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Exploring the impact of COVID-19 hard lockdown on service provision for survivors of violence against women in South Africa: a qualitative study

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ABSTRACT

Objective To explore the impact of South Africa's COVID-19 hard lockdown on the provision of services to survivors of violence against women (VAW).

Design We conducted a qualitative study using semistructured interviews. Data was analysed thematically. We conducted 18 semistructured interviews (10 face-to-face and 8 online or by phone) with service providers and key informants (KIs).

Setting The study was conducted across healthcare facilities, social services, national helplines and shelters in Gauteng province, South Africa. Data was collected between September 2022 and October 2023.

Participants The sample included 18 participants, purposively selected, comprising 13 frontline service providers (nurses, social workers and managers) and 5 KIs. Participants shared their experiences of delivering VAW services during the lockdown.

Results The findings highlight five key themes affecting VAW service provision during COVID-19. (1) Confusion and uncertainty: initial uncertainty about whether VAW services were essential led to temporary closures and reduced availability. (2) Decreased demand for services: fear of mobility restrictions and reporting barriers reduced access, particularly in the first lockdown month. (3) Adaptations by providers: services shifted to remote counselling, while shelters paused new intakes. (4) Challenges in service provision: staff shortages, resource constraints (eg, personal protective equipment shortages) and disrupted referral systems hindered service delivery. (5) Emotional impact on frontline workers: health and helpline workers faced stress, fear of infection, social stigma and burnout, affecting their well-being and capacity to respond effectively.

Conclusions The study highlights how South Africa's COVID-19 hard lockdown disrupted essential VAW services, emphasising the need for resilient service delivery models during crises. Strengthening staffing, resources and improving referral pathways are critical for mitigating the emotional and operational challenges faced by service providers and for ensuring sustained support for survivors.

STRENGTHS AND LIMITATIONS OF THIS STUDY

⇒ This qualitative study allowed for the collection of participants' perceptions and experiences of the impact of COVID-19 lockdown on service provision for survivors of violence against women (VAW), contributing to a deeper understanding of this phenomenon.
⇒ This study advances the literature in understanding the barriers and facilitators frontline providers in VAW services (including shelters and social workers) face in offering care for VAW during crises.
⇒ This study's findings may have limited generalisability due to the small sample size, mostly from Gauteng, which may not reflect the experiences of service providers in other provinces or sectors during the lockdown.
⇒ Recall bias might have been a limitation in our study, as participants were asked to share retrospective accounts of perceived impact of COVID-19 on service provision.

INTRODUCTION

Violence against women (VAW) is a global public health problem with 30% of women worldwide having experienced physical and/or sexual violence in their lives, mostly by an intimate partner.[1] Women who experience violence are more likely to suffer from physical injuries, poor mental health (eg, depression) and other sexual and reproductive health problems, including sexually transmitted infections like HIV, unplanned pregnancy and abortion and gynaecological conditions.[2] These health impacts, combined with the social and economic damage they cause at individual, family and community levels, make a healthcare and psychosocial response to VAW a global priority.

In March 2020, COVID-19 was declared a global pandemic, leading to increased VAW as many countries implemented lockdowns and social distancing to curb the virus' spread.[3] This outbreak period not only saw an increase in VAW—particularly intimate partner violence (IPV),[4] but also exacerbated existing societal and economic pressures, along with gender inequalities,[3 5] which are all known risk factors for

VAW. Studies from Australia and Africa also indicated reduced demand for VAW services due to mobility restrictions, fear of stigma and infection, and limited access to health and psychosocial support for VAW survivors.[6–9] Moreover, essential services for women, including those addressing VAW, were disrupted or closed, mirroring the challenges faced during previous public health emergencies and leaving women and girls with few options for assistance.[3 10 11]

In South Africa, a state of emergency was declared, initiating a hard lockdown from 27 March 2020 to 31 May 2020, which included stay-at-home orders and travel bans.[12] VAW services were not initially prioritised until President Cyril Ramaphosa announced their operational status on 13 April 2020.[13] As lockdown measures eased in June,[14 15] varying restrictions were reintroduced due to new COVID-19 variants.[16]

Despite South Africa's high prevalence of VAW at 24%,[17] the national response—through police, social services and healthcare systems—has often been inadequate and lacking prioritisation.[18] Shelters and non-governmental organisations (NGOs) provide psychosocial support, ensuring access to healthcare and legal services, such as protection orders. They also assist with employment, childcare and school relocation.[19] Survivors of partner violence, rape and sexual assault can access medical treatment at VAW crisis centres or Thuthuzela Care Centres (TCCs)—multidisciplinary one-stop centres for survivors of violence, often located in public hospitals.[20]

During the lockdown, VAW reports to the police and national helpline surged. By 5 April 2020, there had been 2230 reports of gender-based violence (GBV),[21 22] though the true extent of IPV during this period remains unclear. Development partners and intergovernmental organisations reported a decrease in survivors seeking health and psychosocial services for VAW,[23] indicating serious barriers to access and widening the gap between service demand and availability. The South African Interim Steering Committee on Gender-Based Violence and Femicide succeeded in obtaining essential service status for VAW response services for non-governmental and community-based organisations in the country; however, this response was delayed and not done in the early days of the lockdown.[7]

Previous experience with major disease outbreaks like Ebola and Middle East Respiratory Syndrome (MERS) indicates that frontline service providers face increased pressure to deliver health and psychosocial care to women and girls experiencing violence.[24–26] These providers had to adapt their service delivery to observe lockdown restrictions.[27] However, research on the impact of COVID-19 and strict lockdown measures on VAW service provision is scarce,[28 29] with the majority of research documenting trends in violence during the pandemic.[3] Consequently, little is known about the challenges experienced by VAW service providers and the adjustments they made to respond to the needs of survivors.

This article aims to explore the impact of COVID-19 hard lockdown on VAW service provision in Gauteng, South Africa.

METHODS

Study design

Between September 2022 and October 2023, we conducted a qualitative study to: (1) assess the nature and extent of service provision for VAW survivors and (2) explore barriers and facilitators to VAW service provision and adjustments made to ensure continued VAW services during COVID-19 hard lockdown periods. We followed a phenomenology approach to understand how service providers and key informants (KIs) experienced or made meaning of VAW service provision during COVID-19 hard lockdown.

Study setting

Gauteng is a densely populated province of South Africa, with highly burdened unemployment, poverty, crime, overcrowding and rapid urbanisation and migration. Provincial estimates indicate high levels of IPV exposure and non-partner sexual violence among women. 51.3% of women had experienced psychological, economic, physical or sexual violence in their lifetime, with the majority from intimate partners.[30] Gauteng hosts a number of specialised VAW services, including TCCs, helplines such as the GBV Command Centre, and shelters and other NGOs.[31]

Participants' sampling and recruitment

We purposively selected 18 participants: 13 frontline service providers and 5 KIs offering specialised VAW care and support in Gauteng. We interviewed six health workers and one social worker from TCC and VAW crisis centres; and three social workers from a national GBV helpline. From shelters, two were managers and a matron. Five KIs with expertise and knowledge of the VAW response management of NGOs and shelters in Gauteng were also involved. The inclusion criteria included health workers, service providers and KIs who had been operating in their designated work areas during the COVID-19 lockdown and who received approval from their departmental head and facility managers to participate in the study. Despite the varied roles of frontline service providers and KIs (see table 1 below), all participants were affected by similar external stressors, such as changes in service provision, resource constraints and health risks. The findings thus capture a common experience of adaptation and resilience in the face of a global crisis, which underpins the validity of our findings.

Data collection

NJS, an experienced VAW researcher, conducted 18 semi-structured interviews (10 face-to-face and 8 online or by phone) with service providers and KIs between September 2022 and October 2023. Participants discussed their

Table 1 Participants' information

Participant ID	Role/function
Frontline service providers	
Participant 1	Matron, shelter
Participant 2	Manager, shelter
Participant 3	Manager, shelter
Participant 4	Health worker (TCC/VAW Crisis Centre)
Participant 5	Health worker (TCC/VAW Crisis Centre)
Participant 6	Health worker (TCC/VAW Crisis Centre)
Participant 7	Health worker (TCC/VAW Crisis Centre)
Participant 8	Health worker (TCC/VAW Crisis Centre)
Participant 9	Health worker (TCC/VAW Crisis Centre)
Participant 10	Social worker (TCC/VAW Crisis Centre)
Participant 11	Social worker (National GBV helpline)
Participant 12	Social worker (National GBV helpline)
Participant 13	Social worker (National GBV helpline)
Key informants	
Participant 14	Key informant—shelter
Participant 15	Key informant—NGO
Participant 16	Key informant—NGO
Participant 17	Key informant—shelter
Participant 18	Key informant—shelter

GBV, gender-based violence; NGO, non-governmental organisation; TCC, Thuthuzela Care Centre; VAW, violence against women.

experiences with service provision, challenges faced, adjustments made and barriers to women's help-seeking during lockdown. KIs also addressed policies related to VAW services during this period. Efforts were made to establish rapport with participants, even during telephone interviews, to foster trust and open communication. Data collection ceased when saturation was reached, ensuring the sample adequately captured the diversity of experiences related to VAW service provision during lockdown, and there were no new insights coming from the interviews. Interviews, lasting 30–45 min, were conducted using an interview guide (see online supplemental material 1) and transcribed and translated into English as needed. Data was anonymised, stored in password-protected files and made accessible to the authors.

Data analysis

Transcripts were analysed thematically following an inductive approach[32] by the three authors who familiarised themselves with the data, created broad codes (through a jointly developed code frame) and searched for themes within those. To enhance the credibility of the findings, the analysis process included regular online debriefing sessions where the research team reviewed and discussed emerging themes to ensure they were grounded in the data. The authors engaged in remote group analysis sessions to discuss recurring patterns in the data, reached consensus on the emerging code frame and charted summary information into an Excel matrix. A clear audit trail was maintained throughout the coding and theme development process, allowing for transparency and traceability of analytical decisions. Independent coding was conducted on a subset of transcripts to enhance reliability, with discrepancies resolved through team discussion during online analysis sessions. The analysis initially followed a deductive approach, guided by preidentified research questions, before transitioning to an inductive approach to generate themes based on participants' experiences. These themes captured insights into service provision for VAW during the COVID-19 lockdown restrictions, including adjustments made and challenges and opportunities encountered. Reporting was conducted in accordance with the Standards for Reporting Qualitative Research (Consolidated criteria for Reporting Qualitative research checklist—online supplemental material 2).

Ethics

The study adhered to WHO guidelines for VAW research.[33] Informed consent was obtained from all participants, with privacy and confidentiality assured. Information about referrals for psychosocial support and other services was available and provided as needed.

Patient and public involvement

None.

RESULTS

The findings (summarised in figure 1) are organised around five key emerging themes: (1) confusion and uncertainty around service provision; (2) decrease in demand for VAW services; (3) changes and adaptations to VAW service provision; (4) challenges to service delivery; (5) impact of COVID on health providers.

Confusion and uncertainty around service provision

At the beginning of the pandemic, health services and shelters were the main support systems for VAW survivors. Health services remained open and continued to offer VAW-related services during the day, while also being at the forefront of COVID-19 testing and care. Post-rape and other VAW services remained operational. However, during the hard lockdown, the readiness to respond to VAW survivors and the related demands for services proved challenging. Social workers were no longer able to provide face-to-face counselling for follow-up cases. Shelters could not accommodate new women due to lockdown restrictions and the lack of personal protective equipment (PPE). Additionally, all outreach programmes organised by health services and shelters were halted, including in-person follow-up by field social workers working with the national GBV helpline. Despite these challenges, the helpline continued its telephonic services and linkages to police throughout the lockdown.

Finding	Description
Confusion and uncertainty	Initial uncertainty about the essentiality of VAW services led to temporary closures and reduced availability.
Decrease in demand for services	Fear of mobility restrictions and reporting decreased access to VAW services during the first month of lockdown.
Adaptations by service providers	Service providers shifted to telephone counselling and online services, while shelters temporarily halted new intakes.
Challenges in service provision	Staffing shortages (e.g. due to staff relocation to Covid screening; alternate schedule), resource constraints (e.g., lack of PPE), and disrupted referral systems were significant challenges.
Emotional impact on frontline workers	Health and helpline workers experienced significant emotional stress, including fear of infection, social stigma, and burnout.

Figure 1 Summary of challenges and adaptations in VAW service provision during the COVID-19 lockdown, including initial uncertainty, decreased service demand, provider adaptations, operational challenges and the emotional toll on frontline workers. PPE, personal protective equipment; VAW, violence against women.

In the first month of lockdown, confusion over permit requirements and mobility restrictions led to service closures or reductions among NGOs and shelters. A lack of guidance from the Department of Social Development (DSD) contributed to uncertainty about whether VAW services were classified as essential. This confusion affected psychosocial support for new and existing survivors, with some walk-in NGO services closing their doors and shelters halting new intakes.

> There was a lot of confusion during the first three weeks of the lockdown… lack of understanding of what is going on. (Participant 14)

> That was, for us, a period that was characterised by very little information, confusion, fear, and poor communication, particularly from government, and we were not even sure whether we were supposed to be one of those services that were essential for quite a while. So early on, we just closed like everybody else…. (Participant 18)

However, NGO-managed shelters co-operated and helped each other accommodate new women when possible.

> The other shelters shared with us – as I said some shelters couldn't not have new intake and others were referring to us so other shelters stepped in with what they had available. (Participant 1)

Decrease in demand for VAW services

During the first month of lockdown, mobility restrictions, fear of arrest and under-reporting led to a decline in VAW cases at health services, with most cases brought in by the police.

> People were restricted […] scared of being arrested or that the police wouldn't believe them they were going to the hospital for help. (Participant 10)

> It [lockdown] did [impact the services] because the very first month we didn't see a lot of cases. […] GBV cases were slow [in coming in]. (Participant 6)

Respondents highlighted a shift in the nature of assaults, with non-partner sexual VAW mostly occurring during commutes for essential work, and domestic violence becoming more prevalent within confined spaces. Instances of statutory rape, particularly among teenagers, were also noted, along with reports of emotional and financial abuse linked to financial disputes.

> During Covid19, I don't know what was going on, there were a few women who reported GBV but then according to the stats, those that were coming as rape cases were those who were going to work during Covid. (Participant 6)

> Cases [of VAW] dropped because no one was moving around… incidents happened indoors. (Participant 4)

Sexual violence against children, often committed by family members, was common but under-reported due to fear, coercion and family cover-ups.

> [Sexual violence] with children happened inside the houses… often by uncles in the same family. (Participant 6)

> Some cases involved a child, but the family tried to keep it under the carpet. (Participant 11)

Although direct reporting of violence to health providers was low or delayed (until after the lockdown),

NGOs and helplines received grievances via phone and social media, indicating women were experiencing violence but were unable to seek help.

> Estimate that during lockdown 50 to 60% of cases weren't reported. Women were complaining on NGO websites. (Participant 6)

Restricted movement, fear of stigma and a belief that incidents could be resolved privately further hindered VAW reporting. Some respondents said that women felt it was impossible to seek help while being trapped at home with their abusers.

> Many feared reporting rape… partners would beat them but they couldn't go out to report it. (Participant 9)
>
> Many cases were resolved by themselves… because they happened indoors. (Participant 4)

One NGO manager pointed out the impossibility of seeking help while locked down with perpetrators, criticising the lack of understanding from authorities.

> Our government doesn't understand what GBV looks like in this country because… you have now locked us in our homes with our perpetrators, with nowhere to go. Our support systems are not available to us because we can't leave our homes and you are expecting me as a poor woman who's living in a very small house or shack or whatever to pick up the phone and phone you while my perpetrator is right there. (Participant 15)

On the other hand, shelters and the national helpline reported an increase in cases, with calls (to the helpline) from women seeking to escape their abusive partners doubling or tripling during the lockdown.

> During COVID, we saw a spiralling number, a high influx of calls and for the first time in the history of the centre, we've received in a day about 1000 or 1500 calls. […] And much of these cases you find that they are domestic violence cases. (Participant 12)

Changes and adaptations to VAW services during COVID lockdown

Health services

The onset of the COVID-19 pandemic led to significant changes to VAW services to accommodate public health measures and ensure safety. Initially, staff were redeployed to focus on COVID-19 testing and screening, leaving reduced personnel for VAW services, which saw a drop in cases.

> Our centres were quiet […] we need more soldiers out there now to be screening for COVID… So it was sort of like a contingency plan. (Participant 8)
>
> So at that point [1 month of lockdown], actually the centres were very quiet and we had to go and work on the highway to screen people. (Participant 7)

Staff reductions occurred in various clinics due to low case volumes, physical distancing requirements and alternating schedules (eg, working hours were reduced to 3 days a week unless emergencies, like child rape cases, arose). Access procedures were updated to include temperature checks, masks and distancing, though these measures made service access slower and may have deterred some from seeking help.

> Everyone that came in, they had to spray (sanitizer). We had to do the thermometer and everything… before they were coming inside. (Participant 7)

Medical care for VAW survivors, including postexposure prophylaxis and emergency contraception, continued, but counselling services faced delays. Face-to-face sessions were paused until June 2020, replaced by telephone counselling, which presented challenges in interpreting emotions without visual cues.

> Some patients had to use telephone counselling so I will call them and provide counselling telephonically. (Participant 10)

Awareness campaigns were also halted, with staff instead engaging with clients directly before service entry. The redeployment of nurses to COVID screening, social workers not working during the first 3 weeks of lockdown and the initial halt in NGO partnerships disrupted follow-up counselling. However, by May 2020, the Department of Health social workers developed informal support networks to reach clients remotely, compensating for the continued lockdown restrictions.

> But in [hard lockdown], everyone had no plans. We only started to come up with plans around May 2020 […], we needed to reach out to the people. So we had to come up with such strategies when we had to utilise telephone counselling. (Participant 10)

Shelters and NGO services

Shelters reached full capacity and temporarily closed during the hard lockdown to limit the spread of the virus and manage fears of infection, which led to a shortage of safe accommodation spaces for VAW survivors.

> There was an increase in numbers (of women needing accommodation), but we couldn't take anyone at the time because of this virus. We had said - just to safeguard our home and our kids, we're not gonna take new people. So we didn't take anyone new. (Participant 1)

Respondents from NGOs and shelters noted that psychosocial services for VAW were largely unavailable during the hard lockdown, with little counselling offered by either government or NGOs due to fear of contracting COVID-19 through in-person services.

> … During the very initial part of lockdown, we didn't really offer any one-to-one services because there

was a great fear of what is this virus all about and are we safe? So, there was quite a lot of and ignorance around and fear greatly. (Participant 16)

National helpline

Despite a surge in calls, the national helpline struggled to adjust its services during the hard lockdown. Some support from management included debriefing sessions for emotional support and transportation assistance for staff, but the workforce remained insufficient, and the effectiveness of these measures varied across branches.

> Social work interns were brought in at some point. But I think it was still not enough because on a normal day you'd find that you deal or rather you are handling, let's say about 50 calls. (Participant 12)

Counselling was unavailable as field social workers in the referral pathway were not conducting visits during the lockdown.

Challenges around service provision

The COVID-19 pandemic intensified the difficulties service providers faced in delivering VAW care, creating significant obstacles related to resources and infrastructure.

Infrastructure and resource strains

Staffing shortages were a critical challenge due to the redeployment of personnel and staff contracting COVID-19. This shortage compromised care quality and burdened remaining staff. Communication breakdowns, such as prolonged telephone line suspensions, disrupted follow-up appointments and forced reliance on less accessible methods like text messaging.

Shelters reached full capacity, while the national helpline was overwhelmed with calls, straining resources and delaying assistance. Shelters also lacked PPE, and staff reductions impacted the limited on-site counselling services.

> People forget that there were already women in shelters…[…] shelters were already full, and they could not take any more women. (Participant 14)

> Had no capacity to support women [remotely] as needed. Not really because it was so difficult cause my whole being was gathered just trying to survive trying to help someone who was sick. (Participant 18)

Instead of providing traditional services, shelter staff found themselves taking on additional responsibilities, such as distributing food parcels, teaching children and handling daily tasks previously outsourced.

> We had to adjust our programs to keep the routine for our toddlers. We did the lesson plan for the kids at the shelter. We implemented a mini library […] We had to come up with a simple program for the ladies. […] we had to deal with conflict because there was an increase in conflict because of the different personalities. (Participant 2)

Funding was scarce until the Solidarity Fund launched, prompting shelters to pursue income-generating activities, such as mask-making.

Referral system challenges

The COVID-19 lockdown strained referral systems for VAW support. Temporary police station closures disrupted the referral process, while cleaning protocols delayed access to justice and essential services, increasing survivors' distress.

Shelters enforced strict admission criteria, only accepting new cases with police involvement, creating barriers for helpline staff attempting to assist vulnerable individuals. Many contacts with women were related to housing needs, as individuals had nowhere to live, and DSD's alternative housing facilities were often inaccessible or delayed, contributing to a sense of helplessness and frustration among its staff.

> Shelters were full. We have a limited number of shelters and as a centre we are not in power to order the shelters to accept clients that we were referring to them. It is a pain and a disappointment. (Participant 11)

Impact of COVID-19 on service providers

The emotional impact of COVID-19 on frontline health and helpline workers was profound, driven by pervasive fear of contracting the virus and the risk of severe illness or death. Workers described the overwhelming fear and uncertainty they faced, which heightened as they continued to work, while most organisations shifted to virtual platforms.

> Covid disturbed our lives big time, especially when you hear of someone passed away somewhere […]. I was living in fear. (Participant 9)

> It was a very emotional and very difficult time because we found ourselves coming to work… Well, most organisations closed and said no, no, no, let there be virtual platforms. With us, we had to be physically [there]…because we're considered frontline workers, our services were needed 24/7. (Participant 12)

This anxiety extended to concerns about transmitting the virus to family members, amplifying frontline workers' feelings of guilt and responsibility. Social stigma from their communities added to their distress, with some healthcare providers wrongly accused of spreading the virus, prompting them to hide their COVID-19 diagnoses.

> They would say one of the nurses tested positive for covid and stuff, but then there was no name mentioned, but you would feel the pinch [of stigma]. (Participant 7)

Support for emotional well-being was lacking, with staff feeling unsupported by the government. The absence of prioritised counselling services amid rising fatalities

took a toll on staff morale and resilience, leading to widespread COVID-19 fatigue.

> They [government telephone line set up for staff] couldn't do anything, they only asked you how you feel you would tell them how you feel that's it, they will tell you do you have signs and symptoms and what is you fear that's it . […]. no, it was not helpful. (Participant 7)

Helpline staff managed increasing caseloads, witnessing the devastating effects of the pandemic on survivors, which compounded their own personal and emotional challenges. The strain of balancing professional responsibilities with personal hardships limited their capacity to go above and beyond for survivors in need.

> I am from another [Name of the province], so my family is there, my kids are there and I couldn't (travel). The fact that I couldn't travel, it put so much strain on me emotionally. And imagine, with all these challenges and just still expected to sit down and provide counselling to the people who critically need it. It was a very difficult moment. The fear, the panic and the anxiousness. (Participant 12)

Many providers expressed frustration over the inability to conduct home visits and felt powerless against systemic barriers and resource constraints. Despite their dedication to supporting survivors, helpline workers faced heightened workloads, often cutting breaks to remain available for incoming calls, leaving little room for self-care.

Some reported feelings of exhaustion and heavy hearts as they dealt with continuous calls, including distressing cases of child rape. This demanding environment made it difficult for them to maintain their own mental health while striving to support survivors.

> How are you going to offer assistance to someone else when you are miserable yourself? You are not functioning. (Participant 13)

> It was so challenging and straining, and emotional because after just disconnecting on the first call, there's going to be immediately another call that has to do with GBV or domestic violence. So we had to prepare ourselves emotionally…Sometimes they [victims] are crying and you have to find a way to immediately attend to the emotional feelings… and some they'll tell you: 'I'm at a point where I cannot take it anymore and I just want to end it'. […] You go home, it is with heavy hearts. I'm to go to work the following day, it just doesn't end, they keep coming in. (Participant 12)

DISCUSSION

The findings of this study have revealed five critical issues: confusion and uncertainties around VAW service provision, a decrease in demand for VAW services, changes and adaptations made to service delivery, challenges to service provision and the impact on health providers. Our findings show how the COVID-19 lockdown significantly impacted the availability and accessibility of VAW services, further affected by government inability to clarify rules for essential services and deprioritisation of VAW response. The early stages of the pandemic were marked by significant confusion and uncertainties about VAW service provision. The lack of clear communication and guidance from the government contributed to inaction, where NGO service providers were unsure of their operational status as essential services, which led to the temporary closure or reduction of services. This uncertainty hampered their ability to provide critical psychosocial support to VAW survivors. Confusion around service permits and mobility restrictions for NGOs, and lack of guidance from government shows deprioritisation of VAW within the national COVID response at high level, which is also discussed elsewhere.[7] This highlights the need for clear, timely communication and guidance from governmental bodies during crises to ensure continuity and accessibility of essential services.

Globally, the initial lockdown period saw a noticeable decrease in the demand for VAW services primarily due to restricted mobility and under-reporting. Police and health services recorded minimal cases of VAW, with many women unable to leave their homes or fearing stigma and legal repercussions.[34] This decline in accessing services—also reported in our study—was not indicative of a decrease in violence, but rather of the barriers women faced in seeking help due to the closed economic activity, stay-at-home orders, fear of virus exposure and NGO services being constrained.[34–36] Our findings, though, indicate a significant increase in VAW calls to the national helpline, indicating that violence was still occurring, but was not being formally reported in health services. Since the COVID-19 pandemic, initial commentaries and a few studies in low- and middle-income countries have noted an increase in VAW and disruptions to services.[5 7 28 37–39] While our study explores how the government's COVID-19 responses specifically affected VAW service provision, further research is warranted on how health and support services can be more accessible and responsive to service utilisation changes and the needs of VAW survivors, even when physical mobility is restricted.

The pandemic forced significant changes and adaptations in the delivery of VAW services. Health services altered the usual service delivery model, with reduced staff and telephone counselling replacing face-to-face sessions. Shelters and NGOs also had to adapt, initially closing their doors to new cases to prevent infections. However, the halt in awareness campaigns and the lack of on-site counselling services during the hard lockdown period significantly impacted service provision and uptake, as also reported in other studies.[7] In South Africa, adaptations were ad hoc and changes/strategies were implemented by individual providers showing resilience and motivation to support VAW survivors. This underscores the need for flexible and innovative service delivery models that can sustain support for VAW survivors during and after crises.

Systematic reviews on factors influencing VAW responsiveness during COVID-19 highlight the critical role of health systems in preventing and addressing VAW. They also emphasise the need for stronger collaboration across sectors (health, social services, police, NGOs)[40] and with community health actors.[41]

Unlike other African countries, where toll-free helplines for reporting VAW were not operating during COVID-19,[42] the National South African Helpline remained available, serving as a crucial support system for many women. It is therefore essential to ensure that such services and their staff receive adequate support during emergencies.

Our findings underscore the significance of adequate resource allocation and contingency planning. While these adaptations ensured some level of continued support, they posed challenges in effectively interpreting and responding to women's needs. Service providers faced numerous challenges during the pandemic, primarily related to staff resource constraints and infrastructural issues, and shelters and helpline workers feeling overwhelmed. Social workers at the TCC/VAW Crisis centres, who were already accustomed to counselling women over the phone, felt a deep frustration due to their inability to fully grasp the facial cues indicating how desperate the callers were. Staff at the GBV national helpline realised that the women were in extremely dire situations, which heightened their own frustration.

Referral systems were also disrupted, with temporary closures of police stations and stringent shelter admission criteria complicating the process of seeking justice and support for survivors. It was not the first time a shelter was full and staff could not make referrals, but the COVID-19 situation became more desperate due to the increasing number of people needing placement. These challenges reveal the fragility of existing support systems and underscore the urgent need for robust, resilient frameworks capable of sustaining operations during emergencies.

The COVID-19 pandemic added to the pressure frontline health staff and helpline social workers were under. Our results have highlighted the critical need for a comprehensive support system for healthcare providers, social workers and all critical personnel involved in VAW service provision, including mental health services and adequate protective measures, to sustain their well-being and capacity to deliver essential services. Frontline health and social workers faced a profound emotional impact of COVID-19, also reflected in other studies in sub-Saharan Africa,[10 43] with constant fear of contracting the virus, concerns about transmitting it to family members, emotional distress and social stigma. The lack of adequate mental health support for healthcare and helpline workers further exacerbated their stress and burnout. This highlights the need for prioritisation of interventions that promote mental wellness of frontline workers during and after outbreaks.

This study has several limitations that should be considered when interpreting the findings. The analysis is based on a limited sample of frontline service providers and KIs from Gauteng, which may not be generalisable to all services in the province or beyond. Additionally, some data were collected via telephone interviews, which posed methodological challenges, including reduced ability to establish rapport and connection with participants over the telephone.[44] Furthermore, while recall bias is an inherent limitation in retrospective accounts, the detailed nature of participants' reflections and their direct involvement in service delivery during the lockdown strengthens the credibility of the findings, offering valuable insights into the challenges faced by providers.

CONCLUSION

The COVID-19 pandemic has exposed and exacerbated existing vulnerabilities in VAW service provision. The findings of this study have significant implications for policy and practice in addressing VAW during crises like the COVID-19 pandemic. Moving forward, it is imperative to establish clearer communication channels, ensure resource availability and develop resilient service delivery models that can withstand the pressures of a global crisis, ensuring continuous support for VAW survivors and the well-being of service providers.

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REFERENCES

1 World Health Organization. Violence against women prevalence estimates, 2018. Geneva World Health Organization; 2021.
2 World Health Organization, London School of Hygiene and Tropical Medicine, and South African Medical Research Council. Global and regional estimates of violence against women: prevalence and health impacts of intimate partner violence and non-partner sexual violence. World Health Organization Geneva; 2013.
3 Peterman A, Potts A, O'Donnell M, *et al*. Pandemics and violence against women and children. CGD working paper 528. Washington, DC Center for Global Development; 2020.
4 Kifle ME, Aychiluhm SB, Anbesu EW. Global prevalence of intimate partner violence during the COVID-19 pandemic among women: systematic review and meta-analysis. *BMC Womens Health* 2024;24:127.
5 Roesch E, Amin A, Gupta J, *et al*. Violence against women during covid-19 pandemic restrictions. *BMJ* 2020;369:m1712.
6 Pfitzner N, Fitz-Gibbon K, McGowan J, *et al*. When home becomes the workplace: family violence, practitioner wellbeing and remote service delivery during covid-19 restrictions. Victoria, Australia Monash Gender and Family Violence Prevention Centre, Monash University; 2020.
7 John NA, Bukuluki P, Casey SE, *et al*. Government responses to COVID-19 and impact on GBV services and programmes: comparative analysis of the situation in South Africa, Kenya, Uganda, and Nigeria. *Sex Reprod Health Matters* 2023;31:2168399.
8 Sapire R, Ostrowski J, Maier M, *et al*. COVID-19 and gender-based violence service provision in the United States. *PLoS One* 2022;17:e0263970.
9 Kaswa R. The impact of the COVID-19 pandemic on healthcare service access for the victims of sexual assault. *S Afr Fam Pract (2004)* 2004;63:e1–4.
10 John N, Casey SE, Carino G, *et al*. Lessons Never Learned: Crisis and gender-based violence. *Dev World Bioeth* 2020;20:65–8.
11 Bakraniaa S, Chavez C, Ipince A, *et al*. Impacts of pandemics and epidemics on child protection. lessons learned from a rapid review in the context of covid-19. In: *Innocenti Working Paper 2020-05*. 2020.
12 Republic of South Africa. Government Gazette Staatskoerant. Pretoria, South Africa Government Printers; 2020.1–16.
13 Republic of South Africa. From the desk of the president. 2020.
14 Wills G, Patel L, van der Berg S, *et al*. Household resource flows and food poverty during South Africa's lockdown: short-term policy implications for three channels of social protection. Working Paper Series NIDS-CRAM Wave 1; 2020.
15 Kollamparambil U, Oyenubi A. Behavioural response to the Covid-19 pandemic in South Africa. *PLoS One* 2021;16:e0250269.
16 Staff Writer. What's next for covid-19 and lockdowns in South Africa. Pretoria Business Tech; 2021.
17 National Department of Health and ICF. South Africa demographic and health survey 2016. National Department of Health - NDoH - ICF Pretoria; 2019.
18 Sibanda-Moyo N, Khonje E, Brobbey MK. Violence against women in South Africa. A country in crisis. South Africa; 2017.
19 Lopes C. Intimate partner violence: A helpful guide to legal and psychosocial support services. *S Afr Med J* 2016;106:966.
20 Bougard NB, Booyens K. Adult female rape victims' views about the Thuthuzela Care Centres: a South African multi-disciplinary service delivery model. *Acta Criminologica: African Journal of Criminology & Victimology* 2015;2015:19–33.
21 eNCA. Decrease in serious crimes due to unavailability of alcohol: Cele. 2020. Available: https://www.enca.com/news/decrease-serious-crimes-due-unavailability-alcohol-cele
22 Africa Check. South African police record 2,300 gender-based violence complaints in first week of lockdown –not 87,000. 2020.
23 UN Trust Fund. In focus: ending violence against women in the context of covid-19 UN trust fund to end violence against women: dialogue on impact of covid-19. 2020. Available: https://untf.unwomen.org/en/news-and-events/in-focus-covid-19#U7
24 McKay G, Black B, Janvarin A, *et al*. Sexual and reproductive health ebola response: a neglected priority. Humanitarian Exchange; 2020.30–2.
25 Onyango MA, *et al*. Gender-based violence among adolescent girls and young women: a neglected consequence of the west African Ebola outbreak. In: Schwartz D, Anoko J, Abramowitz S, eds. *Pregnant in the Time of Ebola*. Cham: Springer, 2019: 121–32.
26 Viero A, Barbara G, Montisci M, *et al*. Violence against women in the Covid-19 pandemic: A review of the literature and a call for shared strategies to tackle health and social emergencies. *Forensic Sci Int* 2021;319:110650.
27 Dlamini NJ. Gender-Based Violence, Twin Pandemic to COVID-19. *Crit Sociol (Eugene)* 2021;47:583–90.
28 Slakoff DC, Aujla W, PenzeyMoog E. The Role of Service Providers, Technology, and Mass Media When Home Isn't Safe for Intimate Partner Violence Victims: Best Practices and Recommendations in the Era of COVID-19 and Beyond. *Arch Sex Behav* 2020;49:2779–88.
29 Trudell AL, Whitmore E. Pandemic meets pandemic: understanding the impacts of covid-19 on gender-based violence services and survivors in Canada. Ottawa & London, ON; 2020.
30 Machisa M, Jewkes R, Lowe Morna C, *et al*. The war at home: gender based violence indicators project. Johannesburg, South Africa Gauteng Research Report; 2011.
31 Women Voice and Leadership Fund in South Africa. Mapping of women's rights organisations in South Africa. Johannesburg; 2019.
32 Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol* 2006;3:77–101.
33 World Health Organisation. Ethical and safety recommendations for intervention research on violence against women. Building on lesson from the WHO publication putting women first: ethical and safety recommendation for research on violence against women. Geneva, Switzerland World Health Organisation; 2016.
34 Kourti A, Stavridou A, Panagouli E, *et al*. Domestic Violence During the COVID-19 Pandemic: A Systematic Review. *Trauma Violence Abuse* 2023;24:719–45.
35 Boserup B, McKenney M, Elkbuli A. Alarming trends in US domestic violence during the COVID-19 pandemic. *Am J Emerg Med* 2020;38:2753–5.
36 Shai N, Mahlangu P, Colombini M. A qualitative exploration of women's help-seeking pathways/behaviour during covid-19 lockdown in South Africa. Forthcoming.
37 Evans DP. COVID-19 and violence: a research call to action. *BMC Womens Health* 2020;20:249.
38 Johnson K, Green L, Volpellier M, *et al*. The impact of COVID-19 on services for people affected by sexual and gender-based violence. *Int J Gynaecol Obstet* 2020;150:285–7.
39 Martins-Filho PR, Damascena NP, Lage RC, *et al*. Decrease in child abuse notifications during COVID-19 outbreak: A reason for worry or celebration? *J Paediatr Child Health* 2020;56:1980–1.
40 Sánchez OR, Vale DB, Rodrigues L, *et al*. Violence against women during the COVID-19 pandemic: An integrative review. *Int J Gynaecol Obstet* 2020;151:180–7.
41 Chavula MP, Matenga TFL, Halwiindi H, *et al*. Factors shaping responsiveness towards sexual gender-based violence during the COVID-19 Pandemic in Africa: A systematic review. *Cogent Public Health* 2023;10:2234600.
42 Rockowitz S, Stevens LM, Rockey JC, *et al*. Patterns of sexual violence against adults and children during the COVID-19 pandemic in Kenya: a prospective cross-sectional study. *BMJ Open* 2021;11:e048636.
43 Mahlangu P, Sikweyiya Y, Gibbs A, *et al*. "I Carry the Trauma and Can Vividly Remember": Mental Health Impacts of the COVID-19 Pandemic on Frontline Health Care Workers in South Africa. *Int J Environ Res Public Health* 2023;20:2365.
44 Freitas-Jesus JV, Sánchez ODR, Surita FG. The Remote Approach in a Qualitative Study During the COVID-19 Pandemic: A Perspective Considering the Researcher's Life Experiences and the Trustworthiness. *Qual Health Res* 2024:10497323241244957.