# Family Violence Prevention in the Context of COVID-19 and Forced Displacement

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# SUMMARY

The COVID-19 pandemic has heightened pre-existing gender inequalities, harmful social sentiments and several other risk factors leading to an increase in family violence, including intimate partner violence (IPV) and violence against children (VAC). Displaced women, girls and boys already faced increased risk for family violence due to the disruption of social support networks and communities, changed gender norms and family dynamics, and limited privacy in overcrowded shelters, food and economic opportunity. Countermeasures for COVID-19 have exacerbated these risk factors and reduced access to existing preventive protection channels in displacement contexts. This knowledge brief explores violence prevention and response strategies for displaced communities in the context of COVID-19, when service providers are also constrained in their reach and ability to respond to family violence.

## KEY MESSAGES

1. COVID-19 has exacerbated risk factors leading to an increase in family violence. Simultaneously, pandemic countermeasures have reduced access to protection services and limited protective factors that forced displacement and migration have already eroded.
2. Services that respond to intimate partner violence and violence against children must be considered essential services and included in preparedness and response planning for COVID-19.
3. Violence prevention strategies must be adapted to the pandemic and guided by priorities identified by women and girls, at least by addressing the following challenges: adapting safe spaces to adhere to physical distancing protocols, providing accessible and relevant remote service delivery, identifying and activating alternative system entry points for survivors to seek help, strengthening community protection mechanisms, and promoting positive and supportive relationships.

# WHY SHOULD WE EXPECT THE PANDEMIC TO TRIGGER MORE VIOLENCE?

**Box 1:** Definitions of violence [i]

**Intimate Partner Violence (IPV)**: Intimate partner violence refers to any behavior within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship. This may include acts of physical violence, sexual violence, emotional abuse and/or controlling behaviors.

**Violence Against Children (VAC)**: Violence against children includes all forms of violence against people under 18 years old, whether perpetrated by parents or other caregivers, peers, romantic partners, or strangers.

**Gender-Based Violence (GBV)**: GBV is an umbrella term for any harmful act that is perpetrated against a person's will and that is based on socially ascribed (i.e. gender) differences between males and females. It includes acts that inflict physical, sexual or mental harm or suffering, threats of such acts, coercion, and other deprivations of liberty. These acts can occur in public or in private.

Violence that is directed at an individual based on their biological sex, gender identity, or perceived adherence to socially defined norms of masculinity and femininity. It includes physical, sexual, and psychological abuse; threats; coercion; arbitrary deprivation of liberty; and economic deprivation, whether occurring in public or private life. Types of gender-based violence can include female infanticide; child sexual abuse; sex trafficking and forced labor; sexual coercion and abuse; neglect; intimate partner violence; elder abuse; and harmful traditional practices such as early and forced marriage, "honor" killings, and female genital mutilation/cutting.

[i] Taken from: World Health Organization and the IASC GBV Guidelines.

# The pre-COVID-19 "violence crisis"

**Even before the onset of the COVID-19 pandemic, the prevalence of family violence**, which includes intimate partner violence (IPV) and violence against children (VAC) -see Box 1-, **was unacceptable and persisted at devastating levels** (Figures 1 and 2)**.** IPV and VAC are not only significant public health problems, but a major barrier to achieving the 2030 Sustainable Development Goals (SDGs). Consequently, the international community, including public, private and multilateral organizations, have made important efforts to reduce the prevalence of violence against women and children.[1]

**Globally, the prevalence of IPV is** high. It is estimated that one in three women over the age of 15 who have ever been in a relationship globally has experienced physical or sexual IPV; IPV is generally underreported due to fear of stigma and retaliation.  In low and middle income regions, IPV prevalence is highest in South-East Asia (37.7%), and lowest in the Western Pacific (24.6%). Across high income regions, IPV prevalence is 23.2%. The Global Burden of Disease (GBD) study offers a more nuanced view of regional differences.[2]  The **considerable regional variation suggests that violence is not inevitable, and can be prevented**. Implementation of preventative strategies early in life is fundamental, since **IPV starts early, and** continues across the lifespan.[3]

**Globally** half of all children **ages 2 through 17 years (that is, over one billion) have experienced VAC**. In 2016, 50% or more of children in Asia, Africa, and North America experienced such violence in the last year. Rates of child abuse and neglect are five times higher for children in families with low socio-economic status compared to those with higher socio-economic status. Large numbers of cases are unreported due to social stigma, lack of appropriate reporting mechanisms, and the fact that violence is often perpetrated by parents, relatives, or close acquaintances, making it particularly difficult for children to come forward.

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[1] In May 2016, a World Health Assembly resolution endorsed the first ever WHO Global Plan of Action which aims at strengthening the role of the Health Systems in articulating national multisectoral responses to address interpersonal violence, in particular against women and girls. Additionally, in July 2016 the UN Secretary-General launched the Global Partnership to End Violence Against Children, a global entity exclusively focused on ending all forms of VAC, gathering over 420 members - including governments, UN agencies, research institutions, i-NGOs, civil society organizations and private sector groups.

[2] Central Sub-Saharan Africa presents the highest prevalence, with nearly two-thirds (65.6%) of all ever-partnered women reporting IPV.  Alternatively, 16.3% of all ever-partnered women in East Asia report experiencing IPV. Between one quarter and one fifth of ever-partnered women have experienced partner violence even in high-income Western Europe (19.3%), North America (21.3%), Central Asia (22.9%) and Southern Latin America (23.7%).

[3] Nearly one-third (29.4%) of women between the ages of 15-19 report IPV. The prevalence of IPV then progressively increases within each age group, and peaks at age 40-44 years (37.8%). Although the reported prevalence of IPV is lower among older women, it is important to note that the data is sparse, and not much is known about IPV among women older than 50 years of age.

**Figure 1:** Country prevalence rates of IPV, 2016.  Share of woman, older than 14, who experienced physical or sexual violence by an intimate partner in the last year
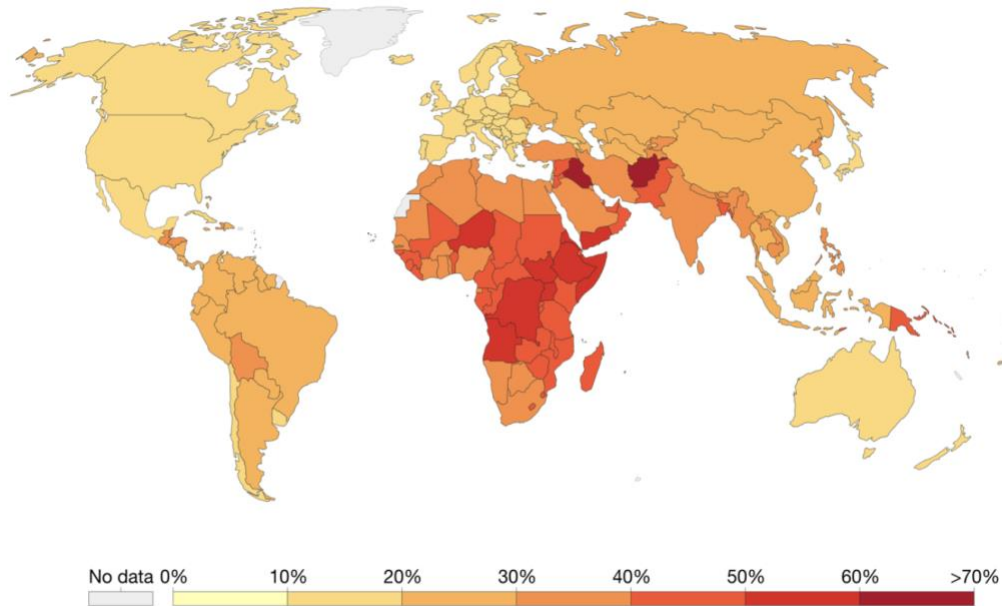


Source: Institute of Health Metrics & Evaluation. Retrieved from:
https://ourworldindata.org/grapher/women-violence-by-an-intimate-partner

**Figure 2:**  Child homicide rate, 2015. Homicide victims younger than 20 years old (per 100,000 children within the same age-group)
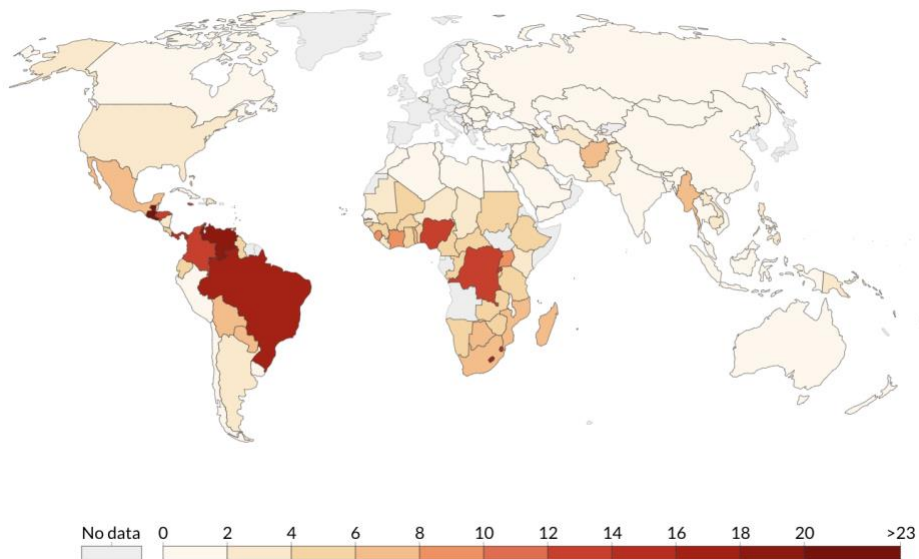


Source: UNICEF - Know Violence in Childhood Report (2017). Retrieved from:
https://ourworldindata.org/violence-against-rights-for-children

### Consequences of violence

**Experiencing IPV results in a number of <u>adverse mental and physical health consequences</u> affecting women and girls.** The direct and indirect <u>consequences of IPV</u> include injury, mental health problems (depression, alcohol and other substance use disorders); poor sexual and reproductive health control (unsafe sex practices) which may result in HIV/AIDS, sexually transmitted infections and/or unintended pregnancies and abortion; poor perinatal health, which may result in premature birth or low birth weight; and death from suicide or homicide (<u>more details available here</u>). IPV results in significant <u>costs</u> related to medical expenses, mental health care and loss of productivity for women and their families. **Globally, it is estimated that <u>the annual cost of IPV is an astonishing US$4.3 trillion</u>.**

Similarly, VAC is linked to numerous mental health (depression, anxiety), maternal and child health (unintended and adolescent pregnancy), communicable disease (HIV, STIs), noncommunicable disease (chronic lung disease, heart disease), and injury related outcomes (fractures, burns) over the life course. **VAC also has important consequences for the social and economic health of nations as a whole. In 2014, it was estimated that VAC has a <u>global cost of US$7 trillion</u> per year** - equivalent to the sum of the yearly Gross Domestic Product (GDP) generated by Australia, Canada, India and Mexico. Moreover, the global investment to prevent much of that violence -which is preventable- is less than this massive cost of inaction.

### Risk and protective factors of violence

**Risk factors** include a combination of individual, relationship, community, and societal factors that directly and indirectly contribute to an increased likelihood of violence. While victims of violence are not responsible for the harm inflicted upon them and not everyone who is identified as "at risk" becomes involved in violence, certain factors have been found to increase their risk of experiencing violence.

**Protective factors** are characteristics that buffer against the risk of violence in otherwise adverse circumstances by either reducing the impact of risk, or changing the way a person responds to it.

Risk and protective factors are typically consistent in their effects across races and cultures. Figures 4 and 5 present a list of the risk and protective factors of IPV and VAC that are most frequently found in violence prevention literature.

# Why are migrants and refugees more vulnerable to violence?

**The simultaneous aggravation of risk factors and erosion of protective factors is amplified in humanitarian settings** where women, girls and boys are often cut off from institutional service providers and resources. In particular, the disruption of social and protective networks such as extended family and communities may further exacerbate family violence and its consequences. For instance, women may have less contact with family and friends who provide support and protection from violence by a partner. Perpetrators may further restrict access to services, help, and psychosocial support from formal and informal networks.

**In humanitarian settings, the ripple effects of the COVID-19 pandemic stand to impose hardships on some of the world's most vulnerable women**, who face significant barriers to information and services, insufficient financial resources, and a lack of autonomy over their own sexual and reproductive health, leaving them susceptible to exploitation and abuse. While food aid, water, and sanitation are vital in disaster responses, comprehensive sexual and reproductive health services are often weak or unavailable in humanitarian settings, although they are integral to long-term rebuilding. **Risk factors for migrant or displaced women that are unique to humanitarian settings may include**:

- changing gender norms and family dynamics due to displacement;
- separation from families and breakdown of community structures;
- the length of displacement or time spent in a camp setting;
- disproportionate care responsibilities;
- limited economic opportunities for women and men;
- limited access to food and adequate shelter.

**Figure 4:** Risk and Protective Factors associated with IPV
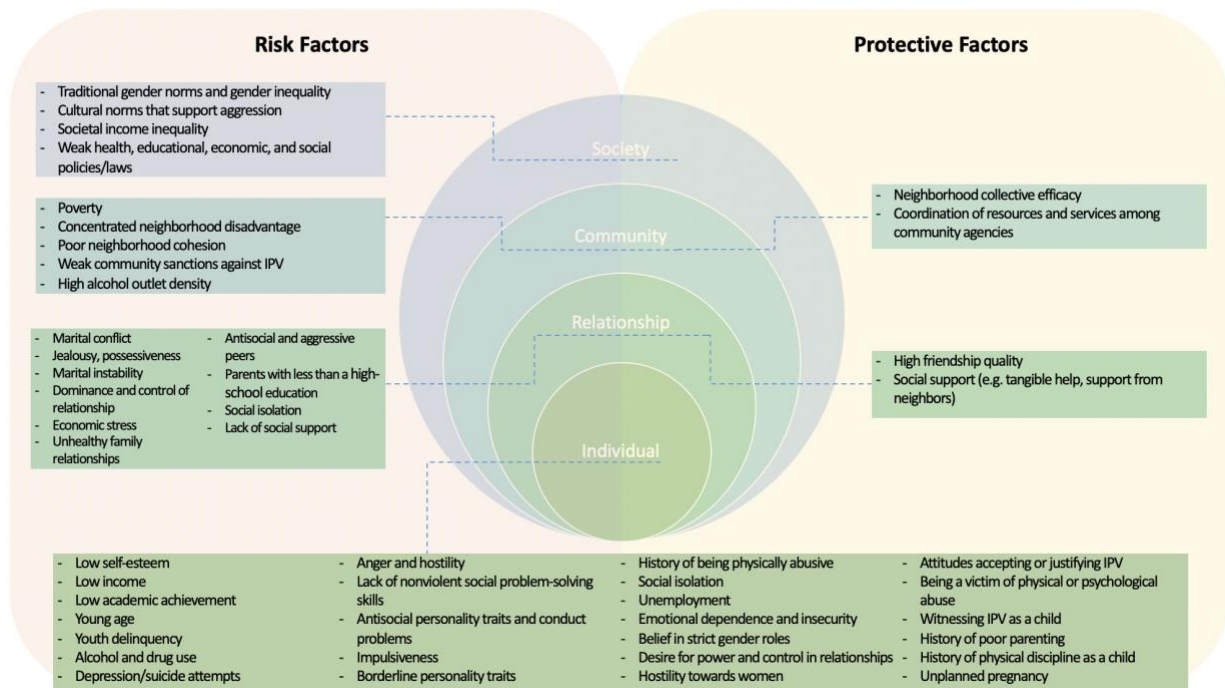


**Forcibly displaced and migrant children are also at increased risk of violence.** To be effective in combating VAC, policy and practice recommendations must be appropriate to the national and/or local context and be guided by the principles of 'the best interests of the child' and 'do no harm'. Thus, **it is important to understand the added vulnerability in displacement contexts.** Prior research on violence has shown the drivers of IPV are usually exacerbated in humanitarian settings. For example, communities characterized by low levels of social cohesion

often place children at an increased risk of exposure to child maltreatment, neglect, and intimate partner violence. In addition, individuals with inadequate economic resources, or who experience social isolation, are more likely to perpetrate various forms of violence against intimate partners and children. However, **there are risk factors of VAC that are unique to humanitarian settings.** Such risk factors may include:

- the length of displacement or time spent in a camp or shelter setting;
- who is accompanying or caring for a child during displacement;
- the type of shelter in which children and families are residing;
- the likelihood of recruitment of children into fighting factions;
- and a family's access to food rations.

**Figure 5:** Risk and Protective Factors associated with VAC
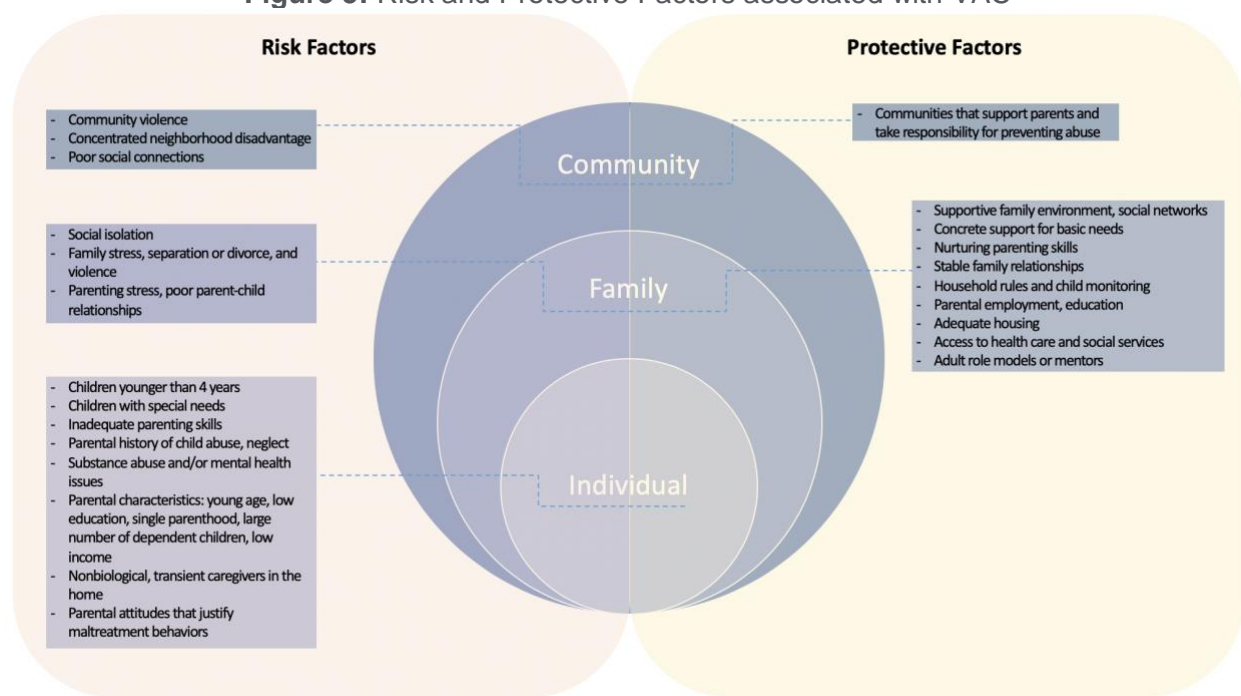


In addition, children's age, sex, and other socio-cultural factors are also likely to be correlated significantly with the risk of exposure to various forms of violence in humanitarian contexts. **Younger children and girls have even fewer opportunities than adults or young men to leave the home to seek help, and when they are in vulnerable shelters, their opportunities are further constrained.** Additionally, school closures have a profound effect on safe spaces available for children, even children who have been forcefully displaced or are in humanitarian crisis.

# WHAT IS HAPPENING IN THE CURRENT PANDEMIC?

**A third of the global population is on COVID-19 lockdown, and school closures have impacted more than 1.5 billion children. Home should be the safest place for everybody, and the first line of defense and protection. However, stressors related to COVID-19 are threatening that defense.** Stay-at-home orders, loss of income, isolation, overcrowding, and high amounts of stress and anxiety increase the likelihood that women and children experience and observe physical, psychological, and sexual abuse at home, particularly for those who already live in violent or dysfunctional family situations. Households are struggling to cope with new restrictions on travel and work, while coping with concerns related to health, food security, financial instability, and conflicting information on a range of issues. These and other risk factors associated with COVID-19 for violence, abuse and neglect of children were identified by UNICEF (Box 2).

Evidence from previous natural disasters, such as hurricanes, earthquakes, tsunamis and fires, and pandemics suggests that the current COVID-19 crisis is generating extremely high levels of stress in home environments, and with this an increasing likelihood that women experience IPV and children experience abuse or observe IPV. In addition, in the short, middle and long term it is causing economic vulnerability that could lead to increases in child labor, child marriage, and many other child protection issues.

## Box 2: Risk factors for violence, abuse and neglect of children associated with Covid-19.[1]

According to UNICEF, there are nine common risk factors for violence, abuse and neglect of children associated with Covid-19 include:

- ❏ increased poverty and food insecurity due to the loss of jobs and incomes;
- ❏ the inability of children to access education either in person or online;
- ❏ an increase in children's digital activity and a decrease in caregiver monitoring, which exposes them to greater digital risks;
- ❏ an absence of nutritious meals previously provided by schools and care programmes;
- ❏ the disruption of peer and social support networks for children/caregivers;
- ❏ the disruption of community and social support services for children/caregivers;
- ❏ a breakdown in routines for children/caregivers;
- ❏ increased alcohol and/or substance use by adolescents/caregivers; and
- ❏ ad hoc child care arrangements.

[1] Taken from: https://www.unicef.org/sites/default/files/2020-05/COVID-19-Protecting-children-from-violence-abuse-and-neglect-in-home-2020.pdf

Though data are scarce, media coverage and reports from organizations that respond to violence against women and children reveal an alarming picture of increased reports of IPV and VAC during this outbreak, including partners using physical distancing measures to further isolate affected women and children from resources. **The available evidence suggests that the COVID-19 pandemic and the associated isolation measures have led to a rise in family violence in many countries - if not globally.** According to the UNHCR-led Global Protection Cluster, 19 (out of 21) GBV sub-clusters involved in humanitarian responses report that GBV is occurring; over 60% say it is occurring with high impact due to the COVID-19 crisis.

In April 2020, UNFPA released new projections predicting an additional 31 million cases of gender-based violence if efforts to contain the virus limit people's movements for at least six months. For every three months the lockdown continues, an additional 15 million cases are expected. They also predict 13 million additional child marriages in the next decade due to COVID-19 disruptions. Since COVID-19 lockdowns began, in India, there were 92,000 reports of child abuse to one help line, during the first 11 days of lockdown. In north-east Nigeria, reports of GBV more than doubled in one month (from 50 cases in March, to 115 cases in April 2020). In two districts in eastern Uganda, a total of 117 cases of child sexual abuse were reported in the first two months of national lockdown. Likewise, between March and April 2020, 238 femicides were identified and almost 164,000 GBV-related calls were made to helplines, in Latin America and the Caribbean (Table 1).

**Table 1:** GBV related calls made to helplines and Femicides registered, during the first month of lockdown (or restrictive measures), Latin America and the Caribbean

| Country | Calls | Femicides | Data source |
|---|---|---|---|
| Argentina | 3810 | 25 | 144 helpline |
| Bolivia | NA | 4 | Special Forces to Combat Violence (FELCV) |
| Brazil | NA | 50 | Brazilian Public Security Forum |
| Chile | 2197 | 2 | *La Tercera* (national media); Ministry of Women and Gender Equality |
| Colombia | 3951 | 15 | Colombian Women's Observatory; Femicide Foundation Colombia. |
| Costa Rica | 12609 | NA | 911 National Emergency System |
| Cuba | NA | 3 | The *YoSíTeCreo* Cuba independent platform. |
| Dominican Republic | 787 | 5 | *Linea Mujer* 212, Ministry of Women. Press. |
| Ecuador | 10695 | 3 | Integrated Security Service ECU 911. State Attorney General. |
| Guatemala | 479 | 12 | Women's Observatory of the Public Ministry. |
| Honduras | NA | 7 | Police reports and media. |
| Mexico | 115614 | 78 | 911 helpline; National Public Security System. |
| Nicaragua | NA | NA | |
| Paraguay | 626 | 1 | Ministry for the Protection of Women's Rights; Women's Observatory. |
| Peru | 10679 | 5 | 100 helpline; Prevention and Eradication of VAW Program. |
| Puerto Rico | 393 | 2 | Office of the Women's Ombudsman; Media monitoring. |
| El Salvador | NA | 4 | Organization of Salvadoran Women for Peace. |
| Uruguay | 1557 | 1 | Google search analytics; Press. |
| Venezuela | NA | 21 | Independent femicide monitor. |

## Evidence specific to humanitarian crisis contexts

Refugee and displaced women are at an increased risk of violence, due to a baseline higher level of violence and the disproportionate effect of the pandemic and lockdown on refugee populations. The vast majority of refugee populations worldwide reside in low and middle income countries (LMIC), with weak social protection mechanisms. Refugee populations rely heavily on aid from international organizations, but aid is often not enough and informal work is essential for refugees to ensure the provision of basic necessities. Many men and women living in refugee camps and informal settlements rely on the informal economy to secure a daily wage. Mobility restrictions coupled with the economic slowdown have left these people without a source of income, and some women have expressed concern that they may be forced to rely on their abusive partners and families.

**Syrian refugee crisis:** Syrian refugee women have reported that financial struggles and increased stressors following displacement have contributed to an increase in family violence as husbands take out their anger and frustration on family members. During the pandemic, economic hardships and stressors are escalating, placing women at a higher risk of violence. An assessment conducted in Lebanon in May 2020, showed that 65% of respondents, the vast majority of whom were Syrian refugee women, lost more than 50% of their household income. In addition to the general expression of concerns about rising tensions within the family, 12% reported an increase in IPV, and 29% an increase in VAC. The GBV Information Management System shows a 5% increase in physical assault in March 2020 (compared to January 2020), and a 3% increase in IPV during the first quarter of 2020 (compared to 2019). In another assessment conducted by the Inter-Agency SGBV Task Force in Lebanon, 54% of respondents witnessed increased violence against other women, 85% of which was observed in their own homes. UN Women conducted an assessment with vulnerable women in Jordan including Syrian refugees, and found that 62% of respondents reported increased risk of emotional and physical violence as a result of increased tensions in the household. 54% of these women were experiencing economic hardships, having to borrow money or food from others.

**Figure 6:** Types of Violence Observed the Most Since the COVID-19 Outbreak among Syrian refugees in Lebanon
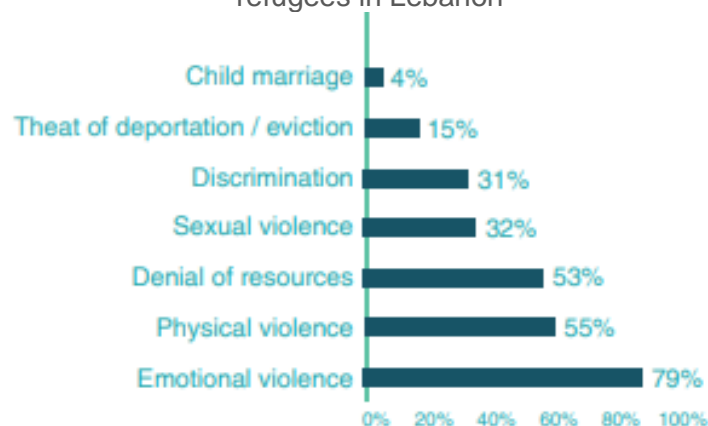


Source: Inter-Agency Coordination Lebanon - Impact of COVID-19 on the SGBV Situation in Lebanon (2020). Retrieved from: https://data2.unhcr.org/en/documents/download/76729

**Venezuelan refugee and migration crisis:** Data collected by Save the Children from beneficiaries of programs in Venezuela and neighboring countries also show an alarming landscape. In the Colombian border territories, a 33% increase in demand for GBV-related support services during the period of strict confinement is observed. Most of these cases are related to sexual violence against girls and boys, and psychological and physical IPV against women. In Colombia, staff report an increase of nearly 80% in the frequency of calls to the NGO's helplines and a 62% increase in psychological first aid consultations related to family violence cases. Recently, the Organization of American States' Peace Support Mission in Colombia (MAPP/OEA) and the NGO Coalition Against the Involvement of Children and Young People in the Armed Conflict in Colombia (COALICO) warned that the pandemic - and the implemented countermeasures - have also increased the risk of violations against children and adolescents due to the internal armed conflict. Official data show that, between January and May 2020, there was an increase of 113% in forced recruitment of children and adolescents by illegal armed groups, compared to the same period in 2019. Many of these events have happened in Colombian municipalities with a high influx of Venezuelan children and youth, who are an easier target given their illegal migratory status and socioeconomic vulnerability.

### Is this just the tip of the iceberg?

Family violence is systematically underreported: stigma, fear and difficulties accessing protection services are some of the reasons that deter women and children from speaking out against cohabiting perpetrators and seeking help. Meta-analyses have shown that this underreporting bias is huge: child sexual abuse events are estimated to be 30 times larger than the number of reported events; and child physical maltreatment events are 75 times the number of officially registered cases. Evidence suggests that, during the COVID-19 pandemic, underreporting has too exacerbated, especially in displacement contexts.

Reporting of cases and accessing the necessary services has become increasingly challenging with the lockdown and restricted mobility. In Jordan, there has been a 68% reduction in GBV cases reported, with humanitarian workers warning that the decrease is not due to a drop in cases, but as a result of increased barriers to reporting. Many refugee women reside in overcrowded camp and camp-like settlements, sharing a room with multiple family members. Kafa, an NGO in Lebanon working on gender-based violence, reported a drop in calls from Syrian refugee women during the pandemic, postulating that it is due to a lack of privacy to call the hotline as women are in constant proximity to their families. Similarly, the International Rescue Committee (IRC) reported a 50% decrease in GBV reports in Cox's Bazar, Bangladesh and a 30% decrease in Tanzania between February and March 2020.

The suspension of public transport has made it increasingly difficult for women to access shelters and support provided by NGOs. Furthermore, legal aid and service centers may not be operating at full capacity or are not exempt from closure as essential services. In a number of refugee-hosting countries, such as Greece and Lebanon, discriminatory movement restrictions have been placed on refugees making it even more difficult for women to leave the household and report cases or seek necessary medical and legal services. Women and children may also have limited

private access to phones and technology to be able to access services remotely or contact hotlines. In Lebanon, among women who received GBV services remotely by phone, 33% reported difficulty due to limited access to cell phones, safety concerns talking on the phone or restricted access to phones by partners or a family member.

# RECOMMENDATIONS TO PREVENT FAMILY VIOLENCE AND PROTECT SURVIVORS IN DISPLACEMENT CONTEXTS, DURING THE PANDEMIC

A number of factors, such as increasing stressors and tension between household members, overcrowding and difficult living conditions, and limited access to social support networks are contributing to the rise of family violence during the pandemic, and specifically for migrants and refugees. Both preventive and protection strategies are necessary to counteract the increased risk of violence against women and children resulting from the COVID-19 pandemic and its countermeasures.

There already exist important compilations and repositories of technical resources available to adapt, design and implement interventions to offset risk factors and promote protective factors associated with VAC and GBV. For instance, INSPIRE gathers an ample inventory of strategies that have documented evidence of effectiveness in reducing VAC (Box 3). In addition, the international community has made great efforts to adapt and share specific resources to guide a rapid response to the potential surge in violence among migrant and refugee families in the midst of the COVID-19 pandemic (for example, from UNHCR, UN Women, World Bank's Gender Group, Inter-Agency Standing Committee, IRC, Global Alliance to End Violence Against Children and Global Protection Cluster).

In addition to the general recommendation to account for culture and context to mitigate unintended harmful consequences (i.e. implementing a "do no harm approach", see Knowledge Brief 1), the following six actions have been identified as relevant, urgent and necessary to prevent family violence and protect survivors during the pandemic in displacement contexts (Box 4).

## 1. Guarantee the continuity of protective prevention and response strategies

**Advocate for the inclusion of GBV and VAC response services as essential services**, and ensure they are included in preparedness and response planning for COVID-19 and appropriately resourced. WHO recommends that governments and policy makers include essential services to address violence against women in preparedness and response plans for COVID-19. Similarly, The Alliance for Child Protection in Humanitarian Action, End Violence Against Children, UNICEF, WHO highlighted the need to guarantee that authorities, para-social workers and community-level workers have the necessary technical and economic resources to deliver child protection services in fragile contexts and humanitarian crises.

An alarming trend has emerged of NGOs and humanitarian agencies shifting their focus to respond to the pandemic, diverting funding from existing programs to COVID-19 specific projects and aid. Sexual and reproductive health services and programs, including those that address GBV, are particularly at risk of being sidelined. Lack of funding for GBV programs that may be deemed as "non-essential" can have dire consequences on the safety of women. Less than 1% of funding requested for COVID-19 response in humanitarian contexts was for GBV response.

## 2. Adapt safe spaces

Recognizing the strains that the pandemic response has put on existing sexual and reproductive health services and resources, **it is important to avoid** converting safe shelters for IPV **into additional capacity for COVID-19 health response**. It is critical that women are involved in planning and coordination of COVID-19 response. In addition, **authorities should anticipate the need of Interim Care Centers (ICCs)** for children in need of temporary care (due to caregivers falling ill, dying or abandonment). Save the Children has created guidance to provide interim care during the COVID-19 pandemic to children in need of isolation or quarantine or who are not suspected of being infected.

Where possible, **adapt safe spaces for women and for children** to adhere to physical distancing protocols so they remain open. Provision of appropriate personal protective equipment (PPE) and training to GBV and VAC case workers is key in this adaptation. Abaad, an NGO in Lebanon, has guidance for infection prevention to ensure that physical safe spaces continue to safely provide psychosocial support to women and girls, even during COVID-19. This may also require reducing the number of women or children in the space at one time to ensure physical distancing. In Tanzania, women participants helped establish a new schedule for these smaller sessions to help encourage continued use of the space.

## Box 3: INSPIRE - Seven Strategies to End Violence Against Children[1]

**(I) IMPLEMENTATION AND ENFORCEMENT OF LAWS**: Promotion and implementation of laws that ban violent punishment (both physical or psychological), criminalize perpetrators, prevent youth alcohol misuse and youth access to firearms.

**(N) NORMS AND VALUES**: Changing harmful or destructive societal norms.

**(S) SAFE ENVIRONMENTS**: Making environments and public infrastructure safer to halt the spread of violence throughout a community.

**(P) PARENT AND CAREGIVER SUPPORT:** Engaging parents and caregivers through home visits, group activities in community settings, and other evidence-based programmes.

**(I) INCOME AND ECONOMIC STRENGTHENING**: Reducing economic instability through cash transfers and microfinance initiatives, combined with gender norm training.

**(R) RESPONSE AND SUPPORT SERVICES:** Providing evidence-based and appropriate interventions to serve the needs of survivors and children at risk.

**(E) EDUCATION AND LIFE SKILLS**: Promoting access to safe and enabling school environments that foster children's knowledge about violence and exploitation.

[1]Adapted from: https://www.end-violence.org/inspire.

### 3. Provide adapted and relevant remote service delivery

**Identify ways to make GBV and VAC protective services accessible in the context of COVID-19 restrictions** and physical distancing measures. The GBV Area of Responsibility (AOR) HelpDesk introduced guidance on providing GBV case management under COVID-19. Also, governments should ensure that child and family courts adapt to public health measures and continue to hold emergency hearings that in many contexts the care and protection of children who are at an immediate risk of neglect or abuse.

**Where this is not possible, these and other essential protection and response services should shift support to remote service delivery**. IRC has guidelines for remote GBV service delivery using technology such as hotlines, chat or SMS. IRC's multi-platform information hub CuentaNos, used in El Salvador, Guatemala and Honduras, has helped provide two-way communication on WhatsApp allowing women to seek information and service providers or reach out to trained moderators for support. In Uganda, UNHCR has established a call center with trained protection agents speaking 15 languages to manage a helpline for GBV survivors that provides counseling. Child Helpline International, a worldwide network of 173 helplines across the world, has generated specific resources to adapt and strengthen helplines to operate in the current crisis. For example, they provide strategies to integrate child-friendly COVID-19 counsellor training and adapted referral strategies. The National Network to End Domestic Violence has produced a  set of recommendations on how to use technology to communicate with survivors during a public health crisis. Interestingly, this work provides guidance on the factors to consider in the process of technology selection and adoption.

**Technology strategies may only be appropriate in certain settings** and should be implemented with consideration of challenges such as limited access to phones, confidentiality, protection when a woman is living with her abuser. UNICEF has some guidance for non-phone, low or no-tech options. One strategy is to consider making phones available for women to use to contact GBV case managers in existing safe spaces, as in north-east Nigeria, where an NGO has converted safe spaces into 'tele-health' centers with individual phone booths that incorporate infection prevention protocols. In Myanmar, UN Women provided 60 social workers from the Department of Social Welfare mobile phones to operate 24/7 GBV and COVID-19 hotlines; they are also proactively reaching out to girls with GBV messages.

**Remote service delivery strategies must be accompanied by appropriate staff training**. Health workers need an updated toolkit to properly identify GBV and IPV risks and cases, handle disclosures in a compassionate, non-judgmental way, and know the current referral pathways for survivors.

### 4. Identify alternative entry points for survivors

**Identify all available entry points for connecting survivors with violence prevention and protection services**. For instance, in humanitarian contexts, work with GBV specialists to identify appropriate alternative entry points, for example: food or cash distribution points, markets, pharmacies, water points, and health service facilities. Consider how information on available GBV services can be safely shared at those places. Specific training should be provided to staff and volunteers working in each response sector (Camp Coordination and Camp Management, Child Protection, Education, Food Security and Agriculture, Health, Livelihoods, Nutrition, Protection, Risk Communication and Community Engagement, Shelter/Non Food Items and Water, Sanitation and Hygiene) on how to safely respond to a disclosure and ensure they have the most up-to-date referral pathways. For example, in Lebanon, UNHCR has trained staff in the Health, Shelter, WASH and Basic Assistance sectors on GBV risk mitigation measures including safe disclosure and referral of survivors.

**All professionals who may be in contact with children** (for example, medical personnel, school staff, police or first responders), despite physical distancing measures, **can play an important role in identifying and reporting signs of abuse and neglect**. In Uganda, UNDP is working with partners to adapt e-learning modules for police, public prosecution, judiciary and prison officers to ensure familiarity with adapted services.

In the current crisis, public health systems should **leverage existing mHealth reporting pathways to help report suspected cases of IPV and VAC within displaced communities**. As community health workers and health services staff report on suspected cases of COVID-19 and follow up they could report and refer via the mHealth app or tool they are using. mHealth tools are already used for disease surveillance and referral and follow up of medical cases in migrant communities. **COVID-19 response strategies provide a new opportunity for family violence surveillance.**

## 5. Strengthen community protection mechanisms

**Strengthen community protection networks to raise awareness of protection risks, identify cases of family violence and support response.** It is important to inform the community of the heightened risk to women and children of IPV and VAC related to the Covid-19 control measures. Community volunteers can provide information on GBV services that are available and be trained on how to support a survivor who discloses violence to access these services.

Community health workers or others doing home visits should be trained on how to effectively identify family violence, to safely respond to a disclosure, and provide the most relevant and up-to-date referral pathways. To guarantee adequate training, **regular check-ins with GBV and child protection service providers and local women's groups are key to understand changes in safety risks** for vulnerable women and children, and to consequently adapt information and service delivery.

Community leaders could be supplied with pocket cards containing relevant contact information, and give away visual representations of referral pathways and helpline numbers. In addition, information on where support is available may be disseminated via radio, WhatsApp or other social media. Low tech signal alerts or code words have been used to signal the need for support without the woman having to reach out to contact someone.

UNHCR uses community radio to raise awareness on GBV prevention and response in Kenya and Rwanda. In north-east Nigeria, mobile teams with the International Organization for Migration (IOM) go door-to-door to raise awareness of GBV services with physical distancing measures, rather than gathering women in groups. In Somalia, UNDP is working with partners to develop "neighborhood watch" systems, whereby elected men and women receive training to patrol their neighborhood to prevent or mitigate incidents of violence. Abaad, a Lebanese NGO, launched a national IPV awareness campaign asking people to share their helpline number from their balconies so that women who were isolated at home with an abuser would have the information. They also encouraged influencers to share the number via Tik Tok and other social media.

## 6. Promote positive and supportive relationships

Stay-at-home orders have stressed intra-household relationships, especially for displaced families, who usually face difficult living conditions, overcrowding and economic instability. Additionally, school and care facility shutdowns have cut abruptly positive and supportive relationships on which children rely when coping with stressful situations. Promoting healthy parenting strategies is urgently needed to **mitigate increases in physical and psychological violence by providing caregivers the necessary tools to understand children's needs, improve communication and manage children's behavior during and after the pandemic and social isolation times**. Additional to the immediate VAC preventive impact, these strategies have an important cascade effect by nurturing protective factors, such as socioemotional and communication skills in children and youth, that decrease the propensity of suffering or perpetrating all kinds of violence in the future.

Parents Make the Difference is a parenting intervention developed by the IRC that has been proven to be effective in conflict and crisis settings, such as Liberia. The program focuses on providing parents self-care tools, and teaching them that dysregulated or difficult to manage behavior of children is usually associated with natural brain development processes or a result of toxic stress. Another promising intervention to promote positive and supportive relationships is Semillas de Apego, a group-based psychosocial support intervention for primary caregivers in the context of forced displacement that has shown positive impacts in Tumaco, Colombia. By replenishing caregivers' emotional health and promoting healthy child-parent attachments, the program fosters proper development among children exposed to violence.

However, usually these and other similar interventions rely on the geographical and economic stability of migrant families (to guarantee adherence), and on the viability of having face to face activities. Thus, in order **to offer appropriate support, the delivery of these types of programs should consider particular family needs and dynamics, and physical distancing measures during and after the pandemic**.

**Box 4:** Specific recommendations

1. Implement a "do no harm approach".
2. Adapt safe spaces to adhere to physical distancing protocols so they remain open.
3. Guarantee the continuity of protective prevention and response strategies.
4. Provide adapted and relevant remote service delivery.
5. Identify alternative entry points for survivors to seek help.
6. Strengthen community protection mechanisms.
7. Promote positive and supportive relationships.

# Authors

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