SPECIAL REPORT

NO. 501 | AUGUST 2021 UNITED STATES INSTITUTE OF PEACE www.usip.org

Gender-Based Violence and COVID-19 in Fragile Settings: A Syndemic Model

By Luissa Vahedi, Jessica Anania, and Jocelyn Kelly

Women wear protective masks while visiting a market in Rawalpindi, Pakistan, on May 9, 2020. (Photo by Anjum Naveed/AP)

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Summary

- The COVID-19 pandemic has compounded the preexisting epidemic of gender-based violence. In turn, gender-based violence can directly and indirectly contribute to COVID-19 vulnerability and community transmission.
- Gender-insensitive COVID-19 policy responses have reinforced this negatively synergistic relationship, reducing the effectiveness of disease control measures and contributing to gender inequality in fragile settings, which are already characterized by conflict, poverty, displacement, and weak infrastructure.
- This syndemic relationship is explored through three key avenues: constrained access to health and social services, the militarization of movement, and reduced socioeconomic status.
- To interrupt the negative synergistic interaction of gender-based violence and COVID-19 in fragile settings, policymakers must implement responses targeting the gendered consequences of disease control measures.
- Understanding the mutually reinforcing interactions of gender-based violence and COVID-19 can help practitioners and policymakers better address the interaction between gender-based violence and infectious disease in other existing or emergent infectious disease outbreaks.

United States Institute of Peace
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SPECIAL REPORT

NO. 501 | AUGUST 2021

GENDER

ABOUT THE REPORT

This report examines the avenues through which the COVID-19 pandemic has compounded the preexisting epidemic of gender-based violence in fragile settings and, in turn, how gender-based violence can directly and indirectly contribute to COVID-19 vulnerability and community transmission. The authors' research was supported by the Gender Policy and Strategy Program at the United States Institute of Peace and the Missing Peace Scholars Initiative.

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Special Report No. 501. First published 2021.

ISBN: 978-1-60127-864-7

UNITED STATES
INSTITUTE OF PEACE PRESS

A medical worker administers a nasal swab test for COVID-19 to one of a group of Rohingya refugees stranded on Idaman Island in East Aceh, Indonesia, on June 4, 2021. (Photo by Rahmat Mirza/AP)

Introduction

The COVID-19 pandemic and associated public health policies have exacerbated preexisting threats to human safety and dignity in fragile settings—contexts already characterized by conflict, poverty, displacement, and weak infrastructure. In particular, the long-standing pandemic of gender-based violence has been worsened by COVID-19 and related containment measures. These interactions can be understood and addressed by applying the syndemic model to the COVID-19 pandemic and gender-based violence in fragile settings.

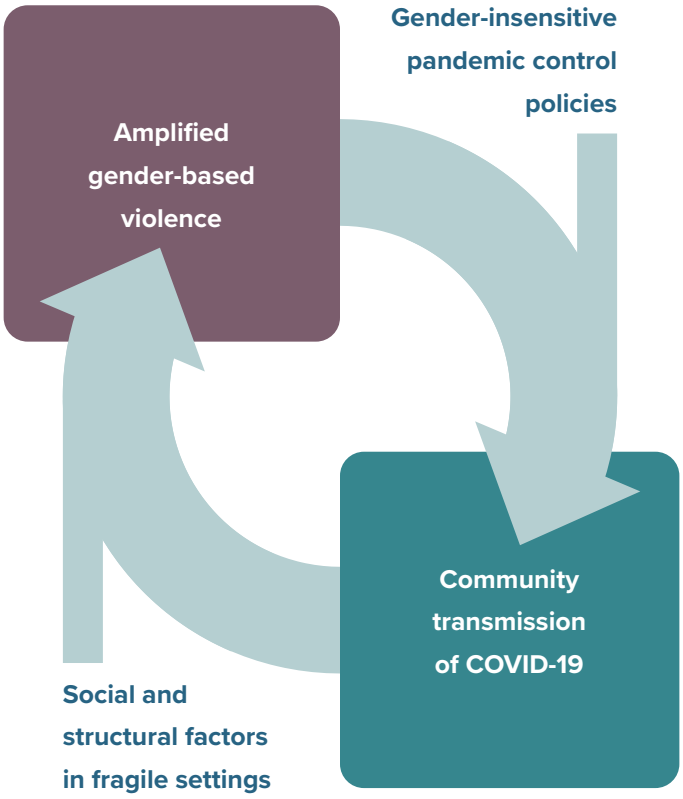
A syndemic is the co-occurrence of two or more epidemics or pandemics that interact in a population to compound the severity of each through biological, social, psychological, or behavioral pathways and interactions.[1] Identifying actionable policy areas to address both gender-based violence and COVID-19 community transmission should help practitioners and policymakers better manage not only future infectious disease pandemics but also the ongoing COVID-19 pandemic, which continues to ravage a number of fragile settings where conflict and political instability have weakened public health response and the capacity to mobilize vaccinations.[2]

Fragile contexts are among the most dynamic and complex environments in which to mount a pandemic response. Gender-based violence in particular is likely to increase in fragile contexts for a number of reasons. National governments are less able to fulfill such essential responsibilities as protecting citizens from conflict, reducing poverty, maintaining effective legal

FIGURE 1.

Syndemic Relationship between Gender-Based Violence and COVID-19

A syndemic is the co-occurrence of two or more epidemics or pandemics that interact in a population to compound the severity of each through biological, social, psychological, or behavioral pathways and interactions.



The COVID-19 pandemic has compounded the preexisting epidemic of gender-based violence. In turn, gender-based violence can directly and indirectly contribute to COVID-19 vulnerability and community transmission. State fragility reinforces vulnerabilities to both gender-based violence and COVID-19.

and justice systems, and providing health care and social services infrastructure.[3] Though infectious disease pandemic control policies have begun to focus on fragility and gender, COVID-19 responses in fragile settings have not yet adequately integrated protections for women, girls, and other gender minorities.[4] This report addresses this shortcoming by drawing on the syndemic framework to highlight both the impacts of the COVID-19 pandemic on gender-based violence and the impacts of gender-based violence on COVID-19 transmission and vulnerability.

Gender-based violence refers to any form of violence rooted in gender-inequitable norms or power dynamics. Violations may be physical, emotional, psychological, or sexual and may include sexual violence, intimate partner violence, and other forms of sexual abuse and exploitation.[5] Though persons of any gender can and do experience these violations, women and girls in fragile settings are disproportionately affected.

State fragility—encompassing complex social and political factors, including destabilized governance, conflict, and inadequate humanitarian aid—reinforces vulnerabilities to both

The increased health burden resulting from the COVID-19 and gender-based violence syndemic manifests in elevated community disease transmission and vulnerability, an increase in gender-based violence, and the erosion of gender equality.

gender-based violence and COVID-19.[6] The negative consequences of gender-insensitive disease control policies are fertilized by the power vacuum in state and civil institutions and by weakened judicial mechanisms, often in a sociopolitical context that prioritizes male leadership and decision-making.[7] Furthermore, fragile settings are characterized by a lack of systems needed to mount a response to an infectious disease pandemic, including public health infrastructure, health and social services, referral pathways, and accurate and reliable communication about health risks. This environmental background to the current syndemic should help policymakers and practitioners broaden their outlook so that they better understand the structural factors underpinning the two pandemics when they design and implement treatments. In the long run, failing to incorporate gender protections within responses to the COVID-19 pandemic has the potential to further erode and reverse progress made with respect to gender equality in fragile settings.

The increased risk of gender-based violence in fragile settings also affected by COVID-19 was highlighted in an October 2020 report by the International Rescue Committee. In a survey conducted in fifteen of the most fragile contexts across the globe, this group found that 73 percent of refugee and displaced women reported increased domestic violence during the COVID-19 pandemic and 51 percent reported increased sexual violence.[8] Creating more effective protections for women can not only disrupt cycles of violence but also support a holistic pandemic response that advances the women, peace, and security agenda, which aims to improve the participation of women in peace and security processes through political, economic, and social empowerment.[9]

This report applies the syndemic model to illustrate the intersection between gender-based violence and the COVID-19 pandemic within fragile settings. The model can also be used to understand the intersection of gender-based violence and other emergent or existing infectious disease outbreaks, such as those caused by the West Africa Ebola outbreak in 2014–16 and the Zika virus epidemic that began in Brazil in 2015.

A syndemic achieves its effects through biological, social, psychological, and behavioral interactions that increase the impact of two or more epidemics on an affected population. The COVID-19 pandemic in a fragile setting represents not simply a pandemic but rather one part of a syndemic that magnifies gender-based violence; gender-based violence in turn directly and indirectly affects COVID-19 community transmission and vulnerability.[10] This mutually reinforcing relationship between the COVID-19 pandemic and gender-based violence in fragile settings is depicted in figure 1. The increased health burden resulting from the COVID-19 and gender-based violence syndemic manifests in elevated community disease transmission and vulnerability, an increase in gender-based violence, and the erosion of gender equality. Thus, women and girls in fragile settings—those who are most vulnerable to gender-based violence—are no longer navigating the threat of gender-based violence as an isolated phenomenon.

Three Avenues of Interaction

The risk of gender-based violence is navigated within the context of COVID-19-related social limitations, including movement restrictions (lockdowns) and social distancing (such that vulnerable women and girls are unable to seek help from women-focused aid agencies). When such pandemic control measures are developed and implemented without consideration for social protections that safeguard the well-being of women and girls with respect to violence and harmful gender norms, unintended syndemic vulnerabilities arise. Vulnerabilities to COVID-19 exposure and gendered modes of transmission suggest three main avenues by which the COVID-19 pandemic and the pandemic of gender-based violence interact to increase the disease burden of the population: curtailed access to health care and social services, the militarization of movement, and a reduction in economic well-being and social status.

BARRIERS TO ACCESSING HEALTH CARE AND SOCIAL SERVICES

Weak health care and social systems in fragile settings are key factors in increasing COVID-19 infection risk and creating feedback loops that negatively affect women's agency and elevate the risk of gender-based violence. One study of women in informal urban settlements in four conflict- and displacement-affected countries found that the COVID-19 pandemic reduced health care access at all sites.[11] Not only were survey respondents at high risk for contracting the virus because of crowding and a lack of available health services, respondents noted they no longer sought health services. This finding is in line with trends others have noted in fragile contexts, where the COVID-19 pandemic has disincentivized health care seeking.[12] In fragile contexts, access to health care is often restricted already, and in some cases there is an underlying mistrust of the health care system. Poorly managed public health responses can exacerbate rather than allay these negative perceptions.

These trends did not originate with the COVID-19 pandemic. Reciprocal relationships between infectious disease epidemics and gender-based violence were noted in the Ebola responses in Central and West Africa. Fear of virus transmission acted as a barrier to service seeking related to gender-based violence, and social distancing measures restricted women's and girls' access to safe spaces, reducing opportunities to connect with protective social networks. Communities also reported an increase in sexual and physical violence, sexual abuse and exploitation, child marriage, and trafficking—at the same time that access to services and social support networks are constrained.[13] Similar dynamics are being seen as a result of the COVID-19 pandemic and related social isolation policies.[14] These dynamics not only affect short-term care seeking and health outcomes during the crisis, they can also have negative long-term effects on population health and well-being.

Lack of access to critical women's health services in some fragile settings has been made more acute because earlier disease outbreaks, such as the Ebola and Zika virus epidemics in the mid-2010s, diverted critical resources away from sexual and reproductive health services, including prenatal care, family planning, and HIV/AIDS care.[15] Disruptions in sexual and reproductive health care have had extremely detrimental effects during past infectious disease pandemics. In Sierra Leone, disrupted services and decreased attendance at health centers contributed to an estimated 3,600 maternal and perinatal deaths—a number rivaling the number of

Health workers wearing protective gear check on a mother of four whose husband died of Ebola, at an Ebola treatment center in Beni, Congo, on July 13, 2019. (Photo Jerome Delay/AP)

Ebola-related deaths. In Guinea, sexual and reproductive health care seeking did not recover to pre-outbreak levels for six months.[16] Qualitative evidence from low-resource settings suggests the same dynamics are at play in the COVID-19 pandemic, with governments and health services diverting resources and attention away from existing health issues, including other infectious diseases, as well as preventive services and maternal and child health needs.[17] Because sexual and reproductive health services provide an important entry-point for women to access other kinds of health care, disinvestment in these services can be expected to lead to women's long-term disenfranchisement from the health care system.

While formal care seeking outside the home is increasingly restricted during the COVID-19 pandemic, women are also stepping into more demanding roles as caregivers themselves. Globally, it is estimated that 60 to 80 percent of caregiving within families is done by women, including childcare, elder care, and care for those sick with COVID-19.[18] In a review of Ebola outbreaks from 1976 to 2014, women's increased exposure to the virus was linked to caregiving roles and responsibilities.[19] As women take on greater responsibility for caregiving within the home, they face an increased risk of exposure to the virus at a time when external services are highly constrained.

Social Isolation and Nonreporting

The extended social restriction of lockdowns brings risks and challenges of its own, including anxiety, depression, stigmatization, isolation, and social unrest. These dynamics can in turn exacerbate the risk that individuals will experience or perpetrate gender-based violence. Despite the risk of increased violence, reporting has decreased in many places around the world. It is widely recognized that global estimates of levels of gender-based violence are low due to underreporting. Survivors may be unable or unwilling to report out of fear of further violence, lack of knowledge about or access to services, social stigma, mistrust of institutions, or other reasons.

During the COVID-19 pandemic, many avenues of reporting, such as health care clinics, have been blocked by pandemic-related shutdowns, diversion of funds, and fear of contracting the virus. These obstacles merely add to the pre-pandemic underreporting of gender-based violence. While digital tools such as Facebook, WhatsApp, and other social media platforms show promise in overcoming physical and logistical barriers to accessing health care and reporting instances of gender-based violence, in fragile contexts they may be unavailable or their use may be prioritized for males in the household. Only 19 percent of households in the least-developed countries had internet access by 2019, and globally, women are 23 percent less likely than men to use the mobile internet.[20] This gendered digital divide deepens existing inequalities and undermines the ability to seek health care, report incidents of interpersonal violence, or receive critical public health messages.

THE MILITARIZATION OF MOVEMENT

Efforts to halt the spread of COVID-19 typically have included the curtailment of physical movement through border closures, curfews, lockdowns, mandatory quarantines, and temperature checkpoints, any of which may involve police or military enforcement. In fragile settings, militarized forces already present may be called on to enforce COVID-19-related movement restrictions. For example, UN peacekeepers have been part of the COVID-19 response, including in fragile contexts such as the Democratic Republic of the Congo. This increased militarization of public health has unintended consequences for gender-based violence.[21]

Militarization may heighten gender-based violence as a result of increasingly unequal power dynamics, linking the idea of "being a man" to violence, and real or perceived impunity for militarized forces.[22] A pattern has emerged of militarized forces using COVID-19 as a pretext or catalyst for detaining, arresting, or otherwise opportunistically targeting individuals for gendered violence. Armed conflict location data reveal that the incidence of sexual violence has been related to enforcement of COVID-19 control measures throughout the pandemic.[23] COVID-19-related lockdowns created a new and unique opportunity for soldiers to perpetrate sexual violence within a context of defined military power.

Paradoxically, many measures put in place to contain the spread of COVID-19 have increased opportunities for contact between civilians and militarized forces, raising the risk of both disease transmission and gender-based violence. Forces may now monitor health care sites and food distribution lines, ostensibly to enforce social distancing. The risk of gender-based violence through these activities is exacerbated by the disproportionate burden on women to carry out household and care duties, such as gathering food and water or seeking health care for sick relatives.

A Kenyan police officer prevents a resident from leaving the Eastleigh area of Nairobi on May 7, 2020. (Photo by Brian Inganga/AP)

Checkpoints similarly increase the risk of exposure to both pandemics as personnel may now be required to monitor temperatures, ensure compliance with mask requirements, and enforce COVID-19-related movement restrictions. Reports from Nigeria in 2020 illustrate this risk: security forces tasked with enforcing COVID-19-related restrictions allegedly arrested or detained women under the pretext of their not wearing face masks, then gang-raped them. At least one of these incidents reportedly happened at a checkpoint.[24] Militarization, particularly in the context of greater socioeconomic and power disparities in humanitarian and fragile settings, can make such sexual exploitation and abuse more likely. This trend has been documented in previous infectious disease pandemics, such as the Ebola outbreak in Sierra Leone.[25] Because such forms of sexualized violence increase contact between women and girls and militarized perpetrators of violence, they elevate the risk of COVID-19 community transmission, thereby completing the syndemic loop.

The monitoring of persons required to quarantine in shared facilities outside the home is another setting in which the militarization of movement has led to increased exposure. Many countries have relied on "quarantine centers," such as converted schools, hotels, or hospitals, which are often overseen by military personnel. Just as movement checkpoints create targets of opportunity for militarized perpetrators, quarantine facilities increase vulnerability to gender-based violence by isolating

Just as movement checkpoints create targets of opportunity for militarized perpetrators, quarantine facilities increase vulnerability to gender-based violence by isolating detained women and girls and providing them with no access to social services.

detained women and girls and providing them with no access to social services.[26] For example, in Kenya, a prison warden was arrested for allegedly raping a woman being held in a COVID-19 isolation ward he had been tasked with guarding.[27] Such violence may also contribute to the spread of COVID-19 when guards or other quarantine center personnel return to their communities and households after perpetrating sexual violence against individuals who are COVID-19 positive.

Not only are opportunities for disease exposure and assaults increased, but women's and girls' protective strategies are eroded by COVID-19-related movement restrictions. Moving in a group is a common protection strategy to help women feel safer and reduce their vulnerability to sexual violence, while solitary movement related to water acquisition, sanitation, and hygiene is frequently cited as increasing vulnerability to sexual violence.[28] Social distancing measures, limitations on group size or household mixing, and fear of contracting the virus may curtail these protective strategies, thereby heightening the risk of gender-based violence.

Before the COVID-19 pandemic, women and girls could travel in groups to perform quotidian tasks such as using public toilet facilities, collecting fuel or water, or shopping for food items. The use of communal hygiene facilities has been linked with gender-based violence: women and girls report a greater risk of violence both while using these locations and while traveling to and from them.[29] The risk of these daily tasks continues, even as the COVID-19 pandemic necessitates further interaction with these facilities. For example, a survey by the International Rescue Committee of 850 refugee and displaced women in East Africa, West Africa, and the African Great Lakes region observed that "31% reported harassment and sexual violence on the way to water points and 21% reported harassment upon arrival."[30] This risk is magnified by the COVID-19 pandemic as women and girls must make more frequent trips to collect water in order to perform enhanced hygiene measures.

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Understanding the intertwined pandemics of gender-based violence and COVID-19 as a syndemic shows the mutually reinforcing aspects of risk in fragile contexts: not only does the militarization of movement as part of COVID-19 control measures increase the risk of gender-based violence, but gender-based violence arising from enforcement of movement restrictions increases the risk of exposure to COVID-19. Decisions to avoid seeking COVID-19-related health care or accessing hygiene services may be made strategically, to protect against the possibility of gender-based violence, particularly in the context of increased militarization of movement. At the same time, inability to perform such disease-preventing measures as handwashing could render people more vulnerable to contracting COVID-19. Previous research has also highlighted systemic abuses of power by peacekeepers and humanitarian actors through transactional sex and sexual exploitation and abuse.[31] Transactional sex between civilians and military forces and sexualized violence perpetrated by soldiers increase the number and points of contact with military personnel and may further magnify the risk of COVID-19 community transmission, further affirming the synergistic relationship between the COVID-19 pandemic and gender-based violence.

REDUCED SOCIOECONOMIC STATUS

Financial stress is a defining characteristic of the COVID-19 pandemic for many people living in fragile settings. The associated economic disruptions, especially loss of employment and the consequent loss of financial agency, have been felt particularly among women and girls, whose income, education, and occupation were already negatively affected by conflict, civil unrest, and the breakdown of social safety nets.[32] The risk of intimate partner violence is heightened as male heads of household encounter economic threats. For example, studies in a number of contexts have documented that as men's income and status within the household are eroded, domestic and physical intimate partner violence increase as a way to reassert control and rigid gender norms.[33] Shifting gender dynamics in the household within the context of the COVID-19 pandemic can also spark psychological coercion wherein the perpetrator threatens to expose the victim to COVID-19 or limit access to hygiene products or public health services like testing or vaccination.[34]

Access to education is one of the world's most powerful tools to help women and girls achieve economic and gender equity. Yet COVID-19-related school closures and the curtailment of other social services are fueling new disparities in knowledge acquisition with ramifications in many arenas. Though the Global North has by and large adapted education and employment to online and tech-based platforms, the same adaptations cannot be assumed to work in fragile settings, where women are often excluded from the virtual economy and from remote classrooms and devices.[35] Even when curricula are adapted for remote learning, compared to their male counterparts, girls face additional barriers to accessing the internet, computers, mobile phones, television, and radio because of the gender digital divide and restrictive gender norms vis-à-vis education when technology is scarce.[36] Homeschooling of girls is also threatened by familial pressure for girls to undertake gendered domestic work and care for younger children or sick relatives. For example, data from Bangladesh between April and May of 2020 showed that the lockdown resulted in increased household chores delegated to adolescent girls.[37] Thus, because of gender-inequitable norms and the gender digital divide, families may prioritize the remote education of male children.

The educational impacts of the COVID-19 pandemic for girls in fragile settings are pervasive. A 2020 report highlighted that adolescent girls in the Gaza Strip worried they would have no other choice but to drop out of school because of their families' deteriorating economic situation.[38] The same report noted that in Jordan, the Ministry of Education implemented remote learning broadcasting through national TV channels; however, access to educational programs is limited among adolescents in Jordanian refugee camps and among families with one TV set for the entire household. The adverse educational impacts on women and girls can also be expected to affect their level of literacy and access to accurate health information during the COVID-19 pandemic. Inadequate health literacy, including inability to access or apply digital health information, adversely affects health and may increase community disease transmission by delaying or inhibiting screening, testing, and COVID-19 vaccination.[39]

Because education serves as a protective factor against child marriage, the interruption of education is a gendered consequence of COVID-19-related lockdown measures and favors child marriage, thereby perpetuating gender-based violence.[40] Research has shown that child marriage is associated with increased rates of domestic violence and adverse physical health outcomes

that require medical attention, such as pregnancy and delivery complications, forced sexual intercourse, HIV/AIDS, neonatal death, and stillbirth.[41] The uncertainty regarding when schools will safely reopen may further magnify pressures on adolescent girls to marry, out of the belief that marriage will keep the girl physically safe from stranger sexual assault and protect her socioeconomic status.[42] It is unlikely that the health and medical needs of girls who enter child marriages in fragile settings during the COVID-19 pandemic will be met, owing to cutbacks in sexual and reproductive health services and fear of community disease transmission. If continuing their schooling is not prioritized and if remote learning is not regarded as a worthwhile endeavor for girls, married girls may be coerced by family members and in-laws into bearing children earlier than planned. The subsequent loss of economic agency and consignment to low socioeconomic status can be expected to increase vulnerability to the next economic or pandemic shock.[43]

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Failure to integrate socioeconomic protections for women and girls during the COVID-19 pandemic has myriad harmful gendered consequences. Women and girls may face an increase in intimate partner violence because of family-level economic stressors, rely on transactional sex to alleviate financial strain, and face a heightened risk for child marriage when educational progression is circumscribed by the inequitable gendered division of digital technology access. Gendered disparities in freedom of movement, agency, and access to digital technologies all amplify the risk of exposure to COVID-19 and community transmission. Whether through increased points of contact with perpetrators of transactional sex, the intentional limitation of access to lifesaving hygiene resources, or reduced health literacy, gender-based violence threatens the effectiveness of COVID-19 pandemic control measures. As a result of economic shutdowns, women and girls in fragile settings face distinct syndemic-related vulnerabilities to both COVID-19 and gender-based violence.

Conclusion and Policy Recommendations

The COVID-19 and gender-based violence syndemic has thrived on reciprocal avenues of vulnerability, particularly striking for women and girls living in fragile contexts. This report identifies three key avenues through which these two pandemics achieve their synergistic effects: reduced access to health and social services, the militarization of movement and social interactions, and diminished socioeconomic well-being.

The closure of *health and social services*, including sexual and reproductive health care for survivors of gender-based violence, has exacerbated harms resulting from gender-based violence. Heightened levels of gender-based violence in turn can limit individuals' ability to seek medical services for life threatening conditions, including COVID-19. In fragile settings, *militarized forces* may be deployed to halt the spread of COVID-19 through border closures, curfews, lockdowns, and other limitations on personal movement. Yet militarization heightens

gender-based violence as a result of increasingly unequal power dynamics, linking the idea of "being a man" to violence, and real or perceived impunity for militarized forces. Sexualized violence perpetrated by militarized forces increases points of contact between persons and has the potential to propagate COVID-19. Lastly, the COVID-19 pandemic has brought severe *socioeconomic strain* affecting the education, employment, and income of the most vulnerable households. Household financial stress can spark distinct forms of psychological intimate partner violence that control the accessibility of COVID-19-related health care. Failing to prioritize the educational progression of girls by providing access to remote learning opportunities also perpetuates child marriage and inadequate health literacy.

Taken together, these three avenues have generational impacts, setting back gender equality for decades in the world's most unstable places. The avenues discussed in this report are by no means exhaustive, however; and the syndemic offers a unique opportunity to address the root social, economic, and political causes of gendered vulnerability to both COVID-19 and gender-based violence. An understanding of the syndemic relationship between these two pandemics—how each exacerbates the other—can help policymakers recognize unexpected interactions and develop the means to mitigate them.

The implementation of gender-insensitive COVID-19 control policies can exacerbate the negative effects of that pandemic while further entrenching harmful norms and power inequalities that lie at the root of gender-based violence. Gender-sensitive measures, according to UN Women and the United Nations Development Programme, seek to directly address the challenges faced by women and girls during the COVID-19 crisis, namely, unpaid care work, violence against women and girls, and economic insecurity.[44] In the absence of responses that put protections for women and girls front and center, existing risk factors for gender-based violence are magnified, even as new risk factors emerge. In the long run, failing to incorporate gender protections within responses to the COVID-19 pandemic has the potential to further erode and revert progress with respect to gender equality in fragile settings.

The presence of an infectious disease pandemic, however, does not inherently demand the erosion of gender equity in fragile settings. During disease outbreaks, policymakers should resist designing gender-blind health policies that reinforce harmful power dynamics, just as practitioners should consider how best to implement infection control measures to avoid magnifying gender disparities and gender-based violence. An increase in gender-based violence only contributes to destabilizing fragile settings. Recognition of this should lead to policies that integrate gender protections within COVID-19 response measures and address vulnerabilities, such as gendered socioeconomic impacts and digital divides, that perpetuate both COVID-19 and gender-based violence.

The following policy recommendations simultaneously address the synergistic pandemics of gender-based violence and COVID-19 within fragile settings. They are relevant to both practitioners seeking locally actionable remedies and policymakers concerned with broad-based prevention and aid goals at the national or international level.

Integrate gender-based violence information within public health communication. Official COVID-19-related communications—including government or organizational press conferences; leaflets; social media posts; and loudspeaker, radio, or television broadcasts—should leverage

Women wait in line to get tested for COVID-19 in New Delhi, India, on July 2, 2021. (Photo by Manish Swarup/AP)

platforms and audiences to include information on identifying and accessing resources for gender-based violence. At the local level, these communications can utilize points of contact for COVID-19-related services by broadcasting, distributing, or posting gender-based violence information at health clinics or near aid distribution lines. Digital media platforms should also be used, including to share information communicated via graphics to account for possible literacy barriers. One example of this is the inclusion of domestic violence information in COVID-19 messaging in Cameroon, where radio stations are broadcasting messages about both COVID-19 and domestic violence in West African pidgin.[45]

Provide COVID-19 health resources to women tasked with caregiving. Women disproportionately shoulder the burden for gathering household and caregiving supplies, putting them at increased risk of contracting COVID-19 and experiencing gender-based violence through movement and subsequent interaction with militarized forces. Health resources should be earmarked for female heads of household and women identified as caregivers. These resources could include hygiene items, such as face masks, or early access to vaccination through identification of these women as key personnel. When possible, resources should be brought directly to women, reducing their need for movement and interaction with military and police personnel.

Use COVID-19-related service touchpoints to provide gender-based violence services. Seeking COVID-19-related services, such as access to hygiene supplies, screening, testing, and vaccination, creates points of contact (touchpoints) between health care providers or humanitarian actors and persons living in fragile settings. These touchpoints provide an opportunity to also provide services for those at risk of or who have experienced gender-based violence. Clinicians, community health workers, and humanitarian actors can assess individuals for gender-based violence risk, refer them to services in the moment, offer brief health promotion interventions, and integrate gender-equitable messaging while persons are waiting for or receiving health services. Socially distanced safe spaces for women and girls should be positioned near such COVID-19-related touchpoints so that women and girls can access quick and confidential information and support. These services will look and feel different from those offered in the past because of social distancing but will provide the opportunity to gain lifesaving access to specialists trained in gender-based violence and sexual and reproductive health.

Provide women and girls with tools for digital employment and education. It is vital to acknowledge that women and girls have less access to digital tools and therefore fewer skills, particularly as the COVID-19 response digitizes life; this inequity is the gender digital divide. Enabling or increasing access to technology should be a funding priority, insofar as technology is a vital bridge to accessing education, public health services and communications, and employment. One solution would be to earmark funds in COVID-19 recovery plans to close the digital divide. This has been seen in Global North contexts—such as the UK's allocation of £8 million for digital skill "boot camps"—as well as in fragile contexts.[46] For instance, the World Bank in 2020 began funding digitization projects in Afghanistan to address the digital divide.[47] Programs intending to alleviate the digital divide must be expanded and tailored for application in fragile contexts. Areas of focus include internet and smartphone access, digital literacy, and further research into how remote schooling can more equitably serve both girls and boys.

Develop and strengthen socioeconomic safety nets for women and girls. In light of the adverse gendered impacts on socioeconomic status, national COVID-19 response measures should compensate women and girls for the unpaid care of sick family members or relatives and account for the additional burden of domestic labor. Universal basic income or cash transfers during periods of national or regional lockdown may alleviate household financial stressors that trigger domestic and intimate partner violence. A report published by the World Bank in May 2021 details how to leverage social safety nets to prevent and mitigate gender-based violence; such approaches are particularly relevant during infectious disease pandemics.[48]

Utilize community-led service provision to reduce militarization. Fragile contexts have turned to police and military forces to provide services and enforce measures related to COVID-19, putting women and girls at greater risk of gender-based violence. Community organizations, including women-led organizations, should be supported, and integrated into service provision pipelines whenever possible and involved in organizing interactions that bring women and girls into contact with militarized forces. For instance, community organizations could distribute hygiene and sanitation kits rather than send individuals to collect them from a militarized distribution site. Effective implementation of this recommendation will vary greatly based on context and existing community networks, so localized knowledge and application are key.

Incorporate gender sensitivity into COVID-19 responder training. Security forces, peacekeepers, military, police, and service providers responding to the COVID-19 pandemic will likely undergo COVID-19-specific training. The parts of this training that address gender issues, especially gender-based violence, should include explanations of these forms of violence and how infectious disease pandemics increase women's and girls' vulnerability to violence and should communicate a clear message of zero tolerance. For instance, training in gender-based violence has been included in the World Health Organization's emergency training of health care providers in the COVID-19 response in Afghanistan.[49] At international and national levels, the COVID-19 pandemic can be a catalyst to continue reform of military, security, and peacekeeping structures. Militarized responses to public health crises present an opportunity to continue work on integrating a gender lens within military and peacekeeping contingents, as well as among all humanitarian service providers. Training should address both COVID-19 and gender-based violence to bring to light and interrupt the critical connections between these two pandemics.

Notes

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2. Merrill Singer and Barbara Rylko-Bauer, "The Syndemics and Structural Violence of the COVID Pandemic: Anthropological Insights on a Crisis," *Open Anthropological Research* 1, no. 1 (October 2020): 7–32.
3. Diana Cammack et al., "Donors and the 'Fragile States' Agenda : A Survey of Current Thinking and Practice," report submitted to the Japan International Cooperation Agency (London: Poverty and Public Policy Group, Overseas Development Institute, 2006).
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