Perceived Barriers to Disclosure and Help Seeking by Female Survivors of Intimate Partner Violence: A Case of Mwenezi District, Zimbabwe.

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Abstract

Intimate partner violence (IPV) is a psychosocial and public health problem which is as pervasive and underreported in Zimbabwe as elsewhere in the world. This qualitative study explored the perceptions of twenty four female survivors of IPV in a rural setting, as well as three key informants regarding factors impeding formal disclosure and help seeking behaviour. Coping mechanisms women employ in the face of IPV were also examined and strategies to enhance formal disclosure were suggested. Three focus group discussions were conducted with survivors, complemented by three semi-structured interviews with key informants. The Model of Help Seeking and Change, and the Disclosure Processes Model were utilised. Women perceived IPV as normal, as a sign of love, distrusted service providers and had narrower definitions of what constitutes abuse. An intricate interplay of individual, ecological, and socio-cultural factors combine to impede disclosure and help seeking by survivors. Internal resources such as hope and spirituality are employed as coping strategies. Building the capacity of existing formal support systems, and decentralising social services are suggested strategies to improve disclosure and help seeking behaviour. Efforts to deconstruct misconceptions and cultural customs that condone abusive practices against women should be scaled up. One limitation of this research is the small sample size. Further work with bigger random samples is imperative for generalisation of findings.

Keywords: intimate partner violence, barriers, disclosure, help-seeking.

Introduction

Intimate partner violence (IPV) is a significant psychosocial ill and public health problem which is as pervasive in Zimbabwean society as it is globally. Although women and men can be both perpetrators and victims of IPV, research statistics consistently reveal that women bear the brunt, and evidence is abound that the most common perpetrator of violence against a woman is her male intimate partner. It is estimated that internationally, 30% of ever partnered women aged 15 years and older have experienced physical and/or sexual intimate partner violence (IPV) in their lifetimes (Devries, Mak & Garcia-Moreno, 2013). There is consensus amongst researchers that gender based violence (GBV) is typically under reported, especially IPV, and this poor disclosure and failure to seek help occurs worldwide (WHO, 2005; Palermo, Bleck & Peterman, 2013; MWAGCD & Gender Links, 2013). There is therefore a strong possibility that there are barriers, perceived or real, that hinder disclosure and utilisation of formal, as compared to informal support services by 'victims' of IPV and the present study attempts to highlight these for women in marginalised rural settings.

Globally, the problem of violence against women can no longer be impugned, and has been designated by the World Health Organisation (WHO, 2011) as a pandemic.

According to the WHO Multi-country Study on Women's Health and Domestic Violence (2006) between 15% and 71% of women worldwide have experienced partner violence. Regional rates range from 16.3% in East Asia to 65.64% in Central sub-Saharan Africa, with variations being partly explained by prevailing cultural dictates (Devries et al., 2013). The USA National Violence against Women Survey (NVAWS) established that 1 in 4 women report being raped and/or physically assaulted by a current or former spouse, cohabiting partner, or date at some point in their lifetime (Tjaden & Thoennes, 2000). A study by Walton-Moss, Manganello, Frye and Campbell (2005) cited by Keeling (2011) identified that 9.8% of women in the USA had experienced abuse within the previous two years while in the UK, the British Crime Survey (BCS) 2009-2010, identified that 29% of women had experienced some form of domestic violence during their lifetime. From the global north to the global south, the prevalence rate of IPV suggests that it knows no bounds and permeates socio-economic boundaries, although WHO (2006) revealed that it is more pronounced in less developed countries (global south), notably Africa, due to cultural norms and other locally prevailing conditions such as poverty. Yet a recurrent trait across the whole world is gross under reporting, failure to disclose and seek help. A technical report from the WHO Multi-country Study on Women's Health and Domestic Violence (2006) established that while 34% -74% of women experiencing physical abuse by intimate partners had ever disclosed to anyone, reports to formal sources ranged from 0.3% - 9.8% to police, 0% - 1.2% to non-governmental organisations (NGOs) and 1.3% - 6% to medical services. According to Watson (2009) most clinical researchers notably Miller, Veltkamp, and Kraus (1997) have established that intimate partner abuse tends to be underreported, and to date, the research on partner abuse remains difficult to interpret because of the underreported nature of the problem.

Palermo et al. (2013) analysed Demographic and Health Survey data collected between 2004 and 2011 from women in 24 developing countries including Zimbabwe, and established that only 7% of victims reported to formal sources which reflects that despite IPV being widespread globally, it is vastly underreported and those who disclose systematically and significantly differ from those who do not. Okenwa et al. (2009) corroborate this observation and point out that though the prevalence of intimate partner violence (IPV) remains high in less developed countries; these figures potentially represent gross underestimation considering that many women are unwilling to disclose abuse. Despite the notable discrepancy, that is quantitative/statistical differences between IPV prevalence and those disclosing/seeking formal help, little is known about the qualitative question of '*why'* there is that vast difference and what deters victims from formally disclosing, reporting and seeking professional help. An appreciation of the determinants or barriers to disclosure and help seeking as perceived by female victims has direct practical implications on prevention, protection and programming intervention strategies.

Statistics from the Zimbabwe Demographic and Health Survey (ZDHS, 2010-2011) consistent with the global figures, revealed that 30% of women aged 15-49 have experienced physical violence since age 15. Furthermore, 27% of women reported that they have experienced sexual violence, and in 9 out of 10 cases, their current or former husband, partner, or boyfriend committed the act. The MWAGCD and Gender Links (2013) echoed similar findings and established that nearly 26% of women in Zimbabwe experienced some form of violence (psychological, emotional, physical and sexual) perpetrated by an intimate partner in the period 2011 to 2012. Despite the enaction of over 18 pieces of legislation to address historical and social gender imbalances, as well as other laws and regulations against intimate partner violence (IPV), notably the Domestic Violence Act of 2007 in Zimbabwe, the prevalence of IPV remains alarmingly high. These figures, high as they are, potentially represent a gross under-estimation if global trends that a significant proportion of women are unwilling to disclose abuse and seek

help are anything to go-by (Miller, Veltkamp & Kraus 1997; Watson 2009; Okenwa et al., 2009). Findings of the Violence Against Women (VAW) Baseline Study (MWAGCD & Gender Links, 2013) illustrated that women are failing to speak out, seek help or justice for abuse suffered, as evidenced by high under-reporting of cases to formal support systems such as the police, health facilities, courts and other social service providers. The study established that only 1 in 14 women who were physically abused reported to the police, and only 1 in 13 interviewed women who were physically abused by intimate partners in their lifetime sought medical attention after injuries. From these findings MWAGCD and Gender Links (2013) recommended that further research is necessary to understand the underreporting of violence against women and IPV in particular so as to empower women and encourage them to speak out and seek help. This research is therefore an attempt to probe what women in Zimbabwe perceive as obstacles or barriers to reporting and disclosing IPV as well as why they are reluctant to seek professional help in its aftermath.

Despite these somewhat lacklustre attitudes towards disclosure and seeking help in the aftermath of IPV, there is consensus amongst researchers regarding the consequences of IPV on victims. Sylaska and Edwards (2014) point out that research has documented consistently the devastating psychological, physical, interpersonal, and occupational effects IPV has on the victim, her friends and family, and the society in general. These outcomes have long been identified and widely documented. Of particular interest to this research are the consequences on the individuals abused. Victims of IPV often manifest an array of emotional and psychological symptoms that affect their ability to perform routine tasks effectively. Baird (1996) as well as Sahin and McVicker (2009) highlighted the psychological outcomes associated with IPV which include higher risk of psychiatric disorders such as posttraumatic stress disorder (PTSD); major depressive disorder, and substance abuse. More specifically, IPV is associated with depression, anxiety, dissociation, personality disorders, psychosexual dysfunction, obsessive-compulsive disorder, substance abuse, somatisation, suicide ideations, anxiety, phobias, sleep disorders and nightmares, panic attacks, nervousness, heart palpitations, hyper vigilance, and hypersensitive startle responses (Watson, 2009). Beyond the somewhat covert emotional and psychological effects are overt physical consequences which include the injuries caused by the physical assaults, notably abrasions, lacerations, fractions, and dislocations, chronic pain, migraines, speech disorders, sexually transmitted infections, ulcers, pelvic pain, intestinal problems (Coker, Smith, Bethea, King, & McKeown, 2000 cited by Watson, 2009). The worst consequence however is death at the hands of an intimate partner. Studies have found that 65% to 80% of victims of intimate partner femicide (the murder of a woman) were previously abused by the partners who killed them (Watson, 2009 citing Campbell, 2004; Sharps, Koziol-McLain, Campbell, McFarlane, Sachs & Xu, 2001). In summing up the effects of IPV on female survivors, MWAGCD and Gender Links (2013) emphasised physical injury, poor mental health symptoms, unplanned pregnancies, stigmatisation, absence from work for days, STI symptoms, increased risk to HIV and out-of-pocket expenses as more common in Zimbabwe. Notwithstanding this myriad of physical and mental health consequences however, disclosure and help seeking behaviour remains low. In light of the multiplicity of these subsequent adverse consequences of the problem of IPV, efforts to understand and support the process of disclosure and help seeking by victims of intimate partner violence are of significant urgency for women experiencing IPV to lead fulfilling lives.

Zimbabwe has made significant progress in so far as establishing the necessary mechanisms and structures for response to IPV issues is concerned, from the enacting of requisite legal instruments such as the Domestic Violence Act (DVA) of 2007 to the establishment of specialised Victim Friendly Units (VFU) within the Zimbabwe Republic Police, Victim Friendly Courts (VFC) within Judicial Services Commission and Victim

Friendly Clinics under Ministry of Health and Child Care (MWAGCD & Gender Links, 2013). More notable is perhaps the popular One Stop Centre (OSC) concept which envisages provision of medical, legal and psycho-social services under one roof to survivors of gender based violence (GBV). Significant progress has also been made with regards to providing crisis centres, or places of safety or refuge for survivors of domestic violence and other forms of GBV through the establishment of Community Based Safe Shelters, for instance in Mwenezi District and Ward 4 in particular. Established in conjunction with Musasa, these shelters are aimed at providing a safe refuge as well as specialised social support services such as counselling for women and children (Bote, 2008). However in-spite of all the efforts and although research findings clearly indicate the importance of social support in the lives of and outcomes of IPV victims, victims do not always ask for the support they need (Liang et al., 2005). Indeed Walsh, Banyard, Moynihan, Ward and Cohn (2010) noted that although the development of specialised services is encouraging; creating services and programmes does not guarantee their use. There appears to be a general reluctance amongst female survivors of IPV to access existing formal social support services in Zimbabwe as elsewhere in the world.

Livesey (2002a) as cited by Keeling (2011) argues that despite the verbal act of disclosure being a simple process, the actual act of speaking the words is far more complex. She points out that disclosing domestic violence at any stage of a woman's life appears to be complex and dependent upon personal, organisational and professional factors, which can best be understood as barriers. Walsh et al. (2010) conceptualised a *barrier* as any factor that serves as an impediment to disclosure, reporting, or help seeking and that makes it less likely that a survivor will tell someone else about her victimisation or seek formal services for help in the aftermath of the victimisation. The significance of identifying these barriers to disclosure and to the use of supportive services is that it aids and informs the ways in which a more supportive environment for trauma victims, such as female survivors of IPV can be created. Ullman (2010) noted that disclosure of trauma is often viewed as an important and beneficial initial step in trauma recovery because both delayed disclosure and nondisclosure may negatively impact the recovery process. Walsh et al. (2010) corroborated this and highlighted that disclosure can reduce isolation and initiate connections with supportive services and resources; and in some cases it can also result in the punishment and removal from the community of the perpetrator with an adequate criminal justice system response. Disclosure and reporting of violence is thus an imperative first step in the quest to finding a long lasting solution to the vicious cycle of violence, failure of which heavily constrains management interventions for IPV.

This study took aboard the recommendations by the MWAGCD & Gender Links (2013) which suggested that further research is necessary to probe what women in Zimbabwe perceive as barriers to disclosure of IPV and their reluctance to seek help, in order to empower women and encourage them to be proactive, speak out and seek help. Documenting these factors will go a long way in informing and re-engaging key stakeholders in fighting this pandemic and enabling survivors to access available services. This exploration will provide an enlightened perspective of IPV in communities and what professional service providers (such as community based counsellors, health care workers, police) can do to tackle the barriers to disclosure and help seeking.

Conceptual Framework

The study was largely informed by Liang, Goodman, Tummala-Narra and Weintraub's (2005) theoretical model of Help Seeking and Change that views help seeking as a process in it-self. A review of Chaudoir and Fisher's (2011) Disclosure Processes Model (DPM), was also imperative given its emphasis on disclosure as an individual decision shaped by outcomes and responses of confidants or the general

community. A combination of both models conceivably provided a comprehensive analysis of determinants to disclosure and seeking help for female survivors of IPV.

Liang et al. (2005) proposed a meta-theory combining promising elements of the ecological model, trans-theoretical model of change, survivor theory, process models, and symbolic interactionist role theories in advancing IPV disclosure research (Sylaska & Edwards, 2014). They advocate a theoretical model of help seeking in which help seeking is viewed as a process in itself, whereby the victim crucially (a) recognises and defines the problem, (b) makes a decision to seek help, and (c) selects a particular type and source of support; and at each of these stages, variables related to the ecological context of the individual come into play i.e. influences by the individual, interpersonal, and socio-cultural factors) (Walsh et al., 2010). To that end, the utility of this model in this study lies on its emphasis on the multiplicity of ecological determinant factors or variables influencing female survivors of IPV's decision processes to disclose and seek help for violence suffered.

The Disclosure Processes Model (DPM) was proposed by Chaudoir and Fisher (2011) as a framework that examines *when* and *why* interpersonal disclosure may be beneficial especially to people with concealable stigmatised identities. They posit that disclosure must be conceptualised and studied as a single dynamic process that necessarily involves both antecedents and outcomes and is composed of a decision-making process and an outcome process. For Chaudoir and Fisher (2011) people who live with a concealable stigmatised identity, for instance a mental illness, experiences of abuse or assault (such as IPV), or an HIV-positive diagnosis, repeatedly deal with issues of disclosure (and nondisclosure) over the course of a lifetime. Their emphasis on the outcomes of disclosure or responses of confidants and the general community as key determinants of whether disclosure and reporting occurs or not, complements Liang et al.'s (2005) model. The DPM assists in understanding the complex components of the disclosure process for females who live with concealable stigmatised identities of IPV victimisation and who need to harness the power of disclosure, reporting and seeking help in order to enhance their lives.

Purpose of the Study

The study sought to put into perspective the factors that impede disclosure and help-seeking as perceived by female victims of intimate partner violence (IPV). The study was particularly guided by the following research questions:

- What is your understanding of intimate partner violence (IPV)?
- What factors impede reporting or disclosure and help seeking in the face of intimate partner violence?
- What coping mechanisms do female survivors of intimate partner violence employ?
- What strategies can be adopted to enhance reporting, disclosure and help seeking by female survivors of IPV?

Method

Research Design

This study was framed within the qualitative tradition of inquiry known as phenomenology. According to Creswell (2009) a phenomenological study describes the meaning of lived experiences of a concept or a phenomenon for several individuals.

Consistent with a qualitative approach, a descriptive case study design which explores unique individual meanings and experiences was adopted. This enabled concentration on a small geographical area to which emphasis was on depth rather than breadth of data gathered from a limited number of individuals. This research paradigm facilitated a deeper understanding of multiple social realities attached by women to intimate partner violence and their particular lived experiences which cannot be universalised. The in-depth focus on the subject under study necessitated a deeper analysis and understanding of observed social phenomena such as the challenges women face and the coping strategies they employ. Such experiences were captured using focus group discussions, complemented by three key informant interviews. Ultimately, this type of qualitative investigation is intended to inform practice by providing elaborate and detailed descriptions of specific processes or concerns governing disclosure and help seeking by intimate partner violence survivors.

Research Context and Participants

This article presents findings from data collected in Ward 4, Mwenezi District in Masvingo Province. A total of thirty (30) women suffering 'behind closed doors' and practising the 'culture of silence' were purposively identified and conveniently engaged to participate in the study based on the author's knowledge of the research area as a government employee in the Ministry responsible for Gender. However, twenty four (24) women participated in the three (3) focus group discussions with the size of the groups ranging from 6 to 10 participants. The twenty four respondents were deemed reasonable to facilitate an in-depth understanding of IPV issues by the researcher. The women's responses were also augmented by narratives elicited from three (3) key informant interviews. These three key informants, from government, a nongovernmental organisation and a local traditional leader were purposively sampled given their role in the fight against IPV.

Data Collection

Data was collected using key informant and focus group interviews which were all audio recorded. As succinctly noted by Kamberelis and Dimitriadis (2005) focus group discussions stimulate debate and engagement around specific events or experiences shared by participants in the group, generating large quantities of material in fairly short periods of time. Furthermore, they produce data that cannot be obtained in individual interviews, because they rely on the interaction between participants to elicit opinions and perceptions. In this study, three FGDs were conducted in the Ward and involved between six and eight participants per group. Discussions ranged from 30 minutes to 1 hour. All FGDs sessions were guided with a written guide of questions. Respondents spoke in third person terms, even in instances where it was clear that personal experiences were being described. Key informant interviews were conducted with all three sampled experts with knowledge and information pertaining to the study matter (Leedy, 1998). This allowed for considerable diversity and expert analysis which ensured that responses fitted well with IPV trends.

Data Analysis

Data was analysed by transcribing audio recordings and classifying the findings into categories and themes. Emerging responses were systematically organised and coded. This thematic analysis of focus group data was aimed to identify broad categories and, within these, key emerging themes. The data were sorted and organised in relation to objectives and research questions of the study. This analysis

facilitated the formulation of insightful, meaningful and comprehensive responses to the research questions.

Trustworthiness

According to Leedy and Ormrod (2004) trustworthiness of data collected is enhanced if consideration is given to the credibility, transferability, dependability, confirmability and authenticity of the data. Qualitative data is said to be more often than not easily influenced by the researcher's biases and values, but in this study care was taken to ensure guaranteed soundness of research findings by being rigorous in data collection, checking and analysis. As part of preparations the researcher conducted a mini exercise with 7 participants at a meeting at MWAGCD Provincial Offices. The researcher sought constructive criticism and advice from the workmates. This enabled the researcher to revise questions so as to avoid ambiguity. The soundness of the research questions was assessed and adjustments were made accordingly. Population validity was ensured through data collection from a purposive sample.

Ethical Considerations

Due procedure was followed to obtain permission to conduct the study from Local Government authorities. Regarding participants, the study addressed such ethical issues as right to withdraw, right to privacy and confidentiality, and protection from harm through obtaining their express informed consent. The purpose of the research was enunciated to all the participants. Participants were made to append their signatures on pre-designed *Informed Consent Forms* and *Consent to be Recorded Forms.* Participation was therefore on voluntary basis as all respondents could stop or withdraw if they so wished. Confidentiality and privacy were emphasized due to the personal nature of the information being discussed. The researcher appealed to all participants to be as honest as possible with their responses to ensure that the generated data are a good reflection of their distinctive life experiences.

Results

The findings presented below constitute the key patterns that emerged from the data. Four major themes emerged from the study, and these broad themes were composed of several sub-themes. The four major themes were: (1) Understandings of IPV by women, (2) Impediments to disclosure and help seeking, (3) Coping mechanisms employed in the face of IPV and (4) Strategies that can be adopted to enhance disclosure and help seeking.

Understandings of IPV by Women

Two sub-themes emerged from the study on the understandings women have on IPV. These sub-themes were perception of IPV as synonymous with Domestic Violence (DV) and perception of IPV as only physical violence and not inclusive of other forms such as sexual, emotional or psychological abuse.

IPV as synonymous with Domestic Violence (DV) and as Physical Abuse Only

The majority of respondents showed a minimal appreciation of what the term IPV entails. However from the responses given during FDGs, the researcher could infer that they had insight into the problem with the majority viewing it as synonymous with domestic violence. They understood domestic violence as 'couple violence' which they concurred occurs between a husband and wife. Others understood it as 'wife battering' and one respondent stated that;

> '*Intimate partner violence is violence which occurs when a husband beats his wife'.*

Most respondents understood domestic violence but not its specific form of IPV. The discussions revealed that the majority of respondents viewed IPV as physical violence between a husband and his wife. One respondent said;

> *'Physical fighting, beating, slapping, strangulation, kicking, or shoving between a husband and wife is what constitutes violence'.*

Most respondents however did not construe sexual abuse as a form of IPV with most participants saying it is not possible to imagine a wife being raped by her own husband. One respondent mentioned that,

> *'A married woman cannot be raped by her husband; it is her duty to sexually satisfy him'.*

Other respondents said;

> *'Women are not expected to refuse sex to their husbands no matter the circumstances'.*

> *'Bride price was paid to my parents for me to sexually satisfy my husband at all times as such I cannot deny him sex or be raped by him.'*

Moreover, most respondents could neither conceptualise nor understand psychological abuse, emotional abuse, verbal abuse, and economic abuse as forms of intimate partner violence. For the majority, violence was understood in physical terms only and resulting in prominent physical injuries, bruises and torn clothing for it to suffice as IPV.

However, a couple of young women begged to differ from the majority responses given by others. One emphatically stated that;

> *'If I don't want to have sex I must not be forced into doing so because that will be rape'.*

A handful of youthful women concurred that one must not be forced into having sex.
The Matron at the Safe Shelter with Musasa whose core business is counselling battered women and other female survivors of GBV understood the broad nature of IPV as being multi-faceted. She said;

> *'IPV is physical, sexual, emotional or psychological and economic abuse by either partner but mainly by a man on their female partner'.*

She however mentioned that the majority of clients admitted into the shelter are those physically abused, which perhaps reflects the understandings of IPV by women in the community. The local Chief lamented the recent modern conceptualisations of domestic violence and IPV saying that;

> *'Almost everything is now perceived as abuse of women. 'Spousal rape' is non-existent because a husband pays 'bride price' to have exclusive sexual rights from his wife.'*

He further said;

> *'Traditionally, domestic violence and even IPV were unheard of because women knew their status in relation to their husbands, but now it is different due to the clamour for gender equality.'*

He dismissed emotional and psychological abuse as forms of intimate partner violence (IPV).

Impediments to Disclosure and Help Seeking by Survivors

Respondents identified a variety of distinct barriers female survivors of IPV face in disclosing or reporting violence to formal supports such as the police, health care workers or other local social service agents. The identified key emerging factors necessitated the categorisation of barriers to disclosure and help seeking under the following three sub-themes which emerged; victim's personal or interpersonal factors; situational or environmental factors and socio-cultural factors.

Personal and Interpersonal Factors

In spite of the verbal act of disclosure being seemingly a simple process, the actual act of speaking the words appeared extremely intricate for most respondents. Personal and interpersonal reasons cited for reluctance to disclose and seek help included a perception of violence as normal and not serious, perception of violence as a sign of love, shame and stigma, fear of getting the abuser in trouble, fear of retaliation or other possible repercussions, fear of divorce and a general lack of awareness on what constitutes abuse as well as the available services.

In discussing the factors that impede disclosure and seeking help in the face of violence, a majority of the female respondents felt the violence must be serious enough and result in easily observable injuries to warrant reporting. One respondent stated;

> *'A scarred face, swollen eyes, bleeding nose or torn clothing are physical proof and evidence of violence that would make it worth reporting or seeking help for.*

Another vocal respondent added;

> *'If you are not injured or swollen then going to the police or to the clinic is a waste of time, they will ask you for the evidence and proof of being beaten'.*

Thus other forms of abuse such as emotional or psychological abuse such as name calling or verbal abuse were perceived as relatively normal and not serious because they do not result in evident or observable injuries.

> *'You cannot report to the police or go to hospital for being ridiculed or scolded by your husband because such forms of abuse do not cause any serious injury or problem.'*

From the responses given, it would seem that in some households, emotional and psychological abuse or victimisation have been so constant that they are viewed as normal and, unless an alternative is presented, the abused do not consider themselves to be victims at all.

However one of the key informants, the ZRP VFU Coordinator who is male, indicated that;

> *'The reason why women perceive verbal abuse such as name calling, scolding or ridiculing as normal is because they are the majority of the perpetrators of such a form of abuse hence they see it as normal since they hardly suffer from it'.*

Against the same perception of violence as normal, some respondents went further to mention that violence is actually a sign of love. One respondent said;

> *'A man who beats you up or who is extremely possessive or jealousy is the one who loves you'.*

This sentiment sparked a lively debate in one of the FDGs which divided respondents' opinion although a significant number supported it in the end.

> *'It is better for a man to beat you when you are wrong than for him to remain quiet and not punish you in any way. Beating you is a sign that he loves and cares for you.'*

Another factor raised was fear of attracting the attention of the public or strangers which many respondents perceived as shameful, embarrassing and stigmatising. One respondent said;

> *'Reporting or disclosing abuse suffered to a helping professional such as the police means recounting or reciting the circumstances leading to the abuse over and over again, which is quite embarrassing.'*

Furthermore, they mentioned reporting to the police would make neighbours and relatives aware of the goings on in their private home, which one respondent said amounts to;

> *'Washing dirty linen in public and makes the victim a subject of gossip.'*

This perception of violence as a private matter, coupled with the fear of shame and embarrassment therefore deters most women from disclosing their abuse to the police or to health care workers. One respondent mentioned that;

> *'It is not uncommon to hear a woman with a swollen eye or a scarred face lying or exaggerating the source of such IPV injuries by saying she bumped into an open window or just fell onto something that hurt her.'*

The fear of getting their husbands in trouble, fear of retaliation or fear of other possible repercussions such as divorce were some of the other barriers deterring disclosure and seeking help from professional sources. One respondent stated that;

> *'Going to the hospital would get your husband in trouble with the law enforcement agents such as the police which can consequently cause him to retaliate.'*

They said they would rather endure the abuse than report or disclose for fear that it would enrage their abusers who would respond with even more impunity and violence. Furthermore, a fear of being divorced for reporting violence to authorities was cited as another barrier. Most respondents feared that disclosing or reporting abuse would ultimately end their relationships or result in divorce.

A general lack of awareness on what constitutes IPV and the subsequent available services was also an apparent barrier to disclosure and help seeking. Despite efforts to

raise awareness by both governmental and non-governmental organisations (NGOs) into domestic violence and IPV in particular, some respondents professed ignorance about what constitutes or defines IPV, did not know who to contact, and even where to go. The ZRP VFU District Coordinator for Mwenezi concurred and said that;

> *'Women are often unaware of the legal instruments that are in place for their protection and some do not even know the legal procedure and options available to them.*'

These women are therefore unlikely to seek any professional help given their lack of information and knowledge.

Situational and Environmental Factors

The second category of barriers that influence victims' disclosure and help seeking pertained to situational and environmental factors such as economic dependence on abuser, financial issues, distance to the service, biased attitudes of service providers and subsequent distrust in them.

The economic dependency of women on their husbands for almost everything was also cited as a significant barrier to reporting. Resources such as land, livestock, homesteads and other sources of livelihood pertinent in rural settings are owned by men, and women victims seldom own anything economically significant to provide an alternative in the event of leaving the abusive relationship. One participant mentioned that;

> *'If you do not have a job, and you have your husband arrested then no one will take care of you'.*

Thus to the extent that women have poor access to economic resources, and are too dependent on their abusers, disclosing and reporting abuse seems to be inconceivable.
Another barrier mentioned was that of financial constraints. Most respondents concurred that;

> *'Money is central to everything and lack of it hinders accessibility of services because we need it for transport, payment of service fees, purchasing medication and for general welfare.'*

Respondents mentioned that transport was quite expensive in the context of Mwenezi as a district, because they need to travel long distances to access various services. Reference was made to the geographical setup of the district which has 3 main district centres namely Mwenezi, Rutenga and Neshuro, which makes it difficult for IPV survivors to navigate and access needed services. One respondent emphatically stated that;

> *'A transport fee from here to Neshuro is $3.00 and from there to Mwenezi is $10.00. The bus fare is just too much that in the end, disclosing abuse to an aunt is the only option'.*

Apart from the physical factors affecting the accessibility of service providers, another barrier raised was the biased attitudes of service providers and subsequent distrust in them. One respondent stated that;

> *'The police are lacklustre and reluctant to assist women reporting cases of abuse.'*

The ZRP VFU District Coordinator partially confirmed this reluctance. He pointed out that,

> *'An attempt is made to solve domestic disputes in an amicable manner without initiating litigation or prosecution because most women subsequently withdraw cases before they are finalised.'*

Women however misconstrue this reluctance as corruption as they often see perpetrators scot free after spending only 1 or less days in police custody. One participant said;

> *'The police officers are corrupt; they accept bribes end of story'.*

Therefore, women in the rural areas seemingly lack confidence in the police such that even when violated or abused do not report such cases.

Another notable factor cited was complexity and discomfort of reporting the matter to a police officer of opposite sex. One respondent had this to say;

> *'I am more comfortable reporting an incident of abuse, harassment or rape to a female police officer than to a male officer'.*

The VFU officer concurred that rural police posts are either understaffed or manned by police officers who are not well versed with, or well equipped to handle IPV cases although the Government is addressing the issue.

Socio-Cultural Factors

The third theme concerning barriers to women disclosing and seeking help is the socio-cultural context such as cultural beliefs and attitudes, religious beliefs, traditional practises and the response of family and community.

The majority of interviewed respondents concurred with one respondent who stated that socialisation in the Shona culture which is highly patriarchal, has;

> *'Taught us to allow the males to dominate, to look upon the man as the head of family who has control in the home and must be respected. We have been socialised to accept that being a woman always comes with endurance of hardships, with abuse being one of those hardships.'*

In discussing the factors that obstruct reporting and seeking help in the face of violence, cultural beliefs and attitudes were cited as playing a central role. Respondents were in agreement that in Shona culture women are from an early age taught to be obedient and submissive to their husbands who are *'the heads of the house'.* Wives are therefore not encouraged to disclose or report any skirmishes with partners or that they have been beaten by their husbands. One respondent mentioned that;

> *'Conflicts in relationships are not only private and confidential, but happen to all women who should therefore endure, soldier-on and persevere with their marriages despite abuse'.*

Asked about instances whereby a man is justified to beat his wife, one respondent said;

> '*If a wife disrespects her husband, does not cook for him, refuses him sex or cheats on him, she can be beaten by her husband. If he does not beat her for such behaviour, then he does not love her at all.'*

The prevailing cultural beliefs and attitudes reflected a high degree of tolerance and acceptability of IPV as a normal aspect of life.

Closely related to cultural attitudes and beliefs, religious beliefs, predominantly Christianity was also singled out as a significant barrier to reporting of IPV. All the respondents admitted to being Christians of different denominations but concurred that their Christian beliefs as guided by the bible, discourage divorce which they said can result from reporting husbands to the police. One vocal respondent said;

> *'Reporting your husband to police is the same as choosing to separate from him or divorcing him, which is condemned as a sin by the bible. The bible encourages women to submit themselves to their husbands.'*

Thus due to these strong religious beliefs, women are reluctant to disclose and seek help for IPV experienced for fear of terminating their relationships.

Fear of the response of the family, neighbours and the greater community was also a notable factor raised to explain why women are reluctant to disclose abuse and seek formal professional help. Respondents pointed out that disclosing abuse was tantamount to *'breaking up the family'* because families would be divided between those sympathising with the victim and those supporting the abuser. One respondent mentioned that;

> *'Some relatives can blame the beaten woman for exaggerating or lying while others simply blame her for not leaving the abusive relationship, although the act of leaving is not as easy as they imagine.'*

Coping Mechanisms Employed by Women in the Face of IPV

Leaving Home and Seeking Refuge

Some women reported that they would run away or temporarily leave their homes and seek refuge elsewhere. One respondent reported that;

> *'It is not uncommon for some victims to spend the night outside for fear of being severely harmed by a drunken husband who becomes violent at night when he arrives from drinking.'*

Others concurred that most victims seek refuge at neighbours or relatives for the night, only to return home the following day or after a while. Others said that for serious physical abuse, they can go back to their original families of birth but would normally return after the abuser follows up and invites them to come back.

Fighting Back

Respondents reported that fighting back is one way they use to defend and protect themselves from further harm. One respondent mentioned that;

> *'Women typically use kitchen utensils such as pots or pans to physically retaliate abuse.'*

Others however pointed out that women cannot stand toe to toe or match men physically hence resort to verbal retaliation through scolding and demeaning their abusers.

Use of Informal Social Supports

Women often develop several strategies to ameliorate their suffering without necessarily reporting their victimisation to formal support services. Most respondents said they would cope by turning to extended family members who would facilitate dialogue with their abusive spouses. A few reported engaging friends, neighbours or church mates. The use of social capital helped women as some spouses came around although some women noted that some men proved difficult at first indicating that;

'*As heads of households, they would not be told what to do by anyone'.*

Women Groupings/Clubs

Some women noted that they realised that there is strength in numbers and came together into small groups and ventured into income generating activities (IGAs). One woman mentioned that;

> *'Generating my own income eases tensions with my husband as it avoids me from requesting money for basic food stuffs from him time and again'.*

They again said these group activities enabled them to share experiences and advice on matters of concern. They mentioned that such clubs offered them platforms to occupy themselves with meaningful activities rather than sit back and stress over the violence being experienced.

Use of Religion

A majority of women indicated that they;

'*Turned to God through prayer'.*

Their religion and spiritual beliefs gave them solace and they noted that they simply waited for a miracle to happen as they sought divine intervention or waited for the Holy Spirit to intervene and transform their abusive partners. Through praying, reading the bible and going to church, most respondents said they found strength to endure abuse and sustain their marriages.

Consulting Prophets or Traditional Healers

Some respondents added that, women in violent partner relationships may also seek help from prophets or even traditional healers whom they think might be able to appease the violent spirit of the abuser through traditional medicine and customary rituals. Although viewed by some as bad, some respondents supported the idea of getting *'love portions'* to rid of the violence and spice up their marriages or relationships.

Strategies that can be adopted to Enhance Disclosure and Help Seeking

Decentralising Social Services

Most respondents agreed that there is need to bring social service providers such as health care workers, the police and other social service providers from NGOs closer to the people and be accessible all the time. One respondent stated that;

'Challenges in having to travel long distances to report to police or to get medical care are discouraging hence establishing smaller service centres such as police bases or rural health centres that would be a walking distance away can encourage women not to to report and seek professional help for IPV.'

Implementation and Adherence to Policy Guidelines

One key informant indicated that the frameworks and structures for response and management to IPV are in place but falter at the level of implementation. He noted that;

'As much as Government has passed laws and policies aimed at ending gender discrimination and opening more doors for women, these have largely remained on paper and not taken down to the marginalised communities where majority female IPV survivors are.'

He suggested that full implementation of policies such as the National Gender Policy (NGP) and full administration of the Domestic Violence Act (DVA) is pertinent to enhance disclosure and reporting. He however applauded Government efforts which they observed are hampered by resource/financial constraints.

Provision of Small Loans to Women

Respondents agreed that;

'The Government should avail small loan packages so as to boost our projects or IGAs.'

They concurred that their economic dependency on their husbands is reduced as they become financially self-reliant which boosts their social status, enhances self-confidence and self-esteem. Availability of financial resources was suggested to be critical and central in determining disclosure and help seeking.

More Awareness Campaigns and Meetings Targeting both Sexes

The majority of respondents indicated that there is need to continuously undertake more awareness campaigns and meetings educating women on IPV as well as the mechanisms in place for its management. Such meetings would further enlighten communities so that there is a by-in from everyone concerned. One respondent stated that;

'More awareness campaigns supported by IEC material such as t/shirts printed with messages in vernacular, can help spread the message and encourage women to be pro-active and seek help for the victimisation they are going through.'

Continuous Engagement of Traditional Leaders

The majority of respondents stated that unpacking cultural dynamics and addressing cultural values that condone and normalise IPV is also a critical starting point. One key informant noted that;

'Since traditional leaders are custodians of culture, their incorporation in such issues would imply that they have a buy-in and all issues related to culture will be

dealt with. Furthermore, increasing the punishment or sanctions for wife abuse is also a notable strategy.'

Availing Resources for IPV Management Programmes

Respondents highlighted that women's disclosure and help seeking can be enhanced provided that resources for IPV management programmes are availed by the government and other stakeholders. One key informant suggested that;

'The establishment of more Community Based Safe Shelters such as the one established through Musasa in Ward 4 is imperative as it provides a safe refuge for battered women for critical services in times of crisis such as counselling.'

Discussion of Findings

Narrow Definitions of IPV

This article reports the perceived barriers to disclosure and help seeking by female survivors of IPV with special reference to women in Ward 4, Mwenezi district. In doing so, the study crucially established that women in rural settings have somewhat narrower understandings, conceptualisations and definitions of IPV, which are compounded by a general lack of awareness on what constitutes IPV and subsequent available services. A significant implication of such low awareness and narrower definitions of IPV is that women neither perceive their abuse as victimisation nor view themselves as victims of IPV, hence they do not realise the need to disclose or seek help. The DVA defined domestic violence and conceptualised IPV as repeated insults, ridiculing, stalking and demonstrations of obsessive possessiveness and jealousy of a partner as domestic violence (DVA, 2006). Paradoxically, the same attributes of stalking, obsessive possessiveness and jealousy, are considered 'signs of love and care' by a majority of the women, which means they do not perceive themselves as victims at all.

This position is in tandem with Liang et al. (2005) who in their stage Model of Help Seeking and Change observed that a battered woman's appraisal or definition of her situation shapes her decisions around whether to disclose and from whom to seek help. For them, the first stage of 'problem recognition and definition' is the critical first step to whether an abused woman will decide to disclose or seek help for violence experienced. By necessary implication, failure to recognise and define a situation as abusive entails failure to disclose and seek help. Thus women in Ward 4, Mwenezi perhaps do not disclose and seek help for violence experienced because they do not recognise and define their relationships as abusive. Although influenced by the ecological and socio-cultural context in which the women exist, the definition or perception of whether what has occurred is abuse or victimisation is an individual or personal cognitive process determined by awareness and knowledge levels. This lack of awareness is also echoed in Makahamadze et al.'s (2012) study in which they observed that women have limited knowledge of legal provisions that define what abuse is, in order to protect their rights and this prevents them from taking advantage of the law by disclosing and seeking help for violence suffered.

This finding highlights the need for improved methods and concerted efforts by the Zimbabwean government and stakeholders, to disseminate information to sensitise women and communities and thus raise their awareness on IPV and related issues, especially conceptualisations given in legal instruments such as the Domestic Violence Act (DVA).

Intricacies of Impediments to Disclosure and Help Seeking

Findings of this study reflect an intricate interplay of individual, interpersonal, familial, ecological, and socio-cultural factors put forward to account for why women may decide not to disclose abuse or seek help in its aftermath. One such factor is the perception of IPV as a personal and private matter. This concern with privacy and confidentiality is perhaps driven by the shame and stigmatisation surrounding being a victim of IPV. Fear of attracting the attention of the public or strangers, and being a subject of gossip, which many respondents perceived as shameful, embarrassing and stigmatising was raised as an impediment to disclosure and seeking help by women in Mwenezi. Equated to washing dirty linen in public, reporting IPV elicits intrapersonal feelings of shame and embarrassment within the female victims of IPV which perhaps reflects the wider social stigma common to violence against women. To avoid such shame, embarrassment and stigma, female victims of IPV keep to themselves and do not disclose or seek professional help.

Effects of the experiences of shame and stigma on the decision to report or disclose abuse are perhaps best expounded by Chaudoir and Fisher (2011) in their Disclosure Processes Model (DPM). They point out that people who live with a concealable stigmatised identity, such as survivors of IPV, are nested within an on-going process of 'stigma management' and the outcomes of these cognitive processes determine whether they disclose or not, and thus shape the overall disclosure trajectory. Therefore to the extent that female survivors of IPV perceive being abused by their partners as shameful or stigmatising, they may make use of a facade that portrays an image of wellness and do not disclose or seek help for violence experienced. The implication of this finding is that helping professionals such as health care workers, social service agents, or the police should be well equipped to detect the subtle indicators of possible abuse so as to positively probe and facilitate disclosure of IPV.

Findings of this study are also consistent with the findings by Chuma and Chazovachii (2012) who established that fear of shame and stigma is one of the greatest challenges that prevent women from lodging their complaints with the law enforcement agents (police). It deserves mention that such stigma is not only at the individual level but is also at the family level. As Chuma and Chazovachii (2012) elucidate, relatives, particularly in-laws have often actively discouraged and even stopped women from pressing charges against her husband fearing unnecessary attention, shame and embarrassment which tarnishes the family image. In light of the foregoing, although IPV victims may disclose to informal supports or relatives such as aunts, as is typical in the Zimbabwean context, the responses they receive are not always supportive and sometimes actually reinforce their feelings of self-blame, shame and embarrassment. Furthermore, they may be blamed for causing such abuse, tarnishing family image and are thus actively stopped from seeking legal recourse or any other help. Effects of such familial and socio-cultural responses are echoed by Chaudoir and Fisher (2011) who pointed out that disclosure is shaped by prior experiences or shaped by responses of initial confidants. They observed that when individual disclosure events create positive outcomes and enhance well-being, they may serve to increase future disclosure likelihood while, when individual disclosure events create negative outcomes and are detrimental to well-being, they may serve to decrease future disclosure likelihood. To avoid both individual and family stigma, female survivors of IPV therefore choose not to disclose abuse to formal supports and seek professional help.

The implication of this finding is that it is absolutely imperative to reduce the social stigma surrounding violence against women and IPV in particular. The drive to empower women and build their self efficacy is an absolute imperative while at the same time,

continuous engagement of the traditional leadership as custodians of culture is important to the extent that it can promote the likelihood that people in rural settings will respond with appropriate support and care if someone they know discloses experiences of violence.

This study also established that women in rural settings face a plethora of ecological barriers in their quest to disclose and seek help in the aftermath of IPV. Although one such factor is classified as economic dependence on abuser, it speaks volumes and reflects much more than just financial or material dependence. Women in this study reported that resources such as land, livestock, homesteads and other sources of livelihood pertinent in rural settings are owned by men, and female victims seldom own anything economically significant to provide an alternative in the event of having to leave the abusive relationship. Lack of a sound economic and material foundation coupled with the obvious financial constraints; apparently deter female survivors from disclosing and seeking help for IPV for fear of losing everything. Makahamadze et al. (2012) established similar findings as women stated that they do not report cases of domestic violence because they would lose economic support if they reported their husband. However such findings reflect wider and deeper socio-cultural norms and practices for instance the patriarchal framework embedded in Shona culture, and not merely the superficial aspect of economic or financial dependence. Zimbabwean women are from an early age socialised and taught to be obedient and submissive housekeepers to their husband breadwinners and custodians, as such they are always in positions of less power compared to men, both socially and economically. The net-effect of this socialisation on the individual level for female survivors is a recurrent and incessant inferiority complex, lack of self esteem and low self confidence to challenge cultural grand narratives that have been passed over from generation to generation and irretrievably internalised.

What is therefore often categorised as barriers to disclosure and help seeking, for instance financial issues or economic dependence, is apparently an intricate combination of ecological and socio-cultural factors manifesting at the individual or personal level as low self esteem and low confidence, that deters the individual victim from challenging cultural grand narratives and acting on a decision to disclose and seek help for abuse. This intricate interplay and combination of factors is what is portrayed by Liang et al.'s (2005) theoretical framework, which importantly notes that the economic, political, and cultural context in which the life experiences of female survivors of IPV are embedded, is critical in determining whether disclosure is done or help is sought.

Some of the cited reasons for not disclosing abuse and utilising help services significantly resonate with the second stage of Liang et al.'s (2005) Model of Help Seeking and Change, that is the 'decision to seek help' itself. These reasons include the fear of retaliation from the abuser, fear of getting the abuser in trouble, or significant distrust in the service providers, notably distrust in the police. It deserves mention that these reasons were raised as significant barriers to disclosure and service use by female survivors of IPV in Mwenezi district notwithstanding their realisation that what has happened is actually abuse or victimisation. Most respondents felt that reporting their husbands would get them in trouble with the law enforcement agents such as the police which they consequently felt would cause an escalation of the abuse as the abuser retaliates for being reported. Sylaska and Edwards (2014) noted that a victim's feelings or fear of retaliation has been observed to impact negatively on disclosure of IPV. Okenwa et al. (2009) found out that threats of more violence from partners in retaliation deterred a significant number of Nigerian women from disclosing abuse and seeking the help of medical professionals. Similar findings were also made by Chuma and Chazovachii (2012) who established that many women opt to remain silent about violence suffered at the hands of male partners for fear of reprisals or that the attacker would retaliate and further harm them.

Despite perhaps making a decision to report or seek professional help (as in Liang et al.'s second stage), some women are deterred from actually acting on that decision due to deep seated distrust in the service providers, for instance the police. This study established that women lacked confidence and trust in the police whom they accused of being corrupt and not following reported cases to their logical conclusion. Indeed prior to the enactment of the Domestic Violence Act, reported cases were more often dismissed as 'domestic' issues best resolved in the home through negotiations and reconciliation. Thus women still accuse the police of being indifferent, lacklustre and reluctant to assist female victims of IPV. Palermo et al. (2013) similarly observed that discriminatory and stereotypical attitudes towards victims in courts and law enforcement settings were a significant barrier to disclosure and utilisation of police services. A study by Melinda (2008) in South Africa established that despite reporting incidents to the police and applying for protection orders, a significant proportion (over 50%) of victims do not return to court to have their temporary protection orders finalised by the courts. Her research explored and cited several personal, social and structural barriers that affect women's decisions to proceed with or retract from the criminal justice process. Chuma and Chazovachii (2012) made similar findings and discovered that the intimidating nature of state institutions to the majority of women is another huge barrier for them to circumvent in order to get any remedy for victimisation. Reporting to a police officer of the opposite sex was raised as discomforting, which raises another potential barrier.

However a closer scrutiny of this barrier in question reveals that perhaps there is more to the issue of distrusting the police than meets the eye. It would seem despite establishing VFU sections across police stations in Zimbabwe, the utilisation of these sections is still negligibly minimal, which echoes the observation by Walsh et al. (2010) that although the development of specialised services is encouraging; creating services and programmes does not guarantee their utilisation. Judging by the attrition rates of reported cases from the police and the courts, the hands of the police are perhaps tied. As established by Melinda (2008) more than 50% of women withdraw pending cases before the courts finalise them and this perhaps contributes to the reluctance of police to immediately press criminal charges on offenders. This reluctance is therefore perhaps misconstrued at best as indifference or lackluster, or at worst as corruption. Judging by the cycle of IPV suggested by Walker (1984) as cited by Watson (2009) women are manipulated by their abusers in the third phase, which is the 'honeymoon phase', and they withdraw cases before they are prosecuted. Furthermore, it would seem the female survivors are also compelled by social factors and cultural norms as families and relatives of the abuser influence them to withdraw cases before the courts.

Individual Ingenuity vs. Structures

All individuals have been noted to employ coping strategies in the face of life challenges, and female survivors of IPV are no exception. A closer scrutiny and analysis of women's experiences of IPV revealed that women exercise agency and varying degrees of control of their lives, even within the constraints of multiple forms of victimisation. It is therefore, vital to acknowledge that women who experience violence, specifically IPV are not merely passive 'victims' but 'survivors' who actively seek to cope with their difficult circumstances. Even though there are limited formal support services available to women in Mwenezi District as a whole, most of which are not easily accessible, the women have developed their own coping strategies and mechanisms that draw on informal networks such as family and friends, as well as internal resources that generate self esteem and self confidence such as engaging in IGAs, resort to religion and self-distraction through social gatherings and groupings.

Itimi et al. (2014) pointed out that the benefits of problem-focused coping, such as acceptance, positive reframing, and turning to religion or spirituality by survivors of IPV have been highlighted by researchers. Their study established that a positive correlation exists between the increase in the spirituality of the patients and their psychological wellbeing and functions. Moreover they conclude that an increase in religious coping strategy has been found to decrease anxiety, depression, and hopelessness and stimulates psychological functions, adaptation to the illness process, life satisfaction, and quality of life in IPV victims. This study therefore confirmed similar findings as women also referred to turning to God, prophets or even traditional leaders as some of their coping strategies in the face of IPV.

Bottom up vs. Top down Strategies

From the findings, enhancing disclosure and help seeking hinges on addressing structural issues raised. At family level, social support should be provided by household members so that women do not self blame, or get scared from sharing their experiences. Although it came out strongly that the Government is trying its level best through policy and legal enactments, the study concluded that the majority of the rural populace hardly knows of the provisions of such instruments and how they serve to help them. Therefore, as a strategy, the study put forward that the government and other non state actors should undertake civic education campaigns so that women know what constitutes violence because according to Liang et al. (2005) problem recognition and definition is a critical first stage determining help seeking behaviour.

The study found that, women in the rural areas are bound by the yoke of patriarchy. In light of this, since culture is a learned behaviour there is need to gradually change the status quo through re-socialisation, behavioral change initiatives and teaching the upcoming generations to accept gender parity. This concurs with Chuma and Chazovachii (2012) who state that the problem of gender inequality needs to be reversed in the process of socialisation. The study therefore suggests bridging the knowledge gap by conducting psycho-educational campaigns targeting both individual women and the wider community.

Limitations of the Study

The focus group methodology was utilised for this study to allow women to identify and generate a wide range of barriers to disclosure and help seeking in a relatively short period of time. However this qualitative methodology has the obvious limitation of generating findings (barriers) that cannot be generalised across the greater Zimbabwean population as a whole. The study used just one Ward utilising purposive/convenient sampling thus limiting generalisability of findings. An attempt was made however to offset this limitation by complementing the FDGs with key informant interviews and reviewing secondary data from published literature to improve generalisability of findings. Although FGDs have the inherent restriction of limited confidentiality for the individual participants to share some important experiences which may be deemed sensitive, it was quite encouraging to note that all the participants in the 3 FGDs were quite vocal and actively participated in the proceedings, giving spontaneous responses which did not suggest any ‘censoring’ of shared information.

Conclusions

The present study aimed to put into perspective and understand the factors that impede disclosure and help-seeking as perceived by female victims of IPV in Ward 4, Mwenezi district, with a view to suggest measures to increase awareness of the menace and enhancing reporting and utilisation of formal services. Despite high global prevalence statistics for IPV, there is growing worldwide consensus amongst researchers that such statistics are a 'tip of the ice-berg' because IPV is generally underreported. This discrepancy is also quite notable in Zimbabwe, and this prompted the research question to qualitatively explore the impediments or obstacles to formal disclosure and seeking professional help.

Findings of this study portray a narrow picture of women's understanding of IPV, as well as an intricate interplay of how individual, interpersonal, familial, ecological, and socio-cultural, factors impede disclosure and help seeking by female survivors of IPV in Zimbabwe. A general lack of awareness, access to and availability of IPV services was highlighted thus there is need to improve structural arrangements that would enable women in rural settings to disclose and utilise professional services. It is postulated that barriers to disclosure and seeking help are both instigated and exacerbated by lack of information and awareness on IPV issues. The need for taking information about IPV and violence against women in general to the rural community settings, or scaling up current campaigns is thus of utmost importance. Breaking the ecological barriers such as distance or transport factors by bringing more services nearer to communities will cut down expenses perceived in travelling to distant police, health or social service centres and inevitably increases awareness of the services. The need for concerted efforts to deconstruct misconceptions and cultural traditions or customs that reinforce abuse of women can thus not be overemphasised.

Recommendations

The following recommendations are informed by, and a direct attempt to address the perceived barriers to disclosure and help-seeking in Mwenezi District;

- Financial and material resource constraints are an inescapable reality in the generality of IPV management and response programmes. The government and development partners should mobilise and increase the resources (both human and material) available to women in need of support. Further to that, availing small loans to women for income generating activities can enhance their economic self sufficiency, social status and ultimately self-esteem and confidence to face the challenge of IPV.
- Efforts should be made to enhance the capacity of existing formal support systems to ethically and effectively deal with cases of IPV in the best interests of the individual survivors.
- Zimbabwe has enacted very good legal instruments and policies that however somehow mostly exist on paper and remain relatively unknown in rural settings. It is imperative that these instruments are articulated to them and enforced through various government departments. In the process, communities should be continuously concientised and educated on their provisions.
- Traditional leadership, i.e. Chiefs who are the custodians of culture, should be continuously engaged and equipped to lead the re-socialisation process to fight the broader normalisation of IPV and structural violence against women.

Implications for Future Research

A more comprehensive study assessing wider determinants of IPV disclosure among women in Zimbabwe utilising random samples that are representative of female survivors of IPV nationwide would facilitate generalisation of findings.

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