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Stopping Abuse and Female Exploitation in Zimbabwe: Baseline Report

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This document has been approved for submission by Tetra Tech International Development Project Director, based on a review of satisfactory adherence to our policies on:

- Quality management;
- HSSE and risk management;
- Financial management and Value for Money (VfM);
- Personnel recruitment and management;
- Performance Management and Monitoring and Evaluation (M&E)

Jamie Fotheringham

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Signature:

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Acronyms

CBT	Cash-based transfer
ELU	Evaluation and Learning Unit
FQOL	Family quality of life
GBV	Gender-based violence
HLPC	High Level Political Compact
IPV	Intimate partner violence
ISAL	Internal Savings and Loans
MRCZ	Medical Research Council of Zimbabwe
MWACSMED	Ministry of Womens' Affairs Community Small and Medium Enterprise
RCT	Randomised Control Trial
RCZ	Research Council of Zimbabwe
SAFE	The Stopping Female Abuse and Exploitation Programme
ToC	Theory of Change
ToR	Terms of Reference
USD	United State Dollar
VAWG	Violence Against Women and Girls
VSLA	Village Savings and Loan Association
WFP	World Food Programme
ZHARP	Zimbabwe Humanitarian and Resilience Programme

Executive Summary

Introduction

This report presents Tetra Tech International Development's (Tetra Tech) findings from the baseline study of the "Stopping Female Abuse and Exploitation" (SAFE) programme – a five-year (October 2019 – March 2024) gender-based violence (GBV) prevention and response programme funded by the UK's Foreign, Commonwealth and Development Office (FCDO). Tetra Tech leads the programme's evaluation and learning unit (ELU), which seeks to strengthen the evidence base on what works to prevent and respond to violence against women and girls (VAWG).

The SAFE Programme

The SAFE Communities programme aims to prevent and respond to GBV, specifically intimate partner violence (IPV), in Chiredzi, Chikomba and Mwenezi districts in Zimbabwe, through a social and economic empowerment intervention, Toose. IPV is the most reported form of GBV in Zimbabwe and includes physical, sexual, economic and emotional abuse by an intimate partner.

The intended impact of the SAFE programme is to reduce the prevalence of violence against women and girls in SAFE focal wards, with a focus on IPV, and improve family wellbeing. The SAFE Theory of Change (ToC) (see Section 1.1.3 and Annex 2 for detail) has five outcomes:

- Outcome 1: Households are able to manage economic stress
- Outcome 2: Intimate partner and family relationships are more gender equitable and do not resort to violence to resolve conflict
- Outcome 3: Communities in focal wards have reduced tolerance to IPV and/or other forms of GBV
- Outcome 4: Increased access to essential GBV services by women and adolescent girls
- Outcome 5: Evidence on what works to prevent VAWG in Zimbabwe to support programming and policy

SAFE Communities is implementing Toose, an adapted Gender Action Learning System model[1] coupled with Internal Savings and Loans Schemes (ISALs). In Chiredzi, the programme layers Toose onto a cash-based transfer (CBT) intervention implemented under the World Food Programme's (WFP) Zimbabwe Humanitarian and Resilience Programme (ZHARP) in partnership with Plan International.

Toose contains both prevention and response components. The GBV prevention component is framed as a family well-being programme, using gender transformative social and economic empowerment approaches, which operate at both household and community levels. The GBV response component seeks to strengthen community-based response anchored in GBV Community-based Clubs (GCBC), provide accompaniment for survivors and contribute to the delivery and quality of non-governmental direct services to GBV survivors in SAFE districts.

The baseline study

The baseline study was conducted by Tetra Tech, in partnership with Q Partnership, who are based in Harare. All data collection was undertaken by women enumerators recruited by Q Partnership. The Tetra Tech Team Leader reviewed and approved the enumerators CVs as a point of quality control in the recruitment process, and the enumerators were trained by Tetra Tech's Deputy Team Leader and Quantitative Lead, as well as the Q Partnership programme manager and director, as detailed in Section 2.

The purpose of the baseline study is twofold:

- To provide a 'snapshot' of the intervention context that can be used by the SAFE programme to inform the learning and adaptation of Toose.
- To provide a comprehensive quantitative baseline dataset against which a future impact evaluation could measure the impact of the Toose intervention against its theory of change (ToC).

To do so, it responds to seven research questions:

[1] GALS (Gender Action Learning System) is a community-led empowerment methodology that uses principles of inclusion to improve income, food and nutrition security of vulnerable people in a gender-equitable way. It positions poor women and men as drivers of their own development rather than victims, identifying and dismantling obstacles in their environment, challenging service providers and private actors. It has proven to be effective for changing gender inequalities that have existed for generations, strengthening negotiation power of marginalized stakeholders and promoting collaboration, equity and respect between value chain actors. (Oxfam Novib, 2014)

1) What are the key household, couple and individual characteristics and dynamics of SAFE Communities beneficiaries?
2) What is the prevalence of different types of GBV among SAFE Communities beneficiaries?
3) What are the prevailing attitudes towards GBV, including GBV response, among SAFE beneficiaries?
4) What are the most significant risk factors for GBV among SAFE beneficiaries?
5) How does the SAFE Communities intervention align with or respond to national-level efforts to reduce GBV in Zimbabwe?
6) What existing activities related to economic drivers of GBV or GBV prevention and response are there in the SAFE intervention districts and wards? To what extent are SAFE activities coordinated with these?
7) To what extent do the ToC assumptions hold? What are potential barriers and how can the programme address these?

These questions were answered primarily through a household survey completed by 1,245 women beneficiaries in all three of SAFE's implementation districts. Male beneficiaries were not included in the baseline survey, firstly because programme and baseline sequencing issues meant that the ELU could not be sure that men sampled at baseline would then go on to participate in Toose, and this would limit the programme's ability to measure impact among men at endline. Second, there were ethical risks sampling men and women from the same households if men had not consented to participate in the intervention or were unaware of it at baseline. Given that the baseline survey would ask sensitive questions about women's experience and men's perpetration of violence, there is a significant risk of men's backlash violence against their female partners.

This quantitative component was supplemented by 15 key informant interviews with representatives from relevant civil society organisations, as well as local council members and village heads.

Summary of key findings

Female beneficiary characteristics

The 'average' female Toose beneficiary is 40 years old. Respondents from Chiredzi were the youngest on average of the three districts – 75% of respondents from Chiredzi were under the age of 40, compared to 41% in Chikomba and 49% in Mwenezi. Almost all women reported having had at least some education and almost two thirds had attended secondary school. The vast majority of Toose beneficiaries reported affiliation to a Christian faith, and 40% belong to the Apostolic Church (mainly in Chikomba and Mwenezi), which is in line with national rates of Apostolic affiliation. Twelve percent of respondents reported having a disability, which is slightly lower than the national prevalence rate. Physical and sensory disabilities were more commonly reported than cognitive ones, which is also in line with national data in Zimbabwe. Feelings of anxiety or depression were common among Toose beneficiaries, especially in Chiredzi (19%).

The large majority of women (89%) reported having been married at some point in their lives, with customary marriages being the most common type of marriage (particularly in Mwenezi), and eight out of ten reported that they had been in a relationship in the past 12 months. Out of married respondents, one in ten reported being in a polygamous marriage, which is aligned with the national rate of women in polygamous marriages. The rate of polygamous marriage was highest in Mwenezi, which is also where the number of wives was the highest on average.

Of all ever-married women, a quarter were married before the age of 18, which is lower than the national estimate of 34%, although early marriage was more common among women from the Apostolic church (29%), women in Mwenezi (30%) and among women with disabilities (30%), and even higher among women in polygamous marriages (42%). The payment of lobola for respondents' first marriage was reported by almost three quarters of women who had ever been married.

Ninety-nine percent of female Toose beneficiaries make their own money, primarily through petty trading, handicraft and unskilled labour, and agriculture in Chikomba and Mwenezi. Almost all beneficiaries in Chiredzi reported receiving financial support from charity, which is expected as the SAFE programme combines Toose with a cash-based transfer (CBT) programme in Chiredzi that provides food vouchers for beneficiaries). Charity support is also common in Mwenezi. In Chikomba beneficiaries were more likely than in the other two districts to receive money from other family members through remittances.

Household characteristics

A 'typical' Toose beneficiary household is male headed (69% of households), with one wife, two girl children and two boy children. A large majority (88%) of Toose beneficiaries' households have a mobile money account, though bank accounts are less common (28%). Bank accounts are most commonly owned by female Toose beneficiaries' partners; however, mobile money accounts were most commonly reported to be owned by the beneficiary themselves. Two thirds of Toose beneficiaries' households have no savings, and 47% have taken out loans in the last year, most often to pay for school fees, business activities or food or household expenses.

There were some variations in household economic characteristics across the three districts, some which appear to be shaped by urban or rural status, such as livestock and land ownership being much more common in Chikomba and Mwenezi (rural), and access to electricity and electrical appliances being more common in Chiredzi. Other variations may be more linked to the Toose intervention itself. For example, food insecurity was low across Toose beneficiaries' households overall, but lower in Chiredzi than the other two districts, which may be because beneficiaries in Chiredzi have been receiving food through CBT alongside Toose. Having experienced economic shock in the past 12 months was common in the baseline sample, with common coping strategies being related to consumption of food (e.g., less food, less preferred or expensive food). It is surprising that no respondents reported marrying girls to cope with economic shock, which is at odds with evidence that suggests that poverty and economic insecurity are important drivers of early marriage to offset household economic expenses or to receive bride price.

Household and relationship dynamics

The baseline results revealed a number of findings that are in line with the wider evidence in Zimbabwe, including that women are overwhelmingly responsible for domestic tasks and childrearing, although men are reportedly slightly more involved in childcare.

Two thirds of female respondents reported that their partner had engaged in any paid work or productive activities in the last 12 months. The majority (58%) of female Toose beneficiaries surveyed reported deciding what they do with their own earnings, and 54% of respondents also said that they decide jointly with their partner how to spend his earnings. The majority of women also reported that they take an active role in making decisions about household purchases, savings and loans. These findings suggest that women take an active role in household financial decision making, which is in line with the national data in Zimbabwe. However, there were some important variations in the findings on decision making according to socio-demographic characteristics. For example, while younger women are more likely than older women to decide alone about how their partner's earnings are used, older women are more likely to make the sole decision about their own earnings.

A large proportion of respondents (approximately three in five) reported that their household often or sometimes came together to make a plan to increase household income or assets or had agreed on a shared vision for improving family quality of life. These findings suggest that Toose is starting some of its economic planning and visioning activities with a set of beneficiaries that may already be putting some of these concepts into practice. This is at odds with programme monitoring data, which has suggested that Toose participants describe participating in planning and visioning activities for the first time. However, it is possible that respondents' definitions of what economic planning and shared visioning entail were different at baseline (prior to the start of the intervention), and have subsequently changed after their participation in the intervention.

The majority of women in a relationship (63%) reported that they and their partner used healthy approaches to managing conflict, such as discussing and compromising. Further, the majority of female respondents also reported feeling valued and respected by their partner overall in the past 12 months and reported feeling that their partner felt valued and respected by them. These results are surprising given the high levels of IPV prevalence reported by women. It is possible that IPV often occurs through force, or through normalised behaviour, rather than directly as a result of conflict. It is also possible that couples use respectful and non-violent conflict resolution methods to resolve some types of disagreements, but not others.

Attitudes towards gender equity and GBV

The baseline study has found that respondents have predominantly gender-inequitable attitudes related to division of household labour and women's and men's roles in decision making, although some attitudes are slightly more equitable in Chiredzi (urban location).

Women in all three districts felt that housework and childcare were primarily women's responsibility. They also strongly agreed that women should control the household finances, including their partner's earnings. However,

women also believe that men should be more dominant in the relationship. For example, 72% of respondents felt that a man should decide whether his partner works outside the home, and two thirds of respondents felt that men should have the final say in all household matters. Forty-one percent of respondents felt that there was at least one circumstance in which physical IPV could be justified, most commonly if a woman cheated on her partner.

Attitudes regarding early marriage are mixed. The vast majority of respondents (99%) reported that neither they nor their partner would consider marriage for a daughter under the age of 18. Yet there are widespread perceptions that early marriage increased in the past year, and that many girls were married before the age of 18 in their community and increasing, particularly in Chiredzi. This aligns with reports from KIIs that early marriage surged during the pandemic due to high levels of teen pregnancy and high school drop-out rates.

Prevalence of past year GBV

Violence against women is highly prevalent in the baseline sample, highlighting the urgency of prevention efforts in SAFE target districts and Zimbabwe more widely. Forty-seven percent of women had experienced at least one type of IPV in the past year, and 54% reported controlling behaviour from their partner. Prevalence of IPV was highest in Chiredzi and declined linearly with age in all districts. Emotional IPV was the most commonly reported (39%) followed by economic IPV (30%). Rates of physical and sexual IPV were lower at 18% and 12%, respectively. Nineteen percent of respondents who had been in a relationship in the last year had experienced severe IPV, which means repeated incidences of physical or sexual violence. It is notable that the prevalence of IPV in the baseline sample is higher than the national prevalence rate according to 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 (1%), were low in the baseline sample; however, the rate of non-partner sexual violence is in alignment with national prevalence rates reported in the ZDHS.

Thirty-three percent of respondents reported polyvictimisation: that they had experienced more than one type of IPV, or physical family violence or non-partner sexual violence.

More than half of female Toose beneficiaries (53%) reported that they have used corporal punishment against a child in the past year. This finding is concerning and may indicate the need for further work at the household level on the prevention of violence against children.

Factors associated with women's experience of IPV

The baseline study found a number of factors that are significantly associated with women's experience of IPV, which are in line with the evidence in Zimbabwe and in the wider global literature. These include women's: younger age, poor mental health, affiliation with the Apostolic church, exposure to violence in childhood, male partners' frequent alcohol consumption, male partners working away from home, male partners' controlling behaviour, and experience of early marriage (below the age of 18) at first marriage. Household food insecurity and household economic shock in the past year are also significantly associated with higher prevalence of women's IPV experience.

The baseline study also found some unexpected associations, or lack of associations, between various factors and women's experience of IPV. The global literature and evidence in Zimbabwe suggest that women with disabilities are at higher risk of experiencing IPV; however, this association was not found in the baseline sample. The evidence also suggests that there is an association between lobola paid for women's first marriage and women's IPV experience, but the inverse was found in the baseline sample. Early analysis of the data from SAFE ELU's longitudinal qualitative cohort study2 suggests that economic decline in Zimbabwe has restricted men's ability to pay lobola, which may lead to conflict within the couple and women's wider feelings of disrespect within the relationship and for women's families, which may explain the association with women's IPV experience. Finally, the baseline study found that the risk of IPV is greater when women make decisions about certain economic issues alone, but that risk is diminished when women input into decision making or are able to make their own decisions if they wanted to. It is possible that women's sole decision making, particularly about household income and expenditure, leads to conflict within couples and subsequent IPV.

[2] The Deep Dive 2 report is due to be submitted to FCDO in December 2022.

Awareness and experience of GBV response

Eighty-seven percent of respondents knew of at least one type of GBV service in their community, with the most commonly known service being the police (72%). Knowledge of services was consistently lower in Mwenezi. The vast majority of women in all three districts felt confident about helping someone who had experienced GBV (91%) and 95% of respondents said that they would be likely to encourage a woman or girl to seek GBV support. Ninety-three percent of respondents reported that they, too, would seek help if they experienced IPV. However, a much lower proportion of women who had experienced violence in the past 12 months actually did seek help. Fifty-eight percent of respondents who had experienced IPV reported that they had told anyone, and only 28% reported that they had accessed services. When respondents did disclose abuse, this was most likely to be to a relative outside their immediate family (21%). Women were more likely to have accessed services when the IPV was physical or severe, particularly police services.

Affordability was the largest **barrier** to accessing services, especially in Chiredzi and Chikomba where just over half of respondents from each district (51% and 52% respectively) reported this as a challenge. Other reasons were mainly associated with negative consequences (such as more violence, getting in trouble, break-up of the relationship and fear of abandonment/divorce) or lack of knowledge of services.

Economic empowerment and GBV programmes

Survey respondents reported being aware of or having participated in GBV prevention activities in their community. Forty-seven percent of respondents reported that they had seen people in their community doing something to prevent violence against women in the past 12 months.

Respondents in all three districts (37%) and especially in Chikomba (56%) had seen or heard the slogan **'Love Shouldn't Hurt'**, being implemented by Population Services International (PSI) and Population Solutions for Health (PSH), with the most frequent modality being through community dialogues.[3]

Almost all survey respondents reported participating in an ISAL or VSLA, which was expected given that survey respondents were sampled from ISAL groups. Some respondents, particularly in Mwenezi, reported being in an ISAL or VSLA for more than six months, which may indicate that respondents have been exposed to other economic programmes in the area, or that some ISAL groups supported by SAFE are continuing from older groups.

While survey respondents reported exposure to GBV prevention programmes, KIs more frequently described GBV response programmes operating in SAFE districts, including both small, informal community-based support groups, and larger, more formalised GBV responses services. The description of predominantly GBV response programmes highlights a potential gap in GBV prevention services across SAFE Communities' three implementation districts, a gap which SAFE was widely recognised as filling, mainly through its economic empowerment approach.

The KIIs shed limited light on the extent to which SAFE is aligned with or responds to national-level efforts to reduce GBV in Zimbabwe. However, national-level key informants did emphasise the importance of integrating GBV prevention into wider economic and livelihoods policy and programming efforts, a task that SAFE is actively pursuing through its partnership with CBT programming in Chiredzi.

Implications for SAFE theory of change

The baseline findings have a number of implications for SAFE's theory of change and the assumptions underlying it. In particular, there are strong associations between outcomes in the theory of change and IPV prevalence, and the expected pathways to impact appear to hold for outcomes 1 and 2, and partially for outcome 3 given that fully understanding this pathway to change requires a community-based rather than household-based study. Pathways to impact for outcome 4 cannot be measured through the baseline study. There are other aspects of the baseline study that help to interrogate the programme's theory of change and its assumptions.

The baseline has confirmed significant diversity among the intervention population, including partnered women, women in polygamous marriages, women in female-headed households, women with disabilities, and women whose partners work away from home. This supports the programme's emphasis on a family-centred approach that is inclusive of diversity.

3 This is a SIDA-funded campaign that was originally intended to be part of the SAFE programme, but de-coupled due to delays in SAFE implementation that resulted from the Covid-19 pandemic.

The baseline results suggest that Toose is addressing significant drivers of IPV, including economic stress, unhealthy communication, negative conflict resolution methods and men's alcohol consumption.

There is an assumption in the theory of change that a key pathway to impact is through encouraging joint decision making between couples or between other family members, rather than encouraging women's autonomous decision making. The baseline study has some mixed results in relation to this assumption. It is clear that joint decision making is related to a number of positive outcomes, including the more frequent use of non-violent conflict resolution strategies, and women's sole decision making on some issues is significantly related to higher prevalence of IPV. However, women inputting into decision making or their ability to make their own decisions if they wanted to are both significantly associated with lower IPV prevalence. This may suggest that joint decision making is not necessarily linked to women's agency given that men may still ultimately be the final decision maker or may try to coerce women into agreeing with their decision. This may further suggest that the *process* of decision making is just as or more important than the outcome.

Recommendations

Overall, the choice of the Toose intervention, combining social and economic empowerment, is appropriate given the types of, and factors associated with, GBV identified in the baseline study. There are, however, some adaptations that could strengthen the intervention.

- The baseline evidence of women's perpetration of physical violence against their children suggests that incorporating additional content on violence against children into the intervention could strengthen impact.
- Given the importance of women's agency and negotiating power in the household in the theory of change, Toose would benefit from a more explicit focus on the *process* through which family members, particularly couples, arrive at decisions and the value of women's inputs and choice in this process.
- The baseline finding that a substantial number of women have partners working away from home, and that partners working away from home is associated with IPV (particularly economic IPV) poses some challenges for the intervention given that partners are unlikely to attend Toose session (regularly or at all) if working away from their communities. SAFE Communities could consider building additional modalities into the intervention that allow for greater engagement with these households, including male partners who work away from home.
- The finding that the majority of women report both knowledge of peaceful conflict resolution methods, and putting these into practice with their partners, but that IPV remains highly prevalent, is curious and may suggest that IPV often occurs through force rather than conflict. This may justify a stronger and more explicit emphasis in Toose on GBV and the normalisation of violence.
- The relationships between positive family and relationship dynamics (e.g., making economic plans jointly and healthy partner communication) and women's lower IPV experience may suggest that SAFE could highlight couples who practice these behaviours as role models. Conversely, the programme may need to more explicitly target those couples and family members who do not display these behaviours.
- While the GBV response component of Toose is directly addressing two key barriers to survivors' access to services, including women's lack of awareness of GBV response services, and accessibility of affordable services, additional barriers related to stigma that drive blame of survivors could be more explicitly addressed.
- The baseline survey has identified perceived or actual infidelity and issues with trust as key drivers of conflict. These issues could be more strongly integrated into the Toose manual, including in sessions covering quality of relationships.
- The finding that early marriage is very common but that respondents deny intention to practice it may be related to social desirability bias. This bias may also negatively influence the emphasis that key programme actors place on early marriage as an important issue to be addressed in community-level activities. SAFE could usefully ensure that this issue does not drop off the agenda by explicitly encouraging community dialogue on early marriage.

1. Introduction

This document presents the findings and conclusions from the baseline study conducted by Tetra Tech as part of the Stopping Female Abuse and Exploitation (SAFE) programme.

The SAFE programme is a five-year (October 2019 - March 2024), gender-based violence (GBV) prevention programme funded by the UK's Foreign, Commonwealth and Development Office in Zimbabwe (FCDO Zimbabwe). The SAFE programme is implemented in Chiredzi, Chikomba and Mwenezi districts and comprises two components[4]:

- **SAFE Communities**, led by Ecorys in partnership with Social Development Direct and Southern Africa HIV and AIDS Information Dissemination Service which seeks to strengthen prevention and response to VAWG through a social and economic empowerment intervention, Toose; and
- **SAFE Evaluation and Learning Unit (ELU)**, led by Tetra Tech and supported by Q Partnership, which seeks to strengthen the evidence base on what works in preventing and responding to violence against women and girls in Zimbabwe.

The remainder of this section presents a brief overview of the SAFE programme and its operating context. The report then consists of the following sections:

- Section 2 introduces the baseline study, including its purpose, objectives and scope and the approach and methods used.
- Sections 3, 4 and 5 presents findings related to Toose beneficiaries' individual characteristics, households, and relationship dynamics respectively.
- Sections 6 and 7 then present our findings related to Toose beneficiaries' attitudes towards, and past year experience of, GBV.
- Section 8 presents our findings about factors associated with experience of intimate partner violence.
- Section 9 then reports on respondent's awareness of GBV services and their experiences of using them.
- Section 10 presents our findings related to other economic empowerment interventions and respondent's engagement with them.
- Section 11 discusses coordination mechanisms for economic empowerment and GBV response and prevention programmes.
- Section 12 presents a summary of national-level coordination efforts to target GBV, based on key informant interviews.
- Sections, 13 and 14 present our discussion and conclusions, and recommendations, respectively.
- Section 13 presents the bibliography for the baseline study.

1.1. Context

GBV is widespread in Zimbabwe despite various resources being committed to reduce it across the country. According to national statistics, 35% of married women between the ages of 15 and 49 across Zimbabwe have ever experienced physical or sexual violence from a spouse and 37% of these have experienced physical injury as a result of this violence.[5] Zimbabwe is also one of the 44 hot spots of child marriage: a third of Zimbabwean women reported having been married before the age of 18.[6] Further context on GBV in Zimbabwe drawn from national and international datasets from the Zimbabwe National Statistics Agency and UN and other multi-lateral agencies is provided in Annex 1.

4 In January 2021, the third component funded by SIDA – SAFE Campaigns, delivered by PSI – was formally decoupled from the SAFE programme. However, the other two components are expected to coordinate and engage with them as external partners working within the GBV sector in Zimbabwe.
[5] Zimbabwe National Statistics Agency and ICF International (2016) Zimbabwe Demographic and Health Survey 2015. ZimStat and ICF International. Harare, and Rockville, Maryland, USA.
[6] Zimbabwe National Statistics Agency (ZIMSTAT) (2019) Multiple Indicator Cluster Survey 2019, Snapshots of Key Findings. Harare: ZIMSTAT.

1.1.1. The SAFE Communities programme

SAFE Communities is implementing a pilot intervention, Toose, which uses an adapted Gender Action Learning System model[7] coupled with Internal Savings and Loans Schemes (ISALs). The intervention is being piloted in communities in focal wards in three districts: Chikomba (rural), Mwenezi (rural) and Chiredzi (urban). In Chiredzi, the programme layers Toose onto a cash-based transfer (CBT) intervention implemented under the World Food Programme's (WFP) Zimbabwe Humanitarian and Resilience Programme (ZHARP) in partnership with Plan International.

What is GALS?

GALS (Gender Action Learning System) is a community-led empowerment methodology that uses principles of inclusion to improve income, food and nutrition security of vulnerable people in a gender-equitable way. It positions poor women and men as drivers of their own development rather than victims, identifying and dismantling obstacles in their environment, challenging service providers and private actors. It has proven to be effective for changing gender inequalities that have existed for generations, strengthening negotiation power of marginalized stakeholders and promoting collaboration, equity and respect between value chain actors. (Oxfam Novib, 2014)

Toose contains both prevention and response components. The GBV prevention component is framed as a family well-being programme, using gender transformative social and economic empowerment approaches, which operate at both household and community levels. The GBV response component seeks to strengthen community-based response anchored in GBV Community-based Clubs (GCBC), provide accompaniment for survivors and contribute to the delivery and quality of non-governmental direct services to GBV survivors in SAFE districts.

The SAFE Communities programme is implementing Toose in three consecutive cohorts to enable learning and adaptation to be integrated into subsequent cohorts. All three cohorts use ISALs as the entry point for recruiting community members into the household-level family wellbeing intervention. The programme targets adult women and men, including in couples and polygamous marriages, and other family members in cases where women are in female-headed households and have no partner or have a partner who is living and/or working away from home. The intervention also targets both women that have a disability and women who live in a household with a member who has a disability recognising that disability is a family experience. The intervention draws from a cascaded facilitation model whereby SAFE Communities' Implementing Partners facilitate the household wellbeing curriculum for cohort 1, and recruit Toose participants to become facilitators who incrementally take ownership of facilitation across subsequent intervention cohorts and roll out community activism activities.

Toose is being implemented by a number of downstream partners, including the Self-Help Development Foundation and Mwenezi Development Trust Centre in Mwenezi, Caritas in Chikomba and Plan International in Chiredzi. The GBV response component of the SAFE programme is being implemented in all three districts by Musasa.

1.1.2. The SAFE Evaluation and Learning Unit

The SAFE ELU seeks to strengthen the evidence base on GBV in Zimbabwe by iteratively testing the effectiveness of the SAFE programme; informing programme adaptation; optimising delivery to maximise the impact of Toose on women and girls in Zimbabwe; helping to explain what is working to prevent and respond to violence against women and girls, including how and why; and contributing to the wider GBV knowledge base, both nationally and internationally.

The SAFE ELU will undertake the following activities over the course of the programme (until March 2024): designing and implementing **a baseline study** in target areas where SAFE Communities is operating; undertaking a series of **qualitative deep dive research studies** over the course of implementation; and undertaking a final **summative evaluation**. Two of the deep dive studies will comprise the baseline and endline of a qualitative longitudinal cohort study with SAFE beneficiaries.

1.1.3. The SAFE Theory of Change

The intended impact of the SAFE programme is to reduce the prevalence of violence against women and girls in SAFE focal wards, with a focus on IPV, and improve family wellbeing. The SAFE Theory of Change (ToC) (see Annex 2) has five outcomes:

[7] GALS (Gender Action Learning System) is a community-led empowerment methodology that uses principles of inclusion to improve income, food and nutrition security of vulnerable people in a gender-equitable way. It positions poor women and men as drivers of their own development rather than victims, identifying and dismantling obstacles in their environment, challenging service providers and private actors. It has proven to be effective for changing gender inequalities that have existed for generations, strengthening negotiation power of marginalized stakeholders and promoting collaboration, equity and respect between value chain actors. (Oxfam Novib, 2014)

- Outcome 1: Households are able to manage economic stress
- Outcome 2: Intimate partner and family relationships are more gender equitable and do not resort to violence to resolve conflict
- Outcome 3: Communities in focal wards have reduced tolerance to IPV and/or other forms of GBV
- Outcome 4: Increased access to essential GBV services by women and adolescent girls
- Outcome 5: Evidence on what works to prevent VAWG in Zimbabwe to support programming and policy

The central hypothesis of SAFE's ToC is that to reduce intimate partner violence and other forms of violence against women and girls, changes are needed at both the household level (outcomes 1 and 2) and community level (outcome 3). These are the main points of intervention for SAFE, which focus on prevention through reducing economic drivers of violence, addressing harmful social and gender norms that proscribe how women, men, boys and girls are expected to behave, and reducing tolerance and acceptability of GBV.

Providing survivors of violence with access to essential services is a vital component of an ethical approach to GBV prevention. SAFE's approach therefore seeks to enable survivors of violence to access the services they need by tackling critical barriers and improving quality of services (outcome 4).

To maximise the impact of SAFE in focal wards and elsewhere in Zimbabwe, evidence is needed of an effective intervention model that can be used to prevent and respond to intimate partner violence and other forms of violence against women and girls. SAFE therefore seeks to (1) carry out formative learning to inform its pilot intervention model, (2) use data to improve and adapt the pilot intervention and (3) generate (summative) evidence following its pilot intervention on what works to prevent and respond to violence against women and girls in Zimbabwe (outcome 5).

2. The baseline study

2.1. Purpose, scope and objectives of the study

The baseline study's purpose is twofold:

- To provide a 'snapshot' of the intervention context that can be used by the SAFE Communities programme to inform the learning and adaptation of the Toose intervention.
- To provide a comprehensive quantitative baseline dataset against which a future impact evaluation could measure the impact of the Toose intervention against its theory of change.

It is important to note here that whilst a baseline study typically would inform the development of a programme or intervention's log frame and indicators through which to monitor the programme's success, this baseline study, as noted above, focuses on the programme's theory of change. As such, it provides indicators, detailed in Annex 8, which differ from those found in the programme's log frame. The reasons for this are:

1) When the baseline study was designed, the programme had not yet recruited men, though they have since been included in the programme. As such, there are indicators in the logframe that track outputs related to men that are not reflected in this study.
2) The study was designed prior to the full development of the programme's log frame and M&E framework. The logframe was revised following the full design of the programme's interventions, and this logframe revision coincided with the start of the baseline data collection. Further, due to ethical approval having been granted based on the baseline design, it was not possible to change the design of the study to more closely align to the indicators in the logframe as this would have significantly delayed the implementation of the baseline study.
3) The intervention modality and target beneficiaries changed from the first to second cohort (see more on this in Section 1.1.1) and as such the indicators in the logframe were updated in response to this change in approach.

Despite these challenges, the results of the baseline study did inform the most recent revisions made to the programme logframe, including to the impact and outcome indicators.

To fulfil its purposes, above, the study seeks to understand:

- The demographic break-down and economic context of the intervention population at the household level.
- The prevalence of, risk factors for and attitudes towards different forms of GBV among women beneficiaries participating in the Toose intervention in target wards and districts, and how these vary across demographics and other characteristics.
- The household dynamics among Toose beneficiaries, including decision making, gendered division of labour, economic planning, and forms of communication and conflict resolution.
- The environment related to GBV response, including help seeking behaviours among survivors of GBV, barriers to help seeking and access to services, and beliefs and actions related to supporting survivors to seek help.
- Which other similar interventions are being implemented in Toose target districts and the national level frameworks and strategic plans that this intervention should align with and contribute to.

In doing so, the study explores the differences in the findings across the Toose intervention districts: Chiredzi, Chikomba and Mwenezi. The study also discusses the heterogeneity of experiences between target beneficiaries of the SAFE Communities intervention in rural and urban areas, in different relationship types, and between beneficiaries with and without disabilities.

This baseline study will also allow for the ELU's qualitative longitudinal cohort studies (deep dives 2 and 5) to track changes in programme beneficiaries through the course of the programme.[8] The qualitative longitudinal cohort study will: a) add methodological rigour in assessing impact by complementing the quantitative survey and providing a comprehensive qualitative dataset that can help a future impact evaluator to contextualise the results of a quantitative end line impact assessment; and b) help the ELU measure impact in the programme timeframe. The latter is important given the uncertainty about whether a final impact assessment will be commissioned.

8 The qualitative longitudinal study (deep dive 2) drew from a sub-sample of the baseline survey across the two cohorts. For the end line of the qualitative longitudinal cohort study (deep dive 5), deep dive 2 participants will be re-contacted.

The full Terms of Reference (ToR) for the baseline study are contained in Annex 3.

2.2. Research questions

The study is guided by seven research questions, which have been devised in consultation with SAFE Communities and the FCDO to respond to the study's purpose and objectives outlined above. The baseline evaluation framework, including a full mapping of research questions against the SAFE ELU's Evaluation and Learning questions and against primary data sources, can be found in Annex 4.

Research Question	Data collection method
1. What are the key household, couple and individual characteristics and dynamics of SAFE Communities beneficiaries?	Survey
2. What are the prevailing attitudes towards GBV, including GBV response, among SAFE beneficiaries?	Survey
3. What is the prevalence of different types of GBV among SAFE Communities beneficiaries?	Survey
4. What are the most significant risk factors for GBV among SAFE beneficiaries?	Survey
5. What existing activities related to economic drivers of GBV or GBV prevention and response are there in the SAFE intervention districts and wards? To what extent are SAFE activities coordinated with these?	Survey & KIIs
6. How does the SAFE Communities intervention align with or respond to national-level efforts to reduce GBV in Zimbabwe?	KIIs
7. To what extent do the ToC assumptions hold? What are potential barriers and how can the programme address these?	Synthesis of evidence from survey and KIIs

2.3. Approach and methods

2.3.1. Research approach

The study offers insights into the operating context of the SAFE programme and will also allow any future impact evaluation to measure whether the programme resulted in a reduction of IPV and other forms of GBV, and changes in the outcomes and intermediate outcomes targeted by the programme. The ELU developed a set of baseline indicators to measure the impact, outcome and intermediate outcome statements in the SAFE theory of change (see Annex 2), alongside corresponding standardised tools to enable the measurement of these indicators should an endline impact evaluation be contracted by FCDO. This set of indicators, with standardised measures used, baseline values and expected direction of change at endline, is included in Annex 8. The baseline approach was designed in line with international best practice in research and evaluation on violence against women, as recommend in the World Health Organization's (WHO's) Ethical and safety recommendations for intervention research on violence against women (2001 and updated in 2016).

The baseline study is a predominantly quantitative study that responds to the objectives and purposes stated above by measuring indicators related to GBV and specifically to IPV through surveys with female Toose beneficiaries. It also includes responses from a small sample of key informant interviews with local officials and NGOs.

The baseline study spanned two cohorts to ensure data validity. This was necessary for two reasons:

- **To achieve a large enough sample size for generalisability.** Given the programme implementation timelines and cohort-based delivery modality, the baseline would not have had a large enough sample size if sampling was completed from the first cohort only.
- **To ensure an accurate and representative baseline dataset.** Sampling from two intervention cohorts ensures the overall sample is more representative of the total programme beneficiary group. However, the sample is not fully representative of the beneficiary population as there is a third cohort due to begin implementation in 2023.

2.3.2. Methods

Data from cohort 1 was collected in January 2022, and between July and August 2022 for cohort 2, using the following methods:

Household survey. We conducted 1,245 household surveys with women beneficiaries of SAFE Communities' Toose intervention aged 18 years and over, split evenly between the two cohorts. Surveys were completed in all Toose implementation wards in all three implementation districts. The sample was derived from the beneficiary lists provided by the SAFE Communities programme teams (see Section 2.3.2 for sampling strategy).

The surveys were conducted by female enumerators with previous experience in conducting research on violence against women and children, recruited by Q Partnership. The Tetra Tech Team Leader reviewed and approved the enumerators CVs as a point of quality control in the recruitment process. The enumerators were trained by Tetra Tech's Deputy Team Leader (in person) and Team Leader and Quantitative Lead (remotely) as well as the Q Partnership programme manager and director (in person). Respondents' consent was obtained at the start of the surveys. No compensation for respondents' participation was provided; it was understood that participation was on a voluntary basis.

Fieldwork reports were submitted to FCDO following each round of data collection, in February and September 2022, which detail the data collection process, including enumerator training, methods used, data collection challenges, governance and management arrangements and limitations. A copy of these fieldwork reports is available upon request.

The survey questions were categorised into thematic groups, and these were developed by adapting and tailoring standardised data collection tools wherever possible. A summary of the thematic areas of the household survey can be found in section 2.2.1 of the ToR for the baseline evaluation (see Annex 3) and the survey tool can be found in Annex 5. The survey tool was translated from English to Shona by Q Partnership, and a full translation check was conducted by the SAFE ELU.

Surveys were conducted in-person using tablets equipped with COSMOS, Tetra Tech's data collection software.

Pilot surveys were used to test the methodology and data collection tools, after which some minor refinements were made following discussion between Q Partnership and the SAFE ELU team, mainly to the Shona translations.

Quality assurance of survey data collection was ensured by conducting regular checks of daily uploaded data, and through daily and weekly updates and reports from Q Partnership, including on any challenges encountered and mitigating actions. On completion of the data collection, the survey data was reviewed and cleaned by the Quantitative Lead, with data quality and reliability deemed to be high. The levels of prevalence of key variables showed very good consistency across the two cohorts, which demonstrates strong internal/time-consistency and is a good indicator of quality and reliability of the data. Further information on piloting and quality assurance is provided in the Baseline Fieldwork Reports, submitted to FCDO in February and September 2022, available upon request.

Key informant interviews. In addition to the baseline survey, we conducted 15 key informant interviews (KIIs) with stakeholders at the community, district and national level. The primary focus of these interviews was to understand what other similar interventions are being implemented; what coordination mechanisms exist that SAFE Communities could link into; and what national level VAWG frameworks and any associated policies and/or action plans exist to help inform SAFE Communities' programming decisions. Semi-structured key informant interviews were completed by the SAFE ELU deputy team leader through a combination of face-to-face and telephone interviews. A list of key informants interviewed, sampled purposively based on a stakeholder mapping, is provided in Annex 6.

Literature review. In addition to the primary data collection detailed above, the Team Leader also reviewed and updated the SAFE ELU literature review, first conducted in September 2020. This literature review consisted of a search of both peer-reviewed and grey literature. Peer-reviewed literature was sought by developing a set of search terms at two levels: (1) key words related to GBV,[9] and (2) geography (Zimbabwe). Keywords were combined into a phrase including Boolean (AND/OR) terms, and searches were applied within the title and abstract fields. The ELU applied the search terms to PubMed and Google Scholar, with date parameters set at any literature published since the year 2000. Grey literature was sought by direct online searches of key organisational websites, including UN, NGO and government websites of those organisations operating in Zimbabwe.

2.3.3. Survey sampling strategy

The 1245 household surveys with women Toose beneficiaries were equally split across Cohorts 1 and 2, and equally split across the three districts of intervention. The study's planned and achieved sample size is shown in detail in the

[9] (IPV OR "intimate partner violence" OR "intimate partner physical violence " OR "intimate partner sexual violence" OR "domestic violence" OR "domestic partner violence" OR "partner violence" OR "partner abuse" OR "spouse abuse" OR "spousal abuse" OR rape OR "marital rape" OR "dating violence" OR "sexual violence" OR "violence prevention" OR GBV OR "gender-based violence" OR SGBV OR sexual and gender-based violence" OR "violence against women" OR "non-partner violence" OR "non-partner sexual violence" OR "non-partner physical violence" OR "early marriage" OR "child marriage")

table below. An attrition buffer of 20% has been included in our sampling design. This implies that up to 20% of the baseline sample interviewees could drop out of a potential end line study[10] while still achieving the target statistical power of our survey.

The different number of ISALs sampled across wards within the same district reflects the number of ISALs per ward targeted by the SAFE Communities programme that include a sufficient number of women beneficiaries, based on information shared by the programme team.

Table 1: Target survey sample

	COHORT 1				COHORT 2			
	No. ISALs sampled	Number of surveys per ISAL	Number of surveys	Actual number of surveys	No. ISALs sampled	Number of surveys per ISAL	Number of surveys	Actual number of surveys
					Chikomba			
Ward 18	4	10	40	40	4	10	40	31
Ward 23	4	10	40	40	4	10	40	48
Ward 27	5	10	50	50	5	10	50	43
Ward 28	5	10	50	54	5	10	50	42
Ward 16	2	10	20	20	2	10	20	44
					Mwenezi			
Ward 2	4	10	40	45	4	10	40	43
Ward 3	4	10	40	40	4	10	40	39
Ward 8	3	10	30	30	3	10	30	42
Ward 11	4	10	40	40	4	10	40	42
Ward 12	5	10	50	50	5	10	50	44
					Chiredzi			
Ward 3	4	10	40	45	4	10	40	54
Ward 4	5	10	50	50	5	10	50	59
Ward 5	6	10	60	60	6	10	60	52
Ward 8	5	10	50	50	5	10	50	52
Total	**60**	**-**	**600**	**610**	**60**	**-**	**600**	**635**
TOTAL HOUSEHOLD SURVEYS - 1200								

Our intended sampling approach followed a two-stage clustered design. First, ISALs (clusters) would be selected within SAFE wards, based on the lists provided by the SAFE Communities team. Second, female respondents would be randomly selected within the members of the previously selected ISALs. However, upon receiving the sample lists, we confirmed that the total number of SAFE beneficiaries was only nominally larger than our intended sample. As such, we adjusted our sampling approach to include all listed beneficiaries, understanding that refusal or attrition would likely result in us meeting our intended sample. This is a way to avoid the practical and ethical difficulties of having to exclude just a few ISAL members from the sample, while maximising cluster size (number of respondents per ISAL), hence the statistical power of our survey.

Women from marginalised groups or at risk of marginalisation (e.g., widows, divorced women, women in polygamous marriages, women with disabilities, etc.) have been included in our sample without being considered subgroups as such, as they do not form analytical units of sufficient size from which to draw any statistically meaningful findings.

The final achieved sample slightly exceeded the target: 614 completed household surveys were used in our analysis of Cohort 1 data, and 631 surveys were used for Cohort 2, for a total overall sample size of 1,245 surveys. This amounts to slightly more than 400 completed surveys per district across the two cohorts, which is the minimum sample size required to achieve a 5% margin of error at the 95% confidence level. In other words, prevalence of behaviours, attitudes or any other relevant indicator can be meaningfully reported for each separate district, in addition to the overall sample.

The full baseline sampling approach is contained in section 2.3 of the baseline study ToR (Annex 3).

2.3.4. Coding and analysis

Quantitative analysis was conducted in Excel and Stata by the SAFE ELU Quantitative lead. Data was first processed and cleaned using Stata. This involved correcting ISAL and respondent identifiers to ensure they matched with SAFE Communities beneficiary lists, identifying outliers and investigating any gaps or unexpected values with the research

10 Tetra Tech's ELU contract does not include an end line study, but as noted in Section 1.2 of this report, one of the purposes of this study is to provide a comprehensive data set against which an end line study could be compared.

teams. Analytical variables (including indexes and scales, separate variables for multiple-response options, etc.) were then generated from the cleaned data. Syntax was created in Stata to automatically generate the tabulations and cross-tabulations of all variables against the main categories and subgroups (cohort, district, age categories, disability status, relationship status) and export figures (proportions, means, medians and p-values from statistical tests) into an Excel file. This file was subsequently used by the team to identify and draft the main findings. Where subgroups are binary, such as presence or absence of a disability, differences that are statistically significant are reported based on the results of a Student's t-test.[11]

The qualitative data was coded using Dedoose software, using an established coding framework based on the qualitative tools with additional codes added to capture unexpected phenomena.

2.3.5. Reporting

Throughout this report we consistently report on differences observed between respondents from different districts, and from different age categories. As part of the analysis process, we also compared responses from the following binary sub-groups:

- Those affiliated with the Apostolic Church vs those with other or no religious affiliation(s).
- Respondents that reported a disability vs those that did not
- Respondents that were in a couple vs those that were not
- Respondents that were in polygamous marriages vs those in monogamous ones.

Throughout the report, we refer to differences in these binary sub-groups only where they are significant according to a Students t-test using a 95% confidence interval ($p \leq 0.05$), which confirms that the means of the two sets of data (variable 1 and variable 2) are expected to be different in 95% of cases. Statistical significance is denoted by an asterisk in graphs.

The sample base is all 1,245 respondents, unless otherwise stated in this report.[12] The sample base for all comparisons between respondents in polygamous and monogamous marriages is 868, which corresponds to the total number of respondents that were married.

2.3.6. Ethics and safeguarding

The baseline study was guided by the SAFE Ethical Framework, which is compliant with a range of key frameworks and guidelines, including:

- the SAFE Safeguarding Framework;
- instructions on Institutional Review Board (IRB) ethics review submissions to the Medical Research Council of Zimbabwe;
- the World Health Organisation (WHO) Ethical and safety recommendations for intervention research on violence against women (2001, and updated in 2016);
- the Child Protection Monitoring and Evaluation Reference Group Ethical principles, dilemmas, and risks in collecting data on violence against children (2012);
- the guiding concepts and principles set out in DFID's Evaluation Policy (2013),
- DFID's Research Ethics Guidance (2011),
- DFID's Ethical guidance for research, evaluation and monitoring activities (2019)
- DFID's Digital Strategy 2018 to 2020: doing development in a digital world;
- the HM Government Involving Disabled People in Social Research Guidance by the Office for Disability Issues (2011);
- and the General Data Protection Regulation (2018).

The ethical protocols ensured that:

- Informed consent was obtained from all participants;

11 Students t-test compares the means across two independent samples of data and assesses whether or not they are different, according to a set level of confidence.
12 NB: Not all respondents answered all questions, so there may be a small negative variance to this figure on certain questions.

- Participants were informed of their right to withdraw, and offered channels to raise complaints or ask questions about the study
- Safeguarding processes and reporting mechanisms were followed;
- 'Do no harm' principles were respected, including minimising distress and establishing appropriate mechanisms for handling distress;
- GBV referral mechanisms were in place and accessible for survivors;
- Confidentiality and privacy were maintained;
- Data protection protocols were compliant with General Data Protection Regulation (GDPR) commitments;[13]
- COVID-19 risks were mitigated.

The baseline study proposal was submitted to both the Medical Research Council of Zimbabwe (MRCZ) and the Research Council of Zimbabwe (RCZ). We submitted an amendment to the MRCZ in December 2021 to update the sampling strategy and data collection wards, in response to a slight change in the implementation wards for the SAFE Communities' programme. Ethical approval for this amendment was granted on 14 January 2022.[14]

Full details of the ethical and safeguarding protocols and procedures can be found in section 2.5 of the ToR for the baseline evaluation (see Annex 3). Full details of processes and materials available to participants for raising complaints or referrals to GBV services are provided in the Baseline Fieldwork Reports submitted to FCDO in February and September 2022 for cohorts one and two respectively and are available upon request.

In accordance with the terms and conditions governing the overarching framework agreement for this contract, ownership of all intellectual property relating to the data, analysis and this report, is owned by the FCDO. Under the licence granted by the FCDO, Tetra Tech will use the data and analysis to generate knowledge and policy briefs and fulfil its obligations related to dissemination of the findings and recommendations. Tetra Tech assumes responsibility for the safe storage of the data and analysis generated and will ensure the integrity of the data is preserved in order to avoid any corruption or loss of the data.

2.3.7. Influence and use plan

Due to funding cuts in the first year of the SAFE inception period, the development of an evidence influence and use plan was removed from the SAFE ELU contract. The FCDO subsequently took the lead on developing and implementing, with support from the SAFE ELU and SAFE Communities, a SAFE Learning and Engagement Plan (see Annex 7), with a focus on delivering Output 4 in the programme logframe (corresponding to Outcome 5 in the programme ToC).

At the time of finalising the baseline report, the SAFE ELU has led on and participated in a number of both internal and external activities to disseminate the baseline findings. Internally, the SAFE ELU facilitated two online workshops with SAFE Communities and FCDO in March and April 2022 to present and discuss preliminary baseline findings from cohort 1 and possible adaptations to Toose prior to roll out of the intervention with cohort 2. A set of recommendations from the complete baseline report will be used to inform programme adaptations to cohort 3 of Toose.

Externally, the SAFE ELU has led or supported a number of engagements, including:

- Presenting preliminary findings from cohort 1 of the baseline study, alongside programme adaptations made, in a joint FCDO and UN Women research symposium on VAWG in Harare (June 2022).
- Publishing a blog containing preliminary findings from cohort 1 of the baseline study, alongside evidence and learning from other SAFE ELU studies.
- Contributing to a 'Learning Circle' online session on SAFE, including preliminary findings from cohort 1 of the baseline study, alongside programme adaptations made, with the Prevention Collaborative (September 2022).
- Presenting the complete baseline findings to key stakeholders in Zimbabwe, alongside evidence and learning from other SAFE ELU studies (November 2022).

Further dissemination will take place through the publication of research briefs and presentation of findings to key actors in the GBV prevention field, both nationally and internationally. The SAFE ELU will also work with SAFE

13 FCDO has final ownership and copyright of all data, analysis and reports produced from the baseline study and has unlimited access to all materials produced from the research. The quantitative dataset will be fully de-identified and made available for use on an online or offline platform agreed by the FCDO.
14 Data collection commenced prior to this approval only in areas that were unaffected by the changes included in the amendment. This data collection was therefore covered by the approval granted from the RCZ in November 2021.

Communities to develop a mechanism for reporting the baseline results to beneficiaries and other community members in SAFE target wards.

2.3.8. Limitations

Desirability bias and reliability of personal accounts of GBV

GBV-related issues are sensitive. As a result, people, especially vulnerable populations and young people, may have been unwilling to talk or to express their views in a sincere and accurate manner. This could have created a bias towards 'socially acceptable' views, and substantial underreporting of occurrences and severity of violence. Women who experience violence may not be willing to share their experiences due to feelings of shame and/or fear of retaliation from perpetrators.

Our instruments, forms and protocols were designed to minimise such biases as much as possible, drawing on our teams' expertise, international standards and best practices. The fieldwork teams received training to familiarise themselves with the purpose and specificities of the surveys and topic guides, and how to ensure the confidentiality of interviewees. Despite this, interview biases cannot be fully eliminated and must be kept in mind when analysing and interpreting the data.

No surveys with men

Baseline surveys were only conducted with female Toose beneficiaries and not their male partners. This was a decision taken jointly by the ELU, SAFE Communities Team and the FCDO in response to an assessment of the risks and benefits of doing so. The primary two issues that led to this decision were:

1) That there were no male beneficiaries enrolled in the Toose intervention at baseline. As a result, the ELU could not be sure that men sampled at baseline would then go on to participate in Toose, and this would limit the programme's ability to measure impact among men at endline.
2) Ethical risks of sampling men and women from the same household, when men had not consented to participate in the Toose intervention and may not have been aware of the intervention and its focus. Given that the baseline survey would ask sensitive questions about women's experience and men's perpetration of violence, the teams concluded that there was a significant risk of backlash violence to women participants if men were also included in the study. This was not a justifiable risk for the study to take, nor was it a risk that the team could reasonably mitigate. The decision to include only women in the survey was in line with WHO guidance on research and evaluation of GBV interventions.[15]

No comparison group

The quantitative baseline design is not experimental or quasi-experimental and does not include a control or comparison group. An experimental design, consisting of a randomised controlled trial (RCT), was not feasible for SAFE given that intervention wards and communities were already established and could not be randomised. The choice was made not to include a quasi-experimental design for several reasons. Given budget cuts to the programme, the baseline study budget was not sufficient to include a comparison group. Further, at the time of designing the baseline study, it was foreseen that funding for an endline impact study would be unlikely. Given the programme's focus on learning and using evidence to inform intervention adaptation, it was agreed that following confirmation of evidence of effective intervention implementation and positive intervention impact through the longitudinal qualitative cohort study, recommendations for scale up could be made with future plans to conduct an experimental study, such as an RCT.[16]

CBT having started in Chiredzi

Cash-based transfers (CBT), implemented by WFP, had already started in Chiredzi at the time of the baseline survey. CBT began in September 2021 for some beneficiaries and in November 2021 for others. Consequently, cohort 1 beneficiaries will have received CBT for up to three months and cohort 2 beneficiaries will have received CBT for up to ten months prior to participating in the baseline survey. Consequently, the baseline survey in Chiredzi is not a "true"

[15] WHO (2012) Understanding and addressing violence against women: Intimate Partner Violence. World Health Organization.

[16] This is in line with global evidence, which recommends that RCTs should be implemented after pilot interventions have been tested through strong mixed methods (quantitative and qualitative) that can enable the 'ironing out' of design and implementation issues, thus focusing on learning and adaptation. See for example: Jewkes, R., Gibbs, A., Chirwa, E. & Dunkle, K. (2020) What can we learn from studying control arms or randomised VAWG prevention intervention evaluations: reflection on expected measurement error, meaningful change and the utility of RCTs. Global Health Action, 13:1, 1748401.

baseline. This will need to be factored into an endline impact study (if FCDO contracts one), as CBT in Chiredzi may have begun to mitigate the economic drivers of IPV prior to the start of Toose.

Triangulation with qualitative data

The baseline includes a small sample of qualitative interviews with key stakeholders, which responds primarily to a few specific research questions in the evaluation framework (see Annex 4). Data collection for the first wave of the longitudinal qualitative cohort study (deep dive 2) has been completed; however, data analysis is ongoing. Consequently, this baseline study report does not include qualitative findings from the longitudinal study, which would help to contextualise some of the quantitative findings. The ELU recognises the value in drawing from qualitative data to triangulate the baseline survey findings and will combine key findings from the baseline quantitative survey and longitudinal qualitative cohort study in a dedicated brief for both internal and external use.

3. RQ1: Toose beneficiaries' individual characteristics

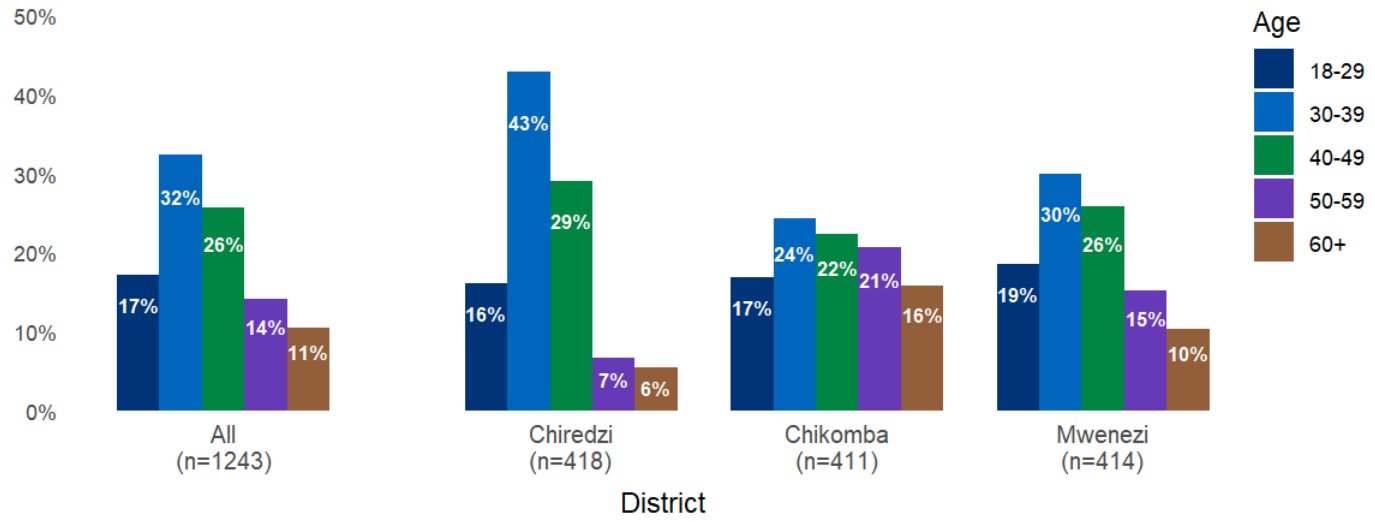
The following three sections present our findings related to Toose beneficiaries. They look at Toose beneficiaries' individual characteristics, their households and their relationships in turn. Combined, they respond to the study's first research question:

> *RQ1: What are the key individual, household and couple characteristics and dynamics of SAFE Communities beneficiaries?*

This section is concerned with Toose beneficiaries' individual characteristics, such as educational attainment, religion and age; and their income generating activities, Toose beneficiaries' age and religion.

A total of 1,245 women were surveyed, with 419 from Chiredzi, 411 from Chikomba and 415 from Mwenezi.[17] As shown in Figure 1, respondents included adult women of varying ages, with respondents from Chiredzi being younger overall than respondents from Chikomba or Mwenezi.

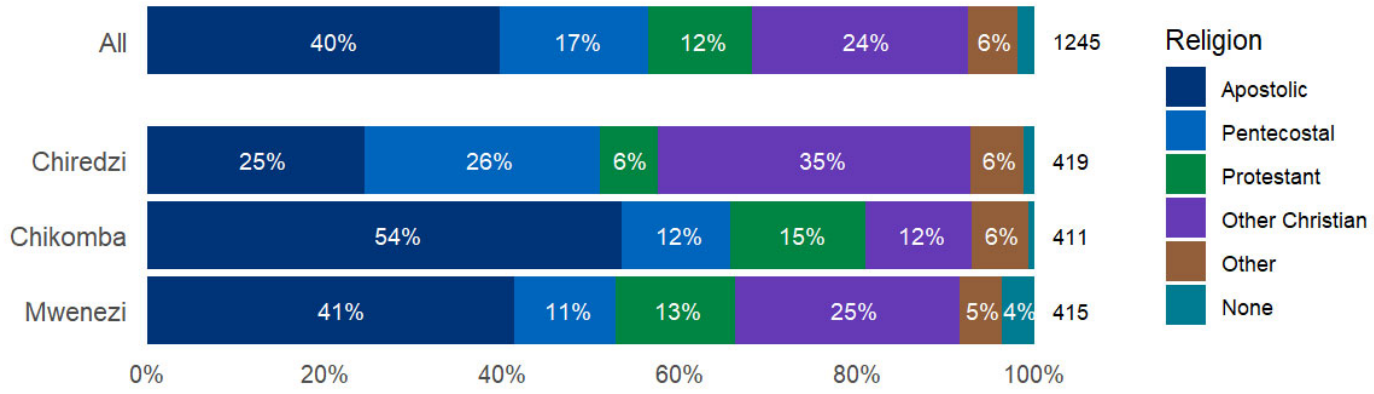
Figure 1: The distribution of respondents' ages by district



Across all districts, 93% of respondents reported affiliation with Protestant, Pentecostal, Apostolic, or 'Other – Christian' religions. The proportions of each of these denominations varied across the three districts, as shown in Figure 2. In both Chikomba and Mwenezi, the denomination with the greatest representation was the Apostolic Church, with 54 % of respondents from Chikomba and 41% from Mwenezi reporting affiliation whilst in Chiredzi, the sample was much more evenly distributed across different Christian groups.

17 Figure 1 shows n=1423 as two survey respondents did not answer this question

Figure 2: Toose beneficiaries' religion, by district

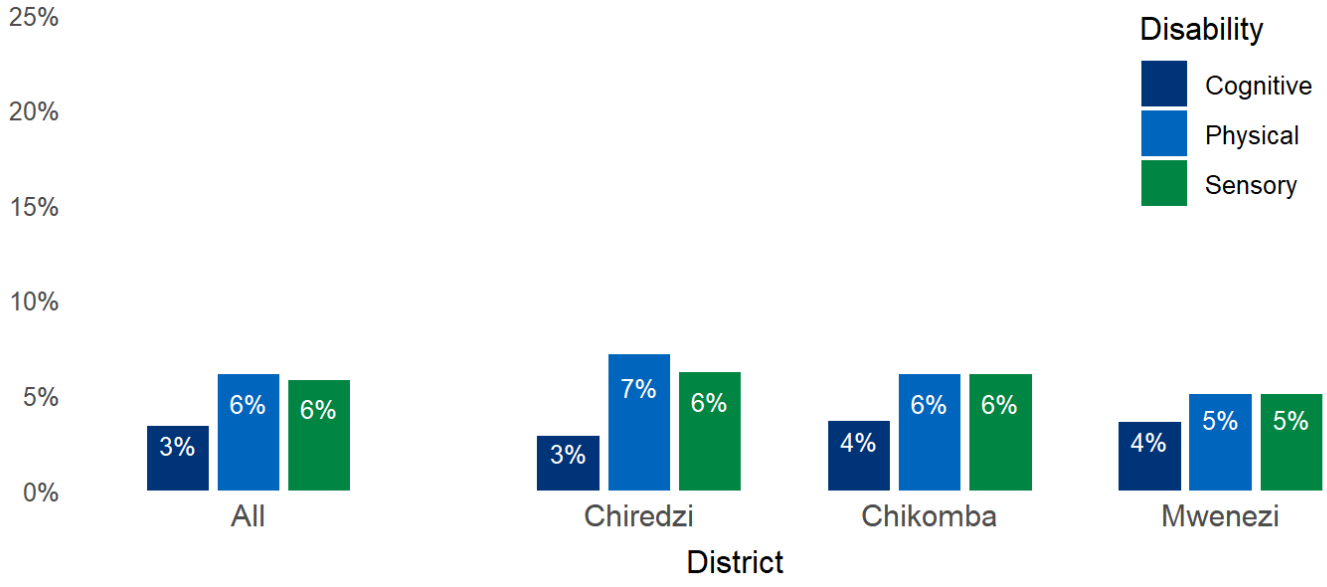


3.1. The prevalence of disability among Toose beneficiaries

All respondents were asked about their disability status using the Washington Group Short Set questions. These ask participants to score their functional level of difficulty in seeing, hearing, walking or climbing steps; remembering or concentrating; self-care and communicating. A disability is coded if a respondent reported having 'a lot of difficulty' doing something or is unable to do it at all, even when allowing for corrective action such as using a hearing aid or wearing glasses.

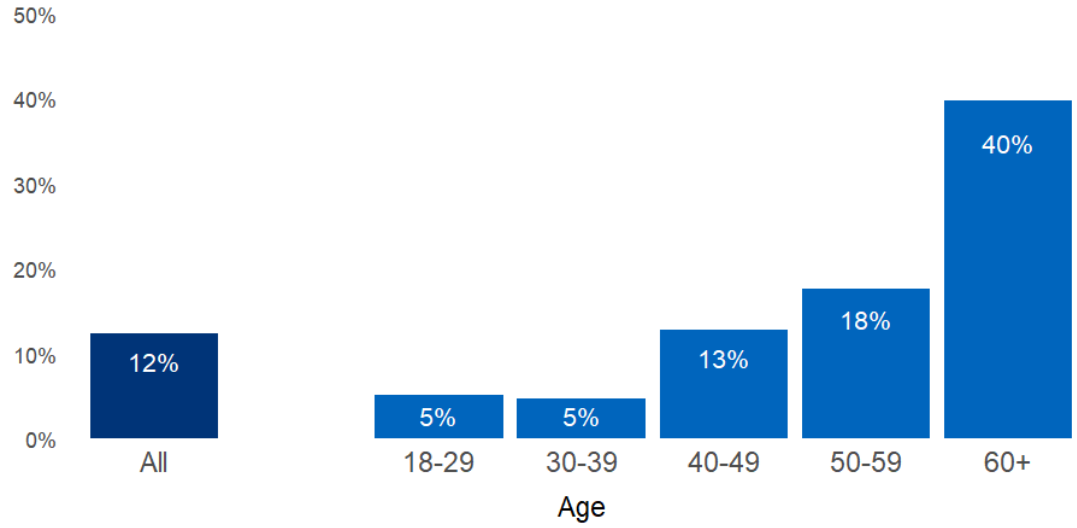
Across all six types of disability included in the Washington Group Short Set, 12% of all respondents reported some type of disability. This was consistent across districts. Physical[18] and sensory[19] disabilities were more commonly reported than cognitive[20] disabilities, as shown in Figure 3. There was also a strong correlation with age as shown in Figure 4.

Figure 3: Prevalence of disability types among Toose beneficiaries, by district



18 Physical disabilities include difficulties walking, climbing steps or with self-care
19 Sensory disabilities include difficulties seeing or hearing
20 Cognitive disabilities include difficulties remembering or concentrating, or communicating),

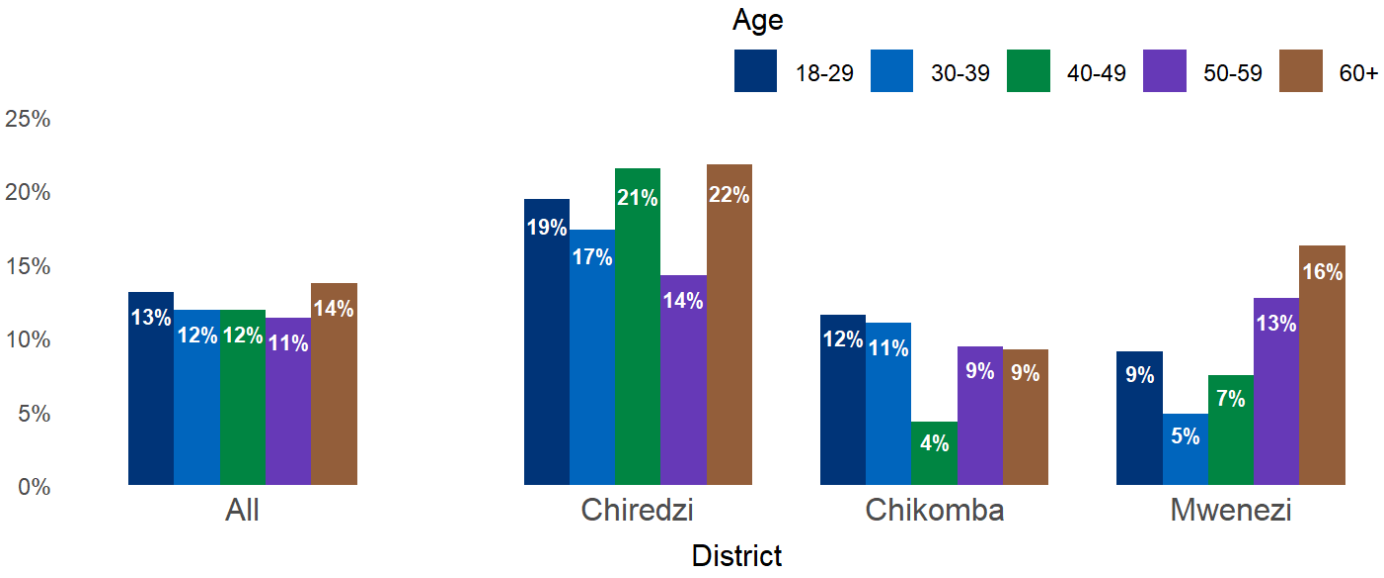
Figure 4: Prevalence of any reported disability, by age



Respondents were also asked two additional questions from the Washington Group Extended Set to measure the prevalence of respondents' feelings of depression and anxiety. As shown in Figure 5, the prevalence of daily feelings of depression or anxiety was highest in Chiredzi, with 19% of respondents reporting such feelings, compared to 9% of respondents in both Chikomba and Mwenezi. In Chiredzi and Chikomba, levels of daily feelings of anxiety or depression were consistent across age groups, although in Mwenezi age was positively correlated with such feelings, with the exception of respondents aged 18-29.

Respondents who reported a disability through the Washington Short Set were also significantly more likely to report feelings of anxiety or depression, with 24% of respondents doing so, compared to 11% of those without a disability.

Figure 5: Prevalence of daily feelings of anxiety or depression, by district



3.2. Toose beneficiaries' level of education

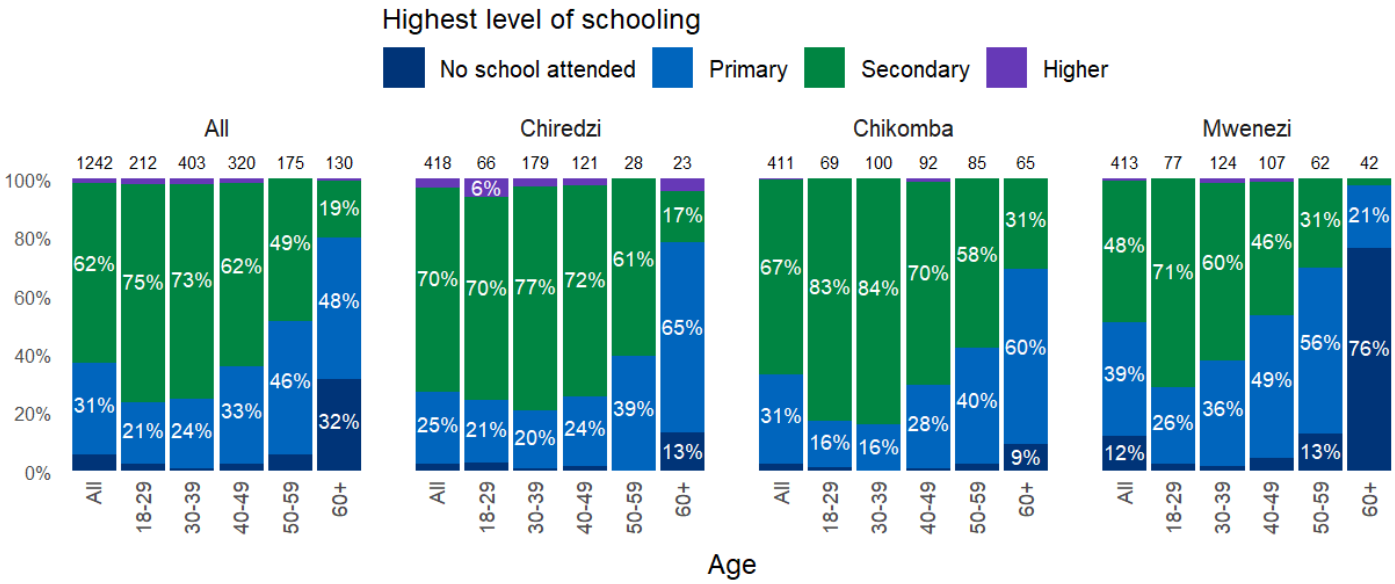
Ninety-four percent of all respondents (n=1,245) reported that they had attended school. This figure was consistent against population subgroups with four key exceptions:

- Respondents from Mwenezi were less likely to have attended school than those in Chikomba or Chiredzi
- Respondents aged 60 or over were the least likely to have attended school

- Women who were in a polygamous marriage were less likely to have attended school than those who were in a monogamous marriage
- Respondents who reported a disability were less likely to have attended school than those without a disability.

Figure 6 shows the level of educational attainment in each district, by age.

Figure 6: Educational attainment, by district



Sixty-two percent of all respondents reported having attended secondary school, whilst 31% had only attended was primary school. Only 1% of the total sample attended higher education. The highest level of secondary school attendance across all age groups was in Chiredzi (70%) and the lowest in Mwenezi (48%). There is also a clear negative correlation between age and level of education, with younger women being significantly more likely to have completed secondary school.

Women in a polygamous marriage were significantly less likely to have received a secondary education (38%) than women who were in monogamous marriages (67%).

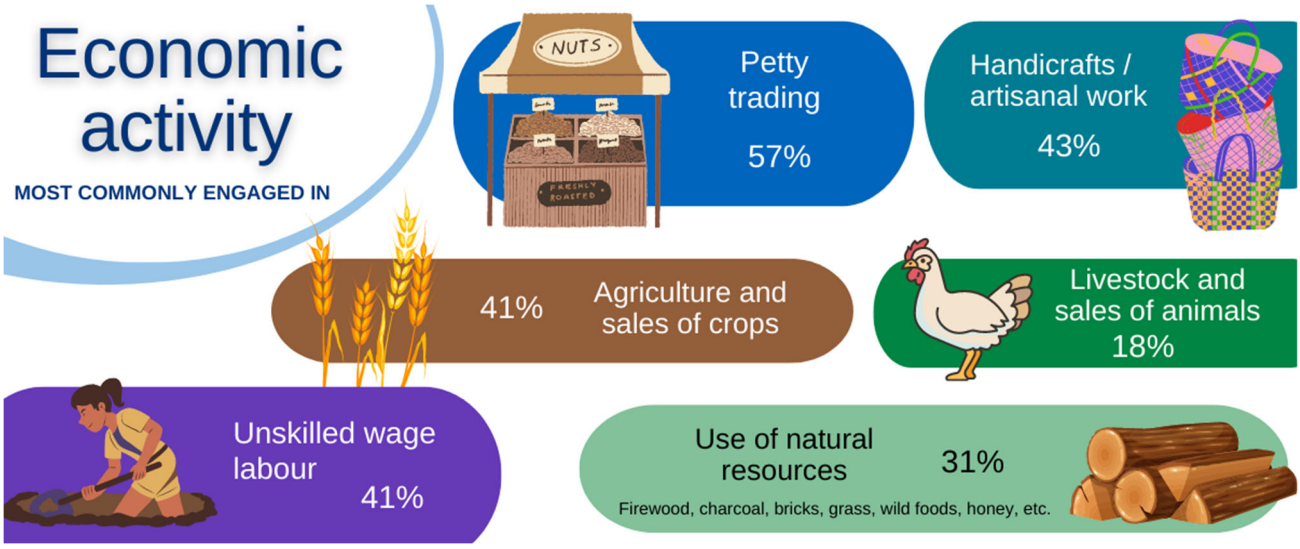
3.3. Toose beneficiaries' income generation

Toose beneficiaries were asked about different methods of income generation, including through economic activities and external financial assistance.

Respondents reported a broad range of income generating activities over the past 12 months. These were primarily agricultural or informal economic activities with few respondents reporting that they had worked in skilled labour (1%), commercial activities (3%) or in salaried or hourly waged roles (4%).

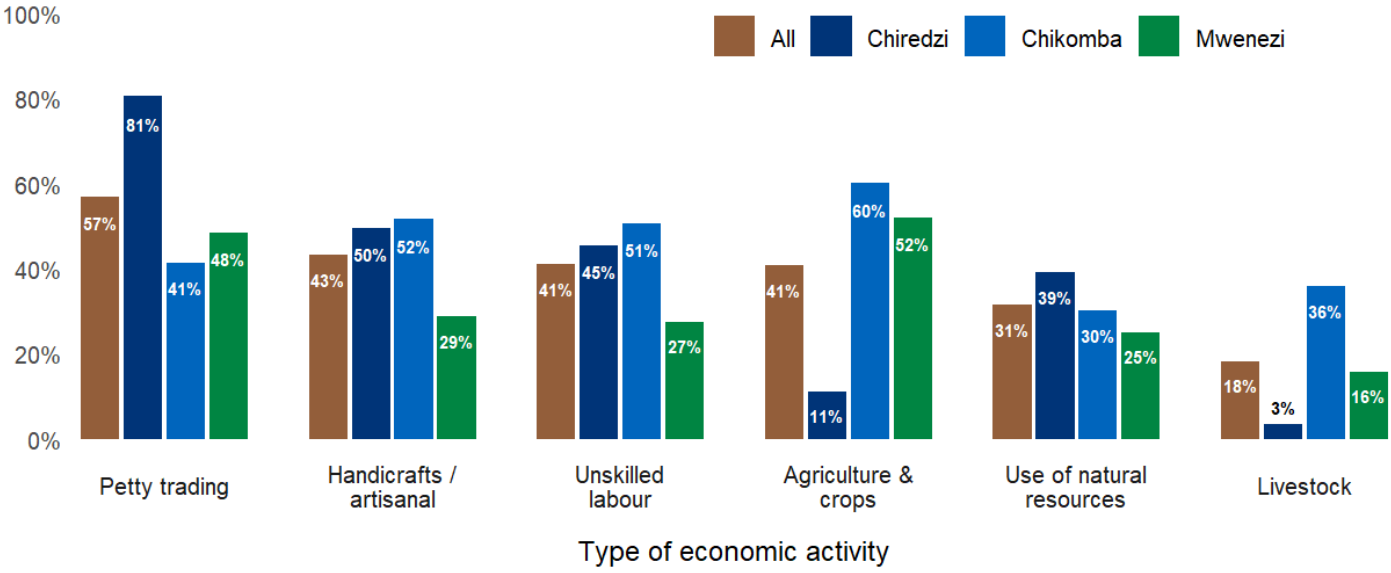
The most commonly reported economic activities that respondents had engaged in during the past 12 months are outlined in Figure 7.

Figure 7: The most common economic activities engaged in by Toose beneficiaries



Respondents in different districts reported participation in different types of economic activity, as shown in Figure 8. Participants in Chiredzi were predominantly involved in petty trading, handicraft and artisanal work and unskilled labour, with very low rates of agriculture or sales of animals, which is expected for an urban district. Chikomba was the most diverse district in terms of income generation with respondents reporting participation in many different types of economic activity including agriculture, handicraft, and livestock rearing or selling. Agriculture and petty trading were the primary forms of income generation in Mwenezi.

Figure 8: Economic activity, by district



Toose beneficiaries reported varying levels of external financial support from either government allowances, remittances, or charities. As shown in Figure 9 remittances[21] were most commonly reported in Chikomba, where 71% of respondents had received remittances, compared to 42% in Mwenezi and 11% in Chiredzi. This does not appear to be related to respondents' male partners working away from home in the past 12 months given that this was most common in Mwenezi, with only 25% of women in Chikomba reporting that their partner worked away from home in the past 12 months.

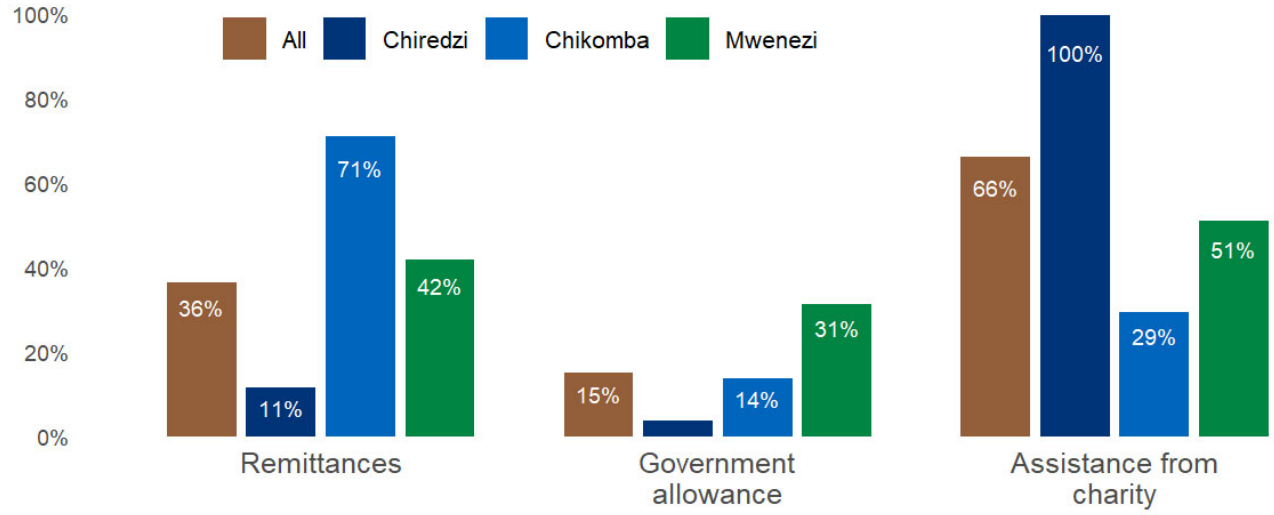
Government allowances, such as pensions and disability support were less common in all three districts, with 3%, 14% and 31% of respondents in Chiredzi, Chikomba and Mwenezi reporting receiving these. Finally, 100% of respondents received assistance from charity in Chiredzi, though this was expected as CBT is included in the SAFE

[21] Remittances refer to money sent back to Toose beneficiary households from family members that do not live at home (usually working overseas).

programme modality in this district. In contrast, 29% of respondents in Chikomba and 51% of respondents in Mwenezi had received assistance from charity in the past 12 months.

Respondents who were not affiliated with the Apostolic Church received assistance from charity significantly more than those who were and those who were not in polygamous marriages received support from charity significantly more than those who were.

Figure 9: Types of external financial assistance received by Toose beneficiaries, by district



4. RQ1: Toose beneficiaries' households

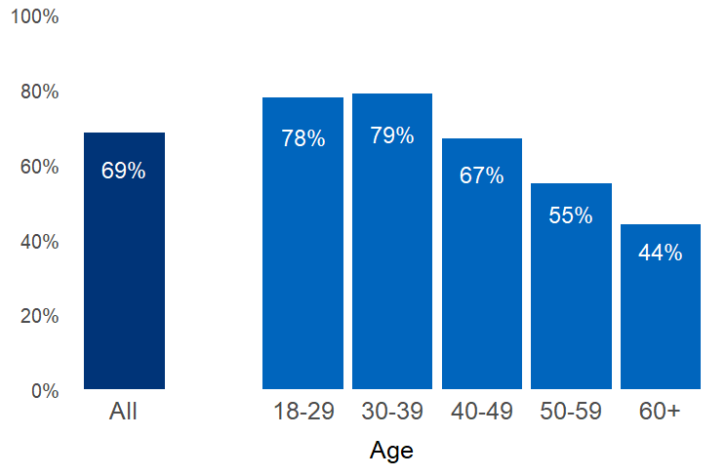
This section responds to the part of RQ1 that is concerned with Toose beneficiaries' household. It presents finding related to beneficiaries' household size and composition, economic status and ability to weather economic shocks, as well as their levels of food security and ability to meet basic needs.

> *RQ1: What are the key individual, **household** and couple characteristics and dynamics of SAFE Communities beneficiaries?*

4.1. Household composition

The average household size across all districts is 5.6 household members with Mwenezi respondents reporting the highest average of 6.2, followed by Chiredzi with 5.8 and Chikomba with 4.9 household members on average. Respondents in polygamous marriages had an average household size of 6.8. A 'typical' Toose beneficiary household is male headed (69% of households), with one wife, two girl children and two boy children. Younger respondents were more likely to live in a male headed household than older respondents, as shown in Figure 10.

Figure 10: Percentage of Toose beneficiaries living in a male-headed household, by age



Respondents that were in polygamous marriages were significantly less likely to report living in a male-headed household than those that were in monogamous marriages (73% and 93% respectively), which may indicate that some women in polygamous marriages live in separate households to their husband.

Respondents that reported disabilities were also significantly less likely to be in a male-headed household than those that did not report a disability (53% and 71% respectively).

4.2. Toose beneficiaries' intimate relationships

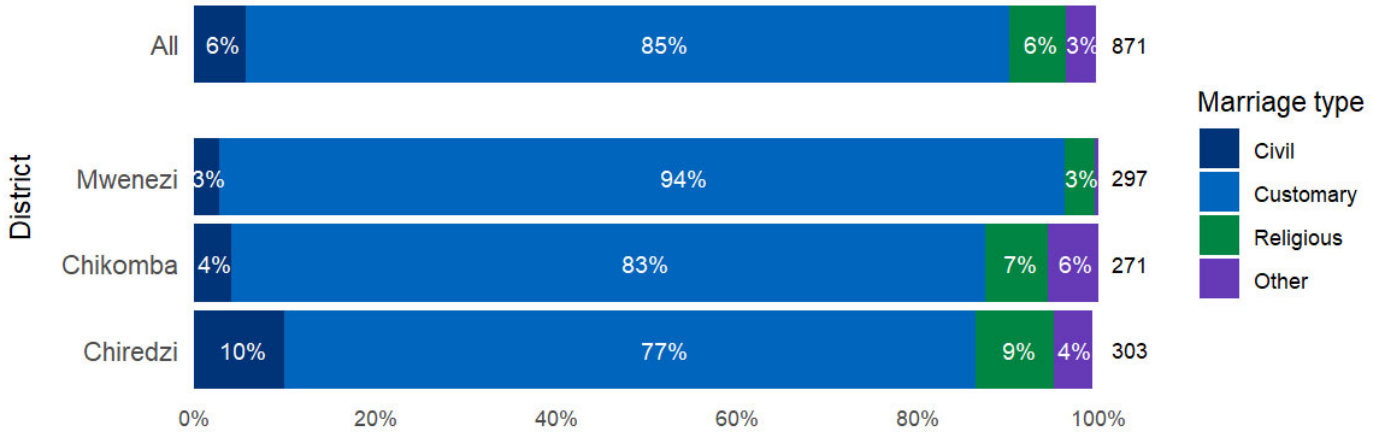
This section presents information about Toose beneficiaries' intimate partnerships. Specifically, it includes their relationship and marital status, and the prevalence of polygamy, early marriage and lobola payment among Toose beneficiaries.

4.2.1. Relationship and marital status

Eighty-nine percent of all respondents reported having been married at some point in their lives. This trend was seen across most sub-groups, with only five sub-groups showing a difference from the total sample. Respondents from Mwenezi were least likely to have ever been married (80%), respondents from Chikomba were most likely to have ever been married (95%), and in Chiredzi 92% of respondents had ever been married. The other major distinction across subgroups was at either end of the age distribution: women aged 60 or over were the most likely to have ever been married (96%) and 18-29 year olds were the least likely to report having ever been married (78%).

Seventy-eight percent of all respondents (n=1245) reported that they were currently in a relationship, whilst 81% reported that they had been in a relationship in the past 12 months. Of women who reported currently being in a relationship, 89% were married, 6% were in a non-cohabiting couple and 4% were in a cohabiting couple. Marriages reported were most commonly customary unions, particularly in Mwenezi, as shown in Figure 11.

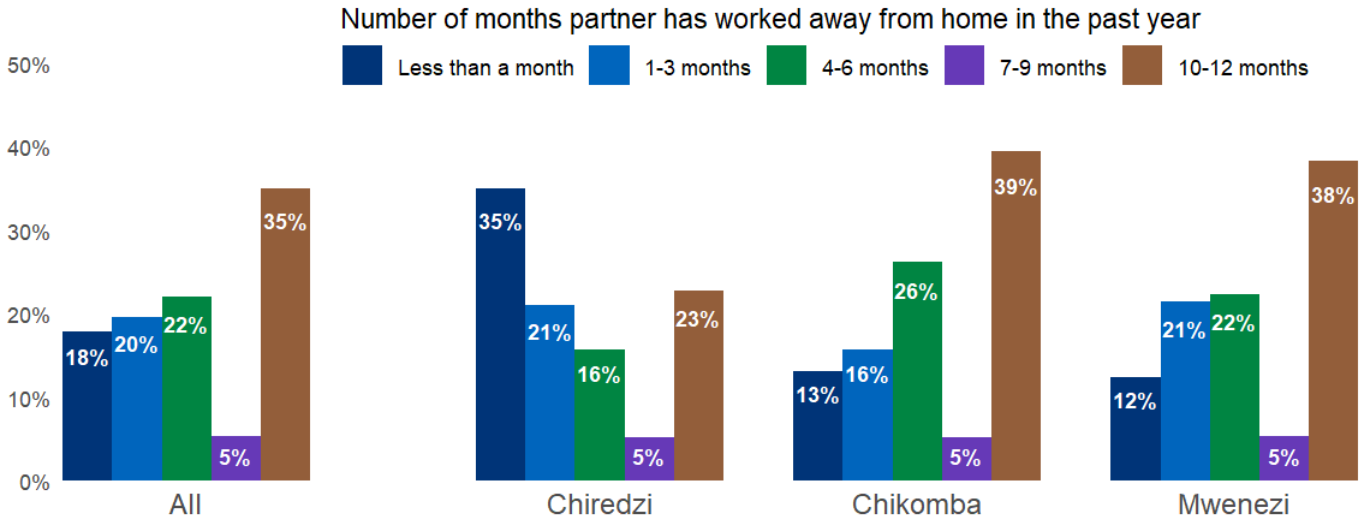
Figure 11: Marriage type, by district



Husbands were on average 6.4 years older than their wives, with the smallest average age gap in Chiredzi (5.2 years) and the largest average age gap reported in Chikomba (7.3 years). Women aged 50-59 and women in polygamous marriages had the largest average age gap in their marriages, with 8.1 and 9.9 years respectively.

Respondents' partners were most likely to work away from home in Mwenezi, where 35% of respondents in a relationship reported their partner having worked away from home in the past 12 months, for an average of 3.4 months of the year. In Chikomba, 25% of respondents reported that their partners worked away from home (also for an average of 3.4 months per year) and in Chiredzi 17% of respondents reported that their partners worked away from home, for an average of 2.6 months per year. Figure 12 shows the distribution of months partners spent away from home in all three districts.

Figure 12: Length of time that Toose beneficiary partners spend working away from home



Respondents in the youngest age category (18- 29) were most likely to report that their partners worked away from home (36%) and reported that their partners spent an average of three months a year away. Respondents with disabilities were the least likely to report that their partners worked away from home (10%).

4.2.2. Prevalence of polygamy

Out of married respondents (n=872), 9% reported being in a polygamous marriage, which is in line with national estimates of 11% of married women being in polygamous marriages as per the Zimbabwe Demographic and Health

Survey. The rate of polygamous marriage was highest in Mwenezi, where 14% of women reported being in a polygamous marriage. Women with disabilities (13%), who are members of the Apostolic church (11%) and who are over the age of 40[22] were all more likely to be in a polygamous marriage than their respective counterparts.

Across all districts, polygamous women's husbands were most likely to have a further two wives. There was a greater proportion of larger marriages in Mwenezi, where 21% of respondents in polygamous marriage reported that their husband had four wives in total. The majority of respondents in polygamous marriages reported being their partners first or second wife.

Prevalence of early marriage

Of all respondents that had ever been married (n=1091), 25% got married before the age of 18. Similar to total levels of marriage, reported above, Chiredzi had the smallest proportion of early marriages (20%), compared with 25% in Chikomba and 30% in Mwenezi.

The sub-group with the highest prevalence of early marriage was women in polygamous marriages, 42% of whom reported being married before the age of 18. Respondents with disabilities (30%), members of the Apostolic church (29%) and respondents that were either aged 18-29 (33%) or 60+ (29%) all reported higher levels of early marriage compared to the total sample.

Respondents were also asked about the girls in their household. Of respondents that reported living with a girl under the age of eighteen (n=549), 7% reported that a girl in their household had a boyfriend, and 3% were reported to be married.

4.2.3. Lobola payment

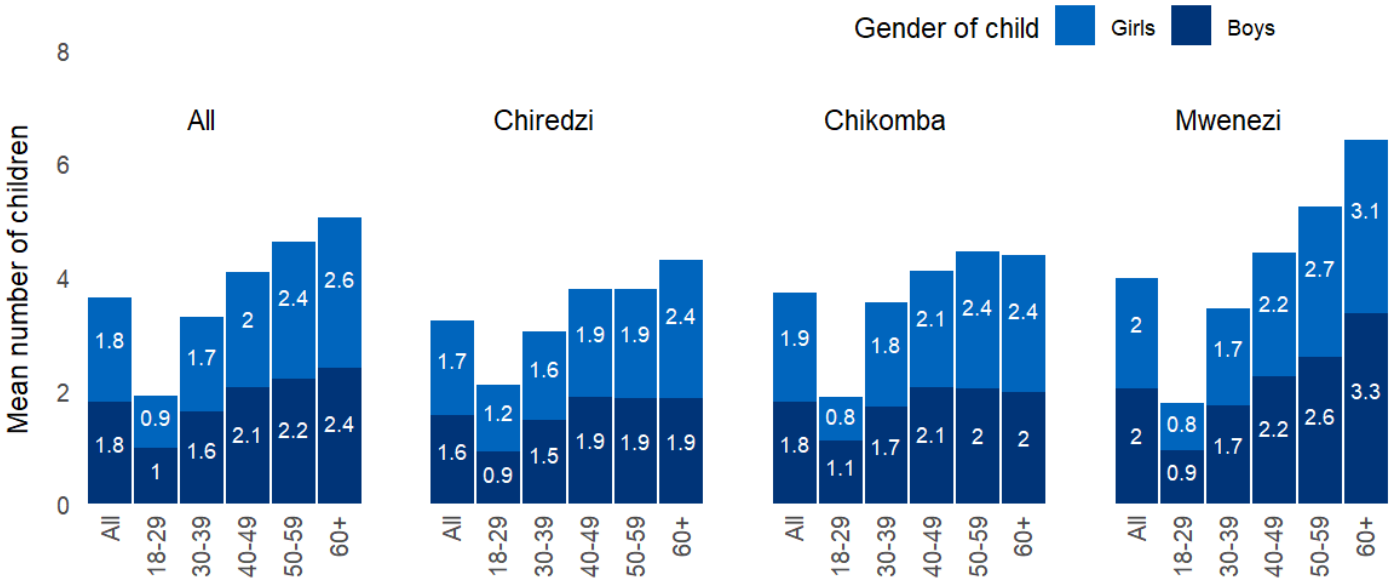
The payment of lobola for respondents' first marriage was reported by 73% of women who had ever been married. Frequency of lobola payment varied across multiple population sub-groups. First marriages of women over 50, women from Mwenezi, those with disabilities and those not from the Apostolic Church, were most likely to include payment of lobola (bride price). In contrast, first marriages of women from the youngest age category (18-29) were least likely to include a bride price, which could possibly indicate a movement away from lobola payment in recent years. Respondents who are affiliated with the Apostolic Church were significantly less likely to report that lobola was paid for their first marriage than respondents with other or no religious affiliation.

4.3. Toose beneficiaries' children

Ninety-seven percent of respondents reported having children, and had 3.6 children on average, evenly split between boys and girls. Women between 18-29 had the fewest children, averaging 1.9 in total, and there was a positive correlation between age and total number of children as shown in Figure 13, with this being especially pronounced in Mwenezi.

22 12% for women aged 40-49, 13% for women aged 50-59 and 11% for women aged 60+

Figure 13: Mean number of children Toose beneficiaries have, by age of beneficiary and district



4.4. Economic status of households

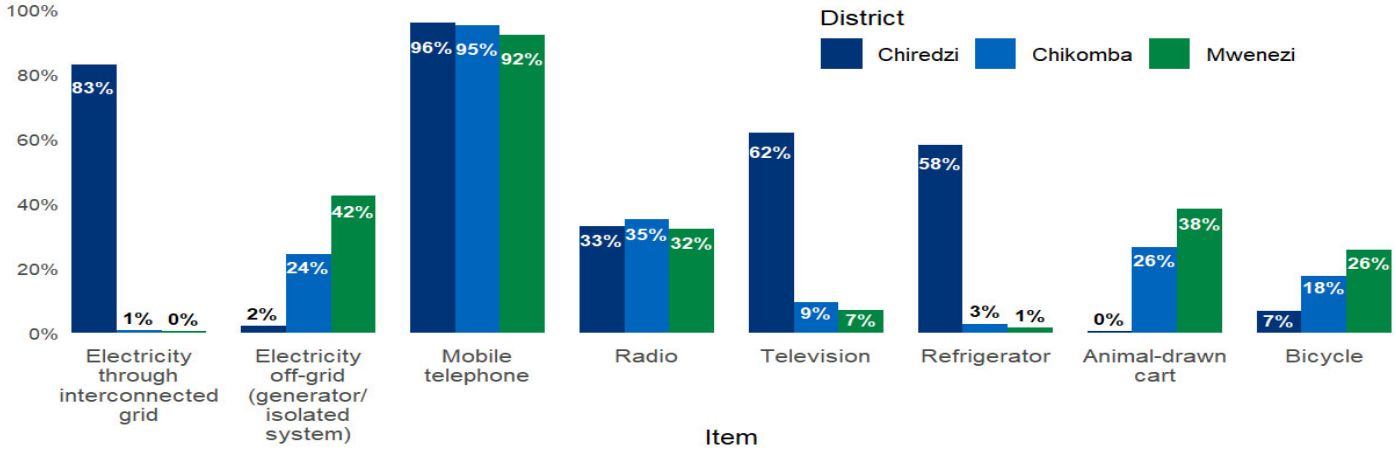
Respondents were asked about their household's economic status including questions about ownership and access to particular goods and services such as: ownership of household electrical items, modes of transport, access to electricity, as well as indicators of financial security such as land ownership and access to bank accounts and mobile money.

Electricity access. Electricity access shows a clear divide between Chiredzi as an urban district and Chikomba and Mwenezi as rural areas. In Chiredzi, 83% of Toose beneficiaries access electricity through the interconnected grid, whilst this is almost non-existent in the other two districts. In contrast, 42% of respondents in Mwenezi and 26% of respondents in Chikomba access electricity through off-grid solutions like generators, although the majority of respondents in both districts do not have electricity access through either means.

Household items. Ninety-four percent of Toose beneficiaries own a mobile phone and 32-35% of respondents in all three districts own a radio. Ownership of refrigerators and televisions was low in Chikomba and Mwenezi, and much higher in Chiredzi.

Modes of transportation. The majority of Toose beneficiaries do not own a form of transport. For those that do, an animal drawn cart is the most common form of transport owned in Mwenezi and Chikomba followed by a bicycle. Respondents in Chiredzi rarely reported owning transportation, with 7% owning a bicycle. Across all districts, a small minority of 3% of respondents owned a car.

Figure 14: Share of households owning specific items or accessing services



Respondents were also asked about land ownership and the financial products that they own and use.

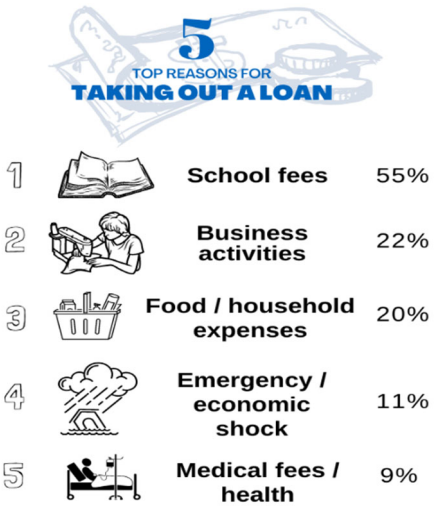
Livestock and land ownership. Sixty-three percent of respondents' household's own livestock, but the share is significantly higher in the rural districts of Chikomba (90%) and Mwenezi (89%) than the more urban district Chiredzi (11%). Age is also positively correlated with owning livestock, but this is likely driven by the fact that the urban population is on average younger than the rural one. A similar picture emerges with regard to land ownership. in Chiredzi, only 16% of respondents own land, while the number is much higher in Chikomba (99%) and Mwenezi (93%).

Mobile phone money and bank accounts. Eighty-eight percent of respondents' state that a member of their household has a mobile phone money account, such as ecocash, telecash or onemoney. This is more widespread in Chiredzi (96%) and Chikomba (90%) than in Mwenezi (76%).

Having a bank account is less common with only 28% of respondents overall stating that their household has one. There is, however, large heterogeneity between the districts. In Mwenezi, only 10% of households have a bank account compared with 34% in Chikomba and 40% in Chiredzi. Having a bank account is more common among those who are in a couple (30%) than those who are not (20%). Respondents living in polygamous marriages also more commonly report having a bank account in the household than those in monogamous marriages (77% and 69% respectively).

Savings. Two thirds (66%) of respondents' state that their household does not have any savings. This is particularly pronounced in Chiredzi where 88% of respondents have no savings compared to 52% in Mwenezi and 57% in Chikomba. Of the 34% of Toose beneficiaries that did report having a savings account (n=425), 53% kept their savings in a credit union, 51% in their own house, 6% in a bank account and 1% in a Rotating Credit Association (ROSCA) or Savings and Credit Cooperative Organisation (SACCO). The use of Credit unions was more common in Chikomba (62%) and Mwenezi (55%) whilst keeping savings in the house was most common in Chiredzi (63%).

Figure 15: Top 5 reasons Toose beneficiaries take loans



Loans. In Chiredzi, 47% of respondents reported that their household had taken out a loan in the past year, in contrast to 20% of respondents in Mwenezi and 11% of respondents in Chikomba. The proportion of respondents that had taken a loan in the past year decreased with age from 32% for 18-29 year olds to 11% for those aged 60 or over.

As shown in Figure 15, the most common reason to take out loans is to pay for school fees, especially in Chiredzi where 63% of respondents selected this as a reason, compared to 45% in Mwenezi and 39% in Chikomba. Business activities are the second most common reason for taking a loan in Chiredzi and Chikomba (26% of respondents in both districts), whilst in Mwenezi it was to pay for food or household expenses (32% of respondents). Emergencies/economic shocks were more frequently chosen as the reason to take out a loan in Chiredzi and Chikomba (13%) than in Mwenezi (4%).

4.5. Food security, basic needs and economic shocks

Respondents were asked three questions to measure household food insecurity in the last four weeks, including whether they had ever: run out of food through lack of resources; gone to sleep hungry; or spent a whole day and night without eating because there was not enough food available. The possible options ranged from 'never' to 'often'. Responses were then used to build a food security scale, with values ranging from 3-12, with lower scores indicating less food insecurity and higher scores indicating higher food insecurity.

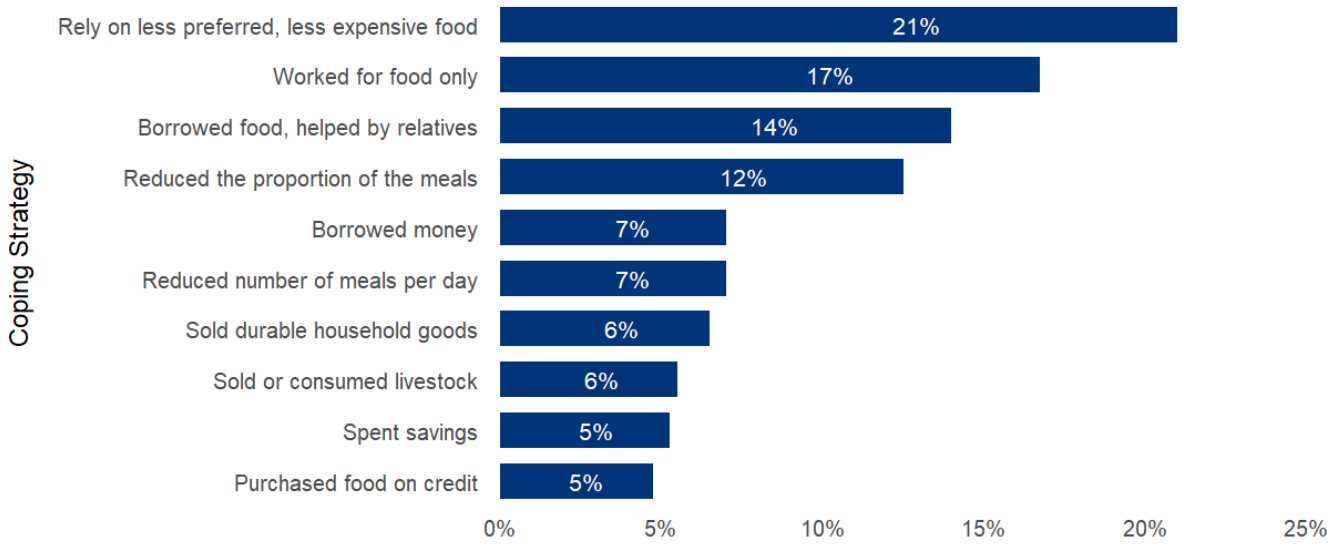
The findings indicate that food insecurity is low across Toose beneficiaries. Sixty-nine percent of respondents answered 'never' to all three questions, and the overall mean score on the food insecurity scale was low (4.2). In Chiredzi, food insecurity is lower than in the other districts, with a mean food insecurity score of 3.4 compared with 4.3 in Chikomba and 4.9 in Mwenezi.

When asked whether in the past month they were able to meet their families' most basic needs such as securing food, paying for housing, hygiene and medical costs, or schooling costs for children, the majority of respondents (84%) stated that they are able to meet only some, very few, or none of their households most basic needs. Only 15% of respondents reported that they were able to meet most or all needs in the past month. Households in Chiredzi were more likely to report that they could meet their needs, with 18% doing so compared to 7% and 8% in Chikomba and Mwenezi respectively.

One third of respondents (33%) stated that their household experienced an unexpected loss of income or assets in the past 12 months, a trend that was consistent across population sub-groups. Respondents adopted a wide range of coping strategies to respond to loss of income. The most common strategy was to rely on less preferred, less expensive food, followed by working for food only, borrowing food or getting help from relatives and reducing the proportion of meals. However, it should be noted that each of these strategies were only selected by a small percentage of respondents (see Figure 16). Notably, no respondents stated that they married girl(s) or that they sold land in order to cope with the income loss, and 1% of respondents said that they removed girls or boys from school.

When asked how easily their household could find 10 USD in case of an emergency, 45% of respondents said this would be "very difficult", 33% "somewhat difficult" and 23% "fairly easy" or "very easy".

Figure 16: Most common coping strategies in response to an economic shock



5. RQ1: Toose beneficiaries' relationship dynamics

This section reports our findings related to how Toose beneficiaries divide labour and responsibilities and make decisions and plan with their intimate partners and households. In doing so it responds to the third part of the studies first research question:

*RQ1: What are the key individual, household and **couple** characteristics and dynamics of SAFE Communities beneficiaries?*

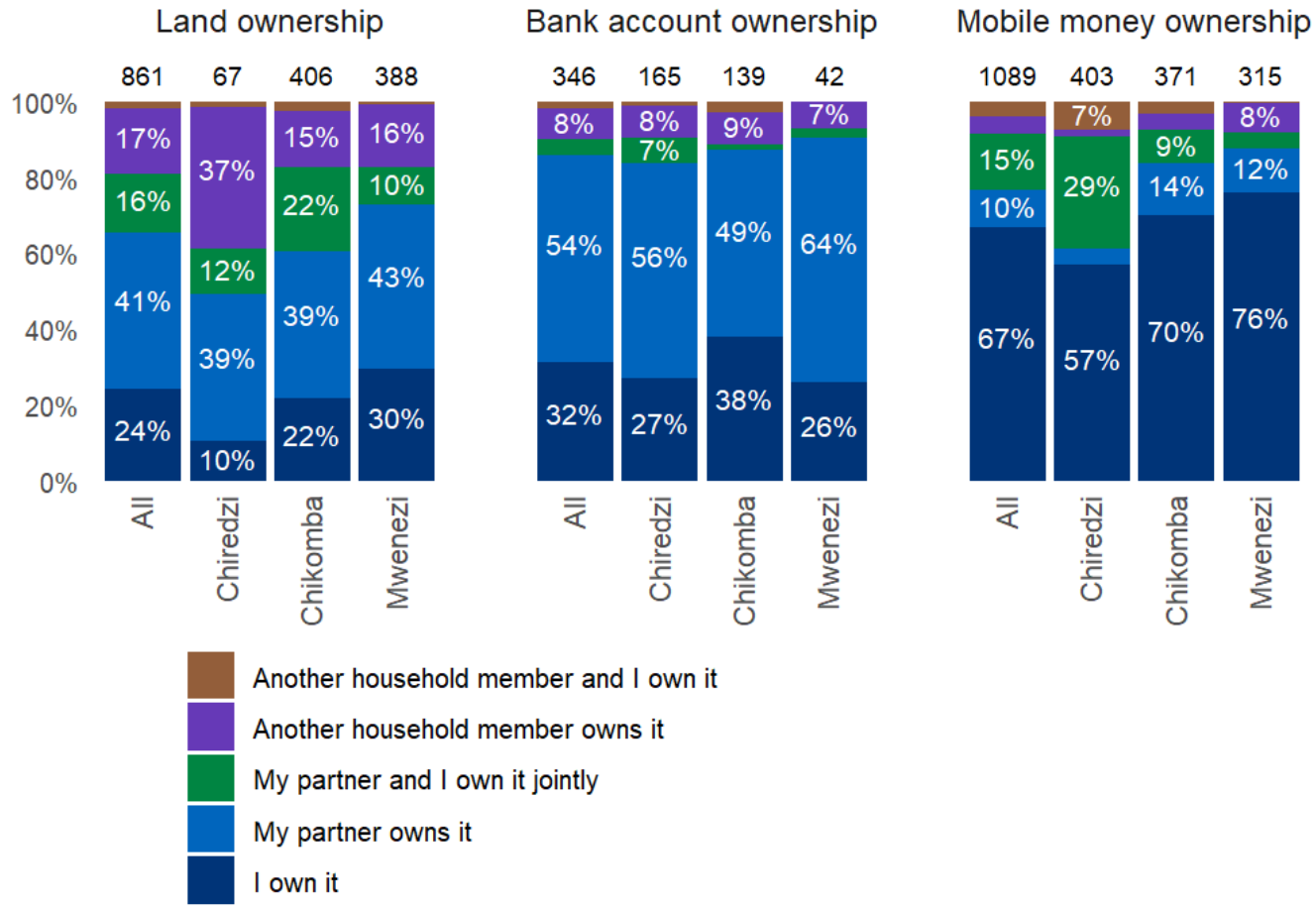
Specifically, it looks at who owns and makes decisions about money and financial assets, the division of household labour and how households plan together. It then looks at the interpersonal dynamics of beneficiaries' households, including family wellbeing and management of conflict.

5.1. Financial asset ownership

Respondents that reported that their household owned a bank account, mobile money or land were asked about who owned these assets and financial products.

Of households that own land (n=860), the largest share of respondents reported that their partner owns this land (41%). This share is relatively even across all districts. Overall, 24% of respondents are themselves the owner of the land, most commonly in Mwenezi. In total, 16% of respondents own land together with their partner, with shared ownership being more common in Chikomba than the other two districts, as shown in Figure 17. In Chiredzi, 37% of respondents reported that the land belongs to another household member who is not their partner, which is less common in the other two districts.

Figure 17: Ownership of land, bank accounts and mobile money in Toose beneficiary households



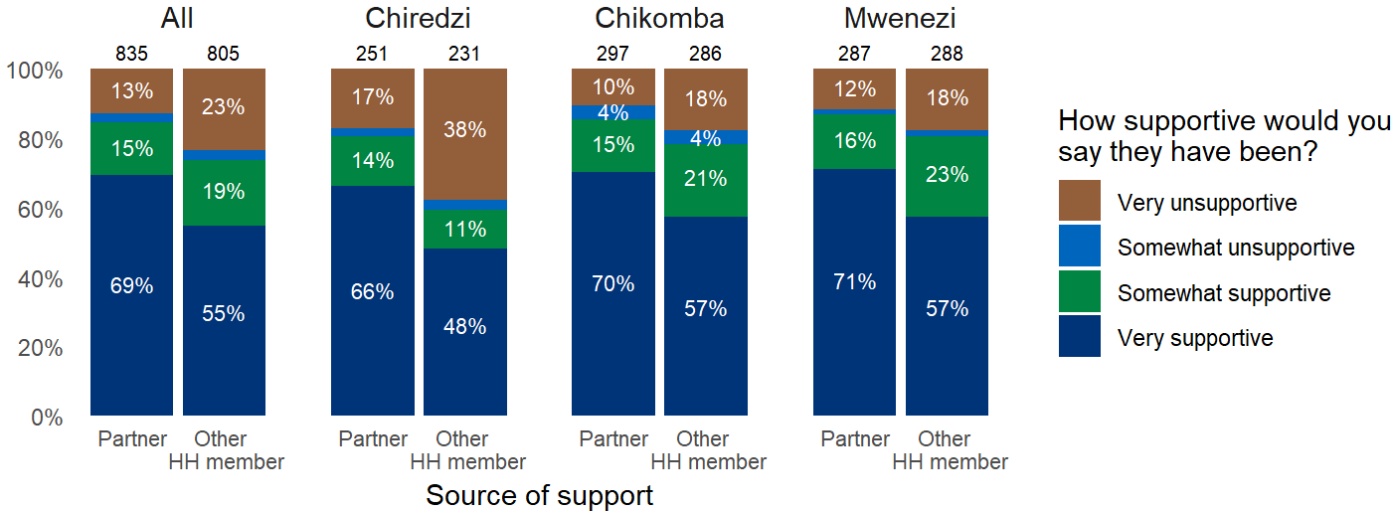
Among those households that have a bank account (n=346), the male partner is most frequently the owner of the bank account (54%), followed by the respondent herself (32%). Joint ownership is not very common (4%). There is a difference between the districts with 38% of respondents reporting sole ownership of a bank account in Chikomba compared to 26% and 27% respectively in Mwenezi and Chiredzi. The difference between age groups is more pronounced: only 6% of 18-29 year olds own their own bank account while 51% of 50-59 year old's own one. Across the three districts, 67% of respondents state that they own the mobile money account of their household, 15% share an account with their partner and 10% state that their partner is the owner of the account. The distribution of ownership varies between the districts. Partner ownership of the mobile money account is higher in Chiredzi (29%)

than in Chikomba (9%) and Mwenezi (4%). Overall, respondents aged 50-59 make up the largest share of those who own the account themselves (84%). Account ownership is also more common among single respondents (86%) than among those living in a couple (62%). Women who live in a polygamous marriage are more often account owners (80%) than those not living in a polygamous marriage (59%).

5.2. Toose beneficiaries' and their partners' work and earnings

As detailed in Section 3.3, 99% of Toose beneficiaries reported being involved in some form of income generating activity. Sixty-nine percent of respondents said their partner had been "very supportive" about their engagement in income-generating, savings or loans activities and this was consistent across all three districts. Respondents in a polygamous marriage felt significantly less supported than respondents who are not in a polygamous marriage: 23% of those in a polygamous marriage felt their partner was "very unsupportive" compared to 9% in monogamous marriages.

Figure 18: Partner and other household member support of Toose beneficiary participation in economic activities



Two thirds (67%) of respondents stated that their partner had engaged in some paid work or productive activities over the past 12 months. These numbers vary slightly between the districts with a lower share in Chikomba where only 58% of respondents' partners were engaged in such activities compared to 71-72% in the other two districts. This also varies between age groups. Older respondents' partners are less often engaged in productive activities than partners of younger respondents; for example, in the group of respondents aged 18–29, 73% reported that their partner had been engaged in paid work compared to 23% of the respondents aged 60 or older.

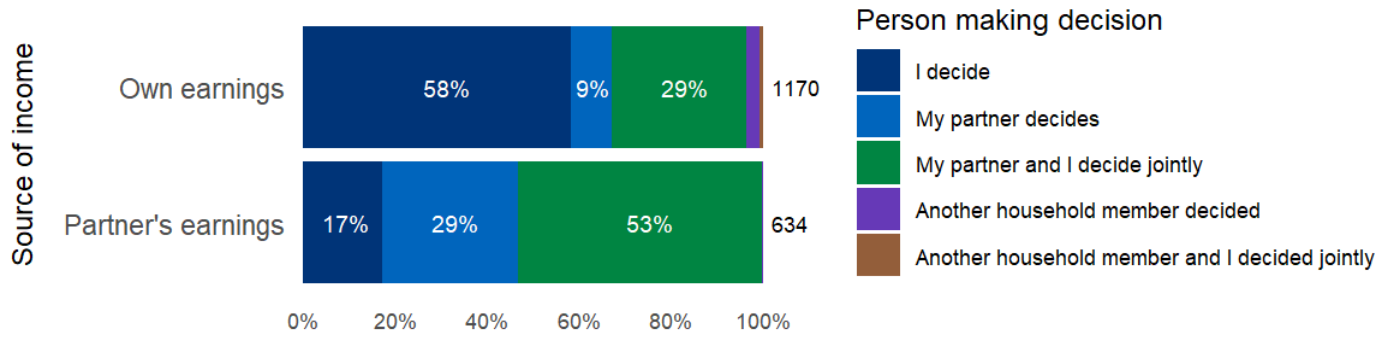
Among respondents in couples (n=941), 66% declared that they earned less than their partner. Respondents in the oldest age group (60+) were more likely to earn more than their partners (34%) than other age groups where 11-18% of respondents did.

5.3. Decisions about earnings

Respondents were asked about how they and their partner make decisions about how their earnings are used. Fifty-eight percent of respondents decide themselves how their own earnings are used, 29% decide jointly with their partner and 9% stated that their partner decides alone (see Figure 19). This trend is relatively even across the three districts. Women aged 60 or older more commonly decide about the use of their earnings themselves, with 75% in that age group doing so compared to 47% of the 18–29-year-olds. Women in polygamous marriages also have more autonomy than those in monogamous marriages: 74% of respondents in polygamous marriages decide themselves how their earnings are used compared to 44% in monogamous marriages. The latter, however, more often decide jointly with their partner (43% compared to 15% in polygamous marriages).

The majority of respondents (76%) reported that they feel they can make their own personal decisions regarding how their earnings will be used if they wanted to. Only 3% feel that this is not at all the case. Again, the answers are similar across districts, but this sense of autonomy increases with age: while 65% of the youngest respondent group feel they can make their own decisions, this share increases to 82% among the oldest age group.

Figure 19: Decisions over use of beneficiaries' and their partners' earnings

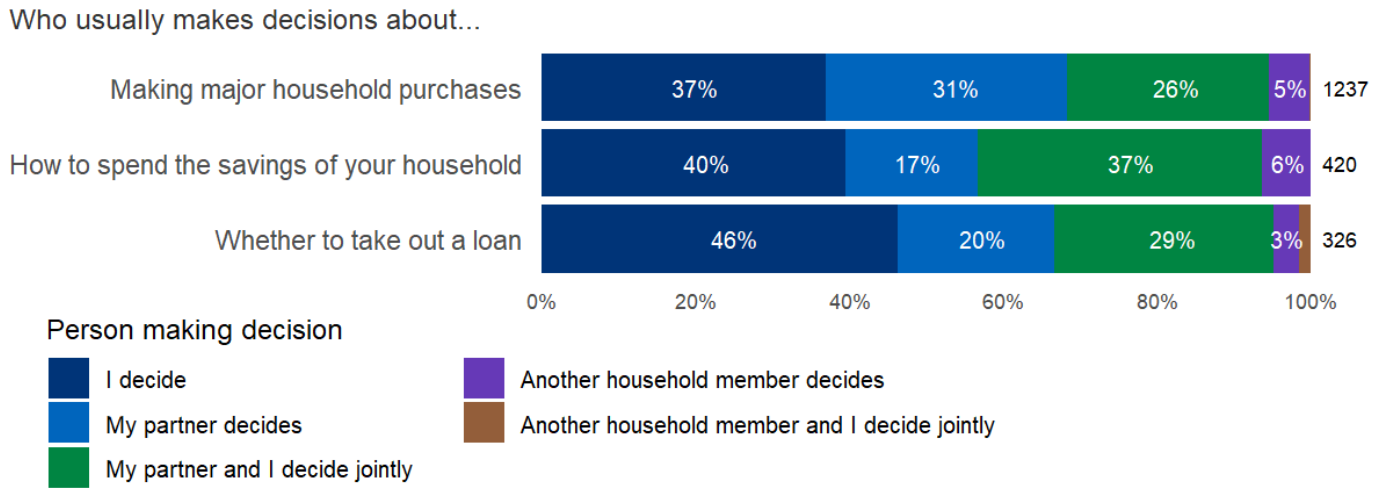


With regard to partners' earnings, 53% of respondents (whose partners worked (n=634)) decide jointly how his earnings are used, while 29% say their partner decides alone and 17% of women decide themselves (see Figure 19). This is more common among younger women. Of respondents aged 18-29, 26% say they decide about the use of their partner's earnings while only 7% of those aged 60 or older say so. In polygamous marriages, it is much less common for women to decide on the man's earnings jointly – only 30% state this is the case compared to 59% in non-polygamous marriages. In polygamous marriages, most often the partner decides himself how his earnings are used (47%).

5.4. Decisions about household purchases, loans, and savings

Respondents were also asked who usually makes decisions about major household purchases, about taking loans, and about how savings are spent. Across the three categories, the most common response overall was that women decide this themselves. However, as shown in Figure 20, it is more common that couples decide jointly about how savings are spent while women more often decide themselves about taking out a loan.

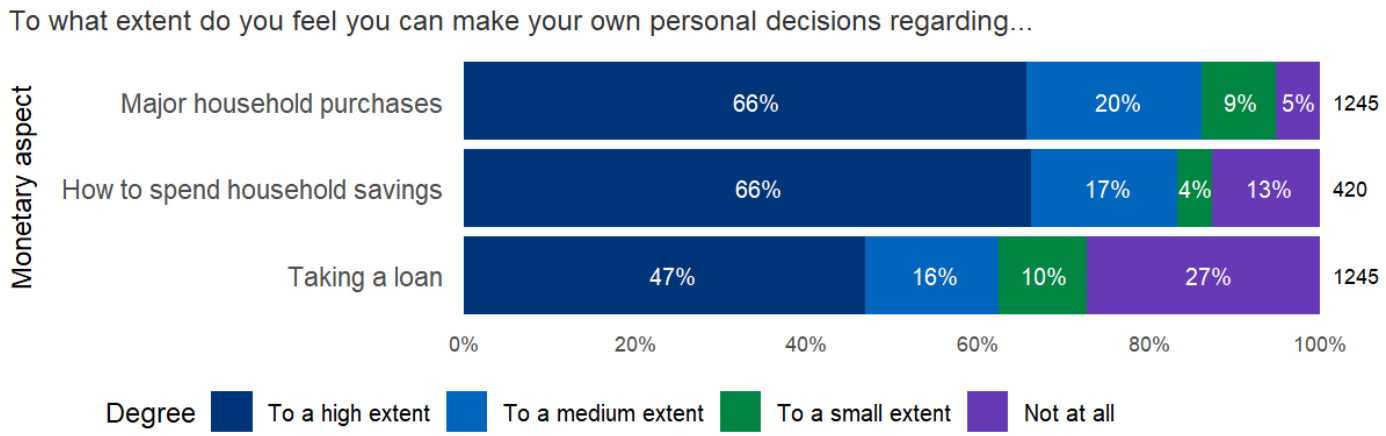
Figure 20: Division of responsibility for household monetary decisions



Respondents were also asked how much input they had into these decision-making processes. A consistent majority of between 64-71% of respondents stated that they have input into most or all decisions about household purchases, loans and savings, and a further 24-28% of respondents reported that they had input into some decisions.

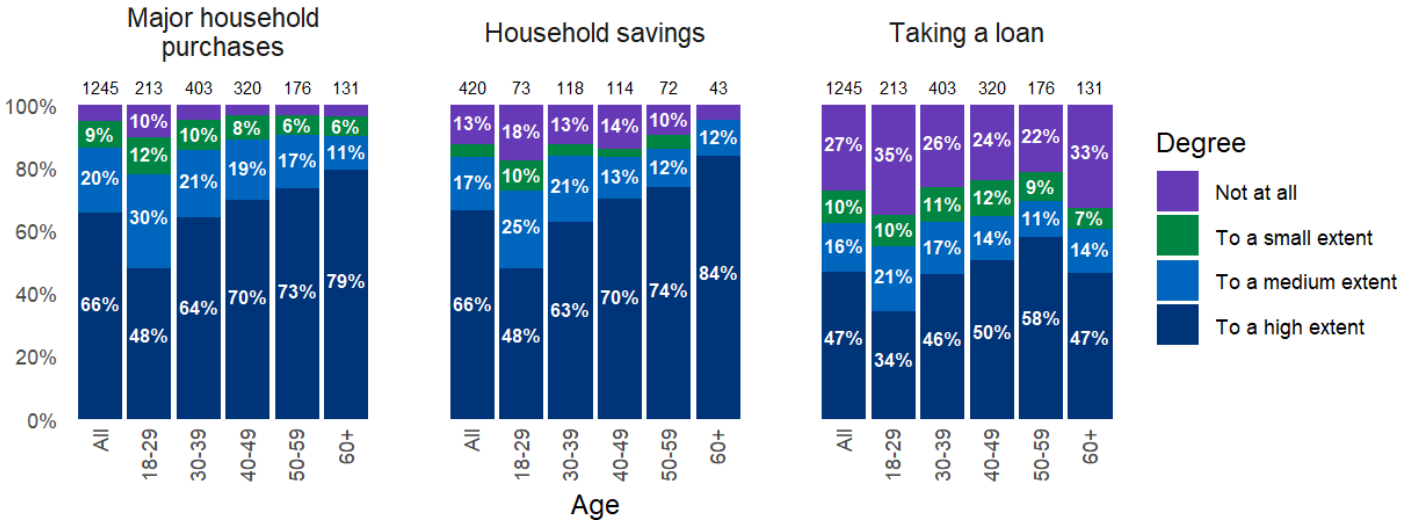
When asked to what extent they felt that they could make their own personal decisions regarding household purchases, taking out loans or how to spend household savings, most respondents felt that they could do so to a high extent, as shown in Figure 21. However, only 47% of respondents felt this way about being able to make a personal decision about taking out a loan and 27% felt they could not do so at all.

Figure 21: Agency in financial decision making



Across all categories, autonomy on decision-making in the household increased with age. Older respondents generally felt they had more input into decision-making and greater autonomy on taking personal decisions if they wanted to, as shown in Figure 22).

Figure 22: The extent to which women feel able to make their own personal financial decisions, by age



5.5. Toose beneficiaries' household planning

Respondents were asked about whether their households come together to plan strategies to improve their household financial status or their family wellbeing and if so, who is involved in these plans.

5.5.1. Economic planning

Twenty-three percent of Toose beneficiaries reported that their households come together to make a plan to increase household income or assets 'often', and a further 36% do 'sometimes'.

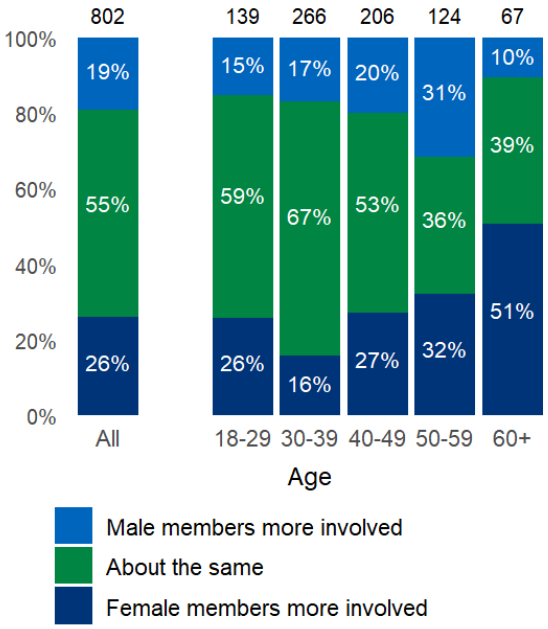
Households in Mwenezi plan together most frequently (33% reported they do so often) followed by Chikomba (21%) and then Chiredzi (14%).

Of women in a relationship who had made a household economic plan (n=655), the majority (59%) felt that planning was evenly split between men and women, as shown in Figure 23.

Respondents were asked who in the family was involved in making these plans. Seventy percent of respondents stated that their **partner or husband** is involved in the planning and this is largely consistent across districts. However, this was much more prevalent for younger beneficiaries' households: Between 72-85% of respondents aged 18-49 reported that their husband was included in the household financial planning, whilst only half of respondents aged 50-59 and 31% of respondents aged 60 or over did.

Women in polygamous marriages were significantly less likely to report that their husband was involved in financial planning (70%) than those in monogamous marriages (92%).

Figure 23: Women's and men's involvement in household economic planning



Toose beneficiaries' **parents** were primarily only reportedly involved in household planning for Toose beneficiaries in the youngest age group (18-29-year-olds) and those who are not in a couple.

A third of respondents reported that they include their **sons or daughters** in household economic planning. It is more common for children to be involved in planning in Chikomba (44%) and Mwenezi (41%) than in Chiredzi (24%). There is also a positive correlation between age and involvement of sons and daughters in planning, which is likely explained by those in older age groups having older children, who can more easily and usefully engage in planning activities. Sons and daughters are more likely to be involved in economic planning in polygamous marriages (50%) than in monogamous ones (25%).

About a third of respondents' state that **adolescent girls** in the household are involved in economic planning and this is more common in Chikomba (42%) than in the other two districts (28%). Those who are not in a couple are also more likely to involve adolescent girls in economic planning (59%) than those who are in a couple (26%).

Economic planning is significantly associated with food security, with mean food insecurity scores being lower among those who plan often than those never or rarely plan.

5.5.2. Shared vision for family quality of life

Of all respondents, 56% say their household agreed on a shared vision for improving family quality of life in the past 12 months. This was more common in Mwenezi (67%) than in Chiredzi (53%) or Chikomba (48%).

These figures are consistent across age sub-groups, with the exception of the oldest survey respondents, aged 60 or over, of which 44% had agreed on a shared vision. Respondents in monogamous marriages were significantly more likely to have agreed on a shared vision than polygamous ones (62% and 50% respectively). Respondents that reported having disabilities were significantly less likely to report that their households had agreed on a shared vision compared to those without (43% compared to 58%;)

The trend around male and female involvement in agreeing on a shared vision for quality of life mirrors the numbers for household economic planning described in the previous section – about half of respondents feel that men and women are involved about the same, 28% feel that women are more involved and 20% feel that men are more involved in creating a shared vision for family quality of life.

Adolescent girls were most frequently involved in agreeing on a shared vision in Chikomba, (53%, n=191) compared to 35% in Mwenezi and 33% in Chiredzi.

Creating a shared vision for family quality of life is significantly associated with household food security, with mean food insecurity scores being lower within households that have agreed on a shared vision than those that have not.

Respondents were also asked about whether they felt their household was working towards achieving its vision. Forty-one percent of respondents felt that their households were doing so "to a medium extent" and 29% "to a high extent". The remaining 30% feel this has been done to a small extent or not at all. Respondents in Mwenezi were especially positive about their household achieving its shared vision, with 86% reporting that their household had achieved its vision to a medium or high extent.

5.6. Gendered division of household labour

Respondents were also asked about household work and the division of household tasks between themselves and their partner, or other household members for those women without partners. Specifically, respondents were asked about washing clothes, cleaning the house, cooking and providing childcare.

Ninety-seven percent of women who were in relationships said that they always cleaned the house and 98% said that they always did the household laundry. The majority of women in all three districts also said that they always do the cooking, although a higher proportion of women in Mwenezi (9%) responded that they usually do the task with some help from their partner, compared to 2% in Chikomba and Chiredzi.

Childcare is also predominantly done by women. However, there was some variance across the districts, with 94% of respondents reporting they always provide their child's daily care in Chikomba, 90% in Chiredzi and 83% in Mwenezi, where 17% of respondents said that they usually look after their children "with some help from" their partner.

For respondents who were not in a relationship, 96-98% of women reported that they always do each task. Consistently, across all tasks, women in Chiredzi were most likely to get help doing tasks, with 89-94% of women reporting that they were helped with tasks by a household member.

5.7. Toose beneficiaries' family wellbeing and management of conflict

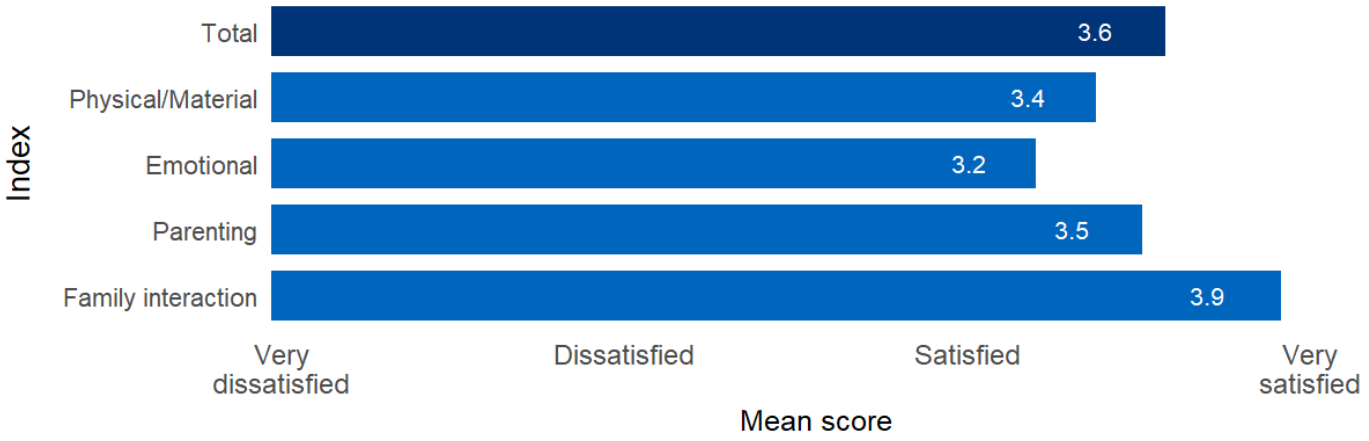
This section looks at how Toose beneficiaries' family members interact with one another and the level of wellbeing and satisfaction in respondents' family relationships. Specifically, it outlines reported levels of family wellbeing, including emotional, material and relational wellbeing and satisfaction as well as approaches to managing conflict.

5.7.1. Family wellbeing

To determine family wellbeing, respondents were asked to rate 16 statements on a scale from 1 to 5 with 1 meaning "very dissatisfied" and 5 meaning "very satisfied".[23] These statements were then combined into a total family quality of life indicator, and four sub-indicators for different types of wellbeing: family interaction, parenting, emotional and physical/material. Figure 24 shows the mean scores for each wellbeing category.

23 The survey drew from an adapted version of the Family Quality of Life (FQOL) scale.

Figure 24: Mean family quality of life scores



The family interaction indicator is calculated based on questions about the family spending time together, family members talking openly with each other, the family solving problems together, family members supporting each other to accomplish goals, and the family being able to handle life's ups and downs. Across all districts and sub-groups respondents reported they were "satisfied" with their family interactions.

The mean parenting wellbeing score was 3.5, showing that, on average, respondents were moderately satisfied with the parenting in their families. Questions included under this domain related to family members: helping the children with schoolwork and other activities; teaching the children how to get along with others; teaching the children to make good decisions, and whether adults in the family have time to take care of the individual needs of every child. Satisfaction levels are slightly higher in Chikomba (3.7) than in the other districts.

The emotional wellbeing score is calculated from a set of questions related to how satisfied families are that they have the support and social networks they need to relieve stress and take care of the needs of all family members. The mean score for these questions is 3.2 indicating that overall, respondents are moderately satisfied. This is homogenous across the sample except for Chikomba where the mean core is slightly lower at 3.1, indicating that overall, respondents from this district are neither satisfied nor dissatisfied with the emotional wellbeing of their families.

Physical/material wellbeing relates to the family's ability to get medical care when needed, whether their family has a way to take care of expenses, and whether their family feels safe at home, work, school, and in the neighbourhood. Overall, respondents were moderately satisfied with their physical/material wellbeing with a median score of 3.4 across the sample. Satisfaction with physical/material wellbeing is also higher in Chikomba and Mwenezi (3.7) than in Chiredzi (3.3). Respondents above 60, women living in polygamous marriages, and Apostolics also seem more satisfied in this regard than their respective counterparts.

Respondents were also asked about their satisfaction with their family relationships. Eighty percent of respondents reported that they were satisfied or 'very satisfied' with their relationships with their partner, and this was consistent across all districts. Women in polygamous marriages were significantly less satisfied than women in monogamous marriages, with 23% reporting they were 'dissatisfied' or 'very dissatisfied' with their partner, compared to 10% in monogamous marriages. Respondents in all districts and across all sub-groups were 'satisfied' or 'very satisfied' with their relationships with their children (96% - 98% across all sub-groups). Eighty-seven percent of respondents reported that they were 'satisfied' or 'very satisfied' with family relationships in their household (and this was consistent across all districts and sub-groups), but that they were less satisfied with relationships with other family members from outside the household. This is especially seen in Chiredzi (64%) Chikomba (66%), whilst in Mwenezi 77% of respondents reported being satisfied with family relationships outside their household.

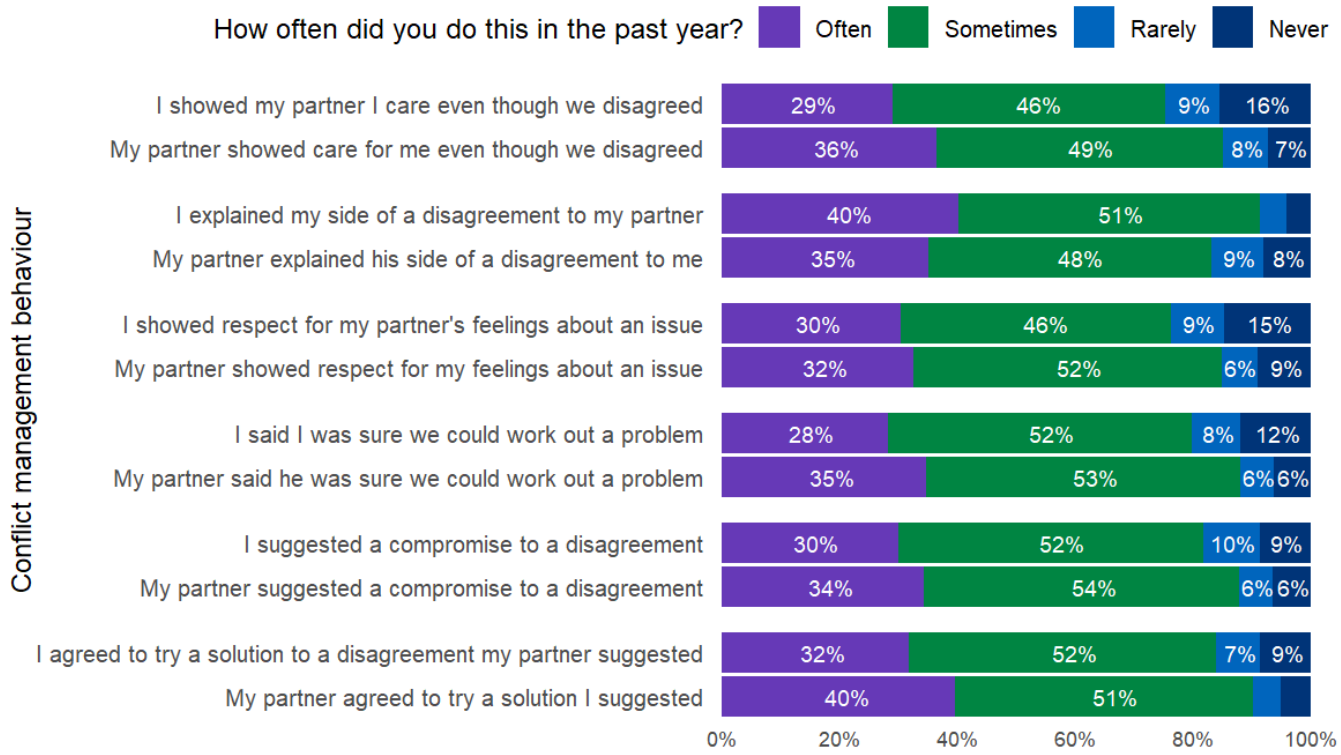
5.7.2. Conflict management – partner

To gauge Toose beneficiaries' knowledge of non-violent conflict management in their intimate relationships, respondents were asked about a hypothetical scenario that describes a woman being upset with her husband because he had spent his money on alcohol, and asked to choose whether a passive, assertive or aggressive response was most appropriate.

Seventy-six percent of respondents chose the assertive response option, which is an indicator of a healthy approach to managing conflict. Nineteen percent of respondents thought that the passive response was the best option, and the aggressive response was the least popular across all respondents (4%). Respondents aged 18-29 years old were more likely than those in other age groups to choose the passive response (27%), whilst respondents aged 60 or over were most likely to choose the assertive response (85%). There were no significant differences across any other population sub-groups.

Respondents were then presented with six statements that demonstrate a healthy approach to conflict management, such as “I showed my partner I care even though we disagreed”. Respondents were asked to choose an option between ‘never’ and ‘often’ to reflect their own relationship in the past 12 months. The same set of six statements were then repeated, but respondents were asked to reflect on their partner’s behaviour. The results are summarised in Figure 25.

Figure 25: Toose beneficiaries’ approaches to conflict management



As shown in Figure 25, for most statements the majority of respondents reported that they sometimes or often used healthy conflict management strategies and demonstrated love and care even during disagreements. Respondents generally felt that their partner more consistently did so than themselves, with the exception of explaining their side of a disagreement, where a greater proportion of respondents felt they did this than the other way around.

Respondents were also asked whether they felt valued and respected by their partner overall in the past 12 months, and how much they felt their partner had felt valued and respected by them. Seventy-nine percent of respondents reported that they felt very valued by their partner, and 87% reported that they thought that their partner felt valued and respected by them. Perceptions of value and respect are lower in Mwenezi, both for women’s own feelings of being valued and respected (77%) in their intimate relationships and perceptions of their partner’s feelings (82%).

Lastly, respondents were asked to reflect on the three most recent disagreements that they had with their partner, and how these were addressed. Respondents chose from options ranging from constructive solutions like discussing the disagreement and sharing feelings, through increasingly unhealthy responses up to the threat or perpetration of physical violence.

Between 61% and 63% of respondents reported using each of the three healthy approaches to managing conflict (discussion, expressing feelings and coming up with solutions and compromises). This was seen across all districts.

Twelve percent of couples reported blaming and criticising each other during their three most recent disagreements, and 5-8% of respondents reported that their conflict with their partner had resulted in swearing, threats of negative

consequences or one partner insisting that the argument was resolved their way. One percent of respondents reported that they had been physically violent towards their partner during a conflict, whilst 5% reported that their partner had been physically violent towards them. Women in polygamous marriages were significantly more likely to report that they or their partner had sworn at each other, threatened each other with negative consequences.

5.7.3. Conflict management – other household member

Respondents were also asked about how valued and respected they felt by other household members, and how they managed conflict with other household members, using the same set of statements as used for partners (starting from healthy behaviours gradually worsening to the option of perpetration of physical violence).

Eighty-one to 83% of respondents from across the three districts reported that they felt very valued and respected in their households.

Respondents were less likely to report using healthy conflict management strategies with household members than in their intimate relationships. The most common response across all respondents was suggesting possible solutions and compromises (50%), with 39% and 43% of respondents, respectively, reporting that they would discuss the disagreement or express their feelings to the household member.

The proportion of respondents reporting unhealthy conflict management strategies with household members was also smaller than the proportion of respondents reporting unhealthy conflict management strategies in their intimate relationships. Seven percent of respondents reported that they might blame or criticise each other and only 1% reported that they or a household member would use a more aggressive option such as swearing, threatening or being physically violent.

6. RQ2: Toose beneficiaries' attitudes towards GBV

This section presents findings that respond to the second research question:

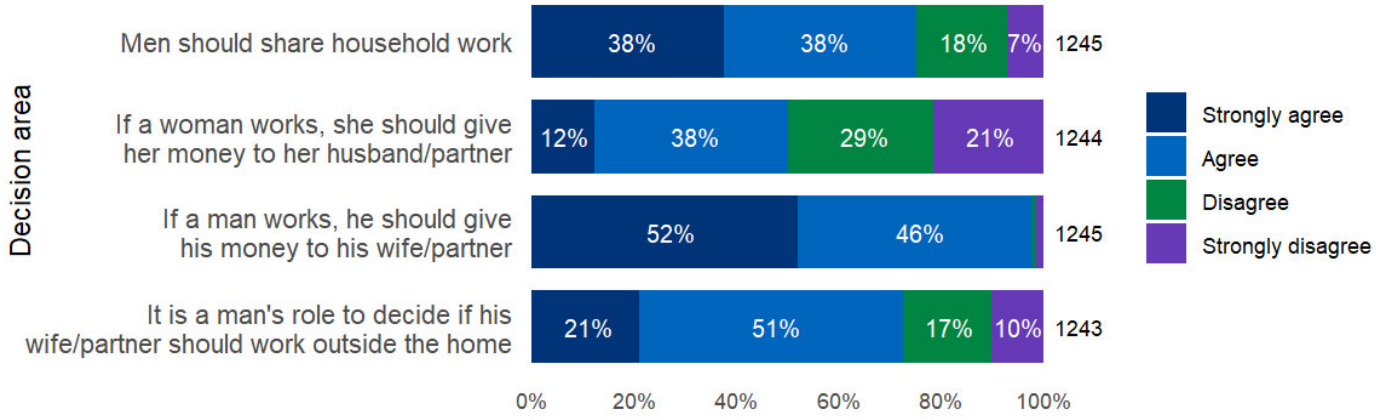
RQ2: What are the prevailing attitudes towards GBV among SAFE beneficiaries?

Specifically, it reports on sections of the survey related to early marriage, the justification for physical IPV, and respondents' gender-equitable attitudes.

6.1. Gender-equitable attitudes

Respondents were asked to respond to a series of statements about women's and men's roles in decision-making and household division of labour to gauge their attitudes towards gender equality.

Figure 26: Toose beneficiaries' agreement with gender in/equitable attitudes



With regards to housework and childcare, the majority of respondents (83%) agreed or strongly agreed that a woman's most important role is to take care of the home and cook, and agreement was even more pronounced in respondents aged 60+ years (91%). However, most respondents also agreed that men should share work around the house with women, such as doing dishes, cleaning and cooking, as shown in Figure 26. With regards to childcare the trend was reversed. Ninety-five percent of women disagreed or strongly disagreed that men should share childcare responsibilities with their partners; a trend that was reflected across all population sub-categories.

For questions related to money, there is a clear agreement across districts and sub-groups that men should give money that they earn to their partner – 98% of women across all categories agreed with this. Responses about whether a woman should give money that she earns to her partner were more mixed, as shown in Figure 26, with roughly equal proportions of women agreeing and disagreeing.

A large proportion of respondents also agreed with statements related to men's decision making and control in the family, although some district variations were observed in Chiredzi which suggests that attitudes are slightly more equitable in urban areas. Seventy-two percent of respondents overall agreed or strongly agreed that a man should decide whether or not his wife or partner works outside the home, with less agreement in Chiredzi (Figure 26). Similarly, two thirds of women (66%) felt that men should have the final say in all family matters, increasing to 70% and 71% in Chikomba and Mwenezi respectively, and reducing to 61% in Chiredzi.

6.2. Early marriage

This section first looks at respondents' perceptions about the prevalence of early marriage in their respective communities and compares this to information from key informant interviews with members of civil society

organisations and local government. It then presents respondents' attitudes towards early marriage including in which circumstances, if any, they consider it to be appropriate.

Seventy-two percent of respondents in Chiredzi, 48% in Chikomba and 64% in Mwenezi reported that 'many' girls were married before the age of 18 in their community. No significant differences in perceptions of prevalence of early marriage were found across sub-groups. Respondents were also asked whether they thought that the practice of early marriage had increased, decreased or stayed the same in their community in the past year. Seventy-three percent of respondents in Chiredzi thought that the practice of early marriage had increased in the past year, compared with 49% of respondents in Chikomba and 57% in Mwenezi.

Officials and key informants from local organisations in all three districts reported that child marriage was prevalent and highlighted the prevalence of a practice of 'hiding' child marriage under the auspice of children going to stay with relatives and that this is the primary way that child marriage evades legal or community scrutiny.

National and ward-level respondents also agreed that lockdowns associate with the Covid-19 pandemic had increased numbers of forced child marriages (Ward KII 11, Ward KII 10, Ward KII 9, Ward KII 8, Com 3, Ward 4, Nat KII 3). The primary reasons cited for this were an increase in number of children becoming pregnant and to relieve household economic hardship due to reduced household income (Ward KII 1, Nat KII 2 and Nat KII3). As one national level key informant reported: "*harmful practises during the lockdown were common as more than 4000 girls got pregnant in Mashonaland Central only during the Jan-February 2021 lockdown, of those about 1500 were forced into child marriages"* (Nat KII 3). One respondent in Chikomba also reported that sometimes child marriage is voluntary and driven by a girl's desire to escape the poverty she faces at home (Ward KII 2)

To gauge attitudes towards early marriage, respondents were first asked what they thought was a 'good' age for a woman or girl to first get married. They were then posed a set of questions regarding the marriage of their own daughter, real or imagined, and whether they or their partner would ever consider marriage for their daughter before the age of 18.

Despite widespread perceptions that early marriage has increased in the past year, the vast majority of respondents did not express attitudes that are supportive of early marriage. Ninety-five percent of all respondents (n=1231[24]) suggested that a good age for a girl or woman's first marriage was between 18 and 25 years of age. Only 1% of respondents suggested that a girl should get married before the age of 18, and these respondents were predominantly older women (50+) from Mwenezi. More specifically, respondents most commonly reported that they felt that either 18, 20 or 25 was a 'good' age for a woman or girl to get married for the first time, with these three options accounting for 70% of all responses.

Ninety-nine percent of all respondents reported that neither they nor their partner would consider marriage for a daughter under the age of 18. This trend was consistent across all subgroups, with the exception of women in polygamous marriages, 11% of whom said that their partner would consider early marriage for a daughter.

6.3. Justification of Physical IPV

Respondents were asked about circumstances in which they felt a man would be justified in beating his wife or female partner and whether they strongly agreed, agreed, disagreed or strongly disagreed with each option.[25]

Across all respondents, 41% agreed with at least one of these statements, indicating that they perceive the perpetration of physical IPV to be acceptable in at least one of these circumstances. Respondents in Mwenezi were more likely to justify physical IPV, with 49% agreeing with at least one statement compared to 38% and 37% respectively in Chiredzi and Chikomba.

There was largely consistency across the population subgroups in the justification for IPV, with some variations. For instance, younger women (aged 18-29) were more likely than older women to justify IPV in any circumstance. Women in polygamous marriages and members of the Apostolic church were also more likely to justify physical IPV (45%) than women in monogamous marriages and from non-Apostolic religious groups (39%). There is also a clear trend in the types of circumstances in which physical IPV is most commonly justified. Across all districts, the primary justification for physical IPV was a woman being unfaithful: 29% and 30% of respondents in Chiredzi and Chikomba and a slightly higher proportion of respondents in Mwenezi (37%) agreed with this justification. This was twice as high as the response rate for any other circumstance. The circumstance in which the fewest respondents justified physical

24 Base sample is lower for this question because we excluded 'don't know' responses
25 The options presented were: If she goes out without telling him; if she neglects the children if she argues with him; if she refuses to have sex with him; if he is not satisfied with the way does the housework; if she disobeys him; and if he finds out that she has been unfaithful.

IPV was when a husband was dissatisfied with his partner's housework, whilst all other circumstances were seen as justifiable by 10-15% of respondents.

Respondents from Mwenezi were consistently most likely to see all circumstances as a justification for IPV. Respondents form the apostolic church were also significantly more likely to report that any option was a justification for IPV when compared with respondents with different or no religious affiliation.

7. RQ3: Prevalence of past year GBV experience

This section first presents our findings related to the prevalence of GBV experience in the past year among Toose beneficiaries with a focus on IPV. In doing so, it responds to research question 3:

RQ3: What is the prevalence of different types of GBV among SAFE Communities beneficiaries?

Specifically, this section reports Toose beneficiaries' past year experience of controlling behaviour from their partner; economic, emotional, physical and sexual IPV; severity of IPV; non-partner sexual violence (NPSV); physical violence perpetrated by family members who are non-partners; and the co-occurrence of different types of violence (polyvictimisation).

Lastly, the section also looks at women's perpetration of corporal punishment against their children, and reports about their partners' corporal punishment against their children. In addition, we draw from responses from community, district and national level stakeholders about prevalence of different types of GBV, based on KIIs with representatives from civil society organisations and representatives from local councils.

7.1. Controlling behaviours

Respondents were first asked about their experience of controlling behaviour from a partner. It should be noted here that controlling behaviour is not included in the definition of intimate partner violence, and so is not included in IPV prevalence figures. It is, however, an important risk factor for intimate partner violence, and an important indicator of relationship dynamics between intimate partners.

Toose beneficiaries were asked about their experience of five indicators of controlling behaviour by their current or former partner in the past 12 months.[26] Fifty-four percent of respondents reported experiencing at least one of these behaviours from their partner in the previous year. This rate is highest in Chiredzi, where 65% of respondents reported at least one controlling behaviour, compared to 53% in Chiredzi and 46% in Mwenezi.

Women aged 18-29 were more likely report controlling behaviours from a partner (64%), with reports of controlling behaviours decreasing with age down to 29% of respondents aged 60 years or over. There was no significant difference in prevalence across other population sub-groups. Women who are currently single (but had a partner in the past 12 months) reported the highest rate of controlling behaviours in the past 12 months (79%).

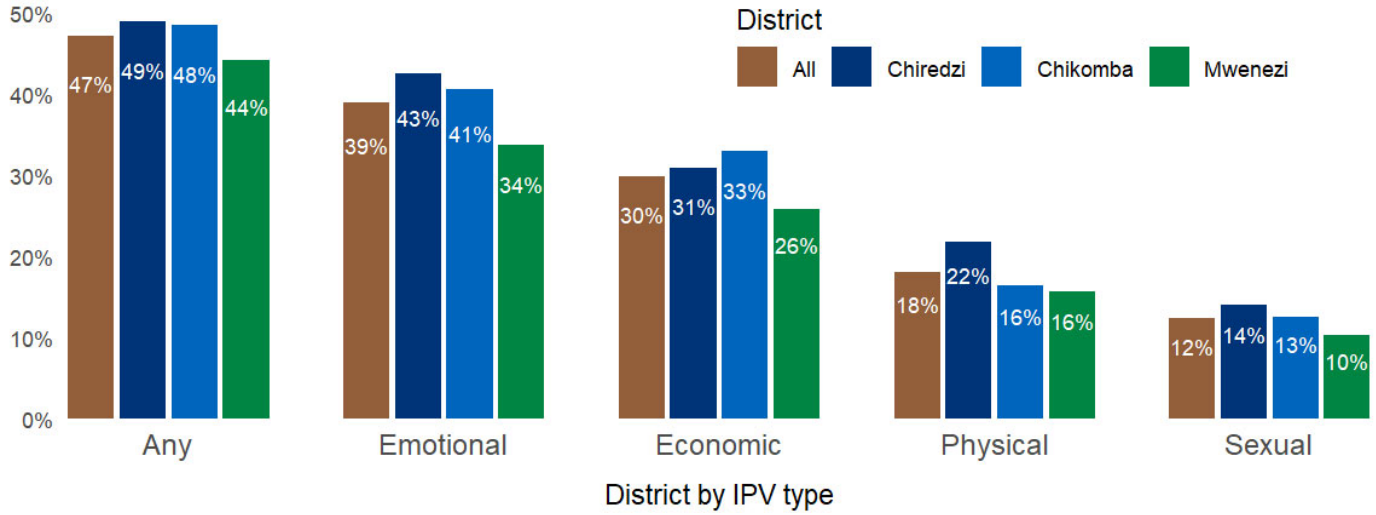
7.2. Prevalence of IPV

Respondents were asked about their experiences of emotional, economic, physical and sexual violence perpetrated by an intimate partner in the past 12 months.[27] Figure 27 shows the prevalence of different types of IPV across the three SAFE implementation districts. Forty-seven percent of women in a relationship in the past 12 months reported that they had experienced at least one type of IPV.

26 These included: being jealous or angry if she talks to other men; accusing her of being unfaithful; not permitting her to meet her female friends; limiting her contact with her family; and insisting on knowing where she is at all times.

[27] To assess the prevalence of emotional IPV, respondents were asked about whether their husband, boyfriend or partner had insulted them or made them feel bad about themselves; belittled them or humiliated them in front of other people; threatened to leave or hurt them, or hurt someone they care about; or had purposefully scared or intimidated them in the past 12 months. Economic IPV was measured through three items, including whether their partner had in the past 12 months: stopped them from getting a job, going to work or trading or earning money; taken their earnings when they didn't want them too; or spent money on things for himself when there was not enough money for household expenses. Physical IPV was measured through seven items ranging from: being slapped; being pushed, shaken or having something thrown at them; having their arm twisted or hair pulled; being punched with a fist or other object; being kicked, dragged or beaten; being choked or burned on purpose; or being threatened or attacked with a knife, gun or other weapon. Sexual IPV was measured through two items, including whether a partner had: forced her physically or with threats to have sexual intercourse when she didn't want to; or forced her with threats to perform any other sexual acts she did not want to do.

Figure 27: Prevalence of last year IPV experience by Toose beneficiaries, by type of IPV and district



Across all three districts, emotional IPV is the most common type of IPV, with 39% of all respondents reporting some form of emotional IPV in the past 12 months. Economic IPV is also highly prevalent, at 30%, with prevalence of physical and sexual IPV being lower (18% and 12% respectively). Prevalence of IPV varied across the districts, with prevalence rates being highest in Chiredzi and lowest in Mwenezi for all four types of IPV, with the exception of economic IPV which was most prevalent in Chikomba. Further differences according to sub-groups are reported in the section of the report on risk factors for IPV.

Box 1: Key definitions

Intimate partner violence (IPV) includes any act of physical, sexual, psychological or economic violence occurring within an intimate relationship involving either a current or former partner. There are four main types of IPV:

Physical IPV refers to physically hurting or attempting to hurt a partner by slapping, hitting, kicking or beating them, or using any other kind of physical force.

Sexual IPV refers to coerced or forced sexual intercourse or other types of sexual acts.

Psychological or emotional IPV refers to any kind of verbal insult, abuse or humiliation, and intimidation or threats of harm.

Economic IPV refers to controlling a partner's ability to access and use economic resources and putting at risk their economic security and self-sufficiency.

National and district level key informants were also asked about prevalence rates of IPV in SAFE's implementation districts. All four national level key informants highlighted that all forms of intimate partner violence were prevalent in the three implementation districts. IPV was also reported to be prevalent by district level stakeholders. In all three districts physical IPV was most frequently cited by respondents (Ward 2, Com2, Ward 3, Ward 4, Ward 10, Ward 5, Ward 7, Ward 1, Ward 11, Ward 9, Ward 8). Emotional abuse was the next most commonly mentioned type of abuse in Mwenezi, whilst in Chiredzi and Chikomba it was economic.

These KII findings contrast with the prevalence figures collected in the baseline survey and may be due to physical IPV being more visible, and emotional and economic IPV being less well understood or recognised as significant types of violence.

7.2.1. Severity of IPV

The severity of IPV was analysed using the 'What Works' metric for assessing IPV severity.[28] This method logs prevalence of 'severe' IPV for any respondent who either offers an affirmative response to more than one question

28 See for example: Alangea, DO. et al. (2020) Evaluation of the rural response system intervention to prevent violence against women: findings from a community-randomised controlled trial in the Central Region of Ghana. Global Health Action, 13(1); and Dunkle, K. et al. (2020) How do programmes to prevent intimate partner violence among the general population impact women with disabilities? Post-hoc analysis of three randomised controlled trials. BMJ Global Health, 5(12).

about physical and/or sexual violence by an intimate partner in the past 12 months, or responds that they experienced any form of physical or sexual intimate partner violence a 'few' or 'many' times in the past 12 months.29

In Chiredzi, 25% of women who had been in a relationship in the past 12 months in reported having experienced severe IPV using this measure compared to 19% in Chikomba and 15% in Mwenezi.

7.3. Prevalence of physical family violence

All Toose beneficiaries (n=1245), were asked about their experiences of physical violence perpetrated by another family member who was not the respondent's intimate partner. Only two percent of respondents (n=21) reported that they had been slapped, hit or beaten by a family member that was not their partner in the past 12 months. This was consistent across all three districts. There were no significant sub-group variations given the very small number of women who reported non-partner physical family violence.

7.4. Prevalence of non-partner sexual violence

When asked about sexual violence by anyone that was not the respondent's intimate partner, only 1% of all Toose beneficiaries (n=11) reported that someone other than a husband, boyfriend or partner had ever forced or persuaded them to have sex when they didn't want to. All reported non-partner sexual violence was perpetrated by men. There was a higher prevalence in Chiredzi (1.7%) compared to Chikomba or Mwenezi (both 0.5%). There were no significant sub-group variations given the very small number of women who reported non-partner sexual violence.

Of the respondents that reported non-partner sexual violence (n=11), 91% reported a violent incident in the last month, and 45% reported that they had experienced non-partner sexual violence 'a few times' in the last month.

7.5. Polyvictimisation

Polyvictimisation refers to the experience of multiple 'types' of violent experience and also includes experience of controlling behaviours. This is scored when a respondent provides an affirmative answer to a question in more than one category of controlling behaviour or gender-based violence. A maximum score is therefore 7 and would be scored if a respondent had experienced controlling behaviour; emotional, economic, physical and sexual intimate partner violence; non-partner sexual violence; and physical violence perpetrated by another family member other than their intimate partner. Across all Toose beneficiaries (n=1245), 33% of respondents reported polyvictimisation.

7.6. Perpetration of violence against children

Respondents were also asked about whether they or their husband or male partner had perpetrated violence against a child as punishment, by smacking or beating them, in the past 12 months.

Twenty-eight percent of respondents reported that their husbands had smacked or beaten their child in the past 12 months, with 14% reporting that this had happened once, 12% reporting 'a few times' and 2% reporting 'often'. There was little variance across the three districts and population sub-groups, with the exception of members of the Apostolic church, who were significantly less likely to report that their husband had hit their child (25% of Apostolic and 34% of non-Apostolic respondents respectively). Reporting of violence against a child perpetrated by a husband or male partner decreased with the age of the respondent: 12% of women aged 60 or over and 17% women aged 50-59 reported that their husband had smacked or beaten their child in the past 12 months, compared to 28% of 18-29-year-olds and 38% of 30-39-year-olds. This may be due to older respondents having adult children who are less likely to experience corporal punishment by a parent.

In contrast, 53% of respondents reported having smacked or beaten their child in the past 12 months, with 13% reporting having done this once, 32% 'a few times' and 9% 'many times'. Women's self-reported perpetration of violence against their child varied by district: women in Chiredzi were most likely to report smacking or beating their child (60%), whilst respondents from Chikomba were least likely to have done so (43%). Women with disabilities were significantly less likely to report having been physically violent towards a child (45%) than women without disabilities

29 It is common practice in the field not to model a combined variable for severity of IPV that includes economic and emotional abuse given that the field's understanding of these types of IPV is at a much earlier stage. See for example: Jewkes, R. et al. (2017) Women's and men's reports of past-year prevalence and prevalence of intimate partner violence and rape and women's risk factors for intimate partner violence: A multicountry cross-sectional study in Asia and the Pacific. PLOS Medicine, https://doi.org/10.1371/journal.pmed.1002381

(54%). As per respondents' partners' perpetration of violence, a similar age trend is seen for respondents' own perpetration of violence against their child: 55% of respondents aged 18-29 and 67% of respondents aged 30-39 reported that they had been violent towards their child in the past 12 months, compared to 43% of respondents aged 50-59 and 27% of those aged 60 or over.

8. RQ4: Factors associated with women's experience of IPV

This section presents our findings related to factors associated with women's last-year IPV experience, in response to the study's fourth research question:

> **RQ4:** What are the most significant risk factors for GBV among SAFE beneficiaries?

One–thousand-and-six Toose beneficiaries reported that they had been in a relationship in the past 12 months. As such, the base sample for the remainder of this section is n=1001-1006 (to allow for a few respondents choosing not to answer the question), unless otherwise stated.

Respondents from cohort 2 were significantly more likely to be in a relationship than those from cohort 1, likely due to the change in SAFE Communities' recruitment strategy outlined in Section 1.1.1 above. Given that only women who reported that they'd been in relationships in the past 12 months were asked about their experiences of IPV, respondents from cohort two are more represented in our findings than respondents from cohort 1.

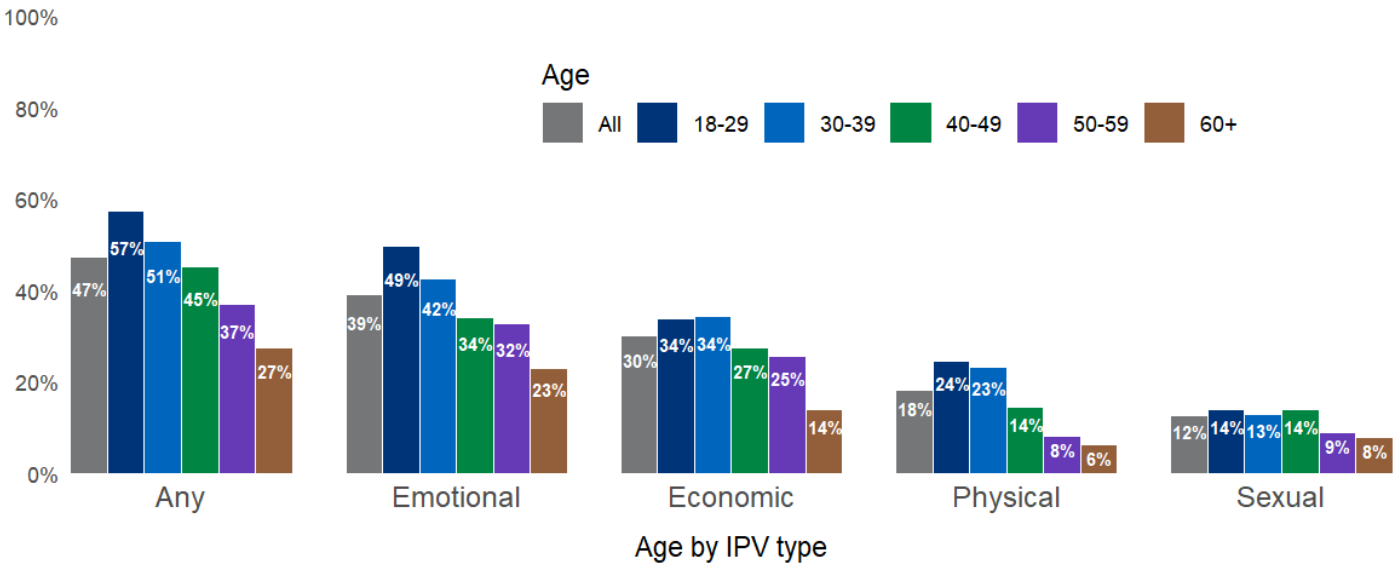
8.1. Women's individual characteristics

This section explores the association between IPV and women's individual characteristics, including age, disability status, level of education, religion, alcohol use, childhood experience of violence and attitudes related to the justification of IPV.

8.1.1. Age

Age is significantly associated with women's experience of IPV: IPV decreases incrementally as age decreases. For example, 57% of respondents aged 18-29 reported experiencing IPV in the past 12 months compared to 27% of respondents aged 60 or over. This trend is seen across all types of IPV, as shown in Figure 28, although the decline is not as steep for sexual IPV.

Figure 28: Association between age and experience of IPV

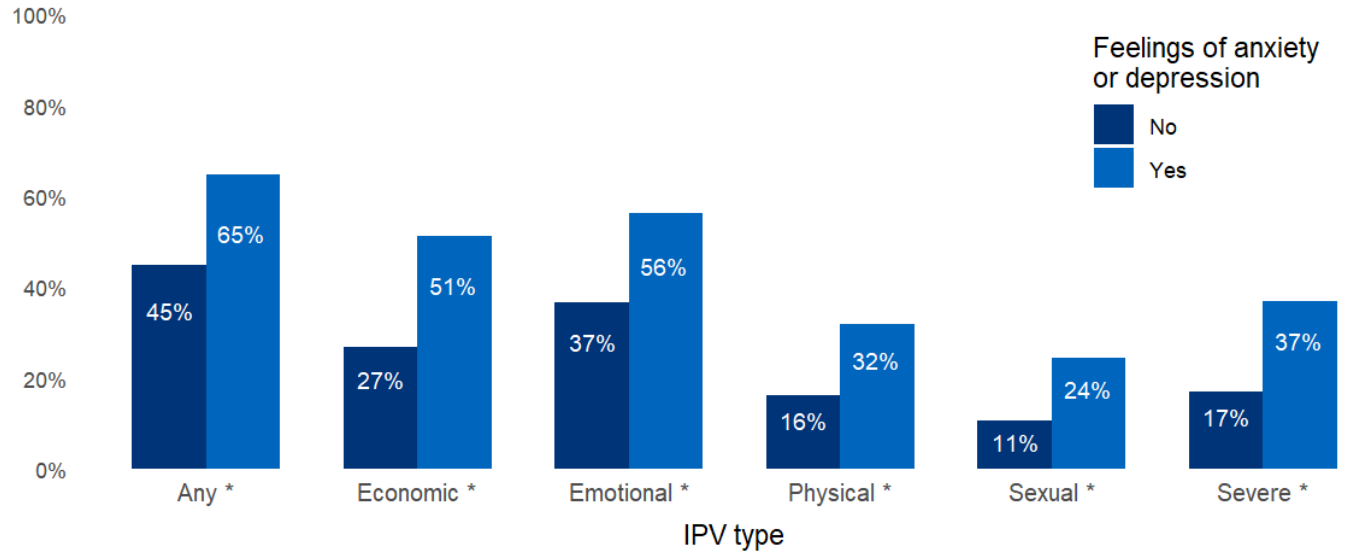


8.1.2. Disability status

Women who reported a disability according to the Washington Short Set (see Section 3.1, above for more information on disability prevalence) were equally likely to report any type or severity of IPV than respondents without a disability.

Women who reported daily feelings of anxiety or depression were, however, more likely to report experience of IPV (65%) than those without depression or anxiety (45%) (see Figure 29). This association is repeated across all types of IPV, including severe IPV.

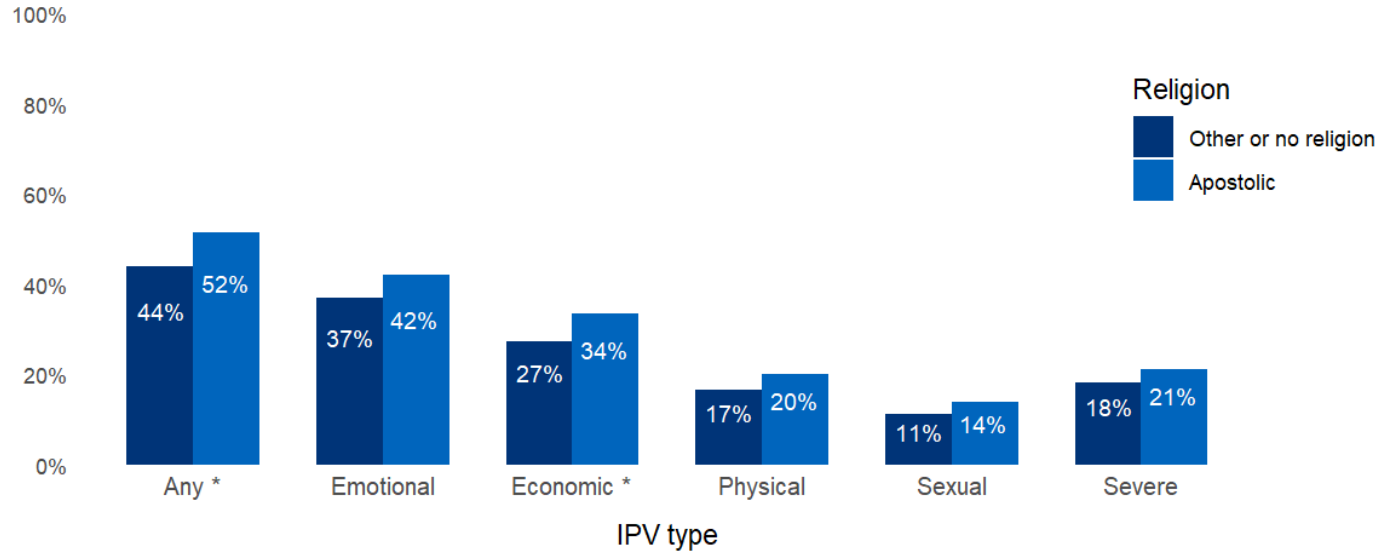
Figure 29: Association between daily feelings of anxiety or depression and experience of IPV



8.1.3. Religion

Respondents that were members of the apostolic church were significantly more likely to report at least one type of IPV in the past 12 months than those with other (or no) religious affiliation. However, when looking at the four types of IPV, this difference is only statistically significant for economic IPV, as shown in Figure 30.

Figure 30: Association between Apostolic religion and experience of IPV



8.1.4. Level of education

Neither overall school attendance nor highest level of school attended was significantly related to any type, or severity, of IPV experience.

8.1.5. Alcohol use

Respondents were asked about their use of alcohol and whether their drinking had been the topic of any 'quarrels' between them. Only four percent of respondents (n=42) reported having drunk alcohol in the past 12 months, and 10 respondents reported having drunk alcohol at least 2-3 times per week or more. Of those respondents who reported drinking alcohol in the past 12 months, 27% reported that they had quarrelled with their partner about their own drinking, and 17% said that these disagreements had taken place more than once. IPV prevalence positively correlated with arguments about respondents' drinking. However, this was not statistically significant, likely due to the very small sample size (n=42).

8.1.6. Childhood experience of violence

Respondents were asked about their experience of violence as a child growing up. Specifically, they were asked whether a parent or caregiver had smacked or beaten them as a child; and whether they recalled seeing or hearing their mother being beaten by their father or another cohabiting intimate partner, or by someone else in the household.

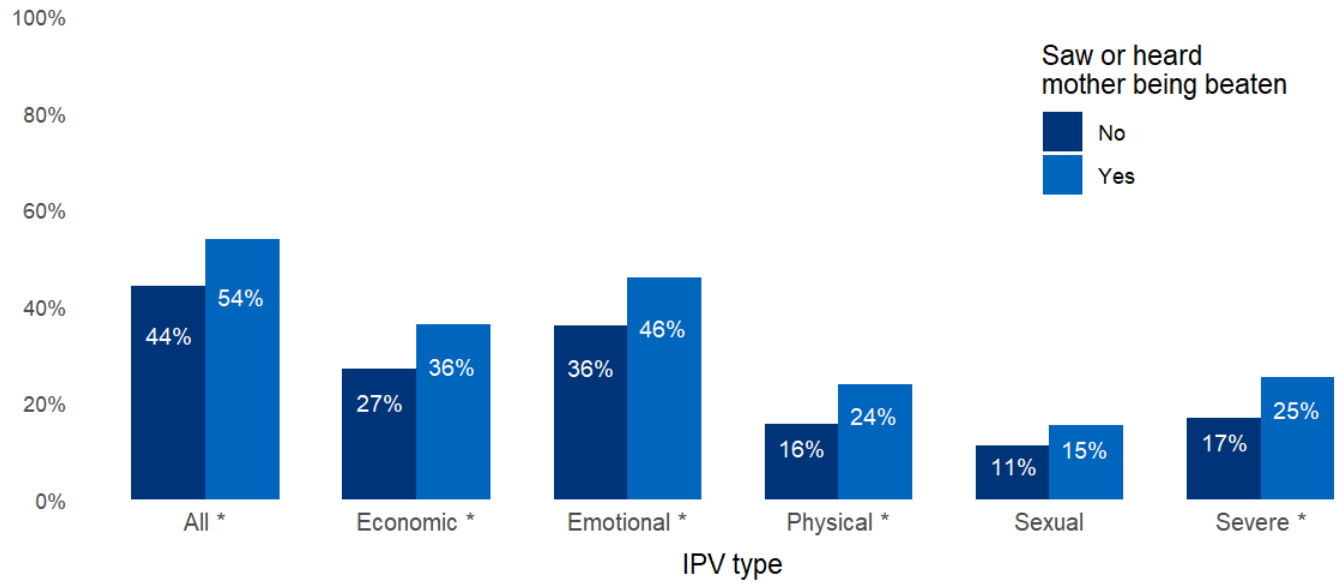
Seventy-four percent of respondents reported being smacked or beaten by a parent or caregiver growing up and 24% reported that this happened 'often'. This trend was consistent across all population subgroups, although there is some variation in the prevalence across districts, with respondents in Mwenezi (81%) being more likely to recall experiencing violence perpetrated against them as a child than respondents in Chiredzi (72%) or Chikomba (68%).

The experience of ever being smacked or beaten as a child was not statistically associated with IPV experience in the past 12 months for any type, or severity, of IPV. However, the risk of IPV experience in adulthood increases significantly as frequency of being smacked or beaten by a parent/caregiver during childhood increases, suggesting that repeated exposure to violence in childhood is significantly associated with IPV experience.

Thirty percent of respondents reported having ever seen or heard their mother being beaten by their father or another cohabiting intimate partner. This was also consistent across population sub-groups, with some variation across districts: 34% of respondents in Chiredzi, 29% in Chikomba and 27% in Mwenezi reported that as a child they had observed their mother being beaten by a partner. The only statistically significant exception to this trend was for 18-29 year old respondents, who were less likely to report this (17%) than the rest of the sample.

As shown in Figure 31, women who recalled having seen or heard their mothers being beaten were significantly more likely to report all types of IPV, except for sexual IPV.

Figure 31: Association between childhood observation of mother being beaten and experience of IPV



Four percent of women reported that they had seen or heard another family member perpetrating physical violence against their mother. This proportion was too small to be able to assess with confidence associations with IPV experience.

It is important to note that childhood experience of or exposure to violence is not just a risk factor for women's experience of IPV in adulthood but is also a risk factor for women's perpetration of physical violence against their children. The baseline data shows that prevalence of women's past year beating of a child increases significantly as the frequency of their own experience of childhood corporal punishment from a partner increases. For example, 44% of women who were never beaten as a child reported beating their own child in the past year compared with 61% of women who reported having been beaten as a child often.

8.1.7. Justification for IPV

Women who justified physical IPV in any of seven circumstances (see Section 5.3 for a description of the circumstances) were equally likely to report experiencing any type or severity of IPV as those who did not justify IPV. This finding held for all seven circumstances presented to respondents, with the exception of when a woman disobeys her partner. Women's justification of physical IPV when a woman disobeys her partner was significantly associated with any IPV experience and emotional IPV, although not with any of the other types of IPV or severe IPV.

8.2. Women's partners' individual characteristics

This section explores the association between IPV and women's partners' individual characteristics, including their alcohol use and their work away from home.

8.2.1. Partner's alcohol use

Respondents were asked about their partners' use of alcohol and whether or not their partner's drinking habits had been the topic of any 'quarrels' between them. Forty-three percent of 997 respondents reported that their partner had drunk during the past 12 months, and 26% reported that their partner drank frequently (at least 2-3 times per week or more). Of those who reported their partners' frequent drinking (n=423), 47% said that they had argued with their partner about his drinking over the past 12 months, and 19% said that they had done so 'many times'.

In contrast to women's drinking, both a male partner's frequent drinking and arguing about a male partner's drinking are associated with all types of IPV, including severe IPV, as shown in Figure 32 and Figure 33.

Figure 32: Association between partner's drinking and women's experience of IPV

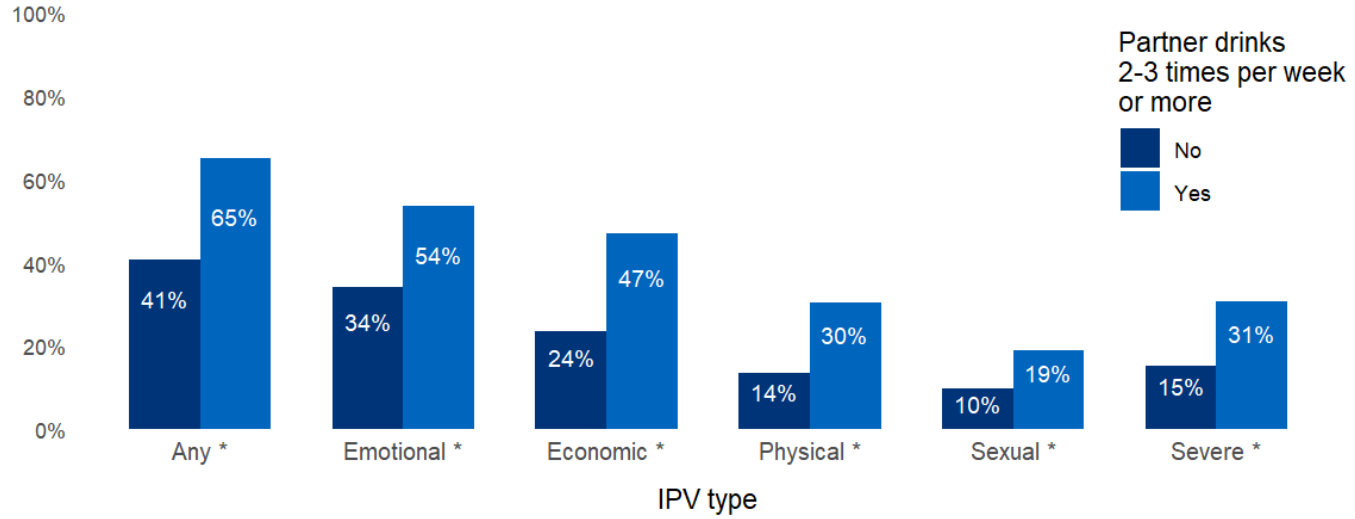
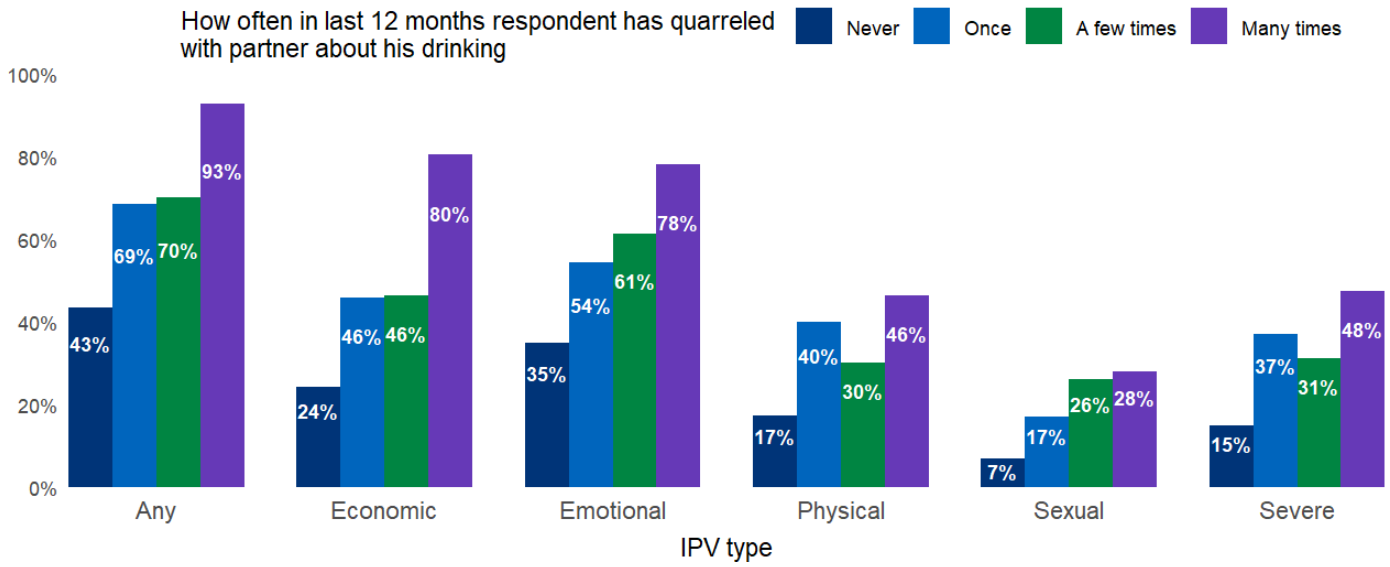


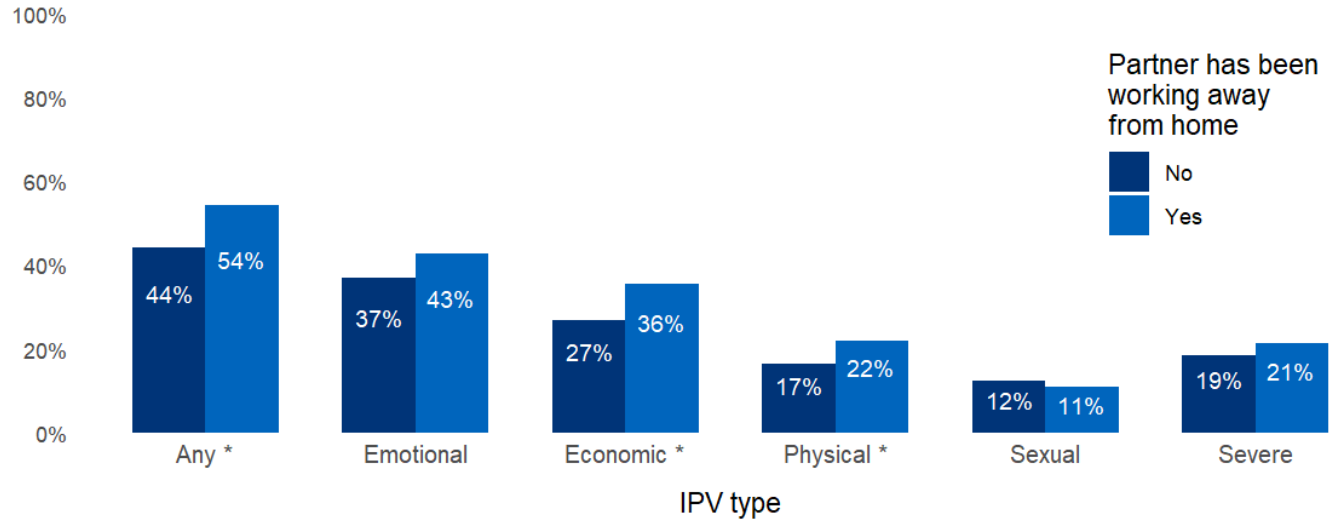
Figure 33: Association between conflict over partner's drinking and women's experience of IPV



8.2.2. Partner working away from home

As presented in Section 4.2.1, 25% of Toose beneficiaries who are in a relationship (n=969) reported that their partner worked away from home. These respondents were significantly more likely to report any IPV experience in the past 12 months than respondents whose partners do not work away. As shown in Figure 34 this significant association was found for physical and economic IPV although not for emotional, sexual or severe IPV. There was, however, no significant association between any type of IPV and the length of time women's partners spent working away from home in the past year.

Figure 34: Association between partner's work away from home and women's experience of IPV



8.3. Relationship characteristics

This section explores factors associated with IPV that relate to a person's relationship status, marital status, age at first marriage and lobola payment at first marriage.

8.3.1. Relationship status

Respondents were asked about their experience of IPV in the past 12 months if they reported having been in a relationship in the past 12 months, regardless of whether they were currently in a relationship or not. Respondents

who reported having been in a relationship in the past 12 months but who were currently single were significantly more likely than those currently in a relationship to have experienced any IPV (62% vs 47%), emotional IPV (56% vs 38%), economic IPV (54% vs 29%) or sexual IPV (24% vs 12%) in the past year. This may suggest that IPV experience led to a separation in the relationship, although this cannot be determined from the baseline data.

There were no significant differences between IPV experience between married and unmarried couples, with the exception of economic IPV, which unmarried respondents were significantly more likely to report than married couples (31% vs 28%).

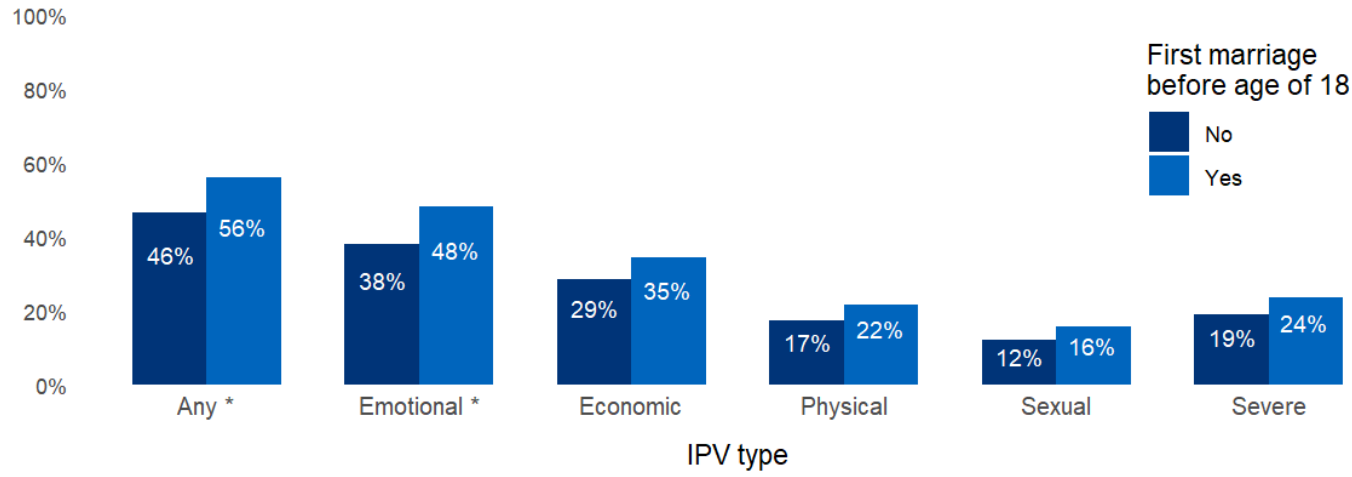
8.3.2. Polygamous marriages

Women in polygamous marriages were more likely to report experience of economic IPV (35%) than women in monogamous marriages (28%), and less likely to report experience of physical IPV (10%) than women in monogamous marriages (18%). However, these differences were not significant, likely because of the small sample size for women in polygamous marriages.

8.3.3. Age at first marriage

Respondents who reported that they had first gotten married before the age of eighteen were significantly more likely to report past year experience of IPV than respondents who first got married as an adult. This effect was seen for all types of IPV, including severe IPV, although this was only statistically significant for any type of IPV and emotional IPV, as shown in Figure 35.

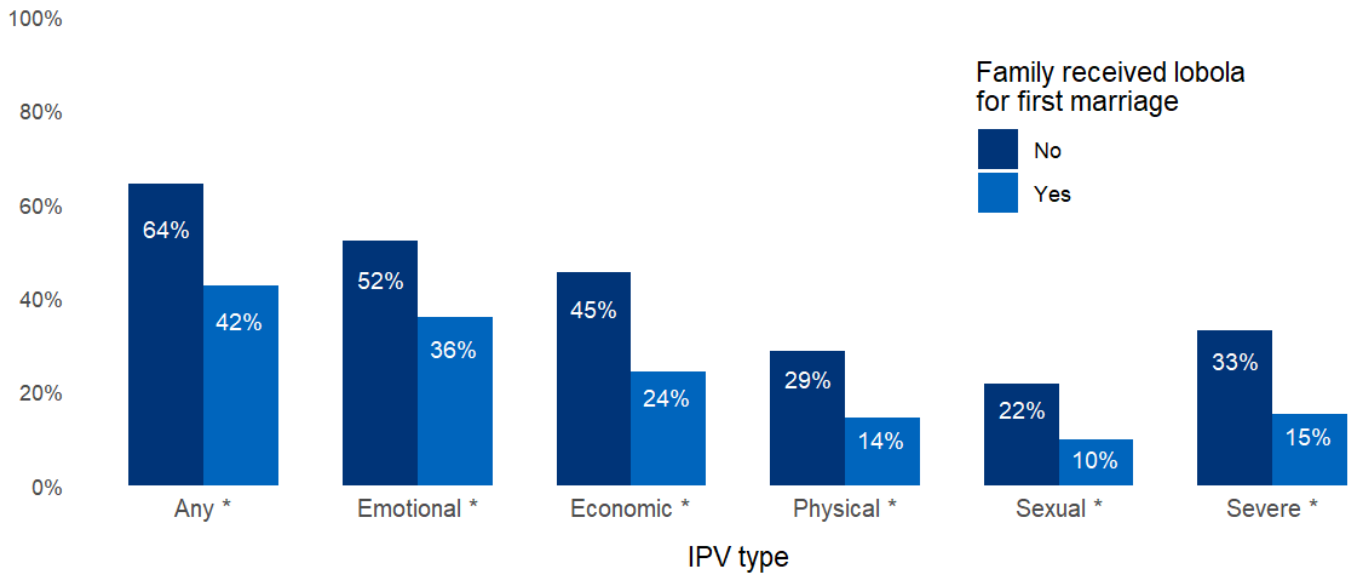
Figure 35: Association between age at first marriage and experience of IPV



8.3.4. Payment of lobola

As noted in Section 4.2.1, 73% of women who had ever been married reported that their husband had paid lobola for their first marriage. Women who reported lobola payment for their first marriage were significantly less likely to report any type of IPV in the past year. This was the case across all types of IPV, as shown in Figure 36.

Figure 36: Association between lobola payment at first marriage and experience of IPV



8.4. Relationship and family dynamics

This section explores the relational dynamics around women's intimate and family relationships, specifically dynamics around power and agency, such as how couples and families plan and create shared visions for wellbeing, make decisions and resolve conflict, and whether there is evidence of men's controlling behaviours in intimate relationships.

8.4.1. Financial decision making

Figure 37 outlines positive (+), negative (-) and not statistically significant (grey) associations between different types of IPV and a series of indicators related to women's financial position, decision making and agency. The findings suggest that multiple types of IPV are positively correlated with women earning more than their partner, and usually deciding about key financial issues, including deciding how to use their own earnings or their partner's earnings, and about major household purchases, spending household savings and taking out loans. Interestingly, while women making decisions is associated with higher prevalence of IPV, the data also shows that their input into decision making or their ability to make their own decisions if they wanted to are negatively associated with IPV.

Figure 37: Positive (+), negative (-) or no (grey) association between decision-making and types of IPV

Respondent…	Any IPV	Physical IPV	Sexual IPV	Emotional IPV	Economic IPV	Severe IPV
Earns more than their partner	+	+		+	+	
Usually decides how to use their own earnings	+	+		+	+	+
Can make their own decisions about using their earnings	-	-	-	-	-	-
Usually decides how to use their partner's earnings	+	+		+	+	+
Has input into decisions about using their partners' earnings	-	-	-	-	-	-
Usually decides about making major household purchases	+	+	+	+	+	+
Has input into decisions about major household purchases	-	-	-	-	-	-
Can make their own decisions about major household purchases	-	-	-	-	-	-
Usually decides about how to spend household savings		+			+	
Has input into decisions about how to spend household savings					-	
Can make their own decisions about how to spend household savings						
Usually decides about taking loans	+		+	+	+	+

Respondent…	Any IPV	Physical IPV	Sexual IPV	Emotional IPV	Economic IPV	Severe IPV
Has input into decisions about taking loans						
Can make their own decisions about taking loans	-					

8.4.2. Shared vision for quality of life and shared economic planning

Respondents that have a household shared vision for improving family quality of life were significantly less likely to report experiencing any type of IPV (45%) compared to those without a shared vision (51%), and this pattern was also found for all specific forms of IPV except for emotional IPV.

Respondents who experienced IPV reported that their households made economic plans less often than respondents who did not report past year experience of IPV. This trend was seen for all types of IPV apart from physical IPV. Husband/partner and children's involvement in the household economic plan were both negatively correlated with IPV experience. In contrast, respondent's parents' involvement in household economic planning was positively correlated with IPV experience.

8.4.3. Managing conflict in relationships

Respondents who reported IPV were significantly less likely to report that they felt valued by their partner or believe that their partner felt valued by them.

As discussed in Section 5.7.2, respondents were asked about how they responded to each other during times of conflict. Table 2 shows that each statement was associated with some form of IPV, and seven out of eleven statements were significantly associated with all types of IPV, including severe IPV.

Table 2: Relationship conflict management strategies and their association with IPV

Statement	Type of IPV significantly associated
I showed my partner I care even though we disagreed	None
My partner showed care for me even though we disagreed	Every type
I explained my side of a disagreement to my partner	Severe
My partner explained his side of a disagreement to me	All except for sexual
I showed respect for my partner's feelings about an issue	Emotional and economic
My partner showed respect for my feelings about an issue	Every type
I said I was sure we could work out a problem	Every type
My partner said he was sure we could work out a problem	Every type
I suggested a compromise to a disagreement	Every type except for physical
My partner suggested a compromise to a disagreement	Every type
I agreed to try a solution to a disagreement my partner suggested	Every type
My partner agreed to try a solution I suggested	Every type

This trend was also observed when respondents were asked to reflect on their last three arguments with their partner. Respondents were asked whether they had taken any of thirteen possible courses of action during a disagreement that ranged in severity from discussing the agreement to being physically violent. Respondents who reported that they and their partner had taken positive and healthy actions such as trying to discuss the disagreement, expressing feelings or suggesting possible solutions, were all significantly less likely to report experience of IPV than those who didn't choose these options. Respondents who chose negative or unhealthy options such as blaming and criticising each other, swearing or calling names, insisting that disagreements had to be solved in one or other parties' way, or being physically violent, were consistently more likely to report IPV experience than those that did not.

8.4.4. Family quality of life

The family quality of life (FQOL) scale (described in Section 5.7.1) was also used to assess how the dynamics of the broader household are associated with women's experience of IPV.

On all of the four quality of life domains – parenting, emotional, family interaction and physical/material wellbeing – scores were significantly associated with all types of IPV, including severe IPV, such that higher quality of family life is significantly associated with lower IPV prevalence.

8.4.5. Controlling behaviour

Controlling behaviours by a partner were significantly associated with all types of IPV, including severe IPV. Sixty-seven percent of respondents who reported experiencing controlling behaviours from a partner (see Section 7.1 for details) reported experiencing any IPV in the past 12 months, compared to 23% of respondents who did not report controlling behaviours. This was observed across all types of IPV, including severe IPV.

8.5. Economic factors

The section looks at the extent to which indicators of economic insecurity such as household food insecurity and difficulty meeting basic needs, and women's participation in transactional sex or sex work are associated with women's experience of IPV.

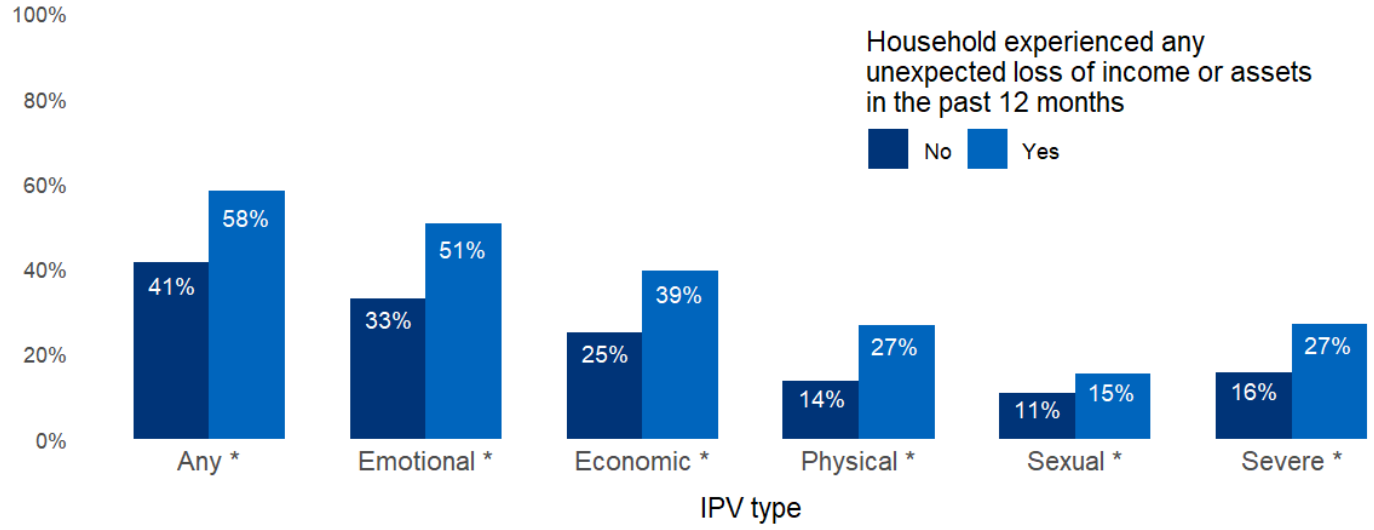
8.5.1. Food insecurity

Levels of food insecurity among Toose beneficiaries were low overall, with a mean score of 4.2 on the household food insecurity scale (range 3-12) with lower scores indicating lower food insecurity. Respondents' past year experience of IPV is significantly associated with higher levels of food insecurity and this is true for all types of IPV, including severe IPV.

8.5.2. Financial security

Household ability to meet basic needs was not significantly associated with women's experience of any type, or severity, of IPV. However, the data indicates that household experienced of economic shock in the past year was associated with women's IPV experience and severity. As shown in Section 8.5.2, 58% of Toose beneficiaries who reported a sudden loss of income or assets in the past year reported experiencing any IPV, compared to 41% of respondents who did not report a loss of income or assets. This trend was statistically significant and seen across all types of IPV, including severe IPV.

Figure 38: Association between household economic shock and experience of IPV



8.5.3. History of transactional sex and sex work

Respondents were asked about their participation in transactional sex – defined as *"sex with a non-primary partner because he provided, or you expected that he would provide you with, food, cosmetics, clothes, transport, cash or*

other things that you needed" - and sex work – defined as *"engaging in sex with people with whom you share little to no emotional intimacy, in exchange of money or things of value".*

A small proportion of Toose beneficiaries in all three districts reported having participated in transactional sex and sex work, with 2% of respondents reporting that they had participated in transactional sex and 4% of respondents reporting that they had engaged in sex work. Participation in both transactional sex and sex work were highest in Chiredzi (3% and 5% respectively). Participation in transactional sex was most commonly reported by women in polygamous marriages, with 5% of respondents in this sub-group participating in transactional sex in the past 12 months. Single women and women aged 40-49 were most likely to have engaged in sex work in the past 12 months with 6% and 7% respectively having done so.

Participation in transactional sex was not significantly related to prevalence of any type, or severity, of IPV; and participation in sex work was only found to be significantly associated with emotional IPV. However, in both groups IPV prevalence was consistently, while not significantly, higher overall, as shown in Figure 39 and Figure 40.

Figure 39: Association between participation in transactional sex and experience of IPV

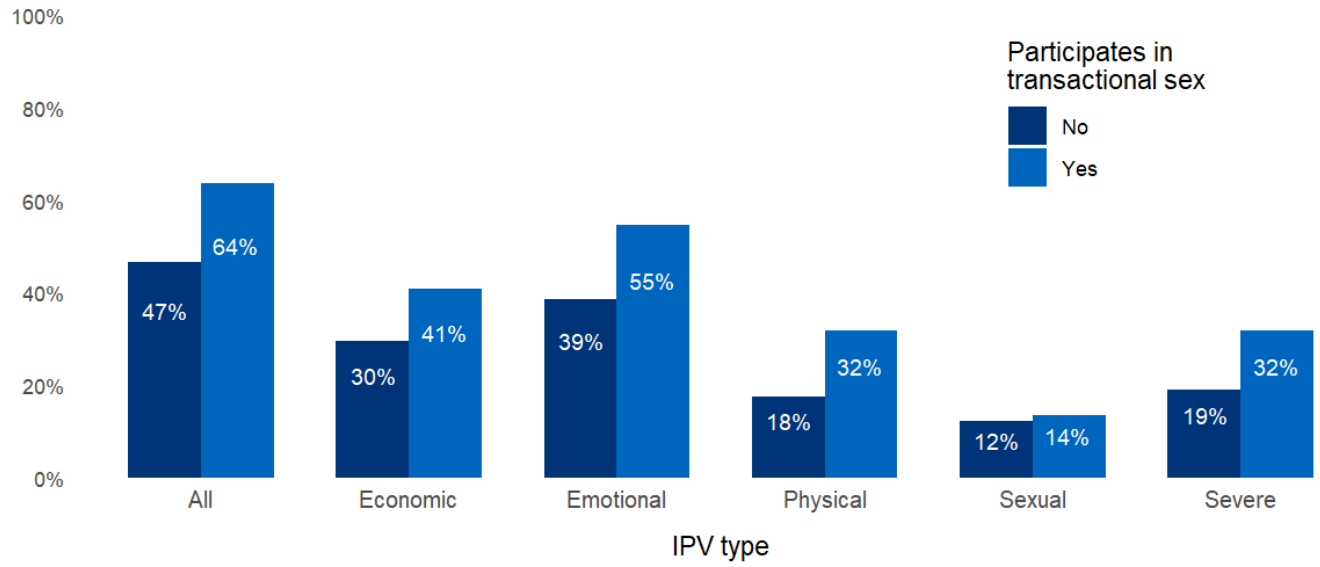
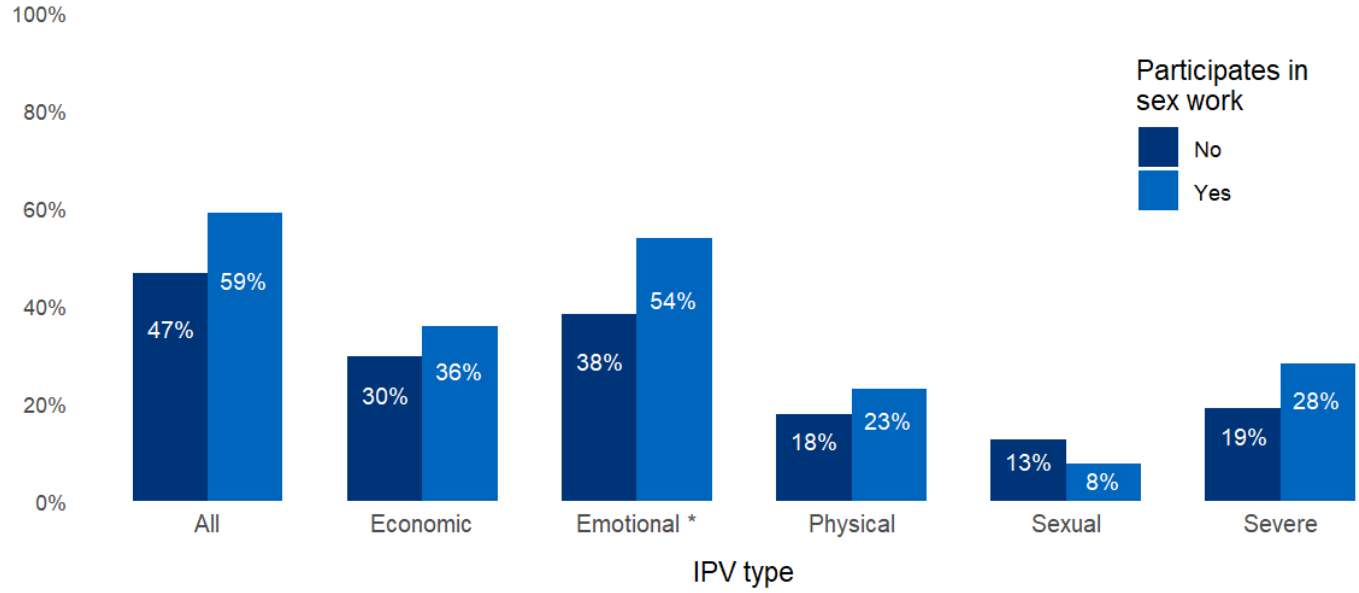


Figure 40: Association between participation in sex work and experience of IPV



9. RQ5: GBV prevention programmes in SAFE implementation districts

This section responds to our findings related to GBV prevention and response activities, and to the first part of the study's fifth research question:

> **RQ 5:** What existing activities related **to GBV prevention and response**, or the economic drivers of GBV are there in SAFE districts and wards? To what extent are Toose activities coordinated with these?

9.1. GBV interventions reported by key informants

Key informants from SAFE intervention wards and communities reported that men and women seek help from both formal and informal groups for support with relationship issues. Formally, men and women seek help from Musasa, SAFE (Com KII 1, Com KII 3), Legal Resources Foundation and MWACSMED (Com KII 3) and Police (Com4) for support, especially in cases of violence. Informally, people go to elders in the community, including women who lead informal women and girls' groups (Com KII 3).

Key informants reported that most of these formal and informal groups emphasise the participation of women, though they may accept male members, and focus on issues such as misunderstanding, conflict and communication breakdowns.

Respondents in Chiredzi also mentioned GBV Community-based Clubs, trained by the SAFE programme and described these groups as helping to solve issues such as GBV and problems with communication and conflict, raise awareness about GBV, increase prosecution of perpetrators and victim protection in GBV cases, and support counselling and training (Com KII 1, Com KII 3).

It is interesting to note here that the services that were consistently mentioned by ward- and community-level key informants were all GBV response activities. This highlights the potential gap in GBV prevention services across SAFE Communities' three implementation districts.

9.2. Toose beneficiaries' awareness of GBV interventions

Respondents' knowledge of at least one type of GBV service in the community was high, with only 13% overall stating that they knew of no GBV services, with a higher proportion having no knowledge in Mwenezi (19%). A significantly higher proportion of women in polygamous marriages (21%) than women in monogamous marriages (13%) did not know of any GBV services, and lack of knowledge of services was least frequent among women aged 50-59 (6%).

Almost three quarters of respondents (72%) had knowledge about the police; however, knowledge was lower for other types of GBV services, including counselling (31%), shelters (25%), medical (15%), traditional/religious (15%), educational (11%) and legal counselling (9%) services.

Knowledge of GBV services was consistently lower in Mwenezi and higher in Chikomba for most types of services. Forty-eight percent of respondents in Chikomba reported knowing about GBV shelters in their community, almost four times as many as those in the other two districts.

Respondents were also asked about different programmes or advocacy campaigns that they were aware of in their district relating both to GBV prevention and economic empowerment.

As noted in the introduction, in January 2021 SAFE Campaigns, the third component of the SAFE programme, funded by SIDA, was formally decoupled from the SAFE programme and branded '*Love Shouldn't Hurt*'. This advocacy programme includes a national-level campaign implemented by Population Services International (PSI) and Population Solutions for Health (PSH), with additional localised community-level advocacy and engagement.

Toose beneficiaries were asked whether, in the past 12 months, they had seen or heard the slogan '*Love Shouldn't Hurt*'. Thirty-seven percent of respondents said they had seen or heard the slogan, with 56% of respondents in Chikomba reporting exposure to the slogan compared to 35% in Chiredzi and 20% in Mwenezi. When asked where respondents had seen or heard the slogan, 60% said they had been exposed through community dialogues and this

figure was as large as 77% among women in Chikomba and lower for women in Mwenezi (51%) and Chiredzi (39%). Other modalities of exposure included radio, which was most common in Mwenezi, TV or digital/social media, which were more common in Chiredzi, and outdoor modalities such as billboards, posters or flyers.

Forty-seven percent of respondents also reported that they have seen people in their community doing something to prevent violence against women in the past 12 months. Respondents from Chikomba were most likely to report having seen GBV prevention activities (58%) compared with respondents in Mwenezi (46%) and Chiredzi (37%). Respondents in Chikomba were also much more likely to report having participated in any activity about safe and healthy relationships or training on violence against women and girls in the past 12 months. The greater knowledge of and participation in prevention activities in Chikomba may be related to exposure to GBV prevention campaigns.

9.3. Toose beneficiaries' access and use of GBV services

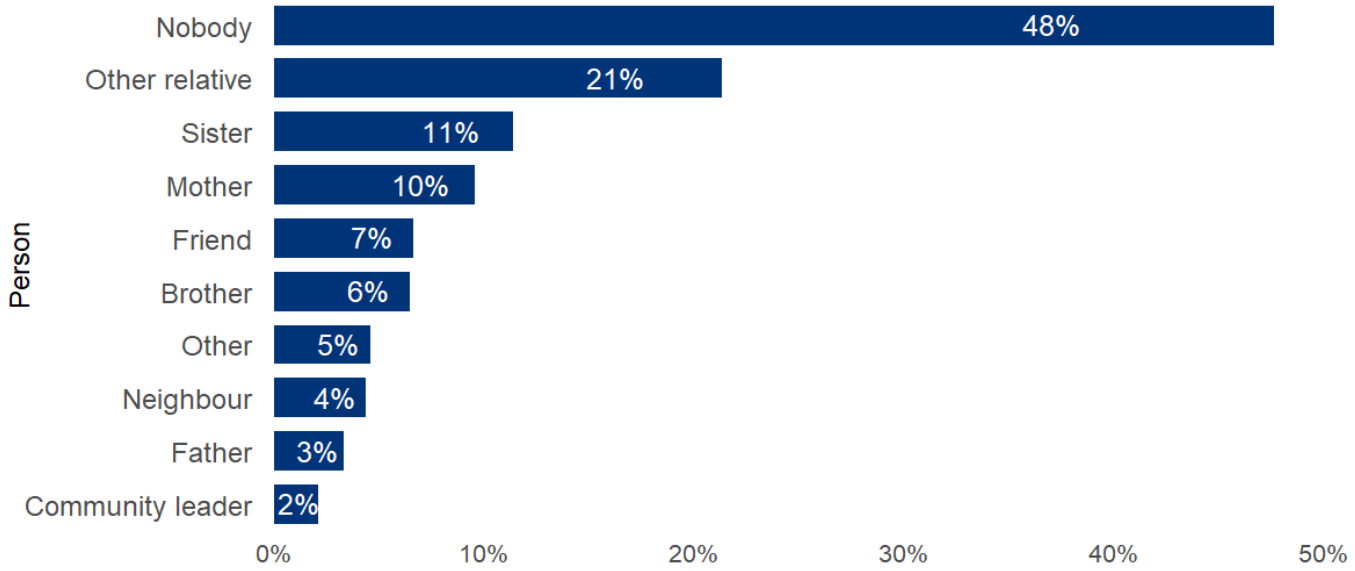
Respondents were asked about whether they themselves would seek help from family and friends, or from services if they experienced violence. Respondents who reported any type of IPV or non-partner sexual or physical violence were also asked whether they had sought help and if so from whom or which services, and their reasons for, and for not, doing so.

Ninety-one percent of respondents felt they were 'very' or 'somewhat' likely to seek help or support from family or friends if they experienced violence. Respondents from Mwenezi were the most likely to report that they were 'very' or 'somewhat' likely to seek help or support from family or friends if they experienced violence, with 95% of respondents stating so, compared to 89% in Chiredzi and 88% in Chikomba. This range was consistent across all age groups and sub-groups.

A similar trend was seen with regards to seeking help from services: 93% of respondents reported that they were 'very' or 'somewhat' likely to seek help from GBV services if they experienced violence and this was observed across all three districts and all sub-groups.

Despite the majority of respondents suggesting that they would be likely to seek help if they experienced violence, a much lower proportion of women who had experienced violence in the past 12 months actually did seek help. Forty-eight percent of survivors reported telling no one about the violence, a trend that was consistent across all districts and sub-groups. When respondents did tell someone about the abuse, this was most likely to be among relatives outside their immediate family (21%) or close female family members including their mother (10%) or sister (11%) (see Figure 41). No respondents reported telling their partner, teacher or employer.

Figure 41: Family members and community members that beneficiaries were most likely to tell about IPV



There were a few notable differences between district and subgroups. Namely, respondents in Chiredzi were significantly more likely to talk to their friends or neighbours than women in Chikomba or Mwenezi, which may suggest that drawing on social networks outside of families is more common in urban than rural areas. Women who

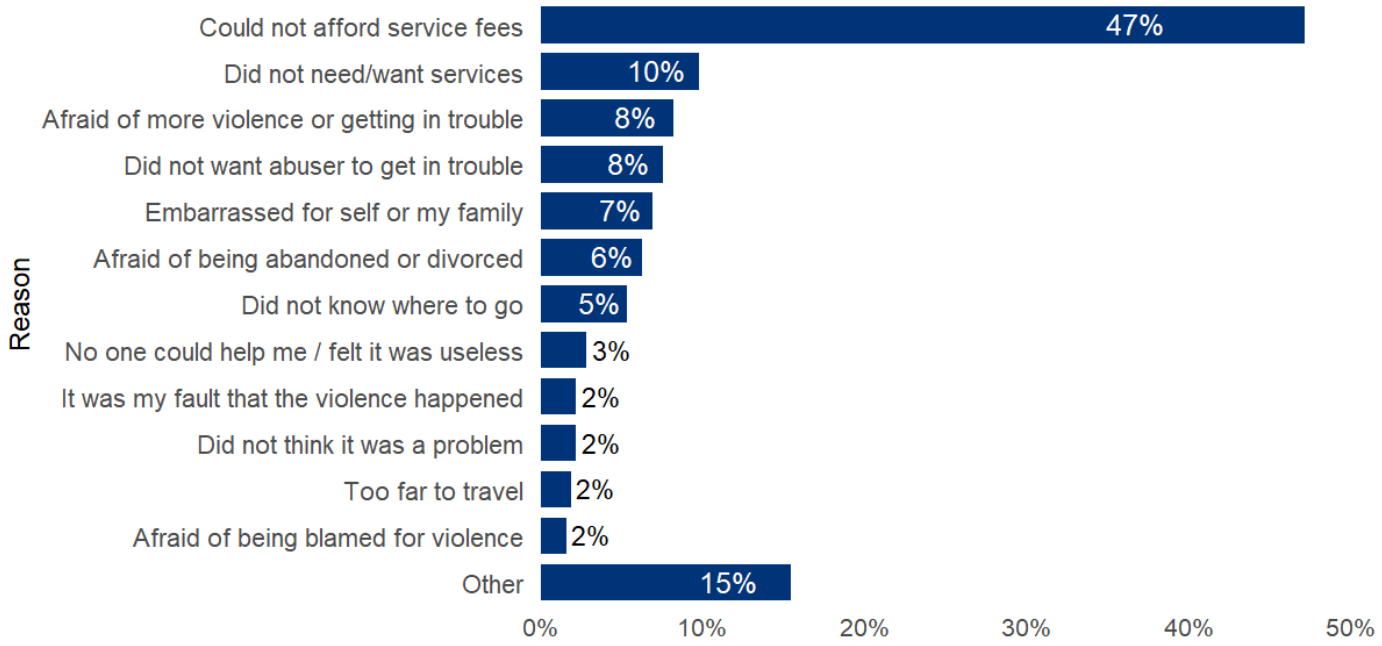
reported having a disability were also more likely to talk to their friends with 14% doing so compared to 6% of women without disabilities.

Twenty-eight percent of respondents who experienced violence in the past 12 months (n=447) went to some kind of GBV service for help. Women in Mwenezi were least likely to access services (16%) compared with respondents in Chiredzi (31%) and Chikomba (46%). Survivors who were not currently in a couple were significantly more likely to have accessed GBV services in the past 12 months (52%) than those currently in a couple (27%). There were no other significant variations across other population sub-groups.

Women who experienced IPV were slightly more likely to access services when the IPV was physical or severe than emotional or economic, particularly police services. Nevertheless, large proportions of women who experienced physical IPV (61%) or severe IPV (65%) still accessed no services. It is interesting to note that the majority of women who did access formal services in the past 12 months had experienced severe IPV.

Respondents that had reported IPV experience but did not seek help (n=318) were asked about why they hadn't done so. Figure 42 shows the different reasons offered and the proportion of respondents that chose each one.

Figure 42: Reasons GBV survivors did not access services

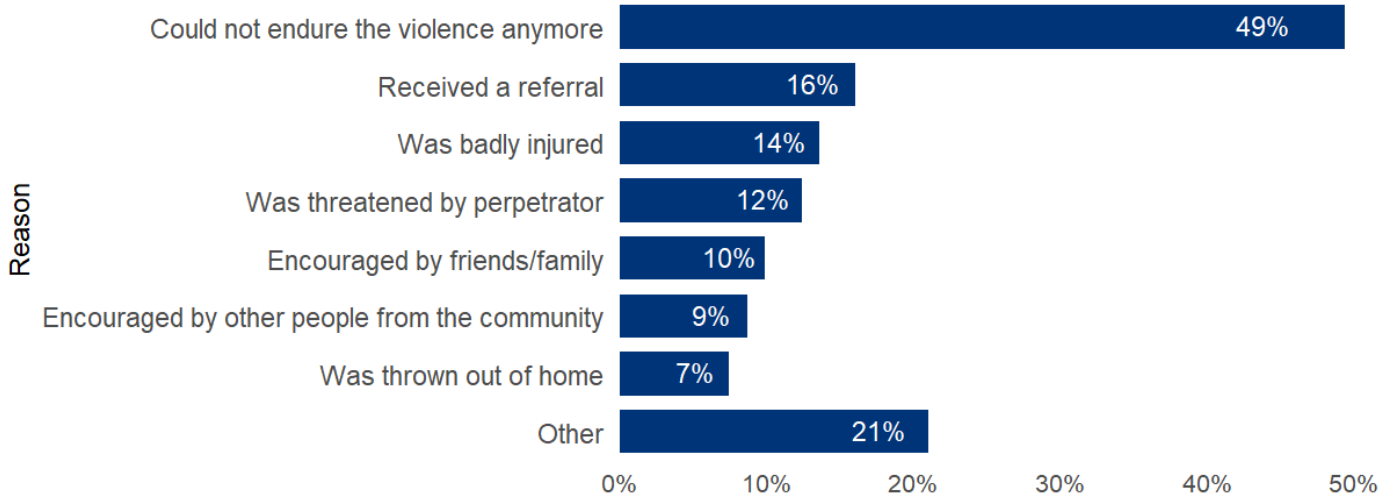


Key variations between districts or population subgroups related to the reason that GBV survivors did not seek help included the following:

- Affordability was a more common barrier to accessing services in Chiredzi and Chikomba where 51% and 52% of respondents respectively cited this reason compared to 38% in Mwenezi
- Respondents that were members of the Apostolic church were significantly more likely to say they were afraid of more violence than non-Apostolic women (13% compared to 5%)
- Respondents that were currently single were significantly more likely to report that they didn't want their abuser to get into trouble, with 23% offering this as a reason, compared to 7% of women who were currently in a relationship. These feelings were most prevalent in Chikomba, with 6% of respondents reporting this compared to 3% in Chiredzi and 0% in Mwenezi. Respondents that reported disabilities were also more likely to report not wanting the abuser to get into trouble (12%) compared with respondents with no disability (2%). Women aged 60 or over were the most likely age category to report fears of abusers getting in trouble (14%).
- Respondents in Chikomba were more likely to report that they feared being blamed for violence (4%) compared to those in Chiredzi (1%) or Mwenezi (0%).
- However, respondents in Mwenezi were most likely to report that they felt that they were to blame for the violence happening, with 5% of those asked saying so compared to 1% each in Chiredzi and Chikomba.

Lastly, respondents were asked about the reasons that they had sought help from GBV services. These are summarised in Figure 43.

Figure 43: Reasons GBV survivors sought help



As shown in Figure 43, the most common reason for help-seeking among beneficiaries was being unable to endure the violence anymore. However, these responses were not consistent across districts, with 81% of respondents in Chikomba reporting this as a reason compared to 31% in both Chiredzi and Mwenezi. Of respondents that offered this reason, 70% reported experiencing severe IPV or physical IPV; 92% emotional IPV, 89% economic IPV and 46% sexual IPV. Women who were not in a couple (64%), in monogamous marriages (49%), and who did not report a disability (54%) more often reported this reason than women in polygamous marriages (29%), women who were currently in a relationship (47%) or women who did have a disability (27%) although none of these differences are statistically significant due to the very small sample size of respondents (n=81)

Across other reasons offered for accessing GBV services there were some differences between sub-groups, although none of these are statistically significant, most likely due to the very small sample size of respondents that answered this question:

- Receiving a referral was more common in Chiredzi (27%) and Mwenezi (23%); whilst no respondents in Chikomba reported having been referred to a GBV service. All referrals were reported by women under the age of 50. There were also no referrals reported by women who were in polygamous marriages.
- Women who were not a member of the apostolic church reported higher levels of referrals (21%) than those who did belong to the church (9%).
- Women in Chiredzi were most likely to be encouraged by their friends to access services (16% compared to 3% in Chikomba and 8% in Mwenezi) as were women who reported a disability (18%) and women aged 50 or over (25%). No women from polygamous marriages reported being encouraged to access services by their family or friends.
- Respondents who reported accessing services because they had been threatened by a partner were all under the age of 40, and no women with a disability reported accessing services for this reason.
- Respondents who reported seeking help because they were badly injured had all experienced severe IPV, and 26% of 40-49 year olds sought help for this reason – the greatest proportion from across any age category.
- Respondents in Chikomba were most likely to report that they had sought help from GBV services because they had been thrown out of home (16% compared to 8% in Mwenezi and 0% in Chiredzi). Women aged 50-59 were the most likely age category to report this, with 25% of respondents doing so. Women who were not currently in a relationship were also more likely to do so (22%) than women who were currently partnered (6%).
    - Encouraging help seeking and offering help to others

Respondents were asked a set of questions about how confident they felt about supporting a woman or girl who had experienced violence. Reported confidence in supporting a GBV survivor was high in all three districts: 91% of respondents in Chiredzi and Mwenezi and 95% of respondents in Chikomba reporting that they felt either ‘very’ or ‘somewhat’ confident in supporting a GBV survivor. Respondents in Chikomba were most confident, with 74% reporting that they were very confident, compared to 57% in the other two districts. The only sub-group variation in feelings of confidence supporting women and girls who experience violence was among women in polygamous marriages who were less likely (88%) to express confidence than women in monogamous marriages (94%).

Respondents were also asked to rate how likely they were to encourage a woman or girl to seek GBV support. The vast majority of respondents (95%) said that they were either 'very' or 'somewhat' likely to encourage a woman or a girl to seek GBV support, and this was consistent across all three districts and population subgroups. The only statistically significant difference was between respondents with and without a disability, with 91% and 96% of respondents respectively reporting likelihood of encouraging support.

While reported confidence in supporting survivors and likelihood of encouraging survivors to access services is high across the sample, fewer respondents (46%) said that they had offered any help to a woman or girl who had experienced violence in the past 12 months. This rate was consistent across districts and between subgroups, with a few exceptions related to age; for example, younger women (aged 18-29) were the least likely to have offered help to a survivor (39%).

Of those women who had provided support to a survivor in the past 12 months, the most common type of support was comforting her (60%) and encouraging her to access services (42%), with fewer respondents reporting having spoken with the perpetrator or his family (17%) or accompanying her to a service (11%).

9.4. Barriers accessing GBV services

All respondents were asked about any challenges they felt they would face in accessing services if they experienced violence. Fifteen percent of women said that they would not face any challenges. Table 3 shows other commonly cited responses along with district and sub-group variations. Lack of knowledge of services is the most common reason. Other reasons are mainly associated with negative consequences, such as more violence, getting in trouble, break-up of the relationship and fear of abandonment/divorce, or accessibility challenges, such as unaffordability of transport, distance to travel or unaffordability of service fees. Twelve percent of women also suggested that poor quality of services was a barrier.

Table 3: Challenges Toose beneficiaries reported in accessing GBV services

Challenge / barrier	%respondents that reported (n=1245)	Notable variation between district or sub-group
Wouldn't know where to go	24%	Women with disabilities are significantly more likely to know where to go (25%) than those without (18%).
Would be afraid of more violence or getting into trouble	18%	More common in Mwenezi (22%) than Chiredzi (17%) or Chikomba (16%).
Would break my relationship	15%	Women aged 50 and over less likely to report this than younger women
Would not be able to afford transport	12%	Mainly in Chikomba, where 27% of people reported unaffordable transport compared to 4% in Chiredzi and 6% in Mwenezi.
Poor quality of services	12%	Predominantly from respondents in Chiredzi (24%) compared to 7% in Chikomba and 3% in Mwenezi.
Would be afraid of being abandoned or divorced	11%	Women who did not report a disability were significantly more likely to cite this reason (12%) than those with a disability (6%).
Would be worried about the future of my children	10%	Most commonly reported in Chikomba (14%) and least in Mwenezi (6%).
Too far to travel	9%	Most common in Chikomba (15%) with fewer citing this reason in Mwenezi (9%) and Chiredzi (2%).
Would be afraid of being blamed for violence	9%	Most common in Chiredzi (12%), followed by Chikomba (8%) and Mwenezi (7%). Women who are not currently in a couple reported this significantly more often (14%) than those in a relationship (8%)

Challenge / barrier	%respondents that reported (n=1245)	Notable variation between district or sub-group
Would be embarrassed for self or family	6%	Least common in Chikomba (4%) compared to Chiredzi (7%) or Mwenezi (8%)
Would not want to get abuser into trouble	5%	Most common in Mwenezi (7%) then Chiredzi (5%) and Chikomba (2%) Women in polygamous marriages more likely to report this (9%) than women in monogamous marriages (3%)
Would not be able to afford service fees	3%	Consistent across all sub-groups
Would be worried about losing income	2%	Consistent across all sub-groups

10. RQ5: Economic interventions in SAFE implementation districts

This section presents our findings related to existing activities related to the economic drivers of GBV and responds to the second part of the study's fifth research question:

> **RQ 5:** What existing activities related to GBV prevention and response, **or the economic drivers of GBV** are there in SAFE districts and wards? To what extent are Toose activities coordinated with these?

10.1. Key economic empowerment and GBV interventions

This section reports ward and community-level key informants' feedback on the types of economic empowerment interventions and GBV services that are available in their local areas, and that members of their community access.

Respondents were also asked about the particular target population groups that these programmes target. Ward- and community-level respondents consistently reported the following vulnerable groups as being primary target groups, demonstrating consistency between intervention areas and the need for strong coordination efforts:

- People with disabilities (Ward KII4, Ward KII 5, Ward KII 8, Ward KII 9, Com KII 2);
- Child-headed families (Ward KII 4, Ward KII 5, Ward 9);
- Female-headed households (Com KII 2, Ward KII 5, Ward KII 7, Ward KII 8, Ward KII 11;
- Polygamous families (War KII 5, Ward KII 7, Com KII 2); and
- Orphans and vulnerable children (Ward KII 5, Ward KII 7).

ISALs and VSLAs were reported to be the primary type of economic intervention reported by ward- and community-level key informants in all three districts as playing an important role in helping their community members with support for food and money as well as savings (Ward KII 1, Ward KII 2, Ward KII 3, Ward KII 4, Ward KII 5, Ward KII 7, Ward KII 8, Ward KII 9, Com KII 1). The SAFE Communities programme was specifically mentioned by several respondents, with one mentioning that SAFE helps people in their community to access money and funding to "*start businesses, pay fees and address other basic needs"* (Com KII 1).

Other interventions mentioned by Ward-level officials were:

- Food distribution in all three districts (Ward KII 5, Ward KII 9, Ward KII 11);
- Cash transfers were mentioned by key informants in Chiredzi and Mwenezi (Ward KII 3, Ward KII 8, Ward 11);
- Financial assistance for school fees in Chikomba and Mwenezi (Ward KII 4 and Ward KII 5); and
- Financial grants, loans and start-up funds for microbusinesses from MWACSMED in all three districts (Ward KII 3, Ward KII 9, Com KII 2).

Community-level key informants reported that, in addition to the services mentioned above, members of their communities seek financial assistance from community leaders such as *Sabhuku (*a sheriff*),* councillors, village heads or headmen (Com KII 4, Com KII 1), who likely refer these individuals to non-governmental organisations such as Plan International, Musasa and the SAFE programme (Com KII 2) for support with food and money dependent on their situation and need. They also referenced support from smaller local groups such as Muka Ushande, Lucky Stars and Fushai (Com KII 3 and Com KII 4).

Respondents also explicitly linked financial support offered by these programmes to a reduction in GBV, specifically child marriage, by asserting that school dropouts are reduced because parents can afford school fees, with this in turn reducing the rate of child marriage (Com KII 3).

10.2. Toose beneficiaries' awareness of and participation in economic interventions

Respondents were also asked about their participation in an ISAL or VSLA, with 99% reporting their current membership in a savings and loans group. This was expected given that survey respondents were sampled from ISAL groups. The majority (86%) reported that they had been members for less than six months, whilst 11% had been involved in an ISAL or VSLA for six months to one year, most commonly respondents from Mwenezi (17%). This may indicate that respondents have been exposed to other economic programmes in the area, or that some ISAL groups supported by SAFE are continuing from older groups.

Thirteen percent of respondents reported that they had access to loans before joining the savings and loans group. This was consistent across districts, age categories and other population sub-groups. Thirty percent of respondents reported that they have taken a loan from the group of which they are currently a member with respondents from Mwenezi being most likely to have taken a loan (37%) followed by those in Chikomba (31%) and Chiredzi (23%). Respondents that reported taking loans from their current ISAL or VSLA (n=379) usually responded that they had taken 1 or two loans, though some respondents had taken up to 10 loans.

In the past 12 months almost all households in Chiredzi reported receiving a CBT (98%) whilst almost none from Chikomba (1%) or Mwenezi (5%) did, which is line with SAFE's partnership with WFP through the ZHARP programme in Chiredzi, implemented by Plan International.

10.3. Implementation challenges for GBV interventions

Almost all respondents noted that support for GBV services had reduced during the Covid-19 pandemic due to restrictions on movements and financial constraints. Two respondents in Chikomba and Mwenezi suggested that whilst GBV efforts reduced initially, they later increased due to more involvement from local leadership and cited active Victim-Friendly Units in police stations and 'victim-friendly' court sessions as examples of this (Ward KII 2, Ward KII 9). One respondent in Chiredzi also lauded Plan International's efforts to maintain advocacy during the pandemic through its radio programmes (Ward KII 5).

Key informants also cited challenges in the volume of support offered by GBV programmes, highlighting that lack of resources means that many communities do not receive the support that they need: *"We have 30 wards in this district and the programme is only assisting 5 wards. I think if they can assist all the other wards that are left it will be great, and we will have GBV free district" (Ward KII 4).* Lack of resources was especially highlighted in terms of the logistical challenges and high fuel costs associated with travelling to remote areas, with respondents requesting that organisations improve mobility in districts and increase the availability of resources (Ward 9, Ward 8, Ward 3). Lastly, one respondent in Chikomba also highlighted the importance of continued and increased financial support to ensure sustainability of economic empowerment and GBV outcomes: *"More financial support is needed to make sure the empowerment projects are sustainable enough to keep the households safe, otherwise they have been helping to reduce GBV because, most of GBV cases start as a result of poverty and lack of capital within the household." (Ward KII 2).*

10.4. Enablers and barriers for participation in GBV prevention and economic empowerment programmes

National and district level key informants were also asked about what they felt were the primary enablers and barriers to GBV survivors accessing services. The enablers that were most commonly cited by respondents were:

- Having a supportive environment for, and being designed specifically for, women participants (Ward 1, Ward 3, Ward 7);
- Services having awareness and being sensitised to GBV and tailored to survivor's needs (Ward 9, Ward 2);
- Services focussing on women's empowerment (Ward 8); and
- Services being supported by legislation (Ward 7).

The most common barriers that key informants reported that women face in accessing economic empowerment or GBV support services were:

- Needing permission from their husbands, (Ward 11, Ward 10, Ward 9, Ward 8, Ward 7, Com 1, Com 3, Com 4).

- Timing of programmes clashing with household roles such as care work, chores, farming, etc. (Com 4, Ward 10, Ward 8, Ward 7, Com3).

Other barriers to GBV prevention programmes specifically included: fear of reporting cases against husbands and thus negative repercussions (Com 1 and Ward 3); logistical challenges especially in cases where programmes may be implemented far away from where a beneficiary lives (Ward 3); or bad experiences from previous unsuccessful projects (Com 3).

11. RQ5: Ward- and community-level coordination mechanisms

This section responds to the second part of the study's fifth research question and presents our findings related to the coordination mechanisms reported by ward- and community level respondents for the economic and GBV-focused interventions reported in the preceding two sections.

> **RQ 5:** What existing activities related to GBV prevention and response, or the economic drivers of GBV are there in SAFE districts and wards? **To what extent are Toose activities coordinated with these?**

Most respondents reported that there are coordination mechanisms in place between different interventions, including between economic empowerment interventions and GBV prevention interventions, though few were able to offer detailed descriptions of these coordination mechanisms. A couple of respondents, however noted that it was positive that women's economic empowerment programmes recognised the need to coordinate with GBV services and were aware of the associated risks of GBV being perpetrated as a result of men feeling threatened by their partner's economic empowerment, which goes against the socials norms of women having a submissive status in the relationship.

A couple of respondents noted formal coordination mechanisms such as:

- Formal Gender coordination meetings (Ward 2, Ward 4, Ward 7, Ward 8, Ward 10, Ward 11) led by MWACSMED (Ward 3) led by the District Development Officers (DDOs) that are attended by representatives from social services, the judiciary and NGOs. These monthly meetings were highlighted by respondents in Chiredzi and Mwenezi as the primary form of coordination and were reported to involve debriefs on activities being implemented, progress reports, challenges and recommendations, and referrals. One respondent in Mwenezi also mentioned that reports on implementation are sent to the DDOs, and that these are then compiled and forwarded to provincial and national levels (Ward 11).
- Both Plan International and World Vision's coordination between their economic empowerment initiatives and Musasa's response efforts in Mwenezi, where Musasa assists with GBV awareness, education and response as needed, and also refers some of their service users to the economic empowerment initiatives (Ward 11).

With regards to coordination between programme implementing partners and local officials on a more operational basis, the general response from KIIs were that these worked well and closely together. Specific examples of this coordination included:

- Sharing of information on GBV referrals and outcomes (Ward KII 9), and programme initiatives and support needed from community leaders (Com KII 1).
- Close working of implementation teams with Ward-level officials. For example, one respondent from Chikomba explained that: *"we support them through different ways that is allowing them to meet with the people, mobilizing the community to attend to these projects and allowing them to do these interventions in our area, we also provide chairs and accommodation for them to carry out their meetings. We also work together as local leadership to address GBV issues such a male child beating up his mother, a man beating up here wife, and also even fights among couples. Sometimes there is just need as leaders to talk with such couple and help them with counselling, we also offer advice on how to approach some GBV cases." (Ward KII 1).*

Ward- and community-level key informants all noted areas where they felt coordination efforts could be improved, specifically by:

- Improved dissemination of information regarding GBV awareness, so that even hard to reach target audiences receive messaging (Com KII 2).
- Increased involvement and consultation with local leaders was highlighted in Chiredzi: *"we are the leaders that are aware of our vulnerable groups that we deal with on daily basis, we don't need more involved but just to sensitise us through workshops and trainings in relation to the efforts that are being done to help the community against all forms of social ills, especially GBV*". (Ward KII 5).

12. RQ6: National-level efforts to reduce GBV in Zimbabwe

This section summarises findings from key informant interviews with national-level stakeholders from MWACSMED and the UN Women, Women's Coalition of Zimbabwe and Zimbabwe Gender Commission. These interviews focused on the legal frameworks that guide GBV prevention and response activities in Zimbabwe, and the extent to which the SAFE programme aligns to any specific priority actions articulated by the Government of Zimbabwe. In doing so, this section responds to the final research question:

> **RQ 6:** How does the SAFE Communities intervention align with or respond to national-level efforts to reduce GBV in Zimbabwe?

12.1. Overview of national-level GBV prevention and response efforts

National, ward and community level stakeholders were consistent in their reports that GBV services are supported by local and national authorities in Zimbabwe, and in particular by MWACSMED. However, national level stakeholders also cited some significant limitations and barriers to GBV prevention activities.

Firstly, they noted that GBV services were not originally deemed essential services in Zimbabwe and that this had particular consequences during lockdowns resulting from the Covid-19 pandemic and as such were unable to run effectively (Nat1). Another national-level stakeholder cited a lack of concerted coordination efforts to mainstream GBV interventions as having constrained the potential impact GBV efforts could have nationwide (Nat2).

The four national-level key informants were asked about the extent to which they felt that the SAFE Communities (Toose) programme aligned with national-level efforts to reduce GBV in Zimbabwe. These respondents highlighted that economic growth and empowerment is a known priority in the reduction of GBV, but that GBV is not explicitly mentioned in national economic plans such as the National Economic Print, or the National Development Strategy (Nat1).

According to one respondent, the MWACSMED used to have a National GBV Strategy, which set out the government's objectives and priorities related to GBV eradication, but this has not been updated since 2015 (Nat2). However, GBV is one of eight priorities set out in the National Gender Policy. The High-Level Political Compact, developed by the Government of Zimbabwe, the European Union Delegation to Zimbabwe, and the United Nations in Zimbabwe under the Spotlight Initiative30 also sets priorities for GBV support in Zimbabwe (Nat3; Nat4).

The coordination mechanism for GBV prevention at the national level is reportedly that GBV objectives are set by the government, with input from UN agencies and civil society groups. The government is then accountable for their implementation, and civil society organisations are tasked with monitoring the government's implementation (Nat3). However, evidence from these key informant interviews suggests that efforts may be quite highly devolved and locally led, suggesting that alignment and coordination with local level officials may be a more pertinent priority for the SAFE Communities programme.

30 See Zimbabwe's Spotlight Initiative launches High-Level Political Compact to end gender-based violence, harmful practices | United Nations in Zimbabwe for more details.

13. Discussion and conclusions

The baseline study has revealed some important findings about the socio-demographic characteristics, attitudes, behaviours and experiences of Toose beneficiaries, which can help the SAFE programme to expand its understanding of the implementation context and support programming decisions. These are summarised below along with corresponding implications for the programme theory of change, where relevant. In addition to offering a broader discussion on the findings of this study, this section, and especially sub-section 13.9 also respond to the study's final research question:

> **RQ 7:** To what extent do the SAFE Communities ToC assumptions hold? What are potential barriers and how can the programme address these?

13.1. Beneficiary characteristics

Overall, the baseline sample consists of a moderately educated population, with almost all women having had at least some education, although slightly less than two thirds had attended secondary school.

There is a large proportion of women from the Apostolic church participating in Toose (40%), which mirrors national figures that suggest that approximately 34% of the population aged 15 years and older is affiliated with the Apostolic sect.[31]

The prevalence of disability in the baseline sample (12%) is slightly higher than the estimated national prevalence of disability among women in Zimbabwe (10%).[32] Further, the higher prevalence of physical and sensory disabilities in the baseline sample reflects national trends.[33] Feelings of depression and anxiety were also common in the baseline sample, particularly in Chiredzi where almost one in five women reported feeling depressed or anxious daily.

The large majority of women reported having been married at some point in their lives, and eight out of ten reported that they had been in a relationship in the past 12 months. Of those in a relationship at the time of the baseline survey, nine in ten were married, with customary marriages being the most common type of marriage, particularly in Mwenezi.

Out of married respondents, one in ten reported being in a polygamous marriage, which is aligned with the national rate of women in polygamous marriages reported in the ZDHS (11%).[34] The rate of polygamous marriage was highest in Mwenezi, which is also where the number of wives was the highest on average. Women with disabilities, who are members of the Apostolic church and who are over the age of 40 were all more likely to be in a polygamous marriage than their respective counterparts.

Of all ever-married women, a quarter were married before the age of 18, which is lower than the national estimate of 34%,[35] although early marriage was more common among women from the Apostolic church (29%), women in Mwenezi (30%) and among women with disabilities (30%), and even higher among women in polygamous marriages (42%). The payment of lobola for respondents' first marriage was reported by almost three quarters of women who had ever been married.

13.2. Household economic characteristics

Some household economic characteristics are very much defined by urban or rural status, with electricity and ownership of refrigerators and televisions being much more common in Chiredzi (urban), and livestock and land ownership being much more common in Chikomba and Mwenezi (rural). Other resources and assets are less dictated by urban or rural status, including ownership and use of radios, mobile phone money and bank accounts, with the latter used by slightly more than a third of respondents in Chikomba and Chiredzi, although much less among those in

31 ZimStat (2017) Inter-Censal Demographic Survey 2017. Zimbabwe National Statistics Agency and UNFPA.
32 ZimStat (2017) Inter-Censal Demographic Survey 2017. Zimbabwe National Statistics Agency and UNFPA.
33 Ministry of Health and Child Care and UNICEF (2015) Zimbabwe Living Conditions Among Persons with Disability Survey 2013 - Key Findings Report. Ministry of Health and Child Care and UNICEF.
34 Zimbabwe National Statistics Agency and ICF International (2016) Zimbabwe Demographic and Health Survey 2015. ZimStat and ICF International. Harare, and Rockville, Maryland, USA.
35 Zimbabwe National Statistics Agency (ZIMSTAT) (2019) Multiple Indicator Cluster Survey 2019, Snapshots of Key Findings. Harare: ZIMSTAT.

Mwenezi. Among those households with a bank account, the male partner is most frequently the owner of the bank account, followed by the respondent herself (particularly in Chikomba). Joint ownership is not common.

The findings for household savings and loans are quite heterogenous across districts. Although two thirds of respondents said that their household does not have any savings, this was much more pronounced in Chiredzi compared to the two rural districts. Respondents in Chiredzi were also more likely than those in the two rural districts to have taken out a loan in the past year. This may be partly related to economic shock or insecurity but does not appear to be directly related to poverty or food insecurity. Food security and ability to meet basic needs was higher in Chiredzi than the other two districts, which may suggest either that loans in Chiredzi are used to cover basic needs and access to food, or that loans are taken for other reasons. The latter is in line with the findings that school fees and business activities are important reasons for taking out loans in Chiredzi. Lower food insecurity in Chiredzi may also be related to Toose being implemented alongside a CBT programme in this district. In any case, food insecurity in the baseline sample was low overall, albeit higher in rural areas, despite the majority of respondents stating that their household was able to meet only some, very few or none of its basic needs.[36]

One third of respondents stated that their household experienced an unexpected loss of income or assets in the past 12 months, with a wide range of coping strategies reported to respond to economic shock. The most common strategies were related to consumption of food, including relying on less preferred, less expensive food, working for food only, borrowing food or reducing the proportion of meals. No respondents stated that they married girl(s) to cope with the income loss, which is at odds with the evidence emerging from the SAFE ELU's deep dive study on social norms that drive IPV and early marriage, which suggests that poverty and economic insecurity are important drivers of early marriage to offset household economic expenses (especially related to girls' education) or receive bride price.

The baseline sample indicates very high levels of economic activity among Toose beneficiaries, although the type of activity does vary between urban and rural contexts, with agriculture being much more common in SAFE's two rural districts (Chikomba and Mwenezi) and petty trading, handicraft and unskilled labour being more common in Chiredzi. While almost all women reported engaging in some kind of productive or income generating activity, fewer respondents (two thirds) stated that their partner had engaged in some paid work or productive activities over the past 12 months.

13.3. Household relationship dynamics

The baseline results related to household and relationship dynamics revealed a number of findings that are in line with the wider evidence in Zimbabwe. That women are overwhelmingly responsible for domestic tasks and childrearing is in line with wider normative expectations of women's role in Zimbabwe (see SAFE ELU deep study on social norms that drive IPV and early marriage), and is also in line with baseline women's own attitudes that women are primarily responsible for domestic labour and childcare (see following sub-section).

Baseline findings related to household decision making are also largely in line with the evidence in Zimbabwe, which suggests that women have substantial participation in household decision making related to economic issues and finances, particularly joint decision making with their partner. For instance, the ZDHS found that large proportions of women make joint decisions with their partner in relation to how to use their own and their partner's earnings, and major household purchases.[37]

The baseline study revealed similar results in relation to women's decision making, although with some variations. Baseline respondents were more likely than ZDHS respondents to decide alone about how their earnings are used (58% vs 32%), although figures for men's sole decision making were small across the two surveys (9% in the baseline study and 5% in the ZDHS). With regards to partners' earnings, a smaller proportion of women in the baseline survey reported joint decision making with their partner than in the ZDHS (53% vs 71%), with 29% of women in the baseline survey compared with 15% in the ZDHS reporting men's sole decision making. In relation to major household purchases, 26% of women in the baseline survey compared with 59% in the ZDHS decide jointly with their partner, and 37% of women in the SAFE baseline and 28% in the ZDHS decide alone.[38]

There were some important variations in these findings. For example, while younger women are more likely than older women to decide alone about how their partner's earnings are used, the opposite is true for decisions about one's

[36] The survey tool defines basic needs as including: "securing food, paying for housing, hygiene and medical costs, schooling costs for children, or other things that your household sees as its most essential needs".
37 Zimbabwe National Statistics Agency and ICF International (2016) Zimbabwe Demographic and Health Survey 2015. ZimStat and ICF International. Harare, and Rockville, Maryland, USA.
38 Zimbabwe National Statistics Agency and ICF International (2016) Zimbabwe Demographic and Health Survey 2015. ZimStat and ICF International. Harare, and Rockville, Maryland, USA.

own earnings, with older women more likely to make the sole decision than younger women. Fewer women in polygamous than monogamous marriages participate in decisions, either alone or jointly with their partner, about how his earnings are used. However, women in polygamous marriages have more autonomy than those in monogamous marriages in deciding themselves how their earnings are used.

A key component of the Toose intervention is working with families at the household level to support inclusive household economic planning and create a shared vision for family quality of life. Approximately three in five respondents reported that their household often or sometimes came together to make a plan to increase household income or assets or had agreed on a shared vision for improving family quality of life. Both economic planning and creating a shared vision were most common in Mwenezi, and while women involving their partner or husband in planning or visioning was common across the districts, the inclusion of children, including adolescent girls, was most common in the rural districts, particularly Chikomba. Respondents in Mwenezi were especially positive about their household achieving its shared vision, with almost nine in ten respondents reporting that their household had achieved its vision to a medium or high extent.

These findings suggest that Toose is starting some of its economic planning and visioning activities with a set of beneficiaries that may already be putting some of these concepts into practice. However, it is possible that respondents' definitions of what economic planning and shared visioning entail may change after their participation in the intervention.

In relation to communication strategies in intimate partner conflict resolution, the baseline study found that the majority of respondents both have knowledge of peaceful conflict resolution methods and put these into practice. Three quarters of respondents recognised that assertive communication is a healthier approach to managing conflict than passive or aggressive communication, and the majority also reported sometimes or often using healthy conflict management strategies, such as showing care, explaining one's side of a disagreement, showing respect and suggesting compromise. These results are in line with respondents' predominant reports that they felt valued and respected by their partner overall in the past 12 months, and that they felt that their partner felt valued and respected by them.

The results described above are somewhat surprising given the high levels of IPV prevalence reported by women, particularly emotional IPV which, by definition, involves verbal insults or abuse, humiliation or intimidation. This seeming contradiction is difficult to explain, but it is possible that IPV often occurs through force rather than conflict. For instance, if men perpetrate IPV to control or punish their wives/partners, rather than in response to conflict, and if women normalise or accept this behaviour, IPV could preclude the need for peaceful communication and conflict resolution methods. It is also possible couples use non-violent conflict resolution methods to resolve some types of disagreements, but not others.

13.4. Gender equitable attitudes and attitudes towards GBV

The baseline study has found that respondents have predominantly gender-inequitable attitudes related to division of household labour and women's and men's roles in decision making. The large majority of women agreed with statements supporting gender norms that women are primarily responsible for domestic labour and childcare, although most women simultaneously agreed that men should assist women with household duties. A large proportion of respondents also agreed with statements related to men's decision making and control in the family, including men deciding whether women work or not, or having the final say in all family matters. The findings related to men's decision making, however, differ across the districts, suggesting that attitudes are slightly more equitable in urban areas. The findings were more mixed for attitudes related to control over income. While almost all women agreed that men should give money they earn to their partner, approximately half of women agreed that a woman should give money that she earns to her partner.

A large proportion of women sampled for the baseline survey (approximately three in five) agreed that physical IPV (a man beating his wife or partner) is unacceptable in any of the seven circumstances presented. However, justification for physical IPV is more prevalent for some circumstances than others, with a third of respondents suggesting that violence is justified when a woman is unfaithful. This finding is consistent with the findings of the SAFE ELU's deep dive study on social norms that drive IPV and early marriage, which found that both women and men tended to justify physical IPV in cases where a woman was perceived to transgress her perceived sexual responsibilities to her partner, including refusing sex and being unfaithful.

Attitudes regarding early marriage are mixed, and sometimes appear to be contradictory. The vast majority of respondents reported that neither they nor their partner would consider marriage for a daughter under the age of 18.

Yet there are widespread perceptions that early marriage increased in the past year, and that many girls were married before the age of 18 in their community (particularly in Chiredzi). These results are consistent with the findings of the SAFE ELU's deep dive study on social norms driving IPV and early marriage, which found that while marring girls before the age of 18 is widely perceived to be unacceptable, the practice remains very much prevalent. These findings could suggest that respondents are aware of the illegality and increasing unacceptability of early marriage and are responding positively due to social desirability bias.

13.5. Prevalence of GBV

Violence against women is highly prevalent among Toose beneficiaries, highlighting the urgency of prevention efforts in target districts and Zimbabwe more widely. The prevalence of IPV in the baseline sample is higher than in the most recent Zimbabwe Demographic and Health Survey (ZDHS).[39] Comparisons made to the ZDHS must be done with caution. The ZDHS measures physical, sexual and emotional IPV, samples women aged 15-49 years and is based on nationally representative data. In contrast, the SAFE baseline measures four types of IPV (economic IPV in addition to the types measured in the ZDHS) among women aged 18 years and above and is based on a beneficiary-targeted sampling approach in three districts. Nevertheless, the scale of IPV prevalence in the SAFE baseline sample is telling. Almost half of women (47%) reported experiencing any type of IPV in the past year compared with 30% in the ZDHS. The prevalence of physical IPV and sexual IPV is slightly higher in the SAFE baseline sample (18% and 12%) than in the ZDHS (15% and 9%), and the prevalence of emotional IPV in the SAFE baseline sample is almost double the ZDHS past 12 month prevalence rate (39% and 24% respectively).

Past year prevalence for other types of GBV was extremely low, with only 21 respondents reporting having experienced physical violence from a non-intimate-partner family member, and only 11 reporting having experienced non-partner sexual violence. The finding related to non-partner sexual violence may be related to social desirability bias and women's reluctance to report sexual violence. However, the figures found in the baseline survey are similar to those found in the ZDHS, which suggest that sexual violence is much more frequently perpetrated by an intimate partner, with lower than 1% of women in the national survey reporting past year non-partner sexual violence.

The SAFE theory of change does not make explicit reference to violence against children but does retain some flexibility given its focus on wider family wellbeing. The finding that more than half of Toose beneficiaries have used corporal punishment against a child (i.e., beaten smacked) in the past year is concerning and may indicate the need for further or more explicit work at the household level on the prevention of violence against children. This is particularly so given known multi-generational effects of violence, and the observed associations in the baseline survey between childhood violence and IPV experience or perpetration of physical violence against children.

13.6. Factors associated with IPV experience

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

- Women's experience of IPV is associated with age such that younger women are more likely to experience IPV than older women and this has been found in other studies in Zimbabwe,[40] and also in wider global contexts.[41]
- The baseline survey found an association between IPV experience and women's daily feelings of depression or anxiety, which is very much in line with global evidence showing that mental health is closely linked to IPV experience.[42] The evidence does not necessarily show the causal relationship between IPV and mental health, but it does suggest that the relationship is bi-directional: IPV experience can lead to poor mental health, and poor mental health can also increase women's risk of experiencing IPV.[43]
- Religion is a significant factor related to IPV, with a significant association found between women's affiliation with the Apostolic church and their experience of any past year IPV, although when examining specific types of IPV this finding only held for economic IPV. The association between IPV and Apostolic affiliation has been observed

39 Zimbabwe National Statistics Agency and ICF International (2016) Zimbabwe Demographic and Health Survey 2015. ZimStat and ICF International. Harare, and Rockville, Maryland, USA.
40 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.
41 Abramsky, T. et al. (2011) What factors are associated with recent intimate partner violence? findings from the WHO multi-country study on women's health and domestic violence. BMC Public Health, 11: 109.
42 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.
43 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.

in other studies in Zimbabwe. For example, the ZDHS found that among ever-married women aged 15-49, lifetime physical, sexual or emotional IPV was greatest for those women affiliated with the Apostolic sect (46%).[44]

- Women's exposure to childhood violence is associated with risk of IPV experience in adulthood, which is very much in line with the global evidence on the multi-generational impacts of violence, and the intersections between violence against children and violence against women.[45]
- The baseline study confirms a strong relationship between 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.[46] It is also in line with the findings from the ZDHS, which show that women whose husbands are drunk very often are twice as likely to have experienced lifetime physical, emotional or sexual IPV (75%) than women whose husbands do not drink alcohol (38%).[47] Other studies on GBV in Zimbabwe have also identified men's frequent alcohol consumption as a risk factor for IPV perpetration.[48]
- Women's partners working away from home in the past year is associated with any IPV experience, although the significance of this association only holds for physical and economic IPV when exploring specific types of IPV. The finding related to economic IPV may be related to male partners more strictly controlling women's access to income or denying women's access to income when they are away from the household for periods of time. This is in line with the SAFE ELU's deep dive study on social norms supporting IPV and early marriage, which suggests that men working away from home may 'punish' their wives for perceived mishandling of household resources and spending, or other behaviours (e.g., perceived infidelity) by withholding income. The deep dive study also found that men who work away from home may perpetrate physical IPV against their wives or partners when returning home if women deny sex or if the couple quarrels over household income or expenditure, which may partly explain the association between men's work away from home and physical IPV in the baseline study.
- The baseline study has revealed interesting findings in relation to how relationship status intersects with women's IPV experience. Single women's higher risk of IPV when compared with currently partnered women may indicate that experience of IPV can lead to separation among some women. The ZDHS suggests that lifetime IPV experience is higher among women who are divorced, separated or widowed (51%) when compared with women who are married or living with their partner (44%), although these findings are not directly comparable to the results of the baseline study given that the ZDHS reports risk factors for lifetime IPV rather than past year IPV.[49] The baseline finding that women in polygamous marriages experience higher levels of economic IPV but lower levels of physical IPV than women in monogamous marriages is interesting but should be read with caution given that these associations are not significant (likely due to the small sample of women in polygamous marriages). It may be that economic IPV is linked to competition or conflict between wives over household economic resources, a hypothesis which will be explored further in a research brief that brings together the findings of the baseline study and qualitative cohort study.
- The finding that IPV experience is associated with first marrying before the age of 18 is in line with the evidence in Zimbabwe,[50] with a secondary analysis of DHS data in 34 countries finding that marriage under the age of 18 was associated with higher prevalence of both physical and sexual IPV in Zimbabwe.[51]
- The findings related to family and relationship dynamics and their association with women's IPV experience are much in line with SAFE's theory of change. IPV prevalence is lower when women report higher quality of family life, and when households have developed a shared vision for improving family quality of life or made economic plans jointly, in the latter case including when these plans are made with husbands'/male partners' and children's participation. IPV prevalence is also lower when women report feeling valued by their partner and that their partner feels valued by them. There is a significant association between non-violent conflict resolution / communication in women's intimate relationships and reduced prevalence of IPV and, conversely, an

44 Zimbabwe National Statistics Agency and ICF International (2016) Zimbabwe Demographic and Health Survey 2015. ZimStat and ICF International. Harare, and Rockville, Maryland, USA.
45 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.
46 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.
47 Zimbabwe National Statistics Agency and ICF International (2016) Zimbabwe Demographic and Health Survey 2015. ZimStat and ICF International. Harare, and Rockville, Maryland, USA.
48 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.
49 Zimbabwe National Statistics Agency and ICF International (2016) Zimbabwe Demographic and Health Survey 2015. ZimStat and ICF International. Harare, and Rockville, Maryland, USA.
50 Plan International (2016) Counting the Invisible: Using the data to transform the lives of girls and women by 2030. UK: Plan International.
51 Kidman, R. (2017) Child marriage and intimate partner violence: a comparative study of 34 countries. International Journal of Epidemiology, 46(2): 662-675.

association between negative or unhealthy partner communication (such as blaming, criticizing, swearing, name calling) and increased prevalence of IPV.

- Globally, men's controlling behaviours are recognised as an important risk factor for IPV,[52] and this pattern was also found in the baseline study. This result should be read with caution given that there is some crossover between controlling behaviours and the types of behaviours one might observe in cases of emotional or economic IPV.
- The baseline findings related to economic risk factors for experience of IPV suggest that IPV experience is significantly associated with food insecurity.[53] This finding is further supported by the finding that household economic shock, measured through household sudden loss of income or assets in the past year, is also significantly associated with women's past year experience of IPV.
- Finally, the SAFE ELU posited that women's participation in transactional sex or sex work may be a risk factor for IPV experience. This hypothesis was made given the findings in both the ELU's deep dive study on social norms driving IPV and early marriage, and SAFE Communities formative research study, which suggest that women's participation in transactional sex or sex work can lead to marital conflict and subsequent IPV. While the baseline study did not find significant differences in women's IPV experience according to their participation in transactional sex or sex work, the trends indicate that IPV prevalence is higher among those women participating in these activities. It is very possible that a non-significant finding is linked to the very small sample of women who reported participating in transactional sex or sex work, which may itself be linked to social desirability bias and women's reluctance to speak about such sensitive matters.

The baseline study also found some unexpected associations, or lack of associations, between various factors and women's experience of IPV.

- The global literature suggests that women with disabilities are at higher risk of experiencing IPV,[54] and evidence in Zimbabwe also suggests that women and girls with disabilities are more likely to experience physical or sexual abuse than those without a disability.[55] However, no relationship between disability and IPV experience was found in the baseline survey.
- Evidence in Zimbabwe suggests that the justification of physical IPV is a significant risk factor for women's experience of and men's perpetration of IPV.[56] This trend was not observed in the baseline study when considering women's justification of IPV in any of seven circumstances. There was, however, an association between respondents' justification for physical IPV in one circumstance, when a woman disobeys her husband, and past year experience of any IPV or emotional IPV. This finding may suggest that IPV experience is more closely linked to attitudes that support men's hierarchy and control over their wives or partners.
- The finding that lobola paid for women's first marriage is negatively associated with IPV is curious, and contrary to the wider literature which suggests that IPV is higher among women whose families are paid bride price. The evidence posits that this association is due to payment of bride price being associated with men's greater feelings of dominance and ownership over their wives when an economic exchange between marital families has taken place. A study on domestic violence in Zimbabwe also found this pattern, with women reporting that their husbands felt that they owned them given they had paid bride price, leading to women's vulnerability and treatment as 'property'.[57] Early analysis of the data from the longitudinal qualitative cohort study suggests that economic decline in Zimbabwe has restricted men's ability to pay lobola, which may lead to conflict within the couple and women's wider feelings of disrespect within the relationship and for women's families and, subsequently, men's perpetration of IPV. This will be further explored in a research brief bringing together the findings of the baseline survey and qualitative cohort study.
- The baseline survey included a number of measures related to women's decision making in their households about economic matters. The primary measures were drawn from standardised items (such as those used in the DHS and other population surveys) asking about whether women make decisions about specific matters alone or together with their partner, or if their partner makes the decision alone. These items were supplemented with

52 Abramsky, T. et al. (2011) What factors are associated with recent intimate partner violence? findings from the WHO multi-country study on women's health and domestic violence. BMC Public Health, 11: 109.
53 Duvvury, N., Scriver, S. and Gibbs, A. (2017) What Works Evidence Review: The relationship between poverty and intimate partner violence.
54 Dunkle, K., van der Heijden, I. Stern, E. & Chirwa, E. (2018) Disability and Violence against Women and Girls: Emerging Evidence from the What Works to Prevent Violence against Women and Girls Global Programme.
55 Ministry of Health and Child Care and UNICEF (2015) Zimbabwe Living Conditions Among Persons with Disability Survey 2013 - Key Findings Report. Ministry of Health and Child Care and UNICEF.
56 Fidan, A. & Bui, HN. (2016) Intimate Partner Violence Against Women in Zimbabwe. Violence Against Women, 22(9): 1075-1096.
57 Chireshe, E. (2015) Christian Women's Experiences of Domestic Violence in Zimbabwe. Journal of Women and Social Work, 30(3): 380-394. See also: Matavire, M. (2012) Interrogating the Zimbabwean traditional jurisprudence and the position of women in conflict resolution. A case of Shona tribes in Muzarabani district. International Journal of Humanities and Social Sciences, 2(3):218-223; and Mesatywa, N.J. (2014) Validating the evidence of violence in partner relationship with regard to Xhosa women. Social Work, 50(2):235-257.

additional questions drawn from the Women's Empowerment in Agriculture Index (WEAI), which asks how much input women have in decision making and the extent to which they feel they can make personal decisions about these issues if they want(ed) to. These additional questions seek to move beyond final decision making itself and explore the process of decision making, including the extent to which women can input into and make personal decisions about things that they value. These elements of decision making are recognised in the literature as important indicators of women's agency, of which 'final' decision making is not necessarily an accurate proxy.[58] The baseline findings that risk of IPV is greater when women make decisions about certain economic issues alone, but that risk is diminished when women input into decision making or are able to make their own decisions if they wanted to, are telling. It is possible that women's sole decision making, particularly about household income and expenditure, leads to conflict within couples and subsequent IPV. That women's inputs into decisions and ability to make their own decisions about issues that they value are linked to lower prevalence of IPV may indicate that agency (rather than decision making per se) is a protective factor against women's experience of violence.

13.7. GBV response

The vast majority of respondents expressed both confidence in their ability to support women and girls who have experienced violence, and the likelihood that they would do so. Confidence and intention do not necessarily translate into action, with less than half of respondents stating that they had offered support to a survivor in the past year; however, this result should be read with caution given that respondents may not have been presented with the opportunity to provide support.

The large majority of respondents also suggested that they were likely to seek help or support, or access services, if they experienced violence. Despite this finding, a much lower proportion of women who had experienced violence in the past 12 months actually did seek help. Approximately half of survivors sampled told nobody about the violence and the majority of those who did experience violence sought support from relatives outside their immediate family or close female family members. There were a few notable differences between districts, including women in Chiredzi being more likely to seek support from friends or neighbours, which may suggest that drawing on social networks outside of families is more common in urban than rural areas. Further, just over a quarter of women who experienced violence in the past 12 months went to any kind of GBV service for help. Women who experienced IPV were slightly more likely to access services when the IPV was physical or severe than emotional or economic, particularly police services, and the majority of women who did access formal services in the past 12 months had experienced severe IPV. This suggests that some women may only access services when IPV escalates in terms of frequency or force, which is in line with evidence from the SAFE ELU's deep dive study on social norms that drive IPV and early marriage, which found that help seeking is seen as more acceptable when women experience physical or severe IPV.

Respondents' knowledge of GBV services in the community was high overall, particularly their knowledge of the police as a service that survivors could access. However, knowledge of other types of services, including health, psychosocial, legal and traditional/religious services was lower. Knowledge of GBV services was consistently lower in Mwenezi and higher in Chikomba for most types of services, and half of respondents in Chikomba reported knowing about GBV shelters in their community, almost four times as many as those in the other two districts.

Despite reported knowledge of GBV services being high overall, when asked about barriers that women might face accessing services, lack of knowledge of services was the most common reason stated. Other reasons are mainly associated with negative consequences (such as more violence, getting in trouble, break-up of the relationship and fear of abandonment/divorce), or accessibility challenges (such as unaffordability of transport, distance to travel or unaffordability of service fees). Poor quality of services was also a barrier that was reported.

These barriers reported by all respondents are similar to the ones reported by survivors who did not seek help in the past year when asked why they did not do so. A key difference, however, is that rather than lack of knowledge of services, the most common reason for survivors not accessing services was related to affordability, with almost half saying they could not afford service fees. Other reasons provided, albeit by smaller proportions of survivors, included that they didn't want or need services, they felt it was their fault or they didn't think the violence was a problem. This may indicate that when considering whether a violent incident justifies seeking help, some IPV survivors may not consider the violence perpetrated by their partner to be wrong and, rather, may feel it is justified. This is in line with the results of the SAFE ELU's deep dive study on social norms that drive IPV and early marriage, which suggest that some men and women believe that violence can be prevented if women obey their husbands or act as 'good wives',

58 Donald, A. et al. (2017) Measuring Women's Agency. Policy Research Working Paper 8148. World Bank Group.

thus putting the onus of violence prevention on women. Another barrier to help seeking identified by a small proportion of survivors is the belief that asking for help is useless or that nobody could help them, suggesting a concern that help would not be forthcoming.

There were a number of variations in survivors' reasons for not accessing help according to sub-groups, which indicate that barriers may vary widely for women with different intersecting characteristics. For instance, lack of affordability of services was most common in Chiredzi and Chikomba but less common in Mwenezi. Further, respondents who were members of the Apostolic church were significantly more likely to say they were afraid of more violence than non-Apostolic women. Relationship and disability status also appear to influence barriers to help seeking, with single women and women with disabilities being more likely than partnered women and women with no disabilities to express concern about the abuser getting in trouble.

Among those survivors who did seek help from GBV services in the past year, the most common reason for why they did so was because they could no longer endure the violence, with more than three quarters of survivors in Chikomba providing this reason, more than two and half times as many as those in the other two districts. 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).

13.8. GBV and economic empowerment programming

Survey respondents reported being aware of or having participated in GBV prevention activities in their community. For instance, just over a third of respondents reported having been exposed to the 'Love Shouldn't Hurt' campaign, with exposure highest in Chikomba, and with the most frequent modality being through community dialogues. Almost half of respondents also reported that they have seen people in their community doing something to prevent violence against women in the past 12 months, particularly in Chikomba, where reported participation in training on safe and healthy relationships or violence against women and girls was also most common. These findings do not necessarily mean that multiple, separate activities have been implemented in SAFE districts, as exposure could, for instance, be predominantly linked to the 'Love Shouldn't Hurt' campaign, although it is not possible to ascertain this from the baseline data.

While survey respondents reported exposure to GBV prevention programmes, KIs more frequently described GBV response programmes operating in SAFE districts, including both small, informal community-based support groups, and larger, more formalised GBV responses services. The description of predominantly GBV response programmes highlights a potential gap in GBV prevention services across SAFE Communities' three implementation districts, a gap which SAFE was widely recognised as filling, mainly through its economic empowerment approach.

Almost all survey respondents reported participating in an ISAL or VSLA, which was expected given that survey respondents were sampled from ISAL groups. Some respondents, particularly in Mwenezi, reported being in an ISAL or VSLA for more than six months, which may indicate that respondents have been exposed to other economic programmes in the area, or that some ISAL groups supported by SAFE are continuing from older groups. Further, almost all households in Chiredzi reported having received a CBT in the past 12 months, which is line with SAFE's partnership with WFP through the ZHARP programme in Chiredzi.

Key informants reported that ISALs and VSLAs are the primary type of economic intervention being implemented in all three districts. The SAFE programme was particularly mentioned by respondents, although KIs also described other economic programmes operating in SAFE districts, including other savings and loans groups. The KIIs did not shed light on the extent to which SAFE is coordinated with these other economic programmes. However, the longer length of time that survey respondents have spent in an ISAL beyond the Toose start-up of ISAL groups, particularly in Mwenezi, may indicate some, albeit minor, duplication in efforts.

The KIIs shed limited light on the extent to which SAFE is aligned with or responds to national-level efforts to reduce GBV in Zimbabwe. However, national-level key informants did emphasise the importance of integrating GBV prevention into wider economic and livelihoods policy and programming efforts, a task that SAFE is actively pursuing through its partnership with the ZHARP programme. At the district level, while SAFE inter-organisational coordination was not explicitly mentioned, key informants did refer to the strength of prevention and response partnerships, such as between Plan International and Musasa, including Musasa's referral of service users to economic empowerment initiatives. This may reflect stakeholder knowledge of SAFE partnerships in Chiredzi where Plan International is implementing CBT alongside Toose.

13.9. Implications for SAFE theory of change

The baseline findings have a number of implications for SAFE's theory of change and the assumptions underlying it. There are strong associations between outcomes 1, 2 and 3 in the theory of change and IPV prevalence, although not on all measures. Further, the expected pathways to impact appear to hold.

- **Outcome 1**: There is a clear relationship between outcome 1 (household ability to manage economic stress) and IPV when using food insecurity as a proxy measure for economic stress – women's higher IPV prevalence is significantly associated with higher household food insecurity. The theory of change posits that household economic planning, developing a shared vision for family wellbeing and women's and men's joint decision making are key pathways to change. The baseline results support this hypothesis, with household economic planning and creating a shared vision both found to be significantly associated with lower food insecurity. Food insecurity is also lower when women make decisions alone or jointly with their partner about how his or her income is used when compared with decisions being made only by men.
- **Outcome 2**: There is also a clear relationship between outcome 2 (intimate partner and family relationships are more gender equitable and do not resort to violence to resolve conflict) and IPV in relation to non-violent conflict resolution - IPV is consistently less prevalent when women and men use healthy communication and conflict resolution strategies. There is, however, no significant association between IPV and women's gender inequitable attitudes. The theory of change posits that taking forward a shared vision for improving the family's quality of life and making significant household decisions together are key pathways to change. The baseline results support this hypothesis. The frequency of partners' respectful and peaceful conflict resolution strategies increases as the likelihood increases that households have worked towards achieving their shared vision. Further, women's partners' use of non-violent conflict resolution is more frequent when women and men make joint decisions about how women's or men's earnings are used.
- **Outcome 3**: There is an ambiguous relationship between outcome 3 (communities in focal wards have reduced tolerance to IPV and/or other forms of GBV) and IPV prevalence. Overall, the baseline study did not find an association between respondents' justification of physical IPV if any of seven circumstances, although there was an association between justifying physical IPV in one circumstance (when a woman disobeys here partner) and past 12-month IPV experience. Given that outcome 3 is based on community rather than household attitude and behaviour change, the pathways to impact cannot be measured through the household survey.
- **Outcome 4**: The relationship between outcome 4 (increased access to essential GBV services by women and adolescent girls) and IPV prevalence cannot be tested given that all GBV survivors had experienced IPV in the past year. However, the baseline study does shed light on some important aspects of the outcome 4 pathway. The pathway's assumption that survivors face multiple barriers accessing GBV services hold strongly. Further, the two outputs in this pathway appear to be targeting two of the most significant types of barriers: women and girls' lack of awareness of GBV response services, and accessibility of services. In relation to this latter barrier, survey respondents noted a number of accessibility-related barriers, including lack of affordability of services. A gap in the theory of change is in relation to addressing the negative consequences of survivors seeking help (e.g., more violence or getting into trouble, fear of abandonment, being blamed for violence). While most of these are likely out of scope for SAFE to address, several barriers, such as those related to stigma against survivors, could be more explicitly addressed through the community level component of the programme.

There are other aspects of the baseline study that help to interrogate the programme's theory of change and its assumptions. One key one is the confirmation of significant diversity among the intervention population, including partnered women, women in polygamous marriages, women in female-headed households, women with disabilities, and women whose partners work away from home. This supports the programme's emphasis on a family-centred approach that is inclusive of diversity.

The baseline results suggest that Toose is addressing significant drivers of IPV, including economic stress, unhealthy communication, negative conflict resolution methods and men's alcohol consumption. In relation to economic stress, an upcoming deep dive study on the role of ISAL groups in reducing economic stress and mitigating IPV will provide additional reflection on the extent to which Toose is able to successfully address this important driver.

There is an assumption in the theory of change that a key pathway to impact is through encouraging joint decision making between couples or between other family members, rather than encouraging women's autonomous decision making. The baseline study has some mixed results in relation to this assumption. On the one hand, it is clear that joint decision making is related to a number of positive outcomes, including the more frequent use of non-violent conflict resolution strategies. Further, women's sole decision making on a number of household financial issues is

significantly related to higher prevalence of IPV. On the other hand, women inputting into decision making or their ability to make their own decisions if they wanted to are both significantly associated with lower IPV prevalence. The tension here is subtle but important. Joint decision making is not necessarily linked to women's agency given that men may still ultimately be the final decision maker or may try to coerce women into agreeing with their decision. The baseline results suggest that the process of decision making is important, as is a woman's agency to both input into decisions and to make their own decisions about things that are important to them. This may indicate the need to build in more specific content in the Toose manual on the processes involved in *how* couples and other household members arrive at decisions, the explicit value of women's contributions and the importance of compromise.

14. Recommendations

Overall, the choice of the Toose intervention, combining social and economic empowerment, is appropriate given the types of, and factors associated with, GBV identified in the baseline study. There are, however, some adaptations that could strengthen the intervention.

The baseline evidence of inter-generational violence and women's frequent perpetration of physical violence against their children suggests that incorporating additional content on violence against children, either into the Toose manual or community-level activities, could strengthen impact.

Given the importance of women's agency and negotiating power in the household in the theory of change, Toose would benefit from a more explicit focus on the *process* through which family members, particularly couples, arrive at decisions and the value of women's inputs and choice in this process.

The baseline finding that a substantial number of women have partners working away from home, and that partners working away from home is associated with IPV (particularly economic IPV) poses some challenges for the intervention given that partners are unlikely to attend Toose session (regularly or at all) if working away from their communities. SAFE Communities could consider building additional modalities into the intervention that allow for greater engagement with male partners who work away from home, such as supporting Toose facilitators or community influencers to engage directly with households with men working away from home to disseminate Toose processes more widely within the household.

The finding that the majority of women report both knowledge of peaceful conflict resolution methods, and putting these into practice with their partners, but that IPV remains highly prevalent, is curious and may suggest that IPV often occurs through force rather than conflict. This may justify a stronger and more explicit emphasis in Toose on GBV and the normalisation of violence.

The relationships between positive family and relationship dynamics (e.g., making economic plans jointly and healthy partner communication) and women's lower IPV experience may suggest that SAFE could highlight couples who practice these behaviours as role models. Conversely, the programme may need to more explicitly target those couples and family members who do not display these behaviours.

While the GBV response component of Toose is directly addressing two key barriers to survivors' access to services, including women lack of awareness of GBV response services, and accessibility of affordable services, additional barriers related to stigma that drive blame of survivors could be more explicitly addressed through the community level component of the programme.

Given the wide differences between rural and urban areas, and between some population groups (including women in polygamous and monogamous marriages) on some key measures in the baseline survey, Toose may require some adaptations in implementation to respond to the needs of different groups.

The baseline survey and deep dive study on social norms that drive IPV and early marriage have both identified perceived or actual infidelity and issues with trust as key drivers of conflict. These issues could be more strongly integrated into the Toose manual, including in sessions covering quality of relationships.

The finding that early marriage is very common but that respondents deny intention to practice it may be related to social desirability bias. This bias may also negatively influence the emphasis that community influencers and Toose facilitators put on early marriage as an important issue to be addressed in community-level activities. SAFE could usefully ensure that this issue does not drop off the agenda by explicitly encouraging community dialogue on early marriage.

Lastly the key informant interviews confirmed that Plan International and WFP, who are already engaged in the programme are two of the key INGOs operating EE and GBV interventions in SAFE's implementations districts. However, it is important that there is a joined-up approach between the SAFE intervention and other programmes that are being implemented on the ground. SAFE Communities therefore should encourage lesson and knowledge sharing and coordination with these programmes. In addition, there are other external programmes suggested by key informants as having prominent GBV and EE interventions, including programmes implemented by Christian Care and Nutrition Action Zimbabwe. The FCDO could continue to support coordination efforts between the SAFE Communities programme and these other organisations, building on the GBV Symposium in June 2022, to harmonise GBV prevention and response programming and share lessons and best practice.

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Annex 1: GBV in Zimbabwe (further context)

Zimbabwe has signed, ratified and domesticated various international and regional instruments like the Committee on the Elimination of Discrimination against Women (CEDAW), Maputo Protocol and Southern Africa Development Community (SADC) Gender Protocol that prohibits all forms of gender-based violence. CEDAW creates an obligation for States to take measures against GBV in both private and public spheres.[59]

Despite various national strategies and action plans aimed at addressing GBV, including specific plans to end child marriage, violence against women and girls persists. Although there has been some progress, this has mostly been at the policy and legislative levels, which have not always translated into tangible changes in women's situations due to prevailing harmful gender and social norms.

Addressing GBV has come with its challenges, including a lack of evidence-based research to inform interventions. Other challenges include persisting barriers to women reporting cases of GBV. In 2020 a CEDAW report revealed the increase of GBV cases reported to the Zimbabwe Republic Police (ZRP) and handled by the National Prosecuting Authority (NPA) from 2012 -2016. Although reports increased, the number of cases withdrawn at the request of the survivor also increased during that period.[60] The government of Zimbabwe noted that the persistence of negative traditional, cultural and social norms had impeded efforts to reduce GBV.[61]

IPV in Zimbabwe

IPV is one of the most common forms of violence against women, including in Zimbabwe, and includes physical, sexual, economic, and emotional abuse by an intimate partner. IPV occurs amongst all socio-economic, religious and cultural groups and consequences of IPV include negative physical and mental health impacts.[62]

The Zimbabwe Demographic and Health Survey (ZDHS) conducted in 2015 found that 45% of ever married women aged 15-49 had experienced any type of IPV in their lifetime, and the prevalence of past 12-month IPV was 30%. The survey also found that physical and emotional IPV are the most common forms of IPV in Zimbabwe.[63] Reports by civil society organisations reflect that IPV is one of the most prevalent forms of GBV. In 2019, the Musasa Project alone recorded 32,344 cases of GBV; one of the most common types was IPV.[64]

Child marriage in Zimbabwe

Over the past five years, there has been a large focus on ending child marriage[65] in line with the Sustainable Development Goals[66,67] and the Marriages Bill and Child Justice Bill, which states that the age of marriage for both boys and girls is 18.[68] However, child marriage continues to be highly prevalent in Zimbabwe. In the 2019 MICS study, one in three women aged 20-24 reported that they married before the legal age of 18 and 5% married before the age of 15.[69] The study also found that child marriage was more common in rural areas and among women with low educational attainment or who were poor. the Marriages Bill and Child Justice Bill, which states that the age of marriage for both boys and girls is 18.

COVID-19 and GBV in Zimbabwe

GBV has become further exacerbated by the COVID-19 pandemic. Analysis by UN Women revealed that GBV cases globally increased during lockdowns from one in three women to two in three women.[70] In Zimbabwe, cases also increased: the Musasa Project, for example, recorded 7,342 cases during the period April to June 2019 and recorded 10,892 cases for the same period in 2020, when the country was in lockdown.

The increase in GBV cases was due to a number of factors; for example, the hard economic conditions that exacerbated IPV, and women and girls being confined at home with perpetrators and unable to access assistance. The declaration of the COVID-19 pandemic in Zimbabwe led to a national lockdown in March 2020, which disrupted

[59] CEDAW (2019) CEDAW General Recommendation No. 19: Violence Against Women. UN Committee on the Elimination of Discrimination Against Women (CEDAW).
[60] CEDAW (2020) Concluding observations on the sixth periodic report of Zimbabwe. UN Committee on the Elimination of Discrimination Against Women (CEDAW).
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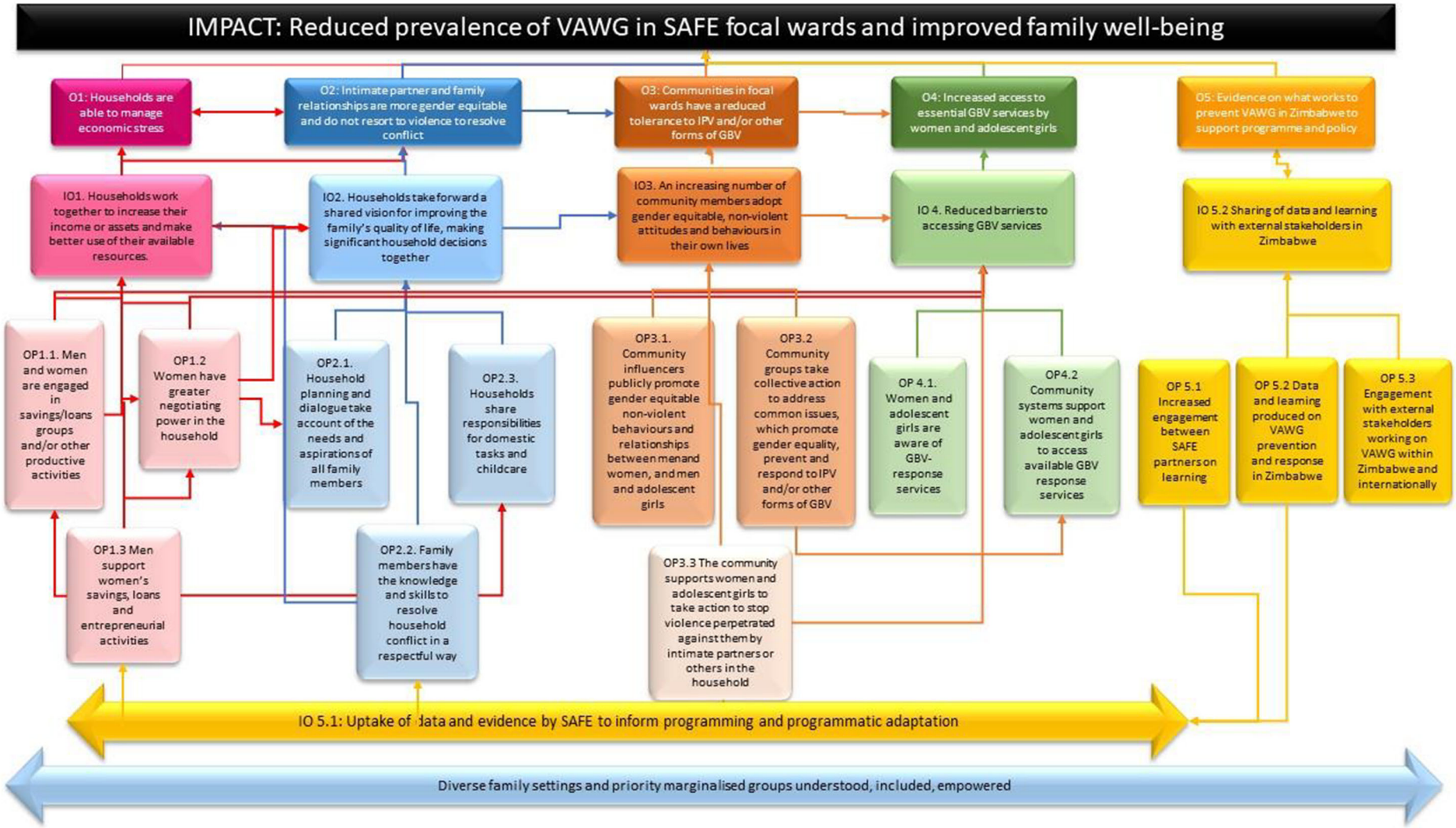
[62] WHO (2012) Understanding and addressing violence against women: Intimate Partner Violence. World Health Organization.
[63] Zimbabwe National Statistics Agency and ICF International (2016) Zimbabwe Demographic and Health Survey 2015. ZimStat and ICF International. Harare, and Rockville, Maryland, USA.
[64] Musasa Project Annual Report, 2019.
[65] For more detailed information on commitments made by Zimbabwe, see https://www.girlsnotbrides.org/child-marriage/zimbabwe/
[66] SDG 5 Gender Equality target 5.3 ending child marriages
[67] S78(1) of the Constitution of Zimbabwe[Chapter 20]
[68] S78(1) of the Constitution of Zimbabwe[Chapter 20]
[69] Zimbabwe National Statistics Agency (ZIMSTAT) (2019) Multiple Indicator Cluster Survey 2019, Snapshots of Key Findings. Harare: ZIMSTAT.
[70] https://www.unwomen.org/en/news/in-focus/in-focus-gender-equality-in-covid-19-response/violence-against-women-during-covid-19

all non-essential services. As GBV services are not considered essential services, this severely limited GBV service provision and hindered women's access to services.

Annex 2: The SAFE Communities programme theory of change



Annex 3: Baseline Study Terms of Reference

1. Introduction

1.1. Background to the Study

The UK Foreign Commonwealth and Development Office (FCDO) Zimbabwe is funding a 4-year programme (October 2019 - March 2024) called 'Stopping Abuse and Female Exploitation' (SAFE), which aims to protect women and girls in Zimbabwe from the most severe forms of violence, including child marriage. Violence against women and girls (VAWG) is one of the biggest human rights violations in Zimbabwe. Intimate partner violence (IPV) is the most reported form of gender-based violence (GBV) in Zimbabwe. According to national statistics, 35% of married women between the ages of 15 and 49 across Zimbabwe have experienced physical or sexual violence from a spouse and 37% of these have experienced physical injury as a result of this violence (Zimbabwe Demographic and Health Survey (ZDHS), 2015). Zimbabwe is also one of the 44 hot spots of child marriage: a third of Zimbabwean women reported having been married before the age of 18 (Multiple Indicator Cluster Survey (MICS), 2019).

The SAFE programme comprises two components[71]:

- **Component 1** (SAFE Communities), which seeks to strengthen community actions to prevent and respond to violence against women and girls; and
- **Component 2** (SAFE Evaluation and Learning Unit, ELU), which seeks to strengthen the evidence base on what works in preventing and responding to violence against women and girls. More specifically, it seeks to iteratively test the effectiveness of the SAFE programme; inform programme adaptation; optimise delivery to maximise the impact of interventions on women and girls in Zimbabwe; and help explain what is working, how and why and contribute to the wider GBV knowledge base (see section 1.3 for the evaluation's objectives).

SAFE Communities is being delivered by a programme consortium led by Ecorys. SAFE ELU is being delivered by a consortium, led by Tetra Tech International Development (henceforth Tetra Tech). Q Partnership is the local data collection agency in Zimbabwe collecting the data as part of the Tetra Tech consortium.

As part of component 2, the SAFE ELU will undertake the following activities over the course of the programme (until March 2024): designing and implementing **a baseline study** in target areas where SAFE Communities is operating; undertaking a series of **qualitative deep dive research studies** over the course of implementation; and undertaking a final **summative evaluation**. Although the baseline study will provide a dataset against which a future impact evaluation could measure the impact, we will not conduct a final quantitative impact assessment as this does not fall within the ELU contract. FCDO may however contract an endline impact evaluation independent to the ELU contract.

This study proposal relates to research activities planned as part of the baseline study undertaken under Component 2 of the SAFE Programme. Fieldwork for the study will be conducted between October 2021 and January 2022 and between April and June 2022. These dates correspond to the first cohort (C1) and second cohort (C2) of the intervention (see sampling in section 2.3 for more details).

1.2. Context of the Assignment

1.2.1. GBV in Zimbabwe

GBV is still widespread in Zimbabwe despite various resources being committed to reduce it across the country. Zimbabwe has signed, ratified and domesticated various international and regional instruments like the Committee on the Elimination of Discrimination against Women (CEDAW), Maputo Protocol and Southern Africa Development Community (SADC) Gender Protocol that prohibits all forms of gender-based violence. CEDAW creates an obligation for States to take measures against GBV in both private and public spheres.[72]

Despite various national strategies and action plans aimed at addressing GBV, including specific plans to end child marriage, violence against women and girls persists. Although there has been some progress, this has mostly been at the policy and legislative levels, which have not always translated into tangible changes in women's situations due to prevailing harmful gender and social norms.

[71] In January 2021, the third component funded by SIDA – SAFE Campaigns, delivered by PSI – was formally decoupled from the SAFE programme. However, the other two components are expected to coordinate and engage with them as external partners working within the GBV sector in Zimbabwe.
[72] CEDAW General Recommendation 19

Addressing GBV has come with its challenges, including a lack of evidence-based research to inform interventions. Other challenges include persisting barriers to women reporting cases of GBV. In 2020 a CEDAW report revealed the increase of GBV cases reported to the Zimbabwe Republic Police (ZRP) and handled by the National Prosecuting Authority (NPA) from 2012 -2016. Although reports increased, the number of cases withdrawn at the request of the survivor also increased during that period.[73] The government of Zimbabwe noted that the persistence of negative traditional, cultural and social norms had impeded efforts to reduce GBV.[74]

IPV in Zimbabwe

IPV is one of the most common forms of violence against women, including in Zimbabwe, and includes physical, sexual, economic, and emotional abuse by an intimate partner. IPV occurs amongst all socio-economic, religious and cultural groups and consequences of IPV include negative physical and mental health impacts.[75]

The Zimbabwe Demographic and Health Survey (ZDHS) conducted in 2015 found that 45% of ever married women aged 15-49 had experienced any type of IPV in their lifetime, and the prevalence of past 12-month IPV was 30%. The survey also found that physical and emotional IPV are the most common forms of IPV in Zimbabwe.[76] Reports by civil society organisations reflect that IPV is one of the most prevalent forms of GBV. In 2019, the Musasa Project alone recorded 32,344 cases of GBV; one of the most common types was IPV.[77]

Child marriage in Zimbabwe

Over the past five years, there has been a large focus on ending child marriage[78] in line with the Sustainable Development Goals[79][80] and the Marriages Bill and Child Justice Bill, which states that the age of marriage for both boys and girls is 18.[81] However, child marriage continues to be highly prevalent in Zimbabwe. In the 2019 MICS study, one in three women aged 20-24 reported that they married before the legal age of 18 and 5% married before the age of 15.[82] The study also found that child marriage was more common in rural areas and among women with low educational attainment or who were poor. the Marriages Bill and Child Justice Bill, which states that the age of marriage for both boys and girls is 18.

COVID-19 and GBV in Zimbabwe

GBV has become further exacerbated by the COVID-19 pandemic. Analysis by UN Women revealed that GBV cases globally increased during lockdowns from one in three women to two in three women.[83] In Zimbabwe, cases also increased: the Musasa Project, for example, recorded 7.342 cases during the period April to June 2019 and recorded 10.892 cases for the same period in 2020, when the country was in lockdown.

The increase in GBV cases was due to a number of factors; for example, the hard economic conditions that exacerbated IPV, and women and girls being confined at home with perpetrators and unable to access assistance. The declaration of the COVID-19 pandemic in Zimbabwe led to a national lockdown in March 2020, which disrupted all non-essential services. As GBV services are not considered essential services, this severely limited GBV service provision and hindered women's access to services.

1.2.2. SAFE Communities intervention (Component 1)

SAFE Communities will implement an adapted Gender Action Learning System (GALS) model[84], coupled with Village Savings and Loans Associations (VSLAs) and Internal Savings and Lending Schemes (ISALs). In Chiredzi, the programme will also layer GALS onto a cash transfer intervention implemented under the World Food Programme's (WFP) Zimbabwe Humanitarian and Resilience Programme (ZHARP).

[73] Zimbabwe CEDAW report 2020 Cases withdrawn by survivor at ZRP and NPA increased from 2012 -2016 with 5714 cases withdrawn at ZRP in 2012 and 9903 in 2016 and 1209 cases withdrawn by survivor at court in 2012 and 1944 in 2016.
[74] Zimbabwe Report on the Beijing Platform for Action +25
[75] WHO 2012,Understanding and addressing VAW ,Intimate Partner Violence WHO web site http://www.who.int/about/licensing/copyright_form/en/index.html)
76 Zimbabwe National Statistics Agency and ICF International (2016) Zimbabwe Demographic and Health Survey 2015: Final Report. Rockville, Maryland, USA: Zimbabwe National Statistics Agency (ZIMSTAT) and ICF International.
[77] Musasa Project Annual Report, 2019
[78] For more detailed information on commitments made by Zimbabwe, see https://www.girlsnotbrides.org/child-marriage/zimbabwe/
[79] SDG 5 Gender Equality target 5.3 ending child marriages
[80] S78(1) of the Constitution of Zimbabwe[Chapter 20]
[81] S78(1) of the Constitution of Zimbabwe[Chapter 20]
[82] Zimbabwe National Statistics Agency (ZIMSTAT) (2019) Multiple Indicator Cluster Survey 2019, Snapshots of Key Findings. Harare: ZIMSTAT.
[83] https://www.unwomen.org/en/news/in-focus/in-focus-gender-equality-in-covid-19-response/violence-against-women-during-covid-19
[84] GALS (Gender Action Learning System) is a community-led empowerment methodology that uses principles of inclusion to improve income, food and nutrition security of vulnerable people in a gender-equitable way. It positions poor women and men as drivers of their own development rather than victims, identifying and dismantling obstacles in their environment, challenging service providers and private actors. It has proven to be effective for changing gender inequalities that have existed for generations, strengthening negotiation power of marginalized stakeholders and promoting collaboration, equity and respect between value chain actors. (Oxfam Novib, 2014)

SAFE Communities' core objective is to reduce the prevalence of GBV, in particular IPV, driven by economic insecurity and social norms operating at household-level in focal communities. A secondary objective of the programme will be to address the tolerance of child marriage and other forms of violence.

The **prevention** approach will be framed as a family well-being programme, using gender transformation and economic empowerment approaches, which operate at both household and community levels. To achieve this, SAFE Communities will adopt and adapt the current GALS model to make it more explicitly GBV-prevention focussed, using the evidence from other combined social and Economic Empowerment (EE) models tested under the FCDO funded 'What Works to Prevent Violence Against Women and Girls' Programme, while maintaining its overall simplicity.

In relation to GBV **response**, the SAFE Communities intervention package will include activities to improve both the accessibility and quality of GBV services in focal districts. The programme anticipates an integration of its prevention and response activities, applying the GALS model to identify barriers to accessing services, providing for the referral of women moving out of shelters and into EE initiatives, alongside developing and implementing interventions to strengthen accessibility to services through accompaniment interventions or support to safe spaces. SAFE Communities' intervention will also incorporate other forms of support that target the quality of GBV services, and these will be identified during further planned mapping of existing GBV services in each district.[85]

1.3. Research Aim and Objectives

The SAFE ELU's overarching evaluation has three objectives:

1. The **learning** component of the evaluation design will focus on informing programme design, learning about what is working (and not working), and why, and informing subsequent programme adaptation, during both the inception and implementation periods.
2. The **impact** component of the evaluation design will seek to test and validate the intervention model through the measurement of its impact on violence against women and girls and on primary and intermediate outcomes in the SAFE theory of change and understand why impact has occurred or not.
3. The **scale up** component of the evaluation design will seek to understand possibilities for scaling up the SAFE intervention if it is observed to be effective and impactful.

The baseline study contributes to two of the ELU evaluation objectives (the learning and impact objectives) through the aims presented in Table 1. Although the ELU will not conduct a final quantitative impact assessment, we will measure impact qualitatively, including how and why change happens, during the lifetime of the contract, through a qualitative longitudinal cohort study.

Table 1. Mapping of baseline research aims against ELU evaluation objectives

SAFE ELU Evaluation objectives	Research aims
Learning	• To provide a 'snapshot' of the intervention context that can be used by the SAFE Communities programme to inform the learning and adaptation of the SAFE intervention.
Impact	• To provide a comprehensive quantitative baseline dataset against which a future impact evaluation[86] could measure the impact of the SAFE Communities intervention against its theory of change.

To achieve the aims presented in Table 1, the study has five objectives. Namely, to understand:

1. The demographic break-down and economic context of the intervention population at the household level.
2. The prevalence of risk factors for and attitudes towards different forms of GBV among beneficiaries participating in the SAFE Communities intervention in target wards and districts, and how these vary across demographics and other characteristics.
3. The household dynamics among SAFE beneficiaries, including decision making, gendered division of labour, economic planning, and forms of communication and conflict resolution.
4. The environment related to GBV response, including help seeking behaviours among survivors of GBV, barriers to help seeking and access to services, and beliefs and actions related to supporting survivors to seek help.
5. Which other similar interventions are being implemented in SAFE Communities target districts and the national level frameworks and strategic plans that this intervention should align with and contribute to.

[85] SAFE refined designs options, April 2021
[86] As discussed above, the ELU will not conduct a quantitative impact evaluation, but a future impact evaluation may be contracted separately by FCDO. This evaluation will be able to draw from the data collected in this baseline study to assess impact.

In doing so, the study will explore the differences in the findings across the SAFE intervention districts. The study will pay particular attention to the heterogeneity of experiences between target beneficiaries of the SAFE Communities intervention in rural and urban areas, in different relationship types, and between beneficiaries with and without disabilities.

The baseline study will be a mixed-methods study with qualitative and quantitative components.

Baseline quantitative component (survey)

The quantitative component will contribute to the ELU's learning objective within the evaluation design by providing a 'snapshot' of the intervention context that can be used by SAFE Communities to inform the learning and adaptation of the intervention. It will also contribute to the impact objective by providing a comprehensive baseline dataset against which a future impact evaluation could measure the impact of the SAFE intervention against its theory of change.[87] Specifically, the baseline study will measure indicators that would enable an endline assessment to measure whether the programme resulted in a reduction of IPV and other forms of GBV, and outcomes and intermediate outcomes targeted by the programme. This would also allow a future study to interrogate change pathways articulated in the SAFE Communities' theory of change and to test the assumptions that underpin them. Participants will be tracked and may be recontacted towards the end of the programme if a future quantitative impact assessment is commissioned by FCDO.

Baseline qualitative component (interviews)

Key Informant Interviews (KIIs) with key stakeholders at the community, district and national level, will complement the data from the quantitative component. In particular, this component will contribute to the ELU's learning objective by complementing the 'snapshot' provided by the quantitative component.

1.3.1. Study questions to be addressed through the study

The study will be guided by seven study questions, which have been devised in consultation with SAFE Communities and the FCDO. These research questions both respond to the study objectives outlined above and contribute to the overarching SAFE ELU evaluation and learning questions, which all ELU activities contribute towards answering.

Table 2 below presents the overarching study questions and shows which of the overarching evaluation and learning questions each of the study questions align with. Annex 6 presents the evaluation framework, which contains a more comprehensive mapping that includes the sub-study questions that form the basis of the data collection instruments. Please note that the questions presented below are not final and may be adapted to reflect developments in the SAFE theory of change.

Table 2. Mapping of study questions against SAFE Evaluation and Learning questions

Study questions	Corresponding ELU E&L questions
1. What are the key household, couple and individual characteristics and dynamics of SAFE Communities beneficiaries?	• What are risk factors and high-risk populations for experience and perpetration of GBV? • What are the key drivers of GBV in Zimbabwe (social norms, poverty, religion, etc.) to inform SAFE programme design and delivery? • Is SAFE reaching its target audience? Who changed – did it reach those women and girls most at risk of experiencing violence / those men and boys most at risk of perpetrating violence? • To what extent does the SAFE theory of change hold and what (if any) modifications to the programme are required?
2. What is the prevalence of different types of GBV among SAFE Communities beneficiaries?	• What are the key drivers of GBV in Zimbabwe (social norms, poverty, religion, etc.) to inform SAFE programme design and delivery? • To what extent does the SAFE theory of change hold and what (if any) modifications to the programme are required? • How effective is the SAFE model in preventing GBV, particularly IPV? • How far has SAFE reduced prevalence of GBV and changed attitudes, practices and underlying norms related to GBV in communities where it operated?
3. What are the prevailing attitudes towards GBV, including GBV	• How far has SAFE reduced prevalence of GBV and changed attitudes, practices and underlying norms related to GBV in communities where it operated?

[87] The ELU has not been contracted to quantitatively measure impact at endline. An endline impact evaluation may still take place but this would be contracted by FCDO independent to the ELU contract.

Study questions	Corresponding ELU E&L questions
response, among SAFE beneficiaries?	
4. What are the most significant risk factors for GBV among SAFE beneficiaries?	• What are the key drivers of GBV in Zimbabwe (social norms, poverty, religion, etc.) to inform SAFE programme design and delivery? • To what extent does the SAFE theory of change hold and what (if any) modifications to the programme are required? • How effective is the SAFE model in preventing GBV, particularly IPV?
5. How does the SAFE Communities intervention align with or respond to national-level efforts to reduce GBV in Zimbabwe?	• **To what extent are the community-level activities coherent with national-level efforts to reduce GBV?**
6. What existing activities related to economic drivers of GBV or GBV prevention and response are there in the SAFE intervention districts and wards? To what extent are SAFE activities coordinated with these?	• To what extent are the activities of the SAFE programme coordinated with other GBV prevention and response activities in Zimbabwe? • How far has SAFE reduced prevalence of GBV and changed attitudes, practices and underlying norms related to GBV in communities where it operated?
7. To what extent do the TOC assumptions hold? What are potential barriers and how can the programme address these?	• To what extent does the SAFE theory of change hold and what (if any) modifications to the programme are required?

1.3.2. Intended use of this study

The primary audience for these products is the SAFE Communities and FCDO teams. The primary use of the study will be to inform SAFE Communities' intervention planning and adaptive management. The secondary audience of the study would be an evaluation team commissioned to complete an endline impact assessment upon the intervention's completion. This study could also be used by other organisations that were planning similar interventions to help to avoid duplication of research efforts, if applicable.

Further dissemination opportunities will be considered upon the research findings becoming available. These opportunities will be discussed collectively with the SAFE Communities team and other relevant stakeholders, including the FCDO and Q Partnership (the ELU's local research partner) to ensure a coordinated approach to research uptake and dissemination. Such opportunities may include, for example, developing a summary brief (depending on the interest from relevant stakeholders such as the Ministry of Women Affairs, Community, Small and Medium Enterprises Development (MWACSMED), FCDO Zimbabwe and CSOs working on GBV within Zimbabwe) to highlight and share top-level findings.

The SAFE ELU team will ensure that all communication and dissemination is aligned and coordinated with the programme's research uptake and dissemination plans.

1.4. Scope of work

The study will measure impact, outcome and output indicators according to the SAFE theory of change in each of the three intervention districts of the programme (Chikomba, Mwenezi and Chiredzi).

The study will sample from two of the intervention cohorts, which will be more representative of the total beneficiary group than sampling from one cohort. It will draw from Cohort 1, which is expected to commence in October 2021 in Chiredzi and in November 2021 in Mwenezi and Chikomba, and from Cohort 2, which is expected to commence in June 2022 in all three districts.

In line with the SAFE theory of change, and expected results of the intervention, the study will measure different types of GBV. There will be a specific focus on IPV, including physical, sexual, emotional and economic IPV.[88] However, we will also measure other forms of GBV, including the prevalence of women's experience of non-partner sexual violence

[88] There are four main types of IPV:
- Physical IPV refers to physically hurting or attempting to hurt a partner by slapping, hitting, kicking or beating them, or using any other kind of physical force.
- Sexual IPV refers to coerced or forced sexual intercourse or other types of sexual acts.
- Psychological or emotional IPV refers to any kind of verbal insult, abuse or humiliation, and intimidation or threats of harm.
- Economic IPV refers to controlling a partner's ability to access and use economic resources and putting at risk their economic security and self-sufficiency.

(quantitative component), women's experiences of physical violence from other household members (quantitative and qualitative components) and women's (and their male partner's) perpetration of physical violence/punishment against children in the household (quantitative component). Although the SAFE intervention's emphasis on targeting early marriage is less significant than its emphasis on targeting other forms of GBV, the study will measure beliefs and norms related to early marriage of girls.

Selection of districts by the SAFE programme was based on qualitative district entry mapping research conducted by SAFE Communities in February, March and April 2020 (for Mwenezi and Chikomba) and in 2021 (for Chiredzi), including consultative workshops and key informant interviews in each of the districts. The research includes mapping of types of violence as well as GBV response and prevention services and similar interventions to map and understand the existing GBV prevention and response actors, interventions, and services in the respective districts, identify where gaps and challenges exist, and inform the selection of implementing partners and specific wards where the SAFE programme will be implemented. It also considered the potential for learning opportunities, rural/urban context, the risk of politicisation in the lead up to elections, the beneficiary profile, transaction costs and potential partnership opportunities. Three districts were subsequently selected by SAFE Communities for programme implementation, and the ELU purposively sampled these districts for the baseline study. An overview of the findings of the qualitative mapping exercise is provided below:

Chikomba district

- There are inadequate resources for awareness raising efforts in the community. Very few NGOs and other CSOs work on targeted GBV programmes in the district.
- There is limited GBV response and prevention capacity amongst existing partners.
- Prevention interventions are not always implemented over a sufficiently long period and therefore not always effective. There is need for longer-term programmes with more prolonged strategies for behaviour change, sustained by community ownership.
- The district is diverse in terms of religious and cultural practices - one-size fits all programming does not work and interventions need to take into consideration ward-levels dynamics.

Mwenezi district

- Mwenezi is a large district and with limited accessibility and availability of GBV prevention and response services, mainly because of long travel distances and bad terrain. There is an inadequate support to community structures because of the lack of resources.
- The district has very few GBV partners and most have limited capacity. For instance, there are few NGOs implementing GBV prevention programmes in the district and the coverage is still low (5 wards out of 18). in terms of response services. Geographical barriers hamper access to services, including HIV testing and counselling.

Chiredzi district

- Chiredzi has a moderate to high prevalence of GBV and is not yet saturated with GBV response and prevention services.
- Working in Chiredzi allows SAFE to partner with the Zimbabwe Humanitarian and Resilience Programme (ZHARP), implementing their intervention in conjunction with ZHARP's humanitarian cash transfers. This combined intervention would provide great opportunities for learning.
- Chiredzi provides a range of contexts that could be valuable for learning, including settings that are agriculturally based and vulnerable to economic crisis and unpredictable climatic conditions, and which have high levels of migration and wards that experience similar drivers of IPV and child marriage.

2. Methods

2.1. Approach

The study will be a mixed-methods study that draws on a combination of primary and secondary data (with a stronger focus on primary data collection). It will be a large quantitative study, supplemented by a small sample of key informant interviews (KIIs). As part of the quantitative component, we will conduct 1,200 household surveys with women across the three implementation districts (see Section 2.2.1 for sampling approach and breakdown). The qualitative component will supplement this data collection with 15-20 KIIs with stakeholders from relevant organisations such as Civil Society Organisations (CSOs) and Women's Rights Organisations (WROs) working on similar programmes in the intervention districts, as well as representatives from local councils.

Table 3 below maps out the baseline research questions against the two primary data sources of the study to show how these will combine, to illustrate the purpose and complementarity of the research methods.

Table 3. Mapping of study questions against primary data sources

Baseline study question	Household survey (quantitative)	Key informant interviews (qualitative)
1. What are the key household, couple and individual dynamics and characteristics of SAFE Communities beneficiaries?	✓	✓
2. What is the prevalence of different types of GBV among SAFE-Communities beneficiaries?	✓	
3. What are the prevailing attitudes towards GBV among SAFE beneficiaries?	✓	
4. What are the most significant risk factors for GBV in SAFE target wards?	✓	✓
5. How does the SAFE Communities intervention align with or respond to national-level efforts to reduce GBV in Zimbabwe?		✓
6. What existing activities related to economic drivers of GBV or GBV prevention and response are there in the SAFE intervention districts and wards? To what extent are SAFE activities coordinated with these?		✓
7. To what extent do the TOC assumptions hold? What are potential barriers and how can the programme address these?	✓	✓

Specific research activities will include:

- **Design research methodology**, including sampling approach and data collection instruments to be used in three focal districts (see Annexes 2A-4B for draft data collection instruments, in English and Shona).
- **Obtain ethical approval from appropriate bodies,** including the Medical Research Council of Zimbabwe (MRCZ) and the Research Council of Zimbabwe (RCZ).
- **Review of secondary data,** using relevant existing data sources to inform the research methodology and complement primary research.
- **Conduct qualitative and quantitative primary research** in three districts, based on the agreed methodology and data collection instruments. This will include 1,200 household surveys with women and 15-20 KIIs with key stakeholders.
- **Systematically analyse, triangulate and synthesise data collected in each district and prepare reports** that present findings against the key study questions and key trends. The report will include findings of the comparative analysis across districts and, where relevant, any other useful comparisons.
- **Validate the findings of the research** with the wider SAFE team for discussion before the finalisation of the report.

2.2. Methodology

As outlined in the preceding section, the baseline study will draw from primary data collected through quantitative research methods (household surveys) as well as qualitative methods (KIIs). It will also include a review of secondary data to inform the study design and to substantiate the findings. Each data source is explained in turn below.

2.2.1. Research methodology

Household survey – we will conduct 1200 household surveys with women aged 18 years and over in SAFE Communities' implementation districts and wards. We will not sample children given that SAFE beneficiaries enrolled in the intervention are expected to be adults, and also due to the ethical challenges of collecting data with children on sensitive topics related to experience of violence. We will not sample men for a number of reasons. At the time of fielding the baseline data collection, while SAFE will have recruited women into the intervention, it is unlikely that their

male partners (or other male household members) will have been recruited. This poses methodological challenges as male partners of female beneficiaries may not go on to participate in the intervention, limiting the ability of the baseline survey to sample male beneficiaries of GALS. There are also ethical implications of sampling men for the baseline survey given the sensitive nature of the baseline survey questions, and the heightened risk of male backlash IPV or other forms of violence against women. By sampling women only for the baseline, we will not be able to quantitatively measure risk factors for men's perpetration of violence. Nor will we be able to quantitatively measure baseline outcomes and impacts for men, limiting a quantitative endline impact assessment only to impacts and outcomes among women. However, these issues can still be explored through the qualitative component (IDIs in particular), which will sample women from the baseline and, where relevant, their male partners. Further, an endline impact evaluation contracted separately by FCDO will focus on measuring the impact statement of the theory of change (reduction in IPV), and this is best measured through women's reported past 12 month experience of IPV rather than men's reported past 12 month perpetration of IPV.

The survey will include questions about:

- T**he socio-demographic profile of households**. Characteristics include household size, number of children in the household, household income and economic status, access to resources and assets and household food security. In addition, participants will be asked about their perceptions of their family's quality of life drawing from the Family Quality of Life Scale (FQLS).
- **The socio-demographic profile of individual respondents**, including age, disability status, educational attainment, marital and family status, and individual economic characteristics including participation in income generating activities, access to savings and loans and participation in household decision making. This also includes age at first marriage, educational and literacy level and disability status. Disability status will be measured using the Washington Group on Disability Statistics short set of questions.
- **Individual attitudes** related to gender equality, acceptability of GBV, the justification for and tolerance of GBV and help seeking will be measured through attitudinal scales, which include the Gender Equitable Men Scale (GEMS), and the DHS set of questions on justification for physical IPV. Questions related to attitudes about early marriage have also been included in the survey, drawing from recommended global indicators.
- **Help seeking behaviours and access to services** for women who report having experienced GBV in the past 12 months will be measured through a number of sources, including items adapted from the WHO multi-country study on women's health and domestic violence, and the DHS domestic violence module.
- **Household decision making** will be measured through items on women's participation in decision making about important household decisions (i.e., herself, her partner, herself jointly with her partner), derived from the Demographic Health Survey (DHS). Additional questions aimed at understanding women's role in negotiating decision making have been derived from the Women's Empowerment in Agriculture Index (WEAI).
- **Gendered household roles and responsibilities** will be measured through an adaptation of the IMAGES survey on gendered division of household labour.
- **Additional known risk factors for IPV** beyond those demographic measures identified above for participants, will also be measured. These include:
    - Male partner's alcohol use and severity of alcohol use (adjusting the Alcohol Use Disorders Test (AUDIT)).
    - Childhood experience of violence
    - Participation in transactional sex or sex work
    - Self-reported depression or anxiety, drawing from additional items from the long version of the Washington Group disability questions.
- **Past 12-month prevalence of IPV experience** will be measured, including severity of IPV. Prevalence of IPV experience will be measured by using the corresponding set of questions on physical, sexual and emotional IPV in the WHO multi-country study on women's health and domestic violence and supplemented with additional questions on economic IPV developed and used in FCDO's What Works to Prevent Violence Against Women and Girls Global Programme. Additional questions will be asked to establish whether the IPV occurred in the last month.
- **Past 12-month prevalence of non-partner sexual violence (NPSV) experience** will be measured through items derived from FCDO's What Works to Prevent Violence Against Women and Girls Global Programme.
- **Communication and conflict resolution** between women and her male partners and/or other household members will be measured through a number of items and scales, including the negotiation sub-scale of the Conflict Tactics Scale, and a vignette related to communication in conflict resolution developed from couples curricula from which SAFE training content will be derived.

- **Perceptions of the prevalence of early marriage** in the community and norms and beliefs around early marriage.
- **Exposure to other GBV interventions or programming** in target districts and wards.

Household surveys will be undertaken by our research partner, Q Partnership, in Zimbabwe. This will be subject to national and international guidance concerning research activities during the COVID-19 pandemic.

Key informant interviews (KIIs) – we will also conduct 15-20 key informant interviews with key stakeholders at the community, district and national level. The primary focus of these interviews will be to understand which other similar interventions are being implemented and which coordination mechanisms exist that SAFE-Communities could link into. These interviews will also seek to understand the national level VAWG framework and any associated policies and/or action plans to help inform SAFE-Communities' programming decisions so that they can optimise their coherence with other local and national strategic priorities and initiatives. In-person KIIs will be carried out by our in-country SAFE ELU Deputy Team Leader, who is a Co-Investigator for this submission. This will be subject to national and international guidance concerning research activities during the COVID-19 pandemic.

The KIIs will include questions about**:**

- Perceptions of GBV prevalence and economic challenges and coping strategies in the intervention wards, districts, and in Zimbabwe more broadly.
- National GBV priorities and objectives, including how these have been affected by COVID.
- Coordination mechanisms at the national, district and ward level, and evidence sharing and uptake.
- Enabling factors and barriers to GBV and economic empowerment programming in the intervention wards, districts and Zimbabwe more broadly, including support from local and national authorities and factors that support or constrain men's and women's engagement.
- Examples of successful and unsuccessful GBV programming, including those that have targeted women with disabilities and non-traditional households, and effectiveness and suitability of intervention types and modes.
- KIIs will be undertaken by our in-country ELU team and will not be affected by national and international guidance concerning research activities during the COVID-19 pandemic as they can be conducted remotely if needed.

Review of secondary data – the study will also draw from secondary data collected by the programme, including from SAFE Communities' formative research and the SAFE ELU's deep dive study on social norms related to IPV and early marriage in Zimbabwe, which will be completed in October 2021. This also includes findings from the SAFE ELU literature review and SAFE Communities literature and evidence reviews conducted early last year. This secondary analysis will complement and build further insight into our baseline findings related to the prevalence of GBV and its drivers. Where relevant, we will also consult with existing publications to verify our findings against established evidence of the prevalence and drivers of GBV in Zimbabwe.

2.2.2. Sampling approach

Sampling for household survey

The 1200 household surveys with women GALS champions will be equally split across Cohorts 1 and 2 and across the three districts, according to the distribution shown in Table 4 below. Equal splits are considered the most statistically efficient way for comparing samples across different cohorts and districts.

An attrition buffer of 20% has been included in our sampling design. This implies that up to 20% of the baseline sample interviewees can be lost while still achieving the target statistical power of our survey. Although we will not be responsible for the endline design and implementation (this will be contracted by FCDO separately), we would recommend that all the drop-out participants are replaced with new participants from the same ISAL or, if not possible, ward area, so the endline sample is of the same size as the baseline sample and of similar composition. Dropouts from baseline can be either included or not at endline, depending on the type of analysis that will be carried out. Usually, dropouts will be treated separately from recontacted participants and will be not included in baseline-to-endline cohort comparisons so as to not bias the sample.

Table 4: Overview of sampling for the household survey: target numbers of completed interviews

	Cohort 1	Cohort 2	Total
Chikomba	200	200	400
Ward 18	40	40	80
Ward 23	40	40	80
Ward 27	40	40	80

Ward 28	40	40	80
Ward 29	40	40	80
Mwenezi	200	200	400
Ward 2	40	40	80
Ward 3	40	40	80
Ward 8	40	40	80
Ward 11	40	40	80
Ward 12	40	40	80
Chiredzi	200	200	400
Ward 3	50	50	100
Ward 4	50	50	100
Ward 5	50	50	100
Ward 8	50	50	100
Total	600	600	1200

Sampling will follow a two-stage clustered design. The first stage will consist of the random selection of programme VSLAs/ISALs (clusters) within the SAFE wards in the three intervention districts. The second stage will consist of randomly selecting female respondents within the members of the previously selected VSLAs/ISALs.

As intervention design is still underway at the time of writing this proposal, the ELU is considering two design options at this stage (see table 5). SAFE ELU will select an option once the programme intervention design is finalised and relevant details are confirmed, including the number of programme VSLAs/ISALs per ward and the expected number of female beneficiaries per VSLA/ISALs.

- **Option 1** would target a cluster size of 10 surveys, which amounts to interviewing 10 female individuals per selected VSLA/ISAL. This would imply sampling eight VSLAs per target ward in Chikomba and Mwenezi and 10 VSLAs per target ward in Chiredzi.
- **Option 2** would target a cluster size of 20 surveys, which amounts to interviewing 20 female individuals per selected VSLA/ISAL. This would imply sampling four VSLAs per target ward in Chikomba and Mwenezi and 5 VSLAs per target ward in Chiredzi.

From a design perspective, options 1 and 2 only differ in cluster size and number of clusters (the target number of surveys is the same across the two options).

The two options, however, differ in their statistical power. Under the assumption of a 95% confidence level (alpha error of 5%) and intra-cluster correlation of 20%, the household survey design will allow us to detect differences between districts of a size equal or larger than 0.2 standard deviations in any direction[89], with a statistical power of at least 85% for option 1 and 70% for option 2. The sample will have similar statistical powers when analysing differences between intervention types (merging Chikomba and Mwenezi district samples together and comparing it with the Chiredzi sample). Under the same assumptions, the household survey sample will also be able to detect differences between cohorts with a statistical power of 95% for option 1 and of 85% for option 2.

While option 1 would be the preferable option from a statistical perspective, it would require at least 10 VSLAs/ISALs to be set-up within each of the Chiredzi target wards (five per cohort) and eight VSLAs/ISALs in each ward of the other two districts (four per cohort) by the time fieldwork commences. At the time of writing this proposal, it is unclear if this will be the case. Programme activity sequencing may require the adoption of a hybrid approach; a combination of options 1 and 2, with the aim of maximising the number of VSLAs/ISALs selected within each ward, thereby reducing the cluster size and optimising the statistical power of our sample.

Table 5. Overview of sampling for household survey: options for clustering

	Total number of clusters selected (VSLAs) – Option 1	Total number of clusters selected (VSLAs) – Option 2	Total number of individual surveys
Cluster size	*10 individual surveys*	*20 individual surveys*	
Chikomba	**40**	**20**	**400**
Ward 18	8	4	80
Ward 23	8	4	80
Ward 27	8	4	80

[89] A difference of 0.2 standard deviations is a standard measure of a "small-size effect" according to the widely-adopted guidelines suggested by Cohen (1988). Confidence levels of 95% are the most widely used benchmark in social sciences while a statistical power of 80% or higher is usually considered good practice.

Ward 28	8	4	80
Ward 29	8	4	80
Mwenezi	**40**	**20**	**400**
Ward 2	8	4	80
Ward 3	8	4	80
Ward 8	8	4	80
Ward 11	8	4	80
Ward 12	8	4	80
Chiredzi	**40**	**20**	**400**
Ward 3	10	5	100
Ward 4	10	5	100
Ward 5	10	5	100
Ward 8	10	5	100
Total	**120**	**60**	**1200**

The availability of beneficiary lists from which survey respondents could be drawn at random is still unknown at the time of writing this proposal. If beneficiary lists are available before baseline data collection, the sample of selected women will be drawn according to the design described above. First, the ELU team will randomly select programme VSLA/ISALs; second, beneficiary women will be randomly selected within each VSLA/ISAL previously sampled. If no lists of beneficiaries are available, or if they are deemed incomplete or inaccurate, field supervisors will visit VSLA/ISALs locations at pre-specified dates and times to be agreed with the meeting organisers and implementing partners. Upon arrival, supervisors will create a list that includes the names of all the women participating in the VSLA/ISAL activities. Survey participants will then be randomly selected from this list by supervisors, either using a Kish Grid[90] or picking names from pieces of paper out of a hat or a box.

In the case of COVID-19 restrictions, public and/or private gatherings may not be permitted at the time of fieldwork (see section 2.5.3 for more details). In this case, fieldwork supervisors and enumerators will work with VSLA/ISAL group organisers to contact and make appointments with selected women at different times of the day, so interviews can take place one after the other without participants having to gather at the same time and place. As far as possible, survey interviews will be held in public areas (which could be an outdoor location or building, such as the place where VSLA/ISALs community meetings take place in normal times) rather at participants' homes. At home, participants are more likely to be disturbed and we cannot guarantee their safety and privacy. To allow for an ethical, safe and secure conduct of the interviews, survey enumerators will ensure that survey respondents cannot be heard by other household members or village people.
All beneficiary women identified by the programme will be eligible to be included in the household survey sample, whether they are single, part of female-headed households or have a partner (and whether this partner participates in the GALS programme activities or not). By selecting women at random, the sample will be representative of the entire population of SAFE beneficiaries. Similarly, women from marginalised groups or at risk of marginalisation (widows, women with disabilities, survivors of violence, etc.) will be included in our sample without being considered subgroups as such, as they would not form analytical units of sufficient size from which to draw any statistically meaningful findings.

Sampling for KIIs

Key informants will be selected for interview using a purposive sampling approach. This approach will ensure that we cover key stakeholder groups at the ward, district and national level to comprehensively respond to research questions 5, and 7 (see table 2).

Table 6 below details the stakeholder groups that we will include in our sample, indicative stakeholders for each group and an indicative number of key informants per stakeholder group.

Table 6. Indicative list of stakeholders for KIIs

Locality	Stakeholder group	Indicative organisation	Number of interviews conducted
Ward-level	CBO	• Ministry of Women Affairs, Ward Coordinator • Ministry of Youth Ward Coordinator • Child Care Case Workers	6 (1 per ward)

[90] The Kish grid is a method for selecting members within a household to be interviewed. It uses a pre-assigned table of random numbers to find the person to be interviewed.

Locality	Stakeholder group	Indicative organisation	Number of interviews conducted
		• Health Care Workers • School Development Committees	
District level	Local government official	• Ministry of Women Affairs District Development Officer • Ministry of Health District Development Officer • Ministry of Local Government-Gender Focal Person (Rural/Urban Councils each have GFP) • Ministry of Youth District Development Officer • Ministry of Social Welfare District Development Officer • ZRP-Victim Friendly Unit • Ministry of Justice-Magistrate/Area Prosecutor	3 (1 per district)
District level	CSO / NGO	• GBV Cluster coordinated by Ministry of Women Affairs • Plan International • YWCA • JCT • Musasa shelter • Disability Based Organisation	3 (1 per district)
National level	Government official	• Ministry of Women Affairs District Development Officer • Ministry of Health District Development Officer • Ministry of Local Government-Gender Focal Person (Rural/Urban Councils each have GFP) • Ministry of Youth District Development Officer • Ministry of Social Welfare District Development Officer • ZRP-Victim Friendly Unit • Ministry of Justice-Magistrate/Area Prosecutor	Up to 3
National level	NGO / WRO / CSO	TBC	Up to 3

2.2.3. Tracking approach

In line with its longitudinal approach, the ELU will use a comprehensive tracking system to enable follow up of respondents at endline. For the quantitative component (survey), each respondent will be given a unique numerical identifier. Enumerators will generate the unique ID prior to conducting each survey, for instance, with six digits based on three levels: (1) Enumerator ID number (e.g., 15), (2) Ward number (e.g., 05), and (3) a number indicating the ordering of the participant (e.g., 02 for the 2nd participant the enumerator has interviewed in that ward). In this case, the unique ID would be 150502.

The tracking system will include recording full details of participants during baseline data collection, including (for each unique numerical identification code): participant's name, address and phone number. These details will be recorded separately to any data collected and only unique identifiers will be recorded in surveys.

We will use the beneficiary lists provided by the SAFE Communities programme teams to cross-check the personal information provided by participants to the survey teams. We will resolve any inconsistency with the interviewees

themselves before the interview. The participants whose individual information cannot be matched with that provided by the programme teams will not be included in our survey sample.

2.3. Conducting the Research

2.3.1. Fieldwork

Household surveys with beneficiaries will be conducted by our local research partner, Q Partnership, in Zimbabwe. All survey data collection will be subject to travel restrictions and other national and international guidance concerning research activities during the COVID -19 pandemic. Where needed, we will also draw on support from and coordinate with SAFE Communities for sampling purposes. Household surveys will be conducted using tablets. Q partnership's COVID-19 protocols specify that all interviewers will maintain at least 1.5 metres distance, wear and offer interviewees new, unused masks and will adhere to strict handwashing and hygiene protocols.

We understand that study participants may be asked to participate in follow up research, and we will follow several protocols to mitigate against survey fatigue. We will always ask for the respondent's consent at the start of a survey or interview and let them know the expected time that the process will take. We will also ask for consent to contact them in a few years' time to conduct a follow up survey (in case the FCDO contracts an endline impact assessment). Halfway through, enumerators will also check that the respondent does not suffer from fatigue and ask whether they agree to carry on. At the end of the survey, they will ask for the respondent's consent to participate in a follow-up in-depth qualitative interview shortly after the baseline survey (for the qualitative longitudinal cohort study). We will not invite any participants for a follow up interview if they have not given consent to be recontacted. We do not expect survey fatigue to be a problem for possible endline data collection as this is expected to occur up to three years post-baseline (if contracted by the FCDO), which is unlikely to lead to participants' survey fatigue.

Community, district and national level KIIs will be carried out by our in-country SAFE ELU team members.

Qualitative data will be voice recorded and later transcribed and translated into English, when required. In the case that participants do not consent to recording, extensive notes will be taken. All data will be encrypted and stored confidentially, with access restricted to key members of the SAFE team (see 'confidentiality assurances and data protection' section below for more details). Data from the interviews will be coded using a simple coding framework developed to identify key themes.

A debrief between the SAFE ELU team and our local research partner will be held following the completion of qualitative interviews to discuss emerging findings prior to more detailed coding taking place.

Costs, compensations and reimbursements

We will not provide any compensation for respondents' participation; it is understood that participation is on a voluntary basis.

2.3.2. Training and Piloting

Interviewers will be trained by Q Partnership and the SAFE ELU team based in Zimbabwe, with support provided by international SAFE ELU team members joining remotely. This will ensure they are enabled to more effectively probe and elicit responses from participants, therefore making the research more effective. They will also be trained in our safeguarding and ethical safety protocols and policies prior to conducting research (see also 'ethical practices and procedures' section below).

We will conduct pilot surveys and interviews to test the methodology and data collection tools, after which some refinements may be made. Following this pilot, our research partner (Q Partnership) will debrief with the SAFE ELU team to agree on any modifications to the data collection tools.

Given the nature of the study, we will conduct in-person surveys. Collecting data remotely may present significant risks for respondents as it will be difficult to ensure privacy. At the time of writing, Zimbabwe has been placed under restrictions to curb the spike in COVID-cases. If extended, these measures will pose significant risks to data collection (see table 8 for a full risk assessment and mitigation strategies).

A debrief between the SAFE ELU team and our local research partner will be held following the completion of surveys and interviews to discuss emerging findings prior to more detailed analysis taking place.

2.3.3. Data Analysis and Reporting

Coding and analysis

The data collected will be systematically analysed, triangulated and synthesised by the SAFE ELU team. The baseline survey data will be analysed using a number of techniques, including: using frequencies and means to report on individual and household characteristics, prevalence of GBV, attitudinal scales and perceptions of household and family (including couple) dynamics; using bivariate and regression analysis to explore risk factors for women's experience of GBV; and using cross-tabulations and regression analysis to explore linkages between outputs, intermediate outcomes and outcomes in the SAFE theory of change and, thus, test the expected pathways to change.

The qualitative data will be coded using Dedoose software. We will develop a simple data collection and analysis template to gather and synthesise data against the key research questions. The template will be informed by the research questions, and survey and interview guides, and will be used to collate and synthesise findings from both the desk-based review and primary research. We expect to refine and adapt the tool iteratively as we carry out our document review and data collection.

Reporting

Following analysis, the ELU team will deliver a preliminary report after completion of the first round of data collection (Cohort 1) presenting the combined headline findings of the study. Upon completion of the second round (Cohort 2), we will also deliver a comprehensive baseline report, presenting complete baseline findings against the key study questions.

2.4. Ethical Practice and Procedures

2.4.1. Informed consent process

We will adopt the following protocol in order to create a safe research environment and ensure we obtain informed consent from all research participants. The protocol focuses on how to obtain consent and assent when conducting face-to-face interviews.

All participants will be asked if they fully and meaningfully consent prior to an interview or other research activity taking place. The process by which this happens is listed below:

- Interviewer greets participant and makes high-level introduction to put the participant at ease. Note: male participants will be interviewed by men, and women participants will be interviewed by women.
- Interviewer ensures that they have located a private space for the interview prior to speaking to the research participant, which the participant feels comfortable with, preferably the participant's suggestion.
- Interviewer shares a consent form that includes a Plain Language Statement (PLS) for the research with participants (see Annexes 5A-5F). The PLS is written in accessible language and available in both English and Shona. It contains information about the content and purpose of the interview, possible benefits and risks of participation, the anticipated uses of the data, and how data will be stored and kept secure. The PLS uses an accurate description of the research but one that does not put participants at risk by specifically referring to violence.
- Interviewer reads out the content of the consent form for participants. This step is particularly important for participants who are not literate and who cannot read the consent form. However, reading out the content of the PLS for all participants, regardless of their literacy, can help with comprehension and to establish rapport and trust.
- As part of the introduction, interviewers will seek to minimise 'therapeutic misconception' – or the belief among participants that participation in the research will mitigate violence and/or improve their circumstances – by ensuring that the benefits and risks of participation are clearly explained.
- The consent forms include an explanation of the longitudinal nature of the study[91] and that participants may be re-contacted in follow up waves of data collection (see 'ongoing informed consent for follow-up' below). Participants will be asked to consent to this. If they decline, the interviewer will terminate the interview. For the qualitative interviews, women in couples/polygamous unions, will also be asked to consent for the ELU to contact their male partner. If they decline, the interviewer will terminate the interview.
- Interviewer asks the participant if they have any questions and answers these questions accordingly. Interviewer then asks the participant to repeat what they have understood and if this is correct, asks them if they consent to the interview and then to sign the consent form. It is important that the participant understands that it is okay to accept or decline to take part and that they can stop the interview and withdraw their consent at any point during

[91] For the quantitative component, the second wave of data collection will take place in late 2023. In addition, for the quantitative component, FCDO may contract an endline impact evaluation that would sample the same participants as this baseline study.

or after the interview. For participants with limited literacy or who feel uncomfortable signing a written document, a thumbprint will be provided.

- Consent forms are scanned and stored in duplicate in two separate safe storage sites.
- The interviewer reminds the participant that they can ask to terminate the interview at any point and have their data withdrawn, or decline to answer a specific question, and then logs this on the survey script or makes a note of this for qualitative interviews.

Given possible COVID-19 restrictions at the time of fielding the baseline data collection, KIIs are likely to be conducted remotely. Remote data collection is not expected to raise notable ethical issues given that key informants will not be asked to speak about their own experiences of GBV but, rather, reflect on the status of GBV prevention and response interventions at the national, district or community levels. Consent will be obtained verbally over the phone prior to conducting the interviews, in line with the introduction and pre-briefing script in the KII tools (see Annexes 2A-2E).

Ongoing informed consent for follow-up

The consent forms include an explanation of the longitudinal nature of the study, that participants may be re-contacted in follow up waves of data collection and the period of time between these waves. Participants will be asked to consent to this, although they will also be informed that they can withdraw their consent at any time, including at follow up. If they decline, the interviewer will terminate the interview.

Consent procedures will be repeated when tracking and following up participants in the second round of data collection. This is important as, with the passing of time, participants may forget information about the study or about their rights (for instance, to withdraw their participation or refuse to answer particular questions). Further, risks and benefits of participation may change over time. For instance, if information about the topic of a study related to GBV has spread throughout a community in the time since the first round of data collection, women may feel more at risk participating in the study. We will ensure that research participants are provided with multiple opportunities to provide or withdraw informed consent over the period of the study.

2.4.2. Safeguarding and referrals

Safeguarding approach and processes

This section sets out the safeguarding approach, including processes as they will apply throughout the research and evaluation activities. The processes set out below are intended to complement Tetra Tech's Safeguarding Policy[92] and the SAFE Safeguarding Policy[93] by providing additional general guidance and context-specific guidance, including the roles and responsibilities of different staff members.

Safeguarding reporting mechanism

Our safeguarding framework includes robust protocols to monitor and respond to safeguarding risks and is aligned with the SAFE and Tetra Tech safeguarding policies. All of our consultants, subcontractors and researchers are expected to comply with our rigorous safeguarding procedures and researchers will be fully trained in their application before deployment to the field. Researchers will also receive a safeguarding card with key information on how to deal with safeguarding concerns and who to report them to. In case of a safeguarding concern or complaint safeguarding procedures include the following:

- All concerns and allegations of abuse or breach of the Safeguarding or related Tetra Tech policies, whether internal to the research team or external should be reported to the Q Partnership Safeguarding Focal Point in the first instance, to be subsequently passed on the ELU Team Leader as soon as possible and within 24 hours.
- The Q Partnership Safeguarding Focal Point and ELU Team Leader discuss an appropriate response as necessary. Where appropriate, the SAFE Communities focal point will also be informed.
- The first priority will be for the Safeguarding Focal Point to ensure that the vulnerable or affected person by abuse is at no risk of further harm. Depending on the context, this may include for example immediately reporting the incident to the appropriate authorities, or if the alleged perpetrator is a research team member, immediately removing them from their position while the incident is investigated.
- If for any reason, a staff member does not feel comfortable reporting to the Q Partnership Safeguarding Focal Point, they should report their concern directly to the Team Leader or Deputy Team Leader or follow the Tetra Tech whistleblowing reporting procedures[94] within a 24-hour reporting period.

[92] Available at: https://intdev.tetratecheurope.com/wp-content/uploads/2020/07/Safeguarding-Policy.pdf
[93] SAFE Safeguarding Framework, 2020
[94] Available at: https://intdev.tetratecheurope.com/wp-content/uploads/2020/07/Whistleblowing-Policy.pdf

This process is detailed in the Tetra Tech Safeguarding Policy[95] and Whistleblowing Policy.[96]

Table 7: Safeguarding guidance and roles and responsibilities

Team member	Responsibility
ELU Team Leader, Julienne Corboz	Holds the ultimate accountability over the programme, including application and adherence to safeguarding and ethical research protocols, to the FCDO. Available to receive reports of breaches or suspected breaches of the policy if individuals do not feel comfortable reporting concerns to Safeguarding Focal Point.
ELU Deputy Team Leader, Ngoni Marimo	Accountable for safeguarding processes being implemented across the team on a day-to-day basis. Responsible for overseeing integration of safeguarding risks into the risk register and ensuring their mitigation. Available to receive reports of breaches or suspected breaches of the policy if individuals do not feel comfortable reporting concerns to Safeguarding Focal Point.
Q Safeguarding Focal Point, Deborah Barron	Responsible for implementation of and adherence to safeguarding processes in line with this framework and Tetra Tech corporate policies, including through completion of Tetra Tech Safeguarding checklist. Responsible for being the first port of call to receive all concerns and allegations of abuse or breach of the policies (Safeguarding Focal Point). Responsible for escalating any concerns or risks to the Team Leader as appropriate and in line with the reporting process.
All ELU and Q Partnership team members and other staff	Comply with code of conduct, safeguarding and whistleblowing policies and the safeguarding framework. Escalate all concerns as per procedures in line with the reporting process. Act as safeguarding ambassadors for the programme, proactively promoting safeguarding principles.

Reports received by researchers

If a researcher receives or becomes aware of an allegation, suspicion or concern relating to a potential or actual Sexual Exploitation, Abuse and Sexual Harassment (SEAH) incident through a local reporting mechanism, they should not seek further information about the incident, or the persons involved. Instead, they should pass the information (without reading it) through appropriate channels to the Q Safeguarding Focal Point – within 24 hours.

If a researcher receives the report in person, they must tell the informant or the victim / survivor that they are not a Safeguarding Focal Point. They should then follow these steps:

- The researcher should ask the informant or victim / survivor if they need any immediate support – such as protection or medical treatment.
- Explain who the Safeguarding Focal Point is – their name and contact details. If the informant / survivor agrees, they should offer to call the Focal Point immediately so the informant or victim / survivor can speak with them.
- If the Safeguarding Focal Point is unavailable and the informant or victim / survivor wishes to continue speaking with the researcher, they should re-iterate that they are not a Safeguarding Focal Point and that if the informant or victim / survivor wishes to make a report the researcher will need to pass on the information they receive to the Safeguarding Focal Point for appropriate follow up. However, they will only pass on the informant's or victim's / survivor's personal details (or any other identifying information) with their consent – exempting cases that involve children or persons with disabilities who lack capacity to make decisions in their own best interests.
- The researcher should reassure the informant that what they say will remain private and confidential – they will need to take follow up action but unless the informant gives their consent, neither the informant nor the victim / survivor will be identified in any way.
- The researcher must tell the informant that, in the case of children, they cannot make this guarantee of confidentiality as the best interests of the child is the primary consideration. The same applies to cases of adults with impaired decision-making capacities.
- With their informant's / survivor's permission, the researcher should write down the details of what happened, when and where, and who did this.

[95] Available at: https://intdev.tetratecheurope.com/wp-content/uploads/2020/07/Safeguarding-Policy.pdf
[96] Available at: https://intdev.tetratecheurope.com/wp-content/uploads/2020/07/Whistleblowing-Policy.pdf

- The researcher should advise the informant or the victim / survivor what will happen with the report after it is given to the Safeguarding Focal Point, including aspects relating to confidentiality.
- The researcher should not take any further action.

Researchers should keep in mind that:

- It is very important to give the informant support and validation for coming forward, especially if they are the target / survivor of the inappropriate sexual behaviour they are reporting. This might include for example reiterating to the informant:
    - "I'm sorry this happened to you."
    - "No one deserves to be abused."
    - "I'm glad that you were able to tell me this. After we finish speaking, I will provide you with some referrals for where you can receive additional support, if you would like."
- It is not their responsibility to initiate investigations into who the victim / survivor and/or the perpetrator are, or what may have happened.
- If they know the parties concerned, they must under no circumstances speak with them about the report, or even let them know that a report has been made. It is a violation of the Code of Conduct for the researcher to inform anyone against whom a report has been made that they are the subject of such a report. If they do this, they will face disciplinary measures.
- They should not communicate the fact that they received the report, and they should not disclose the contents of the report, to anyone outside of the appropriate channels. In this case, the only appropriate person with whom to communicate is the Q Safeguarding Focal Point who will make an assessment dependent on the nature of the incident about how and when to escalate the report to other channels (such as referral pathways, local law enforcement or other local health services).
- The only exception to this would be a case in which the researcher has reason to believe the victim/survivor is at risk of imminent physical harm and this cannot be immediately discussed with the Safeguarding Focal Point, in which a researcher should report the risk to appropriate local authorities. If urgent medical support is required, this should be sought by the researcher in all cases without disclosing specific details of the incident to the medical authorities above what is required to provide the necessary medical care. Details will be discussed with researchers in initial training, with tailoring to the local context as needed.
- It is not the job of the researcher to assess the veracity of the allegation before forwarding it on to the Safeguarding Focal Point. The researcher must forward all allegations, suspicions and concerns relating to a potential or actual Sexual Exploitation, Abuse and Sexual Harassment to the Safeguarding Focal Point within 24 hours, even if they are not sure that they constitute SEAH. This includes uncertainty as to whether misconduct has taken place and what type of misconduct it might be. This includes both reports of misconduct both within the research team and external to the team.

Types of report

The research team may become aware of an actual or potential case of SEAH through one of many sources:

- A general feedback or reporting box or other mechanism, including a hotline, established by our local data collection partner;
- A referral from the authorities;
- A verbal report from a colleague from one of our suppliers or research partners;
- A verbal report from someone in another organisation;
- The researcher's own observations; or
- The email or phone reporting mechanism;
- The information regarding actual or suspected SEAH may be very detailed or quite vague:
- We may receive very detailed information about a known or suspected SEAH incident, specifying what happened to whom, when and where.
- We may receive vague information about "bad behaviour" or people "feeling uncomfortable" that suggests possible SEAH.

The identities of the parties involved may be known or unknown:

- The identity of the person accused or suspected of perpetrating SEAH may be known or unknown. If their identity is known, this should be communicated when the report is passed to the focal point. If their identity is unknown, as many details as possible should be included (age, height, build, skin colour, ethnicity, clothing, any visible logos on t-shirt, lanyard, cap, tattoos, body marking, etc).
- The identity of the person who may have experienced the potential or actual SEAH may be known or unknown. If their identity is unknown, the report to the Safeguarding focal point should include as many details as possible relating to the victim's / survivor's age, location where the incident may have occurred, roughly when the incident may have occurred, the context in which the incident may have occurred. This is important for two reasons: first, to help locate persons who might require protection and/or survivor assistance; and second, to identify weak points in order to strengthen prevention and mitigation measures.

The report may concern individuals from the evaluation team; implementing organisations; or the community in which the research is taking place:

- Researchers may receive reports of, or become aware of, potential safeguarding concerns involving (a) fellow Tetra Tech or Q Partnership researchers, (b) persons associated with SAFE Communities, or (c) members of the child's family / community.
- At the same time, Tetra Tech or the SAFE Communities may receive reports of, or become aware of, safeguarding concerns involving Tetra Tech researchers.

In either case, the concern must be reported to the designated Safeguarding Focal Point within 24 hours of becoming aware of it, and the person sharing the concern must receive confirmation of receipt within 24 hours. Reports are often made anonymously, and this should be encouraged and allowed.

Referral mechanism for GBV services

Our safeguarding approach also contains provisions for cases in which women disclose having experienced violence (not related to the SAFE programme or staff) and survivors of violence who show distress or re-traumatization as a result of participation in the research. The SAFE research team has an established referral system in place, which consists of information cards with lists of services available in target districts. These include health, psychosocial counselling, GBV, legal and justice services for survivors of violence (see Annex 1B). Research teams will ensure these services are functional before sharing referral information and that the list of services has been updated since the onset of the COVID-19 pandemic to ensure services remain open and available.

Information cards also include other kinds of services unrelated to GBV (e.g. agricultural services, employment services, veterinarian services) to avoid raising suspicions from possible perpetrators of violence who may see information cards. It is possible that some communities may not have accessible VAWG services for survivors. If this is the case, we will develop an alternative approach to providing psychosocial support for survivors who experience re-traumatisation. For instance, research teams could provide transportation costs for survivors to reach a VAWG service provider or psychosocial counsellor.

If survivors wish to access services but are unable to because of lack of transport (e.g., if services are far from communities) or for other reasons, the SAFE team will support them by facilitating transport to services and providing refreshments. We will do this with the support of Musasa, which is a key partner on the SAFE programme, and which has a contract with the SAFE programme to provide transport, accompaniment etc to survivors. Once researchers support survivors to access Musasa facilities, continuity of care will transfer from the research team to Musasa.

It should be noted that the study will not implement any kind of mandatory reporting of cases of violence (not associated with SAFE staff) and will not breach survivors' confidentiality by reporting their cases to services. Survivors' access to services will at all times be through their own choice and consent. However, researchers will encourage survivors to seek assistance through the referral information provided, or directly through SAFE's partner Musasa.

2.4.3. Risks and benefits to participants

There are no direct immediate benefits to participants as a result of their participation in the research. However, there are important medium- and longer-term benefits. The study will produce learning and recommendations for the design and adaptation of the SAFE programme intervention, which will aim to strengthen household economic security, prevent violence against women and girls, and support services for survivors of violence. In the Zimbabwean context of escalating economic insecurity as a result of the COVID-19 pandemic, heightened risk of GBV and stress on GBV services, the benefits of the research, which will inform how the SAFE intervention is shaped and outweigh the low risks posed.

At the broader social level, the research will also benefit other stakeholders, including governmental and non-governmental stakeholders supporting women's rights and the prevention of GBV, through the dissemination of the research findings.

Table 8 below presents a detailed description of the potential risks to participants, assessed seriousness of these risks, the likelihood of these risks occurring and the risk mitigation strategy for each type of risk.

Table 8: Risks and mitigation strategies

Risks	Seriousness	Likelihood	Risk mitigation strategy
Physical risk of COVID-19 infection of research participants and researchers	Moderate	Moderate	The likelihood of research participants or researchers being infected with COVID-19 as a result of participating in or conducting the research is considered moderate. The following risk mitigation strategies will be implemented to protect participants and researchers from COVID-19. • Researchers will explain the COVID-19 protocols (as outlined below) to participants before starting data collection and any participant refusing to follow the protocol will not be sampled for the research. • Researchers will wear masks at all times and will take spare masks for participants and emphasize that all participants must wear a mask for the duration of the interview. Researchers will use hand sanitizer frequently and will take additional sanitizer for participants. • Researchers will take their own temperature at regular intervals during the fieldwork and will stop work immediately and seek medical services if they have a temperature higher than 38 degrees. Researchers will check the temperature of research participants prior to starting an interview and will refer any participants with a temperature higher than 38 degrees to medical services and they will be excluded from the data collection. • Researchers will ensure they maintain a two-metre distance from participants and will avoid physical contact. • Researchers will ensure that spaces where interviews are taking place have had all surfaces cleaned and sanitized and do so before and after each interview.
Physical risk of COVID-19 infection of participants with HIV/AIDs or others who are immunocompromised as a result of participation in the study	High	Moderate	Participants with HIV/AIDS or others who are immunocompromised may be at greater risk of adverse health complications if infected with COVID-19. To mitigate this risk, we will implement the measures presented above. In addition to this, we will implement the following measure, in line with the HIV Prevention Trials Network (HPTN) Ethics Guidance Document (EGD) (February 2020 revised edition): • Researchers will inform participants of the increased risk for those who are immune compromised as part of the consent process and will give participants the opportunity to share their views and preferences. Participants will decide if they want to participate in the research or opt out.
Psychological risk of survivors of violence feeling distressed or reliving trauma	Moderate	Low	Speaking about sensitive topics, including GBV, can be difficult, particularly for survivors of violence, and can lead to distress or re-traumatisation. • Researchers will be trained on identifying signs of distress, and how to handle these cases. Our research partner Q Partnerships, Deputy Team Leader Ngoni Marimo, and GBV Adviser Dorcas Makaza, have years of experience in delivering safety and ethics training to research staff, including on recognising and responding to survivors' trauma and distress. Our team will develop and deliver comprehensive training to ensure risk to survivors is mitigated and disclosures of violence are handled correctly. If distress is observed, researchers will pause the interview or terminate the interview if this is what the participant wants. • The data collection will be led and supervised by Team Leaders who have years of experience working for Q Partnerships on leading research related to violence against women and children. These Team leaders will be mobilised to the field to oversee all data collection and supervise the research team. Researchers/data collectors will be selected through a careful review of CVs and recruitment according to specific criteria, including having: at least one year of experience working on research or programming related to violence against women or children, previous data collection experience, and knowledge of ethics and safeguarding related to working with vulnerable groups (including survivors of violence). • Researchers will be provided with referral information that they will provide to survivors who show distress or who ask for help. This referral information will contain contacts for health, GBV, psychosocial counselling and legal/justice

Risks	Seriousness	Likelihood	Risk mitigation strategy
			services available in the participant's district or ward (see section above on safeguarding and referrals for further details). • If survivors wish to access services but are unable to because of lack of transport (e.g., if services are far from communities) or for other reasons, the SAFE team will support them by facilitating transport to services and providing refreshments. We will do this with the support of Musasa, which is a key partner on the SAFE programme, and which has a contract with the SAFE programme to provide transport, accompaniment etc to survivors. Once researchers support survivors to access Musasa facilities, continuity of care will transfer from the research team to Musasa.
Ethical risk of breach of confidentiality in face-to-face data collection	Moderate	Low	As noted above, confidentiality and privacy are essential when conducting research on sensitive topics such as GBV, particularly for survivors of violence. The risk of breaches of confidentiality when conducting face-to-face interviews is low due to the following risk mitigation procedures. • Researchers will be trained on privacy and confidentiality protocols, including for face-to-face interviews. • Before starting an interview with a participant, researchers will emphasize the importance of conducting the interview in a private location with nobody else physically present or in a location where there is auditory privacy. Researchers will not begin an interview if privacy cannot be ensured and will attempt to find a new location or reschedule the interview. • If at any time the interview is interrupted, researchers will pause the interview until the person has left and privacy can be ensured. Researchers will terminate the interview if privacy cannot be ensured and arrange another time to continue the interview.
Ethical risk of breach of confidentiality if data is lost in the field	Moderate	Low	For qualitative interviews, we will use audio recorders that are password protected. Enumerators are instructed to download the audio onto their laptops (also password protected) as soon as they finish the interview. For surveys, enumerators will use password protected tablets to collect survey data that will be uploaded to a protected server.

2.4.4. Confidentiality assurances and data protection

We have implemented several processes to ensure compliance with our General Data Protection Regulation (GDPR) commitments to the FCDO around the transfer and storing of data. These are mirrored in our consultancy and sub-contractor agreements, which our team have signed up to. All data is stored on our secure drives meeting our stringent requirements around data protection. Audio recordings will be kept in secure storage by our data collection partner in Zimbabwe, Q Partnership.

Further details on this are listed below.

- Data protection – as defined by the Data Protection Act 2018 – involves the secure handling of data and associated data, and the correct level of anonymisation of data sources. In line with this:
- All data will be stored securely in a manner proportionate to the type of participant groups and the volume and the sensitivity of records involved as collation takes place.
- All identifiers (address, telephone and names) will be stored separately and linked by a project key. They will be archived and released for use only for data linkage that has been approved by the participant and relevant ethical bodies (e.g. RCZ), and for re-contact, where permission has been given.
- All identifiers (such as name, date of birth, location) will be removed from all internal analytical products.
- All identifiers and potentially disclosive information (such as unusual combinations of occupation and location) will be removed from external products in a manner proportional to the risk of identification and sensitivity of context; and
- Where vulnerable groups are identified in the population, supervisors will take appropriate steps to ensure that all recording and transmission of information is managed correctly and that any verbatim notes or open-coded information in the relevant records are not transmitted or stored incorrectly – in other words to enforce normal best practice.

With our survey data collection application, COSMOS, data is protected throughout the collection and transfer process, including end-to-end encryption, allowing us to protect sensitive data. The COSMOS software running on survey devices is password-protected. Once survey data has been collected and verified by fieldwork supervisors, it is saved on the device and cannot be modified. Upon network availability, collected data will be automatically uploaded to the secure COSMOS remote database owned and managed by Tetra Tech. For the qualitative data collection, interviews will be audio recorded on password protected audio recording devices and at the end of the day supervisors in the field will upload audio recordings onto our research partner Q Partnership's secure online drive. Once uploaded, the data will be verified by Q Partnership staff in the main office in Harare and backed up on Tetra Tech's secure SharePoint. Once the data has been fully uploaded and backed up, supervisors will be instructed to delete audio files from recording devices.

All notes, audio files, data transcripts and consent forms will be stored in a safe server with access limited to authorised project staff working on the study. Given the longitudinal nature of the study, we will collect contact details for tracking participants. To ensure full anonymity of the survey, the personal characteristics of respondents will be recorded separately on paper, converted into a digital file, and both paper and digital copies will be stored securely by our research partner (in locked cabinets in the case of paper copies, and in password protected files in the case of digital copies). We will separate the contact details from the survey data by using unique IDs for the contact information that will also be used for the survey data uploaded on COSMOS. A separate file mapping the ID to the original identification information will be kept separately in the safe storage site. Transmission between project parties will involve only de-identified data. At the end of the study, all electronic files (and hard copies, where these have been made) will be archived for five years in a secure site. At the end of five years, a decision should be made to destroy the data. If the decision is not to destroy the data, the storage will continue for another five years.

The analysis and interpretation of findings is equally important, and all researchers are ethically obliged to ensure that findings from the research are properly presented and interpreted in the final study report. This means consulting and validating the findings with relevant stakeholders including SAFE Communities, the FCDO and Q Partnership to ensure these are sensitive and appropriate and will not bring about harm to research participants.

Annex 4: Baseline Evaluation Framework

All evaluation activities conducted by SAFE ELU are guided by the following overarching evaluation framework.

Table 1: Baseline evaluation framework

				Approved
OECD-DAC criteria1	**High level evaluation questions (ToR)**	**Sub-questions and learning questions (indicative)**	**Component:**	**Baseline**
			Timescales:	**2021**
Relevance	What are the key drivers of GBV in Zimbabwe (social norms, poverty, religion, etc.) to inform SAFE programme design and delivery? What are the risk factors and high-risk populations of child marriage? What are the links between disability and gender-based violence?	What are key patterns and drivers of GBV, specifically IPV and child marriage? Including: What are the prevailing attitudes, norms, beliefs and behaviours that contribute to child marriage and IPV and prevent help-seeking?		✓
	Is SAFE designed in a way to/ does SAFE address the prevailing attitudes, norms, beliefs and behaviours that contribute to GBV and prevent help-seeking?	To what extent does the SAFE theory of change hold and what (if any) modifications to the programme are required? How and why does change happen (or not happen) as a result of SAFE?		
	Is SAFE reaching its target audience? Who changed – did we reach those women and girls most at risk of experiencing violence / those men and boys most at risk of perpetrating violence?			
Relevance, effectiveness, equity	How appropriate is the SAFE programme's theory of change and is it different in different areas, and for different groups (including assumptions)?	To what extent does the SAFE theory of change hold and what (if any) modifications to the programme are required? How and why does change happen (or not happen) as a result of SAFE?		✓
	What has worked (or not), how and why, and for different target groups (e.g. gender, age, disability)? Why did change occur? what component or element(s) of the intervention caused the change? What else influenced the change? What are the differences across contexts?	How have different enabling and inhibiting factors contributed to and/or limited the achievement of intended and unintended outcomes in different contexts? How and why does change happen (or not happen) as a result of SAFE? How effective is the SAFE model in preventing GBV, specifically IPV and child marriage?		✓

				Approved
OECD-DAC criteria1	**High level evaluation questions (ToR)**	**Sub-questions and learning questions (indicative)**	**Component:**	**Baseline**
			Timescales:	**2021**
	Which interventions have potential to be scaled up further?	What is the scalability of SAFE?		
	What changes could be made to make the SAFE programme more effective and more efficient for different groups i.e. to improve the design and delivery of activities?	To what extent does the SAFE theory of change hold and what (if any) modifications to the programme are required? How and why does change happen (or not happen) as a result of SAFE? How effective is the SAFE model in preventing GBV, specifically IPV and child marriage?		✓
	What unintended outcomes (both positive and negative) are evident as a result of the SAFE programme?	How effective is the SAFE model in preventing GBV, specifically IPV and child marriage?		
Sustainability	To what extent are the outcomes from the programme likely to be sustainable?	What issues affect the sustainability of different activities and what needs to change to ensure the programme can continue to be effective and can be replicated or adapted to achieve the overall outcomes and impact? How effective is the SAFE model in preventing GBV, specifically IPV and child marriage?		
Coherence	To what extent are the community-level activities coherent with national-level efforts to reduce GBV?	To what extent are the activities of the SAFE programme coordinated with other GBV prevention and response activities in Zimbabwe?		✓
			Cross-cutting	Leave No One Behind (disability and HIV)
			Research methods	Primary research: Mixed methods Secondary research
			Key data sources	Literature review

				Approved
OECD-DAC criteria1	**High level evaluation questions (ToR)**	**Sub-questions and learning questions (indicative)**	**Component:**	**Baseline**
			Timescales:	**2021**
				Baseline research

The baseline study was guided by seven research questions, which were devised in consultation with SAFE Communities and the FCDO. These research questions both respond to the study objectives and contribute to the overarching SAFE ELU evaluation and learning (E&L) questions, which all ELU activities contribute towards answering.

Table 2 presents the overarching study questions and sub-questions and shows which of the overarching E&L questions each of the study questions align with. Table 3 maps the overarching study questions against the baseline primary data sources.

Table 2: Mapping of study questions and sub-questions against SAFE Evaluation and Learning questions

Study questions	Study sub-questions	Corresponding ELU E&L questions
1. What are the key household, couple and individual characteristics and dynamics of SAFE Communities beneficiaries?	• What are household and couple socio-demographic profiles and characteristics of SAFE Communities beneficiaries, including household size, economic characteristics and food security • What are individual socio-demographic profiles and characteristics of SAFE Communities beneficiaries, including age, disability status, educational attainment, marital and family status, participation in income generating activities, and access to savings and loans. • What are household and couple dynamics and practices among SAFE Communities beneficiaries, including decision making, gendered division of labour, communication and conflict resolution/management?	• What are risk factors and high-risk populations of IPV? • What are the key drivers of GBV in Zimbabwe (social norms, poverty, religion, etc.) to inform SAFE programme design and delivery? • Is SAFE reaching its target audience? Who changed – did we reach those women and girls most at risk of experiencing violence / those men and boys most at risk of perpetrating violence? • To what extent does the SAFE theory of change hold and what (if any) modifications to the programme are required?
2. What is the prevalence of different types of GBV among SAFE Communities beneficiaries?	• What is the past-12-month prevalence, of GBV experience (among women), including severity of IPV? • Is GBV, including different types of IPV, more prevalent in particular geographical areas? How does prevalence differ across marital and relationship status and type, age groups, disability status, and level of education?	• What are key patterns and drivers of GBV? • To what extent does the SAFE theory of change hold and what (if any) modifications to the programme are required? • How effective is the SAFE model in preventing GBV, specifically IPV? • How far has SAFE reduced prevalence of GBV and changed attitudes, practices and underlying norms related to GBV in communities where it operated?
3. What are the prevailing attitudes towards GBV, including GBV response, among SAFE beneficiaries?	• How do these attitudes differ between men and women? Between respondents in urban and rural areas? And across different age groups, marital and relationship status and type, disability status and level of education? • What different types of attitudes related to GBV are prevalent among SAFE beneficiaries? e.g. justification/tolerance for IPV; acceptance of child marriage; attitudes towards gendered roles and responsibilities in the household?	• How far has SAFE reduced prevalence of GBV and changed attitudes, practices and underlying norms related to GBV in communities where it operated?

Study questions	Study sub-questions	Corresponding ELU E&L questions
	• What are the prevailing attitudes towards help seeking among SAFE beneficiaries? What are the prevailing attitudes and behaviours among survivors of GBV?	
4. What are the most significant risk factors for GBV among SAFE beneficiaries?	• To what extent are known drivers of GBV (e.g., household economic distress, alcohol use, gender inequitable attitudes, childhood experience of violence) associated with women's GBV experience? • How do risk factors differ across marital and relationship status and type, age groups, disability status, and level of education?	• What are the key drivers of GBV in Zimbabwe (social norms, poverty, religion, etc.) to inform SAFE programme design and delivery? • To what extent does the SAFE theory of change hold and what (if any) modifications to the programme are required? • How effective is the SAFE model in preventing GBV, specifically IPV?
5. How does the SAFE Communities intervention align with or respond to national-level efforts to reduce GBV in Zimbabwe?	• What are the relevant legal frameworks and policies that govern GBV programming in Zimbabwe? • Who is responsible for national-level data collection and reporting on GBV, and how can the SAFE programme contribute to this? • How can learning from the SAFE programme contribute to furthering evidence on GBV in Zimbabwe? How can it be applied to other GBV prevention and response interventions in Zimbabwe?	• To what extent are the community-level activities coherent with national-level efforts to reduce GBV?
6. What existing activities related to economic drivers of GBV or GBV prevention and response are there in the SAFE intervention districts and wards? To what extent are SAFE activities coordinated with these?	• What other GBV prevention and response interventions are being implemented in SAFE target districts and wards, including interventions targeting vulnerable populations (e.g., women with disabilities) and non-traditional households (e.g., female headed, polygamous) and those that target social and economic drivers of GBV? • What coordination mechanisms are in place for GBV prevention and response interventions? and for sharing evidence on GBV? • What are barriers to help seeking and access to services? How aware are SAFE beneficiaries of GBV response services? How accessible are these services, including referral processes?	• To what extent are the activities of the SAFE programme coordinated with other GBV prevention and response activities in Zimbabwe? • How far has SAFE reduced prevalence of GBV and changed attitudes, practices and underlying norms related to GBV in communities where it operated?
7. To what extent do the TOC assumptions hold? What are potential barriers and how can the programme address these?	• Are VSALs/ISALs an appropriate vehicle for addressing economic insecurity in the household? Is the programme targeting the right economic activities? • To what extent are men willing to engage in GBV prevention activities? • To what extent does GBV remain a priority in the context of the COVID pandemic? Is there a of risk crowding out? • To what extent are stakeholders in Zimbabwe and elsewhere willing and able to engage with and share learning and evidence with SAFE partners? • What are the main barriers to taking up existing evidence on GBV to scale up and adapt GBV programmes in Zimbabwe? • What are the main barriers to preventing and responding to GBV for key stakeholders in Zimbabwe? • What are examples of successful and unsuccessful approaches to GBV messaging/language at the community level? How do other local GBV interventions avoid interfering in cultural/traditional systems?	• To what extent does the SAFE theory of change hold and what (if any) modifications to the programme are required?

Table 3. Mapping of study questions against rationale and primary data sources

Baseline study question	Rationale for inclusion of question and contribution to evaluation objectives, programme approach and indicators	Household survey (quantitative)	Key informant interviews (qualitative)
1. What are the key household, couple and individual dynamics and characteristics of SAFE Communities beneficiaries?	Contributes primarily to the first evaluation objective, to provide a snapshot of the intervention context. Also contributes to the second evaluation objective, providing a baseline dataset against which an endline could be measured, with a focus on measuring indicators for outcome 1 and outcome 2 in the programme's theory of change.	✓	✓
2. What is the prevalence of different types of GBV among SAFE-Communities beneficiaries	Contributes to the first evaluation objective, to provide a snapshot of the intervention context, by measuring the prevalence of past year IPV. The question also contributes to the second evaluation objective, providing a baseline dataset against which an endline could be measured, with a focus on measuring reduction of IPV as per the impact indicator in the programme theory of change.	✓	
3. What are the prevailing attitudes towards GBV among SAFE beneficiaries?	Contributes to the first evaluation objective, to provide a snapshot of the intervention context. The question also contributes to the second evaluation objective, providing a baseline dataset against which an endline could be measured, with a focus on measuring outcome 3 in the programme theory of change.	✓	
4. What are the most significant risk factors for GBV in SAFE target wards?	Contributes to the first evaluation objective, to provide a snapshot of the intervention context to inform learning and adaptation, in order to understand whether the intervention is targeting the rights risk factors for IPV.	✓	✓
5. How does the SAFE Communities intervention align with or respond to national-level efforts to reduce GBV in Zimbabwe?	Contributes to the second evaluation objective, providing a baseline dataset against which an endline could be measured, by assisting the evaluation team to measure the scalability of the intervention if found to be impactful.		✓
6. What existing activities related to economic drivers of GBV or GBV prevention and response are there in the SAFE intervention districts and wards? To what extent are SAFE activities coordinated with these?	Contributes to the first evaluation objective, to provide a snapshot of the intervention context, by seeking to understand which other GBV prevention programmes are operating in SAFE districts. Also contributes to the second evaluation objective, providing a baseline dataset against which an endline could be measured, by assisting the evaluation team to predict whether any impact observed could be related to other interventions in target locations.		✓
7. To what extent do the TOC assumptions hold? What are potential barriers and how can the programme address these?	Contributes to the first evaluation objective, to provide a snapshot of the intervention context in order to test theory of change assumptions and inform programme learning and adaptations.	✓	✓

Annex 5: SAFE Baseline Survey Tool for Women

Section	Q No.	Question	Response options	Code	Logic skips
Pre-survey information	Note: survey times, dates, device name and GPS coordinates will be recorded automatically by the data collection software.				
	0.0	Respondent ID	_____		
	0.1	District	Chikomba Chiredzi Mwenezi	1 2 3	
	0.2	Ward Number	_____		
	0.3	Village name	_____		
	0.4	Enumerator name	_____		
	0.5	Supervisor name	_____		
Household characteristics		First, I would like to ask you some questions about your household.			
	1.1	How many members of your household are there in total? [insert number of household members]	_____ household members Don't know Refusal	 98 99	
	1.2	How many children under the age of 18 are there living in the household?	_____ Number of boy children _____ Number of girl children Don't know Refusal	 98 99	
	1.3	Is the head of household male or female?	Male Female Don't know Refusal	1 2 98 99	

Section	Q No.	Question	Response options	Code	Logic skips
Household economy	1.4	Does your household have? (multiple responses allowed)	Electricity through interconnected grid Electricity off-grid (generator/isolated system) Radio Refrigerator Television Non-mobile telephone Mobile telephone Bicycle Motorbike/scooter Car Truck Computer Animal-drawn cart	1 2 3 4 5 6 7 8 9 10 11 12 13	
	1.5	Does your household own any livestock, herds, other farm animals, or poultry?	Yes No	1 2	
	1.6	Does any member of this household own any land that can be used for agriculture?	Yes No	1 2	If 2, go to 1.8
	1.7	Who owns this land?	I own the land My partner owns the land My partner and I own the land jointly Another household member owns the land Another household member and I own the land jointly	1 2 3 4 5	
	1.8	Does any member of this household have a mobile phone money account, such as ecocash, telecash, onemoney, etc?	Yes No	1 2	If 2, go to 1.10
	1.9	Who owns this mobile money account?	I own it My partner owns it My partner and I own it jointly Another household member owns it Another household member and I own it jointly	1 2 3 4 5	
	1.10	Does any member of this household have a bank account?	Yes No	1 2	If 2, go to 1.12

Section	Q No.	Question	Response options	Code	Logic skips
	1.11	Who owns this bank account?	I own it My partner owns it My partner and I own it jointly Another household member owns it Another household member and I own it jointly	1 2 3 4 5	
Household food security	1.12	In the past month (4 weeks), did it happen that there was no food to eat of any kind in your house because of lack of resources to get food?	Never Rarely Sometimes Often	0 1 2 3	
	1.13	In the past month (4 weeks), did it happen that you or any household member went to sleep hungry because there was not enough food?	Never Rarely Sometimes Often	0 1 2 3	
	1.14	In the past month (4 weeks), did it happen that you or any household member went a whole day and night without eating anything at all because there was not enough food?	Never Rarely Sometimes Often	0 1 2 3	
Basic needs	1.15	I would like to ask you about your household's ability to meet its most basic needs, such as securing food, paying for housing, hygiene and medical costs, schooling costs for children, or other things that your household sees as its most essential needs. In the past month (4 weeks), to what extent was your household able to meet its most essential needs?	Able to meet all needs Able to meet most needs Able to meet some needs Able to meet very few or no needs Don't know Refusal	1 2 3 4 98 99	
Response to economic shock	1.16	In the last 12 months, has your household experienced any unexpected loss of income or assets?	Yes No	1 2	If 2, go to 1.18
	1.17	What did the household do to compensate for this loss of income and/or assets? (Select up to five things you did to compensate)	Rely on less preferred, less expensive food Borrowed food, helped by relatives Purchased food on credit Consumed seed stock held for next season Reduced the proportion of the meals Reduced number of meals per day	1 2 3 4 5 6	

Section	Q No.	Question	Response options	Code	Logic skips
			Skipped days without eating	7	
			Some household members migrated	8	
			Sold durable household goods	9	
			Sent children to live with relatives	10	
			Married girl(s)	11	
			Removed girl(s) from school	12	
			Removed boy(s) from school	13	
			Reduced expenditures on health and education	14	
			Spent savings	15	
			Gathering food	16	
			Sold or consumed livestock	17	
			Sold agricultural tools, seeds, or other inputs	18	
			Worked for food only	19	
			Sold crop before harvest	20	
			Rented out land	21	
			Sold land	22	
			Borrowed money	23	
			Other	97	
	1.18	If your household had an emergency and needed 10 USD, how easy would you say it would be to find the money?	Very difficult	1	
			Somewhat difficult	2	
			Fairly easy	3	
			Very easy	4	
Family wellbeing		Now I would like to ask you some questions about how satisfied you are with certain parts of your family life. Your family may include different people, such as a partner, parents, parents-in-law, children, aunts, uncles, grandparents. We are interested in knowing about those family members who live in your household. Please think about your satisfaction with your family life over the past 12 months. How satisfied are you that:			
	1.19	Your family enjoys spending time together	Very dissatisfied	1	
			Dissatisfied	2	
			Neither	3	
			Satisfied	4	
			Very satisfied	5	
			Don’t know	98	
			Refusal	99	

Section	Q No.	Question	Response options	Code	Logic skips
	1.20	Your family has the support it needs to relieve stress	Very dissatisfied Dissatisfied Neither Satisfied Very satisfied Don't know Refusal	1 2 3 4 5 98 99	
	1.21	Your family members have friends or others who provide support	Very dissatisfied Dissatisfied Neither Satisfied Very satisfied Don't know Refusal	1 2 3 4 5 98 99	
	1.22	Your family members help the children with schoolwork and other activities	Very dissatisfied Dissatisfied Neither Satisfied Very satisfied Don't know Refusal	1 2 3 4 5 98 99	
	1.23	Your family members talk openly with each other	Very dissatisfied Dissatisfied Neither Satisfied Very satisfied Don't know Refusal	1 2 3 4 5 98 99	
	1.24	Your family members teach the children how to get along with others	Very dissatisfied Dissatisfied Neither Satisfied Very satisfied	1 2 3 4 5	

Section	Q No.	Question	Response options	Code	Logic skips
			Don't know Refusal	98 99	
	1.25	Your family solves problems together	Very dissatisfied Dissatisfied Neither Satisfied Very satisfied Don't know Refusal	1 2 3 4 5 98 99	
	1.26	Your family members support each other to accomplish goals	Very dissatisfied Dissatisfied Neither Satisfied Very satisfied Don't know Refusal	1 2 3 4 5 98 99	
	1.27	Your family members show that they love and care for each other	Very dissatisfied Dissatisfied Neither Satisfied Very satisfied Don't know Refusal	1 2 3 4 5 98 99	
	1.28	Your family has outside help available to take care of special needs of all family members	Very dissatisfied Dissatisfied Neither Satisfied Very satisfied Don't know Refusal	1 2 3 4 5 98 99	
	1.29	Adults in your family teach the children to make good decisions	Very dissatisfied Dissatisfied Neither	1 2 3	

Section	Q No.	Question	Response options	Code	Logic skips
			Satisfied	4	
			Very satisfied	5	
			Don't know	98	
			Refusal	99	
	1.30	Your family gets medical care when needed	Very dissatisfied	1	
			Dissatisfied	2	
			Neither	3	
			Satisfied	4	
			Very satisfied	5	
			Don't know	98	
			Refusal	99	
	1.31	Your family has a way to take care of expenses	Very dissatisfied	1	
			Dissatisfied	2	
			Neither	3	
			Satisfied	4	
			Very satisfied	5	
			Don't know	98	
			Refusal	99	
	1.32	Your family is able to handle life's ups and downs	Very dissatisfied	1	
			Dissatisfied	2	
			Neither	3	
			Satisfied	4	
			Very satisfied	5	
			Don't know	98	
			Refusal	99	
	1.33	Adults in your family have time to take care of the individual needs of every child	Very dissatisfied	1	
			Dissatisfied	2	
			Neither	3	
			Satisfied	4	
			Very satisfied	5	
			Don't know	98	
			Refusal	99	

Section	Q No.	Question	Response options	Code	Logic skips
	1.34	Your family feels safe at home, work, school, and in the neighbourhood	Very dissatisfied Dissatisfied Neither Satisfied Very satisfied Don't know Refusal	1 2 3 4 5 98 99	
		Overall, how satisfied are you with your family relationships with:			
	1.35	Your husband/partner	Very dissatisfied Dissatisfied Neither Satisfied Very satisfied Not applicable (no partner) Don't know Refusal	1 2 3 4 5 97 98 99	
	1.36	Your children	Very dissatisfied Dissatisfied Neither Satisfied Very satisfied Don't know Refusal	1 2 3 4 5 98 99	
	1.37	Other family members living in your household	Very dissatisfied Dissatisfied Neither Satisfied Very satisfied Don't know Refusal	1 2 3 4 5 98 99	

Section	Q No.	Question	Response options	Code	Logic skips
	1.38	Other family members living outside of your household	Very dissatisfied Dissatisfied Neither Satisfied Very satisfied Don't know Refusal	1 2 3 4 5 98 99	
Individual characteristics		I would now like to ask some questions about you.			
	2.1	How old are you? [enumerator instruction: Enter age in years. If the respondent is unable to tell her exact age, ask her if she is closer to 20, 30, 40, 50, 60, 70 or older, and enter the corresponding number.]	_____ years Don't know Refusal	 98 99	
	2.2	What is your religious affiliation?	Traditional Roman Catholic Protestant Pentecostal Apostolic Sect Other Christian Muslim Other None Don't know Refusal	1 2 3 4 5 6 7 8 9 98 99	
	2.3	What is your place of birth?	Zimbabwe Other country (specify) _____ Refusal	1 2 99	If 1 or 99, skip Go to 2.5
	2.4	How long ago did you come to Zimbabwe?	_____ years		

Section	Q No.	Question	Response options	Code	Logic skips
			Don't know Refusal	98 99	
Education	2.5	Have you ever attended school?	Yes No Don't know Refusal	1 2 98 99	If 2, 98 or 99, skip Go to 2.8
	2.6	What is the highest level of school you attended?	Primary Secondary Higher Don't know Refusal	1 2 3 98 99	If 98 or 99, Go to 2.8
	2.7	What is the highest (grade/form/year) you completed at that level? (If completed less than one year at that level, record '00')	Grade/form/year _____ Don't know Refusal	 98 99	
Marriage and relationship status	2.8	Have you ever been married?	Yes No Don't know Refusal	1 2 98 99	If 2, 98 or 99 GO TO 2.11
	2.9	How old were you when you first married?	_____ years Don't know Refusal	 98 99	
	2.10	Did your family receive a lobola or bride price for your first marriage?	Yes No Don't know Refusal	1 2 98 99	
	2.11	What is your current relationship status?	Single Married Boyfriend (cohabiting) Boyfriend (not cohabiting) Widowed Divorced or Separated Don't know	1 2 3 4 5 6 98	If 1, 5, 6, 98 or 99 Go to 2.19

Section	Q No.	Question	Response options	Code	Logic skips
			Refusal	99	If 3 or 4 Go to 2.16
	2.12	If married, is this a civil, customary or religious marriage?	Civil Customary Religious Other (specify) _____ Don't know Refusal	1 2 3 4 98 99	
	2.13	If married, is this a polygamous marriage?	Yes No Don't know Refusal	1 2 98 99	If 2, 98 or 99, Go to 2.16
	2.14	How many other wives does your husband have? (Insert number)	_____		
	2.15	What number wife are you?	First Second Third Other (_____)	1 2 3 4	
	2.16	How old is your current partner?	_____years Don't know Refusal	 98 99	
	2.17	Has your partner been working away from home in the past 12 months?	Yes No Don't know Refusal	1 2 98 99	If 1, Go to 2.19
	2.18	For how many months in the past 12 months has your partner worked away from home?	Less than a month 1-3 months 4-6 months 7-9 months 10 -12 months	1 2 3 4 5	

Section	Q No.	Question	Response options	Code	Logic skips
			Don't know Refusal	98 99	
Children	2.19	Do you have any children?	Yes No	1 2	If 2, GO TO 2.22
	2.20	How many children do you have?	_____ boys _____ girls Don't know Refusal	 98 99	
	2.21	How many of your children live with you in your household?	_____ boys _____ girls Don't know Refusal	 98 99	
	2.22	How many other children live in your household?	_____ boys _____ girls Don't know Refusal	 98 99	
	2.23	How many of the girls in the household who are under the age of 18 have a boyfriend (not married)?	_____ Not applicable (no girls under age of 18) Don't know Refusal	 97 98 99	If 97, Go to 2.25
	2.24	How many of the girls in the household who are under the age of 18 are married?	_____ Don't know Refusal	 98 99	
Early marriage	2.25	What do you think is a good age for a woman or girl to get married for the first time? [enumerator instruction: enter age in number of years]	_____ years Don't know Refusal	 98 99	

Section	Q No.	Question	Response options	Code	Logic skips
	2.26	Would you ever consider a marriage before the age of 18 for one of your daughters? [Even if they do not have a daughter, ask respondent to imagine if they had one]	Yes No Don't know Refusal	1 2 98 99	If 2, 98 or 99, Go to 2.28
	2.27	In which circumstances would you consider marriage for a daughter under the age of 18? [Don't read out and select all that apply]	If she had a boyfriend If she was pregnant If the family/household was having economic problems To collect bride price (lobola) To ensure that she was economically taken care of Other (specify)_____ Don't know Refusal	1 2 3 4 5 6 7 98 99	
	2.28	Do you think your partner would consider marriage for a daughter under the age of 18? [Even if their partner does not have a daughter, ask respondent to imagine if they had one]	Yes No Not applicable (no partner) Don't know Refusal	1 2 97 98 99	If 2, 97, 98 or 99, Go to 2.30
	2.29	In which circumstances do you think your partner would consider marriage for a daughter under the age of 18? [Don't read out and select all that apply]	If she had a boyfriend If she was pregnant If the family/household was having economic problems To collect bride price (lobola) To ensure that she was economically taken care of Other (specify)_____ Don't know Refusal	1 2 3 4 5 6 7 98 99	

Section	Q No.	Question	Response options	Code	Logic skips
	2.30	Approximately how many girls do you think are married before the age of 18 in your community?	None Very few Some Many All Don't know Refusal	1 2 3 4 5 98 99	
	2.31	In your opinion, has the practice of marrying girls before the age of 18 increased, decreased or stayed the same in your community in the last year?	Increased Decreased Stayed the same Don't know Refusal	1 2 3 98 99	
Economic characteristics	2.32	In the last 12 months, have you received any of the following?	Remittances Government allowance (pension, disability benefit) Assistance from charity	1 2 3	
	2.33	Have you participated in any of the following activities over the last 12 months?	Agriculture and sales of crops Livestock and sales of animals Brewing Fishing Unskilled wage labour Skilled labour Handicrafts/artisanal work Use of natural resources (firewood, charcoal, bricks, grass, wild foods, honey, etc.) Petty trading Seller, commercial activity Worked as an employee for salaries, wages Begging Other	1 2 3 4 5 6 7 8 9 10 11 12 97	If no activities, Go to 2.37
	2.34	[For each activity between 1 and 10 selected above] Have you done this work	For family member For someone else Self-employed	1 2 3	

Section	Q No.	Question	Response options	Code	Logic skips
		for a member of your family, for someone else, or are you self-employed?			
	2.35	[For each activity between 1 and 10 selected above] Do you usually engage in this work throughout the year, or do you work seasonally, or only once in a while?	Throughout the year Seasonally/part of the year Once in a while	1 2 3	
	2.36	[For each activity between 1 and 10 selected above] Are you paid in cash or kind for this work or are you not paid at all?	Cash only Cash and kind In kind only Not paid	1 2 3 4	
	2.37	Who usually decides how your earnings will be used?	I decide My partner decides My partner and I decide jointly Another household member decides Another household member and I decide jointly Not applicable (don't earn money)	1 2 3 4 5 97	If 97, Go to 2.41
	2.38	How much input do you have in making decisions about how your earnings will be used?	No input or input in few decisions Input into some decisions Input into most or all decisions	1 2 3	
	2.39	To what extent do you feel you can make your own decisions regarding how your earnings will be used?	Not at all Small extent Medium extent To a high extent	1 2 3 4	
	2.40	Would you say that the money that you earn is more than what your partner earns, less than what he earns, or about the same?	More than my partner Less than my partner About the same Partner has no earnings Don't have a partner Don't know	1 2 3 4 5 98	If 5, Go to 2.44
	2.41	Has your partner engaged in any paid work or productive activities over the past 12 months?	Yes No	1 2	If 2, Go to 2.44

Section	Q No.	Question	Response options	Code	Logic skips
	2.42	Who usually decides how your partner's earnings will be used?	I decide My partner decides My partner and I decide jointly Other	1 2 3 97	
	2.43	How much input do you have in making decisions about how your partner's earnings will be used?	No input or input in few decisions Input into some decisions Input into most or all decisions	1 2 3	
	2.44	Who usually makes decisions about making major household purchases?	I decide My partner decides My partner and I decide jointly Another household member decides Another household member and I decide jointly	1 2 3 4 5	
	2.45	How much input do you have in making decisions about major household purchases?	No input or input in few decisions Input into some decisions Input into most or all decisions	1 2 3	
	2.46	To what extent do you feel you can make your own decisions regarding major household purchases?	Not at all Small extent Medium extent To a high extent	1 2 3 4	
	2.47	Does your household have any savings?	Yes No	1 2	If 2, go to 2.49
	2.48	If yes, where did you put your savings?	In house (in your house or that of a family member/friend) Bank account Credit union ROSCA (Rotating Credit and Savings Association) SACCO (Savings and Credit Cooperative Organization) Other	1 2 3 4 5 97	
	2.49	Who usually makes decisions about how to spend the savings of your household?	I decide My partner decides	1 2	

Section	Q No.	Question	Response options	Code	Logic skips
			My partner and I decide jointly Another household member decides Another household member and I decide jointly	3 4 5	
	2.50	How much input do you have in making decisions about how to spend savings?	No input or input in few decisions Input into some decisions Input into most or all decisions	1 2 3	
	2.51	To what extent do you feel you can make your own decisions regarding how to spend household savings?	Not at all Small extent Medium extent To a high extent	1 2 3 4	
	2.52	In the past twelve months, has your household taken a loan?	Yes No	1 2	If 2, go to 2.56
	2.53	What were the main reasons why you took this/these loan(s)? (Select the most important reasons, with a maximum of three)	Food/household expenses Repaying debts School fees Family celebration/ceremony House improvements Medical fees/health Business activities To buy household assets Emergency/economic shock Other	1 2 3 4 5 6 7 8 9 97	
	2.54	Who made the decision to take this/these loan(s)?	I decided My partner decided My partner and I decided jointly Another household member decided Another household member and I decided jointly	1 2 3 4 97	
	2.55	How much input did you have in making the decision to take this/loan(s)?	No input Some input A lot of input	1 2 3	

Section	Q No.	Question	Response options	Code	Logic skips
	2.56	To what extent do you feel you can make your own decisions regarding taking a loan?	Not at all Small extent Medium extent To a high extent	1 2 3 4	
	2.57	Thinking about the different savings, loans and income generating activities you have engaged in over the last 12 months, how supportive would you say your partner has been of your participation in these activities?	Very supportive Somewhat supportive Somewhat unsupportive Very unsupportive Not applicable, no activities No applicable, no partner Don't know Refusal	1 2 3 4 5 6 98 99	If 5, Go to 2.59
	2.58	And how supportive would you say other household members have been of your savings, loans and income generating activities over the last 12 months?	Very supportive Somewhat supportive Somewhat unsupportive Very unsupportive Don't know Refusal	1 2 3 4 98 99	
	2.59	In the past 12 months, how often have you and your household members worked together to come up with a plan to increase household income or assets?	Never Rarely Sometimes Often Don't know Refusal	1 2 3 4 98 99	If 1, 98 or 99, Go to 2.63
	2.60	Which household members were involved in working together with you to come up with plans? [Don't read out - select all that apply]	Husband/partner Mother/father Mother/father-in-law Son/daughter Brother/sister Other household members Don't know Refusal	1 2 3 4 5 6 98 99	

Section	Q No.	Question	Response options	Code	Logic skips
	2.61	Were any adolescent girls in the household involved in planning?	Yes No	1 2	
	2.62	Would you say that female or male household members have been more involved in planning, or would you say it has been about the same?	Female members more involved Male members more involved About the same Don't know Refusal	1 2 3 98 99	
	2.63	In the past 12 months, has your household agreed on a shared vision for improving family quality of life?	Yes No	1 2	If 2, Go to 2.68
	2.64	Who in your household was involved in agreeing on this shared vision? [Don't read out - select all that apply]	Husband/partner Mother/father Mother/father-in-law Son/daughter Brother/sister Other household members Don't know Refusal	1 2 3 4 5 6 98 99	
	2.65	Were any adolescent girls in the household involved in agreeing on the shared vision?	Yes No	1 2	
	2.66	To what extent do you feel your household has worked towards achieving its shared vision?	Not at all Small extent Medium extent To a high extent	1 2 3 4	
	2.67	Would you say that female or male household members have worked more towards achieving this vision, or would you say it has been about the same?	Female members have worked more Male members have worked more About the same Don't know Refusal	1 2 3 98 99	
Functional difficulties		Now I would like to ask you some questions about difficulties you may have doing certain activities because of a health problem.			

Section	Q No.	Question	Response options	Code	Logic skips
	2.68	Do you have difficulty seeing, even if wearing glasses?	No, no difficulty Yes, some difficulty Yes, a lot of difficulty Cannot do at all Don't know Refusal	1 2 3 4 98 99	
	2.69	Do you have difficulty hearing, even if using a hearing aid?	No, no difficulty Yes, some difficulty Yes, a lot of difficulty Cannot do at all Don't know Refusal	1 2 3 4 98 99	
	2.70	Do you have difficulty walking or climbing steps?	No, no difficulty Yes, some difficulty Yes, a lot of difficulty Cannot do at all Don't know Refusal	1 2 3 4 98 99	
	2.71	Do you have difficulty remembering or concentrating?	No, no difficulty Yes, some difficulty Yes, a lot of difficulty Cannot do at all Don't know Refusal	1 2 3 4 98 99	
	2.72	Do you have difficulty (with self-care such as) washing all over or dressing?	No, no difficulty Yes, some difficulty Yes, a lot of difficulty Cannot do at all Don't know Refusal	1 2 3 4 98 99	
	2.73	Using your usual language, do you have difficulty communicating, for example understanding or being understood?	No, no difficulty Yes, some difficulty Yes, a lot of difficulty Cannot do at all Don't know Refusal	1 2 3 4 98 99	
	2.74	How often do you feel worried, nervous or anxious? Would you say it is:	Daily	1 2	

Section	Q No.	Question	Response options	Code	Logic skips
			Weekly Monthly A few times a year Never Don't know Refusal	3 4 5 98 99	
	2.75	How often do you feel depressed? Would you say it is:	Daily Weekly Monthly A few times a year Never Don't know Refusal	1 2 3 4 5 98 99	
Gender equitable attitudes and justification/ tolerance for VAWG		In this community and elsewhere, people have different ideas about families and whether there are situations where a man can use violence with his partner. In these questions we would like to learn from you what you think about some of these issues. There are no right or wrong answers, please answer honestly. Your answers will not be shared with anyone you know or used publicly.			
		Sometimes a man does not like the things his wife or partner does. I am going to ask you, in your opinion, if a man is justified in hitting or beating his wife or partner in any of the following situations. Please respond if you strongly agree, agree, disagree or strongly disagree with the statements.			
	3.1	A man is justified in beating his wife/partner if she goes out without telling him	Strongly agree Agree Disagree Strongly disagree Don't know Refusal	1 2 3 4 98 99	
	3.2	A man is justified in beating his wife/partner if she neglects the children	Strongly agree Agree Disagree Strongly disagree Don't know Refusal	1 2 3 4 98 99	

Section	Q No.	Question	Response options	Code	Logic skips
	3.3	A man is justified in beating his wife/partner if she argues with him	Strongly agree Agree Disagree Strongly disagree Don't know Refusal	1 2 3 4 98 99	
	3.4	A man is justified in beating his wife/partner if she refuses to have sex with him	Strongly agree Agree Disagree Strongly disagree Don't know Refusal	1 2 3 4 98 99	
	3.5	A man is justified in beating his wife/partner if he is not satisfied with the way she does the housework	Strongly agree Agree Disagree Strongly disagree Don't know Refusal	1 2 3 4 98 99	
	3.6	A man is justified in beating his wife/partner if she disobeys him	Strongly agree Agree Disagree Strongly disagree Don't know Refusal	1 2 3 4 98 99	
	3.7	A man is justified in beating his wife/partner if he finds out that she has been unfaithful	Strongly agree Agree Disagree Strongly disagree Don't know Refusal	1 2 3 4 98 99	
		Now I would like to ask your opinion on some statements about what YOU think about relations between men and women. Please respond if you strongly agree, agree, disagree or strongly disagree with the following statements.			

Section	Q No.	Question	Response options	Code	Logic skips
	3.8	Women's most important role is to take care of her home and cook	Strongly agree Agree Disagree Strongly disagree Don't know Refusal	1 2 3 4 98 99	
	3.9	I think that a man should have the final say in all family matters	Strongly agree Agree Disagree Strongly disagree Don't know Refusal	1 2 3 4 98 99	
	3.10	I think that men should share childcare responsibilities with women.	Strongly agree Agree Disagree Strongly disagree Don't know Refusal	1 2 3 4 98 99	
	3.11	I think that if a man works, he should give his money to his wife/partner	Strongly agree Agree Disagree Strongly disagree Don't know Refusal	1 2 3 4 98 99	
	3.12	I think that men should share the work around the house with women such as doing dishes, cleaning and cooking.	Strongly agree Agree Disagree Strongly disagree Don't know Refusal	1 2 3 4 98 99	
	3.13	I think that if a woman works, she should give her money to her husband/partner	Strongly agree Agree Disagree Strongly disagree Don't know Refusal	1 2 3 4 98 99	

Section	Q No.	Question	Response options	Code	Logic skips
	3.14	I think that it is a man's role to decide if his wife/partner should work outside the home	Strongly agree Agree Disagree Strongly disagree Don't know Refusal	1 2 3 4 98 99	
Couple and family dynamics		Now I would like to ask you some questions about you and household work. First, I'd like to ask you about who usually does household tasks – you, your partner or both together.			
Gendered division of household labour	4.1	Washing clothes/laundry	I always do the task I usually do the task with some help from my partner Task shared equally or done together My partner usually does the task with some help from me My partner always does the task Not applicable (no partner) Don't know Refusal	1 2 3 4 5 6 98 99	If 6, go to 4.2. For all other responses, go to 4.3
	4.2	Washing clothes/laundry	I always do the task I usually do the task with some help from other household members Task shared equally or done together Other household members usually do the task with some help from me Other household members always do the task Don't know Refusal	1 2 3 4 5 98 99	Go to 4.4
	4.3	Cleaning the house and surroundings	I always do the task I usually do the task with some help from my partner Task shared equally or done together My partner usually does the task with some help from me My partner always does the task	1 2 3 4	Go to 4.5

Section	Q No.	Question	Response options	Code	Logic skips
			Don't know Refusal	5 98 99	
	4.4	Cleaning the house and surroundings	I always do the task I usually do the task with some help from other household members Task shared equally or done together Other household members usually do the task with some help from me Other household members always do the task Don't know Refusal	1 2 3 4 5 98 99	Go to 4.6
	4.5	Cooking for the household	I always do the task I usually do the task with some help from my partner Task shared equally or done together My partner usually does the task with some help from me My partner always does the task Don't know Refusal	1 2 3 4 5 98 99	Go to 4.7
	4.6	Cooking for the household	I always do the task I usually do the task with some help from other household members Task shared equally or done together Other household members usually do the task with some help from me Other household members always do the task Don't know Refusal	1 2 3 4 5 98 99	Go to 4.8
	4.7	Providing daily care of children	I always do the task	1	Go to 4.9

Section	Q No.	Question	Response options	Code	Logic skips
			I usually do the task with some help from my partner Task shared equally or done together My partner usually does the task with some help from me My partner always does the task Don't know Refusal	2 3 4 5 98 99	
	4.8	Providing daily care of children	I always do the task I usually do the task with some help from other household members Task shared equally or done together Other household members usually do the task with some help from me Other household members always do the task Don't know Refusal	1 2 3 4 5 98 99	
Managing conflict in relationships		No matter how well a couple gets along, there are times when they disagree, get annoyed with the other person, want different things or just fight because they are in a bad mood or for some other reason. Couples also have different ways of settling their differences. I am going to describe a hypothetical scenario of a conflict that might happen within a couple, and I will ask you about the best way to resolve it.			
	4.9	Maida is upset that her husband Tendai earned some money and spent it on alcohol rather than contributing the money to household needs, like food and school costs for the children. I am going to read out some things that Maida might say to Tendai to deal with the conflict, and I would like you to tell me which is the best way.	You are a drunk! You come home and don't bring any money to help our family. Other wives have real husbands who support them! When you make decisions like this, it upsets me because I feel that it hurts our family. Oh well, I suppose we will just have one meal a day now that we don't have enough money for food.	1 2 3	
		Now I am going to read out a list of things that might happen when you have differences with your partner. Please tell me how many times you did each of these things in the past year (12 months), and how many times your partner did them in the past year (never, rarely, sometimes or often).			(If no partner in past 12 months,

Section	Q No.	Question	Response options	Code	Logic skips
					go to 4.25)
	4.10	I showed my partner I care even though we disagreed	Never Rarely Sometimes Often Don't know Refusal	1 2 3 4 98 99	
	4.11	My partner showed care for me even though we disagreed	Never Rarely Sometimes Often Don't know Refusal	1 2 3 4 98 99	
	4.12	I explained my side of a disagreement to my partner	Never Rarely Sometimes Often Don't know Refusal	1 2 3 4 98 99	
	4.13	My partner explained his side of a disagreement to me	Never Rarely Sometimes Often Don't know Refusal	1 2 3 4 98 99	
	4.14	I showed respect for my partner's feelings about an issue	Never Rarely Sometimes Often Don't know Refusal	1 2 3 4 98 99	

Section	Q No.	Question	Response options	Code	Logic skips
	4.15	My partner showed respect for my feelings about an issue	Never Rarely Sometimes Often Don't know Refusal	1 2 3 4 98 99	
	4.16	I said I was sure we could work out a problem	Never Rarely Sometimes Often Don't know Refusal	1 2 3 4 98 99	
	4.17	My partner said he was sure we could work out a problem	Never Rarely Sometimes Often Don't know Refusal	1 2 3 4 98 99	
	4.18	I suggested a compromise to a disagreement	Never Rarely Sometimes Often Don't know Refusal	1 2 3 4 98 99	
	4.19	My partner suggested a compromise to a disagreement	Never Rarely Sometimes Often Don't know Refusal	1 2 3 4 98 99	
	4.20	I agreed to try a solution to a disagreement my partner suggested	Never Rarely Sometimes Often Don't know	1 2 3 4 98	

Section	Q No.	Question	Response options	Code	Logic skips
			Refusal	99	
	4.21	My partner agreed to try a solution I suggested	Never Rarely Sometimes Often Don't know Refusal	1 2 3 4 98 99	
	4.22	Now, thinking about the most recent three disagreements you had with your partner, can you tell me how the disagreements were addressed? [Enumerator guidance: Read out and select all that apply]	We tried to discuss the disagreement We expressed our feelings to each other We suggested possible solutions and compromises We blamed or criticized one another We threatened each other with negative consequences I called my husband/partner names or swore at him My husband/partner called me names or swore at me I insisted that the disagreement had to be resolved my way My husband/partner insisted that the disagreement had to be resolved his way I was physically violent towards my husband/ partner My husband/partner was physically violent towards me Other (specify) _____ Don't know Refusal	1 2 3 4 5 6 7 8 9 10 11 12 98 99	

Section	Q No.	Question	Response options	Code	Logic skips
	4.23	Overall, in the last 12 months, how valued and respected have you felt by your partner?	Very valued and respected Somewhat valued and respected Somewhat unvalued and not respected Very unvalued and not respected Don't know Refusal	1 2 3 4 98 99	
	4.24	And in the last 12 months, how much do you feel your partner has felt valued and respected by you?	Very valued and respected Somewhat valued and respected Somewhat unvalued and not respected Very unvalued and not respected Don't know Refusal	1 2 3 4 98 99	
	4.25	Now, thinking about the most recent three disagreements you had with another household member (who was not a partner), can you tell me how the disagreements were addressed? [Enumerator guidance: Read out and select all that apply]	We tried to discuss the disagreement We expressed our feelings to each other We suggested possible solutions and compromises We blamed or criticized one another We threatened each other with negative consequences I called the household member names or swore at them The household member called me names or swore at me I insisted that the disagreement had to be resolved my way The household member insisted that the disagreement had to be resolved their way I was physically violent towards the household member The household member was physically violent towards me Other (specify) _____ Don't know Refusal	1 2 3 4 5 6 7 8 9 10 11 12 98	

Section	Q No.	Question	Response options	Code	Logic skips
				99	
	4.26	In the last 12 months, how valued and respected have you felt by other household members?	Very valued and respected Somewhat valued and respected Somewhat unvalued and unrespected Very unvalued and unrespected Don't know Refusal	1 2 3 4 98 99	
Experience of VAWG		The next questions are personal and may be uncomfortable to answer. Women like you may experience violence by strangers or people they know well, such as a romantic partner. I am going to ask some questions about this because we want to learn more about what women experience in their lives. I want you to speak freely and remember that everything you say will be confidential, and you can skip any questions that you don't feel comfortable answering. [Enumerator guidance: Ensure that there is auditory privacy and that there are no other people in the interview location who can overhear the following questions]			
		First, I am going to ask you about common situations faced by women. Think about the last 12 months, and please tell me if these situations apply to your relationship with any current or former husband/ boyfriend/ partner.			
	5.1	He (is/was) jealous or angry if you (talk/talked) to other men?	Yes No Not applicable (no partner in last 12 months) Don't know Refusal	1 2 3 98 99	If 3, go to 5.40
	5.2	He (accuses/accused) you of being unfaithful?	Yes No Don't know Refusal	1 2 98 99	

Section	Q No.	Question	Response options	Code	Logic skips
	5.3	He (does/did) not permit you to meet your female friends?	Yes No Don't know Refusal	1 2 98 99	
	5.4	He (tries/tried) to limit your contact with your family?	Yes No Don't know Refusal	1 2 98 99	
	5.5	He (insists/insisted) on knowing where you (are/were) at all times?	Yes No Don't know Refusal	1 2 98 99	
		In any relationship there are good times and bad times, I now want to ask you about some of the bad times. Can you please tell me if any current or past husband, boyfriend or partner has done any of the following things in the past 12 months?			
	5.6	Insulted you or made you feel bad about yourself?	Yes No Don't know Refusal	1 2 98 99	If 2, 98 or 99, Go to 5.8
	5.7	How many times did this happen during the last 12 months?	Never Once A few times Many times Don't know Refusal	1 2 3 4 98 99	
	5.8	Belittled or humiliated you in front of other people?	Yes No Don't know Refusal	1 2 98 99	If 2, 98 or 99, Go to 5.10
	5.9	How many times did this happen during the last 12 months?	Never Once A few times	1 2 3	

Section	Q No.	Question	Response options	Code	Logic skips
			Many times Don't know Refusal	4 98 99	
	5.10	Threatened you by saying they will leave you or divorce you?	Yes No Don't know Refusal	1 2 98 99	If 2, 98 or 99, Go to 5.12
	5.11	How many times did this happen during the last 12 months?	Never Once A few times Many times Don't know Refusal	1 2 3 4 98 99	
	5.12	Threatened to hurt you or someone you care about?	Yes No Don't know Refusal	1 2 98 99	If 2, 98 or 99, Go to 5.14
	5.13	How many times did this happen during the last 12 months?	Never Once A few times Many times Don't know Refusal	1 2 3 4 98 99	
	5.14	Done things to scare or intimidate you on purpose, for example by the way he looked at you, by yelling and smashing things?	Yes No Don't know Refusal	1 2 98 99	If 2, 98 or 99, Go to 5.16
	5.15	How many times did this happen during the last 12 months?	Never Once A few times Many times Don't know Refusal	1 2 3 4 98 99	

Section	Q No.	Question	Response options	Code	Logic skips
	5.16	Stopped you from getting a job, going to work, trading or earning money?	Yes No Don't know Refusal	1 2 98 99	If 2, 98 or 99, Go to 5.18
	5.17	How many times did this happen during the last 12 months?	Never Once A few times Many times Don't know Refusal	1 2 3 4 98 99	
	5.18	Taken your earnings from you when you didn't want him to	Yes No Don't know Refusal	1 2 98 99	If 2, 98 or 99, Go to 5.20
	5.19	How many times did this happen during the last 12 months?	Never Once A few times Many times Don't know Refusal	1 2 3 4 98 99	
	5.20	Spent money on things for himself when he knew there was not enough money for food or school fees or other essential household expenses?	Yes No Don't know Refusal	1 2 98 99	If 2, 98 or 99, Go to 5.22
	5.21	How many times did this happen during the last 12 months?	Never Once A few times Many times Don't know Refusal	1 2 3 4 98 99	
	5.22	Slapped you?	Yes No Don't know Refusal	1 2 98 99	If 2, 98 or 99, Go to 5.24

Section	Q No.	Question	Response options	Code	Logic skips
	5.23	How many times did this happen during the last 12 months?	Never Once A few times Many times Don't know Refusal	1 2 3 4 98 99	
	5.24	Pushed you, shook you or threw something at you?	Yes No Don't know Refusal	1 2 98 99	If 2, 98 or 99, Go to 5.26
	5.25	How many times did this happen during the last 12 months?	Never Once A few times Many times Don't know Refusal	1 2 3 4 98 99	
	5.26	Twisted your arm or pulled your hair?	Yes No Don't know Refusal	1 2 98 99	If 2, 98 or 99, Go to 5.28
	5.27	How many times did this happen during the last 12 months?	Never Once A few times Many times Don't know Refusal	1 2 3 4 98 99	
	5.28	Punched you with his fist or with something that could hurt you?	Yes No Don't know Refusal	1 2 98 99	If 2, 98 or 99, Go to 5.30
	5.29	How many times did this happen during the last 12 months?	Never Once A few times Many times Don't know	1 2 3 4 98	

Section	Q No.	Question	Response options	Code	Logic skips
			Refusal	99	
	5.30	Kicked you, dragged you or beat you up?	Yes No Don't know Refusal	1 2 98 99	If 2, 98 or 99, Go to 5.32
	5.31	How many times did this happen during the last 12 months?	Never Once A few times Many times Don't know Refusal	1 2 3 4 98 99	
	5.32	Tried to choke you or burn you on purpose?	Yes No Don't know Refusal	1 2 98 99	If 2, 98 or 99, Go to 5.34
	5.33	How many times did this happen during the last 12 months?	Never Once A few times Many times Don't know Refusal	1 2 3 4 98 99	
	5.34	Threatened or attacked you with a gun, knife or other weapon?	Yes No Don't know Refusal	1 2 98 99	If 2, 98 or 99, Go to 5.36
	5.35	How many times did this happen during the last 12 months?	Never Once A few times Many times Don't know Refusal	1 2 3 4 98 99	

Section	Q No.	Question	Response options	Code	Logic skips
	5.36	Forced you physically or with threats to have sexual intercourse with him when you didn't want to?	Yes No Don't know Refusal	1 2 98 99	If 2, 98 or 99, Go to 5.38
	5.37	How many times did this happen during the last 12 months?	Never Once A few times Many times Don't know Refusal	1 2 3 4 98 99	
	5.38	Forced you physically or with threats to perform any other sexual acts you did not want to do?	Yes No Don't know Refusal	1 2 98 99	If 2, 98 or 99, Go to 5.40
	5.39	How many times did this happen during the last 12 months?	Never Once A few times Many times Don't know Refusal	1 2 3 4 98 99	
		The next questions are about things that may have happened to you with someone other than a husband/boyfriend/partner.			
	5.40	In the past 12 months, has somebody other than a husband/boyfriend/partner ever forced or persuaded you to have sex when you didn't want to?	Yes No Don't know Refusal	1 2 98 99	If 2, 98 or 99, GO TO 5.44
	5.41	How many times did this happen during the last 12 months?	Never Once A few times Many times Don't know Refusal		
	5.42	Who did this to you?	Male relative	1 2	

Section	Q No.	Question	Response options	Code	Logic skips
		[Select all that apply] [Prompt: Anyone else?]	Female relative Teacher Police officer Employer Community/traditional/religious leader Friend Classmate / schoolmate Neighbour Other (specify who) _____ Don't know Refusal	3 4 5 6 9 10 11 12 98 99	
	5.43	What was their gender?	Male Female Both (if more than one perpetrator) Don't know Refusal	1 2 3 98 99	
	5.44	In the last 12 months, were you slapped, hit or beaten by any of the following family members? [Select all that apply]	Mother Father Son Daughter Mother-in-law Father-in-law Brother Sister Uncle Aunt Grandmother Grandfather Co-wife (if in polygamous marriage) Other (specify) _____ Don't know Refusal	1 2 3 4 5 6 7 8 9 10 11 12 13 14 98 99	If no family member, Go to 6.1
	5.45	How many times did this happen during the last 12 months?	Never Once A few times	1 2	

Section	Q No.	Question	Response options	Code	Logic skips
			Many times Don't know Refusal	3 4 98 99	
Actions taken by VAWG survivors		(Enumerator guidance: The following questions should be asked of any woman disclosing any instance of physical or sexual violence in the last 12 months, whether from a husband/partner/boyfriend or another person in or outside of the family, or any instance of emotional or economic violence from a partner)			(If no experience of violence in past 12 months, go to 7.1)
		You have shared with me that in the past 12 months you have had some experiences of people trying to hurt you or force you to do things you didn't want to do. Now I would like to talk to you about any support you may have received after experiencing these things in the past 12 months.			
	6.1	In the last 12 months, who in your family or community have you told about the violence you experienced? [DO NOT READ OUT] [Select all that apply]	Nobody Mother Father Sister Brother Other relative Husband / boyfriend / partner Teacher Employer Community chief/leader, or religious leader Friend Neighbour Other person (specify who) _____ Don't know Refusal	1 2 3 4 5 6 7 8 9 10 11 12 13 98 99	
	6.2	In the past 12 months, did you ever go to any of the following services for help? (READ EACH OUT AND SELECT ALL THAT APPLY) Any other services?	Police Court/lawyer/prosecutor Healthcare professional (Doctor, nurse, or other) Social services Legal advice service NGO / women's organisation Shelter	1 2 3 4 5 6 7	If 10, continue If 98 or 99, Go to 7.1

Section	Q No.	Question	Response options	Code	Logic skips
			Community chief/leader, or religious leader Other (specify) _____ Did not go to any services Don't know Refusal	8 9 10 98 99	For all other responses Go to 6.4
	6.3	What are the reasons you did not seek any help? [DO NOT READ OUT] [Select all that apply]	Did not know where to go Afraid of more violence or getting in trouble Embarrassed for self or my family Did not want abuser to get in trouble Too far to travel Afraid of being abandoned or divorced Afraid of being blamed for violence It was my fault that the violence happened Did not think it was a problem Could not afford transport Could not afford service fees Did not need / want services No one could help me / felt it was useless Other (specify) _____ Don't know Refusal	1 2 3 4 5 6 7 8 9 10 11 12 13 14 98 99	For all – Go to 7.1
	6.4	What were the reasons that made you go to these services for help? [DO NOT READ OUT] [Select all that apply]	Received a referral Encouraged by friends/family Encouraged by other people from the community Could nor endure the violence anymore Was badly injured Was threatened by perpetrator Was thrown out of home Other (specify) _____ Don't know Refusal	1 2 3 4 5 6 7 8 98 99	
Knowledge of VAWG services		Now I would like to ask you a few questions about services and support for survivors of violence in your community			

Section	Q No.	Question	Response options	Code	Logic skips
	7.1	Overall, what services do you know of that support women and girls who have experienced violence in your community? By violence, I mean any type of physical or sexual violence from a partner, family member or any other person, or emotional abuse from a partner. Violence may also include forced or early marriage of girls. [DO NOT READ OUT] [Select all that apply]	I don't know any services Counselling services Medical services Legal counsel Traditional/religious services Police services Educational programs Shelter Other (specify) _____ Don't know Refusal	1 2 3 4 5 6 7 8 9 98 99	
	7.2	How confident are you of how to support a woman or girl who has experienced violence?	Very confident Somewhat confident Somewhat unconfident Very unconfident Don’t know Refusal	1 2 3 4 98 99	
	7.3	How likely is it that you would encourage a woman or girl that you know who has experienced violence to seek support from services?	Very likely Somewhat likely Somewhat unlikely Very unlikely Don't know Refusal	1 2 3 4 98 99	
	7.4	In the past 12 months, have you provided any type of support to a woman or girl who has experienced violence?	Yes No Don’t know Refusal	1 2 98 99	If 2, Go to 7.6
	7.5	What type of support did you provide? [DO NOT READ OUT] [Select all that apply]	Comforted her Spoke with the perpetrator or his family Encouraged her to access services Accompanied her to a service Other (specify) _____ Don’t know Refusal	1 2 3 4 5 98 99	

Section	Q No.	Question	Response options	Code	Logic skips
	7.6	How likely would you be to seek help or support from family or friends if you experienced violence?	Very likely Somewhat likely Somewhat unlikely Very unlikely Don't know Refusal	1 2 3 4 98 99	
	7.7	How likely would you be to seek help or support from services if you experienced violence?	Very likely Somewhat likely Somewhat unlikely Very unlikely Don't know Refusal	1 2 3 4 98 99	
	7.8	Are there any challenges you feel you would face in accessing services if you experienced violence, and what would these be? [DO NOT READ OUT] [Select all that apply]	No challenges Would not know where to go Would be afraid of more violence or getting in trouble Would be embarrassed for self or my family Would not want abuser to get in trouble Too far to travel Would be afraid of being abandoned or divorced Would break my marriage/relationship Would be worried about the future of my children Would be worried about losing income Would be afraid of being blamed for violence Would not be able to afford transport Would not be able to afford service fees Poor quality of services Other (specify) _____ Don't know Refusal	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 98 99	
Risk behaviours		Next, I would like to ask you about sexual relationships with somebody other than your primary partner. No one else will know your answers so please feel free to answer openly and honestly. There are no right or wrong answers.			
Transactional sex and sex work	8.1	In the past 12 months, how often have you had sex with a non-primary partner because he provided you with, or you expected that he would provide you with, food, cosmetics,	Never Rarely Sometimes	1 2 3	

Section	Q No.	Question	Response options	Code	Logic skips
		clothes, transport, cash or other things that you needed?	Often Don't know Refusal	4 98 99	
	8.2	And in the past 12 months, have you participated in sex work? By sex work, we mean an activity through which you engage in sex with people with whom you share little to no emotional intimacy, in exchange of money or things of value.	Yes No Don’t know Refusal	1 2 98 99	
Alcohol use		I would like to ask you some questions about your use of alcohol. Remember that your answers will remain confidential.			
	8.3	In the past 12 months, how often have you drunk alcohol?	Never Monthly or less 2-4 times per month 2-3 times per week 4 or more times a week Don't know Refusal	1 2 3 4 5 98 99	If 1, 98 or 99, GO TO 8.5
	8.4	How often in the last 12 months have you quarrelled with a husband //boyfriend/ partner about your drinking?	Never Once More than once Not applicable (no partner in last 12 months) Don't know Refusal	1 2 3 4 98 99	If 4, go to 9.1
	8.5	In the past 12 months, how often has your husband / boyfriend / partner drunk alcohol?	Never Monthly or less 2-4 times per month 2-3 times per week 4 or more times a week Don't know Refusal	1 2 3 4 5 98 99	If 1, 98 or 99, GO TO 9.1

Section	Q No.	Question	Response options	Code	Logic skips
	8.6	How often in the last 12 months have you quarrelled with your husband/ boyfriend/ partner about his drinking?	Never Once More than once Don't know Refusal	1 2 3 98 99	If 1, Go to 9.1
	8.7	Why did you quarrel? (Don't read out - select all that apply)	Partner spending money on alcohol Partner became violent when drunk Other (specify) _____ Don't know Refusal	1 2 3 98 99	
Intergenerational effects of violence		Now I want to ask some questions about your children and also your experience growing up.			
	9.1	In the past 12 months, how often have any of your children witnessed or overheard you and your partner arguing?	Never Once A few times Many times I don't have children I haven't had a partner in the past 12 months Don't know Refusal	1 2 3 4 5 6 98 99	If 5 GO TO 9.5 If 6 GO TO 9.4
	9.2	In the past 12 months, how often have any of your children overheard any incident of physical fighting between you and your partner?	Never Once A few times Many times Don't know Refusal	1 2 3 4 98 99	
	9.3	In the last 12 months, how often did your husband/ partner punish your children by smacking or beating them?	Never Once A few times Many times Don't know Refusal	1 2 3 4 98 99	

Section	Q No.	Question	Response options	Code	Logic skips
	9.4	In the past 12 months, how often did you punish your children by smacking or beating them?	Never Once A few times Many times Don't know Refusal	1 2 3 4 98 99	
		Now I want you to think back to your own childhood growing up			
	9.5	Before the age of 18, how often were you punished by a parent/ caregiver by being smacked or beaten?	Never Rarely Sometimes Often Don't know Refusal	1 2 3 4 98 99	
	9.6	Do you recall ever seeing or hearing your mother being beaten by your father or another partner she lived with?	Yes No Don't know Refusal	1 2 98 99	
	9.7	Do you recall ever seeing or hearing your mother being beaten by somebody else in the household?	Yes No Don't know Refusal	1 2 98 99	
Exposure to interventions		We are about to finish the interview. I just want to ask you some questions about activities that may have been happening in your community recently.			
	10.1	In the last 12 months, have you seen people in your community doing something to prevent violence against women?	Yes No Don't know Refusal	1 2 98 99	
	10.2	In the last 12 months, have you participated in any activity about safe and healthy relationships?	Yes No Don't know Refusal	1 2 98 99	

Section	Q No.	Question	Response options	Code	Logic skips
	10.3	In the last 12 months, have you participated in any training on violence against women and girls?	Yes No Don't know Refusal	1 2 98 99	
	10.4	In the last 12 months, have you seen or heard the slogan “Love shouldn’t hurt”?	Yes No Don't know Refusal	1 2 98 99	If 2, 98 or 99, Go to 10.6
	10.5	If yes, where did you see or hear it? [Don't read out and select all that apply]	TV Radio Celebrity songs Celebrity videos Digital/social media Outdoors (billboards, posters, flyers etc) Community dialogues Neighbourhood Watch Other Don’t know Refusal	1 2 3 4 5 6 7 8 9 98 99	
	10.6	Are you a member of an ISAL/VSLA?	Yes No	1 2	If 2, go 10.13
	10.7	For how long have you been a member of the ISAL/ VSLA?	Less than 6 months Between six months and a year 1-2 years More than 2 years	1 2 3 4	
	10.8	Did you have access to loans before joining the VSLA?	Yes No	1 2	If 2, go to 10.10
	10.9	If yes, did you ever take out a loan from a different organization?	Yes No	1 2	

Section	Q No.	Question	Response options	Code	Logic skips
	10.10	Have you ever taken a loan from the ISAL/ VSLA?	Yes No	1 2	If 2, go to 10.13
	10.11	If yes, how many loans?	_____ Don't know	 98	
	10.12	What were the main reasons that you took this/these loan(s)? (Select three maximum)	Food/household expenses Repaying debts School fees Family celebration/ceremony House improvements Medical fees/health Business activities To buy household assets Emergency/economic shock Other	1 2 3 4 5 6 7 8 9 97	
	10.13	In the past twelve months, have you received any cash transfer or voucher?	Yes No	1 2	
	10.14	Which organisation provided the cash transfer or voucher?	_____		
Closing section	11.1	That concludes our questionnaire. Would you give consent for one of our researchers to contact you again in the following weeks to invite you to participate in a follow up interview?	Yes No	1 2	
	11.2	Overall, how comfortable did you feel answering the survey questions today?	Very comfortable Somewhat comfortable Somewhat uncomfortable Very uncomfortable Don't know Refusal	1 2 3 4 98 99	
	11.3	At any point during the interview, were you afraid that someone might hear your	Yes No Don't know	1 2 98	

Section	Q No.	Question	Response options	Code	Logic skips
		answers and hurt you in any way because of what they heard?	Refusal	99	
	11.4	Did my asking you any questions about violence make you feel upset because the violence reminded you of a past experience?	Yes No Don't know Refusal	1 2 98 99	
	11.5	Did you find it upsetting or stressful to answer any of these questions?	Yes No Don't know Refusal	1 2 98 99	
		I would like to thank you very much for helping me. I appreciate the time that you have taken. I realise that these questions may have been difficult for you to answer, but it is only by listening to people like you that we can really understand about the issues faced by people in your community. Sometimes the questions I have asked might remind you of times when you, or people you know, have experienced difficulties in life and you may think that you would like to talk to someone about this. This might be now or at any time in the future. I have a list of organisations here that provide various types of services that may be of interest to you. Please contact them if you need help or wish to find out more information about what they offer. You can contact them whenever you would like to. Do you have any questions you would like to ask me?			

Annex 6: List of Stakeholders Interviewed

District	Organisation	Role
Chikomba	Ward Development Committee	Representative
	Musasa	Field Officer
	Ward Development Committee	Representative
	CARITAS	Field Agent
Chiredzi	Ward 4	Councillor
	Ward level official	Councillor
	Musasa	Field Officer
	Legal Resources Foundation	Paralegal
Mwenezi	Gender Community Based Club	Leader
	District-level official	CDO
	District-level official	District Development Officer
	District-level official	District Development Officer
	Community Leader	Village Head
	Musasa	Field Officer
National-level stakeholders	UN Women	EVAW Programme Associate
	MWACSMED	Acting Deputy Director
	Women's Coalition of Zimbabwe	Policy and Advocacy Officer
	Zimbabwe Gender Commission	Officer

Annex 7: SAFE Learning and Engagement Action Plan

SAFE OUTPUT 4 – LEARNING AND ENGAGEMENT ACTION PLAN
MARCH 2022

This paper sets out an outline plan on how the SAFE programme can deliver output 4 of the programme ('SAFE partners learn from, generate and disseminate relevant evidence on GBV and vulnerability in Zimbabwe'). This is intended to be a living document, which will be updated and adjusted as the programme develops, and different opportunities for learning and engagement emerge. It looks at the reach of evidence generated by SAFE; how widely learning from the programme is disseminated; and use of different channels to reach different stakeholders. Reporting against output 4 indicators should also look at the extent to which SAFE evidence is targeted to key audiences, in order to influence policy and practice at national level, and to contribute to the wider evidence base on prevention of GBV at national, regional and global levels. It also covers collaboration with other stakeholders and relevant initiatives – to provide the best platforms for sharing SAFE's work, and potentially for joint research and learning activities.

Ongoing development of this plan will include consideration of who we are engaging with and why, including marginalised groups, and consideration of how our approach will be based upon analysis of the political economy/opportunities for change. We may want to look at the extent to which SAFE might exercise influence at policy level (for example planning and tracking engagements with stakeholders falling outside of planned 'formal' activities, such as ad-hoc engagements with government stakeholders), while understanding that it is not explicitly resourced for such activities, and therefore should not be held accountable for doing so.

Table 4:

INPUT (WHAT)	WHO	WHEN
Branding of the programme/ intervention developed and agreed	SAFE-C	Jan 2022
Establishment of an ad-hoc and informal reference group for advice on research, evidence and learning tools, outputs and external engagement	Sam/FCDO, with inputs from SAFE ELU and SAFE-C	Oct 2021 set up, with ongoing engagement
Specific dissemination plans/activities for research, evidence and learning outputs: - TAF outputs - Deep dives - Baseline study - Summative evaluation This should involve production of 1 dissemination output (brief / blog / webinar, etc) for each of TAF outputs and SAFE ELU deliverables. The specific type of output will be assessed on a case-by-case basis and tailored to different audiences; with suggested input from the ad hoc reference group to shape and inform what type of output would be most useful and how and where best to disseminate this.	All	To break down by output. DD1 summary with infographics produced Mar 2022
National engagement and dissemination through events, in collaboration with Spotlight - Initial research symposium; collaboration with Spotlight and GBV 365 (UNFPA) - Further thematic research symposia/other learning events TBC - Potential joint event with HeForShe/British Embassy National engagement and dissemination through gender sector groups and structures - GEWE DPG, GBV Sub-Cluster - Explore opportunities for establishing a Zimbabwe GBV Community of Practice *(NB tentative idea and SAFE has no resources to deliver, only to contribute technical content)* - Ad-hoc development partner roundtable discussions	Sam/FCDO, Spotlight (UN Women/UNICEF), HeForShe (DHM British Embassy Harare), with participation from ELU and, SAFE-C Sam/FCDO in liaison with What Works and Prevention Collaborative	Symposium and any other events in collaboration with Spotlight TBC Ongoing discussions with UN Women regarding national co-ordination structures Engage with What Works and Prevention Collaborative Q1 2022
Collaborations with the wider research community (e.g. academic partnerships and via the reference group) on an ad hoc basis to deepen, grow evidence base, make the most of data collected through secondary analysis	SAFE-C and ELU	TBC
Internal (SAFE) learning and adaptation structures and plans, to ensure continuous feedback loops within the programme	SAFE-C and ELU	Quarterly reflection sessions as per MERL framework

INPUT (WHAT)	WHO	WHEN
Internal FCDO comms, to share learning and raise awareness on the programme	FCDO	Internal seminar slated for April/May
Media/social media engagement to promote learning from the programme	All	Ongoing

Annex 8: SAFE baseline indicators and measures

Level of measurement	Theory of change statement	Indicator	Measurements used	Baseline value	Expected direction at endline
Impact	Reduced prevalence of VAWG in SAFE focal wards	% of women reporting past 12 month experience of VAWG, disaggregated by type of violence[97]	IPV measured through domestic violence module from the Demographic and Health Survey, and WHO Multi-Country Study on Women's Health and Domestic Violence, and supplemented with measures of economic IPV from FCDO's What Works to Prevent Violence Against Women and Girls Global Programme ('What Works'). NPSV measured from 'What Works'.	IPV: 47% NPSV: 1% NPPV: 2%	↓
	Improved family wellbeing	Mean family quality of life score	Family Quality of Life Scale	3.6	↑
Outcome 1	Households are able to manage economic stress	Mean household food insecurity score	Household Food Security Scale	4.2	↓
		% of women reporting that their household is able to meet most or all of their basic needs (according to their own priorities)	TearFund Perceived Ability to Meet Basic Needs indicator and survey item	15%	↑
Intermediate outcome 1	Households work together to increase their income or assets, and make better use of their available resources	% of women who report that their household often engages in joint planning to increase income or assets	Single item on joint planning	23%	↑
Outcome 2	Intimate partner and family relationships are more gender equitable and do not resort to violence to resolve conflict	% of partnered women who report having resolved their most recent three disagreements with an intimate partner in a non-violent way	Conflict Tactics Subscale	69%	↑
		% of non-partnered women who report having resolved their most recent three disagreements with non-intimate partner household members in a non-violent way	Adapted from Conflict Tactics Subscale	61%	↑
Intermediate outcome 2	Households take forward a shared vision for	% of women who report that their household has worked towards	Single item on achieving shared vision	56%	↑

[97] Types of violence include: IPV (physical, sexual, emotional, and economic); non-partner sexual violence (NPSV); and non-partner physical violence (NPPV) from another family member.

	improving the family's quality of life, making significant household decisions together	achieving a shared vision for family quality of life in the past 12 months % of women reporting joint decision making about household financial issues (household purchases, spending savings, taking loans)	Demographic and Health Survey questions on decision making, supplemented with Women Empowerment in Agriculture Index (WEIA) on inputs into decision making	Major household purchases: 26% Spending savings: 37% Taking loans: 29%	↑
Outcome 3	Communities in focal wards have reduced tolerance to IPV and/or other forms of GBV	% of women who agree that a man is justified in beating his wife/partner in at least one circumstance	Demographic Health Survey questions on justification for wife beating, with additional situations added in line with 'What Works' studies	41%	↓
		% of women who would consider marrying a daughter before the age of 18	Single item on whether respondents would marry a daughter before the age of 18	1%	↓
		% of partnered women who believe their partner would consider marrying a daughter before the age of 18	Single item on whether respondents believe their partner would marry a daughter before the age of 18	1%	↓
Intermediate outcome 3	An increasing number of community members adopt gender equitable, non-violent attitudes and behaviours in their own lives	% of women who strongly agree with 5 statements related to gender equitable household roles and responsibilities	Adapted from Gender Equitable Men Scale	48%	↑
Outcome 4	Increased access to essential GBV services by women and adolescent girls	% of women (experiencing past 12 month physical or sexual IPV, NPSV or other family physical violence) who report accessing services	Adapted to Zimbabwe context from WHO Multi-Country Study on Women's Health and Domestic Violence	28%	↑
Intermediate outcome 4	Reduced barriers to accessing GBV response services	% of women who report barriers to accessing GBV services	Items on challenges accessing services, adapted from WHO Multi-Country Study	75%	↓

Annex 9: summary of enumerator training content

Enumerator training included the following modules:

Module title	Content summary
Arranging the interview, first impression and obtaining consent	Safety, privacy and confidentiality Informed consent The consent form and process
Conducting an interview: how to interact with the interviewee	Sensitivity, Being neutral and non-judgmental Scenario based role play using example questions
Keeping the interviewee safe	Handling interruptions Threats to physical safety Responding to distress When to terminate and interview
Introduction to survey	Line-by-line read through and comprehension and translation check
Introduction to Cosmos	How to load, complete and upload surveys on Tetra Tech's digital data collection platform Creating and logging unique identifiers
Roleplay: general guidelines, introductions and obtaining consent	Roleplay of beginning an interview including the things to check at the beginning of an interview (confidentiality, privacy, consent, Covid protocols etc.).
Roleplay and survey practice	Section by section practice of data collection activity
Roleplay: timing check	Run through of full survey instrument to check completion times
Safeguarding	Reporting protocol Disclosures of abuse Making a referral to GBV services
Keeping ourselves safe	Vicarious trauma Looking after your own well-being Support available and how to access it

Logistics and next steps	Training manual Queries and questions Field governance and management processes Logistics planning