A PANDEMIC OF THE STATE AND HOME:

Gambian women's experiences of sexual and gender based violence during Covid-19

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WELCOME

In recent years, many African feminists and women's rights groups have celebrated several wins regarding rights and access to different gender related policy law and progress limitations. These many changes include the criminalization of Female Genital Mutilation, decriminalization of queer and abortion right laws, increasing access to reproductive health rights access and representation of women in places of power in different levels of politics, local, national and even global. However, the COVID-19 pandemic that hit in 2020 also showed the level of inequalities present in our social, economic, domestic and political lives, and the different structures and systems that exacerbate these inequalities i.e. technology, income disparity, education etc. "What the present crisis highlights across the African continent is the ineffectiveness of past measures. It seems the little Band-Aids that existed in normal pre-pandemic times have been ripped off, and the perpetual state of violence that African women experience can no longer be ignored."[1]

In 2018, many women in African countries - Nigeria, Sudan, Kenya, Zambia - protested the rise in rape, intimate partner violence (terrorism as MonaEltahawy, an Egyptian feminist writer would call it), economic and other social impacts of the pandemic. In The Gambia, a Women's Lives Matter movement co-opted a protest in September 2020 to highlight the alarming rate of maternal mortality, which was already above the 77% the baseline reduction rate as per the 2030 SDG3 Goal.

> **WHAT ALL THIS IS SAYING TO US IS THAT MORE NEEDS TO BE DONE TO ATTAIN COMPLETE FREEDOM FOR WOMEN AGAINST ALL FORMS OF INEQUALITY...**

[1] Kagumire, R. Ouya, V. (2020). African women face two pandemics. Accessed here: https://www.aljazeera.com/opinions/2020/7/30/african-women-face-two-pandemics/

What all these is saying to us is that more needs to be done to attain complete freedom for women against all forms of violence, and more importantly, that inequality and oppression does not happen in a vacuum, and as we continue to see more abnormal circumstances inequalities will continue to widen and be visible.

It is against this background that a baseline survey was conducted by Equals Now in order to understand the prevalence and prevailing situation of sexual and gender-based violence in The Gambia during Covid-19. We hope this report will be used to support advocacy, policy change and rethinking of our strategies and methods in combating violence against women and girls during and beyond the pandemic

Maimuna Jeng
Executive Director
Equals Now

This research was conducted by Dr. Mat Lowe, an Independent Consultant, Social Scientist -Researcher, and Lecturer of Gender, Health, Population and Development Practice. There were also other contributors at different stages of the research process.

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Contributors:

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We are also really grateful to all the women, health care workers, men and every respondent who took their time to speak to us and provide us with data for our qualitative research.

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"WE HOPE THAT THIS REPORT WILL BE USED TO SUPPORT ADVOCACY, POLICY CHANGE AND RETHINKING OF OUR STRATEGIES AND METHODS IN COMBATING VIOLENCE AGAINST WOMEN AND GIRLS DURING AND BEYOND THE PANDEMIC."

ACRONYMS/ABBREVATIONS

ANC	Antenatal Care
Covid-19	Coronavirus Disease-2019
FGM	Female Genital Mutilation
GBV	Gender-Based Violence
PNC	Postnatal care
SGBV	Sexual and Gender Based Violence
SRHS	Sexual and Reproductive Health Services

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EXECUTIVE SUMMARY

Emerging evidence suggests that the Covid-19 outbreak has negatively affected sexual and reproductive health services and support programs for women and girls, therefore exacerbating the prevalence of Sexual and Gender-Based Violence (SGBV) in vulnerable communities. In The Gambia, since the emergence of the Covid-19 there has been a record number of cases of GBV[2]. It is against this background that this baseline survey was conducted to support the collection and analysis of data on the prevalence and prevailing situation of SGBV in The Gambia during Covid-19. The baseline survey is part of a larger project implemented by Equals Now that seeks to address the effects of Covid-19 on women and girls' access to sexual and reproductive health rights and their safety from SGBV in The Gambia.

"THE RISK OF PHYSICAL VIOLENCE AGAINST WOMEN BY AN INTIMATE PARTNER COULD ALSO BE LINKED TO THE ADOPTED COVID-19 MITIGATION STRATEGIES INCLUDING THE STAY AT HOME MEASURES THAT FORCED PEOPLE TO STAY HOME."

The survey methodology involved the use of a cross-sectional household survey with 332 women and girls (aged 15-45 years and above) and 57 health providers. In-depth interviews with 4 frontline responders that included a nurse, a medical doctor, two representatives of women's rights organizations and 10 young and older women and men were also conducted as part of the survey. Three types of survey questionnaires (A Household Questionnaire, A Questionnaire for Women and Girls and A Questionnaire for Health Providers were used to facilitate the quantitative data collection with women and girls and health providers. The Household Questionnaire was used to identify women and girls eligible to be interviewed in the survey in each selected household. The Questionnaire for Women and Girls was then used to collect information on the socio-demographic characteristics of women and girls, their feeling of safety, knowledge of support services for SGBV, and their experiences of sexual and gender-based violence and difficulties in accessing sexual and reproductive health services before and during the Covid-19 pandemic. The Questionnaire for Health Providers, on the other hand, was used to collect data on the socio-demographic characteristics of health providers, their knowledge of cases of SGBV during the Covid-19 and capacity to provide support services for women survivors of SGBV, as well

[2] Gambia: Covid-19 & Public Safety - Gambia Records Unprecedented Cases of GBV. https://allafrica.com/stories/202104281000.html

as their training needs in responding to cases of SBGV. The survey also involved the use of a question guide which was used to collect qualitative data with frontline responders and young and older women and girls. The question guide collected information on knowledge, attitudes and perceptions towards SGBV among frontline responders, women, girls and men.

The survey results highlight some very interesting findings on the prevailing situation and prevalence of SGBV in The Gambia during the Covid-19 pandemic. The results showed (221) women and girls have reported fear that they might face risk of economic violence. A total number of (191) of women and girls also expressed anxiety that they might be subjected to physical violence. This is compared to a relatively few women and girls that reported fear that they might face sexual abuse (44) and sexual violence (52). A probable explanation for why the risk of economic violence might be more common among all forms of sexual and gender-based violence against women and girls during the Covid-19 pandemic could be related to the loss of income for husbands. During the in-depth interviews many women narrated that asking for the daily expenses when the husband has little or no money could lead to violence including physical violence, such as beating and the use of abusive language. The risk of physical violence against women by an intimate partner could also be linked to the adopted Covid-19 mitigation strategies including the stay-at-home measures that forced people to stay home.

Regarding their knowledge and access to information and use of SGBV support services, most women and girls (69.8%) do not know where to report violence or get information on services for victims of sexual and gender-based violence. Also, (69.9%) do not know of any telephone hotlines set up to support victims of violence during the Covid-19. But it is also interesting to note that an overwhelming majority (76.5%) of women and girls indicated that if a confidential hotline to report sexual and gender-based violence is to be provided or was available, they would use it.

> **...AN OVERWHELMING MAJORITY, (76.5%) OF WOMEN AND GIRLS INDICATED THAT IF A CONFIDENTIAL HOTLINE TO REPORT SEXUAL AND GENDER-BASED VIOLENCE IS TO BE PROVIDED OR WAS AVAILABLE, THEY WOULD USE IT. THIS IS AFTER 69.9% REPORTED THAT THEY DO NOT KNOW OF ANY DIGITAL SERVICES SETUP TO SUPPORT VICTIMS.**

The survey also found that access to and utilization of the available sexual and reproductive health (SRH) services among women and girls was generally low both before and during the Covid-19 outbreak. But there is a slight difference in the number of women and girls who reported accessing and using SRH services before and during the Covid-19 pandemic, with more women and girls reported going to the health facility for SRH services before than during the Covid-19 pandemic. This finding affirms that the Covid-19 pandemic has disrupted and limited women's and girl's access and use of the SRHS in the Gambia. The qualitative findings revealed that many women have avoided going to the health facilities for antenatal care (ANC) and postnatal care (PNC) in the early epidemic phase for fear of being infected with Covid-19.

To assess their feelings of safety, women and girls were also asked whether before and during the Covid-19 pandemic they have avoided using some streets or visiting some areas out of fear. It was found that before the Covid-19 outbreak, 47.9% of women and girls indicated avoiding using some streets or visiting some areas out of fear. This percentage increased to 56.8% of women and girls who reported that they have avoided using some streets or visiting

some areas out of fear during the Covid-19. Also, during the Covid-19, 127 had experienced emotional violence such as insults either by an intimate partner or non-partner. Of the women and girls who had experienced emotional violence, 74.4% did not know where to report the abusive behavior (s) they had experienced and 18.4% indicated that they were prevented from seeking healthcare or other forms of support by their abuser.

In general, 43.7% of women and girls thought that sexual and gender-based violence against women and girls by their partners, acquaintances or strangers is common in their community during the Covid-19 pandemic, whereas only 27% believed it is not common at all and 8.5% do not know if it's common in their communities. Of the women and girls who reported that SGBV during the Covid-19 are common in their communities, 175 knew of a woman or girl who had been a victim of emotional violence, 144 knew of a girl who was a victim of early forced marriage. At the same time, 125 stated that they knew of women or girls who have been a victim of physical violence. In addition, 70.4% indicated that cases of sexual and gender based violence occurs in their community and 60.5% indicated that they need support services on sexual and gender-based violence.

According to the survey results of health providers, the kinds of violence that women survivors of sexual and gender-based violence were subjected to was mainly sexual abuse and exploitation (50%) and the services requested by the women survivors were mainly referral to specialized gender-based violence (GBV) services (39.0%), followed by treatment of injuries (32.1%). When asked whether they or anyone of their health staff have ever received training on SGBV, only 16 (30.4%) indicated that they have received training on SGBV, the rest 36 (69.2) stated that they or their health staff had never received training on SGBV, and 41 (93.2%) felt that they need training on prevention and management of cases of sexual and gender-based violence.

The topic areas that the health providers indicated that they needed
training the most are on clinical management of rape (72.9%), followed by mental health and psychosocial support (60.4%).

In conclusion, the results of this baseline survey highlight the prevailing situation and prevalence of SGBV in the Gambia during the Covid-19. The findings suggest that in the communities where the survey was conducted
the perpetuation of economic violence and physical violence have increased during the Covid-19 pandemic, owing probably to the loss of economic income, particularly for husbands. The extended domestic stay for girls as a result of the school closure could also explain the reason why early and forced marriages were reported to be widespread during the Covid-19
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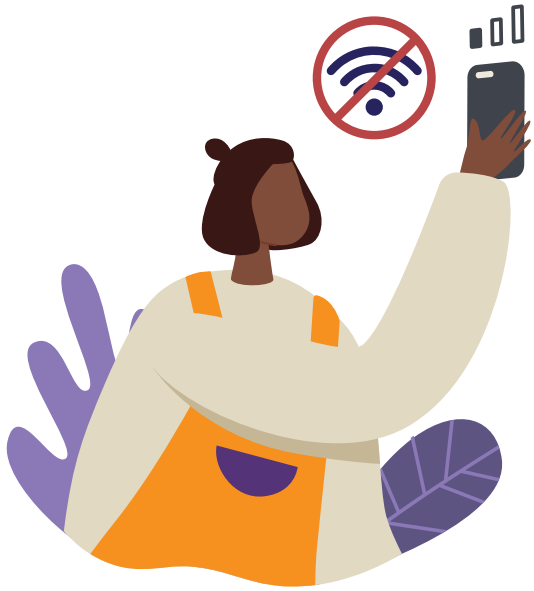


the perpetuation of economic violence and physical violence have increased during the Covid-19 pandemic, owing probably to the loss of economic income, particularly for husbands. The extended domestic stay for girls as a result of the school closure could also explain the reason why early and forced marriages were reported to be widespread during the Covid-19. Women and girls also reported difficulties in accessing SRHS and have limited knowledge of support services for survivors of SGBV. This finding suggests that future advocacy programs on Covid-19 in The Gambia should integrate awareness raising around SGBV and information about existing support services for survivors of SGBV during the Covid-19 pandemic. Information on hotlines for the prevention and management of cases of SGBV should also be made known to women and girls through the use of TV and radio which have been reported in previous studies in The Gambia as the most trusted sources of news on Covid-19. Gender and equality considerations should also be included in media reports of Covid-19 and in national response efforts including in the training of health providers. As reported by the health providers, a small number of them had ever received training on SGBV and expressed the need to be trained mainly on clinical management of rape and mental health and psychosocial support and injury treatment. Training for health providers in these topic areas could enhance their capacities to provide support services for survivors of SGBV both during and after the Covid-19 pandemic in The Gambia.

THE EXTENDED DOMESTIC STAY FOR GIRLS AS A RESULT OF THE SCHOOL CLOSURE COULD ALSO EXPLAIN THE THE REASON WHY EARLY AND FORCED MARRIAGES WERE REPORTED TO BE WIDESPREAD DURING THE COVID-19

SECTION ONE: BACKGROUND

The Coronavirus Disease - 2019 (Covid-19) was declared a pandemic of global magnitude by the World Health Organization on March 11, 2020. Since the declaration, countries have instituted response measures to curtail the spread and propagation of the virus. In the Gambia, since the first case of Covid-19 was confirmed on March 17, 2020[3], various response measures including physical distancing requirements, cancellation of public gatherings, closure of workplaces and borders have been implemented as part of a nationwide State of Emergency[4]. Although the government later relaxed these measures as the number of Covid-19 cases declined, the response measures may have already put women and girls at increased risk of sexual and gender-based violence. Evidence from diverse settings suggests that during global public health emergencies such as the Covid-19 pandemic, women and girls are at heightened risk of sexual and gender-based violence, including child marriage and female genital mutilation[5] and exposure to intimate partner violence[6] because household economics and social protection mechanisms during these periods are often disrupted[7,8,9]. Pandemics such as the Covid-19 could also affect women and girls' access to and utilization of existing sexual and reproductive health services[10,11].

In The Gambia, earlier studies have explored the socio-economic impact of Covid-19 and the effects of response strategies on women and girls[9]. The fact that the Covid-19 pandemic has been shown in previous studies[1-9] as having

[3] Darboe Mustapha K. Gambia confirms first coronavirus case. Anadolu Agency; 18 March 2020
[4] Mat Lowe. Using rapid online survey to assess public perceptions of Covid-19 in Gambia.
[5] Impact of the COVID-19 Pandemic on Family Planning and Ending Gender-based Violence, Female Genital Mutilation and Child Marriage.
[6] Schneider D, Harknett K and McLanahan S, Intimate partner violence in the great recession, Demography
[7] Paola Pereznieto & Ilse Oehler. Social Costs of the COVID-19 Pandemic. Background paper 9
[8] A Martin. Socio-Economic Impacts of COVID-19 on Household Consumption and Poverty
[9] Kansiime MK, Tambo JA, Mugambi I, Bundi M, Kara A, Owuor C. COVID-19 implications on household income and food security in Kenya and Uganda: Findings from a rapid assessment
[10] Laura D. Lindberg, Alicia VandeVusse, Jennifer Mueller and Marielle Kirstein. Early Impacts of the COVID-19 Pandemic: Findings from the 2020 Guttmacher Survey of Reproductive Health Experiences
[11] Zara Ahmed. COVID-19 Could Have Devastating Effects on Adolescents' Sexual and Reproductive Health and Rights.

negative impacts on sexual and reproductive health and services and support to communities and programs[1] vital in the fight against GBV suggests that it may exacerbate the prevalence of GBV in vulnerable communities in The Gambia. Anecdotal evidence[10] suggests that since the government imposed social distancing measures, there have been reported violence cases on women and girls in the forms of sexual harassment toward sex workers, rape, and child sexual violation. On March 20, 2020, some neighbors in the Greater Banjul Area also reported witnessing the harassment and assault of sex workers; three reported rape and sexual assault cases on 9, 10, and 17-year-old girls. The latter is said to be suffering from a mental disorder. Women-Led Organizations have also reported FGM and child marriage cases in communities due to the economic effects of the Covid-19 pandemic on families[11]. It is against this background that this baseline survey was conducted to support the collection and analysis of data on the prevalence and prevailing situation of gender-based violence in The Gambia during the Covid-19 pandemic. The survey is part of a larger project being implemented by Equals Now that seeks to address the effects of Covid-19 on women and girls' access to sexual and reproductive health rights and their safety from sexual and gender-based violence in The Gambia.

SECTION TWO: METHODOLOGY

2.1 DESIGN, PARTICIPANTS AND SAMPLING STRATEGY

The cross-sectional survey was done across the country with households selected by a systematic and convenience sampling to select respondents in each community leading to the usage of both quantitive and qualitative research methods. Households in the survey will be selected by systematic sampling and convenience sampling will then be used to select respondents within each household. Three Hundred and Thirty Two (332) respondents from one hundred and sixty six (166) households across fifteen (15) communities within the six administrative regions of The Gambia participated in the quantitative survey. The Inclusion criteria for participating in the survey was based on gender and age, targeting women from age of 15 who had experience of or need access to sexual and

A total sample of 500 respondents was targeted for the household survey. However, the survey ended up recruiting 332 respondents from 166 households across fifteen (15) communities across all the six administrative regions of The Gambia. Table 1 below compared with the other administrative regions, the North Bank Region had the highest number of surveyed communities because of its geographic location and ethnic representation. Compared with the other administrative regions, the North Bank Region had the highest number of surveyed communities because of its geographic location and ethnic representation. These were reasons for selecting more communities in the North Bank Region than in the other administrative regions.

Table 1: Survey Communities

Region	Name of community
West Coast Region	Darsilameh Giboro Kuta Kerr Ardo
North Bank Region	Kerr Ali Sare Jamiddo Sakalang Wollof Bangadara Tallen Fula Chogen Fula
Upper River Region	Nyamanarr Fatoto
Central River Region	Tabanding Njallal Toro
Lower River Region	Sibito Dingria

In each administrative region, communities were selected based on convenience and simple balloting proportional to population size and ethnic representation. The Directory of Settlements of the 2013 Population and Housing Census of the Gambia served as the sampling frame for selecting the survey communities in **Table 1** above.

The baseline survey also targeted a sample of 100 health providers but interviewed a total of 57 health providers. The survey team used a combination of snowball and convenient sampling methods to recruit the health providers who participated in the survey. Focus group discussions were also planned but because of the sensitive nature of the research topic they could not be held. Instead, individual in-depth interviews were conducted in 4 communities (namely, Banjul, Jambangjelly, Farafenni, and Basse) with women and men. The participants for the individual in-depth interview were chosen based on their openness to discussing sexual and gender-based violence issues.

Two types of questionnaires (a Household Questionnaire and Questionnaire for Women and Girls and a Frontline Responders Questionnaire were used to collect quantitative data. The Household Questionnaire was used to identify women and girls eligible to be interviewed with the Questionnaire for Women and Girls in each selected household. On the other hand, the Questionnaire for Women and Girls was used to collect information on the socio-demographic characteristics (such as age, ethnicity, religion, education level) of women and girls and their experiences of sexual and gender-based violence and in accessing sexual and reproductive health services before and during the Covid-19 pandemic. The questionnaires were developed based on a review of similar studies, the experience of the lead consultant and the objective of the baseline survey. The questionnaires were pilot tested before they were put to full-scale administration. The survey was conducted by a team of 10 field researchers, who were trained by the lead consultant on the administration of the survey questionnaires. The training was held from July 5-6, 2021, and consisted mainly of group discussions and simulation exercises on the survey questionnaires.

For the quantitative data management and analysis, following completion of the data collection, a Database was developed using Google Form and used to enter the survey data. After the data entry, the individual responses of the survey were exported and downloaded in Excel file format and used to validate the data. Finally, survey results were calculated and presented using simple frequency and percentage. For the qualitative data management and analysis, the data resulting from the individual in-depth interviews were audio-recorded, transcribed verbatim, and investigated manually using deductive and inductive thematic analyses.

2.3 ETHICAL CONSIDERATIONS

Informed consent, verbal and written depending on the level of literacy was obtained from survey respondents. Respondents were informed about the purpose of the survey, confidentiality of the data and data collection process. And their reserved rights to participate or not to participate. Courtesy calls were made to village heads (locally known as "Alkalo") in the selected survey communities to inform them about the purpose of the survey and to seek their permission. The research team also sought heads of households on behalf of respondents for any interview. Due to the culturally sensitive nature of the survey topic, interviews were held in places considered safe for women and girls,

such as either at the village health post or community development center, to ensure that respondents can express themselves freely and are safe from reprisal.

ETHICAL CHALLENGES

The nationwide research trip led us into very remote areas of The Gambia. We were able to meet young girls and women to seek to understand the impacts of Covid-19 on their lives and livelihoods. Although, the baseline survey was successfully completed, it was not devoid

Despite the team being a diverse one, there were villages where language was a barrier and delayed the interview process. In some of these instances, only one or the respondents because they were the only ones who understood the language, and this was overwhelming on them.

The **location** of some of the villages are very remote and **accessing** them especially during the rainy season when the research was carried out, was extremely difficult. There have been instances where the vehicle got stuck in the mud and on one occasion the team had to choose a different community

Fear and years of **Socialization** made it challenging to access the respondents or get accurate information from them. On several occasions, a respondent either refuses to answer some questions due to fear or due to socialization, believes that gender-based violence is normal and acceptable. In some communities, the team isolates the respondents so they can have open and honest conversations, however their male counterparts for some reason, loiter around and this made

Throughout the data collection, mask wearing, handwashing with soap and physical distancing was promoted among the research team to minimize risk of infections.

In addition, because the survey covered sensitive and stigmatized issues around gender-based violence, care was taken to ensure that all questions were asked in a culturally-respective and non-judgmental way.

This was achieved through the careful training of Field Researchers, as well as by the design of the survey questionnaires. Field Researchers were trained on the sensitivity of the survey topic and possible effects that the questions could have on them and on the respondent. They were informed that the respondent is at liberty and free to terminate the interview at any point that the effects of the interview seemed too negative. For minors under the age of 18 years, informed consent will be sought from their parents or guardians and particular age-specific and appropriate statements will be included to ensure that the survey is understood and to prevent them from feeling obliged or pressured to participate. All interviews ended on a positive note with the Field Researcher reinforcing the respondent's own coping mechanisms and reminding them that the information they shared is important and will be used to help other women.

SECTION THREE: RESULTS

Table 1: Demographic information of respondents

Variable	Frequency (%)
Marital status	
Married	209 (63)
Never married	98 (29.5)
Widow	15 (4.5)
Divorced	7 (2.1)
Cohabiting	3 (0.9)
Religion	
Muslim	326 (99.1)
Other	3 (0.9)
Ethnicity	
Mandinka	65 (19.6)
Fula	133 (40.1)
Wolof	86 (25.9)
Sarahuleh	17 (5.1)
Serer	9 (2.7)
Bambara	9 (2.7)
Jola	5 (1.5)
Other	8 (2.1)
Education level	
University	2 (0.6)
High school	81 (24.8)
Primary school	57 (17.4)
Technical training	2 (0.6)
Other	130 (39.8)
No schooling completed	55 (16.8)
Disability	
Yes	86 (26.6)
No	237 (73.4)
Age	
15-18	9 (12.0)
19-22	11 (15.0)
23-27	9 (12.0)
28-31	7 (10.0)
32-36	9 (12.0)
37-40	9 (12.0)
41-44	3 (4.0)
45 and above	15 (21.0)

3.1 HOUSEHOLD SURVEY

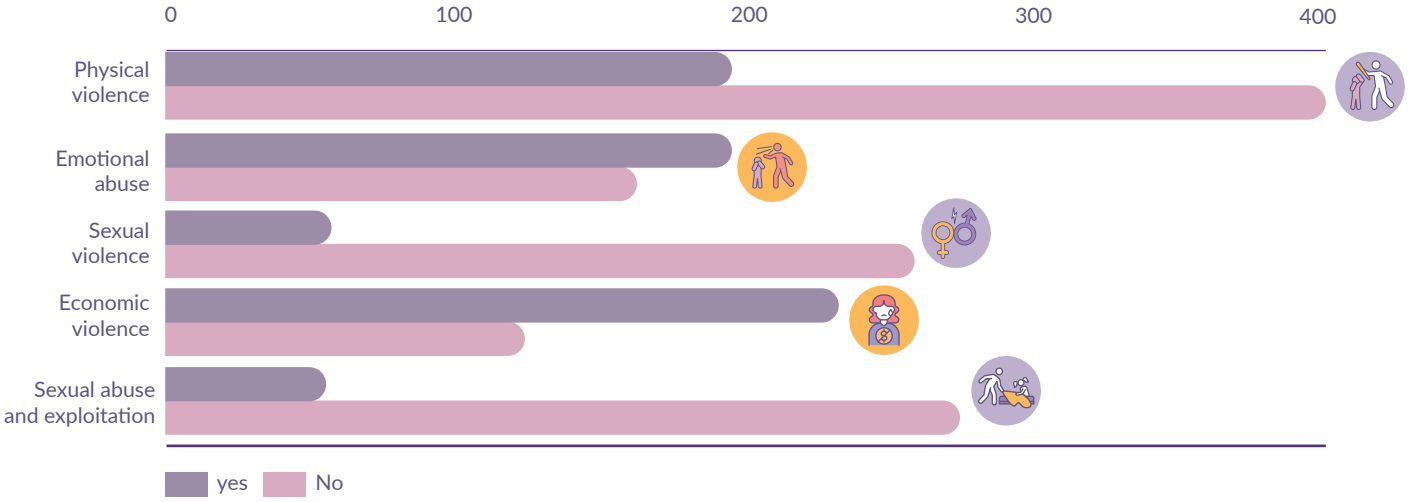
3.1.1 Demographic information of respondents

All the respondents in the household survey were female, of which 63% are married, 29.4% have never been married, while 4.5% are widow. In addition, 99.1% are Muslim. In terms of ethnicity, 19.6% are Mandinka, 25.9% are Wolof and 40.1% belong to the Fula ethnicity. 26.4% of respondents indicated having some form of disability. Categorizing by age range, the majority of respondents were aged 45 years and above, followed by aged 19 to 22 years.

3.1.2 Risk of sexual and gender-based violence against women and girls

When asked whether they might face the risk of any form of sexual and gender-based violence during the Covid-19 pandemic, a significant number of women thought they might face the risk of economic violence (221) and physical violence (191). However, very few women reported fear that they might face sexual abuse (44) and sexual violence (52), respectively. A probable explanation for why the risk of economic violence might be more common among all forms of sexual and gender-based violence against women during the Covid-19 pandemic could be related to the loss of income for husbands. In addition, the risk of physical violence against women by an intimate partner might also be more pronounced during the Covid-19 pandemic due to the measure message of stay-at-home that promotedextended domestic stays for both men and women.

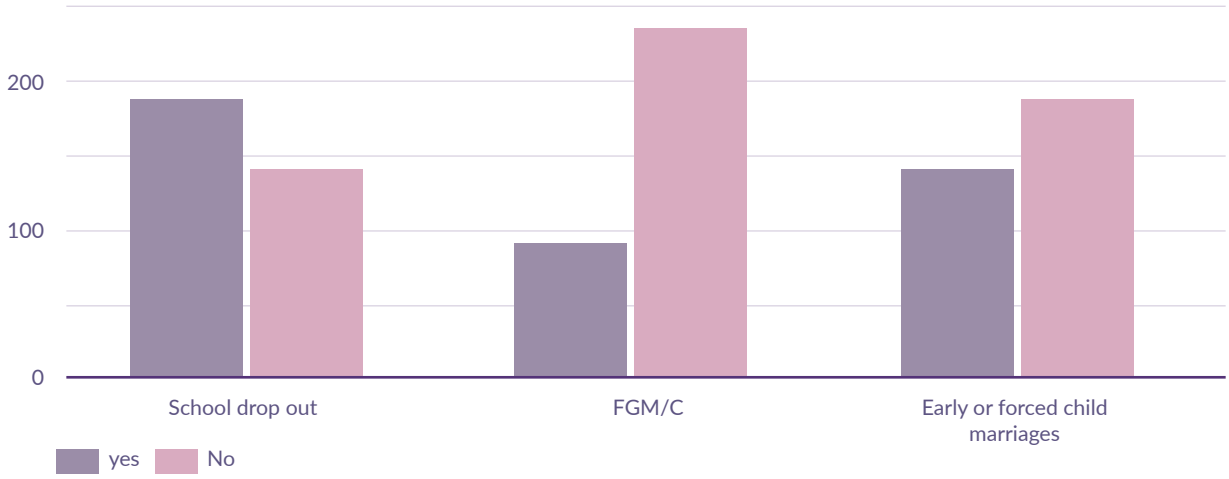
Figure 1. Risk of sexual and gender-based violence against women during the Covid-19 pandemic

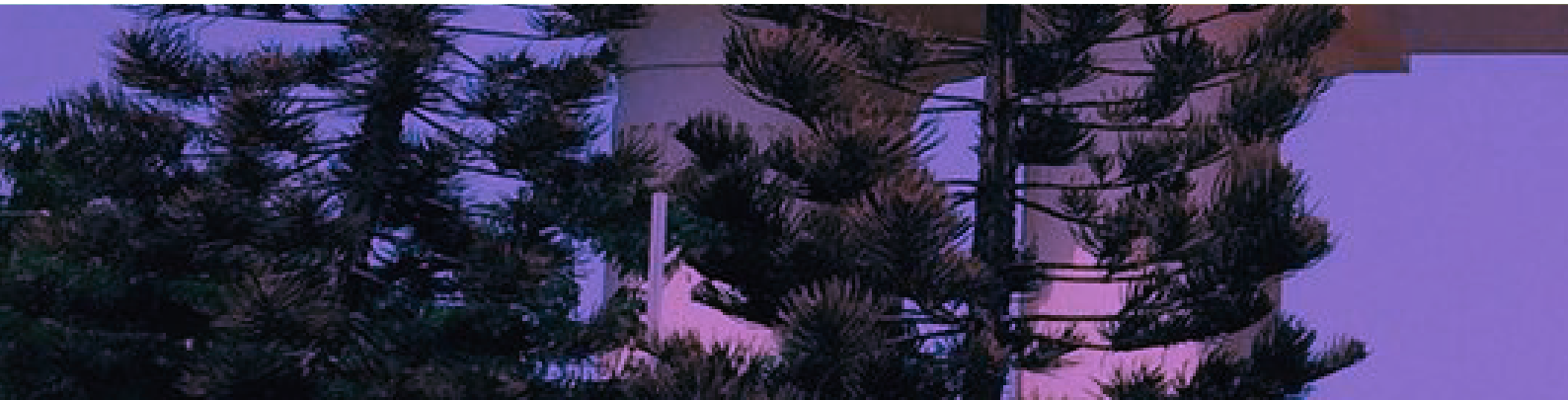


The risk of sexual and gender-based violence was also reportedly high for girls. For example, many women reported that girls in their community might leave school or there was a high chance of them getting married early due to the school closures.

However, the number of women who reported fear that girls might face the risk of female genital mutilation was lower (93) compared with the risk of school dropout (189) and child, early and forced child marriages (144).

Figure 1. Risk of sexual and gender-based violence against women during the Covid-19 pandemic





3.1.3 Knowledge about GBV hotlines

With reference to reporting violence, most women and girls 69.8% do not know where to report violence or get information on services for victims of gender-based violence. Also, 69.9% do not know of any telephone hotlines set up to support victims of violence during the Covid-19 pandemic. However, an overwhelming majority 76.5% indicated that if a confidential hotline to report gender violence is to be provided or was available, they would use it. A woman echoed: **"Yes. I would use it if there is any because we need it".**

3.1.4 Access to and use of available SRH services

Although access to and utilization of the available sexual and reproductive health (SRH) services among women and girls was generally low both before and during the Covid-19 outbreak, there is a slight difference in the number of women and girls who reported accessing and using SRH services before and during the Covid-19 pandemic, with more women and girls reported going to the health facility for SRH services before than during the Covid-19 pandemic. A respondent in the in-depth interview explained this situation in the following: "We cannot go to the hospital during the early phase of the epidemic because of fear that we might be infected with Covid-19". Another added: **"It was really not safe during that time. There were physical distancing requirements and even health care workers were not readily available at the point of care. They were also very worried of being infected with Covid-19"**. These statements demonstrate that during Covid-19 pandemic had impacted access and utilization of the available sexual and reproductive health services for women and girls.

Table 2: Knowledge about and use of hotlines for reporting SGBV

Response (Yes/No)	Frequency (%)
Do you know where to report violence or get information on services for victims of gender-based violence?	
Yes	98 (30.2)
No	227 (69.8)
Are you aware of any telephone hotlines set up to support victims of violence during the COVID-19 pandemic?	
Yes	99 (30.1)
No	230 (69.9)
If a confidential hotline to report gender violence is to be provided or was available, do you think you would use it?	
Yes	250 (76.5)
No	77 (23.5)

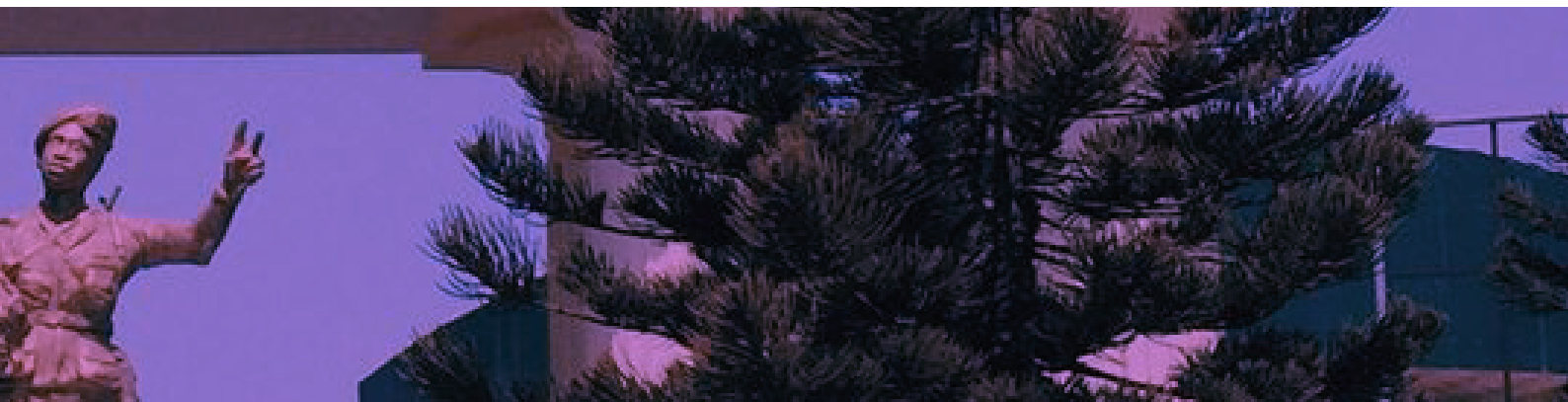
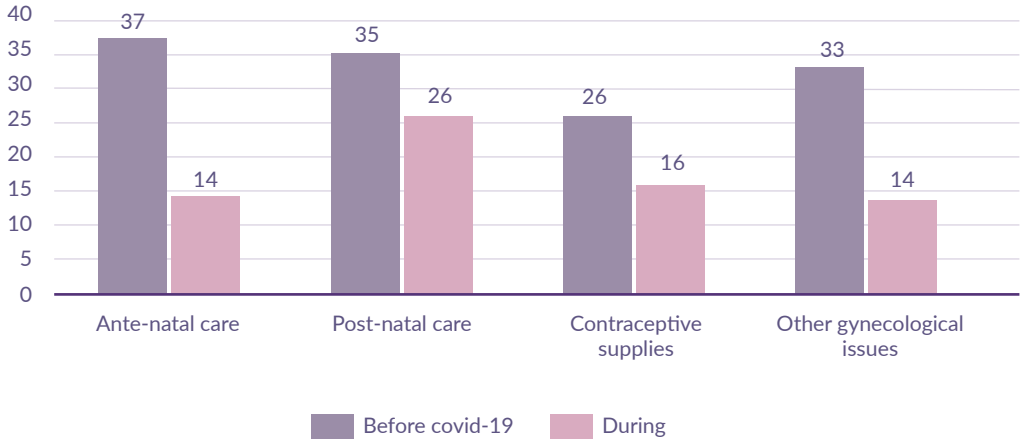


Figure 3. Access to and use of SRH services before and during Covid-19



3.1.5 Feelings of safety during and before the Covid-19 pandemic

To assess their feelings of safety, women and girls were asked whether before and during the Covid-19 pandemic, they have avoided using some streets or visiting some areas out of fear. Before the Covid-19 outbreak, 47.9% of respondents indicated avoiding using some streets or visiting some areas out of fear. This percentage increased to 56.8% of respondents who reported they are currently avoiding using some streets or visiting some areas out of fear. Many women and girls reported that they avoided certain streets particularly during the state of emergency **"because the street where disserted and felt that were not safe since there were not many people going out".**

3.1.6 Experiences and perceptions of sexual and gender-based violence

During the last twelve months, 70 respondents experienced beatings, 127 experienced insults, 32 experienced Sexual assaults and 45 experienced Cyberstalking and harassment either by a partner or non-partner. Of the women and girls who had experienced sexual and gender-based violence, 74,4% did not know where to report the abusive behavior(s) they had experienced and 18.4% indicated that they were prevented from seeking healthcare or other forms of support by their abuser. Even if they know where to seek medical care and support services, many women reported that they are largely dependent on their husbands for finances to seek care. A woman explained:

YOU CANNOT GO BECAUSE YOU DO NOT HAVE MONEY FOR TRANSPORTATION AND OTHER RELATED EXPENSES. SO, YOU ARE LEFT WITH NO OPTION BUT TO STAY AT HOME.

3.1.7 Prevalence of sexual and gender-based violence

In general, 43.7% of women and girls thought that sexual and gender-based violence against women and girls by their partners, acquaintances or strangers are common in their community during the Covid-19 pandemic, whereas only 27% believed it is not common at all and 8.5% do not know if it's common in their communities. Of the women and girls who reported that SGBV during the Covid-19 is common in their communities, 175 knew of a woman or girl who has been a victim of emotional violence, 144 knew of girls who had been subjected to early and forced marriage, while 125 stated that they knew of a woman or a girl who has been a victim of physical violence. In addition, 70.4% indicated that gender-based violence occurs in their community and 60.5% of indicated needing support services on sexual and gender-based violence.

Figure 5. Types of violence that women survivors of SGBV were subjected to

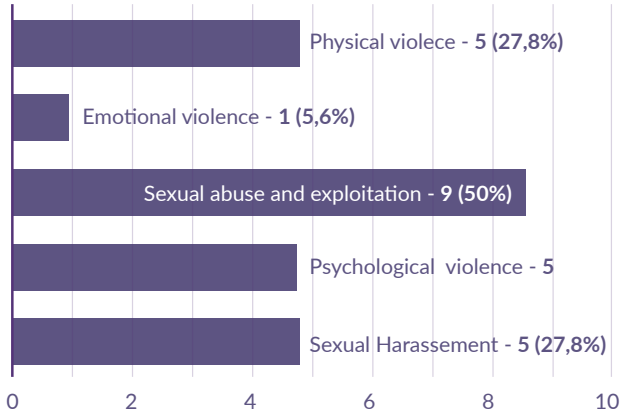
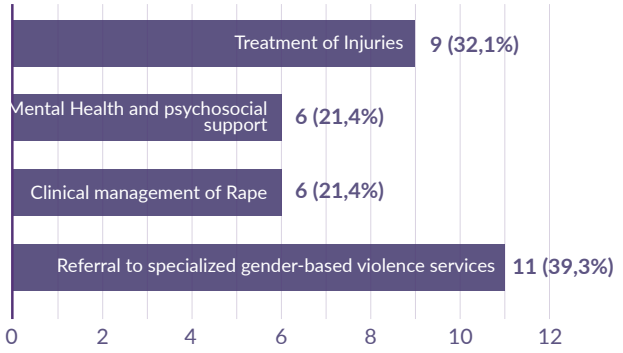


Figure 6. SGBV services requested by women survivors



3.2.3 Training on SGBV for health providers

When asked whether they or anyone of their health staff have ever received training on SGBV, only 16 (30.4%) indicated that either they or their health staff have received training on SGBV, the rest 36 69.2 stated that they or their health staff have never received training on SGBV, and 41 93.2% felt that they need training on prevention and management of cases of sexual and gender-based violence. The topic areas that the health providers indicated they needed training the most are on clinical management of rape 72.9%, followed by mental health and psychosocial support 60.4% and injury treatment 33.3%

Table 3. Demographic information of health providers

Response	Frequency (%)
Have you or your health staff received training on SGBV?	
Yes	16 (30.8)
No	36 (69.2)
Do you feel you need training on prevention and management of cases of sexual and gender-based violence?	
Yes	41 (93.2)
No	2 (4.5)
Maybe	1 (2.3)
If you feel you need training on prevention and management of cases of sexual and gender-based violence, please state on what topics ?	
Injury treatment	16 (33.3)
Clinical management of rape	35 (72.9)
Referral to specialized GBV services	19 (39.6)
Referral to specialized GBV services	29 (60.4)

3.2 HEALTH PROVIDER SURVEY

3.1.3 Knowledge about GBV hotlines

Among the 57 health providers who participated in the survey of frontline responders, (51.9%) were female and (48.1%) are male. The larger majority (77.8%) between the ages of 25 to 40 years old. Most of them hold a certificate or a diploma (60.4%) and are nurses (83%).

Table 3. Demographic information of health providers

Variable	Frequency (%)
Sex	
Male	26 (48.1)
Female	28 (51.9)
Age	
18-24 years	10 (18.5)
25-40 years	42 (77.8)
41-50 years	1 (1.9)
51 years and above	1 (1.9)
Educational Level	
Certificate/ diploma	32 (60.4)
Bachelor's degree	13 (24.5)
Higher school leaving certificate	5 (9.4)
Master's degree	2 (3.8)
Doctorate degree	1 (1.9)
Occupation	
Medical doctor	6 (11.3)
Nurse	44 (83.0)
Lab Scientist	1 (1.9)
Student nurse	1 (1.9)

3.2.2 Sexual and gender-based cases reported by health providers

When asked whether their health facility has seen an increase of women survivors of sexual and gender-based violence coming for help during the Covid-19 outbreak, 16 (30.2%) indicated that their health facility has seen an increased in women survivors of sexual and gender-based violence during the Covid-19. The kind of violence that the women survivors of sexual and gender based violence were reported by the health providers reported that sexual abuse and exploitation (50%) were the most common types of sexual violence that women sought services for, where 39% of these women were referred to specialised gender based violence service providers and of these 32.1% were treated of injuries from the abuse.

SECTION FOUR. CONCLUSIONS AND RECOMMENDATIONS

The findings of this baseline survey highlight the prevailing situation and prevalence of SGBV in the Gambia during Covid-19. The findings suggest that in the communities where the survey was conducted the perpetuation of economic and physical violence by an intimate partner have increased during the Covid-19 pandemic, owing probably to the loss of economic income, particularly for husbands and the extended domestic stay that were promoted as Covid-19 mitigation strategies. The extended domestic stay for girls as a result of the school closure could also explain the reason for why early and forced marriages were reported to be widespread during the Covid-19. Women and girls also reported difficulties in accessing SRHS and have limited knowledge of support services for survivors of SGBV. This findings suggest that advocacy programs and public health interventions on Covid-19 in The Gambia should integrate awareness raising around SGBV and information about existing SRHS services during the Covid-19 pandemic. Information on hotlines for SGBV should also be disseminated to women and girls through the use of TV and radio which have been reported in previous studies in The Gambia as the most trusted sources of news on Covid-19. Gender and equality considerations should also be included in media reports of Covid-19 and national response efforts including in the training of health providers. As reported by the health providers many of them have not been trained on SGBV and expressed the need to be trained, particularly on clinical management of rape, mental health, psychosocial support and injury treatment were most regarded as topic areas that they needed training the most. These trainings could enhance the capacity of health providers to provide support services to victims and survivors of sexual and gender-based violence both during and after the Covid-19 pandemic.

"EXPRESSED THE NEED TO BE TRAINED PARTICULARLY ON CLINICAL MANAGEMENT OF RAPE, MENTAL HEALTH, PSYCHOSOCIAL SUPPORT AND INJURY TREATMENT"

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