Pandemics and Violence Against Women and Children

Amber Peterman, Alina Potts, Megan O'Donnell, Kelly Thompson, Niyati Shah, Sabine Oertelt-Prigione, and Nicoele van Gelder

Abstract

Times of economic uncertainty, civil unrest, and disaster are linked to a myriad of risk factors for increased violence against women and children (VAW/C). Pandemics are no exception. In fact, the regional or global nature and associated fear and uncertainty associated with pandemics provide an enabling environment that may exacerbate or spark diverse forms of violence. Understanding mechanisms underlying these dynamics are important for crafting policy and program responses to mitigate adverse effects. Based on existing published and grey literature, we document nine main (direct and indirect) pathways linking pandemics and VAW/C, through effects of (on): (1) economic insecurity and poverty-related stress, (2) quarantines and social isolation, (3) disaster and conflict-related unrest and instability, (4) exposure to exploitative relationships due to changing demographics, (5) reduced health service availability and access to first responders, (6) inability of women to temporarily escape abusive partners, (7) virus-specific sources of violence, (8) exposure to violence and coercion in response efforts, and (9) violence perpetrated against health care workers. We also suggest additional pathways with limited or anecdotal evidence likely to effect smaller sub-groups. Based on these mechanisms, we suggest eight policy and program responses for action by governments, civil society, international and community-based organizations. Finally, as research linking pandemics directly to diverse forms of VAW/C is scarce, we lay out a research agenda comprising three main streams, to better (1) understand the magnitude of the problem, (2) elucidate mechanisms and linkages with other social and economic factors and (3) inform intervention and response options. We hope this paper can be used by researchers, practitioners, and policymakers to help inform further evidence generation and policy action while situating VAW/C within the broader need for intersectional gender- and feminist-informed pandemic response.

Keywords: Pandemics, public health emergencies, violence against women, violence against children, intimate partner violence, COVID-19

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"We are in uncharted territories in terms of what survivors are going to experience."— Katie Ray-Jones, CEO of the US National Domestic Violence Hotline, speaking about COVID-19 (Bowerman, 2020)

1. Framing the Issue: Pandemics and Violence against Women and Children

Crises and times of unrest have been linked to increased interpersonal violence, including incidence of violence against women and children (VAW/C) (Fraser, 2020; Palermo and Peterman, 2011). Pandemics are no exception. In fact, the regional or global nature and associated fear and uncertainty of pandemics provide an enabling environment that may exacerbate or spark diverse forms of VAW/C. While rigorous studies estimating increases in reporting of VAW/C during or post-pandemic are scarce, media reports and anecdotal evidence are widespread. For example, when the Ebola outbreak hit West Africa, an "epidemic" of "rape, sexual assault and violence against women and girls" was reported to have been largely undocumented as collateral damage (Yasmin, 2016). In the current novel coronavirus outbreak (COVID-19), as of mid-March 2020, there are already reports from Australia, Brazil, China and the United States suggesting an increase in VAW/C. In China's Jianli County (central Hubei province), the police station reported receiving 162 reports of intimate partner violence (IPV) in February—which was three times the number reported in February 2019 (Wanqing, 2020). According to Wan Fei, the founder of an IPV non-profit, "90 percent of the[se] cases of violence are related to the COVID-19 epidemic." In the United States, the National Domestic Violence hotline issued a statement in early March 2020 on "Staying Safe" during COVID-19, including anecdotal evidence of how perpetrators were using the virus as a scare tactic to threaten or isolate victims, and urging those at risk to make a safety plan, practice self-care and reach out for help (National Domestic Violence Hotline, 2020). In Australia, a survey of 400 frontline workers indicated that 40 percent reported an increase in "pleas for help" and 70 percent indicated an increase in complexity of cases (Lattouf, 2020).[1]

While all pandemics are unique in their level of transmission and breadth of impact, the severity and recent policy attention to the COVID-19 pandemic, which has affected nearly every country globally, offers an opportunity to revisit the literature linking pandemics to VAW/C. While VAW/C comprises a wide range of distinct violence typologies, for the purpose of this paper, we focus primarily on interpersonal violence, including IPV, sexual violence and exploitation (including violence experienced by adolescent girls), and violence against children (including violent discipline, abuse and maltreatment).[2] Though evidence directly

[1] The survey was reportedly conducted by Women's Safety New South Wales, however note that New South Wales Police and Bureau of Crime Statistics noted "it's too early to have statistical evidence of any shifts in arrest or police call outs."

[2] The main categories we focus on in this review are: IPV, including economic, emotional, physical or sexual violence between married, cohabiting or dating partners; Sexual violence and exploitation, including coerced or forced sex or sexual acts, rape or transactional sex (while recognizing that the latter can have multiple interpretations); Violence against children, including psychological or physical violent discipline or other forms of child abuse and maltreatment. For IPV and adolescent sexual violence, we primarily characterize this as male perpetrated towards a female victim, however we acknowledge that men and boys can be victims. We also acknowledge the wider range of VAW/C experiences vulnerable populations may experience, including but not limited to child marriage, child labor and harassment or public violence, increased criminal activity and hate crimes with related drivers to those we discuss here. These are all important to address during crises, however fall outside the scope of this specific review. Finally, reviewed articles often define and measure violence in different ways, and we aim to make our discussion consistent with original research, whenever possible. We acknowledge that by nature of a review article covering many types of violence, we will be unable to explore all the cross-cutting perspectives and specific risk factors justified for each type of violence.

examining these linkages is scarce, a broader body of related literature can, in the short term, provide an evidence-informed understanding of mechanisms linking pandemics to VAW/C.[3] In this rapid review, we draw on learning from infectious disease epidemics that rose to become regional crises (Ebola, Zika), as well as those designated global pandemics (HIV/AIDS, H1N1), to draw from available learning around large-scale outbreaks and VAW/C in various contexts. An understanding of these mechanisms can inform policy and program responses to mitigate against increases in violence as part of pandemic preparedness, as well as during and in the aftermath of the pandemic. Finally, in reviewing the literature, we identify research gaps and opportunities in both understanding the issue, as well as crafting successful responses. Laying out these research gaps during early stages of a pandemic is useful, as it may elucidate opportunities to fill them within ongoing studies or with quick investments in new, targeted research.

Why focus on VAW/C, rather than general crime or conflict during a pandemic? Several reasons. First, VAW/C is widespread across the globe, and thus there is almost certain likelihood of pandemics interacting with vulnerable populations affected by VAW/C.[4] The best available evidence suggests that globally, one in three women of reproductive age have experienced physical and/or sexual IPV in their lifetime, and more than a third of female homicides are committed by an intimate partner (Devries et al., 2013a; Stockl et al., 2013). VAC is also widespread globally with half of children aged two to 17—the equivalent of one billion children—experiencing past-year emotional, physical or sexual violence from a range of perpetrators (Devries et al., 2018; Hillis et al., 2016). Second, VAW/C is underreported to police and authorities due to shame, stigma, and fear of repercussions, among other reasons. One result of this underreporting is that we have a limited understanding of how VAW/C responds to pandemics—in contrast to other types of violence and criminal activity where data is more readily available (Palermo et al., 2014; Pereira et al., 2020; Palermo and Peterman, 2011). Shining a light on these gaps in knowledge is a first step in obtaining better information and evidence. In addition, VAW/C can have particularly severe adverse consequences, with wide-ranging psychological, economic and physical effects for women and children over their lifetimes. Finally, although specific definitions of what constitutes VAW/C varies, there is broad consensus that unequal gender relations and patriarchal norms are important causes, and these have potential to further magnify and modify risk and protective factors during times of crises (Heise and Kotsadam, 2015; Gibbs et al., 2020). These considerations motivate an in-depth investigation into both linkages and potential policy responses.

While the global pandemic of VAW/C is silent, pandemics due to novel diseases are garnering more attention. For the purposes of this review, we are defining a pandemic as "an epidemic occurring over a very wide area, crossing international boundaries, and usually affecting a large number of people (Porta 2014)." Pandemics are identified by their geographic scale and reach (and when most people do not have immunity), rather than the severity of illness (WHO, 2010). Over the last 50 years, different parts of the world have seen at least 10 different disease outbreaks, from Marburg in 1967 to Ebola in 1976 to Middle East Respiratory

[3] In addition, a rapid systematic search of estimates of pandemics and global health emergencies in the last 40 years and their quantitative impacts on VAW/C is underway (protocol available here). This review will be added to a revised version of this manuscript. Initial findings from five disease outbreaks and over 1500 screened articles yielded only four qualifying studies of mixed and methodologically weak results.

[4] Earlier this year, the Lancet Commission called gender-based violence and child maltreatment a "pandemic", noting, "Few if any health conditions or risk factors affect such large segments of the global population, and people living in poverty and vulnerable situations, including forced migration and humanitarian emergencies, are especially at risk" (Knaul et al. 2020).

Syndrome (MERS) in 2012, with some, such as Ebola resurfacing multiple times (Ross, Crowe and Tyndall, 2015).[5] Nearly 75 percent of emerging diseases, including those driving most pandemics, originate in animals and are transmitted to humans (referred to as zoonotic diseases) (Jones et al., 2008). Given the increasing rate of growth and interconnectedness of the global population and the resulting consumption and infringement on the environment, experts predict that zoonotic diseases and outbreaks will continue to surface. The dynamics of pandemic outbreaks require effective engagement, coordination and cooperation among a wide range of sectors and actors, including not only public health agencies focused on human and animal health, but also, critically, social and environmental sciences. For example, "One Health" is an interdisciplinary collaborative effort led by the United States Center for Disease Control (CDC) with the goal of optimal health for people, animals, and environment (PREDICT Consortium, 2016).[6] There have been some efforts to integrate gender, violence and risk analyses into the One Health approach, however lack of global coordination and implementation (to name a few) has resulted in uneven uptake.[7] Strategies and policy guidelines developed by large global institutions have only minimally included short- and long-term effects of pandemic outbreaks and how they may impact women and men differently (Harman, 2016). This gap is particularly apparent when examining issues of VAW/C, both in and outside of the home. Lessons learned from previous epidemics have clearly illustrated the need to have a gender responsive, inclusive, and intersectional approach.

Based on existing published and grey literature, we document nine (direct and indirect) pathways linking pandemics and VAW/C, through effects of (on): (1) *economic insecurity and poverty-related stress,* (2) *quarantines and social isolation*, (3) *disaster and conflict-related unrest and instability*, (4) *exposure to exploitative relationships due to changing demographics*, (5) *reduced health service availability and access to first responders*, (6) *inability of women to temporarily escape abusive partners*, (7) *virus-specific sources of violence*, (8) *exposure to violence and coercion in response efforts*, and (9) *violence perpetrated against health care workers*. In addition, we explore several other potential pathways which are likely to affect smaller groups of the population or are supported by anecdotal information. In providing a holistic view of potential mechanisms and dynamics, we aim to shine light on mechanisms and factors which may be more prevalent in resource-poor settings, areas with non-independent media or where advocacy and civil society is restricted. In addition, while we aim to draw distinctions between mechanisms in each pathway, we acknowledge that many are interlinked and interact. We propose eight policy and program responses which can be tailored to national and local settings to address some of these factors and mitigate against increases in VAW/C pre-, mid-, and post-pandemic. Finally, we propose three groups of priority research questions to guide a research agenda going forward linking diverse pandemics to VAW/C: (1) *understand the magnitude of the problem*, (2) *elucidate mechanisms and linkages with other social and economic factors,* and (3) *inform intervention and response*

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[5] There are a several distinct types of pandemic threats. The most severe viruses can spread globally quickly, including the influenza viruses due to their transmission potential from human to human and the challenge of being able to effectively and quickly detect symptomatic characteristics. Another group of viruses such as H5N1 are less severe because they are not as easily spread human to human, but they have the potential to adapt and mutate. A final group of viruses such as Ebola has a lower risk of global transmission, due to higher detection and containment potential, but can potentially spread regionally and internationally (Madhav et al. 2017).

[6] One Health takes a collaborative, multisectoral, and transdisciplinary approach—working at the local, regional, national, and global levels—with the goal of achieving optimal health outcomes recognizing the interconnection between people, animals, plants, and their shared environment. While the approach is not new, it has gained importance in recent years given numerous global outbreaks of varying lengths and degrees.

[7] See USAID Gender One Health training materials and resources (accessed March 10, 2020).

options. We hope this paper can be used both by researchers, practitioners and policymakers to help inform further evidence generation and policy action while situating VAW/C within the broader need for intersectoral gender and feminist informed pandemic response (Wenham, Smith, and Morgan, 2020).

2. What Does the Evidence Say?

Drawing on a rapid review of both quantitative and qualitative literature linking pandemics to VAW/C, and the broader literature, we propose nine main possible mechanisms through which increases (decreases) may occur. We order these roughly in order of importance, based on the estimated percentage of population which may be affected by each pathway.[8] For each mechanism, we detail, where available the potential magnitude of increase (decrease) and context specific factors which may play a role—focusing on both differences between high-income country (HIC) settings versus low- and middle-income country (LMIC) settings—as well as underlying gender norms or existing levels of VAW/C. In several cases, a large body of rigorous peer-reviewed literature does not exist, however, where possible, we also indicate evidence of anecdotal reports, which may lead to hypothesis building for future research efforts. We acknowledge that other possible pathways exist, particularly linked to smaller sub-groups or to broader forms of gender-based violence that we have not captured here. Finally, while we focus primarily on the pathway between pandemics and VAW/C, we acknowledge these relationships may often be reciprocal and survivors of violence are in many cases at higher risk for infection, co-morbidities or long-term consequences of pandemics. Finally, we acknowledge that we are not the only ones who have highlighted this link, and we draw lessons from contemporary rapid summaries and briefing notes as a starting point for this review (Fraser, 2020; Yaker and Erskine, 2020).

2.1 Economic Insecurity and Poverty-Related Stress

A large body of global literature links economic insecurity to multiple types of VAW/C. While much of this evidence is correlational, it suggests that economically insecure populations tend to live in locations with weaker access to health and legal services—they are also more likely to live in economically depressed areas—often with higher rates of crime (Haugen and Boutros, 2015). On a household and individual level, economic insecurity has been linked to poor coping strategies, including substance abuse, taking on debt, transactional sex and other risky behaviors, which are in turn linked to various types of VAW/C (Doyle and Aizer, 2018; Renzetti, 2009). Economic insecurity and negative coping strategies also result in acute and chronic stress, which is a trigger for conflict, arguments and IPV. For these reasons, both the WHO's recent guidance on preventing violence against children (INSPIRE) and violence against women and girls (RESPECT) include economic strengthening programs as promising intervention typologies (WHO, 2016a; 2019a).

Causal estimates linking economic programming to VAW/C generally reinforce these pathways, particularly the social protection and social safety net literature. For example, there is a robust body of causal literature linking cash transfers as a form of economic strengthening to reductions in IPV in LMICs, and longitudinal evidence linking economic insecurity to increases in child maltreatment (primarily in HICs). Buller and

[8] This is a very rough estimation, based on the current COVID-19 pandemic, and thus not necessarily applicable to all pandemics with different characteristics. In addition, there is heterogeneity in the proportion of the population likely affected in different settings –in particular in HIC versus LMICs.

colleagues (2018) review quantitative and qualitative literature from rigorous evaluations of cash transfer programs and find that out of 22 studies, the majority (73 percent) find reductions in IPV, and that these effects are larger for physical and/or sexual IPV.[9] While program design is diverse, the majority of programs are poverty-targeted safety nets, operationalized through small monthly or bi-monthly direct cash support given to women, representing 6 to 50 percent of pre-program household expenditures. Where reductions in IPV are observed, they are meaningful in magnitude, ranging from 11 to 66 percent. Analysis of pathways and a large body of supporting evidence confirms that increases in economic security and reductions in poverty-related stress and conflict are key mechanisms for impacts within cash transfer programming (Bastagli et al., 2016; Hidrobo et al., 2018). Research from sociology on *family stress models* confirms this as an important pathway linking economic stress to intra-familial violence (Fox et al., 2002; Renzetti, 2009).

> *"There had been many fights. Because children needed many things that we could not have afforded. I asked my husband and he used to say there is no money. Then I used to get upset and started to yell. We had many fights because of poverty. Not only for us, for all poor, fights come from suffering."* — Female beneficiary of cash transfer program (Turkey; Yildirim et al., 2014)

However, a similar review of the impact of social safety nets in LMICs on violence against children shows less-promising results. Peterman and colleagues (2017a) find that only one in five impacts (out of 57) analyzed over 11 studies from LMIC show significant reductions in violence against children indicators, however evidence is limited by inconsistent and weak measurement of violence outcomes. Overall, results indicate protective impacts for adolescent females are the most promising, with 44 percent of all outcome indicators significant at conventional levels (including transactional sex and age-disparate sex, largely from studies in sub-Saharan Africa).[10] From HICs, a quasi-experimental evaluation of the US supplemental nutrition assistance program (SNAP) found that shifting benefits from first-of-the-month to later distribution in the month led both to increases in IPV by 6.9 percent and child maltreatment by 30 percent (Carr and Packham, 2019). Taken together, this evidence suggests that increasing economic security via social safety nets

[9] In two studies, there were mixed results – meaning both increases and decreases in different forms of IPV within the same population. Several studies also have shown heterogeneous impacts, whereby sub-groups of women showed increases in emotional or psychological IPV as a result of the program. These dynamics point to the importance of continual monitoring and commitment to the 'do no harm approach' and designing gender-sensitive programs. Finally, these same promising impacts have not been observed within cash programming in the humanitarian sector—which may be in part due to lack of rigorous studies evidencing this link (Buller et al. 2018).

[10] While transactional and age-disparate sex may have multiple interpretations, in this case, as samples included children < 18 years, Peterman et al. (2017a) classify them as sexual exploitation, particularly when age differences are large (10 years or more). More recent publications from experimental studies in Bangladesh and Mali show that cash transfers reduced violent discipline for children (Heath, Hidrobo and Roy, 2019; Roy et al. 2019). In Mali, Heath and colleagues (2019) show that a government quarterly cash transfer program given to household heads (primarily men) over two years reduced prevalence of physical punishment (by 6.6 pp) and number of psychological and physical acts reported (by 0.33 acts)—and these effects were larger (up to 16.7 pp reductions) in polygamous households. In Bangladesh, Roy and colleagues (2019) found that a transfer (food or cash) plus intensive nutrition behavior change communication program reduced past-week harsh physical punishment (by 12 pp) and likelihood of hitting back when child hits parent (by 8 pp), approximately 6 to 10 months after the program ended. However, these promising post-intervention effects were not observed in the study arms which received food or cash alone, suggesting impacts were realized via mechanisms unique to the nutrition training component (including the increased social standing and social empowerment impacts of group nutrition trainings) or via an interaction between the two.

(including cash and complementary services), particularly for poor households can reduce VAW/C at meaningful levels.

The broader literature linking economic insecurity to VAW/C is more complex, however it also demonstrates important relationships. One body of literature examines the linkages between IPV and unemployment among women and men. Using quasi-experimental techniques, Schneider and colleagues (2016) show that unemployment at the household level during the Great Recession in the United States was positively related to abusive behaviors (increases of 3 pp), even after accounting for unemployment and economic distress, potentially due to anticipatory anxiety. On a global level, Bhalotra and colleagues (2019) examine differences in male and female unemployment using cross-country data from 31 countries. They find that a 1 percent increase in male unemployment is associated with a 0.50 percentage point (pp) (2.5 percent) increase in physical IPV for women. In contrast, increases in female unemployment are associated with decreases in IPV by similar magnitudes (0.52 pp or 2.75 percent).[11] Why are the effects of unemployment different by sex? One hypothesis is that male unemployment triggers *male backlash* due to feelings of inadequacy and emasculation as they feel failure in their ability to fulfill a traditional male breadwinner role (Schneider et al. 2016).[12] As this hypothesis hinges on expression of gender norms across settings, this relationship may not be universal. For example, Anderberg and colleagues (2016) found the opposite relationship during the recession in the United Kingdom—an increase in male unemployment decreased IPV—as female's relative economic position increased, while an increase in female unemployment increased IPV. Unsurprisingly, heterogeneity in findings points to the complexity of dynamics which are closely tied to local gender social norms and cultural contexts of power dynamics.[13]

> *"An inability to meet social expectations of successful manhood can trigger a crisis of male identity. Violence against women is a means of resolving this crisis because it allows expression of power that is otherwise denied."* —Jewkes (2002).

A broader literature linking diverse types of women's empowerment (rather than disempowerment as within the unemployment literature), including employment, income generation or livelihoods trainings, microfinance and savings on VAW/C produces mixed results—partially due to the relatively scarce literature from studies able to identify causal impacts of economic components (Tankard and Iyengar, 2018; MacGregor et al., 2019; Peterman, Palermo and Ferrari, 2018). However, some literature from HICs suggests protective effects of women's employment and earnings, while literature from LMICs is less conclusive

[11] In addition, the study finds that pooled unemployment rates (male plus female) has no significant association with IPV rates.
[12] In addition, research suggests that long-term unemployment can have significant negative emotional tolls on both men and women, which may reinforce or exacerbate marital conflict (Basbug and Sharone 2017). In turn, poor mental health and mental disorders are linked to VAW/C (Devries et al. 2013b; Oram et al. 2014). More generally, literature has also established a mutually reinforcing relationship between poverty and common mental disorders in LMICs (Lund et al. 2010). See section 2.2 on quarantines for further details.
[13] Another poignant example of variation based on social norms comes from Spain, where using quasi-experimental methods, Tur-Prats (2019) finds that the relationship between unemployment and IPV depends on family structure shaped by past cultural norms. More specifically, in settings with traditionally nuclear families (single couples) a decrease in female unemployment relative to male unemployment increases IPV. The opposite effects are found in settings with traditionally stem families (larger extended families where domestic work is shared across generations).

(Aizer, 2010; Chin, 2012; Kotsadam and Villanger, 2020; Munyo and Rossi, 2015).[14] Finally, a recent systematic review of temporal linkages between economic insecurity and child maltreatment found that economically insecure children experience three to nine times more maltreatment as compared to their economically secure counterparts (Conrad-Hiebner and Byram, 2020). Among 26 longitudinal studies, primarily from HICs, the most salient relationships were found with income loss, cumulative material hardship and housing hardship.

While the depth and severity of the COVID-19 pandemic is still uncertain, it is clear that households in affected areas will feel some economic shock—with the largest effects among the population of already economically vulnerable. These shocks could be large, for example households may face increased unemployment (or the reduced ability to work due to location or nature of economic activities) and/or reduced level of earned income. In addition, women in particular may be disproportionately affected by additional unpaid care (caretaking and caregiving) work, which may further decrease ability to undertake paid work (Wenham, Smith and Morgan, 2020).[15] The aggregate economic impact of pandemics can be huge. For example, economic costs of the 2014 Ebola outbreak in West Africa have been estimated to range from $2.8 to 32.6 billion in lost gross domestic product (GDP) (Huber, Finelli and Stevens, 2018). While the full range of economic impacts from COVID-19 is unknown, in mid-March 2020, the US Treasury Secretary warned Congress that unemployment rates could reach levels of 20 percent if the government did not intervene.[16] Even without direct shocks to earning levels, pandemics may incite temporary food insecurity and increased stress due to uncertainty about future economic security or general wellbeing. A broad body of evidence suggests that even in HICs, and especially in LMICs, these points of economic insecurity can lead to large increases in likely both the incidence and frequency of IPV and violence against children. Further, economic shifts may result in changes in economic power between partners—with predictions of both increases and decreases in IPV when women gain additional economic power, depending on the underlying gender norms and men's reaction (accepting or resisting) to shifts in power.

2.2 Quarantines and Social Isolation

Pandemics and health emergencies, including SARS, Swine Flu, and influenza, have been associated with problematic coping behaviors, anxiety, suicide attempts and mental health disorders, including post-traumatic stress and depressive disorders, with quarantines, social isolation and limitations on freedom as possible contributing factors (Brand et al., 2013; Lau et al., 2005; Mak et al., 2009; Reissman et al., 2006; Yeung and Fung, 2007). For example, in a population-based telephone survey in Hong Kong conducted in June 2003 and January 2004 investigating the social responses to SARS, 16 percent of respondents showed signs of

[14] For example, Aizer (2010) uses variation in local demand for male versus female labor in California and finds that relative increases in female as compared to male wage rate is linked to decreases in IPV. Chin (2012) uses plausibly exogenous variation in women's working status using rainfall and rice to wheat prices, finding female employment significantly reduces IPV. Kotsadam and Villanger (2020) use experimental allocation of jobs to women in Ethiopian factors and find limited impacts on IPV, despite increases in earnings and earning shares for women. Munyo and Rossi (2015) use fluctuations in the real exchange rate for traditionally male versus female industries in Uruguay and find that increases in the male to female wage gap leads to increases in IPV. Most of this literature focuses on impacts related to IPV, rather than discussing or examining trade offs with workplace violence, including sexual harassment and exploitation, which may be important trade-offs to consider during pandemics (MacGregor et al. 2019).

[15] A recent article in the New York Times estimates that women's unpaid labor is worth about $10.9 trillion globally and while the figures are massive, they are not officially counted in GDP calculations (accessed March 25, 2020).

[16] Mnuchin warns senators of 20% US unemployment without coronavirus rescue, source says (CNBC, accessed March 18, 2020).

post-traumatic symptoms and high percentages reporting feeling horrified, helpless and apprehensive (Lau et al., 2005). Quarantines can be particularly challenging for parenting, with existing vulnerabilities and abuse magnified for children due to a confluence of school closures, stress, fear and uncertainty (Cluver et al., 2020). Although quarantines are typically implemented in the short-run, adverse effects on mental health may persist for years post-pandemic. These include but are not limited to mental health issues (e.g., PTSD, depression, anxiety, suicidality); sleep difficulties; substance abuse; and emotional and behavioral problems in children (Brooks et al., 2020). In turn, poor mental health, mental disorders and related factors, including alcohol abuse, have been shown to increase risk of VAW/C, with hypothesized effects both during and after times of quarantine (Devries et al., 2013b; Oram et al., 2014; Capaldi et al., 2012; Okeke-Ihejirika et al., 2018).

Quarantines also risk increasing VAW/C through increasing women and children's day-to-day exposure to potential perpetrators. Recent evidence suggests that when men migrate away from home, rates of IPV decrease due to exposure reduction. In Bangladesh, when men in ultra-poor households were offered interest-free loans to facilitate migration, seasonal male migration reduced female exposure to physical and/or sexual IPV over a six-month period by 3.5 percent (Mobarak and Ramos, 2019). Evidence focused on other crisis settings, including refugee camps and humanitarian assistance zones, confirms that when family members are in close proximity under conditions of duress for extended periods of time, rates of VAW/C increase (Wako et al., 2015; Falb et al., 2013; Horn, 2010). In many senses, forced quarantines and social isolation measures are analogous to settings where forcibly displaced persons are relocated (e.g. camps or temporary centers), increasing exposure to perpetrators, living in containment with decreased freedom and privacy, under circumstances of physical and psychological stress. Further, quarantine measures and other restrictions on movement may lead to greater food insecurity, linking to pathways of risk via economic insecurity (section 2.1) and exploitative relationships (section 2.4).

Controlling behaviors and further acts of violence may also be coping mechanisms for perpetrators who feel a loss of control due to quarantine. Isolation is an established abuse tactic for IPV even outside of pandemic contexts. Numerous forms of isolation as a control tactic have been documented, including *social isolation* (e.g. from family and friends), *functional isolation* (e.g. when peers or support systems appear to exist, but are unreliable or have alliances with the perpetrator), *physical or geographical isolation* (e.g. no means for talking or communicating with others, living remotely), as well as victim surveillance and regulation of daily activities (e.g. sleeping, showering) (Hagan, Raghavan, and Doychak, 2019; Campbell, 2017; Harris and Woodlock, 2019; Stark, 2007). Quarantine may increase both existing controlling behaviors by perpetrators as they struggle to regain a sense of control, including practices of social and other forms of isolation.

2.3 Disaster and Conflict-Related Unrest and Instability

Increases in VAW/C, have been found in the wake of natural disasters, including earthquakes, cyclones, hurricanes, wildfires and volcanic eruptions (Anastario, 2009; Bermudez et al., 2019; Castañeda Camey et al., 2020; IRC and GWI, 2015; Schwefer, 2018). For example, a study exploring effects of the 2010 Haiti earthquake found that two years after, women who lived in areas with higher earthquake devastation had higher levels of physical and sexual IPV, citing probable economic and social factors (Weitzman and Behrman, 2016). While needed attention has been paid to sexual violence in conflict and other humanitarian emergencies (Vu et al., 2014), other forms of VAW/C, including IPV in both conflict and disaster settings is

also pervasive and often found at higher rates (GWI and IRC, 2016; IRC, 2015a; Stark and Ager, 2011).[17] Infectious disease outbreaks are also linked to increased VAW/C, largely perpetrated by men (Fraser, 2020; IRC, 2019; UNDP, 2015, UNICEF 2018). While 'sudden onset' disasters and humanitarian settings fundamentally differ from pandemics and disease outbreaks, lessons from the former can prove instructive to understand dynamics and mitigation solutions for pandemics in some contexts (O'Sullivan and Bourgoin, 2010).

First, pandemics may result in the breakdown of societal infrastructure, similar to experiences in conflict and disaster-affected settings, as functional health, transport, food, sanitation, legal, security and other governance structures may temporarily contract or become dysfunctional (Briody et al., 2018). This may lead to increased exposure of women and children to unsafe and risky settings, including exposure to sexual violence and harassment during procurement of basic goods, including food, firewood, and water (Castañeda Camey et al., 2020; Bermudez et al. 2019; De Oliveiro et al., 2019; First et al., 2017; WRC, 2009). Lack of access for paid workers in some areas due to insecurity or bureaucratic constraints may further "displace" risk onto local staff and women in both formal and informal support roles. A study of remote management strategies in northwest Syria notes, "*Networks were also mobilised inside the country to channel medical supplies across military obstacles, e.g. through doctors sometimes relying on women from their family, as they were less likely to be searched at checkpoints* (Duclos et al., 2019)." Finally, breakdown of generalized services means that some forms of routine detection and referrals for VAW/C will be lost. For example, potential child abuse and maltreatment are often identified via the educational system, which may no longer be functioning or be operating at greatly reduced capacity.

Second, where mobility is restricted or where populations are forced to relocate, family separation may occur. Research from humanitarian settings demonstrates that family separation is particularly impactful for women and children, who are often economically dependent on others for basic survival needs (IRC and GWI, 2015; IRC, 2015a) and may already be living separated from their families and communities (including unaccompanied and separated children). Migration policies and border closures in Europe, North America, and elsewhere, may also put women and girls seeking asylum at further risk of violence and exploitation while also making it much more difficult for them to access services (Potts, 2018). Third, rapid changes in gender norms may contribute to increased forced and/or child marriage in crisis settings, which is linked directly to IPV, including marital rape (IRC, 2015a). In a global pandemic that threatens existing informal and formal support structures, forced/child marriage may be further exacerbated in crisis settings, as has been the case within the cholera response in Syria and Yemen (UNICEF, 2018). Other factors, including survival needs, may lead to increases in exploitation, and protection risks of adolescent girls, including risk of sexual violence (these dynamics are further discussed in section 2.4; McAlpine et al., 2016).

In their *Global Humanitarian Overview 2020* (released in 2019), the UN Office for the Coordination of Humanitarian Affairs (OCHA) estimates 167.6 million people will require humanitarian aid and protection in 2020, and noted that outbreaks of cholera and Ebola already exacerbate some of the "worst humanitarian crises in the world" in Yemen and DR Congo, respectively; with cholera, measles, dengue, malaria, HIV/AIDS, and other viral hemorrhagic diseases like Ebola posing risks in fragile settings. "Infectious

[17] For example, a population-based survey in three conflict-affected sites in South Sudan found 54 to 75 percent of ever-partnered women and girls had experienced IPV, in comparison to 28 to 33 percent experiencing non-partner sexual violence (GWI and IRC, 2017). Thus, even in insecure environments, "home" may not be a safe place for crisis-affected women and children.

disease events" may occur in areas already experiencing humanitarian crises, or may be designated an emergency in and of themselves (IASC, 2016). Plainly put, COVID-19 arriving to these contexts is expected to be devastating (Lemmon, 2020). For example, while the underlying cause of VAW/C in emergencies continues to be underlying gender inequality (IRC, 2015a), all nine of the pathways noted in this paper also magnify existing levels of VAW/C in humanitarian settings, including pathways exacerbated by already fragile mental health and post-traumatic stress. The contexts within which they do this are even more resource-constrained, and the legal status of those affected—refugees, asylum seekers, or "irregular migrants"—more precarious.

2.4 Exposure to Exploitative Relationships due to Changing Demographics

Increased mortality, morbidity, and fertility rates driven by pandemics have implications for the risks of VAW/C within extended family networks, as well as exploitative relationships for women and girls, especially those facing economic vulnerability (GBD 2017 Influenza Collaborators, 2019; Chin and Wilson, 2017). This dynamic has been documented in the HIV/AIDS pandemic, where an estimated 32 million people have died from AIDS-related illnesses, and an estimated 17 million children have lost one or both parents (90 percent of these children are located in sub-Saharan Africa) (UNAIDS, 2018; UNICEF, 2006; Foster and Williamson, 2000). At a smaller but nonetheless traumatic scale for those impacted, the outbreak of Ebola resulted in about 11,000 deaths (WHO, 2020) across Guinea, Liberia, and Sierra Leone, with deaths concentrated among working-age adults (Evans and Popova, 2015a). Nearly 10,000 children lost one or both parents, meaning 0.11 percent of children were left orphans in Guinea, Sierra Leone, and Liberia due to Ebola.[18]

Deaths and morbidity among working age parents have implications for care of young children. Increased mortality and morbidity rates change dependency ratios, often placing strains on extended family networks supporting children whose parents and caregivers have died (UNICEF, 2006). Extended family networks, often the only source of support for orphans in countries with limited state capacity, may already be sick and/or economically vulnerable, and at the same time they need to absorb additional children who have lost their parents or primary caretakers.[19] These factors impose increased barriers to children's consistent access to sufficient and healthy food, medical care, and schooling, and they may subject children to new and/or heightened forms of VAC within their new households. For example, some reports have suggested orphans whose parents died of Ebola have been stigmatized, received underinvestment in their basic needs, or been increasingly subjected to child labor or domestic work (Ferguson, 2019; Evans and Popova, 2015b). Qualitative studies of orphans' integration experiences in Lesotho and Malawi in the face of the HIV/AIDS epidemic have revealed that children have been ill-treated by new guardians (Ansell and Young, 2004). A review of qualitative studies across sub-Saharan Africa of orphaned children living with extended family members found patterns of intra-household discrimination, material and educational neglect, excessive child labor, exploitation by family members and psychological, sexual and physical abuse (Morantz et al., 2013).

Pandemics are also proven to drive increased fertility rates among affected populations (including early transitions to sexual behavior). Governments have historically closed schools to slow the spread of disease in the face of pandemics. For example, response to Ebola, schools closed for six to eight months across Guinea,

[18] Notably, this population is a small fraction (1.4 percent) of the overall orphan population (702,000 across the three countries).
[19] For example, In the wake of Ebola, orphans whose parents had died of the disease were taken in by extended family networks, and the quality of care provided to each child in resource-scarce environments was predicted to decline (Evans and Popova, 2015b).

Liberia, and Sierra Leone, affecting an estimated five million children (World Bank, 2015). With the outbreak of the H1N1 flu epidemic, schools closed across a range of countries, including the United States, France, China, Thailand, and Serbia (Cauchemez et al., 2014). Even short-term school closures can impact children's long-term opportunities and create demographic shifts at the margin. For example, in many settings, women and girls living in poverty encounter pressures to engage in intercourse with sexual partners who can provide financial or in-kind support, ranging from transportation to food and clothing, in exchange (Robinson and Yeh, 2011; Gausman et al., 2019). During the Ebola outbreak, adolescent pregnancies in some parts of Sierra Leone increased by 65 percent, with reports of over 18,000 girls becoming pregnant during the epidemic (Onyango et al., 2019; UNDP, 2015; UNFPA, 2015). In Sierra Leone, absent intervention to ensure out-of-school girls spent time engaged in productive activities with other girls within their age group, girls' time spent with older men increased significantly, pregnancies outside of marriage rose, and girls experienced a 16 percent decrease in school enrollment once schools reopened (Bandiera et al., 2018).[20] In the longer-term, early marriage and adolescent pregnancy are associated with increased threats of violence, both during pregnancy and over the lifetime (Kidman, 2016; Taillieu and Brownridge, 2010). Taken together, while increases in risk due to demographic shifts in mortality and fertility (transitions to sexual behavior) are often overlooked in HICs, underlying vulnerabilities, particularly in LMICs, make this an important area of mitigation particularly for young children and adolescent girls.

2.5 Reduced Health Service Availability and Access to First Responders

Health providers and emergency first responders are often the first point of contact for women experiencing violence, as well as sources of short-term physical protection for women experiencing a severe violent episode. While evidence is still debated, current guidance suggests that in non-emergency settings, the most appropriate way to screen for VAW/C in health care settings it to train healthcare workers to identify women and children who may be experiencing violence to conduct further screening (rather than screening all individuals) (O'Doherty et al., 2015; WHO, 2019c). However, even in non-emergency settings, health care providers have noted a number of barriers to effectively screening, including lack of time, knowledge and discomfort in discussing sensitive issues, among others (Salber and McCaw, 2000; Sprague et al., 2012). Despite these challenges, health systems are often the first point of contact for seeking help—health care providers are seen as trusted sources of help and information—and there is a growing body of evidence demonstrating effectiveness of health service interventions for VAW/C (Garcia-Moreno et al., 2015; Spangaro, 2017).

An obvious outcome of any pandemic is an increased burden on health services and first responders. While the increased stress on the health sector will vary substantially based on the nature of the pandemic, during the Ebola outbreak in 2014, it is estimated that 500 health workers died (an estimated 1.45 percent of the workforce in Guinea, 6.85 percent in Sierra Leone and 8.7 percent in Liberia), many health facilities were forced to close due to diversion of resources to fight the pandemic (Huber, Finelli and Stevens, 2018). In a systematic review of economic costs due to the Ebola outbreak, the largest component, $18.8 billion, was due

[20] Not all children who wish to return to school are able to return. As schools reopened in Sierra Leone after the Ebola epidemic, the Government instituted a ban on pregnant girls returning to school. (EqualityNow n.d.). Estimates for the number of girls affected by the ban range from 3,000 to 10,000 girls (EqualityNow n.d.). The ban in Sierra Leone has since been overturned, but other similar ones remain, including in Tanzania where President Magufuli refuses to abolish the ban in spite of local and global civil society pressure.

to non-Ebola mortality (ibid), likely in part driven by fewer health workers, leading to increase maternal and infant mortality (Evans, Goldstein, and Popova, 2015). During the SARS outbreak in Toronto, restrictions on non-urgent hospital services were put into place on March 2003, leading to a major reduction in elective procedures, but also in a reduction in non-SARS emergency visits and other high acuity emergency visits (Schull et al., 2007). The contraction of routine health services means barriers to screening and service provision for VAW/C will be amplified, including reduced supply of essential services for victims of violence, such as emergency contraception, post-exposure prophylaxis and psychosocial support. Referral pathways may change during a pandemic or post-emergency, and there can be a failure of complementary health and legal services to address immediate and medium-term needs of women (UNFPA, 2019). Survivors who face difficulties accessing medical facilities may further be impaired in seeking justice, if they are not able to obtain medical reports (Perry and Sayndee, 2017). Finally, in settings where pandemics trigger a militarization of the health system, for example the utilization of military forces to set up field hospitals and provide security, there may be important negative effects (Smith, 2019). The presence of military forces, which are predominantly men, in the community can lead to increased risk of VAW/C and a perception of fear and lack of security for women and girls (ibid).

During a pandemic, reductions in service provision for survivors of violence may also stem from reductions in *demand* for services. For example, anecdotal evidence from the COVID-19 pandemic suggests that women may be less willing to seek help, particularly for health care, because of perceived risks of contracting viruses.

> *"I spoke to a female caller in California that is self-quarantining for protection from COVID-19 due to having asthma,"* an advocate at the National Domestic Violence Hotline wrote in the organization's logbook. *"Her partner strangled her tonight. While talking to her, it sounded like she has some really serious injuries. She is scared to go to the ER due to fear around catching COVID-19."* (NDVH, 2020; Godin, 2020)

This dynamic is also supported by evidence from the Ebola outbreak, showing that women are generally less likely to seek services for maternal and newborn health services for fear of infection and the potential for transmitting the virus to their families (Jones et al., 2016; 2017; Sochas et al., 2017).

2.6 Virus-Specific Sources of Violence

Fears around the nature of specific viruses may create an enabling environment justifying the use of coercive and controlling behaviors, as well as more severe forms of violence. If a pandemic is novel or survivors have limited information regarding the nature of transmission, perpetrators may use misinformation or scare tactics to control or blame them (NDMH, 2020). In addition, if a particular virus is transmitted via direct or indirect contact or small particle aerosol as SARS, MERS or COVID-19, perpetrators may withhold necessary safety items (e.g., hand sanitizers, soap, disinfectant, protective masks). For pandemics with known treatment options, similar forms of controlling behaviors may be used in relation to vaccines, other forms of treatment or preventative medicine. Finally, linking with mechanisms around economic insecurity and women's ability to temporarily escape, perpetrators may also withhold health insurance or economic support which becomes more crucial during periods of outbreak.

> *"A health professional still living with their abuser called and said they were physically abused that night because their abuser was sure they were trying to infect them with COVID-19."* —Hotline chatter (United States; NDMH, 2020).

Second, if viral transmission is linked to sexual behavior (e.g., HIV), individuals who become infected may face violence upon discovery or disclosure to their partners or to the broader community. In many settings, women are more likely to undergo routine HIV testing during ante-natal care and learn their serostatus before male partners. Disclosure of HIV status has been linked to increased risk of serious forms of IPV, including femicide in diverse settings, despite lack of rigorous quantitative studies with causal links between the two (Siemieniuk, Krentz and Gill, 2013; WHO, 2006). In a mixed-method review, Kouyoumdjian and colleagues (2013) document qualitative studies showing people infected with HIV may deliberately try to infect their partners through forced sex, and/or that attempts to spread HIV may be used as an act of punishment or revenge. In addition, misinformation linked to HIV "cleansing," including the myth that having sex with a child virgin may cure HIV may have led to increases in child rape in some settings (Leclerc-Madlada S., 2010). However, it is unclear how widespread this phenomenon was in practice, given the inability to assess underlying causal linkages and the already high burden of child sexual abuse in some settings.

Third, if the consequences of a virus manifest in harmful outcomes for children, this could put strain on partnerships through financial and psychological stress. For example, the Zika virus outbreak in 2015 has been shown to coincide with Guillain–Barré Syndrome, microcephaly and other neurological impairments in newborns. There is a broad body of literature linking disabilities to increased experience of violence, both for women and children (Hughs et al., 2012; Jones et al., 2012). Children affected by birth defects induced by Zika have been shown to be those in the lower socio-economic status, thus reinforcing existing vulnerabilities and inequalities (UNDP, 2017). Children and families affected with disabilities and health impairments are likely to experience increases in multiple types of violence over the medium- and longer-term.

A final virus-specific pathway relates to social and economic repercussions of infection, including social stigmatization, violence, and destruction of property from family and community members. For example, research from Brazil indicates that mothers of children affected by Zika-induced microcephaly are subject to harassment and discrimination in public, including accusations that they attempted abortion (Carneiro and Fleischer, 2018). A more extreme example, in the context of the Ebola outbreak, houses where people were known to be infected or have died were demolished or burned by local authorities because they were seen as "infected" or "contact points" for the virus (Risso-Gill and Finnegan, 2015). Literature for both IPV and child maltreatment suggests that access to secure housing and women's ownership of housing and durable assets are protective factors against victimization—however most literature from LMICs is associational (Conrad-Hiebner and Byram, 2020; Peterman et al., 2017b). Taken together, these pathways demonstrate that the knowledge and potential fears surrounding a virus, modes of prevention, transmission and treatment can be important enabling sources of VAW/C, which require attention within mitigation efforts.

2.7 Inability to Temporarily Escape Abusive Partners

Literature suggests that women's interest and ability to leave abusive partners is complex—particularly in LMICs and where divorce is uncommon and where social norms and financial realities value family preservation. Women may opt to stay with abusive partners for a host of reasons, ranging from emotional attachment, psychological distress, financial dependence, or fear that separation will elevate harm to personal physical safety or the safety of their children (Rajah and Osborn, 2020; Ciurria, 2018; St Vil et al., 2017; Hall, Walters, and Basile, 2012). Each of these may be compounded in pandemic contexts. As previously noted, quarantining and other social distancing measures limit both physical mobility and potentially increase economic vulnerability among women experiencing interpersonal violence. During pandemics, women may

worry about their physical safety or experience additional mental or emotional distress, making it even more difficult to create necessary space in the relationship and mitigate immediate risk for violence.

Outside of personal and familial constraints, women's access to legal systems and safety support services can be limited during times of crisis. These measures compound the pre-existing, significant challenges that prevent legal systems from responding efficiently and effectively to the needs of IPV survivors. Consistently low conviction rates in turn, create a positive feedback loop, wherein malfunctioning systems discourage women from reporting incidents of violence, thus shielding perpetrators—particularly in LMICs where access to formal legal services and systems is extremely limited (Mueller et al., 2019; Larcombe, 2011). In light of the COVID-19 pandemic, court officials across countries have been advised to stay home, and hearings have been postponed in the United States, the United Kingdom, and elsewhere (Reynolds, 2020; Zou, 2020). Some court systems have carved out exceptions for family law proceedings, though reduced staffing at courts still risks delays in the issuance of court-ordered restraining orders, separation and divorce proceedings, and child custody hearings, including those that IPV survivors rely on to facilitate distance or departure from abusive partners. Related support services, including screenings at medical facilities and crisis support services, may also be affected and cause additional delays. A UNDP study assessing the response to gender-based violence during the Ebola epidemic reflects that delays in medical testing resulted in legal cases being thrown out due to lack of sufficient evidence (UNDP, 2015).

Pandemics may also have effects on law enforcement operations, which may in turn have consequences for VAW/C. For example, in the context of COVID-19, if guidance to *"drastically limit the number of people who are arrested and then detained"*—in an effort to limit prisoners' exposure to the disease—is observed, police officers may be less likely to assess cases of IPV as high-priority for arrest and detainment (ACLU, 2020). This dynamic was also observed during the Ebola outbreak, especially as police officers were hesitant to enter homes and conduct thorough investigations out of risk of disease exposure (UNDP, 2015). Such action would be consistent with and compound many police officers' decision to leave issues of IPV as a "personal" or "family" matter even outside of pandemic contexts (Wolf et al., 2003). In the current COVID-19 outbreak, the American Civil Liberties Union advises that parole officers should prioritize social distancing and communicate via voice or video call, which may limit their ability to fully assess chances of recidivism, including those that may put IPV victims at increased risk (ACLU, 2020).

First responders, crisis hotlines, and civil society organizations such as women's groups who often serve as first points of call, intermediaries connecting women to legal channels, crisis support and safety planning, and foundations of housing and financial assistance are all critical as women navigate departure from abusive partners (Postmus et al., 2009). With social distancing measures instituted, as well as economic strains, these organizations may be less active and able to support women and children in need. Hotline support services and emergent SMS-based safety planning and support programs are essential lifelines in times of crisis in their ability to provide crisis counseling and strategic safety planning even remotely.

2.8 Exposure to Violence and Exploitation in Response Efforts

Sexual exploitation and abuse (SEA) was first brought to light in the humanitarian aid sector almost two decades ago, when a UNHCR and Save the Children assessment exposed abuses by members of international aid actors against people living as refugees (UN, 2002). Unequal power dynamics between aid workers—including those involved in aid delivery, such as drivers, contractors, and volunteers—and aid recipients, underlie such abuses. Dependency on aid for survival, and lack of accountability for perpetrators, are factors

that contribute to its prevalence and serve as barriers to reporting (Lattu, 2008). In this context of extreme power inequalities, a population-based study in parts of South Sudan found 20 percent of female respondents reported transactional sex (GWI and IRC, 2017). In a systematic review, women were identified as more likely to experience sexual exploitation during conflict than men (McAlpine, Hossain, and Zimmerman, 2016). A participatory action, longitudinal qualitative study of SEA in relation to aid distributions in Lebanon and Uganda found that sexual exploitation and abuse by aid as well as non-aid actors is pervasive across the five types of aid explored: food, WASH, shelter, cash and voucher assistance, and fuel and firewood. This includes SEA by host community members with whom women and girls must negotiate for access to firewood or water sources; as in this example from a South Sudanese adolescent girl living in Uganda as a refugee:

> *"the water in the area may not be supplied on time. So sometimes you have to go and collect from the watercourse where they are supplying. When you go there, these men may want to be in a love relationship with you. If you refuse, they will not open for you the water. If you refuse you will not be free to fetch the water.*" (Potts et al., 2020).

Reports of SEA during the Ebola outbreak in West Africa include sexual assault of girls by taxi drivers responsible for transporting goods as well as people (The Alliance for Child Protection in Humanitarian Action, 2018), and reports of SEA of girls by Ebola burial teams who provided food and cash in exchange for sex (Kostelny et al., 2016) or even by frontline health workers offering the vaccine in exchange for sex (Holt and Ratcliffe, 2019).

The current COVID-19 outbreak may make existing protective strategies identified by women and girls—such as moving in groups or ensuring aid workers are accompanied when visiting refugee households—more difficult to implement. At the same time shortages in goods mean women and girls face more pressure to access these items for themselves and their households (Potts et al., 2020). In many cultures, women and children are the primary collectors of water and those responsible for cleaning the household. The increased pressure on WASH resources in this pandemic may also lead to increased exploitation by responders, as well as other types of VAW/C, with female- or child-headed households particularly at risk (Pommells, 2015; CARE, 2020). An aid assessment from Sierra Leone notes that transactional sex was mentioned in relation to accessing food as well as water (Risso-Gill and Finnegan, 2015). Given potential shortages of qualified female staff due to containment measures, illness, or competing care needs in their own homes, it may be increasingly difficult to fully staff women's and children's safe spaces and services (Fraser, 2020). Having women in response roles, such as clinicians and aid workers, is seen as an important part of mitigating SEA within aid efforts and may be important as well in the context of pandemics.

2.9 Violence Perpetrated against Health Care Workers

Globally, women are estimated to account for approximately 70 percent of the health workforce, and the majority of those in informal care taking roles in health (WHO, 2019b). Violence against female health workers and sexual harassment is endemic in the health and social sector—with female health workers experiencing violence at the hands of male colleagues, male patients and members of the community (ibid). Reporting of sexual harassment and violence varies. For example, the 12-month prevalence of verbal abuse among female nurses sampled from a University Hospital in South Korea was 64 percent, followed by threats of violence (42 percent), physical violence (22 percent) and sexual harassment (20 percent) (Park, Cho and Hong, 2015). In Germany, in a sample of 737 physicians, 76 percent of female physicians and 62 percent of male physicians reported experiencing any form of sexual harassment during their careers, and women

reported significantly more harassment from supervisors than their male colleagues (Jenner et al., 2019). In Nepal, among a sample of 200 female health workers in Kathmandu, 42 percent reported experiencing verbal and physical abuse and 64 percent reported harassment from a senior male colleague (Prasad and Bhusal, 2015).

In emergency settings, female health workers are at heightened risk to both routine and severe violence. For example, "Safeguarding Health in Conflict" reports over 700 health-related attacks globally in 2017, including 23 attacks in Nigeria, a country heavily hit by such violence. Among health staff alone in Nigeria, 13 were killed, 2 injured or assaulted, 6 sexually violated, and 15 kidnapped (Safeguarding Health in Conflict, 2017). In 2018, two midwives in Nigeria were abducted by the Islamic State West African Province militia group (Harper, 2018). After public pleas by the International Committee of the Red Cross, one midwife was released, however the second was later murdered. The continued harassment and violence facing health care workers in northern Nigeria leaves populations in critical health service deficits—as the region was reported to have less than 50 midwives in 2018. More broadly, the prevalence of sexual harassment and violence experienced by female health workers has a negative impact on individuals and the health system itself, including decreases in productivity and reduction in morale and lack of retention of female health workers (Safeguarding Health in Conflict, 2017; WHO, 2019b). As populations and health systems are under severe stress during pandemics, it is important not to overlook potential exposure of health care workers to additional violence from colleagues, patients and the public.

2.10 Other Potential Pathways

There are a number of other potential pathways, which have the ability to affect smaller segments of the population—or have weak and anecdotal evidence to inform them. For example, during times of perceived unrest and uncertainty, there are reported increases in purchase of firearms and ammunition, particularly in HIC such as the United States. For example, media reports in Seattle indicate background checks increasing 176 percent since the start of March 2020 due to COVID-19 concerns (Oxley, 2020; ARLNow, 2020). In the United States, stricter firearm laws are associated with lower ratios of firearm use in female intimate partner homicide, and lax-targeted legislation is associated with overall higher female homicide rates (Gollub and Gardener, 2019). In addition, using nationally representative data from the United States, Kivisto and Porter (2020) find that firearm use in domestic homicides increases the risk of multiple victims. While the magnitude of gun purchases and composition of owners pre- and mid-pandemic for COVID-19 is unknown, it is possible that women and children are at greater risk of both accidental and intentional injury and death.

In addition, other forms of generalized violence are important, and may occur during pandemics, including elder neglect and abuse, child online solicitation and abuse, or hate crimes driven by xenophobia (all potentially relevant to COVID-19). For example, older people may be living in situations of increased dependency and isolation due to quarantine measures or living in heavily impacted residential facilities, which may in turn increase their vulnerability to violence in gendered ways. These pathways, while not fully explored here, deserve further focused research and action. In addition, indigenous and ethnic minority groups, sex workers, other marginalized populations (including people of diverse sexual orientations and gender identities), as well as those living with disabilities, may have cross-cutting risks for all types of VAW/C explored in this review (Brownridge et al., 2017; Burnette, 2015). While we are unable to expand each of these important areas of marginalization, we hope further efforts to elucidate pathways and propose solutions for VAW/C and intersecting vulnerabilities will focus on these issues.

3. Policy and Program Response

Based on the available evidence suggesting multiple mechanisms across typologies of VAW/C, we draw on policy and implementation guidance to inform a gender-responsive strategy to avert additional VAW/C. These strategies are meant to complement the existing literature of promising prevention strategies in the absence of pandemics—rather than replace or revise existing recommendations (Ellsberg et al., 2015). We also acknowledge that in many cases, there does not yet exist rigorous pandemic-specific evaluations linking these recommendations to causal reductions in VAW/C, including sufficient details guiding sequencing or timing of actions over the course of, and post-pandemic. In addition, where existing services are weaker or do not exist, as in many LMICs, response may not be possible or face great challenges. Despite this, based on broader literature, these strategies may both reduce average risk for women and children, as well as for a smaller percentage of individuals at high risk for severe violence. The applicability of each intervention will vary based on context of the pandemic and existing level of services and development in any given context (see also Annex for linkages to additional operational guidance):

1. *Bolster violence-related first-response systems:* At the outset of outbreaks, prepare for a surge in VAW/C. Concrete actions may include increasing staff or temporary operations for existing violence prevention and response hotlines and outreach centers—as well as increasing communication and awareness of services through routine news and advocacy efforts. Information sharing may include online or virtually accessible documentation or guidelines of general resources or pandemic-specific contingencies around family conflict, divorce and violence help-seeking options (Rempel et al. 2019).[21] Within a quarantine context, these should include security and privacy measures such that users can quickly exit and no trace is left in their search history (common safety elements employed by IPV care providers). It is also important to target informal supports such as friends or family, with whom survivors may still be in contact even while isolated at home, who may be able to seek help on their behalf. Community-based empowerment approaches that guarantee confidentiality, a safe environment, and psycho-education, are recommended in refugee settings (Robbers et al., 2017). Dedicated approaches are needed for child protection case management services, including use of social workers, as children are unlikely to have access to the same outreach resources (Yaker and Erskine, 2020). If physical locations for one-stop centers are shut down, it is recommended to explore virtual options—with attention to the existing inequalities in access to information technology services, including cell phones and the internet. These contingencies should ensure that referral systems, including mental health and counseling referrals allow virtual options to be reimbursed by insurance, provide phone/internet credit, and/or be free of charge. This also means re-enforcing training and action plans for pandemic-safe response by police and legal personnel, with clear guidelines of how operations may differ during times of temporary shutdown of referral services. Funding, training and support to VAW/C first responders is also needed to expand and maintain quality support in the longer-run, or to establish such services in rural or resource-low settings, where they do not already exist.

[21] An example of online platform is from Australia (I-DECIDE). An example of a hotline initiated during the COVID-19 pandemic comes from Belgium. An example of online guidance comes from China, the first country hit by COVID-19, via the Family and Community Development Services (online Guidance to Help and Answers for Victims of Domestic Violence (in Chinese)).

2. *Ensure VAW/C is integrated into health systems response*: Minimum care standards should be followed to ensure health system and first responders are prepared to address VAW/C within pandemic settings. These are well documented in the "Inter-Agency Minimum Standards for Gender-based Violence in Emergency Programming" (UNFPA, 2019) and include ensuring there is access to female health care workers, confidential spaces, and non-judgmental, empathetic care. Similar guidelines exist for management of child maltreatment and health sector responses to children and adolescents who have been sexually abused (WHO, 2017; 2019d). Further, health care providers should be trained in identifying women at risk of violence present in all testing and screening locations, such that recommendations for "self-quarantine" or "shelter at home" are accompanied by an assessment of the safety of doing so. Healthcare services should be made available for those experiencing IPV or sexual violence that is of high-quality, survivor-centered and includes sexual and reproductive health services. Bystander training and other existing violence prevention, mitigation and response strategies should be integrated into existing curricula, on-boarding and training for all levels of health services pandemic response agents to ensure women can be safely identified and referred at all levels of health care personnel (Decker et al., 2018).

   In parallel, in pandemics when there is an acute and critical shortage of health workers, it is essential that health systems have in place protections for female health workers to address sexual harassment and violence. This includes ensuring that all workplaces have strong policies and codes of conduct against the same, that all health workers are assured dignity regardless of their sex or gender, that adequate pathways are in place to address issues of violence and harassment and that there are legal measures in place to address harassment and violence (WHO, 2019b). Frontline providers should also have support if they need to report to work, such as alternative and subsidized childcare options, and to also prevent the potential of untrained childcare providers and/or neglect (abuse) of their own children.

3. *Expand and reinforce social safety nets:* A broad body of literature exists and is rapidly expanding on both macro- and micro-economic responses to pandemic-induced economic shocks. The fiscal instruments and programming employed are likely to vary substantially by level of development, including existence of pre-pandemic social protection and social safety net measures, percentage of affected population in formal versus informal employment and financial infrastructure (including rates of financial inclusion for LMICs) (Gentilini et al., 2020). Proposals for rapid expansion of social safety nets, including paid sick leave, unemployment insurance, direct cash or food voucher payments and/or tax relief are all immediate options—with emphasis on pro-poor or universal schemes of sufficient monetary value. A large number of global and local organizations already exist who specialize in implementation of social safety nets, including shock-responsive and humanitarian cash transfers, who are well positioned to absorb financial shocks and mitigate against longer-term economic crises.[22] From a VAW/C perspective, there are at least four important considerations. First, efforts to maintain both household, as well as, individual-level benefits are encouraged—this

[22] For example, the SPIAC-B (social protection inter-agency coordinating board), lead by the ILO coordinates social protection response at a global level for multi-national organizations. The cash learning partnership (CaLP) coordinates over 80 emergency and humanitarian actors engaged in cash and voucher assistance. Ugo Gentilini at the World Bank is compiling a running list of COVID-19 social safety net responses in his weekly social protection newsletter.

may include employment benefits or insurance which will allow victims to maintain control and access to other services. Second, consider that delivery mechanisms will affect the ability of some individuals—particularly those in controlling relationships—to access benefits. Benefits which are automatic, rather than entailing administrative hurdles or conditionalities will result in fewer vulnerable individuals, including victims of VAW/C being excluded. Third, consider if targeted economic benefits can be directed to survivors of VAW/C to address financial needs related to accessing health, legal or psychosocial services and future violence (see Annex on Resources; Manell et al., 2019; WRC et al., 2017).[23] Finally, to ensure an adequate level of care to all children, as well as mitigate risks of violence out of resentment or stigma towards orphaned children, financial support, including in the form of food subsidies, and/or cash transfers should be directed at vulnerable households who may absorb additional caregiving responsibilities.

4. *Expand shelter and temporary housing for survivors:* Temporary shelter and transitional housing for survivors of violence is likely to be reduced during pandemics, as it becomes used for other purposes (including sheltering the sick, homeless populations, incarcerated, and other vulnerable populations). While these populations may also be at high risk for contraction of a virus, there is need to ensure surge housing available for high risk women and children which is pandemic-safe (see annex for VAWnet guidance on preventing and managing spread of COVID-19 within IPV shelters). Evaluations of IPV shelters in HICs suggest that women feel safer, have improved mental health, are able to access critical services including counseling, legal advocates and, importantly that future intensity and experience of violence may be reduced when staying in shelters (Sullivan, 2012). Baker and colleagues (2010) lay out a number of promising policy actions to address housing instability and homelessness for survivors, which include actions like expanding definitions of targeting criteria for subsidized or access to housing services (to include VAW/C), expanding services to include additional benefits (e.g. waiving of application fees, move in costs, other expenses), increasing funding for emergency shelters and programs that address affordable housing, and improving communication between housing (homeless services) and violence service providers. While many of these suggestions are longer-term action points, an immediate response in the short-term during pandemics is simply increasing funding for organizations providing emergency shelter. For example, the Canadian government announced a $82-billion COVID-19 aid package on March 18, 2020 which included earmarked increases in $50 million funding for GBV shelters and sexual assault centers (Harris, 2020). Adequate housing supports for those at risk for VAW/C can also buffer against potential reengagement with or financial reliance on abusive partners during or after pandemics, thus reducing risk of VAW/C in rebuilding phase. Finally, alternative care arrangements are needed for children at risk of maltreatment, abuse and harm and should be considered as a critical component of safe housing during pandemics.

5. *Encourage informal (and virtual) social support networks:* Research shows that informal networks (e.g. to friends, family members, coworkers) are likely to be the first source of informal disclosure for victims of all ages across diverse settings (Palermo et al., 2014; Pereira et al., 2020; Sylaska and Edwards,

[23] While social safety nets are primarily thought of as individual or household-level benefits, evidence shows that direct cash payments implemented by seven governments across Africa have meaningful local economy multiplier effects—as beneficiaries spend money in the local economy. Multipliers range from 1.27 in Malawi to 2.52 in Ethiopia (Handa et al. 2018).

2013). Engaging in informal networks has also been a key strategy for safety of women experiencing IPV, resulting in calls for social network-oriented approaches to services and prevention programming (Goodman and Smyth, 2011; Wood, Glass and Decker, 2019). Within the contexts of pandemics, there are a number of options to scale-up and leverage existing online and virtual platforms for online support networks, including examples from the United States (MyPlan, Glass et al., 2015; New Zealand (isafe, Koziol-McLain et al., 2015), Canada (iCan, Ford-Gilboe M. et al., 2017), and the Netherlands (SAFE).[24] In settings without options for online platforms, options for text (WhatsApp) based networks can be encouraged, building on existing women's groups and collectives. These mechanisms may help women and children feel connected and supported, as well as serve as an alert or mitigation mechanism if perpetrators are aware that women and children maintain their social networks and are not isolated.

6. *Clear communication and support during quarantine mandates:* While quarantines and self-isolation is often a necessary public health response to pandemics, they also come with significant costs to population physical and mental health. In a rapid review of mental health effects of quarantine, scanning 3,166 papers and including 24 studies, Brooks and colleagues (2020) recommend several measures for minimizing adverse effects of quarantines. These include encouraging officials to quarantine individuals for no longer than required, providing clear rationale for quarantine and information about protocols, and ensuring there are sufficient supply of goods and essential services to populations under isolation. In addition, they suggest that officials should appeal to altruism through messaging about positive externalities and public benefits to communities and society. While decision-making during pandemics is complex, local and national leaders and news outlets can play an important role in both communicating information, as well as messaging around morale to reduce adverse mental health impacts. Civil society and organizations supporting children and adolescence can offer support and resources to facilitate healthy parenting (Cluver et al., 2020; see annex resources). In the longer-term, funding and resources are needed to support basic mental health and psychosocial services which can address post-pandemic effects and allow flexible expansion during crises.

7. *Integrate VAW/C programming into longer-term pandemic preparedness:* VAW/C should be integrated into disaster risk reduction (DRR) and preparedness, as well as pandemic preparedness. Preparedness efforts should incorporate a gender and age lens throughout: ensuring women and children are included in preparedness processes and decision-making, and are recognized as persons with skilled roles to play in response (Willmer, 2020). Both One Health and Global Health Security Agenda are prime entry points to integrate VAW/C programming. For example, business continuity plans should be developed (or modified), and include first responders, violence shelters, child protection systems and case management. Pre-positioning of commodities, such as those necessary for implementation of the "Inter-Agency Minimum Standards for Gender-based Violence in Emergency Programming" and clinical management of rape, is important and should be included in current or future planning (UNFPA, 2019). "Localization" efforts should include the leadership of women responders (CARE, 2018) and coordination, advocacy, and participation remain essential. For example, in Cox's Bazar refugee camp in Bangladesh—where the first cases of COVID-19 have been confirmed in the nearby host community—women are being engaged in "systematic preventative health and health

[24] The Safe trial is currently in progress in the Netherlands.

promotion messaging in their communities" in recognition of the camp being 70 percent female and women's roles in managing households and modeling behaviors for children (Karim, 2020).

8. *Implement and invest in flexible funding mechanisms:* In times of uncertainty and crises, donors and implementers should reflect timely policies and guidelines for grantees and staff which allow flexible funding. This includes provisions to allow funding to be allocated away from contractual requirements and to operating (overhead) expenses with decreased reporting requirements. These flexible mechanisms would allow organizations to allocate funds where they need quickly and efficiently. Existing guidance and a pledge spearheaded by the Ford Foundation, at the time of writing with 40 philanthropic foundations signed on, lays out a set of recommendations for donors in the context of COVID-19. [25] Multilateral and bilateral donor institutions should also prioritize increased and gender-responsive investment to curb the full array of risks brought on by pandemics, including heightened VAW/C. Through financial support facilitating the interventions proposed above (e.g., cash transfers to ensure social safety nets for vulnerable populations, expanding support for survivors of violence), donor institutions can contribute to limiting the extent of harm causes by pandemics. National, state, and city/local government associate relief funds should also include provision of resources and funds to bolster existing organizations providing VAW/C services (Murphy, 2020).

4. Defining a Research Agenda

Based on the existing literature and evidence gaps, we propose three areas of research which could better inform VAW/C mitigation in the current COVID-19 pandemic, as well as future pandemics: (1) *understand the magnitude of the problem*, (2) *elucidate mechanisms and linkages with other social and economic factors*, and (3) *inform intervention and response options*. We briefly summarize each of these, in the hope that researchers and implementers can capitalize on inter-disciplinary expertise, data availability (including ongoing studies and availability of open access administrative data) and funding opportunities to advance the knowledge frontier. Participatory research methods that emphasize power-sharing in the knowledge creation process are important, and relevant, to all of the proposed research areas below, as well as taking an intersectional approach to research and data collection (Equality Challenge Unit, 2017).

4.1 Understanding the Magnitude of the Problem

A basic question, which we still do not know is: *How big is the problem?* While rates of potential increases (decreases) are likely to vary by nature of the pandemic and specific location—additional evidence could help in decisions of how to allocate resources and raise awareness of dynamics. An important part of better understanding dynamics will be understanding how different types of violence respond, for example: (1) *Do rates of IPV increase more (less) as compared to rates of violence against children, sexual exploitation and other types of VAW/C?* In addition, given high levels of pre-pandemic poly-victimization faced by vulnerable populations, we might be interested in knowing: (2) *Does the composition of violence experienced shift for individuals or populations during a pandemic?* Based on our review, we hypothesize that VAW/C will increase during and post-pandemic (rather than decrease), however there could be circumstances or sub-groups for which typologies of violence

[25] Top Foundations Pledge Flexible Funding to Grantees in Wake of COVID-19 Crisis (Ford Foundation, accessed March 27, 2020).

could decrease. For example, if children are not going to school, prevalence of violent discipline perpetrated by teachers and bullying from peers may decrease, while prevalence of violence from family members increases. Likewise, if women are not going to work, prevalence of workplace harassment may decrease, while IPV may increase (MacGregor et al., 2019). Importantly for equality concerns, we might also be interested to know: (3) *What populations are most at risk for increases in violence, and do these map to existing vulnerabilities along economic or social inequalities (including sex, age, race, economic status, among others)?*

The empirical challenge for this stream of research is two-fold. First, simply showing population-based changes in VAW/C rates before, during and after a pandemic does not necessarily imply the pandemic was responsible for these changes (i.e., a direct causal relationship). This is because rates could be trending upward or downward even in the absence of the pandemic. Therefore, to develop more reliable estimates, researchers will need to identify pre- and post-pandemic trends (e.g., interrupted time series approaches or regression discontinuity approaches), and/or use the intensity of pandemic across time and geographies to isolate unbiased estimates.[26] In many settings, this will be challenging, due to the inability of frequently collected VAW/C data, particularly in LMICs. Therefore, in lieu of population-based or administrative data, another opportunity may be to use ongoing panel surveys of selected samples to estimate these linkages. A second challenge is the reliability of VAW/C data. We know from existing studies that data captured within surveys and within administrative data to formal sources is a fraction of the true burden of violence. A cross country study using 28 LMICs estimates that prevalence of gender-based violence among women aged 15 to 49 based on health systems, police reports or social services may underestimate the total prevalence ranging from 11- to 128-fold, depending on region and reporting source (Palermo et al., 2014). These underreporting issues are magnified in conflict and disasters due to break down of administrative data collection and basic services or freezes on household data collection (Palermo and Peterman, 2011). Therefore, data collection and analysis will need to carefully consider if experience of pandemics also increases or decreases disclosure rates, and how this will change interpretation or limitations placed around results.

4.2 Elucidate Mechanisms and Linkages with Other Social and Economic Factors

A second group of research questions relates to better understanding potential mechanisms, as well as how VAW/C relates to broader social and economic dynamics during a pandemic. While review of operational research and documentation can inform these questions, a key methodology is likely to be ethnographic and qualitative research which can be rolled out within a shorter timeline than large quantitative data collection. Some stories may already be collected or available in public press. For example, the French newspaper 'Le Monde' recently released a call for testimonials of up to 1500 words on the experience of 'marriage under quarantine' *("Parfaite lune de miel ou guerre des tranchées? Is it a honeymoon or trench warfare?"*).[27] These types of stories, although selective, are likely to help raise the public awareness of how pandemics may affect VAW/C,

[26] This will require fairly sophisticated data on the number of cases or severity of cases by geographic area (or associated social and economic responses), over time, which may be available for more recent or future pandemics as surveillance systems become more advanced.

[27] Vous êtes en couple et confiné avec votre conjoint ou votre conjointe ? Témoignez (accessed March 18, 2020).

as well as link to broader social and economic dynamics, including marital dissolution and changes in family demographics and circumstances.

However, more dedicated ethnographic and qualitative work can help test specific hypotheses for proposed mechanisms, as well as understand how women, men and children with specific characteristics respond to pandemics. For example: (1) *What evidence of diverse pathways appear important for different populations in linking direct and indirect effects of pandemics to VAW/C?* Further, (2) *Are there additional pathways which do not fall into the categories identified in this review?* In addition, we might be interested in better being able to predict responses based on the nature of a pandemic (including morbidity and mortality rates, how it is transmitted, among others). Therefore, we could ask: (3) *What unique characteristics of specific pandemics may be important considerations for beginning to group or better hypothesize the nature of pathways and VAW/C experiences?* Finally, focus groups and other community-based data collection approaches may help understand how social norms and collective behavior underlay these dynamics. In particular: (4) *How might social norms and collective behaviors matter for pathways and mitigation of VAW/C experiences?*

Taken together, a better understanding of mechanisms can help the global community understand both typologies of interventions which may be promising to pilot or scale, as well as how the relevancy of interventions may vary across geographies and populations. This work may also help understand the linkages between VAW/C and other important intersectoral social dimensions of pandemics, including impacts on health and education sectors. For example, as discussed earlier, in the Ebola crisis, school age girls who became pregnant[28] during the outbreak were 16 pp less likely to return to school (at that time Sierra Leone's Ministry of Education prohibited visibly pregnant girls from re-enrolling in school) (Bandiera et al., 2018). System linkages can help identify where a systems or co-financing approach to intervention will maximize efficiency and resources.

4.3 Inform Intervention and Response Options

The third area of research involves identifying innovative and effective response options to pandemics. Traditionally, these studies use quasi-experimental or experimental quantitative methods to understand if a particular policy or program delivery either pre-, mid- or post-pandemic can directly lead to beneficial changes for participants (in this case reductions in VAW/C). Traditional "gold standard" social science methodologies include experimental randomized control trials—however these types of studies may be harder in emergency and pandemic settings. Part of this is due to the need for rapid roll out of interventions, as well as ethical considerations around delaying on withholding treatment to the control group—if it is already known that the intervention will result in benefits. However, a body of literature has shown that rigorous impact evaluation is possible in such settings, for example, leveraging natural exogenous variation in policies or programs, or by using ongoing trials to collect data on exposure and experience with the particular pandemic. An evaluation of the Empowerment and Livelihoods for Adolescents program in Sierra Leone underway when the Ebola crisis hit was able to use quasi-random across village variation in the severity of the outbreak to examine the effects on subsequent wellbeing among young women and adolescent girls (Bandiera et al., 2018). Trials related to priority response options detailed in Section 3 currently underway in affected settings offer unique and credible ways to inform the effectiveness of future responses. In addition to quantitative methods, in-

[28] While the authors are not able to attribute all pregnancies to sexual violence, the evaluation data, as well as reports from implementers, including Amnesty International show that sexual abuse and exploitation was widespread (Bandiera et al. 2018).

depth qualitative and operational data collection can also be leveraged to understand the success or implementation challenges in program response efforts.

Based on the list of promising policy responses, some priority research questions are: (1) *Are policies and programs (e.g., emergency cash transfers or unemployment insurance) effective in mitigating against increases in VAW/C?* Further, (2): *What is the value for money or cost-effectiveness in implementing successful approaches?* In addition, timing and duration of interventions may matter for mitigation effects. As consequences of VAW/C may have long-term and multiple generational effects, we may also want to know: (3) *How does the timing, duration and intensity of intervention affect short- medium- and long-term experience of VAW/C and future wellbeing?* Examining these questions across LMICs, as well as contexts affected by conflict and/or natural disaster in addition to pandemics, will be important in crafting interventions that work for those living in more fragile contexts.

In answering these questions, new research efforts initiated during pandemics may need to employ innovative methods which allow data to be collected virtually, and there are resources testing and exploring diverse methods (Braun, Clark and Gray, 2017). In addition, as with all violence-related research, in particular primary data collection, this data must be collected with participant protection as a first priority (WHO, 2007; 2016b). The added layer of vulnerability within pandemics will magnify the need for extra precautions and safeguards to ensure that participants are not exposed to health-related risks while participating in research efforts, as outlined in new research ethics guidelines (PAHO, 2020). With these caveats in mind, we encourage researchers who are well poised to conduct additional studies, including those with ongoing trials to consider how small changes in study design or additional questions can inform the broader debate and inform future pandemic response. These responses may build off the evidence reviewed in this paper or identify additional interesting and relevant questions. We also encourage donors and research organizations to identify ways they can augment existing research programs, grants or open new funding windows to accommodate rapid pivots in research efforts and stimulate further innovation.

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Annex. Information Sources and Guidance

Resources Guiding Immediate Violence Response

End Violence Against Children. Protecting Children During the COVID-19 Outbreak (global institution including variety of resources and links to help-lines in 173 countries across the world).

Futures without Violence. Information on COVID-19 for survivors, communities and DV/SA programs (US-based organization working to end violence globally).

National Domestic Violence Hotline. Staying Safe During COVID-19 (US hotline with information and assistance for violence)

National Network to End Domestic Violence (NNEDV). Resources on the Response to the Coronavirus (COVID-19) (United States).

UNFPA. Gender Equality and Addressing Gender-based Violence (GBV) and Coronavirus Disease (COVID-19) Prevention, Protection and Response. UNFPA Interim Technical Brief.

Resources for VAW/C in Emergencies and Pandemics

Alliance for Child Protection in Humanitarian Action. Protection of Children During Infectious Disease Outbreaks (various resources).

CARE. Gender Implications of COVID-19 Outbreaks in Development and Humanitarian Settings (brief).

GBV AoR Helpdesk Research Query. GBV Case Management and the COVID-19 Pandemic. (drafted by Robin Yaker and Dorcas Erskine)

GBV Guidelines. COVID-19 resources to address gender-based violence and Pocket Guide for humanitarian practitioners (Guidelines and pocket guide [app] for Integrating Gender-Based Violence Interventions in Humanitarian Action).

UNFPA. Inter-Agency Minimum Standards for Gender-based Violence in Emergency Programming.

VAWG Helpdesk Research Report. Impact of COVID-19 Pandemic on Violence against Women and Girls (drafted by Erika Fraser)

VAWnet. Preventing and Managing the Spread of COVID-19 within Domestic Violence Programs (including links to guidance on managing risk in domestic violence shelters and temporary housing).

Resources for Parenting and Addressing Mental Health in Outbreaks

MHN, a global community of mental health innovators. Addressing Mental health and psychosocial needs during COVID-19 Outbreak (briefing note and resources).

World Health Organization. Parenting in the time of COVID-19 (six one-pagers with tips for parents, including managing stress and bad behavior).

Resources for Implementation of Emergency Cash and Voucher Schemes

Cash Learning Partnership (CaLP). Gender and Inclusion Resources (humanitarian coordinating network for emergency cash and vouchers):

- CVA in COVID-19 contexts: guidance from the CaLP network
- Cash and voucher assistance and gender-based violence compendium (CARE International)
- Guide for Protection in Cash-based interventions (UNHCR)
- Toolkit on Mainstreaming Gender-based Violence Considerations in Cash and Voucher Assistance and Utilizing CVA in GBV Prevention and Response (WRC, Mercy Corps and IRC)
- Cash Transfers for Food Security in Epidemics: A Review of the USAID Food for Peace Response to the Ebola Crisis in Liberia and Sierra Leone (USAID and CaLP)

World Bank. Social Protection and Jobs Responses to COVID-19: A Real-Time Review of Country Measures (compiled by Ugo Gentilini, Mohamed Almenfi and Ian Orton).

Other Resources (Including Data, Research, and Response)

Data 2X. Gender and Data Resources Related to COVID-19 (ongoing list gender and gender data related to COVID-19).

Gender and COVID-19 Working Group. COVID-19 and Gender Resources (living google document with resources including guides, articles and research by thematic area).

Inter-Agency Standing Committee (IASC). COVID-19: How to include marginalized and vulnerable people in risk communication and community engagement.

International Organization for Migration (IOM). IOM COVID- Camp Management Operational Guidance Frequently Asked Questions (draft 15 March 2020).

Nuffield Council on Bioethics. COVID-19 ethical resources (compilation of resources which focus on ethical aspects of the COVID-19 pandemic).

The US Department of Housing and Urban Development. Infectious Disease Toolkit for Continuums of Care: Preventing & Managing the Spread of Infectious Disease within Shelters (guidelines).

World Health Organization (WHO). COVID-19 Solidarity Response Fund for WHO. ("Donations support WHO's work to track and understand the spread of the virus; to ensure patients get the care they need and frontline workers get essential supplies and information; and to accelerate efforts to develop vaccines, tests, and treatment.