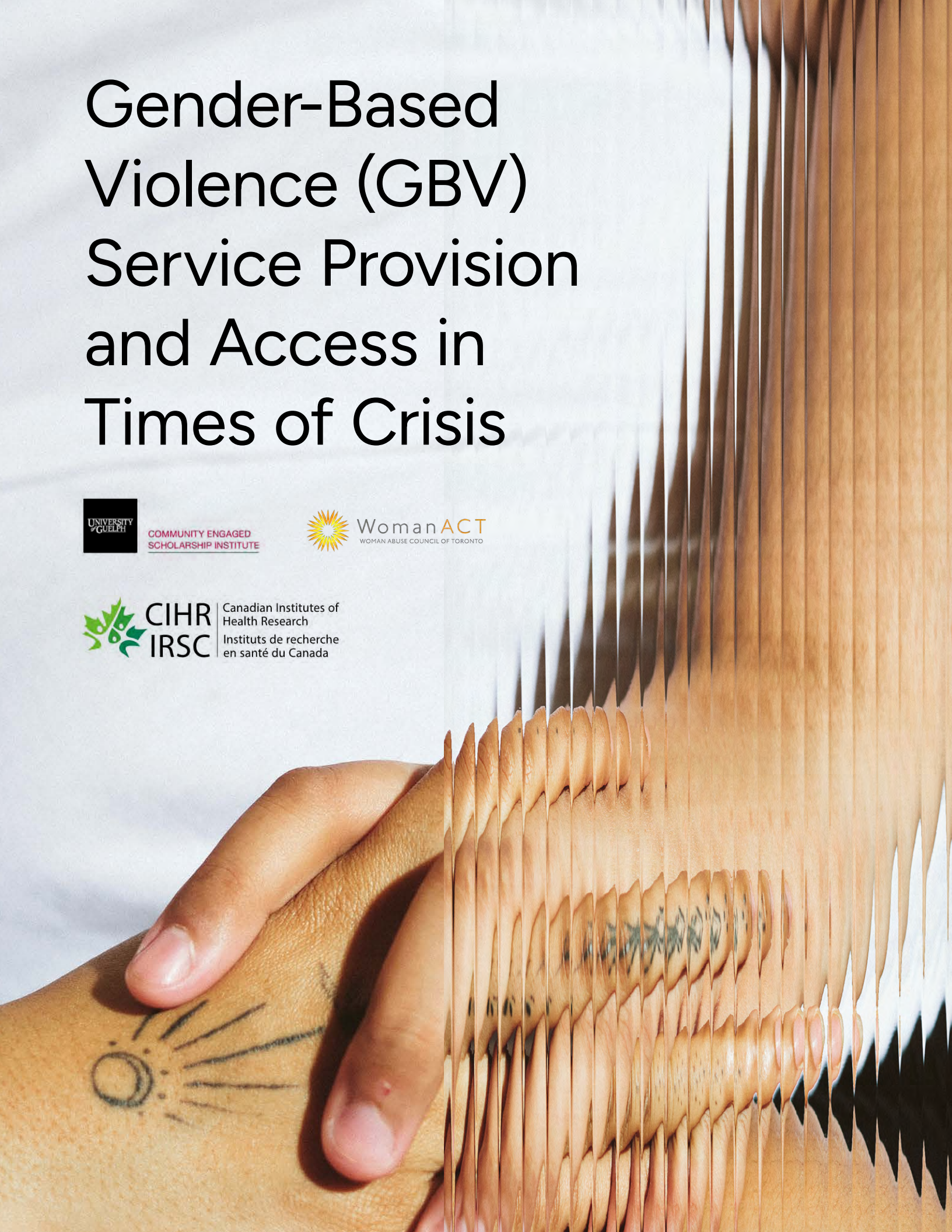
Gender-Based Violence (GBV) Service Provision and Access in Times of Crisis



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Crises cause disruptions and changes to structures, systems, and patterns, but the extent and magnitude of the disruptions or changes are rarely understood. This is especially true in prolonged crises or the case of an already precarious industry. During the COVID-19 pandemic, the GBV sector faced these changes, but little was known about their extent and magnitude.

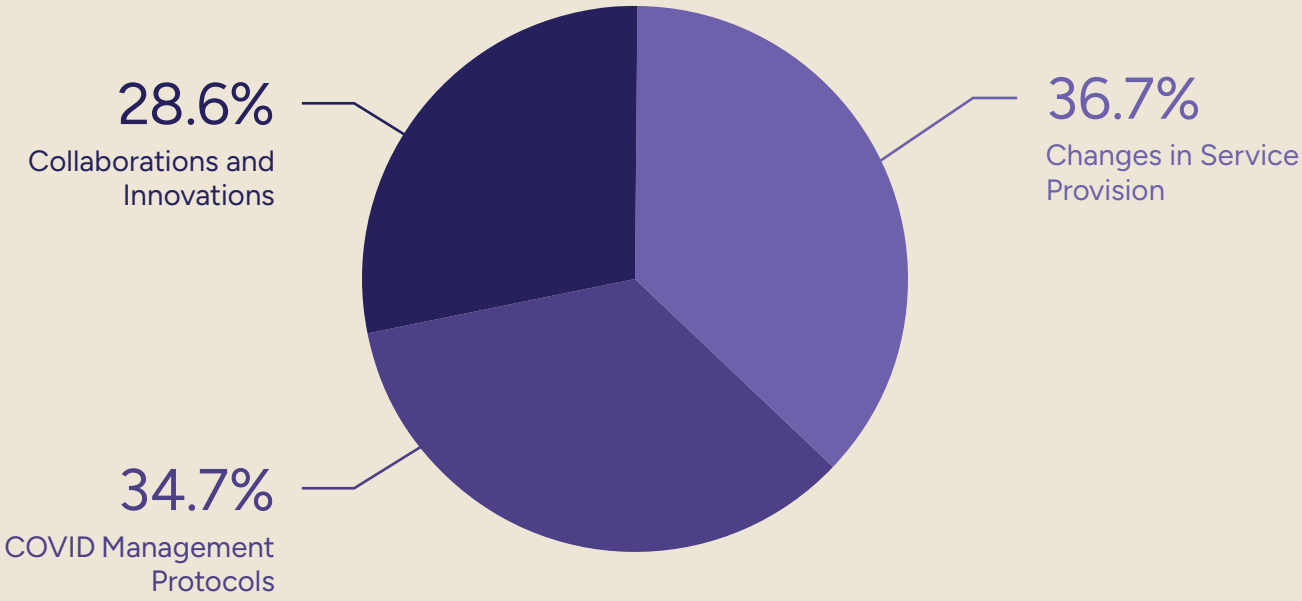
This issue brief reviews the main changes that were experienced in the sector, highlighting the impact of COVID-19 on intimate partner violence (IPV) survivors and service provision sectors. The brief informs policy formulation on service sector re-categorization, service provision support, and intra- and inter-sector collaborations. These findings are intended to be useful for policymakers, legislators, and administrators.

Issue Brief

Studies show that service access and delivery were greatly affected during the COVID-19 pandemic. Gender-based violence and related social services were among those hit the hardest due to their dependence on in-person interactions and support from the government [1]. The challenges to delivering services related to gender-based violence are attributed to the government's COVID-19 management measures and the de-prioritization of this sector [2,1,3].

The pie chart below shows interventions that were used to cope with the challenges.

Interventions for service delivery



COVID-19 and Intimate Partner Violence

COVID-19 management measures, which included social distancing, shelter-in-place orders, and isolation, enabled governments to contain and reduce the spread of the COVID-19 virus from within and across borders [4,5]. However, they also facilitated IPV, as some IPV survivors were locked in the same spaces as their abusers [9,10]. This enabled perpetrators to exercise maximum surveillance on their victims and to control victims' access and use of social media and mobile devices [12,13]. This continued surveillance and control became a barrier for survivors to access IPV services, seek help, or disclose abuse to their formal and informal support systems [12,14,13]. It also made it harder for them to seek help or support at a time when these services were mostly remote [14]. Survivors' proximity to their abusers also removed protective barriers and escapes, reducing opportunities for abuse detection [27]. Forms of help-seeking also decreased significantly [8,15] as social support systems were inaccessible, closed or reduced in their capacities for many clients [2,1,3]. This resulted in wait lists and longer wait times [2,1,3].

COVID-19 and services

The second issue was the failure to categorize GBV/IPV services as essential from the onset of the pandemic. This failure greatly affected the sector's service delivery capacity [16,17]. At the onset of the pandemic, being in the category of an essential service was important since most governments were providing extra support, financially and otherwise [4,5]. Those in the non-essential category, like gender-based violence-related services, were deprioritized, leading to:

- changes in service delivery such as closures, reduced capacities, and reduction in services offered, as well as shifts to remote, hybrid, and telehealth service provision, [16,17].
- reduced opportunities for service access, [18].
- reduced funding, [1,19,20,18] and
- transition challenges in the move from in-person service delivery to remote/ hybrid service delivery [21].

Recategorization of GBV services as essential did happen later, but this was after GBV rates started rising [17].

Service delivery during COVID-19

COVID management protocols and deprioritization of services complicated survivors' needs and impacted how services were accessed and delivered. To cope with these changes, most service providers transitioned to telephones, online chat boxes, social media, and virtual platforms like Zoom [14,5,27]. This transition was facilitated by technology that enabled a continuation of services [8,10], highlighting the importance of digital interventions [3] and the potential for retaining their usage post-pandemic [8,23,10].

Remote services were found to be helpful in several ways. For instance, providers found that the shift enabled them to stay in touch with their clients by providing opportunities to check on clients more often than ever [3]. This move was particularly easy for clients and providers who had access to technology and could use it with less effort [3,10].

The shift also enabled:

- improved attendance and retention rates, surpassing rates in pre-pandemic times, [3,22,10].
- increased attendance, especially in populations where attendance was previously challenging, such as adolescents, [3,11,23].
- increased flexibility of service delivery, providing an opportunity for service providers to assess and understand their clients' physical and social environments, enabling them to adjust their delivery methods, [24,6,12] and,
- the invention of alternate modes of service delivery that factored in the possibility of new dangers and challenges [3,4,5].

Problems of remote service delivery

Despite the opportunities that remote delivery service provided, it was not without challenges:

- It reduced physical contact with clients [11,23,22,1] introducing new barriers. For example, virtual spaces limit adequate assessment of clients in general [3,4].
- As a major communication barrier, it decreased client-provider rapport and trust [11,23,22,1]. The decreased rapport made it harder for providers to keep their clients engaged, hindering the maintenance of effective participation [11,23,22,1]. Clients also depersonalized providers, making it harder to build trusting relationships [23, 25,26].
- Remote service delivery required access to and knowledge of computer and internet usage. This was a challenge for less tech-savvy providers and service users [21,11,14].
- Service providers carried increased workloads i.e., remote service delivery and hybrid modes increased preparation time and paperwork. This was in addition to numerous trainings and the learning of new communication and technical skills to facilitate the shift to remote service delivery [27].
- Parents also experienced additional responsibilities, such as supporting online schooling while working remotely or accessing other services [16].

Summarily, remote service delivery introduced new challenges to survivors and providers as survivors experienced complex changes attributed to the pandemic [5]. Remote services were easier for abusers to track and control, making it harder for survivors to seek and access the services; providers also found it hard to protect clients' privacy and confidentiality [3,4].

Problems unique to service providers

Service providers experienced unique sets of challenges during this period, which included increased workloads, reduced support, blurred boundaries, and secondary and vicarious trauma [3,8]. The transition to working from home blurred the work-personal boundaries, as providers had to set up their offices at home, bringing work-related trauma with them [24,11,5]. This transformation of homes into workspaces was particularly burdensome for providers with children [16].

In addition, providers had to adapt to the demands of digital service provision, which resulted in more work [24,16]. Providers put in longer hours, attending more meetings and taking fewer breaks [3, 8]. The growing amount of preparation and administrative tasks only added to their fatigue, as their work became increasingly time-consuming [24].

The continuous exposure to clients' experiences with violence and COVID-related hardships took a toll on the providers, heightening secondary and vicarious trauma for them [16]. This emotional burden was exacerbated by the isolation of working from home, which diminished the support systems they had relied on, such as the colleague-to-colleague support that in-person spaces typically provided [8,5]. This transformation of spaces also affected providers who were experiencing intimate partner violence themselves or living with their abuser [5].

Innovations: Partnerships and collaborations

Service providers collaborated across organizations and sectors, creating new and private partnerships. For instance, providers organized among themselves to attend to their client's personal needs and ease existing challenges. GBV agencies, like My Sister's Place, started online fundraisers to provide grocery gift cards [1,28], and arranged food pick-ups and drop-offs for their clients [1]. Some organizations kept their clients engaged by providing personal necessities like diapers and hygiene products [21]. When digital services increased, organizations provided technological necessities such as tablets, laptops, and data packs [23]. Supermarkets and pharmacies also set up assistance points nationwide to help IPV survivors at the onset of the pandemic [15]. Some stores coordinated pick-ups and drop-offs of essential products like food and survival kits [1,23,21]. They also cooperated with GBV service providers by displaying flyers with information about survivor services and their hours of operation [15].

Providers also displayed information strategically for IPV/GBV victims in locations that victims frequented [24] and came up with creative solutions for remote service delivery to ensure client safety [23,12]. They created interactive teaching and learning content like guidebooks using digital platforms like social media [19].

Partnerships were also formed with hospitality, housing, legal services, and police departments [15,11,20,28]. For example, local hotels, landlords, and the police partnered to help survivors address housing insecurities; some police departments, for instance, helped IPV survivors requisition hotel rooms [1,11,2,25], while other organizations worked with landlords and property owners to secure renting and private places for victims [26].

Hotels were also used as shelters to help adhere to social and physical distancing mandates [29].

Providers' networks also facilitated access to services and resources beyond their scope [6,25]. For example, providers connected with counterparts in other organizations to find resources they did not have access to. Organizations eligible to apply for COVID-19 monies also worked with ineligible organizations and provided extra support [6]. These innovations helped service providers cope with the pandemic and make long-standing improvements that could be adapted post-pandemic [19,23].

Main Takeaways

1

Government responses in times of crisis influence how people experience crises [17]. This study showed transparency in the decision-making process, as well as higher levels of support, resulted in less confusion and disruption [17]. Sectors that had more support during the pandemic experienced less disruption, e.g., in countries like Australia and New Zealand, where the gender-based violence sector received more funding to support projects such as the building of shelters [14].

2

Revision of laws and policies is important, especially the relaxation of stringent laws around GBV-related support. Examples include the categorization of gender-based violence services as essential and the revision of organizations' eligibility for funding streams. The review found that these changes led to more allocation of funds to the sector, which resulted in the provision of more support and resources. Revision of eligibility also strengthened existing partnerships and enabled the formation of new partnerships [15,22].

3

Flexibility and adaptability are key. The GBV service sector's flexibility enabled the building, continuity, and sustenance of new collaborations and partnerships. The flexibility in coping with COVID-19 management protocols with limited resources enabled continuity of services [16,24]. The use of remote and hybrid modes of service delivery introduced flexible options that worked best for survivors with no childcare, as well as for adolescents. Investing in these modes to improve service provision for these groups is useful in bridging service gaps.

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