Technical Guidance: Gender-Based Violence During COVID-19

PURPOSE

Preventative and response services for gender-based violence (GBV) constitute essential health services and must be safeguarded during the COVID-19 pandemic. Women and girls are particularly vulnerable in crisis situations due to pre-existing gender inequality which increases their exposure to multiple forms of GBV. Protecting their rights through GBV *risk mitigation, prevention, and response must remain a priority while balancing the importance of limiting viral spread* and protecting health workers and vulnerable populations. The guidance presented in this document is to support governments, as well as national and local GBV systems, to minimize disruption of services and continue to safely deliver high-quality care and support during the mitigation, surge, and recovery/suppression phases of the COVID-19 pandemic.[1] This guidance is meant to complement comprehensive GBV clinical guidance. Once the epidemic is contained or eliminated, programming can return to standard, evidence-based practices.

OVERVIEW

In the past 12 months, 243 million women and girls experienced sexual and/or physical violence by intimate partners[2] Times of crisis and stress invariably provoke escalations in GBV due to pre-existing gender inequality. It is expected that vulnerable populations, including women and girls, will be exposed to multiple forms of GBV during the COVID-19 pandemic. The stay-at-home orders and movement restrictions have and will continue to disrupt social and protective networks and decrease access to services.

The interruption of normal life can lead to heightened tension or stress within the household that can hinder the ability to find space or avoid volatile moments with partners, increasing exposure to violence. Early reports from countries affected by COVID-19 suggest a 30%-60% increase in domestic violence within weeks of stay-at-home guidance going into effect.[3] Further, the disruption of normal life, economic strain, and food insecurity increases the risk of sexual exploitation and abuse and may place girls in situations of child, early, and forced marriage (CEFM). Violence by non-partners may also be exacerbated, including non-partner sexual violence, forced and/or child marriage, and disrespectful or abusive sexual and reproductive health (SRH) service provision, including the risk of obstetric violence.[a]

As the COVID-19 pandemic places a strain on health and protection systems, GBV, the "shadow pandemic," must not be overlooked and must be addressed through continued access to SRH care and essential GBV services.[4] Prevention of sexual violence and respect for survivors is crucial and a priority action in the Minimum Initial Service Package (MISP) for SRH in crisis situations.

[a] Globally, low-quality sexual and reproductive health care has resulted in high prevalence of systematic dehumanization during care, emotional, sexual, or physical abuse by health workers, and denial of autonomous decision making. International guidelines and frameworks include the WHO Guidelines for Improving the Quality of Care, the White Ribbon Alliance's Respectful Maternity Care guidance, and UN statements have highlighted health system constraints and stress placed on health workers as key drivers of this form of violence against women.

We must balance the demands of responding directly to COVID-19 while maintaining the provision of essential GBV services. Identifying policy, structural, and gender-related barriers that impede provision and access to standards-based GBV services must be a priority, especially during COVID-19. It is also critical to adapt programmatic and service delivery strategies to foster and strengthen coordination with ministries of health and other local stakeholders including regional health and protection cluster leads where there is active humanitarian response coordination. Without close coordination and a multi-sectoral effort, we will not successfully protect health care workers, clients, and vulnerable populations.

GUIDING PRINCIPLES AND PRIORITIES

Maintain essential SRH services.

Shield the most vulnerable from socioeconomic shocks, especially women and girls in our communities, by supporting gender equality, resilient social/health systems and economies.

Do No Harm. As programs across the phases of the pandemic are adapted, it is imperative that interventions align with global standards and do not lead to further suffering among those we serve.

Adapt. The evolving nature of the COVID-19 pandemic requires agility and adaptability as we move from one phase to another. As much as minimum standards for services delivery are non-negotiable, adaptability is required to maintain provision of services during mitigation, surge, recovery/suppression, and stabilization.

Protect the safety and well-being of staff, health workers, and program beneficiaries.

Interrupt the virus in our communities to safeguard healthcare workers, staff, beneficiaries and the broader community.

Coordinate and collaborate with the ministry of health, local and national stakeholders, and across sectors to optimize utilization of resources and ensure an effective response and coverage of service delivery.

REQUIREMENTS AND RECOMMENDATIONS BY OUTBREAK PHASE

Requirements	Outbreak Response Phase		
	Mitigation	**Surge**	**Recovery/Suppression**
Infection prevention and control (IPC) and personal protective equipment (PPE)	Disseminate evidence-based technical guidance for preventing the transmission of COVID-19. Set up IPC **protocols** to ensure all clients are screened for COVID-19. Orient facility managers and providers on country IPC protocols. When providing clinical management of rape or other traumatic injury care, ensure that physical examination, or any procedure where the provider can't keep the physical distance (1 meter or 3.3 feet) with the suspected or confirmed COVID-19 patient is done with the recommended PPE. Allocate a specific space for the provision of clinical management of rape or care for traumatic injuries to suspected or confirmed COVID-19 patients to avoid contact with other clients. This measure will also encourage non-exposed clients who fear visiting health facilities because of the risk of being exposed to COVID-19 and therefore will not seek GBV services when face-to-face interaction with provider is required. Decontaminate the examination room as per COVID-19 IPC protocols immediately after caring for the survivor. All care including triage, case management, and counseling should be conducted with use of face masks and physical distancing.	Maintain the and visual displays in each supported health facility to manage patients and visitors flow. Ensure that physical examination where the provider can't keep the physical distance with the suspected or confirmed COVID-19 patient is done with the recommended PPE (disposable gloves, long-sleeved fluid repellent disposable gown, fluid resistant surgical mask, and disposable eye protection). Clinical procedures likely to generate aerosol/respiratory spray (mouth swabs, oral examination, breath assessment in the case of thoracic injury, etc.) warrant the use of N95 and face shields. Allocate a specific space for the provision of clinical management of rape or care for traumatic injuries to suspected or confirmed COVID-19 patients to avoid contact with other clients. This measure will also encourage non-exposed clients who fear to visit health facilities because of the risk of being exposed to COVID-19 to seek GBV services when face-to-face interaction with provider is required. Conduct all other care including triage and counseling with use of face masks and physical distancing. Maintain physical distance (a minimum of 1 meter) from other persons (as much as possible). Limit # of individuals in any one service provision space. Decontaminate the procedure room as per WHO protocols or national protocols in the context of COVID-19 immediately after providing services to a survivor.	Maintain IPC measures as for surge including triage system.

Requirements	Outbreak Response Phase		
	Mitigation	**Surge**	**Recovery/Suppression**
Integrated response services	Maintain comprehensive services; continue to utilize One Stop centers or other centralized response sites to minimize # of locations a survivor must go to. Plan for disruptions to supply chain and order additional local stock of essential commodities (e.g. PPE, EC, PEP, Tetanus Toxoid vaccine). Institute counseling on COVID-19 prevention and how to access services during surge measures into SOPs for all facility levels. Inform and alert all service providers about the heightened risk of domestic violence related to the prevention and control measures associated with the outbreak. Identify safe houses, shelters or social service referrals for individuals at risk of or facing violence during quarantine periods. Provide information about changes made to services (e.g. locations, opening hours, contact details).	Provide information about changes made to services (e.g., locations, opening hours, contact details). Maintain essential services; continue to utilize One Stop centers or other centralized response sites to minimize # of locations a survivor must go to. Maintain exterior triage space that confers visual privacy for survivors at service sites to enable COVID-19 screening and testing into SOPs. Maintain segregated visit rooms. Strive for at least one dedicated room for those clients determined to have exposure or symptoms of COVID.	Static GBV response services should anticipate surge in client volume as survivors regain ability to leave their homes. Maintain elevated staffing levels for initial weeks following local declaration of containment of community-transmission.
Psychological first aid	Enhance responses to survivors and provide support for their needs, including for mental health and psychological support. All health workers, particularly SRH service providers and CHWs should receive orientation and virtual training on responding to disclosures of violence and provision of psychological first aid. Psychological first aid orientation and virtual training should also be provided to other community agents such as women's groups and TBAs relationships.	Wear a face mask and maintain physical distancing from the survivor, when possible. Explain why it is necessary to take these precautions and use words where body language is hindered to establish a rapport with the survivor. Use of gloves and advanced IPC protocols can enable compassion displays such as offering a survivor your hands to hold. Balance standard physical distancing guidance with assessment of the individual client's mental state. Verbal and self-guided techniques are critical (e.g., *I'm sorry I can't sit closer to you and you can't see my mouth, but I'm here to help. You deserve to be safe. Ask questions whenever you need).*	Maintain routine training on psychological first aid and standard operating procedures for responding to disclosures of violence. This is always a critical function for the health sector.

Requirements	Outbreak Response Phase		
	Mitigation	**Surge**	**Recovery/Suppression**
Community-based services	Maintain community-based home and protection services. Identify and orient/train CHWs and other home visiting workers on community engagement during COVID-19 and IPC measures. Equip CHWs and other home visiting workers with PPE and sanitation items. Encourage CHWs and other home visiting workers to establish a 'safe word' protocol with clients that could be used during COVID screen in the event a client perceives themselves to be in acute danger. These safe words should not be widely shared on social media or otherwise publicized. Non-verbal alert systems can also be established for high-risk clients. See UNICEF brief under additional resources for more detail. Consider establishing 'community safe sites' at essential service locations that will remain open (e.g. pharmacies). Workers at these sites will need orientation on what to do if a community member arrives needing services.	Follow local governance order when determining if 1:1 visits can continue. Advocate for GBV-related home visits to retain classification as essential service. Strive to conduct home visits outside to improve privacy and reduce transmission risk. Ensure CHWs are given with masks and hand cleaning supplies (see technical IPC guidance for additional information and procurement resources). Institute phone ahead screening for symptoms (e.g., coughing/sneezing/fever). Establish phone connections between community safe sites and first line GBV response (police and/or health responder) to enable rapid response if a survivor needs urgent protection and help. Police help desks should only be used in contexts where prior work with judicial services on survivor-centered response has taken place. Ensure services and information hubs that alert survivors to protection services include information on availability of pharmacies as safe site to go following or if in fear of violence.	Revert to routine community-based services as soon as possible based on local/national outbreak details.

ENDNOTES

[1] **Mitigation:** Coronavirus case clusters or community transmission are confirmed/presumed. Non-pharmaceutical interventions (and vaccines or drugs, if available) are used to "flatten the curve" to reduce the health impact of an epidemic but are not interrupting transmission completely. . Ferguson Neil M et al. "Impact of non-pharmaceutical interventions (NPIs) to reduce COVID19 mortality and healthcare demand." Imperial College of London. https://doi.org/10.25561/77482

Surge: As soon as the number of confirmed or presumed COVID-19 cases requiring care approaches the healthcare system's capacity to provide care (i.e. the ability to maintain essential services is severely stressed or impossible, the capacity of intensive care unit beds is surpassed).

Suppression: Coronavirus transmission is reduced, a peak period of transmission/hospitalization/deaths has passed, and the country is moving towards containment. The health system can respond to COVID-19 cases as well as maintain essential services and certain non-essential services. This will be a protracted phase with a step-wise. Ferguson Neil M et al. "Impact of non-pharmaceutical interventions (NPIs) to reduce COVID19 mortality and healthcare demand." Imperial College of London. https://doi.org/10.25561/77482

Stabilization: Coronavirus is eliminated or contained through herd immunity and/or broad vaccine coverage. Health system strengthens, including planning for future shocks.

[2] UN Women. "The Shadow Pandemic: Violence Against Women and Girls and COVID-19." https://www.unwomen.org/-/media/headquarters/attachments/sections/library/publications/2020/issue-brief-covid-19-and-ending-violence-against-women-and-girls-infographic-en.pdf?la=en&vs=5348

[3] Loi Almeron. "Domestic violence cases escalating quicker in time of COVID-19." Mission Local. March 27, 2020, https://missionlocal.org/2020/03/for-victims-of-domestic-violence-sheltering-in-place-can-mean-more-abuse/; Euronews. Domestic violence cases jump 30% during lockdown in France. March 28, 2020, https://www.euronews.com/2020/03/28/domestic-violence-cases-jump-30-during-lockdown-in-france; Amanda Taub. A New Covid-19 Crisis: Domestic Abuse Rises Worldwide. April 6, 2020, https://www.nytimes.com/2020/04/06/world/coronavirus-domestic-violence.html; Girls Not Brides. Taking action to address child marriage: the role of different sectors, https://www.girlsnotbrides.org/wp-content/uploads/2016/03/6.-Addressing-child-marriage-Food-Security-and-Nutrition.pdf

[4] CARE. "Gender-Based Violence and COVID-19: The Complexities of Responding to "the Shadow Pandemic." May 2020, https://reliefweb.int/sites/reliefweb.int/files/resources/GBV_and_COVID_Policy_Brief_FINAL.pdf.

ADDITIONAL RESOURCES

Guidance on GBV Case Management in the Face of COVID-19, Robyn Yaker and Dorcas Erskine

Issue Brief on COVID-19 and Ending Violence Against Women and Girls, UN Women

Safety Planning during COVID-19, UNICEF

A Pocket Guide to Supporting Survivors of VAWG in the absence of a GBV specialist, IASC

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