

# Barriers to Gender Based Violence (GBV) health services in humanitarian settings during COVID-19

A desk review from  
Cox's Bazar (Bangladesh), Iraq, &  
Northeast Nigeria



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Dr. Krista Bywater from the READY Initiative for conducting the desk review.

Key members of the peer group contributing to the overall development of this work: Dr. Henia Dakkak (UNFPA); Dr. Egmond Evers (Health Sector, Cox Bazar, Bangladesh); Donatella Massai (READY Initiative); Dr. Kamal Olleri (Health Cluster, Iraq); Dr. Rana Mohammed (WHO Iraq); Anna Rita Ronzoni (Eastern Mediterranean Regional Office, WHO); Dr. Eba Pasha (Global Health Cluster); Muhammad Shafiq (Health Cluster, Nigeria); Saba Zariv (Global Health Cluster)

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# Overview

## Scope

This desk review summarizes the impact of the COVID-19 pandemic on gender-based violence (GBV) health-related services in Bangladesh (Cox's Bazar), Iraq, and Northeastern Nigeria. Given the focus on GBV health-related services in humanitarian settings, a review of broader COVID-19 national country plans is not included. Literature and evidence published between March 2020 and May 2021 inform the summary.

## Problem Statement

Gender-based violence, especially intimate partner violence against women and girls, has increased at alarming rates since the start of the COVID-19 pandemic.<sup>2, 3, 16, 22</sup> In addition to pre-existing gender and power inequalities, the lack of gender-responsive COVID-19 measures has exacerbated the risk of GBV.<sup>1, 7</sup> New drivers of GBV during the pandemic include:

- Government restrictions and quarantine measures, which further limit the mobility of women and children resulting in increased exposure and proximity to abusers.<sup>2</sup> Perpetrators, who are predominantly men, can use curfews and lockdowns to exert further control over all aspects of intimate partners and household members' lives.<sup>16</sup>
  - According to UNFPA estimates, every 3 months of lockdown contributes to an additional 15 million cases of GBV worldwide.<sup>25</sup>
- Redirection of funding to the COVID-19 response leading to the reduction or suspension of GBV response and prevention programming.<sup>14</sup>
- Loss of livelihoods and economic stressors that can exacerbate the risk of household conflict and violence perpetrated against women and children by men, particularly in domestic settings.<sup>2, 14, 15, 22, 24, 31</sup> Economic loss can also heighten the vulnerability of women and girls to various forms of GBV, such as child, early, and forced marriage and sexual exploitation and abuse.
- The lack of gender-responsive COVID-19 health measures can increase the risk of GBV for women and girls. For example, the lack of gender-separated facilities, lack of female staff, and harassment of workers and patients at vaccination sites may compromise the safety of health service environments and deter health service utilization and disclosure of abuse.<sup>12, 21</sup>

- Increased presence of armed security actors (e.g. police, military, militia) to enforce lockdowns and mobility restrictions may require that a survivor disclose to these actors in order to gain access to other services.<sup>20</sup> An increase in the number of security actors may also increase the risk of abuses of power leading to perpetration of GBV. These actors often lack GBV training and expertise to provide appropriate care including referrals.<sup>29</sup>

The dramatic increase in rates of GBV during the pandemic was not inevitable. Gender-responsive COVID-19 preparedness and response is necessary to identify GBV risks and to design and adapt programming to prevent, mitigate, and appropriately respond to GBV cases.

## Impact of COVID-19 on GBV Health Services

- The pandemic has placed an immense burden on national health systems. Many governments and humanitarian actors prioritized the COVID-19 response over GBV-related health service provision and failed to integrate GBV risk mitigation measures into emergency response plans.
  - A severe lack of funding continues to hamper the humanitarian response efforts. The Global Humanitarian Response Plan only included US \$50 million (out of a total budget of US \$2.01 billion)<sup>27</sup> for delivery of GBV programs in 16 of 63 countries that were prioritized for COVID-19 humanitarian assistance.<sup>3</sup>
- GBV funding, health care provision, and providers have been redirected to address COVID-19. Many other GBV programs and services have reduced hours, limited staff, or have been suspended.<sup>29</sup> For example, GBV case management, including existing reporting mechanisms and referral pathways, have been disrupted, reducing GBV survivors access to vital services such as sexual and reproductive health (SRH) services and psychosocial support (PSS).
- Many organizations have pivoted to virtual service provision to continue support. This change has left many women and girls in humanitarian settings—who have little or no access to technology—with limited or no access to GBV health services.<sup>7</sup> Even where remote case management has been useful in providing individual psychosocial support, a decrease in the use of other GBV health services remains a persist issue.<sup>16</sup>
- GBV health services lack trained staff, as providers face problems traveling to facilities because of mobility restrictions. Additionally, health providers are often concerned about contracting COVID-19 and spreading it to their families due to the lack of personal protective equipment (PPE).<sup>20, 29, 33</sup> Female health workers, who comprise 70% of the global healthcare workforce, also face safety and security vulnerabilities including poor working conditions, isolation, stigma, stress, workplace violence, and GBV at home and en route to service delivery points.<sup>33</sup>

## Common Barriers to GBV Health Services

COVID-19 has exacerbated pre-existing obstacles to GBV health services and raised new hurdles for GBV survivors that limit and prevent their access and use of services.

- Survivor-side barriers include:
  - Lack of: transportation to service delivery points, money/resources to access providers in-person and remotely, accurate information about GBV services, and technology to access service information<sup>1, 2, 7</sup>
  - Limited mobility due to movement restrictions and quarantine measures often make it difficult to reach in-person services<sup>15, 16, 29</sup>
  - Concerns about the risks of contracting COVID-19 at health and GBV service points can also deter survivors from seeking service<sup>15, 16, 29</sup>
- Provider-side barriers include:
  - Lack of: funding,<sup>2, 3</sup> trained providers and frontline workers,<sup>2</sup> PPE, mental health and psychosocial support (MHPSS), mobility, sexual and reproductive health supplies and commodities, and infrastructure and operational procedures to support remote service provision<sup>10</sup>

## Humanitarian GBV Response and Adaptations

At the beginning of the COVID-19 pandemic, organizations and consortiums such as the World Health Organization (WHO),<sup>31</sup> the United Nations High Commissioner for Refugees (UNHCR),<sup>27</sup> and the Global Protection Cluster<sup>11</sup> recommended adaptations for GBV service providers including:

- Context-specific risk assessments to identify what essential GBV services should be maintained and how and where these services can be delivered<sup>11</sup>
- Updated referral pathways for locally available services such as psychosocial support, protection services, hotlines, and shelters<sup>11</sup>
- Adaptation to the mode of service delivery. For example, the use or scale up of remote services, telemedicine, outreach, and group interventions where necessary.<sup>11,31</sup> Remote service provision typically enables emotional support and case management through phone hotlines, chats, and internet based services.<sup>7</sup>
  - For example, at ABAAD in Lebanon, case management activities for low- and medium-risk groups were conducted over the phone. For high-risk cases, consultations remained face-to-face.<sup>5</sup>
- In-person service points (with infection control provisions) targeted to women and girls who lack connectivity to mobile phones and the internet<sup>2</sup>
- Inclusion of an “alert object” in dignity kits that women and girls receive. If they need services, women and girls can wear the object to signal the need for support<sup>7</sup>
- Dissemination of code words for survivors to use at regularly frequented locations, such as pharmacies, so women and girls can discretely seek GBV help and services<sup>2</sup>

# Cox's Bazar, Bangladesh

## Context

In Cox's Bazar, reported incidents of GBV among Rohingya refugees, particularly physical assault perpetrated by an intimate partner, have increased since the start of the pandemic. GBV reports spiked in April 2020, the first month after the lockdown<sup>14, 17</sup> and in September 2020, one month after the resumption of GBV prevention activities.<sup>17</sup> Quarantine restrictions overlap with the initial increase in GBV reports and correspond with the resumption of GBV services in September 2020, which enabled women and girls to resume reporting incidents.

The Government of Bangladesh initially suspended GBV prevention activities deeming them non-essential to prevent the spread of COVID-19. Suspended programs, which were adapted for the Rohingya response prior to COVID-19, include Girl Shine, SASA by Raising Voices, and IRC's Engaging Men through Accountable Practices (EMAP).<sup>15</sup> Fortunately, the Ministry of Health has added the clinical management of rape and intimate partner violence (IPV) to its list of essential primary health services.

Despite growing need for GBV response, funding for GBV services in Cox's Bazar has declined since the beginning of the pandemic with only 16.8% of GBV funding and 50.8% of protection funding requirements met.<sup>14</sup> Reductions in funding, resources, and services, along with COVID-19 restrictions, resulted in:

- Decreased humanitarian presence
  - In camps, the decreased presence of protection partners reduced the Rohingya communities' trust of and outreach to protection actors.<sup>2</sup>
- Lack of GBV programming, including lack of male engagement in GBV prevention and sensitization activities<sup>14</sup>
- Closure of community facilities, including learning centres and safe spaces<sup>14</sup> that are often places where women and girls can seek GBV information, case management, and services
- Limited access to livelihoods, vocational training, and mediation and legal services.<sup>2</sup> These changes exacerbated barriers such as the lack of money for transportation and treatment, which can restrict women and girls from seeking GBV services.

## Context-specific Barriers to GBV Health Services

- Misinformation about COVID-19 screenings being required to access GBV health services and rumors that survivors accessing services will be placed under quarantine<sup>15</sup>
- Concerns associated with being identified as having or being exposed to COVID-19 when seeking GBV services at health facilities<sup>15</sup>
- The closure of GBV gender-responsive facilities, such as Women Friendly Spaces or Multipurpose Centres offering GBV-SRH integrated services, which are also the preferred choices for women and girls at risk or survivors of GBV and where health workers (i.e. midwives can inform survivors about available GBV services and referrals)
- The closure of MHPSS services where not integrated into a health post or primary health centre, reduced another avenue for access to GBV services

## Humanitarian GBV Response & Adaptations

Service providers continued to work despite funding cuts and to use remote service provision when possible.<sup>15</sup> In order to continue to provide services:

- Community volunteers have been trained to fill gaps in delivery.<sup>17</sup>
- Gender training and Protection Mainstreaming training has been rolled out for frontline health workers and program managers.<sup>17</sup>
- Providers have continued to engage with women community leaders as well as LGBTI rights organizations and working groups (i.e. Age and Disability Working Group) or networks to reach GBV survivors on the basis of sex, sexual orientation or gender identity, as well as disability status.<sup>15</sup>
- Referral pathways to survivor services have been updated and enhanced to improve efficiency.<sup>15</sup>
- The Health Sector translated the guideline *Clinical Management of Rape and Intimate Partner Violence Survivors* (CMRIPV) into Bangla to enhance their usage by frontline health providers.
- The Health Sector strengthened cooperation and coordination between its SRH Working Group and the GBV Sub-sector to ensure GBV service continuity even as GBV case management and psychosocial support services faced access restrictions.



# Iraq

## Context

Areas with adequate GBV services at the beginning of the pandemic, such as Ninewa governorate, faced risks of funding shortages near the end of 2020. Areas with no or minimal GBV services, primarily Al-Najaf, Babil, Baghdad, and Karbala governorates, were among those most affected by COVID-19 and remain in need of prioritization for service scale-up.<sup>9</sup>

The Iraq GBV Sub-cluster conducted an online survey in 11 governorates (Al-Anbar, Al-Sulaymaniyah, Babil, Baghdad, Diyala, Duhok, Erbil, Kirkuk, Ninewa, Salah Al-Din, Thi Qar) between April and May 2020 to examine GBV service utilization during the pandemic. A total of 36 GBV partners including 23 national NGOs and 13 INGOs participated in the assessment. They shared information on 109 GBV service provision points (including 92 static centers and 17 GBV mobile teams) in April-May 2020. Sixty-five percent of the service provision points had an increase in the reported cases of GBV. Among those reporting an increase, 94% observed an increase in disclosures of intimate partner and family member violence. Respondents indicated that female-headed households, adolescent girls, under-age mothers, and families perceived to be affiliated with extremist groups were the groups most at risk of experiencing GBV.<sup>9</sup>

While reported GBV incidents increased during the initial months of the pandemic in Iraq, there was an overall reduction in GBV response services. Prior to the pandemic, some government health facilities lacked preparedness to provide adequate clinical care to survivors of GBV, particularly survivors of rape. As compared to humanitarian programming targets, GBV case management services decreased by 50%, psychosocial support decreased by 60%, and awareness raising activities decreased by 50% in March and April 2020. The service points included in the study also reported delays in referrals and the distribution of dignity kits.<sup>9</sup>

## Context-specific Barriers to GBV Health Services

- GBV service providers face movement restrictions and in many cases must obtain government approval to continue to function.<sup>26</sup>
  - Approximately 87% of respondents reported experiencing government imposed movement restrictions. These requirements reportedly resulted in an inability to identify new cases and delays referrals to other services. Half of the providers surveyed reported needing government access letters to operate.<sup>9</sup>
- Suspension of services provided by Family Protection Units<sup>9</sup>
- Lack of protocols and training on remote service provision: Service providers have reported not knowing when to call GBV survivors without exposing the survivor and risking their safety.<sup>9</sup>

## Humanitarian GBV Response and Adaptations

- In collaboration with Iraq's Health and Protection Clusters, providers have channeled resources into: <sup>26</sup>
  - Remote case management
  - Individual psychosocial support
  - Dignity kit distribution
  - Training sessions conducted by WHO on the GBV handbook, GBV-related issues during COVID-19, prevention, and addressing social stigma associated with COVID-19.<sup>16</sup>
  - GBV, mental health, and psychosocial support messages in health and COVID-19 prevention activities. For example:
    - Dary NGO integrated GBV services into their mental health and psychosocial support programs in the Ibn Sina Mental Health Center in Mosul.<sup>26</sup>
    - In Anbar, UNFPA supported reproductive health facilities to develop service information materials for GBV survivors seeking psychosocial support and other services accessible at women's centres and other points of care.<sup>16,26</sup>
- With WHO technical support, the Iraq Health Cluster created a face-to-face and remote GBV counseling flowchart for primary healthcare workers that clarifies management methods and referral pathways.<sup>16</sup>
- WHO Iraq trained frontline staff from the Ministry of Interior and Ministry of Defense on GBV and psychological first aid. As these workers enforce movement restrictions, they are often survivors' first point of contact and are a key source of GBV referrals.<sup>16</sup>
- Seventy-four service provision points reported having hotlines during the lockdown, and almost half operate 24 hours a day, seven days a week. The hotlines and other GBV activities are promoted on social media platforms such as Facebook and YouTube.<sup>26</sup>
- GBV service providers participating in the GBV Sub-Cluster Rapid Assessment reported 16% have continued to offer in-person services, 34% have shifted to remote service provision, and 43% are applying a mixed approach to adapt to COVID-19 health and safety regulations.<sup>26</sup>

# North East Nigeria

## Context

Preliminary data from 24 states in Nigeria indicates that during the initial two weeks of lockdown, reported GBV incidents increased by 56%. GBV cases rose from 346 in March 2020 to 794 in early April 2020. Research from UN Women indicates that GBV incidents included the rape of children by relatives and tenant–landlord assaults, which in some cases resulted in murder.<sup>29</sup> The Alliance for Africa in Nigeria documented an increase in child abuse and exploitation as a direct result of stay-at-home orders.<sup>22</sup>

Prior to the pandemic, women and girls in conflict-affected states in the Northeast, particularly Borno, Yobe, and Adamawa, faced increased risk of GBV, especially child, early, and forced marriage. Government restrictions, like lockdowns and quarantine measures, and the economic impact of the COVID-19 have exacerbated conditions that increase the risk of GBV including child marriage.<sup>29</sup> Lack of funding has further restricted GBV service provision. For example, a Sexual Assault Referral Centre in Adamawa temporarily closed in 2020 due to lack of resources.<sup>20</sup>

## Context-specific Barriers to GBV Health Services

- Closures of health facilities and services due to the lack of PPE and staff concerns about contracting COVID-19<sup>29</sup>
- COVID-19 related committees did not consider GBV and protection services essential<sup>4</sup>
- Even when services were technically open, many staff struggled to get passes that exempt them from movement restrictions and allowed them to travel to service points<sup>20</sup>
- Healthcare workers are reluctant to treat internally displaced persons (IDPs) out of fear of contracting COVID-19<sup>4</sup>
- COVID-19 measures restricted IDPs ability to leave camps, which reduced their access to services<sup>4</sup>
- The increased presence of security agents and community militia members, who frequently harass women and girls traveling to providers, deter those seeking GBV services<sup>20</sup>
- While many law enforcement officials were deployed into communities, they have focused on enforcing measures to reduce COVID-19. Consequently, they are not readily available and often do not have the

ability to document reports of abuse.<sup>8</sup> Even when police such as those in the Family and Support Units are available, they often cannot reach survivors as they lack official transportation.<sup>20</sup>

- Humanitarian actors do not regularly update referral pathways impeding GBV case management. The GBV Sub-Sector Rapid Assessment in three states in Northeastern Nigeria found that of the 26 partners with GBV programming, only 38.5% updated referral directories every quarter, and 28% updated them monthly.<sup>13</sup>
- GBV programs often lack specific protocols or standard operational procedures to facilitate remote service provision and GBV helplines to ensure safe, quality, and ethical operations.<sup>13</sup>

## **Humanitarian GBV Response & Adaptations:**

- The Nigerian government and EU-UN Spotlight Initiative launched a GBV data situation room and dashboard. It serves as the hub for GBV data and houses the infrastructure for the online reporting platform. The dashboard enables real-time data visualization and analytics for timely response and includes official platforms for reporting on Facebook, YouTube, and Twitter.<sup>23</sup>
- In Borno, Adamawa, and Yobe States, toll-free hotlines provide GBV services at no cost.<sup>12</sup>
- Although not located in Northeastern Nigeria, GBV awareness raising in Jos has successfully continued through flyers, messaging apps, and radio announcements.<sup>18</sup>

# Recommendations

The following recommendations outline ways to mitigate barriers to GBV health-related services and to promote the provision of quality GBV healthcare in humanitarian settings during the COVID-19 pandemic. They are drawn and adapted from existing guidance produced by a variety of stakeholders including UN agencies, governments, NGOs, and healthcare providers.

There is no single, easy solution or set of adaptations that will address the needs of all GBV survivors in all contexts. Stakeholders can reference the following overarching and country-specific recommendations as starting points to adapt approaches and programming as appropriate for different contexts.

# Overarching Recommendations

## All actors

- **Designate clinical management of rape and IPV and GBV case management and psychosocial support as essential services in COVID-19 preparedness and response plans.** This designation ensures the continuity of GBV service provision throughout COVID-19 response. Services should include hotlines, referrals, and remote and direct psychosocial services to survivors.<sup>4</sup> Post-exposure prophylaxis (PEP) and emergency contraception (ECP) should be on the list of essential medicines and in supply chain systems for COVID-19 response.<sup>30</sup>
- **Ensure continuity of SRH and MHPSS services and include these services in COVID-19 preparedness and response plans.** Avoid the diversion of staff and resources from comprehensive SRH. Ensure continuation of life-saving services in line with the Minimum Initial Service Package for SRH in crisis settings. Prevent the conversion of safe spaces for women and girls, including domestic violence shelters, into additional capacity for COVID-19 health response. Rather, continue to promote the integration of GBV case management, psychosocial support, and SRH services in these spaces to maintain safe, discrete entry points for GBV disclosure and care for survivors.<sup>30</sup>
- **Enhance interagency coordination among relevant actors such as local and national government agencies, NGOs, UN agencies, donors, and healthcare providers.** Improved coordination is needed to integrate GBV prevention and response into COVID-19 plans and activities. It is also essential for efficient and streamlined programming across sectors and helps to maximize the impact of funding and activities.<sup>9</sup>
- **Conduct intersectional, GBV risk and gender analyses** and use findings to systematically incorporate GBV risk mitigation, prevention, and response strategies into COVID-19 interventions. These analyses can be standalone studies or incorporated into rapid assessments. They enable context-specific and gender-responsive approaches and should be used to design, adapt, monitor, and evaluate activities. Analyses should be conducted with the full participation of at-risk populations, particularly women and girls.<sup>3, 4</sup>
- **Raise awareness among key populations including healthcare workers, government officials, and community members about the risk of GBV during health emergencies.**
- **Ensure risk communication and community education on COVID-19 is accessible and includes information on preventing GBV** through addressing harmful social and gender norms, while promoting positive masculinities.<sup>29</sup>

- **Support the training of healthcare workers to properly identify GBV risks and manage cases**, to handle disclosures in a compassionate, non-judgmental way, and make referrals for additional care.<sup>3</sup> Training should cover topics including GBV basic concepts, confidentiality, a survivor-centred approach, IASC GBV guiding principles, the GBV Pocket Guide, and how to refer survivors to services.<sup>7</sup> Training can be provided through a standalone session or be integrated into existing trainings such as those on COVID-19.
- **Support livelihood opportunities for GBV survivors.** Livelihood programs and women's economic empowerment initiatives should be an integral part of GBV programming. These programs help women gain economic independence, obtain GBV services, and avoid negative coping mechanisms, such as child, early, and forced marriage.<sup>15</sup> Activities may include targeting survivors and adolescent girls and women at increased risk of experiencing GBV with direct cash transfers as part of financial support measures.<sup>29</sup> The provision of small and medium grants and/or cash assistance for creating small businesses can also contribute to women's economic empowerment.<sup>9</sup> Programming should ideally employ a gender-transformative approach by addressing barriers, like inequitable social norms and gaps in knowledge and skills, to ensure sustainability.<sup>15</sup>
- **Amplify the role of female healthcare workers, women leaders, and women-led organizations in health services and COVID-19 response efforts.** These groups should be part of decision-making processes and members of COVID-19 response committees to make sure that responses use gender-responsive strategies that adequately address the needs of women and girls in each community and do not exacerbate GBV risks.<sup>3</sup> Involving gender and GBV experts in all levels of response teams from planning to implementation is equally imperative. Increased community education on COVID-19 presents an opportunity to integrate GBV awareness into messaging and to ensure that women's networks play key roles in community awareness and sensitization. Leveraging these networks and platforms also helps to amplify women's knowledge and strengthen women's leadership on eliminating GBV in the COVID-19 response.<sup>22, 29</sup>
- **Prioritize addressing GBV risks and gender barriers as essential for a safe, equitable COVID-19 vaccine distribution.** GBV survivors, along with health workers including GBV service providers, SRH workers, community health workers, healers, and practitioners of traditional medicine, should be prioritized for receiving vaccines. When arranging access, vaccine rollouts should also consider the disproportionate secondary impact of COVID-19 on specific groups of women and girls, such as female caregivers, pregnant and lactating women, women living in poverty, single mothers, and female-headed households.<sup>21</sup>
- **Take immediate steps to ensure the safety and wellbeing of frontline healthcare workers**, particularly women.<sup>33</sup> For example, it is important to have adequate MHPSS for staff and to conduct safety audits of service points, which should examine potential GBV risks to survivors as well as staff.
- **Publicize information on where GBV survivors can seek help** with special attention given to groups that experience marginalization and discrimination, including adolescent girls and boys, women and girls living with disabilities, and women and girls living with HIV.<sup>29</sup>
- **Increase funding for standalone GBV programming and integration of GBV prevention and response into COVID-19 response plans.** Funding for quality multi-sectoral service provision, reporting mechanisms, and outreach efforts ensures that GBV survivors can use essential services during the pandemic, including GBV case management, medical care, specialized psychosocial support, dignity kits, temporary shelter, and other forms of support- exploring all possible and safe modalities in line with the Inter-agency Standing Committee (IASC) GBV guiding principles and survivor-centred approaches.<sup>9</sup>
- **Adapt all programs and ensure alignment with social distancing and infection prevention control (IPC) measures, guided by operating procedures agreed with WHO and the GBV Area of Responsibility (AoR).**

## Governments

- **Remove barriers that restrict healthcare workers' and GBV survivors' mobility due to COVID-19 quarantine restrictions.** Allow exceptions to movement restrictions for healthcare workers, GBV service providers, GBV survivors, and those at-risk of GBV to enable them to seek safety and access services during lockdowns and curfews.<sup>9</sup>
- **Train and collaborate with security personnel (e.g., military, police) and relevant government officials** to prevent and mitigate GBV perpetrated by security forces and ensure personnel have appropriate GBV training to respond to GBV incidents including to provide referrals.<sup>20</sup>

- **Ensure quarantine facilities and spaces adhere to IASC GBV guidelines and risk mitigation measures.**<sup>9</sup>
- **Scale up GBV health service provision and allocate additional resources to women’s shelters, one-stop centers, and SRH service delivery points** (including ensuring last mile access to contraceptives, safe maternal care, and access to antiretroviral therapy) as part of the COVID-19 response. This should include providing supplies, PPE, and logistical support to protect frontline service providers and survivors from COVID-19.<sup>29</sup>
- **Update GBV referral pathways regularly with a focus on health facilities and medical service providers**, as these are most likely to remain open even during quarantines or lockdowns. Inform key communities and service providers about the updated pathways. Listed services should follow WHO recommendations in terms of infection prevention and control measures and IASC GBV guidelines.<sup>7, 9</sup>
- **Strengthen existing laws and the implementation of laws against GBV and violence against children.** Strong legal protections are fundamental for effective GBV prevention and response during the pandemic.

## NGOs

- **Advocate for additional donor and government funding for quality, multisectoral service provision to address GBV.**<sup>9</sup>
- **Create entry points and systems where survivors can access or can signal a need for support.** For example, integrate GBV services in existing structures (a general women and girls’ helpdesk in permitted areas or open services) at pharmacies, grocery shops/food markets/food distribution points, water pump stations, etc. Well-mapped entry points and relationships with trusted community stakeholders who are permitted to operate during the pandemic are essential. GBV phone booth stations can also be added to physical safe spaces for women and girls to facilitate phone-based case management support.<sup>7</sup>
  - **Establish and disseminate protocols for remote GBV health service provision** prior to beginning or expanding phone or online GBV health services. Protocols should ensure survivors’ confidentiality and outline data protection procedures.<sup>29</sup>
  - **Integrate gender equality messaging and activities into ongoing programming and implement GBV prevention programming that engages men and boys to address the root causes of GBV.**<sup>14</sup> Gender-transformative programming that addresses inequitable gender norms is necessary to spur sustainable social change and stop all forms of GBV.<sup>15</sup>
  - **Strengthen systems for preventing and responding to sexual exploitation and abuse (SEA).** Each organization should have clear reporting and response procedures for SEA and train staff and volunteers on policies and procedures.<sup>33</sup>

## Healthcare providers

- **Ensure the continuity of high-quality clinical management of rape and IPV services in primary healthcare settings.**
- **Ensure health facilities follow IASC GBV guidelines and risk mitigation measures.** Service points must be safe and accessible. Ensure the separation of male and female patients, availability of female healthcare staff, and identify and mitigate barriers to access.<sup>30</sup>
- **Collaborate with the Protection Cluster, especially GBV Sub-cluster partners, to develop key messages and information about local GBV health services** (e.g., hotlines, shelters, rape crisis centers, counseling for survivors including service hours and contact details, etc.) and disseminate information to health partners and within health facilities including those providing COVID-19-related testing and treatment.<sup>30</sup>
- **Update GBV referral systems and services regularly and verify that health providers are familiar with the latest information.**
- **Train healthcare staff so that they are aware of GBV risks and health consequences, are able to identify cases, appropriately handle disclosures, offer first-line support and relevant medical treatment, and refer patients for additional services.**<sup>30</sup>
- **Incorporate essential training modules on identifying, treating, and referring GBV survivors into existing COVID-19 or other healthcare trainings.**<sup>30</sup>



## The UN and Donors

- **Fund intersectional, gender and GBV risk analyses as part of GBV-specific and COVID-19 preparedness and response programming.** Budgeting for this research ensures that partners can implement gender-responsive programming that is evidence-based and informed by local conditions and contexts. Analyses can be conducted as standalone studies or integrated into other data collection processes, such as project baselines.
- **Support comprehensive, multisectoral service packages for survivors of GBV,** including support related to CMRIPV, SRH, MHPSS, legal and justice services, and livelihood support and opportunities.
- **Provide funding to operational partners** that is timely, flexible, and channeled to trusted frontline responders with the capacity to uphold and expand life-saving programming, including GBV interventions.<sup>14</sup> Support women-led and feminist organizations through funding mechanisms to ensure that gender-responsive approaches are utilized and that GBV risks are addressed.
- **Increase funding for the digital and online capacity of service providers to adapt remote and flexible approaches for GBV service provision** that respect survivors' privacy, confidentiality, and data protection.<sup>29</sup>
- **Contribute to efforts to update GBV referral pathways and coordinate with local primary and secondary healthcare facilities** to ensure services are correctly reflected, as services may no longer be available due to emergency response to COVID-19.<sup>9</sup>
- **Devote more resources to researching the gendered implications of public health emergencies,** especially disease outbreaks, so that public health and COVID-19 preparedness and response plans can be gender-responsive and mitigate harm to groups that experience discrimination and marginalization including women, girls, people with disabilities, IDPs, etc.<sup>3</sup>
- **Ensure appropriate funding is available for prevention activities that engage and work with men and boys to address harmful gender norms.**<sup>15</sup> Emphasis on prevention activities can be part of mid and long-term response efforts.

# Recommendations: Cox's Bazar, Bangladesh

## All actors

- **Assess progress and gaps in the GBV response to inform a five-year GBV Action Plan (2021-2025)** to meet the needs of refugees and host communities.<sup>15</sup>

## The Government of Bangladesh

- **Identify critical GBV services as essential**, including clinical care for sexual assault and psychosocial support. Adapt and provide prevention services through remote methods, such as mobile loud speakers and mobile phones, as possible.<sup>15</sup>
- **Collaborate with humanitarian agencies to build camp leadership** structures that are inclusive, representative, and gender-balanced (with equal representation and decision-making power for women and men) to replace the current mahji system.<sup>15</sup>
- **Reinstate all refugees' access to mobile and internet networks**. This connectivity is essential for women and girls to receive up-to-date and timely GBV service provision.<sup>15</sup>
- **Support women's livelihoods in camps through partnerships with international donors**. Opportunities exist to expand home-based enterprises and preferred value chain activities.<sup>15</sup>

## The GBV Sub-sector

- **Offer sensitization sessions, training, and technical support on GBV programming and standards** to the Refugee Relief and Repatriation Commissioner's (RRRC) office, including the Camp-in-Charge, to facilitate high-quality GBV programming.<sup>14</sup>
- **Advocate for the RRRC to identify all critical GBV response services as essential**.<sup>14</sup>

## UN agencies

- **Advocate to the Government of Bangladesh to ensure center-based GBV prevention and response services are designated as essential** and follow IASC GBV guidelines and COVID-19 protocols to enable the continuation of GBV care.<sup>14</sup>

## NGOs

- **Support efforts of national and international GBV responders and healthcare workers capacity strengthening**, including local women rights groups through training, mentoring, and technical support. This work allows the delivery of services that meet IASC GBV Minimum Standards, gender mainstreaming in sectoral programming, and supports women to participate in decision-making and lead GBV response efforts.<sup>15</sup>

## Donors

- **Ensure donor strategies include GBV prevention and response, and support increased funding levels for the 2021 Joint Response Plan (JRP).**<sup>15</sup>
- **Commit to implement outcomes of the Call to Action Road Map (2021-2026) in the Rohingya response**, including requiring the use of sex and age disaggregated data.<sup>15</sup>
- **Coordinate with implementing agencies, the Government of Bangladesh (including Ministry of Women and Children's Affairs), and UN agencies to agree on a strategy for the localization of the Rohingya GBV response.** Multi-year funding with appropriate timeframes for implementation should be established.
- **Use INGOs primarily to support national capacity and transfer of programming to national NGOs and women-led organizations** working in their communities. Shifting to locally-led programming should be coordinated to avoid any gaps in managerial and technical systems and capacity and ensure adherence to IASC GBV Minimum Standards.<sup>14</sup>

## Recommendations: Iraq

### The Government of Iraq

- **Designate GBV services as essential, include them in COVID-19 preparedness and response plans, and adequately fund them.**
- **Develop a GBV strategy, particularly for the health system, to prevent and sustainably respond to the needs of GBV survivors, including during health emergencies.** The strategy should include relevant national guidelines and align with IASC GBV Guidance and protocols and policies for addressing GBV.<sup>30</sup>

### UN agencies and NGOs

- **Use the guidance notes for GBV service provision**, including remote case management and PSS, that were produced, contextualized, and circulated by the GBV Sub-Cluster Iraq.<sup>9</sup> These guidelines ensure GBV service providers offer quality care.
- **Work with the Iraq's Ministry of Health to develop a capacity strengthening strategy for healthcare workers** on the clinical management of rape and IPV and firstline support.<sup>19</sup>
- **Establish common indicators and monitoring systems for collecting anonymized GBV data from health facilities.** The aim should be to integrate these data into the regular health information management system at the facility-level and into the national health surveillance systems.<sup>19</sup>
- **Work with Iraq's Ministry of Health to develop formal and updated referral pathway guidelines** informed by IASC GBV Guidelines and provide each health facility with at least one copy.<sup>19</sup>

# Recommendations: North East Nigeria

## The Government of Nigeria

- **Enhance data collection through centralized GBV data collection and management.** System strengthening can be improved by:
  - Bolstering the capacity of the National Bureau of Statistics, National Agency for the Prohibition of Trafficking in Persons (NAPTIP), the National Human Rights Commission, and other agencies to collect and synchronize GBV data at federal and state levels
  - Enhancing the GBV information management system used by humanitarian actors in the Northeast<sup>29</sup>
- **Pass the Violence against Persons (Prohibition) Act or VAPP Act** in the remaining 27 states and develop funded action plans for its implementation.<sup>29</sup>
- **Incorporate a revised National Strategic Framework into the National Gender Policy.** The Federal Ministry of Women Affairs should work in collaboration with partners, including those in the humanitarian sector involved with GBV in emergencies.<sup>29</sup>
- **Support an expansion of community surveillance structures set up in six Spotlight Initiative states** to prevent GBV including practices such as child marriage and trafficking.<sup>29</sup>

## NGOs

- **Advocate for the immediate passage of the VAPP Act** in the remaining 27 states and for the development of funded action plans for its implementation.<sup>29</sup>
- **Community education and engagement efforts on GBV and COVID-19 should leverage existing and recently established youth and women's platforms** at the community level, youth networks, and the African Women Leaders Network.<sup>29</sup>

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