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FACULTY OF SOCIAL SCIENCES AND HUMANITIES

DEPARTMENT OF SOCIAL WORK

POJECT RESEARCH TOPIC:

ASSESSMENT OF THE RELATIONSHIP BETWEEN GENDER-BASED VIOLENCE (GBV) AND HUMAN IMMUNODEFICIENCY VIRUS (HIV) PREVALENCE. A STUDY OF CHIREYA WARD 4, GOKWE NORTH DISTRICT.

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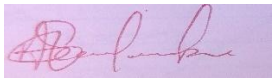
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Dedication

I, Amos Mushawezaru, dedicate this study to the Almighty God, my families (Mushawezaru and Chishiri), and all survivors of Gender-Based Violence and people affected by HIV, with the hope that it contributes to awareness, empowerment, and improved support services.

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I sincerely thank the Almighty God for His guidance, strength, and protection throughout this study. I am deeply grateful to my supervisor, Mr Sadomba, for his valuable guidance and support. My appreciation also goes to the Chishiri family and my family, the Mushawezaru family, for their encouragement, sacrifices, financial support prayers, and unwavering support. Special thanks are extended to ZAOGA FIF on Campus (ZOC) for their spiritual guidance and fellowship, as well as to my friends for their constant encouragement. I also acknowledge all those individuals who provided their support either directly or indirectly.

ABSTRACT

This study examined the relationship between GBV and HIV in Chireya Ward 4, Gokwe North District. The study was guided by three objectives: to assess the relationship between GBV and HIV, identify the key drivers of both GBV and HIV, and explore the challenges faced by survivors of GBV living with HIV in accessing support services. The Human Rights-Based Approach and Feminist Theory informed the study by providing insight into how gender inequality, unequal power relations, and human rights violations contribute to the persistence of both GBV and HIV. An explanatory sequential mixed-methods design was adopted, in which quantitative data was collected and analysed first, followed by qualitative data collection to further explain the quantitative results. The target population comprised community members who had experienced GBV and key informants from relevant institutions within the study area. The sample size was 100 victims of GBV for primary participants and 4 Key informants. Data was collected through questionnaires and key informant interviews and analysed using multivariate analysis, bivariate analysis and univariate analysis and thematic analysis was used for qualitative data. Quantitative data was presented using tables, pie charts and graphs. The findings established a strong link between GBV and HIV, with women being disproportionately affected due to sexual violence, limited bargaining power in sexual relationships, and unequal gender relations. Ignorance, harmful cultural practices, multiple sexual partnerships, and economic insecurity emerged as the main drivers of both GBV and HIV. The study also identified resource shortages, transport barriers, poor referral systems, fear of disclosure, lack of awareness, and fear of retaliation as major challenges affecting survivors. The study recommends strengthening awareness programmes, expanding integrated GBV and HIV services, increasing resources, and promoting women's empowerment initiatives.

LIST OF ACRONYMS

Acronym	Full Meaning
AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
GBV	Gender-Based Violence
HIV	Human Immunodeficiency Virus
HRBA	Human Rights-Based Approach
IPV	Intimate Partner Violence
MCP	Multiple Concurrent Partnerships
NAC	National AIDS Council
NGO	Non-Governmental Organization
PEP	Post-Exposure Prophylaxis
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
WHO	World Health Organization
ZIMSTAT	Zimbabwe National Statistics Agency
FGM	Female Genital Mutilation
SDGs	Sustainable Development Goals
VCT	Voluntary Counselling and Testing

Acronym	Full Meaning
ARVs	Antiretroviral Drugs

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CHAPTER ONE: INTRODUCTION AND BACKGROUND

1.0 Introduction and Background of the study.

This chapter creates a basis of the study through discussing the background of the research, goal, research objectives and questions as well as the problem statement. This chapter provides a discussion of the research gap, justification and limitations of the study as well as the geographical location of the study area.

Gender-Based Violence (GBV) and HIV remain deeply interconnected global challenges that continue to disproportionately affect women and girls for instance, low- and middle-income countries. Evidence shows that a proportion of women worldwide experience physical or sexual violence, and this greatly increases their vulnerability to HIV infection due to forced or unprotected sex, limited power to negotiate safe practices, and the emotional and psychological effects of abuse (WHO, 2021; Jewkes et al., 2010). Studies further suggest that women who have their involvement in intimate-partner violence reach about 1.5 times have a great potential to contract HIV (UNAIDS, 2020). The situation is more severe in the sub-Saharan Africa where women contribute to 60% of people living with HIV, largely due to persistent gender inequalities and socio-cultural norms that sustain both violence and infection (UNAIDS, 2022; Shamu et al., 2011). Beyond the health impact, the combined burden of GBV and HIV often leads to stigma, economic difficulties, and reduced access to essential services, which further traps survivors in cycles of vulnerability. Overall, these global patterns highlight the urgent need for integrated, survivor-centred approaches that address both GBV and HIV together in order to effectively reduce their impact.

In developed countries, the negative impact of GBV on HIV outcomes is significant, affecting the physical and mental health of survivors and complicating HIV prevention and treatment efforts. In the United States, nearly 24% of women who experience severe intimate partner violence are prone to contact HIV because increased risk of HIV infection is triggered by limiting women's ability to negotiate safer sex and their access to healthcare services (Centres for Disease Control and Prevention [CDC], 2020; Dean et al., 2019). Among women living with HIV, studies showed that around 55% reports of people experiencing some form of GBV is associated with poorer adherence to antiretroviral therapy and higher rates of depression and trauma (Waldron et al., 2021). In the United Kingdom, research showed that women affected by domestic violence are at higher risk of late HIV diagnosis and face increased stigma, which hinders timely treatment (Public Health England, 2019). Similarly,

Indigenous women in Australia experience both GBV and HIV at rates up to three times higher than the general population, exacerbating health disparities and social marginalization (Australian Institute of Health and Welfare [AIHW], 2021). These statistics underscore how GBV intensifies the HIV epidemic in developed settings by creating barriers to prevention, diagnosis, and care, ultimately worsening health outcomes for vulnerable populations.

In many African nations beyond Zimbabwe, the connection of Gender-Based Violence (GBV) and HIV continues to have devastating negative impacts on health, social well-being, and economic stability. In South Africa, which is one of the highest HIV prevalence rates globally, studies reveal that women who are victims of intimate-partner violence are 50% prone to acquire HIV. This due to forced sex, trauma, and limited capacity to negotiate condom use (Zuma et al., 2022).In Kenya, the national Demographic and Health Survey (2014) indicates that 39% of women aged 15-49 have experienced physical or sexual violence, a factor strongly linked to higher HIV infection rates among young women (Kenya National AIDS Control Council, 2018). Similarly, in Uganda, women exposed to GBV have an increased risk of HIV, with research showing that up to 40% of women report experiencing some form of violence, which undermines prevention efforts and access to care (Muldoon et al., 2015). In Nigeria, pervasive GBV, including sexual violence and harmful cultural practices, contributes to rising HIV infections among women, especially in rural areas where healthcare services are limited (National Agency for the Control of AIDS [NACA], 2020). These negative impacts illustrate how GBV fuels the HIV epidemic across diverse African contexts, exacerbating vulnerabilities and posing significant barriers to effective prevention and treatment strategies.

In Zimbabwe, the relationship between Gender-Based Violence (GBV) and HIV continues to have serious health, social, and economic consequences, particularly for women. National statistics show that about 34% of women aged 15–49 have experienced physical or sexual violence, while HIV prevalence remains higher among women (13.1%) than men (7.4%) (ZIMSTAT & ICF, 2016; National AIDS Council, 2021). This suggests that women are disproportionately affected by both GBV and HIV. Studies by Gumindoga and Maphosa (2018) found that survivors of violence often experience emotional trauma, fear, and social isolation, which can make it difficult for them to access HIV prevention, treatment, and support services. Similarly, findings from the Zimbabwe Demographic and Health Survey (2015) revealed that intimate partner violence is widespread and is associated with higher HIV infection rates among women (Ncube et al., 2020). Chari and Kurebwa (2017) further

noted that the stigma surrounding both GBV and HIV discourages many survivors from seeking medical attention and support early, resulting in delayed diagnosis and treatment. In addition, Mushunje and Mutambara (2021) observed that the financial costs associated with violence and ill health often worsen poverty, especially in rural communities where access to resources is already limited. These findings highlight the urgent need for integrated interventions that address both GBV and HIV simultaneously, while also tackling the social, economic, and cultural factors that increase vulnerability.

Zimbabwe has made significant efforts to address the closely linked challenges of Gender-Based Violence (GBV) and HIV through legal, health, and community-based interventions. The government, through the National AIDS Council (NAC), has incorporated GBV prevention and response into national HIV programmes, recognising that violence and HIV are interconnected public health concerns (National AIDS Council, 2021). Legal frameworks such as the Domestic Violence Act of 2007 have been put in place to protect survivors and hold perpetrators accountable, while reforms within the justice sector seek to improve access to legal support and remedies (Ministry of Justice and Parliamentary Affairs, 2019). Within the health sector, healthcare workers have been trained to identify and respond to cases of GBV during HIV testing and counselling, ensuring that survivors receive timely referrals, medical care, and psychosocial support (Mutambara et al., 2020). According to the Zimbabwe Demographic and Health Survey (2015), these efforts have improved awareness of GBV services, with many women reporting knowledge of available support systems, although access to these services remains a challenge in some communities. In addition, community programmes targeting men, women, and young people have been introduced to challenge harmful gender norms and promote healthier relationships (Moyo & Sibanda, 2019). Despite these achievements, gaps in resources, service coverage, and accessibility continue to hinder progress, particularly in rural areas. Therefore, there remains a need for stronger coordination, increased funding, and integrated interventions that simultaneously address both GBV and HIV to ensure that vulnerable populations receive comprehensive support and protection.

1.1 Problem Statement

In Chireya Ward 4 of Gokwe North District, Zimbabwe, the intertwined challenges of Gender-Based Violence and HIV/AIDS significantly impact the local population, particularly women and girls. GBV in the region manifests through physical, emotional, and sexual

violence, often exacerbated by socio-economic hardships and cultural norms. The occurrence of GBV is frequently entrenched in cultural and social beliefs that promote discrimination and violence, leading to serious psychological and physical effects. Concurrently, the persistent HIV epidemic poses a grave health concern, affecting women disproportionately due to various biological, social, and economic aspects. According to REPSSI (2017), Sexual Gender-Based Violence (SGBV) is widespread, contributing to problems including child marriages, teenage pregnancies, and rising rates of new HIV infections. The link between GBV and heightened HIV prevalence is clear, as many victims struggle to advocate for safer sexual practices. This study seeks to fulfil the critical need for enhanced awareness and education within the community regarding safer sexual practices. It also underscores the necessity of creating referral systems for survivors of GBV to guarantee they obtain the necessary medical care, which, in turn, can lessen the risk of HIV infection.

1.2 Research Aim

The research aims at assessing the relationship between Gender-Based Violence (GBV) and HIV prevalence in Chireya Ward 4 of Gokwe North District, Zimbabwe.

1.3 Research Objectives

1. To explore the casual relationship between Gender Based Violence and Human Immune Virus in Ward 4 of Gokwe District.
2. To identify the key drivers of Gender Based Violence and HIV in Chireya ward 4, Gokwe North District.
3. To identify key barriers to seeking help among GBV survivors who are also living with HIV in Chireya Ward 4, Gokwe North District.

1.4 Research Questions

1. . What is the l relationship between Gender Based Violence and Human Immune?
2. . What are the key drivers of HIV and Gender Based Violence?
3. . What are challenges to seeking help among GBV survivors who are also living with HIV?

1.5 Justification of the study

A. Target Population

The findings of this study, which explored the relationship between GBV and HIV in Gokwe North Ward 4, Chireya, offered several benefits to the target population. Firstly, the study raised awareness about the interconnected nature of GBV and HIV transmission, helping communities understand how violence, particularly sexual and intimate partner violence, increased vulnerability to HIV infection. By identifying local risk factors and social dynamics that perpetuated both GBV and HIV, the research informs community-based interventions and policy responses tailored to the specific needs of women and men in Gokwe North (Campbell et al., 2008). Moreover, the results will guide health workers and local leaders in integrating GBV prevention into HIV programs, improving access to support services and fostering safer, more equitable relationships. Ultimately, the study empowers the community by promoting education, reducing stigma, and contributing to improved health and well-being outcomes.

B. Organisations or Civil Society Organisations

This research on the relationship between GBV and HIV is crucial for both organizations and civil society organizations (CSOs) as it provides evidence-based insights that can enhance intervention strategies and policy formulation. For healthcare organizations and HIV/AIDS support groups, understanding the link between GBV and increased vulnerability to HIV infection allows for the development of integrated programs that address both health issues simultaneously, improving the effectiveness of prevention and treatment efforts (Leddy et al., 2019). Civil society organizations, which often work at the grassroots level to support vulnerable populations, can use the findings to advocate for stronger legal protections and social support systems for survivors of GBV, thereby reducing their risk of HIV. Additionally, this research informs capacity-building initiatives, enabling organizations to train staff and volunteers on the intersectionality of GBV and HIV, fostering more empathetic and comprehensive care. Ultimately, the study contributes to creating a coordinated response that addresses the multifaceted challenges faced by affected individuals, promoting public health, social justice, and empowerment within communities.

C. Government Departments, Ministries

The findings from this research are valuable to government departments and ministries particularly those responsible for health, gender affairs, justice and social welfare. By clarifying the relationship between Gender-Based Violence and HIV, the study provides critical data that can inform the design, the execution of more targeted and effective policies

and programs (Tappis et al., 2016). Ministry of Health can utilize the insights to integrate GBV prevention and response into national HIV/AIDS strategies, ensuring a holistic approach that addresses both issues concurrently. The Ministry of Woman Affairs can leverage the research to strengthen protective legislation and support services for survivors, while the Ministry of Justice may benefit from enhanced understanding to improve legal frameworks and prosecution of GBV-related offenses. Additionally, the Ministry of Education can incorporate findings into awareness campaigns and school-based programs aimed at reducing GBV and HIV transmission among youth. The research supports evidence-based policymaking, resource allocation, and inter-ministerial collaboration, which are essential for reducing the incidence of GBV and HIV and promoting the health and rights of all citizens (Raftery, 2023).Therefore, this research finding will help the governments departments and Ministries.

D. Academic Literature

This study offers valuable contributions to academic literature by exploring the intricate link between gender-based violence and HIV in the localized context of Gokwe North District, Chireya Ward 4. As noted by Campbell (2002), GBV is a significant driver of HIV infection, particularly in sub-Saharan Africa, where social and cultural norms often exacerbate vulnerability (Nwokedi et al., 2025). Furthermore, (Humbert et al., 2025) emphasized the importance of context-specific research to understand how GBV and HIV infection intersect within different communities to inform tailored interventions. By focusing on a rural Zimbabwean setting, this research fills a critical gap in localized empirical data, supporting the development of nuanced theoretical models that reflect socio-cultural realities. Additionally, this study will strengthen the academic discourse by bridging gaps between public health, gender studies, and community-based research, thereby providing a solid foundation for future scholarship and policy formulation aimed at reducing both GBV and HIV prevalence.

1.6 Assumptions

- Ontological Assumptions

The study assumes that gender-based violence and HIV are real social and health phenomena that exist in Chireya ward 4 communities and can be observed and interpreted through the experiences of survivors and key informants. According to Crotty (1998), ontology relates to

the nature of reality, and this study adopts a perspective that social realities, such as GBV and HIV, are tangible and can be systematically studied.

- Epistemological Assumptions

It is assumed that knowledge about GBV and HIV can be generated through interaction with participants and systematic analysis of both quantitative and qualitative data. Creswell and Plano Clark (2018) argue that mixed-methods research offers a deeper understanding of multifaceted social issues through combining numerical measurements with in-depth exploration of lived experiences. The study further assumes that participants are capable of providing reliable and truthful information regarding sensitive issues like GBV and HIV (Patton, 2015).

The study assumed that social, cultural, economic, and institutional factors play a significant role in shaping individuals' experiences of GBV, HIV and access to services. It was further assumed that these broader structural conditions influence how survivors interpret violence, respond to abuse, and make decisions about seeking help from health, legal, and social welfare systems.

1.7 Delimitations

This study was geographically delimited to Gokwe North District, Ward 4, as the primary focus area for investigating the linkage between gender-based violence and HIV. The selection of this specific rural locality reflects an understanding that GBV and HIV dynamics are influenced by local social, cultural, and economic contexts, which can differ widely across regions. As highlighted by (Carrera-Rivera et al., 2022), delimiting a study to a defined geographical area enables researchers to conduct a thorough contextual analysis while managing the scope and resources of the research. Additionally, focusing on Ward 4 allows the study to provide detailed, community-specific findings that contribute to addressing localized challenges, although this focus may limit the broader applicability of the results to other districts or urban areas with different characteristics (Morse, 1994). Such delimitations are essential to maintain clarity and depth in research guaranteeing that the research remains practicable and relevant to the targeted population and setting.

1.8 Limitations

One of the major limitations of this study was that the findings may not be easily generalized to the wider population because qualitative research involves a comparatively small number of participants who are selected from a specific context (Creswell & Poth, 2018). The study also relied heavily on participants' personal accounts and experiences, which may have been influenced by memory lapses or the desire to provide socially acceptable responses, particularly given the sensitive nature of Gender-Based Violence (GBV) and HIV-related issues (Maxwell, 2013). In addition, the interpretation of qualitative data is largely dependent on the researcher, creating the possibility that personal perspectives or assumptions may influence the analysis of the findings (Patton, 2015). The study was also time-consuming, as collecting and analysing detailed qualitative data required considerable time and effort, which limited the number of participants and the scope of the research (Denzin & Lincoln, 2018). Despite these limitations, the qualitative approach was valuable because it provided an in-depth understanding of the lived experiences, perceptions, and challenges faced by survivors of GBV and HIV, generating rich insights that may not have been captured through quantitative methods alone.

1.9.1 Definition of Key terms

1.9,2 Gender Based Violence

Gender Based violence is any act of violence that is directed to any individual based on their gender and results in physical, sexual or psychological harm or suffering (WHO,2002). These include the intimidation of such acts, pressure or subjective deficiency of liberty whether occurring in public or private life.

1.9,3 Human Immune Virus Infection.

According to UNAIDS (2020), HIV infection is a chronic condition that if not treated, weakens the body's ability to fight infections and can eventually progress to Acquired Immunodeficiency Syndrome (AIDS).

1.9,4 Gender-based violence Survivors

Survivors as defined by Campbell et al. (2009), these are individuals who have experienced gender-based violence and continue to live with its physical, emotional, and social consequences while seeking support and recovery.

1.10 Chapter summary

This chapter addressed key foundational aspects of the study including the back ground, problem statement, research objectives and questions, significance of the study and limitations of the study as well as the geographical location of the study area.

CHAPTER TWO: LITERATUTRE REVIEW

2.0 Introduction.

This section identifies a set of papers from several researchers on the interlinkage between Gender Based Violence and HIV that is they encompass related literature review on causal relationship, key drivers of GBV, HIV and identifying factors affecting the survivors of GBV who are living with HIV and seeking help. This section also includes the conceptual framework applicable to the study as well as the research gap.

2.1 Literature review

Literature review refers to survey books, scholarly articles and other sources relevant to a particular issue, area of research and they provide a description, summary and critical evaluation of these works in relation to the research (Arlene,2015). The literature seeks to review how interconnectedness between HIV and GBV is being understood in Southern Africa and Zimbabwe in particular. Research across sub-Saharan Africa has consistently established a close relationship between GBV and HIV with violence acting both as a root of HIV. According to (Güler et al., 2024), women who experience physical or sexual violence from their partners have a 1.5 times higher risk of acquiring HIV compared to those who do not experience such violence. Decker et al. (2014) further explain that GBV undermines women's capacity to negotiate safer sex practices, thereby increasing their exposure to infection

2.1 Theoretical framework

2.1.1 Human rights-based approach

The study was guided by the Human Rights-Based Approach (HRBA). It emphasizes that every individual has the right to dignity, protection, equality and access to healthcare services regardless of gender, social status, or background. The Human Rights-Based Approach is grounded in international human rights values that focus on respecting, protecting and fulfilling people's rights. In relation to this study, the approach assisted the researcher to

understand how social inequalities, harmful cultural beliefs, dishonour, discrimination and unequal power relations continue to contribute to GBV and the infection of HIV in communities such as Chireya Ward 4. The approach also stresses participation, inclusion, and non-discrimination, meaning that survivors of GBV and people living with HIV should have equal access to healthcare, counselling, legal protection, and support services without fear of stigma or exclusion. (Mhlanga et al., 2024) further explains that the approach promotes sexual and reproductive health rights and encourages programmes that protect human dignity and empower vulnerable groups. In the same way, the United Nations Development Programme and the National AIDS Council of Zimbabwe emphasize that women have the right to self-protection, access to HIV information, and freedom from violence and discrimination. Therefore, this approach was important in this study because it explained how denial of rights, poverty, gender inequality and limited access to services increase the defencelessness of women and other survivors of GBV to HIV infection.

2.1,2 Feminist Theory

The theory provided the third critical framework for this research, offering a structural and ideological understanding of GBV as a manifestation of patriarchal influence and control over women' and their sexuality. According Lomazzi (2023), violence against women arises from historical systems of male authority surrounded within cultural, economic, and political structures. Feminists such as Hooks (2000) and Butler (1999) further argued that patriarchy constructs rigid gender roles that subordinate women and normalize male dominance, creating a climate where violence is both tolerated and internalized. From a feminist perspective, GBV is not merely a private issue but a social and political problem rooted in inequality. In the rural context of Gokwe North, these patriarchal ideologies are reinforced through traditional beliefs that valorise male authority, bride price practices that commodify women, and social norms that silence victims of abuse. The theory also provides a framework to understand how such gender oppression contributes to HIV vulnerability: women are often unable to negotiate condom use, access reproductive health services, or disclose their HIV status without fear of violence or rejection. As Miedema (2019) notes, feminist approaches to HIV prevention must therefore centre on women's empowerment, education, and the transformation of social structures that sustain gender inequality. By applying feminist insights, this study acknowledges GBV and HIV as interconnected consequences of patriarchy and seeks to illuminate how power relations at both household and community levels sustain these public health challenges in Chireya. Moreover, this theoretical approach

advocates for social change and empowerment-based interventions that challenge harmful norms, promote gender equality, and support survivors in reclaiming agency over their bodies and health.

2.3,0 The key drivers of Gender Based Violence

2.3.1 Economic Insecurity

Economic insecurity remains one of the major factors driving both GBV and HIV infection across the world, although its effects are more severe in developing countries. In developed countries, studies such as Mellar et al. (2024) found that women who are dependent financially on abusive associates frequently struggle to negotiate safer sex practices or access HIV prevention services, which increases their vulnerability to infection. Similarly, Dunkle and Decker (2013) observed in Europe that immigrant women facing poverty and social exclusion were more exposed to both GBV and HIV, showing that economic inequality continues to affect women even in wealthier countries. In developing countries, however, the situation is more critical because of widespread poverty, unemployment, and limited opportunities for women. Studies conducted in South Africa revealed that women's dependence on male partners was strongly linked to intimate partner violence and HIV infection (Jewkes et al. 2010). Maman et al. (2000) note that lack of financial independence discouraged many women from leaving abusive relationships or seeking HIV testing and treatment. In Zimbabwe, scholars such as Shamu et al. (2013) and Mudzongo (2019) highlighted that economic hardships force some women into transactional sex and make it difficult for them to escape violent relationships, increasing their vulnerability to HIV infection. These findings demonstrate that poverty and economic insecurity continue to fuel cycles of violence and HIV globally, but the effects are even more visible in rural communities such as Chireya Ward 4 in Gokwe North District, where limited economic opportunities leave many women vulnerable to abuse and health risks.

2.3,2 Ignorance

Ignorance, which includes lack of awareness, misinformation, and denial, has been widely recognized as one of the main factors contributing to both HIV transmission and Gender-Based Violence (GBV) across the world. In developed countries, studies by Campbell et al. (2008) in the United States and Stockman, Lucea, and Campbell (2013) in North America

found that many women had limited knowledge about HIV prevention and the health effects of intimate partner violence, making it difficult for them to protect themselves from abuse and infection. Similarly, research conducted in Canada by Logie et al. (2011) showed that stigma and lack of information surrounding sexual violence discouraged many survivors from seeking HIV testing and treatment, increasing their vulnerability. In Europe, Dunkle and Decker (2013) further highlighted that misinformation about HIV transmission and silence around GBV issues contributed to underreporting and delayed interventions, even in countries with better healthcare systems. Limited understanding of HIV and GBV often results in low uptake of HIV testing, poor adherence to antiretroviral therapy (ART), and continued belief in harmful myths, such as the idea that HIV can be cured through traditional herbs or avoided simply through faithfulness in relationships. According to Joint United Nations Programme on HIV/AIDS (2023), inadequate HIV knowledge and persistent stigma remain major barriers to controlling the epidemic, especially in rural communities with limited access to education and media. Therefore, in communities such as Chireya Ward 4 in Gokwe North District, lack of awareness and misinformation continue to fuel fear, silence, and risky behaviours, which not only increase the spread of HIV but also contribute to the persistence of Gender-Based Violence.

2.3,3 Multiple concurrent partnership

According to Gras et al. (1999)Multiple concurrent partnership as an overlay of sexual partners in a given period with two or more immediate sexual partnerships. They further argued that most adolescents in in Sub-Saharan countries engage in sexual practices with multiple partners concurrently, thus placing them at high risk of HIV infection, unwanted pregnancies and subsequently leading to child marriages. According to Anderson et al (2008), higher rates of numerous partners are constantly related with GBV. Those who reported rape and infant sexual molestation were sexually harassed or experienced violence. Those who reported that their first involvement in sexual activities was coerced had a potential of having multiple partners (Arriola et al. (2005). Anderson et al. (2008), revealed that marginal women in the USA who were sexually abused reported higher rates of sexual partner changes in a month, 3 months and in 12 or more months. Assessment of these behaviours using chi-square, t-tests, and logistic regression were made by history of sexual abuse. Sexually abused women were more likely to have lower incomes, earlier coitus, STD history, currently abusive partners, new sex partners and this increased their risk of reinfection, violence from abusive partners. The studies further reflected that multiple partnerships are widespread

among young people in informal settlements where there is poor access to health services which worsens the risk of HIV infection.

2.3.4 Harmful Cultural Beliefs

There are harmful cultural beliefs such as misguided beliefs on HIV and AIDS which continues to publicize the idea that sex with a virgin can help treat HIV or AIDS (Meel ,2003). According to Madiba & Ngwenya (2017), lobola or bride price perpetuate the idea that a woman is her husband's property and it encourages the usage of condoms in settings that increase women's vulnerability to infection. The same belief triggers arguments that lead to violence and violent contact from their counterparts. Akazilli et al (2020) postulated that, socio-cultural and religious factors such as myths, stigma and misconceptions negatively affect the provision and uptake of some reproductive health services inclusive of condoms for safer sex. Jewkes et al. (2015),also argued that patriarchal cultural norms that promote male dominance and female submissiveness often legitimize violence against women and limit their ability to challenge abusive relationships. Heise (2011) also argues that cultural beliefs which support unequal gender relations create an environment where GBV is normalized and tolerated. In Zimbabwe, there are cultural practices such as bride price (lobola), child marriage, and traditional expectations of women's obedience that link to increased vulnerability to physical, sexual, emotional, and economic abuse (Chireshe, 2015). These practices are particularly prevalent in rural areas where traditional customs remain influential. Therefore, harmful cultural practices continue to perpetuate GBV by restricting women's autonomy, limiting access to justice, and sustaining gender inequalities within households and communities.

2.4 The relationship between Gender Based Violence and Human Immune Virus

2.4,1 Increased Risk of HIV Infection Due to GBV

Gender-Based Violence (GBV) significantly increases the risk of HIV infection, a relationship well-documented by scholars in public health and social sciences. According to Jewkes et al. (2010), sexual violence, particularly forced or coerced intercourse, often results in physical trauma that facilitates the transmission of HIV by providing direct entry points for the virus. Additionally, Campbell et al. (2008) emphasize that women experiencing intimate partner violence frequently lack the agency to negotiate condom use, heightening their

vulnerability to HIV infection. The psychological consequences of GBV, including trauma and depression, may also lead to behaviours such as substance abuse and unprotected sex, further exacerbating risk (Maman et al., 2000). Furthermore, survivors of GBV often face barriers to accessing HIV prevention and treatment services due to stigma and fear, limiting their ability to protect themselves and receive timely care (Dunkle & Decker, 2013). These findings underscore the complex interplay between GBV and HIV and highlight the need for integrated interventions that address both issues simultaneously.

2.4,2 Cycle of Vulnerability

The cycle of vulnerability between GBV and HIV creates a self-reinforcing pattern where each condition increases the risk and severity of the other. According to Campbell (2003), women who experience GBV are more susceptible to HIV infection due to forced sexual encounters, limited capacity to negotiate safe sex, and the psychological effects of trauma that may lead to risky behaviours. Once infected, these women often face stigma and further violence related to their HIV status, which can hinder access to treatment and support services(Aziz & Smith, 2011). This ongoing exposure to violence and discrimination exacerbates their vulnerability, creating a continuous cycle that is difficult to break without integrated interventions addressing both GBV and HIV simultaneously (Reza et al., 2009). Campbell highlights that comprehensive support and preventative measures are essential to disrupt this cycle and improve health outcomes for survivors.

2.4,3 HIV as a Consequence of GBV

HIV as a consequence of GBV has become a main public health and human rights concern across the world. Researchers have shown that GBV, especially sexual violence, increases the risk of HIV infection in several ways. According to Dunkle and Decker (2013), forced or violent sexual intercourse can cause physical injuries and trauma, creating direct entry points for HIV transmission. Survivors of violence also often have little power to make decisions about their sexual and reproductive health, making it difficult for them to negotiate condom use or refuse unsafe sex. Similarly, Lausi et al. (2023) noted that unequal power relations in abusive relationships leave many women vulnerable to unprotected sex and repeated exposure to HIV infection. The World Health Organization (2013) further explains that the emotional and psychological effects of GBV, such as trauma, fear, depression, anxiety, and low self-esteem, may push survivors into risky behaviours including substance abuse or engaging in unsafe sexual relationships as a coping mechanism. In many cases, survivors

remain trapped in abusive relationships because of economic dependence, fear of retaliation, or concern about losing family support. Stigma and fear also discourage many victims from reporting abuse or seeking HIV-related services such as testing, counselling, treatment, and post-exposure prophylaxis (PEP). As a result, survivors may delay seeking medical attention until their condition worsens, increasing both health complications and the spread of HIV. These findings show that GBV and HIV are deeply interconnected, as violence not only exposes individuals to infection physically, but also creates emotional, social, and economic conditions that increase vulnerability and limit access to protection and healthcare services.

2.4,4 HIV Infection Can Lead to GBV

HIV infection can itself be a significant trigger for Gender-Based Violence (GBV), creating a vicious cycle in which health status becomes a source of stigma, rejection, and abuse, particularly for women in patriarchal and economically constrained settings such as Gokwe North Ward 4, Chireya. Hatcher et al., 2014 further argued that women living with HIV are at heightened risk of experiencing violence from intimate partners, family members, and communities after disclosure of their status. In Chireya ward 4, traditional gender norms and misconceptions about HIV transmission further exacerbate this problem. Many men interpret a woman's HIV-positive status as evidence of promiscuity or infidelity, leading to verbal, emotional, or physical abuse (Klaar, 2012). Women, therefore, often delay or completely avoid disclosure of their HIV status to protect themselves from retaliation, abandonment, or divorce behaviours that unfortunately perpetuate hidden transmission chains.

2.5 Challenges to seeking help among GBV survivors who are also living with HIV

2.5,1 Fear of Disclosure

Fear of blame, accusations of infidelity, social rejection, or further violence from intimate partners and family members discourages survivors from disclosing their HIV status and reporting abuse, thereby limiting access to medical care, legal redress, and psychosocial support (Jewkes et al., 2010; UNAIDS, 2019).In Zimbabwe, stigma and low awareness about post-rape services contribute to delay reporting of sexual violence, despite the availability of post-exposure prophylaxis (PEP), which must be initiated within 72 hours to be effective. National and UNFPA reports indicate that fewer than 35 percent of survivors seek medical assistance within this critical period, resulting in missed opportunities for HIV prevention and comprehensive care (UNFPA Zimbabwe, 2021; NAC, 2021. This fear may prevent them from seeking medical care, legal redress, or psychosocial support. Delayed disclosure can

also mean missing the critical window for post-exposure prophylaxis (PEP) or other vital health interventions.

2.5.2 Transport Barriers

Health centres that provide integrated GBV and HIV services are often located far away from rural communities, creating major challenges for survivors who need urgent assistance. In many rural areas, poor road networks, limited public transport, long travelling distances and high transport costs make it difficult for survivors to access healthcare facilities, police stations, counselling services and social welfare offices on time. Wercholuk et al (2022) noted that transport challenges continue to prevent many survivors from receiving timely medical attention and HIV-related care. In addition to transport costs, many survivors are already struggling with poverty and caregiving responsibilities, making it even harder for them to afford food, accommodation, medication, hospital fees, and repeated visits to healthcare facilities. Reports from the Government of Zimbabwe (2023) and the United Nations Population Fund (2022) further show that these economic and logistical barriers contribute to delayed reporting of abuse, low utilization of GBV and HIV support services, and increased vulnerability among women and other survivors. In the context of Chireya Ward 4 in Gokwe North District, transport barriers are particularly important because most services are located far from the community, while poor roads and limited transport options make travelling very difficult. As a result, many survivors fail to access immediate medical care after violence, including HIV testing, counselling, post-exposure prophylaxis (PEP), and psychosocial support, which are essential in reducing HIV infection and helping survivors recover physically and emotionally. Delays in reaching health facilities may therefore worsen both the health and social consequences of GBV and HIV within the community.

2.5,3 Resource Constraints

Even when survivors get to clinics or one-stop centres, services may be inadequate. There may be shortages of essential supplies (e.g., PEP, STI treatment, ARVs), staff trained to respond to both GBV and HIV needs, legal aid, or psychosocial support. Research across sub-Saharan Africa shows that under-resourced health systems, shortages of trained personnel, and inadequate supplies of medications and counselling resources reduce survivors' ability to access comprehensive care, particularly for those requiring both GBV and HIV services (Watts & Zimmerman, 2002; Kishor & Johnson, 2004). In Zimbabwe, similar dynamics are evident: health facilities often lack the necessary commodities (such as

post-exposure prophylaxis, anti-retroviral, and STI treatment), and there are documented shortages of trained clinicians and counsellors able to manage the complex needs. Follow-up services may be weak or absent in the community. For example, the Zimbabwe GBV strategy notes a shortage of social workers and limitations in follow-up counselling sessions. Hence shortage of resources affects the survivors to seek help.

2.5,4 Poor Referrals

Survivors often need multiple services: medical treatment, HIV counselling and treatment, psychosocial support, legal services, police reporting, etc. If referral pathways are weak or if different agencies (health, social welfare, legal, law enforcement) are not well coordinated, survivors may fall through the cracks (Donnelly et al., 2023). When referral pathways between health facilities, social welfare departments, legal aid providers, and law-enforcement agencies are weak or poorly coordinated, survivors are more likely to disengage from care, particularly those living with HIV who require sustained follow-up and continuity of treatment, (Jewkes, Sen & Garcia-Moreno, 2014). In low-resource settings such as Zimbabwe, fragmented referral systems mean that survivors may receive initial clinical attention but fail to access longer-term HIV care, counselling, or legal redress due to unclear procedures, lack of case management, and poorLack of clear, accessible information about where to go, and whom to trust, complicates help-seeking. Reports on healthcare workers note that poor referral systems discourage GBV survivors.

2.5,5 Lack of Awareness

A major challenge faced by survivors of gender-based violence who are living with HIV is lack of awareness, which operates as a barrier across both developed and developing countries. In developed contexts, studies such as Logie et al. (2011) in Canada, Lucea, and Campbell (2013) in the United States revealed that many survivors lacked knowledge about available support services, HIV treatment options, and the health consequences of violence, leading to delayed help-seeking and poor health outcomes. Similarly, Dunkle and Decker (2013) highlighted that misinformation and stigma surrounding HIV and GBV discouraged disclosure and reduced utilization of counselling services in Europe. In developing countries, the problem is more acute due to limited education and weak health infrastructure; for example, in South Africa found that women often remained in abusive relationships because

they were unaware of the link between GBV and HIV risk, while Maman et al. (2000) in Kenya showed that ignorance about voluntary counselling and testing services hindered uptake among survivors. In Zimbabwe, Shamu et al. (2013) emphasized that cultural silence and misinformation perpetuate stigma, discouraging women from seeking both HIV care and GBV support, while Mudzongo (2019) noted that many rural women lack awareness of legal protections and available health services. They may not understand how quickly some medical treatments need to be accessed (e.g., PEP within 72 hours after sexual assault) or the legal protections and remedies available. The "72Hours Campaign" in Zimbabwe indicates that many survivors are not aware of or do not access services within that critical timeframe.

2.5,6 Risk of Retaliation.

Fear of retaliation is a major obstacle preventing survivors of GBV who are also living with HIV from seeking help, and this challenge is evident across both developed and developing countries. In high-income settings, studies such as Campbell et al. (2008) in the United States and Stockman, Lucea, and Campbell (2013) across North America found that women often avoided reporting abuse or accessing HIV services because they feared further violence, abandonment, or social isolation from their partners. Similarly, Dunkle and Decker (2013) noted that in Europe, survivors frequently remained silent due to threats of retaliation, particularly when they were financially dependent on abusive partners. In developing countries, the risk is intensified by weaker legal protections and entrenched cultural norms; for example, Jewkes et al. (2010) in South Africa showed that disclosure of abuse often led to escalated violence, while Maman et al. (2000) in Kenya documented that fear of violent backlash discouraged women from using voluntary counselling and testing services. In Zimbabwe, Shamu et al. (2013) highlighted that women often conceal both their HIV status and experiences of violence to avoid further abuse or community ostracism, while Mudzongo (2019) emphasized that rural women face compounded risks due to cultural silence and lack of protective mechanisms. The evidence demonstrates that retaliation is a universal barrier, narrowing to developing regions where weak enforcement and stigma intensify the danger, and finally contextualizing to Zimbabwe where survivors in rural communities such as Chireya Ward 4, Gokwe North District are particularly vulnerable, making help-seeking both risky and difficult.

2.6 Research Gap

Although extensive research has explored the relationship between gender-based violence (GBV) and HIV in both developed and developing countries, significant gaps remain that justify this study. Much of the existing literature has focused on urban populations or broad national trends, often overlooking the unique realities of rural communities where socio-economic hardship, cultural silence, and limited health infrastructure intensify vulnerability. In Zimbabwe, Shamu et al. (2013) and Mudzongo (2019) have examined GBV and HIV in urban contexts, few studies have investigated how these issues intersect in rural wards like Chireya Ward 4, Gokwe North District, where poverty, ignorance, and fear of retaliation may uniquely shape survivors' experiences. This gap motivated the choice of the target population, as rural women and men often face compounded risks yet remain underrepresented in academic research. Methodologically, the study adopts a mixed-methods approach combining quantitative surveys to establish prevalence and correlations with qualitative interviews to capture lived experiences ensuring both statistical rigor and contextual depth. The geographic delimitation to Chireya Ward 4 is deliberate, as this area exemplifies rural socio-economic challenges, cultural norms, and health service limitations that make it a critical site for understanding the GBV-HIV nexus. By addressing these gaps, the study contributes localized evidence that can inform more targeted interventions and policies in Zimbabwe and beyond.

2.7Chapter Summary.

This chapter provided the connection between GBV and HIV infection. The chapter provided that the relationship is not only casual but GBV increases the risk of HIV infection as well as worsening it, creating a cycle of vulnerability for women and men in the community. Gender-Based Violence and HIV key drivers have been discussed which include poverty, multiple sexual partners, ignorance, economic insecurity and harmful cultural practices. Theoretical frameworks such the Human rights approach and the feminist theory have been explained to understand how social norms, power imbalances, and gender inequality influence both GBV and HIV. Barriers that survivors face in seeking help—like fear of disclosure, transport difficulties, limited resources, weak referral systems, lack of awareness, and fear of retaliation were also highlighted. The chapter also explained the research gap of the study.

CHAPTER THREE: METHODOLOGY

3.0 Introduction

This section provides details of the research methodology that were employed by the researcher in conducting the study. The chapter as well explains the research design, research approach, sampling and data collection techniques. Methodology comprises of research ethics, research instruments, sampling techniques, sample size, target population and data analysis. Mixed methodology of qualitative methodology and quantitative methodology are to be discussed in this chapter.

3.1 Research Philosophy

Research philosophy is defined as the underlying beliefs and assumptions that guide how a researcher understands the world, gathers knowledge and interprets reality (Dulal, 2025). It shapes how a study is designed and how data are collected and analysed. This study is guided by the pragmatist research philosophy, which holds that no single viewpoint can fully explain complex social problems and that research methods should be chosen based on their ability to address the research questions effectively. Pragmatism recognizes both objective and subjective realities and therefore supports the integration of quantitative and qualitative approaches. In examining the relationship between gender-based violence and HIV in Gokwe North District, pragmatism allows the researcher to combine statistical evidence on the prevalence and patterns of GBV and HIV with in-depth qualitative insights into the lived experiences, perceptions, and social contexts of affected individuals. This philosophical stance was particularly appropriate because the GBV–HIV nexus is shaped by measurable health outcomes as well as cultural norms, gender relations, stigma, and power dynamics. By adopting pragmatism, the study is able to generate practical, context-specific knowledge that can inform effective interventions and policy responses.

3.3 Research Approach

The study adopted mixed methods of both quantitative and qualitative methods to comprehensively examine the relationship between GBV and HIV in Gokwe North District. According to Creswell (2014), quantitative research is a method that tests objective theories by examining relations among variables using numerical data and statistical analysis. The prevalence of GBV, HIV risk factors, and access to services are measured to determine possible associations between GBV exposure and HIV vulnerability. Denzin and Lincoln (2011) define qualitative research as an approach that seeks to understand social phenomena through participants lived experiences and the meanings they attach to them. In the case of this study, it helps explain and interpret statistical findings by exploring survivors'

perceptions, community norms, dishonor, and institutional responses influencing both GBV and HIV in rural Zimbabwe. Through combining both approaches in an explanatory design, the study enhances validity through triangulation and generates context-specific evidence to inform integrated GBV and HIV interventions in Gokwe North District.

3.4 Research Design

According to Kumar (2011), a research design refers to a systematic plan that specifies how data will be collected and measured as well as analyzed to achieve the objectives of a study. Yin (2018) defines it as the logical plan that connects the experimental data to the initial research questions and to the study's conclusions. This research used an explanatory sequential research design. Explanatory sequential research design is a mixed methods approach in which researchers first collect and analyze quantitative data to identify patterns, relationships, or trends, then follow up with qualitative data collection to explain or elaborate on those initial findings (Creswell & Plano Clark, 2017).The design involved a deliberate two-phase process in which quantitative phase uses instruments such as surveys to gather measurable data from a large sample, producing statistical results that provide a broad understanding of the research problem. Based on these results, researchers then purposefully select participants or develop qualitative questions for the second phase, which involves methods like interviews to explore underlying reasons, contexts, or meanings behind the quantitative findings (Reza et al., 2009). In this design, numbers were collected and analyzed first through survey. After that, the researcher gathered detailed information through key informant's interviews to explain why those results happened. Quantitative data was collected in form of numeric using questionnaire and analyzed using descriptive statistics. The qualitative selected participants based on quantitative phase and conduct interviews to explain the quantitative results giving a deeper understanding of the quantitative findings. This design was of paramount advantage as it helped to explain unexpected findings. This sequential integration allowed for a comprehensive understanding by connecting numeric patterns with rich, contextual explanations, ensuring that the qualitative phase directly addresses and deepens insights from the quantitative results

3.5 Target population

According to Willie (2024), the target population is the entire group of individuals or elements that meet the specific criteria established for a research study, from which the researcher intended to generalize the results. This definition emphasize that the target

population includes all individuals who have characteristics that are relevant to the research problem and from whom a sample can be drawn. In the context of this study, the target population comprised of individuals directly or indirectly affected by GBV and HIV within the selected community or district. This population includes both victims of GBV and individuals living with HIV, as well as key informants of the study.

a. Primary Population

The primary population refers to the main group of interest or the direct participants from whom data will be collected (Asiamah et al., 2017). This group provided first-hand information relevant to the study objectives. For this research, the primary population consisted of women and men aged 15–49 years who have either experienced GBV or are living with HIV in the selected area. According to UNAIDS (2024), approximately 1.3 million people in Zimbabwe are living with HIV, and national surveys indicate that about 35% of women and 29% of men have experienced some form of GBV (ZIMSTAT, 2022). Therefore, the primary population is drawn from this demographic segment, as they directly reflect the intersection between GBV and HIV vulnerability.

b. Secondary Population

The secondary population includes individuals or groups who are not the main focus but have relevant knowledge, experience, or influence related to the study (Saunders, Lewis & Thornhill, 2019). In this study, the secondary population consisted of healthcare providers, social workers, and NGO representatives working in HIV and GBV programs. Their insights will provide contextual understanding of interventions, policies, and support mechanisms available to the primary population. For instance, in Zimbabwe, approximately 4,800 healthcare workers and over 600 registered social workers are engaged in community health and GBV response programs (Ministry of Health and Child Care, 2023). Their perspectives enrich the study's understanding of systemic responses to the dual challenges of GBV and HIV.

3.6 Sample size

Sample refers to a subset of a population selected for study to represent the characteristics of the whole group (Kazerooni, 2001). According to Kothari (2014), a sample is a smaller group chosen from the target population for investigation, while Creswell (2014) defines it as

participants selected to represent a larger population to which results can be generalized. The primary population consisted of 100 participants (both men and women aged 15 years and above) who have experienced Gender-Based Violence (GBV) or are living with HIV, providing first-hand insights into their lived experiences. The secondary population included five key informants two health officer from the local health facility which was Chireya Mission Hospital and two social workers one from Ministry of Woman Affairs and NGO representative from FACT Zimbabwe and one traditional leader who was the ward Councillor who are involved in GBV and HIV programs who offered expert views on community interventions and support systems.

3.7 Sampling techniques

Sampling involves the selection of a representative group to participate in research, enabling conclusions to be drawn about the whole population (Meredith, 1998). The techniques are classified into probability and non-probability methods. Probability sampling gives every member an equal chance to be selected, thereby enhancing representativeness and generalizability, while non-probability sampling involves selecting participants based on specific characteristics or experiences relevant to the study (Bryman, 2016). In this study, probability sampling in the form of stratified random sampling was used for the quantitative survey to obtain statistically reliable data, whereas non-probability sampling, specifically purposive sampling, was used to select key informants such as GBV survivors and healthcare providers to gain in-depth contextual insights. The integration of both approaches strengthened the validity and comprehensiveness of the study findings.

3.7,1 Purposive sampling

Purposive sampling, also known as a non-probability sampling technique where participants are intentionally chosen based on specific characteristics, knowledge, or experience relevant to the research topic (Patton, 2002). This method worked by identifying individuals who are most likely to provide rich, detailed, and relevant information, rather than selecting participants at random. In the context of this study, purposive sampling targeted key informants such as healthcare providers and social workers who possess direct experience or specialized knowledge about GBV and HIV. The importance of using non-probability sampling lied in its ability to provide detailed, context-specific information from knowledgeable respondents, which was critical for understanding complex social issues and complementing quantitative data from the primary population. By focusing on key

stakeholders, the study ensured that expert perspectives on policies, interventions, and challenges related to GBV and HIV are captured, enhancing the overall depth and quality of the research findings.

3.7,2 Stratified random sampling

Stratified random sampling is a technique in which the population is divided into distinct subgroups, or strata, based on specific characteristics, and then participants are randomly selected from each stratum (Kumar, 2014). This technique ensured that all relevant subgroups are adequately represented in the sample, enhancing the precision and reliability of the results. In the context of this study, the primary target which are the survivors of Gender Based Violence was stratified by age, gender and respondents were then randomly selected from each stratum. Stratified random sampling was important because it reduced sampling bias, allows for comparison between subgroups, and ensured that the diversity of the population was reflected in the study (Babbie, 2010). By applying this method, the study captured the experiences of GBV and HIV risk across different segments of the community, providing more nuanced and representative quantitative data for analysis. By systematically selecting participants from the primary population, the study can generate findings that reflect the experiences and perspectives of GBV survivors in the community, providing a strong empirical basis for understanding.

3.8 Data collection Method

According to Kothari (2014), data collection refers to the process by which researchers gather empirical evidence using various tools and techniques to generate meaningful findings. This research employed a mixed data collection method, which was most appropriate for exploring human experiences, perceptions, and social interactions. The main methods of data collection in this study was semi-structured interviews and questionnaires. Semi-structured interviews were conducted with key informants such as healthcare workers, social workers, and survivors of GBV and HIV. These interviews provided detailed, personalized accounts of experiences and perceptions related to GBV and HIV transmission. As Nyawaranda (2017) notes, semi-structured interviews are useful in Zimbabwean community research because they allow flexibility for probing while maintaining a consistent thematic focus.

3.8,1 Surveys

Surveys, as defined by Babbie (2016), are a systematic method of data collection that use structured questions to obtain standardized information from a defined population. In this study, surveys were employed to collect quantitative data from the primary population of survivors of GBV and individuals living with HIV in Chireya Ward 4, Gokwe North District. The instrument will be a structured questionnaire, composed mainly of closed-ended questions such as multiple choice, yes/no, and Likert scale items, which are effective for capturing measurable variables like demographics, exposure to violence, HIV knowledge, and access to services. As noted by Creswell (2014) and Fowler (2014), surveys are particularly valuable for producing standardized, comparable data across large groups, while anonymity encourages honest disclosure of sensitive information. This makes them especially suitable for researching GBV and HIV, where stigma and fear of retaliation often hinder open discussion. By systematically gathering responses from this rural population, the survey method ensures reliable, quantifiable evidence that can be analysed to identify high-risk groups and inform targeted interventions in Zimbabwe.

3.8,2 Key informant interviews

Key Informant Interviews are a qualitative data collection method that involves in-depth, semi-structured or unstructured conversations with individuals who hold specialized knowledge or experience relevant to the research topic (Patton, 2015). In this study, they were conducted with healthcare workers and social workers who interact directly with survivors of gender-based violence (GBV) and HIV-affected individuals, making them valuable sources of expert insight. The interview guides were semi-structured, consisting mainly of open-ended questions that allow participants to freely express their perspectives on the prevalence of GBV, the challenges in prevention and response, the linkages between GBV and HIV transmission, and the effectiveness of existing support services. As Kvale (1996) and Creswell (2014) emphasize, the strength of key informant interviews lies in their ability to capture rich, contextualized narratives that surveys alone cannot provide. Their importance in this study is that they generated nuanced qualitative data that reveal underlying social and structural dynamics, and they complement the quantitative survey findings by offering professional perspectives and explanations that deepen understanding of the GBV-HIV nexus. Thematic analysis of these interviews helped to identify patterns, explanations, and contextual factors, thereby strengthening the mixed-methods approach and ensuring that the study captures both measurable trends and lived realities.

3.9 Validity of research instruments

Research instruments are the tools designed to acquire information on a topic of interest. The researcher is going to use questionnaires, a pen, a recorder as well as a note pad as research instruments to carry out the research study. Middleton (2019) stated that validity is used to evaluate the quality of research that indicates how reliability is about the consistency of a measure. Validity in research was used by the researcher to see whether the research instruments are practically measuring the variables that the research is focusing on. Legality can be measured through content and develop validity. Content validity focusses on determining whether examination instruments sufficiently contained inquiries to cover the aim of the study. The researcher guaranteed content legitimacy through taking into consideration the aim of the study amongst the outlining of research questions.

3.9,1 Reliability

Reliability refers to the consistency, stability, and repeatability of research findings over time and across different situations (Creswell & Creswell, 2018). In this study on GBV and HIV in Gokwe North District, reliability was ensured through careful development and pre-testing of data collection instruments. The questionnaires are structured with clear, unambiguous questions and piloted to identify potential errors or inconsistencies, while the semi-structured interview guide was standardized to ensure consistency in the way questions are asked across participants. Polit and Beck (2017) emphasize that reliability in social research is enhanced by using well-designed instruments, training data collectors, and applying systematic procedures for data coding and analysis. Furthermore, Bryman (2016) notes that consistency in administration, data recording, and analysis increases the dependability of both quantitative and qualitative results. By implementing these measures, the study ensures that the findings reflect participants' experiences accurately and can be replicated in similar contexts, producing dependable evidence on the linkages between GBV and HIV in the rural Zimbabwean setting.

3.10 Ethical considerations

Research ethics refers to the set of moral principles and guidelines that oversee the conduct of research to ensure integrity, respect, and protection of participants (Resnik, 2018). Ethical considerations in research involve safeguarding participants' rights, including obtaining informed consent, ensuring confidentiality and anonymity, minimizing harm, and maintaining

honesty and transparency throughout the study (Israel & Hay, 2006). Upholding ethics is crucial because it protects the dignity and welfare of participants, fosters trust between researchers and communities, and enhances the credibility and validity of the research findings. In studies involving sensitive issues such as Gender-Based Violence and HIV, ethical vigilance is especially important to prevent traumatization, respect privacy, and promote voluntary participation without coercion.

3.10,1 Informed Consent

Informed consent guarantees that participants voluntarily agree to take part in a study after being fully informed about its purpose, procedures, risks, and benefits (Beauchamp & Childress, 2013). In this study, participants received detailed information sheets explaining the research aims and processes in a language they understand. Consent forms was provided, and participation proceeded after obtaining written or verbal consent, ensuring that individuals participate willingly and with full awareness.

3.10,2 Confidentiality

Confidentiality refers to the responsibility of the researcher to protect participants' personal information from being disclosed to unauthorized people (Sieber, 1992). In this study, confidentiality was treated as a very important ethical principle because the research focused on sensitive issues related to GBV and HIV. To protect participants' identities and privacy, all information collected during questionnaires and interviews was coded using unique identifiers instead of participants' names or personal details. This helped ensure that responses could not be traced back to specific individuals. Both electronic and printed data were securely stored, with electronic files protected by passwords and physical documents kept in safe locations accessible only to the researcher and authorized research personnel. Participants were also assured that the information they provided would be used strictly for academic purposes and would not be shared with community members, family members, or any outside individuals. During the reporting and presentation of findings, data was presented in summary or aggregate form so that no participant could be personally identified. The researcher also avoided including statements or descriptions that could expose participants or place them at risk of stigma, discrimination, retaliation, or emotional harm. Maintaining confidentiality was important in building trust with participants and encouraging them to speak openly and honestly about their experiences with GBV and HIV without fear of exposure or judgment.

3.11,3 Voluntary Participation and Right to Withdraw

Participants have the right to freely decide whether to participate and can withdraw from the study at any time without penalty or negative consequences (Israel & Hay, 2006). Participants were informed explicitly about their right to decline or discontinue participation at any point. Researcher respected respect these decisions fully and did not apply any pressure or inducements to coerce continued involvement.

3.10,4 Anonymity

Anonymity ensures that participants' identities remain unknown even to the researchers, preventing any linkage between data and individual identities (Kaiser, 2009). Where possible, the study collected data in ways that do not require personal identifiers. For example, surveys or interviews were conducted without recording names or identifiable information, thus safeguarding participants from potential stigma or reprisal.

3.11Chapter Summary

The chapter explained methods used by the researcher to collect information. The study was also described as being both qualitative and qualitative in nature which was used to collect data relating to power dynamics and their contribution to GBV and HIV infections in Gokwe North Chireya ward 4, the challenges affecting the survivors of GBV and HIV in accessing assistance, the impact of awareness raised in promoting behaviour change to bring to end violence in but not limited to intimate relationships, other drivers of high GBV prevalence and HIV incidence.

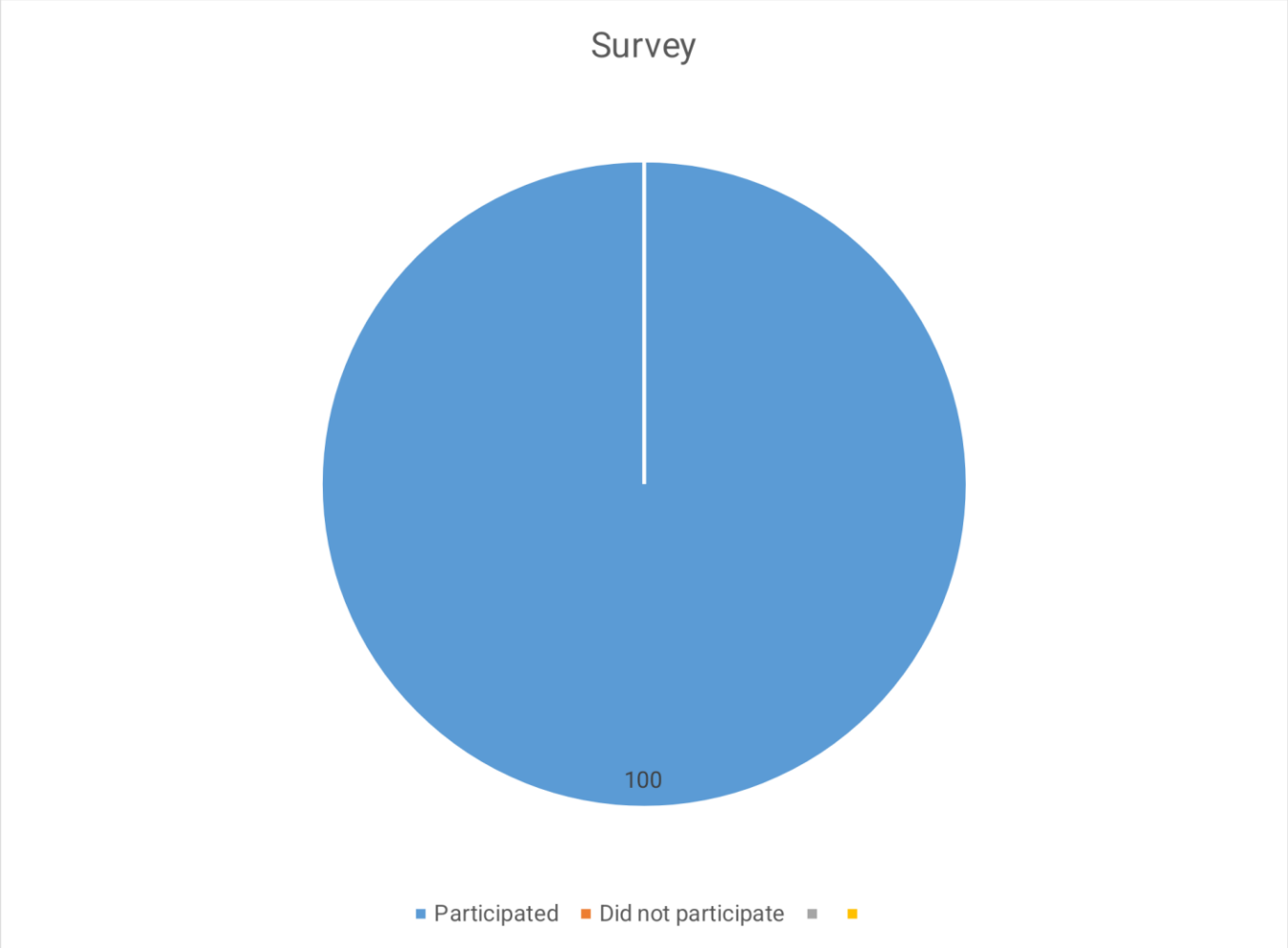
CHAPTER 4: DATA PRESENTATION AND ANALYSIS

4.0 Introduction.

This chapter presents the statistics and opinions extracted from survivors and fatalities of Gender-Based Violence and the key informants on the relationship between Gender Based Violence and HIV infection in Gokwe North Chireya Ward 4. The findings are to be presented in respect of research objectives of the study. The researcher gathered data through surveys by the use of semi-structured questionnaires and through key informant interviews which applied Key informant interview guides. Quantitative data from questionnaires is to be presented using bar charts, tables and pie-charts in form of percentages and numbers while data from interviews is to be presented through sub-themes which are to be supported by verbatim responses from participants.

4.1 Response Rate

4.1 Survey



The research targeted 100 participants and all of them participated giving a response rate of 100%

Table 4.2 KEY INFORMANT INTERVIEW RATE

TARGETED KEY INFORMANTS (n1)	PARTICIPATED KEY INFORMANTS (n2)	RESPONSE RATE (%)
5	4	80%

(n)= targeted key informants (n2) Key informants interviewed

The research targeted 5 Key informants and 4 Key informants were interviewed giving a response rate of 80%.

4.2 DEMOGRAPHIC DATA PRESENTATION

4.2,1 Demographic data presentation

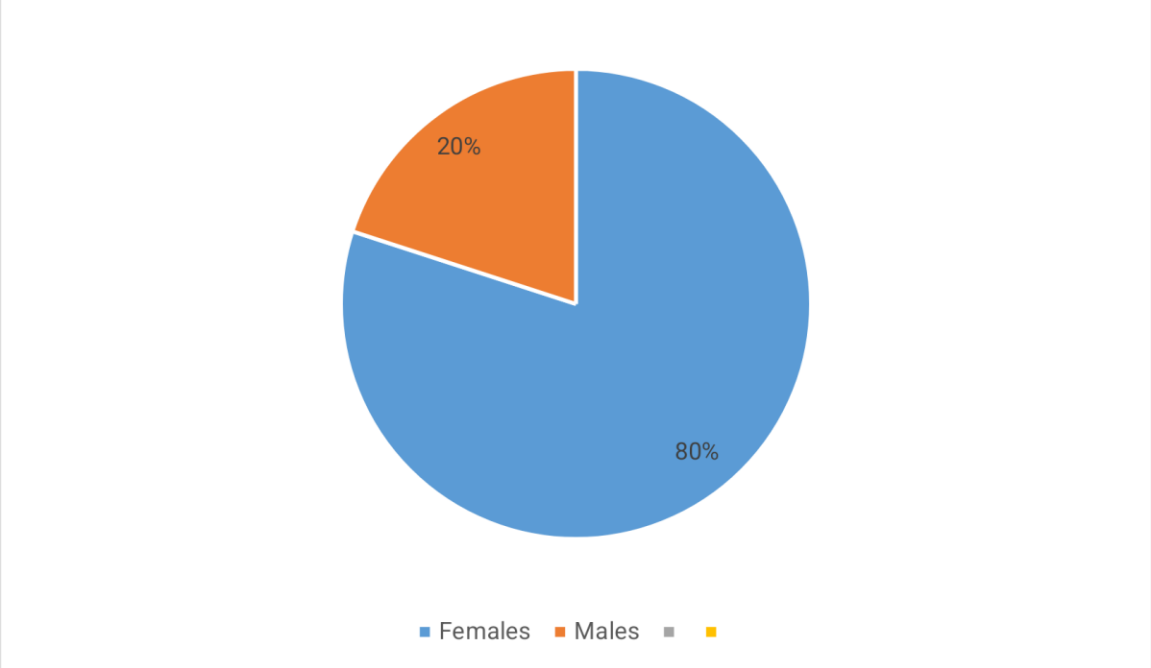
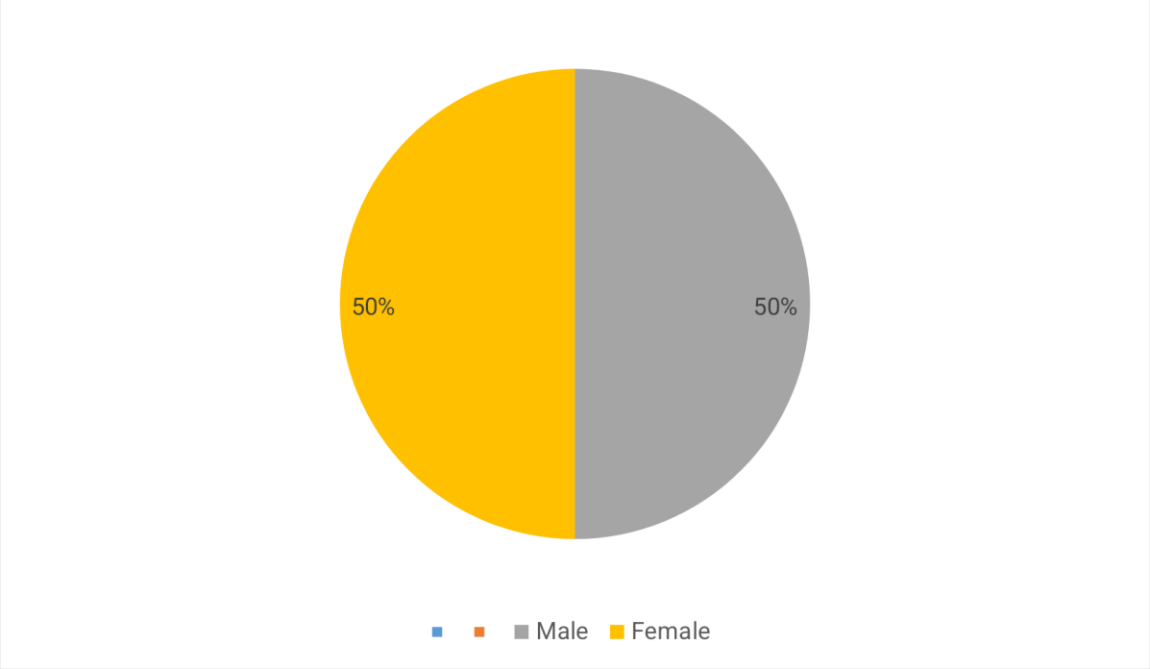


FIG 4.2,1 **n=100**

Surveys were conducted in Chireya ward 4 of Gokwe North which involved distribution of questionnaires to the survivors and victims of Gender-Based Violence. From the survey 100 members out of 100 targeted participants participated in the survey giving their opinions and experiences of Gender-Based Violence through ticking of the semi-structured questionnaires which was 85% of the response rate. Females who participated ranged to 80% while males occupied 20%. Participants comprised of men and women from the age of 15 years old to 49 years who are either married, single, widowed or cohabitating. This provided statistics from a variety of age groups who possess different educational profession from farmers, house maids and professional workers. The researcher gained much knowledge on the frequency and rate of the relationship between HIV and GBV, the frequency of key drivers as well as the challenges being faced by the survivors and victims of GBV in seeking help.

4.2,2 Key Informant Interviews'

FIG **4.2,2**



N=100

The graph shows the demography of the key informants in which 2 males participated giving 50% and 2 females participated giving a 50% representation out of 4 key informants reached by the researcher. Key informants interviewed were 4 (80%) out of 5 targeted key informants who were Registered General Nurses from Chireya Mission Hospital, Community Development Co-coordinator from MWACSMED and social worker from FACT Zimbabwe

4.4 The casual relationship between Gender Based Violence and Human Immune Virus in Ward 4 of Gokwe North District.

4.4.1 Victims of GBV and their status by gender

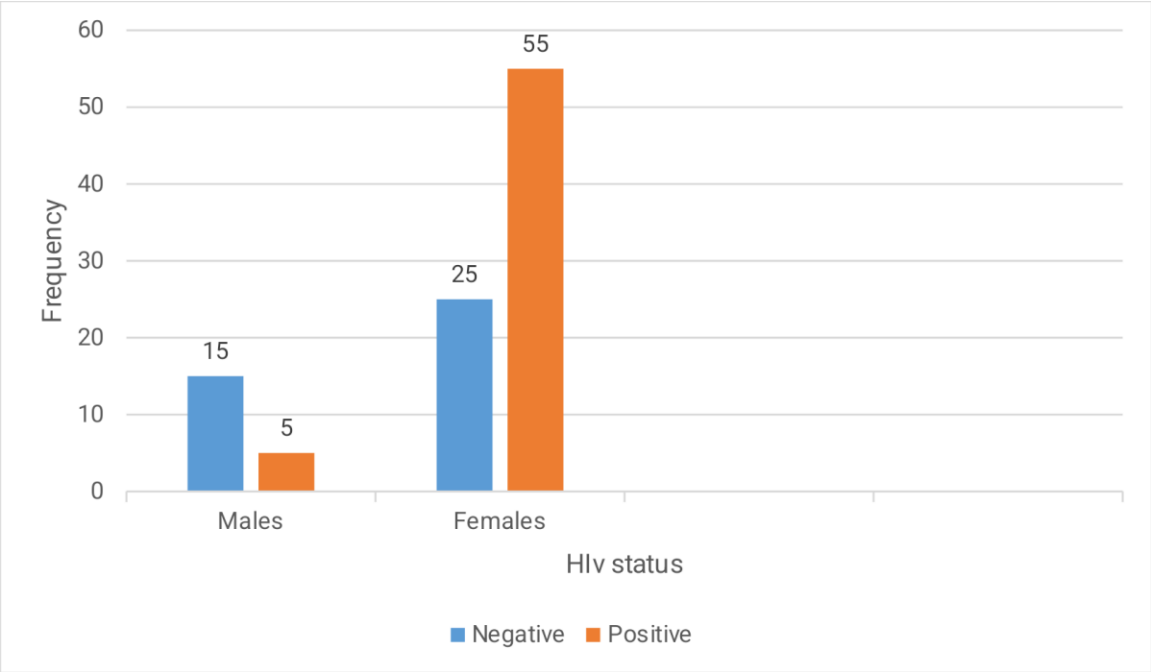


FIG 4.4.1 n=100

The above graph shows the HIV status of the Victims of GBV by gender. Males who were HIV positive summed up to 5% while negative males gave 15%. GBV female victims gave 55% positive while 25% were negative as shown above.

4.4.2 Victims of Gender Based Violence infected with HIV

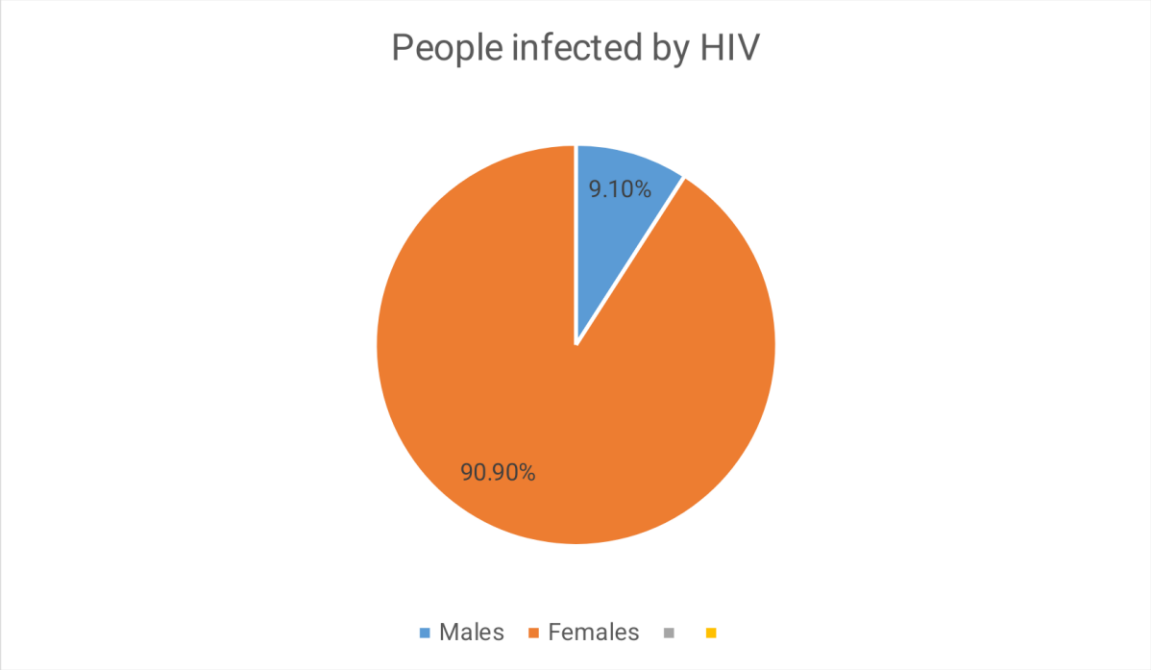
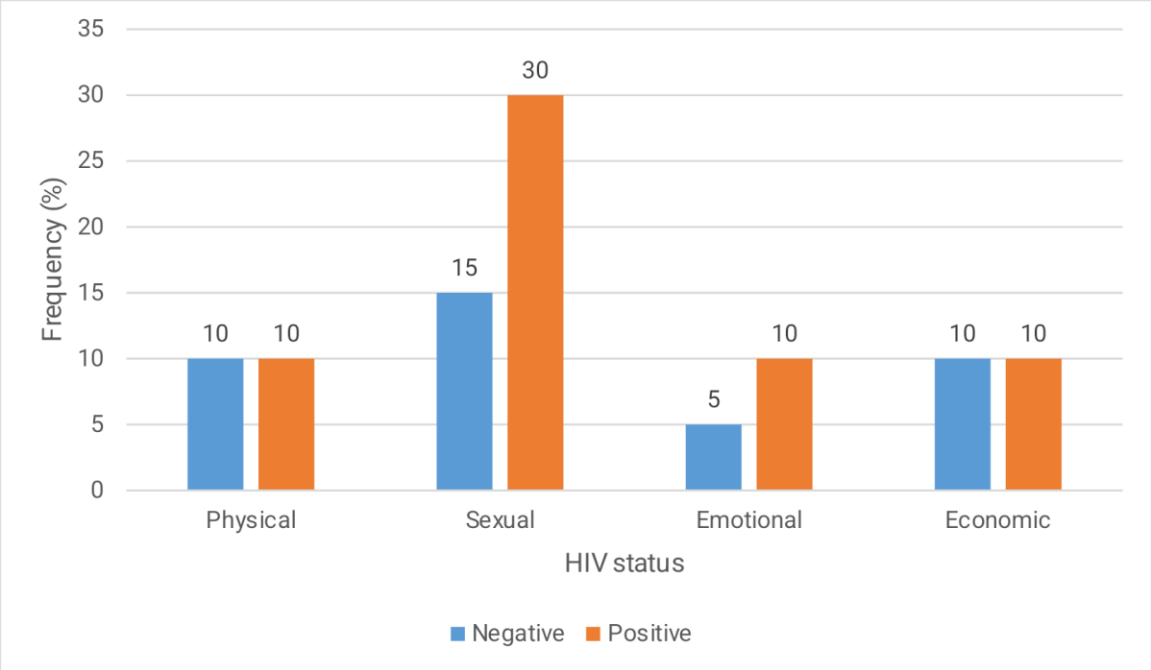


FIG 4.4.2

The chart shows statistics of GBV victims infected by HIV grouped by sex where males occupied 9.1% and females 90.9% out of the total number of infected victims which was 60 out of 100 participants.

4.4.3 Types of GBV by HIV status

Fig 4.4.3 Gender Based Violence types



N=10

The above graph shows the common types of GBV in which sexual abuse had 30% of HIV positive victims and 15% negative, Physical abuse had 10% negative and positive, Economic abuse had 10% positive and negative and economic abuse had 10% positive and 5% negative.

4.3.4 Type of GBV by HIV status and gender

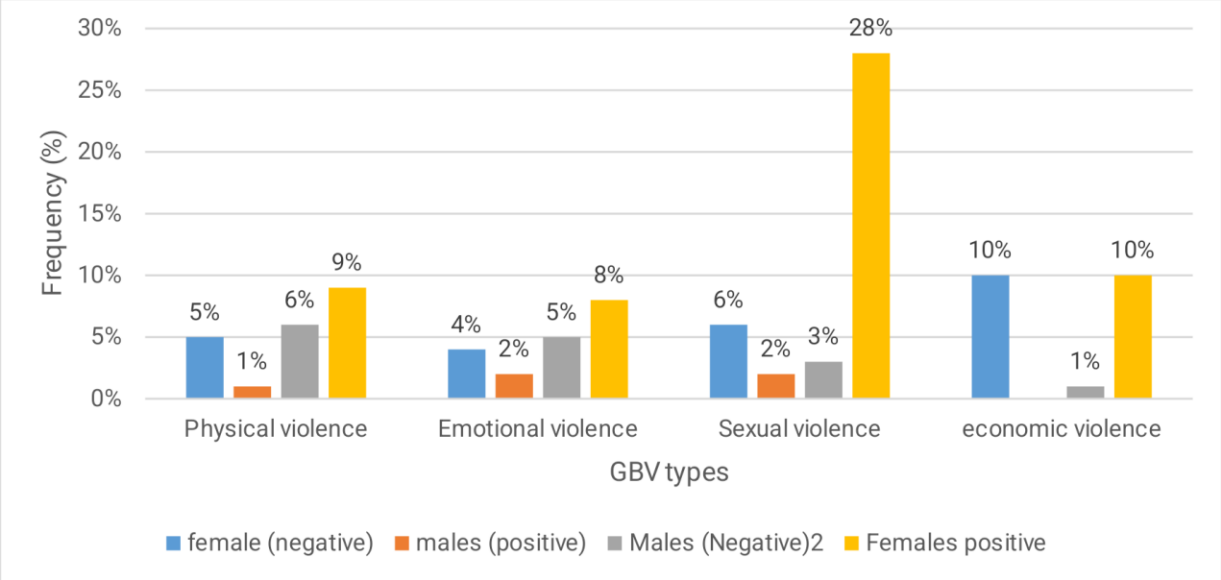


FIG 4.3.4 **n=100**

The above data was presented according to HIV status and gender in which female who experienced physical violence summed up to 9 percent and 5 percent negative, males 1% positive and 6% negative. Emotional abuse, 8% females were positive 4% negative, 2% males positive and 5% positive. Sexual abuse 28% female positive, 6% females negative, 3% males negative and 2% positive. Economic violence only 10% females positive and 10% negative and 1% males negative.

4.5 The key drivers of Gender Based Violence and HIV in Chireya ward 4 , Gokwe North

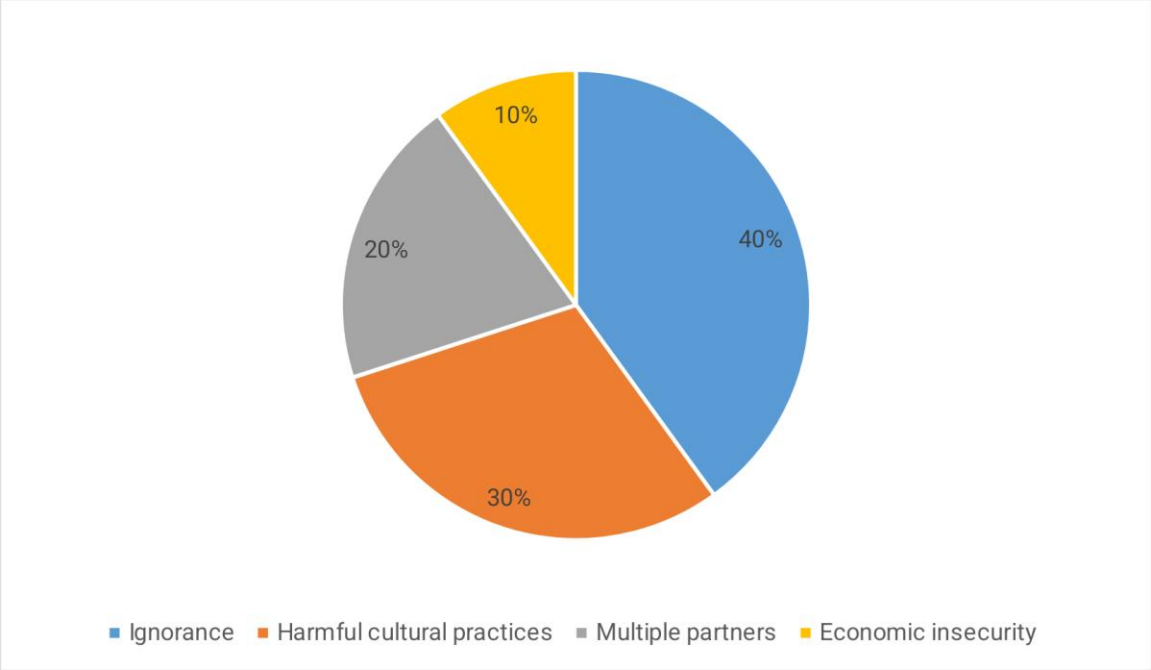
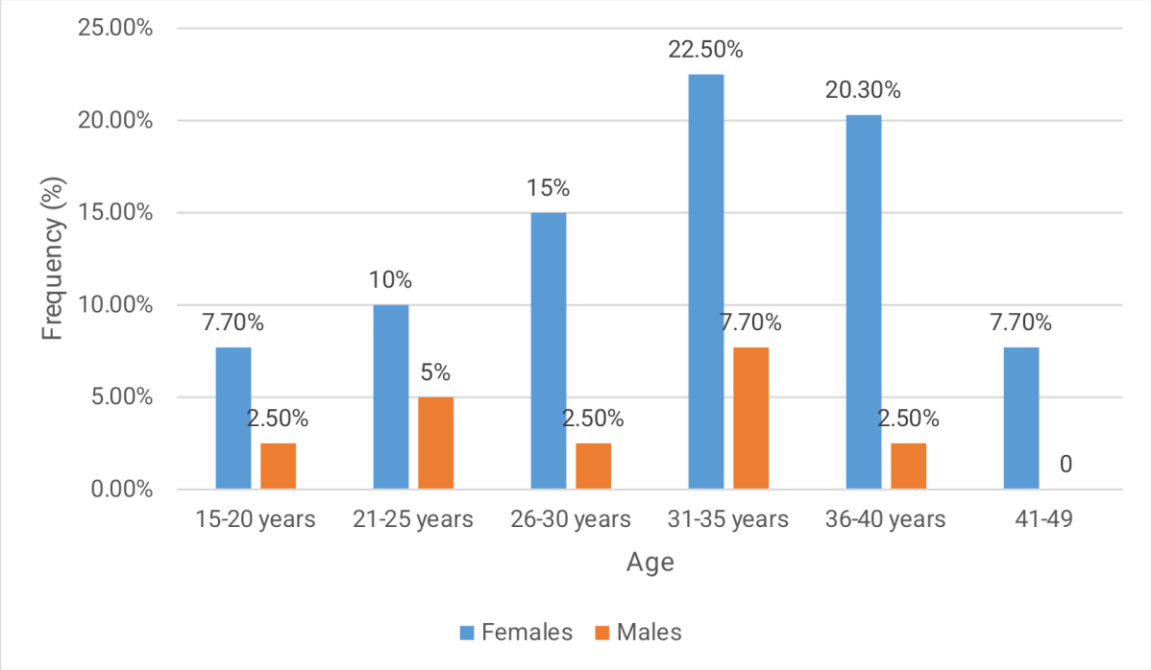


FIG 4.5

The pie chart above shows the statistics of data obtained from participants through questionnaires in form of percentage rate for the key drivers of Gender-Based Violence. Ignorance had 40%, economic insecurity had 10%, multiple partners 20%, harmful cultural practices 30%.

4.5,2 Ignorance

FIG 4.5,2 Ignorance by age and sex

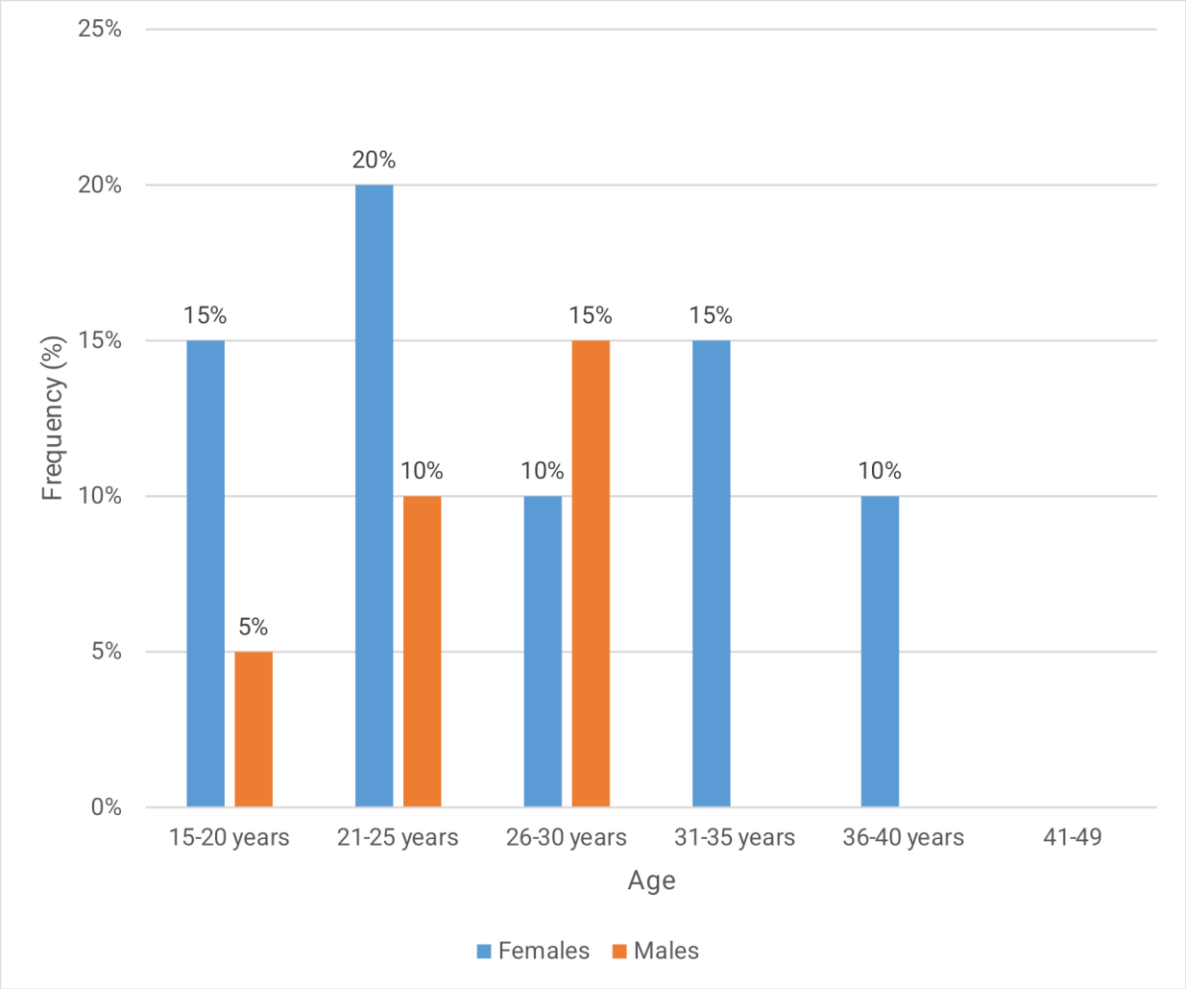


n=100

Data was presented according to age and gender in which females from 31 -35 years had the highest frequency of 22.5%, males 7.7%%, 36-40 years showed again 20.3% for females, 2.5% for males, 26-30 years had the median of 15% females and 2.5% males, 21-25 years 10% for females and 5% males, 15-20 years females had 7.7%, males 2.5%- and 41-49-years females 7.7%.

4.5,3 Multiple concurrent partners

FIG 4.5,3 Multiple partners by age and sex

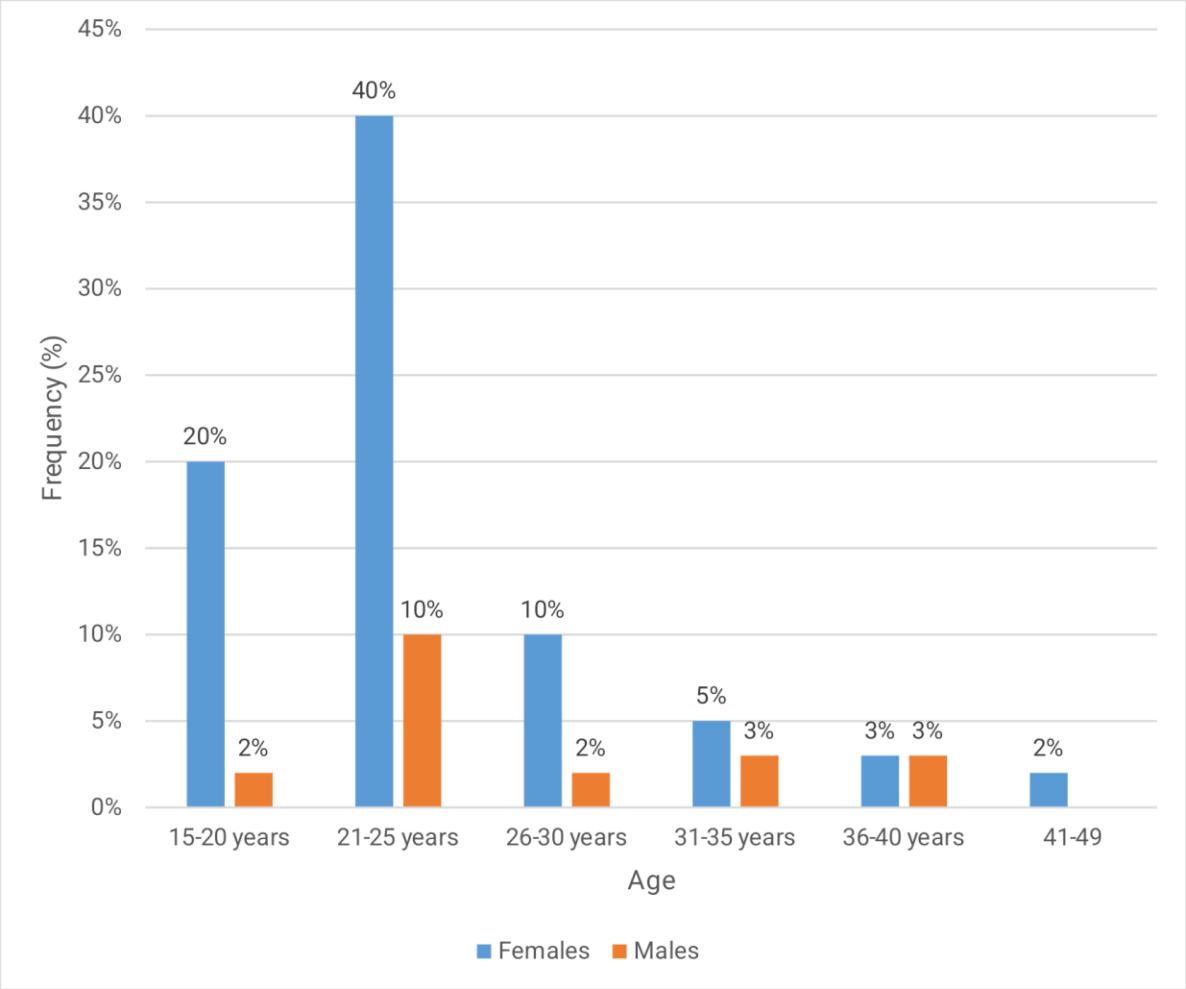


N=100

Data was presented according to age and gender in which females had the highest frequency from 21-25 years showed 20%, males 10%, the age 26-30 years being the second 15% males, 10% females, the age 31-35 years the third with 15% females and 15-20 years 15% females, 5% males the least one is the age 36-40 years with only 10% females.

4.5,3 Harmful cultural practices

FIG 4.5,3 Harmful cultural by age and sex

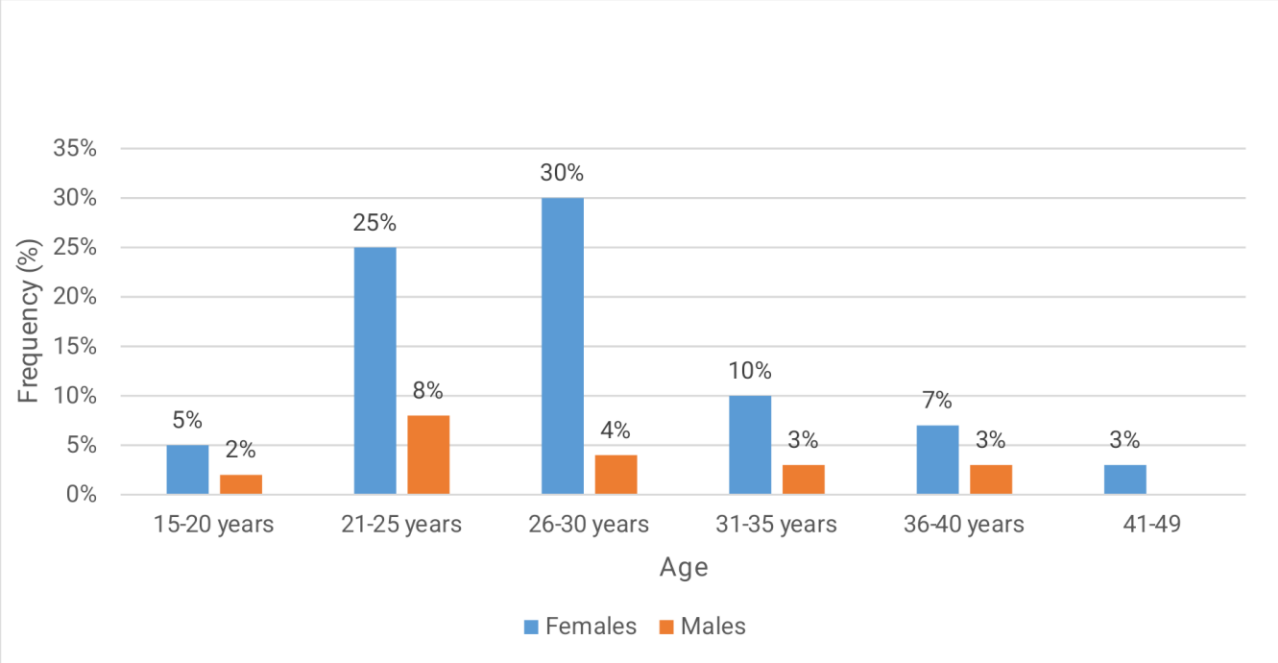


n=100

Data was presented according to age and gender in which females rom 21 -25 years had the highest frequency of 40%, males 10%, 26-30 years showed again 10% for females, 2% for males, 15-20 years had the median of 20% females and 2% males, 31-35 years 5% for females and 3% males, 36-40 years' females had 3%, males 3%- and 41-49-years females 2%.

4.5,5 Economic insecurity

FIG 4.5,5 Economic insecurity by age and sex

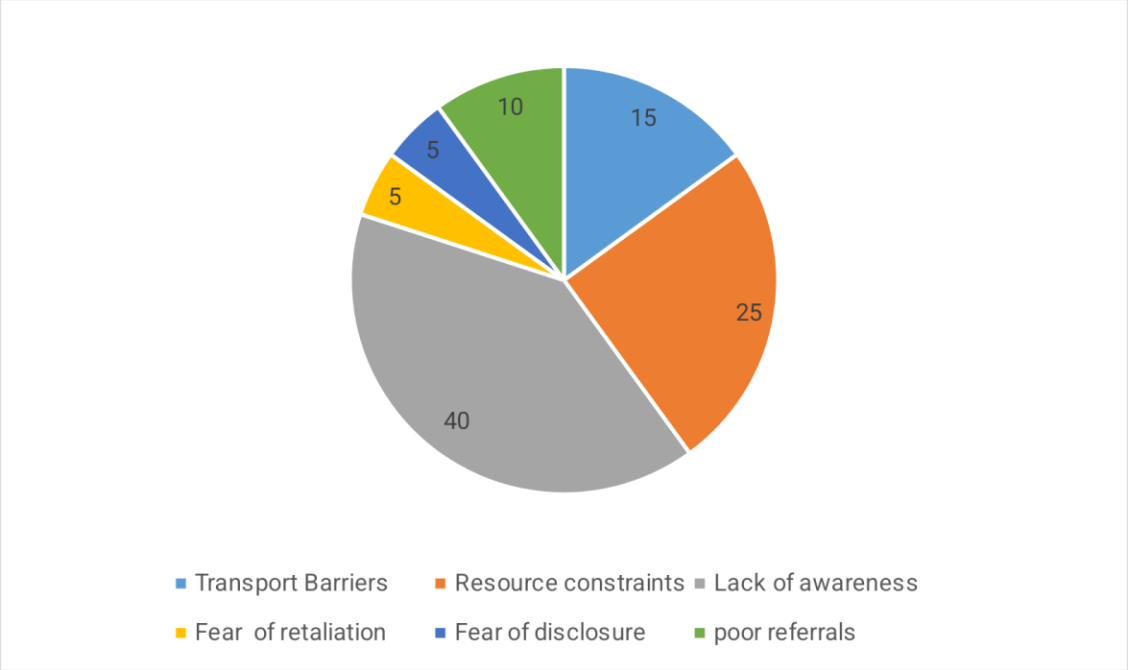


N=100

Data was presented according to age and gender in which females rom 26 -30 years had the highest frequency of 30%, males 10%, 21-25 years showed again 25% for females, 2% for males, 15-20 years 5% females and 2% males, 31-35 years 10% for females and 3% males, 36-40 years females had 7%, males 3%- and 41-49-years females 3%.

4.6 Challenges in seeking help for the victims and survivors of Gender-Based Violence and HIV infection in Chireya ward 4, Gokwe North District

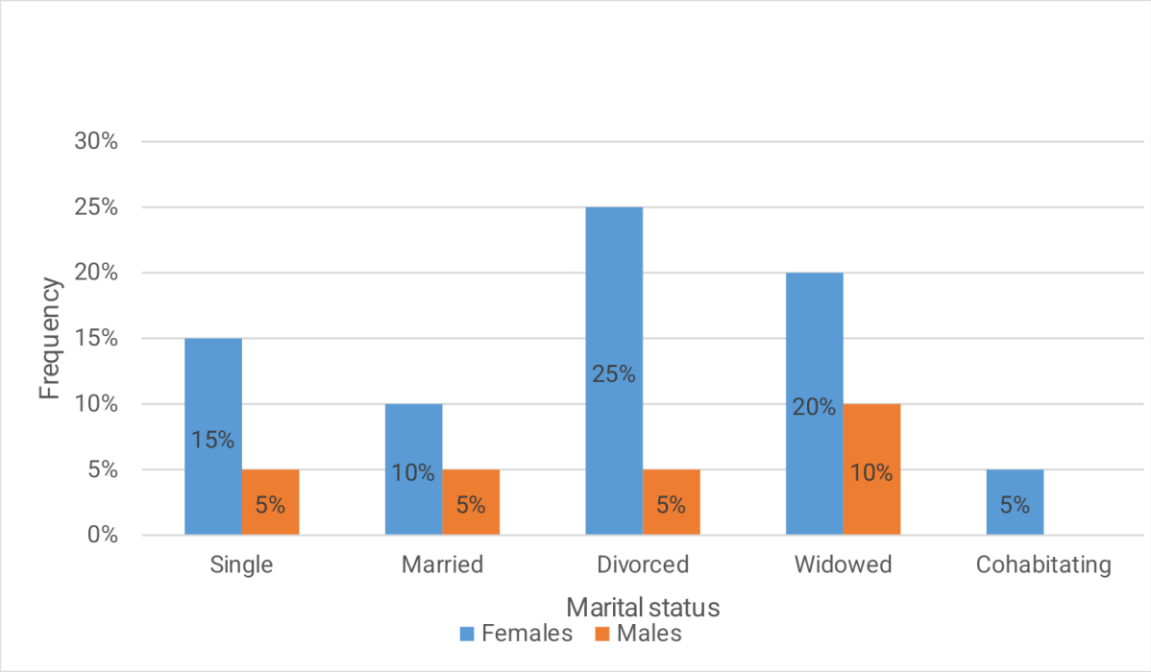
FIG 4.6 Challenges Faced



Lack of awareness showed to have the mode frequency of 40%, resource constraints 25%, transport barriers 15%, poor referrals 10%, fear of disclosure 5% and fear of retaliation 5%.

4.6,1 Resource constraints

Fig 4.6,1 Resource constraints by Marital status and sex

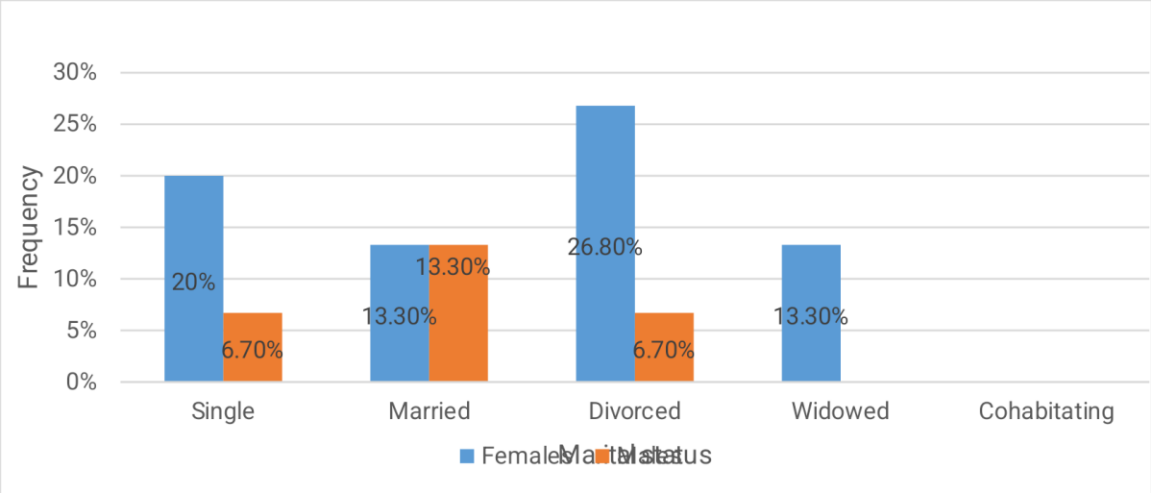


n=100

The above graph shows data on resource constraints by marital status and sex. Single females 15%, males 5%, married females 10%, males 5%, divorced females 25%, males 5%, widowed 20% males 10% and cohabitating females 5%.

4.6,2 Transport barriers

Fig 4.6,2 Transport barriers by Marital status

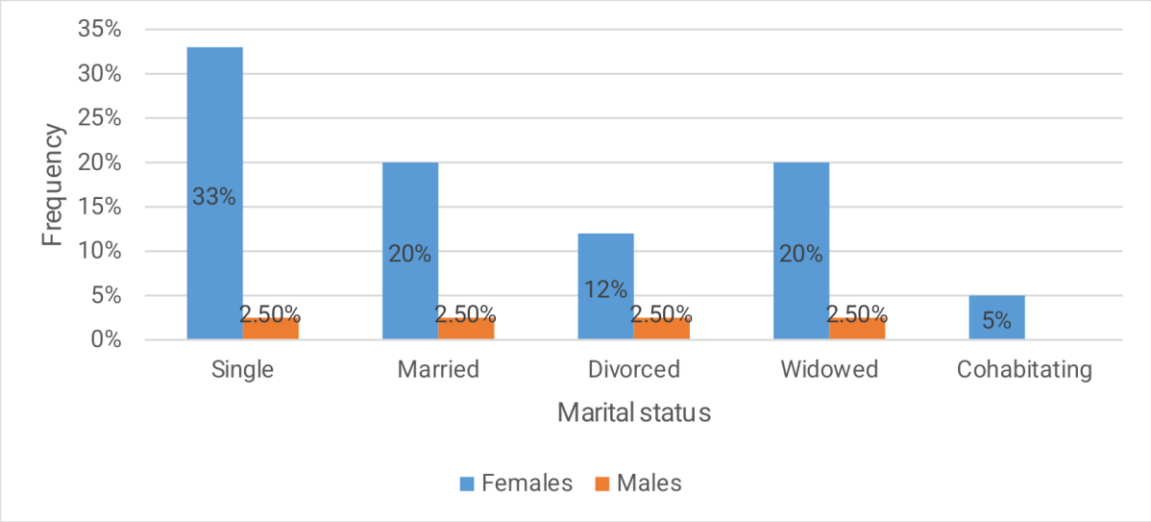


n=100

The above graph shows data on transport barriers by marital status and sex. Single females 20%, males 6.7%, married females 13.3%, males 13.3%, divorced females 26.7%, males 6.7%, widowed 13.3% males.

4.6,3 Lack of awareness

Fig 4.6,3 Lack of awareness by marital status and sex

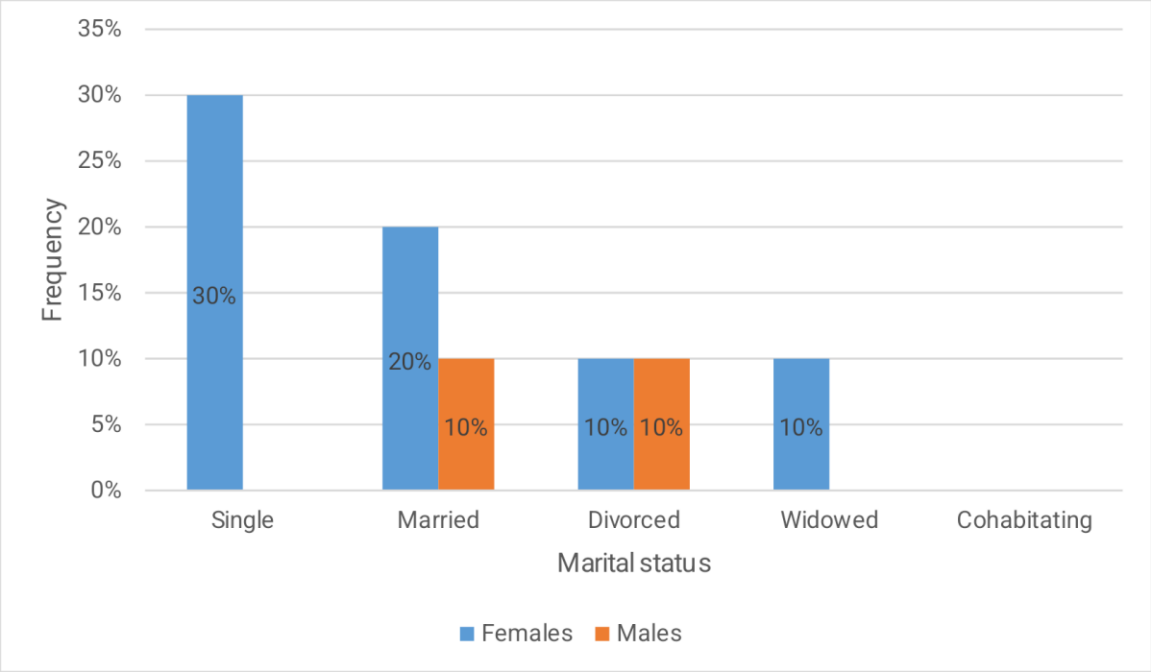


n=100

The above graph shows data on lack of awareness by marital status and sex. Single females 33%, males 2.5%, married females 10%, males 2.5%, divorced females 12%, males 2.5%, widowed 20% males 2.5% and cohabitating females 5%

4.6,4 Poor referrals

Fig 4.6,4 Poor referrals by marital status and sex

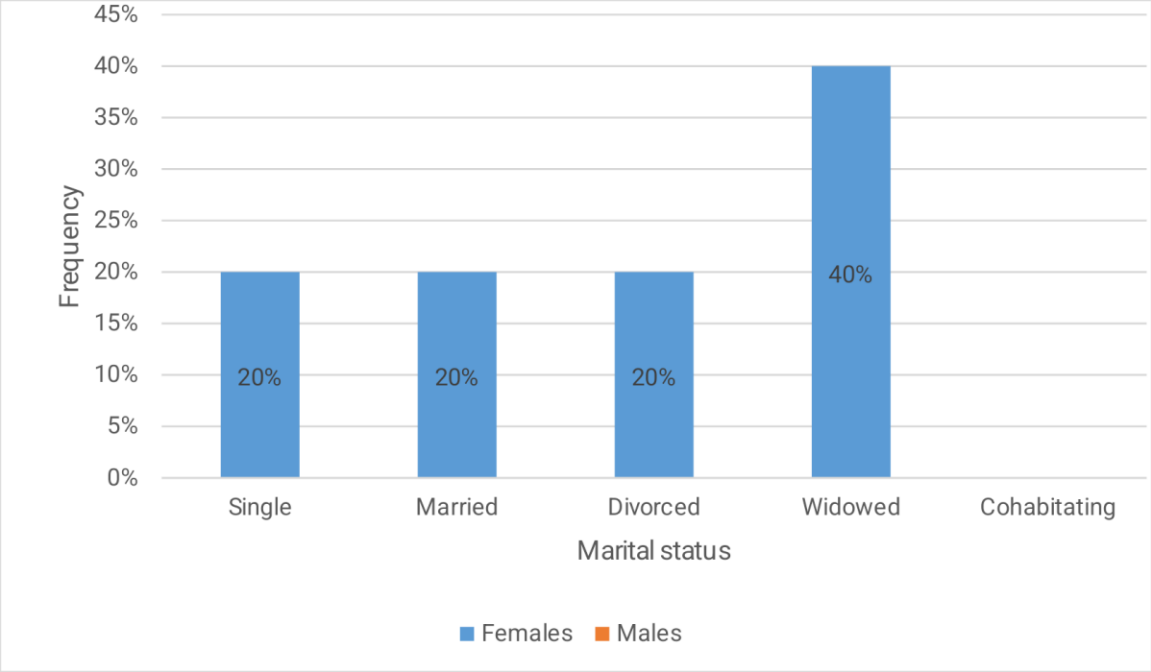


n=100

The above graph shows data on poor referrals by marital status and sex. Single females 30%, married females 20%, males 10%, divorced females 10%, males 10%, widowed 10%

4.6,5 Fear of disclosure

Fig 4.6,5 Fear of disclosure by marital status and sex

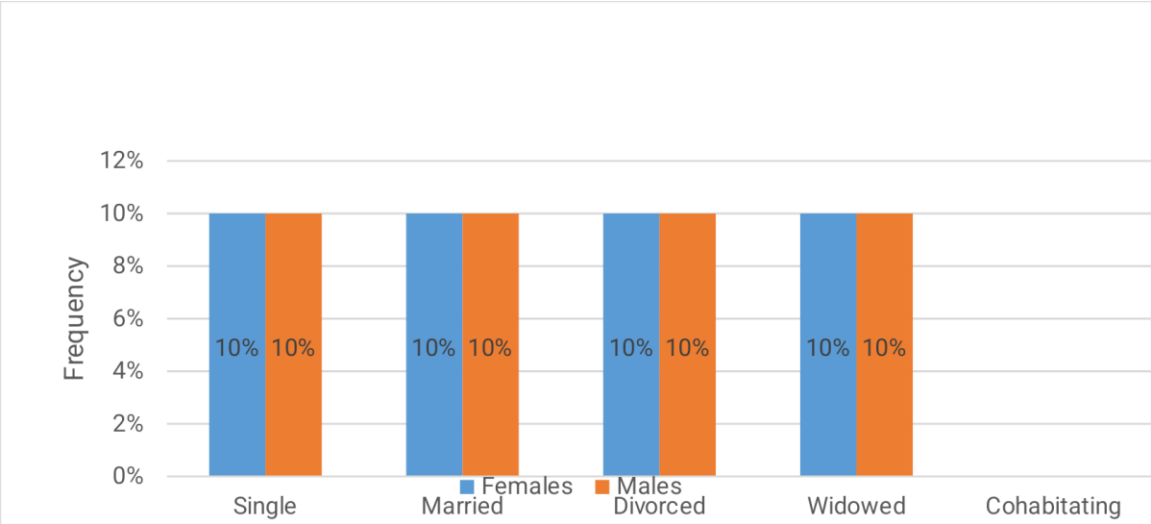


n=100

The above graph shows data on fear of disclosure by marital status and sex. Single females 20%, married females 20%, divorced females 20%, widowed 40% males

4.6,6 Fear of retaliation

Fig 4.6,6 Fear of retaliation by marital status and sex



n= 100

The above graph shows data on fear of retaliation by marital status and sex. Single females 10%, males 10%, married females 10%, males 10%, divorced females 10%, males 10%, widowed 10% males 10%

4.7,0 Discussion of findings

4.7,1 Victims of GBV and their status by gender

Many victims of GBV showed to have HIV infection especially women as statistics showed that they dominated almost 80% than men. Few males were infected according to the statistics. The findings clearly show that women are the most affected victims of GBV as supported by the Feminist theory which stated that GBV is not merely a private issue but a social and political problem rooted in inequality. In the rural context of Gokwe North, these patriarchal ideologies are reinforced through traditional beliefs that valorise male authority, bride price practices that commodify women, and social norms that silence victims of abuse.

In addition to the above another Key informant insisted on the infection of HIV by gender highlighting females as the main targets of the infection

"Women are economically dependent on their husbands and this makes it difficult for them to leave abusive relationships even when they suspect their partners are HIV positive." ***(Key informant FACT)***

Key informants strongly supported these findings, explaining in practical terms how GBV directly contributes to HIV transmission. They pointed out that during episodes of sexual violence, victims often have no opportunity to negotiate safe sex, which greatly increases the likelihood of infection. They also added that the psychological impact of abuse can leave survivors emotionally distressed and sometimes engaging in risky behaviours as a coping mechanism, further increasing their vulnerability. One informant emphasized that GBV and HIV cannot be separated because violence creates conditions that expose victims to infection, while another highlighted how trauma and low self-worth can push survivors into behaviours that heighten their risk.

This suggests that women in Chireya Ward 4 are disproportionately affected by the dual burden of Gender-Based Violence and HIV infection. The views expressed by key informants support these findings, particularly the observation that many women remain in abusive relationships because of economic dependence on their partners, even when they suspect that their partners may be HIV positive. These findings can be understood through both the Feminist Theory and the Human Rights-Based Approach. Feminist Theory argues that GBV is rooted in unequal power relations between men and women, where patriarchal norms and cultural practices often place women in subordinate positions, limiting their ability to make decisions about their own health and safety. In the context of Gokwe North, traditional beliefs, gender inequalities, and social expectations may prevent women from negotiating safe sex, reporting abuse, or leaving violent relationships. Similarly, the Human Rights-Based Approach emphasizes that every individual has the right to live free from violence, discrimination, and preventable health risks, including HIV infection. The high proportion of HIV-positive female survivors therefore reflects not only a public health concern but also a violation of women's fundamental rights to health, dignity, equality, and protection. The findings highlight the need for interventions that promote women's authorization, gender equality, and fortification of human rights in order to reduce both GBV and HIV vulnerability among women.

The findings imply that interventions aimed at reducing HIV infection should also address GBV, gender inequality and women empowerment as females are mostly prone to HIV infection as highlighted by Mberi et al. (2018) found that gender inequality and socio-cultural norms that tolerate male dominance contribute significantly to both GBV and HIV vulnerability, particularly in rural areas where women’s economic dependence on men is high.

4.7,2 Victims of Gender Based Violence infected with HIV

The findings showed that 60% of the victims of GBV were HIV positive of which many were females other than men. This showed that females are more prone to HIV infection as indicated by the statistics obtained from the questionnaire. In support to the above the key informants insisted that GBV victims are prone and vulnerable to HIV infection; supported by the opinions of the Key informant below,

*"Yes, Gender-based Violence promote high chances of HIV infection this is because of the fact that when a person is involved in Gender-based Violence maybe in form of Sexual abuse, at that moment of having sex with the perpetrator there will be no time to negotiate for safe or protected sex hence high chances of HIV transfer due to that unprotected sex in form of abuse so the two cannot be separated" (**Key Informant)***

Another Key Informant added on;

*"Yes, I agree that Gender-based violence create greater chances of HIV infection as Gender based violence if not dealt with or if not given much attention to the trauma experienced mostly likely emotional abuse among women by their husbands. Those victims they develop a self-denial mechanism of not valuing their selves and start to engage into sexual behaviors to fix their relatives or husbands then they get into HIV infection "(***Key Informant).**

This clearly shows that HIV infection is being influenced by Gender-Based Violence as the Key informants from various organizations were repeating the issue of increased vulnerability among the victims and survivors of Gender-Based Violence to HIV infection. This is further supported by Jewkes et al. (2010), who proposed that sexual violence, particularly forced or coerced intercourse, often results in physical trauma that facilitates the transmission of HIV by providing direct entry points for the virus. As highlighted by the key informants many survivors are HIV positive due to their vulnerability that is created by the trauma which came from the flames of Gender Based Violence.

This indicates that women are more defenceless to HIV infection within abusive relationships and violent environments. The views shared by key informants supported these findings, emphasizing that many survivors of GBV are exposed to HIV because they often lack the power to make decisions about their sexual health. One key informant explained that during incidents of sexual violence, survivors are unable to negotiate for condom use, increasing

their risk of HIV transmission. Another key informant highlighted that the emotional trauma caused by violence can affect a person's self-esteem and decision-making, making them more vulnerable to risky behaviours that may lead to HIV infection. These findings resonate with the Feminist Theory, which argues that violence against women is rooted in unequal power relations between men and women. In many communities, women have less control over decisions regarding sex, relationships, and their own health, making them more susceptible to both GBV and HIV. The theory further explains that patriarchal norms and gender inequalities often place women in situations where they are unable to protect themselves from abuse or negotiate safer sexual practices. Therefore, the high number of HIV-positive female survivors in this study reflects not only a health challenge but also the effects of gender inequality that continue to disadvantage women. The findings suggest that reducing HIV infections among women requires addressing the underlying causes of GBV through women's empowerment, gender equality promotion, and interventions that strengthen women's ability to make informed choices about their health and wellbeing.

4.7,3 Types of GBV by HIV status

The findings showed common GBV types which were emotional abuse, sexual abuse, physical abuse and economic violence. The study findings revealed that sexual abuse had the highest proportion of HIV positive victims at 30%, while 15% of the victims who experienced sexual abuse were HIV negative. Physical abuse recorded 10% HIV positive victims and 10% HIV negative victims. Emotional abuse contributed 10% HIV positive victims and 5% HIV negative victims, while economic abuse accounted for 10% HIV positive victims and 10% HIV negative victims. The findings demonstrate that sexual violence has a stronger relationship with HIV infection compared to other forms of GBV. The findings imply that survivors of sexual violence are at a greater risk of contracting HIV due to forced and unprotected sexual intercourse, inability to negotiate condom use and exposure to multiple sexual partners. Physical, emotional and economic abuse also contribute indirectly to HIV infection because victims may experience fear, low self-esteem, dependency and inability to make independent sexual and health decisions.

The key informant seconded the findings;

"Most women who experience sexual violence fail to seek immediate medical help because they fear stigma and shame. This increases the risk of HIV infection." ***(Key Informant)***

These findings agree with the results having GBV a cause of HIV infection as Jewkes et al. (2010) noted that, sexual violence, particularly forced or coerced intercourse, often results in physical trauma that facilitates the transmission of HIV by providing direct entry points for the virus. Additionally, Campbell et al. (2008) emphasize that women experiencing intimate partner violence frequently lack the agency to negotiate condom use, heightening their vulnerability to HIV infection.

This pattern suggests that sexual abuse exposes victims to direct, often unprotected sexual contact, while other forms of violence still increase risk indirectly through fear, dependency, and reduced ability to make informed health decisions. Key informants reinforced these findings by emphasizing that many survivors of sexual violence do not seek immediate medical attention due to shame, stigma, and fear of being judged, which delays access to post-exposure care and increases vulnerability to HIV infection. Taken together, both the quantitative results and key informant insights show that GBV and HIV are deeply interconnected, with violence not only acting as a direct route of infection but also creating social and emotional conditions that make prevention and early treatment difficult.

4.7,4 Type of GBV by HIV status and gender

In cases of physical violence, 9% of female respondents who experienced abuse were HIV positive and 5% were HIV negative. Among males, 1% were HIV positive and 6% were HIV negative. Emotional abuse followed a similar pattern, with 8% of affected females being HIV positive and 4% HIV negative, while males recorded 2% HIV positive and 5% HIV negative. Sexual violence stood out as the most severe form, with 28% of female survivors being HIV positive and 6% HIV negative. In contrast, males recorded much lower figures of 2% HIV positive and 3% HIV negative. Economic violence affected both HIV positive and HIV negative females equally at 10% each, while only 1% of males reported HIV negative status.

The study results show clear differences in how Gender-Based Violence (GBV), HIV status, and gender interact among participants. Women were disproportionately affected across all forms of violence when compared to men.

The Key informant further explained the above results;

"Most women who are abused by their partners fail to refuse unsafe sex because they fear more violence or abandonment." ***(Key Informant)*** *Another Key informant seconded by giving another insight on the two heath twins.*

"Sexual violence is one of the major causes of HIV infections among women in this community because many survivors do not have power to negotiate safe sex." ***(Key informant)***

Key informants helped to explain these realities in a more personal way, pointing out that many women are unable to negotiate for safe sex during abusive relationships because they fear further violence or being abandoned by their partners. They also noted that sexual violence remains one of the main ways through which women in the community are becoming infected with HIV, as victims often lack the power to protect themselves or seek help immediately after abuse. These experiences reflect what is happening in everyday life in the community, where fear, control, and inequality silence many survivors. Overall, both the statistics and the voices from key informants show that GBV and HIV are closely linked, with violence increasing women's vulnerability and limiting their ability to make safe choices about their health.

The findings demonstrated a strong and interlinked relationship between GBV and HIV, particularly among women, where violence directly increases vulnerability to infection and limits their ability to protect themselves. Contemporary documents also insisted the results as Campbell (2003), postulated that women who experience GBV are more susceptible to HIV infection due to forced sexual encounters, limited ability to negotiate safe sex, and the psychological effects of trauma that may lead to risky behaviours. These findings align with Feminist Theory, which argues that gender inequalities and unequal power relations within society place women at a disadvantage and increase their vulnerability to both violence and HIV infection. The Human Rights-Based Approach further supports these findings by emphasizing that every person has the right to safety, dignity, equality, and the highest attainable standard of health. When women experience violence and are denied the ability to make decisions about their own bodies and sexual health, these fundamental rights are violated. Therefore, the findings suggest that reducing HIV infections among women requires not only medical interventions but also efforts to address gender inequality, promote women's empowerment, protect human rights, and create environments where women can freely access support services and make informed decisions about their health and wellbeing.

4.8 The key drivers of Gender Based Violence and HIV in Chireya ward 4, Gokwe North District.

4.8.1 Key Drivers of Gender-Based Violence and HIV

The study showed that respondents identified a number of key factors contributing to GBV within the community. According to the data presented in the pie chart, ignorance emerged as the major driver of GBV, accounting for 40% of the responses. Harmful cultural practices followed with 30%, while multiple sexual partners contributed 20%, and economic insecurity accounted for 10%.

The high percentage associated with ignorance suggests that lack of awareness and limited knowledge about human rights, gender equality, and the effects of violence continue to promote GBV in the community. Many participants highlighted that violence is often viewed as normal behaviour, especially within intimate relationships and marriages, because some people are not adequately informed about the rights of women and the negative impacts of abuse.

One key Informant further insisted;

"*Some men abuse women because they believe it is normal in marriage and they do not know that it is a violation of women's rights.*" ***(Key Informant)***.

Another respondent explained adding to the above;

"*People in rural communities are not fully educated about GBV, so many cases remain hidden because victims think abuse is part of life.*" ***(Key Informant).***

The findings on the key drivers of Gender-Based Violence (GBV) and HIV in Chireya Ward 4 show that ignorance was the leading factor, followed by harmful cultural practices, multiple sexual partnerships, and economic insecurity. This suggests that many cases of GBV in the community are strongly influenced by limited knowledge about human rights, gender equality, and the consequences of violence. As a result, some people tend to normalise abusive behaviour, especially within intimate relationships and marriages, because they do not fully understand that it violates women's rights and has serious social and health consequences. Key informants supported this view, explaining that some men continue to abuse women because they believe it is acceptable within marriage, while others noted that many cases remain hidden because victims assume abuse is part of normal life. These

insights show how lack of education and awareness contributes not only to the persistence of GBV but also to its underreporting in the community.

The findings suggest that ignorance plays a significant role in driving both Gender-Based Violence (GBV) and HIV infection in Chireya Ward 4. The views of the key informants revealed that many people continue to tolerate or conceal violence because they lack adequate knowledge about human rights, gender equality, and the harmful effects of abuse. As a result, some men perceive violence against women as acceptable within marriage, while many victims remain silent because they have normalized abuse as part of everyday life. These findings are consistent with the contemporary documents which showed that ignorance, misinformation, and stigma contribute to the persistence of both GBV and HIV. Ferrer and Klein (2015) argued that when people underestimate their risk of HIV infection or rely on myths and misconceptions, they are less likely to adopt preventive measures such as condom use, HIV testing, and treatment adherence. Similarly, limited awareness of GBV often leads to underreporting and delays in seeking support services. The findings can also be explained through Feminist Theory, which argues that unequal gender relations are maintained through socialization, cultural beliefs, and limited awareness of women's rights. When communities accept male dominance and fail to challenge discriminatory norms, violence against women becomes normalized and women are denied the power to protect themselves from both abuse and HIV infection. Therefore, the high level of ignorance identified in this study highlights the need for community education programmes that promote gender equality, human rights awareness, HIV prevention, and the empowerment of women to challenge harmful social norms and practices.

4.8,2 Ignorance

The study findings revealed variations in respondents according to age and gender on ignorance as a driver of GBV. Female respondents constituted the majority across most age groups compared to males. The age group of 31–35 years recorded the highest frequency, with females accounting for 22.5% and males 7.7%. This was followed by the 36–40 years' category where females recorded 20.3% while males accounted for 2.5%. Respondents aged 26–30 years recorded 15% for females and 2.5% for males. In the 21–25 years' age group, females contributed 10% while males accounted for 5%. The 15–20 years' category recorded 7.7% for females and 2.5% for males, while females aged 41–49 years accounted for 7.7%.

The key informants further explained on ignorance as a cause of HIV;

"Most cases of GBV continue because people are not fully aware of women's rights and the laws against domestic violence." **(Key Informant)**

Another Key informant explained;

"Some women grow up believing that being beaten by a husband is normal because that is what they saw in their families." ***(Key Informant)***

The findings suggest that ignorance continues to play a major role in fuelling Gender-Based Violence within the community, particularly among women in the economically active age groups. Women recorded higher frequencies than men across most age categories, indicating that they are more affected by the consequences of limited awareness about their rights and the protections available to them. The views expressed by key informants reinforce this observation, revealing that many cases of GBV persist because some community members are not fully aware that violence against women is a violation of human rights and the law. In some families and communities, abusive behaviours are passed down from one generation to another and become normalized, leading some women to believe that being beaten or controlled by a husband is a normal part of marriage. These findings are consistent with the Human Rights-Based Approach, which emphasizes that every individual has the right to live with dignity, equality, safety, and freedom from violence. The approach further stresses the importance of empowering people with knowledge of their rights so that they can recognize abuse, seek protection, and hold perpetrators accountable. When women lack this knowledge, they may remain trapped in abusive relationships, fail to report violence, and become more vulnerable to negative outcomes such as HIV infection. Therefore, the findings highlight the need for continuous community education and awareness programmes that promote human rights, gender equality, and access to support services, helping community members understand that GBV is not a normal part of life but a serious violation of fundamental human rights.

The findings suggest that ignorance regarding Gender-Based Violence is more prevalent among women within the adult and economically active age groups. Many respondents indicated that lack of education and awareness about women's rights, healthy relationships, and the effects of violence continues to contribute to GBV within the community. Women in these age groups are often exposed to traditional beliefs and societal expectations that normalize violence in relationships and marriages. This is further supported by Musvosva (2018), who further showed that there is a certain percent of young men and women who do

not possess much knowledge of HIV, STIs and GBV and the researcher managed to identify the need of providing information to the community so as to reduce low risk perception and inconsistent use of condoms to reduce the spread of HIV. The lack of knowledge can be attributed to the set-up of the community in which most children are school dropouts and have no any other means of accessing knowledge pertaining to HIV and GBV.

4.8,3 Multiple concurrent partners

The study findings revealed variations in respondents according to age and gender. Females constituted the majority in most age categories compared to males. The age group of 21–25 years recorded the highest frequency, with females accounting for 20% and males 10%. This was followed by the 26–30 years' age group, where males recorded 15% while females accounted for 10%. The 31–35 years' category recorded 15% for females, while respondents aged 15–20 years accounted for 15% females and 5% males. The least represented category was the 36–40 years' age group, which recorded only 10% females.

In addition, the researcher went further to seek clarity on the obtained results having the informants airing their views on multiple concurrent partners as a cause of GBV and HIV thereby answering the research objective of identifying the key drivers of GBV and HIV. The key informants highlighted many factors associating or influencing multiple concurrent partners such as the patriarchal society, need for financial support and infidelity of a partner.

'Many people in this ward of Chireya are being involved into multiple concurrent partners where men they seek to fulfil their sexual desires. Being a man is now measured by the number of sexual partners that you have. Having these perceptions, many women are being drawn by the need of finance as you all know that we are in a remote area where money very difficult to possess so when women see the opportunity to get money they become prone to engage into sexual activities which then made it easier for the members to be vulnerable or being exposed to high risk of HIV infection. These activities again they lead to GBV especially physical abuse as some will be married members hence violence will begin' **(key informant)**.

The findings are consistent with existing documents which shows that young adults, especially women in their reproductive and economically active years, are more vulnerable to GBV due to gender inequality, unemployment, and social pressures. Feminist Theory also explains that unequal power relations in society place women at greater risk of violence, particularly during early adulthood when they are expected to fulfil family and relationship

roles.This clearly shows that multiple concurrent partners create a pathway for HIV infection and Gender-Based Violence as supported by Nalukwago, Alaii, Borne, Bukuluki & Crutzen (2018), who define MCP as an overlap of sexual partners in a given time period, with two or more simultaneous sexual partnerships. They further argue that most adolescents in in Sub-Saharan countries engage in sexual practices with multiple partners concurrently, thus placing them at high risk of HIV infection, unwanted pregnancies and subsequently leading to child marriages

4.8,4 Harmful cultural practices

The study findings revealed differences in the distribution of respondents according to age and gender. Female respondents recorded higher frequencies across almost all age categories compared to males. The age group of 21–25 years had the highest proportion of respondents, with females accounting for 40% and males 10%. This was followed by the 15–20 years' category, where females contributed 20% and males 2%. Respondents aged 26–30 years recorded 10% for females and 2% for males. In the 31–35 years' age group, females accounted for 5% while males recorded 3%. The 36–40 years' category recorded equal proportions of 3% for both females and males, while the 41–49 years' age group recorded only 2% for females.

The qualitative findings further supported these results through direct responses from participants. Key informant explained that:

"Young women are the most affected because many of us depend on partners for financial support and fear losing that support if we report abuse." **(*Key informant)***

Another respondent added:

"Girls my age often stays silent because they are afraid of being judged or not believed by family members." (Key ***informant)***

The findings on harmful cultural practices show that younger women, particularly those aged 21–25 years and 15–20 years, were the most affected, while older age groups and males recorded lower levels of exposure. This suggests that young women are more vulnerable to Gender-Based Violence (GBV) due to cultural expectations, financial dependence on partners, and fear of negative social judgement if they report abuse. Many participants indicated that survivors often remain silent because they fear being rejected, blamed, or not believed by their families and communities. Key informants supported this, explaining that

cultural norms and community attitudes often pressure young women to endure abuse rather than seek help. From a Human Rights-Based Approach, these practices undermine basic rights such as dignity, safety, and equality, as victims are denied the freedom to report and access protection services. This also aligns with Feminist Theory, which highlights how patriarchal systems and unequal power relations continue to disadvantage women, especially the young, by limiting their voice and agency.

These findings are consistent with previous studies which show that young women in their reproductive years are more vulnerable to GBV due to poverty, gender inequality, and dependence on intimate partners. Feminist Theory also supports these findings by explaining that unequal power relations in society place women, especially younger women, at greater risk of violence and exploitation.

4.8,5 Economic insecurity

The study findings revealed variations in the distribution of respondents according to age and gender regarding economic insecurity as a driver of Gender-Based Violence (GBV). Female respondents recorded higher frequencies across almost all age groups compared to males. Women aged 26–30 years had the highest frequency at 30%, while males in the same category accounted for 10%. This was followed by the 21–25 years' age group, where females recorded 25% and males 2%. Respondents aged 31–35 years accounted for 10% females and 3% males. In the 36–40 years' category, females recorded 7% while males accounted for 3%. The 15–20 years' age group recorded 5% females and 2% males, while the 41–49 years' category recorded only 3% females.

Key informant indicated,

"In our community most women are vulnerable to their husbands for financial support which led to a difficult in seeking divorce ***(Key informant)***

The findings from Chireya Ward 4 indicate that ignorance remains a key driver of Gender-Based Violence (GBV), especially among women in the economically active age groups, who reported higher levels of exposure compared to men across most categories. This suggests that limited awareness of rights, protection mechanisms, and available support services continues to leave women particularly vulnerable to abuse. Key informants reinforced this view, explaining that many community members are not adequately informed about women's rights or the legal protections that exist for survivors, and as a result, some women grow up

accepting violence as a normal part of marriage due to long-standing cultural beliefs passed down through generations. These observations are consistent with Logie et al. (2011) and Stockman, Lucea, and Campbell (2013), who found that inadequate knowledge of GBV and HIV reduces help-seeking behaviour, while Dunkle and Decker (2013) similarly noted that misinformation and silence around violence contribute to underreporting and continued victimization. Ferrer and Klein (2015) further argue that when individuals lack accurate information, they tend to underestimate risk and are less likely to take protective action. Viewed through the Human Rights-Based Approach, these findings show how ignorance undermines people's ability to recognise and claim their rights to dignity, safety, equality, and protection from violence. Without this awareness, survivors are less likely to challenge abuse or access justice, which allows GBV and its related health risks, including HIV vulnerability, to persist.

4.9 Challenges in seeking help for the victims and survivors of Gender-Based Violence and HIV infection in Chireya ward 4, Gokwe North District

4.9.1 Barriers to Seeking Help among Survivors of Gender-Based Violence and HIV

The study findings revealed several challenges faced by survivors in seeking help and accessing support services for Gender-Based Violence (GBV) and HIV-related issues. Lack of awareness emerged as the most common challenge, accounting for 40% of the responses. This was followed by resource constraints at 25%, transport barriers at 15%, poor referral systems at 10%, while fear of disclosure and fear of retaliation each accounted for 5%.

The high percentage recorded under lack of awareness suggests that many community members have limited knowledge about available GBV and HIV support services, legal protections, and reporting procedures. Some survivors may not know where to seek help or may fail to recognize certain forms of abuse as violations of their rights. Limited awareness also contributes to silence and underreporting within communities.

Key informant explained:

"*Many women do not know where to report abuse or where they can get help, so they continue suffering in silence." (**Key informant)***

Another Key informant insisted:

"Some people think domestic violence is a private family matter, so they do not seek assistance." ***(Key informant)***

The findings show that victims of GBV and HIV in Chireya Ward 4 face several interconnected challenges when trying to access help, with lack of awareness being the most significant, followed by resource constraints, transport barriers, poor referral systems, and relatively lower but still important levels of fear of disclosure and retaliation. This suggests that many community members are not fully informed about available support services, legal protections, or the proper channels for reporting abuse, which often results in silence and delayed help-seeking. Key informants supported these findings, explaining that many survivors continue to suffer in silence simply because they do not know where to go for assistance, while others view domestic violence as a private matter that should not involve external support systems. These insights highlight how misinformation, poverty, and weak service structures combine to prevent timely access to care. Both the data and key informant views show that survivors are constrained not only by personal fears but also by systemic gaps, reinforcing the need for stronger community awareness, improved coordination of services, and more accessible support systems to ensure that victims receive timely and effective assistance.

The findings therefore demonstrate that victims face multiple social, economic, and institutional barriers when seeking help for GBV and HIV-related challenges. Lack of awareness, poverty, and limited access to services continue to prevent many victims from receiving timely support. The study highlights the need for increased community awareness campaigns, improved referral systems, accessible support services, and stronger protection mechanisms for survivors.

4.9,2 Resource constraints

The findings presented in the graph revealed variations in resource constraints according to marital status and sex. Divorced females recorded the highest percentage at 25%, followed by widowed females at 20%. Single females accounted for 15%, while married females recorded 10% and cohabiting females 5%. Among males, widowed respondents recorded the highest proportion at 10%, while single, married, and divorced males each accounted for 5%.

"*Our health facilities they lack adequate material resources to help individuals from HIV infection, to start with limited condoms, HIV and AIDS pills are not sufficient for the population of this ward and clinical workers are facing work burnouts as there is limited stuff which then made it difficult for individuals to receive timely care on HIV services*" **(Key informant)**

The other key informant insisted;

"There are few trained personnel to offer professional counselling as a way of dealing with trauma which then continue to affect the victims and survivors of GBV and some are even committing suicide as a result of the trauma experienced be it sexual or emotional and some are losing confidence in themselves" **(Key informant)**

The results on resource constraints show that divorced women were the most affected, followed by widowed and single women, while married and cohabiting women recorded lower proportions. Men reported relatively lower and more consistent levels across all categories. This pattern suggests that women who are already in more vulnerable social and economic positions tend to feel the impact of weak health and support systems more strongly. Key informants confirmed these challenges, explaining that health facilities in the area often struggle with shortages of essential HIV-related supplies such as condoms and antiretroviral drugs, as well as a lack of counselling services and trained staff. Because of these gaps, survivors of GBV and people needing HIV care often face delays in receiving help or fail to get the full range of services they need. One key informant further noted that the shortage of trained counsellors leaves many survivors without proper emotional support, which can lead to ongoing distress, low self-esteem, and in some cases, severe psychological breakdown or suicidal thoughts.

These findings are in line with Watts and Zimmerman (2002), who explain that poorly resourced health systems limit effective responses to GBV and HIV by reducing access to essential prevention, treatment, and support services. Kishor and Johnson (2004) also highlight that when health facilities lack trained personnel and basic supplies, survivors are less likely to receive timely and comprehensive care, especially in low-income settings. In Zimbabwe, similar challenges have been noted by Shamu et al. (2013) and Mudzongo (2019), who point out that shortages of medicines, such as antiretroviral therapy and post-exposure prophylaxis, along with limited counselling services, continue to weaken the response to GBV and HIV, particularly in rural communities. Taken together, these studies support the

findings from Chireya Ward 4, showing that resource shortages are not just operational problems but factors that directly increase survivors' suffering and reduce their chances of recovery and protection.

4.9,3 Transport barriers

The findings presented in the graph revealed differences in transport barriers according to marital status and sex. Divorced females recorded the highest percentage at 26.7%, followed by single females at 20%. Married females and widowed females each accounted for 13.3%. Among males, married respondents recorded 13.3%, while single and divorced males each accounted for 6.7%.

Furthermore, the researcher went on to seek understanding and capturing the Key informants' opinions on transport barriers as a challenge being faced. The Key informants were showing that the community is located from a faraway area from the Government Offices where they can get help on Gender Based Violence related issues such as counselling and other services. The area again had no road networks to connect the people to the District offices.

Key informant explained;

"In this area transport is the major problem which is being experienced to get to the District Offices, the roads are very poor so the bus fare is very expensive which is leading to negligence on the serious issues of GBV and HIV. People they just forgo the need for help because we are already financially insecure in this community." **(Key informant)**

The other key informant insisted;

"The general hospital for this District is in Mtora area which is located kilometres away from this ward which is very difficult to refer patients to the hospital to get some of the HIV prevention and treatment measures very early. The referral is being delayed due to the bad roads for instance PREP and Prophylaxis treatments for HIV" **(Key informant)**

These findings are closely supported by key informants, who described how the community's remote location and lack of proper road networks continue to hinder access to services. They explained that many survivors are forced to abandon seeking help because they simply cannot afford transport, despite facing serious GBV and HIV-related challenges. One key informant pointed out that poor roads and expensive transport lead people to "forgo the need for help,"

while another emphasized that delays in reaching distant health facilities affect timely access to critical HIV prevention and treatment services such as PEP and Prep Overall, these views highlight how transport challenges combine with poverty and infrastructure gaps to limit access to care, leaving many survivors without the urgent support they need.

This concurs again with the Government of Zimbabwe, 2023; UNFPA 2022, which postulated that many survivors are also constrained by caregiving responsibilities, poverty and poor roads to acquire timely care as cited in the literature review. Limited public also another transport challenge which is affecting the people from Chireya Community. This is further supported by the works of Sachs, Ladd & Thomas, (2022), victims of sexual abuse are also diagnosed for HIV and upon negative testing, they are initiated on PEP, which is a combination of antiretroviral drugs taken for 28 days, and in some cases perpetrator and victim are tested simultaneously and the result of the perpetrator guide administration of PEP to the victim accordingly.

4.9,4 Lack of awareness

The findings presented in the graph indicate variations in lack of awareness as a barrier to accessing Gender-Based Violence (GBV) and HIV-related services according to marital status and sex. Single females recorded the highest proportion at 33%, followed by widowed females at 20%. Divorced females accounted for 12%, married females 10%, and cohabiting females 5%. Among males, all marital categories (single, married, divorced, and widowed) each recorded a relatively low and consistent percentage of 2.5%.

The qualitative findings strongly support these patterns. Key informants emphasized that many women only seek help when situations have become severe due to limited awareness of available services.

"*Most of the clients we receive only come for help after a long time because they do not even know that what they are experiencing is abuse or that services are available for them."* ***(Key informant)***

Similarly, another key informant explained:

"We often see cases where victims only come when the situation has worsened, simply because they were not aware that early reporting and support services exist." ***(Key informant)***

The findings are in consistence with Logie et al. (2011) in Canada and Stockman, Lucea, and Campbell (2013) in the United States who revealed that many survivors lacked knowledge about available support services, HIV treatment options, and the health consequences of violence, leading to delayed help-seeking and poor health outcomes. Similarly, Dunkle and Decker (2013) highlighted that misinformation and stigma surrounding HIV and GBV discouraged disclosure and reduced utilization of counselling services in Europe.

The findings show that lack of awareness is a major barrier to accessing GBV and HIV-related services, with single females being the most affected group, followed by widowed, divorced, married, and cohabiting females, while males recorded consistently low proportions across all categories. This pattern suggests that many survivors, particularly women, are not fully informed about available support systems, legal protection mechanisms, or the importance of early reporting. As a result, they often delay seeking help until the situation becomes severe or unbearable. The quantitative data is strongly supported by the views of key informants, who observed that most survivors only present themselves for assistance at advanced stages of abuse, mainly because they do not initially recognise their experiences as forms of violence or are unaware that help services exist. One key informant noted that many clients only seek help after a long time due to limited knowledge of available services, while another highlighted that victims often come when conditions have already worsened simply because they were not aware of early intervention options. These perspectives reinforce the idea that limited awareness continues to silence survivors and reduce timely access to care, highlighting the need for stronger community education and outreach programmes on GBV and HIV services. **4.9,5 Poor referrals**

The findings presented in the graph indicate variations in poor referral systems as a barrier to accessing Gender-Based Violence (GBV) and HIV-related services according to marital status and sex. Single females recorded the highest proportion at 30%, followed by married females at 20%. Divorced females, widowed females, and males each accounted for 10%

In addition, key informants also highlighted that poor referrals are a challenge for the survivors of GBV in the ward. Survivors often need multiple services: medical treatment, HIV counselling and treatment, psychosocial support, legal services, police reporting, etc. If referral pathways are weak or if different agencies (health, social welfare, legal, law enforcement) are not well coordinated, survivors may fall through the cracks. When referral pathways between health facilities, social welfare departments, legal aid providers, and law-

enforcement agencies are weak or poorly coordinated, survivors are more likely to disengage from care, particularly those living with HIV who require sustained follow-up and continuity of treatment,

"*There is no coordination of service providers such as Ministry of Woman Affairs and other agencies such law enforcement agency in helping the victims and survivors of Gender-Based Violence." (**Key informant)***

The findings on poor referral systems show that single females were the most affected group, followed by married females, while divorced and widowed females together with males recorded lower but still significant proportions. This suggests that although GBV and HIV services exist in different institutions, survivors in Chireya Ward 4 often struggle to move smoothly between them due to weak coordination. Key informants emphasized that survivors require integrated services such as medical care, HIV testing and treatment, counselling, psychosocial support, and legal assistance, but these are often delivered in isolation. As a result, many victims are lost in the system before receiving complete care, especially those who need continuous HIV-related treatment and follow-up support.

These findings are strongly supported by the current documents, which shows that fragmented service delivery systems significantly reduce survivors' access to comprehensive care. Jewkes, Sen and Garcia-Moreno (2014) argue that when referral pathways between health, social welfare, legal aid, and law enforcement institutions are poorly coordinated, survivors are less likely to complete the care continuum, increasing their vulnerability to both repeated violence and poor health outcomes. Similarly, Colombini, Mayhew and Watts (2008) highlight that weak inter-agency collaboration leads to delays, duplication of services, and loss of clients along the referral chain, particularly in low-resource settings where systems are already overstretched. In line with these studies, the views of key informants from Chireya Ward 4 confirm that the lack of coordination among service providers such as the Ministry of Women Affairs, health facilities, and law enforcement agencies creates gaps in support, leaving survivors unsupported at critical stages of recovery. This shows that improving referral systems is not only about availability of services, but also about ensuring effective coordination, communication, and follow-through so that survivors receive timely, continuous, and holistic care.

4.9,6 Fear of disclosure

The findings presented in the graph show variations in fear of disclosure as a barrier to accessing Gender-Based Violence (GBV) and HIV-related services according to marital status and sex. Widowed males recorded the highest proportion at 40%, while single females, married females, and divorced females each accounted for 20%.

A social worker highlighted how stigma and cultural expectations prevent survivors from speaking out:

"Many clients fear being judged by the community. Women worry about being blamed for the violence, while men fear being seen as weak." ***(Key Informant)***

The findings on fear of disclosure show that widowed males recorded the highest proportion (40%), while single, married, and divorced females each accounted for 20%. This suggests that while fear of speaking out cuts across different groups, it is particularly strong among widowed men. Key informant insights help explain this pattern, as a social worker noted that many survivors remain silent due to fear of judgment from the community—women often worry about being blamed for the violence, while men fear being perceived as weak or unable to "handle" their households. In this way, cultural expectations around gender roles continue to shape who feels able to report abuse and who remains silent.

These findings are supported by the existing documents such as Dunkle and Decker (2013), who argue that stigma, shame, and fear of social rejection are major barriers that prevent survivors of GBV from seeking help, even when services are available. Similarly, Campbell et al. (2008) highlight that fear of disclosure is often intensified by community norms that silence survivors and discourage reporting, particularly in intimate partner violence situations. From a feminist theory perspective, this silence reflects unequal power relations and entrenched patriarchal norms that position men as dominant and women as subordinate, while also punishing men who deviate from ideals of masculinity by showing vulnerability. At the same time, the Human Rights-Based Approach emphasizes that every individual has the right to safety, dignity, and access to justice without fear of discrimination or stigma. However, the persistence of fear of disclosure in Chireya Ward 4 shows that these rights are not fully realized in practice, as social pressure and stigma continue to prevent survivors from exercising their right to report abuse and access support services.

4.9,7 Fear of retaliation

The findings presented in the graph indicate that fear of retaliation is a consistent barrier across all marital status categories and both sexes in relation to accessing Gender-Based Violence (GBV) and HIV-related services. Single females, married females, divorced females, widowed females, as well as males across all categories each recorded an equal proportion of 10%.

The key informants highlighted that the challenge of fear of retaliation is mostly affecting those who are married they have fear of losing their marriages so they do not seek help mostly on GBV. They stay in those abusive relationships because they think when they seek help their husbands will leave them.

"Most women they do not seek help on GBV because they fear to lose their marriages and even if they consult their relatives they just comfort them. Having this perception in our community people they do not seek for help being at police station as their husbands might be arrested" **(Key informant)**

This is supported by the Feminist Theory discussed in the literature review, which explains that women are often placed in vulnerable positions within society where they fear speaking out against abuse. Many women continue to suffer quietly because they are afraid of losing their marriages, financial support, family respect, or even custody of their children. Some survivors remain in abusive relationships hoping that the situation will improve, while others fear that reporting their partners may lead to more violence or rejection by the community. The emotional pain of keeping abuse secret slowly affects their mental and physical wellbeing, leaving many victims stressed, depressed, and hopeless. Similarly, Dunkle and Decker (2013) noted that survivors in Europe also remained silent because of fear of retaliation, especially when they depended on abusive partners for survival. In developing countries such as Zimbabwe, the situation becomes worse because of poverty, cultural expectations, and weak support systems that discourage women from exposing family problems. Jewkes et al. further explained that many survivors avoid reporting abuse or seeking HIV-related services because perpetrators may threaten them with violence, divorce, or withdrawal of financial support. In communities like Chireya Ward 4, women are often encouraged to endure suffering in order to protect their marriages and family image. As a result, many victims continue to live in fear and fail to access counselling, medical care, legal assistance, and other support services that could help them recover from both GBV and HIV-related challenges.

4.10 Chapter Summary

The chapter focused on data presentation and analysis of the research findings from Chireya ward 4 as an area of study. The findings were obtained through Surveys and key informant interviews. Data gathered through surveys was presented through tables, pie charts and graphs. Findings from Key informants was presented using verbatim. Findings from this study have been found to be consistent with related studies reviewed in literature review chapter on the connection between HIV and GBV, key drivers of HIV and GBV, exploration of the barriers in seeking help on GBV and HIV. The survivors of GBV showed that there is a strong connection between the two twin health issues and the stakeholders gave their insights and opinions on the nature of their relationship.

CHAPTER FIVE: SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.0 Introduction

This chapter provides a summary of the research study, conclusions and recommendations on the research findings of the connection between Gender-Based Violence and HIV infection in the District of Gokwe North ward 4 Chireya through examination of the casual relationship of the two variables. The research also looked at the key drivers in Chireya ward 4 communities. Concluding observations are to be given in this chapter concerning the connection between GBV and HIV Infection after an assessment of the key drivers and exploration of the barriers affecting people in the community from seeking help on the survivors and victims of abuse. Recommendations shall also be presented and explained on the response to be put in place to the occurrence of GBV and HIV infection in the community and how the barriers and key drivers can be dealt on with.

5.1 Chapter Summary

Chapter One of the study focused on the background, problem statement, research objectives, research questions, limitations, and delimitations of the study. The study aimed to assess the connection between GBV and HIV in Chireya Ward 4, Gokwe North District, with emphasis on the causal relationship between GBV and HIV, the key drivers of the two variables, and barriers affecting survivors in seeking help. The chapter also highlighted the high commonness of GBV and HIV within the study area. Chapter Three discussed the methodology of the study, which implemented a mixed-methods approach using an explanatory sequential design. Quantitative data were first collected through semi-structured questionnaires administered to 50 randomly selected GBV survivors, followed by qualitative data collected from 4 purposively selected key informants through interviews. Quantitative findings were analysed using descriptive statistics such as frequencies and percentages and presented through tables, bar charts, and pie charts, while qualitative data were analysed thematically and presented in narrative form under themes related to the relationship between GBV and HIV, key drivers, and barriers to seeking help.

5.1.1 Objective 1: The casual relationship between GBV and HIV in Chireya ward 4, Gokwe North District

The findings of the study revealed a strong connection between GBV and HIV infection in Chireya Ward 4, with women being the most affected group compared to men. The results showed that many victims of GBV were HIV positive, particularly females, highlighting how violence increases women's defencelessness to HIV infection. Sexual violence emerged as the major form of abuse associated with HIV infection because survivors often fail to negotiate safe sex and are exposed to forced and unprotected sexual intercourse. Physical, emotional, and economic violence also contributed to HIV vulnerability by creating fear, trauma, low self-esteem, and dependence on abusive partners, making it difficult for victims to make independent sexual and health decisions. Key informants emphasized that many women remain in abusive relationships because of economic dependence and fear of abandonment, while others fail to seek immediate medical assistance due to stigma and shame. The findings therefore demonstrate that GBV and HIV are closely interconnected social and health problems, particularly among women in rural communities. The study further highlights that gender inequality, patriarchal norms, and women's limited decision-making power continue to increase vulnerability to both violence and HIV infection, showing the need for integrated interventions that address GBV, HIV prevention, women empowerment, and gender equality simultaneously

5.1,2 Objective 2; The key drivers of GBV and HIV in Chireya ward 4, Gokwe North

The findings on the key drivers of GBV and HIV infection in Chireya Ward 4 revealed that ignorance was the major contributing factor, followed by harmful cultural practices, multiple concurrent sexual partners, and economic insecurity. Many community members lacked adequate knowledge about women's rights, healthy relationships, HIV prevention, and the effects of violence, leading to the normalization and underreporting of abuse. Harmful cultural beliefs and patriarchal norms were also found to increase women's vulnerability to violence and HIV infection, particularly among young women who often depend on their partners financially and fear speaking out. Multiple concurrent sexual partnerships further contributed to the spread of HIV and the increase of GBV, as issues of infidelity, unequal power relations, and financial dependence exposed individuals, especially women, to unsafe sexual practices and violence. Economic insecurity was another major driver, with many women remaining in abusive relationships because of financial dependence on their partners,

while others engaged in risky sexual behaviours for survival. The findings demonstrated that GBV and HIV in Chireya Ward 4 are driven by interconnected social, cultural, and economic factors, highlighting the need for community education, women empowerment programs, economic opportunities, and awareness campaigns aimed at reducing both GBV and HIV infection within the community.

5.1,3 Objective 3; Challenges faced by victims of GBV who are also living with HIV in seeking help in Chireya ward 4, Gokwe North District

The findings on barriers affecting survivors and victims of GBV and HIV in seeking help revealed that lack of awareness was the major challenge, followed by resource constraints, transport barriers, poor referrals, fear of disclosure, and fear of retaliation. Many victims lacked knowledge about available support services, legal protections, and reporting procedures, which contributed to delayed reporting and silence within the community. Resource constraints such as shortage of medication, trained personnel, and counselling services also affected access to timely care. Transport barriers were another major challenge due to poor road networks, long distances to health facilities, and high transport costs, especially in rural areas. Poor referral systems further weakened service delivery as institutions such as hospitals, police, and social welfare departments lacked proper coordination in assisting survivors. Fear of disclosure and fear of retaliation also discouraged many victims from seeking help because of stigma, cultural expectations, fear of losing marriages, and threats from perpetrators. The findings therefore demonstrate that survivors of GBV and HIV in Chireya Ward 4 face multiple social, economic, and institutional barriers in accessing support services, highlighting the need for improved awareness campaigns, better referral systems, accessible healthcare services, and stronger protection mechanisms for survivors.

5.2 Conclusion

The first objective examined the relationship between GBV and HIV, and the findings clearly show a strong link between the two, particularly where sexual violence is involved. The results indicate that victims of GBV especially those who experienced sexual abuse were more likely to be HIV positive, largely because of forced or unprotected sex, limited power to negotiate safer sexual practices, and delays in accessing medical and counselling services. These findings are supported by Campbell (2003) and Jewkes et al. (2010), who explain that GBV increases women's vulnerability to HIV through physical injury, emotional trauma, and

reduced ability to protect themselves during sexual encounters. From a Feminist Theory perspective, this situation reflects deeper gender inequalities and power imbalances that leave women with less control over their bodies and sexual health. In addition, the Human Rights-Based Approach highlights that when individuals are denied autonomy, safety, and access to health services, their basic human rights are being violated. The findings of this study supported the ontological assumption that GBV and HIV are really social and health challenges that exist within communities and can be understood through the experiences of affected individuals. In relation to the first objective, the study established a clear relationship between GBV and HIV, revealing that experiences of violence, particularly sexual violence, increase vulnerability to HIV infection. Participants and key informants highlighted how forced sexual encounters, unequal power relations, and limited access to healthcare contribute to the spread of HIV among survivors and victims of GBV.

The second objective examined the main drivers of GBV and HIV in Chireya Ward 4. The findings revealed that ignorance was the most influential factor, followed by harmful cultural practices, multiple sexual partnerships, and economic hardship. This suggests that many incidents of GBV and HIV vulnerability are shaped by limited awareness of human rights, gender equality, and the consequences of violence. In many instances, abusive behaviours are normalized and accepted as part of everyday life rather than being recognized as violations of individual rights. These findings are consistent with Dunkle and Decker (2013) and Ferrer and Klein (2015), who argue that misinformation, low awareness, and poor risk perception contribute significantly to both violence and HIV infection. Feminist Theory further explains these findings by highlighting how patriarchal norms and unequal power relations continue to disadvantage women and limit their ability to challenge abuse or make informed decisions regarding their health and wellbeing. The findings also support the epistemological assumption of the study, which held that knowledge about GBV and HIV can be generated through engagement with participants and systematic analysis of data. The experiences shared by community members and key informants provided valuable insights into the underlying factors driving GBV and HIV within the study area. The findings demonstrate that GBV and HIV are influenced not only by individual behaviour but also by broader cultural, social, and economic factors that perpetuate vulnerability within the community.

The third objective of the study examined the challenges faced by survivors of GBV and HIV in accessing support services in Chireya Ward 4. The findings showed that survivors were commonly affected by resource shortages, transport difficulties, weak referral systems, fear

of disclosure, and fear of retaliation. These barriers were worsened by limited awareness of available services, inadequate health system capacity, and long distances to health and support facilities. As a result, many survivors delayed seeking help until their situations became severe, while others remained silent due to stigma, fear of blame, or negative community attitudes. These findings are consistent with Logie et al. (2011) and Stockman, Lucea, and Campbell (2013), who note that poor awareness and weak service delivery systems reduce help-seeking behaviour and increase vulnerability among GBV survivors. From a Human Rights-Based Approach, these challenges reflect gaps in the realization of essential rights such as access to information, health care, safety, and justice, as many survivors are unable to reach or benefit from available services. The findings also support the social reality assumption of the study, which emphasizes that individuals' experiences of GBV, HIV, and help-seeking are shaped by broader social, cultural, economic, and institutional conditions. In this study, poverty, cultural expectations, weak institutional coordination, and limited health resources significantly influenced survivors' ability to access support. Fear of retaliation and community stigma further discouraged disclosure and service uptake. Overall, the findings highlight that addressing GBV and HIV requires more than individual awareness; it demands stronger health systems, improved service accessibility, and coordinated structural interventions that respond to the lived realities of survivors.

5.3 Implication to social work practice.

This section shows the importance of this research study to social work practice. This is to be presented through mentioning roles of social workers and how they influence Gender-Based violence and HIV programming. Social work is interdisciplinary, trans-disciplinary and intersectional in the sense that it operates from other disciplines and uses individual and community experiences to advocate for individuals from grassroots level to macro level.

The findings highlighted the need for social workers to adopt a holistic and integrated approach when dealing with GBV and HIV cases. These two issues need to be addressed simultaneously not separately. Social workers should recognize the interrelationship and provide combined interventions that include psychosocial support, HIV counselling and referral services. This will ensure that survivors and victims of GBV receive comprehensive care that addresses both safety and health needs. The approach ensures that survivors receive comprehensive care that addresses both their safety and health needs.

Secondly, social workers serve as brokers, hence linking the survivors and victims of GBV to appropriate social service system. They can work with resource system to make sure that they become more responsive and make referrals within service provision systems which assist in improving the response to abuse and quality of services provided to victims of abuse. This will meet the main goal off social work practice of restoring normal social functioning of individuals.

Thirdly, social workers have a role of advocacy. They raise voice for the voiceless in the communities like Chireya ward 4 in which people still practice activities that violate people's rights. The study revealed that harmful cultural practices are contributing to GBV and HIV infection. Therefore, social workers should intervene raising the voice of girl child for societal norms to change as well as educating the community to challenge those harmful cultural practices.

Social workers promote particular participation among community members. This ensures that survivors of GBV become actively participate in the process of addressing the problems that affect them as noted by Paulo Freire who introduced conscientization in which he emphasized that human beings they need to be worked with. This will promote empowerment of the survivors and the victims of GBV to become aware and able to overcome the problems they face in relation to the two health issues.

5.4 Recommendations

There is need for awareness campaigns, disseminating information on the causes and consequences of GBV, the drivers of HIV infection among sexually active populations. The community needs volunteers who reach the community with information with targeted programs targeting the survivors and victims of GBV and HIV. There is need to implement economic initiatives to generate income especially for women. This will reduce women from engaging into commercial sex work. If people become empowered with knowledge of generating income and knowledge of HIV infection chances of being infected by HIV will be reduced.

5.4,1 One stop centres.

These are facilities where people can access multiple services at one place including medical services, psychosocial support, legal assistance and police services. This integrated approach will reduce poor referral challenges as indicated by the research findings that people in

Chireya community they are facing challenges of poor referrals in seeking help. Burden will be reduced on survivors who would otherwise have to move in different institutions to seek help. The centres need to be revived and strengthened to function efficiently in order to adequately address people's needs. Resources and infrastructure must be provided in the centres as this will help to enable people to seek help easily for those who need GBV and HIV related services.

5.4,2 Economic strengthening initiatives or projects.

The research findings showed that people especially women are facing economic challenges which will make them vulnerable and become prone to GBV. Many women have been reported to engage into sexual relationships for the exchange of material and financial resources which create chances of HIV infection. Therefore, there is need to bring initiatives or women based projects to empower them to be finically capable for their living. NGOs and government must venture in service delivery to launch economic strengthening initiatives like gardening by drilling of boreholes and construction of dams to serve as water banks to reserve the water for gardening in rural communities. This initiative will help to reduce economic dependency on women and economic vulnerability as some reside in areas which are hotspot of HIV such as mining areas.

5.4,3 Strengthening of the provision of psychosocial support.

Gender-Based Violence and HIV infection can lead to mental health issues which then require psychological support to restore normal social functioning. The findings reported that there is lack or limited professional service delivery for the survivors and victims of GBV such as counselling. Stakeholders were reportedly to be few to cover the entire population and those who are available they need to be trained on GBV related programs and also with counselling skills. This will help to deliver professional services which reduce labelling, name calling, stigma or discrimination by service providers which will end instilling fear in people of reporting their cases and seek help.

5.4,4 Educating girls.

The findings showed that girls are underprivileged by societal norms and they are unaware of their rights. Lack of knowledge shows to be the root cause off their abuse as they are school drop outs. Many in the community are involved in child marriages which is another environment of their abuse. The government and NGOs must intervene with initiatives that

promote girl child education by paying of school bills and other educational levy. However, there is an NGO called CAMFED but it's not covering all vulnerable children and it only include secondary schools skipping the primary stage. Educating a girl child makes her exposed to sexual and reproductive health knowledge and rights. This will reduce exposure to intimate partner violence and increasing their risk of financially insecure. Education equips girls with knowledge, skills, and confidence to make informed decisions about their sexual and reproductive health. The findings of the study indicated that low levels of education among women increase their vulnerability to GBV and limit their ability to negotiate safe sexual practices, thereby increasing the risk of HIV infection.

5.5 Areas of further research.

The future studies should focus on the impacts off GBV and HIV on boys and men as this study focused much on girls and women. The studies to come again must do a comparative study of the relationship between GBV and HIV in urban set ups as the study mainly focused on Gokwe North District which is a rural set up though GBV and HIV can have their relationship portrayed in town set up.

5.6 Chapter Summary

The chapter intended to offer a summary of the research findings. The conclusion of the study was discussed where HIV and GBV showed that they are linked by the key drivers such as harmful cultural practices, ignorance and multiple concurrent partners. The challenges which are faced by the survivors and victims of GBV showed that there is need of initiatives and projects to address the challenges. It also deliberated the implications of the study to social work practice. Lastly the recommendations were suggested on the improvement of GBV and HIV related services.

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List of Appendix

Appendix 1: QUESTIONNAIRE: Structured

Title: The Relationship Between Gender-Based Violence (GBV) and HIV in Ward 4, Chireya, Gokwe North District

Instructions: Tick (✓) or fill in the appropriate answer. Responses are confidential.

Section A: Demographic Information

1. Age

   ☐ 15–19 ☐ 20–24 ☐ 25–29 ☐ 30–34 ☐ 35–39 ☐ 40–49

2. Gender

☐ Female ☐ Male

3. Marital Status

   ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Cohabiting

4. Level of Education

   ☐ No formal ☐ Primary ☐ Secondary ☐ Tertiary

5. Occupation

   ☐ Unemployed ☐ Farmer ☐ Self-employed ☐ Employed

Section B: The casual relationship between Gender Based Violence and Human Immune Virus in Ward 4 of Gokwe District

Explores the relationship between GBV and HIV

5. Have you ever experienced any form of gender-based violence?

   ☐ Yes ☐ No

6. If yes, which type(s)?

   ☐ Physical ☐ Sexual ☐ Emotional ☐ Economic

7. What is your HIV status?

☐ Positive ☐ Negative

8. GBV increases the vulnerability of women to HIV infection in this community?
   ☐ Strongly agree ☐ Agree ☐ Neutral ☐ Disagree ☐ Strongly disagree

9. Survivors of GBV are less likely to negotiate safe sex due to fear of further violence?
   ☐ Strongly agree ☐ Agree ☐ Neutral ☐ Disagree ☐ Strongly disagree

10. Women who experience GBV are more likely to contract HIV?
    ☐ Strongly agree ☐ Agree ☐ Neutral ☐ Disagree ☐ Strongly disagree

11. In your opinion, is there a link between GBV and HIV infection in your community?
    ☐ Yes ☐ No ☐ Not sure

Section C: Drivers of GBV and HIV

11. Which factors contribute to GBV in your community? (Tick all that apply)
☐ economic insecurity ☐Harmful Cultural beliefs ☐ Multiple concurrent partnership ☐ Ignorance

12. Financial dependence on a partner makes it difficult for women to leave abusive relationships

☐ Strongly agree ☐ Agree ☐ Neutral ☐ Disagree ☐ Strongly disagree

13 Multiple concurrent partnerships increase the risk of HIV infection
☐ Strongly agree ☐ Agree ☐ Neutral ☐ Disagree ☐ Strongly disagree

14. Lack of knowledge about HIV contributes to risky sexual behaviour

☐ Strongly agree ☐ Agree ☐ Neutral ☐ Disagree ☐ Strongly disagree

15. Limited awareness about GBV leads to its continuation in the community

☐ Strongly agree ☐ Agree ☐ Neutral ☐ Disagree ☐ Strongly disagree

16. Cultural norms encourage male dominance in relationships
    ☐ Strongly agree ☐ Agree ☐ Neutral ☐ Disagree ☐ Strongly disagree

17. Economic dependence increases women's vulnerability to GBV and HIV
☐ Strongly agree ☐ Agree ☐ Neutral ☐ Disagree ☐ Strongly disagree

Section D: Barriers to Seeking Help

18. Have you ever reported GBV to any authority?
☐ Yes ☐ No

19. If NO, what prevented you?
☐ Fear of disclosure ☐ Poor referrals ☐ Transport challenges ☐ Resource constraints☐ Lack of awareness ☐ fear of retaliation

20. Are GBV support services accessible in your area?
☐ Yes ☐ No ☐ Not sure

21. What challenges do GBV survivors living with HIV face when seeking help?
☐ Stigma ☐ Discrimination ☐ Transport costs ☐ Confidentiality concerns ☐ Other:__

22. Are HIV services (testing/treatment) easily accessible?
☐ Yes ☐ No

Appendix 2: KEY INFORMANT INTERVIEW GUIDE

Section A: Bibliographic Information

Organisation	Interviewee Position/Job Title	Sex [Male (M)/ Female (F)]

<u>Section B:</u> To explore the causal relationship between HIV and GBV in Gokwe North District ward 4

1. Do you have knowledge on the causal relationship between GBV and HIV infection?

2. In your opinion, which groups are most vulnerable to both GBV and HIV, and why?

3. Based on your experience, how does GBV increase women's vulnerability to HIV?

<u>Section C:</u> To explore the key drivers of Gender- Based Violence and HIV infections in Gokwe North District ward 4

1. What are other drivers of GBV and HIV in Gokwe North District ward 4

2. How does poverty or financial dependence contribute to GBV and HIV risk?

3.Cultural beliefs appear to influence GBV and HIV risk. Can you give examples of harmful cultural practices or norms that perpetuate this?

3.How do multiple sexual partners contribute to HIV infection…

4.How does lack of knowledge about HIV prevention or GBV affect women's vulnerability?

<u>Section D:</u> What are challenges to seeking help among GBV survivors who are also living with HIV in Chireya Ward 4

1. Are health care services accessible to anyone without specific documentation that victims may not have which might delay accessing health services? Explain

2. . Does financial dependence on the abuser prevent women from seeking help or leaving abusive relationships?

3. Is there referral protocol which must be followed, are there any protection and safety services (safe place) provided to victims?

4. In your understanding is there legal counselling available to advise survivors of their legal rights and on the process for criminal proceedings?

Appendix 3

PARTICIPANT CONSENT FORM

Dissertation topic: The connection between Gender-Based Violence (GBV) and the human Immunodeficiency Virus (HIV). a study of Chireya ward 4, Gokwe North District.

Objectives

1. To explore the casual relationship between Gender Based Violence and Human Immune Virus in Ward 4 of Gokwe District.
2. To identify the key drivers of Gender Based Violence and HIV in Gokwe North ward 4 Chireya
3. To identify key barriers to seeking help among GBV survivors who are also living with HIV in Gokwe North Ward 4.

The research shall be conducted by **MUSHAWEZARU AMOS,** a student at the Bindura University of Science Education currently studying a Bachelor's degree in Social Work. The study is a requirement by the department in order to complete his studies.

I am giving consent to be interviewed by the researcher and the objectives of the study have been clearly explained to me in a language that I understand. By signing this document, I understand that participation in this study is voluntary. I also agree to be audio-taped and I am aware that I am free to withdraw from the study at any given time. I have been given clarification concerning the study. I understand that confidentiality is guaranteed and my identity will not be revealed.

I also understand that if I have any questions about my rights as a participant, I can contact Mr. A Mushawezaru through the following contact details

Cell number: 0782911225

Email address: amosmushawezaru@gmail.com

Participant's signature: …… Date: ……

Researcher's signature: ……. Date: …….

Appendix 4

Approval letter

Chireya High School

P.O.Box 03

Gokwe

28 January 2026

Dear Amos

Good day ***Mr Amos Mushawezaru***, I want to confirm you that the Councillor of ward 4 Chireya Gokwe North district has granted you permission to carry out the research in the community with the topic " The connection between Gender-Based Violence and Human Immunodeficiency Virus (HIV) in Gokwe North ward 4 Chireya.

The following conditions should be followed when conducting your research, your work must not disturb the daily activities of people in the community and you should not consider the political aspects of the ward. All of the conditions above must be strictly followed but if violated, your research can be immediately terminated and dismissed in the ward. After conducting your research, you must submit a copy of your work for future benefit.

Yours faithfully, Chireya Ward 4 Councillor

Christopher Mapindu

