CHAPTER 2: A Review on Strategies for Educating Community Members on the Prevention and Control of Domestic Violence

Literature review is an integrated summary of all available literature relevant to a particular research question (Bless *et al.*, 2013: 392). During literature review the study will acquire knowledge of current theory and research in the field through the process of reviewing the existing literature on the subject matter. The necessary variables will be identified and both the conceptual and the operational definitions will be developed. The study will then formulate testable hypotheses in relation to the stated research questions (Bless *et al.*, 2013: 20). Literature review helps the study to learn first-hand information about what has been studied on a specific question and thereby increase understanding of the concept under investigation by asking more relevant questions (Bless *et al.*, 2013:21). A survey of the literature for this study is aimed at developing strategies for educating communities within an African Context on the prevention and control of domestic violence affecting married women in Zimbabwe. The study rose out of concern that given the availability of the constitution that protects the rights of women, married women are still violated. There is a broad literature available on studies that have been carried out on domestic violence among married women that it is on the increase but it is under reported as a global epidemic having health, educational, legal, economic and above all human rights implications (WHO; 1996:4, Madhivanan *et al.*, 2014:169-170; Matinson, 2014; Para *et al.*, 2014:122-123; Tanvir *et al.* , 2014;Chin *et al.*, 2009:1134; Stephenson *et al.*, 2013; Feseha *et al.*, 2012:1; Rahman *et al.*, 2011:1).

The importance of literature review was noted by Kim (2013), as not only to survey what other researchers have done in the past pertaining

to the subject of interest but to appraise, encapsulate, compare, contrast, and correlate various scholarly books, research articles, and relevant sources directly related to the current study. Domestic violence among married women needs to be recognised and addressed to decrease the suffering of women. In this study domestic violence was reviewed as a concept, occurrence of domestic violence in Zimbabwe, effects of domestic violence, Zimbabwean culture on domestic violence, the conceptual model, the roles of community members in the prevention and control of domestic violence, the experiences of married women about domestic violence and strategies for educating community members on the prevention and control of domestic violence.

According to Sebastian & Lorenzetti (2015:7), domestic violence is a barrier to building healthy families and safe communities. It can include emotional, verbal, physical, sexual, financial and spiritual forms of abuse and neglect. This can impact women, children, men, seniors, parents, extended family members, and others who share relationships of trust upon one another in and various ways. In addition, domestic violence can be viewed as follows:

- A personal issue: It affects the lives of everyone involved, the victim, the offender and the witness as they feel helpless to stop it.
- A family issue: It affects the well-being of every member of the family – parents, children, grandparents, uncles and aunts as it takes the joy and happiness out of the household.
- A social issue: It can be a learned behaviour that is passed along to the next generation. Society pays a high cost for domestic violence including social and economic costs.
- A public health issue: It can rob people of their senses of mental health and well-being and creates additional burdens on healthcare system and other systems and services in our communities.

Domestic violence is the infliction of physical pain or injury with the intent to cause harm which may include pushing, shoving, biting, slapping, punching, kicking, hair pulling, chocking, burning, arm twisting, fracturing or even strangling through physical aggression (Bibi *et al.*, 2014:123; Rahman *et al.*, 2014:2).

Mashiri (2013:95) indicated that domestic violence is regarded as a major problem and has been approached from three different perspectives sequentially namely:

- The criminal justice perspective that has been primarily adopted initially in the early stages of examining domestic violence.
- The health and societal perspectives that was approached from the consequences of domestic violence.
- The universal human rights violation perspective that was viewed as a phenomenon that deprives women of their universal rights to enjoy their freedom, security and the right to equal opportunity and personal development. Furthermore, the human right perspective on domestic violence has a very important implication as it has an obligation to protect women.

In addition, according to Mashiri (2013:94) domestic violence is regarded as being rooted in the historically unequal power relations between men and women. The reality is that domestic violence against women and girls is the result of imbalance between women and men. The violence against women is tied to the history of women being viewed as property and a gender role assigned to them to be subservient to men. Male tacit supremacy over women has historical extractions and its functions and manifestations over time.

Amongst the historical power relations responsible for domestic violence against women are the economic and social forces that exploit female labour and the female body (Mashiri, 2013:94). He also revealed that because of unequal power dynamics women have been placed into a subordinate position, where the male sex dominates over the

female sex. In turn, this deprives women from realizing their full potentials and opportunities for personal development.

In a different perspective (Mashiri, 2013:95) pointed that domestic violence encompasses a wide range of abuses that range from sexual threats, exploitation, humiliation, assaults, molestation, physical abuse, incest, involuntary prostitution, torture, insertion of objects into genital openings to attempted rape. Female genital mutilation and other harmful traditional practises, including early marriage have substantially increased maternal morbidity and mortality.

According to Domestic Violence Act, 2006 (Chapter 5:16), the definition of domestic violence is any unlawful, act, omission or behaviour that results in death, or the indirect infliction of physical abuse, sexual abuse, emotional abuse, economic abuse, intimidation, harassment, stalking, malicious damage to property and abuse derived from negative cultural or customary rights such as forced virginity testing and forced wife inheritance. According to Oyediron & Isiugo–Abanihe (2005:1), domestic violence is a universal problem affecting millions of women worldwide every day.

Domestic violence is often used to dominate and maintain control over women within the context of intimate relationships (Clowes& Ratele, 2010:15; Nawaz *et al.*, 2008:74; Petersen, 1983:24). Because of domestic violence, marriage becomes "a long night winter, devoid of warmth and contentment according to Nkealah (2009: 36). As a result, marriage relationship becomes a terror & trauma instead of being characterised by love, harmony, security and happiness.

The concept of domestic violence incudes physical, sexual, emotional and economic abuse (Alelhie, 2011:63; Nawaz & Majeed, 2008:74; Takyi &Mann, 2006:61-62; Van Dyke, 2005:2; Manneta *et al.*, 2003:6; Yoshi, 2002:383).

Violence against women takes place in the home, on the streets, in schools, at work places, at farm areas and at refugee camps and it is perpetrated by persons in positions of power (Feseha *et al.*, 2012:2) According to Kaur *et al.* (2014:31), domestic violence is aggravated by social pressures, women's lack of access to legal information, lack of effective law and inadequate efforts by public authorities to promote awareness of existing laws.

Factors associated with domestic violence against married women were found to be independently associated with age, being younger than 18 years at the time of marriage and having a husband who drinks alcohol and smokes cigarettes (Madhvanan *et al.*, 2014:169–170). On a different view, Weitzman (2014:67) linked domestic violence with women who have more education and earning more than their spouses, or women who are sole earners in marriage as they threaten men's dominant status. Whereas, McCloskey *et al.* (2014:5) found that women with less education are more prone to abuse than their educated peers at a ratio of 1:7.

In Sub-Saharan Africa characteristics associated with domestic violence include having many children, having experienced sexual abuse during childhood and having less than eighth grade of education (McCloskey *et al.*, 2014: 2). Partner characteristics most predictive of domestic violence include lower educational attainment, alcohol abuse, multiple partners, illegal drug use and irregular or intermittent employment (Madhvanan *et al.*, 2014:170).

The common risk factors associated with domestic violence reported from United Kingdom, India and Uganda are drug addiction, extramarital relations, contraception, number of children, male-dominated society, household affairs, subordinate status, lack of knowledge, obeying husbands according to socio-cultural norms social isolation, and adolescent marriage (Bibi *et al.*, 2014:124). Unequal

power relations between women and men contribute substantially to spousal violence (USAID, 2009:2). All these issues should be taken in cognisance of when planning strategies for educating women about their constitutional rights regarding domestic violence. Domestic violence reflects and re-enforces differences between men and women (Zimbabwe Women Lawyers Association (ZWLA), 2011:1).

Domestic violence against married women is a global pandemic that is both a manifestation of gender inequality and discrimination of women. Through the acts of violence, abusers violate women's rights to bodily integrity, security of person, right to life, among other human rights. One of the priority areas by different stakeholders post 2015 development agenda focused on the creation of a world free from domestic violence (Made, 2015:85).

Domestic violence against married women is a worldwide concern. About one in four men admitted to have raped a woman, according to just one large study released by the British medical journal Lancet in September 2013. About one in 10 men admitted having raped a woman who was not their partner. The study was limited to six Asian nations: Bangladesh, China, Cambodia, Indonesia, Sri Lanka and Papua New Guinea.

“Domestic violence against married women is far more widespread in the general population than we thought," Rachel Jewkes of South Africa's Media Research Council that carried out the research on behalf of United Nations agencies, told the Associated Press. Perhaps even worse, more than 70% of the men surveyed who admitted have forced a woman to have sex said they did it out of a sense of "sexual entitlement."

Domestic violence is not an isolated phenomenon. The World Health Organisation (2013) estimated that more than a third of women in the

world have been victims of either physical or sexual violence, with low-income countries disproportionately affected (Alesina *et al*., 2016). The World Health Organisation (WHO) has reported estimates of 10% to 69% of women worldwide who continue to suffer from domestic violence (Bibi *et al*., 2014:123). However, on a different note, according to surveys conducted by Human Rights Watch, about 70% to 90% of married women have suffered from some form of violence (Bibi *et al*., 2014:123).

According to the World Health Organisation (WHO), domestic violence is a global problem affecting millions of women (Kimani, 2012:22). The World's Women, 2010 Trends and Statistics found that little has been done to prevent the problem of domestic violence against women. However, many researchers namely Matizha (2014:1); Zimbabwe Women's Lawyers Association (2011:4); Victorian Government (2012:5) have taken the issue seriously and are actively advocating for government and communities to address the problem before it becomes a crisis.

The world today is full of domestic violence against women that comes in many forms. Across the globe, one of the most common forms of domestic violence is physical abuse against women by their husbands or intimate partners. Domestic violence, that is both a social and a health problem, is pervasive and occurs across the world cutting across all divisions of class, race, religion, age, ethnicity, and geographical region (Reed, 2010:22; Yigzaw *et al*., 2010:39; Nawaz *et al*., 2008:74; Tracy, 2006:280; Manneta *et al*., 2003:6)

Domestic violence has been part of the fabric of many societies and cultures worldwide. It is a common place, in fact, that it has often gone unnoticed and failed to receive the level of concern it deserves considering the devastating effects it can have on children and families (Wolfe *et al*., 1999:133).

The 2014 Multiple Indicators Cluster Survey findings show that a higher proportion of women (37%) between the ages of 15 and 49, compared to 23.7% of men, believe that a man is justified in hitting or beating his wife in certain circumstances (Made, 2015: 9).

44% of married women in Kenya reported being beaten repeatedly by their husbands. Domestic violence affects more women than men in the United States of America, according to survey estimates where each year approximately 1.5 million women are physically abused compared to 834 700 men who are physically abused by an intimate partner (Bureau of Labour Statistics Department, 1996).

The impact of this global epidemic is far reaching. According to the World Bank, domestic violence accounts for as much death and ill-health in women aged 15-44 years as cancer does. Domestic violence is a greater cause of ill-health than malaria and road traffic accidents combined. The World Health Organisation (2005:1) has recognized that if domestic violence against women is not addressed effectively, many of the agreed global poverty eradication targets will be compromised.

Domestic violence is not only a human rights abuse, but it is also an economic drain. Research by the World Bank (1993:31) shows that domestic violence has significant impact on each country. Conservative estimates of lost productivity from domestic violence range from 1.2% in Brazil and Tanzania to 2% in Chile. Despite international agreements to address domestic violence, there are still many countries where it is not yet considered a crime. This is significant because when governments fail to implement laws and policies to stop domestic violence against women, it continues and its root causes in everyday discrimination are strengthened (Spreshmann *et al.*, 2013:9).

Married women continue to experience high levels of physical and sexual violence. Physical abuse is a hidden burden in Zimbabwe as it is not discussed in the home by family members or reported to the police station as it is regarded as taboo (Matizha, 2014:1). Figures of physical abuse are disheartening despite numerous efforts of enactment of laws to protect women, gender-based violence by government of Zimbabwe and development partners, it has remained a major challenge in Zimbabwe (Matizha, 2014:1; Zimbabwe Women Lawyers Association, 2011:2).

Domestic violence has increased steadily from 1 940 in 2008 to 10 351 cases in 2013 in Zimbabwe. Women (70%) in Zimbabwe scored the government slightly higher than men did (67%) in the citizen's ranking on domestic violence. Married women continue to experience high levels of physical and sexual violence. Domestic violence remains one of the most pervasive women's rights violations and perpetrators use it to keep women in subordinate roles. All forms of domestic violence negatively affect the political, economic and social empowerment of women and girls (Made, 2015:81).

The highest number of cases 56% was recorded in Mashonaland Central Province, while Mashonaland West Province had 47%, Harare had 42%, Matabeleland South had 39%, Bulawayo 29% and Matabeleland North Province had the lowest 17% of recorded cases. In the year 2010, 17% of married women experienced domestic violence by an intimate partner (Zimbabwe Central Statistical Office, 2010:1; Musasa Project Annual Report, 2010:1; Zimbabwe Demographic and Health Survey, 2010:1).

Musasa Project conducted a survey in Midlands Province to obtain the accurate figures on the extent of domestic violence against women and found out that in 1996 60% of women were physically abused. In 1997,

48% of women were physically abused. In 1998, 50% of women were physically abused and in 1999, 62% of women were physically abused. Physical abuse against women ranked fourth among the different forms of abuse in Midlands Province, and almost one in three women have reported being physically abused since the age of 16 (Musasa Project Annual Report Zimbabwe, 2000).

According to the National Police Annual Report for the year 1999 in Zimbabwe, 9512 women reported being physically abused in Zimbabwe (Police Annual Report 1999). Physical abuse affects more women than men, in a ratio of about 3 to 1 (Musasa Project Report Zimbabwe, 1996; National Police Annual Report Zimbabwe, 2000). According to statics, a woman is battered every 15 seconds in Zimbabwe (Meierehoffer, 1992). Compared to non-abused women, abused women are 5 times more likely to attempt suicide, 15 times more likely to abuse alcohol and 9 times more likely to abuse drugs (Bean, 1992). There are many cases of women who are admitted in hospitals, but they never reveal that it's due to physical abuse (Musasa Project Report Zimbabwe, 2000). The relatives or health personnel sometimes do not have enough time to find out the real cause.

In Zimbabwe the actual scene of death to physical abuse against women is that most of the victims died at their homestead that is 53%, while 12.9% died in hospital and 30% died in other places, such as bushes, or being drowned in a dam or killed somewhere and put under a bridge. Some victims were found by the roadside or hanging in a tree (Musasa Project Annual Report Zimbabwe, 1999-2000). South African Organisations conducted a survey and found out that 1 in 6 women was regularly assaulted by her partner. 60% of South African women were found to be regularly being battered by their boyfriends or husbands (Wits University, 1994).

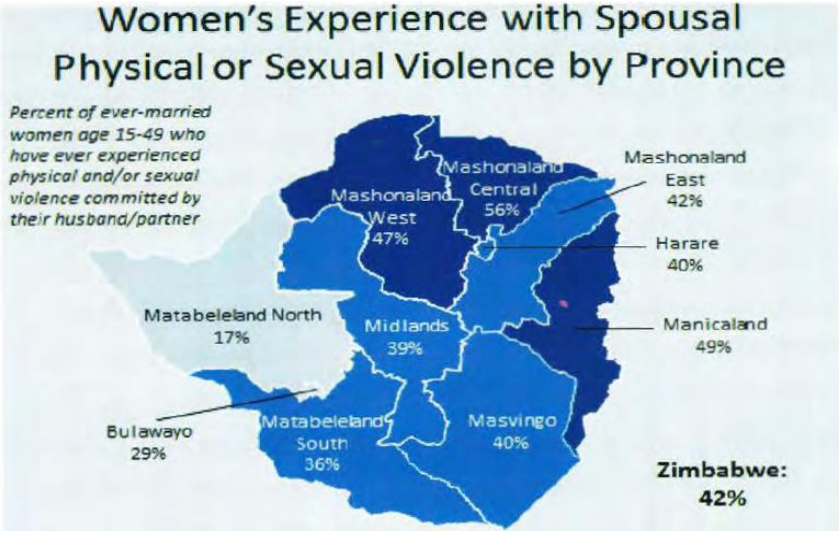


Figure 1: Adopted from UN Country Analysis Report for Zimbabwe, 2010.

The above figure illustrates the prevalence of domestic violence which ranges from 17% in Matabeleland North Province to 56% in Mashonaland Central. 42% of women in Zimbabwe have experienced physical, emotional or sexual violence (or both) at some point in their lives. (UN Country Analysis Report for Zimbabwe, 2010).

In Zimbabwe domestic violence is seen particularly as a human rights violation because of the physiological make up and gender roles performed. In addition, women are the more affected than men (Zimbabwe Women Lawyers Association (ZWLA), 2011:1).

Sources report that domestic violence is an issue of on-going concern in Zimbabwe (United States (US), 2010; Sec. 6 Freedom House, 2010; Musasa Project, 2009:1). According to Zimbabwe/Macro International (2007:259), 4,658 married or previously married women experienced a form of physical, social or emotional violence by their husband or partner. Among Zimbabwean women between 15 and 49 years, 41.1%

have experienced a form of physical violence, sexual or emotional violence by their husband or partner. Specifically, 27.3% have experienced emotional violence, 29.5% have experienced physical and sexual violence, 18.9% have experienced sexual violence, 10.2% have experienced physical and sexual violence and 38.2% have experienced physical or sexual and sexual violence (*ibid:* 260).

Country Reports (2009) state that domestic violence is underreported because it is viewed as a 'private matter' and perpetrators are only arrested when there is physical evidence of assault (US, 2010:2). Sources report that gender-based violence in Zimbabwe often goes unreported (US, 2012:2; IOM, 2009:2). According to Musasa Project (2009:1) 1 in 3 women in Zimbabwe were in abusive marriages. Musasa Project also expresses concern at the increase in cases of sexual abuse perpetrated by caregivers, guardians, teachers and policemen (*ibid*: 2) Over 60% of murder cases in Zimbabwe were linked to domestic violence (UN, 2007:1).

Despite significant attention given to domestic violence, it continues to be a massive problem with enormous individual and societal consequences (Townsend, 2008:41; Tracy, 2007:74; Okereke, 2006:4; Van Dyke, 2005:2).

The effects of domestic violence on women go beyond the immediate physical-injuries, they suffer at the hands of their abusers. Frequently, domestic violence victims suffer from an array of psychosomatic illnesses like eating disorders, insomnia, and devastating mental-health problems like post-traumatic stress disorder (PTSD) (Croft, 2017). According to Nealon-Wood (2016), domestic violence causes mental effects such as post-traumatic stress disorder, depression, and anxiety and these are common among victims. Mental health is an important foundation for the attainment of emotional, intellectual, economic, social and educational well-being. Accordingly, mental disorders are an important contributor to the worldwide burden of disease (WHO, 2001). The VAW Baseline Studies established that experience of domestic violence is significantly associated with mental health problems such as depression and suicidal tendencies (Made, 2015:87).

Hasan *et al.* (2014:3) reports that women experiencing domestic violence are more likely to suffer from depression, sleeping problems, and attempting suicide.

Evidence suggests that women who are abused by their partners suffer from high levels of depression, anxiety and phobias than non-abused women. In the WHO multi-country study, reports of emotional distress, thoughts of suicide, and attempted suicide were significantly high among women who had experienced physical or sexual violence than those who had not been abused. In addition, alcohol and drug abuse, eating and sleep disorders, physical inactivity, poor self-esteem, post-traumatic stress disorder, smoking, self-harm, and unsafe sexual behaviour has also been linked to effects of domestic violence (WHO, 2012:5-6).

Many abused women find it difficult to function in their daily lives because of the effects of domestic violence. Absences from work, due to injuries or visits to the hospital, often cause them to lose their jobs, making them unable to leave their abusive situations. They may feel ashamed that their partners abuse them, see themselves as unworthy of love, and suffer from a significantly diminished self-perception because of their feelings of low self-worth, these women become isolated from friends and family and do not participate in social activities common to others in their demographic (Croft, 2017). There are other complex and serious issues that arise because of domestic violence against women, such as facing humiliation and restrictions in the family (Kaur *et al.*, 2014:33). On a different view Nonell (2013:127) supported by Victorian Government (2012:2) victims of violence often feel completely isolated, unable to reach out for support, unable to receive support they need, are stopped from going to work and from participating in the community and belittled by their partners. According to Victorian Government (2012:27) domestic violence affects women's personal wellbeing, disrupts families and community relationships. Victims also suffer from a diverse set of factors, including demographic, socio-economic, cultural disability and death in many countries (Feseha *et al.*, 2012:2).

Meyer (2011:11) observed that women experiencing domestic violence face discrimination and lack of support by the police combined with the fear of retributive victimization by the intimate partner and dissatisfying outcomes. Meyer (2011:11) further states that many victims felt that they were not taken seriously because of not terminating the relationships permanently as one victim spent 11 years with her abusive partner before and after the implementation of domestic violence.

In addition, women continue to suffer due to socio–cultural norms, misinterpretation of religious beliefs, subordinate status and economic dependence. This rising burden is partly exacerbated by lack of knowledge and familiarity with legal systems such as police and judiciary and social isolation as well as fear of the abuser. This places women at risk of being abused by their partners (Bibi *et al.,* 2014:124).

A significant majority of domestic violence victims are at a high risk of suffering from heart diseases and asthma (Nealon-Wood, 2016). According to Rahman *et al.* (2014: 1), domestic violence is linked to adverse reproductive health outcomes such as miscarriages, premature delivery and pelvic inflammatory disease. Madhivanon *et al.* (2014: 170) states that domestic violence has been linked to serious physical injuries, homicides, unwanted pregnancies, miscarriages, induced abortions and vulnerability to HIV and other sexually transmitted infections. On a different view, domestic violence is also associated with an increased risk of adverse mental health outcomes, Winter & Hindin (2013:1133).

The World Health Organisation have identified that for all women aged 15–44, violence against women is the greatest cause of female injury and illness on a global scale (Cornwall, 2016:2). In addition, the impact of domestic violence is costly not only to the victim in terms of the personal, physical and emotional cost but also to the economy, with increased costs for health services, the criminal justice system, housing, safeguarding and social care costs and the lost economic productivity (Cornwall, 2016:2).

Domestic violence against women is an important public health concern owing to its substantial consequences for women's physical, mental and reproductive health problems (Feseha *et al.*, 2012:1). It's the most cause of morbidity and mortality. The most common of violence against women are physical, sexual and emotional abuse by husband or intimate partner. In addition, the effects of Intimate Partner Violence (IPV) include physical injuries such as bruises, broken bones and death. It is also linked to adverse reproductive health outcomes such as miscarriages, premature delivery and pelvic inflammatory diseases and it cuts across all national boarders, race, class, ethnic and religious lines and educational levels (Rahman *et al.*, 2011:1-2).From the review the study ascertained that domestic violence is not just a social issue but has health implications with some of them having a lasting effect on women.

According to Duran et al;2009:1135, Stephenson *et al.* 2013, the range of mental health outcomes associated with domestic violence includes depression, sleep problems, anxiety, mental distress, post-traumatic stress disorder (PTSD), and suicidal thoughts.

According to Feseha *et al.* (2012: 4-5), domestic violence was found to have health related consequences on women, such as facing difficulties with activities of daily living, pain, fractures, dislocations and psychological disturbances. In addition, pregnant women were also found to be victims of domestic violence.

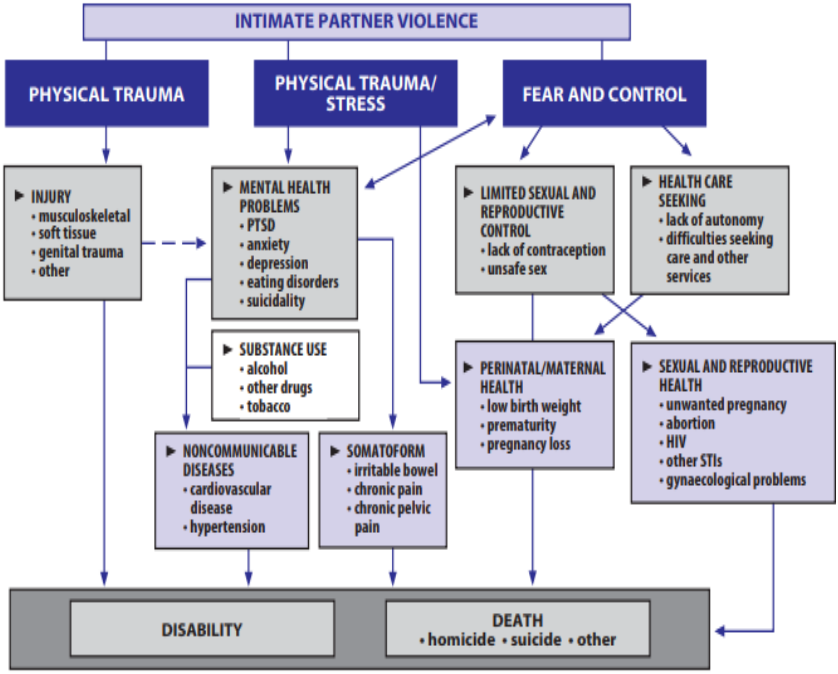
The physical damage resulting from domestic violence can include bruises and welts; lacerations and abrasions; abdominal or thoracic injuries; fractures and broken bones or teeth; sight and hearing damage; head injuries; attempted strangulation; and back and neck injuries (WHO, 2012:5). Domestic violence may lead to a host of negative sexual and reproductive health consequences for women, including unintended and unwanted pregnancy, abortion and unsafe abortion, sexually transmitted infections including Human immune Virus (HIV), pregnancy complications, pelvic inflammatory disease, urinary tract infections and sexual dysfunction. Domestic violence can

have a direct effect on women's sexual and reproductive health, such as sexually transmitted infections through forced sexual intercourse within marriage, or through indirect pathways, for example, by making it difficult for women to negotiate contraceptive or condom use with their partner (WHO, 2012:6).

Domestic violence is recognized not only as a pervasive human right violation but also as an increasingly important public health problem with substantial consequences for women's physical, mental, sexual and reproductive health (Rahman *et al.,* 2011:1).

While Madhvanan *et al.* (2014 :169–170) argues that domestic violence against married women has been linked to homicide, unwanted pregnancies, miscarriages, induced abortions, vulnerability to HIV and Sexually Transmitted Infections (STIs) and serious physical injuries. Domestic violence compromises the health, dignity, security and autonomy of victims. In addition, it serves to perpetuate male power and control and is sustained by a culture of silence and denial of the seriousness of health and social consequences of abuse (Zimbabwe Women Lawyers Association, 2011:1). According to World Health Organisation (in Cornwall, 2016:3), women experiencing violence suffer from injuries and illnesses on a global scale.

Exposure to violence against women (VAW) significantly increases other health risk factors for survivors, including increased likelihood of early sexual debut, forced sex, transactional sex and unprotected sex (Population Council, 2008). Domestic violence against women increases women's risk of adverse health effects. Globally the range and magnitude of violence against women (VAW) has tremendous negative impact for both individuals and society. Research has documented the consequences of VAW within various settings; these include increased rates of injuries, morbidity, mortality, sexually transmitted diseases including HIV, and health risks associated with unwanted pregnancies (Krug *et al.,* 2002; Terry & Hoare, 2007).



Source: WHO (2013) Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence.

Figure 2

According to Jones & Horan (1997) and Bohn & Holz (1996), victims of domestic violence experience many physical injuries (lacerations, bruises, broken bones, head injuries, internal bleeding), chronic pelvic pain, abdominal and gastrointestinal complaints, frequent virginal and urinary tract infections, sexual transmitted diseases, and Human Immune Virus (HIV). Pregnancy-related problems are also experienced by victims. Poor weight gain, pre-term labour, miscarriage, low infant birth weight, and injury to or death of the foetus is some of the risks that women who are battered during pregnancy face.

Battering by men is the most significant cause of injury to women in society and a major cause of child abuse, murder, substance abuse and female suicidal attempts. Women who have experienced domestic violence are more likely to report a disability due to a generalised chronic pain and mental illness compared to those who never experienced domestic violence. Women who have experienced domestic violence are more likely to report a disability due to a generalised chronic pain and mental illness compared to those who never experienced domestic violence.

As women grow older they seem to be affected by medical difficulties caused by injuries sustained by domestic violence. Arthritis, hypertension and heart diseases have been identified by battered women as directly caused by aggravated domestic violence early in their adult lives. Medical disorders such as diabetes or hypertension may be aggravated in victims of domestic violence because the abuser may not allow them access to medication or adequate medical care (Perrone, 1992).

According to Worth (1989:27), domestic violence can increase a woman's risk by limiting her willingness or ability to get her partner to use a condom; therefore, she will not be able to protect herself from HIV and other sexually transmitted infections (STIs). Domestic violence may also be responsible for a sizable but unrecognized share of maternal mortality, especially among young unwed pregnant women (Ugalde, 1988:25).

Arthritis, hypertension and heart disease have been identified by battered women as directly caused or aggravated by domestic violence suffered early in their adult lives (Browne *et al.*, 1987). The effects of domestic violence vary in terms of physical health effects, victims are known to suffer physical and mental problems because of domestic

violence. Battering is the single major cause of injury to women, more significant than auto accidents, rapes, or muggings (O'Reilly, 1983).

Domestic violence costs more than $5 billion in medical and mental health care each year, and an estimated 8 million days of paid work are lost annually because of domestic violence (Nealon-Wood, 2016). The issue of family violence emerged as a key community priority. Every level of the community, including leaders, residents, members of media and businesses stepped up to initiate discussions, explore biases, question beliefs about healthy relations, and most importantly, challenge each other to speak out and act (Sebastian & Lorenzetti, 2015).

Alesina et al. (2015) found that economic factors influence current spousal violence in 18 sub-Saharan African countries. The study found that the economic value of women affects men's violence against them. Socio-economic arrangements made women economically valuable and this led to women being viewed as productive, more equal to men, and these gender roles bring about less intra-family violence today.
However, additional and subtle factors come into play. An economically more independent woman may have more bargaining power within the marriage, which may lead to a negative reaction of men and ultimately to an increase as opposed to a decrease in violence. Indeed, when considering contemporaneous correlates of intimate partner violence. The study found that if women currently work, spousal violence against them is high (Alesina *et al.,* 2015).

Interestingly, Bertrand *et al.* (2014) show that even in advanced societies, intra-marital difficulties jump up discretely when the wife earns more than the husband. That is, when the wife 'surpasses' the man in terms of earning ability, there is a discrete negative psychological reaction of the man against the woman, holding everything else constant.

Mashiri (2013:95), found that domestic violence has substantial costs to society in terms of medical care of domestic violence victims and prosecution of the perpetrator of domestic violence. There is also reduced labour productivity of abused married women and lost man hours. All this negatively affects society development.

It is estimated that each year in Canada domestic violence results in $487 million in lost wages, costs the criminal justice system $872 million, costs the health care system $408 million, and results in increased social service costs of $2.3 billion. In total, the economic impact of domestic violence is approximately $6.9 billion a year (Berman *et al.*, 2011).

Women reporting domestic violence are usually lower in socio–economic status, lower educational attainment and lack of remunerated occupation (Madhvanan *et al.*, 2014:170). Vanda (2008:59) reports that economic abuse may consist of the unreasonable withholding of economic or financial resources from a complainant who is legally entitled to or which the complainant requires of necessity, including the withholding of necessities or refusal to pay mortgage or rent in the context of shared residence (Vanda, 2008:59).

In general women in Beleluane are economically dependent on their husbands and believe that should they divorce their husbands they will not be able to survive without them because they will not have any income. Economic factors highly contribute to the increase in domestic violence. In most cases divorce is a remote option for most women. They would rather endure the abuse than face the prospect of lack of income and other basic needs for survival required for sustaining themselves.

Poverty plays a great role for the permanence of domestic violence in relationships. Men leave their wives with no money for them to sustain

the house and if they question this they are usually assaulted (Vanda, 2008:59).

Domestic violence, through its effects on a woman's ability to act in the world, can serve as a brake on socio–economic development. Women cannot come up with creative ideas fully when they are burdened with physical and psychological scars of abuse (Heise *et al.*, 1994:24). In addition, domestic violence can also lead to lower educational attainment and income levels for women and therefore limit their engagement in the world. Violence against women can also hinder the development of the wider community development projects (Heise *et al.*, 1994:24).

Domestic violence against women diverts scarce resources to the treatment of a largely preventable social illness (Koss & Woodruff, 1991:22).

Alesina *et al.* (2015:1) investigated how cultural factors influence current spousal violence, for example, having had bride price in the past is associated with a significant decrease in the probability and intensity of spousal violence. This suggests that if men traditionally had to pay for marrying their wives, they attributed a greater value to them and cared more about them. Interestingly, in line with this argument, the effect of low actual violence seems to be driven by low acceptance of wife beating on the part of the man. In addition, the study found that being from an ethnicity that was traditionally endogamous (i.e. where members marry within the same ethnic group) has a positive and significant impact on spousal violence episodes, even when societies evolve. This may reflect less 'modern' cultural values of ethnicities which practiced endogamy in the past, or the possibility that beating a wife from a different ethnic group may bring about retaliation across ethnicities.

According to Mashiri (2013:95), violence against married women is the result of an imbalance of power between men and women. The African culture of Zimbabwe views violence against women as being tied to the history of women being seen as property and a gender role assigned to them to be subservient to men (The 2010 Gender-based violence forum). Thus, women's experiences and perceptions of domestic violence are influenced by their social position in both religion and culture. It should be borne in mind that in most cases it is difficult to distinguish between African religious and cultural aspects, given that religion pervades all aspects of life. Religion is also a cultural aspect that directs the culture of the African people.

Domestic violence arises from social, cultural and religious practices that subordinate women. It thrives in communities where violence is acceptable as a form of conflict resolution. It is facilitated by patriarchal (male controlled) social hierarchies, acceptance of violence as a mode of social interaction and political interface, by socio-economic inequality and a break down in norms and social structures (ZWLA, 2011:1). In addition, cultural and traditional practices have perpetuated the subservient position of women, making them more vulnerable. Patriarchal socialization portrays women as minors who can be punished by their fathers, brothers and husbands.

According to Multiple Indicator Monitoring Survey (2009), cultural beliefs in Zimbabwe are still strongly linked to domestic violence despite having the Domestic Violence Act in place. In addition, most rural women are over reliant on their husbands for survival and end up submitting themselves to go through beatings over petty issues like burning a pot of *sadza.* Cultural beliefs and total submission has resulted in women accepting whatever their husband does to discipline them.

Domestic violence has its foundation in culture and tradition. First, women are taught

from an early age that they must submit to men. Sons and daughters adopt the social roles and behaviour of their parents, with the results that violence against women is often intergenerational. Religious edicts or customs prescribe and legitimise male violence against women. In other words, religious edicts or traditional customs advocate for male domination and women are expected to be submissive to their husbands. Violence is frequently used as a means of conflict resolution within the family and a means to silence women. Finally, African legal systems support the exercise of male power within the family.

Consequently, domestic violence is endemic and broadly viewed as a legitimate practice. According to the United Nations (UN) most countries in Africa do not have specific laws to address abuses within the family, and the police rarely respond positively to complaints of domestic violence (Vaida, 2008).

Shona marriage is by its very nature a patriarchal institution. Since the Shona society is hierarchical and patriarchal, the husband is the head of the family. All Shona men benefit from what Connell (1995:79) terms 'the patriarchal dividend' whereupon men in general gain from the overall subordination of women. This is apparent from the Shona terms for marriage. In the Shona culture the man marries (*kuroora*) and the woman gets married (*kuroorwa*). The two Shona terms in brackets imply acquiring and being acquired, respectively. As such, the man acquires and the woman is acquired; a notion that is reinforced by the husband's payment of *roora* or *lobola*. Male leadership and domination are traditional and taken for granted (Burn, 2005:263; Bourdillon, 1993:30; Hatendi, 1973:137).

This study was guided by Betty Neuman's systems model that has been used widely in nursing practice. Betty Neuman was born in 1924 and her model was developed in 1970 and her first theory was published in 1972, which is a model for teaching total person approach to patient's problems in nursing. The first edition on conceptual models for nursing practice was published in 1974 and 2nd edition was published in 1980. The model was last updated on 28/01/2012 and accessed on the 09/09/2013. The development of the Neuman's model was influenced by the philosophy writer deChardin. Refinement of the model concepts has continued over the past 20 years since its foundation (Current Nursing, 2012).

The Neuman's Systems Model is a unique, systems-based perspective that provides unifying focus for approaching a wide range of nursing concerns. The Neuman's Systems Model is a comprehensive guide for nursing practice, research, education, and administration that is open to creative implementation, has the potential for unifying various health-related theories, clarifying the relationships of variables in nursing care and role definitions at various levels of nursing practice (Current Nursing, 2012).

The structure of the model was originally designed for graduate students. It views a person as a complete system, the subparts of which are interrelated; physiological, psychological, sociocultural, spiritual, and developmental factors (Current Nursing, 2012). All the systems described in the framework are relevant in quality comprehensive care and support of violated women. Neuman's Systems Model according to Olin (2011), addresses the physiological factors that refer to the bodily structure and function. Psychological factors refer to mental processes, functioning and emotions. Sociocultural factors refer to relationships and social/cultural functions and activities. Developmental factors refer to life's developmental processes and spiritual factors refer to the influence of spiritual beliefs aspects of the

person as they interact with internal and external environmental stressors.

A system in this study will be composed of the client, the family, the community that provide support and the nurse who strengthens the family and community support. The study presented the model from the community's perspective. The central focus of the model was on the individual's relationship to stress and his or her reaction to stressors and reconstitution factors. A review of the literature reveals diverse applications for the use of the Neuman's Systems Model. The Neuman's System model has been used by various researchers to help them conceptualize and link the model to the problem (Louis & Koetoslyecy, 1989). The inter-personal environment being the client's relationship with her husband who had dementia and was difficult to manage at times, with her children living 100 miles away and not being available to assist her to care for her husband. Friends have stopped visiting. The nurses then planned on extending the inter-personal environment by identifying potential family resources such as church leaders in planning interventions. Health providers were also identified to interact effectively with the elderly.

Read (1982) adopted the Neuman's System Model for use in family psychosocial assessment. She used the model effectively to review and assess the family systematically and implemented interventions aimed at maintaining stability of the family.

Bowman (1982) adopted the Model successfully for use in childcare settings. Clemants & Roberts (1983) and Moore & Munro (1990), used the model effectively when assessing and managing aging families.

Neuman's Model has been used effectively by Knight (1990), who applied it to care for a patient with multiple sclerosis. In this case study the illness was multiple sclerosis, and the inter-personal environment

was identified as the relationship the client had with her fiancé. The inter-personal environment has been widened by nurses who intended getting the client to accept referral to the Multiple Sclerosis Society. The nurses also reinforced the client appropriate use of the nursing staff for emotional support and explorations of his feelings.

A study based on Neuman's System Model by Ziemer (1983), considered the effects of primary preventions by building the patience's lines of defence against the stressors of abdominal surgery. The stressor was the impending surgery and primary prevention was by providing different types of information for the patient, the effects of stressor on the lines of defence was the patient's reported behaviour, and the impact of the stressor was indicated by the presence of symptoms. Community support can be considered as primary, secondary or tertiary prevention by building on the client's lines of defence against domestic violence.

Story & Ross (1986) used Neuman's model effectively as the basis for their family centred community health nursing. Ross & Bourbonnais (1985) also used the Neuman's Model successfully for a case study of a patient with myocardial infarction. The interpersonal environment is the relationships of the family, friends, community, and caregivers with the client.

Smith (1990) utilized the case study approach with success in relation to the public health nursing. Lindel & Olsson (1990) explored how the Swedish midwife can practically use the Neuman's system model effectively by providing oral contraceptive counselling. In their case study, the interpersonal environment was identified as the relationship between the man and woman who are seeking the oral contraceptives and the nurse who provides counselling. In their case study, the interpersonal environment was identified as the relationship between the man and man who are seeking the oral contraceptives and the

nurse who provides counselling. The health component is the desire to remain healthy by preventing unwanted pregnancy.

Galtacher (1987), successfully used the Neuman's model to evaluate services for prevention and controlling of sexually transmitted disease in a male adolescent health centre. Haggard (1993) used the Neuman's systems model effectively in a study on critical analysis of Neuman's systems model in relation to public health nursing, using the concept of community as a client.

Public health views Neuman's model as an interactive process which is consistent with systems and all things are viewed as related. Reed (1993) used Neuman's systems model with success in family nursing where she describes the family as a client. The focus of the adaptation of the model was to identify family concepts that are compatible and comparable to the levels of defence and basic structure described by Neuman (Reed, 1983).

The systems theory which forms the basis of the Neuman's model is entirely consistent when working with the community as a client (Anderson & McFarlane, 1988). Betty Neuman's system model may represent an individual or group of clients, the community, family or an organisation (Mayer & Watson, 1982).

The multidimensionality and holistic systemic perspective of the Neuman's Systems Model is increasingly demonstrating its relevance and reliability in a wide variety of clinical and educational settings throughout the world (Neuman's systems model, 2002). Neuman's model provides a comprehensive flexible holistic and system-based perspective in nursing (Current Nursing, 2012).

Betty Neuman's Systems Model (1995) provides a theoretical framework for this study. Neuman's Systems Model as elaborated by

Current Nursing (2012)), the model focused on the response of the client system to actual or potential environmental stressors. Neuman (1995), in Current Nursing, viewed the client as an open system consisting of a basic structure, made up of the five variable areas namely physiological, psychological, sociocultural, spiritual and developmental. Stressors are defined as any environmental force which can potentially affect the stability of the system producing either negative or positive effect on the client system (Neuman, 1995 in Current Nursing, 2012).

The use of several levels of nursing prevention intervention for attaining, retaining and maintaining optimal client system wellness is advised. Nursing action according to Current Nursing (2012), focused on the variables affecting the client's response to stressors on the primary, secondary and tertiary levels of disease prevention. Neuman (2011) defined the concern of nursing as preventing stress invasion. If stress is not prevented, then the nurse should protect the client's basic structure to obtain or maintain a maximum level of wellness.

Neuman (1995) as elaborated by Current Nursing (2012) views the client as an open system composed of a core and surrounded by protective rings. The core is the person's basic survival factors. Examples of these core factors include the ability to regulate body temperature, genetic structure and organ strength or weakness.

According to Neuman (1995), as elaborated by Torres (2010), an adaptation level of health for a person is developed over time.

Neuman's Systems Model is described by Olin (2011), as assisting in identifying mechanisms that protect the individual's stability when faced with a stressor and it allows for a simple classification of the severity of a problem. The flexible line of defence is a cushioning mechanism that protects the normal line of defence from penetration

by stressors. The Model is concerned with stressors, which may disrupt stability of the system.

The stressor was identified as a possible risk to the body's flexible and normal lines of defence (Olin, 2011). In addition, the individual's degree of reaction to the stressor is dependent upon the time of occurrence of the stressor and the present and past condition of the individual. The nature and intensity of the stressor, and the amount of energy required by the individual to adapt to the stressor also affect the degree of reaction (Olin, 2011).

Neuman (1995), as elaborated by Current Nursing (2012), defined intrapersonal stressors as internal environmental forces occurring within the boundary of the client (Neuman, 1989:31). Thoughts, feelings, self-awareness, self-image, attitudes, and coping skills that occur within a person (violated married woman) are examples of the intrapersonal stressors. The interpersonal stressors are defined as external environmental interaction forces occurring outside the boundaries of the client at proximal range. Role expectations that occur between individuals (violated married woman) are examples of the interpersonal stressors.

When married women associate with the community, the community's perception of the married women is likely to be altered. The altered perception can be a stressor for the married women. The extra-personal stressors are defined as external environmental interaction forces occurring outside the boundaries of the client at distance range. Financial and job concerns are examples of extra-personal stressors that occur outside the individual (violated married woman). In addition, the external environment may include extended family members and neighbours (Neuman, 1989:31).

It is assumed by the study that high incidents of domestic violence are because of financial and job concerns as the salaries may not be enough to sustain a family. The study seeks to identify strategies for educating communities within an African Context on the prevention and control of domestic violence affecting married women in Zimbabwe. Identifying educational strategies will assist the nurse managers and psychiatric nurses to strategize measures to minimize domestic violence among married women.

The goal of nursing in this model is the promotion of optimal wellness of an individual through maintenance or attainment of system stability. This goal is accomplished through intervention at three prevention levels (Neuman, 1995), as elaborated by Current Nursing (2012) that described primary prevention as an intervention before a reaction occurs. This type of intervention may begin when a risk factor or potential stressor is suspected or identified. Primary prevention promotes wellness by protecting the normal lines of defence. Primary prevention also includes health promotion and maintenance of wellness (Current Nursing, 2012).

This is done by reducing the likelihood of an individual's encounter with stressors and by strengthening flexible lines of defence (Sohier, 1997), as elaborated in Current Nursing (2012).

Therefore the primary nursing intervention focuses on keeping stressors and the stress response from having a detrimental effect on the body. Primary prevention relates to general knowledge that is applied in client assessment and intervention in identification and reduction or mitigation of risk factors associated with environmental stressors to prevent possible stressor reactions (Neuman, 1989:77).

Secondary prevention relates to symptomatology following reaction to stressors, appropriate ranking of intervention priorities and treatment

to reduce their noxious effects (Neuman, 1989:77) as elaborated in Current Nursing (2012). Secondary prevention occurs after the system reacts to a stressor. It also focuses on the preventing damages to the central care by strengthening the internal lines of resistance and removing the stressor (Neuman, 1989:77), as elaborated in Current Nursing (2012).

Strategies that might be used in primary prevention include immunization, health education, exercise, and lifestyle changes. This intervention occurs when the risk or hazard is identified but before a reaction occurs (Gonzalo, 2011).

In a different view according to Gonzalo (2011), secondary prevention occurs after the system reacts to a stressor and is provided in terms of existing symptoms. Secondary prevention focuses on strengthening the internal lines of resistance and, thus, protects the basic structure through appropriate treatment of symptoms. The intent is to regain optimal system stability and to conserve energy in doing so. If secondary prevention is unsuccessful and reconstitution does not occur, the basic structure will be unable to support the system and its interventions, and death will occur.

Tertiary prevention relates to the adjusted processes taking place as reconstitution begins and maintenance factors move the client back in a circular manner towards primary prevention. It also occurs after the system has been treated through secondary prevention strategies and it offers support to the client and attempting to add energy needed to the system or reduce energy needed to reconstitute facilitation (Neuman, 1989:77), as elaborated in Current Nursing (2012)

Tertiary prevention occurs after the system has been treated through secondary prevention strategies. Its purpose is to maintain wellness or protect the client system reconstitution through supporting existing

strengths and continuing to preserve energy. Tertiary prevention may begin at any point after system stability has begun to be re-established (reconstitution has begun). Tertiary prevention tends to lead back to primary prevention. (Neuman, 1995).

Secondary prevention is aimed at treatment of existing symptoms. Its focus is on the strengthening of internal lines of defence to reduce the degree of reaction and promote reconstitution. The experiences violated married women face will be categorised under physiological, psychological, sociocultural, spiritual, occupational and developmental factors. Intervention measures are instituted accordingly. Violated married women with physiological problems will be referred to the physicians for assistance. Those with psychological and sociocultural and developmental problems will be referred to the psychologist for assistance. Those with spiritual problems will be referred to the reverend or pastor for assistance and those with occupational problems will be referred to the occupational therapist.

The primary goal is to strengthen resistance by reducing the exposure to stressors to prevent recurrence of a reaction Neuman (1995), as elaborated by Current Nursing (2012). An example of tertiary prevention is the formation of domestic violence association and establishing domestic violence act. These measures will ensure violated married women have a forum where violated married women discuss issues pertaining domestic violence.

Neuman's Model seeks to strengthen the flexible lines of defence through primary prevention strategies. These are strategies that aim to promote client wellness by stress prevention through health promotion strategies. Thus, identification of healthy to handle the experiences faced by violated married women, thereby protecting the normal line of defence from the stress (Current Nursing, 2012).

Betty Neuman's Systems Model was used in this study. Person, environment, health and nursing were the selected concepts for this study. Violated married women are clients or person for this study. The study explored the experiences faced by violated married women. The environment includes the socio-cultural, psychological, physical, emotional and financial environments of the violated married women. Violated married women are bio-psychosocial beings and the experiences faced affect their health, social and occupational function. Health in this instance is not just the absence of a disease or infirmity but a state of optimum physical, social, psychological, spiritual, and emotional function.

Current nursing (2012), accepted that health, person, and environment are the selected concepts. In this study, physically abused married women are the clients or person. The environment is not just the external environment, but it will also include the internal environments of the clients.

The application of a conceptual model in nursing research provides a mechanism for contribution to nursing knowledge. Betty Neuman's Systems model has been applied as a conceptual framework for numerous research studies. The situations in which the model was applied provide support for adaptation of the model in the exploration of challenges faced by physically abused married women. The application of Neuman's model in research has been described in the literature and demonstrated both clinical and educational settings. Galtacher (1987), successfully used the Neuman's model to evaluate services for prevention and controlling of sexually transmitted diseases in a male adolescent health centre. Haggart (1993), used the Neuman's model effectively in a study on a critical analysis of Neuman's systems model effectively in a study on a critical analysis of Neuman's model in relation to public health nursing, using the concept of community as a client.

Fraser (1996:256), researched on the threat to lung cancer patient's quality of life and their coping abilities .Nursing was found as a strategy to help clients to overcome stress using the model. Fraser (1996:256), also carried out a study on the relevance of the model to the patient with multiple sclerosis and she found out that there is detained assessment of stressors to patient and nurses' perceptions of stressors. The use of Betty Neuman's model in a general hospital was also successfully introduced. In addition (Fraser, 1996:256), applied Neuman's Systems model on information giving on post-operative coping and giving coping information. Results did not make statistical difference to patient's general coping behaviours.

Hinton *et al.* (1996:104), also applied Neuman's Systems model successfully for use in nursing education, nursing research, nursing practice and nursing administration. The structure of the model was originally designed for graduate students. In addition, the Neuman's Systems model provides a structure for organising curricular content for students. It also introduces relevant nursing concepts and help to illustrate the relationship among them. The model also provides a guide for nursing practice (Hinton *et al.*, 1996:108). According to Fraser (1996:257), Neuman's model (1980), edition claims to be appropriate for use by health workers other than nurses.

Gigliotti (1999) used the Neuman's Systems model and investigated the relationship of multiple role of stress to psychological and sociological variables of the flexible line of defence. Questionnaire instruments were used to operationalize the psychological component with the perceived role as a student and as a mother. The socio–cultural component with social support and the normal line of defence as perceived through multiple role stress. Chiutsi (2004) reported that Lindel & Olsson (1991) utilized Neuman's model by integrating sociological, psychological, philosophical, and developmental and interpersonal stressors to facilitate contraceptive counselling as

primary prevention against the stressor of undesired pregnancy. Bishop (2005) used the model on nursing knowledge and attitudes regarding the pain management of cancer patients and noted that other researchers had also used the systems model.

The Neuman Systems Model has been used effectively by Moore & Munro (1990), who applied it to the mental health nursing of older adults in a case study. In their case, study health was considered to be continuum with old age and its complications on the illness.

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New nurses often bring new knowledge into the work area, which may result in resistance from peers. The new nurses must be courageous and share knowledge with peers to reduce fear and help

them to appreciate the value of using nursing conceptual models and nursing theories, that the researcher are convinced will reduce workload and increase positive client outcomes.

Lack of knowledge generates fear of the unknown. Hopefully, sharing knowledge of the value of a nursing conceptual model as a directive for care would offset fear and motivate cooperative work and lead to client satisfaction.

Positive outcomes will support the value of the nursing conceptual model but that may take time, so patience is needed.

In caring for victims of crime and violence, the Neuman's Systems model provides a complete assessment of the client condition. Joint goal planning is critical to relevant use of available resources or creation of needed ones. Use of the three preventions as interventions primary, secondary and tertiary is an important typology in this situation.

According to Neuman's System Model (NSM) (2012), there can be many ways in which the model can be used beyond the nursing field, since it is a comprehensive problem-solving process with evaluation capacity.

Some suggestions of the model are used with elementary and high school student groups.

Other disciplines find the model easy to use as its terminology, concepts, and processes are easy to understand.

The major strength of the model is its flexibility for use in all areas of nursing that is administration, education and practice.

The model has presented a view of the client that is equally applicable to an individual, a family, a group, a community, or any other aggregate.

The model particularly is presented in the model diagram, and it is logically consistent.

Betty Neuman's system model provides a comprehensive flexible holistic and system-based perspective for nursing.

According to Gonzalo (2011), once understood, the Neuman Systems Model is relatively simple, and has readily acceptable definitions of its components.

The emphasis on primary prevention, including health promotion is specific to this model.

The use of the model can be of benefit to urban leaders in creating healthy communities because the information gathered from its use reflects existing positive aspects and for creating a healthy community. Nurses can work effectively in broadly based planning using the concepts and processes of the Neuman's model as a guide.

The Neuman's model is congruent with the global health trends of holism and prevention.

Published papers and presentations at the Neuman's model symposia documented that the model is universally applicable and culturally relevant.

The Neuman's model is congruent with the global health trends of holism and prevention.

Neuman's model is universally applicable and culturally relevant as the concepts and processes remain the same across cultures and countries.

However, the major weakness of the model is the need for further clarification of terms used. Interpersonal and extra-personal stressors need to be more clearly differentiated.

The delineation of Neuman of three defence lines was not clearly explained. In reality, the individual resist stressors with internal and external reflexes which were made complicated with the formulation of different levels of resistance in the open systems model of Neuman. Neuman made mention of energy sources in her model as part of the basic structure. It can be more of help when Neuman has enumerated all sources of energy that she is pertaining to. With such, new nursing interventions as to the provision of needed energy of the client can be conceptualized.

The holistic and comprehensive view of the client system is associated with an open system. Health and illness are presented on a continuum with movement toward health described as negentropic and toward illness as entropic. Her use of the concept of entropy is inconsistent with the characteristics of entropy which is closed, rather than an open system (Gonzalo, 2011).

Community members should engage key stakeholders and positively influence them to become part of the solution to domestic violence. Both individual and collective efforts are needed. Community members should work with institutions such as governments, faith-based organisations, cultural, sports and other community-based associations, schools and the media to support prevention messages, initiatives and policies. Here are some examples as to what roles these institutions can play.

Figure 3: Adopted from Sebastian, B. & Lorenzetti, L. (2015: 20)

Literature review reveals that Sebastian, & Lorenzetti, (2015:7) suggested the roles of community against domestic violence as indicated below:

- The community members should honour the right of everyone to lead a life of happiness and freedom, irrespective of gender, race, ethnicity, class, colour, age, abilities, and religion.

- The community members should ensure that everyone live in a free from fear, intimidation, guilt and shame in personal relationships.
- The community members should ensure the physical, psychological, spiritual and mental growth and development of each one in society.
- The community members should secure a brighter, happier and safer future for the next generations.
- The community members should be role-models to the youngsters about healthy relationships, nonviolence and equality.
- The community members should ensure that the community is a kinder and safer place where people feel a sense of belonging.
- The community members should ensure that married women are living in environments that are free from abuse and instilling in them the values of compassion and care for others, positive communication and healthy self-esteem.
- The community members should treat the married women with care and supporting their sense of happiness and well-being in the latter parts of their lives.
- Given the nature of the problem under study, I strongly recommend that you adopt this conceptual framework adopted from Sebastian & Lorenzetti (2015) because it speaks to the problem and the role of different stakeholders in the Afrocentric education ecosystem. Think about it because the other model is not very much in sync with the problem on the role of the IKS in preventing and resolving domestic violence.

Findings by Nonell (2013:127) suggests that community members should familiarise themselves with the possible signs and indicators of domestic violence, as someone who may not appear to be a victim of domestic violence maybe suffering in silence. In addition, community

members should be able to educate as many people as possible about domestic violence, its impact and how to intervene safely, in collaboration with police community outreach officers, women's organisation, local schools, local companies and local domestic violence shelters. Therefore, there is need for community members to implement talk shows, town hall meetings and group sessions to prevent and control domestic violence.

Nonell (2013:127), emphasised that community members should intervene to stop domestic violence or making the community a place where domestic violence will not be tolerated, have neighbourhood watch to stop violence, helping the victim to leave the abusers safely, and boosting community support network with technology by downloading a safety app, by alerting support network if the victim is in danger through a smart phone.

According to Victorian Government (2012:1), community members' roles are to provide measures to help prevent and control domestic violence before it occurs, assist those women who are at risk of experiencing violence, and also provide early intervention measures to help change the behaviour of those at risk of committing violence before it occurs. In addition, community members' roles are to provide a strong law and order focus, signalling its intention to deter perpetrators from committing violence, hold them accountable for their behaviour and help change their behaviours. Community members also need to be compassionate and have supportive response for women who experience domestic violence because these women need support to rebuild their lives.

Kivulin women's rights organisation (2011-2015:4), put forward the view that all members of the community need to increase ownership of the problem since violence affects everyone. In addition, community members will have to increase knowledge about rights and legal

provisions for women, thereby increasing reports on violent cases to formal and non-formal institutions and advocating women to live free from domestic violence.

Domestic violence affects us all, it impacts all aspects of the community including community health, crime rates, and the ability to participate in the workforce, child development, and family dynamics (Berman *et al.*, 2011).

According to Christiaensen (2016), one third of African women report to have experienced domestic violence (physical or sexual). Madhivanan *et al.* (2014:170) observed that women experiencing violence have been linked to serious physical injuries, homicides, unwanted pregnancies miscarriages, induced abortions and vulnerability to HIV and other sexually transmitted infections.

Sandeep *et al.* (2014:33), put forward the view that married women (100%) who experienced domestic violence faced humiliation and restriction in the family. On a different note, about 84% of married women have reported having experienced at least one act of violence from a partner during their life time.

A study done by Hasan *et al.* (2014:2), is supported by Feseha *et al.* (2012: 2), and the Victorian Government: 2012:25), revealed that most of the women experiencing domestic violence reported sufferings from reproductive, physical and psychological problems, constituting serious threats to their physical and mental wellbeing. The study findings by Nonell (2013:127), are supported by the Victorian Government (2012:2), that women experiencing domestic violence often feel completely isolated, unable to reach out for support, unable to receive the support they need, are stopped from going to work and from participating in the community and belittled by their partners.

The domestic violence experienced by married women takes place mostly within the privacy of their homes and to a larger extent has contributed to a culture of silence as regards to the health consequences (Mashiri, 2013:96), supported by Zimbabwe Health Demographic Survey (ZDHS) (2005–2006).

According to Robin (2013:9), despite the similarities in women's experiences with domestic violence across cultures and societies, understanding the specifics within a particular society is necessary for the development of legislative reform and policy development, prevention and intervention initiatives and systems of protection and support for victims and survivors of domestic violence.

The Victorian Government (2012:27), estimated that 50 to 80% of women experiencing violence suffer from psychiatric conditions such as depression, anxiety, self-harm tendencies and suicidal thoughts. Victims are more likely to experience financial difficulties resulting in economic dependence on their partners making it difficult for them to escape violent partners, losing confidence and skills. In addition, their lives are interrupted by court appearances, difficulties in securing stable jobs, ending up homeless and vulnerable to further assault on the streets, in hostels, refugee camps and squatters and linking with drug abuse and prostitution (Victorian Government, 2012:28).

Feseha *et al.* (2012:2), states that women experiencing domestic violence also face difficulties with daily activities, 63% in pain, and 23.5% have difficulty during walking, 14.8% have fractures or dislocations, 2.5% have damage to ears because of slapping, 2.5% have deep cuts on their body parts and psychological disturbance. Pregnant women were also found to be victims of physical violence. Nyamayemombe *et al.* (2010:2), indicated that in the results of the preceding Zimbabwe Demographic Health Survey (ZDHS) (2005–2006), 47% of currently married women aged 15–49 in Zimbabwe have

experienced some form of spousal violence, 28% having experienced physical violence, 29% emotional violence and 18% sexual violence.

According to Victorian Government (2012: 2), women experiencing domestic violence are usually isolated, unable to reach out for support and unable to receive support they need, as they are stopped from going to work and from participating in their communities. The impact of domestic violence on the health of women experiencing violence is profound and spans many quality-of-life measures. In addition, women living domestic violence experience massive social and economic costs.

On a different view according to (Cornwall et at.2011-2015), women experiencing domestic violence suffer from personal, physical, emotional costs and also to the economy, with increased costs for health service, the criminal justice system, housing, safeguarding and social care costs and the lost economic productivity.

Meyer (2011:11), indicated that women experiencing violence face discrimination and lack of support by the police combined with the fear of retributive victimization by the intimate partner and dissatisfying outcomes. In addition, many victims of violence felt that they were not being taken serious because of not terminating the relationship as one victim spent 11 years with her abusive partner before and after the implementation of domestic violence. Physically abused married women also often experience further negative reactions when going to court. They are traumatized and often not respected when the judge or magistrate lack understanding for the perceived risk of victims and their dependent children (Meyer, 2011:14).

Rahman *et al.* (2011:1-2), found out that women experiencing domestic violence suffer from reproductive health outcomes such as

miscarriages, premature delivery and pelvic inflammatory diseases and have limited mobility to reside with in-laws. In addition, women with no education experience domestic violence more than educated women. Pervasive human rights violation of women experiencing domestic violence was recognised.

In a study done by Coker *et al.* (2000), they found that domestic violence against women can cause psychological problems such as post-traumatic stress disorder characterized by depression, physical problems such as migraine headaches and arthritis.

Compared to non-abused women, abused women are 5 times more likely to attempt suicide, 15 times more likely to abuse alcohol and 9 times more likely to other drugs and it was found to be the most common prominent cause of morbidity and death (Bean, 1992).

Prevention measures must incorporate a strong focus on the promotion of gender equality, women's empowerment and the enjoyment of their human rights. Building a strong consciousness and understanding of these issues among women and men at all levels is essential for preventing domestic violence against married women because families and in-laws are often the first support system women turn to when they have been abused. The 2010-2011, Zimbabwe Demographic and Health Survey (ZDHS) findings show that survivors of gender violence look for support and help first from their own family (56.9%) and in-laws (36.6%). Only 15% go to the police and 2.2% report seeking help from a social service organisation (Made, 2015:91).

The country has also adopted the 365-Days of Action campaign initiative to keep domestic violence in the public discourse throughout the year. It includes traditional, religious and community leaders as major actors in addressing domestic violence at the local and community levels. The Ministry of Women Affairs, Gender and

Community Development's programmes and campaigns to empower women economically closely links to enabling women to reduce their vulnerability to domestic violence (Made, 2015:92). Sebastian & Lorenzetti (2015:10) pointed out that successful community-based initiatives are guided by a shared vision, willingness, preparedness, capacity and commitment to make change happen. This includes leveraging existing resources, capabilities and skills to serve the purpose of promoting healthy relationships and preventing domestic violence. Careful planning is needed, including developing ways to evaluate if their actions have been successful. Adopting a community-based approach to violence prevention includes finding and building on community assets, using culturally appropriate messages, services, cultivating and supporting local leaders who can advocate for and sustain change as follows:

- Changing social and community conditions that contribute to domestic violence.
- Raising awareness of the problem of domestic violence and establishing social norms that make violence unacceptable.
- Building networks of leaders within a community.
- Connecting community residents to appropriate and culturally safe services.
- Making services and institutions accountable to community needs.

The relationships with neighbours and active community involvement can go a long way in preventing domestic violence. These initiatives focus on making domestic violence a community issue (Sebastian & Lorenzetti, 2015:18). Break the Cycle provides tools and resources for community members. Their interventions range from organising public campaigns to advocating for effective policies and programmes. The campaign is built on the belief that everyone is entitled to lead a safe and happy life regardless of their gender, sexual orientation, race, class or other areas of diversity. Their continuum of support includes helping married women to identify the warning signs of abuse,

developing safety plans and providing legal services for those who are already in the cycle of abuse. Their flagship programmes focus on women leadership and education within community settings, where they encourage married women to speak out about domestic violence to promote home safety. The program teaches married women to distinguish between what are healthy, unhealthy and abusive behaviours (Sebastian & Lorenzetti, 2015:22).

The approach documented below is one of many initiatives that encourage faith-based communities and religious leaders to lead the work of domestic violence prevention within their communities. Religion and faith have an active influence in the lives of millions of people. Therefore, religious leaders are best positioned to positively influence conversations on interpersonal and family relationships (Sebastian & Lorenzetti, 2015:23). An effective prevention strategy must also focus on making the home and public spaces safer for married women, ensuring women's economic autonomy, security, increasing women's participation, decision-making powers in the home, relationships, in public life, and politics. Awareness raising and community mobilisation, through media and social media is another important component of an effective prevention strategy (Made, 2015:92).

To address domestic violence, there is a need to engage all relevant stakeholders, from community to national government level. There is a recent recognition of involving traditional and religious leaders in the efforts to combat domestic violence as society views these people as the custodians of culture and religion. For many women around the world, community-based, customary justice mechanisms remain the only available method of redress. While people often use traditional practices to justify violence, culture is dynamic and can change through training, public education, and access to new information (Made, 2015:84).

CARE and its partners have made great strides in addressing domestic violence, but more work is needed to engage individuals, communities and institutions in violence prevention and reaching victims with appropriate services. Everyone has a role to play in ensuring that everyone can live and thrive safely and free of violence (Sprechmann *et al.*, 2013:11).

Ending domestic violence involves social change work at the deepest levels. It is important to avoid concerns about violating cultural boundaries because this can lead to the perpetuation of its invisibility and render us timid in our response. There is need to start from a firm understanding that societies cannot claim a cultural right to violence any more than a right to slavery or genocide. CARE found that issues of domestic violence are so deeply embedded in social and cultural traditions, the most effective programmes are those most closely attuned to local context and where local leaders and activists are supported to lead the process of change (Sprechmann *et al.*, 2013:11).

Local knowledge and the trust of the community are essential. International aid organisations such as CARE can be a catalyst, but the researchers have learned that the full formula for effective change requires working in partnership with communities. Rather than engaging outside experts, CARE aims to develop expertise in the prevention and control of domestic violence. The communities, however, do not exist in isolation. The most effective programmes are those that work across a range of actors and levels of society. To address the deep roots of domestic violence, CARE works simultaneously with individuals, couples and families, communities, and state institutions using a combination of prevention and response strategies. This includes working with the community at all levels, including government agencies and civil society movements (Sprechmann *et al.*, 2013:13).

CARE recognizes that it is essential to work with all members of communities whether they condone or reject gender inequality, discrimination, and violence. This includes engaging men and boys together with women and girls, and traditional leaders, religious leaders, public officials and civil society leaders, to address and challenge underlying beliefs, attitudes, and practices around violence. The work at community level is further strengthened by supporting the provision of vital services for domestic violence victims, in partnership with government and civil society, and the development and implementation of enabling legal and policy environments (Sprechmann *et al.*, 2013:13).

Through multiple strategies, such as engaging couples to address violence and mobilising community action, CARE seeks to change behaviour by challenging the social norms that perpetuate violence. The efforts should include working with men and boys as champions of change, enabling them to challenge gender norms and enjoy more equitable relationships in their own lives. Gender inequality should be addressed by supporting activities, such as economic development, education, leadership and life skills training, that increase women's and girls' ability to know and claim their rights and help reduce their vulnerability to violence (Sprechmann *et al.*, 2013:14).

Partnerships and networks across multiple sectors, including the legal system, medical and psychosocial services, police, and other support services, are the cornerstone of effective domestic violence victim's response. CARE works with partners taking care not to single out domestic violence victims and stigmatize them to establish and build the capacity of local community support systems that help keep victims safe from domestic violence, such as community watch groups and safe houses. Sometimes, the most critical need for the communities to work is to identify and raise awareness of services for domestic violence victims already available to them. In emergency responses,

CARE prioritizes the Minimum Initial Service Package (MISP) for reproductive health. The MISP includes prevention and response to sexual violence (Sprechmann *et al.*, 2013:14).

Laws and policies relating to gender equality and domestic violence play an important role in preventing and responding to domestic violence. CARE's advocacy work spans all levels to create, revise, or improve implementation of laws and policies to tackle domestic violence. This work is firmly based on international agreements, such as the Declaration on the Elimination of Violence against Women and Security Council Resolution 1325. Their focus is both on advocating for new policies and laws and ensuring that they are effectively resourced and implemented. Both approaches involve awareness raising, public mobilisation, lobbying and following up on individual domestic violence cases all of which help to transform policies, and cultural and social attitudes and norms, leading to a more favourable climate for domestic violence prevention. In addition to these strategies, CARE conducts regular research and evaluations to better understand the complex causes and consequences of domestic violence. CARE reviews which strategies are successful in reducing domestic violence and how research and evaluation can help improve their programmes (Sprechmann *et al*., 2013:15).

For almost 20 years, CARE has addressed the underlying causes of domestic violence and its effect on victims in conflict, humanitarian crises and stable development settings. In this chapter we present the results and impacts of some of CARE's actions. Measuring attitudes and social norms around domestic violence, and changes in actual rates of domestic violence, poses well-known ethical and methodological challenges. It is their commitment, starting with this publication, to contribute to finding solutions and ways forward for obtaining more accurate data about the approaches that have the

greatest success in tackling domestic violence (Sprechmann *et al.*, 2013:22).

While individual reflection is critical, men and women often yearn to share their reflections and transformations with each other. CARE works with men and women to prevent violence in 'intimate partner' relationships the most common form of domestic violence worldwide. In many of CARE's projects, couples' dialogue sessions address the issue of unequal power relationships between men and women. A marked improvement in communication between spouses has resulted in women and men having a better understanding of the root causes of domestic violence, and men playing a more active role in domestic duties. CARE's programmes in East and West Africa highlight 'model couples' – those who live in equal relationships – as an example to other couples and the wider community (Sprechmann *et al.*, 2013: 22).

CARE's programmes in Burundi, Uganda, Rwanda and the Democratic Republic of Congo create forums for men and women to discuss issues that contribute to domestic violence such as alcoholism, gambling, domestic violence and polygamy. The approach uses personal stories of change to help men in the community work towards non-violent and more equal relationship with women and girls. As part of the program, a couple who has signed up to it may 'adopt' five other couples to support their journey towards a violence-free relationship. These five 'model couples' will in turn work with other couples to create a multiplier effect across the community (Sprechmann *et al.*, 2013:22).

CARE's three-year women's empowerment program in central Nepal worked with the most socially excluded and vulnerable women in Churia district to enhance their meaningful participation in decision-making at all levels. 'Reflect Centres' have provided useful meeting places for women to learn about their rights, challenge caste

discrimination and gain access to essential information. The women thrived in this environment, finding strength in working with others in solidarity. But they also told CARE that for them to be empowered, men in the villages had to be involved in making changes. Men should join women in the Reflect Centres once a month to discuss non-violent approaches to family relationships. These forums should increase understanding of legal rights around domestic violence and have seen a 30% reduction in violence against women at a household level (Sprechmann *et al.*, 2013: 24).

CARE works in close partnership with men and boys. Their experience indicates that engaging men and boys to challenge views that see violence as part of manhood is key to achieving greater equality between women and men. This work seeks to enable men and boys to become agents and activists for change and to challenge and explore alternative masculinities based on justice and human rights. CARE works with men and boys across a range of programmes, from challenging their attitudes to women in several East African countries, to working with male community leaders in the Middle East to end traditional harmful practices such as child marriage and invest in the wellbeing of girls and women in their communities (Sprechmann *et al.*, 2013:25).

Domestic violence remains a huge obstacle to development in the Balkans across Croatia, Bosnia & Herzegovina and Serbia. CARE has introduced a 'gender transformative' curriculum that includes school-based workshops, residential retreats and the 'Be a Man' awareness campaign. The program encourages young men to reflect on the reasons behind their violence towards women. Thousands of young men across the Balkans have been encouraged to treat women and girls as equals as part of the 'Be a Man' campaign. This program also has a strong component to address homophobic violence. It supported 5,635 adolescent boys in the Balkans reported they had decreased the

use of violence against married women and peers. Violence is not a sign of masculinity. The conferences raised awareness of the importance of directly targeting men in violence prevention efforts and achieved significant media attention. In Bangladesh, CARE's program used a mix of research, capacity building and educational strategies to transform men's behaviour (Sprechmann *et al.*, 2013:25).

Most male participants came from rural areas and had been physically and verbally violent towards their wives. Their reasons ranged from anger and frustration and the need to feel more powerful to a lack of understanding of the impact that violence was having upon their wives and children (Sprechmann *et al.*, 2013:25).

CARE works with community leaders and forums to encourage grassroots discussions on preventing sexual violence and the impact of harmful traditions. CARE works in many countries where there is a high prevalence of female genital cutting (FGC). In Sierra Leone, CARE's program worked closely with community leaders and FGC practitioners to facilitate discussions about human rights in the local context that challenge existing beliefs about reasons to perform FGC. The program took an inter-generational approach to addressing harmful cultural practices. Together with the local bye-laws that penalize practitioners, CARE's approach enabled practitioners to stop practicing FGC in their communities (Sprechmann *et al.*, 2013:25).

CARE recognizes that GBV affects all aspects of survivors' lives – including their legal and economic status, and their health and emotional wellbeing. CARE is careful not to single out individual survivors in its approach to supporting them. Instead, CARE coordinates integrated aftercare through working with a range of local partners including the police and schools, alongside legal and medical services. CARE believes every GBV survivor deserves a confidential, comprehensive support package to include quality medical care,

counselling, and protection by police or others for physical security, psychosocial support, and access to legal assistance and shelter (Sprechmann *et al.*, 2013: 29).

CARE engages with a variety of locally based protection and treatment programmes to support women and children in their communities. These range from supporting schools to identify child domestic violence victims; training traditional leaders and local activists to offer advice and basic counselling and referral; training case managers to support women in accessing services and meeting their psychosocial needs; and working with women survivors and medical, police and legal services to ensure survivors have access to any emergency care and legal support they require (Sprechmann *et al.*, 2013: 29).

CARE also supports survivors of domestic violence to find alternative livelihoods through Voluntary Savings and Loans Associations (VSLA). In Burundi, the DRC, Rwanda and Uganda, VSLA groups supported by CARE helped victims of domestic violence find solidarity. They also provided a means to economic opportunities and reintegration (Sprechmann *et al.*, 2013:29). Supporting services for survivors In Zambia, CARE supported 'one-stop' Coordinated Response Centres that provided comprehensive services to victims of domestic violence in seven districts. In addition, located in or near public health facilities, the centres provide survivors access to medical, legal and mental health services. They also serve the community more broadly as focal points for domestic violence prevention to ensure integrated and coordinated response for domestic violence. CARE also worked extensively with traditional leaders and other community members to create awareness and behaviour change regarding domestic violence, with 4,236 traditional and other local leaders sensitised on domestic violence, 52% of who were women leaders. CARE's program became a national model which was scaled up by the Zambian government country-wide (Sprechmann *et al.*, 2013:29).

In the community, CARE staff trained teachers and administrators on gender, law and codes of conduct, and developed joint management with community organisations and increased accountability in schools. Girls and boys were shown how to identify and report incidents of abuse using complaint boxes and a system of peer support. A referral system was set up to support women and children who were identified as having been sexually abused, offering professional counselling and supporting the prosecution of perpetrators (Sprechmann *et al.*, 2013:30).

The community organisations also created a 'zero-tolerance' environment where perpetrators of domestic violence faced public action. Research found that the fear of punishment and public exposure of student abuse cases by other teachers, has led to a reduction of sexual abuses of girls. In schools serviced by the program, the drop out of girls from schools due to the fear of domestic violence dropped by 50% (Sprechmann *et al.*, 2013:30).

In Bolivia, CARE supported school and community initiatives to prevent the sexual abuse of married women and students. Local 'Rights Defence Committees' made up of teachers, parents and teenage students have adopted strategies, including training teachers in domestic violence prevention and referral procedures to stop violence against married women and girls. Since 2011, teenage students have been educated in sexual and reproductive rights. In addition, the recruitment of a specialist psychologist has contributed towards decreasing levels of violence in 10 schools. Reported violence at home decreased by 13% with students indicating a greater use of mediation and dialogue techniques (Sprechmann *et al.*, 2013:30).

In partnership with local organisations, CARE Burundi has established a network of community support to enable domestic violence victims to access services quickly and efficiently. The network includes trained

legal assistants, counsellors and elected leaders supported by community activists. These activists play a leadership role in their local area and are recognized for providing direct legal, medical and emotional support to domestic violence (Sprechmann *et al.*, 2013:31).

As part of the programme, health care workers are provided with 'sensitivity training' in treating victims. Most of the programmes' counsellors are female. This has greatly encouraged female victims to come forward since most women, when asked, prefer to discuss abuse with another woman. Effective referral systems are in place to allow domestic violence to receive emergency medical care, including the post-exposure prophylaxis within 72 hours to prevent HIV infection (Sprechmann *et al.*, 2013:31).

CARE research with Ministry of Health staff has confirmed that the project has been effective in strengthening the technical capacity of health centres to provide safe medical and emotional support to women survivors in line with the National Protocol. Women now feel more informed of their rights and where to access support services; the reporting of domestic violence incidents has increased (Sofia Sprechmann *et al.*, 2013:31).

CARE's presence and expertise in some of the most marginalized communities worldwide means it is well placed to support women's rights organisations, and women and men affected by domestic violence often those without a representational voice in lobbying for societal change. As long as they lack a voice, the absence of accountability for these crimes is likely to continue (Sprechmann *et al.*, 2013: 32).

Changing laws and policies that discriminate against women and girls can help create shifts in social attitudes through establishing a climate of non-tolerance for domestic violence. For example, advocating for

broadening the definition of rape has been instrumental in dispelling the notion that domestic violence or related violence is a private family matter. CARE and partners are working with governments at all levels to strengthen policies against domestic violence and their effective implementation in a range of countries and at international level (Sprechmann *et al.*, 2013:32).

A CARE program focused on women's rights in Benin developed the first countrywide approach to tackling domestic violence. CARE supported a national coalition of civil society and public sector activists to lobby for the successful passage of a new law to tackle GBV. The coalition brought together the Ministry of Family and National Solidarity, 46 Beninese NGOs and 85 centres for social protection. Its goal was to improve national response to domestic violence, including support services for victims and better enforcement of policies and laws. The campaign built ample support through media awareness campaigns, community mobilisation and orientation for policy dialogue meetings. The coalition supported drafting the legislation and provided input into a national action plan for stopping violence. The new bill was enacted into law in 2012. A similar process in Zambia, supported by CARE and partners, led to the passing of the Anti-Gender Violence Law in 2011 (Sprechmann *et al.*, 2013:32).

CARE's efforts contributed to the approval of domestic violence legislation in Bangladesh, Benin, Bolivia, El Salvador, Uganda and Zambia. In Benin, an advocacy coalition of which CARE was part sensitised the population at mass scale: 4,495 community trainers and mobilisers were trained and 740,883 people sensitised about domestic violence and women's rights. In 2012 a bill to tackle domestic violence was enacted into law. For effective advocacy, it is vital to gather solid data on the prevalence and cost of domestic violence. In several contexts, CARE has calculated the social and economic costs of violence to use as evidence in lobbying for policy change. In

Bangladesh, CARE's initiative 'Cost of Violence against Women' calculated the social and economic costs of violence at community level and used this data as evidence for national-level advocacy. Its research found that domestic violence has a knock-on financial impact on individuals, households and whole societies and includes lost wages, increased medical bills, legal fees and relocation expenses. In 2010 the study calculated that costs to the economy of Bangladesh were equal to 2.2% in 2010 or the equivalent of 12.7% of the total expenditure budget of the government for that year. The study produced one of the few comprehensive national costs Uganda (Sprechmann *et al.*, 2013: 32).

Advocating for public policies to end domestic violence, CARE's programmes provide services to populations in conflict and post-conflict areas, offering a range of specialist support services. These include providing timely medical and psychological care for domestic violence victims and creating safe spaces for married women to deal with domestic violence induced trauma (Sprechmann *et al.*, 2013:33).

Even before the current conflict, South Sudan was one of the world's harshest environments in which to come of age as a woman. Conditions have only deteriorated since the fighting broke out in December 2013: more women and even girls were engaging in transactional sex to gain access to food or water for their families; parents are encouraging their daughters to marry early to gain access to bride price, reduce the number of mouths to feed and as a means of protection for their girls in a conflict situation; and rape and sexual assault has become a weapon of war. CARE is providing food, water and health care to some of those left homeless by the conflict in South Sudan and who have fled across the border to neighbouring a call for stopping violence in Uganda (Sprechmann *et al.*, 2013:33).

CARE is tackling the widely held view that violence against women and girls is acceptable through several approaches. These include personal change approaches, engaging couples to address violence, the development of male activists as 'champions of change' and mobilising community support. Promoting personal change knowing that change starts at the personal level, CARE works to build in personal reflection and change activities into almost all domestic violence programming. This includes offering workshops and training space for personal reflection on values, beliefs and cultural expectations of gender roles and responsibilities. These opportunities for personal reflection present the springboard for future attitude or behaviour change and build champions for tackling domestic violence (Sprechmann *et al.*, 2013: 17). Health systems are challenged by the effects of domestic violence and strategies for educating communities are required to reduce domestic violence within the African Context. According to Victorian Government (2012:5), early intervention is a critical part of addressing violence against women. There is need to identify women who are at the greatest risk of violence and provide strategies that reduce their risk and increase their safety. Initiatives include the expansion of family violence risk assessment; management training and resources for service professionals to identify and manage the safety of women at risk of violence. Action will also be focused on changing the behaviour of men who use violence.

Initiatives to include training for mainstream services so that they are better equipped to work with men who are at risk of being violent. In addition, a comprehensive, integrated system should provide consistent, coordinated and timely responses to women and should hold perpetrators of family violence to account. Support services to women in areas of greatest need should be expanded through family violence counselling and to continue building community confidence to report family violence to police (Victorian Government, 2012:5).

Victorian Government (2012:5) further explored that reducing domestic violence is an operational priority and there is need to introduce enhanced Family Violence Service Delivery Model and currently engages dedicated Family Violence Advisers and Family Violence Liaison Officers. In addition, utilising family violence teams in areas of high demand across the state. Police should continue to reduce domestic violence by responding swiftly and effectively to increased rates of reporting proposing new laws to hold perpetrators to greater account and to enhance court processes, so that family violence matters can be dealt with more expeditiously.

New offences and penalties being introduced for breaches of family violence intervention orders, including the introduction of an indictable offence with a maximum penalty of five years imprisonment. There is also need to extend the operation of Family Violence Safety Notices issued by police so that they will better protect women by extending the immediate protection police can provide to family violence (Victorian Government, 2012:5).

Women experiencing domestic violence should feel more confident to report experiences of violence and receive the right services at the right time, protecting and empowering them. In addition, those who are at risk of committing violence should be targeted (Victorian Government, 2012:7). Community members should be educated to change attitudes and behaviours, promoting respectful non – violent relationships and promoting gender equity and stop violence (Victorian Government, 2012:8). There is need to raise awareness campaign to prevent violence, making a pledge to say no to violence (Victorian Government, 2012:9).

There is also need to understand the causes and contributing factors, determining why it persists (Victorian Government, 2012:27). It is vital that all statutory, voluntary and community agencies are committed working together to prevent domestic violence, raising awareness to

issues surrounding it and to deliver accessible and effective services to both the victims and perpetrators, as no single agency can adequately deal with domestic violence.

Table 2. Anti-Domestic Violence Council (Adopted from Ministry of Women Affairs Gender and Community Development, 2015).

Government Institution		No/
	Ministry of Justice and Legal Affairs	1
	Ministry of Women's Affairs, Gender and Community Development	1
	Ministry of Health and Child Welfare	1
	Ministry of Education, Sports, Art and Culture	1
	Department of Social Services	1
	Zimbabwe Republic Police	1
Civic Society	Representatives of the interests of PVOs concerned with the welfare of victims of domestic violence, children's rights and women's rights	3
	A person representing the interests of churches in Zimbabwe	1
Other	Council Chief	1
	A person representing the interests of any other body or organisation with the Minister considers should be represented on the council.	1

The functions of the Anti-Domestic Violence Council include:

- To keep under constant review the problem of domestic violence in Zimbabwe.
- To take all steps to disseminate information and increase the awareness of the public on domestic violence.
- To promote research into the problem of domestic violence.

- To promote the provision of services necessary to deal with all aspects of domestic violence and monitor their effectiveness.
- To monitor the application and enforcement of this Act and any other law relevant to issues of domestic violence.
- To promote the establishment of safe house for the purpose of sheltering the victims of domestic violence, including their children and dependants, pending the outcome court proceeding under the Act.
- To promote the provision of support services of complaints where the respondent who was the source of support for the complaint and her or his dependants has been imprisoned.
- To do anything necessary for the effective implementation of this Act.

Adopted from Ministry of Women Affairs Gender and Community Development (2015).

According to Kimani (2012), the Committee on the Elimination of Discrimination against Women (CEDAW) was officially established. In 1992, the committee affirmed that violence against women was a "violation of their internationally recognized human rights" and "a form of discrimination" that "nullified their right to freedom, security and life." The committee asked governments to identify and end customs and practices that perpetuate violence against women. It urged them to conduct public education, create safe heavens, institute counselling and rehabilitation programmes for victims, sensitise law-enforcement officials and draft relevant laws to protect women against all kinds of violence.

The biggest challenge is changing the social attitudes and beliefs that confine women to an inferior status. There is need more women to know their legal rights. There is need to teach the community why it is important to protect women and how it benefits the entire community when women are afforded better protection.

Educating both men and women on domestic violence is critical. It sends a message that domestic violence is not an issue just for women, but a problem affecting the whole community (Kimani, 2012).

The African campaign seeks to involve African governments, civil society, the private sector and schools and colleges, and to "empower women and their communities in stopping domestic violence and demanding accountability."

The Africa-UNiTE campaign urges governments to consult with civil society to identify areas to be strengthened in current national legislations. Civil society groups have organised workshops for local journalists on domestic violence. Private companies have introduced "zero tolerance" policies against gender discrimination and sexual harassment. And schools and universities have included awareness-raising activities in their curriculums (Kimani, 2012).

The issue needs to be addressed by joint working and multi – agency strategies (Cornwall & Islets of Scilly, 2011-2015). The policemen have an important role to play in tackling domestic violence among married women which is traditionally regarded as enforcement. All agencies should have appropriate and sufficient tools, such as training and data to tackle domestic violence at local levels. In addition, there is need of sharing effective international best practice models assisting all sections of communities to feel safe (Cornwall & Islets of Scilly, 2011-2015).

Government would support the public, local areas & organisations to access the tools and information they need, giving them a strong voice with police and crime commissioners (Cornwall & Islets of Scilly, 2011 -2015). Discussions and training workshops, mobilising the community to prevent and control domestic violence. There is need for public awareness campaigns through video sessions, festivals and community

dialogues. Providing refresher courses to strengthen legal aid services to women and influencing use of by - laws to safeguard the rights of women in the homes. In addition, intensifying training of law enforcers for example police officers, health care providers and community groups. (Kivulin Women's Rights Organisation, 2011-2015:5). Training to prevent sexual assaults in communities like the U.S. military focuses on either raising awareness to change the culture from within or adopting a posture of zero tolerance for any sexual aggression or violence. In national communities like India, the challenge can be even harder (Smyth, 2013).

Training journalists how to avoid being targeted for sexual assault requires a different approach, one focused not on the society or culture but on the individual reporter. This is a relatively new field, one complementing the more traditional hostile environment training long available to journalists. The training involves using situation awareness to avoid becoming a target, adopting the demeanour and tone of voice to project confidence, and learning simple but effective physical techniques to deescalate and escape altercations. But whether one is training journalists how to influence society, or how they can protect themselves, the two approaches still share a common thread (Smyth, 2013).

"The media are a powerful tool in fighting domestic violence] because they not only report on society but help shape public opinion and perceptions," notes Gender Links, a Johannesburg-based group that will be training journalists how to cover sexual violence throughout Southern Africa as part of the campaign.

Increasing education and awareness among citizens is vital to prevent and control domestic violence against women. In addition strengthening the capacities of various institutions such as (police and ward tribunal members) and social institutions (health personnel, local

government officials and religious leaders) to respond to needs of women (Kivulin Women's Rights Organisation, 2011–2015:16).

Local government authorities should enact and strengthen by-laws, plans and budgets that address domestic violence within the human rights framework. Youth should be empowered to use a Solution Focused Approach, taking a lead on domestic violence prevention (Kivulin Women's Rights Organisation, 2011–2015:16). All members of the community that is men, women and children should increase ownership of the problem of domestic violence and increase effective use of Information Communication Technology on the prevention and control of domestic violence as elaborated by the Kivulin Women's Rights Organisation (2011–2015:16).

Behaviour change strategies can contribute to the shifting of domestic violence from a private matter to one that merits public attention and prevention, acknowledging the widespread nature of the problem which can as well contribute to reducing domestic victims' isolation and creates an environment which is conducive (ZDHS, 2010-11:13). Furthermore, sensitisation of community leaders on domestic violence will create a critical mask of option leaders to promote the message of social change for a zero tolerance to domestic violence (ZDHS, 2010-11: 14-15) Women should be empowered economically to reduce their dependence on men and hence their vulnerability to violence. Income generating projects for women should be initiated and created. Furthermore, credit facilities should be introduced for women to increase women's access to resources for economic initiatives (ZDHS, 2010:11-16).

The first and primary level of domestic violence prevention should ensure the adoption and implementation of protective laws and policies for example strengthening the Domestic Violence Act 2007,

Sexually Offences Act 2001, the Matrimonial Cause Act 1987 and the Maintenance Act 1989.

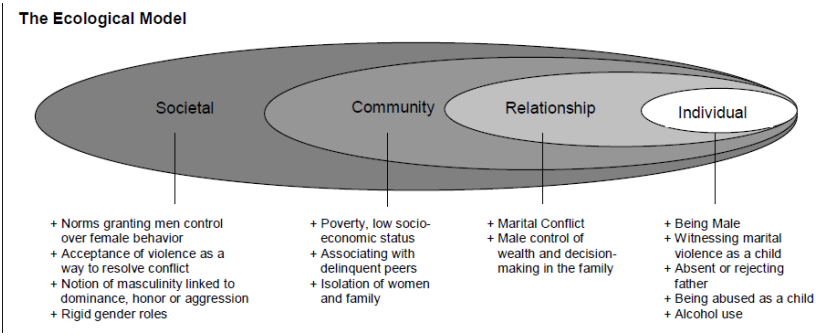

Figure 4: Adopted from Krug *et al.*, 2002:16.

Mobilising communities to prevent domestic violence involves engaging communities in supporting, developing, and implementing prevention strategies that target change in individuals, and in the community and society. Potential strategies include educating the community, building support among key stakeholders for prevention efforts, developing programmes that strengthen social networks, organising community groups to challenge social norms that contribute to the use of violence, and advocating for community accountability. Community mobilising strategies hold the potential for transforming those social norms and structures that are the root causes of domestic violence. The cultivation of grassroots community leadership can enhance the long-term sustainability of violence prevention efforts (Shepard & Zelli, 2008).

The work of preventing violence against women is daunting yet the Ecological Model can provide a useful framework for understanding the task of preventing violence. Long-term success in the prevention of violence will increasingly depend on comprehensive approaches at all levels of the Ecological Model (Krug *et al.*, 2002:16).

This is especially true for primary prevention approaches where the efforts focus on preventing the violence before it occurs. Primary prevention for violence against women involves creating a legal and policy environment that supports women's rights, a culture in the community which promotes non-violence, relationships based on equity, and individuals who take a personal and public stand against abuse. Creating a culture supportive of women's right to live free of violence requires long-term, sustained efforts in a community that address the root causes of violence against women. It means moving beyond programmes that work with one sector (e.g., health, police, education, judiciary, etc.) or one group (e.g., policy makers, battered women, youth, etc.) because societal change requires building a critical mass of individuals and institutions that believe in and live these beliefs.

According to the World Health Organisation, to date there has been an emphasis on secondary and tertiary prevention or efforts that work after the violence has occurred, and an abundance of program working at the individual or relationship levels of the Ecological Model. These programmes aim to influence individuals and their intimate relationships, but there remains an imbalance in the focus of programmes ñ community and societal strategies are under-emphasized compared with programmes addressing individual and relationship factors (WHO, 2002:28).

Furthermore, there are even fewer programmes that address the multiple spheres (individual, relationship, community and societal) and factors at the same time. Yet because multiple spheres and factors are at play in determining likelihood of perpetrating and experiencing violence, programmes must also be able to engage and support these different spheres.

Over the last five years, raising voices has worked to create programmes that engage the various spheres to help organisations and communities build critical mass necessary to create a new climate in communities that is supportive of women's right to live free of violence.

A holistic, approach, the community mobilisation approach attempts to reach individuals, relationships, communities, and the larger society. It breaks down this large task of affecting wide scale social change down so that organisations can stay focused and effective.

Key components of the approach are: Guiding principles articulate the conceptual framework for the work, process of Community Mobilisation describes the design and theoretical assumptions of the work, implementation strategies organise the myriads of activities suggested to ensure that all the spheres within the Ecological Model are reached.

The Guiding Principles for Mobilising Communities include:

PREVENTION

To effect long-term, sustainable change, organisations need to adopt a proactive rather than a reactive stance. A primary prevention approach assumes it is not enough to provide services to women experiencing violence or to promote an end to violence without challenging communities to examine the assumptions that perpetuate it. Primary prevention involves addressing the root causes of violence against women by introducing a gender-based analysis of why domestic violence occurs. This means recognizing women's low status, the imbalance of power, and rigid gender roles as the root causes of domestic violence.

Preventing domestic violence requires commitment from and engagement of the whole community. Ad hoc efforts that engage isolated groups or implement sporadic activities have limited impact. Efforts to prevent domestic violence need to be relevant and recognize the multifaceted and interconnected relationships of community members and institutions. This means it is important for organisations to acknowledge the complex history, culture, and relationships that shape a community and individual's lives within it. Efforts must creatively engage a cross section of community members, not just women or one sector (e.g., police or health care providers, etc.) to generate sufficient momentum for change. People live in community with others; thus, the whole community needs to be engaged for community wide change to occur (Michau & Naker, 2003:3).

A PROCESS OF SOCIAL CHANGE

Changing community norms is a process, not a single event. Projects based on an understanding of how individuals naturally go through a process of change can be more effective than haphazard messages thrust into the community. Thus, efforts to try to influence social change must be approached systematically. Organisations that attempt this work can become skilled facilitators of individual and collective change by working with, guiding, facilitating, and supporting the community along a journey of change.

REPEATED EXPOSURE TO IDEAS

Community members need to be engaged with regular and mutually reinforcing messages from a variety of sources over a sustained period of time. This contributes to changing the climate in the community and building momentum for change. For example, in one week a man may hear a sermon about family unity in church, see a mural questioning domestic violence on his walk to work, hear a radio program about human rights, and be invited by a neighbour to join a men's group to

discuss parenting skills. Repeated exposure to ideas from a variety of sources can significantly influence perception and reinforce practice.

HUMAN RIGHTS FRAMEWORK

A rights-based approach to preventing domestic violence is empowering to women and the community. It uses the broader framework of human rights to create a legitimate channel for discussing women's needs and priorities and holds the community accountable for treating women as valuable and equal human beings. It challenges community members to examine and assess their value system and empowers them to make meaningful and sustainable change. Without this foundation, projects tend to appeal to the goodwill or benevolence of others to keep women safe.

COMMUNITY OWNERSHIP

Effective projects aimed at changing harmful beliefs and practices in a community must engage and be led by members of that community. Organisations can play an important facilitative and supportive role, yet the change must occur in the hearts and minds of the community members themselves. Organisations can work closely with individuals, groups, and institutions to strengthen their capacity to be agents of change in their community. In this way, their activism will live long after specific projects end.

PROCESS OF COMMUNITY MOBILISATION

As implied in the Ecological Model, behaviour is a result of individual experiences, attitudes, and beliefs, which are deeply linked to the prevailing belief system in the community. Thus the attitudes and actions of neighbours, friends, co-workers, religious leaders, police, health care providers, etc. greatly influence an individual's behaviour choices and collectively create the climate in the community.

Mobilising communities to prevent domestic violence requires individuals to identify the problem of domestic violence, consider its importance, evaluate their own behaviour, and then begin making changes in their lives. Although each individual is unique and will come to the issue of domestic violence differently, the process of how individuals change often follows a similar pattern. Raising Voices uses the Stages of Change Theory (Prochaska *et al.*, 1992) of how individuals can change their behaviour to develop long-term programmes for community mobilisation. While there are many different theories of how people change, we have found this one to be intuitive, simple, and generally cross-cultural.

Raising Voices adapted the Stages of Change Theory of individual behaviour and scaled it up to the community level. We propose that a community also goes through a distinct process of change before any given value system is adopted. Therefore, if projects can recognize this process and operate in harmony with it, they are more likely to facilitate enduring change. The Stages of Change Theory is presented below with a parallel, actionable process scaled up for affecting wide scale social change.

The researchers found that breaking down the process of community mobilisation into distinct steps helps organisations create longer-term programmes and stay focused, thereby deliberately structuring their interventions within the community. This avoids the common pitfall of endless raising awareness activities and helps move individuals and the community through a structured process of change. It can also help avoid burnout and backlash because it helps organisations start where the community is and grounds the project in the community itself with clear milestones for each phase.

Within each of the five phases described below, five strategies for organising and conducting activities are used: developing and using

creative and appropriate learning materials, strengthening capacity of a wide range of community members, engaging the mainstream media and organising community events, advocacy, and fostering local activism. These strategies are designed to help organisations reach a wide variety of people in each of the spheres of influence of the Ecological Model. Each strategy engages different groups in the community and thus builds momentum, increases community ownership, and improves the sustainability of positive change.

The community is conceptualized broadly to include religious leaders, health care providers, general community members, shopkeepers, women's groups, other NGOs, governmental and community leaders, police officers, local court officials, etc., allowing for a multi-faceted response. For each strategy there is a variety of diverse and participatory activity ideas designed to maximise the impact of the project. The nature and the level of the activity suggested corresponding to the phases of community mobilisation. The activities are designed to help organisations reach a critical mass of individuals and groups within the community to build momentum for change. The activities are designed to help organisations reach a critical mass of individuals and groups within the community to build momentum for change (Michau & Naker, 2003:5).

While all the activities are meant to be adapted and contextualised, ideally the sequence of the five phases of community mobilisation, use of diverse strategies, and outreach to various groups should be maintained. These are the practical expressions of the six guiding principles upon which community mobilisation to prevent domestic violence is based.

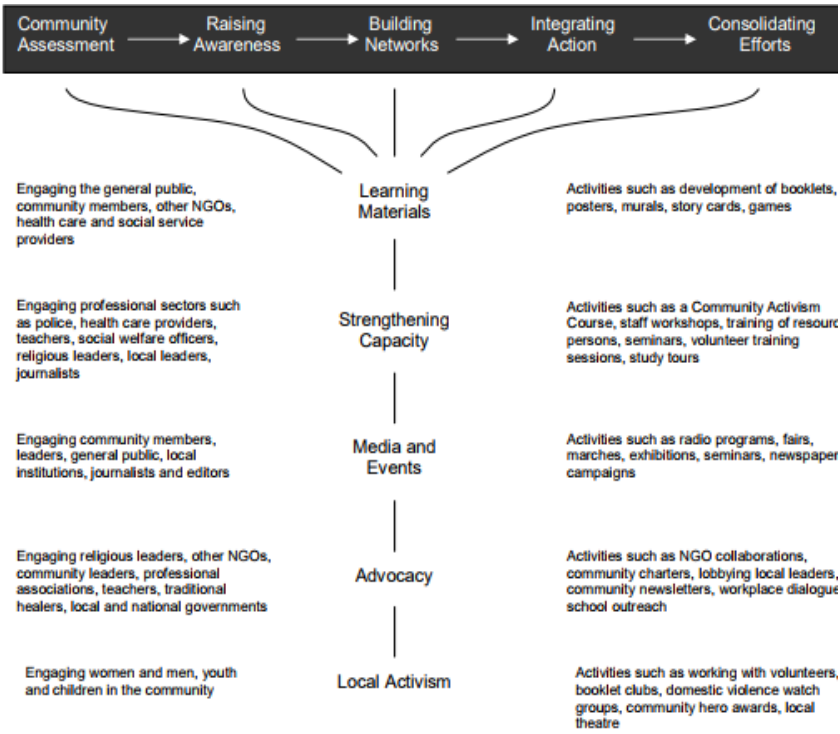

Figure 5: Adopted from Fullwood (2002:4)

One of the priorities in any community mobilisation effort is to raise awareness against domestic violence so that people know that family violence exists in the community, highlighting its impact or know where to turn for help, they will be unlikely to get involved or to communicate the unacceptability of violence. Violence is often seen as a private matter, one that families are hesitant to talk about. Therefore, families who have a safe-place and opportunity to speak about violence have no reluctance to do so (Fullwood, 2002:4). In addition, raising awareness allows people to think differently about the problem and owning the issue. In addition, there is need to help community members to see family violence as a priority as they have more on their mind,

According to Wolfe & Jaffe (1999:133) crisis intervention is a necessary response to domestic violence and can be highly effective at points in time. There is need for recent changes in public policy legislation, and service delivery illustrating a growing commitment to reduce harmful effects of domestic violence. In addition there is need for public health campaigns to eliminate health risks and to encourage health behaviours among particular segments of a population. Domestic violence prevention strategies must include some understanding of the underline causes of domestic violence and a vision of what constitutes a healthy, nonviolent family.

Developmental research shows early intervention of domestic violence may restore normal developmental processes among individuals and minimize the risk of further exposure to abuse (Wolfe & Jaffe, 1999:134). There are three prevention strategies of domestic violence namely Primary, Secondary and Tertiary prevention.

Primary Prevention reduces the incidence of the problem before it occurs whereas secondary prevention decreases the prevalence after early signs of problem and tertiary prevention is intervening when the problem is already clearly evident and causing harm to individual (Wolfe & Jaffe, 1999:135).

Training journalists how to better cover gender-based violence can help challenge attitudes that foster sexual attacks. Thus, helping journalists learn personal skills to safely navigate sexual aggression can help prevent them from becoming victims themselves.

Zimbabwe's legal framework provides for protection against domestic violence and the law includes traditional and cultural practices in the expanded definition of domestic

Zimbabwe's legal framework to prevent all forms of domestic violence in the public and Violence Act, 2006).private spheres is relatively strong. There is legislation to address domestic violence in the private sphere. The courts recognise marital rape as a criminal offence (see section on prevention later in this chapter). However, implementation remains weak, because there has not been a holistic approach, or a commitment by government to dedicate financial and human resources to drive effective implementation (Made, 2015:85).

Zimbabwe also has strong laws and policies in place to prevent and eradicate domestic violence against women. These include the Domestic Violence Act 2006 [Chapter 5:16]6; Criminal Codification and Reform Act [Chapter 9:23]7; the National Gender-based Violence Strategy 2010-2015; Zimbabwe National HIV and AIDS Strategic Plan II (2011-2015; and the Zimbabwe Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV. The VAW Baseline Survey found a high awareness level among women and men in the country of the Domestic Violence Act (Patricia A. Made P.A, 2015: 85).

Zimbabwe has comprehensive legislative and policy frameworks to enhance women's security, but women have difficulty accessing the requisite security. The biggest threat to the security of married women in Zimbabwe is domestic violence which, according to the baseline survey by Gender Links and the Ministry of Women Affairs, Gender and Development, is an extensive problem (Mushonga, 2015).

Government continues to strengthen the legal and policy framework to prevent and respond to all forms of domestic violence. In June 2014, the Ministry of Women Affairs, Gender and Community Development launched the National Action Plan against Rape and Sexual Violence (Made, 2015:9).

Zimbabwe has a new policy framework that was ushered in by the promulgation of a new national constitution in May 2013. The Constitution exposes gender balance in governance and leadership positions, and mandates the state to take positive measures to rectify gender discrimination and imbalances resulting from past practices and policies', thus prescribing affirmative action measures. Constitution of Zimbabwe Amendment (No. 20) Act of 2013, chapter 2, section 17 also legislates the rights to security, human dignity and freedom from torture or cruel, inhuman and degrading treatment or punishment.

Domestic violence law provides the criminal rules for punishing those who cause emotional or physical harm to others with whom they share a family or other close relationship. It also deals with the civil protections available to victims of this type of harm. Federal legislation in Zimbabwe has been enacted making domestic violence a crime, most notably the Violence against Women Act (VAWA). However, most domestic violence offenses are prosecuted under state law.

Convictions for domestic violence in all states require that the defendant's conduct and relationship to the victim meet certain standards. The statutory provisions describing these aspects of the crime differ from state to state, but generally, both the conduct and the relationship are defined broadly.

For example, a typical state statute will prohibit any conduct that causes harm to the victim, or poses a threat of harm that puts the victim in immediate, realistic fear for his or her physical safety. Whether the conduct forms the basis for a misdemeanour or felony will depend on the severity of the harm done. As far as the necessary relationship between the defendant and the victim, any past or present family, household, or dating relationship will usually qualify.

In Zimbabwe there have been many initiatives, by both governmental and non-governmental institutions, to raise the status of women and thus in a way to address violence against women, for example, gender-sensitive legislation such as the Legal Age of Majority of 1982. This piece of legislation ensured that anyone who attains the age of eighteen becomes a legal major regardless of gender.

Women, who previously were regarded as perpetual minors, now attain majority status at the age of eighteen, effectively becoming capable of representing themselves in courts of law. In 1995, the Fourth World Conference on Women was held in Beijing China, during which a Platform for Action was set in motion. Its main objective was to seek protection for women and girls facing domestic violence, among other abuses (Mesatywa, 2009:21).

The Government of Zimbabwe enacted the Domestic Violence Act (Chapter 5:16) on the 26th of February 2007, it became operational on the 25th of October 2007 and the Regulations were gazetted on the 20th of June 2008 to protect women against gender-based violence but such violence continues to occur. The Domestic Violence Act spells out the protection and relief of victims of domestic violence and provides for matters connected with or incidental to that.

The Anti-Domestic Violence Council of Zimbabwe established to keep under constant review the problem of domestic violence, to disseminate information and increase awareness of the public on domestic violence issues , promoting research into the problem of domestic violence, promoting provision necessary to deal with all aspects of domestic violence and its effectiveness, monitoring the application and enforcement of this Act, promoting establishment of safe house for sheltering the victims of domestic violence, pending the outcome of court proceedings and anything necessary for the effective

implementation of this Act. (Ministry of Women's Affairs Gender and Community Development, 2015).

The CEDAW Committee urged the Zimbabwe government in 2012 to take the following measures to strengthen the response and support for domestic violence;

- Provide adequate assistance and protection to women victims of violence, by strengthening the capacity of existing shelters and establishing more shelters, especially in rural and remote areas, and enhancing cooperation with NGOs providing shelter and rehabilitation to victims,
- Encourage women to report incidents of domestic and sexual violence, by de-stigmatising victims and raising awareness about the criminal nature of such acts,
- Provide mandatory training for judges and prosecutors on the strict application of legal provisions dealing with violence against women and train police officers on procedures to deal with women victims of violence (Made, 2015:91).

There was also establishment of Victim Friendly Units in police stations for reporting domestic violence. The Zimbabwe Republic Police Victim Friendly Unit (VFU) was established towards the end of 1995 as a pilot project. The VFU is mandated to police violence against women and children, particularly sexual offences and domestic violence. It is staffed by personnel specifically trained to handle vulnerable witness.

Victim Friendly Unit (VFU) investigators are responsible for investigation, arrest of offenders, docket complication and any necessary referrals. During the investigation process the investigators ensure that the reporting environment is conducive, private and friendly and that confidentiality is maintained. Every report of sexual violence or abuse or domestic violence should be treated as apriority crime and should be attended to in accordance with the minimum standard outlined in the Police and Service Charter.

Emergency medical care is to be given and, where necessary. Police will prioritise supporting victims with timely access to medical examination, treatment and access to Post Exposure Prophylaxis (PEP) and Emergency Contraception (EC0 within 72 hours of the incident. A victim may report at any Police Station at any time. No victim may be turned away. Even where a matter is alleged to have occurred in another jurisdiction the receiving officer must deal with the case as if the offence occurred in their jurisdiction for the purposes of opening a docket and ensuring appropriate medical care.

All sexual violence and abuse and domestic violence cases should be investigated by a Victim Friendly Unit Officer and investigations must not be unnecessarily delayed for any reason. The privacy of a victim should be respected by all parties, at all times. Thee Police must take all reasonable steps to ensure that the identity of a victim and the details of their matter are protected and remain confidential. It is however, permissible and encouraged, to have a trusted family member (or other appropriate adult) present to support a victim throughout their participation in the investigation and subsequent processes.

Throughout the investigation and subsequent process, efforts must be made to promote the safety of the victim and reduce trauma. In cases where a child victim, witness or alleged offender has a disability or is minor, specific measures should be taken to ensure that they are supported to actively participate in the justice process.

Where an alleged perpetrator lives in the same community as a victim, it is preferable for the victim to be supported to remain in their home.

However, the Court may order the perpetrator to find alternative accommodation or bail may be denied. Removal of a victim to a place of safety should be considered a last resort. Where the perpetrator has been granted bail, the Investigating Officer should ensure the safety of the victim. The Investigating Officer should follow a matter through to the finalisation of the trial. Regardless of whether the trial is heard in an ordinary or specialised Victim Friendly Court (VFC) sensitivity should be always maintained.

Where the alleged perpetrator is a child, special measures must be taken by the investigating officer in liaison with the Probation Officer to ensure that the Protocol's guiding principles, including the 'best interest of the victim are applied. The victim's right to privacy, dignity and safety must be respected.

Where a report is received by phone, the officer receiving the call must immediately seek to ascertain where the caller is phoning from whether there is any imminent danger. The officer receiving the call should take all necessary steps to have the scene attended immediately and if necessary, ensure emergency medical services are sent.

The Officer-in-Charge of a station must ensure that scenes of crime are attended to in accordance with the police minimum standards. Where a report is received in person, the front desk must immediately take the victim into a private room for interviewing.

Wherever possible, a VFU Officer should conduct an in-depth interview and explain the procedures and what is expected of the victim during the process. The Officer-in-Charge should take all necessary steps to enable or provide continuity and the IO should see the matter to its finalisation.

Prior to interview, an officer must create rapport with the victim and explain the process and services that the Police can offer. The Investigating Officer should be aware that children have a short attention span; therefore, the interview should be kept short and interesting.

Victims are at times traumatised and are often in a state of shock following an incident of sexual or domestic violence. Children are also often subjected to intimidation in any effort to try to and stop them from disclosing the abuse. So officers need to be sensitive and empathetic. A Police officer of the same sex preferably should interview the child or adult victim.

Victims can change their mind and take break of interview anytime they want.

A victim should be interviewed in the presence of a trusted support person who may be a parent or guardian, provided that person is not a material witness or perpetrator in the case under investigation. However, in some situations, having a parent or guardian as part of the interview may distract or put pressure on the victim. This affects the quality of evidence that is obtained from the victim.

Victims should be interviewed in a private, safe and friendly space. Where a victim appears reluctant, or explicitly refuses to open up, the VFU Officer is responsible for ensuring that the victim is referred to a counsellor, social worker or psychologist. No victim is to be forced, coerced or pressured to give evidence.

It is the responsibility of the VFU Officer to escort the victim for medical examination and to explain to the victim what to expect and the process which will be followed.

Specialized clinics, such as the Family Support Clinics, may be used where available. Where these are not available, cases should be referred to the local Health Centre.

The escorting officer is responsible for ensuring the maintenance of the chain of evidence. Where a Government Health Centres does not offer free medical treatment, the matter should be brought to attention of the VFSC Chairperson who is to immediately contact the Provincial Medical Director.

The Declaration of Elimination of Violence against Women (DEVAW) is firmly rooted in international HR instruments. The right of non-discrimination in DEVAW is provided for specifically in Article 1

which defines discrimination against women as a distinction, exclusion or restriction made based on sex. DEVAW recognizes domestic violence as "a manifestation of the historically unequal power relationship between men and women and it condemns the violence as one of the crucial social mechanisms by which women are forced into subordinate positions compared with men. The declaration includes explicit direction to member countries not to invoke any customs, tradition or religious consideration to avoid their obligation with respect to its elimination"21. The Declaration also provides for specific steps a member state should take to combat domestic violence 22. These steps include investigating and punishing acts of domestic violence, developing comprehensive legal, political, administrative and cultural programmes to prevent violence domestic violence, providing law enforcement mechanisms and promoting research and collecting statistics relating to the prevalence of domestic violence cases.

Victims of domestic violence are protected under both federal and state laws, and may seek relief in civil and criminal court. For example, victims may help law enforcement build a criminal case against their abuser while at the same time filing a civil lawsuit for assault and battery. Federally, the Violence Against Women Act (VAWA) offers additional resources for victims of domestic violence. FindLaw's Domestic Violence Laws sub-section includes state-specific links to domestic violence laws, related information and forms; an overview of the federal Violence Against Women Act; information about criminal stalking; and more.

The Violence Against Women Act of 1994 (VAWA) has provisions designed to improve both victim services and arrest and prosecution of batterer. As described by the National Coalition of Domestic Violence, VAWA created a national domestic violence hotline and allocated substantial funds for many different kinds of initiatives and

programmes, including shelters and other services for battered women, judicial education and training programmes, and programmes to increase outreach to rural women. VAWA not only reauthorized STOP grants, which support programmes designed to improve law enforcement and prosecution response to domestic violence, but also mandated that domestic violence advocates be involved in the planning and implementation of these programmes. VAWA also reauthorized funds for Victim and Witness Counsellors, who work with domestic violence victims in federal prosecutions.

A provision of VAWA that created a federal civil right of action that would have allowed a victim of violence, such as sexual assault or domestic violence; to sue the perpetrator for civil damages resulting from the attack was challenged as unconstitutional under United States law.

The Victims of Trafficking and Violence Prevention Act of 2000 created a new form of relief for victims of domestic violence in the United States. The new law created "U-Visas," which allow immigrants who are victims of certain crimes, including domestic violence, or have information about those crimes, to apply for residency in the United States. A law enforcement official must certify that the individual's assistance is necessary for the investigation.

The Institute for Law and Justice publishes Review of State Laws Relevant to Violence Against Women (Domestic Violence, Sexual Assault, Stalking, and Related Laws), Neal Miller, 1 December 2002. This report contains a survey of U.S. state laws on domestic violence, including laws that affect prosecutor and police policies.

Domestic Violence & Stalking: A Comment on the Model Anti-Stalking Code Proposed by the National Institute of Justice, Nancy K.D. Lemon, December 1994, provides an excellent overview of some of the issues

that should be considered in drafting anti-stalking legislation. Critical to such legislation is that it account for the domestic violence context in evaluating whether the behaviour is threatening, include implied threats in the definition of stalking, and be based on a "reasonable woman" standard, not a "reasonable person" standard in determining whether behaviour was threatening.

Minnesota's Domestic Abuse Act, Section 518B.01 of Minnesota's statutes, creates a civil remedy of an Order for Protection (OFP), designates the procedures that must followed in applying for and granting an OFP, and describes the kind of relief that can be granted. For example, the Act sets forth the circumstances under which an ex parte order may be granted and requires that a hearing be held within ten days after the issuance of such an order.

The Act also describes penalties for violations of both OFPs and No Contact Orders; orders issued against a defendant in criminal proceedings for domestic violence and describes how law enforcement officials should enforce such orders. In addition, the Act includes many provisions that facilitate victims' access to the legal system. For example, the Act waives the filing fees for orders of protection and provides that an individual filing for an OFP may request that his or her address not be disclosed to the public.

Section 609.2242 of Minnesota's statutes criminalizes domestic violence. Under this law, an individual commits the crime of domestic assault by causing another to fear immediate bodily harm or death, or inflicting, or attempting to inflict, such harm. Penalties are increased when the perpetrator has previously committed one or more domestic assaults within a certain period.

Minnesota has also enacted a domestic violence arrest law, Section 629.341 that allows officers to arrest an individual without a warrant if

there is probable cause to believe that the individual has committed domestic abuse, and that requires officers to provide victims of domestic violence with notice of their legal rights.

Section 629.342 of Minnesota's statutes provides that police departments must develop policies and protocols for dealing with domestic violence, and explicitly requires police officers to assist victims in obtaining medical treatment and providing the victim with a notice of his or her legal rights.

New York State's Domestic Violence Prevention Act creates a comprehensive network of services for victims of domestic violence. The Act requires social services districts to offer emergency shelter and other services, including advocacy, counselling and referrals. The Act requires shelters that receive funding under its provisions must to maintain a confidential address and also mandates that other government agencies keep such addresses confidential.

New York State's law on warrantless arrest permits localities to establish mandatory arrest regulations or policies. The state's law on criminal procedures for family offenses directs officers investigating "a family offense" under that provision to "advise the victim of the availability of a shelter or other services in the community" and to "immediately give the victim written notice of the legal rights and remedies available to a victim of a family offense." This law provides an example of the kind of information an officer might give to a victim, and mandates that the notice be prepared in multiple languages if necessary.

New York State also passed a law creating an Office for the Prevention of Domestic Violence. The Office is charged with advising the governor and legislature "on the most effective ways for state government to respond to the problem of domestic violence" and to

"develop and implement policies and programmes designed to assist victims of domestic violence and their families, and to provide education and prevention, training and technical assistance."

California Passes Tough New Domestic Violence Laws, Marie De Santi's, Women's Justice Centre, provides an overview of California's new domestic violence law and discusses the ways in which the law could be further improved. The California Penal Code includes links to Section 836, the state's law on arrest, and sections of Part 4 Title 5 of the Penal Code, governing the law enforcement response to domestic violence.

California's Family Code contains provisions governing protections for victims of domestic violence, including the issuance and enforcement of OFPs (called "protective orders" under the Family Code), and the duties of law enforcement officers.

Chapter 209A of the General Laws of Massachusetts provides for the issuance and enforcement of OFPs, the confidentiality of the victim's address, and the abuser's surrender of weapons. Section 7 of Chapter 209A requires judges to conduct searches of a defendant's record "to determine whether the named defendant has a civil or criminal record involving domestic or other violence," sets forth the warning about penalties for violation of an OFP that must be provided to the batterer, and details the kinds of communications that, when a batterer has been sentenced to a batterers' treatment program, should occur between the program, battered women's shelters, the court, and the probation office for the purpose of ensuring victim safety and batterer accountability. Treatment for substance abuse may be ordered "in addition to, but not in lieu of" batterers' treatment programmes. Finally, this provision requires the defendant to pay the victim restitution for damages in the case of a violation of a restraining order issued by another jurisdiction.

The UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) did not specifically address gender-based violence when adopted in 1979. However, General Recommendation No. 19 adopted by the CEDAW Committee in 1992 specified that discrimination against women includes gender-based violence. Gender-based violence is defined in GR19 as "violence directed against a woman because she is a woman or that affects women disproportionately" and "includes acts that inflict physical, mental or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty." (CEDAW General Recommendation No. 19).

This chapter provided a review of literature. It highlighted the strategies for educating communities within an African context on the prevention and control of domestic violence affecting married women in Zimbabwe. Other sections discussed the roles of community members in the prevention and control of domestic violence and the experiences of married women about domestic violence.

Furthermore, it has addressed and documented literature reviewed by various researchers and scholars. Women who are exposed to domestic violence were found to be at an increased risk of sexually transmitted infections including HIV/AIDS. Rate of disclosure and help seeking behaviour was also found to be minimal. Health systems are also challenged by the effects of domestic violence.

The goal of nursing on this study is the promotion of optimal wellness of the individual through maintenance of system stability. The chapter concludes by illustrating the Betty Neuman's Systems Model, which forms the foundation of this study.

In addition, the chapter has also reviewed literature on domestic violence in Zimbabwe in general and this has been linked to the focus of the present study. Generally, most of the studies and surveys

referred to seem to suggest that women in Zimbabwe do not usually report cases of domestic violence. It also appears that cultural values and lack of appropriate legislation on domestic violence partly explain why most women are reluctant to report cases of domestic violence. The next chapter focuses on methodology of data gathering.

The high prevalence of domestic violence particularly in Sub Saharan Africa has contributed to increased disabilities, psychological, physical, reproductive, unwanted pregnancies, miscarriages, induced abortions and emotional problems. Domestic violence is a hidden burden in Zimbabwe as it is not reported to the police as it is regarded as a taboo. Community members should intervene early to stop domestic violence as it is critical. Progress of violent prevention efforts will depend on the level of public and governmental commitment to making prevention a long-term priority. A national policy of zero tolerance for violence is necessary.