THE SECONDARY PANDEMIC: INCREASED VIOLENCE AGAINST WOMEN AND GIRLS DURING COVID-19

An Assessment

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Ministry of Women, Children and Social Welfare

and

UNFPA The Gambia

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LIST OF ACRONYMS

ADRS	Alternative Dispute Resolution Secretariat
CMR	Clinical Management of Rape
COVID	Novel Corona Virus Disease
CRR	Central River Region
DHS	Demographic and Health Survey
FGM	Female Genital Mutilation
FLAG	Female Lawyers Association of The Gambia
GBV	Gender-Based Violence
IASC	Inter-Agency Standing Committee
IPV	Intimate Partner Violence
ISSD	Information Services System Development
KII	Key Informant Interview
MHPSS	Mental Health and Psychosocial Support
MoH	Ministry of Health
MoWCSW	Ministry of Women, Children and Social Welfare
NALA	National Agency for Legal Aid
NGBV	Network against Gender Based Violence
OSC	One Stop Centre
PEP	Post Exposure Prophylaxis
PSS	Psychosocial Support
SDG	Sustainable Development Goal
SMS	Short Message Service
SOP	Standard Operating Procedure
URR	Upper River Region

1.0 SUMMARY FINDINGS

Since the outbreak of COVID-19, several countries have reported a surge in gender-based violence (GBV) following the imposition of lockdown measures and 'stay-at-home' orders. In The Gambia, the case seems to be the same as the assessment revealed **a notable increase in gender-based violence (GBV), including domestic and intimate partner violence, driven by:**

1. Pre-existing gender inequality in education, income, labour force participation, political participation, access to and control over resources;

2. Pre-existing gender and social norms that influence discriminatory practices against women and girls;

3. Increased economic vulnerability, stress and anxiety due to the lock down.

It is important to note that there are proxy indicators that provide evidence of increased risks of GBV in The Gambia. It should however be noted that, there is no standalone factor that can be attributed to the increased risks of GBV during the pandemic, as these factors are multi-layered and complex.

Therefore, dealing with GBV during the COVID-19 outbreak requires strengthening existing GBV response and support systems in The Gambia and adapting new ways of reaching women and girls for protection and response to GBV.

To respond to, and mitigate GBV during the pandemic in The Gambia, the report recommends that:

1. GBV prevention and service provision efforts be integrated into national and partner COVID-19 response plans;

2. GBV referral pathway that integrates protection, case management and law enforcement including decentralised services through community structures be developed;

3. One Stop Centres (OSC) to adequately provide essential services for women and girls be created and/strengthened;

4. Shelters, safe spaces and halfway homes with overnight facilities for vulnerable and affected women and girls be developed;

5. Remote and online protection and response services for women and girls, including psychosocial support be provided;

6. Advocacy and awareness campaigns targeting women, men at home and communities be increased.

2.0 BACKGROUND

Human rights violations specifically targeting women have been recorded for decades. Violence against women and girls in public and private spheres, including sexual and other types of exploitation is one of such. Sustainable Development Goal (SDG) 5.2 calls for the elimination of all forms of violence against women and girls by 2030. However, limited progress has been made by countries in West Africa including The Gambia towards the attainment of this target. As it is known that pandemics affect men and women disproportionately, the outbreak of COVID-19 exacerbates gender-based violence. As the pandemic deepens and countries enforce lockdowns or stay-at-home orders, women are forced to stay at home with their abusers with limited options. Evidence coming out of countries indicates an increased rate of up to 25% in incidences of sexual and gender-based violence, especially intimate partner violence (IPV) and intimate partner femicide.[1]

The Secretary General of the United Nations has called for an end to gender-based violence everywhere and urged countries to pay attention to the increasing rate of violence at home, against women and girls.

Similar to other countries in the West Africa sub-region, The Gambia has a considerable GBV incidence rate. In the status quo, 1 in 4 Women aged 15-49 years will experience sexual and gender-based violence, while 26% of ever-married women have experienced physical, sexual and emotional violence by their husbands or intimate partner and about 24% of ever-married women have physical injuries due to intimate partner violence. The occurrence of GBV in some communities in The Gambia has been 'normalised' to the extent that 40% of women believe it is acceptable for their partner(s) to hit them.

Although concrete data to substantiate the level of increase in GBV during the pandemic in The Gambia is not yet available, evidence from the 2014 outbreak of Ebola in West Africa shows that due to economic hardships fostered by movement restrictions and border closures (as we have seen in this current pandemic) survival, forced and transactional sex increased during the period. Further to this, France in the past weeks recorded a 30% increase in domestic violence cases and this reality is likely to be mirrored in The Gambia in the absence of appropriate measures.

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[1] See CAROLINE BECK, Alabama Daily News; March 27, 2020 at 12:51 PM CDT - Updated March 27 at 12:51 PM. Available at: https://www.wbrc.com/2020/03/27/crisis-calls-increase-domestic-violence-shelters-have-covid-plans/

See CDC website. CDC> Injury Centre>Violence prevention> Intimate Partner Violence. Available at: https://www.cdc.gov/violenceprevention/intimatepartnerviolence/fastfact.html

See The Guardian. Covid-19 will slam the door shut': Australia's family services brace for domestic violence spike. Available at: https://www.theguardian.com/world/2020/mar/28/covid-19-will-slam-the-door-shut-australias-family-services-brace-for-domestic-violence-spike

See The Globe and Mail Inc. Domestic violence reports rise in China amid COVID-19 lockdown. Available at: https://www.theglobeandmail.com/world/article-domestic-violence-reports-rise-in-china-amid-covid-19-lockdown/
See GBVAOR, Gender in Humanitarian Action. The COVID Outbreak and Gender. Available at: https://gbvaor.net/sites/default/files/2020-03/GiHA%20WG%20advocacy%20%20brief%20final%5B4%5D.pdf

See WHO. 26 March 2020. COVID-19 and violence against women What the health sector/system can do. Available at: file:///C:/Users/Lenovo/Desktop/Work%20File/COVID-%20Response/GBV%20and%20MHPSS/COVID-19-VAW-full-text.pdf

This is often due to the fact that pre-existing gender inequalities are further deepened as a result of the pandemic. However, the further weakening of limited national and community systems that respond to GBV and protect women and girls remains a factor.

It is worth noting that the Inter-Agency Standing Committee (IASC) GBV Guidelines admonishes humanitarian personnel to regard GBV as a life-threatening issue stating that *"all humanitarian personnel ought to assume GBV is occurring and threatening affected populations; treat it as a serious and life-threatening problem regardless of the presence or absence of concrete 'evidence*". It further states that *"waiting for or seeking population-based data on the true magnitude of GBV should not be a priority in an emergency due to safety and ethical challenges in collecting such data."*

Thus, the guidelines indicate that GBV actors, do not have to wait for research or data to substantiate anecdotal evidence of the magnitude of GBV before instituting programmes, systems and measures to address it. Services can be set up even without in-depth knowledge of the actual situation and then improved gradually. Over time, the types and magnitude of GBV, the risk factors and catalysts for programming can be established. Additionally, any emerging factors may be included in the response to GBV cases particularly in relation to COVID-19 triggered cases which are likely to manifest new dynamics in the occurrence of GBV.

2.1 OBJECTIVE

The assessment was conducted to ascertain the barriers and challenges that exist within national and community systems that prevent and respond to GBV and its related issues with a view to informing programmes and policies during the COVID-19 pandemic.

2.2 RESEARCH QUESTIONS

1. To what extent do GBV survivors have access to quality services from the health, legal, psycho-social and protection sectors?

2. What are the potential strengths and risks with regards to remote GBV services under the current COVID-19 pandemic?

2.3 METHODOLOGY

A qualitative assessment was conducted to establish challenges and barriers that exist within the GBV prevention and response structures at national and community levels. At the preliminary stage, a desk review on the proxy indicator related to gender inequality and GBV was carried out. Given that restrictions on travel have been imposed in The Gambia, Key Informants Interviews(KII) were used as the primary means of data collection. The targeted key informants to understand the availability and practicality of GBV response and mitigation programmes in the Gambia were: health care providers who provide direct services to the survivors; relevant government ministries - Director, Ministry of Women, Children and Social Welfare (MoWCSW); women groups - President, National Women's Council; civil society - Network Against Gender Based Violence (NGBV); Paradise Foundation. An interview guide with open-ended questions was used to understand service availability in the area of health, legal, social protection and

psychosocial service aspects.[2] In addition to that, the access to quality services were captured from the key informants. Each interview lasted for 70 to 120 minutes. The interviews were conducted after verbal consent was sought and given and prior approval and appointments were made. The period of data collection was from 16 to 18 April 2020. Data analysis followed the content analysis. All findings were classified into three broad thematic categories:
(1) Evidencing GBV amidst COVID-19;
(2) Service Availability for GBV survivors;
(3) Quality of Services;
(4) Remote Services in COVID-19.

2.4 LIMITATIONS

- The assessment could not adequately capture a certain demography of the population including women, girls, boys, men, persons with disability, and those who live in remote rural areas.
- The assessment did not include information from the police, lawyers and social workers, which will be captured in the next assessment.
- In addition to that, there was no scope to do a safety audit of the service delivery points and the capacity assessment of GBV related service providers. These issues will also be captured over the course of time.

3.0 KEY FINDINGS

The findings of the assessment are discussed under three broad thematic areas:
(1) Evidencing GBV amidst COVID-19;
(2) Service Availability & Quality for GBV survivors;
(3) Remote Services in COVID-19.

3.1 EVIDENCING GBV AMIDST COVID-19

The Gambia is a patriarchal society, where men are seen as individuals with authority over women and have the ultimate decision-making power in their households. Thus, this belief is a sentiment that is widely shared in most communities. As such, men are given authority over women, therefore engineering a situation where women do not participate as much as men in politics, education, wealth creation, etc.[3] Further, such discrimination often validates the tendency of men to abuse women, girls and children.

Economic vulnerabilities have increased during the Pandemic and this has aggravated Domestic Violence.

Pre-existing gender-related narratives have essentially been aggravated due to lockdown measures put in place to mitigate the spread of infections. In The Gambia, where women make up the majority of the informal sector, an estimated 52,000 people are at risk of losing their jobs in both formal and informal sectors.[4] The situation is even worse in rural areas where more than 69% of

[2] See the List of Open-Ended Questions in Annex II
[3] See both DHS 2013 and MICS 2018
[4] See socio-economic Impact of COVID19, brief #4.

people live below the poverty line[5] and are mainly dependent on agricultural activities. This economic loss has impact on the increased risks of GBV. Some of the key informants mentioned that the frustration and anxiety surrounding the loss of jobs, has essentially caused panic, fear and anger among men who are supposed to be the breadwinners in their homes. Their ability to provide food, shelter and clothing for their households, is often seen as where their legitimacy as an authority over their household comes from. With that authority at risk of being questioned, it is likely that men will resort to violence to ensure that they continue to exert power and authority over their wives and households.

> *"In The Gambia, there is no practice that a man will stay at home all day. Therefore, there are some psychological concerns that the private space of both men and women in the family have been affected due to this new condition. As men are household heads in the society, due to all these situations, when there is a need to show their anger and frustration, it is the wives who are the first points. This also existed before, but with COVID-19, the manifestations of those psychological expressions of masculinity have increased. Hence, there are heightened risks of GBV in The Gambia too."*

The culture of silence among women might hinder efforts to collect evidence on the increasing incidence of GBV

Social and gender norms in The Gambia are influenced by religion and culture. These have a profound influence on societal values that often discriminate against women. Historically, some of these values have been the basis on which harmful traditional practices such as Female Genital Mutilation (FGM), early and forced marriages have been founded. In the last decade, 90% of women had been mutilated. In this decade, more than 49% of women believe that FGM should be continued.[6] Even with such staggering numbers, the reporting of GBV to the police is very rare except in the cases of rape and extreme physical wounds. Given the under-reporting of cases, the data reflected in the Demographic and Health Survey (DHS) may not necessarily represent actual rates of GBV incidences in communities.

> *"In The Gambia, we have a culture of silence. A woman will never lodge a complaint against her husband if she is not extremely wounded. Besides, women are socialised to keep this as a private matter, only to be discussed with family and not with neighbours, peer networks."*

Although respondents agreed that the culture of silence on GBV poses a threat to adequately capturing data on its incidence, others mentioned that when women are provided with trusted contacts to report GBV cases to, they are able to lodge reports in certain instances.

[5] See socio-economic Impact of COVID19, brief #4.
[6] See MICS 2018

"In the last 15 days, I have received 5 incidence reports on both domestic violence and sexual violence. Before COVID-19, I used to get maximum 2 to 3 reports in one month. I am not the only one who receives information on GBV incidences on. There are other sources too. Therefore, I believe GBV has increased."

3.2 SERVICE AVAILABILITY & QUALITY FOR GBV SURVIVORS

The key informants confirmed the existence of structures to prevent and respond to GBV, listing social welfare, health facilities, police, local authorities, village chiefs/Akalos, women councillors. The respondents established that although inadequate and to some extent weakened, there are existing channels through which survivors/victims of GBV can lodge reports and access support. However, they did indicate that there was no dedicated hotline available 24/7 which survivors could call for assistance which is particularly important during the current pandemic. In the absence of such a hotline and with the state of weakened structures, women and girls in general have to talk about their GBV experiences with their peers, friends and relatives.

Accessing medical care for GBV survivors can be a challenge for many

In recent years, medical care for a GBV survivor has become free and medical treatment can be given in the absence of a police clearance or police report. A survivor gets physical examination and primary health care for any physical injury. In cases of rape, they are provided Post Exposure Prophylaxis (PEP) kits as part of clinical management of rape cases. The kits are available in the facilities, including the One-Stop-Centre (OSC). There are OSCs in three hospitals, namely: Edward Francis Small Teaching Hospital, Serrekunda Hospital and Bansang Hospital. In the regional hospitals where there are no OSC, most GBV survivors, especially those with severe injuries are referred to the OSC in the closest health facility, accompanied by a nurse.

However, the NGBV supported the clinical management of rape (CMR) training of approximately 50 doctors in The Gambia. The government of Gambia has also developed a five-day training manual on CMR. Once survivors seek medical attention in the hospital or clinic, doctors are required to directly submit medical reports to the court, minimising incidences of mishandling of reports or breaking confidentiality. To protect doctors, the identity of such doctors are not revealed to perpetrators.

Although, these are indeed good measures to ensure that the health care system is better able to respond to the needs of survivors, there are still a myriad of challenges that exist within the health care system, and key informants pointed them out accordingly.

First among these challenges is the **unavailability of OSCs in all hospitals**, especially in other regions outside the Greater Banjul Area and the Central River Region (CRR). Noting that access to health care is indeed a human right, it is unfortunate that some survivors would have to move from the Upper River Region (URR) to the CRR to seek health care. This discourages a good

number of survivors from seeking health care when they are sexually and/or physically assaulted. This also denies the survivor a chance to get justice as she is not able to establish any evidence of abuse because a medical report to substantiate the survivor's claim will simply be non-existent. In addition to this, existing OSCs have no Standard Operating Procedures (SOPs) and there are no periodic safety audits to assess quality of services. Furthermore, for the few that are able to access health care, they are often faced with the realities of 'free' medical care- where medical counselling and treatment is free but lab tests come at a price.

Secondly, while OSCs exist, there are often **difficulties with the availability of doctors and social workers** skilled in the provision of CMR and psychosocial support to operationalise the centres. With the unavailability of doctors and social workers comes the challenge of ensuring appropriate medical follow-ups within communities. Some key informants mentioned that logistics and fuel costs also aggravate the challenges.

Thirdly, there are **challenges with reporting and incidence recording** by medical professionals, which sometimes weakens the legal cases and impedes justice outcomes from the courts for survivors.

Fourthly, a directive from the Ministry of Health orders doctors to pass on information about the survivor and her injuries or condition to the police without the consent of the survivor in question. This violates the choices and rights of a survivor that she has over her own life.

> *"Whenever we have a domestic violence/GBV case, we make sure that the police are involved. The police are part of the OSC. We discuss with the relatives and make sure police are involved. Most of the time, the history of an incidence is given by relatives. Therefore, when we find resemblances during the medical examinations, we involve the police."*

Some key informants mentioned that "*the reason some families are not willing to engage the police is the fear of social stigma."* Thus, it is essential that the medical professionals, social workers and the police work together in conjunction with the survivor, consulting her at every stage of the process. Finally, respondents mentioned that at the local level, perpetrators may threaten families but not the doctor or social worker. As such, if the survivor is not consulted before a case is lodged with the police, it may lead to life-threatening consequences.

Providing psychosocial care and support for survivors is still a difficulty

Multiple factors influence challenges in the provision of support systems that offer services for the healing and recovering from emotional, psychological and social effects of GBV.

Presently, there are **no emergency shelters or safe houses for survivors** fleeing abusive homes, meaning that there is no support to assist women and girls with shelter in the event they want to leave their abusers. In some cases, the best that survivors receive is being sent to the Home for the Elderly or resorting to the culture of staying with relatives or parents which usually does not lead

to positive outcomes for survivors. For some survivors the absence of such places where their children at least can be relocated to, often causes them to stay with their abusers.

> *"There is no practice for a survivor to stay in a safe house because there is evidence of 'good practice' of staying with family. We are claiming that women do not stay outside without ensuring such provision. However, we may need a place which is appealing, such as a* ***Women's Multi-Purpose Centre*** *which is holistic and comprehensive and includes night stay provisions along with Psychosocial support (PSS) interventions. We need to articulate messages on this as a place where women can have diverse information and services."*

In The Gambia, GBV programmes are heavily concentrated on medico-legal services due to **a lack of comprehensive PSS programmes and GBV referral pathway**s. Hence, there is no long-term intervention to reintegrate a survivor into her normal life. Further, with the **already limited number of social workers having little to no knowledge on comprehensive PSS and GBV case management services**, they are unable to efficiently render GBV case management services which require long-term case follow-up and support.

Sadly, **existing PSS programmes do not provide consistent counselling sessions** for survivors and in the absence of an integrated referral pathway, women are often left with little choices to make. Beyond this, these programmes **do not provide training, livelihood opportunities or economic interventions** for survivors for successful social reintegration and to ensure financial independence. Thus, women and girls are put back almost immediately into abusive situations. In all of this, running any type of PSS programme without sourcing appropriate feedback from survivors might cause such programmes to suffer.

Safety and Protection Systems face challenges in responding GBV

As previously established, there are existing structures to prevent and respond to cases of GBV. In the status quo, there are gender and child protection officers in every police station who help with the rescue of survivors. Furthermore, there are community structures such as village development committees, women and youth groups, women councillors, that help with response at the community level. However, while most of these community groups and committees mainly serve as service providers, with the capacity building interventions, they can help with the prevention of GBV in their communities by helping with mass disseminations and community based advocacy network strengthening against GBV.

The common pathway for lodging cases in most communities in The Gambia, begins with the sharing of the abusive incidents with parents, the elderly and the clan, after which survivors would usually go to the Alkalos and the Chiefs. Once Alkalos and Chiefs inform women councillors about an incident, the councillors come in to support the women with seeking health care, medical attention and legal redress. In The Gambia, there are three agencies that provide free legal services, namely: National Legal Aid Agency (NALA), Female Lawyers Association of The Gambia (FLAG) and Alternate Dispute Resolution Secretariat (ADRS). It is interesting to note that the

MoWCSW has an independent Women's Council with 53 elected councillors, who have key roles to protect the rights of the grassroots level women and girls.

Again, even with the structures in place, there are still real challenges with safety and protection systems. For one, survivors are faced with difficulties of accessing timely assistance from the police service when their **places of residence are far from the police stations**. In the absence of a toll-free hotline, vehicles to commute and fuel to run vehicles on, survivors are left with no assistance from the police. Even when survivors are able to access police services, there is still **a lack of gender-policing,** thus, there are no dedicated chamber rooms to provide confidential services.

Secondly, **accessing legal services in The Gambia is a challenge** for many as it is often unaffordable. Even though various organisations are providing free legal aid services, there are still challenges to encounter. For example, NALA does not have lawyers in the region outside Banjul, FLAG does not have any financial support to continue uninterrupted service provision and ADRS is not popular to people, although they are located in the regions.

Lastly, **foreigners who experience GBV are often left with no support** except for medical and legal services. Any survivor should have support irrespective of their nationality to respect the principle of human rights. This may extend to helping her to reintegrate with her family in her home country through consular missions.

3.3 REMOTE SERVICES IN COVID-19

The Ministry of Health (MoH) runs a toll-free hotline ***'1025'*** for mobile users in The Gambia to call in and report feelings of fear, anxiety and stress related to COVID-19. Paradise Foundation provides support to the MoH with operators and technical messages on COVID-19 prevention. However, it is not dedicated to GBV services. While key informants from Paradise Foundation reported benefits of running such a service, they also reported certain challenges that come with the service.

According to some key informants, the general population in The Gambia often associates the term GBV with physical domestic violence, rape and other forms of sexual abuse. As such, reporting such cases require confidentiality as survivors especially of rape are often stigmatised. Thus, they mentioned that in providing channels for reporting, these factors should be considered.

Mobile or Hotline services in The Gambia have been utilized effectively to an extent

70% of people in The Gambia have access to mobile phones, with key informants reporting an equal access by both women and men. The high patronage of social media platforms including Facebook and Twitter can give some sense of mobile penetration and internet accessibility for most Gambians. Again, the access to mobile phones makes it prudent to use Short Message Service (SMS) or Information Services System Development (ISSD) services to reach a segment of the population.

Considering the existing socio-cultural dynamics, the use of hotlines can play a big role in enhancing access to GBV information and services for women and girls as it will provide and protect the anonymity of survivors to some extent.

As systems and budgets become overwhelmed because of COVID-19, using mobile/remote services will likely enhance the provision of GBV prevention and support services including mobile referrals to designated persons, to get confidential and dignified services without wasting time. To ensure efficiency in such a system, a structured referral pathway should be established.

Online messages and providing online support through Twitter and WhatsApp by considering age, sex and other diversity, could also be used. In very remote rural areas, the radio can be used as a means of creating awareness about existing community structures and resources for survivors.

Although there are great opportunities to improve the efficiency of existing structures during the pandemic by using these described means, they do not come without certain barriers. KIs reported that **referral and follow-ups are often a serious challenge**. In some instances, there is a likelihood that when survivors are referred to health facilities from the call centre, they might encounter poor quality of services and that could prevent them from using the service again.

Also, the **expertise or knowledge of the hotline operators may not be enough** to provide the caller with all the essential information the he or she may need.

Sharing experiences from the operation of the MoH hotline, key informants said that they **hardly receive calls from women and girls** because there is generally a lack of awareness about the fact that the hotline can be used to report a number of things. Given the status quo, women and girls generally have lower access to information this is likely to be the case even with the establishment of a GBV dedicated hotline especially in the absence of a rigorous awareness creation campaign.

There is also **a lack of Standard Operating Procedures** as the hotline is a new experience in The Gambia., coupled with **a lack of technological capacity and logistics**, including service costs.

4.0 CONCLUSION AND RECOMMENDATIONS

The assessment took a look into the likelihood of an increases in GBV incidences within The Gambia during this pandemic and the institution of lockdown measures, the availability and quality of existing GBV support and services and finally the existence of mobile and remote services, including their benefits and challenges.

4.1 CONCLUSION

From the assessment, it can be deduced that even with the existing structures put in place at national and community levels to respond to and prevent the occurrence of GBV, there are structural, systemic and systematic challenges that reduce the efficiency of these systems. Especially during this pandemic, that resources, efforts and attentions have been focused on the reduction of infections and prevention of the spread of COVID-19, GBV related issues which prior to the pandemic, were not given as much attention will suffer if appropriate measures are not put in place.

Furthermore, although the accounts from key informants might not be enough to establish a nationwide increase in GBV incidences, we cannot ignore the fact it is being perpetuated and from all indications, it is evident that given the socio-economic plight of many men, women, girls and children are likely to suffer emotionally and physically from abuses inflicted on them by frustrated fathers, husbands, brothers etc. Again, this puts a strain and stress on the already fragile GBV structures that exist. Police services, medical and legal services are being stretched and survivors are not getting the help and support they need.

In some existence especially in the area of psychosocial support and services, there is simply a non-existence of structures and services. Although this is compensated by women and girls turning to their confidants to talk about their experiences, they are often left with no help to enable them recover from trauma and stress.

The assessment also took a look at the existing MoH hotline, currently providing services during the pandemic, looking at its associated challenges and benefits. It can be deduced that while providing online and mobile services has its perks, in the event of applying this innovation to the area of preventing and responding to GBV, appropriate precautions must be taken and referral pathways, which are highly important should be structured and efficiently implemented to ensure the success of hotline services for GBV.

4.2 RECOMMENDATIONS

Based on the responses from the key informants, literature review and anecdotal evidence, this report makes a number of recommendations:

Availability, accessibility and quality of GBV services

1. Each region in The Gambia should have at least one OSC with a multi-sectoral partnership with various service providers, such as doctors, GBV service providers, legal counselors and police, along with a structured referral pathway;

2. Free medical services should also include free lab tests for survivors;

3. Periodic safety audits and facility readiness assessments be put in place to develop a standard operating procedure for OSCs;

4. All hospitals be provided a minimum of 2 to 3 doctors with skills on CMR and basic Psychosocial support services, especially in facilities without OSCs and GBV service providers to ensure medical and psychosocial follow-ups.;

5. The involvement of doctors in the reporting of cases should be carried out only with the consent of the survivor with a consideration for the mental state of the person in question. If the GBV case management services are in place, that incidence will be already recorded with the service providers with a dedicated Code Number. When a survivor is ready, she can use that "code number" to file a case at the police station with willingness of the survivor, not by their relatives. Medical evidence is already with doctors, hence no scope of deprivation of her legal justice. However, respecting the choice of a survivor should encompass an overall justice to her that goes beyond the legal justice system, which can only be possible if a survivor-centered approach is in place;

6. The MoWCSW should establish a multi-sectoral GBV case management service with a dedicated GBV officer. If any case comes to the OSC, after a one-time PSS service, the social worker should refer this case to the GBV officers for further support;

7. Every region be provided at least one "Women's Multi-Purpose Center" with a comprehensive PSS and GBV case management programme. This should also include night stay provisions for cases of fleeing abusive homes. Therefore, this house should have enough space to conduct various psychosocial and recreational activities. In this COVID-19 situation, such places can be established in Banjul (due to the population size) and in the CRR (due to its central geographical location and accessibility from other regions);

8. There is a need for a rigorous service mapping to design an up-to-date multi-sectoral referral pathway;

9. Police officers should be trained on gender and child friendly policing. They should also be provided the needed logistical support to provide timely and quality services to women and girls. In addition, a dedicated chamber or room to ensure confidentiality and a standard operating procedure for this desk should be provided;

10. Community structures should be enhanced to prevent GBV and support people with mass information dissemination, including reporting on various challenges that aggravate GBV and harmful practices. These structures have a great role to enhance community surveillance systems to prevent GBV and to make GBV service referrals functional;

11. For improved reporting and monitoring of GBV situations and that of harmful practices such as child marriage and FGM, women councillors can be brought under a mechanism to inform bottom-up policies and programmes under the MoWCSW.

Mobile/hotline services

1. Establish a dedicated hotline for women and to provide information on their rights and serve availability. Information about of this designated hotline for women and girls needs to be disseminated widely;

2. PSS service providers who can be available upon calls to the hotlines, be designated for each region;

3. A standard protocol to ensure hotline and remote PSS services be established. They can be connected to the GBV case management services as well;

4. Hotline operators should maintain the highest degree of confidentiality;

5. Additionally, both operators and PSS providers need intensive training to handle cases and to ensure services. This includes but not limited to the training on incidence recording, case classification and supporting to send to the appropriate PSS providers and referral.

6. Uninterrupted logistics support is required;

7. The existing mobile SMS services are available in English and in all local language so that no one is left behind;

8. Dedicated support services through Twitter and Facebook for young people on GBV prevention, gender equality and any other information on human rights should be available. Dedicated support services through WhatsApp on GBV prevention be available for the elderly. There is a need for one dedicated responder;

9. To ensure high coverage/reach in remote rural areas, radio programmes on a regular basis along with the functioning hotline will be valuable.

APPENDICES

APPENDIX I: PROXY INDICATORS FOR GBV IN THE GAMBIA

Direct/Proxy Indicators to Understand GBV	DHS 2013		MICS 2018	
	Women	Men	Women	Men
Experience of physical violence by women 15-49 years since the age 15 years.	41%	X	X	X
Experience of physical violence by women 15-49 years at least once in their life time	5%	X	X	X
Ever-married women experiences of emotional, physical, or sexual violence from their spouse	26%	X	X	X
Ever-married women experienced physical injuries from their spouse	24%	X	X	X
Women sought help those to stop violence	38%	X	X	X
% employed in the past 12 months among ever married women and men	58.8%	96.6%	X	X
Ownership of house	25%	35%	X	X
Ownership of land	21%	29%	X	X
Women expressed the decision-making on the majority of the household issues **done by their husband**	49%		X	X
The frequency of decision-making between women and men in the family matters	X	90%	X	X
Husbands are justified to beat wife for at least one reason according to never married women and men	63%	33%	X	X
Husbands are justified to beat wife for at least 1 reason	X	X	49.9%	26%
Prevalence of FGM among women 15-49 years.	75%	X	75.7%	X
Prevalence of FGM among girls 0-14 years.	X	X	50.6%	X
Who believe that FGM should be continued	65%	X	X	X
Who collects water for household needs	X	X	85%	5.4%
Married before the age of 18 years	X	X	34.2%	X
Who had more than one sexual partners in last 12 months	X	X	18.9%	34.6%
Performed at least 1 activity in the computer in the last 3 months	**X**	**X**	6%	17.3%
Used computer once in a week during last 3 months			6.3%	17.4%
Own a Mobile Phone			74%	85%
Used Internet at least once in a week during last 3 months			36.6%	50%
Household ownership of radio			69.3%	
Household ownership of a television			52.6%	
Household ownership of a computer			18.9%	
Household access to internet			63%	

APPENDIX II: INTERVIEW GUIDE

BASIC SERVICE AVAILABILITY (Service Providers)

Thematic Area	Specific Service Availability Questions
Medical treatment and health care	Initial examination and treatment provided? Example? PEP given? Available? Is there any system of follow-up of medical care? Example? How do you ensure the mental health and wellbeing of GBV survivors? Example? How do you maintain health-related legal services? How do you manage legal documentation, evidence protection and the reports of the survivors? How do you use that?
Psychosocial care and support	How do you support healing and recovery from emotional, psychological and social effects of GBV? Example? What measures are prioritised when a survivor comes after the incidence? How do you ensure longer-term emotional and practical support for GBV survivors and their families? Is there any active system of GBV case management now? Is there any connection with the national Mental Health and Psychosocial Support (MHPSS) unit to ensure integrated services?
Safety and protection	If a GBV survivor needs immediate support to stay at night, where will you refer her to stay? Any shelter/safe home? Is there a community based protection system? How will you rescue a woman/girl, if she is tortured in lockdown? What are the risks or benefits of engaging the police or community leaders? Which one would you prefer to ensure safety between the police and community customary system? Why? Is there any system of relocation, such as care for children of the survivor?
Legal Enforcement Services	To what extent are the existing criminal investigation and prosecution systems confidential?

	How do legal officers treat survivors/perpetrators? Are there any free legal aid services for GBV cases in the Gambia? Who are they and what kind of support is given? Is there any court support, including transport fee?
Education and livelihood opportunities	Is there any system that ensures a GBV survivor receives education support? or their children? Is there any opportunity of livelihood/business support? Is there any opportunity of adult learning options available? Is there any targeted economic intervention available?
Other protection services, including durable solutions	If a survivor is not a national, how do you ensure their protection and safety from GBV?

Access to services/quality of services (perceptions):

Question
Do you think service delivery points such as police station/ medical centre/PSS providers are within reasonable distance in The Gambian context? (explain)
Do you think security at the service delivery points is enough? Or, survivors perceive to be safe and secure in those points? Is there any risk on the way to reach to the service delivery point?
Do survivors need to pay fees for any services?
Is/are there any trained personnel on GBV services? What are the components of the training on GBV?
How does the facility/organisation ensure confidentiality in delivering GBV services?
What are the attitudes of service providers towards GBV survivors?
How do people in the community perceive services for survivors of GBV?
What does the community believe about sexual purity and family honor?
Is there any family pressure not to seek services after suffering GBV/ IPV/ rape? Why?
What are the family or community repercussions for disclosing violence against women/girls?

Do administrative barriers, such as requirements to obtain documentation from the police before accessing medical treatment, lack of official identity card, etc. affect access to GBV services?
Are there services for foreign nationals or immigrants on GBV? How are these services delivered?
When we speak about GBV services what do we exactly mean? When we speak about PSS what exactly do we mean?

Research question 2:

1. In general, what kind of GBV you hear about? Probe to explain details.
2. What are the commonly used channels for reporting gender-based violence in The Gambia?
3. From who do you typically receive reports of sexual violence? *(PROBE: victims/survivors, family members, health professionals, etc.)*
4. Are the staff who manage contact or receive calls being trained to handle reports of intimate partner violence, sexual violence or other forms of gender-based violence?
5. How long did the training last and who provided it?
6. Do all survivors (domestic violence/rape) receive support in similar ways from you?
7. Are there any Protocols for the management of GBV or other protection-related calls and data in place? If so, can you please explain or provide an example.
8. Do you have both male and female operators/hotline staff available? Are persons who call able to request specifically a male or female operator to speak with?
9. If you receive a report of GBV, to what services are you able to refer? (police, health, legal, psycho-social, livelihoods, housing/shelter, other) Do you have specific contacts/focal points in those services? How frequently are the contacts updated?
10. How does your organisation ensure confidentiality for persons who call/report?
11. What are some of the achievements and challenges your organisation is experiencing, particularly in the context of maintaining services for people in need during the COVID-19 crisis?

Mobile phones

1. Does the affected population have access to mobile phones? If so, provide data on percentages of access where possible.

2. What are the gender, age and disability dynamics of mobile phone access? Do women and men use mobile phones on an equal basis? Do children, the elderly and persons with disability generally access mobile phones?
3. Who are the major mobile service providers? Are they privately or government owned?
4. Does mobile phone access usually come with internet access?

Affordability:

Are there socio-economic dynamics to phone usage? Do economically vulnerable members of the community have equal access to mobile phone usage compared to others?

Programmatic consideration:

1. Is the cost of the hotline sustainable, in particular if outsourcing, and including if the calls increase?
2. Which is the mitigation strategy to have reasonable costs - e.g. any "social partnership" possible with telecommunication companies to reduce programme cost or any advocacy to be taken with Gender and Welfare ministries?

Best practice:

Are there any documented examples of mobile phones being used to provide social or protection services?

Free Mobile SMS services:

1. Does the affected population have access to SMS services in a local language? which languages are accessible?
2. Are free mobile SMS services used currently by service providers, particularly in the Health, Nutrition, or Social /Protection sectors?

INTERNET:

1. Are there gender, age and disability dynamics of internet usage?
2. What are the most commonly used communication applications in the context by beneficiaries and service providers? For example, WhatsApp, Skype, Viber, Messenger etc. Which are the dynamics of the use of these apps by gender, age and disability?
3. Does the population and/or service providers use YouTube or other audio-visual apps to receive or provide information or services?

Social Media

1. What social media platforms are most widely used? For example, Facebook, Twitter etc.

2. What are the dynamics of the use of these forums by gender, age and disability?
3. Is social media used by Health, Protection or other sectors to provide communication material about services?
4. Are social media or specific apps used in an informal manner for peer support or any counseling services?

Radio/ Television:

1. How is radio for communication in communities? What percentage can access radio/television?
2. Do individuals have access to radios, or are radios communally held and managed asset?
3. Which are the dynamics of the use of radios by gender, age and disability?

Emergency call phones

1. Do service providers provide "emergency call" if needed next time?

Overall:

1. *Are there specific benefits or risks documented in evaluations in relation to the use of any of these technologies to communicate information about or provide GBV services?*
2. *Are hotline services currently part of GBV or other protection referral pathways or SOPs? Why or why not?*
3. *Are there any pre-existing Information, Education and Communication material that disseminate information on Emergency Hotlines or other remote GBV service provision mechanisms?*