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Full Length Research Paper

In their own voices- understanding GBV in Zimbabwe: Evidence from a survivor's perspective

Emmanuel Siziba, Jephias Mapuva*, John Bowora, Tendai Samukange and Manford Gomo

Department of Sustainable Development, Bindura University of Science Education, P. O. Box 1020, Bindura, Zimbabwe.

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Gender based violence against women is a prevalent public health challenge that poses a serious threat to women's physical, social and mental health. Zimbabwe has taken proactive and reactive steps to deal with gender-based violence (GBV) through legislation and policies. Despite this seemingly conducive environment 1 in 3 women continue to experience GBV in Zimbabwe. While sustained research in the country indicate the risk factors associated with GBV that are driven from population surveys, few details survivors' narratives and insights into this type of violence. This paper provides unique accounts of two women's experiences in an abusive relationship as well as perspectives to better understand complexities and pervasiveness of GBV.

Key words: Gender based violence, coping strategies, physical violence, and emotional violence.

INTRODUCTION

Broadly construed as violence against a person because of their gender (EIGE, 2021), gender-based violence (GBV) continues to be one of the most notable and grave social human rights violations that occurs within all societies (United Nations, 2015; Eldoseri and Sharp, 2017; EIGE, 2021). Although people of all genders experience GBV, the majority of victims are women and girls. While studies have shown that the drivers of GBV are multiple, pervasive and complex (Heise, 1998; Fleming et al., 2015; Sida, 2015) gender discriminatory norms and unequal balance of power between girls, women boys and men in patriarchal societies are the overarching root causes. It poses a serious threat to women's mental and physical health including depression, suicide and self-harm, chronic physical pain. Gynaecological problems, femicide and post-traumatic stress disorder among other adverse health outcomes (Dillon et al., 2013; Satyanarayan et al., 2016).

In Zimbabwe studies have shown that GBV affects the health of women and girls physically, emotionally and psychologically (Mashiri, 2013). According to the Zimbabwe Demographic Health Survey (2015) physical violence is the most common form of GBV in Zimbabwe. Women and girls continue to be physically, sexually and emotionally abused despite the country having a comprehensive multisectoral legal and policy framework that mandates institutions like the police and health sectors to come up with strategies and interventions to prevent GBV. For example the police established the victim friendly unit (VFU), a separate department in the police force that deals exclusively with GBV issues. To buttress the legal environment, the country has national

*Corresponding author. E-mail: mapuva@gmail.com.

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legislation like the Domestic Violence Act of 2006, the National Gender Based Violence Strategy (2012-2015), and the ratification of relevant international and regional instruments such as the CEDAW; the Beijing Declaration and Platform of Action; Protocol to the African Charter on Human and Peoples Rights on the rights of Women in Africa; the SADC Gender Protocol; the United Nations Convention on the Rights of the Child; the Plan of Action of the International Conference on Population and Development; and the Sustainable Development goals, among many others.

Studies on the causes of GBV (Saffitz, 2010; Abramsky et al., 2011; Fulu et al., 2013; Fleming et al., 2015; Fidan and Bui, 2016; Finley, 2016; Farver and Hamieh, 2016) and effects (Lang et al., 2011; WHO, 2013; Wagman et al., 2015; Shamu et al., 2013; Decker et al., 2014) are vast and cover both low and high income countries. However these are from nationally representative samples and are often perception studies. These lack the narratives of GBV survivors which give real accounts of their experiences at the hands of the perpetrators, how they are treated by service providers and law enforcement institutions like the police. Real experiences of GBV survivors are crucial not only in understanding the nature of GBV but also can be the basis of context specific intervention strategies. The following narratives offer unique and insightful experiences of GBV victims in Zimbabwe.

METHODS

The researcher approached an organization that offer temporary accommodation to survivors of gender based violence as well as offering skills to improve their livelihoods. At any given time the organization has different categories of survivors that include the traumatised and those who have received counselling, are undergoing training and have reached a certain level of emotional stability. Among the emotionally stable survivors two women were purposively identified and consented to give narrations of their experiences. The two received pre-counselling to reduce the chance of bad memories degenerating into distress.

Data collected was confidential and personal to identify information not solicited from the two selected survivors. During data collection arrangement to send the survivors to the counsellor were made in case the survivors ‘break’ during the interview. However all the survivors managed to go through their interviews without showing signs of distress? The survivors were made aware that their narratives might be published and they consented to this effect by signing a consent form. The study was approved by the Medical Research Council of Zimbabwe (A2379). The survivors in question were approximately 30 years of age and not formally employed.

FINDINGS

The experience of Sarah (not her real name)

I was married for ten years and I have two children from the marriage. It all started when I gave birth to my first child. He would come home late around 12 midnight or in the early hours of the day.

Whenever he arrived he would ask me to cook. He was against the idea of reserving food for him as he wanted ‘fresh food’. It was difficult, given the fact that I wake up at 4 am and go to the market to buy tomatoes and vegetables for resell at my place near the road where I stay. At times having cooked the sadza he would not eat saying ‘I don’t eat sadza with vegetables’. He would shout at me accusing me of not being resourceful in order to buy meat.

During weekends he would not come home. Upon seeing him on Friday morning I would see him on Sunday evening. It became a norm for the greater part of our marriage. Asking him where he was would invite beatings. When I did not ask he would be angry at me for not asking and at times beat me for that. It was difficult.

I used to report to my aunt (sister of my husband) who at first encouraged me to soldier on. Seeing the frequency of the beatings she used to talk to him but he would temporarily change. He would be a good person for a couple of days before starting again to disappear during weekends. I never knew how much he earned. At the end of the month he would buy the basics like sugar, mealie meal, soap and flour and on daily basis I had to ask for money to buy relish. At times he would provide but at times quarrels started when I asked about money.

On many occasions he would beat me and I used to go to the hospital for treatment. I used to lie that I got hurt working in the garden but the health workers were often suspicious. One day he beat me and I decided to kill myself by drinking poison. I did not know what happened next but I found myself in the hospital. While at the hospital I learnt about (name withheld) this organization and I decided to come here after the treatment. My parents were against it as they said it will constrain my marriage. I stood my ground as the marriage was already constrained. The organization helped me to apply for a divorce and it was successful. At the moment I am receiving training on how to run small businesses and I hope to continue with my life.

The experience of Brenda (Case 2 not her real name)

I got married when I was 21 years and this is my fifteenth year in marriage. It is a marriage characterised by verbal insults, beatings sexual coercion and intimidation. My husband is a taxi driver and when at home he is always on his mobile cell phone. His cell phone is part of him and one day he left it while he was bathing. An alert indicating that a message has been received, caused me to get hold of the cell phone and simultaneously before I read the message he grabbed my hand forcibly taking the phone. That day he was furious at me and I was thoroughly beaten. He warned me not to touch his phone and never to answer any incoming calls.

During weekends he usually calls to report that his

vehicle has broken down or that he is in a fuel queue. Strikingly he would say so consistently on Fridays or Saturdays and I suspected he would be at a 'small house'. I am afraid of contracting HIV. He is the kind of a person with extremes- he would beat me and after that either asks for forgiveness or sex. On many occasions he would demand it (sex). The idea of being beaten and shortly after being intimate to him is devastating.

One day he came drunk and started accusing me of having boyfriends. He said men are seen loitering at the place where I sell vegetables and potatoes and tomatoes. He started to beat me and I escaped with my child and went to the police. The police decided to offer counselling to him after cautioning him and decided to refer me to this place. This is the reason why I am here and I hope it will work out…..

DISCUSSION

The two survivors of GBV describe their experiences of this type of violence demonstrating that GBV is fuelled by both rigid social norms as well as modernization attributes like social media. Sarah's experience show that various acts of GBV start with unusual behaviour. The husband would come home later at night and ask the wife to cook for him. She indicated that he was against the idea of her preparing the food in advance and that this behaviour started when she gave birth to her first child. In Zimbabwean culture married women are supposed to physically serve food to their husbands at any time of the day. This practice is centred on unequal power relations between men and women and is exacerbated by payment of lobola. Having paid lobola (or part of it as is the norm) many men in Zimbabwe treat their partners as slaves and as sex objects.

The husband would ask Sarah to cook food and having put all her effort to do it sometimes would not eat it. In the narratives accusations are made and the intention is to stretch the women's patience. The shouting and non-eating of food constitute emotional violence which is the second form of GBV in Zimbabwe after physical violence (ZIMSTATS and ICF, 2016). Emotional violence is a product of actions, harsh words and the way women are disturbed from their sleep. Emotional violence is a sensitive, harrowing debilitating marital issue that affect 1 in 3 women in Zimbabwe despite the presence of legislation to curb GBV. However in Zimbabwe emotional violence is not recognised by the Domestic Violence Act (2007) and this leaves women with limited options to address the situation through the traditional arrangements.

From arriving at midnight the husband extended the time to coming home after three days. Sarah described a desperate situation and dilemma where she would be beaten for asking his whereabouts as well as for not asking. Research has shown that women's responses to GBV are shaped by the circumstances of the abuse (Abrahams, 2005; Ruhi, 2010). Sarah opted to keep quite as well as engaging her husband. Keeping quite is less confrontational, covert and engaging the husband has the potential to ignite physical violence. The selection of the coping strategies by women reflects the existing cultural, social and economic conditions in any society. Research in India has shown that women used strategies like silence, unspoken confrontations, hiding, talking back and contemplating suicide (Abraham, 2005).

Women strategically find a way within the cultural, social and economic and structural environment to respond to GBV. While, they often do not always succeed on their effort to empower them in building resilience against GBV. This explains why many women in Zimbabwe stay in abusive relationship for the greater part of their married life.

As a result of physical violence the survivors sought help from the relatives and disguised the violence at the clinic. The survivor wanted to preserve marriage at any cost. Marriage is an important social achievement not only for the women but for her biological family and those not married are often regarded as social outcasts. Keeping this reality in mind, the survivor adopted strategies that preserve marriage. However marriage as a private domain is likely to curtail reporting thus complicating efforts to curb GBV as well as perpetuating this type of violence. Although marriage is a critical socialization institution, it can be a breeding ground for future violence. Research has shown that men who perpetrate violence are more likely to have witnessed parental violence in childhood (Fleming et al., 2015). This is because children learn behavior from their experiences and observation of social interactions. These observations have an impact if the modelers are of high status like parents and caregivers. As a result, when children experience GBV they learn that violence is acceptable and can later use it in their lives (Gomez, 2011; Hamby et al., 2012). The intergenerational transmission of violence has been found to be a risk factor for both engaging in GBV and for victimization (Barrett et al., 2012). Marriage as an institution facilitates the transmission of violence covertly and overtly.

Overall, studies in middle low income countries have shown that those who had witnessed parental violence when they were young are likely to be perpetrators of GBV, to hold permissive attitudes towards use of violence against women, and to consider women to be of less value (Speizer, 2010; Fleming et al., 2015).

The results show that survivors of GBV can change their emotion based on coping with strategies to problem of focused coping strategies. Emotion focused strategies seek to manage the situation by using techniques that modify emotions while problem focused on coping strategies use observable techniques to address the challenges (Shannon et al., 2006). From an emotion focused strategy perspective the survivor tried to conceal

violence at the clinic thus sweeping things under the carpet or denying the problem. From the narrative it is clear that family pressure and economic dependency were the factors that initially discourage the survivor from leaving the abuse relationship. The persistent of physical abuse and the survivor's exposure to public life (hospital and civic organization) shaped her desire to leave the abusive relationship. Being aware of where and how to get help when abused is key for women to choose strategies to escape violence.

The narratives by Brenda presented a complex picture of GBV in which intimidation; unequal power relations as well as modernization (measured by use of social media) can fuel this type of violence. Extra marital relationships are potential causes of GBV and these are often exposed by social media. In patriarchal societies married are confined to private life but become aware of what happens in the public life through social media.

In the era of multimedia environment use of cell phones to make bank transactions and to communication (messages and pictures) has the potential to expose information that can increase tension between men and women. WhatsApp conversations can expose extra marital relationships in marriage or the existence of another relationship to those dating.

What used to be private is increasingly becoming 'public' because of cell phone use thus increasing the risk of perpetrating or experiencing GBV.

Results show that emotional abuse comes in many forms and usually emanates from fear, denial, coercion and intimidation and after an incident of physical or sexual assault that results in injury the perpetrator may use this experience (injury) to intimidate his spouse (Mashiri, 2013). Furthermore, male partners can be excessively jealous of their sexual partners and restrict them from visiting their relatives, deciding the types of friends one has to relate with and going through mobile phones checking history of chats and calls. In Zimbabwean culture this excessive jealous or 'kuchengera' is a key determinant of emotional abuse. The victims are often blamed for offenses, which they did not commit, and this tends to be psychologically damaging.

The Shona and the Ndebele cultures which are predominant in Zimbabwe condone multiple sex partners for men and the constant fear of contracting HIV by the married women contribute to emotional abuse. Unequal power relations within marriage compromise women's ability to negotiate safe sexual practices and due to cultural and social norms women are supposed to be silent, submissive and conform in sexual relation. In addition, economic abuse can contribute to emotional abuse when the male partners as the breadwinner fail to take care of their families. Financial resources could be channeled to 'small houses' a phenomenon that is increasing in Zimbabwe. Small house is when a husband has another 'secret' family besides the official one that is often neglected. The small house phenomenon is common among older couples and this may result in aging women being starved of both sex and financial resources.

The link between economic and emotional abuse confirm other studies which showed that women rarely experience one type of violence (Scott-Storey, 2011; Ansara and Hindin, 2010; Cavanaugh et al., 2012).

Demonstrating lack of sensitivity and care Brenda's partner would beat her and force her to be intimate with him. This form of marital rape is psychologically damaging. To those who experience marital rape in Zimbabwe, discriminatory attitudes and practices of authorities place barriers in women's access to justice. The prosecution of marital rape (which has a bearing on the levels of sexual abuse in Zimbabwe) requires the consent of the Attorney General (AG) (Social Institution and Gender Index 2014). The AG assesses if there is reasonable evidence to justify the process of prosecution taking into account the issue of conjugal rights and the cultural situations. This means that the survivor is not in control of the legal process after she has been raped and such a situation inhibits reporting. Furthermore entrenched institutional and societal attitudes that deny marital rape as a form of violence against women also prevent women from reporting thus contributing to perceived low rates of sexual abuse. Reporting spousal rape is also curtailed by lack of awareness that marital rape is a crime, police reluctance to be involved in domestic disputes and the bureaucratic hurdles like the process of applying to the AG for consent. Police reports and courts records are important sources of sexual abuse data and their action has a bearing on the reported levels of this type of violence.

The Zimbabwean society masks marital rape through the payment lobola, which gives men a sense of ownership over their wives. Currently lobola has been commercialized, that is exorbitant prices are demanded by parent thus cementing the ownership mentality by men. Even those who are cohabiting by paying rent, school fees, buying food and other gifts men tend to have a sense of ownership of women they stay with. The sense of ownership makes men to demand sex whether the woman is sick, tired or on menstrual cycle. Cohabitation and marriage are sexual relationship in which it may be difficult to report rape and more so to prove it competently in the courts of law. As a result of cultural norms that promote secrecy around sexual issues, economic dependency of women and children on men and the stigma associated with rape there is a gap between what is reported and what is happening on the ground. A sizeable number of women and girls are abused sexually daily in Zimbabwe but the reported rates points to the contrary.

The story of Brenda demonstrated the link between use of alcohol and GBV. The false accusations made indicate that GBV can be a premeditated crime in which alcohol

can be blamed as a scapegoat. However research has established relationship between alcohol abuse and GBV (Abbey et al., 2011; Thompson et al., 2015). Alcohol tends to affect people's perceptions and judgement and this interact with a complex set of social and psychological factors to fuel GBV (Flake, 2005). Generally drinking especially heavy drinking is associated with unruly behavior and diminishing morals as well as lack of respect for both self and others. As a result, they are at a greater risk of developing sexually and physically aggressive behavior than men who drink in small quantities (Abbey et al., 2011). Use of alcohol impacts one's cognitions and is associated with over perceiving of sexual interests and a diminishing ability to read social cues. For men the combination of alcohol use, hostile masculinity and perceived approval of use of violence as a conflict resolution strategy, increase the risk of GBV perpetration.

Aware that the police can help, Brenda reported the case to the police who decided to take the non-legal route to solve the problem. The temporary physical separation between the survivor and the perpetrator creates anxiety for both of them if they are in an intimate relationship. This may explain why she concluded her narration by "I hope it will work out." Research has shown that police intervention do not always prevent relationship continuation and deter future violence (Bonomi et al., 2011; Sloan et al., 2013). Therefore, instead of navigating the complex legal route pathway, victims opt for the non-legal route, which help to preserve the family relations. Police interventions especially using the legal route has the potential to ignite further abuse if the abuser 'wins' the case. Furthermore, the legal route requires 'continuity evidence', which can be difficult to sustain when lawyers confront the police officer. Continuity of evidence refers "to the ability of the investigator to honestly and accurately testify in court that physical evidence being presented is in fact the same item as the original…" (UNODC, 2010).

The two narrations documents how women experience GBV in the face of their subordinate and powerless positions in patriarchal societies like Zimbabwe. The women do not only suffer in silence but used a combination of strategies to cope with violence. Nonetheless due to rigid social and religious norms that condone violence, the country's efforts to curb GBV are in vain. Zimbabwe has a powerful civil society institutional set up like the police as well an elaborate legal framework to deal with GBV. Despite this seemingly conducive environment to fight this type of crime laws alone cannot effectively help the abused women. Zimbabwe lacked a proactive institutional response backed by the media which should facilitate the process of women empowerment. The causes of gendered discriminatory norms and unequal power relations between men and women in patriarchal societies like Zimbabwe are the root causes. Only empowered women can challenge repressive patriarchal system in Zimbabwe.

Limitations

While the cases may not be representative of all women experiencing GBV in Zimbabwe or anywhere in the world they do provide insights into the pervasiveness of nature, causes and effects of GBV. The cases demonstrate that GBV is highly contextual and generalization tends to simplify real issues of this type of violence. The cases portray the experiences of the two survivors and therefore may not be generalized to population of women who experience GBV in Zimbabwe.

Conclusion

GBV especially physically and emotional violence are increasing in Zimbabwe despite the presence of a legal framework to curb this type of violence. Reported cases of GBV are low in societies whose women strictly subordinate themselves to men. However globalization ushered many women in the public life where they are exposed to employment, human rights, social media and ways in which they can escape abusive relationships. Thus globalization tends to weaken the traditional patriarchal advantage enjoyed by men. The perceived lack of power by men, results in resorting to the use of force to heightening GBV in Zimbabwe. Furthermore, GBV now consists of many highly diverse sets of actions and behaviors (beating, use of harsh words, searching of women's phones) with significant health implications that can only be addressed with great sensitivity and care. The narratives in this paper provides invaluable information about the pervasive nature of GBV and gaps in prevention efforts. Studies that narrate why perpetrators commit this crime and how survivors cope with it are necessary to develop an evidence based program to curb GBV.

CONFLICT OF INTERESTS

The authors have not declared any conflict of interests.

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