Gendered intersections between labia elongation, child marriage, bride price, polygamy and HIV infection

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'The thesis is submitted in partial fulfilment of the requirements for the award of the degree of Doctor of Philosophy of the University of Portsmouth.'

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Recommendations

‘Whilst registered as a candidate for the above degree, I have not been registered for any other research award. The results and conclusions embodied in this thesis are the work of the named candidate and have not been submitted for any other academic award’

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Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ART	Anti Retro Viral Treatment
DREAMS	Determined. Resilient. Empowered. AIDS Free. Mentored. Safe
FGM	Female Genital Mutilation
GBV	Gender Based Violence
GoZ	Government of Zimbabwe
HCPs	Harmful Cultural Practices
HIV	Human Immunodeficiency Virus
INGOs	Inter Governmental Organisations
IPV	Intimate Partner Violence
LE	Labia elongation
NGOs	Non -Governmental Organisations
OAU	Organisation of African Unity
PrEP	PreExposure Prophylaxis
RSA	Republic of South Africa
SRHR	Sexual and Reproductive Health Rights
UN	United Nations
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
VAWG	Violence Against Women and Girls
What Works	What Works to End Violence
WHO	World Health Organisation

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Dissemination

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Abstract

This thesis explores the links between harmful practices such as labia elongation, child marriage, bride price, polygamy and HIV infection. Women are more commonly infected with HIV due to men's promiscuity and violent sexual behaviours that draw on patriarchal gendered socialisations that promote male supremacy and female subordination rendering women and girls vulnerable to HIV. This gender ideology is justified and reinforced through restrictive norms that devalue women and girls. I argue that HIV, due to the violent ways in which it is transmitted, should be regarded as a form of violence alongside LE, child marriage, bride price and polygamy. It is important to link these forms of violence because they exist due to the same structural inequalities that grant men power and control over women and girls. This thesis is based on 30 in-depth qualitative interviews with development practitioners and their stakeholders in Harare, Venda, Musina and Beitbridge. I also conducted 2 focus group discussions with 10 women from the community in Beitbridge. Analysis was done thematically, using an inductive approach and also deductively for those themes from literature review that I tested in my data. Findings suggest that top level development practitioners do not appreciate the nuanced relationship that exists between these practices and HIV. Development practitioners and their stakeholders recognise the role social, gender and religious norms play in increasing women and girls' vulnerability to HIV infection however this knowledge is not translating into programmes. Instead, the development sector silos each form of violence. Furthermore, programming does not approach end VAWG through a strategy that links these forms of violence to the underlying gendered inequalities. My thesis argues for a more holistic and mainstreamed approach to programming in order to maximise opportunities to end this violence. Approaching end VAWG through a focus on one type at a time weakens overall efforts in development to achieve gender transformation. I therefore propose a mainstreaming tool that integrates all of these practices and challenges the norms that sanction them in HIV response models.

Chapter 1

Introduction

1.1 Thesis layout

This first chapter serves to introduce my thesis which is formed of ten chapters. Beginning with this introductory chapter, I lay out the context of my research and outline the structure of the thesis. I explore what the global literature tells us about violence against women and girls (VAWG), and briefly highlight the implications of harmful cultural practices (HCPS) such as Female Genital Mutilation (FGM) type iv labia elongation (LE), child marriage, bride price and polygamy towards women and girls' experiences of violence and how, through these practices, they become vulnerable to HIV infection. My research context lies in the border region between Zimbabwe and South Africa, thus I give the contextual background of my research which includes rationale, and I also make an introduction to an important strand of my thesis in which I argue that different forms of VAWG should be linked (rather than siloed) in development practice.

My argument is in three stages. Stage one of my research demonstrates that LE, child marriage, bride price, polygamy, and HIV, should be seen as triggered by the same negative gender ideology that devalues girls and women. In stage two, I evidence a disconnect in development programming which fails to respond to the lived and linked experiences of women and girls of LE, child marriage, bride price, polygamy, and HIV. In stage three, I go on to present my case for the need to integrate interventions to end the violence that women experience as a result of harmful cultural norms.

The rest of the thesis is laid out as follows: Chapter 2 presents the methodology which outlines the approach I employed to answer my research question and demonstrate the siloed nature of VAWG interventions in development, and to create space for women and girls to narrate their own lived experiences of violence. In Chapter 3 I present my theoretical framework which lays out my argument in conceptual terms stating that the normalisation of violence is what perpetuates it and increases women and girls' vulnerability to other forms of violence. Chapter 4 highlights the process through which violence is constructed, the interface between gender and violence, and how gender synergises with social and cultural factors to shape women and girls' experiences of violence. Chapter 5 explores how LE, child marriage, bride price, and polygamy operate to increase women and girls' vulnerability to further violence including HIV infection.

In Chapter 6 I explore linkages between these HCPs and go on to conceptualise vulnerability and

explore the impact of gender programming to understand the extent to which interventions are responsive to the gendered dimensions of vulnerability. Chapter 7 reflects on the effectiveness of HIV and VAWG programming in Zimbabwe. In chapter 8 I present community level data where women narrated their own experiences of violence. Chapter 9 elucidates my proposed mainstreaming tool that is tailored to inform an effective mainstreaming approach to increase the sensitivity of policy makers across development sectors to opportunities to end VAWG and HIV infection. Chapter 10 offers a summative conclusion to the thesis.

1.2 Definitions

I made some specific decisions on terminology which I need to set out here. I decided to employ the term Violence Against Women and Girls (VAWG) in place of gender-based violence (GBV) but there are contexts where it is contextually appropriate to refer to the phenomenon as GBV rather than VAWG. My decision was influenced by the UN General Assembly's definition of VAWG which highlights key issues of domestic violence, intimate partner violence (IPV), sexual violence, including harmful practices such as forced marriage, FGM, female infanticide, trafficking, honour killings, bride price, and virginity testing (UN, 1993; UN, 2018). IPV is abuse which takes places within an intimate relationship. Both men and women could be victims or perpetrators, but the majority of the burden is experienced by women with men being perpetrators (WHO, 2010). Examples of this include but not limited to financial control, social isolation, sexual coercion, physical abuse.

The UN concisely defines VAWG as "any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women and/or girls, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or private life" (UN, 1993, p. 2). I focus on the gendered dimensions of HIV infection, and its link to LE, child marriage, bride price, and polygamy; both HIV and the aforementioned HCPs encapsulate the UN's definitions of VAWG which entail harm and suffering (UN, 1993; UN, 2020). A critical element of my argument is to make the case that HIV, LE, child marriage, bride price and polygamy are seen as part of the spectrum of VAWG. LE is globally not seen as a form of FGM as severe as types I-3, a view I contest strongly in this thesis as I go on to argue the implications of the practice in further sections of the thesis. Similarly, bride price is not considered violence and neither is polygamy. While there is consensus that child marriage is harmful (UNICEF, 2020; Parsons et al, 2015; Boyden, Pankhurst & Tafere, 2013; Akter et al, 2022), I argue in subsequent sections of this chapter why

these other practices should be seen as violence hence my decision to include them under the term 'VAWG'.

In certain contexts, I refer to LE as FGM while in certain instances I explicitly refer to it as labia elongation for clarity and coherence. There are contestations as to whether LE constitutes FGM since it does not involve cutting. Before 2008, the WHO classified labia elongation as a procedure that constituted FGM type iv amongst other procedures such as: "pricking, piercing or incision of the clitoris and/or labia; stretching of the clitoris and/or labia; cauterization by burning of the clitoris and surrounding tissues; scraping of the vaginal orifice (angurya cuts) or cutting of the vagina (gishiri cuts); introduction of corrosive substances or herbs into the vagina to cause bleeding, into the vagina or for the purposes of tightening or narrowing it" (WHO, 1995).

However, by 2008 it was concluded that LE did not cause any harm to warrant its inclusion in that category which now cites: "all other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterization (WHO, 2008, p.1). Although there are contestations about the nature of the harm it causes, LE was still referenced by WHO as a "harmful cultural practice that violates human rights" due to the social pressure on young girls to perform it and the permanent changes that it creates on the female genitalia (WHO, 2013). The lack of evidence for LE's harm means that it is not included in global anti-FGM campaigns however it remains that it is an alteration of the female genitalia for non-medical reasons. Furthermore, the rationale for FGM types 1-4 is similar to that of LE, that is preparation for womanhood and for one's gendered role in society (Venganayi, 2017; Bagnol & Mariano, 2008, 2012; Perez, Azna & Bagnol, 2014) hence my decision to refer to LE as FGM.

1.3 Background and research context

The relationship between women and girls' lived experiences of VAWG and the extent to which it is responded to through development programming is the key focus of my thesis. VAWG is one of the most prevalent human rights violations globally and covers a wide range of abuses against women and girls in the home, at work and public life. Whilst many of these forms of abuse also affect men and boys, they disproportionately impact women and girls. Violence is mostly perpetrated by male intimate partners (Garcia Moreno et al 2006; Hester, 2009) and studies have evidenced female perpetrated violence against men however there is under reporting of this phenomenon (Chibber

& Krishnan, 2011; Yigsaw et al, 2010; Shaw & Lee, 2009). Most studies have documented male perpetrated violence against women and although this thesis draws on the repertoire of that literature it does not to suggest that men are generally violent.

Experiences of violence have serious psychological, emotional and physical consequences and may contribute to multiple disadvantages in a woman or girl's life (Sikweyiwa et al, 2020; Skovdal et al, 2022). VAWG occurs not only in one type of relationship, which is marriage, but also within other situational social and complex family relationships. An increasing amount of research is beginning to offer a global overview of the extent of VAWG, with the most common and most severe forms of violence being IPV, forced prostitution, debt bondage of women and girls, sex selective abortion, child marriage, and sexual violence in war (UN WOMEN, 2023).

VAWG is both a cause and consequence of gender inequality (HM Govt, 2016a). The fact that HIV prevalence remains high in Zimbabwe, and that women are particularly vulnerable and disproportionately affected is linked to the normalisation of violence and unequal gender relations (Gwatimba et al, 2020; Chiweshe et al, 2014; Seidu et al, 2021). Ojo argues that "marriage and the family are the bedrock of kinship and it is therefore the most significant feature of African society" (1997, p. 65). However it is this reverence of the institution that marriage is prized above everything else (Kambarami, 2006; Chiweshe, 2016). In a context where practices such as LE, child marriage, bride price and polygamy are prevalent, and all linked through marriage, there is potential to understand any possible links between the different forms of violence that women and girls are exposed to because of these practices, and their exposure to the risk of HIV infection.

In order to achieve Sustainable Development Goal 5 "Achieve gender equality and empower all women and girls" (UN, 2015), it is imperative that drivers of VAWG become a key focus of attention. VAWG interventions require solutions that are suitably intricate, multi- dimensional, intersectional, and informed by the voices and perspectives of as many actors and stakeholders as possible, and most importantly, survivors. My thesis applies the ecology model (Heise, 1998) to understand where action for change is and is not happening. Change is occurring at state level through policy in Zimbabwe, but the extent to which this translates into change on the ground is not yet understood.

My research is exploring the links between LE, child marriage, bride price, polygamy, and HIV infection, which I argue are all forms of VAWG. In development contexts, programming tends to focus on one form of violence with little understanding of how they may be linked to others.

Understanding the links is important in terms of challenging the gender inequalities that underpin VAWG and HIV transmission. Whilst we have knowledge of the root causes of violence, a paradigm shift is needed in terms of reversing the patterns of VAWG. In order to eliminate VAWG, there is a need to specifically address the cultural and social norms behind the violence that women and girls suffer. My thesis argues that we robustly challenge these deep-rooted harmful norms, attitudes and behaviours that normalise LE, child marriage, polygamy, bride price and HIV and I propose a more holistic and mainstreamed approach to programming in order to maximise all opportunity to end these forms of violence.

1.4 Research Rationale

My thesis is framed within a feminist perspective which enables me to explore women and girls' experiences of gender inequality, which I argue, is behind the different forms of violence they currently navigate. I draw on global literature to explore links between LE, child marriage, bride price, polygamy and HIV transmission, a gap which my thesis intends to fill. I chose to focus on these HCPs because they are all interlinked through cultural and religious norms that inform marriage. Gendered marriage norms that are socialised in childhood when LE is performed function as vehicles through which vulnerability to HIV infection is increased. I account for these practices in my argument because of the progressive nature and sequence in which they occur. I highlight my rationale for focusing on these issues in subsequent sections in detail. I include literature on South Africa in this thesis, not comparatively, but in a theoretical and development context because there is a plethora of literature written based on the South African context in terms of understanding the triggers and understanding constructions of masculinities that lie behind the violence experienced by women and girls. Most importantly, my field site in Zimbabwe shares a border with South Africa and the communities on both sides of the border share cultural commonalities such as ethnicity.

South Africa presents a unique opportunity to best understand the nexus of HIV and gender inequality and the implications for responses and programming (Jewkes & Morrel, 2010). Additionally, in terms of innovations around what works to end violence, a lot of scientific studies have been done particularly led by the South African Medical Research Council. This makes the inclusion of South Africa as a secondary case study in my research useful. Although I use contextual literature about South Africa my contribution is the primary data in relation to the border area of Beitbridge and Musina/Venda. I therefore assert here that my decision to include South Africa in

my thesis is not to insinuate that violence is something that is unique to the context because the evidence is clear that violence is a global problem. I go on to present my argument on why LE, child marriage, bride price, polygamy and HIV should first and foremost be seen as violence.

1.4.1Why Labia Elongation should be seen as violence

In this section I elucidate how labia elongation structures women's vulnerability in later life. Labia elongation is the manual manipulation and stretching of the outer labia minora until they reach a certain length which can be between 2 and 8 centimeters (Perez, Aznar & Bagnol, 2014); aided by the use of herbs, dried bat wings and oils to ease the elongation process (Bagnol & Mariano, 2008, 2012; Khau, 2012)**.** Instructions can either be given in initiation schools, in homes, as well as in peer groups, and it is peer pressure that typically influences the practice and continuation to stretch the labia once girls have learned about it (Bhebe, 2020). This process of elongation can take place in adulthood however is recommended during childhood from the age of 8 before meniarche when labia are expected to grow quickly (Mwenda, 2006). Expectation over the precise length of elongation may lead to young girls overstretching their labia particularly in instances where they are not monitored leading to body image insecurity in adulthood (Mutunami & Bradley, 2022).

Dapper, cited by Baker (1974) mentioned LE among females of the Hottentot tribe of South Africa in 1668 although among this tribe it was regarded as a hereditary feature and not from manual manipulation of the labia (Gallo et al, 2006; Baker 1974). In British Central Africa young girls were also found to pull both the labia and the clitoris for elongation purposes (Stannus, 1910). LE is reported in Zimbabwe, Zambia, Lesotho, South Africa, Mozambique, Tanzania, Namibia, Malawi, Democratic Republic of Congo, Burundi, Rwanda, Mali, Uganda and Benin (Amadiume, 2006; Green et al, 2001; Nabaitu et al, 1994; Janssen 2002; Koster & Price, 2008; Adeokun et al, 1995; Kaggwa et al, 2023). LE is known as Vushani in Venda, Chinamwari in Remba, and Khona in Shangani whereas the Karanga and Zezurus term it simply '*kudhonza*'(pulling). Similarities are also noted in the way it is practised across the ethnic groups. The common theme is around stretching the labia and going through vaginal inspection for virginity before the girls are married off.

Reports of traumatic pain and infections are well documented (Khau, 2012), The procedure is associated with physical pain, itching (due to herbs used to facilitate the process), irritation, bleeding and swelling needing hospitalization (Bhebhe, 2014), pain during urination and

psychosocial problems (Perz, Aznar & Bagnol, 2014). New evidence has emerged which shows that due to the prolonged process of achieving long labia, girls and women endure physical and mental distress (Kaggwa, Chaimowitz & Olagunju, 2023). However other studies have reported sexual satisfaction for women with elongated labia who also reported that the herbs used to aid the process have medicinal purposes (see Koster & Price, 2008). This view is countered by other research that takes a survivor centric approach and evidence vulnerability and exposure to other forms of violence (Mutunami & Bradley, 2022).

Although LE is prevalent in Zimbabwe, no research has been conducted at national level to produce empirical evidence. Additionally, LE is not considered FGM and neither is it perceived as harmful. Because the settings within which LE takes place appear 'safe' it sends the message that elongating labia is a voluntary process. However, "girls are frequently forced or coerced to participate rather than asked to give their consent" (Tshugulu et al, 2023, p. 255). It is under these circumstances that young girls are "trained to be sex experts as they consider it to be one of the main characteristics of womanhood… and training involves serious explicit sexual demonstrations" (Muzingili & Taruvinga, 2017, p. 37; Parikh, 2005; Khau, 2012) thereby sexualising children prematurely (Muzingili, 2017). It is also during the initiation rites that young girls are socialised that failure to elongate labia will result in divorce or being sent back to one's natal home to perform LE (Khau, 2012; Mutunami & Bradley, 2022).

There is a correlation between LE and child marriage and the same is evident with FGM types 1-3. Men prefer to marry girls who have gone through LE regard them as "women who have expertise in sex" which explains the continuation of the practice (Muzingili & Taruvinga, 2017, p. 39; Berg & Denison, 2013). Girls who have been through initiation schools are also preferred for their subordinate disposition which is taught in the initiation schools (Muzingili & Taruvinga, 2017). Reports from studies in Zimbabwe have found that girls who attend initiation schools often do not return to mainstream school but instead go on to be married as their communities consider them 'women' (Chimuka, 2011; Muzingili & Taruvinga, 2017). A study in Malawi revealed that once girls complete the initiation school curriculum, they will be expected to find a husband within three months of graduation (Chanza, 2014; Ahmed, 2014). Muzingili & Taruvinga argue that exposing children to sexual content is itself abuse and their study reported that newly initiated girls in the Shangaan tribe will be "coerced to find a sexual partner as soon as they are initiated" (2017, p. 38).

Although practised by girls and women, LE is centred around men's sexual needs and desires, and as such is a process that is done in order to get married (Venganayi, 2017). By elongating their labia minora from a young age means that girls can explore and relate with their own bodies in order to make a connection with their "individual and social life" and womanhood (Beasley, 1999, p.78). The rationale for elongating labia is formed around cultural notions of ideal femininity and enhancing male sexual pleasure (Mano, 2004). "This places girls at a lower level than male children because girls are seen as serving the sole purpose of pleasing men" (Tshugulu et al, 2023, p. 251). Fearing social exclusion and failure to secure marriage, or rather be 'returned' to your parents, girls comply with the practice (Jeater, 2000; Bhebe, 2020). Thus, young girls are initiated into womanhood through LE, prepared for marriage, enamored with the ability to 'please' a man sexually (Hilber et al, 2012; Perez, Azna & Bagnol, 2014).

Cultural and gender norms of female subordination to male authority are socialised as part of initiation rites when LE is performed. Girls are reprimanded to be 'good girls' (Skovdal,et al, 2022; Mugweni et al, 2012) and expected to be 'good wives' in marriage where they deprioritise their own needs and desires (Aulette-Root, Boonzaier & Aulette, 2013). This concept of emphasised femininity is a compliance to subordination and is "oriented to accommodating the interests and desires of men" (Connell, 2013, p. 183) The importance of marriage is reiterated during this time and girls are sensitised to notions of shame and stigma that is associated with divorce (Khau, 2012; Chiweshe, 2016; Chisango et al, 2022) thereby reinforcing the idea that one has to endure marriage however difficult they find marital circumstances (Gwatimba et al, 2020; Fidan & Bui, 2016). Hence marriage is portrayed as a union that is fraught with hardship that a woman must endure to avoid divorce (Chireshe, 2015).

1.4.2 Why Child Marriage should be seen as violence

Child marriage is classified by the UN as a harmful practice prevalent in Africa and is defined as a formal marriage (or informal union) between children under the age of 18 or with an adult (UNICEF, 2022). Of the global 20 countries with high prevalence of child marriage, 15 are in Africa (Girls Not Brides, 2021). Regionally, in sub-Saharan Africa 39% of girls marry before their 18th birthday. 13% also marry by their 15th birthday (UNICEF, 2016). Zimbabwe is one of the contexts with higher than average child marriage prevalence. Its child population is estimated to be 47% and

31% of girls are married before the age of 18 with 5% marrying before they are 15 years old (UNICEF, 2020). Religion has been found to encourage child marriage in Zimbabwe (Machingura, 2014), with the traditional Christian churches reporting high levels of the practice at 43%, followed by the Apostolic church (42%), Zion church (34%), and the Pentecostal churches at 21% (Girls not Brides, 2023). Because premarital sex is forbidden girls are married to preserve purity (Ojo, 1997; UNICEF, 2014). Culturally, young girls are coerced into marriage for falling pregnant with the responsible young men expected to pay fines to the pregnant girls' fathers (Bourdillon, 1976; Weinrich, 1982). In some cases, young girls are entered into marriage for engaging in premarital sex or coming home late (Girls Not Brides, 2023). Girls also face the prospect of being expelled from home for falling pregnant before marriage (Masvawure, 2013). These circumstances are all considered dishonourable behaviours to the honour of the family (Filamusi, 2012; Idowu, 1996) and effecting marriage in this way is considered a rational way of mitigating shame.

Poverty is cited as the reason behind most HCPs such as child marriage (Wamoyi et al, 2014). Evidencing gender discrimination parents reportedly marry their daughters off to ease the financial hardship (Akter et al, 2022; Hague et al, 2011; Corno et al, 2016; Corno & Voena, 2016; Fakomogbon, 2021) and to much older men (Oranje, 2016) in expectation of bride price. The prospect of a marriage is perceived as a means to a girl's financial security however child marriage has adverse economic effect as the girls' social and economic development is impeded (Parsons et al, 2015; UNICEF, 2005). This explains the correlate that of those girls who enter into child marriage 50% typically come from poorer families compared to only 14% from wealthier households (UNICEF, 2022; Girls Not Brides, 2023).

The level of education also determines the risk of child marriage with girls from poorer households making the majority of those who drop out of school for lack of funds to pay for tuition. Additionally, women that marry as children are considerably poorer, uneducated, and have less access to health care compared to those that marry as adults (UNICEF, 2005; ICRW, 2007; Nour, 2009; Nasrullah et al, 2014). Because child brides forgo educational attainment, the cycle of poverty becomes intergenerational with lower economic outcomes for their families (Hamilton, 2012; Dahl, 2010). Furthermore, poverty will force them to tolerate leave abusive relationships due to dependency and economic insecurity (Ahinkorah et al, 2022).

Young girls are culturally perceived as more 'valuable' as they come with no sexual experience and therefore more malleable in personality and highly likely to 'obey orders' (Packer, 2002; Chitakure, 2016; Machingura, 2014). The incidence of IPV to a child in marriage is high due to controlling

behaviours from older partners, and perpetuates the cycle of vulnerability where girls are exposed to multiple forms of violence including sexual and psychological violence (Nasrullah, Zakar & Zakar, 2014; Ahinkorah et al, 2022; Maswikwa et al, 2015). Similarly, the sexual and reproductive health rights (SRHRs) of child brides are compromised with far reaching consequences for their health and wellbeing, their children and also the overall development of their families and communities (Rumble et al., 2018; Parsons et al, 2015). A girl is culturally considered mature by the onset of menstruation and their ability to undertake household chores (Chinyoka & Ganga, 2011). Furthermore, a married woman is expected to become pregnant in the first year of marriage which exposes child brides to risk of childbirth complications during pregnancy (Yaya, Odusina & Bishwajit, 2019).

It is established that complications related to pregnancy are the leading cause of death among adolescent girls (Rumble et al., 2018; Gibbs et al, 2012). IPV and child marriage are underpinned by culture whereby cultural practices and traditions reproduce IPV and other forms of violence through child marriage (Ahinkorah et al, 2022). "The consequences of lobola (bride price) are far more serious in relation to child marriages where a child may be threatened from leaving an abusive husband because he paid lobola" (Sibanda, 2011, p. 8) Furthermore within a cultural environment that promotes boy child superiority and associates that with the social and cultural positioning of a girl child's subordination and subservience, child marriage will thrive (Parsons et al, 2015; Burn & Evenhuis, 2014). Equally IPV flourishes due to cultural support, acceptance and justification of male dominance (Sunmola et al., 2018; Bolis & Hughes, 2015).

1.4.3 Why Polygamy should be seen as violence

Polygamy, a common cultural practice in most mid and low -income countries alludes to a man being married to more than one woman at a given time (Thobejane & Takayindisa, 2014; Taryor, 1984; Muthengi, 1995; Elbedour et al, 2002; Mwambene, 2017). The practice is permitted in nearly 83% of global societies, and more prevalently in Africa, Asia, and the Middle East (Al-Sharfin, Pfeffer & Miller, 2015). Nearly a third of the world's population belong to communities where the practice is tolerated. In the African context polygamy was traditionally practised prior to the arrival of Colonists and missionaries; and functioned as part of family law underpinned by cultural values and beliefs (Mwambene, 2017; Omotosho, 2021). As a practice, it performed valuable cultural and social functions such as avoiding divorce in the event of infertility as any African marriage affected by infertile is incomplete (Muthengi, 1995).

If a woman could not bear children, a man was allowed to marry another wife to provide him with

offspring. Additionally, a culturally belief existed that menopausal women will no longer be sexually active whereas their husbands would still be hence the need for younger co- wives (Baloyi, 2010). Baines, Bailey & Amani (2005) assert that polygamy also resolved issues surrounding pregnant and nursing or menstruating wives engaging in sexual activities, an act considered taboo in some African cultures (Mill & Anarfi, 2002). In the event of a man's death his widow can be provided for through marriage to her late husband's brother who may already be married thus polygamy would facilitate a livelihood for the widow and her children (Goercke, 2004). Having established this, it can be opined that in a polygamous marriage "the wives do not have exclusive rights over the husband" (Omotosho, 2021, p. 145) as he is co-owned.

In Zimbabwe, studies have evidenced that young girls as young as 10 years of age are reportedly married off to older men in polygamous marriages to protect them from engaging in premarital sex (Girls Not Brides, 2023). Girls are married off to men who fall into a demography within which the risk of HIV infection is considerably high (Miller et al, 1997; Dupas, 2011; de Oliveira et al, 2017; Schaefer et al, 2017). Similarly, virginity testing a practice common in Zimbabwe, Ethiopia, South Africa and Zimbabwe (Mdhluli & Kugara, 2017; Farise, 2019) sees girls who have lost their virginity before marriage shamed into finding virgin wives for their husbands as compensation. These girls are marked on their foreheads to signify their dishonourable state (Girls Not Brides, 2023).

The importance of marriage in Zimbabwe cannot be underestimated (Kambarami, 2006). Spinsterhood attracts a lot of stigma (Rutoro & Madimbo, 2015) and women opt to be married in a polygamous union to circumvent the shame. Studies have shown that menopausal women are traditionally not expected to have sexual relations with their husbands hence the need to have much younger co-wives to satisfy the husband's sexual needs (Baloyi, 2013). Zimbabwean culture values children (Chigidi, 2009; Mahuntse, 2021; Tshugulu et al, 2023) and polygamy provides the opportunity to produce a large family. The size of a family is historically perceived to offer stability and socio-economic security particularly in a context like Africa where child mortality was higher compared to other regions. Polygamy thus offered that security which could not be guaranteed in monogamous families (Hillman, 1975). In polygamous marriages wives are tasked with reproduction while daughters guarantee bride wealth (Gwirayi, 2016). Polygamy reinforces the notion that women are commodities and objects to be owned by men (Oduyoye & Kanyoro, 2005), and this ideology is characterised by male authority and a lack of autonomy for the females involved (Lees et al, 2018; Fidan & Bui, 2016; Lowes & Nunn, 2017). As with LE, girls are not expected to give consent to these marriages but instead the marriages are a result of entrenched

religious, social and cultural factors that benefit parents and help to sustain notions of honor for the families at the detriment of girl children's development and wellbeing.

Age and power imbalances characterise polygamous marriages. Consequently, these unions are often associated with high incidence of sexually transmitted infections (STIs). The sexual behaviours of men in these unions particularly the multiplicity of sexual partners is the cause of the increased risk of HIV infection (Mswela, 2009; Munjoma et al, 2010; Kurewa et al, 2010; Machingura, 2011; Mutseta, 2016). IPV is also reportedly high in polygamous marriages (Heath et al, 2020; Behrman, 2019; Hayes and van Baak, 2017; Abramsky et al, 2011). Because of polygamy's patriarchal foundations, women in these unions are socialised into subservience which inhibits their participation in family and public life (Cook & Kelly, 2006). Research has also shown that women in polygamous marriages face increased risk of mental health disorders (Al –Sherbiny, 2015).

Omotosho opines that polygamy in not a union "driven by unrestrained sexual impulses" (2021, p. 150) but rather provides benefits which include producing offspring in circumstances where a wife is infertile (Kunhiyop, 2008) and other functions that are akin to "supporting and catering for the neglected women in the society that do not tolerate women independence and adultery" (Omoshoto, 2021, p. 150). Similarly, African societies place much value on a boy child so polygamy is useful for assauging the fear of not having a male heir that is needed to preserve inheritance in the family (Omoshoto, 2021). Additionally, "a family without a male child is considered as a family that is tagged with partial barrenness" (Omoshoto, 2021, p. 149) and because female children move to their husbands' households and relinquish their fathers' names upon marriage, they cannot preserve their father's name (Hillman, 1975).

1.4.4 Why bride price should be seen as violence

The payment of bride price is a cultural practice and a contextual factor. There are different perspectives to the exchange of gifts and commodities at the point of marriage depending on context. The expectation of bride price payment is universal in Zimbabwe (Mubaiwa, 2020). Traditionally bride price entailed the bridegroom paying a 'token' of appreciation to signal his commitment to his wife (Mangena & Ndlovu, 2013) and "an outward manifestation of the man's love for his fiancé and is a safeguard against groundless divorce" (Andifasi, 1970, p. 28) thereby a man was accorded status by attaching value to the woman (Mangena &Ndlovu, 2013). Anthropological literature supports this view of bride price as "a compensation for the expense, the care and trouble spent on the bride's upbringing ...It is compensation for the complete loss of a worker as a bride withdraws from

her own kindred and henceforth belongs to her husband's" Vroklage (1952, p. 135).

It entailed a groom paying one to two cows and a few bags of corn or the offer to work the fields of his in laws, augmenting that with hunted game (Janhi, 1970). In post-colonial Zimbabwe, the groom is expected to pay the bridegroom's family in cash and kind (e.g. cattle) for the possession of a wife (Chitsike, 2010; Kelsy et al, 2006; Mubaiwa, 2020). The reason for the payment firstly is to confer on the groom "exclusive sexual rights" over his wife (Sikweyiya et al, 2020; Kambarami, 2006) and secondly to grant rights to the groom over children born to his wife (Vroklage, 1952; Bourdillon, 1982; Lowes & Nunn, 2017). The bride in turn brought household goods gifted by her family to signal their participation in the marriage process (Mangena & Ndlovu, 2013). In this way marriage was established on egalitarian terms.

Bride price is regarded as essential in forming and establishing family culturally, and promotes bonding between the families involved (Mangena & Ndlovu, 2013, Mubaiwa, 2020, Chisango et al, 2022). Where bride price is not paid, the 'union' is regarded as 'casual sex' or 'prostitution' while the payment of bride price legalises the marriage (Bourdillon, 1997), and validates it traditionally (Mangena & Ndlovu, 2013). Marriages are regarded as a binding contract in Zimbabwe underpinned by social and cultural norms which leave unmarried and divorced women facing shame and social stigma (Chireshe, 2015). In the Zimbabwean culture, particularly in the Shona tribe, marriage accords women social status (Kambarami, 2006; Barnes, 1999) married women are considered more respectable than their divorced or unmarried counterparts (Mukonyora, 1999; Chireshe, 2015; hence the need for bride to be paid to cement the marriage.

The domain of bride price is highly gendered. The bride's family calculate the total cost they want to charge for bride price and this "involves putting a price on what is charged; which in this case is, unfortunately a woman" (Mangena & Ndlovu, 2013, p. 477). On the one hand men are seen as the main actors in charge of paying (bride groom) and charging (father of the bride) and women (the commodity) are silent participators. The father of the bride determines the 'price' to be paid for his daughter considering the total cost of her educational attainment, food and clothing, healthcare costs throughout her life (Mangena & Ndlovu, 2013). On the other hand, women are expected to repay for the bride price through wifely duties and services that include fulfilling their husbands sexually (Skovdal et al, 2022; Sikweyiya et al, 2020), and bearing children (Mubaiwa, 2020; Chiweshe, 2016; Chitakure, 2016). In this regard, there is a mutual benefit for both men and women through sexual activities (Mangena & Ndlovu, 2013). Higher bride prices are paid

particularly for girls who have gone through LE as they are considered 'ideal women' (Muzingili & Taruvinga, 2017; Mugweni et al, 2012; Skovdal et al, 2022).

However, research has established that bride price facilitates violence against women (Hove & Gwazane, 2011; Chireshe & Chireshe, 2010). Upon its payment, men assume ownership of women and expect absolute obedience (Chisango et al, 2022) while feeling legitimised to chastise them when they feel they have misbehaved. Women's sexual and reproductive rights are ignored (Eryenyu, 2014) because money was paid for them to produce progeny for their husbands (Gwatimba et al, 2020). Similarly, the risk of IPV increases as "men beat their wives for suggesting that they use condoms as they think the condom disturbs what the man rightfully owns" (Mangena & Ndlovu, 2013, p. 478). Bride price objectifies women and they are viewed as inferior thereby reinforcing male decision- making power (Chiweshe, 2014; Chireshe, 2015). It is a cultural norm in many contexts for a woman to be subordinate to her husband and bride price solidifies this as she has been paid for (Mubaiwa, 2020).

Notions of subordination are reinforced during girls' initiation rites ceremonies where LE is introduced and these socialisations promote notions of male dominance and female subservience (Mutunami & Bradley, 2022; Fidan & Bui, 2016; Seidu et, 2021). In such a culturally and socially controlled environment, women and girls would tolerate harmful behaviours such as promiscuity in order to stay in marriage (Seidu et al, 2021). However, in instances where a husband engages in risky sexual behaviours, women and girls are left vulnerable to violence including HIV (Skovdal et al, 2022). Women who may want to leave abusive relationships could be restricted by their dependency on their husbands and their economic insecurity (Ahinkorah et al, 2022; Gwatimba et al, 2020). Furthermore, in instances where bride price has been paid, women cannot negotiate safe sex (Koster et al, 2015; Chiweshe, 2014) because their husband 'paid' for sexual rights (Gwatimba et al, 2020). We therefore see here a conspicuous nexus between a cultural practice and violence.

Although some of the literature cited above seem to depict bride price as belittling women leading to suggestions of inhumane and degrading treatment of women it remains a valuable practice throughout contexts where it is practised. Although bride price is theorised to encourage early marriage and high fertility rates (Anderson et al, 2018) studies in the Democratic Republic of Congo

revealed that larger bride prices are not associated with these variables. Instead, they yield good quality marriages and satisfaction (Lowes & Nunn, 2017). Bride price is also considered a marker of identity for marriages particularly in the African context (Burman & van der Werff, 1993; Walker, 1992). The irony for the contention is that bride price is an act of benevolence which should not have negative implications and yet it is associated with adverse outcomes for women (Chisango et al, 2022). The negative connotations of bride price are attributed to the shift from traditional forms of tokenism benevolence to the commercialisation of the practice where sexist tendencies entangled with aspects of benevolence are distinct and obvious from the beginning, but with elements of hostility that remain dormant until the woman transgresses the terms of 'contract' (Chisango et al, 2022).

1.4.5. Why HIV should be seen as violence

Globally, 38.4 million people live with HIV, over 1.7 million of these are minors under 14 years of age. Women and girls make up the majority of people living with HIV at 54% (UNAIDS, 2022). Young women, particularly adolescent girls are the most vulnerable group for HIV infection; in 2015 alone 100 000 of young women were infected with the virus (UNAIDS, 2017a). In Zimbabwe, 1 200 000 people are HIV positive and women make up 60.83% of this population. For the newly infected figures in 2019, 9000 were young women (15-24 years) while 4200 young males got infected (UNAIDS, 2020b). HIV continues to affect populations and the UNFPA postulates that the number of new HIV infections per 1000 uninfected population in 2020 was 1.74 (UNFPA, 2022b). HIV leads to violations of human rights which leads to vulnerability to HIV (UNAIDS, 2006). The impacts of HIV feed on human rights violations such as discrimination against women and girls thereby sustaining poverty leading to further violence. Inequality and vulnerability are both impacts which are clearly highlighted by HIV and these lead to further vulnerability to infection specifically among already vulnerable groups such as women and girls. Poverty generally exacerbates the problem among poor societies and with discriminatory practices, women lack decision making rights that would act to protect them (Seidu et al, 2021).

Although associated with respectability (Ruark, Kennedy & Mazibuko, 2016; Kambarami, 2006) it is well established that marital status is a risk factor for HIV infection. Statistics reveal that at most risk of HIV infection are women who are married and those in long term relationships with domineering and violent partners (Dunkle et al, 2004, 2020; Shri & Muhammad, 2018). Married women experiencing IPV are more likely to test positive for HIV than those that do not face

violence in their lives (Mugweni et al, 2012; Chakraborty et al, 2016; Henderson et al, 2017). Additionally, women experiencing IPV from husbands that also abuse alcohol are also most likely to contract HIV (Shri & Muhammad, 2018; Dude, 2011). These groups of women are usually trapped in marriage because of the social and cultural desirability of marriage, and the economic dependency upon their husbands (Dube et al, 2017).

HIV is commonly transmitted through forced sex (Mugweni et al, 2012; Sa et al, 2008; Stockman et al, 2013; Jewkes et al, 2010; Folayan et al, 2014) and usually as a result of the norms of male entitlement to sex in heterosexual relationships and particularly in marriages (Dubeet al, 2017; Mugweni et al, 2015). These norms are upheld by female behaviours of subordinance and subservience to men socialised during childhood as part of initiation rites, and the impact is negatively experienced in men and women's health (POPACT, 2008). The increase in frequency of sex and the limited decision -making rights of women in these marriages mean that women cannot negotiate condom use (Hageman et al, 2010; Seidu et al, 2021; Tenkorang, 2012). In sub-Saharan African, condom use is relatively low and it is near impossible for married women to refuse to engage in sexual activities with their husbands (Maharaj & Cleland, 2004; De Walque, 2007; Rombo, 2009). Sexual activity is closely associated with child bearing which makes condom use in marriage unacceptable (Maharaj & Cleland, 2004; Bauni & Jarabi, 2003). Furthermore, women will need to overcome cultural and social barriers including gendered power dynamics to negotiate safe sex (Mumtaz et al, 2005; Hageman et al, 2010; Seidu et al, 2021; Tenkorang, 2012).

Culturally condom use is restricted to sexual activities outside of marriage (Turner et al, 2009) and refusing to have engage in sexual activities in marriage is frowned upon (Tenkorang, 2012). Restrictive gender roles dictate that women can not initiate sexual matters (Koster et al, 2015) and to request one's husband to use a condom would infer lack of trust or an admission to extra marital relations (Bauni & Jarabi, 2003; Maharaj & Cleland, 2004; Koster et al, 2015). Thus, women are expected to be subservient although this may increase their risk of HIV contraction (Feyisetan & Oyediran, 2020).

Men dominate sexual and reproductive health rights decision making processes while women are expected to be subservient to their male partners (Montgomery et al, 2012; Skovdal et al, 2011; Chiweshe, 2016) however women can autonomously make choices in their relationships such as the covert use of contraceptives (Adeleye et al, 2011; Skovdal et al, 2011). Interventions have also shown that promoting condom use in married couples increases use and empower women to gain control over negotiations (Callegari et al, 2008). Married women have been found able to ask their

husbands to use condoms due to having prior knowledge of their own status and of the efficacy of condom against HIV prevention (Tenkorang, 2012). Studies in Zimbabwe have also found that women are more likely to request condom use particularly after testing positive for HIV despite their marital status (Turner et al, 2009). Additionally, women with higher educational and wealth levels are found more likely to have autonomy to ask for condom use than their counterparts with lower educational attainment and economic insecurity (Tenkorang, 2012; Koster et al, 2015; Amoyaw et al, 2015).

1.5 The interconnectedness of HCPs

The brevity of my argument highlights the complexity of gender relations in life that might be interpreted as a deliberate construction of women and girls as 'victims' that are 'passive' to their oppression. The question is, are women and girls in Zimbabwe victims of their culture? In this section I seek to elucidate how issues that I have discussed so far intersect to bring out this 'victimhood'. I begin by considering whether or not LE is harmful to warrant its inclusion in global campaigns, and whether girls can choose to forgo not only LE, but also child marriage, polygamy, and bride price, and how through exercising agency they can circumvent HIV risk. As I alluded to earlier, the debate on whether LE is harmful is contentious and is also a subject of contestation among scholars including African feminist scholars. Khau argues that LE is a "genital modification as opposed to genital mutilation because it does not compromise the health of women" (Khau, 2009, p. 31).

Taking a rights based approach Mwenda argues that "as long as labia elongation does not violate public policy or any laws of the country, or natural justice, good conscience and equity, and as long as LE is undertaken freely, and with full consent, it does not violate the rights of women" and that "a line must be drawn between voluntary LE and other forms of FGM that either compromise the health of women or are non-consensual" (Mwenda 2006, p. 353– 354). What I do not agree with here is that LE is performed in childhood and to some extent by children themselves as instructed by adults. Considering their immaturity at the time when LE is carried out, could we substantively validate their decision to go through LE or any other form of FGM as informed choice? Shell - Duncan contributes to this debate conceding: "Below a certain age, girls are recognised as unable to provide consent because of diminished capacity, and their vulnerability has provided a compelling basis for prohibiting FGM" (2022, p. 170).

Feminist scholars such as Khau and Koster & Price have also questioned the issue of consent for LE

in regards to children citing the "legitimacy of free and consensual elongation decided on by an eight-year-old" (Khau, 2012; Koster & Price, 2014). If an adult woman chose to elongate her labia their rights would have to be recognised because they are exercising their right to body autonomy and their right to culture (Bhalla, 2018). This assertion however needs to be taken with caution because the woman might only be going through LE to conform to the prevailing social convention. Moreover "there is social pressure and punitive sanction"' (Achode et al, 2021, p. 48) for not conforming with the practice particularly in communities that support it. Because of this pressure "women are as vulnerable as children and may be subjected to the practice without their valid consent" (Achode et al, 2021, p. 49).

Shell-Duncan posits that "another factor that complicates individual choice is that the decision to perform FGM is rarely made by individual women in isolation, but instead by a group of decision-makers who vary in power of persuasion" (2022, p.172). With children, coercion and fear mongering are some of the tactics used to bring them into submission. Furthermore, children are told that LE is the price required to be assured of a long-lasting marriage (Khau, 2012; Mutunami & Bradley, 2022). While I recognise children's agency and do not see them as nonsexual (Nyanzi et al, 2001) I argue that accepting that children should choose to mutilate their own bodies or enter a child or polygamous marriage, will be suggesting that children are implicated in their own decisions. If anything, their agency should be harnessed and reconstituted into interventions to end violence against them. I will go on and unpack the notion of agency first in relation to women and girls bearing in mind these practices they are forced to endure.

1.6.1 Contextualising Agency: Rights, Choice and Consent

The debate on whether women can act agentic and make decisions to undergo LE and the capacity to give informed consent over the matter is linked to conceptualisations of female agency (Shell-Duncan, 2022). When considering the universal individualistic human rights framework, we also need to factor in the contextual realities that may affect the decision-making capabilities of those individuals affected by cultural practices. A brief look at some of the definitions of the concept of agency in academic literature is necessary. Sen (1985) defines agency as the freedom to do and attain what one regards as important or valuable while Kabeer (1999) frames agency as the operationalisation of choice where one is capable of defining and acting on their goals. We cannot however talk about agency without mentioning empowerment which Kabeer cites as: "the ability to make choices: to be disempowered, therefore, means being denied choice" (1999, p. 436). However, choice too is not without constraints as those choices to be considered have to be

genuine and variably there should be other alternatives if the concept of choice is going to be meaningful. To this effect Kabeer argues that it is crucial that a woman is "able to at least imagine the possibility of having chosen differently" (Kabeer, 1999, p. 441). The solidarity within a shared social and cultural norm context and the extent to which those norms are enforced may also limit individual choice (Shell- Duncan,2022). Paradoxically women's agency is underscored by having choice and being empowered to choose what one wants and their autonomy upheld (Shell-Duncan, 2022). Lokot et al argue that "agency involves not just the exercise of choices, but the exercise of a *good* choice' (2021, p. 3). The availability of choice is determined by whether an individual's act of selection from what is on offer will cost the individual and her family or not.

Citing the social norms theory, the notion of being divorced, (because one did not elongate their labia), or refusing to be married because one is still a minor or pregnant out of wedlock (particularly when your family can benefit financially from that marriage), or being unmarried (when culture deems you should be married after a particular age) or that you should seek divorce (when bride price was paid) are all states that are shameful and therefore disapproved of. What this means theoretically is that these situations "shape the viability of options" (Mackie & LeJeune, 2009). Ignatieff asserts that choice has limits with some 'genuinely intolerable, and some excuses for abuse that are unsupportable" (Ignatieff, 2001, p. 22). Speaking of limitations to personal choice and the ability to consent reference should be made to an "external normative setpoint, a set of values other than the woman's own" (Kabeer 1999, p. 458).

There are inherent problems with the principle of informed consent when dealing with children than the dominant ethical paradigm will acknowledge. Consent, defined as "the invisible act of evaluating information and making a decision, and the visible act of signifying the decision" (Alderson & Morrow, 2004, p. 96), calls for participants to have full understanding of the "nature, purpose, and anticipated consequences" (BPS 2006, p. 12) of their involvement *before* taking part (Gallagher et al, 2010) in order to willingly participate (Morris, 1998). Where children have the freedom and certainly the right to choose, and the choices have costs, it is imperative that children have the capacity to understand what the costs are and crucially, what the consequences entail (Sen, 1992). Applying the notion of 'choice' to social affairs of any given cultural community *is* challenging, and it is the most vulnerable members of the community who do not have choice-children (Irving, 2008). Similarly, women too have traditionally been accorded the same status as children due to the power and influence of patriarchy (Mswela, 2009; Benson & Chadya, 2005).

Global standards and local standards of social equity differ and we must not make assumptions

about the universalism of individualistic rights, particularly where the cultural functionality of a community is underpinned by homogeneity. There is little room for personal autonomy and this links in to social conventions and how they influence behaviour at individual level (Abebe, 2019). The issue of informed consent is problematic and contains limitations, however if we add the complexity of cultural relativism it brings in further complexities. One needs to understand the African culture and also the positions children occupy in the society in order to appreciate the complexity of processes of decision making and consent. Once a man becomes a father, he acquires power and is recognised as the head of the family (Chuma & Chazovachii, 2012; Thebe, 2018) whereas a woman only acquires decision making power as she grows older (Shell- Duncan et al, 2020). Through gender norms women have to "show deference to men and older women in higher positions in the social hierarchy" (Shell -Duncan et al, 2022; p. 172; Shell- Duncan et al, 2020). Upholding tradition and showing respect to elders is highly valued and this makes it difficult for girls to question the need for FGM (Shell- Duncan et al, 2018; Shell- Duncan et al, 2011).

It is against the African culture for adults to seek consent from a child for a cultural practice to be performed, particularly that which is regarded a convention. Decision for such practices are made by family members (Shell-Duncan, 2022). "Children's rights to be heard are also violated by this practice because children do not consent to it, but are rather forced or coerced into it" (Tshugulu, et al, 2023, p. 251). Furthermore, Chitakure argues that "children cannot consent to forced marriages "because they are minors" (2016, p. 13). Thus, children are expected to follow instructions as given and do not have space to question why they have to go through a cultural tradition and certainly cannot contradict their parents/guardians (Togarasei, 2020; Museka & Machingura, 2014). This has been evidenced in other FGM practising contexts where children do not choose whether or not they want to undergo FGM because they understand their position within the hierarchy and it is cultural to maintain that position (Kesby et al, 2006). This marks a dichotomy between Western ways of socialising children and African precepts of obedience, docility and subordination (Abebe, 2019).

1.7 Understanding Harm

If an intervention results in harm, it violates the ethical code (Farrel, 2005; Alderson & Morrow, 2004). My concern with issues that arise from consent discourses are firstly, understanding what constitutes 'harm' to a girl, and secondly how that will translate into adulthood. A few questions come to mind, if a child is made to understand the level of pain they will experience from elongating their labia (and possible risk of infection) would they freely choose to go through it?

Also, if they were made to understand the risk of abuse, or that entering them into marriage at such a young age is abuse, would they willingly choose to go through it? And to what extent would children understand the harm they could encounter by being in a polygamous marriage? Besides, a child might interpret harm differently, hence the process of consent should seek to clarify those differences (Alderson & Morrow, 2004).

In the instance of LE, part of its harmfulness is mental health distress (Kaggwa et al, 2023; Khau, 2012), physical pain (Mutunami & Bradley, 2022; Khau, 2012). With child marriage and polygamy, it is the loss of years of development and productivity (UNICEF, 2020) and I argue that where a practice brings a health -related issue, and therefore harm, the ethical code is violated. During initiation rites ceremonies, and before a girl leaves her birth family for her marital family they are sensitised to the complexity of marital life including the prospect of a husband having extramarital relationships, being abusive towards her and are exhorted to hold on to marriage however difficult the circumstances get (Chiweshe, 2016; Kambarami, 2006; Gwatimba et al, 2020). Marriage is portrayed as a battle ground from which the girl/wife must conquer by staying steadfast (Chiweshe, 2016). This socialisation is problematic because it normalises sexual and physical violence in marriage (Fidan & Bui, 2016; Sikweyiya et al, 2021) informed consent in this instance is misinformed particularly as the information is contradictory. Children's rights are violated and their agency compromised when they are supposedly 'counselled' and therefore prepared for future abuse in marriage as part of gender role socialisations. This marks the beginning of the normalisation of patriarchal violence (Sikweyiwa et al, 2021; Gwatimba et al, 2020) and should be condemned instead of promoting it to children. They are also nurtured to be 'good wives' (Skovdal et al, 2022; Mugweni et al, 2012) which is marked by submissiveness and subordination to their husbands (Fidan & Bui, 2016; Sikweyiya et al, 2021; Seidu et al, 2021).

1.8 Towards a mainstreaming approach

Addressing VAWG in all its forms is key to ending gender inequality. VAWG prevention can be aided by partly reflecting on the lessons learned and considering the failures of gender mainstreaming approaches. Gender mainstreaming, influenced by feminist development theorists such as Boserup (1980) was considered as the missing link in achieving gender parity, and gained traction in the mid to late 1990s (OECD, 2011) but has not produced much evidence that it has reduced gender inequality. Gender mainstreaming arguably provoked a twofold paradigm shift, firstly it generated a more inclusive mindset among at least some development actors, and secondly, the design and evaluation of programmes began to disaggregate data to ensure more marginalised groups were

reached (EIGE, 2020). Many different programmes have since attempted to address gender inequalities and gender- related health and development issues, and in many cases, evidence has been lacking to assess which programmes are effective in reaching their goals in serving the intended populations (Bloom, 2008).

A major critique of gender mainstreaming is that women's rights concerns have been turned into a binary issue which focuses on equal representation at the expense of crucial considerations of the power-related reasons behind women's social disadvantage (Mannell, 2012). Gender mainstreaming ignored the fact that men already occupied positions of privilege in terms of access to resources (whether economic, social or cultural resources) before the approach was introduced and interventions failed to account for this disparity. Furthermore, resource allocation for interventions sought to represent men and women equally and this interpretation of gender mainstreaming did not seek to change the structural inequalities that existed previously. In other words, gender mainstreaming, for some, fell short of reversing embedded patterns of gendered inequalities (Budlender, 2006; Razavi & Hassim 2006).

Gender mainstreaming has also been viewed to have "functioned as a retreat from women's equality and used to render feminist perspectives more palatable to those who resist them" (Palmary & Nunez, 2009, p. 65). For some gender mainstreaming became detached from its more radical theoretical (feminist) foundations. They felt the model did not in practice do what it promised and failed to simultaneously improve women's access to development programmes whilst driving deeper structural change (Palmary & Nunez, 2009). The critiques suggest lack of commitment in achieving women and girls' rights. Arguably a focus on ending VAWG will need to bring with it a commitment to challenge this key barrier to gender equality. Mainstreaming responses to the pool of gendered issues such as LE, child marriage, bride price and polygamy in HIV programming will not only maximise the potential for transforming gender dynamics but will also reverse negative trends of gender inequality.

There is no agreed, commonly applied approach to mainstreaming end VAWG activities across development sectors. The main approaches to ending VAWG deliver interventions in a siloed nature, and I argue for a VAWG mainstreaming approach. There are many policies and programmes designed to end VAWG but without a systematic model for mainstreaming an end to VAWG gender equality and women's empowerment will not be achieved (Bradley & Gruber, 2018). These authors propose "a VAWG mainstreaming framework that addresses how to centralise a VAWG lens into development programming, irrespective of programmatic priorities" (Bradley & Gruber, 2018, p.

16). The end FGM Africa led movement (ALM) is an example of a major programme that has mainstreaming of FGM as one of its objectives but the expertise on implementation is only just gathering impetus (see https://thegirlgeneration.org). The focus of mainstreaming approaches is to acknowledge the violence and discrimination that women and girls experience, explore the causes and structures that fuel and sustain the violence, and provide interventions in an integrated way to address those issues. I anticipate that my thesis will contribute on a practical level to the exploration of how, not only LE (and all other forms of FGM) but also child marriage, bride price, polygamy can be integrated into HIV programming. My research is therefore pioneering in piloting a new lens into addressing these forms of VAWG in HIV programming with the potential for the approach to be mainstreamed across development sectors.

1.9 Research Originality

What is original about my research is that I am exploring links between LE, child marriage, bride price, polygamy, and HIV infection. Currently VAWG, specifically IPV, is being integrated in HIV programming but to the best of my knowledge, there is very little work that is making this additional link with LE, child marriage, bride price and polygamy in terms of programming. Zimbabwe has high prevalence of LE, child marriage, bride price, polygamy and HIV and this calls for investigation to establish determinants of the correlation. Existing literature fails to sufficiently link FGM and HIV; literature written around FGM in relation to type three FGM where a girl's labia majora is completely infibulated has established that if such a girl is abused and raped, the chances of HIV transmission are increased because of the likelihood of skin tears (Monjok et al, 2007; Olaniran, 2013). In the context of LE because it is connected to initiation rites, it renders girls more vulnerable to other forms of violence that can cause HIV infection. Literature documents triggers for HIV infection as well as social norms fueling and sustaining FGM but does not offer a broader understanding into the correlation of the two.

HIV links to further abuse but the full extent of the link is not obvious because of the different dimensions involved. Not all women would have gone through LE in these settings so the extent to which the link is going to be true for every woman's experience will differ. Women's experience of this ecology will differ depending on other intersectional factors such as socio-economic position and age but the gendered norms that shape it remain the same for all. I am conscious that the link I am arguing is nuanced, and will therefore not be obvious. This juxtaposes my argument, and exacerbated by the absence of any previous work to build on, my argument is thus complex not least because LE, child marriage, bride price, polygamy and HIV have not been theorised as

violence before. This highlights the disconnect between my theoretical thinking and the practices' epistemic conceptualisations thereby deeming my argument controversial**.**

In chapter 3 I interrogate the norms underpinning the legitimisation of violence as a theoretical conceptual framework and in the same chapter I draw on literature that discusses these HCPs from a feminist perspective in terms of how they represent a fundamental vehicle through which gender inequality is reproduced. This showcases a part of my research's originality because I make links in my argument in ways that have not been made quite so explicitly before. I also go one step further and look at how HIV programming can mainstream child marriage, bride price, and polygamy and within that could also create an opportunity to educate practitioners and support women and girls who may have undergone the HCPs and the linked forms of violence.

Socialised gender norms form an ideology that renders women inferior (Fidan & Bui, 2016; Sikweyiya et al, 2020; Skovdal et al, 2021; Chiweshe, 2016) which increases their vulnerabilities. Findings from a previous study (Mutunami & Bradley, 2022) have provided sufficient evidence to demonstrate that different forms of violence are linked, particularly LE and child sexual abuse (Mutunami & Bradley, 2022). The findings from this thesis build on that evidence base, and argue for mainstreaming LE, child marriage, bride price and polygamy in HIV and wider VAWG programming. My argument is that these practices exist and must be acknowledged as a key reason for why HIV transmission is so high among women in contexts where so many other forms of violence flourish (Siemieniuk et al, 2013; Jewkes et al, 2010; Kouyoumdjian et al, 2013).

We need to see these issues as linked so that we tackle them simultaneously and maximise opportunity to end them. The conclusions of the What Works to end VAWG research consortium https://www.whatworks.co.za/) had a key recommendation around mainstreaming VAWG across development sectors (Crawford et al, 2020). This research will be ground-breaking because the vulnerability to violence that women and girls experience from cultural practices such as LE, child marriage, bride price and polygamy, and the heightened risk to HIV infection has not been explored before. My research thus proposes a VAWG sensitised lens in HIV programming not only to tackle HIV infection but also to close the routes to vulnerability to infection in the first place., and to demonstrate the lens's applicability across development sectors.

The starting point of any project should be to understand the experiences of vulnerable groups (for example, women and girls) and working outwards into the environment and contexts in which they live and asking: what can the programme do to end the violence they suffer? Before developing an

intervention strategy to respond to VAWG, project teams should understand the legal, social and epidemiological situation in the country, region or local community as they relate to VAWG. New programmes or activities should be developed with an in-depth understanding of the ecology of cultural and social constraints women face in the project context:

- whether the social empowerment of women is an explicit goal with definable impacts
- or whether the project can actually contribute to reinforcing gender stereotypes or traditional roles.

These can lead to greater inequalities between men and women in the access of rights and agency, and the rejection of harmful practices, therefore triggering the risk of a backlash (Dutton & White, 2013), potentially increasing the vulnerability of women.

Conclusion

Violence against women and girls is now recognised as the biggest challenge in achieving gender equality. The focus of my thesis is on the link between LE, child marriage, bride price and polygamy. These issues are linked to a conceptual approach that places each form of violence experienced as a result of the individual cultural practices in a holistic web. The links that I am making theoretically are not straightforward however it helps to see them as strands that intersect to create an ecology that sustains gender inequality. I have evidenced that girls are forced to perform FGM as culturally expected and I have also shown that not all women have the space to exercise their sexual and reproductive health rights because of the contextual factors that compromise those decisions such as culture and poverty. Girls too, are entered into child marriage because of those same contextual factors. Similarly, women and girls enter into polygamous marriages because of religious and cultural factors that stigmatise unmarried women, and in certain instances due to poverty. Bride price concretises these forms of marriages and brings women into positions of vulnerability to violence.

These practices, and in varying degrees, increase women and girls' vulnerability to other forms of violence and also to the risk of HIV infection (Mswela, 2009). Understanding the social and cultural norms which underpin and normalise LE, child marriage, bride price, and polygamy is paramount to any programming and should in turn guide more holistic approaches designed to reverse these

harmful norms. Essentially all programming needs to challenge the norms that link LE, child marriage, bride price and polygamy. The links need to be broken through the denormalisation of these practices, and programming must focus on this too. The concept of agency and autonomy to oppose the practice whether in childhood or adulthood is contested however it is also evident that contextual realities limit the extent to which women and girls can be agentic.

As already stated, gender mainstreaming has been half-heartedly applied and lacks a women's rights approach (Palmary & Nunez, 2009). Without a rights-based approach and shifting the way women and girls are perceived and treated the underlying structural inequalities will not be removed. This arguably is the only way reductions in HIV transmission and other forms of VAWG can be realised (Sardinha et al, 2022). To see change in sexual behavior, there has to be change in attitudes and beliefs towards desired behavior, including autonomy to negotiate safe sex and women and girls exercising their rights. Agency is limited due to social and cultural norms that are structurally embedded in gender inequality (Kesby et al, 2006). Equally the recognition of children's agency needs to be rationalised within a framework that concedes that "children must be understood both as competent and independent agents of social change and as vulnerable social becomings in need of protection" (Kesby et al 2006, p. 185).

The aim of my research is to demonstrate that LE, child marriage, bride price, polygamy and HIV are linked therefore programming needs to tackle them together. My research stresses the urgency to develop tools that demonstrate a link based on the hypothesis that it feeds into women's vulnerability by reinforcing a cultural ecology that does not value women (Chiweshe, 2016; Fidan & Bui, 2016) and makes them highly vulnerable to HIV. I propose that LE, child marriage, bride price and polygamy need to be mainstreamed within a lens that is already sensitised to other forms of the violence which women and girls experience. Limiting an approach to interventions with a focus on a single harmful practice fails to see these practices as violence and is limited in effectiveness as a result.

Arguably a discourse change is needed within the aid-development field that views LE, child marriage, bride price, polygamy and HIV as forms of violence and will not single them out for sole programmatic focus. Programming needs to be viewed through a holistic lens that does not silo HIV but should see it as linked with LE, child marriage, bride price, and polygamy, and underpinned by gender inequality. Whatever the specific issue is, programmers and stakeholders need to apply this holistic understanding of how these different issues are connected in order to inform their specific activities and maximise opportunity to challenge the links.

Chapter 2

Researching links between HIV, Labia elongation, and other forms of violence

Introduction

In my introductory chapter I laid out the foundations of my research and general context of the thesis.

This chapter details a description, explanation, and justification of the methods and protocols I used to conduct my research for this thesis. Epistemology is the study of the nature of knowledge and justification of beliefs held to be true (Crotty, 1998). It also entails justifying knowledge theoretically as we cannot create knowledge without preconceived ideas about what it entails and how it is created. A researcher's view of the world and of knowledge strongly influences their interpretation of data and therefore their philosophical standpoint should be made clear from the beginning. Additionally, the construction of knowledge influences the relationship between the researcher and the participant, how the researcher will disseminate the research findings, and how research vigour will be demonstrated (Carter & Little, 2007). This is important to my methodology because through following rigorous research protocols I was able to consider my research processes in order to ascertain research vigour.

The chapter is structured as follow:

Section 1 presents details of the research design and the tools I used to gather data and answer my research question. Section 2 presents justification for my chosen methods.

Section 1

2.1.1 Statement of aims

My research aims were:

- to understand the links between LE, child marriage, bride price, polygamy and HIV transmission.
- to understand across my field contexts which social and cultural norms are most prevalent in terms of justifying and legitimising different forms of violence against women and girls,

and the extent to which these norms are recognised as harmful, and by whom, including stakeholders within the development sector.

- to understand the specific norms that underpin and generate women's vulnerability and, particularly what the triggers might be for reversing or changing those norms.

My research objective was to inform an effective mainstreaming approach to increase the sensitivity of policy makers across development sectors to opportunities to end violence against women and girls including LE, child marriage, bride price, polygamy and HIV infection. My secondary objective was to design a tool that will be operationalised as means to a mainstreaming approach to ending VAWG within HIV programming and, across development sectors.

2.1.2 Research design

The first stage in my methodology was to carry out an extensive literature review using existing evidence about the epidemiology of violence against women and girls. I used naturally occurring data- policies, reports (pre-existing materials), demography and health surveys, textbooks, and journal articles to build the baseline for my research. I scoped through organisational documents including INGO websites and civil society organisations' websites, books and journal articles. I gathered data on prevalence, types of violence, patterns, and consequences of violence against women. Additionally, I gleaned data from academic sources from websites such as Ebsco host, google scholar, ProQuest and Discovery that carried out systematic reviews on studies that investigated social norm theory and violence against women and girls including harmful cultural practices. Furthermore, I used data disaggregated by sex from demographic health surveys and administrative statistics collected by non -governmental organisations, inter-governmental organisations, government departments, and health facilities in order to understand how violence affected women differently from men and what interventions were put in place to address this situation in different contexts. I was able to frame a holistic picture about how unsurprisingly, gender is understood in a binary restrictive way across contexts and that gender framing does have implications in terms of gender identity and thinking about how that might lead them to become targets for violence.

Anthropological literature around cultural relativism was useful in trying to understand culturally why women are still practising LE with some, to an extent, supporting it (Danial, 2013; Boddy, 2016; Greenbaum, 2001) and why bride and polygamy are also still relevant. The literature also enabled me to glean rich data from which learning will be possible into what policy could look like in order

to end these practices and HIV transmission. Reviewing the literature enabled me to capture in detail the drivers for women's vulnerabilities and revealed the knowledge gap on how initiation rites socialisations sustain child marriage, bride price and polygamy which exposes women and girls to HIV. This formed the basis for my research to investigate how women and girls' vulnerability to HIV is framed, within the harmful cultural practices' context. and most importantly how that can be addressed and mainstreamed in HIV programming. The next stage was to conduct interviews with identified participants in order to get in-depth understanding of how these practices are linked and how they synthesise to produce an ecology of violence against women and girls, and above all, whether norms that fuel them are recognised, and could be reversed.

2.1.3 Sampling and Recruitment

My research was interested in understanding which social norms exposed women and girls to vulnerability of violence and crucially what legitimised those norms and who if any recognised those norms as harmful. I wanted to find out whether there was any recognition also of the possible links between the different forms of violence such as LE, child marriage, bride price, polygamy and HIV across my participant cohorts. To understand this in detail 40 participants were recruited to participate in individual interviews and focus group discussions. Employing a qualitative approach 13 development practitioners, 6 nurses, 5 primary school teachers, and 6 advocacy practitioners were individually interviewed using semi- structured technique of questioning. Additionally, 10 women participated in two focus group discussions.

For sampling purposes, I drew on post-structuralist feminism which contends with notions of quantifying and homogenising women's (and to an extent, men's) experiences. That perception symbolises an essentialist construction of women in third world countries as victims of culture fueled by patriarchy (Mohanty, 1988, p. 66-68). This way I was taking into consideration the heterogeneity of sexual practices and experiences of Zimbabwean women. Through purposive sampling Advocacy practitioners (ZANA and Masimanye) acted as gatekeepers and identified suitable and willing participants for the focus group discussions, and the nurses and teachers' individual interviews. The organisations secured the participants, created and provided a safe space for the discussions and interviews to take place. Furthermore, they were present throughout the discussions to offer psychological support if any one of the participants became distressed. For the development practitioners category I approached them directly through email addresses obtained on the internet and invited them to participate in the study. Advocacy practitioners were also approached directly through contact details available on the internet and invited to participate in

the research.

2.1.4 Development practitioners and stakeholder category

Since my research sought to understand whether there are links between LE, child marriage, bride price, polygamy, and HIV infection I also wanted to understand the role social norms play in framing women and girls' vulnerability to HIV infection, and whether any of those norms were recognized as harmful and by whom, amongst my participants. What I gathered from the gap in literature was that understanding the ways in which these practices are linked, and the recognition of the role cultural and social norms play in legitimatizing LE, child marriage, bride price and polygamy would be crucial in designing policies and programmes that would ensure a reversal of those norms and an end of HIV transmission. I therefore interviewed this category of participants because development practitioners have a remit to develop HIV intervention policies and programmes. As I have alluded to in the thesis introduction, all development projects need to be built on greater understanding of the context in which programmes are implemented.

There is a need to understand the experiences of vulnerable women and girls accessing HIV services, and the political, social, and economic situation in the country as they relate to vulnerability to HIV infection. As such development practitioners would need an in-depth understanding of the ecology of the cultural and social landscape and how it frames women and girls' vulnerability, and mainstream those issues within HIV programming. I included healthcare practitioners and nurses in this category because of their proximity to women and girls accessing HIV services. Nurses in particular, work closely with vulnerable women and girls at grassroots level. It was crucial to find out whether they recognised any links between LE, child marriage, bride price and polygamy with the risk of HIV. I wanted to capture their views on linking health messages with those cultural practices, and particularly to understand what from their experiences working with vulnerable groups in the community the dominant cultural norms were and what legitimized them and how they impacted women and girls' health and wellbeing. Participants are stratified by ethnicity and gender in the table below:

Role	Gender	Ethnicity	Participant ID
Programme director	M	African (other)	**ZDPPP4**
Programme director	M	Zimbabwean	**ZDPPP5**
Programme manager	M	African (other)	**ZDPPP12**
Programme manager	M	Zimbabwean	**ZDPPP1**
Programme coordinator	F	Zimbabwean	**ZDPPP2**
Programme director	M	Zimbabwean	**ZDPPP9**

Programme director	M	African (other)	**ZDPPP3**
Country manager	M	African (other)	**ZDPPP10**
Country manager	M	Zimbabwean	**ZDPPP8**
HIV Specialist	F	Zimbabwean	**ZDPPP11**
HIV specialist	F	African |(other)	**ZDPPP13**
Programme Coordinator	F	Zimbabwean	**ZDPPP6**
HIV specialist	M	Zimbabwean	**ZDPPP7**
Nurse 1	F	Zimbabwean	**ZNPPP1**
Nurse 2	F	Zimbabwean	**ZNPP2**
Nurse 3	F	Zimbabwean	**ZNPP3**
Nurse 4	F	Zimbabwean	**ZNPP4**
Nurse 5	F	Zimbabwean	**ZNPP5**
Nurse 6	**F**	Zimbabwean	**ZNPP6**

Table 2.1 Participant category- Development practitioners

2.1.5 Teachers category

With the teachers category, I was flirting with the idea that in other contexts where anti-FGM global campaigns are well established, girls are targeted in empowerment projects (see Girls Generation site: https://thegirlgeneration.org/), and most of the work takes place in school and after school club settings. I therefore wanted to understand how if at all, girls could be targeted through education to discuss cultural practices to counter the sexuality education that is offered in initiation schools and also within familial settings. South Africa and Zimbabwe (in particular) are lauded for launching sexuality education curriculum for primary school children and I therefore sought to find out the extent to which that curriculum addressed cultural practices and gender norms, and if not whether LE and cultural and gender norms could be specifically discussed in lessons. For this I sought to capture teachers' perceptions as well as insight. Participants are stratified by gender and ethnicity in the table below:

Role	Gender	Ethnicity	Participant ID
Teacher 1	M	Zimbabwean	**ZTPP3**
Teacher 2	F	Zimbabwean	**ZTPP2**
Teacher 3	F	Zimbabwean	**ZTPP1**
Teacher 4	F	Zimbabwean	**ZTPP5**
Teacher 5	F	Zimbabwean	**ZTPP6**

Table 2.2 Participant category- Teachers

2.1.6 Advocacy Groups

I identified and purposively sampled (Patton, 2002; Cresswell & Plano Clark, 2011) six organisations (3 in South Africa, 3 in Zimbabwe) that work on women's rights and empowerment and support women practically and emotionally. Participants are stratified by gender and ethnicity in the table below:

Role	Gender	Ethnicity	Participant ID
Group Director	F	South African	**SAOGPP1**
Group Coordinator	F	South African	**SAOGPP2**
Group Facilitator	F	South African	**BBOGPP1**
Group Director	M	Zimbabwean	**ZOGPP3**
Group Coordinator	F	Zimbabwean	**ZOGPP1**
Group Facilitator	F	Zimbabwean	**ZOGPP2**

Table 2.3 Participant category- Advocacy groups

In development, there is a chain of partnerships from a donor to an implementing partner, which might be a big organisation but most work is delivered by these grassroots groups (Banks, 2022).
Being able to evidence the impact of interventions at a grassroots level is important in terms of understanding what works or not. Inter-governmental organisations (INGOs) tend to subcontract national and local organisations to deliver activities on the ground. I felt that identifying those local organisations who do the work from the outset is effective in terms of not only being able to evidence impact but also to bring about change to start with. Advocating for women's rights, this is a vital sector in Zimbabwe providing support services to women seeking refuge and empowerment.

I sought to understand their perceptions of ongoing GBV interventions which is crucial in terms of understanding the nature and extent of interventions and unpicking whether or not the environment is enabling enough to respond to the needs of women and girls. I also wanted to unpack what this category of participants perceived as dominant social and cultural norms and practices, and whether they viewed them as harmful or not. Additionally, I wanted to establish whether they saw any links between LE, child marriage, bride price, polygamy and HIV and what they thought would work to empower women and girls to reject these practices. I was interested in hearing the groups' perceptions of VAWG and what they envisaged would work to end harmful practices. Thus my sampling method maximised my study's validity and efficiency (Morse & Niehaus, 2009). It was therefore crucial that I capture their views on what interventions were working well or not and what they perceived could work better.

2.1.7 Inclusion Criteria

For the focus groups participants were females over the age of eighteen, either married, , never married, divorced or widowed, and accessing HIV treatment and/or support for GBV. I did not seek disclosure of the participants' HIV status and the participants were aware that I did not have access to that confidential information. For the development practitioners, nurses, teachers and advocacy categories all participants were over the age of 18 regardless of gender. Although the goal of my research was to generate evidence that will create space for women and girls to voice their own lived experiences I decided to exclude girls under the age of 18 from the sample for ethical reasons. The sensitivity of the issues under investigation made me conscious not to cause retraumatisation for my participants and therefore complied with UNICEF's 'do no harm' principle (UNICEF, 2019; Council of Europe, 2019). This however did not compromise the research goal as the social and cultural factors that determine young girls' experiences were still discussed by the sample I included. Additionally, the sample yielded rich data that highlighted young girls' experiences of gender inequality from an individual level as participants in the focus group discussions narrated their life histories from young ages right up to adulthood. Although these experiences cannot be generalized it was indicative of growing up in a socio-cultural context controlled by a restrictive gender ideology.

What I found intriguing in the participant pool was that development practitioners were not all ethnically Zimbabwean, as highlighted in the category table stratified by gender and ethnicity. This category turned out to yield more male participants than the other categories which revealed that senior positions in the sector are mostly occupied by men. I did not set out to interview more men than women in this category but individuals with programming remit turned out to be mostly male. This finding confirms the claim that senior positions are occupied by men and reveals a gender disparity which is consistent with findings elsewhere that men tend to occupy higher and specialist positions (Ayres et al, 2015; Adams & Berg, 2017). Patriarchal arrangements visible in the overrepresentation of men in top level positions (Catalyst, 2018) can be used to explain the gender dynamics in the context of programming. Fundamentally the under representation of women in decision making bodies (EIGE, 2020) and roles is a stark contrast to lower positions such as nursing where this study's participants turned out to be all female. Is it therefore worth considering the impact of having male dominated policies and practice culture that seeks to address VAWG and how development policies are formulated for instance? What will be useful is to understand how a

gender balanced view of programming would look like and what its implications for gender equality would be.

2.1.8 Conducting Interviews

The individual interviews with development practitioners, nurses, teachers and advocacy groups were conducted in English while focus group discussions were conducted in Shona. The focus group discussions were open- ended, and I framed questions that I wanted my participants to answer emphasising what they felt was important in their lives. I used the conversations that emerged as a way to prompt answers to my research question. I was interested in women's life experiences and wanted to explore with them the role that initiation rites play both negatively and positively in their lives. Furthermore, I wanted to explore what these rites of passage might tell us about the role of women in families and community as a whole and perhaps help us to understand better the challenges women and girls face in terms of negotiating vulnerability to HIV against restrictive gender norms.

To counter, the issues around group dynamics, the researcher created a safe and inclusive environment for all participants in the focus groups to ensure open and honest discussions. I thus established ground rules (Kitzinger, 1995) at the beginning of the focus group for respectful and open dialogue. I also emphasised the importance of maintaining a non-judgmental and safe space for all participants. I also acknowledged that the topic was sensitive and reassured participants that their perspectives and experiences will be respected. Both the focus group and individual interviews were audio recorded and transcribed. As a native Shona speaker, I translated the focus group discussions' transcripts into English. All transcripts were imported into NVivo for ease of management of data and storage. Below is the interview guide by category.

Development practitioners and nurses

- Do you see a link between HIV, IPV, and labia elongation?
- What makes a girl or woman more or less vulnerable to HIV transmission?
- To what extent is transmission gendered?
- Does it make sense to link health messaging around harmful practices such as labia elongation and domestic violence with HIV? And to what extent is this already happening?
- What are the challenges women face in accessing treatment for HIV and how do

you address these?

- How are you addressing gender- based violence in your programming initiatives?

Advocacy practitioners

- What makes a woman or girl more or less vulnerable to violence and HIV transmission?
- What efforts have been made to break the cycle of intergenerational relationships? How effective do they seem to be? Is it poverty that is really the major dimension that is preventing these interventions from working?
- What are the most common interventions or activities around supporting domestic violence survivors? How effective or ineffective are they?
- Can you see links between HIV, domestic violence and initiation rituals like labia elongation?

Primary school teachers

- How far does the sexuality education curriculum go in addressing initiation rites including labia elongation?
- Why do young people drop out of school?
- To bridge the gap of knowledge of HIV, what can be done to keep young people in schools?
- Can you see sense in integrating lessons on labia elongation, domestic violence and HIV?

Focus groups

- What are the main challenges women face in the communities you live?
- What do you think about rituals and initiation ceremonies for women and girls? How important are they? Do they prepare girls/young women for the life ahead? What can outsiders learn from them?
- Is there a link between labia elongation, marriage, domestic violence and HIV?
- Do you talk about HIV during initiation ceremonies?
- Do you talk about domestic violence during initiation ceremonies?
- How important is marriage to you? What are the implications of not getting

married?

- Are initiation schools safe spaces for young women and girls to talk about problems?
- Are all of your needs catered for within the service provision available for health and social support?

2.1.9 Methods and choice of analysis

I used a bottom -up approach in analysis which was data driven and identified the important elements of my research question. I iteratively analysed the data as I collected it to ensure my research questions were being answered. I saturated my categories when the process of constant interviewing stopped delivering any anomalies to help me learn anything new (Miles & Hubberman, 1994; O'Reilly & Parker, 2013). It was not only the most mentioned issue but the meaning and significance of the issue for the participants and relative to my research question that mattered. Additionally, I used NVivo computer assisted qualitative data analysis as a tool to primarily organise my data and support analysis. I realised that NVivo could not analyse data for me but assisted in organising it. What I also observed with NVivo was that the computer seemed to distance me from my data, which was a different experience from coding manually. However, NVivo was useful in enabling me to find bits of data more quickly than I would have done manually.

Coming on to data analysis I chose hand coding to inform the process. Coding is a judgement call; theories that structured my research are reflected in my findings including epistemological and methodological issues. Coding is linking data to an idea and from the idea to all the data pertaining to that idea (Williams & Mosser, 2019). Initial coding was inductive (Allen et al, 2011) and looking at what my participants were saying led me to create the codes thus the process was all data driven. I had this broad understanding of what my participants thoughts were about links between the cultural practices under consideration and HIV, and the first stage of analysis delivered broad ideas about what was going on in the data, and not in my own thoughts. An iterative process, the data was telling me of the codes and categories and the categories were presented as the best albeit provisional explanation of the data I had gathered (Charmaz, 1993).

Coding as inferred in NVivo cannot create themes which contrasts with hand coding because with

hand coding one can understand data, understand the meaning of data and can see connections in the data more than NVivo could. NVivo could also not interpret interview transcripts and neither could it link my findings to the literature I had reviewed. William & Mosser concede that "The researcher still must move through each phase of coding; the software simply supports an easier capture of the researchers' coding and construction of meaning" (2019, p.45). Thus frequent, significant initial codes were used to analyse the new data which helped to speed up the analytic process and give it a clear focus and direction.

I employed thematic analysis (Braun & Clarke, 2006; 2020) as a framework for the analytical process. I chose to use inductive thematic analysis to explore the research subject, code, and interpret the data I collected to in order to come up with the meaning of what I was analysing (Boyatzis, 1998; Saldana, 2009). I chose thematic analysis because it is considered the foundational method for qualitative analysis (Braun and Clarke, 2006) and a generic approach for analysing qualitative data. From my raw data I compiled inductive themes which together with themes identified from literature underpinned the analysis. The themes that emerged in my data were inductively identified through the coding process. I had grouped codes according to their similarities and matched them with predefined themes from the literature review. I summarised the main themes and issues that emerged from each particular data set. The literature review revealed that child marriage, bride price, and polygamy were critical factors in underpinning the linkages between the different forms of VAWG and vulnerability to HIV.

The majority of pre-identified themes were synergetic with themes that emerged from my data, revealing poverty, restrictive gender and social norms, and the significance of cultural practices as recurrent themes. Using a thematic analytical approach enabled me to establish the knowledge gap and strengthen the analytical process on the one hand while increasing research vigour on the other.

Section 2

2.2.1 Methods Rationale

Since my research was about the exploration of links between LE, child marriage, bride price, polygamy and HIV, and to understand which particular norms justified, legitimised and normalized the violence and whether the norms were recognised as harmful I had to use a flexible qualitative method. This approach "provides opportunities to locate the genesis of a phenomenon, explore

possible reasons for its occurrence, codify what the experience of the phenomenon meant to those involved" (Williams & Moser, 2019, p. 45). This would enable me to capture my participants experiences and insights over whether these practices are linked and draw up a narrative over the subject matter (Lofland & Lofland 2006). I also took into consideration the work undertaken by the UN in their VAWG prevention programmes worldwide and I also considered methodologies employed by the What Works to end violence against women research consortium in researching VAWG. This work utilized multiple approaches to find what works to end VAWG and in my Masters research project I undertook to understand the complexities that researchers in that consortium faced in researching VAWG. What was evident was the use of various methods in order to have a holistic picture of the depth of the problem of VAWG (qualitative) and its breadth (quantitative) (Patton, 2002).

Consensus would veer towards touted mixed methodology approaches as a means to holistically account for depth and breadth of a phenomenon (Tashakkori & Cresswell, 2007) by integrating qualitative and quantitative research results (Bryman, 2006). However, Kelle (2006) cites that "qualitative and quantitative methods should be combined in order to compensate for their mutual and overlapping weaknesses" (p. 293). My research did not seek to capture statistics on women who had elongated their labia and went on to be infected with HIV but was on understanding how vulnerability to HIV infection is constructed through cultural practices that include LE, child marriage, bride price and polygamy. Influenced by my research question, my chosen method of enquiry consisted of obtaining and analysing textual data for deeper understanding of the phenomena which would have been unachievable in quantitative methods which yield empirical evidence- the breath of understanding (Patton, 2002). My research objective was to inform an effective mainstreaming approach to increase the sensitivity of policy makers across HIV programming to opportunities to reduce VAWG; providing them with empirical evidence would not have revealed the intersections of social and cultural factors that increase women and girls' vulnerability to HIV in my research sites.

My research thus aimed to theoretically and qualitatively evidence how, through social norms sanctioning and normalising LE, child marriage, bride price and polygamy, women and girls are rendered vulnerable not only to HIV but other forms of violence. I discounted other methods of enquiry such as positivist stance which is characterised by quantitative methods of enquiry which are concerned with hypothesis testing, reproducible designs, and law-like generalisations

including the pursuit of factual knowledge and quantifiable observations (Avis, 2005). This philosophical approach relies on structured methodologies and not theory (Remenyi et al, 2005). The structured approach would constrain my participants in expressing their beliefs and thoughts freely. With my chosen method of enquiry I encouraged my participants to tell their stories, thus giving them voice to develop their own narratives from their own perspectives which was also a way of validating their experiences (Boylorn, 2008)- I did not see my participants as objects but co-creators of knowledge (Pope, 2022).

It is important for research projects to build on tried and tested approaches for validity and reliability. Debate is ongoing about whether these terms (including generalisability) can be applied in evaluating qualitative research (Rolfe, 2006; Long, Johnson & Rigour, 2000; Sandelowski, 1993; Noble & Smith, 2015). While validity and reliability are determined through tests and measures in quantitative research, such tests are not applicable to qualitative research (Rolfe, 2006; Long, Johnson & Rigour, 2000; Sandelowski, 1993). In a broader context however, validity and reliability can be applicable as validity is interpreted as "the integrity and application of the methods undertaken and the precision in which the findings accurately reflect the data" (Noble & Smith 2015, p. 34) while reliability implies the consistency in the analytical processes used in the research (Long, Johnson & Rigour, 2000).

Because my epistemic position and purpose is intrinsically different from quantitative approaches I had to consider an alternative framework to establish rigour (Sandelowski, 1993) such as 'truth value', 'consistency and neutrality' and 'applicability' (Lincoln & Guba, 1985). For the first element (truth value) I had to account for my personal biases to ensure they would not influence the interpretation of my findings (Morse et al, 2002). In keeping my own prejudiced biases I was conscious throughout the research process to interrogate my positionality (Foucault, 1980; Chambers, 2012). I was conscious that I could not disassociate the evidence I gathered from the feminist theory that I employed to guide its production- a theory that allows women to make sense of their experiences. I had to reflect on my own perceptions of LE, child marriage, bride price and polygamy and to aid this process I maintained a reflective journal to document and examine biases and assumptions I took for granted (Chambers, 2012). Having been born and bred in a cultural context where these practices were prevalent I had several theories to explain those phenomena. However, after initial interviews with programming stakeholders where I focused mainly on whether these participants identified links between the practices and HIV infection, I conducted subsequent interviews holistically.

I did not regard interviews narratives as purely sources of data but as "particular social encounters in which identities are performed relationally" (Pattman, 2015, p. 82). Furthermore, I acknowledged the need through reflexivity for researchers to situate themselves within their studies because "researchers are part of what they study, not separate from it" (Charmaz, 2006, p. 178). I had to acknowledge this position because of sharing the same cultural heritage with my participants. Sharing aspects of a researcher's personal information is considered to encourage transparency/ openness from participants (Venganai, 2017) however for ethical reasons I did not disclose personal information on any of the issues. I refrained from asking direct questions whether women had elongated their labia, married as minors, had bride price paid, or experience of polygamy. I premised that any form of disclosure on my part would either have discouraged or encouraged a plethora of disclosures, and I was conscious of the possible risk of retraumatisation and for this reason self- disclosures of experiences with any of the practices were voluntary.

In terms of positionality (Berger, 2015; Moser, 2008), I declare that I embarked on this research having intersectional privileges of ethnicity, gender, with inside knowledge; what some may term as 'insider' researcher which enabled easy access to the target populations. However, my presence as an insider researcher might have had an effect in the responses my participants reported (England, 1994). The frankness with which they gave narratives of intimate issues about LE, bride price, child marriage and HIV might have been influenced by their consciousness of me being from the same culture. However, I cannot ascertain whether a researcher from a different culture would have gathered similar of different responses. In another aspect of showcasing truth value my findings had to be representative of the phenomena (Noble & Smith, 2015). My participants across five cohorts willingly shared their experiences at length and in great depth which clarified the findings for the duration of the research. Similarly, audio recording the interviews allowed me to revisit the data for any emerging themes while adhering to my participants' original narratives. Using my participants' verbatim extracts enabled me to establish whether the themes coming out of the data represented my participants' narratives (Lincoln & Guba, 1985).

For the second element (consistency and neutrality) I had to ensure that my research process is transparently and clearly described from the initial stage and mentioning when I had to change data collection tools (such as moving to virtual interviews when Covid 19 emerged), and also in reporting my findings. I also employed a research diary where I documented all issues and challenges which helped me to maintain fluidity and consistency between my study aims, research

design and the research methods. This way my research could be audited (Lincoln & Guba, 1985). Lastly, in terms of applicability, although my study design could not generate generalizable findings, the rich detail of the data enables my study's conclusions to be evaluated and transferred to other contexts (Lincoln & Guba, 1985).

2.2.2 Research philosophy and justification

Methodology justifies the methods and is a theory and analysis of how research should proceed. Through methodology, researchers are able to analyse the procedures, principles, and assumptions in a particular approach to an inquiry (Carter &Little, 2007). My choice of methodology resulted from critical reflection on my role and values as a researcher, the social processes of generating data (Carter & Little, 2007), and the role of post-colonial feminist theory in conceptualising the evidence I would go on to glean and analyse through a specific epistemology shaped by feminist postcolonial thinking. My research philosophy is interpretivism (Saunders, Lewis, & Thornhill, 2009) because I was concerned with understanding the links between different forms of harmful cultural practices such as LE, child marriage, bride price, polygamy, and HIV infection. I also wanted to explore the role of cultural and gendered norms and how they justify and legitimise violence against women and girls rendering them vulnerable to more violence, specifically HIV infection. My research was also concerned with understanding whether those norms were recognised as harmful and by whom, in order to equally understand how they could be reversed.

My epistemic position was therefore chosen as the most appropriate in interpreting people's values, beliefs, and perceptions of their lives within their environment as experienced by them (Popay, 1992). My methodology thus provided a primary source of justification for my project's relationship to theory (Avis, 2003). It is also of paramount importance to identify one's research philosophy earlier on, as it helps to justify one's research design (Easterby-Smith, Thorpe, & Lowe, 1999). My employment of post-colonial feminist theory as a tool to interpret my findings was influenced, and partly dictated, by my choice to situate my thesis within feminist discourse. Besides, epistemological justification depends on the internal consistency of arguments used to support a specific knowledge claim which should be based on evidence, and theory. My evidence base came from the post-colonial feminist stance which seeks to provide a lens for women to explain their life experiences as lived by women themselves (Mohanty, 1988).

Thus a qualitative approach was useful for understanding my participants' perceptions, emotions, and beliefs particularly when looking at health-related behavior or evidence based practices (Palinkas et al, 2013). This method is person-centred and therefore treats participants as holistic

entities and “not as a collection of physical parts” (Holloway, 2005, p.1). It is useful to unpack the social context of people’s lives and how they understand their lives (Avis, 2005) and similarly allow researchers to “see through the eyes of the people they are studying” (Bryman, 1988, p. 61). A qualitative inquiry methodology resulted from critical reflection on my role and values as a researcher, the social processes of generating data (Carter & Little, 2007), and the role of post-colonial feminist theory in conceptualising the evidence I would go on to glean and analyse through a specific epistemology shaped by feminist postcolonial thinking.

The approach allowed me to interact with my participants in order to explore the meanings they attached to marriage and LE and to see through their eyes the impact the issues have on their lives and in their own terms during fieldwork (Avis, 2005). Through observation (notes), and semi-structured questions, I gained from my participants, knowledge I did not have and recognized that my participants were not mere tools from which to ‘collet’ knowledge. I learnt from them (Spradley, 1979) thus my data was not ‘collected’ but produced through interaction with my participants (Avis, 2005). The qualitative approach enabled me to interpret how social norms and prescribed cultural practices such as LE, child marriage, bride price and polygamy seem to disempower women and render them vulnerable to further violence as the theoretical literature suggests. Because of its open-ended approach, qualitative research allows for “change of direction and new insights” (Bryman, 2006, p.111). Being exploratory in nature, participants may not always be fully informed when they sign consent forms before interviews because their ideas inform lines of enquiry (Iphofen, 2005), particularly where semi-structured interviews are used. I adopted a “flexible plan of enquiry” for all my participant cohorts to maximise ideas they were expressing and therefore did not maintain a “rigidly predefined protocol’ for sampling, data collection, and analysis” (Avis, 2005, p. 5).

In consistency with qualitative research framework, I did not embark on my research with a hypothesis- rather my hypothesis was theoretical (Holloway, 2005) which allowed me to develop the hypothesis that links between LE, child marriage, bride price, polygamy and HIV were not well understood and therefore propelled me to increase the sample size (Silverman, 2010). In order to achieve this, I emailed research questions to those participants who had been reluctant to participate in audio interviews. Abandoning “traditional scientific control” (Agar, 1986, p. 12) in this way underpins the flexibility of this method of enquiry underscoring why I deemed it appropriate for my study. Qualitative research entails constant critical reflection on decisions a researcher makes (Mason, 2017) and also the recognition that they are the research instrument and that

methods of enquiry evolve with the study and therefore one cannot rely on standard research protocols to address reproducibility and bias. This leads to reflexivity and issues of transparency as part and parcel of the flexible plan of enquiry (Avis, 2005, p.5). For community level fieldwork I employed two focus group discussions with five women in each group. Due to the sensitive nature of my research topic, I facilitated the discussions in safe spaces used by ZANA and Masimanye as offices spaces. The spaces were an enabling environment because I could call for support from professional counselling personnel provided by the two organisations if any one of my participants became distressed. I chose this method of enquiry because group interviews are ideal for exploring collective cultural experiences. Equally, people in group interviews resonate to each other's experience, and one person often brings up topics that the whole group then explores (Kitzinger, 1995). Due to time constrains in my research project, as a result of the Covid 19 pandemic, focus group discussions allowed me to sample a wide range of experiences in a relatively short time (Corbin & Strauss, 2008).

2. 2.3 Rationale for context

First and foremost, Beitbridge and Venda lie along the border between Zimbabwe and South Africa. The border was established from the London Convention of 1884 (UK Parliament, 1895) and the Venda ethnic group was separated when it was drawn during the colonial period (Moyo, 2016). The border was drawn to separate Southern Rhodesia (Zimbabwe) and South African Republic and neither the Zimbabwean nor the South African governments "recognise the existence of border citizens at Beitbridge" (Moyo, 2016, p. 427). Before colonization, both communities lived as one community, with the same linguistics and culture and only separated by the Limpopo river. Today the Venda people are found on either side of the border adopting a double identity while identifying as South African Vendas or as Zimbabwean Vendas and their lives "straddle the border" (Moyo, 2016, p. 428).

The tribe have thrived each in their locality however living along border regions is correlated with marginality, a concept which I will unpack in order to justify my rationale for the context. Borders are identified as "critical zones at the margins of state control and nation imagination" (Cons & Sanyal, 2013, p. 6); Harris (2013); Gellner (2013); and Kalir & Sur (2013). Gatzweiler et al define marginality as "an involuntary position and condition of an individual or group at the margins of social, political, economic, ecological, and biophysical systems, that prevent them from access to

resources, assets, services, restraining freedom of choice, preventing the development of capabilities, and eventually causing extreme poverty" (2011, p. 3). Marginality encapsulates a group of people's geographical location and what they have. Defining it more succinctly Cons & Sanyal posit that marginality is "the position of people on the edges, preventing their access to resources and opportunities, freedom of choices, and the development of personal capabilities (2013, p. 3). Cons & Sanyal theorise margins as "spaces of exception, spaces of contradiction, spaces of danger and violence, and spaces of ambiguity" (2013, p.8). Harris (2013) and Smith (2013) link these spaces to 'a broader set of marginalized locals' and, to 'intimate forms of marginaliSation carried out on gendered bodies and spaces of minority worship'.

Margins and marginality have long been associated with urban poverty and ethnic minority in the global south (De la Rocha et al, 2004). Being situated on the margins of society, and excluded from developmental processes and general process in the community analogously outlines marginality and is considered a root cause of poverty (von Braun et al. 2009). Studies have also tried to understand how through marginality and exclusionary practices, poverty becomes entrenched in people living along border margins (Wacquant, 2008; Perlman, 2003). Poverty, a result of multiple factors, experienced in different ways can be conceptualised as marginality and a poor person will experience marginality in various dimensions (Gatzweiler et al, 2011). These two concepts overlap and complement each other however marginality encompasses social exclusion and relative deprivation (von Braun & Gatzweiler, 2014).

Scholarly debates on margins and borders concede that "such spaces are privileged zones for understanding processes unfolding in "centers" and that, indeed, the very notion of centers is fundamentally predicated on the relational production of margins, borders, and zones of exclusion" (Cons & Sanyal, 2013, p. 7; see also Aggarwal & Bhan, 2009; Yiftachel, 2009). Marginality can be conceptualised in various ways that can include social, cultural and structural forms. Focussing on margins through the lens of marginality gives a broader understanding of how exclusion is constituted in a place where historical backgrounds are both similar and divergent, and clarifies the ways in which space and social status overlap. This move also enables the comprehension of social exclusion within the confines of ethnicity which is useful in interrogating the nature of marginalisation of communities on the periphery. Instead of perceiving these sites as exceptional to the norm, we can understand through marginality how border communities are then moulded by governing structural processes.

Border regions such as Beitbridge and Musina characterise “spaces of particular forms of transience and flux” (Cons & Sanyal, 2013, p. 10). It was with this in mind that the thesis sought to understand how people’s spatial location could affect their health outcomes, and how and if cultural practices were maintained in these regions of high social mobility. The movement of people has been a regular phenomenon between South Africa and Zimbabwe over the centuries starting with the discovery of mines in Witwatersrand and other places where Zimbabweans are known to have emigrated to find work in the mines. This movement of people chimes with the anthropological accounts of the historical and geographical background of the Venda ethnic group (also known as Venda) that inhabit the Limpopo province. The Venda occupy this space and have been found in the area of Soutpanssberg Mountains South Africa. The area they occupy today Shares its border with Zimbabwe.

Venda culture consists of an integration of cultural characteristics from Nguni and Sotho, Central Africa and East Africa (Ralushi, 1978, p. 55). For example, the practice of male circumcision practised among the Sotho, and the prohibition of pork consumption, a practice most common among the Lemba (known as the Remba in Zimbabwe) and a practice observed in East African coastal areas synonymous with Islam (Matshidze, 2013) are all practices prevalent in the VEnda people. Oral history on the Venda’s origins and initial entry into Zimbabwe is scarce however Stayt (1931, p. 250) suggests that they could have originated from the Great Lakes region in East Africa. The Venda people speak Luvenda, a dialect that emerged in the 16th century, and evolved from Lungona which is a Ngoni language. The Tshivenda lexicon, akin to Sotho language -SeSotho (Wentzel, 1983, p.7), also has grammatical similarities to Zimbabwe’s Shona dialects.

There are also noteworthy intrinsic linkages between the Venda and Shona ethnic groups. Wentzel (1983, p. 9) posits that the Tshivenda Shona dialects most likely influenced Tshivenda before Venda reached the Limpopo province. Oral tradition has it that the Venda settled in Bulawayo, Zimbabwe for a protracted period of time which is also literary the same place that the Karanga (Shona) people of Zimbabwe had settled after their arrival as part of the Bantu migration to Southern Africa. This interaction betweenthe Venda and the Shona is cited by Wentzel (1983, p. 9) to signify a close relationship which is sealed by language. What cannot be scientifically substantiated but discovered (through oral history) are claims that “the BaPedi of Hananwa of Khalushi, the Karanga (Shona) or Nyai of VhuKaranga (currently Zimbabwe), and the Venda were originally the same nation, called the Ngona (or Bakoni)” (Matshidze, 2013, p. 66). Because of the paucity of data to

evidence the Venda people's origins, Stayt (cited by Ralushai, 1977, p. 22) concedes that it is difficult to account for the reason why they are found in the areas they settled in.

Understanding the position of the Venda people in both Zimbabwe and South Africa is salient particularly when considering literature on marginality. Living along the border, there is a flux of cultures aided by the transient nature of border communities. Keyl (2017) posits that spaces of habitation can impact people's social, cultural and economic status. Poverty is synonymous with ecologically marginal spaces (von Braun et al. 2009). It is apparent that these two regions will experience the same levels of marginality both socially, culturally and economically. It is quite clear that both areas are structurally deprived economically and not infrastructure secure. It is within this framework of marginality that I intended to explore how social and cultural norms are experienced, and crucially since liminality is also contextualised within marginality, understand how culture is maintained in these contexts. Researching cultural norms in a transient marginalised community and understanding how those cultural norms were negotiated in these contexts was an important part of my study. I also wanted to explore whether the socio- cultural and ecological structures of the communities were understood in HIV programming and whether interventions were targeted. The findings would be useful in understanding what norms were problematic and crucially how those norms could best be addressed for effective HIV interventions.

Furthermore, I decided to focus in Zimbabwe and South Africa and align more closely with my own cultural contextual knowledge and networks that lie in these contexts. I have a Zimbabwean heritage, from the Shona tribe and fluent in Shona and Ndebele languages which are spoken in Zimbabwe. I am also familiar with South Africa having travelled to the country multiple times in the past. This enabled me to facilitate research both remotely and in person. Both countries are high priorities for global end Violence Against Women and Girls programming with many ongoing interventions. I also decided to situate the project on the South African/ Zimbabwean border region because of the greater access to live programming in those contexts. Crucially ongoing end FGM research works with the hypothesis that increasing gender equality will reduce the incidence of FGM. Working with that hypothesis I decided that my research would focus on mainstreaming LE, child marriage, bride price and polygamy in HIV programming.

Figure 2.1 Zimbabwe and South Africa border

In terms of developing the mainstreaming tool, an opportunity arose for me to align my mainstreaming research within the Foreign Commonwealth and Development Office programme to end FGM in Africa. With the University of Portsmouth leading the monitoring and evaluation and learning for that programme, and one of the pathways in the theory of change is focused on mainstreaming ending FGM inside other sectoral programmes, I had the chance therefore to bring impact through my research by feeding the learning from my data into the programme.

In my literature review however, I use South Africa as a secondary case study because there is more that has been researched and documented on HIV and VAWG in the context of South Africa. I drew on the research in South Africa because there are similarities in the culture, particularly in terms of this border area with Zimbabwe. There is literature on LE in Venda; initiation schools are well established and openly talked about in the region. In Beitbridge, initiation schools are also prevalent, but little is documented about their existence. Although my field work was focused on Zimbabwe, primarily not only because of my own contextual knowledge and heritage, but also because there is significantly less written about Zimbabwe and therefore less that is known, it means that the original data that I collected is vital as a tool to initiate the conversation.

2.2.4 Ethical consideration

The ethics of conducting data collection on issues around violence against women is challenging (Petillo & Hlavka, 2022; UN, 2005) Building partnerships for the purposes of researching the

phenomenon is crucial because of the sensitivities surrounding the subject and therefore the possibility of causing harm. Relationships between researchers and gatekeeper organisations is important not only because of the data gathering challenges, but also because for data to be gathered ethically researchers need to create an enabling and safe environment in order to circumvent triggering trauma. I went through the process of familiarizing myself and building relationships with grassroots women's organisations in my research sites to ensure that referral mechanisms for trauma incidents would be in situ once fieldwork commenced. I also developed a risk matrix before data gathering (see matrix in appendix). Interview protocols were derived from the UN research on VAWG, the University of Portsmouth and the ESRC/UKRI research ethics and policies websites. I acknowledged that gathering data on sensitive topics such as LE, child marriage, and HIV, there is a responsibility that as a researcher I will be asking people to share traumatic stories. It was therefore imperative that I demonstrate that my participants would not be harmed importantly and that their stories will feed into something meaningful and positive.

In interviewing teachers, nurses, development, and advocacy practitioners I asked specific questions that were geared more towards their operations as institutions either responding to VAWG and/or providing healthcare, education or advocacy services, and not whether they had experiences of the issues I was investigating. I was however conscious that these sub-groups might also have personal experiences of either FGM or HIV and experiences of other forms of VAWG. I acknowledged the risk in my risk matrix. Since my research involved vulnerable human subjects, I applied for ethical approval from the University of Portsmouth Ethics Committee to ensure participants were not harmed in any way. I followed strict protocols which are in place for other University of Portsmouth projects researching VAWG and I adapted the protocols to reflect the specifics of my research. The study was therefore granted ethical approval Number: FHSS 2020-058.

In line with conducting ethical research of a sensitive topic with humans I had to obtain consent from my participants. The process of seeking consent was to ensure that they were fully informed of the nature of the research before making an informed choice to participate. For the development practitioners' category, I emailed participant invitation letters to participate, and participant information sheet outlining the nature and scope of the study. I also sent out consent forms seeking their consent to participate and to be recorded verbatim before interviews commenced. I also emailed advocacy groups with these forms, which they used themselves to familiarize with my research, and later forwarded to the teachers and nurses' categories whom they identified as suitable participants. The use of consent forms apart from the development

practitioners was adhoc for individuals in the other categories (see consent form in appendix). Contexts are different and asking someone to sign a form might be perceived in a completely different way. People, because of the political contexts in Zimbabwe (and possibly) South Africa, will likely get nervous around official processes and nervous about putting their name on or signing what looks like an official document. To gain consent I used an adaptive checklist for all the participant cohorts except for focus group participants. With this cohort I informed them prior to the discussions that at times our conversations could stray into topics that were sensitive and hard for them to talk about (see focus group protocol in appendix). I wanted to be clear that they were in control of what they did or did not tell me from the onset. I also informed them that if at any point they felt uncomfortable, we would stop the conversation. To ensure confidentiality I asked all focus group participants to agree to a verbal contract of confidentiality. Equally, I also did not give this group participant information sheets but spent time talking about the project instead. (See the checklist in appendix). I provided assurance to all participants in the Participant Information Sheet and in the consent form (where the latter was used) that any verbatim quotes would be anonymised and that the participants could choose not to be quoted verbatim.

2.2.5 Methodological Challenges

The Covid pandemic brought a twist to the country focus in terms of field work but did not change the actual thrust of the research itself. Firstly, the research design was originally set to be a systematic comparative approach between Zimbabwe and South Africa but travel limitations brought on by the pandemic meant that I had to change the design and employ remote digital data collection methods including WhatsApp audio, Skype, and email. This meant that participants were not necessarily concentrated in the exact field sites (except for community level participants) but situated mainly in administrative locations outside Beitbridge and Venda.

Those with programming remit at UN level, although not geographically present in these two sites have control over programming for both Zimbabwe and South Africa. Secondly, the contingency planning was focused on using an in-country researcher to support data collection, and they possessed a wealth of knowledge in researching HIV and working with vulnerable women. Thirdly, while fieldwork became possible in the latter stages of this project, it was not programmatic to do the same extensive level of community fieldwork like I was physically able to in Zimbabwe. I decided to include literature from South Africa in my review not least because of the shared cultural heritage between the two contexts but also because of the plethora of literature on VAWG written about South Africa in comparison to Zimbabwe.

With the adopted methods, there were variables I could manipulate as a researcher that I would not have been able to in a face to -face interview. For example, one can exploit the online environment. With audio virtual interviews I felt that the approach removed me from the space so anyone discomfited by my presence would have found the space liberating and therefore could speak freely. For the cohorts I interviewed virtually, I felt that the method removed me from the space so anyone bothered by my presence would have found the space liberating. However, I also encountered a few challenges with written responses as there was no scope for seeking elaboration on answers that were not articulated clearly. I also encountered responses that appeared to have been pulled out of published texts and these were eliminated from data analysis.

2.2.6 Critique of Methodology

I need here to acknowledge some methodological issue. Firstly, qualitative research technique is time consuming and for this reason the number of interviews that can take place is limited. However, through my population study I was able to build a sizable verifiable data set that after triangulation, the findings in their robustness were enough to make policy recommendations. Secondly, the focus of my research was to provide a contextual understanding of social norms governing cultural practices that reinforce women's vulnerability to HIV infection in the border area between Zimbabwe and South Africa from my participants' view therefore I was not interested in producing findings generalisable to the wider Zimbabwean and South African populations. This does not imply that qualitative findings cannot be generalised to other settings but will depend on the manner in which findings can be made to fit with general social and not sampling theory (Dingwall, 1992).

Conclusion

Although this methodology enabled me to evidence links between LE, child marriage, bride price, polygamy and HIV infection, it was not my aim to generate generalizable data. My participants' experiences gave adequate insight into these issues which was sufficient to produce policy recommendations for reversing harmful norms that perpetuate the forms of violence covered in the thesis. My methodology enabled me to protect my participants above all from harm which is critical when researching sensitive issues. Although flawed in several places mainly due to the Covid pandemic caused delays in fieldwork until the last eight weeks of the project life, my methodology enabled me to comprehensibly understand the extent to which the different forms of

violence discussed are linked and how this generates vulnerability to HIV infection. It also enabled me to understand and identify what the most prevent and dominant social and gender norms were and that were both supported and considered causal to violence across my participant categories. My methodology also enabled me to gather valid and reliable data that supports mainstreaming LE, child marriage, bride price and polygamy in HIV programming. In the next chapter I present my theoretical framework and a specific analytical lens which helps me to understand why violence is normalised and legitimised when it so evidently disadvantages and discriminates against women and girls.

Chapter 3

Understanding the normalisation of violence: A theoretical conceptual framework

Introduction

In the last chapter I presented my methodology which detailed the process I employed to researching the links between LE, child marriage, bride price, polygamy and HIV. In that chapter I explained my rationale for choosing the specific research design and detailed how I was going to approach the process of answering my research question. In this chapter I present my theoretical framework which draws mainly on post-colonial feminist theory in order to interrogate the norms which underpin the legitimization of violence. Sections in this chapter will contribute to the broader argument of the thesis– that is the normalisation of violence fuels the continuation of multiple forms in the daily lives of women and girls. I draw on literature that discusses FGM from a feminist perspective arguing that violence represents a vehicle through which gender inequality is reproduced. The construction of violence against women and girls is a consequence of patriarchy which ultimately reinforces patriarchy (Gnanadason, 2012; Christiansen, 2010).

In my theoretical framework, the feminist lens allows me to make links between LE, child marriage, bride price, polygamy and HIV. The lens is useful in elucidating these issues and understanding them within a wider and deeper context of power relations. This perspective also serves to strengthen the originality of my thesis. Theoretically I incorporate the notion of gender, social, cultural and religious norms and frame these norms as the root problem of these harmful practices. My thesis argues that the high rates of HIV transmission in women reflect that HIV is gendered, increases vulnerability and should be seen as a form of violence. Furthermore, harmful practices such as child marriage, LE, bride price and polygamy must also be seen as violence along with other forms of gendered violence. These forms of violence will only end once the rights of women and girls are acknowledged, and harmful gender norms that render women and girls inferior to men are reversed (UN Women, 2023).

The chapter is structured as follows:

Section 1 introduces the post-colonial feminist theory which argues that women's experiences of oppression are as a result of patriarchy (Fidan & Bui, 2016; Al- wazedi, 2021). My thesis is built upon this theory and uses its lens to explore women's experiences of violence. I also outline the

implications of gender inequality for women and girls' agency and autonomy, and discuss the reasons for women and girls' subservience to the predominant patriarchal system in Zimbabwe. In section 2 I unpack the theory of norms in order to understand how power relations are established, and whether or not women and girls can negotiate their autonomy against the structural role played by those norms. Section 3 discusses and critiques the theory of change to investigate the extent to which it could be harnessed to bring about change that can govern behaviour and end LE, child marriage, polygamy, bride price and HIV infection. I also introduce the concept of agency and explore whether women and girls can negotiate the inegalitarian cultural environment and become agentic. The chapter ends with a brief conclusion summarizing key concepts discussed in the chapter.

Section 1

3.1 The Post-Colonial Feminist Lens

Feminist approaches advocate safe spaces for women to narrate their experiences and empower themselves. Mohanty argues against depictions of Third World women as victims of culture and patriarchal control and urges an interrogation of cultural differences and the historical context from which masculine control emerged (1988). This would lay out the differences in which women and girls experience patriarchy and how the north and south divide has framed feminist discourses around violence against women and girls. Feminist lenses are critical in elucidating how socialised gender norms bring out a gender ideology (Goebel, 1999) that renders women inferior (Fidan & Bui, 2016) which increases their vulnerabilities to many forms of violence. I posit that LE, child marriage, bride price and polygamy, are essentially mechanisms for reinforcing vulnerability and inferiority and this is what lies at the heart of what triggers other forms of violence, including HIV infection.

Arguably, all feminist perspectives (Socialist/Marxist, liberal, radical) are committed to investigating women's experiences and view the world through them. In particular, post-colonial feminism seeks to critically explore the experiences and realities of women offering representations of their lives that are owned by them (Townsend, 2008). In this regard Mohanty and Narayan argue that all too often the lives of women in the global south are co-opted and represented by scholars outside of their context who understand little of their lived experience (Mohanty, 1988; Narayan, 1998). The authors argue that the violence suffered by women in the global south, cannot be simply reduced to 'culture'. Not least because, even if the cultural element

were to be removed, violence would still occur. Women's experiences of male violence are best understood through a feminist perspective on patriarchy and the subsequent subservience of women. Patriarchy cannot be universalised because it manifests differently in places however violence against women and girls can be theorised by contextualising the gender ideology and the socio-economic structure of the society, including family traditions, in order to understand the actors that contribute to women and girls' vulnerabilities (Fidan & Bui, 2016).

Drawing on post -colonial feminist theory I argue that the patriarchal nature of the Zimbabwean society is largely to blame for the violence that women and girls experience. The impact of cultural practices normalises and embeds women and girls' subordination legitimising multiple forms of violence (Goebel, 2005; Johannsdottir, 2009). Harmful practices such as LE, child marriage, bride price and polygamy are deeply embedded in Zimbabwean cultural norms and traditions. I am aware that taking this route means that I am set on a collision course with feminist post-colonial arguments that have always critiqued the use of culture to explain gender inequality and the abuse women suffer in developing contexts. Narayan claims that such cultural explanations are racist, reductionist, imperialist and Eurocentric and reinforce colonial power relationships in ways which are unhelpful (Narayan, 1998). However, as an African scholar speaking for and against elements of Zimbabwean culture, I am conscious that "the woman writer in Africa has a special task. She has to present the position of women in all its aspects" (Ba, … cited by Stratton, 1994, p. 55). My argument therefore continues and I position culture as a key strand in a deeper web of patriarchal gendered norms that weave to limit a woman's room for maneuver (Chuma & Chazovachii, 2012; Goebel, 2005).

Based on reviewed literature, it is apparent that Zimbabwean culture supports and sustains the existence of these practices. Furthermore, my data also antagonises Nayaran's argument as my research participants attributed women's experiences of violence to culture and tradition. Narayan's work is contextualised in Asia where further intersectional dimensions could combine with the specific legacy of colonialism and colonial narratives driving her powerful critique. Zimbabwe too, as a formerly colonised country, experiences the legacy of colonialism however, Zimbabwean women engage with forms of colonialist culture when it suits them. Although there are elements of colonial culture many preserve alongside modernity (a residue of colonialism) Zimbabwean women choose aspects of pre-colonial attributes they want to be associated with (Venganayi, 2017). Thus, many women regard themselves as modern (a colonial attribute) and yet

engage in practices such as LE (a cultural practice condemned by the colonisers).

To expose therefore a cultural explanation of VAWG may lead to a narrow definition of VAWG which ignores contextual nuances and differences missing the ways in which context produces norms that legitimise many forms of violence including those that are shaped by culture (Ozaki & Otis, 2017). Such critiques are positioned in wealthy institutions (mostly in the West) and largely generated from outside the contexts they attempt to describe. Furthermore, contextual experiences are quite different say, those of South Asia and Africa (which in itself is highly diverse). The specific cultural and gendered ecology of any given context is different and so women and girl's experiences are not the same. Homogenising global south women's experiences of violence leads to an over generalisation and a form of stereotyping (Fontes & McCloskey, 2011). Nevertheless, through my data I was able to identify a dominant cultural narrative that seems to challenge post-colonial arguments positioning culture as the main problem in projecting gender inequality as the norm.

3.1.2 Colonial legacy and Patriarchy

At the heart of male oppression over women is inequality which is constructed by, and located within the historical, political, economic and cultural contexts (Fidan & Bui, 2016; Quayson, 2000; Mohanty, Russo & Torres, 1991). It is undisputable that women were oppressed in pre-colonial Zimbabwe (Shenje-Peyton, 1999) however colonialism and capitalism exacerbated gender divisions by adding to the patriarchal structure of traditional pre-colonial society, sex-based prejudices. The consequence was that "the assumption of male authority over women that was intrinsic to the indigenous sex gender systems became distorted [and] in many respects reinforced by the impact of colonialism" (Shenje-Peyton, 1999, p. 111). Postcolonial feminist theory critiques the hegemonic power that was established by indigenous males following the end of colonial rule (Al- Wazedi, 2021).

Prior to that period the colonial era had also marked the introduction of Christianity in Zimbabwe and the colonisation of Africa as a whole became the machinery through which the continent was evangelised (Okon, 2014). Iwe (1985) states the period as a time of the planting of Western forms of Christianity. Notwithstanding that pre-colonial Africa had deities that people worshipped however colonial administrators regarded Africans' belief systems as idolatrous and actively sought to convert them to Christianity. Mission Christianity was "was imposed through colonial military power" (Okon, 2014, p. 192). These forms of control were not lost to the men and were soon

replicated as men exerted power over women in response to the pressure of humiliation they felt from the oppressors.

European values, and religious beliefs were imported to Africa with a determination that sought to change a dark, godless, idolatrous and uncivilized Africa (Adogame, 2022; Wisjen, 2020). This form of control fostered patriarchy and in this sense patriarchy was modelled around ideologies brought in by colonial administrators. Contradictorily Ogbomo states that the oppression of women evident in Africa today was not phenomenal in pre-colonial Africa although men responded to women's autonomy in discursive ways (Ogbomo, 2005). It is through the emergence of religions such as Christianity and Islam on the continent which fostered patriarchal domination that the social political and economic wellbeing of women shifted (Ogbomo, 2005). Western influence weakened and destroyed women's traditional power and autonomy leaving women without alternative arrangements for these lost privileges in exchange (Van Allen, 1982).

African women were involved in the political systems before the colonial era however colonial administrators failed to recognise African women's political institutions and roles thereby weakening indigenous women's agency (Van Allen, 1982). This attitude from the British missionaries and colonial administrators evidences that they perceived politics to be male centred business. This so partly because they internalised socialised England's Victorian attitudes and beliefs about male and female roles (Van Allen, 1982). Women became invisible in this period of social and political change as missionaries also reinforces the Christian belief that a woman's role and natural place is to be a man's 'helpmate'. These beliefs and values were propagated in tandem with the reigning Victorian ideology 'woman's place is in the home' (Van Allen, 1982).

A common strand in feminist theory is the critiquing of patriarchy- which is seen as the institutionalisation of male power over females within social, political, religious, economical, and marital relations (Fidan & Bui, 2016; Rotunda, Williamson, & Penfold, 2004). Lerner cites patriarchy as "the manifestation and institutionalization of male dominance over women and children in the family and the extension of male dominance over women in society in general" (Lerner, 1986, p. 239). Hunnicutt's definition of patriarchy is particularly fitting for the practices that I discuss here as the author poses the concept of the fluidity of the system which constitutes "social arrangements that privilege males, where men as a group dominate women as a group, both structurally and ideologically—hierarchical arrangements that manifest in varieties across history and social space" (2009, p. 557). Focusing on the social arrangements that Hunnicutt alludes to, it

can be argued that LE, child marriage, bride price and polygamy are all arrangements that benefit men more than women and where patriarchal cultural values of female powerlessness and male dominance thrive (Ozaki & Otis, 2017). The hierarchy of power is supported within the patriarchal framework (Fidan & Bui, 2016) and this system is normalised as the status quo the world over. In these intimate partner situations women and girls are put in vulnerable positions (Ozaki & Otis, 2017) because of the hierarchical gendered relations where all decisions are made by men (Bhana & Nkani, 2014). Intimate partner violence reflects male power over women (Bengesai & Khan, 2020; Townsend, 2008) and it is this component of 'control over' someone that grants patriarchy the legitimacy to use violence (Tracy, 2007, p. 282; Chuma & Chazovachii, 2012; Fidan & Bui, 2016). Tracy argues that patriarchy is the key variable in causing violence against women and girls therefore male hegemony is maintained and expressed through violence against women.

3.1.3 Patriarchy and Religion

African women are marginalised in decision making roles and are often relegated to performing subordinated roles in society, church and the home (Manyonganise, 2023). This position is compounded by the nexus between patriarchy and religion which combine forms of masculine control that are exerted over women and girls. Religion is a strong force in Zimbabwe, with Christianity being the dominant religion. 69.2% of the population identify as Christian Protestant, 8% Catholic, and 6.9% nondenominational Christian (World Population Review, 2023). African traditional beliefs are also recognized as a religion so is atheism, which has a 10.2 % following in the Zimbabwean population. Patriarchy dominates religious traditions (Mapuranga, 2013) and in other sects of Christianity such as the Marange Church and Paul Mwazha women are marginalised and discriminated against speaking in public with subordination reinforced both in church and at home (Mapuranga, 2013).

Patriarchy draws on interpretations of the Bible's teachings of female subordination to male authority (Holy Bible, 1611, 1 Peter 3 verse 7; Machingura & Nyakuhwa 2015, p. 95) and women also draw on the same discourses to reinforce their own submission. Emphasis is placed upon doing what the husband wants according to Biblical commands thereby conforming to 'good woman' ideals. Men personify culture and in relation to sexuality and gender in the same way the Bible is deified and reified as an omnipotent person (Pattman, 2001, p. 235). With Christianity, the strength of the values and beliefs projected during services no doubt has a role in embedding patriarchy. Oduyoye (2001) urges caution when approaching Biblical texts noting its relevance to cultures that are different from African religio-cultural beliefs. Oduyoye argues that some cultures

depicted in the Biblical texts may not benefit women. Deploying positive womanhood and femininity would then be akin to questioning "oppressive African religio-cultural beliefs and practices as well as biblical texts" (Manyonganise, 2023, p. 221) which means that one is rejecting normative appropriations of religio-cultural beliefs and practices and of biblical texts. It is therefore conclusive to concede that these binaries are both liberative and oppressive (Manyonganise, 2023).

In religion, men monopolise the top positions and the few women in similar positions are found to be unwilling to challenge patriarchy but instead bargain with the system and promote instead biblical hermeneutics that is subservient (Mapuranga, 2013a). While women may seem to be marginalised in this way they can also exercise agency and take up positions in leadership within religious spaces (Mapuranga, 2013b). These are however not formal leadership positions per se but roles that seem to subvert patriarchal order such as prophesying, testifying or singing (Mapuranga, 2013b), or as healers, preachers and church founders (Chitando, 2004). Hackett asserts that "religious symbols and practices shape women's perceptions of themselves, their relations with others, their ability to act, and provide strategies for survival and empower and disempower them within the context of their religious and wider communities" (1995, p.262).

3.1.4 Patriarchy and Sexuality

Patriarchy, a socio-cultural and historical force (Mapuranga, 2013) regulates male and female sexuality. Girls invest in their virginity as a symbol of status, as they conform with instead of resist cultural norms they are both contradictorily subordinated and simultaneously empowered (Matswetu & Bhana, 2018). In Zimbabwe girls' sexuality is culturally and socially produced (Chisale & Moyo, 2016) and this process marks out girls' subordination (Matswetu & Bhana, 2018). Girls are expected to maintain their virginity while boys are not (Matswetu & Bhana, 2018). This disparity reinforces unequal gender relations and promotes double standards (Bhana, 2018) that legitimise male infidelity (Matswetu & Bhana, 2018). These unequal standards condemn sexual experience in teenage girls but support and promote it in adolescent boys (Schalet et al., 2014; Leclerc-Madlala, 2001; Zaikman & Marks, 2016). Because of traditional gender ideologies, masculinity is often constructed to some degree, with regard to sexual activity particularly emotionally unattached sexual encounters (Mangena, 2015; Ganle, 2016). Thus, "unmarried young men have the freedom to engage in sexual liaisons without any adverse repercussion on their social standing" (Matswetu

& Bhana, 2018, p. 2). As a result, boys acquire status over their peers by the sexual conquests which they publicise (Schalet et al, 2014; Museka & Machingura, 2014). These activities however have implications on the risk of HIV infection. While multiple premarital sexual encounters for men are neither contested nor problematised women are held responsible for the spread of HIV (MacEntee, 2016). Thus, gender inequality fails to hold men accountable to their sexuality and promotes the spread of HIV (Matswetu & Bhana, 2018).

The violence that women suffer is multidimensional consisting of layers of social codes e.g. that often state a bride most be a virgin at marriage or else risk dishonouring her family. In Zimbabwe, female virginity is "valued based on gender asymmetrical relations of power and supported by kinship systems and family values" Matswetu & Bhana, 2018, p. 1). Virgin brides are perceived to maintain fidelity in marriage (Venganai, 2017; Museka & Machingura, 2014). While teenage girls are made to appreciate their virginity, it reinforces male dominance in the marriage market thus disadvantaging non- virgin girls who will be considered of loose morals (Cinthio, 2015). Female virginity is however contested and challenged as women who are economically insecure can use sexuality and sex to bargain in transactional sex relationships (Masvawure, 2011; Groes-Green, 2013). In the Shona culture a groom pays *mombe yechimanda* a cow that symbolises the bride's virginity in bride price negotiations (Vengeyi, 2016). This marks a public show of the girl's virginity status and is a token of gratitude to the bride's parents for ensuring their daughter's virginity (Vengeyi, 2016; Museka & Machingura, 2014). If however the groom fails to pay the cow the family is dishonoured, hence the need for girls to preserve their virginity (Vengeyi, 2016).

The practice of virginity testing which is common and regaining traction in Zimbabwe (Vengeyi, 2016) is considered harmful as it reinforces male dominance and female submissiveness and inferiority (Chisale & Moyo, 2016). However adverse the implications of forced virginity testing may be, the practice can be positively harnessed in the fight against HIV as that would entail girls delaying their sexual debut (Chisale, 2016) thus empowering them from HIV risk. By choosing to preserve their virginity girls exercise agency however in a patriarchal context where maintaining virginity is obligatory, the choice may not simply be explained as an autonomous act (Matswetu & Bhana, 2018). However this does not rule out girls sexual agency nor the efficacy of their decision to embrace virginity as a tool for self-preserving and self-advancing their motives (Bay-Cheng & Goodkind, 2015) to determine future prospects (Matswetu & Bhana, 2018). The perception that girls have the ability to lose or maintain virginity means that virginity is an affirmation of agency

however contrarily the agency is “located in the very discourses which regulate female sexuality” (King, 2014, p. 312). It is rather the cultural norms that foster their agency with regards to their sexuality and their bodies (Matswetu & Bhana, 2018).

3.1.5 Patriarchy and gender inequality

Drawing on Kelly’s violence continuum theory, it is important to understand that all behaviours, acts and manifestations of violence are underpinned by domination and are rooted in gender inequality and function to maintain the gender inequality status quo (Kelly, 1988). Human relationships fall within a hierarchy and are shaped by one group exercising power and dominance over another (Fiske, 1991). This analogy embodies patriarchy as a form of gendered power lying at the heart of LE, child marriage, bride price and polygamy. These practices are a manifestation of gender inequality and discrimination and express the social imbalance of power between the sexes. The practices symbolise the control and subordination of women in society, and the institutionalization of male force by means of a manipulation of women and girls (Matswetu & Bhana, 2018). The practices correlate with the traditionally lower status of women and girls in patriarchal societies in all spheres, including economic and political life, and access to all kinds of resources (Lerner, 1986).

All of these practices play a major role in the construction of gender identity and the definition of gender roles which are found in the confines of marriage. The control of women’s bodies becomes the expression of mechanisms of power that act at the level of both the family and society (Finke, 2006). There is a correlation between patriarchal societies and inequitable power relationships where men have dominance over women. Resonating with Mohanty (1988) Kelly argues that intersectionality affects both social structures and women in unique ways which can include beliefs, poverty, age, and sexuality. Where such circumstances intersect with oppression, modes of discriminations accumulate and affect each other to establish multiple dimensions of complex lived experiences. Being dominated not only affects how one experiences abuse but also the support and resources one gets, and whether they will be able to live or end the abuse (Kelly, 1988).

Gender inequality plays a significant role in many aspects of women’s and girls’ lives. Their subordinate role in patriarchal societies finds its expression in the private sphere—the family—as well as in the public spheres of social, economic and political life (Lerner, 1986). Women’s low level of empowerment/agency, both within the community and in the domestic sphere, results in their

limited economic and social power. This has a direct impact on the degree of choice they have over their lives, including decisions related to LE, child marriage, polygamy, and the risk of HIV infection. Zimbabwe is a patriarchal society (Mutekwe & Mutekwe, 2012; Chikunda, 2014) that normalises spousal physical abuse (SAFAIDS, 2009). Kumari, cites Foucault who argues that: "individuals internalise oppressive social norms to become self-limiting and self-disciplining" (Kumari, 2012, p. 80). As such cultural and religious norms prevent women from reporting violence and abuse (Chireshe, 2015). Additionally, it tarnishes the family name if the wife reports her husband for domestic violence (Chuma & Chazovachii, 2012). The culture of silence that instructs women to preserve family secrets as a means to uphold family honour is also synonymous with religious instructions of persevering in abusive marriages believing that God will change the perpetrator (Manyonganise, 2017). This leads many women to normalise their experiences as fate however for those women with Christian beliefs, it will be perceived as a divinely sanctioned phenomenon (Manyonganise, 2023).

Women are thus vulnerable to gendered violence and this ingrained, normalised belief that they are 'owned by men' is facilitated and concretized by practices like bride price and polygamy. Furthermore, women have little say in issues affecting their daily lives and for this reason they may be found to endorse discriminatory norms which oppress them simply because gender roles are prescribed by the community (UNICEF, 2010). Women are expected to be 'obedient'; failure to comply with marital duties is punishable by physical violence which is normalized under patriarchal cultural milieu (Chuma & Chazovachii, 2012). Women are however becoming agentic and taking advantage of the advancement in legal protocols that protect women (Bannerman, 2009).

Children are exposed and socialized early on in childhood to models of masculinity and femininity in relation to gender roles, behaviour, characteristics and occupational structure of their society (Mutekwe & Mutekwe, 2012). It is during these formative years that children internalize key aspects of gender ideology and express them in discursive forms of everyday behaviour (Mutekwe & Mutekwe, 2012). In similar ways, cultural beliefs lead to tolerance and normalization of child marriage, polygamy and bride price (Chuma & Chazovachii, 2012). These are viable means of financial income which legitimizes and normalises them. Because of gender inequality, marriage provides a material and financial safety net for women which means that they cannot challenge cultural practices which may impact marriage opportunities for example bride price and LE. In Bâ's study from 1979, it was established that women in Senegal were enduring polygamy due to gender

and economic disparities. In this instance the husband would provide a livelihood notwithstanding the complexities that a polygamous marriage would bring. In a similar way, women will instead of transgressing the prescribed gender ideology, conform to the 'good wife' attribute and stay in an abusive marriage so long they are provided for financially.

3.1.6 How power asymmetries are produced and reproduced

Power imbalances within gender relations can be understood through Bourdieu's *habitus* framework (1989) which gives an insight into how women are subordinated and therefore endure violence and abuse. Habitus are "the mental, or cognitive structures through which people deal with the social world and are acquired as a result of long-term occupation of a position within the social world and allows people to make sense out of the social world" (Bourdieu, 1989, p. 18). Habitus demonstrate divisions in social classes and how these are structured, age, gender, and social activities. Femininity and masculinity are markers for social division and a major classification in society which could be argued, is a predeterminant of tradition and everything that it represents (Bourdieu, 1989). Drawing on this theory, one may postulate that patriarchy survives because women absorb and submit to it passively. Patriarchy is recognised as an element of the social order, it's practice cannot be contested because of this recognition (Bourdieu, 2002). This could be likened to tradition which is passed on through generations; there are no reminders which are sent out instead people automatically follow it.

Schema change occurs "when the dominated have the material and symbolic means to reject the definition of the real that is imposed on them through logical structures reproducing the social structures" (Bourdieu, 2002, p. 170). What would be the driving force in leading women to reject the status quo? Are they completely powerless to the forces of patriarchy and the deeply entrenched gender inequality? Kabeer posits that "powerlessness suggests total absences of power whereas in reality even those who appear to have very little power are still able to resist, to subvert and sometimes to transform the conditions of their lives" (Kabeer, 1995, p. 224). Udayagiri goes further and suggests that women are anything but powerless and have agency over their fate (Udayagiri, 1995, p. 161).

Section 2

3.2 Theorising gender and social norms

3.2.1 Understanding power dynamics

In this section I present a theoretical critique of gender and social norms in order to conceptualise how power plays out in the everyday lives of women and girls. A key strand to my conceptual framework is the operation of gender and social norms, which I argue underpin LE, child marriage, bride price and polygamy. In many contexts and Zimbabwe in particular, concepts of gender roles and attitudes are acquired early on in childhood and are reinforced in tacit ways throughout life (Price et al, 2009). Gender norms are a subset of social norms that specifically relate to gender differences between what is regarded as acceptable and unacceptable male or female behaviour and the respective binary roles (Cislaghi and Heise 2018). Gender socialisations instill and shape gender roles and uphold ideals of femininity and masculinity in society, for example, in personal and interpersonal relationships, in vocational and/or educational environments, in the community and right down to family level. It is also within this hierarchy that violence is experienced at these different levels. Gendered socialisation accords power to individuals which plays out through cultural products and individuals enact this power in daily life (World Bank, 2012). Once imbibed and ingrained, gendered roles shape the identity of self, and beliefs about binary attributes.

Gender norms legitimise violent masculinities; through gender role socialisation, women and girls are predisposed to victimisation through violence and the power inequality diminishes their ability to resist it (Jewkes, 2010; Buiten & Naidoo, 2016). The discrimination that women and girls experience due to gender norms leads to unequal access to decision making powers in the family and the wider community in general. Further repercussions will include reduced educational opportunities for girls where educating boys is prioritised which consequently translates into poorer economic outcomes and financial dependency in later life (Ozaki & Otis, 2017). Social norms on gender issues such as power, hierarchy and value make it acceptable to use violence on women and girls such as women's role of wife and mother which is at the heart of LE, child marriage, bride price and polygamy.

Women and girls' vulnerable positions are produced through social and cultural norms that are rooted in an unequal gender ideology (Matswetu & Bhana, 2018). Social norms are defined as either (i) individual beliefs about other people's attitudes and behaviours, (ii) collective attitudes, and (iii) behavioural patterns (Morris et al., 2015; Young, 2015). Social norms govern behaviours,

functioning as informal, unwritten rules within a social group (Mackie et al, 2015). Social norms are upheld by convictions on what is deemed acceptable and unacceptable behaviour and through social interactions, are enforced and passed on. As such, social norms influence our behaviour and inform our perception of other people's expectations of what we should do and inadvertently inform our own expectation of other people's behaviours (Young, 2015); thus, expectations are mutual (Bicchieri 2005).

For example, the power of social norms in shaping women's behaviour was explained by one of my advocacy participants in Venda who claimed:

> "When you ask why women keep going back to an abusive relationship its not financial, not in our area. Its tradition, what will the neighbours think? What will the family think?" (SAOGPP2, advocacy, female).

Social norms ultimately inform and determine people's choices in a community (Mackie et al. 2015; Cislaghi & Heise (2018), specifically in relation to behaviours linked to health-related issues and "people conform to norms because of anticipated rewards or punishments for compliance and non-compliance respectively" (Cislaghi & Heise, 2018, p. 2). To avoid the stigma of divorce women choose to stay in abusive marriages and where the cultural context presents marriage as a marker of status, women (and girls) would rather conform with tradition and become vulnerable to further violence and risk of HIV than risk social shame (Chisango et al, posit that "marriage represents the epitome of a woman's success and responsibility, whereas the unmarried and divorced are stigmatized" (2022, p. 564). In FGM-practising communities, marriage is usually seen as the only suitable context for sexual life, which explains why men would pay more bride price for virgins. However, bride price creates unequal power relations and impacts women's sexual and reproductive health rights as men claim exclusive rights of these rights upon paying bride price (Price et al, 2009). These unequal power relations are normalized through social and cultural norms that value men's input in paying bride price, and view men as 'heads' of the family (Ozaki & Otis, 2017).

Within a social setting, norms are perceived differently according to life experience and individuals' gender lens. Similarly, sexual and physical abuse is minimized and normalized which promotes it and legitimizes it. The desire to conform with prevailing custom generates an intrinsic motivation which reinforces social norms. This is attributable to girls performing LE in order to leverage the marriage

market. Additionally, women and girls get into polygamous marriages as a marital status symbol because the undesirability of perceived sanctions such as stigma (Chisango et al, 2022) causes conformity to social norms thus rewards are gained and sanctions are avoided through conformity. In Zimbabwe early marriages are also prevalent (UNICEF, 2023) and spinsterhood is looked down upon (Ntoimo & Isiugo-Abanihe, 2014; Ojilere et al, 2012). Because of these normative expectations and the fact that social rules have to be followed, "the interaction of individuals makes conforming in their best interest" (Shell-Duncan et al, 2019, p. 2). Additionally, social institutions strongly affect the health outcomes of women and their families. In addition to discrimination against girls through LE, early and child marriage, social norms deny women and girls decision-making authority (Chiweshe et al, 2014) over their own health which is identified as a major challenge for agency and autonomy: "the right of all women to control all aspects of their health, in particular their fertility, is basic to their empowerment" (UN, 2013, para. 92).

Mackie (1996) theorised FGM as a social norm underpinned by interdependent expectations in regard to the marriage market. In cultures where FGM is common, the practice has become an important part of female cultural identity. The practice is upheld by social dynamics linked to the belief that members of a community expect the practice to be followed. Abandoning the practice is perceived as exposing daughters to social sanctions and marginalisation. The practice is perceived by women as the price of securing other important "benefits", in particular a good marriage, motherhood, freedom of movement and social acceptance. Mutunami & Bradley (2022) however found that going through FGM did not guarantee a good marriage and in that study most women were found to be either divorced or separated from their partners even though they had gone through LE. Through culture, FGM maintains an unequal gendered hierarchy and essentially reflects the inferior position of women and girls which is then carried through into marriage (Mubaiwa, 2020). Though culture is a resource, it also holds women in bondage where their position is predetermined through FGM. Social norms sanction an array of violence and FGM is typically violence that is maintained through a combination of social rewards for performing it, and social sanctions for those who fail to carry it out (Mackie, 1996). Bride price is a practice that has implications for both men and women's situational positions because of cultural and social expectations for its payment.

Men are obligated to pay bride price for a marriage to be acknowledged (Bourdillion ,1976; Mubaiwa, 2020; Lowes 7 Nunn, 2017). Thus, marriage is a union underpinned by social and cultural norms (Chireshe, 2015). Research has established that men who cannot afford to pay bride price

feel demasculinised and disgruntled which makes the marital union volatile while those that pay it expect value for their money such as respect, sexual rights and submissiveness (Lowes & Nunn, 2017; Mubaiwa, 2020). On the other hand, women whose husbands have not paid bride price feel under -valued by their husbands while many women go on to experience marital violence under the husband's ownership (Ozaki & Otis, 2017). The odds for IPV are higher for those girls who are entered into child marriage, and into polygamous marriages (Heath et al, 2020; Behrman, 2019) as both unions are associated with high levels of male dominance and control- correlates of patriarchal values (Ozaki & Otis, 2017).

The social cost of not conforming to social norms can be extremely high, especially in communities that place particular importance on a woman's dual role of mother and wife, and in societies where there are few opportunities for women to become financially and socially independent (AIDOS, 2015), In this sense, women and girls would be vulnerable not only to FGM but to child marriage, polygamy and HIV as their livelihood would depend on being married. Social pressure creates a commitment to conform to societal norms of marriage practice, as well as a belief that failure to do so will have negative consequences, such as stigma, ridicule, exclusion, rejection and/or an inability to find a husband or to be divorced. (Chisango et al, 2022). To avoid shame girls may end up conforming to FGM or offering themselves as co-wives in polygamous marriages. A report on Kenya's Merus found that FGM turned girls into women, granting them authority in the community (Thomas, 2000, p. 136). When clitoridectomy was banned in 1956 young girls resorted to performing it amongst themselves and although peer pressure might have influenced this move, both stigma and the shame of being uncut could have informed personal choice to be cut (Thomas, 2000; Mackie & LeJeune (2009).

3.2.2 Sexual norms and governing behaviour

The sexual behaviour of both men and women is guided by gendered sexual norms which are socialised very early on in life (Price et al, 2009; Mashiri, 2013). The perpetration of GBV and risky sexual behaviour is seen by young men in Zimbabwe as appropriate male behavior and a means to showcase manhood (Price et al, 2009; Padare, 2012). Such roles are anchored in patriarchal attitudes where dominant forms of masculinity are reinforced (Price et al, 2009). Furthermore, sexual practices such as LE that socialise subordination and subservience encourage these forms of hegemonic masculinities which in turn encourages and normalises male perpetrated violence (Jewkes & Morell, 2012). To reduce incidence of HIV, 'good behaviour' is needed however such

behavior is often decided by the social hierarchy rather than by an objective understanding of 'good' (Foucault, 1965). In Zimbabwe's instance men are at the top of that social hierarchy as the 'head of the family (Ozaki & Otis, 2017) therefore they will determine the normative behavior for themselves and for the women in their lives.

Male dominance affords men to behave in ways they please and are unaccountable for those behaviours whereas women cannot be accorded such liberty. Between the ages of 18-19, women would already be searching for potential husbands however premarital sex is not expected and neither is it permissible. In sharp contrast to this, boys are regarded as ripe for marriage after having a number of sexual encounters and this, usually in their late twenties (Gregson et al, 2000; Singh et al, 2000). This phenomenon clearly elucidates how men tend to have more sexual partners than women. Most of these relationships do not necessarily constitute long term but also include accessing sexual workers and to some extent casual sexual relationships (Nkomazana & Maharaj, 2014). It is not only the number but also the age difference in relationships which impacts women negatively.

Tolerance for male promiscuous behaviours is high in Zimbabwe (Mutseta, 2016) however such behaviour is not acceptable for women who are expected to be 'good wives (Christiansen, 2013; Kambarami, 2006). This marks the epitome of double standards and highlights how gendered norms reinforce patriarchal prejudices. Male dominance affords them to behave in ways they please and are unaccountable for those behaviours whereas women cannot be accorded such liberty. This was highlighted in my data by a participant who argued:

> "If there isn't enough money at family level to support fees for education, boys are prioritized over girls. If a man has extra-marital affairs, woman are counselled to accept and normalize it. On the contrary, if a woman has extra-marital affairs, she will be thrown out of the home" (ZDPPP9, development practitioner, male)

Apart from establishing what acceptable sexual norms look like, patriarchy holds the belief that it is harmful for a man to abstain from sex for prolonged periods, a concept which explains and seems to justify polygamy (Vos, 1994). Vos continues to argue that women may underreport their sexual activities because of the prevailing social norms. Rape in marriage is legitimised by several factors including hegemonic masculinities which entitle men to dominance and sex on demand while femininity calls for women to tolerate forced sex informed by a desire to please the husband

(Kambarami, 2006). This form of submission is thought to foster this cycle of abuse (Mugweni et al, 2012). Additionally, forced sex can be perceived to convey love (Jewkes & Morrell, 2011), the idea that a man desires a woman explains away the violence. This also includes being beaten for activities such as infidelity which women explain away. Violence is also tolerated because it is commonly used in social life including violence against children by parents.

3.2.3 Fluidity and change in social norms

The reasons for practising FGM are fluid and Mackie & LeJeune (2009) argue that they should not be described as static. Beginning as a social convention, FGM has also become both a norm and a convention which is sustained by social norms. Studies in Guinea Bissau established that FGM is no longer a prerequisite for marriage but linked to religious and personal identity (Chikhungu & Madise, 2015). Questions could be asked about how harmful social conventions can be transformed. In the case of LE what could bring momentum to bring about not only acknowledgement of its link to child marriage, bride price, polygamy and HIV but also its abandonment? Gruenbaum stresses that "understanding the diversity of reasons is the central issue if there is to be any hope for cross-cultural understanding, fruitful dialogue, or effective change efforts" (Gruenbaum, 2001, p. 33).

The author continues to argue that educating girls might positively impact girls and delay marriage or FGM however the success of this strategy in safeguarding girls would depend on the age at which FGM itself is performed. For instance, LE is performed between the ages of nine and fourteen which means that education could delay marriage but have no effect on LE or on polygamy where women keen to avoid the stigma of being unmarried may choose it. Besides, challenging cultural practices runs the risk of cultural resistance (Gruenbaum, 2001) and this is true in Zimbabwe's context where marriage is regarded highly (Yigzaw et al., 2010; Gonzalez, 2010). In this context, LE is not regarded as harmful due to cultural and traditional connotations rather it is a bargaining tool in the marriage market. Furthermore, global influence does not seem to have affected marriage traditions (Mubaiwa, 2020) therefore delaying marriage might be seen to undermine morality, raising the complexities of attempting to change cultural systems.

There is no doubt that social norms are the drivers of VAWG and HIV rates; they also endorse restrictive gender and social norms (Jewkes, Flood & Lang, 2015). Because of this dialectical relationship, whether an individual's risk to HIV can change is due to a change in social norms but

the question then is, how do we transform gender and social norms? Many of the tasks in VAWG prevention require breaking the cycle of exposure that drives violence, which in this case, all evidence points to the institute of marriage. Change would be twofold- addressing LE, child marriage, bride price, and polygamy and the desirability of these practices, engaging men in behaviour change and HIV interventions. The latter would be difficult considering Gibbs et al (2015) and Jewkes et al (2014) evidenced that change can easily regress. In their study in South Africa boys and men had embraced positive attitudes in relationships during the intervention but reverted to abusive behaviours after the programme. What could bring along lasting change? I will now move to explore the approach of a theory of change which is now common in the design of development programmes.

Section 3

3.3.1 Theory of Change

Theories of change are based on a notion that transformation happens in stages and along a continuum of shifts (Cislaghi & Heise, 2019). A certain logic underpins theories of change that dictates how change is most likely to happen based on a series of assumptions around why a problem exists to start with. In order to understand behaviours that relate to people's health and to generate change by means of specifically designed interventions that will transform people's practices, social norms theory becomes a useful framework to employ (Shell-Duncan et al, 2019). The norm perspective has long been employed to address several issues (DuBois et al, 1996; Bronfenbrenner, 1992; Heise, 1998; Swearer & Espelage, 2004) and most prominently, FGM (Mackie, 1996; Shell-Duncan et al, 2019).

Social interactions need to be investigated in order to understand social norms (Shell-Duncan et al, 2019, p. 5). Parallel to this is the need to also identify influential individuals who can champion change and taking advantage of the fluid and variable nature of social norms to design interventions amiable to the abandonment of FGM (LE), child marriage, bride price and polygamy. This way, tradition and cultural value is not undermined (Shell-Duncan et al, 2019, p. 1). Mackie (1996; 2000) cites Schelling's game theory to elucidate the complexities which perpetuate FGM. Game theory is a useful model in trying to understand how the decision- making processes can be

relational and interdependent- one person's choice depends on what others have chosen to do (Schelling, 1960). In this way, where FGM is identified as essential for acquiring a marriage match, it then operates as a social norm. Non-adherence would translate into losing out on marriage and/or having legitimate children. The latter is a situation that culturally stigmatises women and girls as it is not normative to produce offspring outside marital relationships. The major reason for this stigma is because of one's reduced marriage prospects or reduced bride price (Delius & Glaser, 2005) Children, as a result of their father paying bride price thus become legitimate.

With child marriage and polygamy which are underpinned by poverty it becomes complex to attempt to end those practices as they are not necessarily social conventions. Bride price however is a social convention and with it being highly valued, and together with child marriage and polygamy solves familial financial crises, it is hard to challenge the norms that justify these practices. Mackie (ibid) argues that if intermarrying families could be persuaded to abandon FGM and to believe that this would not have any negative connotations for marriageability, then change would be facilitated with no threat of punishments. However alternative information would need to be provided for individuals involved for them to be reassured that they were choosing a viable option and that others will follow their decision therefore mitigating the risk of sanctions against their decision.

To change the condition, it is necessary to coordinate abandonment among intermarrying families. Citing the difficulty of obtaining a unanimous decision to abandon FGM, Mackie (2000, 1996) advocates for a 'critical mass' to reach a consensus to abandon FGM initially where the commitment to abandon the practice would be communicated publicly and effectively. This would help in designing intervention strategies by coordinating abandonment through the critical mass of identified intermarrying families. Cultural values and meanings are heterogenous; coupled with a reconsideration of the shift in social attitudes and realities, means that this fluidity in culture could inform social transformation (Shell-Duncan et al, 2019). Furthermore, identifying advocates who can champion change and harnessing the fluidity and variability in practices and norms would open the door to build on existing processes of social change. This might align well with the objective of realising FGM abandonment. Civil society in Zimbabwe is championing an end to child marriage and bride price to a lesser extent however LE is not on the radar of these campaigns as it is not considered harmful, and neither is polygamy regarded as an issue of concern. It is evident that marriage links LE, child marriage, bride price, polygamy and HIV. A highly desirable union, marriage is found at the heart of all these issues particularly the necessity that is placed on it.

3..3.2 Social norm theory critique

The social norm and behaviour change discourse does not necessarily incorporate gender as a critical lens. While it is not enough just to pinpoint social norms in the context of LE, child marriage, bride price, polygamy and HIV it is necessary to understand the nature and the extent of their gendered impacts on the lives of women and girls (Cislaghi & Heise,2020). Social norm theory is also critiqued for not considering the importance of context. Social norms are regarded as things that exist in a similar way in every context. This leads to the question: Why are HIV rates higher in my field site compared to other contexts for example? Employing my framework enables me to understand why particular forms of mobility are stronger in my field sites compared to other places. There might be much lower incidences of HIV but other forms of VAWG will be there. In bringing HIV into a framework that is trying to understand the link between LE, child marriage, bride price and polygamy is quite radical in the sense that I can argue quite strongly that HIV transmission is often, although not always, a form of violence. What triggers it and how it happens often has violent connotations at its roots, but these are not often presented or talked about in that way.

All of these issues need to be understood together within a mainstreaming approach. The approach is appropriate because the issues are intrinsically linked that we cannot just look at one but must look at them all together. If we reduce child marriage, we will most likely reduce transmission of HIV, and are also likely to challenge the need for LE. Essentially, to reduce any of these four we need to deal with the structural inequalities that underpin them. This could be routed through LE, or through reducing HIV transmission or even through IPV interventions. If we have a sensitivity towards how the forms of violence are linked then whichever route we take we can also have a positive impact on the other two. It can also be argued that social norm theory does not tend to go far enough in explaining the causes for women's vulnerabilities. It tends to be used to try and understand a single issue while understanding the extent to which that single issue exists because crucially, it is being propped up by the existence of other things. It is more than just stigma-; stigma operates to maintain these norms (Gist-Mackey & Dougherty, 2021). It is much more than stigma; it is power.

Although power uses stigma, it is the reason why vulnerabilities persist, and it is these kinds of abilities that then render certain groups of women and girls alike to be subjected to practices like LE, child marriage and polygamy. Development practitioners and academics have been looking at

possible ways to transform norms and incite behaviour change in a bid to improve people's health (Mollen, Rimal & Lapinski, 2010). However, if improved health outcomes were to be achieved through shifts in gender norms, we would need to understand how we could integrate such a lens into a wider social change approach. Arguably we need a deeper understanding of the influence of norms as a driver of behaviour before we consider applying social norm theories to specific interventions to yield results (Cislaghi & Heise, 2019). I will now unpack behaviour change theory to understand how it could be applied to approaches designed to reduce risky sexual behaviour.

3.3.3 Behavioural change and HIV risk

It is clearly evident that we need to do more in terms of ending VAWG besides confronting social norms. Behaviour needs to change and that starts with challenging dominant norms. Messages about abstinence and condom use have been around for decades yet new HIV infections continue to be recorded. I have argued in detail about the association between IPV and HIV infection and that these two issues are also closely associated with child marriage, bride price and polygamy. The relationship between these issues affects women in Zimbabwe and at the heart of this are the underlying gendered socialisations which manifest as risky and harmful behaviours mainly imbibed by men at the expense of women's health and wellbeing. Nubed & Akoachere (2016) and Letamo (2011) argue that the awareness of what constitutes risky sexual practices does not transform into safe sex practice in young people. Instead, there is a need to understand the causative factors in engaging in those risky behaviours which can be attributed to firstly, socialisation and secondly power and domination (Malisha, Maharaj & Rogan, 2008; Chuma & Chazovachii, 2012). For men to stop in engaging in risky sexual behaviours it would be a paradigm shift but that is not say it is not feasible.

While theoretical models for understanding behaviour change have been developed over the years, the aspect of behaviour change itself has been found to be a complex concept particularly in the context of FGM (Shell-Duncan & Hernlund, 2006). Behaviour change is not instant but operates along a continuum. Behaviour change theories assume stages of change which are difficult to account for in LE, bride price payment since they are social conventions and therefore change would entail collective and not individual input (Shell-Duncan & Hernlund, 2006). There would be a need to engage and negotiate with the multiple individuals involved with making the decisions and taking into consideration the variability of individuals' opinions.

		Individual preference		
		Supports FGM	Ambivalent	Opposes FGM
Actual behaviour	Has or will circumcise daughter	Non-contemplative (Willing practitioner		Reluctant Practitioner
	Not sure		Contemplative	
	Will not circumcise daughter	Reluctant Abandoner		Willing abandoner

Table 3: Dimensions of readiness to change FGM (Shell-Duncan (2006).

The process of making decisions about FGM is fluid and to dichotomise those who oppose and those who support the practice oversimplifies the complexity involved in the decision-making processes in FGM cases (Hernlund & Shell-Duncan, 2007). There would need to be a readiness for change at an individual level. As individuals shift attitude, we would expect to see a ripple affect across a community. However, the question remains, with risky sexual behaviour what would motivate an individual to change behaviour and then be active in shifting the views of others? Research has also established that changing risky 'behavioural interventions' can be useful in halting the spread of HIV with AIDs labelled "a consequence of behaviour" (Fishbein & Ajzek, 2010). However high -risk sexual behaviours are on the increase in spite of the plethora of behaviour change interventions over the years since the emergence of HIV. These include early sexual experiences, inconsistent condom use, age disparate relationships, and multiple concurrent sexual partners (Zuma et al, 2016). These early sexual experiences are also attributed to child marriages and polygamous marriages.

3.3.4 Variable governing behavior

Culture and gender affect health not only because of biological differences between the sexes but also because "cultural constructions of gender affect experiences and behaviour patterns, and social structures shape cognition and behaviour" (Abraham et al, 2011, p. 624). To ignore the effect of social structures on health behavior limits the effectiveness of behavior change interventions that seek to change determinants of health behavior (Brooker et al, 2014). Cognitive models of health behaviour (Conner & Norman, 2015) argue for condom use, faithfulness and abstinence to reduce risk of HIV infection. Health education programmes continue to be delivered in schools which emphasise the same values as those argued above, yet we continue to see record levels of new HIV infections, particularly among young females. Sexual behaviour is complex and the circumstances

under which sexual activity take place are also psychologically complex.

The theory of reasoned action to HIV prevention (Ajzen & Fishbein, 1980; Fishbein & Middlestadt, 1989) and the health belief model (Becker, 1974; Rosenstock, Strecher, & Becker, 1994) posit that appropriate social norms, attitudes and beliefs provide enough psychological willpower for an individual to regulate their sexual behaviour. The motivation to protect oneself from HIV underpins these theories however anthropological research of HIV would be essential to understanding behaviour in its social contexts.

These models fail to account for patriarchal contexts where masculinity is defined by one's sexual prowess and dominance over females (Price et al, 2009). These conditions are hardly conducive to reducing risky sexual behaviours. Furthermore, people are primarily concerned about preserving a relationship than contracting HIV (Farrington, Bell, & DiBacco, 2016), particularly where women are financially depending on their male partners, and where young girls are married off for financial gains. Women in abusive marriages cannot negotiate condom use and those who are in age disparate relationships such as child marriages and polygamy are also not able to negotiate safe sex (Chiweshe & Chiweshe, 2017; Svodziwa et al, 2016). Additionally, women whose husbands paid bride-price cannot negotiate safe sex because their marriage contract granted sexual rights to their husband (Besong, 2018; Mubaiwa, 2020; Bashai & Grossbard, 2008) The decision to change sexual behavior is therefore taken away from women and girls, and lies solely with their partners.

To an extent, social norms function to motivate and promote condom use (Ajzen, 1991; Catania et al, 1990). Contrastingly other norms including religious norms discourage condom use because their pro-life beliefs (Katikiro & Njau, 2012). While at community level condom use might be acceptable and advocated for, at individual level it becomes subjective (Pendergast, Durant, & Gaillard, 1992; Weinstock et al, 1993). Social norms evolve (Abraham & Sheeran, 1994) and behaviours which are deemed socially acceptable are reinforced such as e-cigarette use over conventional cigarettes as seen in recent studies (Berg et al, 2015) This change in social norms is attributed to market expansion, and positive advertisement and diversity of products (Vasiljevic, Petrescu, & Marteau, 2016; D'Amico et al, 2018). Whether such interventions could work in regulating social norms that justify these risky behaviours is questionable. Besides, the complexities that entail comparative analyses of phenomena in different contexts are massive.

3.3.5 Childhood Agency and social and gender norms

I will unpack the concept of agency in childhood because it highlights the route to vulnerability to HIV because of the normalisation of practices such as LE, child marriage, polygamy and bride price. Agency discourses would argue that children can determine whether or not they want to participate in these practices by exercising their rights but as I alluded in the thesis introduction, this assumption is consistent with conceptualisations of autonomous agency as voice, the right and entitlement to participation, and that every child has capacity to exercise that entitlement - a reflection of liberationist ideals of autonomy (Spyrou 2018). I must point out that agency and children's right to participate in decisions over matters affecting their lives are dichotomous and we run the risk of overlooking the wider impact of their social, cultural, and political context by equating them (Punch, 2016). Furthermore research and legal studies have established that children are not necessarily competent and will not always act in their best interests (Alderson & Morrow 2011; (Kjørholt, 2004) therefore narratives of agency and competency should be contextualised within the wider society that shape it- whether it enables or restricts that agency (Spyrou 2018). For example, Zimbabwe is a hierarchical society, and children are situated at the bottom of that hierarchy (Kesby, Gwanzura-Ottemoller & Chizororo, 2006).

Because of this positioning children are not consulted for these practices to happen but are rather forced and coerced into it (Tshugulu et al, 2023). So how could they meaningfully exercise their agency in relation to LE, child marriage and polygamy? I recognise that children have agency but how does their context shape it and how does their agency relate to these cultural practices if the children are supposed to be seen and not heard? Children are independent beings but their existence is interdependent with others (Abebe, 2019), and with social structures, institutions, and relationships (Kesby, Gwanzura-Ottemoller & Chidzororo, 2006). We should not overlook the importance of generational power and influence in the African context as emerging research in other contexts is showing that older generations still support harmful practices such as FGM and want it to continue (Shell-Duncan, 2023). Agency is not a universal experience but is situational, dynamic and contextual. We need to consider the material factors and types of future that the child might experience and navigate because of the choices that they have to make (Abebe, 2019), and the intersections of age, maturity, and the familial relationships they have to negotiate with, including the political economy.

These factors may mean that children's agency is compromised (Esser et al, 2016) because of the

binary oppositional and dichotomous states (dependent/independent) of childhood. We need to exercise caution because in the process of exercising their agency children could willingly sacrifice themselves in the interest of others (Hart & Brando, 2018) particularly in circumstances where a girl may knowingly and willingly choose to get married to ease the family's financial struggle. In this way there is a possibility that children may not fully understand the implications and consequences of their choices to cause harm in the longer term thereby inadvertently compromising their wellbeing. Drawing on the capability approach Sen suggests that human freedoms should be promoted although in the case of children, caution should be exercised as they may not also make the best decisions given the opportunity. He argues:

> "there is a special problem in the case of children, since they do not, frequently enough, take their own decisions. If rights are interpreted in terms of freedoms that the right-holders should have, their usefulness must depend on how those freedoms are exercised. But can children take their own decisions? If the application of human rights to children must involve the children themselves taking well-considered decisions on the exercise of those freedoms then we would seem to be on the threshold of a manifest contradiction. Can children really take these decisions? But is that the right question?" (Sen, 2007, p. 9).

Understandably, "applying the capability approach to children entails taking a stand with regard to their capacity for self-determination" (Ballet, Biggeri, & Comim, 2011, p. 25), and promoting children's freedom and participation in childhood can be fundamental in building the capabilities skill set required in adulthood (Hart & Brando, 2018). Nonetheless, "in a reaction to overprotective or paternalistic conceptions of childhood, there is a tendency to consider children as competent agents regardless of their age" (Stoecklin & Bonvin, 2014, p. 65).

In the Zimbabwean context adults control the narrative and make decisions on behalf of the child and the family so we see the intersections of poverty and gender determine how much agency female children will have and exercise. Children are active agents who can make decisions but in terms of LE, child marriage, and polygamy, it is questionable whether they could make decisions in their best interests because these practices reinforce notions of inferiority which render them vulnerable to violence and abuse (Tshugulu et al, 2023; Muzingili & Taruvinga, 2017). We need to move beyond popular debates about children's agency and focus on what kind of agency is deemed 'productive' for them and how the family relationship they find themselves in enables or restricts it (Abebe, 2019). While taking into consideration children's agency and competency, we also have to be mindful that cultural notions of subordination can either enable or disable

children's capacity for assertiveness, both in childhood and later on in adulthood. This means that we need to acknowledge intersectionality between social, cultural, geographical and political, contexts of childhood within the harmful cultural practices discourse.

3.3.6 Female agency and social and gender norms

It is worth unpacking women and girls' positions within the framework of rights, agency and cultural and social norms. These issues are all manifestations of gender inequality and I explore the concept of agency to understand how women and girls navigate the gendered constraints that are sanctioned and mandated by culture. The portrayal of African women as victims of cultural practices, and male control is well documented (see Kaler, 1998; Jewkes, 2002; Dunkle et al, 2004, 2020). Women's positions have significantly improved over the decades including unprecedented gains in human rights, health and education rights, and access to resources and political offices (Baland & Ziparo, 2018). Feminist scholars such as Masvawure posit that women are not passive and have agency over matters that affect their sexuality, although she also acknowledges that these struggles (female victimhood and patriarchal control) are an everyday reality for many African women (Masvawure, 2013). The author's findings over women's agency and autonomy are contextual as her participants alluded that they could exercise their sexuality in autonomous ways because they were studying at university students living away from their parents (Masvawure, 2013). In this study young women were free to draw on their sexuality as a resource to get material things from their older sexual partners, thus asserting their agency. This study accounts for the impact of social class on agency and the need to avoid generalisation of women's subordination (Mohanty, 1991).

In my argument however, and to my knowledge, young girls are not consulted before being entered into child marriage, or into a polygamous marriage, and certainly they are silent when parents ask for bride price. They are instructed to elongate their labia in preparation for marriage and similarly are not consulted whether they are willing to do it or not. Additionally, women end up in marital circumstances not of their choosing but culturally dictated with little to no room for negotiating their safety or exit terms. I therefore argue that agency is contextual as women and girls would have to deal with a whole spectrum of intersectional constraints around exercising their autonomy. It cannot suffice to explain women's agency through a monolithic discourse as it

becomes clear that power essentialism can impact women' agency (Al- wazedi, 2021). These realities point to the urgent need to view HIV transmission as a form of violence. Viewing HIV as violence will support the emergence of more sensitive and holistic policy and action on the ground that focuses on how women experience violence in multiple forms.

Female autonomy in a development context is, "the ability of women to make choices and decisions within the household relative to their husbands" (Anderson, Beaman & Platteau, 2018) however if their household consists of a monolithic unit where decisions are made by one individual then autonomy is unquestionable. Some familiar structures have been maintained particularly in marginal remote geographical locations. This model of unitary households is however contradicted as more household models in the developing world are evolving to be conflictual rather than atomistic (Donni & Chiappori 2011). Social norms restrain female autonomy *(*Baland & Ziparo, 2018) lest because they curb the scope of women's action both within and outside of their household. In developing contexts, women's dependency shift from their father in childhood to their husbands in adulthood (Baland & Ziparo, 2018).) This results in marriage being regarded an important aspect of a woman's life and nearly universalising early marriages. Child marriage undermines autonomy and agency and this arises from the structural complexities of the households that women and girls belong to *(*Baland & Ziparo, 2018). Marriage is arguably important for a woman's social and cultural wellbeing because it provides livelihoods however economic dependency can arise situating women in vulnerable circumstances thereby reducing their autonomy. It becomes necessary to lower one's autonomy under these harsh circumstances with women forced to not only tolerate but accept behaviours that are not in their interest *(*Baland & Ziparo, 2018).

To expound complexities women and girls face in an attempt to exercise agency I will also look at Gidden's Structuration Theory (1984). The author theorises that agency co-exists with 'structure' - and that they constitute each other since neither can exist independently. By 'structure' Gidden means a society's regular patterns of behavior thus structures form the basis of habitual activity into which people fit their lives (Chuma & Chazovachii, 2012). Example of structures could mean culture, tradition, family, or even poverty that control people's lives. Without their realisation they become subjected to the structure's power (Gidden, 1984). Under these circumstances it becomes increasingly difficult to completely be autonomous let alone control the structures in which a woman or girl's life is embedded. Apart from culture, poverty operates as a structure that limits women's choices to resist violence because of economic insecurity however women can still

circumvent these structures and exercise their agency to overcome their subjugation (Chuma & Chazovachii, 2012).

Conclusion

The legacy of colonialism is evident in the patriarchal structures that exist in the Zimbabwean society. The social hierarchy order places men at the top as heads of the households (Chuma & Chazovachii, 2012) and prevailing gender norms embody cultural schemas of what masculinity is and what femininity is (Shakya et al, 2019). Patriarchy impacts women and girls in various tacit and elaborate ways that include social, cultural and political dimensions. The normalisation of violence sustains the power structures that pedal it through norms that prescribe what one can and cannot do in life (Chiweshe et al, 2014). The result of this is the vulnerability that women face at every level in life. Male violence against women is normalised through the lens of culture and norms which victimise women and girls through LE, child marriage, bride price and polygamy. These practices synergise to elevate women and girls' risk to HIV.

Marriage is highly desirable in Zimbabwe and is a vehicle through which vulnerability to HIV is also increased. Male dominance and control over women is justified and legitimised through prescribed restrictive gender norms (Fidan & Bui, 2016). Women and girls are systematically discriminated against and through patriarchal values which intersect with religious norms are kept in subordinate positions (Manyonganise, 2023; Chuma & Chazovachii, 2012). The issues involved in bringing girls into positions of vulnerability are multifaceted. While girls are expected to be virgins at marriage (Matswetu & Bhana, 2018) and monogamous in marriage, men can engage in extramarital relationships and are expected to have a few emotionally unattached sexual encounters before marriage (Mangena, 2015; Ganle, 2016). The ingrained socialisation of male superiority over females lies at the heart of risky sexual behaviour that encourages having multiple concurrent relationships. The norms behind this socialisation make men unaccountable for their sexual behaviours at the detriment of women's health, particularly the risk of HIV.

The role of poverty in sustaining women and girls' vulnerability to HIV risk is clear and is what lies at the heart of normalising these practices. This brings about challenges in transforming social, religious and gender norms that normalise child marriage and polygamy where young girls might be married off to ease the family's financial burden. Similarly, bride price is a driver of violence against women particularly IPV, and accords men control over women's sexual and reproductive health

rights (Mubaiwa, 2020; Lowes & Nunn, 2017) which is justifiable under social and cultural norms that view women as inferior to men and once married, as owned by men. Additionally, women lose the right to safe sex once bride price has been paid and social norms dictate that a woman cannot negotiate condom use with their husband.

The normalisation and legitimisation of LE, child marriage, bride price, and polygamy, and the violence that women and girls experience from these practices inform my theoretical conceptual framework and essentially, I propose that programming needs to challenge these issues, whether they are part of the socialisation processes or not. The theory of change does not go far in interrogating causes of vulnerability and certainly does not incorporate gender as a critical lens. For these reasons I argue for the need to integrate harmful norms that are behind these practices and synergise to increase women and girls' vulnerability to HIV otherwise we lose opportunities to try and denormalise such norms. In the next chapter, I look at the constructs of violence in Zimbabwe and how the ecology of violence plays out to disadvantage women and girls and increase their risk to HIV infection.

Chapter 4

The construction of violence

Introduction

In the last chapter I discussed how violence is normalised through patriarchal socialisations which underpin gender inequality. That discussion established that patriarchy functions as a machinery that grants men power to control and dominate women (Fidan & Bui,2016; Sikweyiya et al, 2020). It is through this oppressive system that women and girls are discriminated and subjected to performing LE in order to enhance their marriage prospects. That level of discrimination also results in girls being entered into child marriage and polygamous unions. Marriage, which is sealed by the husband's payment of bride price is at the heart of these practices and it is that sole aspiration to attain and sustain marriage (Kambarami, 2006) that women and girls become vulnerable to HIV. It is within intimate partnership domain often characterised by marriage that women and girls experience violence and gender inequality with men being able to and legitimised to perpetrate this violence freely. My argument is not suggesting that all men are violent or that all women experience violence in intimate partner relationships because that will be challenging the institute of marriage itself which is not the aim of this research. My aim is to explore the nature of these relationships with a view to understand how women experience violence and crucially how they become vulnerable to HIV.

In this chapter I discuss constructions of violence, the interface between gender and violence, and how gender synergises with social and cultural factors to produce an ecology that brings about different levels of vulnerability in the lives of women and girls. I unpack the rationale why men express violent masculinities and most importantly, why they are not accountable for their behaviour. Through a historical lens I look at the constructs of violence and masculinities in order to understand how they shape women's experiences of the phenomenon. When cultural factors intersect with other dimensions such as poverty, violence becomes even more prevalent. VAWG is a global problem and not something that is unique to Zimbabwe; my analysis of the phenomenon is by no means intended to give the impression that men in Zimbabwe are more violent than men elsewhere. In order to develop my analysis I use the ecology model to illustrate how violence occurs at different levels.

The ecology model (Heise, 1998) is useful in researching VAWG because it helps us understand how cultural, social, political and economic factors can synthesise to create an environment that legitimises certain gender constructs that either empower or oppress women. I utilize the model to illustrate the gendered nature of the environment at different levels and unpacks how individual behavior and beliefs that are informed by social norms can shape not just institutions but relationships in society. I apply the model to the situational analysis of VAWG in Zimbabwe and this will enable me to not only draw out the underlying causes of women's vulnerabilities but also draw conclusions on the extent to which the environment enables challenging violence and supporting survivors.

The chapter is structured as follows:

Section 1 discusses the cultural context and conceptualises masculinity in order to understand why violence is legitimised. In this section I also explore the historical dimensions of violence in Zimbabwe in order to understand how that influences the perpetration of VAWG. In section 2 I consider perpetrating factors and frame HIV as violence and I go a step further to explain the link between the experience of violence and that of HIV infection. I include HIV in this chapter because it is through harmful behaviour- aggressive behaviours, and the sense of entitlement that some men have around sex (Bhana & Moosa, 2015, p. 2; Bhana, 2015; Gibbs et al, 2014) that propel them to impose themselves on women that HIV is mainly transmitted. Section 3 details the triggers of violence drawing on the social ecology model. The section ends with a discussion that delineates the constrains posed by the cultural environment to women's agency. A brief summary of issues explored in the chapter follows the discussion.

Section 1

4.1.1 Understanding the Cultural Context

Violence against women and girls occurs under different contexts; in order to reverse patterns of abuse that are deeply embedded a closer look at the cultural dimensions is crucial. Continuous exploration is useful to understand the underlying factors at play as well as the root causes that may negatively affect efforts to tackle the issue. Drawing on this, it is imperative to interrogate the cultural ecology of violence to understand what shapes individual beliefs and subsequent

behaviour. The What Works global research programme generated knowledge on violence and its perpetration as well as what might work well as prevention. The programme suggested more research to understand the drivers of violence and called for the designing of context specific interventions (Crawford et al, 2020). The evidence from the What Works programme (https://www.whatworks.co.za/) cited poverty, social norms, and poor legislative frameworks as the main elements fueling VAWG. (Kerr-Wilson et al, 2020). What Works also documented evidence on the triggers about how violence becomes deeply internalised and becomes a subconscious historical memory. Several studies have pointed to gender and cultural norms, poverty, forced sex, age inequalities and women's inability "within the context of male sexual privilege and entitlements" (Bhana & Moosa, 2015, p. 2; Bhana, 2015; Gibbs et al, 2014).

In some cultural contexts, women are held in subordinate positions due to inequitable gender norms which regard them as inferior and therefore subject them to abuse and violence (Crawford et al, 2020). Focused in twelve low and middle -income countries, What Works research evidenced high prevalence of IPV and other forms of VAWG and established that there is a relationship between social norms and VAWG. Consequently, the research also posited that a change in social norms would alter the risk of violence and called for the cycle of exposure to violence to be broken. Realising change is a complex and tall order considering that the structures needed to facilitate that change are the same ones sustaining the patriarchal ideology and normalising violent masculinities (Crawford et al, 2020). Preventative work around IPV is increasingly targeting and including men (Jewkes et al., 2015), which is essential and is mooted as effective although Gibbs et al (2020) argue that masculinities can present in multiple forms in different contexts associating differently with perpetrating behaviours. This undoubtedly would produce varying results in the different groups of masculinities for any interventions to end VAWG. Gendered social norms and masculinity need to be acknowledged as having a major implication in violence although it is imperative to mention that not every man is violent.

4.1.2 Contextualising masculinities

The South Africa Medical Research Council has conducted research on VAWG and masculinities which is useful in terms of understanding the impact of different forms of masculinities which have not been explored at great depth in Zimbabwe. Masculinity exist in different forms (Connell, 1995) and can be adopted and expressed according to social, cultural and political contexts and situations

(Bhana & Mayeza, 2019). Masculinity positions are hierarchical and, in their plurality are also mutable with some legitimated and others censored (Connell, 1995). These masculinities are reproduced in the context of culture, social circumstances, and the gendered history of a particular society. Masculinities perform differently according to their position in the hierarchy of power with hegemonic masculinity at the top of the hierarchy (Connell, 1995). Additionally, context determines which type of masculinity ascends to power and varies across societies. It is also equally possible for masculinities to occupy different positions of power just as the versions of existing masculinities can also differ in the same context (Bhana & Mayeza, 2016).

Hegemonic masculinity defines a masculinity that is preoccupied with power and status (Bhana et al, 2021), and "guarantees the dominant position of men and the subordination of women" (Connell, 1995, p. 77). Hegemonic masculinity is a "dominant cultural ideal of masculinity centred on authority, physical and emotional toughness, superiority, sporting prowess, aggression, violence, heterosexuality and male homo-social bonding" (Bhana & Mayeza, 2016, p.38) drawing on a patriarchal gender system that subordinates women to men. In other words, hegemonic masculinity is a "cultural ideal of manhood that gains its legitimacy from acceptance that is shared between those who embody and benefit from the ideal and those subordinated through it" (Jewkes & Morrel, 2012, p. 1730; see also Gramsci, 1971). Bhana & Nkani present hegemonic masculinity as a "culturally exalted form of masculinity" "rooted in violent practices towards alternate masculinities" (2014, p. 41; see also Connell, 1995).

Unpacking hegemonic masculinity is also useful for understanding men's values, ideals and practices. Jewkes & Morrell (2018) and Ratele (2016) assert that hegemonic masculinity is a resource from where men access power over other masculinities, and power over girls and women. Hegemonic masculinity is multifarious (Connell and Messerschmidt, 2005) and holds power at a particular point in time (Connell, 1995) while coexisting with other versions of masculinity that do not necessarily support violence or aggression (Morrell et al, 2012). Controlling and dominating women characterises hegemonic masculinity and the use of violence is justified when one pursues and demonstrates this. Configuring masculinity in this way underpins the prevalence of VAWG. In conceptualising hegemonic masculinity (Connell, 1995) we can understand how men strive to achieve power. This produces gendered power relations and female subordination (Bhana & Mayeza, 2019) and helps to explain gender inequalities and the way racial, social and class differences produce divergent masculinities. Jewkes & Morrell (2012) argue that hegemony suggests "the existence of agreed values and practices, not necessarily associated with repression

and violence" (p. 1729).

Connell alludes to the practices and social processes that support dominant gender discourses, and privilege masculinity over femininity as part of hegemonic masculinity (1995). Although not widely embodied by a majority of men (and boys), many men support hegemonic masculinity because it accords them power (Bartholomaeus, 2013; Jewkes & Morrell, 2010) and dominance over women and girls and other men who do not conform to its tenets (Hearn & Morrell, 2012). In South Africa boys that do not conform to hegemonic masculinity have been seen to be scrutinised (Mayeza, 2015; Bhana, 2005; Swain, 2006) however this is not to suggest that South African masculinities are or should be homogenous in any way. Just as in any other context masculinities differ so also are they shaped by, and shape their context. Not only does hegemonic masculinity explain unequal power relations between men and women but also the formation of power relations. As well as that, hegemonic masculinity also describes the "diversity, inequalities, power hierarchies, multiplicities, diversity, pluralities and divisions that are present in the male category itself" (Connell & Messerschmidt, 2005).

Societies interpret hegemonic masculinity differently and in any given society, men are not homogenous and they will support and/or conform to prevailing hegemonic masculinities differently (Swain, 2006). In evaluating the Stepping-Stones and Creating Futures intervention, (Gibbs et al, 2015) found that men appreciated group peer support and were open to discussing personal matters in a safe space. Men were also found to reject hypermasculinity and its associated promiscuity and moved towards traditional masculinity that used provision to subtly exerted power in relationships in less dominant ways. Similarly, Jewkes et al (2014) found that men became less controlling in their personal relationships, adopting more gender equitable behaviours and resorted to traditional forms of masculinity. An improvement in livelihoods was also established as part of that change. This suggests that when presented with alternative masculinities men do not necessarily turn to violence.

The subject of masculinity is often discussed in tandem with femininity. This highlights the social constructs of male characteristics in comparison to their female counterparts and may vary between communities from time to time. Masculinity is conceptualised alongside gender although different societies hold different perceptions over the binary; while gender is clearly understood in most societies, masculinity is not regarded as an entity in some (Connell, 1999). The whole concept

of masculinity hinges on one's behaviour and whether they are meeting the 'standard.' Masculinity is associated with a disposition to high libido and also a high interest in energy intense sports like football. Failure to meet these standards translates as weakness and one would be labelled as not 'man enough' (Connell, 1999). However, modernisation has precipitated such seismic social change and the rise of women in both economic and political and social spheres means that men's hegemonic positions and masculine tendencies and privileges are under constant challenge. For example, more women are now able to attain higher educational qualifications and earn more than men in the job market thus usurping men as traditional breadwinners. Women are also able to delay marriage and exercise autonomy in multiple ways than before. These developments upset the traditional family set up and threaten the dominant masculinities (Nicholson, 1994; Cleaver 2003).

Violent masculinities pose a problem and to understand violence against women in this context, patriarchy and its manifestations must be understood first since violence against women is "the product of socially constructed gender norms and power" (Buiten & Naidoo, 2016, p. 537). Most African societies are patriarchal which means that men should be seen to be strong, dominant- with the evidence being the ability to control the women in one's life. Men also use violence to compete with other men and defend one's honour among other men (Ragnarsson et al. 2010; Gibbs, Sikweyiya and Jewkes 2014). Hunnicutt (2009) argues that "men's violence toward women is a product of social structural conditions" (p. 555) where dominance is enhanced and subordination is reinforced (Walby, 1990). Patriarchy fuels violence against women and girls and the phenomenon is widespread and is often under-reported and pervasive (Mosavel, Ahmed, & Simon, 2012). Violence is used to assert patriarchal power and privilege (Bhana & Mayeza, 2016) and to control women and maintain gender hierarchy. Masculinities thrive in controlling women; any situation that diminishes their sense of control will likely result in using violence to re-establish power and control (Wandera et al, 2015; Sprague et al, 2016). Kundapur (2017) argues that men can use intimate partner violence as a strategy to enforce control over their partners if they feel threatened by a woman's economic independence and education.

Masculinity is constructed around notions of 'real men' and this image is exerted over women, controlling them in sexual relationships. To understand how male control influences sexual behaviour, this dynamic needs to be acknowledged (MacPhail, 2003). Young men are also likely to imbibe masculinist egos that will exert themselves over their future wives and promote

domineering behaviours. Additionally, young men might also perceive themselves as invincible to infections such as HIV and such beliefs determine what practices and activities are deemed acceptable for both men and women (MacPhail, 2003). Violence legitimises male power as Morrell (1998) found out in a South African study on masculinities that poor black men performed violent hegemonic masculinity in their relationships. Bhana & Mayeza (2016) found out in a separate study on playground violence with school children in South Africa that boys used violence and subordinated non-conformant boys (and girls) to signal their hegemonic masculinity as a normal part of the hegemonic male discourse. This serves to evidence that power and control are attained and sustained through violence Mashiri, 2013). Although women (and girls) can resist hegemonic masculinity, the attempt to evade violence and subordination could "reinforce the very processes through which hegemonic masculinity is achieved". Furthermore, "resistance to violence cannot be addressed without firstly changing the violent gender relations and masculine privilege within the broader social context" (Bhana & Mayeza, 2016, p. 15-16).

4.1.3 Historical dimensions to violence

Conflict and violence are shaped by political, economic and cultural contexts and are by no means agendered. Zimbabwe's history is mired with violence in response and opposition to colonial rule and the quest to end white hegemony (Osirim, 2003). While currently there is no active inter-ethnic conflict in Zimbabwe, historic inter -tribal violence is well documented. Similarly, the association between colonial inequalities and men's propensity to use violence in turbulent social conditions is well established (Shefer, 2014) as was evident in Zimbabwe's case. This violence coupled with colonial aggression led to political and social tensions that were underpinned by the quest for racial equality and a rebellion to colonial authority, fighting for cultural autonomy (Alexander et al, 2000; Ranger, 1985; Alan, 1995). The African resistance were convinced that "violence was the only language that the colonialists could understand" (Alexander & McGregor 2004, p.84-85) and as such honour could only be restored through violence.

Through this we see different expressions of masculinities that drew on gender relations and contextual realities which were not fixed. For example, masculinities were acted out in various ways in colonial Zimbabwe and exploring the events during this period will enable a better understanding of the ways in which violence can shape masculinities. Similarly gender and sexual violence can also be explained through their link to colonial structures that transformed the social, political and economic paradigm in colonial Zimbabwe and is evident in post-colonial Zimbabwe

(Fidan & Bui, 2016). Understanding the historical aspect of violence and men and women's experiences during the colonial period in Zimbabwe is therefore crucial in elucidating the epidemic of violence and its contribution to women and girls' vulnerabilities.

Zimbabwe's history of colonialism and civil wars between ethnic groups that took place during that period enables us to understand the constructs of violence and masculinities and its legacy. The impact of these events is gendered and easily explained by Enloe (1993) who argues: "No person, no community, no national movement can be militarised without changing the ways in which femininity and masculinity are brought to bear on daily life" (Enloe, 1993, p. 120). The political economy in colonial Zimbabwe was preoccupied with controlling the colonised population's mobility through ideologising spaces as 'white only' where indigenous people were not allowed to enter or if they were, only temporarily and with permission (Barnes, 1992, p. 586). These regulations were enforced through 'passes' that had to be carried on person and the pass laws were also gendered in multiple ways. For example, they stipulated "for whom and for what level of payment an African man could work; where he could travel; where and with whom he could live" (Barnes, 1997, p. 59). Additionally, they created" physical and ideological barriers between these two sets of spaces to ensure that it was only on the state's terms that the two races- and – sexes could meet" (Barnes, 1992, p. 586). Furthermore, the policy led to the creation of gendered spaces where women were resigned to the 'reserves' where internal mobility for indigenous people was permitted. Their roles included looking after the rural home and working on the arid lands while men migrated to urban areas in search for wage -based work. Not accounted for in the labour force women were excluded from the economic arena therefore reinforcing their economic dependence on men and the perception of women as second- class citizens (Shenje-Peyton, 1996).

These arrangements created a different type of family unit where men lived in urban areas usually in bachelor accommodation (Benson & Chadya, 2005) to work in the industries, mines and on farms while their wives were confined to the reserves (Benson & Chadya, 2006). Only those men who had work passes were granted accommodation, and only a few single women were allowed to live in the urban areas to provide sexual services as prostitutes to black men. Women could only successfully migrate to the urban areas if they were in a union with a man and that entailed either being in a marriage, *mapoto* (cohabitation) or prostitution (White, 1990). Married women would need certificates to prove their marital status. Thus colonialism created an infrastructure that was male-centred, and under which prostitution could thrive albeit with every woman in the city

being stereotyped as a prostitute. Additionally, the colonial rulers constructed African women as "legal minors who needed control for their own protection or as VD [venereal diseases]-spreading prostitutes whose control was essential for the protection of society" (Benson & Chadya, 2005, p.590). The other reason why African men felt the need to regulate women's population in the urban areas was that women would become promiscuous and therefore difficult to control (Schmidt, 1990). The colonial rulers viewed Zimbabwean women negatively and considered them uncooperative compared to their male counterparts and therefore they contrived to have Zimbabwean men control the women (Fidan & Bui, 2016). This strategy "allowed Zimbabwean men to assert their authority over women and maintain control over children and marital assets" (Fidan & Bui, 2016, p. 1079).

However the decision by colonial administrators to allow black women's population in the urban areas was to deter black men from pursuing white women. In turn white women felt threated by black women fearing that they would attract their husbands' attention and therefore refused to employ them as house maids, choosing instead to have men as cooks and house boys (Benson & Chadya, 2005). Racist practices of segregation and name calling 'boy' regardless of a man's age and working in settlers' kitchen (which was regarded indigenously as women's work) undermined men's authority and status (Vambe, 1976).This shift in gender roles where black men engaged in traditionally female roles and the restriction of movement by the colonial rulers in a space that was considered a birth right and having that right violated created resentment and anger that challenged traditional masculinities. Following up were calls for true African manhood to emerge and challenge the colonial rulers (Sithole 1977; Caute, 1983).

Notions of womanhood and manhood were pitted together in a competition for the struggle for legitimacy and power (Parpart, 2008, p. 180). Men took up arms against the colonial rulers and many women "fought in the war for independence on equal footing with men" (Shenje-Peyton, 1996, p. 115) and here we see masculinities playing a vital role. Thus, the uprisings to colonial rule were viewed as essential and the fighters were framed as heroes and saviours of the nations. The discourses of masculinities were gendered from the start because they framed women as loyalists to the cause even though in Zimbabwe, there were unspecified numbers of female liberation struggle fighters- "traditionally undertakings associated with masculinity" (Parpart, 2008, p.192). On the domestic front Zimbabwean men felt threatened and undermined by the changes in gender roles and resorted to venting their anger and frustrations on women (Osirim, 2003). State violence, coupled with African resistance to state sanctioned violence, colluded to increase violence against

women both inside homes and in the public arena. Sexual violence, which intensifies in periods of conflict (Pwiti & Ndoro, 1999) also reared its head and Barnes cites multiple incidents of sexual gender-based violence during the 1940s-1950s black nationalist struggles (Barnes, 1999). On the war front female combatants experienced physical and sexual violence from their male counterparts. This included married women that were used for sexual gratification by male combatants (Chigudu, 1998).

The 1940s saw women's emancipation into the cities however the violence did not cease immediately and men resorted to offering rape victims money in order to justify the violence (Benson & Chadya, 2005). Housing could only be accessed through marriage as did protection from physical and sexual harassment, enrolling children in school and accessing maternity services (Barnes, 1999). Through marriage women asserted themselves as moral and respectable over those who were single and independent which evidences that marriage has been associated with upgrading one's social class (Barnes, 1999, p. 111). In this hierarchy, poor women experienced the extreme forms of sexual violence and insecurity, and ended up cohabiting with men who could not afford to pay bride price (Little, 1973).

To cope with the urban frustrations, men resorted to gendered mechanisms that oversaw the construction of masculine sexual aggression- violent hegemonic masculinity not only peculiar to Zimbabwe but also in other formerly colonised contexts such as South Africa (Bhana & Mayeza, 2019) where it was exacerbated by apartheid. The implication here is not that poor men would engage in sexual violence but the frustrations of being subservient to the colonial rulers coupled with poverty in the form of low wages and inadequate accommodation fueled these forms of violence (Benson & Chadya, 2005). The absence of familial support networks to keep the sexual aggressions in check in the urban areas also exacerbated the violence with poor working -class men taking out their frustrations on women (Benson & Chadya, 2005).

The inter-ethnic conflict between the Shonas and Ndebele saw the defeat of the Shona, and created hostilities that were often expressed in masculinist terms with the Ndebele ridiculing Shona warfare skills and masculinising their own physical prowess (Shire, 1994, p. 149). The British colonialists exacerbated the impact of these insults by describing the Shonas as "a dirty cowardly lot while praising the Ndebele as bloodthirsty devils but a fine type" (Ranger, 1979, p. 3). Parpart, 2008 (p. 183) argues that such mythical masculine stereotypes continue to legitimise racial and gender

inequalities today. The colonial settlers reinforced imaginary masculinities through memories of quashed local resistance in Zimbabwe, depicting themselves as heroes in the process (Lovett, 1977). Thus, the settlers defined their own model of masculinity (Morrell, 2001, p. 139) reinforcing a white male heterosexuality, racial superiority and toughness which was played out in schools, in daily life, and on the sporting field (Vambe, 1976; McCulloch, 2000). This affected African masculinities also through loss of political authority, land, and influence (Schmidt, 1991; Barnes, 1999). The Shona and the Ndebele ethnic tribes eventually united forces against the colonial aggressors however the nationalist unity was disrupted by inter-tribal violence (Ndlovu-Gatsheni & Willems, 2009) which continued for over a decade before the armed liberation struggle commenced.

The history of violence cannot be erased in Zimbabwe, and the struggle for power and dominance cannot be underestimated. The end of the Second World War brought with it an economic expansion and liberal politics which in turn ushered in new models of womanhood and manhood (Parpart, 2008 p 184). There was an increase on the uptake of western education, dress sense and food and lifestyle by those black African, Asian and minority groups who were rich and aspiring to be affluent. Parpart argues that others were more cautious and sceptical about this new way of life and preferred to stay true to localised gendered notions of respectability and masculinity and mostly older men remained attached to "privileged and notions of patriarchal authority than be swayed to Western civilisations for rewards they could not account for" (Parpart, 2008, p. 184). In spite of the rising enthusiasm for modernity brought on by Western civilisation, patriarchal control over women and younger men remained a marker for successful masculinity although women's increased economic autonomy particularly in urban areas was found to threaten male authority. It is the nationalist struggles of the 1950s Zimbabwe that disrupted this moment. However, images of 'true' masculinity had already been sown. On the one hand the post-colonial nationalist narrative in Zimbabwean politics reinforces the masculine identity which is associated with protecting the nation, women and children while on the other hand, ideal femininity is associated with endurance and vulnerability and through this we see how gendered nationalism is and also often a "masculinist project" (Giles & Hyndman, 2004, p. 10; Enloe, 1993).

Zimbabwe's acquisition of independence in 1980 was followed by a period of economic crises which challenged the normative gender roles which led to increased levels of GBV (Osirim, 2003). By the late 1980s the significant gains that the Zimbabwe economy had made dropped and through

economic structural adjustment policies many men were made redundant from work creating masses of unemployed breadwinners and women depending on men economically. This economic situation created tensions and transformed gender roles while men lashed out at their partners (Osirim, 2003). This was in stark contrast to the colonial context where men became gainfully employed and acquired first class citizenry over women who relied on them for livelihoods (Shenje-Peyton, 1999). This elevated status of men enforced submission and subjugation of women even further as men possessed the means to survival. The emergence of independence however did not erase the experiences of violence and the challenge upon existing masculinities and the reproduction of situational masculinities (Oxlund, 2012). In these instances, the way men made sense of their masculinity varied by situation and content. Studies have also established that diverse masculinities usually emerge from backgrounds of poverty, gender inequalities and experiences of trauma (Gibbs et al, 2019; Jewkes & Morrell, 2018).

Section 2

4.2.1 Factors determing the perpetration of violence

Patterns of violence are different globally and men are different in any one environment**.** Men who utilise violence do so in multiple ways and violence perpetration commonly occurs when they are younger and it usually continues for the duration of the relationships (Fulu et al, 2013a; Fulu et al, 2013b). Jewkes et al (2015) argue that "the perpetration of violence against women and girls by men could span a life course" (p. 1581.). One might argue the connection between childhood experiences of violence and its perpetration in adulthood. Several studies posit that adolescent males who grow up witnessing violence are most likely to be aggressive, impulsive, lack empathy, remorseless, and ultimately perpetrate violence (Mathews, Jewkes, & Abrahams, 2011; Jewkes et al, 2011; Bourgois, 1996; Jewkes et al, 2013; Fulu et al, 2013).

There is also an overrepresentation of this group of people in gangs where masculinity is characterised by men dominating women and violently competing against each other (Jewkes, Flood, & Lang 2015). Additionally, it has been established that men who have been through adverse experiences of violence are not only violent but are also more supportive of violence (Gibbs et al, 2020). Furthermore, male on male violence correlates with perpetration of VAWG and to some extent experiences of victimhood (Katz, 2006; Fulu et al,2013b). Whilst it is plausible that children can be sexual violence perpetrators Jeweks et al, (2015) argue that it is most likely in adolescence that they commit sexual violence like rape. Adult males who go on to rape do so in teenage years first (Jewkes et al, 2011).

Not all male victims of violence will go on to perpetrate intimate partner or sexual violence, but the level of probability is present (Jewkes et al, 2011). Furthermore, in a context where there is high prevalence of VAWG, it is hardly surprising to find that male perpetrators would either be victims of violence themselves or be perpetrators of violence against other men at some point (Jewkes et al, 2015). Exposure to domestic violence and socialisation processes can encourage behaviours which constitute VAWG when assimilated by young people as values, beliefs, and attitudes (Fakunmoju & Rasool, 2018, p. 1). This in turn foments gender inequalities in the primary years which could shape later life patterns (Bhana & Mayesa, 2016 p. 41). Similarly, violence against children is also synonymous with violence against women as depicted in Figure 4.1.

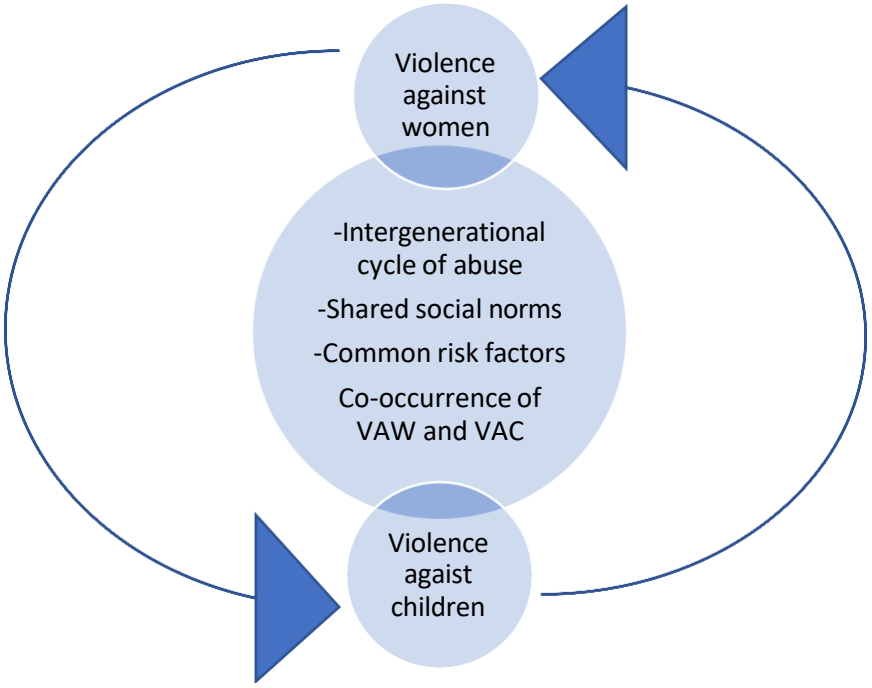

Figure 4.1 Circular relationship of Violence against women and Violence against children (Jewkes, 2018)

Studies have shown that such a subjection to violence could also cause violence perpetration in personal and interpersonal relationships including the transmission of violence intergenerationally (Stoddard et al, 2015; Jewkes et al, 2011; Heinz et al, 2017; Mueller et al, 2013). Jewkes (2002) and Levinson (1989) argue that a cultural and social environment that tolerates and accepts violence will also 'permit' different forms of violence; thus, culture and the use of violence are relative. This argument could be empirically evidenced but that still would not explain the gendered nature of violence and why men and not women are predominantly likely to perpetrate violence (Black et al, 2011) or the link between male-on-male violence and sexual violence against women and girls (Jewkes et al, 2019; Fulu et al, 2013). Studies have shown that the legacy of colonialism, economic landscape and migration created aggressive masculinities that are predisposed to violence Bhana, 2015; Shefer, 2014).

In order to articulate the connection between different forms of violence, there is a need to understand how masculinity and violence are related. The ways in which men perceive their gender identity, their intimate and social relationships and policy and institutional frameworks is affected by values and ideas related to gender (Connell, 1987; Hearn et al, 2012). Gender plays a major role in this argument since it marks 'appropriate' roles, values, attributes and behaviours for both men and women (Connell, 1987). Society determines these ideas which is why they differ across societies and form social norms which are maintained through people's actions and to some extent institutions (Morrell, 1998; Morell, 2001). In supposedly 'equitable' societies gender differences may be less visible yet all societies seem to esteem men and value them above women which is where male power over women and subsequent norms emanate from (Hearn et al, 2012). This by no means infers those men are all violent; many oppose violence against women and girls but most settings unwittingly accord men power to employ violence on women (Moodie, Ndatshe, & Sibuye, 1994; Grieg, Kimmel & Lang, 2000). To demonstrate this, men would get into competitions to show these attributes of masculinity such as honour and territorial fights (Bourgois, 1996; Morrell, 1998; Breckenridge, 1998).

The masculinities of men who use violence differ individually and may not always be hegemonic (Hearn, 2004; Hearn et al, 2012; Bourgois, 1996). The gender theorist Connell (1987) cites hegemonic masculinity as the most recognised and legitimate type of masculinity to evidence the distinctiveness of the way the position is attained inside a community or society (Connell, 2005). Culture also dictates what masculinity should look like particularly those forms it

deems acceptable (Cislaghi, 2019). Connell argues that rather than an imposition of this masculinity's dominance it is more of a silent acceptance and a normalisation of it by both men and women and the notion is adopted from an early age such that most men aspire to it including those who cannot fulfil the related roles for one reason or another (2005). One such example could be poverty which might prevent men from providing for their families. Mostly importantly there is a consensus between men and women that such social ideals define gender relations (Morrell, Jewkes, & Lindegger, 2012).

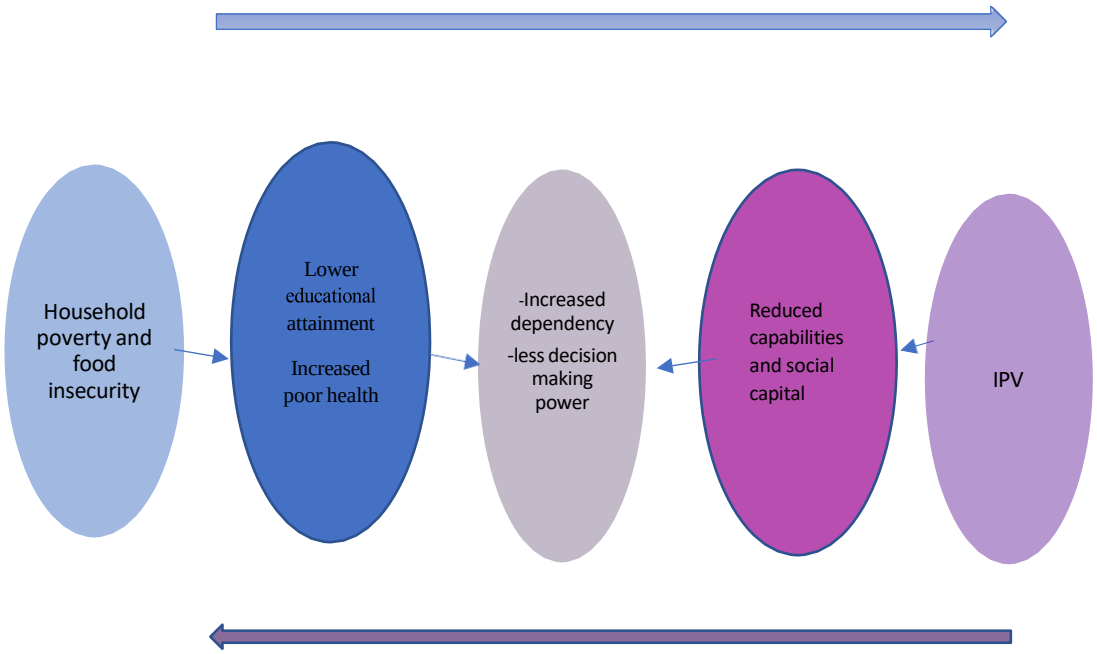

Figure 4.2 Circular relationship between poverty and violence (Jewkes, 2018)

The What Works concluded that it is imperative that we understand the intersection between poverty and men's perpetration of violence in interventions to end violence. One's ability to establish and maintain a heterosexual household and provide for it economically determines whether they ascribe to traditional masculinity or 'provider masculinity' (Bhana & Nkani, 2014) and through this, men earn respect (Gibbs, Sikweyiya, & Jewkes, 2014; Hunter 2010). Poverty arguably functions to facilitate violence especially as it conflates with men's gendered roles. Culturally men are regarded as breadwinners and if one cannot provide for his family, it equates to failure which will impact negatively on masculinity. Patriarchal misogyny might be partly to blame but how do men reclaim their masculine dignity especially when they cannot provide for their family? To 'reclaim masculine power' (Jewkes and Morrell, 2018; Connell, 2017) men make themselves feel strong by

subordinating a weaker person (Bhana & Mayeza, 2016) and that can only be through aggression and the focus for that aggression is those that are not as physically strong and those immediately around them- women (Connell, 1995). Such notions of becoming violent because of perceived failure as a provider become deeply ingrained in the psyche and will be difficult to recognise late alone break. Practices such as bride price feed into this as they essentially legitimise male feelings of owning women in compensation for their perceived failure.

A circular relationship exists between drivers of different forms of violence which then seems to empower these drivers; this is phenomenal in contexts of IPV and poverty where the connection is clear (Jewkes, 2018). Household poverty and food insecurity lowers social status, increases stress and ill health. Most importantly with IPV, it reduces engagement and productivity, reduces social capital and capabilities and produces negative mental, physical and reproductive health impacts which increases dependency and reduces power within households (Jewkes, 2018). Gibbs et al (2016) observe that IPV is widely prevalent in informal settlements where residents are usually younger, unemployed and therefore poorer than those in formal settlements. Gibb's et al's study concluded that the improvement in livelihoods supported men's endeavour to participate in traditional masculinity through material provision in relationships (2015).

However, change was not absolute; some men were observed to regress and continue with abusive behaviours after the intervention. Additionally, quantitative data analysis showed no impact on IPV perpetration, crime involvement, alcohol misuse, and non-partner rape (Jewkes et al, 2014). Although they are linked, masculinity and violence are not intrinsic. Where there is an expectation for women to be subordinate to men, the means to achieve this is improvised and this could include the use of threat, sexual or physical force. Any resistance to prescribed gender norms will sanction punishment as part of the control mechanisms. For the most part masculinities are exaggerated to mimic a perceived ideal emphasising force and power. Men who have experiences of childhood violence are most likely to exhibit such masculinities (Mathews, Jewkes, & Abrahams, 2011).

4.2.2 Framing HIV as Violence

HIV has long been framed as a development and human rights issue (Mann & Kay 1991) with IPV linked to a higher likelihood of HIV infection. Sexual decision -making norms and gender weave into

the complexities that exposure to violence and HIV risk already present, creating a web of vulnerabilities to further violence. In a systematic review of studies on the intersection of IPV and HIV/AIDS, Campbell et al found that risky sexual behaviours that are linked to IPV work through both sexes, and the physical impact is experienced more by women throughout their lives (2008). Reducing male on female violence and male sexual risky behaviours would address causality to an extent. The association between HIV and IPV and the risk factors shared between the two burdens are well documented. While IPV increases the risk of HIV acquisition, the presence of HIV also increases the risk of new or worsening IPV. The trauma from IPV in the context of HIV infection may not only have important negative social implications but also may have significant clinical consequences on HIV care. There is a bidirectional relationship between IPV and HIV. While the risk of HIV infection could be increased by the presence of IPV, a diagnosis of HIV could potentially precipitate IPV experience (Siemieniuk et al, 2013).

Li et al (2014) sought to assess evidence of a correlation between IPV and HIV infection among women in a systematic review of studies to this effect and were able to evidence a moderate statistically significant association between IPV and HIV infection. Several other studies have confirmed the link between IPV and HIV infection (Decker et al, 2009; Kayibanda, Bitera & Alary, 2012; Barros, Schraiber & França-Junior, 2011). Power inequity in relationships and IPV increase the risk of HIV infection (Jewkes et al, 2010). Kouyoumdjian et al (2013) also found an association between experiencing IPV and HIV infection although they could not establish a causal association between the two. Harling, Msisha, & Subramanian (2010) did not find any association between IPV and HIV. What then could be the underlying pathways fostering this causal link?

The scientific evidence on the association between IPV and HIV is compelling, and the UN recognised male perpetrated IPV as one of the social drivers of HIV that needed to be addressed in order to reduce women's vulnerability to HIV (UN, 2021). Both clinical and social effects of IPV have negative implications on women's health particularly where HIV is present. An HIV seropositive status is also closely associated with male control over women and IPV particularly in contexts of high HIV prevalence (Dunkle et al, 2020; Decker et al, 2009). Gender power differences account for violence and the violence reproduces this power inequity (Jewkes & Morrell, 2010). HIV prevention has focused on testing, abstinence, condom use by men and on initiatives such as male but have not touched on addressing gender issues which underline the violence that vulnerable women experience (Greig et al, 2008; Christofides & Jewkes, 2010).

The risk of HIV is elevated by dominant masculinities which increases women and girls' vulnerabilities to further risk of violence thereby reinforcing gender inequalities (Kaufman et al, 2008). Research linking gender inequality, HIV, and VAWG has shown the problematic nature of patriarchy particularly its preoccupation with controlling women and the promotion of masculinity ideals as an indication of toughness and strength (Coovadia et al, 2009; Jewkes & Morrell, 2010). Such ideals promote risky and predatory sexual behaviours including further violence against women (Fleming, DiClemente, & Barrington, 2016; Jewkes & Morrell, 2010). This behaviour also legitimises men into having multiple partners whose sexual behaviours they will control. Male perpetration of violence is associated with HIV infection (Decker et al, 2009; Jewkes et al, 2009) because women have limited influence over safe sex which means that sex could be more frequent resulting in reduced condom use (Wood, Maforah & Jewkes, 1998; Pettifor et al, 2004; Jewkes et al 2007).

The most obvious route for HIV transmission is through sexual intercourse (Mugweni, Pearson & Omar, 2012; Sa et al, 2008; Stockman, Lucea & Campbell, 2013; Jewkes et al, 2010; Folayan et al, 2014) however pathways for infection are not straightforward but are rooted in gender inequality and violence. For example, in persistently violent relationships and where a woman has also experienced childhood violence, the risk is greater (Jewkes et al, 2010). IPV increases this risk through forced sex which may cause lacerations in the genital mucosa even though "overall risk of transmission is lower at ~1 transmission per 1000 coital acts" (Gray et al, 2001). Thus, the risk of HIV infection from a single episode of rape is low (Siemieniuk et al, 2013). However, in the context of prolonged IPV, the risk then increases due to frequent episodes of rape (Hyginus et al, 2012; Kouyoumdjian et al, 2013). IPV heightens HIV infection risk in multiple ways. For example, women in controlling relationships have little sexual assertiveness and can therefore not negotiate safe sex resulting in getting infected with HIV (Morokoff et al, 2009; Stockman, Lucea, & Campbell, 2013). Inconsistent condom use is also associated with most forms of IPV (Kouyoumdjian et al, 2013; Deering et al, 2013). This does not in any way mean that inconsistent condom use will mediate the heightened risk of HIV transmission in IPV settings (Jewkes et al, 2010; Kouyoumdjian et al, 2013).

Research has also established a correlation between victimhood of IPV and a multiplicity of sexual partners and inconsistent condom use (Dunkle et al 2020; Andersson & Cockcroft, 2012; Harling, Msisha, & Subramanian 2010; El-Bassel et al 2011) which elevates their risk of HIV infection (Andersson & Cockcroft, 2012). The long -lasting impact of violence is partly to blame for this

association (Wang & Rowley, 2007) as women may be seeking affection or be manipulated and controlled by their partners (Wingood & DiClemente, 1998; Johnson, Cunningham-Williams, & Cottler, 2003). Arguably, the cyclical nature of violence is evident- abuse brings exposure to HIV and exposes individuals to further abuse (Jewkes et al, 2010). The authors evidenced causal association between IPV and power inequity in relationships and the risk of HIV infection.

The variables had a plausible link which is supported by other studies. The authors however caution that experimental evidence is needed to support the hypothesis that reducing VAWG will automatically reduce HIV infections (Jewkes et al 2010). Further scrutiny of perpetrator behaviour is necessary when trying to understand the pathways between HIV infection and IPV. Of the most importance is the fact that HIV prevalence is higher within populations of IPV perpetrators, and in addition risky sexual behaviours (Decker et al, 2009; Jewkes et al, 2011) therefore exacerbating risk of transmitting the virus to their partners. To portray social determinants directly linking IPV to HIV infection is challenging because there are several social risk factors that complicate the lives of those at the receiving end of IPV. Women face multiple challenges concurrently with IPV and being infected with HIV may just be a result of a compounded series of challenges in their lives (Siemieniuk et al, 2013). This narrative enables me to get into the next section where I unpack some of the social determinants that could impact women and girls in the trajectory of HIV.

Section 3

4.3 The Social Ecology model: Understanding the triggers of violence

This research highlights how cultural practices that embed a sense of female inferiority and male ownership lie behind other forms of violence such as IPV and also HIV. I now use the social ecology model (Heise, 1998) to elucidate how at different levels violence is experienced. The model encapsulates the different dimensions and spheres of oppression from how an individual's social circumstances lead to controlling behaviour and IPV and how the socio-economic status exacerbates a woman's plight of violence. Social norms then concretise this status by informing gender stereotypes and normalising and legitimising violence (Heise,1998). I conceptualise individual perpetrator, community and society characteristics within the ecology model which account for the normalisation of forms of female oppression at different levels.

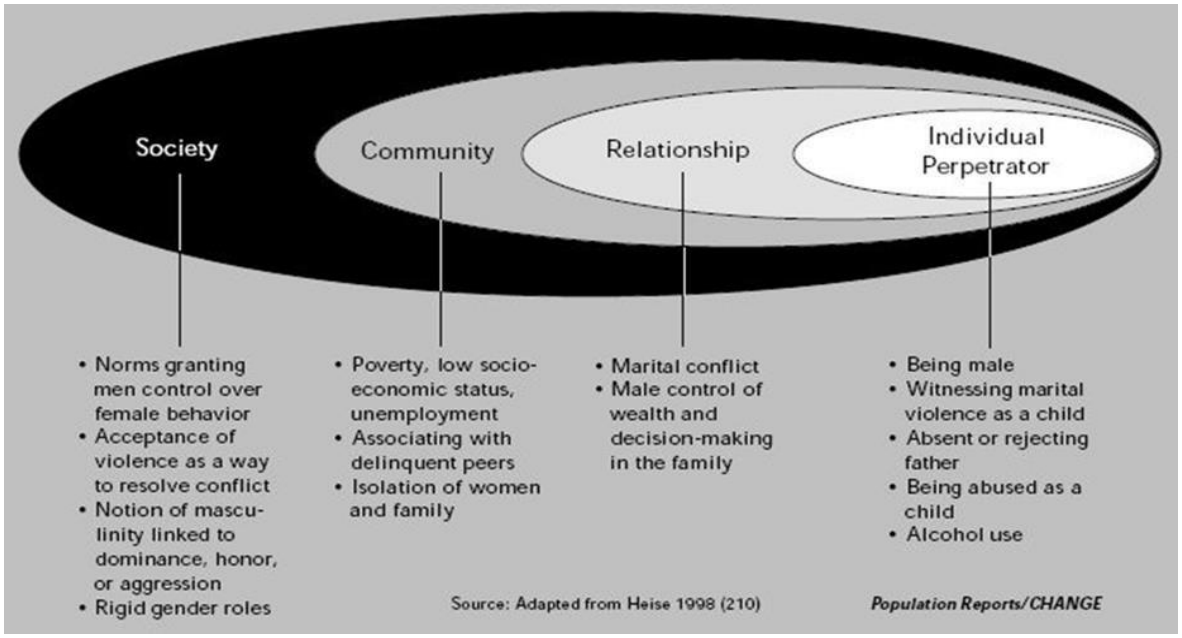

Figure 4.3 Social ecology model (Heise, 1998)

4.3.1 Individual perpetrator level

There are social issues also such as whether or not there is a normalisation of male public drinking which has been evidenced as a trigger of violence in a lot of contexts (Caniberra et al 2018). In a South African study by Gibbs et al (2018) established that male dominance, food insecurity and alcohol abuse exacerbate women's experiences of violence. In a different study Machisa et al (2017) also found a positive correlation between IPV and alcohol abuse and evidenced that patterns of alcohol consumption were consistent with recent cases of intimate partner violence. Men that witnessed abuse between parents as children are likely to perpetrate violence (Lasong et al, 2020). Alcohol intake is also a contributing factor in perpetrating violence especially among families with more than five children and in polygamous marriages (Lasong et al, 2020, p. 8).

4.3.2 Relationship level

Culturally women are considered inferior and subordinate and as such are not involved in decision making processes (Shilubane & Khoza, 2014, p.85). Because of their submissive disposition, they are unable to fathom any freedom opportunities that may be available because 'ownership' labels imposed on them by men. This ownership concept enables men to control women's sexuality in order to ensure "patrilineal inheritance" (Van Dyk, 2003; Astbury, 2006). Decision making and better choices in life are the result of a good education which translates into empowerment for

individuals. Significantly education enables one to communicate better which might protect them from violence. Other studies have also evidenced the protective factor of better education against domestic violence for both men and women (Sapkota et al, 2016; Kargar et al, 2015).

This argument is controversial as evidence has shown that educational attainment is a significant risk for IPV (Mohamadian et al, 2016; Rapp et al, 2012). Women lack sexual decision -making powers and self- efficacy which means that they cannot negotiate condom use (Seidu et al, 2021; Tenkorang, 2012). The gender inequalities that exist mean that young women in particular cannot insist on safe sexual practices. Intimate partner violence is prevalent in Zimbabwe and wife beating is justified for trivial issues such as arguing or refusing sex with one's husband. In the Demographic Health Survey (DHS) of 2015, 33% of men and 39% of women responded that burning food and leaving the house without informing the husband justified a beating from him (Govt of Zimbabwe, 2015). Lasong et al, (2020) found that age is a trigger and contributes to violence against women with younger women experiencing violence more than their counterparts. Reasons for this discrepancy were not explicit in this study and highlights a gap in knowledge.

4.3.3 Community level

Women who reside in rural areas are less likely to attain higher education and go on to marry young without any employment prospects. Lasong et al (2020) argue that this renders them financially insecure and reliant on their husbands which predisposes them to violence. On the other hand, their counterparts in the urban areas fare better in accessing higher education and consequently better employment opportunities which minimizes their risk of domestic violence (Semahegn & Mengistie 2015; Begum et al, 2015). Because of poverty, women depend on men economically and this trend fuels early marriages. Additionally, social norms interact with economic factors to confine women to abusive relationships with women staying in abusive marriages for the economic welfare of their children. Such decisions are underpinned by internalised norms which define what is considered best interests of the children (Izugbara et al, 2020).

Furthermore, women's financial dependency on their husbands reinforces the position (Ahinkorah et al, 2022) and perpetuates women and girls' vulnerabilities. Poor women, often those who marry young are found to condone wife beating as they are marginalized and powerless without capacity to challenge their husbands safely and prevent violence against themselves (Izugbara et al, 2020, p. 15). There is clear evidence that women's experience of poverty and gender inequalities drives their experience of IPV (Krishnan et al., 2008; Kim & Watts, 2005). For men there is a strong qualitative theoretical argument that their economic marginalization leads to an increase in IPV

perpetration (Gibbs et al, 2014; Bourgois, 1996). However, in a cross -sectional study of rape perpetration in South Africa Jewkes et al (2011) found that in descriptive analysis those with less earnings were more likely to rape, but also those hungry due to lack of money were also more likely to perpetrate violence. Higher maternal education was associated with rape suggesting that being better off was also linked to rape.

Furthermore, it has also been proven that strengthening men's livelihoods without transforming gender norms/relationships can increase HIV-risk behaviors. This is a major issue as large number of interventions are focusing on increasing young people's access to work (Gibbs et al, 2016). For women a constellation of factors shapes their risk of IPV driven by poverty. Poverty drives poorer educational outcomes, and also delivers poorer mental health outcomes. Poverty drives gender inequalities, primarily in the form of controlling behaviors which reinforces the need for comprehensive gender transformative and economic strengthening interventions. When it comes to men, we see a clustering of factors linked to IPV- being slightly better off (in the context of poverty), working more in the past 12 months, and viewing self as a successful man. There is also a strong link with gender inequitable practices and childhood traumas which can lead to depression, substance use/misuse and eventually perpetration of IPV (Gibbs et al, 2016). A man may steal because of hunger and this behaviour is linked with arguing in relationships and coercive control.

This reflects the argument that men who are slightly better off are associated with greater sense of sexual entitlement and control of women which in turn raises significant issues about just rolling out economic strengthening interventions with men, without focusing on gender transformative interventions at the same time. Transforming gender norms and facilitating empowerment and strengthening livelihoods reduces IPV (Pronyk et al., 2006; Ellsberg et al., 2015). While an educated woman might recognise IPV, her risk of it might also be heightened consequentially; cultural masculine norms regard men as household heads and decision makers however this sense of entitlement might be threatened by a woman's education (Motsa & Morejele, 2019). Economic dependency leads to increased risk of violence against women (Vyas & Watts, 2008; Rahman; Hoque, & Makinoda, 2011) but women may resort to strategies that protect them from violence such as subservience and being nonconfrontational (Riddell et al, 2009).

4.3.4 Society level

Similarly, extended families exacerbate women's vulnerabilities to HIV as they advocate for women's perseverance in marriages where the risk is known to be high (Mugweni et al, 2015;

Chingandu, 2007; Taruberekera et al, 2009). Women are advised to endure abuse under the demise that marriage is a complex union and 'things would improve'. Emphasis is often laid on the belief that marriage survives only when the woman commits to the hard work necessary for the marriage to work (Chireshe, 2015); consequently, women are regarded as the "healers of wounded marriages" (Nadar & Potgieter, 2010, p. 151). For this reason, women cannot seek prosecution for abusive husbands. Reporting violence is negatively viewed and further reinvents the cycle of violence as there is often backlash from the husband (Chireshe & Chireshe, 2009; Ntlama, 2010). Reporting spousal abuse to the police is often interpreted as forfeiting one's marriage because a 'good' woman will not bring shame upon her husband by exposing his behaviour to strangers such as the police. Any such behind implies that the woman is not acting according to marriage scripts of subordination and should be divorced. Similarly, women persevere in risky marriages where the threat of HIV infection is ever present because of the social stigma of divorce and a lack of protection rights for women (Mugweni et al, 2015).

Research has shown that higher rates of violence and community crime render women and children more vulnerable to abuse (Collins, 2013) because of lower social control and the normalisation of violence (Beyer et al, 2015). Reporting spousal violence carries connotations of disloyalty and is seen to violate culturally acceptable behaviours (Jewkes, Levin, & Penn-Kekana, 2002). Disclosure of abuse and seeking help is associated with stigma (including from family members) and shame; cultural and social norms dictate that women should maintain the family's harmony and as such are not expected to ask for a divorce (Shokane & Masoga, 2018). Mogstad et al (2016) found an association between power and control over oneself and others at the heart of dominant models of masculinity. The family unit is considered a private domain by religious and cultural institutions which must be guarded against outside intervention, chiefly law enforcement agents. This view makes reporting abusive husbands' behaviours undesirable thus maintaining the culture of secrecy.

At societal level marriage is regarded highly and takes precedence over a woman's health; likewise, community needs trump those of an individual's welfare which Chireshe (2015) asserts is ubiquitous in African societies. A woman is often stigmatised for getting divorced citing divorce as failure on her part. Consequently, married women are conferred respect over divorced or single women (Mukonyora, 2007; Armstrong, 1998). Image is revered in Zimbabwe, and marriage is viewed as part of the social status and should therefore be preserved (Armstrong, 1998; Yigzaw et al., 2010; Gonzalez, 2010) reporting violence would thus undermine not only one's social status,

but also that of the husband's, the family's and the religious community (Chireshe, 2015).

While the ecology model enables us to understand how violence plays out at different levels it is critiqued for not showing the relationships between the different levels of violence. Initiation rites LE happen at community level and as such pressure exists at community level not household level although the stigma for not going through it for both boys and girls will be felt at household level. As for the link between community and individual decisions it can be argued that decisions for LE are a community norm. Practising LE is a community and peer driven decision however with child marriage and polygamy, family decisions are made for children to be entered into these marriages. Not all communities support these practices therefore responses to them are not systematic.

4.3.5 Female Agency

I will begin this section by exploring femininity which like masculinity, is also plural. Multiple studies have discovered a culturally dominant 'traditional' femininity (Harris, 2004; Gavey, 2005) and an 'emphasised femininity' (Connell, 1987). This form of femininity complies with accommodating men's interests and desires, and to a larger extent subordination. Those women that enact or endorse emphasised femininity collude with the unequitable gender relations thereby tacitly accepting their subordination (Jewkes & Morrell, 2012). There are social sanctions and rewards that come from adopting certain femininities and these are enforced through discourses about good and bad morals and threats of violence which limits women's choices.

Women, like femininity are not homogenous and are not all victims of men. How they acquiesce or resist patriarchal inequality and gendered power relationships is different by context. Challenging patriarchy is complex in terms of gender relations and with women legitimising male control it leaves little room for resisting that which is perceived as natural. Women's sexual agency, (Vance, 1989) and the desire to express it for pleasure in unsafe contexts can result in women being "placed at risk by the very actions they took to affirm femininity" (Jewkes & Morrell, 2012, p. 1730). This is not to suggest that they are passive and cannot negotiate their sexuality as women that engage in transactional sex can determine the circumstances and the number of sexual partners they will have (Leclerc- Madlala, 2004; Masvawure, 2013). Young women have also been found agentic in condom use (Harrison et al, 2006) and to determining contraceptive use and motherhood (Wood & Jewkes, 2006) and in abstaining from sex (Jewkes & Morrel, 2012).

Although women can be agentic, "there are strong cultural roots to messages girls receive, that

they should be passive, innocent and will be held accountable for how they are treated by men" (Jewkes & Morrell, 2011, p. 1730; see also Bhana, 2007; Jewkes et al, 2005). For this reason, men understand attempts to negotiate safe sex as defiance and disrespect that results in violence such as rape (Varga, 2004). In a study on young women's sexual agency Jewkes & Morrell (2012) found women have agency to choose a partner but once they make the choice, their power is circumscribed to the point of surrender. Thereafter all major decisions are made by the male partners as 'the way it should be' and reflects the natural order. This shows that once women are 'caught in the powerful matrix of heterosexual masculinities' their ability to exercise agency becomes constrained. Although their participants gave narratives of flirting with and engaging in multiple partner sexual relationships Jewkes & Morrel found that the women 's agency and freedom was severely constrained by the socio-economic context, dictates of patriarchy and other structural elements in their lives. This limits women and girls' agency as men's expectation is to control women in both violent and non-violent ways with women expected to show respect and obey the men. This also leaves women in fear of their male partners even in instances where physical violence is not employed.

With diverse femininities also comes diverse expressions of identity as some women are culturally conservative and would acquiesce to the prevailing order. These instances are characterised by women accepting prescriptions of unequal gender relations, male domination, publicly passivity, obedience and unquestioning respect. However, under these circumstances, women will also seek some respect and power in these intimate relationships albeit with variable success. Conservatism and acquiescence could lead women to be supportive of traditional practices that are oppressive and supporting the gendered order that is known to be harsh. This ideal is reinforced cross-generationally including by mothers who are educated as evidenced by Jewkes & Morrell (2012).

The Stepping Stones project in South Africa revealed an emergent feminist consciousness that is comparable to the dominant traditional femininity. In this 'new' form of femininity women expressed 'modernity' as they adopted a 'modern girl' approach that opposed the culturally conservative model (see https://steppingstonesfeedback.org/). However Jewkes Morrell (2012) found that conservative femininity is perceived to be rewarded as much as it is socially expected. Unlike masculinity, there is no hegemonic femininity albeit all forms of femininity being subordinate to male power. Women willingly enter relationships for pleasure, respect and gain and can choose to have older or younger partners, mainly shaped by socio-economic vulnerabilities. However, poverty also locks women into dependency on men that are violent for survival which in

turn limits their agency (Fidan & Bui, 2016).

Women also seek to assert their identities and autonomy without rejecting or challenging the structures that control families in their localities. Where they have sought for gender equitable relationships, research has established that HIV risk is reduced. Violence intersects with gender inequity which highlights the implications of gender inequality in the risk of HIV infection (Jewkes, Dunkle, Nduna & Shai 2010). Agency discourses ignore the fact that women surrender power to conform to the cultural expectation of a 'good' woman and this is sustained by conservative femininities loyal to the gender pact although these forms of femininity in themselves are not fixed. This is because gender is constituted in dynamic relationships and the constructions are 'part of a systematic and collective process' (Connell, 1995).

Conclusion

Zimbabwe has a history of political and social violence as a consequence of its colonial past and of deep poverty and inequality. In this chapter I have illustrated how masculinities played out in colonial and post-colonial Zimbabwe. Most processes are shaped from this history and male authority has been over-emphasised at every turn in its history. Masculinities are not fixed but can shift according to context and situation (Oxlund, 2012). The suppression of black male authority through colonial rule brought tensions and reduced established ideals of masculinity. This resulted in toxic masculinities that ruled over others and quelled any resistance calling for obedience. This scenario advocated for the restoration of manhood and dignity through war and suppression of resistance (Alexander & McGregor 2004; Ranger, 1985). In the periods of identity crisis and renegotiated manhood men in Zimbabwe intensified their control over women as a means to recoup their status. These models of masculinity have been sustained and are played out in the everyday life.

Violence can manifest intergenerationally, and lived experience of childhood violence can negatively impact adulthood perceptions of masculinity. There is violence fueled by deep poverty and inequality and there is great deep- rooted discrimination against women and girls. The triggers and drivers of violence are linked to social norms which are characteristically dominant resulting in gender inequalities. Those entrenched social and cultural norms mean that women continue to be at risk of further violence and HIV infection. Men assert power to control women and have a sense of entitlement to exert the power over women (Bhana & Mayeza, 2019; Fidan & Bui, 2016) because of the socialisation processes. Vulnerability means that women are susceptible not only to violence

but also to HIV as a form of violence which all comes down to individual perpetrator behaviour. Violence exists in different forms in order to maintain a certain unequal status quo which disadvantages women and girls at different levels as I have illustrated drawing on the ecology model. I have also argued that HIV is violence due to its irrefutable association with IPV and power and control over women. Relationships that are characterised by violence particularly IPV expose women to HIV as safe practices around sex are usually non- negotiable for women (Morokoff et al, 2009; Stockman, Lucea, & Campbell, 2013).

The environment in which VAWG plays out is deeply rooted in patriarchal values and traditions that stigmatise non-conformity (Mugweni et al, 2015), and increases the risk of further violence. Violence is experienced at different levels in society and this evidences that challenging patriarchal structures of inequality is a complex venture that limits women and girls' agency to resist the status quo. It is evident that the environment is not enabling in terms of supporting women and girls experiencing violence. Women end up colluding with the same structures that oppress them because subordination is culturally desirable and idealises femininity (Skovdal et al, 2022; Mugweni et al, 2012). As I move into my next chapter, I begin to explore more and contextualise LE, child marriage, bride price, and polygamy as violence and explore how and whether or not they are linked to HIV infection.

Chapter 5

Linking different forms of Violence Against Women and Girls

Introduction

In the previous chapter I embarked on a situational analysis of violence in Zimbabwe which established that the Zimbabwean society is rooted in patriarchy, and it is this system that endorses gender inequality, creating a platform for violence. The approach I took enabled me to understand the ecology of violence which I was in turn able to explain through the social ecology model. In turn this supported a more detailed analysis into the foundation and context of VAWG in Zimbabwe. I interrogated the constructions of violence and the expressions of masculinity through which gender inequalities are sustained. I introduced social ecology model (Heise, 1998**)** to map out the multiple levels at which VAWG operates. By applying the model, I was able to understand how and why violence exists, and also highlight the different levels at which it occurs. The ecology model highlights the structure through which VAWG exists, from society right through to individual level. At societal level it shows how norms grant men control over women from bodily autonomy to decision making and mobility. In this chapter I delve specifically into cultural practices to understand how they are linked to certain social, religious and gender norms and serve to increase women and girls' vulnerability to other forms of violence including forced transmission of HIV.

In contextualising the ecology model, I analyse LE, bride price, child marriage and polygamy as specific harmful cultural practices that act as key mechanisms through which men are granted control over women. These practices render women inferior to men legitimising male authority (Al-wazedi, 2021) and the use of violence (Dunkle et al, 2020). I explore the extent to which culture influences these practices and their intersection with patriarchal gender norms. I also allude to the social ecology model to elucidate the levels of women's experience of oppression and how those experiences are compounded by unresponsive legal frameworks within that social ecological theory. I also present some of my data in the analyses to link with what we already know about women and girls' experiences of violence.

The chapter is structured in the following way: section 1 gives context to what I conceptualise as harm and I address cultural and ethical concerns towards my stance in maintaining that LE, child marriage, polygamy, and bride price are harmful and linked and that the link leads to HIV infection. I go on to unpack LE as an initiation rite and explore how it serves to prepare girls for sexuality and

highlights the nuanced nature and risk of harm and violence in later life. The issue of bride price is addressed in section 2 where I confront the concept of harm in light of a cultural practice that has support in the research context. In section 3 l discuss child marriage and its implications for girls and women's agency. I move on to interrogate polygamy and discuss the role of religion in perpetuating and sustaining the practice in section 4. Chapter 5 situates the practices in the social ecology model where I attempt to understand how they are reinforced at different levels. I also look at the challenges that arise when attempting to regulate HCPs and I interrogate the legislative framework that informs government responses to issues of gender inequality that render women vulnerable to abuse and violence and critique the framework in section 6. I add a concluding summary to the chapter's discussion at the end.

Section 1

5.1.1 Contextualising harm

There is an urgent need to understand that FGM needs to be considered alongside intimate partner violence and other forms of domestic abuse. My contribution is to provide a lens through which we can see the correlation between all these issues and demonstrate that the siloed approach that we see in development programming is not going to end discriminating practices such as FGM, child marriage, bride price, polygamy and disproportionate transmission rates of HIV in women unless we acknowledge the linkages. My argument is that there are links between all these harmful practices and that they all need to be seen as forms of violence because bride price often is not, and neither is polygamy. These practices are not necessarily always seen as forms of violence in the same way as IPV or domestic abuse, and I argue that they should all be considered under the same umbrella of harm. Challenging culture is problematic; Narayan alludes to this:

> *"This belief is perhaps a feminist version of a mistaken but common place belief, and that a deeply critical stance against one's culture places one entirely outside its orbit and influence"* (Narayan, 1997, p.55).

I am aware that not all ethnic minority, particularly African feminist academics, will agree with my stance on the problematic nature of LE. Drawing on the theoretical work of Narayan, (1998); Rosaldo, (1980); Moraga & Anzaldúa (2015), and Mohanty (1988), who all concur that essentialising about the lives of African women in negative demeaning language is unhelpful and unethical, it is

not my intention to replicate this problematic narrative but instead to offer a nuanced and sensitive picture of the realities of Zimbabwean women's lives. I write as a black African feminist scholar based in a Western context and although I acknowledge my 'privileged' position, I aim to avoid "racism and imperialism" (Narayan, 1997, p. 55) because I am interrogating my own culture and through a critical process of reflection in which my own experiences form part of my lens. I have approached this process with the intention to avoid views being 'imposed upon me' as Narayan writes:

> *"Many third –world feminist criticisms-say, of the position and treatment of women within their families or of institutions such as dowry- are both influenced by, and bear resemblance to, criticisms voiced by many non-feminist women within the culture reflecting upon their life-experiences as affected by these institutions. In this respect, many Third-world feminist issues are hardly "foreign imports" or "Westernised agendas" imposed by feminists onto contexts where "culturally authentic" non-feminist women would entirely fail to see what the feminist fuss was about*" (1997, p.1).

Uniquely, I do not object to other feminist scholars who may view some aspects of my culture as problematic as long as data backs their arguments. Additionally, definitions of what constitutes violence against women and girls vary between contexts (Mubaiwa, 2020). If people's lived experiences are informed by culture and they report it as that, then it would be morally and ethically erronous to invalidate their experiences because they are living it and experiencing it in their own way and attributing everything they are experiencing to that culture. In my arguments, I too, choose to let my data speak not only for me but for my participants. Narayan sums up my subjective experience in this regard:

> *"Many feminists from Third-world contexts confront voices that are eager to convert any feminist criticism they make of their culture into a mere symptom of their 'lack of respect for their culture' rooted in the 'westernisation' that they seem to have might like a disease"* (1997, p.6).

I believe my research forces an even more complex and nuanced post-colonial critique to emerge. One that states that cultural norms are strong in influencing the continuation of harmful norms and behaviours therefore practices such as LE, child marriage and bride price must be seen as forms of

violence alongside others. My thesis challenges the feminist post-colonial critique that argues that culture has been overused to explain processes of marginalisation and violence inflicted on women in the global south. Cultural norms are indeed part of the problem but must be situated alongside other gendered norms that continue to devalue women. My overall argument then is that violence is linked to vulnerability- these practices deepen inequalities and thereby render girls more vulnerable to male control (Fidan & Bui, 2016) which is often exercised violently. The practices themselves are theoretically safe but because of the way in which they limit the possibility and the agency of women and girls this is where they are seen as harmful.

I gave my participants the platform to speak of their own experiences in community discussions, and to development and stakeholder categories and the teachers and advocacy practitioners, the opportunity to narrate the experiences of the women and girls they serve. The data reveals that culture- gender, social and religious norms lie behind women's experiences of oppression and vulnerability to HIV infection. Having said that, I understand that my argument is controversial because it is theoretical and as such is difficult to empirically evidence. I am conscious that we do not have an evidence base, yet my argument is absolute. The importance of my thesis is that I am making the argument that whether the entry point is through HIV as in this instance, or sexual reproductive health, or even education should not matter. What the development entry point is within the process of programming should be the lens through which the issues are addressed and that is the narrative I am conveying. I will now turn to those practices to provide further insight.

5.1.2 Labia elongation: Preparation for sexuality and reproduction

In this section I lay out the conditions under which LE occurs in Zimbabwe. I define this stage as the point at which a girls' life is set up for vulnerability to HIV in later life. We may not locate LE as a violent act within a cultural discourse and we may not view it as such however it is what it represents that is crucial. Its symbolic nature in terms of sexualising girls' bodies, commodifying and feeding into the objectification of women ((Bareket & Shnabel, 2019) and their sexuality, that then becomes controlled by men becomes an issue of concern. It is the vulnerability that it embeds that becomes problematic for women's autonomy. FGM programming is non-existent in Zimbabwe as type four is not acknowledged or regarded as a human rights issue. While a few studies on LE have been carried out in Zimbabwe, none focused on capturing empirical evidence, although they all established prevalence. A study by Afruca (2014) in the UK investigated Zimbabwean women's

experiences of LE as did Mutunami & Bradley (2022). In- country studies identified the Venda, Shona, Remba and the Shangani ethnic groups as populations where LE is commonly practised (Venganai, 2016; Mutanda & Rukondo, 2016). Mutunami and Bradley (2022) found that both Shona and Ndebele tribes practised LE. There are reports of type 3 FGM (infibulation) in the Remba ethnic group as reported by Orchid Project (2022). As stated in chapter 1, LE is a practice that is taught as part of the initiation rites of adolescent girls as they transition into womanhood (Bagnol & Mariano, 2012). Knowledge is transmitted orally, usually by older females (Bagnol & Mariano, 2008, p. 45; 2012) or a female relative such as a paternal aunt who would "prepare and sexualise the young girl's body, teaching her how to lengthen her labia minora" (Parikh, 2005, p. 131). My participants confirmed this with one noting:

> "The other phenomenon that's coming is labia elongation is not really taking place much in these institutionalised type of initiations there is the culture of urban aunts, culture of myths of sexual pleasures where women are pressurised into actually mutilating their genitals so we have urban aunts, we have these people doing videos circulating them of chinamwari (*initiation rite*) sexual gyrations where they teach women how to perform the sexual gyrations in bed and also how to elongate their labia and they are taught not necessarily in these formal camp types like the ones they have in Chiredzi, Mwenezi, Shangani and Remba speaking areas but they take place even informally" (ZTPP3, teacher, male).

Thereafter momentum to stretch the labia is sustained in peer group settings. Upon reaching puberty Venda girls go through three initiation schools, for example Vhusha, Tshikanda and Domba where older women facilitate the ceremonies (Jeannerat 1997). LE is taught and practised in lessons and the main purpose of the teachings is to prime girls for their future roles as caregivers and wives and also to acquire sexual knowledge- a prerequisite in marriage (Blacking, 1998). The curriculum prepares young women for marriage and are equipped with an understanding of respect, and young women associate initiation processes with these attributes. Lessons include sexual conduct and gendered roles including serving the husband (Mabuwa,1993). Malisha, Maharaj & Rogan (2008) discovered consistent ideals of subservience and respect in initiation teachings which clearly play a role in the HIV context. Shangani girls are instructed to submit to gender relations which are accepted culturally through songs and dance and these media facilitate subtle socialisation that determine what is deemed appropriate social behaviour (Mutanda & Rukondo, 2016).

Initiation includes teachings on death, marriage and puberty with emphasis on gender roles and

expectations on girls which conform to prevailing patriarchal social norms. During Khomba, girls are sensitised to these gendered roles which clearly outline the role of men as the controllers of their bodies which leaves women out of touch with their own sexuality in later life. Parikh (2005, p.132) argues that girls' sexuality is essentially manipulated in order to respond to male desires. This explains how women's safety is compromised (Mutanda & Rukondo, (2016) and limits their ability to negotiate safe sex (Bagnol & Mariano, 2012). Notions of subservience to husbands which are socialised during initiation rites perpetuate female oppression as girls grow up with an inferiority mindset. My participants in the advocacy category reported these views and one said:

> "the same thing that stops women from insisting on condoms or not allowing a man to beat her up it's the same deep indoctrination that makes her succumb to that kind of ritual of labia elongation (SAOGPP2, advocacy, female).

In the second phase, girls are taught about dry sex practices and multiple sexual partnering (Mutanda & Rukondo, 2016). Dry sex practice entails the insertion of dry herbs into a woman's vagina in order to tighten it. Girls are taught that men prefer tight vaginas during sex because of the increased friction and this can be achieved by inserting substances precoitus. Arguments that have been made which suggest that uterine cancer is caused by inserting substances into the vagina which may also result in the destruction of flora of the vagina paving the way for infections, including HIV or the risk of them (Bagnol & Mariano, 2008, p. 48). It has been established that women who insert substances in their vaginas for the purposes of tightening them had a 31% increased risk of HIV infection (Low et al, 2011). These results are also confirmed by Atashili et al, (2008) and van de Wijgert et al (2009) who evidenced that the disruption of vaginal flora through insertion of tightening substances increases women's risk of HIV infection.

During initiation rites, girls are also taught to be 'good' wives (Kambarami, 2006; Christiansen, 2013) whereas initiation rites for boys on the other hand focus on 'manly' issues such as bravery and inflated masculinities which prepare them for their future roles as fathers and husbands thus reinforcing male ideals in the patriarchal society (Markstrom, 2008). Snipes et al (2015) however posits that could be potentially useful because it would mean that once men assume superiority, then they can potentially make positive choices regarding issues such as theirs and their wives/partners' health. Incidentally, involving men in child and maternal health is a valuable strategy to promote health in low and middle- income contexts (Comrie-Thomson, 2020, p. 723).

Engaging men would likely increase health seeking and engagement with community- based practises thereby reducing morbidity and mortality (Tokhi et al. 2018). Audet et al (2017) found that women with elongated labia or planning to have it done were at higher odds of testing for HIV. Since this study involved participants who were either planning or choosing to elongate their labia, the validity of their empowerment and agency cannot be compared to girls who are made to elongate their labia as children.

5.1.3 Transitioning into womanhood

As a cultural rite of passage, LE determines the transition between childhood and womanhood and once achieved, girls are considered ready for marriage (Perez & Namulondo, 2011). LE transforms the body of a girl into womanhood, a process that is necessary to becoming a 'real' woman (Bagnol & Mariano, 2012). Alluding to the childhood/adulthood binary a participant from the development practitioner category narrated:

> "If the man likes a woman with elongated labia and the woman doesn't have elongated labia they can be told that they have juvenile private parts, private parts of a small child" (ZDPPP10, development practitioner, male).

This contrasts with boys who do not need to modify their bodies to attain manhood hence the expressions like 'becoming a woman' and 'being a man' (Bagnol & Mariano, 2012). For boys, the processes involve circumcision which brings the reality of manhood and a time when skills necessary to survive are acquired. This dynamic is crucial in understanding how power and gender intersect to determine health seeking and sexual behaviour (MacPhail, 2003). It contrasts with the teachings that boys receive where bravery and dominance is at the core of the curriculum (Malisha, Maharaj & Rogan, 2008, p. 591). It is mainly girls' bodies that should be subjected to permanent transformation on their bodies to conform to cultural criterion of femininity thus a child's body must transform in order that she becomes a woman (Bagnol & Mariano, 2012). This echoes de Beauvoir's assertion that "one is not born a woman, one becomes a woman" which infers that femininity is defined drawing on male norms that universalise men's bodies and manhood. Parikh found out that a common belief in Uganda was that if the labia are not elongated, "when you start to give birth the child sees that what is coming is a very open place and will be afraid to come out" (Parikh, 2005, p. 133).

LE forms part of the construction of the female identity where a woman with unelongated labia is "cold or even a man" while elongated labia "keep the vagina warm and support the

penis"(Aschwanden, 1982, p.77). LE is an initiation which is central in preparing for an erotic expression of sexuality which is believed to be increased by elongated labia. Women without elongated labia are stigmatised and labelled “cold woman” or as “men” (Aschwanden,1982, p. 77) which highlights the role of the practice in constructing a female identity orientated towards pleasing men. Bagnol argues that womanhood is achieved through labia elongation “as a woman without long labia is not a woman” (2003, p.11). Parikh explains that although sexuality is prepared primarily to fulfil male desire and pleasure, the girl’s desires are not ignored. LE is considered to increase a woman’s pleasure of masturbation and sexual desire.

Additionally, it provides sexual pleasure for both men and women (Aschwanden, 1982; Perez et al, 2014) as it enlarges the surface area for stimulating the clitoris. Furthermore, LE is believed to prepare the body for sexual activity and childbirth, and elongated labia are considered a doorway. For men, having sexual intercourse with a woman with unelongated labia is akin to “entering a house without a door” which emphasises that “the vagina needs a cover and present the image of a gate by associating both with modesty” (Parikh, 2005, p. 133). With LE the clitoris becomes more pronounced and protruded, and the lengthened clitoris is meant to hold and guide the penis into the vagina (Shoko, 2009). Similarly, the elongated labia are believed to hold the penis in place during sexual intercourse (Pérez, Bagnol, & Aznar, (2014).

Women are socialised to give prominence to their husbands’ desires at the expense of their own. LE is therefore practised as it is perceived to enhance sexual pleasure for their husbands. The absence of LE constitutes a reason for divorce. In their study in Shangani Mutanda & Rukondo (2016) found that LE is a prerequisite for marriage and men will demand it in order to keep women in subordination, and husbands can send a woman back to her family for not having elongated labia (Mubaiwa, 2020). Studies have also shown that having elongated labia does not guarantee a good marriage; there is evidence to suggest that men have extramarital relationships with women who have not elongated their labia even though their wives have elongated labia (Khau, 2009) and high divorce rates for women who have elongated their labia (Mutunami & Bradley, 2022; Bhebe, 2014). Venganai proposes that “the accentuation of male sexual pleasure rather than female sexual desire is connected with women performing particular versions of femininities constructed around making sexual sacrifices as wives and lovers” (Venganai, 2016). Her study found that women desire to please men sexually believing that the men would stay faithful and LE is cited as the tool to achieve this commitment from men (see also Bagnol & Mariano, 2012). It is within the confines of

this relationship context that domestic violence might be tolerated to 'save' one's marriage. Intrinsically, women's vulnerability to HIV could be exacerbated as the route of infection is ironically regarded as the pathway to maintain marriage- providing sexual intercourse whenever the husband demands it. Women are thus socialised to not refuse their husbands' demands for sex although this might expose them to further risk, particularly those women married to promiscuous men.

5.1.4 Impact of LE on girls' SRHRs

Initiation schools play a role in influencing sexual behaviour in young people which cannot be underestimated. Initiates are taught about sex and how to please their husbands sexually. It is taught that flexibility is expected during sexual intercourse and girls are taught how to gyrate (Shoko, 2009, Bagnol & Mariano, 2012). Mabuwa recalls that girls are asked to lie on their backs and support themselves by their hands and legs and "directly under her waist is placed some hot ashes, then she is asked to suspend herself so that she won't be burnt" (Mabuwa, 1993, p. 25). Sometimes a needle is used to prick the girl's waist whilst she is lying on her back by the facilitator at the camp to stimulate movements in the waist (Mabuwa 1993).

Participants in Malisha, Maharaj & Rogan's study (2008) reported that initiation schools encouraged them to engage in sexual activities of which some concomitantly regretted attending. Former attendees argued that they were sensitised to sexual activities which made them sexually active at a young age. Being taught about sexual intercourse at young age exposes children to sexual abuse (Tshugulu et al, 2023) and teenage pregnancies and sexually transmitted infections (Muzingili & Taruvinga, 2017). To explain the vulnerability which conflates with girls' agency an advocacy practitioner in the Beitbridge area said:

> "In terms of link about initiation schools' genital elongation with issues of HIV contractions, girls want to experiment and the guys give them the platform to experiment because they are young girls" (BBOGPP1, advocacy, female).

Initiation schools and adult relatives could be avenues for information and awareness of contraceptives in order to prevent pregnancy and sexually transmitted infections (Ndou-Mammbona & Mavhandu-Mudzusi, 2022) however the use of contraceptives by young unmarried girls is culturally unacceptable (Remez, Woog & Mhloyi, 2014; Ahinkorah et al, 2020), and premarital sex is considered promiscuous behaviour (Moyo & Rusinga, 2017). It is questionable whether initiation schools equip girls (and boys) for adulthood in terms of sexual and reproductive health. Facilitators at the schools argue that the curriculum is designed to 'prepare' pupils for

reproductive and sexual issues which will be encountered in adulthood. However, for the pivotal role they are assigned, the potential to address sexual health issues is strong yet they neither offer information on this issue nor are they willing to adapt to the changing landscape of sexually transmitted infections and other development issues such as child marriage and unwanted pregnancies. My participants in the focus groups confirmed that initiation school do not offer SRHR education but instead focus on fertility as the main purpose for sexual intercourse.

In the curriculum, ancestral knowledge is perceived as absolute and is monopolised over biomedical knowledge which presents a dilemma over battling emerging infections such as HIV in this context. In the initiation of Venda girls, elders interpret AIDS through ancestral knowledge as being rooted "in the build-up as being rooted in the build-up of pollution in female bodies that do not adhere to the rules laws of the initiation school" (McNeill, 2011, p. 75). For example, condom use is perceived as an absurdity due to the lubrication in condoms (Bagnol & Mariano, 2008). Malisha, Maharaj & Rogan (2008, p. 594) acknowledge the role of initiation schools in providing some form of sexual education but they nonetheless critique the curriculum's efficacy in reducing the risk of HIV. They argue instead that the schools serve to reinforce gender roles that prevent young people from negotiating safe sexual practices. In the next section I discuss the next stage that follows LE initiation and that is bride price.

Section 2

5.2.1 Contextualising Bride price

Bride price is cultural and underpins the gender ideology that reinforces women's inferiority and vulnerability (Moore, 2013) and renders them vulnerable to other forms of violence. In Zimbabwe it is highly regarded and cherished as the glue that binds families together upon marriage (Mubaiwa, 2020). It solemnises and formalises a marriage union before a man and a woman are legally registered as husband and wife upon payment, thus bride price validates customary marriages in many African contexts (Hague, Thiara & Turner, 2011). The groom pays bride price to the bridegroom's family and this transaction is viewed as a bilateral contract between the two families (Mubaiwa, 2020). Bride price typically involves paying or handing in money, cattle, goats, chicken or sheep but the nature of tokens varies depending on the groups practising it. The payment, whether in cash or kind, legitimises the union culturally (Oguli Oumo, 2004) and until bride price is

exchanged there is no recognition of the marriage (Dery & Akurugu, 2021) bride price is seen as an essential vehicle to stabilise a family union (Weigh, 2003). Vroklage suggested that bride price is "a compensation for the expense, the care and trouble spent on the bride's upbringing ...It is compensation for the complete loss of a worker as a bride withdraws from her own kindred and henceforth belongs to her husband" (1952, p. 135). Bride price is synonymous with patrilineal descent values, and is considered as "a compensation payment for the bride's future children, who will no longer belong to her parents' family" (Lowes & Nunn, 2017, p. 118). Bride price also gives sexual the bridegroom sexual rights over his bride (Vroklage, 1952; Bourdillon, 1982; Lowes & Nunn, 2017; Sikweyiya et al, 2020). After these transactions where she becomes a legitimate member of the family, "control over the woman is transferred from her agnatic kin to her husband's kin" after which she is "required to obtain permission from their 'owners' in all instances before taking any major decision (Akurugu et al, 2022, p. 11).

Although the colonial administration had contempt for the Zimbabwean matrimonial system they "entrenched customary law and the institution of lobola (bride price) as the sole legal regime under which Africans could marry" (Shenje-Peyton, 1999, p. 112). "While displaying African patriarchy, oppressive patriarchies of colonialism worked in complex ways to empower men and disadvantage African women" (Akurugu et al, 2022, p. 5). They saw bride price as a form of control over women that benefited their agenda. Firstly, men would migrate to the cities and engage in paid labour to afford bride price thereby sustaining capitalism. Secondly girls and women would be under the control of their fathers who would monitor their movements to ensure morality because of bride price prospects and later on under the control of their husbands, decreasing 'surplus women' that will otherwise engage in prostitution or lead rebellions against colonial rule (Schimdt, 2004; Jeater, 1993).

Missionaries equated African marriage with cattle, as commercial transactions, degrading women as mere chattels" (Murray, 1981, p. 126). In fact, bride price payment was practised in Zimbabwe long before the colonial era. Bride price was a communal collective, the groom's extended family were all involved in one way or another including assisting with provision of tokens that were given to the bride's family (Mubaiwa, 2020; May, 1983, Bourdillion, 1982). Parents also subsidised the groom's contribution thus a bride was accountable to the entire family because of their participation and contribution to the process. The payment of bride price also served to introduce the bride to her husband's ancestors as one who was coming to extend their lineage.

The advent of a cash economy introduced by the colonial administration changed the nature of bride price tokens into what we see today in exorbitant payments demanded by in-laws (Mubaiwa, 2020). The author argues that bride price has "become more commercial and its original meaning, which was as a symbol of appreciation and consensus between two families (of the bride and groom), seem to have been eroded or transformed to include payment of expensive financial and material resources. Thus, the practice is now seen as a means of acquiring material goods" (Mubaiwa, 2020, p. 42-43).

Bride price practice cuts across class with differentiations observed both in the amount and nature of the tokens presented. Its nature has also evolved alongside modernity and commercialisation and constitutes paying large amounts of money in excess of US$10 000, including buying brand new cars and furniture as demanded by in laws (Mubaiwa, 2020; Mangena & Ndlovu, 2013; Rudwick & Posel, 2014). Thus bride price *"*has become an element of the capitalist system that works to benefit men and that socially, politically and economically alienates women" (Chiweshe 2016, p. 1). The cultural shift towards materialism implicates women by having to resort to paying their own bride price or contribute towards it (Mubaiwa, 2020).

Bride price is largely legitimised for the purpose of kinship affirmation and its cultural value however its commercialised nature has eroded that sentiment. Bride price was originally intended to show an appreciation of the bride and to harmonise the two families coming together; instead, it is now characterised by a penchant demand for exorbitant materialistic resources (Mubaiwa, 2020). Modernisation and the increased social mobility have caused a major shift in items of what prospective bridal families can request. Recent trends show people asking for, in addition to the traditional tokens, electronics, furniture, cars and land titles as part of bride price. Because people can afford (through social mobility) to pay exorbitant amounts of money as bride price, it is now perceived as a showy class affair (Moore, 2013). Needless to say, expectations of these astronomical prices place unnecessary pressure on prospective grooms on low incomes.

Those who are rich will pay off the total amount the bride's family ask for but the general assumption and prevailing custom is that bride price will be paid off over time (Murray, 1981) and instance can outlive the marriage (Akurugu et al, 2022). Educated women and girls command higher bride price than those that are less educated (Gaspart & Platteau, 2007) because of the expected turnover to the groom's family. These authors however contend that the rationale for the higher fetching value is because highly educated women are in short supply therefore the higher

demand. Another rationale could also be that the bride's family would have spent more and for longer in her upkeep and education costs (Weigh, 2003). As a practice that has existed for a long time, one would assume the legitimacy of such a practice would become questionable but in the Zimbabwean context the opposite is true. Bride price has gained momentum and continue to do so over generations which evidences that it is considered highly valuable. Mubaiwa (2020) found strong support for bride price from both men and women albeit for varying and conflicting reasons. On the one hand his participants argued that bride price rendered women inferior and therefore not necessary while on the other hand they supported its continuation arguing that it was fundamental to their cultural identity.

Other female participants also argued that if a man paid bride price it showed that they were valued and loved, and male participants also concurred with this notion. Mubaiwa's participants placed huge emphasis on the importance of maintaining their cultural identity which underpinned bride price custom, and this leads to one questioning the post-colonial feminist narrative which argues against overemphasising culture to explain gender inequalities. Akurugu et al's study on bride price and women's autonomy in Ghana found that across the study areas men and women referred to women in marriage as "having been purchased, and thus being subordinate" (2022, p. 11). In some communities a breakdown of a marriage will lead a bride's family to return all bride price tokens to the groom's family (Lowes & Nunn, 2017) so it is upon the woman to ensure the marriage succeeds. This practice of bridal wealth returning is detrimental in that it might stop women from leaving unhappy and abusive marriages.

5.2.2 The gendered nature of bride price

Children that are born in a union where the groom does not pay bride price belong to the woman (Weigh, 2003). This could be a direct challenge for families that are patrilineal as it challenges notions of masculinity and manhood. These attributes are associated with fathering children where a man who possesses a large family gains more respect in the community (Elbedour, Bart & Hektner, 2003). Bride price impacts women's autonomy in several ways and has implications for gender inequity. Bride price is in itself highly gendered, and notions of masculinity are evident in the Zimbabwean context (Mubaiwa, 2020) as money and wealth in these transactions is associated with men while women are the commodities bought by that money. Lorber argues that bride price constitutes "an institution that establishes patterns of expectations for individuals,

orders the social processes of everyday life, is built into the major social organisation of society, such as the economy, ideology, family and politics and is also an entity in and of itself" (Lorber, 1999, p.1).

While men would engage in extramarital affairs, it would not be permissible for a married woman (Filamusi, 2012) particularly one whose bride price was paid (Bashai & Grossbard, 2008). Tamale (2009) concurs that through socialisation girls are encouraged to be 'good' girls and grow into 'good' women who are well mannered in order to fetch higher bride price amounts and men will pay more money for a bride who has been raised well. Socialisations that start during LE rites are reinforced before bride price payments that a woman ought to respect men, dress decently and never to upset their husband even when he misbehaves (Tamale, 2009). This process of socialisation reinforces gender stereotypes of what an ideal woman/bride looks like- thus perpetuating inequitable masculinities.

It is through such stereotypical views that African societies have developed customary practices, laws, and social structures that promote women's subordination (Musisi, 2002; Mama, 1996; Schmidt, 1991; Fidan & Bui, 2016). Bradley (2011) has evidenced a link between marriage practices and violence while looking at the impact of dowry in India. Owning women is part of the expression of hegemonic masculinity which also underpins violence. Bride price provides a realm for these stereotypes to be vented as I alluded in the previous chapter. Hegemonic masculinities and behaviours of male dominance over women are created and sustained by male assumptions that they 'own' women through bride price payment (Mubaiwa, 2020) and are entitled to their bodies (Bashai & Grossbard, 2008). Men would volitionally pay and in some instances overpay bride price to feed their masculine ego of feeling like a 'complete man' simply because they can afford to pay for a cost that they have been charged. Wealth is in this instance signified by the ability to afford huge bride price payment symbolises masculinity. Bride price therefore needs to be seen as a form of violence because of the way in which it reduces women to objects of male control which is abusive and leads to other forms of violence specifically HIV.

5.2.3 Bride price and sexuality

Greater significance is placed upon female virginity in bride price contexts in comparison with the male counterparts which here reveals double standards within patriarchal values (Palit & Allen, 2019; Museka & Machingura, 2014). Young men are free to engage in premarital sex without any implications for their social status. Bhana alludes this to the use of virginity as "an element of

normative patriarchal restrictions on women's sexuality" (Bhana, 2018). Thus, unequal gender relations are maintained by these normative values (Matswetu & Bhana, 2018). Patriarchal interests are served by female virginity which raises the future husband's status. Marrying a bride that has not engaged in premarital sex assures the groom of legitimate bloodline progeny which guarantees the continuation of patrilineage thus assurance that the heir biologically belongs to the husband. The assumption that girls who abstain from premarital sex will go on to maintain fidelity in marriage is also widely held in Zimbabwe (Venganai, 2016; Museka & Machingura, 2014). It is therefore necessary for girls to maintain virginity, a view which is reinforced in bride price transactions which can be inflated in cases where virginity is confirmed (Mabuwa, 1993) and men are willing to pay more for a virgin bride. Engaging in premarital sex is immoral (Chiweshe & Chiweshe, 2017), perceived as defiling, and a girl will not fetch much in bridal- wealth terms.

In addition, the loss of virginity brings dishonour to the family name (Filamusi, 2012; Idowu, 1996). This also came through strongly in the focus group discussions as my participants narrated experiences of the shame the girl and her family will experience if virginity had been lost before marriage. In Johane Marange Apostolic sect women who lose their virginity before marriage are required to bring virgins to their husbands in compensation (Vengeyi, 2016). These girls could be acquired from one's family members who are usually under- age girls from the same religious sect. This shows that patriarchal values will prevail at any cost and in the process devaluing women even further. In the next section I explore child marriage which is a practice also fueled by bridal wealth payments.

Section 3

5.3.1 Contextualising Child marriage

Child marriage, as with other harmful cultural practices is rooted in culture (UNICEF, 2022) which might limit the extent of opposition and intervention. Violence that rests under the category of culture, as with FGM, has been too easily ignored by wider development and gender rights programming. We therefore see an emergence of competing forces between those that project concepts of cultural rights (freedom to observe cultural practices) and those who see child marriage as a breach of the rights of the girl child (UNICEF, 2022). As with FGM, shifting how child marriage is perceived has been fundamental and organisations working to end child marriage argue that it must be framed as abuse. Societal reasons are cited for causing child marriage and these include deeply rooted social norms that support the practice (Plan International 2016; UNICEF, 2014). Poverty and its correlate of lower levels of education are to blame for most child

marriages (UNICEF, 2022) and school offers some form of protection against such situations like pregnancy (Umbro, 2021). Most girls who drop out of school do so because of teenage pregnancy.

In a Zimbabwean study investigating child marriage it was evidenced that nearly 50% of secondary school aged girls (15-19) without this level of education had become parents compared to one in five that had completed secondary school education (Sayi & Sbanda, 2018). Lower educational attainment is associated with child marriage and prevalence among richer people is lower than those in poorer wealth quintiles (Sayi & Sibanda, 2018). Similarly, girls in rural areas are most likely to marry young compared to their counterparts and the reasons for this are varied. However, in their study on child marriage in Zimbabwe, Sayi & Sibanda (2018) found that contrary to what was expected, "urban residence was not associated with significantly different odds of marrying by age 18 than rural residence" (p. 2382).

5.3.2 The gendered nature of child marriage

Contextualising gender discrimination, Adetunji (2001) concedes that girls experience it from birth as the birth of a girl child in African families is not celebrated with the same enthusiasm as that of a boy which marks a girl's fate in life. Furthermore, Olabode argues that "immediately a child is born, the question that will be posed will centre on sex, not minding of health of the mother. If the baby is a female, the mother will be scolded and treated as a lazy, good for nothing woman. On the other hand if the child is a male, praise will be showered on the mother, not considering the fact that biology has shown that it is the father who determines the sex of an offspring" (2009, p. 136). Some families due to discrimination still believe that educating a girl is wasting meagre resources that they would rather invest into educating boys. Families experiencing financial shocks can enter young girls into early marriages in expectation of bride price (Corno et al, 2016; Corno & Voena, 2016).

This narrative ran across my participant categories and a participant in the teachers' category commented:

> "if they have very few funds, they can just, they can just give the funds to the boy child and then leave the girl child to just be at home or to get married"
>
> (ZTPP2, teacher, female).

Preference for the boy child also means that girls are married off early when financial resources are limited. My participants confirmed this poverty dimension to child marriage. One participant in the

teachers' category said:

> "The cultural aspect of most people is gender biased, discrimination of the girl child, tends to involve the boy child, rather than the girl child" (ZTPP3, teacher, male).

In African contexts girls are discriminated because boys carry on the patrilineal name while girls get married and adopt their husband's name. Because of bride price payments the children born by a daughter belong to her husband (Bourdillion, 1976). Therefore a girl child will upon marriage benefit her marital family by providing labour and progeny while a boy child will remain in the natal home providing labour and progeny, possibly a male heir who will inherit the family name. Thus, "a male child populates the family while the female one depopulates it" (Familusi, 2012, p. 302) as she leaves her natal family to join her marital family. Additionally, educating a girl child will benefit her marital family financially through future earnings while her natal family lose money through that process. Thus in bride price negotiations, these factors are considered and the money charged for bride price will go towards compensating the bride's parents for raising her (Bourdillon, 1997; Mangena & Ndlovu, 2013). A participant from the advocacy practitioners in Beitbridge explained how poverty intersects with cultural norms and values that seem to legitimise and normalise child marriages including in cases of sexual violence. She explained:

> "You find a child who is sexually abused a parent will be like go where ever they are, you are now a wife to that person , it's just an issue of another parent seeing it as a burden being taken away from them, it's one mouth less to feed it's not their problem so a child is taken away and becomes a child wife so to say and we cover it up" (BBOGPP1, advocacy, female).

What this means is that family honour is important and a girl that is sexually defiled will bring dishonor to the family and therefore should be disposed to the perpetrator. We see here that poverty too, sustains child marriages. Recent studies have evidenced the presence of illegal gold panners throughout the country luring girls into marriage because of the quick turnover in their wages. This means that the panners maintain a constant flow of cash which attracts young impressionable girls who assume that they will lead better lives in terms of financial provision. Alluding to this claim a participant responded:

> "Statistics shows that girls fifteen to nineteen are the ones that are getting infected the most. Beitbridge being a very busy place with a high in-transit population the girls are exposed. The men flash money, they promise marriage and more and

then the girls fall for that and at the end of the day you have sexual intercourse taking place and contracting the disease*"* (BBOGPP1, advocacy, female).

This scenario showcases the aspiration to marriage for girls as young as 15 and how marriage is seen as the way out of poverty. Cultural values of purity mirror religious values (Ojo, 1997) and these elements play out in early and child marriage where young girls are required to maintain virginity therefore the way to sustain this value is by getting married.

Religious beliefs particularly of the Apostolic faith church in Zimbabwe also promote marriage for young people to avoid 'sinful' premarital sex (UNICEF, 2014). Ojo (1997) cites sectarian charismatic Christian religion as a means to control girls' sexuality by preaching holiness and purity modelled around abstinence. The prevalence of early and child marriages is high among the Johanne Marange Apostolic sect which boasts followers up to 1.2 million Zimbabweans. My data supported this claim and citing their school catchment area a participant from the teachers' cohort commented:

"The Mapostori Masowe (*religious sect*) shun sending a girl child to school. They may send her up to a primary level. If they are very poor, also they may withdraw her which leads to early marriages" (ZTPP3, teacher, male).

A crucial gendered dimension of missed education opportunities was raised in one of the interviews. A participant from the teachers' cohort narrated:

"Some of the religious practices in Zimbabwe encourage early child marriages these prophets will say I dreamt you to be my wife then maybe the child is around 12 years and the parents agree with that that their child is married at such a tender age, and they no longer come to school" (ZTPP1, teacher, female).

In contrast to multiple studies on child marriage in Zimbabwe, Sayi & Sibanda (2018) found that prevalence of child marriage is among girls with no religious backgrounds followed by those of the Apostolic Sect. Considering the small population of the religious sect mainly advocating child marriage against the Zimbabwean population as a whole would corroborate this finding. Religious norms present challenges for development and human rights programming. For example, young brides in the Johane Marange religious sects do not attend mainstream healthcare facilities for maternity services but instead access makeshift hospitals which are improvised by the church to

provide care for pregnant women. Because the sect does not believe in conventional modern medicine, maternal mortality risk is higher for pregnant women particularly those who are forced into early marriage (Machingura, 2011). The sect considers prayer and water portions (holy water) as a divine tool that can be employed to heal diseases and treat the sick (Machingura, 2014) Furthermore, women are not permitted to use any modern methods of contraception which leads to young brides bearing children earlier and also to bigger families in polygamous unions. Contraception is considered an evil plan that contravenes God's laws on reproduction which is modelled around big families similar to those in Biblical times Israel.

The sect believes that by giving birth a woman is naturally emptying contents from her spirit that consist of human souls therefore she would be depriving those souls an existence if she used contraceptives (Mutumwa, cited by Machingura, 2014). These teachings convey the message that feed into masculinity and contrive women's reproductive health rights. Machingura opines that women and girls are acquired by men to serve their sexual appetites (2011, p. 79). Literature supports this narrative that deifies these 'prophets' and" lift them to a higher level above the ordinary man and as such church members accord to such a person much respect" (Machingura, 2014, p. 187; Kachere, 2012). Therefore, the prophecy will not be questioned resulting in elderly men marrying minors. Religion as practised in the Johane Marange also facilitates polygamy as children are socialised to marry within their religion in order to preserve their holiness. In this way young girls become compliant and complicit in accepting their fate to enter forced, early and polygamous marriages (Machingura, 2014, p. 188).

5.3.3 Impact of child marriage

Child marriage is a human right abuse and reduces life attainment due to loss of education opportunities and compromises child development and increases the risk of domestic, sexual, and psychological violence including HIV infections (UNICEF, 2022). Girls who enter into early marriages are increasingly vulnerable to HIV infection because more often than not they marry partners who are much older than they are and the men also fall within the age groups with high prevalence of HIV (UNICEF, 2022; de Oliveira et al, 2017; Schaefer et al, 2017). Because of the power differentials they are not sufficiently empowered to exert their rights in meaningful ways. These power dynamics limit their capacity to negotiate safe sex, and neither are they able to exercise wider SRHRs (Koster, Bruinderink & Janssens, 2015; Chiweshe, 2014). Although acceptable culturally, child marriages amount to exploitation of children (UNICEF, 2022) and the social acceptance of the

practice does not eliminate the fact that girls are exposed to sexual abuse and exploitation usually by their parents or family. Entering into marriage early with little or no education, girls face reduced economic opportunities that compound their vulnerability to HIV transmission as they rely on their husbands for livelihoods (Machingura, 2014).

The psychological impact of early and child marriage on a girl cannot be underestimated. The lack of exposure to the outside environment that comes with early marriage means that girls develop low self- esteem which perpetuates their powerlessness and vulnerability to poverty (Machingura, 2014). The effects of child marriage also have wider impact upon a nation's development indicators including elevating population growth, lowering educational attainment, negatively affecting health infrastructure, and impact the demographic dividend (Sayi & Sibanda, 2018). Ueyama & Yamauchi (2009) also contribute to this debate and assert that earning losses and lost growth opportunities perpetuate intergenerational cycles of poverty, promote gender inequality, and lowers women' status. Barry (2005) concurs with these authors and asserts that child marriages perpetuate a cycle of limited life opportunities.

Barry posits that the offspring of young uneducated mothers cannot attain higher levels of education and therefore yield little financial benefits in their lifetime. Newly married women are under pressure to transition into their intended roles which is to produce offspring and this expectation is to be fulfilled within a year of marriage to prove their fertility (Chitereka & Nduna, 2010). Notwithstanding this expectation heightens the risk of maternal and child mortality including morbidity (Sayi & Sibanda, 2018) due to underdevelopment of the girl. This all comes as a result of the girl being considered a woman after transitioning from childhood through initiation rite of passage (Bagnol & Mariano, 2008). In the next section I discuss polygamy a practice into which girls that marry as children end up in.

Section 4

5.4.1 Contextualising Polygamy

Polygamy is rooted in the ancient history of Zimbabwean culture and tradition ((Thobejane & Takayindisa, 2014; Elbedour, Bart & Hektner, 2003; Gumani & Sodi, 2009) and is widely prevalent and tolerated in Zimbabwe. The practice is legalised under Marriages Act law however, an unregistered customary law marriage can also be polygamous. A marriage within this union is underpinned by the payment of bride price upon which a man and a woman become husband and

wife. In this instance a man is free to marry as many wives as he wants as long as he pays bride price which solemnises the marriage. Polygamy was mostly associated with rich individuals such as kings and chiefs because of the sizes of their families (Bourdillion,1976). It was traditionally practised to curb infidelity, address infertility, and also to respond to high mortality rates in ancient times (Gelfand, 1973). It was found to be honourable and regarded as a symbol of power if one had a large family. Producing many children through polygamy was "the guarantee of permanence to the community" (Kristeva 1986, p.140).

Individual choices coupled with cultural beliefs lead men to engage in polygamous marriages which disadvantages women in those unions (Thobejane & Takayindisa, 2014). At blame are patriarchal structures of power which promote the practice. The practice is credited for providing more labourers, particularly in subsistence economies. The plurality of wives was traditionally considered an economic benefit due to the increased labour force from additional wives and progeny (Boserup, 1970). This scenario encouraged wives to seek more wives for their husbands in order to lighten the burden of work. This is also thought to divert the husband's close control over the wife to other wives, freeing her in the process to pursue economic opportunities. Polygamy is encouraged and prevalent in Apostolic sect churches and is also culturally permitted amongst the Shona tribe (Machingura, 2011) where non- believers of the religion are referred to as pagans. Consequently, women are not allowed to marry outside of the sect thus they are practically led into polygamous marriages because the dating pool is reduced. It is within polygamous marriages that child marriages are often conducted (Machingura, 2011) in order to sustain not only the labour force but also uphold religious values.

Girls as young as eight are known to have been entered into polygamous marriages along three or four other wives (Machingura, 2011). Girls within polygamous families regularly go through vaginal examinations and are expected to pass the test. This is because virginity is highly valued not only amongst the apostolic church sects but also the Shona tribe (Thobejane &Takayindisa, 2014). Those girls who are found not to be virgins are then married off to married men while virgins are reserved for single men (Machingura, 2011). Similarly, the birth of girls in polygamous marriages ensures streams of income through bride price paid for the daughters (Thobejane & Takayindisa, 2014). Thus, in order to ensure maximum benefit from bride price, girls are entered into early and polygamous marriages. Children are regarded as an important part of family and polygynous families regard fertility highly which means that women are under pressure to produce more children (Rice, 2000). In the same light if a woman has a low sex drive, barren or cannot bear children, specifically a boy, then the husband is obliged to marry another wife (Rice 2000; Baloyi, 2013). Failure to

produce a son equally results in a man marrying another wife or subsequent wives until a son is finally born to him (Gwirayi, 2017). This is as a result of the patrilineal nature of the Zimbabwean communities that practice polygamy that views sons born into the families as a surety of the continuity of the family name.

If the first wife does not bear a son her status in the line of wives which up until this time would have been high is lowered if the second wife bears a son. Sons are perceived to not only carry forth the family's name but also care for their parents in old age (Gelfand, 1973). Mawere and Mawere (2010) argue that through a son, the connection between the living and the dead ancestors is maintained through the shared family name for without a son to carry the family name, the genealogy which is closely associated with identity will cease. This perception places much value on male children and subsequently men in general through cultural emancipation (Rice, 2000).

Compliance with polygamy in Zimbabwe ensures conformity to culture for women and shields them from social discrimination (Rodriques, 2007). Issues of inheritance upon a men's death mean that is wife/wives is 'forced' to marry or be 'inherited' by his living brothers whether the brother is already married or not. The brother will also inherit their late brother's wealth including land thus the woman/women are owned by the late husband's brother. Refusal to remarry in this situation can amount to being chased away from the family and being separated from her children. Thus, women could be forced into polygamous situations to avoid the predicament. If the late brother was a wealthy man, the more reason his male relative would have to inherit the wife in order for the wealth to remain in the family. Barrenness in polygamy is perceived as witchcraft and charges of infertility would be brought against women in the Johane Marange Apostolic sect (Mukonyora, 2007). Women who fail to bear children might suggest their husband marry another woman for fear of being asked to return bride price (Machingura, 2011). Alternatively, women could opt to bring their niece (brother's daughter) or their younger sister to marry their husband and bear children for him; women who had no fertility issues could still do this in order to keep the man in the family and if he were particularly wealthy, then the wealth remained in the wife's family alone.

5.4.2 Impact of polygamy

Earlier studies evidenced that women in polygamous marriages may develop mental health illnesses (Ozkan et al., 2006). Furthermore, domestic violence is likely to be more prevalent in polygamous marriages than monogamous unions (Ashimi & Amole, 2015; Ali, Yassin, & Omer, 2014). Studies conducted by Hassouneh-Phillips (2001); Ahinkorah, (2021); Jansen & Agadjarian,

(2020) and Heath, Hidrobo & Roy (2020) evidenced severe IPV in women in polygamous marriages however Thobejane &Takayindisa (2014) argue that not all polygamous marriages are abusive. In separate studies Rehman (2011) & D'Amour & Carmichael (2004) found support and contentment amongst co-wives while Chambers (1997) found that women would welcome another wife for their husbands. Reasons for this support included companionship and love within polygamous families. These findings lead to Solomon (2003) and Palmerr & Perrin (2004) questioning the perceived harm in polygamous marriages although there is acknowledgement of possible adverse effects of polygamy to children through rivalries amongst co-wives.

Polygamous wives always have quarrels, and their households are fraught with jealousies, rivalry, and hatred (Gwirayi, 2017). Contrasting the supposedly trust and love within polygamous families, children from these unions lack the scope to develop varied beliefs and exposure to different aspects of life apart from those that form the basis of their families because of stringent patriarchal control. This instils polygamous beliefs in them and propel them to marry into polygamous families in turn creating generational cycles of polygamous relationships. Children from polygamous families are also thought to be associated with low educational attainment, bitterness and neglect (Al-Krenawi & Slomin- Nevo, & Graham, 2006; Al-Sharfi, Pfeffer, & Miller, 2015), which in the grand scheme of things, perpetuates the cycle of poverty. Polygamous households are also usually large, and this might impact on the reach of resources per head thereby creating lack and consequently poverty. One can argue that if a man does not have enough resources, they cannot afford to provide for multiple wives which means that women will not only be treated unequally but will also not be adequately provided for.

Polygamy presents opportunities for discrimination and unequal treatment by husbands which can be attributed to the gendered and patriarchal nature of the Zimbabwean society. For example, women's sexual and reproductive health rights in apostolic sects are severely infringed and contraception is strictly forbidden (Bishau, 2010). This stance exposes women to HIV transmission and AIDS and prohibits them to exercise their sexual and reproductive health rights (Machingura, 2011). The DHS (2015) established that more those in polygamous marriages were living with HIV compared to 16% in monogamous relationships (Govt of Zimbabwe, 2015). Citing this indiscriminate aspect of the practice in HIV vulnerability one of my participants claimed:

> "One thing which we learned with HIV infection from some of our dialogues is that men still practise polygamy and according to men he doesn't need to get tested because his wives get tested its part of ignorance and part of the arrogance"

(SAOGPP2, advocacy, female).

However, Higgins, Fenrich & Tanzer, (2006) found that polygamy was used as a mechanism to curb promiscuity among husbands in order to prevent HIV infections. This is because sexual activity is limited to the participants within that union however this depends on whether the family was free from HIV to begin with and also whether the husband would not seek additional wives. Cultural nuances in the way polygamy is practised due to modernity cannot be underestimated. A new form of polygamy has emerged in Zimbabwe that is modelled against traditional polygamy. 'Small houses,' is an arrangement that sees men have rights over a sexual partner similar to those they have for their traditional or civil wife sans the burden of paying bride price. The unmarried woman from the small house expects provision from her 'husband' and provides sexual services similar to those provided by the wife. This arrangement might entail bearing children for the man however sexual exclusivity between such relationships is questionable as the 'husband' lives with his 'legitimate' family most of the time (Mutseta, 2016).

This means that the man is at liberty to have other partners while he expects the 'wife' from the small house to be faithful to him. Another example of gender inequity in multiple partnering relationships is polyandry. This is a practice where a woman is married to two or more men and polyandry has faced resistance in African societies that have normalised polygamy (Montle, 2021). This reveals indiscriminate ways in which patriarchy policies women's bodies and limits their agency to self -determination over sexual matters while men indulge their sexual desires. It also lays bare the double standards that operate to normalise a cultural convention that privileges men over women. However, polygamy continues to be contentious in both social and religious contexts (Machingura, 2011). In the next section I explore how LE, child marriage, bride price and polygamy can be explained within the ecology model with the view to understand implications for interventions.

Section 5 The ecology of HCPs

5.5.1 Marriage in the ecology model

Marriage is a societal norm, that girls are socialised to aspire to for a relationship to be acknowledged (Pauli & van Dijk, 2016). Within Zimbabwean culture is the belief that a man is not complete without a woman and vice versa (Mubaiwa, 2020). This belief also chimes with the Christian teaching that a man is incomplete without a woman (Holy Bible, 1611) and considered

"unholy if they do not marry" (Dery, 2015, p. 35) therefore we see cultural and religious formative ideals that support and essentialise marriage. Women are portrayed as "healers of wounded marriages" (Nadar & Potgieter, 2010, p. 151) and such socialisations serve to expose women to the risk of HIV infection in unions where men engage in risky sexual behaviours (Gwatimba et al, 2020; Seidu et al, 2021. However, women's performance of this normalised womanhood corresponds to their formative socialisation and thus legitimates the sexual inequality between men and women (Khau, 2009).

Social and cultural values then define sexual relationships, the kind of partners one will have and accord men autonomy and "possibility of varying their partners than women" (Bagnol & Mariano, 2012, p. 44). Women get sustenance through seduction and by holding on to the man through practices such as LE. However, in this cultural matrix, men feel socially obliged to take multiple partners under a gendered cultural environment that supports it. In Zimbabwe engaging in sexual activities, and bearing progeny outside of marriage is condemned (Remez, Woog & Mhloyi, 2014) while the use of contraceptives outside of marriage is simultaneously looked down upon and considered promiscuous (Matswetu & Bhana, 2018). Pregnancy resulting from premarital sex often leads to forced marriage for both partners (Matswetu & Bhana, 2018). Policing women and girls' bodies in this way ensures that girls are `best positioned for marriage as marriage would be the only viable option to have sexual intercourse and bear progeny.

5.5.2 LE in the ecology model

LE confers honour and gender identity on a woman and through it she gains respect from not only her spouse but also the community (Perez, Bagnol & Aznar, 2014). On the one hand, the majority of women having been made into a proper and powerful woman and empowered through initiation for marriage purposes, are assumed to be able to elicit change in their lives. However, girls are advised at Komba to maintain family secrets (Shoko, 2009) which aids their socialisation into a culture of silence which protects ongoing gendered abuse and violence which increases girls' vulnerability to more violence. Abuse that takes place within a marriage is regarded as a family secret which feeds into non-disclosure of violence. Notions of family honour and its protections are centred around keeping such secrets and this view is embedded in the wider society. Honour defines society and patriarchy is obsessed with ideals of honour. In contexts where FGM types 1-3 are practised a family's honour is upheld when the unmarried female members are chaste (pure) and have undergone FGM (Bhanbhro et al, 2016; Gill & Walker, 2020). Although marriage confers honour and status on women (Kambarami, 2006; Barnes, 1999) it can be the domain of violence

and the source of practices such as LE, child marriage, bride price, polygamy and HIV. Honour is highly regarded in Zimbabwe and the extent to which men go to protect it was elaborated by my participants. A female nurse opined:

> "Some men are very oppressive to the extent that they do not allow their wives to go and collect their HIV medication because they are afraid of their image. They would rather have full blown AIDS than have people know that they have HIV" (ZNPP1, nurse, female).

5.5.3 Bride price in the ecology model

Cementing marriage is bride price payment, a scenario where tradition has been turned into a commercial enterprise (Chiweshe, 2016) with grave consequences for women and girls' autonomy. When marriages are conducted in Zimbabwe, both bride and groom's extended families are informed and gathered for the procedures (Mubaiwa, 2020). Traditionally the extended family contributed towards the tokens which bonded not only extended families but the entire community and this in turn bonded and defined society. It is against this background that bride price and marriage are societal preoccupations in Zimbabwe even today. Dery contends that "marriage is a union between two families and not two individuals (2015, p. 15). Rather than bring together the individual couple the payment of bride price also unites their family and the wider community. As such it is made up of a wider network of actors and the homogeneity of family in this context will impact the process of decision making concerning the couple's wellbeing. This was evidenced by my participants in the focus groups that a woman's agency to access healthcare services is also policed by her in-laws. Participants in the focus groups noted how a woman would need the permission of her in-laws to attend healthcare facilities if her husband was away from home.

This also came out strong in discussions with development practitioners and advocacy categories. The Zimbabwean society is patrilineal and as such bride price secures recognition, dignity and respect for both herself and her children (Akurugu et al, 2021; Anderson, 2007). The loss of this status upon divorce would impact not just herself but her children, her family and that of the marital family. The role of the family and community in supporting and sustaining marriages should therefore not be overlooked considering the "complex network of relations that characterises marriage" in African settings" (Akurugu et al, 2022, p. 6). Because a bride marries into a family, negotiating exit terms will be difficult to navigate because one will have to go through the barriers of the husband's immediate and extended family and her own to put across their argument.

5.5.4 Polygamy and child marriage in the ecology model

Child marriages show patriarchies oppressing women and constraining agency and autonomy (Akurugu et al, 2022). Cases where children are entered into polygamous relationships and child marriage in general are not reported which means that offenders continue to abuse girls and women. This is in conformity with the culture that protects men and the normalisation of such practices. This not only impacts on the girl's physical and psychological development but also increases the risk of exposure to HIV transmission and increases rates of maternal mortality due to child marriages and early teenage pregnancies (Machingura, 2011). The Zimbabwean traditional patriarchy chimes well with biblical patriarchy (Togarasei, 2020). Culture and religion both prescribe forms of control which are mutually inclusive. Among the Shona tribe, "children (are) to be subservient to parents and elders. Listening and obedience lead the list of desirable qualities in a child" (Museka & Machingura, 2014, p. 131). Loyalty is demanded, particularly to the father (Togarasei, 2020). In Zimbabwean culture, children are not allowed to question their parents and "the word of the parent (especially that of the father) is an authority in itself" (Togarasei, 2020, p.218).

In their defense of the polygamous marriages, Christian sects cite the Bible as underpinning their beliefs. The main argument which sustains the treatment of women is based upon the bible instruction on women to be submissive to their husbands (King James Version Bible, 1611, Ephesians 5: verse 22). Similarly, the bible also instructs children to obey their parents (Colossians 3: verse 20; Ephesians 6: verse 1). In Christianity the Bible is considered the absolute word of God that speaks to every event in their everyday life, thus the Bible's principles are unquestioned (Adamo, 2015; Nthaburi & Waruta, 1997). Religious institutions are therefore other actors that sanction gender discrimination in the ecology of violence. In the next section I move on to discuss some of the challenges with legislating against HCPs with a focus on implications for agency.

Section 6

5.6.1 Legislating Cultural Practices: The Challenges

Zimbabwean feminists have campaigned and petitioned the government against bride price arguing that it promotes gender inequality and needs to be abolished. Their contention was that bride price reduced women to commodities owned by husbands, thereby making them vulnerable to violence. The Zimbabwean government developed national instruments to outlaw and criminalise child marriage; the Constitutional Court Zimbabwe (Govt of Zimbabwe, 2015a) and South African

Law Reform Commission respectively. The Convention on the Rights of the Child [CRC, Article 3] (UN,1989), Sustainable Development: Goal 5, Target 5.3 (UN, 2015), and the African Charter on the Rights and Welfare of the Child (AU,1999) all prohibit child marriage. Similarly, the UN Human Rights Committee (UN, 2005), and CEDAW (1979, Article 16) advocates against bride price and polygamy respectively. Zimbabwe and South Africa are signatory to these instruments however the realisation of the efforts depends on robust policy implementation and enforcement beyond political will.

Furthermore, legislating against these practices is contrary to religious and customary norms therefore any action to address these issues will be deemed contentious. The Zimbabwean government enacted the Domestic Violence Act in 2006 as a provision against violence (Govt of Zimbabwe, 2006). However, seeming to condone human rights violations are unresponsive legal frameworks and family decisions to be implicitly silent over these issues (Goosen & Klugman, 1996; Van Dyk, 2003). The newly passed Marriages Amendment Bill (Govt of Zimbabwe, 2022) makes it mandatory for bride price to be paid under the provisions of the customary marriage. The bill gives marriage officers power to ascertain whether the transactions have been made before a marriage union can takes place. The Marriages Amendment Bill was highly advocated for by traditional chiefs who argued that bride price constitutes the hallmark of marriage under Zimbabwean culture and abandoning it would constitute undermining cultural values. Chiefs and traditional leaders were consequently ordained as marriage officers.

Although legislation against violence exists in Zimbabwe women continue to experience the phenomenon (Chuma & Chazovachii, 2012) and endure violence in marriages in order to avoid divorce which is frowned upon and prohibited in the Bible (1611). Zimbabwe's cohabiting unions are termed marriages including affairs which brings elements of ownership over the girlfriends. Adjei (2017) states that patriarchy manifests in marital relationships and bride price underscores women's subordination therefore reinforcing the idea of ownership including women's sexuality and labour. Women that cohabit with men that have not paid bride price, are regarded as 'wives' and are 'owned' by their partners because culture generally regard women as inferior to men and will experience the same abuse as those in marriages. Thus, women still endure violence despite the absence of bride price payment as men feel inferior when they cannot afford to pay it. Some Zimbabwean men secure bank loans in order to settle bride price bills (Mubaiwa, 2020) which increases marital tensions and violence from the financial burden brought on by debt.

There is no consistence between the provisions of the Customary Marriage Act and the Domestic Violence Act with the new Constitution in Zimbabwe to protect girls against child marriage. Children's rights legislation does not align with the Constitution and the provisions are also vague for example, customary marriage law does not specify the age of marriage or the age at which girls can consent to sex as consent is sought from the girl's guardian. The government could be applauded for prohibiting the expulsion from schools, girls who fell pregnant in an effort to address gender inequalities (Govt of Zimbabwe, 2020). The tensions between tradition/customary law and secular laws also function as a barrier in trying to challenge the normalisation of violence that often leads to HIV transmission. For example, customary law legitimises practices such as polygamy which justifies extramarital relations and considers IPV an intimate matter that should be discussed within families thus failing to condemn GBV. The spectrum of violence covered by law and interventions is narrow and leaves out many HCPs such as LE and bride price. The government of Zimbabwe has legislated against FGM but this does not include LE because it does not involve cutting or removing parts of female genitalia which is how 'FGM' is commonly referred. As such, the underlying reasons for women and girls' vulnerabilities are not tackled. What we are seeing is an epistemological advance where laws are concerned; we have imaginations of how gender equality could be and how it is modelled and how it could be enacted however on the other hand we seem to have political influences moving against it and violating the progress that has been made in women's quest for equality.

5.6.2 Implications for agency

Women and girls are limited in how they can exercise agency because essentially, one can only exercise the agency that their immediate environment supports. If you are caught up in a very conservative family, you might have learnt about the concept of empowerment and agency but ultimately, if you live in a place where you cannot choose but got no option but to obey what your father or your husband instruct you might will the situation to be different and search for ways of resisting but ultimately, the limit will still exist. Kabeer (1995) writes about the limit of agency, how agency and empowerment are all highly contextualised concepts. The women that you that I have spent time with at community level indicated that there is a limit to what life pathways are open to them. There's a limit to the resources that they have available to them and the limit are the gendered patriarchal structures and the unsupportive environment. I do not deny that women have agency but that their agency will be quite distinct and shaped by the environment that they exist in.

Research in humans has revealed that “women’s strategies are often constrained by the forceful and manipulative behaviour of men” (Akurugu et al, 2022, p. 3) and their autonomy and agency is restricted within marriage because of men’s role and that of their kinsmen. Bride price accords social status in patrilineal societies (Dery & Bawa, 2019) and although it arguably normalises violence, constrains autonomy and brings women into subordinate social positions Akurugu et al (2021) argue against its abolishment as women’s gains in this respect will be lost. Not to mention their own legitimacy in the marital family, their children’s will also be simultaneously lost. Men are also known to oppose the abolition of bride price because they will lose the avenue to deriving patriarchal dividends that enable them to oppress women. We see here the interdependence of multiple characters in sustaining the institution by solving problems communally which in itself limits one from exercising agency. Explaining the complexities of family dynamics in decision making processes a participant noted:

> “The way our families are structured it’s not an individual choice. It’s actually a choice that is affected by family, the kind of family dynamics” (ZDPPP7, development practitioner, male).

Similarly, drawing back on Masvawure’s study (2013) as discussed previously, essentially as university students her participants had the opportunity to flourish in a different environment where they could exercise agency over their sexuality. It meant that they were able to express their agency differently compared to how they might have expressed it if they had not moved away from home. In this way agency itself is something that is culturally, socially, politically and economically constructed, and it will not look the same. Children’s agency too will be limited where the family decides to marry them off to ease financial burden whether into a polygamous or monogamous marriage. Similarly, LE as a social convention will be fed into their subconscious with limited agency to resist it because that will be going against cultural prescriptions ((Museka & Machingura 2014; Togarasei, 2020). Because unquestionable subservience is expected for both women and girls in patriarchal and religious prescriptions (Adamo, 2015), the scope to exercise agency is limited.

Conclusion

In this chapter I laid out the different cultural and traditional practices and gender norms that prevail in Zimbabwe and used available literature to frame my analysis. I went further and demonstrated how LE, child marriage, bride price and polygamy link with social, cultural and

religious norms to compound women and girl's vulnerabilities exposing them to HIV transmission**.** The practices set women up for inequalities in marriages as they reinforce patriarchal structures which advocate for the commodification and control of women (Fidan & Bui, 2016) thereby increasing their vulnerability to further violence. Having analysed the practices, the question ensues that what makes a revered cultural practice harmful? When a practice commodifies a girl or woman and projects a sense that she is owned, rendering her vulnerable to other forms of abuse and violence, that constitutes harm. The practices I have reviewed here conform to that conceptualisation. These practices reduce the gains that have been made in women's empowerment and the attainment of gender equality. Bride price, child marriage, and polygamy all seem to label a girl as 'owned' by her husband upon marriage. The argument must be made though that not all initiation rites are harmful. Some are presented as being quite empowering and positive and reinforcing agency. Researchers take nuanced viewpoints of initiation rites with some seeing them as an important moment in a woman's life, as her identity, and something worth celebrating (Bagnol & Mariano, 2008).

Unequitable gendered constructs of masculinity increase women's vulnerability to different forms of violence and are fueled by patriarchy (Al, wazedi et al, 2021). During initiation, girls are prepared for marriage and notwithstanding the violence they may encounter, they are socialised to endure it. The whole essence for the teachings is to uphold one's marriage no matter what and so to forfeit a marriage signifies failure in one's role in life. Having been primed for marriage, one has to live out the script of the teachings. This challenges the moral position of the initiation teachings as the landscape has changed because of modern infections such as HIV and AIDS meaning that a change is necessary for the curriculum to incorporate the risk posed by HIV (McNeill, 2011). Polygamy sanctions male control and authority over wealth and decision making. The normalisation of practices like child marriage, polygamy and bride price is problematic because it essentially reinforces ideas of female inferiority.

When viewed through a feminist lens, one could argue that LE, child marriage, polygamy, and bride price constitute harmful practices. Bride Price feeds into misogynistic patriarchal perceptions of women. Arguing through a post-colonial feminist lens, I concur that the practices I have discussed in this chapter have negative implications for women and girls. LE sexualises children and instils inferiority complexities in later life. It takes decision making capacity away from as early as childhood during initiation rites where subservience is taught. Bride price commodifies women and

renders them inferior not only to their husbands but to every other male in their families (Lowes & Nunn, 2017). Child marriage and polygamy hamper child development and severely reduce life opportunities and attainment. All of these practices combine to create a repertoire of sexual vulnerabilities for women and girls which ultimately lead to HIV infection.

Whilst culture may be a strong influencing factor these practices should not be reduced to 'cultural' but seen as violence against girls. Ecologising the linkages I also showed how the practices are sustained at different levels, which has implications for women and girls' autonomy to exercise agency. Unresponsive legal frameworks further compound the women and girls' vulnerability to further violence. The legal framework in Zimbabwe is not particularly responsive to the insecure status of women and girls affected by the practices and fails to provide robust safety networks. This makes the cultural environment unsupportive to women and girls' needs for emancipation. In the next chapter I present data from the nurses, development, and advocacy categories which helped me to understand my participants' perception of the links between these forms of violence that I have discussed. Capturing their views on the linkages of violence will enable me to critique whether programming is addressing the issues and the extent to which all issues are covered in interventions.

Chapter 6

Understanding the links between Labia elongation, child marriage, bride price, polygamy and HIV: The evidence

Introduction

In the previous chapter I outlined labia elongation, child marriage, bride price, and polygamy as HCPs that render women inferior to men legitimising male authority and the use of violence. I articulated how these practices themselves are forms of violence and showed how they lead to other forms of violence such as HIV infection. I explored the link between these cultural practices and social, gender and religious norms. In particular I sought to understand how they reinforce each other resulting in deeply embedded vulnerabilities for women and girls through marriage. I laid the foundation for recognising the links between the different practices which, I argue should be acknowledged and responded to integrally in programming. While I argue that LE, child marriage, bride price, polygamy and HIV infection are linked, in this chapter I take my argument further and use data from my participants to explore the linkages more. I included this chapter to enable me to analyse whether HIV and GBV programming meets women and girls' needs that my participants identify here.

I draw on their responses to establish whether they understand the interconnectedness of these forms of violence with HIV infection. Additionally, the chapter looks at the responses around conceptions of vulnerability and association with religious, gender and social norms as understood by my participants. Furthermore, I explore the impact of gender in programming to understand the extent to which interventions are responsive to the gendered dimensions of HIV and vulnerability. The categories of participants I allude to in this chapter were not interviewed for their own experiences but for their understanding from working with women, how forms of violence are linked. It was critical for me to understand how they perceived vulnerability and the influence that gender has on women and girls' vulnerability. The chapter is laid out as follows:

Section 1 details my responses on whether or not LE, child marriage, bride price, polygamy and HIV infection are linked. Section 2 explores women and girls' vulnerability to HIV and I discuss my participants' responses across the categories to understand its causation. I go on in section 3 to explore the gendered dimensions of HIV transmission and the section is followed by a conclusion to

the chapter.

Section 1

6.1. Links between LE, child marriage, bride price, polygamy and HIV

To generate responses in my bid to understand whether links exist between different forms of violence I asked my participants the question: '**Do you any see links between LE, child marriage, bride price, polygamy and HIV?'** Responses were varied and most participants articulated responses that encapsulated cultural, biological, and social factors. While it was evident that my participants identified links between IPV and HIV, they could not associate LE, child marriage, bride price, polygamy with HIV in the broader sense. Furthermore, there was not much evidence from my participants that LE and bride price is harmful. It is from this strand of argument that responses sought to isolate LE from HIV and violence against women in general. Participants in the nurses' category acknowledged links between HIV, child marriage, and LE.

This evidences that practitioners who work with women and girls at grassroots level understand how violence is linked. Responses from development practitioners however present a rather different picture. Their views diverged mainly by gender and ethnicity. Top level development practitioners, mainly female participants were the least likely to recognise links between HCPs and HIV. A few participants in this category were able to link child marriage to LE socialisations. The level of seniority reinforced perception that issues of violence are isolated problems. Those participants that could identify the links and articulate them were also able to link them to cultural norms and the entailing socialisation processes. Those participants that acknowledged links drew on biological perspectives of cuts to the labia during elongation and exposure to HIV.

The lack of baseline data on LE in Zimbabwe is problematic and challenging in many ways. On the one hand it is not recognised as FGM and therefore not a form of VAWG while on the other it is upheld as a harmless rite of passage for girls and women. My participants reported isolated violence linked to men demanding their partners elongate labia. Participants in the development practitioner category also mentioned that they have established through empirical data, a link between IPV and HIV and that evidence does not support a link with LE or bride price. The link was associated based on women's reduced capacity to negotiate for safe sex because of financial and material insecurity (Jewkes & Morrell, 2010). The most identified link that my participants attributed LE to HIV is in circumstances where husbands engage in extramarital sexual relationships because their wives do not have elongated labia; that narrative ran throughout the

interviews.

6.1.1 Social norms' influence on link perception

In linking social norms with violence and HIV responses from male participants were ambivalent however female participants substantively dismissed the possibility of links between HCPs and HIV. A female participant responded:

> "Ah no no, maybe domestic violence and HIV. I know it (labia elongation) is a tradition which was started way back as an intervention which enhances sexual enjoyment for the woman and so I don't see a link" (ZDPPP6, development practitioner female).

Here LE is justified as a tool for the enhancement for eroticism for women and therefore cannot be conceptualized or associated with harm. This view expressed by a female practitioner reveals that women may not necessarily consider LE as harmful and this was evident in most responses from female participants in the development practitioner category. The impact on childhood socialisations of social and gender norms can also be observed in such narratives that challenging these perceptions will be running counter to cherished cultural traditions and conventions. Most female participants also reported that LE is a source of sexual pleasure for them and that they cherished the practice. While showing support for LE and acknowledging the need for safe sex education, a participant argued:

> "It's not a taboo subject for the girls, it's something that they have learnt from discussing sexuality and being encouraged to do. With FGM there is no discussion of anything, its trauma. Now we are saying this elongation is dangerous that I am being encouraged to start sex, in that way maybe, I am almost convinced that sexual debut is earlier, they are still not experienced, there has to be this [sexuality education] information. My question is, is it measurable?" (ZDPPP11, development practitioner, female).

In acknowledgement of young people's sexual activity and the need to provide them with sexuality education, a practitioner equates initiation school socialisations with early sexual debut therefore their argument is that either way young girls are going to end up sexually active. This statement deviates from cultural and patriarchal scripts of sexuality that refuse to acknowledge that young people are engaging in premarital sex (Chiweshe & Chiweshe, 2017).

6.1.2 Gender norms' influence on link perception

Gendered socialisations reinforce values that objectify women's bodies (Bareket & Shnabel 2019) and inform qualities in a girl that is considered 'wife material.' A participant explained:

> "imagine someone who grew up being told that this is what men want and you get married to someone who does not have those where can you put them? and you are being constantly told that your vagina is ugly you know…so that's also domestic violence" (ZNPP3, nurse, female).

This quote reveals that LE carries connotations of aestheticism which means that concepts of beauty are modelled around it. However, Mutunami & Bradley (2022) and Khau (2013) found that women that elongated their labia in childhood faced insecurities with body image due to the extreme lengths they achieved. Women are thus judged from the appearance of their genitals and objectified in the process. Bareket & Shnabel found that men's social dominance orientation correlated with their tendency to sexually objectify women (2019, p. 28). Through patriarchal arrangements women and girls' bodies become objectified and commoditised for men's pleasure (MacKinnon, 1987). By sexually objectifying women, men present and judge women according to the appearance of their sexual organs and their bodily functions disregarding their subjectivity and personality (Bareket & Shnabel, 2019; Langton, 2009). Women's objectification has been theorised in feminist discourses to reflect gendered hierarchies where the dominated group is subordinate to the dominant group (MacKinnon, 1987; Dworkin, 1974; Jeffreys, 2005), and the promotion of women's subjugation and derogating their value reinforces those hierarchies (Bareket & Shnabel, 2019). Furthermore, being objectified forces women into submissive roles which justifies the existing gender order (Calogero, 2013) and promotes male hegemonic beliefs (Wright & Tokunaga, 2013).

6.1.3 Understanding context

Alluding to the absence of baseline evidence on LE a development practitioner argued that there was not evidence to suggest that LE drove HIV infection. They drew on biological explanation for transmissibility therefore no links could be observed.

Most participants also argued that LE is not FGM and one participant said:

> "FGM is not very common in Zimbabwe. I know it's common in West Africa and some other places, but I know that labia elongation is a very common practice here so FGM has not been explored enough in Zimbabwe" (ZOGPP2, advocacy,

male).

The statements highlight that within advocacy and activism in Zimbabwe, LE is not regarded as FGM that is considered a practice peculiar to certain regions. What this means is that the harm it causes in terms of embedding an inferiority complex in childhood is ignored over cultural aspirations to marriage where patriarchal values and religious norms are reinforced to keep women subordinate as inferior beings (Kambarami, 2006).

My participants that acknowledged linkages between LE and harmful gender norms, a participant from the advocacy category responded:

> "Labia elongation has literally died down in Venda but if you think of the principle of it why are they doing that? It's to please men so that all comes again from the early socialisation under patriarchy that really your existence is simply to look after men and to please men" (SAOGPP2, advocacy, female).

Contradicting this narrative another participant also referring to the Venda region responded:

> "Genital mutilation is still going on here, there is a way of doing it especially after giving birth. If a woman has given birth vaginally, she has to be cut each time after giving birth, it is traumatic. They also cut you even when you give birth through C-section but they shouldn't, only those that give birth vaginally should be cut" (SAOGPP1, advocacy, female).

While these two participants work in advocacy within the Venda area, the difference in their perceptions about LE prevalence is remarkable and informed by their ethnic backgrounds. The participant who reported that LE is no longer practised in Venda is of white South African origin while the participant citing prevalence of genital mutilation in the area is of black African origin. This discrepancy highlights the level of knowledge that local practitioners might have and the implication on interventions is critical. In development, local knowledge has been marginalised in favour of top down approaches (Engdasew, 2022; Rosy, 2015) which is evidenced in this case. What this means is that local populations will have a greater understanding of the context and the norms that sanction VAWG which might not necessarily be factored in programming leading to less effective interventions therefore understanding context is crucial. My participants in the development and advocacy practitioners' categories that did not consider these practices as contributing factors to women and girls' vulnerability to HIV drew on global definitions of FGM that do not consider LE as genital mutilation and this was alluded to by a female participant who argued:

> "In HIV circles, we don't even call it genital mutilation, its enhancement and for the benefit of the woman as well as they say the men like it but its also necessary for their pleasure. I am not sure why its categorised as mutilation because to me, mutilation is destroying but for this one there is no destruction its enhancement. I am not sure where the definition comes from to include labia elongation under genital mutilation" (ZDPPP13, development practitioner, female).

While alluding to the harmful nature of FGM, participants were keen to point out that LE is not FGM. One participant narrated:

> "FGM is a taboo, everything is so bad, and they demonise the whole sexuality while in elongation culture, it's an opportunity to discuss, to play around with themselves and to experiment what will happen when they grow so it's a practice that makes sexuality very open and also allows discussion and may be an opportunity for girls to discuss sexuality from older people and get ideas and it's probably the right messaging" (ZDPPP6,development practitioner, female).

While this statement alludes to the discovery of sexuality as a natural process of development, it also outlines a dichotonomy between 'harmful' FGM and 'beneficial' labia elongation. Because LE is a cultural norm, framing it in the context of benefit to women (and men) makes it difficult to challenge the practice and make the links with child marriage, bride price polygamy and HIV. My participants could therefore not see beyond the practice' perceived benefits. When queried about the impact of sexualising children the participant responded:

> **"**Yes, but then down the line, it's not as scary, bad, or demonised for these women to try and experiment. it reduces the fear and taboo around it and you might want to try sex earlier because you have been practising, you have been taught and you have been told its pleasure for you and for the husband. Your aunties and your cousins have been going through these processes together" (ZDPPP13, development practitioner, female).

The narrative maintains that LE is safe, and where the ways in which it links with child marriage, bride price and polygamy are not known, the argument is justified. Thus, because young girls are familiarised with sexual content in childhood they will not be afraid of engaging in sex in adulthood. Additionally, because all female relatives would have gone through it before, the practice should be safe.

Section 2

6.2 Contextualising vulnerability

Understanding context is crucial in terms of framing vulnerability. My participants across the categories did not seek elaboration on what vulnerability meant which means that vulnerability is clearly understood in any given context and therefore is contextual. Western theoretical frameworks of vulnerability might diverge from African and most certainly Zimbabwean concepts however there is some overlap in definitions. For example, being economically disadvantaged is a form of vulnerability while being a subordinate in a hierarchical order (CIOMS, 2002) also places one in a position of vulnerability. I discussed in earlier chapters the hierarchical nature of the Zimbabwean society where women and children fall in the bottom of the rung and I will return to this thought shortly. In health legal terms, vulnerability is conceptualised as a lack of capacity and characterised by disability, mental illness or children. Vulnerability is also correlated with gender-being female (Hurst, 2008) and cultural background and ethnicity (Danis & Patrick, 2002). In medical terms vulnerability refers to "heightened susceptibility to harm that individuals or groups experience in conditions of particular risk or helplessness" (Neal, 2020, p. 77). Vulnerability also entails "increasing likelihood of incurring additional or greater wrong" (Hurst, 2008, p.191) and this is the definition I am inclined to employ in framing vulnerability in the Zimbabwean context.

What this definition calls for is to clarify that which might likely go wrong and as such from the onset of initiation rites, it is the problematic cultural gendered and religious socialisations of characteristics such as subordination, submissiveness, servitude and inferiority which are hailed as hallmarks of a 'good' wife, and attributes that men want in a wife (Christiansen, 2013; Kambarami, 2006). We see here the seeds of vulnerability sown and that, in a patriarchal environment that controls the narrative of values and tradition. Two concepts that emerge in attempting to define vulnerability are 'autonomy' and self-determination (Neal, 2020). By self-determination the presumption is that a woman or girl has the ability and the right to make decisions for themselves over a particular issue in their lives. Vulnerability is a concept that women in Zimbabwe are familiar with and I frame it in terms of women having full capacity to make informed choice and consent but restricted from doing so because of the oppressive patriarchal dictates disseminated through rigid gender, social and religious norms. Because of normative social, cultural and economic environments, situations such as those of economic and social dependency over men become entrenched.

To understand how vulnerability to HIV can be caused I asked my participants in the nurses, development, and advocacy cohorts the question: '**What makes a girl or woman more or less vulnerable to violence and HIV infection?'** Responses were varied according to the level of practitioner engagement with women. Responses summed up the ubiquity of IPV and domestic violence and participants attributed the prevalence of violence to couples blaming each other for bringing HIV. Amongst others, social, cultural, and biological factors were cited as contributing to women's vulnerability to HIV. Responses from advocacy practitioners' category ranged from poverty to notions of power and intrinsic cultural norms as causation of vulnerability to HIV.

6.2.1 Gender and social norms impact on HIV vulnerability risk

Gender norms underpin all patriarchal systems of socialisation and form the oppressive structures that women and girls have to contend with in their daily lives. Thus gendered cultural expectations that are levied upon women and girls contribute to their vulnerability. A participant succinctly argued:

> "It's a question of expectations, we all have our images of ideal hubby/wife based on socialisation, our socialisation teaches us that a correct woman should look like this. If I am supposed to find a woman with long labia, elongated and if they are not there then what do I have in front of me? I don't have a woman. So, if I don't have a woman, how will I treat her from there on? Maybe I will look for a woman. It's socialisation more than anything describing what a marriage and a woman should have and not have" (ZDPPP3, development practitioner, male).

This narrative confronts the argument of idealised versions of womanhood that are determined by gender and social norms. For one to be a 'woman', social norms dictate what that looks like and in this context it entails conforming to cultural practices such as LE. Furthermore, social norms determine what an ideal woman looks like and the failure to fulfill that stereotype can increase the risk of violence. A participant alluded:

> "If your culture tells you that a woman must have elongated labia and suddenly you don't find them you may not express it openly that you are very disappointed but it may then come out as violence so in part the domestic violence can be in two ways partner finds the elongated labia are either missing, or present or in whatever form and is not satisfied may then find someone else who has the appropriate labia and therefore that's already cheating and exposing the other part to HIV" (ZDPPP2, development practitioner, male).

Another participant echoing sentiments about gender socialisations argued:

> "There is a high likelihood that a girl who enters these rituals early on in life will lead her life thinking that she becomes a real woman by learning the art of man pleasing, changing/ modifying her body, beliefs maybe in order to keep a man. Such a girl and later on a woman would do anything even risky sexual behaviour no condom use/ no prior HIV testing, etc. in order to keep a man because it has already been hammered into her from an early stage in life that her very existence is to ensure man's pleasure" (ZOGPP1, advocacy, female).

This quote highlights the gendered socialisations that inform marriage and that can be a source of vulnerability for girls and women in adulthood. The vulnerability cuts across social and economic status as evidenced by Masvawure (2013) on her study in Zimbabwe where participants were from middle class backgrounds. These social norms justify the root to vulnerability because it is cultural to prepare oneself for marriage. A participant opined:

> "From a cultural perspective, it is expected, every woman should have elongated labia. In our culture here in Zimbabwe, it's taken to be normal. Then when we look at how this is happening, how girls are growing up and being taught about this thing. The question is how are they being taught about these things; are they being forced or not? All the women that I have seen as adults had long labia, they say its normal, they are preparing themselves for marriage. So, they do not see anything wrong with that" (ZDPPP8, development practitioner, male).

LE is perceived as part of preparation for sexuality in marriage and therefore normalised. Because girls are coerced into elongating their labia, rather than someone physically performing it on them, the narrative is that it is consensually practised and therefore justified. However, I have argued in great detail in Chapter 5 how girls, through patriarchal and gender norm prescriptions are forced to conform to sexual socialisations (Jewkes & Morrell, 2010). Citing gender norms that govern marriage a participant explained:

> "The woman is supposed to listen to the man. You get married, your wife has to listen to you. You can say or do whatever you want and she cannot dispute it" (ZDPPP12, development practitioner, male).

Social norms cut across socio- economic status. Masvawure (2013) found urban middle- class

women supporting LE while denigrating other aspects of the Zimbabwean culture they did not like. It serves to show that educated women can be vulnerable to culture and fail to exercise agency when feminist discourse purports that they can. A participant narrated:

> "You will be surprised at the number of people who have elongated labia who have never attended those initiation ceremonies and the challenge is that even some who are from very educated or seemingly empowered communities still do those things. It's a case where the individual is not empowered as an individual they are subjected to cultural pressures" (ZOGPP3, advocacy, male).

Whether empowerment can resist gender and social norms that sanction these practices is debatable. Masvawure (2013) evidenced that women with high levels of education chose from the milieu of cultural practices which ones to conform with including LE, while Mubaiwa (2020) found that educated women also supported bride price even though they acknowledged the risk of violence associated with it. This elucidates the ifluence and impact of cultural norms which are strongly tied to concepts and theories of identity.

Instead of opposing violent hegemonic masculinities women comply and tolerate violence including infidelity (Jewkes & Morrell, 2010). Female partners of hegemonically masculine men are at risk of HIV because by gendered prescription, men initiate and control the sexual experience (Zinanga, 1996) and females acquiesce to their behaviour as a tradeoff made to secure material and social rewards. This idealised version of femininity does not need violent mechanisms to endorse it; the patriarchal apparatus determines it because of the social rewards and sanctions (Jewkes & Morrell, 2010). Such identities draw on ideals that are rooted in cultural and social processes which makes it difficult to question and make choices. Those women emotionally and materially insecure, to shield themselves from the sanctions and be best placed for rewards will expose themselves to vulnerable situations (Jewkes & Morrell, 2010).

Polygamous marriages and 'small houses' were singled out as factors that increased women and girls' vulnerability to HIV infection. My participants cited unequitable gender norms that normalise male promiscuity as a cultural expectation which they concluded increases risk of HIV infection. Perceptions of LE's role in framing and modelling sexuality in Zimbabwe are widely held across sectors and responses revealed that in the development sector the practice is supported specifically among female development practitioners. In the nurses' category, LE was as a problemitised as a social norm rooted in culture. Participants in this pool identified the practice as

the major cause of women's inferiority status and a violation of their rights.

Women are perceived as vulnerable in the Zimbabwean culturally informed notions of being the 'weaker' gender that is 'soft and gentle' (Kambarami, 2006; Sawyer, 2004; Bareket & Shnabel, 2019) and religious scripts such as "Husbands, in the same way be considerate as you live with your wives, and treat them with respect as the *weaker partner* and as heirs with you of the gracious gift of life" (Holy Bible, 1611, 1 Peter 3, verse 7) while men are culturally perceived to be stronger physically and intellectually and therefore capable of heading the household (Chuma & Chazovachii, 2012; Thebe, 2018).

These concepts reinforce male dominance and female submissiveness (Sawyer, 2004), and religion particularly Christianity, draws on biblical scripts such as that quoted above where concepts of strength and weakness are associated with masculinity and femininity. In religious socialisations men are also viewed as 'protectors' of the weaker vessels therefore a woman will be 'incomplete' (Mubaiwa, 2020; Holy Bible, 1611) and vulnerable without this protection. Furthermore, in a patriarchal society "women are not 'individuals' in the way that men are, since it is men who have self-mastery and reason, the prime qualities of contracting 'individuals', while women are characterised as intuitive, natural, emotional" (Jackson, 2012, p. 42). A participant in the nurses' category alluded:

> "Women are weaker vessels in our culture, they are not allowed to ask for sex, they are forced to have sex even if they don't give the consent. All this is taught by aunts when a girl is growing up to submit and never say no to sex even if one suspects male partner is cheating or has a disease i.e. HIV or any STI. No condom negotiation is allowed with a woman. It's the male partner who decides when, how, where to have sex with the woman partner" (ZNPP1, nurse, female).

This narratives echoes initiation schools socialisations whereby girls are introduced to notions of subservience and subordination (Khau, 2012). Participants associated women and girls' risk of HIV to culture because of the social norms that are reinforced as tradition under patriarchal codes. While the universal individualistic human rights discourse is widely received in tandem with notions of what it means to be vulnerable and therefore entitled to having one's rights protected through social security mechanisms, these concepts conflate within Western and Westernised societies where the social space to harmonise the two concepts exists. Zimbabwean society is largely patriarchal and that system limits the extent to which the same universalised human rights

can be exercised.

If the husband is the head of the house and therefore the power to make important decisions that affect every individual in the household lies unchallenged with him (Chuma & Chazovachii, 2012; Thebe, 2018) where would be the space for exercising those rights? Women, as my participants in the community data revealed, do not support the status quo but because of perceived benefits that come with marriage such as honour in society, and financial security they are willing to forgo their rights. In the focus group discussions participants revealed that obedience is socialised in initiation schools therefore the concept of individual human rights that seem to contend with patriarchal values will be contentious and counterproductive where one's obedience to their husband guarantees their marriage survival.

The lack of agency in determining sexuality was cited by most my participants in the nurses' category as a cause for vulnerability. Citing the influence of cultural conventions, a participant went on to elaborate:

> "Within our society, you will find out that a girl or a woman cannot openly express her love to a male counterpart, and as a result, most of our first sexual encounters they are to some extent GBV or rape. Under those circumstances the woman cannot negotiate for safer sex because the woman is supposed to be refusing sex, if she just gives in, she is perceived as loose and also things like polygamy and so on they also fall within that category" ZDPPP5, development practitioner, male).

This statement explains how gender norms prescribe sexual transcripts that view women as passive objects that in a way can still be wayward. Research is replete with evidence of autonomous women in Zimbabwe and activism also evidences that women are exercising agency and claiming their space and independence from the patriarchal order. However, if livelihood depends upon a man (financially), and family (and one's) values and honour are dependent on marriage (according to formative and normative socialisations) and where society functions in homogenous ways and ascribe to patrilineal and patriarchal values then one's autonomy and agency will be curtailed.

The outcome will be the absence of contingent alternatives but succumb to physical, emotional, economic, social and health insecurity and vulnerability. Where one is discriminated on the basis of gender and choice is taken away, one becomes vulnerable to the control and machinations of those with power to control narratives and resources. Having said that, vulnerability can be

situational (Neal, 2020) a child could be vulnerability secure today and be married off tomorrow the same way a woman could be in a vulnerable position today but turn her circumstances around tomorrow. Thus, vulnerability is universal, in other words, anyone could be vulnerable at any specific point in time. Emphasising the role of marriage norms in increasing women's vulnerabilities a participant argued:

> "In our culture its believed that once you get married no matter how hard things are you cannot leave that marriage you have to stay there. In the end women in those kinds of marriages end up with HIV" (ZNPP5, nurse, female).

With such immense societal pressure to conform to normative ideals of family image it is inevitable that women find themselves in compromised positions where they cannot negotiate their exit terms. Women and girls are socialised to believe that they have lower social, intellectual, and physical power and that men always know better as heads of the household (Chuma & Chazovachii, 2012; Thebe, 2018). They are also socialised to bend to a man's will even if it is destructive to their own wellbeing (Mugweni et al, 2015; Taruberekera et al, 2009). Growing up with such social viewpoints women and girls then ensure that their behaviour fits into this narrow inequitable gendered framework that devalues them. Girls are raised to look forward to marriage to the extent that an unmarried woman has lower social status than her counterpart. Kambarami opines that "the desired destination of most Shona women is marriage" (2006, p. 4) and that women and girls are thus socialised to believe that their role is to serve men's needs with their bodies.

The commodification of bodies chimes with Smallwood (2007) and Cooper (2015)'s arguments of the trading of African slaves which "created a societal structure that equalised the value of human life with a market value" (Cooper, 2015, p. 22). Cooper argues that slavery became "a rigid structural system of oppression" through which "bodies became objectified" (p.22). Parallels can be drawn here with patriarchy and the systemic oppression of women through bride price payment that legitimises marriage and transfers the ownership of a woman to her husband (Akurugu et al, 2022). The terms of reference for this transaction stipulate servitude and loyalty and where a woman's life revolves around market value and is perceived as valuable "only for the potential profitability they may bring, the very fabric that holds communities together shifts" (Cooper, 2015, p.23). Economic values govern social and cultural norms and this is what happens when women and girls' bodies are commodified. Economics is now the primary driver of bride price, a practice which underwrites women and girls' commodification that is rationalised through oppressive patriarchal values that promote subordination, in the same way slave owners expected

from their subjects (Smallwood, 2007; Cooper, 2015). Access to healthcare was sanctioned by the slave owners (Rayner, 1981) and in similar ways the system also mirrors the colonial oppressions experienced by black African populations where colonial masters sanctioned movement through legalised permits (Barnes, 1992).

Vulnerability to HIV is also reinforced by social norms that draw on cultural ideals of what a 'good' woman (Christiansen, 2013; Kambarami, 2006) looks like, a participant elaborated on this concept:

> "a woman has to fit into society's framework of what a good woman is, a woman who does not question, who does not dominate much and who is not too argumentative and as such they have to continue having unprotected sex with man/ husband/ boyfriend who is evidently unfaithful to them, maybe sick with clear signs of sexually transmitted infections in order to maintain the marital status" (ZOGPP1, advocacy, female).

Patriarchal attitudes are bred in the family through the socialisation process" (Kambarami, 2006, p. 2). Roles are sexually differentiated through socialisations that view women and girls as sexual beings (Charvet, 1982) and children accept them and make it a lifelong ambition to fulfil those roles. Society define women in relation to men albeit as subordinate and dependent on men (Fidan & Bui, 2016). Consequently, women are socialised in childhood to possess such qualities which reinforce dependence. Qualities such as submission, passivity, gentleness are socialised with girls exhorted to and strive towards pleasing men always. In the Shona culture, "once a girl reaches puberty all teachings are directed towards pleasing one's future husband as well as being a gentle and obedient wife…her sexuality is further defined for her, as she is taught how to use it for the benefit of the male race" (Kambarami, 2006, p. 3). Citing the intersections of gender and social norms a participant in Venda commented:

> "What I witnessed in my 40 years in Venda is that people are socialised under the patriarchal system that literary from birth the girl child has self -esteem bred out of her she doesn't seem to make any decisions, no choices, everything is decided for her. The minute they can walk they are carrying their baby brother on the back they are doing all the household chores the boys don't have to do anything the girls have even to wash the boys' nappies. To me it's an indoctrination that means they cannot say no" (SAOGPP2, advocacy, female).

Patriarchal norms were also cited as key contributors to violence women and girls experience because the norms define the power imbalances between men and women. In several ways, girls are more vulnerable, vulnerable to exploitation, vulnerable to HIV because they cannot negotiate for safer sex. The role culture in perpetuating these vulnerabilities was also highlighted by a participant that cited its social implications arguing:

> "We have interventions that targeted men for example male circumcision, but we don't have specific interventions for the women. Only the female condom, but the female condom you need to get consent from a man, so, some men they don't want it, that makes a woman vulnerable and in our African culture, you don't decide, the woman does not decide when to have sex. So, sometimes even for their own body they need to consult a man to get a man`s approval, so that makes them more vulnerable" (ZDPPP4, development practitioner, male).

A participant in Venda explained:

> "With the HIV infection it's trying to get men to wear a condom which they just won't and female condoms have never been properly marketed in our area, never. You have no bodily integrity everything belongs to someone else" (SAOGPP2, advocacy, female).

The key issue here are the gender norms that men have control over women's bodies and will decide and control the sexual experience. Women's autonomy to self -determine in this instance is restricted. However, the question to ask is why female condom use is not promoted and the answer would be that men will not allow its utility and because of limited bargaining power, it will be in the best interests of the women to comply with the judgement call.

6.2.2 Cultural and religious norms' impact on HIV vulnerability risk

Within programming child marriage is singled out as abuse however the link with bride price and polygamy is not observable. Once a girl has gone through LE they become a woman (Bagnol & Mariano, 2012). Articulating the role of initiation rites in child marriage risk a participant from the advocacy category said:

> "The culture does not really consider the age of marital consent if a child is

> initiated into preparation for sexual activity at 12, 13 do you think that community will be bold enough to then say wait until you are above 18?" (ZOGPP3, advocacy, male).

This explains how normative values disregard vulnerability and highlights how going through LE can impact girls' risk to child marriage and polygamy. The normalisation of child marriage was also explored in the interviews and the role of religion and religious norms in sustain child marriages. A participant narrated:

> "There is bed culture, which is a culture where it becomes normal for someone to come home and say I have married an under aged girl and the community accepts it" (ZOGPP2, advocacy, female).

A participant cited religion as a major driver of vulnerability alluding:

> "we know of white garment churches where girls are pledged as young as 10 years, 12 years for marriage" (ZOGPP3, advocacy, male).

In Zimbabwe children are universally acknowledged to be at risk of harm on the basis of their immaturity which, institutions such as the Apostolic church manipulates in sanctioning child marriage as children are considered less difficult to control in marriage (Machingura, 2014). Children are thus vulnerable to practices such as LE and child marriage because of their immaturity which affects their capacity to consent or not. Children should be safeguarded against making choices and decisions that they do not fully understand the consequences thereof. Child protection legislation is weak and this can be traced back to colonial Zimbabwe where women were regarded as minors therefore vulnerable and needed protection. Because of the perceived lack of capacity to make rational decisions women were placed under the control and guardianship of their husbands upon marriage, having transferred from that of their fathers in childhood (Akurugu et al, 2022). The prevailing gender narrative similarly prescribes men's control over women and children's (girls) fate. Alluding to concepts of subservience from religious and cultural norms a female participant narrated:

> "There are no equal rights or powers in a heterosexual union, one has to submit to the other, and this ***<u>one</u>*** is the woman. This is backed by a bible verse, a Holy book most reverenced by devout Christians, this verse however, has found its way even to unbelievers and or folks who do not frequent or even go to church. "A woman has to be submissive to her husband" Some use submission in the context of the contemporary African way of life (culture) others in religion whilst most borrow from both. Most women in these unions and

some not in any often say, “you need to know your place as a woman, *zvekuti ndakazoenda kuchikoro* (claiming that I am educated) doesn’t work with our typical African men” (ZOGPP1, advocacy, female).

Conceptualising Zimbabwean women as autonomous to exercise agency against all odds is a view that “emphasises the rational agentic subject—an almost hyper-responsible self—who makes individualised choices, removed from any contextual constraints, structural or otherwise, free from the influence of cultural norms and expectations” (Braun, 2009, p. 236; Baker, 2008). This is not a view that my participants across the categories shared. When choice is mandated by social norms one cannot have options but to conform and the options are not viable in any realistic sense. If for example, a woman chooses to undergo LE or to marry into a polygamous union, which are both social conventions, the decision made for either choice is to conform to a social norm therefore that decision is not informed by individual choice (Braun, 2009). Where norms are concerned, choice is constrained and so is agency.

6.2.3 Poverty’s impact on HIV vulnerability risk

The theme of poverty ran throughout my participants’ responses. They also cited cultural norms as increasing the susceptibility of adolescent girls to HIV infections. My data also revealed that early sexual debut contributes to girls’ risk of HIV infection. The attribution of HIV incidence to early sexual debut highlights the consequences of parents’ denial of adolescence sexual engagement as Chiweshe & Chiweshe (2017) found in their study in Zimbabwe. Acknowledging adolescence sexual agency would provide an opportunity to educate and encourage safe sexual practices within the HCPs’ discourse. However, in a cultural environment where premarital sex is forbidden and carries stigma with negative social sanctions safer routes of incorporating such discussions would need to be devised. Sexual activity among adolescents is strife in Zimbabwe (Chiweshe & Chiweshe, 2017) which reveals that young people have and can exercise agency in engaging it and although gender attitudes are shifting to accommodate these changes the marriage market still determines the outcome for the deviance.

My participants revealed that because of poverty women experiencing domestic violence usually do not have anywhere else to go. Because they are financially insecure, their parents will not receive them but will instruct them to return to their husbands. The rationale behind this decision broadly lies around issues loss of family honour and stigma from divorce (Chisango et al, 2022),

financial insecurity of the parents, and because Zimbabwean society is patrilineal, the divorced woman's children belong to the husband because of bride price payments (….), and therefore should reside with their paternal family. The role of poverty in exacerbating women and girls' vulnerability to violence and HIV was also highlighted in the responses from the advocacy category. Alluding to intersectionality my participants alluded to the heterogeneity of women with those financially secure being less vulnerable to coercion into marriage however educated women are also found to experience violence including polygamy and HIV (Thompson et al, 2015; Lasong et al, 2020). In terms of gendered power dynamics and their link to women and girls' vulnerability a participant in Venda narrated:

> "With poverty you find most people even if they report violence to the police they cannot leave a relationship because the man is the provider so a case opens today tomorrow is closed because they have to rely on the partner so in a way people become more exposed to GBV and HIV. Here it is the culture that men have power" (SAOGPP1, advocacy, female).

The emphasis is on the power imbalance and entrenched gender inequality that entitles men to forms of resources that women cannot access. This problem is underscored by gender disparities in childhood where boys get better educational opportunities than girls who will be forced in later life to depend on men for livelihoods (Fidan & Bui, 2016; Kambarami, 2006). Referencing the role of poverty in vulnerability to sex work and subsequent exploitation of young girls a participant explained:

> "The lure of transactional sex or transactional relationships is made worse by poverty we know cases where in Gutu girls were going out of school over lunch, Zvishavane another example they would go behind the school toilets and have transactional sex with gold panners for them to access a loaf of bread. Its survival transactional sex so poverty has a major role to play" (ZOGPP3, advocacy, male).

It is unquestionable that poverty exacerbates women and girls' vulnerability to violence and HIV. Citing intergenerational relationships my participants revealed that young girls usually enter into relationships with men older than them and the power dynamics in these relationships mean that men will have more power over the girls with implications for their risk to HIV. Poverty fuels these relationships and a participant alluded to this. Data from development practitioners' category revealed that participants acknowledged the gendered nature of socialisations. There was

consensus among all participants in this category that women cannot exercise sexual agency because of gender inequality. A development practitioner explained:

> "There is the element of the economy or finance, you do not expect a 45-year-old man who has money to give a young university student 22/23 years old a hundred dollars anytime. To have that girl to be able to negotiate for safer sex?" (ZDPPP3, development practitioner, male).

What this means is that where choice is limited, agency cannot be exercised because choice and agency are complimentary (Gavey, 2005). Besides, my participants as alluded to by my participants, families will be aware of these inequitable power relationships, and for the young girls- the need to provide for their family pressures them into these positions. We see roles transformed here; men are traditionally providers of the family (Motsa & Morejele, 2019) but the declining state of the Zimbabwean economy means that high levels of unemployment have made this traditional role tenable with families turning to commodities at their disposal- girls engaging in age disparate and transactional relationships to ensure the family's survival. Contradictingly, families are forgoing virtues of purity and preservation of virginity because of survival crises. Choice is shaped by context (Gavey, 2005) and "individual choices … are culturally situated and culturally shared" (Bordo, 1993, p. 300). Where the economic situation is dire, it might be acceptable to engage in these forms of relationships because on both sides of the border my participants alluded to their prevalence. For girls to choose to be in such precarious relationships where the risk of HIV is well known shows how agency can be a contestation of will.

Women and girls' vulnerability according to my participants comes more from a lack of economic and knowledge (rights) empowerment. There is the knowledge part which women and girls may have but because of the unsupportive environment such as the economic downturn and the declining infrastructure (Mangundu et al, 2023; Kanyenze et al, 2017) may fail to be agentic.
A male participant narrated:

> "If you look at the situation we had in Makoni, at one point Makoni had the highest HIV prevalence in Zimbabwe. The reason was that there were truck drivers who were coming from Mozambique going to Harare, they would stop in town and pick up these young girls and this is how these young girls ended up getting HIV. These young people were vulnerable because they cannot afford to send themselves to school, they cannot afford to buy food, they up end sexually exploited, not that they

> are sex workers, but they are exposed to sexual exploitation because of poverty" (ZDPPP8, development practitioner, male).

This narrative drives the role of poverty in increasing risk of HIV infection and participants also confirmed the impact of parents' decisions to send boys to school at the expense of girls which keeps girls in cycles of poverty and forced marriages. Gender discrimination is evident here while the social inequality due to Zimbabwe's volatile economic situation (World Bank, 2023; IMF, 2023) is also to blame for the predicament girls and women find themselves in.

Section 3

6.3 The gendered dimensions of HIV

When I asked my participants the question: '**To what extent is HIV gendered?**' responses highlighted several issues about the role of gender in perpetuating violence against women. The repressive nature of gender norms came out in responses from both male and female participants. My participants associated gender with vulnerability and some responses were culturally contradictive. Expounding on the theory of the gendered transmission of HIV, one participant narrated:

> "If you visit our infectious diseases hospital or our opportunistic infections clinic, you will see a higher burden of women there. We may say its because of the good health seeking behaviour of women but even if you go to the general population, you will find out that women are more, and have a higher burden than the males. So, to that extent, there is a big gender dimension to HIV transmission" (ZDPPP5, male).

My participants reported that women are disproportionately affected by HIV than men although more men die of AIDs than women because of health seeking behaviour, and adherence with ART treatment. Studies have evidenced that reasons for the spreading of HIV are gendered. A participant from the development practitioner cohort confirmed this arguing:

> "Labia enlargement in our culture they say if you have got big labia you give the man a lot of pleasure and then the ladies, they can become promiscuous because of that just to experience to see if they are really XXXX, that can cause HIV but if you educate them you can stop that approach of transmission" (ZDPPP4,

development practitioner, male).

Women are blamed for spreading HIV (Kalipeni, 2008; Rujumba et al, 2012; Yonah et al, 2014) hence views that having elongated labia promotes promiscuity. The indiscriminate blame of women for the spread of HIV has long been posited and the double standards that support male promiscuous behavior is glaringly obvious. On one hand women are required to have elongated labia in order to fit in cultural ideal of femininity while on the other hand they are victimised for conforming to those gendered inequitable ideals. Furthermore, the Zimbabwean society blames the woman for a positive diagnosis citing that her husband had extramarital relationships and acquired HIV because the she did not provide her husband with enough sex (Kamabarami, 2006). Skovdal et al also found out that "being a woman means that you have to sexually satisfy your husband" (2022, p. 5). In this case femininity is defined by one's sexuality and their ability to meet their husband's sexual demands. However, with multiple partnering and high prevalence of promiscuity among married men in Zimbabwe (Chadambuka et al, 2023; Jackson, 2012) it is debatable whether a woman can ever meet that expectation. Gender norms thus associate manhood with insatiable sexual libido that is measurable and has to be matched by an emphasised femininity that meets men's sexual desire (Connell, 1987).

My participants also concurred that transmission is gendered especially at a young age where the social determinants of health and socio-economic opportunities are very gendered suggesting that the needs of a young girl or an adolescent woman are very disproportionate compared to the needs of a young man. In trying to achieve equality young women and girls end up falling victim and exposing themselves to the older age groups for transactional sex. Another participant argued:

> "Our data from the HIV estimates shows that women are disproportionately affected by HIV, especially young women aged 15-20, the risk is three times more for young women than for young men. The 20-28 its even 6 times more, the men don't go for HIV testing, their health seeking behaviour is poor. Women have better health seeking behavior" (ZDPPP9, development practitioner, male).

This statement supports gender discourses around masculinities that correlate health seeking with femininity and therefore weakness. Boys are socialised to be tough and bear pain in silence because expressing emotion characterises femininity and weaker versions of masculinity (Bhana & Mayeza, 2016; Collins, 2013). Collins suggests that these social constructs of gender make boys dominant and violent and may be contributing to male perpetrated violence in the case of South Africa with society societal

normalizing these risky sexual behaviours. However, participants also posited different views over the gendered transmission of HIV with some rejecting such constructs. A male participant recounted:

> "Transmission is generally not gendered. The country changed the term Mother to child transmission to Parent to child transmission in an attempt to remove finger pointing or blaming mothers for transmission to their babies. This was despite the science that transmission happens from mother to child no matter if the mother was infected by the father or otherwise" (ZDPPP1, development practitioner, male).

Female participants in the development practitioner category mostly blamed men for HIV transmission because in the Zimbabwean society men have the autonomy to socialise outside the home and engaged more in extra-marital affairs with sex workers. They also propositioned that men are responsible for utility of condoms. What my female participants in this category suggested that men are in charge of practising safe sex thereby relinquishing themselves of sexual and reproductive rights. Why my participants felt strongly that sexual rights should be determined by men can be explained through the lens of socialised patriarchal norms that place men in decision making positions and expect women's acquiescence to that order (Jewkes & Morrel, 2012). Citing Bourdieu (1998), women rely on the *habitus* because it gives sense to their existence and through it, they maintain familiarity. Thus the status quo is normalised and internalised and the passivity fuels and sustains patriarchy.

Conclusion

In my theoretical conceptual framework I discussed links between LE, child marriage, bride pride, polygamy and HIV infection. I progressively wanted to explore with my participants the extent to which these theoretical links resonate with their work. I included this chapter to enable me to analyse whether HIV and GBV programming meets the needs that my participants identified in the chapter. The data shows that programming is not addressing the multitude of issues that are leveraged by patriarchal gendered, social and religious norms. Responses to my questioning around the intersections between HIV, child marriage, and LE confirm this theory however my participants could not make further inks with bride price or polygamy. The data I gleaned from my participants allowed me to further evidence that different forms of violence are often linked. My participants in the development and advocacy practitioner categories certainly did not understand the nuances

behind the links between these forms of violence. Participants in the nursing category acknowledged the links which evidences that practitioner level of engagement with grassroots groups is crucial in developing and implementing programmes. The data also revealed that links are not explicitly made at programming level which identifies an important strand to my argument. My data is important because, without my participants seeing the links, then it would have been akin to making the links on a theoretical basis. What this shows is that more research- based interventions that seek to bridge prevailing gaps between theory policies and implementation practice are needed and my research is a step towards that. The data I presented in this chapter reveals that practitioners understand vulnerability and how it is gendered even though they do not suggest that LE necessarily causes risk of HIV infection. From my participants' responses it is evident that intersectionality underpins vulnerability which might have implications for interventions towards VAWG. It is however concerning that advocacy practitioners, those that champion women and girls' rights do not consider LE as a harmful practice.

My participants in the development practitioner category, while acknowledging the harm from IPV, focused on biological risk of transmission and discounted the nuanced risk of HIV infection. All participants in the development practitioner category concurred that GBV disempowered women from making informed decisions however responses did not express how the other HCPs affected decision making processes. Participants from the advocacy category articulated and reiterated the role of social norms in perpetuating and fuelling women's risk of HIV linked more broadly to cultural norms. My data evidenced that gender intersects with culture and religion to influence and determine vulnerability to HIV infection. Few of the participants from advocacy category recognised LE as FGM. There was also discussion on the lack of economic empowerment for women to become autonomous and reduce dependency on violent men. Included in the list of systemic constraints were cultural and religious norms which increase women and girls' vulnerability to HIV. It is through socialised norms that women are seen as responsible for HIV acquisition. Poverty also emerged as a theme around the risk of HIV infection. In the next chapter I discuss programming and interventions that are designed to respond to VAWG and HIV in order to understand whether or not they are addressing the challenges discussed in this chapter.

Chapter 7

Programming Responses to HIV and VAWG

Introduction

In the previous chapter I laid out my findings from development practitioners and their stakeholders in an attempt to fulfil my key aim of establishing whether or not they understood and acknowledged links between LE, child marriage, polygamy, bride price and HIV. Additionally, I wanted to understand whether development practitioners and their stakeholders recognised the links as avenues for reproducing women and girls' vulnerability to further violence and HIV infection I also wanted to gather my participants' perceptions on the impact of gender and social norms on women and girls' vulnerability to HIV infection. Furthermore, I wanted to explore the ways in which gender intersected with culture and to an extent religion to influence and determine vulnerability.

While some understanding of linkages between LE, IPV and child marriage was registered, my participants in the development and advocacy practitioner categories did not substantively acknowledge those links with HIV infection. The evidence I gathered seem to point to both a lack of understanding of the nuances between these forms of violence and a lack of acknowledgment of the problematic nature of these practices as a mechanism which reinforces women's vulnerability and exposes them to further violence including HIV infection. This chapter serves to reflect on the effectiveness of programming in Zimbabwe. I explore ongoing interventions that are designed to address VAWG, HIV, and SRHR and critically analyse the extent to which these interventions address or not religious, gender and social norms at the intersections of forms of violence such as LE, child marriage, bride price and polygamy that increase risk of HIV infection. Because I wanted to explore what activities could be integrated within programming, I proposed integrating health messages with these HCPs to development practitioners. To this effect I also interrogated mainstream educational initiatives designed to respond to the HIV epidemic and explored how education could integrate the HCPs in the school curriculum to leverage on the influence of education to transform harmful religious, gender and social norms at the heart of women and girls' vulnerability to HIV. Responses from development, advocacy and teaching practitioner categories are disparate and useful for future programming implications. The chapter is structured as follows:

Section 1 explores how HIV and VAWG programming is approached and the extent to which religious, gender and social norms intersect with interventions. Section 2 explores ongoing integration activities and discusses interventions that could potentially integrate LE, child marriage, bride price and polygamy. In section 3 I consider the effectiveness of programming and some of the challenges that render interventions ineffective. The chapter ends with a conclusive summary of issues discussed in all of the sections.

Section 1

7.1.1 HIV Programming

In this section I look at programming in Zimbabwe and reflect on the extent to which approaches are tailored to the broader realities of VAWG that link to HIV infection. The main interventions that HIV programming targets are GBV and SRHR. Harmful and risky sexual behaviours and attitudes, which we know lead to HIV infection play a major role in focusing on HIV and SRHR. A national campaign was launched in 2014 with prevention as the aim to reduce HIV transmission, intergenerational relationships and discordant couples in long term relationships (MoHCC, 2019). The theme for these interventions was to encourage faithfulness and monogamy. Since then various activities have ranged from engaging sexually active individuals in workplaces and in communities in sexual behaviour change programmes and training inmates and prison staff in generic HIV knowledge. The focus of these interventions is on unprotected sex as the main trigger for transmission, however this approach fails to account for the social, religious and gender norms that sanction promiscuity in men (Mugweni et al, 2012) and lead women into coerced and unprotected sexual intercourse. Thus, condom distribution and usage are interventions that are prioritised in terms of responding to HIV.

The ministry of health runs interventions targeting male partners to support women seeking health care, for example the male mobiliser program encourages men to attend antenatal, delivery and postnatal services with their partners and getting counselling and testing together, as well as supporting each other to adhere to treatment. Interventions also include outreach activities in order to reach those who need ARVs as well as differentiated service delivery offered and tailor-made for every patient in the form of multi-month drug dispensing to reduce clinic visits. In the community, ART refill groups facilitate community collection of ART within self-forming groups.

The National AIDS Council (NAC) focuses on school age young people that are out of school and

provides HIV information in both rural and urban areas. Part of this work is funded by the European Union. NAC also works with communities to address cultural issues that can facilitate behaviour change (Chevo & Bhatasara, 2012, p. 6). Mentors and community-based youth leaders also deliver similar projects to those young people who are out of school (MoHCC, 2019). However, men and young people remain hard to reach for community- based behaviour change programmes as the engagement model involves door- to door interaction to discuss HIV risk. This initiative is volunteer led and as such volunteers often lack legitimacy to challenge cultural norms which influence behaviour (MoHZ, 2017). There is high visibility of CSOs in HIV prevention work and groups run behavioural change programmes aimed at young people. They offer information on sexual and reproductive health and promoting HIV testing. Individuals engaging with similar initiatives in South Africa were found to comply with testing and condom use more than those who did not (Sloot et al, 2020, p. 4). However, CSOs that rely on the government for funding cannot hold the government accountable for policies that are deemed ineffective (SANAC, 2017).

Most cited among interventions was the Determined, Resilient, Empowered, AIDS-free, Mentored and Safe (DREAMS) which was implemented in 2014; a partnership project between USAID, community, faith based organisations, and NGOs which aims to reduce rates of HIV among young women and adolescent girls in countries with the highest prevalence of HIV. DREAMS subsidises girls' education of those that come from poor backgrounds, empowering them to seek HIV services and understand their rights. This project however is not implemented across the country as some of my participants would go on to point out. Commenting on the reach of the DREAMS project participants reported that DREAMS is rolled out in 20 districts that are PEPFAR (U.S. President's Emergency Plan for AIDS Relief) supported and 4 that are Global fund supported. This means that 24 districts out of 65 districts have comprehensive programmes while the rest of the districts receive information through government programmes that are run by the ministry of women's affairs, and also programmes disseminated through social media. The evidence points to the need to engage communities in similar dialogues and integrate interventions in order for the same messages to be diffused widely.

DREAMS is targeted at adolescent girls and when I asked my participants what its implications are for social norms. I also wanted to understand what the rationale was for leaving out mothers and older women. A development practitioner responded:

"The reason why we talk more of the young woman it's because when you look at the

> HIV programming, incidence is highest in 15-19, 20-24. As you grow older the incidence becomes lower. We are focusing on incidence, right now, we are talking about epidemic control and all the gains that we have made in the HIV program to sustain them. For us to sustain them, we need to keep everyone who's on treatment, on treatment, find those ones who are newly infected and put them on treatment, find those that are vulnerable and prevent them from getting infected. This is why all these efforts around the DREAMS is around prevention, care and treatment, mostly prevention" (ZDPPP8, development practitioner, male).

Participants opined that older groups were already compliant with HIV services provided by older health care workers because they regarded them as peers. The gap in service uptake is prominent in the younger cohorts because they are nervous of approaching older nurses to request condoms or STI tests. Power dynamics play out in discursive ways in different relationships in Zimbabwe. Younger people are expected to respect and obey those that are older than them (Togarasei, 2020). In this patriarchal hierarchy, young people and children fall at the bottom of the power rung in the system and this explains the hesitancy of young adolescent girls to ask for sexual health services from older nurses. In tandem with this is the stigma attached to accessing sexual health services outside of marriage (Matswetu & Bhana, 2018).

7.1.2 VAWG Programming

Grassroots activism is the most visible effort in addressing VAWG in Zimbabwe. CSOs work with grassroots women's groups towards empowerment to address interpersonal and structural violence. The Domestic Violence Act and the Anti-Domestic Violence Council were simultaneously passed in 2007 by the government (Govt of Zimbabwe, 2015b). The national strategy on GBV aims to make violence non -tolerable, provide services for victims and survivors, and provide evidence-based programming and to integrate systems and institutional frameworks (Govt of Zimbabwe, 2015b). The UNFPA provided financial and technical assistance to the women's ministry in its campaign to have the Domestic Violence Act enacted in spite of the government's loss of donor funding at the time. In its drive to promote women's empowerment and gender equality, UNFPA works with NGOs and women's rights activists who are addressing violence against women including those that are providing counselling and refuge services for survivors. UNFPA provides financial and technical support in initiatives within advocacy organisations researching VAWG (UNFPA, 2022b).

The United Nations, supported by the European Union is delivering the Spotlight Initiative (2019-2022) to contribute towards ending GBV in Zimbabwe. The programme has six pillars which are interconnected and aim to address VAWG on women's rights movement, data, services, strengthening institutions, laws and policies, and social norms and prevention. The programme's remit is "prevention, protection of survivors, participation of communities and the provision of services to survivors, as well as increased reporting of cases of violence against women and girls" (ILO, 2019, para. 5). The initiative focuses on women and girls realising their full capabilities in a gender responsive, and violence free environment. The empowerment of women with education includes rights orientation however with the individualistic connotations of human rights (Boddy, 2016) their promulgation in a communal patriarchy such as Zimbabwe means that women and girls will have face challenges in exercising them. Where sexuality is culturally policed and decision - making powers are monopolised by men at family level (Bhana & Nkani, 2014) and where marriages are communal affairs the freedom to exercise one's rights will be curtailed. Furthermore, alluding to individual rights and its homogeneity connotations would be akin to expressing individuality and separating oneself from kinship (Boddy, 2016). However, women are expressing agency in several ways. Reporting violence (Chuma & Chazovachii, 2012) and delaying marriage are some of the actions that are evidencing this shift.

In the same manner, the Department for International Development (DfID) launched the "Stopping Abuse and Female Exploitation" (SAFE) programme in April 2019 which aims to prevent and respond to extreme types of GBV, including modern slavery and child marriage. The programme delivers projects at community-level aimed at preventing and responding to violence through behavioural change towards women and girls and making services accessible to survivors. Communities are empowered to protect vulnerable women and girls and uphold their choices and rights leading to the reduction of modern slavery and child marriages. SAFE aims to "improve the availability of, and implementers' capacity to use evaluation evidence, research and data to optimise impact, value for money, and targeting in programming" (DfID, 2019, para. 1).

Responses from nurses, development, and advocacy practitioner categories were informative on analysing interventions that are responding to VAWG. The question I asked to generate responses was: '**How are you addressing gender-based violence in your programming initiatives?'** Participants from the advocacy category reported that the most common activities around supporting GBV survivors was the provision of temporary shelter for women and their children and

legal help for those seeking divorce, child maintenance, and protection orders. Participants also cited that they deliver assertive training and empowerment courses while others set up and facilitate support groups for survivors of GBV. Interventions also included one stop centres, a government- initiative, supported by different development partners to bring services for survivors under one roof. My data also shows that healthcare workers and community cadres are trained to respond to GBV while capacity at health care facilities is built to offer targeted services. Similarly, communities are sensitised to report GBV and, in the case of sexual gender violence, to report to the healthcare facilities in order to receive PrEP, emergency contraceptive, STI screening and HIV testing. From the nurses' cohort responses reflected a more direct approach to addressing GBV which include health education, counselling couples and families and escalating case to the police and community discussions. In a major highlight of the siloed and fragmented nature of some interventions, participants mentioned that some HIV interventions did not have scope for GBV due to a lack of funding. A participant narrated:

> "These are some of the areas which are a bit swept under the rag. We don't get any funding to support initiatives addressing gender-based violence. There are awareness campaigns which are carried out in schools but it's an area with a gap. There are little meaningful activities in this area. We are just scratching the surface; the deeper issues are difficult to address" (ZDPPP9, development practitioner, male).

This statement reveals that addressing norms that govern social and cultural aspects life is considered emotive and practitioners are not keen to engage with controversial emotive and subjective issues.

7.1.3 Gender norms impact on HIV counselling and testing interventions

In Zimbabwe a suppressed health infrastructure means that important services such as viral load testing is not routine and mostly available in cities thereby marginalisng the majority of the population who dwell in the rural areas (Roberts et al, 2016). Zimbabwe's National AIDS policy implemented in 2001 includes voluntary counselling and testing service aimed at promoting more testing (Chevo & Bhatasara, 2012, p. 5). In spite of this initiative, testing rates among men are found to be lower than women. My participants also revealed that the fear of violence affects those who are living with HIV to the extent that they fail to disclose their HIV positive status. This leads to non-adherence to treatment and since they lack the social support system required to cope with an HIV

diagnosis, women end up double burden of disease and violence.

Orr et al (2017) found in a South African study that men were concerned about being labelled as HIV positive if they were seen queuing at HIV testing facilities. It is believed that honour and dignity will be compromised once one is associated with a positive diagnosis. Men are also reported to avoid getting tested for fear of a positive result. A positive correlation between socio-economic status and likelihood for testing is well established. Individuals with high levels of education, in employment and with knowledge of HIV and therefore an awareness of risk will get tested for HIV (Peltzer et al, 2018). Similarly, urban dwelling populations are also twice more likely to get tested for HIV than their compatriots in the rural areas (Johnson et al, 2017; Peltzer et al, 2018). This could be as a result of the proximity and ease of access to testing facilities. Testing among pregnant women is not universal which means that a significant number of pregnant women who could potentially be infected could go on to transmit the virus to their children. This is because some women do not present in prenatal care for various reasons that include lack of financial resources to pay for maternity care and religious norms that prohibit modern medical care (Machingura, 2014).

7.1.4 Masculinities impact on accessing Antiretroviral treatment (ART)

In Zimbabwe ART was made widely available in 2016 regardless of CD4 count (MoHCC, 2016; UNAIDS, 2016), however treatment rates differ by gender as women are more likely to access treatment than men. This shows the divergence in health seeking behaviours between the sexes. Masculinity has been found to be a barrier to men accessing HIV treatment (Skovdal et al, 2011). The reason for this discrepancy is that it is considered demasculinising for a man to attend a healthcare facility and the act of engaging with health care service and accessing treatment is considered feminine (Orr et al, 2017). In 2016, 94% of pregnant women accessed ARVs (UNAIDS, 2019a) which accounts for high prevalence in care for women. Men are therefore less likely to be virally suppressed than women as they often present late in care (UNAIDS, 2017b). These behaviours are fueled by gender norms that associate illness with weakness leading to the feminisation of healthcare facilities (Orr et al, 2017). Addressing these issues in Zimbabwe is a male led advocacy group; a participant alluded to the intervention recounting:

> "As a gender organisation we bring in men for conversations around challenging these negative forms of manhood so in a way, we are into sensitisation of men, not necessarily for them not to be abusers but also to seek services. What we are also trying to do is move away from the notion that masculinity in its toxic form, it deters

men from accessing services, but also deters from being abusers as well as for them to be recipients of services" (ZOGPP2, advocacy, male).

Retention rates in care for men and women are comparable although dropout rates for children and young people are high (GoZ, 2017). To rectify this community adolescent treatment supporters (CATS), and young volunteer counsellors provide peer support for young people living with HIV to remain in care. The initiative yielded remarkable results for retainment among individuals taking part than those who did not take part (Willis et al, 2019). Having their own peers mentoring them resonate with cultural norms that promote power hierarchies (Togarasei, 2020) therefore young HIV infected people can relate with people of their age group without the complexity of power dynamics.

7.1.5 Gender, social and religious norms impact in interventions

HIV prevention, care and treatment services are free in all public health facilities however social pressures hinder women from accessing treatment. Women seeking HIV treatment face numerous challenges among which culture, gender and religious norms emerge as a major constraint. To understand this further I asked my participants the question: **'What challenges do women face when accessing HIV treatment?**' Gendered roles and gender disparities in both the social and economic sphere emerged as vehicles through which vulnerability is exacerbated. Among my participants, there was consensus that women are more likely to seek treatment than men although they also conceded that there was still a large number of women who faced challenges in accessing treatment. Among the challenges women faced in terms of accessing treatment for HIV were, distance and transport costs to travel to healthcare facilities, unsupportive healthcare staff attitudes and confidentiality breaches. My participants informed me that although HIV treatment was free in the rural areas there were not enough outlets to dispense treatment drugs. Others also pointed out to a lack of test kits and ARVs at certain times.

There is evidence to suggest that programming is mainstreaming gender in projects however programming does not go far enough in addressing gender norms that underpin women and girls' vulnerabilities. A participant responded:

"We have got a very strong engendered services approach to make sure that its

> gender friendly. We are providing care to those affected by gender -based violence particularly sexual assault. We are assisting them to get post exposure prophylaxis, pregnancy testing, STI testing as well as linking them to other services like the courts of law and we really make sure that we ensure we do it within the Rights based approach to make sure that they get all the reproductive health services which they need" (ZDPPP5, development practitioner, male).

Participants cited marginalised women as forbidden by their husbands to attend medical appointments and need their male partners' approval to access HIV prevention, care and treatment programmes. My participants also narrated that young women need parental consent to seek HIV testing. A participant alluded:

> "Culturally you will find out that the woman still need to seek permission, in some cases from the extended family or from the husband to go for that treatment" (ZDPPP5, development practitioner, male).

Men as heads of the household (Chuma & Chazovachii, 2012) assume those decision-making powers in hierarchical gendered relations (Bhana & Nkani, 2014) that can extend to sanctioning a woman's right to medical care. These statements reveal that these women are restricted in exercising agency because of gender norms that confer absolute power to men. This power hierarchy is reinforced and normalised within the patriarchal framework that increase women and girls' vulnerability (Ozaki & Otis, 2017).

A female participant explained:

> "In the rural areas women seek consent from their partners to get tested or be initiated onto treatment. Sometimes the men will not be around for example in the southern regions of the country, the men will be in South Africa and only come back once a year but the woman could have been diagnosed for HIV in February, but the husband will only be back around December. The women are not empowered to make decisions about getting onto ART when sometimes the men would be on treatment" (ZDPPP6, development practitioner, female).

This narrative chimes Goebel (1999) assertions of "a prevailing gender ideology that condones the supremacy of male authority even in the absence of men" (p.77-78) hence women fail to make decisions without authorisation from their husbands. Gender disparities are also evident in this narrative; some men could take HIV treatment that their wives cannot access unless under explicit permission. This highlights a situation where male power and control over women is tolerated and

typifies double standards within patriarchal values (Palit & Allen, 2019; Museka & Machingura, 2014) that regard men's health more important than that of women. Similarly, with a positive diagnosis we see dynamics that are informed by gender norms where women are blamed for transmitting HIV (Kalipeni, 2008; Rujumba et al, 2012; Yonah et al, 2014). Through prevention of mother to child transmission (PMTCT) and SRHR programmes, women have more opportunities for HIV testing than men which means that more often than not, women will be the first to know in the event of a positive diagnosis. A participant narrated:

> "Once one goes to the facility, once diagnosed HIV positive first, they are considered the ones who have brought HIV into the family. They have got a challenge in terms of disclosing, hence some resort to taking their medicines at their offices, at their friend`s place because they cannot disclose to their partner. They suffer violence because they are the ones being accused of bringing HIV into the household" (ZDPPP7, development practitioner, male).

Citing the impact of gender norms on women's health seeking determinants another participant narrated**:**

> **"**If you go to Chipinge, go to the border towns/districts, married women who are staying with their in-laws because their husbands are [working] in South Africa, they are left into the custodian of their in-laws. If they want to go to the clinic, they must tell their in-laws that they want to go to the facility and their in-laws are supposed to escort them, the issues to do with confidentiality also come in again" (ZDPPP7, development practitioner, male).

This explains the level of control that marriage places upon a woman and gives credence to Akurugu et al's argument (2022) that upon marriage a woman transfers from her father's control to that of her husband's however in the absence of her husband her in-laws assume that control. This highlights that one marries into a family and not just their husband and spotlights the communal nature of Zimbabwean marriages. These are the layers of kinship that a woman enters into and that have to be negotiated in exit terms.

Citing the impact of gender norms on interventions a male participant argued:

> "The problem is the men. If you continue pushing and working saying you are building the voice of the woman, she will be beaten to death in the home. Talk to

> the man so that he appreciates that these practices are bad and unacceptable. Meaningful and constructive engagement of men" (ZDPPP10, development practitioner, male).

When questioned whether men were being engaged at community level the participant answered:

> "No, whatever you may say, well it's a men's world. The world is dominated by men, unless if you go to the men, nothing is going to change. If women raise their heads in the home, they will be beaten thoroughly or they will be dumped, told that "leave me, I am moving on, there can't be two men in this house" (ZDPPP10, development practitioner, male).

Contextualising the patriarchal nature of the Zimbabwean society and the structural inequality it represents a participant argued:

> "People don't know, even our donors, they talk of DREAMS, Determined, Resilient, Empowered, AIDS-free, Mentored, its ********. How can you be Determined, empowered in a country like our own? When you are not dealing with the causative issues, how can they be empowered. Root-cause analysis. You see someone who will be a DREAMS girl, advocating and facilitating DREAMS initiative during the day but at home she is being beaten thoroughly. The DREAMS is work, when she gets home, she is changed. Those are the issues" (ZDPPP9, development practitioner, male).

What this statement shows is that interventions that seek to empower women against HIV infection can only go as far as the environment will allow. Women express agency and autonomy outside of the home that they cannot replicate in the home because of restrictive social and gender norms that dictate what a girl or woman can and cannot do (Museka & Machigura, 2014). A male participant also highlighted the backlash (Dutton & White, 2013) experienced by women from their male partners after accessing the interventions commenting:

> "Intimate partner violence is real but people talk of HIV self -test kits. They say the woman is given a HIV self- test kit for secondary distribution to the partner, that woman will get beaten, she will be told your results are my result" (ZDPPP3, development practitioner, male).

This elucidates women's precarious positions when they take the initiative to determine their HIV status. It also explains patriarchal power and influence in determining what a woman can and cannot do without the husband's approval (Togarasei, 2020).

7.1.6 Gender and social norms impact on Pre-exposure prophylaxis (PrEP)

PrEP entails medicating HIV negative individuals at high risk of HIV with ARVs in order to prevent them from acquiring the virus (WHO, 2015). As of 2016, only 403 HIV positive individuals had accessed PrEP in Zimbabwe (UNAIDS, 2018). The widespread introduction of PrEP is lauded for success in halting HIV transmission however for girls accessing PrEP presents several challenges. For example, unmarried girls cannot access sexual health services freely because social norms associate sexual activity with marriage (Chiweshe & Chiweshe, 2017) and for a young unmarried woman to access PrEP they will be found out that they have been sexually active. Similarly, for women accessing sexual health services carry negative connotations and policing women's sexual health are gender norms informed by patriarchal values that determine what a 'good' woman look like. While unmarried young women and girls cannot openly access contraceptives, accessing HIV treatment carries similar forms of stigma. A response from a participant highlighted this:

> "if a woman is seen or known to be accessing treatment from the hospital or clinics they are considered to have been promiscuous for some reason. Women are blamed for that either because you could not take care of your husband so that he would not cheat and bring HIV or maybe you are possessed by evil spirits and you cannot keep a man that's why your husband brought HIV. You are regarded as a beautiful, responsible and a submissive wife if you do not have HIV and if your husband does not cheat" (ZNPP1, nurse, female).

The narrative alludes to LE socialisations that promote yielding to one's husband's sexual needs on demand to prevent him from engaging in extramarital sex thereby eliminating the risk of HIV. If a couple therefore acquire HIV the blame is placed on the woman for failure to provide sexual services to her husband as stipulated be a marriage contract (Vroklage, 1952; Bourdillon, 1982; Lowes & Nunn, 2017).

7.1.7 Social norms' impact on SRHRs

Cultural and religious norms interpret sexual activity as a domain for adults (Mutema, 2013) and an act of immorality if young people come into contact with it (Remez, Woog & Mhloyi, 2014). Young people's sexual agency is denied by such dominant sexual scripts to the extent that there is activism against provision of SRH services to young people below the age of sixteen based on the presumption (and denial) that this cohort does not engage in sexual activities (Chiweshe & Chiweshe, 2017). The campaigners argue that engaging in sexual activity at that age is illegal and therefore victims would need a police report to access medical services or at least be accompanied by an adult. This infers that when a child under the age of sixteen has engaged in a sexual activity, they must have been raped. However, the Zimbabwean constitution does not penalise consensual sexual activities between young people of these ages (Govt of Zimbabwe, 2013b). Yet the denial of this service when young people are engaging in consensual sexual activities (Chiweshe & Chiweshe, 2017) fringes on the' best interests of the child' principle (Govt of Zimbabwe, 2013b) because this then leads to teenage and unplanned pregnancies upon which marriage will be enforced to avoid stigma of single parenthood and dishonor to the girl's family (Remez, Woog & Mhloyi, 2014). In the event that the responsible male does not have the financial means to pay bride price, the girl's parents will forgo such expectations to preserve honour.

The Zimbabwe National Family Planning Strategy (2016-2020) made allowances for girls sixteen years and over to access contraceptives without parental consent but healthcare workers are not willing to prescribe. My focus group participants and some from the nurses' category asserted these views and detailed girls' experiences with healthcare practitioners. Their reluctance stems for cultural and gender norms that police girls' sexuality and stereotype those seeking sexual health services such as contraceptives as promiscuous (Matswetu & Bhana, 2018). Confidentiality challenges on using contraceptives mean that young women forgo their use as they fear the impact from being found out (Chazireni & Chidzawo, 2017). Participants from the nurses' category claimed that it is normal for older nurses to refuse young girls' requests for contraceptives due to cultural values on premarital sex. A participant explained:

> "The sister just told this young girl, 'go back home you shouldn't be asking for contraceptives at your age. You should not be engaging in sex at all'. As a younger nursing staff member, I cannot challenge these views" (ZNPP3, female).

This response elucidates the institutionalisation of the power hierarchy where younger people cannot

challenge the views of their older folks (Togarasei, 2020; Museka & Machingura, 2014) even in work spaces.

Zimbabwe's legal age of consent was amended from sixteen to is eighteen after high level advocacy however adolescent girls cannot access SRH services due to policy provisions. This is in spite of Section 76 (1: Constitution of Zimbabwe) stating that: "Every citizen and permanent resident of Zimbabwe has the right to have access to basic health-care services, including reproductive health-care services" (Govt of Zimbabwe (2013b, p. 37). However, the Public Health Act (2018) Section 35 states that "persons under the age of 18 require parental or adult consent to access medical health services" and fails to mention SRH services. This nuance is purported by children's organisations to imply that parental consent is needed for a child under 18 years to access such services (Justice for Children, 2019). As a result, many adolescent girls are unaware of their HIV status and to get tested, they need parental consent which they cannot ask for because they do not want to be seen as engaging in premarital sex. Yet ironically, 16,000 new HIV infections in 2020 were from young never- married women (World Bank, 2021). Young girls are introduced to sexual activities in the initiation schools without education on the risks of unprotected sex.

Contrastingly, sexuality education in the school curriculum advocates for condom use yet these age groups cannot access any form of contraceptives. Studies on the usage of contraceptives in Zimbabwe have found several challenges that hinder both young and older women from accessing contraceptives which results in high proportions of unwanted pregnancies, early marriages, abortions and STIs (Chazireni & Chidzawo, 2017). Parents, with the support of healthcare practitioners object to the distribution of condoms in schools because it is viewed as encouraging young people to engage in premarital sex which is against cultural norms and values. There is conflict here in terms of the role initiation rites play in sensitising children to sexual activities only for them to be denied sexual health services. My data also evidences this paradox. One participant narrated:

> "We used to implement PrEP, but the problem with PrEP is the parent/caregiver is not going to accept that this young girl is engaging in unprotected sex. So, at the end of the day what this means is this girl cannot take PrEP because if she takes PrEP and the person at home finds out they are going to beat them and throw away the tablets. At the end of the day this girl is not able to protect herself from what she knows she is going to experience because of that kind of environment. Unfortunately, the social protection aspect always

comes in and disturbs the work that you are doing" (ZDPPP8, development practitioner, male).

Social norms that police sexuality perpetuate heteronormative attitudes which serve to disadvantage women and limit their ability to exercise SRHR. A participant from the development practitioner category alluded to this arguing:

> "Married women in Zimbabwe are less free than single women, they control very little, including their bodies and fertility. They belong to someone else, men decide that it's time to have the next baby not the woman herself. Someone decides that their children are now enough, or we need another one. You have these people dictating to the woman what she needs to do and when. Even when she has HIV she wants to know what these significant others wants her to do with her body" (ZDPPP3, development practitioner, male).

Section 2 Integration of HCPs in programming: the challenges

7.2.1 Ongoing integration activities

The UNFPA also collaborates with the ministry of health to distribute condoms and provide sexual and reproductive health information through food distribution initiatives (UNFPA, 2022b). This strategy engages women with family planning services while tackling food insecurity, and could do more towards empowering women and address harmful norms while addressing felt needs. While women (and their families) are fed, they still return to their domestic situations where gender oppression is entrenched therefore such interventions miss the opportunities to address women's vulnerabilities. I will allude further on how such opportunities could be harnessed for gender transformative approaches in Chapter 9. When I asked my participants **to what extent the Ministry of women, ministry of health and stakeholders were integrating VAWG and HIV activities** my participants reported that DREAMS employed an integrated approach where partners collectively deliver sensitisation sessions in the community. Using different models like 'Stop the Bus' practitioners set bases in communities and provide GBV screening, treatment, counselling and HIV testing. Girls that drop out of school can be identified through this intervention with DREAMS subsidising their tuition. Through this layered approach of services, the practitioners avoid silo programming however a development practitioner had this to say:

> "The problem is that we have been doing it piece-meal, this partner comes in, they

have got this small amount of money that they have been given to come in to assist with 1,2,3. They come in and start assisting, then another partner comes in and starts something else. That's why you find DREAMS is being implemented by different partners who are supposed to be collaborating, health guys, social science, education, making sure that we are addressing the knowledge part, we are addressing the social circumstances and addressing the health part. That's a good way of doing it but unfortunately when you are in an environment where the economy is not doing well. Where people, even professionals, can barely afford some of these services, it becomes more difficult" (ZDPPP8, development practitioner, male).

The comment above reveals that programming is integrated in parts but also highlights the challenges brought on by an over reliance on donor funding (Moyo & Mafuso, 2017; Moyo, 2009; Karanda, & Toledano, 2018).

7.2.2 Integrating HCPS in mainstream education

Although the risk of HIV infection is high in the young peoples' age groups their lack of knowledge of HIV is highlighted as a major issue in prevention efforts. In one study, the ministry of health evidenced that only 75% of the young people interviewed knew that they could protect themselves from HIV by using condoms correctly each time they had sex (MoHCC, 2019). Muchabaiwa & Mbonigaba (2019) argue that a lack of communication material on behaviour change and education on life skills prevent young people from acquiring the knowledge needed to protect themselves and others from HIV. Akinyemi, & Odimegwu, (2019) found that the risk of young people to HIV infection can be attributed to their lack of knowledge on how to prevent HIV infection in a South African study. Another study found that sexually active young people have better knowledge about HIV than those who abstain (SANAC, 2017).

Mutanda & Rukondo (2016, p. 56) argue that HIV/AIDS interventions that address sexuality should target initiation teachings particularly Khomba and LE through which patriarchal values aimed at satisfying men sexually are entrenched. Mainstream education therefore would provide a safer pathway to comprehensive sexuality education that holistically integrate HCPs. To mitigate this the government sanctioned sexuality education in primary schools which is embedded in the curriculum and trained 12 000 teachers to deliver the lessons (MoHZ, 2017). Included in the

curriculum are topics on rights, gender, life skills and reproductive health. I then sought to understand how much sexuality education was equipping these young people for adulthood and the risk of HIV. In interrogating the teachers' category on integrating HCPs in the curriculum I posed the question: **'Does it make sense to integrate cultural practices such as LE, child marriage, bride price and polygamy in HIV education?'** Views were mixed and responses ranged from those who supported the inclusion of the practices in mainstream lessons to those who perceived the issues as taboo. Others reiterated that LE affects subcultures and therefore should not be inclusively taught. By subcultures participants referred to the Venda, Remba and Shangani tribes even though these practices are also widely practised amongst the Shona and the Ndebele. Participants advocated for awareness raising sessions only for the latter groups which evidences that there is a gap of knowledge in prevalence amongst the education practitioners.

Although the Zimbabwean education curriculum stipulates that teaching of sexuality education starts in early childhood development (Govt of Zimbabwe, 2018), my participants from the teachers' cohort mentioned time constraints within the teaching timetable. Responses revealed a lack of urgency in educating learners of HIV. This situation is worrying considering that the age group is already of concern regarding teenage pregnancies and child marriages. Furthermore, young girls are vulnerable at primary school age where they receive formative initiation rites socialisations. This is succinctly elaborated by a female teacher who narrated:

> "Now they are saying if you waste time if you spend most of your time teaching about HIV and AIDS, who doesn't know about HIV and AIDS? so you have to spend most of your time teaching them mathematics teaching them science, because they say they (learners) have a future in these subjects. So now that is the main challenge, they don't take it that serious, because they're telling us hah even in Science you're going to learn about HIV. Yes it's there because some of these topics interlink. They cut across all the learning areas but we are saying they need time; you sit down with them and really teach them about these things so that they really understand and know the effects that HIV has in their lives as young people" (ZTPP3, teacher, male).

Passing English and Mathematics is highly recommended in the education curriculum both at primary and secondary education. This is because they are major core subjects which are highly ranked within the education curriculum and without English and Mathematics at GCSE O level, one

cannot enter into tertiary education and most occupations also require these qualifications. Zimbabwe's labour market is competitive and the downturn of the economy makes it even more competitive to secure wage-base employment. One participant narrated:

> "Everything to do with HIV and AIDS is taught under Guidance and Counselling, but when you look at it you would see that on a timetable sometimes it is just allocated one period per week, a period is only 30 minutes. They say for those 30 minutes, you must teach them, then you find that at the same time when the schools are making those timetables, they'll give it only one period a week, then the second thing is that it is never taught sometimes we can spend like four weeks without teaching Guidance and Counselling. The major reason is because they want learners to pass so they're like teach the science, teach the Maths" (ZTPP4, teacher, female).

Participants in this category acknowledged the influence of cultural norms in fueling the practices. To this effect a participant said:

> "We normally leave that for cultures because when children come to school they're from different cultures, from different religions so that part of labia elongation it's not being taught. We have to maintain their cultures and their beliefs" (ZTPP1, teacher, female).

Discussions with this category of participants revealed that cultural norms are revered and as such should not be challenged through mainstream education. Sexuality lessons instead focused on the effects of early sexual debut, teenage pregnancies and contracting HIV and AIDS. Some participants did not support the integration of cultural practices in the curriculum citing the different cultures represented in the schools. One female participant argued:

> "For labia elongation it makes sense to a lesser extent, maybe for those people who believe in it, depending on the culture, the cultural group that you belong to because I realise that especially our youth in Remba culture for as an example they actually marry each other, from that same culture because of issues about initiation rites and labia elongation but for others, it's not a problem, it's not a factor for them. For HIV and for domestic violence yes I see so much sense in it" (ZTPP2, teacher, female).

Most participants however did not support the integration of LE into lessons deeming it. Only relevant to the Venda, Rhemba, Shangani cultures. They supported the integration of domestic violence while acknowledging its role in increasing the risk of HIV infection. A participant argued:

> "I don't see any sense in implementing knowledge about labia elongation in schools because these are cultural initiatives which may not seem necessary in other family cultural backgrounds. On domestic violence, it can be integrated in the school curriculum. lt will help to emotionally establish those students who come from backgrounds that are characterized by violence" (ZTPP5, teacher, female).

A male participant who supported integration argued:

> "If you integrate these things, you are giving awareness of these practices, you are also at the same time, removing the myths associated with some of these practices. For example, the first about labia elongation you are removing the myth, and you are highlighting to the child to understand, to know and to make proper decisions through acquiring informed knowledge from the information which the teacher will be imparting to the child" (ZTPP3, teacher, male).

This response indicates that children will be able to make decisions on whether or not to engage in LE however this contradicts with cultural dictates that expect unquestionable obedience by children (Museka & Machingura, 2014; Togarasei, 2020). This is not to suggest however that children will not be able to exercise agency and reject the practice.

Expressing the gender divide within cultural and social norms, a participant reasoned:

> "HIV and domestic violence can be handled in a mixed class but as of initiation rites by its nature cannot be done likewise because it is gender specific and at times may require practical demonstrations as it is done within the cultural and secret groups. If you attempt to do so in a mixed class there might be resistance, i.e. they may not take the lesson seriously and the boys especially will after the lesson mock the girls. Some of the learners especially girls who may have gone through the training in their home groups may feel bad and sometimes end up having a low self- esteem hence affecting their general learning pattern" (ZTPP6, teacher, female).

The response confirmed that cultural conservatism (UNESCO, 2009) is also regarded within educational settings and highlights the institutionalisation of gender and social norms. The participant is conscious of the need to preserve the gender binary and education in this instance poses as a tool for sustaining cultural heritage and values. This also chimes with parents' reluctance for sexuality education in general to be taught in schools citing that children will become

promiscuous (Svodziwa et al, 2016) and informed by religious and social norms, parents cite sex as an activity for adults (Mutema, 2013) that should occur in marriage (Remez, Woog & Mhloyi, 2014).

7.2.3 Integrating HCPs in health messages

I posed to my development practitioners and stakeholders' category the concept of integrating LE, child marriage, bride price and polygamy messages into their wider work. I asked my participants in the development practitioner category the question: **'Does it make sense to link health messages with cultural practices including labia elongation, child marriage and bride price?** Perspectives differed however what also emerged was that there was some form of integration taking place although the extent to which it was happening could not be established**.** Participants narrated that linking the practices in health messaging will highlight the social and religious norms that perpetuate them and senstitise communities to the risk they pose for women and girls' wellbeing. While acknowledging that the practices fall under SRHR, participants in the development practitioner category said that health services in Zimbabwe utilise a public health approach which targets most common conditions offering high quality, affordable and acceptable interventions. Alluding to this a male development practitioner responded:

> "Our studies, surveys, program data have not yet shown us that HIV infections are being driven by labia elongation so to craft messages including labia elongation really requires identifying the risk groups and targeting the messaging for the highest impact" (ZDPPP1, development practitioner, male).

What participants were conveying was that unless a link could be established between HIV and these practices integration would be of no real value. At top level programming participants also alluded to the lack of baseline evidence of prevalence specifically for LE and although they suggested that integration was taking place this could not be clearly evidenced in programming. A participant responded:

> "Where evidence exist, it makes sense to link the messages. UNFPA already links harmful practices to HIV transmission" (ZDPPP2, male).

Because LE is not recognised as FGM, evidence shows that it is not included in programming. There also seemed to be a view among my participants that Zimbabweans should decide whether or not LE is harmful. In development context that would be ethical and but within the human rights framework it is

the discrimination of girls that are coerced into practising it that it would be framed as a harmful practice. Alluding to the right to determine, a participant responded:

> "To integrate labia elongation I think what we need to get a baseline assessment just to find out what our people say about it because there is that part which says every girl should have long labia so that she is able to satisfy her man" (ZDPPP8, development practitioner, male).

This highlights that at programming level LE is not considered harmful hence the need to establish community perceptions on the practice. The narrative below also highlights the complexity in addressing the cultural practice before integration efforts can be implemented. A participant said:

> "First and foremost it might be prudent to ask what groups? And then, if it is cultural to say that it has always been there and done but the woman no longer like it or the man like it because they have been told that a woman must have it then we will have a very difficult situation of trying to convince them to stop the practice and therefore we may need to see how we accommodate it within the messaging" (ZDPPP3, development practitioner, male).

Other participants cited the paucity in CSO presence in the community which would enable to establish the prevalence of these practices for integration. It was also posed that bringing up messaging in a systematic way within practising communities would ease integration of the risk of HIV in the messaging. My participants were able to identify associations between HIV and IPV and articulated the relevance of integrating them within health messaging. They acknowledged that HIV, and IPV synergise to increase a woman's risk of violence but not LE or bride price. A development practitioner argued:

> "I don't really understand the link between labia elongation and HIV so I don't think it makes sense to link them in health messaging. There is a link between HIV and domestic violence but not with labia elongation" (ZDPPP6, development practitioner, female).

Acknowledging stigma as a drawback in pushing through integration a participant narrated:

> "It makes a lot of sense to link those messages, in terms of giving an integrated message. However, there is a risk of stigmatisation, or the public might misread the message, that everyone who has HIV, at some point was elongating their labia, or experienced some domestic violence, or some GBV

> at some point. But the only, danger is the public now relating things, or stereotyping victims or survivors as the message will be coming as one linking three things" (ZDPPP12, development practitioner, male).

This narrative serves to shows the level of influence and impact that social norms wield in preserving one's image in Zimbabwe.

Section 3 Measuring effectiveness: The challenges

7.3.1 How do we measure effectiveness?

Upon asking my participants what they envisaged for effective interventions my participants responses varied. Some participants mentioned engaging men in all interventions since the occupy positions of authority and decision making. My participants reported that women endure violence and abuse because of economic insecurity and that if empowered economically women and girls will reject violence and determine their sexuality. They therefore called for participatory approaches to empower women using innovative methods of engaging with young people to increase their bargaining power in sexual relationships. My participants advocated for interventions that address women's long-term financial security, through education and sustainable income generating projects. Studies have however shown that women who are financially secure do experience abuse and violence (Cools & Kotsadam, 2017) while others assert that financial autonomy is a safeguard against violence (Dialo & Voia, 2016; Vyas & Watts, 2008). Social and cultural determinants of these outcomes are reliant on the level gender inequality is embedded in the environment. Theoretically, economically secure women may assume a higher status than their husband thereby reducing their risk of violence and abuse. Conversely, their husbands/partner may feel threatened due to the shift in gender norms and power balance. The status quo is thus threatened in the process triggering abuse (Vyas & Watts, 2008).

In terms of programming impact participants in the advocacy category conveyed that interventions were effective but what would be a useful unit for measuring effectiveness? Cited most was the increased number of reports of GBV reported, we might take it as negative to say it means the cases are increasing but it also means that reporting is increasing so effectiveness is measurable in this context. What this shows is that women are exercising agency against the patriarchal ideals of 'maintaining family secrets' (Manyonganise, 2015) by reporting their partners for abuse and violence. However, it is worth considering the extent to which those reports are addressed by the

police. In terms of interventions in Venda advocacy practitioners cited a lack of momentum due to migration of people and social mobility. This is as a result of the fluid state of the border and the fact that the Venda's frequent "interaction across the border seems to suggest that they do not 'cross' the border, but that the border has 'crossed' them (Lamb, 2014, p. 3). Hence, "the numerous interactions with Venda people on either side of the border could be perceived as 'unmaking, unmarking and remaking and remarking' the border to a status of pre-colonial times" (Moyo, 2016, p. 430). Thus, the transiency makes it difficult to sustain intervention. Furthermore, participants conceded that responses were not meeting the needs of women and girls. A participant argued:

> "There have not been many interventions on GBV in Venda, only half-baked efforts to get hold of a group of people together and girls and talk to them and there is an intervention, there is a lot of talk but real effort has not been made, national conferences talking about a problem all the academics and the researchers getting together and talking about the problem year after year but when you get down to the schools very little if anything is being done" (SAOGPP2, advocacy, female).

This narrative shows the gap in interventions that could be covered either in or by schools directly where young girls and young boys could be targeted by holistic messaging that addresses HCPs and HIV. A participant in the Musina area critiquing interventions responded:

> "We run these campaigns working with young people, fighting teenage pregnancy but what I am seeing is that this work is more responsive than preventative like if you look around you will find that there are many shelters around which accommodate girls and women and if you look into those cases you find that there are some who are already pregnant some are survivors of violence and if you look deep into their cases you will also find that its emanating from engaging in sex at a tender age and some also they are migrants they are not based here so it goes in line with some of the push factors again in the country of origin" (SAOGPP1, advocacy, female).

These responses about the lack of resources and effective services as reported by my participants serve to evidence women and girls' experiences of marginality. Although reported on the Zimbabwean side, my data suggests that marginality is experienced more in the Venda area. It is questionable whether the concentration of other ethnicities in the Beitbridge area influences more

resource allocation.

7.3.2 Religious norms impact on interventions

Religious groups are delivering initiatives to reduce GBV by re-interpreting biblical texts which have been misinterpreted by religious leaders to promote the narrative of male superiority and dominance and female subordination. This misinterpretation draws on the teaching from Ephesians 5, verse 22-24: "wives submit to your own husbands…let the wives be to their own husbands in everything". Furthermore, religious leaders are trained as counsellors to better respond to GBV in their congregations (Magezi & Manzanga, 2019). The impact of their interventions is however debatable because they draw on such biblical texts of perseverance in hardship (The Bible, 1611) in faith and hope that God will 'change' the perpetrating partner (Manyonganise, 2015). Citing the impact of religious norms in HIV interventions a participant narrated:

> "We have gone to some extent where we have had to deliver ARVs to people's doorsteps in very hidden packages dressed in disguise not in our uniforms because we know this woman has HIV and the husband because of their tradition they don't believe in taking pills from the Apostolic sect. In some cases we had to meet them at the streams just dressed in normal clothes and we would take our buckets as if we wanted to fetch water and we would go with their medicine to the stream so we can just give them and save their lives we would even go as far as removing labels from bottles because their husbands does not want them to take pills and do not want to hear anything about that" (ZNPP3, nurse, female).

This narrative reveal some of the ways in which women are exercising agency and determining their health outcomes against these oppressive religious norms that deify men (Chuma & Chazovachii, 2012). The influence of cultural and religious norms in sustaining vulnerability was discussed in interviews and a participant conceded:

> **"**The challenge is culture…divorce is still seen as bad even in churches" (ZOGPP3, advocacy, male).

This highlights that women that may wish to exit violent marriages will be restricted by social, gender or religious norms ((Ahinkorah et al, 2022). Furthermore, the stigma of divorce (Chisango et al, 2022) will further constrain women's autonomy to self- determine.

7.3.3 Poverty and impact on interventions

Participants across categories cited the impact of poverty on the effectiveness of some of the interventions. Critiquing the DREAMS project a participant narrated:

> "It's the same problem we used to face with malnutrition, you find an adult malnourished, you give them Plumbynut, when they get home because the kids are hungry, they end up giving them to the kids. When they come back at review, nothing has changed. You start to think my treatment is not working, yet no, the treatment is not working because the person has not taken the treatment. That's one of the challenges I feel we need to revise in our DREAMS project. Yes, the DREAMS project is health oriented, but you can't talk about health without talking about the social life of the people. That's the biggest problem we have" (ZDPPP8, development practitioner, male).

It is unquestionable that the burden of intergenerational relationships is driving rates of HIV infection high. Similarly increasing poverty levels in Zimbabwe are fueling these relationships and considering the dire economic situation faced by families, young girls are pawned to older men for sex (Oranje, 2016) in order to ease the financial strain experienced by families. It is the commodification of girls that families approve of these relationships. I gathered from my participants that ongoing interventions to break the cycle of these relationships including awareness in schools, and in homes grooming mothers as mentors to create awareness of risk of HIV posed by intergenerational relationships. Advocacy practitioners also use role models of women that have delayed marriage to mentor girls as an alternative to engaging in risky age disparate relationships. Education is pivotal in delaying marriage (Shapiro & Gebreselassie, 2014; Soler-Hampejsek et al, 2009), and while delaying marriage might reduce early marriages, in a cultural environment where marriage is regarded as highly as it is in Zimbabwe, it will have negative implications in the marriage market for the women because a delay in marriage correlates with high incidence of premarital sex (Soler-Hampejsek et al, 2009, Westoff, 2003). Women will therefore lose leverage in bride price where virginity is a bargaining tool.

The National AIDS Council and Global Fund support engage 'mentor mothers' who advocate for women rights, women accessing HIV services, and supporting them with stipends to run economical activities such as the ASLEs, (Internal landing and savings), and to undertake projects such as poultry and farming (MoHCC, 2019). This is on the premise that addressing economic vulnerability by financially empowering and educating girls, the tendency to rely on men for

financial support becomes less. Moreover, if the woman or girl's capacity to negotiate safe sex is increased, the rate of HIV transmission is significantly cut (see also Reed et al, 2017). There is however a caveat to consider in this intervention. Because of power imbalances in these relationships empowering girls through training on the importance of condom use and safe sexual practices can only work to a limited extent. Firstly, in the case where these relationships are transactional, it is implausible for a girl largely vulnerable and financially insecure to be the one for example voicing against unprotected sexual intercourse, because she needs the money, she may have to endure the risky sexual behaviour.

Secondly, she may also not be able to advocate for HIV testing prior to the intercourse because of the power imbalance and gendered sexual scripts (Chiweshe & Chiweshe, 2017; Svodziwa et al, 2016). Hence interventions on training women about safe sexual practices can only work in equitable power relationships where decisions are mutually inclusive. There was however a caveat to consider other than the nuances in power imbalances in these relationships. Participants highlighted the complexities around safe sex practice interventions to protect this group of young women because of the poverty that underpins these relationships.

A participant in Venda argued:

> "Huge problem, we call them blessers and unfortunately in South Africa it's not only fashionable but in many circles its regarded as acceptable and even something to boast about and that is the scary part so the problem with the schools is you have guys waiting outside in their cars to pick up the young girls so she is actually boasting he's bought me a cell phone and I've been able to have braids done. A lot of it is triggered by poverty and to some extent families encourage it because it's bringing something in the homestead, it's not only poverty but also materialism, the two go together" (SAOGPP2, advocacy, female).

The extent to which poverty normalise and legitimise these relationships is a cause for concern. Poverty and its correlates are evident in this narrative with parents supporting the relationships because of their transactional nature. From this evidence it is imperative that poverty alleviation interventions are revisited. We need to have different conversations about how we can turn around the landscape of development in terms of addressing gender inequality which exacerbates poverty levels.

7.3.4 Gender norms in intergenerational relationships

On one hand young girls prefer older financially stable men as they offer more financial security than boys or men of their age range according to my participants, while on the other hand older men prefer younger women who they can manipulate through power dynamics into having unprotected sex (Leclerc-Madlala, 2008). Similarly, it is also difficult for girls to ask boys or men to use condoms because the gender role socialisation infers that sexual intimacy should be initiated by men (Masters et al, 2013; O'Sullivan et al, 2007; Harrison et al, 2005). This implies that "gender scripts for sexual behavior overlap with traditional scripts" (Masters et al, 2013, p. 409), Because of entrenched inferiority, and the gender role dynamics a girl often cannot communicate her need for safer sex within that relationship. However, young women have also been found in agentic positions where they demand safe sex in their relationships (Jewkes & Morrel, 2012).

Citing the predicament that women experience from normative gender and traditional scripts of sexuality a participant alluded:

> "There are few methods or interventions which are in the control of women. It also goes down to stigma, on a date you can't expect the woman to bring condoms, its unacceptable" (ZDPPP9, development practitioner, male).

It is also a commonly held view in Zimbabwe that condoms reduce sexual pleasure (Chazireni & Chidzawo, 2017). For this reason, men's utility of condoms is inconsistent while it is viewed as culturally unacceptable for women to have access to condoms.

7.3.5 Funding and resources' impact on interventions

The influence of gender, social and religious norms in determining outcomes for Violence and HIV cannot be underestimated. The impede access to and adherence to treatment and police women and girls' sexuality in ways that increases their risk to HIV infection. However, the inconsistent flow of resources also has a negative impact on interventions as the majority of interventions are heavily subsidised by donors. Participants expressed concern at the level of attention that HIV is receiving which suggests that GBV prevalence is not systematically mapped out. It came through that GBV prevalence data was low whereas HIV has been well researched. High level advocacy was cited for GBV which has resulted in legislative instruments being developed and capacity building expanded however they lack infrastructure to monitor GBV in a systematic way in order to address

gaps in knowledge. The nature of donor funding, and the entailing conditionality (Karanda & Toledano, 2018) mean that there cannot be diversification for resources which results in HIV being funded more than GBV. Besides GBV is normalised and tolerated and does not constitute a national security concern like HIV (Yartey, 2015; Elbe, 2017). In the discourse of national security discourse securitising HIV justifies the disproportionate resource allocation meaning that GBV is not regarded as a national threat.

Transforming norms requires much infrastructure to build and sustain momentum. Cislaghi (2019) recommends the trajectory towards change be community led and equally, Mackie (1996) argues for a critical mass to be achieved to spearhead change of social conventions. My participants alluded to this theory but cited constraints of resources in achieving a critical mass necessary to change norms. A male participant commented:

> "We have piece-meal interventions. We have enough resources to make changes in a few villages or in a few districts and not have a nationwide mass campaign. The more we cover deeply across the country the more we begin to create a new culture but even if we change people here the influence of the work that we have done might be diluted by the fact that in the next nearby district there has not been reached because of resources so the culture that we are trying to change might not take place as fast as we want" (ZOGPP3, advocacy, male).

Evidently funding restricts what can possibly be achieved in programming and should inform development policy to sustain the impetus for change.

Conclusion

In this chapter I have delineated interventions that are ongoing in response to VAWG and HIV. It is evident from my data that HIV interventions in Zimbabwe are robust even though prevalence rate of new infections is high. While in principle programming deliver targeted interventions, the data I presented in this chapter serves to highlight the shortcomings of those interventions because the social drivers of violence such as gender inequality are largely ignored. Data from the teachers' category evidenced conservative views about dominant hegemonic gender and social norms which are normalised institutionally. I had considered it necessary to understand whether or not education could play a role in addressing VAWG and challenge harmful cultural gender norm socialisations and empower girls (and boys) against violence. I propositioned that learning could support social

norm reversal in that regard and mitigate vulnerability to further violence however, even though the education curriculum supports sexuality education, the teachers I interviewed felt that integrating cultural practices would be intrusive and irrelevant as the practices were not universally practised. My participants revealed that a lack of resources in Zimbabwe hampers the various stakeholders' uncoordinated interventions which results in victims not getting the support they need. Funding constraints undermine the sustainability of the work that CSOs do in HIV prevention work. Foreign aid, which is targeted at single causes provides an entry point although this does not necessarily address all forms of violence experienced by women. There is evidence of integration of different services aimed at addressing GBV in general. My data also revealed that the health infrastructure is overstretched with staff and resource shortages.

The findings from the interviews revealed that cultural and restrictive gender norms limit women's agency by restricting their autonomy to determine their health outcomes. As a critique to the interventions and their sustainability some of these interventions besides being top- down (Servaes, 2022), they should also be informed more by what is happening at grassroots community level so that interventions are tailored to meet the different geographic, and cultural dimensions that are evident in the different areas of implementation, and to ensure buy-in and sustainability. For example, DREAMS is tailored for adolescence girls however empowering young people when they their autonomy to exercise what they learn is limited will not be effective unless religious, gender and social norms are transformed. The cultural environment will inform what their empowerment look like and the extent to which they could operationalise it.

The interventions are limited in terms of not addressing the root causes of HIV infection. Specifically, there are no targeted interventions on factors that cause and influence LE, child marriage, polygamy, or bride price. Programming is largely focused on providing responsive support for both HIV/AIDS and GBV. Support attempts targeting the most vulnerable however does not go as far as preventing young women from being infected with HIV or to stop abuse happening so in other words does not tackle the harmful behaviours that lie behind HIV transmission and GBV. The interventions for HIV in particular do not link risky behaviours to dominant gender and cultural norms that render women more vulnerable to sexual assault and sanction male promiscuous behaviour. The omission of LE, child marriage, bride rice and polygamy in programming means that they are not seen as VAWG alongside other forms. What this means is that their link to HIV infection is not acknowledged.

Furthermore, my participants' responses point to a lack of understanding of the ways in which different forms of violence are linked to form a web of vulnerabilities for women and girls. My data revealed ambivalent views on integrating LE, child marriage, bride price and polygamy in HIV programming because of the lack of understanding how these practices are all interlinked and synergise to increase risk of HIV infection. My data also revealed that cultural, gender, religious and social norms are observed across institutions which makes it difficult to challenge attitudes that fuel women and girls' vulnerability to HIV infection. Additionally, my data does not point to solutions in programming that are designed to alleviate poverty which increases HIV risk, in meaningful and sustained ways. Similarly, programming is not addressing the gender, social and religious norms that sanction and expect women and girls to conform to submissive and subordinate versions of femininity. Unless these gender norms are transformed, women and girls will continue to experience gender inequality in repressive ways. In the next chapter I delve into community responses where I sought to understand women's experiences of VAWG and perceptions of the HCPs behind vulnerability to HIV, and find scope within their experiences to situate them within the harmful norms' response discourse.

Chapter 8

The normalisation of violence: Community level findings

Introduction

In the previous chapter, I outlined HIV and VAWG programming in Zimbabwe. The chapter also presented responses from development practitioners, nurses, teachers, and advocacy practitioners in an effort to understand the extent to which interventions on VAWG. In addition, I documented development and advocacy practitioners' thoughts on what could be more effective in terms of addressing the different forms of violence affecting women and girls. Essentially, I wanted to capture my participants' views on linking health messages around HCPs. Integrating health messages with all forms of VAWG including LE, child marriage, bride price and polygamy would not only spotlight these practices as violence but also precipitate and sustain the impetus to reduce VAWG. My data also highlighted a reluctance among teachers to engage with cultural practices and integrate initiation rites in the school curriculum. The wider implications for such a stance have a profound effect on how gender is shaped in young children as they grow into adulthood. We know schools are places of influence and I argue that this is a missed opportunity in terms of creating more spaces to demystify gendered ideologies that create and sustain women and girls' vulnerability and risk to HIV and other forms of violence. This raises further questions in terms of how much influence patriarchal socialisations shape adulthood life and experiences of violence and subsequent vulnerability?

In this chapter I present findings from community level discussions which highlight the impact of these socialisations in shaping experiences of violence. I draw on data from community fieldwork from which I was interested in understanding women's life experiences and most importantly understand what shaped their experiences of violence. Furthermore, I wanted to explore with my participants the role that women's initiation rites play both negative and positive to impact their health and wellbeing and whether they contributed to their vulnerability to HIV infection. I critically wanted to explore what these rituals might tell us about the role of women and perhaps help us to understand better the challenges women face and how those challenges could be addressed. Conducting field work in both regional and local migration hotspots like Musina and Beitbridge ensured that my community discussions captured views from different ethnicities and tribes on the cultural aspects of the practice of LE and initiation rites and the role they play in informing marriage norms. This also allowed me to note similarities and understand the differences

and the meanings that my participants attached to those nuances.

The chapter is structured as follows:

Section 1 explores women's experiences of gender inequality in the community. In section 2 I outline how gendered socialisations enforce vulnerability through prescriptive norms that justify violence. In section 3 I explore my participants' conceptualisation of HCPs and explore the implications for agency. Section 4 outlines the normalisation of HIV and implications for programming. I end the chapter with a conclusion.

Section 1

8.1. Experiences of culture and gender in the community

The influence of culture to determine gender identity and intended roles in life is huge. To understand this further I asked my participants the question: **What are the main challenges women face in the communities you live?** Group perceptions diverged at times. Interestingly, the responses established what we already know that women are systematically discriminated in all spheres of life which exacerbates their vulnerability. Views also revealed deep rooted gender inequalities that highlight the role social and cultural norms play in perpetuating and sustaining women's low status in society. What I also learned is that women are supportive of some of those norms that seem to bring about forms of oppression and vulnerability in their lives. Articulating some of their life experiences, it was clear that intersectionality also plays a role in terms of differentiating the levels of vulnerability that women face. One's marital status, financial status, and age presented different challenges within this cohort and their views reflected this. I noted that age and ethnicity was behind the discursive views expressed and upon analysis, age was found to be the determining factor in the viewpoints expressed. The majority of my participants alluded to the cultural norms that men are superior to women in patriarchal societies (Fidan & Bui, 2016; Sikweyiwa et al, 2020). A participant claimed:

> "We are looked down upon as women, men just have those views. We just know that the man is the head of the house and you could be treated as though you are not a human being" (PP4FGD1).

Concurring to this sentiment a participant argued:

> "Men are better off in life women have always lagged behind. Men get jobs quite easily. Some men forbid their wives to work insisting that they should stay at home and look after the children. Even in the workplace, men are promoted before women" (PP3FGD1).

My data alludes to the fact that the mistreatment of women by men and gender-based discrimination is a significant issue in many parts of Musina and Beitbridge. Most of the participants echoed that they often face numerous challenges and obstacles in various aspects of their lives, including employment opportunities. These challenges can be attributed to a combination of cultural, social, and economic factors. Citing societal attitudes towards gender roles another participant added:

> "The community cannot accept that, there is nothing like that. Even your husband will not agree to do it he will tell you that chores are a woman's responsibility his responsibility is to go out and search for means to survive" (PP3FGD1).

The issue of rigid gender roles in Musina and Beitbridge is a significant and complex issue that has social, economic, and cultural dimensions. These traditional gender roles place the primary responsibility for household chores and caregiving on women. This expectation according to the focus groups can limit women's opportunities for education, employment, and personal development. The group argued that without intervention male children growing up witnessing violence and abuse might also become perpetrators of violence in adulthood (Jewkes et al, 2013; Fulu et al, 2013). One participant cited initiation schools for boys within the *Remba* community as one of the places where boys are taught good behaviour and gender roles. However, the participant could not explain the extent to which this education addressed gender equality issues. The focus group discussions highlighted that gender inequality in Musina and Beitbridge is a complex issue with various challenges that women face in their communities. These issues are often exacerbated by deeply rooted cultural norms and gender stereotypes which often perpetuate gender inequality. In addition, the intersection of these issues with poverty and other social factors makes the situation particularly complex (Sikweyiya et al, 2020).

Ethnicity	Age	
Zezuru	34	PP1FGD1
Karanga	26	PP2FGD1
Karanga	27	PP3FGD1
Manyika	40	PP4FGD1
Karanga	25	PP5FGD1

Table 8.1: Participants' demographics stratified by age and ethnicity/tribe

Participants in the focus groups lamented the lack of respect and opportunities for women in the community and workplace. There was consensus among the group that there was generally a lack of respect for single mothers in the community (Kambarami, 2006; Barnes, 1999). The lack of respect and opportunities for women in this part of Africa, as in many parts of the world, is a pressing issue that stems from a complex interplay of social, cultural, economic, and political factors. One single woman responded:

> *"hapana kana chaunotaura ukanzwikwa semunhu asina murume. Tinotarisirwa pasi takasvorwa zvekusvorwa zviya. Hapana anombokuteerera* (there is nothing you can say and be listened to as a single woman. We are looked down upon like scum, no one will listen to a single woman) (PP1FGD2).

When asked about the role of women in the community there were sentiments of resignation expressed throughout the group. Women accepted the status quo and referred to it as part of life. One participant narrated:

> "Men look down on us, that we cannot survive without them. It is the way it is, it has always been like that" (PP2FGD2).

Referencing the role of community as an enabling environment the group echoed sentiments from the first group that women were unwilling to rely on their community for support in cases of abuse and violence because of a lack of trust. According to the focus group discussion, male control over women is rooted in culture (Thebe, 2018; Akurugu et al, 2022) and also tied to women's dependency on men for livelihoods (Fidan & Bui, 2016; Thebe, 2018). Norms of entitlement were also cited as mechanisms that sustained male superiority over women (Bhana & Moosa, 2015; Bhana, 2015; Gibbs et al, 2014). The issue of men controlling women in Beitbridge and Musina, according to my data, is a manifestation of gender inequality and power imbalances deeply rooted in societal norms, traditions, and cultural practices. One participant claimed:

> "It is because of our culture that men look down on us, that is the way it as always been" (PP3FGD2).

In a different dimension to the argument some participants suggested that financial autonomy gives women leverage over their fate in relationships (Dialo & Voia, 2016; Vyas & Watts, 2008). The group however antagonised over whether economic empowerment had advantages over women's bargaining power in relationships and concluded that even those women who are economically resilient are still being abandoned by men over unemployed women including house maids. Although the group upheld the argument over economic autonomy, the overruling fact was that

financial autonomy enabled women to provide for their children in the event of a relationship breakdown, but not to sustain marriage. Here the normative idea is that one should never leave marriage particularly where financial resilience is lacking. A participant contradicting this bargaining power consciousness asserted:

> "If a man leaves you, it means you will either get into prostitution or remarry but if you are working you can wait until your husband comes back and apologises because women get into sex work because of poverty" (PP4FGD2).

The challenges here according to my participants is that gender inequality is deeply entrenched in their society. In addition, the focus group highlighted the lack of education although acknowledging that progress has been made in increasing girls' access to education, gender disparities persist. In some areas of Beitbridge and Musina, girls are more likely to drop out of school due to early marriages, household chores, or lack of access to sanitary facilities. As a result, women often have limited access to economic opportunities and are more likely to be engaged, in low-paying and informal jobs. The group explored other channels through which violence could come from and agreed that not only the husband but his extended family could be a source of violence and abuse. The group reported that some men become jealousy of their wives' autonomy and will forbid them from working because they feel threatened by this 'independence' (Vyas & Watts, 2008).

Ethnicity	Age	
Venda	60	PP4FGD2
Venda	28	PP1FGS2
Karanga	29	PP5FGD2
Remba	47	PP3FGD2
Shangani	50	PP2FDG2

Table 8.2: FGD2 Participants' demographics stratified by age and ethnicity/tribe

Efforts to promote gender equality in Beitbridge and Musina, as in any part of the Africa, should be about ensuring that women can exercise their rights, make their own choices, and live free from discrimination, violence, or control. Gender equality benefits society as a whole by fostering a more just and equitable environment where all individuals can reach their full potential.

Section 2

Gender socialisations and vulnerability

8.2.1 Sexuality and gender norms

To understand the role of initiation rites in crafting vulnerability to HIV I asked my participants the questions**: What do you think about initiation rites such as labia elongation? What can outsiders learn from them?** Group dynamics (Kitzinger, 1995) played a part in the focus groups. Participants who initially denied the continuation of LE eventually admitted its existence after affirmation from others who were confident in articulating both its existence and perceived impact. Ultimately, individual perceptions of the importance of LE varied widely. The issue of practising LE as part of culture came out strongly with the significance and necessity of virginity emphasised. A participant responded:

> "Where I come from in Mhondoro, we are taken as group of girls and get trained what to do to a man, how to handle him. Culture is still being practised. The grandmothers and aunties are responsible for teaching you your roles as a wife and besides where I come from girls are inspected for virginity" (PP1FGD1).

I questioned my participants whether virginity still mattered as a prerequisite to marriage and a participant responded:

> "The Zezurus place a lot of importance on this aspect of culture, a white cloth is presented at marriage and if you are not a virgin the cloth is torn to show that you are not a virgin. If you enter marriage as a virgin your mother will receive a cow [as part of bride price]" (PP3FGD1).

While abstaining from premarital sex accorded financial rewards to a girl's parents (Mabuwa, 1993) in the form of extra bride wealth such as the extra cow, engaging in premarital sex brought shame and stigma to the family (Filamusi, 2012; Idowu, 1996). My participants narrated that a mother will lose respect if her daughter engaged in premarital sex and this will be publicly proclaimed. Some participants argued that abstaing from premarital sex will deter a husband from being promiscuous. A participant explained:

> "I think it helps because a man might not abuse you because you were a virgin when he married you. Even if he thinks of cheating, he will come back even if he wants to illtreat you he will be reminded of your virginity but if you were not a virgin argh" (PP1FGD1).

This narrative expresses the desirability and perceived benefit of preserving virginity until marriage. In the Zimbabwean culture men respect women that do not engage in premarital sex. Other participants that disagreed with this notion argued that any special treatment might be temporary. One participant said:

> "Men even if they marry you as a virgin for the first few days of marriage, they might treasure you but later haah zvinenge zvisati zvabata" (he just won't have started -being unfaithful) (PP2FGD1).

The full impact and meaning of this statement is best understood from engaging with the socialisation processes of marriage norms in childhood. Understanding the role and influence of initiation schools in cultural socialisation requires a thoughtful and culturally sensitive approach.

8. 2.2 Preparation for womanhood

My engagement with the community was to gain deeper insight into the significance and impact of cultural socialisations. I asked my participants the question: '**Do initiation rites teachings prepare a woman for the life ahead in marriage?'** Responses projected different views but reinforced the importance marriage. One participant responded:

> "For those who pay heed to the teachings it is very helpful in marriage, sometimes it will also depend on how your husband was raised" (PP3FGD1).

It is evident from my data that initiation rites prepare girls for aspects of married life but their role and influence vary. To understand the specific influence of initiation rites on a woman's preparation for marriage, one must consider the cultural context and the nature of the initiation practices in that particular society. Citing the gender discrepancies in initiation school teachings a participant observed:

> "In the initiation schools we are trained on how to sexually handle a man, there is nothing about the importance of a woman it's all about prioritising men and inflating their ego. Men are never taken anywhere to be trained on how to treat women. It is always about men; he can treat me like a worthless person yet you are taught to treat him with respect and handle him like an egg" (PP3FGFD1).

One participant argued for the respect of men in marriage stressing that if men were not accorded the respect they deserved they would leave the marriage. There was consensus it is men's prerogative to leave a marriage and never the woman. My participants also conceded that women have to be subordinate to their husbands (Crawford et al, 2020; Jewkes & Morrell, 2012; Fidan & Bui, 2016) or risk abandonment. A participant argued:

"A woman's life is to be always under your husband, you are not allowed to raise your head at all (PP3FGD1).

.This narrative signifies gender socialisations that reinforce superiority of men over women as heads of households (Chuma & Chazovachii, 2012; Thebe, 2018) and women as inferior subordinates (Fidan & Bui, 2016). The influence and impact of initiation rites on a woman's preparation for married life can vary significantly depending on the specific cultural context as the nature of the initiation rites themselves. These rites can play a role in preparing women for various aspects of marriage and adult life, but the extent to which they do so is culturally determined. In some cultures, initiation rites for women may encompass teachings and experiences that are designed to prepare them for their roles as wives and mothers (Bagnol & Mariano, 2012; Khau, 2012). These teachings can include lessons on domestic responsibilities, family life, child-rearing, sexual education, and cultural norms and values related to marriage. Initiation rites might also include instruction on interpersonal skills, communication, and conflict resolution, which can be important in a marital relationship. My data showed that the rites of passage in Zimbabwe are cultural societal ceremonies that mark significant life transitions (Perez & Namulondo, 2011; Bagnol & Mariano, 2012). While some rites of passage rituals may have traditionally been male-dominated or centred on male experiences, many societies have evolved and adapted their practices to be more inclusive and equitable. It is essential to recognise that these rituals can serve purposes that extend beyond gender appeasement and may encompass a range of cultural and social functions, such as social integration, spiritual or religious significance, psychological development, cultural preservation and personal growth (Bagnol & Mariano, 2012).

8.2.3 Links between HCPs and HIV

Having established the importance of marriage and the essential culturally informed preparations for it, I wanted to find out what my participants thought about the continuation for LE and its desirability. To generate responses, I asked them the question: **Is there a link between labia elongation, marriage, domestic violence and HIV?** My participants understood child marriage and polygamy within the lens of marriage and therefore discussions did not bring about these practices but focussed on marriage. What they emphasised on was the role LE played in marriage and they reiterated that it played a salient role in the marriage market. Additionally, my participants did not link LE with HIV infection. My data revealed that families and communities expected women to undergo LE to conform to cultural norms and ideals of femininity. In Beitbridge and Musina, LE is seen as a cultural tradition that has been passed down through generations. It is often considered

an essential part of a girl's journey into womanhood and her preparation for marriage. Societal shifts in familial structures due to increased mobility and migration were cited by my participants for the loss of familial bonds which means that female aunties no longer perform the roles of chaperoning their nieces into marriage. The aunties often played a key role in preparing girls for marriage. They offered advice on choosing a suitable partner, maintaining a healthy marriage, and fulfilling the expectations of married life. They also provided guidance on issues related to intimacy and child-rearing. While these teachings can still be accessed from initiation schools, the shift according to my participants explains the rise in the prevalence of divorce. To the consensus of the group one participant argued:

> "Our children are disadvantaged now, what we had they cannot have teaching from initiation schools and extended family that's why most marriages are ending in divorce. There is no one to counsel them, marriages do not last anymore (PP1FGD1).

The role of marriage is one domain that according to my participants has been affected the most by society's makeup. A participant confirmed:

> "That training on how to keep a marriage is no longer given, everyone is now just minding about their own family which is not helpful" (PP4FGD1).

My participants argued that traditional aunties were responsible for teaching girls essential life skills and helped prepare girls for their future roles as wives and mothers and this socialisation helped to preserve cultural heritage and ensured that younger generations understood their culture. Another participant concluded:

> "What I see is that nowadays marriages break down because people have lost cultural values and they get married without receiving teaching from initiation schools and from their aunties and grandmothers" (PP1FGD1).

The role of the aunties according to my data was to assist in resolving conflicts within the family or community. They provided mediation and advice to help resolve disputes and maintain harmony. It is important, however, to note that LE is a complex issue with both positive and negative aspects. Additionally, the practice has been criticised for perpetuating gender stereotypes and infringing on women's bodily autonomy.

Section 3

8.3.1 Bride price and conceptualisations of vulnerability

Studies have revealed that HIV risk increases in marriage particularly where IPV is experienced

(Mugweni et al, 2015; Henderson et al, 2017). To understand the reasons behind desirability for marriage I asked my participants the question: **How important is marriage to you? What are the implications of not getting married? Is bride price important to you?** Here again responses varied subjectively by individual. Participants agreed on multiple levels in their responses. Some participants advocated for bride price to be paid as a token of respect while others claimed that bride price justified violence that might occur later in a marriage. One participant suggested:

> *"varume vanofanira kubvisa something kwete kungotora mwana wevamwe vanhu womuchaisa mapoto ndizvo zvimwe zvinoshaisa chiremerera mukati mevanhu. Ngaanobvisawo something kuratidza kuti ane chiremera* Men should pay bride price not to just cohabit with someone's else's daughter, that shows a lack of respect in society let him pay something to show that he has respect" (PP1FGD2).

The participant expressed that paying bride price should be a 'painful' experience for a man in order to feel that they are parting with something of value in exchange for a wife. The pain would be intended as a deterrent to future violence and will guarantee respect for the wife because she cost him money. We see here women commodifying themselves and this clearly shows that bride price is an HCP which is often deeply ingrained in cultural traditions and notions of identity. It is understood as a symbol of respect for culture and reinforced as tradition. According to my focus groups, bride price is seen as a way to recognise and appreciate the worth of the bride and her contribution to the groom's family. It can elevate a woman's status and value in her community as evidenced by Kambabrami, 2006). Furthermore, my participants believed that bride price provided economic security for them and their families. Some of older participants highlighted that the exchange of gifts and wealth in the form of bride price can help strengthen ties between the two families fostering a sense of connection and interdependence which they believe is important in African communities.

It is important to note that while bride price can have positive aspects, it also has its critics. Some of my participants argued that bride price reinforces patriarchal norms and can potentially lead to violence. A participant gave a historical perspective to the connection between violence and bride price narrating:

> *"kare murume aiti achirova mukadzi aiuchira maoko oti ndichamborova mombe dzangu saka ndizvo zvaachakurovera. "*long ago a husband would clap his hands before hitting his wife and say I am now hitting my cows- so he will hit you for that" PP4FGD2).

While this quote was narrated by an older participant and seemed to infer historical contexts of

bride price, literature cites studies where bride price induced IPV is prevalent (Lowes & Nunn, 2017; Mubaiwa, 2020; Sikweyiya et al, 2020). It became clear during the focus group discussions that bride price can commodify women, and that this perspective may contribute to a perception of ownership, which can lead to controlling and unaccountable behaviour. While my participants all aspired to marriage, it was evident that rites of passage socialisations framed the lens through which women understand their position and gender roles in life. What this means is that my participants could not see that their aspirations for marriage implicated their risk to violence particularly HIV. A participant claimed:

> "As a married woman you should just know that your husband is not yours alone, that is the honest truth, no man is perfect, they do not belong to you alone. Once you acknowledge that your husband has other sexual partners and that he is hiding it from you just thank God for it. They do not leave their mobile phones around and you should avoid finding out, is it a lie? PP1FGD2).

While this quote normalises promiscuity, it also reinforces patriarchal gender roles and inequitable norms, where women are seen as inferior and subject to male control and abuse of power, a finding also established by Lowes & Nunn (2017), Chiweshe (2016) and (Chireshe & Chireshe, 2010). This can foster an environment where violence against women is more likely. The focus groups concurred that this was the status of many marriages; characterised by male infidelity although they acknowledged that it was a difficult situation that had to be accepted. Upon questioning why this behaviour was acceptable participants disclosed discursive responses that could be attributed to the age distribution within the group. One older participant responded:

> "For you to get used to it depends on how he is doing it. A man can have extramarital relationships but if he is discreet about it and takes care of you and the children then everything should be fine" (PP4FGD2).

The focus group discussions highlighted that questioning a man's infidelity in Africa (in this case Beitbridge and Musina) can be challenging due to various social, cultural, and personal factors. The societies in Beitbridge and Musina have traditional gender roles that place men in dominant positions. Challenging a man's infidelity may be seen to challenge these roles and cultural norms, which could lead to social ostracism or even violence against the woman who questions them. Yet another participant reiterated the sentiment that a woman should not try and question their husband's fidelity. She reasoned:

> *"As an adult you just have to be brave and this depends on how the husband is going about*

his infidelity. Zviri zvokuti ndazvinzwa nemakuhwa aah ndinogona kungoshinga handiti wanzwa nemakuhwa" [If I hear of it through gossip I will persevere, it's just gossip] (PP2FGD2).

My data showed that women that question their partners' infidelity may be labelled as troublemakers, not 'good' women (Skovdal et al, 2022; Mugweni et al, 2012) and their reputation may be tarnished. However, the main challenge that many women in Beitbridge and Musina face is are economic insecurity and the ensuing dependency on their male partners. My participants expressed that confronting infidelity can lead to abandonment or loss of financial support, making it challenging for them to speak out. In addition, my participants felt that they did not have adequate legal protection or recourse in cases of infidelity or relationship disputes. This left them feeling powerless in such situations. The younger women in the groups concurred with the older women that women have to tolerate their husbands' risky behaviours in order to avoid divorce. They all emphasised the importance of ignoring their partners' behaviours insofar as the men were discreet and respectful about their infidelity. Emphasising this point a participant argued:

"Kana une murume mumba, mamwe makudo haumboatsvagi" (when you are married, you do not need to look for baboons- *husband's mistresses*) (PP3FGD2).

This statement reveals that being married is perceived prestigious where mistresses are considered as animals. In this way marriage confers status and those women that are married are seemingly unperturbed that their husbands are promiscuous as long as they can hold on to their status. The younger participants in the groups echoed the same sentiments of perseverance while others reasoned that they could potentially give up on marriage where their husbands. Narrating her desire for marriage a younger participant narrated:

*"nesu vechidiki tinotodzidawo dzimba kutonzi ari mumba make ane murume wake so kuzobuda mumba panenge pane zvatonetsa unowana kamwe karespect so (*us younger women also desire to have a husband and stay married so for one to walk out something major would have happened, you earn respect -in the community- by being married) (PP5FGD2).

To the group's concurrence another participant from the older cohort added:

"zvinodawo kungotanga wapinda mumba mako unowana respect so chero zvikazoramba asi unenge wamboyedzawo, tinotokurudzira kuti pindai mudzimba imba ndeyekushingirwa zvinorema (It's desirable to have a taste of marriage, you get some respect for being married that even when the marriage breaks down at least you would have tried, marriage is for perseverance, it's not easy) (PP3FGD2).

Older group members however argued that this was not a new way of responding to male promiscuity but that women have always held that view. However, one participant protested the notion of overlooking a promiscuous husband's behaviour. She argued:

> "I didn't get married for food or clothing, I came for my husband I want to be loved, there was food in my mother's house and I could have stayed there but chose to be married instead" (PP3FGD2).

This highlights that women can be agentic when the determining factors are conducive to such a decision. There was consensus among the group that one could leave their marriage if their partner was physically abusive. Interestingly my participants perceived risky sexual behaviour as acceptable and tolerable than physical violence. A participant responded:

> *"Marriage inoshingirirwa kunze kwekuti kana achikuabuser violence yekukurova aiwa iyo unoenda"* (you persevere in marriage unless your husband physically abuses you and hits you then you can leave) (PP1FGD2).

Here women suggest that a man that hits his wife does not love her and one that is promiscuous loves her and is therefore worth living with. Another participant dismissed physical aggression insisting that a husband should fulfil conjugal rights above everything else. Participants suggested that as long as the husband satisfied his wife sexually it should not matter that he was having extramarital relationships but the participant disagreed:

> *"Kana murume angonyenga zvatochinja, anenge asisina mafeelings anenge ava kungoita zvekungotiwo. Handidi kuvharwa mahwani, ndinoda kudiwa* (once your husband has a mistress, everything changes, there is no intimacy during sex. He will just do as a chore. I do not want to be deceived; I want to be loved) (PP3FGD2).

Reminiscent of initiation school teachings a participant maintained her argument that men like to come to a clean home and to neatly dressed wives and be pampered and have their shoes taken off by their wives after a long day at work. To this narrative a participant retorted:

> "Men do not care about having their shoes taken off when they come home anymore- uyu mwanana uyu, (this participant is too young to understand these things), once Apostolic faith church love portions have been used on them by their mistresses, men will leave comfortable marital beds to go and sleep on the floor in their poor mistresses' houses" (PP2FGD2).

This statement reveals that older women, because of life experience have insight of some of the initiation rites' teachings and can interpret their significance pragmatically according to their life experience while on the other hand young girls will take the socialisations literally. These

discussions have shed light on the difficulties associated with challenging a man's infidelity which can sometimes lead to domestic violence. Women who speak out may be at risk of physical or emotional abuse. In addition, according to my data, there can be a tendency to view cultural practices and beliefs through a relativistic lens, which can sometimes discourage outside intervention or support for women in these situations. In many African societies, Beitbridge and Musina included, the family and community play a significant role in relationships. Challenging a man's infidelity may invite pressure from extended family and community members to maintain the status quo. My data also highlighted that some women may have limited access to education and information about their rights and options, making it more challenging for them to address infidelity within a relationship. Efforts to address these challenges should involve promoting gender equality, women's rights, and access to education and information. Initiatives that work to empower women and challenge harmful norms will be vital in addressing these complexities that women experience. My participants reported that they pay for contraceptives and healthcare although pregnant women and those with young children can access them for free. My participants also confirmed that ARVs are offered free of charge throughout the country. On the affordability of contraceptives, a participant argued:

> "If you do not have money to buy contraceptives you just get pregnant, you will end up with as many children as possible unless donors give out some. When you give birth, they give you 3 months -worth of contraceptives and that's it" (PP4FGD1).

When prompted about the possibility of using condoms as contraceptive one participant answered:

> "He will just tell you that you have rebelled against me today, it becomes a crime to ask for a condom…you cannot say that; you cannot ask for a condom, where do you even get the courage to say it?" (PP4FGD1).

While this shows a lack of empowerment to make decisions on SRHRs access to and the affordability of contraceptives can be a significant challenge for women in Beitbridge and Musina due to a range of factors. Some women lack SRHR rights to enforce condom use (Chazireni & Chidzawo, 2017) because of their husbands and partners'perceived sexual entitlement (Bhana & Moosa, 2015, p. 2; Bhana, 2015; Gibbs et al, 2014). Furthermore, my participants highlighted the challenges that women face in negotiating condom use with their husbands, even when the husband is known to be infected with HIV. This problem can be attributed to a range of reasons, including gender power imbalance as a result of societal norms which often place men in dominant roles within relationships. Women may feel disempowered to negotiate safe sex practices, fearing

repercussions or abuse if they insist on condom use.

8.3.2 Agency and vulnerability to HIV

Having established that marriage was clearly important and necessary to all of my participants in this category I was interested in finding out what they perceived to be the consequences of persevering in the type of marriages they described. I particularly wanted to find out whether my participants saw any risk to preserve in marriages where partners were clearly known to be promiscuous and also find out what risk to them looked like. All participants in this category acknowledged that it was a difficult situation to accept considering that marriage is deemed to be important in the community. While some participants reasoned that they could negotiate condom use the rest of the participants cited various reasons as constraints to negotiating condom use. Participants debated the possibility of remarrying and potentially meeting partners with a seropositive status. Responses registered resignation to the fact that they will be infected with HIV eventually. One participant responded:

> "Even if you decide to leave you might have already acquired HIV by then" (PP4FGD1).

Controversially another participant argued that there is no reassurance that a new partner would be free of HIV and countered:

> "What if you both get tested and are found to be negative then your boyfriend cheats behind you and get infected with HIV, what will you do? (PP4FGD2).

This statement also shows that women expect their partners to engage in multiple sexual relationships during courtship. In the likelihood of experiencing IPV with a new partner after divorce my participants revealed the same resignation they expressed about HIV. They all conceded that IPV was prevalent and normalised it. Citing reasons to stay in abusive marriages that are characterised by promiscuity another participant commented:

> "Men are bribing doctors to get fake negative HIV diagnosis so you might be tricked by a new partner who already has the infection" (PP3FGD2).

My data showed that the issue of women in Beitbridge and Musina staying in marriages where risk of HIV can be complex and is influenced by social, cultural, economic, and individual factors. The participants in the focus groups believed that cultural norms and societal expectations in some Beitbridge and Musina communities placed greater emphasis on the importance of marriage and family. Leaving a marriage, especially due to an HIV diagnosis, might be considered taboo or culturally unacceptable. One participant maintained that she would insist on condom use with a new partner however opinion varied as participants doubted their own resilience to enforce condom use. One participant argued:

> "In all earnest it is not easy, there could be circumstances you can ask for a partner to use a condom but how do you even say it?" [PP5FGD2).

This statement highlights the gendered dimensions of Zimbabwean sexual scripts (Chiweshe & Chiweshe, 2017; Svodziwa et al, 2016) in Zimbabwe that grant men control over women's sexual rights. Another participant cited the similarities between leaving a promiscuous husband and getting into a relationship with someone else who might also be promiscuous and increasing their risk to HIV. She argued:

> "Sex workers always carry condoms with them but what if you get a long-term boyfriend? You will stop using condoms with him but he might be married and probably have other girlfriends too so what is the difference between him and the husband you left?" (PP4FGD2).

This narrative revealed the complexity of navigating sexuality in the HIV era particularly multi-partnering which seems to be endemic in Beitbridge and Musina as my participants suggested. Literature also cite the prevalence of promiscuity among married Zimbabwean men (Chadambuka et al, 2023; Jackson, 2012). Another participant mentioned the interference of extended family in marriages particularly where agency to negotiate safe sex can be constrained. She argued:

> *"Ndikangoda kuti yowe izvozvi vanoswera vasvika pano ndave kugadzwa dare hanzi ndanzi ndishandise condom. Asi kana iri boyfriend ndinogadzwa dare nani?* (If I ask for a condom my in-laws would be here in no time to question why I am asking my husband to use a condom but if it's a boyfriend no one will question me) (PP3FGD2).

Those participants who expressed empowered views and insisted for HIV testing with intimate partners were notably single or divorced but those participants that were married clearly expressed the constraints of having to ask for condom use. The quote above shows how through the ecology model women's vulnerability to HIV is reinforced by the familial structures that characterise Zimbabwean marriages. This is evident in marriages where decisions on women's sexual rights are decided at family level because bride price legitimises marital family interference in such matters. Participants explored some of the challenges women have to encounter in disclosing a positive HIV status to a new partner. Some cited stigma and rejection while others purported ignorance of established seropositive statuses. A participant commented:

> *"Sesu takatosara tiri masingle mother's upenyuzve unenge uchitsvaga kuraramisa mhuri*" (as a single mother your concern is providing for your children and it is not easy to disclose your HIV status) (PP3FGD2).

It became clear through my discussions with my participants that women feared the stigma and

shame associated with HIV/AIDS and condom use in many Beitbridge and Musina communities as evidenced by Kalipeni (2008), Rujumba et al (2012) and Yonah et al (2014). Similarly, Mkwanazi et al (2015) also evidenced participants' difficulties in disclosing HIV status to intimate partners in a study in South Africa. My participants recounted that discussing or insisting on condom use can carry stigma and might be perceived as an accusation of infidelity, leading to shame or conflict within the relationship. While women's risk to HIV has often been blamed on men in literature (Greig et al, 2008; Dunkle et al, 2004) and while this portrayal is accurate, my data in agreement with Mkwananzi et al's research its contribution "presents a more assertive, women's voice, with women gaining autonomy over their health through access to care, and the ability to make decisions about their sexual health (Mkwanazi et al, 2015, p. 70). One participant pointed out to the importance of getting tested for HIV before engaging in sex with a new partner. However, upon asking whether women felt confident to ask men to go for testing the majority of the women responded that they felt empowered to do so. Championing this claim was one participant who cited her experience of divorce as empowerment towards the exercise of her sexual rights. The same could not be said of the rest of the group as they did not have such experience to draw on. One woman claimed that asking for HIV test results from male partners might jeopardise one's financial status. Other participants however contradicted this view and reported that they would end the relationship which revealed women's ability to exercise agency.

Section 4

8.4.1 The normalisation of HIV

Zimbabwean society has been traumatised by the HIV and AIDS epidemic. Health messages that were aimed at behaviour change a few years ago do not have as much impact now. Because of the success of ARVs in the management of HIV, it is now globally identified as a manageable illness (McGrath et al., 2014) with healthcare providers and activists keen to promote treatment supporting the discursive 'normalisation' of HIV as 'a disease like any other' (Moyer & Hardon, 2014, p.263). So normalised is HIV that my participants did not see it as an issue of concern and their responses all revealed a lack of concern for a seropositive diagnosis. Such findings have also been established by Mkwanazi et al (2015) in South Africa and Mazanderani & Paparini (2015) in the UK where participants also normalised HIV as a chronic illness. While this is a positive way of promoting adherence to treatment, it might have negative implications for those women and girls that are HIV seronegative.

A general feeling is evident of being relieved by the advent of ARVs that HIV is not the once feared infection it was twenty years ago. The level of normalisation is to the extent that women almost expect to contract it in their lifetime. Women view HIV as "causing a chronic, rather than fatal, illness and pride rather than shame" (Mkwanazi et al, 2015, p. 69). Mazanderani & Paparini (2015) argue that people's experiences both reinforce and contradict the normalisation of HIV. While individuals may normalise a seropositive status, they face several social pressures in experiencing the normalcy that comes with this paradigm. It does not remove some of those structural issues that entails positive diagnosis such as stigma and discrimination. This is the reason why I make the argument that HIV needs to be reframed as violence. It is violence because of the violent behaviours behind its transmission and the social and psychological impact on individuals.

The availability and efficacy of ARV, while lauded for removing the stigma once surrounding HIV and the death sentence that AIDS once was (Mazanderani & Paparini, 2015), is partly to blame for such relaxed attitudes towards HIV acquisition. My participants covered every scenario where one could get HIV and all arguments led to the conclusion that HIV is part of life and should be expected. What then does this mean for interventions? This normalisation of HIV while it is helpful as a message to those already infected by the virus, who need all the support and encouragement that they need, it may be received in a different way by those who are HIV negative, particularly young people. My participants in the teachers and nurses' cohorts also highlighted how HIV has been normalised as a trivial infection that is easily treatable. There is nothing wrong with this assertion expect that it sends the wrong message and leads to behaviours that encourages irresponsible sexual encounters because there is treatment for HIV.

8.4.2 Programming challenges: accessing healthcare

When I asked my participants whether there are any challenges women may encounter to accessing healthcare some responses highlighted issues of power and control by male partners which determined whether one could seek health services or not (Chiweshe et al, 2014). Access to healthcare in Beitbridge and Musina is a complex issue according to my data, and women face several unique challenges in this regard. These challenges can vary by region, but some common ones include male control. One participant highlighted:

> "The issues we face are multifaceted, you cannot do anything or go anywhere without your husband's knowledge. Even with health matters they want to know why you are attending hospital and you might be told that the problem will go away so do not go to the hospital"

(PP3FGD1).

The data reveals that cultural norms and societal expectations can limit women's autonomy and decision-making power regarding their healthcare (Chiweshe et al, 2014). This can affect their ability to seek and receive appropriate care. Gender dynamics and healthcare access are complex issues influenced by a variety of factors, including cultural, social, economic, and political factors. The participants reported cases of gender-based control or restrictions on healthcare access in some Beitbridge and Musina regions. Another participant, although seemingly asserting her autonomy, acknowledged that women could be controlled in terms of accessing health services for themselves. She argued:

> "Even if I respect you I will not allow to be controlled over my health, I could understand explaining my whereabouts but *unogona kungonzi imwa mapain ease zvinopera"* (you will be told to just take painkillers and let it to pass) (PP2FGD1).

In terms of the community being an enabling environment, my participants reported that there were limited counselling services in their community which they found unhelpful in terms receiving support for domestic violence. Responses also revealed a lack of trust within families to access support when required. Alluding to this notion a participant stated:

> "It depends on the kind of person you talk to whether they can keep your secret because you might share with them and then they go and share with your family where you came from in the first place" (PP3FGD1).

Accessing counselling centres was impacted by stigma and cultural norms according to the focus groups. In Beitbridge and Musina, there is a stigma associated with seeking counselling, particularly for women. Discussing personal problems or mental health issues can be seen as a sign of weakness or disgrace. This also correlates with the feminisation of healthcare facilities that sees men refusing to be seen as weak for accessing healthcare (Orr et al, 2017). In addition, the lack of awareness of these services came out strongly in these discussions. Many women were not aware of the existence of counselling centres or the services they offer. In some cases, centres may not actively promote their services to the communities. Another participant agreed with this notion and argued:

> "Women would open up about their problems once they know they can access help. A lot of people are suffering internally because there is nowhere to go, they do not know anyone who can help them because going to neighbours about my problem everyone will find out about it. Women just do not know where to go to get help" (PP3FGD1).

To this end my participants mentioned the DREAMS programme which they revealed is targeted to

young girls. In support of DREAMS one participant said:

> "Our children are being influenced by older men who use them [sexually] and give them diseases so DREAMS is better in terms of helping young girls to avoid these relationships" (PP2FGD1).

Upon asking whether domestic violence was addressed in healthcare settings my participants reported that they were not aware of any such programmes. Other participants mentioned that health centres usually run health classes for mothers with babies and young children however one participant who was pregnant claimed that this was not the case anymore. She responded:

> "There is nothing like that, I attend clinic there. They just pray with you and say *vasikana munofanira kuva neutsanana nhasi munotariswa nasekuru munofanira kuva* smart (girls you should maintain hygienic conditions at home and around children, the male nurse will examine you today" (PP4FGD1).

Responses from my data shows that interventions are inadequate to fully offer support and enable women to challenge the structures that impinge their SRHRs. Interventions are limited in terms of their scope and reach and this is exacerbated by inadequate resources.

Conclusion

It is evident from my data that gender inequalities exist in my field sites. Cultural attitudes towards marriage fuel the desire to be married because women will be conforming to their gender roles. My participants highlighted the sanctions that are associated with failure to get married or to stay in a marriage as deterrence against leaving a marriage. These cultural pressures lead women to stay marriages which are risky in terms of acquiring HIV. LE remains a vehicle through which, according to my participants, marriage thrives. My participants claimed that a marriage' s success depended on the preparation that a woman had before marriage and such a woman could be returned to her parents particularly where LE was not performed. The link that my participants made between LE and GBV was that of the breakdown of marriages due to a decline in the practice. My participants evidenced support for LE and bride price and did not perceive harm towards women because of these practices. My participants also revealed a culture of normalising violence which is consistent with the normalisation of risky sexual behaviours and HIV. The normalisation of HIV was a sobering thought however, it only reinforces my argument that HIV should be reframed as violence, largely because of the violent behaviours through which it is transmitted. While promoting marriage and upholding cultural values on family and marriage my participants acknowledged that staying in abusive marriages could increase the risk of HIV

infection. They also pointed out that one could acquire HIV after leaving a marriage. My participants acknowledged that this is a dilemma that women face after leaving abusive marriages and they all concluded that women need to accept that they will be infected with HIV either way. This led to a normalisation of HIV with women pointing out that one as to accept this as part of life, revealing its acceptance as a "chronic illness" (Mkwanazi et al, 2015, p.70). What this means is that interventions will always be responsive because beneficiaries may not be proactive in preventing HIV infection in the first place.

My participants highlighted the lack of resources within the healthcare sector which participants from other cohorts had also highlighted. While some participants felt they could access health services independently others revealed a level of control over their lives and this control determines the state of a marriage. The issues of gender inequality are multifaceted as my participants have revealed. We need to have different conversations to be able to respond to these issues, conversation that will augment community-led social norm change approaches (Cislaghi, 2019) to address individual behaviour for change towards the elimination of LE and risky sexual behaviours that lead to HIV infection. The success of these interventions will lie in the experiences of affected individuals. Where support for harmful norms that sustain marriage the entry point for challenging those norms might be difficult to identify.

It important to note that the decision to stay in a marriage where risk of HIV is deeply personal and influenced by a range of factors, and it may not apply universally to all women in similar situations. Additionally, some women might choose to stay in these marriages for reasons of love, commitment, or personal beliefs about marriage and family. Efforts to address this issue involve providing comprehensive support services, including education, access to healthcare, economic empowerment, and legal protections for women. These services can help empower women to make informed decisions about their health and relationships. Counselling, community support, and access to antiretroviral therapy are also vital in helping individuals manage their health and make informed choices about their relationships. Finally, supporting women in their ability to negotiate safe sex practices within their relationships is essential for their overall health and well-being. It involves addressing the societal and cultural barriers that hinder these discussions and promoting a more open, informed, and empowered approach to sexual health.

My main argument is the integration for LE, child marriage, bride price, polygamy in HIV programming. My participants in this category did not recognise links between these practices, and

neither did they link them with HIV infection. They supported bride price and LE as practices that sustain marriage and their failure to evidence links is an interesting finding in itself. The social, gender and cultural norms that inform the vulnerabilities to HIV risk brings about an ecology that cements women's inferiority and vulnerability to HIV. These are the harmful norms informed by patriarchy, which women seem to support. Patriarchy and its prescriptions of restrictive gender and social norms need to be challenged. I propose a model for gender transformation in policy interventions in the next chapter.

Chapter 9

Policy Response to LE, child marriage, bride price, polygamy and HIV - a new approach

Introduction

In the previous chapter I presented community level data which evidenced the influence of gender and social norms in perpetuating VAWG and increasing women and girls' vulnerability to HIV infection. The power of culture and tradition through socialisations is evident and this runs counter to the efforts of divergent interventions to address gender inequality and most importantly ending VAWG in all its forms. I have also revealed that development practitioners do not acknowledge that LE, child marriage, bride price, polygamy and HIV infection are linked. Low level practitioners in the healthcare sector such as nurses do see links between these forms of violence however they do not have programming remit to effect changes towards addressing the links. Programming, although robust in responses to HIV and GBV is not proactive in preventing instances of these forms of violence because it is responsive in practice. SRHR is integrated in HIV programming however gender, social and religious norms restrict women and girls' agency to self-determine and access services. Entrenched gender, social and religious norms govern women and girls' sexuality however women are being agentic in certain circumstances where the social and cultural environment will permit.

In this chapter I seek to outline my research objective which is to inform an effective mainstreaming approach to increase the sensitivity of policy makers across development sectors to opportunities to end FGM (LE), child marriage, bride price polygamy and reduce the transmission of HIV in women and girls. There is an urgent need to mainstream VAWG in all forms in development if it is to be eradicated. HCPs such as LE, child marriage, bride price and polygamy should be a key focus, regardless of sectorial focus. Eliminating VAWG is crucial to achieving gender equity and for the sustainability of social and economic development and capacity building which is a priority for development.

The chapter is structured as follows:

In section 1 I outline my argument for the integration of HCPs in HIV programming. I go to critique some of the approaches that have been employed to address gender inequality in order to develop a more

informed and effective approach. I present a brief summary in the same section of data from development practitioners where I sought to understand the extent to which they engaged with gender mainstreaming policies.

In section 2 I delineate some of the challenges that practitioners might encounter in the process of integrating HCPs in HIV programming. I go on to present my integration tool in section 2 and end the chapter with a conclusion section.

9.1 Argument for an integrated approach

Preparation for marriage underpins practices such as LE that conceptualise subordination and inferiority to men as qualities of the highest demand in the marriage market. The framing of marriage as a form of idealised identity for women and girls constrain their agency because they have to conform to cultural ideals of femininity that are stereotypically marriage material. Marriage routes in the environment are variable but include child marriage and polygamy. Both forms of marriage are substantiated through the payment of bride price. Such sociaisations expose girls to the risk of violence in adulthood primarily the incidence of HIV. My data from the community discussions reveal a normalisation of HIV; while the infection is no longer a death sentence it was before, copious amounts of resources are poured into efforts to respond to it when they could be targeted at reducing poverty levels that are responsible for the cycle of vulnerability. Confronted with such compelling evidence, different conversations need to be had in the face of the normalisation of HIV because it is no longer an issue that concerns people in the Zimbabwean community, particularly vulnerable women.

Data from lowlevel development practitioners showed that participants did recognise the links between LE, child marriage, IPV and HIV, but not with bride price or polygamy however programming does not consider the links. This lack of nuance is due to the disconnect between programme designs and local practitioners who have an appreciation of the web of complex factors that result in women and girls' vulnerabilities to HCPs and HIV. Interventions are responsive in terms of providing treatment but little else is being done to challenge the gender, social and religious norms that drive risky behaviours through which HIV is transmitted. Discursive interventions have been implemented among young people with minimal translation to behaviour change in relation to gender norm transformation.

Violence is the biggest challenge that women and girls experience women and should be a priority for any interventions; ignorance of violence means underlying causes of such infections as HIV can

never be addressed. Moreover, understanding the social, cultural and religious norms which underpin and normalise LE, child marriage, bride price, polygamy and HIV is paramount to any programming because that understanding will accurately inform interventions. My research has established the need for integrating a VAWG lens in HIV programming which can also be adapted for other development projects as proposed by Bradley & Gruber (2018) in order to holistically end address VAWG and gender inequality. I argue for an approach in programming whereby mainstreaming would be the integrated way of tackling these HCPs in HIV programming. I also go one step further to look at how HIV programming can mainstream gender- based violence and within that could also create an opportunity to educate around LE and provide support to women who may have it, and because of violence, contracted HIV. That opportunity could also be utilised to deconstruct harmful social, gender, and religious norms that are socialised in childhood that are responsible for the passivity and acceptance and normalisation of HIV by women.

These HCPs needs to be mainstreamed within a lens that already is sensitised to other forms of violence that women and girls experience such as HIV because it is limiting to approach interventions with a focus on a single HCP. Firstly, there is need to acknowledge that there is a whole spectrum of other equally harmful practices such as LE, child marriage, bride price, polygamy and secondly, that they are linked to other forms of violence such as IPV and to HIV infection. Foreign aid, which is usually targeted at single causes provides an entry point although this may not necessarily address all forms of violence experienced by women and girls. As such, monitoring and evaluation of the impact of VAWG within mainstream development projects should focus on whether all forms of violence that women and girls experience are integrated in interventions. HIV programming is targeting treatment, and to an extent GBV but as I have argued, child marriage, bride price, polygamy and LE are all forms of violence that affect the same women accessing these interventions. While women (and girls) access HIV treatment they are returning to the same violent settings where they experience further violence whereas programming could simultaneously address the root cause of violence while providing HIV treatment for holistic responses to VAWG.

9.2 Review of existing mainstreaming tools

I briefly critiqued gender mainstreaming approaches in my introductory chapter. In this section I I take occasion to critique the approaches, which, as a paradigm shift, was meant to address gender inequality. The paucity in successes of gender mainstreaming were as a result of ignoring the

privileged roles that men occupied and the resource inequities that already existed. I asked my participants in the development practitioner category the question: "What is your understanding of gender mainstreaming? interviewed to understand what gender mainstreaming meant to them in order to establish the extent to which gender programming was happening. Responses largely revealed limited knowledge of the approach however I will point out here that this does not mean that gender is not mainstreamed in development interventions in Zimbabwe. Responding to the question one participant claimed:

> "What we do, wherever we do it, if we are doing it for a group we must think of gender issues, not just numbers but effective participation and engagement in what we are doing whether we are assigning roles, assigning responsibilities, assigning resources, or allocating resources, without talking of quotas or fractions and not leaving others out, simply because of their gender" (ZDPPP3, development practitioner, male).

Another participant also concurred:

> "We are saying in whatever activity in which we are doing as a service provider, we need to look at the gender dimension, are we serving the women, are we serving the youth, are we serving both boys and girls in a way that at the end of the day we are responsive to their needs without discriminating" (ZDPPP5, development practitioner, male).

Other participants however revealed that they were not familiar with gender mainstreaming. A male participant responded:

> "Gender mainstreaming, to be honest, I am lost" (ZDPPP4, development practitioner, male).

While another participant chimed:

> "I don't know, what is that?" (ZDPPP6, development practitioner, female).

However, alluding to the pervasive nature of gender and social norms a participant responded:

> "Gender mainstreaming, what is that? Gender inequality is very real in our lives. The impact is so big but I think the programming is theory more than practice, that is my personal opinion. Do you think people give the word gender or gender issues its place? When we can

> see gender inequality is very real when we look at the programming part of it, there HIV and gender including myself, you get tired. In terms of planning, conceptual processes, there is a lot of gender mainstreaming that has happened. Implementation not necessarily. We need to learn gender differently, we need a different word, people have grown tired" (ZDPPP2, female).

The participant went on to elaborate:

> "When we look at school attendance and the difference with that of a boy, the difference is stark right. If we didn't put the word gender there, everyone will look at it and see there is a problem but when there is gender, the response will be "oh its women, women are always complaining" So I think the world has to catch up, we need a new word which will not be stereotyped" (ZDPPP11, female).

The responses given by my participants show that gender mainstreaming as an approach is being incorporated in projects in Zimbabwe although the levels it is happening varies. Although we have approaches for gender mainstreaming, the tools that have been developed to support practitioners on the ground are limited mainly to budgeting and monitoring rather programme design. Gender budgeting entails "gender-based assessment of budgets, incorporating a gender perspective at all levels of the budgetary process and restructuring revenues and expenditures" (Council of Europe, 2005, p. 10). Beijing Platform for Action advanced the impetus for gender sensitive approaches in national governments by advocating for visibility of women and for coordination of women's units in governments with matching budgets to sustain government efforts towards addressing gender inequality (UN, 2015).

Beijing Platform for Action also spurred impetus for gender analysis integration into development processes including gender mainstreaming and monitoring and evaluation of data. Gender analysis frameworks utilise a gendered perspective to design, implement, and evaluate projects. They also analyse division of labour by gender while some gather data on gender power relations at both community and household level (March et al, 1999). Globally, governments have made attempts to integrate aspects that concern gender related issues into their budgets to show their commitment to addressing gender inequality (Hopper, 2019). Gender budgeting will undoubtedly have positive implications for the 2030 agenda in terms of achieving gender parity but there are pressing challenges towards that goal. Monitoring on the other hand is defined as "the continuous assessment of project implementation in relation to agreed schedules and of the use of inputs,

infrastructure, and services by project beneficiaries" (World Bank, 2005, p.1).

This approach is useful for continuously monitoring women's participation in politics and the enjoyment of their rights and emphasises component outcomes so the design and management of the project focuses on result and not on the monitoring inputs and outputs. "The aim is to provide managers and decision-makers with an understanding of project failure or success in reaching its desired outcomes" (World Bank, 2005, p. 2). When used in a framework that is based on results, gender sensitive monitoring and evaluation will reveal a project's performance in terms of improving people's lives both socially and economically. At implementation, gender sensitive monitoring can improve the performance of a project and also enables any amendments to be done midway and allows for learning for follow on projects.

Data monitoring tools were increasingly used to capture evidence during austerity in the global North and therefore resources for development were intended to go a long way thereby enhancing resource efficiency. Women's rights organisations were under pressure to produce results (Batliwala, 2011) and 'make' women realise empowerment (gender equality and women's rights not priority) from a development agency perspective. Chant & Sweetman, (2012) term gender "smart economics" however since this approach focuses mainly on economic participation and efficiency, arguments arise that it might limit programming and monitoring and evaluation as the emphasis is on empowering individuals economically (Bowman & Sweetman, 2014).

Gender budgeting discourses on the other hand are proving to be contentious, with arguments claiming that the approach is used "as a disruptive and radical approach to decision-making on public resources and public policy" (O'Hagan, 2018, p.37) to engender macroeconomic policies that aim to reduce gender inequality, and tackle VAWG and enhance women's rights and status (Budlender, 2006; Budlender & Hewitt, 2002). Increased rates of sexual violence globally provided an impetus to policy change regarding gender budgeting but with limited resources, women's enjoyment of rights is still difficult to realise (Jhamb, Mishra & Sinha, 2013). On an economic level, it can be argued that gender sensitive budgets are not sustained particularly where other 'pressing needs' arise and become prioritised, defence is one good example of this. Policy wise, gender responsive budgeting has not always matched resource allocations to run critical interventions for women with severe implications for VAWG. Additionally, most gender commitments are not followed through (Jhamb, Mishra & Sinha, 2013).

Implementing gender sensitive budgets is also dependent on context and we need to consider

intersectionality when comparing women in developed and to their counterparts in developing countries. Women in the latter contexts endure disparities in access to health, education, and nutrition (Dey & Dutta, 2014). These women are economically insecure, primarily engage in unskilled or semi-skilled labour markets or work in their homes for no pay (Patel, 2011; Abwalaba, 2014) or in insecure positions such as domestic employment (ILO, 2018, p. 1). This means that any institutionalised efforts within a gender sensitive budget will not protect these women's rights. Furthermore, gender budgets are increasingly funded by donor agencies and foreign investors (Elson, 2004) which means that they are administered as part of economic development and we do know that inequality stops women from enjoying the benefits of economic growth where it is realised (Nallari & Griffith, 2011; Dey & Dutta, 2014).

Furthermore, gender budgeting tools are more successful where institutions are held financially accountable (IMF, 2014) therefore using these tools in developing contexts is challenging. Levels of governments' responses and commitment to addressing gender inequality and advance women differ. In Italy, Del Gesso (2019) found that the integration of gender into the government's strategy is homogenised, yet it covers four different intersecting themes such as addressing GBV, enhancing social inclusion, encouraging women to take up employment, and promoting equal opportunities for both genders. Additionally, monitoring gender performance is not robust and reporting mechanisms are not systematic. This calls for greater cultural commitment and organisation to institutionalise gender performance budgets (Del Gesso, 2019).

However, gender budgeting is akin to a tick box exercise whereby organisations disclose gender inclusion commitments (Miles, 2011) and prove accountability and transparency to stakeholders (Hossain et al, 2016). Although this would satisfy organisational financial obligations, the approach does not go far enough in terms of social responsibility and societal wellbeing as argued for in the SDGs. (Hopper, 2019). Thus, reports on gender performance indicators do not comprehensively indicate how women will benefit economically, socially, and environmentally including from governance frameworks. Similarly, Gori, Romolini & Fissi (2018) found gender mainstreaming frameworks lacking clarity to capture performance indicators and impact, including resources and strategies that would ensure effective gender policies.

Gender budgeting tools operate mainly at reporting stages and this does not allow for holistic inclusion of gender related issues and as such, policies need to be defined at the design stage to define what wellbeing for both men and women would look like and what indicators would be looked at to determine binary impact (Addabbo et al, 2011; Galizzi, 2010). Gender budgeting has

produced some positive outcomes albeit limited (Polzer, Nolte, & Seiwald, 2020) but have failed to assist governments identify inefficiencies in allocating funds according to the difference needs of men and women (Mahadevia, Bhatia & Sebastian, 2019). Issues of disassociating mainstreaming tools from their use has also been cited as a failure in terms of measuring success of the approach. Similarly, projects have been abandoned after donor agencies retreated (Zakirova, 2014). Some gender mainstreaming tools have also been critiqued for focusing solely on gendered roles and responsibilities and ignoring the role of power relations as argued by Kabeer in her Social Relations approach (Kabeer,1994) which is key in perpetuating gender inequality.

Although gender budgeting entails gender analysis for the purpose of improving fiscal policymaking (Polzer, Nolte, & Seiwald, 2020), the mainstreaming tools do not go far enough in addressing VAWG because they are very limited in terms of just reminding practitioners that they need to gather data on women and ensure that services reach women. Governments have honoured their commitments to gender mainstreaming and gender budgeting, but how successful have the tools been? To what extent was gender budgeting and mainstreaming successful in terms of contribution to and achievement of sustained women's empowerment? It should not just be the existence of a string of policies that do not yield tangible transformation of women's lives with the evidence being a sustained socio- economic status. Until this, and equity is realised not only in resource allocation but also in every sphere of life, and in measurable terms, would we be able to determine the effectiveness of these tools. In response to these critiques, gender transformative models have emerged that are focused on shifting harmful norms and promoting commitment to gender equality in a holistic sense rather than as a measurement tool.

Efforts to develop approaches to integrate FGM in development programming is at a very early stage. At present the focus is on integrating FGM in sectors where gender is already a central dimension, for example, SRHR, WASH programming, and Education of Girls. The rationale here being that only minor tweaking to activities already in operation is needed to include FGM as part of the conversations and training that is implemented. In terms of the development of models Unicef, UN Women, UNDP and the EU have published gender transformative approaches which include FGM as a component (Unicef, 2020; AIDOS, 2015). Unicef have published their holistic model for ending FGM which includes awareness raising beyond FGM programming. The UN Women's gender transformative framework includes monitoring rates of FGM as part of prevention and response to VAWG (UN Women, 2013). The UNDP developed a gender recovery

toolkit which mainstream GBV including FGM for a more holistic support in building resilience (UNDP, 2019). The UNDP's Gender Equality Strategy 2022-2025 the full integration of gender expertise across technical teams and the investment of adequate financial resources. The act calls for increased dialogues between grass-roots groups and decision-makers in order to influence and advance gender-responsive public policies. (UNDP, 2022). The EU have also produced what they term a mainstreaming of FGM approach. The EU Gender Action Plan which is mandatory for all external relations of the EU frames FGM as a human right and argues for its inclusion in policy and programming (EU, 2020). In general, these models focus on capacity strengthening and awareness raising of key actors at multiple levels including policy and community delivery. This is certainly a critical dimension in the mission to integrate but highlights that another level of work is needed to ensure commitment to end FGM embeds across sectoral programmes and at all levels. Some of these approaches have recently been developed therefore it is not feasible to evaluate them. While these approaches have sought to address gender inequality none of them have attempted to address harmful social, gender and religious norms. The approaches offer superficial solutions that in the end become tickbox exercises. While they address specific challenges most suited to the minority word, therefore evidencing the one-size-fits all favoured in development (Cornwall & Brock, 2005) they certainly fall short of addressing the challenges that I have outlined in this thesis.

Section 2

9. 2.1 Gender and social norm challenges

As my data has revealed, patriarchal gender, social and religious socialisations are pervasive in Zimbabwean society and determine health inequality. However, addressing inequality in health has so far not been possible due to inconsistent and ineffective policies stemming from a lack of awareness of gender issues on the programmers' part and such key issues as women left out of decision-making processes, and more importantly a lack of essential data (Crespi-Llorens et al, 2021). It is therefore imperative that HIV programming emphasise, at design level, policies which are HCPs sensitive in order to address gender inequalities in the health sector. Furthermore, my data revealed that gender intersects with dimensions of inequality such as socio-economic status, age, sexuality and religion (Allotey & Gyapong, 2005). Programme delivery at community level in turn is also shaped by gender as evident in my participant categories where top -level development practitioners turned out to be male. Programming must navigate these inequalities to ensure that

they do not disadvantage women. The reluctance of these practitioners to acknowledge LE as a form of FGM and therefore violence is testament that interventions will not in any time soon, address LE as a matter of agency. Further female development practitioners support LE as a celebration of sexuality and here the impact of gendered childhood socialisations is evident. These practitioners do not recognise the harm that emanates from these socialisations because women and girls are conforming to their cultural identity.

9.2.2 Programming and use of local knowledge

An important dimension to my arguments is supported by development literature which presents critiques highlighting the devaluing of local knowledge and the importance of context. The question stands; why is it that development practitioners cannot use local knowledge better? Is it appropriate or accurate to argue that their approaches and their tools and frameworks are not sufficiently nuanced? What I argue is needed is a more holistic and integrated approach such as the mainstreaming tool I propose. Development sector frameworks need to heed and utilise local knowledge. In my data, practitioners with local knowledge identified important links between the HCPs while practitioners of foreign heritage could not because of limited understanding of context. The devaluing of local knowledge is not a new argument and has been made over time by many post development scholars (Escobar, 1984; Sachs, 1992; Rist, 1997). These scholars argue that development institutions are essentially predominantly Western-led and that development agendas are set by donors heavily determined by Western hegemonic influences (Wright, 2012). This argument is however not new yet the critique I am presenting is relevant and valid. What is new in my argument is that I am applying it to a very specific context and call for an understanding of the context and the nuanced contextual realities as experienced by the populations in order to holistically address the challenges. Programming should not be premised on "the universalisation of Western experience" but should take into account the diversity of experiences, needs … of those it claims to assist" (Matthews, 2004, p. 379).

9.2.3 Challenges with implementing change

A well-established limitation in the implementation of social norm change programmes is that development programmes usually have short cycles, this is even the case in programmes presented as longer term that last usually no more than 5-7 years. It takes time to implement a programme therefore to then expect massive change is often unrealistic, particularly in fragile contexts where infrastructure might disintegrate suddenly. Yet we know that the sustainability of funding is critical

to long term success. There is pressure in the aid system to demonstrate results to secure funding (Albertson et al, 2018; Howard & White, 2020). This can often operate against a commitment to pursue evidence- based approaches and more radical transformative models that in essence require time and may not deliver tangible quick results.

However, as Yanguas (2018) argues, large budget allocations of development aid do not automatically guarantee aid effectiveness and "ineffective programming equals waste" (p. 4). Whilst in recent years we have seen a shift to a 'localisation' agenda (Kumi et al, 2021) theoretically driven by context this still does not guarantee that the voices of the most vulnerable and marginalised will be heard and included in programme design. My participants know and understand the cultural constraints in their environment and they highlighted how women and girls' agency is limited by the norms informed by a patriarchal order (Togarasei, 2020). I believe that my research highlights the importance of an approach that brings the most marginalised more centrally into the design and implementation of programmes. In doing so it is also likely that a more integrated holistic approach will emerge as the most likely to achieve goals of gender norm transformation Robust approaches that adopt bottom up approaches will be well informed and responsive to the needs of affected women and girls.

9.2.4 Operationalising the HCP integration policy tool

To theorise my integration tool, the entry point that my data suggests would, firstly pushing for the holistic application of a sensitised lens that appreciates how HCPs are linked and manifest to increase women and girls' risk of HIV infection. In the first instance gaps in knowledge of prevalence need to be addressed. Prevalence surveys are needed to understand levels of LE and its impact on women and girls' bodily integrity, psychological impact, and social impact. Understanding the impact of LE will further enable us to understand how it correlates with child marriage, bride price, polygamy and HIV because of harmful socialisations that accompany the process of initiation. Secondly there will need to challenge the gendered cultural, social and religious norms that shape women and girls' vulnerability to HIV infection. These norms normalise violence and are reinforced through oppressive patriarchal values and traditions. Because of harmful socialisations, women now normalise HIV because marriage, the institute that all these socialisations led to, has been proven to be the main source of HIV infection. At the same time, new interventions could be trialled to try and understand what works best to reverse the behaviours and mindsets that we know lie behind

the violence represented by the HCPs.

Drawing on my data, particularly from the development practitioner category and community category, I present a mainstreaming tool to support practitioners in identifying opportunities to end the HCPs. This tool is a way of focusing programme designers and practitioners around the underlying gender social and religious norms that essentially are the problem and getting them to think through the extent to which the activities that they run maximise on the opportunity to challenge those harmful norms. My tool represents a gender lens specifically for the purpose of identifying opportunities for gender transformation. The tool simply presents a number of questions that can help practitioners think through and identify opportunities for integration in existing HIV programming but could however be adapted across development sectors. In doing so it may also point to gaps in contextual knowledge that should be filled before programme design. The tool works across the levels of the ecology model and works with the hypothesis that change will only be sustainable if it occurs at multiple levels.

Level	Questions	Answers	Actions
Individual	How might current programme activities increase or decrease the vulnerabilities and risks of LE, child marriage an individual girl faces? How might current programme activities increase or decrease the vulnerabilities and risk of LE, bride price and polygamy an individual woman faces? Do the activities include opportunities to build and nurture the agency of girls and women to challenge LE, child marriage, bride price, polygamy? Are implementing staff adequately trained to respond to the needs of girls specifically in relation to LE, child marriage? And what are the protocols? Does the programme have reporting and support mechanisms in place specially relating to FGM, child marriage?		
Household	Do programme activities include dialogues with household members on issues to do with gender equality? And the rights of girls and women? Can mechanisms be put in place to support families in rejecting LE, child marriage, bride price and polygamy?		
Community	Are there opportunities within the programme to engage the community in dialogues on ending LE, child marriage, bride price and polygamy? And can these dialogues be linked to the central focus of the activities? How might programme messaging be tweaked to include a greater focus on promoting the rights of girls?		

County/ Regional	To what extent does the current programme engage with policy makers at country/regional level? Is it possible to include, in dialogues at this level, end LE, child marriage, bride price and polygamy messaging?		
National	To what extent can the programme work to educate stakeholders not directly involved in end LE, child marriage, bride price and polygamy work to incorporate messaging in their work?		

The purpose of the tool as I already explained is to suggest a number of questions that can help practitioners think through and identify opportunities for HCPs integration. Operationalisation will entail taking into consideration what the local cultural practices are, what common views people have about those practices, what the social norms at the socio -cultural level, and finally what kinds of gender, religious and cultural norms and practices exist that essentially reinforce patterns of violence against girls and women. Furthermore, meta questions could be employed to establish what mechanisms at community level exist to mitigate violence and crucially how strong is that enabling environment at community level to respond to it and what dynamics exist at household level that might support or perpetuate violence. To operationalise the tool practitioners would then need to think about any views that emerge and have to be challenged including particular harmful gendered norms that a programme needs to embed activities into; that ultimately seek to transform those harmful norms. Practicalising the tool, how can effective gender and social transformative change activities be built upon within an HIV programme?

9.2.5 Socio-cultural level

Questions at the socio-cultural level will relate to the programme focus. Practitioners will need to query the ways in which HIV programming can be linked with gender related activities and whether they can be adapted to better respond to gendered dimensions of HIV infection. There will be a need to answer the questions- in what ways is gender influential in increasing risk to HIV infection? What is our understanding of what the harmful triggers are around HIV, and in what ways is HIV in Zimbabwe a gendered problem? Answering these questions will enhance practitioners' awareness of what they are doing. These questions will be aimed at sensitising practitioners to the kind of gendered elements of HIV and the intricate link with LE, child marriage, bride price and polygamy.

Within operationalisation practitioners would need to think through how expressed views can be seen to increase vulnerabilities and risk. For example, through a critical gendered lens, are women engaging with HIV programming and how are they engaging with it? For example, just at a level of

response and treatment? Or is there engagement in relation to prevention? Is everyone identified to be HIV sero-positive consistent in receiving treatment and are they retained in care? If not, why? What could be the issue prohibiting them from receiving care and how can this be addressed within programming? My data has already established that women need permission from their husbands to access treatment and should they defy their husbands, they become more vulnerable to violence. Attention should therefore be directed to thinking through how women and girls engage with the programme, and what their specific needs are. Arguably by addressing and positively tackling the underlying harmful gender norms women's freedom to access HIV services would increase.

9.2.6 Community level

Here practitioners would need to consider what mechanisms exist at community level to mitigate or offer security to victims of violence. This again, is about sensitising practitioners to the gendered contextual realities. For example, questions around what level of protection exists and crucially, what reporting mechanisms exist and to what level do they support women in relation to accessing services? The problem of women failing to report abusive partners is well documented in literature and my participants also reported it. To contextualise this problem, HIV programming could seek to build in measures to enhance the overall enabling environment for women. We now understand that women are socialised to be submissive during initiation rites that function to embed inferiority and in turn this make them vulnerable to HIV. Programming could provide initiatives that tackle the normalisation of subservience which in turn would need to involve a challenge to the HCPs.

9.2.7 Household level

At household level practitioners would need to understand as a programme, the dynamics that exist which perpetuate vulnerabilities. For example, what sort of specific behaviours that go on at household level need to be challenged? That again, would reduce women's vulnerability so practitioners could think of how the programme can introduce activities that would help to minimise those vulnerabilities and consider what room there is for individuals to express their own agency to bring about the change that they need. For example, to what extent could a woman who realises that she is in an unhealthy risky relationship leave? Is she able to leave or to exercise agency to protect herself? It is at this point that practitioners could map out what the programme can do to empower women in such situations at an individual level.

Conclusion

This chapter has spoken to my research objective which was to inform an effective mainstreaming approach to increase the sensitivity of policy makers across HIV programming to opportunities to reduce HIV infection. I have also critiqued current gender mainstreaming approaches although they have enabled informed gendered responses in programming and policy reevaluation. Because of mainstreaming approaches development policies have been strengthened to ensure interventions account for robust gender sensitive responses across development sectors. However a key conceptual question is to what extent has this approach and several others that I have discussed in this chapter addressed gender dynamics related to Zimbabwean women and girls' experiences of oppressive patriarchal cultural norms that discriminate them because of their gender? Gender mainstreaming has not quite addressed the inequalities that existed between the sexes before the development of the approach. Men continue to enjoy certain privileges particularly those of dominance over women and continue to view women as inferior to them (Crawford et al, 2020). Patriarchal socialisations support and fuel these views and these are issues that programming may not be aware of before interventions are rolled out. Furthermore where culture is particularly strong in a society, programming may not wish to intervene and this is what lies at the heart of non-interference in cultural realities in beneficiary populations.

I have laid my argument for wider integration and proposed a new model for integrating HCPs into HIV programming (and potentially other sector programming). To the best of my knowledge and certainly from my data, I have not been able to evidence that LE, child marriage, bride price and polygamy are all integrated in HIV programming in Zimbabwe. The cultural gender and social norms that fuel these practices should be interrogated before programme design and incorporated for implementation. The lens I proposed will support practitioners in thinking through the extent to which the activities that they run really maximise on the opportunity to transform harmful cultural and gender norms behind women and girls' vulnerability to HIV infection. The next chapter gives a conclusive summary of my research findings and elucidates how I answered my research question and study aims.

Chapter 10

Conclusion

Introduction

This conclusionary chapter to my thesis presents an outline of the main findings of my study. I set out to synthesise my research aims and findings in the chapter and present a summary of my participants' responses outlining the extent to which my data has been able to speak to these aims and objectives. My research aims were to understand the links between LE, child marriage, bride price, polygamy and HIV infection. I also sought to understand across my field contexts which social and cultural norms were most prevalent in terms of justifying and legitimising these practices and HIV and the extent to which these norms were recognised as harmful, and by whom, including stakeholders within the development sector. My research also sought to understand the specific norms that underpin and generate women's vulnerability and, particularly what the triggers might be for reversing or changing those norms. This chapter thus details how my findings enabled me to answer my research question. It also presents recommendations for policy interventions to end VAWG. I present a summary of findings as a framework for the mainstreaming tool that I propose for policy intervention.

10. 1 Summary of findings

The themes I identified from my research findings were social, gender and religious norms, poverty and culture and their intersections with women and girls' vulnerability to HIV infection. These themes ran across all participant categories. My participants' failure to bring out the link between LE, child marriage, bride price, polygamy and HIV infection is a significant finding for my research, particularly top-level development practitioners, and women in the community. Low level practitioners recognised links between these HCPs and HIV infection however this is not reflected in programming. My data enabled me to understand across my field contexts that social, gender and religious norms legitimise LE, child marriage, bride price and polygamy. Through my data I was also able to establish that these norms are recognised as harmful across my participant categories although some in the development practitioner category did not see LE as problematic because they did not associate it with harm but saw it as a cultural tradition. My data from the community reveals that women support LE and bride price and believe that the two HCPs sustain marriage. Poverty, which is highly prevalent in Zimbabwe is driving HIV incidence because young girls are

engaging in transactional sex with older man for survival. These men fall within the demography with high rates of HIV infection. Because of poverty which intersects with a gendered set of norms that devalues women and sets them on a trajectory towards HIV infection young girls are entered into marriage. The Zimbabwean culture, and its patriarchal prescriptive norms function to legitimise and sustain women's vulnerability to violence including HIV infection. Women's agency is limited by several factors including social, cultural and economic factors that determine room for autonomy.

10.1.1 Recognition of links between LE, child marriage, bride price, polygamy and HIV

Evidencing links between LE, HIV, IPV, child marriage, bride price, and polygamy was the crucible of my research. It was salient for me to understand development practitioners' perspectives on the links to understand how and if at all they acknowledged the links in programming. My data revealed that links are not recognised and most importantly, not explicitly made at programming level which identifies an important strand to my argument. My participants from the development practitioners' cohort revealed that GBV and HIV are associated but could not extend that linkage to LE. Furthermore, LE is not recognised as a form of violence; a male participant from the development practitioner category challenged the terminology 'harmful cultural practices' and retorted:

> "Why do you say its harmful? I thought the only harmful thing is mutilation, cutting of the labia and I thought elongation is as a result of just slight pulling of the labia?" (ZDPPP10, development practitioner, male).

Upon asking whether there would be any pain in pulling the labia the participant answered:

> "Who said circumcision is not painful? It's painful but it's not a harmful practice. But what I can tell you is that a woman with elongated labia enjoys sex more than one who doesn't because sex is nicer on the outside than the inner. So the more surface you have the more enjoyable it is" (ZDPPP9, development practitioner, male).

What this statement means is that because LE is considered a cultural practice, it can therefore not be associated with harm. Furthermore, LE has perceived sexual benefits hence pain is negligible where there is pleasure.

In the nurses' category participants were more knowledgeable about the kind of challenges that

women generally face and were more articulate about the links between HIV, IPV, LE and child marriage. Participants acknowledged that LE and initiation rites were harmful as they pedalled constructs of women and girls' inferiority to women and girls. Because of working in proximity to women at grassroots level these participants had better understanding of the nuances between the different forms of violence. While this might be a starting point towards ending VAWG in all its forms, a paradigm shift is needed and the power to change the course of interventions lies in programming- in the hands of individuals and organisations that do not currently recognise that LE is linked with child marriage, bride price, polygamy and HIV infection.

My participants were not able to make the links because it is more of a behavioural evidence base. They did not recognise that what drives the risky behaviour in relation to VAWG generally, specifically HIV transmission are the religious and cultural norms which are ultimately misogynistic and patriarchal (Skovdal et al, 2018; Sikweyiwa et al, 2020). It is those norms that shape those behaviours in relation to HIV - that is the evidence base for the link. My participants' responses revealed intersectionality between organisational type, rank, and gender of the narrators. The level of seniority intersected with perceptions in ways that could be analysed through the gendered lens of feminist discourses. Top level programmers from intergovernmental organisations acknowledged links between HIV and IPV while those from governmental organisations cited a lack of baseline evidence that LE was problematic. Participants in this category turned out to be mostly male- at the top level of programming. These participants called for baseline evidence to establish LE prevalence while affirming a link between HIV, IPV and child marriage.

A question to ask is why are these top positions occupied by men in the first place? The other question to ask is, would staffing these positions with women make any meaningful impact? Evidence from my research argues otherwise. Female participants in the development practitioner category were dismissive of conceptualising LE as FGM. They expressed conservative views about culture and tradition, and though they were familiar with initiation rites, including those participants that were not ethnically Zimbabwe, had knowledge about LE. Female participants were supportive of LE in so far as they did not see anything wrong with children acquiring sexual knowledge at an early age. My participants in the advocacy category did not see LE as problematic because they felt if a person is socialised to believe that LE is part of who they are then seeing it as a marker of vulnerability is not likely. I did not hypothesise this finding before embarking on data gathering however it was quite important in terms of identifying my original argument, because my

data clearly evidenced that this link was not being made at higher levels and the data supports the argument.

Most importantly my participants in the community did not link LE with IPV or HIV. This was a surprising finding revealing that at community level gender and social norms are deeply entrenched and not seen as factors increasing women's vulnerability to HIV infection. My participants revealed that they were not concerned about the risk of acquiring HIV from abusive and violent partners because marriage was important to them. They also conceded that leaving a promiscuous partner would not guarantee that their next partner would be HIV negative. My participants normalised an HIV positive status and resigned themselves to the 'inevitability' of HIV infection. Marriage, according to my participants entitles men to power and control with extreme forms of masculinity enacted in this union through violent behaviour.

10.2 Determinants of vulnerability to violence including HIV

10.2.1 Religious, gender and social norms

The role of cultural and religious norm socialisation in causing vulnerability to HIV cannot be underestimated. My participants in the development practitioner category recognised, because of their local knowledge, the gender norms that make women and girls vulnerable to HIV and were able to link them to culture and tradition. They understood and conceded that the Zimbabwean culture reinforces gender inequality. My data reveals that gender inequality reinforces women's vulnerability to HIV as women, because of economic dependency on men, a woman cannot negotiate safe sex. Women often become trapped in marriages or relationships with violent men that display risky sexual behaviours (Mutanda & Rukondo, 2016). Furthermore, divorce is disapproved because of perceived shame and dishonour it attracts to the family name. For this reason, women endure violent marriages to avoid the stigma that entails divorce (Chisango et al, 2022). My data articulates the role of culture in women conforming to the prevailing norms of marriage. Additionally, my data also revealed that women do not seek divorce because they lack financial autonomy to provide for themselves and their children after divorce. My participants also pointed out that women and girls are disadvantaged because of their biological makeup which makes them susceptible to HIV infection as they receive and retain sexual fluids for longer than men.

My data revealed an awareness of the gendered nature of HIV among development practitioners although there is a missing link in programming's response to it because interventions for GBV do not specifically address the inequitable gender norms that discriminate against women and girls. Social norms of female subordination (Fidan & Bui, 2016) to men and strict gender norms were identified by my participants as underpinning violence that women and girls experience. While my participants from the development and advocacy categories recognised social norms and practices that legitimise violence, they did not associate LE with HCPs. This finding has wider implications for policy decisions particularly where my community level data evidences unwavering support for LE and bride price. Norms that frame women's acquiescence to men as ideal models of femininity fuel traditional masculinity and sustains male dominance over women. Men prefer to marry women that are subservient because they regard them easy targets for control (Sikweyiya et al, 2020). The array of religious, cultural and social factors rooted in patriarchy coalesce to inform constructs of hegemonic masculinities. Decision making processes are designated men's prerogative (Chiweshe, 2016; Gwatimba et al, 2020; Sikweyiya, 2020).

Additionally, gender attitudes are informed by patriarchy and men exhibit violence against women to achieve desired forms of masculinity that are rooted in power relations prescribed by patriarchy informing men's superiority and dominance over women (Sikweyiya et al, 2020). My data evidenced that culture and the associated social norms synergise to expose women and girls to HIV. Norms that entitle men to sex in relationships including marriages (Sikweyiwa et al, 2020; Bergen, 1999) are responsible for women and girls' vulnerability to HIV. My participants at community level supported initiation rites including LE. They reported that the teachings dispensed from initiation schools empower them for their future roles as wives and mothers. My participants also articulated that the practice sustains marriages and women who did not elongate their labia are at risk of divorce. My participants claimed that the decline in the practice is behind the rise in marriage breakdowns because women no longer follow the prescriptive gendered teachings.

10.2.2 Gendered intersections of vulnerability to violence

Studies have shown that IPV is common in societies that value male dominance in relationships and support VAWG (Counts et al, 1992; Fidan & Bui, 2016). Men with controlling behaviours are also likely to perpetrate VAWG (Gibbs et al, 2016). Explaining IPV through the lens of patriarchy is problematic for several reasons. For example, conceptualisations of patriarchy assume a transcultural, ahistorical, and universal phenomenon (Mohanty, 1988; Acker, 1989). As such, the

concept fails to recognise the nuances in the diverse forms of gendered dominance and the multiple forms of gender inequalities and women's agency globally (Walby, 1989). Male dominance in some way is experienced by all women yet not are they equally oppressed (Hooks, 1984). Feminists such as Mohanty (1988) and Merry (2009) caution against homogenising women's experiences but to understand their experiences contextually. Notwithstanding the commonality of VAWG it is related to cultural, historical, economic and political factors affecting gender inequality in certain contexts (Merry, 2009)**.** Women's experiences of violence differ from context to context; my data informed me that women in Zimbabwe experience violence that is underpinned by patriarchy which was also evidenced by Mashiri (2013) and Mugweni et al (2012). Intersectionality plays a part and distinguishes how women's experiences might differ with gender, culture and poverty underpinning those experiences.

The violence that women experience is explained by participants in cultural terms which conflicts with the way that postcolonial feminists are asking us to frame VAWG in the global south. I am aware that the cultural essentialist argument has been imbibed and is deeply embedded in how practitioners approach these issues. We cannot though avoid the fact that culture is a huge influence in shaping these practices. Culture shapes and legitimises related practices that we know render women vulnerable to other forms of violence. My data challenges the postcolonial critique (see Mohanty, 1988; Narayan, 1998) that violence against women should not be reduced simply to a cultural explanation. This is my participants' viewpoint, and my question is, why are their experiences of violence contextualised in this way, and critically, what is the challenge with such a viewpoint?

My argument is not that postcolonial feminists are wrong but that the argument needs to be nuanced. Culture is a big factor, and a web of interlocking factors that are directly responsible for certain practices which we can deem as harmful, but those practices in themselves are part of a deeper gendered ideology that renders women more vulnerable to other forms of violence. Culture informs normative behaviour through socialisations and in Zimbabwe cultural and religious norms regard marriage highly (Kambarami, 2006) with girls socialised to aspire to marriage. Other studies have found that violence is more likely to be experienced in marital relationships than casual relationships. Ironically gender socialisations marriage is associated with safety and security for women where men are the heads of the household (Mubaiwa, 2020, Chuma & Chazovachii, 2012) nevertheless, the search for this safety net leads women and girls to conform to norms that expose

them to further forms of violence.

I would not only explain IPV, or GBV through a cultural lens but employ a political economy approach to understanding the different interlocking factors such as patriarchy and structural inequalities underpinning VAWG. Culture is a vehicle through which these things are communicated, particularly in marginalised and poorer communities where culture is a resource because it embodies what as a person has when one owns little else. To elucidate this, when communities sink deep into poverty, they use any means they have to stay alive. In contexts like Zimbabwe girls are commodified (Chiweshe, 2016) and HCPs like LE become necessary because then girls can leverage on the marriage market. Culture is not the only factor, but reinforces, legitimises and normalises these practices because of the gendered ideology that devalues women and girls.

If we did not have bride price, if we did not have LE or if child marriage did not exist, we probably still would have gendered inequalities and some forms of violence therefore it is not sufficient just to challenge bride price or challenge LE; we have to challenge the ideology. In that sense I am agreeing with the postcolonial feminist theory, but I am bringing the challenge back to them. Undeniably, specific cultural norms, not culture per se, are the problem. It is the specific way in which certain cultural norms intersect with gendered norms, and how they form the base of certain practices which in themselves are harmful and make women vulnerable to yet more forms of violence. The emergence and dominance of culture in my data reveals that culture is gendered. The dominance of men over women, and the subservience of women to men (Seidu, et al, 2021) through prevailing cultural norms confirms the gendered nature of culture.

It is evident from the community data that gender inequality is entrenched in women's day to day experiences of life. Strict gender norms serve to keep women in subordinate roles (Fidan & Bui, 2016). There is a validation of women's vulnerability in every sphere of life as they negotiate the constraints of their gendered roles. My participants reported that women are routinely discriminated in the community and one's marital status determines how they will experience the discrimination. Unmarried women are disproportionately stigmatised and marginalised in decision making processes as established by Kambarami (2006) and Chisango et al (2023) which exposes them to gendered violence.

10.2.3 Poverty as a determinant of vulnerability

Poverty emerged in my data as a key theme and was cited by my participants across categories as the main reason for women and girls' vulnerability to HIV infection. Studies have also established that socio-economic status is a determinant of IPV risk with women that have limited education and are unemployed most likely to experience violence (Hoque et al, 2009). Poverty is gendered is skewed towards women and its feminisation leads to dependency upon men (Fidan & Bui, 2016; Thebe, 2018) exacerbating women's vulnerability to HIV infection. There is a very strong hypothesis within gender and development that if women are economically independent and engaged, they will be able to challenge the inequalities and in particular the violence that they experience ((Dialo & Voia, 2016; Vyas & Watts, 2008). Several studies have interrogated that hypothesis and found that the link is a little bit tenuous (Vyas & Watts, 2008). I am not arguing that it is not important to empower women economically, but that there is no magic bullet in women being financially independent, and then ending the violence that they experience. Looking at this in a much more nuanced way, where economic empowerment sits alongside a number of other factors and challenges that we need to overcome in order to really see dramatic reductions in prevalence levels is crucial but what would that look like?

Firstly, income does not magically remove violence (Cools & Kotsadam, 2017), not to say that it is not important that must be made clear. Secondly, HIV infection that occurs linked to social and gender norms, brings about dramatic increases in violence, particularly IPV, but alongside that, we discover that development organisations and governments still are not robustly integrating responses to these increases in humanitarian programming or policymaking. Responses to violence against women and girls, even outside of the humanitarian context, are still very siloed and I argue the case for the integration of a more sensitised lens to HCPs, all other forms of VAWG and HIV projects. Regardless of how a woman earns an income, regardless of her social status, it doesn't have this automatic impact, but can make the situation worse. Bradley (2016) found that if women are economically successful in micro businesses that threatens the gender status quo within their families and results in an increase particularly in forms of harassment, but also more serious forms of domestic violence such as IPV. In the context of women who are working in professional capacities, it cuts across the intersectional differences therefore quite often when women are perceived to be successful in income generation backlash occurs (Dutton & White, 2013).

Poverty functions as a driver of sexual mobility however here policy frameworks particularly fail

young women. My research evidenced that intergenerational relationships are fuelling HIV transmission among young women. They are engaging in sexual relationships with much older men who fall in the age ranges most likely to be HIV infected. Parents support age disparate relationships because of the financial rewards although studies have revealed that they fuel IHV infection (Mangwa & Ingwani, 2014, p. 147). The implications of these inequitable relationships are that power dynamics often favour the men and disadvantage the young women. Adolescent girls engage in these age disparate relationships for transactional sex which limits their agency to negotiate safe sex (Koster et al, 2015; Chiweshe, 2014). Since poverty is the driver of these relationships, what could be the entry point for programming? Interventions that seek to empower young girls and women have been trialled including micro credit projects, yet we continue to see elevated levels of poverty. Unless poverty levels are reduced, we will continue to see girls transacting sex for survival, young girls being married off for their parents' economic survival (Corno et al, 2016; Corno & Voena, 2016) and women enduring violence in risky marriages because they cannot afford to provide for themselves and their children.

10.2.4 The importance and desirability of marriage

My participants made it clear that marriage is important to them in many ways. This confirms what Dodo (2021) suggests that marriages are useful for society's development. To my participants, initiation rites were the glue that held both marriage and society together. They also reported that through marriage they can express themselves more be listened to as it accords them respect in the community. The burden of patriarchal attitudes and values and gender inequality which intensifies in marital unions remain the primary source and key driver of ongoing transmission of HIV (Jewkes et al, 2010). My participants affirmed that there are no discussions about sexual and reproductive rights in initiation schools apart from being taught to fulfil their role of subservience to men's sexual demands in marriage, a finding that Khau (2012) also made in a study in Lesotho. I also established that initiation schools do not equip young girls with safe sex education but rather emphasise that women should acquiesce and submit to their husbands' sexual desires in order to 'hold on' to them (Khau, 2012).

Marriage clearly serves to maintain oppressive power dynamics that render women vulnerable to a range of abuse. The lack of women's decision-making rights in marriage (Chiweshe et al, 2014) is problematic and having little financial autonomy directly translates into vulnerability to HIV and other forms of violence. Women in Zimbabwe have lesser financial security, and this is attributed to gender inequality. Due to scarce financial resources, it is preferable for a boy child to remain in

mainstream education while girls can be married off if resources are scarce or when religion sanctions it (Machingura, 2014). The lack of educational attainment leads to financial dependency on men in marriage. Because of cultural socialisations girls are raised as recipients and homemakers whilst boys are socialised to be providers and breadwinners (Chuma & Chazovachii, 2012). Cultural socialisations of subservience and the social and cultural stigma of divorce or failing to secure a marriage (Chisango et al, 2022) means that women cannot leave violent marriages and will endure sexually risky marriages even though the risk of contracting HIV will be high (Magezi, 2007).

Young girls are forced into polygamous marriages which hampers both their emotional and physical development while women choose to marry into such unions to secure status as married women (Kambarami, 2006). These relationships have unequal power dynamics and increase women's vulnerability to violence. Early and child marriage has long term implications for development as girls' participation in meaningful contribution to wider development goals is severely reduced. Furthermore, groups of women in polygamous marriages are vulnerable to further violence and HIV (Machingura, 2011; Mutseta, 2016) because of lack of room to exercise agency**.** My findings reveal that women support the payment of bride price LE. This confirms what Mubaiwa (2020) evidenced in his study on bride price in Zimbabwe. This is despite studies finding that after the bride price payment, men assume ownership of their wives (Sikweyiya et al, 2020; Lowes & Nunn, 2017; Mubaiwa, 2020) and claim exclusive sexual rights over them (Chiweshe, 2016; Vroklage, 1952; Bourdillon, 1982; Sikweyiya, 2020) thereby limiting women's agency to autonomy. My participants confirmed that IPV is prevalent in marriage but did not associate this phenomenon with bride price, neither did they acknowledge that bride price "creates unequal gender relations" (Muzulu, 2014, p.14; Davies, 2008, Goody,1973). The women recognised dominant and repressive gender and social norms and were able to articulate and situate those norms within their own experiences of violence. Crucially, my participants in the community normalised violence and HIV as long as one acquired the marriage status.

This revealed that women support practices that are harmful yet condemn the violence that arises from the provisions of the practices. The women associated LE with their culture, and they framed bride price within cultural bounds. It is within this complex web of loyalties and cultural identity that women tend to support practices that serve to reinforce gender inequality and perpetuate their vulnerability to violence. It is that lack of recognition that HIV is transmitted violently, and

that LE is abuse that leads to vulnerability because of socialisations of inferiority that it entails. It is also the lack of recognition that this practice creates gender differences that set power boundaries between men and women. It is the starting point of a lifetime of subservience and inferiority when a girl has to be 'prepared' sexually for marriage in order to please her husband (Kambarami, 2006; Sikweyiya et al, 2020).

10.3 Programming challenges

10.3.1 Gender norms as barriers to accessing health services

The triangle between women and girls' lived experiences, the interventions for GBV, and programming is quite an interesting and intriguing matter from a development perspective. GBV programming in Zimbabwe is not designed to address LE, bride price or polygamy and neither is HIV programming. The relationship between these HCPs affects women and at the heart of this is the underlying gendered socialisations which manifest as risky and harmful behaviours mainly imbibed by men at the expense of women's health and wellbeing. My data reveals that repressive gender norms affect women and girls' health seeking behaviour in several ways. Firstly, women and girls require permission from their male family members or in- laws to access health care services (Gwatimba et al, 2022). Adolescent girls cannot access SRHR services without parental consent. Because premarital sex is prohibited culturally, adolescent girls cannot freely access contraceptives for fear of being found out while parents are in denial that their adolescent girls are sexually active (Chiweshe & Chiweshe, 2017). This translates into young girls engaging in unprotected sex risking not only early and unplanned pregnancies but also STIs including HIV. Women on the other hand, do not have autonomy to decide when to use contraceptives which means that they cannot plan their families independent of the husband's decision and neither can they practice safe sex (Seidu et al, 2020; Gwatimba et al, 2022).

My participants reported that little is happening in terms of addressing GBV in other projects within HIV programming, partly due to funding constraints and practitioners' reluctance to engage in domestic situations. Also, gender norms function as barriers to addressing VAWG as my data establishes that men disrupt intervention efforts because women face backlash (Dutton & White, 2013) after attending programme activities such as DREAMS. HIV and GBV programming does not specifically target the causal factors of HIV which are the norms that inform marriage in Zimbabwe. Responses from development practitioners revealed that they have knowledge of the social and

cultural drivers of HIV transmission, yet we do not see these issues integrated in interventions. They understood that HIV transmission is gendered and there is evidence of gender mainstreaming in programming however there is no evidence that programming is addressing the gender, social and religious norms behind LE, child marriage, bride price and polygamy, HCPs behind HIV vulnerability.

10.3.2 Development approaches

Participants in the advocacy category revealed that their efforts are centred around provision of safe houses and access to legal services. Some organisations are also involving men in dialogue to address issues of domestic violence. It is evident that interventions are responsive to incidents of domestic violence, including IPV but little evidence exists to show that cultural dimensions of violence are being challenged. My participants also posited that interventions are modelled around a top- down approach and may not be fully informed by the practicalities at grassroots level. Existing evidence shows that the intersection I have outlined is not how the international development sector responds to these issues. Firstly, programming utilises siloed approaches in interventions and secondly, where interventions are implemented, they are usually partial and unsystematic in delivery. My argument, ultimately, is that we need robust holistic programming if we are ever going to transform the gendered ideology that is responsible for women and girls being susceptible to HIV transmission.

Although IPV and SRHR is being linked into HIV programming, I cannot confirm that it is done with an understanding of how these issues exist because of a gendered ideology; that we cannot separate them out and we need to deal with them simultaneously. There is a need to consider whether or not there should be programming that solely focuses on gendered empowerment and transformation of these gendered behaviour norms rather than activities that are only aimed at treatment provision for HIV. Programming would also need to consider whether there are separate activities for men that could encourage them to think through their behaviour and reflect on the kind of harmful gender norms that lead to violent behaviour. It is therefore possible in a cost-effective way to adjust ongoing programmes in a way that they respond more directly to these underlying norms. Adaptations can be made to programming that would enable it to do more at different levels whether culturally, individually, or at national level.

10.3.3 Legal frameworks

Looking at policy, we can never look at it in isolation and we know that tackling VAWG, policy development, and activities across the legal sector is only one part of a big puzzle that is complex, difficult, and lengthy; a process that involves change across many different levels. It is culturally disapproved for a woman to report or seek prosecution for IPV because women are expected to be 'good women' (Mugweni et al, 2012) that keep family secrets and uphold their husband's honour and that of the family name. Inadequate and unpoliced legal frameworks further weaken the response to VAWG as they ascribe to dominant social norms which favour men and disapprove women who seek redress for IPV from law courts. Furthermore, weak institutions and policies further weaken women's positions. Women are rendered vulnerable to further violence because of lack of support and political will to police and enact domestic violence laws. There was acknowledgement from my participants that LE is criminalised in Zimbabwe however it is ironical that LE is not regarded as FGM therefore the claim to its criminalisation is not clear.

10.4 Agency and its limitations

Childhood studies view agency as exercising free will against constraints brought on by social structures (Hammersley, 2017; Mizen & Ofosu-kusi 2013).These assumptions counterpoise individual children to culture and society and give the implication that when individualism trumps over collective matters, then agency can be exercised. In this perspective, agency is linked to a selfhood of independence and liberal individualism that is free from social and cultural constructions, comparable to Western individualism (Imoh & Ansell, 2014; Durham, 2011). This version of agency is a derivative of Western philosophy that recognises and privilege individual capabilities, particularly an individual's capacity to resist social and cultural expectations (Durham, 2011). This version of agency is also entrenched on narratives of family and "neoliberal ideology of personhood" (Abebe, 2019). However the perception of children as 'independent', rather than 'interdependent' risks separating children's lives from their socio-cultural environment within which their agency is embedded (Kjørholt, 2004).

Child rights- based discourses and agency centred studies carry several assumptions; that child agency is universal, and the assertion that a child is first of all an individual, and then a member of a family and community, second (Anderson, 1996). These assumptions draw extensively on the CRC (UN, 1989) which recognises that children's voices should be heard, and that children can and will act in their best interest and make decisions if consulted. Although supported in principle by the

Convention of the Rights of the Child (UN, 1989) children's ability to exercise agency is not supported and neither is it evident globally (Hart & Brando, 2018). Children's agentic rights are premised on the explicit inclusion of children's interests in and for allowing their 'voices' to be heard in matters that concern their lives (Mayne & Rennie, 2018; Harcourt & Hägglund 2013; Hart & Brando, 2018). Literature that apply Western theories on child agency against African contexts is limited because the structural contexts that children grow up in within these (African) contexts (e.g. modes of socialisations, poverty, familial arrangements, livelihood activities) are similar (Abebe, 2019).

Similarly, intersectionality impacts children's agency and cuts across gender, societal expectations, experience, geography, social maturity and stage of childhood (Abebe, 2019). I premise that supporting agency in circumstances where harm is incurred cannot be justified and "the trade-off between freedom and achievement requires consideration of the respective harms that may be inflicted on the child's interests in comparison with the respective benefits that may be yielded for the child's overall development" (Hart & Brando, 2018, p. 302). I recognise children's agency as indeed does research guidelines which construct children as active agents of their own lives that are "dependent on adults as intermediaries" (Gallagher et al, 2009). Where children *are* deemed capable of decision-making, I argue that they should be transparency (Alderson & Morrow, 2004) about the harm brought on by socialisations which embed notions of inferiority against men.

10.5 The argument and challenges for integration

10.5.1 Building an evidence base

My participants reported that integrating HCPs with health messages would be effective however this was dependent on a few issues. Firstly, programmers needed baseline evidence that LE was problematic and that it was driving HIV infections before considering its inclusion in programming. Secondly, because links were not made between LE and HIV infection, there were concerns that health seeking could be affected if non-affected communities were indiscriminately targeted with LE messages. My participants also felt that linking HIV and LE could potentially cause stigmatisation for women and girls that underwent the practice. My participants also alluded to integration already taking place within SRHR programming, but no evidence exists that HCPs are mainstreamed. On critical reflection, acknowledging that LE, child marriage, bride price and polygamy are problematic, and all constitute violence will place us on a trajectory to end VAWG in

all its forms. Informed by gender inequality, there is a need to deal with the underpinning norms that VAWG draws on.

FGM and the practices it is related to such as bride price, child marriage, and polygamy are a big part of it. This means that we cannot ignore the social and cultural landscape and its effect in eliminating the space to negotiate women's autonomy. A more robust framework to quell the effect of these socio-economic structures of gender inequality is needed and I presented my argument for it in the previous chapter. My integration tool has the potential to support practitioners in identifying opportunities to address FGM within HIV programming. It is a tool that will alert programme designers and practitioners to the social, cultural and political economy of the contexts they work in. The tool will support them to design activities that transform harmful social and gender norms and maximise all opportunities to end HCPs and HIV transmission. The tool is useful because it works across the levels of the ecology model and works with the programme conceptual framework. We understand through the ecology model that lasting change can only be realised if change occurs at multiple levels.

10.5.2 Understanding context

On the debate of conflations between local knowledge and acquired contextual knowledge, most of my participants in this cohort were of Zimbabwean origin with a diverse tribal background. Other participants who were mainly from within sub-Saharan Africa and held positions in programming had extensive knowledge of HCPs which also overlapped with those in their own countries of origin. Although local knowledge of dominant social and gender norms existed, and because links were not made, this will not translate into programming. Local knowledge is not being mainstreamed into programming even though the development agenda now prioritise localisation of development agenda (Kumi et al, 2021). There are several challenges with engaging with local knowledge in this instance. Firstly, knowledge of prevalence of all HCPs under consideration is required. My data revealed that LE is not considered harmful by key actors within the development sector including women's advocacy organisations and women in the community. Secondly, donor agencies do not see harm in LE therefor LE prevalence cannot be established which means that research to further understand its impact may not be commissioned unless proven otherwise. My participants revealed awareness of local knowledge of gender, religious and social norms that fuel VAWG and HIV in Zimbabwe yet the entry point into addressing social norms is elusive.

Key programmes in Zimbabwe which are being delivered have an HIV and SRHR focus and incorporate GBV. These are the key programmes and interventions that tend to get funded most. In terms of HIV prevention, condom use and distribution are interventions that are prioritised. 'GBV' programming does not specify which elements it covers along the VAWG spectrum but responses point towards IPV. Looking at HIV programming, there is evidence of 'GBV' integration but within that there is no specific targeting of challenges that arise or cause child marriages, bride price or polygamy. What are the barriers to addressing these issues? Firstly, LE is not included in programming because it is not categorised as a form of FGM or VAWG. Responses from my participants across the board have highlighted that it is not seen as harmful but a cultural practice and that is contrary to where the discourse on FGM is going, which is very much challenging the cultural narrative. We should not be labelling FGM as a cultural practice but as VAWG, and more specifically as child abuse. For this reason LE needs to be seen alongside other forms of child abuse. Secondly, there is limited amount of time to cover HIV programming in schools because technical subjects are considered more useful than social studies under which HIV education falls. My participants in the teachers' category reported that LE is not discussed in schools as it is perceived to be a sub-culture that is not practised across the country, yet studies have established that it is widespread. Participants in the teachers' category articulated links in terms of gender socialisations causing vulnerability to HIV however they distanced themselves from what they perceived as cultural nuances and subjectivities in raising children. I argue that this is the time when children should be sensitised to issues of gender inequality and the problematic nature of cultural gender socialisations. While in Zimbabwe the education curriculum has been modified to provide domestic violence education to children from four years old, concepts like gender and other forms of VAWG are largely ignored. There is a need for policymakers to adopt transformative educational curricula underpinned by literature and conceptualisations of gender in VAWG that are critically informed and more gender neutral.

There is also a high level of school dropouts due to financial constraints and parents cannot afford tuition fees. The issue of teenage pregnancies and early/child marriages which participants alluded to also compounds the case for integration because all these issues synergise to raise a disconnect between local and national levels of knowledge with implications for interventions. Thirdly, marriage is a highly regarded institution in Zimbabwe (Kambabrami, 2006). LE prepares a girl for marriage. Whether marriage takes place through child marriage, polygamy, or under conventional circumstances, it always entails bride price. This is what cements the marital union (Bourdillion, 1976; Mubaiwa, 2020). Married women are disproportionately affected by HIV (Mugweni et al,

2012; Tenkorang, 2014) and marriage intersects with all the HCPs that I have discussed in this thesis evidencing that they are linked. Additionally, women support the same structures of patriarchy that inform marriage norms and seem to oppress them. This position supports Bourdieu's *habitus* framework (1989) where women acquiesce to male dominance because they understand their social position in subservience terms. Furthermore, due to patriarchal structures women's autonomy is limited which also highlights Gidden's structuration theory (1984).

Recommendations

Much credit can be accorded to the Zimbabwean government on commissioning sexuality education in primary schools however there is need for the government to implement policies to discuss sexuality matters in more meaningful ways seeing that young people are indeed engaging in sexual activities (Chiweshe & Chiweshe, 2017). The government also needs to promote adolescent, particularly girls' SRHRs and adopt monitoring mechanisms that ensure those young people that need contraceptives can access them freely to reduce teenage and unintended pregnancies. Cultural attitudes towards premarital sex mean that young women and girls face barriers in accessing contraceptives. As long as adolescents face these barriers the factors exacerbating vulnerability to HIV infection will continue. It is therefore crucial that social, cultural, and gender norms that inform attitudes towards SRHR are challenged. Alerting women and girls to their rights is useful however it is one thing to educate people on their rights and it is another thing to get them to exercise those rights, building within them the self -agency and ensuring that they have robust support systems around them. It is imperative that women and girls are socialised in ways that they do not see marriage as a pathway to status (Kambarami, 2006) and security. This way they can be less vulnerable to forms of violence including HIV.

Family, community, and school are some of the spaces where norms are reproduced. I argue that the government of Zimbabwe should consider the use of literature for primary school children that neutralises the issue of gender binaries so that the issues of VAWG are dealt with at that level. We know that to a greater extent, it is about how people are socialised, how they get to normalise certain behaviours and how they learn certain norms. Looking at it from that perspective, where the literature that is taught in those early stages of education emphasises equality and the neutrality of gender, that will deconstruct existing patriarchal norms where certain people are perceived to be more powerful or are expected to have more power than others. I argue that when children begin to construct their gender identities in those norms, they will in later stages in life, enact those norms they learnt in those early formative stages a process Bandura (1969) alluded to

in his social learning theory. Education can therefore play a critical role in influencing policy in that way. Additionally, it is at this stage in primary school that young girls undergo LE a process which marks a divergent of roles between the sexes entrenching views of inferiority and subservience to men (Seidu et al, 2021). Mainstream education could therefore be harnessed to socialise children in equitable ways of addressing gender ideologies which lie at the heart of the violence women and girls suffer.

In conclusion I argue that there needs to be greater integration in programming. Crucially, there needs to be greater integration between HIV, LE, child marriage, bride price, and polygamy. My data reveals that HIV or the transmission of it is completely normalised that women no longer see it as a problem. Violence including IPV, is also normalised in my research context. My data has evidenced that HCPs are rooted in culture, and that inequitable gender socialisations are also rooted in culture. Essentially, the argument that I am making with LE is that it needs to be seen as a form of violence. LE is literally a cultural category; something that people do as part of their cultural identity and therefore not regarded as violence. That is the same argument I also make with HIV, but the challenge I have is that in order for these two issues to be considered as violence, I have to challenge the normalisation of them. Currently, it is just part and parcel of what happens in life, it's part and parcel of women's lives. My critique of the programmes that are ongoing in relation to HIV and GBV is that they do not challenge the normalisation of GBV and HIV. Instead, HIV programming focuses on the treatment of HIV, rather than challenging the social, cultural and gender norms behind the HCPs that fuel its transmission.

References

Abraham, C. & Sheeran, P. (1994). Modelling and modifying young heterosexuals' HIV-preventive behaviour; a review of theories, findings and educational implications. *Patient Education and Counselling, 23*(3). 173-186. https://doi.org/10.1016/0738-3991(94)90033-7.

Abraham, C., Sheeran, P., & Henderson, M. (2011). Extending social cognition models of health behaviour. *Health Education Research*, *26*(4), 624-637.

Abwalaba, O, N. (2014). "Gender disparities in Kenya." *Journal of Research in Gender Studies, 4(*2), 298-312. https://genderandsecurity.org/projects-resources/research/gender-disparities-kenya.

Achode, L.A., Kimondo, K. and Muigai, M.W. (2021) *Judgement Nairobi High Court constitutional petition* No. 244 of 2019 Dr. Tatu Kamau v AG & Others.

Acker, J. (1989). The problem with patriarchy. *Sociology, 23*, 235-240.

Adamo, D. T. (2015). The task and distinctiveness of African biblical hermeneutic (s). *Old Testament Essays*, *28*(1), 31-52.

Addabbo, T., Badalassi, G., Corrado, F., & Picchio, A. (2011). A social-reproduction and well-being approach to gender budgets: experiments at local government level in Italy. In E. Addis, P. de Villota, F. Degavre, & J. Eriksen (Eds.), *Gender and Well- Being. The Role of Institutions* (pp. 105-124). UK: MPG Books Group.

Adams, A., & Berg, J. (2017). When home affects pay: An analysis of the gender pay gap among crowdworkers. *Social Science Research Network*. https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3048711

Adeleye, O. A., Aldoory, L. & Parakoyi, D.B. (2011). Using local culture and gender roles to improve male involvement in maternal health in southern Nigeria, *Journal of Health Communication: International Perspectives,* 16(*10*), 1122–1135.

Adeokun, L. A., Twa-Twa, J., Ssekiboobo, A. & Nalwadda, R. (1995). Social context of HIV infection in Uganda. *Health Transition Review, 5*, (Suppl.), 1–26. http://www.jstor.org/stable/40652150.

Adetunji, H. A. (2001). "Re-Orientating the African Woman Today" in Akintude, D.O. (Ed) *African Culture and the Quest for Women's Right*, Ibadan: Sefer

Adjei, S.B. (2017). Entrapment of Victims of Spousal Abuse in Ghana: A Discursive Analysis of Family Identity and Agency of Battered Women. *Journal of Interpersonal Violence*, *32*(5), 730-754. http://doi.10.1177/0886260515586375.

African Union. (2015). *Campaign to end Child Marriage in Africa: Call to Action*. https://au.int/sites/default/files/pages/32905-file-campaign_to_end_child_marriage_in_africa_call_for_action-_english.pdf.

African Union. (1999). African Charter on the rights and welfare of the child. https://au.int/sites/default/files/treaties/36804-treaty-african_charter_on_rights_welfare_of_the_child.pdf.

Afruca. (2014). *Voices of the Community: Exploring Type IV (Labia Elongation) Female Genital Mutilation in the African Community across Greater Manchester.* (An AFRUCA Community Research Project). https://www.afruca.org/research-1.

Agar, M. H. (1986). *Speaking of ethnography* (2). Sage: London.

Aggarwal, R., & Bhan, M. (2009). "Disarming violence": development, democracy, and security on the borders of India. *Journal of Asian Studies, 68(*2), 519e542.

Ahearn, L.M. (2001) Language and agency, *Annual Review of Anthropology*, 30. 109–137. doi: 10.1146/annurev.anthro.30.1.109

Ahinkorah, B. O., Hagan Jr, J. E., Seidu, A. A., Sambah, F., Adoboi, F., Schack, T., & Budu, E. (2020). Female adolescents' reproductive health decision-making capacity and contraceptive use in sub-Saharan Africa: What does the future hold? *PloS one*, *15*(7), e0235601.

Ahinkorah. B. O. (2021). Polygyny and intimate partner violence in sub-Saharan Africa: Evidence from 16 cross-sectional demographic and health surveys. *Population Health, 13,* https://doi.org/10.1016/j.ssmph.2021.100729.

Ahmed, B. (2014). Confronting a sexual rite of passage in Malawi. *The Atlantic,https://scholar.google.com/scholar?hl=en&as_sdt=0%2C5&q=Ahmed%2C+B.+2014.Confronting+a+sexual+rite+of+passage+in+Malawi.+&btnG=#d=gs_cit&t=1700006315948&u=%2Fscholar%3Fq%3Dinfo%3AgvYJv4Ju1JwJ%3Ascholar.google.com%2F%26output%3Dcite%26scirp%3D0%26hl%3Den*

Aikman, S., Unterhalter, E., & Boler, T. (Eds.) (2008). *Gender equality, HIV, and AIDS: a challenge for the education sector*. Oxfam GB.

Ajzen, I. (1991). The theory of planned behaviour. *Organisational Behaviour and Human Decision Processes, 50*(2), 179–211. https://doi.org/10.1016/0749-5978(91)90020- T.

Ajzen, I. & Fishbein, M. (1980). *Understanding attitudes and predicting social behaviour*. Englewood Cliffs: Prentice-Hall.

Akurugu, C. A., Dery, I., & Domanban, P. B. (2022). Marriage, bridewealth and power: Critical reflections on women's autonomy across settings in Africa. *Evolutionary Human Sciences*, *4*, e30.

Akurugu, C. A., Domapielle, M. K., & Jatoe, M. M. (2021). Bridewealth, women's subordination and agency in marriage: An ethnographic critique of gender activism in rural north-western Ghana. *Journal of Asian and African Studies*, 0021909621992783.

Albertson, K., Fox, C., O'Leary, C., Painter, G., Bailey, K., & Labarbera, J. (2018). Introduction: outcome-based payment and the reform of public services. In *Payment by Results and Social Impact Bonds* (pp. 1-12). Policy Press.

Allen, K. R., Kaestle, C. E., & Goldberg, A. E. (2011). More Than Just a Punctuation Mark: How Boys and Young Men Learn About Menstruation. *Journal of Family Issues, 32*(2), 129–156. https://doi.org/10.1177/0192513X10371609

Alexander, J. & McGregor, J. (2004). *War Stories: Guerrilla Narratives of Zimbabwe's Liberation War*. https://muse.jhu.edu/article/169735/pdf.

Ali, A. A., Yassin, K., & Omer, R. (2014). Domestic violence against women in eastern Sudan. *BMC Public Health, 14*, 1136.

https://doi.org/10.1186/1471-2458- 14-1136.

Al-Krenawi, A., Slonim-Nevo, V., & Graham, J. R. (2006). Polygyny and its impact on the psychological well-being of husbands. *Journal of Comparative Family Studies, 3*(45), 173–189. https://cris.bgu.ac.il/en/publications/polygyny-and-its-impact-on- the-psychosocial-well-being-of-husbands/.

Allotey, P. & Gyapong, M. (2005). *The gender agenda in the control of tropical disease: a review of current evidence, in the gender agenda in the control of tropical disease: a review of current evidence.* WHO/TDR.

Al-Sharfi, M., Pfeffer, K., & Miller, K.A. (2015). The effects of polygamy on children and adolescents: A systematic review. *Journal of Family Studies*. https://doi: 10.1080/13229400. 2015.1086405.

Al wazedi, U. (2021). *Postcolonial feminism.* https://www.scribd.com/document/594521228/Postcolonial-Feminism.

Andersson, N. & Cockcroft, A. (2012). Choice-disability and HIV infection: a cross sectional study of HIV status in Botswana, Namibia and Swaziland. *AIDS Behaviour, 16*. 189–98. http://doi. 10.1007/s10461-011-9912-3.

Anderson, S. (2007). The economics of dowry and brideprice. *Journal of Economic Perspectives, 21*(4), 151–174.

Armstrong, A. (1998). *Culture and choice: Lessons from survivors of gender violence in Zimbabwe. Harare*: Violence against women in Zimbabwe Research Project.

Ashimi, A. O., & Amole, T. G. (2015). Prevalence and predictors for domestic violence among pregnant women in a rural community Northwest, Nigeria. *Nigerian Medical Journal, 56*(2), 118–21. https://doi.org/10.4103/0300-1652.150696.

Aschwanden, H. (1982). *Symbols of Life*. Gweru: Mambo Press.

Associazione Italiana Donne per lo Sviluppo (AIDOS). (2015). *Addressing FGM in Development Projects and Programmes*. https://tinyurl.com/k3gawa4.

Astbury, J. (2006). Violence against women and girls: Mapping the health consequences. *International Congress Series, 1287*, 49-53. https://doi.org/10.1016/j.ics.2005.11.099.

Atashili, J., Poole, C., Ndumbe, P. M., Adimora, A. A., & Smith, J. S. (2008). Bacterial vaginosis and HIV acquisition: a meta-analysis of published studies. *AIDS*, *22*(12), 1493–1501. https://doi.org/10.1097/QAD.0b013e3283021a37.

Audet, C. M., Blevins, M., Cherry, C.B., González-Calvo, L., Green, A.F., & Moon, T.D. (2017). Understanding intra-vaginal and labia minora elongation practices among women heads-of-households in Zambézia Province, Mozambique, *Culture, Health & Sexuality, 19*(5), 616-629, https://doi: 10.1080/13691058.2016.1257739.

Avis, M. (2003). Do we need methodological theory to do qualitative research? *Qualitative Health Research, 13*(7), 995-1004. https://doi.org/10.1177/10497323032532.

Avis, M. (2005). Is there an epistemology for qualitative research? In: Holloway, I. (Ed). *Qualitative Research in Health Care*. Berkshire: Open University Press.

Ayres, I., Banaji, M. & Jolls, C. (2015). Race effects on eBay. *The RAND Journal of Economics, 46*(4), 891-917.

Bagnol, B. (2003). *'Identities and Sexual Attraction: Female Adolescent Rituals in Northern Mozambique and Healers in Southern Mozambique*. (Paper presented at the 4th International IASSCS Conference) University of the Witwatersrand, Sex and Secrecy Conference: Johannesburg.

Bagnol, B., & Mariano, E. (2008). Vaginal practices: eroticism and implications for women's health and condom use in Mozambique. *Culture, health & sexuality*, *10*(6), 573–585. https://doi.org/10.1080/13691050801999071.

Bagnol, B., & Mariano, E. (2012). Gender, sexuality and vaginal practices. Maputo, Mozambique: DAA, FLCS, UEM.

Bailey, M. J., Baines, B., Amani, B., & Kaufman, A. (2005). *Expanding Recognition of Foreign Polygamous Marriages: Policy Implications for Canada*. http://dx.doi.org/10.2139/ssrn.3771981

Baker, J. (2008). The ideology of choice. Overstating progress and hiding injustice in the lives

of young women: Findings from a study in North Queensland, Australia. In *Women's Studies International Forum*, *31*(1), 53-64). Pergamon.

Baker, J. R. (1974). *Race.* Oxford: Oxford University Press.

Baland, J. M., & Ziparo, R. (2018). Intra-household bargaining in poor countries. *Towards gender equity in development*, *69*(1).

Baloyi, E. M. (2013). Critical reflections on polygamy in the African Christian context. *Missionalia: Southern African Journal of Mission Studies*, *41*(2), 164-181.

Baloyi, E. M. (2010). "An African View of Women as Sexual Objects as a Concern for Gender Equality: A Critical Study". *Verbum et Ecclesia* 1-6.

Baloyi, E. & Manala, J. (2019). Reflections on the challenges of preferring the male child in an African marriage: A practical theological observation. *Verbum et Ecclesia, 40*(1). 1-9.

Bandura, A. (1969). Social-learning theory of identificatory processes. *Handbook of socialization theory and research*, *213*, 262.

Banks, N. (2022). What's our role in changing the international aid system? A personal and practical reflection. Global Development Institute Blog. http://blog.gdi.manchester.ac.uk/whats-our-role-in-changing-the-international-aid-system-a-personal-and-practical-reflection/

Barnes, G. (1999). Private violence, gendered justice. *Alternative Law Journal, 24*(2). http://classic.austlii.edu.au/au/journals/AltLawJl/1999/12.html.

Barnes, T. A. (1992). The fight for control of African women's mobility in colonial Zimbabwe, 1900-1939. *Signs: Journal of Women in Culture and Society*, *17*(3), 586-608.

Barnes, T. (1997). "Am I a Man?": Gender and the Pass Laws in Urban Colonial Zimbabwe, 1930-80. *African Studies Review*, *40*(1), 59-81.

Barnes, T. (1999). *We Women Worked So Hard': Gender, Urbanization and Social Reproduction in Colonial Harare, Zimbabwe, 1930 – 1956.* Heinemann: Portsmouth, New Hampshire.

Bareket, O., & Shnabel, N. (2020). Domination and objectification: Men's motivation for dominance over women affects their tendency to sexually objectify women. *Psychology of Women Quarterly*, *44*(1), 28-49.

Barros, C., Schraiber, L. B., & Junior, I. (2011) Association between intimate partner

violence against women and HIV infection. *Revista de saúde pública, 45*, 365-72. https://doi.10.1590/S0034-89102011005000008.

Barry, J. (2005). *The Effect of Socio-Economic Status on Academic Achievement*. Kansas, USA: Department of Sociology, Faculty of Graduate School of Wichita State University.

Bartholomaeus, C. (2013). Colluding with or challenging hegemonic masculinity? Examining primary school boys' plural gender practices. *Australian Feminist Studies*, *28*(77), 279-293.

Batliwala, S. (2011). *Strengthening Monitoring and Evaluation for Women's Rights: Thirteen Insights for Women's Organizations.* Toronto: AWID. https://www.awid.org/ Library/Strengthening-Monitoring-and-Evaluation-for- Women-s-Rights-Thirteen-Insightsfor-Women-s-Organizations.

Bauni, E. K., & Jarabi, B. O. (2003). The low acceptability and use of condoms within marriage: evidence from Nakuru district, Kenya.

Becker, M. H. (1974). The health belief model and personal health behaviour. *Health Education Monograms. 2.* 324–508. http://dx.doi.org/10.1177/109019817400200407.

Begum, S., Donta, B., Nair, S., & Prakasam, C. P. (2015). Socio-demographic factors associated with domestic violence in urban slums, Mumbai, Maharashtra, India. *The Indian journal of medical research*, *141*(6), 783–788. https://doi.org/10.4103/0971-5916.160701.

Bekker, L.G., Hughes, J., Amico, R., Roux, S., Hendrix, C., Anderson, P. L., Dye, B., Elharrar, V., Stirratt, M. J., & Grant, R. (2015). *HPTN 067/ADAPT Cape Town: a comparison of daily and nondaily PrEP dosing in African women.* https://www.croiconference.org/abstract/hptn-067adapt-cape-town-comparison- daily-and-nondaily-prep-dosing-african-women/.

Bennetta, J, R. (1975). *African Apostles: Ritual and Conversion in the Church of John*

Marange. London: Cornell University Press.

Bengesai, A. V., & Khan, H. T. (2021). Female autonomy and intimate partner violence: findings from the Zimbabwe demographic and health survey, 2015. *Culture, Health & Sexuality*, *23*(7), 927-944.

Benson, K., & Chadya, J. M. (2005). Ukubhinya: Gender and sexual violence in Bulawayo, colonial Zimbabwe, 1946–1956. *Journal of Southern African Studies*, *31*(3), 587-610.

Berg, C. J., Stratton, E., Schauer, G. L., Lewis, M., Wang, Y., Windle, M., & Kegler, M. (2015). Perceived harm, addictiveness, and social acceptability of tobacco products and marijuana among young adults: marijuana, hookah, and electronic cigarettes win. *Substance Use Misuse, 50*(1), 79-89. doi: 10.3109/10826084.2014.958857.

Berg, R. C., & Denison, E. (2013). A tradition in transition: factors perpetuating and hindering the continuance of female genital mutilation/cutting (FGM/C) summarized in a systematic review. *Health care for women international*, *34*(10), 837-859.

Berger, R. (2015) Now I see it, now I don't: researcher's position and reflexivity in qualitative research, *Qualitative Research*, 15(*2*), 219–34.

Bertrand, J. T., Ross, J., & Glover, A. L. (2022). Declining yet persistent use of traditional contraceptive methods in low- and middle-income countries. *Journal of biosocial science*, *54*(5), 742–759. https://doi.org/10.1017/S0021932021000341.

Besong, E. N. (2018). Low Bride Price Culture, a Panacea for Rising Singlehood: Nsadop's Example.

Beyer, K., Wallis, A. B., & Hamberger, L. K. (2015). Neighbourhood Environment and Intimate Partner Violence: *A Systematic Review. Trauma, Violence, & Abuse, 16*(1), 16–47. https://doi.org/10.1177/1524838013515758.

Bhalla, N. (2018). *Kenyan doctor goes to court to legalize female genital mutilation, Reuters*, 19 January, www.reuters.com/article/us-kenya-women-fgm/kenyan-doctor-goes-to-court-to-legalize-female-genital-mutilation-idUSKBN1F8296.

Bhana, D. (2018). *Love, sex and teenage sexual cultures in South Africa: 16 turning 17.* Abingdon: Routledge.

Bhana, D. (2015). Sex, gender and money in African teenage conceptions of love in HIV

contexts. *Journal of Youth Studies*, *18*(1), 1-15.

Bhana, D., & Moosa, S. (2016). Failing to attract males in foundation phase teaching: An issue of masculinities. *Gender and Education*, *28*(1), 1-19.

Bhana, D., & Nkani, N. (2014). When African teenagers become fathers: Culture, materiality and masculinity. *Culture, health & sexuality*, *16*(4), 337-350.

Bhana, D., & Mayeza, E. (2016). We don't play with gays, they're not real boys… they can't fight: Hegemonic masculinity and (homophobic) violence in the primary years of schooling. *International journal of educational development*, *51*, 36-42.

Bhana, D., & Mayeza, E. (2019). 'Cheese boys' resisting and negotiating violent hegemonic masculinity in primary school. *Norma*, *14*(1), 3-17.

Bhana, D., Janak, R., Pillay, D., & Ramrathan, L. (2021). Masculinity and violence: Gender, poverty and culture in a rural primary school in South Africa. *International Journal of Educational Development*, *87*, 102509.

Bhana, D. (2007). Childhood sexuality and rights in the context of HIV/AIDS. *Culture, Health & Sexuality, 9,* 309e324.

Bhanbhro, S., Cronin De Chavez, A., & Lusambili, A. (2016). Honour based violence as a global public health problem: a critical review of literature. *International Journal of Human Rights in Healthcare*, *9*(3), 198-215.

Bhebhe, H. S. (2014). *Labia elongation and identity (re)construction among the Ndebele women of Zimbabwe.* Doctoral thesis. Anglia Ruskin University, United Kingdom.

Bicchieri, C. (2005). *The Grammar of Society: Nature and Dynamics of Social Norms*. Cambridge: Cambridge University Press.

Bishai, D. & Grossbard, S. (2010). "Far above Rubies: Bride Price and Extramarital Sexual Relations in Uganda." *Journal of Population Economics, 23*(4), 1177–1187. http://www.jstor.org/stable/40925856.

Bishau, D. (2010). Reign with him for thousand years (Rev 20:6). In R, Gunda.; L. Togarasei.; E. Chitando., & N. Taringa. (Eds). *A Sociological hermeneutical Exposition of biblical and Contemporary millenarian Movements in Zimbabwe as Radical Responses to Deprivation.* Bamberg: University of Bamberg Press.

Black, M. C., Basile, K. C., Breiding, M. J., Smith, S. G., Walters, M. L., Merrick, M.T., Chen, J., & Stevens, M. R. (2011). *The National Intimate Partner and Sexual Violence Survey (NISVS).* (2010 Summary Report). Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

Black, N., Johnston, M., Michie, S., Hartmann-Boyce, J., West, R., Viechtbauer, W., Eisma, M. C., Scott, C., & de Bruin, M. (2020). Behaviour change techniques associated with smoking cessation in intervention and comparator groups of randomized controlled trials: a systematic review and meta-regression. *Addiction (Abingdon, England)*, *115*(11), 2008–2020. https://doi.org/10.1111/add.15056.

Blacking, J. (1998). *Venda children's songs: a study in ethnomusicological analysis*. Johannesburg: Witwatersrand University Press.

Bloom, S. S. (2008). *Violence Against Women and Girls: A Compendium of Monitoring and Evaluation Indicators.* https://www.measureevaluation.org/publications/pdf/ms-08- 30.pdf.html.

Boddy, J. (2016). The normal and the aberrant in female genital cutting. Shifting paradigms. *Journal of Ethnographic Theory, 6(*2), 41–69. doi:10.14318/hau6.2.008.

Bordo, S. (2023). *Unbearable weight: Feminism, Western culture, and the body*. University of California Press.

Bourdieu, P. (1989). Les rites comme actes d'institution. *Actes de la recherche en Sciences sociales*, *43*(43), 8-63.

Bourdieu, P. (2002). *Interventions, Science sociale et action politique*. Marseille: Agone

Bourdillon, M. F. C. (1976). The Shona peoples: Ethnography of the contemporary Shona, with special reference to their religion. Gweru: Mambo Press.

Bourgois, P. (1996). In search of masculinity—Violence, respect and sexuality among Puerto Rican crack dealers in East Harlem. *British Journal of Criminology 36*(3), 412–427. https://llr.primo.exlibrisgroup.com/.

Bowman, K., & Sweetman, C. (2014). Introduction to gender, monitoring, evaluation and

learning. *Gender & Development*, *22*(2), 201-212. https://doi.org/10.1080/13552074.2014.934525.

Boyatzis, R.E. (1998). *Transforming qualitative information: thematic analysis and code development*. Sage.

Boylorn, R. M. (2008). Participants as co-researchers. In L. M. Given (Ed.), *The SAGE encyclopedia of qualitative research methods* (pp. 600-601). Thousand Oaks, CA: SAGE.

Bradley, T. (Ed) (2011). *Women, Violence and Tradition: Taking FGM and Other Practices to a Secular State*. London: Zed Books.

Bradley, T. & Gruber, J. (2018). VAWG mainstreaming in access to justice programmes: a framework for action. *Development in Practice, 28*(1), 16-32. https://doi.10.1080/09614524.2018.1398716.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101. https://doi.org/10.1191/1478088706qp063oa.

Braun, V. & Clarke, V. (2021). One size fits all? What counts as quality practice in (reflexive) thematic analysis? *Qualitative Research in Psychology, 18*(3), 328- 352, https://doi.10.1080/14780887.2020.1769238.

Braun, V. (2009). The Women Are Doing It For Themselves' The Rhetoric of Choice and Agency around Female Genital 'Cosmetic Surgery. *Australian Feminist Studies*, *24*(60), 233-249.

Breckenridge, K. (1998). The allure of violence: men, race and masculinity on the South African gold mines 1900–1950. *Journal of Southern African Studies, 24*(4), 669-693. https://doi.10.1080/03057079808708596.

Brooker, D., Fontaine, J. L., Evans, S., Bray, J., & Saad, K. (2014). Public health guidance to facilitate timely diagnosis of dementia: ALzheimer's Cooperative Valuation in Europe recommendations. *International Journal of Geriatric Psychiatry*, *29*(7), 682-693.

Bryman, A. (Ed.). (1988). *Doing research in organizations*. London: Routledge.

Bryman, A. (2006). Integrating quantitative and qualitative research: how is it done? *Qualitative Research, 6*(1), 97–113. https://doi.org/10.1177/1468794106058877

Budlender, D. (2006). Expectations versus realities in gender-responsive budget initiatives. In S. Razavi, & S. Hassim (Eds.). *Gender and Social Policy in a Global Context: Uncovering the Gendered Structure of 'the Social'* (pp. 322-339). London: Palgrave Macmillan. https://doi.org/10.1108/MEDAR-07-2015-0046.

Budlender, D., & Hewitt, G. (2002). *Gender budgets make more cents: country studies and good practice.* London: The Commonwealth Secretariat.

Buiten, D., & Naidoo, K. (2016). Framing the problem of rape in South Africa: Gender, race, class and state histories. *Current Sociology, 64*(4), 535–550. https://doi.org/10.1177/0011392116638844.

Busza, J., Mtetwa, S., Fearon, E., Hofisi, D., Mundawarara, T., Yekeye, R., Magure, T., Mugurungi, O., & Cowan, F. (2017). Good news for sex workers in Zimbabwe: how a court order improved safety in the absence of decriminalization. *Journal of the International AIDS Society*, *20*(1), 21860. https://doi.org/10.7448/IAS.20.1.21860

Butler, J. (1999). *Gender trouble: Feminism and the subversion of identity*. 2nd Edition. New York: Routledge.

Butler, J. (1990). *Gender Trouble: Feminism and the Subversion of Identity*. 1st Edition. London: Routledge.

Campbell, J.C., Baty, M.L., Ghandour, R.M., Stockman, J.K., Francisco, L., & Wagman, J. (2008) The intersection of intimate partner violence against women and HIV/AIDS: a review. *International Journal of Injury Control and Safety Promotion, 15*(4), 221-231. https://doi. 10.1080/17457300802423224.

Carter, S. M., & Little, M. (2007). Justifying knowledge, justifying method, taking action: Epistemologies, methodologies, and methods in qualitative research. *Qualitative Health Research, 17*(10), 1316-1328. https://doi.org/10.1177/1049732307306927.

Catania, J. A., Kegeles, S. M., Coates, T. J. (1990). Toward an understanding of risk behaviour: an AIDS risk reduction model (ARRM). *Health Education Quarterly, 17*. 52–72. http:// doi: 10.1177/109019819001700107.

Catalyst. (2018). *Quick take: Women in the workforce: United States*.

https://www.catalyst.org/knowledge/ women-workforce-united-states

Chadambuka, P., Pelser, A., & Muzvidziwa, V. (2023). "Sex is sex, marriage is marriage": infidelity amongst married women in Shamva, Zimbabwe. *Anthropology Southern Africa, 46*(1), 51-63.

Chambers, D.L. (1997). "Polygamy and same -sex marriage." *Hofstra Law Review 26*, (1). https://scholarlycommons.law.hofstra.edu/hlr/vol26/iss1/2.

Chant, S. & Sweetman, C. (2012). 'Fixing women or fixing the world? 'Smart economics', Efficiency approaches, and gender equality in development.' *Gender & Development 20*(3): 517–529. https://doi.org/10.1080/13552074.2012.731812.

Chanza, H. (2014). *Malawi sex initiation camps.* Nigeria village square.

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. London: Sage Publications.

Charmaz, K. (1993). Book Reviews. *Gender & Society, 7*(4), 614–616. https://doi.org/10.1177/089124393007004013

Chazireni, E & Chidzawo, H. (2017). Challenges in accessing appropriate contraception among students in Zimbabwe State Universities*. Journal of Pharmaceutical and Biological Sciences, 5*(2), 37-41. https://www.jpbs.in/article-details/4095.

Chevo, T., & Bhatasara, S. (2012). International Scholarly Research Network ISRN Immunology. (Review Article) *HIV and AIDS Programmes in Zimbabwe: Implications for the Health System Sociology Department, University of Zimbabwe*. 1-11. http://doi.10.5402/2012/609128

Chikunda, C. (2014). Identifying tensions around gender-responsive curriculum practices in science teacher education in Zimbabwe: An activity theory analysis. *African Journal of Research in Mathematics, Science and Technology Education*, *18*(3), 264-275.

Chikhungu, L.C., Madise, N.J. (2015). Trends and protective factors of female genital mutilation in Burkina Faso: 1999 to 2010. *International Journal of Equity*

Health, 14(*42*)., https://doi.org/10.1186/s12939-015-0171-1

Chimuka, M. (2011). *Old habits die hard.* http://www.ghanaforum.com

Chingandu, L. (2007). *Multiple Concurrent Partnerships: The story of Zimbabwe- Are small houses a key driver?* Southern African HIV and AIDS Information Dissemination Service: Harare.

Chinyoka, K., & Ganga, E. (2011). An exploration of psychological effects of poverty on child development in Ngundu in Zimbabwe. *NAWA Journal of Language and Communication, 4*(6), 143–154.

Chireshe, E. (2015). Christian Women's Experiences of Domestic Violence in Zimbabwe. *Affilia, 30*(3), 380–394. https://doi.org/10.1177/0886109914563156.

Chireshe, E. & Chireshe, R. (2010). Lobola: The perceptions of Great Zimbabwe University students. *Journal of Pan-African Studies, 3*(9), 211-221. http://www.jpanafrican.org/docs/vol3no9/3.9Lobola.pdf.

Chisango, T., Mafa, I., & Maunganidze, L. (2022). Investigating the Sexist Implications of Bride Price (Lobola) in Zimbabwe. *Society*, *59*(5), 564-575.

Chitakure, J. (2016). *Shona Women in Zimbabwe--A Purchased People?: Marriage, Bridewealth, Domestic Violence, and the Christian Traditions on Women* (12). Wipf and Stock Publishers.

Chitereka, J., & Nduna, B. (2010). *Determinants of unmet need for family planning in Zimbabwe. Harare, Zimbabwe*: Zimbabwe National Family Planning Council and Liverpool School of Tropical Medicine.

Chiweshe M, Chiweshe M. (2017). 'Not My Child': Parents' Denial About Adolescent Sexuality in Harare, Zimbabwe. *Journal of Family Reproductive Health, 11*(3). 119-127. PMID: 30018648; PMCID: PMC6045689.

Chiweshe, M. K., Chakona, L., & Helliker, K. (2014). Patriarchy, women, land and livelihoods on A1 farms in Zimbabwe. *Journal of Asian and African Studies*, *50*(6), 716-731.

Chiweshe, M. K. (2016). Wives at the Market Place: Commercialisation of Lobola and Commodification of Women's bodies in Zimbabwe. *The Oriental Anthropologist*, *16*(2), 229-243. https://doi.org/10.1177/0976343020160202.

Christiansen, L. B. (2013). 'Respectable Women'versus 'Small Houses': Feminist Negotiations of Sexual Morality, Marriage and the Challenge of HIV/AIDS in Zimbabwe. *Journal of Southern African Studies*, *39*(3), 511-526.

Christofides, N., & Jewkes, R. (2010). Acceptability of universal screening for intimate partner violence in voluntary HIV testing and counseling services in South Africa and service implications. *AIDS care*, *22*(3), 279–285. https://doi.org/10.1080/09540120903193617

Chuma, M., & Chazovachii, B. (2012*). Domestic Violence Act: Opportunities and challenges for women in rural areas: The case of Ward 3, Mwenezi District, Zimbabwe.*

CIOMS. (2002). International Ethical Guidelines for Biomedical Research Involving Human Subjects. Geneva, Switzerland: CIOMS.

Cislaghi. B. (2019). The potential of a community-led approach to change harmful gender norms in low- and middle-income countries. Advancing Learning and Innovation on Gender Norms. file:///C:/Users/user/Documents/Cislaghi%202019%20community_led_approach_report.pdf.

Cislaghi, B., & Heise, L. (2020). Gender norms and social norms: differences, similarities and why they matter in prevention science. *Sociology of health & illness*, *42*(2), 407-422. https://doi.org/10.1111/1467-9566.13008.

Cislaghi, B., & Heise, L. (2019). Using social norms theory for health promotion in low- income countries. *Health promotion international*, *34*(3), 616–623. https://doi.org/10.1093/heapro/day017.

Cislaghi, B., & Heise, L. (2018). Theory and practice of social norms interventions: eight common pitfalls. *Globalization and health*, *14*(1), 83.https://doi.org/10.1186/s12992-018-0398-x

Cleaver, F. D. (Ed). (2003). *Masculinities matter: Men, gender and development*. London: Zed Books.

Cools, S. & Kotsadam, A. (2017). Resources and Intimate Partner Violence in Sub-Saharan Africa. *World Development, 95,* 211-230. https://doi.org/10.1016/j.worlddev.2017.02.027.

Cooper, I. (2015). Commodification of the black body, sexual objectification and social hierarchies during slavery. *Earlham Historical Journal*, *7*(2), 21-41.

Coovadia, H., Jewkes, R., Barron, P., Sanders, D., & McIntyre, D. (2009). The health and health System of South Africa: historical roots of current public health challenges. *Lancet, 374,* 817–34. http://doi: 10.1016/S0140-6736(09)60951-X.

Coetzee, J., Jewkes, R., & Gray, G. E. (2017). Cross-sectional study of female sex workers in Soweto, South Africa: Factors associated with HIV infection. *PloS one*, *12*(10), e0184775. https://doi.org/10.1371/journal.pone.0184775.

Collins, A. (2013). Gender-Based Violence. *Encyclopaedia of Critical Psychology, Springer,* http://doi.10.1007/978-1-4614-5583-7_121.

Collins, A. (2013). Bullies, sissies and crybabies: Dangerous common sense in educating boys for violence. *Agenda*, *27*(1), 71-83.

Comrie-Thomson, L., Mavhu, W., Makungu, C., Nahar, Q., Khan, R., Davis, J., Stillo, E., Hamdani, S., Luchters, S., & Vaughan, C. (2020). Male involvement interventions and improved couples' emotional relationships in Tanzania and Zimbabwe: 'When we are walking together, I feel happy'. *Culture, health & sexuality*, *22*(6), 722–739. https://doi.org/10.1080/13691058.2019.1630564.

Connell, R. (1995). *Masculinities.* Cambridge: Polity.

Connell R. (1987). *Gender and power: Society, the Person and Sexual Politics.* Palo Alta, California: University of California Press.

Connell R. (2005). *Masculinities.* (2nd ed) Cambridge: Polity Press

Connell, R. W., & Messerschmidt, J. W. (2005). Hegemonic masculinity e rethinking the concept. *Gender and Society*, 19(6), 829e859.

Connell, R. (1987). Gender and Power: Society, the person and sexual politics. Palo Alta, California: University of California Press.

Connell, R. W., & Messerschmidt, J. W. (2005). Hegemonic Masculinity: Rethinking the Concept. Gender & Society, 19(6), 829-859. https://doi.org/10.1177/0891243205278639

Conner, M., & Norman, P. (2015). *EBOOK: predicting and changing health behaviour: research and practice with social cognition models*. McGraw-hill education (UK).

Corbin, J., & Strauss, A. (2008). *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory.* (3rd ed). Thousand Oaks, CA:

Sage.

Cornell, M., Johnson, L. F., Wood, R., Tanser, F., Fox, M. P., Prozesky, H., Schomaker, M.,

Corno, L., and A. Voena (2016). '*Selling Daughters: Age of Marriage, Income Shocks and the Bride Price Tradition'.* Working Paper. Chicago, IL: University of Chicago.

Corno, L., N. Hildebrandt, & A. Voena (2016). '*Weather Shocks, Age of Marriage and the Direction of Marriage Payments'*. Working Paper. Chicago, IL: University of Chicago.

Cornwall, A., & Brock, K. (2005). What do buzzwords do for development policy? A critical look at 'participation', 'empowerment'and 'poverty reduction'. *Third world quarterly*, *26*(7), 1043-1060.

Council of Europe. (2005). *Gender Budgeting*. Council of Europe: Strasbourg.

Council of Europe. (2019). *Child Safeguarding Policy*. https://rm.coe.int/2019-council-of-europe-child- safeguarding-policy/168098c6cf

Counts, D. A., Brown, J. K., & Campbell, J. C. (Eds.). (1992). *Sanctions and sanctuary: Cultural perspectives on the beating of wives.* Boulder, CO: Westview Press.

Crawford, S., Lloyd-Laney, M., Bradley, T, Atherton, L., & Byrne, G. (2020), '*Final Performance Evaluation of DFID's What Works to Prevent Violence Against Women and Girls Programme', DFID's What Works to Prevent VAWG Programme*. IMC Worldwide: Surrey.

Crespí-Lloréns, N.; Hernández-Aguado, I.; Chilet-Rosell, E. (2021). Have Policies Tackled Gender Inequalities in Health? A Scoping Review. *International Journal of Environmental Research and Public Health, 18*, 327. https://doi.org/ 10.3390/ijerph18010327.

Cresswell, J. W., & Plano Clark, V. L. (2011). *Designing and conducting mixed method research* (2nd ed.). Thousand Oaks, CA: Sage.

Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process.* London: Sage Publication.

Cushion, C. J., & Jones, R. L. (2014). A Bourdieusian analysis of cultural reproduction: Socialisation and the 'hidden curriculum' in professional football. *Sport, education and society*, *19*(3), 276-298. https://doi.org/10.1080/13573322.2012.666966.

D'Amico, E.J., Rodriguez, A., Tucker, J.S., Pedersen, E.R., & Shih, R.A. (2018).

Planting the seed for marijuana use: Changes in exposure to medical marijuana advertising and subsequent adolescent marijuana use, cognitions, and consequences over seven years. *Drug and Alcohol Dependence, 188*, 385-391. https://doi.org/10.1016/j.drugalcdep.2018.03.031.

D'Amour, M. (2004). *"Sect Wives Defend Lives: Women say polygamy choice is theirs*." https://papers.ssrn.com/sol3/papers.cfm?abstract_id=1360230.

Danial, S. (2013). Cultural Relativism vs. Universalism: Female Genital Mutilation, Pragmatic Remedies. *Prandium - The Journal of Historical Studies, 2*(1), 1-10. http://jps.library.utoronto.ca/index.php/prandium/article/view/19692

Danis, D. & Patrick, L. (2002). Health Policy, vulnerability, and vulnerable populations. In M, Danis, C. M., Clancy, & L. R. Churchill. (Eds.). *Ethical dimensions of health policy*. New York: Oxford University Press.

Davies, A. (2008). Intersectionality as buzzword: A sociology of science perspective on what makes a feminist theory successful. *Feminist Theory, 9*(1), 114-145. https://doi. 10.1177/1464700108086364.

De Beauvoir, S. (1972). *The Second Sex.* Trans. H.M. Parshley. Harmondsworth: Penguin.

Decker, M. R., Seage, G. R., Hemenway, D., Raj, A., Saggurti, N., Balaiah, D., & Silverman, J. G. (2009). Intimate partner violence functions as both a risk marker and risk factor for women's HIV infection: findings from Indian husband-wife dyads. *Journal of acquired immune deficiency syndromes (1999)*, *51*(5), 593–600. https://doi.org/10.1097/QAI.0b013e3181a255d6

Decosas, J. & Padian, N. (2001). The profile and context of the epidemics of sexually transmitted infections including HIV in Zimbabwe. *Sexually Transmitted Infection, 78*(I), 40–46. http://dx.doi.org/10.1136/sti.78.suppl_1.i40.

Deering, K. N., Bhattacharjee, P., Mohan, H. L., Bradley, J., Shannon, K., Boily, M. C., Ramesh, B. M., Isac, S., Moses, S., & Blanchard, J. (2013). Violence and HIV risk among female sex workers in Southern India. *Sexually transmitted diseases*, *40*(2), 168–174. https://doi.org/10.1097/olq.0b013e31827df174.

Del Gesso, C. (2019). Gender Budgeting Implementation in Italian Regional Governments:

Institutional Behaviour for Gender Equality and Women's Empowerment. *International Business Research*, *12*, 110-124. RePEc:ibn:ibrjnl:v:12:y:2019:i:12:p:110.

De la Rocha, M., Jenin, E., Perlman, J., Roberts, B. R., Safa, H., & Ward, P. M. (2004). From the marginality of the 1960s to the "New poverty" of today: a LARR research forum*. Latin American Research Review, 39*(1), 183e187.

Delius, P., & Glaser, C. (2005). Sex, disease and stigma in South Africa: historical perspectives. *African Journal of AIDS research*, *4*(1), 29-36.

De Oliveira, T., Kharsany, A.B.M., Gräf, T., Cawood, C., Khanyile, D., Grobler, A., Puren, A., Madurai, S., Baxter, C., Abdool Karim, Q.A., & Abdool Karim, S.S. (2016). *Transmission networks and risk of HIV infection in KwaZuluNatal, South Africa: a community- wide phylogenetic study*. *Lancet HIV, 4*(1), 1-22. http://doi:10.1016/S2352- 3018(16)30186-2.

Depart for International Development. (2019*). Stopping Abuse Female Exploitation (Safe) Programme Zimbabwe.* Development Tracker. https://devtracker.fcdo.gov.uk/projects/GB-GOV-1-300024/summary.

Dery, I. 2015 Bride price and domestic violence: empirical perspectives from Nandom district in north western region of ghana. *International journal of development sustainability,* 4(3), 258-271

Dery, I., & Akurugu, C. A. (2021). '"Real men" support their wives': Reconstructing masculinity among men in rural northwestern Ghana. *Hypatia, 36*(1), 172–190

Dery, I. & Bawa, S. (2019). Agency, social status and performing marriage in postcolonial societies. *Journal of Asian and African Studies, 54,* 980–994.

De Walque, D. (2007). Sero-discordant couples in five African countries: implications for prevention strategies. *Population and development review*, *33*(3), 501-523.

De Wet, N., Akinyemi, J., & Odimegwu, C. (2019). How Much Do They Know? An Analysis of the Accuracy of HIV Knowledge among Youth Affected by HIV in South Africa. *Journal of the International Association of Providers of AIDS Care,18*, hhttps://doi:10.1177/2325958218822306.

Dey, J. & Dutta, S. (2014), "Gender responsive budgeting in India: trends and analysis", *International Journal of Social Sciences, 3*(4), 495-509. https://doi.org/10.5958/2321-5771.2014.00024.6.

Diallo, A. & Voja, M. (2016). The Threat of Domestic Violence and Women Empowerment: The Case of West Africa Saikou. *African Development Review,* 28*(*1), 92–103.

Dingwall, S. (1992). Leaving telephone answering machine messages: Who's afraid of speaking to machines? *Text -Interdisciplinary Journal for the Study of Discourse*, *12*(1), 81-102. https://doi.org/10.1515/text.1.1992.12.1.81.

Dodo, O. (2021). Selected approaches for conflict resolution in marriage disputes in Zimbabwe. *International Journal of Modern Anthropology, 2*(15), 414 – 438. http://dx.doi.org/10.4314/ijma.v2i15.2.

Doucet, M. H., Pallitto, C. & Groleau, D. (2017). Understanding the motivations of health- care providers in performing female genital mutilation: an integrative review of the literature. *Reproductive Health, 14*(46), 1-15. https://doi.org/10.1186/s12978-017-0306-5.

Dunkle. K. L., Jewkes, R.K., Brown, H. C., Gray, G. E., McIntyre, J. A., & Harlow, S.D. (2004). Gender- based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa. *Lancet, 363*, 1415–21. https://doi: 10.1016/S0140-6736(04)16098-4.

Dutton, D. G., & White, K. R. (2013). Male victims of domestic violence. *New male studies: An international journal*, *2*(1), 5-17.

Dzimiri, C., Chikunda, P., & Ingwani, V. (2017). Causes of Child Marriages in Zimbabwe: A Case of Mashonaland Province in Zimbabwe. IRA-International Journal of Management & Social Sciences (ISSN 2455-2267), 7(1), 73-83. doi: http://dx.doi.org/10.21013/jmss.v7.n1.p9.

Eakle, R., Bothma, R., Bourne, A., Gumede, S., Motsosi, K. & Rees, H. (2019). 'I am still negative": Female sex workers' perspectives on uptake and use of daily pre-exposure prophylaxis for HIV prevention in South Africa.' *PLoS One, 14*(4). https://doi.org/10.1371/journal.pone.0212271.

Easterby-Smith, M., Thorpe, R. & Lowe, A. (1999). *Management research*: An

introduction. (1st ed). London: SAGE Publications.

Egger, M., Davies, M., & Boulle, A. (2017). Twelve-year mortality in adults initiating antiretroviral therapy in South Africa. https://doi.org/10.7448/IAS.20.1.21902.

EIGE. (2020). *Gender Equality Index 2020: Digitalisation and the future of work.* https://eige.europa.eu/

Elbe, S. (2017). Should HIV/AIDS be securitized? The ethical dilemmas of linking HIV/AIDS and security. In *Global Health* (pp. 239-264). Routledge.

El-Bassel, N., Gilbert, L., Witte, S., Wu, E., & Chang, M. (2011). Intimate partner violence and HIV among drug-involved women: contexts linking these two epidemics-- challenges and implications for prevention and treatment. *Substance use & misuse*, *46*(2-3), 295–306. https://doi.org/10.3109/10826084.2011.523296.

Elbedour, S., Bart, W.M., & Hektner, J. (2003). Intelligence and Family Marital Structure: The Case of Adolescents from Monogamous and Polygamous Families Among Bedouin Arabs in Israel, *The Journal of Social Psychology, 143*(1), 95-110. https://doi.10.1080/00224540309598433.

Ellsberg, M., Jansen, H.A., Heise, L., Watts, C.H., & Garcia-Moreno, C. (2008). Intimate partner violence and women's physical and mental health in the WHO multi- country study on women's health and domestic violence: An observational study. *The Lancet, 371*, 1165–1172. https//doi.10.1016/s0140-6736(08)60522-x.

Ellsberg, M., Arango, D. J., Morton, M., Gennari, F., Kiplesund, S., Contreras, M., & Watts, C. (2015). Prevention of violence against women and girls: What does the evidence say? *The Lancet, 385*(9977), 1555–1566. https://doi.org/10.1016/ S0140-6736(14)61703-7.

Elson, D. (2004), "Engendering government budgets in the context of globalization(s)." *International Feminist Journal of Politics, 6*(4), 623-642. https://doi.10.1080/1461674042000283390.

England, K. V. (1994). Getting personal: Reflexivity, positionality, and feminist research. *The professional geographer*, *46*(1), 80-89.

Engdasew, Z. (2022). Harnessing Indigenous Knowledge for Sustainable Pastoralist Education Development in Ethiopia. *Ethiopian Journal of the Social Sciences and Humanities*, *18*(1), 121-144.

Enloe, C. (1993). *The morning after: Sexual politics at the end of the Cold War*. Los Angeles: University of California Press.

Escobar, A. (1984). Discourse and power in development: Michel Foucault and the relevance of his work To the Third World. *Alternatives,10*. 77–400.

European Union. (2020). *Gender Action Plan. Putting women and girls' rights at the heart of the global recovery for a gender- equal world.* https://ec.europa.eu/commission/presscorner/detail/en/IP_20_2184.

Fakunmoju, S.B. & Rasool, S. (2018). Exposure to Violence and Beliefs About Violence Against Women Among Adolescents in Nigeria and South Africa. *Reproductive Health in Sub-Saharan Africa,* 1-17. http://doi.10.1177/2158244018817591.

Fakomogbon, G. (2021). Why is child marriage so prevalent in West Africa? https://www.globalcitizen.org/en/content/child-marriage-west-africa-explained/.

Familusi, O. O. (2012). African culture and the status of women: The Yoruba example. *The Journal of Pan African Studies*, *5*(1), 299-313.

Farrington, E. M., Bell, D.C. & DiBacco, A.E. (2016). Reasons People Give for Using (or Not Using) Condoms. *AIDS Beaviour, 20,* 2850- 2862). https://doi.org/10.1007/s10461-016-1352-7.

Farise, K. (2019). Ban harmful virginity testing. Mail & Guardian, 12 December 2019. https://mg.co.za/article/2019-12-12-00-ban-harmful-virginity-testing/.

Feyisetan B, Oyediran KA. Can married or cohabiting women negotiate protective sex? Findings from Demographic and Health Surveys of two West African countries. *Journal of Biosocial Science*, *52*(6), 785-808. doi:10.1017/S0021932019000798.

Fiske, A. P. (1991). *Structures of social life: The four elementary forms of human relations: Communal sharing, authority ranking, equality matching, market pricing*. Free Press.

Fidan, A., & Bui, H. N. (2016). Intimate partner violence against women in Zimbabwe. *Violence against women*, *22*(9), 1075-1096.

Finke, E. (2006). Genital Mutilation as an Expression of Power Structures: Ending FGM through Education, Empowerment of Women and Removal of Taboos. *African Journal of Reproductive Health / La Revue Africaine de La Santé Reproductive*, *10*(2), 13–17. https://doi.org/10.2307/30032454.

Fishbein, M. & Middlestadt, S. E. (1989). Using the theory of reasoned action as a framework for understanding and changing AIDS-related behaviours. In V. Mays, G. Albee, & S. Schenider (Eds.). *Primary prevention of AIDS: psychological approaches.* p. 93–110. Newbury Park: Sage.

Fishbein, M. & Ajzen, I. (2010). Predicting and Changing Behaviour: The Reasoned Action Approach. https://doi.10.4324/9780203838020.

Fisher, J. D., & Fisher, W. A. (2000). Theoretical approaches to individual-level change in HIV risk behaviour. In J. L. Peterson & R. J. DiClemente (Eds.). *Handbook of HIV prevention.* (pp. 3–55). https://doi.org/10.1007/978-1-4615-4137-0_1.

Fleming, P. J., DiClemente, R. J., & Barrington, C. (2016). Masculinity and HIV: Dimensions of Masculine Norms that Contribute to Men's HIV-Related Sexual Behaviours. *AIDS and behaviour*, *20*(4), 788–798. https://doi.org/10.1007/s10461- 015-1264-y.

Fontes, L. A., & McCloskey, K. A. (2011). Cultural issues in violence against women. *Sourcebook on violence against women*, 151-168.

Foucault, M. (1980). *Power/knowledge*. New York: Vintage Books.

Foundation for Professional Development. (2020). *Gender- Based Violence Project*. https://www.foundation.co.za/g-b-v.

Fulu, E., Warner, X., Miedema, S., Jewkes, R., Roselli, T. & Lang, J. (2013a). *Why Do Some Men Use Violence Against Women and How Can We Prevent it? Quantitative Findings from the United Nations Multi Country Study on Men*

and Violence in Asia and the Pacific. Bankok: United Nations Development Programme, United Nations Population Fund, United Nations Women and United nations Volunteers.

Fulu, E., Jewkes R., Roselli, T. & García-Moreno C. (2013b) Prevalence and risk factors for male perpetration of intimate partner violence: Findings from the UN Multi-country Study on Men and Violence in Asia and the Pacific. *Lancet Global Health, 1*, 187– 207. https://doi. 10.1016/S2214-109X(13)70074-3.

Gallo, P. G., Tita, E. and Viviani, F. (2006) At the roots of ethnic female genital modification. In G. Denniston, P. Grassivaro Gallo, F. M. Hodges, M. F. Milos & F. Viviani (Eds.). *Bodily integrity and the politics of circumcision. Culture, controversy, and change.* pp. 49– 55. http://eknygos.lsmuni.lt/springer/59/49-55.pdf.

Galizzi, G. (2010). The formulation of gender sensitive budgets: Integrating gender into the Balanced scorecard. *Economia Aziendale Online-*, *1*(3), 335-343. http://dx.doi.org/10.4485/ea2038-5498.335-343.

Gamell, A., Luwanda, L. B., Kalinjuma, A. V., Samson, L., Ntamatungiro, A. J., Weisser, M., Winfrid, G.,Tanner, M., Hatz, C., Letang, E. & Battegay, M. (2017). Prevention of mother-to- child transmission of HIV Option B+ cascade in rural Tanzania: The One Stop clinic model. *PLoS One, 12*(7), http://dx.doi. org/10.1371/journal.pone.0181096 PMID: 28704472.

Gaspart, F. & Plateau, J.P. (2007). The perverse effects high of bride prices. World development, 35(7), 1221-1236.

Gatzweiler F, Baumüller H, von Braun J, Ladenburger C (2011) Marginality: addressing the root causes of extreme poverty. ZEF working paper no 77, Center for Development Research. University of Bonn: Bonn.

Gavey, N. (2005). *Just sex? the cultural scaffolding of rape*. Hove, Sussex: Routledge.

Gelfand, M. (1973). *The genuine Shona*. Gweru: Mambo Press.

Gellner, D. (Ed.). (2013). Borderland lives in northern South Asia. Durham: Duke University Press (in press).

GCI. (2012). Gender based violence and spousal abuse among couples in Zimbabwe, (Policy Brief). https://catalogue.safaids.net/sites/default/files/publications/GCI%20National%20Dialogue%20Report%20Sept%202012.pdf.

Gibbs, A., Sikweyiya, Y., & Jewkes, R. (2014). 'Men value their dignity': securing respect and identity construction in urban informal settlements in South Africa. *Global health action*, *7*(1), 23676. http://doi.10.3402/gha.v7.23676.

Gibbs, A., Jewkes, R., Mbatha, N., Washington, L., & Willan, S. (2014). "Jobs, Food, Taxis and Journals: Complexities of Implementing Stepping Stones and Creating Futures in Urban Informal Settlements in South Africa." *African Journal of AIDS Research, 13*, 161–67. 10.2989/16085906.2014.927777

Gibbs, A., Jewkes, R., Sikweyiya, Y., & Willan, S. (2015). "Reconstructing Masculinity? A Qualitative Evaluation of the Stepping Stones and Creating Futures Intervention in Urban Informal Settlements in South Africa." *Culture Health & Sexuality 17*, 208–22. http://doi.10.1080/13691058.2014.966150.

Gibbs, A., Washington, L., Ntini, N., Khumalo, T., Willan, S., Sikweyiya, Y., Shai, N.J., Chirwa, E., & Jewkes, R. (2016). *Prevalence and drivers of violence in informal settlements in eThekwini, South Africa - Project Empower/HEARD.* https://www.whatworks.co.za/resources/project-resources/item/202-prevalence-and- drivers-of-violence-in-informal-settlements-in-ethekwini-south-africa-project-empower- heard.

Gibbs A., Dunkle K., Ramsoomar L., Willan S., Jama Shai N., Chatterji S., Naved R., & Jewkes R. (2020). New learnings on drivers of men's physical and/or sexual violence against their female partners, and women's experiences of this, and the implications for prevention interventions. *Glob. Health Action,*

13, 1739845. http://doi.10.1080/16549716.2020.1739845.

Gibbs, A., Myrttinen, H., Washington, L., Sikweyiya, Y., & Jewkes, R. (2019). Constructing, reproducing and challenging masculinities in a participatory intervention in urban informal settlements in South Africa, *Culture, Health & Sexuality, 22*(5), 535-550. http://doi. 10.1080/13691058.2019.1614671.

Gibbs, A., Dunkle, K., Willan, S., Jama-Shai, N., Washington, L., & Jewkes, R. (2018). Are women's experiences of emotional and economic intimate partner violence associated with HIV-risk behaviour? A cross-sectional analysis of young women in informal settlements in South Africa. *AIDS Care,* https://doi.10.1080/09540121.2018.1533230.

Giddens, A. (1984) The Constitution of Society. Outline of the Theory of Structuration. University of California Press, Berkeley.

Giles, W., & Hyndman, J. (Eds.). (2004). *Sites of Violence: Gender and Conflict Zones* (1st ed.). University of California Press. http://www.jstor.org/stable/10.1525/j.ctt1ppb4j.

Gill, A. K., & Walker, S. (2020). On honour, culture and violence against women in black and minority ethnic communities. In *The emerald handbook of feminism, criminology and social change* (pp. 157-176). Emerald Publishing Limited.

Girls Not Brides. (2013). *Women' Rights and Gender Justice*. https://www.sharednation.org/collections/shared-nation-fall-2017/ products/girls-not-brides.

Gist-Mackey, A. N. & Dougherty, D.S. (2021) Socio-material struggle: An ethnographic analysis of power, discourse, and materiality in a working class unemployment support organization. *Communication Monographs, 88*(3), 306- 329. https://doi. 10.1080/03637751.2020.1818801.

Goody, J. (1973). Polygamy, Economy, and the role of women. In J. Goody (Ed.*). The character of kinship (pp175-190)*. London: Cambridge University Press.

Goody, J. (1973). Bride wealth and Dowry in Africa and Eurasia in BRIDEWEALTH AND

DOWRY *Cambridge Papers in Social Anthropology, 7.*

Goosen, M. & Klugman, B. (1996). *The South African Women's Health Book*. Cape Town: Oxford University Press.

Goebel, A. (1999). "Here it is our land, the two of us": women, men and land in a Zimbabwean Resettlement Area. *Journal of Contemporary African Studies*, *17*(1), 75-96.

Goebel, A. (2005). *Gender and land reform: the Zimbabwe experience*. McGill-queen's press-mqup.

Goercke, B. (2004). The Impact of Traditional Shona Beliefs on HIV/AIDS Intervention Work in Zimbabwe.

Gori, E., Romolini, A., & Fissi, S. (2018). Local Authorities' Policies for Disseminating Gender Equality. Evidence from Italy. *Transylvanian Review of Administrative Sciences, 14*(53), 38-53. https://doi.org/10.24193/tras.53E.3.

Government of Zimbabwe. (2006). *Domestic violence Act*. https://www.justice.gov/sites/default/files/eoir/legacy/2013/11/08/domesti c_vio lence.pdf

Government of Zimbabwe. (2005). *Criminal Law Codification and Reform Act.* (Chapter 9: 23). https://www.veritaszim.net/node/225/

Govt of Zimbabwe (2013). *Constitution of Zimbabwe.* https://www.veritaszim.net/sites/veritas_d/files/Constitution%20of%20Zimb abw e%20Amendment%20%28No.%2020%29.pdf

Government of Zimbabwe. (2017). *EXTENDED ZIMBABWE NATIONAL HIV AND AIDS STRATEGIC PLAN(ZNASP) 2015 – 2020. COMMITMENT TOWARDS FAST TRACKING 90 90 90 TARGETS BY 2020 AND ENDING AIDS BY 2030.* https://procurement- notices.undp.org/view_file.cfm?doc_id=114051.

Government of Zimbabwe. (2015). *Zimbabwe Demographic Health Survey. Final Report.* https://dhsprogram.com/pubs/pdf/FR322/FR322.pdf.

Government of Zimbabwe. (2015a). *Zimbabwe Constitutional Court***.** https://www.veritaszim.net/sites/veritas_d/files/Constitutional%20Court%20Act %20No.%205%20of%202020.pdf.

Government of Zimbabwe. (2015b). *Zimbabwe National Gender Based Violence Strategy*.

https://www.veritaszim.net/sites/veritas_d/files/Zimbabwe%20National%20Gend er%20Based%20Violence%20Strategy%202012%20-%202015.pdf.

Government of Zimbabwe. (2020). *Amendments to the Education Act.*

http://mopse.co.zw/sites/default/files/public/downloads/EDUCATION%20A MEND MENT%20ACT%2C%202019%20%5B%20Act%2015-2019%5D.pdf.

Government of Zimbabwe. (2022). *Marriages Amendment Bill*.

https://www.veritaszim.net/sites/veritas_d/files/MARRIAGES%20ACT%20No.%201%20of %202022.pdf.

Gramsci, A. (1971*). Selections from the Prison Notebook.* London: Lawrence & Wishart

Grand, N., & Mazuru, M. (2011). The'Small house'in the era of the HIV/AIDS pandemic: the case of the Shona in Zimbabwe. Nawa: *Journal of language and communication,* 5(2), 31-50.

Grant, E. (2006). Human rights, cultural diversity and customary law in South Africa.

Journal of African Law, 50(1), 2-23. https://doi.10.1017/S0021855306000039.

Gray, R. H., Wawer, M. J., Brookmeyer, R., Sewankambo, N. K., Serwadda, D., Wabwire-

Mangen, F., Lutalo, T., Li, X., van Cott, T., Quinn, T. C., & Rakai Project Team (2001). Probability of HIV-1 transmission per coital act in monogamous, heterosexual, HIV-1-discordant couples in Rakai, Uganda. *Lancet*, *357*(9263), 1149–1153. https://doi.org/10.1016/S0140-6736(00)04331-2.

Greenbaum, E. (2001). *An Anthropological Perspective. The female Circucision Controversy*. Philadelphia: University of Philadelphia Press.

Green, J., Pool, R., Harrison, S., Hart, G. J., Wilkinson, J., Nyanzi, S. & Whitworth, J. A. (2001) Female control of sexuality: Illusion or reality? Use of vaginal products in southwest Uganda. *Social Science and Medicine, 52*(4), 585–598. https://doi.10.1016/s0277- 9536(00)00162-3.

Gregson, S., Nyamukapa, C., & Mlilo, M. (2000). *Are women or men more affected by HIV in Southern Africa? Insights from studies in rural Zimbabwe*. 2-7. Harare: SAFAIDS News.

Greig, A., Peacock, D., Jewkes, R., & Msimanga, S. (2008). Gender and AIDS: time to act. *AIDS, 22*(2), S35–S43. https://doi.org/10.1097/01.aids.0000327435.28538.18.

Grieg, A., Kimmel, M., & Lang, J. (2000). *Men, Masculinities and Development: Broadening Our Work towards Gender Equality*. New York: United Nations Development Programme.

Gruenbaum, E. (2001). *The Female Circumcision Controversy: An Anthropological Perspective.* Philadelphia: University of Pennsylvania Press.

Gumani, M. A., & Sodi, T. (2009). The experiences of rural VaVhenda women involved in polygamous marriages. *Journal of Psychology in Africa, 19*(2), 199-205. https://doi. 10.1080/14330237.2009.10820279.

Gwatimba, L., Raselekoane, N. R., & Nwafor, A. O. (2020). Obstacles to the realization of women's reproductive health rights in Zimbabwe. *African Journal of Reproductive Health*, *24*(3), 146-153.

Gwirayi, C. (2017). Experiences of Shona Men in Polygamous Marriages in Ward Four of Chivi District, Masvingo Province, Zimbabwe. Africology: *The Journal of Pan African Studies, 10*(1), 25-39. https://www.ajol.info/index.php/gab/article/view/153113.

Hague, G., Thiara, R. K., & Turner, A. (2011). Bride Price and its links to domestic violence and poverty in Uganda: A participatory action research study. *Women's Studies International Forum, 34*(6), 550-561. https://doi.org/10.1016/j.wsif.2011.06.008

Harding, S. (1991*) Whose Science? Whose Knowledge?* Ithaca: Cornell University Press.

Harling, G., Msisha, W. & Subramanian, S. V. (2010). No association between HIV and intimate partner violence among women in 10 developing countries. *PLoS One, 5*(12). https://doi.org/10.1371/journal.pone.0014257.

Harris, A. (2004). *Future Girl: young women in the twenty-first century.* New York: Routledge

Harris, T. (2013). Trading places: new economic geographies across Himalayan borderlands. *Political Geography, 35*, 60e68.

Harrison, A., Cleland, J., Gouws, E., & Frohlich, J. (2005). Early sexual debut among young

men in rural South Africa: heightened vulnerability to sexual risk? *Sexually transmitted infections*, *81*(3), 259-261.

Haroz D, von Zinkernagel D, Kiragu K. (2017). Development and impact of the Global Plan. *Journal of Acquired Immune Deficiency Syndrome, 75*(1), 2–6. http://dx.doi.org/10.1097/QAI.0000000000001318 PMID: 28398991.

Hassouneh-Phillips, D. (2001). Polygamy and wife abuse: A qualitative study of Muslim women in America. *Health Care for Women International, 22*(8), 735– 748. https://doi.org/10.1080/073993301753339951.

Hearn, J. (2004). From hegemonic masculinity to the hegemony of men. *Feminist Theory, 5*, 49–72. https://doi.org/10.1177/1464700104040813.

Hearn, J., Nordberg, M., Andersson, K., Balkmar, D., Gottzén, L., Klinth, R., Pringle, K., & Sandberg, L. (2012). Hegemonic Masculinity and Beyond: 40 Years of Research in Sweden. *Men and Masculinities, 15*(1), 31–55. https://doi.org/10.1177/1097184X11432113.

Hearn, J. & Morrell, R. (2012). Reviewing Hegemonic Masculinities and Men in Sweden and South Africa. *Men and Masculinities, 15*(*1*), 3 – 10. DOI**:** 10.1177/1097184X11432111

Heath, R., Hidrobo, M., & Roy, S. (2020). Cash transfers, polygamy, and intimate partner violence: Experimental evidence from Mali. *Journal of Development Economics, 143,* 102410. https://doi.org/10.1016/j.jdeveco.2019.102410.

Heinze, J. E., Stoddard, S. A., Aiyer, S., Eisman, A., & Zimmerman, M. A. (2017). Exposure to violence during adolescence as a predictor of perceived stress trajectories in emerging adulthood. *Journal of Applied Developmental Psychology, 49,* 31-38. https://doi:10.1016/j.appdev.2017.01.005.

Heise, L. (1998). Violence against women: An integrated, ecological framework. *Violence Against Women, 4*, 262-290. https://doi. 10.1177/1077801298004003002.

Heise, L. & Fulu, E. (2015). *What works to prevent violence against women and girls evidence reviews.* Paper (1) State of the field of violence against women and girls. https://www.whatworks.co.za/documents/publications/16-global-evidence-reviews- paper-1-state-of- the-field-of-research-on-violence-against-women-and-girls/file.

Henderson, L., Zerai, A., & Morrow, R. L. (2017). Intimate partner violence and HIV status among ever- married and cohabiting Zimbabwean women: an examination of partners' traits. *African journal of reproductive health*, *21*(4), 45-54.

Her Majesty Government. (2016a). *Multi-Agency Statutory Guidance on Female Genital Mutilation*.https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/512906/Multi_Agency_Statutory_Guidance_on_FGM-_FINAL.pdf.

Her Majesty Government. (2016b). Department of Home Affairs. *Ending Violence Against Women and Girls Strategy 2016-2020.* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/522166/VAWG_Strategy_FINAL_PUBLICATION_MASTER_vRB.PDF.

Hernlund, Y., & Shell-Duncan, B. (2007). Contingency, Context, and Change: Negotiating Female Genital Cutting in The Gambia and Senegal. *Africa Today*, *53*(4), 43–57. http://www.jstor.org/stable/4187809.

Hester, M. (2009). Who Does What to Whom? Gender and Domestic Violence Perpetrators. *European Journal of Criminology, 10*(5), http://doi.10.1177/1477370813479078.

Higgins, T.E., Fenrich, J., & Tanzer, Z. (2006). Gender Equality and Customary Marriage: Bargaining in the Shadow of Post-Apartheid Legal Pluralism. *Fordham International Law Journal, 30*(6), 1653- 1708. https://ir.lawnet.fordham.edu/ilj/vol30/iss6/1.

Hillman, E. (1975). *Polygamy Reconsidered, African Plural and the Christian Churches.* Maryknoll, New York: Orbis Books.

Hooks, B. (1984). *Feminist theory: From margin to center*. Cambridge, MA: Free Press.

Holloway, I. (2005). *Qualitative Research in Health Care*. London: McGraw-Hill Education.

Hopper, T. (2019). Stop accounting myopia: – Think globally: a polemic. *Journal of Accounting & Organizational Change, 15*(1), 87-99. https://doi.org/10.1108/JAOC-12-2017-0115.

Hoque, M. E., Hoque, M., & Kader, S. B. (2009). Prevalence and experience of domestic violence among rural pregnant women in KwaZulu-Natal, South Africa. *Southern African Journal of Epidemiology and Infection*, 24. http://www.sajei.co.za/index.php/SAJEI/article/view/106

Hosegood, V., McGrath, N., & Moultrie, T. (2009). Dispensing with marriage: Marital and partnership trends in rural KwaZulu-Natal, South Africa 2000- 2006. *Demographic research*, *20*, 279–312. https://doi.org/10.4054/DemRes.2009.20.13.

Hove, K. & Gwazane, M. (2011). A study to determine factors associated with domestic violence among concordant and discordant couples in Zimbabwe. *International Journal of Humanities and Social Science, 1*(7), 155-162. http://www.ijhssnet.com/journals/Vol._1_No._7_[Special_Issue_June_2011]/20.pdf

Howard, L., Trevillion, K., Khalifeh, H., Woodall, A., Agnew-Davies, R., & Feder, G. (2010). Domestic violence and severe psychiatric disorders: Prevalence and interventions. *Psychological Medicine, 40*, 881–893. https://doi.10.1017/s0033291709991589.

Howard, G., & White, Z. (2020). Does payment by results work? Lessons from a multi-country WASH programme. *Journal of Water, Sanitation and Hygiene for Development*, *10*(4), 716-723.

Human Sciences Research Council (2018). *Policy guidance: Improving access to gender-affirming healthcare for transgender women.* https://hsrc.ac.za/news/impact-engagement/policy-guidance-improving-access- to-gender-affirming-healthcare-for-transgender-women/.

Hunnicutt, G. (2009). Varieties of patriarchy and violence against women: Resurrecting "patriarchy" as a theoretical tool. *Violence Against Women, 15*, 553-573.

Hunter M. (2006). Cultural politics and masculinities: multiple-partners in historical perspective in KwaZulu-Natal. *Culture, health & sexuality*, *7*(3), 209–223. https://doi.org/10.1080/13691050412331293458.

Hurst, S. A. (2008). Vulnerability in research and health care; describing the elephant in the room? *Bioethics*, *22*(4), 191-202.

Hunnicutt, G. (2009). Varieties of patriarchy and violence against women: Resurrecting "patriarchy"as a theoretical tool. *Violence Against Women, 15*, 553-573. https://doi.10.1177/1077801208331246.

Hyginus, E., Chukwuemeka, I., Lawrence, I., & Sunday, M. (2012). HIV-related intimate partner violence among pregnant women in Nigeria. *East African*

journal of public health, *9*(1), 29–32. https://pubmed.ncbi.nlm.nih.gov/23120946/.

Idowu, E.B. (1996). *Olodumare: God in Yoruba Belief.* Lagos: Longman Nigeria Limited.

Ignatieff, M. (2001). *Human Rights as Politics and Idolatry*, Princeton, NJ: Princeton University Press.

International Labour Organization. (2019). *Spotlight Initiative launched in Zimbabwe to tackle gender based violence.* https://www.ilo.org/africa/countriescovered/zimbabwe/WCMS_712640/lang-- en/index.html.

International Labour Organisation. (2018). *Empowering Women Working in the Informal Economy.* ILO: Geneva.

International Monetary Fund. (2023). *IMF concludes staff visit to Zimbabwe*. https://www.imf.org/en/News/Articles/2023/10/25/pr23361-zimbabwe-imf-staff-concludes-staff-visit

International Monetary Fund. (2014). *Budget Institutions in G20 Countries*, IMF: Washington, DC.

Iphofen, R. (2005). Ethical issues in qualitative health research. In I. Holloway (Ed.), *QualitativeResearch in Health Care. (*pp. 17-2). McGraw-Hill Education: UK.

Intervention with Microfinance for AIDS and Gender Equity. (2020). *Health and Sexual and Reproductive Health and Rights* https://womendeliver.org/case-studies/intervention-microfinance-aids-gender- equality-image-study/.

Iwe, N. S. S. (1985). *Christianity, Culture and Colonialism in Africa*. Port Harcourt: COE.

Izugbara, C. O., Obiyan, M. O., Degfie, T. T. & Bhatti, A. (2020). Correlates of intimate partner violence among urban women in sub-Saharan Africa. *PLoS ONE 15*(3), https://doi.org/ 10.1371/journal.pone.0230508.

Jansen, D. F. (2002). *Growing up sexually in sub-Saharan Africa. World reference atlas*. (Interim Report). http://www2.rz.hu-berlin.de/sexology/GESUND/ARCHIV/GUS/AFRICAOLD.HTM

Jansen, N., & Agadjanian, V. (2020). Polygyny and Intimate Partner Violence in Mozambique.

Journal of Family Issues, 41(3), 338–358. https://doi.org/10.1177/0192513X19876075

Jaravaza, D.S. (2013). Traditional Contraceptives and Indigenous Knowledge Systems in Mutasa District of Manicaland Province, Zimbabwe. International *Journal of Academic Research in Progressive Education and Department, 2*(2), 29-35.

Jeannerat, C. F. (1997) Invoking the female *Vhusha* ceremony and the struggle for identity and security in Tshiendeulu, Venda. *Journal of Contemporary African Studies, 15*(1), 87-106, https://doi.10.1080/02589009708729604.

Jackson, L. (2002).‘ “When in the White Man’s Town”: Zimbabwean Women Remember Chibeura.’In J. Allman, S. Geiger & N. Musisi (eds). *Women in African Colonial Histories* Bloomington, Indiana University Press. pp. 191 – 215.

Jackson, C. (2012). Conjugality as social change: A Zimbabwean case. *Journal of Development Studies*, *48*(1), 41-54.

Jeffreys, S. (2005). *Beauty and misogyny: Harmful cultural practices in the West.* London, England: Routledge

Jewkes, R., Dunkle, K., Nduna, M., & Shai, N. (2010). Intimate partner violence, relationship gender power inequity, and incidence of HIV infection in young women in South Africa: a cohort study. *The Lancet, 367*, 41e48

Jewkes, R., Penn-Kekana, L., & Rose-Junius, H. (2005). “If they rape me, I can’t blame them”: reflections on the social context of child sexual abuse in South Africa and Namibia. *Social Science & Medicine, 61,* 1809e1820.

Jewkes, R., & Morrell, R. (2018). Hegemonic masculinity, violence, and gender equality: Using latent class analysis to investigate the origins and correlates of differences between men. *Men and masculinities*, *21*(4), 547-571.

Jewkes, R., Levin, J., & Penn-Kekana, L. (2002). Risk factors for domestic violence: findings from a South African cross-sectional study. *Social science & medicine*, *55*(9), 1603– 1617. https://doi.org/10.1016/s0277-9536(01)00294-5.

Jewkes, R. (2018). WHAT WORKS TO PREVENT VIOLENCE AGAINST WOMEN AND GIRLS: AN OVERVIEW. https://whatworks.co.za/documents/publications/175-what-works-

jewkes-15-feb-2018-final/file?cv=1.

Jewkes, R., & Morrell, R. (2010). Gender and sexuality: emerging perspectives from the heterosexual epidemic in South Africa and implications for HIV risk and prevention. *Journal of the International AIDS Society*, *13*, 6. https://doi.org/10.1186/1758-2652-13-6.

Jewkes, R. K., Dunkle, K., Nduna, M., & Shai, N. (2010). Intimate partner violence, relationshippower inequity, and incidence of HIV infection in young women in South Africa: a cohort study. *Lancet (London, England)*, *376*(9734), 41–48. https://doi.org/10.1016/S0140-6736(10)60548-X.

Jewkes R, Sikweyiya Y, Morrell R, Dunkle K. (2011) Gender inequitable masculinity and sexual entitlement in rape perpetration South Africa: Findings of a cross-sectional study. *PLoS One; 6*(12), https://doi.org/10.1371/journal.pone.0029590.

Jewkes R. (2002). Intimate partner violence: causes and prevention. *Lancet*, *359*(9315), 1423–1429. https://doi.org/10.1016/S0140-6736(02)08357-5.

Jewkes, R., Morrell, R., Hearn, J., Lundqvist, E., Blackbeard, D., Lindegger, G., Quayle, M., Sikweyiya, Y., & Gottzén, L. (2015). Hegemonic masculinity: combining theory and practice in gender interventions. *Culture, Health & Sexuality, 17*(2), 112-127, http://doi.10.1080/13691058.2015.1085094.

Jewkes, R., A. Gibbs, N. Jama-Shai, S. Willan, A. Misselhorn, M. Mushinga, L. Washington, N. Mbatha, & Y. Sikweyiya. (2014). "Stepping Stones and Creating Futures Intervention: Shortened Interrupted Time Series Evaluation of a Behavioural and Structural Health Promotion and Violence Prevention Intervention for Young People in Informal Settlements in Durban, South Africa*." BMC Public Health 14,* 1325. http://doi.10.1186/1471- 2458-14-1325.

Jewkes, R., Fulu, E., Roselli, T., Garcia-Moreno, C., & UN Multi-country Cross-sectional Study on Men and Violence research team (2013). Prevalence of and factors associated with non-partner rape perpetration: findings from the UN Multi-country Cross- sectional Study on Men and Violence in Asia

and the Pacific. *The Lancet. Global health*, *1*(4), e208–e218. https://doi.org/10.1016/S2214-109X(13)70069-X.

Jewkes, R., Flood, M., & Lang, J. (2015). From work with men and boys to changes of social norms and reduction of inequities in gender relations: a conceptual shift in prevention of violence against women and girls. *Lancet (London, England)*, *385*(9977), 1580–1589. https://doi.org/10.1016/S0140-6736(14)61683- 4.

Jewkes, R., Dunkle, K., Nduna, M., Levin, J., Jama-Shai, N., Khuzwayo, N., Puren, A., & Duvvury, N. (2007). Factors associated with HIV sero-status in young rural South African women: Connections between intimate partner violence and HIV. *International journal of epidemiology, 35*, 1461-8. https://doi.10.1093/ije/dyl218.

Jewkes, R., Sikweyiya, Y., Morrell, R. & Dunkle, K. (2009*). Understanding men's health and use of violence: interface of rape and HIV in South Africa.* (Technical report). Pretoria: Medical Research Council. Retrieved: http://www.mrc.ac.za/gender/interfaceofrape&hivsarpt.pdf.

Jhamb, B., Mishra, Y., & Sinha, N. (2013). The paradox of gender responsive budgeting. *Economic and Political Weekly, 48*(20), 35-38. https://www.jstor.org/stable/23527366.

Jobson, G., Khoza, S., Mbeng, R., Befula, N., Struthers, H. E., Kerongo, G., & Peters, R. P. H. (2019). Bridging the Gap: Reaching Men for HIV Testing Through Religious Congregations in South Africa. *Journal of acquired immune deficiency syndromes (1999)*, *81*(5), e160–e162. https://doi.org/10.1097/QAI.0000000000002078.

Johnson, M. C. (2000). Becoming a Muslim, Becoming a Person: Female" Circumcision," Religious Identity, and Personhood in Guinea Bissau. In B. Shell- Duncan, & Hernlund, Y. (Eds). *Female "Circumcision" in Africa. Culture, Controversy, and Change*. pp. 215-234. Boulder: Lynne Riener Publishers Inc.

Johnson, S. D., Cunningham-Williams, R. M., & Cottler, L. B. (2003). A tripartite of

HIV-risk for African American women: the intersection of drug use, violence, and depression. *Drug and alcohol dependence*, *70*(2), 169–175. https://doi.org/10.1016/s0376-8716(02)00345-9.

Johnson, L. F., Dorrington, R. E., & Moolla, H. (2017). Progress towards the 2020 targets for HIV diagnosis and antiretroviral treatment in South Africa. *South African Journal of HIV Medicine,18*(1), 694. https://doi.org/10.4102/sajhivmed.v18i1.694.

Jones, H., Wringe, A., Todd, J., Songo, J., Gómez-Olivé, F.X., Moshabela, M., Geubbels, E., Nyamhagatta, M., Kalua, T., Urassa, M., Zabaa, B., & Renju, J. (2019). Implementing prevention policies for mother-to-child transmission of HIV in rural Malawi, South Africa and United Republic of Tanzania, 2013–2016. *Bulletin of the World Health Organisation, 97*(3), 200–212 http://dx.doi.org/10.2471/BLT.18.217471.

Justice for Children. (2019). *AGE OF CONSENT, SEXUAL INTERCOURSE WITH YOUNG PERSONS AND ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH CARE IN ZIMBABWE*. https://kubatana.net/wp-content/uploads/2019/07/Age-of-Consent-Sexual- Intercourse-with-Young-Persons-and-Access-to-Sexual-and-Reproductive-Health- Care-in-Zimbabwe.pdf

Kabeer, N. (1994). *Reversed Realities: Gender Hierarchies in Development Thought*. London and New York: Verso.

Kabeer, N. (1999). Resources, agency, achievements: reflections on the measurement of women's empowerment, *Development and Change*, 30, 435–64. doi: 10.1111/1467-7660.00125

Kalipeni, E. (2008). *HIV/AIDS in women: stigma and gender empowerment in Africa.*

Kalir, B., & Sur, M. (Eds.). (2013). *Transnational flows and permissive polities: Ethnographies of human mobilities in Asia*. Amsterdam: IIAS Publications.

Kambarami, M. (2006). *Femininity, sexuality and culture: Patriarchy and female subordination in Zimbabwe.* South Africa: ARSRC.

Kanyenze, G., Chitambara, P., & Tyson, J. (2017). *The outlook for the Zimbabwean*

economy. Supporting Economic Transformation, London.

Karanda, C., & Toledano, N. (2018). Foreign aid versus support to social entrepreneurs: Reviewing the way of fighting poverty in Zimbabwe. *Development Southern Africa*, *35*(4), 480-496.

Karekwaivanane, G. H. (2017). *The struggle over state power in Zimbabwe: law and politics since 1950. Laying Down the Law: A Historical Background, 1890–1950*. Cambridge: Cambridge University Press.

Kargar J. M., Jamali, S., Rahmanian, K, A., & Javadpour, S. (2015). Prevalence and Risk Factors of Domestic Violence Against Women by Their Husbands in Iran. *Global Journal of health science*, *8*(5), 175–183. https://doi.org/10.5539/gjhs.v8n5p175.

Katikiro, E., & Njau, B. (2012). Motivating Factors and Psychosocial Barriers to Condom Use among out-of-School Youths in Dar es Salaam, Tanzania: A Cross Sectional Survey Using the Health Belief Model. *ISRN AIDS*. https://doi.org/10.5402/2012/170739.

Katz, J. (2006). *The macho paradox: Why Some Men Hurt Women and How All Men Can Help*. Naperville: Illinois.

Kaufman, M. R., Shefer, T., Crawford, M., Simbayi, L. C., & Kalichman, S. C. (2008). Gender attitudes, sexual power, HIV risk: a model for understanding HIV risk behavior of South African men. *AIDS care*, *20*(4), 434-441.

Kayibanda, J. F., Bitera, R., & Alary, M. (2012). Violence toward women, men's sexual risk factors, and HIV infection among women: findings from a national household survey in Rwanda. *Journal of acquired immune deficiency syndromes*, *59*(3), 300–307. https://doi.org/10.1097/QAI.0b013e31823dc634.

Kelle, U. (2006). Combining qualitative and quantitative methods in research practice: purposes and advantages. *Qualitative research in psychology*, *3*(4), 293-311.

Kelly, L. (1988). *Surviving Sexual Violence*. A Feminist Perspective. Polity Press: Oxford.

Kerr-Wilson, A., Gibbs, A., McAslan, F. E., Ramsoomar, L., Parke, A., Khuwaja, H. M. A., & Jewkes, R. (2020). *A rigorous global evidence review of interventions to prevent violence against women and girls*. What Works to Prevent

Violence Against Women and Girls Global Programme. Pretoria: South Africa.

Keyl, S. (2017). Subaltern pedagogy: a critical theorizing of pedagogical practices for marginalized border- crossers. *The International Journal of Critical Pedagogy*, *8*(1), 173.

Kim, J. C., & Watts, C. H. (2005). "Gaining a Foothold: Tackling Poverty, Gender Inequality, and HIV in Africa." *BMJ, 331*,769–72. https://doi:10.1136/bmj.331.7519.769.

Kiragu, K., Collins, L., Von Zinkernagel, D., & Mushavi, A. (2017). Integrating PMTCT into maternal, newborn, and child health and related services: experiences from the global plan priority countries. *Journal of Acquired Immune Deficiency Syndrome, 75*(1), 36–42.

Kirwan, M., Parkhill, M. R., Schuetz, B. A., & Cox, A. (2019). Within-subjects analysis of men's alcohol- involved and nonalcohol-involved sexual assaults. *Journal of Interpersonal Violence, 34,* 3392–3413. https://doi.org/10. 1177/0886260516670179 PMID: 27662889.

Kitzinger, J. (1995). Qualitative research: introducing focus groups. *Bmj*, *311*(7000), 299-302.

Knettel, B. A., Cichowitz, C., Ngocho, J. S., Knippler, E. T., Chumba, L. N., Mmbaga, B. T., & Watt, M. H. (2018). Retention in HIV care during pregnancy and the postpartum period in the Option B+ era: a systematic review and meta-analysis of studies in Africa. *Journal of acquired immune deficiency syndromes (1999)*, *77*(5), 427.

Koster, W., Bruinderink, M. G., & Janssens, W. (2015). Empowering Women or Pleasing Men? Analyzing Male Views on Female Condom Use In Zimbabwe, Nigeria and Cameroon. *International Perspectives on Sexual and Reproductive Health*, *41*(3), 126–135. https://doi.org/10.1363/4112615

Koster, M. & Price, L.L. (2008). Rwandan female genital modification: Elongation of the Labia minora and the use of local botanical species. *Culture, health & sexuality, 10*, 191-204. https://doi.10.1080/13691050701775076.

Kouyoumdjian, F., Findlay, N., Schwandt, M., & Calzavara, L.M. (2013). Systematic review of the relationships between intimate partner violence and

HIV/AIDS. *PLoS One, 8*(11), 81044. https://doi.10.1371/journal.pone.0081044.

Kristeva, J. (1986). *About Chinese Women*. Trans. Anita Barrows. New York: Marion Boyars. Kundapur, R., Shetty, S. M., Kempaller, V. J., Kumar, A., & Anurupa, M. (2017). Violence against Educated Women by Intimate Partners in Urban Karnataka, India. *Indian journal of community medicine: official publication of Indian Association of Preventive & Social Medicine*, *42*(3), 147–150. https://doi.org/10.4103/ijcm.IJCM_41_16.

Kumi, E., Yeboah, T., Afadzinu, N., Hodgson, J., Emerhi, E., Vandyck, C., & Fomunjong, J. C. (2021). *Localisation Agenda, Shift the Power and African Philanthropic Models in Burkina Faso, Ghana, Nigeria and Senegal*. West Africa Civil Society Institute (WACSI).

Kunhiyop, S. W. (2008). *African Christian Ethics*. Kenya: Hippo Books.

Lagdon, S., Armour, C., & Stringer, M. (2014). Adult experience of mental health outcomes as a result of intimate partner violence victimisation: A systematic review. *European Journal of Psychotraumatology, 5*, 24794–24806. https://doi.10.3402/ejpt.v5.24794.

Langton, R. (2009). Sexual solipsism: Philosophical essays on pornography and objectification. Oxford, England: Oxford University Press. doi:10.1093/acprof:oso/9780199247066.001.0001

Lasong, J., Zhang, Y., Muyayalo, K. P., Njiri, O.A., Gebremedhin, S. A., Abaidoo, C. S., Liu, C. Y., Zhang, H., & Zhao, K. (2020). Domestic violence among married women of reproductive age in Zimbabwe: a cross sectional study. *BMC Public Health, 20*(354). https://doi.org/10.1186/s12889-020-8447-9.

Leclerc-Madlala, S. (2004). Transactional sex and the pursuit of modernity. *Social Dynamics, 29*, 1e21.

Leclerc-Madlala, S. (2008). Age-disparate and intergenerational sex in Southern Africa: *The dynamics of Hyper-vulnerability. Aids, 22,* S17–S25.

Lerner, G. (1986). *The creation of patriarchy*. New York: Oxford University Press.

Letamo, G. (2011). Does correct knowledge about HIV and AIDS lead to safer sexual behaviour? The case of young people in Botswana. *African Population*

Studies, 25(1), 44-62. http://dx.doi.org/10.11564/25-1-266.

Levinson, D. (1989). *Family violence in cross-cultural perspective*. Newbury Park: Sage

Lincoln, Y. S. & Guba, E.G. (1985). *Naturalistic inquiry*. Beverly Hills, CA: Sage.

Lipsky, S. & Caetano, R. (2007). Impact of intimate partner violence on unmet need for mental health care: Results from the NSDUH. *Psychiatric Services, 58,* 822–829. https://doi.10.1176/ps.2007.58.6.822

Little, K. (1973). *African Women in Towns: An Aspect of Africa's Social Revolution*. London: Cambridge University Press.

Li, Y., Marshall, C. M., Rees, H. C., Nunez, A., Ezeanolue, E. E., & Ehiri, J. E. (2014). Intimate partner violence and HIV infection among women: a systematic review and meta- analysis. *Journal of the International AIDS Society*, *17*(1), 18845. https://doi.org/10.7448/IAS.17.1.18845.

Lofland, J.& Lofland, L. H. (2006). *Analyzing social settings*. Belmont, CA: Wadsworth *Publishing Company*.

Lorber, J. (2000). Using Gender to Undo Gender: A Feminist Degendering Movement. *Feminist Theory, 1*(1), 79–95. https://doi.org/10.1177/14647000022229074.

Lugones, M. (2016). The Coloniality of Gender. In W. Harcourt. (Ed.). *The Palgrave Handbook of Gender and Development.* London: Palgrave Macmillan. https://doi. 10.1007/978-1-137-38273-3_2.

Mabuwa, C. (1993). *The Komba ritual of the VaRemba Tribe of Mberengwa.* Bachelors Dissertation, University of Zimbabwe. Dissertations@UoZ.

Machingura, F. (2011). A Diet of Wives as the Lifestyle of the VaPostori Sects: The Polygamy Debate in the Face of HIV and AIDS in Zimbabwe. *Africana 5,* (2) pp 185-210. http://africanajournal.org/wp-content/uploads/A-Diet-of-Wives-as-the-Lifestyle-of-the- Vapostori-Sects-The-Polygamy-Debate-in-the-Face-of-HIV-and-AIDS-in-Zimbabwe- AFRICANA-Vol5-No2.pdf

Machingura, F., & Nyakuhwa, P. (2015). Sexism: A hermetical interrogation of Galatians 3: 28 and women in the Church of Christ in Zimbabwe. *Journal of Pan African Studies*, *8*(2), 92-113. http://www.jpanafrican.org/docs/vol8no2/8.2-7-Machingura-

Nyakuhwa.pdf.

Machingura, F. (2014). The martyring of people over radical beliefs. *Multiplying in the spirit*, *175*.

Machisa, M. T., Christofides, N., & Jewkes, R. (2017) Mental ill health in structural pathways to women's experiences of intimate partner violence. *PLoS ONE 12*(4): e0175240. https://doi.org/ 10.1371/journal.pone.0175240.

Mackie, G. (1996). Ending Footbinding and Infibulation: A Convention Account. *American Sociological Review*, *61*(6), 999–1017. https://doi.org/10.2307/2096305.

Mackie G. (2000). Female genital cutting: the beginning of the end. In: B. Shell-Duncan. & Y. Hernlund. (Eds). *Female "circumcision" in Africa: Culture, controversy, and change.* pp. 253-283. Boulder: Lynne Rienner.

Mackie, G. and Lejeune, J. (2009). Social dynamics of abandonment of harmful practices: a new look at the theory. In UNICEF (Ed.) *Special Series on Social Norms and Harmful Practices*. Florence: Innocenti Research Centre.

Mackie, G., Moneti, F., Shakya, H. & Denny, E. (2015). *What are Social Norms? How are They Measured?* New York: UNICEF and UCSD.

MacKinnon, C. A. (1987). *Feminism unmodified: Discourses on life and law*. Cambridge, MA: Harvard University Press.

MacPhail C. (2003). Challenging dominant norms of masculinity for HIV prevention. *African journal of AIDS research*, *2*(2), 141–149. https://doi.org/10.2989/16085906.2003.9626568.

Magezi, V. (2007). *HIV/AIDS, Poverty, and Pastoral Care and Counselling: A Homebased and Congregational Systems Ministerial Approach in Africa*. Harare: African Sun Media.

Magezi, V. & Manzanga, P. (2020). 'COVID-19 and intimate partner violence in Zimbabwe: Towards being church in situations of gender-based violence

from a public pastoral care perspective.' *In die Skriflig, 54*(1), 1–9. https://doi.org/0.4102/ids.v54i1.2658.

Mahadevia, D., Bhatia, N., & Sebastian, R. (2019). Gender Responsive Budgeting for Indian Cities: The Case of Bhopal and Pune. *Environment and Urbanization ASIA, 10*(1), 44–62. https://doi.org/10.1177/0975425318821806.

Maharaj, P. (2005). Patterns of condom use: perspectives of men in KwaZulu-Natal, South Africa. *Development Southern Africa*, *22*(2), 187-197.

Maharaj, P., & Cleland, J. (2004). Condom use within marital and cohabiting partnerships in KwaZulu-Natal, South Africa. *Studies in family planning*, *35*(2), 116-124.

Mahuntse, S. L. (2021). *A social work programme on the contribution of Indigenous Knowledge Systems (IKS) to child protection: A Tsonga case study*. Doctoral thesis. University of Pretoria, South Africa.

Makaudze, G. (2015). Sex and the female body in Shona society. *Journal of Pan African Studies, 7*(8), 140 - 152.https://www.academia.edu/64794210/Sex_and_the_Female_Body_in_Shona_Society.

Makahamadze, T., Isacco, A. & Chireshe, E. (2012). "Examining the perceptions of Zimbabwean women about the Domestic Violence Act." *Journal of interpersonal violence, 27,4*, 706-727. https://doi.org/10.1177/0886260511423239.

Malisha, L., Maharaj, P., & Rogan, M. (2008). Rites of passage to adulthood: traditional initiation schools in the context of HIV/AIDS in the Limpopo Province, South Africa. *Health, Risk & Society, 10*(6), 585-598. http://doi.10.1080/13698570802533713.

Mama, A. A. (1996). *Women Studies and Studies of Women in Africa during the 1990s* (Council for the Development of Economic and Social Research in Africa. Working Paper, Series 5/96. Dakar: CODESRIA.

Mannell, J. (2012). 'It's just been such a horrible experience.' Perceptions of

gender mainstreaming by practitioners in South African organisations. *Gender & Development, 20*(3), 423-434. DOI: 10.1080/13552074.2012.731753.

Mann, J. M. & Kay, K. (1991). "Confronting the Pandemic: The World Health Organization's Global Programme on AIDS" (1986-1989). *AIDS,5* (2), 221-229. https://genomics.ucsc.edu/publications/.

Mangundu, M., Roets, L., & ES, J. V. R. (2023). The Economic Crisis (2008-2019) and Health Care in Zimbabwe: A Structured Literature Review. *The Open Public Health Journal*, *16*(1).

Manjokoto, C., & Ranga, D. (2018). Opportunities and challenges faced by women involved in informal cross-border trade in the city of Mutare during a prolonged economic crisis in Zimbabwe. *Women's Economic Empowerment in the Indian Ocean Region*, 25-39.

Manyonganise, M. (2015). Women in Zimbabwe's War of 'Liberation': An Ethical Appraisal of the Sexual Conduct of Male Guerrillas. *Philosophy in African Traditions and Cultures*, 117.

Manyonganise, M. (2023). Daring Patriarchy? A Biblical Engagement with Gender Discourses on Political Participation in Post-colonial Zimbabwe. *Bible in Africa Studies*.

Mapuranga, T. P. (2013). Bargaining with Patriarchy?: Women Pentecostal Leaders in Zimbabwe. *Fieldwork in Religion*, *8*(1), 74-91.

March, C., Smyth, I. & Mukhopadhyay, M. (Eds.). (1999). *A Guide to Gender-Analysis Frameworks*. Oxford: Oxfam.

Markstrom, C. A. (2008). *Empowerment of North American Indian girls: Ritual expressions at puberty*. University of Nebraska Press.

Maseko, S. & Ndlovo, L. (2012). *Condoms as evidence: police, sex workers and condom confiscation in Zimbabwe*. Presentation at the 19th International AIDS Conference. Washington: DC. https://accelerator.prepwatch.org/female-sex-workers-profile/

Mashiri, L. (2013). *Conceptualisation of gender- based violence in Zimbabwe.*

Mason, J. (2017). *Qualitative researching*. (3rd ed.). Sage: London.

Masters, N. T., Casey, E., Wells, E. A., & Morrison, D. M. (2013). Sexual scripts among young

heterosexually active men and women: Continuity and change. *Journal of sex research*, *50*(5), 409-420

Mathews, S., Jewkes, R., & Abrahams, N. (2011). 'I had a hard life': Exploring childhood adversity in the shaping of masculinities among men who killed an intimate partner in South Africa. *The British Journal of Criminology, 51*(6), 960-977. https://doi.org/10.1093/bjc/azr051.

Matshidze, P. E. (2013). *The role of Makhadzi in traditional leadership among the Venda*. Doctoral dissertation, University of Zululand.

Matswetu, V. S., & Bhana, D. (2018). Humhandara and hujaya: Virginity, Culture, and Gender Inequalities Among Adolescents in Zimbabwe. *SAGE Open, 8*(2). https://doi.org/10.1177/2158244018779107.

Mawere, M., & Mawere, A. (2010). The changing philosophy of African marriage: The relevance of the Shona customary marriage practice of Kukumbira. *Journal of African Studies and Development, 2*(9), 224-233. http://www.academicjournlas.org/JASD.

Mawodza, O. (2019). The impact of the customary practice of chiramu (sexual dalliance) on the rights of girls in Zimbabwe. *International Journal of Sustainable Development, 12*(3), 19- 26.

Mayeza, E. (2015). Exclusionary violence and bullying in the playground: football and gender'policing'at school. *African safety promotion*, *13*(1), 49-70.

Mazanderani, F., & Paparini, S. (2015). The stories we tell: Qualitative research interviews, talking technologies and the 'normalisation'of life with HIV. *Social Science & Medicine*, *131*, 66- 73. https://doi.org/10.1016/j.socscimed.2015.02.041.

Mbiba, B. (2012). Zimbabwean Diaspora Politics in Britain: insights from the Cathedral Moment 2009. *Commonwealth & Comparative Politics, 50*(2), 226-252. http://doi.10.1080/14662043.2012.671606.

Mbiti, J. S. (1975). I*ntroduction to African Religion, Ibadan-Nairobi Lusaka*: Heinemann Education Books Ltd.

McCall, L. (2005). The Complexity of Intersectionality. *Signs*, *30*(3), 1771-

1800.https://doi.org/10.1086/426800.

McCulloch, J. (2000). *Black Peril, White Virtue: Sexual Crime in Southern Rhodesia.* Bloomington: Indiana University Press.

McGrath, J.W., Winchester, M.S., Kaawa-Mafigiri, D., Walakira, E., Namutiibwa, F., Birungi, J., Ssendegye, G., Nalwoga, A., Kyarikunda, E., Kisakye, S., Ayebazibwe N. & Rwabukwali, C. B. (2014) Challenging the Paradigm: Anthropological Perspectives on HIV as a Chronic Disease, *Medical Anthropology,* 33(4) 303-317, DOI: 10.1080/01459740.2014.892483

McGregor, A. (2009). New possibilities? Shifts in post-development theory and practice. *Geography Compass*, *3*(5), 1688-1702. https://doi.org/10.1111/j.1749- 8198.2009.00260.x.

McNeill, F.G. (2011). *AIDS, Politics, and Music in South Africa*. Cambridge: Cambridge University Press.

Mdhluli, T. D. & Kugara, S. L. (2017). Probing virginity testing on girl child: The case of KwaZulu-Natal, South Africa. *Gender and Behaviour, 15*(2): 9250-9259.

Meekers, D. (1993). The noble custom of roora: the marriage practices of the Shona of Zimbabwe. *Ethnology*, *32*(1), 35-54.

Miles, K. (2011). Embedding gender in sustainability reports. *Sustainability Accounting, Management and Policy Journal, 2*(1), 139-146. https://doi.org/10.1108/20408021111162164.

Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded sourcebook* (2nd ed.). Thousand Oaks, CA: Sage.

Mill, J. E., & Anarfi, J. K. (2002). HIV risk environment for Ghanaian women: challenges to prevention. *Social Science & Medicine*, *54*(3), 325-337.

Ministry of Health and Child Care Zimbabwe. (2019). *Zimbabwe Population-based HIV Impact Assessment (ZIMPHIA)* 2015-2016. (Final Report). Harare: MOHCC; August 2019. https://phia.icap.columbia.edu/wp-content/uploads/2019/08/ZIMPHIA-Final- Report_integrated_Web-1.pdf.

Ministry of Health and Child Care Zimbabwe. (2019). '*Comprehensive Sexuality Education for Out of School Young People in Zimbabwe.* https://www.nac.org.zw/wp- content/uploads/2021/05/Comprehensive-Sexuality-Education-Facilitators- Manual.pdf.

Ministry of Health and Child Care Zimbabwe. (2016). *Operational and Service Delivery Manual. For the Prevention, Care, and Treatment of HIV in Zimbabwe*. https://www.ophid.org/treat- all-toolkit/MOHCC%20Guidelines/MOHCC%20Zimbabwe%20OSDM%202017.pdf.

Ministry of Health Zimbabwe. (2017). *Comprehensive Sexuality Education (CSE) and Life Skills. Zimbabwe's Experiences.* https://www.malecircumcision.org/resource/comprehensive- sexuality-education-cse-and-life-skills-zimbabwe%E2%80%99s-experiences.

Ministry of Health and Child Care Zimbabwe. (2020). *AIDS and TB.* http://www.mohcc.gov.zw/index.php?option=com_content&view=article&id=148 &Itemid=669.

Mkwanazi, N. B., Rochat, T. J., & Bland, R. M. (2015). Living with HIV, disclosure patterns and partnerships a decade after the introduction of HIV programmes in rural South Africa. *AIDS care*, *27*(1), 65-72.

Mogstad, H., Dryding, D., & Fiorotto, Ol. (2016). Policing the private: Social barriers to the effective policing of domestic violence. *South African Crime Quarterly*. https://doi.10.17159/2413-3108/2016/v0n56a414.

Mohamadian, F., Hashemian, A., Bagheri, M., & Direkvand-Moghadam, A. (2016). Prevalence and Risk Factors of Domestic Violence against Iranian Women: A Cross-Sectional Study. *Korean journal of family medicine*, *37*(4), 253–258. https://doi.org/10.4082/kjfm.2016.37.4.253.

Mohanty, C. (1988). Under Western Eyes: Feminist Scholarship and Colonial Discourses. *Feminist Review, 30*(1), 61–88. https://doi.org/10.1057/fr.1988.42

Moodie, D., Ndatshe, V., & Sibuyi, B. (1994). *Going for gold: men, mines and migration*. Berkeley: University of California Press.

Moore, M. (2013). *Chinese Brides for Gold: Parents are Lavishing Bigger and Bigger Dowries on their Daughters.* The Daily Telegraph. https://www.telegraph.co.uk/news/worldnews/asia/china/9780786/Chinas-brides-go-for- gold-as-their-dowries-get-better-and-bigger.html.

Mojab, S. (Ed.). (2015). *Marxism and feminism*. Bloomsbury Publishing.

Mollen, S., Rimal, R. N., & Lapinski, M. K. (2010). What is normative in health communication research on norms? A review and recommendations for future scholarship. *Health communication*, *25*(6-7), 544–547. https://doi.org/10.1080/10410236.2010.496704.

Montgomery, E. T., Chidanyika, A., Chipato, T., & van der Straten, A. (2012). Sharing the trousers: gender roles and relationships in an HIV-prevention trial in Zimbabwe. *Culture, health & sexuality*, *14*(7), 795–810. https://doi.org/10.1080/13691058.2012.697191

Montle, M. E. (2021). Appraising the Motion for Polyandry In The South African Context Through The Selected Episodes of Generations the Legacy. *e-BANGI*, *18*(7), 14-24.

Moraga, C, & Anzaldua, G. E. (2015). *This bridge called my Back*. (5th ed). Albany: State University of New York Press.

Morrell, R., Jewkes, R., & Lindegger, G. (2012). Hegemonic Masculinity/Masculinities in South Africa: Culture, Power, and Gender Politics. *Men and Masculinities, 15*(1), 11–30. https://doi.org/10.1177/1097184X12438001.

Morrell, R. (1998). Of boys and men: masculinity and gender in Southern African studies. *Journal of Southern African Studies, 24*(4), 605-630. http://doi. 10.1080/03057079808708593.

Morrell R. (2001) *From Boys to Gentlemen: Settler Masculinity in Colonial Natal*. 1880– 920. Pretoria: UNISA Press.

Morris, M. W., Hong, Y.-y., Chiu, C.-y., & Liu, Z. (2015). Normology: Integrating insights about social norms to understand cultural dynamics. *Organizational Behaviour and Human Decision Processes, 129,* 1–13.

https://doi.org/10.1016/j.obhdp.2015.03.001.

Morokoff, P. J., Redding, C. A., Harlow, L. L., Cho, S., Rossi, J. S., Meier, K. S., & Brown-Peterside, P. (2009). Associations of sexual victimization, depression, and sexual assertiveness with unprotected sex: A test of the multifaceted model of HIV risk across gender. *Journal of Applied Biobehavioral Research*, *14*(1), 30-54. http://doi: 10.1111/j.1751-9861.2009.00039.x

Morse, J. M., Barrett, M., Mayan, M., Olson, K., & Spiers, J. (2002). Verification strategies for establishing reliability and validity in qualitative research. *International journal of qualitative methods*, *1*(2), 13-22.

Morse, J. M., & Niehaus, L. (2009). *Mixed method design: Principles and procedures*. Walnut Creek, CA: Left Coast Press.

Mosavel, M., Ahmed, R., & Simon, C. (2012). Perceptions of gender-based violence among South African youth: Implications for health promotion interventions. *Health Promotion International, 27,* 323-330. https://doi.10.1093/heapro/dar041.

Moser, S. (2008.) Personality: a new positionality? *Area*, 40(*3*), 383–92.

Motsa, N. & Morojele, P. (2019). Vulnerable masculinities: Implications of gender socialisation in three rural Swazi primary schools. *South African Journal of Childhood Education, 9,* http://doi.10.4102/sajce.v9i1.580.

Moyer, E. & Hardon, A. (2014) A Disease Unlike Any Other? Why HIV Remains Exceptional in the Age of Treatment. *Medical Anthropology*, 33(4), 263-269. DOI: 10.1080/01459740.2014.890618

Moyo, S., & Rusinga, O. (2017). Contraceptives: adolescents' knowledge, attitudes and practices. A case study of rural Mhondoro-Ngezi district, Zimbabwe. *African journal of reproductive health*, *21*(1), 49-63.

Moyo, I. (2016). The Beitbridge–Mussina interface: Towards flexible citizenship, sovereignty and territoriality at the border. *Journal of Borderlands Studies*, *31*(4), 427-440.

Moyo, D. (2009). *Dead aid: Why aid is not working and how there is a better way for Africa*. Macmillan.

Moyo, L., & Tsakata Mafuso, L. (2017). The effectiveness of foreign aid on economic

development in developing countries: A case of Zimbabwe (1980-2000). *Journal of Social Sciences*, *52*(1-3), 173- 187.

Mubaiwa, O. (2020). *The Dynamics of Bride Price in Zimbabwe and the UK Diaspora*. Malaga: Vernon Press.

Muchabaiwa, L. & Mbonigaba, J. (2019). Impact of the adolescent and youth sexual and reproductive health strategy on service utilisation and health outcomes in Zimbabwe. *PLoS ONE, 14*(6), 1-19. https://doi.org/10.1371/journal.pone.0218588.

Mueller, V., Jouriles, E. N., McDonald, R., & Rosenfield, D. (2013). Adolescent beliefs about the acceptability of dating violence: Does violent behaviour change them? *Journal of Interpersonal Violence, 28*, 436-450. http://doi:10.1177/0886260512454716.

Mugweni, E., Pearson, S. & Omar, M. (2012). Traditional gender roles, forced sex and HIV in Zimbabwean marriages. *Culture, Health & Sexuality, 14*(5), 577-590. http://doi.10.1080/13691058.2012.671962

Mugweni, E., Omar, M., & Pearson, S. (2015). Understanding barriers to safer sex practice in Zimbabwean marriages: implications for future HIV prevention interventions. *Health education research*, *30*(3), 388–399. https://doi.org/10.1093/her/cyu073.

Mukoni, M. (2015). Traditional gender roles of men and women in natural resource conservation among the Vhavenda people in Zimbabwe: implications for sustainable development. *International Journal of Humanities and Social Science*, *5*(4), 1.

Mukonyora, I. (2007). *Wandering a Gendered Wilderness: Suffering & Healing in an African Initiated Church*. Bern: Peter Lang.

Murry, C. (1981). *Families divided: the impact of migrant labour in Lesotho.* Cambridge: Cambridge University Press.

Museka, G., & Machingura, F. (2014). Interaction of the Old Testament with the Shona traditions on children. In L. Togarasei & J. Kugler (Eds.), *The Bible and children in Africa* (pp. 127- 141). Bamberg: University of Bamberg Press.

Musisi, N. (2002). The Politics of Perception or Perception as Politics? In J. M.

Allman, S Geiger, & N. Musisi. (Eds.). *Women in African Colonial Histories*, 95-115. Bloomington: Indiana University Press.

Mutanda, D. & Rukondo, H. (2016). The impact of FGM on Shangani women in Zimbabwe. *International Journal of Human Rights in Healthcare, 9(*1), 52-61. https://doi.10.1108/IJHRH-05-2015-0013.

Mutunami, P., & Bradley, T. (2022). Labia elongation and the experiences of Zimbabwean women in the UK. *Journal of Gender-Based Violence*, 1-17. https://bristoluniversitypressdigital.com/view/journals/jgbv/aop/article-10.1332- 239868021X16510596244963/article-10.1332-239868021X16510596244963.xml.

Mutekwe, E., & Mutekwe, C. (2012). Manifestations of the gender ideology in the Zimbabwean school curriculum. *Journal of educational and instructional studies in the world*, *2*(3), 193-209.

Mutema, F. (2013). Breaking the silence: Communication between parents and secondary school adolescents in the context of HIV/AIDs in Zimbabwe: A Case of Mkoba high density suburb, Gweru. *Journal of Emerging Trends in Educational Research and Policy Studies*, *4*(4), 604-612.

Muthengi, J. K. (1995). "Polygamy and the Church in Africa: Biblical, Historical, and Practical Perspectives," *Africa Journal of Evangelical Theology.* https://www.africabib.org/rec.php?RID=Q00020564

Mutseta, A. (2016). The 'Small House' Phenomenon in Zimbabwe's Urban Space: Study in Glen Norah- Harare. *Open Science Journal.* https://doi.org/10.23954/osj.v1i2.484

Muzulu, P. (2014). "Zimbabwe needs Comprehensive Sexuality Education", Newsday (6 February 2014) http://www.newsday.co.zw/2014/02/06/

Mwambene, L. (2017). What is the future of polygyny (polygamy) in Africa? *Potchefstroom Electronic Law Journal/Potchefstroomse Elektroniese Regsblad*, *20*(1). http://dx.doi.org/10.17159/1727- 3781/2017/v20i0a1357

Mwenda, K. K. (2006) Labia elongation under African customary law: A violation of women's rights? *International Journal of Human Rights, 10*(4), 341–357.

http://doi.10.1080/13642980600976369.

Nabaitu, J., Bachengana, C., & Seeley, J. (1994). Marital instability in a rural population in south-west Uganda: implications for the spread of HIV-1 infection. *African Journal of the International Institute of African Languages and Cultures*, *64*(2), 243–251. https://doi.10.2307/1160982.

Nadar, S., & Potgieter, C. (2010). Liberated through Submission?: The Worthy Woman's Conference as a Case Study of Feminism. *Journal of Feminist Studies in Religion*, *26*(2), 141–151. https://doi.org/10.2979/fsr.2010.26.2.141.

Nallari, R. & Griffith, B. (2011). *Gender and Macroeconomic Policy* World Bank. Washington, DC.

Narayan, U. (1998). Essence of Culture and a Sense of History: A Feminist Critique of Cultural Essentialism. *Hypatia*, *13*(2), 86–106. http://www.jstor.org/stable/3810639.

Narayan, U. (1997). *Dislocating Cultures: Identities, Traditions, and Third-World Feminism.* New London: Routledge.

Ndou-Mammbona, A. A. & Mavhandu-Mudzusi, A.H. (2022). Could Vhavenda initiation schools be a panacea for HIV and AIDS management in the Vhembe district of South Africa? *Curationis, (45)*1, 1-10. http://dx.doi.org/10.4102/curationis.v45i1.2356

Neal, M. (2020). The idea of vulnerability in healthcare law and ethics: from the margins to the mainstream? *Embracing Vulnerability: The Challenges and Implications for Law*, 68.

Ndlovu-Gatsheni, S. J., & Willems, W. (2009). Making sense of cultural nationalism and the politics of commemoration under the Third Chimurenga in Zimbabwe. *Journal of southern African studies*, *35*(4), 945-965.

Nicholson, L. (1994). Interpreting Gender. *Signs*, *20*(1), 79–105. http://www.jstor.org/stable/3174928.

Nthaburi, Z. & Waruta, D. (1997). *"Biblical Hermeneutics in African Insti-tuted Churches*." In H. W. Kinoti & j. Mwalligo (eds.) The Bible in African Christianity. pp 40-57. Nairobi:

Acton Publishers.

Ntoimo, L. F., & Isiugo-Abanihe, U. (2014).'Patriarchy and singlehood among women in Lagos, Nigeria. *Journal of Family Issues, 35*(14). 1980-2008. doi:10.1017/S0022278X0000598X.

Oduyoye, M. A. (2001). *Daughters of Anowa: African women and patriarchy.* Orbis Books.

Ojilere, A., Adekilekun, K., & Umeh, S. (2021). Violation of Dignity of Vulnerable Women in African Customary Law and Socio-Religious Mythology. *ACARELAR, 2*(44). https://heinonline.org/HOL/

Oguli Oumo, M. (2004). *Bride Price and Violence Against Women: The Case of Uganda*. Paper presented at the International Bride Price Conference. Kampala: Uganda.

O'Hagan, A. (2018). Conceptual and Institutional Origins of Gender Budgeting. In A. O'Hagan, & E. Klatzer (Eds*.). Gender Budgeting in Europe: Developments and challenges* (pp. 19- 42). Cham: Palgrave Macmillan. https://doi.org/10.1007/978-3-319-64891-0_2.

Ojo, M.A. (1997). Sexuality, Marriage and Piety among Charismatics in Nigeria, Religion, 27:1, 65-79, DOI: 10.1006/reli.1996.0065

Ojo-Ade, F. (1979). Roots of a Revolution: Scenes from Zimbabwe's struggle by Ndabaningi Sithole Oxford, London and New York, Oxford University Press, 1977. pp. 142. *The Journal of Modern African Studies, 17*(3), 497-503.

Okon, E. E. (2014). Christian missions and colonial rule in Africa: Objective and contemporary analysis. *European Scientific Journal*, *10*(17). https://core.ac.uk/download/pdf/236413903.pdf

Olabode, B. O. (2009). "African Gender Myth in Proverbs and Verbal Discourses; A Case Study of the Yoruba of South-Western Nigeria" in Kehinde, A.(ed) Gender and Development: Essential Readings. Ibadan: Hope Publications.

Omotosho, O. J. (2021). Abrahamic and African cultural identities: an appropriation of polygamy. *Humanus Discourse, 1(*1), http://dx.doi.org/10.2139/ssrn.3807053

Orchid Project. (2022). Zimbabwe. https://www.orchidproject.org/about-fgc/where-does-

fgc-happen/zimbabwe/.

Organisation of African Unity. (1981). *African Charter on Human and People's Rights.* https://www.achpr.org/legalinstruments/detail?id=49.

Orr, N., Hajiyiannis, H., Myers, L., Makhubele, M. B., Matekane, T., Delate, R., Mahlasela, L., & Goldblatt, B. (2017). Development of a National Campaign Addressing South African Men's Fears About HIV Counseling and Testing and Antiretroviral Treatment. *Journal of acquired immune deficiency syndromes*, *74*(1), 69–73. https://doi.org/10.1097/QAI.0000000000001204

O'Reilly, M., & Parker, N. (2013). 'Unsatisfactory Saturation': a critical exploration of the notion of saturated sample sizes in qualitative research. *Qualitative Research, 13*(2), 190–197. https://doi.org/10.1177/1468794112446106.

Osirim, M. J. (2003). Crisis in the state and the family: Violence against women in Zimbabwe. *African Studies Quarterly*, *7*(2), 154-166.

O'Sullivan, L. F., Harrison, A., Morrell, R., Monroe-Wise, A., & Kubeka, M. (2006). Gender dynamics in the primary sexual relationships of young rural South African women and men. *Culture, Health & Sexuality*, *8*(02), 99-113.

Oxlund, B. (2012). It made me feel good and man enough: Love, sex and situational masculinity in a South African university context. *norma*, *7*(1), 25-49.

Oyewumi, O. (1997). *The Invention of Women: Making an African Sense of western Gender Discourse.* Minneapolis: University of Minnesota Press.

Ozaki, R., & Otis, M. D. (2017). Gender Equality, Patriarchal Cultural Norms, and Perpetration of Intimate Partner Violence: Comparison of Male University Students in Asian and European Cultural Contexts. *Violence Against Women, 23*(9), 1076-1099. https://doi.org/10.1177/1077801216654575

Ozkan, M., Altindag, A., Oto, R., & Sentunali, E. (2006). Mental health aspects of Turkish women from polygamous versus monogamous families. *The International journal of social psychiatry*, *52*(3), 214–220. https://doi.org/10.1177/0020764006067207

Nkomazana, N. & Maharaj, P. (2014) Perception of risk of HIV infections and sexual behaviour of the sexually active university students in Zimbabwe. *Journal of Social Aspects of HIV/AIDS, 11*(1), 42-50. https://doi.10.1080/17290376.2014.886082.

Nubed, C. K., & Akoachere, J. T. K. (2016). Knowledge, attitudes and practices regarding HIV/AIDS among senior secondary school students in Fako Division, South West Region, Cameroon. *BMC public health*, *16*(1), 847. https://doi.org/10.1186/s12889-016-3516-9.

PADARE (2012). *Padare/Ekhundleni Men's Forum Zimbabwe.* https://www.padare.org.zw/

Palit, M., & Allen, K. R. (2019). Making meaning of the virginity experience: Young men's Perceptions in the United States. *Sexual and Relationship Therapy, 34*(2), 137–152. https://doi.org/10.1080/ 14681994.2016.1237771.

Palinkas, L. A., Horwitz, S. M., Green, C. A., Wisdom, J. P., Duan, N., & Hoagwood, K. (2015). Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. *Administration and policy in mental health and mental health services research*, *42*, 533-544.

Palmary I, Nunez L. (2009). The Orthodoxy of Gender Mainstreaming: Reflecting on Gender Mainstreaming as a Strategy for Accomplishing the Millennium Development Goals. *Journal of Health Management, 11*(1):65-78. doi:10.1177/097206340901100105.

Palmer, D. & Perrin, D. (2004). *Keep Sweet: Children of Polygamy*. USA: Dave's Press Limited.

Parikh, S. A. (2005). From auntie to disco: The bifurcation of risk and pleasure in sex education in Uganda. In: V. Adams. & S. L. Pigg (Eds.). *Sex in Development: Science, Sexuality and Morality in Global Perspective*. (pp. 125–158). Durham: Duke University Press.

Parpart, J. L. (2008). Masculinities, gender and violence in the struggle for Zimbabwe. In J. L. Parpart. & M. Zalewski. (Eds). *Rethinking the Man Question: Sex, gender and violence in international relations*, (pp.181- 198). London: Zed Books.

Patel, V. (2011). "Women and inclusive growth." *The Indian Economic Journal, 58*(4), 164- 174. https://www.journal.sagepub.com.

Pattman, R. (2001). "The beer drinkers say I had a nice prostitute but the church goers talk about things spiritual: Learning to be men at a teachers' college in Zimbabwe." In R. Morrell. (Ed.). *Changing men in Southern Africa, Durban*. (pp. 225-238). University of Natal & Zed Press.

Pattman, R. (2015). *Ways of Thinking About Young People in Participatory Interview Research*. 79- 92. 10.1007/978-981-4451-15-4_20. https://doi. 10.1007/978-981-4451-15-4_20.

Patton, M. Q. (2002). *Qualitative research and evaluation methods* (3rd ed.). Thousand Oaks, CA: Sage

Pauli, J., & Van Dijk, R. (2016). Marriage as an end or the end of marriage? Change and continuity in Southern African marriages. *Anthropology Southern Africa*, *39*(4), 257-266.

Peltzer, K., Setswe, G., Matseke, G., Ramlagan, S., Weiss, S. M., Violeta J. Rodriguez, Sifunda, S., Cook, R., Lee, T. K., & Jones, D. (2018) Sexual risk behaviour among HIV-infected women in the first twelve months after delivery in South Africa. *Journal of Psychology in Africa, 28*(4), 330- 335. http://doi. 10.1080/14330237.2018.1435048.

Pendergrast, R. A., Jr, DuRant, R. H., & Gaillard, G. L. (1992). Attitudinal and behavioral correlates of condom use in urban adolescent males. *The Journal of adolescent health: official publication of the Society for Adolescent Medicine*, *13*(2), 133–139. https://doi.org/10.1016/1054-139x(92)90080-u.

Pérez, G. M., Bagnol, B., & Aznar, C. T. (2014). Autoerotism, homoerotism, and foreplay in African women who practice labia minora elongation: a review. *International Journal of Sexual Health*, *26*(4), 314-328.

Perez, G. M. & Namulondo, H. (2011). Elongation of labia minora in Uganda: including Baganda men in a risk reduction education programme. C*ulture, Health & Sexuality, 13*(1), 45–57. http://doi.10.1080/13691058.2010.518772.

Perez, G. M., Bagnol., B. & Aznar, C. T. (2014). Autoerotism, Homoerotism, and Foreplay in African Women Who Practice Labia Minora Elongation: A Review. *International Journal of Sexual Health, 26* (4), 314-328. doi.org/10.1080/19317611.2014.910585.

Perlman, J. (2003). Marginality: from myth to reality in the favelas of Rio de Janeiro. In A. Roy, & N. AlSayyad (Eds.), *Urban Informality: Transnational perspectives from the Middle East, south Asia and Latin America* (pp. 105e146). Lanham: Lexington Books.

Petillo, A. & Hlavka, H. (2022). *Researching Gender-Based Violence: Embodied and Intersectional Approaches*. New York, USA: New York University Press. https://doi.org/10.18574/nyu/9781479812219.001.0001

Pettifor, A. E., Measham, D. M., Rees, H. V., & Padian, N. S. (2004). Sexual power and HIV risk, South Africa. *Emerging infectious diseases*, *10*(11), 1996.

Plan International. (2016). *In-depth review of legal and regulatory frameworks on child marriage in Zimbabwe*. https://www.girlsnotbrides.org/wp-content/uploads/2016/11/PLAN_18_country_report_zimbabwe_final.pdf

Popay, J. (1992). "My health is all right, but I'm just tired all the time": Women's experience of ill health. In Roberts, H. (Ed.), *Women's health matters*. (pp. 99– 120). London: Routledge.

Pope, E. M. (2020). From participants to co-researchers: Methodological alterations to a qualitative case study. *The Qualitative Report*, *25*(10), 3749-3761.

Posel, D. & Casale, D. (2009). '*Sex ratios and racial differences in marriage rates in South Africa.'* (ERSA Working Paper No. 153). https://econrsa.org/wp-content/uploads/2022/06/wp153.pdf

Posel, D., Rudwick, S., & Casale, D. (2011). Is marriage a dying institution in South Africa? Exploring changes in marriage in the context of ilobolo payments. *Agenda, 25*(1), 102-111. http://doi.10.1080/10130950.2011.575589

Pwiti, G., & Ndoro, W. (1999). The legacy of colonialism: Perceptions of the cultural heritage in Southern Africa, with special reference to Zimbabwe. *The African Archaeological Review*, *16*(3), 143-153.

Polzer, T., Nolte, I. M., & Seiwald, J. (2021). Gender budgeting in public financial

management: a literature review and research agenda. *International Review of Administrative Sciences, 0*(0), https://doi.org/10.1177/00208523211031796.

PrEPWatch. (2018). *Country Overview*: Zimbabwe. https://www.prepwatch.org/countries/zimbabwe/

Pronyk, P. M., Hargreaves, J. R., Kim, J. C., Morison, L. A., Phetla, G., Watts, C., Busza, J., & Porter, J. D. (2006). Effect of a structural intervention for the prevention of intimate- partner violence and HIV in rural South Africa: a cluster randomised trial. *Lancet (London, England)*, *368*(9551), 1973–1983. https://doi.org/10.1016/S0140- 6736(06)69744-4.

Ragnarsson, A., Townsend, L., Ekstrom, A., Chopra, M., & Thorson. A. (2010). "The Construction of an Idealised Urban Masculinity among Men with Concurrent Sexual Partners in a South African Township." *Global Health Action 3,* 5092. http://doi:10.3402/gha.v3i0.5092.

Rahman, M., Hoque, M. A., Makinoda, S. (2011). Intimate Partner Violence Against Women: Is Women Empowerment a Reducing Factor? A Study from a National Bangladeshi Sample. *Journal of Family Violence, 26,* 411–420. https://doi.org/10.1007/s10896- 011-9375-3.

Ralushai, V.N.M. (1977). *Conflicting accounts of Venda History with particular reference to the role of mutupo in social organization*. Unpublished Doctoral thesis, Queens University Belfast, UK.

Ranger, T. (1985). *The Invention of Tribalism in Zimbabwe*. Gweru: Mambo Press.

Ranger, T. (1979). *Revolt in Southern Rhodesia, 1896-97: A study in African Resistance*. London: Heinemann.

Rao, V. (1993). The Rising Price of Husbands: A Hedonic Analysis of Dowry Increases in Rural India. *Journal of Political Economy*, *101*(4), 666–677. http://www.jstor.org/stable/2138743.

Rapp, D., Zoch, B., Khan, M.M.H., Pollmann, T., & Kramer, A. (2012). Association between gap in spousal education and domestic violence in India and Bangladesh. *BMC Public Health, 12*, 467. https://doi.org/10.1186/1471-2458-12-467.

Ratele, K. (2016). *Liberating masculinities*. Cape Town: HSRC press.

Reed, E., West, B.S., Salazar, M., Monroy, R.V. (2018). Economic Empowerment to Improve Sexual and Reproductive Health Among Women and Girls. In: Choudhury, S., Erausquin, J., Withers, M. (eds) *Global Perspectives on Women's Sexual and Reproductive Health Across the Lifecourse.* Springer, Cham. https://doi.org/10.1007/978-3-319-60417-6_17

Rehle, T., Johnson, L., Hallett, T., Mahy, M., Kim, A., Odido, H., Stover, J. (2015). A comparison of South African national HIV incidence estimates: A critical appraisal of different methods. *PLoS One, 10*(7), e0133255. http://dx.doi.org/10.1371/journal.pone.0133255

Remenyi, D., Williams, B., Money, A. & Swartz, E. (2005). *Doing research in business and management: An introduction to process and method*. (1st ed). London: SAGE Publication.

Remez, L., Woog, V., & Mhloyi, M. (2014). *Sexual and reproductive health needs of adolescents in Zimbabwe.*

Republic of South Africa. (2019). *National Strategic Plan on Gender-based violence & Femicide Human Dignity and healing, safety, freedom & equality in our lifetime.* https://www.justice.gov.za/vg/gbv/nsp-gbvf-final-doc-04-05.pdf.

Republic of South Africa. (2016). *South Africa Demographic and Health Survey 2016.* https://dhsprogram.com/pubs/pdf/FR337/FR337.pdf

Republic of South Africa. (2017). *Policy Guideline for HIV Counselling and Testing.* (HCT)https://www.justice.gov.za/vg/hiv/docs/2009_FinaDraft-HCT-Policy-PIC- 22oct.pdf

Rice, P.L. (2000). *Hmong women and reproduction*. New York: The FordFoundation.

Riddell, T., Ford-Gilboe, M., & Leipert, B. (2009). Strategies used by rural women to stop, avoid, or escape from intimate partner violence. *Health Care Women International, 30*(1-2),134-59. https://doi. 10.1080/07399330802523774. PMID: 19116826.

Rist, G. (1997). *The History of Development: From Western Origins to Global Faith*. London: Zed Books

Rodrigues, J. (2007). *Aids in Zimbabwe How socio-political Issues Hinder the fight against HIV/AIDS:* Government Publications.

Rombo, D. O. (2009). *Marital risk factors and HIV infection among women: a comparison*

between Ghana and Kenya. University of Minnesota Digital Conservancy. https://hdl.handle.net/11299/56005.

Rosaldo, M. Z. (1980). The Use and Abuse of Anthropology: Reflections on Feminism and Cross-Cultural Understanding. *Signs*, *5*(3), 389–417. http://www.jstor.org/stable/3173582.

Rosenstock, I. M., Strecher, V, J., & Becker, M. H. (1994). The health belief model and HIV risk behavior change. In R.J. DiClemente (Ed.). *Preventing AIDS: theories and methods of behavioural interventions.* (pp. 5-24). New York: Plenum Press.

Rosy, S. Y. (2015). Contributions of Anthropology in Bringing Forth Local Perspectives and Challenges in Development Processes. *Anthropol*, *2*(140), 2332-0915.

Rotunda, R. J., Williamson, G., & Penfold, P. M. (2004). Clergy response to domestic violence: A preliminary survey of clergy members, victims and batterers. *Pastoral Psychology, 52*, 353–365. https://doi.org/10.1023/B:PASP.0000016939.21284.a3.

Rujumba, J., Neema, S., Byamugisha, R., Tylleskär, T., Tumwine, J. K., & Heggenhougen, H. K. (2012). "Telling my husband I have HIV is too heavy to come out of my mouth": pregnant women's disclosure experiences and support needs following antenatal HIV testing in eastern Uganda. *Journal of the International AIDS Society*, *15*(2), 17429.

Sachs, W. (ed) (1992). The Development Dictionary: A Guide to Knowledge as Power. London: Zed Books.

Saferspaces. (2019). *Gender-based violence in South Africa.* https://www.saferspaces.org.za/understand/entry/gender-based-violence- in-south-africa.

Saldana, J. (2009). *The Coding Manual for Qualitative Researchers*. Los Angeles, CA: Sage Publications.

Sandelowski, M. (1993). Rigor or rigor mortis: the problem of rigor in qualitative research revisited. *Adv Nurs Sci, 16, 1–8.*

Sapkota, D., Bhattarai, S., Baral, D., & Pokharel, P. K. (2016). Domestic violence and its associated factors among married women of a village development committee of rural Nepal. *BMC*, *9*, 178. https://doi.org/10.1186/s13104-

016-1986-6.

Sardinha, L., Maheu-Giroux, M., Stöckl, H., Meyer, S. R., & García-Moreno, C. (2022). Global, regional, and national prevalence estimates of physical or sexual, or both, intimate partner violence against women in 2018. *Lancet (London, England)*, *399*(10327), 803–813. https://doi.org/10.1016/S0140-6736(21)02664-7

Sardinha, L., Nájera C., & Hector, E. (2018). Attitudes towards domestic violence in 49 low- and middle-income countries: a gendered analysis of prevalence and country-level correlates. *PLoS One, 13*(10), e0206101. https://doi.org/10.1371/journal.pone.0206101.

Saunders, M., Lewis, P. & Thornhill, A. (2009). *Research methods for business students*. 5th ed. Harlow: Pearson Education Limited.

Sawyer, J. (2004). On male liberation. *Feminism and masculinities*, 25-27. Oxford Unversity Press: USA.

Sayi, T. S., & Sibanda, A. (2018). Correlates of Child Marriage in Zimbabwe. *Journal of Family Issues, 39*(8), 2366–2388. https://doi.org/10.1177/0192513X18755198.

Seidu, A. A., Aboagye, R. G., Okyere, J., Agbemavi, W., Akpeke, M., Budu, E. & Ahinkorah, B. O. (2021). Women's autonomy in household decision-making and safer sex negotiation in sub-Saharan Africa: An analysis of data from 27 Demographic and Health Surveys. *SSM-Population Health*, *14*, 100773.

Sen, A. (1985) *Commodities and Capabilities*, Amsterdam: North Holland.

Schelling, T. C. (1960). *The Strategy of Conflict*. Cambridge: Harvard University Press.

Schmidt, E. (1991). Patriarchy, Capitalism, and the Colonial State in Zimbabwe. *Signs*, *16*(4), 732–756. http://www.jstor.org/stable/3174571.

Schmidt, E. (2004). *Peasants, traders, and wives: shona women in the history of Zimbabwe, 1870-1939*. London: James Gurry.

Schmidt, E. (1990). 'Negotiated Spaces and Contested Terrain: Men, Women, and the Law in Colonial Zimbabwe, 1890–1939', *Journal of Southern African Studies*, 16, (*4*), pp. 622–648.

Semahegn, A., & Mengistie, B. (2015). Domestic violence against women and

associated factors in Ethiopia, systematic review. *Reproductive Health, 12*(78), https://doi.org/10.1186/s12978-015-0072-1.

Sengendo, J. & Sekatawa, E. (1999). *A cultural approach to HIV/AIDS prevention and care: Uganda's experience–country report.* UNESCO/UNAIDS Research Report (Kampala: Studies and Reports, Special Series, Issue 1, Special Series of Cultural Policies for Development Unit).

Servaes, J. (2022). Communication for development and social change. In *The Routledge Handbook of Nonprofit Communication* (pp. 23-31). Routledge.

Shakya, H., Domingue, B., Nagata, J. M., Cislaghi, B., Weber, A., & Darmstadt, G. L. (2019). Adolescent gender norms and adult health outcomes in the USA: A prospective cohort study. *The Lancet Child & Adolescent Health*, *3*(8), 529–538. https://doi.org/10.1016/S2352-4642(19)30160-9.

Shapiro, D., & Gebreselassie, T. (2014). Marriage in sub-Saharan Africa: Trends, determinants, and consequences. *Population research and policy review*, *33*, 229-255.

Shefer, T. (2014). Pathways to gender equitable men: Reflections on findings from the international men and gender equality survey in the light of twenty years of gender change in South Africa. *Men and Masculinities*, *17*(5), 502-509.

Shell-Duncan, B., & Hernlund, Y. (2006). Are There "Stages of Change" in the Practice of Female Genital Cutting? Qualitative Research Findings from Senegal and The Gambia. *African Journal of Reproductive Health*, *10*(2), 57–71. https://doi.org/10.2307/30032459.

Shell-Duncan, B., Moreau, A., Wander, K., & Smith, S. (2019). "*Reference guide: Factorial focus group analysis methods for studying social norm change." Evidence to End FGM/C: Research to Help Girls and Women Thrive.* New York: Population Council.

Shell-Duncan, B., Wander, K., Hernlund, Y. and Moreau, A. (2011) Dynamics of change in the practice of female genital cutting in Senegambia: testing predictions of social convention theory, *Social Science and Medicine*, 73(8): 1275–83. doi: 10.1016/j.socscimed.2011.07.022

Shell-Duncan, B. (2022). Social and structural factors influencing women's agency regarding

female genital mutilation/cutting: an intersectional analysis – a reply to 'The prosecution of Dawoodi Bohra women' by Richard Shweder. *Global Discourse*, *12*(1), 167-187. https://doi.org/10.1332/204378921X16345524513807

Shell-Duncan, B., Moreau, A., Wander, K. and Smith, S. (2018) The role of older women in contesting norms associated with female genital mutilation/cutting: a factorial focus group analysis, *PLoS ONE*, doi: 10.1371/journal.pone.0199217.

Shell-Duncan, B., Moreau, A., Smith, S. and Shakya, H. (2020) Women's business? A social network study of the influence of men on decision-making regarding female genital mutilation/cutting in Senegal, *Global Public Health, 16*(6), 856–69. doi: 10.1080/17441692.2020.1826996

Shilubane, H.N. & Khoza, L.B. (2014). Violence against women in Limpopo Province, South Africa: Women's health issues. *African Journal for Physical, Health Education, Recreation and Dance, December, 1*(1), 83-93. https://hdl.handle.net/10520/EJC168441.

Shire, C. (1994). Men don't go to the moon: Language, spaces and masculinities in Zimbabwe.In A. Cornwall & N. Lindisfarne, (Eds.). *Dislocating masculinities: Comparative Ethnographies*. (pp. 147–58). London: Routledge.

Shokane, A. & Masoga, A. (2018). African Indigenous Knowledge and Social Work Practice: Towards an Afro-sensed Perspective. *Southern African Journal of Social Work and Social Development, 30*(180*)*, https://doi.10.25159/2415-5829/2320.

Shoko, T. (2009). Komba: girls' initiation rite and inculturation among the VaRemba of Zimbabwe. *Studia Historiae Ecclesiasticae, XXXV*(1), 31-45.http://hdl.handle.net/10500/4508

Sibanda, M. (2011). Married too soon: child marriage in Zimbabwe. *Res Advocate Unit*, 1-22.

Siemieniuk, R., Krentz, H. & Gill, M. l. (2013). *Intimate partner violence and HIV: A review*. (HIV/AIDS reports). https://doi. 10. 10.1007/s11904-013-0173-9.

Sikweyiya, Y., Addo-Lartey, A. A., Alangea, D. O., Dako-Gyeke, P., Chirwa, E. D., Coker-Appiah, D., & Jewkes, R. (2020). Patriarchy and gender-inequitable attitudes as

drivers of intimate partner violence against women in the central region of Ghana. *BMC public health*, *20*, 1-11.

Silverman, D. (2010) *Doing qualitative research*. (3rd ed.). Sage: London.

Simbine, S. L., le Roux, L. & Muridzo, N. G. (2023). An exploration of the Vatsonga people's markers of childhood. *Journal of Human Rights and Social Work, 8*(2), 1-11.

Singer, M. (1996). A dose of drugs, a touch of violence, a case of AIDS: conceptualizing the SAVA syndemic. *Free Inquiry Creative Sociology, 24*, 99–110. https://www.ojp.gov/ncjrs/virtual-library/abstracts/dose-drugs-touch-violence- case-aids-conceptualizing-sava-syndemic.

Singh, S., Wulf, D., Samara, R., & Cuca, Y. P. (2000). Gender Differences in the Timing of First Intercourse: Data from 14 Countries. *International Family Planning Perspectives*, *26*(1), 21–43. https://doi.org/10.2307/2648286.

Skinner, J., Underwood, C., Schwandt, H., & Magombo, A. (2013). Transitions to adulthood: examining the influence of initiation rites on the HIV risk of adolescent girls in Mangochi and Thyolo districts of Malawi. *AIDS care*, *25*(3), 296–301. https://doi.org/10.1080/09540121.2012.701721.

Skovdal, M., Campbell, C., Madanhire, C., Mupambireyi, Z., Nyamukapa, C., & Gregson, S. (2011). Masculinity as a barrier to men's use of HIV services in Zimbabwe. *Globalization and health*, *7*(1), 1-14.

Skovdal, M., Maunzagona, T., Dzamatira, F., Magoge-Mandizvidza, P., Maswera, R., Moyo, B. K. & Gregson, S. (2023). 'Condoms are hard to get by': access to HIV prevention methods during lockdown of the COVID-19 epidemic in eastern Zimbabwe. *Global Health Action*, *16*(1), 2206207.

Sloot, R., Glenshaw, M.T., van Niekerk, M., & Meehan, S. (2020). Rapid point-of-care CD4 testing at mobile units and linkage to HIV care: an evaluation of community-based mobile HIV testing services in South Africa. *BMC Public Health, 20*(528), 1-9. https://doi.org/10.1186/s12889-020-08643-3.

Smallwood, S. E. (2007). *"Turning African Slaves into Atlantic Commodities." Saltwater Slavery: A Middle Passage from Africa to American Diaspora*. Cambridge, MA: Harvard.

Smith, S. (2013). "In the past, we ate from one plate": memory and the border in

Leh, Ladakh. *Political Geography, 35*, 47e59.

Snipes, S., Constant, T., Trumble, B., Goodreau, S., Morrison, D., Shell-Duncan, B., & O'Connor, K. (2015). Masculine perspectives about work and family concurrently promote and inhibit men's healthy behaviours. *International Journal of Men's Health*, *14*(1), 1- 20. https://doi.10.3149/jmh.1401.1.

Soler-Hampejsek, E., Mensch, B. S., & Hewett, P. C. (2009). *Education and the timing of sexual initiation and marriage in rural Malawi: A longitudinal analysis of the effect of attendance, attainment and repetition*. Paper Presented at Population Association of America Annual Meeting, Detroit.

Solomon, D.A. (2003). *Predators, Prey, and Other Kinfolk: Growing Up in Polygamy*. New York: W. W. Norton.

South Africa National AIDS Council. (2017). *Breaking Ground. SANAC's Sex Worker HIV Plan.* (SANAC's Newsletter, Issue 14). https://sanac.org.za/wp-content/uploads/2019/02/SANAC14lowspreads.pdf.

South Africa National AIDS Council. (2014). *The National Strategic Plan.* https://sanac.org.za/about-sanac/the-national-strategic-plan/

South African National AIDS Council Civil Society Forum. (2017). *South African civil society and the AIDS response.* https://sanac.org.za/south-african-civil-society-and-the-aids- response-preface/ .

Southern African Development Cooperation. (2021). *Parliamentary Forum. SADC Model Law on Gender Based Violence*. https://www.sadcpf.org/index.php/en/media-release/press- release/363-sadc-pf-countries-support-sadc-model-law-on-gbv.

Southern African Development Cooperation. (2008). *Protocol on Gender and Development*.https://www.sadc.int/files/8713/5292/8364/Protocol_on_Gender_and_Development_20 08.pdf.

Spradley, J. P. (1979). *The ethnographic interview*. New York: Holt, Rinehart, & Winston.

Sprague, C., Hatcher, A.M., Woollett, N., Sommers, T., & Black, V. (2016) 'They can't Report abuse, they can't move out. They are at the mercy of these

men': exploring connections between intimate partner violence, gender and HIV in South African clinical settings. *Culture, Health & Sexuality, 18*(5), 567-581, https://doi.10.1080/13691058.2015.1096420.

Stannus, H. S. (1910). Notes on some tribes of British Central Africa. *Journal of the Royal Anthropological Institute of Great Britain and Ireland, 40,* 285–335. http://www.jstor.org/stable/2843261.

Stayt, H.A. (1931). *The Bavenda.* London UK: Frank Cass/Oxford University Press.

Stöckl, H., Devries, K., Rotstein, A., Abrahams, N., Campbell, J., Watts, C., & Moreno, C. G. (2013). The global prevalence of intimate partner homicide: a systematic review. *Lancet*, *382*(9895), 859–865. https://doi.org/10.1016/S0140-6736(13)61030-2.

Stockman, J. K., Lucea, M. B., & Campbell, J. C. (2013). Forced sexual initiation, sexual intimate partner violence and HIV risk in women: a global review of the literature. *AIDS and behaviour*, *17*(3), 832–847. https://doi.org/10.1007/s10461-012-0361-4.

Stoddard, S. A., Heinze, J. E., Choe, D. E., & Zimmerman, M. A. (2015). Predicting violent behavior: The role of violence exposure and future educational aspirations during adolescence. *Journal of adolescence*, *44*, 191–203. https://doi.org/10.1016/j.adolescence.2015.07.017.

Svodziwa, M., Kurete, F., & Ndlovu, L. (2016). Parental knowledge, attitudes and perceptions towards adolescent sexual reproductive health in Bulawayo. *International Journal of Humanities Social Sciences and Education*, *3*(4), 62-71.

Swain, J. (2006). Reflections on patterns of masculinity in school settings. *Men and Masculinities,* 8(3), 331 – 349. DOI: 10.1177/1097184X05282203

Tamale, S. (2009). A human rights impact assessment of the Ugandan Anti-homosexuality Bill 2009. *The Equal Rights Review, 4*, 49-57. https://www.equalrightstrust.org/sites/default/files/ertdocs//Sylvia.pdf.

Taruberekera, N., Kaljee, L. M., Mushayi, W., Astatke, H., Shekhar, N., & Chommie, M. (2009). *Concurrent Heterosexual Partnerships, HIV Risk, and Related Determinants among the General Population in Zimbabwe*. Washington, DC:

Population Services International.

Taryor, N. K. (1984). *Impact of the African Tradition on African Christianity* Chicago: IL, Strugglers.

Tashakkori, A., & Creswell, J. W. (2007). Editorial: The New Era of Mixed Methods. *Journal of Mixed Methods Research, 1*(1), 3–7. https://doi.org/10.1177/2345678906293042

Teasdale, C. A., Sogaula, N., Yuengling, K.A., Wang, C., Mutiti, A., Arpadi, S., Nxele, M., Pepeta, L., Mogashoa, M., Rivadeneira, E. D., & Abrams, E. J. (2018). HIV viral suppression and longevity among a cohort of children initiating antiretroviral therapy in Eastern Cape, South Africa. *Journal of International AIDS Society, 21*(8). http://doi.10.1002/jia2.25168. Community Press.

Tenkorang, E.Y. (2012). Negotiating Safer Sex Among Married Women in Ghana. *Arch Sex Behav 41,* 1353– 1362. https://doi.org/10.1007/s10508-012-9960-4

Tenkorang, E. Y. (2014). Marriage, widowhood, divorce and HIV risks among women in sub-Saharan Africa. *International health*, *6*(1), 46-53.

Thebe, V. (2018). 'Men on transit'and the rural 'farmer housewives': women in decision-making roles in migrant-labour societies in north-western Zimbabwe. *Journal of Asian and African Studies*, *53*(7), 1118-1133.

The Holy Bible. (1611). NKJV Online. https://www.kingjamesbibleonline.org/.

http://dx.doi.org/10.1097/QAI.0000000000001323 PMID: 28398995.

Thobejane, T. D., & Takayindisa, F. (2014). An Exploration of Polygamous Marriages: A Worldview. *Mediterranean Journal of Social Sciences*, *5*(27), 1058-1066. http://doi. 10.5901/mjss.2014.v5n27p1058

Thomas, L. (2000). "Ngaitana (I Will Circumcise Myself)": Lessons from Colonial Campaigns to Ban Excision in Meru, Kenya. In B. Shell-Duncan & Y. Hernlund (Eds*.). Female "Circumcision" in Africa: Culture, Controversy, Change*. (pp. 129-150). Boulder, USA: Lynne Rienner Publishers.

Thomson, D. R., Bah, A. B., Rubanzana, W. G., & Mutesa, L. (2015). Correlates of intimate partner violence against women during a time of rapid social transition in Rwanda: analysis of the 2005 and 2010 demographic and health surveys. *BMC women's health*, *15*, 1-13.

Togarasei, L. (2022). State as patriarch and biblical discipline: theorising state sponsored

violence in Zimbabwe. *African Identities*, *20*(3), 215-224.

Tokhi, M., Comrie-Thomson, L., Davis, J., Portela, A., Chersich, M., & Luchters, S. (2018). Involving men to improve maternal and newborn health: A systematic review of the effectiveness of interventions. *PloS one*, *13*(1), e0191620. https://doi.org/10.1371/journal.pone.0191620.

Townsend, T. G. (2008). Protecting our daughters: Intersection of race, class, and gender in African American mothers' socialisation of their daughters' sexuality. *Sex Roles, 59*(5-6), 429- 442. https://doi.org/10.1007/s11199-008-9409-3.

Tracy, S. R. (2007). Patriarchy and domestic violence: Challenging common misconceptions. *Journal-Evangelical Theological Society*, *50*(3), 573-94. https://mlhlsi.infiniteuploads.cloud/2021/01/PatriarchyDV.pdf.

Tsanga, A.S. (2003). *Taking law to the people: Gender, law reform, and community legal education in Zimbabwe.* Harare: Weaver.

Tshugulu, A. N., Simbine, S. L., Charamba, S., & Muridzo, N. G. (2023). The influence of culture on child rights violations in Zimbabwe: a case study. *Social Work*, *59*(3), 245-259. https://dx.doi.org/10.15270/59-3-1141

Turner, A. N., Miller, W. C., Padian, N. S., Kaufman, J. S., Behets, F. M., Chipato, T., & Morrison, C. S. (2009). Unprotected sex following HIV testing among women in Uganda and Zimbabwe: short-and long-term comparisons with pre-test behaviour. *International journal of epidemiology*, *38*(4), 997-1007.

Udayagiri, M. (1995). "Challenging modernisation: Gender and development, postmodern feminism and activism". In M. Marchand. & J. Parpart, J. (Eds). *Feminism, postmodernism development*. (pp. 159-177). London: Routledge.

Ueyama, M., & Yamauchi, F. (2009). Marriage behaviour response to prime- age adult mortality: evidence from Malawi. *Demography*, *46*(1), 43–63. https://doi.org/10.1353/dem.0.0039

UK Parliament. (1895). *British sovereignty over the Transvaal*. *30*. https://hansard.parliament.uk/Commons/1895-02-07/debates/0d3e1828-1fb6-4c7c-

ab51-89d9fca5cf85/BritishSuzeraintyOverTheTransvaal

UNAIDS. (2004). *Facing the Future Together*. (Report of the Secretary-General's Task Force on Women, Girls and HIV and AIDS in Southern Africa). https://data.unaids.org/publications/external-documents/sgreport_facingfuture_en.pdf.

UNAIDS (2012). *UNAIDS highlights Zimbabwe's progress in responding to AIDS*.

http://www.unaids.org/en/resources/presscentre/featurestories/2012/may/20120528fsz imbabwe.

UNAIDS (2017a). *Country Progress Report.*

https://www.unaids.org/sites/default/files/country/documents/ZWE_2019_count ryreport.pdf.

UNAIDS. (2017b). *Prevention gap report*.
https://www.unaids.org/en/resources/documents/2016/prevention-gap.

UNAIDS (2018). *Programme Coordinating Board sees South Africa's AIDS response first- hand.* https://www.unaids. org/

UNAIDS. (2016). *Global Plan Country Factsheet*. Zimbabwe.

https://www.unaids.org/sites/default/files/media/documents/UNAIDS_GlobalplanCountr yfactsheet_zimbabwe_en.pdf.

UNAIDS (2017). *South Africa launches new plan to advance progress towards ending AIDS.*https://www.unaids.org/en/resources/presscentre/featurestories/2017/april/201 70403_south-africa-NSP.

UNAIDS. (2015). *2015 progress report on the global plan towards the elimination of new HIV infections among children and keeping their mothers alive*. Geneva: Joint United Nations Programme on HIV/AIDS; 2015. http://www.unaids.org/sites/default/files/media_asset/JC2774_2015ProgressReport_GlobalPlan_en.pdf.

UNAIDS. (2019). *PEOPLE LIVING WITH HIV RECEIVING ART – AS OF 30 JUNE*.

http://aidsinfo.unaids.org/

UNAIDS. (2020). *South Africa*.

https://www.unaids.org/en/regionscountries/countries/southafrica.

UNAIDS. (2020a). *Country Factsheets. Zimbabwe*.

https://www.unaids.org/en/regionscountries/countries/zimbabwe.

UNAIDS. (2020b). *Country Factsheets. South Africa.*

https://www.unaids.org/en/regionscountries/countries/southafrica.

UNAIDS. (2022). *Full report- In Danger: UNAIDS Global AIDS Update 2022.*

https://www.unaids.org/en/resources/documents/2022/in-danger-global-aids- update.

UNESCO & UNFPA. (2012). Sexuality Education: a 10-country review of school

curricula in East and Southern Africa.
https://unesdoc.unesco.org/ark:/48223/pf0000221121.

UNESCO (2022). Zimbabwe*: Education and Literacy*. https://uis.unesco.org/en/country/zw.

UNESCO (2009). Conservation of cultural heritage. UNESCO Institute for Statistics, 2009 UNESCO Framework for Cultural Statistics and International Centre for the Study of the Preservation and Restoration of Cultural Property (ICCROM), Risk Preparedness: A Management Manual for World Cultural Heritage.
https://uis.unesco.org/en/glossary-term/conservation-cultural-heritage

UNDP. (2022). *Gender Equality Strategy 2022-2025*.

https://www.undp.org/publications/gender-equality-strategy-2022-2025.

UNFPA (2022a). Zimbabwe. *Female Genital Mutilation*. Frequently asked questions.

https://www.unfpa.org/resources/female-genital-mutilation-fgm-frequently-asked-questions

UNFPA (2022b). *World Population Dashboard Zimbabwe. Sexual and Reproductive Health.*

https://www.unfpa.org/data/world-population/ZW.

UNICEF. (2010). *Gender Toolkit. Integrating Gender in Programming for Every Child in South Asia*.

https://www.unicef.org/rosa/media/2336/file.

UNICEF. (2014). *Zimbabwe Country Office, Gender Review Report*. file:///C:/Users/user/Downloads/UNICEF_Zimbabwe_Annual_Report_2014.pdf.

UNICEF. (2015). *Child Marriage Brochure*. https://data.unicef.org/wp-. content/uploads/2015/11/UNICEF-Child-Marriage-Brochure-High-Single_246.pdf.

UNICEF. (2016). *'State of the world's children 2016: A fair chance for every child.'* https://www.unicef.org/publications/files/UNICEF_SOWC_2016.pdf.

UNICEF. (2022). *To end child marriage, we need to empower women*. https://www.unicef.org/zimbabwe/press-releases/end-child-marriage-we-need- empower-women.

UNICEF. (2018). *ACCELERATING EFFORTS TO ELIMINATE CHILD MARRIAGE IN AFRICA.* file:///C:/Users/user/Downloads/01-Child-Marriage-Africa-Brochure-online-version.pdf.

UNICEF. (2020). *Child marriage around the world*. https://www.unicef.org/stories/child-marriage-around-world.

UNICEF. (2022a). *Child marriage.* https://data.unicef.org/topic/child-protection/child-marriage/

UNICEF. (2022b). *Female Genital Mutilation*. https://data.unicef.org/topic/child- protection/female- genital-mutilation/.

UNICEF. (2019). *Zimbabwe Child Poverty Report: An analysis using the Poverty, Income, Consumption and Expenditure Survey* (PICES). https://www.unicef.org/zimbabwe/media/3261/file/Zimbabwe%20Child%20Poverty%20 Report%202019.pdf.

United Nations. (1989). *Convention on the Rights of the Child*. https://www.unicef.org.uk/what-we- do/un-convention-child-rights/.

United Nations. (1979). *Convention on the Elimination of All forms of Discrimination Against Women.* https://www.un.org/womenwatch/daw/cedaw/.

United Nations (1948). *Universal Declaration of Human Rights.*

https://www.un.org/en/about-us/universal-declaration-of-human-rights.

United Nations. (1966). *International Covenant on Civil and Political Rights.*

https://www.ohchr.org/en/instruments-mechanisms/instruments/international- covenant-civil-and-political-rights.

United Nations. (1993). *Violence against women.*

https://www.un.org/womenwatch/daw/vaw/reports.htm#declaration

United Nations. (1995). *Report of the Fourth World Conference on Women.*

https://www.un.org/womenwatch/daw/beijing/pdf/Beijing%20full%20report%20E.pdf

United Nations. (2001). *Declaration of Commitment on HIV/AIDS.*

https://data.unaids.org/publications/irc-pub03/aidsdeclaration_en.pdf.

United Nations. (2001). *Declaration of Commitment on HIV/AIDS. United Nations*

General Assembly Special Session on HIV/AIDS. https://www.unwomen.org/en/what-we-do/hiv-and- aids/global-norms-and-standards.

United Nations. (2005). *Civil and Political Rights: The Human Rights Committee*.

Fact Sheet No. 15.https://www.ohchr.org/en/publications/fact-sheets/fact-sheet-no-15-rev-1-civil- and-political-rights-human-rights-committee.

United Nations (2006). *International Guidelines on HIV/AIDS and Human Rights*.

https://www.ohchr.org/sites/default/files/Documents/Publications/HIVAIDSGuidelinesen.pdf.

United Nations. (2015). *Transforming our world: the 2030 Agenda for Sustainable*

Development. https://sdgs.un.org/2030agenda.

United Nations. (2018). *United Nations agencies call for ban on virginity testing*.

https://www.who.int/news/item/17-10-2018-united-nations-agencies-call-for- ban-on-virginity-testing.

United Nations (2019). *Zimbabwe. Annual Narrative Progress Report*.

https://spotlightinitiative.org/sites/default/files/publication/AR2019_ZIMBABWE_spotlig htinitiative_FINAL.pdf?cv=1.

UN WOMEN. (2013). *A transformative stand-alone goal on achieving gender equality, women's rights and women's empowerment: Imperatives and key components*. https://www.unwomen.org/en/digital-library/publications/2013/7/post-2015-long-paper.

UN WOMEN. (2023). Types of violence against women and girls. https://www.unwomen.org/en/what-we-do/ending-violence-against-women/faqs/types-of-violence

UN Women. (2023). *Focusing on prevention: Ending violence against women. https://www.unwomen.org/en/what-we-do/ending-violence-against women/prevention.*

Vambe, L. (1976). *From Rhodesia to Zimbabwe*. Pittsburgh: University of Pittsburgh Press.

Vance, C. (Ed.). (1989). *Pleasure and Danger: Exploring female sexuality*. London: Pandora.

van de Wijgert, J. H., Morrison, C. S., Brown, J., Kwok, C., Van Der Pol, B., Chipato, T., Byamugisha, J. K., Padian, N., & Salata, R. A. (2009). Disentangling contributions of reproductive tract infections to HIV acquisition in African Women. *Sexually transmitted diseases*, *36*(6), 357–364. https://doi.org/10.1097/OLQ.0b013e3181a4f695.

Van Dyk, P. (2003). Violence and the Old Testament. *Old Testament Essays, 16*(1), 96-12. https://hdl.handle.net/10520/EJC85527

Varga, C. A. (2004). How gender roles influence sexual and reproductive health among South African adolescents. *Studies in Family Planning, 34,* 160e172.

Vasiljevic, M., Petrescu, D. C., & Marteau, T. M. (2016). Impact of advertisements promoting candy-like flavoured e-cigarettes on appeal of tobacco smoking among children: an experimental study. *Tobacco control*, *25*(e2), e107–e112. https://doi.org/10.1136/tobaccocontrol-2015-052593.

Venganai, H. (2016). "Negotiating Identities Through the 'Cultural Practice' of Labia Elongation Among Urban Shona Women and Men in Contemporary Zimbabwe." *Culture Unbound, 8*(3), 306–324. http://www.cultureunbound.ep.liu.se.

Vengeyi, E. (2016). The Bible, violence, women and African initiated churches in Zimbabwe. *The Bible and violence in Africa*, *20*, 257-268.

Viljoen, F. (2008). Model legislation and regional integration: Theory and practice

of model legislation pertaining to HIV in the SADC. *De Jure*, *41*, 383. https://heinonline.org/HOL/LandingPage?handle=hein.journals/dejur41&div =36&i d=&page=.

Von Braun, J., & Gatzweiler, F. W. (2014). *Marginality: Addressing the nexus of poverty, exclusion and ecology* (p. 389). Springer Nature.

von Braun, J., Hill, R. V, & Pandya-Lorch, R. (eds). (2009). *The poorest and hungry: assessments, analyses, and Actions.* International Food Policy Research Institute, Washington, DC.

Vos T. (1994). Attitudes to sex and sexual behaviour in rural Matabeleland, Zimbabwe. *AIDS care*, *6*(2), 193–203. https://doi.org/10.1080/09540129408258630.

Vroklage, B. (1952). 'Bride Price or Dower'. *Anthropos, 47*(1/2). 133–146.

Vyas, S. & Watts, C. (2008). How does economic empowerment affect women's risk of intimate partner violence in low- and middle-income countries? A systematic review of published evidence. *Journal of International Development, 21*, 577–602. https://doi.org/10.1002/jid.1500 70.

Wacquant, L. (2008). Urban outcasts: A comparative sociology of advanced marginality. Cambridge: Polity Press.

Walby, S. (1990). *Theorizing patriarchy.* Cambridge: Basil Blackwell.

Walby, S. (1989). Theorizing patriarchy. *Sociology, 23*(2), 213-234.

Wamoyi, J., Mshana, G., Mongi, A., Neke, N., Kapiga, S. & Changalucha, J. (2014). A review of interventions addressing structural drivers of adolescents' sexual and reproductive health vulnerability in sub-Saharan Africa: Implications for sexual health programming. *Reproductive Health, 11*, 1-15.

Wandera, S. O., Kwagala, B., Ndugga, P., & Kabagenyi, A. (2015). Partners' controlling behaviours and intimate partner sexual violence among married women in Uganda. *BMC Public Health,15*, 214. https://doi.org/ 10.1186/s12889-015-1564-1 PMID: 25884572.

Wang, S, H. & Rowley, W. (2007). *Rape: how men, the community and the health sector respond.* Geneva: Sexual Violence Research Initiative and World Health Organization. http://www.svri.org/rape.pdf

Watts, C., & Zimmerman, C. (2002). Violence against women: global scope and magnitude. *Lancet*, *359*(9313), 1232–1237. https://doi.org/10.1016/S0140-6736(02)08221-1.

Weigh, S.F. (2003). *Between Continuity and Change: The Concept of Tradition and Modernity.* Enugu: SNAAP Press Ltd.

Weinstock, H. S., Lindan, C., Bolan, G., Kegeles, S. M., & Hearst, N. (1993). Factors associated with condom use in a high-risk heterosexual population. *Sexually transmitted diseases*, *20*(1), 14–20. https://doi.org/10.1097/00007435-199301000-00004.

Wekwete, N., Sanhokwe, H., Murenjekwa, W., Takavarasha, F., & Madzingira, N. (2014). The Association between Spousal Gender Based Violence and Women's Empowerment among Currently Married Women aged 15-49 in Zimbabwe: Evidence from the 2010-11 Zimbabwe Demographic and Health Survey. *African Population Studies, 28*(3), 1413-1431. https://doi.org/10.11564/28-3-640.

Wentzel, P.J. (1983). *The relationship between Venda and Western Shona*. Pretoria, South Africa: University of South Africa.

Westoff, C. F. (2003). *Trends in marriage and early childbearing in developing countries.* DHS Comparative Reports No. 5. Calverton, MD: ORC Macro.

What Works. (2020). *What works to Prevent Violence*. https://www.whatworks.co.za/.

White, L. (1990). *The Comforts of Home: Prostitution in Colonial Nairobi*. Chicago: University of Chicago Press.

Willis, N., Milanzi, A., Mawodzeke, M. Chengetai, D., Armstrong, A., Yekeye, I., Mtshali, P., & James, V. (2019). Effectiveness of community adolescent treatment supporters (CATS) interventions in improving linkage and retention in care, adherence to ART and psychosocial well-being: a randomised trial among adolescents living with HIV in rural Zimbabwe. *BMC Public Health, 19*(117), 1-9. https://doi.org/10.1186/s12889- 019-6447-4.

Wingood, G. M., & DiClemente, R. J. (1998). Rape among African American women:

sexual, psychological, and social correlates predisposing survivors to risk of STD/HIV. *Journal of women's health*, *7*(1), 77–84. https://doi.org/10.1089/jwh.1998.7.77.

Wood, K., & Jewkes, R. (2006). Blood blockages and scolding nurses: barriers to adolescent contraceptive use in South Africa. *Reproductive Health Matters, 14*(7), 109e118.

Wood, K. & Jewkes, R. (1994). Dangerous' love: reflections on violence among Xhosa Township youth. In R. Morrell. (Ed.). *Changing men in Southern Africa*. (pp. 317–36). Pietermaritzburg/London: University of Natal Press, Zed Press

Wood, K., Maforah, F., & Jewkes, R. (1998). "He forced me to love him": putting violence onadolescent sexual health agendas. *Social science & medicine*, *47*(2), 233–242. https://doi.org/10.1016/s0277-9536(98)00057-4.

World Bank. (2023) *The World Bank in Zimbabwe*. https://www.worldbank.org/en/country/zimbabwe/overview#:~:text=Growth%20in%202023%20will%20be,inflation%2C%20and%20exchange%20rate%20pressures.

World Bank. (2005). *Gender Responsive Social Analysis: A Guidance note. Incorporating Social Dimensions into Bank Supported Projects.* https://documents1.worldbank.org/curated/en/217381468313758622/pdf/35137 0REV0GenderGuidelines0SANS.pdf.

World Bank. (2021) *Teenage mothers (% of women ages 15-19 who have had children or are currently pregnant)*. https://data.worldbank.org/indicator/SP.MTR.1519.ZS?locations=ZW&most_recent_value_desc=false.

World Health Organization. (2005). *Researching violence against women: practical guidelines for researchers and activists*. https://apps.who.int/iris/handle/10665/42966

World Health Organisation. (1995). *Female Genital Mutilation Integrating the Prevention and the Management of the Health Complications into the curricula of nursing and midwifery*. A Student's Manual. https://apps.who.int/iris/bitstream/handle/10665/66857/WHO_FCH_GWH_01.4.pdf

World Health Organisation. (2008). *Eliminating Female genital mutilation. An interagency statement OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, WHO.*http://apps.who.int/iris/bitstream/handle/10665/43839/9789241596442_eng.pdf;jsessio nid=C1707A7EF8169890D6646216A44C2416?sequence=1

World Health Organisation. (2010). *Preventing intimate partner and sexual violence against women: Taking action and generating evidence.* Geneva, Switzerland: .http://www.who.int/violence_injury_prevention/publications/violence/9789241564007_eng.pdf.

World Health Organisation. (2013). *Female genital mutilation (FGM) Prevalence of FGM.* http://www.who.int/reproductivehealth/topics/fgm/prevalence/en/.

World Health Organisation. (2015). Policy brief: pre-exposure prophylaxis 9PrEP): WHO expands recommendation on oral pre-exposure prophylaxis of HIV infection (PrEP). https://apps.who.int/iris/handle/10665/197906.

World Health Organization. (2021a). *Violence against women prevalence estimates, 2018: global, regional and national prevalence estimates for intimate partner violence against women and global and regional prevalence estimates for non-partner sexual violence against women*. https://apps.who.int/iris/bitstream/handle/10665/341337/9789240022256-eng.pdf?sequence=1.

World Health Organisation. (2021b). *Tracking progress towards a world without violence against women. New data from WHO's Violence Against Women Policy Database show further efforts are needed to deliver the Global Plan of Action on Violence*. https://www.who.int/news-room/feature-stories/detail/tracking-progress- towards-a-world-without-violence-against-women.

World Health Organization. (2021) *Female Genital Mutilation. Fact sheet*. https:// www.who.int/news-room/fact-sheets/detail/female-genital-mutilation.

Wright, G.W. (2012). NGOs and Western hegemony: causes for concern and ideas for

change, *Development in Practice, 22*(1), 123-134. https://doi.10.1080/09614524.2012.634230.

Wright, P. J. & Tokunaga, R. S. (2013). Activating the centerfold syndrome: Recency of exposure, sexual explicitness, past exposure to objectifying media. *Communication Research, 42,* 864–897. doi:10.1177/009365021350966.

Yanguas, P. (2018). *Why we lie about Aid. Development and the Messy Politics of Change*. ZED: London.

Yartey, F. N. A. (2015). The critical condition of rhetorical choices: The Bush administration's framing of HIV/AIDS as a national security threat in PEPFAR. *The Journal of International Communication*, *21*(2), 226-240.

Yaya, S., Odusina, E. K., & Bishwajit, G. (2019). Prevalence of child marriage and its impact on fertility outcomes in 34 sub-Saharan African countries. *BMC international health and human rights*, *19*(1), 1-11.

Yiftachel, O. (2009). Critical theory and 'gray space:' mobilization of the colonized. *City and Community, 13*(2e3), 246e263.

Yigzaw, T., Berhane, Y., Deyessa, N., & Kaba, M. (2010). Perceptions and attitude towards violence against women by their spouses: A qualitative study in Northwest Ethiopia. *Ethiopian Journal of Health Development, 24*(1), http://doi. 10.4314/ejhd.v24i1.62943

Yoder, J. D. (2001). Making leadership work more effectively for women. *Journal of Social Issues, 57*(4), 815–828. https://doi.org/10.1111/0022-4537.00243.

Yonah, G., Fredrick, F., & Leyna, G. (2014). HIV serostatus disclosure among people living with HIV/AIDS in Mwanza, Tanzania. *AIDS research and therapy*, *11*(1), 1-5.

Young, H. (2015). The Evolution of Social Norms. *Annual Review of Economics, 7,* 359-387. http://dx.doi.org/10.1146/annurev-economics-080614-115322.

Yuval-Davis, N. (1997). Women, Citizenship and Difference. *Feminist Review*, *57*, 4–27. http://www.jstor.org/stable/1395799.

Zablotska, I., Gray, R., Koenig, M., Serwadda, D., Nalugoda, F., Kigozi, G., Sewankambo, N., Lutalo, T., Wabwire-Mangen, F. & Wawer, M. (2009). Alcohol Use, Intimate Partner Violence, Sexual Coercion and HIV among Women Aged 15–24 in Rakai, Uganda. *AIDS Behaviour, 13*, 225-233. https://doi.10.1007/s10461-007-9333-5.

Zakirova, V. (2014). Gender inequality in Russia: the perspective of participatory gender budgeting, *Reproductive Health Matters, 22*(44), 202-212. https://doi.10.1016/S0968-8080(14)44806-7.

Zinanga, E. (1996). Sexuality and the heterosexual form: The case of Zimbabwe. *Southern African Feminist Review*, *2*(1), 3.

Zuma, K., Shisana, O., Rehle, T. M., Simbayi, L. C., Jooste, S., Zungu, N., Labadarios, D., Onoya, D., Evans, M., Moyo, S., & Abdullah, F. (2016) New insights into HIV epidemic in South Africa: key findings from the National HIV Prevalence, Incidence and Behaviour Survey. *African Journal of AIDS Research, 15*(1), 67-75. https://doi.10.2989/16085906.2016.1153491.

Appendices

Appendix 1

Risk	Mitigation	How
Retraumatisation	I will enlist the help of ZANA in Beitbridge Zimbabwe and Masimanye in Venda South Africa who will act as an enablers/ gatekeepers and will help to identify, recruit participants and offer support to participants who might become distressed. I also will follow strict UoP protocol guidelines on researching. I will also use the World Health Organisation's gold standard protocols on collecting data around violence against women and girls.	I have contacted ZANA and Masimanye that have agreed to provide support to participants who might become distressed during interviews. (Support letter is appended). UoP follows the UKRIO Code of Practice for Research which checklists: whether there are any ethical issues and whether ethics review is required; the potential for risks to the organisation, the research, or the health, safety and well-being of researchers and research participants. I have read the WHO guidelines and received training from my supervisor. The WHO guidelines are as follows:
		Interview only one woman per household. Don't inform the wider community that the survey includes questions on violence. Don't interview men about violence in the same households or clusters where women have been asked about violence. Interviews should be conducted in complete privacy. Dummy questionnaires may be used if others enter the room during the interview. Candy and games may be used to distract children during interviews. Train interviewers to recognize and deal with a respondent's distress during the interview. End the interview on a positive note that emphasizes a woman's strengths.

Intensifying stigma	I will carry out the interviews in a safe place provided by ZANA and Masimanye.	I have read the WHO guidelines above I have received training from my supervisor on interviewing vulnerable women to avoid stigmatisation
Intensified stigma and re traumatization may trigger an increase in domestic violence if a husband finds out; I might raise suspicion which might trigger violence at home.	Making sure the interview venue is a safe space as recommended and allocated by ZANA and Masimanye.	I will ask ZANA and Masimanye to help me with following up the women to make sure that there are no consequences after the interviews. I will follow UoP and WHO protocols I will make sure to get consent before interviews
I will keep my research confidential from the wider community because FGM is a sensitive topic that could provoke emotions of anger and the community may feel upset by topic.	ZUNA and Masimanye will facilitate safe spaces for the interviews and profile participants.	I have read WHO guidelines mentioned above and ensure that only research participants know the nature of the research questions as thay are profiled by ZANA and Masimanye I will interview only one woman per household and I will not inform the wider community that the survey includes questions on violence. Interviews will be conducted in complete privacy.
Whilst I am going to ask more direct questions to development practitioners, women's action	I will be asking them questions in a professional capacity and I will not expect them to give me	The participants will be referred to their organisational networks
groups, and teachers, there is a possibility that they could be HIV positive and that they might also have suffered domestic violence.	personalised answers and this should leave a degree of separation emotionally for my participants so they will not have to disclose their own experiences unless they wish to.	of support should they become distressed.
One member of the group may get distressed.	I have experience from my professional background of FGM running support groups for vulnerable women	I will stop the discussion and refer them to ZANA and Masimanye who will follow them up for support.

Confidentiality between group members is breached.	Set out in the ground rules that everything discussed in the group remains confidential and that everybody adheres to those rules. If anyone is not comfortable with the rules to adhere to them, I will ask them to leave. I will also go through the rules again at the end of the discussion. I will make it clear to the group that I will not be asking people to share personal experiences and that they could choose the level to which they bring in their own personal experiences.	All participants would be HIV positive and possibly might have experienced domestic abuse; the probability of breach of confidentiality is minimal because of these shared experiences. and the stigmatisation surrounding a positive status. If confidentiality is broken, the participant responsible will be asked to leave and the offended participant will be referred to either ZANA or Masimanye for support. I will ask them to agree to a verbal contract of confidentiality (see focus group tool in appendix)
Risk to myself of being traumatised.	I will have regular check ins with my supervisor and access to the UoP counselling service	

Appendix 2

CONSENT FORM

Title of Project: Monitoring and Evaluating the Impact of Mainstreaming Violence against Women and Girls (including FGM) in HIV programming

Name and Contact Details of Researcher: Patience Mutunami,

patience.manhovo@port.ac.uk

Name and Contact Details of Supervisor: Professor Tamsin Bradley,
Tamsin.bradley@port.ac.uk

University Data Protection Officer: Samantha Hill
023 9284 3642 or data- protection@port.ac.uk

Ethics Committee Reference Number:FHSS- 2020-058

1. I confirm that I have read and understood the information sheet dated January 2020 (version 2.7) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time before the 1st of May 2021 without giving any reason. ☐

3. I understand that data collected during this study will be processed in accordance with data protection law as explained in the Participant Information Sheet January 2020, version 2.7 ☐

4. I consent for my interview to be audio recorded. ☐

5. I consent to being quoted verbatim and for the verbatim quotes to be used in publications ☐

6. I understand that to maximise the re-use and societal benefit of this research, anonymous data (which does not identify me) will be publicly shared at the end of the project and made open access under a CC-BY licence. I understand that this means anyone else (including researchers, businesses, governments, charities, and the general public) will be allowed to use this anonymised data for any purpose that they wish (including commercial purposes), providing that they credit the University and research team as the original creators. ☐

7. I understand that the results of this study may be published and / or presented at meetings or academic conferences and may be provided to research commissioners or funders. I give my permission for my anonymous data, which does not identify me, to be disseminated in this way. ☐

8. I agree to take part in the above study.

Name of Participant: **Date:** **Signature:**

Name of Researcher: **Date:** **Signature:**

Appendix 3

Dr Theresa Callan,
Interim Dean of the Faculty of
Humanities and Social Sciences

T +44 (0)23 9284 6012
E theresa.callan @port.ac.uk

FAVOURABLE ETHICAL OPINION (with advisory notes) **Name:** Patience Manhovo

Faculty of Humanities and Social Sciences
Park Building
King Henry I Street
Portsmouth PO1 2DZ

T: +44 (0)23 9284 8484
port.ac.uk/fhss

Study Title: Monitoring and Evaluating the Impact of Mainstreaming Violence against Women and Girls (including FGM) in HIV programming

Reference Number: FHSS 2020-058

Date: 25/01/2021

Thank you for resubmitting your application to the FHSS Ethics Committee and for making the requested changes/ clarifications.

I am pleased to inform you that FHSS Ethics Committee was content to grant a favourable ethical opinion of the above research on the basis described in the submitted documents listed at Annex A, and subject to standard general conditions (*See Annex B)*. With this there are a number advisory notes you may wish to consider, all shown below.

The panel agreed that this resubmission addressed most comments and queries clearly and appropriately. The resubmission crucially addressed the earlier concerns about distress procedures and withdrawal of consent.

The panel would however like to draw attention to the following 5 advisory notes:

Advisory Note(s)[1]

We were still concerned about **consent from gatekeepers**. Emails have been obtained and included in the revised application, but they only express their supports. ***The panel would advise the researcher to prepare an information sheet (including the information provided in the PIS) and consent form for gatekeepers***, so that the researcher and the gatekeepers clearly agree about what they are asked to do and what happens to the participants they introduce to this research.

11.2 Key dates: the ***start and end dates should be erased from this application*** now that the researchers do not expect to start the research for the foreseeable future.

1. **11.5** did not specify the **amount of the monetary token to be given to participants**. ***It would be advisable that this amount be appropriate and suitable for this research***. In future applications the researcher should please state the monetary token and relate this to the monetary value in the country of research, i.e. provide the panel with the information they need to evaluate the ethical dimension of remuneration.

2. The revised **12.3** on the application is still unclear on the **issue of open access data**, though this issue is explained in more detail in the covering letter. ***Please ensure this issue is dealt with as explained in the covering letter***.

The comments are given in good faith and it is hoped they are accepted as such. The PI does not need to adhere to these, or respond to them, unless they wish to.

Please note that the favourable opinion of FHSS Ethics Committee does not grant permission or approval to undertake the research/ work. Management permission or approval must be obtained from any host organisation, including the University of Portsmouth or supervisor, prior to the start of the study.

Wishing you every success in your research

Chair

Dr Brigitte Leucht

Email: ethics-fhss@port.ac.uk

Annexes

A - Documents reviewed

B - After ethical review

ANNEX A - Documents reviewed

The documents ethically reviewed for this application

Document	*Version*	*Date*
Application Form	2	11/12/2020
Invitation Letter	2	11/12/2020
Participant Information Sheets	2	11/12/2020
Evidence From External Organisation Showing Support	2	11/12/2020
Interview Questions / Topic List	2	11/12/2020
Focus Group Questions / Topic List	2	11/12/2020
Focus Group Ground Rules	2	11/12/2020
Script for Oral Consent	2	11/12/2020

Research Protocol	2	11/12/2020
Checklist	2	11/12/2020

ANNEX B - After ethical review

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1. This Annex sets out important guidance for those with a favourable opinion from a University of Portsmouth Ethics Committee. Please read the guidance carefully. A failure to follow the guidance could lead to the committee reviewing and possibly revoking its opinion on the research.

2. It is assumed that the work will commence within 1 year of the date of the favourable ethical opinion or the start date stated in the application, whichever is the latest.

3. The work must not commence until the researcher has obtained any necessary management permissions or approvals – this is particularly pertinent in cases of research hosted by external organisations. The appropriate head of department should be aware of a member of staff's plans.

4. If it is proposed to extend the duration of the study beyond that stated in the application, the Ethics Committee must be informed.

5. Any proposed substantial amendments must be submitted to the Ethics Committee for review. A substantial amendment is any amendment to the terms of the application for ethical review, or to the protocol or other supporting documentation approved by the Committee that is likely to affect to a significant degree:

(a) the safety or physical or mental integrity of participants
(b) the scientific value of the study
(c) the conduct or management of the study.

5.1 A substantial amendment should not be implemented until a favourable ethical opinion has been given by the Committee.

6. At the end of the work a final report should be submitted to the ethics committee. A template for this can be found on the University Ethics webpage.

7. Researchers are reminded of the University's commitments as stated in the Concordat to Support Research Integrity viz:

· maintaining the highest standards of rigour and integrity in all aspects of research · ensuring that research is conducted according to appropriate ethical, legal and professional frameworks, obligations and standards
· supporting a research environment that is underpinned by a culture of integrity and based on good governance, best practice and support for the development of researchers
· using transparent, robust and fair processes to deal with allegations of research misconduct should they arise

· working together to strengthen the integrity of research and to reviewing progress regularly and openly.

8. In ensuring that it meets these commitments the University has adopted the UKRIO Code of Practice for Research. Any breach of this code may be considered as misconduct and may be investigated following the University Procedure for the Investigation of Allegations of Misconduct in Research. Researchers are advised to use the UKRIO checklist as a simple guide to integrity.

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Appendix 4 Form UPR16

FORM UPR16

Research Ethics Review Checklist

Please include this completed form as an appendix to your thesis (see the Research Degrees Operational Handbook for more information

Postgraduate Research Student (PGRS) Information			**Student ID:**	616840
PGRS Name:	Patience Mutunami			
Department:	SASSHPL	**First Supervisor:**	Professor Tamsin Bradley	
Start Date: (or progression date for Prof Doc students)	**01/10/2019**			
Study Mode and Route:	Part-time ☐	MPhil ☐	MD	
	Full-time ☒	PhD ☒	Professional Doctora	

Title of Thesis:	Gendered Intersections between Labia elongation, Child marriage, Bride Polygamy and HIV infection
Thesis Word Count: (excluding ancillary data)	88 000

If you are unsure about any of the following, please contact the local representative on your Faculty Ethics C for advice. Please note that it is your responsibility to follow the University's Ethics Policy and any relevant academic or professional guidelines in the conduct of your study

Although the Ethics Committee may have given your study a favourable opinion, the final responsibility for t conduct of this work lies with the researcher(s).

UKRIO Finished Research Checklist:
(If you would like to know more about the checklist, please see your Faculty or Departmental Ethics Committee rep or se the full checklist at: https://ukrio.org/publications/code-of-practice-for-research

a) Have all of your research and findings been reported accurately, honestly and within a reasonable time frame?	YE N
b) Have all contributions to knowledge been acknowledged?	YE N
c) Have you complied with all agreements relating to intellectual property, publication and authorship?	YE N
d) Has your research data been retained in a secure and accessible form and will it remain so for the required duration?	YE N
e) Does your research comply with all legal, ethical, and contractual requirements?	YE N

Candidate Statement:

I have considered the ethical dimensions of the above named research project, and have success obtained the necessary ethical approval(s)

Ethical review number(s) from Faculty Ethics Committee (or from NRES/SCREC):	FHSS- 2020- 058

If you have *not* submitted your work for ethical review, and/or you have answered 'No' to one questions a) to e), please explain below why this is so:

Signed *(PGRS)*:	338	**Date:** 18/01/2024

Appendix 5 Data Tables

Development and advocacy practitioner cohorts Data Table 1

Participant	Link recognition	Linking health messages	Vulnerability	Gendered transmission
ZDPPP1	I have no data on labia elongation or its effect on HIV transmission but one clear thing is that cuts to the genitals, sores or any lack of skin integrity increase the chances of acquiring HIV and other STIs	It makes a lot of sense because both are topics which fall under sexual and reproductive health. These topics are covered in sexual and reproductive health IEC. Kindly note that our health services utilize a public health approach which is an approach which targets most common conditions offering high quality, affordable and acceptable interventions. Our studies, surveys, program data have not yet shown us that HIV infections are being driven by labia elongation so to craft messages including labia elongation really requires identifying the risk groups and targeting the messaging for the highest impact. In societies where it is rampant messaging emphasizes the activity for example in Binga communities	Biologically women act as a receiver during intercourse, the reproductive organs of a woman have a greater surface area for the HIV to penetrate through, STIs increase chances of acquiring HIV yet most STIs may go unnoticed in women owing to their biology example being syphilis. In patriarchal societies women have little power or say towards their health or lives, they cannot negotiate for safe sex using condoms	Transmission is generally not gendered. Once the c term Mother to child transmission to Parent to chil attempt to remove finger pointing or blaming mom their babies. This was despite the science that tran mother to child no matter if the mother was infect otherwise.
		who pierce their bodies, ears, nose (not sure about the labia) messaging targets the community practices		
ZDPPP2	Gender based violence is considered to have a role both directly through instances like forced unprotected sex and indirectly through disempowering women to make an informed decision. I am not aware of any evidence that links labia elongation to increased risk of HIV.	Where evidence exist, it makes sense to link the messages. UNFPA already links harmful practices to HIV transmission.	Early sexual debut, unprotected sex, and multiple and concurrent partnerships, particularly of adolescent girls and young women with older men. Transactional sex is also considered widespread. and many harmful cultural norms and practices, and the heightened physiological susceptibility of adolescent girls to HIV infections.	Immatur adolesce risk of HI unprotec

ZDPPP3 Director 1	If your culture tells you that a woman must have elongated labia and suddenly you don't find them you may not express it openly that you are very disappointed and you wanted them elongated but then expectations that people have when they get into a relationship they either verbalize them or express them or do not and when they are not met and then they fail to express how those things can be improved it may then come out as violence so in part the domestic violence can be in two ways partner finds the elongated labia are either missing, or present or in what ever form and is not satisfied may then find someone else who has the appropriate labia and therefore that's already cheating and exposing the other part	First and foremost it might be prudent to ask what groups? And then, if it is cultural to say that it has always been there and done but the woman no longer like it or the man like it because they have been told that a woman must have it then we will have a very difficult situation of trying to convince them to stop the practice and therefore we may need to see how we accommodate it within the messaging	It's a question of expectations, we all have our images of ideal hubby/wife based on socialization, our socialization teaches us that a correct woman should look like this. If I am supposed to find a woman with long labia, elongated. If they are not there then what do I have in front of me? . I don't have a woman. So, if I don't have a woman, how will I treat her from there on? Maybe I will look for a woman. This is how I see this link, its socialization more than anything describing what a marriage and a woman should have and not have	women are disproportionately more affected by HI there are more men dying of HIV than women bec like health seeking behavior, adherence issues whe women will always be more affected and there are anyway.
ZDPPP4 Director 2	some of the domestic violence are related to sex. If a woman denies sex for a man, the man can beat the woman and abuse her sexually, that can be in the marriage as well as outside of the		We have interventions that targeted men for example male circumcision, but we don't have specific interventions for the women. Only the female condom, but	now we know there`s now transgenerational relati male. You can see the older woman getting a youn man getting a younger woman. So for me its just 5 younger women dating an older man because of ec more biased to women. The risk of acquiring HIV is more in female than in interventions are targeting to protect men and not

	marriage. Outside of the marriage especially if the man is used to get sexual favours from the woman and then they are used to doing it for example with a condom, if now he comes and the woman doesn't want, he can abuse her without because now it will be a forced one. Labia enlargement in our culture they say if you have got big labia you give the man a lot of pleasure and then the ladies, they can become promiscuous because of that just to experience to see if they are really XXXX, that can cause that but if you educate them you can stop that approach of transmission.		the female condom you need to make a consent from a man, so, some men they don't want it, that makes a woman vulnerable and in our African culture, you don't decide, the woman does not decide when to have sex. So, sometimes even for their own body they need to consult a man to get a man`s approval, so that makes them more vulnerable.	
ZDPPP5 Director 3	Labia elongation is not a natural thing, its something which we are doing for sexual pleasure and so on, so that also predisposes to injury and injury makes it easier for HIV to infect the woman"	"It's very important because these three they actually complement each other in putting the woman at risk so it's a very good idea to integrate the three and provide it as one package. Its happening, but the problem its fragmented. If all the people who are involved in HIV prevention, gender and woman`s issues should be speaking the same language	the natural make-up of a woman also makes a woman vulnerable to HIV and even if we are to be controversial the marriage institution also makes a woman vulnerable. within our society, you will find out that a girl or a woman cannot openly express her love to a male counterpart, and as a result, most of our first sexual encounters they are to some extent GBV or rape. Under those circumstances the woman cannot negotiate for safer sex because the woman is supposed to be refusing sex, if she just gives in she is perceived as loose and also things like polygamy and so on they also fall within that category.	bu visit our infectious diseases hospital or our oppor you will see a higher burden of women there. We the good health seeking behavior of women but ev general population, you will find out that women a higher burden than the males. So, to that extent, t dimension to HIV transmission
ZDPPP6 Coordinato r 1	"Ah no no, maybe domestic violence and HIV. I know it was a tradition which was started way back as an intervention which enhances sexual enjoyment for the woman and so I don't see a link".	I don't really understand the link between labia elongation and HIV so I don't think it makes sense to link them in health messaging. There is a link between HIV and domestic violence but	Women were not empowered to negotiate safe sex, and could not demand condom use from their partners.	Men are mostly blamed when there is HIV transmi who go out to have fun in the bars and engage in e sex workers.

		not with labia elongation.		
ZDPPP13	"I don't see the link between domestic violence and labia elongation, the fact that the women who have elongated their labia, report that it's a source of pleasure for them during the time of intimacy with their partner. So, it is something that they cherish having. "In HIV circles, we don't even call it genital mutilation, its enhancement and for the benefit of the woman as well as they say the men like it but its also necessary for their pleasure. I am not sure why its categorized as mutilation because to me, mutilation is destroying but for this one there is no destruction its enhancement. I am not sure where the definition comes from to include labia elongation under genital mutilation	it makes sense for domestic violence and inserting foreign objects but with elongated labia I don't think its something that can be linked. I don't know if there is any study that has been done to look at labia elongation as something that would drive HIV infection, I doubt that, I don't know how the biology would work for it to drive HIV transmissibility. Domestic violence yes	"the first thing is lack of knowledge around HIV and the lack of power within a relationship, and this includes issues of age where a young person is taken advantage of in terms of sexual violence, maybe they are raped, incest. "Some women believe in inserting stuff to dry up their private parts and that causes abrasions that can also allow HIV transmission, which is also a result of lack of knowledge that what they are doing when they insert these foreign objects to dry their vagina for the purposes of sexual intercourse they are making themselves more vulnerable to HIV infection"	The women`s biology makes them more vulnerable infected there are also those issues around, even if infected at the same time, usually the woman find woman will definitely seek health care services firs health care facility whilst men look for other reme from the medicine cupboards in their homes or fro medicines) from their Gotchie gotchie place (socia
ZDPPP12	Most of the people that practice labial elongation, usually don't practice it safely, in terms of infection prevention and control (IPC) or even in terms of the risk of getting disease is reduced for example, let's say someone has been pulling out the labials in an attempt to elongate, sometimes, that person will end up having cracks or even inflammation of those labia because of the way those things have been done. If they end up indulging in sex, they up being at a higher risk of transmission of HIV.	it makes a lot of sense to link those messages, in terms of giving an integrated message. However, there is a risk of stigmatization, or the public might misread the message, that everyone who has HIV, at some point was elongating their labia, or experienced some domestic violence, or some gender based violence at some point. But the only, danger is the public now relating things, or stereotyping victims or survivors as the message will be coming as one linking three things	In our African culture, its more of patriarchal, so by that virtue alone, by that point alone it means women have got less negotiation power, in terms of asking their partners to wear condoms. their [women's] organs are mostly receptive, which means that even the fluids that will be produced during sex have more time of penetrating their system, compared to their counterparts who are men. If there is poor hygiene to add on to that, it means that they will be more at risk. most women are not as educated as their counterparts, and they don't have economic opportunities like	transmission is gendered especially at a young age determinants of health and socio-economic oppor gendered. You find that the needs of a young girl c they are very disproportionate compared to the ne trying to balance that, women will end up falling v themselves to the older age group having transacti Even in marriage setups, they also will be depende spouses, the male counterparts they will usually be more economically empowered, so, they will be de vulnerable than their actual age groups counterpar tilt and go the opposite direction when we talk of 50s, they will become more vulnerable, possibly be riskier, possibly of other reasons, even reasons to d even poor risk perception so they will become mor their counterparts the females at the older age gro going up there

			men. So, at the end, they will be dependent on men for their survival and sometimes they will be forced to do things that predispose them to HIV compared to their counterparts who are men because of the financial power or the economic vulnerability.	
ZDPPP7	there is that close link with HIV and GBV but what we are not sure in research, what we are not finding in general in Zimbabwe is the reported violence linked to HIV but there is isolated violence that is linked to men demanding for their partners to have elongated labia which result in some instances having violence if a man finds out that probably his woman does not have the elongated labia, so, it has got a close link more to do with domestic violence but because we know that those who are suffering violence are also closely likely to end up getting infected	, in our messaging that we will send out to communities and societies, we need to tailor-make those messages to link the messages of forcing certain cultural beliefs and practices with HIV and with GBV. I would say to a lesser extent if we were speaking about messaging around the labia. To an extent, whilst we have pushed messages around GBV, whilst there have been messages to report gender-based violence, we still have a huge gap in terms of laws and policies that we do have for the practice	women's biological makeup makes them susceptible to tear and wear during sex, so, when they engage in unprotected sex, they might also then be at a higher chance of getting infected as compared to men. we have got culture issues to do with forced marriages that affects women and issues to do with dropping out of school for women because culture generally says that in the event that at family level people are not affording to send children to school, they decide to send the boy to school as compared to the girl child which also then makes that vicious cycle of poverty which makes women always depending on men, looking up to men for survival, and will end up being in a more disadvantaged position as far as negotiating for safer sex. power lies with men so, where they [women] are dependant on men for economic survival, men have the power to decide whether they want unprotected sex or not and because of that they then become susceptible to HIV infection	the man is the one who is allowed to engage in mu relations and the society kind of agrees to that whi a gendered issue in that aspect that men are the d the way that they engage in multiple concurrent se society normalizes that. HIV in our culture, it's a ge more to do with heterosexual relationships, but m being accused as the ones who are spreading HIV, is the one that also goes around to sleep around w its normal in this society of ours
ZDPPP8	in terms of the data that we have, there is a strong link between gender-based violence and HIV. But between HIV and genital mutilation, it depends	Domestic violence, yes, a lot of sense. But with labia elongation I think what we need to do is sort of look at the baseline, to get a baseline assessment	if you look at the situation we had in Makoni, at one point Makoni, had the highest HIV prevalence in Zimbabwe. The reason	the woman is actually on the disadvantaged side. going to deposit his infected sperm there, it stays t infection are even higher. Its even worse when its relationships where there is a bit of abuse, the wo gets bruised, she gets infected. For the men, neith we talk about the 0.01% transmission to a man but

	on which one or how you define mutilation. If you are talking about genitals being cut that's an obvious one, for elongation, unfortunately, I don't have any evidence From a cultural perspective, its expected, every woman should have elongated labia. In our culture here in Zimbabwe, its taken to be normal. Then when we look at how this is happening, how girls are growing up and being taught about this thing. The question is how are they being taught about these things; are they being forced or not? All the women that I have seen as adults had long labia, they say its normal, they are preparing themselves for marriage. So, they did not see anything wrong with that.	just to find out what our people say about it because there is that part which says every girl should have long labia so that she is able to satisfy her man of which, unfortunately for me, I have no evidence to show that a woman who has got long labia versus one with short labia there is a difference there for the man	was that there were truck drivers who were coming from Mozambique going to Harare, they would stop in town and pick up these young girls and this is how these young girls ended up getting HIV. These young people were vulnerable because they cannot afford to send themselves to school, they cannot afford to buy food, they up end sexually exploited, not that they are sex workers, but they are exposed to sexual exploitation because of poverty vulnerability is always one of the things that we have as a country and unfortunately when you look at social protection in our country, things have really gone down so badly. So, if someone doesn't have the resources to be able to live a normal life, it lives them vulnerable	look at the number what now plays is the repeatab how the men end up getting infected

ZDPPP9	Of the three things, I see a link between HIV and domestic violence, because where there is domestic violence, negotiating for safe sex will be difficult. Labia elongation may be societal pressures on women, that's how I see it, society has it that women with elongated labia make the best sexual intercourse.	It makes sense but I think there is a gap there which needs to be addressed, not just the messaging but a wholistic approach which will attend to the structural issues and biological issues. Women are not getting options to protect themselves from HIV. We are talking about dapivirine rings for women but the choice to use the dapivirine ring will still be heavily dependent on the male partner. The dapivirine ring is more empowering compared to the condom because the woman can conceal the ring inside her reproductive organs.	in principle trauma increases the chances of acquiring HIV. If sexual intercourse occurs soon after the elongation and trauma has occurred, then the chances of transmission will be higher. Our HIV prevention interventions are more skewed to men, the most common preventive measure, the condom, will be with the male partner, the male has more control on deciding the use of the condom. Even on a date, its more difficult for the woman to bring her own condoms. If there isn't enough money at family level to support fees for education, boys are prioritized over girls. If a man has extra-marital affairs, woman are counselled to accept and normalize it. On the contrary, if a woman has extra-marital affairs, she will be thrown out of the home. Even if you look at the demographics, like rural versus urban you find that women are vulnerable. . Educational status, employment status makes women vulnerable to HIV. There are few methods or interventions which are in the control of women. Also goes down to stigma, on a date you cant expect the woman to bring condoms, its unacceptable. Interventions like the female condom were not accepted well by women	Our data from the HIV estimates shows that wome affected by HIV, especially young women aged 15- three times more for young women than for young even 6 times more, the men don't go for HIV testin behaviour is poor. Women have better health seek they get home with a HIV positive diagnosis, they a HIV into the family.

ZDPPP11	FGM is usually very silent, it's a taboo, everything is so bad, and they demonise the whole sexuality while in elongation culture, its an opportunity to discuss, to play around with themselves and to experiment what will happen when they grow . So, it's a practice that makes sexuality very open and also allows discussion and may be an opportunity for girls to discuss sexuality from older people and get ideas and its probably the right messaging. Yes, but then down the line, its not as scary, bad, or demonised for these women to try and experiment. it reduces the fear and taboo around it and you might want to try sex earlier because you been practicing, you have been taught and you have been told its pleasure for you and for the husband. Your aunties and your cousins have been going through these processes together. it's not a taboo subject for the girls, it's something that they have learnt from discussing this issue from being sexuality and being encouraged to… Now we are saying this elongation is dangerous but I am being encouraged to start sexual, in that way maybe, I am almost convinced that sexual debut is earlier, they are still not experienced, there has to be this information. My question is, is it measurable? With FGM there is no discussion of anything, its trauma, you are just told you are supposed to enjoy anything. The fact that if you have elongated labia, you are going to be beaten I don't see the direct link	There is recognition at the technical level, but I think that the way that programs are funded and the way that we manage them result in things that we could have integrated together are not necessarily integrated together. The way I look at these programs, the funding determines how things are done. Forced marriage is a form of violence and we need to link them to HIV, so if you look at harmful practices such as things like early child marriage, the power to say no. That is just not right, there is something wrong with child marriage. The school of thought is that the programming still needs to have these things speaking to each other and maybe if we didn't put so much money for HIV, we would be integrating elsewhere. The way HIV resources are channelled determines how we do things.	gender inequality makes girls more vulnerable even after campaigning in communities, we have to look at the body of a girl and the susceptibility, their early sex, its dry sex mostly with older men, they may feel they need to provide for the family, even when the mom know what's happening, they are more of the exposure from the home	Men outside of the biology have power to control women. The biology of the women and the positio they are more vulnerable. They are likely to be infe
ZDPPP10	When there is violence and penetration it means there is more	Why do you say its harmful? I thought the only harmful thing is	At times it also stamps from the need for social protection.	If you look at the data from the HIV estimates for Z disproportionately affected compared to males in t especially in the young. The younger females are a

	bruising to the woman and the more there is bruising, their natural defence mechanism is broken. there might be some men who don't like elongated labia so one can be abused for that, either emotionally. Some men don't like it, so they can be emotionally abused or physically abused. If the man likes a woman with elongated labia and the woman doesn't have elongated labia they can be told that they have juvenile private parts, private parts of a small child, that's also emotional abuse because you are you know	mutilation, cutting of the labia and I thought elongation is as a result of just slight pulling of the labia? Who said circumcision is not painful? Its painful but its not a harmful practice. ".There is no scientific evidence that labia elongation has anything to do with our [HIV] idemic. But what I can is that a woman with labia enjoys sex more e who doesn't because er on the outside than . So, the more surface he more enjoyable it is. deeper, just focus on the	You`ll have a young woman, she wants an iPhone, she wants to go on holiday to South Africa, Cape Town, Dubai, and a boy of the same age cannot do the same. She wants to have her hair done every month, she cant get that from someone in her age class. She ends up getting an older man, but the older man has 20, 30 years of sexual experience and that comes with other sexually transmitted infections because this girl is looking for extra protection but in the end she fails to negotiate for safer sex, she ends up sleeping with this older men who has years of sexual experience and she ends up getting all of these STIs.	to their male counterparts. So, females are more li their male counterparts. Everyone is responsible for transmission, the fema and the men get HIV from the females but I don't k person says . But like I said, men are the ones who a condom or not.
SAOGPP1	"Labia elongation has literally died down in Venda but if you think of the principle of it why are they doing that? It's to please men so that all comes again from the early socialisation under patriarchy that really your existence is simply to look after men and to please men. I think the same thing that stops women from insisting on condoms or not allowing a man to beat her up it's the same deep indoctrination that makes her succumb to that kind of ritual of labia elongation. I cannot imagine that its pleasant for the woman, do women like it because men enjoy sex better or .. ? The only part that stimulates us is the clitoris so I cant imagine how labia hanging off my legs is gonna make you feel good?"		With the HIV infection it's trying to get men to wear a condom which they just won't and female condoms have never been properly marketed in our area, never. You have no bodily integrity everything belongs to someone else" (SAOGPP2). "One thing which we learned with HIV infection from some of our dialogues is that men still practice polygamy and according to men he doesn't need to get tested because his wives get tested its part of ignorance and part of the arrogance"	MKKKK

ZOGPP1	Training young girls in labia elongation to me is pushing them into early sexual debut of which most of this training is not accompanied with realistic life lessons such as the importance of condom use, HIV or STI testing before the intercourse of which these are very necessary. Teenagers may rush into early sexual debut without adequate information to protect themselves from HIV. Because initiation rituals such as labia elongation are centred on grooming females to please males rather than grooming them for high self-esteem and putting their needs and health concerns first, there is a high likelihood that a girl who enters these rituals early on in life will lead her life thinking that she becomes a real woman by learning the art of man pleasing, changing/ modifying her body, beliefs maybe in order to keep a man. Such a girl and later on a woman would do anything even risky sexual behaviour no condom use/ no prior HIV testing, etc.) In order to keep a man because it has already been hammered into her from an early stage in life that her very existence is to ensure man's pleasure.		In most Zimbabwean communities, especially low socio – economic ones. Women and girls are socialised to believe that they have lower social, intellectual, physical and political power to effect change in their relationships with men. I have heard of phrases such as "…A man whether he has married you or not is your king, your leader, he knows better, you cannot object to his viewpoints in public or even in private lest you bruise his ego or he goes off to find a woman who will not embarrass him, or who listens to him and recognises his position as a leader over the woman. Women are socialised to bend to a man's will even if it is destructive to her or to the society at large, a man knows better. Growing up with such social viewpoints women and girls then ensure that their behaviour fits into this narrow framework. Women and girls are raised to look forward to marriage and or any union with a man to an extent that a woman with no husband has lower social status than her counterpart living with a man whether formally hitched or not	
BBOGPP1	In Beitbridge they have initiation schools for girls, they recruit each other within the school setup and they are taught how to please a man. So basically when they are being taught this things labia elongation is going to be there because they don't practice genital mutilation"	So maybe if it can be coiled together with formal education maybe we would see lesser interest. After initiation a girl will need someone who can tell her that we have impacted the skill on you but you need to be responsible. If you decide to use this skill the consequence is you are going to fall pregnant you are going to have a caesarean you are not	When they come after graduating you find that this thing is usually done in April, we are moving towards winter and at the end of the year you have diasporians who come and try to find out who has gone to the initiation school it means these are the people who know what's to be done to please them. This person has been living in South Africa you do not know his sexual	

		going to deliver normally you are going to be exposed to STIs. STIs cause this and that you know? Coin it together with reproductive health topics. If you coin it together with reproductive health topics it means people are discussing it its no longer a secret "I believe the lessons taught in the initiation schools, if you go to the people who have done this older women , they will tell you '' No its not like we are teaching them to go and have sex we are teaching them how to manage their womanhood, but because of the context that we are living in they would probably need someone to discuss it so that they understand what is happening and they really sort of like manage themselves and not feel that I've done this thing I am superior I should experiment	history, you do not know his HIV status, so these are the people who come in and are vying for these girls and these are girls as little as thirteen years, fourteen years, fifteen years and then they marry them. "statistics shows that girls fifteen to nineteen are the ones that are getting infected the most. Beitbridge being a very busy place with a high in-transit population the girls are exposed. In terms of link about initiation schools, genital elongation with issues of HIV contractions, girls want to experiment and the guys give them the platform to experiment because they are young girls. The men flash money, they promise marriage and more and then the girls fall for that and at the end of the day you have sexual intercourse taking place and contracting the disease They then enter into child marriages, some of them are not even child marriages so to say. They then indulge into sexual intercourse ,so now you can find the situation is this guy has been sexually active in South Africa and has contacted the disease he can then pass it on to this young girl and when this young girl falls pregnant and she delivers maybe she then discovers she's HIV positive. At this age their status is not divulged, they can live without people knowing she's HIV positive. Some may fall pregnant some may not so to say you are not sure if she contracted the disease or not	

			"sexual abuse is everywhere. It's not scary, it's very open we are now taking it as something very normal. It's not something that you can say is new. How I'm putting it that we have normalised it, if you look at the ages with which children give birth now, we have this thing of fearing the perpetrators because of the situations we find ourselves in poverty. These cases go unreported because you fear getting the perpetrator imprisoned "You find a child who is sexually abused a parent will be like go where ever they are, you are now a wife to that person and maybe that's when we can then see an element of violence coming in maybe she gets in an abusive relationship but we just think if a child is found with a man under age as she is that man should take over but in other words we are infringing on her rights. She's becoming sexually abused and she can't say no she doesn't have the power to say no. So it's just an issue of another parent seeing it as a burden being taken away from them, it's one mouth less to feed it's not their problem so a child is taken away and becomes a child wife so to say and we cover it up	
ZOGPP2	Its criminal especially the part what is also being claimed as dehumanising but you also see there is a gender dimension to it there's also some sexual undertones its said its done to please men and older women are		the key contributors to violence against women and girls it is mainly rooted in culture, and cultural practices. You know, we live in a patriarchal society, which defines the power imbalances between men and	

	encouraging that to these younger women so that they can stay in marriage. They say that's the recipe to stay in marriage. Of course, it's an abuse, but it's also in a way still endorsed as a cultural rite that is necessary to sustaining marriages. But we then also see that forced initiation itself is also a crime according to the domestic violence act. FGM- elongation, it attracts a lot of men it also attracts a lot money for the young girls who have gone through the process and also pre-exposes them to HIV as they engage especially with very many sexual partners as it were so that's somehow the link. But I wouldn't say there's a direct link really between HIV in the literal sense of it. And FGM I haven't I heard so much around that yet maybe its an unexplored area because FGM is not very common in Zimbabwe. I know it's common in West Africa and some other places, but I know that labia elongation is a very common practice here so FGM has not been explored enough in Zimbabwe		women. In a way, girls are more vulnerable, because vulnerable to abuse, vulnerable to even HIV because they can't negotiate for safer sex. Usually, they are involved with people, or with men older than them, and its usually a relationship which is tilted in power imbalance, which mean men have more power over the girls, because of economics, because of even physically the man is also more powerful than the girl. it's mainly because the girl child is predominantly viewed as inferior, and in a way she doesn't have so much power to negotiate, she can't determine when to have sex and how to have sex or with whom to have sex with protection or no protection, issues of power and economic exploitation issues and also the vulnerability issues that are usually befalling these girls and also some of the girls they are also abused by people who are supposed to be the keepers, like the extended family the uncles and all. All those dynamics affect the girl child through abuse, and also HIV infection, or some of the girls can engage in transactional sex for survival	
ZOGPP3	the links are there, initiation is done in communities where culture is strong. And that culture does not really consider the age of marital consent if a child is initiated into preparation for sexual activity at 12, 13 do you think that community will be bold enough to then say wait until you are above 18? You will be surprised at the number of people who have elongated labia who have never		vulnerability is a function of power whether the woman has the power to protect herself from the violence. Its also a function of culture because the power that we are talking about is bestowed upon someone by the environment that they live in. Whereas in some societies, its unacceptable for women to be treated	

	attended those initiation ceremonies and the challenge is that even some who are from very educated or seemingly empowered communities still do those things. however the links are there, it's a case where the individual is not empowered as an individual they are subjected to cultural pressures and such cultural pressures may lead to transactional relationships, unequal power relationships, and they can lead to HIV.		less. For others its quite acceptable for women to be deemed of lesser value hence low negotiating power to negotiate safe sex or to fight and wade off gender- based violence. When we talk of power we also talk of do they have power as a group of women? We also talk of individual power to stand against societal expectations are there laws that are there that are systemic constrains which is another function? Are there laws or cultures or religions or acts of parliament that protect them? Those are systemic constrains that are there in the environment that can have an effect on the vulnerability of women and girls. **I also think that** women are not a homogenous group so some professional women might actually be less vulnerable than non-professional women. Some non- working women and some who are following a vocational trade financially but have enough income for themselves, they can delay marriage, pursue education, they don't involve in transactional relationship for them to survive and get food that's also another function. The challenge is culture…divorce is still seen as bad even in churches	
SAOGPP1	Yes there is, like I mentioned also the issue of poverty you find most people even if they report violence to the police they cannot leave a relationship because the man is the provider so a case opens today tomorrow is closed because they have to rely on the partner so in a way people become		"it speaks a lot about the economic status pf the province as well as the implications for development and how it affects the population, so if you look at statistics again you will find that we have high numbers of women who are	

	more exposed to GBV and HIV "here it's the culture that men have that power and they are in charge even if you look at the means of production and land ownership men control all this		unemployed so in a way it has a bearing on their future the same applies to the high numbers of teenage pregnancies" They are still doing genital mutilation here, with the initiation schools they are very strict and I doubt if they will allow education to be part of it for instances they have big campaigns about medical circumcision I have seen some people also taking children to the doctors which is a positive development" "They have their own way of doing it with the women to do the genital mutilation especially after giving birth they do that in Venda. If a women has given birth vaginally she has to be cut each time she gives birth, it is traumatic. They also cut you even when you give birth through c-section but they shouldn't	

Development, and advocacy practitioners' cohorts Data Table 2

	GBV Interventions	Gender mainstreaming
ZDPPP1	rkers are trained to screen for gender -based violence and intimate partner violence as well as to first responders when violence is identified. Our programs utilize a human rights- based approach and are all inclusive including key populations like the LGBTI, sex workers, etc. We have components on Human rights, gender equality and community engagement Ministry also has one stop centres where there are comprehensive services incorporating the police and lawyers	
ZDPPP2	Ending GBV is one of the priorities of [XX]. We seek to help countries to among other things: develop gender responsive legislation and policies; establish integrated and multi-sectoral survival centered services; advocate for gender equitable social norms; and support quality data that uses gender lens	
ZDPPP3/Director 1	had some programs such as DREAMS which are for young women, otherwise if you catch them young and empower them while they are young, educate them when they are young they are likely to not be victims of gender based violence in a prolonged way or should I say persist in a situation which is abusive because it will be the only outlet they can see or the only outlet available to them	hat we do, wherever we do it, if we are doing it for a group we mu belongs to a ministry, gender belongs to whatever, we are saying Whatever we are doing, wherever we are, not just numbers but ef whether we are assigning roles, assigning responsibilities, assignir are we balanced here, have we been fair? To me that's gender ma any way not left others out, simply because of their gender
ZDPPP4/Director 2		Gender mainstreaming, to be honest, I am lost".
ZDPPP5/Director 3	we are providing care to those affected by gender based violence particularly sexual assault. We are assisting them to get post exposure prophylaxis, pregnancy testing, STI testing as well as linking them to other services like the courts of law and we really make sure that we ensure we do it within the Rights based approach to say that it's a human right of that woman to make sure that they get all the reproductive health services which they need. Be they	We are saying in whatever activity in which we are doing as a serv serving the women, are we serving the youth, are we serving both responsive to their needs without discriminating

	victims of sexual assault or the usual woman who is seeking care.	
ZDPPP6/Coordinator 1	"I don't know. We haven't yet touched on gender-based violence but that question you should be able to get an answer if you check the joint HIV health sector strategy. There is a section on gender-based violence, you should check it up. I remember there was someone from gender when we developed the joint HIV health sector strategy or if I am mistaken it's the Zimbabwe National AIDS Strategic Plan (ZiNASP). There is something about gender.	"I don't know, what is that?"
ZDPPP13	before covid we had regular low cost communal meetings under the trees in the rural areas or in community halls in urban areas. We bring together the leaders of the different groups when we have updates of new issues and concerns which would have been brought to the attention of the groups and we also encourage women to communicate any issues or grievances they might have with the facility staff encourage feedback on how their grievances or issues were resolved at the facilities. We also educate women on their rights as well as their obligations as well. Our interventions have been disrupted by covid. The covid lockdowns and restrictions made it difficult for women to access their facilities. Security forces were stopping people on the roads and to get to the facility people were forced to divulge their HIV status and they would be requested to produce their medical notes which reveal the ARVs which they are taking exposing them. This was later resolved but it was a problem when the lockdowns started.	Gender mainstreaming, actually I have discarded that from my vo cosmetic on reports and documents. I think gender mainstreamin intervention that gender is taken into consideration at every level gender is recognized"
ZDPPP12	the DREAMS programs is targeting young girls going to school, in terms of paying for their school fees, empowering them in seeking HIV services, even giving them stipends and making sure that they know their rights and they are well educated. Also through the National AIDS Council and Global Fund support, we have the young mentor mothers, who are advocating for women rights, advocating for women to access HIV services, even in supporting them with stipends, empowering them through economical activities such as the ASLEs, (Internal landing and savings) to do projects like poultry, like farming, etc.	I am not quite sure, maybe it's the terminology that you have use "Maybe its trying to do your programming addressing specific gen are peculiar to women and they might not necessarily be of value project, you might want to make it specific or relevant".
ZDPPP7	we do not have that in our messaging because again, these are some of the cultural practices that people tend to ignore and because we do not have much that has been researched on to say how much violence is coming from issues to do with labia elongation. It requires us to do further investigations to see to what extent do we have violence that is coming from issues to do with labia elongation or not elongated. We do have messages for HIV, we do have messages for GBV but we don't have messages that says GBV leads to HIV infection, stop GBV. We have that parallel messaging, that is happening for a certain issue, to address a certain issue, that goes to a certain issue, which again defeats the purpose if we do have data that is pointing towards that HIV and domestic violence. through the program like the DREAMS, which is in 20 districts that are PEPFAR supported and 4 that are Global fund supported. That is 24 districts out of 65 districts that have comprehensive GBV programs but the rest of the districts they also do have, they receive information through government, programs that are being run by the ministry of women affairs which is the custodian of the gender policy and are also the custodians of the GBV that also sensitize the communities. There are also programs on radio that also send mass media information. We do have programs that are training our health care providers, our community cadres to respond, to be more like the first line responders of GBV through training that	My understanding of gender mainstreaming is making sure that formulation, planning, monitoring, evaluation, at every stage of p of both men and women. But because our communities are tryin past years, we are promoting the inclusion of women more as cor advantage. But when we are talking about gender mainstreaming **does not speak to women**

	they are given. We also have been training our health care facilities to be able to be able to offer services, we also have been sensitizing communities on the need to report GBV, if its sexual gender violence, on the need to report straight to the facility, for them to receive PrEP, for them to receive emergency contraceptive, get STI screening and HIV testing. we also do have things like the emergency shelter that you can find in the community if someone is abused, they can be taken to that temporary shelter, we do have free legal representation, if somebody is abused and they want legal representation, they can get free legal representation. the DREAMS program is an integrated approach. The partners go together in the communities to do sensitizations. They use different models like Stop The Bus, where we can go and camp in a community and providing GBV screening, treatment, HIV testing, you are busy also sensitizing the community, so this is done in a wholistic manner, which is trying to do what we refer to as layering of services. Such that if you find a girl who has been abused, at that particular time in the community, you can actually get her legal support, you can get her treatment, you can get her HIV testing. If they had dropped out of school, they could get educational subsidies, they can be sent back to school so we are using a layered approach of services where we are really promoting people to work together, our partners to work together and we don't want to promote silo programming because we are targeting the same communities, the same people anyway	
ZDPPP8	The problem is that we have been doing it piece-meal, this partner comes in, they have got this small amount of money that they have been given to come in to assist with 1,2,3. They come in and start assisting, then another partner comes in and starts something else. That's why you find DREAMS is being implemented by different partners who are supposed to be collaborating, health guys, social science, education, making sure that we are addressing the knowledge part, we are addressing the social circumstances and addressing the health part. That's a good way of doing it but unfortunately when you are in an environment where the economy is not doing well. Where people, even professionals, can barely afford some of these services, it becomes more difficult. The older group are not being left behind because already they are older, they are already accepting the service that is being provided by the older health care workers because they are like their peer. The gap that we had was with the younger ones because they were afraid of coming to the 30 year old nurse and say I have got an STI or saying I want a condom so that's why this initiative came in to specifically to focus on that group. The older ones, most of them are already married, they are no longer shy, they are coming to the health facility doing their ANC. They are the ones, if you look at our delivery data they are delivering in the health facilities. The younger ones because they are afraid and a whole lot other issues they are the ones who are likely to deliver at home. the reason why we talk more of the young woman it's because when you look at the HIV programming, incidence is highest in 15-19, 20-24. As you grow older the incidence becomes lower. We are focussing on incidence, right now, we are talking about epidemic control and all the gains that we have made in the HIV program to sustain them. For us to sustain them, we need to keep everyone who's on treatment, on treatment, find those ones who are newly infected and put them on treatment, find those that are vulnerable and prevent them from getting infected. This is why all these efforts around the DREAMS is around prevention, care and treatment, mostly prevention.	That's a word I have always heard but I have never really tried to u women are put on the same level, whatever services you are prov a complementary package. If its young men, you also need to assu issue of adolescent corners that we were talking about, we imple they said this is like a traditional clinic it is full of women and babi going to the men's clinics. When providing a service, you should m opportunities, if its for growth, if its opportunities for employmen understanding, I don't know the actual correct definition but that'

	When you look at the linkages between health care and other services we don't have someone who is really focussing on how do we groom these young women, how do we mentor these young women so that they are able to make the right decisions, how do we create the right platform so that these women can grow up normally It's the same problem we used to face with malnutrition, you find an adult malnourished, you give them Plumbynut, and all these things to go when they get home because the kids are hungry, they end up giving them to the kids. When they come back at review, nothing has changed. You start to think my treatment is not working, yet no, the treatment is not working because the person has not taken the treatment. That's one of the challenges I feel we need to revise in our DREAMS project. Yes, the DREAMS project is health oriented, but you can't talk about health without talking about the social life of the people. That's the biggest problem we have	
ZDPPP9	projects such as DREAMS but they are not covering all districts and even in the districts where they are present, they do not cover all people in need of them. The DREAMS covers only a few people. In our papers, we say women, especially young women, are key populations but I don't think the people, the target recipients of care know it because all the available options haven't reached saturation to the extent that people are aware. We have effective options but the target recipients of service they may not know especially in the hard-to-reach areas and rural areas of which these areas have women who experience the greatest power dynamics. The urban woman are empowered to an extent, some are gainfully and professionally employed whereas the rural woman is totally dependent on the male partner. These are some of the areas which are a bit swept under the rag. We don't get any funding to support initiatives addressing gender-based violence. There are awareness campaigns which are carried out in schools but its an area with a gap. There are little meaningful activities in this area. We are just scratching the surface; the deeper issues are difficult to address.	These are big words in my vocabulary. I don't know, maybe you ca
ZDPPP11	DREAMS is a good example where the integration has been done. The whole package, the women are supposed to be more empowered, HIV free, and continue to reduce vulnerability as they get older. That's a good way of doing it but it's an expensive model. When you look at the community response the people at the village, there we have not yet got it quite right. The service pack, the systems are in place, maybe the challenges are the processes, but we know what to do right now, public health settings. The public health facilities can respond, that is already advanced. When we go to the communities now, I just find that we haven't got it quite right, integration and even making sure that they are empowered, they know what they are saying. If there is no NGO in the community, its very hard to find these things. We need to find ways of having these messaging authentically brought up in the system and in these elongation cultures, we need to integrate the risk of HIV in the messaging. In those traditions where they are helping the young girls to get their labia elongated that they think about HIV. We need to talk to the chiefs when we are talking about GBV, HIV and other health problems, SGBV. Already it's a taboo and no one talks about it in the community. The whole community no one talks about it. That's where the gaps are, that's where we need to work on.	Gender mainstreaming, what is that? Gender inequality is very rea is theory more than practice, that is my personal opinion. Do you When we can see gender inequality is very real when we look at t myself, you get tired. In terms of planning, conceptual processes, Implementation not necessarily. We need to learn gender differen We need to take the girls, when we look at school attendance and If we didn't put the word gender there, everyone will look at it an will be "oh its women, women are always complaining" So I think be stereotyped

	When we look at gender-based violence, the data is low, you know HIV is so advanced, we can tell you the prevalence, the incidence, we can tell you so much, there is so much research, we are ahead of the game than a lot of programs. You will find that for gender- based violence, there is a lot of high- level advocacy, change of law and capacity building but the system to monitor GBV in a systematic way, nationwide, not an NGO based one, there is a lot of gaps in GBV and we need to take the lessons that we have had in the HIV program to speak to GBV programs as well to make sure that they are effective.	
ZDPPP10	Intimate partner violence is real but people talk of HIV self test kits. They say the woman is given a HIV self test kit for secondary distribution to the partner, that woman will get beaten, she will be told your results are my result. "the problem is the men. If you continue pushing and working saying you are building the voice of the woman, she will be beaten to death in the home. Talk to the man so that he appreciates that these practices are bad and unacceptable. Meaningful and constructive engagement of men. No, whatever you may say, well it's a men`s world. The world is dominated by men, unless if you go to the men, nothing is going to change. If women raise their heads in the home, they will be beaten thoroughly or they will be dumped, told that "leave me, I am moving on, there cant be two men in this house." People don't know, even our donors, they talk of DREAMS, Determined, Resilient, Empowered, AIDS-free, Mentored, its bullshit. How can you be Determined, empowered in a country like our own? When you are not dealing with the causative issues, how can they be empowered. Root-cause analysis. So you see someone, who will be a DREAMS girl, advocating and facilitating DREAMS initiative during the day but at home she is being beaten thoroughly. The DREAMS is work, when she gets home she is changed. Those are the issues if you want to have a brighter future in terms of all these problems, don't focus on the women, focus on the men because the men are the causes. older men are dating young girls, and we have a problem with older men, but these young boys will also grow up to become older men. So, we should integrate with the ministry of education and make sure that boys are taught to have the right schema of mind, they should know that its not right to have unprotected sex and before sex get tested, be faithful.	
SAOGPP2	"There have not been many interventions on GBV in Venda, only half-baked efforts to get hold of a group of people together and girls and talk to them and there is an intervention, there is a lot of talk but real effort has not been made, national conferences talking about a problem all the academics and the researchers getting together and talking about the problem year after year but when you get down to the schools very little if anything is being done" Use of media has got its own disadvantages like in the remote areas there are some areas where they do not have the time to listen to the radio they do not have radios, and the use of the internet how many people have got data in the rural areas? There is a need to advocate for free wi-fi in the community or advocate for a library that will also make it easy for the community	

SAOGPP1	"we run these campaigns working with young people, fighting teenage pregnancy but what I am seeing is that this work is more responsive than preventative like if you look around you will find that there are many shelters around which accommodate girls and women and if you look into those cases you find that there are some who are already pregnant some are survivors of violence and if you look deep into their cases you will also find that its emanating from engaging in sex at a tender age and some also they are migrants they are not based here so it goes in line with some of the push factors again in the countries of origin" "When working with youths you have to be creative, things like theatre, drama, the media if you find ways to engage the youth to be exposed to such it makes them learn fast and interested in what you are telling them so it will be more effective than old methods of just talking	
ZOGPP1	Efforts are centred on advocacy on condom use, safe sexual practices, education and economic empowerment especially as opposed to condemning these relationships; these interventions are premised on the theory that once a woman is financially empowered and educated her tendency to rely on older financially stable men for financial support becomes less or next to zero. Moreover if the woman/ girl's capacity to protect herself from sexually transmitted diseases is increased, the rate of HIV transmission is significantly cut. Temporary shelters for survivors and sometimes their children- some organisations restrict the children they can accommodate to those 18 years of age and below.	
ZOGPP2	What I know is that MSASA is running SAFE shelters for temporary keeping of women who are running away from abuse in different areas. They have shelters in Gutu, Marange, Mwenezi, Gweru Harare, Mvurwi So they've got quite a number of these across the country to cater for women who mainly physically abused or sexually abused and they can't go back to the area where violence occurred so they are being kept temporarily as they also seek for services to assist them. Then they are also interventions around legal issues around maintenance also child custody issues, which are also being provided by the Legal Resources foundation, issues of inheritance those are also issues being assisted by the Legal Resources foundation Legal services that are offered for free. Then there's also the health component that is catered for by Musasa, other women's rights organisations like ZIWALA (Zimbabwe Lawyers Association) offers Legal Aid or legal assistance, and support women. Women Law in Southern Africa, they also offer Legal Aid, legal support for women mainly. Then we also have got One stop centres. Each province I'm sure it's got a one stop centre. whenever a survivor of domestic abuse gets to the hospital these days are located near the provincial federal or provincial hospitals. They get all the services under one roof, there is a counsellor who is stationed there, there is a nurse who is stationed there, the police officers also close by a phone call away for victim friendly system to facilitate all these services provided under one roof so that they don't have to be moving around. W know survivors of abuse don't have money. such interventions besides coming from top going down, they should also be inspired more by what's happening at grassroots level so that interventions are also tailored to meet the different geographic, and even cultural dimensions that are also evident in these different areas so that we can then realise results which I think that even in terms of sustainability in, in terms of buy-in, even in terms of running further with the programme, I think it will be	

	more sustainable if it is community driven and community focussed.	
ZOGPP3	one is general awareness going around schools, homes dealing with mothers as mentors to create awareness of the dangers and the ills associated with transgenerational relationships. The other one is the use of role modelling where organisations are taking girls or women who have delayed marriage to go and mentor others on an alternative way to transgenerational relationships Poverty helps to exacerbate the situation so dealing with poverty itself helps. If people are poor they cant keep girls at school so imagine a teenager who is experiencing all these physical changes in their bodies hormones are running wild they are bound to experiment and there is no control, there is no meaning there is no target that they have to achieve like they would if they were at school. Imagine what would happen to them and so poverty definitely has an impact on that. The other is lack of resources where we have piece-meal interventions. We have enough resources to make changes in a few villages or in a few districts and not have a nationwide mass campaign. The more we cover deeply across the country the more we begin to create a new culture but even if we change people here the influence of the work that we have done might be diluted by the fact that in the next nearby district there has not been reached because of resources so the culture that we are trying to change might not take place as fast as we want	
BBOPP1		

Teachers' cohort Data Table

Participant	LE & Sexuality Education	Integrating HIV, LE, & DV in lessons	Missed opportunities	Povert
ZOGPP1			It is girls who drop mostly out of school and some never to bounce back in the case of teenage pregnancy whilst the boy continues with his school, These girls may resort to prostitution or enter unequal power relationships for money and survival whereby they may fail to negotiate for safer sexual practices leaving them to become vulnerable to HIV/AIDS as well other forms of violence.	povert in caus interge first pla nature older fi offer m boys or it is nex mostly exampl anal or she ne to end She ma for HIV interco vulnera
ZTPP1	we normally leave that for cultures because when children come to school they are from different cultures, from different religions so that part of Labia is mostly not being taught we have to maintain their cultures and their beliefs.	they are just told to do it but they don't even understand what they are doing it for. They are just doing it for the sake of the parents they don't even know what is the meaning of it. It should be taught it should be well explained to them so that they choose to do it or not to do it..	Some of the religious practices in Zimbabwe encourage early child marriages these prophets will say I dreamt you to be my wife then maybe the child is around 12 years and the parents agree with that that their child is married at such a tender age, and they no longer come to school	
ZTPP2	We major in teaching about the effects of engaging in sexual activities in sexuality education. The initiation rites-labia elongation, is not for everyone so they don't put it in sexuality education.	for Labia elongation, to a lesser extent, maybe for those people who believe in it, depending on the cultural group that you belong to, but for HIV and for domestic violence Yes I see so much sense in it, because if we teach these learners when they are at an early age that it is wrong to beat up wives that it is wrong to have violence in the home and we buttress these points into them they grow up with it as part of their lives as part of their thinking process and their mentality that they're not supposed to engage in violence. I think it would be a better tomorrow for us.	Young girls mainly drop out of school because of teenage pregnancy. In some areas they still believe that they don't have to be serious about educating the girl child. If they have very few funds, they can just give the funds to the boy child and leave the girl child to just be at home or to get married. We also have situations whereby because of the changes in parents going to seek for better job opportunities in other countries, you'd find that some children like both the boys and the girls, but mainly it affects the girls, you know they can get abused then later on, you find that they are no longer in school.	

ZTPP3	the current curriculum they now emphasise sex education. It highlights to students, the girl child mostly her rights and also, it empowers, if you are powered academically, you actually know the correct decision to make. The current curriculum is now gender sensitive, it's no longer secretive, like the traditional form of learning where you could say this lesson is for the ladies, but this time we're doing it, everyone is doing it"	The integration will necessitate the depth of understanding of both of these because they are interrelated so that integration especially on elongation, HIV and also violence will also come into play when someone is HIV positive, there is that blame game within parties- attribution theory. hence if you integrate these things, you are giving a sort of awareness of these practices, you are also at the same time, removing the myths associated with some of these practices. you are highlighting to the child to understand, to know and to make proper decisions through acquiring informed knowledge from the information which the teacher will be imparting to the child. So since it will be revolving on the same area it will also be assessing them to understand the root cause of domestic violence because most causes related to HIV, they can lead to domestic violence, poverty within the family can lead to domestic violence and that poverty within the family can also leads to HIV.	Children tend to drop out from school because the parents are not employed They may even only have the option to send the boy child to school. With reference to girls there's the problem of early teenage pregnancies. there is also that religious aspect of the *Mapostori* (religious sect) who shun sending a girl child to school. They may send her for at least roughly, up to a primary level. If they are very poor, also they man withdraw her which leads to early marriages, and then culture, the cultural aspect of most people is gender bias, discrimination of the girl child, they tend to involve the boy child, rather than the girl child	Becaus make a their fa indulgi
ZTPP4			Pregnancy is another reason. Most girls drop out of school once they get pregnant. Some parents also leave the country to go and work abroad leaving their children without anyone to take care of them. Some parents whether rich or poor have an I don't care attitude or sometimes it could be the death of both parents.	
ZTPP5	I don't think there is need for that to be taught in schools because schools have	Children need to be taught that domestic violence is bad so that they grow up with an understanding of it	They drop out of school because of early marriages, poor background and lack of resources.	

	different learners from different cultures so it's unnecessary for the topic to be taught"	and that it can cause death or ending up in prison. Domestic violence must be combined because most domestic violence is the root cause for HIV and mostly violence leads to HIV and AIDS at the end of the day. Labia elongation mostly is do with cultures, some cultures do not believe in it. In addition some traditional powders zvinozoshandisiwa pakudhonza mwana (used in stretching children's labia) end up causing cervical cancer"	Children are also orphaned which leads to child-headed families. All this make children leave school out of poor family background and poverty and death of parents. Drugs also contribute to children leaving school early.	
ZTPP6	The current curriculum does not address any of the initiation rites issues at all. Most of those practising initiation usually do so in their own family groups/ church groups according to their respective cultural beliefs"	"HIV and domestic violence can be handled in a mixed class but as of initiation rites by its nature cannot be done like -wise because it is gender specific and at times may require practical demonstrations as it is done within the cultural and secret groups. If you attempt to do so in a mixed class there might be resistance, ie they may not take the lesson seriously and the boys especially will after the lesson mock the girls. Some of the learners especially girls who may have gone through the training in their home groups may feel bad and sometimes end up having a low self-esteem hence affecting their general learning pattern	School especially in Zimbabwe has proved not relevant whatsoever, so children have lost faith in it, they consider it a waste of time and family resources. So they leave and some settle for anything that can give them money faster like gold panning, marriage, prostitution and they are blind to the consequences. Children also drop out of school because their role models, their teachers are now so poor that it makes no sense to listen to them	
ZTPP7		I don't see any sense in implementing Knowledge about labia elongation in schools because these are cultural initiatives which may not seem necessary in other family cultural backgrounds. On domestic violence, it can be integrated in the school curriculum. It will help to emotionally establish those students who come from backgrounds that are characterized by violence.	young people normally drop out of school because of unwanted pregnancies which are mainly caused by poverty, in trying to get financial solutions they end up falling in love with gold panners etc and fall prey to sexual abuse and therefore become impregnated by people who never sought to marry them	To eas could b could b help if engage that th person
ZTPP8		There is need to educate children on domestic violence and HIV so that they are equipped for adulthood. About labia elongation that must be left to cultural beliefs. A lot of people do not regard this as important nowadays	financial constraints, lack of motivation because of unemployment, early marriages, religious beliefs especially the apostolic sect	
ZDPPP8				These ki because enough t decisions house it not prob the end to fit in t their pee are going want to that nice nice dres phone. S vulnerab

				it. That i these gi with the being vu HIV infe the youn girls. It's

Nurses Cohort Data Table

	HIV, LE, DV Link recognition	Linking health messages around HCPs	HIV risk & social norms	Is HIV transmission gendered?	Challenges in accessing HIV treatment
			,		
ZNPP2			In most cases women do not have control over sexual intercourse hence they do not have power to deny their husbands sex as a result their chances of getting the infection increase... Even if they want say maybe to use protection during sex most men will not agree		
ZNPP1	Yes, a big one because labia elongation is done just to please men and one has to continue doing the elongation and sometimes therefore bruises caused by the *muti* (herbs) thus causing HIV transmission through the bruises	there is a big linkage that more education is needed in our communities to both male and females. In schools also to teach our growing boys and girls advantages and disadvantages.	Women are weaker vessels in our culture, they are not allowed to ask for sex, they are forced to have sex even if they don't give the consent. All this is taught by aunts when a girl is growing up to submit and never say no to sex even if one suspects male partner is cheating or has a disease i.e. HIV or any STI. No condom negotiation is allowed with a woman. It's the male partner who decides when, how, where to have sex with the woman partner.	More women are exposed to HIV because of African cultural beliefs that women are sex objects	Most women in the rural areas walk a long distance to access treatment. If one is found to be HIV positive she is chased away. There is need for more clinics to be built in the rural areas, more campaigns on the disease also gender based violence
ZOGPP2	Labia elongation, FGM, HIV all these define domestic violence rather different forms of domestic violence as defined by the domestic violence Act in Zimbabwe. it also gives rise to especially FGM-elongation, it attracts a lot of men it also attracts a lot money for the young girls who have gone through the process and also pre-exposes them to HIV as they		as the key contributor to violence against women and girls it is mainly rooted in culture, and cultural practices, we live in a patriarchal society, which defines the power imbalances between men and women. girls are more vulnerable to abuse, vulnerable to even HIV because they can't negotiate for safer sex. Usually, they are involved with people, or with men older than them, and	in dealing with issues of HIV prevention, even HIV services uptake, even issues around pregnancy we need the support of men, you know, whenever we talk about going to the prenatal or postnatal, a man needs to be there because he is the father he also needs to make decisions	

	engage especially with very many sexual partners as it were so that's somehow the link. But I wouldn't say there's a direct link really between HIV in the literal sense of it. And FGM I haven't I heard so much around that yet maybe its an unexplored area because FGM is not very common in Zimbabwe. I know it's common in West Africa and some other places, but I know that labia elongation is a very common practice here so FGM has not been explored enough in Zimbabwe		its usually a relationship which is tilted in power imbalance, which mean men have more power over the girls, because of economics, But it's mainly because the girl child is predominantly viewed as inferior, and in a way she doesn't have so much power to negotiate, she can't determine when to have sex and how to have sex or with whom to have sex woman with protection or no protection there is a gender dimension to it there's also some sexual undertones its said its done to please men and older women are encouraging that to these younger women so that they can stay in marriage. They say that's the recipe to stay in marriage. Of course, it's an abuse, but it's also in a way still endorsed as a cultural rite that is necessary to sustaining marriages.	in terms of gender dynamics, and issues of lobola. Men need to continuously be involved in order to even out the skills in terms of how interactions in the flow of information within the home, is also framed.	
ZOGPP1	Training young girls in labia elongation to me is pushing them into early sexual debut of which most of this training is not accompanied with realistic life lessons such as the importance of condom use, HIV or STI testing before the intercourse of which these are very necessary. Teenagers may rush into early sexual debut without adequate information to protect themselves from HIV. Because initiation rituals such as labia elongation are centred on grooming females to please males rather than grooming them for		Women and girls are socialised to believe that they have lower social, intellectual, physical and political power to effect change in their relationships with men. I have heard of phrases such as "…A man whether he has married you or not is your king, your leader, he knows better, you cannot object to his viewpoints in public or even in private lest you bruise his ego or he goes off to find a woman who will not embarrass him, or who listens to him and recognises his position as a leader over the woman. Women are socialised to bend to a man's	A woman who endures abuse from an intimate partner has a high likelihood of being infected with HIV, my view is if she cannot stand up for herself and leave the abusive relationship whether it is emotional or economic, physical or sexual she sure will not be able to advocate for condom use, safe sexual practices or even be able to deny the partner sexual intercourse maybe when she	

	high self- esteem and putting their needs and health concerns first, there is a high likelihood that a girl who enters these rituals early on in life will lead her life thinking that she becomes a real woman by learning the art of man pleasing, changing/ modifying her body, beliefs maybe in order to keep a man. Such a girl and later on a woman would do anything even risky sexual behaviour no condom use/ no prior HIV testing, etc.) In order to keep a man because it has already been hammered into her from an early stage in life that her very existence is to ensure man's pleasure.		will even if it is destructive to her or to the society at large, a man knows better. Growing up with such social viewpoints women and girls then ensure that their behaviour fits into this narrow framework. Women and girls are socialised to believe that they are created in order to serve men's needs and aspirations, "a female person in a sexual relationship with a male can find it hard to negotiate for safe sex because they have to fit into society's framework of what a good woman is, a woman who does not question, who does not dominate much and who is not too argumentative and as such they have to continue having unprotected sex with man/ husband/ boyfriend who is evidently unfaithful to them, maybe sick with clear signs of sexually transmitted infections in order to maintain the marital status.	suspects infidelity or wilful transmission of HIV to her, etc.	
SAOGPP2			What I witnessed in my 40 years in Venda is that people are socialised under the patriarchal system that literary from birth the girl child has self esteem bred out of her she doesn't seem to make any decisions, no choices, everything is decided for her. The minute they can walk they are carrying their baby brother on the back they are doing all the household chores the boys don't have to do anything the girls have even to wash the boys' nappies. To me it's an indoctrination that means they cannot say no"		

			With the HIV infection it's trying to get men to wear a condom which they just won't and female condoms have never been properly marketed in our area, never. You have no bodily integrity everything belongs to someone else" (SAOGPP2). "One thing which we learned with HIV infection from some of our dialogues is that men still practice polygamy and according to men he doesn't need to get tested because his wives get tested its part of ignorance and part of the arrogance"		
SAOGPP1	"There is a link, with the issue of poverty you find most people even if they report violence to the police they cannot leave a relationship because the man is the provider so a case opens today tomorrow is closed because they have to rely on the partner so in a way people become more exposed to GBV and HIV. Here it is the culture that men have power		"They are still doing genital mutilation here, with the initiation schools they are very strict and I doubt if they will allow education to be part of it for instances they have big campaigns about medical circumcision I have seen some people also taking children to the doctors which is a positive development" "They have their own way of doing it with the women to do the genital mutilation especially after giving birth they do that in Venda. If a women has given birth vaginally she has to be cut each time she gives birth, it is traumatic. They also cut you even when you give birth through c-section but they shouldn't.		"It is that general knowledge but at the same time you find that when they visit a clinic it is the attitude of the nurses but otherwise especially here we are in the rural settings and a lack of knowledge and how accessible are the contraceptives we have only two clinics but in some places you do not find clinics in the townships you will find that also influences also the issue of access-information is key" These are remote areas and we are not exposed to that important information.