COVID-19 in the Global South

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Responses
The ‘Shadow Pandemic’

Addressing Gender-based Violence (GBV) During COVID-19

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As cases of COVID-19 increased and the World Health Organization (WHO) declared a pandemic, reports on the gendered impacts of the virus streamed in. While acknowledging that there have been higher mortality rates among men, women’s rights organizations called for attention to other, less initially visible repercussions faced by women and girls. Due to their disproportionate representation within the healthcare sector, for example, women may be at higher risk of exposure to COVID-19 (CARE, 2020). That women are still the primary caregivers within the home could also increase their likelihood of exposure, not to mention jeopardize women’s financial security or career progression as schools and paid care options close shop with unclear plans for reopening (Topping, 2020). These few examples are the beginning of a longer list of gendered repercussions that some say may set back gender equality progress by decades (Topping, 2020.).

In the wake of this reality, Simone de Beauvoir’s warning continuously comes to mind: ‘Never forget that a political, economic or religious crisis will be enough to cast doubts on women’s rights. These rights will never be vested’. Barring the omission of ‘pandemic’ from de Beauvoir’s list of crises, her words unfortunately could not be truer, even a half a century since they were written.

Without a doubt, the most grievous violation of women’s rights during COVID-19 is the rise of gender-based violence (GBV). GBV is any harmful act that is perpetrated against someone’s will and based on socially ascribed gender differences and can include acts of physical, sexual or mental harm, and threats or acts of coercion in public or private (Inter-Agency
The detrimental impacts of GBV should not be understated: they can be life changing and long term, causing forced pregnancy, physical injuries, mental health issues and even death.

Although anyone can experience GBV, women and girls are at greater risk than men and boys (Inter-Agency Standing Committee, 2015: 5), and persons with intersecting identities – such as women and girls with disabilities, ethnic minorities, and Lesbian, Gay, Bisexual, Transgender, Intersex, Queer (LGBTIQ) persons – may face higher rates of GBV (OutRight Action International, 2020). The commonly cited statistic from the United Nations Entity for Gender Equality and the Empowerment of Women (UN Women) is that one in three girls and women will experience physical or sexual violence by an intimate partner or sexual violence by a non-partner within their lifetime. This figure is a static average, though, and therefore does not capture repetitions of violence that women and girls experience or geographical variances in GBV prevalence.

The shadow pandemic

Across the world, as shelter-in-place or lockdown orders came into effect, there were spikes in reports of GBV. In Bogota, Colombia, police saw a tripling of calls to its 24/7 domestic violence hotline, while all other crime reports were down (Janetsky, 2020); in Australia, Google searches on domestic violence went up by 75 per cent (Hegarty and Tarzia, 2020). Media pieces from countries across the globe highlighted increased reports of GBV, particularly domestic violence (RTÉ, 2020). The reality is that many people – women and girls in particular – are stuck in close quarters with an abusive partner, parent or family member and previously existing tensions and equalities are exacerbated.

It is important to note that changes in reported rates of GBV are difficult to interpret in the short term, as there may have already been a previous upward or downward trend depending on context. Much of the data are likely incomparable, coming from various locations, sources and
services, such as hotlines, hospitals or police data. Regardless, actual prevalence rates of GBV are difficult to obtain ethically in any context, and the initial statistics coming in are alarming. Reported cases are usually lower than the actual prevalence of GBV, because many survivors do not seek help or report due to shame, stigma or fear of retaliation (Peterman et al, 2020: 1). As shocking as the increases in reported GBV may have been for newsreaders across the world, however, they were unfortunately not surprising. Already existing gender inequalities – as well as prejudice based on disability or ethnicity and race – worsen during crises due to added stresses and tensions, resulting in the perpetration of GBV at increased rates.

In the case of COVID-19, the difficult irony is that the very measures meant to protect the vast majority of the population – shelter-in-place and lockdown orders – are the same that endanger women and girls at the hands of perpetrators. So globally universal is the increased risk of GBV during COVID-19 that UN Women has called it the ‘shadow pandemic’ (UN Women, n.d.). It is apparent now more than ever that no society is immune to GBV and that crises call into question the protection of women, girls, and others vulnerable to violence.

**Impacts of the shadow pandemic in the Global South**

While the shadow pandemic is affecting women and girls across all corners of the globe, its impacts are particularly concerning in the Global South. In many low- and middle-income contexts, data show a higher tolerance towards violence against women and girls in society – as measured via an indicator of percentage of women who agree that a husband/partner is justified in beating his wife/partner under certain circumstances – coupled with fewer legal protections around domestic violence and rape (OECD, n.d.). The anticipated global economic downturn may have a more acute impact on livelihoods and poverty in the Global South, especially in areas with weak social protection systems, leading to financial or personal stresses that could exacerbate
already violent interpersonal relationships. These contextual factors, coupled with relatively low availability of, or access to, health services and psychosocial supports for survivors of violence, suggest that women and girls in the Global South may not receive the help they need. Gaps in the availability of essential healthcare are highest in sub-Saharan Africa and Southern Asia (WHO, 2017).

In humanitarian contexts characterized by breakdown of social structures and impunity for perpetrators, women and girls were already at incredible risk of experiencing GBV prior to COVID-19. In addition to high rates of intimate partner violence, displaced women and girls are at risk of trafficking (IRC, 2015; IOM, 2019). Additionally, sexual exploitation of women and girls – for example, requiring sexual favours in exchange for goods – by humanitarian personnel is pervasive across food, shelter, cash and water and sanitation distribution and yet remains largely unaddressed (Global Women’s Institute, 2020). If left unaddressed, these forms of violence could become worse during COVID-19.

The pandemic will also have severe impacts on girls in the Global South. While children across the globe are facing school closures that are predicted to have adverse impacts for years to come, girls in settings where child marriage and female genital mutilation (FGM) are practised face the gravest consequences. As girls are out of school and financial pressures within families mount, the United Nations Population Fund (UNFPA) predicts that there will be 13 million additional child marriages, as families seek to reduce expenditures (UNFPA, 2020). Equally worrisome for girls, due to humanitarian and development programme disruption as a result of COVID-19, UNFPA has estimated that two million more girls than usual will undergo FGM over the next decade (for reference, normally it is estimated that approximately three million girls and women undergo FGM annually) (UNFPA, 2020; World Health Organization, n.d.). In the approximately 30 countries where FGM is often practised – primarily across the Horn of African and East Africa, as well as parts of the Middle East – this would amount to reversing what has been decades of positive progress in reducing rates (UNICEF, 2016).
Responses to previous health emergencies have neglected the needs of survivors of GBV

Not only are women and girls in crises more likely to experience GBV, but previous public health emergencies point to alarming shortcomings regarding addressing the needs of survivors. When an epidemic arrives, there is the tendency for governments and aid agencies to shift their focus and resources almost entirely to the primary health response to the virus or disease, which can impact negatively on other routine services such as pre- and post-natal care and sexual and reproductive healthcare, for which resource allocation is already scarce (CARE, 2020).

In the case of the Ebola outbreak in Guinea, Liberia and Sierra Leone, Davies and Bennett (2016) found that maternal mortality rates rose by 75 per cent within 18 months. The impact on women’s health during the Ebola epidemic was widespread. The International Rescue Committee (IRC) conducted research on the Ebola outbreak in the Democratic Republic of Congo and found that survivors of GBV were less likely to seek care at clinics if they were bleeding, out of fear that they would erroneously be channelled through an Ebola Treatment Centre and consequently be exposed to the disease (McKay et al, 2019: 18). During the Zika epidemic, as another example, Oxfam (2017) found that among the women they surveyed in the Dominican Republic who suspected that they had the virus, 73 per cent did not seek medical help. According to focus group discussions, it was suspected that this high figure was due not only to difficulties in paying medical fees but also testimonies by women of abuse experienced within hospitals and high levels of GBV experienced on public transport (Oxfam, 2017).

In the above instances, the needs of survivors of GBV or increased threats of violence faded to the background within the primary health response to the virus, offering a warning to humanitarians as they respond to the COVID-19 pandemic. The discussion of the impact of violence on women’s rights and survivors of GBV is also relatively absent in the literature: Davies and Bennett (2016) conducted a search on Scopus and found that only 1 per cent of articles between
2014 and 2016 explored the human rights or gendered impacts of Ebola and Zika. In sum, past experience does not bode well for the health and rights of survivors of GBV during COVID-19.

**Global outcry in response to GBV: will it result in action?**

Despite the shortcomings of previous health crises regarding the protection of those who are vulnerable to GBV, the rhetorical response to the shadow pandemic on the part of global and multilateral leaders has been swift. In early April, United Nations Secretary General António Guterres said that ‘violence is not confined to the battlefield and that for many women and girls, the threat looms largest where they should be safest: in their own homes’. Although evoking war language that many feminists view as problematic during a health crisis (Enloe, 2020), this speech was received positively by many women’s rights organizations and feminist humanitarians, particularly because it called for specific action. Guterres urged all governments to ‘make prevention and redress of violence against women a key part of their national response plans to COVID19’ (Guterres, 2020a).

Shortly after this, the Director-General of the WHO, Tedros Adhanom Ghebreyesus, also made a press statement, stating that, ‘There is never any excuse for violence’ and calling on countries to ‘include services for addressing domestic violence as an essential service that must continue during the COVID19 response’. Of particular importance is that Ghebreyesus referred to domestic violence services as *essential* services, which is indeed how the WHO classes them, despite the fact that they are often sidelined. These essential health services include emergency contraception, post-exposure Prophylaxis (PEP) to prevent HIV for survivors of rape and sexual assault, as well as psychological first aid and referrals to additional supports if desired or necessary for survivors of any form of GBV (WHO, n.d.).
Now is the time to act

If women, girls and vulnerable people are not considered throughout all aspects of the COVID-19 response, evidence from previous health crises indicates that this pandemic will be the next story of who was left behind. Given that GBV services are an essential health service, action must be taken to ensure that life-saving services for GBV survivors do not fall by the wayside but rather are maintained or implemented during the COVID-19 humanitarian response.

In the immediate term, it is important to maintain as many GBV-related services for women and girls as possible. In the first half of 2020, NGOs globally quickly closed in-person supports for women and girls and scrambled to scale up remote services such as hotlines or virtual meeting spaces. Since then, however, there has already been crucial learning on this challenge. The International Medical Corps (IMC), IRC and Norwegian Church Aid issued joint guidance indicating that, wherever possible, in-person, life-saving services such as women and girls safe spaces (WGSS) should not be closed at first sight of COVID-19 but instead adapted with safety measures. This guidance has particular salience when considering that certain estimations – such as the aforementioned increases in child marriage and FGM – are calculated partially on the disruption or halting of existing programmes.

In the medium and long term, as the COVID-19 response is scaled up, governments, NGOs and humanitarians must work together to apply a gender lens to all programmes. Given the heightened risk of GBV in crises, this issue should feature prominently in the global Humanitarian Response Plan (HRP) and accompanying indicators. Such high-level attention would promote donor funding of GBV programmes, which represented only 0.12 per cent of the $41.5 billion allocated to humanitarian response during 2016–2018 (IRC, 2019). Furthermore, increased funding allocated to violence against women and girls at an international and institutional level would in turn push NGOs to more seriously implement GBV response, prevention, mitigation and mainstreaming plans.
Finally, the shadow pandemic also serves as a reminder for aid agencies to look within. First, there is a need for aid organizations to ensure that their own personnel are not perpetrating sexual exploitation and abuse (SEA) against fellow staff members and beneficiaries (IASC, 2015: 8), a problem which seriously calls into question the effectiveness of international aid and commitment to the principle of ‘do no harm’. Second, as global movement is reduced and Western-based organizations are not able to easily deploy their surge capacities, now is the time for aid agencies to take more seriously the commitments of the Grand Bargain on localization, which aims to get more of committed humanitarian resources directly to those in need. This includes working with local women as knowledge bearers and agents of change within their communities. Now is the time to move the rhetoric of the potential transformative nature of humanitarian response into action.

**Crises should not cast doubt on women’s rights**

COVID-19 is not only a crisis but a test. Risk of GBV rises during health crises, and COVID-19 has already proven no different – if anything, shelter-in-place and lockdown measures render these crises more dangerous to women and girls who are trapped in close quarters with an abuser. Women and girls living in the Global South may face disproportionate impacts due to relatively higher social tolerance of violence in many contexts as well as inadequate access to healthcare, including psychosocial supports.

Time will crucially tell whether the rhetorical ambitions of multilateral leaders are realized. Now and into the foreseeable future, there is a need for continued leadership – from multilaterals, governments, NGOs and communities – for the protection of women, girls and other vulnerable groups to remain at the fore of the global response to COVID-19. Violence should never be accepted as an inevitable symptom of a pandemic, and no crisis should cast doubt on the rights of those who are vulnerable or marginalized. The needs of survivors of GBV during COVID-19 must not be forgotten.
References


