From Crisis to Accountability: Moral Leadership, Gender-Based Violence Prevention, and Lessons from Rural Migori County, Kenya for an Age of Polycrisis

Kutisha T. Ebron[1,*], Anne Ngunjiri[2] and Anthony C. Andenoro[3]

[1]*Southern New Hampshire University, 2500 North River Road, Manchester, NH 03106, USA*

[2]*LVCT Health, Nairobi, Kenya, Sonning Suite, Suna Road, Off Ngong Road, Nairobi*

[3]*Charlie Liffe & Leadership Academy*

Abstract: Before COVID-19, the World Bank (2019) reported that 35% of women globally experienced physical or sexual violence. The United Nations Development Programme (2020) documented a surge in gender-based violence (GBV) during the pandemic, with an estimated 15 million additional cases for every three months of lockdown. COVID-19 prevention measures, lockdowns, curfews, and school and business closures, exposed and deepened pre-existing fault lines across health systems, economies, and governance structures, disproportionately burdening women in rural communities with heightened unemployment, poverty, and diminished access to essential services.

This study examines the intersection of moral leadership, GBV prevention, and compounding crises in rural Migori County, Kenya, drawing on interviews with six policymakers and eighteen pregnant women or new mothers to assess how lockdowns and movement restrictions directly escalated GBV among vulnerable populations. The inclusion of pregnant women and new mothers centers the voices of those at greatest intersectional risk, navigating simultaneous health, economic, and safety precarity during crisis conditions. Findings reveal that entrenched gender norms normalize GBV and entrench inequality, while also illuminating accountability gaps in local and national policy responses. Situated within an era of polycrisis, where health emergencies, financial instability, and political fragility converge. This study advances a moral and transformational leadership framework for dismantling structural conditions that enable GBV. Lessons from Migori County offer transferable evidence for policymakers, practitioners, and scholars navigating the compounding crises of the present moment.

Keywords: Moral leadership, transformational leadership, gender-based violence, polycrisis, COVID-19, rural Kenya, Migori County, pregnant women, new mothers, women and girls, SDGs, policy accountability, compounding crises.

INTRODUCTION

The World Health Organization declared COVID-19 a global pandemic on March 11, 2020. By April 2020, the United Nations predicted a devastating impact on women's lives worldwide, particularly through the exacerbation of Gender-Based Violence (GBV), referred to as the 'Shadow Pandemic.' Prior to COVID-19, statistics indicated that GBV affected one in three women over their lifetimes (World Bank, 2019). Despite these alarming figures, the pandemic introduced additional barriers for women, as lockdowns and other mitigation measures intensified gender inequalities among already vulnerable populations. Marginalized women experienced not only increased GBV but also inadequate protections, as shelter-in-place orders resulted in higher levels of Intimate Partner Violence (IPV) and the breakdown of socioeconomic and health services (Meinhart *et al*., 2021). COVID-19 mitigation strategies further disadvantaged women socioeconomically. Vulnerable and marginalized women faced mental and physical abuse within their homes, often with little or no opportunity to escape their perpetrators (Nigam, 2020).

The inadequacy of governmental responses during this period highlights a broader crisis in moral and transformational leadership. Burns (1978) and Bass (1985) argue that transformational leaders inspire collective action toward justice and equity, qualities that are essential when compounding crises expose society's most vulnerable members. Across health emergencies, financial collapses, and political instability, failures in leadership have disproportionately endangered women. A moral leadership framework, grounded in disinterestedness, accountability, and human dignity (Brown *et al*., 2005), provides a critical lens for evaluating policy responses and identifying pathways toward gender-just governance.

The compounding vulnerabilities faced by women, girls, and marginalized populations during crises necessitate a leadership framework that is morally grounded, systemically transformative, and operationally responsive. Moral leadership anchors policy responses in accountability, disinterestedness,

*Address correspondence to this author at the Southern New Hampshire University, 2500 North River Road, Manchester, NH 03106, USA;
Tel: 202-540-0544; E-mail: kebron@stu.edu

and human dignity, ensuring that the protection of GBV victims is not subordinated to competing crisis priorities such as economic recovery or political stability (Ebron *et al*., 2025). This moral foundation is essential because GBV during crises is often perpetuated not by the absence of policy, but by leaders' willingness to treat survivor protection as secondary to more visible governance demands. Transformational leadership provides the mobilizing capacity that moral leadership alone cannot, specifically the ability to inspire collective action and shift institutional norms toward justice and equity (Akinbi, 2025).

Addressing entrenched gender norms that normalize GBV requires more than ethical intent; it demands leaders who can move health, security, and social protection systems beyond minimal compliance toward proactive, survivor-centered responses. Adaptive leadership (Heifetz *et al*., 2009) addresses a distinct gap: the operational versatility required when crisis conditions exceed the scope of existing standards. Polycrisis conditions, where health emergencies, economic collapse, and governance fragility converge, are inherently situations without established protocols (Miklian & Katos, 2024). Adaptive leadership elucidates how policymakers must diagnose novel problems, such as the closure of GBV shelters and services during lockdowns and mobilize improvised solutions in real time. When integrated, these three frameworks address not a singular failure but the compounded governance deficits, ethical, structural, and operational that leave women, girls, and marginalized populations disproportionately exposed during crises (Smith, 2025). Moral leadership clarifies why survivor protection must remain non-negotiable; transformational leadership demonstrates how leaders inspire the systemic shifts necessary to challenge entrenched gender norms; and adaptive leadership explains how these shifts are enacted under unpre-cedented conditions. Collectively, these frameworks provide a more comprehensive theoretical account of gender-just crisis governance, particularly relevant to the polycrisis conditions examined in this study.

Many women lost their incomes without access to government financial support, which enabled men to control household finances and led to increased economic abuse (Jayachandran, 2021). Lockdowns and rising male unemployment intensified controlling behaviors toward spouses. Some women were unable to seek medical assistance due to abuse, further restricting access to reproductive and sexual health services (Emezue, 2020). GBV survivors require both immediate and long-term support. As men lost employment, shifting gender roles created conflict, with women assuming the role of breadwinner and experiencing economic abuse through financial control (Sanders, 2015). These patterns indicate not only individual failures but also systemic governance deficits that moral and transformational leaders must urgently address. This study seeks to answer the following research questions: How did the compounding crisis conditions produced by the COVID-19 pandemic, specifically lockdowns and movement restrictions in Migori County, Kenya, affect pregnant women, mothers, and GBV? What do these findings reveal about leadership and accountability gaps in policy responses during crises for women and vulnerable populations?

LITERATURE REVIEW

Gender-based violence is among the most pervasive and systematically under addressed human rights violations of the contemporary era. GBV encompasses all forms of violence perpetrated on the basis of sex or gender, including emotional, physical, mental, financial, and sexual harm, coercion, and deprivation of liberty (Opanasenko *et al*., 2021). It is not a private or interpersonal phenomenon; it is a structural one, produced and sustained by systems of power that assign unequal value to human beings based on gender identity and expression. The World Health Organization (2021) classifies GBV as a global public health crisis, noting that its health consequences, including physical injury, psychological trauma, reproductive harm, and mortality, rival those of many communicable diseases in their scale and severity. Yet unlike communicable diseases, GBV is not the product of a pathogen. It is the product of governance failures, cultural permissiveness, and the chronic absence of moral and accountable leadership at every level of social organization.

Recent international guidance has continued to evolve since the initial COVID-19 response, offering frameworks directly relevant to this study's findings. WHO and UN Women, as co-leads of the Generation Equality Action Coalition on GBV, have advanced the RESPECT women framework's seven evidence-based prevention strategies through an interactive platform launched in 2023. Yet, WHO report indicates only 40% of countries include even one of the three essential RESPECT strategies: empowering women, ensuring relevant services, and transforming gender attitudes. A gap that mirrors precisely the institutional absence this

study documents in Migori County. UN Women and the Equality Institute's 2023 *Together for Prevention* handbook similarly establishes multisectoral national action plan standards for GBV prevention, offering a benchmark against which Migori County's crisis-era governance response can be assessed. UNFPA's *Strategy and Operational Plan to Scale Up and Strengthen Interventions on Gender-Based Violence in Emergencies (2023–2025)* extends the earlier Minimum Standards specifically into ongoing emergency contexts, reinforcing that GBV response infrastructure is expected to function continuously through crisis, not only in its acute onset (Rudzinski, *et al*., 2025)

These updated frameworks also confirm that the compounding dynamics this study terms "polycrisis" are now a documented, rather than speculative, concern within the international GBV field. A 2025 UN-backed study found that 93.1 million people were affected by weather-related disasters and earthquakes in 2023 alone, while an estimated 423 million women experienced intimate partner violence, with one study finding a 28 percent increase in femicide during heatwaves, demonstrating that the leadership and accountability gaps this study identifies in a pandemic context extend to climate-driven crises as well, and that the burden of overlapping crises falls disproportionately on women in poverty, including smallholder farmers and those in informal urban settlements, a population directly analogous to the rural, agrarian women interviewed in Migori County. Underscoring the persistent resource gap behind these governance failures, UN Women's 2023 Gender Snapshot reported that 245 million women and girls continue to face physical and/or sexual violence from intimate partners, while prevention efforts remain severely underfunded relative to the scale of the crisis. Taken together, this recent literature situates Migori County's findings not as an isolated pandemic-era failure, but as one documented instance of a broader, ongoing pattern that international frameworks have identified but that governance systems have yet to operationalize (UN Women, 2023; UN Women 2025).

The theoretical framework of transformational leadership offers a powerful lens through which to evaluate and reimagine governance responses to GBV in crisis contexts. Bass and Riggio (2006) posit that transformational leaders are distinguished by four core dimensions: idealized influence, inspirational motivation, intellectual stimulation, and individualized consideration. Applied to GBV governance, these dimensions translate into specific leadership imperatives. Idealized influence demands that leaders model the gender-equitable values they seek to institutionalize, that their own conduct, appointments, and public communications signal unambiguously that violence against women is incompatible with the moral standards of governance. Inspirational motivation requires articulating a compelling, affirmative vision of gender justice, not merely framing GBV reduction as a crime reduction strategy but as a foundational condition of social development and human flourishing. Intellectual stimulation calls on leaders to challenge the patriarchal assumptions embedded in existing policy frameworks, to commission and act on evidence about what works, and to create space for survivor-informed innovation in service design. Individualized consideration demands that leaders attend to the particular needs, circumstances, and vulnerabilities of the women and girls most at risk, recognizing that GBV is experienced differently across age, income, geographic location, disability status, and ethnicity, and that effective responses must be correspondingly differentiated.

In the context of GBV, transformational leaders are those who challenge patriarchal norms rather than accommodate them, who center survivor voices in policymaking, and who mobilize institutions toward structural change. Burns' (1978) foundational distinction between transactional and transformational leadership is particularly instructive here. Transactional governance responds to GBV by processing cases through existing institutional channels, police reports, prosecutions, shelters, without questioning the structural conditions that produce the cases in the first place. Transformational governance asks the deeper question: what kind of society, economy, and political culture would need to exist for GBV to be rare rather than epidemic? And it marshals institutional resources, legal reform, educational investment, economic empowerment, cultural change, in sustained pursuit of that vision. The COVID-19 pandemic revealed a stark absence of such leadership in many contexts, particularly in rural Kenya, where lockdowns and movement restrictions worsened economic instability, mental health, food insecurity, and access to essential services for women and girls (Opanasenko *et al*., 2021).

Complementing transformational leadership theory, moral leadership scholarship provides a normative framework for evaluating the conduct of leaders in relation to their obligations to the most vulnerable.

Brown *et al*. (2005) define moral leadership as the demonstration of normatively appropriate conduct through personal actions and interpersonal relationships, and the promotion of such conduct to followers through two-way communication, reinforcement, and decision-making. In the GBV context, this definition carries specific implications: moral leaders do not merely refrain from perpetrating or condoning violence. They actively create the institutional conditions in which violence is named, reported, investigated, and addressed without shame, retaliation, or bureaucratic indifference. Hassan *et al*. (2014) extend this framework to the public sector, demonstrating that moral leadership in government produces measurable improvements in accountability, transparency, and institutional responsiveness. These are precisely the qualities most absent in the governance failures documented throughout this study. Adaptive leadership theory further contributes to this framework by providing tools for navigating the complex, contested terrain of cultural change that genuine GBV prevention requires acknowledging that shifting deeply embedded patriarchal norms is not a technical problem with a technical solution, but an adaptive challenge that demands sustained engagement with community values, power dynamics, and historical grievances (Heifetz *et al*., 2009).

Kenyan policies during COVID-19 exposed vulnerable women to compounding risks across political, social, and economic systems, with particularly devastating effects for women in informal work sectors who had no employment protection, no savings buffer, and no pathway to government assistance (Winter *et al*., 2021; Bukenya, 2021). These vulnerabilities did not develop during the pandemic; they were produced over decades by governance systems that designed economic policy around formal sector workers, social protection systems around nuclear family structures, and law enforcement around the interests of property holders rather than those of the most precarious. COVID-19 did not create Kenya's GBV crisis; it revealed it, at scale, with urgency, and with consequences that continue to reverberate in the communities most affected.

A critical gap persists in the existing literature: the voices of vulnerable women in Migori County, Kenya, those most directly affected by government lockdowns and escalating GBV rates, remain largely absent from erudite and policy analysis. This absence is not incidental. It reflects the same structural exclusion that characterizes the governance failures under examination. Women who are geographically isolated, economically precarious, linguistically marginalized, and socially stigmatized are precisely those least likely to appear in administrative data, policy consultations, or academic research. Their exclusion from the knowledge base perpetuates the conditions of their exclusion from governance. This study is, in part, an act of epistemic justice, a deliberate effort to center the experiential knowledge of the women of Migori County as authoritative evidence about what governance failures cost and what transformational leadership must address.

The urgency of this work lies in addressing systemic power imbalances rooted in patriarchal, socioeconomic, cultural, and governmental norms that perpetuate GBV and suppress women's agency. The imbalances that do not resolve themselves between crises but that deepen with each governance failure and each generation of children who observe violence normalized within their households and ignored by their institutions. Moral leadership scholarship (Brown *et al*., 2005; Hassan *et al*., 2014) provides a framework for understanding how leaders can either entrench or dismantle these structural conditions. The choice between entrenchment and dismantlement is not merely a policy option, it is a moral one. And it is a choice of direct relevance to the era of polycrisis now unfolding, in which financial instability, political fragility, health emergencies, and climate disruption converge simultaneously and in which the communities most vulnerable to GBV are also those most exposed to every other dimension of compounding crisis (Tooze, 2022). Coined by Adam Tooze, polycrisis denotes a circumscription in which multiple crises occur simultaneously and interrelate. Leadership that fails women in these conditions does not merely fail women. It fails the foundational project of just and sustainable governance itself.

Intersection of GBV, SDGs, and Social Mobility

Social mobility refers to movement in social position within families or social strata, with economic mobility being a central aspect (Dribe & Smith, 2021; Holst & Niehoff, 2021). When women face social, economic, and health challenges, overall social mobility is constrained (Dribe & Smith, 2021). Systemic inequities, rooted in patriarchal structures, hinder women's progress (Feagin, 2013). COVID-19 policies disrupted girls' education, limiting social protection and exposing them to risks such as teenage pregnancy and child marriage, directly impeding progress toward the United

Nations Sustainable Development Goals (SDGs) by 2030. A lack of comprehensive understanding of the various obstacles to GBV perpetuates cycles of poverty and contributes to higher mortality rates (Shahrokh & Wheeler, 2014).

Transformational and moral leadership are essential to reversing these trends. Leaders who align institutional priorities with the SDG framework, particularly SDGs #1 (No Poverty), #2 (Zero Hunger), #3 (Good Health), #4 (Quality Education), #5 (Gender Equality), #8 (Decent Work and Economic Growth), #10 (Reduced Inequalities), and #16 (Peace, Justice, and Strong Institutions), demonstrate a commitment to justice that extends beyond crisis management to structural transformation. Moral leaders prioritize transparency and safeguard the privacy and confidentiality of survivors when collecting sensitive data on GBV (Hassan *et al*., 2014); transformational leaders go further, institutionalizing survivor-centered approaches as a governance norm rather than an exception.

Kenya was not included in the World Economic Forum's Global Social Mobility Index for 2020; however, the Index, which assesses nations across Health, Education, Technology, Employment, and Protection and Institutions, offers a valuable accountability framework for governments seeking to address the intersecting root causes of GBV. Countries with higher social mobility exhibit greater equity among citizens (Goudeau *et al*., 2021). Without transformational leadership that actively dismantles structural barriers, the Global Social Mobility Index risks overlooking opportunities for governments to address pressing inequalities. Increasingly, an individual's life chances are shaped by socioeconomic status at birth and place of origin, a 'lock-in' from birth with wide-ranging implications for societal growth, cohesion, and innovation (Holst & Niehoff, 2021).

Moral and Transformational Leadership as a Crisis Response Framework

Effective governmental action against GBV necessitates moral leadership defined by fair policymaking, condemnation of injustice, and sustained engagement with experts and survivors to understand GBV's multidimensional impacts (Hassan *et al*., 2014; Brown *et al*., 2005). Moral leaders prioritize transparency and safeguard the privacy and confidentiality of survivors when collecting sensitive data. Transformational leaders extend this further: they inspire systemic change, challenge entrenched norms, and build institutional cultures of accountability that persist beyond any single crisis. The lessons of COVID-19 and the emergent landscape of compounding health, financial, environmental, and political crisis demand a leadership paradigm that is simultaneously principled and adaptive. Burns' (1978) foundational articulation of transformational leadership emphasized the moral elevation of both leader and follower toward higher purposes; applied to GBV governance, this means policies that do not merely react to violence but proactively reshape the conditions that produce it. In rural Migori County, and across analogous contexts globally, the question is not whether leaders know that GBV escalates during crises, as the evidence is unambiguous, but whether they are willing to exercise the moral courage to act.

GBV has long impacted women's socioeconomic status, and COVID-19 exacerbated these challenges. Lockdowns and stay-at-home orders led to a rise in intimate partner violence (IPV) and economic violence, further compromising women's safety and rights. The pandemic's onset was predicted to push between 40 and 60 million people into extreme poverty around the. globe, with women experiencing income reduction, job losses, and decreased work opportunities, especially in rural areas. By the second year of the pandemic, the World Bank estimated that 75 to 95 million people were living in extreme poverty due to pandemic-related factors, inflation, and other global events. In Kenya, where many rely on daily wages, the inability to work leads to families struggling to meet basic needs and food insecurity (Pastrana *et al*., 2021).

Lockdown measures formulated without considering the informal work sector disproportionately affected women who rely on activities such as street vending for income (Chirisa *et al*., 2022). Moreover, rural socioeconomic dynamics in Kenya, including male migration to urban areas for employment have long placed women in charge of household sustenance (Rocheleau *et al*., 2013). COVID-19 further amplified this burden, leaving women as primary providers for their families. Transformational leaders attuned to these gendered structural realities must design crisis responses that account for intersectional vulnerability rather than defaulting to gender-neutral policies that render women's disproportionate risks invisible.

Culture

In rural Kenya, poverty, limited education, and scarce financial resources are widespread (Njuki *et al*., 2008). Social capital is crucial for women, enabling

them to build trust, create economic opportunities, and address challenges collectively (Nyangena & Sterner, 2008). However, women in rural areas encounter unequal access to public services, resources, and employment compared to men (United Nations Economic & Social Council, 2018). These structural disparities are not incidental. They furthermore reflect governance environments shaped by patriarchal norms that moral and transformational leaders must actively dismantle rather than passively accommodate.

Women in rural communities face heightened risks of physical, emotional, and financial violence, evident in practices such as Female Genital Mutilation (FGM) and early marriage (Ellsberg *et al*., 2015). The Kenya National Bureau of Statistics (2015) reported that approximately 44.8% of Kenyan women aged 15 to 49 experienced intimate partner violence (IPV). These numbers reflect the cultural normalization of GBV, perpetuated from an early age as boys and girls observe dynamics in which violence toward a partner is framed as a sign of love (Sjödin, 2019). Transformational leadership theory importunities that leaders at all levels from community elders to national policymakers, interrupt this intergenerational transmission of normalized violence by elevating moral standards and reorienting cultural expectations toward equity and dignity (Burns, 1978; Bass & Riggio, 2006).

Entrenched patriarchal norms and seclusion ideologies mandate women's roles in rural communities (Mehta, 1996). These biases permeate governmental structures, policies, and practices, reinforcing women's dependency on men (Mancini & Palazzo, 2021). Culturally ingrained norms influence government, business, and national identity (Rosen *et al*., 2000). Moral leaders bear a particular responsibility to challenge these institutional biases, not merely through policy declaration but through the sustained, visible modeling of equitable practices that Brown *et al*. (2005) identify as central to Moral leadership in organizational and governance contexts.

While women's leadership roles are evolving in rural Kenya, significant challenges persist within existing institutional frameworks. Prioritizing women's well-being and leadership across healthcare, government, economy, and education is not merely a matter of equity. It is a prerequisite for effectuations governance. Without women's active participation, policymakers lack a comprehensive understanding of GBV's impact on social mobility, and the nation's ability to achieve the SDGs by 2030 is fundamentally compromised (Shen & Joseph, 2021). Transformational leaders recognize that inclusive governance is not an optional aspiration but a structural necessity for sustainable development.

Kenyan governmental dynamics are deeply influenced by cultural factors, including ethical, gender, and ethnocultural identities (Magara, 2020). These dimensions shape governmental approaches across dimensions such as pragmatism versus idealism, individualism versus collectivism, and traditionalism versus modernity (Bass & Bass, 2008). Gender biases exacerbate resource and opportunity disparities for women, particularly in single-headed households (Watson & Hayward, 2010). Historical factors including economic inequality and marginalization contribute to GBV tolerance and impede access to essential services and development. A moral leadership lens foregrounds these historical inequities as governance responsibilities — recognizing that silence or inaction in the face of structural injustice is itself a leadership failure (Hassan *et al*., 2014).

The economic repercussions of COVID-19 and the broader polycrisis of compounding health, financial, and political instability may catalyze opportunities to advance the SDGs and enhance social mobility in Kenya. Cross-cultural governance that integrates both masculine and feminine viewpoints fosters peace and inclusivity (Higgins *et al*., 2022; Hofstede, 2001), benefiting women and marginalized groups disproportionately burdened by crisis conditions. In rural areas, women rely heavily on subsistence farming, facing persistent gender disparities (Dlamini, 2021). Despite their vital role in agriculture, women encounter obstacles including limited land ownership and financial barriers (O'Donnell *et al*., 2021). Strengthening women's agricultural capacities is vital for their economic empowerment and entrepreneurship (Awour *et al*., 2021), and addressing gender biases in land ownership policies is foundational to promoting structural equality (Zuvalinyenga & Bigon, 2021). Transformational leaders who champion these reforms not only advance individual women's livelihoods but contribute to the macro-level social mobility gains that underpin national development.

Collaboration across sectors is essential in an era of interconnected crises. Yet a critical gap persists; rigorous research on government interventions that simultaneously address GBV reduction, social mobility enhancement, and SDG advancement remains insufficient. Investigating the impact of women in leadership on GBV's physical and mental health effects

is vital. Understanding how women in government roles reshape community attitudes toward violence and equity is essential for empowerment and for building the accountable, inclusive governance institutions that moral and transformational leadership theory envisions as both possible and necessary.

METHODOLOGY

In March 2020, the Kenyan government implemented COVID-19 lockdown measures and movement restrictions to curb the virus's spread. However, these measures inadvertently heightened the vulnerability of women and girls to GBV, exacerbating its multifaceted impacts. This study investigates how COVID-19 lockdown measures affected GBV and vulnerable women in rural Migori County, Kenya, examining the socioeconomic and health repercussions of strict regulations on women and girls based on their lived experiences and evaluating the moral leadership failures that allowed these harms to go unmitigated.

Participants were recruited from the LVCT Health DREAMS site, a Non-Governmental Organization Medical Clinic in rural Migori County, Kenya, specializing in programming for adolescent girls and women. Potential participants were contacted via telephone by the research team and provided with information about the study. Informed consent was obtained from all participants before conducting interviews. For virtual participants, consent forms were digitally signed and emailed to the researcher prior to the interview.

The study comprised eighteen pregnant women or new mothers, selected based on enrollment forms by choosing every third female aged 17 or above who met the criteria for these two populations. Table **1** presents the demographic details of respondents and their roles within their nuclear families. Data collection involved semi-structured interviews and key informant interviews, allowing participants to share their perspectives and experiences regarding the impact of COVID-19 on their health, socioeconomic status, and access to essential services. Qualitative narrative research methodology was employed to examine the nuances, realities, and social implications of women's experiences during the COVID-19 lockdowns (Berger, 2015), facilitating the collection of diverse viewpoints (Creswell, 2013).

Data collection was conducted via telephone and virtual platforms, including Google Meetings, Microsoft Teams, and Zoom, to ensure the safety of research

Table 1: Participants Demographics

Respondents Identifier	Age	Pregnancy or Women with children	Marital Status
PNM001	30	Seven children	Married
PNM002	21	Two children	Married
PNM003	20	One child	Married
PNM004	18	Pregnant	Not Married (Resides with Parents)
PNM005	28	Four children	Widow
PNM006	28	Four children	Married
PNM007	18	Pregnant	Single (resides with parents)
PNM008	30	Five children	Married
PNM009	18	Pregnant	Single (lives with parents)
PNM010	19	Pregnant	Single (lives with parents)
PNM011	29	One child	Married
PNM012	17	Pregnant	Single (living with parents)
PNM013	31	Two children	Married
PNM014	19	Pregnant	Married
PNM016	20	1 Child	Married
PNM018	23	Four children	Married
PNM019	25	One child	Married
PNM020	32	Pregnant with two children	Married

Table 2: Policy Makers Interview Profiles

Policy Maker Assigned Number	Role	Job Function
PM001	County coordinator Children Services	Developed Gender Policy and Informed on Interventions.
PM002	Chief Officer in charge of Medical Services	Prepares guidelines for COVID-19 prevention and treatment.
PM003	Nurse	Coordinating Gender-Based Violence activities at the county team management level; ensuring regulations stipulated by the ministry of health are adhered to by the staff and the community.
PM004	Chief Officer, Health Department	Guidance for adolescents' activities and interventions for COVID-19.
PM005	Program Officer, GBV	Guide GBV prevention, sensitization, awareness, and monitoring & evaluation that informs future programming.
PM006	Country Coordinator for Gender	Coordinator of gender intervention activities and develops policies for COVID-19.

team members and participants from COVID-19 transmission. The Principle of Active Interview was applied, with researchers guiding respondents to provide detailed descriptions of events and experiences beyond generic responses (Bevan, 2014). Probing questions were used to seek clarification and explore participants' responses in depth, with researchers able to reword questions as needed. Participants were also encouraged to share additional comments at the end of interviews.

LVCT Health, based in Nairobi, Kenya, employed an exploratory qualitative research design to gain a philosophical understanding of women's experiences during the COVID-19 pandemic (Creswell, 2013). Through comprehensive semi-structured interviews, researchers conducted constant comparative analysis of existing qualitative data to develop a grounded theory elucidating rural women's experiences (Blee & Taylor, 2002; Charmaz & Mitchell, 2001). Given that populations from rural counties are often marginalized during health crises (Ford *et al*., 2018), thorough analysis of women's experiences was critical, particularly regarding access to essential services, employment, economic assistance, and healthcare. This methodological commitment to centering marginalized voices is itself an expression of moral leadership praxis, reflecting Brown *et al*.'s (2005) emphasis on the leader's responsibility to hear and respond to those most affected by systemic harm.

Manual coding was conducted rather than software-assisted analysis in order to preserve close, sustained engagement with the sensitive and contextually specific nature of participants' accounts. Given the relatively small, information-rich sample of six policymakers and eighteen pregnant women and new mothers, manual coding allowed for repeated, iterative immersion in each transcript. A depth of engagement was particularly necessary when analyzing disclosures of gender-based violence, where meaning is often conveyed indirectly and shaped by cultural and linguistic context specific to Migori County. Furthermore, this approach aligned with the inductive logic of grounded theory, which requires the researcher to move continuously between data collection and analysis as categories and themes emerge, rather than mediating that emergence through automated coding software. Hence, manual coding preserved the interpretive acuity necessary to accurately capture participants' lived experiences while maintaining methodological consistency with the study's grounded theory design.

All interviews were conducted with participants' consent and recorded for accuracy. Interview topic guides were pre-tested in local languages, Swahili, Dholuo, and English, at LVCT Health sites, involving individuals from the study population. Semi-structured interview guides were reviewed by a staff member from LVCT Health's gender-focused programs. Trained research assistants assessed the adequacy of tools, including estimating interview duration. Piloting helped identify ambiguities and facilitated revisions before data collection (Hurst *et al*., 2015), providing the research team with valuable experience in qualitative data collection within the Gender and COVID-19 thematic area.

Utilizing content analysis, researchers adhered to the core principles of qualitative research, contextualizing findings through data saturation via the

inductive thematic saturation method (Carroll *et al*., 2013). Trustworthiness, a cornerstone of naturalistic research, was upheld through the four principles of Credibility, Transferability, Dependability, and Confirmability (Lincoln & Guba, 1982; Anney, 2014), paralleling internal validity, external validity, reliability, and objectivity in quantitative analysis. Triangulation techniques were employed to examine all aspects of the data (Denzin, 2011). Grounded theory, inductively derived from systematically collected and analyzed data, fosters reflection and offers opportunities to explore underlying personal issues while respecting local culture (Sawatsky, 2018).

FINDINGS

The qualitative analysis, utilizing constant comparative and content analysis methodologies (Charmaz & Belgrave, 2012), presents narrative findings in alignment with the research objectives. The study involved 18 women aged 17 to 32 from rural Kenya, either pregnant or new mothers, representing vulnerable populations disproportionately affected by GBV exacerbated by COVID-19 (Opanasenko *et al*., 2021). The Kenyan government and local leaders made diligent efforts to disseminate COVID-19 information in English, Swahili, and Dholuo, with all women (100%) reporting awareness of COVID-19 by March 2020 and understanding its transmission, symptoms, and precautions through radio, television, friends, family, and Community Health Volunteers (CHVs). Respondent PNM0009 shared:

> *"Corona is a killer. It is from India. This information was being shared with people in the market and those passing by the road... I heard about it on TV, radio, I also heard people talk about it, that is when we knew Corona is real — when people started putting on masks, that is how we realized it was real."*

Among the women surveyed, 89% reported encountering misinformation in informal settings, while information from official sources, radio, television, and CHVs, was perceived as reliable by 100% of respondents. Effective communication proved crucial in equipping communities with prevention knowledge. These findings underscore the moral responsibility of transformational leaders to ensure that accurate, accessible information reaches the most marginalized during crises, a duty that, when fulfilled, demonstrably shapes community behavior and trust (Bass & Riggio, 2006).

The economic impact of lockdowns was severe, with 94% of respondents reporting declining household income. For 38%, employment was tied to opportunities beyond their villages in cities such as Nairobi, Mombasa, or neighboring countries; 16% experienced direct job loss due to COVID-19 closures. Prior to the pandemic, 72% worked as informal laborers or entrepreneurs reliant on daily earnings, with 56% operating businesses selling clothing or agri-cultural produce. Entrenched cultural norms, including the bride dowry system, perpetuated male dominance in decision-making, contributing to high rates of female entrepreneurship in rural Kenya (Onidiba & Matsui, 2019) while simultaneously constraining women's economic autonomy. Respondent PN001 described the collapse of her livelihood:

> *"My life has been hurt by corona because since the start of corona my business had to stop... When I go, I do not make any money so there is no money, buyers are not there by 8:00. I am back home, those small goods for my stall are what I come back and feed on with the children, then the next day I go again and I eventually failed in the business."*

Entrepreneurs with supply chains beyond Migori faced rising costs and movement restrictions affecting inventory access. Many switched businesses in response to shifting demand, only to encounter new unprofitability. These findings reveal the absence of transformational economic leadership, policies that would have protected informal workers, the majority of whom were women, from the disproportionate financial devastation of lockdown measures.

School Closures

School closures for up to nine months caused severe delays in children's education, affecting 61% of households. The closures impacted teenage girls in compounding ways: many quit school altogether (Mhagama & Onyango, 2021), and when families could no longer afford school fees, girls from vulnerable populations became susceptible to pregnancy, sexual exploitation, and GBV (Small *et al*., 2022; Merrill *et al*., 2021). Forty percent of single pregnant teenagers reported never leaving home during lockdowns and described increased community violence during the pandemic. Professionals are called to consider incest, rape, assault, child marriage, and transactional sex as outcomes of these conditions (Munala *et al*., 2022). Respondent PNM010 shared:

> *"Okay COVID-19 has caused us to come home from school and we stayed home for so long, then many things happened which I didn't expect. Like this pregnancy, I didn't expect."*

Notably, single respondents aged 17–18 did not disclose the circumstances of their pregnancies, a silence that speaks to the depth of shame, fear, and power imbalance these young women navigate. Furthermore, 98% of girls aged 18–19 with unintentional pregnancies were not in school (Shikuku *et al*., 2021), and the Kenyan Ministry of Health reported that girls aged 10–19 were acquiring HIV every week between January and February 2021.

These findings constitute a direct indictment of governance failures at multiple levels. Moral and transformational leadership demands decisive governmental action, including expanded access to reproductive health education, contraception, and healthcare, alongside sensitization of formal and informal community leaders to interrupt the normalization of sexual violence. Burns' (1978) transformational leadership imperative to elevate collective moral purpose is nowhere more urgent than in the protection of adolescent girls whose futures are foreclosed by systemic neglect.

Violence and Conflict

Fifty-five percent of women discussed conflict or violence in their households, though few described direct physical violence against themselves, a pattern consistent with the literature on underreporting driven by fear, stigma, and economic dependency. Much of the conflict stemmed from financial stress, unemployment, food insecurity, and prolonged confinement. Respondent PNM020 described the precarious calculus of survival:

> *"It has caused conflict in other homes, but in my case, I do not like quarreling, so I always prefer to remain silent... The husband could not bring home the much money that he used to before so that would lead to arguments... Now, if you are someone who likes arguing, won't you be beaten every day?"*

Financial strain, prolonged confinement, and escalating household stress created conditions in which women calculated silence as survival. This silence is strategic, not passive and it reflects what moral leadership scholarship identifies as a profound failure of institutional protection: when women cannot safely report violence or seek help, the accountability mechanisms that moral governance requires have collapsed (Brown *et al*., 2005; Hassan *et al*., 2014). Transformational leaders must build systems robust enough that women do not face a choice between speaking and safety.

Access to Healthcare and Essential Services

Women in rural Migori were heavily dependent on public hospitals for their healthcare needs (Gitonga, 2022). During the pandemic, government hospitals suspended non-COVID services, redirecting patients with lower-priority conditions to private facilities that were financially inaccessible to most. Respondent PNM002 described the collapse of accessible care:

> *"Accessing essential healthcare services can be challenging when hospitals are far away and movement is restricted. Before COVID-19, family planning services, including contraception, were free, but now payment is required."*

Respondent PNM005 captured the community's fear of medical facilities:

> *"Women in my community often avoid hospitals due to a fear of medical facilities. Instead, they prefer self-medication with over-the-counter drugs for ailments like malaria, despite being in pain."*

Pregnant women were turned away from hospitals if their condition was not COVID-related. The once-free contraception services foundational to women's reproductive autonomy were discontinued, and supply chain disruptions rendered pharmaceutical drugs inaccessible. Respondent PNM012 recounted: "*There was no medication during Corona. Or maybe you had malaria, you would only be given Panadol and asked to go and buy malaria medications because they didn't have medications.*" While 91% of mothers reported successfully obtaining mandatory childhood vaccinations, access to broader healthcare remained severely compromised.

These healthcare failures are not merely logistical; they are moral and leadership failures. A moral leadership framework requires that governments anticipate the gendered dimensions of health system stress during crises and protect the most vulnerable from cascading consequences of service withdrawal

(Hassan *et al*., 2014). Transformational leaders who govern with moral intentionality design crisis-responsive health systems that strengthen rather than abandon women's access to reproductive and primary care.

Psychosocial and Emotional Health

The challenges posed by COVID-19, including isolation, income loss, and disrupted routines, exacerbated existing mental health conditions and triggered new ones among women (Garg *et al*., 2020). Sixty-six percent of respondents expressed fears related to COVID-19, alongside feelings of isolation due to reduced communication with friends, family, and community networks, and mounting financial pressure. Eighty percent reported emotional distress and depression linked to the inability to afford rent. Respondent PNM003 described the pervasive strain:

> *"Struggling with rent affects us greatly because it's hard to come up with the money every month. If we can't pay, we end up owing the landlord. Some land-lords are understanding and give us time to pay, but others aren't. It puts pressure on us to explain and find ways to pay. This affects the whole family as we have to cut back on expenses to cover rent."*

Respondent PNM013 described the intersection of financial pressure and gender-based coercion within the household:

> *"The situation at home is tough when my husband returns without money. He might ask me to find something to contribute financially, but often, there's nothing I can do. It's stressful, especially when he expects meals, but we can't afford them. Women bear the brunt of this financial strain as we worry about providing for our children with limited resources."*

These accounts reveal that psychosocial harm during crisis is inseparable from economic and structural conditions. Transformational leaders who respond to mental health crises without addressing their material roots offer inadequate solutions. Moral governance requires integrating psychosocial support with economic relief, food security, and gender-based violence protections, a holistic approach that Burns' (1978) vision of moral leadership demands.

Local Leadership

None of the respondents reported seeking assistance from their village chief or elders. Their unanimous reluctance, reflected in responses such as "No. Why?" and "What for?", reveals a profound crisis of institutional trust. Rather than perceiving local leaders as protectors or resource mobilizers, women viewed chiefs primarily as enforcers of lockdown measures and administrators of burial logistics. Sixteen percent reported any direct communication with village chiefs, and none sought them out for food, financial aid, or safety concerns.

This finding is among the most consequential in the study from a leadership standpoint. It documents a near-total collapse of transformational and moral local leadership at the moment of greatest community need. Burns (1978) argued that transformational leaders elevate followers by attending to their needs and moral development; Bass and Riggio (2006) identified idealized influence and inspirational motivation as core competencies of transformational leadership. The village chiefs in Migori County, as experienced by these eighteen women, exercised neither. Their absence from women's crisis narratives is not incidental, it reflects a governance vacuum in which patriarchal authority was enforced but protective authority was absent. Rebuilding community trust requires local leaders who are accountable, accessible, and oriented toward the most vulnerable, a standard that moral leadership theory holds as non-negotiable (Brown *et al*., 2005; Hassan *et al*., 2014).

The Ebola Crisis as a Test Case: Moral and Transformational Leadership in Real Time

The lessons documented in this study, drawn from the governance failures and human costs of the COVID-19 pandemic in rural Migori County, are not historical artifacts. They are active, urgent, and directly applicable to the current Ebola outbreak caused by the Bundibugyo strain, now spreading across the Democratic Republic of the Congo (DRC), Uganda, South Sudan, and neighboring East African nations. How governments, multilateral organizations, and community leaders respond to this outbreak will determine whether the lessons of COVID-19 have been learned, or whether the same failures of moral and transformational leadership will be repeated at the expense of the same vulnerable populations.

The current Ebola response marks a deliberate departure from the blanket lockdown model that

defined COVID-19 containment. There are no COVID-style nationwide lockdowns in any affected country. Instead, governments and public health agencies are deploying targeted, evidence-based interventions calibrated to Ebola's specific transmission dynamics: because Ebola spreads only through direct contact with bodily fluids rather than through the air, health officials have determined that tight border controls, rapid patient isolation, and aggressive contact tracing are both sufficient and more proportionate than the sweeping restrictions that devastated informal economies and escalated GBV during COVID-19 (WHO, 2025). Uganda has suspended mass gatherings, concerts, festivals, sporting events, and large public assemblies in high-risk zones and the capital Kampala, while health authorities across East Africa are advising communities to avoid physical greetings and large religious gatherings. Uganda and Rwanda have heavily restricted or closed land borders with the DRC, with exceptions for humanitarian aid, cargo, and authorized response teams. At the international level, the United States has temporarily banned entry for certain non-citizens who have visited the DRC, Uganda, or South Sudan within the preceding 21 days, routing returning citizens through four designated airports for advanced medical screening. Canada, Thailand, Rwanda, and Bahrain have enacted mandatory 21-day quarantine policies for arrivals from the outbreak's epicenter.

This more targeted approach reflects a meaningful, if partial, application of lessons learned from COVID-19. It demonstrates that governments can calibrate crisis responses to the specific epidemiological characteristics of a pathogen, and that doing so reduces the disproportionate economic and safety burden that blanket lockdowns imposed on women, informal workers, and rural communities. This is precisely the kind of evidence-informed, context-sensitive decision-making that moral leadership demands and that transformational leadership operationalizes through institutional learning (Bass & Riggio, 2006; Heifetz *et al*., 2009). The absence of COVID-style lockdowns is not merely a public health judgment; it is a governance choice with profound equity implications, and it reflects a leadership posture that is, at minimum, more attentive to the costs borne by the most vulnerable than the blunt instruments deployed in 2020.

Yet attentiveness is not the same as accountability, and a more calibrated containment strategy does not automatically translate into gender-responsive, ethically grounded crisis governance. The fundamental structural conditions documented in Migori County, the informality of women's economic lives, their dependency on public health infrastructure, the patriarchal dynamics that intensify under household stress, and the absence of protective local leadership remain present in every affected community. Mass gathering bans, however proportionate, still threaten the market-based livelihoods of women vendors who depend on peak shopping hours and communal economic spaces. Border closures, however necessary, disrupt the cross-border trade networks through which many rural women in East Africa sustain their households. Mandatory quarantines, however, epidemiologically sound, remove breadwinners from families with no guaranteed income replacement and as COVID-19 demonstrated with devastating clarity, financial stress within households is a direct predictor of intimate partner violence (Meinhart *et al*., 2021; Opanasenko *et al*., 2021). Transformational leaders cannot simply adopt a less harmful containment model and declare the equity problem solved. They must actively design protective measures that accompany every restriction, economic support, GBV response capacity, reproductive health access, and community communication, or they will replicate the harm through a different mechanism.

The Ebola response also surfaces the unresolved crisis of the global development architecture identified earlier in this study. The dismantling of USAID and the contraction of Global North development financing has weakened precisely the systems, community health networks, NGO service delivery infrastructure, cross-border humanitarian coordination, that effective Ebola containment requires. The DRC has experienced repeated Ebola outbreaks over decades, and the international community's repeated investment in emergency response capacity rather than long-term health system strengthening means that each outbreak finds the same structural gaps waiting to be exploited. The Bundibugyo strain is now spreading through communities where local health workers are underpaid, under protected, and operating within institutions that were not built for long-term stability. The same structural reality that leaves development practitioners globally vulnerable to workplace violence and institutional collapse when funding contracts. As this study has argued, an organization or a health system that cannot protect its own workers cannot sustainably protect the communities those workers serve (Brown *et al*., 2005).

The moral leadership imperative in the current Ebola crisis is therefore threefold. First, governments

must apply the proportionality lessons of COVID-19 consistently designing restrictions that contain transmission without producing the secondary waves of GBV, economic devastation, and psychosocial harm that swept through communities like Migori County. Second, multilateral organizations and donor governments must resist the temptation to treat Ebola as another discrete emergency to be managed through short-term project funding, and instead use this moment to invest in the durable community health infrastructure, locally owned response capacity, and protected health workforce that transformational leadership theory demands and that COVID-19 proved the absence of was catastrophic. Third, and most critically, the voices of women in affected communities' pregnant women, new mothers, informal workers, rural agricultural laborers must be centered in every layer of the response, from community communication strategies to national policy design to international coordination mechanisms. The eighteen women of Migori County whose experiences anchor this study were excluded from every decision that shaped their crisis. The women of the DRC, Uganda, and South Sudan facing Ebola today must not be.

Burns (1978) argued that transformational leadership is ultimately a moral relationship, one in which leaders and followers elevate one another toward higher collective purposes. The Ebola outbreak of 2025 and 2026 is a test of whether the global community has internalized that moral relationship in the years since COVID-19 exposed its absence so devastatingly. The targeted rather than blanket response strategy suggests some institutional learning has occurred. But institutional learning is not the same as transformational change. Transformational change would mean that the women most at risk of GBV during the Ebola response already have economic protection in place, that local health workers already have stable employment and safe working conditions, that community leaders already have the training and accountability structures to serve their most vulnerable constituents, and that the development architecture already has the community-owned, domestically financed resilience to function when Global North donors redirect their attention. That transformation has not yet occurred. This study is, in part, an argument for why it must and an evidence base for how.

DISCUSSION

COVID-19 did not create the conditions that endangered women in rural Migori County, it exposed and accelerated them. The lockdowns, movement restrictions, school closures, and economic contractions that defined the pandemic response functioned as a stress test of governance systems already weakened by patriarchal norms, institutional neglect, and the chronic underfunding of services upon which rural women depend. The findings of this study reveal that when health, economic, and political crises converge, as they do with increasing frequency in the contemporary global landscape, it is women, and particularly the most marginalized among them, who absorb the compounding consequences of every failure of moral and transformational leadership.

The significance of these findings extends far beyond the COVID-19 pandemic. The world is entering an era of polycrisis, a term capturing the simultaneous, mutually reinforcing nature of climate disruption, economic instability, democratic backsliding, and recurring public health emergencies (Lawrence *et al*., 2022). In each of these crisis typologies, the patterns documented in Migori County are not anomalies, they are harbingers. Understanding how GBV escalates under crisis conditions, how women's economic agency is eroded by governance failures, and how local leadership either protects or abandons its most vulnerable constituents offers a roadmap for building more resilient, just, and accountable societies across every dimension of the polycrisis landscape.

Economic Crisis

The economic dimensions of this study carry direct implications for governance during financial downturns, inflationary shocks, and austerity regimes. When 94% of respondents reported declining household income and 72% of informal laborers, predominantly women, lost their livelihoods with no government safety net, the findings document more than pandemic hardship. They document the predictable outcome of economic systems that treat women's labor as expendable and informal work as invisible. These patterns replicate themselves in every major economic contraction: the 2008 global financial crisis, austerity-driven cuts across sub-Saharan Africa in the 2010s, and the inflation crises of 2022–2023 all produced documented surges in GBV (UN Women, 2020; Vyas & Watts, 2009).

Transformational economic leadership requires anticipating this dynamic before crisis strikes, building portable social safety nets, gender-responsive fiscal policies, and economic protection mechanisms that cover informal workers. The Migori findings

demonstrate that women who lose income do not merely face poverty; they face an erosion of the autonomy that protects them from violence. Economic policy is, therefore, GBV policy. Leaders who fail to recognize this connection are not only economically negligent, but they are also ethically culpable (Brown *et al*., 2005; Burns, 1978).

Political Crisis and the Collapse of the Development Architecture

The near-total absence of protective local leadership documented in this study, with only 16% of respondents having any contact with village chiefs, and none seeking their help, is a finding that transcends Kenya. It speaks to a global pattern in which political instability, elite capture, and the entrenchment of patriarchal authority structures produce governance vacuums that women experience as abandonment. When political systems prioritize enforcement over protection, control over care, and loyalty over accountability, the most vulnerable bear the greatest cost.

Moral leadership theory insists that leaders are morally accountable to those they govern, not merely to those who elected or appointed them (Brown *et al*., 2005; Hassan *et al*., 2014). During political crises, whether electoral violence, democratic backsliding, or institutional capture, this accountability is most likely to fracture along gender lines. The women of Migori did not trust their chiefs to help them because their chiefs had not earned that trust through consistent, responsive, and equitable leadership. This erosion of institutional legitimacy is both a cause and consequence of political crisis. Transformational leaders who invest in trust-building during stable periods create the relational capital that sustains communities when crises arrive; those who do not leave their communities without recourse precisely when recourse is most urgently needed (Bass & Riggio, 2006).

The sixty-fifth Commission on the Status of Women called on states to address the structural causes of violence against women through prevention measures, enhanced coordination, and collaboration with local communities. This study provides empirical grounding for that call documenting precisely what happens when such coordination fails and what it costs the women left behind.

The structural fragility exposed by COVID-19 is further compounded by a seismic shift in the global development architecture. Multilateral organizations have incorporated capacity development into countless projects across decades of international programming. Yet, since COVID-19, projects and communities built on that foundation have collapsed with alarming speed. The dismantling of USAID and the broader contraction of development funding from Global North donors is not merely a financial disruption; it is empirical evidence that capacity development was either not incorporated into these projects in any meaningful sense or was architecturally structured in ways that created dependency rather than self-determination. When external funding withdraws and communities cannot sustain the gains made, the architecture was never genuinely transformational, it was transactional. Burns (1978) distinguished precisely between these two orientations: transactional leadership exchanges resources for compliance, while transformational leadership builds the intrinsic capacity of followers to lead themselves. The international development sector's chronic reliance on the former has left communities like those in Migori County structurally exposed at the moment their need is greatest.

This fragility does not only devastate the communities these systems were designed to serve it devastates the workers within them. The structures of human development were not built for long-term stability, even for the practitioners who dedicate their careers to serving the most vulnerable populations. Decades of short-term project cycles, results-based financing, and donor-driven programming have produced a workforce that is itself precarious sustained by rolling contracts, dependent on funding renewals, and perpetually vulnerable to institutional collapse. As funding contracts and organizations downsize, many who remain in the field face a crisis that compounds their professional mission with personal survival: workplace violence rooted in job insecurity. Competition over diminishing resources, anxiety about organizational survival, and the erosion of institutional protections have created environments in which even those committed to ending violence against women are themselves subjected to hostile, coercive, and unsafe working conditions. This is not incidental; it is the logical outcome of a development architecture that treats human capacity as a project input rather than a long-term institutional investment.

The moral dimensions of this reality cannot be overstated. Brown *et al*. (2005) argue that moral leaders model the behavior they seek to cultivate, that integrity, dignity, and accountability must flow from the

top of institutions downward. When development organizations fail to protect their own workforce, they sever the moral coherence that gives their programming legitimacy. An organization that cannot guarantee the safety and dignity of its gender advisors, GBV coordinators, and community health workers cannot credibly claim to be building the safe, dignified communities its mandate describes. Transformational leadership demands that institutions invest in the wellbeing of their people as a precondition for sustained impact, not as a human resource afterthought but as moral and strategic imperatives. The women of Migori County deserve advocates who are institutionally protected, professionally stable, and personally safe. So do the advocates themselves.

This is a leadership failure of the highest order and one with direct consequences for GBV. When USAID-funded GBV prevention programs, reproductive health services, and women's economic empowerment initiatives disappear overnight because donor priorities shift or political winds change, the women who depended on those services do not simply go without a program. They go without protection. The moral leadership imperative, to design institutions and programs that outlast their funders, that transfer genuine power rather than managed dependency, and that root accountability in communities rather than in donor reporting cycles has never been more urgent. The current contraction of Global North development financing must serve as a catalytic reckoning: not a reason to abandon the communities most in need, but a mandate to fundamentally reimagine how capacity is built, owned, and sustained.

Health Crisis

The healthcare findings of this study constitute a detailed anatomy of what health system failure looks like from the perspective of the most marginalized. Pregnant women turned away from hospitals, contraception no longer freely available, pharmaceutical supplies disrupted, and women self-medicating with whatever drugs they could access these are not edge cases. They are the predictable outcomes of health systems designed around average users rather than the most vulnerable, and crisis responses that treat gender-responsive care as a luxury rather than a right.

These patterns will recur. Climate change is projected to drive increased disease burden, displacement, and health system stress globally (WHO, 2023). Future pandemics remain an epidemiological certainty. In each of these scenarios, the women documented in this study, pregnant, economically precarious, geographically isolated, and institutionally abandoned, represent the population whose needs will again be deprioritized unless moral leadership frameworks are embedded in health system design before the next crisis arrives. Ryan and El Ayadi (2020) argue that lessons from GBV during COVID-19 offer invaluable insights for optimizing care in future unforeseen challenges; the Migori findings give those lessons specific, urgent content: reproductive health services must be designated as essential and protected from crisis-driven reallocation, community health infrastructure must be strengthened rather than stripped, and women's voices must be included in health emergency planning as a governance requirement, not an afterthought.

Environmental and Climate Crisis

While this study focused on the COVID-19 pandemic, its findings are structurally applicable to the emerging landscape of climate-driven crisis. Climate change is not gender neutral. In rural agricultural communities like those in Migori County, where women bear primary responsibility for subsistence farming, food security, and household water access, environmental disruption compounds every dimension of vulnerability documented in this study. Drought, flooding, and crop failure generate the same economic precarity, household tension, and erosion of women's autonomy that lockdowns produced without the temporary nature that pandemic restrictions carried.

The women in this study who pivoted from clothing sales to agricultural produce in response to shifting market conditions were already practicing the adaptive resilience that climate survival demands. What they lacked was the institutional support, land ownership rights, financial access, and leadership representation that would allow that resilience to be sustained. Transformational leaders governing in climate-stressed environments must recognize that GBV prevention, agricultural empowerment, land reform, and climate adaptation are not separate policy domain, they are dimensions of a single justice imperative (Zuvalinyenga & Bigon, 2021; Awour *et al*., 2021).

RECOMMENDATIONS

The findings of this study that are drawn from interviews with six policymakers and eighteen pregnant

women and new mothers navigating the Migori County lockdowns, reveal a consistent pattern: GBV escalated not because protective frameworks were absent in principle, but because moral, transformational, and adaptive leadership failed in practice at precisely the moments those frameworks were tested. Situated within this leadership framework, the following recommendations respond directly to the specific governance failures documented in the findings, for governments, policymakers, international organizations, and community leaders navigating compounding crises.

Institutionalize Gender-Responsive Crisis Protocols

Participants in this study described crisis plans that made no provision for GBV prevention, reproductive health access, or women's economic protection during lockdown, a gap that directly enabled the escalation of abuse this study documents. Every emergency response plan, whether for pandemics, economic shocks, political instability, or climate events, must include explicit provisions for these protections. Crisis plans that are gender-neutral in design are gender-harmful in effect, as this study's findings demonstrate; moral leadership demands that this gap be closed before the next crisis, not during it.

Invest in Transformational Local Leadership

The governance vacuum documented in Migori County, where participants described village chiefs functioning as enforcers of lockdown compliance rather than protectors of vulnerable residents, is not inevitable. It is the product of leadership selection, training, and accountability systems that prioritize compliance over care, precisely the dynamic this study's interviews with policymakers revealed. Governments and civil society organizations must invest in the transformational and moral leadership development of community-level leaders, centering their capacity to serve the most vulnerable. Both men and women require this training to challenge the harmful patriarchal norms this study found to be entrenched at the community level and to build the inclusive leadership cultures that sustainable communities demand (Heifetz *et al*., 2009; Yukl & Mahsud, 2010).

Build and Protect Social Safety Nets for Informal Workers

The economic devastation described by the women in this study, job loss, loss of financial autonomy, and resulting economic abuse, was not inevitable; it was the predictable result of social protection systems that excluded informal workers, the same exclusion participants identified as compounding their vulnerability to violence. Financial subsidies, food vouchers, mobile cash transfers, and community-based mutual aid structures must be designed, funded, and tested before crises arrive, with particular attention to women-headed households and those in rural informal economies.

Mandate Women's Inclusion in Decision-Making at Every Level

The sixty-fifth Commission on the Status of Women's call for women's participation in policy processes must be operationalized at the community level as well as the national level. This study's own findings illustrate why: the women who lived through the Migori lockdowns possessed direct, irreplaceable knowledge of what was needed, yet were excluded from the decisions that determined what was provided. Moral leadership frameworks demand bidirectional communication between leaders and those they serve (Brown *et al*., 2005); transformational governance requires that women's voices are not merely heard but institutionally empowered to shape outcomes, closing the exact gap this study's participants described experiencing.

Protect and Expand Gender-Responsive Health Services during Crises

Reproductive healthcare, family planning, and GBV support services must be classified as essential services ring-fenced from crisis-driven reallocation. The withdrawal of free contraception services documented in this study's findings was a policy choice, one participant linked directly to cascading consequences for their autonomy, safety, and long-term socioeconomic status. Adaptive leadership requires that health systems be redesigned to absorb crisis pressure without transferring that pressure onto the most vulnerable, as this study's evidence makes clear was not the case in Migori County (Heifetz *et al*., 2009).

Address Land Rights and Agricultural Barriers as GBV Prevention

In rural communities where women's economic autonomy is constrained by barriers to land ownership, credit access, and market participation, constraints reflected in this study's findings on the economic dimensions of participants' vulnerability, economic

empowerment is inseparable from protection from violence. Structural reforms to land policy, agricultural finance, and market access must be framed and implemented as components of a comprehensive GBV prevention strategy and as moral governance imperatives in an era of climate-driven rural stress (Zuvalinyenga & Bigon, 2021).

Redesign Capacity Development as Genuine Structural Transfer, Not Donor-Dependent Programming, and Protect the Workforce that Delivers it

The collapse of community-level programs following the dismantling of USAID and the contraction of Global North development funding exposes a foundational flaw this study's findings bring into sharp relief: capacity was built into projects, not into communities. Multilateral organizations, national governments, and civil society partners must transition from program-delivery models toward architecturally transformational approaches that embed leadership, financial management, advocacy capacity, and institutional knowledge within local structures, structures that survive the departure of any external funder.

Equally critical, and directly evidenced by this study's interviews with policymakers, is the recognition that the human development workforce itself has been structurally neglected. Practitioners serving the most vulnerable, GBV coordinators, gender advisors, community health workers, field-based researchers, have been sustained on short-term contracts, inadequate institutional protections, and perpetual funding uncertainty, a precarity this study's participant themselves described experiencing. As development budgets contract, those who remain in the field face not only professional precarity, but workplace violence driven by competition over scarce resources and organizational instability. This is a moral failure that undermines the entire enterprise. No organization can sustainably protect marginalized communities while exposing its own workforce to the same precarity and harm it claims to be fighting. Moral and transformational leadership requires that development institutions build safe, stable, dignified working conditions for their people as a foundational governance commitment, not as a contingency dependent on donor generosity.

For GBV programming specifically, the findings of this study point toward sustainable transformation built on community-owned data systems, locally trained and compensated GBV response networks, women-led governance structures with genuine decision-making authority, and financing mechanisms rooted in domestic resource mobilization. Adaptive and complexity leadership frameworks offer the conceptual architecture for this transition, recognizing that sustainable change emerges from within communities, not from external intervention alone (Heifetz *et al*., 2009; Tourish, 2019). The era of donor-dependent, workforce-exploiting capacity development must end; the era of community-owned, ethically grounded, institutionally protected, and transformationally structured resilience must begin. Finally, this study's findings also expose a gap in the literature on government interventions addressing GBV reduction, social mobility, and SDG advancement simultaneously a gap that must be closed. Multi-sectoral research partnerships engaging governments, NGOs, religious organizations, and grassroots communities are needed to identify best practices, evaluate impact, and generate the evidence base that moral and transformational leaders need to act with both moral conviction and empirical grounding.

Taken together, these recommendations answer the two questions this study set out to address: they specify how the compounding crisis conditions of COVID-19 lockdowns in Migori County affected pregnant women, mothers, and GBV risk, and they translate the leadership and accountability gaps this study revealed in policy response into concrete governance commitments of moral, transformational, and adaptive leadership for protecting women and vulnerable populations in future crises.

CONCLUSION

This study documents not merely what happened to eighteen pregnant women and new mothers in rural Migori County during a global pandemic. It documents what happens to the most vulnerable members of any society when moral and transformational leadership is absent at the moment of greatest need. The lockdowns of 2020 were a crisis within a crisis, exposing the structural violence that had always existed, accelerating its harms, and removing the fragile coping mechanisms that women had constructed in the absence of institutional support. The trends revealed here are the escalation of GBV under economic stress, the collapse of protective local leadership, the withdrawal of essential health services, the silencing of women through fear and dependency, the

compounding of vulnerabilities across health, economic, and social dimensions, the dismantling of underfunded development architectures, and the abandonment of the very workforce charged with protecting the most vulnerable, are not unique to COVID-19, not unique to Kenya, and not unique to pandemics. These institutional failures are also cultural ones: toxic organisational cultures normalize immoral behavior through social conformity and loyalty, gradually overriding officers' adherence to external rules and professional standards (Lyle & Manyan, 2026), a dynamic that helps explain why crisis-response institutions in Migori County and elsewhere fail to protect the vulnerable even when formal protective policies exist on paper. They are the signature of governance systems that have not yet aligned with the moral and transformational leadership principles that justice demands and that the polycrisis era makes urgent.

The structures of human development have failed not only the communities they were built to serve but the practitioners who have devoted their professional lives to that service. When those practitioners face workplace violence, institutional instability, and professional precarity, the moral architecture of the entire development enterprise is compromised. Rebuilding that architecture on foundations of genuine community ownership, long-term institutional investment, workforce dignity, and transformational rather than transactional governance is not a programmatic adjustment. It is a civilizational reckoning. The women of Migori County did not lack resilience. They lacked the institutional, financial, political, and structural support that moral leaders are obligated to provide. Building that support before the next crisis, at every level of governance, with women's voices at the center, and with the workers who serve them protected and valued, is not merely good policy. It is a moral imperative, and the defining leadership challenge of our time.

POLICY IMPLICATIONS

The findings from Migori County carry policy relevance beyond the immediate context of COVID-19. First, they indicate that GBV protection infrastructure must be classified as essential, not auxiliary, within national and local crisis response frameworks, ensuring that shelters, health services, and protective personnel remain operational during future lockdowns or emergency restrictions rather than being deprioritized alongside other "non-essential" services. Second, the economic dimensions of GBV documented here suggest that crisis-response financial protections direct cash transfers, income continuity measures, and safety-net expansions should be designed explicitly with attention to their downstream effects on intimate partner control and economic abuse, rather than treated as gender-neutral interventions. Third, the collapse of local leadership capacity documented in this study, compounded by the organisational-culture dynamics described above, points to a need for pre-crisis investment in moral and transformational leadership development among local governance actors, so that institutional cultures of accountability are established before a crisis strikes rather than improvised during one. Finally, the precarity experienced by the development workforce itself suggests that workforce protection and institutional stability should be treated as policy preconditions for an effective GBV response, not a secondary concern.

FUTURE RESEARCH

These findings also point toward several directions for future research. Comparative studies across other Sub-Saharan African contexts, and beyond Kenya, would help establish whether the leadership, accountability, and organizational-culture gaps identified here reflect a broader regional or global pattern in crisis governance, or whether Migori County's experience reflects more localized institutional conditions. Longitudinal research tracking GBV rates, leadership responses, and institutional recovery beyond the acute crisis period would help clarify whether the gaps identified during lockdown persisted, deepened, or were addressed in the years following. Additionally, future research should examine the lived experience of the development and frontline workforce itself; the practitioners who’s own precarity this study's findings raise but do not directly investigate, as a distinct population meriting dedicated study, including how organizational culture shapes their capacity to respond ethically under institutional pressure. Finally, further work applying the integrated moral–transformational–adaptive leadership framework proposed here to other crisis contexts of climate displacement, armed conflict, and economic collapse would help test whether this framework generalizes as a model for gender-just governance across the range of conditions the polycrisis era is expected to produce.

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