



EAST AND SOUTHERN AFRICA

Gender-Based Violence and COVID-19 Actions, Gaps and the Way Forward



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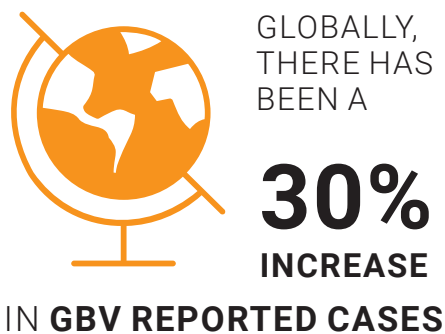




DO GENDER-BASED VIOLENCE NUMBERS MATTER?

We know that gender-based violence (GBV), sexual exploitation and abuse increase in times of crisis and fragility. Humanitarian and health crises disproportionately impact women and girls.

Emerging data on gender-based violence (GBV) and COVID-19 show a sharp increase in violence against women and girls (VAWG). Globally, there has been a **30 per cent increase in reported cases of GBV**. However, evidence suggests that in some contexts, fewer cases are reported than occur. These numbers need to be interpreted with caution as they may be the result of a combination of issues that



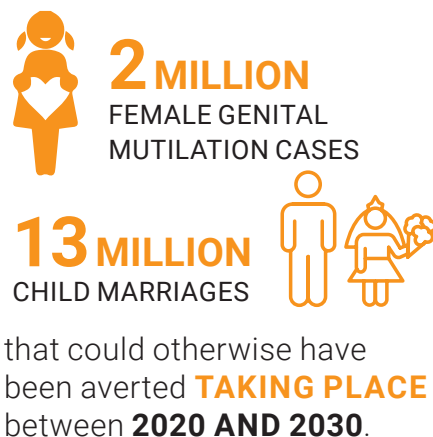
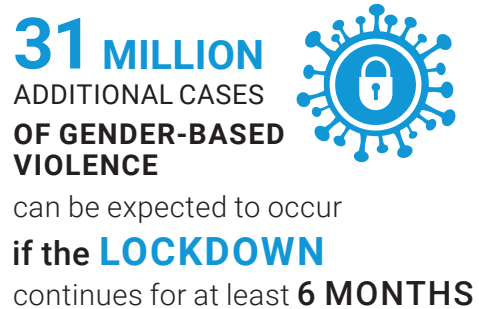
include: girls and women stuck at home with their perpetrator and unable to reach out for help; girls and women who may not have their own phones or Internet access; and girls and women who may not be able to find a private space to speak/ask for help openly.

UNFPA's latest projections indicate that:

31 million additional cases of gender-based violence can be expected to occur **if the lockdown continues for at least 6 months**. For **every 3 months the lockdown continues**, an additional **15 million extra cases** of gender-based violence are expected.

Due to the disruption of programmes to **prevent female genital mutilation (FGM)**, in response to COVID-19, **2 million FGM cases** that could have been averted, may occur **over the next decade**. **COVID-19 will disrupt efforts to end child marriage**, potentially resulting in an additional **13 million child marriages taking place between 2020 and 2030**.

The pandemic has also seen a shift in reporting from the use of hotlines to WhatsApp/ChatBox, Skype, and other social media platform. As a result, there has been under-reporting but also a surge in new reporting methods for GBV cases during the lockdown period.



A SHIFT IN
REPORTING MECHANISMS
FOR GBV CASES
from **HOTLINES** to
different **SOCIAL**
MEDIA apps such as
WHATSAPP, SKYPE
AND CHATBOX.



SNAPSHOT OF COVID-19 AND GBV DATA

The information below was gathered in **April and May 2020** through a country snapshot analysis for **East and Southern Africa by UNFPA**.

1 DEMOCRATIC REPUBLIC OF THE CONGO (DRC)

Sharp **INCREASE IN CHILD MARRIAGE CASES** from **11-15%** (Kasai Central) **4-28%** (Kasai) between **January and March**.

3 UGANDA

The Uganda National Child Helpline reported over 256 **GBV/VAC (VIOLENCE AGAINST CHILDREN) CASES** in the span of two weeks during **March**. These were received as phone calls made to the Helpline.

2 KENYA

From **January to February**, Shining Hope for Community (SHOFCO) registered an **AVERAGE OF 150 GBV/CHILD PROTECTION CASES** across four sites. In **March**, **355 CASES** were handled across all four sites.

4 ZAMBIA

Data from call centres show a sharp increase of VAC and VAWG (Violence Against Women and Girls) through March and April. There was a **27% INCREASE** in cases of **VIOLENCE AGAINST GIRLS** and a **38% INCREASE** in cases of **VIOLENCE AGAINST WOMEN**.

5 ZIMBABWE

An **INCREASE OF OVER 90%** in **GBV CALLS** was recorded by the Zimbabwe National GBV Hotline **since the beginning of the lockdown, from March 30 to May 5**.



HOW GBV SERVICES HAVE BEEN PRIORITIZED BY GOVERNMENTS IN THEIR COVID-19 RESPONSE AND RECOVERY PLANS

The UNFPA Global Response Plan on COVID-19 identifies addressing gender-based violence and harmful practices as one of the three strategic priorities for UNFPA. The Plan states that UNFPA is ensuring the continuity of lifesaving, multi-sectoral services for survivors of GBV and the most at-risk women and girls. UNFPA is helping to ensure a flexible and adaptive approach in the current context of movement restrictions, confinement, connection failures and closure of service points, to ensure that life-saving services continue to be made available without compromising the safety of GBV caseworkers or survivors.¹

At the onset of COVID-19 in the East and Southern Africa (ESA) region, UNFPA carried out a snapshot analysis throughout April and May 2020, which indicated that the majority of countries have a National COVID-19 Response Plan and/or a COVID-19 Task Force in place. It also shows that only 13 out of 23 ESA countries have recognized GBV services as an essential part of their COVID-19 Response Plan, although recognition is a critical step towards ensuring the continuity of those services.

SNAPSHOT OF UNFPA RESPONSE TO GBV IN THE COVID-19 PANDEMIC IN EAST AND SOUTHERN AFRICA



Use of information and communication technologies (ICTs) (e.g. TV, community radio, social media, and phone) to disseminate COVID-19 and GBV prevention messages.

Community outreach through community-based protection mechanisms such as the establishment of GBV brigades to provide information about GBV referral pathways; also, provision of psycho-social first aid to women and girls who are survivors of, or at risk of, GBV (Mozambique, Lesotho, Uganda and Madagascar).

Community outreach through World Food Programme (WFP) distribution channels to share information on COVID-19, sexual and reproductive health, and GBV – as well as contact details for social workers providing psycho-social support (Namibia).



Strengthening, setting up and scaling up of GBV hotlines for survivors and GBV frontline workers. This includes the provision of psychological support and GBV case management. Almost all countries noted that helplines and/or hotlines are available. In many countries these helplines are run by civil society organizations, often with the support of the state and/or UNFPA and other UN agencies, while for a few countries these services are provided directly by the

¹ https://www.unfpa.org/sites/default/files/resource-pdf/UNFPA_Global_Response_Plan_Revised_June_2020_.pdf

State. For instance, UNFPA has been setting up, scaling up and strengthening toll-free hotline services (phone, SMS, apps) to provide GBV case management and psycho-social support for women and girls and GBV frontline responders, including for men and boys in Burundi, Democratic Republic of the Congo, Mozambique, Zimbabwe, Rwanda and Namibia. These hotline services, in addition to providing a space to report violence, are in some cases providing psycho-social first aid, counselling and legal aid for survivors of violence.

Strengthening and/or setting up of shelters and transit centres for women and girls who are survivors of, or at risk of, GBV and identifying alternative shelters where necessary.

Setting up a GBV mobile response through the deployment of GBV and SRHR mobile clinics and mobile One-Stop Centres to reach women and girls in out-of-reach communities. The mobile One-Stop Centres provide a multisectoral response to GBV via frontline service providers from the health, police, justice, and social sectors.

Distribution of COVID-19 adapted Dignity Kits that include (depending on the context) phone, data leaflets, phone credit, sanitizers, chamber pots, pads, soaps, and more.

Distribution of Dignity Kits to vulnerable girls and women during lockdown movement restrictions, through partnership with the World Food Programme (WFP).



Online training workshops on GBV case management for health workers, GBV social workers and case managers, police officers, hotline responders, and GBV frontline workers at a community level.

Capacity building of frontline health workers on psycho-social first aid, including **mental health and psycho-social support training tools** for midwives and other health staff.

Capacity building in the provision of remote legal services, including justice services, to ensure access for survivors.

Sensitization and capacity building for the security sectors on human rights, protection, GBV and the abuse of authority.

Development of guidelines and practical tools for service providers (including frontline workers, shelters, and one-stop crisis centres) to support them in managing **GBV remote support services**.



YOUTH ENGAGEMENT

UNFPA's Global Response Plan identifies youth engagement as one of the four accelerators to advance our response in the COVID-19 context. UNFPA recognizes that young people are critical partners in responding effectively to the pandemic and its various impacts.

Across the region, UNFPA is partnering with other UN agencies, civil society organizations (CSOs), and youth and women's networks to ensure continuity of GBV services in lockdown contexts. Young people – particularly adolescent girls – are often survivors of GBV and their vulnerability has increased as a result of COVID-19. Our COs are working with

their youth networks to reach out to the most vulnerable young girls. They are doing this through the following means:

- UNFPA is partnering with young people, governments and other allies to create videos, TV messages and radio spots for youth on **COVID-19 prevention**, as well as response messages for pregnant women and other young people on **GBV prevention**.
- UNFPA country offices are supporting the strengthening and scaling up of **child and adolescent-specific hotlines**, which are in some cases run by youth networks.
- UNFPA is working with youth networks to monitor **GBV cases** in their communities and among their peers to offer help and provide referral information.
- At the regional and national levels, UNFPA has been designing webinars and virtual regional consultations with young people to discuss GBV, exchanging information about young people's response to GBV in their communities and working with UNFPA and other partners to ensure the continuity of **SRH and GBV services** targeted at youth.



ADVOCACY AND COORDINATION

At the country level, UNFPA has supported advocacy efforts to ensure the continuity of **SRHR and GBV services** through the recognition of GBV services as essential services in national COVID-19 response and recovery plans.

Under the Inter-Agency Standing Committee structure, **GBV sub-clusters** have been set up in a limited number of countries responding to several complex humanitarian crises. Among those countries, UNFPA leads the

sub-cluster on GBV in six ESA countries² and as such, coordinates the GBV response in the COVID-19 context.

At the UN Country Team level, in 14 ESA countries UNFPA is co-leading the gender/human rights thematic group.

In 16 out of 23 countries in ESA countries, UNFPA is supporting the national gender coordination mechanism.

WHAT ARE THE GAPS IN GBV PREVENTION AND RESPONSE?

Limited availability of shelters and safe spaces for women and girls. The COVID-19 pandemic has exacerbated the scarcity of shelters and safe spaces for women and girl survivors of, or at risk of, GBV. Despite shelters being available in most countries before COVID-19 struck, almost all of these were under-resourced and had limited capacity. Shelters and crisis centres are not equipped to meet the needs of GBV survivors, especially those living with disabilities. Now, with the pandemic and the spike in cases of violence, almost all shelters are full and overstretched. In a number of countries, it is hard for survivors to access shelters due to movement restrictions. In some countries where GBV services have not been recognized as essential, shelters have been closed.

Communication mechanisms for girls and women to reach out for help may have limited coverage or accessibility. For example, hotline services may not cover the entire country while other forms of communication support, such as Skype, WhatsApp, and Messenger often require Internet access and connectivity. In

² Burundi, Zimbabwe, Mozambique, DRC, South Sudan, Ethiopia (although, there it is a joint sub-cluster with CP, who also have a Coordinator). These are the "official" cluster countries.

several contexts, hotline services do not always cover the whole country. These hotlines also depend on women and girls having access to telephones or a private space in which they can speak, which is often not the case.

Lack of clear guidance or exemptions in the “stay at home” policy. Even where these exemptions exist, lack of information, fear of infection and/or ‘punishment’ for violating the lockdown measures, mean that most women stay at home with their abusers. Staying at home creates a greater risk for women and girls and it does not allow them to seek help. This can be due to a lack of access to a telephone or to a private space where they can make calls.

Negative impact on women’s access to justice, since the courts have been closed or operate at reduced hours. As a result, there are limited hearings and considerable delays in processing cases. Moreover, while some courts are operating at reduced capacity, in many countries, domestic violence cases are not prioritized by the courts. While most countries noted that **protection orders are available, accessibility is a challenge.** The closing of courts and other legal services in some countries has often resulted in protection orders being delayed.

Major disruption of sexual and reproductive health services, with these services taking a “back seat” and often considered “non-essential” for countries to prioritize. As a result, sexual and reproductive health professionals (e.g. midwives) have been redirected to support COVID-19 health efforts or have not been prioritized in the distribution of Personal Protective Equipment (PPE) required for them to operate effectively. A further concern noted that **restrictive travel protocols** have made it hard for pregnant women to access health services.

Family planning services provided by civil society are restricted to operate during certain times, hindering access to vulnerable groups such as sex workers and survivors of domestic violence.

Global supply chains for commodities have also been impacted, putting at risk the availability and accessibility of contraceptives. Women and girls living in remote areas or in refugee/IDP camps are particularly impacted by these restrictions.

Lack of trained GBV personnel on the ground. The response shows a lack of trained personnel offering psychological aid to survivors, as well as a lack of existing guidelines, protocols, and resources on how to act in emergency situations such as the COVID-19 pandemic.

Lack of inclusion of key experts on GBV prevention and response in national COVID-19 task forces, who can make sure GBV is mainstreamed in the different sectoral responses.

Limited participation of women and girls in COVID-19 decision-making processes.

Data collection on GBV has proved to be challenging. In several countries it has been difficult to collect updated and accurate information on GBV in the COVID-19 context. In other cases, data was available but not disaggregated by age or other key factors (e.g. disability, location, etc.).

Mental health concerns have grown considerably since COVID-19 started. For girls and women, the impact on mental health has been significant and compounded by the violence they face, as well as other factors related to COVID-19 and its mitigation measures. Psycho-social support needs to be an integral part of responses to GBV, but this is often not the case.

RECOMMENDATIONS FOR IMMEDIATE ACTION

1. **Ensure the recognition of GBV services as essential under COVID-19 national responses.** This is a critical step to ensure the continuity and expansion of GBV services such as shelters, which can be lifesaving in the circumstances. Accordingly, adequate resources should be allocated to ensure the continuity and availability of these services.
2. **Update and strengthen GBV referral pathways.**
3. **(a) Ensure that the COVID-19 national response and recovery plans are gender responsive.** It is critical to strengthen and ensure women's leadership in COVID-19 decision-making processes, solutions and recovery efforts. This includes the provision of information and the creation of platforms to share experiences on COVID-19 prevention and response strategies and messages. The needs and demands of women and girls affected by the pandemic must inform COVID-19 national response and recovery efforts.
(b) Ensure that COVID-19 national response and recovery plans are inclusive. It is critical to promote an inclusive COVID-19 response that addresses the needs and demands of women and girls who are left behind and are disproportionately affected by the pandemic on both health and socio-economic levels. Women and girls with disabilities; those living in remote areas; women from indigenous, nomadic, refugee and internally displaced populations; and women who are illiterate are disproportionately affected by the pandemic and GBV.

4. **Ensure that high-quality technical support is available** on gender and GBV mainstreaming in COVID-19 response and recovery plans.
5. **Strengthen partnerships with young people** to effectively combat GBV in the current context among their peers and within their own communities.

LONG-TERM ACTION

6. **Ensure that social protection mechanisms and economic stimulus packages properly respond to the needs and demands of women and girls.** It is important that governments and partners invest in social protection packages that target assistance to vulnerable women and girls, including those in the informal sector, female front-line health workers, as well as girls and women with disabilities.
7. **Ensure integration of mental health and psycho-social support** within GBV prevention and response mechanisms.
8. **Strengthen and maintain partnerships with young people** to work with them in addressing GBV among their friends/peers and within their own communities.
9. **Work with communities to challenge harmful practices** and address GBV in the COVID-19 context.
10. **Leave no one behind** – reach out to the most vulnerable girls and women (those living with disabilities, in out-of-reach settlements, etc.)



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