



Gender-Based Violence during a Sanitary Crisis: The Case of Covid-19

Algeria, Egypt, Jordan, Lebanon, Morocco, Palestine and Tunisia

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GENDER-BASED VIOLENCE DURING A SANITARY CRISIS:
THE CASE OF COVID-19

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THE CASE OF COVID-19

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www.cawtar.org
<http://www.genderclearinghouse.org>
cawtar@cawtar.org - info@cawtar.org

WORK TEAM

CAWTAR

- **Dr. Soukeïna Bouraoui**, Executive Director
- **Dr. Faiza Benhadid**, Report writer

Reflexions Research & Consulting Firm in Marketing and Sociology

Field survey team:

- **Ms Manel Hammami**: General Director
- **Mr. Ramzi Faissal, Mr. Issam Salem, Ms Hana Chebbi and Mr. Raed Driss**

Editor

- **Ms Meriem Boudjadja**

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* <https://www.adecco.fr/candidats/entretien-telephonique/>

** https://github.com/witness/Conducting-Interviews-with-Survivors-of-Gender-Based-Violence/blob/master/EN-SGBVGuide_Markdown_v1_0.md

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Foreword and Acknowledgment

Since its inception in 1993 and with the constant aim of improving the status of women in the region, the Arab Women Center for Training and Research/CAWTAR has always chosen to focus its efforts on key and emerging issues to foster knowledge that can contribute to the improvement of women's and girls' lives and welfare. The evidence generated is a crucial lever for triggering mechanisms of change through advocacy and policy dialogue on a wide range of issues that address the status of women in society and the realization of their legal and human rights.

CAWTAR's mission is "to contribute to the empowerment of women in the Arab world so that they can fully exercise their human rights, economically, socially and politically on an equal footing with men..." taking into account the reality of their lives and the challenges they face on a daily basis. Thus, when at the end of the first quarter of 2020, alert systems were triggered here and there regarding the real and/or potential risks incurred by women with the emergence of the COVID-19 pandemic and the set-up of the lockdowns and related measures, the CAWTAR team once again mobilized. It was about being there to listen and respond to urgent needs. In this context, a number of initiatives has been implemented by CAWTAR, in collaboration with its network of media professionals in the Arab region to name but a few examples:

- "Publication of an audio magazine for women and visually impaired people to accompany them during the global health crisis (47 issues on the center's YouTube channel). Several topics were covered such as human rights, rights enshrined in national legislation, including rights related to personal status and women's rights within the family, and/or preventing and combating violence against women, international conventions (CEDAW, CRC, Disability convention ...), health including Sexual and Reproductive Health, lockdown and measures against contamination of COVID-19;
- Organization of a regional photo contest on women and COVID-19 (68 participants, 375 photos);
- Preparation of 4 educational video flashes on Violence Against Women during the COVID-19 pandemic, including cyberviolence;
- 251 distance learning licenses under the theme of financial inclusion, were granted to benefit the youth of both sexes and civil society activists during the lockdown period;
- Emergency institutional and material support to 8 NGOs for the benefit of GBV survivors, their multi-service care and their socio-economic reintegration.

CAWTAR's work is based on a gender and human rights' perspective, which is the preferred approach when it comes to detecting gender disparities due to the discrimination that women experience on a daily basis, throughout their life cycle and in many cases even before birth. If discrimination has been defined as synonymous with violence,⁽ⁱ⁾ the latter is not discriminatory, since it is recognized by international consensus that Violence Against Women occurs on all continents and in all countries and contexts, making it one of the most widespread human rights violation in the world. It has even been called "the most shameful violation".⁽ⁱⁱ⁾

This violation is further heightened in specific situations such as the increase in Violence Against Women and Girls/VAWG, particularly domestic violence, and greater exposure to intimate partner violence. Indeed, the movement restriction and social isolation measures necessary

to overcome the COVID-19 pandemic have contributed to the exacerbation of these risks by closing off opportunities for those women most likely to seek help for their own safety and to access services. Family circumstances, economic and social pressures caused by the pandemic and lockdown underpinned by toxic social norms and pre-existing gender inequalities only worsened the situation for women. It is thus a long and no less fruitful journey that has led CAWTAR today to such a topic as GBV/VAWG during a sanitary crisis using the COVID-19 pandemic as a framework for analysis, as both cause and consequence.

In a context like the coronavirus pandemic, the main challenge can be summarized in one question: How to manage two parallel pandemics? How to prevent the COVID 19 pandemic without increasing the second pandemic of Violence Against Women? How to prevent Violence Against Women without increasing the risk of COVID-19? What measures can be taken for both that are not dangerous for either?

Due to the pandemic and the consequent lockdown, the implementation of a number of activities planned within the project "Preventing Gender-Based Violence in Public Spaces: From Knowledge to Action for Change" has been questioned. Thanks to the ongoing successful partnership Arab Women Center for Training and Research/CAWTAR-Open Society Foundations/OSF, it was agreed to adapt the work to the situation and emerging issue which did not augur well on any fronts.

The two partners agreed to use the remaining funds and time to conduct a rapid assessment on "Gender-Based Violence during a Sanitary Crisis; the Case of COVID-19" in order to generate realistic data needed to assess the impact on women's status, rights, and safety rethink and adapt approaches to addressing discrimination and Violence Against Women during such crises and their subsequent "double-edged" measures.

This is what I would like to present to you today in this report with the words of the women who have agreed to declare themselves survivors of violence, or not and share with us their painful experience and their dreams. I would like to take this opportunity to thank them from the bottom of my heart and to express our total solidarity by telling them that their fight is ours and their survival is ours.

I would also like to thank all those who participated in this work, both in CAWTAR and within "Reflexions", the research and consulting firm in marketing and sociology, which conducted the field survey in the seven countries covered by this work, as well as the stakeholders and our partners in Algeria, Egypt, Jordan, Lebanon, Morocco, Palestine and Tunisia who contributed to the validation of the methodology and tools presented by CAWTAR, participated in the rapid assessment or discussed the results with us recognizing the efforts and consolidating the expectations and recommendations expressed by the hundreds of women from our region.

Dr Soukeïna Bouraoui
Center of Arab Woman
for Training and Research
CAWTAR

i. CEDAW general Recommendation No 19
ii. Kofi Annan, <https://www.un.org/press/en/1999/19990308.sgsm6919.html>

INTRODUCTION

BACKGROUND

Facing the unknown with the occurring of the global pandemic COVID-19, in early 2020, governments around the world took several measures to limit its spread such as total lockdown and its consequential social distancing and restriction of liberty and movement for populations. This situation has led to families and their members being isolated and a sort of forced coexistence of women and men: let's say rather a lockup of women and their potential or habitual aggressors, in a stressful atmosphere. Lockdown measures that aimed at preventing and reducing the spread of the coronavirus pandemic paved the way for domestic violence and contributed to its spread, limiting, at the same time, access to the means of its prevention and propagation. Furthermore, from the beginning, specialists alerted that it was highly probable that these governmental measures will contribute to restraining the chances of vulnerable women to seek help.

Although the phenomenon of Gender-Based Violence/GBV is declared as a global phenomenon, the deterioration of the socio-economic situation in some countries should not be overlooked, creating additional difficulties and more fragile situations (fragile health system, poverty, countries in a state of war or conflict, etc.). In fact, while the Coronavirus Disease/COVID-19 pandemic affects men and women equally, its socio-economic and security implications are far more pronounced for women and girls, to the point of challenging gender equality gains of recent decades, according to the United Nations Organisation, which strongly recommends to reverse this alarming trend.⁽¹⁾

The social isolation measures necessary to overcome the COVID-19 pandemic have had serious repercussions in many homes. Not only have these measures increased the number of women who are victims of domestic violence, but they have also limited the chances of those who are more vulnerable to seek help safely. Actually, during the lockdown period, figures and cases were reported and shared widely, especially in the social media. Yet many seemed "surprised" as if it was unknown that women in special situations (war, conflict, natural disasters...) face more deprivation, discrimination and violence... Red alerts were going off everywhere at the international, regional and national levels but no serious attention was drawn nor effective measures taken to save women and girls.

In this context and beyond the direct impact of the Coronavirus Disease, UN Women highlights the security conditions of women, affected by the lockdown and restrictions on movement, noting that, "perversely", the means used to combat the spread of the virus "create ideal situations for aggressors".⁽²⁾ The dossier published in April 2020 highlights new evidence of the impact of the recent global COVID-19 pandemic on Violence Against Women and Girls while highlighting the current lack of data on the gaps in the current response to the pandemic and its impact on critical sectors.

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1. Inégalités de genre et COVID-19: les réponses des entités de l'ONU <https://www.un.org/fr/%C3%A9quipe-de-communication-de-la-riposte-de-l%E2%80%99onu-au-covid-19/in%C3%A9galit%C3%A9s-de-genre-et-covid-19-les>
 2. UN-Women: COVID-19 and ending violence against women and girls, Avril 2020 <https://www.unwomen.org/en/digital-library/publications/2020/04/issue-brief-covid-19-and-ending-violence-against-women-and-girls>

Worldwide, with half the world population in lockdown due to COVID-19, 243 million women and girls between the ages of 15 and 49 were sexually and/or physically abused by an intimate partner in the past 12 months (2019) with no real GBV data specific to the impact of the COVID-19 pandemic on the security of women despite the assumptions, alerts and awareness on the risks incurred. COVID-19 is likely to have been responsible for similar trends since then, and at the present time.⁽³⁾ Women's fear and experience of sexual and other forms of violence in public spaces⁽⁴⁾ is likely to intensify, as observed in many countries, such as the Philippines and India, where COVID-19 has gained a foothold in urban and rural areas because social distancing has emptied the streets and transports from people, except those providing essential services.

Alongside increased reports of VAWG, greater complexity of violence is also observed. The Ebola pandemic demonstrated that multiple forms of violence are exacerbated within crisis context, including trafficking, child marriage and sexual exploitation and abuse.⁽⁵⁾ GBV increases during every type of emergency-whether economic crises, conflict, war or diseases outbreaks. The COVID-19 outbreak has globally intensified Gender-Based Violence and more specifically in the domestic space.⁽⁶⁾ Within the context of the COVID-19 emergency, migrant and refugee women are in particularly precarious situations as they are exposed to xenophobia, which makes them targets of violence and limits their chances of finding fair employment or access to needed services.⁽⁷⁾

As early as March 2020, a plethora of research was launched throughout the world to rapidly assess the impact of the COVID-19 pandemic and subsequent lockdowns on the economy, society, environment, education... with a special interest on the consequences on women and girls on issues of gender equality, access to economic resources, social and family responsibilities, Gender-Based Violence/GBV and other real or potential risks to their well-being and survival.

The findings of this work, resulting primarily from existing knowledge and statistical data and analysis of the causes of Gender-Based Discrimination and Violence, outside the realm of this sanitary crisis and related lockdown, have made it possible to: assess urgent needs to be addressed, emergency plans to be drafted, advocacy strategic interventions and/or develop policy briefs to mobilise both public opinion and resources to address emergencies for the protection and safety of women and girl survivors of GBV.

The mission of the Center of Arab Women for Training and Research/CAWTAR is to “*contribute to the empowerment of women in the Arab world so that they can fully exercise their human rights, economically, socially and politically...*”. Therefore and like many organisations, CAWTAR was compelled to contribute to this sensitive sanitary crisis and situation by producing factual data, essential to assess the consequences of the crisis in order to rethink and adapt the approach to addressing consequential discrimination and violence against women and preserve their health and safety during the COVID-19 pandemic and related lockdowns.

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3. IASC(2015) Guidelines for integrating Gender Based Violence interventions in Humanitarian Crises : Food Security and agriculture ; UNGA A/70/723. Protecting Humanity for future Health Crises : Report of the high-level global response to Health Crises;
 4. <https://www.indiatoday.in/crime/story/jharkhand-minor-girl-accuses-friends-8-others-of-rape-in-dumka-1660566-2020-03-28>
 5. UNGA A/70/723, protecting humanity from futures healthcare crises: Report of the high-level global response to Health Crises; “GBV in Emergencies: Emergency Responses to public Health Outbreaks”, September 2018, p.2
 6. UNDP Brief Gender Based Violence and COVID 19 11 May 2020 <https://www.undp.org/content/undp/en/home/librarypage/womens-empowerment/gender-based-violence-and-covid-19.html>
 7. UNDP, The economic impacts of COVID-19 and Gender Inequality recommendations for Policy Makers (Briefing Note, Apr 6, 2020) prepared by the UNDP Gender Area for Latin America and the Caribbean in collaborations with other agencies and partners https://www.latinamerica.undp.org/content/rblac/en/home/library/womens_empowerment/los-impactos-economicos-del-covid-19-y-las-desigualdades-de-gene.html

Given the circumstances a number of planned activities under the CAWTAR-OSF⁽⁸⁾ agreement were cancelled allowing for CAWTAR to conduct this Rapid Assessment. Their focus was on Gender-Based Violence/GBV in public spaces targeting university space.⁽⁹⁾ The project's extension provided an opportunity in terms of financial resources and time which also made it possible to cover 7 countries in the MENA region, namely Algeria, Egypt, Jordan, Lebanon, Morocco, Palestine and Tunisia. The research, studies and opinion poll firm "REFLEXIONS" was recruited to conduct the field survey.

RESEARCH FRAMEWORK

1. The Assumptions

Demonstrating exemplary courage, abnegation and determination, women have always played an essential role when and where they are needed, in crisis, armed wars or any other kind of fight, as in the current case of the war against coronavirus worldwide. This includes both women in key positions where their better management of the coronavirus has been widely recognized and celebrated (in Iceland, Taiwan, Germany, New Zealand, Finland, or Denmark...) as well as countless ordinary women around the world, whether professionals or at home, although none of the latter make headlines.

Indeed, at the forefront of the fight against COVID-19, in their homes, in strategic sectors (health, food security, education...), the private sector or other, women are the coronavirus warriors. Despite this, emerging evidence shows that since the development of the COVID-19 pandemic, Violence Against Women and Girls/VAWG and more particularly Domestic Violence/DV has intensified. In addition, 70% of workers in the health care sector are women at the forefront of the COVID-19 response. At work, they also face multiple risks to their well-being and safety and there have been increased reports of both physical and verbal attacks on healthcare workers in China, Italy and Singapore.⁽¹⁰⁾

The restrictive measures adopted worldwide to combat COVID-19 intensify the risk of domestic violence. Dubravka Simonovic, the UN Special Rapporteur on Violence Against Women reminded that *"home is recognized as to be a place of fear and abuse for too many women and children. She warned that isolation, such as the restriction measures imposed during the COVID-19 pandemic, makes this situation much worse"*. Despite that, it must be stressed that the interest of the international community is far from being commensurate with the intensity of this sanitary crisis—or previous ones—and the risks of domestic violence for women and girls.

Just for instance, in 2016, the United Nations Secretary-General Ban Ki-Moon established a Task Force on Global Health Crises, but only for one year. Its mandate was to support and monitor the implementation of the recommendations of the High-level Panel on Global Action on Health Crises in its report entitled "Protecting Humanity from Future Health Crises" (A/70/723), and ensure that the Panel's recommendations are implemented in line with the observations of the Secretary-General in his report entitled "Strengthening the global health infrastructure" (A/70/824). Meanwhile, it was not reactivated during this pandemic.

8. Open Society Foundation

9. A regional and two country reports (Morocco and Tunisia) "Prevention of Gender- Based-Violence at the University: From knowledge to action towards change" were published in 2020 and launched during the 16 Days of Activism against Gender-Based Violence (25 November-10th December, 2020) <http://www.cawtar.org/en/clearing-house>

10. https://miguelorenteaupsia.wordpress.com/2020/03/16/confinamiento-violencia/amp/?twitter_impression=true

Many initiatives are reported here and there as a gender response to COVID-19 pandemic but mainly based on assumptions, policy recommendations and/or some ad-hoc and short terms solutions. Interventions of governments to deal with this “GBV pandemic” were neither discernible nor at the same level of morbidity or mortality risks as those facing the COVID-19 disease contamination. In this context, associations were only able to adapt their limited means to this complex situation or to ring the bells. Even women shelters were not sufficient nor equipped for such circumstances. In spite of their experience in various contexts and related resolutions, international organizations that have adopted global barrier measures were not able to foresee this situation, let alone adapt to it, given the gender blindness of the proposed response.

On the top of various areas and levels of vulnerability, the WHO has clearly stated that GBV is a “*global health problem of epidemic proportions*”. Social distancing policies and mandatory quarantines required to contain the spread of virus, increased the risk of exposure to Intimate Partner’s Violence. The analysis of the research’s findings⁽¹¹⁾ identified at least four factors that anticipate a rise of VAW and a potential increase of femicides and therefore requiring urgent responses:

1. The increase in quantity of time shared by perpetrator and victim;
2. The growth of daily conflicts due to promiscuity, family and domestic issues;
3. Prolonged violence without interruption by normal daily activities such as shopping, school, family visits, work... and,
4. The loneliness of the victim and her perceived security and impunity of the perpetrator.

The multitude of contributions in their diversity allowed defining the state of art as regard to the lockdown causes and consequences on women, yet the proposed policy recommendations and strategic interventions need to be more innovative to address and not only dress gender dimension in such context and sanitary crisis.

In their essence, the barrier measures taken to combat the COVID-19 pandemic pave the way to the GBV increase. The question is:

- How to deal with these double penalty and risks for women?
- What would be the alternative and efforts that will avoid jeopardizing the fight against the pandemic at both family and community levels from one side while limiting the risks women and girls are facing because of the parallel GBV pandemic, on the other?

Given the preliminary available information, it is very likely that rates of widespread domestic violence will increase during this uncertain period. No one is able to say how this pandemic will evolve, let alone when it will stop. According to the WHO, the pandemic will continue to expand and autumn will be harsh. It seems that this will go far beyond.

11. <https://miguelorenteaupsia.wordpress.com/2020/03/16/confinamiento-violencia/amp/?twitterimpression=true>

In fact, throughout the world, the reported figures (summer 2020) are higher than those recorded during the lockdown period. The trend has been accelerating since September of last year. Some countries already speak of the COVID-19 second and third wave. Moreover, with the new strain or strains (England, South Africa...), some are even talking about COVID-20 and 21. If these names are not confirmed by the scientific community, they are worrisome when we look at the development in the second half of 2020 and the beginning of 2021, providing a gloomy forecast for the future. Does this mean that GBV rates will increase with the same parallel intensity and speed?

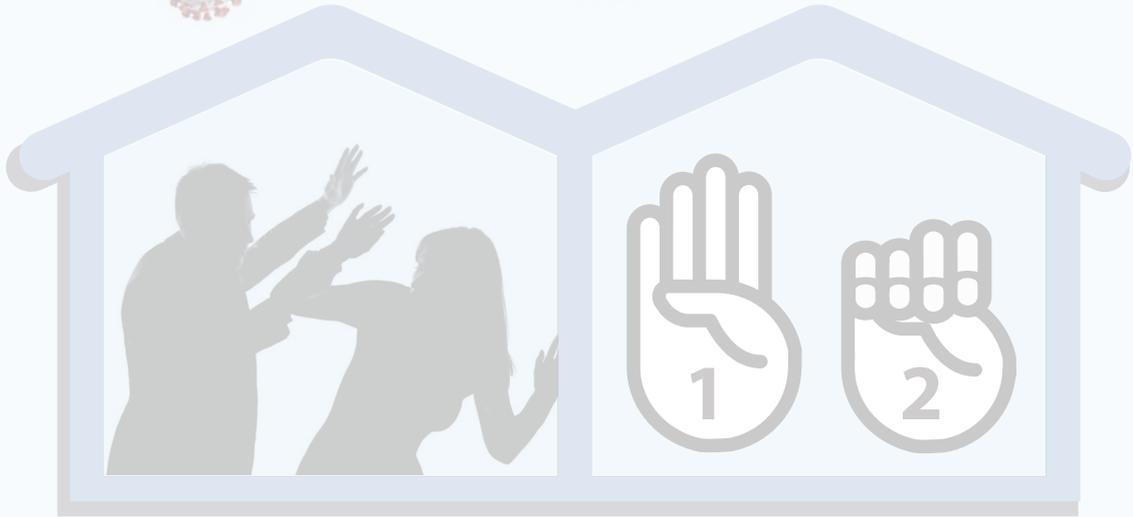
In the meantime, it will be necessary to find the means to better assess the situation and to produce the evidences that will allow concerned actors to propose adapted and pertinent solutions. This is why, however modest it may be, given the limits of the exercise in terms of timing and budget, CAWTAR proposes to conduct a Rapid Assessment on Gender-Based Violence during a sanitary crisis with the example and experience of the COVID-19 pandemic. The focus will be on Domestic Violence/DV before, during and after the containment period. The seven countries covered are Algeria, Egypt, Jordan, Lebanon, Morocco, Palestine and Tunisia, with a sample of one thousand respondents covering women and concerned stakeholders.

2. The objective

The purpose of this Rapid Assessment on Gender-Based Violence before, during and after the coronavirus pandemic and COVID-19 lockdown is to take stock of the current situation and assess the multiple effects of confinement due to a health crisis on women and girls, including economic impacts, where possible.

The ambition is not to conduct a prevalence survey, but rather to assess the extent of the phenomenon through the chosen approach, to confirm the hypotheses as to the causes and consequences of this violence. It will be possible to assess unmet needs in terms of protection, security and health services during such crisis and the ways to access them.

Consultation with women, associations and institutions/organisations that are closely monitoring the situation will allow reflection on the solutions to be proposed so that women's needs are met and rights are taken into account in the proposed measures.



PART I : THE FRAMEWORKS

PART I : THE FRAMEWORKS

PART I-1 : CONCEPTS, CONTEXT AND LAW

THE CONCEPTUAL FRAMEWORK

1. VAWG/GBV: Definition/s & Framework

1.1. The definition

While there is no universal definition of GBV—i.e. there is no legally binding definition, as for example in the case of the implementation obligations of State Parties following their ratification of international conventions—most countries, in all regions, at least those that have put in place national policies or even laws, have more or less adopted in their official documents the definition of GBV as proposed by the Declaration on the Elimination of Violence Against Women/DEVAW. In order to address issues related to Violence Against Women and Girls/VAWG and Gender-Based Violence/GBV, it is essential to define the concept(s) and analyse its ins and outs in order to determine and clarify the referral framework.

DEF. 1: For the United Nations, the term “Violence Against Women” means “any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.”⁽¹²⁾

DEF. 2: Intimate partner violence refers to “behaviour by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse and controlling behaviours.”⁽¹³⁾

DEF. 3: Sexual violence is “any sexual act, attempt to obtain a sexual act, or other act directed against a person’s sexuality using coercion, by any person regardless of their relationship to the victim, in any setting. It includes rape, defined as the physically forced or otherwise coerced penetration of the vulva or anus with a penis, other body part or object.”⁽¹⁴⁾

1.2. The Gender framework of violence: From VAW to GBV

Gender-Based Violence includes the word gender because most victims of interpersonal violence are women and perpetrators are men. Gender-Based Violence is a form of violence, which the women and the girls in all steps of their life undergo above all else because of their sex as a female and their Gender identity as a woman as defined by/in the society. It is a complex social phenomenon,

12. United Nations General Assembly. Declaration on the elimination of VAW. Proceedings of the 85th Plenary Meeting, Geneva, Dec. 20, 1993. United Nations General Assembly.

13. VAW: Intimate partner and sexual violence against women, WHO Fact sheet. Updated November 2017, <http://www.who.int/mediacentre/factsheets/fs239/en/>

14. Idem

deeply rooted in existing gender power relationships, sexuality, self-identity and, the structure of social institutions. The three criteria differentiate GBV from other forms of violence including against women⁽¹⁵⁾ are:

1. **Sex Based Discrimination:** Violence is directed against women through life cycle because they are female. As a matter of fact, because they are female, women through their life cycle, face a systematic discrimination on behalf of a system entrenched in its beliefs and practices.
2. **Gender Balance of Power:** Imbalanced gender relationships and distribution of power between the perpetrator of (man) and the survivor of violence (woman), characterized by the duality: supremacy of-submission to.

The gender-based discrimination system—and recognized gender distribution of roles, status and power—rationalizes gender-based power relationships, perpetuating a universal model characterized by the duality obedience/subordination, supremacy of-submission to which places women and girls on a very high level of vulnerability with respect to the physical, sexual and psychological acts and/or threats practiced by the men whether members of their family or community: husband, brothers, fathers, boys-friends, teachers, colleagues and employers.

Gender-Based Violence serves—by intention or effect—to perpetuate male power and control, between the GBV perpetrator and the survivor. However, cross-cultural studies of wife abuse have found that nearly a fifth of peasant and small-scale societies are essentially free of family violence. The existence of such cultures proves that male violence against women is not the inevitable result of male biology or sexuality, but more a matter of how society views masculinity.⁽¹⁶⁾

3. **Societal Tolerance:** *Culture of silence because it falls under the private life sphere therefore GBV is tolerated, accepted and in many times justified.* That means that acts of violence are mainly neglected, ignored or even accepted because they are considered as gender norms and values and as a matter of the private life.

This tolerance is sustained by a culture of silence and denial of the seriousness of the health/survival consequences of abuse. In addition to the harm caused on the individual level, these consequences also exact a social toll and place a heavy and unnecessary burden on health services. When family is supposed to be a haven for all its members all researches and data demonstrate clearly that it is the first place where GBV is practiced.

15. UNFPA, Gender Task Force, 1998

16. UNFPA: Ending Widespread of VAW: Programming for Prevention, Protection and Care, 2007, <https://www.unfpa.org/resources/ending-violence-against-women>

2. VAW/GBV: types, forms and places

In all societies, cultures, political and economic systems, women and girls are victims of physical, sexual and psychological violence that transcends income, class and culture, with different degrees of variation. Acts or threats of violence, whether they occur in the home or community, or are perpetrated or condoned by the state, instill fear and insecurity in women's lives and are obstacles to the achievement of equality and the enjoyment of human rights as well as development and peace.

Violence Against Women shall be understood to encompass, but not be limited to, the following:⁽¹⁷⁾

- a. Physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation;
- b. Physical, sexual and psychological violence occurring in the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution;
- c. Physical, sexual and psychological violence perpetrated or condoned by the State, wherever it occurs.

Other types do exist to only mention:

- Force-feeding and whitening of girls and women's skin to meet certain standards of beauty as part of the cultural beliefs, traditions and practices,
- Violence against girls and women in its worst forms and intensity during periods of conflict such as rape as a weapon of war, slavery and the sale of girls and women in the market places or the matrimony's Jihad which consists of forcing—or not—women and girls to have sexual intercourse with multiple partners at the same time to support "soldiers" in combat at various hierarchical levels in the name of nation, religion or terror. During World War II, it was the case for Japanese women... in recent years women and girls of the Middle East endure it ...

If all women face violence throughout their life cycle regardless of their level of education, social or economic background or political affiliation, religion, country or region, some of them among the vulnerable are even more exposed. Indeed *"Particular groups of women and girls, such as members of racial, ethnic and sexual minorities; HIV-positive women; migrants and undocumented workers; women with disabilities; women in detention and women affected by armed conflict or in emergency settings, may be more vulnerable to violence and may experience multiple forms of violence on account of compounded forms of discrimination and socio-economic exclusion."*⁽¹⁸⁾

17. Declaration on the elimination of VAW (Article 2) <http://www.un.org/documents/ga/res/48/a48r104.htm>

18. Forms of Violence against Women; Last edited: October 31, 2010, <https://www.endvawnow.org/en/articles/296-formes-de-violence-lgard-des-femmes.html+%2C>

The fear of violence, whatever are its form, type and/or extent, is a permanent constraint on women's mobility at every stage of their lives. It limits their access to resources and basic needs, starting with their security till their survival. It is multiplied tenfold in certain contexts and situations. In the case of lockdown, women survivors of GBV could be also considered in detention, but in their "home, sweet home".

THE CONTEXTUAL FRAMEWORK AND STATE OF PLAY

1. The GBV evidences during a "normal" situation

1.1. Throughout the world

Violence Against Women has moved from the private domain to public attention and has become the duty and responsibility of the State, thanks largely to the grassroots activities of women's organizations and movements around the world. This is where the first data come from. These activities have highlighted the fact that VAW is not the result of individual and spontaneous acts of misconduct, but is deeply rooted in the structural relationship of inequality between women and men.

Despite that, information on the prevalence of VAWG is often lacking even if availability of data on VAWG has significantly increased in recent years. Since 1995, more than 100 countries have conducted at least one survey addressing the issue. More than 40 countries conducted at least two surveys in the period between 1995 and 2014, which means that, depending on the comparability of the surveys, changes over time could be analysed⁽¹⁹⁾ including in the MENA Region.

At least 200 million women and girls alive today have undergone Female Genital Mutilation/FGM in the 30 countries with representative data on prevalence. In most of these countries, the majority of girls were cut before age 5.⁽²⁰⁾ Around 120 million girls worldwide (slightly more than 1 in 10) have experienced forced intercourse or other forced sexual acts at some point in their lives. By far the most common perpetrators of sexual violence against women and girls are current or former husbands, partners or boyfriends.⁽²¹⁾

According to global estimates updated by the WHO in November 2017, 35% of women, or nearly 1 in 3 women, report having been exposed to physical or sexual violence by their intimate partner or by others (7%) during their lifetime. In some countries, the VAW rate is as high as 70%.⁽²²⁾ Globally, almost a third of women, 30%, who have been in relationships, report having experienced some form of physical and/or sexual violence by an intimate partner in their lifetime, bearing in mind that intimate partner violence and sexual violence are mainly committed by men against women. As many as 38% of murders of women are committed by their intimate male partners, meaning nearly 4 out of every 10 homicide victims worldwide are killed by their partners.⁽²³⁾

Risk factors related to intimate partner violence and sexual violence that appear at the individual, family, community and broader societal level, have a direct and indirect impact on the physical and mental health of GBV survivors and children. In addition, GBV, intimate partner violence and sexual

19. World Bank Group (2015). Women, Business and the Law 2016, database quoted in <http://www.unwomen.org/en/what-we-do/ending-violence-against-women/facts-and-figures>

20. UNICEF (2016). Female Genital Mutilation/Cutting: A global concern.

21. UNICEF (2014). Hidden in Plain Sight: A Statistical Analysis of Violence against Children, p. 167. quoted in Facts and figures: Ending violence against women <http://www.unwomen.org/en/what-we-do/ending-violence-against-women/facts-and-figures>

22. Global Database on Violence against Women <https://evaw-global-database.unwomen.org/en>

23. Violence Against Women: Key facts, 29 November 2017, <https://www.who.int/fr/news-room/fact-sheets/detail/violence-against-women>

violence also have a socio-economic cost with consequences for the family and society. Women may suffer from isolation, inability to work, loss of wages, non-participation in regular activities and limited ability to care for themselves and their children.⁽²⁴⁾ This is especially true for women and girls with disabilities, ethnic minorities, migrant workers and older women and/or in special circumstances or context. According to data published by UN Women, at the global level, it is estimated that the total direct and indirect costs of violence against women can amount to 1-2 % of countries' gross national product. This amounts to millions of US dollars internationally.⁽²⁵⁾ Noting that where the data exists, comparability across and within countries remains a considerable challenge for global monitoring.⁽²⁶⁾

VAW and its economic and social consequences are worsened in extreme cases such as conflicts, but also and certainly in situations as complex as those created by a sanitary crisis that requires lockdown such as the one caused by the COVID-19 pandemic.

Other forms of Violence are child marriage. Worldwide, 700 million women alive today were married before their 18th birthday and more than one in three girls are married before age 15.⁽²⁷⁾ The largest numbers are in South Asia and the highest prevalence rates are in Africa.⁽²⁸⁾⁽²⁹⁾ According to other sources, almost 750 million women and girls alive today were married before their 18th birthday. Child marriage is more common in West and Central Africa, where over 4 in 10 girls are married before age 18, and about 1 in 7 are married or in union before age 15. Child marriage often results in early pregnancy and social isolation, interrupts schooling, limits the girl's opportunities and increases her risk of experiencing domestic violence.⁽³⁰⁾

An estimated 1-in-3 women will experience physical or sexual abuse in her lifetime which does not know social, economic or national boundaries.⁽³¹⁾ At the same level, overall, 35% of women have experienced either physical and/or sexual intimate partner violence (30% with 38% in some regions) or non-partner sexual violence. While there are many other forms of violence that women may be exposed to, this already represents a large proportion of women in the world. Globally, 7% of women have been sexually assaulted by someone other than a partner and as many as 38% of all murders of women are committed by intimate partners.⁽³²⁾ Among all women who were the victims of homicide globally in 2012, it is estimated that almost half were killed by intimate partners or family members, compared to less than 6% of men killed in the same year.⁽³³⁾

A 2015 United Nations Multi-country Study on Men and Violence in Asia and the Pacific found that nearly half of the more than 8,000 men interviewed reported using physical and/or sexual violence against a female partner, with the proportion of men reporting such violence ranging from 26 to 80 % across sites. In six countries included in the study, 65 and 85 % of men—i.e. the majority—reported using physical or sexual violence against a partner, and that they had committed such violence more than once.⁽³⁴⁾

24. Violence Against Women: Key facts, 29 November 2017, <https://www.who.int/fr/news-room/fact-sheets/detail/violence-against-women>

25. Global Database on Violence against Women <https://evaw-global-database.unwomen.org/en>

26. <http://www.unwomen.org/en/digital-library/multimedia/2017/7/infographic-spotlight-on-sdg-5>

27. UNICEF 2014, Ending Child Marriage: Progress and prospects. <https://data.unicef.org/resources/ending-child-marriage-progress-and-prospects/>

28. African Union Campaign to end child marriage, https://au.int/sites/default/files/pages/32905-file-campaign_to_end_child_marriage_in_africa_call_for_action_-_english.pdf

29. Community Views on Child Marriage in Kassala: Prospects for Change, Samia El Nagar, Manal Mahjoub, Adil Idris, Liv Tønnessen (2018) [https://www.cmi.no/publications/6438-community-views-on-child-marriage-in-kassala#:~:text=Worldwide%2C%20700%20million%20women%20alive,\(UNICEF%202014%2C%201](https://www.cmi.no/publications/6438-community-views-on-child-marriage-in-kassala#:~:text=Worldwide%2C%20700%20million%20women%20alive,(UNICEF%202014%2C%201)

30. UNICEF (2017). Is every child counted? Status of Data for Children in the SDGs, p. 54. quoted in Facts and figures: Ending violence against women <http://www.unwomen.org/en/what-we-do/ending-violence-against-women/facts-and-figures>

31. <https://www.unfpa.org/gender-based-violence>

32. "Understanding and addressing violence against women: Intimate partner violence" http://apps.who.int/iris/bitstream/handle/10665/77432/WHO_RHR_12.36_eng.pdf;jsessionid=3D76D1AA859F84D17093FEC903CE7630?sequence=1

33. United Nations Office on Drugs and Crime (2014). Global Study on Homicide 2013, p. 14.

34. The World's Women 2015, Trends and Statistics, Chapter 6, Violence against Women, United Nations Department of Economic and Social Affairs, 2015

Indeed, the rate of women killed by partner or family member per 100,000 populations, is 3% in Africa, 1,6% in Americas, 1,3% in Oceania, 0,9% in Asia and 0,7% in Europe. Comparatively, if women are safer in Europe, in Africa they are at most risk.⁽³⁵⁾ According to the same source, “a total of 87,000 women were intentionally killed in 2017. More than half of them (58 per cent)–50,000–were killed by intimate partners or family members, meaning that 137 women across the world are killed by a member of their own family every day. More than a third (30,000) of the women intentionally killed in 2017 were killed by their current or former intimate partner–someone they would normally expect to trust.”⁽³⁶⁾

“Violence Against Women and Girls continues unabated on every continent, in every country and in every culture. Most societies prohibit such violence, but the reality is that too often it is hidden or tacitly tolerated... Violence against women and girls leaves a hideous mark on every continent, every country and every culture. It does not take into account your income, class, race or ethnicity. It has a devastating impact on women’s lives, on their families and on society as a whole. It is a threat to all women and should be unacceptable to all humanity.”⁽³⁷⁾

1.2. In the MENA Region

At the country and regional level, the WHO has found that almost a third or 30% of all women who have been in a relationship have experienced physical and/or sexual violence from their intimate partner. Prevalence estimates range from 23.2% in high-income countries and 24.6% in the Western Pacific Region to 37% in the Eastern Mediterranean Region and 37.7% in the South-East Asia Region.⁽³⁸⁾

GBV is neither specific nor unique to the Arab Region.⁽³⁹⁾ Available data show that it transcends cultures, age groups and economic and social status. Closely following South East Asia (37.7%), the percentage of women in the region, who have experienced at least one form of violence in their lifetime is 37%, making it the second highest prevalence in the world. Some indicators show that this percentage may be higher.⁽⁴⁰⁾ GBV encompasses many types of violence of which the most frequently reported in the Arab region is domestic violence as indicated by these herewith few figures:

Table 1 - Country comparative elements of Gender-Based Violence ⁽⁴¹⁾

Country	GBV Forms (%)			
	Economic	Psychological	Sexual	Physical
Algeria	9.4	10.9	21.6	---
Egypt	28	17	62.6	---
Morocco	15.2	8.7	48.2	8.4
Palestine	23.3	9	61.7	---
Tunisia	7.5	9.7	16.8	3.9

35. Global Study on Homicide: Gender-related killing of women and girls, UNDOC, 2018 https://www.unodc.org/documents/data-and-analysis/GSH2018/GSH18_Gender-related_killing_of_women_and_girls.pdf

36. Idem

37. Ban Ki-Moon, Journée internationale de la femme, Événement inter-agences sur l'élimination de l'impunité pour les violences faites aux femmes et aux filles, New York, 8 mars 2007

38. Violence Against Women: Key Facts, 29 November 2017, <https://www.who.int/fr/news-room/fact-sheets/detail/violence-against-women>

39. It is important to note that the WHO Regional Office for the Eastern Mediterranean (EMRO) covers Afghanistan, Bahrain, Djibouti, Egypt, Iran (Islamic Republic of), Iraq, Libya, Jordan, Kuwait, Lebanon, Morocco, Oman, Pakistan, Qatar, Saudi Arabia, Somalia, Sudan, Syrian Arab Republic, Tunisia, United Arab Emirates and Yemen. As a result, not all the member countries of the Arab League are included, i.e. Algeria, Mauritania and the Comoros.

40. <http://www.who.int/reproductive-health/publications/violence/en/index.html> et autres sources

41. The data reported in this table are taken from the national surveys conducted in these countries during the period 2000-2010.

As regards Violence Against Girls/VAG, UNICEF counts Sudan, an Arab-African among the African countries with a high prevalence of child marriage.⁽⁴²⁾ According to other sources, prevalence of child marriages in MENA is near the global average but rising, it "...adds 700,000 child brides every year to its 40 million child brides, including currently married women wed as children."⁽⁴³⁾ Over the past decades, things started evolving positively. Unfortunately, trends significantly reversed mostly in countries facing conflicts. Child marriages have surged in Syria (13% in pre-war), with and increase among all forcibly displaced. In Iraq, they stood at 15% in 1997 but increased to 24% in 2016, including 5% for girls less than 15 years of age. In Yemen, with no legal minimum marriage age (32% in pre-war), two-thirds of marriages involve underage, including 44% under 15. In Libya, which, at 2 %, had one of MENA's lowest rates, the numbers are rising, especially in areas controlled or influenced by radical groups.⁽⁴⁴⁾

The phenomenon of Female Genital Mutilation/Cutting (FGM/C) does exist, in most Arab countries or in certain of its sub-regions, from the Atlantic Ocean to the Arab Gulf, with differences in frequency or severity. The phenomenon is not always officially recognized, and would not be officially known without the studies undertaken by NGOs and the educational role they played with the support of and engagement of specialized international organizations. The non-recognition and almost denial of this phenomenon in many countries makes the information on the subject insufficient, leading to an inability to address the issue in a legal manner. According to the 2013 data available, the phenomenon of FGM/C among women aged 15-49 years old reached 96% in Djibouti, followed by Egypt at 91% and Sudan at 88%. Iraq recorded 8%.⁽⁴⁵⁾ Some data published by UN Women in its VAW Global Database⁽⁴⁶⁾ and drawn from several sources including national data highlights that for example in Egypt, 92% of women and girls between the ages of 15 and 49 have undergone female genital mutilation. 133 million women alive today have undergone Female Genital Mutilation. Recent data show that Female Genital Mutilation has increased to 61% among girls aged 15-17, up from 74% in 2008. Still prevalent in Djibouti, the prevalence decreased to 78%. Public declarations against FGM in 2016 and 2017 helped save nearly 1,000 girls from cutting.⁽⁴⁷⁾

Other harmful practices are force-feeding and skin whitening in addition to trafficking, rape, sexual slavery, economic exploitation and financial deprivation, forced prostitution and killings of women and girls committed in the name of "honour", acid throwing and terrorist killings.

Women and girls account for 70% of all known victims of trafficking, 50% of whom are adult women. 2 out of every 3 children trafficked are girls.

Rapists often receive clemency or are even acquitted in the Arab region if they accept to marry their victims. In a number of Arab countries, legal provisions in the Penal Code allowed rapists to avoid prosecution if they married their victims but many of them repealed, following the civil pressure. More than 6 out of 10 women survivors of violence refrain from seeking support or protection of any kind. The others who do speak out, turn to their family and friends for such support or protection.⁽⁴⁸⁾

42. Community Views on Child Marriage in Kassala: Prospects for Change, Samia El Nagar, Manal Mahjoub, Adil Idris, Liv Tønnessen (2018), [https://www.cmi.no/publications/6438-community-views-on-child-marriage-in-kassala#:~:text=Worldwide%2C%20700%20million%20women%20alive,\(UNICEF%202014%2C%201\).](https://www.cmi.no/publications/6438-community-views-on-child-marriage-in-kassala#:~:text=Worldwide%2C%20700%20million%20women%20alive,(UNICEF%202014%2C%201).)

43. Omer Karasapan, Sajjad Shah: Forced displacement and child marriage: a growing challenge <https://www.brookings.edu/blog/future-development/2019/06/19/forced-displacement-and-child-marriage-a-growing-challenge-in-mena/#:~:text=There%20are%20some%20750%20million,marriages%20to%20one%20in%20five.>

44. Idem

45. New UNICEF report on female genital mutilation/cutting: from opposition to action, 2013 https://www.unicef.org/french/protection/57929_69881.html

46. Global Database on Violence against Women <https://evaw-global-database.unwomen.org/en>

47. UNICEF & UNFPA: Ending female genital mutilation in Djibouti; "I could see the regret in my mother's eyes. But it was too late." Eva Gilliam, <https://www.unicef.org/stories/ending-female-genital-mutilation-djibouti#:~:text=The%20latest%20data%20from%20UNICEF,in%20group%20belief%20and%20behaviour.>

48. Global Database on Violence against Women <https://evaw-global-database.unwomen.org/en>

2. GBV & COVID-19

The literature research focused mainly on publications on this new scourge called coronavirus and the consequences of its pandemic: COVID-19. The number of titles listed in the bibliography that served as a frame of reference for this work is 225 titles.⁽⁴⁹⁾ Just for instance, in one of the titles identified during the documentary research, “Mapping of online articles on Covid-19 and Gender” conducted between April 1 and May 11, 2020, UNESCO registered 151 titles.

In addition to topics related to the pandemic itself, its symptomatology, prevalence, extent, treatment, health risks, morbidity, mortality... other areas of interest have revolved around its economic, social and even political consequences in general and on women and girls in particular with a focus on their rights, their security, their protection especially with the increasingly deafening echoes of the emergence of a Gender-Based Violence parallel pandemic.

It must be pointed out however, that with this unexpected, incomprehensible pandemic and its impact impossible to evaluate, the numerous initiatives were going in all directions with a single objective: to prepare for the most urgent need to know and better face this danger that was beginning to kill. Most of this work (assessment, policy brief, action plan, etc.) was based on prior quantitative and qualitative knowledge of previous pandemics and GBV cases, types and forms, analyses from a gender and rights perspective, as well as hypotheses based on different past situations.

Without calling into question the credibility of these urgently needed and highly informative publications, the data on “GBV and COVID-19” could be reminiscent of the early beginnings of VAWG research in the 1990s. This is why the information collected and the synthesis of the desk review made it possible to articulate this work (as herewith illustrated) and to better refine the axes of what was supposed to be a rapid assessment at the beginning and which was later turned into real research. Indeed, as this work was launched after the lockdown was lifted, it seemed logical to evaluate and analyse the GBV before, during and after the lockdowns.

2.1. Throughout the world

If there was a need for that, the previously shown data demonstrated that GBV is not new in the life of women and girls whatever the space, the situation, circumstances or type of crisis, political, economic or sanitary, may be. The COVID-19 pandemic with its lockdown and other measures and constraints led to a parallel GBV pandemic which was called also by the UN Women when launching its public awareness campaign in May 2020 a “shadow pandemic” focusing on the global increase in Domestic Violence in the context of the COVID-19 health crisis: *“With 90 countries in lockdown, four billion people are now sheltering at home from the global contagion of COVID-19. It’s a protective measure, but it brings another deadly danger. We see a shadow pandemic growing, of violence against women.”*⁽⁵⁰⁾

49. not all cited in this work

50. Violence against women and girls: the shadow pandemic, Statement by Phumzile Mlambo-Ngcuka, Executive Director of UN Women, <https://www.unwomen.org/en/news/stories/2020/4/statement-ed-phumzile-violence-against-women-during-pandemic>

During a virtual event to strengthen global commitment “at a time when women and girls are locked down and locked in, rendering them further exposed to violence and harassment, or at greater risk of being trafficked”, the UNODC Executive Director declared “in every part of the world, we are seeing that COVID has worsened the plight of at-risk women and girls, while also hindering criminal justice responses and reducing support to victims.”⁽⁵¹⁾

While studies, research, rapid assessments and other initiatives have proliferated, this was not always the case for statistical data. Hypotheses and extrapolations have been made during this period and allowed for some estimates to be made. According to UN Women and its sources, calls to hotlines increased fivefold in some countries reporting the increase in intimate partner violence during the COVID-19 pandemic.⁽⁵²⁾

Specific figures indicate that in France for instance, cases of GBV have increased by 30% since the lockdown from March to May 2020. Helplines in Cyprus and Singapore have registered an increase in calls by 30% and 33% respectively. In Argentina, emergency calls for domestic violence had increased by 25% since the lockdown had started.⁽⁵³⁾ The number is likely to increase as security, health and money worries heighten tensions and strains and are accentuated by cramped and confining living conditions.⁽⁵⁴⁾ According to other sources,⁽⁵⁵⁾ there has been a 20% increase in violence against women in the United States, 75% in Australia, 37% in South Africa, 25% in Great Britain, 32% in France, 38% in Turkey, 50% in India, etc...

Restricted movement, social isolation, and economic insecurity are increasing women’s vulnerability to violence in the home around the world⁽⁵⁶⁾ knowing that vulnerability to violence often grafted on top of other women’s vulnerabilities. Situation becomes more complex when research neglects such groups of women as for instance for women living in conflict or post-conflict situation, displaced women, refugees, migrants, domestic workers or women living with disability. Indeed, no initiative was taken to explore the interlinkages between GBV and other vulnerabilities in relation to the COVID-19 pandemic. In fact here also the existing knowledge and experience of the field could give an idea of the impact of such crisis in terms of aggravating “(...) pre-existing inequalities, disproportionately affecting women, girls and other sub-populations, and adding to their risk of violence, abuse and exploitation.”⁽⁵⁷⁾

According to UNDP, women comprise 75% of the health workforce in the world. They represent 57% of medical personnel in Latin America (...) 9 out of 10 of the nursing professionals are women.⁽⁵⁸⁾ For other sources, women comprise 70% of the global healthcare workforce and yet they only 25% get to the senior positions.⁽⁵⁹⁾

51. <https://news.un.org/en/story/2020/11/1078812>, 30 November 2020

52. UN Women (2020). Intensification of efforts to eliminate all forms of violence against women: Report of the Secretary-General (2020), p. 4

53. Infographic: The Shadow Pandemic - Violence Against Women and Girls and COVID-19 <https://www.unwomen.org/en/digital-library/multimedia/2020/4/infographic-covid19-violence-against-women-and-girls>

54. UNDP Brief Gender Based Violence and COVID 19 May 11, 2020, <https://www.undp.org/content/undp/en/home/librarypage/womens-empowerment/gender-based-violence-and-covid-19.html>

55. UN sources quoted in “Violence against women in times of confinement in Algeria”, 22/05/2020 Corona Blog by Louisa Ait Hamou <https://www.fes-mena.org/blog/e/violences-contre-les-femmes-en-temps-de-confinement-en-algerie/>

56. UN Women (2020). Intensification of efforts to eliminate all forms of violence against women: Report of the Secretary-General (2020), p. 4

57. “Care International, 2020, Inter-Agency Standing Committee, 2015” quoted in Disability Considerations in GBV Programming during the COVID-19 Pandemic Author: Emma Pearce, GBV AoR, https://gbvaor.net/sites/default/files/2020-03/Disability%20Considerations%20in%20GBV%20programming%20during%20COVID_Helpdesk.pdf

58. UNDP: Briefing Note: The Economic Impacts Of Covid-19 and Gender Inequality Recommendations For Policymakers <https://www.undp.org/content/undp/en/home/librarypage/womens-empowerment/the-economic-impacts-of-covid-19-and-gender-equality.html>

59. Dr. Inez Myamoto: COVID-19 Healthcare Workers: 75% are women https://www.jstor.org/stable/resrep24863?seq=1#metadata_info_tab_contents

In the same way, a higher proportion of health workers diagnosed with COVID-19 are women. The available data in EU countries show an infection rate varying from 9 to 25% of health workers tested positive with the virus: in Spain 72% of them are women, in Italy 66%. In the USA, for the Center of Disease Control and Prevention, 73% of infected health care workers are women.⁽⁶⁰⁾ Even if these figures are frightening, they are far from surprising.

Moreover the gendered impact of COVID-19 also extends to the health sector workforce, which in many countries relies heavily on women –further adding to their work load burden an infection risk.⁽⁶¹⁾ Indeed, exposed to the COVID-19, related risks and consequences, women face heavy workloads, stress, exhaustion, isolation and separation from their families and loved ones as well as the pain of their patients and loss of life, they also experiment at each moment of their day the engendered effects emerging from the pandemic.⁽⁶²⁾

Pre-existing toxic social norms and gender inequalities, economic and social stress caused by the pandemic coupled with restricted movement and social isolation measures have led to an exponential increase in GBV. During the COVID-19 pandemic, the “Stay home” doesn’t mean necessarily “Stay Safe” for women and girls.

It is worth noting however that after the ad-hoc interventions imposed by the emergency situation of the lockdown and its aftermath during the first-half of 2020, in September of the same year, 48 countries had integrated prevention and response to VAWG into COVID-19 response plans, and 121 countries had adopted measures to strengthen services for women survivors of violence during the global crisis, but more efforts are urgently needed.⁽⁶³⁾

2.2. In the MENA Region

All Arab States have confirmed COVID-19 cases with a consistent increase in infection cases and deaths and more particularly in the most fragile countries (weak and ill-equipped health systems, poverty, war/conflict...). According to the WHO and published by UNFPA-ASRO,⁽⁶⁴⁾ as of June 8, 2020, the situation in numbers in the Arab States Region is 340,443 confirmed COVID-19 cases and 4,566 COVID-19 deaths. As of October 21, 2020, over 2.6 million cases of COVID-19 have been registered in the region, 414,173 of which are active, and 67,869 deaths in total have been reported.⁽⁶⁵⁾ The number of COVID-19 cases in the MENA region increased by 32% increase in just one week.⁽⁶⁶⁾ In November of the same year, over 2.76 million people have been infected. “This global pandemic added another strain on the already politically and economically struggling region.”⁽⁶⁷⁾

60. Dr. Inez Myamoto: COVID-19 Healthcare Workers: 75% are women https://www.jstor.org/stable/resrep24863?seq=1#metadata_info_tab_contents

61. Emma Pearce: Care International, 2020 quoted in Disability Considerations in GBV Programming during the COVID-19 Pandemic, GBV AoR, https://gbvaor.net/sites/default/files/2020-03/Disability%20Considerations%20in%20GBV%20programming%20during%20COVID_Helpdesk.pdf

62. Dr. Inez Myamoto: COVID-19 Healthcare Workers: 75% are women https://www.jstor.org/stable/resrep24863?seq=1#metadata_info_tab_contents

63. Facts and figures: Ending violence against women <https://www.unwomen.org/en/what-we-do/ending-violence-against-women/facts-and-figures>

64. UNFPA Arab States Region COVID-19 Situation Report No. 4 June 2020 <https://www.unfpa.org/resources/covid-19-situation-report-no-4-unfpa-arab-states>

65. <https://reliefweb.int/sites/reliefweb.int/files/resources/UNICEF%20MENARO%20COVID-19%20Situation%20Report%20No.11%20-%202021%20October%202020.pdf>

66. <https://www.unicef.org/media/79751/file/MENARO-COVID19-SitRep-30-April-2020.pdf>

67. <https://www.statista.com/topics/6169/coronavirus-covid-19-in-the-middle-east-and-north-africa/>

These data are not sex-disaggregated however; some hypothesis related to women's infection rate could be extrapolated from the key population group's distribution: 8 M pregnant women, 107 M women of reproductive age, 114 M young people (age 10-24) and 21 M older persons (age +65).

In fact, the Middle East and North Africa Region/MENA represents one of the most "favourable" field for such crisis. Indeed, for the Arab States Regional Office of the United Nations Fund for Population Activities/UNFPA-ASRO, the deteriorating socio-economic situation creates further hardship in already fragile situations with more than 62,5 M people in need of assistance before the COVID-19 pandemic. This includes 15,5 M women in reproductive age of whom an estimated 1,5 million pregnant women.⁽⁶⁸⁾

The region is also known to have conservative social norms supported by data and evidence on the impact resulting in gender inequality and prevalence of Violence Against Women and Girls/VAWG, exacerbating multiple risks during the lockdown period. Moreover, because the region is the one with the highest number of conflicts and wars in the world, it is also the one with the highest number of global humanitarian crises.

As reported throughout the world and by the same above source for the Region, the COVID-19 pandemic exacerbated all forms of Violence Against Women because of forced coexistence, community closures, economic stress and crisis "*perceived as real food insecurity and fears to exposure to the virus*". This is underlined by a marked increase in the number of calls to NGO helplines and support services.

Actually, the warning has been issued in the majority of the countries of the region, mainly by the associations without however precise data being available: No precise GBV figures or only few have been reported, but reference to its increase is systematically made. Absence of both accurate GBV data/rates and increase of GBV were reported including from the associations and specialized agencies and joined lately by governmental institutions—such as women mechanisms—or the police. The figures, even if rare, recorded until recently in various countries are alarming however not consolidated at regional level as total or average. Even research, assessment, survey... presented as regional, cover only a specific number of MENA countries.

"Lockdowns and curfew measures are likely to exacerbate the already high rates of domestic violence across the MENA region, not only due to factors such as mounting concerns over job insecurity, cramped living spaces for large families, reduced services and difficulty to report violence in conditions of lockdown, but also to restrictive social norms that see men as heads of household and responsible for the family income. If the crisis prevents men from upholding this role, frustrations may be vented in the form of Violence Against Women and Girls."⁽⁶⁹⁾

68. UNFPA Arab States Region COVID-19 Situation Report No.4 June 2020, <https://www.unfpa.org/resources/covid-19-situation-report-no-4-unfpa-arab-states>

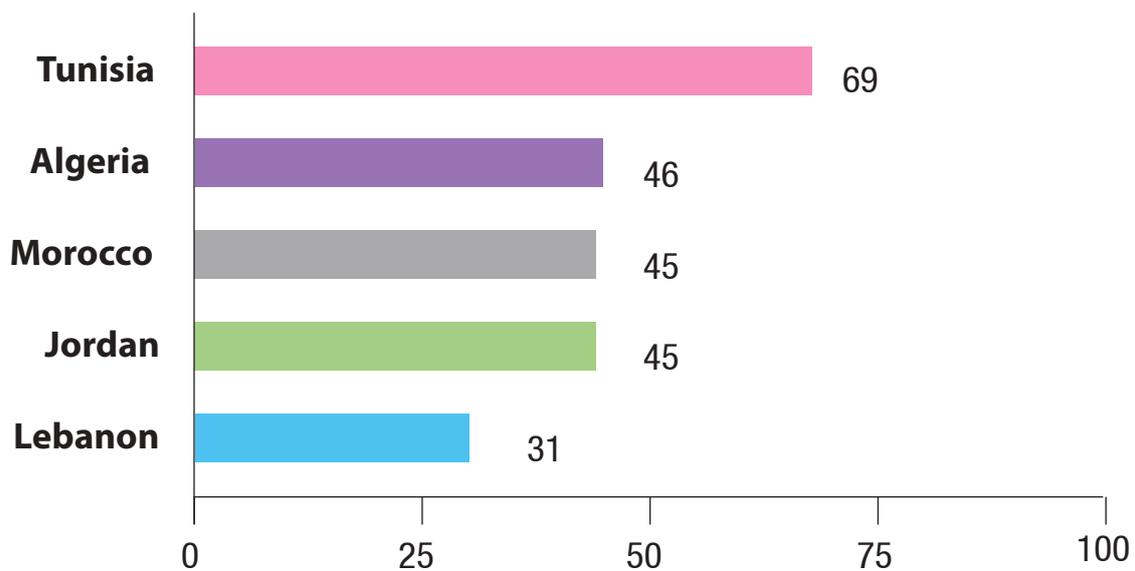
69. OECD Policy Responses to Coronavirus (COVID-19) : COVID-19 crisis in the MENA region: impact on gender equality and policy responses 10 June 2020 <https://www.oecd.org/coronavirus/policy-responses/covid-19-crisis-in-the-mena-region-impact-on-gender-equality-and-policy-responses-ee4cd4f4/#section-d1e115>.

2.3. In the 7 covered countries

Since the emergence of the coronavirus, the region has been able to cope with relatively low morbidity and mortality rates compared to other regions. Almost a year later, the epidemic is accelerating and countries that previously appeared to have some level of control over the pandemic, such as Jordan, Morocco, Lebanon or Tunisia, are experiencing a sharp increase.⁽⁷⁰⁾

This Rapid Assessment is conducted in 7 MENA countries namely Algeria, Egypt, Jordan, Lebanon, Morocco, Palestine and Tunisia. Provision of information for each country or all countries together will depend on the available data as illustrated by the following figures presented by the Arab Barometer.⁽⁷¹⁾

Figure 1 - Gender-Based Violence during COVID-19 Pandemic



ALGERIA

Similarly to the world, the region and other countries, Algeria had to face the consequences of the COVID-19 pandemic and took the necessary measures particularly when the crisis was very high in the beginning or so-called “first wave”. The situation in terms of contamination has calmed down somewhat in recent times (January 2021) but the beginnings have been very difficult. “In most cities in Algeria, a “curfew” had been decreed by the government, a curfew that revives traumas still buried in us from the civil war of the 1990s. Curfew times vary according to the health situation. In Algiers, for example, the population was banned from going out, first from 7pm to 7am, then from 3pm to 7am the next morning and now from 5pm to 7am.”⁽⁷²⁾

70. Arab States Region COVID-19 Situation Report No. 9 (Reporting Period: 1-31 October 2020): Regional Highlights <https://reliefweb.int/report/algeria/arab-states-region-covid-19-situation-report-no-9-reporting-period-1-31-october-2020>
 71. COVID-19 Magnifies Pre-Existing Gender Inequalities in MENA <https://www.arababarameter.org/2020/12/COVID-19-Magnifies-Pre-Existing-Gender-Inequalities-in-MENA-Arab-Barometer>
 72. “Violence against women in times of confinement in Algeria”, 22/05/2020 Corona Blog by Louisa Ait Hamou <https://www.fes-mena.org/blog/e/violences-contre-les-femmes-en-temps-de-confinement-en-algerie/>

Despite all publications in relation with this situation, the country lacks GBV data during the sanitary crisis and related COVID-19 lockdown. One of the reasons and consequences at the same time as stressed by the “Réseau Wassila”⁽⁷³⁾ is because of weak political will in terms of taking urgent measures to protect women and girls, set up appropriate care and prevention mechanisms, on one part and collect data, on the other. Just for instance, the free hotline within the Ministry of Solidarity does not work and the demands of NGOs and feminists for the establishment of a functional green hotline in each wilaya⁽⁷⁴⁾ have not succeeded. The objective conditions of the pandemic and semi-lockdown have blatantly revealed the already existing problems. UNFPA reported increased domestic violence, including women killed by their husbands, that has not translated into more calls to NGOs hotlines services due to the promiscuity during the lockdown and the difficulty to ask for help under such conditions.

During the first nine months of 2019, the General Directorate of National Security/DGSN recorded 7,000 complaints and 5,620 cases of Violence Against Women throughout the country. This included cases of physical violence, intentional assault and battery resulting in death and intentional homicide, in addition to sexual harassment and ill-treatment.⁽⁷⁵⁾ According to the same source, 36 women of all ages, very often mothers of several children, were murdered “...36 families in mourning, devastated, broken children, orphans...”. The statistics of the national press recorded for the same year thirty-nine murders of women—and not 36.

During the first 10 months of the year 2020, and without necessarily linking these facts to the sanitary crisis or the COVID-19 pandemic’s lockdown, the DGSN’s communiqué recorded 5,836 cases of violence. Of the total violence reported, 4,153 cases were physical violence in the form of assault and battery, some of which resulted in death (before and during confinement), and attempted homicides, including 25 femicides. According to Reporters.dz, 36 women were murdered by their husbands, brothers or fathers between January and August 2020.⁽⁷⁶⁾ According to other sources, this figure is well below the truth, since the number of femicides in 2019 is a little more than double, i.e. 75.⁽⁷⁷⁾ Other forms of violence are identified by the DGSN that include sexual violence, sexual harassment, and harassment in the street, on the public highway as well as psychological and verbal violence (mistreatment, insults, neglect) in addition to kidnapping.

Among the 6,185 aggressors, 5,311 of whom are related or in a close relationship with the GBV survivor, the most frequent are the husband (1,679) followed by the brother (418), the son (330), the lovers (152), the fiancé (30) and other family members (994). Contrary to prejudices, the father comes last in the list (29). The 2,553 remaining aggressors are generally foreigners (neighbors, head of department...).

For some associations, these figures are worrisome, representing only the tip of the iceberg, since they refer only to complaints from victims. Many women who are victims of conjugal and domestic violence do not dare to file a complaint because they are not supported in their efforts, discouraged by those around them, sometimes even by the police who remind them that the aggressor is the father of their children, their son or their brother.⁽⁷⁸⁾

73. “Violence against women in times of confinement in Algeria”, 22/05/2020 Corona Blog by Louisa Ait Hamou

74. Governorate

75. Communiqué from the General Directorate of National Security (DGSN) <https://www.aps.dz/societe/98032-plus-de-5-600-cas-de-violence-contre-les-femmes-durant-les-neuf-premier-mois-de-2019>

76. <https://www.reporters.dz/violences-contre-les-femmes-et-femicides-36-femmes-tuees-en-8-mois-en-algerie/>

77. As reported by two initiators of the monitoring project, Narimene Mouaci Bahi et Wiame Awres citées in <https://information.tv5monde.com/terriennes/algerie-artistes-mobilisees-contre-les-femicides-apres-la-mort-de-chaima-380601>

78. “Violence against women in times of confinement in Algeria”, 22/05/2020 Corona Blog by Louisa Ait Hamou <https://www.fes-mena.org/blog/e/violences-contre-les-femmes-en-temps-de-confinement-en-algerie/>, 22/05/2020

EGYPT

Egypt reported the first cases of COVID-19 on February 14, 2020. The measures to contain the outbreak were introduced on March 17, 2020. According to the Egyptian Ministry of Health and Population, in July 2020, 91,072 confirmed cases were registered with a total of 4,518 deaths and 31,970 recovered cases. These data are not sex-disaggregated. However as all over the world, the consequences were devastating in Egypt at the social and economic levels. These were exacerbated by the restriction and the fact that “isolation measures increase the vulnerability to GBV, the unemployment rates of women overloaded women with the burden of reproductive tasks and unpaid care in addition to limiting access to health insurance, information and services.”⁽⁷⁹⁾

In partnership with UN Women, the National Council of Women/NCW initiated a phone survey during the period from April 4 to 14, 2020, to examine the effect of the COVID-19 pandemic on Women and analyse the status quo. Commissioned by the NCW and conducted by the Egyptian Center for Public Opinion Research/Baseera, the poll covered a national representative sample of 1,518 females in the age group 18+. Respondents were accessed through their landlines and mobiles phones during the period 4-14 April, 2020.⁽⁸⁰⁾ As regard to the effect of GBV, only married women were targeted to assess the violence they faced from their husband. 89% of married women declared they had not been exposed to violence in the previous week (i.e. end of March beginning of April 2020) against 11% of married women who had been. Of those who were exposed to violence, 8.1% stated that their husband pushed them, 15.3% that they were hit and 83.4% that they were insulted. The violence among family members i.e. any form of physical violence between spouses or children and parents was also assessed. 19% of respondents noted an increase and 4% a decrease but most of them i.e. 77% considered it remained the same. With regards to the family problems, between spouses or children and parents, for 64% there was no change, 33% considered there was an increase and 3% noted a decrease.

In an aim to assess women needs and develop an appropriate response in Egypt, UN Women published in March 2020 a brief based on the analysis of key gender issues related to the COVID-19 pandemic, distilled from lessons learned from other epidemics.

The basic assumption is that COVID-19 related death affects men more than women either for biological reasons or because of the social construction of masculinity and femininity and corresponding behaviours. In the same manner, the pandemic will have a socio-economic gender-differentiated impact (access to resources such as services, employment, income...) and like all crises, the effects will also increase women’s vulnerabilities and deepen gender inequalities in both public and private spheres. A pandemic magnifies all existing inequalities, class, ability, age and gender (...). Still, its socioeconomic impact will have far-reaching gendered impacts, from exacerbating already unthinkable high levels of Violence Against Women, to stunting women’s engagement in the labour market (...). In short, the pandemic threatens to reverse hard-won gains on gender equality by relegating women back to the domestic sphere, while increasing their vulnerability to violence and exploitation.⁽⁸¹⁾

79. Egypt COVID-19 Response and Recovery interventions of the United Nations in Egypt: People’s stories from the Outbreak of COVID-19 till July 2020 <https://egypt.un.org/en/89430-egypt-covid-19-response-and-recovery-interventions-united-nations-egypt>

80. NCW, UN Women, Baseera: Women and COVID-19 Pandemic <https://www2.unwomen.org/-/media/field%20office%20arab%20states/attachments/publications/2020/05/egypt%20covid-19%20brief/women%20%20covid19%20en.pdf?la=en&vs=1758>

81. Women’s Needs and Gender Equality in Egypt’s COVID-19 Response, 31 March 2020 <https://arabstates.unwomen.org/en/digital-library/publications/2020/04/women-needs-and-gender-equality-in-egypt-covid-19-response#:~>

Yet, specific data on GBV since the beginning of the pandemic have not been produced in this work. In fact, the analysis of the risks and their consequences was based on existing data: “In Egypt, an estimated one in four women was already experiencing domestic violence prior to this pandemic ⁽⁸²⁾ and that number could be expected to increase given survey data that suggests that more than 70% of Egyptian men and women believe that wives should tolerate violence to keep the family together.”⁽⁸³⁾

From then on, assumptions easily verifiable in the field were made to only quote some examples: life conditions of GBV survivors already experiencing or vulnerable to domestic violence will be exacerbated since they found themselves in isolation with their abusers from one part. In addition the economic consequences of the pandemic could also result in a rise not only of domestic violence but also other forms of violence such as sexual exploitation, child and forced marriage and/or trafficking in women and girls.⁽⁸⁴⁾

The NCW established the “Women policy tracker on Responsive Policies and Programs During COVID-19 Pandemic” which is in its fifth edition (January 2021) as an easy tool that can be used as a reference for all women-related policies issued. Its objectives amongst others, are to monitor all issued policies and procedures responsive to the needs of Egyptian women directly and/or indirectly in light of the efforts made to reduce the spread of COVID-19. Documenting coordinated efforts during the COVID-19 outbreak, building more decision makers collaborative & comprehensive vision on means of moving forward are assessed to identify policies either new or up-scaled/expanded that require supporting programs & initiatives.⁽⁸⁵⁾

Just for instance, as regard to GBV, as of June 4, 2020, the National Council for women’s specialized office had totalized 34,000 inquiries and complaints since the start of the outbreak (March 14 to June 4, 2020). The NCW has been promoting the essential service packages for any potential violence against women case since the start of the COVID-19 outbreak. In cooperation with the Ministry of Higher Education and Scientific Research and development partners, launched 3 “Women Safety Units” in the hospitals of Al-Qasr Al-Aini, Mansoura and Ain Shams universities, to deal with women victims of violence, and for that purpose, 190 doctors and nurses were trained. An increase in crimes of Violence Against Women has been observed during the outbreak of the COVID-19: the crime of Female Genital Mutilation (FGM). The National Committee for the eradication of Female Genital Mutilation in Egypt intensified its efforts to spread awareness about this crime and ways to report it and protect against it. Seven hundred eighty-eight on ground activities were held in 2020. Digital campaigns on social media, allowed for the committee’s messages to reach 54 million people.⁽⁸⁶⁾

82. CAPMAS. 2014. Egypt Demographic and Health Survey, quoted in Women’s Needs and Gender Equality in Egypt’s COVID-19 Response, 31 March 2020

83. UN Women & Promundo. 2017. Understanding Masculinities: Results from the International Men and Gender Equality Survey (IMAGES) Middle East and North Africa, quoted in Women’s Needs and Gender Equality in Egypt’s COVID-19 Response, 31 March 2020

84. Women’s Needs and Gender Equality in Egypt’s COVID-19 Response, 31 March 2020 <https://arabstates.unwomen.org/en/digital-library/publications/2020/04/women-needs-and-gender-equality-in-egypt-covid-19-response#:~:>

85. The Fifth edition of the Women Policy Tracker on responsive Policies and Programs During the New COVID-19 Pandemic published in January 2021. <http://ncw.gov.eg/Pdf/476/Fifth-Edition-Women-policy-Tracker-on-Responsive-Policies-and-Programs?fbclid=IwAR1ov54eSG37jYxkchWkQGWTltCvixiTb7kr727KqSSSnJ6upd4lyLu9-eM>

86. Women Policy Tracker on Responsive Policies and Programs during the New COVID-19 Pandemic <http://ncw.gov.eg/Pdf/476/Fifth-Edition-Women-policy-Tracker-on-Responsive-Policies-and-Programs?fbclid=IwAR1ov54eSG37jYxkchWkQGWTltCvixiTb7kr727KqSSSnJ6upd4lyLu9-eM>

JORDAN

A Rapid Assessment was carried out in April 2020 by Plan International in conjunction with the United Nations Population Fund (UNFPA), and the Institute for Family Health/IFH of Noor Al Hussein Foundation in order to measure the impact of COVID-19 in Jordan on GBV and Sexual and Reproductive Health and Rights/SRHR. The study targeted nearly 400 adolescents and adults from five different locations in the country, including adolescent girls (girls 10-17 years old and young women 18-24), Persons with Disabilities/PwD, Syrian refugee camps, as well as service providers (doctors, nurses, midwives, community workers, youth educators) and members of the government. The sample included also adolescent and adult men. “The COVID-19 crisis in Jordan is having a disproportionate impact on girls and young women in the most deprived communities, placing them at greater risk of Gender-Based Violence, making it harder for them to access sexual and reproductive health services, and leaving the vast majority unable to earn an income.”⁽⁸⁷⁾

Among the main findings, 71% of all respondents experience worry related to the pandemic, while adult women in particular reported high levels of worry at 78%. Syrians generally reported higher levels of worry than Jordanians by around 10%, while the refugees of other nationalities (Sudanese, Egyptian, and Gazan) reported very high levels of stress. Palestinians reported the lowest level of concern about the pandemic. 69% of respondents agreed on the GBV prevalence —**particularly domestic violence**—increase during the pandemic and that the types most often perpetrated by an intimate partner or family member are emotional and physical abuse⁽⁸⁸⁾ : “*Many of the girls and women in Jordan’s poorest communities have already endured displacement and conflict. Now the lockdown has severely disrupted their livelihoods and access to support such as family planning services, leaving them with even less control over their lives and bodies than they had before. On top of this, the pressures and stresses of daily life have been magnified, and we know this has led to higher levels of Gender-Based Violence and particularly intimate partner violence.*”⁽⁸⁹⁾

Shame, stigmatization of victims and social pressure continue to be hard barriers to reporting violence, and the restrictions on movement are an additional obstacle. The proportion of women who have no access to family planning at all has increased from 10 to 20% depending on the age group, with women and girls unanimously stating that the pandemic has made access to GBV and SRH services much more difficult, including access to related information. Compared to before the lockdown, this has fallen from 37% to 18%, for 10 – 17-year-old girls. According to the findings of the same study, 90% of women and girls reported not having access to income generating activities or material assistance compared to 74% of men and boys. Only 55% of women were able to meet their family’s basic needs during the curfew compared to 58% of men.⁽⁹⁰⁾

Another study conducted in May 2020, and covering the period sought to assess the extent to which Coronavirus lockdown has exacerbated Domestic Violence in Jordan. Domestic Violence here means violence occurring in the domestic area and affecting “Jordanians” as a whole (men, women children...) and not as a form of VAWG/GBV. 72% of Jordanians among the interviewees thought that curfew measures would certainly increase the rates of Domestic Violence, while in reality only 16% of them reported that there had been an increase in this phenomenon.

87. Daring to Ask, Listen, and Act: A Snapshot of the Impacts of COVID-19 on Women and Girls’ rights and sexual and reproductive health, EU, UNFPA, Institute for Family Health, Plan International, April/May 2020 https://www.planusa.org/docs/COVID-19_And_Gender-Based-Voience_In_Jordan_Report.pdf

88. Idem

89. Declaration of Muna Abbas, Plan International’s Country Director in Jordan

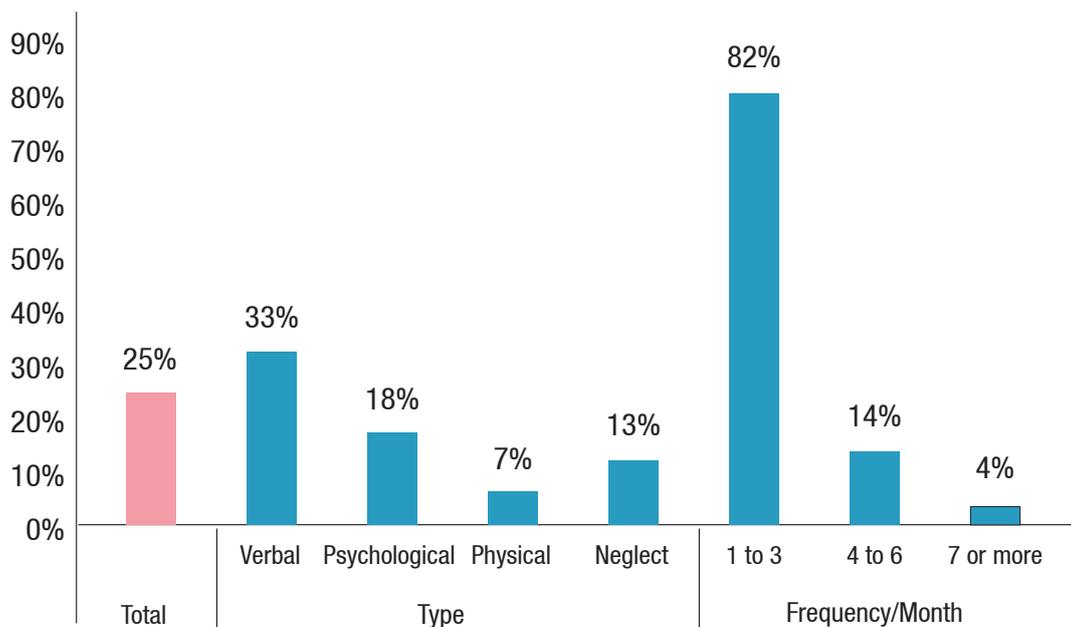
90. Daring to Ask, Listen, and Act: A Snapshot of the Impacts of COVID-19 on Women and Girls’ rights and sexual and reproductive health, EU, UNFPA, Institute for Family Health, Plan International, April/May 2020 https://www.planusa.org/docs/COVID-19_And_Gender-Based-Voience_In_Jordan_Report.pdf

During the mandatory curfew, a total of 35% of Jordanians have been subject to at least one form of domestic abuse with a total of 10% increase avec 58% being victims of abuse by a male family member i.e. father (25%), husband (16.5%), brother (16.5%). 33% were victim of abuse by a female family member namely mother(25%) and sister (8%) and 9% by others.⁽⁹¹⁾

According to the same study, the most prevalent forms of Domestic Violence reported during the survey period i.e. March 21 to April 20-26, 2020, are verbal violence (48%), psychological violence (26%), neglect (17%) and physical abuse (9%).

Comparison of the percentages shows that violent acts occurred 1-3 times among 82% of the domestic abuses prior to the COVID-19 period and decreased to 75% during the pandemic lockdown. This is the only exception since prevalence of all other forms increased.

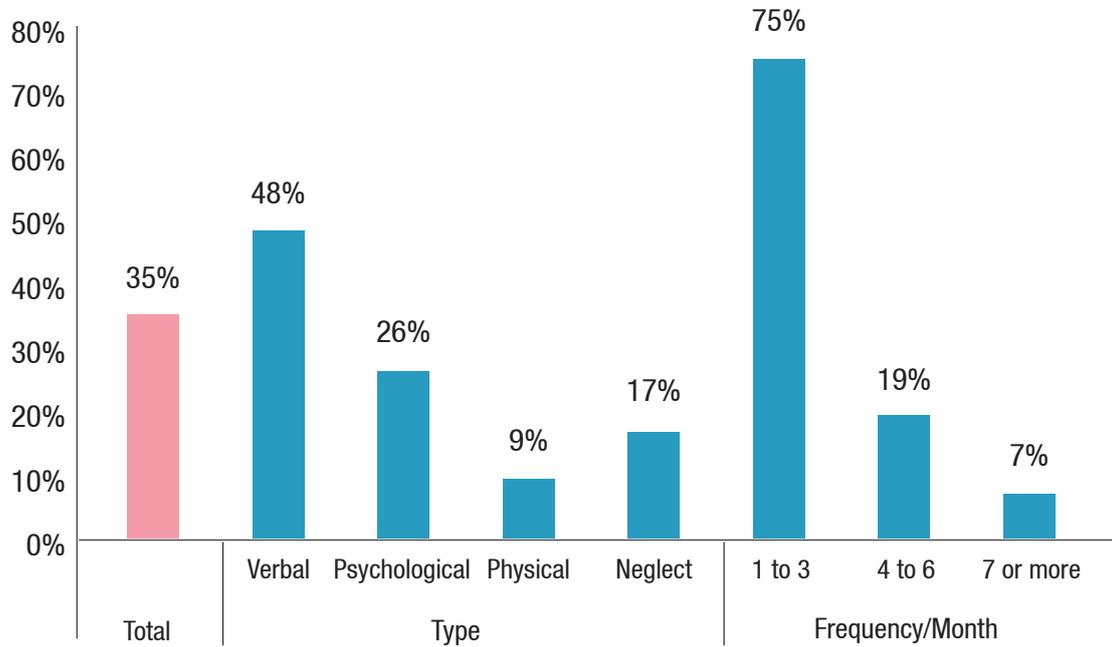
Figure 2 - Domestic Violence prior to COVID-19⁽⁹²⁾



91. Ministry of Foreign Affairs of the Netherlands, Center for Strategic Studies, Women Empowerment 4 Leadership/HIVOS: Coronavirus Lockdown Exacerbating Domestic Violence in Jordan (Results and indicators), Jordan's Barometer: The Pulse of Jordanian Street , May 2020 <https://womeninleadership.hivos.org/assets/2020/05/Domestic-Violence-in-Jordan-Covid-19.English.pdf>

92. Idem

Figure 3 - Domestic Violence during the COVID-19 lockdown⁽⁹³⁾



According to the Family Protection Department of the Jordanian Police, the reporting of Domestic Violence has seen an increase of 33% during the lockdown. However in another study conducted by Euromed Rights, these numbers do not represent the total reality particularly not all women were able to report during the lockdown either via phone or the internet and/or because of the closure and reduction of working hours of some services such as the helplines or just because women ignore how or where to report Domestic Violence occurrences.⁽⁹⁴⁾

Jordanian Civil Society Organisations/CSOs estimated that the above-mentioned “33% increase” represents only 20% of the overall increase in violence during the lockdown. Highlighting the under-reporting of numbers “women have faced an increased risk of domestic violence during the lockdown, which added to the pre-existing barriers in reporting.”⁽⁹⁵⁾ Indeed, the Ministry of Social Development has a social protection line, which received 1,700 Gender-Based Violence cases during the lockdown. Many other governmental and non-governmental agencies run 24/7 phone and online services, have a Facebook page and a WhatsApp number for complaints with a referral system... Yet, the level of awareness on these numbers is quite low.⁽⁹⁶⁾

93. Ministry of Foreign Affairs of the Netherlands, Center for Strategic Studies, Women Empowerment 4 Leadership/HIVOS: Coronavirus Lockdown Exacerbating Domestic Violence in Jordan (Results and indicators), Jordan’s Barometer: The Pulse of Jordanian Street , May 2020 <https://womeninleadership.hivos.org/assets/2020/05/Domestic-Violence-in-Jordan-Covid-19.English.pdf>

94. Idem

95. COVID-19 and the Increase In Domestic Violence Against Women: Cases of Jordan, Italy, Morocco and Tunisia, <https://euromedrights.org/wp-content/uploads/2020/07/Domestic-violence-amid-COVID19-EuroMed-Rights.pdf> April May 2020

96. Idem

Lebanon

In line with emerging global trends, Lebanon's COVID-19 case load indicates a male bias in fatality (69% men vs. 31% women) and infection rates (57% men vs. 43% women). 548 cumulative cases identified (47% women vs. 53% men), 48 health care workers infected (60% women vs. 40% men) and 19 deaths (79% men vs. 21% women).⁽⁹⁷⁾

UNFPA, UN Women, WHO, and the SGBV task force launched the Gender Alert on COVID-19 in Lebanon highlighting “the disproportionate impact of GBV against women and girls during lockdown and an increase in documented cases of cyberbullying, economic violence, and violence against LGBTI persons and migrant domestic workers.”⁽⁹⁸⁾

2020 showed that the COVID-19 lockdown has contributed to an increase in different forms of GBV. On August 4, 2020, the situation was exacerbated by the Beirut explosion which made women and girls more vulnerable to such shocks, increased the risk of violence for them, with an even more limited access to basic services and needs.⁽⁹⁹⁾ Ján Kubiš, the UN Special Coordinator for Lebanon declared “irrespective of all good intentions and hard work for gender equality and women's rights including their political, economic, social and cultural aspects, violence against women and girls in Lebanon not only persists, but risks and occurrences have become even higher in the debilitating context of the compounded crises and the Covid-19 pandemic. Only too often they are first to suffer both at home and in the public sphere from physical and psychological violence, pressure and coercion, with little recourse to protection, accountability, justice and help.”⁽¹⁰⁰⁾

Data collection undertaken by the Inter-Agency SGBV task Force in Lebanon was conducted between April 10 and 24, 2020 using specialized teams of case workers and psychosocial support staff working with a number of agencies and NGOs having an extensive experience with SGBV survivors in Lebanon. A total of 562 individuals with 91% women and 9% girls, disaggregated by nationality (75% of Syrians, 23% of Lebanese and 2% other nationalities) who had previously accessed SGBV services in Lebanon, at least once. Three areas were assessed: 1) Awareness of COVID-19, key information channels, and usefulness of the shared COVID-19 information; 2) Impact of COVID-19 on SGBV patterns and risks; and 3) Access to SGBV and non-SGBV services and related challenges.⁽¹⁰¹⁾

54% of Women and girls who were asked if they have observed any increase of SGBV incidents in their household or community indicate that they had indeed observed an increase of harassment, violence or abuse against other women and girls in the household or the community. The most prevalent types of violence observed by interviewees were emotional abuse (79%), physical violence (55%), and denial of resources (53%), followed by sexual violence (32%), discrimination (31%), threat of deportation or eviction (15%), and child marriage (4%). In terms of locations of violence, interviewees responded that the increase in violence occurred mostly in homes (85%), public places such as streets and neighbourhoods (39%) and markets (21%), followed by public transportation (8%), ATMs (6%), hospitals (4%), and social media on the phones (1%).⁽¹⁰²⁾

97. Official MoPH and WHO Lebanon data, April 8, 2020 quoted in Gender Alert on COVID-19 Lebanon, in focus : Access to Justice and Gender Based-Violence, April, 10, 2020, Issue No 1 <https://www2.unwomen.org/-/media/field%20office%20arab%20states/attachments/publications/2020/04/gender%20and%20covid-19%20in%20lebanon/updated/gender%20alert%20on%20covidlebanon%20english.pdf?la=en&vs=1838>

98. UNFPA Arab States Region COVID-19 Situation Report No. 4 June 2020 <https://www.unfpa.org/resources/covid-19-situation-report-no-4-unfpa-arab-states>

99. The UN, NCLW and the Sexual and Gender-Based Violence Taskforce launch 16-day campaign against gender-based violence [EN/AR] <https://reliefweb.int/report/lebanon/un-nclw-and-sexual-and-gender-based-violence-taskforce-launch-16-day-campaign-against>

100. Idem

101. Impact of COVID-19 on the SGBV Situation in Lebanon, Inter-Agency SGBV Task Force Lebanon, May 2020 <https://data2.unhcr.org/en/documents/details/76729>

102. Idem

Moreover, one in three respondents (33%) reported difficulties in receiving services remotely, due to their limited access to communication means (16%), feeling unsafe talking on the phone (15%), and denial of access to communication means by their partners or family members (2%).

Figure 4 - Increase of the SGBV in the household/community

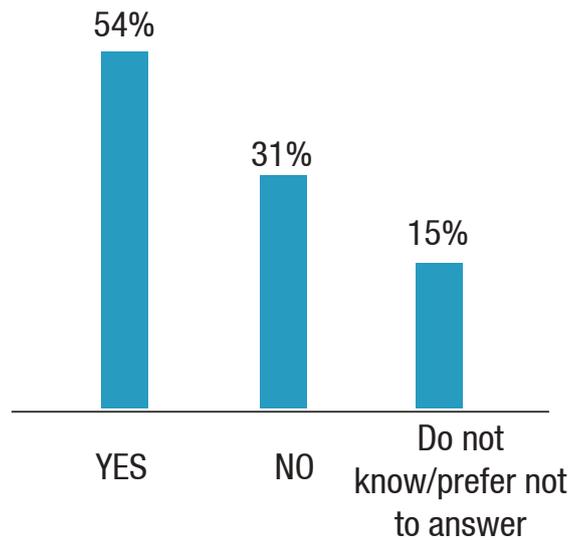
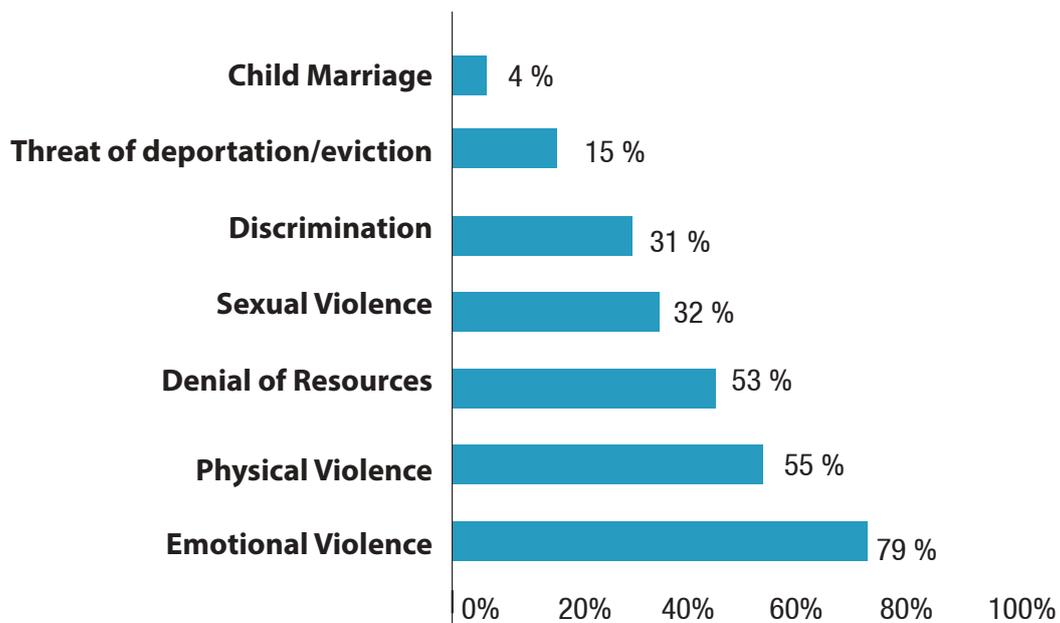


Figure 5 - Most prevalent types of Violence since the COVID-19 outbreak



MOROCCO

Morocco is considered to be one of the most advanced countries in the region in terms of availability of data on violence to rate only the two national GBV prevalence surveys conducted at 10-year intervals (2009-2019). The 2nd National Survey on Violence Against Women was conducted in 2019 by the Haut Commissariat au Plan/HCP.⁽¹⁰³⁾ If a general downward trend is observed mainly in urban areas comparatively to the 1st survey conducted in 2009, the figures remain worrying. Indeed, among 13.4 million women aged 15 to 74, more than 7.6 million have suffered at least one act of violence, in all contexts and forms, in the twelve months preceding the survey, representing 57% of the female population. The prevalence of violence against women is 58% in urban areas (5.1 million women) and 55% in rural areas (2.5 million rural women). Economic violence has risen from 8% ten years ago to 15%, and sexual violence from 9% to 14%. Overall, Moroccan women and men feel that Violence Against Women has increased (73% of women and 55% of men).

Even though everyone agrees in all surveyed publications that rates have been increasing, Morocco is also one of the countries in the region with the least data on GBV occurrence during COVID-19 lockdown, whether official, from CSOs or international agencies. This is the case for all assessed publications to only quote those initiated by EuroMed Rights NETWORK, UNFPA—Country and Arab States Regional offices—, UN-Volunteers/UNV, USAID, Care and many others.

Just for instance, in a study conducted by EuroMed Rights in Morocco, both NGOs and government institutions declared that “(...) reports and information they have been gathering across the territory, a greater number of calls and 3 testimonies from victims of Violence Against Women was witnessed... Domestic Violence has significantly increased during the lockdown period.”⁽¹⁰⁴⁾ Reference is made to the increase in the number of calls registered both at the level of the central administration and in local sections but without facts and figures. The CSOs involved in this study considered that the “government and institutions have overlooked the risk of increased domestic violence during the lockdown (...) [and] remained silent on the issue for the great majority of the lockdown period, despite repeated demands from associations dealing with Violence Against Women and Gender-Based Violence to speak up.”⁽¹⁰⁵⁾

According to a Rapid Gender Analysis of the state of women made by CARE-Morocco,⁽¹⁰⁶⁾ during the COVID-19 outbreak, women faced barriers to access to GBV services hindered by the lack of availability of services during that time especially since national authorities and specialized departments were reacting only to COVID-19 related emergencies. The police, for example, were involved in maintaining containment and public order more than during normal times and the courts had suspended their activities except for emergency situations. “For a society full of sexist perceptions, GBV is not an emergency.”⁽¹⁰⁷⁾ In fact, the main analysis findings came directly from field observations concerning the situation of women after the spread of COVID-19 and its impact on their daily lives. To fill the gaps and meet GBV survivors’ needs, various initiatives were taken by the CSOs to ensure their access to psychological support (list of centres) and the communication means (telephone + communication credit + network coverage, translation from the Amazigh to Arabic Language).

103. The national survey on violence against women and society’s perceptions of such violence 2019, HCP, Morocco.

104. COVID-19 and the Increase In Domestic Violence Against Women: Cases of Jordan, Italy, Morocco and Tunisia, <https://euomedrights.org/wp-content/uploads/2020/07/Domestic-violence-amid-COVID19-EuroMed-Rights.pdf>

105. Idem

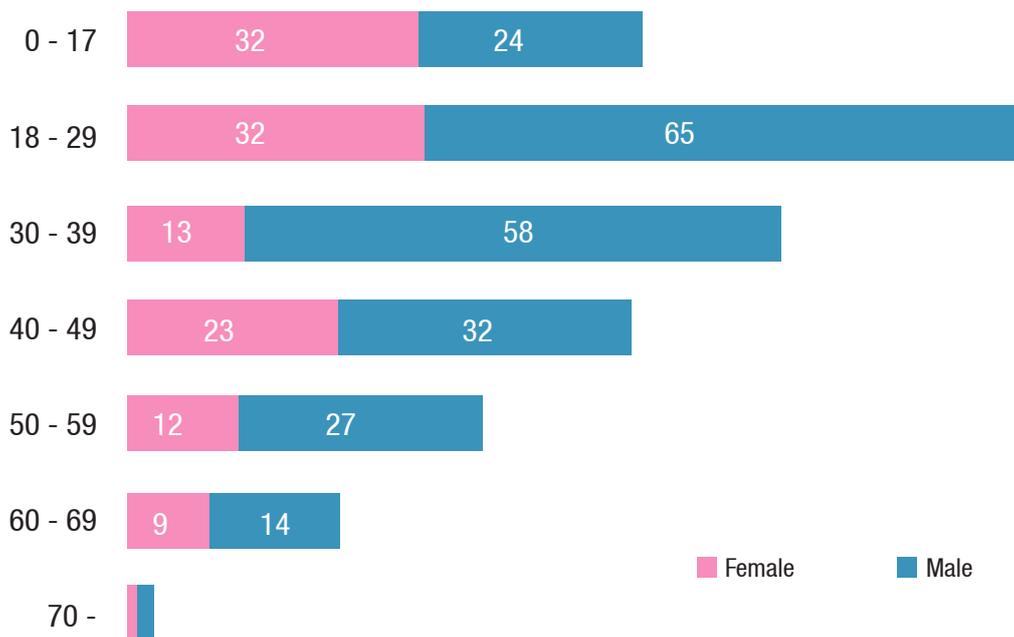
106. Morocco Rapid Gender Analysis: The State of Women, Morocco, and COVID, CARE <https://careevaluations.org/wp-content/uploads/Rapid-gender-analysis-CARE-Morocco.pdf>

107. <https://leconomiste.com/article/1060397-violence-contre-les-femmes-une-scene-en-direct> quoted in Morocco Rapid Gender Analysis: The State of Women, Morocco, and COVID, CARE <https://careevaluations.org/wp-content/uploads/Rapid-gender-analysis-CARE-Morocco.pdf>

PALESTINE

As of April 26, 2020, there were 495 confirmed cases of COVID-19 in Palestine - 325 in the West Bank, 153 in East Jerusalem and 17 in Gaza.⁽¹⁰⁸⁾ According to the Palestinian Ministry of Health/MoH records, as of April 26, 2020, there were 342 confirmed cases of COVID-19 with 221 male (64.6%) and 121 female (35.4%) in the West Bank and Gaza Strip (excluding East Jerusalem).⁽¹⁰⁹⁾

Figure 6 - Palestinians confirmed to have COVID-19 by age group and sex



Among the infected cases, 64.4% are males and 35.4% are females. According to the age distribution, the highest rate is in the 18-50 age group at 63%, followed by those over 50 years of age at 20% and 17% for those under 18 years of age.

In Gaza, as of April 25, 2020, a total of 1,971 people were staying at quarantine facilities; 57.2% (1,123) are males and 42.8% (848) are females.⁽¹¹⁰⁾

The emergency state was announced on March 5, 2020, followed by lockdown measures across the whole Territory, aggravated by a “Palestinian capacity for emergency response significantly reduced by the Israeli occupation, intra-Palestinian strife and a dire economic situation.”⁽¹¹¹⁾ The COVID-19 lockdown represents an even more urgent case in Gaza because of the collective population vulnerability due to the protraction of an Israeli-imposed blockade, the regular closure of the Egypt-controlled Rafah crossing, and Palestinian Authority punitive measures.

108. UN Women: COVID-19: Gendered Impacts of the Pandemic in Palestine and Implications for Policy and Programming Findings of a Rapid Gender Analysis of COVID-19 in Palestine, April 2020 <https://arabstates.unwomen.org/en/digital-library/publications/2020/05/covid-19-gendered-impacts-of-the-pandemic-in-palestine>

109. Palestinian Ministry of Health quoted in <https://www.ochaopt.org/content/how-covid-19-measures-affect-women-girls-men-and-boys-differently>

110. <http://www.moh.gov.ps/portal/wp-content/uploads/2020/04/Corona-Eng.-25-4.pdf>

111. <https://arabstates.unwomen.org/en/digital-library/publications/2020/05/covid-19-gendered-impacts-of-the-pandemic-in-palestine>

Restrictions and policies against Palestinians have no limits⁽¹¹²⁾ and endless consequences. Indeed, the already existing restriction of movements in Palestine with special situation of Gaza were aggravated by the lockdown measures reinforcing isolation of women and girls with increased pressure, Domestic Violence and other GBV forms.

The United Nations Office for the Coordination of Humanitarian Affairs/UNOCHA expected an increase of Domestic Violence due to the declaration of an emergency and the restriction on movement, from one part, and household tension and violence due to the confinement of people in their homes.⁽¹¹³⁾

Violence Against Women in Palestine has been on the rise for the past decade. According to a 2011 survey by the Palestinian Central Bureau of statistics, 37% of women have suffered Gender-Based Violence in Palestine. In Gaza, 51% of women are victims of violence.

In Israel's Palestinian communities, women face similar challenges. According to a 2019 Jerusalem Post report by Emily Schrader and Muhammad Zoabi, "50% of the victims of GBV in Israel are Arab women. These figures are starkly alarming because Israel's Arab community only accounts for 20% of Israel's population. Arab women in the community are disproportionately affected by GBV."⁽¹¹⁴⁾

"[There are] women, who suffer violence on a daily basis, be it physical, sexual, economic, political or psychological violence because they are in lockdown with their abusers under the same roof (...). It is also due, in big part, to the fact that the lockdown has created unemployment and an economic crisis that has increased the level of anxiety and stress among people, and this is something that is being exorcised in the form of violence by men towards women in their households."⁽¹¹⁵⁾

The Palestinian Working Women Society alone reported more than 510 calls for GBV complaints in less than two weeks. Similarly, SAWA,⁽¹¹⁶⁾ another women's organisation, has reported a 10% increase in calls and three cases of suicide attempts. At the same time, restrictions on movements and services prevent women and girls from accessing essential services, including health, protection, security and justice.⁽¹¹⁷⁾

In Palestine, in many cases, Domestic Violence escalates to murder. According to the Women's Center for Legal Aid and Counseling in Jerusalem, 23 women were killed at the hands of family members in the West Bank and Gaza in 2018 alone.⁽¹¹⁸⁾ *"Femicide and violence against women, issues that have plagued Palestinian society for decades, are now becoming more pronounced. Eleven women have been reported killed since the beginning of 2020, six out of whom were murdered in coronavirus lockdown."*⁽¹¹⁹⁾

112. Crisis expected to create and exacerbate gender-specific risks and vulnerabilities: How COVID-19 measures affect women, girls, men and boys differently Adapted from a text included in the Revised COVID-19 Response Plan published on 25 April, Posted on 4 May 2020, <https://www.ochaopt.org/content/how-covid-19-measures-affect-women-girls-men-and-boys-differently>

113. How COVID-19 measures affect women, girls, men and boys differently <https://www.ochaopt.org/content/how-covid-19-measures-affect-women-girls-men-and-boys-differently> Posted on 4 May 2020, Adapted from a text included in the Revised COVID-19 Response Plan published on 25 April 2020

114. Niveen Ghoneim, Domestic Violence in COVID-19 Lockdown: Palestinian Women Are Dying at an Alarming Rate, April 24, 2020 <https://egyptianstreets.com/2020/04/24/domestic-violence-in-covid-19-lockdown-palestinian-women-are-dying-at-an-alarming-rate/>

115. An interviewee in <https://egyptianstreets.com/2020/04/24/domestic-violence-in-covid-19-lockdown-palestinian-women-are-dying-at-an-alarming-rate/>

116. SAWA means together and its motto is "All the women together, today and tomorrow"

117. UN Women: COVID-19: Gendered Impacts of the Pandemic in Palestine and Implications for Policy and Programming Findings of a Rapid Gender Analysis of COVID-19 in Palestine, April 2020 <https://arabstates.unwomen.org/en/digital-library/publications/2020/05/covid-19-gendered-impacts-of-the-pandemic-in-palestine>

118. Quoted in Domestic Violence in COVID-19 Lockdown: Palestinian Women Are Dying at an Alarming Rate, by Niveen Ghoneim, April 24, 2020 <https://egyptianstreets.com/2020/04/24/domestic-violence-in-covid-19-lockdown-palestinian-women-are-dying-at-an-alarming-rate/>

119. Shatha Shiekh Yousef, Palestinian women's rights activist spokesperson of Tal3at, an intersectional feminist movement quoted in Domestic Violence in COVID-19 Lockdown: Palestinian Women Are Dying at an Alarming Rate, by Niveen Ghoneim, April 24, 2020 <https://egyptianstreets.com/2020/04/24/domestic-violence-in-covid-19-lockdown-palestinian-women-are-dying-at-an-alarming-rate/>

The Women's Center for Legal Aid and Counselling/WCLAC conducted a gender assessment⁽¹²⁰⁾ between March 5 –May 31 finding that Palestinian women had to deal, as ever, with the impact of the International Humanitarian Law/IHL violations and the occupation of Israeli Military forces as well as the already prevailing Gender-Based discrimination and violence within society. The COVID-19 exacerbated “all structural inequalities even further” with effects on GBV prevalence and severity as well as difficulty to access support and protection services based on direct observations or testimonials of researchers, social workers or women themselves collected by WCLAC. During the assessed period, 670 women have contacted WCLAC Service and Community Empowerment Unit, requesting psychosocial or legal support. The number of calls to the GBV helpline maintained a similar level throughout the lockdown period, with one clear spike in mid-April. Out of the total number of calls, a majority of concerns related to deprivation of social and economic rights.

The preliminary data of its Rapid Gender Analysis as well as surveys and meetings UN Women had with more than 30 women-led organizations and woman leaders in the West Bank and Gaza, showcased that the pandemic is expected to disproportionately affect women, create and exacerbate pre-existing gender-specific risks and vulnerabilities and widen inequalities.⁽¹²¹⁾ “Under the current COVID-19 crisis, gender inequalities are not only increasing, but roles of women, girls, men and boys are also shifting and creating new dynamics which are being shaped by a series of overlapping economic, social and political factors.”⁽¹²²⁾

The general COVID-19 lockdown as many other similar situations (conflicts, natural disaster, emergency situation including those caused by sanitary crises) affects women, girls, men and boys, but differently. The barrier measures reinforced gender construction of society, unbalanced distribution of roles and power. Confined in their home which becomes a sort of “man-land”, the multiple roles and tasks of women are exacerbated. According to the findings of the UN Women Rapid Gender Analysis, women's household chores have increased for 68% of women compared to 44% for men. Similarly childcare has increased for 52% of women and only 30% of men. Even for the office work at home, women do more (48%) than men (34%). At the emotional and psychological level, 82% of women report higher levels of stress comparatively to 71% of men. 68% of women feel higher level of anger with people close to them compared to 53% of men.⁽¹²³⁾

The Occupational Safety and Health Administration⁽¹²⁴⁾ /OSHA-OPT conducted an analysis on how the COVID-19 crisis is affecting women and girls, men and boys. Among other results, the analysis showed that women and girls who are already under strict control over their movements, access to resources and general rights, the lock-in and lockdown due to the health crisis of COVID-19 could be accompanied by a resurgence of concepts such as “keeping women indoors for their protection” at the household and community level and negatively affecting their psycho-social status.

120. WCLAC's assessment report on COVID-19 and Women's rights in Palestine, for the COVID-19 period, March 5th to May 31st.

121. UN Women: COVID-19: Gendered Impacts of the Pandemic in Palestine and Implications for Policy and Programming Findings of a Rapid Gender Analysis of COVID-19 in Palestine, April 2020 <https://arabstates.unwomen.org/en/digital-library/publications/2020/05/covid-19-gendered-impacts-of-the-pandemic-in-palestine>

122. Crisis expected to create and exacerbate gender-specific risks and vulnerabilities: How COVID-19 measures affect women, girls, men and boys differently Adapted from a text included in the Revised COVID-19 Response Plan published on 25 April, Posted on 4 May 2020, <https://www.ochaopt.org/content/how-covid-19-measures-affect-women-girls-men-and-boys-differently>

123. UN Women: COVID-19: Gendered Impacts of the Pandemic in Palestine and Implications for Policy and Programming Findings of a Rapid Gender Analysis of COVID-19 in Palestine, April 2020 <https://arabstates.unwomen.org/en/digital-library/publications/2020/05/covid-19-gendered-impacts-of-the-pandemic-in-palestine>

124. of the United States Department of Labor

At the same time, their responsibility for maintaining the cleanliness of the household, increasing their burden as primary domestic caregivers and holding them accountable for any misfortunes that occur within the family (...) infection of household members, especially children may cast negative blame against female caregivers generally which may result in stigma.⁽¹²⁵⁾

With such tension, the restriction on movement and the confinement in homes, an increase is expected in Domestic Violence in addition to the psycho-social challenges and violence that was already present. This assumption was confirmed by hotlines experiencing increased physical violence complaints.⁽¹²⁶⁾

This situation also prevents women from accessing essential services. This includes women's access to reliable information on COVID-19, which was lacking for marginalized or vulnerable groups—including refugees, the elderly, and pregnant and lactating women—as well as health and reproductive health services. “Palestinian women who are pregnant or new mothers are at increased risk of not being able to access proper healthcare, especially with the current lockdown measures and the severe reduction in medical referrals to hospitals in Jerusalem and Israel.”⁽¹²⁷⁾ Provision of services to GBV survivors including health, protection, security and justice also folded to the COVID-19 lockdown constraints; negatively impacting more vulnerable groups—and their families—with higher risk of deteriorating health to only quote the immunocompromised, the chronic illnesses, and the elderly who are already considered as burdens in the community.⁽¹²⁸⁾

In terms of access to services, the recently enacted state of emergency comes with added risk for Palestinian women. With the court system operating reduced capacity women locked-in and down with violent family members or spouses see the threat of litigation as a deterrent for perpetrators of violence against women, vanish. In Israel's Palestinian communities, women are doubly discriminated, as women and as Palestinians.⁽¹²⁹⁾ If they turn to Israeli police to report incidents of violence, harassment or sexual assault, they are blackmailed and the complaints dismissed. They find themselves less protected from the country's law enforcement. “*In murder cases against Arab women, the state [of Israel] has only a 20% success rate in holding the perpetrators accountable.*”⁽¹³⁰⁾

The UNDP Briefing Note on “The economic impacts of COVID-19 and Gender Inequality recommendations for Policy Makers”⁽¹³¹⁾ seeks to ensure the response to the COVID-19 emergency will be gender responsive and thus guaranteeing no one is left behind. To support policy makers, three interlinked policy areas UNDP have been identified: 1) Health system strengthening, including procurement and supply chain; 2) inclusive and multisectoral crisis management and response and 3) Social and economic impact: Assessment and response. The Briefing Note, quoted here only as an example, seeks to guarantee the integration of Gender Equality and women's empowerment in the three inter-linked support areas.

125. Crisis expected to create and exacerbate gender-specific risks and vulnerabilities: How COVID-19 measures affect women, girls, men and boys differently Adapted from a text included in the Revised COVID-19 Response Plan published on 25 April, Posted on 4 May 2020, <https://www.ochaopt.org/content/how-covid-19-measures-affect-women-girls-men-and-boys-differently>

126. Idem

127. Idem

128. Idem

129. Niveen Ghoneim, Domestic Violence in COVID-19 Lockdown: Palestinian Women Are Dying at an Alarming Rate, April 24, 2020 <https://egyptianstreets.com/2020/04/24/domestic-violence-in-covid-19-lockdown-palestinian-women-are-dying-at-an-alarming-rate/>

130. The 2019 Jerusalem Post report by Emily Schrader and Muhammad Zoabiin <https://egyptianstreets.com/2020/04/24/domestic-violence-in-covid-19-lockdown-palestinian-women-are-dying-at-an-alarming-rate/>

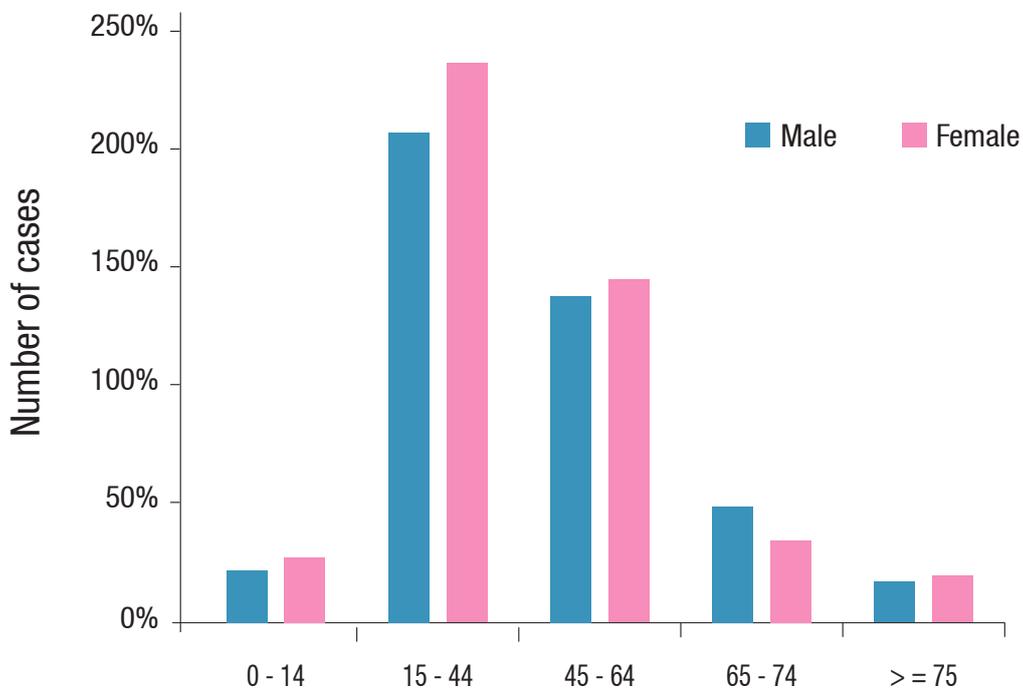
131. UNDP, The economic impacts of COVID-19 and Gender Inequality recommendations for Policy Makers (Briefing Note, Apr 6, 2020) prepared by the UNDP Gender Area for Latin America and the Caribbean in collaborations with other agencies and partners https://www.latinamerica.undp.org/content/rblac/en/home/library/womens_empowerment/los-impactos-economicos-del-covid-19-y-las-desigualdades-de-gene.html

In fact, policy papers were published and plethora of declarations made but no concrete resolution was even discussed by the UN-Security Council that seemed to be paralyzed despite several attempts (March, April and May 2020) to try to provide a multilateral response to the COVID-19 pandemic. The reason is mainly due to the divergent positions at the time, with each member was dealing with in its own territory. As a matter of fact, if consensus was successfully built on how to address Gender issues and GBV in conflict or to mainstream them in humanitarian response, except the case of HIV-Aids, Gender integration including GBV is somewhat weak when related to sanitary crises.⁽¹³²⁾

TUNISIA

As many other agencies and organizations (bi- and multi-lateral cooperation), UN WOMEN Country-Office conducted a rapid review of the impact of the recent pandemic of COVID-19 in Tunisia during the period March-April 2020, focusing on issues related to Gender-Based Violence/GBV, access to justice, women and health, and women’s leadership and political participation. The challenges identified and the proposed recommendations were published in a Policy Brief.⁽¹³³⁾ Among others, it indicates that at the beginning of the COVID-19 pandemic (March-April 2020),⁽¹³⁴⁾ 934 confirmed cases of COVID-19 were registered on April 24, 2020, with almost an equal number of infected men and women. However the mortality rate is almost three times higher for men with a sex ratio M/F of 3.22⁽¹³⁵⁾ confirming the female biological advantage of life expectancy.

Figure 7 - Gender/age group breakdown of COVID-19 cases ⁽¹³⁶⁾



132. VAWG Helpdesk Research Report, UKAid <http://www.sddirect.org.uk/media/1881/vawg-helpdesk-284-covid-19-and-vawg.pdf>

133. UN WOMEN, Gender and crisis of COVID-19 in Tunisia: Challenges and recommendations, Policy Brief (March-April 2020) <https://arabstates.unwomen.org/en/digital-library/publications/2020/05/brief-gender-and-crisis-of-covid-19-in-tunisia>

134. Gender and Crisis of COVID-19 in Tunisia: challenges and recommendations, <https://arabstates.unwomen.org/en/digital-library/publications/2020/05/brief-gender-and-crisis-of-covid-19-in-tunisia>

135. National Observatory of New and Emerging Diseases ONMNE <https://covid-19.localbeta.ovh/uploads/img/46.pdf> quoted in UN Women: Gender and Crisis of COVID-19 in Tunisia: challenges and recommendations, <https://arabstates.unwomen.org/en/digital-library/publications/2020/05/brief-gender-and-crisis-of-covid-19-in-tunisia>

136. Idem

The same source highlights that the assistance unit of the Ministry of Public Health dedicated to managing the psychological impact of the Covid-19 crisis during the lockdown period received between March 30 and April 20, 2020 a total number of 2,111 calls. 60,1% of these calls were made by women (1,269 calls) and 39,8% by men (841 calls). The complaints focused mainly on stress and anxiety. Among the total number, 1,781 persons called for themselves, 162 for their child and 168 for another family member.⁽¹³⁷⁾ According to other sources, the Psychological Assistance Centre/CAP for which 200 psychiatrists and psychologists volunteered to provide remote assistance, there were thousands of calls (e.g. between March 30 and April 28: 60,000 calls) out of which 61.1% were from women.⁽¹³⁸⁾

Already worrying in Tunisia, the rate of Violence Against Women⁽¹³⁹⁾ has increased alarmingly since the beginning of the lockdown: 68% according to the Arab Barometer (see the above Figure 7). According to the data of the Tunisian Ministry of Women, Family, Children and Seniors cited in “Tunisia in the face of COVID-19”,⁽¹⁴⁰⁾ Violence Against Women, which usually affects one woman in two at the time, would have been multiplied by 9 during the lockdown.

For the Network of Tunisian women parliamentarians and civil society campaign for gender-sensitive COVID-19 response “despite its modest COVID case count and progressive legislation concerning GBV that preceded the pandemic, Tunisia has seen a dramatic increase in Domestic Violence throughout the confinement period. During the first six weeks of the crisis, the number of official reports of Domestic Violence increased by a factor of seven to 6,693 cases.”⁽¹⁴¹⁾

Assessing the extent of the VAW increase especially Domestic Violence since the beginning and during the COVID-19 pandemic lockdown, the association Beyti⁽¹⁴²⁾ registered an increase of 31 cases of Domestic Violence and inter-partner violence as compared to 2019. 90,58% of the 85 women registered declared to be unemployed and without income. 5,88% declared to have interrupted their education and 3,52% declared to be working in the business sector.⁽¹⁴³⁾

Other data were confirmed through the daily testimonies of associations on the group #EnaZeda.⁽¹⁴⁴⁾ In fact, the toll-free number “1899”, dedicated to reporting VAW cases, has recorded, until May 3, 2020, 6,693 calls, according to the statistics registered during the total lockdown period.⁽¹⁴⁵⁾ According to the Ministry of Women Affairs’ data, as of May 3, 2020 and since the beginning of the lockdown: the breakdown of the 6,693 calls were recorded on the 1899 hotline, was: 1,347 for physical violence; 1,462 for psychological violence; 329 for sexual violence; 763 for economic violence; 15 for institutional violence and 1,624 for verbal violence. 448 reports were made by and regarding Violence Against Children and 38 reports by senior citizens regarding Violence Against the Elderly.⁽¹⁴⁶⁾

137. UN Women Gender and Crisis of COVID-19 in Tunisia: challenges and recommendations, <https://arabstates.unwomen.org/en/digital-library/publications/2020/05/brief-gender-and-crisis-of-covid-19-in-tunisia>

138. Hamadi Redissi and others La Tunisie à l'épreuve du COVID-19 Observatoire Tunisien de la Transition Démocratique; Friedrich-Ebert-Stiftung <http://library.fes.de/pdf-files/bueros/tunesien/16394.pdf>

139. 47.6% according to the national survey conducted by the ONFP

140. Hamadi Redissi and others La Tunisie à l'épreuve du COVID-19 Observatoire Tunisien de la Transition Démocratique; Friedrich-Ebert-Stiftung <http://library.fes.de/pdf-files/bueros/tunesien/16394.pdf>

141. Ahlem Ben Yahia (Program Officer) and Andrew Blunt (Project Assistant), Network of Tunisian women parliamentarians and civil society campaign for gender-sensitive COVID-19 response. <https://www.ndi.org/our-stories/network-tunisian-women-parliamentarians-and-civil-society-campaign-gender-sensitive>, NDI's Middle East and North Africa

142. My home

143. COVID-19 and the Increase In Domestic Violence Against Women: Cases of Jordan, Italy, Morocco and Tunisia <https://Euro Med rights.org/wp-content/uploads/2020/07/Domestic-violence-amid-COVID19-Euro Med -Rights.pdf>

144. Me too

145. Webinar (Aswat Nissa, AFTURD et AFC) : Les obstacles que les femmes victimes de violence rencontrent depuis le début du confinement <https://jamaity.org/event/webinar-les-obstacles-que-les-femmes-victimes-de-violence-rencontrent-depuis-le-debut-du-confinement/>

146. COVID-19 and the Increase In Domestic Violence Against Women: Cases of Jordan, Italy, Morocco and Tunisia <https://Euro Med rights.org/wp-content/uploads/2020/07/Domestic-violence-amid-COVID19-Euro Med -Rights.pdf>

As in other countries, in Tunisia, the COVID-19 crisis and the subsequent lockdowns further exposed women to more violence as well as exposed them to additional concerns given the absence of adequate mechanisms to ensure their access to health, security and protection services. As in most other countries, all public services were devoted mainly to the COVID-19 emergency situation and the consequences of lockdown measures (limitation of movements, closing of internal and external borders, curfew...). For instance, three weeks after the start of the epidemic in Tunisia, abandonment of support to front-line structures was noted, including maternal and neonatal health consultations and contraception and abortion services, aggravated by the closure of certain centres of the Office National de la Famille et la Population/ONFP.

The survey conducted by the Tawhida Ben Cheikh Group and the Tunisian Association of Midwives/ ATSF in collaboration with UNFPA highlights that “curfews and widespread lockdown, as well as fear of contamination, create additional difficulties for women, particularly during childbirth or in accessing reproductive health emergencies. The risk of an increase in home births and clandestine abortions, with the complications that can result, is real.”⁽¹⁴⁷⁾

The Tawhida Ben Cheikh Group and the Tunisian Association of Midwives rung the alarm on several dangers threatening women’s health, such as the increase in Domestic Violence and in maternal morbidity and mortality, consequences of the non-availability of pregnancy monitoring, the non-identification of at-risk pregnancies, as well as the use of unsafe abortions for women who do not wish to carry their pregnancies to term. “The Covid-19 pandemic has highlighted the deterioration of sexual and reproductive health in Tunisia. But the rise of conservatism also explains certain difficulties.”⁽¹⁴⁸⁾

Thus, during confinement, 10% of Tunisian women gave birth at home, much more than the usual 0.1%. The survey reveals a drop in activity felt in all the centres, whether they are located in governorate capital cities or outside. 50% of the respondent midwives (87) estimate that there has been a drop in activity of more than 60%. 37% report a total interruption of Family Planning activities compared to only 15% for whom the level of activities has remained unchanged. For instance, only 40% of the centres located in the cities and 50% of those located outside the governorate capitals have maintained their activities.

This decrease was observed both at family planning centres (1 centre out of 10 kept its normal level of activity, 8 saw its activity reduced and 1 closed), and at basic centres (5/18 (or 27%) kept normal activity, 11 saw their activity reduced (61.1%) and 2 centres closed). The situation in the Maternal and Child Protection/MCP centres is almost the same (3 having maintained their activity, 8 having seen the pace of their activities decrease and 3 MCPs closed). The same applies to regional and district hospitals, almost a third of which have reduced their activities.

147. Les sages-femmes et les activités de la santé sexuelle et reproductive durant l'épidémie COVID-19 en Tunisie Résultats d'une enquête auprès de 126 sages-femmes Groupe Tawhida Ben Cheikh et l'Association Tunisienne des Sages-femmes, en collaboration avec UNFPA, Tunisie <http://groupe-tawhida.com/DocumentsPublics/Publications/Enquete-les-Sage-Femmes-Covid-et-SSR.pdf>

148. Idem

As regard to access to justice, The Tunisian Minister declared on March 15,⁽¹⁴⁹⁾ that proceedings in all courts will be suspended the day after except in cases of “emergency” or “necessity”. An advocacy campaign was organised asking the Ministry of Justice and the National Council of Magistracy to intervene urgently to enable women victims of violence to have access to justice and in particular family judges to obtain protective measures and alimony.⁽¹⁵⁰⁾

During her meeting with the Network of Tunisian women parliamentarians, the Minister of Women, Children and Seniors revealed a series of measures to support GBV survivors such as among others the creation of temporary shelter of emergency to house women and youth victims of Domestic Violence, the launch of the 24/7 Help Line, and the development of an interactive online platform that will offer psychological support and counseling services to children and families.⁽¹⁵¹⁾ Ms. Asma Shiri, Minister of Women, Family, Children and Seniors announced that the national green line 1899 operational 24/24 and 7/7 days since early March had recorded a fivefold increase in calls received.⁽¹⁵²⁾

There were some initiatives in the country as to use some places to sheltering women in some centres (usually opened for children but closed due to the lockdown) but these centres regained their function once containment was lifted and cases were found to be increasing once again. Women faced difficulties of access to resources and services because of curfews, paralysis of transportation... to only quote access to health and to justice. Indeed proceedings in all courts were suspended except “emergency or necessity” which jeopardized their protection, not to say their survival.

After the “trial and error” of the beginning, a period of hesitation on the different measures to take to stop the pandemic, the Tunisian government reacted fairly quickly by setting-up a support and care system for women victims of violence through a special COVID-19 number (1809). This number was an addition to the existing number 1899. The Tunisian government, in partnership with civil society, has also set up a “confinement” centre for women victims of violence during the COVID-19 lockdown. On May 5, 2020, the Minister of Women’s Affairs presented the following statistics:⁽¹⁵³⁾

Since the beginning of the lockdown:

- 6,693 calls were recorded on the 1899 hotline, including:
 - 1,347 for physical violence
 - 1,462 for psychological violence
 - 329 for sexual violence
 - 763 for economic violence
 - 15 for institutional violence
 - 1,624 for verbal violence.
- 448 reports were made by and regarding violence against children and 38 reports by senior citizens regarding violence against the elderly.

149. Press release of the Ministry of Justice, May 15th, 2020

150. Hamadi Redissi and others La Tunisie à l'épreuve du COVID-19 Observatoire Tunisien de la Transition Démocratique; Friedrich-Ebert-Stiftung <http://library.fes.de/pdf-files/bueros/tunesien/16394.pdf>

151. <https://www.ndi.org/our-stories/network-tunisian-women-parliamentarians-and-civil-society-campaign-gender-sensitive>

152. Crise de la COVID-19 et violences faites aux femmes dans le gouvernorat du KEF Prises au piège du confinement Mars-Avril 2020, Instance régionale de coordination pour la lutte contre les violences faites aux femmes –Kef- Tunisie

153. COVID-19 and the Increase In Domestic Violence Against Women: Cases of Jordan, Italy, Morocco and Tunisia <https://Euro-Med-rights.org/wp-content/uploads/2020/07/Domestic-violence-amid-COVID19-Euro-Med-Rights.pdf>

THE LEGAL FRAMEWORKS & POLITICAL COMMITMENT IN THE MENA REGION

1. The national legal frameworks

A brief analysis of the laws is made to highlight main trends based on a gender and human rights sensitive reading.

1.1. Non-discrimination and equality in national constitutions

- Equality and non-discrimination, including based on sex to gender: Algeria, Egypt, Jordan, Iraq and Morocco,
- Equality between citizens, people, and individuals: Egypt, Kuwait, Lebanon and Morocco,
- Equality with clear specification to Male and Female citizens: Egypt and Morocco,
- Equality under conditions: Saudi Arabia,
- Emphasis on man-woman equality: Algeria, Egypt, Iraq, Morocco and Tunisia,
- Equality with a focus on women's rights and positive discrimination: Algeria, Egypt, Morocco and Tunisia,
- Violence Against Women was mentioned in the constitution: Tunisia, Algeria, Egypt...

1.2. Relying on international and regional human rights frameworks for legislation on Violence Against Women

The basis of laws against Violence Against Women and Girls is the principles of equality and non-discrimination as stated in the Constitution and a number of other laws. However, there are also legal texts (criminal laws, nationality laws, family laws) that establish discrimination and violence (child marriage: legal, legitimate or exceptional...). There are provisions related to Violence Against Women and Girls in the criminal, civil and administrative laws of most countries. However, they are often insufficient due to limitations in definitions, scope, treatment and implementation.

1.3. The GBV legal framework

In most countries, VAWG provisions are often found in criminal, civil and/or administrative laws. Most of them are inadequate and insufficient due to limitations in definitions, dimensions, complaint procedures, evidence, remedies and enforcement. Many more in other countries, perpetuate and/or reinforce discrimination and violence.

Comprehensive legislation to prevent, combat and punish all forms of VAWG is an essential first step to end impunity. In most Arab countries, there are no laws dedicated to dealing with Violence Against Women/Domestic Violence except for some of them namely: Jordan (2008), Kurdistan-Iraq (2011), Saudi Arabia (2013), Lebanon (2014), Algeria (2015), Tunisia (2017), Morocco (2018) and Kuwait (2020).

1.4. National legal frameworks to prosecute sexual violence in conflict situations

Only two countries have recognized sexual violence committed during periods of terrorism (Algeria and Libya) of the “liberation revolution” (Libya). Both countries guaranteed health, psychological and social care and set compensation for victims of sexual violence, as per the Decree 99-47 granting compensation in favor of persons who are victims of terrorism, issued on February 13, 1999, as amended by Executive Decree No. 14-26 of 2014 (Algeria) and the Cabinet Decision No. 119 / of 2014 regarding treatment of the situation of victims of sexual violence (Libya).

1.5. National strategies to combat Violence Against Women in peace and conflict situations (UNSCR1325)

The League of Arab States adopted a regional plan of action in the context of the Agenda 2030 with focus on the SDG5 including GBV as well as a strategy to operationalize the United Nations Security Council/UNSCR 1325 in the more affected region by conflicts. At the level of countries:

- In peace situations: Algeria, Bahrain, Egypt, Iraq, Morocco, Palestine and Tunisia.
- In conflict situations: Algeria, Iraq, Jordan, Lebanon, Palestine and Tunisia.

2. The international Framework and standards

GBV/VAWG has been called “the most pervasive and least recognized human rights abuse in the world. It covers a range of injustices from sexual abuse to systematic rape and from prenatal sex selection to female genital mutilation.”⁽¹⁵⁴⁾

This constitute the basis on which the International Conference on Human Rights (Vienna, 1993), the International Conference on Population and Development/ICPD (Cairo, 1994), the Fourth World Conference on Women (Beijing, 1995) gave priority to this issue, that threatens the lives, bodies, psychological integrity and freedom of women.⁽¹⁵⁵⁾ Later on, these issues were integrated into the Development framework to quote the Millennium Declaration and the Millennium Development Goals/MDGs (2000) as well as the Agenda 2030 and the Sustainable Development Goals/MDGs (2015).

As part of its reform in the mid-2000s, the United Nations even introduced a Human Rights approach to programming in the context of its development assistance,⁽¹⁵⁶⁾ with a view to supporting its partners in the operationalisation of their international commitments (Conventions and International Conferences).

154. Human Rights Conference, Vienna, 1993

155. Ending Widespread Violence Against Women: UNFPA 2007, <https://www.unfpa.org/resources/ending-violence-against-women>

156. See also “ Questions fréquentes pour une coopération pour le développement fondée sur les droits de l’homme <https://unsdg.un.org/sites/default/files/FAQfr.pdf>

2.1. Overall positions

The international commitments on Equality of the members of the League of Arab States/LAS are compliant with their engagements at regional level “Each State party to the present Charter undertakes to ensure that every individual located within its territory and subject to its jurisdiction, shall have the right to enjoy all the rights and freedoms recognised in this [Charter], without distinction on the basis of race, colour sex, language, religion, political opinion, national or social origin, wealth, birth or other status, and without any discrimination between men and women. (Part Two, Article 2).”⁽¹⁵⁷⁾

Most Arab countries have ratified the most important relevant treaties and conventions, including CEDAW (except Sudan) with or without reservations (Djibouti, Morocco, and Tunisia) and the Optional Protocol (Libya, Morocco, and Tunisia). For Egypt, Tunisia, Morocco and Algeria, the ratified conventions prevail over the national law cited in the constitution or in any other law. Any framework of application (decree/executive regulation) and legal reference before the courts, to the point of adopting the definition of Gender-Based Violence (1993): Iraqi Kurdistan, Tunisia, Morocco.

2.2. Analysis and trends

Arab States obligations to international conventions and agreements concerning gender equality in international law range from ratification to reservations that render it null and void. As a matter of fact, with variations from one country to another, it can be said that Arab States have not hesitated to ratify a large number of international human rights conventions and treaties, and thus to adhere to the prohibition of all forms of racial, sexual and ethnic discrimination, including those targeted at specific groups (children, women, migrants and persons with disabilities), specific rights (labour, education, economic & political participation (...)) or specific violations (violence, torture, cruel treatment, trafficking and exploitation of human beings...), in addition to the ratification of a number of optional protocols, even though it is not the rule.

States’ compliance with the principles of equality, equity and women’s empowerment and the progress made in the implementation of the conventions were analysed, in particular with regard to their inclusion in national legislation or their translation into concrete actions and a reality enjoyed by citizens —men and women—in general, and women in particular.

Thus, despite the diverse contexts of the countries in the region, there are a number of common factors among them. These include their commitment to all areas of rights—and the specific groups of rights stipulated therein—but also reservations on certain fundamental principles or articles. Moreover, the failure to translate international commitments into national commitments, even when there are no reservations, is obvious for most countries, whether these commitments concern public or private life.

157. Arab Charter on Human Rights, September 15, 1994 <https://www.refworld.org/docid/3ae6b38540.html>

Indeed, the fluctuations in the position of Arab countries can be summarized as follows and for the same country, there may be:

- a. Reservation on the issue of gender equality in one convention without reference to this reservation in another convention;
- b. Reservations on the issue of gender equality that contradict even the constitutional texts and legal provisions of the country;
- c. Reservations that contradict what the Constitution stipulates in terms of consolidating the status of conventions as higher and superior to national laws, which can be interpreted as a reservation to the Constitution itself;
- d. Often the removal of the reservation is officially announced after a legal reform when this removal loses its meaning and becomes irrelevant due to the national legal reform. However, maintaining other reservations could jeopardize this reform, such as enshrining equality thanks to transmitting nationality to children, lifting the reservation on the relevant article of CEDAW, while maintaining reservations on articles 15 and 16 which concern equality;
- e. Announcing the lifting of all reservations to specific articles and provisions, while maintaining the general reservation, which is considered a reservation to the Convention as a whole;
- f. Establishing national mechanisms for human rights, gender equality and women's empowerment but without a clear mandate or resources to do so;
- g. Develop policies, strategies, programmes and setting up services without any concrete commitment, in particular financial commitment for their implementation;
- h. Adopting the international monitoring and evaluation system that consists mainly of presenting the requested periodic national reports on the status of women and women's rights, and their submission to the relevant international treaty bodies (General Assembly, Council or commissions), but with no real accountability or follow-up to their recommendations.

2.3. Health Crisis and Violence Against Women in International Law

While there is global consensus on how issues related to women and Gender-Based Violence in conflict are addressed or integrated into the humanitarian response, gender mainstreaming, including violence, is considered somewhat weak in relation to the health crisis.

Indeed, with the exception of the Security Council resolution 1983 (2011) which provides specific guidance on the health consequences of HIV/AIDS on the health of peacekeepers, on stability and security or resolution 2177 (2014) on the Ebola epidemic in Africa and its implications for the maintenance of international peace and security, there is no international framework for dealing with a health crisis such as that caused by the pandemic that is gender-sensitive.

In fact, despite the capabilities, mandates and experience of international organizations in addressing critical and dangerous situations in different contexts, including the adoption of restrictive measures globally, regionally or at national level, they were not able to foresee this situation, let alone adapt to it, due to the "gender blindness" of the proposed response.

In conclusion, there are contradictions, not to say conflicts, within national legal and legislative systems, starting with the constitution. A constitution may contain articles—and therefore principles—that are mutually opposed, or between the constitution and other laws, whether equivalent or not, especially those governing public life, such as social, economic and political rights regulating the right to education, health and employment, on the one hand, and those governing private life within the family, behind closed doors, on the other; and finally between national legal and legislative systems and the international obligations and parameters ratified by the country not without counting difficulties in addressing causes and consequences of such sanitary crisis and its impact on the vulnerable, particularly women and girls.

PART I-2: THE METHODOLOGY & TOOLS

The methodology could be summarized as follows:

- A desk review to take stock, assess and analyse data, statistics, information and any kind of literature as well as any related initiative; measures taken by both governmental and non-governmental organizations at national, regional and/or international on the circumstances and consequences of GBV before, during and after the lockdown period.
- A Rapid assessment/poll on the same topic and with the same objectives targeting women (GBV survivors or not) directly or through the specialized associations and centres, NGOs and other GBV service providers, women mechanisms and ministries of health.
- Virtual convenings: one for consultation and information and the other to discuss the preliminary findings and select priorities and recommendations and the other to present results.

RESEARCH METHODS

1. Quantitative and qualitative research and analysis

Quantitative research and/or assessment refer to the quantitative collection of data that can be analyzed using quantitative methods, i.e. numbers, percentages, etc. The use of quantitative methods allows data collection to produce quantifiable results to focus on issues that can be counted, such as: school enrollment rates for girls and boys, percentages of girls in different levels of education (primary to tertiary), infant mortality rates, maternal mortality and morbidity rates (MMM), contraceptive prevalence, GBV prevalence, female and male rates e.g. parliamentarians, wage, etc.

Qualitative analysis and/or assessment focuses on understanding how people make sense of their experiences, their environment or the world.⁽¹⁵⁸⁾ It is narrow in scope, applicable to specific situations and experiences, and not designed to be generalized to broader situations. Qualitative assessment is the examination of non-measurable data (i.e., attitudes, behaviors, images, feelings, etc.).

2. Desk Review: Definition and Objective

2.1. Definition

Documentary review means a study, survey, etc. that does not require fieldwork (interviews, meetings, experiments, etc.). It is essentially the study of existing documentation including available quantitative and/or qualitative data. It refers to the evaluation of existing documentation to make an informed decision. However, the literature research is not limited to data collection. The researcher's role as a user of the literature search is to study the results of previous research to gain a broader understanding of the field in relation to his or her area of interest.

158. Patton, M.Q. (2002). *Qualitative research and evaluation methods*. Thousand Oaks, CA: Sage. quoted in *Quantitative and Qualitative and Assessment Methods* <https://tomprof.stanford.edu/posting/1199>

2.2. Objective of the desk review and analysis

The desk review and analysis aim to provide knowledge to CAWTAR and its partners on the impact of Gender-Based Violence (GBV survivors or not) during the COVID-19 lockdown targeting Women through a sample and/or GBV NGOs, shelters... and other GBV service provision, women mechanisms, ministries of health and any other concerned stakeholders.

Bibliographic research intends to enrich the research and study of the produced literature as a whole and to inform on the relevance, accuracy, and quality of the sources cited or not cited. The bibliography will consist of a list of references, accompanied by electronic copies of the documents used.

2.3. Desk Review: The process

Based on the proposed TORs and with support and coordination with CAWTAR project's team leader, the consultant/researcher will have to undertake the following:

1. Assess/Finalize the list of data collection sources to ensure complete and comprehensive information & knowledge,
2. Complete the list of documents and related references to prepare the detailed bibliography,
3. Conduct the desk review exercise to assess and analyze the content of listed documents (available quantitative data, research, report, survey, policy briefs/papers, strategies and any other related pertinent document) related to GBV during the COVID-19 lockdown period in the MENA region and elsewhere, if any,
4. Organize the overall quantitative and qualitative data and information, to set up a GBV diagnosis during the lockdown,
5. Finalize analysis, synthesis of the findings,
6. Define the challenges and way forward by categorizing the findings stemming from the review, with a summary of conclusions and recommendations that will include :
 - interventions areas by governmental, non-governmental institutions and international organizations,
 - GBV impact on the survivors rights and life,
 - Emergency plans during such period, if any, (e.g. security and legal protection, services, economic income...) using the international references and aspects related to women's status, legal and human rights.

- The corpus of the review and analysis should include various outputs —but not limited to— researches, reports, documented initiatives and interventions, policy papers... on Gender-Based Violence during the COVID-19 lockdown, produced by international and regional organizations & agencies as well as national institutions and associations.
- The presentation of the components/steps of data collection and analysis is not in chronological order and could be carried out in parallel. The process will be initiated to obtain preliminary information to be reviewed during the first technical meeting either face-to-face or virtual.

3. Rapid Assessment Process/RAP: definition & framework

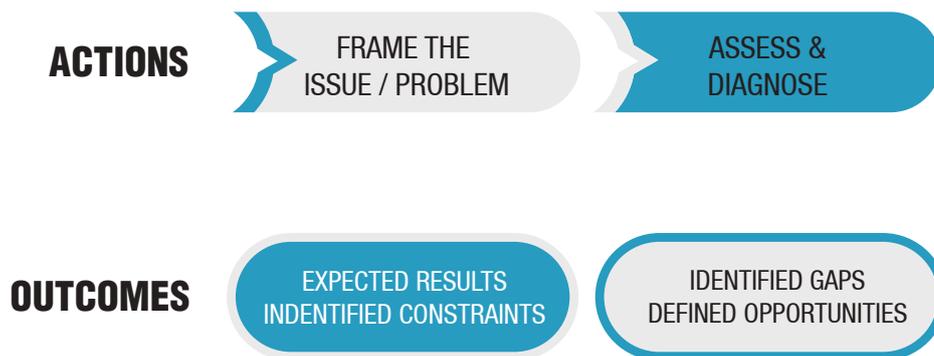
3.1. Definition

RAP is a process and a way to investigate complicated situations, where issues are not well defined and where there is not sufficient time or other resources for long term, traditional qualitative research.⁽¹⁵⁹⁾ RAP is defined as intensive; team-based qualitative inquiry on a case study approach using multiple techniques for data collection, iterative data analysis and additional data collection to quickly develop a preliminary understanding of a situation from the insider's perspective.⁽¹⁶⁰⁾

3.2. The Framework

RAP is also called Rapid Assessment, Analysis and Action Planning/ RAAAP as illustrated in the herewith framework.⁽¹⁶¹⁾

Figure 8 - RAP Framework



4. Rapid Assessment Process/RAP: the proposed tools

4.1. The RAP tool: the questionnaire

Interviews and questionnaires are instruments used to collect data in survey research. They typically include a series of standardized questions that explore a specific topic and collect demographic, opinion, attitude and behavioral information. Three popular programs that allow creation online surveys are Google Forms, Survey Monkey, and Poll Everywhere...

The working steps are detailed as follows:

1. Determining the Survey Topic. What – Who – Where – How?
2. Developing the Survey Questions. The survey questions should serve to answer the main research question.
3. Determining the Survey Method.
4. Training Personnel in Conducting the Survey.
5. Analysing the Results.

159. <https://www.slideshare.net/JamesBeebe/rapid-assessment-process-1st-edition>

160. <https://methods.sagepub.com/reference/sage-encyc-qualitative-research-methods/n365.xml>

161. http://nextforge.com/?page_id=427

4.2. The telephone interview

The telephone is a medium that allows speaking and establishing a relationship by suppressing the physical presence of the interlocutor, and his/her gaze. The time devoted to a telephone conversation with a trained interlocutor is a time “out of the loop”, an in-between between the public sphere in which everyone is integrated and the private sphere where existential difficulties are prevalent.⁽¹⁶²⁾ This is even truer in themes such as those chosen for this research.

Whatever the techniques used in telephone interviews, the various trends are inspired from the theories of the helping relationship, communication, psychology and psychoanalysis. Listeners often have a practice enriched by these different approaches. They draw from one or the other depending on the audience, the theme, the structure in which they work and the situation evoked by the caller. The missions of the telephone system determine the framework of the practices.⁽¹⁶³⁾

4.3. Tips vs. mistakes⁽¹⁶⁴⁾

Five tips for success	Five mistakes to avoid
<p>Efficacy rhymes with preparation ...</p> <p>Contact details, a reminder with useful information, mastery of the tool (simulation of a telephone interview with a colleague/friend)</p>	<p>Letting yourself be destabilized: motivation & determination</p> <p>Difficulty contacting or arranging the date for the interview</p>
<p>Place and time of call</p> <p>Ensure a quiet place; avoid early and late weekends or meal times</p>	<p>Be unpleasant to the contact person</p> <p>Especially after unsuccessful attempts: risk of final rejection</p>
<p>The first few seconds of the interview</p> <p>are the most important and must be taken care of: Clear, succinct and quick presentation of the interviewer and the subject of the call</p>	<p>Be shy</p> <p>Useless excuses and formulas “I am not disturbing you?”</p>
<p>Valuing oneself without monopolizing the spoken word</p> <p>Ask questions, give arguments and strong points, but be the interviewer not the interviewee</p>	<p>Do something else during the interview</p> <p>e.g. using r mobile phone (Mails, SMS, social networks...) it will be heard on the other end of the phone</p>
<p>Conclude with glory ...</p> <p>Give the opportunity to the respondent to add or ask for something and end with a thank-you and a pep word</p>	<p>Be too familiar</p> <p>Kindness/empathy does not mean friendship/co-courtesy</p>

162. http://nextforge.com/?page_id=427

163. Martine Janner-Raimondi, Questions d'éthique et entretien : une approche philosophique in “ S'exprimer et se faire comprendre ”(2015), pages 27 à 47, <https://www.cairn.info/s-exprimer-et-se-faire-comprendre--9782749248486-page-27.htm#>

164. <https://www.adecco.fr/candidats/entretien-telephonique/>

5. The stakeholder analysis

5.1. Definition and objective

Stakeholder analysis involves several key elements: Identifying the major stakeholders (these can be various levels—local, regional, national), investigating their roles, interests, relative power and desire to participate as well as estimating the extent of cooperation or conflict in the relationships among stakeholders. Stakeholder analysis is a two-step process:

- Identify these stakeholders before the project begins; grouping them according to their levels of participation, interest, and influence in the project; and determining how best to involve and communicate each of these stakeholder groups throughout.
- Assess a system and potential changes to it as they relate to relevant and interested parties. This information is used to assess how the interests of those stakeholders should be addressed in a project plan, policy, program, or other action.

5.2. Target groups, populations and samples

The identification of stakeholders, both rights-holders and duty-bearers, is essential not only for the research per se. Firstly, it is important for the preparation of the field research and analysis of its findings and secondly, for the involvement of the actors of change/power relations as regard to the issue of interest—in this case GBV during the COVID-19 lockdowns—but also or for sensitization, policy dialogue and/or advocacy for change. The step-by-step requires:

- a. Identify different stakeholders involved,
- b. Develop an inventory and analysis of actions undertaken by different sectors in support of survivors of Gender-Based Violence or that could be used to support them.

The overall population target groups in the countries covered by the RAP are proposed as follows:

- Women, GBV survivors or not, involved directly or through other pertinent channels,
- Engaged/specialized NGOs/CSOs in GBV/VAWG as a whole but also working on women's human and legal rights, health, reproductive health...
- Entities in charge of and/or dealing with health, reproductive health, women's human rights and/or gender issues including Gender-Based Violence mainly Ministries of Health (Prevention department, COVID-19 Commission...), Justice, Interior and Women Machineries (Ministry, Commission, Council),
- Service providers and units, both governmental and non-governmental (e.g. legal and psychological counselling, shelters, police unit, specialized court...),
- Institutions/Statistics Office,
- Others...

The sampling will consist of more or less 1,000 key informants and 50-100 for virtual stakeholders' consultation. The proportion will be decided later on after the finalization of the listing.

The final sample will be selected, listed and finalized per country. Its size will be also detailed taking into account the feasibility considering that stakeholders in some countries are less cooperative than others.

5.3. Virtual consultation with Stakeholders

A number of brainstorming sessions and convenings will be organized for different purposes:

- Introduce the activity, structure and objectives of the RAP to refine the objectives and RAP's categories/questions and for further stakeholders discussions. The structure of the group discussions, questions and expected answers, even if adapted to each group, should be relevant to the structure of the RAP (objectives and framework of the interview),
- Present and discuss preliminary findings including proposed recommendations,
- Present final findings and products,
- The number of these virtual convenings will vary.

6. The Interview's Framework

6.1. The questionnaires structure

The interview framework should be structured, finalized and adopted for each category of respondent and organized based on the following scheme associated with what the RAP intends to assess and analyze through the interview/s:

- Important aspects of the biographical information of the respondents such as *sex, age, education, marital status, place and type of residence, occupation field of specialization...*
- The Knowledge, Attitudes, Perceptions, Experiences and Practices/KAPEP of key informants in the 7 covered countries associated with GBV during the COVID-19 lockdown as the main category of the research and all associated subcategories as herewith highlighted and detailed in Questionnaire 1 and Questionnaire 2 (Annexes 1 and 2).

Preliminary Observations:

- A minimum of two questionnaires will be prepared targeting: 1) women, GBV survivors directly or through the CSOs/NGOs and 2) the governmental or non-governmental entities concerned by GBV and COVID-19 during the lockdown.
- In each questionnaire (1 & 2), the duration of the lockdown and any other measure will have to be precised for each covered country. The names of the entities either governmental or non-governmental should be specified for each covered country.

- *Questionnaire 1 targeting women, declared GBV survivors or not, directly responding or through the CSOs/NGOs (ANNEX 1)*

CATEGORY 1: Personal data

Depending on the type or purpose of the survey, questions about personal information can be placed at the beginning. Such situations usually concern a short questionnaire, in which the collection of personal data on gender, age or place of residence is the core of the questionnaire. However, if the information sought is related to sensitive issues as it is the case here, it is preferable to ask these questions at the end of the survey, because the request to provide this data at the beginning, may affect its outcome or change the perception of the further part by the respondents.

CATEGORY 2: Experience of GBV before the COVID-19 lockdown organised in two sub-categories: experience, forms/types

CATEGORY 3: Experience of GBV during the COVID-19 lockdown organised in 4 Sub-categories: GBV experienced or not; GBV perpetrator/s; GBV forms and type women face and GBV forms' concomitance and frequency

CATEGORY 4: Impact of the COVID-19 lockdown: GBV and other rights of women and girls organised in three of sub-categories: Health: physical, mental, reproductive... ; Access to resources (education, economic) and Relationships

CATEGORY 5: Barriers and obstacles during the COVID-19 lockdown aggravating GBV and limiting access to protection organised in 2 Sub-categories: Prevention measures/barriers and Difficulties/obstacles

CATEGORY 6: Knowledge/Information on the available services organised in two subcategories: Governmental services (Ministry of Health, Ministry of justice/courts, Ministry of Interior/police, Women mechanisms) and Civil Society Organizations

CATEGORY 7: Experience of GBV after/since the COVID-19 lockdown organised in 4 Sub-categories: GBV experienced or not; GBV perpetrator/s; GBV forms and type women face and GBV forms' concomitance and frequency

CATEGORY 8: Expectation of women/GBV survivors organised in three subcategories: Overall measures; Prevention, protection and security and Multisectoral services

- *Questionnaire 2 targeting concerned governmental and non-governmental institutions and stakeholders (ANNEX 2)*

CATEGORY 1: Personal data; concerned stakeholders (institutional, individual)

CATEGORY 2: Profiling of the entity organized in four sub-categories: Mandate area of intervention, Target groups and coverage (country), Services provision and Role and contributions (policy, services, others)

CATEGORY 3: Experience of GBV before the COVID-19 lockdown organised in two sub-categories: experience, forms/types, examples of specific interventions on GBV

CATEGORY 4: Experience of GBV during the COVID-19 lockdown organised in 4 Sub-categories: GBV experienced or not; GBV perpetrator/s; GBV forms and type women face and GBV forms' concomitance and frequency

CATEGORY 5: Impact of the COVID-19 lockdown: GBV and other rights of women and girls organised in three of sub-categories: Health: physical, mental, reproductive... ; Access to resources (education, economic) and Relationships

CATEGORY 6: Barriers and obstacles during the COVID-19 lockdown aggravating GBV and limiting access to protection organised in 2 Sub-categories: Prevention measures/barriers and Difficulties/obstacles

CATEGORY 7: Knowledge/Information on the available services organised in two subcategories: From NGOs perspective, from Governmental Institutions perspectives Governmental services (Ministry of Health, Ministry of justice/courts, Ministry of Interior/police, Women mechanisms) and Civil Society Organizations

CATEGORY 8: Experience of GBV after/since the COVID-19 lockdown organised in 4 Sub-categories: GBV experienced or not; GBV perpetrator/s; GBV forms and type women face and GBV forms' concomitance and frequency

CATEGORY 9: Entities' expectations for addressing GBV during a health crisis such as the COVID-19 pandemic organised in three subcategories: Overall measures against the COVID-19 pandemic, Policy/Law/ Programmes and Services by sector (governmental and non-governmental)

6.2. Preparation⁽¹⁶⁵⁾ and duration of the questionnaire: general guidelines

Preparing a list of all the questions well thought-out in advance is an important step in conducting a successful interview. This is especially important during the interview with GBV survivors: it is essential to be prepared on the day of the interview and avoid wasting respondents' time or asking them to repeat their story unnecessarily.

- Take the time to create questions in advance to ensure an effective interview and respect the dignity and comfort of respondents,
- Once the list of questions is ready, they should be placed in a logical order to ensure a natural flow of conversation. However in case of difficulty or resistance, the interviewer can go to another category/question and then come back to it,
- It is important to share the questions with respondents before the day of the interview,
- If the interview is recorded, prior permission must be obtained from the respondent and it must be specified who will have rights to the sound recording, both on the medium and on what is heard.⁽¹⁶⁶⁾

The following guidelines will help in preparing the question structure:

- *What to keep in mind when developing questions*
 1. Create open-ended questions,
 2. Avoid questions they can answer with "yes" or "no": The interview framework is prepared not only because it is a specific/specialized issue in order to help the interviewer but also in case the respondent has difficulties in answering.

A good way to ensure a complete response by respondents is to ask questions that begin with an invitation:

- Please describe your experience...
- Could you tell me about it?
- Explain what was said...

Examples of analysis of results are recommended but not limited to:

- a. Female population aged...to...years by age, civil status and place of residence... (see category 1),
- b. Estimated number of survivors of GBV among sampling of the study/survey,
- c. Identify forms/types of violence and assess prevalence,
- d. Frequency/occurrence of Gender-Based Violence by environment if possible,
- e. Impact of GBV on other rights of women and girls,
- f. Consistency of data with country data, the data collected will be compiled and consolidated at the regional level for comparison.

165. https://github.com/witness/Conducting-Interviews-with-Survivors-of-Gender-Based-Violence/blob/master/EN-SGBVGuide_Markdown_v1_0.md

166. <https://ethiquedroit.hypotheses.org/tag/entretien>

In addition to responding to the hypotheses/assumptions of the survey, the field research should help establish a profile and characteristics of GBV survivors such as: age, civil status, economic activity or not. For status of perpetrators identify whether it occurs in the family space or in the workplace, especially since, referring to the health sector, women have been in greater numbers on the front lines of the fight against the coronavirus pandemic.

- Duration: questionnaire and RAP

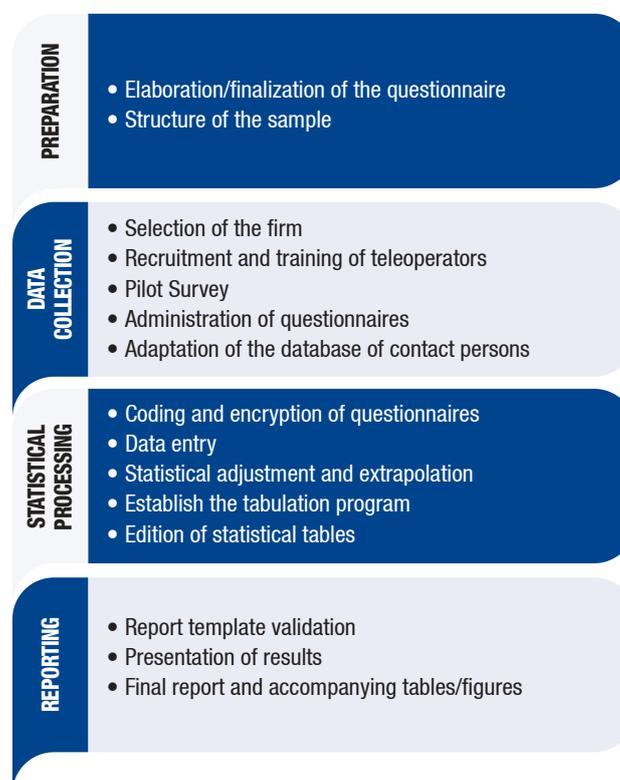
“RAP” is about the necessity to communicate with participants using their vocabulary and rhythm and one definition of “rap” is “to talk freely and frankly.” “Rapid” means a minimum of 4–5 days and, in most situations, a maximum of 6 weeks.⁽¹⁶⁷⁾

In the context of this RAP, a firm and a number of teleoperators will be recruited and trained to fill the questionnaire through telephone calls and collect the required information. The questionnaire duration should not exceed 20-30 mn, to be confirmed with the selected firm, after the testing phase.

7. Technical preparation & operationalization

As referred above, given the purpose and context of this activity, the minimum requirements for the tools to be used are: 1) Bibliographic and documentary research and analysis; 2) a RAP made through a selected sample to collect the needed information organised by phone and through Key Informant Interviews/KII and; 3) a stakeholder analysis through virtual brainstorming meetings.

7.1. The RAP organization and finalization



167. <https://www.sciencedirect.com/topics/medicine-and-dentistry/rapid-assessment#:~:text=The%20acronym%20for%20the%20rapid,a%20maximum%20of%206%20weeks.>

7.2. Expected Deliverables

resulting from the desk review, the RAP and virtual consultations:

1. An assessment report with a platform of recommendations and priority strategic interventions and measures for dissemination and discussion with concerned actors.
 - *A report consisting of an overall introduction and analysis⁽¹⁶⁸⁾ of the content organized from the desk review highlighting the circumstances and consequences of GBV during the lockdown period as well as effects on women and girls including economic effects, with focus on each of the 7 covered countries,⁽¹⁶⁹⁾ if and when possible with all required annexes including a Bibliography/listing of literature review's references (100 to 150 pages max).*
2. A summary of the report (10 pages max) in three languages (Arabic, French, English).
 - Electronic copies of all reviewed documents.

ETHICS: PRINCIPLES & CODE OF CONDUCT

1. The principles

It is essential to take into account the following principles and criteria:

1.1. Individual and social interrelationships

- The boundaries between personality and social dynamics of GBV/VAWG are well defined. This means that GBV/VAWG must, first, be associated with everyday life and refer to the private sphere, even if it occurs in the public sphere.
- Regardless of the GBV form or who is involved, VAWG is always a violation of women's personal and individual integrity and is always based on hegemony.
- For various reasons, measuring VAW is not simple: first, it covers a diverse and complex reality, which needs careful description. Second, it measures something which is not measurable due to its lack of visibility (the culture of silence, the absence of testimonies and complaints, including from the survivors themselves).

1.2. On the side of GBV survivors

An important dimension that has to be taken into consideration when assessing the experience of GBV survivors is “when” the experience of violence occurred. The method of data collection, for example, with a closed questionnaire obliges women to immediately answer “here and now”; therefore, the interviewer should be aware of the following:

- The main problem is associated with memory and its reconstruction, including psychological reconstruction. This mainly involves experienced events that are considered with all sincerity and seriousness.

168. Available Studies, surveys, researches, policy papers/ documents... on GBV during the Covid 19 lockdown and related publications from regional and international organizations.

169. Algeria, Egypt, Jordan, Lebanon, Morocco, Palestine and Tunisia

- This is most likely due to the fact that GBV experiences occurred in the past and were “buried” in the “amnesia of reparation” on the one hand, or only minimized with reference to social norms and tolerance. Therefore trivializing GBV/VAW could be either hidden with a feeling of guilt or shame or simply by denial, on the other hand.
- Very often, the most recent, less dangerous or less serious events can be highlighted to avoid facing experiences that are more serious.

The context of the COVID-19 lockdown, which is a recent past, but at the same time still a present in life, could be a new and interesting variable.

2. Code of conduct

Like any other survey or research, ethical guidelines are necessary and will therefore be developed to be easily applied by the interviewers/teleoperators. They are crucial when they are associated with such sensitive issues. The rules are not different from those associated with research, medical care, psychological counselling or legal assistance. However, before conducting a GBV/VAW research/survey, it is crucial to ensure the following:

CODE OF CONDUCT

- The first rule is to ensure the availability of local services for the care and support of respondents/survivors of violence. If these services are not available in the community or cannot be made available by the research team, the survey/research should not be conducted. In this case at least, 3 associations in each country will have to be identified and their contacts available in case the KI requires such help.
- While all human research protocols require the development of mechanisms to protect the confidentiality and integrity of their research materials. Research on GBV/VAW requires special attention to the potential risk to which GBV survivors (women and girls) are exposed.
- The confidentiality of individuals and the information disclosed at all times and under all circumstances must be protected.
- Informed consent should be given by any person (i.e., responder/interviewee) involved in GBV/VAW research.
- Recordings or photo taking must also be clearly stated and authorization required.
- The data collection team should be carefully selected and trained for this research, and ensure that it receives ongoing support throughout the research process.
- Special safeguards should be put in place on site for anyone under the age of 18 (children as defined by the Convention of the Rights/Child/CRC).
- In documenting GBV/VAW, the potential benefits to respondents or target communities outweigh the potential or real risks. However, information collection and documentation should be carried out with less risk for respondents and the methodology should be reliable, based on current experiences and good practices.
- The safety and security of the research team, the subjects and the research is extremely important and should guide all research decisions. This is particularly true in case of face to face interviews.

3. Preparation of the questionnaire: ethical guidelines

3.1. Challenges in recording incidents of GBV in general and in times of crisis

In this specific and sensitive context, attention should be paid to challenging issues and more particularly:

- Violations against women are diverse but are considered normal, tolerated, justified, not a priority and remain unreported;
- Women are afraid to disclose these violations;
- Medical reports deal with physical health rather than GBV in its various aspects and;
- For many reasons, women hide the real causes of their injuries whatever they are, such as the fear of stigmatization, humiliation or reprisals...

Yet, it is often observed that the woman herself wishes to share her story and requires from counsellors a guaranteed confidentiality; she also wants to ensure that the GBV perpetrator (peer, colleague, intimate partner and/or family members) is not prosecuted, at least at this stage or context.

3.2. Ask questions ethically

- Avoid directly or indirectly blaming the GBV survivor for her experience or suggesting that she could have avoided, prevented or resisted the incident;
- Avoid offensive, harsh or humiliating language;
- Do not intentionally ask questions intending to provoke an emotional response from the respondent or reveal something that she would like to keep private;
- In questions and approach, avoid reinforcing incorrect perceptions about GBV, i.e. that survivors are to be blamed for acts committed against them or that GBV is inevitable.

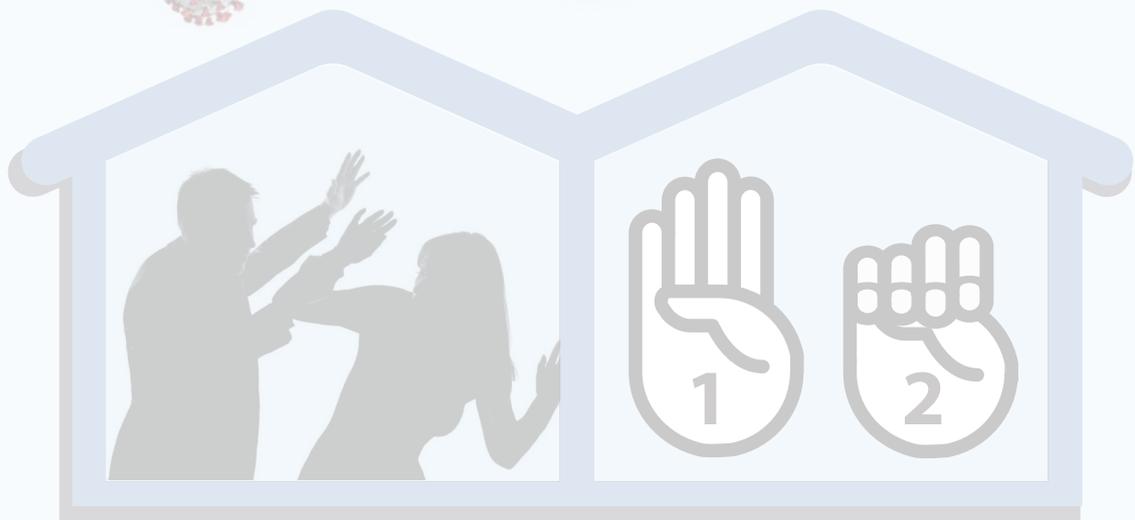
3.3. Ir/relevance of the questions

Impertinent questions:
<ul style="list-style-type: none">• What were you wearing on the night you have undergone GBV (in case, type/form of GBV is specified)• Why weren't you accompanied? (e.g. in case the violence occurs in a public space)• How is it possible that you do not know the identity of the GBV perpetrator against you? (depending on each case, type/form of GBV)
Relevant questions
Tell me about the events leading up to the assault? <ul style="list-style-type: none">• What did you do after the attack?• What are your hopes for the future? ...

3.4. Be aware of the choice of words

The words you use are important:

- Be specific, however, taking into account that some respondents may be unaware of or dislike using certain words (e.g. sexual harassment, abuse, assault, rape...).
- Work with the respondent to determine the best approach, wording and language for their interview. For example, does she identify herself as a victim, survivor, neither or both? Whatever she decides, respect this in the interview and in the final report.



**PARTIE II: GBV & THE SANITARY CRISIS:
THE CASE OF THE COVID-19
PANDEMIC: THE FINDINGS**

PARTIE II : GBV & THE SANITARY CRISIS: THE CASE OF THE COVID-19 PANDEMIC: THE FINDINGS

THE FIELD

The work in the field consisted of 2 main steps: consultation with stakeholders and conducting the assessment/survey through telephone interviews.

1. Sample selection and description

1.1. Selection

In the convenience sampling (also known as grab sampling, accidental sampling, or opportunity sampling) or non-probability convenience sample, each individual in the population has not the equal chance with any other to be selected. It “is defined as a sampling technique in which the researcher selects samples based on the subjective judgment of the researcher rather than random selection. It is a less stringent method.”⁽¹⁷⁰⁾

This sampling type was used to select the sample of the rapid assessment/poll. Its aim was to avoid being in front of a total group of women who had never experienced Gender-Based Violence before. The survey/Poll is conducted in CATI (Computer Assisted Telephone Interviewing) mode targeting the following groups:

- Target 1: Women 18 years of age and older.
- Target 2: Decision makers/managers identified among the population of stakeholders.

The sample of respondents was randomly selected with an initial number of 700 for women (100 from each one of the seven covered countries and 100 for stakeholders. The final number comprises 841 women and 50 stakeholders from 7 MENA countries (see detailed characteristics in each category 1 of the findings of each group).

1.2. Description

In the first days of the survey, the operators/investigators worked freely, retaining all the women who agreed to participate in the assessment. When the total of 80 women who answered “YES” was reached per country, it was decided to stop the sample, which totalled 841.

170. Non-Probability Sampling: Definition, types, Examples, and advantages <https://www.questionpro.com/blog/non-probability-sampling/>

841	Total	Tunisia	Algeria	Morocco	Palestine	Lebanon	Jordan	Egypt
Total	841	145	111	110	126	121	104	124
YES	573	84	81	81	80	82	82	83
NO	268	61	30	29	46	39	22	41

Knowing that the minimum required to have an idea of a given trend is N=75, the initial requirement was to meet the 80% “YES” and 20% “NO” limits. On this basis, a few (even if completely filled out) “NO” questionnaires were randomly eliminated for the 7 countries to yield a sample of 723 individuals spread across the 7 countries, as shown in the following table.

723	Total	Tunisia	Algeria	Morocco	Palestine	Lebanon	Jordan	Egypt
Total	723	105	103	104	102	104	103	102
YES	573	84	81	81	80	82	82	83
NO	150	21	22	23	22	22	21	19

The number of respondents may have varied from one category to another or from one sub-category to another depending on the responses to the questions (yes/no/go to next question). Below the N=75 bar, responses were considered to fall within the qualitative register as was the case for responses related to expectations and recommendations (Category 8).

2. Field implementation

2.1. The process

The survey was conducted in 7 MENA countries with two major cities in each country as showed in the herewith table.

Country	City 1	City 2
Algeria	Algiers	Constantine
Egypt	Cairo	Alexandria
Jordan	Amman	Zarqa
Lebanon	Beirut	Tripoli
Morocco	Casablanca	Marrakech
Palestine	Gaza	West Bank
Tunisia	Tunis	Sfax

Table 3 - Calls/attempts to Women

Calls	Call Back	Do Not Call	Out of Quota	Incomplete	OK	Refusal	Answering Machine	No Answer	Total
PRE_ALG	0,70%	0,40%	2,60%	1,30%	0,90%	9,30%	8,20%	76,70%	100%
PRE_EG	2,50%	0,50%	5,30%	1,10%	1,40%	18,50%	10,80%	60,00%	100%
PRE_JOR	1,20%	1,10%	2,50%	1,30%	0,70%	11,80%	21,00%	60,40%	100%
PRE_LEB	2,50%	0,80%	8,20%	3,10%	2,40%	13,30%	10,80%	58,90%	100%
PRE_MOR	2,70%	1,10%	5,30%	1,30%	1,40%	23,00%	14,40%	50,70%	100%
PRE_PAL	2,50%	0,80%	10,90%	2,80%	3,00%	13,80%	12,80%	53,40%	100%
PRE_TUN	3,80%	0,70%	4,30%	2,40%	5,50%	10,20%	17,50%	55,50%	100%
Average	2,27%	0,77%	5,59%	1,90%	2,19%	14,27%	13,64%	59,37%	100%

Table 4 - Calls/attempts to Stakeholders

Calls	Call Back	Do Not Call	Out of Quota	Incomplete	OK	Refusal	Answering Machine	No Answer	Total
PRE_ALG	0,48%	0,00%	0,00%	2,42%	2,42%	2,42%	0,97%	91,30%	100%
PRE_EG	0,94%	0,00%	0,00%	0,23%	1,87%	3,51%	0,70%	92,74%	100%
PRE_JOR	1,10%	0,00%	1,10%	9,34%	2,75%	7,69%	7,69%	70,33%	100%
PRE_LEB	2,21%	0,00%	0,00%	3,54%	2,65%	10,18%	2,65%	78,76%	100%
PRE_MOR	2,40%	0,00%	1,37%	1,71%	1,71%	5,48%	2,40%	84,93%	100%
PRE_PAL	3,03%	0,00%	0,00%	1,14%	3,03%	3,79%	4,92%	84,09%	100%
PRE_TUN	4,78%	0,00%	1,99%	0,80%	3,59%	9,96%	0,40%	78,49%	100%
Average	2,13%	0,00%	0,64%	2,74%	2,57%	6,15%	2,82%	82,95%	100%

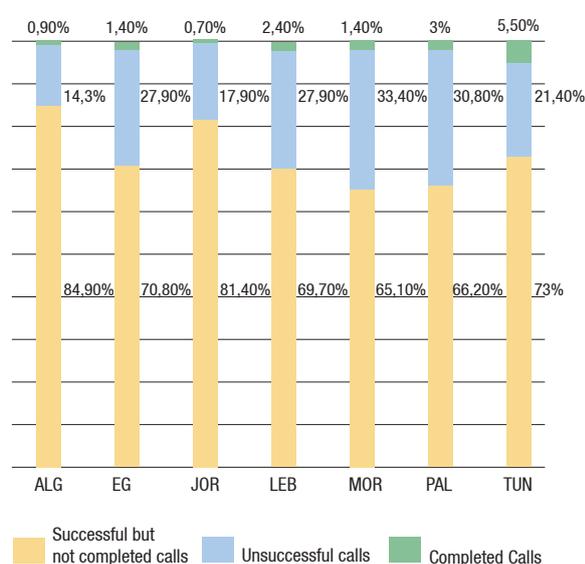
This number does not take into account the calls made by CAWTAR to most stakeholders either governmental institutions or CSOs.

2.2. Calls' analysis

Among all calls made, successful and completed outbound calls represent only 1% of the total outbound calls. The number of incomplete calls represents 14% when 85,5% were unsuccessful (unreachable, interrupted, answering machine...) as indicated in detail for each country in the following figure:

Disaggregated by country, the responses are 0,9% for Algeria, 1,4% for Egypt, 0,7% for Jordan (the lowest), 2,4% for Lebanon, 1,4% for Morocco, 3% for Palestine and 5,5% for Tunisia (the highest).

Figure 9 - Responses by Country



The average of the successful and completed calls for the seven countries is 2,2%. The lowest percentages, below the average of 1%, are recorded in Jordan (0,7%) and Algeria (0,9%) followed by Egypt and Jordan (1,4%), Lebanon (2,4%), Palestine (3,0%) and the highest in Tunisia (5,5%).

In terms of successful and not completed calls, the average of the seven countries is 24,8%. The lowest percentage is recorded in Algeria (14,3%) and the highest in Morocco (33,4%) followed by Palestine (30,8%), Egypt and Jordan (27,9%) and Lebanon (17,9%).

The causes for which calls have not been completed are: the persons called refused to answer (61%), were off-target (22%), asked to be called back (9%) or started to answer but refused to continue (8%). Not all calls were reached: 81% were not answered/not picked up and for 19% an answering machine has been triggered.

3. Operational difficulties

The first difficulty was related to the period of implementation itself i.e. November 2020. In a still very troubled period, and at the time when what was called the “second wave of coronavirus” was well under way, the measures and rules differed between total closure, including borders, and semi-confinements, applied totally or partially, whether in the seven countries taken together or within the same country.

Moreover, this assessment’s implementation encountered several difficulties. For example many people refused to answer or complete the interview, while others made commitments to do so later by telephone or by sending in the filled out questionnaire but did not honour their commitment. The causes are diverse. Some are common to any research in general or a topic as sensitive as Violence Against Women others may refer to the ambient atmosphere of confinement and the stress that resulted made things much more complex but they are not the same as the causes of the violence.

Another issue was related to the questionnaire’s length which was considered to be long by some interviewees. Fortunately they were not the majority but since it was considered long by some interviewees who preferred not to continue answering until the end, which contributed to counting the interview as unfinished and therefore needed to be repeated. For some stakeholders, the length of the questionnaire was an excuse to interrupt the telephone interview and ask for a later call back which was never answered since the telephone number was identified and therefore automatically filtered. In addition, both questionnaires (GBV survivors and stakeholders) included several open-ended questions which were difficult to handle. The processing of the responses required full transcripts of the discussions and a very elaborate and complicated coding process.

3.1. Sensitivity of the subject or denial of reality?

A great proportion of women refused to reveal their exposure to violence, particularly in Algeria and Morocco and categorically denied the existence of violence when others stated that even if there is violence, it is not in their immediate environment.

Several Algerian women refused to participate to the assessment, arguing that they did not believe in studies and that it was not in their customs and culture. For some Jordanian women, the refusal was justified by the potential problems they could face expressing a sort of anxiety not to say phobia of being watched or having their phone tapped. Some women were not able to speak freely and spontaneously because of the presence of the GBV perpetrator near them during the telephone interview.

Expressing their mistrust of talking to a stranger, in Palestine, many women were afraid to contribute to the survey and the interview thinking that it is espionage. Some leaders in Tunisia doubted the credibility of the call center, saying that CAWTAR is used to conducting in-depth individual interviews in face-to-face mode and not by phone.

In the name of Confidentiality and Privacy, some stakeholders refused to answer the telephone questionnaire because they felt that talking about women who have experienced violence is a sensitive and very intimate subject and could not be spread out during a survey. Others directly contacted refused to participate without the prior approval of the line manager and without official letter even if official letters were sent by CAWTAR to all the concerned parties and authorities concerned. Others have given this authorization, but the persons designated have not followed up as required.

3.2. The process

The Rapid Assessment targeted two groups: 1) Women, whether declared survivors of violence or not, directly or through associations, and 2) Stakeholders i.e. decision-makers, advocates or service providers from government institutions or civil society associations. The aim was to evaluate the women's experience of violence and the different forms they had to endure before, during and after the lifting of the lockdown due to the COVID-19 pandemic.

The impact of the COVID-19 lockdown was also assessed from the respondent point of view with focus on GBV and other rights of women and girls such as access to mental, physical and reproductive health services or access to other resources. Impact on relationships was also an area of interest of this category.

The lockdown due to the COVID-19 pandemic and related measures created barriers for the security and protection of women having faced the increase of GBV during this period.

Lack of knowledge and information about available services was also assessed as one of the main barriers due to closure and a GBV aggravating factor, as highlighted in a large body of research conducted during this type of crisis period and confirmed during the COVID-19 pandemic.

Women were also asked to share their experience of GBV after/since the COVID-19 lockdown, if any, and more particularly as regard to their relation with the GBV perpetrator/s; GBV forms and type they faced as well as concomitance and frequency. It was crucial also to know their expectation of women/GBV survivors organised in three subcategories: Overall measures; Prevention, protection and security and Multisectoral services.

Concerning the risks of rejection or resistance by women to be called, it was agreed that if one of them declared that she had never experienced GBV, the proposal would be to ask that if she knew any other woman in her entourage who experienced it, she could also share her experience. As expected during the preparation and discussion of the methodology, there have been many cases where a woman accepts to participate to the survey precisising however from the beginning that she has never faced violence but projecting it onto someone else she knows. During the interview, and without paying attention, she moves to the first person, talks about herself. This back and forth between the "she" and the "I" caused a sort of discomfort to the teleoperators who didn't dare to dig a little deeper into an answer or to delve into an intimate and embarrassing subject.

SAMPLE CHARACTERISTICS

1. The size of the two samples

Countries	Women	Stakeholders	
		CitGIs 2	NGOs & Others
Algeria	103	---	5
Egypt	102	---	7
Jordan	103	1	8
Lebanon	104	1	6
Morocco	104		6
Palestine	102	1	5
Tunisia	105	1	9
Total	723	50	

As indicated and detailed in the herewith table, a total number of 841 women was reached, 141 more than expected since it was initially expected to have 100 women per country, i.e. a total of 700. The final number being 723 respondents as detailed in the above table.

The initial country sample of stakeholders was at a minimum of 100, unfortunately despite the organization of a preliminary virtual consultation where participants committed themselves to be part of and to mobilize concerned actors in their country and other initiatives from CAWTAR (such as contacting them by phone and sending CAWTAR's official letters...), the number reached was very poor even from CSOs. The stakeholders, governmental institutions and non governmental organizations who accepted to participate completely or partially represents only 50 respondents.

For instance, the Director of Human rights department in the Ministry of Interior in one country informed CAWTAR that she was delegated by the Minister himself to collaborate and that she will send the questionnaire throughout the territory to its departments/units... but to date no single one was received. For other institutions such as the women mechanisms nominated focal points only three sent a filled questionnaire. One questionnaire was sent well after the treatment of the data. The concerned stakeholder was only added to the list.

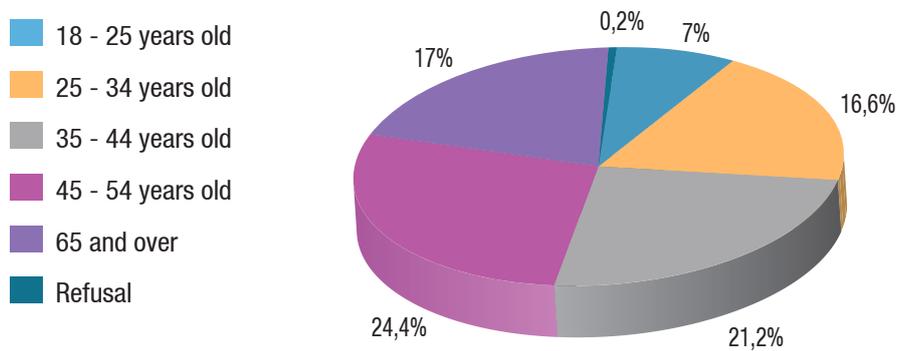
The total number of responses by country all categories included are distributed as follows: Governmental Institutions/GIs either ministry or National Commission [Jordan (1) Lebanon (1) sent by email, Palestine (1) and Tunisia (1)], NGOs [Algeria (5), Egypt (7), Jordan (8), Lebanon (6), Morocco (6), Palestine(5) and Tunisia (9)]. The category "NGOs" includes specialized associations, service centers and other national institutions such as forums, federations, leagues, and unions. It is worth noting that among those who preferred to send the questionnaires filled, not all responded to all categories/questions. It was decided to settle for the number reached, so as not to delay the study more than that.

2. Characteristics of the sample of Women

2.1. Age distribution

Of the 841 women from all countries involved in the assessment, the most common age group was 45-54 years old with a rate of 24.4%, followed by women aged 35-44 years old with 21.2% and 25-34 years old with 16.6%.

Figure 10 - Age distribution

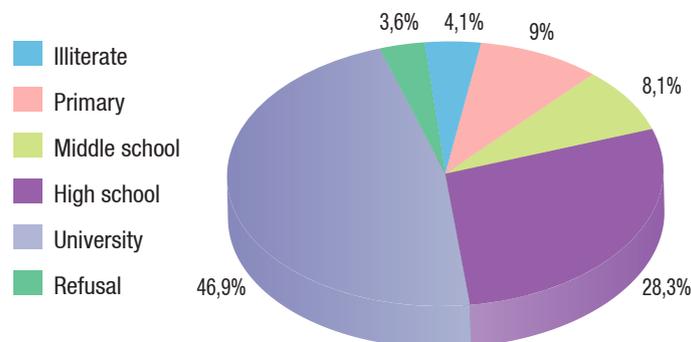


The least represented age groups are those at the two extremes: the youngest (18-25 years) with a percentage not exceeding 7% and the oldest (65 years and over) with a percentage of 17%. A number of interviewees refused to give their age (0.2%).

2.2. Educational attainment

The education levels of the women in the sample are variable as illustrated in the below graph.

Figure 11 - Educational Attainment

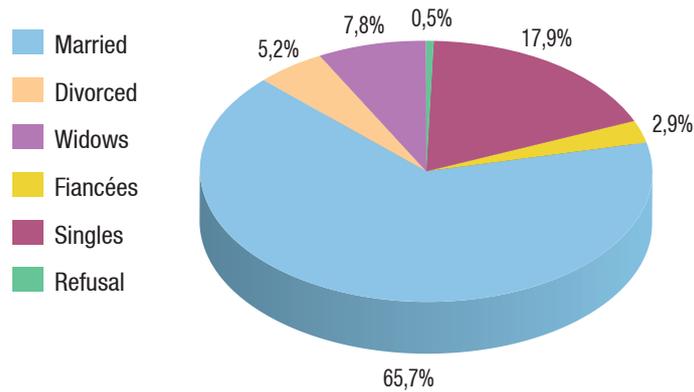


Of the 841 surveyed women, 46.9% of the surveyed women have a university degree and 28.3% of them, a secondary school education. 8.1% is the percentage of women who did not go beyond middle school and 9% say that their education stopped at elementary school. 4.1% are illiterate and 3.6% of the women refused to disclose their level of education.

2.3. Civil status & residence

A number of women refused to give their civil status, others are distributed as shown in the hereunder diagram:

Figure 12 - Civil Status

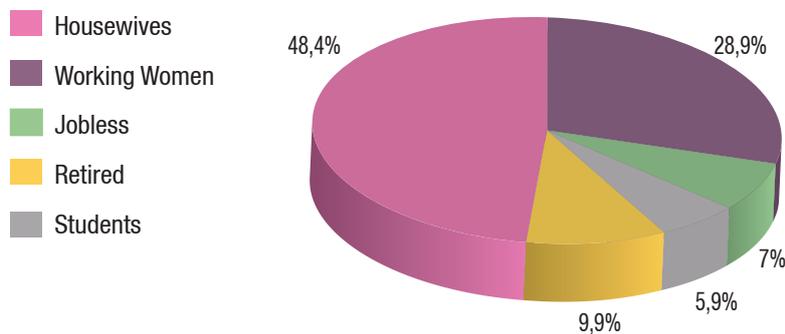


Almost 2/3 of the women who participated in this assessment were married women, with a percentage of 65.7%. The second largest group is single women with a percentage of 17.9%. Widows represent 7.8% of the entire sample with only 5.2% of divorced women.

As for the type of residence, 65% of them live in an apartment compared to 33.8% in an independent house and 0.6% of the sample live in a room, probably among female students.

Among the participants in this assessment, almost half of the women i.e. 48.4%, are housewives.

Figure 13 - Socio-professional distribution

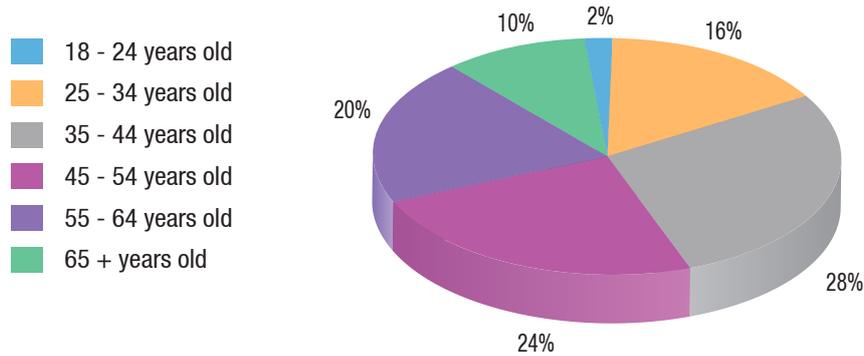


28.9% is the percentage of employed/working women. 9.9% are retired and 7% report that they are unemployed or looking for work. Female students represent 5.9% of the total sample.

3. The characteristics of the sample of stakeholders

As indicated and detailed in the description of the sample, the total number of stakeholders who participated to the assessment is 50 with a majority of women (88%).

Figure 14 - Age distribution



28% of respondents are 35-44 years old followed by 24% in the 45-54 age group and 20% in the 55-64 age group. The least represented age groups are 18-24 (2%), 25-34 (16%), and 65+ (10%). 100% of respondents have a university degree.

Regarding their marital status, almost $\frac{2}{3}$ i.e. 60% are married versus 22% of singles, 10% are divorced, 4% widowed and 2% engaged. 2% of the participants refused to answer this question. 96% of them stated that they work against only 4% who have already retired but apparently continue to be active in civil society. As for the type of residence, 52% of them live in an apartment compared to 42% in an independent house.

PART II-1: WOMEN WHETHER DECLARED GBV SURVIVORS OR NOT

EXPERIENCE OF GBV BEFORE THE COVID-19 LOCKDOWN

The assessment of the GBV was made through simple questions, first to know if the respondent experienced GBV or not, and second, which forms and types of GBV, in different periods —before, during or after the COVID-19 lockdown.

1. GBV experience/s

These statements remain relative to a perception of violence in all its forms and an experience that may have taken place throughout the life of the interviewee. As the figure shows, more than a third of the interviewed women i.e. 37.5%, say they have been exposed to violence in all seven countries in the panel. Although the percentages vary from one country to another, the lowest rate is in Palestine at 28% and the highest in Tunisia at 46.7%.

For ease of analysis, and on the basis of a basis of 723 respondents, a relative categorization of the age groups was made as detailed below:

- 171 youth with 53 for 18-24 year olds and 118 for 25-34 year olds
- 331 adults with 148 respondents for 35-44 year olds and 183 for 45-54 year olds
- 220 seniors with 122 respondents for 55-64 and 98 for 65+ seniors
- 1 person refused to give her age.

Of the regional average of 37.5%, young women are the most affected by violence (41.5%), followed by adults (39%) and seniors (32.3%).

In the 7 countries covered by this assessment, married women seem to be less exposed than single women, with a rate of 34.5% and 39.3% respectively. However, other factors may aggravate their exposure to violence, such as the fact that almost half (49%) of the divorced, engaged or widowed women said they had been assaulted, confirming the fragility of their status in a patriarchal society where the father and the husband can be at the same time the aggressor and the protector.

Figure 15 - GBV experienced by Women per Country

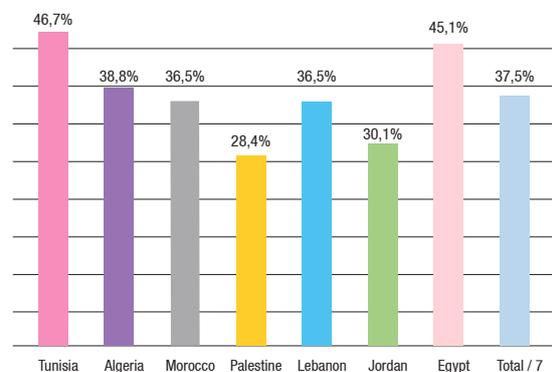
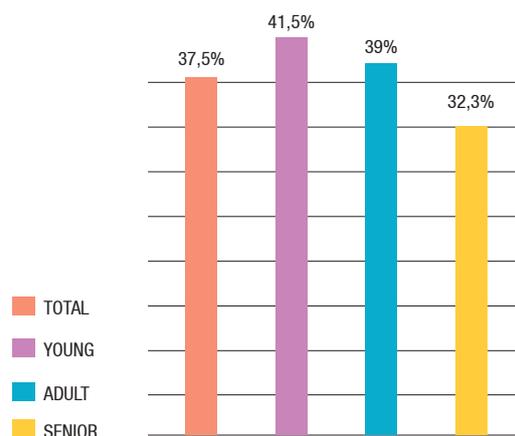


Figure 16 - GBV Survivors by Age group



45.9% of those who report having experienced violence have a primary level of education, followed by 34.6% with a secondary level and 37.9% having completed their university, confirming non-discrimination in violence based on education level. Women Workers experience more violence with a rate of 44.3% compared to 41.8% for women in training or students and 31.5% of housewives.

Violence is pervasive in the environment of women survivors of violence at the regional level, with an average of 41.8% of women surveyed having an acquaintance or a close victim of GBV, the highest rate being among the surveyed Palestinian women (50%), and the lowest among the Tunisian women (33.3%), which seems quite surprising since in terms of violence experienced at the personal level, it was the exact opposite. However the assumption is also that Palestinian women preferred declaring the GBV is experienced by a woman other than herself even if she is in fact relating her own experience. These data confirm the presence of violence in the life of women and their environment. The cumulative figure of nearly 80% for all 7 MENA countries in the sample confirms the pervasiveness of violence.

The violence witnessed or observed by the respondent is specifically related to the exercise of violence affecting other women in her close environment and more particularly within the family. In the 7 covered countries, the interviewed women live in an environment where violence is “familiar” whether they experience it (37.5%) or witness it (41.8%). Indeed, these figures demonstrate that the disparity is not very great between the two regional averages. However, it is worth to note that there is no rule from one country to another. Thus, contrary to the 5 other countries, in Tunisia and Egypt, the rate of violence suffered by the respondent is higher than the violence witnessed in her surrounding area.

Figure 17 - Between GBV Personal experience and that of Others

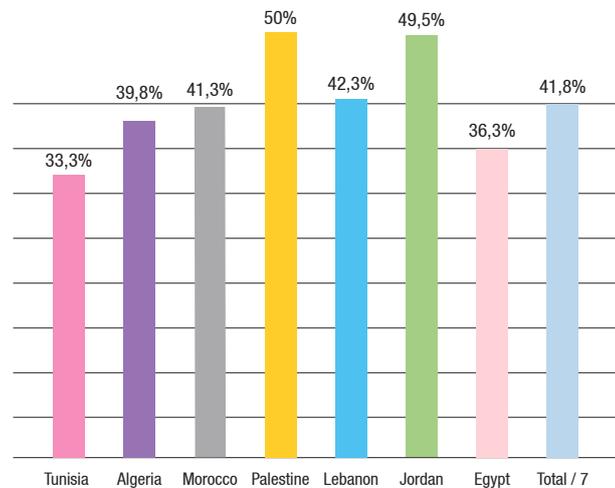
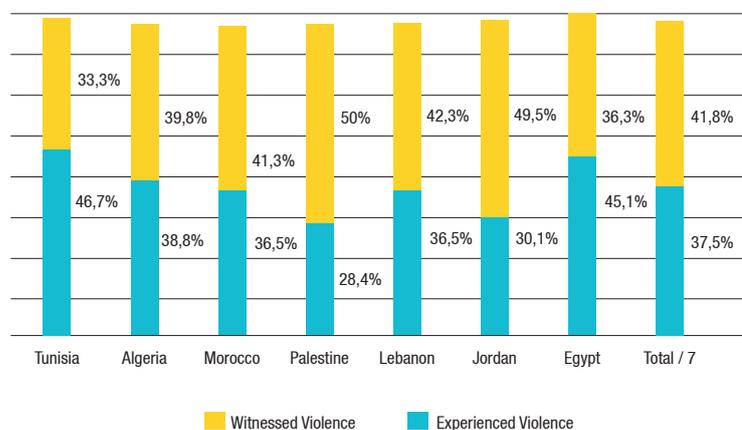
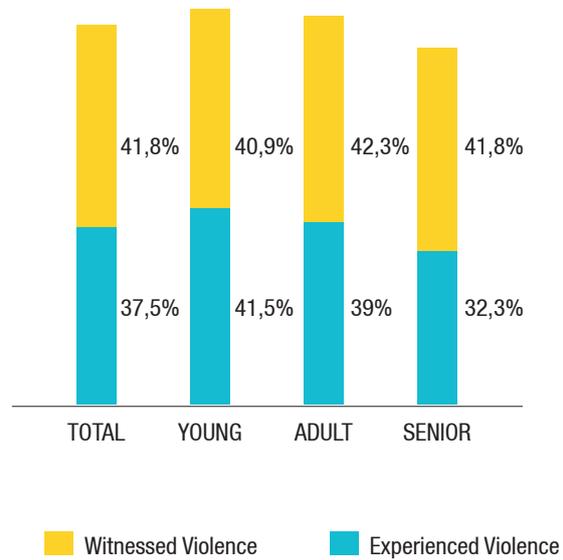


Figure 18 - Between the Experienced violence and the Witnessed violence



The answers obtained for the violence witnessed by the respondent according to age group is not very different from the results found for the violence experienced by the respondent for the same category. However, a decrease is noted for the experienced violence, from 41.5% to 39%, for youth and adults, and an increase in the witnessed violence, from 40.9% to 42.3%. As shown in the herewith Figure 19 for youth and adult women, the cumulative figure of 80% is close to the total. For seniors, and as previously noticed, the experience of violence decreases with age, especially for those who have experienced it personally, which is 32.3% compared to 37.5% for the overall average. Regarding the civil status' distribution, unmarried or single women face personally more violence with a rate of 49% and say they experience less violence among other women in their family. Single women face more violence than married women with rates of 39.3% and 34.5% respectively.

Figure 19 - Experienced violence and Witnessed violence by Age group



2. GBV, types and forms

Defining types or forms of Gender-Based Violence is not always easy. Even if the reference is made to the same concept or content, the definition could differ from a country to another sometimes for political reasons or depending on the mandate or the jargon of a given agency or organisation. Yet, this is not the only reason, sometimes the difficulty in classifying GBV is due to the experience of the GBV survivor herself who can face at the same time several types and forms of GBV, particularly in the private space. “Gender-Based Violence is enacted under many different manifestations, from its most widespread form, Intimate Partner Violence, to acts of violence carried out in online spaces. These different forms are not mutually exclusive and multiple incidences of violence can be happening at once and reinforcing each other.”⁽¹⁷¹⁾

To make the exercise easier for the assessment and channel of communication (phone interview), it was decided to select five types i.e. Physical violence, Verbal violence, Psychological violence, Sexual violence and Economic violence.⁽¹⁷²⁾ The latitude was also left to the respondent to evoke another type of violence through the heading: other(s).

171. <https://eige.europa.eu/gender-based-violence/forms-of-violence>

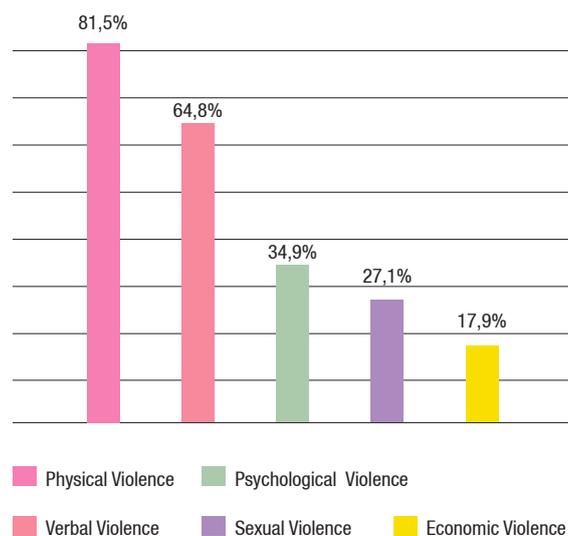
172. Other types such socio-economic violence, domestic violence or in intimate relationships, harassment and sexual harassment are also considered as types of violence

It was also necessary to give some guidance to the interviewers/operators on the GBV forms,⁽¹⁷³⁾ and therefore certain characteristics/guidelines were proposed for each type of violence, always leaving the possibility for the respondent to propose something else if she had a different experience as herewith described:

- Physical violence: Assault and battery, food deprivation, sleep deprivation, care deprivation, other/s,
- Verbal violence: Insults, yelling, other/s,
- Psychological violence: Threat/s, ignorance and contempt, devaluation (in private life or in public), other/s,
- Sexual violence: Marital rape, rape, sexual harassment, touching, other/s,
- Economic violence: The only breadwinner,⁽¹⁷⁴⁾ salary deprivation, subsidy/alimony deprivation, family allowances, other/s.

All respondents declared having faced almost all types and forms of violence with rates decreasing from physical violence to economic violence as described in the herewith findings.

Figure 20 - Types of Violence experienced by Women



According to the respondents' testimonies, the most prevalent form of violence they have to face is physical violence, with a rate reaching 81.5%. Physical violence is often accompanied and/or associated with verbal violence (64.8%) It is followed by psychological violence. In fact, 34.9% of the 723 surveyed women declared having suffered this type of violence, in its mental, moral or even emotional aspects. As for sexual and economic violences, the percentage was lower with respectively 27.1% and 17.9%.

This does not necessarily mean that it is true or false, but it is certainly necessary to link this type of questioning or response to the gendered construction of society and socio-cultural values where sex and money refer to the register of both shame and the forbidden.

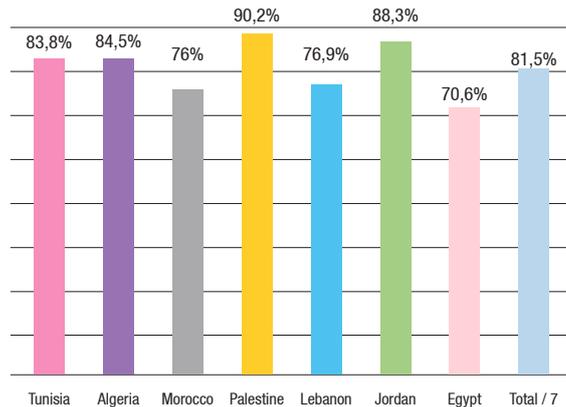
173. Some others consider sexual, emotional or psychological violence as GBV forms

174. For instance, in case the perpetrator is the husband : he doesn't contribute to the family expenses

2.1. Physical violence

Physical violence is the most recurrent form of violence in society in the seven MENA countries with a regional average of 81.5%.

Figure 21 - Physical violence by Country



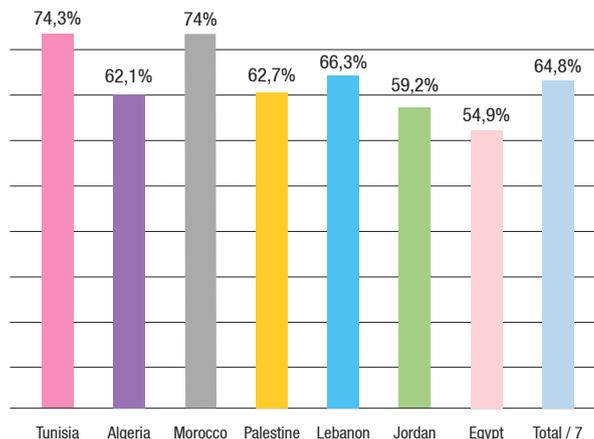
Physical violence is consistent in all cities ranging from 90.2% in Palestine to 70.6% in Egypt. The rest of the percentages were close among different countries with an overall average of 81.5%. These very high figures in Palestine can also be explained by the occupation suffered by the inhabitants of the West Bank and the Gaza Strip, which makes the situation more difficult and leaves women facing an omnipresent state of war.

The most common forms of physical violence for women respondents were assault and battery (78.4%), followed by deprivation of care (12.9%), deprivation of food (6.6%) and sleep deprivation (5.0%), noting that some of these forms may be akin to torture.

2.2. Verbal violence

The majority of participants say that verbal abuse is part of their daily lives, with a regional average of 64.8%.

Figure 22 - Verbal violence by Country

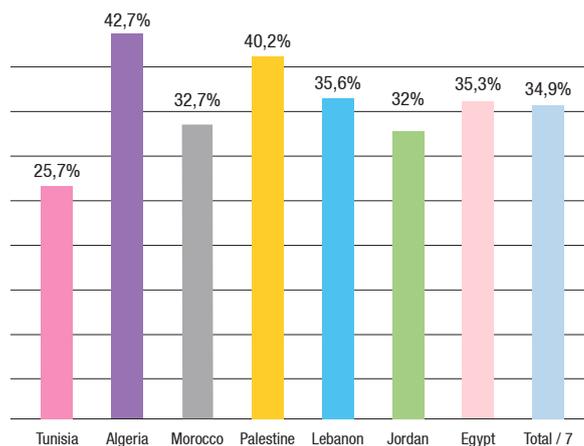


With rates approaching 75%, Tunisia and Morocco rank first in terms of women's exposure to verbal violence, almost $\frac{3}{4}$ of the female population, which is really problematic. Lebanon has a rate of 66.3% followed by Palestine and Algeria with approximately 62%. Jordan and Egypt come in last position with respectively 59.2% and 54.9%. According to the responses, the most common forms of verbal abuse are insults in 61.4% of cases and shouting in 22% of cases.

2.3. Psychological violence

Less present than the first two forms of violence, psychological violence and emotional abuse, however, remain an experience experienced by almost a third of the survey respondents i.e. 34,9% grouping the 7 countries. The low figures may also refer to the fact that women consider the psychological dimension as a consequence of other forms of GBV and not as a form of violence itself. It seems difficult to imagine the absence of psychological impact with such high rates of physical and verbal violence, to mention only anxiety, anorexia or even bulimia, insomnia, feelings of insecurity or depression.

Figure 23 - Psychological violence by Country



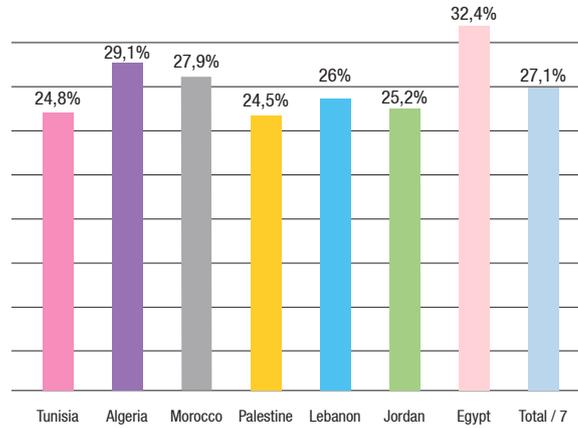
For the 723 respondents who said they had experienced this form of violence in the 7 countries, Algeria and Palestine ranked first, with rates of 42.7% and 40.2% respectively, followed by Lebanon (35.6%), then Egypt (35.3%) and Jordan (32%). It seems that Tunisia is the country where there is less psychological violence directed against women with a rate of 25.7%. Psychological violence is expressed through threats (14.7%), ignorance and contempt (19.9%) and devaluation in both private and public life (21%).

2.4. Sexual violence

According to WHO global estimates (2017), 35% of women or nearly 1 in 3 women, report having been exposed to physical or sexual violence by an intimate partner or someone else in their lifetime. Most often, this violence is perpetrated by the intimate partner.

Among the women in the 7 countries participating in this assessment, 27.1% responded that they also experienced sexual violence.

Figure 24 - Sexual violence by Country



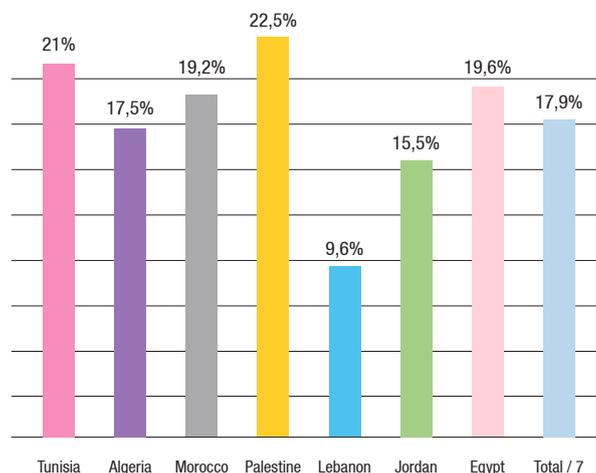
Although the percentages are getting closer, Egypt is the only country to exceed the 30% mark and is therefore ranked first for this form of violence with a rate of 32.4%, followed by Algeria at 29.1%, Morocco (27.9%), Lebanon (26%), Jordan (25.2%), Tunisia (24.8%) and finally Palestine with a rate of 24.5%.

The most frequently reported forms of sexual violence are sexual harassment (22.2%), followed by rape (16.2%). For women who reported such a situation, the rape was committed either by a family member, a friend or a stranger. The rate of the marital rape is estimated at 8.9% and of touching at 5.5%.

2.5. Economic violence

With a rate of 17.8%, which covers the average of the 7 countries, the percentage of economic violence affecting women is the lowest in comparison with the 4 forms of violence that have been previously assessed.

Figure 25 - Economic violence by Country



Palestine is at the top of the list with a rate of 22.5%, followed by Tunisia with 21% then Egypt and Morocco with a rate of 19.6% and 19.2% respectively, Algeria (17.5%) and Jordan (15.5%) and finally Lebanon with the lowest rate of all forms of violence (9.6%).

The aspects in which this economic violence is experienced are the deprivation of resources that includes but non only alimony (13.3%), cases where the respondent is the sole breadwinner (11.5%) and finally the deprivation or control of the salary (11.3%).

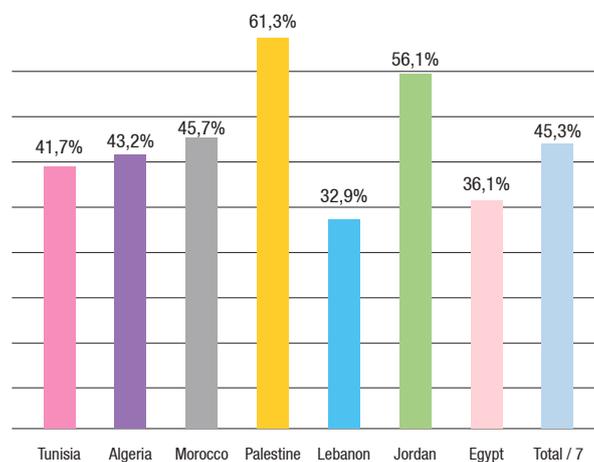
EXPERIENCE OF GBV DURING THE COVID-19 LOCKDOWN

In a comparative perspective, the same sub-categories are assessed and questions asked as those of the previous category/Part.⁽¹⁷⁵⁾ The primary objective was to find out whether acts of GBV had increased, decreased or remained at the same level in terms of % and forms. However, other elements were also introduced to refine the figures and analyze more in-depth such as the frequency of this violence during isolation or the identification of the GBV perpetrators.

1. GBV experience/s during the lockdown period

The majority of women assessed in all 7 covered countries stated that GBV had increased compared to the pre-lockdown period, with a regional average of about 45.3%.

Figure 26 - GBV experienced by Women per Country



Although a minority of women reported that during the period of confinement, violence in their home had decreased, the trend for most respondents, in all countries with variations from one country to another was the increase. As shown in the above figure, the highest percentages were in Palestine and Jordan, reaching 61.3% and 56.1% respectively. The lowest percentages were registered in Lebanon and Egypt with 32.9% and 36.1% respectively. As for the 3 Maghreb countries, Tunisia, Algeria and Morocco, their results are closest to the general average with 41.7%, 43.2% and 45.7% respectively.

175. GBV before the COVID-19 Lockdown period

1.1. GBV survivors by Age Group

The sharp increase in GBV was distributed across all age groups with a regional average of 45.2%. However, it is higher among adults (i.e. age groups: 35-54 years old) with a rate of 49.8% compared to the figures for the experience of Gender-Based Violence before confinement. One of the causes could be related to the interruption of professional and academic activities in addition to the lack of leisure time for all family members during confinement.

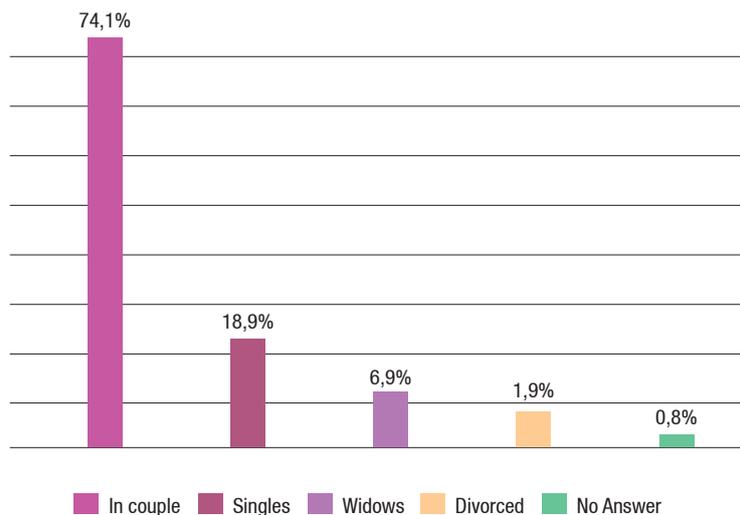
This permanent cohabitation, not to say promiscuity, combined with the increase in time spent with the potential aggressor in an “enclosed” place, increases both pressure and stress, but also potential and real risks.

The rate of violence is 44.7% for young people (i.e. age groups: 18-34 years old) and slightly lower for seniors, the same trend as in the pre-confinement period with a rate of 38%.

1.2. GBV and Civil Status

Very few women refused to respond to this question (0.8%). Conversely to the experience of GBV before confinement, women in couples (husband, fiancé or boyfriend) are the most affected during confinement with 71.4% noting that married women represents the majority in this category. There is a big difference between women in couples and single women, who face the same type of violence (18.9%).

Figure 27 - GBV experienced by Women and civil status during the lockdown period



The rate drops to 8.8% for other categories (engaged, widowed, divorced). These changes could be explained by the conditions of isolation that have reinforced promiscuity within the family with the presence of husbands for married women whereas those with another status were further away from potential aggressors.

1.3. GBV and Education level

In reference to the educational attainment, there is some difference from the pre-confinement GBV experience. The trend is reversed from 45.9% to 39.7% for the primary level. For the secondary and university levels, the figures increase from 34.6% to 47.4% and from 37.9% to 45.5%.

These major changes could be explained by the increase in exposure to violence and stress, especially among women who are used to working outside the home, and the new working conditions that have been moved to the home for most of them. In this situation, they found themselves assuming their multiple roles in the same space with the impossibility of any recourse to public spaces because of the confinement measures.

1.4. GBV and Socio-professional category

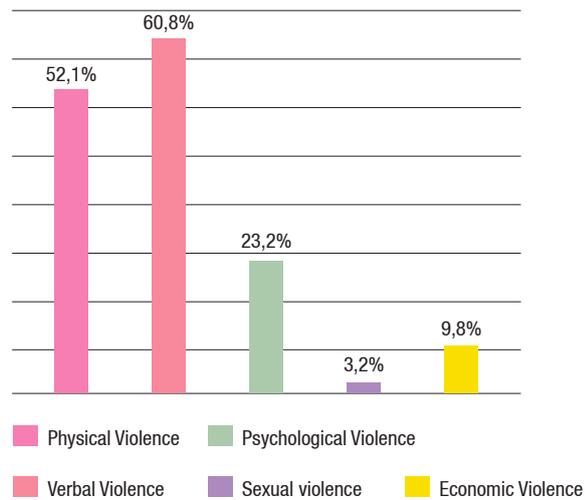
A major change from the trend of the pre-confinement experience is that the housewife experienced more violence than normal, with a rate of 47.3%. This change during confinement is explained by a change in the routine of family life and the presence of the aggressors in the home all day long. It is 45.1% for active women and 40% for other categories (students, unemployed, looking for a job and retired women, etc.).

2. GBV, types and forms

The GBV different types are the same however the increase in some forms compared to the pre-confinement period is clearly exacerbated.

These are mainly physical and verbal abuse, with percentages of 52.1% and 60.8% respectively. However, psychological, economic and sexual violence remain with less variation in terms of importance. Sexual violence decreases comparatively to the pre-confinement period to 3.2% maybe because the GBV in public space is no longer counted.

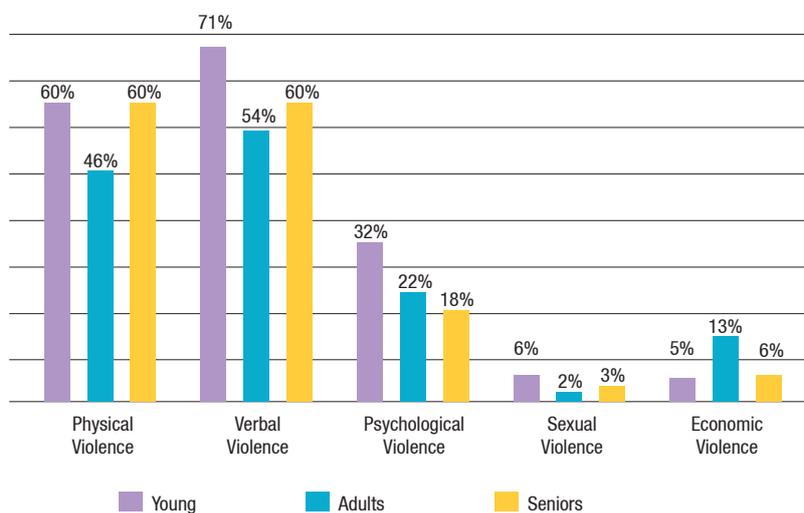
Figure 28 - Types of GBV experienced by Women



Women report having faced concomitant forms of violence even more often than before this very special situation, with a rate of 60.1% for physical and verbal violence, 18.5% for verbal violence accompanied by psychological violence and 13.5% for both physical and psychological violence. 7.7% report having suffered both physical and moral violence at the same time.

2.1. GBV types and Age

Figure 29 - GBV types and Age during the COVID-19 lockdown



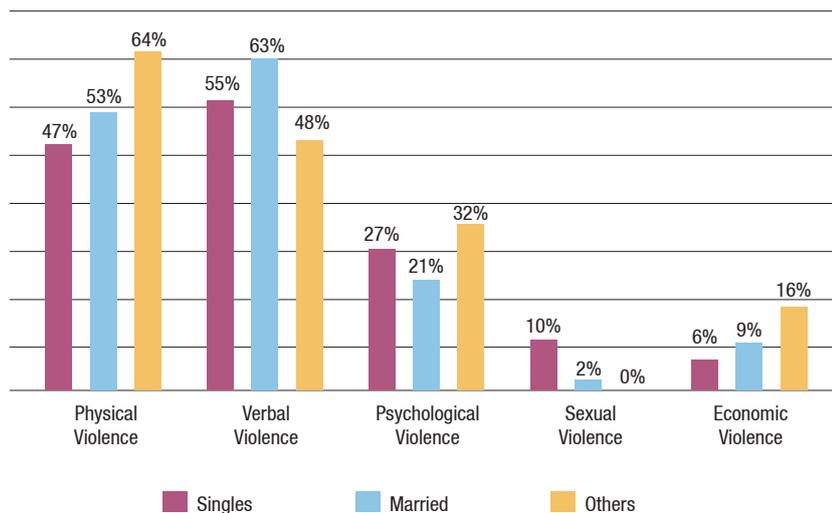
The increase in physical violence is the same in the singles' group as in the divorced and widowed (other) group with a rate of 60%. It is 46% among married women. Verbal violence is again higher among the singles' group with a rate of 71%, followed by widows and divorced women with a rate of 60% and finally married women who are 54% to suffer this verbal violence.

The increase in psychological violence is in the order of 32%, 22% and 18% among singles and married on one part, widowed and divorced women, on the other. Sexual violence increased relatively little during confinement however, it is lower among married women with a rate of 2% and higher among young people with a rate of 6% and 2% among widows and divorced women (others).

The lack of or non-access to public spaces (street, transportation, work and leisure facilities, etc.) could explain the relatively low level of increase in sexual violence in its various versions of touching, sexual harassment and even rape. Married women face more economic violence (13%) and young people slightly less (5%) than widows and divorced women (6%).

2.2. GBV types and Civil status

Figure 30 - GBV types and Civil status during the COVID-19 lockdown

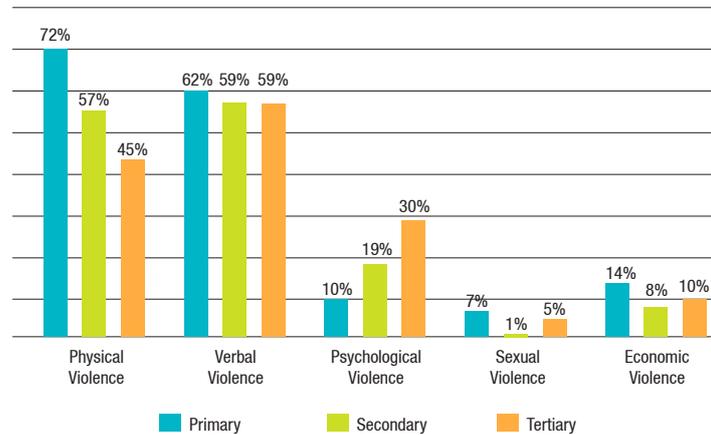


The increase in physical violence is higher in the group of divorced and widows (others) with a rate of 64%; it is 53% among married women and 47% among single women. Verbal abuse is highest among married women (63%), followed by singles (55%) and then widows and divorced women (48%).

The increase in psychological violence is in the order of 32%, 27% and 21% for widows and divorced women, followed by singles and married women. Sexual violence increased relatively little during confinement; however, it is lower among married women (2%) and higher among young people (10%), including all three age groups but excluding the widows and divorced women (0%). Widows and divorced women face more economic violence (16%) followed by married women (9%) and singles (6%).

2.3. GBV types and Education Attainment

Figure 31 - GBV types and the Education Attainment during the COVID-19 lockdown

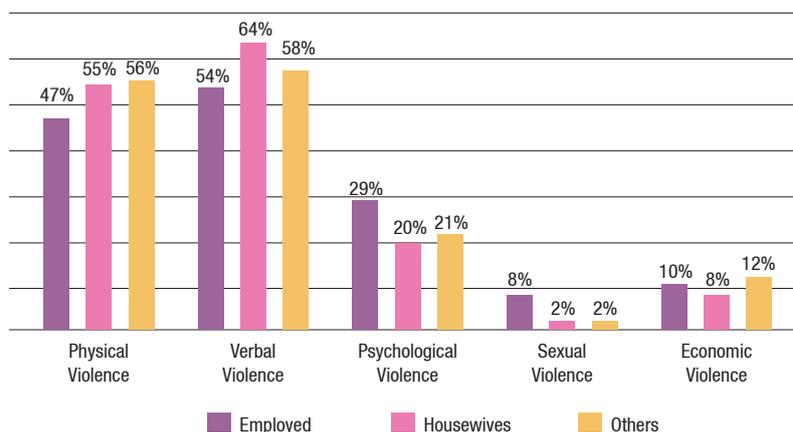


The increase in physical violence is highest among women with a primary school level with a rate of 72%, followed by women with a secondary school level with a rate of 57%. It is lower among women with a university level (45%) although it is not negligible. The rate of verbal abuse is the same for women with secondary school and university education (63%) and higher for those with primary school education (62%).

The increase in psychological abuse suffered by women academics is higher, with a rate of 30%, followed by women with a secondary school education (19%) and those with a primary school education (10%). The increase in sexual violence percentages is at the same level as the other variables, with 7% among primary school respondents, 6% among university graduates and only 1% among high school students. The increase in economic violence cases is decreasing, ranging from 14% among women with primary school education, 10% among university graduates and 8% among those with secondary school education.

2.4. GBV types and Socio-professional category

Figure 32 - GBV types and Socio-professional category during the COVID-19 lockdown



The rate of physical violence is 56% in the group “others”, which includes unemployed or job-seeking women as well as female students. It is 55% among housewives and 47% among working women. Verbal violence peaks at 64% (housewives), 58% (others) and 54% (working women). For psychological abuse, the increase compared to the pre-confinement period is 29% among working women, 21% in the group “others” and 20% among housewives. Sexual violence increased to 8% among working women, 2% among housewives, women without or looking for work and students (others). Rates of economic violence are somewhat close between the three groups: 8% for housewives and 10% for working women, but still 12% for the “others” group.

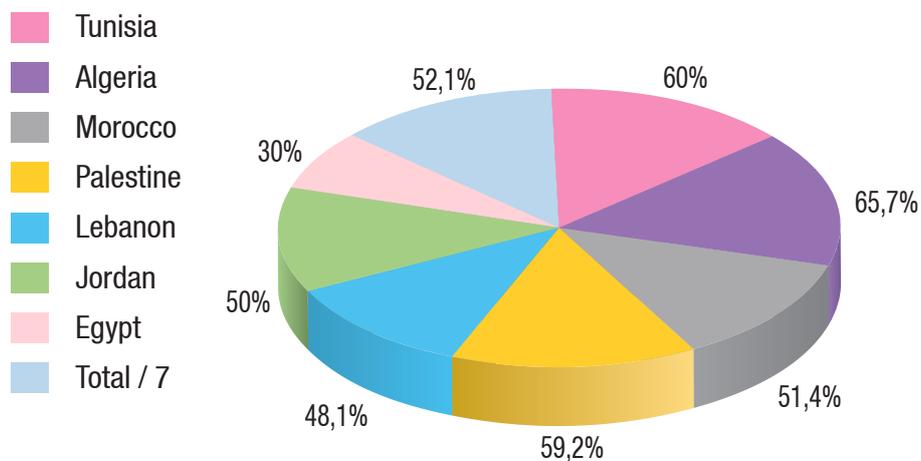
3. GBV, types and forms

These are the same GBV types faced by respondents during the 2020 lockdown due to the COVID-19 pandemic.

3.1. Physical violence

Physical violence committed during confinement is experienced on average in 52.9% of respondents from all covered countries.

Figure 33 - Physical violence by Country

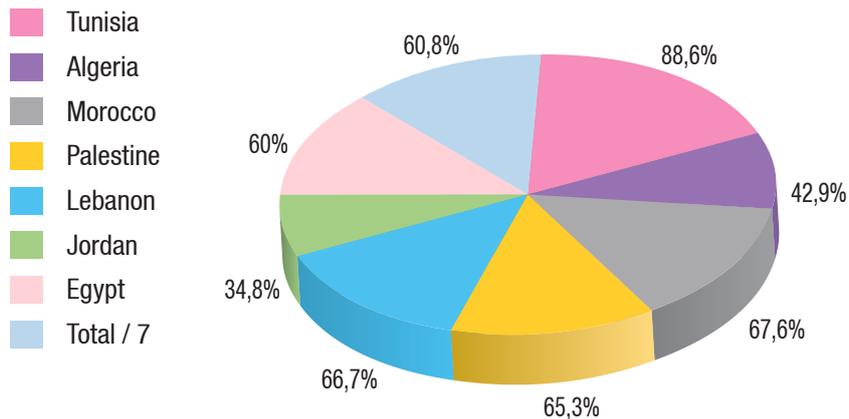


The highest percentage is found in Algeria with 65.7% and the lowest in Egypt with 30%. Tunisia and Palestine also stand out with a presence of physical violence at the level of 60%. The rest of the countries are close to the overall average ranging from 48.1% for Lebanon to 51.4% for Morocco. Most physical violence takes the form of assault and battery (45.4%), followed by deprivation of care (7.7%), of food (2.4%), and of sleep (0.6%).

3.2. Verbal violence

The women interviewed in the 7 countries were exposed to verbal violence during the lockdown period, at an average rate of 59.8% i.e., almost 2/3 of the sample.

Figure 34 - Verbal violence by Country

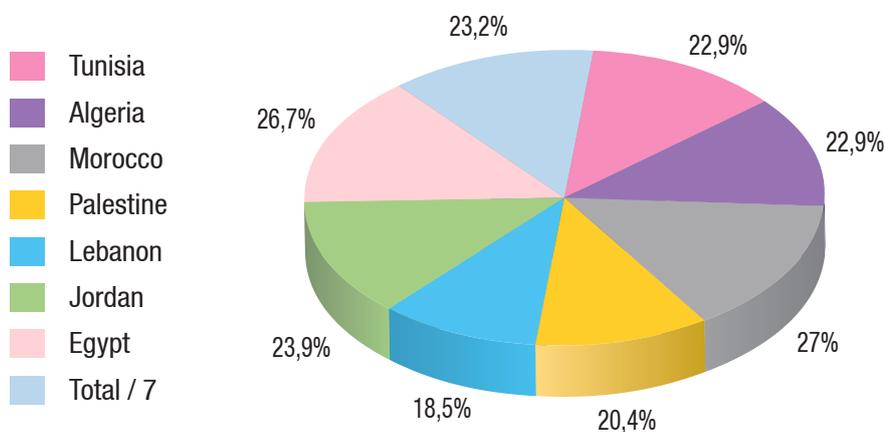


The overall percentage of 60.8% in no way reflects that of Tunisia. As the graph shows, verbal violence was at its peak in this country during the lockdown period with a rate of 88.6%. Jordan recorded the lowest rate of 34.8% for the same period with Algeria (42.9%), even if in the context of GBV, “low” is a very relative concept. The other rates are all well above half of the sample average with Morocco (67.6%), Lebanon (66.7%), Palestine (65.3%) and finally Egypt (60%). More than half of this violence takes the form of insults (53.7%) and 18.9% takes the form of shouting.

3.3. Psychological violence

The average rate of psychological violence/emotional abuse to which those who answered yes to this question were exposed is estimated to be 23.2%, about a quarter of the sample.

Figure 35 - Psychological violence by Country

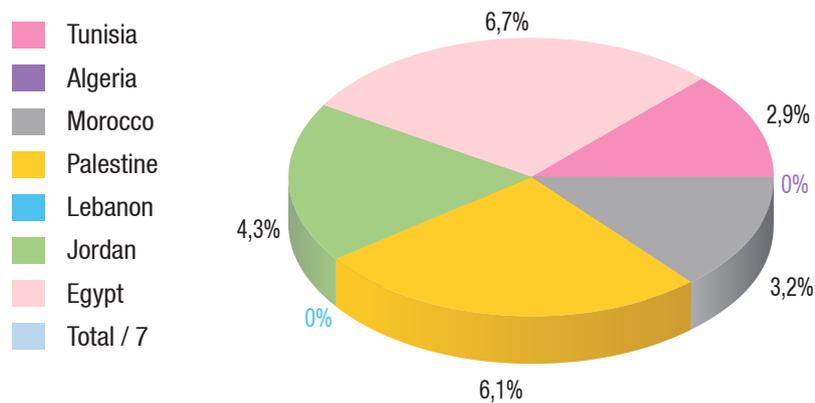


With a regional average of 23.2%, the rates of the countries are close to each other with Morocco leading the way with a percentage of 27%, followed by Palestine (26.7%), Egypt (23.9%), Algeria and Tunisia (22.9%) and Jordan (20.4%). The lowest average is in Lebanon with 18.5%, the only country below 20%. For the respondents, psychological violence is “translated” into devaluation in private and public life (12.6%), ignorance and contempt (9.4%) and threats (5.1%).

3.4. Sexual violence

According to the different answers indicated in the figure below, sexual violence is among the least widespread type of violence—or expressed as such—during the lockdown with a regional rate of 3.2% and a zero value in Algeria and Lebanon (0%). However, it is important to note that this value exceeds 6% in Egypt and Palestine (6.7%/6.1%). It is 4.3% in Jordan, 2.9% in Tunisia and 3.2% in Morocco.

Figure 36 - Sexual violence by Country



The forms of sexual violence reported by the sample during the Covid-19 confinement are sexual touching at 0.5% and rape whose origin is unspecified at 0.3%. The highest values for this subcategory are for marital rape at 1% and sexual harassment at 2%.

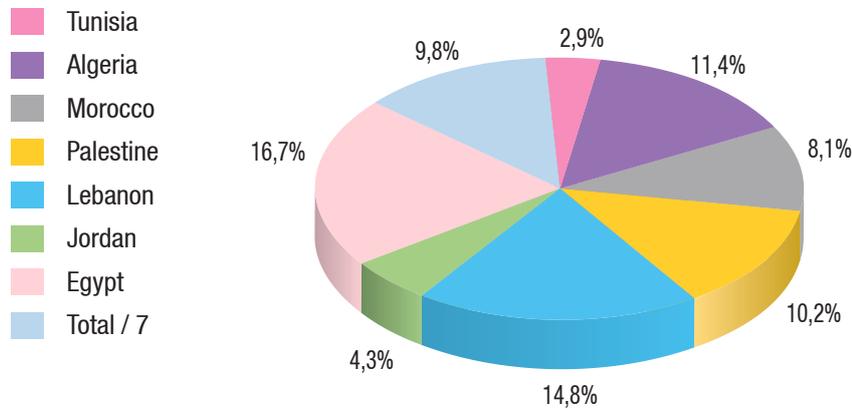
It would have been interesting to establish a correlation between violence suffered in public spaces and sexual harassment in order to define the affected socio-professional categories, given that “70% of workers in the health care sector facing COVID-19 are women, which further aggravates this situation”⁽¹⁷⁶⁾ to only quote the example of Tunisia.

3.5. Economic violence

As illustrated in the figure below, with a regional average of 9.8%, the lowest rate of increase in economic violence is found in Tunisia with 2.9% and the highest in Egypt (16.7%) followed by Lebanon (14.8%), Algeria (11.4%), Palestine (10.2%), Morocco (8.1%) and Jordan (4.3%).

176. Covid-19 : les États doivent combattre la violence domestique aggravée par les restrictions <https://unctunis.org.tn/category/genre/>

Figure 37 - Economic violence per Country



Economic violence mainly takes the form of wage deprivation (4.1%) and of alimony (4.2%). The woman is also the sole breadwinner of the family and is forced to take responsibility and care of the family alone (3.5%).

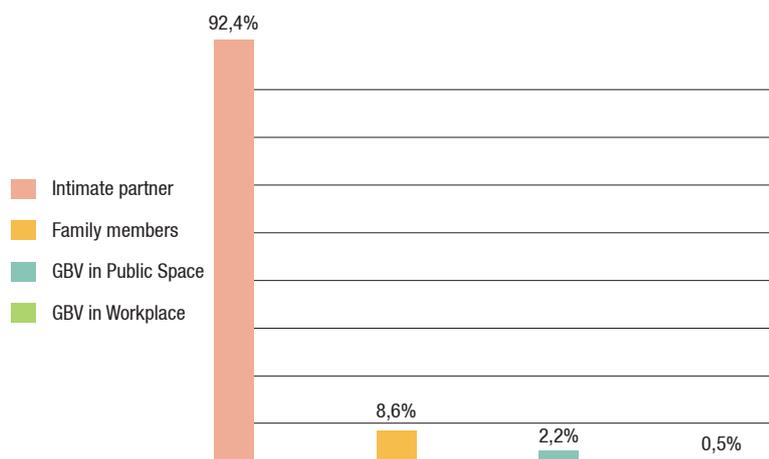
4. Who are the perpetrators of GBV and how often does it occur?

4.1. The GBV perpetrators

An intimate relationship is an interpersonal relationship that involves physical or emotional intimacy and generally involves a sexual relationship. It can also be a non-sexual relationship involving family, friends or acquaintances. In this assessment, the first definition is taken into account allowing for the organization of other categories separately (family, professional sphere, street...). Based on that, for the purpose of this assessment, the perpetrators of GBV are:

- Intimate partners (husband, ex-husband, fiancé, boyfriend),
- Family members (brother, father, son),
- GBV in workplace (employers, colleagues),
- GBV in public space (street, neighbor, unknown people)..

Figure 38 - GBV Perpetrators during the lockdown



As all the global trends indicate, the majority of acts of Violence Against Women is committed by the intimate partner. This is clearly evidenced by the respondents' statements with a rate of 92.4%. Whether it is the husband, the ex-husband, the fiancé or the boyfriend, it is essentially the one who shares the life of these victims who exerts the most violence on his companion, period of confinement or not. However, this situation is even more complicated with the measures taken because of COVID-19 including the confinement.

8.6% of women report that they continue to face violence within their own family (4,3% from the father, 2.7% from the brother and 2.7% from the son). A few cases of violence are reported outside the family context, despite the confinement, representing 2.7% of all responses. This rate is divided between GBV in workplace (employer and colleagues) with 2.2% (i.e. 0.9% for employers and 1.3% for colleagues) and 0,5% of violence committed in public space.

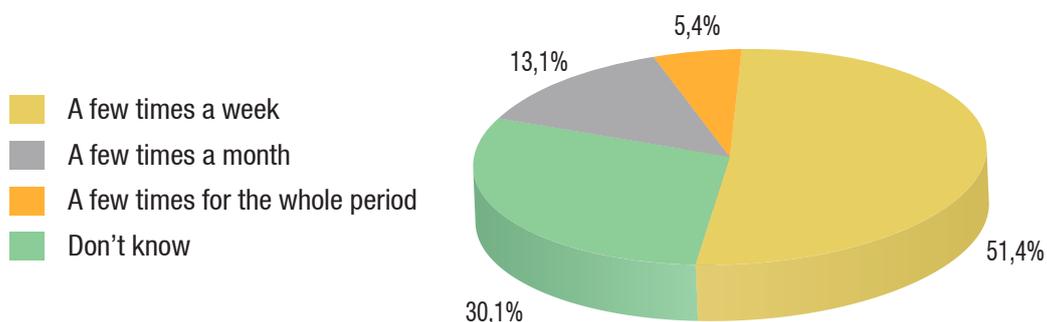
The women GBV experience during the lockdown even limited can be explained by their presence in certain vital sectors such as health or other services, as a result, they remain mobilized day and night. Sometimes they simply go shopping to provide for their families.

5. Frequency of GBV acts during the lockdown

Women GBV survivors—or not—for the period prior to the lockdown taking into account the games that memory can play, especially for such sensitive issues. Indeed, such experiences can be either scotomized, buried in a kind of amnesia, or exaggerated in a kind of inflation because of the trauma caused. However, it should also be noted that this evaluation took place in November 2020, a recent memory for some but which can also be considered quite remote for others.

For the purpose of clarification, in this assessment “*a few times a week*” corresponds to 2 to 3 times a week and “*a few times a month*” corresponds to 8 to 12 days a month.

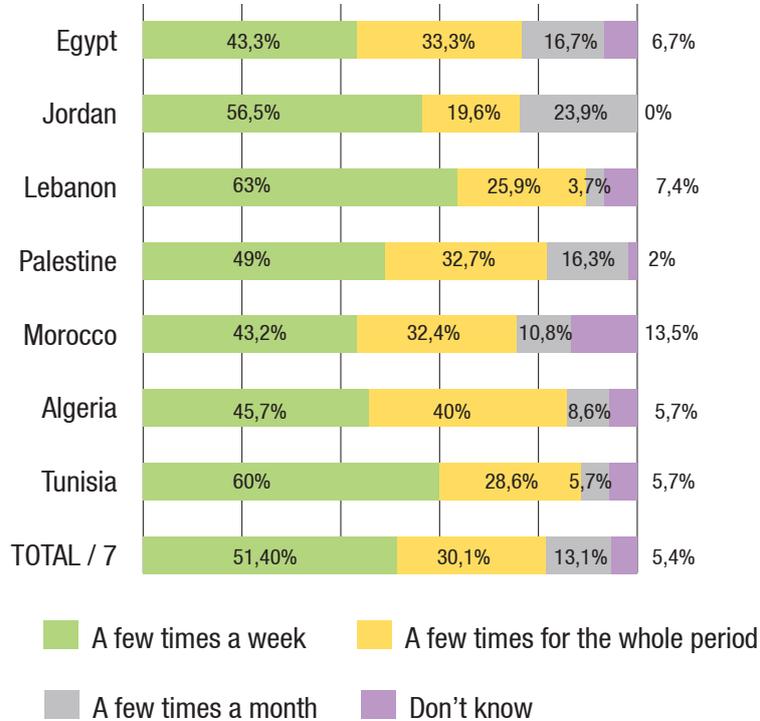
Figure 39 - Frequency of violence suffered by Women



When asked about the frequency of violence in all its forms that they would have suffered during the period of confinement, more than half of the 573 respondents who answered said that the frequency peaked “several times a week” with a rate of 51.4%. 13.1% spoke of a “few assaults per month”, while 30.1% said they had experienced violence “multiple times during the quarantine period”. However, it is important to note that 5.4% i.e. nearly 6% of the respondents are unable to quantify the frequency of their assaults, which could indicate either a non exposure, a rarity or an excess of violence suffered and in all cases maybe a difficulty to talk about it.

The highest frequencies are “few times per week” and “few times during the whole period of confinement” as shown in the figure below:

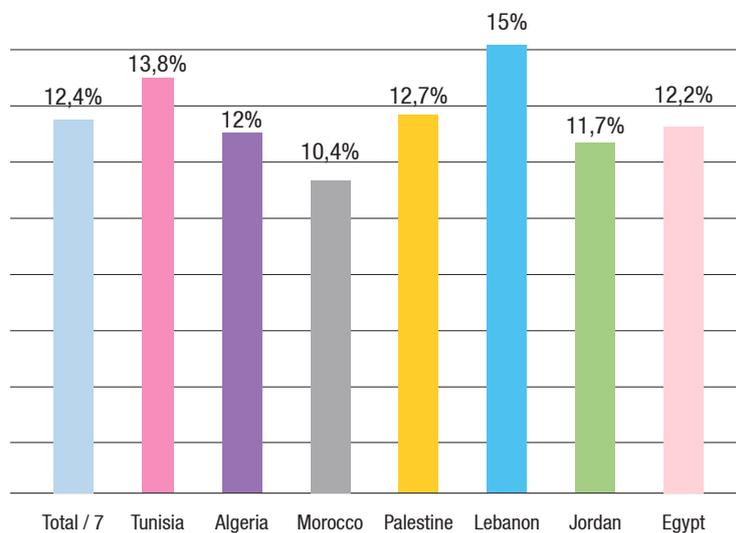
Figure 40 - Frequency of violence suffered by Women per Country



For the frequency “a few times a week”, for example, the highest rates are recorded in Lebanon (63%) and Tunisia (60%), followed by Jordan (56.5%), Palestine (49%), Algeria (45.7%), Egypt (43.3%) and Morocco (43.2%). The frequency rates “few times during the whole period” range from the highest of 40% in Algeria to the lowest of 19.6% in Jordan.

However, it is interesting to note what the meaning of “few times” really means in terms of number of days particularly in a month, taking into account that in the category “frequency of GBV...”, the frequency in the month is ranked among the lowest responses.

Figure 41 - Average Number of Days of Violence per Month



Thus, “a few times a month” may correspond to half of the month, i.e. 15 days as is the case for Lebanon meaning one day out of two and the right answer would be “very frequent”. Tunisia is in the 2nd place with 13.8 days, followed by Palestine (12.7 days), Egypt (12.2 days), Algeria (12 days), Jordan (11.7 days) and finally Morocco (10.4 days). In fact, the hundreds of women GBV survivors—or not—were monthly subjected to GBV to 12.4 days of violence, during the COVID-19 lockdown.

The average of all age groups for the “I don’t know” represents 5.3% of responses. It is senior women who appear to have most suffered the violence “few times a week” with a rate of 56%, followed by adults at 52% and young women at 44%, which corresponds to an average of just over half (51%). There is not much difference between the experience of women seniors, adults and youth in terms of the frequency of violence experienced “a few times during the entire confinement” with an increasing order of 23%, 32% to 33% and a general average of around 30%. Responses “a few times a month” are much less frequent with an overall average of 13% and a higher rate among youth (17%) followed by seniors (16%) and finally adult women (10%).

With regard to the frequency of violence suffered by women during the confinement of COVID-19 according to their marital status, the general average of those who do not know or do not want to estimate it, is 4% for single women, 5% for widows and divorced women and 8% for married women, whether it is the number of acts of violence (whatever they are) during a week, a month or for the entire confinement period. There is no significant difference between married women for responses of all combined categories, although the average is higher among single women (32%) followed by married women (31.3%) and widows and divorced women (30%).

Regarding the frequency of violence suffered by women during the COVID-19 confinement according to level of education, 5% of respondents in all categories (levels of education and frequency values) declared that they did not know the frequency. For those who do know, the results again overlap with the previous category, with a rate of 32.3% for those with primary school level, 31.6% for those with secondary school level and 31.3% for those with tertiary level. It is worth to note however, that the higher the level of education, the lower the frequency of violence (per week, month or during the entire confinement period). 16% of respondents in the socio-professional category responded that they did not know. The percentage is 33% for working women, 30.6% for the category “others”, which includes unemployed women or looking for a job, retired women and students. For housewives the rate is 28%.

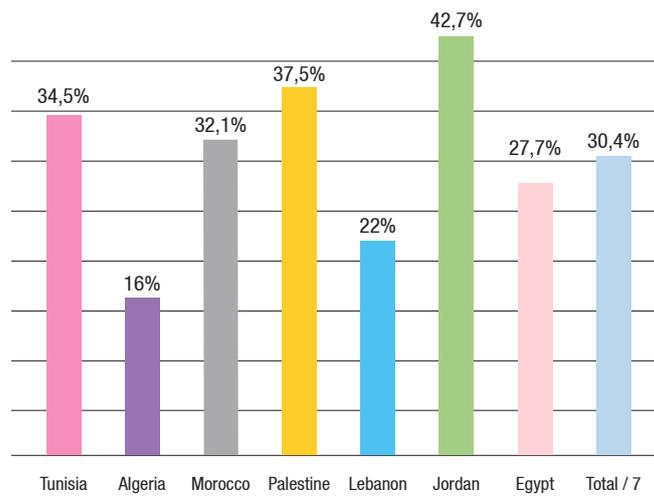
Regardless of the socio-professional status of the woman questioned, the response “a few times a week” is close to the average (50%, 51%, 54%) while for the response “a few times during the entire confinement period”, the rate rises from 23% to 40%. This frequency is explained by the omnipresence of the active woman in her home exposing her more to domestic violence and to an aggressor in her family, whomever he may be.

EXPERIENCE OF GBV AFTER THE COVID-19 LOCKDOWN LIFTING

1. GBV experience/s after the lockdown lifting

In order to better understand and analyze the evolution of Gender-Based Violence during the lockdown period caused by the COVID-19 pandemic, part of the assessment and questionnaire focused on the continuation of this phenomenon and its progress –increase or decrease) after the end of the lockdown.

Figure 42 - GBV experienced by Women per Country (%) after the lockdown lifting



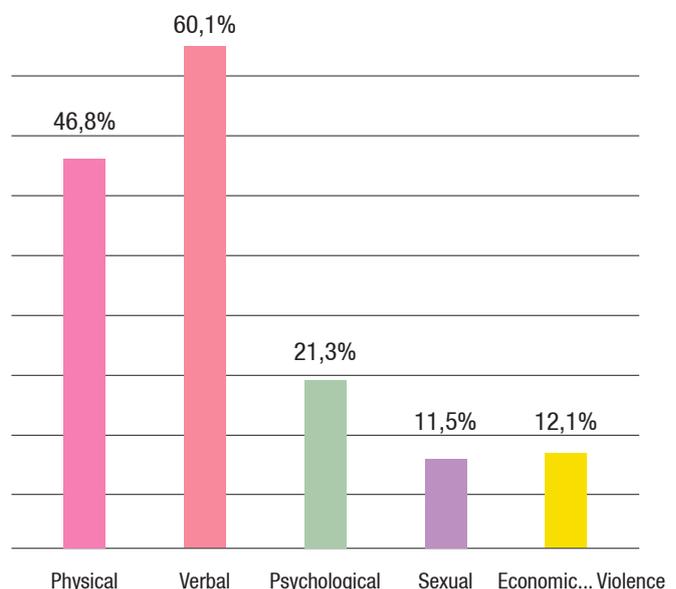
30.4 % of the 573 women surveyed in this category reported that they continued to suffer violence despite the lifting of the lockdown. Obviously these rates vary from one country to another. Jordan is in the lead, if it were decent to use competitive language for this kind of act, with a rate of 42.7% and Algeria coming last with 16%. The other countries follow with 37.5% for Palestine, 34.5% for Tunisia, 32.1% for Morocco, 27.7% for Egypt and 22% for Lebanon.

2. GBV types

The 5 same types of violence are found after the lifting of the lockdown; they follow each other but are not similar at least in terms of percentages. It is therefore essential to look at them one by one as for the phases before and during lockdown.

Although still significant, physical violence has decreased with to a percentage less than fifty percent (46.6%). This can most likely be related to the direct consequence of the end of lockdown in private spaces, with the “closed cup” of the home being broken. However, verbal abuse rebounds to over 60%. The rates of psychological violence (21.3%) and economic violence (12.1%) remain with less variation. Sexual violence increased to 11.5%.

Figure 43 - Types of GBV experienced by Women



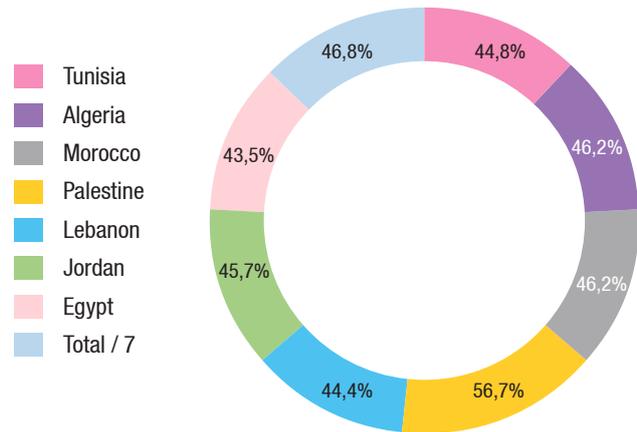
3. GBV forms

As the 5 forms of violence remain present after the lifting of the lockdowns, it is therefore essential to dwell on them one by one as for the phases before and during lockdown.

3.1. Physical Violence

Although, as highlighted above, physical violence has decreased somewhat with an average of 46.8% in almost all countries; ranging from 46.2% in Algeria and Morocco followed by Jordan with a rate of 45.7%, Tunisia (44.8%), Lebanon (44.4%) and Egypt with 43.5%. Only Palestine exceeds this threshold and keeps a percentage that is close to that of the lockdown period, which could be also explained by the constant state of war due to the Israeli occupation.

Figure 44 - Physical violence by Country

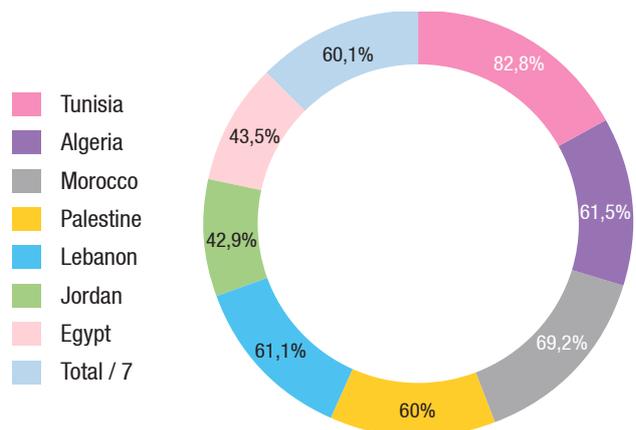


For those who responded, the manifestations of this physical violence are the same as during the lockdown period with more or less 2% difference between the two periods. Assault and battery remains the most frequent with a percentage of 42.5%, followed to a much lesser degree by deprivation of care (7.4%), and deprivation of food and sleep which are at the same level (1%).

3.2. Verbal violence

It is higher in Tunisia, where the rate is estimated at 82.8%, followed by Morocco (69.2%), Algeria (61.5%), Lebanon (61.1%), Palestine (60.0%) with a drop in Egypt at 43.5% and an increase in Jordan from 35% to 42.9%. It appears essentially as insults at 54.3% and shouting at 18.1%.

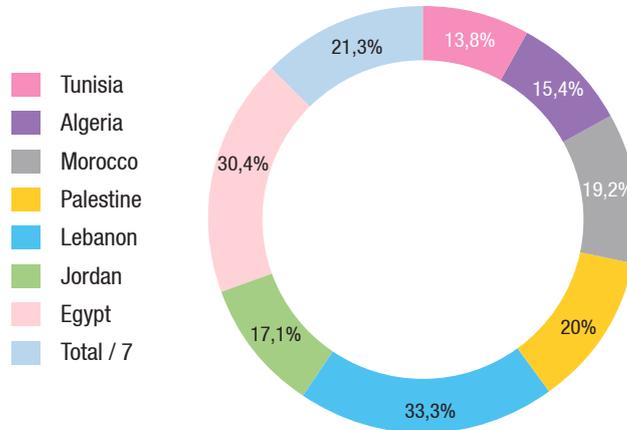
Figure 45 - Verbal violence by Country



3.3. Psychological violence

1/5 of the respondents report having experienced emotional abuse. 21.3% is the average rate for the seven countries where this type of violence is ubiquitous.

Figure 46 - Psychological violence by Country

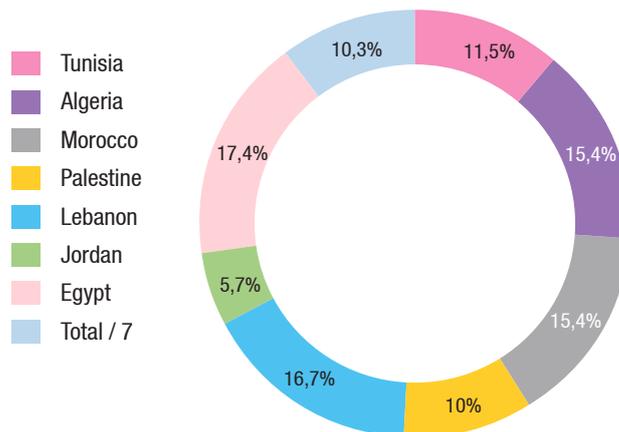


Lebanon with the highest percentage, estimated at 33.3% is followed by Egypt (30.4%), Palestine (20%), Morocco (19.2%), Jordan (17.1%), Algeria (15.4%) and finally Tunisia with 13.8%. The most recurrent psychological violence after the lockdown period with almost 10% is ignorance and contempt. It exceeds the devaluation in private or public life, which is usually in first position, accounting for 8.6% of cases. Threats remain almost the same with 5.7% for 5% during lockdown.

3.4. Sexual violence

Sexual violence increased after the lockdown with an average rate at 10.3%.

Figure 47 - Sexual violence per Country



The rate reached its highest level in Egypt and Lebanon, where it is estimated respectively at 17.4% and 16.7%, followed by Algeria and Morocco (15.4%), Tunisia (11.5%), Palestine (10%) and finally Jordan with the lowest rate at 5.7%.

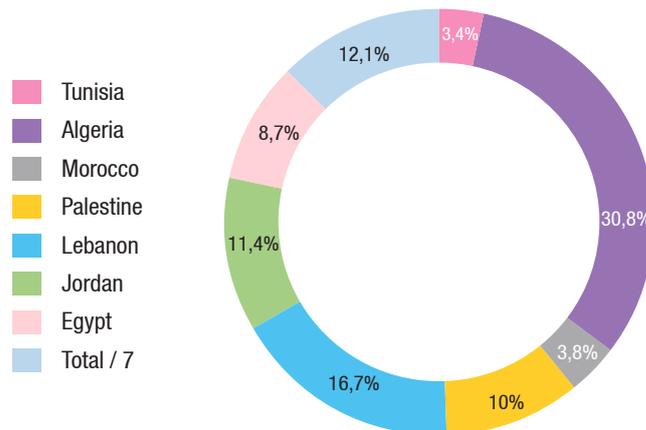
It is observed that after the lockdown, sexual harassment is coming back “in force”, with a rate of 9.7%. Indeed, the removal of lockdown enabled both men and women to reoccupy the public space. They have been able to move again freely and resume their social and economic activities. This means for women daily exposure to violence in public transportation, on the street, in the workplace or in commerce.

Although rape rates have declined, marital rape (1.3%) is still higher than rape (0.5%) committed by someone other than the husband. The fact that touching has also decreased (1.9%) can be explained by the social distancing imposed by barrier measures that make aggressors more cautious because of the risk of contamination.

3.5. Economic violence

Economic violence is still present after the end of COVID-19 lockdown, although reduced with an average rate 12.1%. Yet, this percentage does not refer to Algeria, where the percentage is three times higher (30.8%) as expressed by the Algerian women whereas in Tunisia it is at the lowest rate with 3.4%.

Figure 48 - Economic violence by Country

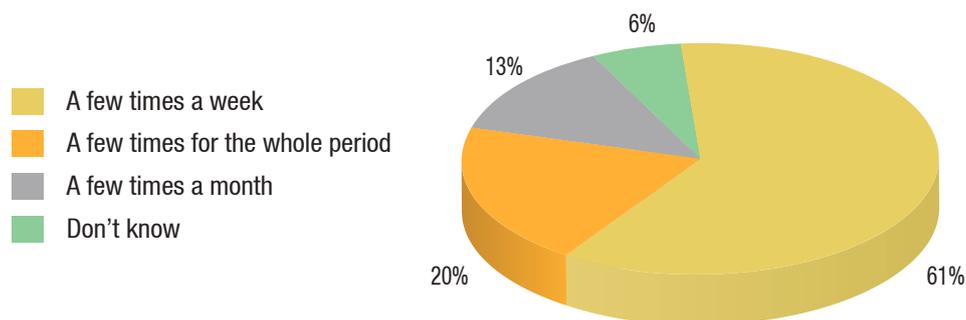


Lebanon has seen a decrease (16.7%) followed by Jordan (11.4%), Palestine (10%), Egypt which has also seen a decrease in the practice of this kind of violence (8.7%) and finally Morocco (3.8%). With the fragile and difficult economic context consequent to the COVID-19 lockdown, a woman considers that economic violence to be finding herself alone responsible for spending for the family (6.3%) as well as being deprived of financial aid or pension (5.8%). These are the two manifestations that continued to increase compared to the period of lockdown and the one prior to lockdown. The deprivation of salary is generally decreasing (2.2%) limited however to the 1.1% of those who declared having faced this kind of violence during this period.

4. Frequency of GBV after the lifting of the lockdown

To the question about the frequency of the presence of violence in all its forms after the lockdown lifting, GBV survivors shared their frequent painful experiences by sharing the number of times they had to face violence in all its forms and at all times.

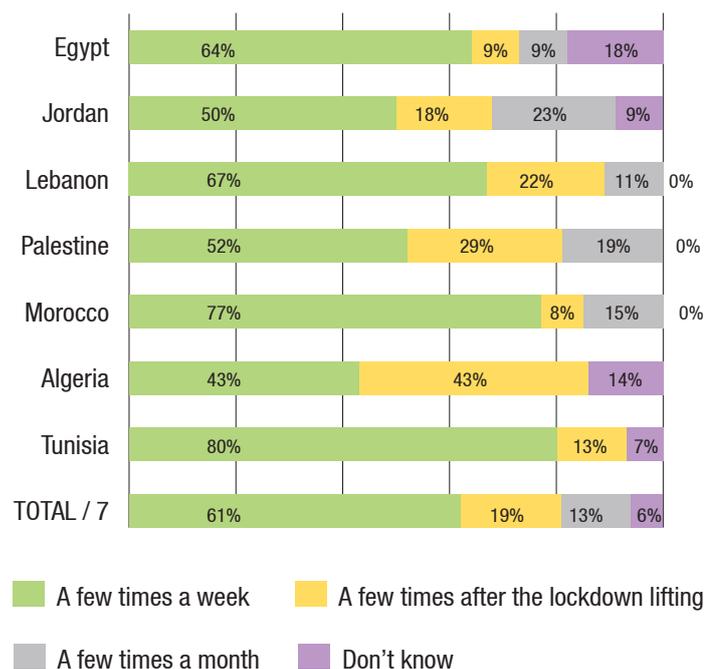
Figure 49 - Frequency of violence suffered by Women



61% of GBV survivors experienced these acts “a few times a week”, which corresponds to at least 2-3 times per week. For 13% of them, it is “a few times a month”, i.e. about 8 to 12 days, while 20% continued to experience violence *since the end of the lockdown* without interruption. Virtually, the same number of women, as in the previous period, said they “do not know” which can have several meanings: either incapacity to quantify this frequency or just refuse to respond to this sensitive question, often seen as humiliating.

With an average of 61% for the 7 countries, the reading of the results highlights that the frequency per week in Tunisia is very high with a rate of 80%. It is followed by Morocco with 77%, Lebanon and Egypt with 67% and 64%, 52% for Palestine and 50% for Jordan. Less than half of Algerian women report having been assaulted once a week (43%), similarly to the previous period. Apart from Algeria, where the rate has been maintained, the frequency is declared to be decreasing for Lebanon (22%), Palestine (29%), Jordan (18%), Egypt (9%) and finally Tunisia, which went from a high rate for “a few times a week”(80%) to a low of 13% which could mean that not all Tunisian women responded to the last frequency questions related to the monthly frequency or since

Figure 50 - Frequency of violence suffered by Women per Country

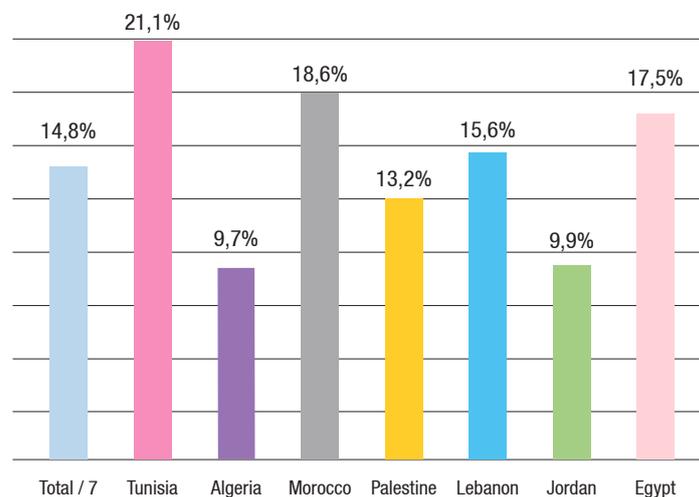


the end of the lockdown. As a matter of fact, the 0% of Tunisia and Algeria may correspond to the responses of women who said they had only experienced it one, two or three days and therefore were considered insignificant, especially in comparison to the responses relating to “a few times a week”. Regarding the frequency “a few times a month” for the other countries, the highest rate is found in Jordan (23%), followed by Palestine (19%), Lebanon (11%) and Egypt (9%).

The inconsistency that could be seen between certain types of frequencies (*a few times a week and since the lifting of the lockdown*), imposes a remark for all responses to the sub-category “Frequency of violence suffered by women” during and after the lockdown. Is this due to respondent fatigue? Is it due to what might have appeared to the respondents as a repetition of the previous questions? Does the answer “don’t know”, which is also evaluated at “0” day, really correspond to a difficulty for women to quantify the frequency or a refusal to answer, to cite only the rate in Algeria (14%) and Tunisia (7%)?

Could it be a methodological issue related to the non-definition of the period itself in terms of duration of the lockdown or the date of its lifting⁽¹⁷⁷⁾ or related to the counting system? For instance, to count the frequency of violence suffered by women, it would be sufficient to multiply the frequency of violence incurred in a week by 4 to get a monthly calculation. On the basis of this calculation and the duration of the lockdown (from establishment to lifting), a number could be computed for the number of occurrences of violence during the lockdown and consequently after. However, in order to do so, it would have been necessary to also know how many weeks they did experience this violence. Thus, the counting of the frequency of violence after the lifting of lockdown was done in a different way i.e. the calculation of the average number of days frequency is the weighted average of all responses as shown in the figure below.

Figure 51 - GBV frequency after the lockdown lifting



In addition to these percentages, it is possible to highlight the number of days after the lifting of the lockdown even if it varies between the 7 countries covered by this survey. Thus Tunisia is the only one exceeding 20 days per month. Morocco with 18.6 and Egypt with 17.5 are two countries experiencing an increase in the period of lockdown compared to the previous period. The lowest average is that of Algeria and Jordan which do not exceed 10 days with 9.7 and 9.9 respectively.

A comparative reading of the frequency between the two periods (during the lockdown and after) will be deepened in the synthesis part.

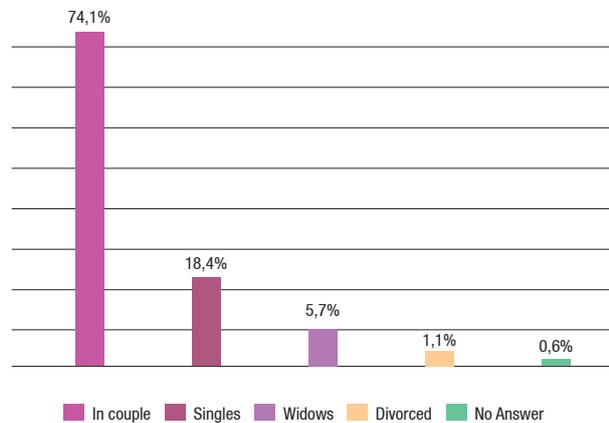
177. Reminding that the assessment was made in November 2020, the lockdown started in March of the same year but its end varied from country to country.

5. GBV experience: Women status and Perpetrators

5.1. GBV and Civil Status

As it was the case during the lockdown, some women refused to respond to this question (0.6%). The number of women in couples (husband, fiancé or boyfriend) facing GBV increased after the lockdown lifting 74.1%. Married women still represent the majority in this category GBV against single women is almost the same with 18.4% after the lockdown lifting against 18.9% during the lockdown period. The rate drops to 6.8% for widowed, divorced women.

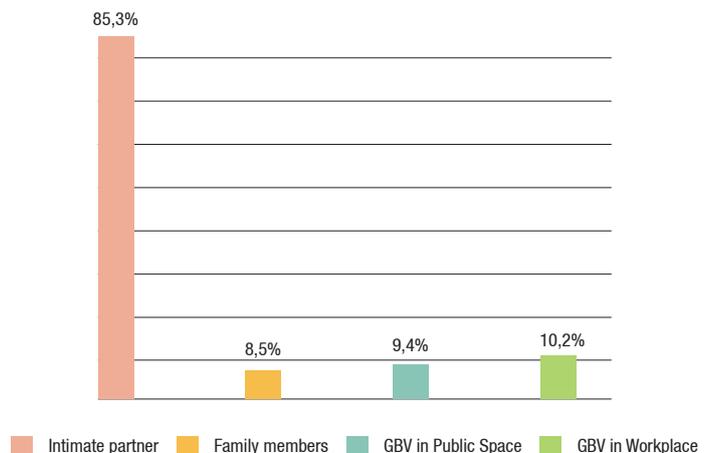
Figure 52 - GBV experienced by Women and civil status after the lockdown lifting



5.2. The GBV perpetrators

Talking about GBV or its frequency necessarily implies questioning about the person who commits this violence whatever is the women status, its form or frequency. The GBV perpetrators of violence have not really changed but their number and specificity of acts of violence have evolved with the evolution of the situation⁽¹⁷⁸⁾ on one hand in relation with the opening up of the public space and subsequent easing of pressure on the private space, on the other.

Figure 53 - GBV Perpetrators after the lockdown lifting



Indeed, violence committed by the intimate partner (husband, ex-husband, fiancé or boyfriend) decreased from 92.4% during lockdown to 85.3% after it was lifted, as shown in the figure 53. There is very little difference between the rates of violence during the lockdown period (8.7%) and after the measures have been lifted with 8.5% of women who declared having faced GBV from their family members (i.e. father 3.1%, brother 2.3% and 3.1% for son).

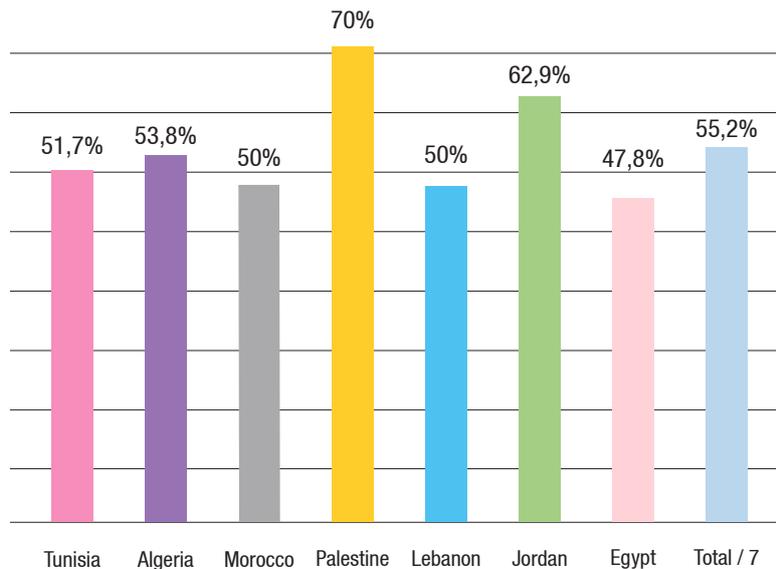
In contrast, violence in the workplace against female employees and colleagues increased from 2.2% (during the lockdown) to 9.4%, combining equally employer/supervisor and co-workers. This increase is explained by going back to work in a difficult and fragile socio-economic context. The GBV in public space is estimated at 10.2% indicating clearly the change due to the removal of a number of restrictions such as of movement but not much since some others to only quote social distancing remain a cautionary measure, as people are still very wary of public transportation, to name just one example.

178. During the lockdown and after

5.3. Concomitance of GBV types

To the question, “*have you experienced more than one form of violence at the same time?*”, slightly more than 55% of the respondents answered in the affirmative, with variations from one country to another.

Figure 54 - Concomitance of GBV types per Country



As shown in the above figure, 70% represents the Palestinian women who reported experiencing more than one type of violence at the same time. They are followed by Jordanian women (62.9%), Algerian women (53.8%), Tunisian women (51.7%), Moroccan and Lebanese women (50%) and finally Egyptian women who experience the least this concomitance (47.8%).

Despite a decrease in violence after the lifting of the lockdown compared to the stressful period before, more than half of the interviewed women (51.1%) said that they had faced, at the same time, both physical and verbal violence (35% in lockdown), 21.5% both verbal and psychological violence and 15.2% suffered both physical and moral violence.

It is important to recall that with the lockdown lifting and resumption of traffic and activities in the society and economy of their countries, the sexual harassment also reappeared with a rate of with 8.6%.

PART II-2: STAKEHOLDERS INVOLVED IN GBV

BACKGROUND

The assessment targeting the stakeholders consisted of virtual consultations and field surveys.

The Center of Arab Women for Training and Research (CAWTAR) organized, on October 21, 2020, a virtual meeting, via ZOOM, on “Gender-Based Violence during a sanitary crisis: The case of COVID-19” which was attended by around 70 stakeholders from the covered seven countries, Ministries, Women mechanisms, Associations and International Agencies (regional and country representatives) were present. The meeting started with opening remarks that set out the meeting goals and agenda, highlighted CAWTAR’s main actions during COVID-19, and presented the research framework, objectives, hypotheses as well as the methodology, tools and expected outcomes.

During the discussion, it was stressed that the study would be context-specific, with focus on the preventive measures taken in each of the concerned countries. It would be conducted using a random sample of (1,000) women and stakeholders, and based on accurate data and statistics from national, regional and international sources. Given the limited time allotted to the study (10 days), the sample could be extended to other associations working outside the field of women’s rights and Gender-Based Violence (GBV).

Participants expressed their readiness to be actively involved in the study by providing their views, initiatives, and suggestions as well as the relevant documents and accurate and updated data and information, while seeking to involve women victims/survivors of GBV in the field research.

Regarding the issue of GBV in relation to COVID-19 lockdown and constraints, participants highlighted, inter alia, the following facts :

- Violence against women, including economic, social and legal violence, had increased during COVID-19 in almost all countries.
- Considerable problems and difficulties have left women victims/survivors of GBV with inadequate or no access to justice.
- Some countries have no clear plans for the prevention and elimination of GBV, nor coherent policies for the promotion of health, social and economic programs in response to the crisis.
- Shelters or any other kind of reception centers for women victims/survivors of GBV are either not available, or difficult to reach.
- Rural women suffer from greater marginalization and inadequate response to their needs.

Among the actions undertaken by the relevant associations and public institutions to combat GBV, participants declared the following :

- Listening to women victims of domestic/marital violence;
- Providing psychological support and legal counsel to women victims/survivors of GBV by specialists over the phone or via social media;
- Concluding agreements with official authorities for the provision of services, advice and financial aid to women victims/survivors of GBV;
- Increasing coordination between civil society and the relevant ministries and institutions to provide shelters, hotlines, (online) complaint mechanisms, and counseling services for women victims/survivors of GBV;
- Launching awareness campaigns targeting large numbers of women, and holding seminars and lectures addressing highly sensitive issues;
- Collecting data and conducting studies on domestic/marital violence and on women’s perceptions of GBV.

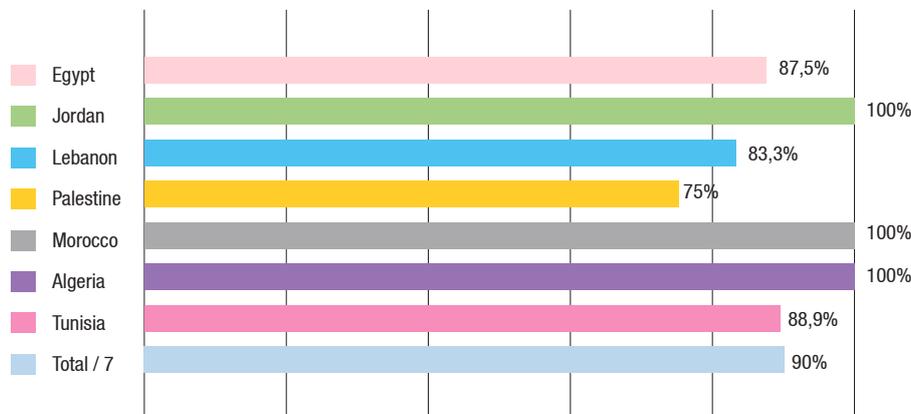
Concerning the field survey, the number of surveyed stakeholders i.e. 50, was not as expected, however the collected information, even if it could not be considered as representative of all stakeholders, describe very well the reality and trends. It completes or confirms the information provided by women either GBV survivors or not and sometimes give the appropriate ways to understand it or analyze it.

EXPERIENCE OF GBV BEFORE THE COVID-19 LOCKDOWN

1. GBV interventions before the COVID-19 lockdown

To the question “Did you have specific GBV interventions before the lockdown?”, 90% of the 50 stakeholder representatives answered in the affirmative.

Figure 55 - GBV specific interventions of Stakeholders, before the pandemic, by Country



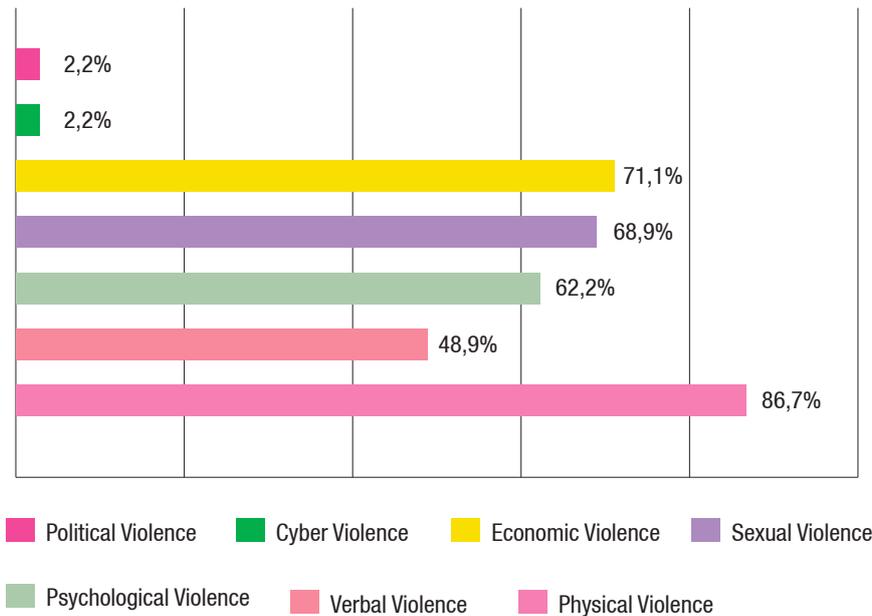
100% of the stakeholders in Algeria, Morocco and Jordan stated that they had specific interventions prior to the lockdown, followed by Tunisia (88.9%), Lebanon (83.3%) and Palestine (75%).

2. GBV, types and forms

2.1. Types de GBV

45 stakeholders had to deal with several types of violence before the lockdown.

Figure 56 - Types of violence dealt with by Stakeholders before the lockdown



86.7% cited physical violence followed by economic violence (71.1%) and sexual violence with 68.9%. Interventions for verbal and psychological violence are estimated at 62.2% and 48.9% respectively. Although the rate is minimal compared to other types, “new” forms not quoted by women, were identified by stakeholders, such as political violence or cyber-violence.

2.2. GBV Forms and related interventions

Stakeholders say they have observed several forms of violence in their work (reception or care), including intimate partner violence (13.3%), cases of multiple/concomitant violences (11.1%) and cases of rape (8.9%) with higher rates than that reported by survivors. As well as girl marriages (6.7%), in which NGOs often play a role as mediators or initiate legal proceedings with the concerned authorities. Father’s violence (4.4%), assault and battery (2.2%) were also mentioned at a lower value, but without being significant in terms of prevalence. In fact, these forms of violence are often dealt with in the emergency services of the health sector, hence the importance of always keeping in mind the type of stakeholders who represent the majority of this sample (i.e. NGOs).

2.3. Type of care and outcomes

In order to understand the type of care provided to GBV survivors by the 45 stakeholders (NGOs/CSOs) in relation to the identified types and forms of violence, they were asked to list their type of interventions. Supervision and psychological support (44.4%) as well as legal assistance (42.2%) were the most frequent before the lockdown. The other interventions consisted of welcoming and orienting the survivors (13.3%). Only 8.9% stated that finding shelter for the victim was part of their duties. Actions such as material assistance to survivors were quoted by 17.8%.

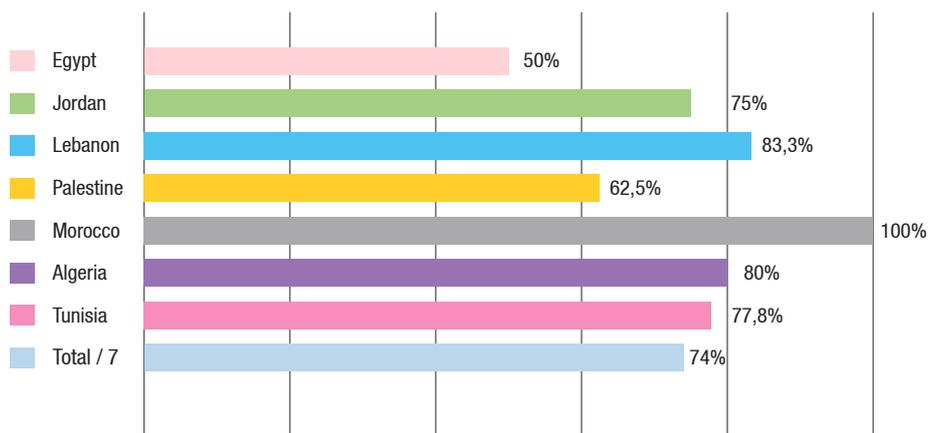
Stakeholders recognized that their intervention made it possible to restore the violated rights of women victims of violence (15.6%), bring a conflictual divorce to a successful conclusion (11.1%), take care of women psychologically (6.7%), help women file a complaint (4.4%) or restore their dignity (4.4%).

EXPERIENCE OF GBV DURING THE COVID-19 LOCKDOWN

1. GBV interventions during the COVID-19 lockdown

74% of the 50 respondents confirmed having had to deal with GBV cases during the lockdown. If the figure is lower than the 90% figure from the previous period, it is still quite significant when taking into account not only the restrictive measures that paralyzed the work of stakeholders, whether government institutions or NGOs that were focused on other emergencies (epidemic, food crisis, economic crisis, citizen safety, etc.) in addition to limited means.

Figure 57 - GBV specific interventions of Stakeholders, during the pandemic, by Country



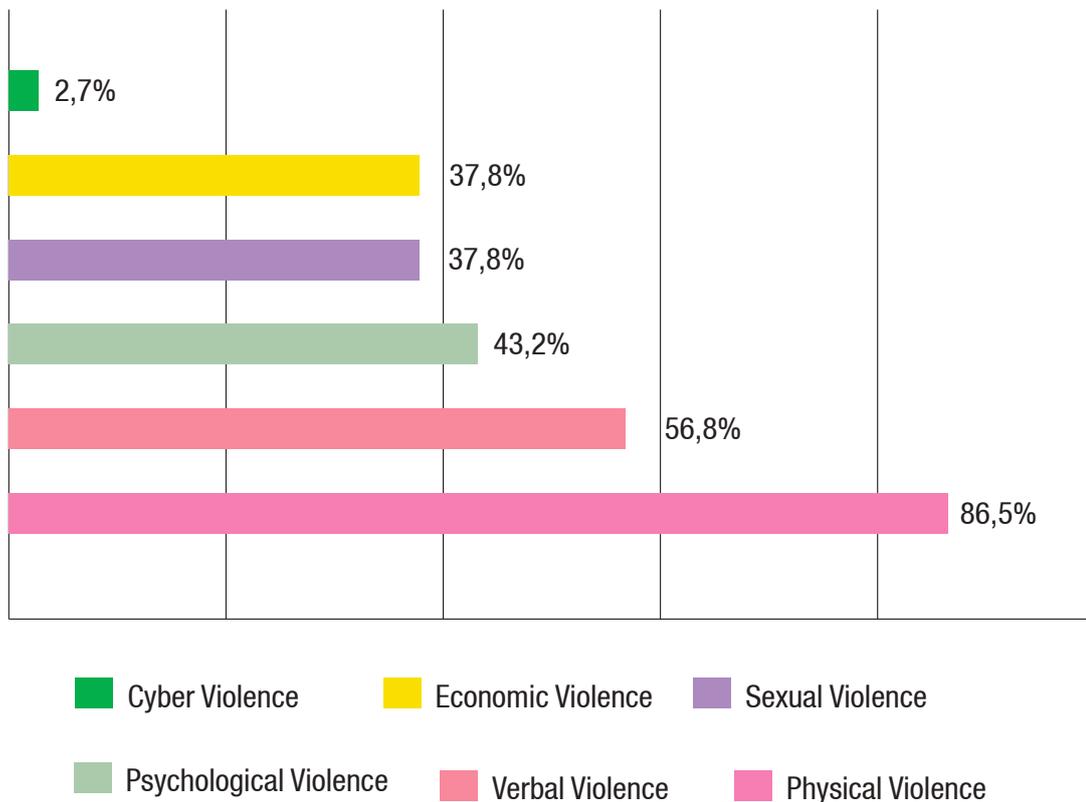
Only stakeholder representatives from Morocco continue to undertake same interventions in addressing GBV (100%). Lebanon maintains the same rate with 83.3%, followed by Algeria (80%), Tunisia (77.8%), Jordan (75%) and Palestine (62.5%). In Egypt, the intervention rate is 50%.

2. GBV, types and forms reported during the lockdown period

2.1. GBV Types

With the exception of cyber-violence, 37 stakeholders had to deal with the same types of violence that the women reported having suffered during the lockdown.

Figure 58 - Types of violence dealt with by Stakeholders during the lockdown



In fact, physical violence remains pervasive with almost the same figure as before the lockdown and as reported by women (86.5%). Verbal violence increases to 56.8%. Interventions concerning psychological (43.2%), sexual and economic violence (37.8%) have decreased. These figures confirm both the impact of barrier measures as a whole and the difficulties mentioned by the women in asking for help, not to say calling for help, due to the permanent coexistence, not to say promiscuity, with the perpetrator of the violence. They also reported that they even felt to be watched over by him or by a third person.

According to the stakeholders, the increase in cyber-violence (2.7%) or experiencing violence increased slightly with the increase in time spent online (work and/or distance learning or even social networks).

2.2. GBV Forms and related interventions

- **Physical Violence**

As for women, physical violence is according to the 37 stakeholders at the relatively high rate of 86.5%. It is estimated at 100% in Algeria, Lebanon and Palestine, 85.7% in Tunisia followed by Jordan (83.3%), Egypt (75%) and Morocco (66.7%). As for the forms in which physical violence manifests itself, these are mainly assault and battery (70%), deprivation of food (13%), deprivation of care (11%) and sleep deprivation (6%).

- **Verbal abuse**

56.8% of respondents stated that verbal violence during the lockdown is an established fact. For the Moroccan stakeholders, verbal violence during the period is estimated at 100%. It is 75% for Algeria, followed by Jordan (66.7%), Palestine (60%), Egypt (50%), Lebanon (40%) and finally Tunisia at 14.3%. The most common or most frequently reported forms of verbal violence are insults (56.8%) and shouting (16.2%).

- **Psychological violence/Emotional abuse**

According to stakeholder responses, women followed in consultation or taken care of during this lockdown period and complaining of psychological violence represent on average for the 7 countries a rate of 43.2%. The highest rates are reported in Morocco (83.3%) and Algeria (75%). The other rates are closer to the regional average with 40% for Palestine, followed by Jordan (33.3%), Tunisia (28.6%), Egypt (25%) and Lebanon (20%). Apart from Lebanon, Egypt and Tunisia, these figures are more consistent than those of the surveyed women. These differences can be generated by a deeper knowledge of psychological violence and its different aspects of professionals or activists compared to ordinary women. The forms of psychological violence identified are threats with a rate of 44%, ignorance and contempt evaluated at 32% and devaluation in public and private spaces at 24%.

- **Sexual violence**

With a regional rate of 37.8%, sexual violence seems to be a relatively high type of violence, according to service providers and associations, but isn't it rather the one that is least reported by the victims themselves? The highest rate is recorded in Palestine (60%), followed by Jordan (50%), followed closely by Tunisia (42.9%), Morocco (33.3%), Algeria (25%) and Lebanon (20%). The most frequently reported forms of rape are marital rape, with a very high rate compared to that reported by the women themselves, followed by sexual harassment (25%), rape in general (17%), and finally touching (12%).

- **Economic violence**

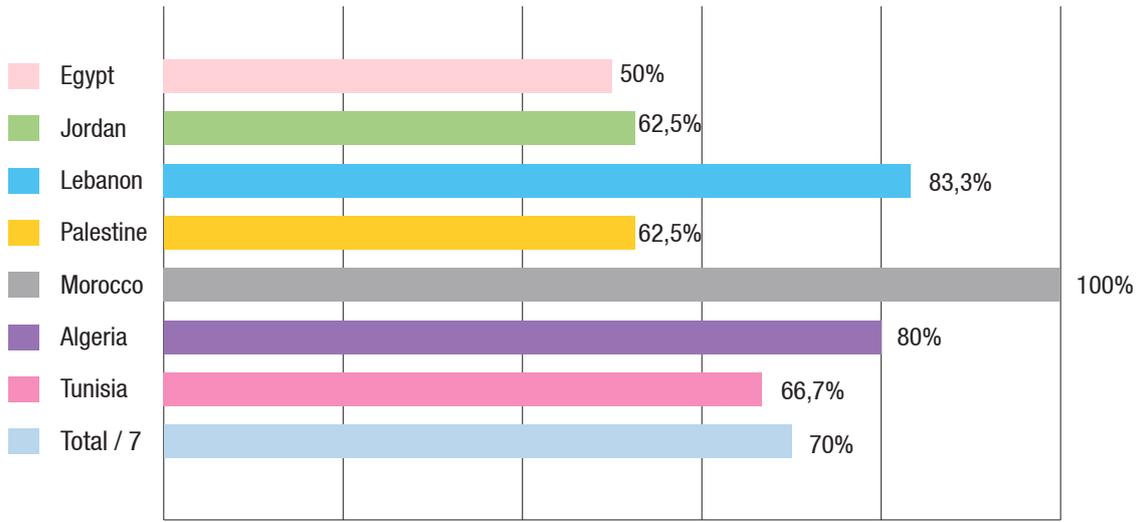
As for women, economic violence—as sexual violence—is the lowest in the 7 countries with a regional average of 37.8%. The figures do not always reflect the reality if we refer to the 0% of Palestine whose economic precariousness is known, including because of the measures imposed by the Israeli occupier in general and in Gaza in particular. Apart from the 0% of Palestine and Egypt and for the remaining countries covered by this assessment, this rate is variable with 60% in Lebanon, 57.1% in Tunisia and 50% in Jordan and Morocco. It is 25% in Algeria and another 0% of responses is recorded in Egypt.

The lack of help in these difficult times and the non-payment of alimony are the most preponderant forms and causes of economic hardship with a rate of the most consequent typology at 48%. Wage deprivation is rated at 36%, which is fairly close to the findings of the assessed women. Being the sole provider of economic and financial support for the family was also noted at 16% among the women either interviewed or monitored by the stakeholders.

2.3. Concomitance of GBV types and forms

70% of the 50 stakeholder representatives attested that the women they monitored reported experiencing or continuing to experience multiple and concomitant types and forms of violence during the lockdown.

Figure 59 - Concomitance of types and forms of violence during lockdown



This concomitance is affirmed at 100% in Morocco, 83.3% in Lebanon, 80% in Algeria, 66.7% in Tunisia, 62.5% in Jordan and Palestine and 50% in Egypt. 35 respondents stated that the types and forms of violence may be concomitant in time and space through several formulas starting with the combination of physical and verbal violence, the most frequent and therefore the highest with a rate of 65.7%. It is followed by the combination of physical and sexual violence with 54.3% and physical and psychological violence with 51.4%. As for verbal and psychological violence, simultaneity is reported at 42.9%. The rates recorded on the concomitances of types and forms of violence vary from country to country.

- **Physical and verbal abuse**

83.3% of stakeholders in Morocco reported having observed the concomitance of these two forms of violence witnessed by their patients or clients, compared to 75% in Algeria and Egypt. Other rates were recorded in Lebanon and Palestine (60%), Tunisia (50%) and Jordan (40%).

- **Physical and sexual violence**

Still for the same number of stakeholders, i.e. 35, this concomitance is evaluated at an average rate of 54.3% for the 7 countries covered by this assessment. This rate is 80% in Lebanon and Palestine, 66.7% in Tunisia, 40% in Jordan followed by Morocco (33.3%), Algeria and Egypt (25%).

- **Physical and psychological violence**

Slightly more than half of the actors who answered this question (51.4%) said that women survivors of GBV who spoke to them reported having experienced both physical and psychological abuse. This number is much higher than the regional average in Jordan (80%) followed by Morocco with 66.7%. The other reported data are more or less equal or inferior to the regional rate with, in order, Egypt and Tunisia (50%), Palestine (40%), Algeria (25%) and finally Lebanon (20%).

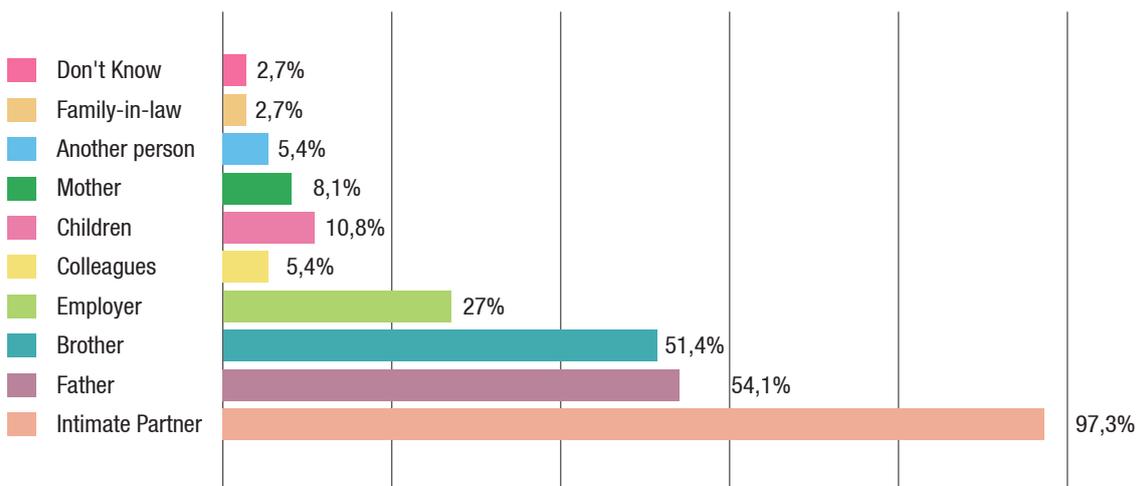
- **Verbal and psychological abuse**

The regional average for the concomitance of these two types is 42.9%. It is 66.7% for Morocco followed by Egypt at 50%. The other results are more or less close to the regional average with 40% for Jordan and Palestine, 33.3% for Tunisia, 25% for Algeria and 20% for Lebanon.

2.4. GBV perpetrators

Stakeholders report that from what they have observed from GBV survivors who have talked to them, it seems that the violence witnessed by women during the lockdown occurs mainly within the family. We would be tempted to say, “what could be more normal?” Indeed, it is a universal reality, established even outside of crises (conflict, natural disaster, pandemic...), that the place where women and girls suffer the greatest number, types and forms of violence is the one where they are supposed to find peace, security and protection i.e. the family. However, one must imagine the extent to which the restrictive measures imposed by the total lockdown, in the form of the permanent coexistence, not to say promiscuity, that puts them in danger day and night and the restriction of movement that prevents them from calling or asking for help.

Figure 60 - GBV perpetrators reported by stakeholders



As usual and across physical and socio-cultural boundaries, in the MENA region and beyond, it is the intimate partner (spouse, fiancé or boyfriend) who is at the top of the “GBV hit parade” with a record 97.3% as it is the case in this assessment. Other perpetrators of violence are fathers (54.1%), brothers (51.4%), children (10.8%), mothers (8.1%) and in-laws (2.7%). Knowing that some professional sectors have not been stopped, women also face violence from their employer at 27% and from their colleagues at 5.4%. 8.1% grouped the answers of those who “do not know” or could not specify “another person”.

Apart from new specifications of perpetrators of violence (mother and in-laws) reported by stakeholders for having heard them from GBV survivors, the stakeholders’ responses confirm and consolidate those of women for this same category.

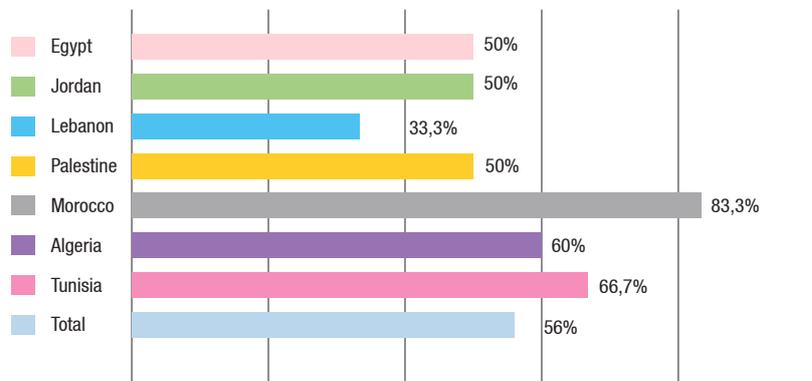
EXPERIENCE OF GBV AFTER THE COVID-19 LOCKDOWN LIFTING

1. GBV observations after the lockdown lifting

Even if the sanitary measures are still more or less in force in the 7 countries from which the samples were selected (women or stakeholders), the lifting of total lockdown has been decreed in most of the countries. The 50 stakeholders also had their say on how this change in situation has had an impact on GBV prevalence, on types and forms of violence or on the concomitance of certain forms. 56% of them declared that they had observed the same GBV experiences as before the lifting of the lockdown, but 44% considered that some changes could be noted.

83.3% of stakeholders in Morocco said they saw no change after the lockdown, followed by Tunisia at 66.7% and Algeria with 60%. Opinions are mixed for Egypt, Jordan and Palestine with 50% declaring having seen a change following the lifting of total loc. The Lebanese observed this change in the situation at 33.3%.

Figure 61 - GBV observations of stakeholders, after the lockdown, by Country

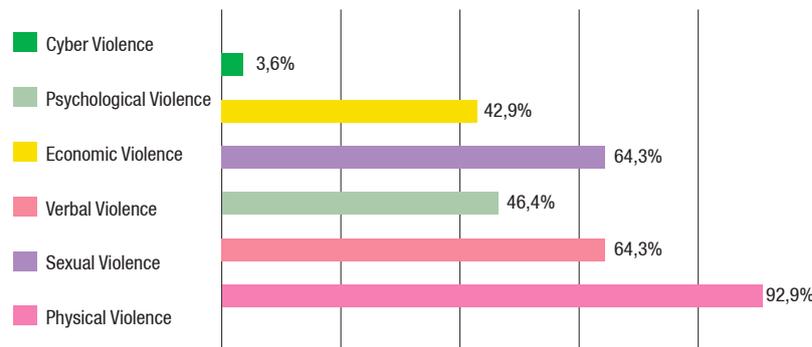


2. GBV, types and forms reported after the lockdown period

2.1. Types of GBV

28 stakeholders reported that they had to deal with the same types of violence witnessed during the lockdown, but that the number of cases they had to deal with increased significantly. The lifting of some measures, such as restrictions on movement seems to be the obvious reasons of that change.

Figure 62 - Types of violence addressed by stakeholders after the lockdown



The highest rate is again physical violence with 92.9%. Stakeholders also noted an exceptional increase in sexual violence with a rate identical to that of verbal violence (64.3%) as well as psychological violence, which rose to 46.4%, followed by economic violence (42.9%) and cyber-violence (3.6%).

2.2. GBV Forms and related interventions

As noted above, it is understandable that stakeholders report that the types and forms of violence against women and girls increased after the lifting of the confinement because they were finally able to get to the various consultations.

- **Physical Violence**

In contrast to the experience of GBV survivors who reported a decrease in physical violence after the lockdown, stakeholders reported an increase in physical violence to 92.2% during this period. With the exception of stakeholders in Morocco, where the rate was 60%, indicating a minimal decrease of 6.7%, the remaining 6 countries unanimously confirmed that the figure has reached 100%. Physical violence is expressed as assault and battery (68%) showing a small decrease (-2%), as is food deprivation (10%), care deprivation (11%), and sleep deprivation (8%). With a rate of 3%, burn is a form that only appeared or was declared after the lockdown.

- **Verbal abuse**

As with other types of violence, stakeholders reported that verbal violence also increased to 64.3%, a regional rate for all 7 countries. This increase is 100% in Jordan and Lebanon after the lockdown while stakeholders in these two countries reported it at 66.7% and 40% during the lockdown. It is 66.7% in Algeria and 50% in Egypt, Palestine and Tunisia. In Morocco, verbal violence, which was at its peak during lockdown (100%), decreased by 40% after the lifting of the measures with a rate of 60%. The forms are the same as before. According to the $\frac{3}{4}$ of the interviewed stakeholders, insults are still high with a rate of 72% followed by shouting at 28%.

- **Psychological Violence/Emotional abuse**

According to 46.4% of stakeholders, the women they receive continue to complain of psychological violence after the lockdown, without any significant change being noted. The highest rate, 80%, was reported by stakeholders in Morocco, followed by Egypt at 75%, Jordan and Palestine at 50%, Algeria at 33.3%, and the lowest is in Tunisia at 16.7%. No information was provided by Lebanese stakeholders. The manifestations of psychological violence are ignorance and contempt at 42%. Threats increased to 37% after the lockdown. As for the devaluation of women, in the public or private space, it decreased somewhat (-3%) to a rate of 21%.

- **Sexual violence**

According to the responses provided and compared between GBV survivors and stakeholders, sexual violence, with a rate of 64.3%, has never been so high, neither before the COVID-19 pandemic nor during the lockdown. Would it have really increased to such a level or would women be much more comfortable confiding in stakeholders because of their mandate and obligations (confidentiality, professional secrecy...)? The rates doubled and sometimes even quadrupled. It is 100% in Algeria, 83.3% in Tunisia, 75% in Palestine, 60% in Morocco, 50% in Egypt and Lebanon, and 25% in Jordan. Stakeholders report having handled cases of rape (39%) and marital rape, which relatively declined but still remains high with a rate of 26%. With the lifting of the lockdown, sexual harassment has "soared" to a rate of 29%, certainly due to the lifting of a number of restrictions and people going back to work. However touching is more or less low, thanks to social distancing but also to the more limited use of public transportation.

- **Economic Violence**

Contrary to other GBV types, participants report that economic violence, with a regional rate of 42.9%, appears to be decreasing slightly (-5%), albeit very slightly. This also refers here logically to the lifting of certain measures that allowed certain sectors to resume their activities, to cite the example of the production and trade sectors. Many workers who had seen their wages suspended or their income disappear, were able to resume their work, especially among day laborers or the informal sector, the majority of whom are women.

Comparing the findings obtained during the lockdown and those for the period after it was lifted, made clear that, as the regional rate, Lebanon and Morocco observe a 10% decrease with responses at 50% and 60%. However, according to stakeholders in each of the countries concerned, an increase of 10% was noted in Algeria (33.3%) and Tunisia (66.7%). Egypt, which was at 0% economic violence during the lockdown, shows a rate of 25% after the measures were lifted.

Deprivation of aid/subsidies remains the highest with the same rate of 48% as during the lockdown period. However, 8% less are no longer facing violence related to the deprivation of their wages, with a rate of 28%. This decrease, similar to the one already observed among women, is explained by the resumption of activity of several businesses and especially by direct access to their income. Women continue to bear the heavy burden of breadwinner alone (24%).

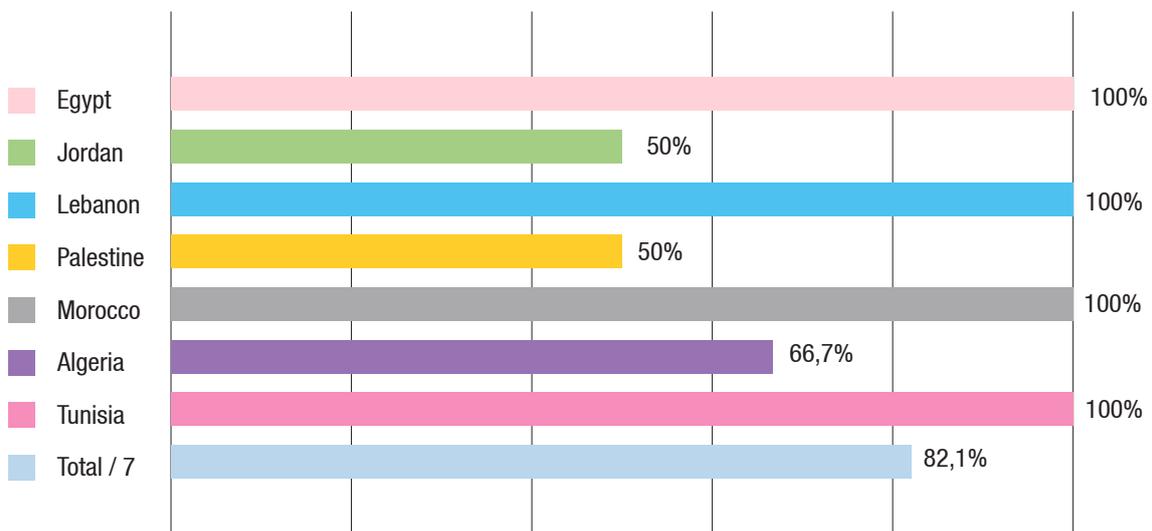
3. Frequency and concomitance of GBV types & forms

The concomitance and frequency of GBV are important variables in assessing the evolution of this phenomenon after the COVID-19 lockdown period.

3.1. Evolution of the GBV frequency after the lockdown

82.1% of the 28 respondents who were able to evaluate the frequency of GBV acts stated that the frequency remained almost the same.

Figure 63 - GBV frequency after the lockdown period, by Country

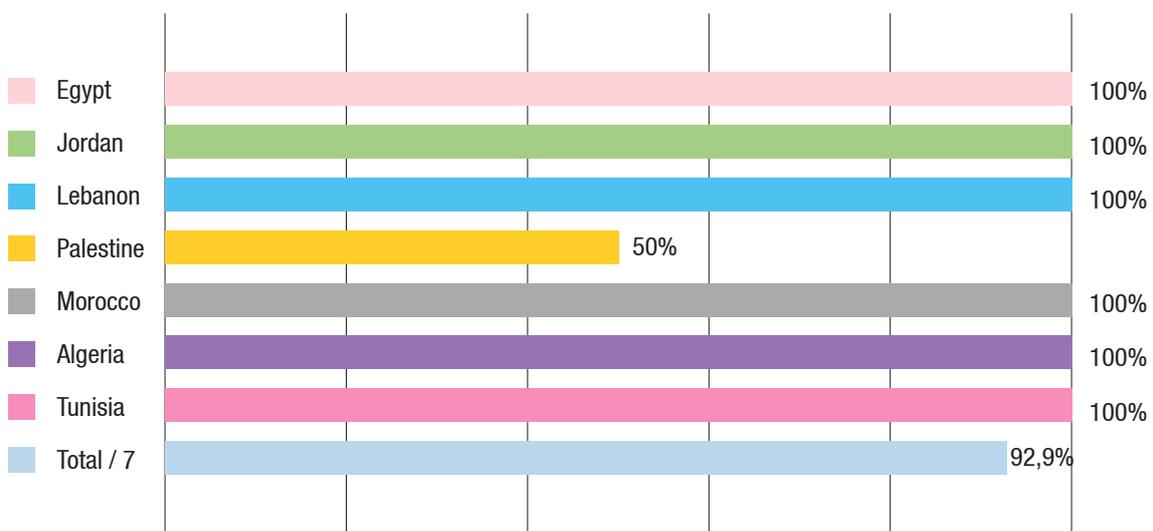


Only 17.9% of the stakeholders declared a change in frequency which is observed in Lebanon and Palestine (50%) as well as in Algeria (66.7%). Based on what GBV survivors said they had listened to, stakeholders in the remaining countries i.e. Egypt, Lebanon, Morocco, and Tunisia reported seeing no change in the GBV frequency compared to previous periods.

3.2. GBV Concomitance after the lockdown period

92.2% of stakeholders believe that, like any misfortune, a type of violence never happens alone, highlighting an increase of more than 20% compared to the lockdown period.

Figure 64 - Concomitance of GBV types and forms, after the lockdown



With the exception of Palestine, where concomitance of GBV forms decreased from 62.5% to 50%, stakeholders, the other six MENA countries report that the situation has not changed for GBV survivors. Despite this, the 26 stakeholders who were able to provide information on this issue stated that the evolution remains consistent. It is around 12% on average except for physical and sexual violence, which increases by 20% compared to the lockdown period. As a result, physical/verbal violence is confirmed with a rate of 88.5%, followed by the combination of physical/sexual violence with 73.1%. Psychological/verbal violence is at 57.7% and psychological/physical violence at 69.2%.

- **Physical and verbal Violence**

Only in Lebanon where no answer is given, physical and verbal violence is clearly increasing in each of the other countries with a regional rate of 88.5%. 100% of the stakeholders in Palestine and Jordan confirm this concomitance of violence after the lockdown, compared to 60% and 40% respectively in the previous period. In Tunisia too, an increase was noted from a rate of 50% (before) to 66.7% after the lifting of total lockdown measures. According to stakeholders in these countries, Algeria (66.7%), Egypt (50%) and Morocco (66.7%) are experiencing a decrease.

- **Physical and sexual Violence**

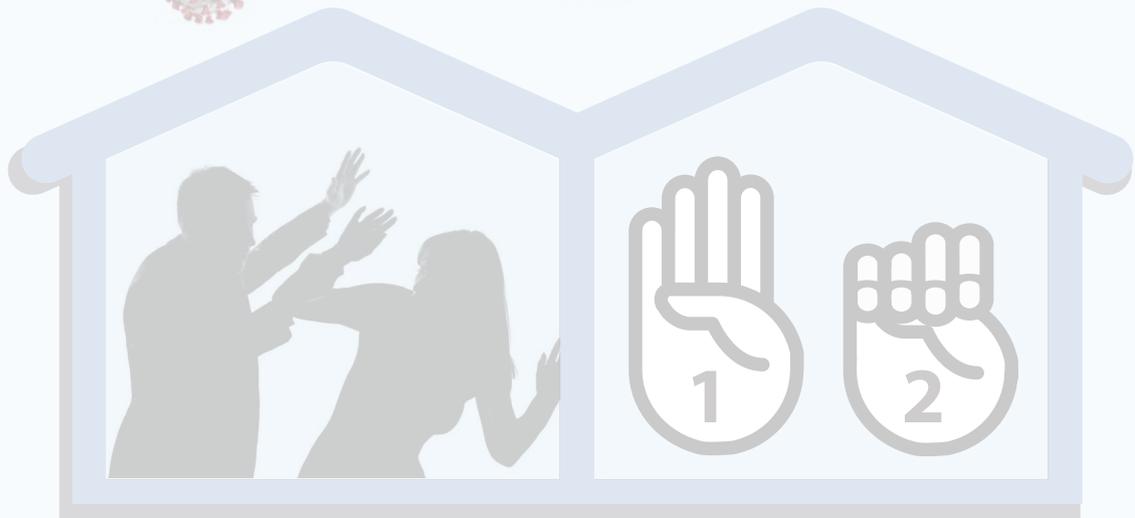
With the dramatic increase in sexual violence after the lockdown, for the various reasons mentioned above, the effect on the “physical/sexual violence” combination could only be evident with stakeholder confirmation at 73%. This significant increase is also reported by stakeholders in Algeria as being 66.7% after the lifting of the lockdown compared to 25% during the previous period. The same is true for Morocco, which increased from 33.3% to 60% while Jordan is at 50%, an increase of 10%. Only Tunisia experienced a decrease from 66.7% to 50%.

- **Physical and psychological Violence**

According to statements from stakeholders in the 7 countries, with a regional rate of 69.2%, this GBV combined form increased by about 18%. The most significant increase is noted in Egypt which went from 50% to 75%, followed by Morocco where stakeholders say it went from 66.7% to 80% and finally Algeria from 25% during the lockdown to 33.3% after it was lifted. Stakeholders in the other countries have rather an experience that makes them assert a decrease in this combined form, as it is the case for Jordan from 80% to 50%, Tunisia from 50% to 33% and Palestine from 50% to 40%. No information was provided on this subject in Lebanon.

- **Verbal and psychological Violence**

As with other forms of concomitant GBV types, verbal violence/psychological abuse also increased after the lockdown (57.7%). With a rate of 50% in Jordan and Palestine, the increase is 10% according to the interviewed stakeholders. With a rate of 60%, it is about 6.7% for Morocco. There was no significant change in either direction in Tunisia (33.3%) and Egypt (50%). No information on this subject is reported by stakeholders in Lebanon and Algeria.



PARTIE III: COVID-19 LOCKDOWN: BARRIER MEASURES & IMPACT

PART III: COVID-19 LOCKDOWN: BARRIER MEASURES & IMPACT

PART III-1: WOMEN GBV SURVIVORS OR NOT

IMPACT OF THE COVID-19 LOCKDOWN ON OTHER RIGHTS OF WOMEN AND GIRLS

1. The parallel pandemic: GBV & COVID-19 Consequences

GBV is the type of violence to which women—more than any other—are exposed at all stages of their lives, because of their biological sex and their gender identity as women in a given community. It is an extremely complex social phenomenon, deeply rooted in patriarchal gender-based relationships, in sexual life, in the formation of self-identity and in the structure of social institutions.

All publications, mainly briefing note or policy papers produced throughout the world including in MENA region were based on assumptions and/or expectations (may, will, could...) inspired by gender knowledge and experience. The purpose was to conduct a COVID-19's impact assessment on women status, needs, Gender Equality, GBV... to propose to policy makers a series of actions to be taken into consideration either in emergencies or for a longer term.

Based on their experience and mandate; most agencies and organizations⁽¹⁷⁹⁾ assessed the multiple risks women had to face during the lockdown period in the MENA region and the impact of the COVID-19 on women and girls. This includes but are not limited to:

- Health care, Sexual and Reproductive Health/SRH,
- Protection of Health workforce,
- Lack of economic opportunities, poverty,
- Food insecurity and malnutrition,
- Access to information (technology and distance learning) ...

In fact, the GBV issue is closely related to Health as well as Sexual and Reproductive Health/SRH. It is defined as a “public health issue” by the World Health Organization and considered as an integral SRH component (ICPD+5).

179. ESCWA, UNFPA, UNDP, UN-WOMEN, EU ...

A World Bank study conducted in 1994 paints a damning picture of the social and health consequences of GBV, considered a major cause of death and disability for women aged 15-44. According to this study, women in this age group face ten risk factors, with the dangers of rape and domestic violence outweighing the dangers of cancer and car accidents, war and malaria.⁽¹⁸⁰⁾

Several studies have highlighted a growing relationship between GBV and HIV/AIDS. For example, 48% of women who have experienced violence are at increased risk of contracting HIV/AIDS.⁽¹⁸¹⁾ Furthermore, the Joint United Nations Programme on HIV/AIDS/ UNAIDS, confirms that, although its rate is still low, the Arab region ranks first in the world in terms of the increase in the spread of this disease, which is also increasing annually throughout the world, especially among women, and married women in particular. This is also linked to the low status of women in society and their inability to make decisions, including those that threaten their sexual and reproductive health and lives. This is due to the social and gender construction of the society, cultural structure and distribution of gender roles and relationships that lead to male dominance, reinforced by laws to only code the Personal Status Code/Family Law.⁽¹⁸²⁾

Just for instance, according to the data published by UN Women and ESCWA on the impact of COVID-19 on Gender Equality,⁽¹⁸³⁾ women in the Arab Region are exposed to conditions that increase their risks to contract the COVID-19. *“It is now difficult for many women to access psychological support, healthcare and safe shelter. They live in a constant state of vulnerability. For communities affected by conflict and displacement, these effects are often compounded”*.⁽¹⁸⁴⁾

Moreover this situation is due not only to the limits to access to health care but also because women in many countries of the region, as it is the case in other regions dominate the health and social professionals (female nurses, midwives and support staff and even physicians in many places and services).⁽¹⁸⁵⁾ Indeed and as also stressed by the OECD, “as in many regions of the world, MENA women are at the core of the health emergency response as they make up the majority of workers in the healthcare and social services sector across the region, thus exposing them to greater risks of contracting the virus”.⁽¹⁸⁶⁾

With regards to the women’s economic situation, for many reasons, more women were expected to fall into poverty during the COVID-19 pandemic affecting female-headed households but also because the impact of the lockdown on the economic situation as a whole. *“There are socioeconomic consequences when these crimes happen, but in times of pandemic, the socioeconomic impact is even deeper”*.⁽¹⁸⁷⁾ According to the same source,⁽¹⁸⁸⁾ the COVID-19 pandemic and consequent lockdown are expected to result in the loss of 1,7 million jobs in the Arab Region with an estimated

180. Heise, Loril; Pitanguy, Jacqueline, Germain, Adrienne, 1994. Violence Against Women: the hidden health burden. <http://documents.worldbank.org/curated/en/1994/07/442273/violence-against-women-hidden-health-burden>

181. <http://www.womenshealth.gov/hiv-aids/women-are-at-risk-of-hiv/violence-against-women-and-hiv-risk> <http://www.genderandaids.org/index.php>

182. High-Level Meeting of Women Leaders of the Middle East and North Africa Region, 10-11 November 2014, Achieving Gender Equality and Combating HIV/AIDS, in the Framework of the Arab Strategy 2014-2020 and the Post-2015 Development Agenda, UNAIDS, Regional Office

183. UN Women and UN ESCWA The impact of COVID-19 on Gender Equality in the Arab Region, <https://arabstates.unwomen.org/en/digital-library/publications/2020/04/the-impact-of-covid19-on-gender-equality-in-the-arab-region>

184. Nobel laureate Nadia Murad, UNODC Goodwill Ambassador and a survivor of ISIL terrors in Iraq, <https://news.un.org/en/story/2020/11/1078812>, 30 November 2020

185. Idem

186. OECD Policy Responses to Coronavirus (COVID-19) : COVID-19 crisis in the MENA region: impact on gender equality and policy responses 10 June 2020 <https://www.oecd.org/coronavirus/policy-responses/covid-19-crisis-in-the-mena-region-impact-on-gender-equality-and-policy-responses-ee4cd4f4/#section-d1e115>

187. The UN Women Executive Director <https://news.un.org/en/story/2020/11/1078812>, 30 November 2020

188. UN Women and UN ESCWA The impact of COVID-19 on Gender Equality in the Arab Region, <https://arabstates.unwomen.org/en/digital-library/publications/2020/04/the-impact-of-covid19-on-gender-equality-in-the-arab-region>

700,000 jobs held by women noting the already high unemployment of women reaching 19% in 2019 compared with 8% for men. *“Forty-seven million more women and girls will be pushed to extreme poverty because of COVID-19, but business is booming for traffickers... Meanwhile, as already scant resources allocated for prevention, rescue and rehabilitation wear thin, women’s health is being put on the line...”*⁽¹⁸⁹⁾

An assessment conducted by EU, UNFPA, Institute for Family Health and Plan International in Jordan⁽¹⁹⁰⁾ covered about 400 respondents including 360 remote and telephone surveys targeting adolescent and adult men and women,⁽¹⁹¹⁾ 28 key informant interviews (KII) with GBV and SRH service providers, youth educators, and members of the government; and two focus group discussions (FGD) with women and girls from the refugee⁽¹⁹²⁾ and Jordanian population. Among the most important findings, the following was highlighted:

The COVID – 19 pandemic related restrictions taken by the government to limit the spread of the virus and consequent loss of mobility, control and agency and personal space either in private or public space “have led to greater uncertainty, stress and health and psychological risks for women and girls, many of whom already faced the challenges of entrenched gender inequality and discrimination.”⁽¹⁹³⁾ The situation is more complex for women and girls who have endured displacement or any other special circumstances”. Worry, stress and anxiety feelings were expressed by 71% of all respondents (women, girls, men, and boys). 78% of adult women in particular reported high levels of worry.⁽¹⁹⁴⁾

86% of all respondents believe that their economic security is threatened and will aggravate poverty. Only 55% of women and 58% of men declared that they were able to meet their family’s basic needs during the curfew. Women and girls’ access to Income Generating Activities/IGA and material assistance in all age groups is less than 50% that of men and boys. For instance, only 7% of adolescent girls reported accessing IGA or material assistance in comparison to 24 % of boys of the same age.⁽¹⁹⁵⁾

The COVID-19 pandemic and related lockdown measures also restricted access to GBV and SRH services particularly in comparison with the period prior to the sanitary crisis. Although virtual sexual and reproductive health and GBV services have been set up, access to them has not always been easy: 48% for 10 to 17 year-olds, 38% for 18 to 24 year-olds and 49% for adult women aged 25 to 34. Women and girls who participated in virtual services generally received them well and said that the service made them feel better, although some respondents and service providers said that virtual services could not really replace face-to-face services.⁽¹⁹⁶⁾

Interviewed women and girls declared facing barriers in accessing sexual and reproductive health services. For at least 10% of all age groups surveyed, there was less information or guidance during lockdown than before on how to access these services. Pills and condoms continue to be available in pharmacies, but access to family planning counselling is not: an increase of 10-20% in the number of

189. Nobel laureate Nadia Murad, UNODC Goodwill Ambassador and a survivor of ISIL terrors in Iraq, <https://news.un.org/en/story/2020/11/1078812>, 30 November 2020

190. EU, UNFPA, Institute for Family Health, Plan International: Daring to Ask, Listen, and Act: A Snapshot of the Impacts of COVID-19 on Women and Girls’ rights and sexual and reproductive health, April/May 2020 https://www.planusa.org/docs/COVID-19_And_Gender-Based-Voillence_In_Jordan_Report.pdf

191. From Irbid, Karak, Amman governorates and Azraq and Za’atari refugee camps

192. Syrian, Palestinian, Egyptian, Sudanese respondents either refugees, displaced or migrants

193. EU, UNFPA, Institute for Family Health, Plan International: Daring to Ask, Listen, and Act: A Snapshot of the Impacts of COVID-19 on Women and Girls’ rights and sexual and reproductive health, April/May 2020 https://www.planusa.org/docs/COVID-19_And_Gender-Based-Voillence_In_Jordan_Report.pdf

194. Idem

195. Idem

196. Idem

women who cannot access family planning at all, is noted.⁽¹⁹⁷⁾ It is reported that in some contexts of Intimate Partner Violence/IPV, the number of cases is tripled as households face additional economic stress and are forced into long periods of isolation in confined spaces due to social distancing and quarantine procedures related to COVID-19.⁽¹⁹⁸⁾

What was a series of hypotheses when the various COVID-19 related publications began in March 2020, became reality almost a year later. According to UNDP,⁽¹⁹⁹⁾ one of the consequences of the quarantine introduced in many countries as a result of COVID-19 has been the increase in unpaid work by women and girls in their households. In this emergency context, migrant women—especially domestic workers—and refugee women found themselves in an even more precarious situation. In addition to restricted movement and isolation, they are exposed to xenophobia, which makes them targets of violence and limits their chances of finding fair employment. Their precarious social and economic situation makes them subject to a higher likelihood of exposure to the disease and vice-versa.

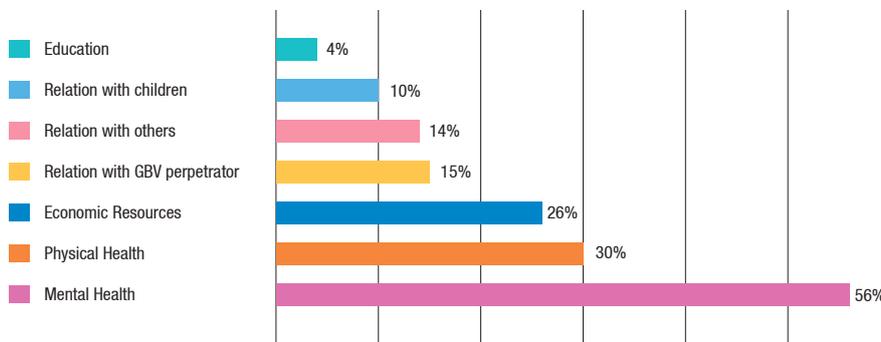
The FAO cited in the same source recognizes that “the basis for the vulnerability of women, especially rural and indigenous women to chronic poverty, is found in discriminatory labor markets and the social exclusion of political and economic institutions”.⁽²⁰⁰⁾

Changes in markets and consumption patterns caused by COVID-19 could exacerbate the level of vulnerability due to a sudden reduction in demand and markets for the sale of agricultural products, reducing available income. Furthermore, the restriction of movement prevents women from carrying out agricultural and livestock activities and obtaining essential resources for their families (e.g. water, firewood, natural food resources, etc.), putting both their well-being and that of their families at risk.⁽²⁰¹⁾

2. The Findings

Women respondents confirmed that the effects of the lockdown period are manifested at several levels and in different areas. The impact can be felt on one’s health, relationships, education and economic situation as summed up in the following graph.

Figure 65 - Effects of the lockdown on Various Aspects & Rights (women)



197. EU, UNFPA, Institute for Family Health, Plan International: Daring to Ask, Listen, and Act: A Snapshot of the Impacts of COVID-19 on Women and Girls’ rights and sexual and reproductive health, April/May 2020 https://www.planusa.org/docs/COVID-19_And_Gender-Based-Voience_In_Jordan_Report.pdf

198. Fraser, E 2020, Impact of COVID-19 Pandemic on Violence against Women and Girls, VAWG Helpdesk, London, UK quoted in Emma Pearce, Disability Considerations in GBV Programming during the COVID-19 Pandemic Author: GBV AoR, https://gbvaor.net/sites/default/files/2020-03/Disability%20Considerations%20in%20GBV%20programming%20during%20COVID_Helpdesk.pdf

199. UNDP: Briefing Note: The Economic Impacts Of Covid-19 and Gender Inequality Recommendations for Policymakers <https://www.undp.org/content/undp/en/home/librarypage/womens-empowerment/the-economic-impacts-of-covid-19-and-gender-equality.html>

200. FAO. The feminization of poverty in the rural sector of the Latin American region: myth or reality? http://www.fao.org/tempref/GI/Reserved/FTP_FaoRlc/old/opinion/anterior/2005/ballara.htm quoted in UNDP: Briefing Note: The Economic Impacts Of Covid-19 and Gender Inequality Recommendations for Policymakers

201. UNDP: Briefing Note: The Economic Impacts Of Covid-19 and Gender Inequality Recommendations for Policymakers <https://www.undp.org/content/undp/en/home/librarypage/womens-empowerment/the-economic-impacts-of-covid-19-and-gender-equality.html>

Of the 723 women who responded to this question, more than half (56%) believe that the negative impact of barriers is more significant for mental health. For one third of them (i.e. 30%), physical health is the most affected.

More than the third declared that their relationships with others (14%) as a whole but also with their children (10%) and their aggressor (15%) were also impacted.

Although the economic crisis caused by the pandemic is global, a quarter of the surveyed women put economic resources in third place with a rate of 26%. Responses on education are not obvious if related to the situation of the education sector during this period.

2.1. Impact on Health

This assessment refers to the WHO definition of Health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.⁽²⁰²⁾ To help both respondents and operators some symptoms and manifestations were provided for each selected sub-category: Physical Health and Mental Health as well as Sexual and Reproductive Health/SRH noting that SRH is also defined as a state of complete physical, mental and social well-being (ICPD, 1994).

It is worth noting that responses on reproductive health issues are very poor.

GBV/VAWG is recognized as a public health issue (WHO/1998) and an integral part of the reproductive and sexual health portfolio (UNFPA 1999). Its prevention is defined as a Development target (MDGs & SDGs).

GBV/VAW has immediate effects on women's health, which in some cases, are fatal. Physical, mental and behavioural health⁽²⁰³⁾ consequences can also persist long after the violence has stopped. The health consequences of violence can be immediate and acute, long-lasting and chronic, and/or fatal.⁽²⁰⁴⁾ Depending on the degree of severity, consequences at the physical and mental levels will be non-fatal or fatal for women and girls who are survivors for a moment. In all cases, both obvious and hidden consequences of Gender-Based Violence on health will have a heavy burden on women's well-being as defined by the WHO and very often their survival.

Any one of the GBV/VAW abuses can damage the health of women and girls in general and leave deep psychological scars. GBV survivors suffer sexual and reproductive health consequences, including forced and unwanted pregnancies, unsafe abortions, traumatic fistula, sexually transmitted infections including HIV, and even death⁽²⁰⁵⁾ to only quote these examples. The morbidity and mortality resulting from GBV/VAW are a concrete and tangible loss: first for women and girls and second for their family, the group to which they belong and the community development.

202. This definition has not been amended since 1948

203. Heise L, Ellsberg M, Gottemoeller M. Ending violence against women. Baltimore, MD, Johns Hopkins University School of Public Health, Center for Communications Programs, 1999. quoted in Understanding and addressing violence against women: Health consequences

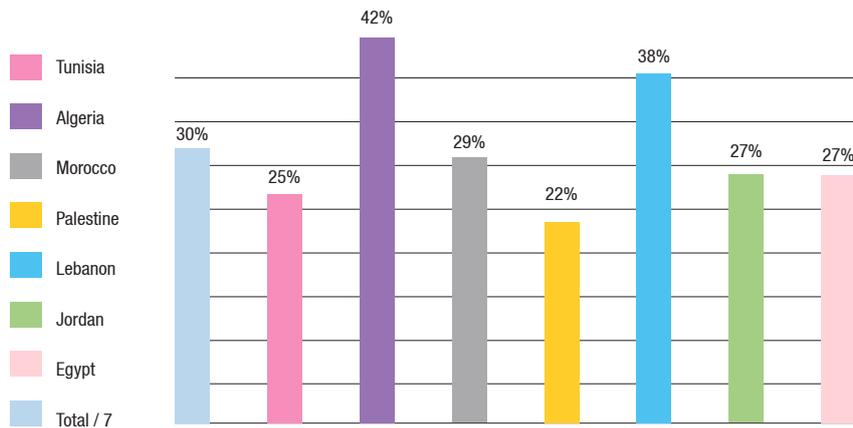
204. Understanding and addressing violence against women: Health consequences http://apps.who.int/iris/bitstream/handle/10665/77431/WHO_RHR_12.43_eng.pdf;jsessionid=C7CCA9C4E688B458861D14CD371EB99D?sequence=1

205. See more at: <http://www.unfpa.org/gender-based-violence#sthash.oma24L8L.dpuf>

2.1.1. Impact on Physical health

30% of the 723 participants in the assessment conducted in the 7 selected countries stated that the lockdown had consequences on their physical health.

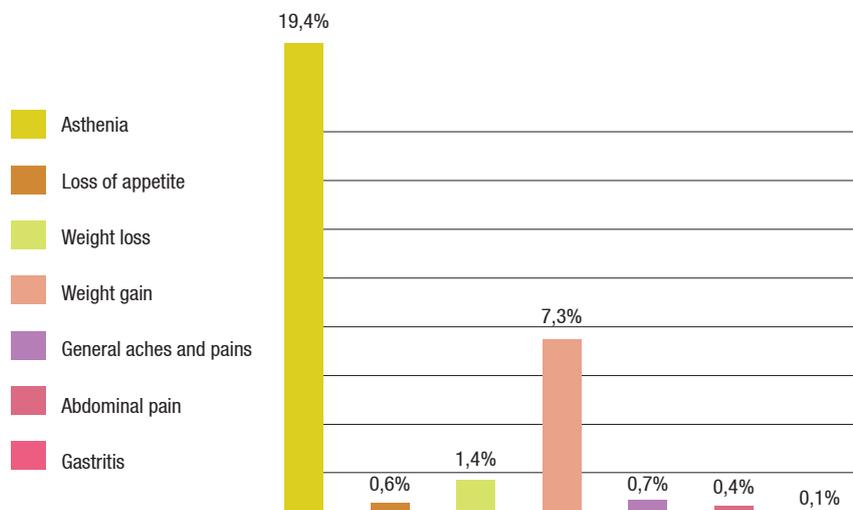
Figure 66 - Impact on Women's Physical Health by Country



However, this impact is above the regional average, for the Algerian respondents (42%) followed by the Lebanese (38%). This rate is 29% for Moroccan women, 27% for Jordanian and Egyptian women and 25% for Tunisian women. Does the 22% of Palestinian women feel that the impact on physical health is less or is it due to the resilience they acquired from living in the difficult conditions imposed by the occupation and war (restriction of movement, curfew, no access to resources...) since generations?

To help both operators and respondents, examples of symptoms have been prepared in advance as to the potential effects of the lockdown impact to only quote asthenia, loss of appetite weight loss, weight gain, general aches and pains (it hurts me everywhere), abdominal pain, gastritis....

Figure 67 - Impact on Physical Health

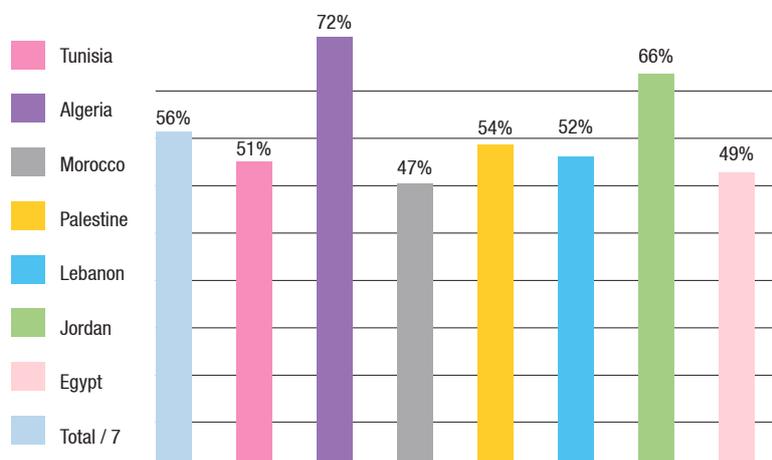


For almost a fifth of the respondents, asthenia is the more important with a rate of 19.4%. 7.3% of the respondents declared gaining weight. Apart from the weight loss reported by 1.4% of the cases, all other responses taken together represents 1,8%.

2.1.2. Impact on Mental Health

Of the 723 women who responded to this question, 56% i.e. more than half, said that this situation had an impact on their mental health, more than on their physical health. These figures could be directly linked to the measures taken in connection with the lockdown and more specifically what resulted from it. Isolation, deprivation of freedom of movement as well as deprivation of the right to meet with family and friends which not only increased the GBV and various forms they had to face but also left them feeling alone. All of this combined with the fragile economic situation and the pressure it may have created.

Figure 68 - Impact on Women's Mental health by Country



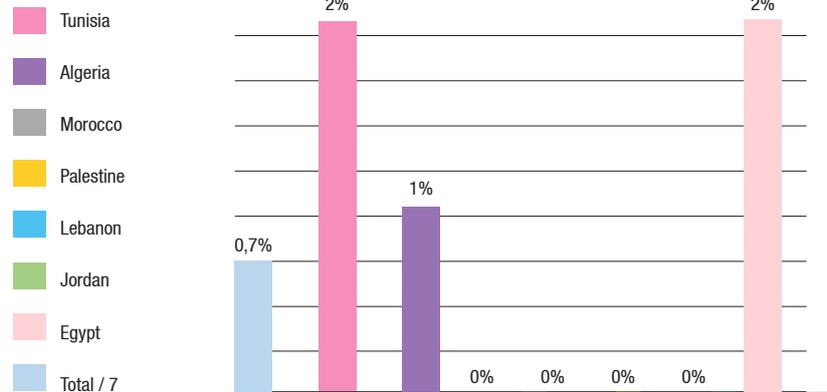
Algeria reached its highest rate of 72% followed by Jordan with 66%. The remaining countries in the sample, close to half, are approaching an average of 50% in terms of the number of women reporting a mental health impact due to the pandemic. 40,6% declared being depressed and 33% suffer from insomnia. They also have eating disorders either anorexia (1,8%) or bulimia (0,7%). 12,9% recognized they are feeling constant irritability.

2.1.3. Impact on Reproductive Health

As indicated above, with an average of 0,7%, the responses regarding the impact of the lockdown on reproductive health are very poor, if not non-existent. Respondents from 4 countries gave 0 answers, despite the confidentiality commitments and the precaution taken of using the concept of Reproductive Health and not Sexual & Reproductive Health. It is worth noting that all covered countries have population policies and reproductive health services available and popular among the target population and the society as whole i.e. no longer taboo.

Figure 69 - Impact on Women's Reproductive Health by Country

Only 2% of the sample in Tunisia and Egypt and 1% from Algeria declared that their reproductive health has been impacted by the lockdown situation. Among those who responded, 0,3% reported they have suffered from uterine pain, 0,3% from dyspareunia⁽²⁰⁶⁾ and 0,1% that they have had abortions/miscarriages.



At this stage of the work, there is no way of going back to understand the “why” as regard to the technical aspect. Is it however really possible to hypothesize that it is because these questions are of a private nature while others were much more private, to mention only the questioning about the forms of violence before, during and after the lockdown, where many respondents did not hesitate to talk about rape, marital rape or sexual harassment. Still, it must be recognized that in a work of this type, no answer can be considered as an answer.

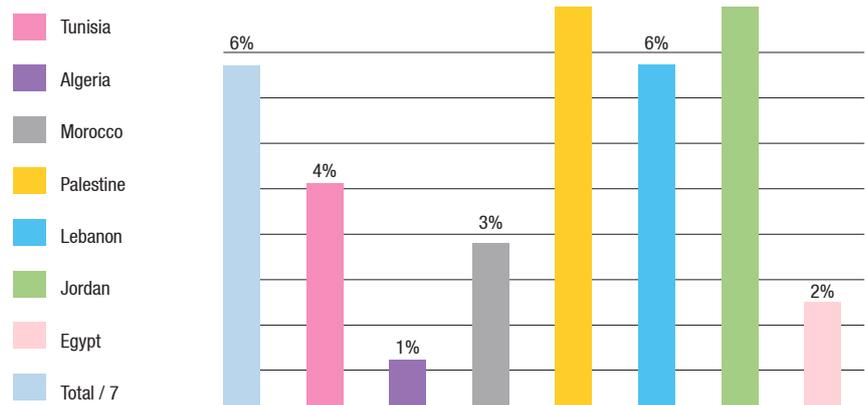
3. Impact on Education and Economic Resources

For this category of rights, two fundamental areas were assessed: the right to education and the right to economic resources.

3.1. Education

Despite echoes of parental concerns about the impact of the pandemic and lockdown on their children's education and health, with a regional average of 6%, the responses in this category can also be considered insufficient.

Figure 70 - Impact on Education by Country



Palestinian and Jordanian women expressed equally their concerns with a rate of 7%, followed the Lebanese respondents (6%), the Tunisian (4%), the Moroccan (3%), the Egyptian (2%) and the Algerian at 1%. For 3,7% the main issue was the distance learning when only few (0,4%) attribute this problem to the lockdown measures themselves since schools were closed.

As a matter of fact, not only have schools and universities been closed, but the solutions found, such as distance learning that required Internet access and computers, have reinforced existing inequalities and disparities.

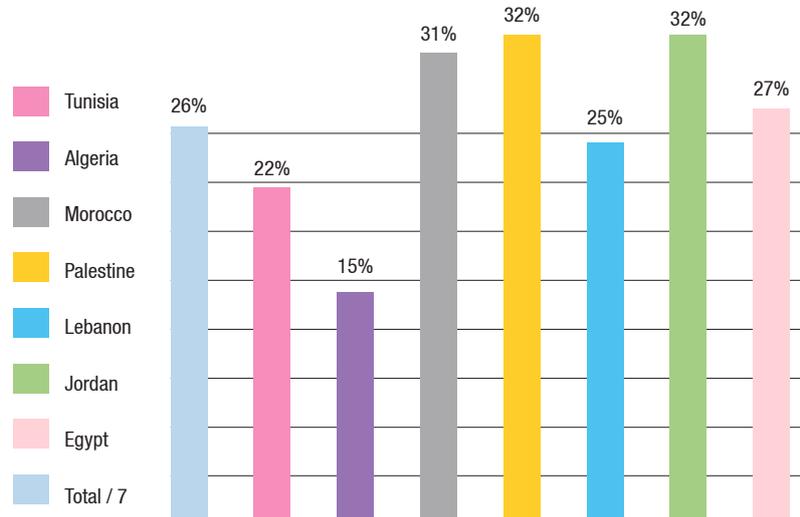
206. Pain at the time of sexual intercourse

3.2. Impact on Economic resources

26% of the 723 women who responded felt the negative impact of the lockdown on access to economic resources.

Four countries are above the regional average starting with Jordan and Palestine (32%), followed by Morocco (31%) and Egypt (27%). Lebanon and Tunisia are below this average with respective rates of 25% and 22% and finally Algeria with only 15% of the sample who declare to have suffered this economic impact.

Figure 71 - Impact on Access to Economic Resources by Country



15.2% consider that this impact has mainly concerned household expenses and 11.1% rather the salary.

4. Impact on the relationship dynamics

Beyond the impact on health, education or the economy, the lockdown caused by the COVID-19 pandemic had also an effect on women’s relational dynamics. Whether it is her relationships with her abuser, with her children or with her family and wider circle of friends, as shown by the figures below.

In terms of relationships, almost 40% of the participants said that this pandemic has affected their relationships with their abuser (15%) and their entourage (14%), but less so with their children (10%).

4.1. Relations with the GBV perpetrator

The impact of the lockdown on the relationship with the aggressor does not need to be guessed or imagined, given the consequences that a “locked-in” this type of situation can have, on one hand, and, as indicated above, the results obtained in the identification of the perpetrators of violence, on the other. An average rate of 15% among the 723 women in the sample from the 7 countries declared that the change was obvious, whether it was positive for a very small minority or negative for most of the respondents.

The highest rates are found in two countries: the first, which is almost double the regional average, is recorded in Jordan (29%), and the second in Algeria (17%). In the other countries, the percentage of women who expressed themselves on this issue is below the regional average, ranging from 14% in Morocco, 13% in Lebanon and Palestine to 11% in Tunisia and Egypt (9%).

Figure 72 - Impact on the relationship with the Aggressor by Country



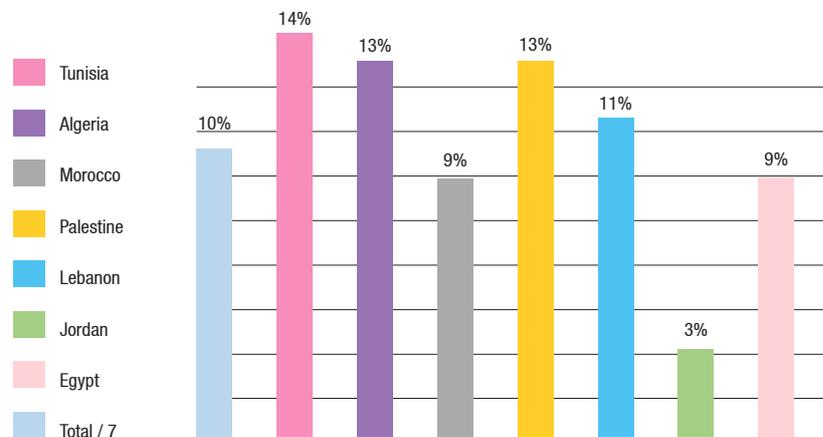
For 9% of the respondents, these relationships were characterized by constant stress, aggressiveness at 6%. Even if they exist, feelings of regret (0.3%) or guilt (0.1%) are very little expressed.

4.2. Relations with children (if any)

10% of mothers among the 723 women of the sample confirmed that health and safety measures also affected their children and their relationship.

Three countries are below the regional average, namely Jordan (3%), Morocco and Egypt (9%). Tunisia has the highest rate of positive responses (14%) followed by Algeria and Palestine (13%) and finally Lebanon (11%).

Figure 73 - Impact on the relationship with Children by Country



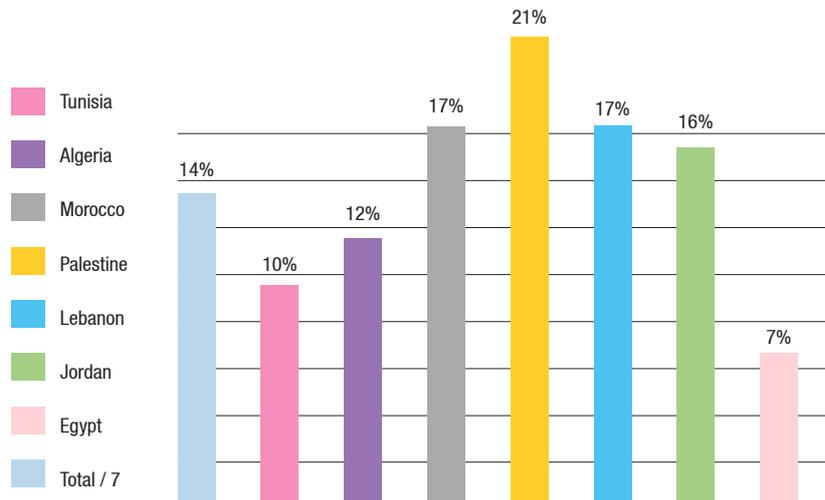
Concerns and preoccupations for and by the child are palpable for the mothers in the sample. The most disturbing effect according to them is the omnipresent anxiety with 8.8% of responses. Sleep (0.8%) and eating disorders (0.4%) are also mentioned to a lesser extent.

4.3. Relations with others

Assessing the impact of the COVID-19 lockdown on women's relationships with their extended environment was important considering its consequences on their protection and safety, which was undermined by the violence they had to endure during this period.

The highest rate is 21% for Palestinian women, followed by Moroccan and Lebanese women (17%), followed by Jordanian (16%), Algerian (12%), Tunisian (10%) and Egyptian (7%) women.

Figure 74 - Impact on the relationship with Environment by Country



14% of respondents of the total sample recognize the effects of the lockdown measures on their relationships with either their parents/family members (4,4%), neighbors (4,1%), friends (4%) and colleagues to a lesser extent.

BARRIERS AND OBSTACLES DURING THE COVID-19 LOCKDOWN

The pandemic caused by the spread of COVID-19 and the consequent lockdowns established as early as March 2020, imposed around the world, preventive measures that were unusual. Many of them much more restrictive compared to other pandemics or even quarantines. These barrier measures were taken to protect against COVID-19 contamination aggravating GBV and limiting access to security and protection; stay home was not always stay safe.

The barriers in question are those that have been put in place to combat the harmful and even deadly effects of the COVID-19 pandemic. They are different in time and space. If health safety measures are maintained in all countries, with or without lockdowns, those related to restriction of movement and physical contamination have changed and evolved with the evolution of the pandemic, different from one country to another or even from one region to another within the same country. Just to understand the situation of instability and insecurity faced by societies and especially by women, a short summary is presented herewith to give an idea of the context of each country during the period in which this assessment was conducted i.e. November 2020, on one hand. On the other hand, highlighting the difficulty to analyze the findings and compare them in reference to the timing benchmarks that have been adopted in the methodology i.e. before, during the lockdown imposed by the COVID-19 pandemic and after its lifting.

In **Algeria**, just to quote for instance, the week of November 11-18, 2020, a partial lockdown had been decided with a ban on meetings and large gatherings. A curfew was established from 11 p.m. to 5 a.m. It was then extended to the period November 15-30, 2020 from 8 p.m. to 5 a.m. in 29 of the 48 Wilayates.⁽²⁰⁷⁾ Public and private urban transport was suspended during weekends throughout the country. Air, land and sea borders were closed except for Algerians returning from abroad (until now). The start of the academic year which was scheduled for November 16 has again been postponed to December 2020.

For the same period (November 11-18, 2020), there was also a partial lockdown in **Egypt** prohibiting events involving more than 2 people. Gatherings were partially authorized with restrictions. Masks were made mandatory in public places. In November 2020, Egypt was the most affected country in Africa with more than 6,600 deaths. On November 4, the country decided to close its air, land and sea borders following the second wave of COVID-19. All public schools switched to virtual learning.

A general re-lockdown has been decided in **Lebanon** for the period of November 14-30, 2020 with alternate traffic during the week and prohibited on Sundays. The curfew had been implemented from 5 p.m. to 5 a.m. Home deliveries were allowed for restaurants, bakeries, rotisseries and water dispensers (from 5 a.m. to 5 p.m.). Some ministries and state institutions operated at 25% of their capacity. Beirut airport remained open despite the total lockdown.

On November 3, a total re-lockdown was proposed by the head of government in **Morocco**. Any form of night travel was banned between 9 p.m. and 6 a.m. and the state of health emergency in force since mid-March was extended. Several health measures were put in place during November, such as the total closure of beaches and markets as well as that of cafes, restaurants, and shopping centers at 8 p.m. Transport was suspended at 9 p.m. Telework was encouraged.

In **Palestine**, medical and political sources warned on November 3 that the health situation in the Gaza Strip was out of control. The city of Ramallah had the highest number of cases of contamination. Palestinian authorities in West Bank and Gaza increased their respective COVID-19 restrictions from November 15. Total lockdown was proclaimed on November 23 in the West Bank with a curfew in the evenings and on weekends. Bakeries, pharmacies and supermarkets remained open. Partial lockdown covered the other cities. COVID-19 restrictions increased until the end of the year.

In **Tunisia**, a series of measures were taken during the first half of November including a curfew (Monday-Friday) throughout the country from 8 p.m. to 5 a.m. and on weekends from 7 p.m. to 5 a.m. A lockdown targeted specifically retirees (+ 65 years old), people with chronic diseases and pregnant women. Distance work was encouraged. Courses were suspended in all schools and universities for a period of time (till Nov. 8 and renewed time to time). Gatherings of more than 4 people in all public places—with the exception for public transportation—were banned. Public and private demonstrations were prohibited until November 15, 2020. The constraint of a reception fixed at 30% in enclosed spaces and 50% in open spaces was imposed to the cafes which were also forced to close no later than 4 p.m. Restaurants and shopping malls were to close at 8 p.m. at the latest. Travel was prohibited between governorates except special circumstances and transport suspended at 9 p.m. As of November 9, 2020, anyone coming from abroad had to present a negative PCR test and observe a 14-day auto-quarantine in a hotel or at home.

207. Governorates

These measures have been put in place and continue to be applied one year later, with the exception of those relating to restrictions on circulation and freedom of movement, which have been progressively lifted in most countries. It should also be noted that when this assessment began, no one knew how the pandemic would evolve with “uncontrolled restarts” reaching such a magnitude in most countries that some spoke of 2nd and 3rd waves. As a matter of fact, measures including lockups were re-established here and there in a sort of stop and go logic but with no really concrete and sustainable impact on the contamination and its progress.

1. Barriers and obstacles during the COVID-19 lockdown aggravating GBV and limiting access to protection

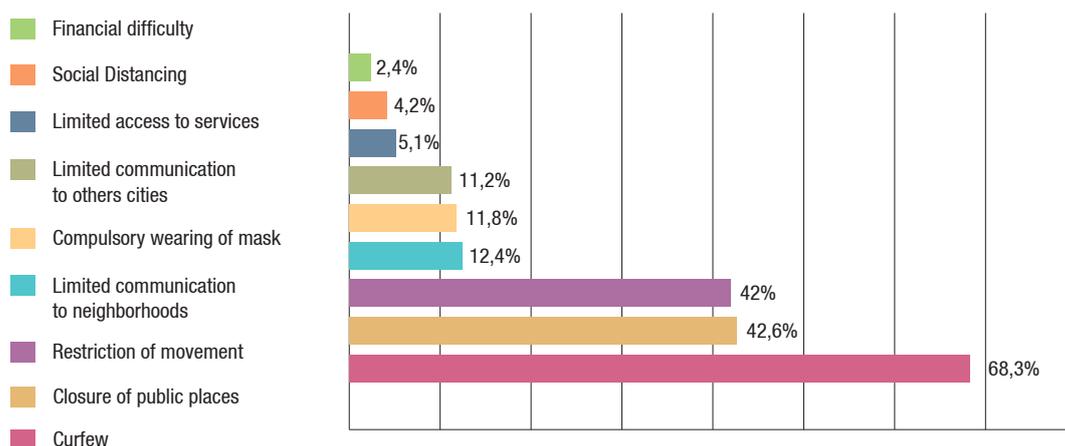
As a reminder, this exercise which was conducted in November 2020 covering three periods: before and during the lockdown and after its lifting, attempted to assess the extent to which the lockdown measures contributed to the GBV increase or maybe decrease in certain cases, as well as the impact it may have had on women’s rights, through the declared experiences of the respondents.

1.1. Barrier measures against contamination and GBV Increase

The intent is to assess to which extent the barrier measures against contamination have contributed to increase Violence Against Women. In the case of affirmative responses, the respondent was asked to explain how based on the examples she would have given among a selected series. These examples included: restriction of movement, curfews, limited communication to other cities, governorates, to neighborhoods and other districts, closure of public places (coffee shops, gardens...), limited access to services (hospital, associations...), and any other barrier measures since these varied from a country to another (i.e. closing of borders). These measures would have also impacted their chance to call for help.

The 331 interviewed women who responded to this question were required to share any difficulty or obstacle they would have encountered in reporting violence during the lockdown period. To help those who were not able to express their feeling or share their experience, some examples were proposed to them to only quote: their fear, not being alone or watched by the perpetrator of GBV or a third party, no means to do so (e.g. no phone), no one who to talk to, nowhere to go, lack of information or of money, ID confiscated or even financial obstacle and any other difficulty or cause.

Figure 75 - Barrier measures against contamination and GBV increase



For most of the respondents, among the *barrier measures against contamination that contributed to increase the violence against them*, curfew is the most present in their minds and probably had the greatest impact on their daily lives with 68.3%. The closure of public spaces (42,60%) and the restriction of movement was also an important element with 42% of the responses. Some respondents consider that the limits imposed to communication within their near or far environment also played a role in the GBV increase such a social distancing with 4,20%, communication with other cities (11,20%) and with neighborhoods (12,40%).

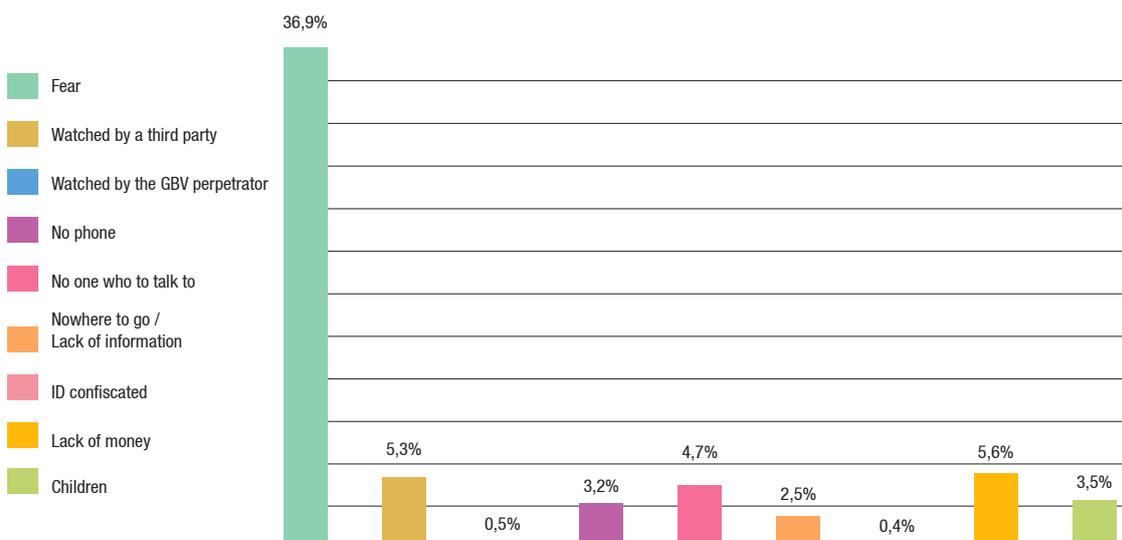
Compulsory wearing of mask also was quoted (11,80%) and 2,40% of women considered that financial difficulty increased pressure and the GBV. 5,40% of them attributed also this situation to their limited access to services.

The collected responses allow establishing a scale of the most influential factors and measures that have the greatest impact on increasing GBV. The restriction of movement, by day (restriction of movement) and by night (curfew) covers the majority of responses (combined reach 110%), followed by issues of communication and contact, either near (social distancing, wearing masks, closing of coffee shops and gardens, access to hospitals and associations (58,6%) or far away, such as communication between cities, governorates, etc. (23,6%). The financial difficulty evoked at 2.4% can be considered as an aggravating factor.

1.2. Difficulties and obstacles in reporting violence during the lockdown period

259 women responded having encountered such difficulty affirm that several constraints and obstacles in their daily lives limit their possibility and ability to report any form of violence they face. They also specify that during the lockdown such obstacles do not only prevent denunciation but also limit their access to services and protection.

Figure 76 - Difficulties/obstacles in Reporting Violence



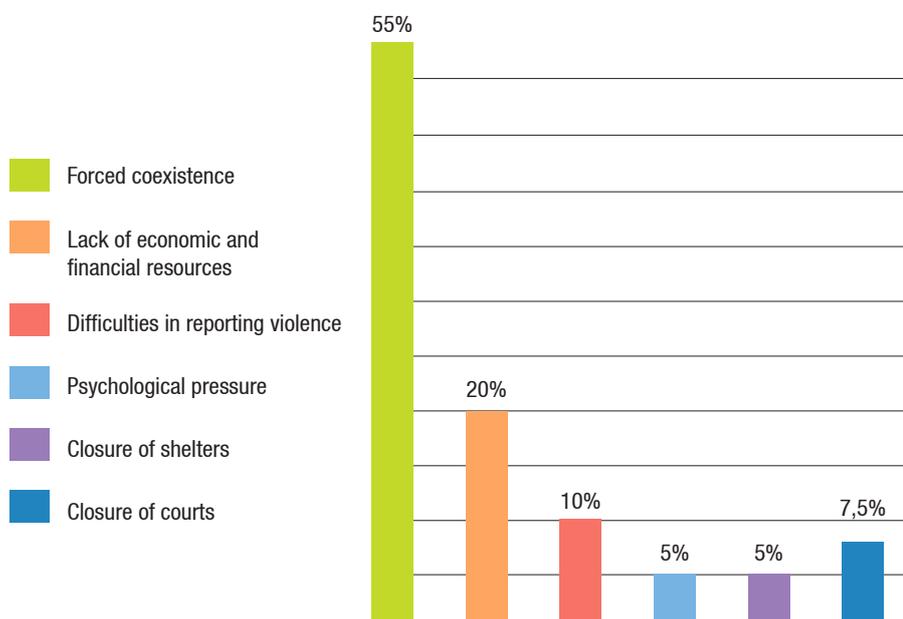
As usual, fear is the main factor preventing women from reporting acts of violence, with a rate of 36.9%. As indicated in the graph above, 5.8% of the GBV survivors indicated that they were being watched by the aggressor or by a third person. Others (7.2%) do not have or know who to talk to among their relatives (family or friends) or because they have “nowhere to go”, or lack information. Many others (5.6%) declared that they could not afford to do so (money). It seems that to date and despite the “democratization” of the cell phone, there are still some people who don’t own one(3.2%).

3.5% of the respondents say that it is by thinking of their children that they have given up any will to denounce.

1.3. Obstacles and Difficulties facing GBV care and support during the lockdown period

The measures taken in different countries aggravated the GBV phenomenon increasing its prevalence. They also made access to services and care for GBV survivors arduous if not impossible in most cases, posing major risks to their protection and jeopardizing their safety.

Figure 77 - Obstacles and Difficulties facing GBV care and support



Among the causes cited by respondents, forced coexistence between women and men (55%), lack of the necessary economic and financial resources (20%), the closure of courts (...) and the difficulties women encounter in reporting violence (17.5%), the psychological pressure women feel because of lockdown (5%), the closure of shelters (5%).

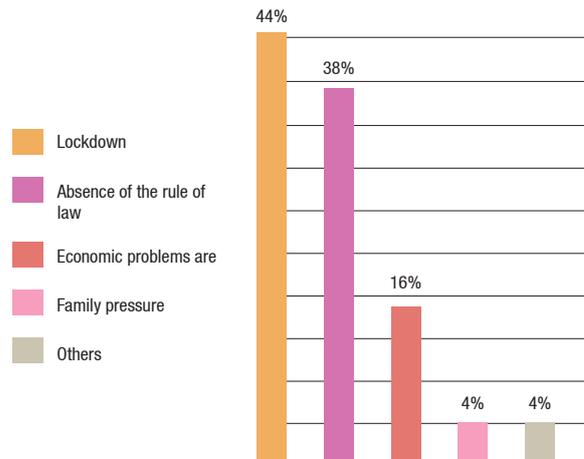
Figure 78 - Challenges faced by Women GBV Survivors

Other obstacles and difficulties have been related to the response of the concerned bodies and specialized associations in terms of speed and therefore efficiency.

Difficulties concern first and foremost the mobilization of specialist providers (26%), difficulties in relation to the services (24%) in terms of quality and responsiveness,

a communication problem (22%) and funding problems (14%). 8% of the respondents think that the difficulties lie in the law itself. Others consider that difficulties relate to the infrastructure (6%), the non-compliance with measures (6%) or difficulty of moving around (6%).

Contact with associations, social coverage and fear are also reported with 2% for each of these difficulties.

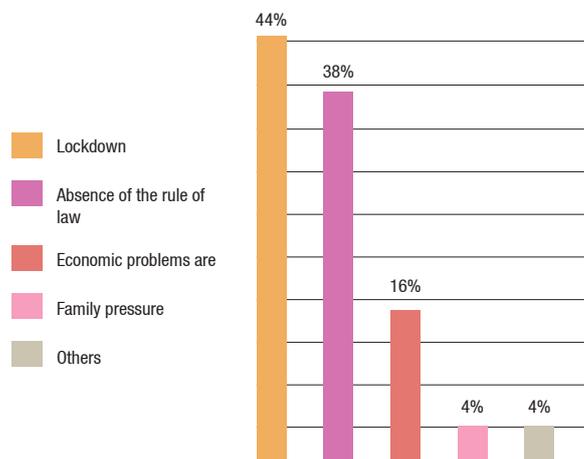


1.4. Other difficulties

Respondents were given another opportunity to propose other responses that would not have been anticipated. Some were reiterated perhaps because they were considered important enough to be highlighted again.

As something that weighs on them and as if they needed to emphasize it again, 44% of respondents consider the lockdown to be THE difficulty.

Figure 79 - Other difficulties related to the measures taken



They also think that one of the main difficulties is due to the absence of the rule of law (38%), reporting the problems they encounter in communicating remotely with associations and other providers. Economic and financial problems are again mentioned (16%) as well as family pressure (4%). The other 4% refer to the lack of coordination between the different organizations, the psychological impact or the customs and traditions that prevent girls and women from complaining about violence against them by their parents.

KNOWLEDGE/INFORMATION ON THE AVAILABLE SERVICES

Due to the obstacles and difficulties GBV survivors declared having in access to services, it was important to assess more in-depth their knowledge and information about their availability either those provided by governmental institutions or Civil Society Organizations/CSOs and specialized associations.

A simple answer requires a simple question, so respondents were asked whether they were aware of the services that government institutions or associations provided. A preliminary generic list of these institutions was prepared to help them better visualize in case they had difficulty doing so: Ministry of Health (GBV center, helpline, emergency, other), Ministry of justice (specialized courts, flagrante delicto procedures, helpline, shelter...), and Ministry of Interior/Police (specialized unit, helpline, shelter...). In case of a positive response, it was important also to know the channel of information, if the respondents *requested and/or benefited from these services and under what circumstances*.

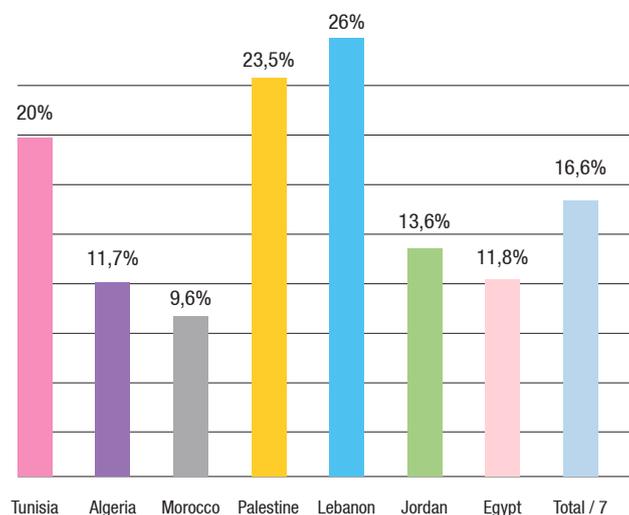
Concerning the Civil Society Organisations/Associations no one was cited, but the respondents were required to *quote at least one association in charge of prevention of GBV. Their knowledge as regard to the services the associations are providing. Some examples were also listed to help them such as GBV center, legal assistance, psychological counselling, helpline, emergency, shelter and any other*.

As per the governmental institutions, to know and to compare, it was important also to ask them about the channel of information and if they *requested and/or benefited from these services and under what circumstances but also to describe their experience..*

1. Knowledge and Use of Government Services

In spite of national strategies, laws, plans and actions put in place to fight against Violence and a multitude of GBV survivors' services offered by the different governments in the MENA region and more particularly in the seven countries covered by this assessment, the results show that for various reasons, the use of these services is still low in MENA as shown by the figures below.

Figure 80 - Knowledge/ Reliance on Government Services



Relationships with the authorities responsible for preventing Violence Against Women or providing services are minimal. Only 16.6% of the sample of 723 women in all countries reported having approached one of these entities. This figure could be symptomatic of a lack of awareness of the role of these entities and the services they provide, or of a fear of facing socio-cultural constraints and pressures to denounce one’s aggressor or even to disclose one’s actions.

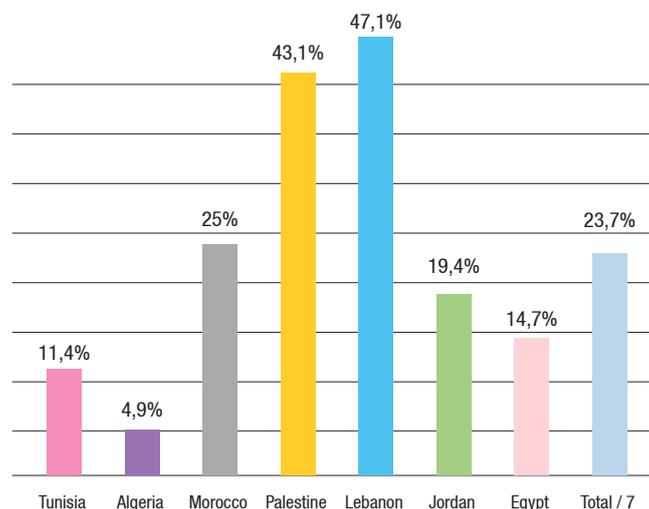
Lebanese women are those who know best or have used these services the most, with a rate of 26%, followed by Palestinian women (23.5%) and Tunisian women (20%). At levels more or less close to the regional average, Jordanian women are at 13.6%, Egyptian women at 11,8%, Algerian women at 11.7% and Moroccan women at 9.6%. Among the 16.6% i.e. 120 women who reported having benefited from the services provided by the associations, 36.7% said it was consequent to an act of violence. 31.7% sought guidance and orientation, 8.6% sought help to enforce their rights as women, 2.4% asked for financial assistance, and 1.6%, psychological support.

14.8% of responses were classified as “others”, grouping together a series of elements, some of which, it must be acknowledged, are not relevant, to mention only asking associations to “improve their services for the protection of the people” or to help them “finish their studies”. In the other responses, some of the interviewed women required the associations to summon the GBV perpetrator and ask him to choose between committing himself to stop his acts or going to prison, others preferred to “get by without having used these services”, to ask for “help from the family”, to “resort to divorce”. A number of them have adapted and/or continued to suffer violence and threats (husband, son-in-law and others). Many refused to respond.

2. Knowledge and Use of CSOs Services

It should be remembered that in most countries of the Region and throughout the world, Civil Society Organizations and Associations have been the first, despite their limited resources, not only to raise the alert about VAWG, but also to conduct prevention campaigns and provide services by offering care, support and monitoring for care, advice and assistance towards “healing” and reintegration, including economic. Of the 723 women who answered this question, only 171 women said they knew associations responsible for preventing GBV in their countries or had used their services, i.e. 23.7%.

Figure 81 - Knowledge of Associations in charge of GBV

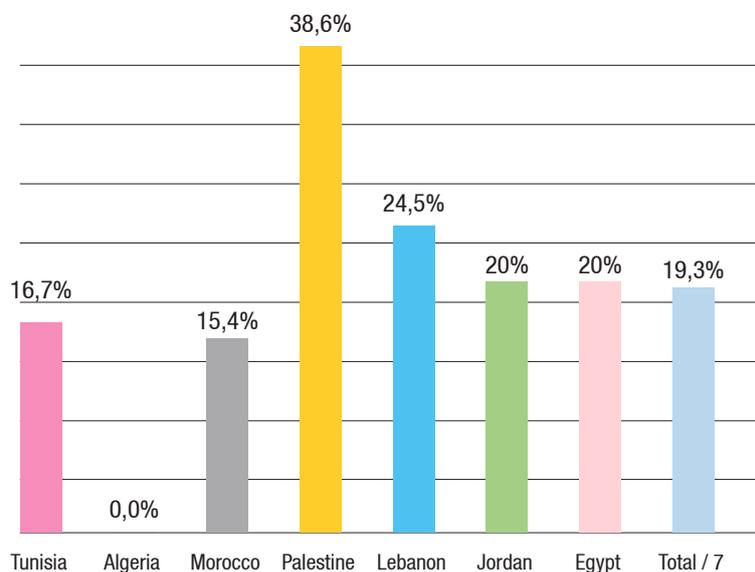


As for the knowledge of governmental services, Lebanese women are still the most aware of associations and what they do in this field with a rate of 47.1% followed by Palestinian women (43.1%) and Moroccan women (25%).

Despite the multitude of specialized associations and the multiplicity of their interventions in each concerned country, Jordanian, Egyptian and Tunisian women have a level of knowledge below the regional average with respective rates of 19.4%, 14.7% and 11.4%. Algerian women record the worrying rate of 4.9%. Based on this, but not solely, it is clear that there is not only a need to strengthen Civil Society Organizations in terms of the number and quality of services' provision, but also to make more efforts to disseminate information about their existence and services and to raise awareness among women and girls in general and Gender-Based Violence survivors, in particular.

Interestingly, respondents were asked to name at least one association working on GBV prevention and any other intervention such as services in their country. All of them were able to do so, unintentionally establishing some sort of priority scale or notoriety with the number of times each was cited. All respondents to this question, the number of which varied from one country to another, quoted names of 4 associations except for Palestinian women who mentioned 6, which is completely in line with the reality and the role of civil society in this country. Of the 171 women who said they knew associations, 19.3% said they had used their services.

Figure 82 - Recourse to the services provided by associations in charge of GBV



Only 24.5% i.e. about half of the Lebanese women who were among the best placed in terms of knowledge of associations and use of their services. The rates are 20% for Egypt and Jordan, followed by Morocco (15.4%) and Tunisia (16.7%). No Algerian woman reported using this type of service.

Because of the historical context of Palestine and the reality on the ground, the majority of the infrastructure and service superstructure is managed by civil society, which could justify the highest rate of responses (38.6%) coming from respondents from this country.

Of the 19.3% of women who requested services from the associations, 19.4% demanded respect for their women's rights, 11.9% needed psychological support, 14.4% asked for legal assistance, and 3.5%, financial assistance. The other types of services consisted of actions to combat violence (8.8%), training and seminars (2.5%) and awareness raising activities (0.8%).

42 respondents agreed to describe their experience but focused more on the types of services they received than on their experience or relationship with these associations. Thus they spoke more about women's rights (15.1%), financial and legal assistance (14.3%), combating violence (10.1%), supervision and awareness programs (8.8%) and psychological support (0.8%).

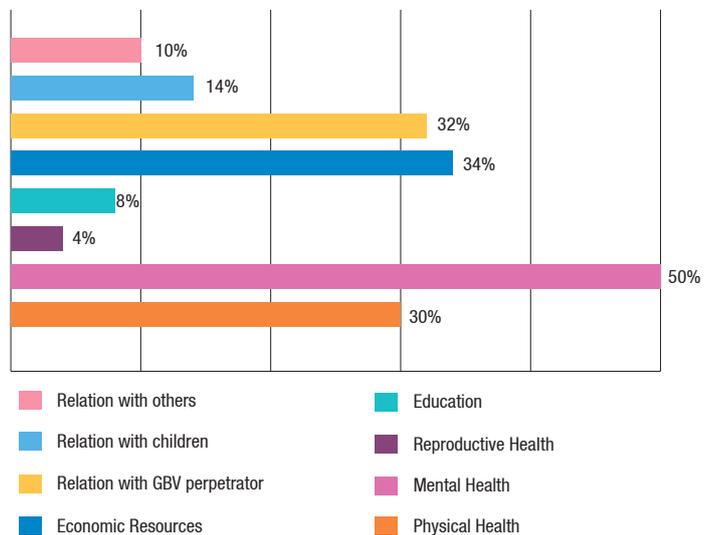
PART III-2: STAKEHOLDERS

IMPACT OF THE COVID-19 LOCKDOWN ON OTHER RIGHTS OF WOMEN AND GIRLS

All of the 50 stakeholders' representatives, government institutions or civil society organizations, who agreed to participate in this Assessment stated that they had cared for/or treated women GBV survivors and had the opportunity to observe the impact of this violence at several levels.

Even if women survivors of violence do not express it as clearly, the stakeholders as service providers consider that the impact was greater on health with 50% for mental health, 30% for physical health and 4% for reproductive health. Like women, the stakeholders did not give as much importance to the impact on education (8%), considering the fact that it remains a fragile sector, including because of the instability incurred by the lockdowns and the governmental decisions that sometimes gave the impression of going in all directions. Economic resources also suffered from this situation according to 34% of the responses. They also noted that relational dynamics were also affected by this situation i.e. relationships with the GBV perpetrator (32%), with children (14%) and with their entourage (10%).

Figure 83 - Effects of the lockdown on various aspects & Rights (stakeholders)



It must be said that the responses are not very different with those of the group of women, without being totally in agreement on the quantitative level, but they agree on the trends.

1. Impact on Health

As assessed by stakeholders, the impact concerns physical, mental and reproductive health. It is worth however to note that as it is the case for the first sample, responses on reproductive health issues are very poor.

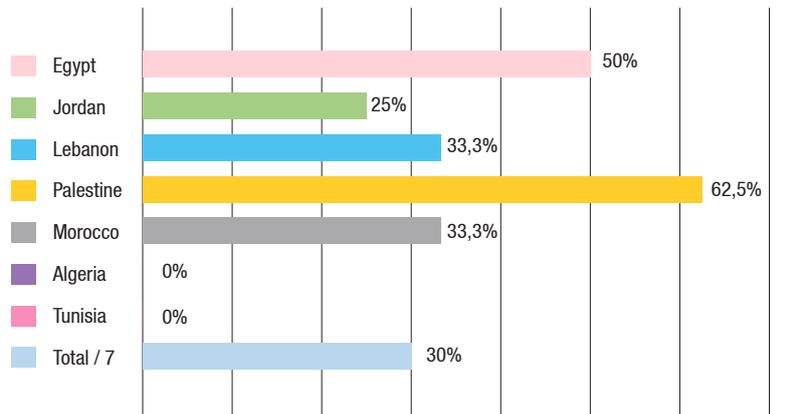
1.1. Impact on Physical Health

30,% of the 50 stakeholders reached in the 7 selected countries stated that the lockdown had consequences on women’s physical health.

The overall percentage of stakeholders reporting that they felt the impact of confinement on physical health is the same as for women, around 30%. However, the distribution of the averages by country is little be different. Palestine stands out with 62.5% of the respondents, followed by Egypt (50%). Exæquo,

Lebanon and Morocco are at 33.3%. As for Jordan, it comes in last position with 25%. No answers were collected in Algeria and Tunisia. Effects of the lockdown on physical health and related syndromes were: asthenia at 61%, general and abdominal pain as well as weight loss were evaluated at 9% each. Weight gain and heartburn (gastritis) were also considered as consequences of this situation at 4% each.

Figure 84 - Impact on Women’s Physical health by Country (stakeholders)



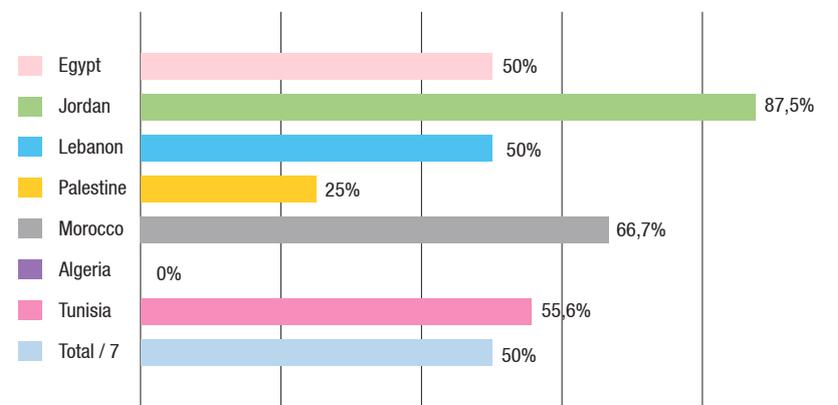
1.2. Impact on Mental Health

50% of stakeholders from the 7 covered countries believe that the lockdown has an impact on mental health.

The highest rate is for Jordan with 87.5%, followed by Morocco (66.7%). The rates of Egypt and Lebanon (50%) as well as that of Tunisia (55.6%) are equal or close to the regional average. It is 25% for Palestine. For 55% of the stakeholders, depression is the highest expression of the effect of the lockdown on mental health, in total agreement with the evaluation of women themselves.

Eating disorders are also symptomatic of this fragile psychological state. In fact, 35% say they have observed cases of bulimia and 2% speak of anorexia. This impact also manifests itself in the form of insomnia and a state of permanent nervousness (8%).

Figure 85 - Impact on Women’s Mental health by Country (stakeholders)



1.3. Impact on reproductive health

The regional average is at 4% and with stakeholders noting that 5 countries did not give any answer to the question on the impact of the lockdown on reproductive health. This feedback is almost identical to the feedback from women, which really raises questions for these countries especially since this subject is no longer taboo. At 12.5%, both Egypt and Jordan stated that the lockdown has had an impact on reproductive health. Moreover, for 100% of respondents the noted experienced effect on their reproductive health was, without exception, in the form of abortions.

2. Impact on Education and Economic resources

As with women surviving to GBV, for this category of rights, two fundamental areas were assessed: the right to education and the right to economic resources.

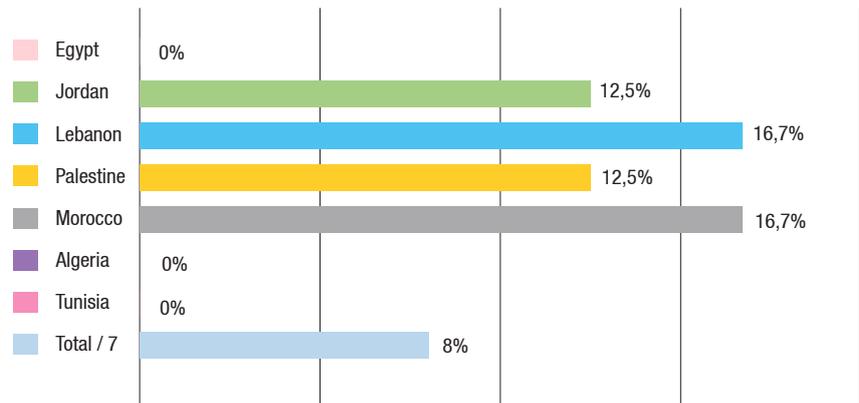
2.1. Education

As mentioned above, only 8% of stakeholders considered that the lockdown had an impact on education.

Indeed, this impact is recognized by stakeholders in Morocco and Lebanon with a rate of 16.7% and in Palestine and Jordan the percentage is 12.5%. Even if neither the stakeholders in Algeria and Egypt nor those in Tunisia expressed any opinion,

this does not mean that the lockdown has had no impact on these countries. To mention only distance education which was cited by 80% of respondents with all that it entails as a constraint for parents and as an inequity for children but also for families who do not have the necessary financial or technical means, which widens some more the social gaps.

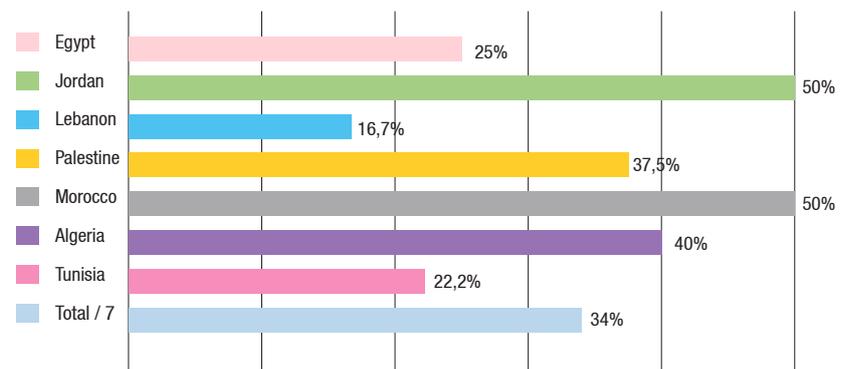
Figure 86 - Impact on Education by Country



2.2. Impact on Economic resources

There is a significant difference between the total responses expressed by the 50 stakeholders (34%) and by the GBV survivors. This can be explained by the fact that stakeholders observe impact on economic resources directly, recognize it from a professional standpoint and by empathy.

Figure 87 - Impact on Access to economic resources by Country (stakeholders)



Whereas GBV survivors, even if they suffer from it, prefer ignore to it, minimize its effects or even hide the reality because of decency.

For 34% of stakeholders, the impact of the lockdown on the economic resources of GBV survivors they care for, is conclusive. It is greater in Jordan and Morocco (50%) and less in Lebanon (16.7%). The difficulties relate to the lack of financial assistance in precarious economic conditions with a major impact on wages (62%) followed by household expenses (37%).

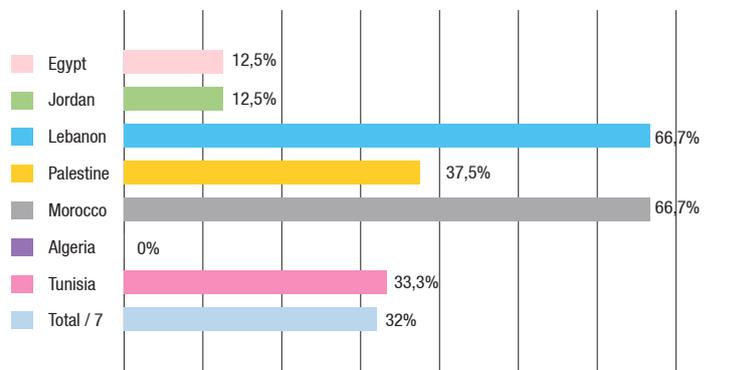
3. Impact on the relationship dynamics

By necessity, stakeholders, service providers and others were also able to observe and evaluate the impact that the lockdowns may have had on the relational dynamics of the women they received, discussed with or cared for.

3.1. Relations with the GBV perpetrator

Figure 88 - Impact on the relationship with the Aggressor by Country

An average rate of 32% among the 50 various stakeholders in the sample from the 7 countries declared that the impact on the relation with the GBV perpetrator was obvious either intimate partner or another member of the family, to only quote these two examples.



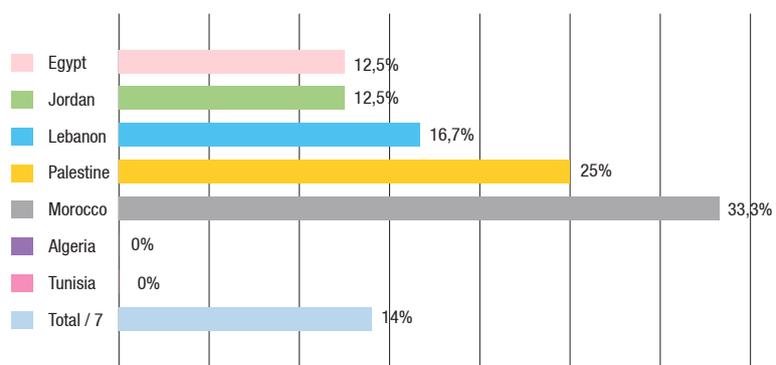
This impact is most palpable in Lebanon and Morocco with 66.7%, followed by Tunisia and Palestine with 33.3% and 37.5% stakeholders respectively. However, it is less felt in Egypt and Jordan with only 12.5%. This impact manifests itself in the form of aggressiveness (50%), stress (41%) and sometimes with some regret (5%) and guilt (4%).

3.2. Relations with children (if any)

The impact observed by stakeholders on relationships with children is not very significant (14%) and not very far from what GBV survivors expressed (10%).

For Algeria, no impact on this relationship is noted, while Morocco comes at the highest rate (33.3%), followed by Palestine (25%), Lebanon (16.7%) and then Egypt and Jordan (12.5%).

Figure 89 - Impact on the relationship with Children by Country

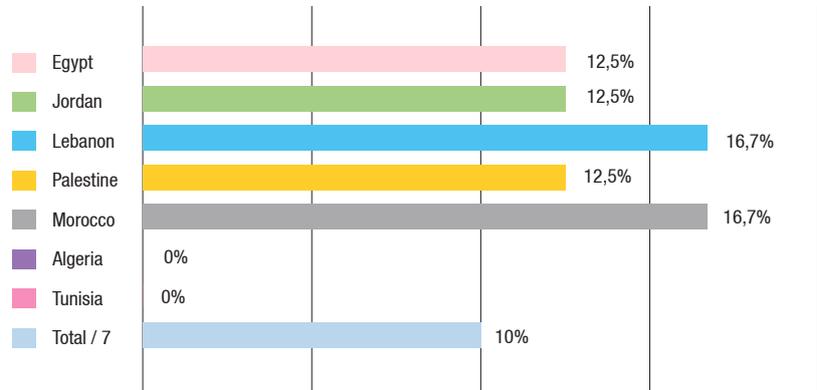


Anxiety is predominant in the relationship with children at 70%. Sleep disorders (20%) and eating disorders (10%) are also mentioned.

3.3. Relations with others

Other family members, colleagues, friends, neighbors... are the environment of women, GBV survivors or not. 10% of the interviewed stakeholders said they had detected an impact on these relationships. As for other relationships, the figures are close to the impact noted by the first group.

Figure 90 - Impact on the relationship with Environment by Country



This impact is felt first in Morocco and Lebanon (16.7%) followed by Palestine, Jordan and Egypt (12.5%). Relationships with parents were the most affected by the lockdown (62%) followed by relationships with friends (13%) are also affected, as well as with colleagues (13%) and neighbors (12%). The obvious cause being the restriction of movement and social distancing not only at 2 meters but many more.

BARRIERS AND OBSTACLES DURING THE COVID-19 LOCKDOWN

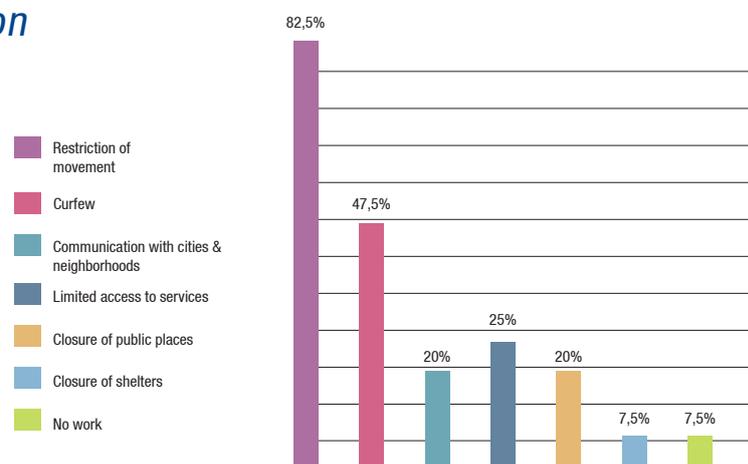
1. Barriers and obstacles during the COVID-19 lockdown aggravating GBV and limiting access to protection

Among those questioned, all countries combined, 80% of the members of associations and NGOs claim that the measures taken to limit the spread of the pandemic have greatly contributed to an increase in GBV during the lockdown period. Stakeholders who are involved in GBV-related activities state that in Algeria and Morocco these percentages reached 100%, followed by Tunisia with a percentage at 90%. ¾ of respondents from Palestine and Jordan state that the measures have worsened the situation of women victims of violence while in Egypt, Lebanon and Morocco the recorded percentages are less than 70%.

1.1. Barrier measures against contamination and GBV Increase

As for the women who were asked to share their experience on the relationship between the measures taken and the increase in violence, the 50 stakeholders gave their point of view on this issue as illustrated by the herewith diagram.

Figure 91 - Barrier measures against contamination and GBV increase



Although measures taken to limit the spread of the pandemic have contributed to an increase in violence against women, participants noted that the impact is not the same from one measure to another. Restriction of movement (82.5%) and curfews (47.5%) with all that it entails in terms of confinement in space and isolation have certainly contributed to pressure even psychologically, including anxiety, stress and depression, as well as limited access to services (25%). The closure of public spaces (20%), limited communication with other cities and/or the districts and neighborhoods (25%), the closure of shelters (7.5%), and work disruption or loss of work are also direct or indirect causes that have had a direct impact on the increase in violence against women.

1.2. Difficulties and obstacles in reporting violence during the lockdown period

The 50 stakeholders reported that they observed a number of difficulties and obstacles that their target groups faced during the lockdown period, endangering their safety, protection, access to services and sometimes their lives.

According to the respondents, the main difficulty in reporting violence is related to the forced coexistence between women and men (55%). The others are the lack of financial and economic resources (20%), the closure of the courts and the slowness, not to mention the lack of feedback from the organizations involved and/or specialized agencies (17.5%), followed by the psychological pressure women are under and finally the closure of shelters.

1.3. Other difficulties

The participants in the assessment report that the other obstacles encountered are mainly related to the care of women victims of violence, with first and foremost the difficulties in mobilizing specialists (26%) and the services put in place (24%). 22% think it is a communication issue and 14% report financial problems. The inadequacy or non-enforcement of the law is cited by 8%, while 6% of respondents consider with an equal value to each that difficulties are related to infrastructure, travel difficulties and non-compliance with stated measures and rules. To a lesser value (2%) for each of these obstacles, difficult contact with associations, social security coverage and fear are also mentioned.

KNOWLEDGE/INFORMATION ON THE AVAILABLE SERVICES

1. Knowledge of/and sources of information on Government Services

1.1. Knowledge related to Governmental Institutions

88% of the 50 stakeholders, the majority of whom are CSOs/NGOs, say they are aware of governmental institutions working in GBV issues.

The percentage recorded reached 100% in Egypt and Morocco. For Tunisia and Jordan, it is close to 90%. Respondents from Algeria and Lebanon stated that they were aware of government institutions that intervene in the area of GBV, with rates of 80% and 83.3%, respectively. The lowest rate was found in Palestine with 75%.

Figure 92 - Knowledge of Government Services



44 stakeholders among those who answered this question were able to cite the government institutions in their country among the most important ones in charge of GBV. Citing first and foremost the Mechanisms (council, commission, ministry) in charge of women's issues with a rate of 58.9%, followed by the Ministry of the Interior and Police Services at 50%, the Ministry of Health at 43.2% and the Ministry of Justice at 34.1%. Other ministries were also mentioned at 38%.

1.2. Nature of services and sources of information

The responses of the 22 stakeholders who shared their knowledge of the provided services and their use are hereunder summarized for the three most directly concerned ministries.

- **Ministry of the Interior and Police Services**

The services of the Ministry of the Interior are best known for their specialized units in charge of GBV cases (40.9%), a hotline available to women (36.4%) as well as shelters (18.2%), providing necessary protection (4.5%) and law enforcement (4.5%). 9.1% of the respondents stated that they were not aware of the services provided by the Ministry of the Interior.

The 22 respondents know these services because they are used to collaborating and coordinating their interventions with the Ministry of Interior or concerned police departments (59.1%), through the entities/units that provide services as well as TV and radio (9.1%). Others just say they know them without citing a source (9.1%) or through awareness campaigns, social networks or through friends and family (4.5%).

- **Ministry of Health Services**

According to the findings, all combined countries, the 19 respondents to this question believe that the services provided by the Ministry of Health are mainly medical care (47.4%), emergencies and specialized centers with an equal value of 15.8%. The other services, which are all evaluated at 5.3%, are the hotline, psychological care, issuance of medical certificate and finally awareness raising and support. 10.5% of respondents said they were not aware of the services available and provided by the Ministry of Health to women victims of GBV.

52.6% of the 19 people who were able to quote their source of information said it was through their coordination with the Ministry of Health. For 10.5%, it is through TV and radio that they know about health services and for 5.3%, the sources are either friends and family or awareness campaigns. 15.8% said they knew about the Ministry and its services without specifying their source, while 10.5% did not know.

- **Ministry of justice**

The Ministry of Justice's efforts to combat GBV are recognized by 15 respondents with regard to a number of provided services, such as flagrante delicto procedures (46.7%), specialized courts (40%), the establishment of shelters, awareness raising and accompaniment of equal value (13.3%), and the provision of a hotline (6.7%). Nearly 7% said they were not aware of the services provided by the Ministry of Justice to combat violence against women.

46.7% of the 15 interviewees consider that knowing the Ministry of Justice is obvious given their ongoing coordination with the relevant structures within the institution. The source of information for 20% of the respondents comes from awareness campaigns, while 6.7% say it is through the government, social networks or via the internet, for the same value. 13.3% do not know, so 6.7% know the Ministry of Justice and its services without specifying the source.

1.3. Collaboration with governmental institutions

- **In general**

As shown in the previous paragraphs, 72.7% of respondents said that, in general, they collaborate or have collaborated with government institutions. This collaboration would be 100% for Lebanon, Morocco and Palestine. It is 75% for Algeria and 62.5% for Tunisia, followed by Egypt (50%) and Jordan (42.9%).

While 2% of respondents do not know if there has been collaboration with government institutions, 11.4% say they have not dealt with them. The circumstances and areas of this collaboration vary: 72.7% report having benefited from the services they provide in general and 22.7% request assistance or access to services for the treatment of specific cases. 20.5% said they needed these institutions and their services during the lockdown, without specifications.

- **In specific situations**

22.7% stated that they had requested collaboration with government institutions in specific situations. The rate of country-specific collaboration reached 42.9% in Jordan and 33.3% in Palestine. It is 25% for Algeria and Egypt, 16.7% for Morocco and 12.5% for Tunisia. No collaboration in specific cases is reported for Lebanon, while it is 100% for collaboration in general.

- **During the lockdown**

During this period, the collaboration rate, all combined countries, at 20.5%. While collaboration with government institutions seems to be absent in Egypt and Lebanon, it could be an example in Jordan where it is reported to have reached a rate of 57.1%. It is 25% in Algeria and Tunisia and 16.7% in Morocco and Palestine. Comparatively to the collaboration in general, it is still relatively low. This may also refer to the obstacles and constraints imposed by barrier measures

2. Knowledge of/and sources of information on NGOs/CSOs

2.1. Knowledge related to NGOs/CSOs

To the question “do you know of any NGOs/associations working in the areas of women’s human rights and/or GBV?”, 94.0% of the 50 stakeholder representatives said they knew of associations and NGOs working directly or indirectly on GBV.

Figure 93 - Knowledge related to NGOs/CSOs by Country



Rates of 100% are recorded in Tunisia, Algeria, Morocco and Jordan. They are 87.5% for Egypt and Palestine and 83.3% for Lebanon. This indicates a perfect knowledge which could be explained by the dynamism of NGOs in the field of GBV control but also by the services provided. The 47 respondents were even able to name⁽²⁰⁸⁾ a number of associations with varying and repetitive rates for different associations, which puts them at the same level of appreciation:

- Algeria: 5 associations with rates of 100% for the most specialized, followed by 60%, 40% and 20% (twice),
- Egypt: 4 associations including the governmental women’s mechanism, which is cited as an association, with rates of 42.9% (twice), 14.3% (twice) and 42.9% who do not know,
- Jordan: 5 associations including a United Nations agency which is presented in this category, with rates of 37.5% (2 times), 25% and 12.5% (2 times),
- Lebanon: 5 associations including the two best known which are equal (80%) and 3 others (20%) of which two are branches of international organizations,
- Morocco: 5 associations with rates of 50.0% (3 times), 33.3% and 16.7%,
- Palestine: 5 associations with rates of 85.7%, 71.4%, 28.6% (twice) and 14.3%,
- Tunisia: 5 associations, one of which is regional with rates of 44.4%, 33.3% and 22.2% (3 times).

The number provided by stakeholders (5) is only slightly higher than that of women (4) with some differences in the names of the proposed associations. The observed difference in rates can certainly be explained by the notoriety and presence in the field of certain national associations. However, since associations represent the majority of stakeholders, these responses may also reflect collaborative networks within a country, as it was the case with government institutions.

208. For obvious reasons, only the number of associations (and not the names) per country is given

2.2. Nature of services and sources of information

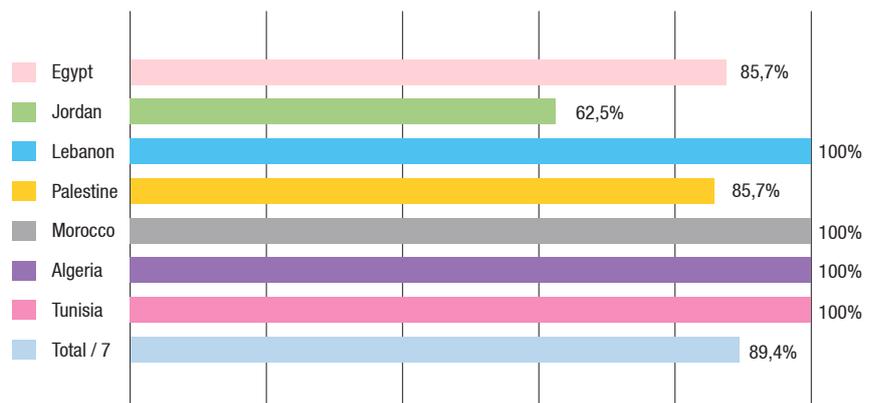
For 42 respondents in the “stakeholders” sample, the main services and interventions provided by the associations were:

- Social services (90.60%): in the form of distributing aids, providing financial resources, setting up and/or managing shelters or caring for women victims of violence,
- Training and counseling (71.50%): in terms of legal advice, capacity building for women and multidisciplinary training (self-empowerment or technical skills),
- Accompaniment and sensitization (81%): as legal assistance, sensitization and advocacy to achieve equality or prevent GBV.

In fact, 89.4% of the 47 respondents in the 7 countries said they were aware of the services provided by the associations.

The rate per country is 100% for Tunisia, Algeria, Morocco and Lebanon. It is 85.7% for Egypt and Palestine and 62.5% for Jordan. 12 respondents were also able to give examples of these services, to mention only the opening and/or management of shelters for GBV survivors (66.7%), specialized intervention units (33.3%) and hotlines (25%). 25% admit to being unaware of the services provided by NGOs.

Figure 94 - Knowledge of Services provided by NGOs by Country



Among the 44 stakeholder representatives who were asked “have you heard about women’s organizations and the services they provide?”, 41.7% responded they had collaborated with them. 8.3% heard about them through various channels such as television and radio, or other stakeholders who make these services available to women (8.3%). 16% have this information but are unable to give the source.

2.3. Collaboration with NGOs/CSOs

As with the question on collaboration with government institutions, 2.1% of respondents did not know whether their organization had worked with NGOs/CSOs, or not. Others answered that they had not dealt with them (2.1%). 76.6% of respondents said that, generally speaking, they collaborated with associations whose goal was to combat GBV, followed by 27.7% for collaboration in specific cases and at minimum during the lockdown, with a rate of 12.8%.

- **In general**

100% of the participants from Lebanon, Morocco and Algeria affirmed that they collaborate with associations whose aim is to fight violence against women. They are 85.7% in Palestine, 66.7% in Tunisia, 57.1% in Egypt and 50% in Jordan.

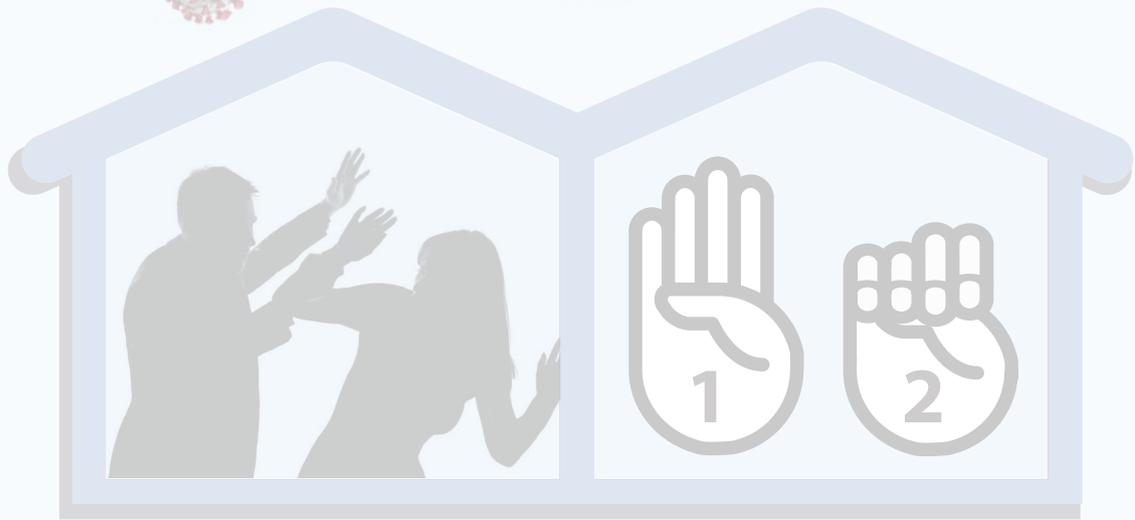
- **In specific situations**

27.7% of stakeholders—all combined countries—say they collaborate with NGOs in specific situations. This type of collaboration is the same as previously for Jordan (50%). It is 42.9% in Palestine, 28.6% in Tunisia, 22.2% in Tunisia, 20% in Algeria and finally 16.7% in Morocco. For Lebanon, which nevertheless declared to collaborate in a general way at 100%, the respondents from this country did not specify anything for this type of collaboration.

- **During the lockdown**

The regional average of 12.8% confirms what has already been observed for government institutions, namely that during the lockdown, collaboration with NGOs was more than minimal, confirming the assumption related to the blockage of the barrier measures, particularly restrictions on movement and communication difficulties, which also limited coordination and collaboration as well as access to services of any kind, for both sides i.e. providers and claim holders.

28.6% of the stakeholders in Palestine claim to have worked with associations confirming once again the importance of the role played by civil society in this country. The rate is 25% for Jordan, representing a little less than half of the reported collaboration with government institutions. It is 20% in Algeria and 16.7% in Morocco. For stakeholders surveyed in Egypt—who gave the same response for collaboration with government institutions—and Tunisia, there appears to have been no collaboration with NGOs/CSOs during the lockdown period.



CONCLUSIONS & RECOMMENDATIONS

CONCLUSIONS & RECOMMENDATIONS

BACKGROUND & FRAMEWORK

1. Background

This quantitative study entitled “Gender-Based Violence during a Sanitary Crisis: The Case of COVID-19” was conducted in 7 countries in the MENA Region, namely: Algeria, Morocco, Tunisia, Lebanon, Jordan, Palestine and Egypt. Launched in June 2020, the field survey could only be conducted in November 2020 due to the uncertainty of the terrain disrupted by the coronavirus pandemic and its subsequent up and down variations.

What was supposed to be an assessment and a quick survey turned into a real research for various reasons, some of which can be herewith recalled:

- The number of countries covered and the size of the sample,
- The three assessment periods (before, during and after the lockdown), the first being before March 2020, called “*before the lockdown due to COVID-19*”, the second entitled “during the lockdown” which corresponds to an almost universal decision of closure and which started more or less at the same time for the majority of countries in the world in March 2020, with the announcement of drastic measures being taken by the States here and there. The third period should correspond in absolute terms to “after the lifting of the lockdown”,
- Total lockdown, partial lockdown, 1st wave, 2nd or 3rd wave of the pandemic, COVID-19 variants that are starting to have a nationality (English, South African, New Zealander and lately a Tunisian even if its announcement has since been retracted), measures that are lifted, postponed or that are changing until now...
- The difficulties were first and foremost technical, such as the number of “absentee subscribers” and the multitude of calls. Thus, 54,983 women’s calls had to be made with 54,142 outgoing calls unanswered to obtain a sample of 841 women. For the stakeholders, 1849 telephone numbers had to be formed, of which only 46 were completed. The other 4 questionnaires were completed through the link sent to them and the 51st questionnaire sent by email by the concerned entities.
- Despite refusals to respond, procrastination, interviews interrupted before completion, suspicion and anxiety about being bugged, and denial of the violence itself, the field survey, which included a telephone interview with 841 women who were reported to be GBV survivors-or not-was completed in November 2020. It was conducted in January 2021, with 50 stakeholders representing both government entities and civil society organizations in charge of GBV.
- The complexity of the questions raised and the entanglement of the answers both horizontally and vertically did not make things any easier...

At the beginning, the vision was clear and the objectives SMART, but the reality of the field, of the pandemic, of the lockdown and its multiple measures changed both the reflection and the work. The questioning and the finding themselves have evolved with the evolution of this health crisis and the changes throughout. Indeed, the 7 countries in the sample have experienced several types of lockdowns since the health crisis began in March 2020. Besides, will the inequitable access to care, prevention and cure, and the COVID-19 vaccination campaigns that began at the dawn of 2021, not sustain this situation of insecurity for women and girls?

2. The Framework

The study attempted as much as possible to assess women's experiences of GBV before, during and after the lockdown and their own lock-in as imposed by the COVID-19 pandemic. The different VAWG types and forms, prevalence, concomitance and frequency were counted and analyzed both quantitatively and qualitatively.

- The figures obtained for the first period (before the lockdown) were not far from the known rates in the world or in the countries concerned. Rates in other countries (during/after) confirmed the warnings launched here and there as well as the hypotheses that were posed for this study, namely the potential or real increase of VAWG during the lockdown and the aggravating causes and conditions.
- The women's point of view was probed of the impact that this double COVID-19 and GBV pandemic, could have or had in terms of risks on their survival, the satisfaction of their needs and the realization of their rights, as well as on their relationship dynamics (couple, children, family).
- Women also had the opportunity to designate their aggressors and thus confirmed the known facts about the role of their intimate partner and other family members.
- Women were able to share their experiences about what they saw as the main elements that contributed to a worsening atmosphere and GBV acts, endangering their safety and limiting their access to protection. The barrier measures lowered the risk of COVID-19 contamination but increased the risk of GBV.
- Family encirclement also paralyzes any willingness to seek help from outside. The woman feels watched by her husband as well as by other members of her entourage. When she finally succeeds, there is no guarantee that she will be able to find someone to answer her call (government entity or CSO).
- The women's responses and those of the stakeholders were compared, which revealed a great deal of agreement on the common issues that were raised on both sides.
- Both women and stakeholders were asked to propose ways to remedy the shortcomings of the care and awareness of women's suffering from this scourge including recommendations for possible improvement and optimization of the services they lacked. Once again, both groups expressed a common vision of their needs as rights holders and duty bearers.

GENDER-BASED VIOLENCE & COVID-19... WHAT TO REMEMBER

As soon as the premise of the coronavirus pandemic was announced, alarms were raised around the world to only quote the UN Secretary-General António Guterres who appealed, as of April 2020, *for a worldwide domestic violence “ceasefire”, urging governments to put women’s safety first as they respond to the crisis.* During the same period, Ghada Fathi Waly, the head of the UN Office on Drugs and Crime/UNODC declared *as the COVID-19 pandemic heightens the dangers of Gender-Based Violence and human trafficking, the need for action on both fronts is greater than ever.* ⁽²⁰⁹⁾ According to the same sources, nearly 150 countries have answered the Secretary-General’s call, pledging to make prevention of Gender-Based Violence and redress a key part of their pandemic response, working together in four key areas: funding essential services, prevention, improving police and justice action, and collecting data.

Women have always played an essential role in “normal time” or in times of crisis, whether as simple actors in society or in tactical positions, in private or in public life. In the fight against COVID-19, in their homes or in strategic sectors where their contribution has been both preponderant and crucial, to only quote health or food provision. Women can be considered as the warriors against the coronavirus, even if they have lacked weapons in the fight against the increase of GBV that they have had to suffer during the lockdown due to this pandemic, which is, to say the least, unique of its kind, if not because of its multiple consequences.

This assessment aimed to check what has been observed around the world and to analyze the phenomenon of GBV increase and intensification and more particularly Domestic Violence, through a comparative temporal dimension: before the emergence of the coronavirus pandemic, during the lockdown this pandemic caused and after its lifting which in most countries, was not a true lifting.

1. GBV evolution Before, During and After the lockdown lifting per country

Lockdowns and policies of both social distancing and domestic confinement have increased the risk of exposure to violence and to the intimate partners’ acting out, reaching its peak during this period. The analysis of the different findings of this study confirms the information collected here and there in the world. The hypotheses that have been put forward in this work are validated to a great extent by the results of the assessment as well as the analysis of the state of play that have well highlighted the following:

- Indeed, the increase of the time shared between the author and the GBV survivor has increased the risks of exposure to GBV,
- The impact of daily stress, at the individual, family and societal levels, due to the fear of disease and death, as well as the fear of confinement and promiscuity, has led to family and domestic problems, with all its consequential conflicts at the couple and family levels,
- This situation, combined with barrier measures that were intended to protect against COVID-19 contamination, have not protected women against the GBV pandemic, increasing insecurity for women survivors and impunity for perpetrators of GBV and its different types, as summarized below for this momentum,

209. <https://news.un.org/en/story/2020/11/1078812>

- Before the COVID-19 pandemic, very close to global data, the regional prevalence was estimated at 37.5%, increasing to 45.3% during the lockdown as a result of the measures that were put in place to limit as much as possible contamination. The rate dropped to 30.4% after the lockdown was lifted, even though the lifting of the lockdown was not really homogeneous between countries.

Figure 95 - Comparative rates - before, during and after the lockdown per country

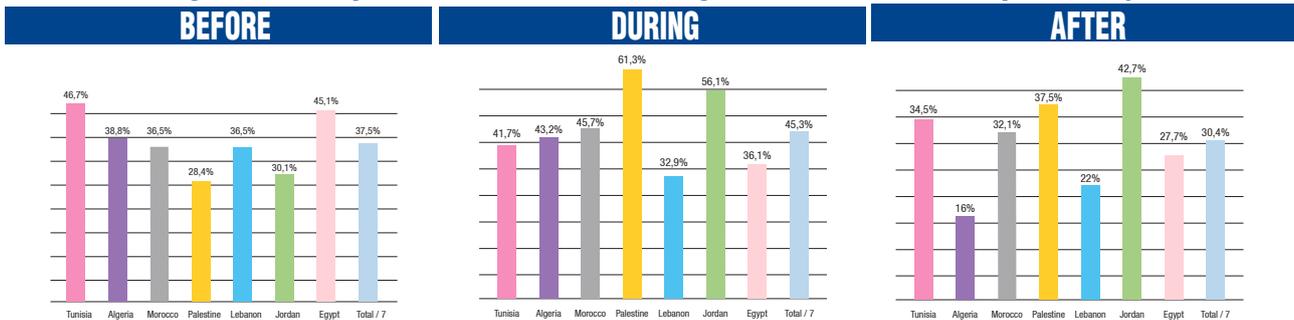
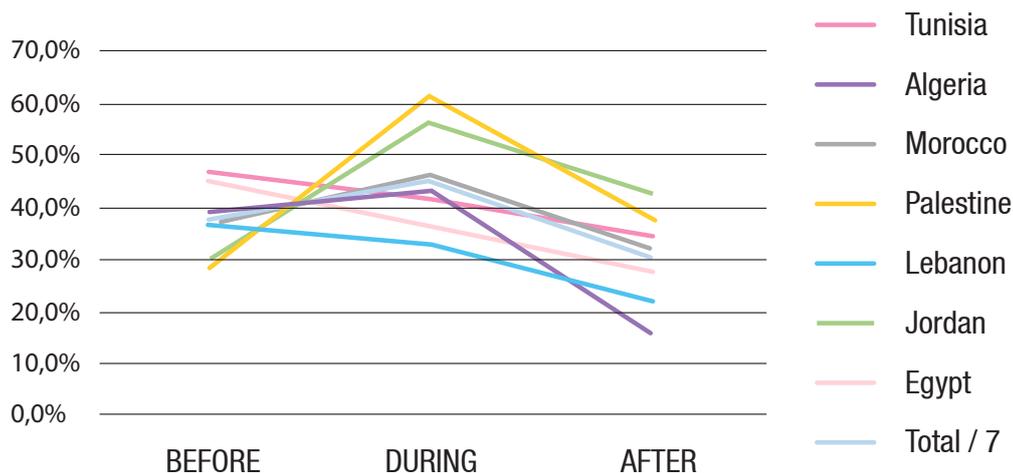
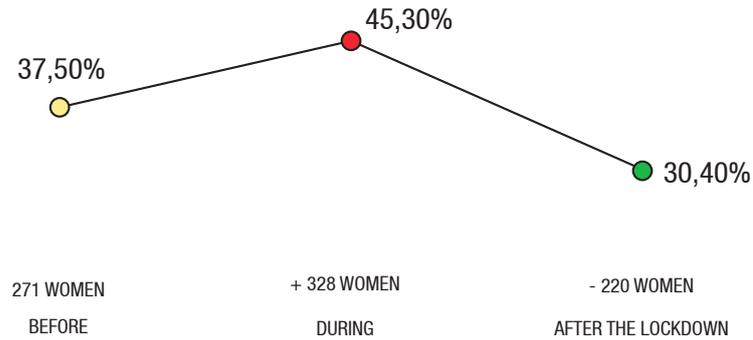


Figure 96 - GBV evolution - before, during and after the COVID-19 per country



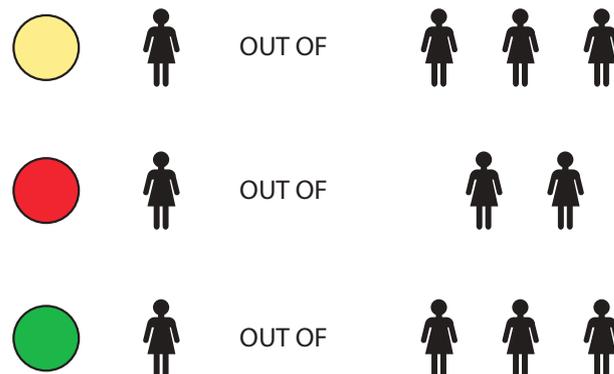
- The increase in Violence Against Women and Girls and GBV during the lockdown that was reported around the world and in the region was not a rumor or a fake.
- It is at least at 45.3% regionally with variations from country to country, as shown in the figures above, and while it drops somewhat after the lockdown to a regional rate of 34.5%, it is still pervasive and significant, as opposed to the period of total confinement.
 - Before: of the 723 women interviewed, 37.5% reported experiencing violence (271 women).
 - During: of the 723 women interviewed, 45.3% reported experiencing violence (328 women): **+21%**.
 - After: of the 723 women surveyed, 30.4% reported experiencing violence (220 women): **-33%**.

Figure 97 - GBV evolution (%/#) Before, During and After the lockdown lifting



- In terms of proportionality, the data evaluated are also almost identical to those found worldwide, especially for the period preceding the onset of the pandemic, with 1 in 3 women reporting having experienced violence. This violence increased during the lockdown to 1 in 2 women and decreased to 1 in 3 women when the lockdown measures were partially or fully lifted.

Figure 98 - GBV evolution (proportion) Before, During and After the lockdown lifting

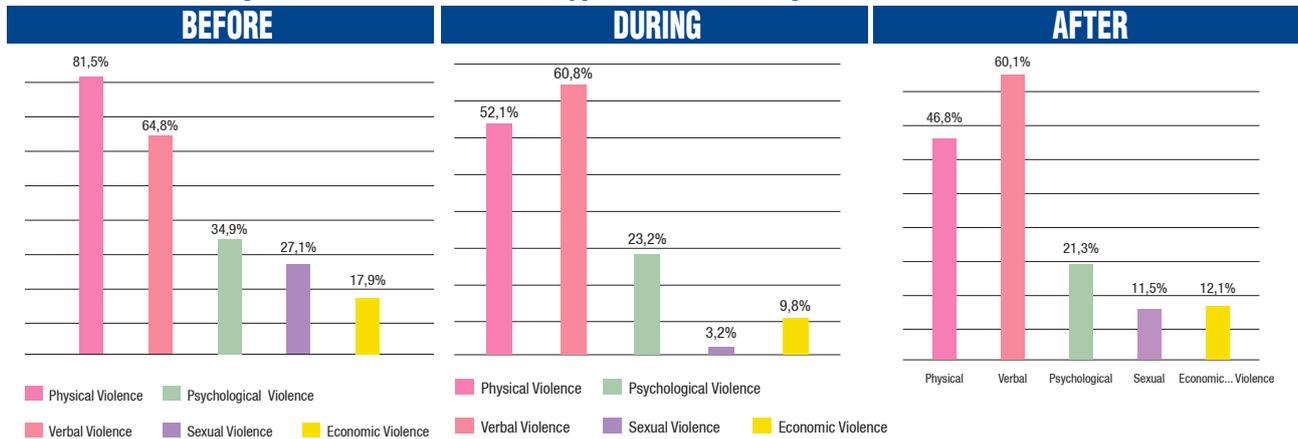


2. Evolution of GBV types: Before, During and After the lockdown lifting

- Assessing the GBV types and forms allows for a better understanding and tracking of its evolution in general.
- Physical violence is the dominant type of GBV before lockdown (81.5%) and a significant increase during lockdown (51.1%) covering both respondents and women in their circle. Assault and battery is the most common form (+40%).
- Verbal violence affects on average two thirds of the sample, all countries included. It is expressed in an almost similar way, in the form of insults or shouting, with rates of around 60% and 20% for the periods studied.
- Psychological violence is experienced by 34% of respondents before the lockdown. It increases by 23.2% in the form of threats, devaluation or even contempt. In absolute terms, it decreases after the lockdown is lifted, even though some of its forms increase relatively.
- Sexual violence was reported by around 11% of respondents who said they had experienced it before and after the lockdown, and only 3.4% during the lockdown. In fact, certain measures of the lockdown (confinement, social distancing, teleworking, etc.) have an opposite effect on certain types and forms of violence, especially those that occur in the public space. Thus, sexual harassment is at 1.9% during the lockdown, whereas it is close to 8.5% (before/after).

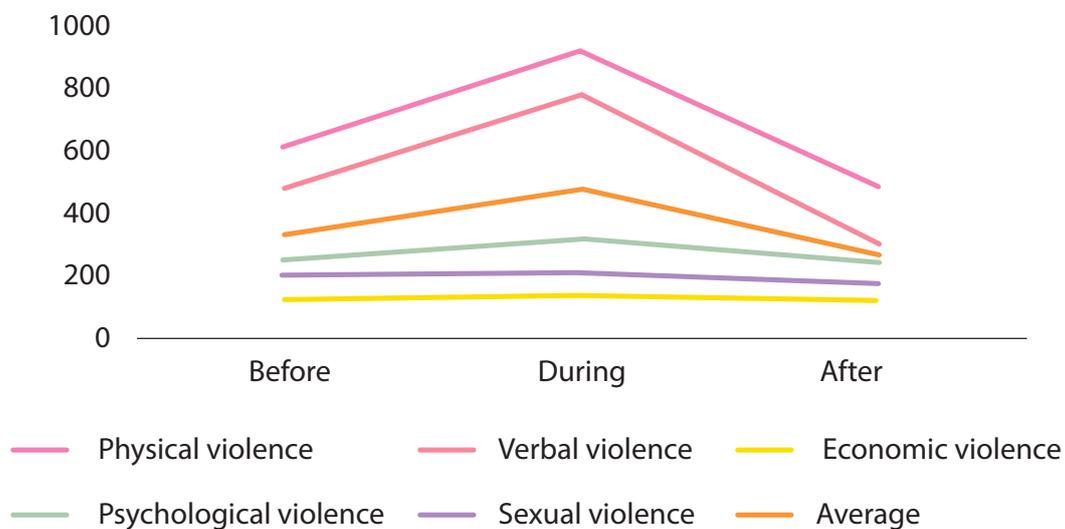
- Economic violence also varies with the decline in income. It was 17.9% before the lockdown, 9.8% during the lockdown and 12.1% after the lockdown was lifted. The women complained most about not having been able to get any kind of financial assistance and support as well as wage loss, often due to unemployment or the bankruptcy of certain companies. Some respondents complained that they were left alone to support their families.

Figure 99 - Evolution of GBV types Before, During and After the lockdown



- Proportionally, the high rate of physical violence (81.5%) before the lockdown certainly refers to the fact that this data covers both public and private space. This is also the case for sexual violence, which did not increase much during the lockdown (3.2%), whereas it was at 27.1% before the lockdown and increased again (11.5%) when the lockdown was lifted. This is related to the mobility that restarted in public spaces or the fact that people returned to work.
- Verbal abuse remains very high whether before (prevalence), during (increase) or after (decrease) the lockdown, in public and private space (before/after) or only in private space. Even though psychological violence increased by 23.2% during the lockdown, once it was lifted, one cannot say that its decrease is really noticeable.

Figure 100 - Evolution of GBV types Before, During and After the lockdown

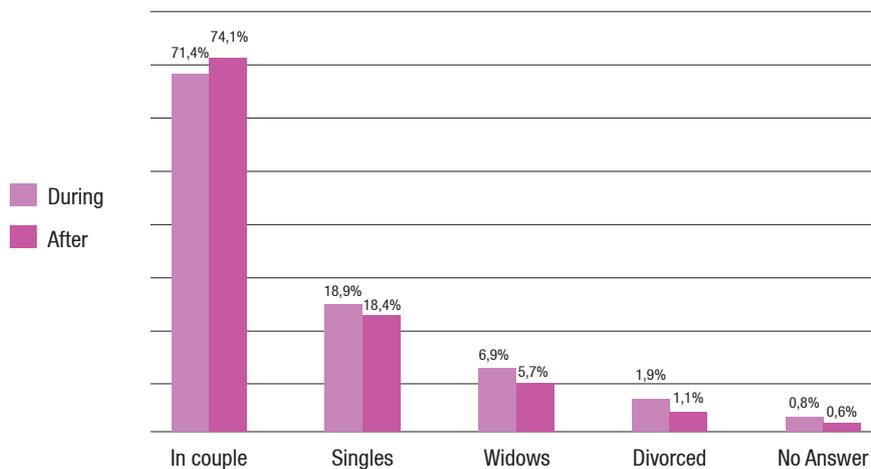


3. GBV experience: civil status and perpetrator during/after lockdown

3.1. GBV and Civil Status

- Women and girls found themselves locked “within four walls” during the lockdown and where “home” is no longer really the “sweet home” or “stay home” is not always as safe as it is made out to be. 54.2% of the interviewed women said that the lockdown measures made their situation worse and that GBV intensified during this period. At least 15% of the GBV survivors consider forced coexistence with the perpetrator as the primary cause and consequence of this state of affairs.
- Yet comparing the during and after the lockdown situation, not an obvious difference is noted as showed in the herewith figure.

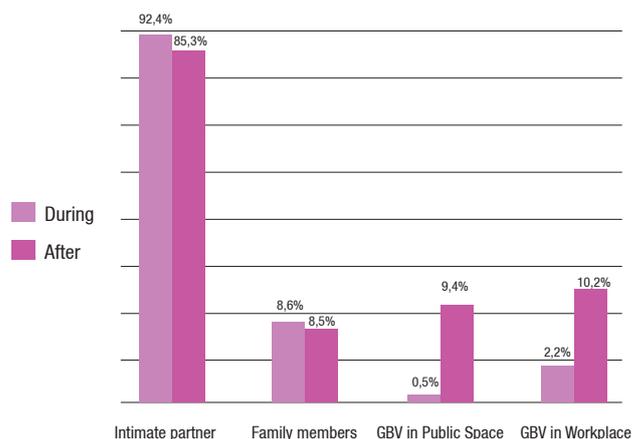
Figure 101 - GBV experience and women civil status



3.2. GBV Perpetrators during the lockdown and after its lifting

- The unfailling fact is that the intimate partner (husband, fiancé, boyfriend) retains his first place as GBV perpetrator during and after lockdown, with a response rate of 71.4% during lockdown and a slight increase to 74.1% after the measures were lifted.
- According to women’s confessions to service providers and other stakeholders, the rate is even higher and close to 100% (97.3%).

Figure 102 - GBV Perpetrators during the lockdown and after its lifting



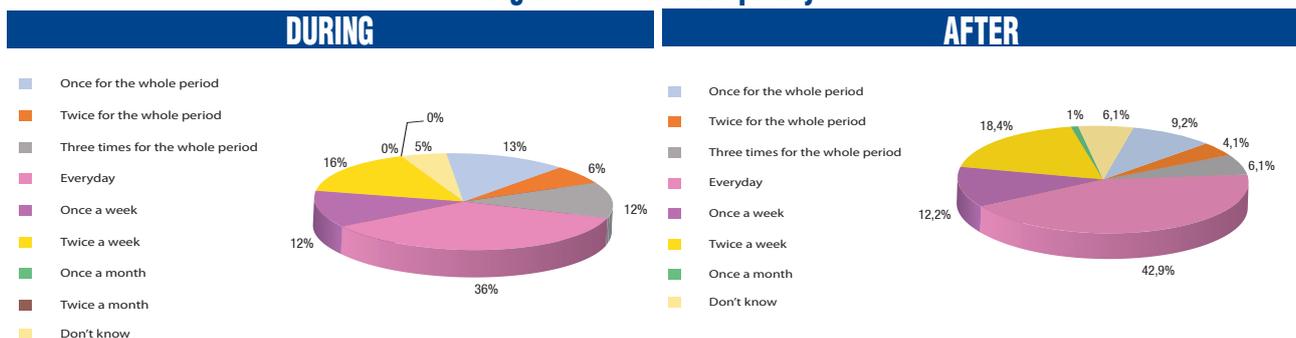
- According to women, things changed for sexual violence, which is perpetrated mainly by the intimate partner during lockdown and by other perpetrators before and after. The same is true for economic violence, which is perpetrated by family members and employers during and after confinement, making women’s situation even more precarious.
- The increase in time spent with the family during the lockdown has accentuated the acts of VAWG by family members (spouse, father, brother, son and even if more rare, mother and mother-in-law...) in number, intensity and multiplicity of perpetrators with however no big difference between the lockdown period and its lifting.
- The reasons why violence has dropped dramatically during the lockdown on the workplace and in public spaces are more than obvious. Their increase after the lifting of the lockdown measures is more than convincing.
- While some GBV forms in public space are minimal during the lockdown, they reappear once the measures are lifted both in the workplace and in the streets. They are still limited in public transport, probably because of social distancing and fear of contamination. In fact, if the forms of violence in the professional world have decreased during the lockdown to a rate of 2%, the return to work has it rising to 7%, characterized mostly by the sexual harassment exercised by both employers and colleagues.

4. Evolution of GBV and Impact of Lockdown on Frequency of Assaults

Understandably, the conditions of the lockdown as above described also had an impact on the evolution of the frequency of GBV acts. Just to clarify the vision and confirm the increase, it was decided to assess the women’s appreciation or experience of the violence they were experiencing in terms of frequency per week, per month, or for the entire period of the lockdown and after it was lifted.

As highlighted, the duration of the lockdown period varied from one country to another and sometimes within the same country, with alternating opening and closing times, day and night, curfew with hours that also varied from one country to another or within the same country from one region to another. It was then agreed to define an average duration of 3 months, i.e. 90 days, in order to be able to estimate the frequency of the GBV during the lockdown and to limit its evolution *after the lifting of the lockdown* to the same duration. The recorded frequency responses were calculated as a percentage and then converted to the equivalent number of days. These data are not intended to be used for generalizations but just to give an indicative sense of the responses recorded and therefore will only be valid in this framework.

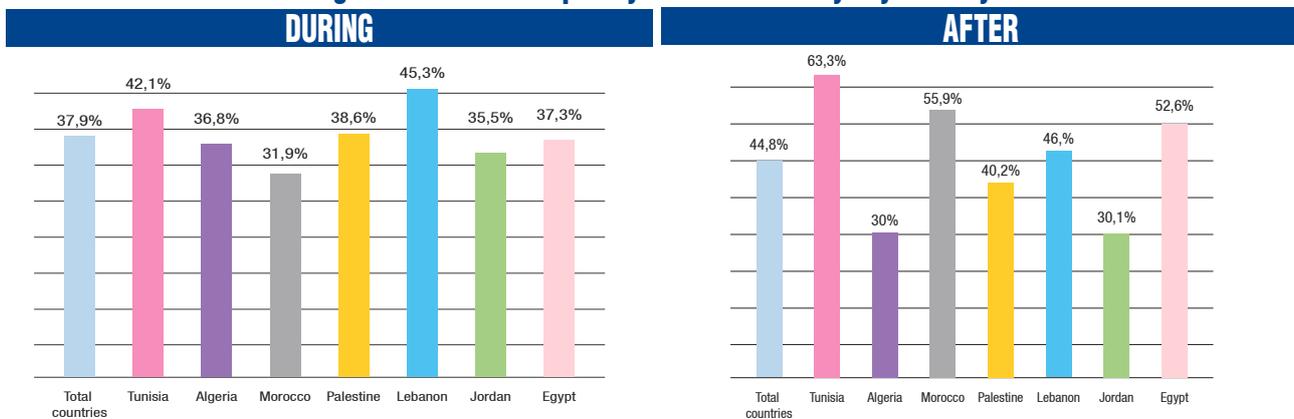
Figure 103 - GBV Frequency



36% of the interviewed women said they experienced violence every day during the lockdown period, 16% twice a week with equal percentages of 12% for “once a week” and “3 times for the entire period”, followed by 1 time for the entire period with a percentage of 13% and 6% twice for the entire period. No woman reported being abused only once or twice a month. They however all confirmed that GBV had increased in frequency.

As for the frequency of GBV (types/forms) after the lifting of the lockdown measures, as in the previous period, 42.9% of the respondents said that they had experienced violence every day, compared to 19% who said that they had experienced it about “twice a week” and 12% “once a week”.

Figure 104 - GBV Frequency in number of days by Country



The recorded frequency percentages consolidate the finding of an increase in the number of assaults experienced by women, even though some respondents were unable to measure these frequencies or simply avoided answering, for reasons that are also understandable.

For the sake of visibility or rather of visualization, these percentages have been converted into number of days and by country: this gives a regional average of 37.9 days over a period of 3 months during the lockdown period and 44.8 days once the lockdown was lifted. This increase does not mean that the frequency was lower during the lockdown, but rather that the “opening of the houses’ doors” allowed GBV in the public space to be “expressed” in other forms and places.

For the seven MENA countries covered by this assessment, variations in frequency are noteworthy and can be further explored. As shown in the above figure, Lebanese women are at the top with 45.3 days of GBV experiences during the lockdown period while the lowest frequency is reported by Moroccan women with about 32 days over 3 months. On the other hand, after the lockdown was lifted, Moroccan women experienced this violence for almost 56 days. Tunisian women reported having been subjected to violence for slightly more than two-thirds of the same period and duration (three months), i.e. 63.3 days. The experience for Algerian women was 30 days, slightly less than during the lockdown period.

5. Impact of the COVID-19 pandemic and its subsequent lockdown measures

In addition to its impact on women's safety, as with any snowball effect, the COVID-19 pandemic impacted other areas of women's personal, family and social lives (e.g., shopping, school, family visits, work...) as well as their rights. For instance, their right to physical health and mental health (30%), since women had difficulty discussing their sexual and reproductive rights. 26% said that their access to economic resources had been diminished (see Part III).

As anticipated in the hypotheses posed at the outset, in addition to the obstacles specific to the lockdown measures or because of it, the women experienced certain difficulties that prevented them from reporting the violence they had suffered, from asking for help or from filing a complaint during the lockdown period. 37.8% stated that the primary reason they did not seek help or file a complaint was fear. The majority stated that they felt watched reporting the impunity enjoyed by the perpetrator of GBV both within the family and with the relevant authorities. This was also confirmed by the stakeholders whose responses were very similar to the women's for most of the raised issues. It should be noted, however, that the responses of stakeholders were sometimes stronger, which can be explained. In fact, it is more than common for women to feel more comfortable confiding their daily pain and suffering to a service provider they may or may not know as opposed to an anonymous phone operator conducting a survey. Thus, although stakeholders confirmed, as did the interviewed women, that GBV, both types and forms, increased during the lockdown, it seems according to the responses provided by the stakeholders, it did not decrease after the measures were lifted, as the women stated. It has been quite the contrary, including in the case of sexual violence.

Access to services

As a reminder, most respondents (GBV survivors or not) reported not being very well informed or having much knowledge of government institutions or associations that work in this area. In fact, only 23% of women in all countries reported having heard of such entities. Knowing the field and the reality of individual and social circumstances, the causes of this "ignorance" or "non-recognition" are multiple.

Starting with the GBV survivors themselves, who do not even know that this type of service exists or that they can use it, this could be related to the norm of silence that surrounds this scourge or sometimes just out of fear. Sometimes this may be due to poor communication and/or limited dissemination of information about governmental and non-governmental organizations, or because of the nature of the services themselves, which must remain confidential for the safety of survivors of violence and their children, if any.

The place given to associations in some countries, the role they play and the means they have are all important elements for access. Thus, the knowledge rate of NGOs is 47.1% in Lebanon and 43.1% in Palestine, which is almost double the regional average. However, the situation is not the same in the two countries. In Lebanon, two associations are well established and were cited by all the respondents, while in Palestine, civil society dominates the provision of services in many areas, not only in GBV. In Algeria, this rate is 5% and it reflects the reality of civil society in this country and that of the associations despite all the efforts undertaken. These facts are confirmed with regards to contact with associations, since 19.3% of the women questioned in the seven countries stated that they had been in contact with associations working on the prevention of VAW. Examples of findings are 38% for the Palestinian women, i.e. double the regional average and no answer was given by the Algerian women (0%).

Was it lockdown, fear, or ignorance that was the major obstacle? Only 16.6% of the women said that they had tried to overcome these obstacles and tried to access this type of service. But did they get it knowing that some of them also raised the problem of the responsiveness of these entities? In fact, it seems that 83.4% of the women targeted in the 14 cities of the 7 countries in the MENA region, did not seek, find help, or benefit from the services required from organizations in charge of GBV.

At the regional level, 12.8% of the associations in the sample confirm what has already been observed for government institutions. Namely that during the lockdown, collaboration with NGOs was more than minimal, as a direct consequence of the barrier measures, in particular movement restrictions and communication difficulties. This situation also limited both collaboration and access to services of all kinds for both parties, i.e., providers and service-seekers. But were these really the only difficulties to access?

Stakeholders participating in the assessment indicated that the obstacles encountered are mainly related to the economic situation that COVID-19 has created and from which they have suffered especially in relation to:

- The non-prioritization of GBV compared to other services considered vital (COVID-19),
- The very poor infrastructure of the shelters and the precariousness of those set up,
- The difficult, if not impossible, access of women victims of violence to various services, whether in terms of care (medical, psychological, social or legal care), of security services (police or national guards)⁽²¹⁰⁾ or of legal protection and access to courts noting that some were closed during the lockdown (in flagrante delicto or otherwise).

In terms of care for GBV survivors, the difficulty cited first and foremost is the mobilization of specialists (26%) and the scarcity of services in place (24%). 22% thought it was a communication issue and 14% reported financial problems. The inadequacy or non-application of the law is cited by 8%, while 6% of respondents consider with equal value to each that the difficulties are related to infrastructure, difficulties in moving and non-compliance with the set out measures and rules. To a lesser extent (2%) for each of these obstacles, difficulties in contacting associations, social coverage and fear were also mentioned.

In fact, there are definite correlations and certain concordances between women's responses and those of the stakeholders, whether they are similar or respond to concerns expressed by the women. Will the expectations and recommendations made by both converge in the same direction?

EXPECTATIONS & RECOMMENDATIONS

In its final stage, the assessment proposed to look at the expectations of women who are reported to be GBV survivors or not and of stakeholders and the changes they could propose to ensure that women exposed to or affected by GBV have access to more effective services and that they are safe and protected during a health crisis such as the COVID-19 pandemic? Responses were organized at three levels:

- Recommended overall actions against the COVID-19 pandemic,
- Recommended changes to improve legislation and services,
- Recommended changes to improve service delivery by sector (government and non-government).

In this pathway, it was essential that the final word in this rapid assessment on GBV in relation to the COVID-19 pandemic be given first to the women who were willing to answer these difficult questions despite unhealed wounds—which they will one day be—and then to the stakeholders, who are always doing the best they can with the little they have, whether they are governmental entities or from civil society. They were asked to propose at least some of the ways to improve the situation with regards to GBV prevention and how to better manage it, whether the measures to be taken are in relation to the COVID-19 pandemic globally or specific by area of intervention or specialized sector. The question was: from their experience what measures should be modified or taken to limit the risks of the GBV pandemic while limiting those of COVID-19, to ensure the safety and protection of women while ensuring health security? Once again, it was interesting to note the confluence of responses and proposals from both groups, indicating the authenticity of the reality experienced on the ground by both of them.

1. Recommended overall measures against the COVID-19 pandemic

It was important to know the respondents' views on these measures and to assess what they thought would be the best ways to limit the risk of GBV and the impact of lockdowns such as those imposed by the COVID-19 pandemic. To do this, both groups were asked "What overall measures should be improved and/or modified to limit the risk of violence?" A subsidiary question on "additional measures" was included not as a tie-breaker but rather to reinforce the answers to the first question or even as a "second chance" in case of a non-answer. The identical answers to both questions virtually consolidated the results and affirmed the prioritization at the level of respondents in both groups.

Each group proposed a series of measures concerning policies, including budgetary and financial, law enforcement and legislative reforms, institutional and association strengthening, as well as programs and services. While many of the proposed measures were identical, they were not always of the same importance to both groups, without being contradictory but with greater or lesser differences. This can also be explained by the concerns of the two groups, as described in some of the most important examples cited.

- **Anti-COVID-19 measures**

43.80% of the women, who are affected by these barrier measures, think that these should be taken despite the incurred risks. 42.81% of them think that health protection measures are crucial. 32% of the stakeholders think it is absolutely necessary to respect the health protocol imposed by COVID-19, 6% suggest avoiding confinement which endangers the victims and increases GBV in the family. Approximately 3% of women think that the curfew should be lifted.

- **Sensitization**

38.74% of the women and 32% of the stakeholders placed awareness raising at the top of their priorities. 15.3% of the women respondents emphasized that awareness raising and the fight against GBV required capacity building for associations, stressing the importance of the role they play in this area. 22% of stakeholders believe that sensitization is necessary for their teams to understand GBV issues in detail. Similarly, 12% cited the provision of shelters. They also emphasized the importance of coordination between government entities and CSOs.

- **Services**

For 12.16% of the women respondents, it was important to ensure that specialized and free services were available to GBV survivors, citing medical consultations, hotlines, listening units, reception of GBV survivors (i.e. police unit) with the highest rate for psychological coaching/counseling (41%). With the exception of psychological support, which 10% of the stakeholders propose to strengthen, 20% of them considered the provision of shelters to be crucial. This is more than consistent with the difficulties as regard to the availability of shelter for women survivors of violence in most of the countries in the study or outside of them. Both groups emphasized the need to strengthen mechanisms to protect women, including in residential settings, in both legislation and security. They emphasized the importance of police readiness and preparedness for rapid response, by day and night, as crucial to both women and stakeholders given the major deficiency during the lockdown that was reported in all countries.

- **Women's Status and rights and gender relations**

For 25.92% of the women declared as GBV survivors or not, the issues of women's rights and gender relations should also be a focus for the State, which should play a more "offensive" role and assume its responsibilities as a primary duty bearer to guarantee women's safety and rights (6%), especially in light of the consequences of the barrier measures taken to limit the contamination of COVID-19. This is another way of saying that any policy, especially in this type of situation, must take into account the gender perspective and reality. 24% of the stakeholders think that the Law should be modified, adapted and enforced. They even recommended the setup of GBV specific courts.

- **Material and financial support**

The issue of material and financial resources was also considered essential by 29.82% of respondents and 20% of stakeholders.

2 Recommended changes toward improvement in legislation and services

- **Desired changes in laws, policies and programs**

For women reported as GBV survivors or not, guaranteeing women's rights (21.23%) cannot be without respecting laws (16.80%). Their main concern about the desired legal change is the sanction and punishment of perpetrators of GBV (35.71%), including imprisonment (9.84%) and the death penalty (3.03%) or the prohibition of drugs (4.11%). They also mentioned reforms that should address other issues such as judicial oversight, women's safety and protection, gender relations, engagement of abuse providers, including within the justice sector, strengthening of NGOs or financial and material allocation.

Very pragmatically, for 42% of the stakeholders, the priority of priorities lies in the firm enforcement of the law. 34% considered that the reform of the law, modification or updating, has as high importance. The other proposals are around the need to adopt laws that protect women's interests and the realization of the principle of justice (14%). Likewise, for 6% of women a certain justice means also dissuasive punishment. Among other important changes, stakeholders recommend deterrent justice, speeding up the processing of legal cases and GBV complaints. Stakeholders think that legal literacy is important too.

For women respondents funding problems paralyze the implementation of programs (26%), this why they propose policy changes as regard to financial aid (28%) in case of further lockdown to combat GBV and ensure provision of appropriate services. That also means adequate budgets for

key actors working in this field both for ministries (10%) and associations (6%). Training should be provided and therefore funded (10%). including those related to the provision of health care to women; awareness-raising (women’s rights, fight against GBV, etc.) and support for projects and programs for the socio-economic reintegration of women. The difficulties faced by the shelters are once again evoked.

3 Recommended changes to improve the provision of services

The recommendations made by women survivors of GBV and by stakeholders refer to services provided by ministries directly involved and civil society organizations. In the summary tables below, the entities and services are listed in the first and second columns, the third column marks services that already exist (+) or do not exist (--), and the fourth column refers to the required improvement (+++) or proposition to establish new services.

- **Ministry of Health**

None of the women respondents from the 7 countries reported that a specialized department for GBV management is in place within the Ministry of Health.

Table 6 - State of play of the Health Sector

Institution/ Organization	Types of services	-/+	Recom.
Ministry of Health	Specialized department	-	+++
	Reproductive health services/centre	+	+++
	Emergency	+	+++
	Hotline	--	+++
	GBV Centre	--	+++

About 30% of women recommended that a relevant department in the Ministry of Health should improve its services including psychological support (22.1%). Emergency rooms should be adapted for GBV survivors with a monitoring system implemented to ensure their safety. The Ministry of Health has a duty to guarantee women’s rights, including reproductive rights, and 31.9% of respondents felt that such services need to be improved. GBV services, including Information, Education and Communication, should be an integral part of the services provided by the reproductive health center. More than a telephone line, women insisted on the need to set-up a listening unit within the reproductive health center and to provide them with the necessary psychological support (22%). They think that the Ministry should play a more active role in coordinating with other sectors, including the police, and in raising awareness about GBV prevention and women’s rights. 83.87% of the interviewed women stressed the importance of devoting a specific budget to this program and related comprehensive services.

The first concern of the stakeholders, the majority of which are associations, is to provide free health care (22%) and ensure specialized training for its teams on the adequate way to take care of abused women (14.6%). The respondents confirm the women’s recommendations as regard to the express need to integrate psychological support considered as essential (12.2%). This will be more effective if the Ministry of Health establishes specialized services (12.2%).

Concerning reproductive health, about 44% of the stakeholders think that more efforts should be made to raise awareness, followed by the improvement of services (20%) as well as the care of women survivors of violence, which should be free of charge and also include the provision of contraceptive means (16.7%). 19.2% recommend improving existing emergency services (reception and care) to adapt them to the GBV specific case and to plan more emergency services for the reception of abused women, which must meet international standards adapted to the treated types of violence (physical violence, sexual violence). This will require presence of specialists. Respondents reiterated the importance of awareness raising (19.2%), free services (11.5%) and psychological support also for emergency services. If the women's answer was not clear for an online assistance, 58.6% of the stakeholders consider that it should be available 24/7 and that this service should be free (24.1%).

- **Ministry of Justice**

There are no specialized GBV courts as such in any of the 7 countries covered, with the exception of courts that deal with family status cases in some of them.

Table 7 - State of play the Justice Sector

Institution/ Organization	Types of services	-/+	Recom.
Ministry of Justice	Specialized courts	-	+++
	Hotline	-	+++
	Shelter	--	+++

57% of the women felt that the Ministry of Justice should improve the efficiency of its courts and make more efforts in terms of legislative strengthening, law enforcement, monitoring and realization of women's rights (24%). 43% suggest that the Ministry of Justice create a legal framework to ensure that women survivors of GBV have the necessary material and financial resources. Free legal aid is also required and the recommended hotline should focus on listening to women whose rights have been violated and ensuring that they are restored. 62% think that the Minister of Justice should mobilize the material and financial resources necessary for its implementation of the online support and ensure to make it known (advertisement). 56.93% of women respondents recommended that the Ministry of Justice should provide accommodation in centers that can guarantee their protection and strengthen their security in coordination with the Police and collaboration and/or involvement of concerned associations.

22.2% of the stakeholders think that the Ministry of Justice should pay more attention to the enforcement of laws, the improvement of courts (structure and functioning), the acceleration of legal procedures and the speed of judgments' execution. 16.7% recommend the creation of a court to deal with issues related to women's rights. 18.2% think that the Ministry of Justice should open a hotline to listen and address women's grievances. 45.5% propose that this line should operate permanently and be dedicated to providing legal advice to callers, especially women. This service should be free (call and advice) with a system that ensures follow-up. For the stakeholders, the Ministry of Justice has a role to play in increasing the number of existing shelters (38.9%) and building new ones (27.8%), given the unmet needs in all the countries covered by this work. This involves contributing to social and psychological support (16.7%), providing services such as orientation and hosting abused women and their children as well as facilitating the procedures for accessing these shelters (33.3%).

- **Ministry of Interior**

Not all ministries of the interior or police departments have a specialized unit, but in many of the covered countries there are such units, including some at the level of police stations, even if this system is not yet generalized. The commitment is there but the implementation and institutionalization require effort, resources and time.

Table 8 - State of play of the Interior/Police Sector

Institution/ Organization	Types of services	-/+	Recom.
Ministry of Interior/Police	Specialized unit	+	+++
	Hotline	--	+++
	Shelter	--	+++

In order to benefit from more effective services, 44% of the surveyed women insisted on strengthening security and called for improvements in the services provided by the Ministry of Interior, both in specialized units, where they exist, and in services open to the general public, to which women turn in most cases. 34% consider that the Ministry of Interior and the police department should pay more attention to women’s rights and to the strengthening of legislation and law enforcement in relation to the mandate of this sector. 55% of women who have experienced violence want to see a change, an improvement in the relief services usually offered to them. 30% of them consider that the emergency hotline is essential. With the exception of Moroccan women who stated that they had not been able to refer any of the women who had experienced domestic violence or other forms of violence to a shelter, 45.7% of the respondents from the other 6 countries recommended improving the services in the existing shelters, although they did not specify that they belonged to the Ministry of Interior. 35% consider that material and financial resources are indispensable.

For 44.8% of the stakeholders, a specialized unit at the Ministry of Interior should meet a number of criteria to be in line with international standards and the needs of women in distress: from the moment of reception, good treatment and understanding, speed of intervention and law enforcement are strongly required. Respondents also recommended the recruitment or training of female staff skilled in GBV cases. Stakeholders emphasize the need for rapid or even instantaneous intervention by police services (36%). The 24/7 toll-free telephone line is recommended for appropriate referral of callers (32%) and active listening (36%). For shelters, the majority of stakeholders (58.3%) think that the role of the Ministry of Interior and Police Services should be mainly to ensure safe shelter and to provide programs and services according to the needs expressed by these centers, including specialists (16.7%). For others, the Ministry of Interior should also participate, in partnership with other sectors, in the renovation of existing shelters (25%), especially those that host women and children (25%) or even in the creation of new shelters (33.3%).

- **Women Mechanisms⁽²¹¹⁾**

All interviewed women consider the women’s mechanism, ministry, commission or council, as THE specialized entity on women’s rights issues, equality and the fight against all forms of discrimination and violence.

211. Ministères/Commission/Conseil/Comité des affaires féminines

Table 9 - State of play of Women's Mechanisms

Institution/ Organization	Types of services	-/+	Recom.
Women Mechanisms	Specialized department	+	+++
	Hotline	+	+++
	Shelter	-	+++

As a result, they think that the tasks of the specialized departments within this entity should be to work on making available the necessary material and financial resources (37.5%), to ensure maximum supervision and sensitization (20%) and ensure the improvement of services (17.3%). The majority of respondents believe in order to foster the biggest change and move things forward, women's mechanisms should work more on strengthening the capacities of associations, a privileged partner in the fight against GBV.

Many of these entities have a green line and most have shelters that are often managed in collaboration with NGOs or other sectors. Yet, both existing and new hotlines need to improve their services (61%) and more publicity should be done to make them known to the greatest number of women. 47% of the women respondents in the seven countries think that the mission of the "women's mechanism" for the establishment of shelters and the improvement of their services is essential, through awareness raising (23%) and the mobilization of material and financial resources to ensure the minimum required for the dignity of its "guests" but also for sustainability.

33% of the stakeholders recommend improving the programs and services offered by the entities in charge of women's affairs, their intervention to support the associations and strengthen their capacities, especially for the management and follow-up of GBV cases after reporting (12.9%). 36.5% consider that all these entities should have a centralized hotline that can be reached 24/7. These services need to be improved in order to ensure active and attentive listening, guidance, including legal, and follow-up of cases. It will be important to promote the service in question in the media, i.e. radio, television and internet. For 62.5%, the most urgent demand that the "women's mechanism" will have to address is to increase the number of shelters that are lacking in the 7 countries and to ensure the safety of women to be hosted (21%). Services and strengthening the staff's capacities will also have to be improved in these shelters.

- **Non-Governmental Organizations**

It may be because their information or knowledge of NGOs was limited (see Part III) that women who reported being GBV survivors-or not-were not able to really identify the role of NGOs and the services they provided to women, in GBV situation or other circumstances. This may be why they did not refer to shelters, but it could also be because of a sense of insecurity, as well.

Table 10 - State of play of NGOs

Institution/ Organization	Types of services	-/+	Recom.
CSOs/NGOs	Counseling	+	+++
	Hotline	-	+++
	Legal assistance		
	Shelter	-	+++

22% of women think that the role of associations is to advocate for the revision and change of laws and to ensure that perpetrators of GBV are severely punished. Their role is also to raise awareness (19.6%) and improve services (18.3%), including health services for women, especially those who have experienced sexual violence.

Among the improvements that 38% of the interviewees would like to see in the services offered by the NGOs, financial and health care, awareness-raising on the fight against GBV, free legal aid and, of course, monitoring and follow-up are noted. 41% of the women recommended that the NGOs should strengthen the psychological support and services and ensure that they are free of charge (24%) with the possibility of call on psychiatrists (12%), whenever necessary. As was the case for the other sectors and under the same conditions, 44% of the respondents think that a hotline at the NGO level is also important to guarantee care and follow-up for GBV survivors.

27% of stakeholders recommend increasing the number of centers and making them available to NGOs, which could manage them with financial support (19.2%). They invite the NGOs to rethink, diversify and improve services in a holistic perspective in anticipation of another lockdown (23.1%). In this case, it will therefore be necessary to strengthen the number of staff and skill them, to consolidate the role of the center as an actor in the orientation, supervision and follow-up, including medical care, of the GBV survivors, and to put in place a more serious process for the care of them. 43% asserted that NGOs, who have been the first to do so, can manage a 24/7 hotline very well. Stakeholders recommend that they be supported in order to improve the quality of listening, including the provision of specialized female staff, and above all to adapt it to special circumstances such as lockdown (17.4%), such as relying on new electronic means of connection or having the ways to immediately intervene in case of a call for help (13%).

In the likelihood of another lockdown or any other crisis, 41.9% of stakeholders recommend increasing the availability of specialists trained for this type of situation (psychologists and psychiatrists, etc.). The recommendations concerning legal and judicial assistance, which should be improved (21.4%), overlap with those made for the other sectors. However, this service provided by NGOs remains essential and should be strengthened as a priority according to 25% of the stakeholders, with the establishment of pools of specialists (lawyers, counselors, etc.) to provide legal advice and initiate legal proceedings, as well as to accompany victims and follow up on their case.

CONCLUSION OF THE CONCLUSION

This report had to be ended with final recommendations of the team who worked on this assessment to at least thank all these women and men who were willing to state their truth, their daily experience and their anguish before, during and after the lockdown. An anguish of the past that is so present and whose future is almost certain when it comes to the Gender-Based Violence that women and girls suffer on a daily basis. In our documentary research, we also had to appraise the initiatives of other organizations which included a World Health Organization web page addressing the Q&A open to those who call for help and to those who want to help, we could not say it better and we are sure that the WHO will not blame us for publishing here as a conclusion of the conclusion, the integral version of these two-questions and answers that perfectly wrap up all this work and the expectations of women, stakeholders and ourselves as women and as stakeholders.

Home is not a safe place for me. What can I do?

If you are experiencing violence, it may be helpful to reach out to family, friends and neighbors, to seek support from a hotline or, if safe, from online service for survivors of violence. Find out if local services (e.g. shelters, counselling) are open and reach out to them if available.

Make a safety plan in case the violence against you or your children escalates. This includes:

- Identifying a neighbour, friend, relative, colleague, or shelter to go to in case you need to leave the house immediately for safety.
- Have a plan for how you will exit the house safely and how you will reach there (e.g. transport).
- Keep a few essential items (e.g. identification documents, phone, money, medicines, and clothes) available, and a list of telephone numbers in case of an emergency.
- If possible, develop a code with a trusted neighbour so they can come to your aid in case of an emergency.

I am worried about someone. How can I help?

If you know of, or are concerned about, someone in an abusive relationship there are some things you can do:

- Keep regularly in touch with the person to check that they are safe, ensuring that it is safe for them to be in touch with you. Assume that a perpetrator of violence can see, hear and or monitor communications, so find out how best to communicate with the person that you are concerned about. Send them an SMS or message via email or social media, in a way that is safe for them. Be discrete in connecting with them when the abuser is present in the home so that they are not placed at risk of additional harm. Check each time, as this may change.
- Find out what services for survivors of violence against women (e.g. shelters, hotlines, counselling services, and women's organizations) are functioning during the COVID-19 pandemic and make this information available through your networks and social media. Only provide this information directly if you can do so discretely without the abuser finding out.
- If someone you know needs urgent help for whatever reason, be prepared to call emergency health services, the police, health centre, or hotline.

ANNEX 1 LIST OF ABBREVIATIONS

LIST OF ABBREVIATIONS	
AIDS	Acquired Immune Deficiency Syndrome
ATSF	Association Tunisienne des Sages-Femmes
ASRO	Arab States Regional Office (UNFPA)
CAP	Psychological Assistance Centre (in Tunisia)
CATI	Computer Assisted Telephone Interviewing
CAWTAR	Center of Arab Women for Training and Research
CEDAW	Convention on the Elimination of Discrimination Against Women
CRC	Convention on the Rights of the Child
CSOs	Civil Society Organisations
COVID	Coronavirus Disease
DEVAW	Declaration on the Elimination of Violence Against Women
DGSN	General Directorate of National Security (in Algeria)
ESCWA	United Nations Economic and Social Commission for Western Asia
EU	European Union
EUROMED	Euro-Mediterranean Partnership
FGDs	Focus Group Discussions
FGM	Female Genital Mutilation
FGM/C	Female Genital Mutilation and Cutting
GBV	Gender-Based Violence
GIs	Governmental Institutions
HCP	Haut-Commissariat au Plan
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
IFH	Institute for Family Health
IGA	Income-generating activities
IHL	International Humanitarian Law
IPV	Intimate Partner Violence
KAPEP	Knowledge, Attitudes, Perceptions, Experiences and Practices
KII	Key Informant Interview
LGBTI	Lesbian, Gay, Bisexual, Transgender and Intersex
MCP	Maternal and Child Protection
MDGs	Millenium Development Goals
MENA	Middle East and North Africa (Region)
MMM	Maternal Mortality and Morbidity rates
NCW	National Council of Women (in Egypt)

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NGOs	Non-Governmental Organisations
OECD	Organisation for Economic Co-operation and Development
ONFP	Office National de la Famille et la Population (in Tunisia)
OSF	Open Society Foundations
OSHA	Occupational Safety and Health Administration of the United States Department of Labor
PCR	Polymerase Chain Reaction
PwD	Persons with Disabilities
RAP	Rapid Assessment Process
RAAAP	Rapid Assessment, Analysis and Action Planning
SDGs	Sustainable Development Goals
SGBV	Sexual and Gender-Based Violence
SRH	Sexual and Reproductive Health
SRH/R	Sexual and Reproductive Health/ Rights
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNICEF	United Nations Children's Fund.
UNFPA	United Nations Fund for Population Activities
UNOCHA	United Nations Office for the Coordination of Humanitarian Affairs
UNODC	United Nations Office on Drugs and Crime
UNSCR	United Nations Security Council Resolution
UN WOMEN	United Nations Entity for Gender Equality and the Empowerment of Women
USA	United States of America
USAID	United States Agency for International Development
VAW	Violence Against Women
VAWG	Violence Against Women and Girls
WCLAC	Women's Centre for Legal Aid and Counselling
WHO	World Health Organisation

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