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Authors

Waterman, Emily A
Edwards, Katie M
Makoni, Evans Irvine
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Zimbabwean Stakeholders' Perspectives on Causes of and Solutions to Gender-Based Violence in Their Community: Findings From a Focus Group

Emily A. Waterman[1], Katie M. Edwards[1], Evans Irvine Makoni[2], Laura Siller[1], Sharon B. Murphy[3], and Jennifer A. Wagman[4]

Abstract

Gender-based violence (GBV) rates are high in Zimbabwe. Looking toward a partnership to prevent GBV in the Victoria Falls region, which lacks GBV prevention initiatives, the current study's aim was to learn about stakeholders' perceptions of GBV causes and their ideas for GBV prevention, and to gauge potential community reactions to GBV prevention. Focus group participants emphasized lack of women's empowerment, alcohol, violence normalization, and tourism as GBV causes, and ideas for prevention included school-based curricular, social marketing campaigns, involving men in prevention, and home visiting programs. Consistent with community-based models, participants emphasized involving all community stakeholders in prevention.

Keywords

gender-based violence, sexual violence, prevention

[1]University of Nebraska–Lincoln, USA
[2]Mosi Advocates, Victoria Falls, Zimbabwe
[3]University of New Hampshire, Durham, USA
[4]University of California, Los Angeles, USA

Corresponding Author:
Emily A. Waterman, Postdoctoral Research Associate, Nebraska Center for Research on Children, Youth, Families, and Schools, University of Nebraska–Lincoln, 160 Prem S. Paul Research Center at Whittier School, Lincoln, NE 68583-0858, USA.
Email: ewaterman1123@gmail.com

Gender-based violence (GBV), a major social problem in Zimbabwe, has received national attention (Shoko, 2017). GBV is violence perpetrated against a person of any gender that results from gender inequality, including but not limited to sexual violence and abuse, domestic and intimate partner violence, human trafficking, and forced and early marriage (International Federation of Red Cross and Red Crescent Societies [IFRC], 2015). Although comprehensive statistics are lacking, both qualitative and quantitative research suggests that GBV is prevalent in Zimbabwe (Duffy, 2005; IFRC, 2015; Summer et al., 2015). For example, 32.5% of Zimbabwean girls and 8.9% of Zimbabwean boys experience some form of sexual violence victimization before the age of 18, with 13.5% of girls and 1.8% of boys experiencing unwanted, completed sex before the age of 18 (Summer et al., 2015). While GBV is relatively high among Zimbabweans, utilization of violence-related services, such as prevention, treatment, and support services, is very low. For instance, among girls and boys who experienced sexual violence before the age of 18, only 2.7 and 2.4%, respectively, received social services (according to surveys collected in 2013–2017; Summer et al., 2015). GBV in Zimbabwe intersects with many other health and social issues, including high rates of HIV infection and other sexually transmitted diseases (STIs; Coffee et al., 2005; Gregson et al., 2011), and alcohol and drug abuse (Kalichman et al., 2007; Mataure et al., 2002)

To address GBV and the associated problems of HIV and substance abuse, prevention programs are critical. Despite this high need, however, effective prevention program development can be challenging. It can be difficult to identify a culturally appropriate intervention setting, to predict community reactions to an intervention, and to determine the appropriate intervention facilitators (Power et al., 2004). Research highlights the importance of developing culturally informed prevention efforts; one promising approach for doing so is described by the community-based participatory action research (CBPAR) model (Baum et al., 2006; Juujärvi & Lund, 2016; Snider et al., 2009). The CBPAR model emphasizes the importance of developing prevention programming by engaging community stakeholders (i.e., youth, local government, social workers, community health workers), listening to their perceptions of community needs, and then developing programming collaboratively, accounting for the information provided by the community stakeholders. Programs that utilize this model have been found to be acceptable to the community, sustainable over time, and effective in reducing GBV and associated health issues (Baum et al., 2006; Harrison & Graham, 2012). The current study utilized a CBPAR framework in the Victoria Falls region of Zimbabwe to gain information to be used to create a GBV primary prevention initiative.

The Current Study

The aim of the current study was to conduct a focus group of stakeholders in Victoria Falls, Zimbabwe, to discuss their perceptions of the causes of GBV, their ideas for preventing GBV, and how they think the community would react to GBV prevention programming. The region where we conducted this study is financially under-resourced

and has very little or no GBV prevention programming. Looking toward the development of innovative and culturally grounded prevention programming, this study highlights local stakeholders' voices surrounding three major themes: (a) the causes for GBV in Victoria Falls, Zimbabwe; (b) ideas to prevent GBV; and (c) potential community reactions to programming and how to overcome any negative reactions to programming. Results from this study can be used by researchers and practitioners to develop relevant GBV prevention programming.

Method

Participants

Participants were 11 stakeholders from Victoria Falls, Zimbabwe, who took part in a 2-day workshop on GBV in January 2019. The workshop was organized by a local organization that is headed by the third author and facilitated by a variety of speakers. The workshop included information about the definition of GBV and other terms (e.g., rape, sexual harassment, sexually transmitted infections) and information about prevention strategies (e.g., bystander intervention, social marketing) that have been used outside of Victoria Falls to respond to and prevent GBV. Although 30 people participated in the workshop, not all chose to participate in the focus group. Five participants were women (45%) and six were men (55%), ranging in age from approximately 20 to more than 50. Stakeholders included, but were not limited to, nurses, primary school teachers, counselors, case workers, and HIV clinic workers.

Procedure

The third author informed workshop attendees that after the workshop, attendees were invited to participate in the focus group and to share their thoughts about GBV in the community. The focus group occurred directly after the workshop in the workshop space; attendees who did not wish to participate simply sat in the workshop space and waited for the focus group to end. That is, they sat among the focus group participants but did not participate. Although it is unusual to hold a focus group in the presence of nonparticipants, we did so to avoid separating the group, which may have been perceived as exclusive. In addition, we did not want to single out any workshop attendees who chose not to participate. The third author read the consent both in English and in Shona (the most common native language spoken in the region). The consent included information about how the focus group would be recorded and then transcribed without identifying information. Participants who wished to participate signed their name on paper. The second author led the focus group in English while the first author took notes. We also recorded the focus group. The focus group lasted approximately 40 min; participants were not compensated but lunch and a snack were offered to all conference participants (whether or not they choose to participate in the focus group). Questions generally guided participants to discuss what they saw as the main causes of GBV in the region, their ideas for preventing GBV, and how other community

members might react to GBV prevention initiatives. The qualitative data were analyzed by the first two authors using content analyses (Krippendorff, 2004), such that we aggregated all possible responses into themes. This study was approved and monitored by the University of New Hampshire Institutional Review Board.

Results

Why Do You Think GBV Happens Here in Victoria Falls?

Several themes emerged regarding the causes of GBV. Participants thought that overall, women were not respected, and that lack of respect led to GBV. For example, when asked why GBV happens, one participant said directly, "lack of respect." This theme reflects the literature on GBV, which shows that lack of women's empowerment is a feature of GBV-prone communities (Gupta et al., 2013; Sanday, 1981a, 1981b). Bars, or "beer holes" as one participant called establishments that served alcohol, were another perceived driver of GBV, as described by participants. Participants stated that bars were risky places (i.e., increasing vulnerability for violence) because of alcohol use and sex work. Again, this theme corroborates a substantial body of literature on GBV, which describes alcohol use, particularly heavy alcohol use, as a robust predictor of GBV (Abbey & Ortiz, 2008; Tharp et al., 2013). In addition, participants thought GBV happens because violence is widely normalized among community members and victims are silenced. For example, one participant said,

> . . . as a woman, if you are a victim of violence, if you're a victim of, you know, GBV, you're told to just, you know, keep it to yourself. If there's an issue at home, you are told, "Don't speak about it. Don't let people know what is happening in your house." And a lot of these cases are not reported. And that's an issue, so I just think that there needs to be more conversation among the people; we need to bring more awareness to, um, these issues that are around us.

Social norms that are accepting of violence have been documented as an important community-level risk factor for violence (Berkowitz, 2010; Tharp et al., 2013).

One specific perceived reason for GBV that was raised by participants is less reflected in the literature: tourism. One participant remarked, ". . . we are focusing more on tourism and tourists, and then we are having less of institutions or organizations that will be able to help and educate people on GBV." Several participants agreed that the infrastructure in Victoria Falls is focused on attracting more tourists, instead of addressing the problem of GBV that is faced by local people. A small body of literature discusses the link between tourism and violence. Tourism development may exacerbate the gender and racial inequalities that are the root of many forms of violence, through marginalization of local people, land dispossession, and pursuit of cheap labor. In addition, tourism is ultimately a capitalist industry which seeks to gain from, not necessarily give back to, the local area (Devine & Ojeda, 2017). Thus, it is likely that this issue is not specific to Victoria Falls and is also experienced by local people

in other tourist regions. However, in general, lack of resources of GBV prevention is a concern in many communities (Mihalic & Irwin, 2003).

What Are Your Ideas to Prevent GBV in the Community?

Enthusiasm for GBV prevention was very high among focus group participants. Many of the prevention ideas raised by participants have been used effectively in other parts of the globe. For instance, one participant suggested integrating GBV prevention into the school curriculum:

> . . . these are social issues, they should be part of, like, your social studies and, you know, the stuff that they teach you at school. It starts- it starts from there. You have to educate your people and that new generation as you bring them up. Bring them up with, uh, you know, with a culture that is against gender-based violence. Educate them in the schools.

School-based violence prevention may be an effective prevention strategy (Foshee et al., 2005; Taylor et al., 2013). Participants also suggested that it was very important for men to be involved in GBV prevention. For example, one participant said, "Why is the responsibility falling on women? What responsibility are men taking?" This comment reflects literature emphasizing the importance of designing prevention programs for men and boys (E. Miller et al., 2012). Another idea raised by participants was the idea of home visiting programs that assess for the presence of GBV. This concept reflects research on home visiting parenting programs, which have been found effective for a variety of outcomes, such as child abuse prevention (Peacock et al., 2013). In addition, participants mentioned that people in the community needed to be educated on the child abuse reporting call line (the national line where child abuse can be reported and addressed). One participant said, "I don't think people really know child line, not at all." Call lines are an important part of addressing child abuse in a community (Schober et al., 2012).

The most frequently discussed GBV prevention idea was a poster campaign, which was raised by a focus group participant. Specifically, participants were excited about the idea of a poster campaign in schools or on billboards. Social marketing campaigns and other prevention initiatives that change norms are an area of growing research (Berkowitz, 2010; Gidycz et al., 2011). Multiple subthemes arose surrounding poster campaigns. Participants thought the posters should use lots of pictures and visuals, and should be designed by students, and should be available in students' native languages. All these ideas are consistent with previous research showing that posters must be attractive and salient to target audiences (Berkowitz, 2010). In addition, these ideas speak to the growing need to include youth in prevention efforts (Edwards et al., 2016). Participants thought that posters should be displayed at the beginning of a school year so that new students will have maximum exposure to the messaging. Participants also offered specific ideas for poster content–for example, educating students about power and rebalancing power. In addition to a poster campaign, participants felt it would be important to educate teachers and students on why the posters are needed. As one participant remarked,

> I think that we need stronger advocates who are willing to lobby and advocate that we want these posters of GBV being displayed in the schools. . . . But we need to educate the teachers while we are bringing the poster. And then, they have to give the opportunity to also speak to the children. So, when we are talking to children, we know they understand that what is going to go on this poster is what you have to implement.

How Might Community Members React to a Poster Campaign?

Because awareness campaigns and posters were the most popular and widely discussed idea, we asked specifically how community members might react to a poster campaign. Participants stated that community members may be hesitant at first, but by involving stakeholders and explaining the posters, the community would accept the posters. For example, one participant remarked, "as long as we explain to the people, they'll love it." Another participant said,

> I think a step-up line to the headmaster, the mayor, to the stakeholders, to everyone who can be involved with this and helping the community . . . who are going to come here and sit down and as most- um, what's it called? . . . It's mostly advocates. We then now get to explain to the stakeholders, that "Guys, want to have a poster campaign. It's not only going to be a campaign with posters, but we are going to involve A, B, C, and D for the poster. But then you are the people who lead other people."

Participants also stated that it would be important to present the posters in multiple different languages, given the diversity of subcultures in the region. Finally, participants stated that it was important to focus on the positive in the posters. This focus on the positive, such as stating that most students do not accept violence or that most students would intervene in a violent situation, is consistent with best practices for social marketing campaigns (Berkowitz, 2004, 2010).

Discussion

Informed by models of community-based research such as the CBPAR (Baum et al., 2006; Juujärvi & Lund, 2016; Snider et al., 2009), the aim of the current study was to conduct a focus group of stakeholders in Victoria Falls, Zimbabwe, to learn about their perceptions of the reasons for GBV, their ideas for GBV prevention, and potential community reactions to GBV programming. This aim is consistent with the Zimbabwean government's mission to implement evidence-based GBV prevention (Shoko, 2017). Overall, we found that stakeholders' perceptions of the reasons for GBV were consistent with the empirical literature on GBV risk factors (Capaldi et al., 2012; Tharp et al., 2013). Similarly, strategies that stakeholders thought may be effective were analogous with promising GBV prevention being implemented in other parts of the globe. Overall, the potential for comprehensive, effective GBV prevention is high and comes with the community support necessary for successful implementation. Findings from this study present opportunities for future research and can be used by researchers and practitioners to create relevant programming in the region and beyond.

Although most of the reasons for GBV named by participants are consistent with the literature (e.g., lack of women's empowerment, alcohol use, and normalization of violence), participants also raised one issue that may be more unique to the specific context. This issue regarded the infrastructure in Victoria Falls focusing resources on tourism instead of GBV, a problem faced by local people. Although previous research describes the association between tourism and sex work (Kibicho, 2005), GBV (Piscitelli, 2017), and other forms of violence (Devine & Ojeda, 2017), this issue warrants future study. For instance, what role does tourism play in preventing or promoting gender-based violence? Is this issue present in other developing tourist areas? What are locals' perceptions of how their community's resources should be used in regard to tourism and GBV prevention? Practitioners and policy makers may consider how resources from tourism may be funneled into prevention and intervention for GBV and other health and social problems.

Stakeholders were very enthusiastic about GBV prevention and raised many promising ideas for prevention. Importantly, these ideas could be integrated into existing services and infrastructure–for example, schools and child welfare services. The breadth of participants' ideas speaks to the need for comprehensive GBV violence prevention that is integrated both with the multiple contexts for individuals' lives (e.g., school and home; Nation et al., 2003; Rotheram-Borus et al., 2008), as well as the need for primary and secondary prevention that prevents violence from ever occurring and for tertiary prevention that stops current violence and ameliorates its effects (Limbos et al., 2007).

The idea of a poster campaign generated the most excitement among stakeholders. Some evidence suggests that social marketing campaigns and other initiatives that change norms have promising efficacy to prevent sexual violence perpetration and increase bystander behavior to stop sexual violence (Berkowitz, 2004, 2010; Fabiano et al., 2003; Gidycz et al., 2011). In particular, it may be efficacious to correct misperceived norms about violence in a community. Norms can be perceived (i.e., what individuals believe about their peers' behaviors and acceptance of behaviors) or real (i.e., actual behaviors and acceptance of behaviors among those same peers; Berkowitz, 2004). Research shows that individuals often overestimate their peers' acceptance of violence and violent behavior. According to the theory of social norms, an overestimation of problem behavior norms leads to individuals' enactment of those problem behaviors (Berkowitz, 2005, 2010). Indeed, quantitative research suggests that misperceptions of violence norms are associated with violence perpetration (Neighbors et al., 2010). Thus, a poster campaign that corrects misperceived norms may be an effective strategy in Victoria Falls.

One of the most important points raised by participants was that it would be necessary to involve key stakeholders. Involving key community stakeholders and organizations is a best practice in prevention (Forden & Carrillo, 2015; R. L. Miller & Shinn, 2005) and is necessary for several reasons. First, prevention must be relevant to the context in which it occurs (Nation et al., 2003). For example, as raised by participants, it is important for posters to be available in multiple languages. Second, related to contextual relevance, prevention must be attractive to the youth that it serves.

Unfortunately, resistance to GBV prevention programs is common among youth, who may feel that such programming does not apply to them (Rich et al., 2002). Third, involving stakeholders is part of building capacity for the program to sustain over time (R. L. Miller & Shinn, 2005). According to stakeholders in the current study, in a project in Victoria Falls, stakeholder involvement in their community would include but not be limited to explaining the reasoning behind posters and having youth design the posters.

The current study has limitations. We engaged a small group of 11 stakeholders in the current study; some other important stakeholders could not attend, such as the town mayor, the chief of the local village, the town's victim-friendly law enforcement unit, and the school's headmaster and guidance counselor. In addition, this study does not include the voices of current students and other youth in the community. Before engaging in any prevention programming, it will be important to involve all of these important community members. Second, in the current study, we did not hear directly from GBV survivors, who are an important stakeholder group. Although it is likely that some stakeholders in the room were survivors, we did not ask about violence victimization due to the public nature of the focus group. Third, the focus group took place in a public setting among nonparticipants, which may have affected stakeholders' willingness to speak candidly. Similarly, research conducted in single-gender groups may yield more honest or candid responses. Fourth, this focus group happened in the context of a conference where some information about GBV causes and prevention was provided. Thus, participants' perceptions and ideas may have been affected by information at the conference. It will be important to also hear from community stakeholders who have no training on GBV, such as parents. In addition, the conference setting introduced selection bias in that all participants were invested in learning more about GBV in the community. We must also hear from community members who do not think GBV is a problem in the community to understand how to reach these community members.

In conclusion, enthusiasm for GBV prevention is high in Victoria Falls, Zimbabwe, for multiple types of potentially effective prevention initiatives. Consistent with the values of community-based research and prevention models, participants emphasized the importance of involving all stakeholders in prevention. The current study was a first step to developing GBV prevention in this region using a community–research partnership. The results of the current study can be applied by research and practitioners to develop and evaluate prevention programming in the Victoria Falls region and beyond.

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ORCID iDs

Emily A. Waterman https://orcid.org/0000-0001-6214-223X
Katie M. Edwards https://orcid.org/0000-0003-1888-7386

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Author Biographies

Emily A. Waterman, PhD, is a postdoctoral research associate in the Nebraska Center for Research on Children, Youth, Families, and Schools at the University of Nebraska—Lincoln. Her research focuses on adolescent and emerging adult development, and the evaluation of preventive interventions that improve the lives of youth, with a particular focus on sexual and dating violence.

Katie M. Edwards, PhD, is an associate professor in Educational Psychology and in the Nebraska Center for Research on Children, Youth, Families, and Schools at the University of Nebraska—Lincoln. Her research focuses on understanding the causes and consequences of interpersonal violence among adolescents, and using these data to implement and evaluate violence prevention efforts.

Evans Irvine Makoni is a youth advocate on sexual and reproductive health rights, environmental and conservation issues. He is the founder of Mosi Advocates on Social, Environmental and Conservation Trust, a Victoria Falls, Zimbabwe, based organization that seeks to address, empower, and educate the urban and rural settlers of this resort town and beyond on GBV, HIV, environment and conservation issues as well as stand for the marginalized and underserved populations in Southern Africa.

Laura Siller, PhD, is a postdoctoral research associate in the Nebraska Center for Research on Children, Youth, Families, and Schools at the University of Nebraska—Lincoln. Her work examines the risk and protective factors associated with intimate partner violence and sexual violence, with a focus on historically marginalized and underserved populations.

Sharon B. Murphy, PhD, is an Associate Professor Emerita in the Department of Social Work at the University of New Hampshire. Her work spans 40 years in the field of domestic and sexual violence as a therapist, educator, researcher, and expert in trials where a victim of domestic or sexual violence was charged with a criminal offense.

Jennifer A. Wagman, PhD, MHS, is an assistant professor in the Department of Community Health Sciences at the UCLA Fielding School of Public Health and director of Violence Prevention Research for the Women's Health, Gender and Empowerment Center of Expertise, which is part of the University of California Global Health Institute. Her research focuses on understanding the health impact of gender-based violence and developing and evaluating public health interventions to prevent violence and promote gender equity and health.