EASTERN AND SOUTHERN AFRICA GENDER PLATFORMS

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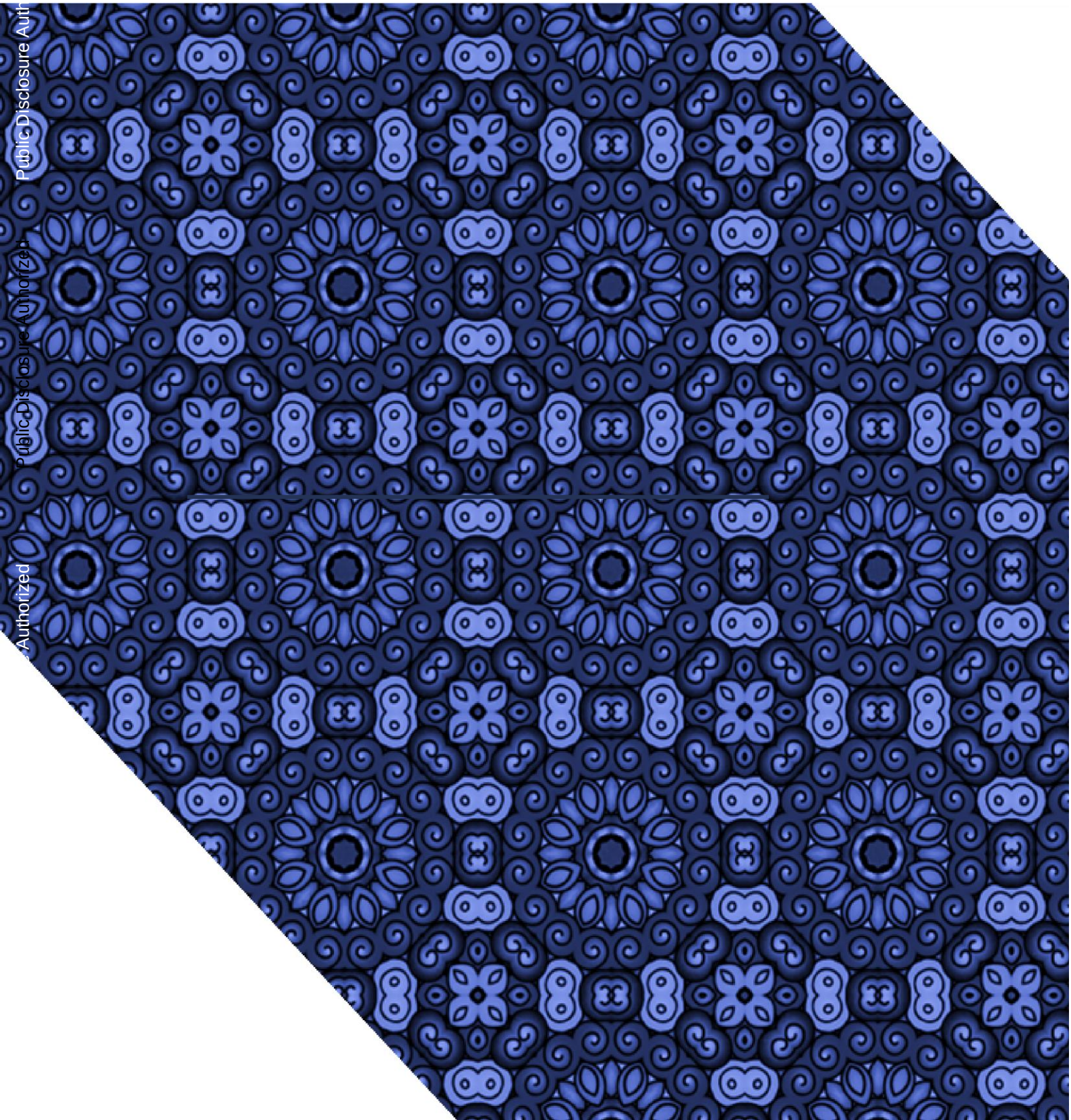
Zimbabwe Gender-Based Violence Assessment

Scope, Programming, Gaps and Entry Points



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ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CBO	Community Based Organization
CCM on ECM	Country Coordination Mechanism on Ending Child Marriages
CRC	Convention on the Rights of the Child
CSO	Civil Society Organization
DDO	District Development Officer
DHS	Demographic Household Survey
DPP	Department of Public Prosecutions
DREAMS	Determined, Resilient, Empowered, AIDS-free, Mentored and Safe
DSS	Department of Social Services
EC	European Commission
ECD	Early Childhood Development
EU	European Union
FBO	Faith Based Organization
FGD	Focus Group Discussions
GBV	Gender-Based Violence
GBV-HP	Gender-Based Violence and Harmful Practices
GDP	Gross Domestic Product
GGG	Global Gender Gap
GII	Gender Inequality Index
GNI	Gross National Income
GoZ	Government of Zimbabwe
GRB	Gender Responsive Budgeting
GTWG	Gender Thematic Working Group
HDI	Human Development Index
HIV	Human Immunodeficiency Virus
HLPC	High-Level Political Compact
HRW	Human Rights Watch
IEC	Information, Education, and Communication
ICT	Information Communication Technology
ILO	International Labour Organization
IMS	Information Management System
IPV	Intimate Partner Violence
JSC	Judicial Services Commission
KII	Key Informant Interviews
LAD	Legal AID Directorate
LMIS	Labour Market Information System
LSMS	Living Standards Measurement Survey
MICS	Multiple Indicator Cluster Survey
MoJLPA	Ministry of Justice, Legal and Parliamentary Affairs
MMR	Maternal Mortality Ratio
MoHCC	Ministry of Health and Child Care
MWACSMED	Ministry of Women Affairs, Community, Small, and Medium Enterprise Development
NAP	National Action Plan
NBSLEA	National Baseline Survey on the Lived Experiences of Adolescents
NDS	National Development Strategy
NGP	National Gender Policy
NGO	Non-Governmental Organization
NFVC	National Victim Friendly Committee
OGBV	Online Gender-Based Violence
PDO	Provincial Development Officer
PEP	Post Exposure Prophylaxis

PWD	Persons with Disability
RGN	Registered General Nurses
SADC	Southern African Development Community
SAFE	Stopping Abuse and Female Exploitation
SDGs	Sustainable Development Goals
SGBV	Sexual and Gender-Based Violence
SI	Spotlight Initiative
SRHR	Sexual Reproductive Health and Rights
STIs	Sexually Transmitted Infections
UN	United Nations
US	United States
UNDP	United Nations Development Programme
VAC	Violence Against Children
VAW	Violence Against Women
VAWG	Violence Against Women and Girls
VFU	Victim Friendly Unit
VoT	Victims of Trafficking
WDC	Ward Development Coordinator
WEE	Women Economic Empowerment
ZIMSTAT	Zimbabwe National Statistics Agency
ZWLA	Zimbabwe Women Lawyers Association

EXECUTIVE SUMMARY

This report presents key findings of the Zimbabwe Gender-Based Violence (GBV) Assessment. The assessment was commissioned by the World Bank (WB), in collaboration with the Government of Zimbabwe (GoZ), through the Ministry of Women Affairs, Community, Small and Medium Enterprise Development (MWACSMED). The purpose of the assessment is to provide a baseline report on the scope of GBV in the country and activities and policies to identify gaps to inform future investments in the country.

KEY FINDINGS

Despite progress significant gender inequalities in the country persist.

Zimbabwe has made progress in narrowing gender disparities, particularly in education, and in helping enshrine gender equality into existing legal frameworks. Across several gender indicators, including the Gender Inequality Index (GII), Zimbabwe ranks better than the averages for Sub-Saharan Africa (SSA), though the country significantly lags behind global estimates on gender equality and other countries in the region.[1] Gender inequalities continue to be found across sectors, for example, in health, women have a higher prevalence of Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS). Compared to men, women have lower levels of formal employment. Compared to men, women are also less likely to finish upper-secondary school.

The prevalence of gender-based violence is high, and incidences of several forms of GBV remain unchanged.

In 2019, around 42.5 percent of women experienced physical and/or sexual violence[2] – similar to the 43.4 rate reported in 2011 – [3] [4] and higher than the global and regional averages of 27 percent and 33 percent respectively.[5] Nationally representative household surveys consistently point to a high, relatively unchanged, prevalence of physical GBV.[6] Prevalence of violence against children (VAC) is also high, and above the estimates of several countries in SSA: with 32.5 percent of females ages 18-24 years ever experiencing it before the age of 18.[7] [8] Other forms of GBV include child marriage, with 33.7 percent of women marrying before age 18, and 5.4 percent before age 15.[9] Over 90 percent of women experience sexual harassment at work.[10]

Harmful cultural norms and practices contribute to the elevated levels of GBV.

Harmful cultural practices include payment of "lobola", a cultural practice which treats women as a property, to be traded for in-kind gifts or cash gift at marriage; early, child, and forced marriages; forced virginity testing; wife inheritance; widow disinheritance. Increased incidences of GBV during humanitarian situations have also been reported.

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[1] Zimbabwe is ranked 129 out of 189 countries on the GII with a value of 0.527, higher than Zambia (137th), Tanzania (140th), and Malawi (142nd) but below Ethiopia (125th), Kenya (126th), and Mozambique (127th).

[2] MICS 2019

[3] DHS 2011

[4] MICS 2019

[5] World Health Organization 2021. Violence Against Women Prevalence Estimates, 2018. New York: United Nations.

[6] The 2006 Demographic Household Survey (DHS) reported intimate partner violence (IPV) at 36 percent, the 2015 DHS reported it at 35 percent, and the 2019 Multiple Indicator Cluster Survey (MICS) reported a prevalence of 39.4 percent.

[7] According to the 2011 National Baseline Survey on the Lived Experiences of Adolescents (NBLEA), 47.8 percent of females and 60.9 percent of males experienced physical violence before age 18.

[8] Muluneh MD, Stulz V, Francis L, Agho K. 2020. Regional estimates on GBV are based on a meta-analysis review of cross-sectional studies in the region.

[9] MICS 2019

[10] ILO 2017

GBV survivors often do not seek help.

Less than half of GBV survivors seek help (37.7 percent).[11] Reasons for not seeking help include normalizing and internalizing the violence; being afraid of getting into trouble; embarrassment for self and family; and not wanting to get the abuser into trouble. The figures for VAC are equally dire; the 2011 National Baseline Survey on the Lived Experiences of Adolescents (NBSLEA) showed that less than 40 percent of survivors of VAC knew where to get GBV services, and of those that knew where to get services, only 5 percent sought and received them.[12]

Zimbabwe has adopted several international and domestic pieces of legislation for combatting GBV.

The country has signed and ratified a myriad of global and regional legal instruments and frameworks on gender equality and GBV.[13] Zimbabwe also has a progressive national legal framework, anchored in the 2013 National Constitution, which prohibits discrimination based on gender and outlaws all forms of GBV. National pieces of legislation addressing GBV include the: 2007 Domestic Violence Act (DVA); 2002 Sexual Offences Act; Criminal Law Codification and Reform Act; Legal Age of Majority Act of 1982; and the 2014 Trafficking in Persons Act, among others. In 2022, the Marriages Act was harmonized with the Constitution to place the legal age of marriage at 18 years, for both men and women.

Additional efforts are needed to improve implementation of GBV legislation and to adopt frameworks to criminalize GBV acts.

Harmonization of laws on GBV has been occurring since the new constitution was adopted in 2013. Progress has been slow for several reasons, which include inadequate financial, human, material, and technical resources; lack of political will by some ministries; and weak coordination among key stakeholders. Several laws have also not been harmonized to meet GBV requirements. Implementation of GBV legislation is also hamstrung by weak accountability mechanisms and inadequate human and financial resources. Additional mechanisms for criminalizing GBV practices need to be put in place. The 2007 DVA, for example, is not comprehensive enough to address harmful cultural practices, fails to criminalize emotional and psychological abuse and does not address GBV cases that happen outside of the domestic sphere.

The adoption and implementation of national GBV programmes and policies face significant issues.

When the National Gender Policy (NGP) ended in 2017 and the National GBV Strategy ended in 2015. no follow-up national policies and processes were put in place.[14] The National GBV Strategy did not have countrywide coverage or provide an adequate domestic framework to help guide GBV response mechanisms nationally. The Anti-Domestic Violence Council (ADVC), which has the mandate to coordinate GBV responses in the country, is barely functional, and suffers from deep financial and

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[11] MICS 2019

[12] NBSLEA 2011

[13] These include: the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW); The Beijing Platform for Action; The Convention on the Rights of the Child (CRC); UN Resolution 1325 (2000) on Women, Peace and Security; The 2030 Agenda of the Sustainable Development Goals (SDGs); The Protocol to the African Charter on Human and People's Rights on the Rights of Women (Maputo Protocol); The African Charter on Human and Peoples' Rights; The Solemn Declaration on Gender Equality in Africa; The Southern African Development Community (SADC) Protocol on Gender and Development, 2008 (revised in 2016); and the SADC Regional Strategy and Framework of Action for Addressing GBV (2018 – 2030).

[14] The existing policy framework for tackling GBV consists of the National Gender Policy (NGP) (2013-2017);The National GBV Strategy (2012-2015); The High-Level Political Compact (HLPC) on Ending Gender-Based Violence and Harmful Practices (2021-2030) in Zimbabwe; The Strategy for the Elimination of Sexual Harassment and Gender Based Violence in the Workplace in Zimbabwe (2021-2025); The Protocol on the Multi-Sectoral Management of Sexual Abuse and Violence in Zimbabwe (2012); The National Action Plan on Ending Child Marriages (2019-2021); and the National Development Strategy 1 (2021-2025).

human capacity issues. The country is mired by absence of an integrated and inter-operable GBV Information Management System (IMS) of existing GBV service providers.

National coordination mechanisms are often incapacitated and have unclear implementation agendas.

The national GBV Coordination Forum, led by the MWACSMED, is the umbrella platform for coordinating GBV programming. Under the national coordination forum, the ADVC is the secretariat mandated to implement the GBV strategy, but it has not been operational.[15] Coordination among GBV stakeholders has been plagued by many challenges, including: i) incapacitation of the ADVC owing to poor funding and inadequate human resources; ii) overlapping and unclear mandates between ministries and across institutions; iii) the absence of clear implementation agendas for several of the coordination services; iv) parallel coordination mechanisms which create fatigue among stakeholders, and weak accountability mechanisms.

Numerous services offered to GBV survivors are often not accessed.

The 2012 Protocol on the Multi-Sectoral Management of Sexual Abuse and Violence in Zimbabwe lays out a series of services in security, access to health services, and legal processing of GBV cases to be offered to survivors, though women experience several barriers in access.[16] These include: i) long distances to health centers; ii) inadequate human resources at health facilities; iii) stock depletion of essential medicines and commodities; iv) lack of knowledge on the existence of GBV services by survivors, v) low legal literacy rates which contribute to a lack of general awareness on service access and vi) human resource shortages in the legal system, which results in the trial of GBV cases taking longer than required. Some cases take up to two years to be finalized and most survivors lack the necessary resources to secure transport money to attend the trails.

GBV prevention programming has led to increased awareness, and to greater access to treatment but long-term challenges remain.

GBV Prevention programming in Zimbabwe is mainly focused on strengthening legal and policy frameworks and raising awareness to change harmful social norms and practices. Comprehensive sex education has also been introduced in schools, through the Guidance and Counselling Module, to educate boys and girls on sexual reproductive health and rights (SRHR) and sexual and gender-based violence (SGBV). Prevention programmes are mainly spearheaded by community service organizations (CSOs), with funding from development partners and in partnership with government, traditional leaders, and communities. These initiatives have led to important policy reforms and greater awareness of GBV, though challenges remain in securing continuity of programming for addressing long-term issues, especially with social norms and customs that enable GBV and discourage help-seeking.

Additional work is needed to sustain long-term, comprehensive GBV programming in the country.

There is ample regional research outlining the economic impacts of GBV: a study of twenty-seven countries in Sub-Saharan Africa (SSA), including Zimbabwe, found that an increase in the share of women subject to violence by 1 percentage point, and the significant drop in female employment associated with it, can reduce economic activities – measured through nightlight activity – by up to 8 percent.[17] Implementation of GBV programming has been affected by existing funding gaps: the UNDP estimates that the government is covering approximately 10 percent of the estimated US$80 million needed annually to sustain existing GBV programming in Zimbabwe.[18] The financing gap is

[15] The Protocol on the Multi-Sectoral Management of Sexual Abuse and Violence in Zimbabwe, led by the Judicial Services Commission (JSC), provides coordination mechanisms for managing sexual violence.
[16] The Protocol on the Multi-Sectoral Management of Sexual Abuse and Violence in Zimbabwe, 2022
[17] Ouedraogo, R. and Stenzel, D. 2021
[18] UNDP 2020. Financing Options for Sexual and Gender-based Violence in Zimbabwe. New York.

predominantly covered by development partners. From among a wide range of interventions available, there remains a strong need to raise funding for successful implementation of GBV programming in the country. This includes establishing a business case for increased GBV funding, providing evidence on the cost of GBV to the local economy, engaging the private sector, and supporting CSOs and FBOs.

Recommendations

A wealth of recommendations emerge from this assessment, to inform the GoZ's GBV prevention and response programming, and help guide its support. These are summarized below, prioritized according to short, medium, and long-term actions. For each of the goals, the relevant stakeholders in charge of implementation, which serve as focal points for further engagement, are identified.

Thematic Area	Recommendation	Priority	Responsibility for Implementation
Legal Framework	Support completion of harmonization of remaining laws and bills with the 2013 Constitution and with global and regional instruments on GBV. Provide different government agencies with financial, human, and technical resources for the harmonization process.	Medium Term	Ministry of Justice, Parliament, MWACSMED
	Improve legal literacy, awareness, and accessibility of GBV laws and policies by designing copies of such legislative frameworks in vernacular language for distribution in communities and schools.	Short Term	
	Support decentralization of the LAD to the district level to enable easy access by GBV survivors from across the country, including in rural areas. Provide adequate human, financial and material resources to the LAD.	Short Term	
	Support the piloting of dedicated and specialized GBV Fast Track Courts to speed up the processing of cases.	Medium Term	
GBV Policies & Strategies	Assist in the development of the updated NGP and National GBV Strategy.	Short Term	MWACSMED
Institutional Framework and Coordination	Restructure coordination platforms to ensure that there is no duplication of efforts, or overlapping of mandates, and that all institutional sub platforms report to the National Gender Forum.	Medium Term	MWACSMED
	Strengthen the ADVC, which has been barely functional in recent years.		MWACSMED ADVC

GBV Prevention	Design, implement and evaluate targeted, systematic, evidence based, wide-reaching awareness raising and education campaigns to change social and gender norms towards non-violence and respectful relationships. Prioritize targeting of GBV "hot spots" and dissemination of accessible information, education, and communication (IEC) material in local languages.	Short Term	MWACSMED CSOs
	Support women to engage in sustainable income-generating activities to enable them to become economically independent and exit abusive and exploitative relationships.	Short Term	
GBV Response	Strengthen the justice delivery system by addressing the bottlenecks that lead to delays in the finalization of GBV cases. Consider establishing Fast Track GBV courts.	Short Term	MWACSMED Ministry of Justice
	Intensify awareness-raising campaigns in communities on the GBV multi-sectoral referral protocol to increase uptake of services.	Short Term	MWACSMED CSOs
	Consider setting up Village--Based One Stop Centers to deliver essential services to GBV survivors.	Medium Term	MWACSMED CSOs
	Improve the capacity of GBV responders to adequately meet the needs of vulnerable and marginalized groups, including persons with disability (PWD). Address incidences of GBV in humanitarian situations.	Medium Term	MWACSMED CSOs
Data	Develop an integrated, interoperable, regularly updated GBV IMS on existing GBV prevention centers and treatment providers; strengthen coordination and collection of nationally representative household surveys on GBV data; expand collection of GBV data in the workplace.	Medium Term	MWACSMED Zimbabwe National Statistics Agency (ZIMSTAT) Development Partners
	Conduct a National Study on the costs of GBV to the country.	Medium Term	

1. BACKGROUND

1.1 Introduction

This report presents key findings of the Zimbabwe GBV Assessment. The assessment was commissioned by the WB in collaboration with the GoZ, through the MWACSMED. The report highlights key findings and introduces several policy and programming recommendations aimed at strengthening national GBV prevention and response efforts.

1.1 Purpose of the Assessment

The purpose of the assessment is to provide GBV baseline information report on the scope, programming, policies, and gaps to assist in identifying potential entry points for investment. Specifically, the GBV assessment aims to: (a) support efforts to address GBV in Zimbabwe; (b) inform strategies to integrate GBV in development programming; and (c) understand the extent of GBV response programming in Zimbabwe. Further, the assessment aims to understand the nature and extent of GBV services that can be made available to survivors – to help mitigate the risk of GBV within development projects. The findings also aim to support the GoZ in finalizing the National GBV Strategy, the NGP, and the Gender Action Plan, all currently under development by the MWACSMED.

1.2 Methodology

For its methodology, the GBV assessment employed a mixed methods strategy, including qualitative data collection methods, comprising of a desk review of academic and non-academic literature, key Informant Interviews (KII), focus group discussions (FGDs), and stakeholder consultations. The assessment also draws from existing nationally representative household surveys to map-out national levels of GBV and illustrate trends over time.

1.2.1 Desk Review

A literature review on GBV was conducted, including both academic and non-academic literature, to determine the burden and causes of GBV, and to identify global and regional evidence on best practices contributing to its eradication. These included legal briefs, government programming reports, GBV policy and strategy documents, and peer-reviewed publications.

1.2.2 Key Informant Interviews

Six KIIs were conducted with staff from various stakeholder institutions, including the government, CSOs, development partners, and donors to gather expert views on the implementation and coordination of the national GBV response. The interviews captured feedback regarding the adequacy and relevance of the GBV national response; the effectiveness of current GBV prevention and response efforts; key achievements and gaps; and priorities and opportunities for future investments in GBV programming. The KIIs also put forward recommendations on strengthening GBV prevention and response programming in the country.

1.2.3 Stakeholder Consultations

Eight national stakeholder consultative workshops were convened during this assessment. A national stakeholder consultative workshop was convened in Mutare with government ministries; independent commissions; development partners; United Nations (UN) agencies; CSOs; international and local non-governmental organizations (NGOs); academic institutions; SADC Gender Directorate; traditional leaders; faith-based organizations (FBOs); media; and the private sector. During the national

consultative workshop, the SADC Gender Division outlined the SADC Regional Strategy on GBV and key priority areas for the region.[19]

Separate consultative workshops were also convened at the national level with groups of stakeholders drawn from the government, civil society, donors, and UN agencies. FGDs were conducted with: directors of gender, and gender focal points across government ministries and institutions; the UN Country Team Gender Theme Group; donors supporting gender equality and GBV programming in Zimbabwe; and CSOs with mandates focused on gender equality and SGBV. The consultations sought to get a sense of current efforts by stakeholders in GBV prevention and response; perceptions about effectiveness of current response efforts; key gaps and challenges in the national GBV response; efficiency of the legal and policy framework in addressing GBV; key GBV programming priorities for the stakeholders moving forward; and recommendations for strengthening GBV programming in Zimbabwe. Similar consultative workshops were convened in six selected provinces with regional representatives and focal points, including CBOs, FBOs, traditional leaders, and survivors of GBV.

1.2.4 Focus Group Discussions (FGD)

Four FGDs were conducted in the City of Bulawayo. Bulawayo was selected because the government has adopted a far-reaching policy agenda for addressing GBV.[20] The FGDs provided an in-depth understanding of the forms and burden of GBV in Bulawayo; current efforts by the local authorities to address GBV and the effectiveness of those efforts; key gaps and challenges in GBV programming; the level of community awareness of GBV issues; and effectiveness of community initiatives to tackle GBV. The FGDs also provided an opportunity for local authorities and communities to offer their insights and recommendations on how to effectively tackle GBV.

1.2.5 Limitations

Although the GBV Assessment aims to offer a wide-ranging picture of GBV in Zimbabwe, it suffers from a series of limitations. Lack of data coordination and sharing among different stakeholders in the country, and the absence of an interoperable GBV database on service providers, made it difficult to centralize and collate data on GBV from the different government agencies. The qualitative data collection component of the report is not nationally representative and has not covered all regions and provinces in the country. Although not exhaustive in scope, this report aims to paint a picture of the different ways that GBV, and, on a lesser degree, VAC, is manifested in the country, as well as to highlight key challenges and opportunities in existing programing and policies.

1.2.6 Organization of the Report

Chapter 2 provides a broad view of gender and development indicators in Zimbabwe, highlighting key gender gaps across sectors in the country and their implications for GBV. **Chapter 3** presents nationally representative data on different forms of GBV i.e., physical violence; sexual violence; experiences of different forms of violence; VAC; child marriages; intimate partner violence; harmful cultural practices; GBV in the world of work; and the help-seeking patterns and behaviors of survivors.

Chapter 4 discusses the country's legal and policy framework on GBV. **Chapter 5** discusses the institutional and coordination framework for GBV in Zimbabwe. **Chapter 6** focuses on GBV prevention and response programming in the country, highlighting key achievements as well as the gaps in current programming. **Chapter 7** briefly discusses the GBV financing landscape in Zimbabwe. **Chapter 8** provides a set of recommendations across the different thematic areas of focus covered in the report.

[19] Activities undertaken as part of the national stakeholder workshops included: GBV Situation Analysis; presentations on GBV programming areas that distinct stakeholders were focusing on; a strengths, weaknesses, opportunities, and threats (SWOT) analysis of GBV prevention and response efforts; and priority setting and recommendations for the National GBV Strategy currently being developed by the MWACSMED.

[20] During the field visits, FGDs were conducted with the two councils' gender focal persons from different departments; CSOs working with the councils to implement gender equality and GBV programme; and separate groups of men and women from the community comprising young men and women, PWD, community leaders and elderly men and women.

2. GENDER AND DEVELOPMENT IN ZIMBABWE

2.1 Development Context

Zimbabwe has a total population of 15 million people – 52 percent females and 48 percent males,[21] and an average household size of four. Over the past two decades, Zimbabwe has faced a myriad of challenges, including constrained economic growth, growing poverty and unemployment, climate-related shocks, the impact of natural disasters, and the COVID-19 pandemic. Zimbabwe's economic development continues to be hampered by price and exchange rate instability, the misallocation of productive resources, low investments, high inflation, and unsustainable debt levels.[22] This economic instability has had deep negative impacts on the socio-economic development trajectory of the country, including on widening existing economic gender gaps.

2.2 Gender Inequality

The 2017 NGP and the National Development Strategy (NDS 1) acknowledge the progress the country has made in expanding women's access to opportunities. However, significant gender gaps in access to reproductive health, female empowerment, women's access and ownership of economic resources and opportunities, and women's participation in decision-making positions, persist.[23] Gaps in gender equality in Zimbabwe are wide, and are echoed across society, including in women's limited access to finance; limited access to land and property; reduced opportunities to influence policy; and patriarchal norms and customs.

Zimbabwe ranks 146 out of 191 countries on the United Nations Development Programme (UNDP) Human Development Index (HDI) (2021-2022) with an index value of 0.593.[24] The Gender Inequality Index (GII),[25] which measures gender disadvantages in reproductive health, empowerment, and the labor market is 0.532, places the country in position 134 out of 189 countries ranked. Although the country ranks slightly better than countries in SSA across HDI and GII indicators, it ranks significantly below global estimates. Moreover, in ranking of GII, Zimbabwe ranks higher than Zambia, Tanzania, and Malawi, but lower than Ethiopia, Kenya, and Mozambique. Table 1 shows gender relevant development indicators for Zimbabwe.

[21] ZIMSTAT National Census Report, 2022
[22] World Bank 2023. Zimbabwe overview. Accessed 31 May 2023 at: https://www.worldbank.org/en/country/zimbabwe/overview.
[23] MWACSMED 2017. Republic of Zimbabwe National Gender policy, 2013-2017. New York: UNDP.
[24] UNDP Data Center. Human Development Index https://hdr.undp.org/data-center/human-development-index#/indicies/HD
[25] GII reflects gender-based disadvantage in three dimensions— reproductive health, empowerment, and the labour market. It shows the loss in potential human development due to inequality between female and male achievements in these dimensions. It ranges from 0, where women and men fare equally, to 1, where one gender fares as poorly as possible in all measured dimensions.

Table 1: Zimbabwe Development Indicators (2021)

Development Indicator	Global Ranking	Global	SSA	Zimbabwe Overall	Zimbabwe Male	Zimbabwe Female
Human Development Index (HDI)	146 out of 191 countries	.73	.55	0.59	0.60	0.58
Gender Inequality Index (GII)	134 out of 189 countries	.47	.57	0.53		
Life Expectancy at Birth (years)		71.4	60.1	59.3	56.2	62.0
Expected years of schooling		12.8	10.3	12.1	12.3	12.0
Mean years of schooling		8.6	6.0	8.7	9.2	8.3
Estimated Gross National Income per Capita (2017 PPP$)		16,752	3,699	3,810	4,397	3,286
Maternal Mortality Ratio deaths/100,00 live births		225	536	363		
Population with at least some secondary education (percent)					72.4	61.8
Labour Force Participation Rate (percent)					88.9	79.3

Source: UNDP Human Development Report 2021-2022 and ZIMSTAT: 2022 National Census Report

Although progress has been made in reducing gender cleavages across a range of indicators, Zimbabwe ranks low in several indicators related to gender equality. As Table 1 shows, compared to men, women have a lower HDI, lower levels of education, lower levels of Gross Per Capita Income, and lower rates of labour force participation. The maternal mortality ratio (MMR), at 363 per 100,000 live births[26] is high, higher than the 225 global average and significantly higher than the 70 births per 100,000 live births target set by the 2030 Agenda for Sustainable Development. [27]

Poverty

Poverty in Zimbabwe has increased significantly over the past decade, and it remains one of the key impediments to women's human capital accumulation. The proportion of citizens living below the extreme poverty line increased from 22.5 percent in 2011 to 43.1 percent in 2021. [28] Poverty is more concentrated in rural areas, where 90 percent of the extremely poor reside. [29] Extreme poverty levels spiked to a high of 49 percent – 62.4 percent in rural areas and 16.4 percent in urban areas – in 2020, during the COVID-19 pandemic.[30] In 2017, 51.9 percent of extremely poor individuals in the country were females, while males comprised 48.1 percent. [31]

[26] ZIMSTAT: 2022 National Census Report
[27] UN. "The 17 Goals | Sustainable Development"
[28] World Bank Group 2021. *Reversing the tide: Reducing Poverty and Boosting Resilience in Zimbabwe.* Washington DC: International Bank for Reconstruction and Development.
[29] MICS 2019
[30] World Bank, 2021
[31] Ibid

Employment

There is a wide gender pay gap in both the formal and informal economy. In 2017, the estimated gross national income (GNI) per capita for 2017 was $4,397 for males and $3,286 for females. As noted in the Interim Poverty Reduction Strategy Paper (I-PRSP) (2016-18),[32] women's average income is a third of that of men. The unemployment rate is higher for females, 17.2 percent, than it is for males, 15.7 percent. The informal sector accounts for 75.6 percent of total employment in Zimbabwe. [33] Most women, 82.7 percent, earn their livelihoods in the informal economy, where they are more likely to be unpaid or to work in unsafe conditions, including under heightened risk of sexual exploitation and abuse.[34]

Education

Females have generally fared slightly better than men in literacy attainment and access to educational opportunities. The adult female literacy rate is higher, 92.1 percent, than that of adult men, 89.4 percent.[35] As Table 2 shows, gender parity in completion rates up to lower secondary school (Forms 1 to 4) has been achieved, with completion rates at lower secondary school at 73 percent and at 72 percent for boys.[36] However, comprehensive interventions are needed to address the gender gaps in completion rates at upper secondary levels. Table 2 below shows female and male literacy and educational attainment rates for the country.

Table 2: Education and Literacy Attainment Rates

Indicator	Percent Females	Percent Males
Adult literacy rate	92.1	89.4
Ever attended school (4 years and above)-2022 Census results	93.9	95.4
Net primary attendance ratio	91.5	89.6
Completion rate Lower secondary (Form1-4)	73	72
Completion rate Upper secondary (form 5 and 6)	13	15

Source: MICS, 2019, 2022 Census and AfDB/UN Women, 2021
Note: The literacy rates are for adults ages 15-49 years

Health

Gender disparities and inequities remain prevalent in the health sector. The 2022 National Census Report recorded MMR at 363 per 100,000 live births, this is below the 536 average for SSA[37] but well above the above the SDG target of 70 maternal deaths per 100,000 live births by 2030.[38] Women are also disproportionally affected by HIV and AIDS; among those ages 15-49, HIV prevalence is at 14.4 percent for females, compared to 8.7 percent for males.[39] HIV among young women, 15-24 years, is almost twice, 4.7 percent, that of young men, 2.6 percent. This is attributed, in great part, to women's limited capacity and ability to access adequate SRHR.

[32] I-PRSP, 2016-18
[33] LFCLS, 2019
[34] Ibid
[35] MICS 2019
[36] UN Women, AfBG. Zimbabwe Gender Profile 2021
[37] UNDP Human Development Report 2021-2022
[38] UN. "The 17 Goals | Sustainable Development"
[39] HIV and AIDS Estimates: UNAIDS Country fact sheets ZIMBABWE, 2021

3. SCOPE OF THE PROBLEM OF GENDER-BASED VIOLENCE IN ZIMBABWE

3.1 Introduction

GBV is a disgraceful and unforgivable practice, a fundamental violation of human rights, and a threat to the health, and overall livelihood of those affected by it. The GoZ recognizes that GBV and harmful practices (GBV – HP) are a fundamental violation of human rights. These practices remain one of the biggest obstacles to women's participation in intra-household decision-making; severely limit women's ability to participate in economic and social activities; and represent significant drawbacks to the country's aspirations for greater economic development.

GBV is rooted in structural gender inequalities, widespread abuses of power, and harmful cultural norms. The violence can take many forms, including sexual, physical, verbal, and psychological (emotional). It is widespread, can be perpetrated by anyone, and permeates across all sectors of society in Zimbabwe. In 2019, 42.5 percent of women ages 15-49 in the country experienced physical and/or sexual violence.[40] This statistic has remained relatively unchanged since 2011, when 43.4 percent of women in that age group experienced physical and/or sexual violence. [41] An estimated 44 percent of women have experienced sexual or physical violence by an intimate partner, [42] compared to the global average of 27 percent and regional average of 33 percent. [43]

3.2 Available Data

Worldwide, the main repertoire of sources for documenting national prevalence of GBV are nationally representative household surveys, such as the DHS, the MICS, and the Living Standards Measurement Survey (LSMS). This report draws heavily from these household surveys to offer nationally representative statistics on GBV. These sources are not meant to provide a granular view of GBV prevalence in the country but do offer the most up-to-date estimates on sexual and physical violence in Zimbabwe. Additional inferences on GBV prevalence are also drawn from stakeholder consultations.

3.2.1 Physical Violence

Women experience physical violence within and outside the domestic sphere – perpetrated by either spouses/partners and by other family members or unrelated individuals. Physical violence refers to any deliberate act that directly impairs the victim's physical well-being. It is the intentional use of physical force with the potential of causing harm, injury, disability, or death. Among other acts, physical violence includes pushing, choking, slapping, punching, and burning.[44]

[40] MICS 2019

[41] DHS 2011

[42] MICS 2019

[43] World Health Organization 2021. Violence Against Women Prevalence Estimates, 2018. New York: United Nations.

[44] UN Women: https://www.unwomen.org/en/what-we-do/ending-violence-against-women/faqs/types-of-violence

Figure 1: Percent Prevalence of Physical Violence 2006-2019

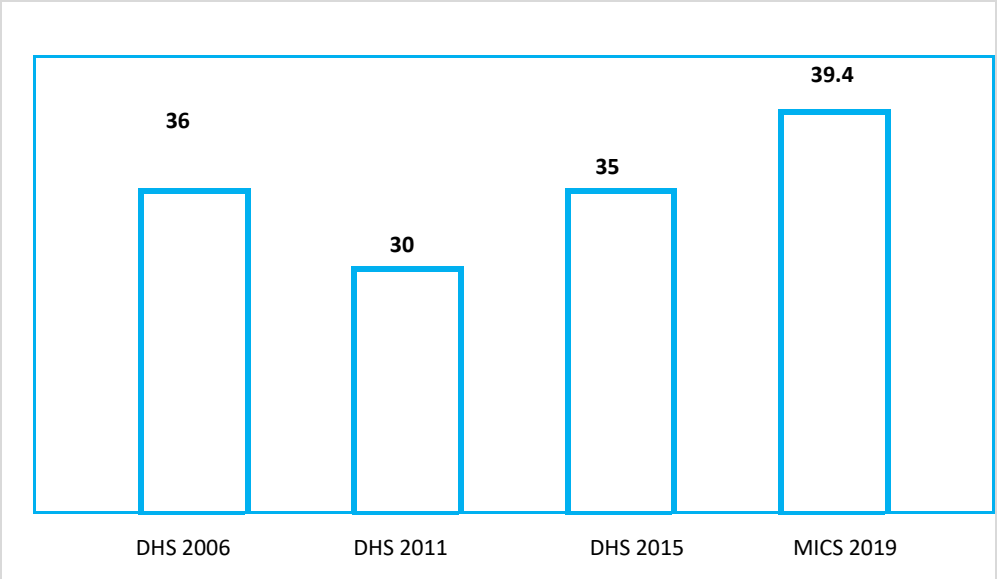


Figure 1 shows trends in the prevalence of physical violence experienced in the year preceding the survey among women ages 15-49 years between 2006 and 2019. The surveys point to relatively unchanged levels of physical violence over time: the prevalence of physical violence was 36 percent in 2006, 35 percent in 2015, and 39.4 percent in 2019, with 5.5 percent of respondents experiencing physical violence in the 12 months preceding the survey.[45] The levels of physical violence against women in Zimbabwe are significantly higher than the global average of 30 percent, and above the regional estimates of 26.1 percent in SSA.[46] [47] This raises the need for more wide-ranging efforts, including more extensive prevention programming, to combat physical violence in the country.

According to the 2019 MICS, at 46.6 percent, physical violence was most prevalent among 30–39-year-olds, followed by those 25-29 years of age, 43.9 percent, and 40-49 years, 43.2 percent. At 23.2 percent, prevalence was lowest among women ages 15- 19 years. The 2019 MICS also shows that physical violence is more prevalent in rural areas, 41.6 percent, compared to urban areas, 36 percent.

3.2.2 Sexual Violence

Sexual violence includes any sexual act directed against a person using force. It includes rape, verbal abuse of a sexual nature, forced marriage, forced abortion, genital mutilation, refusal to practice safe sex, forcing a sexual act against a person's will, inserting foreign objects into a partner/spouse's private parts, and marital rape. This also includes denial of access to sexual and reproductive services and facilities such as birth control.[48] The 2019 MICS survey recorded a sexual violence prevalence of 11.6 percent, with 5.1 percent experiencing violence in the previous year. This represents a slight decrease of three percentage points from the 2015 estimates.

According to the 2019 MICS, the prevalence of sexual violence was almost the same for rural, 11.8 percent, and urban areas, 11.3 percent.[49] The 2019 MICS shows that the risk of experiencing sexual

[45] MICS 2019
[46] Muluneh MD, Stulz V, Francis L, Agho K. 2020. The regional estimates are based on a meta-analysis review of cross-sectional studies in the region.
[47] WHO. Violence Against Women; https://www.who.int/en/news-room/fact-sheets/detail/violence-against-women
[48] UN Women, 2012
[49] MICS 2019

violence increases with age. The data also shows that GBV prevalence is higher among respondents ages 40-49 years, 14.8 percent, followed by 30-39 years, 13.8 percent, and 20-24 years, 12.5 percent. The 15-19 age group had the lowest prevalence rate of 4.7 percent.

3.2.3 Intimate Partner Violence

Women often experience physical, sexual, or emotional violence committed by their current husband/partner or previous partner. An estimated 44 percent of women have experienced physical or sexual violence by any husband or partner in their lifetimes. Physical violence by an intimate partner, a current or recent husband/partner, is experienced by 37.1 percent of the population, with 16.3 percent of the respondents having experienced the violence in the 12 months preceding the survey. At 32.1 percent, the most common forms of IPV experienced is slapping, followed by pushing, shaking, and throwing.

3.2.4 Violence Against Children

VAC includes all forms of violence against people under 18 years old. Globally, it is estimated that up to 1 billion children ages 2–17 years have experienced physical, sexual, or emotional violence or neglect in the past year.[50] VAC takes many forms, including physical, sexual, and emotional abuse. [51] VAC can occur in a wide range of settings, including at home, school, in the community and over the internet. Such levels of violence inflict harm, pain, and humiliation on children, and can even result in their death. [52] Moreover, experiencing violence in childhood impacts individuals' lifelong well-being.

The 2011 NBSLEA is a nationally representative household survey which targeted 1,062 female and 1,348 male respondents ages 13-24. The study measured experiences of emotional, physical, and sexual violence, as well as violence perpetrated by intimate partners. A summary of findings from the NBSLEA is presented in Table 3. Survey findings suggest much higher levels of VAC among female than men. Approximately 32.5 percent of women experienced sexual violence before the age of 18, compared to 8.9 percent of men.

Table 3: Prevalence of Different Types of Violence Against Children in Zimbabwe

Type of Violence	Age group	Female	Male
Sexual Violence			
Sexual violence in the past 12 months	13-17	8.5	1.8
Sexual violence before age 18	18-24	32.5	8.9
Physical Violence			
Physical violence by a parent of relative in the past 12 months	13-17	15.8	16.2
Physical violence by a parent or adult relative before age 18	18-24	47.8	60.9
Emotional Violence			
Emotional violence by an adult prior to age 18	18-24	29.0	39.1
Emotional violence by an adult in past twelve months	13-17	18.6	16.4

Source: NBSLEA, 2011

Male children are more likely than female children to suffer from physical violence.[53] According to the NBSLEA, among the 18– 24-year-old age group, physical violence prevalence was 60.9 percent among

[50] WHO, 2022: https://www.who.int/news-room/fact-sheets/detail/violence-against-children
[51] UNICEF, 2022: https://data.unicef.org/topic/child-protection/violence/
[52] Ibid
[53] Physical violence was defined by NBSLEA as encompassing violent acts against a child including slapping, pushing, hitting with an object, kicking, or beating a child under 18 years. The definition also included if the child was threatened with a weapon, or if a weapon was used

males, compared to 47.8 percent among females, and 16.2 percent among males ages 13-17 years compared to 15.8 percent among females. Among males ages 18-24 years, physical violence by an authority figure was 57.6 percent for males compared to 43.3 percent for females.

Across countries which conducted similar NBSLEA surveys, including Kenya, Tanzania, Malawi, Zambia and Swaziland, Zimbabwe has the highest reported prevalence of physical violence experiences among boys, with three out of every four boys experiencing physical violence from a parent, adult caregiver, or authority figure as a child, and the second highest prevalence for physical violence among girls: with 65 percent of girls experiencing physical violence. The percentage of physical violence among girls in Zimbabwe was higher than the rate for Tanzania, Nigeria, Malawi, Zambia, and Swaziland. [54]

3.2.5 Child Marriages

Child marriage refers to any formal marriage or informal union involving at least one child under the age of 18.SDG 5.3 aims to "eliminate all harmful practices, such as child, early and forced marriage and female genital mutilations" by 2030.[55] Child marriage is often the result of deep, entrenched gender inequality in the country, product of gendered norms and practices, and has widespread social and economic negative consequences for women. Globally, the prevalence of child marriage among boys is just one-sixth of that of girls.[56] Girls who marry before age 18 are more likely to experience domestic violence and less likely to remain in school. Compared to those who marry at a later age, women who marry young experience fewer economic opportunities and higher health risks. Child marriage also has negative, intergenerational, spillover effects, straining a country's capacity to provide quality health and education services.[57]

Table 4 shows changes in child marriage over the past half decade. Although there have been significant reductions in rates of female child marriage, estimates nevertheless remain significantly high; In 2019, 5.4 percent of women 20-24 years of age were married before age 15, and 33.7 percent were married before age 18.[58] Results from the 2022 National Population Census show lower figures for child marriages, with 1 percent of women ages 20-24 having married before age 15 and 16.2 percent before age 18 years.

against them regardless of the reason or circumstances by a parent or adult relative. Source: UNICEF: Understanding determinants of violence in childhood: a secondary analysis of the National Baseline Survey of the Life Experiences of Adolescents in Zimbabwe.2016.

[54] UNICEF: Understanding determinants of violence in childhood: a secondary analysis of the National Baseline Survey of the Life Experiences of Adolescents in Zimbabwe. 2016.

[55] UN. "The 17 Goals | Sustainable Development"

[56] UNCEF: https://www.unicef.org/protection/child-marriage#:

[57] Ibid

[58] MICS 2019

Table 4: Child Marriage Indicators

Child Marriage Indicators	DHS 2015		MICS 2019		National Census 2022	
	Female	Male	Female	Male	Female	Male
20-24 years who married before age 15	3.7 percent	0.1 percent	5.4 percent	0.0 percent	1 percent	
20-24 years who married before age 18	32.4 percent	1.2 percent	33.7 percent	1.9 percent	16.2 percent	
20-24 years who married before age 15-Rural			8.0 percent	0.0 percent	1.6 percent	
20-24 years who married before age 15-Urban			2.3 percent	0.0 percent	0.3 percent	
20-24 years who married before age 18-Rural			43.7 percent	1.2 percent	22.7 percent	
20-24 years who married before age 18-Urban			21.3 percent	2.2 percent	7.2 percent	

Child marriages are more prevalent in rural areas compared to urban areas. In 2022, of those females ages 20-24 years who married before 18 years, 22.7 percent were in rural areas and 7.2 percent were in urban areas.[59] Harmful norms, traditional and religious beliefs and practices and poverty have contributed to high percentage of child marriages, particularly in rural areas. Consultations with communities revealed that some of the marriages are forced; in some religious sects, young girls are pledged to older men by their parents who promote the practice clandestinely. Some of the young girls are allegedly given away by their parents in exchange for food.

3.2.6 Harmful Cultural Practices

Traditional, harmful, forms of violence are those committed against women and girls in certain communities and societies as part of cultural traditions. Several of these customs have been practiced for such a long time that they have been normalized in the country.[60] In Zimbabwe, these cultural and religious norms include payment of lobola ("bride price") during marriage; child, forced and early marriages; forced virginity testing; wife inheritance; and disinheriting widows.

Payment of lobola

Payment of "bride price" or lobola is a common cultural practice across Zimbabwe. It involves the bridegroom offering the family of the bride a certain amount of money, or some form of in-kind gift, as a transaction marking the consummation of the marriage. This creates a patriarchal basis for the marriage. Consultations with communities conducted during the assessment in Bulawayo revealed that social norms, particularly the payment of lobola, has helped establish a sense of male entitlement, domination, and control over the bodies of women and girls, as well as propagated gendered intra-household roles.

Forced Virginity Testing

Virginity testing is a practice based on inspecting the genitalia of unmarried girls and women to determine if they are sexually chaste.[61] It is widely practiced in some rural communities and among some ethnic groups in Zimbabwe. Virginity testing involves physical inspection of the vagina, as well as

[59] 2022 National Population Census

[60] Public Health Scotland. Gender Based Violence. https://www.healthscotland.scot/health-topics/gender-based-violence/harmful-traditional-practices#

[61] Chisale, S.S. & Moyo, H. (2016). Church discipline as virginity: Shaping adolescent girls' sexuality in the Evangelical Lutheran churches in Africa. Alternation. 23 (2), 89-104.: Thobejane, T.D. & Mdhluli, T.D. (2015). Probing the efficacy of virginity testing on the fight against HIV/AIDS: The case of the Kwa-Zulu Natal, South Africa, OIDA International Journal of Sustainable Development. 8 (7), 11-20.

insertion of fingers and sponges into the vagina to determine if the girl is a virgin.[62] In addition to serious ethical concerns, virginity testing also brings with it potential serious health risks, as it is often conducted using unhygienic methods and processes.

The DVA of 2007 outlawed virginity testing as a harmful cultural and religious practice which violates the dignity and rights of women and girls. However, despite what's stipulated in the DVA, existing research suggests that the practice is still happening in several places throughout the country.[63] The prevalence of virginity testing has not been fully captured at the national level – population-based studies such as DHS and MICS do not include, in their survey instruments, a module to capture this. Therefore, additional research needs to be done to establish the magnitude and prevalence of this practice across the country.

Wife Inheritance

The custom of wife inheritance, or *kugara nhaka,* involves the wife of a deceased man being inherited by a relative, usually his brother. If the wife refuses to be inherited, she is usually disinherited by the relatives of the husband and forced away from her home, losing her property and land. A 2016 study by Human Rights Watch (HRW) conducted in 10 provinces of the country documented several cases of forced wife inheritance and dispossession of property by the husband's relatives. The report found that two-thirds of respondents said they faced experiences where their in-laws took over their homes or property, and they had no means to stop it. Others simply did not know that they had property and inheritance rights to begin with and were unable to withstand the intimidation tactics used by their in-laws, such as daily shaming, harassment, and physical assaults, to disinherit them.[64]

The FGDs with men groups illustrated several of the patriarchal assumptions about women, often rooted in harmful norms and customs that men continue to have. Several of these are dilucidated in Figure 2 below.

[62] Durojaye, E. (2016). The Human Rights implications of virginity testing in South Africa. An International Journal of Discrimination and the Law. 16 (4), 228-246; Thabethe, S.N. (2008). A case of culture gone awry": An investigation of female ceremonies and Nyau dance vigils on the rights of teenage girls to education and sexual reproductive health amongst migrant communities in Norton, Zimbabwe. (Unpublished dissertation)

[63] Ibid

[64] Human Rights Watch 2017. "You Will Get Nothing: Violations of Property and Inheritance Rights of Widows in Zimbabwe. Jan. 24. Accessed 1 June 2023 at: https://www.hrw.org/report/2017/01/24/you-will-get-nothing/violations-property-and-inheritance-rightswidows-zimbabwe.

Figure 2: FGDs views among men in Bulawayo

Women must be always submissive to their husbands: *"If women want to be equal with us men, then the issue of lobola should be done away with. You cannot expect me to take orders or instructions from someone I have paid lobola for. So, it's either we abolish lobola altogether or they also pay lobola for us as they do in India, for us men to accept that we are equal with women."*
Women cannot deny their male partner sex, because *"this is what she came into the marriage for and besides I will have paid lobola."*
GBV is justified in some cases because *"women are always provoking us, shouting at us, and disrespecting us as heads of households. If you are not employed, and do not bring enough money into the house, you will be treated like a child, not father of the house."*
Women experience violence because they sometimes dress 'provocatively': *"Some of the dressing is really provocative, it does not leave anything to the imagination. Us men when we see this, we quickly get aroused, and in the end, some might fail to control themselves and end up committing a crime. Women should dress decently."*
Divorced women have less value: "this issue of rights, while good, is destroying families. Some women have misinterpreted the issue of rights, and they really want now to take over as heads of households. That is why marriage is no longer respected especially by the younger generation, it's the reason we are having a lot of divorces and a lot of women have now become single mothers which are not good for raising children'.

3.2.7 Gender-Based Violence in the World of Work

GBV is also common in the workplace. In 2017, the International Labour Organization (ILO) conducted a Rapid Situational Analysis on Violence and Harassment in the Workplace in Zimbabwe which showed the prevalence of many forms of gender violence at work.[65] Incidences of sexual violence were the most common: of those that experienced some form of violence and harassment in the workplace, over 90 percent had experienced sexual harassment.[66] Zimbabwe has developed the Strategy for the Elimination of Sexual Harassment and GBV in the Workplace (2021-2025) to help adopt strategies for reduction of GBV in the labour force. It is vital to ensure effective implementation of the strategy, as well as to expand robust data- collection mechanisms, to capture and address GBV in the formal and informal economy.

3.2.8. Help-Seeking Behaviors Among Survivors of GBV

(a) Help-Seeking Behaviour of Survivors of GBV (15-49 Years)

The 2019 MICS gathers information on help-seeking behavior among female survivors of GBV ages 15-49 years. According to the MICS, out of the females who experienced GBV (both sexual and physical), only 37.7 percent sought help to stop the violence.[67] Another 27 percent did not seek help but told someone about the GBV, while 35.2 percent never told anyone or sought help. Only 31.4 percent of sexual violence survivors reported seeking help to stop the violence.

Close to half of the survivors, 48.8 percent, never sought help or told anyone about the sexual violence. For physical violence, only 35.1 percent sought help, 27.8 percent did not seek help but told someone

[65] ILO Rapid Situational Analysis on Violence and Harassment in the Workplace in Zimbabwe (2017)
[66] Ibid
[67] MICS 2019

about the abuse and 37.1 percent did not tell anyone or seek help. There is thus a high proportion of survivors not seeking help, which is a deeply worrying trend. The proportion of GBV survivors not seeking help was higher in rural areas, 63.3 percent, compared to urban areas, 60.4 percent.[68]

(b) Sources of Help

The 2019 MICS shows that 51.4 percent of GBV survivors sought help from family, 42.8 percent sought help from husbands/partners' family and 28 percent sought help from the police.[69] The police are the third preferred source of help, after the victim's own family and husband/partner's family. During community discussions, lack of confidence in the police, driven by perceived corruption and lack of victim friendly services, were cited as barriers to seeking help.[70] Moreover, underreporting to the police was also attributed to a fear of a potential backlash from the family of the husband/partner or the perpetrator. Survivors are also afraid of facing economic insecurity, should the husband/partner be incarcerated.[71]

The low levels of access to critical health services for survivors of GBV has significant negative health outcomes, including increased risk of HIV and STIs. The 2019 MICS also revealed that the proportion of survivors who sought help from medical doctors or personnel was also very low: 13.6 percent for sexual violence and 2.7 percent for physical violence. A very small proportion of the survivors, 0.5 percent, sought the services of lawyers for both physical and sexual violence. The evidence on the health-seeking behavior of GBV survivors points to the numerous structural, social, and economic barriers that women face in accessing services – as most resort to their own families and their husband's families for help. Few survivors go to professional service providers.

[68] Ibid
[69] Ibid
[70] FGDs with men and women from the community during consultations.
[71] MICS 2019

3.3 Groups Particularly at Risk of GBV

The 2019 MICS data shows that, among women, some populations are more vulnerable to GBV than others. As mentioned previously, IPV is the most common form of GBV, as close to 80 percent of GBV cases are IPV cases, involving married women or women living with their partners. Thus, most of the violence occurs in a domestic context, and hence married or women in a union are the most vulnerable to GBV.[72] Additional vulnerable groups include women in the age groups 20-49, women in the poorest wealth quintiles – 44.9 percent of women in the poorest wealth quintile are survivors of GBV, compared to 31.3 percent of women in the richest wealth quintile –and those with a disability.[73] Moreover, according to the GBV stakeholder consultations[74] additional populations vulnerable to GBV include: sex workers, lesbians, trans-gender, orphans, and girls living on the street.

> *"It is very difficult to report your husband to the police when he abuses you because most of us women rely on our husbands for the survival of the family. So, if you report him and he is arrested, you will suffer more, as no one will look after you. Besides, the husband's relatives will blame you for reporting him and they will be hostile. They will not even care to support you and you will suffer alone. Even other women, your friends will laugh at you and will tell you that you are a fool for getting your husband arrested, now look at the suffering that you are going through. So, most women end up not reporting and continue to suffer in silence. We only report when the violence become life threatening".*
>
> **FGD with women**

3.4 GBV and COVID-19 /Climate Change

The burden of GBV increases significantly during national emergencies. During the COVID-19 outbreak, Zimbabwe experienced a 60 percent increase in reported cases of GBV, with the national GBV Hotline, Musasa, receiving a total of 4,616 GBV-related calls during the lockdown period of March 30 to July 5, 2020.[75] From April to September 2020, almost 432 girls received post-violence care, more than 400 percent of the expected number, highlighting increased need of GBV services during lockdown. The Zimbabwe Gender Commission also noted an increase of GBV during lockdowns.[76]

There is a lack of national data on climate change and GBV in Zimbabwe. Although entire populations are adversely affected by the impacts of climate change, women and girls suffer the most. This was the case with cyclone Idai in Manicaland, where there were reports of sexual exploitation and abuse of women and girls by responders to the disaster.[77] Thus, among humanitarian responders, a culture of impunity can sometimes pervade, where responders may take advantage of the vulnerable conditions of survivors of humanitarian conflicts to abuse them.[78]

[72] MICS 2019
[73] UNPRPD 2019 Report: Female children with disabilities are twice as likely to experience sexual abuse, and they are twice more likely to face sexual violence than females without disabilities.
[74] Stakeholder consultations
[75] UN Office for the Coordination of Humanitarian Affairs. Cluster Status: Gender-Based Violence. Deb, 2021
[76] Gender links 'Gender-Based violence increases in Zimbabwe' https://genderlinks.org.za/news/110074/ (accessed 3 November 2021).
[77] Abigirl Phiri. Gender Responsive Resilience & "Climate change is worsening gender inequality in disaster-prone areas." Intersectionality in Policy & Practice. https://www.grripp.net/post/climate-change-is-worsening-gender-equality-in-disaster-prone-areas
[78] Bharat Desai: Role of Climate Change in Exacerbating Sexual and Gender-Based Violence Against Women: A New Challenge for International Law: Environmental Policy and Law, 2021.

4. LEGISLATIVE AND POLICY ENVIRONMENT FOR ADDRESSING GBV

Zimbabwe has shown a strong commitment to reducing GBV by signing and ratifying several international and regional instruments and treaties. These are summarized in Table 5 below.

Table 5) International, Regional and National Commitments for Reducing GBV

International Commitments	
1.	Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)
2.	The Convention on the Rights of the Child (CRC)
3.	Beijing Platform for Action
4.	United Nations Resolution 1325 (2000) on Women, Peace, and Security
5.	The 2030 Agenda of the Sustainable Development Goals.
Regional Commitments	
1.	African Charter on human and peoples' rights
2.	The Solemn Declaration on Gender Equality in Africa
3.	The Protocol to the African Charter on Human and People's Rights on the Rights of Women (Maputo Protocol)
4.	The African Charter on the Rights and Welfare of the Child
5.	AU Agenda 2063; and the African Youth Charter
6.	The SADC Protocol on Gender and Development, 2008 (revised in 2016)
7.	SADC Regional Strategy and Framework of Action for Addressing GBV (2018 – 2030)
8	Protocol on Politics, Defense and Security Affairs
National Legal Framework	
1.	National Constitution (2013)
2.	The Domestic Violence Act of 2007
3.	The Sexual Offences Act (2002)
4.	The Criminal Law Codification and Reform Act
5.	The Administration of Estates Amendment Act of 1997
6.	The Maintenance Act of 1989
7.	The Matrimonial Causes Act of 1987
8.	The Legal Age of Majority Act of 1982
9.	The Children's Act
10.	Trafficking in Persons Act (2014)
11.	Marriages Act (Chapter 5:17).
12.	Cyber and Data Protection Act (No. 5 of 2021)
National Policy Framework	
1.	HLPC on Ending Gender-Based Violence and Harmful Practices (2021-2030) in Zimbabwe.
2.	National Gender policy 2017 (being reviewed)
3.	Zimbabwe National Gender-Based Violence Strategy (2012-2015) Being reviewed
4.	Strategy for the Elimination of Sexual Harassment and Gender-Based Violence in the Workplace in Zimbabwe (2021-2025).
5.	Protocol on the Multi-Sectoral Management of Sexual Abuse and Violence in Zimbabwe (2012).
6.	National Action Plan and Communication Strategy on Ending Child Marriage

4.1 Legal Framework

4.1.1 International Commitments on GBV

The country has demonstrated a strong committed to eradicating GBV through signing and ratifying several global legislative instruments on GBV. Some of these include: the Beijing Platform for Action, adopted by the Fourth World Conference on Women in 1995, which urges governments and all sectors to take integrated measures to prevent and eliminate Violence Against Women and Girls (VAWG). Moreover, the GoZ also signed and ratified the 2019 ILO Violence and Harassment Convention which places a responsibility on state parties to pursue a policy of "zero tolerance to violence and harassment" and provides universal definitions of GBV in the world of work. The GoZ also subscribed to the 2030 SDG Agenda, including SDG 5, which aims to, by 2030, achieve gender equality and empower all women and girls.

4.1.2 Regional Commitments on GBV

Zimbabwe is also a signatory to various regional commitments on GBV. These include the African Charter on human and peoples' rights; the Solemn Declaration on Gender Equality in Africa; the Protocol to the African Charter on Human and People's Rights on the Rights of Women (Maputo Protocol); the African Charter on the Rights and Welfare of the Child; AU Agenda 2063; and the African Youth Charter. Moreover, the government has signed the SADC Protocol on Gender and Development, 2008, revised in 2016, which is the first commitment by member states towards addressing GBV comprehensively and identifies GBV among the priority areas of focus for the SADC Region.

4.1.3 National Legal Framework

Zimbabwe has enacted several national laws aimed at outlawing GBV; these include the following:

National Constitution (2013) prohibits discrimination on the grounds of sex, gender, and marital status, outlaws all traditional practices, customs and values that constitute a violation of human rights. The Constitution also provides for protection and freedom from all forms of violence from public and private sources, protects citizens from being subjected to physical or psychological torture or to cruel, inhuman or degrading treatment or punishment and adopts measures for the prevention of domestic violence.

The Domestic Violence Act (DVA) of 2007 provides for protection and relief to survivors of domestic violence. The DVA is one of the first domestic acts to address GBV in the domestic space.

The Sexual Offences Act (2002), now part of the Criminal Law (Codification and Reform) Act of 2006, criminalizes marital rape and prescribes sanctions for acts of GBV.

The Administration of Estates Amendment Act of 1997 seeks to protect the property of the deceased for the welfare of the surviving spouse and children.

The Maintenance Act of 1989 ensures provision of monetary or material support for the upkeep of the spouse, children, and other dependents where there is a duty to do so.

The Matrimonial Causes Act of 1987 ensures equitable distribution of property upon divorce.

The Legal Age of Majority Act of 1982, now part of the General Laws Amendment Act, gives women all the rights and benefits of full citizens.

Marriages Act No.1 of 2022 was harmonized with the provisions of the constitution and criminalizes child marriages. The Marriages Act states that "*No person under the age of eighteen years may contract a marriage or enter into an unregistered customary law marriage or a civil partnership.* For breaking the law, the Act prescribes a Level 19 fine or a prison term of up to five years.

The Labour Act makes provision for sexual harassment in the workplace. Although classified as an unfair labour practice under section 8, GBV it is not given the urgency it merits.

4.1.4 Key Strengths, Gaps and Opportunities in Legislation

Although the national legal framework on GBV is robust and progressive, more needs to be done to strengthen it. Key legislative gaps include inadequate implementation of GBV laws owing to several, cross-cutting factors, including patriarchal attitudes among stakeholders in charge of implementing the laws, inadequate human and financial resources, limited capacity among key actors in charge of implementation, corruption, limited awareness of laws and of the modus operandi of the judiciary system and lack of financial resources among GBV survivors.

Additional gaps include a complicated and obscure judicial process and weak accountability mechanisms for implementation. Moreover, progress in harmonizing subsidiary legislation with the Constitution and with international conventions has been slow, owing to inadequate human and financial resources, insufficient political will, weak coordination mechanisms among stakeholders, and the outbreak of the COVID-19 pandemic in 2019. Some of the laws, such as the 2007 DVA need to be reviewed to ensure coverage of emerging forms of GBV.

4.2 Policy Framework

4.2.1 Key GBV Policies and Strategies

Zimbabwe has established a comprehensive policy and strategy framework aimed at promoting gender equality and women's empowerment and ending GBV. Below are some of the key policies and strategies the GoZ has adopted to address GBV.

High-Level Political Compact (HLPC) on Ending Gender-Based Violence and Harmful Practices in Zimbabwe. (2021)

The 2021 HLPC aims to develop a national action plan for implementation for addressing GBV across several areas, including: prevention, service delivery, resource mobilization, coordination, and women's empowerment. It was signed by a wide net of policy actors, including the President of the Republic of Zimbabwe; the UN Resident Coordinator in Zimbabwe; the President of the Chiefs Council; the Chairperson of National Association of NGOs; and the representative of the Zimbabwe Council of Churches. All of these stakeholders committed to the eradication of GBV and harmful practices in Zimbabwe by 2030.

National Gender Policy (2013-2017)

The second NGP, 2012-2017, replaced the first NGP of 2004. The vison of the 2012-2017 NGP aims to strive for *"A gender just society in which men and women, boys and girls, enjoy equity, contribute and benefit as equal partners in the development of the country"* and its goal is to "*eradicate gender discrimination and inequalities in all spheres of life and development".* The NGP is currently being reviewed to align it with emerging trends of GBV and with the updated national social, economic, political, and legal context of the country.

Zimbabwe National Gender-Based Violence Strategy (2012-2015)

The National GBV Strategy was developed to improve the efforts of government, CSO, and development partners to prevent and respond to GBV through a multi-sectoral, effective, and coordinated response. The National GBV Strategy concluded in 2015. No immediate successor of the

strategy was developed. To fill this policy vacuum, the government, with support from development partners and CSOs, implemented the Zero Tolerance 365 National Programme on Gender-Based Violence Prevention and Response (GBV-365) from 2016-2021. The GBV 363 programme became the de-facto GBV Strategy in the absence of a specific National GBV Strategy. A new GBV strategy is currently being developed by the MWACSMED.

National Development Strategy 1 (2021-2025)

The current economic development blueprint for the country is the NDS 1. The NDS 1 acknowledges that there has been limited gender mainstreaming across sectors, and that women still face hurdles in access to economic opportunities. To combat GBV, the strategy seeks to consolidate the implementation of the DVA, implement gender responsive budgeting (GRB) and strengthen women economic empowerment (WEE) initiatives.[79]

National Action Plan on Ending Child Marriages (2019-2021)

The National Action Plan (NAP) on ending child marriages aims for a country free from child marriages. The NAP seeks to: enhance a coordinated response to child marriages in the country; improve monitoring, reporting, and evaluation of programs to end child marriage in Zimbabwe; promote child and youth participation in ending child marriages; enhance compliance with a minimum age of marriage; and reduce incidences of child marriages. The NAP ended in 2021, and no successor plan has been developed to date.

Strategy for the Elimination of Sexual Harassment and Gender-Based Violence in the Workplace in Zimbabwe (2021-2025)

Zimbabwe has developed a strategy for the Elimination of Sexual Harassment and Gender-Based Violence in the Workplace in Zimbabwe (2021-2025). The strategy aims to guide workplace environments in their fight against GBV and sexual harassment.

Protocol on the Multi-Sectoral Management of Sexual Abuse and Violence in Zimbabwe (2012)

The 2012 Protocol on the Multi-Sectoral Management of Sexual Abuse and Violence in Zimbabwe, hereinafter referred to as the Protocol, is a guidance tool for government stakeholders, and CSOs, to assist them in providing a set of wraparound services to survivors of sexual violence and abuse.

The Protocol sets out minimum standards and key procedures for all relevant stakeholders to provide survivor-centered services to survivors of sexual violence and abuse. It also adopts an age, disability, and gender-sensitive approach, and outlines special measures that are required for all stakeholders engaged in preventing and responding to survivors of sexual violence and abuse. The Protocol binds all signatory ministries departments, and CSOs to the management of sexual violence and abuse.

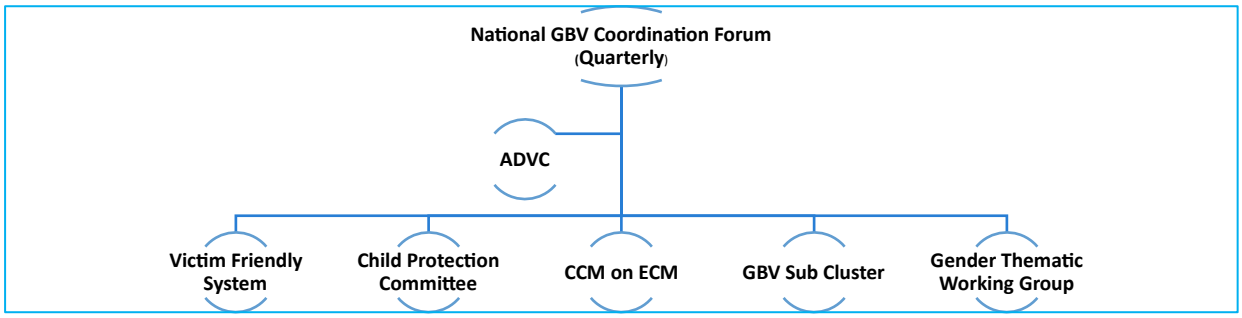
The Protocol sets out a robust organizational architecture to address the needs of survivors of GBV and VAC, which includes cross-collaboration with the Ministry of Justice, Legal and Parliamentary Affairs (MoJLPA), the Ministry of Health and Child Care (MoHCC), the police and the Ministry of Labour and Social Services. The Protocol aims to help ensure that GBV survivors have access to a series of wraparound services, which are triggered as soon as the victim reports the incident. These are discussed, in greater detail, in Chapter 5.

[79] NDS, 2021-2025

5. INSTITUTIONAL FRAMEWORK AND COORDINATION MECHANISMS

As stated in the Protocol, the GBV coordination platforms include National GBV Coordination Forum; Victim Friendly System; Child Protection Committee; Country Coordination Mechanism on Ending Child Marriage; GBV Sub-Cluster; and the Gender Thematic Working Group (GTWG). As shown in Figure 3 below, the ADVC is the secretariat mandated to implement the GBV strategy. However, implementation of the Protocol faces several challenges: national coordination of GBV prevention and response intervention is fragmented, and siloed, as there are parallel structures, and overlapping mandates and organization platforms.

Figure 3: GBV Coordination Mechanism



Source: Protocol on the Multi-Sectoral Management of Sexual Abuse and Violence in Zimbabwe

National GBV Coordination Forum and the ADVC

MoWACSMED has the mandate to coordinate stakeholders working on GBV at the national, provincial and district levels and to administer the DVA. MoWACSMED oversees the National GBV Coordination Forum. MoWACSMED is mandated to coordinate GBV policies and programs through a multi-sectoral approach, which filters down to the province, district, and ward level, intending to make the services accessible to vulnerable populations across all geographic levels. GBV coordination forum meetings are convened monthly at the provincial and district levels, and quarterly at the national level. The ADVC is the secretariat mandated to implement the GBV strategy and oversee the implementation of the 2007 DVA.

Country Coordination Mechanism on Ending Child Marriage

The Country Coordination Mechanism on Ending Child Marriages (CCM on ECM) is chaired by MoWACSMED. The purpose is to coordinate all stakeholders working to end child marriages in Zimbabwe. The GBV-Sub Cluster is co-chaired by UNFPA and MoWACSMED and helps coordinate GBV initiatives at national level. The CCM on ECM is co -chaired by UN Women and MoWACSMED. The technical working group provides support to the National GBV Coordination Forum.

CSOs, including FBOs and NGOs, play a critical role in all the coordination platforms mentioned previously. CSOs assist in the early identification of abuse: support survivors to access statutory services; assists survivors and their families to cope with the effects of the abuse; facilitates the safe

and dignified reintegration of survivors back into their communities; and holds service providers accountable.[80] Traditional leaders also have a role in ensuring the timely reporting of cases by their communities.

National Victim Friendly System (VFS) and the LAD

The Chief Magistrate's Office chairs the National Victim Friendly Committee (NVFC) and is responsible for the overall coordination of policy reform and overseeing the implementation of the Protocol. The JSC is responsible for ensuring that vulnerable survivors and witnesses actively and meaningfully participate in the justice process and that all other interested parties meet their obligations. The MoJLPA has the dual responsibility of leading the development of policy relating to justice for children and important aspects of service delivery, including legal aid and the management of detention facilities. The LAD has the mandate to deliver free legal aid services to impoverished persons across the country.[81]

Child Protection Committee

The Child Protection Committee is chaired by the Department of Social Services (DSS) in the Ministry of Labour and Social Services. The Ministry of Labour and Social Services DSS is the lead government department responsible for implementation of the Children's Act, ensuring protection of children from all forms of abuse. The DSS plays an important role in the protection of children who have experienced abuse or live in a situation where they are at risk.[82]

Key Coordination Challenges

Although there is a widespread institutional network for coordination of the GBV Prevention and Response, several challenges remain. These include incapacitation of the ADVC owing to poor funding and inadequate human resources. Moreover, due to financial constraints, the ADVC has not been able to convene some of its coordination meetings.[83] Similarly, absence of a protocol for some of the coordination platforms have resulted in several of the ADVC meetings not being convened as regularly as required. [84]

Overlapping and unclear mandates between ministries and other institutions often complicate and confuse the implementation of different service interventions. For example, there is lack of clarity on whether it is the MoHCC or the DSS that takes the lead on issues relating to VAC. There is also a lack of precision on which ministry oversees the ADVC. This confusion affects the convening and timely application of coordination meetings. Moreover, duplication of agendas among institutions involved in the national GBV response protocols hampers the efficiency to the GBV response.[85] Similarly, parallel coordination mechanisms create fatigue among stakeholders, who must attend several meetings under different coordination mechanisms.[86]

[80] Protocol on the Multi-Sectoral Management of Sexual Abuse and Violence in Zimbabwe (2012)
[81] Ibid
[82] Ibid
[83] National Stakeholder Consultative Workshop
[84] Ibid
[85] National Gender Forum Report (2020); Stakeholder consultative workshop
[86] National Stakeholder Consultative Workshop

6. GBV RESPONSE AND PREVENTION PROGRAMMING

This section identifies key GBV programmes currently being implemented in Zimbabwe, and discusses the successes, strengths, and gaps in programming. The main GBV programmes currently being implemented in the country include the Spotlight Initiative (SI), Determined, Resilient, Empowered, AIDS-free, Mentored and Safe (DREAMS), Stopping Abuse and Female Exploitation (SAFE) and INSPIRE Women, Men and Children. This chapter will explore the public sector response, which is often coupled with initiatives from NSOs and NSOs, as well as the SI.

6.1 Response Programming

6.1.1 Health Sector Response

The Health Sector Response to GBV is spearheaded by the MoHCC which provides services through its country-wide network of hospitals, clinics, and health centers. As stipulated in the Protocol, the MoHCC offers urgency health services, within a 72-hour window of reporting the incidence, to survivors of sexual violence. The Protocol stipulates that medical examinations and medical affidavits are to be provided to the survivor for free. The MoHCC has medical social workers who also provide psychosocial support to survivors.

CSOs assist GBV survivors to access health services from health centres. NGOs such as Musasa, Adult Rape Clinic, Family Support Trust assist GBV survivors to access health services by providing transport to health centers and providing health services, such as testing for HIV and STIs. Programmes such as the SI, implemented by UN Agencies with funding support from the EU, have supported Mobile One Stop Centres where health services are provided to GBV survivors in remote locations where these services are not readily available.

During stakeholder consultations, several barriers to accessing services were identified. These include long distances to health centres, requiring transport money for commuting, which some survivors cannot afford, inadequate human resources at health centres; stockouts of essential medicines; and lack of knowledge on existence of GBV services.[87] These challenges result in GBV survivors at times missing the 72-hour window for the provision of emergency health services.

6.1.2 Psychosocial Sector Response

The Protocol stipulates that psychosocial support be provided to empower survivors to report abuses to the police and help them safely reintegrate back into society. The Police Victim VFU, as well as psychologists, counselors, or social workers in the DSS, are trained to provide initial counselling to the survivor to reduce trauma. The main challenge encountered in the provision of psychosocial support is the shortage of social workers in the DSS. Feedback from stakeholder consultations suggest that many trained workers have left the DSS, leaving the ministry understaffed. CSOs have had to fill in this vacuum, to provide psychosocial support to survivors.

NGOs supporting government GBV efforts with psychosocial support include counselling, provision of security and economic support. NGOs such as Musasa have GBV One Stop Centres and Safe Shelters where survivors are provided with counselling and are trained in various skills to enable them to attain some level of economic self-independence.

[87] Stakeholder consultations

6.1.3 Legal/Justice Response

Survivors of GBV need legal assistance to access justice. As mentioned previously, the JSC courts are responsible for ensuring that vulnerable survivors and witnesses are supported to participate in the judicial process actively and meaningfully, and that all relevant parties meet their obligations.[88] The Protocol stipulates that all sexual violence and abuse cases are to be treated as priority cases. The LAD, under the Ministry of Justice, has the mandate to deliver free legal aid services to impoverished persons across the country. Legal assistance is provided at GBV One Stop Centers or at the magistrates' courts.

As is the situation with other government departments, the LAD has a shortage of staff, which makes it difficult to provide services to all GBV survivors. CSOs such as Zimbabwe Women Lawyers Association (ZWLA) have been filling this vacuum by providing free legal assistance to GBV survivors. Access to justice for GBV survivors is fraught with several challenges. Due to human resource shortages, the trial of GBV cases is not conducted swiftly. In some cases, it has taken over 2 years for the GBV cases to be completed. Moreover, given that most of the survivors are poor, they are unable to secure transport money to attend the trails. Consequently, some of the survivors end up withdrawing their cases or not showing up. [89]

6.1.4 Security Response

The GoZ, and CSOs such as Musasa, have established safe houses for survivors of GBV. The safe houses are transit centers where survivors stay until their cases are finalized. During their stay at the safe houses, the survivors are provided with counselling, transport to and from courts, and legal services during the processing of their cases by the courts. At some of the safe houses, CSOs train the survivors in skills such as gardening, detergent making, and dressmaking. The objective is to enable the survivors to utilize these skills when they leave the safe shelter to attain some levels of economic self-dependence.

The operation of safe shelters is hamstrung by limited financial and human resources. Some of the shelters do not have vehicles to transport survivors to and from court and must rely on hired private transport, which is expensive. Other shelters lack adequate food and amenities for the survivors. The safe shelters are also exclusively for women and girls and are not designed to handle men and boys. Men and boys who are survivors of SGBV have their security needs largely unmet by the current GBV response interventions.

6.2 GBV Prevention Programming

GBV Prevention intervention programming in Zimbabwe is mainly focused on strengthening the legal and policy framework to change harmful social norms and practices. Comprehensive sexuality education has also been introduced in schools, through the Guidance and Counselling Module, to educate boys and girls on SRHR and SGBV. Prevention programmes are mainly spearheaded by CSOs with funding from development partners and in partnership with government, traditional leaders, and communities. Some of the key GBV programmes implemented in the country include the Joint programme on Gender Equality, GBV 365, SAFE, TRACE, PfP, DREAMS and Child Protection.

The Spotlight Initiative (SI)

The SI is perhaps the most far-reaching GBV programme currently being implemented in Zimbabwe, with funding support from the EU. The SI is a global initiative and Zimbabwe is one of eight participating countries in Africa. In Zimbabwe, the SI has been implemented since 2019, and will end in 2023. The SI is implemented through six UN Agencies led by the UN Resident Coordinator with the UN Women as the Technical Lead. The SI is focused on developing and implementing relevant GBV legislation and

[88] Protocol on the Multi-Sectoral Management of Sexual Abuse and Violence in Zimbabwe (2012)
[89] Stakeholder consultations

policies; strengthening institutions; strengthening prevention services programmes and campaigns; ensuring the collection and use of prevalence and incidence data; and supporting women's rights movements and CSOs, SI reached more than 5 million beneficiaries in the country, including women, men, boys, and girls. SI has also contributed to enshrining protections against GBV into the law and has been active in strengthening the country's GBV legal and policy framework.

While the SI is one of the flagship GBV programmes in the country, coverage has been limited, as it focused on only five provinces. The limited coverage of the programme excluded some areas where GBV prevalence is high. Moreover, although the SI contributed to some very central policy reforms in addressing GBV, additional efforts must be directed at tackling long-standing gendered norms. This requires the implementation of GBV policies programmes of a longer program cycle, of at least 8-10 years.

7. GBV FINANCING

There exists empirical evidence on the economic costs of GBV. A study of twenty-seven countries in Sub-Saharan Africa (SSA), including Zimbabwe, found that an increase in the share of women subject to violence by 1 percentage point, and the significant drop in female employment associated with it, can reduce economic activities, measured by nighttime light activity, by up to 8 percent.[90] UNDP estimates that the government is only able to meet about 10 percent of the country's US$80 million annual GBV program funding requirements, and many external funders have cut resources to this area.[91]

As part of a cross-cutting, holistic approach to addressing GBV, there must be an exploration into available financing mechanisms to support GBV programming. A policy paper by SI on GBV Financing Options made the following recommendations to help increase funding support for GBV interventions in the country, which this report espouses:

- **Establishing a business case for increased GBV funding** from the national budget by providing evidence on the cost of GBV to the national economy. Developing statutory mechanisms for mainstreaming GRB across all government ministries and institutions to ensure that GBV funding is "ring fenced" across the multi-sectoral response mechanism. The statutory provisions should entail institutions to set aside a certain percentage of their budgets for gender equality initiatives, including GBV.
- **Leveraging on government's migration to programme-based budgeting** to ensure that all stakeholders in the GBV multi-sectoral response mechanism develop specific GBV programmes that they will use to bid for funding from the national treasury. For this to succeed, awareness creation across institutions is needed to ensure that these are conscious of the need for GRB when they are developing their programme budget proposals.
- **Private sector engagement** through establishing a business case for addressing GBV, its impacts on the private sector and how tackling GBV can improve the performance and corporate image of the private sector companies.
- **Support CSOs and FBOs** to engage in income-generating activities to enable these organizations to locally fund the GBV local initiatives.
- **Further strengthen the Comprehensive Sexuality Education Curriculum in schools** to foster, at an early stage, changing norms, values, and practices to promote gender equality and gender justice, ultimately leading to a decline in GBV cases and associated service provision costs.

With support from the SI, the GoZ produced its first National Gender Budget Statement for 2022. The budget statement provides a baseline for tracking the government's gender financial commitments and expenditure.[92] The GoZ is also taking seriously the issue of incentivizing submission of GRB by line ministries, which will assist in improving gender mainstreaming in the national budgeting process.

[90] Ouedraogo, R. and Stenzel, D. 2021

[91] UNDP n.d. Spotlight Initiative: Financing Options for Sexual and Gender-Based Violence in Zimbabwe: Policy Brief Summary 147 Spotlight Initiative: Our gains in fighting violence against women and girls

[92] Ibid

8 CONCLUSIONS

Zimbabwe has made significant progress in narrowing gender disparities, particularly in levels of education. The country has also made significant steps to address GBV, by developing a strong legal and policy framework aligned with the National Constitution and with international and regional protocols on GBV. However, despite these areas of progress, overall rates of GBV remain high, and many forms of violence have not significantly changed over the past decade. Additionally, the prevalence of VAC in the country is still worryingly high.

According to the 2019 MICS, 39.4 percent of women in the country experienced physical violence, 11.6 percent experienced sexual violence and 8.6 percent experienced physical and sexual violence. Furthermore, the 2011 NBSLEA estimated that 33 percent of women experienced violence before age 18. Physical violence rates also remain higher than the global averages and have shown little change in the past fifteen years. Violence against children is also a significant issue, with rates of physical violence against children being: 60.9 percent among males and 47.8 percent among females, higher than the rates observed in several countries in SSA. Certain populations, such as women in the poorest wealth quintiles, sex workers, PWD, trans-gender, orphans and girls living on the streets remain particularly vulnerable to GBV.

Patriarchal social norms, such as the payment of lobola, forced virginity testing, and wife inheritance, have been normalized, and have paved gender inequality onto the country's social and economic landscape. Moreover, according to the 2019 MICS, close to half of sexual violence survivors did not seek help. Only 28 percent of survivors of GBV sought help from the police, which illustrates lack of confidence in the authorities, driven, in part, by perceived corruption and absence of victim friendly services.

To effectively combat GBV and protect children from violence, stronger legislative frameworks and policy support is needed. This requires a multi-pronged approach, including full implementation of existing policy and legal frameworks, as well as long-term, sustainable, support to critical response services and prevention programming. Strategies should include completing the of harmonization of remaining laws and bills with the 2013 Constitution, and global and regional instruments on GBV, as well as decentralizing the LAD to the district levels. Prioritizing the finalization of the New NGP and the National GBV Strategy, and strengthening the ADVC, which has been minimally functional in recent years, are also crucial steps.

Zimbabwe is at a turning point, levels of GBV and VAC remain high. The GoZ has demonstrated a strong commitment to combatting GBV, however, renewed efforts are needed to address structural gender inequalities deeply ingrained in the country's social fabric. A comprehensive, multi-pronged strategy is needed, where the GoZ can collaborate with CSOs, FBOs and other development partners to create a robust policy framework and invest in long-term programming to address the high prevalence of GBV and VAC in Zimbabwe.

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