# SAFE Baseline Evaluation Policy and Programme Brief

*This policy and programme brief presents key findings and recommendations from the baseline evaluation of SAFE, conducted by the Evaluation and Learning Unit. The brief is targeted towards researchers, practitioners, government stakeholders, policy makers and donors working on the prevention of VAWG in Zimbabwe.*

## Background

**Violence against women and girls (VAWG) is widespread in Zimbabwe, particularly intimate partner violence (IPV).** The Stopping Abuse and Female Exploitation (SAFE) programme, funded by the UK Foreign, Commonwealth and Development Office (FCDO), is a social and economic empowerment VAWG prevention programme that also includes VAWG response elements. The programme aims to increase family wellbeing and reduce IPV in three districts of Zimbabwe: two rural districts (Chikomba and Mwenezi) and one urban district (Chiredzi).

## Key Findings

- **IPV is highly prevalent: almost half of women had experienced at least one type of IPV in the past year.**
- **Corporal punishment against children is also very common: more than half of women had beaten their child in the past year.**
- **Women's experience of IPV is associated with poor mental health, although the direction of this relationship cannot be established.**
- **Women are more likely to experience IPV if their partner drinks alcohol frequently.**
- **Prevalence of IPV is higher among women who married before the age of 18.**
- **Household food insecurity and economic shock are important drivers of IPV.**
- **Approximately half of survivors told nobody about the violence they experienced.**
- **Barriers to help-seeking include unaffordability of fees or transport, and negative consequences of reporting or seeking help.**

## The SAFE programme

Implemented by:

## Research and evaluation supported by the Evaluation and Learning Unit (ELU)

SAFE's ELU supports the programme by testing the effectiveness and impact of the intervention model, and producing learning about what works in VAWG prevention and response in Zimbabwe.

In 2021, the SAFE ELU conducted a study on social and gender norms that drive IPV and early marriage in SAFE's implementation districts to inform the design of the programme.

## Baseline evaluation

In 2022, **SAFE's Evaluation and Learning Unit conducted a baseline evaluation** of the programme, consisting of a baseline household survey with **1,245** female SAFE beneficiaries, aged **18** years and above, in **14** wards across the three districts where SAFE is being implemented.

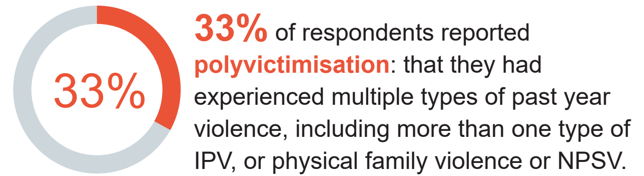
# Key findings

## Prevalence of violence

**IPV is highly prevalent among women participating in the baseline study**, highlighting the urgency of prevention efforts in Zimbabwe.

- **47% of women had experienced at least one type of IPV** in the past year, and 54% reported controlling behaviour from their partner.
- **Emotional IPV was the most commonly reported past-year type of IPV (39%)** followed by economic IPV (30%), physical IPV (18%) and sexual IPV (12%). Nineteen percent of respondents who had been in a relationship in the last year had experienced severe IPV (repeated incidences of physical or sexual violence).
- Experience of past year **IPV and controlling behaviours from a partner were most prevalent in Chiredzi**, which is an urban district, than in Chikomba and Mwenezi (rural districts).
- The **prevalence of past year physical, sexual and emotional IPV** in the SAFE baseline sample is higher than the national prevalence rates for these forms of IPV according to the the Zimbabwe Demographic and Health Survey (ZDHS), particularly emotional IPV.

Prevalence of **physical violence** perpetrated by a family member other than a partner (2%), or **non-partner sexual violence** (NPSV) (1%), were low in the SAFE baseline sample; however, the rate of NPSV is in alignment with national prevalence rates reported in the ZDHS.




**33%** of respondents reported **polyvictimisation**: that they had experienced multiple types of past year violence, including more than one type of IPV, or physical family violence or NPSV.

**53%** of women participating in the baseline survey reported that they had used **corporal punishment against a child** in the past year, and

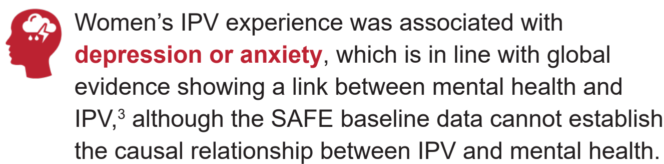
**28%** reported that their partner had done so.

[1] Zimbabwe National Statistics Agency and ICF International (2016) *Zimbabwe Demographic and Health Survey 2015*. ZimStat and ICF International. Harare, and Rockville, Maryland, USA.
[2] Ibid.

# Key findings

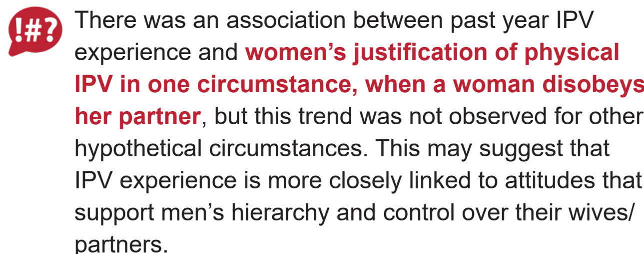
## Factors associated with IPV experience

The baseline study found a number of factors that are significantly associated with women's experience of past year IPV, many of which are in line with the evidence in Zimbabwe and in the wider global literature.

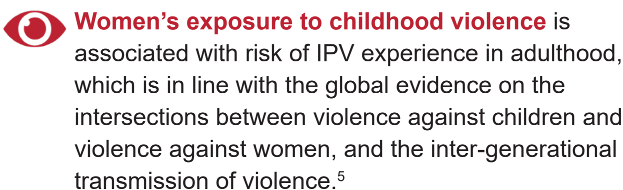


Women's IPV experience was associated with **depression or anxiety**, which is in line with global evidence showing a link between mental health and IPV,[3] although the SAFE baseline data cannot establish the causal relationship between IPV and mental health.

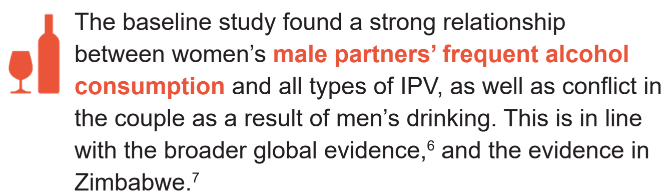
An association was found between **women's affiliation with the Apostolic church** and their experience of IPV, and this association has been observed in other studies in Zimbabwe.[4]



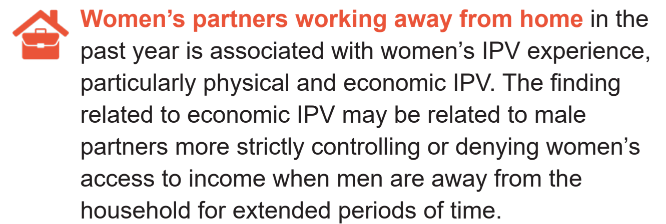
There was an association between past year IPV experience and **women's justification of physical IPV in one circumstance, when a woman disobeys her partner**, but this trend was not observed for other hypothetical circumstances. This may suggest that IPV experience is more closely linked to attitudes that support men's hierarchy and control over their wives/ partners.



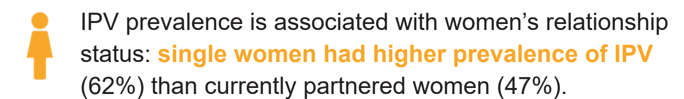
**Women's exposure to childhood violence** is associated with risk of IPV experience in adulthood, which is in line with the global evidence on the intersections between violence against children and violence against women, and the inter-generational transmission of violence.[5]



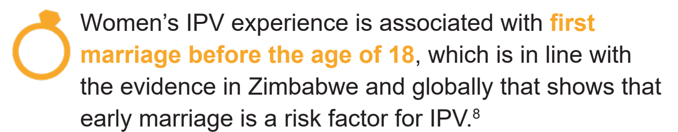
The baseline study found a strong relationship between women's **male partners' frequent alcohol consumption** and all types of IPV, as well as conflict in the couple as a result of men's drinking. This is in line with the broader global evidence,[6] and the evidence in Zimbabwe.[7]



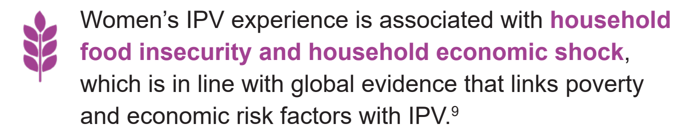
**Women's partners working away from home** in the past year is associated with women's IPV experience, particularly physical and economic IPV. The finding related to economic IPV may be related to male partners more strictly controlling or denying women's access to income when men are away from the household for extended periods of time.



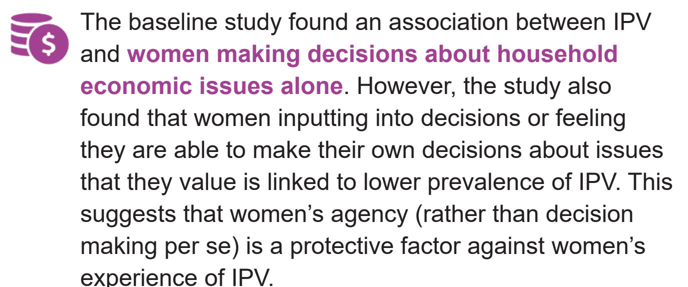
IPV prevalence is associated with women's relationship status: **single women had higher prevalence of IPV** (62%) than currently partnered women (47%).



Women's IPV experience is associated with **first marriage before the age of 18**, which is in line with the evidence in Zimbabwe and globally that shows that early marriage is a risk factor for IPV.[8]



Women's IPV experience is associated with **household food insecurity and household economic shock**, which is in line with global evidence that links poverty and economic risk factors with IPV.[9]



The baseline study found an association between IPV and **women making decisions about household economic issues alone**. However, the study also found that women inputting into decisions or feeling they are able to make their own decisions about issues that they value is linked to lower prevalence of IPV. This suggests that women's agency (rather than decision making per se) is a protective factor against women's experience of IPV.

Note:

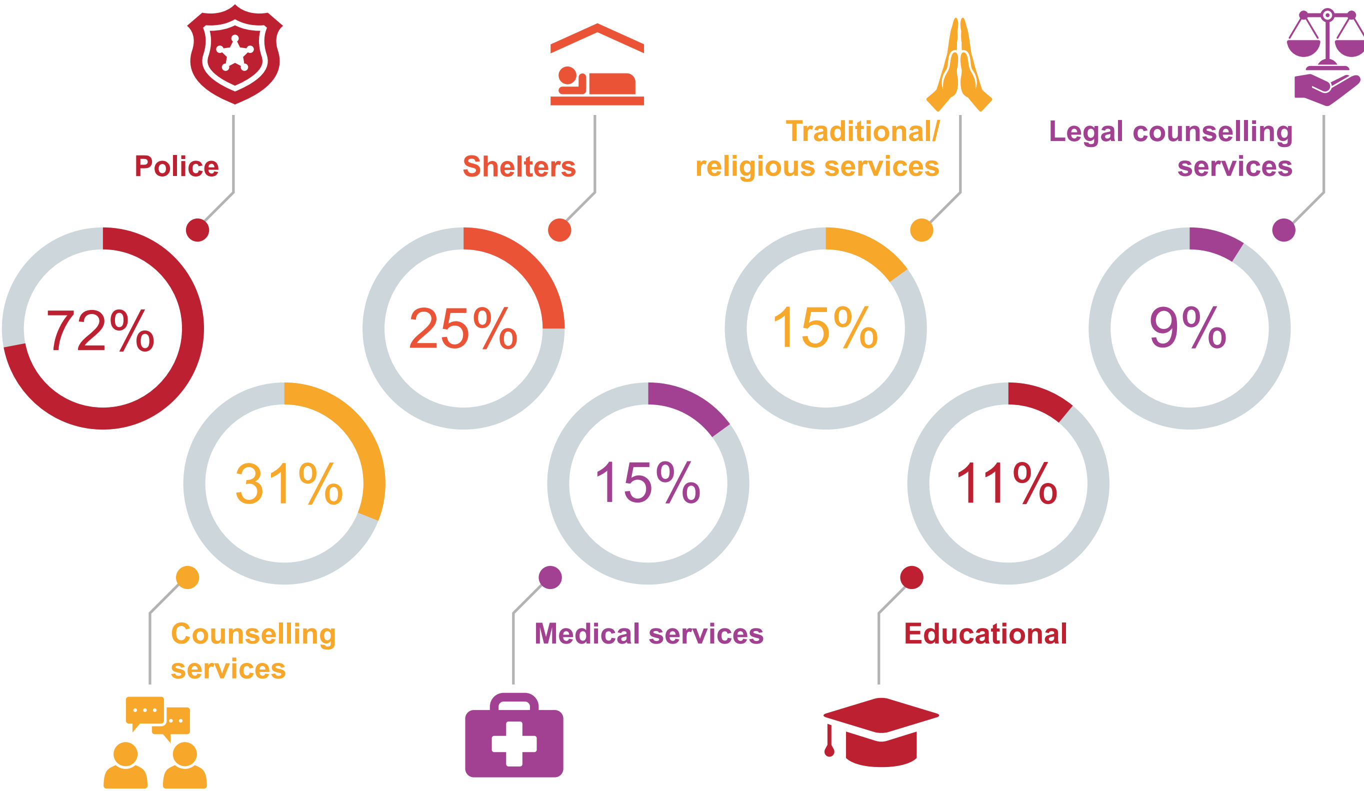
- These factors are linked to women's individual characteristics
- These factors are linked to women's partners' characteristics
- These factors are linked to relationship characteristics
- These factors are linked to relationship and family dynamics

[3] Ramsoomar, L., Gibbs, A., Machisa, M. et al. (2019) *Associations between Alcohol, Poor Mental health and Intimate Partner Violence. Evidence Review*. What Works to Prevent Violence Against Women and Girls Global Programme.
[4] Zimbabwe National Statistics Agency and ICF International (2016) *Zimbabwe Demographic and Health Survey 2015*. ZimStat and ICF International. Harare, and Rockville, Maryland, USA
[5] Guedes, A. et al. (2016) Bridging the gaps: a global review of intersections of violence against women and violence against children. *Global Health Action*, 9: 1.
[6] Ramsoomar, L., Gibbs, A., Machisa, M. et al. (2019) *Associations between Alcohol, Poor Mental health and Intimate Partner Violence. Evidence Review*. What Works to Prevent Violence Against Women and Girls Global Programme.
[7] Zimbabwe National Statistics Agency and ICF International (2016) *Zimbabwe Demographic and Health Survey 2015*. ZimStat and ICF International. Harare, and Rockville, Maryland, USA; Machisa, M. & Chiramba, K. (2013) *Peace Begins @ Home: Violence Against Women (VAW) Baseline Study, Zimbabwe*. Harare: Ministry of Women's Affairs, Gender and Community Development; Machisa, M. & Shamu, S. (2018) Mental ill health and factors associated with men's use of intimate partner violence in Zimbabwe. *BMC Public Health*, 18: 376.
[8] Plan International (2016) *Counting the Invisible: Using the data to transform the lives of girls and women by 2030*. UK: Plan International; Kidman, R. (2017) Child marriage and intimate partner violence: a comparative study of 34 countries. *International Journal of Epidemiology*, 46(2): 662-675.
[9] Duvvury, N., Scriver, S. and Gibbs, A. (2017) *What Works Evidence Review: The relationship between poverty and intimate partner violence*. What Works to Prevent Violence Against Women and Girls Global Programme.

# Key findings

## VAWG response and help seeking

- **Knowledge of VAWG services was high** (87%) and only 13% of women did not know of any services in their community. Almost three quarters of respondents (72%) had knowledge about the police; however, knowledge was lower for other types of VAWG services.
- The large majority of respondents (approximately nine in 10) stated that they were likely to seek help or support, or access VAWG services, if they were to experience violence. Despite this finding, a much lower proportion of women who had experienced violence in the past 12 months actually did seek help. **48% of survivors reported telling nobody about the violence**, and 28% reported having accessed some kind of VAWG service.
- The majority of women who did access VAWG services in the past 12 months had **experienced severe IPV,** which suggests that some women may only access services when IPV escalates in terms of frequency or force.
- **Unaffordability of service fees was the largest barrier to accessing services**. Other access-related barriers included unaffordability of transport, far distance to travel and poor quality of services. Some survivors also referred to **barriers associated with negative consequences**, such as more violence, getting in trouble, break-up of the relationship and being blamed.
- The most common reason for accessing services was that the **survivor could no longer endure the violence**. Other reasons for accessing services were either related to support (for instance, receiving a referral or being encouraged by friends or family) or negative consequences resulting from the violence (such as being badly injured, threatened by the perpetrator or thrown out of home).



# Conclusions and implications

The SAFE baseline findings highlight a number of important implications for donors and policy makers, and VAWG programme implementers and practitioners.

| Conclusion: | Implication: |
|---|---|
| **To enhance effectiveness and impact, fund, design and implement IPV prevention interventions that address multiple drivers of violence.** | The baseline study found a range of factors associated with women's experience of IPV, including gender inequitable attitudes that support men's hierarchy and control, men's frequent alcohol consumption, and household food insecurity and economic shock. Multi-component interventions that target multiple drivers of violence are likely to be more effective and impactful. |
| **To reduce silos in the prevention field, build linkages between the prevention of violence against women and violence against children.** | The violence prevention field has typically siloed work on violence against women (VAW) and violence against children (VAC). The SAFE baseline evidence of the inter-generational transmission of violence and high levels of perpetration of physical violence against children suggests that these silos need to be broken down. This should be done both at the policy level, through integrated VAW and VAC national strategies and policies, and programmatic level, including actively targeting corporal punishment against children in couples or parenting interventions. |
| **For more inclusive programming, develop IPV prevention interventions that target women and men with different types of relationships and family compositions.** | The baseline study found that IPV prevalence differs according to a number of factors, including women's relationship status (single or partnered), relationship type (e.g., polygamous or monogamous marriage) and whether women's male partners work away from home. While IPV prevention interventions often target cohabiting women and men in couples, these interventions should explore adaptations to ensure they are inclusive and effective with participants from diverse relationships and families. |
| **To increase the impact of women's social empowerment outcomes, ensure that violence prevention interventions build women's agency rather than focusing on final decision making.** | The processes associated with decision making, including the extent to which women can input into and make personal decisions about things that they value, are recognised in the literature as important indicators of women's agency, of which 'final' decision making is a poor proxy.[10] Violence prevention interventions that incorporate women's social empowerment outcomes, should directly aim to build women's agency and focus on the process through which families and couples arrive at decisions and the value of women's inputs and choice in this process. |
| **Enhance survivors' access to services by embedding multi-component VAWG response programmes into prevention efforts** | VAWG prevention interventions can support response efforts by promoting non-stigmatising attitudes towards survivors. However, survivors face multiple additional barriers to help seeking, including accessibility and affordability barriers, and lack of knowledge about available services. Multi-component programmes that address multiple barriers to help seeking are likely to be more effective at increasing women's access to and utilisation of VAWG services. |
| **Mitigate the impacts of poor mental health by ensuring that VAWG prevention interventions incorporate response programming that offers access to psychosocial support and counselling.** | The baseline association between women's experience of IPV and daily feelings of depression or anxiety cannot establish causality or the directionality of the relationship. However, the global literature suggests that the relationship is bidirectional: IPV experience can lead to poor mental health, and poor mental health can also increase women's risk of experiencing IPV.[11] VAWG prevention interventions should ensure that VAWG response services are available in target communities, and these services should include psychosocial support and counselling to ameliorate the effects of poor mental health. |

[10] Donald, A. et al. (2017) *Measuring Women's Agency*. Policy Research Working Paper 8148. World Bank Group.
[11] Ramsoomar, L., Gibbs, A., Machisa, M. et al. (2019) *Associations between Alcohol, Poor Mental health and Intimate Partner Violence. Evidence Review*. What Works to Prevent Violence Against Women and Girls Global Programme.