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DEPARTMENT OF SOCIAL WORK

INTERVENTION STRATEGIES ON THE EFFICACY OF GBV SERVICES IN RURAL AREAS IN ZIMBABWE. A CASE OF NGORIMA VILLAGE IN CHIMANIMANI DISTRICT

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A DISSERTATION SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR BANCHELOR OF SOCIAL WORK HONOURS DEGREE IN SOCIAL WORK

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DECLARATION AND RELEASE FORM

I Fortunate Tsododo, a registered student for the Bachelor of Science (Honours) Degree in Social Work at Bindura University of Science Education, fully aware that plagiarism constitutes a grave academic violation and that the falsification of research information is a fundamental breach of Social Work professional ethics, do solemnly declare that,

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Having reviewed this dissertation, the Department Board of Examiners confirms that the work submitted by Fortunate Tsododo entitled **Intervention Strategies on the Efficacy of GBV Services in Rural Areas in Zimbabwe: A Case of Ngorima Village in Chimanimani District**, satisfactorily meets all prescribed academic and examination standards. The Board therefore endorses this study for formal acceptance by Bindura University of Science Education as part of the requirements for the award of the Bachelor of Science (Honours) Degree in Social Work.

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DEDICATION

This dissertation is dedicated to the Almighty God, whose grace and strength carried me through every step of this journey. To the Tsododo family, thank you for your boundless love, unwavering support and endless sacrifices. To all women and girls in rural areas who silently endure the pain of gender-based violence, this work is for you - you are seen and you matter.

ABSTRACT

Gender-based violence (GBV) remains a pervasive challenge in rural communities of Zimbabwe, where access to and utilisation of intervention services were severely constrained by geographic, cultural and socio-economic barriers. This study investigated intervention strategies and their efficacy in addressing GBV in rural areas, with a specific focus on Ngorima Village in Chimanimani District, with an aim of proposing strategies to improve GBV service utilization in rural communities. A convergent parallel mixed method design was adopted combining a household survey of 50 respondents with 5 key informants interviews and 5 focus group discussions involving 30 participants drawn from community members, service providers, traditional leaders and relevant stake holders. Data were analysed through descriptive statistics using SPSS and thematic analysis. Findings revealed that existing strategies included awareness campaigns, traditional leaders engagement, health facility support and VFU services with 96% respondents aware of at least one GBV programme. However, only 10% reported that they or a household member had sought GBV related assistance. This exposed a critical awareness-utilisation gap. Cultural beliefs, distance to services, fear of stigma and economic dependency on perpetrators were the primary barriers to help seeking. These findings indicated that knowledge of services alone was insufficient to drive survivor action, consistence with broader evidence on GBV service gaps in Sub-Saharan Africa. The study concluded that effective rural GBV intervention required integration of norm transformation, economic empowerment, mobile service delivery and coordinated referral systems. Government ministries, traditional leaders, NGOs, social welfare institutions and health services were recommended to adopt a community centered rural GBV model to bridge the identified awareness-utilisation gap.

ACRONYMS

GBV	Gender-Based Violence
VFU	Victim Friendly Unit
NGO	Non-Governmental Organisation
WHO	World Health Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
SADC	Southern African Development Community
MWACSMED	Ministry of Women Affairs, Community, Small and Medium Enterprises Development
IDLO	International Development Law Organization
SVRI	Sexual Violence Research Initiative
SPSS	Statistical Package for the Social Sciences
IBM	International Business Machines
SDG	Sustainable Development Goal
ZDHS	Zimbabwe Demographic and Health Survey
ZIMSTAT	Zimbabwe National Statistics Agency
LMIC	Low and Middle Income Countries
UN	United Nations
UNDP	United Nations Development Programme
UNODC	United Nations Office on Drugs and Crime
RAD	Refugee Aid and Development
OAU	Organisation of African Unity
AU	African Union

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CHAPTER ONE: INTRODUCTION TO THE STUDY

1.1 Introduction

Gender-based violence (GBV) remains a major social, public health and human rights concern in Zimbabwe. Its effects are more visible in rural communities where distance, poverty, cultural expectations and limited service coverage can restrict access to protection and support. In Ngorima Village in Chimanimani District, the problem is shaped by local social norms, uneven access to formal services, fear of stigma and the practical difficulty of reaching police, health, legal and psychosocial support systems. This study therefore examines how existing GBV intervention strategies are functioning in this rural setting and how they can be strengthened.

GBV refers to violence directed at a person because of that person's gender, or violence that affects persons of a particular gender disproportionately (European Commission, 2022). It may include physical, sexual, psychological, emotional and economic harm. Although men and boys can also experience GBV, women and girls remain disproportionately affected because GBV is closely connected to gender inequality, unequal power relations and harmful social norms (WHO, 2024). The World Health Organization estimates that nearly one in three women worldwide experience partner or non-partner sexual violence during their lifetime (WHO, 2024). This global burden confirms that GBV is not a private family matter but a structural problem requiring coordinated prevention, response and accountability systems.

Zimbabwe has developed legal, policy and institutional measures for addressing GBV. These include the Domestic Violence Act, victim-friendly services, health facility support, community awareness programmes, referral systems and multi-sectoral coordination structures. The Zimbabwe National Strategy to Prevent and Address Gender-Based Violence 2023-2030 provides a national framework for prevention, care and support services, capacity strengthening, evidence-based programming, coordination and resource mobilisation (United Nations Population Fund [UNFPA] Zimbabwe, 2023). However, the existence of laws and strategies does not automatically mean that survivors in rural areas receive timely, confidential and effective support. Implementation gaps remain a major concern, especially where services are distant, under-resourced or poorly coordinated.

This study focuses on intervention strategies and the efficacy of GBV services in Ngorima Village. It assesses the strategies already known or used in the community, examines whether they are meeting survivors' needs, and proposes measures for improving GBV prevention and response in rural Zimbabwe. The chapter presents the background of the study, statement of the problem, justification, aim, objectives, research questions, significance, hypotheses, , key terms and dissertation structure.

1.2 Background of the Study

GBV is a global problem with social, cultural, economic, legal and political causes. It is rooted in unequal power relations and is reinforced when communities tolerate violence, silence survivors or treat abuse as a private matter. Poverty, conflict, displacement, low access to education and weak law enforcement can increase vulnerability, especially among women and girls. The nature of GBV therefore requires intervention strategies that go beyond awareness. Effective responses need prevention, survivor-centred care, justice, psychosocial support, community mobilisation, referral systems and long-term work to change harmful social norms.

At the global level, GBV interventions are increasingly framed through rights-based, gender-transformative and survivor-centred approaches. The Sustainable Development Goal framework places gender equality and freedom from violence at the centre of inclusive development. Current global evidence also shows that community and group-based interventions can reduce women's exposure to recent intimate partner violence when they engage communities, address gender norms and use participatory methods (Keith et al., 2023). This means that rural GBV programming should not rely only on short campaigns. It should build sustained community dialogue, involve men and boys, strengthen women's agency and link prevention work with practical support services.

Technology-facilitated GBV has also become a growing concern. The expansion of digital communication has created new spaces where harassment, threats, coercion and humiliation can occur (UNFPA, 2025). The UN Women Data Hub identifies a global increase in measures addressing technology-facilitated violence against women and girls (UN Women Data Hub, 2024). Although Ngorima Village is a rural setting, the growth of mobile phones, social media and digital messaging means that GBV interventions should also include basic digital safety awareness and reporting pathways for online abuse. This is especially relevant for young women and girls who may be exposed to both offline and online forms of violence.

At the regional level, Southern Africa continues to treat GBV as a major barrier to gender equality, peace and development. The Southern African Development Community (SADC) promotes integrated approaches that combine prevention, early identification, survivor support, coordination, monitoring and community-level action. The SADC handbook on effective GBV prevention initiatives stresses the need for evidence-based programming, community mobilisation, engagement with men and boys, work with traditional and faith leaders and continuous monitoring and evaluation (SADC, 2022). These regional priorities are relevant to Zimbabwe because rural communities often rely on local leaders, churches, family networks and informal support structures before survivors approach formal institutions.

In Zimbabwe, GBV is recognised as a national development, justice and public health issue. The Zimbabwe National Strategy to Prevent and Address Gender-Based Violence 2023-2030 identifies persistent gaps that include weak coordination, limited resources, patriarchal values, inadequate awareness of rights and weak help-seeking behaviour (UNFPA Zimbabwe, 2023). To address the issue comprehensively the strategy promotes a combination of preventive actions, support services for affected individuals, institutional capacity development, coordinated stakeholder engagement, evidence informed decision making and acquisition of financial and material resources. These priorities are relevant to Ngorima Village because rural GBV services can only work if national frameworks are translated into accessible community-level action.

One Stop Centres and mobile One Stop Centre models have become important response mechanisms in Zimbabwe. They are designed to bring medical, psychosocial, legal and referral services closer to survivors. UNFPA Zimbabwe reported that mobile One Stop Centre services in Bubi District improved access to GBV care for marginalised women and girls by bringing support directly to communities (UNFPA Zimbabwe, 2024). This model is relevant to remote communities such as Ngorima Village because physical distance from service points can discourage reporting and delay support. However, such models require trained staff, confidentiality, transport, follow-up systems and reliable community referral networks if they are to be effective.

Ngorima Village has specific local conditions that make the study necessary. According to Chingombe and Musarandega (2021), the area was affected by Cyclone Idai in 2019 and this increased vulnerability by disturbing livelihoods, infrastructure and community support systems. Mobile service teams, clinic-based support, community volunteers, traditional leaders, ward

leaders, local organisations, radio discussions, sports-based awareness activities and GBV billboards have been used to raise awareness and improve reporting. These activities show that GBV intervention work is present in the area. The key question is whether these interventions are effective, accessible, trusted and sustainable for survivors.

The present study therefore examines the efficacy of existing GBV services in Ngorima Village. It does so by considering both formal and community-based strategies. Formal strategies include legal aid, police services, health services, psychosocial support and referral pathways. Community strategies include awareness campaigns, local leadership engagement, radio messaging, faith-based mobilisation, volunteer support and public education. The study takes the position that effective GBV intervention in rural Zimbabwe should be culturally sensitive without excusing harmful practices, survivor-centred without exposing survivors to stigma, and coordinated without leaving responsibility to one institution.

1.3 Statement of the Problem

GBV continues to affect women and girls in rural Zimbabwe despite the presence of government, non-governmental and community-based intervention strategies. In Ngorima Village, programmes such as awareness campaigns, community education, referrals, legal support, psychosocial support and engagement with local leaders have been introduced to prevent and respond to GBV. However, these strategies have produced uneven results. Survivors may still face long distances to services, fear of stigma, limited confidentiality, weak referral systems, limited transport, low awareness of rights and cultural pressure to remain silent. The persistence of GBV in Ngorima Village suggests that existing interventions may not be fully addressing the social, cultural and practical realities of the area. Patriarchal attitudes, economic dependence, limited education opportunities, fear of family breakdown, weak law enforcement and inadequate survivor support can reduce the effectiveness of GBV services. When interventions are not properly coordinated, survivors may move from one service point to another without receiving complete care. When awareness programmes are not linked to reporting and support mechanisms, they may increase knowledge without changing behaviour or improving survivor protection. The problem affects more than individual survivors. GBV undermines education, health, family stability, community participation and local development. It can reduce women’s ability to participate in economic activities and community decision-making. It also affects children, caregivers and wider family

networks. Despite this, limited research has examined how GBV intervention strategies operate in Ngorima Village and whether survivors and community members view them as effective. This creates a knowledge gap. The study responds to this gap by examining current intervention strategies, assessing their efficacy and identifying practical measures for strengthening GBV services in rural Zimbabwe.

1.4 Justification of the Study

This study is justified by the continuing need to strengthen GBV prevention and response in rural Zimbabwe. Although national and regional frameworks exist, rural communities often experience implementation gaps because of limited resources, long distances, stigma and weak institutional coordination. Research focused on Ngorima Village can show how these challenges appear at community level and how services can be improved within a real rural context.

The study will contribute to the limited body of knowledge on GBV intervention strategies in rural Zimbabwe. Much of the available literature discusses GBV at national, regional or general community level. Less attention is given to remote villages where cultural norms, geography and local power structures influence reporting and service use. By focusing on Ngorima Village, the study will provide context-specific evidence that can guide social workers, local leaders, policy actors and non-governmental organisations.

The study is also justified because effective GBV intervention requires evidence. Current research on GBV interventions in sub-Saharan Africa shows that participatory, community-based and gender-transformative programmes are more promising when they are sustained and linked to existing platforms (Keith et al., 2023). This supports the need to assess whether current strategies in Ngorima Village are short-term awareness activities or integrated systems capable of reducing harm, improving reporting and supporting survivors.

1.5 Aim of the Study

The aim of the study is to propose intervention strategies that can improve the efficacy of GBV services in rural Zimbabwe, using Ngorima Village in Chimanimani District as a case study.

1.6 Objectives of the Study

The objectives of the study are to:

- To explore five current intervention strategies implemented by NGOs, government and community leaders to curb GBV in Ngorima village by May 2026.
- To examine the efficacy of the current GBV interventions strategies in Ngorima Village by measuring survivor service uptake, reporting rates and community awareness level among 50 households by May 2026.
- To propose five intervention strategies by May 2026 that can be utilized to improve and reduce GBV cases in Ngorima village over a 12 month pilot period.

1.7 Research Questions

The study is guided by the following research questions:

- What are the current GBV intervention strategies implemented by NGOs, government and community leaders to curb GBV in Ngorima village, Chimanimani district?
- How effective are the current GBV intervention strategies in Ngorima village in terms of survivor uptake, reporting rates and community awareness levels?
- What evidence based intervention strategies can be proposed to address identified gaps and improve GBV service delivery to reduce GBV cases in Ngorima village and similar rural areas in Zimbabwe?

1.8 Significance of the Study

The study is significant because it will provide evidence that can help improve GBV intervention practice in rural communities. Its findings may support more responsive prevention and survivor support systems by showing which strategies are known, accessible, trusted and effective in Ngorima Village. The study may also help identify service gaps that require attention from government departments, Non-Governmental Organisations, traditional leaders, community-based organisations and social workers.

For the researcher, the study strengthens skills in social research design, field engagement, data collection, data analysis and critical evaluation of intervention strategies. It also contributes to academic development by linking classroom knowledge in social work to a real community problem. Through this process, the researcher gains practical understanding of how policy, culture, service delivery and community participation interact in rural GBV response.

For the community, the study may help increase attention to GBV prevention, reporting and survivor support. It may assist community members, local leaders and service providers to understand barriers that discourage survivors from seeking help. The findings may also support community dialogue on harmful norms, stigma, confidentiality and survivor dignity.

For policy makers and practitioners, the study may provide context-specific recommendations for improving rural GBV services. These recommendations may support stronger referral systems, better coordination, more accessible service delivery, targeted awareness, and improved use of local structures. Since the Zimbabwe National GBV Strategy emphasises coordinated, accessible and responsive services, local evidence from Ngorima Village can help translate national policy into community practice (UNFPA Zimbabwe, 2023).

For future scholars, the study may serve as a reference point for further research on GBV services in rural communities. It may also inform comparative studies across districts or provinces in Zimbabwe. By documenting local experiences, the study helps expand the literature on rural GBV intervention efficacy.

1.9 Hypotheses of the Study

The study is guided by the following hypotheses:

There is a significant relationship between existing GBV intervention strategies and the reduction of GBV cases.

Improved intervention strategies are associated with reduced violence when they are effectively implemented.

Cultural norms, stigma and resource constraints negatively affect the effectiveness of GBV strategies in Ngorima Village.

Accessibility of GBV services positively influences survivor utilisation of those services in Ngorima Village.

1.10 Definition of Key Terms

Gender-based violence refers to violence directed at a person because of that person's gender, or violence that affects persons of a particular gender disproportionately. It includes physical, sexual, psychological, emotional and economic harm (European Commission, 2022).

Intervention strategies refer to planned actions, programmes, services, policies or community measures designed to prevent GBV, respond to survivors' needs, reduce risk, promote accountability and strengthen protection systems. In this study, the term includes awareness campaigns, referral systems, counselling, legal support, health services, community mobilisation, safe spaces, leadership engagement and multi-sectoral coordination (SADC, 2022; UNFPA Zimbabwe, 2023).

Efficacy refers to whether an intervention works under ideal or highly supported conditions. **Implementation effectiveness** refers to how the same intervention performs in real-world settings where resources, staffing and coordination may be limited (Nilsen et al., 2025). In this study, efficacy is used to examine whether GBV services in Ngorima Village are perceived to meet their intended purpose of prevention, response and survivor support.

Rural areas refer to communities outside major urban centres where settlements are often dispersed and where access to transport, health services, justice systems, digital connectivity and specialised support may be limited. In this study, Ngorima Village is treated as a rural setting because service access and geographical distance shape the way GBV interventions are used.

Survivor refers to a person who has experienced GBV. The term is preferred because it recognises dignity, agency and continued life beyond the abuse. In this study, the term includes people who have accessed services and those who have not reported or received formal support. **One Stop Centre** refers to an integrated GBV service model intended to provide or coordinate medical, psychosocial, legal, justice and referral services for survivors in a more accessible and survivor-centred manner. Mobile One Stop Centres extend these services to communities that are far from fixed service points (UNFPA Zimbabwe, 2024).

1.11 Dissertation Structure

Chapter One introduces the study. It presents the background, statement of the problem, justification, aim, objectives, research questions, significance, hypotheses, definitions of key terms and dissertation structure.

Chapter Two reviews literature related to GBV and intervention strategies. It discusses global, regional, national and local perspectives on GBV, theoretical frameworks, current intervention models, service efficacy and research gaps relevant to rural Zimbabwe.

Chapter Three presents the research methodology. It explains the research design, research approach, research philosophy, study area, target population, sampling procedures, data collection methods and tools, data analysis procedures, ethical considerations and limitations and delimitations of the study and also trustworthness of the methodology.

Chapter Four presents and analyses the research findings. It reports the data collected from Ngorima Village and interprets the results in relation to the study objectives and research questions.

Chapter Five provides the summary, conclusions and recommendations. It links the findings to the research objectives and proposes practical strategies for strengthening GBV services in rural Zimbabwe.

1.12 Chapter Summary

This chapter introduced the study on intervention strategies and the efficacy of GBV services in Ngorima Village, Chimanimani District. It established that GBV remains a serious social, public health and human rights issue in rural Zimbabwe despite existing legal, policy and community-based responses. The chapter showed that rural survivors may continue to face barriers such as stigma, distance, weak referral systems, limited confidentiality, cultural pressure and resource constraints. It also presented the study's aim, objectives, research questions, hypotheses, significance, limitations, delimitations and definitions of key terms. Overall, the chapter provides the foundation for Chapter Two, which reviews literature on GBV interventions and the theoretical frameworks guiding the study.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

This chapter reviews literature on gender-based violence (GBV) and the efficacy of intervention strategies in rural Zimbabwe. It strengthens the study by linking the research problem to current theoretical, empirical and policy debates. The discussion focuses on the causes of GBV, the available prevention and response strategies, the effectiveness of those strategies, and the gaps that remain in rural communities such as Ngorima Village in Chimanimani District.

Current evidence shows that GBV is a public health, human rights and development problem. The World Health Organization reports that about one in three women globally have experienced physical and/or sexual violence by an intimate partner or non-partner sexual violence in their lifetime (World Health Organization [WHO], 2024). In Zimbabwe, recent demographic evidence also confirms that GBV remains a major concern. The 2023-24 Zimbabwe Demographic and Health Survey reported that 27% of women aged 15 to 49 had experienced physical violence since age 15, while 9% had experienced sexual violence at least once in their lifetime (ZIMSTAT & ICF, 2025).

The chapter uses feminist theory and the socio-ecological perspective as its analytical lenses. Feminist theory helps explain how unequal gender power relations, patriarchal norms and economic dependency make women and girls vulnerable to violence. The socio-ecological perspective explains how GBV is sustained through interacting factors at individual, relationship, community and societal levels. These two lenses are useful because the study is concerned not only with whether GBV interventions exist, but also with how rural conditions influence their effectiveness.

2.2 Theoretical Framework

The theoretical framework guides the interpretation of GBV as a social problem and provides a basis for evaluating intervention strategies. A strong framework is necessary because GBV cannot be explained by a single cause. It is shaped by unequal power relations, household dynamics, cultural expectations, institutional capacity, economic stress and access to justice. The study therefore combines feminist theory and the socio-ecological perspective because they address both structural gender inequality and the multiple levels at which violence is produced and prevented.

Feminist theory is used to examine the gendered power relations that create conditions for violence against women and girls. The socio-ecological perspective is used to assess how individual, relational, community and societal factors interact to influence service access, reporting and survivor protection. Together, the two theories support a broad evaluation of GBV intervention strategies in Ngorima Village.

2.3 Feminist Theory

Feminist theory explains GBV as a product of unequal gender power relations rather than as a private family matter or isolated personal conflict. From this perspective, violence is connected to patriarchy, gender norms, economic dependency and the social control of women's choices. This approach is relevant to rural Zimbabwe because community expectations may place women in subordinate positions, limit their decision-making power and discourage public reporting of abuse.

Recent Zimbabwean literature supports this interpretation. Chikhungu and Bengesai (2024) reviewed empirical studies on violence against women and girls in Zimbabwe and found that intimate partner violence and child marriage remain persistent public health concerns. Their review also shows that gaps remain in intervention evaluation, marginalised groups, non-partner violence and long-term regional comparisons. These gaps matter for this study because they show that rural GBV services cannot be evaluated only through national statistics. They must also be understood through local experiences and service barriers.

The Zimbabwe National GBV Strategy 2023-2030 also identifies patriarchal values, attitudes and practices as barriers to the implementation of GBV laws and services (UNFPA et al., 2023). This supports the feminist argument that GBV interventions must address social norms and power relations, not merely provide formal services. A police station, clinic or referral system may exist, but its effectiveness is weakened when survivors fear blame, rejection, family pressure or economic abandonment.

Feminist theory therefore helps this study examine whether intervention strategies challenge or reproduce gender inequality. For example, community awareness campaigns may be effective when they question harmful norms, involve men and boys, and support women's agency. They may be less effective when they only advise survivors to report violence without addressing the social and economic consequences of reporting. The theory also helps assess whether service providers treat survivors with dignity, confidentiality and respect.

2.4 Relevance of Feminist Theory to the Study

Feminist theory is relevant because the study focuses on the efficacy of GBV intervention strategies in a rural setting where gender relations, cultural expectations and economic dependency may influence service use. It explains why survivors may remain silent even when formal laws exist. It also explains why some families and community actors may prefer reconciliation over protection, particularly when the perpetrator is a husband, partner or family breadwinner.

The theory provides a basis for evaluating whether GBV services are survivor-centred and gender-sensitive. A survivor-centred intervention should reduce secondary victimisation, protect confidentiality, support informed decision-making and avoid blaming the survivor. This is consistent with the survivor-centred justice approach promoted in current international guidance, which stresses that justice systems must reduce secondary harm and respond to the lived needs of survivors (International Development Law Organization [IDLO], 2022).

In this study, feminist theory will be used to interpret how patriarchal norms in Ngorima Village shape women's vulnerability, reporting behaviour and access to protection. It will also assist in assessing whether legal, psychosocial, community and referral interventions address the underlying power relations that sustain GBV.

2.5 Socio-Ecological Perspective

The socio-ecological perspective explains GBV as the outcome of interacting influences at different levels of social life. Current public health literature identifies risk factors at the individual, relationship, community and wider societal levels (WHO, 2024). This makes the perspective suitable for studying GBV in rural communities, where violence is influenced by personal histories, intimate relationships, family expectations, local leadership, service availability, economic conditions and national policy implementation.

At the individual level, factors such as knowledge of rights, fear, prior exposure to violence, alcohol misuse, stress and personal attitudes towards violence may affect both the risk of GBV and the likelihood of seeking help. At the relationship level, partner control, marital conflict, economic dependence and household decision-making patterns may increase vulnerability. At the community level, distance to services, local norms, religious influence, stigma, village leadership practices and the presence or absence of support structures shape intervention outcomes. At the

societal level, laws, economic policy, gender inequality, national coordination and funding determine how far local services can operate.

The socio-ecological perspective is also consistent with Zimbabwe's national GBV policy direction. The Zimbabwe National GBV Strategy 2023-2030 recognises GBV as a complex and multi-faceted phenomenon that requires a coordinated multi-sectoral response (UNFPA et al., 2023). This confirms that no single intervention can be sufficient on its own. Effective GBV response requires coordination among police, health services, social welfare, schools, community leaders, legal aid providers, NGOs and development partners.

2.6 Relevance of the Socio-Ecological Perspective to the Study

The socio-ecological perspective is relevant because the study investigates GBV services in a rural community where barriers occur at several levels. A survivor's decision to report violence may depend on personal knowledge, family reactions, transport availability, community attitudes and confidence in police or social welfare structures. A clinic may offer post-violence care, but distance, cost and stigma may prevent survivors from accessing it in time. A legal framework may protect survivors in principle, but weak enforcement may reduce its practical value.

Using this perspective allows the study to assess intervention efficacy holistically. It avoids a narrow focus on whether services exist and instead asks whether those services are accessible, timely, trusted, coordinated and responsive to rural realities. This is important because rural GBV intervention gaps often arise from the interaction between social norms and material barriers. For example, a survivor may know that reporting is possible, yet may still remain silent because of transport costs, fear of family shame, dependence on the perpetrator, or mistrust of authorities.

The theory therefore assists in analysing how local conditions in Ngorima Village shape the implementation and outcomes of GBV intervention strategies. It also supports the study's focus on contextual factors such as culture, poverty, distance, community leadership and institutional capacity.

2.7 Conceptual Framework

The conceptual framework links the main variables in the study. The independent variables are the GBV intervention strategies implemented by government, civil society organisations and community structures. These include awareness and education campaigns, legal and policy

support, counselling and psychosocial services, shelter and referral services, and community-based prevention mechanisms. The dependent variable is the efficacy of GBV services, measured through accessibility, timeliness, survivor confidence, reporting, protection and perceived reduction of harm.

The relationship between intervention strategies and service efficacy is influenced by mediating and moderating rural factors. These factors include patriarchal norms, geographical distance, poverty, transport challenges, stigma, institutional capacity and the availability of trained service providers. Feminist theory explains how gendered power relations shape these factors, while the socio-ecological perspective explains how the factors operate across individual, household, community and societal levels.

Therefore, the framework assumes that GBV interventions are more effective when they are well coordinated, survivor-centred, locally accessible and culturally responsive. It also assumes that intervention efficacy is weakened when services are distant, under-resourced, poorly coordinated or shaped by attitudes that blame survivors or normalise violence.

Figure 2.1 Conceptual framework for the study

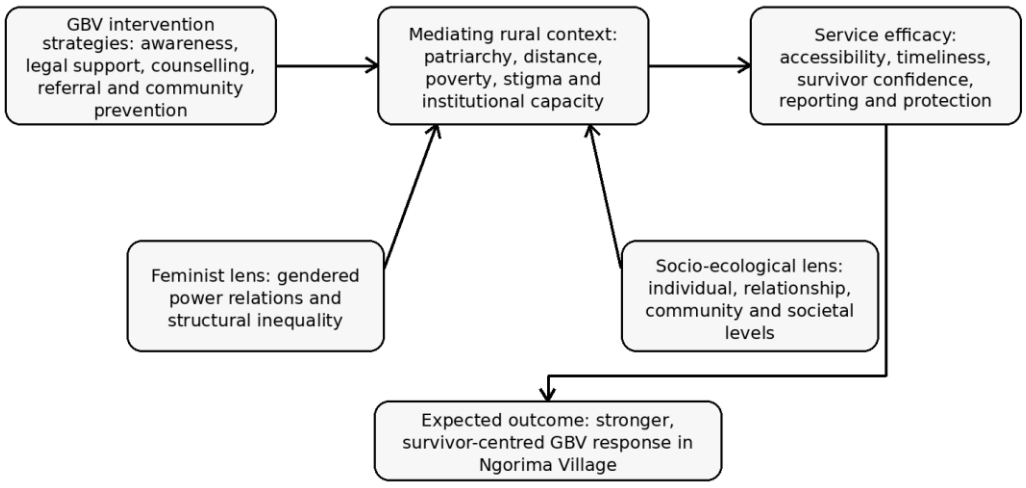


Figure 2.1: Conceptual framework showing the relationship between GBV intervention strategies, rural contextual factors and service efficacy.

2.8 Independent Variables

The independent variables are the GBV intervention strategies available to survivors and communities. Awareness and education campaigns are intended to improve knowledge of rights, reporting channels, referral systems and harmful gender norms. Legal and policy support includes protection orders, police response, victim-friendly procedures, court processes and the implementation of the Domestic Violence Act through local structures. Counselling and psychosocial support assist survivors to recover emotionally and make informed decisions about reporting, safety planning and continued service use.

Shelter and referral services are also important because survivors may need immediate protection, medical care, legal aid, social welfare assistance and economic support. Community-based prevention mechanisms include village-level dialogues, engagement with traditional leaders, men's groups, school-based education and local committees that challenge harmful norms. Current evidence shows that community mobilisation and group-based gender-transformative interventions can reduce intimate partner violence when implemented with adequate intensity and local adaptation (Leight et al., 2023).

In this study, the independent variables are examined to determine how far these interventions are present, accessible and useful in Ngorima Village. The analysis will consider whether the interventions reach rural survivors, whether they are trusted, and whether they are coordinated across service providers.

2.9 Dependent Variable

The dependent variable is the efficacy of GBV services. Efficacy refers to the extent to which intervention strategies achieve their intended purpose. In the context of this study, efficacy includes the ability of services to prevent GBV, support survivors, increase safe reporting, improve access to justice, reduce repeated abuse and strengthen community responsiveness.

Service efficacy cannot be measured only by the existence of programmes. A service may exist but still fail to protect survivors if it is distant, expensive, poorly staffed, culturally mistrusted or slow to respond. The World Bank's Zimbabwe GBV Assessment found that Zimbabwe has made progress in legal and policy frameworks, but implementation gaps, limited resources and service coverage challenges continue to affect the national response (World Bank, 2023). This makes it

necessary to evaluate services from the perspective of accessibility and practical use, especially in rural districts.

In rural communities, efficacy also depends on confidentiality, timeliness, survivor satisfaction, referral completion, and the ability of service providers to reduce stigma. For this reason, the study treats efficacy as a practical outcome rather than a policy statement.

2.10 Mediating and Moderating Factors

The conceptual framework recognises that rural conditions may strengthen or weaken the relationship between GBV interventions and service efficacy. Patriarchal beliefs may discourage survivors from reporting because violence may be treated as a private family matter. Geographical isolation may delay access to clinics, police stations or social welfare offices. Poverty may keep survivors dependent on perpetrators, while transport costs may prevent them from reaching support services.

Community attitudes also influence intervention outcomes. If local leaders, relatives or neighbours blame survivors, reporting becomes risky. If community leaders support survivor protection and condemn abuse, interventions may become more acceptable and effective. UNICEF's regional analysis of violence in the SADC region shows that many girls and women who experience violence do not seek help, and when they do, they often turn first to informal networks such as relatives and neighbours rather than professional services (UNICEF, 2023). This pattern is relevant to rural Zimbabwe because it shows how community-level trust can shape formal service use.

Institutional capacity is another mediating factor. Police, clinics, social welfare officers and community workers require training, transport, coordination systems and survivor-centred protocols. Without these resources, interventions may remain visible in policy but weak in practice. The study therefore examines how rural social and institutional factors influence the effectiveness of GBV intervention strategies in Ngorima Village.

2.11 GBV Prevalence

GBV remains widespread across global, regional and national contexts. Globally, WHO reports that about 30% of women have experienced physical and/or sexual intimate partner violence or non-partner sexual violence in their lifetime (WHO, 2024). The global burden confirms that violence against women is not limited to specific cultures or income groups as it supported by

WHO, (2024). However, its visibility and response differ according to social norms, laws, economic conditions and service systems.

In Sub-Saharan Africa, GBV is intensified by structural inequality, poverty, harmful social norms, limited service access and weak institutional reach in some settings. Current regional evidence shows that attitudes which justify wife-beating remain important indicators of gender inequality and help explain why intimate partner violence persists in many countries (UNICEF, 2023). This is relevant to Zimbabwe because social acceptance of male authority can silence survivors and normalise violence in households.

Zimbabwe reflects these global and regional patterns. Recent ZDHS findings show that 27% of women aged 15 to 49 reported physical violence since age 15, 13% reported physical violence in the previous 12 months, 9% reported sexual violence at least once in their lifetime, and 44% of women who had ever experienced physical or sexual violence sought help (ZIMSTAT & ICF, 2025). Earlier national assessments also show that GBV prevalence has remained high, with national data pointing to persistent levels of physical and sexual violence against women (World Bank, 2023).

In rural communities, the meaning of prevalence goes beyond statistics. Rural survivors may face distance to services, fear of stigma, family pressure, dependency on perpetrators and limited confidential reporting channels. These barriers mean that reported cases may understate the real scale of violence. This study therefore treats prevalence as both a statistical and social issue. The concern is not only how many cases occur, but also how many remain hidden and unsupported.

2.12 Current Intervention Strategies to GBV

GBV intervention strategies have developed across global, regional and national levels. The main approaches include legal and policy frameworks, community-based prevention, survivor support services, awareness and education campaigns, and economic empowerment. These strategies are consistent with current international and Zimbabwean policy thinking, which emphasises on strengthening systems for support and protection, improving collaboration among stakeholders, enhancing institutional capabilities, generating and using research evidence, mobilizing resources and reducing the occurrence of the problem through preventive initiatives (UNFPA Zimbabwe, 2023; World Bank, 2024).

In Zimbabwe, intervention strategies are guided by national laws, government ministries, the police Victim Friendly Unit, health services, social welfare structures, civil society organisations and development partners. The National GBV Strategy 2023-2030 provides a current framework for preventing and responding to GBV through early identification, accessible protection and support services, humanitarian GBV mitigation, national capacity strengthening, data systems, coordination and resource mobilisation (UNFPA Zimbabwe, 2023).

At community level, interventions often rely on awareness meetings, traditional leadership engagement, church structures, school programmes, referral networks and local NGOs. These approaches are important in rural settings because formal services are often distant. However, their effectiveness depends on whether they are consistent, well-resourced, survivor-centred and able to challenge harmful gender norms.

2.13 Legislative and Policy Frameworks

Legislative and policy frameworks are central to GBV intervention because they define abuse, provide reporting pathways and establish state responsibility. In Zimbabwe, relevant frameworks include the Constitution, the Domestic Violence Act, criminal law provisions, victim-friendly mechanisms, national gender policies and the Zimbabwe National GBV Strategy 2023-2030. These frameworks create a basis for prevention, protection and justice.

However, law alone does not guarantee effective protection. The World Bank's Zimbabwe GBV Assessment notes that despite progress in legal frameworks, gaps remain in implementation and service delivery (World Bank, 2023). This means that survivors may still face delays, lack of information, distance to courts, weak referral systems, limited legal aid and fear of community backlash. In rural areas, customary dispute resolution may also influence how domestic violence is handled. When community systems prioritise family unity over survivor safety, formal legal protections may be weakened.

Current international guidance also stresses the importance of survivor-centred justice. IDLO (2022) argues that justice responses should reduce secondary victimisation and make procedures accessible to survivors. In rural Zimbabwe, this means that legal interventions must be supported by trained police officers, confidential reporting spaces, clear referral systems and community education on survivor rights.

2.14 Community-Based Prevention and Social Norms Change

Community-based prevention aims to change the beliefs, relationships and practices that sustain GBV. It usually includes community dialogues, local leadership engagement, men and boys programmes, school-based education, faith-based initiatives and peer support. This approach is important because many survivors first disclose violence to family members, neighbours or local leaders before approaching formal institutions.

Recent evidence shows that community mobilisation and group-based gender-transformative interventions can reduce intimate partner violence in low- and middle-income countries when they address unequal power relations and are implemented with sufficient intensity (Leight et al., 2023). This supports the relevance of community-based strategies in rural areas. However, the evidence also suggests that short-term campaigns are less likely to change entrenched norms unless they are sustained and locally owned.

In Zimbabwe, community-based prevention is reflected in national strategy priorities and civil society programming. Yet rural implementation may be limited by funding shortages, social resistance, limited trained facilitators and leadership structures that may still treat violence as a private matter. For Ngorima Village, the key issue is whether community interventions move beyond awareness and produce visible changes in reporting, support and prevention.

2.15 Survivor Support Services

Survivor support services include counselling, medical care, psychosocial support, legal aid, shelter, safety planning and referral to social welfare. These services are essential because GBV affects physical health, mental well-being, sexual and reproductive health, family stability and economic security. WHO (2024) emphasises that the health sector has an important role in providing care and linking survivors to other services.

In Zimbabwe, support services are provided by government institutions and civil society organisations. The World Bank (2023) identifies multiple GBV actors in the country, including government ministries, police structures, health services, NGOs and development partners. However, service reach remains uneven, especially in rural areas. Survivors may face transport costs, long distances, limited privacy, shortage of trained personnel and inconsistent referral pathways.

Support services are effective when survivors can access them quickly, confidentially and without judgement. They are weakened when services are centralised in towns, when staff lack survivor-centred training, or when survivors must repeat their experience several times to different institutions. For rural communities such as Ngorima Village, effective support requires decentralised referral networks and community workers who can link survivors to professional help.

2.16 Awareness and Education Campaigns

Awareness and education campaigns aim to improve knowledge of GBV, survivor rights, reporting channels and available support services. They may use radio, community meetings, school sessions, posters, drama, churches, social media and commemorative campaigns such as the 16 Days of Activism. In rural areas, radio and community meetings remain especially important because internet access may be limited.

Awareness campaigns are useful because many survivors do not report violence due to fear, stigma or lack of information. The Zimbabwe National GBV Strategy identifies limited awareness of GBV laws, rights and available services as one factor contributing to poor help-seeking behaviour (UNFPA et al., 2023). This means that education campaigns should not only define GBV. They should also explain where survivors can go, what support is available, and how confidentiality and protection are handled.

However, awareness alone is insufficient. Campaigns may increase knowledge without improving service access. If a survivor learns about reporting but still has no transport, no safe shelter and no confidence in local authorities, the campaign has limited practical effect. Therefore, awareness must be linked to accessible services, referral mechanisms and community accountability.

2.17 Economic Empowerment and Livelihood Support

Economic empowerment is a structural GBV intervention because poverty and financial dependency can keep survivors in abusive relationships. Livelihood programmes may include savings groups, microfinance, vocational training, cash support, agricultural projects and business skills training. These interventions aim to increase women’s bargaining power, decision-making capacity and ability to seek safety.

Recent evidence supports this approach but also shows that it must be designed carefully. Allan-Blitz et al. (2023) reviewed randomised trials and found that microfinance interventions were associated with reductions in psychological and emotional intimate partner violence, controlling behaviours and sexual violence, although evidence on physical violence was less certain. This suggests that economic empowerment can be useful, especially when combined with gender training, support networks and safety planning.

In Zimbabwe, economic empowerment is relevant because rural women may depend on male partners for land, income, transport and household resources. However, livelihood support can be weakened by drought, climate shocks, poor markets, limited capital and household resistance. Economic empowerment should therefore be integrated with community norm change and survivor protection. Without this integration, income projects may improve livelihoods but fail to reduce violence (Allan-Blitz et al, 2023).

2.18 Effectiveness of Current GBV Intervention Strategies

The effectiveness of GBV intervention strategies varies by context. Global evidence shows that multi-component approaches are stronger than isolated interventions. Strategies that combines prevention, survivor support, legal protection, economic empowerment and community mobilisation are more likely to address the different levels at which GBV occurs. This aligns with the socio-ecological perspective and with Zimbabwe's national strategy, which calls for a coordinated and multi-sectoral response (UNFPA et al., 2023).

In rural Zimbabwe, effectiveness must be judged against practical conditions. A strategy may be strong in policy but weak in implementation if service providers lack transport, training, funding or coordination. The World Bank (2023) identifies programming gaps and entry points in Zimbabwe's GBV response, showing that the country has important structures but still needs stronger implementation and investment. Therefore, this study evaluates effectiveness as lived experience rather than as policy presence.

The following subsections examine the effectiveness of legislative frameworks, community-based prevention, survivor support, awareness campaigns and economic empowerment.

2.19 Effectiveness of Legislative and Policy Frameworks

Legislative and policy frameworks are effective when they create enforceable protections, improve reporting and hold perpetrators accountable. Zimbabwe's policy environment has improved through the National GBV Strategy 2023-2030, which sets a national goal of reducing GBV and harmful practices by 2030 (UNFPA et al., 2023). The strategy also identifies prevention, service delivery, capacity strengthening, data systems and coordination as priority areas.

Despite this progress, effectiveness is constrained by implementation. Rural survivors may experience long distances to courts, lack of legal information, delays in case handling, economic pressure to withdraw cases and community pressure to preserve marriage or family reputation. IDLO (2022) argues that justice processes must be survivor-centred to avoid secondary victimisation. In practice, this means that rural legal response must include trained officers, confidentiality, clear communication, referral support and protection from retaliation.

Therefore, legal and policy frameworks are necessary but not sufficient. They provide the formal foundation for protection, but their effectiveness depends on enforcement capacity, survivor trust and local accessibility.

2.20 Effectiveness of Community-Based Prevention and Social Norms Change

Community-based prevention can be effective because it addresses the social environment in which GBV occurs. It challenges norms that excuse violence, promotes bystander responsibility and encourages collective support for survivors. Leight et al. (2023) found that community mobilisation and group-based gender-transformative interventions in low- and middle-income countries can reduce intimate partner violence when they are sufficiently structured and implemented.

However, community-based strategies may have limited effect when they are brief, underfunded or delivered without challenging power relations (Leight et al, 2023). In rural Zimbabwe, interventions may also be weakened when traditional or religious authorities support reconciliation without addressing survivor safety. UNICEF (2023) shows that many women and girls in the SADC region still rely on informal networks for help, which means that community attitudes can either support or block formal service use.

For Ngorima Village, the effectiveness of community prevention will depend on whether local leaders, families, churches, schools and community groups actively discourage GBV and support survivor referral. It will also depend on whether men and boys are engaged in changing harmful norms.

2.21 Effectiveness of Survivor Support Services

Survivor support services are among the most important GBV interventions because they respond to immediate harm and support recovery. Health care, counselling, legal aid, shelter and social welfare referrals can reduce trauma, improve safety and encourage continued reporting. WHO (2024) emphasises the health sector's role in providing comprehensive care and referral to other services.

In Zimbabwe, evidence generation remains crucial for strengthening GBV programming. Mazhambe and Mushunje (2023) argue that context-specific evidence is needed to improve GBV response and programming in Zimbabwe. Their review of reported cases showed that poverty, alcohol and drug abuse, infidelity, family pressure and economic dependency influence GBV reporting and withdrawal. These factors show why support services must address both immediate harm and the broader pressures survivors face.

The effectiveness of support services in rural areas is reduced when services are distant, fragmented or under-resourced. Survivors may need to travel to urban centres for specialised care, which creates delays and costs. Therefore, rural survivor support should include clear local referral pathways, trained community-based personnel and coordination between police, clinics, social welfare and NGOs.

2.22 Effectiveness of Awareness and Education Campaigns

Awareness campaigns are effective when they increase knowledge, reduce stigma and link communities to services. They can help people identify forms of GBV, understand survivor rights and learn where to seek help. The Zimbabwe National GBV Strategy identifies limited awareness of GBV laws and available services as a barrier to help-seeking (UNFPA et al., 2023). This shows that education remains a necessary intervention.

However, awareness campaigns have limits. Knowledge does not automatically lead to reporting when survivors face economic dependency, fear of retaliation or pressure from relatives.

Campaigns are strongest when they are connected to actual services, local referral points and trusted community actors. They are weakest when they are one-off events that provide information without follow-up support.

In Ngorima Village, awareness campaigns may be effective if they are delivered through accessible channels such as community meetings, radio, schools, churches and local leadership platforms. They should also be designed in local language and connected to clear reporting and referral processes.

2.23 Effectiveness of Economic Empowerment and Livelihood Interventions

Economic empowerment can reduce GBV vulnerability by increasing women's financial independence and ability to make decisions. Evidence from a systematic review and meta-analysis indicates that microfinance interventions can reduce some forms of intimate partner violence, particularly psychological and emotional violence and controlling behaviours (Allan-Blitz et al., 2023). This supports the argument that livelihood support can form part of GBV prevention.

However, economic empowerment is not automatically protective. If empowerment programmes are implemented without gender-transformative education, they may create household tension or fail to change male control over resources. For this reason, livelihood support should be combined with gender dialogue, safety planning, couple or family communication where appropriate, and community-level norm change. The 2025 rural Ethiopia trial by Agde et al. showed that couple-based violence prevention education reduced intimate partner violence during pregnancy, which suggests that relational approaches can strengthen prevention when carefully designed and contextually adapted.

In rural Zimbabwe, livelihood interventions also face economic and environmental constraints. Climate shocks, poor market access, limited capital and household poverty can weaken sustainability. Therefore, economic empowerment should be treated as one part of a broader GBV response rather than a stand-alone solution.

2.24 Knowledge Gap

The reviewed literature shows that GBV is well documented globally, regionally and nationally. However, important gaps remain in the evaluation of intervention strategies in rural Zimbabwe. National surveys provide useful prevalence data, but they do not fully explain how rural survivors

experience services, why some interventions succeed, and why others remain underused. Chikhungu and Bengesai (2024) also identify limited intervention evaluation and insufficient attention to marginalised groups and regional variation in Zimbabwean GBV research.

Another gap concerns the relationship between formal and informal systems. Rural survivors may interact first with relatives, neighbours, traditional leaders, churches or community health workers before approaching police or social welfare. Yet much of the literature focuses on formal structures without fully examining how these local actors shape help-seeking, referral and survivor protection. This is important because informal responses may either support formal services or discourage reporting.

There is also limited evidence on how cultural norms, economic dependency, distance and institutional capacity affect the efficacy of GBV intervention strategies at village level. While the Zimbabwe National GBV Strategy provides a national framework, local studies are needed to assess how the strategy translates into practice in communities such as Ngorima Village. This study addresses that gap by examining the implementation, perceived effectiveness and contextual barriers of GBV interventions in a rural Zimbabwean setting.

2.25 Conclusion

This chapter reviewed literature on GBV prevalence, theoretical explanations, intervention strategies and the effectiveness of current responses. The review shows that GBV remains a major public health, human rights and development issue globally and in Zimbabwe. It also shows that rural communities face specific barriers, including patriarchal norms, distance to services, poverty, stigma, limited institutional capacity and weak referral systems.

The chapter established feminist theory and the socio-ecological perspective as the guiding analytical lenses. Feminist theory explains how gendered power relations and patriarchy sustain GBV, while the socio-ecological perspective shows how individual, relationship, community and societal factors interact. Together, these theories provide a suitable basis for evaluating GBV intervention strategies in Ngorima Village.

The reviewed literature also shows that no single intervention is sufficient. Laws, awareness campaigns, counselling, referral services, community mobilisation and economic empowerment must work together. The main gap is the limited empirical evidence on how these interventions

function in rural Zimbabwean communities. This study therefore contributes by examining the efficacy of GBV intervention strategies in Ngorima Village and the contextual factors that shape their outcomes.

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 Introduction

This chapter presents the methodology used to investigate intervention strategies and the effectiveness of Gender-Based Violence (GBV) services in rural areas, with specific reference to Ngorima Village in Chimanimani District, Zimbabwe. Methodology is treated as the organised framework through which the researcher selected a research approach, gathered evidence, analysed data and protected participants throughout the study (Creswell and Creswell, 2023). The chapter therefore explains the research approach, research philosophy, research design, study area, target population, sample size, sampling procedures, data collection methods, research instruments, pilot testing, data analysis procedures, trustworthiness, validity, reliability, ethical considerations, limitations and delimitations.

The methodology was developed to suit the sensitive and community-based nature of the research problem. GBV research requires methods that can capture measurable patterns while also allowing participants and service providers to explain lived experiences, service barriers and community dynamics in their own words. For that reason, the chapter maintains a mixed methods structure and applies recent methodological guidance on research design, mixed methods integration, qualitative inquiry, case study logic and ethical practice in sensitive research contexts (Creswell & Creswell, 2023; Creswell & Plano Clark, 2026; Flick, 2022; World Health Organization [WHO], 2024).

3.2 Research Approach

The study adopted a mixed methods research approach. A mixed methods approach combines quantitative and qualitative forms of evidence within one study so that the researcher can examine a problem from more than one angle. This approach was suitable because the effectiveness of GBV intervention strategies cannot be assessed through numbers alone. Survey data were needed to show levels of awareness, service use and perceived effectiveness, while qualitative data were needed to explain the reasons behind those patterns and the meanings attached to GBV services in the village context.

The quantitative component generated structured information from 50 adult household representatives. This allowed the researcher to summarise community responses using frequencies,

percentages and visual outputs generated through SPSS. The qualitative component involved five key informant interviews and five focus group discussions. These methods allowed the researcher to explore the experiences of community members and service actors in greater depth. The two components were therefore complementary. The quantitative strand gave breadth, while the qualitative strand gave context, interpretation and community voice (Creswell & Creswell, 2023; Venkatesh, 2024).

3.3 Research Philosophy

The study was guided by a pragmatist research philosophy. Pragmatism is appropriate where the purpose of research is to solve a practical social problem rather than defend one rigid methodological position. In this study, the concern was not whether quantitative or qualitative research was superior. The concern was how both forms of evidence could be combined to produce credible findings on GBV intervention strategies in Ngorima Village. Pragmatism therefore supported the use of surveys, interviews and focus group discussions within one methodological framework (Creswell & Creswell, 2023; Creswell & Plano Clark, 2026).

The pragmatist position was supported by a gender-sensitive and transformative lens. GBV is shaped by power relations, gender inequality, social norms, economic vulnerability and access to protection systems. A gender-sensitive lens helped the researcher to treat participants not merely as sources of data, but as people located within social conditions that influence their safety, voice and access to services. This was essential because global and local evidence continues to show that violence against women and girls remains a public health and human rights concern, and that rural women and girls can face additional barriers when seeking help (UNFPA Zimbabwe, 2025; WHO, 2024).

3.4 Research Design

The study used a convergent parallel mixed methods design. In a convergent parallel design, quantitative and qualitative data are collected within the same phase of the research process, analysed separately and then brought together during interpretation. This design suited the study because the researcher needed to compare statistical patterns from household survey responses with the explanations given by key informants and focus group participants. The design strengthened interpretation by allowing findings from one strand to confirm, expand or qualify findings from the other strand (Creswell & Plano Clark, 2026).

The design was also supported by a case study strategy focused on Ngorima Village. A case study is appropriate when the researcher seeks to understand a bounded social issue within its real-life setting (Cresswell and Cresswell, 2023). In this study, the case was the effectiveness of GBV intervention strategies in one rural community. The case study strategy allowed the researcher to examine local structures, service actors, household experiences, cultural norms and practical barriers together rather than separating them from the village context. This was necessary because GBV interventions operate through relationships between households, traditional leadership, police services, health services, churches, NGOs and community-based volunteers (Mtisi, 2022).

The convergent parallel design and case study strategy worked together. The convergent design gave the study a clear data integration process, while the case study strategy kept the inquiry grounded in the specific social setting of Ngorima Village. This combination helped the researcher to generate findings that were both empirically organised and contextually meaningful.

3.5 Study Area and Population

The study was conducted in Ngorima Village, Chimanimani District, Zimbabwe. Ngorima Village is a rural community characterised by dispersed households, traditional leadership structures, limited access to some social services and reliance on local community networks. The area was selected because it provided a relevant setting for examining GBV intervention strategies at community level. The presence of government departments, non-governmental organisations and community-based structures also made it possible to assess how different service actors contribute to GBV prevention and response.

The target population comprised adult community members residing in Ngorima Village and key stakeholders involved in GBV prevention, response and community support. These stakeholders included personnel connected to the Victim Friendly Unit, health workers, NGO practitioners, traditional leadership structures, church leaders and community-based volunteers. Women, young women and girls were considered important to the study because GBV affects them disproportionately in many contexts, and rural settings can intensify barriers related to reporting, transport, confidentiality and service access (UNFPA Zimbabwe, 2025; WHO, 2025).

The population was therefore defined broadly enough to include both service users and service providers. This was important because community members could describe awareness and use of

GBV services, while key informants could explain the operation, reach and limitations of intervention systems.

3.6 Sample Size

The study involved 85 participants across the quantitative and qualitative components. The quantitative component consisted of 50 adult household representatives selected from Ngorima Village. Of these, 30 were women and 20 were men. One adult representative was selected from each household included in the survey so that the responses reflected household-level community perspectives without repeatedly drawing from the same household.

The qualitative component consisted of five key informants and 30 focus group discussion participants. The five key informants were a nurse, a police officer, a church leader, an NGO service provider and a chief's messenger. These participants were selected because of their direct knowledge of GBV-related services and community response structures. The focus group component consisted of five groups with six participants in each group. The groups were organised as an adult women's group, an adult men's group, a youth boys and girls group, a young couples group and a confidential group comprising GBV survivors.

The qualitative sample was considered adequate for the purpose of the study because the focus was depth, relevance and saturation rather than statistical representativeness. Recent evidence on qualitative sample size shows that saturation can often be achieved with relatively small but information-rich samples, especially where the study objectives are focused and the participant groups are clearly defined (Hennink & Kaiser, 2022). The total sample of 85 therefore provided enough breadth for survey analysis and enough depth for qualitative interpretation.

3.7 Sampling Procedures

The study used both purposive sampling and simple random sampling. The two procedures were used for different reasons. Purposive sampling was used where the researcher needed participants with specific knowledge, roles or experiences relating to GBV intervention strategies. Simple random sampling was used for household survey participants so that each household in the sampling frame had a fair chance of selection. This combination strengthened the study because it balanced relevance in the qualitative component with fairness in the survey component.

3.7.1 Purposive Sampling

Purposive sampling was used to select key informants and specific focus group participants. The key informants were chosen because they held roles directly linked to GBV prevention, response, counselling, reporting, referral or community mobilisation. Their inclusion was necessary because the study required institutional and community-level insight into how intervention strategies are implemented in Ngorima Village.

Purposive sampling was also used where participant experience was central to the research objectives. This included groups whose views were important for understanding GBV awareness, reporting barriers, service uptake and community perceptions. In qualitative research, purposive sampling helps the researcher obtain information-rich data from participants who are able to speak directly to the research issue (Flick, 2022; Mtisi, 2022).

3.7.2 Simple Random Sampling

Simple random sampling was used to select households for the survey. The sampling frame consisted of 506 households obtained from a household register provided through the village leadership structure. From this list, 50 households were selected, giving a sampling fraction of approximately 9.9% of the total household population. The lottery method was used to support fairness. Each household name was written on a separate slip of paper, placed in a container and drawn until the required number of households had been reached.

This procedure gave every household an equal and independent chance of selection. It also reduced the risk that the researcher would choose only familiar, accessible or cooperative households. After a household had been selected, one adult representative participated in the survey. Although random selection can be difficult in rural communities because households may be dispersed, it remained suitable for capturing broader community views on the awareness, use and perceived effectiveness of GBV intervention strategies.

3.8 Data Collection Methods

The study used three data collection methods: key informant interviews, focus group discussions and a household survey. These methods were selected because the study required both measurable indicators and detailed explanations. The household survey provided structured quantitative data, while the key informant interviews and focus group discussions provided qualitative data on implementation, access, community attitudes and service challenges.

3.8.1 Key Informant Interviews

Key informant interviews were used to collect data from individuals with specialised knowledge of GBV intervention services in Ngorima Village. Five key informants were interviewed. They included a nurse, a police officer, a church leader, an NGO service provider and a chief's messenger. These participants were selected because their roles placed them close to reporting pathways, referral systems, counselling support, community mobilisation or local leadership.

The interviews were semi-structured. This allowed the researcher to follow the interview guide while still asking follow-up questions where clarification was needed. Interviews were conducted at participants' homes or offices, depending on where the informant felt comfortable and where privacy could be maintained. Each interview lasted approximately 15 to 20 minutes. Data were captured through audio recording and handwritten field notes. This combination improved accuracy because the audio recordings preserved the participants' words, while field notes captured context, emphasis and non-verbal observations relevant to interpretation.

3.8.2 Focus Group Discussions

Focus group discussions were used to explore shared community views on GBV intervention strategies. Five focus group discussions were conducted, with six participants in each group. The groups were organised to allow participants to discuss issues with people who shared broadly similar social positions or experiences. This structure helped to create a safer and more open discussion environment.

The focus groups were held at familiar and accessible community venues, including a church, a sporting ground and a women's savings group club. These venues were selected because they were known to participants and allowed discussion to take place in settings that were less formal than offices. Each discussion lasted approximately 30 minutes. The researcher facilitated the sessions using open-ended prompts aligned with the study objectives. Data were captured through audio recording and handwritten notes.

The confidential group comprising GBV survivors was handled with additional care because of the sensitivity of the topic. The researcher avoided forcing disclosure and reminded participants that they could choose not to respond to any issue that made them uncomfortable. This approach was necessary because ethical GBV research must protect participant safety, privacy and

emotional wellbeing throughout the research process (Sexual Violence Research Initiative [SVRI], 2024; WHO, 2024).

3.8.3 Household Survey

A cross-sectional household survey was used to collect quantitative data from 50 adult household representatives. A cross-sectional design collects data at one point in time and is useful for describing current conditions, patterns and associations within a defined population. This made it suitable for measuring awareness, utilisation and perceived effectiveness of GBV intervention strategies in Ngorima Village (Pérez-Guerrero et al., 2024).

The survey was interviewer-administered. The researcher read questions to participants and recorded their responses. This method was appropriate because literacy levels can vary in rural communities, and interviewer administration helped ensure that all respondents understood the questions before answering. Data collection took place at participants' households and at the sporting ground. Each survey took approximately 30 to 40 minutes to complete. The method was efficient and appropriate for generating numerical indicators linked to the study objectives.

3.9 Data Collection Instruments

The study used three research instruments: a key informant interview guide, a focus group discussion guide and a structured questionnaire. Each instrument was designed around the research objectives. The purpose was to ensure that all data collected would contribute directly to answering the research questions on GBV intervention strategies and their perceived effectiveness in Ngorima Village.

3.9.1 Key Informant Interview Guide

The key informant interview guide contained open-ended questions arranged around the main areas of inquiry. These included the availability of GBV intervention services, referral procedures, reporting pathways, implementation challenges, community uptake, stakeholder coordination and perceptions of effectiveness. The guide was flexible, allowing the researcher to probe for detail while maintaining focus on the study objectives. The supervisor reviewed the guide before data collection to check clarity, relevance and alignment with the study purpose.

3.9.2 Focus Group Discussion Guide

The focus group discussion guide was used to direct group conversations without restricting participant interaction. It contained open-ended prompts on community awareness of GBV services, barriers to reporting, social norms surrounding GBV, trust in service providers, confidentiality concerns and suggestions for strengthening intervention strategies. The guide was reviewed before fieldwork to ensure that the questions were clear, non-leading and suitable for a sensitive topic.

3.9.3 Structured Questionnaire

The structured questionnaire was used for the household survey. It was divided into sections covering demographic information, awareness of GBV intervention strategies, use of available services, perceived effectiveness of services and suggestions for improvement. Most questions were closed-ended so that responses could be coded and analysed quantitatively. A limited number of open-ended items were included to allow respondents to add context where the fixed response options did not fully capture their views.

The questionnaire was designed to produce data suitable for descriptive analysis in SPSS. Its structure helped maintain consistency across all 50 respondents. This consistency supported reliability because each respondent was asked the same core questions under similar administration conditions.

3.10 Pilot Testing of Research Instruments

Pilot testing was conducted before the main data collection exercise. The purpose was to identify unclear wording, culturally inappropriate questions, practical difficulties and the approximate time needed to complete the instruments. The structured questionnaire was pretested with a small group of community members who were not included in the final sample. Their responses helped the researcher identify questions that needed rephrasing and sections that required smoother sequencing.

The key informant interview guide and focus group discussion guide were reviewed with the study supervisor before fieldwork. This review served as expert validation. It helped ensure that the questions were aligned with the study objectives, ethically sensitive and suitable for the local context. Pilot testing was especially important because GBV is a sensitive research area. Poorly framed questions can make participants uncomfortable, reduce accuracy or cause avoidable

distress. The pilot process therefore strengthened the clarity, ethical quality and practical usefulness of the instruments (SVRI, 2024; WHO, 2024).

3.11 Data Analysis

The study used separate but connected procedures for quantitative and qualitative data analysis. The two strands were first analysed independently and then integrated during interpretation. This matched the convergent parallel design because the researcher needed to compare numerical patterns with qualitative explanations.

Quantitative data from the 50 household survey respondents were coded and entered into SPSS. Descriptive statistics were then generated. These included frequencies, percentages, tables, pie charts and bar graphs. The analysis focused on levels of awareness, use of services and perceived effectiveness of GBV intervention strategies among community members. SPSS was suitable because it supports structured data entry, descriptive analysis and visual presentation of survey findings (IBM Corp., 2025).

Qualitative data from the five key informant interviews and five focus group discussions were transcribed and supported by handwritten field notes. The researcher used thematic analysis to identify repeated ideas, patterns and meanings within the data. The analysis followed a process of reading the data, coding important segments, grouping related codes, reviewing themes and linking the final themes to the study objectives. Thematic analysis was appropriate because it allows qualitative researchers to organise participant accounts into meaningful patterns while preserving the context in which those accounts were produced (Braun & Clarke, 2022).

The quantitative and qualitative findings were integrated at the interpretation stage. Where the survey showed a pattern, the qualitative data were used to explain why that pattern appeared. Where interviews and discussions raised a strong theme, survey results were used to assess how far that issue was reflected among household respondents. This integration strengthened the credibility and usefulness of the findings.

3.12 Ethical Considerations

Ethical considerations were central to this study because GBV is a sensitive topic involving privacy, safety and possible emotional discomfort. The study followed principles of voluntary

participation, informed consent, confidentiality, anonymity, participant welfare and responsible data handling. These principles were applied before, during and after fieldwork.

Informed consent was obtained before data collection. Participants were given a clear explanation of the purpose of the study, what participation involved, how the information would be used and their right to withdraw without penalty. Consent was obtained verbally because this was suitable for the local fieldwork context and helped avoid unnecessary collection of identifying signatures. Participants were also informed that they could decline to answer any question they did not wish to address.

Confidentiality was maintained throughout the research process. Information collected from participants was treated as private and used only for academic purposes. Audio recordings and notes were stored securely and were not shared with people outside the research process. Personal identifying details were not recorded in the survey instrument. In reporting the findings, codes and pseudonyms were used so that individual participants could not be identified.

Voluntary participation was upheld in all interviews, focus group discussions and surveys. Participants were not pressured to take part. The researcher also remained alert to signs of discomfort, especially during the confidential group discussion involving GBV survivors. Where sensitivity arose, participant wellbeing was prioritised over data collection. This approach was consistent with current ethical guidance for research on violence against women and girls, which places safety, confidentiality and risk minimisation at the centre of research practice (SVRI, 2024; WHO, 2024).

3.13 Trustworthiness

Trustworthiness refers to the steps taken to ensure that qualitative findings are credible, transferable, dependable and confirmable. In this study, trustworthiness was strengthened through triangulation, detailed documentation, careful transcription, field notes and reflexive awareness of the researcher's position in the community. Recent qualitative research guidance identifies credibility, transferability, dependability and confirmability as core pillars of rigorous qualitative inquiry (Ahmed, 2024).

Credibility was enhanced through triangulation. Data were collected from household survey respondents, key informants and focus group participants. This allowed the researcher to compare

information from different participant groups and methods. When similar findings appeared across these sources, confidence in the interpretation increased.

Transferability was supported through detailed description of the research setting, participant groups, sampling procedures and data collection process. This allows readers to judge whether the findings may be relevant to other rural communities with similar social and service conditions. The study does not claim automatic generalisation beyond Ngorima Village, but it provides enough contextual detail for informed comparison.

Dependability was supported through consistent use of research instruments and clear documentation of field procedures. The interview guide, focus group discussion guide and structured questionnaire helped ensure that data collection followed a stable process. Confirmability was supported through audio recordings, field notes and the use of participant-based data rather than unsupported researcher assumptions. Reflexivity was also important because the researcher was familiar with the community and needed to remain aware of how that position could influence access, interpretation and participant interaction.

3.14 Validity and Reliability

Validity and reliability were addressed in both the quantitative and qualitative parts of the study. In survey research, validity concerns whether an instrument measures what it is intended to measure. It is not a fixed property of a questionnaire, but a judgement built through design, evidence and interpretation (Repke et al., 2024). In this study, content validity was strengthened by developing the instruments from the research objectives and literature on GBV intervention strategies. The supervisor reviewed the instruments before fieldwork to confirm that the questions were relevant and sufficient.

Triangulation also strengthened validity. The researcher did not rely on only one source of evidence. Survey results were compared with interview and focus group findings, while qualitative themes were checked against quantitative patterns. This reduced the risk of drawing conclusions from one narrow set of responses.

Reliability refers to consistency in the research process and in the administration of instruments. Reliability was supported by using the same questionnaire structure for all survey respondents and the same core interview or discussion areas for relevant qualitative participants. The interviewer-

administered survey also helped reduce variation caused by literacy differences because questions were read and explained consistently. Audio recordings further supported reliability by allowing the researcher to revisit the original responses during transcription and analysis.

3.15 Limitations of the Study

The study had several limitations. First, some community members were reluctant to participate because GBV is a sensitive subject and because rural communities may be cautious about academic research. The researcher addressed this by explaining the purpose of the study clearly and by using trusted community spaces to build confidence among willing participants.

Second, the study had limited resources. No financial or material incentives were offered to participants. This may have reduced participation among some community members and may have introduced self-selection bias, because those with stronger interest in GBV issues may have been more willing to take part. The researcher reduced this limitation by using random household selection for the survey and by including several participant categories in the qualitative component.

Third, social desirability bias may have affected some responses. GBV is shaped by stigma, fear, community expectations and power relations. Some participants may therefore have given answers that sounded socially acceptable rather than fully expressing their experiences or views. The researcher attempted to reduce this limitation through confidentiality, anonymity and non-judgemental questioning.

3.16 Delimitations of the Study

The study was delimited geographically to Ngorima Village in Chimanimani District. This boundary was deliberate. The researcher focused on one rural village in order to examine GBV intervention strategies within a specific community setting. The geographic focus made it possible to study local structures, service relationships and community norms in more detail.

The study was also delimited thematically. It focused on the effectiveness of GBV intervention strategies at community level. It did not attempt to evaluate the entire national GBV policy framework or all legal instruments relating to GBV in Zimbabwe. This delimitation kept the study aligned with its research objectives and with the local service environment under investigation.

3.17 Summary of the Chapter

This chapter explained the methodology used to study intervention strategies and the effectiveness of GBV services in Ngorima Village, Chimanimani District, Zimbabwe. The study adopted a pragmatist mixed methods approach supported by a gender-sensitive lens. It used a convergent parallel mixed methods design and a case study strategy focused on Ngorima Village.

The chapter described the study area, target population, sample size of 85 participants, purposive and simple random sampling procedures, and the three data collection methods used in the study: key informant interviews, focus group discussions and a household survey. It also explained the research instruments, pilot testing process, data analysis procedures, ethical considerations, trustworthiness, validity, reliability, limitations and delimitations.

Together, these methodological choices provided a coherent framework for generating credible findings on GBV intervention strategies in a rural community setting. The mixed methods structure allowed the study to combine statistical evidence with detailed participant accounts, while the ethical procedures protected participants in a sensitive research area.

CHAPTER FOUR: DATA ANALYSIS, PRESENTATION AND DISCUSSION OF FINDINGS

4.1 Introduction

This chapter present, analyses and discusses the findings of the study titled Intervention Strategies on the Efficacy of GBV Services in Rural Areas in Zimbabwe: A Case Study of Ngorima Village, Chimanimani District. The chapter follows the three research objectives. It first examines the intervention strategies currently used to address gender-based violence in Ngorima Village. It then

assesses the perceived efficacy of those strategies. Finally, it presents participant-driven proposals for improving GBV services in rural Zimbabwe.

The study used a mixed methods design. Quantitative data were gathered through a household survey administered to 50 respondents, while qualitative data were obtained through key informant interviews and focus group discussions. The key informants included a Victim Friendly Unit police officer, a nurse, a chief's messenger, an NGO-linked community service provider and a youth leader. The focus group discussions involved community members who had direct or indirect knowledge of GBV prevention and response activities in the village.

The presentation of results adopts an integrated approach. Survey findings are reported through frequency-based figures generated from the field dataset, while interview and focus group views are used to explain the meaning behind the numbers. This approach follows mixed methods logic because it allows numerical patterns to be interpreted alongside lived experiences and community explanations. Similar research on GBV essential services in Zimbabwe has used both questionnaires and qualitative interviews to strengthen the validity of findings through triangulation (ActionAid Zimbabwe, 2022).

The chapter also situates the findings within current GBV policy and empirical literature. Globally, violence against women remains a major public health and human rights problem, the WHO data indicate that approximately 30% of women globally have faced physical or sexual violence from intimate or non-intimate partners (WHO, 2024). As previously noted, the nationa strategy identifies seven priority areas anchored around prevention and coordinated multi-sectoral response (MWACSMED, 2023). These national patterns provide the context in which the Ngorima Village findings are analysed.

4.2 Demographic Characteristics of Respondents

The demographic profile of respondents provides context for interpreting the findings. Since GBV is shaped by gender, age, family structure and social position, the characteristics of respondents are relevant to how they understand violence, services and reporting practices. The household survey involved 50 respondents drawn from Ngorima Village. Their demographic characteristics are presented according to gender, age and marital status.

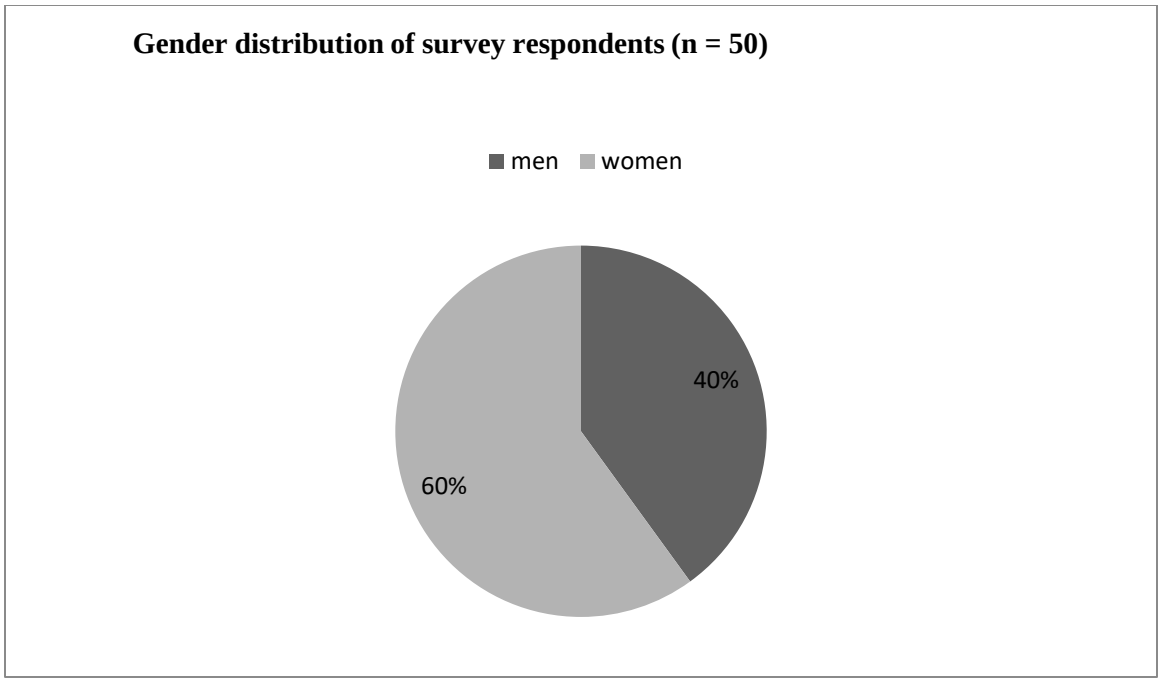


Fig 4.1: Gender distribution of survey respondents (n = 50)

Source: Field data (2026)

Figure 4.1 shows that female respondents constituted 60% (n=30) of the sample, while male respondents constituted 40% (n=20). The higher female representation is useful for this study because women and girls are often more directly exposed to intimate partner violence, domestic abuse and other forms of gendered harm. However, the inclusion of male respondents remains important because GBV prevention requires the participation of men and boys as community actors, partners, relatives, traditional subjects and potential change agents. Current global evidence emphasises that GBV is rooted in unequal power relations and therefore cannot be addressed through women-focused interventions alone (WHO, 2024).

The gender distribution also reflects the realities of rural household-based research. Women are often more available during household visits because of their domestic and caregiving responsibilities. This does not reduce the value of the male responses, but it explains why women formed the majority. Their presence in the sample strengthened the study's ability to capture community knowledge about survivor experiences, reporting barriers and the usefulness of existing interventions.

Age distribution of survey respondents

age group	frequency	percentage (%)
18-20years	7	14%
21-30years	26	52%
31-40years	11	22%
41years and above	6	12%
Total	50	100%

Table 4.2: Age distribution of survey respondents (n = 50)

Source: Field data (2026)

Table 4.2 indicates that respondents aged 21 to 30 years formed the largest age group, representing 52% of the sample. Respondents aged 31 to 40 years accounted for 22%, while those aged 18 to 20 years represented 14%. Respondents aged 41 years and above formed the smallest group at 12%. This age pattern is important because young adults are highly relevant to the study of GBV. Many people in this age group are entering marriage, cohabitation, parenthood and economically dependent relationships, which may expose them to intimate partner conflict, family pressure and social expectations around gender roles.

The prominence of the 21 to 30 age group also gives the findings a forward-looking value. Interventions that shape attitudes in this age group can influence future family behaviour, parenting practices and community norms. Recent evidence on violence against women and girls in Zimbabwe confirms that intimate partner violence and child marriage remain persistent public health concerns, with consequences for health, education, autonomy and social wellbeing (Chikhungu & Bengesai, 2024). The age profile of this sample therefore allowed the study to capture views from a group that is central to both prevention and response.

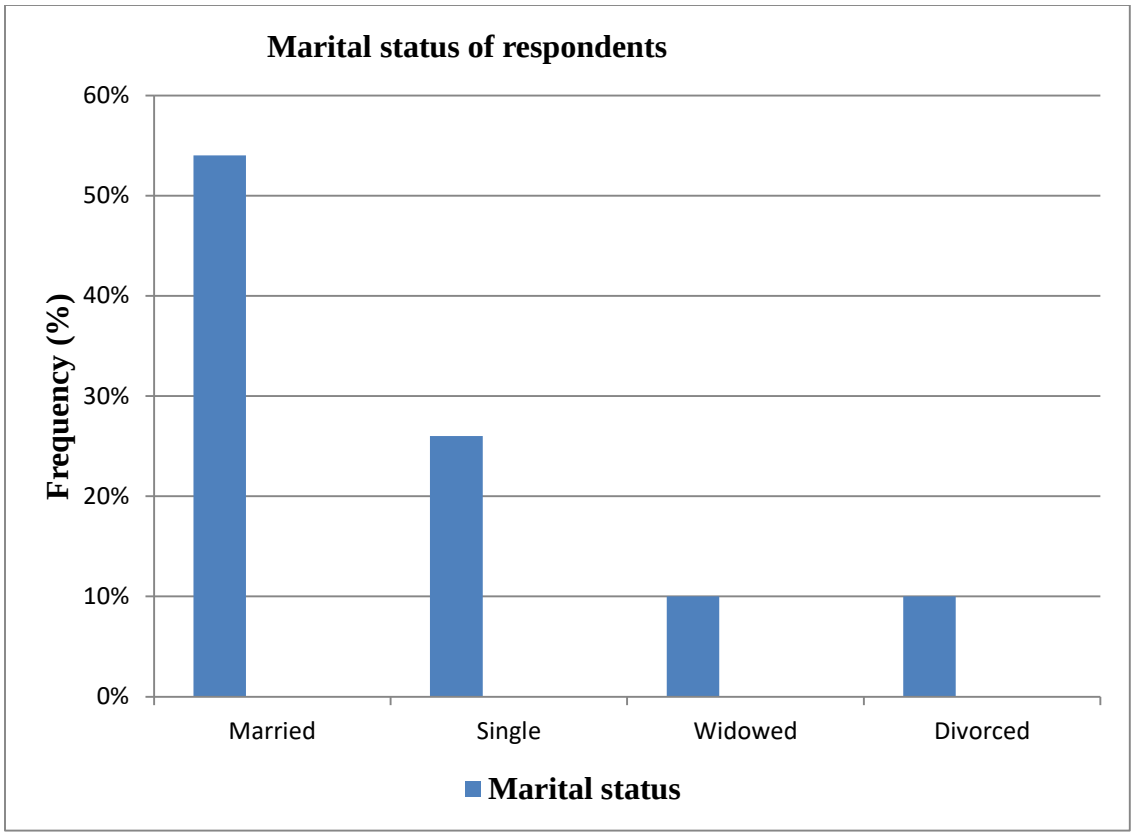


Figure 4.3: Marital status of survey respondents (n = 50)

Source: Field data (2026).

Figure 4.3 shows that married respondents formed the largest category at 54%. Single respondents constituted 26%, while widowed and divorced respondents each accounted for 10%. This distribution is analytically relevant because many forms of GBV occur within intimate partner and family settings. Married respondents are likely to have direct knowledge of marital expectations, domestic decision-making, family mediation and community responses to household conflict.

The presence of divorced and widowed respondents also added depth to the sample. These respondents may have experienced or observed relationship breakdown, bereavement, family dependence and community judgement. Such social positions can influence how individuals view reporting, mediation and survivor support. The demographic structure therefore gave the study access to varied perspectives across relationship statuses rather than limiting the evidence to one household category.

4.3 Current GBV Intervention Strategies in Ngorima Village

This section responds to the first research objective, which sought to explore the current intervention strategies being used to curb GBV in Ngorima Village. Findings from the survey, key informant interviews and focus group discussions show that the response landscape is broad, but uneven. Interventions exist through awareness campaigns, traditional leadership structures, police and VFU channels, health services, NGO-linked programmes, church platforms, school-based messages, radio discussions, community meetings, sports tournaments and informal peer networks.

4.3.1 Existing GBV Intervention Strategies

The most frequently identified intervention was awareness raising. Four out of five key informants mentioned awareness campaigns as a visible and recurring strategy. Other interventions included counselling, referrals, medical treatment for survivors, police reporting, traditional court discussions, family mediation, religious teaching, victim support services, economic empowerment and community support groups. The household survey supported this finding, as almost all respondents reported awareness of at least one GBV prevention or response programme in the community.

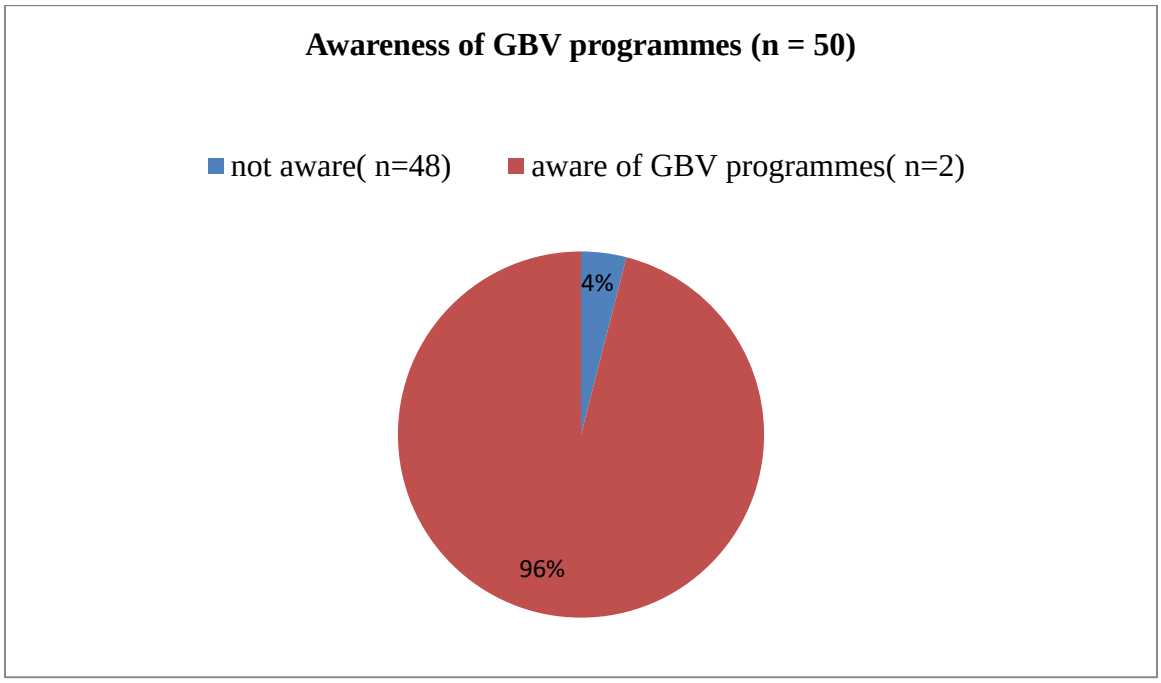


Figure 4.4: Community awareness of GBV programmes (n = 50)

Source: Field data (2026)

Figure 4.4 shows that 96% of respondents were aware of GBV programmes in Ngorima Village, while only 4% were not aware. This finding shows that basic information about GBV has reached most community members. It also suggests that awareness campaigns, public meetings and community networks are functioning as channels for disseminating GBV messages. This aligns with the National GBV Strategy 2023-2030, which emphasises awareness raising, prevention, service access and community-level coordination as central elements of Zimbabwe's GBV response (MWACSMED, 2023).

> *"Awareness campaigns and community meetings have helped people understand that GBV is a serious issue that must be reported." One key informant said.*

The above view shows that awareness activities have helped some community members recognise GBV as a public concern rather than a private family issue. Focus group participants also reported that they encounter GBV messages through churches, schools, village meetings, sporting activities, radio programmes and peer conversations. These channels are important because rural communication often depends on trusted local spaces rather than formal institutions alone. However, awareness by itself does not guarantee reporting, protection or behavioural change. The later sections of this chapter show that high awareness exists alongside low help-seeking.

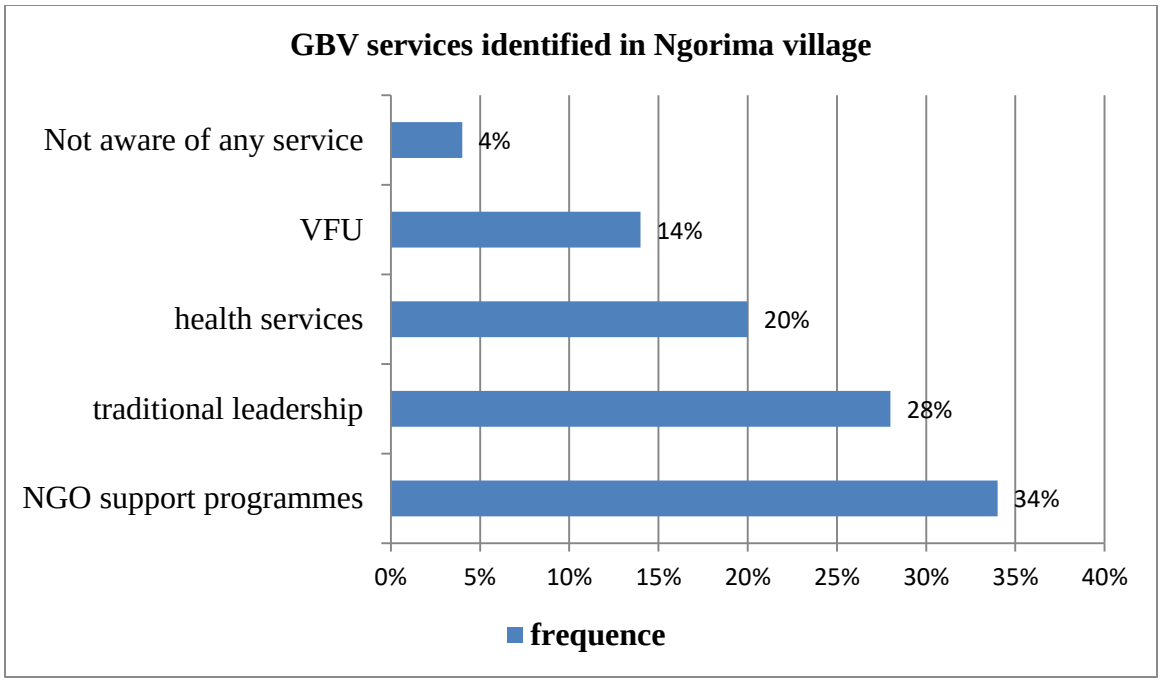


Figure 4.5: GBV services identified by respondents (n = 50)

Source: Field data (2026)

Figure 4.5 presents the services most commonly identified by respondents. NGO support programmes were mentioned by 34% of respondents, followed by traditional leadership interventions at 28%, health services at 20%, police and VFU services at 14%, and lack of awareness of any service at 4%. The dominance of NGO and traditional leadership responses suggests that GBV support in Ngorima Village is strongly community-based. Formal services exist, but respondents appeared to recognise local and civil society actors more readily than state institutions.

The qualitative data clarified the nature of these services. Participants referred to traditional court sessions, village head discussions, church counselling, health referrals, VFU reporting, school messages and NGO-supported outreach activities. One local example mentioned in the focus group discussions was Chabadza Community Development, which respondents associated with sporting tournaments, billboards placement and community education. The reference to NGOs was therefore not abstract. It pointed to visible community-level actors that use public events to communicate GBV messages and encourage reporting.

The range of interventions reflects a multi-sectoral response. This is consistent with the Essential Services Package for women and girls subject to violence, which recommends coordinated health,

justice, policing, social service and community responses (UN Women, UNFPA, WHO, UNDP, & UNODC, 2015). It is also consistent with the Zimbabwe National GBV Strategy, which identifies coordination, service access, prevention, evidence-based programming and resource mobilisation as national priorities (MWACSMED, 2023).

4.3.2 Stakeholders Involved in GBV Interventions

The study found that GBV interventions in Ngorima Village are delivered through a network of actors rather than by one institution. Key informants identified traditional leaders, police officers, VFU personnel, health workers, NGOs like Chabadza community development, community-based groups, churches, teachers, youth leaders and the Ministry of Women Affairs as relevant stakeholders. Among these actors, traditional leaders were the most frequently emphasised because of their everyday authority in the village.

> *"Traditional leaders and the police work together with Chabadza to address GBV cases in the community."*

This statement shows that the local GBV response depends on collaboration between formal and informal systems. In rural Zimbabwe, traditional leaders often remain the first point of contact because they are accessible, culturally legitimate and familiar to families. Police and health facilities become more visible when cases require formal reporting, medical care or legal follow-up. NGOs support awareness, counselling, referrals and material or technical assistance where state services are limited.

The National GBV Strategy recognises the need for coordination at national, provincial, district and ward levels. It identifies traditional leaders, faith-based organisations, civil society organisations, health actors, police, government ministries and community structures as part of the wider GBV coordination architecture (MWACSMED, 2023). The Ngorima Village findings therefore mirror the national policy direction, although the local evidence also shows that coordination still depends heavily on personalities, trust and resource availability.

4.3.3 Most Effective Intervention Strategies

Participants considered locally grounded and participatory strategies to be the most effective. Community dialogues held at the dare, awareness campaigns, counselling, VFU involvement, faith-based counselling and traditional leadership interventions were repeatedly identified as

useful. The dare was treated as especially important because it provides a culturally recognised space for discussing community conduct, family disputes and moral expectations.

> *"When issues are discussed openly at the dare, people learn and change their behaviour."*

This view suggests that participants value interventions that are close to community life. Programmes delivered through familiar settings are more likely to be accepted because they do not appear foreign or imposed. Focus group participants also mentioned drama, music, church gatherings and football tournaments as useful methods because they attract different age groups and reduce the discomfort that often surrounds direct discussions of GBV.

> *"We learn about GBV through meetings, churches and even football tournaments that bring people together."*

The perceived usefulness of participatory methods supports the social ecological approach to GBV prevention. The social ecological model holds that violence is shaped by interacting individual, relational, community and societal factors (Bronfenbrenner, 1979; Heise, 1998). In Ngorima Village, effective intervention cannot rely on individual counselling alone. It must also address family norms, peer pressure, male authority, community silence and institutional access. This explains why respondents valued interventions that combine information, dialogue, culture and service referral.

4.3.4 Challenges in Implementing GBV Interventions

Although the study identified many intervention strategies, it also found several barriers that weaken implementation. Key informants mentioned fear of reporting, lack of financial resources, transport difficulties, shortage of trained personnel, family resistance, religious pressure, cultural silence and community resistance. These barriers affected both service delivery and survivor access.

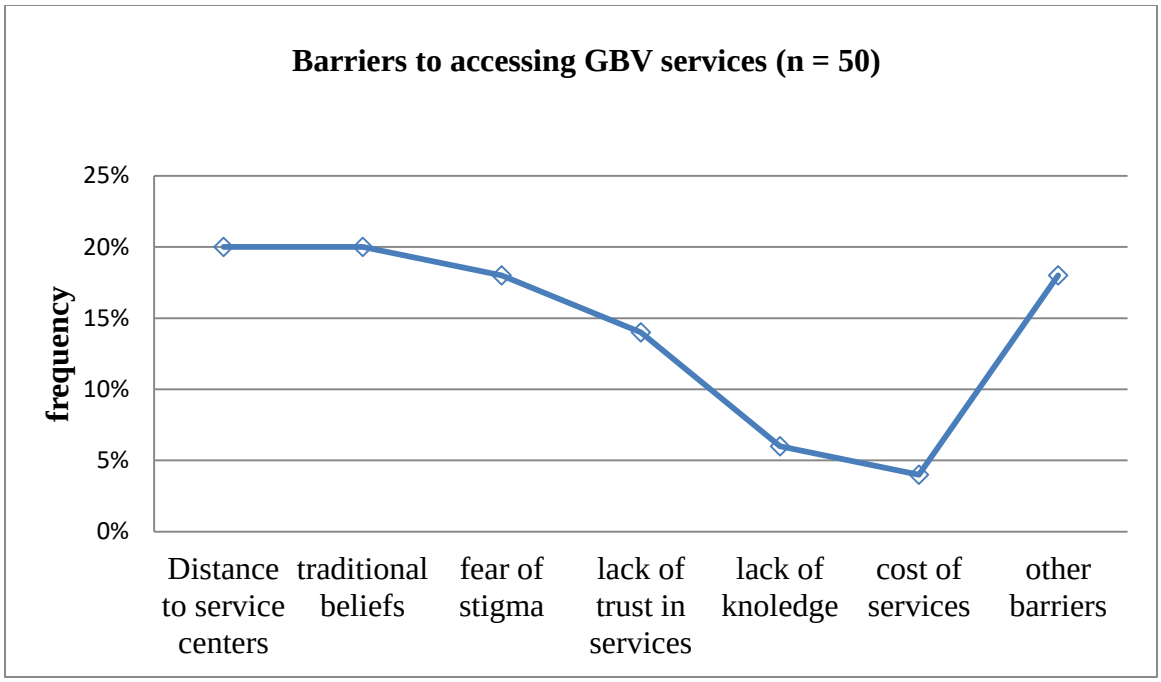


Figure 4.6: Barriers to accessing GBV services (n = 50)

Source: Field data (2026)

Figure 4.6 shows that distance to service centres and cultural or traditional beliefs were the leading barriers, each reported by 20% of respondents. Fear of stigma and other barriers each accounted for 18%, while lack of trust in services accounted for 14%. Lack of knowledge and cost of services were less frequently reported, but they remain important because they affect poor households and isolated survivors.

"Some victims do not report abuse because they fear being rejected by their families."

The findings reveal that access problems are both physical and social. Distance limits access because survivors may need transport money, time and privacy to reach police, health or counselling services. Cultural beliefs limit access because survivors may fear blame, shame, disbelief or pressure to preserve marriage. ActionAid Zimbabwe (2022) similarly found that some GBV response services in Zimbabwe are not readily accessible and that communities face knowledge, technical and service delivery gaps. The Ngorima findings therefore show a local version of a wider national challenge.

"People attend meetings, but survivors are afraid to speak out because of stigma."

This finding explains why awareness levels can be high while reporting remains low. Community members may know that services exist, but still avoid them because of social consequences. The gap between knowledge and action is central to the efficacy problem identified in this chapter. It means that interventions must go beyond information sharing and create conditions in which survivors feel safe, believed and protected.

4.4 The Efficacy of Current Intervention Strategies

This section responds to the second research objective, which sought to examine the efficacy of current GBV intervention strategies in Ngorima Village. Efficacy was assessed through perceived effectiveness, recorded successes, service utilisation and the barriers that continue to limit outcomes. The findings show that community members generally view the interventions as useful, but actual help-seeking remains low. This creates a major gap between perceived effectiveness and practical use.

4.4.1 Perceived Effectiveness of GBV Interventions

The survey results show cautious confidence in existing GBV interventions. Key informants also reported positive changes among church members, young couples and survivors who accessed health or police support. However, the qualitative evidence showed that many cases still remain hidden, delayed or informally settled. This means that perceived effectiveness should be interpreted carefully.

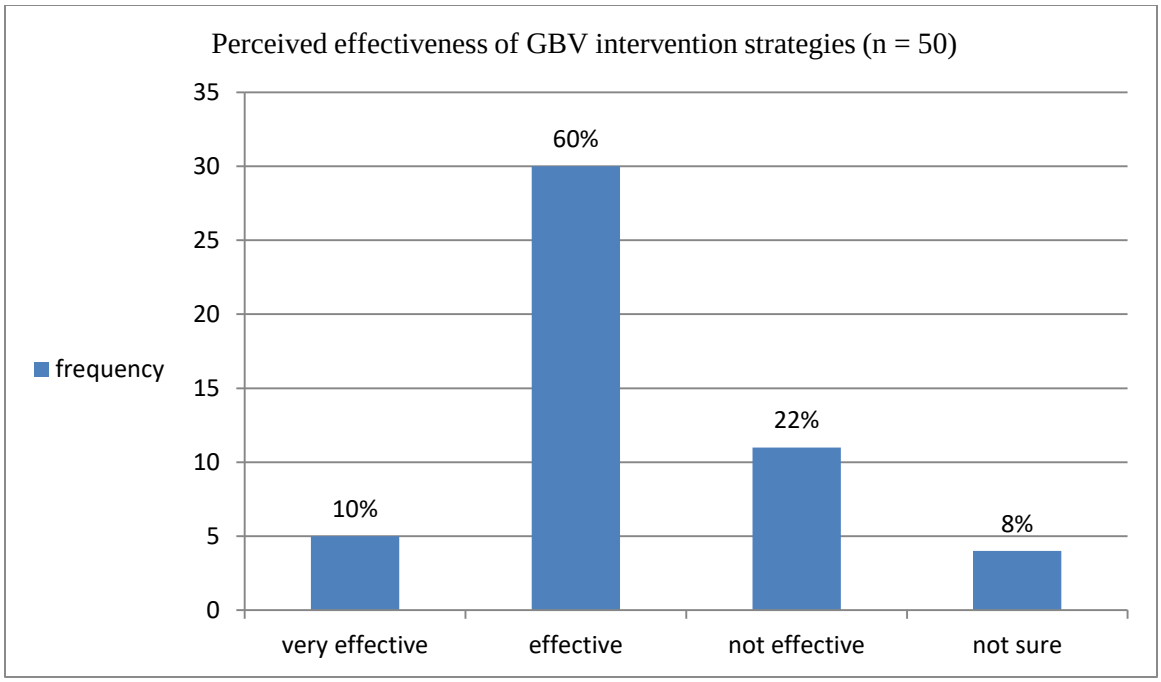


Figure 4.7: Perceived effectiveness of GBV intervention strategies (n = 50)

Source: Field data (2026)

Figure 4.7 shows that 10% of respondents rated GBV interventions as very effective, while 60% rated them as effective. A further 22% rated them as not effective and 8% were not sure. Combined, 70% of respondents therefore expressed a positive view of the current interventions. This result suggests that the community recognises value in existing programmes, especially where they provide awareness, counselling, mediation, referral and case follow-up.

> *"The strategies are effective in handling reported cases, but many cases still go unreported."*

This key informant statement captures the main tension in the findings. The interventions appear to work better when cases are reported early and routed through appropriate structures. Their impact is weaker when cases remain hidden, when families discourage reporting or when survivors lack transport and confidence. The finding is consistent with the Zimbabwe National GBV Strategy, which identifies poor help-seeking behaviour, patriarchal attitudes, human resource constraints and weak coordination as barriers to a stronger national response (MWACSMED, 2023).

> *"There is some reduction, but GBV still happens secretly."*

The focus group view shows that visible community change may coexist with hidden violence. This is important because programme effectiveness cannot be measured only by public awareness or general impressions. It must also consider reporting behaviour, survivor safety, service quality, confidentiality, case completion and long-term protection. Current literature on Zimbabwe confirms that violence against women and girls remains complex and persistent, particularly where gender norms, family structures and economic dependence limit women's agency (Bengesai & Chikhungu, 2025).

4.4.2 Household Use of GBV Assistance

Service utilisation was low despite high awareness and positive perceptions. Only 5 out of 50 respondents reported that they or a household member had sought help for a GBV issue. This represents 10% of the sample. The result is important because it shows that awareness campaigns have reached people, but they have not fully removed fear, mistrust or practical access barriers.

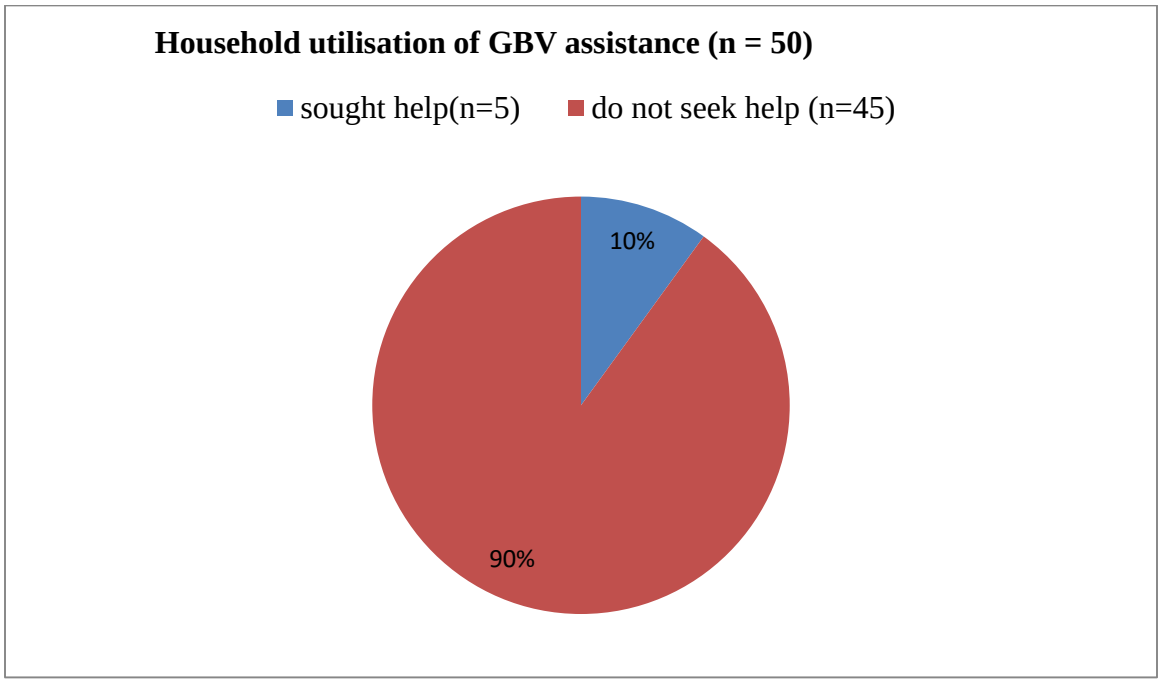


Figure 4.8: Household utilisation of GBV assistance (n = 50)

Source: Field data (2026)

Figure 4.8 shows the scale of the awareness-utilisation gap. Although 96% of respondents were aware of GBV programmes, 90% had not used GBV assistance for themselves or a household

member. This does not mean that only 10% experienced GBV. Rather, it indicates that formal or semi-formal help-seeking remains limited. In a rural context, non-use may reflect stigma, fear of family rejection, distance, limited confidentiality, preference for informal settlement and dependence on the perpetrator or family networks.

This gap has implications for programme design. It suggests that the next stage of intervention should focus on safe access, confidential reporting, survivor accompaniment, transport assistance and community protection. Awareness campaigns should continue, but they should be linked to clear pathways for action. Programmes that inform people without helping them reach services may increase knowledge without increasing protection.

4.4.3 Successes Recorded from GBV Interventions

Despite low utilisation, the study found evidence of meaningful progress. Key informants reported improved awareness, gradual increases in reporting, better recovery among survivors who reached health services, stronger police follow-up in some cases and reduced violence among certain groups, particularly church-linked groups and young couples exposed to counselling. These successes are incremental rather than complete, but they show that interventions are influencing community attitudes.

> *"There is now more awareness and some women are beginning to report cases and depend less on their abusers."*

This statement is significant because it links awareness to survivor agency. Reporting and reduced dependence are not only service outcomes. They are also indicators of changing power relations. Feminist theory explains GBV as a product of unequal gender power, economic dependency and social control. From that perspective, interventions are more effective when they help survivors gain voice, information, economic options and institutional support.

The successes also show the value of combining formal and community-based responses. Police and health services provide protection, evidence, treatment and legal pathways, while community dialogues, churches, schools and traditional leaders can shape norms before cases escalate. The social ecological model supports this layered approach because it recognises that violence prevention requires action at multiple levels rather than isolated service delivery (Bronfenbrenner, 1979; Heise, 1998).

4.4.4 Ongoing Challenges Affecting Service Effectiveness

The study also found that several problems continue to reduce the effectiveness of existing strategies. These include late reporting, resource shortages, limited service reach, fear of retaliation, family pressure, cultural silence and the absence of nearby confidential support structures. These challenges show that intervention coverage is wider than intervention depth. People hear GBV messages, but many are still unable or unwilling to act on them.

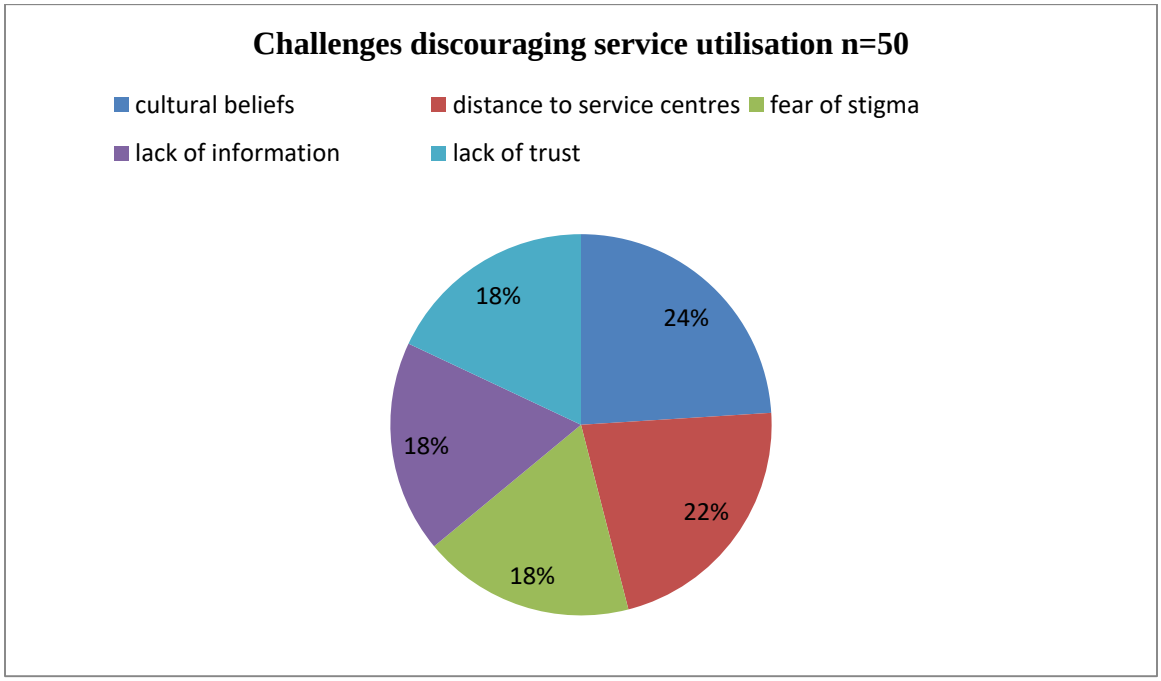


Figure 4.9: Challenges discouraging use of GBV services (n = 50)

Source: Field data (2026)

Figure 4.9 shows that cultural beliefs was the most frequently reported challenge discouraging use of GBV services, accounting for 24% of responses. Distance to service centres followed at 22%, while fear of stigma, lack of information, and lack of trust or cost each accounted for 18%. The closeness of these percentages shows that there is no single barrier. Instead, survivors face a combined system of cultural, economic, informational and institutional obstacles.

"Many victims delay reporting, which makes it difficult to provide effective help."

Late reporting weakens both protection and justice outcomes. In medical cases, delay can reduce the value of immediate treatment and psychosocial support. In legal cases, delay can affect evidence, witness follow-up and survivor confidence. In family and community cases, delay can

allow intimidation, pressure and informal settlement to take over. This finding supports the need for locally accessible first-contact structures that can respond before cases disappear into private negotiation.

The current national policy environment recognises this need. Zimbabwe's National GBV Strategy identifies response, care and support services as a priority area and calls for strengthened coordination, partnerships, capacity and resource mobilisation (MWACSMED, 2023). The Ngorima village findings show the reasons this policy direction matters at village level. Without local access points and trusted referral systems, national policy commitments may not translate into survivor safety.

4.4.5 Influence of Cultural Beliefs and Community Attitudes

Cultural beliefs and community attitudes emerged as the strongest cross-cutting factor shaping the efficacy of GBV interventions. Key informants and focus group participants reported that some norms discourage women from speaking out, normalise male dominance, treat violence as a private marital issue and pressure survivors to preserve family reputation. These attitudes reduce reporting even when services are available.

"Cultural beliefs make it difficult for women to speak out because they fear shame."

The above statement shows that stigma is not only an individual fear. It is produced by social judgement. A survivor may fear that the community will blame her, accuse her of disrespecting marriage or reject her for exposing a family issue. This makes silence appear safer than reporting, especially where the survivor depends on the spouse, in-laws or extended family for shelter, food or social acceptance.

"People say that is how marriage is supposed to be, so women stay silent."

This focus group view shows how violence can be normalised through everyday speech. When abuse is presented as a normal part of marriage, interventions face resistance because they challenge deeply held assumptions about authority, obedience and family privacy. Recent Zimbabwe-focused literature confirms that intimate partner violence is sustained by social norms, unequal power relations and limited autonomy for women and girls (Bengesai & Chikhungu, 2025).

"People fear being judged or not believed, so they keep quiet."

The findings show that effective GBV programming in Ngorima Village must directly address attitudes, not only services. Cultural sensitivity should not mean accepting harmful norms. It should mean using respected local platforms such as traditional leaders, churches, schools, youth groups and community dialogues to challenge harmful beliefs in ways that the community can hear and own.

4.5 Proposed Strategies to Improve GBV Interventions in Rural Zimbabwe

This section responds to the third research objective, which sought to propose strategies for improving GBV services and reducing GBV cases in rural Zimbabwe. The recommendations came from survey respondents, key informants and focus group participants. They point to the need for stronger awareness, community education, improved service access, economic empowerment, traditional leader involvement, male engagement, school-based prevention, mobile reporting and better institutional coordination.

4.5.1 Recommended Improvements to Existing Strategies

Participants recommended improvements that build on what already exists rather than replacing the current response entirely. Key informants proposed more male inclusion, stronger women's economic empowerment, better access to reporting centres, more health education, integration of GBV messages into churches and expansion of safe survivor support mechanisms. Survey respondents ranked awareness campaigns and community education as the top priorities.

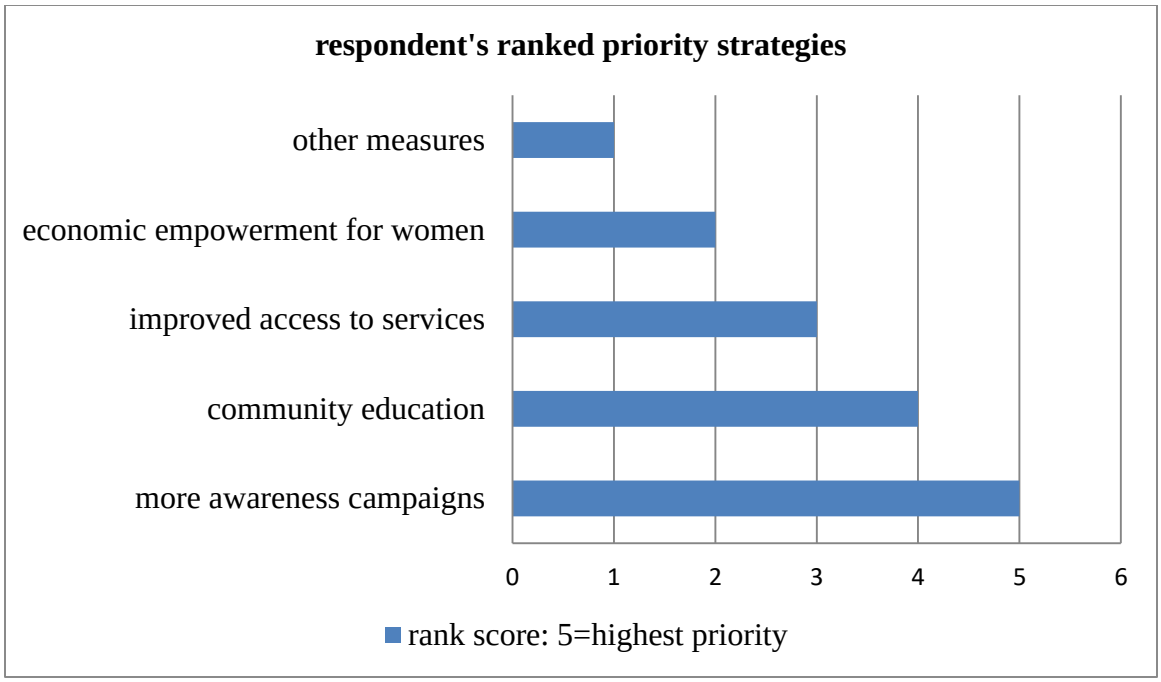


Figure 4.10: Ranked priority strategies for improving GBV services

Source: Field data (2026)

Figure 4.10 presents the ranked priority strategies. Awareness campaigns received the highest rank score, followed by community education, improved access to services, economic empowerment for women and other measures such as shelters and stronger law enforcement. The ranking shows that respondents still believe information and education are necessary. However, the earlier findings show that awareness should now be made more practical, targeted and action-oriented. A key informant said,

"Empowering women economically can reduce their dependence on abusive partners."

Economic empowerment was not the highest-ranked strategy, but it remains central to long-term GBV prevention. Financial dependence can make it difficult for survivors to report abuse, leave unsafe relationships or resist family pressure. Skills training, savings groups, income-generating projects and links to social protection can strengthen survivor options. This aligns with the National GBV Strategy's emphasis on resource mobilisation, partnerships and community-level response systems (MWACSMED, 2023).

The proposed improvements therefore point to an integrated strategy. Awareness should continue, but it should be paired with practical support. Community education should include men, boys,

couples, elders, churches and schools. Reporting pathways should be brought closer to villages through mobile visits, trained local focal persons and confidential referral systems. Economic empowerment should be connected to survivor support rather than treated as a separate development activity.

4.5.2 Role of Traditional Leaders in Strengthening GBV Interventions

One of the strongest findings was the community's support for greater traditional leader involvement. All 50 respondents agreed that traditional leaders can help reduce GBV when they are properly engaged. Key informants suggested that traditional leaders should promote gender equality, discourage harmful practices, encourage reporting, support survivors, enforce community by-laws and work closely with churches, NGOs, health workers and the police.

"Traditional leaders must take the lead in discouraging GBV and supporting victims" one key informant insisted.

The unanimous support for increased traditional leader involvement result is important because traditional leaders are close to households and have authority in rural dispute resolution. If they actively condemn GBV, they can shift community norms. If they minimise abuse, they can reinforce silence. Their role therefore requires training, accountability and clear referral protocols.

The National GBV Strategy includes traditional leaders and ward-level structures within the broader coordination framework for GBV prevention and response (MWACSMED, 2023). The Ngorima findings support this approach but add a caution. Traditional leaders should not be used only as mediators. They should be trained to recognise survivor safety, confidentiality, referral needs, police-reportable offences and the limits of family settlement. Their authority should protect survivors rather than return them to unsafe conditions.

4.5.3 Alternative and Innovative Intervention Approaches

Participants proposed several approaches suited to rural contexts. These included male engagement programmes, school-based GBV education, mobile reporting units, local support centres, youth-friendly services, couple-focused sessions on communication and financial management, drama, music, sport and elder-led community discussions. These proposals reflect the community's understanding that formal offices alone cannot carry the GBV response in a rural setting.

"Using drama and involving elders can help change people's thinking."

Drama, music and sport were seen as useful because they can communicate difficult messages without beginning with accusation or confrontation. These methods create public discussion while reducing fear and defensiveness. They are also suitable for youth and men, who may be less likely to attend formal GBV meetings. In rural communities, prevention messages must travel through the spaces where people already gather.

"Services are far and sometimes we cannot afford transport to reach them."

This statement supports the need for mobile and decentralised services. Mobile reporting days, village-based case management, trained community focal persons, confidential referral cards and periodic outreach by VFU and health workers could reduce the distance barrier. Digital reporting may help some young people, but it should not replace physical access because rural connectivity, phone ownership and privacy are uneven. The most realistic innovation is therefore blended: community-based access supported by formal referral systems.

4.5.4 Institutional Recommendations to Implementing Organisations

Participants also directed recommendations to organisations implementing GBV programmes. These included increasing funding, improving inter-agency coordination, training local actors, strengthening referral systems, creating safe reporting systems, forming survivor support groups, providing transport support and expanding legal, psychosocial, medical and financial assistance. These recommendations show that community members understand GBV services as a system, not as one programme.

"Better coordination and funding can greatly improve service delivery."

Institutional strengthening is essential because weak coordination can cause survivors to move from one actor to another without clear help. The Zimbabwe National GBV Strategy identifies coordination, networking, partnerships, evidence-based programming and resource mobilisation as priority areas for the national response (MWACSMED, 2023). ActionAid Zimbabwe (2022) also found that inclusive GBV service delivery requires stronger accessibility, affordability, acceptability and responsiveness. The Ngorima findings confirm these priorities at local level.

Implementing organisations should therefore strengthen referral mapping, service directories, case follow-up systems and confidentiality protocols. They should also train community actors on

survivor-centred practice. A survivor-centred approach means respecting the survivor's safety, dignity, confidentiality and informed choices. Such practice is consistent with global guidance on essential services for women and girls subject to violence (UN Women et al., 2015).

4.6 Discussion of Findings

The findings show that Ngorima Village has a visible but incomplete GBV response system. Awareness is high, services are known, and several actors are involved. However, reporting and service utilisation remain low. This means the main problem is not absence of all interventions. The deeper problem is the weak conversion of awareness into safe help-seeking and sustained protection.

The first research objective was answered by showing that current interventions include awareness campaigns, traditional leadership interventions, NGO support, health services, police and VFU services, church counselling, school-based messages, community dialogues and informal support networks. These strategies reflect a multi-sectoral response, but the strongest local presence comes from NGOs and traditional leaders rather than formal institutions. This suggests that rural GBV programming must take community authority seriously while still protecting survivor rights.

The second research objective was answered by showing that current interventions are viewed as useful by most respondents, with 70% rating them as effective or very effective. Yet this positive perception is limited by low service utilisation. Only 10% reported that they or a household member had sought help for a GBV issue. This exposes a gap between programme visibility and practical access. The reasons include stigma, distance, fear, cultural beliefs, lack of trust and delayed reporting.

The third research objective was answered through participant recommendations. Respondents called for stronger awareness, community education, improved access to services, economic empowerment, traditional leader involvement, male engagement, school-based education, local support centres, mobile services, survivor support groups and better coordination. These recommendations are consistent with the national policy direction in Zimbabwe, which stresses prevention, response, care and support, capacity strengthening, evidence-based programming, coordination and resource mobilisation (MWACSMED, 2023).

The findings also support feminist theory and the social ecological model. Feminist theory helps explain how GBV is sustained by unequal gender power, economic dependence, cultural silence and patriarchal control. The social ecological model explains why GBV cannot be addressed at one level only. Individual counselling, household mediation, community dialogue, service access, institutional accountability and national policy must reinforce one another. The Ngorima evidence confirms that isolated activities cannot solve a problem rooted in personal, family, cultural and institutional systems.

4.7 Chapter Summary

This chapter analysed, presented and discussed the findings of the study on intervention strategies and the efficacy of GBV services in Ngorima Village, Chimanimani District. The study used a mixed methods approach based on a household survey of 50 respondents, key informant interviews and focus group discussions. The findings were presented using SPSS-style figures generated from the field data, supported by qualitative quotations and discussion.

The findings show that GBV interventions in Ngorima Village are diverse and multi-stakeholder in nature. They involve NGOs, traditional leaders, health workers, police, churches, schools, youth actors and community groups. Awareness of GBV programmes is very high at 96%, which suggests that outreach activities have reached most respondents. However, awareness has not translated into strong service utilisation. Only 10% of respondents reported that they or a household member had sought GBV-related help.

In terms of efficacy, most respondents viewed current interventions positively. Seventy percent rated the interventions as effective or very effective. The qualitative evidence also showed some gains, including increased awareness, gradual reporting, improved case follow-up and growing survivor confidence among some women. However, cultural beliefs, stigma, distance, late reporting, lack of trust and resource constraints continue to limit the full impact of GBV services.

The proposed strategies point to the need for a holistic rural GBV model. The model should strengthen awareness, bring services closer to communities, train traditional leaders, involve men and boys, expand school-based education, improve confidentiality, support survivor groups, provide transport assistance and increase funding and coordination. The next chapter should therefore draw conclusions and recommendations from these findings, with special attention to closing the gap between awareness and actual help-seeking.

CHAPTER FIVE: SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter presents the summary of findings, conclusions, implications for social work practice, recommendations, areas for future study, and a proposed rural GBV intervention model arising from the study titled Intervention Strategies on the Efficacy of GBV Services in Rural Areas in

Zimbabwe: A Case Study of Ngorima Village, Chimanimani District. The chapter brings together the empirical results reported in Chapter Four and relates them to the three research objectives that guided the study. These objectives were to explore the current intervention strategies used to curb gender-based violence in rural areas, to examine the effectiveness of those strategies in Ngorima Village, and to propose strategies that can improve GBV prevention and response in rural Zimbabwe.

The study used a mixed methods design. Data were drawn from key informant interviews, focus group discussions and a household survey of 50 respondents. This approach allowed the study to combine measurable patterns with the lived experiences of community members, service actors, and local institutions. The chapter therefore treats GBV service effectiveness as both a service-delivery issue and a social problem shaped by power relations, community norms, institutional capacity, and access to justice. This framing is consistent with current GBV literature, which presents violence against women and girls as a public health concern, a human rights violation and a development challenge requiring coordinated prevention and response systems (UN Women, 2024. As established in the literature, intimate partner violence affect roughly one third of women worldwide (WHO, 2024).

The chapter is arranged in eight sections. The first section introduces the chapter. The second section summarizes the findings according to the research objectives. The third section presents the conclusions of the study. The fourth section discusses implications for social work practice, training, ethics, and rural deployment. The fifth section gives recommendations for policy and practice. The sixth section identifies areas for future research. The seventh section presents a model for improving GBV service utilisation in rural communities. The final section summarizes the chapter.

5.2 Summary of Findings

This section summarizes the main findings in relation to the study objectives. The findings show that Ngorima Village has several GBV prevention and response structures, but those structures do not fully translate into service use. The most important pattern across the data is the gap between awareness and utilisation. Many residents know that GBV services exist, yet few survivors or affected households approach those services when abuse occurs. This gap is shaped by cultural

beliefs, stigma, distance, economic dependency, limited confidentiality, weak coordination, and uneven service coverage.

5.2.1 Current GBV Intervention Strategies in Ngorima Village

The first objective sought to identify the GBV intervention strategies currently implemented in Ngorima Village. The study established that the local response is diverse and multi-sectoral. The main strategies include awareness campaigns, counselling and referral services, traditional court sessions, victim support services, police intervention through the Victim Friendly Unit, medical treatment for survivors, faith-based counselling, economic empowerment initiatives and community support groups. This confirms that GBV intervention in the village does not depend on a single institution. It depends on formal systems, informal community structures and civil society support.

Quantitative findings showed that NGO-supported programmes were the most visible intervention strategy, accounting for 34% of the responses. Traditional leadership interventions followed at 28%, while health services accounted for 20%. These results suggest that community members are more likely to recognize services that are close to their everyday lives. Traditional leaders, health workers, churches, teachers, peer networks, and NGO workers are visible because they operate within the community space. Formal legal institutions remain important, but distance and fear reduce their practical accessibility.

Awareness of GBV programmes was high. Ninety-six percent of household survey respondents indicated that they knew at least one GBV prevention or response programme. Information reached community members through community meetings, churches, schools, health workers, radio, and peer networks. This finding suggests that awareness messages are circulating widely in the village. It also shows that programme visibility alone cannot be used as proof of programme effectiveness. A community may know that GBV services exist while still avoiding those services because of fear, stigma, pressure from relatives, or distrust of institutional processes.

The study also found that traditional leaders are central actors in the local GBV response. They were the most frequently cited stakeholders, reflecting the legitimacy they hold in rural governance. This finding agrees with recent Zimbabwean research showing that traditional leaders often use mediation, traditional courts, referrals to police, and community awareness activities to address GBV in rural settings (Hodzi, 2024). In Ngorima Village, their influence is a resource that

can strengthen prevention. It can also become a limitation when traditional processes protect family reputation more than survivor safety. This means that traditional leadership should be engaged through structured training, referral protocols, and accountability mechanisms.

Despite the range of interventions, implementation barriers remain significant. Respondents and key informants identified fear of reporting, long distances to service centres, cultural and religious norms, shortage of trained personnel, weak transport support, and resource constraints. These barriers weaken the practical reach of existing services. They also show why a rural GBV response must be designed around local geography, community power structures, and survivor safety. The Zimbabwe National Strategy to Prevent and Address Gender-Based Violence 2023-2030 recognizes this need for a coordinated multi-sectoral response that works across national, provincial, district, ward, and community levels (MWACSMED, 2023).

5.2.2 Efficacy of Current GBV Interventions

The second objective examined the effectiveness of current GBV interventions in Ngorima Village. The study found that existing interventions are producing some positive outcomes, but their overall effectiveness is limited by structural and socio-cultural barriers. Among household survey respondents, 70% rated existing GBV services as effective or very effective. Key informants also reported signs of improvement, including increased reporting, better survivor recovery in some cases, and reduced GBV incidents among some church members and young couples. These findings show that interventions can work when they are trusted, accessible, and supported by community actors.

The strongest evidence of limited efficacy was the awareness-utilisation gap. Although 96% of respondents knew about GBV services, only 10% reported that they or a household member had sought GBV-related assistance. This finding is central to the study. It means that awareness campaigns have succeeded in spreading information, but they have not removed the social and practical costs of help-seeking. The gap was linked to cultural beliefs, cited by 20% of respondents as the main barrier; distance, also cited by 20%; fear of stigma, cited by 18%; and lack of information, cited by 6%. The remaining barriers related to family pressure, fear of retaliation, financial dependency, and distrust of formal systems.

Qualitative findings explained why the gap persists. Participants reported that GBV often remains hidden because families treat it as a private matter. Some survivors delay reporting because they

fear being blamed, rejected, or pressured to return to abusive relationships. Others remain silent because they depend financially on the perpetrator. Delayed reporting weakens medical, psychosocial, and legal responses. It also reduces the ability of service providers to gather evidence, provide timely care, and protect survivors from further harm. Current global guidance emphasizes that violence against women is shaped by interacting individual, family, community and societal factors including gender inequality, societal norms that privilege men, low access to paid employment for women and weak legal sanctions (WHO, 2024).

The study therefore concludes that the efficacy of GBV interventions in Ngorima Village is partial rather than complete. Programmes have created awareness and opened service pathways, but they have not yet transformed the social conditions that prevent survivors from using those pathways. A service can exist and still fail if the survivor cannot reach it, cannot trust it, or cannot use it without losing family support, income, privacy, or safety. The effectiveness of future interventions will depend on whether they reduce these hidden costs of help-seeking.

5.2.3 Proposed Strategies to Improve GBV Services

The third objective sought to identify strategies that could improve GBV services in Ngorima Village and comparable rural communities. Participants proposed a comprehensive set of measures. Household survey respondents ranked increased awareness campaigns as the highest priority, followed by community education, improved service accessibility, economic empowerment for women, and stronger law enforcement. These priorities show that community members want more than information. They want services that can be reached, trusted, and connected to economic and legal protection.

All 50 household survey respondents agreed that greater involvement of traditional leaders is essential to reducing GBV. Key informants made similar recommendations. They called for stronger economic empowerment programmes, more male inclusion in awareness activities, and integration of GBV education into church and school programmes. Focus group participants proposed youth-friendly services, mobile reporting units, couple-focused programmes, survivor support groups, community drama and music as awareness tools, and the provision of shelters, legal aid, and psychosocial support.

Participants also emphasized the need for stronger institutional coordination. They recommended sustained funding, clearer referral systems, better inter-agency communication, and capacity

building for local practitioners and traditional leaders. These recommendations correspond with Zimbabwe's national GBV framework, which recognizing the need for an integrated response, the strategy prioritizes building organizational capacity, fostering collaboration , expanding protection and acre services, utilizing evidence to inform programmes, securing resources and implementing measures that reduces vulnerability and risks (MWACSMED, 2023). The launch of the 2023-2030 National Strategy also confirms that Zimbabwe's policy direction is moving toward a whole-of-society response rather than isolated institutional action (SADC, 2024).

The proposed strategies point to one central lesson. GBV services in rural communities improve when prevention, protection, economic support, justice, and community norm change are treated as connected parts of one system. Awareness campaigns should continue, but they should be linked to confidential reporting, accessible care, economic support, trained community gatekeepers, and visible accountability for perpetrators.

5.3 Conclusions

The study investigated intervention strategies and the effectiveness of GBV services in rural Zimbabwe, using Ngorima Village as a case study. The first conclusion is that GBV services and structures exist in the study area, but they do not consistently reach the people who need them most. The intervention landscape appears broad because it includes NGOs, traditional leaders, churches, police, health workers, schools, and social welfare actors. In practice, however, service reach is weakened by distance, poor funding, limited trained personnel, and weak coordination between agencies.

The second conclusion is that awareness is high, but service utilisation remains low. This is the most significant finding of the study. The low use of services does not mean that residents lack all information. It shows that survivors face social, cultural, economic, and safety barriers that make reporting costly. Stigma, fear of family rejection, pressure to preserve marriage, economic dependency, and community silence prevent many survivors from seeking help. Information campaigns alone cannot solve this problem. They must be combined with social norm transformation, confidential reporting channels, economic empowerment, and survivor-centred support.

The third conclusion is that traditional leaders are essential to rural GBV prevention and response. They are close to the community, widely recognized, and able to influence local norms. Their

authority can improve early identification, referral, community dialogue, and public accountability. However, their role must be reoriented through training and clear protocols so that traditional processes do not silence survivors or treat violence as a private family matter. This conclusion is consistent with Hodzi's (2024) finding that traditional leaders can be important rural GBV actors when they are supported by education, referral links, and institutional collaboration.

The fourth conclusion is that GBV interventions in Ngorima Village need a stronger economic dimension. Many survivors remain in abusive relationships because they lack independent income, transport money, shelter options, or family support. Economic empowerment should therefore be treated as part of GBV prevention and response rather than as a separate development activity. Savings groups, micro-enterprise training, market access, and livelihood support can reduce dependency and increase the practical ability of survivors to seek help.

The final conclusion is that a rural GBV response must be coordinated. No single actor can address GBV effectively. Police, social workers, health workers, traditional leaders, churches, schools, NGOs, and community groups must work through a shared referral pathway. The current system is weakened when survivors move from one office to another without clear guidance, documentation, protection planning, or follow-up. A coordinated model is therefore required to close the awareness-utilisation gap and improve survivor outcomes.

5.4 Implications of the Study

The findings have direct implications for social work practice. They show that individual casework alone is insufficient in rural GBV contexts. Social workers must work with survivors, families, communities, traditional structures, schools, churches, health facilities, police, and local authorities. This layered approach is necessary because GBV is produced and sustained by relationships, norms, institutions, and economic conditions. The role of social work should therefore include counselling, case management, safety planning, community education, advocacy, referral coordination, and policy engagement.

The study also implies that culturally embedded institutions should not be treated only as obstacles to professional intervention. Traditional courts, village leadership, churches, and women's groups are underused platforms for prevention and norm change. In rural communities, these structures often have more daily influence than distant formal institutions. Social workers should engage them while maintaining professional standards of confidentiality, survivor-centred practice, and

human dignity. This requires clear boundaries. Community structures must support survivor safety and referrals; they must not pressure survivors into silence or reconciliation against their interests.

Training institutions also need to revise how they prepare social workers for rural GBV practice. Rural practice requires knowledge of cultural dynamics, trauma-informed care, confidentiality in small communities, men's engagement, traditional authority systems, and multi-sectoral coordination. Mandatory rural field placements would expose students to the service gaps that shape GBV outcomes outside urban centres. This would align social work training with the practical needs of communities where formal services are limited and where paraprofessionals often carry much of the response burden.

The findings further imply that confidentiality is not merely an administrative requirement in rural GBV work. In small communities where people know each other, a breach of confidentiality can expose survivors to blame, retaliation, or social exclusion. Rural GBV services therefore require strict privacy protocols, careful record handling, safe referral practices, and discreet communication systems. Survivor-centred justice approaches emphasize that systems should reduce harm, improve access, and respect survivors' choices throughout the response process (International Development Law Organization [IDLO], 2022).

The study also has implications for workforce deployment. GBV response in Ngorima Village is carried largely by volunteers, paraprofessionals, traditional actors, health workers, and NGO staff. These actors are important, but they cannot replace trained social workers. Deploying qualified social workers to rural facilities and community organizations would improve assessment, counselling, case management, safety planning, and referral coordination. Retention incentives are needed because underserved rural areas should be treated as a professional priority rather than as hardship placements.

Finally, the study contributes to local knowledge production. Rural Zimbabwean GBV models should be grounded in local realities rather than copied from urban or external contexts. The proposed model in this chapter responds to the conditions identified in Ngorima Village: high awareness, low utilisation, strong traditional authority, limited access, economic dependency, stigma, and weak coordination. This makes the model relevant to similar rural communities, while still requiring local adaptation before implementation.

5.5 Recommendations

The following recommendations are drawn from the findings and conclusions of the study. They are directed at government ministries, local authorities, social welfare institutions, traditional leaders, NGOs, churches, schools, and professional bodies involved in GBV prevention and response.

The Ministry of Women Affairs, Community, Small and Medium Enterprises Development, working with the Ministry of Public Service, Labour and Social Welfare, should ensure that high-prevalence rural wards have access to trained social workers and a functional Victim Friendly Unit referral link. The goal should be to reduce the distance between survivors and formal support services.

Government and development partners should fund mobile GBV service units that visit remote villages on a regular schedule. These units should provide confidential reporting, psychosocial support, basic legal guidance, health referrals, and follow-up services. This directly responds to the distance barrier identified in the study.

District Social Welfare Offices should conduct a ward-level GBV service gap analysis. The analysis should identify villages with weak access to reporting channels, health facilities, counselling, transport, legal support, shelters, and trained personnel. The findings should guide the placement of outreach workers and mobile services.

Economic empowerment should be integrated into GBV programming. Savings groups, micro-enterprise training, agricultural livelihood support, and market linkage programmes should target women at risk of abuse and survivors who need financial alternatives. The programme should include measurable income targets and follow-up support.

Traditional leaders, religious leaders, and community gatekeepers should receive structured GBV training. The training should cover GBV recognition, survivor-centred communication, referral pathways, confidentiality, harmful norms, child protection, and the limits of mediation in abuse cases.

Traditional leaders should hold quarterly GBV-focused community dialogue sessions. These sessions should challenge the normalization of abuse, promote survivor support, and publicly

reinforce that GBV is not a private family matter. Traditional courts should refer serious cases to appropriate formal services without delay.

The Social Workers Council of Zimbabwe should introduce a mandatory GBV practice competency for registration and continuing professional development. The competency should include trauma-informed care, rural safety planning, case documentation, inter-agency coordination, and ethical practice in small communities.

NGOs and government departments should establish a shared referral protocol for Ngorima Village and surrounding wards. The protocol should state who receives reports, who provides immediate safety support, who handles health referrals, who provides psychosocial care, who follows up, and how cases are documented without compromising confidentiality.

Schools and churches should integrate age-appropriate GBV education into routine community programmes. These spaces can influence attitudes among young people, couples, parents, and religious groups. The content should focus on respect, non-violence, reporting pathways, bystander responsibility, and support for survivors.

Monitoring and evaluation should be built into all GBV programmes. Indicators should include service utilisation rates, referral completion, survivor satisfaction, number of trained local actors, number of community dialogues, changes in attitudes, and time taken to link survivors to support.

5.6 Areas for Future Study

This study makes a contribution to understanding GBV intervention efficacy in a rural Zimbabwean context. However, its scope was limited to one case site. Future research should build on the findings through the following areas.

5.6.1 Perpetrator Perspectives

Future research should examine the perspectives of GBV perpetrators in rural Zimbabwe. This study focused mainly on survivors, service providers, and community members. Perpetrator-focused research would help explain the attitudes, social pressures, masculine norms, economic stressors, substance use patterns, and cultural beliefs that sustain violent behaviour. This evidence is needed for designing effective behaviour change programmes and male engagement strategies.

5.6.2 Longitudinal Assessment of Intervention Efficacy

The study used a cross-sectional design and therefore captured the situation at one point in time. Future research should track the same community over three to five years. A longitudinal study would show whether interventions produce sustained changes in attitudes, reporting behaviour, service utilisation, and survivor outcomes. This would be particularly useful for evaluating economic empowerment programmes, traditional leader training, school-based programmes, and mobile service units.

5.6.3 Child Witnesses and GBV

The experiences of children who witness GBV in rural households require dedicated research. This group was beyond the main scope of the study, yet children can be affected by fear, disrupted schooling, family instability, and learned acceptance of violence. Future studies should examine how witnessing GBV shapes children's attitudes toward gender, power, conflict, and family relationships. Research should also assess school-based and community-based interventions that can reduce the intergenerational transmission of violent norms.

5.6.4 Digital and Technology-Based GBV Interventions

Future research should examine the feasibility of technology-supported GBV reporting and support in rural areas. Mobile connectivity is expanding, but rural infrastructure, phone ownership, privacy, literacy, and network costs vary. Studies should assess whether USSD reporting tools, confidential helplines, WhatsApp-based referral support, community radio, and SMS awareness systems can improve help-seeking without exposing survivors to new safety risks.

5.6.5 Comparative Rural Studies

The study focused on Ngorima Village in Chimanimani District. Future research should compare several rural districts with different levels of NGO presence, traditional authority structures, economic conditions, and service access. Comparative studies would show which barriers are local and which are common across rural Zimbabwe. This would provide stronger evidence for national policy planning and resource allocation.

5.6.6 The Dual Role of Religion in GBV

Future studies should examine the dual role of religious institutions in GBV prevention and response. This study found that churches can support counselling, awareness, and moral accountability. At the same time, some religious interpretations may reinforce male dominance,

silence survivors, or pressure women to remain in harmful relationships. A dedicated study would help identify the conditions under which faith-based actors become effective partners in GBV prevention and when they become barriers to help-seeking.

5.7 Proposed Rural GBV Intervention Model

The model proposed by this study responds to the central problem identified in Ngorima Village: a high level of GBV awareness combined with low service utilisation. The model assumes that information alone is insufficient where cultural norms, stigma, economic dependency, weak institutions, and poor coordination prevent survivors from seeking help. Its goal is to transform the social conditions that prevent help-seeking while strengthening the practical service pathways that survivors need.

5.7 Model

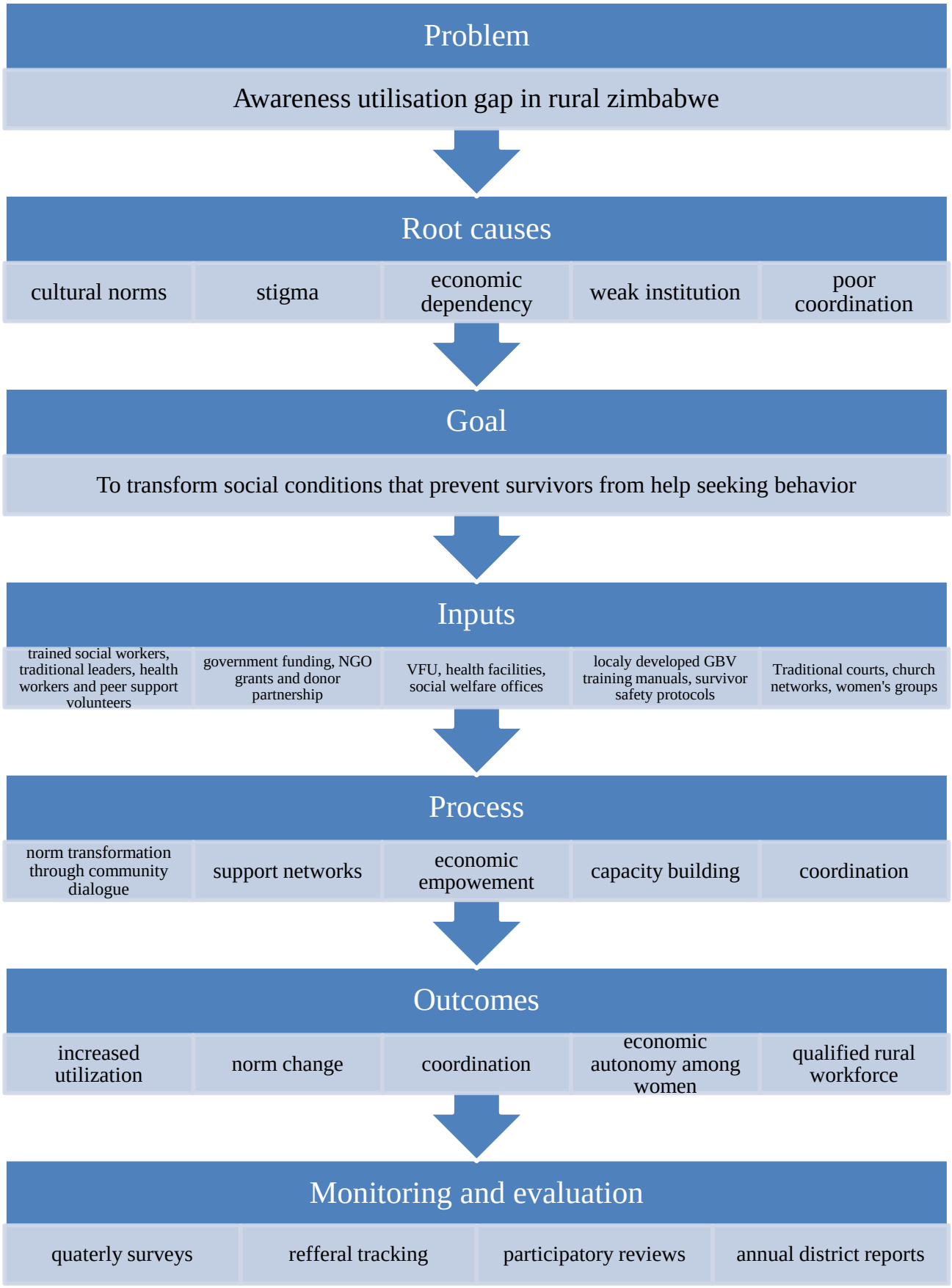

Problem
Awareness utilisation gap in rural zimbabwe
Root causes
cultural norms
stigma
economic dependency
weak institution
poor coordination
Goal
To transform social conditions that prevent survivors from help seeking behavior
Inputs
trained social workers, traditional leaders, health workers and peer support volunteers
government funding, NGO grants and donor partnership
VFU, health facilities, social welfare offices
localy developed GBV training manuals, survivor safety protocols
Traditional courts, church networks, women's groups
Process
norm transformation through community dialogue
support networks
economic empowement
capacity building
coordination
Outcomes
increased utilization
norm change
coordination
economic autonomy among women
qualified rural workforce
Monitoring and evaluation
quaterly surveys
refferal tracking
participatory reviews
annual district reports

Fig 5.1 model

Source: field findings from Ngorima Village (2026).

5.7.1 Recommendations for Model Implementation

The primary responsibility for implementing this model rests with government ministries, traditional structures, and civil society organizations working in a coordinated partnership. The Ministry of Public Service, Labour and Social Welfare should lead the deployment of trained social workers to rural communities. The Ministry of Women Affairs, Community, Small and Medium Enterprises Development should coordinate the model within the national GBV policy framework. The Ministry of Health and Child Care should train frontline health workers in trauma-informed GBV response. The police Victim Friendly Unit should maintain accessible and survivor-sensitive reporting links.

At the local level, District Social Welfare Offices should manage referral pathways and case follow-up. Village-level structures should support confidential reporting and early identification of survivors who need help. NGOs should fill implementation gaps where government resources are limited, while avoiding parallel systems that weaken coordination. Traditional leaders have a unique role because they influence community norms. Their involvement should be formalized through training, referral duties, and accountability measures that prevent mediation from being used where survivor safety requires formal protection.

Economic empowerment must be treated as a core component of the model. The study shows that service utilisation is difficult when survivors depend economically on abusive partners. Savings groups, skills training, micro-enterprise support, agricultural projects, and market linkages should therefore be built into GBV programming. These interventions should be monitored for income growth, retention, and survivor safety rather than reported only as attendance numbers.

A standardized referral pathway is also required. The pathway should state the roles of health workers, social workers, police, traditional leaders, churches, NGOs, and schools. It should define reporting steps, timeframes, documentation requirements, confidentiality rules, and follow-up responsibilities. This would reduce the fragmented support that survivors currently experience when they move between institutions.

Survivor voices should remain central to the model. Participatory review meetings should be held twice a year. These meetings should include survivors where it is safe and ethical to do so, as well as women's groups, youth representatives, traditional leaders, social workers, health workers, and NGOs. The purpose should be to assess what is working, what is unsafe, what is inaccessible, and what needs to change.

The model has significance beyond Ngorima Village. It should be tested through a longitudinal study that tracks service utilisation, community attitudes, referral completion, and survivor outcomes over at least three years. Such research would generate evidence for scaling the model to other rural districts in Zimbabwe. Universities and training institutions should contribute by producing rural-practice-ready graduates and by partnering with communities to test and refine locally grounded GBV interventions.

5.8 Chapter Summary

This chapter presented the summary of findings, conclusions, implications, recommendations, areas for future study, and a proposed intervention model for improving GBV services in Ngorima Village. The findings show that the main challenge is not the absence of awareness. The main challenge is the failure to translate awareness into help-seeking. This failure is produced by cultural norms, stigma, economic dependency, distance, weak institutions, and poor coordination.

The conclusions responded directly to the three research objectives. Current GBV interventions are present and multi-sectoral, but their reach is uneven. The interventions are partly effective, but their impact is reduced by social and structural barriers. Proposed improvements include stronger traditional leader involvement, economic empowerment, accessible services, confidential reporting, male engagement, stronger law enforcement, and coordinated referral systems.

The chapter also showed that social work practice must operate at both individual and structural levels. Rural GBV work requires counselling, safety planning, community norm change, inter-agency coordination, ethical confidentiality, and trained personnel. The proposed model therefore targets the awareness-utilisation gap through norm transformation, economic empowerment, capacity building, coordination, monitoring, and survivor-centred practice. The chapter recommends that this model be tested through future longitudinal research so that Zimbabwe can build a stronger local evidence base for rural GBV prevention and response.

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APPENDICIES

ANNEX A: Chief's approval to conduct the research

ANNEX B: Key Informant Interview (KII) Guide

Topic: Intervention strategies on the efficacy of GBV services in rural areas in Zimbabwe: A case of Ngorima Village, Chimanimani District

Introduction

Thank you for agreeing to participate in this research. The purpose of this interview is to collect in depth information on gender-based violence (GBV) intervention strategies on the effficacy of GBV services in Ngorima Village. The information gathered will be used strictly for academic purposes and confidentiality will be maintained. They are no right or wrong answers and your honest views and experiences are highly valued.

Objective 1: To explore current intervention strategies implemented to curb GBV in rural areas

1. What GBV intervention strategies are currently being implemented in Ngorima Village ?

2. Which institutions or stakeholders are involved in implementing these GBV intervention strategies ?

3. Which intervention strategies has been most helpful in Ngorima village?

4. What are the main challenges faced by in implementing GBV intervention strategies in rural areas?

Objective 2: To examine the efficacy of the current intervention strategies in Ngorima Village.

1. In your opinion, how effective are the current GBV intervention strategies in reducing GBV cases in Ngorima Village?

2. What successes have been recorded so far as a result of these intervention strategies?

3. What challenges or limitations affect the effectiveness of GBV services in this rural community?

4. How do cultural beliefs, traditional practices and community attitudes affect the effectiveness of GBV intervention strategies and service uptake?

Objective 3: To propose intervention strategies that can be utilized to improve and reduce GBV cases in rural Zimbabwe.

1. What improvements would you recommend to enhance the effectiveness of GBV intervention strategies in Ngorima Village?

2. What role should traditional leaders and community structures play in strengthening GBV prevention and response mechanism?

3. What new or alternative intervention strategies do you think would be suitable for reducing GBV in rural Zimbabwe?

4. What recommendations would you make to implementing organization to improve the overall efficacy of gbv services in rural Zimbabwe?

ANNEX C: Focus Group Discussion (FGD) Guide

Topic: Intervention strategies on the efficacy of GBV services in rural areas in Zimbabwe: A case of Ngorima Village, Chimanimani District

Introduction

Thank you everyone for joining this discussion. This focus group discussion aims to gather community perspectives on gender-based violence, existing intervention strategies and the effectiveness of GBV services in Ngorima Village. Participation is voluntary and all views shared will remain confidential. Participants are encouraged to speak freely and respectfully.

Objective 1: To explore current intervention strategies implemented to curb GBV in rural areas.

1. What types of GBV prevention or response activities are you aware of in this community?

2. How did you learn about GBV services and information ?

3. Who are the main actors involved in addressing GBV in Ngorima Village ?

4. How does the community participate in or support these GBV intervention initiatives?

Objective 2: To examine the efficacy of the current intervention strategies in Ngorima Village.

1. Do you think the existing GBV services and intervention strategies are helping to reduce GBV in this community? Please explain.

2. How accessible are GBV services such as health care, police assistance and counseling for community members?

3. What challenges do community members face when seeking help for GBV-related issues?

4. How do traditional beliefs and community attitude in this village influence people's willingness to report GBV or seeking help?

Objective 3: To propose intervention strategies that can be utilized to improve and reduce GBV cases in rural Zimbabwe.

1. What changes or improvements would you suggest to make GBV services more effective in rural communities?

2. How can community members be more involved in preventing and responding to GBV?

3. What culturally appropriate strategies do you think can help reduce GBV in Ngorima Village and similar rural areas?

4. What specific support services or resources do GBV survivors in rural areas need most?

ANNEX D: Community Household Survey Guide

Topic: Intervention strategies on the efficacy of GBV services in rural areas in Zimbabwe: A case of Ngorima Village, Chimanimani District

Introduction

Good day. My name is Fortunate Tsododo and I am conducting research on intervention strategies on the efficacy of Gender Based Violence services in Ngorima village. Your household has been randomly selected to participate in this survey. The interview will take approximately 20-30 minutes. Participation is voluntary, responses will remain confidential and the data will be used solely for academic research purposes. Thank you for your participation.

Age

Sex

Marital status

Objective 1: To explore current intervention strategies implemented to curb GBV in rural areas

1. Are you aware of any GBV prevention or response programs operating in this community?

☐ Yes ☐ No

2. If yes, which of the following services are available in your area? (Tick all that apply)

☐ Police/Victim Friendly Unit

☐ Health services

☐ NGO support programs

☐ Traditional leadership interventions

- Other (specify)_____

3. How did you first learn about GBV services available in your community?

☐ Community meetings ☐ Health workers ☐ NGOs ☐ Police ☐ Other (specify)

4. In your opinion, what are the main barriers that prevent people in Ngorima village from accessing GBV services?{tick all that apply}

- Distance to services centers
- Cost of services
- Fear of stigma
- Cultural and traditional beliefs
- Lack of trust in services
- Lack of knowledge
- Other (specify)_____

Objective 2: To examine the efficacy of the current intervention strategies in Ngorima Village.

1. In your opinion, how effective are the current GBV services in addressing GBV cases in this community?

☐ Very effective ☐ Effective ☐ Not effective ☐ Not sure

2. Have you or someone in your household ever sought help for a GBV-related issue?

☐ Yes ☐ No If yes Where_____

3. What challenges, if any, discourage people from accessing GBV services in this community?

☐ Distance ☐ Fear of stigma ☐ Lack of information ☐ Cultural beliefs ☐ Other (specify)

4. How would you rate the quality of GBV you know?

- Excellent
- Good
- Fair
- poor

Objective 3: To propose intervention strategies that can be utilized to improve and reduce GBV cases in rural Zimbabwe

1. What measures do you think can improve the effectiveness of GBV services in your community? {rank 1-5, with 1 being the most important}

☐ More awareness campaigns

☐ Improved access to services

☐ Stronger law enforcement

☐ Community education

- involvement of traditional leaders
- economic empowerment for women
- shelter facilities for survivors
- other (specify)_____

2. Do you think involving traditional leaders more actively can help reduce GBV?

☐ Yes ☐ No ☐ Not sure

3. Please suggest any additional strategies that can help reduce GBV in Ngorima Village.

THE END