Impact of COVID-19 Pandemic on Violence against Women and Girls

Dr Erika Fraser [1] **16 March 2020**

Query: What is the evidence of how the coronavirus (COVID-19) pandemic[2] might impact on violence against women and girls (VAWG)? Please draw on any emerging global evidence from the current outbreak in corona virus, as well as other similar epidemics? (e.g. Ebola)

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1. Overview

Since its outbreak, COVID-19 has infected hundreds of thousands of people across the world and created a range of primary and secondary effects on different individuals and communities (Wenham et al, 2020). The Director General of the World Health Organisation declared coronavirus (COVID-19) a global pandemic on 11 March 2020. This rapid research query summarises the evidence of the COVID-19 pandemic on violence against women and girls (VAWG), as well as other similar epidemics.

Evidence on the impact of COVID-19 remains at an early stage and mostly comes from news articles and reports from women's organisations. Key evidence gaps from both the COVID-19 pandemic and other similar outbreaks include: (1) limited data on how levels of violence change; (2) lack of disaggregated data particularly for vulnerable groups such as adolescent girls, older women, women and girls with disabilities, and refugee/migrant women; (3) limited research on the pathways of violence and how outbreaks can exacerbate different forms of violence against women and girls; and (4) few documented examples of good practice in preventing and responding to violence against women and girls during an outbreak. So far, we are seeing impacts in middle income and high income countries, but this picture is likely to change rapidly in the coming weeks and concerns have been raised about potential impacts in emergency settings with displaced and mobile populations, as well as in overcrowded peri-urban settlements in many cities throughout the world. Potential impacts are likely to be exacerbated in contexts with weak health systems, weak rule of law, and existing high levels of VAWG and gender inequality.

[1] Identification of evidence on COVID-19 from Italy by Serena Mior.
[2] Note from WHO on how to refer to the COVID-19 virus https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(covid-2019)-and-the-virus-that-causes-it

Emerging evidence suggests there are several ways in which the COVID-19 pandemic may impact on violence against women and girls:

- **Increased risk of domestic violence**. In China, police reports show domestic violence has tripled during the epidemic. Domestic violence organisations have observed increased household tension and domestic violence due to forced coexistence, economic stress, and fears about the virus. The COVID-19 outbreak has also curtailed access to support services for survivors, particularly in the health, police and justice sector. There is also some evidence that authorities have converted women's shelters into homeless shelters. In Italy, similar concerns have been raised about rising levels of domestic violence. However, there are also examples of innovative practices to support survivors including through technological solutions in China and Italy.
- **Increased risk of workplace violence in the health sector** due to the serious stress that the pandemic places on patients, their relatives and other healthcare workers. In China, there have been reports of physical and verbal attacks against frontline healthcare workers. In Italy, the national healthcare workers union have raised concerns about attacks against doctors and nurses as COVID-19 overwhelms health resources and patients' families become increasingly anxious. In Singapore, uniformed healthcare workers have been harassed in public spaces and on transport. There is not yet data on the gendered nature of violence, but research before the epidemic found that most violence is targeted at female nurses in emergency departments with long waiting times, in isolated places at patients' homes, or in geriatric or psychiatric departments.
- **Increased risk of racial and sexual harassment (both online and offline),** with anecdotal reports of targeted sexualised attacks against women of East Asian appearance. In Delhi, for example, female students from northeast India were verbally harassed, had objects thrown at their private parts and their attackers shouted 'Aye, coronavirus!'
- **Increased risk of abuse and exploitation for vulnerable women workers**. In the United States, there have been reports of more coercive and violent behaviour against street-based sex workers in Seattle since the COVID-outbreak began. In Hong Kong, the migrant workers association have warned that domestic workers (most of who are migrant women) are being made to work on their day off, since the government told people to stay inside.
- **Increased risk of VAWG in emergency settings**, including refugee camps and IDP settlements where women may be at increased risk of different forms of violence, including sexual exploitation and abuse. In the Greek island of Lesbos, aid organisations report that women are at high risk of sexual violence and already have limited access to healthcare. Fears are growing that the situation for survivors is likely to deteriorate as health systems become overwhelmed with the first confirmed case of COVID-19 on the island. In Lesbos, some aid organisations have also suspended services due to harassment of aid workers from local anti-migrant groups.
- **Increased risk of sexual exploitation and violence by state officials and armed guards**. In China and Iran, there have been some fears about increased state surveillance and officials abusing their power, but no data yet on gendered state violence due to the pandemic.

Experience from past epidemics suggests the importance of a 'twin track' approach, combining support to organisations working directly with survivors and integrating VAWG into sectoral responses (e.g. health, education, child protection, security and justice, social protection and job creation). A summary of lessons from past epidemics is shown in the table below, based on examples from outbreaks of Ebola (in West Africa and DRC), cholera (in Yemen), and Zika (in the Caribbean, Central and South America) (see Section 4 for further details).

Lessons from other similar epidemics	
 **Providing support to survivors**	• In past epidemics, women and girls were at increased risk of various forms of violence, with the most common forms being intimate partner violence and sexual exploitation and abuse. • Specialised support services for Gender-Based Violence (GBV) survivors are in heavy demand during public health emergencies but remain limited in availability and funding is often deprioritised.
 **Health sector**	• Survivors of GBV can find it difficult to access healthcare due to restrictions on movement and closed clinics. • Fear of violence and mistreatment can prevent women from seeking health services during an epidemic. • Fear of infection can prevent people accessing health services during an outbreak, including life-saving care and support for GBV survivors. • Epidemics can divert healthcare resources away from GBV services and sexual and reproductive health services. • Concerns have been raised about sexual exploitation by health workers during epidemics. • Lack of supervision when caregivers are hospitalised can put adolescent girls and children at risk of abuse and maltreatment. • There are increased risks of abuse, intimidation and harassment of frontline health workers, particularly women nurses.
 **Security and justice**	• Communities report being intimidated by armed forces during outbreaks. In countries with recent memories of conflict-related sexual violence committed by armed forces, the deployment of security services during an outbreak can create fear and tension. • There have also been reports of sexual exploitation by state officials and community members charged with enforcing community level quarantine. • Police and justice systems can become overwhelmed during an epidemic, creating an 'atmosphere of impunity' where GBV increases.
 **Education and child protection responses**	• Quarantine measures and the stress associated with epidemics can create household tensions, leading to increased parental frustration and corporal punishment. • School closures can increase the risks for adolescent girls of different forms of sexual exploitation and abuse, and early marriage. • There are also increased risks of sexual exploitation and abuse associated with outsiders who transport goods into the community and provide services and who demand sex in return for assistance or take advantage of reduced caregiver supervision. • Outbreaks can create and intensify child protection issues due to children being separated from caregivers, being stigmatised, and difficulties accessing services.
 **Social protection and job creation**	• Epidemics have both large immediate economic effects, as well as potentially long-term effects on economic activity. • There is little evidence specifically from epidemics of the impact of economic insecurity on VAWG. However, wider evidence shows that intimate partner violence and violence against children increase during times of economic stress. • Promising practice from the Ebola epidemic includes cash transfer programmes which have integrated GBV elements, such as GBV and sexual exploitation training to mobile money agents and other distribution partners.
 **Humanitarian settings**	• There is little documented evidence on the specific impact of epidemics on VAWG in humanitarian settings; however, we know that there are often increased risks, including sexual violence and intimate partner violence in humanitarian emergencies. • However, there are lessons in how to provide remote GBV case management services safely, which may be applicable during the COVID-19 epidemic.

Other important recommendations are shown in a box below.

Recommendations highlighted in a recent note by the GBV Area of Responsibility and Asia-Pacific Gender in Humanitarian Action Working Group[3] include:

- **Disaggregating data to understand the gendered impacts**, with data disaggregated by sex, age, disability and other relevant vulnerability factors.
- **Understanding which women and girls are at heightened risk** of different forms of GBV and understand how these may vary across settings.
- **Strengthening the leadership and meaningful participation of women and girls** in all decision-making processes in addressing the COVID-19 outbreak
- **Training first responders on how to handle disclosures of GBV** that could be associated with or exacerbated by the pandemic, including how to make referrals for further care.
- **Updating GBV referral pathways** so as not to overwhelm tertiary hospitals
- **Provide psychosocial support** to GBV survivors who are also affected by the outbreak.

2. Methodology and evidence gaps

The methodology for this query is described below.

Search strategy: Studies were identified through searches using Google and relevant electronic databases (Science Direct, and Google Scholar). Due to the rapid and recent nature of the evidence, evidence was also identified on Twitter and other social media. Key search terms included: coronavirus, corona, COVID-19, Ebola, SARS, H1N1, Zika, disease, virus, outbreak, pandemic, epidemic AND GBV, VAWG, violence, violence against women, domestic violence, abuse, harassment, exploitation, rape, and trafficking.

Criteria for inclusion: To be eligible for inclusion in this rapid mapping, evidence had to fulfil the following criteria:

- **Focus**: Evidence on the impact of the COVID-19 virus pandemic and other similar epidemics on violence against women and girls
- **Time period**: January 2000 – March 2020.
- **Language**: English and Italian, with targeted searches in Mandarin using Google Translate
- **Publication status**: publicly available – in all cases published online.
- **Geographical focus**: Global, with targeted searches on countries with the highest number of cases[4] as of mid-March 2020 (China, Italy, Iran, South Korea)

Summary of evidence: Due to the very recent nature of the outbreak, evidence on the impact of COVID-19 remains at an early stage. The main source of evidence came from news reports and the websites of women's organisations and those supporting survivors of violence in China and Italy. No data was found from Iran or South Korea (two other countries with large numbers of cases at the time of writing this report). This paper also identified research from other similar epidemics – primarily Ebola (in DRC and West Africa), Zika (in the Americas), and Cholera (in Yemen). This evidence includes peer-reviewed journals and reports by INGOs and UN agencies.

Evidence gaps: This review identified the following areas where there is limited evidence::

[3] See note for full recommendations on gender and COVID-19: https://asiapacific.unwomen.org/en/digital-library/publications/2020/03/the-covid-19-outbreak-and-gender

[4] Based on Worldometer's daily ranking of countries: https://www.worldometers.info/coronavirus/

- **Limited rigorous data available on how epidemics have changed levels of violence**, with most of the evidence based on the perceptions of communities or organisations working with survivors. There are considerable methodological, contextual and ethical challenges in obtaining prevalence and/or incidence data on GBV during epidemics, as is the case in other humanitarian emergencies (IASC, 2015).
- **Lack of sex-disaggregated data** on the impact of COVID-19 – a key step in identifying those most at risk of infection and with other protection needs (Smith, 2020)
- **Evidence on the impact on vulnerable groups** who may not seek support, testing or care due to distrust of surveillance by government and/or healthcare services (Smith, 2020), as well as groups that are at higher risk of VAWG, for example adolescent girls, older women, women and girls with disabilities, and refugee/migrant women.
- **Limited research on the pathways** by which outbreaks can exacerbate different forms of VAWG**,** including how different drivers of violence change during an outbreak.
- **Examples of good practice** in providing support to survivors during COVID-19 is only starting to emerge from China, with little evidence available from elsewhere.

3. COVID-19

Evidence on the impact of COVID-19 is still at a very early stage and not yet well documented, given that the outbreak begun in January 2020. However, some of the early indications are that there are several areas where women and girls are likely to be at increased risk of violence.

3.1 Increased risk of domestic violence

There is some evidence of increases in domestic violence in China, as well as concerns about support services in Italy and China. However, there is limited evidence from most countries, possibly because social distancing measures have only recently started.

- **China**: Early evidence from China suggests that **domestic violence has dramatically increased – in some parts of China it has tripled during the epidemic** (see box below). Domestic violence organisations have observed that the extended quarantine and other social distancing measures have created additional GBV as a result of household stress over economic and health shocks combined with forced coexistence in narrow living spaces (Wanqing, 2020; Rigoli, 2020).

Evidence that domestic violence is increasing due to the COVID-19 epidemic in China

- A police station in central Hubei province (in Jianli County) received three times more reports of domestic violence in February 2020 (162 reports) than February 2019 (47 reports).
- 90% of the causes of violence reported to an anti-domestic violence organisation in Hubei province are related to the COVID-19 epidemic
- Further from the epicentre of the virus outbreak, the Beijing-based women's organisation Weiping report receiving an increased number of domestic violence-related reports since the Lunar New Year when several cities went into lockdown (Wanqing, 2020).

Support services for domestic violence survivors are increasingly strained by the impact of the outbreak, particularly healthcare and police services. There have been reports that police in China have been reluctant to intervene and detain perpetrators due to outbreaks of COVID-19 in prisons (Wanqing, 2020). Some women's shelters have also been temporarily converted into homeless shelters by authorities (Wanquing, 2020). UN Women have also expressed concerns about the potential for vital GBV health services to be diverted to deal with the outbreak (Owen, 2020). However, there are also examples of innovative practices to support survivors including through technological solutions (see box below).

Women's organisations and activists have developed innovative ways to raise awareness and support survivors during the COVID-19 outbreak

- **Setting up networks** to help survivors. For example, over 2,500 volunteers have signed up to be 'vaccines' for the network 'Vaccines Against Domestic Violence' as "the door can block COVID-19, but it cannot block another virus: domestic violence". The volunteers listen out for abuse and support families to resolve conflicts peacefully (The Economist, 2020).
- **Publishing online manuals**[5] on how women can protect themselves from domestic violence during the epidemic, including directing them to online legal aid (Wanqing, 2020).
- **Hosting livestreamed workshop**s to advise people what they can do to support domestic violence survivors (Wanqing, 2020).
- **Creating posters** reminding bystanders to speak out against domestic violence (Owen, 2020)
- **Raising awareness online** using hashtags such as #AntiDomesticViolenceDuringEpidemic #疫期反家暴# (discussed more than 3,000 times on social media platform Weibo) (Owen, 2020)

Response services have also used technology to help provide services to survivors:

- **A Beijing court has been using online court hearings and 'cloud visits'** to handle cases and protect vulnerable survivors such as women and children during the epidemic

- **Italy:** Women's organisations have raised concerns about increased domestic violence as a result of forced cohabitation with children, husbands and older relatives, increased economic stress, and increased family workload for women combined with remote working (di Redazione, 2020). The national network of domestic violence shelters, DiRe, have reassured Italians that their emergency telephone and Skype support remains open. Approximately 60 out of 80 local domestic violence organisations have emergency cell phones and are answering calls (Ramundo, 2020). On social media, Italians are also sharing the numbers of domestic violence organisations due to fears that the ongoing health crisis and the ban on leaving the house will escalate domestic violence (Il Messagaro, 2020). However, concerns have been raised by DiRe about the impact of COVID-19 on women's refuges (see box).

Impact of COVID-19 on women's refuges in Italy

There are reports from some shelters that the women are terrified about new women and children arriving in the centre in case they are infected. In addition, the psychological pressure of being trapped inside the shelters with no possibility of going out is considerable, as is the challenge of keeping children occupied. Many of the centres have psychologists who can provide support, but at a safe distance and with masks and gloves (Ramundo, 2020).

3.2 Increased risk of workplace violence in the health sector

There are growing concerns that frontline healthcare workers are at increased risk of violence and harassment due to the serious stress that COVID-19 places on patients, their relatives and other healthcare workers. There are also reports of uniformed healthcare workers facing abuse and discrimination in public spaces and on public transport. However, to date, there is only anecdotal data showing an increase in violence and rising concerns expressed by healthcare workers.

- **China:** There have been several reports of violence and abuse against healthcare workers in Wuhan. For example, family members attacked and severely injured two doctors after a patient died at a Wuhan hospital. Others have faced verbal abuse and backlash from patients and their families due to the lack of hospital beds[6]. No research is available on the gendered nature of violence associated with the epidemic, although it is worth noting that 96% of nurses are female in

[5] Manual by Yuanzhong Family and Community Development Service Center, Dongcheng District, Beijing (in Chinese) https://mp.weixin.qq.com/s/qSp14zOcFHLgiCMKxsXQTQ

[6] Anonymous article by Chinese doctor in the Guardian: https://www.theguardian.com/commentisfree/2020/feb/17/wuhan-china-doctors-coronavirus

China and previous studies have found high levels of workplace violence against female nurses in hospitals in China, which is exacerbated by waiting times and issues around medical insurance (Jiao et al, 2015).

Controversy over head shaving for nurses
In Hubei province and the capital Wuhan, more than 90% of nurses are female. In February, a controversial video circulated online showing crying female nurses having their hair shaved off. Many social media users criticised the hospital. Although the hospital claimed that the nurses had volunteered to go bald to prevent infection, a male doctor was shown wearing a higher-grade face mask but still had all his hair. An article on WeChat entitled 'Please stop using women's bodies as a propaganda tool' was viewed over 100,000 times before being censored, and on Weibo, the hashtag #SeeingFemaleWorkers was used more than 700,000 times to recognise the professional contribution of female medics (The Economist, 2020).

- **Singapore:** Healthcare workers have reported experiencing abuse and harassment during the COVID-19 epidemic, including when they are in uniform in public spaces and on public transport. In polyclinics and hospitals, notices remind the public that abuse of healthcare workers will not be tolerated and will be referred to the police. There has been a call to 'take stern action against those who harass healthcare workers in public spaces', including using CCTV cameras on transport to identify and prosecute passengers who abuse healthcare workers (Fernandez, 2020).

- **Italy:** The national healthcare workers union, FNOPI[7], have raised concerns about the additional stresses that COVID-19 will place on healthcare professionals, as well as patient care. Nurses in the frontline of the epidemic are likely to be particularly vulnerable, for example at the patient interface on hospital triage systems with long waiting times or in isolated places at patients' homes (FNOPI, 2020).

High levels of workplace violence among healthcare workers: Research from Italy
Research conducted in a general hospital in northern Italy[8] before the epidemic found that 45% of healthcare professionals reported workplace violence[9] . The most frequently assaulted healthcare workers were nurses (67%), followed by nursing assistants (18%) and physicians (12%). Locations at highest risk for violent incidents were psychiatry departments (86%), emergency departments (71%), and in geriatric wards (57%) – the latter two being areas where COVID-19 are likely to manifest first. The research found that men were more likely to commit physical violence than women, and assaulted professionals were more likely to be female – a statistically significant finding. The two most frequent types of workplace violence identified in the research included: (1) Physical violence by patients in an altered mental state, often related to their clinic condition; (2) Non-physical violence by patients' visitors, family members and caregivers, exacerbated by long and anxious waiting times, insufficiently clear communication, and a perceived lack of empathy or attention from healthcare workers. Verbal violence often caused more frequent psychological distress to healthcare workers than the physical violence from patients. The study recommends putting in place prevention measures (e.g. training and awareness-raising about processes) to provide clear and empathetic communication with visitors, family members and caregivers. (Ferri et al, 2016)

[7] La Federazione Nazionale degli Ordini delle Professioni Sanitarie, known as the National Federation of Orders of Health Professions (FNOPI)

[8] Survey of 419 healthcare professionals – 28% males / 72% females

[9] Workplace violence is defined as "physically and psychologically damaging actions that professionals face in the workplace or while on duty. Examples of WPV include direct physical assaults (with or without weapons), written or verbal threats, physical or verbal harassment, and homicide, which "…involve an explicit or implicit challenge to … safety, well-being or health" of professionals" (Ferri et al, 2016: 263).

- **Iran**: 24% of healthcare workers experienced physical violence in the past year, with nurses being the main victims (78%) and patients' families the main perpetrators (56%) (Fallahi-Khoshknab et al, 2016). This study could find no publicly available evidence on the impact of COVID-19 on Iranian healthcare workers.

3.3 Increased risk of racial and sexual harassment and abuse (both online and offline)

In many countries, there have been reports of increasing racism, harassment and attacks against people of East Asian and Italian origin or appearance as a result of the COVID-19 outbreak. The UN human rights chief, Michelle Bachelet, has called on member states to combat discrimination triggered by the virus.[10] It is not yet clear the extent to which this violence is gendered, with both men and women attacked. However, there is some anecdotal evidence from news reports that the violence against women tends to combine both racist and sexist elements. Examples include:

- **India:** Female students in Delhi and other Indian cities have reported experiencing harassment related to the coronavirus outbreak. Two female students from northeast India (which shares a border with Tibet) were attacked by a group of men: "They threw balloons at my friend and me. We had a male friend with us, but they threw the balloons only at us, aiming at our private parts. They saw that I had Mongoloid features after I took off my pollution mask. After that they screamed, 'Aye, coronavirus!'"[11]
- **US:** An Asian woman wearing a face mask was physical attacked in a New York subway station who also directed various obscenities at her and called her "diseased."[12] In another incident, a woman was verbally assaulted on the subway by someone shouting "Where is your corona mask you Asian b—h," before punching the woman and dislocating her jaw.[13]
- **UK:** In Birmingham, a woman was spat at and punched unconscious by a man in a bar after she defended her Chinese friend from a racist corona-related attack.[14] In Cardiff, female Chinese students were verbally abused by a group of teenage boys.[15]
- **Netherlands:** A Korean American woman was called a "Chinese b—h" online and comments were left on her Facebook photos of "This is Corona"[16].

3.4 Increased risks of abuse and exploitation for vulnerable workers, such as migrant domestic helpers and sex workers

There is some early evidence of the virus putting vulnerable workers at increased risk of violence, discrimination and dangerous situations. Examples include:

- **Sex workers in the United States:** In Seattle's red-light district, organisations supporting street-based sex workers have observed more coercive and violent behaviour from sex buyers since the outbreak begun (see box). Migrant sex workers of Asian origin are at increased risk due to discrimination relating to the coronavirus.

[10] Reuters: https://www.reuters.com/article/us-china-health-rights/u-n-asks-world-to-fight-virus-spawned-discrimination-idUSKCN20L16B
[11] The Sentinel: https://www.sentinelassam.com/north-east-india-news/ne-students-complain-of-attack-near-du-miscreants-scream-aye-coronavirus/
[12] Japan Times: https://www.japantimes.co.jp/news/2020/02/18/national/coronavirus-outbreak-anti-asian-bigotry#.XmkOfXL7QdU
[13] NY Post: https://nypost.com/2020/03/10/unhinged-woman-slugs-asian-lady-for-not-wearing-coronavirus-mask/
[14] Metro: https://metro.co.uk/2020/02/23/woman-knocked-defending-chinese-friend-racist-coronavirus-attack-12286814/
[15] Sky News: https://news.sky.com/story/coronavirus-chinese-people-face-abuse-in-the-street-over-outbreak-11931779
[16] Buzzfeed News: https://www.buzzfeednews.com/article/meghara/coronavirus-racism-europe-covid-19

Increased risks of danger and exploitation for sex workers: Evidence from Seattle
Before the crisis began, Seattle had seen a rise in street-based sex workers due to an 'unprecedented spike' in homelessness and drug addition, combined with two new laws banning online adverts for escorts. Prices had halved and sex workers stopped screening clients or turning down men who gave them a 'bad feeling'. The COVID-19 outbreak means that more clients are staying at home (particularly men over 60 – one of the main demographics) which has in turn meant that sex workers are taking more risks to earn a living. The Green Light Project, a community organisation supporting street-based sex workers has observed that men are using the virus as a leverage: "I'm already taking a risk seeing you. So why should I use a condom?" The organisation has also raised concerns about the difficulties of warning new street workers of which clients are abusive of sex workers". (Hobbes, 2020)

- **Migrant domestic workers in Hong Kong:** During the outbreak, the Hong Kong government advised the estimated 400,000 foreign domestic workers[17] to stay indoors on their day off to risk contamination. The Migrants Workers Association has warned that women workers are at risk of exploitation, with reports of employers insisting they work on their day off and threatening dismissal (Owen, 2020).

3.5 Increased risk of VAWG in refugee camps and IDP settlements

There is growing concern about the potentially catastrophic impact on vulnerable migrant women and girls should the virus spread in refugee camps and IDP (internally displaced persons) settlements, where population density is high; water, sanitation and hygiene provision is poor; and self-isolation is virtually impossible. The inevitable increase in fear and tensions in refugee camps and IDP settlements increases the risk of violence against women and girls, as well as their vulnerability to sexual exploitation and abuse. There may also be a shortage of suitably qualified female humanitarian workers who are able and willing to operate women and child-friendly safe spaces and provide GBV case management services. Humanitarian organisations will have to suspend their operations if staff fall sick and/or refuse to operate in such high-risk situations.

- **Greece**: A confirmed case of COVID-19 on the Greek island of Lesbos has led to concerns about the impact of an outbreak in refugee camps.[18] In Moira refugee camp, anti-migrant violence coupled with fears about COVID-19 have led to some organisations suspending services in the camp. Access to healthcare for asylum seekers and refugees is already limited[19] and the situation is likely to worsen as the COVID-19 pandemic overwhelms the health system (Fallon and Grant, 2020). Aid organisations had reported that the risk of violence is high in the camp with women refugees saying they "feel very, very under threat, constantly" from general as well as sexual violence.[20]

3.6 Increased risk of violence by state and armed guards

To date, there is little evidence of how the COVID-19 pandemic has increased the risk of state violence by security personnel and other state officials. However, other outbreaks have been associated with an increase in violence against women and girls, including sexual exploitation, related to the deployment of security forces (see Section 4). On social media, some Wuhan residents have

[17] Most of the women domestic workers come from the Philippines and Indonesia.
[18] The first case is a Lesbos resident who had travelled to Israel and Egypt, and to date, there are no indications that it has reached the refugee camps.
[19] The Greek government removed AMKA (the Greek social security system) for refugees and undocumented people last July. It introduced new legislation in November, which will give asylum seekers temporary access to healthcare, but this has not yet been implemented.
[20] ITV news: https://www.itv.com/news/2020-03-07/female-refugees-face-dire-situation-after-aid-workers-flee-lesbos/

complained that “the guards are like prison guards, abusing the little bit of power they have” (Yu, 2020). In Iran, authorities have warned that they may use ‘force’ to limit travel between cities to contain the virus, although there is no evidence that any force has yet been used.[21]

4. Lessons from similar epidemics

There are several lessons from other epidemics that could also be applicable during the COVID-19 pandemic, although it is important to note that context is important. The impact of disease outbreaks on VAWG are likely to vary by the type of virus/disease and how it is spread (e.g. by the exchange of bodily fluid, by indirect contact, by insect carriers), and whether quarantines or social distancing measures are introduced. Wider contextual factors will also determine the impact of the outbreak, for example access to healthcare and GBV services, levels of GBV before the epidemic, and whether the outbreak is in a fragile and conflict affected state.

This section includes examples from the Ebola outbreak in West Africa in 2014-2016, the cholera outbreak in Haiti in 2010-2013 and Yemen from 2016 onwards, the Ebola outbreak in the Democratic Republic of the Congo (DRC) in 2018-2020, and the Zika outbreak in 2015-2016. Due to time constraints and size of the literature, this report does not include the lessons from the HIV/AIDS epidemic.

Providing specialised support to survivors

- **In other epidemics, women and girls have experienced increased risk of various forms of violence.** In the most recent Ebola outbreak in DRC, a rapid assessment in North Kivu found that participants perceived an increased risk of VAWG, particularly sexual violence, domestic violence and sexual exploitation and abuse (IRC, 2019). In Sierra Leone, an assessment of case numbers and available services managed by UNDP and partners revealed an increase in VAWG (UNDP, 2015a).

- **Specialised support services for GBV survivors are in heavy demand during public health emergencies, but remain limited in availability and funding is often deprioritised.** During the Ebola crisis in Sierra Leone, the failure to prioritise funding for GBV coupled with a breakdown in health systems and weak coordination severely impacted the availability of specialised services for survivors. Within the public health system, GBV services were severely disrupted due to redirection of resources and personnel. Notably, many GBV service centres known as Rainbo Centres, were able to continue operating either in the same or new locations, as they were supported by INGO funding which gave them a greater level of flexibility and adaptability compared to public institutions. These GBV centres saw a 19% increase in the number of women and girls attending them for health services, counselling and case management compared to the months before the crisis. However, there were only three in the country - not enough to meet the needs of the at-risk population (IRC, 2015).

Health sector

- **Survivors of GBV can find it difficult to access healthcare due to restrictions on movement and closed clinics** (GBViE Helpdesk, 2018). In Liberia, survivors of sexual violence found it difficult to access medical facilities during the Ebola epidemic. In addition, the inaccessibility of GBV services meant that women and girls could not always obtain the doctor’s reports needed to build a legal case against perpetrators (Perry and Sayndee, 2017).

[21] Times of Israel: https://www.timesofisrael.com/adviser-to-irans-foreign-minister-dies-of-coronavirus/

- **Fear of violence and mistreatment can prevent women from seeking health and GBV services during an epidemic:** For example, during the Zika epidemic in the Dominican Republic, 73% of women who suspected they had Zika did not seek healthcare services. In interviews, women reported that a key factor was fear of being assaulted on the way to the healthcare facility. Women and girls also said they were afraid of being victims of abuse and psychological violence in public hospitals and medical centres (Oxfam, 2017). In Liberia, a study found that during the Ebola crisis more than 80% of GBV survivors were denied access to basic health services out of fear that health workers could contract Ebola through contact with bodily fluids (IRC, 2015)

- **Fear of infection can prevent people accessing health services** during an outbreak (Sochas et al, 2017), including life-saving care and support for GBV survivors.

- **Epidemics can divert healthcare resources away from GBV services and sexual and reproductive health services**: During the Ebola epidemic in West Africa in 2014-2016, healthcare resources were diverted from reproductive and sexual health to the emergency response, contributing to an increase in maternal mortality (Sochas et al, 2017).

- **Concerns have been raised about sexual exploitation by health workers during epidemics**. During the Ebola outbreak in DRC in 2018-2020, there were reports of sexual exploitation as part of a vaccination programme. Research focus groups observed that women were asked for sex in exchange for treatment (Holt and Radcliffe, 2019).

- **There are also increased risks of violence and harassment of frontline health workers, particularly women nurses.** In Sierra Leone, nurses working in the Ebola response, particularly women, reported stigmatisation, isolation and abuse (IRC, 2015). In DRC, frontline Ebola workers were attacked more than 300 times in three provinces, leaving six dead and 70 wounded.[22]

- **Lack of supervision when caregivers are hospitalised can put adolescent girls and children at risk of abuse and maltreatment.** For example, during the cholera outbreak in Yemen in 2017, there were reports of children being left alone to sleep outside on the veranda of the cholera treatment centres while their sick caregivers were admitted for treatment. The lack of supervision exposed children, especially girls, to risks of harassment, sexual violence and abuse (The Alliance for Child Protection in Humanitarian Emergencies, 2018)

Security and justice:

- **Communities report being fearful and intimidated by armed forces during outbreaks and deployment of security forces have been associated with an increase in sexual exploitation, abuse and harassment** (Smith, 2019; Tripp et al, 2013). The use of armed force and quarantine measures, coupled with a failure to consult with communities, can exacerbate community tension and distrust during epidemics (DuBois et al, 2015). During the 2014 Ebola outbreak, thousands of military personnel were deployed to help contain the outbreak. Research in Sierra Leone and Liberia found isolated incidents of alleged low-level violence by domestic armed forces to enforce lockdown periods, as well as concerns about the visibility of military personnel carrying guns and dressed in combat fatigues when they were 'fighting' a disease. In countries with recent memories of civil war and conflict-related sexual violence committed by armed forces, the deployment of armed security services during a disease outbreak can create fear and tension (Kamradt-Scott et al, 2015).

- **There have also been reports of sexual exploitation by state officials and community members charged with enforcing community level quarantine**. For example, in Sierra Leone, community members responsible for enforcing quarantine were accused of sexually assaulting

[22] UN News: https://news.un.org/en/story/2019/11/1050551

girls during the Ebola epidemic in Sierra Leone (The Alliance for Child Protection in Humanitarian Emergencies, 2018). Research found that more than 65% of female respondents reported manipulation and exploitation by guards, with women and girls who were quarantined in their homes being financially and sexually exploited by guards in exchange for permission to leave the house for water and firewood (IRC, 2015).

- **Police and justice systems can become overwhelmed during an epidemic, creating an 'atmosphere of impunity' where GBV increases** (UNICEF GBViE Helpdesk, 2018). In Liberia, research[23] found that 27% of people thought that the courts and police had not been working properly to handle GBV cases since the Ebola crisis began – this figure varied geographically and was as high as 87% in Lofa County (Korkoyah and Wreh, 2015). Traditional justice systems also took reduced action, with research in Sierra Leone finding that Chiefs did not punish an Ebola burial team who had exploited and impregnated local girls (Kostelny et al, 2016).

Education and child protection responses

- **Quarantine measures and the stress associated with epidemics can create household tensions, leading to increased parental frustration and corporal punishment.** Research in Sierra Leone found increased tensions in the home during the Ebola epidemic as a result of reduced household income, school closures, anxiety about the disease, and lack of social activities. Children reported feeling angry and frustrated and receiving more beatings from their parents (The Alliance for Child Protection in Humanitarian Emergencies, 2018). This study could find no evidence from institutional settings, such as children's homes, orphanages and boarding schools.

- **School closures can increase the risks for adolescent girls of different forms of sexual exploitation and abuse, and early marriage**. In West Africa, the closure of schools for the Ebola epidemic exposed girls to sexual exploitation and violence (Christian Aid et al, 2015). There was also a 'sharp increase' in teenage pregnancies and early marriages in some affected areas, due to girls' increased school dropout rates (UNDP, 2015b and 2014).

- **There are also increased risks of sexual exploitation and abuse associated with outsiders who transport goods into the community and provide services** and who demand sex in return for assistance or take advantage of reduced caregiver supervision. During the Ebola outbreak in Sierra Leone, there were reports that taxi drivers who transported goods and people between affected communities had sexually assaulted girls (The Alliance for Child Protection in Humanitarian Emergencies, 2018). In one village, there were reports of sexual exploitation by the Ebola burial team who 'flashed the money they were paid' and gave the girls food and money in return for sex (Kostelny et al, 2016).

- **Outbreaks can create and intensify child protection issues due to children being separated from caregivers, being stigmatised, and difficulties accessing services.** In the DRC, more than 4,000 children were separated from their parents during the Ebola epidemic and there are more than 2,000 Ebola orphans. In North Kivu, research found that children living in Ebola-affected areas spoke of fear, isolation and stigma. The study noted that children are at risk of violence, exploitation and abuse unless their needs are a focus of disease prevention and response (Hall, 2019).

[23] A total of 1,562 persons were surveyed, 20 community leaders were interviewed and 180 local residents participated in FGDs.

Social protection and job creation

- **Epidemics have both large immediate effects, as well as potentially long-term effects on economic activity.** In Liberia, Ebola created a 'nation-wide economic shock'. A study using a panel data set of registered firms found that the outbreak caused the most economic damage[24] in cyclical[25] sectors such as restaurants, food and beverages, and construction (the latter only in Monrovia) (Bowles et al, 2016).

- **There is little evidence specifically from epidemics of the impact of economic insecurity on VAWG. However, wider evidence shows that intimate partner violence and violence against children increase during times of economic stress**[26] (Buller et al, 2018). On intimate partner violence, data from 31 countries shows that a 1% increase in the male unemployment rate is associated with an increase in physical violence against women by 0.5 percentage points, which translates to an increase of 50 cases per 10,000 (or 2.75% of the mean prevalence rate of physical violence in the sample) (Bhalotra et al, 2019). On VAC, a systematic review of longitudinal studies found that the most reliable predictor of child maltreatment is economic insecurity, including income losses, cumulative material hardship and housing hardship (Conrad-Hiebner and Bryam, 2018).

- **Promising practice from the Ebola epidemic includes cash transfer programmes which have integrated GBV elements.** For example, a USAID / Food for Peace cash transfer in Sierra Leone provided GBV and sexual exploitation training to mobile money agents and other distribution partners. It also conducted post-distribution qualitative research to capture any challenges faced by beneficiaries as a result of receiving cash (Welcome Radice, 2017).

Humanitarian emergencies

- **There is very little documented evidence on the impact of epidemics on VAWG in emergency situations**; however, we know that in these settings there are often increased risks, including sexual violence, intimate partner violence, early marriage (IRC, 2018). A targeted search of GBV and various recent epidemics (Ebola, cholera, Zika, SARS) in emergency settings found very little, apart from brief references to the cholera epidemic in refugee camps after the Haiti earthquake. A note by UNICEF's Haiti Child Protection Section/GBV Programme (2010) describes how the programme led the way in integrating gender into the Haiti cholera epidemic, including training GBV sub-cluster members on cholera sensitisation with an emphasis on gender analysis. It also mobilised grassroots women's groups on cholera prevention and response.

- **However, there are lessons in how to provide remote GBV case management services safely which may be applicable during the COVID-19 epidemic.** Most models of GBV service delivery are geared towards large camp settings with centralised case management services delivered from women's centre or health facilities. However, the IRC's (2018) *Guidelines for Mobile and Remote Gender-Based Violence (GBV) Service Delivery*[27] provide useful examples and practical advice for remote and mobile GBV case management in both acute and protracted crises. The guidelines were piloted and evaluated in Myanmar, Iraq and Burundi. It may be possible to adapt these for the COVID-19 epidemic, although it is important to think carefully to ensure the mobile element does not spread the disease further among communities.

[24] Jobs lost and contracts lost

[25] Cyclical stocks represent companies that make and/or sell discretionary items and services many consumers buy when the economy is doing well

[26] Twitter thread with key evidence by Amber Peterman (9 March 2020)

[27] https://reliefweb.int/sites/reliefweb.int/files/resources/GBV-Mobile-and-Remote-Service-Delivery-Guidelines_-final.pdf

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