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ORIGINAL ARTICLE

Intimate Partner Violence: Understanding Barriers in Seeking Formal Support Services in a Rural Area in Zimbabwe

Cyndirela Chadambuka[1] · **Ajwang'Warria**[1]

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Abstract

Intimate partner violence (IPV) remains a global problem that requires intervention, yet women residing in rural areas still face challenges in dealing with it. There are no specific studies on the barriers to the use of formal support systems by victims of IPV in rural areas in Zimbabwe. Therefore, this study explored barriers that exist in the use of formal support systems by victims of IPV residing in rural areas in Zimbabwe. A qualitative study was conducted with 25 women between the ages of 19 and 49 years who reside in a rural area in Chimanimani District (Zimbabwe). Study participants were recruited using purposive sampling and on the basis that they had experienced IPV in their former intimate relationships and were not current victims. In-depth face-to-face interviews were conducted with the study participants. Interviews were audio-recorded with the consent of participants and data transcribed verbatim. The data was analysed using thematic analysis. Findings from the study suggest that the desire to preserve marriages, the attitudes of service providers, concerns with confidentiality, and lack of resources were barriers that victims of IPV faced in seeking formal help. Women in rural areas face challenges in accessing and using formal support systems even though they have the same risks of IPV perpetration as women in residing in urban areas. Therefore, there is a need for more resources and context-specific interventions to ensure the protection and uphold the rights of women residing in rural areas.

Keywords Barriers · Formal support services · Intimate partner violence · Rural areas

Intimate partner violence (IPV) remains one of the major global challenges that violate the rights of women. IPV has different forms, which include physical, psychological and sexual harm (McCloskey et al., 2016). Male partners are the most common perpetrators, with 30% of women estimated to have experienced IPV in their lifetime (Abramsky et al., 2018). Globally, one in three women is reported to have experienced IPV in her lifetime (Klugman, 2017). The worst affected regions include South East Asia (38%), Eastern Mediterranean (37%) and Africa (36%) (Alangea et al., 2018).

In Africa, the rate of IPV is recorded as high, given the cultural norms and values that condone the subjection of women and male dominance (Izugbara, 2020; McCloskey et al., 2016). For example, in Uganda, 44% of ever-partnered women reported having experienced IPV, with 58% reporting attitudes of accepting men's use of violence against women in intimate relationships (Abramsky et al., 2018). In Africa, the sub-Saharan region has one of the highest rates of IPV and this is largely attributed to the influence of cultural norms, high levels of unemployment and poverty, which leaves women in vulnerable positions (McCloskey et al., 2016).

The Zimbabwean society, especially in the rural areas where IPV effects are more rampant, is patriarchal and subscribes to social norms that encourage male dominance (Fidan & Bui, 2016). Regardless of the various legislative measures put into place, IPV remains a socio-economic challenge in rural areas in Zimbabwe that requires intervention (Shamu et al., 2013). For women residing in rural areas in Zimbabwe, the situation is worsened by the multiplicity of disadvantages that converge with cultural norms. Nyandoro and Muzorewa (2017) argue that the rapid rural–urban migration in Zimbabwe played a significant role in the centralisation of basic services to meet the growing needs of

✉ Cyndirela Chadambuka
890270@students.wits.ac.za; cchadambuka@gmail.com

Ajwang' Warria
Ajwang.Warria@wits.ac.za

[1] Department of Social Work, University of the Witwatersrand, Johannesburg, South Africa

the urban population. Thus, most of the crucial IPV-related intervention services (e.g. judiciary services, psycho-social services) are in the urban areas, with a few core service providers (e.g. health professionals and police) deployed to rural areas.

There has been considerable coverage of IPV and its consequences for women in Zimbabwe, especially those in urban areas (Chireshe, 2015; Henderson et al., 2017; Shamu et al., 2018), yet critical gaps still exist in terms of formal service delivery in rural areas. While there is a fairly large body of literature on IPV, its consequences and the challenges that women face in seeking help in low-income communities (Conroy, 2014; Evans & Feder, 2014; Riddell et al., 2009), little is known about IPV and barriers in seeking formal assistance in rural areas in Zimbabwe. Studies conducted in other rural contexts such as in Canada by Guruge and Humphreys (2009) and in Kenya by Odero et al. (2014) have shown that lack of awareness about formal support services, confidentiality issues and lack of resources are some of the barriers that IPV victims face as they seek help. Furthermore, although barriers to help-seeking in IPV situations might be similar between rural and urban areas, there might also be distinct differences determined and influenced by the actual setting (Edwards, 2015). Thus practitioners need to understand the uniqueness of women seeking assistance due to IPV in rural areas. Failure to have a full understanding of the context, strengths and barriers existing in rural areas makes intervention efforts fruitless, contributes to rights violations and increases women's vulnerability. This study contributes to debates on service provision to vulnerable pupulations in rural areas, especially women victims of IPV. Based on the literature reviewed, this is the first study conducted to specifically examine the barriers that exist in accessing and using IPV formal support services by women in heterosexual relationships residing in rural areas in Zimbabwe.

Decision-Making in the Context of IPV

The decision to disclose IPV to formal support systems is difficult given the consequences associated with reporting IPV incidents to 'outsiders' (Riddell et al., 2009). One of the key solutions in the prevention of IPV is to enhance women's decision-making capacity, i.e., the ability to acquire resources, agency and ability to make strategic life decisions and choices (Schuler et al., 2018; Stork, 2008). This also includes the ability to seek formal assistance in abusive situations. Although other indicators of empowerment are crucial, decision-making enables victims of IPV to have insight into the extent to which they can exercise choice and control in order to minimise, stop and/or prevent the occurrence of IPV.

IPV is regarded as a serious indicator of disempowerment of women and the extent to which the decision-making capacity of women in IPV situations can be enhanced is determined by societal expectations and gender roles (Kabir & Khan, 2019). It can be argued that societal practices and beliefs, such as the payment of *roora* (bride-price), sets the stage for the commodification of women and normalisation of IPV. This in turn suppresses women's rights to decision-making and ultimately increases their vulnerability to IPV. Furthermore, the discussion on IPV and the empowerment of women, particularly decision-making, is debatable, with some studies indicating that the ability to make crucial decisions in the household can increase their vulnerability to IPV (Abramsky et al., 2018). Interestingly, some studies outline disparate findings on the relationship between IPV and decision-making (Kim et al., 2007). Overally, it can be argued that women's decision-making capacity can have different effects on IPV risk and this is highly dependent on context (Sabarwal et al., 2014).

Researchers further argue that the perpetuation of IPV is largely reinforced by discriminatory laws and exclusionary social norms that undermine the abilities and potential in making strategic life decisions and choices (Klugman, 2017; McCloskey et al., 2016). Goal 5 of the Sustainable Development Goals (SDGs) is on the achievement of gender equality and empowerment of all women and girls, to enjoy decision-making power and have a voice within their family settings. However, this can be difficult to achieve considering that the voice can be regarded as a threat and deviation from social norms (Sanawar et al., 2019). Women's ability to make decisions in IPV-dominated relationships is suppressed by the fact that women, particularly those residing in rural areas, generally depend economically on men and normalise abuse in return for economic and social support (Sanawar et al., 2019). This impedes the help-seeking process and incapacitates their decision-making capacity. This might explain why victims of IPV in rural areas would find it challenging to seek assistance from formal support systems.

Formal Support Systems

Support is crucial in IPV situations and it can be provided by both formal and informal support systems. Informal support systems include one's immediate and extended family members and friends (Guruge & Humphreys, 2009). On the other hand, formal support can be provided by professional service providers such as police officers, health professionals, social workers and shelter personnel. The support that is rendered by formal service providers includes financial assistance, links to resources, psycho-social support and information on seeking protection from the abuser (Evans & Feder, 2014). From a systems theory perspective, IPV is

harmful and has negative effects on the welfare of the individual women, their family and community as a whole and therefore supportive interventions are critical in minimising and preventing its occurrence and the consequences thereof. Systems theory can also be used to understand and contextualise intervention strategies. Formal support is useful in rural areas given that informal networks can be unsupportive due to their adherence to social norms that condone secrecy in IPV cases (Bosch & Bergen, 2006). In some cases, the family provides inadequate support, especially when the abuse is life-threatening and this renders formal support more important. Although seeking help from an informal support network is regarded as a precursor to formal help-seeking (Evans & Feder, 2014), the influence of social norms and geographical distances in rural areas also makes it challenging for victims of IPV to access formal help.

Rural areas in Zimbabwe are geographically isolated, with few intervention resources for assisting victims of IPV. This then means that women in rural areas have limited access to formal support services. Sechele (2016) argues that rural areas are largely characterised by systemic discrimination of resource allocation, and Zimbabwe is not an exception. In Zimbabwe, crucial IPV intervention services are centralised in cities such as Harare and Mutare. Hence essential formal service provision is scarce or even absent in rural areas, which makes informal support a reprieve and a viable temporary alternative for abused women. Victims of IPV in rural areas also face the risk of being turned away due to insufficient programmes and inadequate staffing to deal with IPV cases (Peek-Asa et al., 2011). Likewise, the structure of rural areas *hides* IPV and ultimately inhibits treatment and prevention efforts (Teaster et al., 2006). The provision of formal services in rural areas remains limited due to social and geographic isolation, which present barriers to accessing IPV services. For example, a study by Peek-Asa et al. (2011) revealed that 25% of women in rural areas affected by IPV had to travel around 64 kms to the nearest service provider, unlike those in the urban areas. This is not different from the Zimbabwean situation, where most rural areas are remote with service providers far apart. This is a significant barrier for IPV victims in rural areas as they are exposed to severe and frequent IPV (Conroy, 2014).

The tenacity of social norms that promote gender inequality (Chadambuka & Warria, 2019) and male dominance in intimate relationships plays a significant role in the help-seeking behaviour of victims (Shamu et al., 2018). According to Bosch and Bergen (2006), formal support networks are entrenched in advocating for equality and freedom and building resilience among victims. However, due to their structured way of delivering services (e.g. lack of anonymity and confidentiality), formal support systems may not the best recourse for the many IPV victims in rural areas. As a result, victims of IPV in rural areas seem to have internalised and normalised IPV, and their (financial) dependence on the perpetrator impedes their ability to seek help from formal support systems (Riddell et al., 2009). Thus, it is important to examine and understand the barriers to formal help-seeking in rural areas.

Theoretical Framework

Intersectional feminism acknowledges gender inequality from a perspective of converging social variables. The intersectionality perspective provides a basis for investigating the experiences of marginalised women (Baird et al., 2019). Intersectional feminism acknowledges that no single social variable can adequately explain the experiences of women; rather, multiple disadvantages (e.g. religion, social norms, gender and geographical location) intertwine in contributing to the oppression of women (McCall, 2005). The complexity of IPV indicates the need to deepen our understanding of this phenomenon and how different groups of women experience it. In understanding and explaining IPV experiences, no axis of inequality should be prioritised more than another, as these operate simultaneously in the perpetuation of IPV (Etherington & Baker, 2018). This requires the need to understand how cultural beliefs and structural factors contribute to its perpetuation and ultimately influence victims' help-seeking behaviour. Thus, intersectional feminism strives to acknowledge the wider context in which IPV occurs taking into consideration the intricately intertwined social variables that heighten the risk of women to IPV (Crenshaw, 1991; Hill Collins, 1991).

In this study, intersectional feminism allows for a more nuanced picture of women's experiences of IPV in rural areas and challenges the notion that women have similar experiences of IPV and respond to it in the same way. We posit that the converging disadvantages associated with rural areas cannot be discounted as plausible explanations for the heightened risk to IPV. These disadvantages influence the help-seeking behaviour of victims of IPV in rural areas and inform the availability and accessibility of formal support services.

Methods

Study Context

Chimanimani Rural District is one of the poorest districts in Zimbabwe. The population consists of mostly the Ndau people, who are a Shona sub-ethnic group. The district consists of 23 wards with an average of six to eight villages in each ward. Each village consists of an average of 35 households. For this study only one ward was selected in the district.

The researcher could not interview participants who lived in some of the remote villages due to Cyclone Idai that made a landfall in Zimbabwe in March 2019, destroyed roads and made it dangerous to travel to those villages for interviews. The researcher could access only six villages out of eight. Chimanimani District is largely mountainous and has a rugged terrain, so some villages are far from the road and lack reliable public transport. The district has a police post and clinic in each ward. Most service providers from government departments and non-governmental organisations are centralised in nearest towns and this negatively affects service provision in rural areas (Bosch & Bergen, 2006).

Participants

Qualitative research was used for this study due to its flexibility in probing and understanding the human experiences of different groups of society (Rahman, 2017). Purposive sampling was utilised to select participants, as it enables the selection of information-rich participants who are well informed in the field of study (Sharma, 2017). The sample of the study consisted of 25 women drawn from six out of eight villages in one ward in Chimanimani District. The 25 participants were chosen on the basis that they i) should have experienced IPV in their former intimate relationships and were not in a current abusive relationship; (ii) should be between the ages of 19 and 49 years old; (iii) should be residing in Chimanimani District; (iv) should be available to participate in the study. Current victims of IPV were excluded from the study because of the risks associated with IPV disclosure for both the researcher and participants. No participant revealed on-going IPV during the interviews.

In recruiting participants for the study, the author took advantage of *chisi* (cultural resting day in the Shona society) to explain the purpose of the study. The author approached informal self-help groups in six villages, explained the purpose of the study and invited the women to participate. In upholding confidentiality, the author handed out participant information sheets to all women present and requested them to indicate their preference through the use of 'yes' or 'no'. All the women in the group were literate and could write their names and contact details. Those who were willing to participate were requested to include their contact details for follow-up. Not all women who wanted to participate met the eligibility criteria, as some of them were experiencing ongoing IPV but were willing to share their stories. For those who were in current relationships characterised by IPV, the lead author provided details of the district social worker for further assistance, as they were not comfortable with the researcher making a direct referral. All the women, two or more from each village, who were interviewed in this study consented to participate.

Data Collection

Data collection was done over a three-month period – i.e. from March to May 2019 in Chimanimani Rural District in Zimbabwe. Face-to-face interviews were conducted by the lead author using a semi-structured interview schedule. The semi-structured interview guide was developed in both Shona and English. Questions around available support mechanisms for IPV victims in rural areas were included in the interview guide. For example, *'Can you share with me the support mechanisms that you utilised when you were exposed to IPV? What are the challenges that you faced when you tried to access these support services?* Further probing questions around accessibility, appropriateness and availability were asked to elicit in-depth information on help-seeking. As all participants were Ndau-speaking (Shona dialect), the interviews were conducted in Ndau. Issues surrounding voluntary participation and confidentiality were fully explained and participants' real names were replaced with pseudonyms for privacy and confidentiality and to reduce risks.

All the interviews were audio-recorded with the consent of the study participants to avoid data loss. The author intended to conduct the interviews in two or more sessions, but the majority of the participants opted for one session and they indicated being more comfortable with this. The other important reason cited was the time spent being interviewed in two sessions instead of working in their gardens and/or farm. The interviews were between 40 and 90 min and lasted an average of 50 min. Informed consent (both written and oral) was sought from participants before the commencement of the interviews. In line with research guidelines from World Health Organisation (WHO) (2001) and ensuring safety of the participants in this study, the researcher conducted interviews at a place and time that was convenient and safe as identified by the women. Given the importance of time and the reliance on subsistence farming and gardening, the participants received ZAR100 (approximately US$7) as a token of appreciation for their time and involvement in the study. The money was given in Rands, since at the time of data collection Zimbabwe was using a multicurrency approach which consisted of the South African rand and the US dollar.

Bearing in mind the traumatic nature of IPV, the services of a social worker were made available by Chimanimani Rural District Council if counselling was required. In the event of a participant requiring counselling, the researcher was to refer the participant to the social worker, with the consent of the participant. No participant requested the services of the social worker; however, the researcher shared the contact details of the social worker with women who were facing ongoing IPV who could not participate in the study. As per ethics requirements, permission was obtained

from the Ministry of Women Affairs, Community, Small and Medium Enterprise Development and Chimanimani Rural District Council. Ethics Clearance (No. H18/11/04) was granted by the Human Research Ethics Committee (HREC) (non-medical) at the University of the Witwatersrand. Given the nature of rural areas, permission was also sought from the village headmen as part of the social norms that govern this rural area.

Data Analysis

After completing data collection, the audio-recorded interviews were transferred to the author's password-protected computer. The audio-recorded interviews were transcribed verbatim by the author, as she is fluent in both Shona and English. The interviews were transcribed in Shona and translated into English where necessary. Pseudonyms were used to identify the participants. The transcribed interviews were analysed using the steps outlined by Braun and Clarke (2006). This method of data analysis was selected due to its flexibility in the selection of themes (Braun & Clarke, 2006). While thematic analysis was the main method of data analysis, the authors borrowed some tenets of the phenomenological analysis method so as to ensure an in-depth analysis. The researcher used the six steps in thematic analysis, which include familiarisation with data collected, generating initial codes and searching for themes.

The researcher familiarised herself with the data through the transcribing phase, as she transcribed the interviews herself. Creswell (2013) argues that in phenomenological analysis textual descriptions are important in interrogating what the participants are saying and the relevant topics being expressed by the participants in line with the phenomenon under study. Thus after data familiarisation, each transcript of the interview was thoroughly reviewed, and potentially interesting and relevant texts were highlighted manually, and codes were developed to categorise the data. For example, codes such as *victim blaming* and *lack of sympathy* were developed under this process. After reviewing, the data was collated into groups that were identified by the codes. Saldana (2009) argues that multiple coders in qualitative research are crucial in dealing with researcher bias. Hence, in this study an independent qualitative analyst was invited to assist with data analysis in order to avoid researcher bias. De-identified data was shared with an independent qualitative analyst for further analysis, and discrepancies that emerged were discussed regularly. Creswell (2013) suggests that the process of validation in phenomenological research design includes having agreement between coders and is crucial in addressing researcher bias. In this study, the independent qualitative analyst agreed with the codes developed by the researcher. The codes that emerged were analysed to identify patterns among them and themes were generated. Several codes in this study were combined into themes. For example, the codes *victim blaming* and *lack of sympathy* were combined to form one theme: *attitudes of service providers.* The potential themes were reviewed to check if they represented the data collected and were renamed and defined so that they would be easily understandable to the readers.

Positionality

Positionality in research reflects the position the researcher has taken within a given study and requires the researcher to locate and acknowledge their views, values and beliefs in the research process through self-reflection (Patnaik, 2013; Sherry, 2013). Manohar et al. (2017) argue that when conducting qualitative research various factors (i.e. age, gender) come into play and influence the research process. The lead author is from the Shona tribe and can speak the Ndau dialect – the language used for data collection – fluently, which enabled the study participants to identify with her and ensured ease in discussing sensitive IPV-related and cultural norms.

Manohar et al. (2017) further argue that the age and gender of the researcher influence the research process particularly in terms of trust and relationship. In the Shona culture old age implies respect, hence there was a possibility of older participants finding it difficult to extend respect to the lead author, who was younger than most of them. The lead author, being an unmarried young woman in her late twenties, was not at ease discussing sensitive issues with the older participants – similar to experiences of the service providers to be shared in the next section. However, she ensured that cultural respect was accorded to the older study participants hence rapport was easy to establish and the participants opened up to her and gave her the lead in the discussion of sensitive information.

Previous personal and professional experience – i.e. familiarity with rural areas by living there as a young person and working with victims of gender-based violence in rural areas in Zimbabwe – enhanced this data collection process. These experiences enabled her to establish strong connections with the participants, as she had some understanding of rural life and context. However, it is crucial to note that, from time to time, urban bias crept in and the research supervisor (the second author) assisted her with this – even when she was still in the field collecting data.

Results

The findings from this study reveal the different barriers that women face in accessing formal support systems. These are: (i) the desire to preserve marriages, (ii) the

attitudes of service providers, (iii) lack of confidentiality, (iv) lack of resources. These barriers will be discussed in detail, as listed, next.

"I want My Marriage": The Desire to Preserve Marriages

Participants reported that one of the barriers in seeking formal support was their desire to preserve their marriages. While the desire to preserve marriages is experienced by IPV victims in both rural and urban areas, women residing in rural areas place great emphasis on preserving their marriages regardless of the seemingly deleterious consequences of IPV (Conroy, 2014; Riddell et al., 2009). Given the importance of natal and extended families in solving marital disputes, participants reported that the family would not be supportive if IPV is disclosed to formal service providers, as this was against societal norms. Moreover, relatives and families discourage the use of formal services, particularly the police, in order to avoid arrests, which are regarded as shameful and humiliating. Victims who wanted to report to the police were also threatened with divorce, as it is regarded as disrespectful to the family. One participant noted:

> My husband and his family used to say if I ever go to the police, he will leave me because it means I would have undermined him. I wanted my marriage so I just told myself that this will pass, and I did not report all the abuse that my husband exposed me to (Chipo, 28 years old, divorced and unemployed mother of one).

Another participant mentioned that

> I never went to the hospital or clinic after being beaten, I just thought I will be fine. Besides if you go to the clinic, they will instruct you to go to the police yet I still want my marriage. You know once you involve the police in things concerning your husband when you are married, nothing will move, that marriage ends (Elsie, 32 years old, widowed and unemployed mother of two children).

The need to preserve marriages is central to the help-seeking process among victims of IPV victims. Families are crucial to the success of marriages in rural areas, and in-laws become unsupportive and hostile towards the victim if IPV abuse is disclosed to formal service providers. Social norms surrounding marriage condone the privatisation of IPV, and families are mandated to maintain that status quo by virtue of being the best mediators in marital conflicts. The need to preserve the family's honour and dignity in the community always discourages IPV victims from reporting IPV incidents to service providers.

"They Start Judging and Blaming you": Attitudes of Service Providers

Formal service providers play a major role in assisting victims of IPV in rural areas. Although they are regarded as the last resort, service providers are the first point of contact for those victims who have decided to take a major step of seeking external help. However, considering the victim-blaming attitudes that are associated with IPV service providers (e.g. police and healthcare professionals), participants in this study did not regard formal assistance as effective, hence the decision to avoid formal service providers. The dissatisfaction in their service provision stemmed from the negative attitudes that they display to the women. One participant highlighted that.

> To me, going to the police was a waste of time because police, usually, when you go to them with such cases they start judging and blaming you because they believe as a woman you get beaten because of being rude to the husband. To me, the police did not help and some of them are related to community members and hang around with people known to the abuser, so if you go there everyone in the community will know that you reported your husband to the police (Nancy, 20 years old, divorced and unemployed mother of one).

Another participant highlighted that

> I would go to the clinic and lied to them that I am sick so that they could treat me. I never told them I was beaten because they would require a police report before treating and I cannot report my husband. And nurses are rude once they know you were beaten, they also insult you in front of other patients exposing you to everyone. Sometimes they would even blame you for the beatings (Lydia, 32 years old, divorced and unemployed mother of two children).

The above quotations clearly highlight the strained relationship between formal service providers in rural areas and the victims of IPV. The judgemental and unsympathetic attitudes of service providers in rural areas present a barrier to IPV victims seeking help. The interaction of the prevailing social norms, gender and geographical isolation also affect the way service providers perceive and respond to IPV victims. For example, IPV is considered a criminal offence in Zimbabwe, yet police in rural areas resort to making more use of mediative policing because of the prevailing cultural norms that do not regard IPV as a criminal offence. Notably, police and healthcare professionals in rural areas tend to conform to the social norms of the communities that they serve, which poses challenges in terms of assisting IPV victims. This in turn makes disclosure and discussion of IPV

uncomfortable for victims and survivors, hence the decision not to involve formal service providers.

"Everyone will know your Story": Lack of Confidentiality

Participants highlighted lack of confidentiality as one of the barriers to seeking formal support. Given that rural areas lack privacy and anonymity, participants highlighted that service providers do not adhere to confidentiality and as soon as one seeks assistance from them, it becomes public knowledge. Disclosure of IPV attracts social rejection and lack of support from family members, church members and neighbours, which leaves the IPV victim isolated. The fear of isolation and stigma from both family and community members makes it challenging for victims of IPV to seek professional intervention. One participant mentioned.

> It is a waste of time going to the police because the next thing everyone will know your story. They will not even protect you they will call your husband and ask both of you to have an understanding. You will be surprised to see the same policeman having beer with your husband. So reporting is a waste of time (Mucha, 43 years old, divorced and unemployed mother of six children).

Another participant also said

> I once reported and the next thing everyone was on my case and accusing me of trying to destroy the family. They said I was not a good wife. I decided to keep quiet as disclosing abuse made things worse, you don't even know what will happen. The next thing people will start side-lining you in the community you do not even benefit from the food aid programmes because they will accuse you of betraying the breadwinner. That is why we do not report. There is no point (Rose, 38 years old, divorced and unemployed mother of three children).

Evident in the above quotation is how the intersection of place and social norms influences the help-seeking process. The interconnectedness of social norms and geographical locations makes the structured process of formal assistance challenging. Formal support systems tend to challenge the status quo of rural culture by discouraging IPV, which is considered a disciplinary measure for stray and disobedient wives. Moreover, formal intervention in some cases might include bringing in the perpetrator for questioning or counselling. In most cases, victims prefer discussing the incidents without involvement of the perpetrator and the family. Bearing in mind the nature of rural areas, seeking help from formal service providers is not as private as victims would want. Rural areas are characterised by public visibility and lack of anonymity and this discourages women from seeking formal help, as disclosure of IPV attracts social rejection and re-victimisation. For these reasons, IPV victims in rural areas become reluctant to seek formal assistance.

"They do not have the Resources to Help": Lack of Resources

Lack of intervention resources including transportation was identified as one of the barriers that women residing in rural areas face as they attempt to seek formal assistance. Rural areas in Zimbabwe are largely characterised by inadequate resources for intervention, which ultimately leads to limited knowledge on the existence of such services. The provision of support services is based on the availability of resources for effective intervention. This is supported by participants' quotations below:

> Sometimes the clinics don't have ambulances to take you to the hospital. I once went there I was swollen [from IPV injuries] and pregnant and they told me to go to the police first and hospital with public transport on my own. They said they did not have transport to take me there even though they could see I was heavily pregnant and swollen from beatings. Imagine, so to me going to these people was not the best decision (Cecilia, 40 years old, divorced and unemployed mother of four children).
>
> They do not have the resources to help. The police do not have cars. Once you go there, they will ask you to get a taxi and go to the clinic on your own without anyone accompanying you. The same applies with the clinics, they cannot help us because they also do not have cars and sometimes the medicine to treat wounds is not even there. That's why I never attempted to report to them, they are also struggling these nurses and police (Tendai, 40 years old, divorced and unemployed mother of four children).

Participants also highlighted that the available support services are far from where they live and in order to order to access formal help they would have to walk long distances in the scorching sun as they did not have transport money to use to get to the nearest local clinic. One participant said

> I did not have money to go to clinic (name withheld) because for me to go there it means I will need US$5 or I will have to risk walking this long distance of about 14 km to and from. And with a baby on my back, the sun and the pains from beatings there was no way I would go to the clinic let alone the police (Cecilia, 40 years old, divorced and unemployed mother of four children).

It is evident in the above quotations that strained intervention resources including transportation are a barrier in

the help-seeking process among victims of IPV residing in rural areas. The terrain in Chimanimani is rugged and mountainous, making it difficult for service providers to access victims living in the most remote areas. The closest clinic to the study location did not have an ambulance or a car for transporting patients. This makes IPV intervention challenging, as some victims face life-threatening abuse that requires prompt intervention. Futhermore, some participants in this study live in mountainous areas with high temperatures, and for them to access the nearest police station they would have to travel long distances – which might have monetary implications. Some participants indicated that they had to walk long distances with injuries, and those who did not stay in mountainous areas had no transport money, as the nearest clinic and police were distantly located. This is worse for victims with injuries and those with infants, and this poses a major barrier in accessing formal support services.

Discussion

This study focused on the barriers that exist in the access and use of formal support services by victims of IPV residing in rural areas. Study results show that victims of IPV in rural areas face multifaceted barriers in accessing formal support services. Examining the barriers in rural areas in Zimbabwe provides answers and clearer understanding around the issues of the underreporting of IPV cases and how the intersectionality of social variables (e.g. gender, religion, age, socio-economic status) coupled with the multiplicity of disadvantages such as poor infrastructure and living conditions impede the help-seeking process.

Barriers related to cultural norms that condone IPV appeared at the top of the list of barriers reported by participants in this study. The concerns of confidentiality and the preservation of marriages were identified as central in the IPV help-seeking process in rural areas. Culturally, marital conflicts are dealt with within the family with the aim of preserving the marriages. As such, disclosing IPV to 'outsiders' is deemed unacceptable and warrants social sanctioning (Rees et al., 2014; Riddell et al., 2009). Similar to research conducted, our findings revealed that the need to preserve marriages could also be tied to socio-economic inequalities that give men more power over resources in a way that women end up economically dependent on the perpetrator (Gibbs et al., 2018; Goodman et al., 2009; Klugman, 2017). Economic dependence tends to undermine the decision to seek formal assistance, as exposing the perpetrator is tied to the fear of losing social and economic support. Perpetrators in turn use this dependence to further control and abuse women. This could also be the reason why women in this study pointed out lack of confidentiality as a barrier in help-seeking. We determined that participants' concerns about confidentiality stemmed from the need to ensure that their help-seeking efforts would not interfere with the marriage and ultimately their wellbeing and that of their children. Given the context of rural areas, where public visibility and lack of anonymity feature greatly (Bosch & Bergen, 2006; Conroy, 2014; Riddell et al., 2009), maintaining confidentiality seems to be problematic and the issue of stigma is evident – all which impact accessing of services.

Similar to Overstreet and Quinn (2013), we noticed the interconnectedness of anticipated stigma and social norms in women's decision to seek formal help. Consistent with Murray et al. (2015), the findings from this study show that the need to preserve marriage and maintain the privacy of marital disputes stems from fear of stigmatisation. The fear of being judged and rejected by the community tended to discourage victims from seeking formal help. Labelling and the discrimination that comes with disclosure of IPV to outsiders attract shame and humiliation and this could be the reason why participants in this study prioritised their marriages over their wellbeing. This labelling and stigmatisation affect not only the victim, but also her natal family and in-laws. Thus, the need to protect the family from community rejection and stigma and preserve the honour and dignity of both families could possibly be barriers to help-seeking.

The attitudes of services providers also seem to deter the study participants from seeking services. Participants pointed out that judgemental attitudes and lack of empathy of service providers were also barriers to seeking formal assistance. Rural areas are characterised by social norms that condone the privatisation of IPV; thus for women who do decide to take the bold step of seeking formal assistance, support is greatly required. Most service providers are expected to show empathy and non-judgemental attitudes as they assist IPV victims (Guruge & Humphreys, 2009). However, past research has shown that in some instances service providers in rural areas can be unsupportive and insensitive to IPV victims (Baldry & Pagliaro, 2014; Teaster et al., 2006). Consistent with findings from other studies, these negative attitudes are also reinforced by social norms that formal service professionals subscribe to in the communities that they serve (Baldry & Pagliaro, 2014; Retief & Green, 2015). This unethical conduct is rooted in the cultural norms of the communities they operate in that require them to subscribe to community norms. It is also possible that this unethical conduct could be ingrained in their own patriarchal beliefs and social norms that motivate their reaction to IPV cases (Baldry & Pagliaro, 2014). Similarly, in closely knit rural communities victims and perpetrators of IPV are in some sort of relationship with the service providers considering the structure of rural areas where social cohesion is of paramount importance. Thus, these multiple relationships tend to remove much-needed safeguards such as service providers' objectivity when responding to

victims' needs (Teaster et al., 2006). When these safeguards are removed, service providers tend to exhibit unethical and victim-blaming attitudes towards IPV victims, which in turn discourages women from seeking formal help.

Findings from our study also demonstrated the influence of inadequate intervention resources in the IPV help-seeking process. Past research by Peek-Asa et al (2011) shows that lack of adequate intervention resources is a barrier to help-seeking in IPV situations. This scarcity of crucial intervention resources renders formal service providers unhelpful and unreliable. Findings from this study indicate that while there is a local clinic and a police camp servicing each ward in the district, these centres are not well equipped to respond to IPV situations. Similar to other studies conducted, the geographical isolation of rural areas and the systemic discrimination in terms of resource allocation are plausible explanations for the strained intervention resources in rural areas (Alvarez et al., 2018; Sandberg, 2013; Sechele, 2016). Consequently, the lack of intervention resources makes it challenging to render support to IPV victims and could possibly be the reason why women in this study were not aware of services available to them or their right to access these services. Klugman (2017) argues that the existence of the law does not imply awareness. Although her argument was focused on the legal aspects, it is relevant to this study, as one of the core duties of social services professionals is to refer their clients to the appropriate service providers, legal service providers included. There is insufficient knowledge on legal interventions for women affected by IPV residing in rural areas. This lack of awareness tends to impede the help-seeking process, as women are not even aware of the existence of services that are pivotal in assisting them in dealing with IPV (Agyei-Baffour et al., 2011; Munyoro, 2017).

In addition to strained intervention resources, the findings also revealed that participants in this study reported financial constraints and transport problems as barriers to help-seeking. Rural areas in Zimbabwe are largely characterised by long geographical distances, underdeveloped infrastructure and rugged terrain which makes accessibility of service difficult (Munyoro, 2017). Although rural areas differ according to locality, studies conducted have also indicated that physical distances are a barrier to accessing formal support systems by IPV victims (Bosch & Bergen, 2006; McCloskey et al., 2016; Peek-Asa et al., 2011). For these women transport money was also a challenge, as some of them would have to use public transport to access this service. This is not surprising considering the high levels of unemployment and poverty in rural areas in Zimbabwe. From an intersectional standpoint, it is imperative to acknowledge how the politics of location come into play in the help-seeking process in rural areas. The remote geographical location of rural areas negatively affects not only the perpetration of IPV but also the possible responses to it (Sandberg, 2013). The combination of these geographical barriers and inadequate resources negatively impact on effective intervention. The impact of inadequate intervention resources is huge and increases economic hardships for IPV victims residing in rural areas. When these women fail to get the help needed they ultimately fail to provide food for the family (children included) given that women in rural areas are heavily reliant on subsistence farming. The geographical distances reported in this study pose difficulties to rural women in accessing IPV intervention services, which is crucial given that they are more susceptible to frequent and severe IPV.

As the above discussion indicates, the politics of location and influence of social norms take centre stage in the help-seeking behaviour of IPV victims in rural areas. The isolation of rural areas and their strong adherence to social norms condoning IPV tend to play a significant role on how women respond to IPV and set the parameters of help-seeking. The intersection of gender, cultural norms, geographical location and lack of inadequate resources serves to deepen the isolation of women in rural areas, thereby increasing their vulnerability to severe abuse. The lack of awareness, exacerbated by geographical isolation, makes seeking formal assistance challenging, as the women are not aware of the existence of some of the services that they can use in order to minimise and prevent the occurence of IPV.

Implications for Service Providers Working in Rural Areas

While the government of Zimbabwe has made strides in addressing IPV through the enactment of legal frameworks aimed at ameliorating this phenomenon, a lot still needs to be done to ensure effective intervention in rural areas. Given that IPV violates the rights of women, policy formulation and implementation are crucial in the prevention and minimisation of IPV. It is also important to ensure that the unique experiences of rural women are taken into consideration. Participants in this study highlighted that one of the barriers to their use of formal help is the lack of formal support systems in their communities. Contrary to a study by Odero et al. (2014) in Kenya, which concluded that service providers are available and accessible to rural people, the situation is different in Zimbabwe, where police stations and clinics are far from some communities.

Through an intersectional lens, this centralisation of resources is largely linked to uniformity in terms of implementation of intervention strategies (Bright et al., 2016). Thus, policymakers should ensure the decentralisation of essential services to rural areas so that victims of IPV can have access to them regardless of their geographical location and socio-economic status. This decentralisation should also include the deployment of well-trained practitioners with

special training on screening, responding to and preventing IPV in rural areas based on how it manifests in populations and communities in rural areas. Service providers in rural areas should also be involved in the formulation and implementation of IPV legal frameworks and ensure that these legal frameworks incorporate context-specific interventions that address the actual experiences of IPV victims in these areas. Further recommendations for policymakers should include the re-evaluation of existing policies and intervention strategies and the identification of factors that hinder effective intervention. This re-evaluation process should take into cognisance the lived realities of victims of IPV in rural areas and avoid applying uniform interventions to different groups (i.e. women living in rural areas and those in urban areas) who have different IPV experiences.

Consistent with findings from studies conducted by Chireshe (2015) and McCloskey et al. (2016), the findings from this study indicated that an important factor is the need to preserve marriages, which deters women from seeking formal help. This stems from societal norms that regard disclosure of IPV as deviant behaviour. Despite the fact that service provision in rural areas is inadequate, women in these areas must nonetheless be made aware of the importance of seeking formal assistance for their own physical and emotional wellbeing. Decentralisation of essential services may be futile if the recipients do not understand the importance of such services and are still normalising IPV. Given that social norms that condone violence take precedence over the wellbeing of women, perhaps the starting point for formal service providers should be to shift norms and attitudes that tend to promote the subjugation of women. Psycho-social practitioners (e.g. social workers and psychologists) can sensitise women in rural areas through community dialogues and campaigns. These campaigns and dialogues should include not only women but also men, village elders and other influential people in the community such as church leaders. These dialogues are important in sending the message to the community that IPV is not acceptable and perpetrators should be held accountable. Moreover, these dialogues can also be used to equip informal support networks (i.e. village elders and families) with knowledge and skills in dealing with IPV cases, as they are in close and continual interaction with IPV victims.

Previous research revealed that the lack of intervention resources was one of the barriers in seeking help for IPV victims (Sundborg et al., 2012). This lack of adequate resources can lead to frustrations in service delivery and ultimately judgemental and unsympathetic attitudes on the part of service providers. Hence, psycho-social practitioners working within the scope of IPV in rural areas should advocate for the empowerment of service providers in terms of the provision of resources and adequate training on how to deal with IPV victims in rural areas.

Lack of intervention resources can lead to limited awareness on the availability of formal support services for IPV victims (Bosch & Bergen, 2006; Riddell et al., 2009). As a result, practitioners should strive to conscientise women in rural areas on the availability of these support services and the merits of using them for their wellbeing. Practitioners can make use of the women groups in rural areas, for example those that meet on *chisi* day, to spread awareness on IPV and the support services available for IPV victims. NGOs that provide food aid and agricultural assistance are common in rural areas and should be used as entry points in raising both awareness of IPV and the existence of formal support services or even provision of services. For example, food, fertilizer and/or seed distributors can be trained in rapid screening, referrals and counselling, given that they closely work with women and village heads in gathering information on households as they compile distribution registers.

Limitations

It has been argued that any threat that accompanies the researcher during data collection such as association with authority figures sometimes forces participants to withdraw from the study (Shenton & Hayter, 2004). In this study some participants were uncomfortable, especially with questions that were focused on service delivery. They were not willing to mention the flaws of support service providers, since the researcher had mentioned to them during the introductory sessions that she had gained permission from the Ministry of Women Affairs, Community, Small and Medium Enterprise Development and Chimanimani Rural District Council to conduct her research. To ameloriate this, the researcher assured participants of confidentiality such as by not revealing their real names when reporting the information received.

Sikweyiya and Jewkes (2012) argue that studies that require participants to recall and report about past experiences, especially those involving feelings and emotions, after time has passed may have a problem of recall bias. In this study we relied on the self-reported experiences of women who had experienced IPV in their former intimate relationships and the barriers to help-seeking, so recall bias cannot be ruled out in this study. Furthermore, Neill and Hammatt (2015) report that rural areas differ based on locality and the extent of remoteness. Accordingly, the experiences of IPV victims also differ based on locality. Although findings from this study are important in understanding the barriers that IPV victims in rural areas face in seeking formal assistance, they cannot be generalised to other rural areas and all the women residing in Chimanimani District as they are specific to women who participated in this study.

Conclusion

This paper focused on the barriers that are associated with access to and use of formal support systems in rural areas. It adds to the limited yet growing body of knowledge on IPV in rural areas. Findings from this study reveal the influence of social norms and how they mitigate help-seeking efforts from victims of IPV. The discussion in this article has shown how crucial it is for psychosocial practitioners to effectively respond to the needs of IPV victims while acknowledging their unique experiences in dealing with IPV and the challenges they face in the help-seeking process. It is therefore crucial for practitioners and policymakers to ensure that intervention strategies take into consideration these barriers and ensure that the programmes that are drafted are context-specific and respond to the unique challenges faced by IPV victims residing in rural areas.

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