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ASSESSING THE CAPACITY OF ZIMBABWE'S GBV REFERRAL PATHWAY DURING THE COVID-19 PANDEMIC

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Abstract
This study sought to assesses the capacity of the referral pathway to adequately address the needs of survivors in Zimbabwe during the COVID-19 pandemic, with a specific focus on the Epworth and Hopley communities. The study methodology was grounded within a qualitative narrative design, and data was collected through in-depth interviews and key informant interviews. Theoretically, the study was informed by the Gender Equality and Development Framework propounded by the World Bank (2012). The major findings of the study reveal that the capacity of these services is relatively adequate for medical and counselling services and lacking on policing services, legal and shelter services. A general lack of financial freedom for women and girls compromises their access to services particularly medical expenses that are high. In addition, coordination amongst service partners remains unsatisfactory and the COVID-19 pandemic seriously hindered the reach of services. Conclusions made in the study are that lack of adequate coordination and monitoring, particularly given the COVID-19 pandemic, increases the vulnerability of survivors. The study provides recommendations in line with, inter alia, the coordination and monitoring of services, provision of feedback mechanisms, and addressing socio-cultural barriers to service uptake.

Keywords
Covid-19, Gender Based Violence, referral pathway, survivors.

1. Introduction

The development of the Gender-Based Violence (GBV) referral pathway in Zimbabwe was highly received and applauded by development and human rights practitioners due to its thrust towards holistic service provision. The service pathway is meant to address gaps evident in disjointed and unitary approaches to service delivery for the victims of GBV. This study assessed the capacity of the referral pathway in adequately addressing the needs of survivors in the Epworth and Hopley communities during the COVID-19 pandemic. Given the manner in which the COVID-19 pandemic collapsed service delivery systems, the study sought to examine its impact on the delivery of and access to services through the referral pathway. The Epworth and Hopley communities in Zimbabwe are characterized by an enclave of mushrooming development surrounded by acute levels of poverty and social distress manifested through slum dwelling, over-population, and related social ills such as GBV.

The GBV referral pathway in Zimbabwe was a welcome development that signified hope for the soaring numbers of cases in Zimbabwe. It is common knowledge that unitary

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and disjointed service provision falls short of meeting the multi-dimensional needs of survivors. The thrust of the service pathway represents a multi-pronged approach that addresses these gaps. Through efforts of government, local, and international stakeholders, the service network aims to respond to, reduce and prevent violence against women through a cohort of medical and counselling services, legal services, and shelter services.

The advent of the COVID-19 pandemic led to the imposition of numerous containments associated restrictions, measures that have the potential to exacerbate known drivers of GBV (UN Women, 2020b). On this note, the Women Coalition of Zimbabwe (2020) notes that there has been a 38.5 percent overall increase in reports of violence against women and girl survivors between April and May 2020. April and May 2020 was a time when there was introduced a national lockdown, confining people in their homes. The way in which the COVID-19 virus is transmitted, its level of potency in a country at a particular time, and the stark differences and exponential changes in national government responses, all demanded a higher level of flexibility and a more layered approach to GBV case management service delivery than in past pandemics.

There are various conceptualisations of Gender-Based Violence. The Inter-Agency Standing Committee (2015), defines it as as a harmful act based on socially ascribed male and female differences perpetrated against one's will. Furthermore, this includes attempted rape and rape, sexual exploitation, sexual abuse, female genital mutilation, trafficking as well as domestic violence (Simonovic, 2020). It is imperative to note that, this harmful act against the will of a person can occur in the contexts of cultural and structural inequalities between men and women.

The Gender-Based Violence referral pathway in Zimbabwe is a systematic framework for response to incidences of GBV. According to the Government of Zimbabwe's (2012) Protocol on the Multi-Sectoral Management of Sexual Abuse and Violence, the referral pathway facilitates the provision of medical and counseling services, legal services, and shelter services. Guided by the Multi-Sectoral Protocol on the Management of Sexual Abuse and Violence in Zimbabwe and the National Gender-Based Violence Strategy, the pathway seeks to ensure the coordinated efforts of stakeholders to provide comprehensive services to survivors. This study focuses on this multi-pronged approach to GBV response services provision.

There are several acts of GBV that violate a number of universal human rights protected by international conventions and instruments. Some countries criminate some forms of GBV in their national policies and laws. This also varies in how they implement their laws and policies. The term Gender-Based Violence is commonly used to emphasize how systematic inequalities between men and women characterize most forms of violence against women and girls. According to the United Nations' (1994) resolutions on the Declaration on the Elimination of Violence against Women, violence against women is any form of sexual violence that results in or is likely to cause sexual or psychological, or physical suffering to women. The author further notes that, this violence is a result of unequal power relations among men and women, and this leads to the discrimination of women. Thus, GBV is globally recognized as a human rights violation.

The South African Development Community (SADC) (2008), recognizes gender equality as a fundamental human right and an integral part of regional integration, economic growth, and social development. As such, SADC is committed to tackling all forms of gender inequality at regional and national levels through a range of objectives and actions derived from legally binding international, continental, and regional

instruments. SADC member states' commitment to gender equality is underpinned by the access and consolidation of mechanisms that promote women's human rights, such as the Convention on the Elimination of All Forms of Discrimination against Women, which became a treaty ratified by SADC in March 2004.

At an international and regional level, Zimbabwe is a party to the 1979 Convention on the Elimination of all Forms of Discrimination Against Women; the African Charter on Human and People's Rights; the 2003 Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa; the African Charter on the Rights and Welfare of the Child; the Southern African Development Community Protocol on Gender and Development 2008 and the Common Market for Eastern and Southern Africa (COMESA) Gender Policy among other regional and international instruments. In light of the above, Zimbabwe has due diligence obligations under international and regional human rights to prevent, investigate, prosecute and provide access to justice and effective remedies for GBV.

At a national level, Zimbabwe's commitment to women's participation and empowerment was explicitly shown through the drafting of the 2013 Constitution. The 2013 Constitution is based on the principle of fundamental human rights and freedoms and equality for women. Principles relating to the promotion, protection, and strengthening of women's rights in Zimbabwe include the following: Section 80; Section 85; Section 78; Section 245. The following pieces of legislation were also passed: Domestic Violence Act [Chapter 5:16]; Marriage Act [Chapter 5:11]; Criminal Law (Codification and Reform) Act [Chapter 9:23] and the Children's Act [Chapter 5:06] Matrimonial Causes Act (1987); Maintenance Act (1999); Administration of Estate Act (1997); Sexual Offences Act (2001), Education Act (2004); Labour Act [Chapter 28:01]; among others. Furthermore, in Zimbabwe GBV is not only addressed through the laws discussed above, but also through policies and strategies that have been adopted in recent years. Of particular note is the National Gender Based Violence Strategy 2012-2015 and the National Gender Policy 2013-2017.

Globally, it has been noted that access and provision of GBV services have been affected by the Covid-19 pandemic. According to Fraser (2020) many GBV service providers found securing resources pre-pandemic challenging. With the public health crisis necessitating increased investment in healthcare, there is a risk that funding for GBV life-saving support (including clinical management of rape, reproductive health, and shelter services) could have been deprioritized or diverted, at a time when they are most needed. Additionally, the author further notes that fear of infection and rising public demand for medical care may potentially make accessing GBV support services (where they are integrated and are permitted to operate) in a healthcare setting difficult.

In addition, the pandemic control measures are increasing vulnerability to GBV through the extended quarantine and other physical distancing measures were enacted to manage the pandemic situation. According to Fraser (2020), pre-existing gender inequalities and harmful norms, have combined with an increased exposure to abusers at home and economic shocks to create a potent mix for violence to thrive. An increase in reported incidents of intimate partner violence has been reported in almost all countries affected by the pandemic.

There are various agencies that offer GBV services to survivors of GBV in Zimbabwe. These include Childline Zimbabwe, Musasa Project, Real Opportunities for Transformation Support (ROOTS), Adult Rape Clinic (ARC), Women and Law in Southern Africa (WLSA), and Zimbabwe Women's Lawyers Association. The agencies

have an ethical obligation to do no harm when they address Gender-Based Violence through confidential counseling and psychosocial support services (Inter-Agency Standing Committee, 2015). These are provided by qualified social workers or counselors and are supported by trained community volunteer counselors.

Support for survivors of Gender-Based Violence also includes legal assistance. This dimension speaks to the need for justice. Survivors of Gender-Based Violence experience periods of injustice through the violation of their human rights among others. The need for justice includes information on their rights, information on how to do justice, and support in specific legal processes. Various agencies provide legal assistance to survivors of Gender-Based Violence such as the Zimbabwe Women's Lawyers Association and Care at the Core of Humanity (CATCH) Zimbabwe. Their legal aid and support services ensure that women and girls access justice and economic empowerment. In-house lawyers assist with litigation and carry out in-house counseling and systematic referrals for support services. They support income-generating projects and provide and facilitate training on entrepreneurship. Musasa project has resident lawyers and paralegals who offer legal advice and assist survivors in Gender-Based Violence related cases. Musasa project also conducts legal education campaigns to respond to gaps and issues regarding limited knowledge by women on child protection laws and procedures and women and children's rights.

Health centers may serve as the first "neutral" places to provide information and advice to women and girls on health-related services to GBV. Women may be able to access this type of information if it is within primary health care, and is not provided by specific or individual programmes. Services must also be available to provide immediate assistance to survivors to reduce the harmful consequences of sexual violence. Consequences include severe emotional and physical problems; unwanted pregnancies; abortion problems; pregnancy complications as a result of trauma or diseases; delivery problems and neonatal problems such as low birth weight, and emergency obstetric care services need to be put in place. In Zimbabwe, these services are provided by organizations such as the Adult Rape Clinic and the Musasa Project. The Musasa project ensures that women and girls who have been victims of gender-based violence have prompt access to medical treatment. They ensure that basic precautions to protect women's lives, health and well-being are in place before they begin to address GBV systematically through the routine patient screening.

A study carried out in Botswana found out that participants highlighted the importance of receiving assistance from a service provider who was sensitive to the needs of a survivor of GBV (Government of Botswana, 2017). As mentioned above, the extent of the participants' concern about confidentiality was a barrier to care. Specifically, participants mentioned feeling ashamed for others to know they had experienced violence. Participants also felt frustrated in that police were perceived as not "doing enough" to punish perpetrators. It was found out in the same study that there was greater distrust and dissatisfaction with other providers' service quality. It was reported that providers gave anecdotal evidence of police taking a long time, of unresolved cases, or of police or healthcare workers not dealing with clients sensitively. This was an especially salient concern among the providers based in schools, as exemplified by this quote from an educator.

A study conducted in Mali found out that the Covid-19 pandemic has greatly affected the access and provision of services to survivors of GBV (UN Mali, 2020). It was noted that due to its estimated impact on women's economic stability and on

households, this pandemic reduced the financial access to services. It was reported that the lack of certain means of transport to get to police and health centers and the closure of some due to illness or lack of human resources has a negative impact on access and delivery of GBV services.

The establishment of the Gender-Based referral pathway harbors positive prospects for addressing the needs of survivors in Zimbabwe through facilitating access to medical and counseling services, legal services and shelter services. The capacity of this service network to adequately address the needs of the intended clients remains a concern particularly given the economic challenges facing Zimbabwe that threaten its viability. In addition, the COVID-19 pandemic-associated response measures have exacerbating the known drivers of gender-based violence, increasing the need for services (UN Women, 2020a). The study shall therefore examine the capacity of the gender-based violence referral pathway to adequately provide services to survivors, particularly under the COVID-19 pandemic.

2. Gender Equality and Development Framework

The Gender Equality and Development Framework (GEDF) that was propounded by the World Bank (2012), is the theoretical framework that informed the study. The GEDF posits that, the relationship between economic development and gender equality is shaped by interactions within households, markets, and institutions, formal and informal. These interactions are understood to ultimately determine gender outcomes. As such, the GEDF places emphasis on designing interventions that reduce specific gender gaps. Such interventions should take into account the dynamics obtaining in formal and informal institutions, households and the functioning and structure of markets. The World Bank (2012) insists that when these factors are not taken account of, the intentions of interventions become distorted, muted and contrary.

Within the context of GBV, the Gender Equality and Development Framework allows for the conceptualization of the homogeneity of survivors and their households and the implications for service provision. The concept of decision making is related to the ability and capacity of survivors to take up and follow up on services. The second and third premises are understood as highlighting the manner in which dynamics associated with service provision shape the behavior of and are in turn shaped by individuals and households. Thus, in the context of the Epworth and Hopley communities, the Gender-Based Violence referral pathway is understood as dynamic, both shaping and being shaped by the behavior of survivors and service providers.

3. Methodology

The study was informed by a qualitative approach with a narrative design. The need to capture the life experiences, attitudes, and opinions of participants as emerging from their interaction with the referral pathway set the basis for a narrative design (Creswell, 2014). The study setting was Hopley and Epworth communities, two large informal settlements that are characterised by slum dwelling, over-population, and related urban ills that are characteristic of sprouting urban developments. These are located in Harare, a GBV hotspot with a prevalence of 23% (United Nations Population Fund, 2017). Nineteen In-depth interviewees participated in the study comprising eight participants from the Hopley community and eleven from the Epworth community conveniently selected. All participants were between the ages of 19 and 55. This age group was selected

as they could voluntarily consent at the same time the age group falls within the range of women who mostly experience GBV. A total of five key informants took part in the study, each selected from Musasa Project, Adult Rape Clinic, Childline Zimbabwe, Police VFU and ZWLA.

Data was collected through the triangulation of In-depth interviews and Key informant interviews. The authors recorded the interviews and engaged external assistants to transcribe the data from audio to written form, as well as translating from vernacular to English for ease of presentation. Verbal and written consent was sought from all the participants and key informants. Participants were informed that pseudo names would be used in presenting the findings of the current study. The transcribed data was grouped into thematic sets based on the key study objectives. Codes were developed which informed the categorization of themes. Thematic content analysis was then used to interpret the data. Thus the presentation of findings is in line with the themes that emerged.

4. Findings

The main objective of the study was to determine the capacity of the GBV referral pathway to address the needs of survivors during the COVID-19 pandemic on the delivery and access to GBV services. The data collected through in-depth interviews and key informant interviews are presented. In line with the provisions of provisions of privacy, anonymity and confidentiality ethical considerations, pseudonyms were used to protect their identity and privacy.

4.1. Demographic characteristics of participants

It is imperative that the backgrounds of the participants who took part in the study be outlined as this will provide a context in which to assign meaning to their experiences. Table 1 highlights the socioeconomic characteristics of the participants.

The majority of the participants, 84%, were aged between 19 and 45 years. However, over half of them, 58%, reported that they were aged between 19 and 35 years (Table 1). Age groups 36-45 and 46-55 comprised 26% and 16% respectively of the sample. The sample was universally educated. However, the majority of the participants, 58%, reported that they had only completed primary school education. A fairly large proportion of the participants, 37%, reported that they had completed secondary school education and only 5% had attained tertiary level education.

Married participants dominated the sample. Slightly above four-tenths of the participants, 42%, reported that they were married. However, a significant proportion of the participants, 31%, reported that they were cohabitating. Those that were divorced and single comprised 11% of the sample each. Only a small proportion of the participants, 5%, reported that they were widowed. The majority of the participants 68% were not involved in any form of employment activities, while 32% were engaged in income-generating activities.

Table 1: Participants' demographic and socio-economic characteristics

Demographic characteristics	Percentage
Age group	
18 and below	0
19-35	0.58
36-45	0.26
46-55	0.16
Total	**1.00**
Marital status	
Single	0.11
Married	0.42
Cohabiting	0.31
Widowed	0.5
Divorced	0.11
Total	**1.00**
Level of education	
No formal education	0
Primary	0.58
Secondary	0.37
Tertiary	0.5
Total	**1.00**
Employment	
Self-employed	0.32
Formally employed	0
Unemployed	0.68
Total	**1.00**

N=19

4.2. The capacity of services to address the needs of survivors

The researchers sought to determine the capacity of services offered by the GBV referral pathway to address the needs of survivors in the Epworth and Hopley communities. The participants were asked if, through their direct experience, they considered the available services adequate in meeting their needs. With regards to health services, all the 19 participants highlighted that the health centres in their areas, as well as the Central hospital in the capital Harare (Parirenyatwa Group of Hospitals), offered some form of medical support to survivors of Gender-Based Violence. The findings also show that, four (4) of the participants however submitted that accessibility to medicine and other amenities was subject to one having enough finances to secure such on their own. As noted by Martha aged 31 from Epworth, one of the participants,

> *"If you have experienced Gender-Based Violence, you can get some help from the hospitals. But if you require medicine, especially the expensive kind, they will just give you a prescription and you have to find it yourself"*

In a related way, Chipochashe aged 25 from Hopley, another participant, submitted that,

> *"If you are given a prescription from the hospital and you don't have the money, it is difficult to ask your husband if he is the one who caused the injuries."*

With respect to policing services, participants generally felt there was a huge letdown due to corruption-related and lack of empathy-associated reasons. Anesu aged 29 from Epworth, one of the participants, highlighted that,

"The police will help you if you have the money to pay them. If the person who wronged you has more money, then your case will not go anywhere."

Furthermore, Clara aged 37 from Epworth submitted that,

> *I went to the police and they asked me what was my issue, then I told them I can't stay home my husband has burnt my clothes, then they told me if I had anything to give them so that I can be accompanied by a policeman to bring my husband to the police station, then I said I don't have anything, then they just wrote me a letter only.*

Such sentiments were echoed by Mufaro aged 19 from Hopley, another participant,

> *Ahh, it is quite far for me to walk to the roundabout, sometimes I would have experienced gender-based violence in the evening, for me to walk alone it will be quite difficult, when I arrived they asked me if I had some money for them to arrest my husband, yes this is what I went through.*

Further, Tinotenda aged 39 from Epworth, another participant, mentioned that,

> *People in the community do not go to the police anymore because they do not offer any help. Rather we seek help from friends, elders in our community, or church through Pastors and Deacons.*

Such sentiments of displeasure were echoed by other participants from Hopley,

> *I no longer go to the police to report when I am beaten up by my husband, it is a waste of time. My sister's husband paid the police and was not arrested. I am scared to go to the police because it may actually reduce my morale and self-esteem, I heard that they laugh at you and they don't take you seriously*

Such complaints of corruption averting justice for survivors were highlighted by all the 19 participants, either in respect to their personal experiences or in cases from the community. Tinofara aged 23 from Epworth, one of the participants, submitted that,

> *... the police generally lacked "feeling" for survivors. As such, their handling of cases was associated with certain "looks, tones, and judging" that made the survivors uncomfortable and unnecessarily feel they "owed" the police for help.*

The capacity of legal services to address the needs of survivors was another key issue central to the study. The participants were asked the extent to which they considered legal services rendered to them able to meet their needs. 2 of the three participants who had received legal aid support services noted that the services were able to address their needs when they experienced GBV. One of the participants from Epworth, Thabiso aged 28 years, reported that; *"I was assisted by ZWLA to get a peace order against my husband."* Similarly, Memory aged 30 from Hopley submitted that *"Zimbabwe Women's Lawyers Association helped me with the custody arrangements for her children.*"

The other participant who had received legal aid services, Chenai aged 38, reported that her first encounter with ZWALA left her with a negative experience as she was ignored and felt that her dignity as a person was undermined. She however stated that "*..the way they treated me improved after I told them I had been referred by another organisation and I was going back to tell them how I had been treated."*

The researchers were also interested in determining the capacity of shelter and counselling services to adequately cater for the psycho-social needs of the participants in

the Hopley and Epworth communities. The four participants who had received shelter services were asked if they considered the services, they received to be adequate in addressing their needs at the time of experiencing GBV. The findings show that all four participants acknowledged the role that the provision of shelter played in helping them cope with the situation. As highlighted by Mary aged 20 from Hopley,

> *At that time I didn't have anywhere to go as my friends could not give me a place to say after I had an altercation with my husband. But the church gave me a place to sleep over and a meal the next morning. I don't think I would have managed well that night."*

The other three participants shared similar tales.

With respect to counselling services, the researcher asked the 6 participants who had received such services if they considered the services rendered adequate in addressing their emotional well-being. In response, all the participants testified that the counselling services they received from various organisations including Musasa Project enabled them to deal with the complex and sensitive issues that they were facing at the time. In the case of Chioniso aged 29 from Hopley, one of the participants who experienced intimate partner violence, submitted that,

> *"When I had issues with my partner when we were planning to get married, I couldn't tell anyone what had happened. Even thinking about it was so hard for me. But when I received counselling services from a church-based organisation in our area, I was able to have peace with myself and share the ordeal with some of my relatives. I am much better now."*

Similarly, the other five participants presented their experiences in which counselling services rendered helped them come to terms with their situations and to move on with life.

4.3. Impact of covid-19 on the delivery of and access to services

Given the unprecedented changes and negative impact brought about by the COVID-19 pandemic on all aspects of human service delivery, it was expedient for the researchers to solicit the views of the participants on the manner in which the pandemic had impacted on the delivery of and access to services. As participants are on the receiving end of the service provider network, the researchers posed questions relating to access to services to them. On the other hand, the five key informants provided feedback relating to the manner in which the COVID-19 pandemic affected the delivery of services through the GBV referral pathway.

The feedback from the participants identified several militating factors brought about by the COVID-19 pandemic. These were mostly related to the restrictions on movement brought about by the numerous and ongoing lockdowns imposed by the government as a way to curb the spread of the virus. One participant, Chipochashe aged 42 from Epworth, argued that,

> *"It was difficult even to go and report the case to the police because you could come across soldiers in Epworth and they will chase you away without giving you a chance to say anything."*

On this note, Tinofara aged 32 from Hopley submitted that,

> *"People in the communities generally disregarded the lockdowns and went about their activities. But going to areas like the police station and into town, or where some organisations are located you would meet roadblocks and the police wouldn't let you through."*

In corroboration, Memory aged 40 from Epworth noted that,

> *"We were not doing much business so money to travel or call was difficult to come by. And even if you would want to go to the organisations, there would be no one there."*

The five key participants provided feedback relating to the delivery of services through the GBV referral pathway. They noted similar challenges as raised by the participants, particularly in relation to the national lockdowns. One of the key informants submitted that,

> *"It was not easy to work from home and provide services through technology. Sometimes the resources are difficult and at times you cannot reach the people in need."*

Another key informant highlighted that,

> *"Working from home is not conducive to providing services like counselling. Some of the issues are very private and you don't really have the space to talk about them having children and people at home running around."*

Further, another key informant noted that,

> *"The pandemic led to the imposition of lockdowns which affected the operation of GBV service providers, most of them were closed, that is, the courts. The restriction of movement prevented clients from accessing services, hence many cases went unreported, and some rape victims could not access urgent services like PEP. Up to now, the courts have a backlog of cases which need to go to trial".*

Another key informant submitted that,

> *"COVID-19 has greatly affected our services, us the police because we have been receiving late responses and some cases have gone unreported, and there has also been a postponement of cases at court because it was difficult for the police to get transport to move from one place to another to do their investigations"*

5. Discussion of findings

The biographical information of the participants provided some background into the context in which the participants were situated. This enabled the researcher to make inferences relating to the characteristics of the participants. The majority of the participants, 19, were women. The gendered trends of reporting and seeking services for male survivors of Gender-Based Violence reveal that men continue to find it challenging to speak out against violence against them. This relegates them to the periphery of discourses on gender-based violence, both as victims and as partners. Understood within the Gender Equality and Development Framework, such trends reveal gaps that require focused interventions to address the social and cultural factors that relegate men to the periphery of utilising services through the Gender-Based Violence referral pathway.

The manner in which the COVID-19 pandemic affected access to and delivery of services through the Gender-Based Violence referral pathway was found to be largely deleterious. In particular, the national lockdowns, though arguably effective in combating

the spread of the virus in some spaces, largely promotes a breeding ground for abuse and a culture of silence and under-reporting. As such, the interaction between the people, the survivors, and services, as conceptualised through the GEDF is inhibited resulting in even greater gender parities. This has also been corroborated by UN Women (2020, 4) who observe that the COVID-19 pandemic has worsened the known drivers of GBV. As such, the study notes that in the absence of other supportive measures, lockdowns have a devastating impact with regards to promoting GBV, thereby endangering the lives of key populations such as women, young girls, and the poor.

Corruption emerged a pervasive issue, both relating to the delivery of and access to services. In particular, policing services are observed to be heavily compromised by wanton corruption. Given that all the participants had something negative to say about the nature in which police officers, particularly those outside of the Victim Friendly Unit, handled cases, the severity of the issue becomes evident. As such, the reports given by the participants cease to be isolated incidences and rather point to an unwanted travesty of justice. This corroborates with findings in a study carried out in Botswana where it was reported that participants gave anecdotal evidence of police taking a long time, of unresolved cases, or of police or healthcare workers not dealing with clients sensitively (Government of Botswana, 2017). In the same light, the calls by both the participants and key informants for feedback mechanisms and independent oversight become critical. In the context of the COVID-19 pandemic, such practices cannot be tolerated as the vulnerability of survivors becomes pronounced. Understood within the GEDF, such a context presents barriers to critical interactions between the people and critical institutions that allow for emancipation of those that are acutely vulnerable.

The study, therefore, established that, with regards to the capacity of the referral pathway to meet the needs of the participants, the study found that health and medical services were largely adequate except in the case of cases in which expensive medicine was required. This corresponds with findings from a study carried out in Botswana where it was reported that medical and health services were largely adequate in addressing the need of GBV survivors. Police services were generally noted to be inadequate, particularly due to the prevalence of corruption. For participants who accessed legal aid services, these seemed to be adequate in addressing their needs. Shelter and counselling services were also identified as critical in enabling the participants to cope with the pressures associated with their experiences.

Relating to the manner in which the pandemic had negatively impacted the delivery of and access to services, several militating factors were identified by the participants mostly relating to resource limitations and restrictions on movement brought about by the numerous and ongoing lockdowns imposed by the government as a way to curb the spread of the virus. Services were out of reach of the participants and the ability of service providers to reach the survivors was heavily compromised. This is conforming findings from a study carried out in Mali where it was reported that the lack of certain means of transport to get to police and health centers and the closure of some due to illness or lack of human resources have a negative impact on access and delivery of GBV services (UN Mali, 2020). The emerging trends promoting working from home do not provide a conducive space for helping professionals to attend to the sensitive and confidential cases of the survivors.

6. Conclusions

In light of the findings of the study as given by the participants and key informants, the study reaches particular conclusions. The capacity of medical and health, legal, and counselling services provided through the Gender-Based referral pathway are largely adequate. Policing services are compromised through rampant corruption. Shelter services are largely unknown though provide adequate services to the few who receive them. The national lockdowns make it difficult for survivors to access services and in turn the service providers to reach clients. In respect of the study findings and conclusions, it is recommended that government should provide adequate mechanisms for the coordination and monitoring of services. Appropriate measures should be put in place to encourage and support reporting and uptake of services during lockdowns.

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