

A satellite map of Zimbabwe is shown, with a red overlay indicating a specific region and a blue line representing a water body or boundary. The map is used as a background for the report cover.

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Mapping the WRO sector in Zimbabwe

Research Report

Prepared by Ecorys and Triple Line | 04 2025

Document Control

Document title	Mapping the Women's Rights Organization sector (WRO) working on Gender Based Violence (GBV) in Zimbabwe
Reference no.	ZWE-2822J
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Date	31 March 2025

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List of abbreviations

CEDAW	Convention for the Elimination of All Forms of Discrimination against Women
CMR	Clinical Management of Rape
CSO	Civil Society Organisation
DDO	District Development Officer
EACDS	Expert Advisory Call Down Service
FCDO	Foreign and Commonwealth Development Office
FGD	Focus Group Discussion
GBV	Gender Based Violence
IMS	Information Management System
INGO	International Non-Government Organisation
IPV	Intimate Partner Violence
KII	Key Informant Interview
M&E	Monitoring and Evaluation
MWACSMED	Ministry of Women Affairs, Community, Small and Medium Enterprises Development
NGO	Non-Government Organisation
PDO	Provincial Development Officer
PVO	Private Voluntary Organisation
SAFE	Stopping Abuse and Female Exploitation (FCDO programme)
SSI	Semi Structured Interview
UN	United Nations
US	United States
USAID	United States Agency for International Development
UNFPA	United Nations Population Fund
VFU	Victim Friendly Unit
WCOZ	The Women's Coalition of Zimbabwe
WDC	Ward Development Coordinator
WRO	Women's Rights Organisation

WGRO	Women and Girls Rights Organisation
ZWLA	Zimbabwe Women Lawyers Association

Executive Summary

This report presents the findings of a comprehensive mapping of Women's Rights Organisations (WROs) and Women's and Girl's Rights Organisations (WGROs) working to prevent and respond to Gender-Based Violence (GBV) in Zimbabwe. The study was delivered by **Triple Line** and **Ecorys**, and commissioned by the Foreign, Commonwealth & Development Office (FCDO) through their Expert Advisory Call Down Service (EACDS), Lot 1: Women and Girls. This research aligns with FCDO's strategic objective to **localise and strengthen WROs and WGROs** as a step toward enhancing the effectiveness of GBV interventions for women and girls. The study aims to comprehensively map the WRO ecosystem and existing GBV services in Zimbabwe, identify capacity needs and gaps and uncover strategic opportunities to strengthen WROs' responses to GBV.

Context and Challenges

GBV remains a pervasive issue in Zimbabwe, with one in three women experiencing physical violence and one in four experiencing sexual violence since the age of 15. Despite progressive national policies such as the Zimbabwe National GBV Strategy (2023–2030), service provision remains fragmented, underfunded, and geographically inequitable. Urban centres such as Harare and Bulawayo are relatively well-served, while rural areas, border regions, and provinces like Matabeleland North and South face significant service gaps.

The GBV sector is heavily reliant on donor funding, which has declined sharply in recent years, leading to reduced service delivery and organisational closures. Short-term project-based funding undermines sustainability, while coordination mechanisms and data systems remain inconsistent or underdeveloped. Marginalised groups – including persons with disabilities, lesbian, gay, bisexual, transgender and queer (LGBTQ)+ individuals, adolescent girls, and male survivors – face additional barriers to accessing services.

Research Approach and Methodology

The research employed a mixed-methods approach that combined **qualitative** and **quantitative** research, gathering insights from WROs and relevant stakeholders, including government representatives and development partners. A **feminist research approach** was adopted, which took into account intersectional inequalities and the importance of including organisations representing marginalised groups.

Data collection methods included **key informant interviews (KIIs)** with prominent stakeholders and decision makers in the sector; an **online survey** with organisations working to address GBV in Zimbabwe; **semi-structured interviews** with selected organisations to probe more deeply into survey responses; and **focus group discussions (FGDs)**. This methodology ensured a nuanced analysis of the challenges and opportunities within the GBV sector in Zimbabwe, investigating the experiences of different sizes and types of WROs.

Study Findings

GBV service provision landscape

- **Response services:** While 46 out of 54 surveyed organisations reported providing GBV response services, there is significant variation in geographical coverage, quality, and sustainability. Counselling and psychosocial support are the most widely available services (provided by 77% of respondent organisations), while medical interventions, shelter services, and legal support remain severely limited (each provided by less than 25% of organisations).
- **Geographical disparities:** Service provision is concentrated in urban centres (particularly Harare and Bulawayo), leaving rural, remote, border areas, mining communities, and resettlement areas

significantly underserved. Matabeleland North and South were most frequently identified as service 'deserts', alongside areas of Mashonaland Central and rural parts of Manicaland.

- **Prevention approaches:** While 92% of organisations implement awareness-raising activities, evidence suggests many prevention initiatives lack sustainable funding, follow-up actions, or the use of evidence-based methodologies to achieve lasting behaviour change. There is also a concerning disconnect between prevention and response services, limiting the effectiveness of both.
- **Funding and sustainability:** The GBV sector faces severe funding challenges, with 24 respondents reporting they had closed or significantly scaled back services within the past five years. The recent withdrawal of USAID funding has exacerbated this situation, with many organisations facing immediate existential threats. Most organisations rely heavily on external donor funding, with limited government investment despite policy commitments.

Organisational capacity and coordination

- **Organisational capacity:** While many organisations have developed key governance structures, such as strategic plans (81%) and financial management systems (56% have fully audited statements), smaller organisations struggle with formalisation requirements, limiting their access to funding.
- **Coordination challenges:** Despite formal coordination structures at national, provincial, district, and ward levels, implementation varies significantly. In some areas, organisations operate in silos with little knowledge of other service providers, resulting in duplication of effort and gaps in service.
- **Data and evidence gaps:** The absence of a centralised GBV Information Management System (MIS) hampers effective planning, monitoring, and evaluation. Organisations have limited capacity to collect, analyse, and utilise data to inform programming or demonstrate impact.

Conclusions

The **GBV sector in Zimbabwe remains diverse and dynamic yet deeply constrained by systemic and structural limitations**. Geographic, thematic, and institutional gaps in service provision persist, with over-reliance on a few large actors presenting risks to service continuity. The deteriorating funding environment is leading to service contraction and undermining long-term sustainability.

Shelter provision is particularly inadequate, with concentration in a few areas leaving many survivors without viable options. Medical services represent another critical weakness, with few CSOs equipped to deliver medical interventions. Legal service provision, although historically strong, is similarly constrained by funding limitations.

Despite these constraints, counselling and psychosocial support remain relative strengths, and economic empowerment programming emerges as a widely used approach that cuts across both response and prevention. However, the research uncovered troubling patterns in humanitarian settings, including exploitation, poor safeguarding, and unsustained responses in crisis-affected areas.

Recommendations and practical next steps

For WROs/WGROs and other relevant civil society actors:

Build strategic partnerships to strengthen service delivery

- Actively participate in coordination platforms at all levels to improve referral mechanisms.
- Develop formal partnerships with complementary service providers to create more holistic client-centred support.

- Explore partnerships with traditional leaders, religious institutions, and local governments to expand shelter access.

Enhance organisational sustainability

- Strengthen coordination mechanisms at all levels.
- Develop social enterprise components to supplement donor funding.
- Strengthen financial management and reporting systems to meet donor requirements.
- Explore consortium approaches to access larger funding opportunities.

Improve evidence collection and utilisation

- Standardise data collection on GBV cases and service provision.
- Document successful locally-adapted interventions and approaches.
- Build capacity to measure and demonstrate programme impact.

For development partners (including government) and International Non-Governmental Organisations (INGOs):

Address geographical inequities

- Prioritise investment in underserved areas, particularly Matabeleland North and South, Mashonaland Central, and identified service deserts.
- Ensure funding follows evidence of actual presence and delivery.

Strengthen critical service gaps

- Address the acute shelter shortage through the funding and provision of community-based shelter models with appropriate technical assistance and safeguarding standards.
- Reinvest in medical and legal services, including provision of rape kits and training for health workers.
- Provide training and support for first responders, including community volunteers.

Foster sustainable funding models

- Develop sustainable funding approaches to mitigate the effects of donor withdrawal.
- Provide core and multi-year funding to strengthen institutional sustainability.
- Support blended funding approaches that combine donor, government, and social enterprise support.
- Develop tailored capacity building for smaller organisations to access diverse funding sources.

Enhance inclusion and survivor-centred approaches

- Ensure GBV services are inclusive of all survivor groups, including people with disabilities, male survivors, and LGBTQ+ individuals.
- Provide targeted funding to organisations led by or working with marginalised groups.

Integrate prevention and response programming

- Fund integrated programmes that address both prevention and response.
- Ensure prevention initiatives include clear referral mechanisms for survivors.
- Support evidence-based, sustained prevention approaches rather than one-off awareness activities.

Strengthen country-wide data collection, analysis and storage

- Establish and mobilise a national GBV MIS.
- Ensure data is regularly updated and easily accessible.

1 Introduction

Triple Line and **Ecorys** were commissioned through the FCDO EACDS Lot 1 – Women and Girls to deliver a comprehensive mapping of the ecosystem of WROs working to prevent and respond to GBV in Zimbabwe.

The Stopping Abuse and Female Exploitation (SAFE) programme was supported by FCDO until March 2025. The study was commissioned in order to inform FCDO's planning for support of the women's rights and gender equality agenda, with a specific focus on GBV. A key aim was to build a comprehensive understanding of the ecosystem of WROs working to tackle GBV in Zimbabwe and relevant options for future funding. This assignment aligns with FCDO's strategic objective to **localise and strengthen GBV responses as a step towards enhancing the effectiveness of interventions for women and girls**.

1.1 Study purpose and objectives

There is growing momentum within the gender and women's rights sector (and their allied development partners) in Zimbabwe. Lessons learned from programmes such as SAFE, the Spotlight Initiative¹, and a 2024 scoping study commissioned by FCDO², indicate potential areas for growth and change that could help to transform the sector and create greater sustainability.

Taking these lessons forward will be assisted by a more coherent view of the sector as a whole – its strengths, weaknesses, current and future opportunities (particularly for funding and sustainability) and threats. Information on the sector is relatively patchy at present, particularly with respect to small, local and community-based organisations. To build a strategic approach to supporting the sector, FCDO has commissioned this study to meet these information gaps, and to provide recommendations for development partner interventions going forward.

The study aimed to:

1. Comprehensively map the WRO ecosystem and existing GBV services in Zimbabwe
2. Identify the capacity needs and gaps within the sector
3. Uncover strategic opportunities to strengthen WRO's contributions to the sector.

In this report, we explore and document the scope, quality and reach of existing services and identify critical capacity needs and gaps within the sector, with the aim of informing future initiatives, and identifying strategic opportunities to strengthening WROs' contributions to the GBV prevention and response sector.

Our findings and recommendations have the potential to support the localisation agenda for WROs addressing GBV in Zimbabwe – a potentially transformative effort to shift power, resources and decision-making to local actors who are deeply embedded in their communities. Furthermore, we make steps towards uncovering opportunities for the future inclusion and participation of underrepresented groups, by making smaller and more geographically remote organisations and their potential known to a wider range of development partners, and by giving voice to their perspectives. This will include examining how WROs, including grassroots level organisations, can have more of a say in shaping the direction of GBV programming and practice.

1.2 Structure of the report

Section 2 provides a brief overview of the GBV context in Zimbabwe and key definitions of terms used in the report. **Section 3** summarises the methodology and approach used for the study. **Section 4**

¹ Spotlight Initiative (2023), Final Narrative Programme Report 2019-2023, Available at: <https://www.spotlightinitiative.org/publications/spotlight-initiative-zimbabwe-final-cumulative-report>

² Coope, S. (2024, n.p.), Scoping Study: Enhancing Sustainable Financial Support for Local Women and Girls Rights Organisations on GBV in Zimbabwe. Plan International, Social Development Direct.

provides an analysis of participating WROs, with a focus on the services they provide for GBV prevention, response, and advocacy, the strengths and weaknesses of service provision, and the geographical coverage of services. **Section 5** explores the organisational capacity of participating WROs, with a focus on funding sources and sustainability. **Section 6** examines common areas for GBV response in Zimbabwe, including coordination mechanisms, data collection systems, the role of community and traditional structures, and the specific challenges faced by marginalised groups. **Section 7** summarises the overall conclusions and recommendations.

2 Context of GBV in Zimbabwe

2.1 Prevalence of GBV

GBV is defined as violence inflicted on an individual or group based on their gender.³ Forms of GBV include sexual, physical, mental and economic harm, and includes threats of violence, coercion and manipulation. This can take many forms such as intimate partner violence, sexual violence, child marriage, female genital mutilation and so-called ‘honour crimes’.⁴

Rates of GBV have remained stubbornly high in Zimbabwe, representing a significant human rights issue. In 2019, an estimated one in three women aged 15 to 49 experienced physical violence. One in four experienced sexual violence since the age of 15, and 45% experienced intimate partner violence (IPV), but only 37.7% of these sought support from formal services.⁵

2.2 Policy and legal context

Zimbabwe has ratified various **international conventions** such as the Convention for the Elimination of All Forms of Discrimination against Women (CEDAW) and has incorporated international definitions of GBV into domestic legislation and strategy. In response to the high rates of GBV experienced in Zimbabwe, the National GBV Strategy (2023-2020) and High Level Political Compact on Ending GBV and Harmful Practices in Zimbabwe (2021-2030) set out commitments by the Government of Zimbabwe, development partners, and civil society organisations (CSOs) to develop and implement national policies and standards which are aligned with international best practice. The policies also commit to investing in GBV prevention and responses.⁶ Despite the outwardly enabling policy environment, a review of literature indicates that the landscape in terms of prevention and response remains fragmented and poorly funded, with many organisations reporting declining levels of funding and a subsequent deterioration of the availability and quality of services. Advocacy and movement building is similarly disjointed.⁷

2.3 GBV intervention types: Prevention and response

Addressing GBV requires targeted activities, programming and funding to ensure effective response services are in place to support survivors of violence and to tackle the root causes of GBV. Interventions are typically categorised into primary, secondary, and tertiary levels, both for prevention and response activities.

³ UN Women (2024), Types of Violence Against Women & Girls- Available at <https://www.unwomen.org/en/articles/faqs/faqs-types-of-violence-against-women-and-girls>.

⁴ UNHCR-Gender Based Violence, Available at <https://www.unhcr.org/what-we-do/protect-human-rights/protection/gender-based-violence>.

⁵ Multiple Indicator Cluster Survey (MICS), 2019.

⁶ Government of Zimbabwe (2023) Zimbabwe National Strategy to Prevent and Address Gender Based Violence (2023-2030); Government of Zimbabwe (2021) High-Level Political Compact on Ending Gender-Based Violence and Harmful Practices in Zimbabwe.

⁷ Plan International, Social Development Direct, Coope, S (2025).

2.3.1 Prevention Services or Activities

Primary Prevention: Efforts aimed at stopping GBV before it occurs by addressing underlying risk factors and promoting protective factors.

Secondary Prevention: Interventions that focus on the immediate response to GBV incidents, aiming to detect violence early and prevent its recurrence.

Tertiary Prevention: Measures that address the long-term consequences of GBV, seeking to reduce the impact of ongoing violence and prevent future incidents.

2.3.2 Response Services or Activities

Primary Response: Immediate actions taken to provide safety and support to GBV survivors, including medical care, psychological support, and legal assistance.

Secondary Response: Services that involve early detection and management of GBV-related problems, such as screening patients to detect forms of GBV and managing physical injuries and psychological effects on survivors.

Tertiary Response: Long-term interventions aimed at rehabilitation and support for GBV survivors, including counselling, shelter provision, legal support, and establishment of crisis centres.

2.4 Organisations addressing GBV in Zimbabwe

Throughout the report, we refer to **WROs** or **WGROs** – non-governmental entities specifically established to advocate for the rights and empowerment of women and girls. They work to achieve gender equality by addressing a wide range of issues, including but not limited to: responding to and preventing GBV; ensuring economic justice; increasing women's political participation; and challenging discriminatory social norms. WROs operate at various levels, from grassroots community groups to INGOs.

The study informing this report took an inclusive approach to capturing the views and inputs of a wide constituency, aiming to include all Zimbabwean CSOs who are playing a part in delivering GBV interventions, whether or not they are defined as WROs or WRGOs. 'Allied organisations' included in the study may not solely focus on women's rights but recognise the importance of gender equality and often collaborate with WROs to achieve common goals. These may include organisations supporting LGBTQ+ individuals or providing community-based mental health services. These organisations were included in the sample frame if actively and currently or recently involved in GBV work. Given that the aims of the study included considering the increased location of GBV services, including through support to grassroots organisations, particular efforts were made to reach these constituencies.

3 Research Approach and Methodology

3.1. Research objectives

The research was guided by the following key objectives:

- Identify and document WROs, WGROs and other key allied organisations engaged in GBV-focused work.
- Analyse gaps in technical and organisational capacities to deliver GBV programming, including service provision and advocacy.
- Provide actionable recommendations for strengthening and localising GBV prevention and response, to support the women's movement and key allied organisations in Zimbabwe.

3.2. Approach and methodology

A key aim of the research was to advance the knowledge base on WROs and WGROs in Zimbabwe with a view to strengthening GBV responses and contribute to positive social change. The research methodology combined qualitative and quantitative methods to gather the views and experiences of a wide range of WROs and WGROs, supplemented by KIIs with key influencers and decision makers in the sector (e.g. government stakeholders and development partners). Findings were triangulated as far as possible to provide a robust analysis. Interviews were kept flexible to allow respondents space to shape the conversation, and interview coding included in-vivo coding, allowing for themes to emerge, rather than relying on a pre-ordained analytical structure.

A **feminist research approach** was adopted, which recognises intersectional inequalities, and the overlapping interests and approaches of organisations representing marginalised groups. Core principles of a feminist research approach are:

- **Critically examining gender power relations and inequities** throughout the data collection and analysis and aiming to reflect the perspectives and experiences of the most marginalised.
- **A focus on reflexivity:** A recognition that research can never be completely objective, and is inevitably influenced by the researchers' background, knowledge, political beliefs, experiences and other contextual factors.
- **Participatory approaches:** To the extent that is possible, research that is collaborative and that benefits participants, rather than being extractive.
- **Commitment to social change:** Research is mobilised as a justice tool.⁸

3.2.1. Data collection methods

The study team took an iterative approach to primary and secondary data collection. This enabled the approach to be continually informed and shaped as new information was gathered, ensuring data collection and analysis focused on the most relevant organisations and themes.

Primary and secondary data collection methods used included: document review; KIIs, using a semi-structured interview process; an online survey; and FGDs. The purpose of and scope of these methods are described below.

Document review and web searches: The document review informed an initial mapping of WROs and WGROs in Zimbabwe and provided additional operational context to the exercise. The team conducted a review of pre-existing databases and contact lists of WROs and WGROs to identify a comprehensive list of organisations working on GBV Zimbabwe (the full list of organisations is available upon request). Databases from the Women's Coalition of Zimbabwe GBV Sub-Cluster (chaired by UNFPA), the UN Women's Spotlight Initiatives stakeholder list and contact lists shared by FCDO were reviewed and collated. Additionally, publicly available WRO and WGRO annual reports, strategy documents, and evaluation reports were reviewed, along with additional organisational documentation shared directly by respondents during KIIs and the online survey. A total of 47 organisational documents were identified and rapidly reviewed as part of our analysis (see Annex 1: List of documents reviewed).

KIIs: These were conducted with key senior figures in the women's rights sector in Zimbabwe to help shape the parameters and definitions of 'eligible' organisations, enable access to key information sources (such as organisational databases), and provide critical 'scene-setting' insights and perspectives from key players and influencers. A total of 12 KIIs were conducted (See Annex 2: List of key informants).

Online survey: An online survey was distributed directly to identified organisations, and posted on LinkedIn to encourage wider participation. The survey enabled the collection of organisational information including remit, current relevant activities, past activities, target groups, number of staff,

⁸ Hesse-Biber, S. N. (Ed.). (2012). Handbook of feminist research: Theory and praxis (2nd ed.). SAGE Publications.

number of clients, and questions relating to organisational capacity (e.g. registration, governance and accountability). A total of 54 responses were achieved.

Semi-structured interviews (SIs): Face to face and remote interviews were conducted to deepen organisational information. The SIs also had the effect of boosting participation in the survey and providing information on WROs and WGROs that could be used to populate the survey. While the questions for the KIs did not differ from the online surveys, they allowed the researchers to seek more detailed information in response to open questions on issues such as funding sources and their sustainability, trends in funding and the wider enabling environment. It also enabled a more informed discussion of prevention and response approaches, as well as advocacy priorities and targets. A total of 20 SIs were conducted. All are included as part of the quantitative survey analysis as well as feeding into the qualitative data analysis.

FGDs: These explored sectoral issues and topics to provide a broader view of the structure of, and gaps within, the sector, including communities' needs and geographical spread of services and interventions. FGD participants' views were sought on what is needed to strengthen the ecosystem of WROs and WGROs working on GBV. A key question was how relevant organisations could be supported to stabilise and diversify funding sources, for example by engaging with non-traditional donors and partners. Three FGDs were conducted, two in Bulawayo and one in Mutare. In addition, insights and reflections from an event held in Harare, covering many of the same themes, have been considered and reflected in this report where appropriate. Given the proximity of this event, and the similarity of the themes (risking research/consultation fatigue), the research team opted to harmonise the event themes with the FGD themes as much as possible, rather than holding a separate FGD in Harare.

The data collection tools and guide are provided in Annex 3.

3.1.1 Sampling

A combination of purposive and snowball sampling techniques was used to identify and reach relevant organisations and stakeholders to participate in the study.

KIs: Participants were purposively sampled to include a range of high-level senior figures and decision makers in the women's rights sector in Zimbabwe. The study team utilised existing networks and contacts made through FCDO to achieve the sample set out in Table 1. Most interviews were conducted in person; 4 out of 12 were conducted online.

Table 1: KI sample achieved

Stakeholder type	Total KI
National / International NGOs	7
GBV expert consultant	1
Government officials	1
Donor partners	3
Total	12

Online Survey: The document review and resulting consolidated database identified a total of 151 relevant organisations which were targeted for the online survey. Additionally, the link to the survey was posted on LinkedIn to encourage a higher response rate. A total of 54 responses were received.

SIs: A purposive sample was drawn to ensure coverage of relevant organisations of national level and provincial level organisations; local/small/micro CBOs focusing on GBV; local/small/micro CBOs not focused on, but dealing with GBV issues; and specialist organisations working with marginalised groups. The knowledge of the research team on WROs and WGROs was critical to the sampling

process, while respondents of the recent Plan WRGO Scoping Study and information from KIIs were proactively contacted.

FGDs: Three FGDs were held with women's rights/human rights organisations directly and currently involved in delivering primary, secondary or tertiary GBV prevention and/or response services or activities. The discussions were held in two regional hubs: Bulawayo (2) and Mutare (1). These towns were selected due to the larger concentrations of local organisations within travelling distance. Organisations were purposively sampled for FGD participation with the support of local chapters of the Women's Coalition of Zimbabwe, based on relevance to GBV work, from a range of locations spread over urban and non-urban areas (small towns and rural districts), and varied in size and type, including local CBOs, larger NGOs, and faith-based organizations.

3.2 Limitations and mitigations

Below we outline some of the identified limitations of the study and potential implications of these which should be considered when interpreting the findings, as well as outlining how these limitations were mitigated to the extent possible.

Representativeness of the study: The timeline and budget for the study did not allow for a fully representative study and instead relied on purposive sampling techniques. The survey was distributed widely and openly, but the team deliberately followed up with certain organisations, to ensure the most significant organisations, in terms of client reach and profile, were included and that smaller and more remote organisations were supported to participate. Another key reason was to ensure as wide a geographical spread and as diverse a range of respondents, including those representing marginalised communities. Regional FGDs also seem to have encouraged participating organisations to fill in the survey.

Availability of recent organisational documentation: Accessing recent and up-to-date reports from identified WROs was often challenging, particularly for smaller organisations with limited or no online presence. Furthermore, NGOs are required to submit annual reports to the Government of Zimbabwe by 31st March every year, meaning the most recent reports we were able to access were from 2023 or earlier and therefore did not always provide the most up to date information. This limitation is partially mitigated by triangulating with other data sources.

Rapidly changing funding context: Recent changes in the funding environment due to the closure of the United States Development Aid Agency (USAID), confirmed on February 5th 2025, may mean that even the most up-to-date quantitative information collected may not correspond with organisations' reach, staffing or remit in the immediate future. Organisations were asked about the anticipated impact of these developments on key indicators, but the team recognise that this is sensitive information, that the topic should be handled with great tact and care, and that US-funded organisations may not fully know how these developments will affect them.

Ability to reach the most remote organisations: The study team made efforts to reach organisations in remote locations, including by conducting FGDs outside of Harare and conducting interviews remotely. As mentioned above, some smaller organisations were targeted with SSIs in case it was easier for them to complete the survey by way of a telephone interview than responding online. This seems to have been a successful strategy, given the level of participation from remote areas, including small and 'hyper-local' (ward level) organisations. However, even with these provisions, it is very likely that this study does not proportionately represent small, geographically remote organisations and/or those with low levels of connectivity.

4 Analysis of WROs/WGROs and GBV service provision in Zimbabwe

4.1 Overview of GBV Organisations

The mapping approach used for this exercise combines quantitative data from the survey of CSOs delivering GBV interventions – not all of whom are WROs/WGROs, and qualitative data from KIIs, SSIs and FGDs.

Most organisations responding to the survey are small, with 18 having no more than five staff members, 24 having 6-20 staff, and 11 having more than 20 staff (the largest had 61 staff). Some organisations did, however, have a significant volunteer footprint – the largest had 750 volunteers. There was an even wider range of organisational size/budgets (from \$2,500 to \$5 million annual budgets).

The largest proportion of respondent organisations were trusts. The ‘other’ organisations were churches/faith-based organisations, apart from one consultancy organisation. Almost all organisations were formally registered; of the others, three were pending approval and one was informal/unregistered. Some had Private Voluntary Organisation (PVO) applications in process. At the time of writing, there was reportedly a backlog of PVO registration applications in the system. Historically, organisations in Zimbabwe have often chosen to register as trusts as the process tends to be easier and more accessible, especially for new organisations.

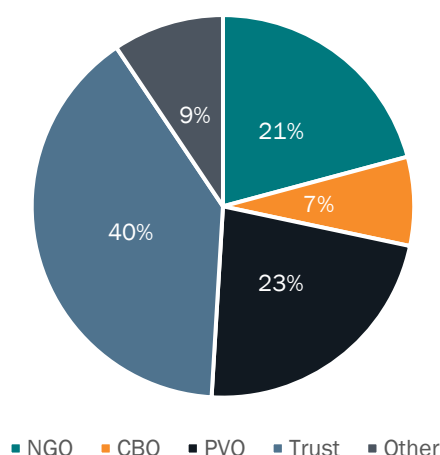


Figure 1: Responses by organisation type (single responses only).⁹

4.2 Analysis of GBV provision

This analysis largely focuses on provision by, and the perspectives of, civil society, and splits analysis into the broad categories of: response; prevention; and advocacy interventions. By way of context, it is worth noting the role of government – particularly health care facilities and the police, traditional and religious leaders, churches and community volunteer structures – in partnering with these organisations. Observations regarding these different actors have been reflected throughout the analysis below. It is also worth noting that while the different intervention categories have largely been analysed separately, holistic service provision and multisectoral approaches are universally accepted as in the client’s best interest – even if services frequently cannot deliver this. Both static

⁹ This categorisation largely reflects the types of civil society organisations permitted to operate in Zimbabwe under the PVO Act. It has inadvertently omitted Faith Based Organisations (who formed most of the ‘other’ group) and Common Law Associations (who do not seem to have formed part of the sample).

and mobile One Stop Centres (OSCs) have been established throughout the country as a way of providing this holistic care, aiming to provide medical, psychosocial, police and legal services all under one roof. This model offers convenience to survivors and addresses the concern that police stations and hospitals often do not provide an appropriate, safe environment for reporting cases of GBV. While OSCs are regarded as best practice in terms of service delivery, most clients will not realistically be able to access them easily given the low number across the country, and may have a more fragmented experience of services.

4.2.1 GBV Response Services

The majority (46 out of 54) of respondent organisations reported delivering some kind of response service. The numbers of clients seen on an annual basis varied extremely widely. Some reported very small numbers: the minimum reported was eight (by a small and specialised grassroots organisation) and the maximum was 39,296 (Musasa Project). As the total number of clients reported by survey respondents overall was 68,560, this means that over half of all response clients reported on by organisations in this survey were Musasa clients. This reflects the long history of the organisation (established in 1988), its diffuse methods of service delivery (including community outreach, hotline and shelters), and its trusted position within the development community. It also supports many smaller organisations in GBV delivery. Having said this, there are other major actors within the GBV sector, also with relatively large reach numbers.

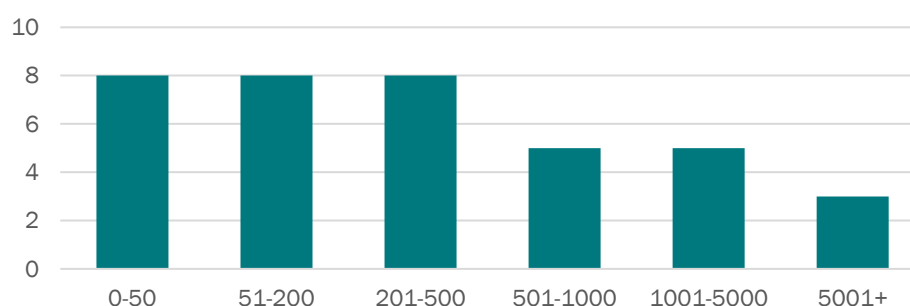


Figure 2: GBV response service numbers reported by surveyed organisations

The most frequently served group, understandably, was women and girls – 35 of the 54 respondent organisations. Rural women were more likely to be targeted than urban women, which is to be expected, given the majority of Zimbabweans live in rural areas. However, this points to the proportion of organisations who did not have women and/or girls as their primary target group; organisations targeting men and boys were well represented, as were those serving persons with disabilities. Of those working with ‘other’ groups, two were focused on mental health support (regardless of client demographic), two worked on policy issues, three were focused on LGBTQ+ populations and one focused on people with drug problems.

Table 2: Numbers of organisations delivering different service types, by client group*

	Women and girls	Urban women	Rural women	Men and boys	Children	People with disabilities	Other
Response services	35	24	31	23	26	25	9
Prevention	41	27	37	35	27	27	10
Advocacy	40	24	31	27	22	22	7
Other	13	10	11	9	9	10	7

* Totals not provided as respondents could select multiple options

The most commonly reported response service was counselling (in person or by phone/text), followed by some kind of long-term recovery (such as economic empowerment of survivors). Comparatively few reported delivering medical interventions (seven), shelters (seven) or legal advice/support (nine delivering ad hoc advice and 10 delivering case management).

Table 3: Response service types

Service type	Percentage	Number
Medical intervention	15,9%	7
Legal advice (ad hoc)	20,5%	9
Legal support (case management)	22,7%	9
Counselling/psychosocial support (in person)	77,3%	32
Counselling/psychosocial support (phone/text)	65,9%	28
Shelters	15,9%	7
Long term recovery e.g. survivors' economic empowerment	59,1%	26
Other	15.9%	7

The qualitative data indicates that these statistics are somewhat reflective of the national picture in terms of service provision trends.

Shelters: There are limited shelters for GBV survivors in the country, resulting in women having to travel long distances to access refuge, which creates additional risks. Musasa is the largest provider of shelters, and was frequently mentioned in interviews, running shelters across the country. However, this coverage is clearly inadequate, and shelters are inaccessible for many clients, and at the time of writing, was clearly being eroded due to bilateral funding cuts. As with all services, funding for survivors to travel to shelters can be hard to come by: *“In Hwange the nearest health facility in some communities such as Matetsi is over 20km away and money is needed for transport, which is usually not available for the survivor.”* (SSI). While some shelter provision is disability-inclusive, respondents mentioned that shelter provision is often not inclusive of marginalised groups – LGBTQ+ groups and persons with disabilities in particular.

Interviewees reported a general trend of donors backing away from funding of shelters as they are relatively expensive to run. Some have had to close due to lack of operating resources. For example, in Mutasa district, a shelter closed due to resource constraints, and other organisations have had to ask the government to take over, with one *“handing over three shelters to the government, where they themselves no longer had the capacity to run them.”* (KII) In such circumstances, while centres may be running in theory, in practice, they may not be functional, or only partly functional and struggling to meet survivors' basic needs. For example:

“The Haven Trust has a shelter, but there is no funding. So, when this survivor has to come to have and shelter, we can offer her somewhere to sleep and support. But we have no food. We have no transport for them to keep following up the case along the court system, and some will stay for a long time, and the case keeps going on and on and on.” (FGD)

Government-run shelters often face funding challenges:

“For the example of FACT, Zimbabwe handing over three shelters to the government, where they themselves no longer had the capacity to run them, so those now really become government facilities, but you'll find in the same breath, then calls for support, you know, from other women's rights organizations, to say, support the government in terms of running,

feeding, manning those shelters, which capacity we again, do not have.”
(KII)

In general, community structures play a crucial role in GBV response, especially in areas with limited formal services. Some town and district councils own schools and polyclinics, and have their own payroll independent of the government. There were suggestions on engaging the councils to join the fight against GBV and possibly construct GBV shelters in some of their areas. *“You know how councils have clinics and schools and pay more than the government, why can't we ask them to put the same effort towards GBV shelters?”* (KII)

Some innovative community-based shelter models have been developed, with reported success. Community ownership can provide locally appropriate, accessible and cost-effective solutions to a lack of provision from external sources, although these still cannot run effectively or ethically without some form of support. One respondent reflected on her organisation's rationale for supporting community shelters: *“Part of why I did that was to reflect on the cost of running a shelter. And secondly... the one thing I was trying to do is to have communities being accountable for GBV.”* (KII)

Another advantage was that local ownership of shelters can strengthen security arrangements:

“One of the amazing things was the community actually taking responsibility for the safety. We never had cases. We actually were struggling with the urban shelter in terms of security. But everyone, you know the chief only had to say that shelter belongs to me as a chief, and I don't want to see any men there. And we never saw any men.” (KII)

In Matabeleland, a model of engagement with traditional leaders through the Zunde ra Mambo concept¹⁰ has shown promise. One interviewee noted that: *“Our engagement with traditional leadership shows they are very much supportive of building spaces for safe shelters. Some have even identified land for such facilities, but capacitation is needed to ensure sustainability.”* (FGD)

However, there are risks in less formal versions of community shelter (and in community responses to GBV in general). Traditional leaders often serve as first responders, providing immediate safety and initial case management, but this informal approach has significant limitations. Many have expressed concern over their capacity to provide effective support, along with a lack of funding or oversight, and ethical and safeguarding issues.

“Some chiefs are using their homes as safe shelters, but are they capacitated enough? More needs to be done to ensure they can offer proper first-responder support.” (FGD)

“It's not sustainable, because [as a survivor with no other options] the chief... has to look after you. Maybe you go with your children, and you know they [the chief and their family] are not getting a salary that can actually facilitate that to happen.” (KII)

Churches also sometimes contribute to GBV response through infrastructure support and resources, and some organisations have found creative ways to partner with churches. One organisation, for example, convinced churches to provide them with practical support, even though their attitudes towards GBV may not have been aligned with that of the partner organisation:

“We got churches to give us buildings for shelters or, you know, community centres, and which is what I was talking about in terms of resources, was to sell the product differently, so you're not going gender-based violence is really saying as a change. Do you? Do you want your girls? We want this

¹⁰ Zunde raMambo is a traditional Zimbabwean practice where chiefs manage communal resources, historically for food security. Modern adaptations are exploring its potential to address GBV by mitigating poverty-related stressors and providing community-based support networks. See e.g. <https://www.rozaria.org/zunde-ramambo-a-community-innovation-for-food-security-and-womens-empowerment/>

because they want a full congregant. They want a congregation that can give them money and all, but they have to be mentally well... Can you take one of your buildings to do this? That's how that shelter model came about. We got support from churches.” (KII)

Medical interventions: Relatively few respondent organisations offer medical interventions, and interviewees generally regarded this as one of the weaker areas of GBV response provision. Medical interventions require significant resources and specialised skills, and some health service providers lack the necessary medical facilities for certain cases. One interviewee from an organisation offering medical interventions described their difficulties in mobilising resources for this work:

“When you approach the funding partners, we've always been told that health is more like a black hole, because you keep on buying medicines and at the end of the day, you cannot really claim whatever will have happened to the money, because it's not like when somebody gets treatment today, they will not come back tomorrow, and like maybe with information, when somebody has been educated with behaviour change, you expect a change in behaviour as your output from that intervention. But when it comes to response, it's slightly different. So a lot of funding partners are not very keen to support health related activities.” (KII)

GBV services are often provided through OSCs, government clinics and hospitals. However, it is widely reported that resource constraints severely affect service quality. There were concerns raised over how some mission hospitals charge survivors for medical help such as rape kits because they need to raise money to purchase the medical supplies.

Legal interventions: There were slightly more organisations offering legal services, and the general picture given by interviewees was that Zimbabwe has historically had strong capacity in terms of legal service provision, but like all aspects of GBV provision, funding squeezes have eroded capacity. Many expressed concerns about delays and lack of follow-up for GBV cases. While legal representation is still provided by organisations like Zimbabwe Women Lawyers Association (ZWLA), many (including ZWLA) have reduced their presence in some geographical areas due to resource constraints.

“I think the other thing that we've encountered is the situation whereby when one comes to report, let's say someone comes for a protection order, you assist that person, they go to court, they're given a court date, but they do not have a place to stay. So then go back to the perpetrator while waiting for the court date.” (Bulawayo FGD)

Counselling was also frequently identified as a strength within the sector, with a relatively good supply of trained counsellors within the country. While services are contracting due to resource constraints, there has at least been an increase in the options for delivering remote counselling over recent years, as connectivity and mobile access has gradually improved. Interviewees from larger organisations did indicate that definitions and quality of counselling can be variable, though, and it is likely that many smaller organisations are not aware of or adhering to sectoral standards. There were also concerns expressed over the role of community actors who inevitably fill in the gaps when trained professionals are not available.

While some traditional leaders have embraced GBV response initiatives, others continue to rely on customary mediation, which may not always align with survivor-centred approaches. One interviewee mentioned that: *“We noticed that some leaders are keen to refer cases, while others still mediate GBV cases informally, which is problematic.” (FGD)*

Many people also go to religious leaders for advice, support and counselling. While this may be the best of limited local options for many survivors, churches and religious leaders generally lack technical capacity to properly support survivors. As with traditional leaders, while many will have received training, there may be critical gaps. For example, focus group participants reported the need for training in the Traditional Leaders Act and, more broadly, their mandate in GBV cases (particularly when it is required for them to refer cases to statutory and specialist services). In addition, for many, the notion of putting an individual woman's wellbeing ahead of keeping a family together is against

their religious (and/or personal) belief system: *"I do not think the church is equipped in any way to support survivors. That's the greatest challenge that we're experiencing. From the church survivors are usually prevented from escalating the matters."* (FGD)

Economic Empowerment Programmes: Many organisations provide skills training and startup kits to empower survivors to regain their independence and reintegrate into their communities – indeed, this was one of the most frequently provided services by the organisations responding to the survey. Many interviewees spoke about economic empowerment in terms of both prevention and response strategies:

"Economic empowerment, it can actually liberate women from GBV, it can be both prevention and also a response mechanism... We run shelters for GBV survivors. We also run economic empowerment programmes where women are when they are in the shelter, they are also equipped with skills, and they are given some startup packs to start their business, so that when someone comes from the shelter, they've got somewhere to start, to start their livelihoods and to improve their life goals." (KII)

It was also mentioned during the study that some of the economic empowerment programs are being offered by the shelters. Economic empowerment interventions are also covered in the 'prevention' section below.

Humanitarian Response: The intersection of humanitarian crises and GBV presents a significant challenge for WROs in Zimbabwe. Research findings indicate that institutional responses to GBV within humanitarian contexts remain underdeveloped. The Women's Coalition of Zimbabwe¹¹ (WCOZ) only recently established a dedicated humanitarian cluster: *"This is a cluster that we established during COVID-19. When we noted our gap, we were not ready in terms of responding to COVID-19 as a humanitarian crisis."* (KII)

This cluster remains in its formative stages, and WROs acknowledge that they have yet to make substantial progress in developing comprehensive GBV responses within humanitarian settings, characterising this area as an ongoing learning process rather than a consolidated domain of expertise.

Stakeholders identified concerning patterns in how humanitarian responses create or exacerbate GBV risks. During the Cyclone Idai response, participants reported scenarios where women were exploited during the distribution of aid:

"There were some connections that have been establishing within the humanitarian space, looking at GBV... where it ought to a point where you would have to give something for you to get something, and if you are a woman in distress, in most cases there's one thing that you just have to give up." (KII)

This indicates serious shortcomings protection and safeguarding procedures and practices within humanitarian coordination structures and responding organisations. A particularly concerning finding relates to the abrupt cessation of services following the acute phase of humanitarian response. Focus group participants in Mutare described an initial surge of humanitarian actors during Cyclone Idai: *"There were so many organisations coming that all the hotel and lodges were fully booked; some were sleeping in their cars."* (KII)

When emergency response funding ended, organisations withdrew rapidly, leaving communities without support to address ongoing or emerging GBV cases, including teenage pregnancies and sexual abuse perpetrated during the crisis period. *"Chimanimani has always been a GBV hotspot, especially for child marriages. CSO distribution improved after Cyclone Idai, but now most have left."* (KII)

¹¹ The Women's Coalition of Zimbabwe (WCoZ) is a national network of women's rights activists and organizations that work to advocate for the rights of women and girls in Zimbabwe. It serves as a central point for collective action on issues affecting women, aiming to achieve gender equality. See <https://www.wcoz.org/>.

This pattern suggests that humanitarian funding cycles create service provision peaks and troughs rather than sustainable response infrastructure. While this is the nature of humanitarian funding, the pattern observed in Zimbabwe indicates that GBV and Protection from Sexual Exploitation, Abuse and Harassment (PSEAH) interventions and the organisations leading them are often not well integrated into the humanitarian system. With climate change increasing disaster frequency in Zimbabwe, these gaps in humanitarian GBV response represent a significant vulnerability for at-risk populations.

Front line responses: While front-line response/first responders were not originally built into the mapping specification, it became clear during the course of analysis that CSOs are very often not the first point of contact for survivors, and other actors in the community pick cases up and refer on to civil society or government providers. According to national statistics,¹² the police tend to be the most commonly approached agency by victims of abuse in Zimbabwe. While the study did not look specifically at police capacity, this issue was mentioned several times during interviews. The Zimbabwe Republic Police Victim Friendly Unit (VFU) is a specialist unit trained to handle crimes of sexual nature against women and children sensitively, should be present in all OSCs and police stations, and co-ordinates with partners for mobile outreach and awareness campaigns.

In some areas, there was evidence that the police were (or have been) active partners in case management: *“We have been coordinating with stakeholders like the police. When we were doing our outreach, we used to form committees which involved the police and the community.”* (Bulawayo FGD). However, in other areas, for example Chimanimani and Chipinge, concerns were raised about the lack of VFU provision, with one officer appointed to cover unrealistically large areas.

The Ministry of Women Affairs, Community, Small and Medium Enterprises Development (MWACSMED) is tasked at local level with coordinating response systems and partners working on GBV and to work with partners to train frontline service providers in counselling and supports traditional and religious leaders in addressing GBV.

Various local actors – e.g. government ‘cadres’ such as Community Case Care Workers, Village Health Workers, ‘Community Champions’ or other volunteers trained by CSOs, NGOs, INGOs or government play crucial roles in responding to GBV, especially in remote or under-served areas: *“These are the local groups that are on the ground, and they need to have those resources to respond to, yeah, so because what we need it’s a more decentralised way of responding to GBV.”* (KII)

There is good evidence that, when adequately supported, trained in dealing with less challenging cases, and in triaging and referring more serious cases to the appropriate service provider, these cadres can be extremely effective in providing first response support. However, they are very often not well supported, and there are complex ethical issues with relying on local volunteers for essential service provision, particularly when not part of a structured programme of support.¹³ Not only is this challenging and skilled work that very often calls for professional help, but it is also often significantly more difficult for them to intervene in cases within their own community than it would be for an outsider.

“On the other side, the other challenge, the champions in the communities, we have a local network of GBV champions, but they get tired... they end up getting tired because there is [sic] no adequate resources to continue doing the work in the communities.” (FGD)

“At times even security for these local GBV champions and activists becomes a challenge. At times they get threatened or they get followed by perpetrators, accusing them of destroying their homes and their families.” (FGD)

¹² DHS 2015: 341. 21% of women survivors who sought help reported to the police. Note DHS 2023/24 figures on this were not available at time of writing.

¹³ See Van Halsema, V., Bansal, A., & Barca, V. (2024). In the Trenches: Understanding and Supporting Africa’s Frontline Social Assistance Workforce.

4.2.2 GBV Prevention

GBV prevention in Zimbabwe encompasses diverse strategies implemented by various types of organisations. These include awareness-raising, community engagement, women's economic empowerment, targeting men and boys, mass media campaigns, household-level interventions, and school-based programmes. Most survey respondents (46 out of 54) reported implementing some form of prevention activity.

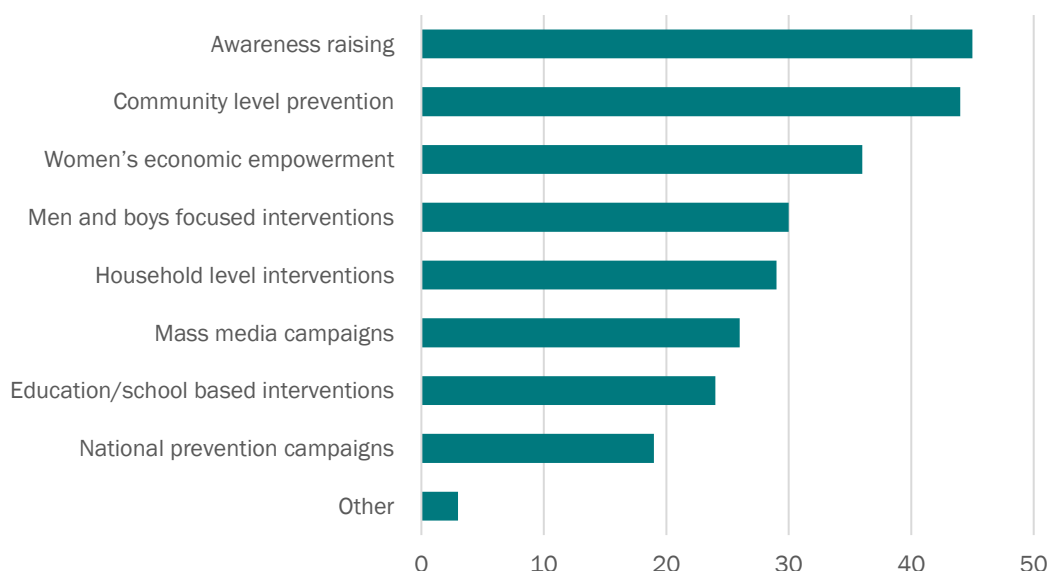


Figure 3: Prevention Interventions (numbers of respondent organisations).

The reach of organisations undertaking prevention work varied widely – the three organisations claiming the highest levels of reach quoted figures of 1.5m, 63,154, and 500,000. All of these organisations undertook some form of media intervention, so it is likely that their figures related to presumed reach of mass media communications.

4.3 Prevention Approaches: Strengths and Limitations

4.3.1 Overview of Prevention Landscape

The mapping exercise identified a diverse array of GBV prevention initiatives across Zimbabwe, reflecting a growing recognition of the multifaceted nature of GBV. Prevention activities predominantly include awareness-raising, community engagement, women's economic empowerment, male engagement, mass media campaigns, and school-based interventions. Many organisations implement a combination of approaches, suggesting some understanding of the need for multifaceted interventions to address the complex drivers of GBV.

4.3.2 Current Prevention Approaches

Economic empowerment as a prevention strategy: A significant strength in Zimbabwe's prevention landscape is the widespread recognition of economic empowerment as a crucial prevention strategy. Survey data indicated that many organisations provide economic empowerment initiatives, including vocational training and entrepreneurship development targeting vulnerable women and youth. This approach reflects an understanding of the relationship between economic independence and vulnerability to violence:

“In an environment like Zimbabwe, the key drivers of GBV prevention around poverty, economic vulnerability, and so if you're not addressing that, even if you do your sensitization, awareness raising, you've not changed the

root causes of GBV, which... for me, then means any prevention initiative to be effective, you actually need to link them with improving the livelihoods of... people.” (KII)

“Empowering women economically is also one of the preventive measures that we use, because when women are empowered, they're able to make informed choices... they're able to assess their... situation, to say, 'Yes, I am able to look after my children, so I can move away from this violation, violence'... But when they are not empowered, even economically, they rely on the perpetrator. Sometimes they are forced to live in that environment.” (KII)

Male engagement initiatives: The survey data indicated that 61.2% of organisations delivering prevention interventions target men and boys, recognising the importance of male allies in preventing GBV, and in addressing the root causes of male violence. Key informants described efforts to transform harmful gender norms through positive masculinity approaches. Some organisations focus specifically on mental health support for men, acknowledging the link between mental health challenges and GBV.

However, the picture on male engagement seems to be rather mixed. Key informants, focus group participants, and open-ended responses in the survey consistently identified male engagement as an area requiring strengthening. This apparent contradiction may reflect a quantitative versus qualitative distinction - while many programmes nominally include men and boys, the quality, approach, or effectiveness of this engagement may be insufficient. It is also likely that the deliberate targeting of men and boys' organisations skewed the quantitative data and that this does not represent an accurate national picture.

A growing concern is the trend of perpetrators who are released back into society recommitting GBV and sometimes committing violence as retaliation for their incarceration. While some male-focused organisations such as Padare, Fathers Against Abuse, and Men Engage have been partnering with WROs to improve rehabilitation programming, this area remains underdeveloped: *“It's being done, but it's a very limited level because of resources. But we work with partners to ensure that when someone is released from prison, they also receive counselling.” (KII)*

Educational/school-based prevention initiatives: The focus on school-based interventions (49% of organisations) underscores the importance of educating young people about GBV from an early age. By addressing these issues in educational settings, organizations are laying the groundwork for future generations to challenge and change harmful behaviours.

There have been programmes and initiatives by some organisations (49%) to implement response and prevention efforts through education, particularly in schools. Some were responding to GBV cases that involve children through child marriages and sexual abuse. To facilitate this, the organisations engage the Ministry of Primary and Secondary Education (MoPSE) and work with them and school authorities. Some work with school counsellors:

“In terms of working with line ministries, we've been working very well with the Ministry of Women Affairs, DSD and the Ministry of Education in rolling out the SASA model, we work with schools and train two teacher mentors and the headmaster for sustainability and the target population being grade six, five and four.” (FGD Mutare)

There were discussions on how schools' involvement in programmes is not enough, and on how to address GBV issues in the national curriculum:

“...if you want to see how serious a government can treat something, it is to mainstream something into the educational curriculum. In the years, there have been many adaptations of the curriculum.” (FGD)

Culturally adapted methodologies: Some prevention methodologies have been adapted to Zimbabwe's socio-cultural context. For instance, the SASA! methodology has been modified for mining

communities, for example, in Insiza, Matabeleland South) and includes traditional leadership engagement, where village heads are trained in unhu/ubuntu-inspired mediation techniques.¹⁴ Intergenerational approaches such as the Nhangwa methodology facilitate dialogue between women and young girls.¹⁵ The SAFE 'Toose' GBV prevention model was also frequently cited as an example of good practice, where international models had been tested and adapted for use in the Zimbabwean context.¹⁶

Evidence-based approaches: While there were some good examples cited, such as the above, a significant concern emerging from the research was the inconsistent use of evidence-based prevention methodologies. Many interventions appear to be implemented without sufficient grounding in proven approaches or sustained engagement: *"There are dotted programmes around that are supposed to be doing prevention, and that may actually not be using proven approaches to prevention, a lot of them are doing, awareness raising or dialogues."* (KII)

The short-term nature of many prevention activities was identified as particularly problematic:

"Most of the prevention work is done in the form of workshops, a form of awareness raising workshops. There is no consistency and follow up, and there isn't enough information that stays within the communities." (KII)

This suggests that while awareness-raising is common (implemented by 92% of those undertaking prevention work), it may not be implemented in ways that lead to sustainable behaviour change.¹⁷

Diverse communication channels: Organisations leverage multiple channels to disseminate prevention messages, including social media, radio shows, and theatre for development. Technology-based prevention methods, such as mobile-based initiatives, are increasingly used to reach wider audiences, particularly younger demographics.

Disconnect between prevention and response: Interview data consistently highlighted a disconnection between prevention and response efforts, with different organisations often working separately on these interconnected aspects of GBV programming:

"We have looked at prevention and response as two separate strands. So you have your success doing response, and then you have another organization doing prevention. And so it's been without realizing that your prevention creates demand for response." (KII).

This bifurcation limits the potential impact of both prevention and response activities and fails to recognise how they should reinforce each other within a comprehensive approach. In particular, raising demand for response services without providing them, can be counter-productive, and in general, holistic programming to prevent and respond to GBV is more effective in reducing GBV and supporting survivors.¹⁸

¹⁴ Unhu/Ubuntu-inspired mediation techniques emphasize community-centred conflict resolution through dialogue, empathy, and restoration, focusing on consensus-building, respect for human dignity, and collective well-being rather than punitive measures.

¹⁵ The Nhangwa methodology in the context of GBV prevention is a culturally rooted, safe-space approach that brings together women and girls in intergenerational dialogues to share experiences, build resilience, and develop collective strategies for empowerment, healing, and addressing gender-based violence through traditional knowledge and community support.

¹⁶ Social Development Act- Stopping Abuse and Female Exploitation, Zimbabwe – SAFE Communities. Available at <https://www.sddirect.org.uk/project/stopping-abuse-and-female-exploitation-zimbabwe-safe-communities>.

¹⁷ Current evidence suggests that a minimum of 18 months is needed for gender transformative change within communities to reduce violence: Available at <https://www.whatworks.co.za/documents/publications/374-evidence-reviewfweb/file>.

¹⁸ What Works to Prevent Violence - Final Evidence Review (2023), available at: <https://www.whatworks.co.za>.

4.4 Advocacy Approaches in GBV Prevention and Response

4.4.1 Overview of Advocacy Landscape

Advocacy initiatives constitute a critical component of the GBV response ecosystem in Zimbabwe. The mapping research indicates that organisations across the country employ diverse advocacy strategies to drive systemic change, challenge harmful norms, and ensure GBV survivors receive appropriate support and justice. These strategies include community engagement, capacity building, media outreach, and survivor-centred advocacy. The multi-pronged nature of these efforts reflects recognition of the need to address GBV through multiple channels and at various levels of society. Organisations were not asked about the numerical reach of their interventions, given that it would be difficult to estimate the reach of many advocacy activities, such as policy work.

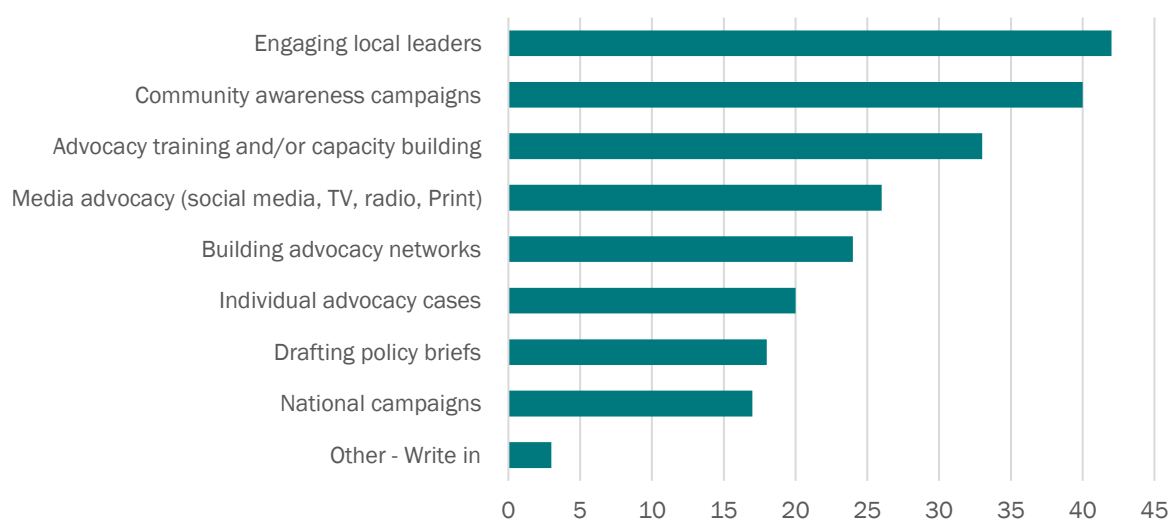


Figure 4: Types of GBV advocacy activities undertaken by surveyed organisations.

4.4.2 Key Advocacy Approaches and Strengths

Engagement with local community leaders: The vast majority of surveyed organisations (91.5%) reported engaging local community leaders in their advocacy efforts. This approach recognises the significant influence traditional leaders have in shifting cultural norms and practices at the community level: *“Traditional leadership is the gatekeepers and we also want to create platforms where we use traditional leadership to also get statistics on GBV related matters.”* (KII). This high level of engagement with community leaders suggests that organisations understand the importance of working within existing power structures to effect change, particularly in rural areas where traditional leadership retains significant authority.

Community awareness campaigns: A large proportion of organisations (87.2%) conduct community awareness campaigns to educate about the causes and consequences of GBV and promote positive attitudes and behaviours. These campaigns represent a foundational step in changing societal norms and encouraging community-led responses to GBV. However, the qualitative data suggests that these efforts often lack coordination: *“We’ve got a lot of partners that are taking part in awareness raising, but in terms of integration of the activities that we do as different partners, CSOs government, I think they still need for us to bridge our services.”* (KII)

Advocacy training and capacity building: Over 70% of survey respondents working in advocacy reported involvement in advocacy training and capacity building initiatives. This indicates a strong emphasis on equipping individuals and communities with the skills and knowledge needed to advocate for themselves and others: *“So we’ll do the trainings with the community activists and then*

the activists will do the sessions in their various communities.” (INGO KII). This focus on building local capacity demonstrates recognition that sustainable advocacy requires community ownership rather than exclusively externally-driven interventions.

Media advocacy: Just over half of advocacy-focused organisations (53.3%) use media advocacy, including social media, television, and radio, to reach wider audiences. While lower than other advocacy approaches, this still represents a significant proportion of organisations leveraging mass communication channels to influence public opinion and awareness on GBV issues.

4.4.3 Limitations and Challenges in Advocacy Work

Implementation gaps: Despite successful advocacy for the enactment of laws and policies, significant challenges remain in their implementation. Several interviewees highlighted that legislative successes have not always translated into meaningful change at the community level. For example, despite advocacy work resulting in the marriages act that criminalises child marriages, this practice remains prevalent in many communities with limited consequences for perpetrators. Interviewees also reported limited follow-through on all sides – for civil society, there is often a gap in monitoring implementation and holding authorities accountable for enforcing legislation and policy.

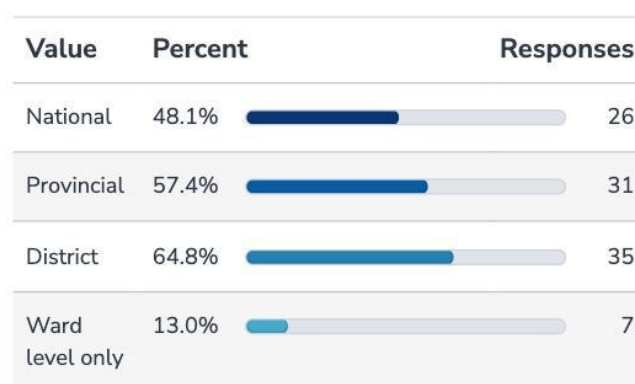
Uncoordinated advocacy efforts: The research indicates that CSOs often conduct advocacy work independently of one another, potentially diluting their collective impact. This fragmentation may limit the effectiveness of advocacy campaigns and result in duplication of efforts across different organisations working in the same geographical areas.

4.4.4 Multi-Level Advocacy Approach

The mapping exercise revealed that advocacy efforts operate at multiple levels, from grassroots to national. This multi-level approach is important for addressing GBV holistically, as it enables organisations to target both community-level norms and national policy frameworks. There was some limited evidence of community campaigning and advocacy feeding into national level advocacy (e.g. on child marriage issues), but the advocacy examples given were generally from organisations working at their own levels (national, provincial, ward) rather than on joined-up approaches.

4.5 Geographical Analysis of GBV Service Provision

Profile of survey respondents: The survey of organisations captured a wide range of different organisational types in terms of size, location, specialism/s and client groups. Figure 5 below gives a good example of this; while nearly half of the respondents have national coverage, the largest proportion reported having a district level presence, and seven organisations were ‘hyper-local’, working at ward level only.¹⁹



¹⁹ Please note that organisations could give more than one answer for this question unless they were only operating at ward level.

Figure 5: Geographical coverage of survey respondents.

The survey of GBV organisations also showed a reasonably good spread across all of Zimbabwe's provinces, as shown in Figure 6 below.

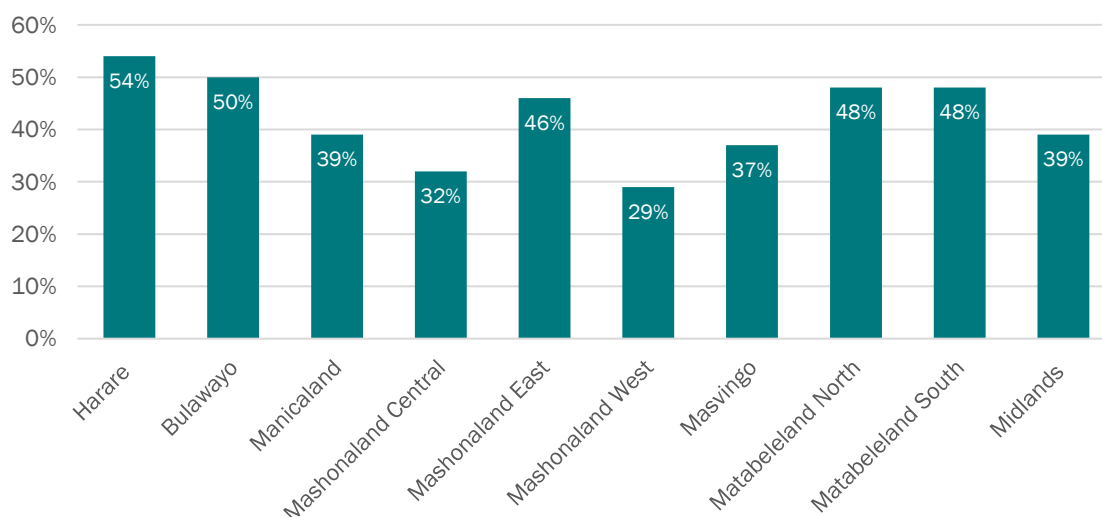


Figure 6: Percentage of organisations with programmes in each province.

However this cannot be treated as a representative sample, as explained earlier - in reality, based on the qualitative data there seems to be significant geographical divergence in service provision. This is both between, and within, provinces. Indeed, there was particularly good representation from small organisations in under-served areas – for example, both Binga and Bubi (in Matabeleland North) were mentioned repeatedly as being under-served areas with acute GBV problems, but they were also well represented by CSOs working in the area (with 5 and 7 responses respectively).

The most significant geographical trend emerging from the research is a pronounced rural-urban divide in service availability. Interviewees consistently noted that many CSOs cluster in easily accessible areas, leaving more challenging terrains underserved. This creates an uneven distribution of services, with some areas having multiple organisations operating while others have little to no presence.

Twenty-nine out of 53 responding organisations were based in Harare – though generally covered other parts of the country too - and the majority of the bigger organisations in terms of staff were also based in Harare. Seven out of the 11 organisations with more than 20 staff were based in Harare. It is worth noting that some organisations also have a significant volunteer footprint. It is also worth noting that some areas were not represented by organisations headquartered in the province (Mashonaland Central and East), and others only represented by one or two organisations (Mashonaland West, Matabeleland North and South, and Midlands). Only Harare, Bulawayo and Manicaland were represented by 5 or more organisations headquartered in the province.

4.5.1 Service 'Hotspots'

Well-served areas tend to be clustered around urban centres. Harare, Bulawayo, Mutare, and Masvingo were most frequently identified as having relatively strong GBV service provision, including One Stop Centres, shelters, referral pathways, and coordination mechanisms.

Harare and surrounding areas: Harare was frequently mentioned as having privileged access to services, although population growth in peri-urban areas and informal settlements (particularly Epworth and Hopley) is creating increasing service demands. In nearby Mashonaland East, areas like Murehwa and Goromonzi have reportedly seen some improvement in service access.

Bulawayo: Bulawayo seems to have a cluster of CSOs working on GBV, judging from the survey responses and the two FGDs Bulawayo. Bulawayo also has a government-run OSC at Pelandaba Hospital, one of the few that are directly managed by the government rather than donor-supported.

Despite the reportedly good levels of co-ordination, and number of active organisations, interviewees from Bulawayo and the wider Matabeleland region reported significant service gaps and low levels of funding, detailed below.

Manicaland: Manicaland was mentioned as one of the higher performing areas in terms of provincial level co-ordination. In terms of service provision, interviews reflected a mixed picture with some well-served areas (Mutare, Makoni), with others neglected. While reportedly under-served areas are often remote and rural areas (e.g. Chimanimani), others are urban (e.g. Rusape). The provincial capital Mutare has a shelter supporting survivors from across Manicaland, although the level of provision has been reducing:

“Mutare has a safe shelter under Musasa, and at one time, it had two safe shelters—one in the rural area and one in the urban area. As far as I’m concerned, for Manicaland, Mutare is the only safe shelter, because we have seen people coming in from Nyanga and Chimanimani to be accommodated there.” (KII)

Makoni was also mentioned: *“Makoni is doing well. The location of the One Stop Centre in Makoni District is at the district hospital. In terms of service provision, they are quite strong, but they lack space for safe shelter provision.” (KII)*

Masvingo and Midlands: Relatively little information on specific services was collected on Masvingo or Midlands; no survey respondents were from these areas, no FGDs were held there, and they were not commented on much by interviewees. Passing references by interviewees, however, were generally positive, indicating that these provinces are regarded as relatively well served in the national context. For example, both provinces were mentioned as having better coordination at the provincial level than others, which contributes to more effective service provision.

Brief secondary research on these regions indicated that this may well be the case; there is evidence of all main forms of GBV response services in operation. For example, Musasa operate four shelters in Masvingo province (Bikita, Zaka, Mwenezi and Nemamwa) and 1 in Midlands (Gweru).

Both areas were also noted of having examples of good partnership working in delivering shelter services.

Masvingo has a model where shelters are operated in partnership with schools and churches, which ensures sustainability. These are the models we need to explore. (FGD).

In Midlands, we saw a model where the shelter was in partnership with local authorities. The council identified a building, and the CSO came in to provide technical support. This ownership model has made it more sustainable. (FGD).

Both provinces have OSCs (in Gweru and Chiredzi). There have been other initiatives in operation – for example, Legal Resources Foundation and ZWLA have reported providing legal services in the area, and several organisations report delivering prevention interventions. Overall, 40 survey respondents reported operating in these provinces. While there was little commentary on specific intervention types, interviewees did, however, comment on co-ordination in these provinces (see section 5).

However, it was noted that service provision is uneven across the provinces, and in Masvingo it was observed that political interference can limit CSO operations: *“Some areas in Masvingo are difficult to work in unless local government is involved. If GBV services are not framed correctly, they can be blocked.” (KII).*

4.5.2 Service 'Deserts'

In terms of geographical 'deserts' **Matabeleland North and South** were most frequently mentioned as under-served. Binga (Matabeleland North) was repeatedly identified as having virtually no services on the ground, where WCOZ reported relying on the Ministry of Women's Affairs for local coordination, which itself has limited capacity. Other underserved areas in Matabeleland include Umguza, Umzingwane, Hwange, and Beitbridge. One interviewee noted these areas have "taken a hard hit" in terms of service availability, implying they have been particularly affected by funding cuts. While there is a One Stop Centre in Gwanda (Matabeleland South), it was reported as having limited capacity.

Other specific gaps identified in Matabeleland were around movement building and advocacy: *"the resources for women's coalition in Matabeleland is next to nothing. Women's coalition was well funded, when it was started by these amazing women...but now here in Bulawayo, there is no funding for the movement."* (FGD).

Border areas and transit routes: Areas with transient populations and border towns are particularly prone to GBV issues, including sexual exploitation and forced marriages, yet often lack sufficient services. Areas around the Beitbridge highway were highlighted by multiple respondents as problematic and not well served:

"So I think we're not doing fantastically well around border towns, and yet we know that [...] there's a lot happening there. So your Beitbridge border, you won't find a massive amount of work going on there, but they are kind of flash points, because I always got the impression that there was a lot going on in border towns because of smuggling. We have truck drivers [...] but if we look at physical presence of organizations like ourselves, yes, a lot of referrals from IOM, for example. But in terms of physical presence, which is not consistent, maybe, let me put it that way...when we're looking at the border towns, because it's very fluid, a lot of movements of goods, of people, you are looking at number one issues around sexual exploitation and abuse.. in particular, we find that our work along the Beitbridge Highway is always, you know, speaking to the sexual exploitation of young girls below 18, because of the high propensity to spend money, and then a lot of need money in those towns, because things also tend to be quite expensive... the propensity to spend money is coming from those who are passing through." (KII)

Despite perceptions of funding concentration, many areas within **Mashonaland provinces** (excluding Harare) were identified as underserved. Some areas (e.g., Mashonaland Central – Mazowe and Mashonaland West – Chinhoyi) were reported as difficult to work in due to political sensitivities, particularly around election time. Uzumba-Maramba-Pfungwe (UMP) in Mashonaland East Province was also reported to have very limited provision: *"UMP is one of the areas where access to GBV services remains a challenge. Some coordination structures exist, but services are very limited in remote parts."* (KII).

In general, many **remote and rural areas**, far from provincial capitals or with difficult road access face significant challenges in accessing GBV services. These areas often lack proper infrastructure, resources, and trained personnel to provide comprehensive support. This can be compounded by a lack of conducive political or cultural conditions for services and interventions. As mentioned earlier, provision in rural areas of **Manicaland** is mixed and for many, dependent on their ability to access Mutare.

Resettlement areas, mining communities, and farming regions (e.g., Mutasa, Inyazura, Hopley Farm) can also be particularly underserved as service institutions are not established when new communities form. Settlements forming as a result of government-mandated or disaster-related relocations lack essential GBV services, as it takes time for support structures to be established. These communities may also lack cohesion and therefore be particularly prone to GBV risks: *"Mining and farming communities are often overlooked. Some CSOs avoid areas where the terrain is difficult, so these places end up without GBV services."* (KII).

5 Organisational capacity, funding and sustainability

5.1 Organisational Capacity and Maturity

Organisational capacity and maturity of survey respondents was broadly assessed through a small number of proxy indicators, on financial capability, monitoring and evaluation (M&E), strategic planning and self-assessed technical capacity, which were analysed separately and together in order to stratify organisations. The analysis showed distinct tiers of organisational maturity, with some demonstrating high maturity across all four areas, while others showing significant gaps.

Capacity, on the whole, seemed relatively strong, with a small number of (local, small) organisations that did not meet generally accepted measures of organizational capacity or formalization.

Financial capability: About 56% of surveyed organisations have fully audited financial statements, 25% have unqualified audits (less formal than full audits), and 19% only prepare financial reports on an ad hoc basis. This represents one of the biggest areas of divergence in governance practices. Organizations with proper financial auditing tend to have stronger governance overall.

Organisations with unqualified audit reports are frequently excluded from applying for funding, particularly to larger funders, although some report feeling trapped by this requirement, as reported by some smaller organisations,²⁰ as they cannot fund independent audits and the connections required with larger organisations in order to make joint bids are not being made.

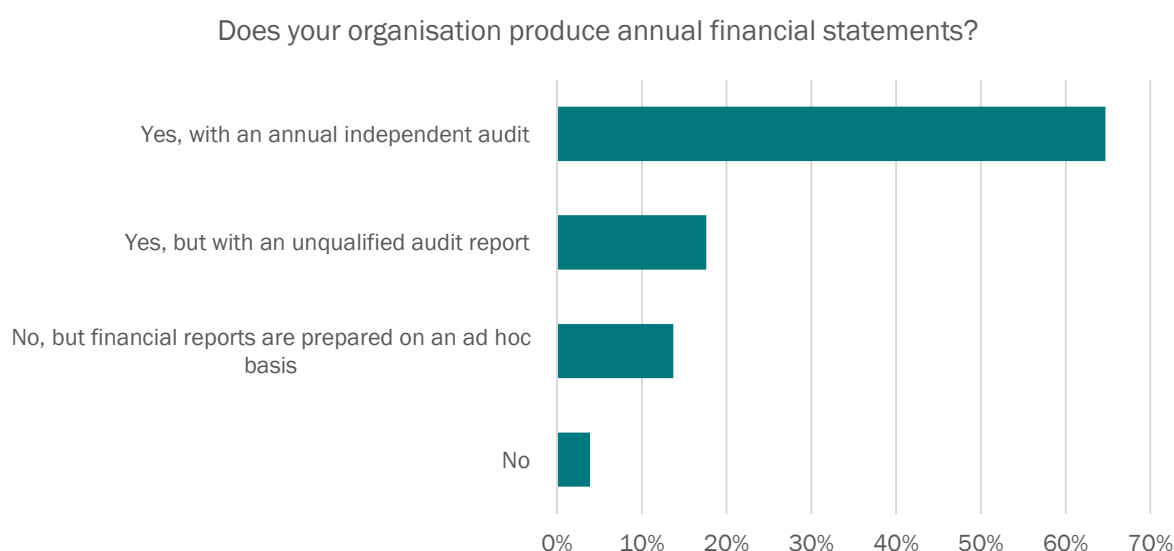


Figure 7: Percentage of surveyed organisations reporting they produce annual financial statements.

Strategic planning: Most organisations (about 81%) reported that they have strategic plans that are regularly reviewed. This suggests that strategic planning is widely recognised as important among WROs and WGROs in Zimbabwe. The few organisations without strategic plans tend to also lack other governance structures.

²⁰ Particularly at the validation event for the “Enhancing Sustainable Financial Support for Local Women and Girls Rights Organisations on GBV in Zimbabwe” study, held on 13th Feb 2025.

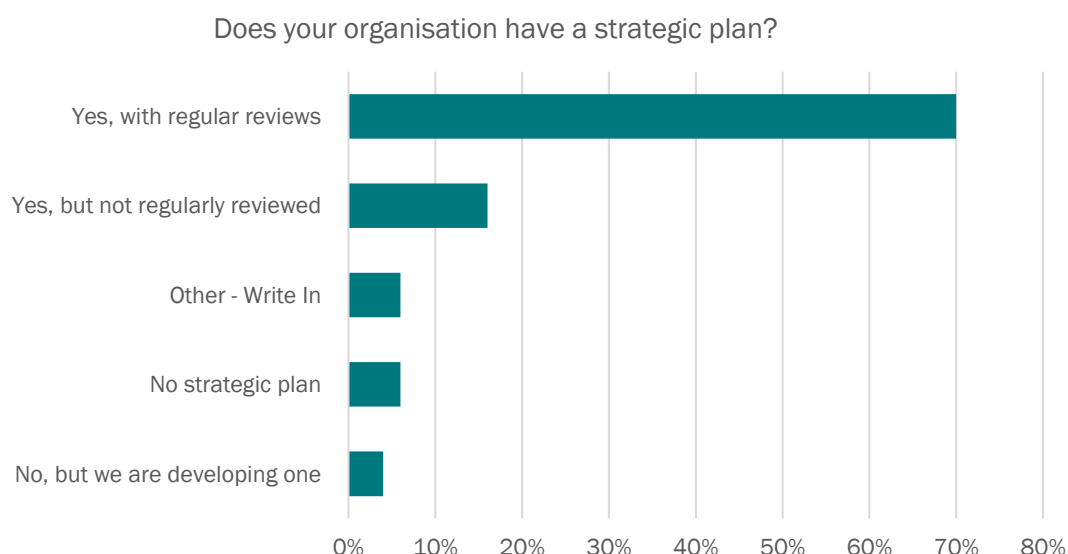


Figure 8: Percentage of surveyed organisations who have a strategic plan.

Self-assessed technical capacity: The largest group (about 56%) reported “significant expertise” in their programme areas. About 31% reported “moderate expertise” and 13% report “limited expertise”. This indicates that most organizations believe they have developed substantial capacity in their areas of focus. However, self-reported expertise should be interpreted cautiously as it may reflect confidence rather than objectively measured capability.

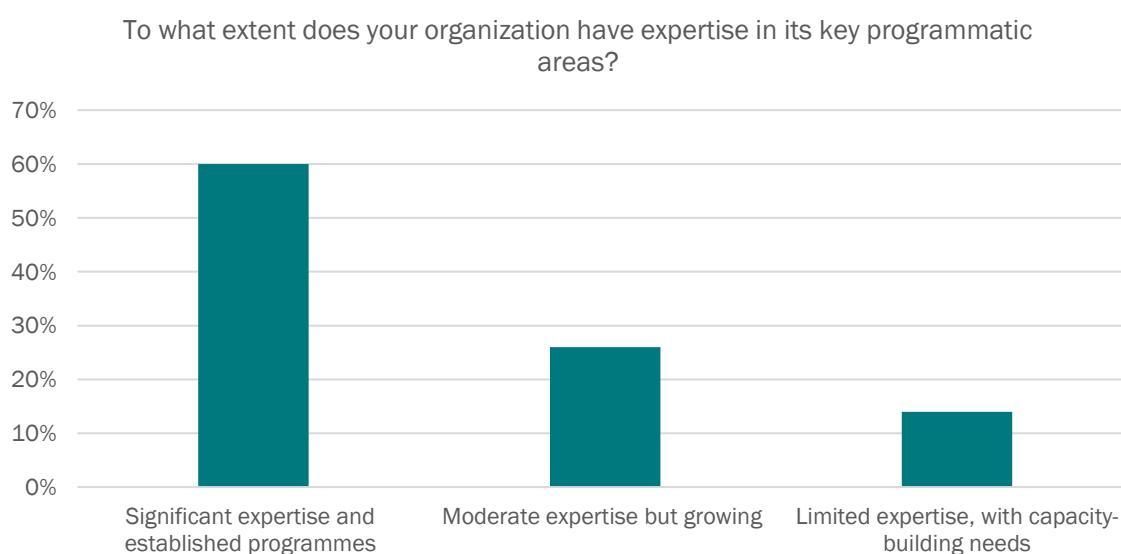


Figure 9: Self-assessed technical capacity of surveyed organisations.

Monitoring and evaluation: About 56% have well-established outcome tracking systems, 25% have informal tracking systems, 6% are developing systems, and 13% have no tracking system. This indicates a significant gap in monitoring and evaluation capacity among some organizations. Without proper tracking systems, organizations may struggle to demonstrate impact and improve programming.

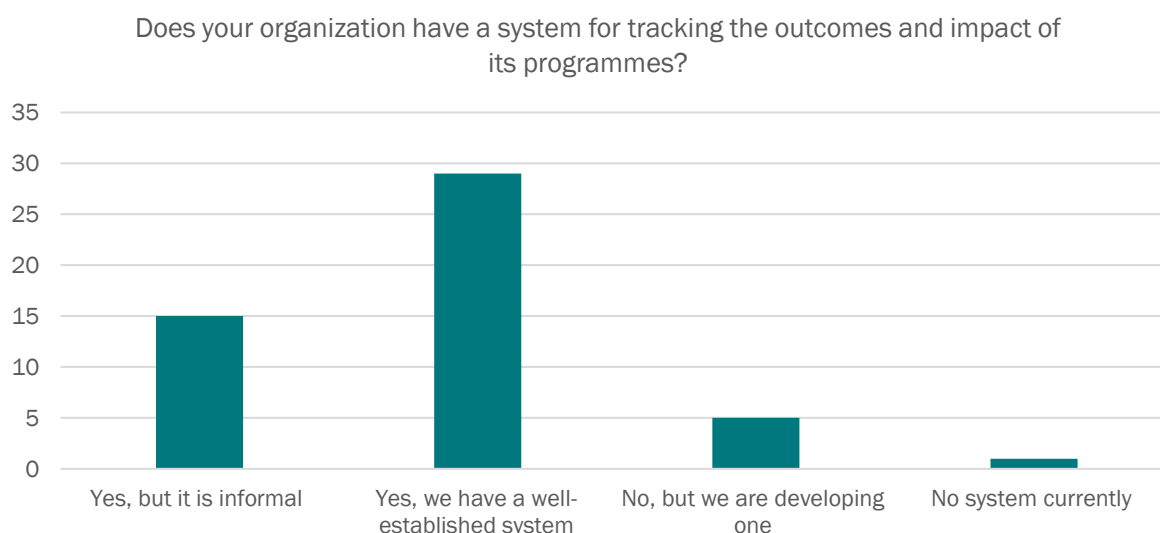


Figure 10: Number of surveyed organisations reporting to have a system for tracking programme outcome and impact.

Organisational maturity: A simple scoring system was developed to produce an aggregate analysis of organisations' overall maturity levels, finding that the majority of organisations (that filled out all of the questions – bearing in mind some organisations with missing answers had to be excluded).

For each organisation, points were assigned for each governance factor:

- **Strategic planning:** three points for "Regular reviews", 0 points for "No plan"
- **Expertise:** three points for "Significant", two points for "Moderate", one point for "Limited"
- **Financial reporting:** three points for "Audited", 2 points for "Unqualified audit", one point for "Ad hoc"
- **Tracking systems:** three points for "Well-established", two points for "Informal", one point for "Developing", 0 points for "No system"

These points were added to create a total maturity score for each organization (maximum possible score: 12)

Organisations were then categorized into maturity levels:

- High Maturity (10-12 point)
- Medium Maturity (7-9 points)
- Low Maturity (4-6 points)
- Very Low Maturity (0-3 points)

This analysis found that the majority of organisations were of 'high maturity' and none were of 'very low maturity.'

Organizational Maturity Levels

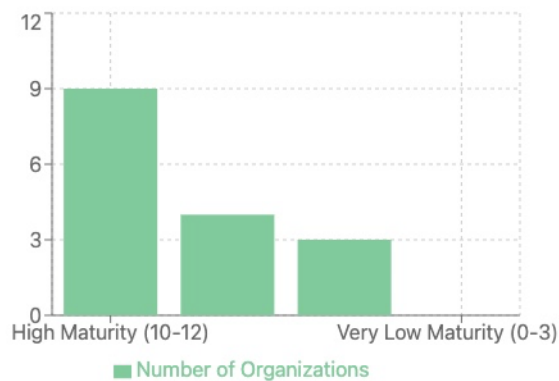


Figure 11: Organisational maturity of surveyed organisations.

The findings indicate a strong correlation between governance factors - organisations with one strong governance practice tend to have others. For example, organisations with regularly reviewed strategic plans are more likely to have well-established tracking systems and audited financial statements. However, expertise is not always tied to formal governance. Some organisations report moderate expertise despite having less formal governance structures, suggesting experience can develop independently of formal systems. Financial reporting is a critical indicator. Organizations with proper financial audits almost universally have better governance across other areas, suggesting financial accountability may be a foundational governance practice.

It is interesting to note that strategic planning is widespread. Most organisations have strategic plans with regular reviews, even when they may lack formal systems in other areas, suggesting it may be the first governance practice adopted by organisations.

The most interesting observation is how these four governance factors cluster together - organisations that lack one typically lack multiple, suggesting improving governance requires a holistic approach rather than addressing individual practices in isolation.

Staffing gaps: The vast majority of organizations (90.6%) reported staffing gaps. Half of all organizations (50.9%) reported critical technical staffing gaps, particularly in M&E, ICT, and data analysis roles essential for programme implementation. Fundraising positions represent the second largest gap (45.3%), creating a vicious cycle where organizations lack the staff needed to secure sustainable funding.

Other significant gaps include communications staff (37.7%), frontline service providers (28.3%), and legal personnel (26.4%) - impacting organizations' ability to reach communities, support survivors, and provide legal assistance for protection orders and court proceedings.

The primary causes of these staffing shortages include:

- Limited funding preventing competitive compensation
- High turnover due to burnout and workload pressures
- Over-reliance on short-term donor funding creating job insecurity
- Dependence on volunteers and part-time staff for essential functions

These staffing constraints directly impact service quality and organisational sustainability, suggesting the need for more stable funding models and targeted capacity building in key technical and fundraising roles.

Funding: As mentioned in section 4, there was a wide range of organisational budgets in the organisations surveyed, corresponding to the varied size and scale of the organisations surveyed, The spread of estimated annual budgets is displayed in Figure 12.

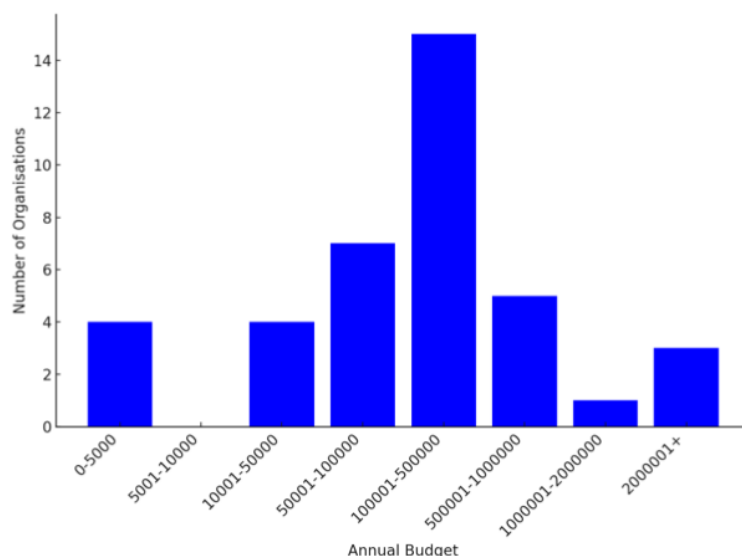


Figure 12: Estimated annual budgets of surveyed organisations (USD).

The most common source of funding was via INGOs, although it is likely that given the small size of most organisations, that they were receiving bilateral and multilateral resources as a second-tier partner. Between a quarter and a third reported receiving funding from the private sector or foundations, individual donations and local NGOs. Ten percent (five organisations) reported generating some funding from social enterprise. ‘Other’ responses included member subscriptions and regional organisations.

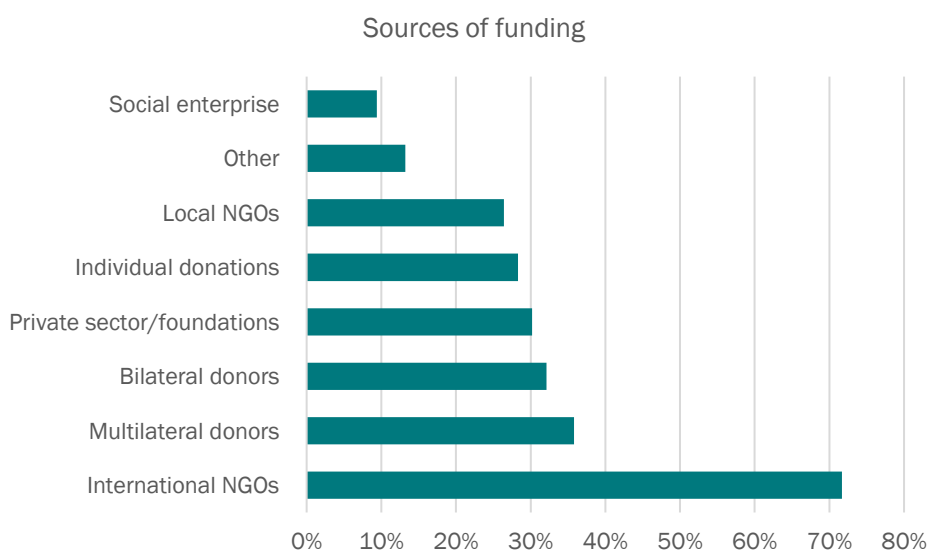


Figure 13: Main sources of funding reported by surveys organisations

Almost all respondents indicated a significant decline in donor funding, with the USAID stop work orders mentioned as the most immediate and severe impact. One respondent noted that the withdrawal has affected “about 80% [of their fund portfolio]” which will “mean even staffing levels will decline by the same percentage.” (Survey respondent).

The funding decline is not limited to US funding. Several organisations mentioned the withdrawal or reduction of other donor funding, particularly from the Netherlands:

“The Netherlands government changes in funding strategy scheduled to take effect in 2027 is also cause for concern as we have three projects funded by

the Netherlands and they are one of the major funders of LGBTI projects in Zimbabwe.” (Survey respondent)

Several respondents noted the changing focus of donors' priorities is affecting the sector broadly:

“Funding has dwindled in the past 3 years. The country is no longer an attractive external donors investment destination as funding priorities are shifting and the global wars are exacerbating the situation...” (Survey respondent).

“It has become increasingly difficult to get funding on GBV programming as most donors' focus has shifted due to their internal policies.” (Survey respondent)

The decline in donor funding to the sector in Zimbabwe has significantly impacted GBV service provision, and services struggle to cope with increasing case numbers. *“Despite the funding trend being on a downward trend, the number of cases is actually on an upward exponential. At times, CSOs become so strained because you've got the pressure to provide a service, but the resources are not available.” (KII)*

When asked if they had scaled back or shut down any GBV service in the past 5 years, 24 survey respondents stated that they had either had to close-down or significantly scale back GBV services, with the vast majority citing funding constraints as the main cause. For many, this reflected challenges with finding new and sustainable sources of funding once donor programming ended. In some cases, GBV services continued but at a much smaller scale, for example, reaching a smaller geographic area, limiting activities, or reducing multisector support where GBV had been mainstreamed into activities. Other reasons provided for the closure of programmes are linked to funding, for example in one case a respondent flagged staff capacity and burnout, while another cited changes in leadership.

This reflects recent analysis within the sector that explored in more detail the negative coping strategies that GBV service providers are employing to absorb funding cuts, with service reach and quality reducing severely, and some services closing down altogether.²¹

Challenges with funding structure and modalities: Several patterns emerged regarding the structure of funding. Many organisations reported relying on short-term grants that undermine sustainability. One respondent reported that: *“[we have] been operating on short-term grants of six months to a year since 2015, some were once-off grants.” (FGD)*. It was also a common problem for organisations to survive on project-based funding, and the lack of core funding for staffing and overheads was flagged by several respondents: *“Most of our funding is activity based which affects institutional sustainability.”; “The grants are regular but with very little amounts resulting in staff underpaid.”; “We have closed office and all staff gone indefinitely as we have no funding we risk losing our office due to the absence of rent.” (Survey respondents).*

Some regions experience service gaps due to donor-driven dynamics and short-term funding cycles. When funding ends, services often cease, creating “deserts” in previously served areas. This can be particularly problematic when expectations have been raised but cannot be met, with the burden falling to traditional leaders who are not equipped to deal effectively with survivors’ needs. These situations were highlighted as being particularly problematic in areas seeing inconsistent services due to short-term humanitarian funding (such as the situation in Chimanimani after Cyclone Idai).

Funding disparities: Interviewees in Bulawayo expressed dissatisfaction over funding disparities between Matabeleland and Mashonaland regions. This was also backed up by Harare-based respondents, indicating that this seems to be a real disparity rather than based on perceptions.

“We really want to talk to donors about the concentration of funding in Harare and Mashonaland. You can actually see that funding is concentrated in

²¹ Coope, S. (2024, n.p.), Scoping Study: Enhancing Sustainable Financial Support for Local Women and Girls Rights Organisations on GBV in Zimbabwe. Plan International, Social Development Direct.

Mashonaland in some areas. So I think as a movement [we] would want to call for equity.” (KII).

Concerns were also raised about Harare-based organisations claiming to work in Matabeleland without substantial presence: *“Harare organisations that claim to be doing GBV work in Matabeleland often it's a lie, these people come to us, ask us to do one or two activities, give us small money for activities and go back to write amazing reports of the work they are doing in the region.”* (FGD)

Finally, it was broadly recognised that more governmental funding needed to go into the sector. There were good partnership models to build on, particularly in partnering with local government and leveraging existing state resources (see Section 4, for example), and intentions within government to increase support to the sector:

“This year, we'll be conducting a research on the cost of GBV to the nation. We want to make a business case on of GBV so that we are able to present a, you know, to the Minister of Finance to say, this is the cost of GBV if we don't put in place preventative measures, this is what is costing the country, but if we are able to fund prevention and response, this is the kind of what the country will gain, so that it becomes an issue of evidence based advocacy with our different stakeholders.” (Government KII)

However while stakeholders expect the Zimbabwean government to lead on funding and coordinating GBV services, actual government investment (and, often, leadership) remains limited with heavy dependence on donor funding, and a gap between policy commitments and implementation. *“Government does not think about what happens when donors pull out. How are we going to continue providing these services?”* (FGD)

Despite some progress – including appointing gender directors in ministries and implementing gender-responsive budgeting – there is clearly a substantial gap between policy commitments and implementation. The key concern is that government currently relies on civil society and donors to provide essential services without creating sustainable mechanisms for when donor funding ends. All respondents were, however, keen to pursue other funding models as well as to push for greater government investment; these are explored below.

5.2 Sustainability

Several approaches to enhancing sustainability emerged from the data. One interesting model mentioned was the community-based shelter model, which could address sustainability challenges by leveraging local resources and ownership (see section 4 for more details). Many others mentioned developing social enterprise components to supplement donor funding, with one mentioning that: *“We will keep looking for funding, but our social enterprise component has kept us afloat.”* (Survey respondent).

Partnering with other organisations to access funding emerged as another strategy, discussed in some interviews, and this was a particular focus of the scoping study validation event. There is clearly growing interest in engaging the private sector more effectively, including among government and donor organisations. However it was also recognised that these approaches needed to be smart, and operate as genuine partnerships, rather than just simple appeals to Corporate Social Responsibility initiatives.

“It may work for some companies [who are] on board with their hearts in the right place, is definitely something to strive for, but [this] shouldn't be the default position...”

The private sector doesn't work on a donation basis. That is not sustainable, because once they don't have the finances or like, profits go down, this is the first thing they will cut. So kind of earmarking this as a donation to me, is not sustainable ... What we need to offer private sector is an investment, and if we say GBV prevention, there are different ways to include that in the workplace, and this is probably where we start, because that's how we get

money, and that's also how we give something back to the private sector.”
(KII).

While this was not explored in the qualitative research, the relatively large proportion of organisations registered as Trusts may have implications for organisational sustainability. While not prohibited from receiving foreign funding, Trusts are not legally recognized as charitable organizations under the PVO Act. As such, receiving foreign funding—especially at scale or for development or humanitarian purposes—can attract scrutiny. The government may require a Trust to register as a PVO if its activities are deemed to fall within the scope of “charitable” work, particularly if it engages in community service, advocacy, or service delivery, yet PVO applications are, at the time of writing, apparently not being cleared. Larger institutional donors typically require recipients to be registered as PVOs, and banks may also query large international transfers to Trusts, therefore limiting the range of fundraising options available to many organisations. Having said this, PVOs are also subject to significant regulatory oversight, including detailed reporting, mandatory registration, and following the 2024 amendments to the PVO Act, compliance requirements have become more stringent, especially for organizations working on governance, human rights, or social justice. As mentioned earlier, at the time of writing, PVO applications are not currently being cleared, leading to a reportedly significant backlog. For either type of organisation, complications may occur, leading to a chilling effect on seeking international funding.

6 Cross-cutting themes

This section examines themes that intersect across various aspects of GBV response in Zimbabwe: coordination mechanisms, data collection systems, the role of community and traditional structures, and the specific challenges faced by marginalised groups. These themes affect all areas of GBV prevention and response, highlighting systemic issues that require attention across the sector.

6.1 Coordination and Collaboration

At a strategic level, the MWACSMED has the mandate to coordinate stakeholders working on GBV at National, Provincial, District, and community levels through the GBV Coordination Forums. These forums operate at different levels with varying (intended²²) meeting frequencies:

- **National level:** Chaired by the Permanent Secretary in MWACSMED, meets quarterly;
- **Provincial level:** Chaired by the Provincial Development Officer (PDO), meets monthly;
- **District level:** Chaired by the District Development Officer (DDO), meets monthly;
- **Ward level:** Coordinated by the Ward Development Coordinator (WDC), meets monthly.

The coordination efforts aim to leverage resources, identify and build on best practices, scale up promising interventions, discuss lessons learned and challenges, conduct research, and avoid duplication: *“We do not work as government alone, but we work with cooperating partners, we collaborate and we help each other.”* (KII).

However these structures are often, if not largely, theoretical, and the lack of coordination, collaboration and genuine dialogue hinders the wider movement building and strength of advocacy of the sector. At the practical level, GBV partners are required to work in a multisectoral way, to ensure comprehensive support and effective case management. Organisations use referral pathways where survivors are directed to appropriate service providers within the ecosystem.

The key protocols established by government include:

- **National GBV Referral Pathway** – Zimbabwe has established a multi-sectoral referral system that connects various service providers including health facilities, police, legal services, and psychosocial support.

²² Reports vary as to whether or not the forums are operational at this time.

- **Clinical Management of Rape (CMR) Protocol** – This protocol standardises medical care for sexual violence survivors, including post-exposure prophylaxis for HIV, emergency contraception, and forensic evidence collection.
- **National Case Management Guidelines** – These provide standardised procedures for handling GBV cases, ensuring survivors receive comprehensive support throughout their journey.

Most FGD and KII respondents identified this collaborative approach (when used) as the greatest strength of Zimbabwean response service providers, as it fosters coordination to address GBV cases more effectively and efficiently. However, while the established protocols are robust in theory, interviewees reflected a very inconsistent picture in terms of their application. Many organisations are unaware of the government protocols, or choose to use alternative methods.

Despite these formal structures, interviews indicated that many WROs and WGROs face challenges in coordination, often operating in parallel due to competition for donor funding. While the WCOZ was initially established to enhance coordination, some respondents expressed concerns that it has evolved into a competing entity rather than a facilitating body: *“The coalition should separate the members' mandate from its mandate so that it implements its mandate effectively. Right now, it competes with its members rather than coordinating them.”* (FGD)

National and local co-ordination of GBV structures and services seems very variable. One participant commented that: *“The National GBV Strategy has a strong pillar on coordination, but at the national level, that platform has been very weak. At the provincial level, something is happening, but at the national level, convening those meetings is a challenge.”* (FGD). However, there was little other comment on national co-ordination, and varying commentary on the quality of local co-ordination.

Positive coordination examples: In Manicaland, stakeholders reported that a collaborative approach between WROs and local government has enabled more structured engagement. Additionally, some provinces have coordinating WhatsApp groups with all GBV service providers where they discuss cases and refer to relevant organisations, though concerns were raised about the appropriateness of this platform for professional case management.

Coordination challenges: In some districts and provinces, organisations implement similar interventions without coordination, partly due to competition for scarce funding: *“We've got a fragmented approach to management. I know the politics behind our fragmentation, competing for resources.”* (KII)

Some FGD participants were meeting other service providers from the same district for the first time during the research discussions, indicating a lack of networking among organisations working in the same area.

6.2 Data and Evidence

There are significant gaps in research and documentation within the GBV sector in Zimbabwe. Although the GBV strategy outlines an aim for MWACSMED to enhance the collection and management of high-quality, disaggregated data and support the development of a GBV Information Management System and database, this system has not yet been established. Key stakeholders acknowledge the critical role of research in informing prevention and response initiatives: *“You cannot prevent what you don't know.”* (KII).

The FCDO-funded SAFE programme was frequently mentioned as a positive example of integrating research components that facilitated learning and adaptation.²³ As mentioned in Section 5.1. MWACSMED intends to conduct research on the economic cost of GBV to strengthen advocacy for resources.

The lack of a co-ordinated system for collecting data on, and managing cases, is damaging to both the quality of service provision and on wider understanding of GBV issues in Zimbabwe. There are plans,

²³ E.g. see this link for the adaptive approach taken by Toose in its pilot phase: https://intdev.tetracheurope.com/wp-content/uploads/2024/11/SAFE-Poster_FINAL.pdf.

however, to establish a GBV MIS, which will improve access to accurate, timely data on GBV prevalence and intervention effectiveness and encourage better case management practice.

6.3 Community, Traditional and Religious Structures

6.3.1 Traditional Leaders and Chiefs

Traditional leaders significantly influence gender norms and can either reinforce harmful practices or champion positive change. Their position as initial contact points for GBV cases gives them particular importance: *“The traditional leadership is weak, very weak... these are the first gatekeepers. GBV issues come to traditional leaders first before they even go to the police...”* (FGD)

Their own behaviour can undermine their effectiveness:

“Traditional leaders do not only need to be targeted on the side of the queen mothers, but on them as individuals. You can actually ask yourselves; how do these chiefs treat their wives? Because as duty bearers, if they are perpetrators and are abusing their wives, they will never be able to accept addressing GBV.” (FGD).

6.3.2 Religious Leaders and Churches

Churches play a complex role in establishing and challenging gender norms, with their influence deeply affecting family structures and individual decision-making. Some religious teachings prevent survivors from seeking outside help:

“Our church says the church is the court of heaven. There's no other court bigger than the church. You cannot refer your fellow sister in Christ to the court. So it's not even allowed within the church for a woman to go to court if they're experiencing GBV...” (FGD).

Internal resolution approaches often fail to prioritise survivor safety: *“So when there is a GBV case in the church, it is taken to the church and is dealt with in the church coffers by the church council and the abuse continues. There's no mechanism to check on the survivors.”* (FGD)

Churches also represent untapped potential for norm change: *“So I think as a collective the movement should start targeting the church for it to be a safe space for women and to have sexual gender-based violence strategies to support survivors.”* (FGD)

6.3.3 Community Structures and Local Champions

Community-based structures provide a foundation for challenging harmful norms when properly supported, while organising often drives national advocacy:

“When the women organise in their individual localities, usually those are the key issues that will then bring to the national fore... But what is happening at the grassroots and the local, local organising there is what mainly informs the actions that we take at national level.” (KII)

6.3.4. Marginalized Groups

The research identified several marginalized populations with specific vulnerabilities and challenges in accessing GBV services:

People with Disabilities (PWDs): People with disabilities face significant barriers to accessing GBV services. One key informant observed that:

“...most [GBV services] are not designed adequately to respond to what their challenges are...It's hardly possible to go to any of the organisations that I've mentioned, and you can actually find someone who speaks in sign

language or to find somebody who is able even to convey message in Braille.” (KII).

While there are organisations within the women's movement led by and representing PWDs, some observed that practical integration into service provision remains minimal, although there has perhaps been more success in integrating disability issues into advocacy work.

Adolescent girls: Adolescent girls emerge as a particularly vulnerable group, with the transcripts highlighting the persistence of child marriages despite legislation outlawing the practice. Girls within certain religious communities, particularly Apostolic sects, were identified as especially vulnerable to GBV and child marriage. Girls forced to drop out of school due to poverty were also identified as especially at-risk.

Male survivors: Male survivors of GBV received brief but significant mention in interviews. Respondents acknowledge cultural barriers that prevent men from reporting GBV: *“Our tradition does not... usually allow men to talk about their being... violated, but we see this is happening, and it's causing a lot of deaths among men as mental health issues.”* (KII) These men are “just dying with their issues” due to inability to report, with respondents indicating *“we are also wanting men to come out and talk about this.”* (KII).

The research also indicated that most prevention and response services are designed primarily with women in mind, potentially limiting their effectiveness for male survivors. One respondent noted: *“GBV services were made with women in mind yet men are victims too, a man cannot seek refuge at a shelter because they are for women, that is why the rate of men suicide has increased because they have nowhere to turn to, the system was designed for women.”* (SSI).

Prisoners and ex-prisoners: The interviews address inmates and ex-prisoners, particularly focusing on male perpetrators' rehabilitation. Concerns about recidivism are evident, with one respondent describing how *“even when they've served... the day that he's released, he's going home, and it's like he's saying, ‘I'm going to deal with that woman.’”* This creates a cycle where *“someone who is released today and then tomorrow, they are already back in court [for] domestic violence.”* Some rehabilitation efforts are mentioned, including work with *“male inmates as well, particularly those that who have been incarcerated due to GBV crimes, also preparing them for life.”* (KII).

Indigenous women and ethnic minorities: Indigenous women and ethnic minorities are identified as target populations for outreach, *“particularly targeting those conserved communities where they are ethnic minorities and indigenous women, for example, we may see Binga as well.”* These areas are described as very hard to reach, with service gaps where *“there's something going on, but we don't really have much interventions coming from women's rights organisations.”* (KII).

LGBTQ+ individuals and sex workers: There was fairly limited evidence gathered on these populations. However there was some evidence of service provision for LGBTQ+ women, from specialist organisations, and of sexual rights services being inclusive of the specific requirements of sex workers with respect to response and Sexual Rights and Health (SRH) services. In the former case, there were reports of lesbian, bi and queer women benefiting from GBV response and prevention interventions. Sex workers may be a particularly vulnerable group in the face of recent USAID cuts, with reports that specialised services had been cut and they now need to access increasingly pressurised community clinics instead (e.g. for ART).

6.4 Summary of cross-cutting themes

The cross-cutting themes identified in this chapter - coordination challenges, data gaps, the complex role of traditional structures, and the specific needs of marginalised groups - reveal both strengths and weaknesses in Zimbabwe's GBV response system. While formal structures exist for coordination and service delivery, their implementation varies significantly across regions. The absence of a centralised data system hampers both service delivery and policy development. Traditional and religious structures can both help and hinder GBV response, depending on how they are engaged.

Finally, specific marginalized groups face additional barriers that require targeted approaches beyond the general GBV response framework.

Addressing these cross-cutting challenges will require concerted effort across sectors, improved resource allocation, and greater attention to the specific needs of different population groups. The planned GBV MIS offers promise for addressing data gaps, while enhanced coordination mechanisms could improve service delivery efficiency.

7 Conclusions and Recommendations

7.1 Conclusions

The findings of this mapping exercise confirm that the **GBV sector in Zimbabwe remains diverse and dynamic**, yet deeply constrained by systemic and structural limitations. Most notably, there is clear evidence of persistent geographic, thematic, and institutional gaps in GBV response services, even as organisations continue to adapt with considerable innovation and commitment.

The **provision of GBV response services is wide-ranging, but access and quality vary dramatically**.

While counselling is commonly provided, more resource-intensive services such as shelters, legal support, and medical care are far more limited. The centrality of a small number of large providers illustrates both the strength and fragility of the system; over-reliance on a few large actors presents risks to service continuity, particularly amid donor withdrawals. The deteriorating funding environment is creating growing inequities in access, particularly affecting rural and hard-to-reach populations.

Shelter provision is particularly inadequate. The concentration of shelters in a few areas leaves many survivors without viable options, while donor reluctance to fund shelters further erodes availability. Community-based shelter models show promise but require institutional support, financial backing, and safeguarding frameworks to be scalable and safe.

The **provision of medical services is another critical weakness**. Few CSOs are equipped to deliver medical interventions, and resource constraints in the public health system compromise survivor care. This is compounded by limited donor willingness to invest in health-related GBV interventions, with implications for survivors' access to post-rape care and treatment. Legal service provision, although historically strong, is similarly constrained by funding limitations. Delays, lack of follow-up, and inadequate survivor support mechanisms undermine access to justice for many survivors. Despite these constraints, **counselling and psychosocial support remain relative strengths within the sector**, aided by a good national supply of trained professionals. **Economic empowerment programming emerges as a key strength** and widely used approach, cutting across both response and prevention.

Geographically, the analysis reveals some troubling disparities. **Rural and remote remain often neglected**, and there are specific areas with elevated needs (for example resettlement communities, mining communities, border towns) that are not matched with service provision. Matabeleland emerges as particularly under-served. Urban centres (particularly Harare) are relatively well served, with clusters of services around the main cities.

Finally, coordination, data, and marginalisation are cross-cutting challenges that both stem from and reinforce the issues observed in service provision. Despite the existence of coordination structures and protocols, their implementation is inconsistent. A lack of reliable data hinders planning, funding, and accountability. Marginalised groups, including PWDs, LGBTQ+ individuals, and ethnic minorities, continue to face significant barriers to accessing GBV services.

7.2 Recommendations

In a context of declining donor funding and increasing need, strategic decisions must be made about where to direct limited resources. The following recommendations focus on the most critical areas requiring immediate attention and sustainable solutions.

Recommendation 1: Strengthen community-embedded response services

Lead stakeholders: Development partners, WROs with established community presence (e.g., Musasa).

Supporting stakeholders: Local government, Traditional leadership, MWACSMED.

Actions:

- Support the adaptation and scaling of promising community-based models that have demonstrated effectiveness, particularly in hard-to-reach areas.
- Invest in quality assurance mechanisms to ensure community-based services adhere to survivor-centred approaches and ethical standards.
- Build on Musasa's experience with adapting services to difficult locations with unlikely partners, documenting and replicating successful approaches.
- Develop mobile service delivery models that can reach survivors in remote areas while maintaining quality and confidentiality.
- Ensure appropriate training and support for community-based response personnel to prevent further trauma to survivors.

Recommendation 2: Revitalise and sustain medical response services

Lead stakeholders: Ministry of Health, Development partners.

Supporting stakeholders: Medical service providers (e.g., ARC, FST), other WROs.

Actions:

- Urgently stabilize funding for critical medical service providers.
- Ensure consistent availability of post-rape kits and essential medicines at district hospitals and health centres.
- Support transportation systems for survivors to access medical facilities, particularly in remote areas.
- Strengthen integration between community-based first responders and formal medical services.
- Explore innovative funding mechanisms, including diaspora support, to sustain medical services beyond traditional donor funding.
- Conduct a comprehensive assessment of the government's medical service footprint for GBV survivors to identify and address critical gaps.

Recommendation 3: Develop collaborative resource mobilisation strategies

Lead stakeholders: WROs, MWACSMED, Development partners.

Supporting stakeholders: Private sector, Diaspora networks, Local philanthropy.

Actions:

- Create platforms for sector-wide collaboration on resource mobilization, breaking down the competitive dynamics that currently fragment efforts.
- Support established organizations to adapt funding models while ensuring they bring smaller organizations along through mentorship and sub-granting.
- Develop joint fundraising initiatives that leverage complementary strengths across organizations.
- Support WROs to diversify funding sources through social enterprise, private sector partnerships, and diaspora engagement.
- Establish resource-sharing mechanisms (e.g., shared office space, transportation, technical expertise) to reduce operational costs across organizations.
- Build capacity of local organizations to access and manage alternative funding streams.

Recommendation 4: Transform the national GBV prevention approach

Lead stakeholders: MWACSMED, Ministry of Education, Development partners.

Supporting stakeholders: WROs, Research institutions, School system.

Actions:

- Develop a comprehensive national prevention strategy grounded in evidence-based approaches and proven methodologies.
- Scale successful models like SAFE/Toose while adapting to different contexts across Zimbabwe.
- Integrate GBV prevention into school curricula at all levels, with increased focus on early childhood development.
- Invest in rigorous evaluation of prevention initiatives to build an evidence base for what works in the Zimbabwean context.
- Discontinue funding for ineffective awareness-raising activities that lack proven impact.
- Counteract the rollback of gender equality norms through strategic use of technology, media, and community influencers.
- Engage with traditional and religious leaders as key influencers in norm change.

Recommendation 5: Reform and strengthen coordinating structures

Lead stakeholders: MWACSMED, Women's Coalition of Zimbabwe (WCOZ).

Supporting stakeholders: Development partners, WROs.

Actions:

- Revitalise the women's movement, including support to WCOZ to execute its core mandate as an apex body focused on coordination and movement building.
- Study successful models of women's movement building, leadership and coordination from other contexts to identify applicable approaches for Zimbabwe, particularly in the context of GBV.
- Strengthen provincial and district-level coordination mechanisms to ensure inclusive participation of smaller organizations.
- Develop clear roles and responsibilities for coordinating bodies at different levels to avoid duplication and competition.

Recommendation 6: Address geographical service inequities

Lead stakeholders: Development partners, MWACSMED.

Supporting stakeholders: Apex bodies, NGOs and WRGOs in marginalised communities.

Actions:

- Prioritize funding for organizations with genuine presence in underserved areas, particularly Matabeleland North and South.
- Develop region-specific strategies that account for the unique challenges and opportunities in different provinces.
- Address the perceived and actual funding disparities between Mashonaland and Matabeleland regions.
- Strengthen monitoring mechanisms to ensure organizations claiming to work in specific regions demonstrate verifiable presence and impact.
- Support locally-led initiatives in underserved areas rather than Harare-based organizations claiming peripheral coverage.

Recommendation 7: Establish the national GBV MIS

Lead stakeholders: MWACSMED.

Supporting stakeholders: Development partners, GBV service providers.

Actions:

- Prioritize the development and implementation of the planned national data system to improve case management and strategic decision-making.
- Ensure the system includes safeguards for data protection and survivor confidentiality.
- Train all relevant stakeholders on system use and data interpretation.
- Use aggregated data to inform resource allocation and identify emerging trends and gaps.

Recommendation 8: Support sustainable shelter models

Lead stakeholders: Local government, WROs, Traditional leadership.

Supporting stakeholders: Development partners, Religious institutions.

Actions:

- Document and scale successful community-based shelter models that have demonstrated sustainability.
- Develop partnerships between local authorities and civil society for shelter management, as seen in promising examples from Midlands.
- Leverage traditional leadership structures, such as the Zunde raMambo concept, to establish community-owned protection mechanisms.
- Create minimum standards and safeguarding protocols for community-based shelters to ensure survivor safety and dignity.

Recommendation 9: Strengthen GBV preparedness in humanitarian contexts

Lead stakeholders: WROs, Department of Civil Protection, MWACSMED.

Supporting stakeholders: UN agencies, Development partners.

Actions:

- Ensure that WROs are represented at the appropriate forums (not just GBV, and not just during active crises)
- Integrate GBV response into disaster preparedness planning and programming, particularly in climate-vulnerable regions.
- Strengthen safeguarding measures in humanitarian response to prevent exploitation.
- Build local capacity for GBV response during emergencies to reduce reliance on external actors.

Recommendation 10: Enhance inclusion of marginalised populations

Lead stakeholders: WROs working with specific marginalised groups.

Supporting stakeholders: MWACSMED, Development partners.

Actions:

- Ensure services are accessible to persons with disabilities through appropriate infrastructure and communication adaptations.
- Develop targeted approaches for other underserved populations including male survivors and LGBTQ+ individuals.
- Integrate inclusion principles across the GBV response system rather than treating them as separate initiatives.

- Support organizations led by marginalized groups to participate meaningfully in the GBV response ecosystem.

In implementing these recommendations, stakeholders must recognize that the current funding environment necessitates difficult choices. Priority should be given to preserving and strengthening the most critical services—particularly community-embedded response, medical care, and effective prevention approaches—while building more sustainable models for the future. Genuinely open coordination and collaboration across the sector will be essential to maximize impact with limited resources.

Annexes

Annex 1. Documents Reviewed

1. Aid Counselling Trust-ACT (2020-2024), Strategy.
2. Apostolic Women Empowerment Trust- AWET (n.d) Gender Based Violence Report.
3. Apostolic Women Empowerment Trust-AWET (2022), National Disability Expo.
4. Campaign for Female Education-CAMFED (2019), Annual Report.
5. Chiedza Child Care Centre (2020), Annual Report.
6. Chiedza Child Care Centre (2021), Annual Report.
7. Chiedza Child Care Centre (2022), Annual Report.
8. Dialogue on Shelter (n.d), Projects.
9. Emthonjeni Women's Forum-EWF (2022), Annual Report.
10. Forum for African Women Educationalists in Zimbabwe-FAWEZI (2022), Annual Report.
11. Female Student Network- FSN (n.d), Organization Organogram.
12. Gender Links for Equality & Justice (2020), Annual Report.
13. Gender Links for Equality & Justice (2021), Annual Report.
14. Gender Links for Equality & Justice (2022), Annual Report.
15. Girls and Women Empowerment Network- GWEN Trust (n.d), Organizational Activities.
16. Jointed Hands Welfare Organization (n.d), Achievements.
17. Legal Resource Foundation-LRF (2022), Annual Report.
18. Maranatha Orphans Care Trust- MOCT (n.d), Fact Sheet.
19. Methodist Development and Relief Agency (2023), Annual Report.
20. MUSASA- Organization Against Gender Violence (n.d), Livelihoods Programme.
21. MUSASA- Organization Against Gender Violence (n.d), Programmes.
22. Mwenezi Development Training Centre-MiDTC (n.d), Funding Partners.
23. Ntengwe for Community Development (n.d), Profile of the Organization.
24. Rozaria Memorial Trust (2017), Annual Report.
25. Rozaria Memorial Trust (2021), Assessment Report.
26. Rozaria Memorial Trust (n.d), Theory of Change for Advocacy.
27. SAWWHAT (?), Success Stories.
28. Tag a Life International- TaLI (2020), Institutional Report.
29. Tag a Life International- TaLI (2020-2022), List of Donors.
30. Tag a Life International- TaLI (2020-2021), TaLI Organogram.
31. The Girls Table (2023), Election Report.
32. Tree of Life Trust (2024), Fact Sheet.
33. Tree of Life (2019), Annual Report.
34. Tree of Life (2020), Annual Report.
35. Tree of Life (2021), Annual Report.
36. Tree of Life (2022), Annual Report.
37. Tony Waite Organization (2019), Annual Report
38. Tony Waite Organization (2020), Annual Report.
39. Tony Waite Organization (2021), Annual Report.
40. Tony Waite Organization (2022), Annual Report.
41. Women's Academy for Leadership & Political Excellence-WALPE (2020), Annual Report.
42. Women (And Men) of Zimbabwe Arise- WOZA (2017), Insight.

43. Women and Aids Support Network (WASN) Zimbabwe (2020), Annual Report.
44. Women's Resource Centre (2022-2023), Annual Report.
45. Women's Academy for Leadership Training & Political Excellence-WALPE (2021), Feminist Leadership Training Manual.
46. UN Women (2024), Types of Violence Against Women & Girls.
47. Zimbabwe Gender Commission-ZGC (2023), Annual Report.

Annex 2. List of key informants

	Organisation	Stakeholder type
1	Musasa	National / International NGO
2	Adult Rape Clinic	National / International NGO
3	Zimbabwe Gender Commission Mutate	National / International NGO
4	Oxfam	National / International NGO
5	Women's Coalition of Zimbabwe	National / International NGO
6	Women in Politics Support Unit	National / International NGO
7	Trocaire	National / International NGO
8	SAFE Programme	GBV Expert
9	European Union	Donor / Development Partner
10	Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ)	Donor / Development Partner
11	UN Women	Donor / Development Partner
12	Ministry of Women Affairs, Community, Small and Medium Enterprise Development (MoWACSMED)	Government

Annex 3. Data collection tools

Key Informant Interview Guide

Introduction

*For the facilitator	
Date	
Location	
Number of participants:	
Time:	

Thank you for taking the time to talk with me today. My name is _____ and I work with Ecorys, partnering with Triple line, a consultancy contracted to conduct a mapping of GBV WROs in Zimbabwe on behalf of FCDO.

The exercise is aimed at mapping and assessing the ecosystem of women's rights organisations (WROs) working to tackle gender-based violence (GBV) in Zimbabwe. This study and accompanying analysis will feed into the design of a possible future business case related to strengthening and supporting the localisation of the GBV sector in Zimbabwe.

You have been selected to participate in this KII as an organisation (in or related to) the sector. This discussion will take around 1 hour to 1hour 30minutes. We ask that you be as open and honest as possible, the information you give us is useful for our study. Please know that anything you say will not be traced back to you or affect your organisation or funding in any way. Some of the questions have to do with numerical data and others will be more descriptive. If you feel you would like to provide the numerical information later or by email, please let me know.

Do you have any questions about what I just explained? Would you like to take part in this survey? *If "yes", I am going to hand out consent forms which I kindly ask that you sign. I am also going to hand out an information sheet about your organisation which I ask that you fill in.*

WRO Mapping Exercise:

1. What are the areas of relative strength (nationally, thematically) in Zimbabwe – in terms of GBV response service provision?
2. Why? What has gone into developing these strengths and what will it take to maintain and grow? What are the enablers?
3. What are the areas of relative weakness (nationally, thematically)?
4. Why? Has it always been this way? What might change the game for each of these areas? What are the bottlenecks and blockers?
5. Same questions for prevention work and advocacy
6. Areas of relative strengths in terms of different types of work (response, prevention, advocacy) in geographical terms:

7. Are there 'hotspots' of activity and momentum in certain localities? What can we learn and how can we build on these?
8. Are there 'deserts' of activity in certain localities? Why is this, and what might be done to make inroads and support these communities?
9. How cohesive and collaborative is the sector? Are there opportunities for supporting organisations to form a stronger movement (for mobilizing resources and wider social change)? What would this take? What can development partners most effectively do to support this?
10. How do you see the funding landscape changing in future and how does this affect the sector?

Interviewer observations/notes

----- Thank you and wrap up -----

Questionnaire

Introduction

1) Do you consent to taking part in the survey?*

- ☐ Yes (Written consent)
☐ Yes (Verbal consent)
☐ No

2) Organisation name*

Basic information about your organisation

3) Type of organisation (Tick List)

- ☐ INGO
☐ NGO
☐ CBO
☐ PVO
☐ TRUST
☐ Other - Write In: _____

4) Year established (approximate is fine)

5) Status/Registration type (Tick list)

- ☐ Pending
☐ Registered
☐ Unregistered/Informal
☐ Don't know/don't want to answer

6) Do you give consent for your organisation's basic details to be shared in a directory of organisations working on GBV issues? This directory will only cover: organisation name, client

group, geographical coverage.

*Note that you can refuse consent for inclusion in the directory, but still participating in the rest of the survey. Your information will be fully anonymised in the research report.**

☐ Yes

☐ No

Geographical coverage

7) Geographical scope of operation (tick all that apply). It is possible to work at multiple levels (e.g. national and provincial level advocacy, district level service provision). Only tick 'ward level' if you only work in wards or smaller geographical units e.g. towns.*

☐ National

☐ Provincial

☐ District

☐ Ward level only

8) Select Provinces

☐ Harare

☐ Bulawayo

☐ Manicaland

☐ Mashonaland Central

☐ Mashonaland East

☐ Mashonaland West

☐ Masvingo

☐ Matabeleland North

☐ Matabeleland South

☐ Midlands

9) Districts: Please select each province you work in, followed by each district. You will need to input one province at a time

Selected Districts

☐ Harare Urban

☐ Harare Rural

☐ Chitungwiza

☐ Epworth

☐ Bulawayo

☐ Buhera

- ☐ Chimanimani
- ☐ Chipinge
- ☐ Makoni
- ☐ Mutare
- ☐ Mutasa
- ☐ Nyanga
- ☐ Bindura
- ☐ Centenary
- ☐ Guruve
- ☐ Mazowe
- ☐ Mbire
- ☐ Mount Darwin
- ☐ Muzarabani
- ☐ Rushinga
- ☐ Chikomba
- ☐ Goromonzi
- ☐ Marondera
- ☐ Mudzi
- ☐ Murehwa
- ☐ Mutoko
- ☐ Seke
- ☐ Uzumba Maramba Pfungwe
- ☐ Chegutu
- ☐ Hurungwe
- ☐ Kariba
- ☐ Makonde
- ☐ Mhondoro-Ngezi
- ☐ Sanyati
- ☐ Zvimba
- ☐ Bikita
- ☐ Chiredzi
- ☐ Chivi
- ☐ Gutu
- ☐ Masvingo
- ☐ Mwenezi
- ☐ Zaka
- ☐ Binga
- ☐ Bubi
- ☐ Hwange
- ☐ Lupane
- ☐ Nkayi
- ☐ Tsholotsho
- ☐ Umguza

- ☐ Beitbridge
- ☐ Bulilima
- ☐ Gwanda
- ☐ Insiza
- ☐ Mangwe
- ☐ Matobo
- ☐ Umzingwane
- ☐ Chirumhanzu
- ☐ Gokwe North
- ☐ Gokwe South
- ☐ Gweru
- ☐ Kwekwe
- ☐ Mberengwa
- ☐ Shurugwi
- ☐ Zvishavane

10) Sub-district - list wards (please complete only if this is the organisation's sole focus - not required for larger organisations)

Organisational focus and functions

11) Main focus of the organisation - client groups, services and interventions

(Please tell us what (1) client groups you work with (women, children, other populations focusing on human rights violations, or any other groups) and (2) what services or interventions you undertake relating to each of these populations (response services - including legal interventions, prevention activities, advocacy (individual cases or policy level), or any other work not listed here)

	Women and girls	Urban women	Rural women	Men and boys	Children	People with disabilities	Other
Response services	☐	☐	☐	☐	☐	☐	☐

Prevention	☐	☐	☐	☐	☐	☐	☐
Advocacy	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐

12) Please share any other information you want to provide on your services

13) GBV response services currently provided

- ☐ Medical intervention
- ☐ Legal advice (ad hoc)
- ☐ Legal support (case management)
- ☐ Counselling/psychosocial support (in person)
- ☐ Counselling/psychosocial support (phone/text)
- ☐ Shelters
- ☐ Long term recovery e.g. survivors' economic empowerment
- ☐ Other

14) Number of GBV response clients in last year recorded (approximate numbers are fine)*

15) Please provide any more information on the response service methodologies that you use (e.g. are your methods evidence based?) - Optional

16) GBV prevention interventions currently provided

- ☐ National prevention campaigns
- ☐ Awareness raising
- ☐ Community level prevention
- ☐ Household level interventions
- ☐ Mass media campaigns
- ☐ Women's economic empowerment
- ☐ Men and boys focused interventions
- ☐ Education/school based interventions
- ☐ Other

17) Please provide any more information on the prevention methodologies that you use (e.g. are your methods evidence based?) - Optional

18) Number of people reached with GBV prevention interventions (last reporting year) - approximate numbers are fine

19) What GBV-related advocacy activities do you undertake?

- ☐ National campaigns
- ☐ Community awareness campaigns
- ☐ Engaging local leaders
- ☐ Individual advocacy cases
- ☐ Drafting policy briefs
- ☐ Media advocacy (social media, TV, radio, Print)
- ☐ Advocacy training and/or capacity building
- ☐ Building advocacy networks
- ☐ Other - Write in: _____

20) Do you undertake other related work and/or work where GBV is integrated but not a primary focus? If so, please describe

21) Have you had to close down any GBV related initiatives in the past five years? Could you provide details if so? - Optional

Organisation size and capacity

22) Total number of staff members (Full time equivalent)*

23) Number of volunteers - Optional

24) Do you have staffing gaps, and if so, what are they?

☐ No staffing gaps

☐ Front line staff

☐ Technical

☐ Legal

☐ Accounting

☐ Admin

☐ Fundraising

☐ Communication

☐ Do not wish to answer

☐ Do not know

☐ Other - Write In: _____

25) Can you provide any further information about your staffing gaps? (Optional)

26) Does your organization have a strategic plan, and is it regularly reviewed (e.g., every 3-5 years)? (Tick list)

☐ Yes, with regular reviews

☐ Yes, but not regularly reviewed

☐ No, but we are developing one

☐ No strategic plan

☐ Other - Write In: _____

27) How important are the following factors in setting your organisation's strategic priorities and/or choice of activities? (1 = Not important,- 5= Very important, X = irrelevant.

	5: Extremely important	4: Very Important	3: Moderately important	2: Moderately unimportant	1: Unimportant	0: Irrelevant
Alignment with donor priorities	[]	[]	[]	[]	[]	[]
Evidence base	[]	[]	[]	[]	[]	[]
Government planning processes	[]	[]	[]	[]	[]	[]
Alignment with lead partner or consortium objectives	[]	[]	[]	[]	[]	[]

28) To what extent does your organization have expertise in its key programmatic areas? *

- ☐ Significant expertise and established programmes
- ☐ Moderate expertise but growing
- ☐ Limited expertise, with capacity-building needs
- ☐ New organization still defining focus areas

29) Does your organisation produce annual financial statements? (Tick list)*

- ☐ Yes, but with an unqualified audit report
 - ☐ Yes, with an annual independent audit
 - ☐ No, but financial reports are prepared on an ad hoc basis
 - ☐ No
-

Funding

30) What are the primary sources of funding for your organization? (Tick List)

*

- ☐ Multilateral donors
- ☐ Bilateral donors
- ☐ International NGOs
- ☐ Local NGOs
- ☐ Private sector/foundations
- ☐ Individual donations
- ☐ Social enterprise
- ☐ Other - Write In: _____

31) Any other information about your funding situation you would like to share? (e.g. projected funding situation over the next 1-3 years; any former funding sources that are no longer active; any anticipated funding in the pipeline; effects of recent USAID stop work orders) - Optional

32) Estimated annual operating budget - according to your last strategic or operation plan if applicable. - Optional

M & E and Coordination

33) Does your organization have a system for tracking the outcomes and impact of its programs?

- ☐ Yes, but it is informal
- ☐ Yes, we have a well-established system
- ☐ No, but we are developing one
- ☐ No system currently

34) How does your organisation co-ordinate and/or collaborate with government, other organisations in the GBV sector, and/or other sectors? - Optional

35) Do you belong to any umbrella bodies, working groups etc? If so, please list - Optional

36) How could the GBV sector be strengthened in future? What are the priorities for change? - Optional

Final questions

37) Please share any further relevant information about your organisation here if possible – any strategic/action plans, last annual report etc - URLs, notes on where to find documents, commitment to send any further documents - Optional

Thank You!

Focus Group Discussion Guide

Introduction

*For the facilitator	
Date	
Location	
Number of participants:	
Time:	

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The exercise is aimed at mapping and assessing the ecosystem of women's rights organisations (WROs) working to tackle gender-based violence (GBV) in Zimbabwe. This study and accompanying analysis will feed into the design of a possible future business case related to strengthening and supporting the localisation of the GBV sector in Zimbabwe.

You have been selected to participate in this FGD as an organisation (in or related to) the sector. This discussion will take around 1 hour to 1hour 30minutes. We ask that you be as open and honest as possible, the information you give us is useful for our study. Please know that anything you say will not be traced back to you or affect your organisation or funding in any way. Some of the questions have to do with numerical data and others will be more descriptive. If you feel you would like to provide the numerical information later or by email, please let me know.

Do you have any questions about what I just explained? Would you like to take part in this survey? *If "yes", I am going to hand out consent forms which I kindly ask that you sign. I am also going to hand out an information sheet about your organisation which I ask that you fill in.*

WRO ecosystem working on GBV

1. How would you describe GBV Response and Prevention in Zimbabwe? Which one are you involved in and how are your activities coordinated?
2. What would you say are the strengths and weaknesses in GBV Response, and Prevention?
3. On average how many women and men access your services quarterly or yearly? *(take note some might need to consult their documents or office for numbers)*
4. Do you have a specific group of focus that you offer services to? (probe: general population, children, PWDs, rural women, elderly women, etc.)

Structure and gaps of the sectors

5. How would you describe your staff capacity (human resources), are they adequate? (Probe: Open positions, staff cuts, job share, hours cut, hybrid (multiple) roles)
6. To what extent is your donor involved in objectives setting for your organisation?
7. How has the sector traditionally been funded? Does this differ for different sized organisations?
8. What are your sources of funding and how stable these sources have been? (Probe: changes in funding trends over the last 5-10 years)
9. What approaches and methodologies does your organisation use? (Probe: evidence-base/tested/innovative approaches?)

Recommendations and future considerations for strengthening the ecosystem of WROs working on GBV.

10. In your opinion how best can WROs work together to better share learning and best practices? (Probe: Strategies and processes)
11. How can organizations better stabilise and diversify funding sources?
12. How can non-traditional donors increasingly be engaged in GBV prevention and response work?

Interviewer observations/notes

----- Thank you and wrap up -----
