THE GBV SUB-CLUSTER RAPID ASSESSMENT ON THE IMPACT OF COVID-19 OUTBREAK ON GENDER-BASED VIOLENCE IN IRAQ

MAY-APRIL 2020

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Executive Summary

The ongoing protracted crisis, deep-rooted gender inequalities in social norms and traditional customary practices, limited resources as well as the lack of livelihood opportunities in conjunction with the recent COVID-19 socio-economic consequences have contributed to increasing the GBV risks and exposure to some of the pre-existing forms of GBV during the time of COVID-19 outbreak in Iraq. In order to better understand and explore the multi-layers impact of COVID-19 on GBV in Iraq, including how partners are adapting to emerging risks of GBV that may help them innovate activities, interventions strategies in order to better respond to survivors' complex and unique needs in the COVID-19 outbreak situation, the GBV Sub-Cluster conducted Rapid Assessment in 11 governorates between April-May 2020. The assessment employed an online structured questionnaire as a primary source of data collection for quantitative and qualitative information from the GBV sub-cluster partners as well as review conducted from the existing secondary sources on GBV. Below is a summary list of the key findings and recommendations from this assessment exercise.

Key Findings:

- **65 per cent of the service provision points reported an increase in one or more types of GBV** in their areas of intervention. Of which, 94 per cent reported a sharp increase in domestic violence reportedly perpetrated by a spouse or other family member/s within the household.
- **123 GBV-related suicide attempts or incidents were reported involving women and girls**, with the majority of incidents being reported in Ninewa, Diyala and Kirkuk governorates.
- **62 incidents were reported where families denied women and girls access to quarantine or health facilities due to strict social norms.** The majority of such incidents reportedly occurred in Ninewa, Diyala, Dohuk, Kirkuk and Erbil governorates.
- **94 per cent of the respondents reported financial constraints,** including **lack or loss of livelihood or income; 92 per cent of the respondents** reported **stress** from the confinement; while 73 per cent of the respondents reported the **lack of social amenities and networks** as the main reasons for reported increase of domestic violence incidents.
- **Female-headed households, adolescent girls, under-age mothers, and families perceived to be affiliated to extremist groups** were reportedly among the top four vulnerable and at-risk groups for acts of GBV by respectively 82 per cent, 80 per cent, 73 per cent and 61 per cent of the respondents.
- **Livelihoods and cash assistance** were reported as the least available services for GBV survivors by 64 per cent of the respondents, followed by legal assistance (by 53 per cent) and safe shelter (by 43 per cent).
- **Loss of income, harmful social norms or traditional practices, lack of health services (including reproductive health), and lack of safe shelter for GBV survivors** were among some of the top reported GBV risks.
- In terms of impact on access and service provision, **87 per cent of the service provision points** reported movement restrictions in their areas of intervention at the time of the assessment.
- **50 per cent of service provision points reported the need for access letters** as a pre-requisite condition from the concerned authorities in order to continue providing services during the COVID-19 outbreak.
- **Movement restrictions were reported as an impediment in the identification of new GBV cases and access to life-saving services for survivors.**

- **An overall reduction in GBV response services was reported by around 50 per cent for case management, 60 per cent for psychosocial support, and 50 per cent for awareness raising activities** in March and April compared with the planned targets**.** Delay of referrals and distribution of dignity kits activities was also reported in most of the assessed service points during the lockdown and curfew.

Findings from relevant secondary sources also confirmed an increase in the number of domestic violence incidents throughout the continued pandemic period, as highlighted below:

- **The Iraq Information Centre (IIC) received a higher number of calls reporting GBV incidents during the lockdown in March and April** (approx. 44 per cent higher compared to the previous months). Almost all calls were about domestic violence.
- According to findings from the Health Cluster Rapid Assessment of the health services response to GBV survivors during the COVID-19 outbreak, **40 per cent of health service providers indicated an increase in the number of women survivors of violence seeking assistance.** 17 per cent of the health service providers reported domestic violence perpetrated by partner/spouse and/or family member/s, while harassment (emotional abuse), and sexual exploitation by strangers were recorded at 3 per cent each.[1]
- Findings from the NPC's *Protection Monitoring at Community Level in Response to the COVID-19 Outbreak*[2] shed light on the main protection issues affecting women and girls in the assessed communities, including as a result of the COVID-19 situation. **The psychological trauma, stress and anxiety, and lack of safe space and privacy were among some of the top main concerns** reported by respectively 62 per cent and 34 per cent of Key Informants (KIs) interviewed. Additionally, 26 per cent of the KIs reported **violence or abuse within families/households** as one of the main protection concerns. In terms of the available services, 44 per cent of the KIs reported concern about the **lack of specialized services for women**. With the prevalence of GBV risks and the absence of specialized GBV services, the vulnerability of women and girls is exacerbated in the concerned communities.
- In terms of GBV service gaps, findings from the GBV Sub-Cluster analysis of the *2020 HRP GBV response: progress and gaps* showed a low response rate, i.e., 10 per cent of coverage as of April 2020. **Gaps in response were identified due to funding constraints and access challenges in Anbar, Diyala, Salah Al-din, and Kirkuk governorates.** Although Ninewa governorate showed an adequate presence of GBV services, several reports from partners highlighted risks of funding shortages toward the end of 2020. In addition, news from the most affected areas by the COVID-19 outbreak highlighted increased needs for GBV services in Baghdad, Karbala, Babil, and Al-Najaf governorates, where no or limited presence of GBV services was reported.

Key Recommendations:

Timely provision of quality GBV services is an essential and life-saving component of the humanitarian response to the COVID-19 outbreak in Iraq. In this respect, GBV services must remain available to and safely accessible by women, girls, boys and men.

Based on the findings revealed, this report recommends and calls upon the Government of Iraq (GOI) and Kurdistan Region of Iraq (KRI) authorities to;

[1] Rapid assessment of the health services response to GBV survivors during COVID-19 emergency in Iraq dashboard. April 2020.

[2] National Protection Cluster*, Protection Monitoring at Community Level in Response to the COVID-19 Outbreak*, May 2020. Available at: https://www.humanitarianresponse.info/en/operations/iraq/protection-cluster

- Allow exceptions to movement restrictions for GBV survivors or those at risk of GBV to enable them to seek safety and access services during the lockdowns and curfew.
- Issue exceptions to the movement restrictions for GBV service providers to continue and scale up service provision, where needed, as long as the pandemic lasts.
- Endorse the anti-domestic violence law and enhance its implementation[3].
- Enhance government capacity to limit the risk factors and respond to GBV incidents across the country, with requisite support of GBV service providers.

The humanitarian donor community should:

- Scale-up funding to expand coverage in under-served areas in light of significant gaps in GBV service provision coupled with increased GBV risks and needs that have emerged during the COVID-19 pandemic.

GBV partners must:

- Ensure that GBV survivors continue to get essential services during COVID-19, including case management, specialized psychosocial support, dignity kits, temporary shelter, urgent medical care, and other forms of support, exploring all possible and safe modalities and in line with the GBV guiding principles.
- Enhance the quality and confidentiality of GBV services and prioritize the safety of GBV survivors.
- Scale-up awareness raising activities using all possible and safe approaches on GBV as well as COVID-19 prevention, response and risk mitigation, and promote positive ways to cope with the stress caused by the current situation.
- Strengthen the existing coordination and referral mechanisms with other sectors, and ensure that GBV survivors are able to access essential multi-sectoral services they may need.
- Ensure that information on existing services, as well as mechanisms for seeking help within the context of the COVID-19 pandemic, are widely disseminated throughout appropriate networks and tools.

Humanitarian partners from other sectors should:

- Incorporate GBV risk mitigation strategies in program implementation in line with the GBV standards and guiding principles.[4]
- Prioritize the sustainability, the timely and quality of health services for GBV survivors during the COVID-19 outbreak and strengthen referral mechanisms between health and GBV services.
- Strengthen the capacity of frontline workers on basic skills to manage disclosure of information and GBV referrals in a safe and timely manner, including during COVID-19.
- Mechanisms should also be put in place and adapted as needed for the provision of cash to support access to necessary assistance for GBV survivors.
- Scale-up multi-sectoral interventions with substantial GBV, health, livelihood, cash, and legal components to enable the GBV survivors to benefit from comprehensive services based on their needs and mitigate the increased risks of GBV during COVID-19 crisis.

[3] Joint UNFPA,OHCHR, UNICEF and UN Women Statement: https://reliefweb.int/report/iraq/un-iraq-raises-alarm-time-endorse-anti-domestic-violence-law-enarku

[4] Identifying and Mitigating Gender-based Violence Risks within the COVID-19 Response https://gbvguidelines.org/wp/wp-content/uploads/2020/04/Interagency-GBV-risk-mitigation-and-Covid-tipsheet.pdf

Background

According to the 2020 Iraq Humanitarian Need Overview (HNO), 2.9 million Iraqis were identified in need of protection services[5]. Of these, 1.29 million persons were identified as at-risk of different forms of Gender-based Violence (GBV), requiring specialized GBV services.[6] According to the GBV Information Management System (GBV IMS), 98 per cent of the survivors reporting incidents of GBV are females, with domestic violence accounting for over 75 per cent of incidents, followed by harmful traditional practices at 10 per cent of reported incidents and early marriage at 8 per cent of reported incidents. Protracted displacement[7], poverty and limited financial resources[8,9,10], lack of safety and security[11], imbalanced gender relations and harmful traditional practices that discriminate against women and girls are the main drivers for GBV in Iraq[12].

The arrival of the COVID-19 pandemic in Iraq has resulted in government-imposed restrictions on the movement to mitigate and/or limit the spread of the virus. Preventative measures have led to worsening socio-economic conditions for Iraqis across the country, with IDPs and returnees at particular risk. Humanitarian assistance has also experienced periods of interruption due to access measures at the governorate level. In the case of curfew or lockdown, families sharing homes, with limited sources of income and socially restricted movement are experiencing emotional and psychological challenges. These factors, in conjunction with pre-existing vulnerabilities, have reportedly contributed to increased GBV risks and some of the forms of GBV. Notably, an increase in incidents of domestic violence is reported throughout the COVID-19 pandemic thus far, as well as incidents of rape, sexual harassment of minors and suicide-related to spousal abuse.

Apart from the IDP and the returnee population, Iraq also hosts some 245,000 Syrian refugees who are expected to remain in Iraq, given prevailing political and security instability in Syria. 99 per cent of the Syrian refugees' caseload resides in the Kurdistan Region of Iraq (KRI), of which, 40 per cent are living in camps[13]. The difficult economic situation and scarcity of livelihood opportunities have affected Iraqi and Syrian refugees the same way and are considered the root cause for protection risks, including GBV[14].

To better understand the impact of COVID-19 on GBV in Iraq, including how partners are adapting to emerging risks and need to modify activities in their areas of intervention, the GBV Sub-Cluster and its partners conducted a rapid assessment with the below main objectives;

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[5] HNO 2020, page 38.

[6] Ibid, page 53.

[7] Of the 1.2 million people displaced outside of camps, more than 70 per cent have been displaced for more than three years. Based on ILA IV inter-sector analysis presented at the Joint Needs Analysis Workshop, 19 September 2019.

[8] 57 per cent of total affected population live under the poverty line. MCNA VII, August 2019 and Cash Working Group data.

[9] The population groups most in need of income support include, acutely vulnerable IDP FHHs in camps, and marginalized returnee youth and returnee FHHs in areas of origin and host communities. HNO 2020.

[10] In terms of the alleged GBV perpetrator occupation, 25 per cent reported 'unemployed', 14 per cent were 'daily workers', and 7 per cent were 'armed forces/armed groups'. GBV IMS, 2019.

[11] Almost half of female-headed households living in critical shelter have heightened needs related to safety and privacy. MCNA VII, August 2019.

[12] GBVIMS, 2019.

[13] Iraq Country Chapter: 3RP Regional Refugee & Resilience Plan 2020-2021 in Response to the Syria Crisis https://reliefweb.int/sites/reliefweb.int/files/resources/74758.pdf

[14] Intimate partner violence is the primary context of GBV reported by Syrian refugee survivors, accounting for 71 percent. Syrian Refugees GBVIMS, 2019.

Objectives

- Get an improved understanding and insight into the impact of COVID-19 on GBV occurrence/s and GBV service provision during the COVID-19 crisis.
- To get a deeper understanding of the needs of survivors of GBV as well as women and girls at-risk of GBV.
- To use the assessment as an evidence-based tool for improved advocacy, resource mobilization, partnership-building to accelerate service delivery, service providers' capacity to respond, and survivors' access to life-saving services

Methodology

An online Kobo-based structured questionnaire was designed to collect quantitative and qualitative data from GBV service providers from 29 April to 10 May 2020. The quantitative part collected information on:

- The respondents and the organizations they represent.
- The service provision points including details about the location, type and staff.
- Movement restrictions in place and the access status during the time of COVID-19.
- Services provided before and after the onset of COVID-19 including details about their status, modality of provision, the number of people reached versus planned (for the period from March to April), and other adjustments during COVID-19.
- Active GBV cases (types and numbers).
- Increased GBV cases during COVID-19 (types and the increase rate).
- Reasons for the reported increases.
- Vulnerable and at-risk groups during COVID-19.
- GBV risks present in the served communities.
- Other non-GBV needs reported by women and girls in the served communities.
- Unavailable services for GBV survivors, women, girls, and other at-risk groups in the served communities.

The qualitative part collected information about the challenges GBV partners continue to experience with service provision since the onset of the COVID-19 outbreak, how did they adapt, and what were their key concerns, needs, messages and recommendations.

Overall, 36 GBV partners (23 National Non-governmental Organization (NNGOs) and 13 International Non-governmental Organization (INGOs)) participated in the assessment exercise. They shared information on 109 GBV service provision points (including 92 static centers and 17 GBV mobile teams) in 11 governorates, covering 28 districts, and 42 sub-districts across Iraq.

The assessment also took into consideration already available secondary data obtained from:

- the Health Cluster's rapid Assessment of the service provision of health actors to GBV survivors throughout the COVID-19 pandemic;
- the Iraq Information Centre (IIC) statistics for the GBV reported incidents;

- findings from the Protection Cluster's COVID-19 community-level monitoring tool targeting key informants;
- findings from the GBV Sub Cluster analysis of the 2020 HRP and 3RP GBV response progress and gaps thus far.

Findings

COVID-19 impact on GBV

The assessment revealed a sharp rise in the incidents of different forms of GBV, in particular, domestic violence[15] which accounted for 75 per cent of the total active reported cases. It is imperative to mention that in 95 per cent of the cases, the survivors of GBV happened to be female[16]. In terms of alleged perpetrators, 61 per cent of incidents were reported to having been perpetrated by the spouse\intimate partner and 39 per cent by other family member(s). Ninewa was accounted for 43 per cent of the total reported active cases, followed by Al-Anbar and Kirkuk at 12 per cent each, Erbil at 9 per cent and Dahuk at 6 per cent[17].

Out of the total active cases, 27 per cent were reported as emerging new cases during the COVID-19 outbreak. Ninewa accounted for 42 per cent of the total new cases, followed by Kirkuk at 17 per cent and Baghdad at 15 per cent.

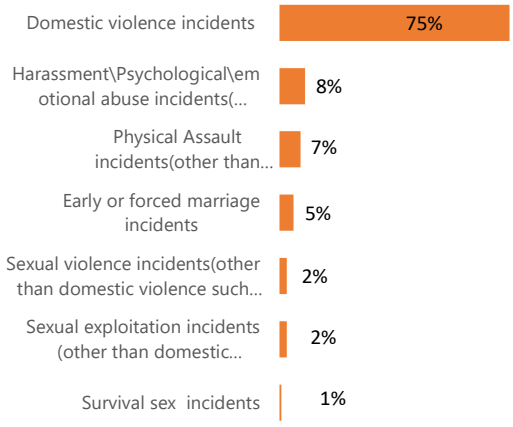

Figure 1: % of the active GBV cases by GBV type

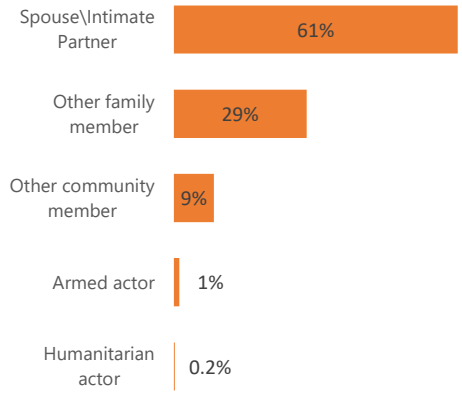

Figure 2: % of the active GBV cases by perpetrator type

[15] Domestic violence' is a term used to describe violence that takes place between intimate partners (spouses, boyfriend/girlfriend) as well as between other family members. Intimate partner violence applies specifically to violence occurring between intimate partners, and is defined by WHO as behavior by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse and controlling behaviors. This type of violence may also include the denial of resources, opportunities or services.

[16] Possible underreporting by male survivors due to social norms that discourage male reporting of GBV.

[17] The data is only from reported GBV incidents to service providers directly working with GBV survivors and is in no way representative of the total incidents or prevalence of GBV in Iraq. Ninewa has relatively a better presence of GBV actors, which affected the participation rate and the findings of this assessment.

Of the total assessed service provision points, 65 per cent reported an increase or worsening in one or more types of GBV during the time of COVID-19 compared with the months before the outbreak. 61 per cent reported an increase in domestic violence cases (accounting for 94 per cent of the total respondents who reported an increase). For other types of GBV, 31 per cent of respondents reported an increase for harassment\psychological\emotional abuse cases, 14 per cent for physical assault cases, and 13 per cent for child or forced marriage cases.

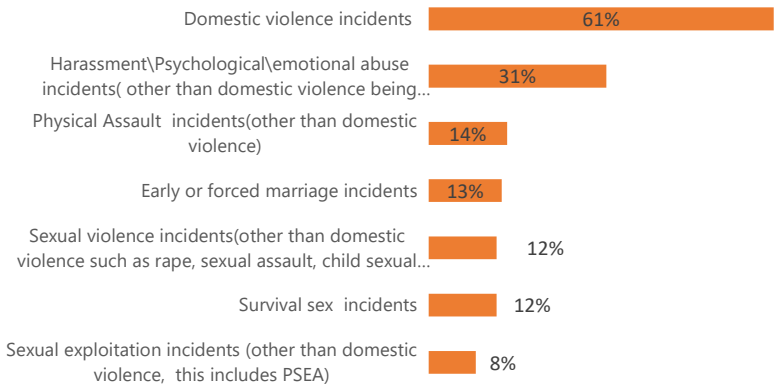

Figure 3: % of the respondents reported an increase in GBV by GBV type

It is worth mentioning that some of the new cases were reported as closed cases but had to be re-opened due to the recurrence of an exacerbated wave of domestic violence by the spouse or other family members. The inability of GBV survivors to get out of their residence to seek safety and other forms of support in view of the COVID-19 restrictions on movement has contributed to increasing their vulnerability and exposure to further risks of GBV.

Moreover, information on 123 GBV-related suicide attempts or incidents involving women and girls, and nearly 62 incidents where families denied women and girls access to quarantine or health facilities due to social norms or fears of exposure to GBV risks had been identified during the COVID-19 in some of the served areas. The majority of reported incidents occurred in Ninewa, Diyala, Dohuk, Kirkuk and Erbil governorates.

Increased tension linked to households facing financial challenges, including lack or loss of livelihood, was reported as the primary cause of GBV by 94 per cent of the respondents. Loss of income in conjugation with uncertainty about the current COVID-19 situation and future implications have resulted in economic strains that might have reportedly fueled violence within households. GBVIMS data shows that the majority of GBV incidents occur in low-income families in Iraq[18]. A fact that can predict the increase in the likelihood of GBV cases if the COVID-19 measures and consequences last for a longer period of time. In addition, in light of the economic uncertainty and loss of income or licit means of livelihood, women

[18] In terms of the alleged GBV perpetrator occupation, 25% reported 'unemployed', 14% were 'daily workers', and 7% were 'armed forces/armed groups'. GBV IMS, 2019.

and girls, especially within female-headed households with limited resources, are at increased risk of exposure to sexual exploitation and abuse and survival/transactional sex. 8 per cent of the respondents reported an increase in sexual exploitation, and 12 per cent reported an increase in survival sex/transactional incidents, mainly in Kirkuk, Ninewa and Al-Anbar.

Other reasons for the reported increase in the GBV incidents was attributed to stress caused by confinement at home reported by 92 per cent of the respondents, lack of social amenities and networks (such as parks, cafes, family gatherings, etc.) by 73 per cent, and harmful traditional practices by 56 per cent. The exposure to domestic violence risks is heightened during the time of COVID-19 as the majority of cases perpetrated by the intimate partner\spouse or other family members at the place of survivors' residence where family members spend more time in close contact (for example, extended family members living together like the in-laws who may fuel domestic violence).

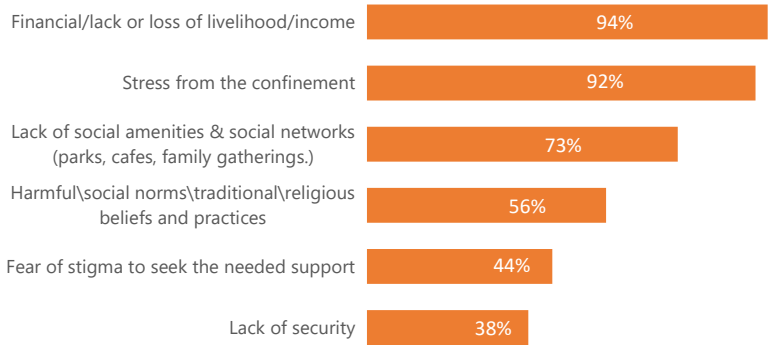

Figure 4: % of the respondents who reported an increase in GBV by reason

In response to a question about GBV risks in the served areas, lack of income, harmful social norms or traditional practices, lack of health services (including reproductive health), and lack of safe shelters for GBV survivors were among the top reported GBV risks during COVID-19 by 96, 77, 69, and 69 per cent of respondents respectively.

Female-headed households were among the top of the vulnerable and at-risk groups reported by 82 per cent of the respondents, followed by adolescent girls by 80 per cent, under-aged mothers by 73 percent, and families perceived to be affiliated to extremist groups\ISIS by 61 per cent.

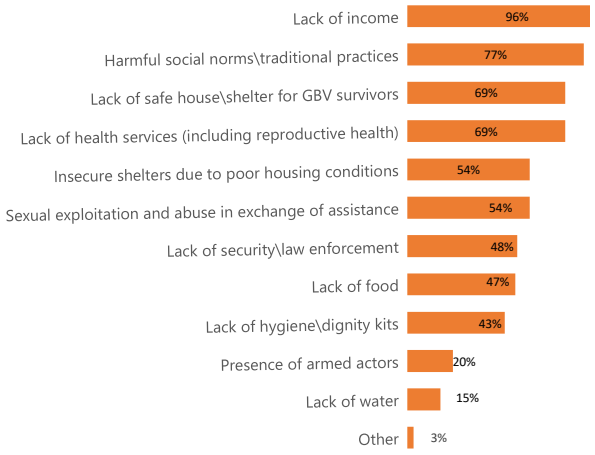

Figure 5: % of the respondents by GBV risk

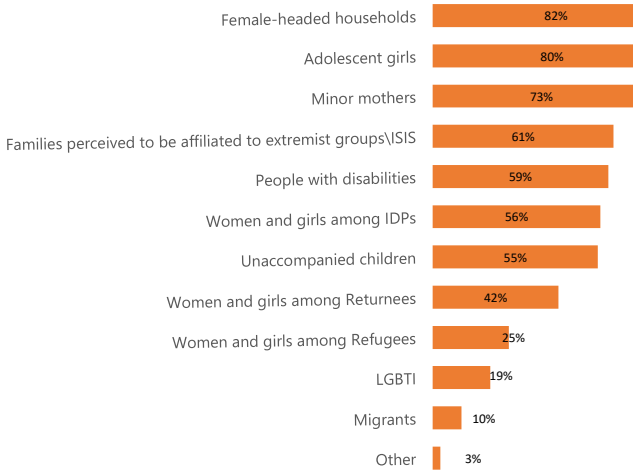

Figure 6: % of the respondents by at-risk group of GBV

In terms of needs reported by women and girls in the served areas, the highest number of cases reported needs for psychosocial support or other health care services at 37 per cent. 16 per cent reported financial needs and 8 per cent for dignity kits needs.

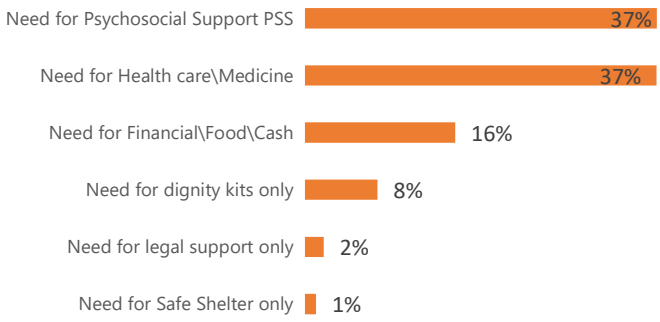

Figure 7: % of non-GBV cases by need type

Secondary data review: Findings from the secondary sources also confirmed an increase in domestic violence during the time of COVID-19. For example, the Iraq Information Center (IIC) received a higher number of calls reporting domestic violence incidents during the lockdown time (in March and April) by around 44 per cent compared with the months before. Almost all received cases accounted for domestic violence. In addition, the IIC conducted a poll on Facebook in April 2020, which aimed at finding out which of the basic needs were affected the most by the COVID-19 pandemic. 70 per cent of the voters reported

loss of livelihoods, followed with access to movements/ restrictions in movements by 11 per cent; and help with domestic violence, exploitation and abuse by 5 per cent[19].

According to findings from the Iraq Health Cluster Rapid assessment regarding the health services response to GBV survivors during COVID-19 emergency, 40 per cent of the participated health service providers indicated an increase in the number of women survivors of violence coming for help during the COVID-19 outbreak. 17 per cent attributed the increase to domestic violence by partner/spouse and/or family member. Followed by harassment (emotional abuse), and sexual exploitation by strangers at 3 per cent for each[20].

Findings from the National Protection Cluster's Protection Monitoring exercise carried out at the Community Level in Response to the COVID-19 Outbreak[21] also sheds light on some of the main protection issues affecting women and girls in the assessed communities. The psychological trauma, stress and anxiety, and lack of safe space and privacy were among the top main concerns, reported by respectively 62 per cent and 34 per cent of Key Informants (KIs). Additionally, 26 per cent of the KIs reported violence or abuse within families/households among the main protection concerns. In terms of the available services, 44 per cent of the KIs reported concern about the lack of specialized services for women. With the prevalence of GBV risks and the absence of specialized GBV services, the vulnerability of women and girls is exacerbated in the concerned communities.

COVID-19 Impact on GBV Service Provision

36 GBV service providers participated in this assessment and shared information about their services in their areas of intervention through 109 service provision points, including 93 static centers and 17 GBV mobile teams across 11 governorates (Al-Anbar, Al-Sulaymaniyah, Babil, Baghdad, Diyala, Duhok, Erbil, Kirkuk, Ninewa, Salah Al-Din, Thi Qar). The service points cover 18 IDP camps, 8 refugee camps, 10 informal settlements and 76 out of camp locations.

In terms of access, 87 per cent of the service provision points reported movement restrictions in place at the time of this assessment. 50 per cent reported needs for access letters from the government to continue functioning during COVID-19 outbreak, of which 80 per cent (43 service points) applied and received the access letter.

The respondents were asked to provide information about the available services in their service provision points before the COVID-19 outbreak and their status, modality, adjustments, and number of people reached versus planned target during March and April for each of the services provided. Overall, 95 per cent of respondents reported continuation of case management activity during COVID-19. 16 per cent reported conducting case management in person, 34 remotely (over the phone), and 43 per cent followed a mixed approach depending on the criticality of the case and access situation. Consequently, 47 per cent of the planned target in March and April was not reached.

[19] The Iraq Information Center (IIC) Newsletter. April 2020.
[20] Rapid assessment of the health services response to GBV survivors during COVID-19 emergency in Iraq dashboard. April 2020.
[21] National Protection Cluster, *Protection Monitoring at Community Level in Response to the COVID-19 Outbreak*, May 2020. Available at: https://www.humanitarianresponse.info/en/operations/iraq/protection-cluster

For structured psychosocial support, 88 per cent of the respondents reported the service is ongoing, 14 per cent continued in-person service provision, 38 per cent adopted remote modality, and 36 per cent reported following mixed approach. Overall, 40 per cent of the planned target was not reached in March and April.

Where in place, movement restrictions were reported to impede the identification of new cases and the GBV survivors` access to GBV life-saving services and delayed referrals to other multi-sectoral services. Therefore, GBV service providers reported having adopted remote modality for the critical services to ensure continuity of care for open cases. GBV services providers used phone calls to follow-up with cases and increased their helplines and airtimes duration. 74 service provision points reported functioning helplines during the lockdown. Of these, 37 were reported operating 24/7. Group activities were reported suspended by the majority of respondents during March and April, with nearly 91 per cent of the planned target not achieved. Messages on COVID-19 response, prevention and mitigation were reported to be incorporated throughout ongoing GBV activities to raise awareness among GBV beneficiaries utilizing all possible platforms like phones and social media.

The charts below and table 1 in the annex show more details and information on other services.

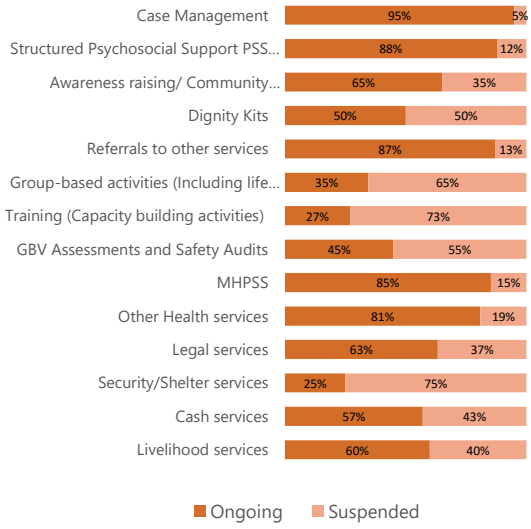

Figure 8: % of the respondents by service status

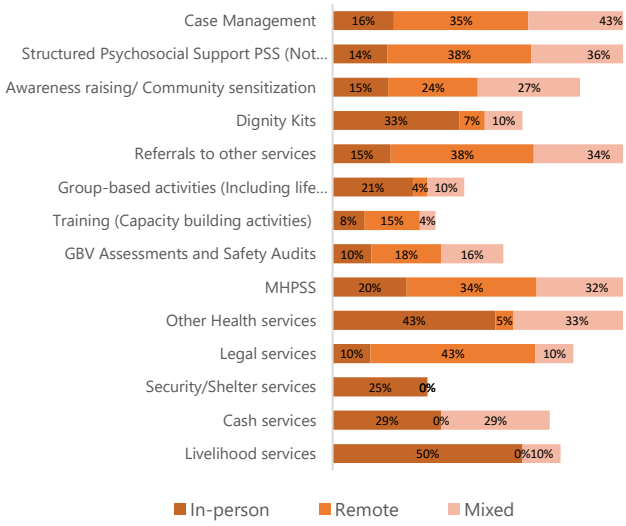

Figure 9: % of the respondents by service modality

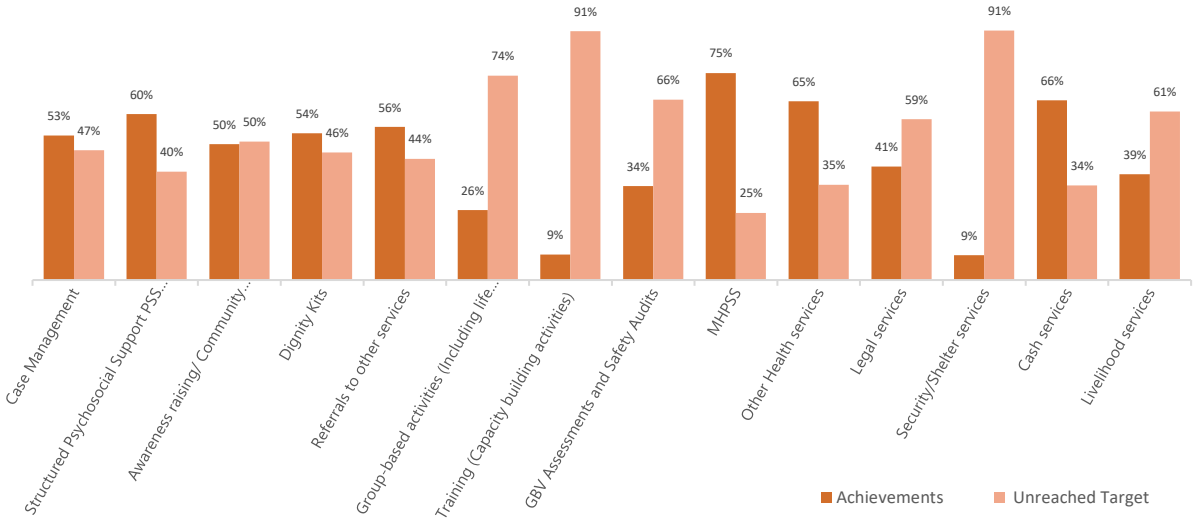

Figure 10: % of achievements & unreached targets in March & April by service type

In response to the most effective communication methods during COVID-19 time, 78 per cent of respondents reported social media such as Facebook/YouTube, and 50 per cent reported sharing information through SMS.

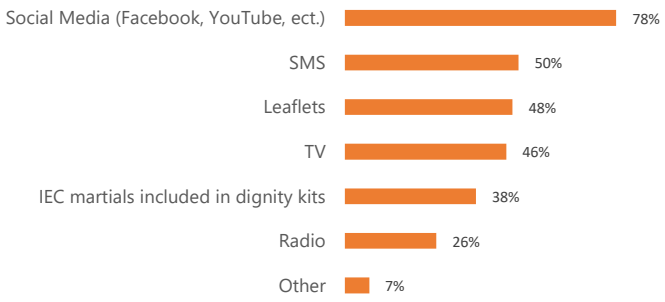

Figure11: % of the respondents by communication method

In terms of main challenges with service provision during COVID-19, respondents reported (a) access challenges and difficulties in communicating with GBV survivors and/or deciding when to call without exposing them, (b) challenges with the referrals of GBV cases to other sectoral services especially to livelihood, cash, and food services, (c) lack of GBV survivors` access to phones and social media, (d) lack of safe shelters, (e) closure of courts and suspension of services provided by the family protection unit, (f) limited services and lack of capacity to follow up on all cases, (g) strong and harmful customs, traditions and social norms impeding the GBV survivors access to services, (h) lack of awareness about human rights, and (i) absence of law and law enforcement against domestic violence.

An Overview of existing GBV Humanitarian Response

HRP response: From January to April 2020, 36 GBV partners reached approximately 59,000 beneficiaries with GBV services, achieving only 10 per cent of the HRP 2020 target. A decrease in the number of beneficiaries reached with GBV services was recorded due to access challenges during the COVID-19 crisis by around 25-50 per cent for case management and PSS services in March and April compared with January and February, and 60 per cent for awareness raising during the same period. An estimated 15,000 people were not reached in March and April due to COVID-19 implications, while 120,000 were not reached since the beginning of 2020 due to lack of funding for the HRP activities, including those prioritized for COVID-19. Gaps in response services provision were identified in Al-Anbar, Salah Aldin, Kirkuk, Diyala, as well as limited GBV actors in areas most affected by COVID-19, such as Baghdad, Al-Najaf, Karbala and Babil.

3RP response: From January to April, 12 GBV service providers reached around 33,446 Syrian refugee beneficiaries with different GBV services in 10 camps and 10 out of camp locations across Erbil, Dahuk, Sulaymaniyah and Ninewa. This shows an adequate presence of GBV services in refugees' locations; however, access issues during COVID-19 reportedly impeded GBV survivors' access to GBV services and created new challenges to identify new cases and provide safe spaces/shelters or safety plans for GBV survivors. Consequently, a reduction in GBV response was observed during March and April compared with January and February by around 45 per cent for case management, 31 per cent for PSS, and 75 per cent for awareness raising and community sensitization activities. GBV partners scaled up distribution of dignity/sanitary kits to meet the emerging new needs during COVID-19 and managed to get movement permission in some areas and reached around 9,000 beneficiaries in April. In addition, gaps in other sectoral services continued to be reported, especially lack of livelihood programming that targets refugees, which contributes to increasing the vulnerability of GBV survivors and other women to protection risks.

Proposed Recommendations

The assessment report proposes the following recommendations to key stakeholders and partners to ensure the provision of quality GBV services as an essential, prioritized, critical and life-saving component of the humanitarian response to the COVID-19 outbreak in Iraq.

The Government of Iraq (GoI) and Kurdistan Region of Iraq (KRI) authorities should:

- Allow exceptions to movement restrictions for GBV survivors or those at-risk of GBV to enable them to seek safety and access services during the lockdowns and curfew.
- Issue exceptions to the movement restrictions for GBV service providers to continue and scale up service provision, where needed
- Endorse the anti-domestic violence law and enhance its implementation[22], because the surge in domestic violence is also linked to discriminatory nature of existing laws that do not bring the perpetrators to justice

[22] Joint UNFPA,OHCHR, UNICEF and UN Women Statement: https://reliefweb.int/report/iraq/un-iraq-raises-alarm-time-endorse-anti-domestic-violence-law-enarku

- With the support of GBV service providers, enhance government capacity to limit the risk factors and respond to GBV incidents across the country.

The humanitarian donor community must:

In view of the enormous surge in the reported cases of GBV during the COVID-19 outbreak, it is important that donors' community scale-up funding resources on emergency basis to expand coverage in under-served areas in light of significant gaps in GBV service provision coupled with increased GBV risks and needs during the COVID-19 pandemic. Considering the long-term cost of GBV, it is imperative that donor agencies make contributions under three pillars approach. Pillar 1, improved response service provision; Pillar 2, Prevention, advocacy, legal and justice reforms, community sensitization, awareness raising to ensure positive behavioural and attitudinal changes in the society. Pillar 3; interventions aimed to empower survivors and at-risk women and girls through the provision of small and medium grants/ cash assistance for creating small businesses, or access to livelihood opportunities that make them resilient, empowered and contribute in their own as well as family well-being and socio-economic development.

GBV partners must:

Ensure that GBV survivors continue to get essential services during COVID-19, including case management, specialized psychosocial support, dignity kits, temporary shelter, urgent medical care, and other forms of support- exploring all possible and safe modalities and in line with the GBV guiding principles and survivor-centred approaches as highlighted below.

Re-adapt key activities:

Women and Girls Safe Spaces (WGSS)/Women Community Centers (WCC):

- Create common guidelines specific to COVID-19 to ensure that Women and Girls' Safe Spaces where caseworkers operate are not crowded and are able to adhere to distancing measures and other health recommendations.
- Equip Women and Girls Centers with dignity kits to ensure menstrual health of women and girls is not compromised.
- Set up handwashing stations at all WGSS (soap and hand sanitizer if available).
- Ensure easy to understand IEC materials are in place and readily available targeting different groups, age and gender appropriate.
- Define depending on capacity and size of space, on the number of participants in the location at one given time.

The GBV service providers are advised to use the guidance notes for GBV service provision, including remote case management and PSS, during the COVID-19 crisis developed, contextualised contextualized and disseminated by the GBV Sub Cluster Iraq[23].

Services referrals: Referral to specialized services is essential for cases which are identified through protection monitoring, at the community centers or through other forms of outreach activities. It is also an integral part of case management and is therefore critical despite potential limited availability of services. It is essential that referral pathways and service/s mapping information are regularly updated at

[23] For further guidance, refer to: GBV Case Management Guidance Note during COVID-19 Outbreak, Iraq

local level to facilitate referrals and related activities. Referrals to specialized services might contribute to the containment, prevention and response to COVID-19, in particular with regards for medical services or PSS activities.

All GBV actors should contribute to efforts to update GBV referral pathways and coordinate with local primary and secondary healthcare facilities to ensure services are correctly reflected, as services may no longer be available due to emergency response to COVID-19.

GBV Support Hotlines: Hotlines provide a remote means for survivors to access services confidentially, and as such they are an important entry point for case management and can be used as part of a mobile response or on their own[24].

Psychosocial Support: PSS activities in both affected and at-risk communities can help to alleviate the stress and anxiety produced by the outbreak and also be used to share information on the containment, prevention and response to COVID-19 if staff are properly trained by health actors and if information material are available. PSS should be available for women and girls who may be affected by the outbreak and are also GBV survivors.

Dignity kits: The provision of dignity kits is essential to the physical and psychological well-being of women and girls and should therefore continue. When distributing dignity kits by GBV case workers and sharing information about hygiene, reproductive health, GBV related issues, and services, information on the containment, prevention and response to COVID-19 can be incorporated, if staff are properly trained by health actors and if approved information material are available.

The following measures should be considered to ensure the safety of staff and beneficiaries:

- Distribution sites are in large open areas to be able to ensure social distancing requirements.
- Distribution should be limited to a specific amount of household per day to prevent overcrowding.
- Communicate and ensure approval by relevant local authorities.
- Location: make assessment with field staff/partners to identify the most appropriate, this may include schools, WCCs.
- Ensure adequate time for staff and beneficiaries to safely return home in light of curfews.

Awareness-raising: GBV service providers are advised to comply with the government directives in terms of avoiding grouping people and adjust their group-based activities plans accordingly. Nevertheless, awareness-raising can be done individually or through remote modalities. GBV service providers are advised to not expose the safety of their beneficiaries and staff and ensure duty of care by ensuring that the recommended precautionary measures to prevent and mitigate the spread of COVID-19 are considered during all activities. Scale up advocacy and awareness raising against domestic violence during the COVID-19 crisis using the messages developed and disseminated by the GBV Sub-Cluster Iraq. The messages may be adapted further and disseminated through social media, TV, radio, posters and with dignity kits.[25]

[24] For further guidance, refer to: Guidelines for Mobile and Remote GBV Service Delivery, IRC

[25] For further guidance, refer to: GBV and MHPSS Awareness Raising Messaging during the Time of COVID-19 – Iraq.

Promote the integration of GBV risk mitigation actions in the interventions related to COVID-19 implemented by other sectors

Violence perpetrated against women and girls has significant, far-reaching and long-lasting impacts on the health, psycho-social and economic well-being and outcomes for not only survivors, but their families and communities as well. Prioritising the urgent, immediate and life-saving protection and health needs of women and girls must remain at the center of response efforts during epidemics, ensuring equitable access to quality multi-sectoral service provision, reporting mechanisms and outreach efforts.

All actors from other sectors should:
Consider how to safely, ethically and effectively address the problem of GBV within the scope of their sectoral interventions. Moreover, the responsibility for preventing and mitigating the risks of GBV is a shared one amongst all humanitarian actors. 'All humanitarian actors must be aware of the risks of GBV and acting collectively to ensure a comprehensive response—prevent and mitigate these risks as quickly as possible within their sectors` specific areas of operation.'

The preparedness planning should ensure:

- Apply a human rights-based approach in the planning of the GBV response throughout the cycle of the COVID-19 response.
- As other sectors develop contingency planning documents; these may require technical advice or support to integrate GBV risk mitigation.

The following are some preliminary considerations for prevention and risk mitigation for other humanitarian sectors:

Health: To coordinate and understand how the COVID-19 is affecting essential health services, and particularly regards to the provision of SRHR and GBV services, especially in the event that existing health service providers and maternity facilitates become overstretched or unable to continue services. Step up training to ensure health actors are trained, especially concerning the possible increase in GBV incidents.

All health providers must ensure a coordinated, survivor-centered approach to the health/medical response to GBV, which follows the principles of safety, confidentiality, respect and non- discrimination is crucial.

- Health providers should be trained and understand GBV Guiding Principles and core concepts, and understand and inform GBV survivors on the important and relevant services such as psychosocial support. This may include linking GBV protection actors with health actors in the local area to support with training and capacity building, or conduct remote trainings for staff on PFA and GBV referrals.

- All medical staff providing care to survivors must provide services and referrals based on the informed consent from the survivor, confidentiality, safety, non-discrimination and respect that adheres to survivor-centered care. Health actors must be aware of the local GBV hotline numbers and how to make referrals. Also consider possibility of integrating protection staff into COVID-19 health response teams.

- Ensure quarantine facilities or spaces adhere to IASC GBV guidelines/risk mitigation measures[26].

Wash

- Analyse physical safety of and access to WASH facilities to identify associated risks of GBV (e.g. travel to/from WASH facilities; sex-segregated toilets; adequate lighting and privacy; accessibility features for persons with disabilities; etc.)
- Consult with GBV specialists to identify safe, confidential and appropriate systems of care (i.e. referral pathways) for survivors, and ensure WASH staff have the basic skills to provide them with information on where they can obtain support.)
- Coordinate with health and WASH actors to ensure that women and girls are able to access distribution points as there might be additional barriers due to gender norms that prevent women and girl's mobility.

Cash and in-kind assistance for mitigating or addressing protection incidents, including GBV: Cash for protection and Individual Protection Assistance modalities are essential as it can contribute to the protection of the persons, and helps address/mitigate protection incidents. This is particularly relevant with regards to the heightened risk of negative coping mechanisms that may result from reduced access to assistance and services, as well as reduced economic opportunities due to COVID-19 situation. Cash and in-kind assistance is done through targeted assessment and distribution at the individual or household level and therefore does not require large social gathering should continue.

[26] For more information, please refer to: Health cluster guide: A practical handbook, Chapter 8, Integrated programming for better health outcomes: a multisectoral approach

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- The COVID-19 Outbreak and Gender: Key Advocacy Points from Asia and the Pacific
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- Guidelines for Mobile and Remote GBV Service Delivery, IRC
- Quick Tips on COVID-19 and Migrant, Refugee and Internally Displaced Children (Children on the Move) https://unicef.sharepoint.com/_forms/default.aspx
- COVID-19 Including Migrants and Displaced People in Preparedness and Response Activities, IFRC
- Health cluster guide: A practical handbook, Chapter 8, Integrated programming for better health outcomes: a multi-sectoral approach.
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- GBV SC-Iraq COVID-19 folder: https://drive.google.com/drive/u/1/folders/1OeG-Vqem6cbBubTxJPFgWrLeJwP0SN0F

Annex

Service	Number of service providers	Status		Modality			% of Response Reduction	Adjustments						
		Ongoing	Suspended	In-person	Remote	Mixed		Reduced working hours	Reduced staff	Reduced number of beneficiaries present at the same time in the center	Increased the hotlines\helplines and airtime	Included awareness raising messages on COVID-19	None	Other
Case Management	99	95 %	5 %	16 %	35 %	43 %	53 %	37 %	19 %	52 %	36 %	55 %	9 %	5 %
Structured Psychosocial Support PSS (Not including the recreational or vocational activities..)	90	88 %	12 %	14 %	38 %	36 %	60 %	28 %	13 %	50 %	28 %	51 %	9 %	4 %
Awareness raising/ Community sensitization	89	65 %	35 %	15 %	24 %	27 %	50 %	24 %	7 %	34 %	24 %	54 %	4 %	7 %
Dignity Kits	30	50 %	50 %	33 %	7 %	10 %	54 %	17 %	10 %	23 %	13 %	17 %	20 %	0 %
Referrals to other services	85	87 %	13 %	15 %	38 %	34 %	56 %	32 %	16 %	34 %	32 %	40 %	13 %	5 %
Group-based activities (Including life skills, recreational or vocational activities..)	52	35 %	65 %	21 %	4 %	10 %	26 %	10 %	2 %	27 %	10 %	27 %	4 %	6 %
Training (Capacity building activities)	48	27 %	73 %	8 %	15 %	4 %	9 %	13 %	6 %	10 %	6 %	25 %	4 %	0 %
GBV Assessments and Safety Audits	49	45 %	55 %	10 %	18 %	16 %	34 %	10 %	2 %	12 %	10 %	22 %	10 %	6 %
MHPSS	41	85 %	15 %	20 %	34 %	32 %	75 %	34 %	10 %	39 %	37 %	54 %	7 %	7 %
Other Health services	21	81 %	19 %	43 %	5 %	33 %	65 %	38 %	10 %	43 %	19 %	52 %	5 %	5 %
Legal services	30	63 %	37 %	10 %	43 %	10 %	41 %	20 %	7 %	13 %	20 %	20 %	7 %	7 %
Security/Shelter services	4	25 %	75 %	25 %	0 %	0 %	9 %	25 %	25 %	25 %	0 %	25 %	0 %	0 %
Cash services	7	57 %	43 %	29 %	0 %	29 %	66 %	29 %	14 %	14 %	29 %	14 %	0 %	0 %
Livelihood services	10	60 %	40 %	50 %	0 %	10 %	39 %	10 %	0 %	10 %	20 %	20 %	10 %	5 %

Table 1: Responses by service