

Adaptive Delivery and Resilience of a Community-Based Gender-Based Violence Response in Rural Zimbabwe During COVID-19 (2020–2022)

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ABSTRACT

The COVID-19 pandemic produced what UN Women (2020) and later global analyses called a “shadow pandemic” of gender-based violence (GBV). Stay-at-home orders, economic shocks, and disruption of formal services coincided with sharp rises in intimate-partner and family violence in many countries. Community-based GBV programs running during 2020–2022 faced two problems at once. Demand for prevention and response services rose. In-person delivery became difficult or impossible. This paper examines how one such program managed and adapted its work through the pandemic. It also reports the outcomes the program achieved by its conclusion. The program is the Womandla Foundation Trust’s GBV Prevention and Response Program. It was implemented in Zvishavane District, a mining-dependent rural area in Midlands Province, Zimbabwe. The study used a convergent mixed-methods evaluation. It integrated a community survey (N = 120), a service-provider survey (n = 60), four focus group discussions, and twelve key informant interviews. We analyse the program’s trajectory using a four-capacity resilience framework. The four capacities are absorptive, adaptive, anticipatory, and transformative. The program ran through three national lockdowns and several COVID-19 waves. At endline, 75.0% of community respondents were aware of common GBV forms. A further 66.7% had taken part in at least one prevention activity. Among trained providers, 83.3% showed high adherence to survivor-centered protocols. Qualitative data indicate that three factors supported these outcomes. First, a quick shift from large public campaigns to radio, WhatsApp, and household-level outreach. Second, a locally embedded volunteer network. Third, faster take-up of digital monitoring tools, which continued after the pandemic. The paper argues that women-led, locally anchored programs with prior community trust showed strong resilience during COVID-19. Several changes introduced during the crisis retain value beyond it. Implications for pandemic-era and future-shock GBV programming in sub-Saharan Africa are discussed.

Keywords: COVID-19; shadow pandemic; gender-based violence; program resilience; adaptive delivery; community health workers.

INTRODUCTION

The global COVID-19 pandemic did not spread its harms evenly. Alongside the biomedical emergency, a second crisis unfolded in households and communities worldwide. Reported gender-based violence (GBV) rose sharply. Contributing factors included stay-at-home orders, economic stress, the closure of schools and safe spaces, and the disruption of formal support services. UN Women (2020) was among the first to call this the “shadow pandemic.” Later empirical work has largely confirmed its scale and patterns. Meta-analyses and systematic reviews covering the first eighteen months of the pandemic reported median increases in reported intimate-partner violence of between 7% and 22%. These estimates cover high- and middle-income settings (Piquero et

al., 2021; Kourti et al., 2023). Increases in lower-income and rural settings are plausible but less well measured. Reporting infrastructure in these contexts is weaker (Peterman & O'Donnell, 2020; John et al., 2021; Mittal & Singh, 2020).

For community-based GBV programs working during 2020–2022, this context created a problem. Demand for prevention and response services rose. At the same time, the usual delivery methods became difficult or impossible. These methods included large public events, in-person training, community dialogues, and face-to-face counselling. Early pandemic-era reports from civil-society organisations in sub-Saharan Africa recorded activity disruption rates of 40% to 80%. Rural and volunteer-dependent programs were particularly affected (Roesch et al., 2020; Dlamini, 2021; Bourgault et al., 2021). Yet some programs not only continued their work under these conditions but also made changes whose value lasted beyond the immediate crisis (Pfitzner et al., 2022; Mojahed et al., 2022; Usta et al., 2021).

This paper adds to that evidence base by examining one such program in detail. The Womandla Foundation Trust's GBV Prevention and Response Program ran in Zvishavane District, Midlands Province, Zimbabwe, between 2020 and 2022. These dates overlap with the pandemic's most acute phases in Zimbabwe. Zvishavane is a mining-dependent rural district of about 59,717 residents (ZIMSTAT, 2022). It has a transient male labour force and marked rural–urban inequalities. It also has socio-economic conditions linked to higher GBV risk in extractive-industry settings (Rustad et al., 2021; Bashwira & Cuvelier, 2022). The district is therefore a useful case. It combines structural vulnerability to GBV, exposure to pandemic-era service disruption, and a program that nonetheless delivered measurable outcomes.

The paper has three objectives. First, it reconstructs the program's implementation trajectory against the timeline of COVID-19 waves and national response measures in Zimbabwe. This allows us to identify the points at which delivery was disrupted and the adaptations that were adopted. Second, it presents endline outcome data on community awareness, participation, and service-provider adherence. These data are read in light of the pandemic-era context. Third, it uses a four-capacities resilience framework to explain the program's resilience. The framework covers absorptive, adaptive, anticipatory, and transformative capacities. It also helps identify which adaptations are worth keeping beyond the pandemic.

The paper makes three contributions. Empirically, it offers one of the few district-level accounts of COVID-era GBV programming in rural sub-Saharan Africa. It draws on an independent outcome evaluation rather than self-reported activity data. Theoretically, it applies a resilience framework that has been widely used in humanitarian and disaster-management scholarship. Its use in GBV programming has so far been limited (Béné et al., 2014; Manyena et al., 2019; Bahadur et al., 2020). Practically, it identifies a set of adaptations with transferable value. These include digital monitoring, radio and WhatsApp outreach, household-level engagement, and volunteer-led continuity. They are relevant to GBV programs facing future shocks, whether epidemiological, climatic, or economic.

BACKGROUND AND CONCEPTUAL FRAMEWORK

COVID-19 and the "Shadow Pandemic" of GBV

The pattern of GBV during COVID-19 has been studied closely since 2020. Early helpline and police-report data from China, France, Italy, Spain, and the United Kingdom showed increases in calls and recorded incidents. The increases ranged from 20% to 60% during the first weeks of lockdown (Mahase, 2020; Usta et al., 2021). Later population-based studies refined these early signals. Piquero et al. (2021), in a meta-analysis of 18 studies across multiple jurisdictions, estimated a median 8.1% increase in domestic-violence reporting during the early lockdown period. Kourti et al. (2023), synthesising 32 studies, found heterogeneous but consistently positive pooled effects across high- and middle-income settings. Evidence from low-income and rural contexts is thinner. It suggests comparable or larger effects, reduced by reporting constraints (Peterman & O'Donnell, 2020; John et al., 2021; Mojahed et al., 2022).

Three mechanisms are consistently identified. First, stay-at-home orders increased the time victims and perpetrators spent together. They also reduced opportunities for rest or disclosure to third parties (Roesch et al., 2020). Second, pandemic-induced economic shocks raised household stress. These shocks included job losses,

income volatility, and food insecurity. They also reduced survivors' economic options for leaving (Bourgault et al., 2021; Heise et al., 2019). Third, formal services were disrupted. Health-sector capacity was diverted to COVID response. Safe spaces were closed or restricted. This weakened the infrastructure on which survivors rely (García-Moreno et al., 2022; Dlamini, 2021). For rural, mining-dependent districts such as Zvishavane, these mechanisms operated in an already-limited service environment. Existing vulnerabilities were intensified.

Program Resilience: A Four-Capacity Framework

The concept of resilience comes from ecological and disaster-management research. It has increasingly been applied to social programs operating under shock conditions. Current formulations distinguish four related capacities: absorptive capacity (the ability to cope with shocks without losing core function), adaptive capacity (the ability to adjust behaviours and strategies as conditions change), anticipatory capacity (the ability to foresee and prepare for disturbances), and transformative capacity (the ability to create structural change that reduces vulnerability to future shocks) (Béné et al., 2014; Manyena et al., 2019; Bahadur et al., 2020). Applied to GBV programming, the framework offers a structured way to examine resilience. It asks not just whether a program survived a crisis, but how. It also asks which adaptations should be retained, and what the experience reveals about underlying organisational and community assets.

The framework has had limited use in GBV programming to date. Most applications have focused on humanitarian response rather than development programming (Bourgault et al., 2021; Pfitzner et al., 2022). This paper uses the framework in two ways. Descriptively, it maps specific program adaptations onto each capacity. Evaluatively, it asks whether observed outcomes can be attributed to the strength of particular capacities. Figure 1 shows the framework as used in this study.

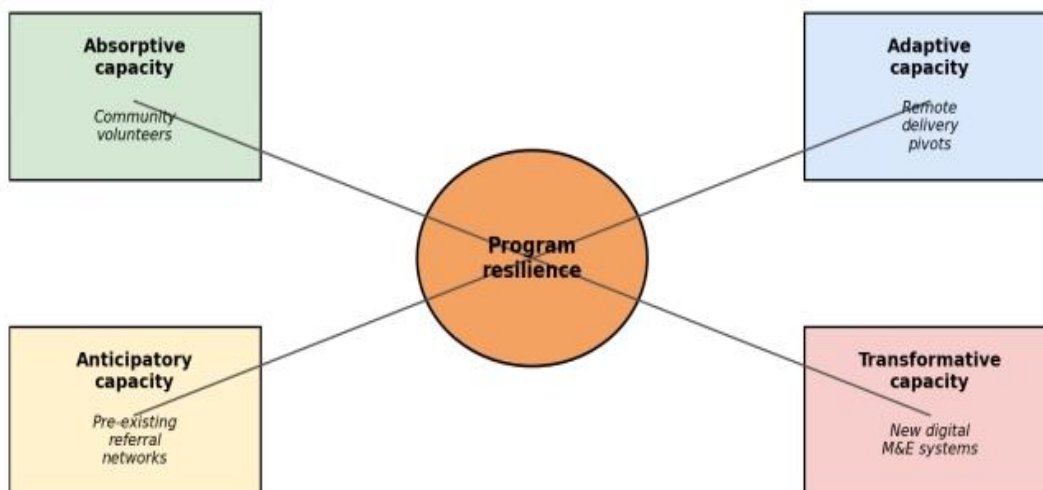


Figure 1. Conceptual framework: four capacities of program resilience during COVID-19.

METHODS

Design and Setting

The study used a convergent parallel mixed-methods design. Quantitative and qualitative data were collected at the same time and analysed together (Creswell & Plano Clark, 2018). Program resilience is multi-dimensional. Numerical outcome indicators require qualitative explanation of the adaptations and mechanisms behind them. The study was conducted in Zvishavane District, Midlands Province, Zimbabwe. Four program wards were covered. They were selected to reflect urban, peri-urban, and rural contexts.

Sampling and Data Collection

Community respondents were drawn using stratified random sampling. This produced a balanced sample by sex and age, with a final total of 120 respondents (60 women, 60 men). Service providers who had completed Womandla's training were sampled purposively from the program roster (n = 60). Four focus group discussions

of 8–10 participants each, and twelve key informant interviews, complemented the survey data. Key informants included Womandla program staff, ward-level volunteer coordinators, nurses, social workers, and police officers. All had been active throughout the 2020–2022 period. This allowed reconstruction of the implementation trajectory from first-hand accounts.

Data collection instruments were developed in English. They were then translated into Shona, back-translated for fidelity, and pilot-tested with ten respondents in a non-sampled ward. A dedicated instrument module captured retrospective accounts of program delivery during each pandemic phase. The phases were pre-lockdown, acute lockdown, mid-pandemic, and recovery. Accounts were triangulated against program activity records. Sensitive interviews were conducted in private settings. A structured referral protocol was activated in any case of participant distress, in line with WHO (2016) ethical guidance.

Analysis

Quantitative data were entered and cleaned in SPSS. Analysis used descriptive statistics, including frequencies, percentages, and cross-tabulations. Results were disaggregated by sex and age. Qualitative data were coded inductively at first. They were then recoded deductively against the four resilience capacities. This produced a structured map of adaptations. Methodological triangulation across survey, FGD, KII, and document-review sources strengthened the credibility of the findings (Nowell et al., 2017). Implementation timeline data were reconstructed from program records and cross-checked against the national COVID-19 response chronology.

Ethics

All participants provided written informed consent. Confidentiality and anonymity were maintained. No participant was asked to disclose personal experiences of violence.

Results

Implementation Timeline Against the Pandemic

The program’s implementation trajectory followed the rhythm of COVID-19 waves and national response measures in Zimbabwe. Figure 2 shows this trajectory. Early 2020 saw a conventional launch phase with large public campaigns and in-person training. From March 2020 onward the program entered an acute disruption phase. This coincided with Zimbabwe’s first national lockdown. During this phase, large gatherings were suspended. In-person training was halted. Face-to-face survivor counselling became logistically and legally constrained.

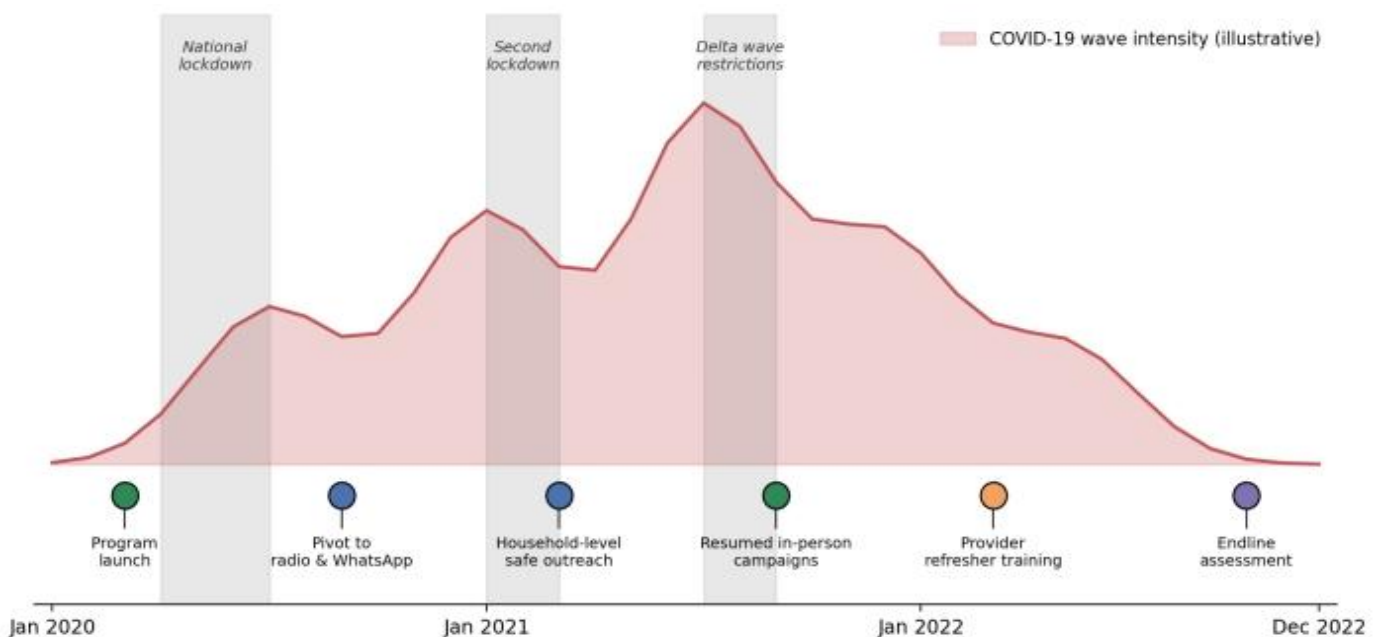


Figure 2. Program implementation timeline against COVID-19 waves in Zimbabwe (2020–2022).

Rather than suspending operations, the program adapted quickly. Within about eight weeks of the first lockdown, implementers had launched a radio-based awareness campaign with a local community station. They had also begun using WhatsApp broadcast lists and SMS to share IEC content. The community-volunteer network was reoriented toward discreet household-level check-ins that complied with gathering restrictions. A second shift during the Delta wave in mid-2021 strengthened phone-based referral. It also expanded the use of outdoor, physically distanced small-group dialogues. By mid-2022, in-person campaigns had resumed alongside the retained digital channels. This produced a hybrid delivery model that outlasted the pandemic itself.

Adaptive Delivery Modes Across Pandemic Phases

Figure 3 summarises the relative intensity of different delivery modes across three pandemic phases. It is based on program records and key-informant accounts. Three patterns are worth noting. First, large public campaigns declined almost completely during the peak pandemic phase. This shows that the program could not have continued on its pre-existing delivery model alone. Second, radio, WhatsApp, and household-level outreach rose sharply during the peak phase. This increase was largely new for the organisation. Informants described these modes as “emergency innovations” not featured in the original program design. Third, recovery-phase data indicate that several of these adaptations were kept alongside the return of in-person activity. By the end of the implementation period, the delivery portfolio was more diverse and arguably more resilient than at the start.

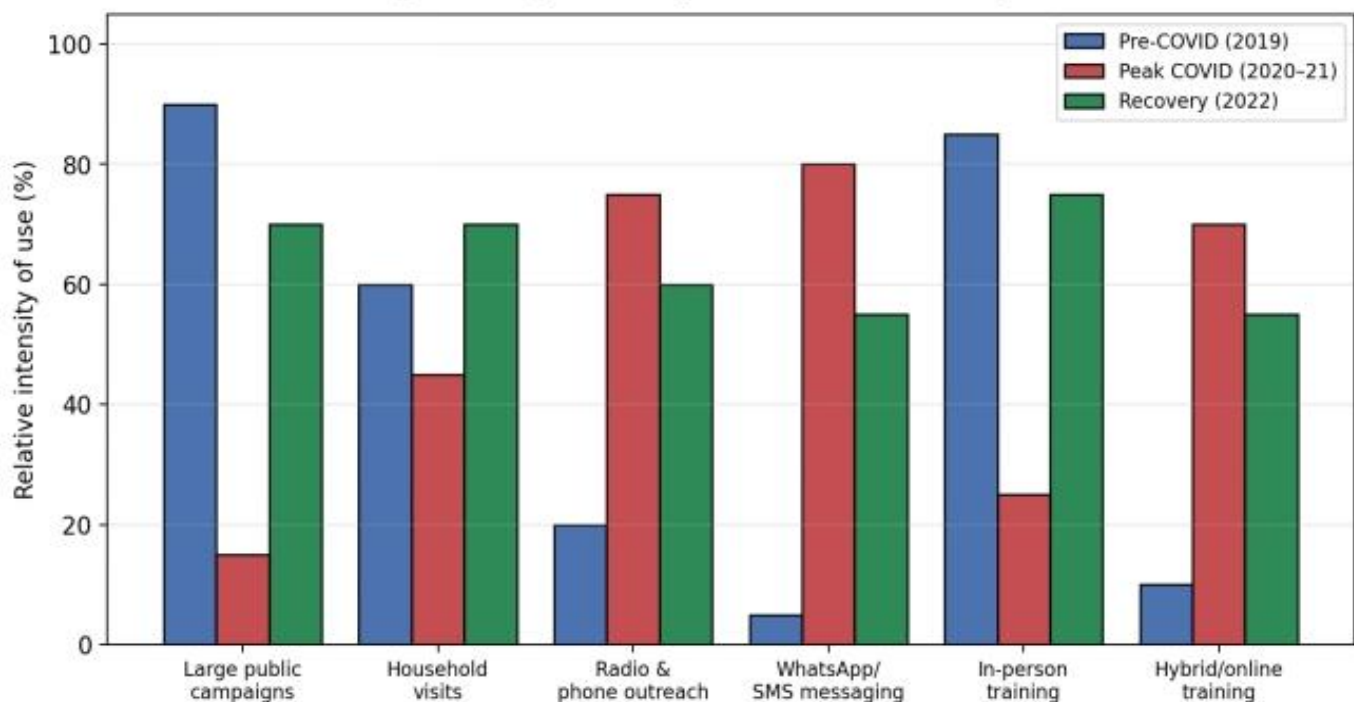


Figure 3. Adaptive delivery modes across COVID-19 phases.

Endline Outcomes

Despite the disruptive context, the program’s endline outcome indicators were strong. Seventy-five per cent of community respondents correctly identified at least three distinct forms of GBV (Figure 4). A further 66.7% had taken part in at least one program activity. Among trained service providers, 83.3% showed high adherence to survivor-centered protocols (Figure 5). Table 1 summarises the core endline indicators. These figures should be read against a baseline in which community knowledge of non-physical GBV forms was limited, and service-provider training coverage was minimal. This baseline is based on key-informant accounts of the period before the program.

Indicator	N	Achievement
Sex balance in community sample	120	50% / 50%

Correctly identifies ≥ 3 GBV forms	120	75.0%
Participated in ≥ 1 program activity	120	66.7%
High adherence to response protocols (providers)	60	83.3%
Awareness among 25–34 age cohort	45	88.9%

Table 1. Summary of endline outcome indicators.

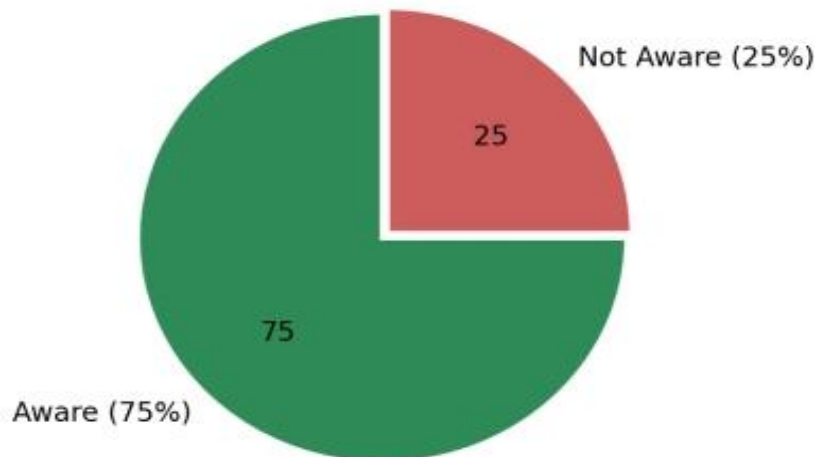


Figure 4. Community awareness of GBV types (N = 120).

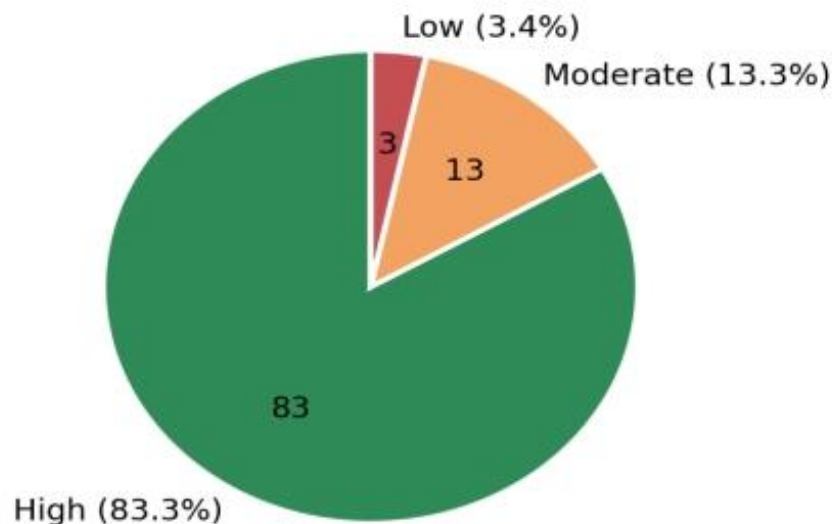


Figure 5. Service-provider adherence to GBV response protocols (n = 60).

Disaggregation by age (Figure 6) showed the highest awareness in the 25–34 cohort, at 88.9%. The other cohorts clustered at 66.7%. Qualitative accounts linked this pattern to the 25–34 cohort’s greater use of digital communication during the pandemic. This aligned well with the program’s shift to radio, WhatsApp, and SMS. Older respondents, by contrast, continued to prefer in-person, community-gathering formats. They were therefore more affected during phases when those formats were suspended.

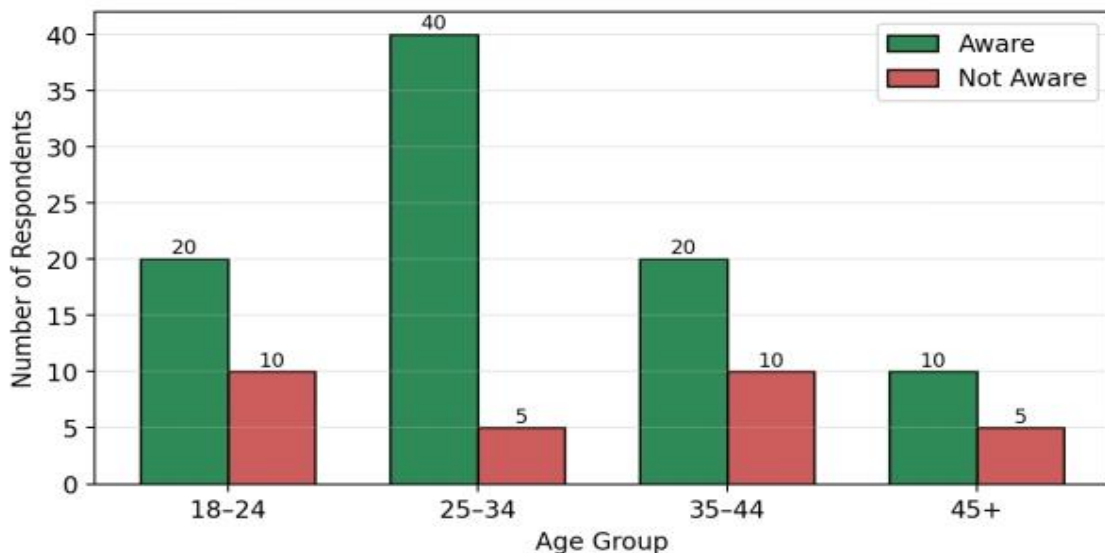


Figure 6. GBV awareness levels by age group.

Qualitative Themes: Sources of Resilience

Thematic analysis of focus group and key informant data identified four recurring sources of program resilience. These mapped closely onto the four capacities in the framework. The first theme, community embeddedness, acted as the program's main absorptive capacity. The volunteer network was drawn from the communities it served. Its members could therefore continue informal outreach when external staff could not travel. A ward-level coordinator observed:

"When the lockdown came, our volunteers did not go anywhere—they were already at home, in their own wards. They continued the work quietly, visiting neighbours, sharing information, supporting women who had nowhere else to turn."

The second theme, rapid technological improvisation, underpinned the program's adaptive capacity. Informants described a learning curve. Radio scripts were written, WhatsApp broadcast protocols were developed, and phone-based referral pathways were established within weeks of the first lockdown. These tools were initially makeshift. Most were later formalised and retained. A Womandla program officer reflected:

"We had never used WhatsApp for program delivery before COVID. Now we cannot imagine working without it. The pandemic forced us to modernise five years in five months."

The third theme, pre-existing referral networks, served as anticipatory capacity. The program had not been designed with a pandemic in mind. However, its earlier investment in multi-sectoral coordination paid off. These links covered health, social services, police, and community leaders. They provided a backbone that proved useful when normal operations were disrupted. Informants consistently credited these prior relationships with enabling continuity of referral even when face-to-face meetings were impossible.

The fourth theme, the emergence of durable digital monitoring, made up the program's transformative capacity. Under pandemic conditions, the program sped up its adoption of mobile data-collection tools and dashboard-based reporting. This created an M&E infrastructure that did not exist before 2020. It has continued into the post-pandemic phase. A senior key informant described this as "an accidental modernisation" that would not have occurred under normal operating conditions.

Persisting Challenges

The program did not emerge from the pandemic without strain. Qualitative data documented three recurring challenges. First, psychosocial-support services were sometimes overwhelmed. This was particularly the case during peak-lockdown phases, when household confinement raised demand while counsellor availability was

constrained. Second, rural survivors with limited mobile-phone access or poor network coverage were left out of digital outreach. This widened pre-existing urban–rural inequalities. Third, some service providers, particularly within the police service, reported burnout and a decline in protocol adherence during sustained peak phases. Similar observations have been made in other COVID-era evaluations (Usta et al., 2021; Pfitzner et al., 2022). These challenges indicate that resilience was unevenly distributed. Further investment in human-resource depth and digital inclusion would strengthen the program’s ability to withstand future shocks.

DISCUSSION

The findings suggest three main conclusions about how community-based GBV programs behave under pandemic conditions. Each has implications beyond the Zimbabwean case.

First, locally embedded, volunteer-driven programs can show strong resilience under crisis conditions. This holds when they have strong community trust and diversified delivery capacity. The Womandla program did not merely survive the pandemic. It achieved outcome-level gains in awareness, participation, and provider adherence. These compare favourably with results reported by programs operating in non-crisis conditions (Abramsky et al., 2014; Dunkle et al., 2020; Kyegombe et al., 2023; Ogum Alangea et al., 2020). The prior embeddedness of its volunteer network was the single most important explanatory factor. This supports recent arguments that community health worker and volunteer-based models are important responses to infrastructural fragility in low-resource settings (Boyce et al., 2022; Ballard et al., 2022).

Second, the pandemic prompted adaptations whose value extends beyond the immediate crisis. The faster adoption of radio, WhatsApp, SMS, and digital monitoring started as emergency improvisation. These adaptations proved effective enough to be kept into the recovery phase. The result is a hybrid delivery model that is arguably more resilient than the pre-pandemic baseline. This pattern aligns with findings from evaluations in Australia, Lebanon, and South Africa. These studies have also documented the persistence of pandemic-era digital adaptations (Pfitzner et al., 2022; Usta et al., 2021; Mojahed et al., 2022). It also supports theoretical arguments that crisis conditions can speed up organisational learning (Béné et al., 2014; Manyena et al., 2019). For donors and implementers, the implication is clear. Investment in digital delivery capacity should be treated as a core element of program design, not a crisis contingency.

Third, and more cautiously, the evaluation shows the limits of programmatic resilience. Digital adaptations served urban and youth populations well during the pandemic. At the same time, they excluded older and rural survivors with limited phone access or network coverage. Psychosocial support services were sometimes overwhelmed. Provider burnout was a recurring theme. These findings echo concerns in the broader COVID-era GBV literature. Technological adaptation risks creating a “two-speed” service environment. Connected populations gain access; disconnected populations lose it (John et al., 2021; Dlamini, 2021). Future programming should treat digital and in-person modalities as complements rather than substitutes. It should also invest specifically in closing the access gap for digitally excluded populations.

Zvishavane’s outcomes were achieved in a mining-dependent rural district. Structurally, this profile would predict particular vulnerability to pandemic disruption. Recent quantitative evidence links extractive-industry contexts to higher GBV risk (Rustad et al., 2021; Bashwira & Cuvelier, 2022). This suggests the Womandla case may be transferable to other mining districts in the region. Transfer would depend on reproducing its reliance on locally embedded volunteer networks and diversified delivery. The transferability of this model warrants further investigation. Comparative studies in analogous districts across Zambia, the Democratic Republic of Congo, and South Africa would be useful.

A brief methodological note is also in order. The four-capacities resilience framework was developed mainly in disaster and humanitarian scholarship. It proved well suited to the analysis of GBV programming under shock conditions. The distinction among absorptive, adaptive, anticipatory, and transformative capacities made it possible to identify what changed during the pandemic. It also helped explain why particular adaptations took the forms they did, and which ones should be retained. The framework could be incorporated into M&E practice for GBV programs more generally. This is particularly relevant in contexts exposed to recurrent shocks—epidemiological, climatic, or economic.

Limitations

Several limitations should be acknowledged. The retrospective, post-only design without a comparison group limits causal attribution. Observed outcomes are plausibly but not definitively attributable to the program. Attribution to specific adaptations is even more tentative. The reconstruction of the implementation timeline relies on key-informant recall. This is subject to hindsight bias. Self-reported awareness and adherence measures are vulnerable to social-desirability bias in a sensitive domain. Triangulation with supervisor ratings and case-file review partially reduced this risk but could not remove it. The sample was drawn from four program wards. It cannot be generalised to the entire district or province. Digital-inclusion patterns were measured only indirectly through qualitative accounts. Dedicated future instruments would help. Finally, men were likely under-represented in qualitative activities, owing to mining-shift patterns. This is a known limitation in mining-community research (Perks & Schulz, 2020). Future evaluations would benefit from quasi-experimental designs, longitudinal follow-up, and pre-registered resilience instruments.

CONCLUSIONS AND RECOMMENDATIONS

The Womandla Foundation Trust's GBV Prevention and Response Program in Zvishavane District was implemented under very difficult operating conditions. These included three national lockdowns, multiple COVID-19 waves, and the full intensity of the global "shadow pandemic" of gender-based violence. Despite these conditions, the program achieved strong endline outcomes in community awareness, participation, and service-provider adherence. This paper has argued that the program's resilience is best understood through a four-capacities framework. The framework distinguishes absorptive, adaptive, anticipatory, and transformative resources. Each capacity drew on a specific organisational asset. These were community embeddedness, rapid technological improvisation, pre-existing referral networks, and the faster adoption of digital monitoring.

On the basis of these findings, seven recommendations are offered for Womandla, peer organisations, and donors engaged in GBV programming in shock-exposed contexts:

- Invest in community-volunteer networks as the main asset for crisis continuity. Their value rests on trust built in non-crisis periods. It cannot be created under emergency conditions.
- Institutionalise hybrid delivery. Keep the digital adaptations developed during the pandemic alongside the return of in-person modalities. Do not default back to the pre-pandemic delivery mix.
- Close the digital access gap. Supplement radio, WhatsApp, and SMS outreach with tailored outreach for older and rural populations whose digital inclusion remains limited.
- Formalise anticipatory planning. Pre-position multi-sectoral memoranda of understanding, contingency referral protocols, and basic digital infrastructure before the next shock occurs.
- Protect provider wellbeing. Provide structured supervision, workload management, and mental-health support. This is especially important for police and frontline health workers who showed signs of burnout during peak-lockdown phases.
- Adopt the four-capacities resilience framework in routine monitoring. Report not only on activity and outcome indicators but on the organisational capacities that sustain them.
- Document and share crisis-era innovations rigorously. Adaptations developed under pressure in one district can then be evaluated, refined, and transferred to peer organisations elsewhere in the region.

If implemented together, these measures would consolidate the gains documented in this evaluation. They would also strengthen the ability of community-based GBV programs across sub-Saharan Africa to withstand future shocks. On current trajectories, such shocks are likely to define the operating environment of the next decade. The shadow pandemic of 2020–2022 will not be the last crisis during which survivors of gender-based violence need continuity of care. The lessons from Zvishavane suggest that locally anchored, women-led, adaptively managed programs are among the most reliable tools for providing it.

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