mental health and coping? *Trauma, Violence, & Abuse*, *10*(4), 306–329. https://doi.org/10.1177/1524838009339754

Hatcher, A. M., Romito, P., Odero, M., Bukusi, E. A., Onono, M., & Turan, J. M. (2013). Social context and drivers of intimate partner violence in rural Kenya: Implications for the health of pregnant women. *Culture, Health & Sexuality*, *15*(4), 1–17. https://dx.doi.org/10.1080/13691058.2012.760205

Itimi, K., Dienye, P. O., & Gbeneol, P. K. (2014). Intimate partner violence and associated coping strategies among women in a primary care clinic in Port Harcourt,

Nigeria. *Journal of Family Medicine and Primary Care*, *3*(3), 193–198. https://dx.doi.org/10.4103/2249-4863.141601

Kanagaratnam, P., Mason, R., Hyman, I., Manuel, L., Berman, H., & Toner, B. (2012). Burden of womanhood: Tamil women's perceptions of coping with intimate partner violence. *Journal of Family Violence*, *27*(1), 647–658. https://doi.org/10.1007/s10896-012-9461-1

Klugman, J. (2017). *Gender based violence and the law* [World Development report background paper]. World Bank. http://hdl.handle.net/10986/26198

Koss, M. P., Figuredo, A. J., & Prince, R. J. (2002). Cognitive mediation of rape's mental, physical, and social health impact: Tests of four models in cross-sectional data. *Journal of Consulting and Clinical Psychology*, *70*, 926–941. https://doi.org/10.1037/0022-006X.70.4.926

Laisser, R. M., Nystom, L., Lugina, H. I., & Emmelin, M. (2011). Community perceptions of intimate partner violence—A qualitative study from urban Tanzania. *BMC Women's Health*, *11*(1), Article 13.

Lindhorst, T., & Tajima, E. (2008). Reconceptualizing and operationalizing context in survey research on intimate partner violence. *Journal of Interpersonal Violence*, *23*(3), 368–388. https://doi.org/10.1177/0886260507312293

Little, J. (2017). Understanding domestic violence in rural spaces: A research agenda. *Progress in Human Geography*, *4*(4), 472–488. https://doi.org/10.1177/0309132516645960

Lokhmatkina, N. V., Agnew-Davies, R., Costelloe, C., Kuznetsova, O. Y., Nikolskaya, I. M., & Feder, G. S. (2015). Intimate partner violence and ways of coping with stress: Cross-sectional survey of female patients in Russian general practice. *Family Practice*, *32*(2), 141–146. https://doi.org/10.1093/fampra/cmu086

Machisa, M., & Shamu, S. (2018). Mental ill health and factors associated with men's use of intimate partner violence in Zimbabwe. *BMC Public Health*, *18*, Article 376. https://doi.org/10.1186/s12889-018-5272-5

Makongoza, M., & Nduna, M. (2017). Awareness and rejection accounts of intimate partner violence by young women in Soweto, Johannesburg, South Africa. *Journal of Interpersonal Violence*. Advance online publication. https://doi.org/10.1177/0886260517726413

Matavire, M. (2012). Interrogating the Zimbabwean traditional jurisprudence and the position of women in conflict resolution. A case of the Shona tribes in Muzarabani district. *International Journal of Humanities and Social Sciences*, *2*(3), 218–223. http://www.ijhssnet.com/

McCloskey, L. A., Boonzaier, F., Steinbrenner, S. Y., & Hunter, T. (2016). Determinants of intimate partner violence in sub-Saharan Africa: A review of prevention and intervention programs. *Partner Abuse*, *7*(3), 277–315. http://dx.doi.org/10.1891/1946-6560.7.3.277

Mitchell, M. D., Hargrove, G. L., Collins, M. H., Thompson, M. P., Reddick, T. L., & Kaslow, N. J. (2006). Coping variables that mediate the relation between intimate partner violence and mental health outcomes among low-income, African American women. *Journal of Clinical Psychology*, *62*(12), 1503–1520. https://doi.org/10.1002/jclp.20305

Moen, T. (2006). Reflections on the narrative research approach. *International Journal of Qualitative Methods*, *5*(4), 56–69.

Mukanangana, F., Moyo, S., Zvoushe, A., & Rusinga, O. (2014). Gender based violence and its effects on women's reproductive health: The case of Hatcliffe, Harare, Zimbabwe. *African Journal of Reproductive Health*, *18*(1), 110–122. https://www.jstor.org/stable/24362499

Nyamukoho, E., Mangezi, W., Marimbe, B., Verhey, R., & Chibanda, D. (2019). Depression among HIV positive pregnant women in Zimbabwe: A primary health care based cross-sectional study. *BMC Pregnancy and Childbirth*, *19*, Article 53. https://doi.org/10.1186/s12884-019-2193-y

Rees, K., Zweigenthal, V., & Joyner, K. (2014). Implementing intimate partner violence care in a rural sub-district of South Africa: A qualitative evaluation. *Global Health Action*, *7*, 24588. http://dx.doi.org/10.3402/gha.v7.24588

Reich, C. M., Jones, J. M., Woodwards, M. S., Blackwell, N., Lindsey, L. D., & Beck, J. G. (2015). Does self-blame moderate psychological adjustment following intimate partner violence. *Journal of Interpersonal Violence*, *30*, 1493–1510. https://doi.org/10.1177/0886260514540800

Riddell, T., Ford-Gilboe, M., & Leipert, B. (2009). Strategies used by rural women to stop, avoid, or escape from intimate partner violence. *Health Care for Women International*, *30*(1–2), 134–159. https://doi.org/10.1080/07399330802523774

Rubin, H., & Rubin, I. (2005). *Qualitative interviewing: The art of hearing data*. SAGE.

Sayem, A. M., & Khan, M. A. U. (2012). Women's strategic responses to intimate partner violence: A study in a rural community of Bangladesh. *Asian Social Work and Policy Review*, *6*, 23–29. https://doi.org/10.1111/j.1753-1411.2011.00060.x

Schaefer, L. M., Howell, K. H., Sheddan, H. C., Taylor, R. N., Shoemaker, H. L., & Miller-Graff, L. E. (2019). The road to resilience: Strength and coping among pregnant women exposed to intimate partner violence. *Journal of Interpersonal Violence*. Advance online publication. https://doi.org/10.1177/0886260519850538

Schenk, R. (2004). Problems rural social workers experience. *Social Work/Maatskaplike Werk*, *40*(2), 158–171. http://dx.doi.org/10.15270/40-2-340

Shamu, S., Abrahams, N., Zarowsky, C., Shefer, T., & Temmerman, M. (2013). Intimate Partner violence during pregnancy in Zimbabwe: A cross-sectional study of prevalence, predictors and associations with HIV. *Tropical Medicine & International Health*, *18*, 696–711.

Shamu, S., Shamu, P., & Machisa, M. (2018). Factors associated with past year physical and sexual intimate partner violence against women in Zimbabwe: Results from a national cluster-based cross-sectional survey. *Global Health Action*, *11*(3), 1625594. https://doi.org/10.1080/16549716.2019.1625594

Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information*, *22*(2), 63–75.

Startup, M., Makgekgenene, L., & Webster, R. (2007). The role of self-blame for trauma as assessed by the Posttraumatic Cognitions Inventory (PTCI): A self-protective cognition? *Behaviour Research and Therapy*, *45*, 395–403. https://doi.org/10.1016/j.brat.2006.02.003

Venganai, H. (2016). Negotiating identities through the "cultural practice" of labia elongation among urban Shona women and men in contemporary Zimbabwe. *Culture Unbound: Journal of Current Cultural Research*, *8*(3), 306–324. http://www.cultureunbound.ep.liu.se/

Waldrop, A. E., & Resick, P. A. (2004). Coping among adult victims of domestic violence. *Journal of Family Violence*, *19*(5), 291–302.

Waltermaurer, E. (2005). Measuring intimate partner violence (IPV) you may only get what you ask for. *Journal of Interpersonal Violence*, *20*(4), 501–506. https://doi.org/10.1177/0886260504267760

Warria, A. (2017). Men at risk: Men's health, illness and the (un)healthy construction of gender identity. *Southern African Journal of Social Work and Social Development*, *29*(2), 1–20.

Wong, J. Y. H., Fong, D. Y.-T., Choi, A. W.-M., Tiwari, A., Chan, K. L., & Logan, T. K. (2016). Problem-focused coping mediates the impact of intimate partner violence on mental health among Chinese women. *Psychology of Violence*, *6*(2), 313–322. http://dx.doi.org/10.1037/a0039496

Wood, S. N., Glass, N., & Decker, M. R. (2019). An integrative review of safety strategies for women experiencing intimate partner violence in low- and middle-income countries. *Trauma, Violence, & Abuse*. Advance online publication. https://doi.org/10.1177/1524838018823270

World Health Organization. (2001). *Putting women first: Ethical and safety recommendations for research on domestic violence against women*.

Worthington, E. L., & Scherer, M. (2004). Forgiveness is an emotion-focused coping strategy that can reduce health risks and promote health resilience: Theory, review, and hypotheses. *Psychology & Health*, *19*(3), 385–405.

Zakar, R., Zakar, M. Z., & Kramer, A. (2012). Voices of strength and struggle: Women's coping strategies against spousal violence in Pakistan. *Journal of Interpersonal Violence*, *27*(16), 3268–3298. https://doi.org/10.1177/0886260512441257

Zastrow, C. H., & Kirst-Ashman, K. (2010). *Understanding human behavior and the social environment* (8th ed.). Brooks/Cole.

Zimbabwe Inter-Censal Demographic Survey. (2017). Zimbabwe National Statistics Agency (ZIMSTAT). https://zimbabwe.unfpa.org/sites/default/files/pub-pdf/Inter%20Censal%20Demography%20Survey%202017%20Report.pdf

Zimbabwe National Statistics Agency. (2012). *Census preliminary report*.

Author Biography

Cyndirela Chadambuka, MA, is a third-year doctoral student under the supervision of Ajwang Warria (PhD) in the Department of Social Work at the University of the Witwatersrand, South Africa. Her research interests include intimate partner violence, women economic development and women's rights in developing countries, and child protection issues.

5.3 CONCLUSION

The above article presented the coping strategies adopted by women residing in rural areas in dealing with IPV. Evident in this article is how various social variables intersect with social norms in influencing coping decisions. In this study, emotion-focused coping strategies are reported to be the common coping strategies adopted by women in rural areas. While these coping strategies are not fully effective in preventing and minimising IPV, they are widely accepted in rural areas as they are in line with social norms that condone the privatisation of IPV. Where coping strategies fail to provide the needed support, IPV victims resort to support systems that are available to them for assistance. Therefore, the following chapter discusses the informal and formal support mechanisms available for IPV victims residing in Chimanimani district in Zimbabwe.

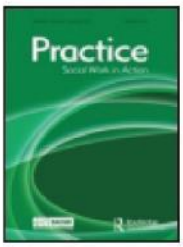
CHAPTER 6
FINDINGS AND DISCUSSION: SUPPORT SYSTEMS AND IPV

6.1 INTRODUCTION

This first article is linked to objective four, which sought to explore the available formal and informal support mechanisms available for IPV victims in Chimanimani district. Research conducted has revealed that IPV has adverse outcomes on the wellbeing of women including those living in rural areas. While women can employ various coping strategies in dealing with the IPV, the frequency and severity of the abuse can force them to seek external support in dealing with the abuse. Although they are commonly known support mechanisms available for women residing in rural areas, it is important to acknowledge that women who are exposed to IPV are capable of seeking help from different support systems. The intersectional perspective recognises that there is no 'one size fits all' when it comes to how women respond and deal with IPV. Thus, support systems available for women residing in rural areas cannot be equated with those available in urban areas considering the disadvantages that are associated with rural areas. Understanding the available support mechanisms available for women residing in rural areas is critical in ensuring that intervention programs are not uniform but rather implement programs that respond effectively to IPV in rural areas. The following article examined the available support systems for IPV victims in rural areas.

6.2 PRESENTATION OF ARTICLE 4

Chadambuka, C., & Warria, A. (2020). Examining Support Systems Available for Victims of Intimate Partner Violence in Rural Areas in Zimbabwe. *Practice: Social Work in Action, 32*(5), 381-399.https://doi.org/10.1080/09503153.2020.1750579



Practice
Social Work in Action

ISSN: 0950-3153 (Print) 1742-4909 (Online) Journal homepage: https://www.tandfonline.com/loi/cpra20

Examining Support Systems Available for Victims of Intimate Partner Violence in Rural Areas in Zimbabwe

Cyndirela Chadambuka & Ajwang' Warria

To cite this article: Cyndirela Chadambuka & Ajwang' Warria (2020): Examining Support Systems Available for Victims of Intimate Partner Violence in Rural Areas in Zimbabwe, Practice, DOI: 10.1080/09503153.2020.1750579

To link to this article: https://doi.org/10.1080/09503153.2020.1750579

Published online: 14 Apr 2020.

Submit your article to this journal

Article views: 41

View related articles

View Crossmark data

Full Terms & Conditions of access and use can be found at
https://www.tandfonline.com/action/journalInformation?journalCode=cpra20

PRACTICE: SOCIAL WORK IN ACTION, 2020 VOLUME 0 NUMBER 0 (MONTH 2020), 1–19

Check for updates

Examining Support Systems Available for Victims of Intimate Partner Violence in Rural Areas in Zimbabwe

Cyndirela Chadambuka and Ajwang' Warria

Intimate partner violence (IPV) in rural Zimbabwe remains pervasive, with adverse outcomes for the wellbeing of women. Support is thus crucial for women who experience such violence in their relationships. Despite the significance of supportive interventions in IPV cases, there is limited research on the support systems available for victims of IPV in rural areas. Therefore, this study sought to examine support systems for female victims of IPV residing in rural areas. The study adopted a qualitative approach, and participants were selected using purposive sampling in Chimanimani District (Zimbabwe). Interviews were conducted using a narrative approach with women between the ages of 19 and 49 years. Findings show that there is a higher reliance on informal support systems in comparison to formal systems. It is thus important for social workers to understand the help seeking behaviour of rural women and the support systems available, as this will enable them to develop community-based strategies for the efficient delivery of IPV interventions in rural areas.

Keywords: intimate partner violence; rural areas; support systems; social work; victims; Zimbabwe

Introduction

Intimate partner violence (IPV) is a global problem that has grave consequences for the wellbeing of women. IPV is defined as abuse perpetrated against an intimate partner that causes psychological and physical harm (Henderson, Zerai, and Morrow 2017). Research conducted has revealed that one in three women experiences IPV in her lifetime (Klugman 2017). Likewise, 30% of women experience IPV in their lifetime, with the rate in East Asia pegged at 16% (Abramsky et al. 2018).

In Africa, IPV rates are recorded as high due to the influence of patriarchal norms that condone the subordination of women. Evidence from studies conducted in Africa revealed that 28% of women in Ghana have experienced IPV

Routledge
Taylor & Francis Group

© 2020 British Association of Social Workers
https://doi.org/10.1080/09503153.2020.1750579

(Tenkorang, Owusu, and Kundhi 2018). In sub-Saharan Africa, IPV against women is pegged at 36% (McCloskey et al. 2016). Furthermore, studies conducted in South Africa indicated that the high post-partum prevalence of IPV is one of the highest reported globally, with women reporting to have experienced one act of IPV in a month during pregnancy and two acts in a month post-partum (Groves et al. 2015).

In Zimbabwe, the IPV rate is pegged at 69%, with its array of negative effects affecting the welfare of women and children (McCloskey et al. 2016). The severity and negative consequences of IPV led to the enactment of the Domestic Violence Act 2007 in Zimbabwe in a bid to minimise, prevent and criminalise IPV. In rural areas in Zimbabwe, IPV is largely characterised by control (reinforced by social norms), which is considered the epitome of masculinity (Chireshe 2015). Hyper-masculinity disregards the rights of women and support patriarchal norms that condone male dominance (Machisa and Shamu 2018). Violence and aggression are behavioural scripts associated with hegemonic masculinity (Warria 2017) and men in rural areas display bravery by exercising their power and control on women. A hyper- masculine man is socialised to dominate and control, and the attitudes displayed to women are those of physical or sexual subjugation (Guerrero 2009). Similarly, studies conducted have indicated that IPV in rural areas is predominantly undisclosed due to the traditional norms that are adhered to that discourage 'publicising' problems arising in intimate relationships (Riddell, Ford-Gilboe, and Leipert 2009; McCloskey et al. 2016). Thus, a woman who resorts to assistance challenges the cultural norms and attracts social rejection.

Rural women struggle to obtain help, and those who seek help reported being negated or treated in an unsupportive way (Bosch and Bergen 2006). Social support is thus crucial in ensuring the wellbeing of women, as it provides a way of escaping the abusive pattern in intimate relationships. Although research on IPV in urban Zimbabwe has been accumulating (Henderson, Zerai, and Morrow 2017; Fidan and Bui 2016; Shamu, Shamu, and Machisa 2018), information on the support systems available for women residing in rural areas remains limited regardless of the vulnerabilities that they are exposed to. Consequently, there is scant knowledge on the available support systems for IPV victims in rural areas, which poses complications for social workers and policy makers in terms of determining the extent of the detrimental effects of IPV on victims in rural areas. Hence understanding the support systems that are available for victims of IPV in rural areas is critical for effective intervention in IPV-dominated settings.

This article seeks to examine the support systems available for victims and survivors of IPV residing in rural areas as well as the implications for social work practice. The focus of this paper is on IPV perpetrated by men against women in heterosexual intimate relationships. The article will first present an overview of IPV as a social work challenge. The second section will focus on the interventions to address IPV in rural areas. This will be followed by a

discussion on the methodology employed in this study. The fourth section will present the emerging themes followed by a discussion of findings section. Lastly, the paper will focus on the implications on social work practice.

IPV as a Social Work Challenge

IPV became recognised socially and has been judicially condemned (Santos, Matos, and Machado 2017). It has also been the subject of research (Sylaska and Edwards 2014; Klugman 2017; Machisa, Christofides, and Jewkes 2018; Schaefer et al. 2019) in the last century due to its dire consequences for the victims, particularly women, residing in resource-constrained settings. IPV remains an issue of great concern legally (Klugman 2017) and socially (Fidan and Bui 2016). It is also seen as a problem to be dealt with in terms of religion (Zakar, Zakar, and Kramer 2012) and public health (Stockman, Hayashi, and Campbell 2015). It has come to be seen as a serious violation of the rights of women, a social work challenge and a public health problem (Fidan and Bui 2016). Of late there has been a rapid dissemination of information on IPV coupled with an increase in reported cases and media exposure (Santos, Matos, and Machado 2017), which clearly exposes the gravity of this phenomenon. Inadequate data on low-income communities (rural areas) makes it difficult to quantify the extent of IPV, but given the influence of traditional norms and social variables that intersect (gender, literacy, socio-economic status), it is assumable that IPV in these communities is far more widespread than it is in high-income communities (urban areas) (Ghose and Yaya 2019).

IPV can be experienced within heterosexual relationships (both male-on-female violence and female-on-male violence) and same-sex partnerships. However, the male-on-female type is common and can be experienced by women of all ages, religions, ethnicity as well as sexual orientation (Ghose and Yaya 2019). The factors surrounding the perpetration of IPV against women are better understood from an intersectional perspective, which facilitates understanding on how converging social variables (e.g. gender, ethnicity, religion, socio-economic status and geographical location) can heighten women's vulnerability to IPV. Given the complex nature of IPV, the lived experiences of victims vary depending on context, which implies that the perpetration of IPV cannot be generalised across different population groups. Sandberg (2013) argues that feminist research on IPV should further intersectionality by incorporating rural/urban areas as social locations that impact IPV experiences. Mehrotra (2010) proposes that feminist intersectional social work should also focus on migration, race and nationality as variables that also impact on the experiences of women. However, in this article we suggest that feminist intersectional social work should focus more on the micro factors (i.e. literacy, socio-economic status, religion, age and ability)

and how they impact on the lived experiences and help-seeking behaviour of IPV victims in rural areas. Due to the socio-economic disadvantages of rural areas combined with geographical distances, there is less access to effective support services and information for IPV victims in rural areas (Sandberg 2013).

Ballan and Freyer (2017) argue that social workers should play a pivotal role in assisting victims of IPV, particularly in accessing services that are critical for their wellbeing. Goal five of the Sustainable Development Goals (SDGs) speaks on the eradication of gender inequalities and promoting the empowerment of women and girls. Gender inequity is influenced by traditional and structural power imbalances that promote the subjection of women and violate their human rights in ways that lead to inequality (Rahman et al. 2013; Willie and Kershaw 2019). The intersectionality of power imbalances and the multiplicity of disadvantages associated with rural areas heighten women's vulnerability to IPV. Drawing from international conventions such as the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) that speak against gender inequality, it is important for one to be cognisant of these power imbalances that exist especially in rural areas because they are the underlying explanations for IPV perpetration and can inform the development of intervention programmes. Social work plays an important role in dealing with such complex issues as evidenced in the definition below.

> The social work profession promotes social change, problem-solving in human relationships, and the empowerment and liberation of people to enhance wellbeing. Utilizing theories of human behavior and social systems, social work intervenes at the points where people interact with their environments. Principles of human rights and social justice are fundamental to social work. (International Federation of Social Workers 2012)

Drawing from this global definition, social work practice in rural areas thrives to improve social conditions and meeting human needs of IPV victims (Humble et al. 2013). This can be done through advocacy and educating women and different community systems that play a significant role in the perpetuation of IPV. Similarly, improving social conditions and well-being of people entails taking into consideration the experiences of their clients and their work/clients' contexts in the development of intervention programmes. This is in line with intersectional feminism, which advocates that practitioners should be alert to the unique experiences of individuals so as to avoid imposing a uniform approach in terms of implementation of intervention strategies. Failure to understand the unique experiences of each group may impact negatively on how social workers assist victims of IPV. Accordingly, it is important to understand the support systems that are available and accessible to women residing in rural areas for effective social work intervention strategies that respond to the IPV situations.

Overview of Interventions to Address IPV in Rural Areas

Female victims of IPV are at a heightened risk of psychological and physical effects that are detrimental to their wellbeing (Delara 2016). These together with other intersecting variables negatively impact on the welfare of victims of IPV. Thus, the goal of IPV intervention strategies is to reduce and prevent its occurrence. The availability and efficacy of these interventions is based on context and the available support systems for IPV victims. Hence, some victims manage to function well regardless of their exposure to IPV (Machisa, Christofides, and Jewkes 2018). This explains the important role of support systems (commonly referred to as social support mechanisms) in enhancing women's resilience to IPV.

Support mechanisms (e.g. family, church) in IPV are important for the wellbeing of victims in abusive relationships. Social support refers to the availability of a supportive network of people that cares, is available and accessible to those in need (Machisa, Christofides, and Jewkes 2018). It is important in ensuring the wellbeing of women in abusive relationships and has managed to assist IPV victims in dealing with the abuse (Sylaska and Edwards 2014). Hence its availability, or lack of it, can hinder or facilitate further victimisation of IPV victims through social isolation. Social isolation has been identified as a key factor that influences victims' help-seeking behaviour, as it weakens social support such that victims are left completely reliant on the abuser (Lanier and Maume 2009). In his work on battered women in rural areas Websdale (2002) revealed that social isolation and its influence on the availability of social support works in two ways. Firstly, social isolation in rural areas is premised on geographical location, which is characterised by remoteness and plays a significant role in concealing IPV and mitigating efforts to seek help, which heightens the vulnerability of women to IPV. Secondly, social isolation is based on socio-cultural factors which speak to the intersectionality of rural culture, gender and patriarchal ideologies and how it generates socio-cultural isolation that makes women susceptible to IPV. This shows the influence of context, which is commonly characterised by impoverished conditions and lack of available structural support services (e.g. health care, legal assistance and social services) that are fundamental to the wellbeing of victims (Lanier and Maume 2009).

In addition, studies conducted revealed that seeking support from a supportive and non-judgemental network enhances the coping skills of IPV victims and mitigates its adverse outcomes (Machisa, Christofides, and Jewkes 2018). On the other hand, victims of IPV are at the receiving end of negative and judgemental attitudes that further promote non-disclosure (Bosch and Bergen 2006). This can be attributed to the influence of context, which speaks to the traditional gender norms that conceal IPV. Hence, communities with unequitable gender roles that promote the subordination of women also lack supportive networks, which makes IPV disclosure difficult (Machisa, Christofides, and

Jewkes 2018). Women who lack social support lack awareness in terms of the existence of such services and their availability. This correlates with their socio-economic status, characterised by high levels of poverty and low income, which makes it challenging to access such services. The frequency and severity of IPV coupled with their trust in the efficacy of formal services also determine the utilisation of support networks by victims (Bosch and Bergen 2006; Fidan and Bui 2016).

In Zimbabwe, gender traditionalism and patriarchy puts women in vulnerable positions that expose them to IPV (Fidan and Bui 2016). The effects of IPV are more visible and rife in rural areas, where the majority of the population resides. Regrettably, given the social norms that rural communities ascribe to which reinforce patriarchy, rural areas in Zimbabwe tend to conceal IPV (Chireshe 2015; McCloskey et al. 2016). Despite the importance of support systems in enabling women to escape the net of abuse in IPV-dominated relationships, there is limited knowledge on the available support mechanisms for rural women. Studies conducted on IPV and gender-based violence (GBV) in Zimbabwe (Chireshe 2015; Fidan and Bui 2016; Machisa and Shamu 2018) have focussed more on urban areas, where support mechanisms are readily available for victims of IPV, yet little is known about rural areas. As a result, this paper focuses on the support systems available for women residing in rural areas.

Methodology

Qualitative research approach was used in this study due to its ability to explore participants' inner feelings and behaviours and giving room for probing, which can open up new topics to explore in the study (Corbin and Strauss 2008). Purposive sampling was utilised in the selection of participants, as it enables the selection of information-rich participants who are experienced and well informed with the area of study (Etikan, Abubakar, and Alkassim 2016). The selection criteria for the 25 study participants were that they: (i) had experienced IPV in their former intimate relationships; (ii) should be between the ages of 19-49 years, considering that this age group is regarded as actively involved in intimate relationships and is free to voluntarily participate in the study (Zimbabwe Demographic and Health Survey 2015; Zimbabwe National Family Planning Strategy 2016-2020); (iii) should be residing in Chimanimani Rural District and (iv) be available to participate in the study. Current victims of IPV were excluded from the study owing to the security risk for both the researcher and the participants and the psychological nature of IPV, which requires intervention. During data collection, no participant revealed ongoing IPV incidents.

Chimanimani Rural District is one of the poorest districts in Zimbabwe and is located in the Eastern Highlands and borders Mozambique to the east. The

population consists of the Ndau people (a Shona sub-ethnic group). It consists of 23 wards with an average of six to eight villages. Each village has an average of 35 households. In this study, the researcher focussed on one ward in the district. However, the researcher could access participants from only six out of eight villages in the ward due to the cyclone which affected the district and destroyed roads and bridges. As per the norm in rural areas in Zimbabwe, *chisi* (resting day) is set aside every week and women meet in each village to discuss various issues, ranging from household issues to children and sharing income-generating ideas (Chimhanda 2014). In this case the lead author (registered social worker) approached informal self-help groups in six villages, explained the purpose of the study and invited the women to participate. In ensuring confidentiality, the researcher gave out Participant Information Sheets (PISs) to all women present in the group and requested them to indicate their preference on the PIS through the use of 'yes' or 'no'. Participants interested in the study were requested to provide their contact details for follow-ups. Each village managed to provide two or more participants.

Face-to-face interviews were conducted by the first author using a narrative approach, and a semi-structured interview schedule was used to guide the interview. The interviews were initially to be conducted in two sessions but some participants were sceptical and opted for one session. The reason for this was that they did not want to talk about their traumatic experiences twice, which was understandable considering the traumatic and sensitive nature of IPV. The other concern raised was on the time spent being interviewed instead of working in their gardens. The interviews were between 40 min and 90 min long and lasted an average of 50 min. Informed consent (both written and verbal) was obtained before the interviews and participants were asked to share their stories regarding their experiences of IPV in their rural context. Bearing in mind the sensitive nature of IPV issues in rural areas, the safety of the participants was prioritised (World Health Organisation (WHO)) 2001). In ensuring participants' safety, the interviews were conducted at a place and time convenient and safe for the participants. The majority of the participants preferred having the interviews at the researcher's place of residence, as they regarded it as more private and safe from prying eyes as compared to their own houses, where they live with family. A few opted to have the researcher at their place of residence, and these were participants who lived alone with their children and far from the researcher's place of residence. Given that women in rural areas survive on peasant farming and informal income-generating projects, time is important to them. Therefore, participants received R100 (approximately £5.50) as compensation of their time and as a token of appreciation.

The interviews were conducted in Shona using the Ndau dialect, which was the participants' preferred language. None of the participants requested to have the interviews in English. Issues surrounding voluntary participation and confidentiality were fully explained and participants' real names were

replaced with pseudonyms for security reasons. Given the traumatic nature of IPV, a qualified and registered social worker was available from Chimanimani Rural District Council for free counselling when required. The role of the social worker was to provide counselling and referral services to the study participants. The social worker has a 4-year social work degree training and 3 years post-graduation experience working in rural areas. However, the first author discussed elements of the research such as the aim, objectives, data collection purpose and methods and ethical considerations with the social worker and she was allowed to ask any questions of concern that she might have had. Information regarding the participant being referred to the social worker for debriefing or counselling would only be shared once the study participant granted consent. However, no participants requested counselling services during the interview. The narrative interviews were audio-recorded to avoid loss of data. As part of ethics, permission was obtained from the Ministry of Women Affairs, Community, Small and Medium Enterprise Development and Chimanimani Rural District Council. Ethics clearance (No. H18/11/04) was granted by the Human Research Ethics Committee (HREC) (non-medical) at the University of the Witwatersrand. Given the nature of rural areas, permission was also sought from the village headmen, as the gatekeeper, as is the norm of the area.

Upon completion of data collection, the interviews were transcribed verbatim. All the interviews were transcribed in Shona and translated into English where necessary. Thematic analysis was used in analysing data. This method was used for its flexibility in the identification and analysis of themes (Braun and Clarke 2006). The findings shared in this paper were reported by the majority of the participants that were interviewed in this study.

Presentation of Findings

The experiences of IPV victims residing in rural areas are unique and reflect the inequalities and vulnerabilities that they face. These vulnerabilities determine the availability of support systems for IPV victims. The findings indicated more reliance on informal support systems (e.g. church and family), as these are always readily available for participants. The following section will present the available support systems that participants resorted to as part of their effort to deal with IPV.

Family

Help from family members was reported to have both negative and positive outcomes. The majority of participants highlighted that their natal family was their source of greater assistance in times of need. In-laws were reported to

be instigators of conflict in the marital relationship which ultimately resulted in IPV. Participants highlighted that seeking assistance from the family was helpful, although the family would reinforce societal norms that condone the submission of women to men in marital relationships. One participant highlighted the following:

> *My family would give me advices when I turned to them for help and my sisters and uncles would talk with my husband. However, they would insist that I go back to my husband's house, indicating that things would change. They encouraged me to stay and I took heed of their advice.*

Another participant mentioned this:

> *I would report to his sisters and aunts, but they did not take my situation seriously. They would say deal with it yourselves because they did not want me as their daughter in law.*

Notable from these quotations is the role of the family in maintaining peace and order in marital relationships. The role of the family can be categorised as either supportive or non-supportive. Based on the data collected it is clear that the natal family of the victims was regarded as supportive and provided assistance (e.g. financial and material assistance) to IPV victims. On the other hand, seeking assistance from in-laws is not the victims' first option because of the jealousies and conflicts that exist between in-laws and IPV victims. This is due to the fact that in-laws usually take the side of the abuser and shift blame to the woman. For these reasons IPV victims residing in rural areas are reluctant to seek formal assistance for fear of family rejection.

Churches

The church was identified as an important support structure accessible to all participants. All participants were members of the African Independent Churches (AICs), which are often referred to as *mapostori* or *masowe* (i.e. white garment churches). These are the common type of churches in rural areas in Zimbabwe, and their doctrines are embedded in African culture, with the backing of some biblical beliefs that foster the submission of women. Participants highlighted that they sought support from the church when the abuse became severe and unbearable. Despite its crucial supportive role, some participants indicated that some churches ended up doing more harm than good. One participant highlighted the following:

> *Non-AICs are better because they tell you to have faith in God and you will be victorious in your marriage. AICs tell you that your mother in law is bewitching you and this adds even more stress on top of the one that you have. I think if I had sought support from non-AICs churches my marriage would still be standing.*

Another participant mentioned that

> *I would get support from the leaders at church (AICs) who would pray for me and give me anointed holy water to use. But to let it out to the church leaders is because I would have no other option. The church leaders encouraged me to stay with my husband, indicating that the abuse was the devil's work and God was going to fight for me.*

It is evident from the above quotations that the church plays a significant role in providing temporary support mechanisms to IPV victims. The support that victims of IPV get from the church in rural areas is mostly mediation, whereas in urban areas churches can also assist with financial and food assistance. However, it should be noted that the role of the church is largely premised on reconciliation and the submission of women, which can further the perpetuation of IPV against women.

Traditional Leaders

Traditional leaders (village heads, headmen and chiefs) are entrusted with the responsibility of protecting the people of their respective communities. In Zimbabwe traditional leaders are recognised by the law, as their role is regarded as important in upholding the cultural values of the communities that they serve. Considering that the village heads are in easy physical contact and interact more with IPV victims, the assumption is that they are a readily available source of support for them. However, participants aired their disgruntlement with traditional leaders. Participants indicated that seeking help from village heads was humiliating, as there is no confidentiality or privacy. One participant mentioned the following in this regard:

> *I went to the village head (name withheld) to report. The village head's right-hand man told my husband that I told the village head about the marital problems that we were having. My husband got drunk and came home called me a witch and beat me. So tell me, in that case how can you trust the village head or his council when they expose you like that.*

Another participant said:

> *The village chief did not help with much but encouraged us to talk about it….and my husband was not even disciplined by the village council for beating me.*

The above verbatim quotation indicates the complex nature of IPV and how social norms influence the provision of support to IPV victims. Village heads in Zimbabwe are mandated to uphold traditional norms and values according to the Traditional Leaders Act 1998 (Chapter 29:17). Their role emphasises reconciliation in marriages more than separation. This explains why victims of IPV

in rural areas face challenges in seeking support from village heads. Moreover, the community court in rural areas does not uphold confidentiality, which in turn perpetuates further victimisation and stigmatisation of IPV victims, given that rural areas are largely characterised by public visibility. This in turn explains why IPV victims in rural areas regard support from traditional leaders as ineffective; rather, to them it is biased and humiliating.

Informal Self-Help Groups (ISHGs)

An uncommon support system in IPV that emerged in this study was Informal Self-Help Groups (ISHGs). ISHGs are popular in rural areas, and this is where women meet to share ideas and unwind. In most villages, women meet on *chisi* (i.e. the resting day) or whenever they find time. There is no standard venue for these meetings. It can be anywhere safe and convenient for them. Participants reported that sharing problems with others helped them gain their self-esteem and confidence back. However, other participants highlighted that despite the support from the ISHGS, maintaining confidentiality was still a problem. One participant said:

> *In the ISHGs we help each other with emotional support, but the moment you turn your back on them they will gossip about you and the next thing the whole community knows your story. When the husband hears about it you will be beaten and insulted. But it did help me although there was no secrecy.*

Another participant highlighted that:

> *When you go to the market and meet other women you comfort each other (chuckles). The problem is gossiping, there is too much gossiping. Sometimes you will hear your stories from other people. But these groups help; they take the stress away*

ISHGs are based on mutual aid and personal interaction, which is key to solving the daily problems that victims of IPV face. Support that is normally rendered in ISHGs is mostly emotional, practical and in rare situations consists of material benefits and is based on reciprocity, which binds ISHGs. According to Olivier (2009), the efficacy of group interactions can be ensured through discussion on issues surrounding confidentiality. Regrettably, confidentiality in rural ISHGs is difficult to maintain. The complexity of the group and the social norms that group members conform to makes it challenging to ensure a safe and trusting environment that promotes non-disclosure. There is also the fear of further victimisation if the abuser discovers that the victim has been discussing the abuse with 'outsiders'. In this regard, victims of IPV tend to benefit more from sharing income-generating ideas than getting emotional support. Although the majority of the participants highlighted the benefits of ISHGs, there were doubts in terms of confidentiality.

Discussion

This qualitative study examined the available support mechanisms for victims of IPV residing in rural areas in Zimbabwe. The study demonstrated that informal support systems are readily available for women residing in rural areas. Family support was reported to be accessible to IPV victims. Similar to a study conducted by Bosch and Bergen (2006) and a later one by Clark et al. (2010), participants reported the natal family to be more supportive as compared to the in-laws, with IPV victims seemingly preferring to involve their immediate family more than their in-laws. However, considering the complexity of rural culture and contexts, the natal family offers support and assistance, but still reinforces the status quo of men as the undisputed heads of the house. The payment of *roora* (i.e. bride-price) which reinforces the commodification of women also exposes them to IPV and limits the support that a woman can get from her family as she does not 'belong' to them anymore. It is important to note that paying *roora* in the Shona culture is a traditional noble practice and perpetrators take advantage of it to control and abuse women. In investigating the risk factors associated with IPV, it is important to consider the family, with in-laws as potential enforcers of IPV.

Participants identified the support they get from churches as effective. Contrary to Chisale (2018) who reports on the churches' reinforcing attitudes of IPV, participants acknowledged the important role that the church plays in rendering IPV support. It is important to consider the interconnectedness of culture and religion as both support male dominance. Studies conducted on churches in rural areas in Zimbabwe indicated that churches such as the African Independent Churches (AICs) are gendered spaces with visible imbalances and use biblical texts to justify the subjection of women (Musevenzi 2017; Mapuranga 2013). Similar to a study by Chireshe (2015) the church can also promote silence about IPV and alienate victims as per the cultural norms and the divine decrees that give women a subservient position in society. Contrary to a study by Zust et al. (2018) on the ability of church leaders to refer and counsel clients, findings from this study show that church leaders in rural areas in Zimbabwe are ill-prepared to deal with IPV issues. They have limited access to formal support systems and most of them subscribe to doctrines that are embedded in patriarchy. Social workers practicing in rural areas in IPV spaces should take consideration of this as church leaders are important because they have close interaction and are trusted by women in rural areas. Churches and church leaders can thus be a pathway for effective social work intervention on IPV in rural areas.

The role of traditional leaders cannot be overlooked. Participants identified traditional leaders as an available source of support. As argued by researchers, traditional leaders in rural areas are regarded as custodians of culture and social order and are the first point of contact in resolving disputes in the community (Chigwata 2016; Subandi 2016). Their belief systems are embedded in

cultural norms that reinforce power imbalances between men and women. Regardless of the role that traditional leaders play in resolving IPV disputes, participants in this study identified lack of anonymity and confidentiality as factors that render support from traditional leaders as ineffective. Consistent with studies conducted previously by Matavire (2012) and Conroy (2014), this study further highlights that traditional courts lack privacy because disputes are resolved publicly. Given that rural culture is embedded in patriarchy, it is possible that traditional leaders reinforce male dominance and control of women, which leave IPV victims vulnerable.

ISHGs were identified as a source of support that is available for women residing in rural areas. These groups are important as they provide safe spaces for dialogues and discussions surrounding IPV in rural areas. Although these discussions challenge the social norms that strive to keep IPV in the private domain (Riddell, Ford-Gilboe, and Leipert 2009), this study highlights their significance because these women-led and occupied spaces enabled the women to de-stress and share their problems with others facing the same predicament. In the absence of social workers, these women were able to normalise their situations and find collective workable and indigenous solutions. This resonates with the findings from a study by Mannell et al. (2018) on the importance of safe spaces for IPV victims where they can fully express themselves. They argue that such groups allow IPV victims and survivors to share and debate issues around IPV and come up with possible solutions in the process. The lack of anonymity and confidentiality associated with disclosure cannot be ignored given that women in rural areas strongly adhere to patriarchal norms that normalise IPV (Klugman 2017; Fidan and Bui 2016; McCloskey et al. 2016). In this study participants reported lack of confidentiality in the ISHGs as one of the challenges and how it can lead to further victimisation. Interestingly, participants still resorted to ISHGs for support, which clearly indicated the importance of the emotional support they got from those spaces. The debates and discussions that are held in ISHGs are useful as they provide a foundation for critical thinking whereby women can start sharing ideas on how to minimise and prevent the occurrence of IPV. This is an area where social work group work can be introduced and facilitated in future.

Limitation of the Study

There was the risk of participants providing answers that were deemed as socially acceptable considering the sensitive nature of IPV and issues surrounding confidentiality and security. It was important for the first author to explain her position to the participants with regard to confidentiality. Thus, during data collection, the lead author assured the participants by explaining the issue of confidentiality and use of pseudonyms to protect their identity.

Implications for Social Work Practice

Social work in the context of IPV in rural areas is complex and dynamic given the intersectionality of various social variables, which increases women's vulnerability to IPV. Accordingly, it is important for social workers to apply a holistic multi-disciplinary approach. In accordance with Goal five of the SDGs which speaks on the eradication of gender inequality and preserving the rights of women and girls, social workers should strive to ensure intervention programmes include engaging with different professionals, community leaders and women in leadership who can assist women in dealing with IPV. Men can also play a key role in IPV reduction in rural areas (Warria 2018). As evidenced in this study, IPV victims in rural areas rely more on informal support networks implying that some professional service such as judiciary services might not be available to them. Bearing in mind the role of culture and social norms, the multi-disciplinary approach should not only entail professional service providers but should also incorporate other important support systems (e.g. family, church) that interact and are in close contact with IPV victims. An approach that recognises these readily available support networks and their influence on the help-seeking behaviour of IPV victims is paramount to effective social work intervention and preservation of the rights of women.

As indicated in the findings, ISHGs are a crucial part of IPV support for women residing in rural areas and are regarded as safe spaces for women to discuss and debate IPV issues. As suggested by Yoon and Lee (2006) social workers should assist with the development of such groups in rural areas as they act as entry points for intervention. Dialogues are important as they facilitate conversation that interrogate gender inequalities and ultimately enlighten women on the effects of IPV and how they can protect themselves (Willie and Kershaw 2019). Intervention should be grounded in cultural norms (Warria 2018). As such, social workers can make use of the ISHGs in spreading awareness on the detrimental effects of IPV as well as conscientising women on the importance of maintaining confidentiality. This can be done through the formalisation of such groups as a community resource that can be used in conscientising other IPV victims in the community (Wituk et al. 2003). In addition, through the ISHGs social workers can assist the IPV victims both in the groups and outside the group access service providers through information dissemination.

Additionally, it is important for social workers to ensure that traditional leaders are trained and empowered on how to handle IPV cases, particularly on issues surrounding confidentiality. Traditional leaders are the custodians of culture and gender roles that violate the rights of women. Machisa and Shamu (2018), Guerrero (2009) and Riddell, Ford-Gilboe, and Leipert (2009) argue that gender inequality is deeply rooted in cultural and historical values and norms that disregard the rights of woman and condone male control and dominance against women. These norms and values that undermine women and

girls must be understood within the wider society and take into consideration the socio-economic and political realities (Warria 2018; Chadambuka and Warria 2019). In this light, social workers should ensure that they actively engage with and involve traditional leaders and church leaders as they are important role players in minimising and preventing IPV. In the Zimbabwean context where service provision is centralised in urban areas, social workers should also advocate for the decentralisation of such services to rural areas, where the majority of the population resides.

Conclusion

This paper aimed to examine the support mechanisms available for victims of IPV in rural areas. The findings of this study indicated that informal support systems are more readily available than formal support service in rural areas. This is largely attributed to the influence of social norms and the geographical isolation of rural areas, which makes resource allocation difficult. Due to these converging disadvantages, social workers are mandated to advocate for decentralisation of resources that are crucial in supporting the victims of IPV. Considering that this paper was based on participants' narratives with regard to the support systems available, there is a need for further in-depth research on the barriers that affect victims of IPV in seeking formal assistance in rural areas.

Acknowledgements

The authors would like to express their appreciation to the participants who participated in this study.

Disclosure Statement

No potential conflict of interest was reported by the authors.

References

Abramsky, T., T. Musuya, S. Namy, C. Watts, and L. Michau. 2018. "Changing the Norms That Drive Intimate Partner Violence: findings from a Cluster Randomised Trial on What Predisposes Bystanders to Take Action in Kampala Uganda." *BMJ Global Health* 3 (6): e001109–15. doi:10.1136/bmjgh-2018-001109.

Ballan, M. S., and M. B. Freyer. 2017. "Supporting Female Survivors of Intimate Partner Violence with Disabilities: Recommendations for Social Workers in the Emergency Department." *Social Work in Health Care* 56 (10): 950–963. doi:10.1080/00981389.2017.1371099.

Bosch, K., and M. B. Bergen. 2006. "The Influence of Supportive and Nonsupportive Persons in Helping Rural Women in Abusive Partner Relationships Become Free from Abuse." *Journal of Family Violence* 21 (5): 311–320. doi:10.1007/s10896-006-9027-1.

Braun, V., and V. Clarke. 2006. "Using Thematic Analysis in Psychology." *Qualitative Research in Psychology* 3 (2): 77–101. doi:10.1191/1478088706qp063oa.

Chadambuka, C., and A. Warria. 2019. "Hurt or Help? Understanding Intimate Partner Violence in the Context of Social Norms as Practised in Rural Areas." *Social Work* 55 (3): 301–310. doi:10.15270/55-3-741.

Chigwata, T. 2016. "The Role of Traditional Leaders in Zimbabwe: are They Still Relevant?" *Law." Law, Democracy & Development* 20 (1): 69–90. doi:10.4314/ldd.v20i1.4.

Chimhanda, F. 2014. "The Liberation Potential of the Shona Culture and the Gospel: A Post-Feminist Perspective." *Studia Historiae Ecclesiasticae* 40 (1): 305–328. http://www.scielo.org.za/scielo.php?script=sci_arttext&pid=S1017-04992014000200018&lng=en&tlng=en (Retrieved August 26, 2019.

Chireshe, E. 2015. "Christian Women's Experiences of Domestic Violence in Zimbabwe." *Affilia* 30 (3): 380–394. 10.1186%2Fs12905-017-0441-8. doi:10.1177/0886109914563156.

Chisale, S. S. 2018. "Domestic Abuse in Marriage and Self-Silencing: Pastoral Care in a Context of Self-Silencing." *HTS Teologiese Studies/Theological Studies* 74 (2): 4784. 10.4102/hts.v74i2.4784.

Clark, C. J., J. G. Silverman, M. Shahrouri, S. Everson-Rose, and N. Groce. 2010. "The Role of the Extended Family in Women's Risk of Intimate Partner Violence in Jordan." *Social Science & Medicine* 70 (1): 144–151. doi:10.1016/j.socscimed.2009.09.024.

Conroy, A. 2014. "Gender, Power, and Intimate Partner Violence: A Study on Couples from Rural Malawi." *Journal of Interpersonal Violence* 29 (5): 866–888. doi:10.1177/0886260513505907.

Corbin, J., and A. Strauss. 2008. *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory.* 3rd ed. Thousand Oaks, CA: Sage Publications, Inc.

Delara, M. 2016. "Mental Health Consequences and Risk Factors of Physical Intimate Partner Violence." *Mental Health and Family Medicine* 12: 119–125. doi:10.25149/1756-8358.1201004.

Etikan, I., S. Abubakar, and R. S. Alkassim. 2016. "Comparison of Convenience Sampling and Purposive Sampling." *American Journal of Theoretical and Applied Statistics* 5 (1): 1–4. doi:10.11648/j.ajtas.20160501.11.

Fidan, A., and H. N. Bui. 2016. "Intimate Partner Violence against Women in Zimbabwe." *Violence against Women* 22 (9): 1075–1096. doi:10.1177/1077801215617551.

Ghose, B., and S. Yaya. 2019. "Experience of Intimate Partner Violence and Help-Seeking Behaviour among Women in Uganda." *Psych* 1 (1): 182–192. doi:10.3390/psych1010013.

Groves, A. K., D. Moodley, L. McNaughton-Reyes, S. L. Martin, V. Foshee, and S. Maman. 2015. "Prevalence of Intimate Partner Violence among South African Women during Pregnancy and Post-Partum Period." *Maternal and Child Health Journal* 19 (3): 487–495. (accessed 26 July, 2019). doi:10.1007/s10995-014-1528-6.

Guerrero, D. A. V. 2009. "Hypermasculinity, Intimate Partner Violence, Sexual Aggression, Social Support, and Child Maltreatment Risk in Urban, Heterosexual Fathers Taking Parenting Classes." *Child Welfare* 88 (4): 135–155.

Henderson, L., A. Zerai, and R. L. Morrow. 2017. "Intimate Partner Violence and HIV Status among Ever-Married and Cohabiting Zimbabwean Women: An Examination of

Partners' Traits." *African Journal of Reproductive Health* 21 (4): 45–54. (Accessed 26 July 2019). doi:10.29063/ajrh2017/v21i4.5.

Humble, M. N., M. L. Lewis, D. L. Scott, and J. R. Herzog. 2013. "Challenges in Rural Social Work Practice: When Support Groups Contain Your Neighbors, Church Members, and the PTA." *Social Work with Groups* 36 (2-3): 249–258. doi:10.1080/01609513.2012.753807.

International Federation of Social Workers. 2012. Global Standards. https://www.ifsw.org/global-standards/ (Retrieved 31 January 2020).

Klugman, J. 2017. Gender based violence and the law. World Development Report Background paper. Washington: World Bank. http://hdl.handle.net/10986/26198

Lanier, C., and M. O. Maume. 2009. "Intimate Partner Violence and Social Isolation across Rural/Urban Divide." *Violence against Women* 15 (11): 1311–1330. doi:10.1177/1077801209346711.

Machisa, M. T., N. Christofides, and R. Jewkes. 2018. "Social Support Factors Associated with Psychological Resilience among Women Survivors of Intimate Partner Violence in Gauteng, South Africa." *Global Health Action* 11 (sup3): 1491114–1491119. doi:10.1080/16549716.2018.1491114.

Machisa, M., and S. Shamu. 2018. "Mental Ill Health and Factors Associated with Men's Use of Intimate Partner Violence in Zimbabwe." *BMC Public Health* 18 (1): 11. 10.1186/s12889-018-5272-5.

Mannell, J., I. Seyed-Raeisy, R. Burgess, and C. Campbell. 2018. "The Implications of Community Responses to Intimate Partner Violence in Rwanda." *PLoS One* 13 (5): e0196584–15. doi:10.1371/journal.pone.0196584.

Mapuranga, T. P. 2013. "AICs as a Gendered Space in Harare, Zimbabwe: revisiting the Role and Place of Women." *Studia Historiae Ecclesiasticae* 39 (2): 303–317. http://www.scielo.org.za/scielo.php?script=sci_arttext&pid=S1017-04992013000200017&lng=en&tlng=en. (Retrieved August 26, 2019.

Matavire, M. 2012. "Interrogating the Zimbabwean Traditional Jurisprudence and the Position of Women in Conflict Resolution. A Case of Shona Tribes in Muzarabani District." *International Journal of Humanities and Social Sciences* 2 (3): 218–223. http://www.ijhssnet.com/.

McCloskey, L. A., F. Boonzaier, S. Y. Steinbrenner, and T. Hunter. 2016. "Determinants of Intimate Partner Violence in Sub Saharan Africa: A Review of Prevention and Intervention Programs." *Partner Abuse* 7 (3): 277–315. doi:10.1891/1946-6560.7.3.277.

Mehrotra, G. 2010. "Toward a Continuum of Intersectionality Theorising for Feminist Social Work Scholarship." *Affilia* 25 (4): 417–430. doi:10.1177/0886109910384190.

Musevenzi, J. 2017. "The African Independent Apostolic Church's Doctrine under Threat: The Emerging Power of Faith-Based Organisations' Interventions and the Johanne Marange Apostolic Church in Zimbabwe." *Journal for the Study of Religion* 30 (2): 178–206. doi:10.17159/2413-3027/2017/v30n2a8.

Olivier, C. 2009. "Enhancing Confidentiality within Small Groups: The Experiences of AIDS Service Organizations." *Social Work with Groups* 32 (4): 274–287. doi:10.1080/01609510902874586.

Rahman, M., K. Nakamura, K. Seino, and M. Kizuki. 2013. "Does Gender Inequity Increase the Risk of Intimate Partner Violence among Women? Evidence from a National Bangladeshi Sample." *PLOS One*. 8 (12): e82423. doi:10.1371/journal.pone.0082423.

Riddell, T., M. Ford-Gilboe, and B. Leipert. 2009. "Strategies Used by Rural Women to Stop, Avoid, or Escape from Intimate Partner Violence." *Health Care for Women International* 30 (1-2): 134–159. doi:10.1080/07399330802523774.

Sandberg, L. 2013. "Backward, Dumb, and Violent Hillbillies? Rural Geographies and Intersectional Studies on Intimate Partner Violence." *Affilia* 28 (4): 350–365. doi:10.1177/0886109913504153.

Santos, A., M. Matos, and A. Machado. 2017. "Effectiveness of a Group Intervention Program for Female Victims of Intimate Partner Violence." *Small Group Research* 48 (1): 34–61. doi:10.1177/1046496416675226.

Schaefer, L. M., K. H. Howell, H. C. Sheddan, R. N. Taylor, H. L. Shoemaker, and L. E. Miller-Graff. 2019. "The Road to Resilience: Strength and Coping among Women Exposed to IPV." *Journal of Interpersonal Violence*, 1–27. doi:10.1177/0886260519850538.

Shamu, S.,. P. Shamu, and M. Machisa. 2018. "Factors Associated with past Year Physical and Sexual Intimate Partner Violence against Women in Zimbabwe: results from a National Cluster-Based Cross-Sectional Survey." *Global Health Action* 11 (sup3): 1625594–1625599. doi:10.1080/16549716.2019.1625594.

Stockman, J. K., H. Hayashi, and J. C. Campbell. 2015. "Intimate Partner Violence and Its Health Impact on Disproportionately Affected Populations, Including Minorities and Impoverished Groups." *Journal of Women's Health* 24 (1): 62–79. doi:10.1089/jwh.2014.4879.

Subandi, E. 2016. "The Role of Village Chief in Improving Public Participation for Rural Development (A Case Study of the Village of Margorejo District of Parengan Tuban Regency)." *Imperial Journal of Interdisciplinary Research* 2 (5): 193–198.

Sylaska, Kateryna M., and Katie M. Edwards. 2014. "Disclosure of Intimate Partner Violence to Informal Social Support Network Member: A Review of Literature." *Trauma, Violence & Abuse* 15 (1): 3–21. doi:10.1177/1524838013496335.

Tenkorang, E. Y., A. Y. Owusu, and G. Kundhi. 2018. "Help-Seeking Behaviour of Female Victims of Intimate Partner Violence in Ghana: The Role of Trust and Perceived Risk of Injury." *Journal of Family Violence* 33 (5): 341–353. doi:10.1007/s10896-018-9959-2.

Traditional Leaders Act. 1998. (Chapter 29:17)

Warria, A. 2017. "Men at Risk; Men's Health, Illness and the (un)Healthy Construction of Gender Identity." *Southern African Journal Social Work and Social Development* 29 (2): 1–20. 10.25159/2415-5829/1827.

Warria, A. 2018. "Girls' Innocence and Future Stolen: The Cultural Practice of Sexual Cleansing in Malawi." *Children and Youth Services Review* 91: 298–303. doi:10.1016/j.childyouth.2018.06.011.

Websdale, N. 2002. *Rural Woman Battering and the Justice System: An Ethnography.* Thousand Oaks, CA: Sage

Willie, T. C., and T. S. Kershaw. 2019. "An Ecological Analysis of Gender Inequality and Intimate Partner Violence in the United States." *Preventive Medicine* 118: 257–263. doi:10.1016/j.ypmed.2018.10.019.

Wituk, S. A., S. Tiemeyer, A. Commer, M. Warren, and G. Meissen. 2003. "Starting Self-Help Groups: Empowering Roles for Social Workers." *Social Work with Groups* 26 (1): 83–92. doi:10.1300/J009v26n01_06.

World Health Organisation (WHO). 2001. *Putting Women First: Ethical and Safety Recommendations for Research on Domestic Violence against Women.* Geneva: WHO

Yoon, D. P., and E. O. Lee. 2006. "The Impact of Religiousness, Spirituality, and Social Support on Psychological Well-Being among Older Adults in Rural Areas." *Journal of Gerontological Social Work* 48 (3-4): 281–298. doi:10.1300/J083v48n03_01.

Zakar, R., M. Z. Zakar, and A. Kramer. 2012. "Voices of Strength and Struggle: Women's Coping Strategies against Spousal Violence in Pakistan." *Journal of Interpersonal Violence* 27 (16): 3268–3298. doi:10.1177/0886260512441257.

Zimbabwe Demographic and Health Survey. 2015. *Key Findings on Gender-Based Violence*. Harare: ZIMSTATS.

Zimbabwe National Family Planning Strategy. 2016-2020. http://ec2-54-210-230-186.compute-1.amazonaws.com/wp-content/uploads/2016/12/Zimbabwe-National-FP-Strategy-2016-2020_9.12.16.pdf (Retrieved, 15 October 2019)

Zust, B., B. Flicek, K. Moses, C. Schubert, and J. Timmerman. 2018. "10-year Study of Christian Church Support for Domestic Violence Victims 2005-2015." *Journal of Interpersonal Violence*, 1-27. doi:10.1177/0886260518754473.

Cyndirela Chadambuka, MA, is a registered social worker and a third year doctoral student under the supervision of Dr. Warria in the Department of Social Work at the University of the Witwatersrand (Johannesburg, South Africa). Correspondence to: Cyndirela Chadambuka Doctoral Student Department of Social Work, University of the Witwatersrand, South Africa. Email: 890270@students.wits.ac.za, cchadambuka@gmail.com

Ajwang' Warria, PhD is registered social worker and a Senior Lecturer in the Department of Social Work at the University of Witwatersrand (Johannesburg South Africa)

6.3 CONCLUSION

This article provided an examination of the available systems that are available to victims of IPV in rural areas. It is evident that informal support networks (i.e. churches, family and traditional heads) are readily available for victims of IPV. Women in rural areas rely more on their natal family for support as family is responsible for mediating in marital conflicts. Central to this discussion is the influence of social norms in the support rendered to women. Although these available support systems provide temporary support, it is important to acknowledge that they tend to reinforce the status quo of patriarchy that condones the subjection of women and ultimately the perpetration of IPV. Where informal support systems fail to provide the needed assistance, formal support systems (e.g. police, social workers and the healthcare officials) play an important role in ensuring that IPV victims get the necessary support. It is therefore important to understand the barriers that victims of IPV in rural areas face in seeking formal assistance. The following article is also linked to the fourth objective and sought to explore the barriers that IPV victims in rural areas face as they attempt to seek formal assistance.

6.4 INTRODUCTION

The previous article in this chapter unpacked the available support systems (i.e. informal support networks) available for IPV victims in rural areas. Evident in the findings is the absence of formal support systems regardless of their pivotal role in minimising and preventing IPV. Formal support is crucial in ensuring that victims receive medical and psychosocial assistance in dealing with IPV given the risks (i.e. trauma and injuries) associated with IPV. Regardless of these deleterious effects, disclosure of IPV to formal support systems remains very low especially in low-income communities including rural areas (Bosch & Bergen, 2006). This is closely linked to social norms in rural areas that promote non-disclosure of IPV to outsiders (Riddell et al., 2009). While these informal support systems are important in providing temporary intervention to victims in rural areas, formal support systems are essential in providing long term and in some cases permanent solutions to the IPV problems especially when the abuse is life threatening. The findings from this study revealed that there are indeed barriers that exist in the help seeking process in rural areas. Understanding these barriers is crucial in addressing the weaknesses in IPV intervention that impede the effectiveness of the formal IPV services rendered in rural areas. Hence, this article presents the barriers that IPV victims in Chimanimani rural areas face as they attempt to seek formal IPV intervention.

6.5 PRESENTATION OF ARTICLE 5

Chadambuka, C., & Warria, A. (2021). Intimate Partner Violence: Understanding Barriers in Seeking Formal Support Services in a Rural Area in Zimbabwe. *Journal of Family Violence*, 1-12. https://doi.org/10.1007/s10896-021-00275-4

Journal of Family Violence
https://doi.org/10.1007/s10896-021-00275-4

ORIGINAL ARTICLE

Intimate Partner Violence: Understanding Barriers in Seeking Formal Support Services in a Rural Area in Zimbabwe

Cyndirela Chadambuka[1] · Ajwang'Warria[1]

Accepted: 5 April 2021
© The Author(s), under exclusive licence to Springer Science+Business Media, LLC, part of Springer Nature 2021

Abstract
Intimate partner violence (IPV) remains a global problem that requires intervention, yet women residing in rural areas still face challenges in dealing with it. There are no specific studies on the barriers to the use of formal support systems by victims of IPV in rural areas in Zimbabwe. Therefore, this study explored barriers that exist in the use of formal support systems by victims of IPV residing in rural areas in Zimbabwe. A qualitative study was conducted with 25 women between the ages of 19 and 49 years who reside in a rural area in Chimanimani District (Zimbabwe). Study participants were recruited using purposive sampling and on the basis that they had experienced IPV in their former intimate relationships and were not current victims. In-depth face-to-face interviews were conducted with the study participants. Interviews were audio-recorded with the consent of participants and data transcribed verbatim. The data was analysed using thematic analysis. Findings from the study suggest that the desire to preserve marriages, the attitudes of service providers, concerns with confidentiality, and lack of resources were barriers that victims of IPV faced in seeking formal help. Women in rural areas face challenges in accessing and using formal support systems even though they have the same risks of IPV perpetration as women in residing in urban areas. Therefore, there is a need for more resources and context-specific interventions to ensure the protection and uphold the rights of women residing in rural areas.

Keywords Barriers · Formal support services · Intimate partner violence · Rural areas

Intimate partner violence (IPV) remains one of the major global challenges that violate the rights of women. IPV has different forms, which include physical, psychological and sexual harm (McCloskey et al., 2016). Male partners are the most common perpetrators, with 30% of women estimated to have experienced IPV in their lifetime (Abramsky et al., 2018). Globally, one in three women is reported to have experienced IPV in her lifetime (Klugman, 2017). The worst affected regions include South East Asia (38%), Eastern Mediterranean (37%) and Africa (36%) (Alangea et al., 2018).

In Africa, the rate of IPV is recorded as high, given the cultural norms and values that condone the subjection of women and male dominance (Izugbara, 2020; McCloskey et al., 2016). For example, in Uganda, 44% of ever-partnered women reported having experienced IPV, with 58% reporting attitudes of accepting men's use of violence against women in intimate relationships (Abramsky et al., 2018). In Africa, the sub-Saharan region has one of the highest rates of IPV and this is largely attributed to the influence of cultural norms, high levels of unemployment and poverty, which leaves women in vulnerable positions (McCloskey et al., 2016).

The Zimbabwean society, especially in the rural areas where IPV effects are more rampant, is patriarchal and subscribes to social norms that encourage male dominance (Fidan & Bui, 2016). Regardless of the various legislative measures put into place, IPV remains a socio-economic challenge in rural areas in Zimbabwe that requires intervention (Shamu et al., 2013). For women residing in rural areas in Zimbabwe, the situation is worsened by the multiplicity of disadvantages that converge with cultural norms. Nyandoro and Muzorewa (2017) argue that the rapid rural–urban migration in Zimbabwe played a significant role in the centralisation of basic services to meet the growing needs of

✉ Cyndirela Chadambuka
890270@students.wits.ac.za; cchadambuka@gmail.com

Ajwang' Warria
Ajwang.Warria@wits.ac.za

[1] Department of Social Work, University of the Witwatersrand, Johannesburg, South Africa

Published online: 15 April 2021

the urban population. Thus, most of the crucial IPV-related intervention services (e.g. judiciary services, psycho-social services) are in the urban areas, with a few core service providers (e.g. health professionals and police) deployed to rural areas.

There has been considerable coverage of IPV and its consequences for women in Zimbabwe, especially those in urban areas (Chireshe, 2015; Henderson et al., 2017; Shamu et al., 2018), yet critical gaps still exist in terms of formal service delivery in rural areas. While there is a fairly large body of literature on IPV, its consequences and the challenges that women face in seeking help in low-income communities (Conroy, 2014; Evans & Feder, 2014; Riddell et al., 2009), little is known about IPV and barriers in seeking formal assistance in rural areas in Zimbabwe. Studies conducted in other rural contexts such as in Canada by Guruge and Humphreys (2009) and in Kenya by Odero et al. (2014) have shown that lack of awareness about formal support services, confidentiality issues and lack of resources are some of the barriers that IPV victims face as they seek help. Furthermore, although barriers to help-seeking in IPV situations might be similar between rural and urban areas, there might also be distinct differences determined and influenced by the actual setting (Edwards, 2015). Thus practitioners need to understand the uniqueness of women seeking assistance due to IPV in rural areas. Failure to have a full understanding of the context, strengths and barriers existing in rural areas makes intervention efforts fruitless, contributes to rights violations and increases women's vulnerability. This study contributes to debates on service provision to vulnerable pupulations in rural areas, especially women victims of IPV. Based on the literature reviewed, this is the first study conducted to specifically examine the barriers that exist in accessing and using IPV formal support services by women in heterosexual relationships residing in rural areas in Zimbabwe.

Decision-Making in the Context of IPV

The decision to disclose IPV to formal support systems is difficult given the consequences associated with reporting IPV incidents to 'outsiders' (Riddell et al., 2009). One of the key solutions in the prevention of IPV is to enhance women's decision-making capacity, i.e., the ability to acquire resources, agency and ability to make strategic life decisions and choices (Schuler et al., 2018; Stork, 2008). This also includes the ability to seek formal assistance in abusive situations. Although other indicators of empowerment are crucial, decision-making enables victims of IPV to have insight into the extent to which they can exercise choice and control in order to minimise, stop and/or prevent the occurrence of IPV.

IPV is regarded as a serious indicator of disempowerment of women and the extent to which the decision-making capacity of women in IPV situations can be enhanced is determined by societal expectations and gender roles (Kabir & Khan, 2019). It can be argued that societal practices and beliefs, such as the payment of *roora* (bride-price), sets the stage for the commodification of women and normalisation of IPV. This in turn suppresses women's rights to decision-making and ultimately increases their vulnerability to IPV. Furthermore, the discussion on IPV and the empowerment of women, particularly decision-making, is debatable, with some studies indicating that the ability to make crucial decisions in the household can increase their vulnerability to IPV (Abramsky et al., 2018). Interestingly, some studies outline disparate findings on the relationship between IPV and decision-making (Kim et al., 2007). Overally, it can be argued that women's decision-making capacity can have different effects on IPV risk and this is highly dependent on context (Sabarwal et al., 2014).

Researchers further argue that the perpetuation of IPV is largely reinforced by discriminatory laws and exclusionary social norms that undermine the abilities and potential in making strategic life decisions and choices (Klugman, 2017; McCloskey et al., 2016). Goal 5 of the Sustainable Development Goals (SDGs) is on the achievement of gender equality and empowerment of all women and girls, to enjoy decision-making power and have a voice within their family settings. However, this can be difficult to achieve considering that the voice can be regarded as a threat and deviation from social norms (Sanawar et al., 2019). Women's ability to make decisions in IPV-dominated relationships is suppressed by the fact that women, particularly those residing in rural areas, generally depend economically on men and normalise abuse in return for economic and social support (Sanawar et al., 2019). This impedes the help-seeking process and incapacitates their decision-making capacity. This might explain why victims of IPV in rural areas would find it challenging to seek assistance from formal support systems.

Formal Support Systems

Support is crucial in IPV situations and it can be provided by both formal and informal support systems. Informal support systems include one's immediate and extended family members and friends (Guruge & Humphreys, 2009). On the other hand, formal support can be provided by professional service providers such as police officers, health professionals, social workers and shelter personnel. The support that is rendered by formal service providers includes financial assistance, links to resources, psycho-social support and information on seeking protection from the abuser (Evans & Feder, 2014). From a systems theory perspective, IPV is

harmful and has negative effects on the welfare of the individual women, their family and community as a whole and therefore supportive interventions are critical in minimising and preventing its occurrence and the consequences thereof. Systems theory can also be used to understand and contextualise intervention strategies. Formal support is useful in rural areas given that informal networks can be unsupportive due to their adherence to social norms that condone secrecy in IPV cases (Bosch & Bergen, 2006). In some cases, the family provides inadequate support, especially when the abuse is life-threatening and this renders formal support more important. Although seeking help from an informal support network is regarded as a precursor to formal help-seeking (Evans & Feder, 2014), the influence of social norms and geographical distances in rural areas also makes it challenging for victims of IPV to access formal help.

Rural areas in Zimbabwe are geographically isolated, with few intervention resources for assisting victims of IPV. This then means that women in rural areas have limited access to formal support services. Sechele (2016) argues that rural areas are largely characterised by systemic discrimination of resource allocation, and Zimbabwe is not an exception. In Zimbabwe, crucial IPV intervention services are centralised in cities such as Harare and Mutare. Hence essential formal service provision is scarce or even absent in rural areas, which makes informal support a reprieve and a viable temporary alternative for abused women. Victims of IPV in rural areas also face the risk of being turned away due to insufficient programmes and inadequate staffing to deal with IPV cases (Peek-Asa et al., 2011). Likewise, the structure of rural areas *hides* IPV and ultimately inhibits treatment and prevention efforts (Teaster et al., 2006). The provision of formal services in rural areas remains limited due to social and geographic isolation, which present barriers to accessing IPV services. For example, a study by Peek-Asa et al. (2011) revealed that 25% of women in rural areas affected by IPV had to travel around 64 kms to the nearest service provider, unlike those in the urban areas. This is not different from the Zimbabwean situation, where most rural areas are remote with service providers far apart. This is a significant barrier for IPV victims in rural areas as they are exposed to severe and frequent IPV (Conroy, 2014).

The tenacity of social norms that promote gender inequality (Chadambuka & Warria, 2019) and male dominance in intimate relationships plays a significant role in the help-seeking behaviour of victims (Shamu et al., 2018). According to Bosch and Bergen (2006), formal support networks are entrenched in advocating for equality and freedom and building resilience among victims. However, due to their structured way of delivering services (e.g. lack of anonymity and confidentiality), formal support systems may not the best recourse for the many IPV victims in rural areas. As a result, victims of IPV in rural areas seem to have internalised and normalised IPV, and their (financial) dependence on the perpetrator impedes their ability to seek help from formal support systems (Riddell et al., 2009). Thus, it is important to examine and understand the barriers to formal help-seeking in rural areas.

Theoretical Framework

Intersectional feminism acknowledges gender inequality from a perspective of converging social variables. The intersectionality perspective provides a basis for investigating the experiences of marginalised women (Baird et al., 2019). Intersectional feminism acknowledges that no single social variable can adequately explain the experiences of women; rather, multiple disadvantages (e.g. religion, social norms, gender and geographical location) intertwine in contributing to the oppression of women (McCall, 2005). The complexity of IPV indicates the need to deepen our understanding of this phenomenon and how different groups of women experience it. In understanding and explaining IPV experiences, no axis of inequality should be prioritised more than another, as these operate simultaneously in the perpetuation of IPV (Etherington & Baker, 2018). This requires the need to understand how cultural beliefs and structural factors contribute to its perpetuation and ultimately influence victims' help-seeking behaviour. Thus, intersectional feminism strives to acknowledge the wider context in which IPV occurs taking into consideration the intricately intertwined social variables that heighten the risk of women to IPV (Crenshaw, 1991; Hill Collins, 1991).

In this study, intersectional feminism allows for a more nuanced picture of women's experiences of IPV in rural areas and challenges the notion that women have similar experiences of IPV and respond to it in the same way. We posit that the converging disadvantages associated with rural areas cannot be discounted as plausible explanations for the heightened risk to IPV. These disadvantages influence the help-seeking behaviour of victims of IPV in rural areas and inform the availability and accessibility of formal support services.

Methods

Study Context

Chimanimani Rural District is one of the poorest districts in Zimbabwe. The population consists of mostly the Ndau people, who are a Shona sub-ethnic group. The district consists of 23 wards with an average of six to eight villages in each ward. Each village consists of an average of 35 households. For this study only one ward was selected in the district.

The researcher could not interview participants who lived in some of the remote villages due to Cyclone Idai that made a landfall in Zimbabwe in March 2019, destroyed roads and made it dangerous to travel to those villages for interviews. The researcher could access only six villages out of eight. Chimanimani District is largely mountainous and has a rugged terrain, so some villages are far from the road and lack reliable public transport. The district has a police post and clinic in each ward. Most service providers from government departments and non-governmental organisations are centralised in nearest towns and this negatively affects service provision in rural areas (Bosch & Bergen, 2006).

Participants

Qualitative research was used for this study due to its flexibility in probing and understanding the human experiences of different groups of society (Rahman, 2017). Purposive sampling was utilised to select participants, as it enables the selection of information-rich participants who are well informed in the field of study (Sharma, 2017). The sample of the study consisted of 25 women drawn from six out of eight villages in one ward in Chimanimani District. The 25 participants were chosen on the basis that they i) should have experienced IPV in their former intimate relationships and were not in a current abusive relationship; (ii) should be between the ages of 19 and 49 years old; (iii) should be residing in Chimanimani District; (iv) should be available to participate in the study. Current victims of IPV were excluded from the study because of the risks associated with IPV disclosure for both the researcher and participants. No participant revealed on-going IPV during the interviews.

In recruiting participants for the study, the author took advantage of *chisi* (cultural resting day in the Shona society) to explain the purpose of the study. The author approached informal self-help groups in six villages, explained the purpose of the study and invited the women to participate. In upholding confidentiality, the author handed out participant information sheets to all women present and requested them to indicate their preference through the use of 'yes' or 'no'. All the women in the group were literate and could write their names and contact details. Those who were willing to participate were requested to include their contact details for follow-up. Not all women who wanted to participate met the eligibility criteria, as some of them were experiencing ongoing IPV but were willing to share their stories. For those who were in current relationships characterised by IPV, the lead author provided details of the district social worker for further assistance, as they were not comfortable with the researcher making a direct referral. All the women, two or more from each village, who were interviewed in this study consented to participate.

Data Collection

Data collection was done over a three-month period – i.e. from March to May 2019 in Chimanimani Rural District in Zimbabwe. Face-to-face interviews were conducted by the lead author using a semi-structured interview schedule. The semi-structured interview guide was developed in both Shona and English. Questions around available support mechanisms for IPV victims in rural areas were included in the interview guide. For example, '*Can you share with me the support mechanisms that you utilised when you were exposed to IPV? What are the challenges that you faced when you tried to access these support services?* Further probing questions around accessibility, appropriateness and availability were asked to elicit in-depth information on help-seeking. As all participants were Ndau-speaking (Shona dialect), the interviews were conducted in Ndau. Issues surrounding voluntary participation and confidentiality were fully explained and participants' real names were replaced with pseudonyms for privacy and confidentiality and to reduce risks.

All the interviews were audio-recorded with the consent of the study participants to avoid data loss. The author intended to conduct the interviews in two or more sessions, but the majority of the participants opted for one session and they indicated being more comfortable with this. The other important reason cited was the time spent being interviewed in two sessions instead of working in their gardens and/or farm. The interviews were between 40 and 90 min and lasted an average of 50 min. Informed consent (both written and oral) was sought from participants before the commencement of the interviews. In line with research guidelines from World Health Organisation (WHO) (2001) and ensuring safety of the participants in this study, the researcher conducted interviews at a place and time that was convenient and safe as identified by the women. Given the importance of time and the reliance on subsistence farming and gardening, the participants received ZAR100 (approximately US$7) as a token of appreciation for their time and involvement in the study. The money was given in Rands, since at the time of data collection Zimbabwe was using a multicurrency approach which consisted of the South African rand and the US dollar.

Bearing in mind the traumatic nature of IPV, the services of a social worker were made available by Chimanimani Rural District Council if counselling was required. In the event of a participant requiring counselling, the researcher was to refer the participant to the social worker, with the consent of the participant. No participant requested the services of the social worker; however, the researcher shared the contact details of the social worker with women who were facing ongoing IPV who could not participate in the study. As per ethics requirements, permission was obtained

from the Ministry of Women Affairs, Community, Small and Medium Enterprise Development and Chimanimani Rural District Council. Ethics Clearance (No. H18/11/04) was granted by the Human Research Ethics Committee (HREC) (non-medical) at the University of the Witwatersrand. Given the nature of rural areas, permission was also sought from the village headmen as part of the social norms that govern this rural area.

Data Analysis

After completing data collection, the audio-recorded interviews were transferred to the author's password-protected computer. The audio-recorded interviews were transcribed verbatim by the author, as she is fluent in both Shona and English. The interviews were transcribed in Shona and translated into English where necessary. Pseudonyms were used to identify the participants. The transcribed interviews were analysed using the steps outlined by Braun and Clarke (2006). This method of data analysis was selected due to its flexibility in the selection of themes (Braun & Clarke, 2006). While thematic analysis was the main method of data analysis, the authors borrowed some tenets of the phenomenological analysis method so as to ensure an in-depth analysis. The researcher used the six steps in thematic analysis, which include familiarisation with data collected, generating initial codes and searching for themes.

The researcher familiarised herself with the data through the transcribing phase, as she transcribed the interviews herself. Creswell (2013) argues that in phenomenological analysis textual descriptions are important in interrogating what the participants are saying and the relevant topics being expressed by the participants in line with the phenomenon under study. Thus after data familiarisation, each transcript of the interview was thoroughly reviewed, and potentially interesting and relevant texts were highlighted manually, and codes were developed to categorise the data. For example, codes such as *victim blaming* and *lack of sympathy* were developed under this process. After reviewing, the data was collated into groups that were identified by the codes. Saldana (2009) argues that multiple coders in qualitative research are crucial in dealing with researcher bias. Hence, in this study an independent qualitative analyst was invited to assist with data analysis in order to avoid researcher bias. De-identified data was shared with an independent qualitative analyst for further analysis, and discrepancies that emerged were discussed regularly. Creswell (2013) suggests that the process of validation in phenomenological research design includes having agreement between coders and is crucial in addressing researcher bias. In this study, the independent qualitative analyst agreed with the codes developed by the researcher. The codes that emerged were analysed to identify patterns among them and themes were generated. Several codes in this study were combined into themes. For example, the codes *victim blaming* and *lack of sympathy* were combined to form one theme: *attitudes of service providers.* The potential themes were reviewed to check if they represented the data collected and were renamed and defined so that they would be easily understandable to the readers.

Positionality

Positionality in research reflects the position the researcher has taken within a given study and requires the researcher to locate and acknowledge their views, values and beliefs in the research process through self-reflection (Patnaik, 2013; Sherry, 2013). Manohar et al. (2017) argue that when conducting qualitative research various factors (i.e. age, gender) come into play and influence the research process. The lead author is from the Shona tribe and can speak the Ndau dialect – the language used for data collection – fluently, which enabled the study participants to identify with her and ensured ease in discussing sensitive IPV-related and cultural norms.

Manohar et al. (2017) further argue that the age and gender of the researcher influence the research process particularly in terms of trust and relationship. In the Shona culture old age implies respect, hence there was a possibility of older participants finding it difficult to extend respect to the lead author, who was younger than most of them. The lead author, being an unmarried young woman in her late twenties, was not at ease discussing sensitive issues with the older participants – similar to experiences of the service providers to be shared in the next section. However, she ensured that cultural respect was accorded to the older study participants hence rapport was easy to establish and the participants opened up to her and gave her the lead in the discussion of sensitive information.

Previous personal and professional experience – i.e. familiarity with rural areas by living there as a young person and working with victims of gender-based violence in rural areas in Zimbabwe – enhanced this data collection process. These experiences enabled her to establish strong connections with the participants, as she had some understanding of rural life and context. However, it is crucial to note that, from time to time, urban bias crept in and the research supervisor (the second author) assisted her with this – even when she was still in the field collecting data.

Results

The findings from this study reveal the different barriers that women face in accessing formal support systems. These are: (i) the desire to preserve marriages, (ii) the

attitudes of service providers, (iii) lack of confidentiality, (iv) lack of resources. These barriers will be discussed in detail, as listed, next.

"I want My Marriage": The Desire to Preserve Marriages

Participants reported that one of the barriers in seeking formal support was their desire to preserve their marriages. While the desire to preserve marriages is experienced by IPV victims in both rural and urban areas, women residing in rural areas place great emphasis on preserving their marriages regardless of the seemingly deleterious consequences of IPV (Conroy, 2014; Riddell et al., 2009). Given the importance of natal and extended families in solving marital disputes, participants reported that the family would not be supportive if IPV is disclosed to formal service providers, as this was against societal norms. Moreover, relatives and families discourage the use of formal services, particularly the police, in order to avoid arrests, which are regarded as shameful and humiliating. Victims who wanted to report to the police were also threatened with divorce, as it is regarded as disrespectful to the family. One participant noted:

> My husband and his family used to say if I ever go to the police, he will leave me because it means I would have undermined him. I wanted my marriage so I just told myself that this will pass, and I did not report all the abuse that my husband exposed me to (Chipo, 28 years old, divorced and unemployed mother of one).

Another participant mentioned that

> I never went to the hospital or clinic after being beaten, I just thought I will be fine. Besides if you go to the clinic, they will instruct you to go to the police yet I still want my marriage. You know once you involve the police in things concerning your husband when you are married, nothing will move, that marriage ends (Elsie, 32 years old, widowed and unemployed mother of two children).

The need to preserve marriages is central to the help-seeking process among victims of IPV victims. Families are crucial to the success of marriages in rural areas, and in-laws become unsupportive and hostile towards the victim if IPV abuse is disclosed to formal service providers. Social norms surrounding marriage condone the privatisation of IPV, and families are mandated to maintain that status quo by virtue of being the best mediators in marital conflicts. The need to preserve the family's honour and dignity in the community always discourages IPV victims from reporting IPV incidents to service providers.

"They Start Judging and Blaming you": Attitudes of Service Providers

Formal service providers play a major role in assisting victims of IPV in rural areas. Although they are regarded as the last resort, service providers are the first point of contact for those victims who have decided to take a major step of seeking external help. However, considering the victim-blaming attitudes that are associated with IPV service providers (e.g. police and healthcare professionals), participants in this study did not regard formal assistance as effective, hence the decision to avoid formal service providers. The dissatisfaction in their service provision stemmed from the negative attitudes that they display to the women. One participant highlighted that.

> To me, going to the police was a waste of time because police, usually, when you go to them with such cases they start judging and blaming you because they believe as a woman you get beaten because of being rude to the husband. To me, the police did not help and some of them are related to community members and hang around with people known to the abuser, so if you go there everyone in the community will know that you reported your husband to the police (Nancy, 20 years old, divorced and unemployed mother of one).

Another participant highlighted that

> I would go to the clinic and lied to them that I am sick so that they could treat me. I never told them I was beaten because they would require a police report before treating and I cannot report my husband. And nurses are rude once they know you were beaten, they also insult you in front of other patients exposing you to everyone. Sometimes they would even blame you for the beatings (Lydia, 32 years old, divorced and unemployed mother of two children).

The above quotations clearly highlight the strained relationship between formal service providers in rural areas and the victims of IPV. The judgemental and unsympathetic attitudes of service providers in rural areas present a barrier to IPV victims seeking help. The interaction of the prevailing social norms, gender and geographical isolation also affect the way service providers perceive and respond to IPV victims. For example, IPV is considered a criminal offence in Zimbabwe, yet police in rural areas resort to making more use of mediative policing because of the prevailing cultural norms that do not regard IPV as a criminal offence. Notably, police and healthcare professionals in rural areas tend to conform to the social norms of the communities that they serve, which poses challenges in terms of assisting IPV victims. This in turn makes disclosure and discussion of IPV

uncomfortable for victims and survivors, hence the decision not to involve formal service providers.

"Everyone will know your Story": Lack of Confidentiality

Participants highlighted lack of confidentiality as one of the barriers to seeking formal support. Given that rural areas lack privacy and anonymity, participants highlighted that service providers do not adhere to confidentiality and as soon as one seeks assistance from them, it becomes public knowledge. Disclosure of IPV attracts social rejection and lack of support from family members, church members and neighbours, which leaves the IPV victim isolated. The fear of isolation and stigma from both family and community members makes it challenging for victims of IPV to seek professional intervention. One participant mentioned.

> It is a waste of time going to the police because the next thing everyone will know your story. They will not even protect you they will call your husband and ask both of you to have an understanding. You will be surprised to see the same policeman having beer with your husband. So reporting is a waste of time (Mucha, 43 years old, divorced and unemployed mother of six children).

Another participant also said

> I once reported and the next thing everyone was on my case and accusing me of trying to destroy the family. They said I was not a good wife. I decided to keep quiet as disclosing abuse made things worse, you don't even know what will happen. The next thing people will start side-lining you in the community you do not even benefit from the food aid programmes because they will accuse you of betraying the breadwinner. That is why we do not report. There is no point (Rose, 38 years old, divorced and unemployed mother of three children).

Evident in the above quotation is how the intersection of place and social norms influences the help-seeking process. The interconnectedness of social norms and geographical locations makes the structured process of formal assistance challenging. Formal support systems tend to challenge the status quo of rural culture by discouraging IPV, which is considered a disciplinary measure for stray and disobedient wives. Moreover, formal intervention in some cases might include bringing in the perpetrator for questioning or counselling. In most cases, victims prefer discussing the incidents without involvement of the perpetrator and the family. Bearing in mind the nature of rural areas, seeking help from formal service providers is not as private as victims would want. Rural areas are characterised by public visibility and lack of anonymity and this discourages women from seeking formal help, as disclosure of IPV attracts social rejection and re-victimisation. For these reasons, IPV victims in rural areas become reluctant to seek formal assistance.

"They do not have the Resources to Help": Lack of Resources

Lack of intervention resources including transportation was identified as one of the barriers that women residing in rural areas face as they attempt to seek formal assistance. Rural areas in Zimbabwe are largely characterised by inadequate resources for intervention, which ultimately leads to limited knowledge on the existence of such services. The provision of support services is based on the availability of resources for effective intervention. This is supported by participants' quotations below:

> Sometimes the clinics don't have ambulances to take you to the hospital. I once went there I was swollen [from IPV injuries] and pregnant and they told me to go to the police first and hospital with public transport on my own. They said they did not have transport to take me there even though they could see I was heavily pregnant and swollen from beatings. Imagine, so to me going to these people was not the best decision (Cecilia, 40 years old, divorced and unemployed mother of four children).
>
> They do not have the resources to help. The police do not have cars. Once you go there, they will ask you to get a taxi and go to the clinic on your own without anyone accompanying you. The same applies with the clinics, they cannot help us because they also do not have cars and sometimes the medicine to treat wounds is not even there. That's why I never attempted to report to them, they are also struggling these nurses and police (Tendai, 40 years old, divorced and unemployed mother of four children).

Participants also highlighted that the available support services are far from where they live and in order to order to access formal help they would have to walk long distances in the scorching sun as they did not have transport money to use to get to the nearest local clinic. One participant said

> I did not have money to go to clinic (name withheld) because for me to go there it means I will need US$5 or I will have to risk walking this long distance of about 14 km to and from. And with a baby on my back, the sun and the pains from beatings there was no way I would go to the clinic let alone the police (Cecilia, 40 years old, divorced and unemployed mother of four children).

It is evident in the above quotations that strained intervention resources including transportation are a barrier in

the help-seeking process among victims of IPV residing in rural areas. The terrain in Chimanimani is rugged and mountainous, making it difficult for service providers to access victims living in the most remote areas. The closest clinic to the study location did not have an ambulance or a car for transporting patients. This makes IPV intervention challenging, as some victims face life-threatening abuse that requires prompt intervention. Futhermore, some participants in this study live in mountainous areas with high temperatures, and for them to access the nearest police station they would have to travel long distances – which might have monetary implications. Some participants indicated that they had to walk long distances with injuries, and those who did not stay in mountainous areas had no transport money, as the nearest clinic and police were distantly located. This is worse for victims with injuries and those with infants, and this poses a major barrier in accessing formal support services.

Discussion

This study focused on the barriers that exist in the access and use of formal support services by victims of IPV residing in rural areas. Study results show that victims of IPV in rural areas face multifaceted barriers in accessing formal support services. Examining the barriers in rural areas in Zimbabwe provides answers and clearer understanding around the issues of the underreporting of IPV cases and how the intersectionality of social variables (e.g. gender, religion, age, socio-economic status) coupled with the multiplicity of disadvantages such as poor infrastructure and living conditions impede the help-seeking process.

Barriers related to cultural norms that condone IPV appeared at the top of the list of barriers reported by participants in this study. The concerns of confidentiality and the preservation of marriages were identified as central in the IPV help-seeking process in rural areas. Culturally, marital conflicts are dealt with within the family with the aim of preserving the marriages. As such, disclosing IPV to 'outsiders' is deemed unacceptable and warrants social sanctioning (Rees et al., 2014; Riddell et al., 2009). Similar to research conducted, our findings revealed that the need to preserve marriages could also be tied to socio-economic inequalities that give men more power over resources in a way that women end up economically dependent on the perpetrator (Gibbs et al., 2018; Goodman et al., 2009; Klugman, 2017). Economic dependence tends to undermine the decision to seek formal assistance, as exposing the perpetrator is tied to the fear of losing social and economic support. Perpetrators in turn use this dependence to further control and abuse women. This could also be the reason why women in this study pointed out lack of confidentiality as a barrier in help-seeking. We determined that participants' concerns about confidentiality stemmed from the need to ensure that their help-seeking efforts would not interfere with the marriage and ultimately their wellbeing and that of their children. Given the context of rural areas, where public visibility and lack of anonymity feature greatly (Bosch & Bergen, 2006; Conroy, 2014; Riddell et al., 2009), maintaining confidentiality seems to be problematic and the issue of stigma is evident – all which impact accessing of services.

Similar to Overstreet and Quinn (2013), we noticed the interconnectedness of anticipated stigma and social norms in women's decision to seek formal help. Consistent with Murray et al. (2015), the findings from this study show that the need to preserve marriage and maintain the privacy of marital disputes stems from fear of stigmatisation. The fear of being judged and rejected by the community tended to discourage victims from seeking formal help. Labelling and the discrimination that comes with disclosure of IPV to outsiders attract shame and humiliation and this could be the reason why participants in this study prioritised their marriages over their wellbeing. This labelling and stigmatisation affect not only the victim, but also her natal family and in-laws. Thus, the need to protect the family from community rejection and stigma and preserve the honour and dignity of both families could possibly be barriers to help-seeking.

The attitudes of services providers also seem to deter the study participants from seeking services. Participants pointed out that judgemental attitudes and lack of empathy of service providers were also barriers to seeking formal assistance. Rural areas are characterised by social norms that condone the privatisation of IPV; thus for women who do decide to take the bold step of seeking formal assistance, support is greatly required. Most service providers are expected to show empathy and non-judgemental attitudes as they assist IPV victims (Guruge & Humphreys, 2009). However, past research has shown that in some instances service providers in rural areas can be unsupportive and insensitive to IPV victims (Baldry & Pagliaro, 2014; Teaster et al., 2006). Consistent with findings from other studies, these negative attitudes are also reinforced by social norms that formal service professionals subscribe to in the communities that they serve (Baldry & Pagliaro, 2014; Retief & Green, 2015). This unethical conduct is rooted in the cultural norms of the communities they operate in that require them to subscribe to community norms. It is also possible that this unethical conduct could be ingrained in their own patriarchal beliefs and social norms that motivate their reaction to IPV cases (Baldry & Pagliaro, 2014). Similarly, in closely knit rural communities victims and perpetrators of IPV are in some sort of relationship with the service providers considering the structure of rural areas where social cohesion is of paramount importance. Thus, these multiple relationships tend to remove much-needed safeguards such as service providers' objectivity when responding to

victims' needs (Teaster et al., 2006). When these safeguards are removed, service providers tend to exhibit unethical and victim-blaming attitudes towards IPV victims, which in turn discourages women from seeking formal help.

Findings from our study also demonstrated the influence of inadequate intervention resources in the IPV help-seeking process. Past research by Peek-Asa et al (2011) shows that lack of adequate intervention resources is a barrier to help-seeking in IPV situations. This scarcity of crucial intervention resources renders formal service providers unhelpful and unreliable. Findings from this study indicate that while there is a local clinic and a police camp servicing each ward in the district, these centres are not well equipped to respond to IPV situations. Similar to other studies conducted, the geographical isolation of rural areas and the systemic discrimination in terms of resource allocation are plausible explanations for the strained intervention resources in rural areas (Alvarez et al., 2018; Sandberg, 2013; Sechele, 2016). Consequently, the lack of intervention resources makes it challenging to render support to IPV victims and could possibly be the reason why women in this study were not aware of services available to them or their right to access these services. Klugman (2017) argues that the existence of the law does not imply awareness. Although her argument was focused on the legal aspects, it is relevant to this study, as one of the core duties of social services professionals is to refer their clients to the appropriate service providers, legal service providers included. There is insufficient knowledge on legal interventions for women affected by IPV residing in rural areas. This lack of awareness tends to impede the help-seeking process, as women are not even aware of the existence of services that are pivotal in assisting them in dealing with IPV (Agyei-Baffour et al., 2011; Munyoro, 2017).

In addition to strained intervention resources, the findings also revealed that participants in this study reported financial constraints and transport problems as barriers to help-seeking. Rural areas in Zimbabwe are largely characterised by long geographical distances, underdeveloped infrastructure and rugged terrain which makes accessibility of service difficult (Munyoro, 2017). Although rural areas differ according to locality, studies conducted have also indicated that physical distances are a barrier to accessing formal support systems by IPV victims (Bosch & Bergen, 2006; McCloskey et al., 2016; Peek-Asa et al., 2011). For these women transport money was also a challenge, as some of them would have to use public transport to access this service. This is not surprising considering the high levels of unemployment and poverty in rural areas in Zimbabwe. From an intersectional standpoint, it is imperative to acknowledge how the politics of location come into play in the help-seeking process in rural areas. The remote geographical location of rural areas negatively affects not only the perpetration of IPV but also the possible responses to it (Sandberg, 2013). The combination of these geographical barriers and inadequate resources negatively impact on effective intervention. The impact of inadequate intervention resources is huge and increases economic hardships for IPV victims residing in rural areas. When these women fail to get the help needed they ultimately fail to provide food for the family (children included) given that women in rural areas are heavily reliant on subsistence farming. The geographical distances reported in this study pose difficulties to rural women in accessing IPV intervention services, which is crucial given that they are more susceptible to frequent and severe IPV.

As the above discussion indicates, the politics of location and influence of social norms take centre stage in the help-seeking behaviour of IPV victims in rural areas. The isolation of rural areas and their strong adherence to social norms condoning IPV tend to play a significant role on how women respond to IPV and set the parameters of help-seeking. The intersection of gender, cultural norms, geographical location and lack of inadequate resources serves to deepen the isolation of women in rural areas, thereby increasing their vulnerability to severe abuse. The lack of awareness, exacerbated by geographical isolation, makes seeking formal assistance challenging, as the women are not aware of the existence of some of the services that they can use in order to minimise and prevent the occurence of IPV.

Implications for Service Providers Working in Rural Areas

While the government of Zimbabwe has made strides in addressing IPV through the enactment of legal frameworks aimed at ameliorating this phenomenon, a lot still needs to be done to ensure effective intervention in rural areas. Given that IPV violates the rights of women, policy formulation and implementation are crucial in the prevention and minimisation of IPV. It is also important to ensure that the unique experiences of rural women are taken into consideration. Participants in this study highlighted that one of the barriers to their use of formal help is the lack of formal support systems in their communities. Contrary to a study by Odero et al. (2014) in Kenya, which concluded that service providers are available and accessible to rural people, the situation is different in Zimbabwe, where police stations and clinics are far from some communities.

Through an intersectional lens, this centralisation of resources is largely linked to uniformity in terms of implementation of intervention strategies (Bright et al., 2016). Thus, policymakers should ensure the decentralisation of essential services to rural areas so that victims of IPV can have access to them regardless of their geographical location and socio-economic status. This decentralisation should also include the deployment of well-trained practitioners with

special training on screening, responding to and preventing IPV in rural areas based on how it manifests in populations and communities in rural areas. Service providers in rural areas should also be involved in the formulation and implementation of IPV legal frameworks and ensure that these legal frameworks incorporate context-specific interventions that address the actual experiences of IPV victims in these areas. Further recommendations for policymakers should include the re-evaluation of existing policies and intervention strategies and the identification of factors that hinder effective intervention. This re-evaluation process should take into cognisance the lived realities of victims of IPV in rural areas and avoid applying uniform interventions to different groups (i.e. women living in rural areas and those in urban areas) who have different IPV experiences.

Consistent with findings from studies conducted by Chireshe (2015) and McCloskey et al. (2016), the findings from this study indicated that an important factor is the need to preserve marriages, which deters women from seeking formal help. This stems from societal norms that regard disclosure of IPV as deviant behaviour. Despite the fact that service provision in rural areas is inadequate, women in these areas must nonetheless be made aware of the importance of seeking formal assistance for their own physical and emotional wellbeing. Decentralisation of essential services may be futile if the recipients do not understand the importance of such services and are still normalising IPV. Given that social norms that condone violence take precedence over the wellbeing of women, perhaps the starting point for formal service providers should be to shift norms and attitudes that tend to promote the subjugation of women. Psycho-social practitioners (e.g. social workers and psychologists) can sensitise women in rural areas through community dialogues and campaigns. These campaigns and dialogues should include not only women but also men, village elders and other influential people in the community such as church leaders. These dialogues are important in sending the message to the community that IPV is not acceptable and perpetrators should be held accountable. Moreover, these dialogues can also be used to equip informal support networks (i.e. village elders and families) with knowledge and skills in dealing with IPV cases, as they are in close and continual interaction with IPV victims.

Previous research revealed that the lack of intervention resources was one of the barriers in seeking help for IPV victims (Sundborg et al., 2012). This lack of adequate resources can lead to frustrations in service delivery and ultimately judgemental and unsympathetic attitudes on the part of service providers. Hence, psycho-social practitioners working within the scope of IPV in rural areas should advocate for the empowerment of service providers in terms of the provision of resources and adequate training on how to deal with IPV victims in rural areas.

Lack of intervention resources can lead to limited awareness on the availability of formal support services for IPV victims (Bosch & Bergen, 2006; Riddell et al., 2009). As a result, practitioners should strive to conscientise women in rural areas on the availability of these support services and the merits of using them for their wellbeing. Practitioners can make use of the women groups in rural areas, for example those that meet on *chisi* day, to spread awareness on IPV and the support services available for IPV victims. NGOs that provide food aid and agricultural assistance are common in rural areas and should be used as entry points in raising both awareness of IPV and the existence of formal support services or even provision of services. For example, food, fertilizer and/or seed distributors can be trained in rapid screening, referrals and counselling, given that they closely work with women and village heads in gathering information on households as they compile distribution registers.

Limitations

It has been argued that any threat that accompanies the researcher during data collection such as association with authority figures sometimes forces participants to withdraw from the study (Shenton & Hayter, 2004). In this study some participants were uncomfortable, especially with questions that were focused on service delivery. They were not willing to mention the flaws of support service providers, since the researcher had mentioned to them during the introductory sessions that she had gained permission from the Ministry of Women Affairs, Community, Small and Medium Enterprise Development and Chimanimani Rural District Council to conduct her research. To ameloriate this, the researcher assured participants of confidentiality such as by not revealing their real names when reporting the information received.

Sikweyiya and Jewkes (2012) argue that studies that require participants to recall and report about past experiences, especially those involving feelings and emotions, after time has passed may have a problem of recall bias. In this study we relied on the self-reported experiences of women who had experienced IPV in their former intimate relationships and the barriers to help-seeking, so recall bias cannot be ruled out in this study. Furthermore, Neill and Hammatt (2015) report that rural areas differ based on locality and the extent of remoteness. Accordingly, the experiences of IPV victims also differ based on locality. Although findings from this study are important in understanding the barriers that IPV victims in rural areas face in seeking formal assistance, they cannot be generalised to other rural areas and all the women residing in Chimanimani District as they are specific to women who participated in this study.

Conclusion

This paper focused on the barriers that are associated with access to and use of formal support systems in rural areas. It adds to the limited yet growing body of knowledge on IPV in rural areas. Findings from this study reveal the influence of social norms and how they mitigate help-seeking efforts from victims of IPV. The discussion in this article has shown how crucial it is for psychosocial practitioners to effectively respond to the needs of IPV victims while acknowledging their unique experiences in dealing with IPV and the challenges they face in the help-seeking process. It is therefore crucial for practitioners and policymakers to ensure that intervention strategies take into consideration these barriers and ensure that the programmes that are drafted are context-specific and respond to the unique challenges faced by IPV victims residing in rural areas.

Acknowledgements The authors would like to thank the women who participated in this study

Declarations

Conflict of interests The authors declared no potential conflict of interest with respect to the research, authorship and/or publication of this article.

References

Abramsky, T., Musuya, T., Namy, S., Watts, C., & Michau, L. (2018). Changing the norms that drive intimate partner violence: Findings from a cluster randomised trial on what predisposes bystanders to take action in Kampala, Uganda. *BMJ Global Health, 3*, 1–15. https://doi.org/10.1136/bmjgh-2018-001109.

Agyei-Baffour, P., Kotha, S. R., Johnson, J. C., Gyakobo, M., Asabir, K., Kwansah, J., Nakua, E., Dzodzomenyo, M., Snow, R. C., & Kruk, M. E. (2011). Willingness to work in rural areas and the role of intrinsic versus extrinsic professional motivations- a survey of medical students in Ghana. *BMC Medical Education, 11*(56), 1–8. https://doi.org/10.1186/1472-6920-11-56.

Alangea, D. O., Addo-Lartey, A. A., Sikweyiya, Y., Chirwa, E. D., Coker-Appiah, D., Jewkes, R., & Adanu, R. M. F. (2018). Prevalence and risk factors of intimate partner violence among women in four districts of the central region of Ghana: Baseline findings from a cluster randomised controlled trial. *PLoS ONE, 13*(7), 1–19. https://doi.org/10.1371/journal.pone.020087.

Alvarez, C., Debnam, K., Clough, A., Alexander, K., & Glass, N. E. (2018). Responding to intimate partner violence: Health care providers' current practices and views on integrating a safety decision aid into primary care settings. *Research in Nursing & Health, 41*(5), 1–11. https://doi.org/10.1002/nur.21853.

Baird, S.L., Alaggia, R., & Jenney, A. (2019). "Like opening up Old Wounds": Conceptualising intersectional trauma among survivors of intimate partner violence. *Journal of Interpersonal Violence*, 1–12. https://doi.org/10.1177/0886260519848788.

Baldry, A. C., & Pagliaro, S. C. (2014). Helping victims of intimate partner violence: The influence of group norms among lay people and the police. *Psychology of Violence, 4*(3), 334–347. https://doi.org/10.1037/a0034844.

Bosch, K., & Bergen, M. B. (2006). The influence of supportive and non-supportive persons in helping rural women in abusive partner relationships become free from abuse. *Journal of Family Violence, 21*, 311–320. https://doi.org/10.1007/s10896-006-9027-1.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa.

Bright, L.K., Mlinksy, D. & Thompson, M. (2016). Causally interpreting intersectionality theory. *Philosophy of Science*, *83*(1), 60–81. http://www.jstor.org/stable/10.1086/684173?origin=JSTOR-pdf.

Chadambuka, C., & Warria, A. (2019). Hurt or help? Understanding intimate partner violence in the context of social norms as practised in rural areas. *Social Work/Maatskaplike Werk, 55*(3), 301–310. https://doi.org/10.15270/52-2-741.

Chireshe, E. (2015). Christian women's experiences of domestic violence in Zimbabwe. *Journal of Women and Social Work, 30*(3), 380–394. https://doi.org/10.1186/%2Fs12905-017-0441-8.

Conroy, A. (2014). Gender, power, and intimate partner violence: A study on couples from rural Malawi. *Journal of Interpersonal Violence, 29*(5), 866–888. https://doi.org/10.1177/0886260513505907.

Crenshaw, K. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford Law Review, 43*, 1241–1299.

Creswell, J. W. (2013). *Qualitative Inquiry and Research Design: Choosing among Five Aporoaches*. Sage.

Edwards, K.M. (2015). Intimate partner violence and the rural–urban-suburban divide: Myth or Reality? A critical review of the literature. *Trauma, Violence & Abuse, 16*(3), 359–373. https://doi.org/10.1177/%2F1524838014557289.

Etherington, N., & Baker, L. C. (2018). From "Buzzword" to best practice: Applying intersectionality to children exposed to intimate partner violence. *Trauma, Violence & Abuse, 19*(1), 58–75. https://doi.org/10.1177/1524838016631128.

Evans, M. A., & Feder, G. S. (2014). Help-seeking amongst women survivors of domestic violence: A qualitative study of pathways towards formal and informal support. *Health Expectations, 19*, 62–73. https://doi.org/10.1111/hex.12330.

Fidan, A., & Bui, H. N. (2016). Intimate partner violence against women in Zimbabwe. *Violence Against Women, 22*(9), 1075–1096. https://doi.org/10.1177/1077801215617551.

Gibbs, A., Jewkes, R., Willan, S., & Washington, L. (2018). Associations between poverty, mental health and substance use, gender power, and intimate partner violence amongst young (18–30) women and men in urban informal settlements in South Africa: A cross-sectional study and structural equation model. *PLoS One, 13*(10), 1–19. https://doi.org/10.1371/journal.pone.0204956.

Goodman, L. A., Smyth, K. F., Borges, A. M., & Singer, R. (2009). When crises collide: How intimate partner and poverty intersect to shape women's mental health and coping? *Trauma, Violence & Abuse., 10*(4), 306–329. https://doi.org/10.1177/1524838009339754.

Guruge, S., & Humphreys, J. (2009). Barriers affecting access to and use of formal social supports among abused immigrant women. *Canadian Journal of Nursing Research, 41*(3), 64–84.

Henderson, L., Zerai, A., & Morrow, R.L. (2017). Intimate partner violence and HIV status among ever-married and cohabiting Zimbabwean women: An examination of partners' traits. *African Journal of Reproductive Health, 21*(4), 45–54. https://doi.org/10.29063/ajrh2017/v21i4.

Hill Collins, P. (1991). *Black feminist thought: Knowledge, consciousness, and the politics of empowerment*. Routledge.

Izugbara, C. O., Obiyan, M. O., Degfie, T. T., & Bhatti, A. (2020). Correlates of intimate partner violence among urban women in sub-Saharan Africa. *PLoS One, 15*(3), 1–21. https://doi.org/10.1371/journal.pone.0230508.

Kabir, R., & Khan, H.T.A. (2019).A cross sectional study to explore intimate partner violence and barriers to empowerment of women

in Armenia. *BioMed Research International*, 1-11. https://doi.org/10.1155/2019/6939684.

Kim, J. C., Watts, C. H., Hargreaves, J. R., Ndhlovu, L. X., Phetla, G., Morrison, L. A., Busza, J., Porter, J. D. H., & Pronyk, P. (2007). Understanding the impact of a microfinance-based intervention on women's empowerment and the reduction of intimate partner violence in South Africa. *American Journal of Public Health, 97*, 1794–1802.

Klugman, J. (2017). *Gender based violence and the law. World Development Report Background paper*. World Bank. http://hdl.handle.net/10986/26198.

Manohar, N., Liamputtong, P., Bhole, S., & Arora, A.C. (2017). Researcher positionality in cross-cultural and sensitive research. *Handbook of Research Methods in Health Social Sciences*, 1–15. https://doi.org/10.1007/978-981-10-2779-6_35-1.

McCall, L. (2005). The complexity of intersectionality. *Signs, 30*, 1771–1800.

McCloskey, L. A., Boonzaier, F., Steinbrenner, S. Y., & Hunter, T. (2016). Determinants of intimate partner violence in sub Saharan Africa: A review of prevention and intervention programs. *Partner Abuse, 7*(3), 277–315. https://doi.org/10.1891/1946-6560.7.3.277.

Munyoro, I. (2017). Research data collection in challenging environments: Barriers to studying the performance of Zimbabwe's Parliamentary Constituency Information Centres. *The African Journal of Information and Communication, 21*, 81–95. https://doi.org/10.23962/10539/26111.

Murray, C.E., Crowe, A. & Overstreet, N.M. (2015). Sources and components of stigma experienced by survivors of intimate partner violence. *Journal of Interpersonal Violence*, 1–22. https://doi.org/10.1177/0886260515609565.

Neill, K. S., & Hammatt, J. (2015). Beyond urban places: Responding to intimate partner violence in rural and remote areas. *Journal of Forensic Nursing, 11*(2), 93–100.

Nyandoro, M., & Muzorewa, T. T. (2017). Transition from growth point policy to liberal urban development in Zimbabwe: The emergence of Ruwa Town, 1980–1991. *The Journal for Transdisciplinary Research in Southern Africa, 13*(1), 1–10. https://doi.org/10.4102/td.v13i1.426.

Odero, M., Hatcher, A. M., Bryant, C., Onono, M., Romito, P., Bukusi, E. A., & Turan, J. (2014). Responses to and resources for intimate partner violence: Qualitative findings from women, men, and service providers in rural Kenya. *Journal of Interpersonal Violence, 29*(5), 783–805. https://doi.org/10.1177/0886260513505706.

Overstreet, N. M., & Quinn, D. M. (2013). The intimate partner violence stigmatisation model and barriers to help seeking. *Basic and Applied Social Psychology, 35*(1), 109–122. https://doi.org/10.1080/01973533.2012.746599.

Patnaik, E. (2013). Reflexivity: Situating the researcher in qualitative research. *Humanities and Social Sciences, 2*(2), 98–106.

Peek-Asa, C., Wallis, A., Harland, K., Beyer, K., Dickey, P., & Saftlas, A. (2011). Rural disparity in domestic violence prevalence and access to resources. *Journal of Women's Health, 20*(1), 1743–1749. https://doi.org/10.1089/jwh.2011.2891.

Rahman, M. S. (2017). The advantages and disadvantages of using qualitative and quantitative approaches and methods in language "Testing and Assessment" research: A literature review. *Journal of Education and Learning, 6*(1), 102–112. https://doi.org/10.5539/jel.v6n1p102.

Rees, K., Zweigenthal, V., & Joyner, K. (2014). Implementing intimate partner violence care in a rural sub-district of South Africa: A qualitative evaluation. *Global Health Action, 7*(1). https://doi.org/10.3402/gha.v7.24588.

Retief, R., & Green, S. (2015). Some challenges of policing domestic violence. *Social work/ MaatskaplikeWerk, 51*(1), 135–147. https://doi.org/10.15270/51-1-432.

Riddell, T., Ford-Gilboe, M., & Leipert, B. (2009). Strategies used by rural women to stop, avoid, or escape from intimate partner violence. *Health Care for Women International, 30*(1–2), 134–159. https://doi.org/10.1080/07399330802523774.

Sabarwal, S., Santhya, K. G., & Jejeebhoy, S. J. (2014). Women's autonomy and experience of physical violence within marriage in rural India: Evidence from a prospective study. *Journal of Interpersonal Violence, 29*(2), 332–347. https://doi.org/10.1177/0886260513505144.

Saldana, J. (2009). *The Coding manual for Qualitative researcher*. Sage.

Sanawar, S. B., Islam, M. A., Majumder, S., & Misu, F. (2019). Women's empowerment and intimate partner violence in Bangladesh: Investigating the complex relationship. *Journal of Biosocial Science, 51*(2), 188–202. https://doi.org/10.1017/S0021932018000068.

Sandberg, L. (2013). Backward, dumb, and violent hillbillies? Rural geographies and intersectional studies on intimate partner violence. *Journal of Women and Social Work, 28*(4), 350–365. https://doi.org/10.1177/0886109913504153.

Schuler, S., Field, S., & Bernhok, A. (2018). Measuring changes in women's empowerment and its relationship to intimate partner violence. *Development in Practice, 28*(5), 661–672. https://doi.org/10.1080/09614524.2018.1465025.

Sechele, L. (2016). Urban bias, economic resource allocation and national development planning in Botswana, department of sociology. *International Journal of Social Sciences, 4*(1), 44–60.

Shamu, S., Abrahams, N., Zarowsky, C., Shefer, T., & Temmerman, M. (2013). Intimate Partner violence during pregnancy in Zimbabwe: A cross-sectional study of prevalence, predictors, and associations with HIV. *Tropical Medicine & International Health, 18*, 696–711.

Shamu, S., Shamu, P., & Machisa, M. (2018). Factors associated with past year physical and sexual intimate partner violence against women in Zimbabwe: Results from a national cluster-based cross-sectional survey. *Global Health Action, 11*(3), 1625594. https://doi.org/10.1080/16549716.2019.1625594.

Sharma, G. (2017). Pros and cons of different sampling techniques. *International Journal of Applied Research, 3*(7), 749–752.

Shenton, A. K., & Hayter, S. (2004). Strategies for gaining access to organisations and informants in qualitative studies. *Education for Information, 22*, 223–231.

Sherry, E. (2013). The vulnerable researcher: Facing the challenges of sensitive research. *Qualitative Research Journal, 13*(3), 278–288. https://doi.org/10.1108/QRJ-10-2012-0007.

Sikweyiya, Y., & Jewkes, R. (2012). Perceptions and experiences of research participants on gender-based violence community based survey: Implications for ethical guidelines. *PLoSOne, 7*(4), 1–9. https://doi.org/10.1371/journal.pone.0035495.

Stork, E. (2008). Understanding high-stakes decision making: Constructing a model of the decision to seek shelter from intimate partner violence. *Journal of Feminist Family Therapy, 20*(4), 299–327. https://doi.org/10.1080/08952830802382128.

Sundborg, E. M., Saleh-Stattin, N., Wandell, P., & Tornkvist, L. (2012). Nurses' preparedness to care for women exposed to intimate partner violence: A quantitative study in primary health care. *BMC Nursing, 11*, 1–11. https://doi.org/10.1186/1472-6955-11-1.

Teaster, P. B., Roberto, K. A., & Dugar, T. A. (2006). Intimate partner violence of rural aging women. *Family Relations, 55*, 636–648.

World Health Organisation. (2001). *Putting Women First: Ethical and Safety recommendations for Research on Domestic Violence Against Women*. WHO.

Publisher's Note Springer Nature remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.

6.6 CONCLUSION

The findings in this paper revealed the complexity of IPV in rural areas. The influence of social norms cannot be overlooked as women reported that their desire to preserve marriages stops them from seeking help from service providers. Similarly, the geographical location of rural areas which is characterised by limited resource allocation, remoteness and isolation also impede the help seeking process. The attitudes of service providers which jeopardises confidentiality and anonymity has a negative effect on how victims of IPV residing in rural areas perceive formal service provision. Given the barriers that participants in this study highlighted, it is important to also understand service provision in rural areas as this is useful in drafting context specific intervention strategies. The next chapter presents the findings of this study based on objective five which seeks to explore the key informants (service providers) perceptions on IPV in Chimanimani rural district.

CHAPTER 7
FINDINGS AND DISCUSSION: KEY INFORMANTS' PERSPECTIVES

7. 1 INTRODUCTION

Service provision should be contextualized to the different settings considering that people tend to experience different problems depending on their circumstances. Contextualising service provision is critical in ensuring effective interventions that effectively respond to the unique needs of people residing in rural areas. This also applies to IPV interventions hence understanding how service providers perceive and understand IPV is crucial in contextualising service provision. The way service providers in urban areas respond to IPV may be similar but there are differences in the way service providers respond to the abuse in rural areas. As reported in the preceding chapter, the way service providers respond and deal with IPV victims has an effect on the way victims view formal service provision. It can encourage or discourage them from seeking formal service provision. While there has been a focus on the existing support systems and the barriers in the help-seeking process, it is imperative to also understand the perspective of service providers who deal with IPV cases in rural areas. Understanding how service providers perceive, understand and respond to IPV incidences is crucial in investigating the effectiveness and quality of services being rendered to IPV victims residing in rural areas. Thus, in accordance with objective five of this study, the following article explored the perspectives of the key informants (i.e. service providers working in Chimanimani district) in terms of how they understand IPV, their roles and the challenges they face in rendering IPV intervention service to IPV victims in rural areas in Zimbabwe.

7.2 PRESENTATION OF ARTICLE 6

Chadambuka, C., & Warria, A. (Under Review). Understanding intimate partner violence in rural areas: Engaging service providers intervening in Chimanimani (Zimbabwe). *Journal of Progressive Human Services*

Understanding intimate partner violence in rural areas: Engaging service providers intervening in Chimanimani (Zimbabwe)

ABSTRACT

Intimate partner violence (IPV) is a global problem and a threat to the wellbeing of women. Service provision is thus crucial in the minimisation and prevention of IPV occurrence. Although considerable efforts have been made in Zimbabwe in addressing IPV and its consequences, critical gaps still exist concerning the efficacy of service provision in rural areas. Hence, this study sought to explore service providers' perceptions of IPV in Chimanimani rural district in Zimbabwe. A qualitative doctoral study was conducted with 25 IPV female survivors and six service providers. However, this paper specifically reports on the experiences of the service providers in rendering IPV interventions in rural areas. The service providers were recruited using a purposive sampling method. Individual in-depth interviews were conducted, and the data was analysed using thematic analysis. Findings indicate that service providers in rural areas have a general understanding of IPV and regard it as unacceptable social behaviour. Given the influence of social norms in rural areas, service providers tend to resort more to the role of 'advising and mediating' as compared to their professional roles. Other findings point to service delivery constraints that negatively influence IPV intervention. Without a doubt, service provision in rural areas is essential in responding and preventing the occurrence of IPV and how service providers perceive IPV affect the quality of services rendered to IPV victims. More context-specific sensitization and training of service providers will go a long way in ensuring effective and timeous responses to IPV in rural areas.

Keywords: intimate partner violence; interventions; rural areas; service providers; Zimbabwe

INTRODUCTION

Intimate partner violence (IPV) remains a global problem which occurs at an alarmingly high rate. It is a form of gender-based violence (GBV) and is often used interchangeably with domestic violence (DV) to refer to abuse in intimate relationships. IPV is defined as physical, psychological and sexual harm by an intimate partner and it occurs regardless of gender identity and/ or sexual orientation (Groves et al., 2015). However, this study focuses on IPV survivors in previous heterosexual relationships.

Approximately 30% of women aged 15 or older experience lifetime IPV with regional estimates ranging from 16% in East Asia to 66% in central sub Saharan Africa (Devries et al., 2013). Giddens and Sutton (2017) further argue that one in three women experience IPV in their lifetime. The prevalence of IPV, at 36%, is higher in sub Saharan Africa considering the prevailing cultural norms that condone the subjugation of women and male supremacy (McCloskey et al., 2016).

Zimbabwe's rate of IPV is high considering that it is a patriarchal society that condones male domination (Mukanangana et al., 2014). These high rates and the deleterious consequences of it necessitate studies focusing on IPV dynamics and service provision. Although most research has focused on the predictors and consequences of IPV on individuals and children (McCloskey et al., 2016), researchers are increasingly recognising the importance of efficient service delivery in responding and preventing the occurrence of IPV. A major concern in the provision of services to IPV victims is to ensure that women are not re-victimised by service providers but treated sensitively.

Research conducted in the past in Zimbabwe on IPV has focused on the experiences of victims and the challenges they faced in accessing formal support (Fidan & Bui, 2016; Mukanangana et al., 2014; Shamu et al., 2013). Far less research has sought to examine service provision in the context of IPV in rural areas in Zimbabwe. Even less is known about how service providers perceive IPV and the challenges that they face in working within IPV contexts in rural areas. Although service provision is reported to be available in rural areas, not much is known about what it entails, which might subsequently jeopardize service delivery. This paper explores IPV-related service provision towards building a practice skill base and contributing to debates on service provision in rural areas.

The focus of this study is on IPV perpetrated in heterosexual relationships by males against females in rural areas. These women are no longer in those violent relationships. The article will first provide a section on service provision in the context of IPV in general narrowing it to service provision in rural areas. This will be followed by a methodology section which will provide an outline of the methods used in this study. Sections on the presentation of findings and discussion of findings will follow. Lastly, the section on implications on context-specific multicultural practice will be presented.

SERVICE PROVISION AND IPV

IPV has detrimental effects that call for professional intervention. Thus, service provision is crucial in responding and preventing the continual perpetration of IPV. Service provision in the context of IPV entails rendering a wide range of support which include formal support services such as healthcare, legal protection and psychosocial services. However, women are a heterogeneous group and they experience IPV differently based on factors such as locality and availability of services. This makes IPV service provision to be context and situation specific (Colombini et al., 2013). Thus, the role of service providers in IPV interventions varies depending on service providers background training and skills set.

In studying service providers' views on IPV and their role in IPV prevention, Baldry and Pagliaro (2014) noted that service providers can be unsympathetic and judgemental towards victims thus negatively contributing to service user's perceptions of services being offered. Stereotypes and misconceptions are present amongst service providers given that some of them share the same norms and beliefs with the community they serve (Colimbini, et al., 2013). The ecological perspective acknowledges that IPV is a multifaceted and multi-level phenomenon and therefore calls for a multidisciplinary response (Eastman et al., 2007). As such, service provision in an IPV context should not operate on a linear level but ought to involve different service providers with varied but complementary roles.

Globally, service provision operates from a micro to macro level bearing in mind that the perpetuation of IPV is based on converging social variables that operate at different levels to increase women's vulnerability to abuse. Two approaches are identified as effective in dealing and managing IPV, that is, a criminal justice approach and a victim-centred approach (McCloskey et al., 2016). However, it has been argued that, in some instances these approaches are neither transferable nor adaptable to the African context due to the difficulties in translating models and lack of infrastructure and resources to respond effectively (Bosch & Bergen, 2006; McCloskey et al., 2016). For example, the under-resourced shelter system compromises the safety and wellbeing of IPV victims especially those residing in rural areas (Klugman, 2017; McCloskey et al., 2016). It is also largely not viable in rural communities in Africa where families, and not shelters, are mandated with the role of resolving IPV related matters.

Cultural attitudes that condone IPV and frequent mistrust of formal support systems can make intervention challenging (Bosch & Bergen, 2006). In rural Zimbabwe, service provision is crucial considering that social norms are more influential in rural areas as compared to urban areas and this places women at a heightened risk of frequent IPV. When one works in a rural area, there is tendency of becoming familiar with the community and its members and this might also compromise service delivery and the way service providers view and respond to IPV (Chadambuka & Warria, 2019). Given the multiplicity of contextual factors associated with rural areas, the roles of service providers can be compromised if the environment is not conducive enough to facilitate effective time-bound responses. Eastman et al. (2007) reports that service provision in rural areas takes on a holistic and generalist approach with practitioners having to take on multiple roles simultaneously. In rural areas, cultural patriarchal norms are not only at the centre of marriages but also influence service delivery and impede the help-seeking process. Barriers such as prevailing social norms that enforce these patriarchal attitudes and limit male participation tend to render intervention efforts futile (Mashiri, 2013).

INTERSECTIONAL THEORY IN THE CONTEXT OF IPV SERVICE PROVISION

The intersectional theory adopted in this study emerged to make the experiences and vulnerabilities of marginalised women (e.g. women residing in rural areas) more visible (Crenshaw, 1991). Intersectionality explains how various social variables (i.e. gender, ability, geographical locations) interact in shaping the varied experiences of marginalised women. Thus, women with multiple disadvantages encounter challenges that may or may not be adequately dealt with by mainstream IPV services (Kulkami, 2019).

IPV victims in rural areas are at the intersection of multiple disadvantages that make them more susceptible to frequent abuse and make intervention efforts less successful. Considering the complexities associated with rural areas, intersectional feminism challenges service providers to closely align programs to the specific needs and preference of IPV victims within their respective communities (Kulkami, 2019). It highlights the need for a structural analysis of hierarchies created by systems so as to accurately describe the experiences of the marginalised groups (Hill-Collins & Bilge, 2016). This requires consideration of different support systems that are involved in the provision of IPV intervention services and recognition that marginalised women navigate these systems differently based on the intersection of multiple social variables

(Lippy, 2020). We therefore argue that, for an accurate representation of IPV experiences and interventions in rural areas, there is need to acknowledge the missing piece of the puzzle by examining how service providers perceive IPV in rural areas as this informs their response to IPV incidences. This is because the converging social variables such as the geographical location, social class, ability, education and social norms have a bearing on the wellbeing of IPV victims and influences provision of IPV services in rural areas.

METHODOLOGY

This study adopted a qualitative approach due to its flexibility when conducting explorative research on sensitive topics and ability to yield meaningful and useful results (Nowell et al., 2017). Purposive sampling was utilised in the selection of participants as it allows for flexibility to choose participants with rich and detailed information pertaining service provision (Sharma, 2017). The service providers, also referred to as key informants, consisted of two gender officials, two village heads, one police officer, one nurse and one social worker.

The inclusion criteria in selecting key informants were: (i) at least 3 years working experience, (ii) residing in Chimanimani District, (iii) has dealt with cases of IPV in Chimanimani during the 3-year period and (iv) willingness and availability during data collection. The recruitment method involved the first author approaching the service providers individually, sharing the participant information sheet and explaining the purpose of the study. They were given the opportunity to ask any questions pertaining to the study prior to written consent being obtained from them. The time and place for interviews was confirmed verbally and through phone calls. Although one of the gender officials did not work and reside in Chimanimani district, his participation in this study was crucial as he worked for the Ministry of Women Affairs, Community, Small and Medium Enterprise Development which is responsible for the development and implementation of gender policies. Out of the seven key informants who had agreed to be interviewed for the study, one was not included due to Cyclone Idai which affected Chimanimani region. The potential study participant was re-deployed to assist victims of the disaster. Given the complexity of rural areas and the damage caused by the cyclone, telephonic or skype interview with the social worker was not possible.

Chimanimani Rural District is amongst the poorest districts in Zimbabwe, with rugged terrain, under-developed infrastructure and remote households/villages. The population of

Chimanimani consists of Shona speakers. Services are provided based on the ward system with each ward being equipped with basic services such as a clinic and satellite police station. All service providers are integrated and they live in this area – amongst the locals.

Data collection was conducted by the first author over three months i.e. between March and May 2019 in Chimanimani. Face to face in-depth interviews were conducted using the narrative approach and a semi structured interview schedule was used. Considering that the key informants were from different professional backgrounds, each interview schedule had questions related to their profession but similar in terms of their understanding of IPV and related experiences in rural areas. All interviews were recorded with the consent of the service providers and they took place at a place and time of their choice.

In accordance with ethics requirements, permission was obtained from the Zimbabwean Ministry of Women Affairs, Community, Small and Medium Enterprise Development and Chimanimani Rural District Council. Ethics Clearance (No. H18/11/04) was granted by the Human Research Ethics Committee (HREC) (non-medical) at the University of the Witwatersrand. In addition, permission was further sought from the village heads as custodians of social norms and traditional leaders.

Audio-recorded interviews were transferred to the lead author's password-protected computer. The lead author transcribed the interviews. The transcribed interviews were analysed using thematic analysis. This method of data analysis was selected due to its flexibility in the selection of themes and subthemes (Nowell et al., 2017). The steps that were utilised in this study included familiarisation with data, searching for themes and reviewing and naming of themes. Triangulation of analysis was applied to this study and de-identified data was shared with another qualitative analyst for further analysis Saldana (2009) argues that the use of multiple coders in qualitative research is essential in addressing researcher bias. Discrepancies that emerged from the coding process were addressed during regular discussions with the qualitative analyst. The reviews from the qualitative analyst were taken into consideration.

FINDINGS

The findings that will be discussed in this section in detail includes: service providers' understanding and attitudes towards IPV, perceived roles by service providers and challenges in service provision.

Service providers understanding and attitudes towards IPV

IPV is abuse: Service providers understanding of IPV

In this study, all service providers understood IPV as a form of violence against women and men in intimate relationships. Their responses were homogenous as they reported that emotional, physical and financial abuse were the most common forms of IPV in rural areas and that IPV has detrimental effects to the wellbeing of victims especially women. These are highlighted in the extracts below:

IPV is abuse between people in a relationship and in this case its abuse against women. There is emotional abuse which involves verbal abuse. The other one is physical and this is very dangerous and sometimes women are beaten to the point of death……There is the aspect of economic abuse which refers to voluntarily withholding money for basic needs from the woman and leaving her and children to starve. This usually reinforces physical abuse. (Gender Officer-District Level)

There is financial abuse which is common. Most women in this area are going through financial abuse because they do not go to work, they wait for their husbands to bring food. It often leads to beatings especially when a woman asks for money. (Police Officer -Ward Level)

…it involves verbal abuse up to the extent of blaming each other for witchcraft; beatings and being deprived of money to buy food and other basic needs. Verbal abuse and beatings can happen to either the husband or the wife. (Village Head 2)

Very few service providers who were interviewed highlighted sexual abuse as one of the forms of IPV in rural areas. This is a concern as sexual abuse might not be viewed as violence if it happens in the context of a marriage. Consistent with a studies conducted by Ali et al. (2009) and Chireshe (2015) which indicated that sex is regarded as a conjugal right in intimate relationships, reports of sexual violence were not common amongst majority of the key informants interviewed in this study. Sexual abuse is shrouded in the culture of silence due to its sensitive nature and women are discouraged from discussing such sensitive issues with

'outsiders'. This reflects the cultural dimension of IPV which places more emphasis on conjugal rights in intimate relationships and makes sexual abuse acceptable.

Service providers understand IPV as abuse that can be perpetrated on anyone in the context of intimate relationships. While the Zimbabwe Domestic Violence Act does not recognise economic abuse as a criminal offence, key informants mentioned it as one of the major forms of IPV and a precursor to physical abuse. This is due to high poverty levels in rural areas and unemployed women who mainly rely on subsistence farming for survival.

This is unacceptable … but they lie: service providers' attitudes towards IPV perpetration

Key informants in this study highlighted that IPV was an intolerable and unacceptable behaviour and not the best way to resolve conflicts in intimate relationships. In addition, they all acknowledged that IPV was generally resolved by the family in rural areas. See quotes below:

A woman is not supposed to be beaten in intimate relationships. In our culture there are better ways of resolving such conflicts without involving violence or insults. Families are critical in resolving such disputes. We do not encourage wife-beating (Village head 2)

The law does not condone wife-beating. Some men beat women, even pregnant ones, thinking they are reprimanding them. They hurt them and it becomes a criminal offence. This is unacceptable and such people should be punished. (Police-Ward Level)

It is interesting to note the differences in quotes provided by the village head who indicates that disputes are resolved at home versus the police who see it as a criminal offence. Such differing viewpoints could impact service provision in rural settings. However, regardless of the intolerant views towards IPV perpetration in rural areas, some key informants reported that there are women in rural areas who lie about IPV in a bid to leave their poor husbands for 'better' ones

*Although IPV is not tolerated there is need to acknowledge that women in this area lie about IPV in a bid to leave their husbands. Remember we have magweja (*illegal miners*) here … they make quick money and most women here end up dating them. Some of the women go about stealing vegetables in people's fields and gardens and when they come here for treatment, they*

*lie that the husband has abused them. So, we are always alert when women come with such accusations (*Nurse - Ward Level)

Notable in the above quotations is the unacceptable nature of IPV in rural areas. Women in rural areas are perceived as weak and powerless and mostly regarded as victims, but when they are thought to have lied, then their status of possible victimhood shifts. There was predominant perception of IPV as a private issue that is generally resolved within the family which explains why intervention from service providers is often regarded as the 'last resort' in the help seeking process. Contrary to research by Goodman et al. (2009) and Ahmadabadi et al. (2017) on poverty and IPV, the nurse in this study highlighted that women in rural areas use IPV as an exit strategy from their poverty-stricken marriages. Whilst this might be true, the influence of social norms should not be discounted in terms of how service providers may respond to IPV reports in rural areas. Subscribing to social norms that hide IPV can have an impact on how service providers perceive IPV and such assumptions without tangible evidence can heighten women's vulnerability to abuse. Service providers who hold such general stereotypes are likely not to prioritise IPV cases that will be reported to them.

Service providers' role in IPV contexts

Our role is to intervene: Perceived roles of service providers

The key informants shared their roles in the provision of IPV services in rural areas. Although service providers in rural areas have varied roles, these roles are context specific and are informed by the unique needs of the abused women and by the expertise of the service provider. What emerged from this study was that service providers in rural areas are aware of their specific roles in IPV intervention (i.e. medical role and law enforcement role) but bearing in mind the nature of rural areas, they tend to shift from these roles depending on the context and situation.

Our role is to intervene in communities and conscientize them. We go to communities and try to encourage to involve women in positions of authority in development committees. ……we make sure we have awareness campaigns where we teach women and men on the dangers of gender-based violence. The thing is we don't directly deal with the victims but we deal with the community as whole with the help of the village heads (Gender Officer-District level)

At the ward level, although they were aware of their specific roles, they also highlighted their advisory role in guiding IPV victims.

*When they (IPV victims) come we get such reports, together we bring in the perpetrator. But sometimes the women themselves do not want their husbands to be arrested. So we end up counselling them and they go home. Some prefer resolving everything with their aunts and uncles (*Police-Ward level).

Mediation appears to be the pillar of IPV intervention as village heads indicated that women tend to report to them and resort to family mediation. Village heads tend to involve the police only when the abuse becomes life threatening.

If the beating is minor and there are no injuries, I assess to see if it the woman would like to proceed further to the police because reporting to police will mean no money or food for her since the breadwinner will be arrested and in other cases pays a fine. So, I advise them as the village head and I also encourage them to resolve the conflict with the help of family members and ask each other for forgiveness (Village Head 1)

Evident in the above quotations is the varied roles that service providers have which are informed by circumstances as well as their locality. At district and national level, the roles of service providers are more focused on raising awareness in communities and this is done in a collective manner. Macro-level interventions are crucial in ensuring that the awareness campaigns reach a wider audience. At ward level, the roles are more focused on 'mediation and advising' more than the professional roles (e.g. medical role, policing). Given the patriarchal nature of rural areas where the goal is to preserve marriage and maintain male supremacy (Matavire, 2012; Riddell et al., 2009); mediation in rural areas is encouraged and considered as the best solution to marital disputes. As such service providers in rural areas often resort to mediation in IPV situations by 'advising' victims to go back to their families and resolve the conflicts with their partners. This in turn jeopardises women's safety and views regarding service provision in rural areas as this can lead to mistrust in the system that is supposed to help them. Ultimately, IPV victims in rural areas refrain from seeking assistance from service providers.

The Constraints in service delivery

Conflicting Identities (Professional identity vs cultural identity)

All key informants indicated that when rendering IPV services in rural areas there is always identity conflict involved. Services providers in rural areas are professionals and at the same time they are part of the Shona community which adheres to patriarchal norms and values. Key informants reported that sometimes it is challenging for them to penetrate communities as they are always met with challenges that affect both their Shona personal identity and professional identity. Additionally, it also seemed difficult to separate their cultural identity from their professional identity given the domination of social norms condoning the control of women. Ultimately, it becomes difficult to speak against such norms that they partially or wholly subscribe to. To this end, when service providers denounce IPV; it can be easily regarded as a sign of weakness and deviation from long standing patriarchal norms that promote male dominance despite one's training.

You would not want to be labelled as a person who does not adhere to the cultural norms of this community and I don't want people to think that I have deviated from our Shona culture……. So at times when we go to these rural areas we tend to avoid these very important issues because it becomes personal and people don't want them to be discussed or else they will walk away from your campaigns (Gender Officer- District Level)

Another indicated that;

……it is a community expectation that a woman should fulfil the sexual desires of the husband regardless of how they feel. So it is difficult to penetrate such communities that condone abuse of women to that extent. They will look at you and question you about your own beliefs as a man. They take it as if you are disrespecting them and no one takes you seriously let alone attending the campaigns. Sometimes you are forced to avoid some crucial topics like sexual abuse….. (Gender Officer- National Level)

From the above quotations it is evident that service providers working in rural areas have conflicting identities which makes it challenging in intervening in IPV situations. Some service providers in rural areas are permanent residents of the communities they serve and this implies that they are expected to abide by the community norms in addition to their professional ethics. This is consistent to studies conducted by Baldry and Pagliaro (2014) and Riddell et al. (2009)

which showed that public visibility and lack of anonymity tend to hamper service provision as service providers tend to conform to social norms that encourage family mediation and disregard formal intervention. In some instances, the service providers can be related to the perpetrators and this negatively impacts the way they respond to such cases. Bearing in mind the nature of rural areas that promote social cohesion, service providers are likely to resort to mediation and advising in order to preserve their personal relationships. Ultimately, they end up serving their own personal interests at the expense of the wellbeing of IPV victims.

Service providers' frustrations

All key informants reported frustrations when dealing with victims of IPV. It was reported that victims of IPV in rural areas who reported to service providers had the tendency of changing their statements especially where the police are involved. Given the nature of IPV, this could have stemmed from the trauma that the victims were subjected to. This coupled with fear of rejection and feelings of self-worthlessness can interfere with the victims' decision to stop or respond to the abuse. One participant said

These women twist the story when they are with their husbands and we cannot force them to admit that they are abused. It will be my word against hers. Sometimes the women are even forced to deny ever talking to me by the husband and they start lying that they got the bruises when they fell on their way to the fields or the river. Even when you see that the person was injured what can you do because everyone, sometimes even the neighbours refuse to disclose the abuse. You know they can make you a fool so it is very difficult to intervene and assist the victims let alone record IPV cases (Police Officer - Ward Level)

The frustrations of the service providers also emanate from the lack of intervention resources which leaves them helpless as they fail to assist victims in emergency cases especially for those working within the medical field.

We do not have adequate resources and we fail to provide emergency services (e.g. ambulance to ferry victims with serious injuries) to the victims and the community does not have confidence in us. It is difficult to provide services in these circumstances……it is very frustrating because the people in this community do not understand that we do not have adequate resources they end up thinking we do not assist them because we do not want to (Nurse - Ward Level)

Frustrations when dealing with IPV reported cases was common amongst all key informants. The key informants in this study argued that women denied having been abused particularly when in the presence of the perpetrator. Consistent with studies conducted by Githui et al. (2018) the women in this study possibly resorted to changing their statements considering the nature of intervention highlighted by the key informants where perpetrators and victims are questioned in the same room. As Riddell et al. (2009) suggests, this kind of intervention that is frequently employed by service providers in rural areas tends to infuriate the perpetrator and can expose the victim to further abuse. In addition, the fear of possible repercussions (i.e. community and family rejection) can also explain why victims change their statements. Consistent with suggestions by other researchers, perhaps women changed their statements considering that some of them are economically and socially dependent on the perpetrators (Katiti et al.,2016; Vranda et al., 2018).

In addition, the frustrations emanated from lack of intervention resources which made it difficult to intervene in emergency situations. There are always disparities in terms of resource allocation between urban areas and this is manifested in both the quantity of resources and quality of services rendered (Li & Chang, 2008). Similar to findings from studies conducted, key informants reported that rural areas lack crucial resources that are needed in responding to IPV and this hinders efficient service delivery in rural areas (Peek-Asa et al., 2011). The lack of resources also results in delayed responses to emergency IPV cases and this perhaps explains the frustrations and judgemental attitudes showcased by service providers. This also possibly explains why service providers in rural areas tend to encourage family mediation which while providing a timeous response, a temporary and partial intervention to IPV incidences.

Limited male participation in intervention programs

This study looked at perpetration of violence on women by men. Thus, interventions put in place need to ensure male participation in programmes that are aimed at minimising and preventing IPV in rural areas. While IPV intervention in rural areas focuses mainly on the provision of assistance to women victims and survivors of the abuse, key informants in this study highlighted that male participation is equally important. Limited male participation in intervention programmes was singled out as one of the constraints in the prevention of IPV in rural areas. Interestingly one participant highlighted that men in rural areas have assigned

gender-based violence under 'women stuff' hence their lack of interest in intervention programs.

> *Another challenge is little male participation even in gender meetings within several communities….. The other thing: the moment we talk of gender issues men have a tendency to link it to women; they say it is women's stuff. Only women show up for these kinds of things. When we call for a meeting on gender-based violence, they think we are only trying to address issues to do with women; which means male participation currently is limited and poses challenges in terms of intervention. As long as the men don't realise that beating your wife is a problem then we still have a problem.* (Gender officer- District level)

Another participant shared the same sentiments indicating that the absence of men tends to hinder IPV prevention efforts.

Men don't take gender based violence (GBV) campaigns seriously because no man in rural areas will tolerate being told by someone from outside that you must not force your wife to have sex with you….. You will be having a GBV community meeting to raise awareness just in front of the community beerhall but the men will not come; they will be drinking……We need to do more advocacy because our intervention programs are sometimes futile because men are not part of them. (Gender Officer- National Level)

Limited male participation in intervention programs in rural areas was identified as one the constraints in service provision within IPV contexts in rural areas. IPV is rooted in patriarchal systems that are created and maintained by men who are socialised into violence and aggressive behaviours often learned from their families and peers hence they rarely recognise IPV as abuse (Antai, 2011; Napoli et al., 2019; Tran et al., 2016). Furthermore, the key informants in this study highlighted that men in rural areas regard meetings on IPV as 'women's meetings' considering that traditional rural masculinity tends to assign hard labour and traditional court meetings as men's duties. Contrary to this, participation of men in IPV programs in rural areas is essential as research has indicated that they are at a higher risk of substance abuse, and some of them might have been exposed to IPV in their childhood hence their abusive behaviour in intimate relationships (Condino et al., 2016; Hossain et al., 2014). For service providers, this is one of the major setbacks as limited male participation will ultimately result in 'half-baked' intervention programmes that fail to address the roots of IPV perpetration. This can possibly explain the high level of abuse regardless of intervention efforts by the government and civil society.

LIMITATIONS

There are limitations associated with this study. Dowrkin (2012) argues that the sample size and the methodology used in a qualitative study determines the quality of data obtained, this study consisted of a small sample size of six key informants drawn from one district in rural Zimbabwe. While the data obtained is important in understanding the perceptions of service providers in rural areas, it is not exhaustive of all service providers that are involved in IPV intervention in rural areas in Zimbabwe. As such the responses cannot be representative of the perceptions of service providers working in IPV contexts in rural Zimbabwe as IPV intervention is context and situation specific

IMPLICATIONS FOR SERVICE PROVISION IN RURAL AREAS

The findings from this study highlighted the uniqueness of IPV interventions in rural areas and this is in line with intersectional feminism which acknowledges the need for tailor-made intervention frameworks that respond to the specific needs of marginalised women. Likewise, urban models of intervention cannot be adapted to rural areas due to the uniqueness of rurality and further work is required in terms of cross cultural multi-disciplinary practice in IPV contexts (Neill & Hammatt, 2015). Our data showed that there are still critical gaps that exist in the way service providers understand and perceive IPV and this ultimately influences the way they respond to IPV cases. For example, sexual abuse is not commonly identified and mentioned as abuse despite its dire effects on the wellbeing of women. These gaps in service provision shows the need for more cultural-sensitive training on IPV. Such training should encompass context-specific and cultural training on IPV and its different forms and manifestations and how to screen and respond to different cases within cultural community settings. Colombini et al (2013) suggests that such training would entail how to interview victims in a sensitive manner, validate their IPV reports, being empathetic and maintaining a strong referral network essential to effective service provision. Sensitisation and awareness workshops with service providers will provide a clear picture on their roles and responsibilities and how they can respond to IPV in the rural communities that they serve. This entails training them on how they can make use of existing informal support systems in strengthening IPV interventions considering that they are readily available for victims (Chadambuka & Warria, 2020).

In this study, the key informants reported that victims of IPV tend to change their statements to hide and deny the abuse and this is due to fear of further abuse and loss of financial support. Service providers in rural areas can create platforms where women can discuss IPV related issues without fear. Research has revealed that women tend to disclose IPV more when they are in their own community groups (e.g. informal self-help groups) (Chadambuka & Warria, 2020; Vranda et al., 2018). These groups can be used as platforms and pathways in sensitising women on the importance of seeking formal assistance which is crucial for their wellbeing. Engaging with them in such groups is not intimidating and encourages women to open up about their varied experiences of IPV. As Colombini et al. (2013) suggests, a well-resourced and supportive environment in terms of resource allocation undoubtedly influences service providers' ability to respond to IPV. Thus, there is a need for the government to ensure that there is adequate resource allocation in rural service agencies. This facilitates coordinated response between service agencies (e.g. law enforcement, healthcare and social service) which is essential in reducing the constraints in service provision.

Findings from this study highlighted the need to include men in prevention efforts. As suggested by Hossain et al. (2014) and Tran et al. (2016), service providers should strive to include men in rural areas in intervention programs regardless of the patriarchal beliefs that they subscribe to. Given the complexity of working in cultural rural settings, there should be a systematic way of intervening which may entail dealing with individual genders before engaging in collective intervention (i.e. men and women). Firstly, this can be done through engaging with village heads (these are mostly men) in awareness campaigns, and platforms such as traditional courts can be utilised as forums for men with the village heads also leading these dialogues. Secondly, service providers can take these dialogues to popular places that men meet (e.g. community beer halls). There is a possibility that when men engage with other men in the absence of their wives, they tend to open up and actively participate. Furthermore, the inclusion of young boys in such programmes is crucial in shifting the attitudes and beliefs that condone IPV. Thus, it is recommended that further studies be conducted on perpetrators of IPV and the role that men can play in preventing IPV against women in rural areas.

CONCLUSION

This paper sought to explore the perceptions of services providers with regards to IPV in rural areas. Findings from the study revealed service providers' understanding of IPV and their

attitudes towards it. The findings also showed how service providers understand their roles and the constraints in IPV intervention in rural areas. Based on the data, the perceptions of service providers regarding IPV are largely premised on the social norms and this influences their responses to IPV situations in the communities that they serve. It is therefore vital for service providers to ensure that IPV intervention programs are cultural and context specific bearing in mind the influence of social norms on everyday life in the communities they serve.

REFERENCES

Ahmadabadi, Z., Najman, J.M., Williamns, G.M., & Clavarino, A.M. (2017). Income, gender, and forms of intimate partner violence. *Journal of Interpersonal Violence,* 1-26. DOI: 10.1177/0886260517719541

Ali, F.A., Israr, S.M., Ali, B.S., & Janjua, N.Z. (2009). Association of various reproductive rights, domestic violence and marital rape with depression among Pakistani women. *BMC Psychiatry*, *9*(77). doi:10.1186/1471-244X-9-77

Antai D. (2011). Traumatic physical health consequences of intimate partner violence against women: what is the role of community-level factors? *BMC Women's Health*, 11(56), 1-13. http://www.biomedcentral.com/1472-6874/11/56

Baldry, A.C., & Pagliaro, S.C. (2014). Helping victims of intimate partner violence: The influence of group norms among lay people and the police. *Psychology of Violence, 4*(3), 334-347. DOI: 10.1037/a0034844

Bosch, K. & Bergen, M.B. (2006). The influence of supportive and Non-supportive persons in helping rural women in abusive partner relationships Become free from abuse. *Journal of Family Violence*, *21*, 311-320. DOI 10.1007/s10896-006-9027-1

Chadambuka, C. & Warria, W. (2019). Hurt or help? Understanding intimate partner violence in the context of social norms as practised in rural areas. *Social Work/ Maatskaplike Werk, 55*(3), 301-310. http://dx.doi.org/10.15270/52-2-741

Chadambuka, C., & Warria, A. (2020). Examining support systems available for victims of intimate partner violence in rural areas in Zimbabwe. *Practice: Social Work in Action*, 1-19. DOI: 10.1080/09503153.2020.1750579.

Chireshe, E. (2015). Christian women's experiences of domestic violence in Zimbabwe. *Journal of Women and Social Work. 30*(3), 380-394. https://dx.doi.org/10.1186%2Fs12905-017-0441-8

Colombini, M., Mayhew, S., Ali, S.H., Shuib, R., & Watts, C. (2013). "I feel it is not enough. .." Health providers' perspectives on services for victims of intimate partner violence in Malaysia. *BMC Health Services Research*, *13*(65), 1-11.

Condino, V., Tanzilli, A., Speranza, A.M., & Lingiardi, V. (2016). Therapeutic interventions in intimate partner violence: an overview. *Research in Psychotherapy: Psychopathology, Process and Outcome, 19*(2), 79-88. doi: 10.4081/ripppo.2016.241

Crenshaw, K. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford Law Review*, *43*, 1241-1299.

Devries, K.M., Mak, J.Y., Garcia-Moreno, C., Petzold, M., Child, J.C., Falder, G., Lim, S., Bacchus, L.J., Engell, R.E., Rosenfeld, L., Pallitto, C., Vos, T., Abrahams, N., & Watts, C.H. (2013). Global health. The global prevalence of intimate partner violence against women. *Science* 3*40*(6140), 1527–1528.

Dworkin, S.L. (2012). Sample size policy for qualitative studies using in-depth interview. *Archives of Sexual Behaviour, 41,* 1319-1320. DOI 10.1007/s10508-012-0016-6

Eastman, B.J., Bunch, S.G., Williams, H.A., & Carawan, L.W. (2007). Exploring the perceptions of domestic violence service providers in rural localities. *Violence Against Women, 13*(7), 700-716. 10.1177/1077801207302047

Fidan, A. & Bui, H.N. (2016). Intimate partner violence against women in Zimbabwe. *Violence against women, 22*(9), 1075-1096. https://doi.org/10.1177%2F1077801215617551

Giddens, A & Sutton P.W. (2017). *Sociology (8th ed).* Cambridge: Polity press

Githui, S., Chege, M., Wagoro, M.C.A., & Mwaura, J. (2018). Nurse's perception on non-disclosure of intimate partner violence by pregnant women: A cross-sectional Study. *International Journal of Contemporary Research & Review, 9*(1), 20198-20203. http://dx.doi.org/10.15520/ijcrr/2018/9/01/403

Goodman, L.A., Smyth, K.F., Borges, A.M., & Singer, R. (2009). When crises collide: How intimate partner and poverty intersect to shape women's mental health and coping? *Trauma, Violence & Abuse. 10*(4), 306-329. DOI: 10.1177/1524838009339754

Groves, A.K., Moodley, D., McNaughton-Reyes, L., Martin, S.L., Foshee, V., & Maman, S. (2015). Prevalence of intimate partner violence among South African women during pregnancy and postpartum period. *Maternal and Child Health Journal 19*(3), 487-495. https://dx.doi.org/10.1007%2Fs10995-014-1528-6

Hill-Collin, P. & Bilge, S. (2016). *Intersectionality*. Malden: Polity Press.

Hossain, M., Zimmerman, C., Kiss, L., Abramsky, T., Kone, D., Bakayoko-Topolska, M., Annan, J., Lehmann, H., & Watts, C. (2014). Working with men to prevent intimate

partner violence in a conflict-affected setting: a pilot cluster randomized controlled trial in rural Côte d'Ivoire. *BMC Public Health, 14*(339), 1-13.

Katiti, V., Sigalla, G.N., Rogathi, J., Manongi, R., & Mushi, D. (2016). Factors influencing disclosure among women experiencing intimate partner violence during pregnancy in Moshi Municipality, Tanzania. *BMC Public Health, 16*(715), 1-9. DOI 10.1186/s12889-016-3345-x

Klugman, J. (2017). *Gender based violence and the law. World Development Report Background paper*. Washington: World Bank. http://hdl.handle.net/10986/26198

Kulkami, S. (2019). Intersectional trauma-informed intimate partner violence (IPV) services: narrowing the gap between IPV service delivery and survivor needs. *Journal of Family Violence, 35*, 55-64. https://doi.org/10.1007/s10896-018-0001-5

Li, H., & Chang, G.H. (2008) Disparity in health resource allocation between rural and urban areas in China: Is it getting worse? *Chinese Economy, 41*(6), 45-55. https://doi.org/10.2753/CES1097-1475410602

Lippy, C., Jumarali, S.N., Nnawulezi. N.A., Williams, E.D., & Burk, C (2020). The impact of mandatory reporting laws on survivors of intimate partner violence: Intersectionality, help-seeking and the need for change. *Journal of Family Violence, 35*, 255-267. https://doi.org/10.1007/s10896-019-00103-w

Mashiri, L. (2013). Conceptualisation of gender-based violence in Zimbabwe. *International Journal of Humanities and Social Sciences*, 3(15), 94-103.

Matavire, M. (2012). Interrogating the Zimbabwean traditional jurisprudence and the position of women in conflict resolution. A case of Shona tribes in Muzarabani district. *International Journal of humanities and social sciences, 2*(3), 218-223. http://www.ijhssnet.com/

McCloskey, L.A., Boonzaier, F., Steinbrenner, S.Y, & Hunter, T. (2016). Determinants of IPV in sub Saharan Africa: A review of prevention and intervention programs. *Partner Abuse, 7*(3), 277-315. http://dx.doi.org/10.1891/1946-6560.7.3.277

Mukanangana, F., Moyo, S., Zvoushe, A. & Rusinga, O. (2014). Gender based violence and its effects on women's reproductive health: The case of Hatcliffe, Harare, Zimbabwe. *African Journal of reproductive health, 18*(1), 110-122.

Napoli, I.D., Procentese, F., Carnevale, S., Esposito, C., & Arcidiacono, C. (2019). Ending IPV and locating men at stake: An ecological approach. *International Journal of Environmental Research and Public Health, 16*(1652), 1-18. doi:10.3390/ijerph16091652

Neill, K.S., & Hammatt, J. (2015), Beyond urban places: Responding to intimate partner violence in rural and remote areas. *Journal of Forensic Nursing,11*(2), 93-100.

Nowell, L.S., Norris, J.M., White, D.E., & Moules, N.J (2017). Thematic analysis: Striving to meet trustworthiness criteria. *International Journal of Qualitative Methods*, *16*, 1-13. DOI: 10.1177/1609406917733847.

Peek-Asa, C., Wallis, A., Harland, K., Beyer, K., Dickey, P., & Saftlas, A. (2011). Rural disparity in domestic violence prevalence and access to resources. *Journal of Women's Health*, *20(*1), 1743-1749. DOI: 10.1089/jwh.2011.2891

Riddell, T., Ford-Gilboe, M., & Leipert, B. (2009). Strategies used by rural women to stop, avoid, or escape from intimate partner violence. *Health Care for Women International*, *30*(1-2), 134-159. https://doi.org/10.1080/07399330802523774

Saldana, J. (2009). *The coding manual for qualitative researchers*. London: Sage.

Shamu, S., Abrahams, N., Zarowsky, C., Shefer, T. & Temmerman, M. (2013). Intimate Partner violence during pregnancy in Zimbabwe: A cross-sectional study of prevalence, predictors, and associations with HIV. *Tropical Medicine & International Health, 18*, 696–711.

Sharma, G. (2017). Pros and cons of different sampling techniques. *International Journal of Applied Research, 3*(7), 749-752.

Tran, T.D., Nguyen, H., & Fisher, J. (2016). Attitudes towards intimate partner violence against women among women and men in 39 low- and middle-income countries. *PLoS ONE 11*(11). doi: 10.1371/journal.pone.0167438

Vranda, M, N., Kumar, C.N., Muralidhar, D., Janardhana, N., & Sivakuma, P.T. (2018). Barriers to disclosure of intimate partner violence among female patients availing services at tertiary care psychiatric hospitals: A qualitative study. *Journal of Neurosciences in rural practice, 9*(3), 326-330. DOI: 10.4103/jnrp.jnrp_14_18

7.3 CONCLUSION

Evident from the findings presented in the above article is the complexity of service provision in rural areas. Service providers understand IPV as a social behaviour that has a negative impact on the wellbeing of women. Challenges in service provision were also reported. The role of social norms in influencing the way service providers perceive IPV and respond to it cannot be ignored. Given that the service providers also subscribed to patriarchy and social norms surrounding marriages, the way they responded to IPV incidences is also influenced by societal norms that they subscribe to. This tends to have negative effects on service delivery and ultimately discourages IPV victims from seeking formal assistance. Thus, it is important that service providers strike a balance between the social norms they adhere to and the professional ethics that they subscribe to, to ensure effective service delivery to IPV victims. Recognising the views and perspectives of service providers in rural areas is essential in improving the quality of services rendered through the realisation of constraints that exist in the intervention process.

CHAPTER 8
FINDINGS AND DISCUSSION: PRACTICE GUIDELINES

8.1 INTRODUCTION

The preceding chapters have extensively discussed IPV in the context of social norms in rural areas. They unpacked the role of culture in IPV experiences of women in rural areas, presented the coping strategies that IPV victims in rural areas adopt in dealing with IPV, presented the support systems available for IPV victims and the barriers they face in accessing them and also explore the perceptions of service provision in IPV contexts in rural area. This is crucial in understanding IPV in rural areas. Evident in the articles presented is the role that social norms play in the way women in rural experience and respond to IPV. Moreover, the influence of social norms trickles into service provision and (in)directly affects how service providers respond to IPV. Understanding these dynamics of IPV in rural areas is critical, though not sufficient in its prevention and minimisation. The intersection of the geographical location of rural areas with social norms makes social work intervention in rural areas difficult (Riddell et al., 2009; Sandberg, 2013). Thus, it is important to develop practice guidelines that are unique to rural areas in order to ensure more effective intervention. These culture-informed practice guidelines are crucial in guiding social workers to render services to IPV victims in rural areas in a manner that responds to their varied and unique experiences. In line with objective six of this study, the following article presents the culture-informed practice guidelines for social workers working in IPV contexts in rural areas. These guidelines were developed based on the findings of the first five objectives of this study.

8.2 PRESENTATION OF ARTICLE 7

Chadambuka, C., & Warria, A. (Submitted). Intimate partner violence in rural areas: Proposed cultural-relevant practice guidelines for social workers. *Journal of Social Development in Africa.*

Intimate partner violence in rural areas: Proposed cultural-relevant practice guidelines for social workers

Cyndirela Chadambuka	Doctoral candidate, Social Work, University of the Witwatersrand ORCiD id: 0000-0002-1300-8760
Ajwang' Warria	Senior lecturer, Social Work, University of the Witwatersrand ORCiD id: 0000-0002-4658-7324

ABSTRACT

Violence against women in rural areas and its consequences is of great concern. Limited studies have focused on healing and recovery processes of IPV victims and survivors in these rural settings. The purpose of this paper, therefore, was to explore IPV narratives of victims of IPV. The data revealed important findings that were converted to practice guidelines. These proposed practice guidelines for social workers as core service providers are presented to assist in service delivery in rural areas.

KEYWORDS: Intimate Partner Violence; Culturally-Relevant Intervention; Practice Guidelines; Rural Areas; Social Work

INTRODUCTION

Globally, one in three women is a victim or survivor of gender-based violence (GBV) (World Health Organisation (WHO), 2013). Intimate partner violence (IPV), as a form of GBV, is a public health concern (Sinko & Saint Arnault, 2020) and a violation of human rights (WHO, 2013). IPV can be stigmatizing (Maticka-Tyndale, Barnett & Trocaire, 2020; McCleary-Sills, Namy, Nyoni, Rweyemamu, Salvatory & Steven, 2015; Murray, Crowe & Overstreet, 2015; Weaver, Elrod & Kelton, 2020), it is an interpersonal violation, and it has elements that confer risk for body shame (Weaver et al., 2020).

Research reveals that one in three women has gone through experiences of IPV in their lifetime (Giddens & Sutton, 2017; Klugman, 2017). Sub Saharan Africa has also been singled out as one of the regions with the highest IPV levels (McCloskey, Boonzaier, Steinbrenner & Hunter, 2016). These high rates signify the pervasive nature of IPV and its detrimental effects on women. This indicates the need for effective social work intervention in minimising and preventing IPV (Hageman & St. George, 2018).

There are many root causes and risk factors associated with IPV (Gilroy, Nava & McFarlane, 2020). IPV is a major social issue resulting in physical injury, psychological and emotional harm, spiritual wounds, occupational incapacity and sometimes even death. IPV is experienced by all genders, although women are mostly affected (Sinko & Saint Arnault, 2020). The consequences of IPV are well researched, but many women decide not to disclose or get assistance for abusive experiences for various reasons (Saint Arnault & O'Halloran, 2016). Internalized and cultural barriers can be the cause of amplified burden subsequently constraining both assistance-seeking, healing and recovery process (Kim & Hogge, 2015; Liang, Goodman, Tummala-Narra & Weintraub, 2005; Mannell, Jackson & Umutoni, 2015; Sinko & Saint Arnault, 2020). Many qualitative studies have focused on victims and survivors' lived experiences (Odero, Hatcher, Bryant, Onono, Romito, Bukusi & Turan, 2014) with few studies (such as Sinko & Saint Arnault, 2020) focusing on healing attributes from the perspective of victims and survivors. According to Sinko and Saint Arnault (2020:1618), "interventions to promote trauma recovery have focused primarily on adapting cognitions, improving coping styles and facilitating social support."

There has been considerable coverage of IPV in different rural contexts and how it affects the wellbeing of women (Bosch & Bergen, 2006; Conroy, 2014; Riddell, Ford-Gilboe & Leipert, 2009; Sandberg, 2013). In the Zimbabwean context, few studies conducted on IPV have focused on urban areas (Chireshe, 2015; Fidan & Bui, 2016; Mukanangana, Moyo, Zvoushe & Rusinga, 2014; Shamu, Abrahams, Zarowsky, Shefer & Temmerman, 2013). Based on the literature reviewed, there is no study carried out specifically on IPV against women in rural areas in Zimbabwe despite its grave consequences on their wellbeing. More so, there is limited literature pertaining to effective social work intervention against IPV in rural areas in Zimbabwe. This is a huge setback considering that in Zimbabwe, majority of the women reside in rural areas and are prone to severe IPV (Zimbabwe Demographic Health Survey, 2015). Green and Nieman (2003) argue that when there is no evidence of effective and meaningful intervention by social workers, this leads to mistrust and frustration amongst IPV victims and survivors. This lack of trust and frustration creates pathways for further privatisation of IPV which ultimately reinforces underreporting.

The doctoral study from which this paper emanates sought to explore the IPV experiences of women living in a rural area in Zimbabwe with the aim of developing culture-informed practice guidelines for social workers working within IPV contexts in rural areas. The aim of this paper was to explore victims' perspectives of their IPV experiences and their journey after leaving the abusive relationship. The analysis of the data collected identified systemic factors that influenced help-seeking and healing. Understanding these narratives from the victims' perspectives is crucial in ensuring interventions are tailored to victims' cultural orientation as well as their healing needs, goals and desires. New and practising social workers working in rural areas can potentially face some complex ethical dilemmas when dealing with IPV. To this end, it is crucial to have practice guidelines that will ensure that their practice is not only culturally acceptable but also within the ethical parameters of social work practice. It is hoped that these culture-informed practice guidelines will provide pathways for effective social work intervention programs aimed at ameliorating IPV in rural areas.

OVERVIEW OF IPV AND INTERSECTIONAL FEMINIST APPROACH

Research on IPV is increasing (Thomas, 2020) and it cuts across disciplines, cultures and genders in understanding and providing better explanations on this phenomenon. IPV is complex, it has been in existence for long and has a negative generational impact. IPV impacts both men and women and recent studies include IPV perpetration in LGBTQ+ relationships. That said, many studies report women and girls to be disproportionately impacted by violence in comparison to boys and men (Thomas, 2020). However, sustainable interventions should target all genders and they also require the commitment of all genders.

The political and social context of IPV perpetration and recovery is crucial (Sinko & Saint Arnault, 2020). Violence in the family, the terminologies used and the legislative frameworks that have been applied have changed, expanded and others emerged to include new voices being affected. Some of these terminologies used in different settings include: domestic violence, home-based abuse, domestic abuse, intimate genocide, domestic terrorism, interpersonal violence, IPV and gender-based violence. Equally diverse and also evolving are theories explaining IPV.

According to Maticka-Tyndale (2020:1190), “the normalisation of violence as an acceptable correction for role failures or violations affects the women’s ability to recognize and define the violence in their lives as a ‘problem.’ Instead, it is their failure that is framed as problematic.” This is a cause for concern and a key aspect that can be tapped into when developing or implementing interventions.

Weaver et al. (2020) report that Black women are disproportionately affected and experience more severe IPV than women of other races. This has been hypothesized to include sociocultural factors, poverty, loss of traditional lifestyles and structural racism playing key roles (Tutty, Radtke, Thurston, Nixon, Ursel, Ateah & Hampton, 2020; Weaver et al., 2020). Furthermore, lack of resources in Black and rural communities influence IPV perpetration (Chadambuka, 2020; Chadambuka & Warria, 2020). Tutty et al. (2020) further reports that higher IPV levels for indigenous women are found in contexts of women being victims of many [other] kinds of violence.

In research related to Indigenous Peoples in the United States (US), the Ecosystemic Framework of Historical Oppression, Resilience and Transcendence was developed by Burnette and Figley (2017). It speaks to the decoloniality debate and “considers both oppressive historical conditions, such as colonization, and those of the present, such as discrimination, in explaining the current problem of IPV” (Tutty et al., 2020:1577). This framework has similarities to the ecological approach - with the identification of risk and safeguarding factors as embedded in the different systems.

For this paper, an intersectional feminist framework was used to analyse data collected and the guidelines that were subsequently developed. The feminist theoretical framework incorporates theory and social activism in understanding IPV (Thomas, 2020:1793). The contribution of Black feminist scholars on intersectionality lies in illustrating how “multiple levels of domination, oppression, sexism, racism, and homophobia have defined Black and Brown bodies as deviant, inherently violent, hyper-sexual, and alien, which has been deeply embedded in our history and throughout our society’s power structures” (Thomas, 2020: 1793).

GENDER-RELATED SOCIAL NORMS AND IPV

Gender norms are unspoken rules and beliefs that are shared, and which denote which behaviours are acceptable or not within social group settings (Cislaghi & Heise, 2019). Although some of these beliefs may not be aligned to reality, many people stand by and practice them as there are positive sanctions. In addition, community members embrace these norms in order to avoid being ridiculed, stigmatized or embarrassed (Chadambuka & Warria, 2020).

How violence and culture intersect is complex and makes it worth exploring from different perspectives. In many societies, even without a strong evidence-base, anecdotal evidence shows that there are indications of social and cultural acceptance of abuse, code(s) of silence, exploitation and violence. These factors have existed for a long time and are on an upward trend. Reason for this is because they have further been glorified, sexualized in entertainment spheres and the media and passed on from generation to generation (Thomas, 2020).

It should be noted that not all gender-related social norms are harmful. However, many social norms help to maintain the unequal gender system (Umubyeyi, Persson, Mogren & Krantz, 2016) and are further reinforced across social, religious, educational and occupational institutions. This happens both in homes (considered to be private spaces and in maintaining the cultural norm of privacy) and in public spaces. Enactment of gender norms in everyday situations, interactions, actions and settings, legitimizes, sustains and reproduces inequalities.

Norms which are gender-related and oppressive contribute to IPV (Jewkes, Flood & Lang, 2015). These oppressive gender norms "reflect and reproduce men's and women's (often unequal) access to resources and freedoms, thus affecting women's and men's voices, agency, and power" (Manji, Heise & Cislaghi, 2020:2064). Multicultural and transnational feminist analysis offer wide-ranging basis from which to assess how issues like race, class and gender intersect for women living in rural areas (Thomas, 2020). This perspective often includes complexities based on the ethnic group's cultural patriarchy, physical and social invisibility and politics. For example, silence when IPV is perpetrated is viewed as a way of shielding oneself, preserving kinship honour and conserving culture, norms and traditions. Thomas' (2020: 1803) study, with Cape Verdean women, interestingly reports that "being silent was not

only a protection against more and excessive violence, but also a method of resistance and power that worked by not giving in to the abuser's desire for control or satisfaction."

The systems perspective can best be used to support the nexus between gender and IPV that lies in patriarchal systems -with gendered power inequalities operating at both relationship/individual, meso and macro/societal levels. These inequalities are evident in the societal ideals linked to masculinity, celebration of male strength, justified male control over actions of females and men's using violence to chastise women when they transgress norms (Manji et al., 2020; Warria, 2017). Internalization of IPV norms decreases help-seeking behaviours while being older, separated, in employment increases chances of seeking assistance. The proposed guidelines that are developed contribute to the literature on social work practice with women victims and survivors of IPV in rural areas and are cognisant of social norms as part of intersectionality.

SOCIAL WORK AND GENDER

Gender is an important aspect of social work practice. Gender features significantly in everyday social work practice but it is an aspect that is "seen-but-unnoticed" (Hicks, 2015). Gender, care and justice are three intertwined aspects that can be applied seamlessly in social work practice. Yet, "gendered psychosocial and physical health perspectives that focus on socio-cultural and structural issues … seem absent from social work research and practice" (Warria, 2017:3). According to Scourfield (2006), and in line with the focus of this paper, social workers must always consider localisation of gender as there are variations in localised gender practices e.g., the role of the male *fisi* in sexual cleansing in Malawi (Warria, 2018) and the maintenance of gender roles, norms, expectations and inequalities (Jewkes et al., 2015; Manji et al., 2020; Thomas, 2020). This had a great influence on how social work tends to be practiced since social workers often tend to construct, assess and intervene with their clients according to localised gendered images. However, Scourfield (2006) notes that these images can be stereotypical, but also reflect dominant local gendered practices.

Social workers as part of the system can be influential in assisting to sustain, produce and reproduce gender inequalities. However, Kiboro, Gakuru, Misaro and Mwangi (2014) indicate that social workers are indeed in powerful positions where they can either minimize or

maximize sexual and gender inequalities. This calls for social workers to be more familiar with the unique gender-based violence and subsequent psychosocial needs of a wide range of genders – including LGBTIQ+ population. Thus, a gender-sensitive social work practice is recommended when conducting assessments, designing programming efforts and when implementing interventions.

The IASC Intervention Pyramid for mental health and psychosocial support in emergencies can be contextualized and used in under-privileged rural settings or in the many communities where social workers practice. In the first layer, service delivery is aimed at meeting the victim's basic needs and addressing situational and cultural IPV protection threat and with the upper top-most later looking at specialized services.

PRACTICE GUIDELINES IN SOCIAL WORK

Thomas (1984:2) stresses that interventions "should be part of a helping strategy in which other components help shape the interventive action and have an influence on the outcomes achieved." Warria (2016:88) further supported this assertion by noting that "the development of guidelines and their proper implementation help to ensure that the client will receive the most efficient intervention possible." Practice guidelines have been advocated for in several social work studies in South Africa and beyond. For example, Warria and Chikadzi (2019) developed basic guidelines for spiritual counselling in trafficking cases. Years earlier, Malesa (2018) proposed directives for social work intervention in a study on sexual and reproductive rights in rural areas, Carter and van Breda (2016) designed a contextually appropriate protocol for social workers when assessing prospective foster parents and Warria (2016) proposed and developed guidelines for social workers working with interpreters.

Despite several studies noting that guideline development and management does not support positive client outcomes, in certain instances it has been reported to ease errors and challenges encountered. Carefully crafted and flexibly implemented social and supportive responses empower victims and influence the healing process (Sinko & Saint Arnault, 2020). Context specific interventions and practice guidelines ensure sustainability (Carter & van Breda, 2016; Swart, 2012)

METHODOLOGY

The methodology for this study has been reported in previous papers (Chadambuka & Warria, 2020; Chadambuka, 2020). This study used a qualitative research approach due to its flexibility in eliciting rich information from participants (Nowell, Norris, White & Moules, 2017). Participants were selected using purposive sampling. The sample consisted of 25 women who had experienced IPV in their former intimate relationships and six service providers as key informants drawn from Chimanimani Rural District in Zimbabwe. A semi-structured interview schedule was used to guide the interview. Data was collected by the lead author using in-depth interviews. The interviews were audio-recorded with the consent of the participants. Data were analysed using thematic analysis and in conjunction with previous literature reviewed.

This paper applied the Rothman and Thomas (1994) Design and Development (D&D) model in developing the culture-informed practice guidelines. Bailey-Dempsey and Reid (1996) argue that the D&D model is useful as it provides a direct link between research and improvements of intervention services. The D&D model has six phases, however, only phase three namely the design phase was applied. According to Rothman and Thomas (1994), the design objective is crucial in this phase as it determines the conditions that guidelines have to satisfy. In this study, the design objective was to develop culture-informed practice guidelines for social workers working in IPV rural contexts. In simpler terms, the design requirements indicate what the culture-informed practice guidelines will do.

Specifying the procedural elements in this phase involves conversion and design process. These processes are information-based and creativity is essential for the successful development of the practice guidelines. Fraser and Galinsky (2010) argue that the procedure of designing an intervention requires appraising and blending existing literature. Rothman and Thomas (1994) further argue that this entails the provision of evidence that shows that sufficient detail is provided in the development of the practice guidelines so as to enable other researchers to replicate the design of the intervention. Thus, the information gathered in the study through qualitative interviews and literature reviews was analysed and transformed into design concepts. Both authors were actively involved in the design process. In accordance with the overall aim of the study, the design requirements in this paper focused on building the capacity of social workers and other professionals working within IPV contexts in rural areas.

The areas to be addressed in the guidelines with no particular order are sustainable livelihood interventions, psychosocial interventions, referrals, participation and empowerment, healthcare, police and legal interventions, case management, and care and support for professionals providing assistance to IPV victims in rural areas.

GUIDELINE DEVELOPMENT, CULTURALLY-RELEVANT AND INTERSECTIONAL APPROACHES AND IPV PROGRAMMING

The development of practice guidelines as part of this study is a move towards ensuring that IPV victims in rural areas get access to good social work service. This design process was cognizant of the diverse and intersecting forms of structural subjugation, bias and disparities that women victims of IPV experience in rural settings. Application of the intersectional feminist lens meant findings ways of engaging community members along the intervention continuum in determining guidelines that address the intersecting forms of structural subjugation, which block access to IPV services and towards meaningful, non-violent, ethnic-sensitive participation. Although men and boys also experience IPV, the proposed prevention and response guidelines are women-centred.

The proposed guidelines are suggestions towards good practice strategies and they could improve practice in rural areas with victims or survivors of IPV, however, they should not "replace the need for sound professional assessment, evaluation and decision making that must be done on a case-to-case basis" (Richey & Roffman, 1999:314). The proposed guideline development was influenced by literature reviewed as well as findings emanating from a larger doctoral study by the first author. The proposed guidelines are recommended largely for social work practice with IPV victims especially in rural areas, but other members of a multidisciplinary team would find them useful as well. In consideration of the latter, specific aspects related to the health and justice system have been included. Contextualization of these guidelines would ensure effective implementation and efforts were made to ensure this. However, despite thorough engagement with this process, implementation might still require flexibility and/or further adaptation and coordination with other partners and stakeholders.

The following guiding principles and approaches underpinned the recommended guidelines: victim/survivor-centred approach (based on safety, confidentiality, respect and non-

discrimination), rights- and community-based and *do no harm* approaches and partnership (incorporating transparency, equality and being results-oriented). These guiding principles and approaches are linked to social work principles and the notion of social justice. These guidelines are thus informed by the legal instruments and they complement existing tools. Depending on the designated role of the social worker, they could address preparedness/ prevention and early intervention, response and/or recovery.

Cultural competency and cross-cultural interventions are becoming mandatory when designing and implementation interventions (Keller, Coe & Moore, 2014; Manson, 2020, Truong, Paradies & Priest, 2014). Cultural competency is a wide concept that is used to describe varied interventions that focus on improving the accessibility and effectiveness of services for people. A culturally-relevant intervention infuses elements and values of culture, beliefs and traditions into the intervention (Keller et al., 2014). It also includes dimensions of knowledge, skills and not only attitudes (Truong, et al., 2014). This also calls for cultural humility with social workers constantly encouraged to engage in self-reflection as reflective practitioners and allowing themselves to be genuine lifelong learners and not experts. According to Saint Arnault and Shimabukuro (2012), cultural formulation of distress and help seeking is crucial in helping professions. The expert model as often taught in schools of social work, though useful in certain situations, "it does not encourage a relationship of trust between the provider [social worker] and the client" with trust being synonymous and valued in rural areas (Thomas, 2020:1806).

PROPOSED GUIDELINES

Guidelines on prevention and in ensuring women's participation and empowerment

i) Consult women regularly on IPV risks, constraints participation, available services and access to services and develop strategies to address these risks.

ii) Identify and address risks along a hierarchy i.e. increased marginalization and IPV risks for certain women and co-design approaches to ensure their participation.

iii) Ensure that discussions with women are facilitated by women and accessible to all women and are held in safe women-friendly spaces and community-acceptable venue/s.

iv) Support representation of older women in community leadership structures, where applicable and encourage and support capacity building of women leaders.

v) Liaise closely with livelihood partners and encourage the inclusion of women in economic empowerment initiatives such as microfinances, natural resource management.

vi) Identify and build on available informal and formal education programmes in the community that provide opportunities for empowerment and life-skills training.

vii) Based on the cultural decorum, women should be allowed to express themselves freely, participate willingly and not be prompted to share information that might hurt, shame, isolate or stigmatize them further.

viii) Women's participation must never lead to protection risks, violence and/or exploitation.

ix) Budget for compensation of women's time to ensure participation - whether in kind on in monetary terms.

x) Involve gatekeepers in the community, where applicable.

xi) Engagement with men as partners, allies and advocates should be based on specific designed strategies that are informed and led by the women.

xii) Conduct safety audits regularly to identify observable risks and as part of situational assessment and analysis.

Guidelines for addressing IPV-related social and gender norms

i) Engage community and religious/spiritual leadership and opinion leaders and gatekeepers to support social change, prevention strategies and be accountable to women.

ii) Explore and understand local world views and norms under-pinning IPV and other forms of violence and help-seeking behaviours.

iii) Monitor norm changes and use the information in designing improved programming.

iv) Tap into family and significant natural support networks to understand and develop programming efforts around them.

v) Mobilize community members to act as community activists.

vi) Transformative training and awareness sessions should be made available towards influencing internalized harmful gender norms.

vii) Facilitate analysis of gender and power dynamics of local systems and norms to identify how they sustain gender inequality and contribute to IPV.

viii) Shift in both individual attitudes and social expectations in programming efforts.

ix) Do not assume cultural consensus but work with allies who can promote more positive shifts in responding and preventing IPV.

x) Community dialogues offer spaces to share experiences and new information.

Guidelines for the health care of IPV victims

i) Strengthen the capacity of community health care providers as they could be a crucial entry point for referrals and support.

ii) Join efforts with health care stakeholders to access the community healthcare centre or clinic's readiness and advocate to address gaps in the system.

iii) Establish safe referral systems – taking into consideration cultural expectations.

iv) Ensure efficient IPV training that is victim-centred and empathy-centred and appropriate to the victim's age, developmental stage and belief system.

v) There should be an IPV-focussed representative at health forums and a health representative in IPV discussion forums.

vi) Victims should be attended to by female staff members at the healthcare facility.

vii) A basic assessment of the victim's psychosocial and mental health should be conducted.

viii) Communication material in the clinic should be clearly described, with illustrations and in the local language/s, the types of services available and that confidentiality will be upheld.

ix) Mandatory legal reporting by healthcare professionals should not be at the expense of victims, but victims should be informed of the limits to confidentiality.

x) Referrals to other service providers should be done in a manner that is respectful, safe and confidential and ensures that the victims are not exposed to harms, risks or violence from partner, family and/or community members.

xi) Follow-up appointments for monitoring and further support should be provided by the healthcare provider.

Guidelines for psychosocial support

i) Social workers should have strong interpersonal skills, belief in gender equality and have basic knowledge of the local language/s and culture.

ii) Provide individual and group work support services.

iii) Create or strengthen existing safe spaces for women.

iv) Investigate and address barriers to women (victims) accessing psychosocial support services.

v) The services provided should foster safety, community cohesion and support, connectedness and a sense of sisterhood.

vi) Home visits should be conducted to ensure wider reach of psychosocial services and support – both as a preventive and early intervention response mechanism.

vii) Community-based assistance, self-help and resilience approaches should be identified and encouraged.

viii) Support services should be provided in the preferred language of the victim and using the local terminologies.

ix) Strengthen victim-centred traditional, community-sanctioned support and coping mechanisms.

x) Counselling should be culturally appropriate and be both information and emotion support-based.

xi) Livelihood and other socio-economic interventions should form the basket of supportive healing interventions.

xii) Spirituality can also be incorporated into the interventions with victims, if deemed applicable or important to the victim.

Guidelines for IPV case management

i) Engage in service mapping and stakeholder engagement to determine existing gaps, services and develop a plan to address the gaps with other stakeholders.

ii) Engage with stakeholders to establish everyone's roles and responsibilities and identify incidents of role duplication.

iii) Develop protocols for IPV coordination and coordinate assistance provision with all service providers.

iv) Development of local protocols for IPV coordination among service providers.

v) Understand context-specific obligatory reporting procedures and highlight community-based reporting systems.

vi) Monitoring and evaluation of services.

vii) Training to ensure uniform intervention and from a victim-centred perspective.

Guidelines for referrals of IPV cases

i) Engage in service mapping and stakeholder engagement to determine existing gaps, services and develop a plan to address the gaps with other stakeholders.

ii) Facilitate regular assessments to identify victim's needs and access to services.

iii) Set regular meetings to discuss successes and challenges – as a form of support and to improve services.

iv) Identify who the central/contact person will be for each organization represented on the referral structure.

v) Regularly assess the referral pathway among and across organisations.

vi) Establish a functioning community-based referral pathway building on available structures and services.

vii) Standardize shared documents such as consent forms, intake forms, and referral forms.

viii) Victims should be guided through the referral system to ensure access to multiple systems without having to re-tell their abuse.

ix) Establish a follow up system to determine the services were completed.

x) All information that is collected by the respective organizations should be done in an ethical manner and stored safely. Access to this information should be limited to persons working on the case.

Guidelines for developing sustainable livelihoods

i) Prior to introduction of livelihood programmes, assess the gender and cultural norms of the area.

ii) Engage community members, including male family members, to support women's participation in livelihoods programming to mitigate risks.

iii) The programming should not reinforce traditional gender roles or increase workload on women, and it should not fuel conflict and heighten the increase in experiences of violence.

iv) Support gender-informed and risk-sensitive livelihood needs assessments.

v) Mapping livelihood support programmes.

vi) Conduct gender analysis to identify potential harms and barriers that women might encounter when participating in the economic activities.

vii) Understand household power dynamics on issues such as resource management, finance control, budgeting and decision-making.

viii) Identify safe settings and provide assistance in planning the location and time of the economic activities.

ix) Livelihood programmes must not only target victims as this could intensify stigma, and compromise confidentiality and their safety.

x) Livelihood and economic empowerment initiatives could be used as entry points for IPV victims to access other supportive services.

Guidelines for police, justice and legal aid intervention

i) Advocate for a victim-based approach which emphasizes rights, needs, dignity and options of victims.

ii) Involve local women's groups to engage with gatekeepers and knowledge holders who enforce customary/informal legal/ justice systems.

iii) Sensitize the community on the different types of justice systems available locally and how to access them i.e. customary and civil - which protect women and uphold their rights.

iv) Use indigenous, community-based justice mechanisms and reforms, where applicable.

v) Encourage development of IPV standard operating procedures using a victim-centred approach – and include police, the headman and/ or chief, spiritual leaders and other locally relevant justice actors.

vi) Motivate and support for the inclusion of females as part of the police force and justice reform.

vii) Listen to women's concerns on access to justice and plan around mitigating the barriers and building on success stories.

viii) Partner with other stakeholders to publicize women's and girl's rights and encourage their equal participation in decision-making processes.

ix) During community-based outreach, provide legal information and legal aid on matters such as divorce, inheritance, child custody etc.

x) Consult community leaders and members regularly about the services being offered, the quality and how they could be improved.

Guidelines for care and support of IPV professionals

i) Regularly conduct staff capacity assessment to identify gaps in knowledge, capacity and attitudes.

ii) Develop a capacity-building strategy for staff based on needs identified and the context.
iii) Staff should be encouraged to share training resources.
iv) Professionals should have safe spaces to speak openly about occupational challenges of intervening with IPV cases in rural areas, stress management techniques, self-care etc.
v) Psychosocial support should be available and accessible to staff working on IPV – though being aware that support needs will vary.
vi) Ensure IPV responses are accompanied by supervision and debriefing sessions for staff.
vii) Motivation and support for hardship allowance should be made.
viii) Staff should be encouraged to take regular breaks from the rural area.
ix) Peer-support and supervision should be part of practice.
x) Establish measures to protect lay and other professionals in their dual roles as service providers and as community members.

CONCLUSION

Changing violence and culturally-sanctioned violent scripts requires community effort. Education is a fundamental aspect of social change – even if it is informally provided in informal social networks. Identification between the internal versus external/contextual factors, private versus public factors can help practitioners understand reasons for not leaving an abusive relationship as well as not accessing assistance [even in instances when it is available].

This paper highlights the crucial role played by social/ gender norms as well as the significance of economic security (Gilroy et al., 2020, Maticka-Tyndale et al., 2020; Sinko & Saint Arnault, 2020) when trying to leave and after leaving an abusive situation. These aspects are built into the proposed guidelines.

This paper encourages professional interaction with victims and survivors with a focus on healing goals and not only on the negative aspects of IPV. The practice knowledge highlighted in the guidelines has the potential to influence social worker's interaction and increase their ability to work within a multi-disciplinary team and with victims to reduce their stress and

anxiety while promoting their empowerment, strength and resilience. This paper calls for greater focus on developing culturally relevant interventions grounded on the local reality and tapping into the voices of the service users. Future research is needed to test if the proposed guidelines are viable on the ground.

REFERENCES

BAILE-DEMPSEY, C. & REID, W. J. 1996. Intervention design and development: A case study. **Research on Social Work Practice**, 6(2): 208–228. https://doi.org/10.1177/104973159600600205

BOSCH, K., & BERGEN, M.B. 2006. The influence of supportive and Non-supportive persons in helping rural women in abusive partner relationships become free from abuse. **Journal of Family Violence,** 21:311-320. DOI 10.1007/s10896-006-9027-1

BURNETTE, C.E. & FIGLEY, C.R. 2017. Historical oppression, resilience and transcendence: Can a holistic framework help explain violence experienced by indigenous people? **Social Work**, 62: 37-44. doi:10.1093/sw/sww05.

CARTER, J. & VAN BREDA, A. 2016. The design of a protocol for assessing prospective foster parents in South Africa. **Social Work/Maatskaplike Werk**, 52(2): 208-226.

CHADAMBUKA, C. 2020. Coping strategies adopted by women who experienced intimate partner violence in the context of social norms in rural areas in Zimbabwe. **Journal of InterpersonalViolence**,1-25. https://doi.org/10.1177%2F0886260520943734

CHADAMBUKA, C. & WARRIA, A. 2020. Examining support systems available for victims of intimate partner violence in rural areas in Zimbabwe. **Practice: Social Work in Action**, 32(5):381-399. https://doi.org/10.1080/09503153.2020.175057

CHAKRABORTY, S, BRIJNATH, B, DERMENTZIS, J & MAZZA, D. 2020. Defining key questions for clinical practice guidelines: A novel approach for developing clinically relevant questions. **Health Research Policy and Systems**, 18(113):1-9. https://doi.org/10.1186/s12961-020-00628-3

CHIRESHE, E. 2015. Christian women's experiences of domestic violence in Zimbabwe. **Journal of Women and Social Work**, 30(3):380-394.

CISLAGHI, B., & HEISE, L. 2019. Using social norms theory for health promotion in low-income countries. **Health promotion international**, 34(3):616–623. https://doi.org/10.1093/heapro/day017

CONROY, A.A. 2014. Gender, power and Intimate partner violence: A study on couples from rural Malawi. **Journal of Interpersonal Violence,** 29 (5):866-888.

FIDAN, A. & BUI, H.N. 2016. Intimate partner violence against women in Zimbabwe. **Violence against women**, 22 (9):1075-1096.

FRASER, W.M., & GALINKSY, J.M. 2010. Steps in intervention research: Designing and developing social programs. **Research on Social Practice,** 20(5):459-466.

GBV-SUB CLUSTER (TURKEY HUB-SYRIA). 2018. Standard operating procedures for gender-based violence prevention and response.

GIDDENS, A & SUTTON P.W. 2017. **Sociology** (8th ed). Cambridge: Polity press.

GLOBAL PROTECTION CLUSTER. 2020. The inter-agency minimum standard for gender-based violence in emergency programming. Inter-Agency Standing Committee (IASC).

GLOBAL PROTECTION CLUSTER. n.d. Guidelines for integrating gender-based violence interventions in humanitarian action; Reducing risk, promoting resilience and aiding recovery. Inter-Agency Standing Committee (IASC).

GILROY, H., NAVA, A. & MCFARLANE, J. 2020. Developing a theory of economic solvency for women who have experienced intimate partner violence. **Violence Against Women**, 26(9): 955-971.

GREEN, S., & NIEMAN, A. 2003. Social Development: Good practice guidelines. **Social Work/Maatskaplike Werk**, 39(2):161-181. http://dx.doi.org/10.15270/39-2-372

HAGEMAN, S.A. & ST. GEORGE, D.M.M. 2018. Social workers, intimate partner violence (IPV), and client financial concerns. **Journal of Social Service Research**, 44(3):391-399, DOI: 10.1080/01488376.2018.1476288

HICKS, S. 2015. Social work and gender: An argument for practical accounts. **Qualitative Social Work**, 14(4): 471-487. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4509879/

JEWKES, R.K., FLOOD, M. & LANG, J. 2015. From work with men and boys to changes of social norms and reduction of inequalities in gender relations: A conceptual shift in prevention of violence against women and girls. **Lancet**, 385(9977):1580-1589. https://doi.org/10.1016/s0140-6736(14)61683-4

KELLER, C.S., COE, K. & MOORE, N. 2014. Addressing the demand for cultural relevance in intervention design. **Health Promotion Practice**, 15(5): 654-663

KIBORO, C.N., GAKURU, O.N., MISARO, J. & MWANGI, S.W. 2014. Role of social work in minimising sexual and gender based inequalities. **Research on Humanities and social sciences**, 4(14):84-88.

KIM, E. & HOGGE, I. 2015. Intimate partner violence among Asian Indian women in the United States: Recognition of abuse and help-seeking attitudes. **International Journal of Mental Health**, 44:200-214.

KLUGMAN, J. 2017. **Gender-based violence and the law**. World Development Report Background Paper. Washington: World Bank.

LIANG, B., GOODMAN, L., TUMMALA-NARRA, P. & WEINTRAUB, S. 2005. A theoretical framework for understanding help-seeking processes among survivors of intimate partner violence. **American Journal of Community Psychology**, 36: 71-84.

MALESA, K.J. 2018. **The perceptions and experiences of rural married men concerning their partners exercising their sexual and reproductive rights: Directives for social work intervention**. Doctoral thesis. UNISA.

MANJI, K., HEISE, L. & CISLAGHI, B. 2020. Couples' equilibrium, gender norms and intimate partner violence in Kirumba, Tanzania. **Violence Against Women**, 26(15-17): 2062-2082.

MANNELL, J., JACKSON, S. & UMUTONI, A. 2015. Women's response to intimate partner violence in Rwanda: Rethinking agency in constrained social contexts. **Global Public Health,** 11: 65-81.

MANSON, S.M. 2020. The role of culture in effective intervention design, implementation, and research: Its universal importance. **Prevention Science**, 21: 93-97.

MATICKA-TYNDALE, E. & BARNETT, J.P. 2020. Exploring the relationship between stigma, stigma challenges, and disclosure among slum-dwelling survivors of intimate partner violence in Kenya. **Violence Against Women**, 26(10): 1188-1208.

McCLEARY-SILLS, J., NAMY, S., NYONI, J., RWEYEMAMU, D., SALVATORY, A. & STEVEN, E. 2015. Stigma, shame and women's limited agency in help-seeking for intimate partner violence. **Global Public Health**, 11:224-235.

McCLOSKEY, L.A., BOONZAIER, F., STEINBRENNER, S.Y, & HUNTER, T. 2016. Determinants of intimate partner violence in sub Saharan Africa: A review of prevention and intervention programs. **Partner Abuse**, 7 (3):277-315. http://dx.doi.org/10.1891/1946-6560.7.3.277

MUKANANGANA, F., MOYO, S., ZVOUSHE, A. & RUSINGA, O. 2014. Gender based violence and its effects on women's reproductive health: The case of Hatcliffe, Harare, Zimbabwe. **African Journal of Reproductive Health**, 18 (1):110-122

MURRAY, C.E., CROWE, A. & OVERSTREET, N.M. 2015. Sources and components of stigma experienced by survivors of intimate partner violence. **Journal of Interpersonal Violence**, 6:157-179.

NOWELL, L.S., NORRIS, J.M., WHITE, D.E., & MOULES, N.J. 2017. Thematic analysis: striving to meet trustworthiness criteria. **International Journal of Qualitative Methods**, 16:1-13. DOI: 10.1177/1609406917733847.

ODERO, M., HATCHER, A., BRYANT, C., ONONO, M., ROMITO, P., BUKUSI, E. & TURAN, J. 2014. Responses to and resources for intimate partner violence: Qualitative findings from women, men, and service providers in rural Kenya. **Journal of Interpersonal Violence**, 29: 783-805.

RICHEY, C. A., & ROFFMAN, R. A. 1999. On the sidelines of guidelines: Further thoughts on the fit between clinical guidelines and social work practice. **Research on Social Work Practice**, 9(3): 311–321

RIDDELL, T., FORD-GIBOE, M. & LEIPERT, B. 2009. Strategies used by rural women to stop, avoid or escape from IPV. **Healthcare for Women International**, 30:134-159.

ROTHMAN, J., & THOMAS, J.E. (Eds.). 1994. I**ntervention Research: Design and Development for human services**. New York: The Harworth Press.

SAINT ARNAULT, D.M. & O'HALLORAN, S. 2016. Using mixed methods to understand the healing trajectory for rural Irish women years after leaving abuse. **Journal of Research in Nursing,** 21: 369-383

SAINT ARNAULT, D. M. & SHIMABUKURO, S. 2012. The clinical ethnographic interview: A user-friendly guide to the cultural formulation of distress and help seeking. **Transcultural Psychiatry,** 49: 302-322.

SANDBERG, L. 2013. Backward, dumb, and violent hillbillies? Rural geographies and intersectional studies on intimate partner violence. **Journal of Women and Social Work** 28(4):350-365. https://doi.org/10.1177%2F0886109913504153

SCOURFIELD, J. 2006. Placing gender in social work: The local and national dimensions of gender relations. **Journal of Social Work Education**, 25(7): 665-679.

SHAMU, S., ABRAHAMS, N., ZAROWSKY, C., SHEFER, T. & TEMMERMAN, M. 2013. Intimate partner violence during pregnancy in Zimbabwe: A cross-sectional study of

prevalence, predictors, and associations with HIV. **Tropical Medicine & International Health**, 18: 696–711.

SINKO, L. & ARNAULT, D.S. 2020. Finding the strength to heal: Understanding recovery after gender-based violence. **Violence Against Women**, 26(12-13): 1616-1635.

SWART, E. 2012. Gender-based violence in a Kenyan slum: Creating local, women-centred interventions. **Journal of Social Service Research,** 38:427-438.

THOMAS, E. J. 1984. **Designing interventions for the helping professions**. CA: Sage

THOMAS, D.M. 2020. A scholar's reflection on intimate partner violence in the Cape Verdean Community. Violence Against Women, 26(14): 1790-1811

TUTTY, L.M., RADTKE, H.L., THURSTON, A.E., NIXON, K.L., URSEL, E.J., ATEAH, C.A. & HAMPTON, M. 2020. The mental health and wellbeing of Canadian indigenous and non-indigenous women abused by intimate partners. **Violence Against Women,** 26(12-13): 1574-1597.

TRUONG, M., PARADIES, Y. & PRIEST, N. 2014. Interventions to improve cultural competence in healthcare: A systematic review of reviews. **BMC Health Services Research**, 99.

UMUBYEYI, A., PERSSON, M., MOGREN, I. & KRANTZ, G. 2016. Gender inequality prevents abused women from seeking care despite protection given in gender-based violence legislation: A qualitative study from Rwanda. **PloS ONE**, 11 (5): 1-13.

WARRIA, A. 2016. Integration of interpreters in social work interventions with child victims of transnational trafficking: Proposed guidelines. **Child Abuse Research**, 17(1): 82-92.

WARRIA, A. 2017. Men at risk: Men's health, illness and the (un)healthy construction of gender identity. **Southern African Journal of Social Work and Social Development**, 29(2). https://doi.org/10.25159/2415-5829/1827

WARRIA, A. 2018. Girls innocence and futures stolen: The cultural practice of sexual cleansing in Malawi. **Children and Youth Services Review**, 91: 298-303.

WARRIA, A. & CHIKADZI, V. 2019. Guidelines for social work spiritual counselling in human trafficking cases. **Journal of Social Development in Africa,** 34(2):39-66.

WEAVER, T.L., ELROD, N.M. & KELTON, K. 2020. Intimate partner violence and body shame: An examination of the associations between abuse components and body-focused processes. **Violence Against Women**, 26(12-13): 1538-1554.

WHO. 2013. Responding to intimate partner violence and sexual violence against women. http://apps.who.int/iris/bitsream/10665/85240/1/9789241548595_eng.pdf.

ZIMBABWE DEMOGRAPHIC AND HEALTH SURVEY. 2015. **Key findings on Gender-based Violence.** Harare: ZIMSTATS.

8.3 CONCLUSION

This article presented culture-informed practice guidelines for social workers working within IPV contexts in rural areas. These practice guidelines are important in ensuring that intervention programmes implemented in rural areas respond to the unique situations of IPV victims and survivors in rural areas. Having presented the culture-informed practice guidelines, the following chapter will present a discussion of the major findings of the study and conclude the thesis.

CHAPTER 9
CONCLUSIONS AND RECOMMENDATIONS

9.1 INTRODUCTION

This study aimed to explore IPV experiences of women residing in rural areas in order to develop culture-informed practice guidelines for social workers practicing in rural areas. The study was intended to contribute to the limited research and knowledge base on IPV in rural areas. Women who had experienced IPV in their former intimate relationships and key informants providing services in rural areas participated in the study and shared their experiences regarding IPV. The aim was to place women residing in rural areas at the centre of the study by exploring their perspectives and lived experiences. This chapter presents the major findings and conclusions of the study. The findings are discussed in relation to the study objectives and the theoretical framework.

Based on the findings from the study there is evidence of frequent IPV against women residing in rural areas. Informed by the intersectional feminism framework, the study findings show that the interconnectedness of social variables (i.e. age, religion, location), gender emanating from patriarchy and social norms influences the perpetuation of IPV against women in rural areas.

9.2 FINDINGS AND CONCLUSIONS OF THE STUDY

The five objectives in this study inform the structure and framework within which the major findings and conclusions in this section are discussed. The objectives are:

i. To explore rural women's experiences of IPV;
ii. To explore the role of culture in women's experiences of IPV;
iii. To explore the context-specific coping strategies that IPV women victims/survivors use;
iv. To investigate the available formal and informal support mechanisms for IPV victims/survivors;
v. To explore key informants' perceptions regarding IPV in Chimanimani District.

9.2.1 To explore how women residing in rural areas experience IPV

Based on the empirical findings from this study and the literature that was reviewed, there are high rates of IPV in rural areas. Noticeably, in the literature reviewed; there were significant variations between IPV in rural areas and urban areas. As evidenced in Article 1, there is limited research on IPV in rural areas and most of the studies conducted are concentrated in urban areas. Chigwata (2016) argues that rural areas in Zimbabwe have a strong adherence to social norms that promote patriarchy and male control and it is evident that women living in rural areas are vulnerable to frequent and severe abuse as compared to women residing in urban areas. Furthermore, the geographical location of rural areas that intersect with varied social variables increases the vulnerability of rural women to IPV. Although the participants in this study consisted of women who had exited abusive relationships, the remnants of IPV were still visible. This was clearly evidenced during data collection when some women indicated that being interviewed at home could raise suspicions amongst neighbours and this could subject them to harassment and social rejection. This indicated the extent to which social norms inform how women respond and react to IPV or any intervention associated with it. The review articles 1 and 2 pointed to rural areas as bastions for people who are custodians of social norms that condone the subjugation of women and male supremacy which facilitate the perpetuation of IPV.

Financial abuse was identified as one of the common forms of abuse in rural areas (Article 3) although it is least recognised in IPV literature in Zimbabwe. Given the intersection of unemployment, high rates of poverty and the geographical isolation of rural areas, it is no surprise that financial abuse is a common form of IPV in rural areas. The Domestic Violence Act of Zimbabwe does not recognise financial abuse as a criminal offence although it reinforces and works in conjunction with other forms of IPV (Articles 2 and 6). While most studies have singled out physical, sexual and emotional abuse as the common forms of IPV (Conroy, 2014; Fidan & Bui, 2016; Mukanangana et al., 2014; McCloskey et al., 2016). Contrary to this, majority of the women who participated in this study did not acknowledge sexual abuse as a form of IPV. Furthermore, few service providers (Article 6) acknowledged that sexual violence was indeed a form of IPV. This is a cause for concern. Given the role that cultural norms play in the normalising of sexual violence and the commodification of women through *lobola* payment (Article 1), it is clear that sexual violence is highly shrouded in the culture of silence. This creates pathways for further abuse that could result in reproductive health complications.

9.2.2 To explore the role of culture in women's experiences of IPV in rural areas

This study contributes to the ongoing debate on the role of culture in IPV experiences of women living in rural areas. In the preceding chapters, culture was viewed to be central to every IPV aspect that was presented, such as coping strategies, support systems and service provision. The study shows that in researching IPV, it is important to go beyond the simplistic and surface manifestations. To this end, researchers should strive to understand IPV in rural areas as a complex phenomenon deeply rooted in cultural norms and values (Chireshe, 2015; Bosch & Bergen, 2006; Fidan & Bui, 2016; Riddell et al., 2009; Sandberg, 2013). Researchers have further argued that different contexts provide different IPV experiences (Etherington & Baker, 2018; Kulkarni, 2019; Sandberg, 2013). From an intersectional lens, the experiences of urban and rural women are different as far as IPV is concerned, as the contexts do not share the same characteristics and features. Sandberg (2013) argues that the politics of location come into play when studying IPV in rural areas. This explains why IPV studies should be studied in each setting and context to ensure that context- and situation-specific intervention strategies can be employed.

The results from this study show how culture condones the male controlling behaviours that ultimately result in IPV. The influence of social norms on IPV against women in rural areas have been reported throughout the study (Article, 1, 2, 3, 4, 5, 6 and 7). Strong association between social norms and IPV was observed (Article 1) as well as the stronger influence of social norms on the formulation and implementation of legislative frameworks (Article 2). The legislative frameworks in Zimbabwe recognise the importance of culture and in so doing they acknowledge the importance of traditional leaders who are regarded as the custodians of culture (Chigwata, 2016). Given that the traditional jurisdiction in Zimbabwe is shrouded in patriarchy (Matavire, 2012), the status quo of traditional leaders in marital disputes is not to permanently break the cycle of IPV but rather preserve the abusive marriage and foster the dominant and controlling status of men. Their intervention strategies are informed by social norms that condone male dominance and the subjugation of women in marriages.

While participants in this study acknowledged that IPV is an intolerable social behaviour, it was evident that adherence to social norms surrounding marriages and non-disclosure of IPV was more important than their own well-being (Article 5). Participants indicated that they found it difficult to report IPV to formal service providers as culturally marital conflicts are to

be dealt with within the family institution. In the Shona culture, marriage is treated with honour and the family is the culturally approved mediator in marital conflicts. A woman who reports IPV to 'outsiders' is regarded as an errant wife and such behaviour warrants 'punishment' from the husband.

Culture is also seen infiltrating into service provision as service providers attempt to strike a balance between their professional and cultural identity (Article 1 and 6). Studies by Baldry and Pagliaro (2014) show that service providers in rural areas are likely to conform to the social norms of the communities that they serve. Due to this fact, service providers tend to adhere to the same cultural norms that condone IPV. While service providers are trained to ethically and professionally assist victims of IPV, it was evident that they (un)intentionally gave victims advice and assistance that encouraged them to stay in abusive relationships thereby contributing to frequent IPV in rural areas. Given the patriarchal nature of rural areas, service providers tended to reinforce the status quo of family mediation that also reinforced patriarchy, which ultimately facilitated IPV. The idea behind family mediation is to facilitate male control and preserve the abusive marriage regardless of its detrimental effects on the women.

9.2.3 To explore context-specific coping strategies adopted by IPV victims in rural areas

Considering that IPV is shrouded in the culture of silence in rural areas, participants in this study indicated that they adopted culture-appropriate coping strategies that assisted them in dealing with IPV (Article 3). Participants reported an increased dependency on emotion-focused coping. As reported in Articles 1 and 2 on the influence of culture and its bearing even on legislative frameworks, participants found it safer to rely more on emotion-focused coping mechanisms as they attempted to protect themselves from further and frequent abuse. Riddell et al. (2009) argues that the common features of rural areas are public visibility and lack of anonymity that implies that every attempt by the victim in dealing with the abuse was in the perpetrator's eyes. Thus, in order to prevent causing greater anger to the perpetrator, participants resorted to emotion-focused coping mechanisms.

Participants relied more on culture-informed coping strategies. The findings revealed that acceptance and placating, self-blame and defiance were the common culture-informed coping strategies. The concept of normalisation and acceptance of IPV was discussed throughout the thesis and was used as a coping mechanism. The normalisation of abuse tended to shift the

blame from the perpetrator and participants blamed themselves for the abuse. Defiance was used as a coping mechanism regardless of the patriarchal nature of rural areas which condone the subjugation of females. The concept of agency is evident as women subtly manipulated patriarchy to protect themselves from further abuse. McCloskey et al. (2016) and Sikweyiya et al. (2020) discuss patriarchy and IPV and argue that men are expected to exercise control over women and aggressive behaviour is linked to masculinity. While it is likely that when women resist IPV there is a greater chance of further abuse, participants in this study reported otherwise. It was revealed that when women fought back against the perpetrator, he would refrain from beating the woman. While this was short-lived, it is commendable as participants demonstrated agency which gave temporary protection from the abuse.

Article 3 further reports on religious-based coping mechanisms. As reported in Articles 3 and 4, the church is an important structure in IPV response in rural areas. Participants also reported a higher reliance on prayer and hope in God as an effective coping mechanism. Furthermore, pastoral mediation played a significant role in resolving marital disputes. Other studies have also reported that the church is an important structure in the response to IPV (Chireshe, 2015; Zakar et al., 2012). In Zimbabwe, churches in rural areas are largely dominated by patriarchy and pastors are mainly focused on preserving marriages rather than destroying them despite the intensity of the abuse. Although no religious leader participated in this study, the narrations from the women indicated that pastoral mediation in these contexts reinforced IPV more than denouncing it.

9.2.4 To explore the available formal and informal support mechanisms for IPV victims in rural areas

Although women in rural areas reported higher reliance on emotion-focused coping mechanisms, they also resorted to informal support in dealing with IPV (Article 4). Participants relied more on informal support networks and the frequency and severity of the abuse was the main push factor for resorting to such informal support networks. The reliance on informal support networks could have been informed by cultural norms that denounce the use of ‘outsiders’ (formal service providers) in resolving marital conflicts in rural areas. Bosch and Bergen (2006) and Sandberg (2013) suggest that support networks in rural areas are centred around the ‘trusted’ members of the community who are deemed appropriate in resolving marital conflicts. Article 4 reported that women relied more on the family, the church, village

heads and informal self-help groups. The findings of this study show how families are regarded as the best mediators of marital conflicts (Articles 1, 2, 3, 4, 5 and 6). However, participants indicated that their natal families are more supportive as compared to their in-laws. This resonates with findings from a study conducted by Bosch and Bergen (2006) which reported the natal family as more supportive. However, the concept of *lobola* payment discussed in Article 1 somehow gives the natal family the mandate to support patriarchy according to the Shona cultural norms that suggest that once a daughter is married she does not belong to her natal family anymore.

In addition, village heads are regarded as a support system for IPV victims in rural areas. As discussed in Article 2, traditional leaders are given the legal mandate to resolve disputes within their communities and these disputes may include marital disputes. Consistent with Chigwata's (2016) findings, traditional leaders are custodians of culture and in this case, their duties include ensuring that the traditional values of the Shona culture are upheld. As they are custodians of culture, their task is to reinforce cultural values and reconciliation in marital disputes. In this regard, it can be argued that regardless of the support rendered by traditional leaders; their role is to ensure that the cultural values are adhered to and ultimately encourage male dominance that facilitates IPV perpetration. While the church was reported to be a support mechanism (Article 3), it also reinforces cultural norms that have a silencing effect on IPV. Articles 2 and 3 report that rural areas rely on African Independent churches which are predominantly patriarchal and reinforces the male dominance which ultimately reinforces IPV. Thus, the support rendered by these churches might not be as effective in assisting victims of IPV in rural areas.

While the role of informal support systems in providing urgent temporary support to IPV victims is important, it is not effective in responding to severe and life-threatening abuse. In Chapter 6 (Article 2), barriers in seeking help were explained by participants. As argued in Articles 2, 3 and 4, social norms are found to be central to help seeking in rural areas. The findings of this study reveal how the interconnectedness of social norms, gender and geographical location influences help seeking amongst IPV victims residing in rural areas. Barriers associated with geographical distances, the participants highlighted cultural norms surrounding the preservation of marriages, lack of confidentiality, strained intervention resources and unsupportive service providers.

9.2.5 To explore key informants' perspectives on IPV in rural areas

In an attempt to develop culture-informed practice guidelines for social workers, this study explored the perspectives of service providers working in IPV contexts in rural areas. The findings from this study demonstrated that service providers in rural areas understand and perceive IPV as unacceptable behaviour and a criminal offence that warrants punishment. Moreover, in explaining their roles, key informants displayed knowledge on their mandate in the context of IPV. Although they understood the importance of professional intervention, they acknowledged the importance of family meditation. Some of the service providers even resorted to mediative intervention. This is consistent with past research that revealed that service providers in rural areas tend to conform to the community norms that condone the perpetuation of IPV and promote family intervention in marital conflicts (Baldry & Pagliaro, 2014).

An interesting finding relates to the challenges faced by service providers (Article 6). Contrary to what was shared by participants on service providers being unsupportive (Article 5), service providers in this study highlighted that IPV victims in rural areas tend to compromise service delivery in rural areas by changing their statements and denying being abused, especially when the perpetrator is present. However, study findings have also revealed that the changing of statements and denying abuse in the presence of the perpetrator could have been fuelled by fear of further abuse and also the desire to preserve their marriages (Article 5). Service providers should ensure that victims of IPV are not questioned in the presence of the perpetrator as this tends to compromise the intervention process and exposes the victims to further abuse (Article 7). Likewise, service providers also highlighted a lack of intervention resources as one of the challenges in service delivery. This lack of intervention resources was also reported as one of the barriers to help seeking by the women participants in this study (Article 5). Limited male participation is closely linked to social norms (Article 2) that promote male dominance and the subjugation of women in marriages. Therefore, increased awareness 'discouraging' male supremacy could be regarded as a threat to traditional masculinity. This explains the limited male participation.

9.3 LIMITATIONS OF THE STUDY

As with any research study, this study had limitations and these were specifically discussed in the articles presented in the previous chapters (Articles 3, 4, 5 and 6) but the major limitations will be presented in this section.

(i) Weather challenges brought about by Cyclone Idai

Researchers have argued that changes in weather can negatively affect accessibility of participants as well as the physical and mental state of the researcher and the participants (Kadir et al., 2013). The researcher failed to interview all the women that she had intended to interview due to Cyclone Idai. Roads and bridges were destroyed and the flooded rivers made it difficult to access the villages. The researcher interviewed women from six out of eight villages. Although these villages were in the same wards, their experiences of IPV somehow differed. For example, some villages were far from the public road and the service providers. In this case, their experiences of IPV could differ from the experiences of women residing in villages closer to the healthcare facilities and the public road. Interviewing these women was important in understanding the dynamics of IPV in rural areas. In addition to that, the researcher could not interview the social worker whose contribution was central to analysing the efficacy of the social work interventions in Chimanimani District.

(ii) Generalisability of research findings

The generalisability of qualitative research findings is one of the potential limitations of qualitative research as the studies focus on a certain population or phenomenon (Leung, 2015). Considering that this study was based in one ward in a rural district in Zimbabwe, findings from this study may not be generalised to all women residing in rural areas as experiences may differ amongst women considering different factors that come into play such as locality, ethnicity and religion, to mention but a few. Although this study focused on women who experienced IPV in their previous intimate relationships, the study did not include current IPV victims, elderly women or IPV victims below 19 years of age who might have different experiences of IPV and may have responded to it differently. Moreover, the study did not include perspectives of men of IPV. Men's perceptions could have assisted in understanding IPV. Factors such as gender equity and traditional masculinity in rural areas and how this facilitates IPV could have been better understood with the inclusion of male voices.

(iii) Absence of the social worker to participate in the study

Initially the researcher intended to interview the social worker who has been pivotal in the provision of psychosocial support to IPV victims in Chimanimani Rural District. Unfortunately, the social worker could not participate in the study due to Cyclone Idai. Interviewing the social worker would have been valuable to this study as it would have provided in-depth understanding of the challenges that social workers face in rendering psychosocial services to IPV victims in rural areas.

9.4 RECOMMENDATIONS

Articles one to seven are concluded with recommendations for practice and policy and as a result, these recommendations are not repeated in this section. This section discusses the main recommendations for practice, policy and research.

9.4.1 Social work practice

The study revealed that social work practice in rural areas should acknowledge the varied and unique experiences of IPV victims in rural areas. This is made possible by the provision of culture-informed social work practice that recognises the role of culture not only in IPV perpetration but also in its prevention. Thus, social work practice within IPV contexts should include training of community members, particularly the community elders, on issues related to IPV, considering that they are the first point of intervention for IPV victims in rural areas. The training of lay community members on IPV issues in rural areas and how to intervene informally can provide the bridge between victims and social workers considering the hidden nature of IPV in rural areas and the limited (formal) resources.

Informal support networks such as the family and friends play an important role in helping or providing support to IPV victims in rural areas. Psychosocial practitioners including social workers can use families as platforms for fostering change. This is important as the study findings show that these support networks are readily available for IPV victims in rural areas. Families should be made aware of the effects of IPV and the importance of non-violent conflict management skills. The people who form part of the informal support networks should also be equipped with basic counselling skills since they are readily available to assist IPV victims in rural areas.

Given the complexity of IPV in rural areas and the unique experiences of IPV victims in rural areas, there is no single correct way to intervene, taking into consideration the multiple needs that IPV victims in rural areas might have. Thus, social work intervention should ensure that provision of assistance is adapted to each victim's individual needs to support recovery and is holistic and empowering. This speaks to social work's mandate to protect the rights of marginalised and vulnerable groups of society.

Furthermore, it was revealed in Article 6 that service providers mostly conduct IPV awareness campaigns in rural areas and men do not attend these campaigns. Perhaps, instead of conducting collective awareness campaigns with both genders, service providers should ensure that they conduct these campaigns separately with men where they will be free to share their thoughts, feelings and experiences of IPV. In addition, IPV-related forums for men should be introduced within rural areas and should accommodate influential people in the rural community such as male-identifying village heads, elders and the religious leaders. The forums that include men can also be conducted at places where men in the community normally meet and spend some time together (e.g. beerhalls, soccer fields).

9.4.2 Social Work Curriculum

Understanding the nature and scope of IPV in rural areas and creating effective intervention strategies is heavily reliant on the ability of social workers to upgrade their knowledge and skills base when responding to IPV. This requires a shift in practice and training of social workers not only in Zimbabwe but also in the whole SADC region. Schenk (2004) and Dziro (2013) made similar recommendations regarding the importance of the social work curriculum being integrated with social work practice in rural areas. Given the recent high rates of IPV, it would be beneficial for the curricula to have specific modules that address social work practice in rural areas with victims of traumatic life events such as IPV. It is important that concepts of social work practice in rural areas be introduced earlier in the social work undergraduate curricular in Zimbabwe as well as in South Africa. Furthermore, practicing social workers in the field of gender should be trained on social work practice within IPV contexts in rural areas.

9.4.3 Social Policy

The findings of this study reveal the uniqueness of IPV experiences of women residing in rural areas. The findings resonate with intersectional feminism which denounces 'one-size-fits all' intervention strategies when dealing with IPV. Thus, policy makers should be wary of the unique experiences of IPV victims residing in rural areas given the influence of social norms in IPV perpetration. Policy makers should incorporate the specific needs and experiences of IPV victims. Service providers who work directly with IPV victims in rural areas should also be part of policy formulation and implementation. Article 2shows that while current IPV related legislative frameworks in Zimbabwe are for all women (e.g. Domestic Violence Act 2007), it is evident that there has not been adequate attention given to each group of women and how they respond to and experience IPV. Policies that target each specific group (i.e. women residing in rural areas and urban areas) and ensure the designing of context-specific intervention strategies for each group creates pathways for effective intervention programmes that minimise and prevent the continual perpetration of IPV.

Moreover, Articles 5 and 6 revealed a lack of intervention strategies as a problem in IPV intervention efforts. Thus the government, through policy implementation, should ensure that essential services for IPV prevention and minimisation are decentralised to rural areas where IPV is proliferating. This will ensure that victims of IPV in rural areas get effective and adequate psychosocial assistance. Decentralisation should also entail the introduction of one-stop centres where IPV victims in rural areas can access the police, health care officials, legal officials, social workers and psychologists in one shared facility. In Article 5, it was reported that IPV victims in rural areas face challenges in seeking assistance due to geographical distances and lack of transport money to reach the closest urban areas where they can get formal assistance. The introduction of these one-stop centres will ensure that IPV victims, including those living in remote areas, can obtain essential formal support services.

Similarly, government departments responsible for IPV related issues in rural areas should ensure that service providers working within IPV contexts receive adequate support in rendering IPV intervention services. In Article 6, it was explained that service providers experience challenges that ultimately lead to ineffective intervention efforts. Strained intervention resources were identified as a source of frustration for service providers. Thus, provision of adequate professional support and availability of adequate intervention resources

(e.g. ambulance and medication) will assist in ensuring effective IPV intervention. Professional support should include continual training workshops to service providers (e.g. social workers, police and health personnel). This training can also extend to schools and focus on the inclusion of IPV related issues in the school curriculum as a way of raising awareness amongst both boys and girls. The culture of non-violent conflict resolution should be taught in rural schools and this is a platform where boys and girls can be taught about the different forms of IPV (i.e. sexual, physical, financial and emotional). This is important in preventing the continued perpetration of IPV in rural areas.

Civil society plays an important role in policy and programme development and implementation and should strive to create awareness on IPV, its detrimental effects and the intervention services available for victims residing in rural areas. In article 5, it was explained that some women residing in rural areas are not aware of IPV intervention services. These awareness campaigns should also focus on changing cultural ideologies and attitudes around IPV and its privatisation. For example, Article 1 analyses the cultural practice of *lobola* payment and its contribution to the commodification of women. Although payment of *lobola* is a noble practice that seeks to honour the family of the bride, its transactional nature has been used to justify IPV. Thus, raising awareness on such issues in rural areas will assist in shifting social norms and attitudes that objectify women and ultimately condone IPV.

9.4.4 Recommendations to theory

There has been remarkable progress on the application of intersectional feminism to IPV studies. However, there is still room for the integration and expansion of intersectional feminism in IPV studies particularly in low income communities where women are faced with multiple disadvantages that make them more susceptible to the abuse. It is important that intersectional feminism be not only applicable in academic research studies but also be incorporated in gender policymaking as it recognises that individuals face multiple interlinked forms of structural discrimination that can affect their well-being. This in turn ensures effective intervention programmes that respond to the unique needs of IPV victims in different settings.

9.4.5 Future research on IPV

It is anticipated that this study will stimulate further inquiry on IPV. The researcher suggests the following areas for further research.

(i) Testing the culture informed practice guidelines

In developing the culture-informed practice guidelines in this study, phase 3, namely the design and development phase of Rothman and Thomas (1994) D&D model was used. Therefore, future research could address the last three phases of the model namely pilot testing, evaluation and advanced development and dissemination of the guidelines.

(ii) Research on children living in IPV-dominated households in rural areas

Further research on children's experiences of IPV in rural areas should be conducted. In this study, all the participants had children living with them during the period when they were abused. Although there has been considerable coverage on children exposed to IPV, the experiences of children in rural areas should be explored given the range of disadvantages in rural areas that can influence the way children respond and react to IPV.

(iii) Research on bystander intervention with regard to IPV in rural areas

Rural areas are governed by social norms that discourage the disclosure of IPV to outsiders. Findings in this study revealed that in rural areas, IPV is regarded as a private issue that is dealt with within the family. As such, outsiders are not encouraged to interfere in marital conflicts. Bearing in mind the concerning extent of IPV in rural areas and its grave consequences on the well-being of women, further studies on IPV in rural areas should explore the concept of bystander intervention. Bystanders are important in de-escalating severe IPV especially in rural areas where formal support systems (i.e. police, nurse) are not readily available to intervene.

(iv) Research on men's views on IPV in rural areas

Based on the findings of this study, limited male participation in intervention programmes was singled out as one of the challenges in rendering IPV services in rural areas. It was reported that men tend to avoid such intervention efforts that challenge traditional masculinity. Hence, in the preceding section, the inclusion of men in IPV discussions through men's forums is recommended. For practitioners to fully understand the dynamics of IPV in rural areas, further research that includes men's views on IPV should be conducted. This will assist in developing

intervention programmes that holistically address the needs of both men and women residing in rural areas with regard to IPV.

9.5 CONCLUDING REMARKS

Gender is an important aspect of social work practice as it is regarded as a basic determinant of social relations and rights that are fundamental for social functioning (Kiboro et al., 2014). Thus understanding the inequalities that are reinforced by gender roles is critical for effective social work practice. IPV as a form of GBV, is an infringement of the rights of women including those living in rural areas and a threat to their well-being. Protection of these rights is essential not only for the well-being of women, but also for their children. In this study, women reported to have experienced IPV in their former intimate relationships regardless of the detrimental effects it has on their well-being. Culture is seen to be at the centre of IPV perpetration and prevention. Thus, through intersectional feminism this thesis reports on how women in rural areas experience IPV uniquely given the multiple disadvantages associated with rural areas that interlink with social variables in increasing their risk of IPV.

Women in rural areas adopted coping mechanisms in dealing with the abuse as they engaged with what it means to be a woman in the Shona culture. The role of culture-based support systems is evident as women reported higher reliance on informal support systems as compared to formal support systems. However, the influence of social norms in IPV perpetration and prevention is notable as women share their challenges in accessing formal services while service providers share their challenges in rendering support services to IPV victims in rural areas.

Although it might be difficult to render assistance to IPV victims in rural areas, provision of high quality social work services remains of paramount importance in the minimisation and prevention of IPV. The limited capacity of women in rural areas to protect themselves, in the context of the social norms that condone IPV perpetration, suggest a stronger need for effective interventions. In this regard, psychosocial practitioners, including social workers, need to honour their obligations towards protecting the rights of IPV victims in rural areas.

REFERENCES

Abrahams, N., Jewkes, R., Martin, L. J., Mathews, S., Vetten, L., & Lombard, C. (2009). Mortality of women from intimate partner violence in South Africa: A national epidemiological study. *Violence and victims, 24*(4), 546–556. https://doi.org/10.1891/0886-6708.24.4.546

Abrahams, N., Matthews, S., Martin, L.J., Lombard, C., & Jewkes, R. (2013). Intimate partner femicide in South Africa 1999 and 2009. *PLOS Medicine, 10*(4), 1-8. https://doi.org/10.1371/journal.pmed.1001412

Adhena, G., Oljira, L., & Temesgen, T. (2020). Physical intimate partner violence among pregnant women in Ofla District, Tigray, Ethiopia. *American Journal of Health Research, 8*(4), 69-77. doi: 10.11648/j.ajhr.20200804.13

Ahmadabadi, Z., Najman, J.M., Williams, G.M., Clavarino, A.M., & d'Abbs, P. (2017). Gender differences in intimate partner violence in current and prior relationships. *Journal of Interpersonal Violence,* 1-23. https://doi.org/10.1177%2F0886260517730563

Ali, F.A., Israr, S.M., Ali, B.S., & Janjua, N.Z. (2009). Association of various reproductive rights, domestic violence and marital rape with depression among Pakistani women. *BMC Psychiatry, 9*(77), 1-13. https://doi.org/10.1186/1471-244X-9-77

Alio, A.P., Salihu, H.M., Nana, P.N., Clayton, H.B., Mbah, A.K., & Marty, P.J. (2011). Association between intimate partner violence and induced abortion in Cameroon. *International Journal of Gynaecology and Obstetrics, 112,* 83–87. https://doi.org/10.1016/j.ijgo.2010.08.024

Alexander-Scott, M., Bell, E. & Holden, J. (2016). *Shifting social norms to tackle violence against women and girls (VAWG).* London: VAWG Help desk.

Al-Tawil, N.G. (2012). Association of violence against women with religion and culture in Erbil Iraq: a cross-sectional study. *BMC Public Health, 12*(800), 1-7. https://dx.doi.org/10.1186%2F1471-2458-12-800

Altheide, D. L., & Johnson, J. M. (1994). Criteria for assessing interpretive validity in qualitative research. In N.K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research (*pp. 485-499). Thousand Oaks, CA: Sage.

Amaya, C.E.G., Acharya, A.K., & Bonfiglio, J.M.I. (2016*).* Gender based violence and reproductive health of indigenous women in Mexico. *Sociology Mind, 6,* 107-113. http://dx.doi.org/10.4236/sm.2016.63009

Ambikile, J.S., Leshabari, S., & Ohnishi, M. (2020). Nurses' and midwives' awareness of intimate partner violence related mental healthcare and associated factors in Tanzania. *Health & Social Care Community*, 1-10. https://doi.org/10.1111/hsc.13129

Amusa, L.B., Bengesai, A.V.s, & Khan, H.T.A. (2020). Predicting the Vulnerability of Women to Intimate Partner Violence in South Africa: Evidence from Tree based Machine Learning Techniques. *Journal of Interpersonal Violence,* 1-18. https://doi.org/10.1177%2F0886260520960110

Anderson, K., & van Ee, E. (2018). Mothers and Children Exposed to Intimate Partner Violence: A Review of Treatment Interventions. *International Journal of Environmental Research and Public Health, 15*, 1-25. https://doi.org/10.3390/ijerph15091955

Antai, D., & Antai, J. (2009). Collective violence and attitudes of women toward intimate partner violence: Evidence from the Niger Delta. *BMC International Health & Human Rights, 9*(12). https://doi.org/10.1186/1472-698X-9-12

Arain, M., Campbell, M.J., Cooper, C.L., & Lancaster, G.A. (2010). What is a pilot or a feasibility study? A review of current practice and editorial Policy. *BMC Medical Research Methodology, 10*(67), 1-7. https://doi.org/10.1186/1471-2288-10-67

Archibald, M.M. (2016). Investigator Triangulation: A Collaborative Strategy with Potential for Mixed Methods Research. *Journal of Mixed Methods Research, 10*(3), 228-250. https://doi.org/10.1177%2F1558689815570092

Attia, M., & Edge, J. (2017). Becoming a reflexive researcher: A development approach to research methodology. *Open Review of educational research, 4*(1), 33-45. https://doi.org/10.1080/23265507.2017.1300068

Attride-Stirling, J. (2001). Thematic networks: An analytic tool for qualitative research. *Qualitative research, 1*(3), 385-405. https://doi.org/10.1177%2F146879410100100307

Babbie, E. (2001). *The Practise of social research* (9th ed). California: Wadsworth/Thomson Learning.

Babbie, E., & Mouton, J. (2001). *The Practice of Social Research*. Oxford University Press Southern Africa: Cape Town.

Bagwell-Gray, M.E., & Bartholmey, E. (2020). Safety and Services for Survivors of Intimate Partner Violence: A Researcher–Practitioner Dialogue on the Impact of COVID-19. *Psychological Trauma: Theory, Research, Practice, and Policy*, *12*(1), 205–207. http://dx.doi.org/10.1037/tra0000869S205

Baldry, A.C., & Pagliaro, S.C. (2014). Helping victims of intimate partner violence: The influence of group norms among lay people and the police. *Psychology of Violence, 4*(3), 334-347. https://doi.org/10.1037/A0034844

Balogun, M.O., & Olufunimilayo, I.F. (2012). Intimate partner violence in South Western Nigeria: Are there rural-urban defences? *Women and Health, 52*, 627-645. https://doi.org/10.1080/03630242.2012.707171

Barbara, G., Facchini, F., Micci, L., Rendiniello, M., Giulini, P., Cattaneo, C., Vercellini, P., & Kustermann, A. (2020). COVID-19, Lockdown, and Intimate Partner Violence: Some Data from an Italian Service and Suggestions for Future Approaches. *Journal of women's health, 29*(10), 1239-1242. https://doi.org/10.1089/jwh.2020.8590

Barker, V. (1997). Definition and Question of 'Woman'. *Hypatia, 12*(2), 186-215. http://www.jstor.org/stable/3810477)

Barrios, V.R., Khaw, L.B.L., Bermea, A., & Hardesty, J.L. (2020). Future Directions in Intimate Partner Violence Research: An Intersectionality Framework for Analyzing Women's Processes of Leaving Abusive Relationships. *Journal of Interpersonal Violence*, 1-20. https://doi.org/10.1177/0886260519900939

Bazeley, P., & Jackson, K. (2013). *Qualitative data analysis with NVIVO* (2nd ed). London: SAGE.

Beauchamp, S., Drapeau, M., & Dionne, C. (2015). The Development of Practice Guidelines in the Social and Human Sciences. *Canadian Psychology/Psychologie canadienn*, 1-12. http://dx.doi.org/10.1037/a0038811

Bell, J.S. (2002). Narrative Inquiry: More than just telling a story. *TESOL Quarterly*, *36*(2), 207-213.

Bhagyathara, D. (2015). Alice Walker and her womanism aesthetics. *International Journal of Research in Humanities and Social Sciences, 2*(1), 6-9.

Bikinesi, L.T., Mash, R. & Joyner, K. (2017). Prevalence of intimate partner violence and associated factors amongst women attending antenatal care at Outapi clinic, Namibia: A descriptive survey. *African Journal Primary Health Care Fam Med*, *9*(1), 1512. https://dx.doi.org/10.4102%2Fphcfm.v9i1.1512

Bird, C.M. (2005). How I stopped dreading and learned to love transcription. *Qualitative Inquiry*, *11*(2), 226-248. DOI: 10.1177/1077800404273413

Blodgett, C., & Lanigan, J.D. (2018). The prevalence and consequences of intimate partner intrusion in the workplace. *Journal of aggression, maltreatment and trauma. 27*(1), 15-34. https://doi.org/10.1080/10926771.2017.1330297

Bloom, S. (2008). *Violence against women and girls: a compendium of monitoring and evaluation indicators.* Chapel Hill NC: Measure Evaluation.

Boonzaier, F.A., & van Schalkwyk, S. (2011). Narrative Possibilities: Poor Women of Color and the Complexities of Intimate Partner Violence. *Violence Against Women, 17*(2), 267-286. https://doi.org/10.1177%2F1077801210397796

Borsa, J. (1990). Towards A Politics of Location: Rethinking Marginality. *Canadian Women Studies, 11*(1), 36-39.

Bowen, G.A. (2009). Document Analysis as a Qualitative Research Method. *Qualitative Research Methods, 9*(2), 27-40.

Bowen, E. (2015). The impact of intimate partner violence on preschool children's peer problems: An analysis of risk and protective factors. *Child Abuse & Neglect, 50,* 141-150. http://dx.doi.org/10.1016/j.chiabu.2015.09.005

Bosch, K., & Bergen, M.B. (2006). The influence of supportive and Nonsupportive persons in helping rural women in abusive partner relationships Become free from abuse. *Journal of Family Violence, 21*, 311-320. DOI 10.1007/s10896-006-9027-1

Brannelly, T. & Boutton, A. (2017). The ethics of Care and transformational research practices in Aotearoa New Zealand. *Qualitative Research, 17*(3), 340-350. https://doi.org/10.1177%2F1468794117698916

Braun, V., & Clark, V. (2006). Using Thematic Analysis in Psychology. *Qualitative Research in Psychology, 3(*2), 77-101

Braun, V., Clarke, V., Hayfield, N., & Terry, G. (2018). Thematic analysis. P. Liamputtong (ed.), *Handbook of Research Methods in Health Social Sciences,* https://doi.org/10.1007/978-981-10-2779-6_103-1

Bright, L.K., Mlinksy, D. & Thompson, M. (2016). Causally interpreting intersectionality Theory. *Philosophy of Science, 83*(1), 60-81. http://www.jstor.org/stable/10.1086/684173?origin=JSTOR-pdf

Brisibe, S., Ordinioha, B., & Dienye, P. (2012). Intersection between alcohol abuse and intimate partner violence in a rural Ijaw community in Bayelsa State, South-South Nigeria. *Journal of Interpersonal Violence, 27*, 513–522. https://doi.org/10.1177%2F0886260511421676

Brown, M.E., Livermore, M., & Ball, A. (2015). Social Work Advocacy: Professional Self-Interest and Social Justice. *Journal of Sociology & Social Welfare, 42*(3), 45-63.

Bruce, A., Beuthin, R., Sheilds, L., Molzahn, A., & Schick-Makaroff, K. (2016). Narrative Research Evolving: Evolving Through Narrative Research. *International Journal of Qualitative Methods,* 1-6. https://doi.org/10.1177%2F1609406916659292

Bryman, A. (2008). *Social Research Methods* (3rd ed). New York: Oxford University Press.

Butina, M. (2015). A Narrative Approach to Qualitative Inquiry. *Clinical Laboratory Science, 28*(3), 190-196.

Buttell, F., & Ferreira, R.J. (2020). The Hidden Disaster of COVID-19: Intimate Partner Violence. *Psychological Trauma: Theory, Research, Practice & Policy, 12*(1), 197-198. http://dx.doi.org/10.1037/tra0000646

Buzawa, E.S., & Buzawa, C.G. (2003). *Domestic Violence: The Criminal Justice Response.* (3rd ed). Thousand Oaks, CA: Sage.

Bwire, G.M. (2020). Coronavirus: Why Men Are More Vulnerable to Covid-19 Than Women? *SN Comprehensive Clinical Medicine, 2*, 874–876. https://doi.org/10.1007/s42399-020-00341-w

Campbell, J. C. (2002). Health consequences of intimate partner violence. *Lancet, 359*, 1331–1336.

Capaldi, D. M., Knoble, N. B., Shortt, J. W., & Kim, H. K. (2012). A systematic review of risk factors for intimate partner violence. *Partner Abuse, 3*(2), 231–280. https://doi.org/10.1891/1946-6560.3.2.231

Callan, A., Corbally, M., & McElvaney, R. (2020). A Scoping Review of Intimate Partner Violence as It Relates to the Experiences of Gay and Bisexual Men. *Trauma, Violence and Abuse,* 1-16. https://doi.org/10.1177%2F1524838020970898

Campbell, C., & Mannel, J. (2016). Conceptualising the agency of highly marginalised women: intimate partner violence in extreme setting. *Global Public Health, 11*(1-2), 1-16. https://doi.org/10.1080/17441692.2015.1109694

Carastathis, A. (2014). The concept of intersectionality in Feminist Theory. *Philosophy Compass, 9*(5), 304-314. https://doi.org/10.1111/phc3.12129

Carpenter, G.L., & Stacks, C.A. (2009). Developmental effects of exposure to Intimate Partner Violence in early childhood: A review of the literature. *Children & Youth Services Review, 31*, 831-839. http://dx.doi.org/10.1016/j.childyouth.2009.03.005

Cassell, C., & Symon, G. (2004). *Essential guide to qualitative methods in organisation research*. London. SAGE

Cassol, H., PeÂtre, Â.B., Degrange, S., Martial, C., Charland-Verville, V., Lallier, F., Bragard, I., Guillaume, M., & Laureys, S. (2018). Qualitative thematic analysis of the

phenomenology of near-death experiences. *PLoS ONE, 13*(2), 1-14. https://doi.org/10.1371/journal.pone.0193001

Castleberry, A., & Nolen, A. (2018). Thematic analysis of qualitative research data: Is it as easy as it sounds? *Currents in Pharmacy Teaching & Learning, 10,* 807-815. https://doi.org/10.1016/j.cptl.2018.03.019

Chamberlain, L., & Levenson, R. (2012). Addressing Intimate Partner Violence, Reproductive and Sexual Coercion: A Guide for Obstetric, Gynaecologic and Reproductive Health Care Settings Second Edition. *Future without Violence*, 1-56.

Chatiza, K., Muchadenyika, D., Makaza, D., Nyaunga, F., Murungu, R.J., & Matsika, L. (2015). When extractives come home: An action research on the impact of the extractives sector on women in selected mining communities in Zimbabwe. *OIDA Journal of sustainable development, 8*(12), 45-72.

Cheema, A.R., Mehmood, A., & Khan, F.A. (2018). Challenges of research in rural poverty: lessons from large field surveys. *Development in Practice, 28*(5), 714-719. https://doi.org/10.1080/09614524.2018.1467881

Chenail, R. J. (2011). Interviewing the investigator: Strategies for addressing instrumentation and researcher bias concerns in qualitative research. *The Qualitative Report, 16,* 255–262.

Chigwata, T. (2016). The role of traditional leaders in Zimbabwe: Are they still relevant? *Law Democracy and development*, 69-90. http://dx.doi.org/10.4314/ldd.v20i1.4

Chipere, M. (2020) Crisis of political leadership in Zimbabwe. *Review of African Political Economy, 47(*164), 313-323. https://doi.org/10.1080/03056244.2020.1722089

Chireshe, E. (2015). Christian women's experiences of domestic violence in Zimbabwe. *Journal of Women and Social Work. 30*(3), 380-394. https://dx.doi.org/10.1186%2Fs12905-017-0441-8

Chisale, S. S. (2018). Domestic abuse in marriage and self-silencing: Pastoral care in a context of self-silencing. *HTS Teologiese Studies/Theological Studies, 74*(2), 1-8. https://doi.org/10.4102/hts.v74i2.4784

Clark, C.J., Ferguson, G., Shrestha, B., Shrestha, P.N., Oakes, J.M., Gupta, J., Mcghee, S., Cheong, Y.F., & Yount, K.M. (2018). Social norms and women's risk of intimate partner violence in Nepal. *Social science and Medicine, 202*, 162-169. https://doi.org/10.1016/j.socscimed.2018.02.017

Coker, A.L., Sanderson, M., & Dong, B. (2004). Partner violence during pregnancy and risk of adverse pregnancy outcomes. *Paediatric & Perinatal Epidemiology, 18,* 260-269. https://doi.org/10.1111/j.1365-3016.2004.00569.x

Coll, C.V.N., Ewerling. F., García-Moreno, C., Hellwig, F., & Barros, A.J.D. (2020). Intimate partner violence in 46 low-income and middle-income countries: an appraisal of the most vulnerable groups of women using national health surveys. *BMJ Global Health 5,* 1-10. http://dx.doi.org/10.1136/

Convention on the Elimination of All forms of discrimination against women (1979).

Conroy, A. (2014). Gender, Power, and intimate partner violence: A study on couples from rural Malawi. *Journal of Interpersonal Violence. 29*(5), 866-888. https://doi.org/10.1177%2F0886260513505907

Conyer, D. (2001). *Regional Development. Module GED 304.* Harare: Zimbabwe Open University.

Cousin, G. (2005). Case Study Research**.** *Journal of Geography in Higher Education, 29*(3), 421-427. https://doi.org/10.1080/03098260500290967

Cramer, E.P., & Plummer, S-B. (2009). People of Color with Disabilities: Intersectionality as a Framework for Analyzing Intimate Partner Violence in Social, Historical, and Political Contexts. *Journal of Aggression, Maltreatment & Trauma, 18*(2), 162-181. https://doi.org/10.1080/10926770802675635

Crenshaw, K. (1989) *De-marginalising the intersection of race and sex: A black feminist critique of anti-discrimination.* Doctrine Feminist theory and antiracist politics.

Crenshaw, K. (1991). Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Colour. *Stanford Law Review, 43*(6), 1241-1299. Retrieved from Stanford Law Review Stable URL: http://www.jstor.org/stable/1229039.

Creswell, J. W. (1998). *Qualitative inquiry and research design: Choosing among five traditions.* London: Sage Publications

Creswell, J.W., Hanson, W.E., Clark Plano, V.L., & Morales, A. (2007). Qualitative Research Designs: Selection and Implementation Criminal Law (Codification and reform Act, Chapter 9:23) Act 23/2004. Harare: Government Gazette, Zimbabwe. *The Counseling Psychologist, 35* (2), 236-264. DOI: 10.1177/0011000006287390

Convention on Elimination of All forms of discrimination against women. (1979).

Davhana-Maselese, M. (2011). *Trapped in the cycle of violence: a phenomenological study describing the stages of coping with domestic Violence.* North West: North West University.

Davis, K. (2008). Intersectionality as a borrowed buzzword: *A sociology of science perspective on what makes a feminist theory successful*. *9*(1), 67-85. London: Sage Publications.

DeJonckeere, M., & Vaughn, L.M. (2019). Semi Structured interviewing in primary care research: a balance of relationship and rigour. *Family Medicine and Community Health, 7*, 1-8. http://dx.doi.org/10.1136/fmch-2018-000057

Dekel, B., & Andipatin, M. (2016). Abused Women's Understandings of Intimate Partner Violence and the Link to Intimate Femicide. *Qualitative Social Research, 17*(1), 1-30. http://dx.doi.org/10.17169/fqs-17.1.2394 .

Delara, M. (2016). Mental health consequences and risk factors of physical intimate partner violence. *Mental health in Family medicine, 12*, 119-125.

De Sousa, J., Burgess, W., & Franslow, J. (2014). Intimate partner violence and women's reproductive health. *Obstetrics, Gynaecology and Reproductive Medicine, 24*(7), 195-203.

Devlin, A.S. (2006). *Research methods: Planning, conducting and presenting research*. California: Thomson/Wardsworth.

Devrie, K.M., Knight L., Child, J.C., Kyegombe, N., Hossain, M., Lees, S., Watts, C. & Naker, D.C. (2016). *Witnessing intimate partner violence and child maltreatment in Ugandan children: A cross sectional survey.* Downloaded from http://bmjopen.bmj.com/ on March 12, 2018

Diamond, D. (2009). The Fourth Wave of Feminism: Psychoanalytic Perspectives. *Studies in Gender and Sexuality*, *10*(4), 213-223. https://doi.org/10.1080/15240650903228187

Dim, E.E. (2020). Differentials and Predictors of IPV against Nigerian Women in Rural and Urban Areas. *Journal of Aggression, Maltreatment & Trauma, 29*(7), 785-807. https://doi.org/10.1080/10926771.2019.1603178

Domestic Violence Act (2007). Harare: Government Gazette, Zimbabwe.

Dodzo, M.K., & Mhloyi, M. (2017). Home is best: Why women in rural Zimbabwe deliver in the community. *PLoS ONE 12*(8), 1-23. https://doi.org/10.1371/journal.pone.0181771

Douglas, E.M., & Hines, D.A. (2011). The Help Seeking Experiences of Men Who Sustain Intimate Partner Violence: An Overlooked Population and Implications for Practice. *Journal of Family Violence, 26*, 473–485. https://doi.org/10.1007/s10896-011-9382-4

Dudgeon, A., & Evanson, T. A. (2014). Intimate partner violence in rural U.S. areas: what every nurse should know. *The American journal of nursing, 114*(5), 26–48. https://doi.org/10.1097/01.NAJ.0000446771.02202.35

Dunkle, K.L., & Decker, M.R. (2013). Gender-based violence and HIV: Reviewing the evidence for links and causal pathways in the general population and high-risk groups. *American Journal of Reproductive Immunology*, *69*(1), 20–26.

Dunkle, K. L., & Decker, M. R. (2013). Gender-based violence and HIV: reviewing the evidence for links and causal pathways in the general population and high-risk groups. *American journal of reproductive immunology (New York, N.Y.: 1989), 69 Suppl 1*, 20–26. https://doi.org/10.1111/aji.12039

Du- Preeze, A. (2004). *Is the subject of science and new technologies still sexed and gendered? The gender perspectives, innovations in economy, organisations and health within the southern African development community (SADC).* New York: P Lang.

Durevall, D., & Lindskog, A. (2015). Intimate partner violence and HIV in ten sub-Saharan African countries: What do the demographic and health surveys tell us? *Lancet: Global Health, 3*, 34–43. http://dx.doi.org/10.1016/S2214-109X(14)70343-2

Duvvury, N., Callan, A., Carney, P., & Roghavendra, S. (2013). *Gender and equality development, Intimate partner violence: Economic roots and Implications for Growth and development.* Washington: World Bank Group.

Dziro, C. (2013). Trends in social work education and training: The case of Zimbabwe. *International Journal of Development and sustainability 2*(2), 1423-1435.

Eckhardt, C.I., Parrott, D.J., & Sprunger, J. G. (2015). Mechanisms of Alcohol- Facilitated Intimate Partner Violence. *Violence Against Women, 21*(8), 939-957. https://psycnet.apa.org/doi/10.1177/1077801215589376

Edwards, K.M. (2015). Intimate Partner Violence and the Rural–Urban–Suburban Divide: Myth or Reality? A Critical Review of the Literature. *Trauma, Violence & Abuse, 16*(3), 359-373. https://doi.org/10.1177%2F1524838014557289

Elghossain, T., Bott, S., Akik, C., & Obermeyer, C.M. (2020). Prevalence of intimate partner violence against women in the Arab world: a systematic review. *BMC International health & Human Rights, 19*(29), 1-16. https://doi.org/10.1186/s12914-019-0215-5

Elliot, J. (2005). *Using narrative in social research.* London: Sage Publication.

Elo, S., Kaariainen, M., Kanste, O., Polkki, J., Utriainen, K., & Kyngas, H. (2014). Qualitative Content Analysis: A Focus on Trustworthiness. *SAGE Open*, 1-10. https://doi.org/10.1177/2158244014522633

Engel, R.F. & Schutt, R.K. (2013). *The Practice of Research in Social Work*: London. Sage Publications

Enyew, B.E., & Mihrete, A.G. (2018). Liberal feminism: Assessing its compatibility and applicability in Ethiopia context. *International Journal of Sociology and Anthropology, 10*(6), 59-64. https://doi.org/10.5897/IJSA2018.0769

Eriksson, L., & Mazerolle, P. (2015). A cycle of violence? Examining family-of-origin violence, attitudes and intimate partner violence perpetration. *Journal of interpersonal violence, 30*(6), 945-964. https://doi.org/10.1177%2F0886260514539759

Esie, P., Osypuk, T. L., Schuler, S. R., & Bates, L. M. (2019). Intimate partner violence and depression in rural Bangladesh: Accounting for violence severity in a high prevalence setting. *SSM population health, 7*, 1-8. https://doi.org/10.1016/j.ssmph.2019.100368

Etherington, N., & Baker, L.C. (2018). From "Buzzword" to Best Practice: Applying Intersectionality to Children Exposed to Intimate Partner Violence. *Trauma, Violence & Abuse, 19*(1), 58-75. https://doi.org/10.1177%2F1524838016631128

Etikan, I., Musa. S.A., & Joyner, K. (2016). Comparison of convenience sampling and purposive sampling. *American Journal of Theoretical and Applied Statistics, 5*(1), 1-4. doi: 10.11648/j.ajtas.20160501.11

European Institute of Gender Equality. (2016). *Analysis of definitions of intimate partner violence.*

Few-Demo, A.L., & Allen, K.R. (2020). Gender, Feminist, and Intersectional Perspectives on Families: A Decade in Review. *Journal of Marriage and Family, 82*, 326-345. https://doi.org/10.1111/jomf.12638

Fidan, A., & Bui, H.N. (2016). Intimate partner violence against women in Zimbabwe. *Violence against women, 22*(9), 1075-1096. https://doi.org/10.1177%2F1077801215617551

Flory, J. (2004). Interventions to Improve Research Participants' Understanding in Informed Consent for Research: A Systematic Review. *JAMA, 292*(13), 1593-1601. https://doi.org/10.1001/jama.292.13.1593

Ford-Gilboe, M., Wuest, J., & Merrit-Gray, M. (2005). Strengthening capacity to limit intrusion: Theorizing family health promotion in the aftermath of woman abuse. *Qualitative Health Research, 15*, 477–501. doi:10.1177/1049732305274590.

Forero, R., Nahidi, S., De Costa, J., Mohsin, M., Fitzgerald, G., Gibson, N., McCarthy, S., & Aboagye-Sarfo, P. (2014). Application of four-dimension criteria to assess rigour of

qualitative research in emergency medicine. *BMC Health Services 18*(120), 1-11. https://doi.org/10.1186/s12913-018-2915-2

Fraser, M.W., & Galinsky, M.J. (2010). Steps in intervention research: Designing and developing social programs. *Research on Social Work Practice, 20*(5):459-466. https://doi.org/10.1177%2F1049731509358424

Fulu, E., Miedema, S., Roselli, T., McCook, S., Chan. K.L., Haardorfer, R., & Jewkes, R. (2017). Pathways between childhood trauma, intimate partner violence, and harsh parenting: findings from the UN Multi-country Study on Men and Violence in Asia and the Pacific. *Lancet Global Health, 5*, 512-522. https://doi.org/10.1016/S2214-109X(17)30103-1

Gass, J.D., Stein, D.J., Williams, D.R., & Seedat, S. (2011). Gender differences in risk for intimate partner violence among South African adults. *Journal of Interpersonal Violence, 26*, 2764–2789. https://doi.org/10.1177/0886260510390960

Gebrewahd, G.T., Gebremeskel, G.G., & Tadesse, D.B. (2020). Intimate partner violence against reproductive age women during COVID-19 pandemic in northern Ethiopia 2020: a community-based cross-sectional study. *Reproductive Health, 17*(152), 1-8. https://doi.org/10.1186/s12978-020-01002-w

Giddens, A & Sutton P.W. (2017). *Sociology* (8th ed). Cambridge: Polity press

Gomo, E. & Munyati, S. (2005). *Household survey of HIV prevalence and behaviour in Chimanimani district Zimbabwe*. Cape Town: HSRC.

Goodman, N. (1992). *Introduction to Sociology*. New York: HarperCollins Publishers.

Goodman, L.A., & Epstein, D. (2020). Loneliness and the COVID-19 Pandemic: Implications for Intimate Partner Violence Survivors. *Journal of Family Violence*, 1-8. https://doi.org/10.1007/s10896-020-00215-8

Goodman, L.A., Smyth, K.F., Borges, A.M., & Singer, R. (2009). When crises collide: How intimate partner and poverty intersect to shape women's mental health and coping? *Trauma, Violence & Abuse. 10*(4), 306-329. https://doi.org/10.1177%2F1524838009339754

Gopaldas, A. (2013). Intersectionality 101. *Journal of public policy and Marketing, 32*, 90-94. https://doi.org/10.1509%2Fjppm.12.044

Gordon, C. (2016). Intimate partner violence is everyone's problem, but how should we approach it in a clinical setting? *SAMJ: South African Medical Journal 106*(10), 962-965. http://dx.doi.org/10.7196/samj.2016.v106i10.11408

Gottert, A., Pulerwitz, J., Haberland, N., Mathebula, R., Rebombo, D., Spielman, K., West, R., Julien, A., Twine, R., Peacock, D., Dufour, M.K., Gomez-Olive, F.X., Pettifor, A., Lippman, A., & Khan, K. (2020). Gaining traction: Promising shifts in gender norms and intimate partner violence in the context of a community-based HIV prevention trial in South Africa. *PLoS ONE, 15*(8), 1-19. https://doi.org/10.1371/journal.pone.0237084

Groenewald, T. (2004). A Phenomenological Research Design Illustrated. *International Journal of Qualitative Methods*, 42–55. https://doi.org/10.1177/160940690400300104

Groves, A.K., Moodley, D., McNaughton-Reyes, L., Martin, S.L., Foshee, V., & Maman, S. (2015). Prevalence and rates of IPV among South African women during pregnancy and the postpartum period. *Maternal Child Health Journal, 19*(3), 487-495. https://dx.doi.org/10.1007%2Fs10995-014-1528-6

Hankivsky, O., Reid, C., Cormier, R., Varcoe, C., Clark, N., Benoit, C., & Brotman, S. (2010). Exploring the promises of intersectionality for advancing women's health research. *International Journal for Equity in Health, 9*(5), 1-15. https://doi.org/10.1186/1475-9276-9-5

Haydon, G., Browne, G. & van der Riet, P. (2017). Narrative enquiry as a research methodology exploring person centered care in nursing. *Collegian, 25*, 125-129. https://doi.org/10.1016/j.colegn.2017.03.001

Haslanger, S. (2000). *Gender and Race: What are they? What do we want them to be?* Oxford: Blackwell Publishers.

Heise, L., Ellsberg, M., & Gottemeller, M. (2002). A global overview of gender-based violence. *International Journal of the gynaecology and Obstetrics Supplement 1*, 55-514.

Heise, L.L., & Kotsadam, A. (2015). Cross-national and multilevel correlates of partner violence: an analysis of data from population-based surveys. *Lancet Global Health, 3*, 322-340. https://doi.org/10.1016/S2214-109X(15)00013-3

Henderson, L., Zerai, A. and Morrow, R.L. (2017). Intimate partner violence and HIV status among ever-married and cohabiting Zimbabwean women: An examination of partners' traits. *African Journal of Reproductive Health 21*(4), 45-54. https://doi.org/10.29063/ajrh2017/v21i4.5

Hipp, J.R. (2016). Collective efficacy: How is it conceptualized, how is it measured, and does it really matter for understanding perceived neighborhood crime and disorder? *Journal of Crime Justice, 46*, 32-44. https://doi.org/10.1016/j.jcrimjus.2016.02.016

Hill-Collin, P. & Bilge, S. (2016). *Intersectionality*. Malden: Polity Press.

Hornosty, J., & Doherty, D. (2003). Responding to wife abuse in farm and rural communities: Searching for solutions that work. In R. Blake & A. Nurse (Eds.). *The trajectories of rural life: New perspectives on rural Canada,* 37–53.

Hoque, M.E., Hoque, M., & Kader, S.D. (2009). Prevalence and experience of domestic violence among rural pregnant women in Kwazulu Natal South Africa. *Southern African Journal of Epidemiology and Infection*, *24*(4), 34-37.

Houry, D., Rhodes, K.V., Kemball., R.S., Click., L., Cerrulli, C., McNutt, L.A., & Kaslow, N.J. (2008). Differences in Female and Male Victims and Perpetrators of Partner Violence with Respect to WEB Scores. *Journal of Interpersonal Violence*, *23*(8), 1041-1055. https://dx.doi.org/10.1177%2F0886260507313969

Howard, M.O., & Jenson, J.M. (1999). Clinical Practice Guidelines: Should Social Work Develop Them? *Research on Social Work Practice*, *9*(3). 283-301. https://doi.org/10.1177%2F104973159900900302

IOM Displacement Tracking Matrix. (2019). Tropical Cyclone Idai Response Multi-Sectoral Location Assessment (MSLA) - Round 6 Chimanimani, Manicaland. https://displacement.iom.int/system/tdf/reports/Zimbabwe_DTM_Multi-Sectorial%20Location%20Assessemnt_April%202020%20rev.pdf?file=1&type=node&id=8979

Izugbara. C.O., Obiyan, M.O., Degfie, T.T., & Bhatti, A. (2020). Correlates of intimate partner violence among urban women in sub-Saharan Africa. *PLoS ONE 15*(3), 1-21 https://doi.org/10.1371/journal.pone.0230508

Jack, S., & Baxter, P. (2008). Qualitative case study Methodology: Study design and implementation for novice researchers. *The qualitative report 13*(4), 544-559.

Jacobson, N.S., & Gottman, J.M. (1998). Anatomy of a Violent Relationship. *Psychology Today, 31*, 60-69.

Janzen, S., McIntyre, A., Richardson, M., Britt, E., & Teasell, R. (2016). Building a Knowledge to Action Program in Stroke Rehabilitation. *Canadian Journal of Neurological Sciences / Journal Canadien Des Sciences Neurologiques, 43*(5), 619-625. https://doi.org/10.1017/cjn.2016.258

Jarnkvist, J. (2018). Fluid positions and changing strategies: a narrative analysis of how parents exposed to intimate partner violence talk about their contact with social services. *Nordic Social Work Research*, 1-12. https://doi.org/10.1080/2156857X.2018.1475298

Jewkes, R. (2002). Intimate partner violence: causes and prevention. *Lancet, 359*, 1423-29.

Jewkes, R., Dunkle, K., Nduna, M., Levin, J., Jama, N., Khuzwayo, N., Koss, M., Puren, A., & Duvvury, N. (2006). Factors associated with HIV sero-status in young rural South African women: connections between intimate partner violence and HIV. *International Journal of Epidemiology, 35*, 1461–1468. https://doi.org/10.1093/ije/dyl218

Jin, J-M., Bai, P., He, W., Wu, F., Liu, X-F., Han, D-M., Liu, S & Yang, J-K. (2020). Gender differences in patients with COVID-19: Focus on severity and mortality. *Frontieres in Public Health, 8*(152), 1-6. https://doi.org/10.3389/fpubh.2020.00152

Joy. E. (2019). "You cannot take it with you": Reflections on intersectionality and social work. *Aotearoa New Zealand Social Work, 31*(1), 42-48.

Kabore, A. (2017). Differentiating African and Western feminism through room symbolism. *Linguistics and Literature Studies, 5(*6), 408-416. https://doi.org/10.13189/LLS.2017.050603

Kadir, S.M.S.A., Yunos, K.R.B.M., Omar, A. H. H., & Hamid, D.T.A. (2013). The Daily Life Challenges Faced by the Researcher in the Arctic. *Procedia-Social and Behavioural Science, 90,* 764-771.

Kapiga, S., Harvey, S., Muhammad A.K., Stock, I.H., Hashim, R., Harven, C., Lees, S. & Watts, C. (2017). Prevalence of intimate partner violence and abuse associated and associated factors among women enrolled into a cluster randomised trial in north western Tanzania. *BMC Public Health, 17* (190). https://doi.org/10.1186/s12889-017-4119-9

Karakurt, G., Smith, D. & Whiting, J. (2014). Impact of intimate partner violence on women's mental health. *Journal Family Violence 29* (7), 693-702. https://dx.doi.org/10.1007%2Fs10896-014-9633-2

Kaur, S. (2016). Educational Status and Constraints of Rural Women in India: Evidence from a study of rural Punjab. *Research Journal Social Sciences, 24*(3), 70-84.

Kessides, C. (2006). The urban transition in sub-Saharan Africa: Challenges and opportunities, Environment and planning. *Government and Policy, 25*, 466-485.

Kelmendi, K. (2013). Violence against Women: Methodological and ethical issues. *Psychology, 4* (7), 559-565. http://dx.doi.org/10.4236/psych.2013.47080

Kimball, E. (2016). Edleson revisited: Reviewing children's witnessing of domestic violence 15 years later**.** *Journal of Family Violence, 31*(5), 625. https://doi.org/10.1007/s10896-015-9786-7.

Kirst-Ashman, K.K. (2007). *Introduction to Social Work and Social Welfare: Critical Thinking Perspectives* (2nded). California: Thomson/Brooks Cole.

Klugman, J. (2017). *Gender based violence and the law. World Development Report Background paper*. Washington: World Bank

Klugman, J., Hanmer, L., Twigg, S., Hasan, T., McCleary-Sills, J., & Santa-Mary, J. (2014) *Voice and agency; Empowering women and girls for shared prosperity*. Washington DC: World Bank.

Kulkami, S. (2019). Intersectional Trauma-Informed Intimate Partner Violence (IPV) Services: Narrowing the Gap between IPV Service Delivery and Survivor Needs. *Journal of Family Violence, 35*, 55-64. https://doi.org/10.1007/s10896-018-0001-5

Kumar, R. (2011). *Research Methodology: A step-by-step guide for Beginners (3rd ed).* London: Sage Publications Ltd.

Korstjens, I., & Moser, A. (2017). Series: Practical guidance to qualitative research. Part 2: Context, research questions and designs. *European Journal of General Practice, 23*(1), 274-279. https://doi.org/10.1080/13814788.2017.1375090

Kouyoumdjian, F.G., Findlay, N., Schwandt, M., & Calzavara, L.M. (2013). A Systematic Review of the Relationships between Intimate Partner Violence and HIV/AIDS. *PLoS ONE 8*(11). https://doi.org/10.1371/journal.pone.008104

Kovacs, R., Ndashe, S. & Williams, J. (2013). Twelve years later: how the Recognition of Customary Marriages Act of 1998 is failing women in South Africa. *In Marriage, Land and Custom: Essays on Law and Social Change in South Africa*. pp. 121–146.

Kovacs, R.J. (2018). The macro-level drivers of intimate partner violence: New evidence from a multilevel dataset. *Global Public Health, 13*(7), 944-956. https://doi.org/10.1080/17441692.2017.1317010

Kvale, S. & Brinkman, S. (2009). *Interviews: Learning the craft of Qualitative research interviewing (2nd ed).* California: SAGE Publication Ltd.

Lanier, C., & Maume, M. O. (2009). Intimate Partner Violence and Social Isolation Across the Rural/Urban Divide. *Violence Against Women, 15*(11), 1311–1330. https://doi.org/10.1177/1077801209346711

Leckning, B., Hirvonen, T., Armstrong, G., Carey, T.A., Westby, M., Ringbauer, A., Robinson, G. (2020). Developing best practice guidelines for the psychosocial assessment of Aboriginal and Torres Strait Islander people presenting to hospital with self-harm and suicidal thoughts. *Australian & New Zealand Journal of Psychiatry, 54*(9), 874-882. https://doi.org/10.1177/0004867420924082

Ler, P., Sivakami, M., & Monarrez-Espino, J. (2020). Prevalence and Factors Associated with Intimate Partner Violence Among Young Women Aged 15 to 24 Years in India: A

Social Ecological Approach. *Journal of Interpersonal Violence, 35*(19-20), 4083-4116. https://doi.org/10.1177%2F0886260517710484

Leung, L. (2015). Validity, reliability, and generalizability in qualitative research. *Journal of Family Medicine and Primary Care, 4*(3), 324-327. https://dx.doi.org/10.4103%2F2249-4863.161306

Lincoln, Y., & Guba, E. G. (1985). *Naturalistic inquiry*. Newbury Park, CA: Sage.

Lipton, M. (1977). *Why poor stay poor: A study of urban bias in world development*. Temple Smith: Harvard University Press.

Loh, J. (2013). Inquiry into Issues of Trustworthiness and Quality in Narrative Studies: A Perspective. *The Qualitative Report, 18*(65), 1-15.

Lopez-Sanchez, M.J., Belso-Martinez, J.A., & Hervas-Oliver, J.L. (2019). A Review of Economic Consequences and Costs of Male Violence Against Women. *Indian Journal of Gender Studies, 26*(3), 424-434. https://doi.org/10.1177%2F0971521519861194

Mackay, J., Bowen, E., Walker, K., & O'Doherty, L. (2018). Risk factors for female perpetrators of intimate partner violence within criminal justice settings: A systematic review. *Aggression and Violent Behaviour, 41*, 128-146. https://doi.org/10.1016/j.avb.2018.06.004

Mack-Canty, C. (2004). Third-Wave Feminism and the Need to Reweave the Nature/Culture Duality. *NWSA Journal, 16*(3), 154-179. Retrieved from https://www.jstor.org/stable/4317085

Made, P.A. (2015). *SADC Gender protocol 2015 Barometer Zimbabwe*. Johannesburg: Gender Links.

Madzudzo, E. (1997). Communal tenure, motivational dynamics and sustainable wildlife management in Zimbabwe. *Zambezia, 24*(2), 147-158.

Mago, S., Nyathi, D., & Hofisi, C. (2015). Non-governmental organisations and rural poverty reduction strategies in Zimbabwe. A case of Binga Rural district. *Journal of Governance and Regulation, 4*(4) 59-68.

Maguranya, B. (2011). Apostolic religion, health and utilization of maternal and child health services in Zimbabwe. Harare: Collaborating Center for Operational Research and Evaluation and UNICEF. Retrieved from https://www.unicef.org/zimbabwe/ZIM_resources_apastolicreligion.pdf

Mahenge, B., & Stockl, H. (2020). Understanding Women's Help-Seeking with Intimate Partner Violence in Tanzania. *Violence Against Women*, 1-15. https://doi.org/10.1177%2F1077801220914389

Malmqvist, J., Hellberg, K., Morlas, G., Rose, R., & Shevlin, M. (2019). Conducting the Pilot Study: A Neglected Part of the Research Process? Methodological Findings Supporting the Importance of Piloting in Qualitative Research Studies. *International Journal of Qualitative Methods, 18,* 1-11. https://doi.org/10.1177%2F1609406919878341

Mapuva, J. (2015*).* Skewed rural development policies and economic malaise in Zimbabwe. *Academic Journal Volume 7*(7), 142-151.

Marshall, C. & Rossman, G.B. (2011). *Designing qualitative research (5th ed).* Washington: SAGE publication Ltd.

Marshall, P.A., Adebamowo, C.A., Adeyemo, A.A., Ogundiran, T.O., Strenski, T., Zhou, J., & Rotimi, C.N. (2014). Voluntary participation and comprehension of informed consent in a genetic epidemiological study of breast cancer in Nigeria. *BMC Medical Ethics, 15*(38), 1-11. http://www.biomedcentral.com/1472-6939/15/38

Martinez-Torteya, C., Bogat, G.A., Lonstein, J.S., Granger, D.A., & Levendosky, A.A. (2017). Exposure to intimate partner violence in utero and infant internalizing behaviors: Moderation by salivary cortisol-alpha amylase asymmetry. *Early Human Development, 113*, 40-48. http://dx.doi.org/10.1016/j.earlhumdev.2017.07.014

Mascarenhas, M.D.M., Tomaz, G.R., de Meneses, G.M.S., Rodrigues, M.T.P., Pereira, V.O.M, & Corassa, R.B. (2020). Analysis of notifications of intimate partner violence against women, Brazil, 2011-2017. *Revista Brasileira de Epidemiol, 23*(1), 1-13. https://doi.org/10.1590/1980-549720200007.supl.1

Mashaphu, S., Wyatt, G.E., Gomo, E., & Tomita, A. (2018). Intimate partner violence among HIV-serodiscordant couples in Durban, South Africa. *SAMJ South African Medical Journal, 108*(11), 960-964.

Mashiri, L. (2013). Conceptualisation of Gender based violence in Zimbabwe. *International Journal of Humanities and Social Sciences, 3*(15), 94-103.

Mason, C.N. (2008). *Leading at the intersections: An introduction to the intersectional approach model for policy and social change*. Women of Colour Policy network.

Matavire, M. 2012. Interrogating the Zimbabwean traditional jurisprudence and the position of women in conflict resolution. A case of Shona tribes in Muzarabani district. *International Journal of humanities and social sciences, 2*(3), 218-223.

Mathhews, S., Jewkes, R. & Abrahams, N. (2014). 'So now I am the man': Intimate partner femicide and its interconnections with expressions of masculinities in South Africa. *British Journal of Criminology*, 1-18. Doi:10.1093/bjc/azu076.

Mazza, M., Marano. G., Janiri, L., & Sani, G. (2020). Danger in danger: Interpersonal violence during COVID-19 quarantine. *Psychiatry Research, 289,* 1-3. https://doi.org/10.1016/j.psychres.2020.113046

McCall, L. (2005). The complexity of intersectionality. *Journal of Women in Culture and society 30*(3), 1771–1800.

McCloskey, L.A., Boonzaier, F., Steinbrenner, S.Y, & Hunter, T. (2016). Determinants of intimate partner violence in sub Saharan Africa: A review of prevention and intervention programs. *Partner Abuse 7* (3), 277-315. http://dx.doi.org/10.1891/1946-6560.7.3.277

McCloskey, L.A., Williams, C. & Larsen, U. (2005). Gender inequality and intimate violence among women in Moshi, Tanzania. *International Family planning perspectives, 31*(3), 124-130. https://doi.org/10.1363/3112405

McDonough, J. & McDonough, S. (1997). *Research Methods for English Language Teachers*. London: Arnold.

McNabb, D.E. (2010). *Case research in public management.* New York: M.E Sharpe.

Meekers, D., Pallin, S.C., & Hutchinson, P. (2013*).* Intimate partner violence and mental health in Bolivia. *BMC Women's Health, 13,* 28-43. https://doi.org/10.1186/1472-6874-13-28

Merriam, S.B. (2002). *Qualitative research in practice: Examples for discussion and Analysis.* San Francisco, CA: Jossey-Bass.

Miller, J. (2006). A Specification of the Types of Intimate Partner Violence Experienced by Women in the General Population. *Violence Against Women, 21*(2), 1105-1135. https://doi.org/10.1177%2F1077801206293501

Miller, E., Decker, M.R., McCauley, H.L., Tancredi, D.J., Levenson, R.R., Waldman, J., Schoewald, P., & Silverman, J.G. (2010). Pregnancy coercion, intimate partner violence and unintended pregnancy. *Contraception, 81,* 316-322. https://doi.org/10.1016/j.contraception.2009.12.004

Mitchell, M.D., Hargrove, G.L., Collins, M.H., Thompson, M.P., Reddick, T.L. & Kaslow, N.J. (2006). Coping variables that mediate the relation between intimate partner violence and mental health outcomes among low income, African-American women, *Journal of Clinical psychology, 62*(12), 1503-1520. https://doi.org/10.1002/jclp.20305

Modie-Moroka, T. (2010). Intimate Partner Violence and Poverty in the Context of Botswana. *Journal of Psychology in Africa, 20*(2), 185-191. https://doi.org/10.1080/14330237.2010.10820362

Mokwena, K. & Adeoti, A. (2014). The prevalence of intimate partner violence in a sample of women attending a Public Hospital in North West Province, South Africa. *African Journal for Physical, Health Education, Recreation and Dance, September (Supplement 1:2)*, 313-323.

Monnete, D.R., Sullivan, J.J., & Dejong, C.R. (2005). *Applied Social Research: A tool for the Human Services.* California: Thomson Brooke/Cole.

Montesanti, S.R., & Thurston, W.E. (2015). Mapping the role of structural and interpersonal violence in the lives of women: implications for public health interventions and policy. *BMC Women's Health, 15*(100), 1-13. https://doi.org/10.1186/s12905-015-0256-4

Moono, P., Thankian, K., Menon, G.B., Mwaba, S.O.C., & Menon, J.A. (2020). Bride Price (Lobola) and Gender-based Violence among Married Women in Lusaka. *Journal of education, society & behaviour, 33*(8), 38-47.

Morris-Paxton, A.A., Reid, S., Ewing, R-M, G. (2020). Primary healthcare services in the rural Eastern Cape, South Africa: Evaluating a service-support project. *African Journal Primary Health Care & Family Medicine 12*(1), 1-7. https://doi.org/10.4102/phcfm.v12i1.2207

Morrrow, V. (2009). *The ethics of social research with children and families in Young LivesL: Practical experiences, Working Paper No. 53*. Oxford: Department of International Development.

Mueller, I., & Tronick, E.D. (2019). Early Life Exposure to Violence: Developmental Consequences on Brain and Behaviour. *Frontiers in Behavioural Neuroscience, 13*(156), 1-7. https://doi.org/10.3389/fnbeh.2019.00156

Mukamana, J., Machakanja, P., Zeeb, H., Yaya, S., & Adjei, N. (2020). Investigating the Associations Between Intimate Partner Violence and Nutritional Status of Women in Zimbabwe. *Research Square*, 1-23. https://doi.org/10.21203/rs.3.rs-49007/v1

Mukanangana, F., Moyo, S., Zvoushe, A. & Rusinga, O. (2014). Gender based violence and its effects on women's reproductive health: The case of Hatcliffe, Harare, Zimbabwe. *African Journal of reproductive health, 18*(1), 110-122.

Mukherjee, R. (2013). Ecofeminism- Role of women in environmental governance and management. *Galgotas Journal of Legal studies, 1*(2), 1-7.

Nadan, Y., Spilsbury, J.C., & Korbin, J.E. (2015). Culture and context in understanding child maltreatment: Contributions of intersectionality and neighborhood-based research. http://dx.doi.org/10.1016/j.chiabu.2014.10.021

Naturale, A. (2007). Secondary Traumatic Stress in Social Workers Responding to Disasters: Reports from the Field. *Clinical Social Work Journal, 35*(3), 173-181. https://psycnet.apa.org/doi/10.1007/s10615-007-0089-1

Netto, L.A., Moura, M.A.V., Queorz, A.B.A, Leite, F.M.C., & Silva, G.F. (2017). Isolation of women in situations of violence by intimate partners: a social network condition. *Escola Anna Nery, 21*(1), 1-8. https://doi.org/10.5935/1414-8145.20170007

Nowell, L.S., Norris, J.M., White, D.E. & Mailes, N.J. (2017). Thematic Analysis: Striving to meet the trustworthiness criteria. *International Journal of Qualitative methods, 16*, 1-13. https://doi.org/10.1177%2F1609406917733847

Nusbaum, L., Douglas, B., Damus, K., Paasche-Orlow, M., & Estrella-Luna, N. (2017). Communicating Risks and Benefits in Informed Consent for Research: A Qualitative Study. *Global Qualitative Nursing Research, 4*, 1-13. https://dx.doi.org/10.1177%2F2333393617732017

O'Campo, P., Smylie, J., Minh, A., Omand, M., & Cyriac, A. (2014). Conceptualising acts and behaviours that comprise intimate partner violence: a concept map. *Health expectations, 18*, 1968-1981. https://doi.org/10.1111/hex.12291

O'Campo, P, Zhang, Y.J., Omand, M., Velonis, A., Yonas, M., Minh, A., Cyria, A., Ahmed, F., & Smylie, J. (2017). Conceptualising intimate partner violence: Exploring gender differences using concept mapping. *Journal family violence, 32*, 367-382. https://doi.org/10.1007/s10896-016-9830-2

O'Neill, D. (1998). A post-structuralist review of the theoretical literature surrounding wife abuse*: Violence against women*, *4*(4), 457-490.

Oyediran, K.A. & Feyisetab, B. (2017). Prevalence and contextual determinants of intimate partner violence in Nigeria**.** *African Population studies, 23*(1), 3464-3477. https://doi.org/10.11564/31-1-1003

Palaganas, E.C., Sanchez, M.C., Molintas, M.V.P. & Caricativo, R.D. (2017). Reflexivity in qualitative research: A journey of learning. *Qualitative Report, 22*(2), 426-438.

Panda, P. & Agarwal, B. (2008). Marital violence, human development and women's property status in India. *World Development, 33*(5), 823-850.

Pasara, M.T., Mutambirwa, T.K., & Diko, N. (2020). The Trivariate Causality among Education, Health, and Economic Growth in Zimbabwe. *Sustainability, 12*, 1-15. http://dx.doi.org/10.3390/su12041357

Pastrana. F.A., Moreland, A.D., Milman. E.J., Williams, J. L., delMas, S., & Rheingold. A.A. (2020): Interventions for child and adolescent survivors of intrafamilial homicide: A

review of the literature. *Death Studies,* 1-14. https://doi.org/10.1080/07481187.2020.1805819

Patnaik, E. (2013). Reflexivity: Situating the researcher in qualitative research. *Humanities and Social Sciences, 2*(2), 98-106.

Patton, M.Q. (2002). *Qualitative research methods and evaluation methods (3rd ed).* California: SAGE Publications Ltd.

Payne, M. (1996). *Modern Social Work Theory*. London: Palgrave Macmillan.

Peterson, C. C., Riggs, J., Guyon-Harris, K., Harrison, L., & Huth-Bocks, A. (2019). Effects of Intimate Partner Violence and Home Environment on Child Language Development in the First 3 Years of Life. Journal of developmental and behavioral paediatrics. *Journal of Developmental and Behavioural Paediatrics, 40*(2), 112–121. https://doi.org/10.1097/DBP.0000000000000638

Pratto, F. (1996*). Sexual politics. The gender gap in the bedroom, cupboard and the cabinet: sex, power and conflict: evolutionary Feminist perspectives*. New York: Oxford University Press.

Randolph, J. (2009). A Guide to Writing the Dissertation Literature Review. *Practical Assessment, Research, and Evaluation, 14*(13), 1-14 DOI: https://doi.org/10.7275/b0az-8t74

Ratele, K. & Duncan, N. (Eds). (2003). *Social Psychology: Identities and Relationships*. Capetown: UCT Press.

Ravi, K.E. & Casolaro, T.E. (2017). Children's exposure to intimate partner violence. A qualitative Interpretive Meta-Analysis. *Child and Adolescent Social Work Journal* https://doi.org/10.1007/s10560-017-0525-1.

Rees, K., Zweigental, V. & Joyner, K. (2014). Implementing intimate partner violence care in a rural sub-district of South Africa: A qualitative evaluation. *Global Health Action, 7*(1), 1-12. https://doi.org/10.3402/gha.v7.24588

Rice, C., Harrison, E., & Friedman, M. (2019). Doing Justice to Intersectionality in Research. *Cultural Studies-Critical Methodologies, 19*(6), 409-420. https://doi.org/10.1177%2F1532708619829779

Richard-Milner, I.V.H. (2007). Race, culture and researcher positionality: Working through dangers seen, unseen and unforeseen. *Educational researcher, 36*(7), 388-400.

Riddell, T., Ford-Gilboe, M., & Leipert, B. (2009). Strategies Used by Rural Women to Stop, Avoid, or Escape from Intimate Partner Violence. *Health Care for Women International, 30*(1-2), 134-159. https://doi.org/10.1080/07399330802523774

Rigby, S.W., & Johnson, L.F. (2017). *The relationship between intimate partner violence and HIV: A model based evaluation, Infectious Disease Modelling*. Cape Town: Centre for infectious diseases epidemiology and research, University of Cape Town.

Rizo, C.F. (2015). Intimate partner violence related stress and coping experiences of survivors.' There is only so much a person can handle'. *Journal of family violence, 31*(5), 581-593. https://psycnet.apa.org/doi/10.1007/s10896-015-9787-6

Roberts, K., Dowell, A., & Nie, J-B. (2019). Attempting rigour and replicability in thematic analysis of qualitative research data; a case study of codebook development. *BMC Medical Research Methodology, 19*(66), 1-8. https://doi.org/10.1186/s12874-019-0707-y

Rollè, L., Giardina, G., Caldarera, A.M., Gerino, E., & Brustia, P. (2018). When Intimate Partner Violence Meets Same Sex Couples: A Review of Same Sex Intimate Partner Violence. *Frontiers in Psychology* 9(1506), 1-13. https://doi.org/10.3389/fpsyg.2018.01506

Roman, N.V., & Frantz, J.M. (2013). Intimate partner violence in the family: A systematic review of the implications of adolescents in Africa. *Family Practice, 30*, 256-265. https://doi.org/10.1093/fampra/cms084

Rotchford, A.P., Rotchford, K.M., Mthethwa, L.P., & Johnson, G.J. (2002). Reasons for poor cataract surgery uptake: A qualitative study in rural South Africa. *Tropical and International Health Journal, 7*(3), 288-292.

Rothman, J., & Thomas, J.E. (Eds.). (1994). *Intervention Research: Design and Development for human services.* New York: The Harworth Press.

Rothman, J., & Tumblin, A. (1994). Pilot testing and early development of a model of case management intervention. In Rothman, J. and Thomas, J.E. eds. *Intervention research: Design and development for human service*. New York: The Haworth Press, 215-233.

SADC Protocol on Gender and Development Monitor (2016). Harare: Southern African Research and documentation centre.

Sandberg, L. (2013). Backward, dumb and violent hillbillies? Rural geographies and intersectional studies on IPV. *Affilia, 28*(4), 350-365. https://doi.org/10.1177%2F0886109913504153

Santana, M.C., Raj, A., Decker, M.R., Marche, A.L, & Silverman, J.G. (2006). Masculine Gender Roles Associated with Increased Sexual Risk and Intimate Partner Violence Perpetration among Young Adult Men. *Journal of Urban Health, 83*(4), 575-585. https://dx.doi.org/10.1007%2Fs11524-006-9061-6

Saldana, J. (2009). *The Coding manual for Qualitative researcher*. London: Sage.

Sarantako, S. (1998). *Social Research (2nd ed).* London: Macmillan Press.

Sarkar, N.N. (2008). The impact of intimate partner violence on women's reproductive health and pregnancy outcome. *Journal of Obstetrics and Gynaecology, 28*(3), 266-271. https://doi.org/10.1080/01443610802042415

Schafer, J.A., & Giblin, M.J. (2010). Policing Intimate Partner Violence in Rural Areas and Small Towns: Policies, Practices and Perceptions. *Women & Criminal Justice, 20*(4), 283-301, DOI: 10.1080/08974454.2010.512226.

Schenk, R. (2004). Problems rural social workers experience. *Social Work/Maatskaplike Werk, 40*(2), 158–171. http://dx.doi.org/10.15270/40-2-340

Sexual Offences Act 8/2001. Harare: Government Gazette, Zimbabwe.

Shams, M., Kianfard, L., Parhizkar, S., & Mousavizadeh, A. (2020). Women's Views About Domestic Violence: A Qualitative Study in Iran. *Journal of Interpersonal Violence, 35* (17-18), 3666-3677. https://doi.org/10.1177%2F0886260517704959

Shamu, S., Abrahams, N., Zarowsky, C., Shefer, T., & Temmerman, M. (2013). Intimate Partner violence during pregnancy in Zimbabwe: A cross-sectional study of prevalence, predictors, and associations with HIV. *Tropical Medicine & International Health, 18,* 696–711. https://doi.org/10.1111/tmi.12078

Shamu, S., Shamu, P., & Machisa, M. (2018). Factors associated with past year physical and sexual intimate partner violence against women in Zimbabwe: results from a national cluster-based cross-sectional survey. *Global Health Action, 11*(3), 59-68. https://doi.org/10.1080/16549716.2019.1625594

Shamu, S., Zarowsky, C., Roelens, K., Temmerman, M., & Abrahams, N. (2016). High-frequency intimate partner violence during pregnancy, postnatal depression and suicidal tendencies in Harare, Zimbabwe. *General Hospital Psychiatry, 38,* 109-114. http://dx.doi.org/10.1016/j.genhosppsych.2015.10.005

Shamu, S., Zarowsky, C., Shefer, T., Temmerman, M., & Abrahams, N. (2014). Intimate Partner Violence after Disclosure of HIV Test Results among Pregnant Women in Harare, Zimbabwe. *PLOS ONE, 9*(10) 1-8. https://doi.org/10.1371/journal.pone.0109447

Sechele, L. (2016). Urban Bias, Economic Resource Allocation and National Development planning in Botswana, Department of Sociology. *International Journal of Social Sciences, 4* (1), 44-60. http://dx.doi.org/10.5296/ijssr.v4i1.8536

Shenton, A.K. (2004). Strategies for Ensuring Trustworthiness in Qualitative Research Projects. *Education for Information, 22*(2), 63-75.

Shenton, A.K., & Hayter, S. (2004). Strategies for gaining access to organisations and informants in qualitative studies. *Education for information, 22*, 223-231.

Sherry, E. (2013). The vulnerable researcher: facing the challenges of sensitive research. *Qualitative research Journal,* 13(3), 278-288. https://doi.org/10.1108/QRJ-10-2012-0007

Shields, S.A. (2008). Gender: An intersectionality perspective. *Sex Roles, 59*, 301-311. DOI 10.1007/s11199-008-9501-8

Shipman, M. (1997). *The Limitations of Social Research.* (4thed). New York: Longman.

Siemieniuk, R.A.C., Krentz, H.B., & Gill, M.J. (2013). Intimate Partner Violence and HIV: A Review. *Current HIV/AIDS Report, 10*, 380-389. DOI 10.1007/s11904-013-0173-9

Sikweyiya, Y., & Jewkes, R. (2011). Perceptions about safety and risks in gender-based-violence research: implications for the ethics review process. *Culture, Health & Sexuality, 13*(9), 10911102.

Sikweyiya, Y., Addo-Lartey, A.A., Alangea, D.O., Dako-Gyeke, P., Chirwa, E.D., Coker-Appaih, D., Adanu, R.M.K., & Jewkes, R. (2020). Patriarchy and gender-inequitable attitudes as drivers of intimate partner violence against women in the central region of Ghana. *BMC Public Health, 20*(682), 1-11. https://doi.org/10.1186/s12889-020-08825-z

Silverman, J.G., & Raj, A. (2014) Intimate Partner Violence and Reproductive Coercion: Global Barriers to Women's Reproductive Control. *PLoS Medicine, 11*(9), 1-4. https://dx.doi.org/10.1371%2Fjournal.pmed.1001723

Simon, H. (2009). *Case study Research in practise.* London: Sage publication Ltd.

Simon, P. (2011). Case study research: design and methods. *Evaluation & Research in Education, 24*(3), 221-222. DOI: 10.1080/09500790.2011.582317.

Snyder, H. (2019). Literature review as a research methodology: An overview and guidelines. *Journal of Business Research, 104*, 333-339. https://doi.org/10.1016/j.jbusres.2019.07.039

Snyder, R. (2008). What Is Third-Wave Feminism? A New Directions Essay. *Signs, 34*(1), 175-196. Retrieved from: https://www.jstor.org/stable/10.1086/588436

Solla, M.F.P. (2009). *Slavery and human trafficking: International Law and Role of World Bank. Discussion Paper*. Washington: World Bank.

Sprague, C., Woollett, N., & Hatcher, A.M. (2020). Enhancing agency for health providers

and pregnant women experiencing intimate partner violence in South Africa. *Global Public Health, 15*(12), 1820-1835. https://doi.org/10.1080/17441692.2020.1780290

Stake, R.E. (2000). *Case studies. In Norman K. Denzin & Yvonne S. Lincoln* (Eds*), Handbook of qualitative research*. Thousand oaks: SAGE,

Stewart, S. (2010). Working on a radical agenda, the Musasa project Zimbabwe. *Gender and Development, 3*(1), 30-35.

Strydom, H., Steyn, M.M., & Strydom, C. (2007). An adapted intervention research model: Suggestions for research and practice. *Social Work, 43*(4):329-342.

Swartz, S. (2011). 'Going deep' and 'giving back': Strategies for exceeding ethical expectations when researching amongst vulnerable youth. *Qualitative Research, 11*(1), 47-68. https://doi.org/10.1177%2F1468794110385885

Taylor, E. (2020). We Agree, Don't We? The Delphi Method for Health Environments Research. *Health Environment Research & Design Journal, 13*(1), 11-23. https://doi.org/10.1177%2F1937586719887709

Thurston, W. E., & Vissandjee B. (2005). An ecological model for understanding culture as a determinant of women's health. *Critical Public Health, 15*(3), 229–42.

Torraco, R.J. (2005). Writing Integrative Literature Reviews: Guidelines and Examples. *Human Resource Development Review, 4*(3), 356-367. DOI: 10.1177/1534484305278283

Tran, T.D., Nguyen, H., & Fisher, J. (2016). Attitudes towards Intimate Partner Violence against Women among Women and Men in 39 Low- and Middle-Income Countries. *PLoS ONE 11*(11), 1-14. https://dx.doi.org/10.1371%2Fjournal.pone.0167438

Turnbull, B. (2019). Interviews with women in India. *Qualitative Research, 19*(6),753-761. https://doi.org/10.1177%2F1468794118803837

USAID. (2010*).* Africa's Health in 2010: *Gender based violence in Sub Saharan Africa: A review of Demographic and Health survey findings and their use in National Planning.* New York: Academy for Educational Development.

Vanclay, F., Baines, J.T., & Taylor, N.C. (2013). Principles for ethical research involving humans: ethical professional practice in impact assessment Part I. *Impact Assessment and Project Appraisal, 31(*4), 243-253. https://doi.org/10.1080/14615517.2013.850307

Van Gelder, N., Peterman, A., Potts, A., O'Donnell, M., Shah, K.T., & Oertelt-Prigione, S. (2020). COVID-19: Reducing the risk of infection might increase the risk of intimate partner violence. *EClinical Medicine, 21,* 1-3. https://doi.org/10.1016/j.eclinm.2020.100348

Venganai, H. (2016). Negotiating identities through the 'cultural practise' of labia elongation among urban women Shona women in Zimbabwe. *Culture unbound: Journal of current cultural research, 8*(3), 306-324. http://www.cultureunbound.ep.liu.se/

Vergunst, R. (2018). From global-to-local: rural mental health in South Africa. *Global Health Action, 11*(1), 1-6. https://doi.org/10.1080/16549716.2017.1413916

Violence against women and Girls Resource guide (2014). Washington DC: World Bank.

Vukoicic, J. (2013). Radical feminism as a discourse in the theory of conflict. *Sociological Discourses, 3*(5), 33-49.

Wadji, D.L., Wanda, G.J.M.K., Morina, C.W.N., & Martin-Soelch, C. (2020). From the mother to the Child: The Intergenerational Transmission of Experiences of Violence in other–Child Dyads Exposed to Intimate Partner Violence in Cameroon. *Journal of Interpersonal Violence,* 1-31. https://doi.org/10.1177%2F0886260520948148

Walby, S. (1990). *Theorising patriarchy.* Oxford: Blackwell.

Walby, S., Armstrong, J., & Strid, S. (2012). Intersectionality in social theory. *Sociology, 46*, 224-240.

Walker, L.E. (1984). *The Battered Woman Syndrome.* United States of America: Springer.

Walker, A., Lyall, K., Silva, D., Craigie, G., Mayshak, R., Costa, B., Hyder, S., & Bentley, A. (2019). Male Victims of Female-Perpetrated Intimate Partner Violence, Help-Seeking, and Reporting Behaviors: A Qualitative Study. *Psychology of Men & Masculinities,* 1-11. http://dx.doi.org/10.1037/men0000222

Walsh, R.S., McClean, B., Doyle, N., Ryan, S., Scarborough-Lang, S-J., Rishton, A., & Dagnall, N. (2019). A Thematic Analysis Investigating the Impact of Positive Behavioral Support Training on the Lives of Service Providers: "It Makes You Think Differently". *Frontiers in Psychology, 10*(2408), 1-6. https://doi.org/10.3389/fpsyg.2019.02408

Walter, B., & Chung, D. (2020). How practitioners respond to men's use of intimate partner violence in rural areas. *Rural Society, 29*(2), 100-115. https://doi.org/10.1080/10371656.2020.1809785

Ward, J. (2006). *If not new: Addressing gender based violence in refugee internally displaced and post conflict settings*. New York: Reproductive Health for Refugees.

Warria, A., & Chikadzi, V. (2018). Guidelines for Social work spiritual counselling in human trafficking cases. *Journal of Social Development, 34*(2), 39-65.

Warria, A. (2018). Girls' innocence and futures stolen: The cultural practice of sexual cleansing in Malawi. *Children & Youth Services Review, 91,* 298-303. https://doi.org/10.1016/j.childyouth.2018.06.011

Webbermann, A.R., Brand, B.L., & Chasson, G.S. (2014). Intimate partner violence and mental health: Childhood maltreatment and intimate partner violence in dissociative disorder patients. European *Journal of Psych Traumatology, 5,* http://dx.doi.org/10.3402/ejpt.v5.24568

Wendler, D., Rackoff, J.E., Emanuel, E.J., Grady, C. (2002). The ethics of paying for children's participation in research. *Journal of Paediatrics, 2, 141*(2), 166–171. https://doi.org/10.1067/mpd.2002.124381

Wendt, (2009). Constructions of local culture and impacts on domestic violence in an Australian rural community. *Journal of Rural Studies, 25*, 175–184. https://doi.org/10.1016/j.jrurstud.2008.11.001

Wilson, I.M., Graham, K. & Taft, A. (2014). Alcohol interventions, alcohol policy and intimate partner violence: a systematic review. *BMC Public Health, 14***,** 881 https://doi.org/10.1186/1471-2458-14-881

Women's Right and Economic Change (2004). A tool for Gender and Economic Justice Number 9.

Woollett, N., & Hatcher, A. (2016). Mental health, intimate partner violence and HIV. *South African Medical Journal, 106*(10), 969-972. https://doi.org/10.7196/SAMJ.2016.v106i10.11410

Woolf, S., Schunemann, H.J., Eccles, M.P., Grimshaw, J.M., & Shekelle, P. (2012). Developing clinical practice guidelines: types of evidence and outcomes; values and economics, synthesis, grading, and presentation and deriving recommendations. *Implementation Science, 7*(61), 2-12. https://doi.org/10.1186/1748-5908-7-61

WHO. (2001). *Putting Women First: Ethical and Safety Recommendations for Research on Domestic Violence against Women*. Geneva: WHO.

WHO. (2005). *Addressing violence against women and achieving the Millennium Development Goals.* Geneva, Switzerland.

WHO. (2010). *Preventing Intimate Partner and sexual violence: Taking Action and generating evidence.* Geneva, Switzerland.

WHO. (2012). Understanding and addressing violence against women: Intimate partner Violence.

WHO. (2013). Global and regional estimates of violence against women: Prevalence and health effects of intimate partner violence and non-partner sexual violence. WHO: Italy World Bank

WDI Micro Poverty Outlook (2013).

Yazan, B. (2015). Three Approaches to Case Study Methods in Education: *The Qualitative Report, 20*(2), 134-152.Retrievedfrom http://nsuworks.nova.edu/tqr/vol20/iss2/12

Yin, R.K. (1984). *Case Study Research: Design and Methods*. Beverly Hills: Sage Publications.

Yin, R. K. (1994). *Case study research: Design and methods* (2nd ed.). Thousand Oaks, CA: Sage.

Yin, R.K. (2002). *Case study research: Design and methods*. Thousand Oaks, CA: SAGE Publications.

Yoshihama, M., Horrocks, J., & Kamano, S. (2009). The Role of Emotional Abuse in Intimate Partner Violence and Health Among Women in Yokohama, Japan. *American Journal of Public Health, 99*, 647-653, https://doi.org/10.2105/AJPH.2007.118976

Yuval-Davis, N. (2006). Intersectionality and Feminist Politics. *European Journal of Women's Studies, 13*(30), 193-209. London: Sage Publication.

Zakar, R., Zakar, M.Z., & Kraemer, A. (2013). Men's beliefs and attitudes towards intimate partner violence against women in Pakistan. *Violence against women, 19*(2), 246-268.

Zastrow, C. (2010). *Introduction to Social Work and Social Welfare: Empowering people* (10thed.). California: Brooks/Cole.

Zeitz, J. (2008). Rejecting the Center: Radical Grassroots Politics in the 1970s — Second-wave Feminism as a Case Study. *Journal of Contemporary History, 43*(4), 673-688. https://doi.org/10.1177%2F0022009408095422 .

Zimbabwe Civil Society's Shadow Report to the CEDAW Committee. (2012). Harare.

ZIMSTAT. (2016). Extended Analysis of multiple Indicator Cluster survey (MICS0 (2014). A Story of inequality and inequity in Zimbabwe. Harare: UNICEF

Zimbabwe Demographic and Health Survey 2010-2011. Harare: Zimbabwe National Statistics Agency

Zimbabwe Demographic and Health Survey. (2015). Key findings on Gender-based Violence. Harare: ZIMSTATS.

Zimbabwe National Family Planning Strategy (ZNFPS). 2016-2020. Harare: Zimbabwe National Statistics Office.

Zimbabwe National Gender Based Violence Strategy 2012-2015. Ministry of Women Affairs, Gender and Community Development.

Zimbabwe National HIV & AIDS Strategic Plan 2 (2011-2015). Zimbabwe agenda for accelerated country action for women and girls, gender equality and HIV.

Zimbabwe National Population Census. (2012). *National Report*. ZimStat: Harare.

APPENDICES

APPENDIX A1: PARTICIPANT INFORMATION SHEET (WOMEN RESIDING IN RURAL AREAS)

Title: Rural women's narratives of intimate partner violence

Good day Madam

My name is Cyndirela Chadambuka. I am a PhD student in Social Work at Wits University in Johannesburg (South Africa). I am conducting a research project for my studies on rural women's experiences of intimate partner violence in Zimbabwe. The aim of this research project is to hear your stories about your experience and then develop practice guidelines for social workers. As part of this project, I would like to invite you to take part in an interview. This activity will involve two interviews where I will be asking you some questions and will take around 45-60 minutes each. With your permission, I would also like to audio record the interview using a digital device. I will also be observing you whilst you are in your informal self-help groups.

You will not receive any direct benefits from participating in this study, and there are no disadvantages or penalties for not participating. You may withdraw at any time or choose not answer any question if you do not want to. The interview will be completely confidential. The information you give to me will be stored safely and not disclosed to anyone else. However, this may be breached if you require counselling, as I will have to make referrals. I will check with you if it is all right to get you necessary help. I will not use your real names when writing my final research report. The interviews will be at a time and place that is convenient to you. If you experience any distress or discomfort, we will stop the interview and resume later or another day. If you need require support or counselling services following the interview, I will be glad to make referrals to Bongai Chinamira (Social Worker) Chimanimani Rural District Office Tel.+263 26 2272/3, Mobile: +263 773 216 001.

If you have any questions afterwards about this research, feel free to contact me on:

Cyndirela Chadambuka (Email: 890270@students.wits.ac.za | Tel.: +263 783784051|+27 78 0000 418)

Further questions about the study can be sent to my research supervisor:

Dr. Ajwang Warria (on Email: Ajwang.Warria@wits.ac.za | Tel: +27 11 717 4482).

If you have any queries, concerns or complaints regarding the ethical procedures of this study, you are welcome to contact:

Shaun Schoeman at the University Human Research Ethics Committee (non-medical), on telephone +27117171408, or email:hrecmedical.researchoffice@wits.ac.za/ Shaun.Schoeman@wits.ac.za

Thank you in advance.

Yours Sincerely,
Cyndirela Chadambuka
Department of Social Work: PhD Candidate

APPENDIX A2: PARTICIPANT INFORMATION SHEET (SHONA VERSION)

Musoro: Kushungurudzwa kwemadzimai ari muwanano anogara kumaruwa.

Vadiwa Muzvare

Zita rangu ndinonzi Cyndirela Chadambuka. Ndirikuita zvidzidzo zveSocial Work paWits University iri kuJohannesburg kuSouth Africa. Ndine tsvagiridzo dzandiri kuita dzakatarisana nekushungurudzwa kwemadzimai ari muwanano kana mukufambidzana nevarume vavo kana vadiwa vavo vanogara kumaruwa. Tsvagiridzo iyi iri maringe nezvidzidzo zvandirikuita paWits University kuSouth Africa. Chinangwa chetsvagiridzo iyi ndechekuti ndikwanise kunzwa nhaurwa yenyu maringe nekushungurudzwa muwanano kana mukufambidzana nemudiwa wenyu kana murume wenyu. Chinangwa chiri chekuti tikwanise kugadzira gwara rakaanaka rinoita kuti maSocial workers anoshanda kumaruwa akwanise kukubatsirai zvakakwana. Naizvozvo ndirikukukumbirai kuti mundibatsire mutsvagiridzo iyi kuburikidza nekubvuma kuita nhaurwa neni iri maererano nekushungurudzwa kwamakaitwa muwanano kana mukufambidzana. Nhaurwa iyi ndichaipatsanura muzvikamu zviviri zvinotora maminitsi makumi mana kusvika pamakumi matanhatu (40-60 minitsi)

Hapana mugove wamurikutarisirwa kupiwa kubva mutsvakiridzo idzi and hamuna mhosva yamunenge mapara nekusabvuma kuva mutsvagiridzo ino. Makasununguka kubuda mutsvagiridzo idzi chero nguva uyezve kana makasununguka kusapindura mibvunzo yamunenge musina kugutsikana nayo. Ndichange ndichichengetedza nhaurwa yedu naizvozvo handikubvunzei zita renyu kana kubvunza mibvunzo inoita kuti zita renyu kana kwamunogara or mhuri yenyu ibude pachena. Zvamuchataura ndichazvichengetedza uye hapana mumwe wandinoudza. Kunyangwe zvakadaro ndikaona kuti muri mudambudziko rakanyanya kana kuti hamusi kunzwa zvakanaka ndichakukumbirai kuti tizivise vanokwanisa kukubatsirai vangava veukama. Makasununguka kuramba kana musina kusunungukirwa nekuti nditaure neveukama. Nhaurwa yedu tichaiita panzvimbo nenguva yakakufaranukirai. Kana musirikunzwa kugutsikana kana kusununguka tiri pakati penhaurwa makasunguka kutaura, zvakare ndinobva ndamisa nhaurwa. Kana muchida rubatsiro rwevana mukoti, mapurisa kana social worker ndinokubatsirai kutaura navo. Munogona kubata Bongai Chinamira (social worker wekuChimanimani) panhamba dzinoti. +263 26 2272/3 kana +263 773216001.

Kana muine mimbvunzo patinopedza nhaurwa iyi munogona kundibata pa Email: 890270@students.wits.ac.za | Runhare.: +263 783784051|+27 78 0000 418.

Kana muine mimwe mibvunzo maererano netsvagurudzo idzi makasununguka kufonera;

Muzvinafundo Ajwang Warria (pa Email: Ajwang.Warria@wits.ac.za | Runhare: +27 11) 717 4482)

Kana muine zvimwe zvichemo nemimwe mibvunzo maererano netsvagurudzo iyi munogonazve kubata Shaun Schoeman paUniversity Human Research Ethics Committee (non-medical), + 27(0)11 717 1408, kana paemail hrecmedical.researchoffice@wits.ac.za / Shaun.Schoeman@wits.ac.za

Ndatenda

Ndini wenyu akavimbika

Cyndirela Chadambuka

Department of Social Work: PhD Candidate

APPENDIX B1: INTERVIEW SCHEDULE (WOMEN RESIDING IN RURAL AREAS)

Title: Rural women's narratives of intimate partner violence

DEMOGRAPHIC INFORMATION

Pseudonym……. Age…….

Education: …… Marital Status…….

Spirituality/ Religion……. Village…….

INTERVIEW QUESTIONS

Objective 1: Exploring rural women's understanding of IPV

i. **Tell me about yourself. (How long have you been staying in this community?**
ii. What is your understanding of intimate partner violence?
iii. Can you tell me your experiences of IPV in your former relationship?

Explore:

- Frequency i.e. how often? Did you have children living in the home during that time?
- Form of violence e.g. physical, sexual, financial etc.
- Was it done in public or in private? Explore: if public, how did the bystanders react?
- Did you confide in anyone? If yes, who and why? If no, what were the barriers?
- Consequences: Explore: children, relationship etc.

Objective 2: Examining the role of culture in women's experiences IPV

i. What are the general perceptions of the community members regarding intimate partner violence?
ii. What role does culture have to play in advancing violence against women?
iii. How are women expected to behave when they experience violence within the relationship?
iv. What happens to men who abuse their wives?

Explore: accountability, heroes, denounced, law enforcement etc.

Objective 3: Exploring context-specific coping strategies that women in rural areas use.

i. How did you deal with the abuse in your former relationship/ marriage?

Explore: internal vs external coping mechanisms

ii. Could you share with me the support that you received from your friends/friends/community? If yes, what kind of support did you get?

iii. How is the community and families assisting victims of intimate partner violence?

Objective 4: Investigating support mechanisms for IPV victims/survivors

i. What support programmes/services are there to assist women who have been exposed to intimate partner violence? *Explore*: availability, accessibility, appropriateness

ii. What support services did you personally utilise when you were exposed to IPV?
Follow up questions: Why did you resort to utilising those services; What are the challenges that you faced when you tried accessing these support services?

iii. How can these programmes be structured better to assist more women? *Explore*: resources, sustainability, cultural-sensitivity etc

iv. In your opinion what should be done to prevent and control intimate partner violence in Chimanimani district?

v. Is there any question or issue that I have not mentioned that you feel is of importance and would like to share with me?

THANK YOU FOR YOUR PARTICIPATION

APPENDIX B2: INTERVIEW SCHEDULE (VAKADZI VEMUMARUWA) SHONA VERSION

Musoro we Tsvagurudzo: Kushungurudzwa kwemadzimai ari muwanano anogara kumaruwa.

DEMOGRAPHIC INFORMATION

Zita……. Makore ekuberekwa…….
Chikoro …… Wanano…….
Chinamato……. Dunhu……

INTERVIEW QUESTIONS

Objective 1: Exploring rural women's experiences of IPV

i. Mava nenguva yakareba sei muchigara mudunhu rino?
ii. Mukufunga kwenyu kana mazwisisire enyu chii chinonzi kushungurudzwa kwemadzimai ari muwanano kana mukudanana?
iii. Munogona kundiudzawo here zvamakasangana nazvo mukushungurudzwa nemurume wenyu?

Explore:

- Zvakaitwa kangani? Maigara nevana here nguva yamakashungurudzwa nemurume wenyu?
- Kwaiva kurohwa here, kubatwa chibharo, kana kunyimwa chouviri?
- Zvakaitwa pachena here kana pakahwandika? Explore: kana pari pachena vaive vakatarisa vaizviona sei uye vakaitei?
- Pane wamakaudza here? Kana mhinduri iri hongu, ndiani and makamuudzirei? Kana mhinduro iri kwete, chii chakatadzisa kusaudza mumwe munhu?
- matambudziko: *Explore:* vana, wanano, ukama nemhuri etc.

Objective 2: Examining the role of culture in women's experiences IPV

i. Sekuona kwenyu vanhu vari mudunhu rino vanoona sei nyaya yekushungurudzwa kwemadzimai ari muwanano nevarume vavo kana mukudanana nevadiwa vavo?
ii. Semafungire enyu magariro edu uye chitendero chedu chinokurudzira sei kushungurudzwa kwemadzimai?

iii. Vakadzi vanotarisirwa kuita sei kana vashungurudzwa muwanano kana mukudanana?
iv. Chii chinoitika kuvarume vanenge vashungurudza vakadzi kana vadiwa vavo?
Explore: kukumbira ruregerero, kubvuma kukanganisa, kushorwa,

Objective 3: Exploring context-specific coping strategies that women in rural areas use.

i. Mungona kundiudzawo here kuti makakwanisa sei kugadzirisa or kutsungirira kushungurudzwa muwananano yenyu kana mukudanana kwenyu nemudiwa wenyu?
ii. Makawana rubetsero here kubva kuhama neshamwari uye mhuri? Kana mhinduro iri hongu makawana rubatsiro rwakadii
iii. Dunhu rino nevagari vemuno varikubatsira sei vakadzi vanenge vashungurudzwa muwananao kana mukudanana?

Objective 4: Investigating support mechanisms for IPV victims/survivors

i. Nderupi rubatsiro kuwana vakadzi vanenge vashungurudzwa muwanano kana mukudanana? Explore: kuvapo kwerubatsiro, vanokwanisa kuwana here uye rubatsiro rwacho runiowirirana nepavanogara here
ii. Imi rubatsirwo rwamakatsvaga nderwupi pamakashungurudzwa muwanano kana mukudanana?
Follow up questions: Nei makasarudza kutsvaga rubatsiro irworwo? Munogona kunditaurirawo matambudziko amakasangana nawo pamakaedza kutsvaga rubatsirwo irworwo?
iii. Rubatsiro rwamuri kuwana kana mapurojekiti arikuitwa sekufunga kwenyu anogona kugadziriswa sei kuti anatsobatsira vakadzi vemudunhu rino varikushungurudzwa muwanana kana mukudanana? *Explore:* zvikwanisiro, anobatsira here, anoenderana nematambudziko emudunhu iri here etc.
iv. Mukufunga kwenyu chii chingaitwa kuderedza kana kupedza dambudziko rekushurungurudzwa kwemadzimai muwananano mudunhu rino?
v. Mune zvimwe zvamungada kuwedzera here kana zvamungada kubvunza maererano nenyaya yekushungurudzwa kwemadzimai muwanano kana mukudanana.

MAZVITA HENYU!!!

APPENDIX C: INTERVIEW SCHEDULE (KEY INFORMANTS: GOVERNMENT OFFICIALS)

Title: Rural women's narratives of intimate partner violence

Demographic information

Pseudonym:…… Age:……...

Training/Education: …… Work Experience…….

INTERVIEW QUESTIONS

1. What is your understanding of intimate partner violence?
2. Tell me about your professional work/ experience with women who have been exposed to intimate partner violence.
3. Can you explain to me the situation in Zimbabwe, particularly rural areas, for women who have been exposed to intimate partner violence?
4. What are the common forms of intimate partner violence that are reported to your office or that you hear of when you visit the rural areas?
5. How do these women in rural areas cope with the abuse from their partners?
6. Take me through the programmes that are in place in rural areas to assist the victims of intimate partner violence? Explore: inclusion of men in programmes, programme development and implementation, successful programming etc.
7. Take me through the challenges that you face when assisting women from rural areas who have experienced intimate partner violence? Explore: Reluctance to report, disclosure, cultural norms/ scripts etc.
8. In your own opinion what should be done to prevent and control intimate partner violence against women residing in rural areas in Zimbabwe?

Is there any question or issue that I have not mentioned that you feel is of importance and would like to share with me?

THANK YOU FOR YOUR PARTICIPATION!!!!

APPENDIX D: INTERVIEW SCHEDULE (KEY INFORMANT-NURSE)

Title: Rural women's narratives of intimate partner violence

Demographic information

Pseudonym:…… Age:……...

Training/Education: …… Work Experience…….

INTERVIEW QUESTIONS

1. How long have you been working in this district as a nurse?

   Follow up question. Are you originally from this community or district?
2. What is your understanding of intimate partner violence?
3. Can you share your experiences working with victims/ survivors of intimate partner violence in Chimanimani District? Explore: What is the common form of intimate partner violence that they are subjected to?
4. Can you take me through the coping strategies that they use to handle their situation (both negative and positive)?
5. Take me through the clinical intervention programmes that are in place to assist the victims/survivors of intimate partner violence in Chimanimani District? Explore:

   □ How do you handle cases that require a social worker or a counsellor/psychologist? □ Do your programmes also include men as the perpetrators/victims as well?
6. Take me through the challenges that you face when assisting women who would have experienced intimate partner violence?
7. In your own opinion what should be done to prevent and control intimate partner violence against women residing in rural areas in Zimbabwe?

   Is there any question or issue that I have not mentioned that you feel is of importance and would like to share with me?

THANK YOU FOR YOUR PARTICIPATION!

APPENDIX E INTERVIEW SCHEDULE (KEY INFORMANT-POLICE OFFICER)

Title: Rural women's narratives of intimate partner violence

Demographic information

Pseudonym……. Age……...

Training/Education: …… Work Experience…….

INTERVIEW QUESTIONS

1. How long have you been working in this district as a police officer?
   Follow up question. Are you originally from this community or district?
2. What is your understanding of intimate partner violence?
3. How many IPV cases do you deal with on average per month in Chimanimani District? Explore: How do you react? What is your average reaction time on receipt of an intimate partner violence complaint? What are the common forms?
4. Can you take me through the process you go through in responding to cases of intimate partner violence? Explore: Roles in dealing with IPV cases in the district? How do you deal with cases that require social work intervention / counselling?
5. Can you share the programmes that have been implemented to acknowledge and address intimate partner violence in Chimanimani district? Explore: Training on how to deal with intimate partner violence? Diverse programmes i.e. for victims and perpetrators etc.
6. Can you share the barriers/challenges (personal or systematic) that you face when assisting victims/ survivors of intimate partner violence? Explore: Evidence-gathering, arrests, working with headmen etc.
7. What is the most common misconception(s) held by communities you serve in terms of your policing of intimate partner violence complaints?
8. In your own opinion what should be done to prevent and control intimate partner violence against women in Zimbabwe?

   Is there any question or issue that I haven't mentioned that you feel is of importance and would like to share with me?

THANK YOU FOR YOUR PARTICIPATION!

APPENDIX F: INTERVIEW SCHEDULE (KEY INFORMANT-HEADMAN SABHUKU)

Title: Rural women's narratives of intimate partner violence

Demographic information

Pseudonym……. Age……...

Training/Education: …… Work Experience…….

INTERVIEW QUESTIONS

1. How long have you been a kraal-head in this village/community?

2. Take me through your understanding of intimate partner violence?

3. Can you share your experiences with IPV cases reported to your traditional court *dare*?

   Explore:

   Who reports (victims or perpetrators or family members) such cases to the traditional court?

- What is the process that you follow in dealing with an IPV case?
- Can you share any success story from your traditional court in terms of dealing with an IPV case reported?
- What do you think is the reason men inflict violence on their intimate partners?

4. What do you think should be done in dealing with IPV especially in rural areas?
5. How does culture ensure stability in homes/relationships?
6. How do you ensure that women are better protected in this community?
7. In your opinion what should be done to prevent and control intimate partner violence in Chimanimani district?

THANK YOU FOR YOUR PARTICIPATION!

APPENDIX G: OBSERVATION SHEET (SELF -HELP GROUPS OF WOMEN RESIDING IN RURAL AREAS)

Title: Rural women's narratives of intimate partner violence

DEMOGRAPHIC INFORMATION

Name of self-help group: …… Village……. ……

Number of members……. Date: …….

Items to Observe

Attendance……

……

Communication patterns (interactions, topics discussed) ……...

…….

…….

Activities engaged…….

…….

……

Other relevant observations…….

……

……

Comments……...

Signature (Researcher)……

APPENDIX H: CONSENT FORM FOR PARTICIPATION IN THE STUDY

Title: Rural women's narratives of intimate partner violence

Name of researcher: Cyndirela Chadambuka

I …… ……. agree to participate in this research project. The research has been explained to me and I understand what my participation will involve. I understand that my identity will not be disclosed and I will be assigned a pseudonym. I understand that my participation in this research is voluntary and I have a right to withdraw from the study anytime during the interview.

I agree that my participation will remain confidential (please circle)	YES	NO
I agree that the researcher may use my pseudonym to quote in her research report	YES	NO
I agree that the interview may be audio recorded	YES	NO

Name of participant…….

Date……

Signature……

APPENDIX I: CONSENT FORM FOR AUDIO-TAPING OF THE INTERVIEW FOR THE STUDY

Title: Rural women's narratives of intimate partner violence

Name of researcher: Cyndirela Chadambuka

I hereby consent to tape-recording of the interview.

I understand that:

- The recording will be stored in a secure location (a locked cupboard or password protected computer with restricted access to the researcher and the research supervisor). My confidentiality will be maintained at all times
- When the data analysis and write-up of the research study is complete, the audio-tapes will be destroyed two years after any publication arising from the study or six years after the completion of the study and there are no publications

Name of participant: .....

Date: .....

Signature: .....

APPENDIX J: CONFIDENTIALITY AGREEMENT FORM WITH INDEPENDENT QUALITATIVE ANALYST

Title: Rural women's narratives of intimate partner violence

Name of researcher: Cyndirela Chadambuka

I ……. have agreed to be an independent qualitative analyst in the above mentioned research study.

I agree to keep all personal information relating to participants and the study site that comes to my attention during the data analysis process in strict confidence

I agree to not disclose any information regarding this study unless authorised by the researcher.

I will disclose this information solely to individuals who have written approval from the researcher to receive this information.

Name of Qualitative Analyst: **…….**

Date: **.....**

Signature: **……**

Name of Researcher: **…….**

Date: **……**

Signature: **…….**

APPENDIX K: PARTICIPANTS' DEMOGRAPHIC INFORMATION (WOMEN)

Pseudonym	Marital Status	Age in years	Number of Children	Educational Level	Economic status
Mucha	Divorced	43	6	Primary School	Unemployed, reliant of subsistence farming
Charmaine	Divorced	24	2	High School	Unemployed and reliant on subsistence farming
Elsie	Widowed	32	2	High School	Unemployed and reliant on subsistence farming and selling honey
Lydia	Divorced	32	2	High school	Unemployed and reliant on subsistence farming
Sara	Divorced	34	2	High School	Unemployed and reliant on subsistence farming and selling honey
Rose	Divorced	38	3	Primary School	Unemployed and reliant on subsistence farming and selling baobab fruits and honey
Tendai	Divorced	40	4	High School	Unemployed and reliant on subsistence farming
Cecilia	Widowed	40	4	High School	Unemployed and relies on subsistence farming and selling honey, charcoal and baobab fruits.
Nancy	Divorced	19	1	High School	Unemployed and relies on subsistence farming
Maria	Divorced	26	2	High School	Unemployed and relies on subsistence farming
Martha	Divorced	35	2	High School	Unemployed and relies on subsistence farming
Agnes	Divorced	Approximately above 35 years. Not sure of her age, does not have a birth certificate	5	Primary School	Unemployed and relies on subsistence farming
Monica	Divorced	23	1	High school	Unemployed and relies on subsistence farming mainly gardening
Mirriam	Divorced	39	2	High School	Unemployed and relies on subsistence farming
Tracy	Divorced	49	2	High School	Unemployed, disabled and relies on subsistence farming
Fadzai	Divorced	47	1	High School	Unemployed and reliant on subsistence farming

Tsitsi	Divorced	42	4	High School	Unemployed and reliant on subsistence farming
Tariro	Divorced	41	4	High School	Unemployed and reliant on subsistence farming
Chipo	Divorced	28	1	High School	Unemployed and reliant on subsistence farming
Tambu	Divorced	33	2	High School	Unemployed and reliant on subsistence farming
Linda	Divorced	40	4	High School	Unemployed and reliant on subsistence farming
Dorothy	Divorced	35	4	Primary	Unemployed and reliant on subsistence farming and selling honey
Dorcas	Divorced	26	1	High school	Unemployed and reliant on subsistence farming
Lucy	Divorced	31	3	Primary School	Unemployed and relied on subsistence farming
Letty	Divorced	29	1	High School	Unemployed and reliant on subsistence farming

APPENDIX L: PARTICIPANTS' DEMOGRAPHIC INFORMATION (KEY INFORMANTS)

Key Informant	Level of professional Training	Years of Practice	Gender
Gender Official (Ministry)	Degree	3	Male
Gender Official (Chimanimani)	Degree	10	Male
Nurse (Ward)	Diploma	15	Male
Police (Ward)	Diploma	30	Male
Village Head 1	High School Education	30	Male
Village Head 2	High school education	20	Male

APPENDIX M: TRANSCRIBED INTERVIEW WITH WOMAN PARTICIPANT

CY: Thank you for agreeing to participate in this study. Are you currently in an intimate relationship or married to another man?

Lucy: No, I am currently not in a relationship, I stay with my kids and I am looking after them.

CY: Okay. What is your highest educational qualification?

Lucy: Grade 7

CY: Did you pass Grade 7?

Lucy: *(Chuckles)* It was not bad.

CY: So why didn't you further your education?

Lucy: I am an orphan and there was no money to fund further education.

CY: When did your parents pass away?

Lucy: My father passed away when I was one year and six months old. My mother is alive but she re-married. She lost her children to my father's relatives because they wanted money. So my mother gave them the children but the people who were responsible for paying out our father's money refused to give it to my relatives. Because of the abuse she endured, my mother did not bring the money to us but gave it to our uncles and they would buy sugar and other groceries. So money for school fees was little and we were four.

CY: So your uncle took care of you when your parents died right?

Lucy: yes

CY: It is okay. How old are you?

Lucy: I am 31 years old.

CY: How many children do you have with your previous husband and where they staying with you during the time you were abused?

Lucy: I have three children which I bore with my previous abusive partner. During the time I was abused I was staying with the children.

CY: Do you go to church and which church do you attend?

Lucy: Apostolic Independent Church

CY: You are from X village?

Lucy: Yes

CY: With your ex-partner how long have you been married?

Lucy: We got married in 2007 when I was 19 years old. I had my first child when I was 19 years old.

CY: How did you meet?

Lucy: We just dated when we were staying at home. Then we came together and because of our apostolic beliefs we influenced each other. He said he is an orphan and was also being abused and I was an orphan so we agreed to come together and help each other. I did not have anywhere to stay and I thought if I get married to an orphan too my life would change for the better.

CY: When you started staying together was everything fine?

Lucy: To be honest when we started staying together we were very fine. Conflicts came but at the very start of the marriage everything was fine without any problems until the girlfriend came.

CY: So when the girlfriend came that is when you started being unhappy in your marriage?

Lucy: Yes everything changed for the worst, there was no happiness it was tears after tears.

CY: When this person came into your marriage, how long had you been married?

Lucy: She came 2014

CY: She came recently then. On that note, could you share with me your understanding of IPV?

Lucy: In my own understanding, abuse of women in marriages includes being deprived of food to eat, means to fend for the children you bore together as a couple. The children become yours only and you will need to ensure that they are clothed and they go to school. Everything will be waiting for you so at the end of the day you will not even have time to rest or relax your body so that your mind can also rest. You will always be stressed thinking about tomorrow *(sighs and takes a deep breath).* It really stresses and worries a lot

CY: I am so sorry; I can see that you are hurt. We can always stop if you are uncomfortable to continue with the interview. Feel free to let me know.

Lucy: (*chuckles)* No it is not a problem, let us talk it helps. I am in pain because this is something that hurt me and I did not have rest even up to today. I do not have rest because I am the one fending for the children.

CY: Yes you will be trying to find food for the children. Can you share with me the circumstances that led to the current situation where you had to separate with your husband?

Lucy: Yes so that they can have something to eat and survive. Do you mean when I was abused by him when I was with him *(sighs and takes a deep breath)*

CY: Yes when you were abused by him. Did he beat you?

Lucy: He did not beat me as such but the problem started when he had the girlfriend. He would get in the house at 10 o'clock and sleep at 2 o'clock and he will be busy on WhatsApp. He would get into the house around 3pm for two minutes and go out again. I could not ask but it stressed me and I would think it is for that day only. It extended to many days until I decided to go back to my natal family. I thought if I go back to my natal family and we spend some time apart things will be better. When I was with my natal family that is when I heard that there is another woman and nothing had changed. I was even more stressed but I thought things would change. At his workplace, his bosses told him that he was not taking care of his family and did not know the woman that he was living with. He was then fired because of that. That is when he really started abusing me. He would look for small jobs and he would buy cool drinks and nice food, the children would be hungry and crying. They would cry by the door while he locks himself inside the house and eat the food alone without even giving the children anything.

CY: So he would lock himself with the girlfriend and eat while the children are outside crying?

Lucy: Yes, the children would be outside crying and calling his name.

CY: This is not right what he did to his children

Lucy: Yes. Things got even worse, my children were not going to school. The older one who was in grade three did not even attend the grade three academic year. He even said the children are not his until the volunteer community members who deal with child abuse and the village head intervened because they knew the children were his. He would say I do not have children with this woman, mine is the one that this woman (his girlfriend) is carrying. So the village head and other community members who deal with child abuse saw the way the children were living and decided that the they were too young to just sit at home and not go to school. But he still insisted that the children were not his.

CY: So what happened to the children that were not going to school?

Lucy: I was now staying with the children at home. They came (village head and the community members) and instructed me to take the children to the headmaster of the local school. The headmaster already knew my story; he had heard about the child abuse. So he indicated that he could not do anything on his own but had to consult with the school committee. So the school committee indicated that they knew the situation and the headmasters told them that it does not matter that they do not have pens or anything they should be in class. I was advised to go and look for piece jobs and to buy

books for the one who was in grade three followed by the one in grade one. I managed to raise money for the books but then school fees became a problem and I was very stressed I was now moving from one-piece job to another. It was hard and the children had to go to school looking clean. The headmaster had advised me to get soap so that the children would come to school clean. I do not know what he (the father) thought when he saw the children going to school. Some people were saying it is a problem, the abuse that the children and the mother are enduring, it's better to go and report to the police so that he can pay maintenance for the children. I could not go there because I am an orphan and I do not have a national identity card. My ex-husband then disappeared. He disappeared for two years and he never send food or even money and we did not know where he was.

CY: So the police could not help you because you did not have a national identity card?

Lucy: Yes. At the police station I was told to go to the maintenance office in town Y but the national identity number was required. I did not have money to go to town Y so I went to the nearest growth point. I could not pursue it further because I did not have money and did not even know what to do.

CY: So in everything that happened there was no physical violence only actions?

Lucy: He did not physically abuse me per se but he would insult me and shout at me a lot. When it comes to beating me he would threaten to kill me with an axe but he never took the axe to beat me. He would just insult me but some of the words were too deep. Sometimes I would feel like I am being insulted because I am dumb and I would keep quiet. So where he disappeared to, things didn't work out and he came back. When he came back I had asked the headmasters to take my children and I promised to work for the school fees at the school. The headmaster gave me a job to clean and cook at the school as well as watering flowers so that I can pay school fees for my children. So I would cook and clean at the school, and the following day I would be doing other piece jobs at home so that I would also be able to buy soap. We were many so we would work in shifts. When he came back my children were already in school. The one in grade one was already doing well in school and was in the top 10 but before that he was very disturbed. In the first term this child was last in the class and the second term he was number 14 and third term he was number four. That's when I realized that things were now better and even my mind was at peace.

CY: You mentioned that he would insult you. Did he insult at home behind closed doors or anywhere even in public places?

Lucy: He would shout at me at home, there were no people around. But you know if people know that you are arguing they would want to intervene. So they would take him and advise him to send me away but I would say I am not going anywhere. I grew up as an orphan and I did not want my children to grow up as orphans when he is alive. He started fixing me thinking I will leave but at that time I vowed that I will not go anywhere. So when he came back for 5 months he was abusing me and I went to report again at the police station. They asked me if I wanted him to be arrested or I wanted him to take care of the children. They advised me to go to town Y, and I told them that I did not have money to even buy a bar of soap so that my children can bath so the money to town Y I would use to pay school fees. I thought I would get there and nothing happened because I do not have a national identity card, I only have a birth certificate and I took it recently so the issue of going to town Y kept worrying me. They told me that for my issue to be solved I have to go to Town Y and I told them I do not know anything and I had come to tell them my problem and they were supposed to take the information there so that my problem can be solved. They told me it does not work like that. I went back home and when he heard that I had gone to the police he disappeared and went to stay at a certain place, that is where he is still staying and it is not too far from here. He started working there and I thought maybe month-end he would give me something. Even if he gave me USD10 I am the one who knew that there is a need to buy soap, pay for school because there is a donor who had given us maize. *(claps her hands)* Ahh when he got paid he never gave me his money. The shop owners would tell me that he would come at around 7pm and buy fish and go home *(sighs*)

CY: He will be giving the new wife?

Lucy: Ahh they were always together even up to now they are always together, people who see them together tell me. They would wash the plates together, do laundry together and this he never did with me when we were still together. He never said to me let me go and look for relish since you are busy doing laundry. I knew that after finishing laundry I had to go and look for relish for my husband. I knew that my husband had to eat on time. But the way he was treating me those days, I would just look at him and cry but I would just say God help me.

CY: So with the abuse that you endured, did you seek support from anyone, I know you mentioned the police but besides them did you seek assistance or even just talking to someone so that you feel better?

Lucy: Yes. You just see that in the community that they are elderly women who are wise and can give good advice, So I would talk to those elderly women and they would tell me that, that is life and it is normal in marriage. They would advise me to endure not to think about suicide because if I kill myself what will become of my children.

CY: So what really caused the divorce between you and your ex-husband?

Lucy: (*sighs*) Ahh I was tired of being of abused. We can say he left me when he brought home his current wife but I do not care about him anymore. I was abused a lot and I lost a lot of weight but I accepted and right now I am only concerned about my children. He can stay with his wife what I only want is for him to provide for the children but he does not care about them even when we were together.

CY: You mentioned that he would not give the children food, did he verbally abused them as well through shouting or insulting them?

Lucy: *(chuckles)* Especially the second born, he does not even want to see this child because the child loves me a lot. Everything that he wants he comes to me even if it is a school bag or pencil he would come to me and when the child asks the father for anything he would say he doesn't have money even up to now. When the child comes to me I would look around for 50cents so that he can buy a pencil. So the child knew that my mother can provide for me so he would tell me everything instead of the father. Even up to now my child is afraid of the father. If he sees the father coming from that direction, he comes running to me and tell me that he saw his father coming from that direction)

CY: So are all the children afraid of their father?

Lucy: Yes. The father would just pass by and never bothered to see the children. So it would stress me a lot and even up to now if he sees the older one he tells him that after Grade 7 he am going to take him to his workplace because his boss has a lot of cars and wants the child to learn how to drive. He is abusing the child again telling him that his education should end at grade 7. This child does not even listen and when I try to talk to me he doesn't even listen anymore. Monday to Friday I will be with this child, making sure he is bathed, his uniforms are clean and on Friday he disappears and goes to his father and its quiet far for child to walk alone. He tells him to come so that they can fix cars.

CY: So in other words the father is now using the child to do his own jobs at his workplace?

Lucy: Yes exactly. The child would come on Sunday covered in dirt. He leaves the dirty uniforms with me to wash, so I would take a certain shrub and when you crush it becomes soapy with foam and I use that to wash the uniforms. This child takes the

uniform and goes to school leaving the dirty clothes with me and I wash them as well. This child does not help me with anything, he used to before he started going to his father's place. If go for a piece-job, I would find the youngest child bathed and he would cook food. But so far I am always stressed because if I want to go for piece jobs on a weekend I do not have anyone to leave the child who is in grade 2 and the other who is 3 years only.

CY: You mentioned that your ex-husband is an orphan. Does he have other relatives?

Lucy: There is an uncle where I once reported this issue when we were still together. This uncle came and instructed me to leave my round hut where I had built and told me to go back to the family home where my ex-husband and the current wife were staying. He told me that regardless of what happens, no matter the struggles I will go through I should never ever leave my husband's family with the children.

CY: Do you know why he would say you must never leave your husband's family?

Lucy: I am not sure. Even up to today I think about that uncle' instruction that I should never leave my husband's house and he sounded like it was going to be fine but it was never fine till I left. I am not thinking of getting back with him, our union ended.

CY: So could it be that the uncle's instruction gave you hope to endure for some time?

Lucy: Yes I was hopeful that God if this marriage is mine it is mine, if it is not mine this man will leave me for good but at that time I did not have anywhere to go.

CY: Given your IPV experiences and in your own opinion what are the general perceptions of community members regarding IPV?

Lucy: People in this community believe that abusing your partner is wrong but there are some that believe a wife is supposed to be beaten and insulted. They are also helpful I will not take that away from them. One December one community member after seeing how my children and I were suffering asked me to come and work in her field in exchange of books for school, some would give me 4 of 5 books for children from nowhere, some would come to me and me USD5 so that I can add to what I have and buy uniforms or even clothes for the children. Some would say I do not have much to give you but I can give you a cup of sugar or mealie meal. All his was to help me so that my children can survive so I can safely say in my case the community was and is still helpful.

CY: Sorry to take you back a bit, did your ex-husband pay the bride-price for you?

Lucy: No he did not

CY: Did he ever say anything about that?

Lucy: During the first days of our marriage he would say I am looking for the money because when we got married he was not working. I gave birth to my first child and he was not working, When I had my second pregnancy that is when he started working. When he started getting money that is when all these problems started. I do not remember him saying anything about paying bride-price when he started working.

CY: Do you think that this could be the reason why he abused you because he did not pay the bride-price to your family?

Lucy: I am not sure because this person was cruel. I think if he had paid the bride-price he would even do worse, like killing me because he would have paid bride-price and thinks he is untouchable.

CY: I am sure that you know that in the Shona culture mostly women are expected to listen and respect their husbands just like what your ex-husband's uncle said that you should stay at home and not leave your husband. So in your own opinion, how do you think culture advances or reduces IPV?

Lucy: I think it contributes but again it depends with the person because there are other men who take care of their wives and follow the cultural norms at the same time. There are certain things that are expected of a wife in the Shona culture. I did those things but still I was abused. I asked myself why he left me for another woman because I also did labia elongation but when we were together I never saw him using those things so I wondered what exactly he had seen in the other woman. If had not done labia elongation, I would have thought maybe the woman has done it but I also had done it. During our gatherings in our informal self-help groups on *chisi* day I would even ask the older women why they told us that men like pulled labia in the bedroom yet they do not use it. But they told me that the men also need training on how to use the pulled labia for sexual pleasure. So I gave birth to all my kids but I never saw that man using it. I do not know what he was given that made him hate me. So sometimes following cultural norms does not actually protect one from abuse because I believe abuse is within and a person chooses to abuse or not to abuse his partner.

CY: So in a nutshell are you saying these cultural norms are helpful or are not helpful to women?

Lucy: It is helpful to those who know but sometimes sticking to these social norms does not help especially in my case. I thought that maybe he is disgusted by the sight of it. If you get married, you husband during the first days should tell you about their tradition. He can tell his aunts who can teach you on how to adhere to their norms in the marriage. It

is like labia elongation; we have in my mother's culture. I have a good size but where my mother comes from they have very big sizes you can even make a rope from their pulled labia *(laughs naughtily).* When we are bathing with other women at the river I actually consider myself better and laugh at other women who did not pull their labia. So after following these cultural norms you actually do not understand where the problem is because even my reproduction role I performed well I gave him three children. I did not even have any complications that would cost money, I gave birth smoothly and never had any difficulties. So I think these cultural norms are not helpful sometimes when it comes to being abused.

CY: So we can say it is the nature of men to abuse women?

Lucy: Yes, it is their nature because my ex-husband when he was asked he would say he is like his father. Yes, his father loved women but from what I heard he would pay bride-price for all the women. Even if you want to leave the marriage, you would leave but he would have paid the bride-price. So if you want to follow your father's footsteps, no one will stop you but go and pay the bride-price. The uncles even advised him to pay the bride-price. So to me, men willingly abuse women because it is their nature and they choose to treat us as dirt.

CY: From what you have said I can see that you did not experience any sexual abuse, am I right?

Lucy: Yes, I did not have any problem and I was not abused sexually. But when this woman came he never came into my bedroom again. Actually, I was deprived of my conjugal rights.

CY: So in your opinion why did he stop having sex with you when the woman came into your marriage?

Lucy: I consulted prophets from our church and they told me that she used some love-portions and witchcraft so that he can forget about me up to an extent that even if he sees me he will not see me as his wife but as another men and that is why he did not want to have sex with me.

CY: I will get back to this issue but for now I just want to take you back a bit, you mentioned before that the village head and some community members intervened but you did not give me detailed information on how they intervened. Did the reprimand your husband or took him to the traditional court?

Lucy: They tried. Some community members stopped helping me because he was holding a grudge against them because they had advised him to take care of his family. They told

him that he should take of his wife even if he takes a second wife and told him that it was better if he had taken his second wife from the community. They gave him an example of the elders of the Apostolic Independent churches who have 4 or 5 wives but still take care of them and do not abuse them and have a good relationship with their children. They even told him that he cannot reject his other children and only accept the unborn child of his second wife because a child is a gift from God. That is when he started saying the children are his and even when the children passed, I heard people saying he was even bragging about it. He was bragging but in terms of food or uniforms or school fees he was doing nothing. I would rather walk naked without underwear while my children have a good life.

CY: So you did not have a problem with polygamy?

Lucy: I did not have any problem with polygamy. I had accepted it because when I got wind of the relationship I knew if I said I do not want to see the woman here he was also going to leave with the woman. So I told myself that if he wants the woman he can take her and we stay together as a family. But he loved her more and there were inseparable, I was nothing to him anymore, there was no love.

CY: Did you report the abuse to the village head?

Lucy: No I did not report the abuse, I only reported when he disappeared and that is when I was added to the list of widows, the elderly and orphans who were receiving assistance so that I could get assistance.

CY: Was your natal family aware that you were being abused?

Lucy: They knew but not much; I did not share the deep stuff with them

CY: Why? I am not saying it is mandatory that you tell them but I would like to know the reasons why you did not share everything with them

Lucy: I did not share because it is my brother, I am the only girl in our family. I was going to end up staying with my sister-in-law and I felt that my children will be insulted because of my situation and thought that it was better to stay. I was afraid that if I tell him he would say come home because he is my brother but most of the time he will be at work and I will be left with his wife. What was going to happen in his absence he would not know even what she was going to do to my children because relations can be easily ruined by children so I thought it was better to stay in the abusive marriage.

CY: very few can accept and cope……

Lucy: (*interrupts*) Yes, especially the young wives would say this would never happen to me I would have left, women would say if it was me I would have 70 or 80 boyfriends but

at that time I realized that it was not going to help. I was going to risk my health yet I still wanted to take care of my children. So I found it better to go door-to-door knocking looking for work even and would ask them to share their food with me. They understood my problem.

CY: So how did you cope with abuse and what made you endure?

Lucy: For me when I looked at my children I would say God the suffering that I am going through, I know there are old women out there who are sitting on comfortable sofas because of their children. I wanted to do everything for my children with the hope that God will remember them and open doors of opportunities for them in but if I am selfish these children will not be able to take care of me in future. So I told myself that I will be strong because my children have somewhere to sleep at least and I can work for them. It is better I wear torn shoes but my child gets everything. It is their right to ask for anything from me. I will also have that right when they are grown because they will remember me as the mother who took care of them. God willing these children will bring me peace one day.

CY: Amen. Did prayers or church help in coping with the abuse?

Lucy: Yes, I was hopeful that if I prayed and share my problem with the pastors it would get better because they would also pray for me. I would be at peace even if my heart is heavy, church and prayers gave me peace. Also, I was given prophecies that his actions were because he had been bewitched and given love potion so I prayed about it and hoped that all was going to be okay. Nothing changed at the end though.

CY: Have you ever gone for counselling or you go to your friends and relatives?

Lucy: I have never met professional counsellors. I would go to the elderly women and I share my problem with them the they 'counsel' me and I would actually see that counselling is helpful and I took heed of their advice.

CY: Was the counselling that you got from the elderly women helpful?

Lucy: During the first day I did not know that a woman has to work and can be independent. I would wait for moth-end so that the husband can give me something. When these women counselled me that is when I realised that I can work and fend for my family. Along the way I realized that the way I was providing for my children through odd jobs, if my husband was giving me money on the side, I would be somewhere I do not have anything but through doing odd jobs I can provide for my children on my own.

CY: So can we say the piece-jobs helped you in coping with the abuse when you were still with your ex-husband?

Lucy: Yes, I knew that if I cannot be given money I can get a bar of soap or cooking oil from odd jobs so that I can cook for my children. I cannot cook without salt; my children will not eat I used to do that a lot. Being able to do odd jobs was very helpful during that time otherwise we would have died because he never gave us food or anything.

CY: In this community are there projects that are being done to assist abused women including current victims of IPV?

Lucy: There is not a single project in this community that is aimed at assisting IPV victims and survivors. Not even one my sister.

CY: On that note, how should IPV victims and survivors can be helped in this district?

Lucy: I wish we could have capital or small projects where we can engage in income-generating projects like goat-rearing projects. Things that you can do at your house are even much better. What I realized during the time I was abused is that when you have something that you are doing to feed your family you will not be affected too much with stress. If you are waiting to be given money and everything by him they will surely abuse you. So it is better that women are empowered so that they can be financially independent and be able to take care of their children because it is the children that suffer the most.

CY: You mentioned that children suffer at the end, in your opinion what should be done to ensure that children are not left vulnerable?

Lucy: In my own situation, I wish I had a national identity card then I would be able to apply for maintenance. My children cannot even play with other children because they wear torn clothes and when the other children see the torn shorts they will jeer at them. At the end my children are not even comfortable playing with other children. So when I do odd job I make sure I pick a few second hand clothes and next time I will focus on the food. So I think even when the parents are fighting its better they hide it from the children because even these men that abuse they too have seen their parents fighting when they were young.

CY: What about the men that are neglecting their families in general what do you think should be done?

Lucy: The law should make sure they are arrested and for us women living in rural areas we would require assistance because some of these things we are not even aware of. So if I am advised to go to town Y for maintenance I do not even know where to start from. Men should just take care of their children. For example, if he earns US$100, I have children going to school all three of them and if he gives me US$60 I will know that

US$30 has to go for school fees and US$20 can cover groceries so that we survive. But if he takes all the money what will happen then?

CY: So the three-year-old is going to crèche and when you went for odd jobs during the period you were abused did you go with any children?

Lucy: I would leave the children with other people I would pay them with anything that I have even one dollar.

CY: In your own opinion how can we end IPV against women?

Lucy: I am not sure but I wish there were people who could offer professional counselling in this community. Yes, a man can have two wives but should not forget the other family. What is more important is to provide for the family not abuse the children.

CY: You mentioned that you were stressed and did not have any peace even up to now. This is not healthy and very dangerous to your wellbeing. This stress can lead to depression or suicide ideation which the elderly women vehemently advised you not to consider. After our interview I am willing to share contact information of the social worker that can assist your further with counselling if you need it. On that note, you also mentioned that you went to the police and you really stay far from the road where you can get public transport to the police station so I am wondering how did you get to the police?

Lucy: I walked to the bus station. It does not matter it is raining or very hot we walk; we are used to but if you are sick it is not a good a good idea to walk this distance otherwise you die *(laughs).* So where I grew up my aunt had passed away and I spend a whole year without going there to see where she was laid to rest. So when it rained I did some piece jobs in people's fields and I got some money and decided to go and see where my aunt was laid to rest. While I was in the process, my ex-husband started to abuse me, insulted and even wanted to beat me together with his wife. I was saved by the village head who came and intervened. The village head's wife came and acknowledged that there was a big problem. We had a church service at home and I shared my problems with the church elders and they told me that they tried to intervene but they had given up. So they advised me to go to the police and report the abuse. Even my ex-husband's aunts and relatives advised me to go to the police.

CY: So who gave you the money to go to the police station?

Lucy: I used the money from the piece jobs and the village head's wife gave me one dollar. our church bishop gave me US$2. They gave me because they did not want me to use all the money from the piece jobs.

CY: What did the police say?

Lucy: When I got to the police station at the gate they asked me if I wanted to make a report and I said yes and they said go to the court. I went to another woman and told her that my husband was abusing me and was neglecting the children. She asked me if I want him to be arrested and I said to her it will not help me much because he will stay in jail for even three years. I just wanted him to take care of the children. I asked the police-woman if they provide counselling or if they can summon my husband and try to talk to him as people of the law. The police-woman took me for a fool and she said you have go to the maintenance office at the passport office. She said they do not handle maintenance issues, they only deal with robberies and murders. She further mentioned that they do not deal with domestic issues. I did not have money to go to court. The court officials were going to end up blaming me because at some point I was not going to go for court hearing because I did not have money to travel.

CY: Have you ever sought help from social workers?

Lucy: What do you mean by social workers?

CY: Okay, in simpler terms I can say social workers work closely with government and non-government organizations, for example, to help people who experienced or who are still experiencing IPV. They can link you with other service providers if there is need like maintenance in your case. They do offer professional counselling that you were talking about and a lot of things. You can also find them in police stations as well.

Lucy: I have never met these people and I do not know anything about them.

CY: You mentioned that they are welfare people in this community who deal with child abuse issues, how do they help other community members?

Lucy: They just come and go to the village heard and ask them to write names of the elderly in the community and we just go and get the things. We have never met the people

CY: So social workers are a new thing to you?

Lucy: It is new but if they help people like us why is that we do not see them here? It means they are only in towns but here people are being abused by men and after the abuse you get HIV/AIDS. If they help they should also come here.

CY: I understand and I will explain further about social work after the interview. So during the time you were abuse if a child gets sick or you were abused and wanted medical how did you go about it?

Lucy: My child was injured and I had to carry him on my back from that side ….

CY: (*interrupts)* You carried your child from home, how many kilometres from your home, I think 5 or 6 right?

Lucy: Yes, it is far and the road is steep and bushy, I came with the child and I shared my problem with one shop owner who gave me money to go to the clinic. I went to inform the school headmaster that I was taking my child to the clinic.

CY: Was the father aware?

Lucy: That is the time he disappeared. I was on my own and I did everything by myself and I just followed the instructions of the nurse because his leg was too swollen but he got healed eventually.

CY: So when he eventually heard about the injury, what did he do or say?

Lucy: No action.

CY: When you were pregnant, did he support you?

Lucy: He was helpful when I had the first child. I had the second child when he was working and I was hoping that I will dress my new-born in new clothes but no that is when he started being unfaithful, he never helped me. He would spend money with his girlfriends. When I gave birth to my second child I had to go to Marondera where he was working with a 10-day-old child. There was no food at home. He has sold all the maize because I was not there, I had gone to some elderly local 'midwife' who assisted me when I gave birth.

CY: So you did not give birth in a hospital and he did not give you money?

Lucy: He did not give me money, a local elderly woman helped me. That elderly woman told me that she had done her part and should go home. I got home with a newly born baby and there was nothing except buckets of water. He sold the maize and all the food. So I started living on handouts and moving door to door. I realized that it is better to borrow money and follow him with the child. He really neglected me and his children a lot.

CY: Earlier on you mentioned something regarding you being deprived of your conjugal rights by your husband, can you explain further?

Lucy: Yes, the problem I had was that my conjugal rights as a married woman were not fulfilled because he was not available as my husband.

CY: When you asked him what was this main reason for not having sex with you, did he say he was tired?

Lucy: I asked him and he said when he sleeps around whilst I am pregnant he was afraid of hurting the unborn child. I asked how was he going to hurt the baby and he never told me how. I told the elderly women and they told me he is sleeping around so you cannot have sex with him to protect your unborn baby and he can give you HIV/AIDS. They advised me to let him be and concentrate on myself and the baby.

CY: I want to ask a question but if you are not comfortable answering it you are free to let me know. On issue of HIV/AIDS that you mentioned it, how did you deal with it given that he was unfaithful?

Lucy: When he came back after disappearing for two years, his family advised us to get tested for HIV/AIDS because he was saying he will not have sex with me because he suspects I was bringing other men in the house while he was away. Other community members told him that they never saw me with another man and I was faithful to him all the time. So they advised the two of us to both get tested. He refused to get tested but I went to the clinic to get tested I was not afraid of anything. I explained my situation to the nurses and they tested me, I got the results and I was negative. When I got home I gave him the results and he just said I will also go and get tested. After two weeks he instructed me to go and tested again and I told him that I had already been tested after two years of not having sex. I told him that he was the one to get tested because he has another wife. He did not go but rather he came into my bedroom. I could not chase him away and I had sex with him but he never got tested. I did not get the money to go and get tested again. He just came into my bedroom that day and after having sex with me he left and never came into my bedroom again till the day I left. The elderly women told me he might be HIV positive and wanted to give me the disease since I was negative. I told them that I was not sure and I was very stressed at that time. They told me not to worry but to go and get tested and if I am still negative I should never have sex with him again. I did not go to get tested again up to today and I think that day he deliberately slept with me to infect me with HIV/AIDS.

CY: Why did you agree to have sex with him? Was it because he was your husband?

Lucy: Yes it was because he was my husband and I had stayed for a long time without having sex so it was difficult to resist. He would have told people that I was refusing to have sex with him because I was sleeping with another man.

CY: I know that sharing this story with me was stressful. Would you like to talk to the social worker after the interview so that I can arrange with her or even your close relatives and friends?

Lucy: Haa I am done, I am fine. Yes, it stresses me especially about my future. If it is counselling, you can give me the phone number of the social worker I will keep it but for now I am very fine. No need for counselling.

CY: You are still young and they are a lot of things that you can achieve. You are 31 years old and they are things that you can still do, do not be stressed too much. This is not the

end of life. You are working for yourself and your children will get the needed help. Is there anything that you would to tell me or questions that you would want to ask?

Lucy: No I do not have.

CY: So if given an opportunity to study are you willing to do it?

Lucy: I am always thinking about my children. A lot of people have given me the same suggestion but am so hurt with the life I am living. I feel my children will also go through the same struggles. I think I have to go home now my children are alone *(chuckles).*

CY: Thank you very much for your participation in this study. I appreciate a lot and you have given me a lot of valuable information and if you have further information that you would want to share or question you would like to ask do not hesitate to contact me or to come here.

APPENDIX N: ETHICS CLEARANCE CERTIFICATE

Research Office

HUMAN RESEARCH ETHICS COMMITTEE (NON-MEDICAL)
R14/49 Chadambuka

CLEARANCE CERTIFICATE	**PROTOCOL NUMBER: H18/11/04**
PROJECT TITLE	Narratives of women residing in a rural area on intimate partner violence: A case of Chimanimani District, Eastern Highlands, Zimbabwe
INVESTIGATOR(S)	Miss C Chadambuka
SCHOOL/DEPARTMENT	Human and Community Development/
DATE CONSIDERED	16 November 2018
DECISION OF THE COMMITTEE	Approved
EXPIRY DATE	17 December 2021

DATE 18 December 2018 **CHAIRPERSON** _____
(Professor J Knight)

cc: Supervisor : Dr A Warria

DECLARATION OF INVESTIGATOR(S)

To be completed in duplicate and **ONE COPY** returned to the Secretary at Room 10004, 10th Floor, Senate House, University. Unreported changes to the application may invalidate the clearance given by the HREC (Non-Medical)

I/We fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and i/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee. **I agree to completion of a yearly progress report.**

Chadambuka
Signature

14 / 01 / 2019
Date

PLEASE QUOTE THE PROTOCOL NUMBER ON ALL ENQUIRIES

APPENDIX O: PERMISSION LETTER FROM CHIMANIMANI RURAL DISTRICT COUNCIL

CHIMANIMANI RURAL DISTRICT COUNCIL

TELEPHONE 0272052272/3
FAX 2403
Email chimanimanirdc@gmail.com

All correspondences to be addressed to the Chief Executive Officer

Stand 267
P O Box 65
Chimanimani

08 August 2018

Cyndirela Chadambuka

Dear Madam

Re: Permission Granted To Conduct Research

Chimanimani RDC hereby grant you the permission to conduct your research.

You are also reminded to adhere to the dictates of your research and not any other as stipulated in the letter from your University.

We also hope you will be able to share your findings with us.

SOCIAL SERVICES DEPARTMENT
CHIMANIMANI R.D.C.
P.O. BOX 65 CHIMANIMANI
DATE: 08/08/2018
SIGNED:

Yours Faithfully

Brian Muchinapo
Community Development and Social Services Department
For The Chief Executive Officer
Chimanimani Rural District Council

APPENDIX P: PERMISSION LETTER FROM MINISTRY OF WOMEN AFFAIRS, COMMUNITY & MEDIUM ENTERPRISE DEVELOPMENT

All communications should be addressed to **The Secretary**

Telephone: 2-708398, 2-735188, 2-790932
www.women.gov.zw

Zimbabwe

Ministry of Women Affairs, Community Small and Medium Enterprises Development
P. Bag 7726 Causeway
Harare

Ref/ Chadambuka Cyndirela
Student Reg No. 890270

8 March 2019

Number 8 Herbert Chitepo Street
Belvedere
Harare

Attention: Chadambuka Cyndirela

REF: PERMISSION TO CARRY OUT A RESEARCH ON NARRATIVES OF WOMEN RESIDING IN A RURAL AREA ON INTIMATE PARTNER VIOLENCE: A CASE OF CHIMANIMANI DISTRICT, EASTERN HIGHLANDS, ZIMBABWE.

The above subject matter refers.

The Ministry has no objection on your proposal to carry out a research on the narratives of women residing in a rural area on intimate partner violence, a case of Chimanimani District.

May you produce this minute to the respondents so that they know you were granted the permission to carry out the research.

We wish you the best in your research.

Min. of Women Affairs, Community, Small & Medium Enterprises Dev.
Director Human Resources
0 8 MAR 2019
P. BAG 7726, CAUSEWAY
HARARE, ZIMBABWE

Mandaza. I
Director Human Resources
For: Secretary for Women Affairs, Community, Small and Medium Enterprises Development.

APPENDIX Q: STANDING ORDERS FOR PHD INCLUDING PUBLICATIONS

S2011/2148

UNIVERSITY OF THE WITWATERSRAND

FACULTY OF HUMANITIES

Standing Orders for PhD Including Publications

These Standing Orders are intended to serve as guidelines for Heads of Disciplines/Programmes, Heads of Schools, the Faculty Office, and are also available to students. They should be read in conjunction with the Faculty Standing Orders for the Degree of Doctor of Philosophy (PhD) and the Degree of Master of Research, as well as the Senate Standing Orders on Higher Degrees.

The Senate Standing Rules and Orders for Higher degrees defines a PhD thesis as "an extended piece of writing based on research that makes an original contribution to knowledge and that may incorporate creative work or publications".

1. Application for Admission

1.1 Application forms are available from the Student Enrolment Centre and on the University website

1.2 Applications must be received by Student Enrolment Centre no later than a date to be determined by the Faculty in conjunction with the School Programme Co-ordinator. Candidates must meet the normal requirements for entry into doctoral studies as specified by the Faculty of Humanities and the appropriate School.

2. Curriculum for the degree

The PhD thesis must comprise a minimum of six chapters (excluding reference list and appendices) which form a coherent thesis both in content and format. The substantive content would include

2.1 Introduction: Aim, Rationale, Theoretical Orientation, Selective Literature Review and Research Design

2.1.2 A clear statement of the research problematic, focus or question/s.
2.1.2 A rationale for the research which shows inter alia how this research will make an original contribution to knowledge.
2.1.3 A critical, selective literature review that locates the proposed research in relation to relevant, related published work.
2.1.4 An outline of the theoretical orientation of the thesis.

2.1.5 A discussion of the method of data generation and analysis, including ethical considerations.

2.1.6 A framework for appreciating how the various chapters of the thesis contribute to the overall integrated argument of the thesis.

2.2 Publishable manuscripts

2.2.1 There should be a minimum of four inter-related manuscripts (each at least 5000 - 8000 words in length). These will constitute the four chapters that form the central body of the thesis.

2.2.2 Prior to the thesis being submitted to an external examiner it is expected that at least one of the manuscripts be published, one be in press, and two be accepted for publication. While the candidate is free to submit these manuscripts to journals of his or her choice, all of these should be reputable, peer-reviewed journals. It is expected that at least one of the journals would be an internationally recognised journal.

2.2.3 At least one of the manuscripts published or accepted for publication should carry the candidate's name as sole author.

2.2.4 The candidate should be first author on all the manuscripts, including those that may be co or multiple authored. The work must be completed in such a way that the candidate has always made the most significant and primary contribution to each manuscript. (Given the supervision intensive nature of the programme it is anticipated that co-publication of one or two of the manuscripts may well be normative. The order of authorship should be compliant with the practice of the relevant discipline).

2.2.5 In the case of the inclusion of jointly authored manuscripts in the thesis the supervisor will be required to sign a declaration indicating that the overall body of work submitted can indeed be attributed to the candidate.

2.3 Each publishable manuscript (should conform to the following criteria)

2.3.1 Be theoretically coherent and structured using the conceptual framework/s that underpin/s the thesis as a whole.

2.3.2 Be able to stand alone as a publishable manuscript. In addition the manuscripts must articulate with each other and together provide an original and substantial contribution to existing knowledge.

2.3.3 Be preceded by a brief explanatory section which outlines the purpose of the manuscript, links it to the preceding chapter, and locates it within the overall argument of the thesis.

2.3.4 In the case of multi-authored manuscripts the contribution made by the candidate should be outlined in this explanatory section, as well as the role of any other authors.

3 General discussion and conclusion

This is a substantial chapter that synthesizes the preceding chapters and provides an argument for how together they constitute an original contribution to existing knowledge in the field. This chapter may also include a reflection on the research

process and its limitations, the implications that flow from the research and recommendations for further research.

4 Reference list

A comprehensive reference list of all material referred to in the thesis should be included, using standard APA referencing style.

5 Appendices

Additional material related to the thesis may be provided in an appendix or appendices.

6. Assessment

The thesis should be examined as a whole in keeping with the procedures for examination of doctoral theses generally accepted in the Faculty of Humanities. Three examiners, holding relevant qualifications and having subject matter expertise to examine the thesis, shall be selected by the supervisor and go through a process of nomination and approval in keeping with current faculty practice. Unless especially motivated to the contrary, there shall be one examiner internal to the university (who is not the supervisor), one external South African examiner and one external international examiner.

October 2011
GE/np

APPENDIX R: PROOF OF EDITING

Laureen Bertin & Associates
Documentation and Organisational Support
CC2010/006901/23
P O Box 87470 HOUGHTON 2041
Telephone 011-485 9252 / 082 685 4043
laureen@lbassociates.co.za/laureenbertin@absamail.co.za

03 December 2020

TO WHOM IT MAY CONCERN

This serves to confirm that the PhD thesis for Ms Cyndirela Chadambuka entitled:

Narratives of women residing in a rural area on intimate partner violence: A case of Chimanimani District, Eastern Highlands (Zimbabwe)

was edited by myself in accordance with recognised academic principles.

Please feel free to contact the writer if further information is required.

Yours faithfully

LAUREEN BERTIN