

# Stopping Abuse and Female Exploitation (SAFE) Zimbabwe Technical Assistance Facility

## Evidence Synthesis:

Secondary impacts of COVID-19 on gender-based violence (GBV) against women and girls in Zimbabwe

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## Acknowledgements:

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Stopping Abuse and Female Exploitation Zimbabwe (SAFE) is funded by the Foreign, Commonwealth and Development Office (FCDO). The programme aims to prevent and respond to GBV in Zimbabwe. SAFE (Communities) is implemented by ECORYS (in partnership with Social Development Direct and SAFAIDS). SAFE (Communities) has been adapted to respond to the COVID-19 pandemic between May 2020 and March 2021 through a GBV Technical Assistance Facility (TAF) staffed with GBV experts ready to provide rapid and contextually relevant support to Zimbabwean stakeholders.

The SAFE TAF provides rapid and contextually relevant support to Zimbabwean stakeholders. TAF is fully funded by FCDO, and accessible to a wide range of humanitarian and development actors working in the country. The TAF provides a variety of support services, including:

Support to advocacy efforts	<ul style="list-style-type: none"><li>• Providing evidence for advocacy by synthesising and analysing data</li><li>• Packaging advocacy messages or facilitating discussions to define messages</li></ul>
Strategic advice for evidence-based decision making	<ul style="list-style-type: none"><li>• Adapting global GBV prevention and response guidelines to the Zimbabwean or organisational context</li><li>• Conducting situation analysis for programme development</li></ul>
Guidance on ethical and do no harm considerations	<ul style="list-style-type: none"><li>• Developing mechanisms for the prevention of sexual exploitation and abuse in specific organisations</li><li>• Developing Leave No One Behind strategies</li></ul>
Practical design and implementation guidance	<ul style="list-style-type: none"><li>• Operationalisation of recommendations contained in guidelines (e.g. how to ensure safety of staff and survivors in shelters; how to concretely mainstream GBV in specific humanitarian programmes)</li><li>• Provision of GBV prevention and response programme TA support (design, implementation), for lockdown, post-lockdown and recovery periods (e.g. developing prevention messages through the radio or other key influencers or messaging for the most marginalised women and girls)</li></ul>

### Disclaimer:

*This material has been funded by UK aid from the UK government; however the views expressed do not necessarily reflect the UK government's official policies*

# Contents

1. Overview.....	4
2. Context in Zimbabwe.....	4
3. Summary .....	5
4. Trends and forms of gender-based violence during COVID-19.....	6
4.1 Overall trends in violence .....	6
4.2 Overall trends in forms of violence .....	7
4.3 Forms of violence.....	8
5. Women and girls most at risk of GBV during the COVID-19 pandemic in Zimbabwe .....	10
6. Drivers of gender-based violence during the pandemic.....	15
6.1 Girls' education .....	15
6.2 Sexual and reproductive health and rights .....	17
6.3 Women's economic situation and rights .....	18
References .....	20
Annex 1: Methodology and limitations.....	25

## Research question:

What are the secondary impacts of COVID-19 on gender-based violence (GBV) against women and girls in Zimbabwe?

Please focus on how the pandemic is impacting on:

1. GBV trends, forms (including violence outside the home in trying to access water and/or humanitarian aid) and which women and girls are most at risk; and
2. Any data and evidence on changes in known GBV drivers in the following three areas: girls' education; access to sexual and reproductive health and rights (SRHR); women's economic situation and rights.

Please prioritise evidence that is specific to Zimbabwe. In the case there is only anecdotal evidence, stronger evidence/data from the region can be included.

## 1. Overview

**The COVID-19 pandemic, and measures taken to contain and mitigate the virus, are associated with a range of secondary impacts on gender-based violence (GBV) against women and girls in Zimbabwe, and across the world.** UN Women described the impact of COVID-19 on violence against women and girls “the shadow pandemic” following a global increase in domestic violence (UN Women, 2020a). Without sufficient attention to preventing and responding to GBV in COVID-19 response and recovery measures, women's and girls' rights across the world are threatened.

**Emerging evidence indicates that the COVID-19 pandemic is exposing and exacerbating existing gender inequalities globally,** with increasing reports of GBV, including domestic violence, child marriage, female genital mutilation, sexual exploitation and abuse, violence by state officials and armed guards, and online violence and abuse (Fraser, 2020; UN Women 2020b). Whilst disaggregated data is limited, evidence suggests that women and girls at heightened risk include adolescent girls, women and girls with disabilities, LBTQI+ women, older women and refugee and migrant women and girls.

**This report summarises available evidence on GBV against women and girls in Zimbabwe during the COVID pandemic.** It starts with Zimbabwe contextual information (Section 2) and a summary of evidence collected as part of this evidence synthesis (Section 3). Section 4 considers the trends and forms of GBV that women and girls are being exposed to, including intimate partner violence, violence at service delivery points and child marriage. Section 5 identifies key data on the women and girls most at risk of GBV in Zimbabwe at this time, including poor women and women in rural areas, women and girls with disabilities, adolescent girls, and LBTQI+ women and girls. Section 6 examines the drivers of gender-based violence during the pandemic, looking specifically at girls' education, access to sexual and reproductive health and rights (SRHR), and women's economic situation and rights. Methodology and study limitations are included at Annex 1.

## 2. Context in Zimbabwe

**Since the first COVID-19 case was reported in Zimbabwe on 21<sup>st</sup> March 2020, there have been 8,531 confirmed cases and 253 confirmed deaths** due to COVID-19, according to World Health Organisation data<sup>1</sup>. In response to the pandemic, the Government of Zimbabwe closed international borders on 23<sup>rd</sup> March 2020,

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<sup>1</sup> Statistics are until 9<sup>th</sup> November 2020 and are available at <https://covid19.who.int/region/afro/country/zw>

closed schools on 24<sup>th</sup> March 2020, declared a national disaster on 27<sup>th</sup> March 2020 and initiated a national lockdown on 30<sup>th</sup> March 2020. Since then, and despite some easing of restrictions in May, the lockdown was extended indefinitely on 16<sup>th</sup> May 2020, leaving many restrictions in place. Whilst the number of COVID-19 cases in Zimbabwe remain relatively low, the experiences of other countries show that if restrictions are eased too soon there could be a sharp rise in cases and deaths. It is therefore likely that COVID-19 related measures will remain in place in Zimbabwe for some time, meaning that risks to GBV against women and girls during the pandemic will continue.

**Before the pandemic, GBV was a pressing issue in Zimbabwe.** According to a 2019 survey by the Zimbabwe National Statistics Agency (ZIMSTAT, 2019) 39.4% of women aged 15-49 had experienced violence since age 15 and 11.6% had experienced sexual violence in their lifetime. 33.7% of women aged 20-24 years were first married or in a union before they were 18 years old (ibid). Evidence presented in this report shows that COVID-19 is revealing these pre-existing high levels of violence and threatens to exacerbate this situation.

**COVID-19 response measures have had immediate and long-term implications for women and girls in Zimbabwe.** School closures have disrupted girls' education and increased the risk of child marriage and early pregnancy. Steps taken to contain the spread of COVID-19, including quarantines, social distancing, movement restrictions and other stay-at-home measures have increased the risks of domestic violence due to forced coexistence and curtailed access to support services for survivors. During the lockdown, a range of GBV service providers and actors in Zimbabwe, including women's rights organisations, have identified increased reports of GBV, with one organisation seeing an average increase of over 60% in calls related to GBV from the start of lockdown until 7th October 2020 compared to the pre-lockdown period (OCHA, 2020a).

**The COVID-19 pandemic is predicted to exacerbate Zimbabwe's economic crisis, with disproportionate impacts on the poor and those who are already marginalised** (UNDP Zimbabwe, 2020). The World Bank predicts that 23 million people in Sub-Saharan Africa will be pushed into extreme poverty due to the COVID-19 pandemic, triggering its first recession in 25 years (Mahler et al, 2020). Emerging evidence in Zimbabwe already shows an increase in food insecurity and household financial instability as a result of the pandemic, with concerning implications for levels of GBV.

### 3. Summary

**GBV service providers in Zimbabwe have seen an increase in reported GBV cases compared to trends prior to the lockdown.** Increases in psychological, physical, economic and sexual violence, and increases in the severity of this violence, have been reported in Zimbabwe (OCHA, 2020a). Intimate partner violence (IPV) is the most commonly reported form of violence against women and girls during the pandemic, with intimate partners representing 69.5% of identifiable perpetrators in SAFE's (2020) analysis of GBV data between March and May 2020.

The COVID-19 lockdown has exposed women to increased violence when accessing services, including at water collection points (New Zimbabwe, 2020; Women's Coalition of Zimbabwe, 2020<sup>2</sup>) and from law-enforcement officers monitoring the lockdown (DIA, 2020). The lockdown is also likely to prevent women and girls accessing reporting helplines and services as movement is restricted and they may be unable to make a private phone call if confined at home with perpetrators.

**Women and girls who face multiple and intersecting discriminations were already at higher risk of violence, which COVID-19 is likely to exacerbate.** Emerging evidence in Zimbabwe indicates that poor women, rural women, women and girls with disabilities, adolescent girls and young women, older women, LBTQI+ women, women and girls with HIV, migrant women and women in quarantine facilities, and refugee women are disproportionately affected. Sex workers, women human rights defenders, women politicians and women essential workers have also faced increased risks of violence in their work. There is an evidence gap on the impacts of

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<sup>2</sup> Sexual harassment against women at boreholes and in accessing water has been highlighted in the regular situation reports published by the Women's Coalition of Zimbabwe.

COVID-19 on violence against women and girls with multiple and intersecting discriminations, which requires further research.

**Without the protective environment of schools, children are exposed to multiple forms of abuse, including sexual violence and child marriage.** Since the lockdown began Zimbabwean organisations have reported significant increases in reports of GBV and child protection concerns (Moshiri et al., 2020) and double the number of reports of children engaging in transactional sex in Mazowe (Matiashe, 2020). Girls, particularly those with disabilities and in rural areas, may also have reduced access to online educational material and those that do are at heightened risk of online violence and abuse.

**The COVID-19 pandemic presents a range of challenges that are likely to negatively impact on women and girls' sexual and reproductive health and rights.** Women and girls, particularly those in rural areas, will face additional barriers in accessing SRH services discreetly due to the restrictions on movement, closures of health clinics and hospitals, and increased financial pressures making contraception, HIV and sexually transmitted infections (STIs) testing and maternity services unaffordable. SRH services offer an opportunity to identify survivors of GBV and provide support. However, as fewer women and girls are accessing SRH services in lockdown, this opportunity is missed (Heidari and Moreno, 2016).

**The COVID-19 pandemic has wide ranging implications for women's economic situation and rights, which were already restricted before the crisis.** In Zimbabwe, the lockdown restrictions have had significant impacts on informal workers, agriculture workers and cross-border traders, which represent large percentages of women, as marketplaces and borders have closed and footfall has decreased. COVID-19 is exacerbating food insecurity in Zimbabwe, which was already severe due to droughts and economic recession. Women and girls are facing increased care burdens with additional time needed for caring for children out of school and family members who cannot healthcare due to hospital closures. Increased financial instability, rising food prices and confinement are leading to increased household tensions and rising numbers of GBV cases.

## 4. Trends and forms of gender-based violence during COVID-19

**Emerging evidence is beginning to shed light on how COVID-19 is impacting GBV in Zimbabwe.** SAFE's analysis of GBV data from July 2020 remains the most cited source of GBV data to date, which is complemented by some more recent data from Musasa (see OCHA 2020a). In addition to these sources, this report considers evidence from internal documents that have been shared for the purpose of this review, as well as reports of GBV shared by media and organisations on their websites, situation reports, blog posts and news highlights.

It is important to note that the available data can only give insight into trends in GBV reporting, as captured by a limited number of GBV service providers and actors responding to GBV. It should not be seen as evidence of the actual prevalence of GBV during the COVID-19 crisis. This research has found no attempt to estimate changes in the national GBV prevalence during COVID-19. Estimating GBV prevalence is challenging even in normal times as GBV is widely underreported, with only a fraction of those who experience violence formally reporting it. With COVID-19, the barriers to reporting are likely to have been exacerbated.

### 4.1 Overall trends in violence

**Available data from NGOs providing GBV services shows that there has been an increase in GBV cases reported to them since the beginning of the national lockdown** compared to trends prior to the COVID-19 outbreak and lockdown. Evidence suggests the following trends during the different stages of lockdown:

- ▶ **Reports of GBV spiked following the introduction of Zimbabwe's lockdown:** during the first 11 days of the lockdown, the National GBV Hotline run by Musasa registered 764 reported cases of GBV, compared to 500-600 cases a month prior to COVID-19 (Sachiti, 2020; SAFE, 2020). About 94% of the calls to Musasa have been from women (OCHA 2020a).
- ▶ A range of NGO service providers and actors responding to GBV report that they have observed an increase in reports of GBV (SAFE, 2020; UNFPA, 2020a). A UNFPA assessment of national hotlines and the work of

organisations that receive GBV reports through online presence and messaging platforms found that “*all the respondents did indicate that there has been a general increase in the number of GBV cases since the start of the lockdown period*” (UNFPA, 2020a).<sup>3</sup>

- ▶ Musasa has received a total of 6,200 calls related to GBV since the beginning of the lockdown until 27<sup>th</sup> November 2020<sup>4</sup>: 1,312 in April, 915 in May, 776 in June, 753 in July, 766 in August, 629 in September, 546 in October and 503 between 1<sup>st</sup> November and 27<sup>th</sup> November 2020. This is an overall average increase of over 60% compared to pre-lockdown trends (OCHA 2020a). In May, Musasa observed a 43% increase in reports of GBV compared to the same month the previous year (SAFE, 2020).
- ▶ A number of countries, including South Africa, have seen a trend of decreasing reports of violence during stricter lockdown periods, which is believed to be a result of women’s restricted movement and limited availability of GBV response and service providers (Haegerman and Vlahakis, 2020; SAFE, 2020).
- ▶ Musasa has reported an upward trend in reported GBV cases in September and October – taking into account phone calls as well as reported cases at Musasa’s shelters and offices around the country (Musasa, 2020). The observed increase coincides with an easing of the lockdown restrictions.

## 4.2 Overall trends in forms of violence

The most recent records from Musasa, presented in UN OCHA’s Protection (GBV) cluster status report (updated 26th October 2020), show the following trends in the types of GBV that are being reported:

- ▶ An increase in psychological violence reported in the past three months, making up 55% of the total cases (August to October 2020) (OCHA, 2020a).
- ▶ The second most frequently recorded form of violence is physical violence (22%) followed by economic violence (15%) and sexual violence (8%) (OCHA, 2020a).
- ▶ About 90% of Musasa’s recorded cases are intimate partner violence (IPV) (OCHA, 2020a).

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<sup>3</sup> Internal report provided by UNFPA Zimbabwe for this research. The assessment consulted Musasa, WFP, Zimbabwe Women Lawyers Association, Youth Advocates Zimbabwe, Population Services International, Population Services Zimbabwe, Padare, Adult Rape Clinic, Shamwari Yemwanasikana, Childline and Roots Africa.

<sup>4</sup> This figure was updated at the time of publication of this report as the Zimbabwe Protection (GBV) cluster updated its status on the 5<sup>th</sup> of December, 2020. The cluster status is updated regularly and is available [here](#).

## 4.3 Forms of violence

### 4.3.1 Intimate partner violence

**There is evidence of an increase in reported IPV during the lockdown in Zimbabwe.** SAFE's analysis of GBV data between March and May 2020 provides insight into IPV during the period when the country was largely in a strict lockdown:<sup>5</sup>

- ▶ IPV remained the most commonly reported form of violence against women and girls in Zimbabwe during the period analysed. Over two-thirds of the identifiable perpetrators were an intimate partner (69.5%) (SAFE, 2020). The proportion of reported IPV cases increased disproportionately relative to the increase in non-partner violence, compared to the same period the previous year.
- ▶ NGO staff highlighted that the IPV reported during the lockdown was characterised by increased severity of violence, particularly physical IPV (ibid).
- ▶ Emotional violence saw the sharpest rise during lockdown. Substantial rises in physical and economic violence have also been reported. Heightened household tensions resulting from confined living conditions and increased financial stress are thought to increase the risk (ibid).

This trend corroborates evidence from UN Women in the East and Southern Africa region (ESAR), where evidence suggest that IPV is one of several forms of violence against women and girls (VAWG) that has escalated during COVID-19 (UN Women, 2020b).

### 4.3.2 Non-partner violence

**There is some evidence that there has been a decrease in reported non-partner violence.** SAFE's analysis of GBV data (March to May) found that 30.5% of identifiable perpetrators were a non-partner (SAFE, 2020). However, reported non-partner violence decreased in absolute numbers compared to the same period the previous year. The SAFE report highlights that this can be an expected development in a situation when women and girl's movement is severely restricted, thereby reducing their contact with non-partner perpetrators (ibid). Increased online activity following the lockdown can expose women and girls to additional threats of violence outside the home, including sexual exploitation and grooming. This is explored in greater detail in relation to girls' education in section 3. As with other forms of GBV, the reported non-partner violence should not be seen as a reflection of the actual prevalence, as significant underreporting which is seen in normal times, as well as the additional barriers to reporting during COVID-19 circumstances, is likely to obscure the true extent of GBV experienced by women and girls.

#### (i) Violence against women at service provision points

**There have been several reports of women being subject to physical and sexual violence when accessing services and aid distribution, mainly at water provision points.** UN OCHA's Protection Cluster's recent status update (26 October 2020) describes that GBV community surveillance systems and mobile services providers have increased their presence around food distribution points, water points, and in mining areas, as these are described as "hotspots" for GBV (UNOCHA, 2020a). The documented cases of GBV at service provision points which have been identified by this review relate to GBV at water points, and include:

- ▶ The Women's Coalition of Zimbabwe reported that women were 'beaten and barred' by law enforcement agents from accessing water at communal boreholes. This has been particularly reported in Masvingo in the Aphiri area (Womankind, 2020).<sup>6</sup>

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<sup>5</sup> The SAFE study reviewed GBV data from Musasa, Adult Rape Clinic, Zimbabwe Women's Lawyers Association, Women and Law in Southern Africa and ROOTS Africa.

<sup>6</sup> Reports of this type of violence are also highlighted in the situation reports from the Women's Coalition of Zimbabwe, many of which were reviewed for this research.

- ▶ There have been reports of sexual exploitation and ‘sextortion’ against women and girls committed by water suppliers at mobile water points in Mabvuku-Tafara, Harare, which continues to suffer from water shortages (New Zimbabwe, 2020). The media reports that water suppliers are openly trying to exchange water for sex, and that younger women and girls are particularly targeted (ibid.).
- ▶ There have been reports of men using violence and force against women queuing at waterpoints in attempts to jump the queue (SAFE, 2020). The SAFE report highlights the risk of sexual violence against women when they walk to fetch water and firewood, which is commonly the responsibilities of women and girls due to social norms (ibid).
- ▶ In October, two women were attacked by a man when they were on their way from fetching water in Mabvuku, Harare. The man tried to rob the women and when they resisted, he physically attacked them and tried to strangle one of the women. The other woman fought back and killed the attacker in self-defence. The two women have appeared in court accused of murder (NewsdzeZimbabwe, 2020). This example highlights how women survivors of violence are often re-victimized by the justice system in Zimbabwe and face multiple barriers in accessing justice.<sup>7</sup>

### (ii) Violence against women by law-enforcement agents

**The Zimbabwean Government have deployed military and police to enforce citizens’ compliance with lockdown regulations** (Democracy in Africa (DIA), 2020). Between March and end of June 2020, 24 COVID-19 related attacks against civilians by state forces were documented in Zimbabwe (Anderton, 2020). According to Democracy in Africa (DIA), the deployment of the state forces has been particularly concentrated to low-income settings that are characterized by overcrowded, dense living-arrangements, where physical distancing is challenging to adhere to (ibid). There are several reports of law enforcement agents perpetrating violence against women who have been alleged for ‘breaching’ the lockdown restrictions:

- ▶ The police have been accused of destroying the stalls and produce of street vendors. These actions have disproportionately impacted women as women comprise the majority of informal traders in Zimbabwe (Shumba, Nyamaruze, Nyambuya and Meyer-Weitz, 2020; Chitando, 2020).
- ▶ There have also been reports of the police physically assaulting women alleged of ‘defying’ lockdown restrictions (DIA, 2020). In May, two women in Bulawayo were physically attacked by police officers when they were queuing outside a supermarket (ibid.).
- ▶ Law enforcement agents have also perpetrated violence against women who have participated in demonstrations against the government’s handling of the COVID-19 response (see section below on violence against women human rights defenders/ women politicians).

### (iii) Child marriage

UNFPA estimates that globally, 13 million more child marriages could take place before 2030 due to the rise of child marriage as a negative coping strategy during the COVID-19 crisis, and the disruption of efforts to prevent child marriages (UNFPA, 2020b). Regional evidence suggests that early marriages is on the rise in East and Southern Africa during COVID-19 (UN Women, 2020b). **There are several reports of child marriages taking place in Zimbabwe since the COVID-19 outbreak**, including NGO workers warning that child marriage is being used as a negative coping strategy amidst economic hardships (based on reports from traditional leaders and Village Health Workers). GBV shelters report that they have received girls who have been at risk of experiencing or have experienced child marriage during COVID-19 (Sachiti, 2020; SAFE, 2020; Tshuma, 2020). One shelter received five girls (aged 15 to 16) who had been subjected to child marriage, followed by sexual violence by their new husband (SAFE, 2020). Further information on child marriage can be found in Section 6 of this report.

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<sup>7</sup> For further information on the barriers that women and girls in Zimbabwe faced accessing justice pre-COVID-19 please see ZWLA’s ‘Routes To Justice’ report (2017) <https://www.womankind.org.uk/resource/routes-to-justice/>

#### (iv) Other forms of non-partner violence

Across the East and Southern African region, there have been reports of an increase in multiple forms of GBV, including sexual violence and rape, sexual slavery, trafficking, sexual harassment, exploitation and abuse, domestic violence, harmful practices including early marriage, police violence against women defying lockdowns and attacks on healthcare workers (UN Women, 2020b). Whilst this evidence synthesis has highlighted increases in a number of specific forms of violence in Zimbabwe, it is likely that other forms of violence are at increased risk in Zimbabwe as across the region, even if data is not currently available.

## 5. Women and girls most at risk of GBV during the COVID-19 pandemic in Zimbabwe

This evidence synthesis has not found any systematic analysis of which women and girls in Zimbabwe are most at risk of GBV during the pandemic. However, **as women and girls who experience multiple and intersecting discriminations are often at higher risk of violence, this is likely to be further exposed and exacerbated during the pandemic.** While the data on GBV during COVID-19 have not consistently collected demographic information such as age, disability, place or geographical areas of violence, and socioeconomic status of the survivors, there is some evidence, including from women's rights organisations and the media, that certain women and girls have been most affected by and are at increased risk of gender-based violence during the pandemic.

#### (i) Poor women and women in rural areas

**Regional evidence highlights that women in rural areas are particularly vulnerable to the effects of GBV due to less access to response services in rural areas** (UN Women, 2020b). However, this evidence synthesis has not identified any data from Zimbabwe or the region specifically on violence against women in rural areas during COVID-19. As many service providers have been forced to switch to remote or phone-based ways of working, there is a risk that poorer women who are less likely to have access to a phone and/or pay for phone credit or data are excluded from GBV reporting channels and support services (SAFE, 2020). SAFE's analysis of GBV cases showed that most of the reports of GBV are from women and girls residing in urban areas (ibid.). As this appears to be the main GBV data analysis study in Zimbabwe during COVID-19, less is known about the situation of GBV against women in rural areas during lockdown to date. Similarly, another assessment of national hotlines and organisations that receive GBV reports through online presence and messaging platforms found that the majority of calls (62.5%) during lockdown were made by women in urban areas, while only 12.5% of the calls came from women in rural areas (UNFPA, 2020a).

#### (ii) Women and girls with disabilities

There is growing evidence globally that women and girls with disabilities are at increased risk of violence, with recent research finding that women with disabilities are at a two to four times higher risk of IPV than women without disabilities (Dunkle et al, 2018). UN Women (2020b) in ESAR highlighted that women with disabilities are at increased risk of violence during COVID-19, for instance due to travel restrictions that may prevent care workers from reaching women with disabilities, which may leave women and girls with disabilities at greater risk of neglect and violence by family members during COVID-19.

Whilst there is limited data on the number of women and girls with disabilities who experience violence in Zimbabwe, **there are growing reports and warnings from women's rights, development and humanitarian organisations in Zimbabwe of an increase in violence against women and girls with disabilities during COVID-19.** However, there is still need for more research in this area, including how women and girls with different types of disabilities are affected by GBV during COVID-19. Evidence of violence against women and girls with disabilities to date include:

- ▶ An increasing number of women with disabilities reached out to GBV service providers during lockdown (SAFE, 2020).

- ▶ Women with disabilities have reported sexual violence by family members, relatives or neighbours, as well as other forms of IPV. The report attributes the increase in reports to an increased dependency on care givers during the COVID-19 lockdown, who are often someone close to the women (SAFE, 2020).
- ▶ Deaf Women Included, an organisation that supports women who are deaf and women and girls with other disabilities, have observed an increase in cases of violence against persons with disabilities during COVID-19.<sup>8</sup> In addition, the organisation highlights that people with disabilities have faced significant barriers to accessing services during lockdown, including health services and rehabilitation. There has also been a lack of accessible information and accessible technology for people with disabilities during COVID-19. This may have a particular impact on their ability to access GBV response services and reporting lines, as service providers have largely operated remotely and provided phone-based services since the COVID-19 outbreak.
- ▶ The Institute of Community Development (IOCD) Zimbabwe has warned that the continued extension of lockdown will result in increased numbers of suicide amongst girls with disabilities due to stress, depression and abuse (IOCD, 2020). At the beginning of the COVID-19 outbreak, IOCD anticipated that violence and abuse against women with disabilities would double due to the restrictions on movement confining people to their homes. UNFPA Zimbabwe raised concerns about the increased risks of violence that women and girls with disabilities would face.<sup>9</sup> In addition to increased risk of violence in the confined space of home, women with disabilities may be at heightened risk of exploitation and abuse by community members and service providers. UNFPA highlights that evidence from previous epidemics shows that women and girls with disabilities often have limited influence in decisions around household responses, which, coupled with shifts in access to social safety nets, information and restricted mobility, may exacerbate the risk of GBV.<sup>10</sup>
- ▶ Zimbabwean NGOs have reported challenges in effectively responding to GBV survivors with disabilities during the lockdown (SAFE, 2020). Challenges include lack of resources for facilitating transport of women with disabilities who have experienced/are at risk of experiencing violence to safe spaces (ibid).

### (iii) Adolescent girls and young women

Plan International's (2020a) rapid assessment of the secondary impacts of COVID-19 in Africa found that adolescents girls are heightened risk of multiple forms of GBV, including domestic abuse, child marriage, and sexual violence, as well as rises in transactional sex due to the adverse economic impacts of the crisis. Adolescent girls and young women are at higher risk of IPV, sexual violence and sexual coercion than older women in normal times due to intersecting inequalities related to gender and age, which are likely to be exacerbated during the current crisis.

**The UN, NGOs and service providers have reported rises in several forms of GBV against adolescent girls and young women since the COVID-19 outbreak in Zimbabwe.** This includes child marriage, transactional sex, and physical and sexual violence, resulting in a rise in early pregnancy (OCHA, 2020a; OCHA, 2020b; SAFE, 2020). **Reported cases of GBV against girls in Zimbabwe have more than doubled since lockdown with increases in early pregnancies and child marriages** (World Vision Zimbabwe, 2020).

At the same time, some organisations working with GBV survivors report that they have received very few or no reports of GBV from adolescent girls. UNFPA's assessment of hotlines and organisations providing GBV services found that none of the consulted organisations had received any cases involving survivors aged 10-14 during the first two months of the lockdown, which may indicate that this age group experiences significant barriers to accessing the current reporting systems and services (UNFPA, 2020a).

In addition to the suspected rise of child marriage as a negative coping strategy, other evidence of violence against adolescent girls since the COVID-19 outbreak include:

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<sup>8</sup> Information shared by Deaf Women Included as part of this research, including this video:

[https://www.youtube.com/watch?reload=9&v=U\\_UhrOdvw3s&app=desktop](https://www.youtube.com/watch?reload=9&v=U_UhrOdvw3s&app=desktop)

<sup>9</sup> "GBV in Zimbabwe during COVID-19"; observations from UNFPA Zimbabwe shared as part of this research.

<sup>10</sup> Ibid.

- ▶ Zimbabwean NGO workers and GBV service providers have observed an increase in cases of violence against adolescent girls in the context of transactional relationships. One NGO reported that 72% of their total cases involved adolescent girls, and out of these, 75% of the girls reported that their boyfriend was the perpetrator of violence (SAFE, 2020). It was noted that in the context of increasing poverty and economic insecurity since the COVID-19 outbreak, girls felt the pressure to stay in transactional relationships even if they were abusive, as the transaction of money and goods for sex may be an important source of income, sometimes for the entire family (ibid.).
- ▶ A press release from the UN Country Team (UNCT) Zimbabwe highlights that a shelter for women and girls who have experienced GBV in Bubi district (Bubi shelter) reported that “the majority of cases” received at the shelter during COVID-19 have involved adolescent girls (UNCT, 2020).
- ▶ In July 2020, 45% of the 653 cases of violence against children reported through the Child Helpline involved GBV against girls. Physical abuse was the most frequently reported form of abuse, constituting 28% of the reported cases followed by sexual abuse at 26% (OCHA, 2020b).
- ▶ The Women’s Coalition of Zimbabwe (2020) have highlighted concerns about violence against children within the household, usually by their guardians or close family members, citing an increase in media reports and calling for improved child protection services and support.

#### (iv) Older women

UN Women (2020b) ESAR has noted an increase in sexual violence against older women during COVID-19 in the region. Data on violence against older women during COVID-19 in Zimbabwe is very scarce. However, SAFE’s (2020) analysis of GBV data during the lockdown found that **cases of survivors older than 60 were recorded in a higher number than prior to COVID-19**. The survivors’ average age would usually be between 20 and 30 years. The report stresses that further research is needed to understand what is driving this change. **This evidence synthesis has not found any further evidence in relation to the experiences of violence of older women in Zimbabwe during the pandemic, suggesting that this is an area where further research is needed.**

#### (v) LBTQI+ women

Similarly to other global crises in the past, **the early stages of the COVID-19 outbreak saw a rise in hate-speech against LBTQI+ communities across the world, blaming the pandemic on LBTQI+ people**. Outright International have reported this phenomenon in several countries across the world, including in Zimbabwe (Bishop, 2020). In Uganda, COVID-19 restrictions were used to target LBTQI+ people in the early stages of the country’s lockdown; 19 people in a LBTQI+ shelter were arrested in March, alleged for disobeying COVID-19 measure (OHCHR, 2020).

**This evidence synthesis has not identified any data on violence against LBTQI+ women in Zimbabwe during COVID-19, suggesting this is an area where further research is needed.** However, reports from the Zimbabwean based LBT organisation Pakasipiti,<sup>11</sup> and from LBT individuals, shed light on how the COVID-19 outbreak and lockdown present unique challenges to LBTQI+ women in Zimbabwe, exacerbating the risk of violence and abuse from several possible perpetrators:

- ▶ Due to the economic impact of the COVID-19 crisis as well as restrictions on movement, many LBTQI+ women are confined in homes with family members and other people who do not know about their sexual orientation

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<sup>11</sup> Internal reflections shared by Pakasipiti following a Zoom call on “Unpacking and understanding the impact of COVID-19 on the LBT community and feminist movement building initiative”, July 2020.

and/or gender identity (SOGI), thereby putting them at risk of abuse and violence if their identity was exposed. Some have been forced to isolate with people who are their abusers.

- ▶ LBTQI+ women who isolate with an abusive partner face the risk of IPV.
- ▶ The restrictions on people's movements during lockdown pose specific threats to LBTQI+ women, in particular trans women, as they can be subjected to targeted attacks by law enforcement agents and be forced to show their ID, putting them at high risk of being violated if their legal ID does not match their gender identity and expression.
- ▶ Pakasipiti also highlights the increased risks of online violence and abuse against LBTQI+ women as social life has rapidly and increasingly moved into online spaces, which are not always safe spaces for LBTQI+ women

Global research by Outright International on the impact of COVID-19 on LBTQI+ people included one respondent from Zimbabwe, a bisexual woman and LBTQI+ activist. The respondent highlighted that the lockdown has halted the work of LBTQI+ organizations on safety and security for LBTQI+ people, which was an urgent issue before the lockdown (Bishop, 2020). It has also restricted LBTQI+ people from meeting up in safe spaces. The respondent further states that the lockdown has had severe consequences on LBTQI+ people's livelihoods, and warns that lesbian women in particular may be forced into survival sex to meet basic needs during lockdown (ibid).

#### (vi) Women and girls living with HIV

Globally, women living with HIV experience higher rates of GBV than the general population (see e.g. Orza et al., 2015). Research have also found that women living with HIV who experience IPV are less likely to access and benefit from health services, including antiretroviral therapy (ART) (Salamander Trust, 2017). There is a global lack of evidence on the impact of COVID-19 on women living with HIV, including rates of and consequences of violence, as well as the impact on access to services (Closson et al., 2020). However, researchers have expressed **concern that stay at home measures during COVID-19 may increase both the rates of GBV against women living with HIV and restrict access to HIV treatment** (ibid.).

In Zimbabwe, ROOTS Africa reports that their shelter received 35 GBV survivors during April and May 2020, 11 of whom were living with HIV (SAFE, 2020). While women and girls living with HIV are likely to be at risk of the same forms of violence as other women and girls in Zimbabwe, there appears to be a lack of evidence on specific risk factors and forms of violence against women and girls living with HIV during the COVID-19 pandemic. However, recent research in Zimbabwe has found that movement restrictions, including road checkpoints and requirements to carry travel authorisation, constitute barriers for women to access antiretroviral (ARV) medication and HIV clinics as they may be forced to disclose their reason for travel (Salamander Trust, 2020).<sup>12</sup>

#### (vii) Sex workers

In April 2020, the Global Network of Sex Work Projects (NSWP) launched a global survey to understand the impacts of COVID-19 on sex workers. It received a total of 156 responses, including 22 responses from 13 countries in Africa (Zimbabwe was not one of them). Sex workers reported that law enforcement agents have used a variety of repressive measures against sex workers during COVID-19, including increased raids, arrests and prosecutions of sex workers, and crackdown in areas known for sex work (NSWP, 2020).

There is a lack of data on how COVID-19 has affected rates of violence against sex workers in Zimbabwe during COVID-19. However, **there have been reports of sexual violence against sex workers, committed by police officers** (SAFE, 2020). The incidents, which took place in two communities and involved fifteen sex workers, took place after police alleged that sex workers broke lockdown restrictions. As set out in Section 6, an increase in household poverty has seen an increase in the number of women and children engaging in sex work, with lockdown and movement restrictions placing them at greater risk of engaging in unsafe sex.

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<sup>12</sup> Internal reflections shared by Salamander Trust related to the research "Our Voices: Impact of COVID-19 on women's and girls' sexual and reproductive health and rights in Eastern and Southern Africa".

### (viii) Migrant women and women in quarantine facilities

National lockdowns and travel restrictions associated with COVID-19 have impacted migrant workers across the world. UN Women (2020b) highlighted that COVID-19 has exacerbated the risk of GBV at all stages of migration. UN Women ESAR reports that there have been cases of forced confinement for migrant workers returning to their countries. There is limited data on the incidence of violence against female migrant workers in the region and in Zimbabwe, however, **there are reports that returning female migrants to Zimbabwe have faced several forms of violence and neglect:**

- ▶ There have been reports of abuse against women migrants who have been placed in quarantine centres for the mandatory 14-day self-isolation upon their return to Zimbabwe (Chitando, 2020). The reports from the quarantine centres have also noted insufficient water, sanitation and hygiene facilities, and breaches against infection prevention and control protocols, with overcrowded centres that put the health and safety of people at risk (ibid.). OCHA (2020c) have also raised concerns around the lack of safe quarantine facilities to host returning women migrants.
- ▶ A rapid assessment from UN Women found that women migrant workers returning home to Zimbabwe from other countries have been denied access to services, and some have faced forced confinement in hotels at their own expense (UN Women, 2020b).
- ▶ In August, OCHA raised concerns around the continued cases of GBV against returning female migrants at points of entry to Zimbabwe (OCHA, 2020c).
- ▶ OCHA highlights that the restrictions on cross-border travel has led to an increase in smuggling in persons and flags the risk of increased sexual exploitation and abuse against women and girls at the border points (ibid.).

### (ix) Refugee women

A survey by the International Rescue Committee (IRC, 2020) with 850 refugee and displaced women in 15 African countries (not including Zimbabwe) found that women reported observing increasing rates of various forms of GBV during COVID-19. More than 70% of respondents reported seeing a rise in domestic violence, more than 50% reported a rise in sexual violence, and almost one in three had observed an increase in early and forced child marriage (ibid.). The report highlights incidents of sexual violence around water points, as well as harassment and violence by police officers on the way to water points. **This evidence synthesis has not found any evidence on GBV against refugee women and girls in Zimbabwe, suggesting that further research is needed in the area.**

### (x) Women human rights defenders and women politicians

Since the early stages of the COVID-19 outbreak, there have been reports of attacks against human rights defenders across the world, including online and physical attacks (Frontline Defenders, 2020). In August, Amnesty International (2020) urged the Southern African Development Community (SADC) leaders to stop the alarming rates of attacks on human rights defenders, peaceful protesters and journalists in various countries in the region. **Amnesty International highlighted the situation in Zimbabwe as particularly concerning, with “a crackdown on dissenting voices with state security forces unleashed on activists, human rights defenders, journalists and opposition supporters”** (ibid.). The Government of Zimbabwe has a history of using violence to shut down protests and silence activists and members of the opposition (DIA, 2020).

Women human rights defenders have been targets of brutal attacks in the past, including torture and sexual violence (Smith, 2020). This has continued during the COVID-19 crisis. For example, in May 2020, three women, all opposition activists and one a member of parliament, were stopped by police at a roadblock in Harare when leaving a demonstration against the Government’s handling of the COVID-19 response (Burke and Chingono, 2020). They were subsequently taken away from police custody and subjected to 24 hours of torture, physical and sexual violence by uniformed men who are believed to be state security agents (Burke and Chingono, 2020; Equality Now, 2020).

### (xi) Women essential workers

It has been reported globally that the increased fear and stress that COVID-19 places on patients, their relatives and other healthcare workers, has increased the risk of workplace violence in the health sector (Fraser, 2020). **UN Women (2020b) ESAR has reported that attacks against health care workers have taken place in the region**, which can be assumed to disproportionately affect women as women make up 70% of health workers. In addition to the risk of violence, women essential workers face increased risks of infections and are exposed to increased risks of contracting COVID-19; up until end of July 2020, 10% of recorded COVID-19 cases in Zimbabwe were among health-care workers, with the majority in the female-dominated nursing profession (Xinhua, 2020). A health workers strike began in June over insufficient personal protective equipment (PPE) and low salaries. **This review did not find evidence specific to violence against healthcare workers in Zimbabwe, making this an area for further research.**

## 6. Drivers of gender-based violence during the pandemic

**The COVID-19 pandemic will exacerbate many existing drivers of GBV.** Patriarchal social norms and gender inequalities across Zimbabwe are key drivers of GBV. Social, cultural and religious practices that subordinate women, as well as an acceptance of violence as a mode of social interaction, contributed to high levels of GBV before the pandemic.

**The lockdown restrictions will exacerbate these pre-existing high levels of violence in Zimbabwe.** Lockdown restrictions mean that women and girls are forced to spend time enclosed with families, trapping many women at home with their abusers; a ZIMSTAT (2019) survey found that the home can be a dangerous place for women in Zimbabwe, with 85% of the cases of sexual violence experienced by married persons committed by current or former husband/partner. For those not married, the main perpetrators are current or former boyfriends (41%) or a family friend (12%). In addition, the socio-economic ramifications of the COVID-19 crisis have intensified financial and food insecurity and reduced access to social support networks, increasing the risks of GBV.

This evidence synthesis looks at three specific drivers of GBV: girls' education, access to SRHR, and women's economic situation and rights.

### 6.1 Girls' education

**Whilst children have largely avoided the direct health impacts of COVID-19, there is evidence that the secondary effects of the pandemic will have a profound and long-lasting negative impact on children.** Mitigation strategies taken by the Government of Zimbabwe, including lockdowns and school closures, have had multiple direct and indirect negative effects on children's lives, disrupting their access to education and other essential services. Longer term, girls' loss of education affects their employment opportunities (CARE, 2020) and increases their likelihood of experiencing VAWG in adulthood (Fulu et al, 2019). Furthermore, girls who are out of school are at greater risk of child marriage and early pregnancy. Whilst national level data on changes in the rates of child marriage during the lockdown is currently unavailable, women's rights organisations have seen an increase in reports and campaigners believe many more cases are going undetected due to movement restrictions (SAFE, 2020).

**Schools in Zimbabwe closed on 24<sup>th</sup> March 2020 to contain the spread of COVID-19, which disrupted the education of more than 4.6 million children** (Moshiri et al, 2020). A Plan International (2020b) rapid assessment carried out in May 2020 found that 98.2% of children in Zimbabwe are not accessing education during the COVID-19 lockdown. Most learners have no or limited access to the internet, particularly those in rural areas, and therefore cannot access online learning materials following school closures. Children with disabilities, who were at a higher risk of dropping out of school prior to the COVID-19 pandemic, face additional barriers in accessing online educational platforms that are not accessible.

**The COVID-19 pandemic has also disrupted tertiary education.** Tertiary education institutions were closed on 21<sup>st</sup> July 2020, with students ordered to vacate halls of residence by 24<sup>th</sup> July 2020 (Mukeredzi and Mashininga, 2020). Newspapers reported that increased numbers of university students dropped out or began engaging in sex

work following university fee increases in March 2020 (Mupauka, 2020). It is likely that the impacts of COVID-19 on financial security will exacerbate this. University accommodation can provide a safe space for young people leaving homes where they may have faced physical, sexual or emotional abuse, particularly girls, members of the LGBTQI+ community and girls with disabilities. As such, closing halls of residence may place students at heightened risk.

**Schools can offer a protective environment for children, without which they are exposed to multiple forms of abuse including sexual violence and child marriage.** Children at risk of violence may be forced to spend lockdown with perpetrators, heightening the risk of abuse or exploitation and reducing their ability to report abuse or seek assistance. Helplines in Zimbabwe reported significant increases in reports of gender-based violence and child protection concerns since the lockdown began, with a majority of perpetrators being people within the child's home and close environment (Moshiri et al., 2020). This is a direct effect of the lockdown that will have immediate and longer term impacts.

**Poverty and lack of access to education are drivers and consequences of child marriage and early pregnancy.** Prior to the pandemic, girls from poorer households and girls with lower levels of formal education were at higher risk of child marriage in Zimbabwe (ZIMSTAT, 2016). With the triple threat of the worsening economic crisis, persistent droughts and the pandemic, more girls are finding themselves in these higher risk groups. Families, and adolescent girls themselves, have reduced income generating opportunities due to the COVID-19 lockdown, which has compounded their economic instability. Consequentially, child marriage may increase as families aim to reduce the perceived economic burden of having a girl child and use the bride price (lobola) for survival.

**Emerging evidence indicates rising levels of early pregnancy in Zimbabwe.** Schools provide access to SRHR education and services, without which girls are at a greater risk of early pregnancies and sexually transmitted infections (STIs). In addition, prior to lockdown schools were able to report girls who were absent and at risk of abuse or early pregnancy to police or education boards, which is not currently possible (Masekesa, 2020). At least 415 girls have dropped out of exam classes in Manicaland province during the COVID-19 lockdown period mainly due to early marriage and pregnancy (Tapfumaneyi, 2020a). In August 2020 Zimbabwe made it illegal for schools to expel pregnant girls, which has been welcomed by women's rights campaigners as a way to stop girls dropping out of school (Matiashe, 2020a). Despite this, stigma and the financial and social ramifications of the crisis, including the increased burden of care, may still prevent girls returning to school to continue their education. As schools begin to reopen the number of girls affected by child marriage and early pregnancy will become more apparent.

**Increased online activity puts children, particularly girls, at heightened risk of online violence and abuse around the world.** Spending more time online may increase the likelihood that children encounter online predators and are groomed for sexual exploitation (UNICEF et al., 2020). A lack of in-person interaction may lead to online risk-taking behaviour, including sharing self-generated sexualized content, which may expose children to extortion, harassment and humiliation. Cyberbullying is also a major concern, particularly for girls, children with disabilities and those who are perceived as different or at greater risk of spreading COVID-19 (ibid). In Zimbabwe, Childline reported that their emergency number for children had been inundated with calls relating to online abuse during the lockdown, with increased reports of cyberbullying, sexting and cases where online violations had escalated to physical abuse (Jachi, 2020).

**Whilst spending more time at home adolescent girls and young women in Zimbabwe have taken on additional care burdens, with 20% reporting an increase in household chores during COVID-19 lockdown** (Plan International, 2020b). The disproportionate burden of household tasks on girls has been linked to reduced academic performance and increased grade repetition and school drop out rates amongst girls in Zimbabwe (Coffey, 2016), which the lockdown is set to exacerbate.

**Whilst schools in Zimbabwe began to reopen on 28th September for examination classes, a teachers' strike, COVID-19 levies and increases in school fees has put additional pressure on access to education** (Cassim, 2020). According to the Progressive Teachers' Union of Zimbabwe 98% of teachers did not report for work in the first week that schools reopened, with teacher's raising concerns over pay and access to personal protective equipment (PPE) and sanitizer (Chingono, 2020). The media has reported increased sexual activity, sharing of indecent images, underage drinking and bullying in Zimbabwean schools where teachers are on strike, particularly in boarding schools (NewsdzeZimbabwe, 2020b).

## 6.2 Sexual and reproductive health and rights

**The COVID-19 pandemic presents a range of challenges that are likely to negatively impact on women's and girls' sexual and reproductive health and rights.** The focus on COVID-19 response has deprioritised provision of SRHR services in Zimbabwe, whilst border closures have increased the risk stock-outs of key SRHR products, exacerbated by factory closures in Asia (Anna, 2020). The socio-economic implications of the pandemic have made SRH services increasingly unaffordable, and movement restrictions have made it more difficult to discreetly access services. Women and girls in rural areas will face additional barriers to accessing services (ibid). Without efforts to mitigate these effects, it is estimated between 88,300 and 371,000 women in Zimbabwe could be unable to access contraception resulting in 2,210 to 111,000 unintended pregnancies (Global Financing Facility and Reproductive Health Supplies Coalition, 2020). The predicted rise in unintended pregnancies and in STIs including HIV, will have a range of consequences on women and girls, including causing distress, increased risk of unsafe abortions and maternal mortality, and further financial implications.

**SRH services offer an opportunity to identify survivors of GBV and provide support** (Heidari and Moreno, 2016). **However, as fewer women and girls around the world are accessing SRH services in lockdown, this opportunity is missed.** Women and girls experiencing abuse may visit SRH providers for contraception, abortion services or maternity services. If signs of GBV are identified, immediate SRH support can be provided and survivors can be referred to GBV support services. Survivors of GBV can also experience SRH consequences, including forced and unwanted pregnancies and STIs, including HIV.

**There is a risk of SRHR being de-prioritised in Zimbabwe, as elsewhere, in the wake of the health emergency of COVID-19.** Whilst pharmacies and other medical facilities have remained open to ensure access to key medicines, some key informants in CARE International Zimbabwe's rapid gender analysis reported that some rural health facilities are only attending to emergency cases (Masomera and Chigwanda, 2020). Dedicated SRH service delivery points have also been forced to close during the lockdown. A survey of International Planned Parenthood Federation (IPPF) national members published in April 2020 found that Zimbabwe was particularly affected by closures of SRH clinics or community-based service outlets, with over 100 forced to close due to the COVID-19 pandemic. Clinics that have remained open in Zimbabwe have reported a 70% drop in client numbers (Anna, 2020).

**Restrictions on movement have made it more difficult for women and girls to access SRH services, which may lead to an increase in unplanned pregnancies and STIs.** In situations where accessing SRH services is stigmatised, women may wish to seek out these services discreetly, which lockdown restrictions prevents. This is particularly challenging for adolescent girls, and women and girls with disabilities, who already had more limited access to SRHR and SGBV response services before the lockdown. Women seeking SRH services may also face harassment from police officers enforcing stay-at-home orders (Morna et al., 2020). Despite access to SRH being declared essential by the Government, Population Services Zimbabwe heard reports from women seeking their services that they were turned away by police at roadblocks (MSI, undated).

**Support to GBV survivors, including the clinical management of rape, has been disrupted as health centres are overburdened with COVID-19 cases,** public transportation is disrupted, and movement is restricted. Musasa is supporting providers with shuttle services to access services and post exposure prophylaxis (PEP), and access to safe shelters away from perpetrators (UNFPA Zimbabwe, 2020). Mobile one stop centres have been operating to help survivors access GBV services during the crisis, however the strike of health personnel is reducing capacity in static facilities to support survivors of rape (OCHA, 2020). Women and girls who experience multiple and intersecting discriminations are likely to face additional barriers accessing support due to the additional layers of discrimination they face, including women and girls with disabilities, refugee/migrant women and members of the LBTQI+ community.

**COVID-19 related disruptions in HIV services has made accessing testing and medication more difficult.** The WHO and UNAIDS (2020) estimated that a six-month disruption of antiretroviral therapy due to the pandemic could lead to more than 500 000 extra deaths from AIDS-related illnesses in Sub-Saharan Africa in 2020–2021. In Zimbabwe, a rapid community survey in April 2020 found that 19% of people living with HIV attempting to access ARV medication had been unable to do so, or were only able to access a partial refill (National Aids Council et al., 2020). Access is likely to be more difficult for GBV survivors; the Zimbabwean women's organisation ROOTS Africa has helped women with HIV access ARV medication secretly so that controlling partners in denial of their

status cannot prevent them from taking them (Harrisberg, 2020). Barriers to accessing testing is likely to have lasting impacts on adolescent girls and young women in Sub-Saharan Africa, who are more than twice as likely to acquire HIV as their male counterparts (UNAIDS, 2020).

**Lockdown restrictions have further restricted women and girls' access to safe abortion services.** Abortion services are restricted in Zimbabwe, with legal abortion limited to cases of rape and incest, when the mother's health is at risk or foetal abnormality. Obtaining the necessary appointments and court documents to access a court-ordered abortion was often delayed even before the lockdown restrictions, making this option unviable for many (Muzarabani, 2020). Before the COVID-19 pandemic women and girls would sometimes travel to neighbouring countries to access abortion services. Without this option there are concerns that women and girls will resort to potentially life-threatening unsafe abortions. Prior to the lockdown, a ministry of health official reported that teenage accounted for nearly a third of Zimbabwe's abortion-related maternal deaths (Phiri, 2018).

**There has been a decrease in the uptake of contraception,** with new clients on combined birth control pills dropping by 90% in Zimbabwe (WHO Regional Office for Africa, 2020). A recent Plan International (2020b) survey found that respondents in Zimbabwe were not active in seeking SRHR information, with only 17.1% saying they had tried to access SRHR information. 50.1% of respondents indicated that they did not have information on where, how and when to access SHRH information during the lockdown.

**The COVID-19 pandemic has had a range of negative impacts on women's and girls' access to maternity services in Zimbabwe,** including staff shortages, resource stock-outs, the closure of antenatal clinics and disruption of public transport. Women and girls may also choose to avoid attending healthcare facilities for fear of contracting the virus. Access to maternity services in Zimbabwe was already reduced due to a doctors' and nurses' strike, which continued through the lockdown (Chengeto Trust and Women's Action Group, 2020). According to preliminary WHO data, in Zimbabwe the number of caesarean sections performed decreased by 42% between January and April 2020 compared with the same period in 2019 and the number of live births in health facilities fell by 21% (WHO Regional Office for Africa, 2020). Before the COVID-19 pandemic, evidence indicated that experiencing intimate partner violence was associated with a lower likelihood of accessing adequate antenatal care and skilled delivery care (Musa et al., 2019) and lockdown restrictions are likely to exacerbate this.

## 6.3 Women's economic situation and rights

**The COVID-19 pandemic has wide ranging implications for women's economic situation and rights,** which were already restricted before the crisis. There is growing evidence that COVID-19 will have a disproportionate impact on women's economic and productive lives compared to men, as women have less access to decent work (e.g. low job security and over-representation in the informal sector) and do the majority of unpaid care work (UN Secretary-General, 2020; Womankind, 2020).

**In Zimbabwe, women represent 65% of informal sector workers** such as vendors and cross-border traders (Masomera and Chigwanda, 2020). Lockdown restrictions have had significant impacts on their livelihoods, as their work often requires access to public spaces and social interaction. Informal sector workers often rely on daily earnings and have few safety nets, making them increasingly vulnerable when these work opportunities are lost. When the lockdown began informal trading places were destroyed and informal traders were arrested in the street (SAFE, 2020). Border closures have disrupted the livelihoods of cross-boarder traders, who are predominantly women, and disrupted the supply chains of key commodities, contributing to rising prices (Nevill, 2020). 42% of respondents to an October 2020 Zimbabwe Resilience Building Fund (ZRBF) survey in rural areas reported a complete loss of job or income, and 60% reported a partial loss of job or income over the previous fortnight, compared to before COVID-19 (Rosen et al., 2020).

**COVID-19 is worsening food insecurity in Zimbabwe, which was already severe due to droughts and economic recession.** The World Food Programme (WFP) projections suggest that by January 2021, the number of food-insecure people in Zimbabwe will rise by nearly 50 percent to 8.6 million, representing 60 percent of the population (Nevill, 2020). The lockdown has led to job losses and falls in informal sector revenues in urban areas as footfall has decreased. In rural areas, the return of unemployed migrants from urban areas and the lack of remittances from family members in urban areas has contributed to increased food insecurity.

**Agriculture, which represents 70% of female employment in Zimbabwe, has also been subject to secondary impacts of the COVID-19 pandemic** (World Bank, 2020). In a July 2020 survey, 85% of coffee farmers reported losing income as a result of COVID-19 and 1 in 8 reported going to bed hungry due to lack of

food (TechnoServe, 2020). 74% of these farmers (men and women) reported challenges selling crops in the past 7 days due to fewer customers, issues with transport and closures of shops and markets (ibid). In this survey, more women reported reduced access to emergency funds compared to men.

**The COVID-19 lockdown is increasing household financial instability.** In Zimbabwe, research by Plan International (2020b) found that at least 83.4% of respondents, the majority of whom were women, said that their households could not sufficiently meet their families' basic needs during the COVID-19 lockdown. In addition, prices of basic food items have risen putting additional pressures on families, with prices in local currency payments increasing during 2020 by an average of 424% (OCHA, 2020d). In an October 2020 survey in rural districts in Zimbabwe, 74% of respondents reported that household expenses had increased, and 90% reported an increase in food prices, since COVID-19 began (Rosen et al., 2020).

**An increase in financial instability and confinement is leading to increased household tensions.** Typically social norms and rigid gender roles place the burden of financial responsibility for the family on men and care and household responsibilities on women. Due to the COVID-19 restrictions, men's ability to fulfil this expectation is limited, which can increase the likelihood of them being violent towards their partner/wife and/or children. Additionally, women are no longer able to use the mediating strategy of supplementing the family income through informal work due to COVID-19 restrictions (SAFE, 2020). Tasks such as collecting water and food have been directly affected by the lockdown restrictions; women are exposed to harassment, violence and sexual exploitation at water collection points and facing increased risks of contracting the virus as they wait in long queues (Tapfumaneyi, 2020b).

**The lockdown has exacerbated an existing unequal burden of care;** prior to the lockdown women in rural areas of Zimbabwe spent more than four times as many hours per day than men on unpaid care and domestic work (Oxfam, 2020). COVID-19 is likely to increase the unequal burden of caring for the sick (both with COVID-19 and other illnesses) and the elderly as hospitals increasingly only admit emergency cases or close to non-COVID-19 cases. School closures mean additional time is required to care for children and meet their home schooling needs. A ZRBF survey found that 67% of surveyed women in rural Zimbabwe and 54% of men reported increased time taken to care for children (Rosen et al., 2020). In a CARE International Zimbabwe rapid assessment conducted in April 2020, women reported being overwhelmed and working long hours to meet the needs of family members during the lockdown (Masomera and Chigwanda, 2020).

**An increase in household poverty has led to an increase in women and girls engaging in sex work in Zimbabwe** (Matiashe, 2020b). There have been reports of increasing numbers of young girls forced into transactional sex in return for cash, food or even sanitary products (Plan International, 2020b). Roots Africa has received 350 reports of children having sex in exchange for money or gifts from March to June – double the previous year – in Mazowe alone (Matiashe, 2020). Sex workers have faced particular challenges as curfews and bar closures have led to women meeting clients in more secluded and less safe places (Salamander Trust, 2020). As clinics and illegal brothels have closed, women have been unable to access free condoms, increasing the risk of unplanned pregnancy and contracting STIs and HIV, exacerbated by reduced access to medical facilities during the lockdown. As set out in Section 5, there have also been reports of sex workers being arrested for breaking curfew and then being raped by police (SAFE, 2020).

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## Annex 1: Methodology and limitations

**Search strategy:** Published studies were identified through searches using Google. Due to the rapid and recent nature of the evidence related to COVID-19, evidence was also identified on Twitter and other social media channels. Unpublished studies were identified through direct recommendations from the SAFE Technical Team. The team also reached out to expert women's rights organisations in Zimbabwe and INGOs via email to share evidence recommendations for published and unpublished material. Key search terms included: gender-based violence, violence against women and girls, GBV trends, GBV forms, domestic violence, intimate partner violence, child marriage, sexual exploitation, abuse and harassment, boreholes, water distribution, Ebola, cholera, fragile and conflict-affected states, girls' education, early and unwanted pregnancy, sexual and reproductive health and rights, abortion, contraception, HIV, STIs, maternity services, women's economic rights, land rights, property rights, poverty, food insecurity.

**Criteria for inclusion:** To be eligible for inclusion, evidence will need to fulfil the following criteria:

- Focus: Evidence on the impact of the COVID-19 pandemic on violence against women and girls and the key themes.
- Time period: January 2000 – October 2020, however most evidence analysed was during the March-October 2020 period.
- Language: English
- Publication status: most sources are publicly available and in all cases published online. Unpublished material has been included only where a direct recommendation was made by the SAFE Technical Team and as a result of email engagement with experts.
- Geographical focus: Zimbabwe. However, regional and global evidence has been drawn on where relevant.

### Limitations

- There is a limited amount of up-to-date national and regional level data, including on reports of GBV, child marriage and early pregnancy, which makes it difficult to establish trends. Many of the reports and articles reviewed for this evidence synthesis referred to the recent SAFE data analysis report (July 2020), which appears to be the main study that looks at trends in GBV in Zimbabwe during the pandemic. The synthesis therefore relied quite heavily on unpublished reports and observations from NGOs and INGOs, as well as news outlets.
- Linked to this, where data is available, there is a lack of disaggregated data which would help assess the differing impact of the restrictions and GBV on women and girls from different social and economic backgrounds and identities.
- There are no estimates of actual GBV data prevalence during the COVID-19 pandemic.
- The synthesis had intended to look at women and girls from different parts of the country, to assess how the pandemic is affecting their risks of GBV. However, no specific evidence of this was found in the timeframe available.

