What Happened?

How the Humanitarian Response to COVID-19 Failed to Protect Women and Girls

International Rescue Committee | October 2020

List of Acronyms

COVID-19	Coronavirus Disease 2019
GBV	Gender-based violence
GHRP	Global Humanitarian Response Plan
IRC	International Rescue Committee
PPE	Personal Protective Equipment
SOGIESC	Sexual orientations, gender identities and expressions and sexual characteristics
SRH	Sexual and reproductive health
VAWG	Violence against women and girls
WPE	Women's Protection and Empowerment

Trigger warning: This report contains direct quotes from survivors of gender-based violence, which may be disturbing to some readers.

Acknowledgements

Written by Nancy Abwola and Ilaria Michelis, October 2020.

With thanks to Franziska Obholzer, Sarah Cornish-Spencer, Sarah Mosely, Helena Minchew, Helen Stawski, Betsy Laird, Chevara Joseph, Angelica D'Souza, Liliane Munezero, Marian Rogers, Rocky Kabeya, Harriet Kezaabu, Hana Chakhari, Esther Muhia, Yolande Longang Tchounkeu, Martin Nyanguba, Esther Karnley, Anita Monger, Ingrid Bigirimana, Elisa Menegatti, Rosemary Ogunjobi Tola, Janette Garber, Noviche Adjoua Rache Kanga, Betelhem Mengistu, Glory Makena, Florence Nassali and Joy Masheti.

The International Rescue Committee would like to thank Irish Aid for their support in the development and printing of this publication. The ideas, opinions and comments are entirely the responsibility of the International Rescue Committee and do not necessarily represent or reflect Irish Aid policy.

Company Limited by Guarantee
Registration Number 3458056
(England and Wales)

Charity Registration Number
1065972

Front cover: Francine Mugabo, Psychosocial Support Assistant, North Kivu, DRC, pictured in her community-based organisation Tupendane. *Kellie Ryan/IRC*

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Bernadette Bakungu in front of her house at Bulengo IDP (internal displaced people) camp. She is living here with her children and grandchildren. *Sven Torfinn/IRC*

Executive summary

As COVID-19 spread across the globe, gender-based violence (GBV) experts and women's rights activists around the world raised the alarm that the pandemic and its ensuing movement restrictions would negatively impact the safety of women and girls. This was evidenced early on by concerning reports from feminist activists and GBV service providers in China, Italy, Spain, and Brazil, amongst others.[i] From the first week of March, the media regularly highlighted the increased risk of violence faced by women and girls locked into homes with their abusers and the barriers they experienced in trying to access lifesaving services.[ii] This rapid recognition of the link between COVID-related restrictions and violence against women and girls (VAWG) was echoed within the humanitarian sector.[iii] At a global level, unprecedented attention was dedicated to highlighting VAWG as the *"shadow pandemic"*[iv] of the COVID-19 health crisis. Most prominently, the UN Secretary General made an appeal for "peace in homes around the world" on 6th April, demanding that "women and girls [are put] at the centre of efforts to recover from COVID-19".[v]

Ten months since COVID-19 was first identified, this report seeks to capture how the pandemic has affected the safety of women and girls in humanitarian emergencies and outlines how the humanitarian response to COVID-19 has largely failed to take their needs and safety into account. The voices of 852 women from refugee, displaced and post conflict settings, living in some of the most underfunded and forgotten humanitarian crises in 15 African countries across East Africa, West Africa and the Great Lakes region are represented in this report. Their experiences are complemented by interviews with 25 GBV response experts currently dealing with the challenges of resourcing and adapting programming to a radically changed world.

These extensive consultations corroborate reports that rates of violence against women and girls (VAWG), and intimate partner violence in particular, have increased. Across all three regions 73% of women interviewed reported an increase in intimate partner violence, 51% cited sexual violence and 32% observed a growth in the levels of early and forced marriage. The women for example reported how the stress of the lock down and its economic repercussions triggered increased violence by their husbands but also highlighted the new dangers affiliated with checkpoints set up by security personnel to regulate the movement of people. A specific area of concern flagged by women across all three regions, was the increased need for water collection, due to the new hygiene practices. 31% of women interviewed reported incidents of harassment and sexual violence on the way to water points; 21% reported harassment at water points.

While the increased risk of VAWG received unprecedented political attention, it proved much more challenging to ensure that the rhetorical commitments to prioritise the safety of women and girls in emergencies would in practice translate into additional financial resources and programming. Experts reported that the first months of the response to COVID-19 demonstrated that many within the humanitarian community failed to take into account lessons learned from the Ebola crises in West Africa and DRC on the gendered impact of public health emergencies and the need to adequately centre women and girls from the earliest stages of humanitarian response. Some experts even suggested that the attention given to GBV in the media may have clouded the fact that not nearly enough was being done to address it in the response.

Despite swift and coordinated international advocacy efforts, funding was neither sufficient nor proportionate to the resources dedicated to the overall response and the Global Humanitarian Response Plan (GHRP) failed to provide an accountability mechanism. GBV accounted for only 0.48% of the overall funding appeal of the GHRP (as of August 2020). The GBV experts interviewed reported funding being withdrawn or re-directed to infection prevention and highlighted that both donor preferences and implementing organisations' requests often failed to prioritise the safety and needs of women and girls. While many donors currently assume part of their unrestricted funding to be allocated to the prevention of and response to GBV, decision-making on funding rarely reflects these expectations, leaving the GBV sector chronically underfunded.

To meet the expected surge in need, the GBV expert community produced a range of new guidelines[vi] and remote technical support demonstrating an unprecedented level of interagency and cross-regional collaboration. While services overall remained available in the countries included in this report, access was often compromised for a host of reasons, such as new challenges in transport or reduced opening hours. Organisations rarely received additional funding to adapt their programmes and had to divert existing programme resources to pay for additional expenses, such as personal protective equipment (PPE) or handwashing facilities. When asked about reasons why survivors would choose to not seek help, women primarily named the fear of being identified as a survivor of GBV and the related stigma (56%). This fear was considerably exacerbated by movement restrictions and the monitoring of movement through checkpoints and community leaders.

Women groups and women leaders working in their communities were critical to maintain essential GBV services.

But many groups who relied on income generation activities to support GBV survivors could not maintain their services as they lost market access. According to key informant interviews, these groups were predominantly excluded in the distribution of PPE and their work inadequately recognised, resourced or supported. Extremely tight timelines set for humanitarian planning effectively prevented consultation with women and girls in multiple contexts.

Women from refugee, displaced and post conflict settings surveyed in this study were asked what they think could be done to create safer communities and increase their access to services. Their recommendations were clear. First and foremost, respondents called for ensuring that GBV services are available and accessible by adapting to the restrictions on movement and association imposed by COVID-19, which pose new logistical and staffing challenges. Respondents also underlined the need for advocacy with local authorities for improved safety within the communities, to ensure safe access to basic services and for greater focus on mitigating the loss of livelihoods (the full set of women's recommendations can be found on page 24-25). In light of the repeated commitments made at the World Humanitarian Summit and the Global Refugee Forum to pay greater attention to the voices of refugees and displaced persons, governments and multilateral agencies cannot afford to ignore the perspectives of the women reflected in this and other reports.[vii]

The findings of this report highlight the importance of the active and meaningful participation of women activists, community respondents, and women-led organisations in upholding service provision and the need to properly recognise, support and resource their essential role. Donors must put words into action by increasing the levels of transparent and accountable funding for lifesaving GBV services through humanitarian response plans, during COVID-19, and in efforts to 'build back better' in the years to come. Finally, the report underlines the need for reform of the humanitarian system to support feminist approaches to crisis response that recognise the centrality of gender equality and freedom from violence at all stages of planning and implementation.

The women from the IRC-supported community-based organization Tupendane (which translated to Let's Love Ourselves) cultivate the land in North Kivu, DRC. *Kellie Ryan/IRC*

Introduction

Ten months after the first outbreak of COVID-19 in China, this report brings forward the voices of over 850 women from refugee, displaced and post conflict settings, living in the midst of humanitarian crises across 15 African countries and 25 GBV experts – working at all levels of the humanitarian system – to examine the impact of the pandemic on women and girls' safety and to assess whether humanitarian responses, specifically in Africa, have appropriately addressed the increased risk of GBV.

As part of a Remote Safety Audit designed to keep in contact with women at this time when humanitarian access was restricted, IRC spoke to 852 women from refugee, displaced and post conflict settings across Africa using a standard safety audit questionnaire administered by phone or in person, depending on movement restrictions in each context. Data trends were analysed by region and include countries from the Great Lakes: Burundi, the Democratic Republic of Congo, and Tanzania; West Africa: Cameroon, Chad, Côte d'Ivoire, Liberia, Niger, Nigeria, Sierra Leone; and East Africa: Ethiopia, Kenya, Somalia, South Sudan, and Uganda (see annex for detailed methodology). This data was used to assess how COVID-19 has affected the lives of women and girls in emergencies. The safety audit also encouraged the interviewed women to come forward with solutions that would improve their situation. Their recommendations have been summarised and grouped along six categories (see p. 24-25).

In addition, the authors talked to 25 GBV experts working in and beyond Africa in a range of roles and organisations, including UN agencies, donor governments, international and national NGOs and civil society organisations, to examine to what extent the humanitarian response to COVID-19 has taken the safety of women and girls into account.

Case studies of Kenya, Chad and Burundi shine a light on how decisions made by government and humanitarian leadership, advocacy efforts of GBV specialists and feminist activists, and existing commitments and structures to address GBV in a specific humanitarian response, have influenced how far GBV responders were able to uphold services.

This report concludes with recommendations based on IRC interviews with displaced and refugee women, women-led organisations, and humanitarian GBV experts. Their voices, experiences, and knowledge need to translate into effective, accountable, and consistent humanitarian action that truly puts women and girls at the centre of COVID-19 response and recovery efforts.

IRC staff conduct mobile outreach in Turkana, Kenya. *IRC*

How has COVID-19 affected the lives of women and girls in emergencies?

The 852 women from refugee, displaced and post conflict settings and 25 GBV experts IRC consulted for this report confirmed that women and girls across Africa have been affected by the COVID-19 pandemic in specific and gendered ways.

> "Women and girls cannot succeed because they are supposed to take care of all the household chores, rock the babies, collect water from the shared water points, do small trade, take care of the children, the sick and the elderly." (Female respondent, DRC Safety Audit)

As of the time of the interviews, restrictions on movement and economic activities, especially within the informal sector where many women are active, were reported to have severely compromised women's capacity to generate incomes and sustain themselves and their families. Refugee and displaced women and girls were hit especially hard by the economic impact of the pandemic, as they are more likely to rely on domestic work, small trade and other informal sector activities for their livelihoods.

> "Most women are not [engaged] in income generating activities due to no periodic market which has caused an increase in domestic violence and decrease in the household income" (Female respondent, Sierra Leone Safety Audit)

Movement restrictions have affected supply chains within and across borders, increasing the cost of goods and reducing their availability. Markets have been shut down or severely limited in their trading hours and number of potential clients. The sources of women's incomes have been decimated and support systems like Village Savings and Loans Associations (VSLAs) have also been disrupted. As a consequence, women reported experiencing a drastic loss of income and savings and increasingly struggling to meet their own and their family's basic needs, including rent.

Across all 15 countries included in the IRC safety audit exercise, women emphasised how increased economic hardship heightened women and girls' exposure to violence and exploitation, both within and outside the home. Closure of schools and limited access to remote learning opportunities left adolescent girls at risk of sexual exploitation, early pregnancy and forced marriages. Women facing compounded forms of marginalisation, particularly women living with a disability and older women, were highlighted as being uniquely affected by COVID-19 containment measures and placed at further risk of GBV as a consequence.

> "I talked about the economic situation that weakens women's agency, women's and girls' agency, to say no because they have lost jobs. The people abusing them are the people on whom they are depending." (National GBV Expert).

Violence against women and girls

In line with global trends, refugee and displaced women interviewed reported a surge in the violence experienced by women and girls during the pandemic. When asked to indicate which types of violence had increased in their communities, **73% of women interviewed across all three African regions named intimate partner violence. Sexual violence was mentioned by 51% of respondents and early marriage was considered to have increased by 32% of respondents**. Sexual violence was more likely to be mentioned in East Africa and West Africa, whereas early and forced marriage was noted as a particular problem in the Great Lakes region. Respondents reported that the closure of schools had detrimental effects on the safety of girls. They observed a rise in early and forced marriage, adolescent pregnancy and sexual exploitation of girls for basic needs.

> "Yes the violence has increased in our country because even yesterday there is a man who hit his wife until he broke her arm just because she asked her husband to wash his hands with soap before eating." (Female respondent, Chad Safety Audit)

Across contexts, respondents noted that while the types of violence they face did not necessarily change because of COVID-19, the pandemic exacerbated the problem of male violence and the subordination of women and girls, both of which are deeply rooted in unequal gender dynamics predating the current crisis.

> "Domestic violence, denial of resources and sexual violence have also heavily increased because men stay at home. The difficulties and men being idle all day long make them nervous, tense, and pushes them to impose and exercise their power excessively." (Female respondent, Cameroon Safety Audit)

Respondents also reported that while violence increased, the pandemic limited women and girls' options to seek safety and support since most of them are trapped at home with their abusers.

Intimate partner violence

The escalation of violence against women and girls within the home was linked by women and GBV experts alike to lockdown measures that forced women and girls to spend more time with their abusers and prevented them from seeking safety, even if temporarily, elsewhere. COVID-19 also increased tension within households, multiplying triggers for abuse. In the majority of contexts where IRC conducted safety audits, the worsening economic conditions were mentioned as a factor contributing to violence within the household and community.

> "The food that is being provided to the families in the camps is not sufficient. The community used to get other means of income such as farming local farms, engaging in small trades and so on to cover the needs of their household but now they are not able to have additional means of income. This is contributing to conflicts among husbands and wives. It is putting women and children at risk of violence." (Female respondent, Ethiopia Safety Audit)

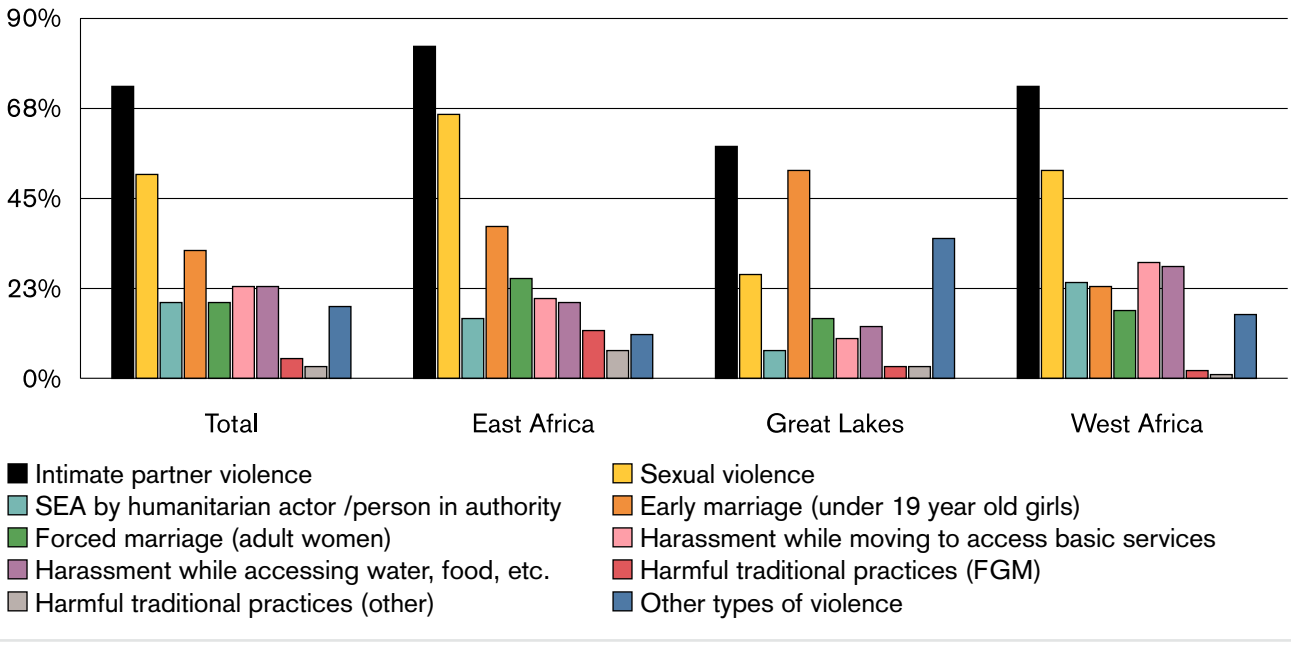
In addition, women and girls reported multiple instances of men perpetrating emotional and physical violence against their partners because they are asked to comply with COVID-19 prevention measures.

> "Our husbands insult us, sometimes they beat us because we give them advice regarding COVID-19" (Female respondent, Chad Safety Audit)

Refugee and displaced[viii] women in Cameroon, Chad, Côte d'Ivoire, Democratic Republic of Congo, Liberia, Sierra Leone, and Uganda noted that some people believed COVID-19 was not present in the region and that it was a disease that only affects white people. As a consequence, men in their communities construed social distancing as disrespectful and against local culture, while husbands interpreted demands to observe hygiene practices – and in some cases, physical distancing – as refusal of sex. Women and girls who followed COVID-19 protocols in these communities were stigmatised and exposed to violence.

> "Sometimes women have to face conflict with a member of the family due to limits on visiting and the habit of hand greetings. When they refuse to shake hands with others, they are considered as undisciplined and difficult women and girls since certain community members don't believe in the existence of the disease in their location" (Female respondent, DRC Safety Audit)

What types of violence against women and girls have increased in your community due to COVID-19?



Risks associated with meeting basic needs

The unequal distribution of household roles combined with COVID-19 prevention measures also exposed women and girls to increased risks of violence as they try to meet their and their family's basic needs. Harassment by boys, adult men, military and police officials was reported as an ongoing issue during travel between homes, checkpoints and service points. 74% of refugee and displaced women mentioned that new checkpoints have been set up by military and police forces to enforce COVID-19 movement restrictions. Across multiple contexts where the safety audit exercise took place, women and girls experienced unwanted touch, had inappropriate comments shouted at them, and faced increased conflict at service points and checkpoints, including by military and police officials.

> "Those checkpoints are sometimes used to rape women who are caught in violation [of COVID-19 restrictions]. Most violence cases are being compromised at the community level due to the fear of being arrested and detained at the checkpoint." (Female respondent, Liberia Safety Audit)

Women reported significantly increased risks associated with water collection. As the need in households rose for increased hygiene practices, 55% of respondents reported that women and girls, primarily girls under the age of 14, had to travel to collect water more frequently. Increased need also resulted in longer lines at water points, with 48% of displaced and refugee women reporting they had to queue longer than 1 hour. This, in turn, was associated with harassment and violence by military and police officials, especially when violating curfew as longer queues and increased need forced some women and girls to walk long distances early in the morning or late in the evening. Traditional strategies to enhance safety, such as walking in groups, were disrupted by social distancing requirements. Some 31% of women interviewed reported incidents of harassment and sexual violence on the way to water points; while 21% reported harassment at water points.

The impact of COVID-19 restrictions and lockdowns on the ability to meet basic needs also forced women and girls to undertake more risky activities, such as venturing outside of refugee camps in search of firewood to sell, and also creates additional opportunities for men to sexually exploit women and girls in exchange for food, sanitary pads and other essential items.

> "Women and girls run a great deal of risk in fetching firewood because they no longer go there in large groups and are vulnerable to easy kidnapping by members of non-state armed groups. The consequence is the limitation of income because it is the wood harvested in the bush that is sold and the income allows them to meet some of their needs." (Female respondent, Cameroon Safety Audit)

What are some challenges women and girls are facing when collecting water?

	% of female respondents who mentioned			
	Total	East Africa	West Africa	Great Lakes
Collecting water more frequently due to increased demand for water	55%	54%	56%	50%
Collecting water from further away due to increased demand for water	39%	48%	36%	38%
Social distancing not being respected when queueing for water	56%	64%	57%	41%
Harassment on the way to water points	31%	28%	35%	19%
Sexual violence on the way to water points	22%	20%	24%	19%
Harassment at water points	21%	22%	21%	21%
Long queues	54%	64%	47%	61%

What closed schools mean for adolescent girls

The pandemic and especially the ensuing closure of schools has exacerbated the risks of violence against adolescent girls. Teenage pregnancies and early marriage of adolescent girls were a particular concern for the women interviewed. Respondents also discussed the effects of the lockdown on girls' safety in their own homes, citing increases in child abuse, rape, physical assault, IPV and women and girls being driven from their homes by their partners.

With no access to schools, adolescent girls lose an important avenue to seek support in their social networks. Without school obligations, adolescent girls are often tasked with high risk activities, such as water collection and fetching firewood in insecure areas, which puts them at risk of sexual exploitation in order to meet basic needs. Due to social distancing measures, they now often travel alone, for long distances, and face discrimination and harassment.

Schools are also where adolescent girls used to receive menstrual hygiene products and many girls fear going to community health centres instead, as they may be stigmatised as having COVID-19.

Many female respondents feared that even when schools opened, girls would not be allowed to return. Thus, there were requests to ensure that schools open as soon as possible, but also a focus on the need for advocacy to ensure that when schools do open, girls can go back and be educated. Other suggestions called for more safe spaces, or educational activities for girls where they can share their experiences and difficulties, and access reproductive health information to reduce the risk of teenage pregnancy.

Adolescents are fetching water at a water point in Liberia. *IRC*

Accommodation

75% of displaced women interviewed flagged specific issues related to accommodation for women and girls, particularly affecting single women and female-headed households.

> "Landlords put pressure while others threaten to evacuate tenants out of their houses, because they themselves (landlords) need money badly thus forcing women to sell their clothes for paying rents." (Female respondent, Uganda Safety Audit)

Women mentioned landlords threatening eviction and committing acts of violence against female tenants, as well as refusing to rent properties to unmarried or widowed women in the absence of a male relative. This trend reflects the ongoing discrimination against women by male landlords denying women access to accommodation, because they assume that women may not be able to generate income during the pandemic. In East Africa, respondents mentioned the need for women-only accommodation to avoid the sexual harassment often experienced in accommodation shared between sexes.

> "Single women and girls cannot find homes to rent in this period, under the pretext that they cannot guarantee the rent, that's the perception of certain landlords. This pushes some women and girls to pretend their brother is their husband to obtain a home" (Female respondent, Côte d'Ivoire Safety Audit)

At the time of the interviews, the lack of affordable homes and movement restrictions caused overcrowded housing conditions which were linked by respondents to sexual violence, especially against girls, and to a lack of space and privacy to manage menstruation, in addition to a higher risk of spreading COVID-19.

Portrait of Sayo Janette, whose granddaughter participates in a girls education project in Masimanimba, Bandundu, DRC. *Tamara Leigh/IRC*

Diverse women and girls face intersecting risks[ix]

Female respondents pointed to various groups of marginalised women and girls as most impacted by movement restrictions and social distancing measures. Women living with disability and elderly women were most likely to be mentioned across the three regions as being exposed to additional risks of sexual exploitation and abuse.

> "We all face some hardship, though those who are physically disabled and the elderly find it very difficult if there is no one to help them" (Female respondent, Cameroon Safety Audit)

Before the pandemic, communities assisted them in accessing basic needs and spontaneous community socialisation was an important source of psychosocial support. With COVID-19 restrictions in place, marginalised women and girls are facing greater isolation, decreased support and higher risks of violence and exploitation.

> "No one is willing to help them [in] this period of COVID. Before abled bodied men would support them by for example lifting their food from a weighing scale to a boda [motorbike taxi] or car." (Female respondent, Uganda Safety Audit)

It is notable that some respondents (15%) mentioned women and girls with diverse sexual orientations and gender identities as experiencing additional risks, even within contexts of widespread homophobia, transphobia and the resultant invisibility of individuals with diverse sexual orientations, gender identities and expressions and sexual characteristics (SOGIESC). Multiple examples of violence and discrimination against individuals with diverse SOGIESC, including trans, lesbian and bisexual women and girls, have been reported during the COVID-19 pandemic.[x] Increased emotional and physical abuse by family members has been an issue for individuals with diverse SOGIESC who have had to quarantine with their family of birth, and police forces have used infection control measures as entry points to harass individuals and organisations protecting them.[xi]

To what extent has the humanitarian response to COVID-19 taken the safety of women and girls into account?

The global picture

In the early stages of the COVID-19 outbreak, GBV experts mobilised quickly, both at a global and individual country level, to raise the alarm on the foreseeable increase of violence that would accompany lockdowns, economic insecurity and the general worsening of living conditions in humanitarian settings. Humanitarian practitioners interviewed for this report consistently praised the rapid and coordinated advocacy efforts of GBV specialists throughout the pandemic, which was considered critical in promoting the prioritisation of women and girls' needs within the humanitarian response to COVID-19.

All international GBV experts interviewed for this report spoke of a level of discussion they had never seen before within the humanitarian system, amounting to a perceived "cultural shift" in considering VAWG a central, rather than marginal, issue for humanitarian response. This widespread acknowledgement and the high-level commitments made by donors and UN agencies raised expectations that programming and funding decisions would support the adaptation and, where needed, the expansion of dedicated services for women and girls as part of humanitarian responses around the world. The reality on the ground, as it emerged from data collected in this report, presents a more complex and, at times, disappointing picture.

> "At the global level, ironically the attention GBV got in the press and high-level speeches gave people impression that it was being included. […] I think it worked against us." (International GBV expert)

While all GBV practitioners interviewed welcomed the unprecedented attention that was dedicated to the issue of VAWG in global discussions about the pandemic, many also emphasised its potentially counterproductive impact. For some, talking about VAWG and investing time and resources in high-level awareness raising campaigns risked detracting from essential, lifesaving services for GBV survivors which continued to be undermined and underfunded across humanitarian settings. As an example, while statements about the need to prioritise women and girls were being made on global platforms, gender and GBV experts within humanitarian organisations reported that they found themselves, once again, advocating from the side-lines to be included in strategic planning and decision-making.

The current Global Humanitarian Response Plan (July – December 2020) is a prime example of the duality observed within the current humanitarian response to COVID-19. The July update of the GHRP differed from its predecessors by providing a rare in-depth analysis of how women and girls were being affected by COVID-19 across humanitarian contexts and focusing specifically on GBV as "one of the most nefarious consequences of the pandemic".[xii] The narrative about impacts of the pandemic on violence against women and girls was robust. However, the level of specificity and urgency in preventing and responding to GBV in the narrative was not matched in the sections of the GHRP that direct response efforts and establish accountability measures.

A woman is washing her hands before entering into a safe space in Ethiopia. *IRC*

Despite calls by a large coalition of civil society, INGO, and government actors, the disaggregation of data by sex, age and disability – a fundamental requirement to evaluate the inclusivity and effectiveness of humanitarian efforts – was included as a footnote instead of being strongly mandated in the GHRP. Likewise, sustained efforts by GBV experts to include a specific objective dedicated to GBV prevention and response within the plan – which they argued would ensure more robust tracking of GBV-specific indicators and funding and ensure that GBV prevention and response were a precondition of a "successful" response – were met with scepticism and were, ultimately, unsuccessful.

While the GHRP is not the only channel for humanitarian funding in response to COVID-19, the lack of a specific objective focused on GBV within the GHRP was considered by the GBV experts interviewed for this report as a fundamental barrier to securing the commitment and resources necessary to ensure GBV programming was safely and adequately adapted to meet the increased needs of women and girls during the pandemic. GBV actors were concerned about their capacity to call for increased attention to GBV programming from Humanitarian Country Teams and other in-country coordination fora in the absence of a clear instrument of accountability, which the GHRP could have provided.

Where's the money?

GBV experts interviewed for this report agreed that funding allocated to GBV prevention, risk mitigation and response was neither sufficient nor proportionate to the resources dedicated to the humanitarian response to COVID-19 globally. GBV accounted for only 0.48% of the overall funding appeal of the GHRP (as of August 2020), which is by any account a shockingly small share given the increased need that had already been observed.[xiii]

GBV programmes that had already been funded and were active on the ground frequently saw their financial resources being rapidly re-directed towards infection prevention measures and, in some cases, health services for COVID-19 patients, according to key informant interviews. GBV experts working for implementing organisations reported rarely receiving additional funding to adapt GBV programmes to the new context, but rather having to use funding dedicated to service provision, thus effectively reducing their capacity to respond to incidents of violence.

> "There were many, many [budget] lines that were redirected towards measures to prevent COVID. To look for handwashing facilities, to intensify awareness raising, to look for masks, there were many activities linked to COVID prevention that used funds that were originally meant for other activities, including funding for GBV activities that was redirected towards COVID." (National GBV expert)

GBV experts also mentioned that some donors took back funds allocated to GBV programs and that GBV funds in the pipeline were at risk of being diverted to the COVID-19 response. As a result, some GBV actors had to suspend, or in some cases permanently eliminate, integral parts of their programmes with little hope of being able to mobilise new resources to reinstate them at a later date. According to key informants, women's social and economic empowerment activities, material support and GBV prevention interventions were most frequently disrupted.

> "There is no funding. Due to COVID, community mobilisation funds were relocated to use on hygiene kits and soap" (National GBV expert)

New flows of funding dedicated to the COVID-19 response tended to prioritise the health and WASH sector and, especially in the early phases, the procurement of PPE. This dynamic was attributed by key informants both to donor preferences and to implementing organisations' requests, expressed through proposals which rarely included gendered analyses or specific provisions for GBV programming. As the global economic impact of the pandemic becomes clearer and concerns about the availability of humanitarian funding in the future emerge, GBV experts stressed the importance of directing existing funding opportunities towards services for survivors of VAWG, rather than waiting for further resources to be made available.

> "The bulk of the funding went to health because that is what partners were asking for." (International GBV expert)

Unsurprisingly, many of the GBV experts interviewed highlighted the critical role that donors played, and should continue to play, in ensuring that GBV is appropriately prioritised and resourced during humanitarian responses. Key informants mentioned multiple examples of agencies including GBV in their humanitarian response plan after receiving feedback from donors encouraging them to do so, though the opposite also happened.

> "There is a discrepancy between what donors tell us globally and what they do in the field. We submitted a number of WASH and other proposals to [various] donors, including a GBV risk mitigation component, and they were asked to take it out. That's a problem! We finally get colleagues to include a small line on risk mitigation and the donor is 'no thanks!'". (International GBV expert)

A woman carries a jerrican after collecting water at a water collection point in Bidibidi camp, Uganda. *Esther Mbabazie/IRC*

Challenges in the tracking and coding of GBV funding

The 2019 *Where is the Money* report by VOICE and IRC, made the recommendation "to improve reporting, tracking and coding of investments to ensure the humanitarian sector has an accurate understanding of its response to GBV, and to increase transparency around donor investments, commitments and priorities so the total amount of funding for GBV can be more easily quantified".[xiv] Corroborating IRC's earlier findings, GBV experts interviewed in the context of COVID-19 consistently pointed to the ongoing challenge of meaningfully tracking funding that is allocated to GBV activities.[xv] GBV is not considered a stand-alone sector within the humanitarian architecture but rather a sub-sector of the Protection Cluster, which is why funding is often not coded accordingly. The need to spread funding across different sectors to mainstream considerations for GBV risk mitigation exacerbates the challenge to track funding for GBV prevention and response. With regard to the COVID-response, this ongoing issue was linked during interviews with the lack of a dedicated objective in the GHRP.

> "We don't have proper mechanisms to track funding for GBV. It's not earmarked for GBV, it might be core funding, project funding, flagged as protection. So many ways to disburse, to organisations or projects, it's not so easily identified as GBV." (International GBV expert)

According to key informants, the ongoing efforts to identify funding flows supporting GBV programming also often fail to distinguish between resources used to provide services directly supporting survivors of VAWG and resources invested in other forms of GBV programming, such as risk mitigation, coordination or awareness campaigns. Therefore, there is no way to determine whether or not we are meeting both obligations or neglecting one aspect.

> "Within GBV, how much goes to services vs coordination? All is important but when you get down to what is programming and within programming what is really services, it's a very, very small piece of that picture. That's definitely lost." (International GBV expert)

At the end of the day, determining how much money has been invested in GBV-related programming since the start of the pandemic, and especially in GBV response services for survivors, remains a guessing game.

From rhetoric to action on the ground: Evidence from 15 humanitarian responses in Africa

The gap between the rhetoric of a *shadow pandemic* and the reality of limited resources for GBV programming was a consistent theme not just at the global level, but also across the 15 African countries examined in this report.

Multiple GBV experts interviewed reported that humanitarian actors and governments were quick to assume that GBV case management and related services could and should be closed or drastically scaled back as part of contingency plans and infection control measures. This dangerous assumption reflected the still marginal consideration given to women and girls' needs and pain during emergencies and confirmed the widespread perception of the COVID-19 pandemic as solely, or primarily, a health crisis. Interviewees stressed how the singular focus on health solutions appeared particularly short-sighted in the aftermath of multiple Ebola outbreaks, which proved time and again the need to prioritise protection programming to minimise the otherwise staggering risks faced by women and girls[xvi].

> "Because it was a health pandemic, it wasn't so evident that there was a gender dimension. This is problematic as we had so many lessons learnt from Ebola and other health crises, they tell us there are gender dimensions. It should have been the first thing [humanitarian actors] profiled, but it was not. That was disappointing." (International GBV expert)

According to key informants, there was a delayed recognition, particularly within public health teams on the ground, of the impact of COVID-19 on women and children, particularly girls, including in terms of caring and hygiene responsibilities, sexual and reproductive health, and GBV. This partial or delayed acknowledgment resulted in early public health interventions that did not prioritise providing PPE specifically designed for female health staff, nor appropriate menstrual hygiene management supplies, nor the ongoing provision of abortion care and other essential sexual and reproductive health services. Public health strategies also relied, in some humanitarian contexts, on the repurposing of women and girls' safe spaces as COVID-19 isolation or treatment centres, without any alternative arrangements put in place to ensure continuity of lifesaving GBV services.

Members of the Togoleta women's group counsel a women from Bidibidi camp, who is seeking their advice in a difficult situation. *Esther Mbabazie/IRC*

The critical role of women's rights activists working in their communities

The role of women's rights organisations working in their communities has always been vital to GBV prevention and response programming.

Annual reporting against the IASC Gender Policy and Accountability Framework, conducted by UN WOMEN on behalf of the IASC Gender Reference Group, for 2019 illustrates the significant positive impact of consultation with local women's groups on ensuring Humanitarian Needs Overviews include a gender analysis. Where local women's groups were consulted, Humanitarian Response Plans were significantly more likely to identify specific impacts on women, girls, men and/or boys and include provisions for GBV mitigation and response, women's livelihoods, and sexual and reproductive health.[xvii]

Interviewees consistently highlighted how, in the African countries surveyed and at global level, advocacy was critical in the early phases of the pandemic to ensure that GBV services, and particularly GBV response services, were deemed 'essential' by local authorities and thus allowed to operate even under strict lockdown conditions. Thanks to the effort of feminist activists and GBV service providers, some governments, such as Kenya and Burundi, recognised the essential nature of VAWG response services and some humanitarian actors invested in PPE and other adjustments required to continue face-to-face service provision. Where this recognition was not forthcoming, women and girls experiencing violence were not entitled to leave their homes to escape violence and access GBV essential services. In those contexts, if and when women had safe access to telephone networks, GBV caseworkers had to limit their support to what could be provided over the phone but were often unable to refer survivors of violence to lifesaving medical or shelter services.

Several interview participants also highlighted how women's informal and formal groups played a frontline role in the COVID-19 response, disseminating information about the virus and how to prevent it, taking charge of improved hygiene practices in their communities and, critically, providing face-to-face support to survivors of violence. This vital role, however, was inadequately recognised, resourced, or supported.

> "Women voices were lacking at the decision-making tables. Even at the point of announcement that this COVID is a crisis, and lockdown measures, the national [government] COVID response task force was made of men only. Women were not consulted. Women were only included after we made noise." (National GBV expert)

As an example, in the DRC, informal or community-based groups that normally rely on small income-generating activities and trade to sustain their GBV response work were dramatically affected by disruptions in local markets and the interruption of local savings associations. They continued to provide emergency support to women and girls affected by violence, but their capacity to assist a survivor access health services, for instance, by covering transportation and medication costs, was severely impacted. As a demonstration of the scarce consideration given to the work of women's groups and women-led organisations, some GBV experts pointed to the fact that they were rarely prioritised for the distribution of personal protective equipment by humanitarian actors.

> "These activities were strongly affected by COVID-19; they can't meet to share or have counselling support, group or individual support. But since they already know each other and to whom to go to seek support, they continue to support each other, but they're not getting money, no technical support." (International GBV expert)

Direct consultation with women and girls living in humanitarian contexts was prioritised almost exclusively by GBV actors who conducted focus group discussions, where possible, and remote interviews (such as IRC's safety audits) to identify urgent needs and suggested solutions. While these exercises were helpful in understanding the impact of COVID-19 on women and girls' lives, safety, and well-being, they had limitations. In many contexts, only women and girls with access to mobile phones could be reached and included in consultations, as was the case with the IRC safety audit exercise. The inclusion of diverse women and girls, including those facing intersecting forms of marginalisation, was not systematic, according to GBV experts, and varied widely across contexts depending on which groups had previously been engaged by humanitarian actors.

> "We do have good practices in some places where GBV actors engage with local networks for community-protection mechanisms and mobilising women leaders to adapt services for survivors. But it is not done systematically, where women are called to the table to seek their opinion on a range of COVID issues, seeking their expertise." (International GBV expert)

Finally, beyond the specific efforts of GBV and gender actors, very few efforts to meaningfully involve women and girls in the broader assessment of humanitarian needs and the planning of responses were mentioned by the GBV experts interviewed. Extremely tight timelines provided for humanitarian planning effectively prevented consultation with women and girls in multiple contexts.

> "When the GHRP was happening and OCHA was reaching out to sub-clusters to get inputs on GBV, they were given 12-hour turnaround. No-one can consult in 12 hours!" (International GBV expert)

Adapting programmes to ensure access to emergency GBV services

The efforts of a global humanitarian community of GBV experts were essential in safely and rapidly adapting existing GBV response programmes to ensure the continuation of lifesaving services for survivors of VAWG. A vast range of new guidance products emerged, including technical briefs, webinars and remote technical support, demonstrating an unprecedented level of interagency and cross-regional collaboration which was considered "one of the best things about this emergency" by interview participants.

Across Africa, with the exceptions of countries like Uganda that adopted strict and sudden lockdown measures, preparedness efforts were possible and were supported by lessons learnt in Asia and Europe, where the pandemic hit earlier. For GBV actors who prioritise working with and for women and girls, this preparedness phase allowed consultation with women and girls, where this was still safe and possible, to develop realistic strategies to continue adapted GBV service provision and maintain a sense of solidarity in the absence of group psychosocial activities normally offered in women's safe spaces. GBV referral pathways were revised and updated in a number of locations and information sharing campaigns on new entry points for GBV services were common across humanitarian responses. Despite the incredible pressure placed on health service providers by the pandemic, humanitarian health actors were able in some contexts, such as Kenya, to provide health actors with training on clinical management of rape and basic psychosocial support to survivors of IPV.

Overall, the roles of female community focal points and/or committees dedicated to addressing GBV in their communities were expanded during the pandemic to ensure a certain level of in-person service provision, either by directly providing psychological first aid, holding and managing a phone that could be used to reach trained GBV staff, or raising awareness about COVID-19 and new GBV service delivery methods. The increased involvement of women living in the community in GBV service provision was widely welcomed by displaced women who took part in the safety audit interviews. They suggested increasing the number and capacity of community structures, while also recommending ongoing training and supervision for these community focal points to ensure a broader range of high-quality services within the community.

Access to case management and psychosocial support

In communities reached by the safety audit, where IRC's Women's Protection and Empowerment (WPE) programmes normally operate, displaced and refugee women indicated that GBV case management and individual psychosocial remained widely available. **65% of refugee and displaced women surveyed reported that in-person GBV case management services were ongoing. Reflecting a common adaptation during the pandemic, 40% of respondents cited the availability of telephone-based services.** Overall, women in West African countries reported being considerably less able to access counselling and psychosocial support services compared with the other two regions, and called for more trained staff to be deployed.

> "Before the Corona virus, survivors were accessing the service 24 hours. Right now the service is open from 8am- 3pm, after 3pm you need pass from the community leader before you access the service" (Female respondent, Liberia Safety Audit)

In locations where in-person services were able to continue, or resume after a period of lockdown, COVID-19 safety protocols were adopted to minimise the risk of infection while ensuring that priority services continued to be available, though for a smaller number of women and girls each day. While these protocols were widely understood and respected, some displaced and refugee women pointed out that longer waiting times and limitations on the number of clients effectively limited service delivery for survivors of VAWG seeking support. The most cited barrier to accessing psychosocial support and case management services, however, remained the fear of being identified as a survivor (reported by 59% of women interviewed), closely followed by the fear of catching COVID-19 (55% of responses).

Group GBV psychosocial support activities happening in women's safe spaces were particularly impacted by restrictions on gatherings. The lack of ongoing group activities exposed survivors of GBV who sought individual support within a safe space, exacerbating fears of stigmatisation and retaliation.

> "Nothing feeling good because it is not easy to meet your loved ones. No gathering to discuss important issues, additional problems in the home." (Female respondent, Sierra Leone Safety Audit)

Women and girls interviewed in all regions also reported increased feelings of isolation since the outbreak of the COVID-19 pandemic due to social distancing protocols, the closure of safe spaces, interruption of psychosocial support services, and movement limitations. Refugee and displaced women stressed how GBV survivors and marginalised women and girls could not benefit from the support of community networks, including those that are created within women and girls' safe spaces[xviii]. The banning of public gatherings, the closure of markets and the increased presence of security forces all reduced opportunities for community socialisation, leading to exacerbated feelings of loneliness and stress. These limitations pointed to an increased need for formal psychosocial support services, such as those offered in women and girls' safe spaces.

> "Isolation and loneliness have increased trauma for survivors. Women are on a daily basis experiencing financial and emotional violence from their intimate partners." (Female respondent, Liberia Safety Audit)

In response to these concerning trends and in an effort to maintain the confidential and safe nature of individual GBV response services provided within women and girls' safe spaces, GBV actors interviewed spoke of adapting group psychosocial and recreational activities within the limits of local COVID-19 protocols, for instance by offering activities in smaller, socially-distanced groups and rotating groups on a weekly basis to minimise overlap and overcrowding. In contexts where all group activities were prohibited and only one-on-one service provision was allowed, some GBV actors explored collaborations with health facilities to provide family planning counselling and other sexual and reproductive health consultations within women's safe spaces in an effort to diversify service provision and thus reduce safety and stigmatisation risks for survivors.

> "The days gone by if we couldn't find the social worker we had to wait for her the other day but for the moment we talk by phone and that helps us a lot and there are many people who give us good reports concerning this service." (Female respondent, Burundi Safety Audit)

A girl is standing outside her family's house in Bidibidi camp, Uganda. *Esther Mbabazie/IRC*

Emergency health services for GBV survivors

Access to emergency health services for survivors of VAWG appeared to have commonly been compromised during the pandemic, perhaps unsurprisingly as many resources were re-directed towards COVID-19 treatment and containment. GBV experts interviewed mentioned restrictions on movement, lack of personal protective equipment and fear of infection amongst health staff, especially in the early stages of the outbreak, as key issues which resulted in reduced opening hours for many health facilities and less frequent visits by mobile clinics.

> "The GBV [health] services hours are reduced from 24 hours to 8-10 hours daily due to the lock down." (Female respondent, Liberia Safety Audit)

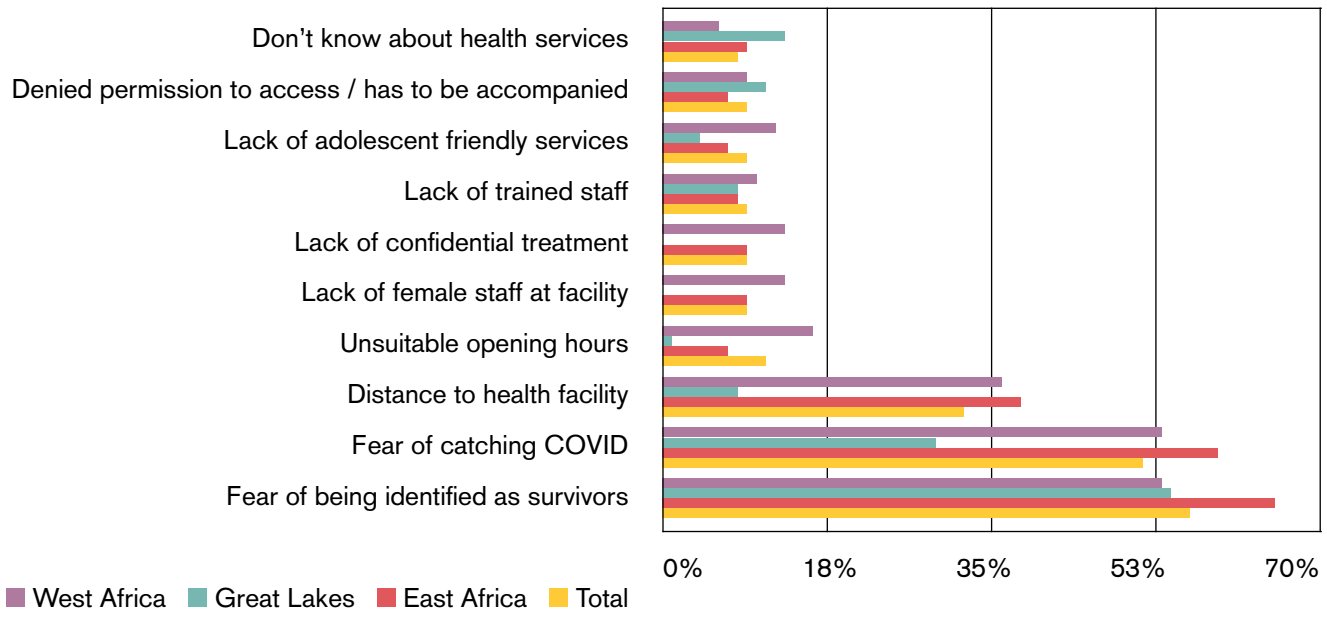
Refugee and displaced women also spoke of reductions in important health services and new protocols to control access and limit the number of patients seen each day resulting in increased waiting times. The compounded effect of the challenges faced by health facilities and infection control measures often meant that women and girls, including survivors of VAWG, struggled to access emergency services, such as post-exposure prophylaxis after sexual violence. Many women and girls mentioned that they felt unable to report abuse they experienced because they did not feel their case would be paid much attention during the pandemic.

> "Pregnant and lactating women do not get priority even though most of them have left a child in the house and they can't stay long hours to get these services." (Female respondent, Ethiopia Safety Audit)

When asked about reasons why survivors of VAWG might choose not to access health or psychosocial support and case management services, the barrier most commonly named by displaced and refugee women interviewed in the three African regions was again the fear of being identified as a survivor of GBV and the related stigma (56%), which remained higher than the fear of contracting the virus (51%). Stigma related to GBV represented a powerful obstacle to seeking support for survivors before the pandemic, but women pointed to specific ways in which the lockdown measures exacerbated it. For example, military and police officials interrogated women and girls at checkpoints to find out where they were going, and what services they were seeking, creating additional concerns for survivors who were worried about their safety and confidentiality.

Other pre-existing factors, such as the distance from a health facility (32%), were also made worse by the pandemic, according to women and GBV experts interviewed. Some health facilities were designated as COVID-19 treatment and isolation centres, meaning women and girls had to travel further to access clinical care for sexual violence and other emergency sexual and reproductive health services, while public transport either was banned or became more expensive. Women and girls who lost their sources of livelihood struggled to pay for transport or medical fees. As a response, IRC and partners were able, in some contexts, to provide additional funds for transportation to enable survivors to access services outside of their community.

Reasons why GBV survivors do not access health services during the pandemic



Lydia is an entrepreneur supported by the Rescuing Futures programme. *Elena Heatherwick/IRC*

Going digital

A prevalent adaptation of GBV service provision was either the creation or the reinforcement of existing hotlines to report incidents of GBV and, in some cases, to directly access remote case management and psychosocial support. The relatively smooth transition to remote service provision in a number of humanitarian responses was a successful example of rapid adjustment by GBV actors to a change of seismic proportions. Displaced women who took part in the IRC safety audit often welcomed this adaptation as it allowed them to remain in contact with GBV service providers while staying safe in the context of the pandemic. In some occasions, the use of telephones was considered even more convenient than traditional face-to-face services.

At the same time, however, interviews with women and GBV experts highlighted the limitations that an almost singular focus on digital and remote solutions had in remote, rural communities or within highly marginalised populations, such as the displaced women and girls interviewed for this report. In these contexts, women and adolescent girls' access to mobile phones and other digital technology was often limited, determined by unequal gender dynamics and, in situations of intimate partner violence, likely be heavily controlled and monitored by the abuser.[xix]

In the rush to devise innovative solutions in light of impeding lockdowns, GBV experts noted a widespread conflation between approaches to create new entry points to services and approaches to actually deliver quality case management and psychosocial support services to survivors. However, entry points are only effective insofar as they are able to connect a woman or girl in danger with quality, comprehensive response services staffed by experienced social workers or case managers, which was not always prioritised. The promotion of remote or digital solutions as the 'default adaptation' for GBV services even risked, in some cases, undermining advocacy efforts to keep in-person GBV services open and available to women and girls in humanitarian contexts with limited access to technology.

> "[Emphasise] the importance of in-person services, importance of PPE to provide in-person services and that they'd remain the main and most viable way of reaching people. Ensure we had safety and funding for that, rather than pretending there were magical options. I don't want people to think a hotline is an alternative to case management services." (International GBV expert)

The use of mobile technologies was undoubtedly critical for many women and girls affected by violence who were able to safely seek support and feel less isolated during periods of strict lockdown. At the same time, humanitarian GBV actors, leadership and donors should be aware of the limitations of digital adaptations and ensure that alternative approaches are considered and resourced to avoid excluding highly marginalised women and girls.

Case studies

Kenya

- **Protracted refugee situation for over 20 years**
- **Hosting 494,921 refugees and asylum seekers, 84% live in camps and 16% in urban areas**
- **Funding: USD $ 164.6 Million required; Funded $72.4 Million (44%) and 92.2million unfunded (56%)**

(UNHCR Updates, July2020)

The Government of Kenya enforced early and strict confinement measures by mid-March to contain the COVID-19 pandemic, including a lengthy nationwide lockdown and curfew, shutting down schools and closing national borders. Data from IRC's safety audit and interviews with GBV experts pointed to increased VAWG, particularly IPV, sexual abuse and early marriage during the pandemic.

Prioritisation of GBV

> "I don't think prioritisation of GBV response changed during COVID. It was just up scaled. GBV response has always been a key factor" (National GBV expert)

Significant efforts were undertaken to ensure that GBV services were prioritised within the refugee camps and host communities in Dadaab, Kakuma, Lodwar and Kalobeyei. There was intense public information and awareness raising through radio and public address systems on the increased risk of GBV and services available. GBV response service delivery was maintained and GBV recovery centres in Dadaab, Lodwar and Kakuma remained operational. GBV response services were intensified and adapted to online platforms and emergency hotlines were set up where they did not exist or strengthened for remote case management and psychological first aid. Community focal points were given phones with data so that women and girls were able to reach out for services. COVID-19 messages were integrated with information on how to access GBV services.

Capacity building for GBV service providers on how to support survivors remotely continued, including health workers, police, social workers, community health volunteers and protection community structures for an effective multi-sectoral response to GBV. Coordination among GBV actors and other sectors was sustained and moved to online platforms to discuss emerging issues and priorities for GBV services. A GBV technical working group was set up among humanitarian actors to adapt programs to the new situation. The composition of the technical team, made up of GBV in emergencies experts, was key in ensuring a clear focus on women and girls.

Many actors advocated to include GBV/SRH services as essential services to mitigate risks of VAWG. At the national level, advocacy efforts by GBV actors and feminist organisations got the attention of the president who directed the National Crime Research Centre to conduct a study on VAWG during the pandemic and report to him. A county government also established a safe house near the main county hospital for GBV survivors. Within the humanitarian sector material assistance to women and girls in form of dignity kits, menstrual hygiene kits and cash vouchers was enhanced.

> "This [advocacy] brought in a statement from Chief justice of Kenya, David Maraga, who announced a pandemic level of GBV. As much as we are responding to COVID-19 now GBV has escalated to pandemic level. So the chief justice was able to publicly declare that GBV has now become a disaster to that level. So that now systems can now be resourced to respond to GBV." (National GBV expert)

While the positive response from the government and the humanitarian leadership in Kenya facilitated the necessary prioritisation and adaptation of GBV services across refugee camps and host communities in the north of the country – the continued lack of funding did not allow GBV responders to capitalise on these commitments to scale up programming to meet the increasing demand.

A community volunteer conducts a one day sensitisation session with adolescent boys to address the role of men and boys in GBV prevention and response in Lodwar, Kenya. *IRC*

Programme adaptations and lessons learnt

GBV programmes were adapted to online platforms to continue services and mitigate the risk of GBV. Prevention activities and awareness raising were conducted through radio, mobile vans, and social media platforms. Case management and psychosocial support were shifted to GBV emergency hotlines. GBV service providers were trained on how to support survivors remotely. The GBV experts noted that the adaptations were largely successful, as many survivors were able to reach out and receive assistance. Quickly moving into virtual capacity building for GBV service providers and supporting them with smartphones, airtime and constantly remote monitoring was effective for continuous service provision. The adaptation of safe spaces was more challenging. IRC adapted the women's and girls' safe spaces (WGSS) to accommodate social distancing measures in place. Groups were divided into smaller cohorts and allocated different times for their activity. However, this led to inconsistency in attendance as women and adolescent girls attending safe space activities were not used to following a strict timetable which became necessary to ensure infection precautions were in place. Additionally, the adaptations increased the workload of the few staff.

Engaging women-led organisations

Women-led and women's rights organisations were engaged in the planning and implementation of the response to COVID-19 in locations where they were already part of GBV structures, such as the national GBV working group and GBV sub clusters. INGOs that had existing partnerships with women-led organisations also engaged them in the planning and implementation of the COVID-19 response, as implementing partners for service delivery. Some women-led organisations faced logistical challenges to participation, as remote work requires access to laptops, smartphones, and internet data, which women-led organisations did not have and could not afford.

Overall, refugee and host community women and girls in Kenya continued to have access to essential GBV services throughout the pandemic. Strong advocacy for the inclusion of GBV services in humanitarian planning and response, capacity building for GBV actors and local structures, effective coordination among GBV actors, and the involvement of women's organisation were all highlighted as critical factors enabling a sustained attention towards the needs of women and girls in the country, including in refugee camps. While insufficient resources limited the extent to which services could be adapted or even expanded to respond to increased risks for women and girls, ultimately the GBV sector was successful in its efforts to ensure that survivors of violence were not left behind.

Distribution of dignity kits to adolescent girls in Kenya. *IRC*

Women during a recreational basket weaving activity in Chad. *IRC*

Chad

- **Complex humanitarian situation driven by food insecurity, natural disasters, health emergency and conflict-related displacement**
- **Hosting 476,399 refugees from Sudan, CAR and Nigeria**
- **Funding: 70% of the country's humanitarian funding needs for 2020 remain unmet[xx].**

(UNHCR Updates, July 2020)

The outbreak of the pandemic in March 2020 corresponded with a period of renewed Boko Haram violence in the Lake Chad region, leading to a combination of security and public health restrictions which severely impaired the capacity of humanitarian actors to provide services and assistance. COVID-19 specific restrictions included a national curfew, restrictions on public and private transport outside of urban areas, the limitation of all gatherings and the closure of non-essential activities and schools, with a distinct impact on trading activities and markets across the country.

Prioritisation of GBV

> "GBV activities weren't placed at the front, in my opinion. It was just 'how to prevent? How to respect the COVID-19 measures?'. This was the priority and we saw in general that GBV risks which this pandemic could create were not prioritised." (National GBV expert)

The humanitarian and government responses in Chad throughout the pandemic largely focused on health, WASH and food security in line with pre-existing priorities with a limited focus on dedicated GBV prevention and response programming. Nonetheless, humanitarian actors already engaged in GBV programmes promoted the inclusion of GBV programming in humanitarian response planning and advocated for the continuation of services to GBV survivors.

Some humanitarian organisations interrupted all in-person GBV activities for a period of three months due to a combination of security and infection-control restrictions, as well as reducing the frequency and level of service provided by mobile health clinics. This had a severe impact on women and girls' ability to seek safety and assistance when they experienced violence. Health service providers prioritised emergency cases and imposed limits on the number of patients seen on a daily basis, often suspending critical sexual and reproductive health services such as family planning and distribution of emergency contraceptives. Access to justice was also critically impacted as noted by GBV service providers. While courts in N'djamena recently resumed activities, cases related to IPV and other forms of GBV were still de-prioritised within court as they were perceived as "not really serious, women's things, something between husband and wife" (National GBV expert).

Interviews with GBV experts and displaced women highlighted the critical need for material and economic support for women whose livelihoods were affected by limitations on trading activities and savings groups. At the time of data collection, little to no funding was forthcoming to address women's increased economic vulnerability and they remained exposed to sexual exploitation and abuse as they ventured further afield to generate income.

Distribution of dignity kits to women's groups in Chad. I*RC*

Programme adaptations and lessons learnt

Humanitarian GBV actors in Chad worked hard to ensure that a minimum of GBV response services and, to the extent possible, risk mitigation activities remained available to women and girls in affected communities. Some organisations were able to transition to radio awareness sessions and, in one case, a mobile van travelling across communities to share information about GBV risks and services. These adaptations were considered very effective in reaching a large number of community members during this time when face-to-face interaction was not possible.

GBV experts interviewed expressed that GBV service providers 'had no choice' but to rely on telephone networks to try and maintain contact with survivors when all face-to-face interactions were halted in the first months after the pandemic was declared. However, this strategy was mostly unsuccessful within the context of Chad due to very limited access to phones and phone credit by women (particularly girls), poor telephone networks, and limited capacity of GBV frontline workers to provide remote case management support. Efforts to establish a toll-free number were delayed and while in some cases community volunteers were able to offer their 'NGO phone' to call caseworkers, ultimately their intermediary role was considered an additional barrier to access for women and girls who were concerned about confidentiality.

> "Movement restrictions have created an issue in terms of access to services, but we haven't really been able to develop strategies to act remotely, help the survivor. These strategies must involve technology necessarily, which is very weak across the country." (National GBV expert)

Engaging women-led organisations

The participation of women-led organisations in the COVID-19 humanitarian response was minimal. Local organisations in Chad historically struggled to directly access humanitarian funding and the limited funding that did become available for local organisations during the COVID-19 response was directed towards male-led organisations focused on health and COVID-19 prevention. Women-led organisations were also unable to influence humanitarian planning as the GBV sub-cluster, where they normally participate, was unable to meet for the first few months of the crisis due to technological limitations.

In Chad, the lack of prioritisation of women and girls' safety within both the national government and humanitarian responses to COVID-19 had a clear impact on the capacity of displaced women and girls to access lifesaving GBV and SRH services. A certain level of remote service provision was guaranteed thanks to the efforts and dedication of existing GBV actors and, importantly, women living in the community who took on responsibilities both in terms of GBV response and awareness raising and within COVID-19 prevention efforts. The accessibility of GBV services provided through mobile phones limited was limited due to very weak networks and very poor access to technology by displaced women and girls. GBV programs which focused on reaching GBV survivors by supporting women in the community to deliver case management and psycho-social support, had more success in sustaining services in these contexts. This example highlights the need for programme adaptations to be rooted in local analysis of the context if they are to be effective.

Burundi

- **Deepening socio-economic crisis, high malnutrition rates and limited livelihood opportunities.**
- **Hosting: 82,319 refugees and asylum seekers mainly from DRC**
- **Funding: $56.8 million required and only 21% has been funded**

(UNHCR Updates, July 2020)

The government in Burundi has not instituted strict COVID-19 containment measures like curfews and lockdowns to-date. The country continued to operate 'normally' internally although the borders were closed. The humanitarian actors engaged in planning and preparedness in case of a lockdown. Their planning was informed by experiences from other countries in Asia and Europe where lockdowns were put in place, increased reporting of VAWG cases were recorded, and challenges to continue to provide GBV services were documented.

Prioritisation of GBV

The humanitarian protection and GBV cluster took the lead in planning and preparing for continuous GBV services in case of a lockdown. A GBV annex was developed for the humanitarian response plan (HRP) against COVID-19 to include activities to respond to women and girls' issues. The government's national response plan for COVID-19 did not include a focus on women and girls and is to be reviewed to include activities that focus on women and girls.

> "There is no interest in women and girls' issues. The focus now is on COVID related health issues. To distribute food, to distribute equipment. The support to GBV survivors, sometimes it's not their priority. So for us, we need to push as we are doing so the woman and the girl issues is also prioritised." (National GBV expert)

Advocacy and coordination with other sectors like food, shelter and cash distribution to consider women's needs and sensitise their staff on sexual exploitation and abuse were conducted. Capacity building and training on how to provide remote GBV services, case management, psychosocial support and protection was conducted for service providers.

Plans were made to install tablets with modems at community centres (Hope Centres) for remote case management and psychosocial support, train community respondents who would be points of contact for GBV survivors and online psychosocial assistance. Plans were made to use radio, megaphones and posters for awareness raising. Humanitarian actors did their best in planning and preparation for continued GBV services, but no funds came through to support these activities.

> "Mental preparation is what was done, but there were no funds coming through. Yes, the women's centre remained opened and operational, but survivors could not access it due to increased cost of transport and the fact that most women lost their livelihoods with the closure of the borders" (National GBV expert)

Women during a recreational sewing activity in Burundi. *IRC*

Programme adaptations and lessons learnt

Interviews with refugee women and GBV experts indicate that because there was no lockdown, access to GBV services was not restricted. 95% of refugee women interviewed indicated that GBV services were available, 73% said opening hours at the health centre for GBV services were not affected and 100% said psychosocial support was available and adapted to the new environment.

However, social distancing measures, reduced number of staff in the camps and increased cost of public transport were de facto limiting access to services. To offset this, GBV actors provided cash vouchers for women and girls and additional funds were acquired from some donors to support women and girls with transport costs to access GBV services. Dignity kits and payment of rent could be provided when clients could not afford it or needed an emergency shelter.

Although the government did not impose restrictions in movement, most humanitarian organisations put in place protection measures to prevent the spread of COVID-19 by regulating their staff movement into the camps and community. This impacted the quality of services provided as these staff could not often be in the camps to support and coach community respondents. Accordingly, prevention activities were largely suspended and GBV response services were moved online. GBV hotlines were used for case management and psychosocial support and phones were made available in the camps so women and girls could contact service providers. Additionally, all health facilities were equipped with post-rape kits. Information on GBV referral pathways, emergency hotlines and police protection helplines were widely disseminated in the community and awareness raising was provided on how women and girls can keep themselves safe.

Engaging women-led organisations

There was minimal participation of women-led organisations. Those that are part of the GBV cluster and had existing partnerships with INGOs were engaged in the planning and implementation of services.

The GBV sub-sector in Burundi was able to advocate for the inclusion of women and girls' needs and GBV services in planning and preparedness exercises by humanitarian actors. In addition, even though the government did not establish a national lockdown or other restrictive measures, GBV service providers working in refugee camps were able to plan and, to a certain extent, implement adaptation measures to limit the spread of COVID-19, such as using tablets and mobile hotlines to remain in touch with GBV survivors and using radios to continue awareness raising. Despite the extensive planning activities, GBV actors struggled to secure sufficient funding to cover additional needs. Ultimately, this case points to the need to not only plan, but secure funding for the planned interventions.

A session of IRC's economic and social empowerment (EA$E) framework is conducted in Burundi. *IRC*

The three case studies of Kenya, Chad and Burundi illustrate how the recognition by national and local decision makers as well as within the humanitarian leadership structures of the enhanced risk of GBV, can bolster or hamstring the work of GBV service providers. It creates the lanes and limitations within which GBV responders are able to reach clients and adapt and maintain their work.

The case studies underline the essential role that coordinated and joint advocacy by GBV actors and, critically, the work of displaced women living in affected communities, played in ensuring that GBV survivors could still access lifesaving services during the pandemic. From advocacy and preparedness efforts, to programme adaptations, GBV experts across the three countries worked hard to ensure the needs women and girls were taken into account in humanitarian response efforts.

The case studies also make clear, however, that even if there is a broad political recognition of the specific risks women and girls face, and even if there is a vibrant GBV community in place to mobilise action; this will have limited impact without the necessary funding. Sadly, in all three case studies, the additional funding was not provided, in fact in many cases funding was diverted into health responses to COVID-19 and failed to include GBV mitigation. The experiences of women and girls continue to not be adequately prioritised, despite the ample evidence pointing to how women and girls are distinctively affected by all emergencies.

Conclusion and recommendations

2020 was intended to be a year to celebrate progress towards gender equality since the Beijing Platform for Action and UN Resolution (1325) on Women Peace and Security and to accelerate progress through the Generation Equality Forum. Instead, the COVID-19 pandemic is rolling back achieved progress on gender equality for all women across the globe, but especially those living in refugee camps, or other displaced and post conflict settings. 2020 has seen a rise in violence against women and girls – particularly amongst the most marginalised – as lock downs and other restrictions on movement and association are exacerbating conditions that put women and girls at risk of GBV.

Not only did the pandemic deeply impact the lives of women and girls in humanitarian emergencies, but so too did the ways in which humanitarian actors responded to this new threat. Despite the early warnings that predicted the effects of the crisis on women and girls, the humanitarian response to COVID-19 did not prioritise the safety of women and girls. Lessons from the Ebola crises were not built on. Globally, the GHRP process highlighted the unique needs of women and girls but failed to translate that acknowledgment into concrete commitments and accountability for humanitarian actors. Nationally, the prioritisation of the needs of women and girls in COVID-19 responses differed widely and more often than necessary, women's safe spaces were closed or re-purposed, and face-to-face GBV services were interrupted or replaced with remote service delivery models.

Ultimately, insufficient resources and unclear funding pathways prevented women's rights organisations and GBV actors from fully realising the promise to centre women and girls in the COVID-19 response. Female leaders, women-led organisations, feminist activists and GBV experts have the tools to keep women and girls safe. They are now asking, perhaps louder than ever, for the necessary resources and support to do so.

This crisis has to be a wake-up call for all humanitarian actors to translate commitments made towards the humanitarian aid reform agenda at the World Humanitarian Summit, the Oslo Conference or the Global Refugee Forum into action. The Generation Equality Forum is an opportunity for the UN, host countries and progressive governments, to chart a way forward towards a humanitarian system that fosters gender equality and centres the voice and agency of women's organisations working in their communities.

The new roadmap of the Call to Action on Protection from Gender-Based Violence in Emergencies is designed to drive change and foster accountability so that every humanitarian effort, from the earliest phases of a crisis, includes the policies, systems, and mechanisms necessary to prevent, mitigate, and respond to GBV. It should be used to inform the Generation Equality Forum's GBV Action Coalition and the Women Peace and Security Humanitarian Compact to secure measurable funding and policy commitments over the next five years. It should also guide G7 commitments under the British G7 presidency to formulate funded and accountable actions to increase GBV prevention, mitigation and response in the global response to COVID-19.

The pandemic is yet another example of how complex humanitarian crises disproportionately affect the most marginalised women and girls. But it also offers us a chance to learn and build back better.[xxi] The findings of this report clearly highlight the needs to shift the ways of working within the humanitarian crisis response towards a more inclusive approach. We need to actively seek out and listen to voices of those most marginalised. Their perspectives needs to feed into decision making at the local and global level alike. This calls for agreed channels and procedures to ensure actors like women's rights organisations working in their communities are resourced and empowered to meaningfully participate in humanitarian planning.

Hand washing practice at a hand washing station by some of the adolescent girls accessing the safe space in Mubi North, Nigeria. *IRC*

Recommendations put forward by women in the safety audit

As part of the remote safety audit exercise, we asked women from refugee, displaced and post conflict settings, to provide their recommendations on how to improve the safety of women and girls in the current context. Their answers are summarised below.

Women recommended to increase the presence of trained staff and community volunteers

- Improve accessibility of services by increasing the number of trained staff or community respondents so that more women and girls can be assisted, opening hours extended as staff could work in shifts; and survivors can feel comfortable reporting to qualified staff.

> "We have to build other [women] centres and also increase the number of staff to allow us to have access to the service since with the arrival of corona, we women are having a lot of problems and having access to the [women] centre has become complicated." (Female respondent, Chad Safety Audit)

- Provide sufficient PPE so that staff feel safe working and extra PPE for women and girls who do not have their own, as this is currently resulting in the denial of services.
- Increase the number of community volunteers and respondents, while ensuring quality through capacity building and ongoing remote supervision by IRC staff was requested.
- Coordinate and raise awareness for GBV with community leaders and religious leaders.

An IRC staffer takes the temperature of a women before entering a Hope Centre in Burundi. *IRC*

IRC incentive workers line up to wash their hands before entering into a safe space. *IRC*

Women recommended to establish alternative modes of delivery

- Where possible, staff or community respondents should provide mobile, face-to-face services. Mobile clinics can bring services closer to survivors. Door-to-door sensitisation is useful in raising awareness for those that cannot leave their homes.
- Where face-to-face services are not possible, increase remote service delivery where women and girls' safe access to phones is possible. Staff should be provided with hardware and training on providing psychosocial support over the phone and the number of hours these services are available should be expanded.

> "Donors must increase their funding to fill the gaps in response services and ensure the IT equipment is available to provide remote case management in the Hope Centres (computers, internet connection, webcams)" (Female respondent, Burundi Safety Audit)

Women recommended to advocate with local authorities

- Humanitarian actors should advocate with local authorities so that essential services can remain open after curfew hours.
- Introduce street lights and lighting in toilet facilities to increase safety for women and girls accessing basic needs.
- Provide capacity building and sensitisation for security officers or police to protect women and girls and so that these actors can be a resource to them rather than another obstacle.

> "Carry out advocacy actions with the military and police authorities to reduce certain restrictive measures but also to carry out checks in strict compliance with the rights of women and girls." (Female respondent, DRC Safety Audit)

- Local authorities must hold men and boys who perpetrate violence against women and girls accountable. Humanitarian actors should coordinate with local and state officials to advocate for policy change or more regular enforcement of existing law.

Women recommended to establish additional service points and increase activities

- Provide additional service points for every service mentioned, from basic needs to women and girls' safe spaces. This could ease problems such as travelling long distances to obtain health services, limited access to safe spaces and long queuing at water points.
- Increase awareness-raising on GBV, specifically of what GBV means and how to access help if a woman or girl experiences violence. The second most commonly requested topic was COVID-19. Some respondents suggested blending awareness-raising sessions to cover both issues.

> "GBV information should be integrated into COVID-19 which is where almost everybody is paying attention to." (Female respondent, Uganda Safety Audit)

- Provide economic opportunities for women and girls to mitigate the collapse of the livelihood activities, including the provision of cash, re-starting VSLAs, providing agricultural support such as seeds and hoes, and conducting skill-building workshops.

Women recommended to provide basic needs support

- Provide communities with an increased supply of food rations. Further, women and girls with disabilities should receive food rations directly to avoid others from taking advantage of them.
- Deliver non-food items such as firewood, water, PPE and other materials, to protect women and girls against risks when collecting basic necessities.
- Provide additional menstrual hygiene products and body soap for bathing, as was common before the pandemic. Provide menstruating women and girls with reusable pads and period underwear. Skill-building in the creation of such products could eliminate the issue of exhausting supplies.

Women recommended to improve water and sanitation services

- Increased water and sanitation service points and the distribution of additional jerricans and buckets would allow women and girls to carry more water from a single visit.
- Set up more handwashing stations not only near latrines but in any place where people gather for services or basic needs
- Provide sex-segregated and inclusive toilets with doors. Currently, communal toilets are often unhygienic, inaccessible for older-aged women and women and girls with disabilities, lacking privacy, and are shared with men and boys.

> "Provide separate toilet for female and male, construct disability friendly latrines." (Female respondent, Ethiopia Safety Audit)

Members of the police in Turkana county after finishing a two day training to foster a comprehensive and coordinated response to GBV and to strengthen the capacity of police officers to adequately respond to GBV in Lodwar, Kenya. *IRC*

Recommendations by IRC

Building on the recommendations put forward by the refugee and displaced women interviewed for this report, this set of recommendations addresses governments, donors and humanitarian actors, to ensure future emergency responses are guided by the learnings of the initial response to COVID-19 and put a focus on the needs of women and girls.

Prioritise GBV Prevention & Response: The safety of women and girls should be an explicit priority in all crisis response, to drive increased resource allocation to GBV services that are inclusive of all women and girls.

- During COVID-19 lockdowns and restrictions on movement, humanitarian actors and governments need to ensure lifesaving GBV services are part of the essential services that are allowed to continue.
- UN OCHA should include a specific objective for GBV in all future multilateral humanitarian appeals, such as the COVID-19 GHRP, to increase resource allocation to GBV services in HRPs.
- Donors should clearly articulate their support for GBV programming as a central component in crisis response in multilateral negotiations – including by demanding accountability in how far unearmarked investments are used for GBV programming.
- The humanitarian community should document and apply the learning of the COVID-19 and Ebola response in line with the Inter-Agency Minimum Standards for Gender-Based Violence in Emergencies Programming.

Understand the needs of women and girls: Existing analytical tools and guidelines should be used to strengthen the analysis of and response to humanitarian needs of women and girls.

- Humanitarian country teams should apply robust gender analysis, including GBV risk analysis, when crafting Humanitarian Needs Overviews (HNOs), Periodic Monitoring Report (PMR) and Humanitarian Response Plan (HRPs).
- Humanitarian organisations, coordinators, country teams, clusters and donors should use the IASC Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action throughout the humanitarian project cycle to mainstream GBV prevention and mitigation in all sectors.
- Donors should make the use of the IASC Gender with Age Marker (GAM) mandatory in project design and monitoring in order to drive resources to under-represented groups.

Transparent and Accountable Funding: A more accurate understanding is needed of how adequately the humanitarian system is responding to GBV.

- Increase the amount of multi-year funding passed through to frontline responders, including local women-led organisations. A target should be agreed at this year's annual Grand Bargain meeting.[xxii]
- All humanitarian actors should work to ensure GBV funding is accurately reflected in the Financial Tracking Service (FTS) and the International Aid Transparency Initiative (IATI) databases through the use of appropriate of GBV and gender equality codes.
- Develop a guide to promote improved coding and tracking of allocations and expenditures, in line with the Inter Agency Standing Committee's (IASC) Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action, through the Generation Equality Forum's GBV Action Coalition in 2021.
- To increase the quality and sustainability of GBV programming, donors should ensure funding is flexible enough to adapt to changing needs.

Participation of Women's Rights Organisations and Groups working in Communities: The safe and meaningful participation of diverse women and girls in decision-making processes, relief services and recovery plans at all levels and throughout the response results in better humanitarian outcomes and quality GBV response services.

- All GBV funding must include a 25% allocation to support women-led organisations working in communities implementing GBV programming, including allocations for organisational strengthening and support of joint learning.
- Donors should adapt accountability and learning systems and procedures to facilitate funding for women's organisations, as these systems may need to be different from the procedures of larger entities.
- The Generation Equality Forum's Women Peace and Security and Humanitarian Action Compact should include a commitment from humanitarian actors to include women's rights organisations working in their communities in the planning of the local crisis response, following the indicators outlined in the Inter-Agency Minimum Standards for Gender-Based Violence in Emergencies Programming on Women's and Girls' Participation and Empowerment.

Annex

Methodology and lead questions

Number of Reponses from Each Region	
East Africa	221
West Africa	474
Great Lakes	148

This report draws on an extensive remote safety audit exercise conducted by the IRC between May and July 2020. Using an adapted version of the IRC's standard GBV Assessment tools[xxiii], 852 interviews were conducted with refugee or displaced women community focal points, including WPE community volunteer case workers, mentors, and activists living and working across 83 communities within 15 African countries in East Africa, West Africa, and the Great Lakes[xxiv] region. Interviews were conducted by more than 100 IRC staff in areas where IRC delivers GBV response services and prevention activities.

The data was collected primarily over the phone due to COVID-19 safety protocols, enabling a wide regional spread but potentially excluding women who did not have access to a telephone or telephone network. Additional limitations included the fact that participants were not randomly sampled but drawn from a pool of female community volunteers and female community leaders IRC was already in contact with and who had expertise in GBV prevention and response programming.

Google Translate was used to translate data that was not collected in English, potentially yielding imprecise translations and data sets varied in size between countries and regions. An analysis by region is presented across the report to mitigate the impact of this disparity.

Countries surveyed

Number of Respondents by Country

Country	
Burundi	41
Cameroon	90
Chad	51
Cote d'Ivoire	25
Democratic Republic of the Congo	27
Ethiopia	38
Kenya	88
Liberia	63
Niger	17
Nigeria	84
Sierra Leone	144
Somalia	8
South Sudan	28
Tanzania	81
Uganda	67

Number of Respondents

8 144

To complement the data emerging from the remote safety audits, the IRC conducted 25 key informant interviews with GBV experts working in a range of roles and organisations, including UN agencies, donor governments, international and national NGOs and civil society organisations. 16 out of the 25 key informants are currently working in one of the three case study contexts, i.e. Kenya, Chad or Burundi, ensuring a strong representation of 'field' and frontline voices amongst the key informants. Interviews were completed remotely during August 2020 using a semi-structured interview guide which covered key topics such as prioritisation of GBV programming, funding trends, participation of women and girls and recommendations for future responses.

Safety Audits in each location were primarily implemented to keep in touch with women focal points within each community during limited movement due to COVID-19 infection restrictions. Regular calls with community focal points and a standardised interview guide enabled WPE teams in each location to identify risks and barriers to service access and to advocate with humanitarian actors to mitigate risks and remove barriers to women and girls safe and equitable access to aid in each setting. This data was then also shared for global analysis and advocacy. Two primary questions guided the data collection and analysis which informs this report. Firstly, the safety audit interview data sought to answer the question: *How did COVID-19 affect the lives of women and girls in emergencies?*; and secondly, all data contributed to addressing the question: *Did the humanitarian sector prioritise GBV services for women and girls in its COVID-19 response?*

Adolescent girls during a girls meeting in a safe space in Liberia. *IRC*

Endnotes

i. https://www.theguardian.com/society/2020/mar/28/lockdowns-world-rise-domestic-violence

ii. A small sample: https://www.axios.com/china-domestic-violence-coronavirus-quarantine-7b00c3ba-35bc-4d16-afdd-b76ecfb28882.html; https://www.nytimes.com/2020/04/06/world/coronavirus-domestic-violence.html; https://time.com/5803887/coronavirus-domestic-violence-victims/

iii. For a repository of reports and technical guidance, check: https://gbvguidelines.org/cctopic/covid-19/

iv. https://www.unwomen.org/en/news/stories/2020/4/statement-ed-phumzile-violence-against-women-during-pandemic

v. https://news.un.org/en/story/2020/04/1061052

vi. For an overview of available guidance for programming, see: https://gbvaor.net/thematic-areas?term_node_tid_depth_1%5B121%5D=121

vii. For example CARE 2020 She told us so or Plan International 2020 Halting lives: The impact of covid-19 on girls.

viii. In some of these post conflict contexts we also work with women in urban or rural settings to build community and government capacity to respond to GBV.

ix. The IRC uses a rights based approach to intersectionality and in partnership with women's rights networks and organisations, has selected the term "diverse women and girls" to highlight the strengths which the different experiences and identities of women and girls bring within women and girls' movements and WPE programming. The IRC also uses the term "marginalized women and girls" to highlight how structures of oppression based on gender inequality intersect with racism, ableism, homophobia, transphobia, xenophobia, classism and other types of discrimination. For more information on the IRC's approach to addressing intersecting inequalities to ensure access to GBV services by diverse women and girls, please read our guidance note: https://gbvresponders.org/emergency-response-preparedness/emergency-response/

x. See for example: https://www.hrw.org/news/2020/06/18/lgbtq-inequality-and-vulnerability-pandemic; https://www.hrw.org/news/2020/05/20/south-africa-end-bias-covid-19-food-aid; https://www.ohchr.org/Documents/Issues/LGBT/LGBTIpeople.pdf

xi. https://www.hrw.org/news/2020/04/03/uganda-lgbt-shelter-residents-arrested-covid-19-pretext; https://www.bbc.co.uk/news/av/world-africa-52835114

xii. https://reliefweb.int/sites/reliefweb.int/files/resources/GHRP-COVID19_July_update_0.pdf

xiii. UN OCHA, Financial Tracking Service. https://fts.unocha.org/appeals/952/summary [accessed on 11th August 2020]

xiv. IRC and VOICE, 2019. Where is the money? https://www.rescue.org/sites/default/files/document/3854/whereisthemoneyfinalfinal.pdf

xv. IRC and VOICE, 2019. Where is the money? https://www.rescue.org/sites/default/files/document/3854/whereisthemoneyfinalfinal.pdf

xvi. See for example: UNDP, 2015. Assessing Sexual and Gender Based Violence during the Ebola Crisis in Sierra Leone. https://www.sl.undp.org/content/sierraleone/en/home/library/crisis_prevention_and_recovery/assessing-sexual-and-gender-based-violence-during-the-ebola-cris.html; IRC, 2020, Not all that bleeds is Ebola, https://www.rescue.org/sites/default/files/document/4416/srhebolareport1172020.pdf; O'Brien and Ximena Tolosa, 2016. 'The effect of the 2014 West Africa Ebola virus disease epidemic on multi-level violence against women'. International Journal of Human Rights in Healthcare, VOL. 9 NO. 3, pp. 151-160

xvii. UN Women, 2019 IASC Gender Policy and Accountability Framework Report (forthcoming).

xviii. IRC, 2012. Let me not die before my time. https://www.rescue-uk.org/sites/default/files/document/990/newircreportdomviowafricauk.pdf

xix. Crabtree, K., & Geara, P. (2018). Safety planning for technology: Displaced women and girls' interactions with information and communication technology in Lebanon and harm reduction considerations for humanitarian settings. Journal of International Humanitarian Action, 3(1), 3. https://doi.org/10.1186/s41018-018-0031-x

xx. UN OCHA, Financial Tracking Service. https://fts.unocha.org/appeals/907/summary [Accessed on 8th September 2020]

xxi. IRC, 2020. When Returning to Normal Doesn't Work for Half the World's Population: How to Build Back Better. https://www.rescue.org/sites/default/files/document/5049/co2007wg-whitepaperd31.pdf

xxii. IRC, 2020. A Win-Win: Multi-year flexible funding is better for people and better value for donors. https://reliefweb.int/sites/reliefweb.int/files/resources/ircwinwinmyffuslv7.pdf

xxiii. You can find IRC's standard GBV assessment tools under: https://gbvresponders.org/emergency-response-preparedness/emergency-response-assessment/

xxiv. These are regional groupings used by the IRC in its programming and include, for East Africa, Kenya, Ethiopia, Somalia, South Sudan, Uganda; for West Africa, Chad, Cameroon, Niger, Côte d'Ivoire, Nigeria, Liberia, Sierra Leone; for the Great Lakes region, Burundi, Tanzania, the Democratic Republic of Congo.

INTERNATIONAL
RESCUE
COMMITTEE

New York
122 East 42nd Street
New York, NY 10168-1289
USA

Amman
Al-Shmeisani Wadi Saqra Street
Building No. 11
PO Box 850689
Amman
Jordan

Bangkok
888/210–212 Mahatun
Plaza Bldg., 2nd Floor
Ploenchit Road
Lumpini, Pathumwan
Bangkok 10330
Thailand

Berlin
Wallstraße 15A,
10179 Berlin,
Germany

Brussels
Square de Meeûs 5-6
De Meeûssquare 5-6
1000 Brussels
Belgium

Geneva
7, rue J.-A Gautier
CH-1201
Geneva
Switzerland

London
3 Bloomsbury Place
London WC1A 2QL
United Kingdom

Nairobi
Galana Plaza, 4th Floor
Galana Road, Kilimani
Nairobi, Kenya

Washington, D.C.
1730 M Street, NW
Suite 505
Washington, DC 20036
USA

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