

CASE STUDY

Integrating gender-based violence considerations into public health emergencies preparedness and response

This case study – focused on UNICEF’s experience integrating gender-based violence (GBV) considerations into public health emergencies preparedness and response – is part of a broader, global project that aims to capture learning, innovative approaches and practical resources on how GBV risk mitigation has been institutionalized within humanitarian response. The project was led by UNICEF, with generous support from the USAID Bureau of Humanitarian Assistance and in collaboration with an inter-agency advisory group.¹

1. Background

Since the launch of the revised [Inter-Agency Standing Committee \(IASC\) Guidelines on Integrating Gender-Based Violence Interventions in Humanitarian Action](#) in 2015, integration of GBV risk mitigation into programming and coordination has gained significant traction across multiple sectors and levels of humanitarian response. In recent years, there has been increasing recognition that to ensure sustainability of these advancements, GBV risk mitigation must also be firmly anchored in the institutional elements that underpin programming.

GBV risk mitigation institutionalization focuses on shifting institutional systems, structures and processes (‘institutional DNA’) to ensure GBV-related risks are proactively identified and addressed in a predictable, self-sustaining manner. What this means in practice is that **humanitarian response is delivered in a way that is safer for and more accountable to women and girls – across every sector, in every emergency, throughout each phase of preparation, response and recovery.**

Through institutionalization, GBV risk mitigation becomes part of the organization’s or humanitarian sector’s standard ways of working and accountability frameworks. It gets triggered automatically and predictably – rather than being dependent on individual personalities or a particular set of contextual factors – meaning GBV specialists can focus less of their time advocating for GBV risk mitigation and instead focus on its implementation (through technical support, capacity-building and adapting tools to fit the context).

2. Introduction

This case study examines why it is important to address GBV within public health emergencies (PHEs – see box 1), the consequences of not doing so, and UNICEF’s efforts to better integrate GBV into PHE responses. It focuses on the collaboration between the UNICEF PHE and Gender-Based Violence in Emergencies (GBViE) teams at Headquarters (HQ) to prevent, respond to and mitigate risks of GBV within UNICEF’s PHE responses. The case study highlights a variety of institutionalization entry points leveraged to advance GBV integration in PHE responses, such as programmatic standards; strategies and policies; and planning and reporting mechanisms.

Working closely with UNICEF staff, information was gathered by Tsunagu, an external consulting team with GBV expertise, through review of primary and secondary documents mostly dated from 2015 to 2024, including organization-specific and/or inter-agency PHE response and preparedness plans. Seven interviews with selected practitioners involved in relevant processes and GBV response work also informed the overview.

Box 1

Public health emergencies

According to UNICEF’s Operational Response Plan Framework for Public Health Emergencies, a public health emergency is “the occurrence or imminent threat of an infectious disease outbreak or other threat whose scale, timing, or unpredictability threatens to overwhelm routine capacities to respond, and poses a substantial risk to the public’s health including excess deaths and/or disability.”² Public health emergencies also include chemical, biological, radiological and nuclear events. Characteristics distinguishing PHEs from other humanitarian emergencies include:

- The response coordination is almost always led by government supported by the World Health Organization (WHO), outside humanitarian cluster or sector coordination mechanisms.
- Rather than interventions organized by sector, PHEs use ‘pillars’ of the public health emergency response, which can be adjusted based on the type of PHE.
- Not all PHEs are considered humanitarian emergencies, nor do they always happen in humanitarian contexts.

3. The relationship between gender-based violence and public health emergencies

Globally, at least one in three women will experience some form of gender-based violence in their lifetime,³ and it is well recognized that humanitarian crises increase the risk of violence for women and girls. While the gendered impact of PHEs has received less attention, research from the coronavirus disease (COVID-19), Ebola virus disease (EVD,⁴ the severe acute respiratory syndrome (SARS), swine flu (H1N1), and cholera⁵ have clearly demonstrated that GBV also increases during PHEs. In parallel, PHEs can result in response services for GBV survivors becoming less available and/or accessible, as evidenced most acutely during the global COVID-19 pandemic where GBV response services were closed, reduced or only available remotely (as part of ‘social distancing’ measures); de-prioritized or not included at all within ‘essential services’ criteria; and/or de-funded in order to redirect financial resources to other components of the public health response.^{6,7}

The specific risks to women and girls vary depending on the type of PHE and necessary response measures. Generally, PHEs can amplify household stress, increase the likelihood of women and girls being confined with abusive partners or other perpetrators, disrupt education and income, heighten care responsibilities, fragment women’s and girls’ social and protective networks, and diminish access to vital services, such as reproductive health care, including GBV services.⁸ These conditions often lead to a surge in intimate partner violence⁹ sexual violence,¹⁰ and the adoption of harmful coping mechanisms,¹¹ escalating the risks of sexual exploitation and abuse and early and forced child marriage.¹² During the COVID-19 pandemic, the reliance on technology for work, social interactions and education also exposed women and girls to more technology-facilitated GBV.¹³ Finally, PHEs can also increase violence against health workers, disproportionately affecting women who constitute the majority of this vital workforce.¹⁴

3.1 The impact of PHEs on women and girls

PHEs can exacerbate and entrench gender inequalities that existed prior to the emergency. Women and girls who experience intersecting forms of discrimination based on age, race, sexual orientation, disability, migration status, and other factors are particularly vulnerable to negative impacts. Some of the primary ways in which PHEs disproportionately affect women and girls include:

Increased care work burden. The burden of unpaid care work, which already disproportionately falls on women and girls, often increases dramatically during PHEs. Globally, women shoulder a significantly larger share of unpaid care work compared to men, with the International Labour Organization (ILO) estimating that men’s contribution scarcely exceeds one-fourth of the total burden.¹⁵ During the COVID-19 pandemic, this inequality in care responsibilities intensified, as “mothers were nearly three times as likely as fathers to report that they took on the majority or all of additional unpaid care work related to school or childcare facility closures.”¹⁶ This not only adversely impacts women’s mental health and well-being

but also increases the likelihood of them being forced to exit paid employment.¹⁷ When care work extends to caring for ill family and/or community members, this also increases caregivers' exposure to pathogens.

Increased economic and social vulnerability.¹⁸ Women are more vulnerable to the economic shocks that can occur with PHEs, particularly as they are more likely to be in informal employment¹⁹ and engaged in precarious jobs that lack social and legal protections or employment benefits.²⁰ In some contexts, women face barriers to using both formal and informal financial and banking systems and have access to fewer financial protections such as government bailouts and emergency subsidies.²¹

Job loss may also disproportionately affect women.²² In COVID-19, while many women lost jobs and their unpaid care and household work increased, they were also impacted by the loss of household income due to a death or lost earnings from the main breadwinner. Women and adolescent girls reported that during PHEs, an increased burden was placed on them to compensate for the loss of or decreased household income.²³ Such situations increase risks of sexual exploitation and sexual abuse.²⁴

Higher risk of education disruption or drop-out. PHE's can negatively impact children's education in highly gendered ways. The school closures during COVID-19 and the West Africa Ebola outbreak of 2014–2015 offer a striking example of the educational and protection risks girls can experience:

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*In Liberia, about 8 of every 100 girls of primary school age were out of school before the outbreak [Ebola]. By 2017, this number had almost tripled to 21. Similarly, in Guinea, as of 2018, girls were 25 per cent less likely than boys to enrol in secondary school compared with pre-crisis levels. One study from Sierra Leone found that girls in highly affected communities were 16 per cent less likely to be in school after they reopened. In the face of greater poverty and parental mortality, girls took on more domestic responsibility and were at increased risk of sexual exploitation, with many forced into transactional sex. In areas where Ebola caused high disruption, girls aged 12 to 17 were 7.2 per cent more likely to become pregnant. Figures show that the outbreak caused the overall teenage pregnancy rate to double.*²⁵

School closures halted gains in girls' education and increased dropouts, leading to increased risks of child marriage, early pregnancy and violence. This has long-term repercussions on girls' livelihoods and on communities as girls' education correlates with delayed marriage, higher incomes, better participation of women in decision-making and better child health, including through increased vaccination rates.²⁶

Lack of access to health services. PHEs often cause significant disruptions to health services, as PHE-related services become prioritized and control measures create more barriers to access. Past PHE responses have shown significant gaps in sexual and reproductive health services in particular, with serious impacts on maternal mortality and morbidity.²⁷ For example, during the West Africa Ebola outbreak:

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In Liberia, access to antenatal care declined by 50 per cent and reported deliveries by skilled attendants and facility-based deliveries declined by 32 per cent and 47 per cent, respectively ... a 10 per cent decline in proportions of women receiving sexual and reproductive health services across 132 low and middle-income countries in April 2020, primarily in Africa and Asia, due to COVID-19, resulting in an estimated 49 million women with unmet needs for contraceptives, 15 million unintended pregnancies within a year, 1.7 million women and 3.6 million newborns experiencing significant complications, and 28,000 maternal deaths and 168,000 newborn deaths.²⁸

Women and girls also face increased barriers to prevention and treatment during epidemics. For example, in the Democratic Republic of the Congo some women faced information, misinformation and financial barriers to receiving treatment and care related to Ebola.²⁹ Similarly, during the COVID-19 pandemic, there was an initial gender gap in vaccination uptake as women reported “significantly higher vaccine hesitancy (25.6% [95% uncertainty interval 24.6–27.2]) compared with men (22.3% [21.1–23.5])”, though this gap decreased over time.³⁰

3.2 Why prioritize GBV in PHEs?

The relationship between GBV and PHEs has been described as ‘syndemic’, meaning GBV and the public health emergency synergistically reinforce the risks and negative impacts that would otherwise arise if either epidemic occurred in isolation.³¹ When a PHE response does not consider such risks of violence or specific needs of women and girls, the response can exacerbate GBV. Furthermore, the lack of consideration of GBV and inclusive planning affects the effectiveness of the PHE response and its reach.

For instance, during the 2023 cholera outbreak in the Democratic Republic of the Congo, the Ministry of Health (Cellule d'Analyse Intégrée) documented a syndemic between GBV and cholera, observing a higher cholera burden in women. At the same time, many women and girls noted feeling unsafe using latrines, potentially increasing their exposure to cholera through open defecation practices.³² As a key informant with a public health background articulated:

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I think you can't have a quality public health emergency response if you don't consider GBV risk mitigation. You just can't. If we're there to serve people, our job is to make sure that they're safe to access services ... So if you're not including that [GBV risk mitigation] in the response, people won't come, or they will come at a very high cost ... Everything is at risk if you don't consider it.³³

Additionally, despite the heightened need for GBV services during PHEs, barriers to access GBV support often increase, particularly in the early stages. Pre-existing barriers such as stigma, gaps in knowledge and information about available GBV services,³⁴ and fear of safety and retribution by perpetrators,³⁵ persist or worsen. At the same time, new barriers emerge due to public health measures and the nature of the public health threat, including fear of virus exposure,³⁶ misinforma-

tion about the nature of transmission or public health response measures, closure or reduction of GBV services (due to de-prioritization of GBV services and redirection of GBV funding to public health response),³⁷ and mobility restrictions.³⁸

In general, PHE responses have not historically implemented sufficient measures to address GBV.³⁹ Gender considerations have not been systematically incorporated into global health policy and practice, despite women's pivotal roles in public health emergencies.⁴⁰ Research on gender, human rights and PHEs found that “less than 1 per cent of published research papers on the Ebola [West Africa] and Zika public health emergencies have explored the gendered impact and implications of these outbreaks.”⁴¹

More recent public health crises, such as the global COVID-19 pandemic, reflect a shift, at least in the recognition of the links between PHEs and GBV. The scale and severity of COVID-19 brought attention to the challenges women face as caregivers, the solutions they can bring, and the increase in GBV due to lockdown measures, which was coined a ‘shadow pandemic’ – a term that gained traction among responders.⁴² However, this increased attention has not yet translated into tangible measures to address GBV within PHE responses. Many response plans for Ebola,⁴³ Zika⁴⁴ and COVID-19 inadequately addressed gender, GBV, GBV risk mitigation, and Protection from Sexual Exploitation and Abuse (PSEA). Factors that have been cited as persistent barriers to action include: the tendency to view gender as secondary to other priorities, limited understanding of the gendered impacts of PHE, insufficient data on GBV within PHEs, the lack and/or marginalization of gender experts within PHE response teams, and the exclusion of gender considerations in PHE evaluations and other data collection exercises.⁴⁵

Importantly, the lack of women's representation in PHE decision- and policy-making structures at all levels is also a factor. Despite comprising the majority of the front line health workforce responding to pandemics, women are underrepresented in PHE leadership positions.⁴⁶ While women and girls were recognized as key to the COVID-19 response in traditional gender roles as caregivers, they were not occupying spaces as leaders or decision-makers, potentially exacerbating pre-existing gender inequality.⁴⁷ Analysis of decision-making bodies related to COVID-19 in 87 countries found only 3.5 per cent achieved gender parity. Some scholars have noted that the “first, second and third International Health Regulations Emergency committees consisted of 23.8%, 23.8% and 37.5% women, respectively.”⁴⁸ Many organizations have advocated for women's meaningful participation and presence in leadership roles in PHE responses,⁴⁹ noting that the absence of women's and girls' voices in decision-making across PHEs can result in policies and programmes that do not adequately respond to their needs.⁵⁰

4. Triggers motivating action on gender-based violence risk mitigation in UNICEF's public health emergency response

The mounting evidence over the last 10 years, especially research coming from within the health sector as well as multi-disciplinary work in women's health for example, has helped draw attention to GBV among health practitioners and actors. Further, COVID-19 and the high-profile reports of sexual exploitation and abuse in the Democratic Republic of Congo during the Ebola response of 2018–2020 served as significant sector 'wake up calls' regarding risks of GBV. These influential events were triggers for action to better institutionalize GBV risk mitigation.

4.1 COVID-19 global pandemic

Despite the growth of evidence and understanding of the gendered impacts and GBV risks in previous PHEs, the unprecedented magnitude of COVID-19 meant that individuals globally not only witnessed but directly experienced a PHE. This impact included GBV risks within the PHE response, an increase in GBV cases, reduced availability and accessibility of GBV services, and related consequences for survivors. It also highlighted the critical roles that women and girls play in PHE response.

In the first six months of the COVID-19 pandemic, multiple multilateral institutions, women's groups and organizations, philanthropists, experts, media commentators, journal editors and social media groups highlighted both the importance of gender in understanding pandemics and how gender was shaping the differential impacts on societies of this particular outbreak.⁵¹ Several communications from the United Nations Secretary General, UNICEF Executive Team and other agencies regarding GBV and PHE also helped emphasize that GBV risk mitigation must be a mandatory component in providing a safe and accessible PHE response (see box 2).

Box 2

High-level communications and commitments related to COVID-19 and GBV⁵²

- United Nations Secretary General video message on GBV and COVID-19 (5 April 2020) calling for 'peace at home' and signalling the spike in domestic violence cases during lockdowns and insufficient services.⁵³
- UN Women brief on the shadow pandemic (6 April 2020)⁵⁴ which becomes a key term to describe the impact of COVID-19 on women and girls.
- WHO Guidance Note 'COVID-19 and violence against women: What the health sector/ system can do'⁵⁵ (7 April 2020).
- Women's Rights Committee of the European Parliament Statement (7 April 2020), 'COVID-19: Stopping the rise in domestic violence during lockdown'.

(...)

- United Nations Policy Brief: ‘The impact of COVID-19 on Women’ (9 April 2020) that warned of deepening pre-existing inequalities and increased GBV.⁵⁶
- 124 countries issued a joint statement ‘Answering the UN Secretary-General’s call on GBV and COVID-19’⁵⁷ (April 2020). By year end 146 countries⁵⁸ had joined.
- UNICEF Gender Section publishes global technical note (2020), ‘Five Actions for Gender Equality in the Coronavirus Disease Response’.⁵⁹ Action 2 is “Prepare for increases in GBV in the COVID-19 outbreak’.
- ‘We must prioritize girls in our COVID-19 recovery’, statement by UNICEF Executive Director Catherine Russell on International Women’s Day (8 March 2022).
- A multitude of UNICEF-produced guidance notes, research and programming briefs, and related documents on GBV and COVID-19 are issued; dedicated public and internal repositories are set up.⁶⁰

This increased attention to GBV also facilitated a more comprehensive inclusion of GBV and GBV risk mitigation within UNICEF’s Humanitarian Action for Children (HAC) for COVID-19, a global funding appeal which evolved and strengthened with each iteration. UNICEF’s report on COVID-19 response to its Executive Board⁶¹ also included a dedicated section on GBV, which was also outlined in the reporting against several of the UNICEF response strategic priorities.

TABLE 1.

Evolution of gender-based violence inclusion in UNICEF Humanitarian Action for Children for COVID-19 revisions in 2020

Initial HAC February	HAC revision March	HAC revision May	HAC revision July
Gender, GBV, GBV risk mitigation and PSEA were not included.	Continuation of GBV service included as one of the activities under Strategic Priority 2. ¹	The impact of COVID-19 and its control measures on women, girls and GBV is explained in detail.	Continuation of GBV services is explicitly included in the Strategic Priority 2. “Continuity of health, HIV, nutrition, education, WASH, child protection, gender-based violence, social protection and other social services; assessing and responding to the immediate socioeconomic impacts of the COVID-19 response.”

Abbreviations: GBV = gender-based violence, GBVRM = gender-based violence risk mitigation, HAC = Humanitarian Action for Children, PSEA = Protection against sexual exploitation and abuse, WASH = water, sanitation and hygiene.

¹ Two indicators (one for access to GBV services together with other essential services and the other related to GBVRM together with PSEA) are included. “Number of children and women receiving essential health care services, including immunization, prenatal and postnatal care, HIV care and gender-based violence (GBV) response care in UNICEF-supported facilities”. “Number or percentage of personnel (staff and volunteers) across all sectors responding to COVID-19 emergency who are trained on GBV – including ‘do no harm’ and risk mitigation, protection from sexual exploitation and abuse (PSEA), safe and ethical handling, including of disclosures, and facilitating appropriate referrals for survivors.”

4.2 Ebola (Democratic Republic of the Congo 2018–20) and sexual exploitation and abuse

Around the same time that COVID-19 was bringing an increased focus on GBV in PHEs, allegations of sexual exploitation and abuse within the Ebola response in the Democratic Republic of the Congo had a similar effect. In particular, the publication of findings from media investigations in September 2020⁶² triggered a high-level inter-agency response, with the IASC Principals calling for “immediate and urgent action”, which was followed by deployment of an IASC field support mission in December 2020 focused on PSEA and, later, creation of an Independent Commission on SEA, as well as a United Nations-wide response mechanism.⁶³

These events ignited many PHE actors to intervene in GBV and at various levels. One key informant reflected on how these events were a trigger for accelerating efforts to integrate GBV risk mitigation activities into response activities and plans, a sentiment that was shared by all interviewees with a public health background:



The collective traumatism that we have faced as UNICEF staff have realised that, despite our good intent, we were not capable of delivering on our commitment for GBV risk mitigation and response, has created a sense of urgency and an imperative to rethink our approach ... I think that has been a key enabler to be able to move the line and to progress on this issue.

UNICEF is the provider of last resort for sexual exploitation and abuse (SEA) cases involving children. GBV response services are a critical component of the agency’s ability to deliver on its responsibilities in this area.

5. UNICEF approach to gender-based violence in public health emergencies

Since its inception, UNICEF has led responses to disease and related impacts⁶⁴ and is “involved every year in over 100 responses related to public health crises”.⁶⁵ In 2019, UNICEF established a Public Health Emergencies unit which sits within Health in the Programme Division in HQ. The unit “provides a global leadership in PHEs preparedness and response and specific expertise in response to diseases ... as well as in International Health Regulations and Epidemic Preparedness”.⁶⁶

Since its formation, the PHE team has embarked on a journey to institutionalize GBV risk mitigation in PHE systems, structures and procedures with the aim that GBV considerations be routinely integrated, and ‘internalized’ as usual business within a PHE response.

PHE and GBV specialists at UNICEF HQ initiated a conversation around how best to seize the moment around discussions arising from PSEA issues in the Democratic Republic of the Congo and the GBV ‘shadow pandemic’ in COVID-19. An informal working group was formed with the view to put in place GBV response, mitigation and prevention measures in PHEs.

At the start of the collaboration between the GBV and PHE teams, the informal GBV/PHE working group created three key principles which served to guide all UNICEF activities related to GBV and PHE (see box 3). One key informant reflected that these principles help by, “recognizing that it [GBV] should be an integral part of our response. I think that was the first good development ... [the approach] actually pushing countries into integrating gender-based violence in their PHE response.”

Box 3

UNICEF: Three key principles on gender-based violence and public health emergencies

PRINCIPLE 1: Ending or controlling an outbreak does not come at the expense of the health, safety, and well-being of the local population, particularly women and girls.

PRINCIPLE 2: This work is not secondary to the PHE response; it is intrinsic to delivering a principled, timely, quality and child-centred response.

PRINCIPLE 3: This approach will be integrated into UNICEF’s contribution to preparedness (UNICEF and country preparedness), response and Integrated Outbreak Analysis.⁶⁷

6. Anchoring gender-based violence in public health emergencies through key institutional entry points

As the designated inter-agency lead on GBV risk mitigation,⁶⁸ UNICEF spearheads GBV risk mitigation efforts globally and has created many technical resources for both programming and humanitarian coordination. Specific resources for PHEs were deemed necessary because:

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The tools we had and the approach we had for GBV in emergencies and in humanitarian settings are good, but are not directly transportable into public health emergency because there are specific vulnerabilities and specific risks that arise from a public health emergency response and a public health emergency context environment. Because of that it requires additional tools, thinking, concept, capacity-building to be able to implement it properly [in PHE responses].”⁶⁹

UNICEF saw an opportunity to anchor GBV in PHE response and preparedness activities into key institutional processes:

- 1. Planning, and reporting:** including the use of a specific indicator in UNICEF Humanitarian Action for Children for COVID-19;

2. **Resource mobilization:** namely including GBV-related activities and resource needs within PHE donor funding proposals; and
3. **Programming standards:** particularly revision of the UNICEF Core Commitments to Children (CCCs) and the related document, 'Key Considerations: Mitigating, preventing, and responding to gender-based violence in public health emergencies.

In addition, UNICEF embarked on capacity-strengthening activities and expert staff deployments to implement new guidance on GBV and PHEs.

6.1 Planning and reporting: Humanitarian action for children for COVID-19

In 2020, UNICEF included a GBV risk mitigation indicator in the global Humanitarian Action for Children for COVID-19. It aimed to measure the level of GBV risk mitigation activity in UNICEF's response in all country offices (COs) responding to COVID-19. The new indicator captured the number or percentage of personnel (staff and volunteers) across all sectors responding to the COVID-19 emergency who are trained on GBV, including 'do no harm' and risk mitigation, protection from sexual exploitation and abuse (PSEA), safe and ethical handling, including of disclosures, and facilitating appropriate referrals for survivors.⁷⁰

Around 90 COs included the GBV risk mitigation indicator in their COVID-19 response plans but not all had GBV-specific programming or GBV risk mitigation activities in place prior to the introduction of the new indicator. To support those COs without specific programming, regional offices delivered a learning series on GBV in emergencies (GBViE). This regional-level training included GBV risk mitigation and was complemented with other support to assist COs to improve their programming and meet the COVID-19 HAC reporting obligations.

An instructional video on GBV risk mitigation and making GBV referrals was also developed in the global online learning platform (Agora), and UNICEF HQ made watching the video mandatory. By the end of the reporting period in April 2021, 84 COs reported GBV risk mitigation activities against the HAC for COVID-19 in 2020; aggregated results are in box 4.

Box 4

UNICEF COVID-19 global response key results achieved⁷¹

- 17.8 million women, girls and boys received GBV risk mitigation, prevention, or response interventions in 84 countries with COVID-19 response plans.
- 210,800 UNICEF personnel and partners completed training on GBV risk mitigation and referrals for survivors in 84 countries with COVID-19 response plans.

Through the process of implementing activities outlined in the HAC, UNICEF raised awareness about the impact of PHEs (including public health measures) on women and girls and GBV among their staff, partners and donor communities. The messaging was far-reaching, including those who had limited or no knowledge of GBV risk

mitigation in the past. One key informant described this new visibility as “a breakthrough moment”⁷² for uptake of GBV in PHEs for UNICEF as an organization and for UNICEF’s partners.

6.2 Key programming standards

The timing of the global COVID-19 pandemic and the PSEA incidents in the Democratic Republic of the Congo coincided more or less with the launch of the UNICEF second edition of the ‘[Core Commitments for Children in Humanitarian Action](#)’ in October 2020. This edition introduced and defined PHEs for the first time and GBV risk mitigation was integrated as part of this inclusion: a strategic window of opportunity had opened and was seized. Effort began to cement GBV risk mitigation in a key guiding document that lays out the way the organization prioritizes in a humanitarian crisis.

The integration of GBV risk mitigation into the CCCs provided a basis and justification to create an accompanying document ‘[Key Considerations: Mitigating, Preventing, and Responding to Gender-Based Violence in Public Health Emergencies](#)’ (Key Considerations).⁷³ UNICEF COs required guidance and support to implement the new CCCs, especially elements related to PHEs and GBV. Close cooperation between the UNICEF GBV and PHE Units was required and was facilitated by the inclusion of GBV integration activities and commitments in a PHE-led funding proposal.⁷⁴

From 2021 to 2022, the Key Considerations document was developed with input from UNICEF HQ, regional and country offices. In addition to internal coordination, UNICEF created a steering committee on the topic with WHO, the Global Outbreak Alert and Response Network ([GOARN](#)), International Federation of Red Cross and Red Crescent Societies, International Organization for Migration, and United Nations Population Fund. The steering committee leveraged UNICEF’s internal initiative to create further momentum at inter-agency level. In turn, this also helped advocates make use of the inter-agency commitments and engagement to increase buy-in within UNICEF more successfully. A public announcement recorded by the then head of GOARN, for example, expressly stated GBV response and risk mitigation as a core component of PHE response.

The document provides PHE responders with a framework to integrate prevention, mitigation and response activities and action into UNICEF’s PHE response. UNICEF Uganda and neighbouring COs used an early version of the framework in response and preparedness planning for the 2022 Ebola outbreak. This experience tested the tool, helped maintain momentum for the work, and encouraged and supported GBV risk mitigation activities to be integrated within the Ebola response. However, the Key Considerations document alone would not affect the necessary changes to keep PHE response safer and effective for women and girls.

6.3 Capacity-strengthening

In order to support the implementation of these programming standards, in 2022 UNICEF developed the toolkit: Gender-based violence (GBV) Risk Mitigation and Response in Public Health Emergencies (PHEs)⁷⁵ with technical input and additional resources from the steering committee organizations. The goal was to

strengthen the capacity of staff and professionals working in PHE response. The toolkit focused on how to implement the Key Considerations within and alongside PHE response activities. It did this by focusing on ‘do no harm’ principles and safe programming and brought together new and existing resources to assist implementation.

In 2021 a pilot training on GBV and PHE was conducted simultaneously alongside the drafting of the Key Considerations with Eswatini, Somalia, Uganda, Zimbabwe COs and in consultation with the Eastern and Southern Africa Regional Office (ESARO). The ESARO Health and GBV focal points also held consultations with UNICEF Ethiopia Health and Child Protection Teams to explore ways in which to best integrate GBV prevention and response activities more meaningfully across existing health emergency and PHE programmes.

Following the pilot training and subsequent revisions, UNICEF Middle East and North Africa Regional Office (MENARO) conducted a hybrid workshop/training with support from the PHE team. The workshop involved regional focal points across all programming sectors and emergencies to adequately up-skill regional colleagues to be able to develop their own regional strategy and support COs in fulfilling their obligations outlined in the Key Considerations. Lessons and feedback from this early use of the training package was used to strengthen both it and the toolkit issued in 2023. A participant of the MENARO workshop reflected positively that:

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It did feel like it was a safe space for people to be honest about what they thought. And you know, however uncomfortable that was at moments in time, I think it was actually quite a healthy workshop in some way, where we did sort of move people's positions even slightly, which is super positive ... I don't think a one-off workshop was going to be sufficient ever ... I think it was a positive thing and I think we did then see [that] when there were cholera outbreaks in Lebanon and Syria. Shortly after that, there was a little bit of a difference of approach in Lebanon and Syria.⁷⁶

Further, the process of creating the Key Considerations and resource package meant UNICEF “really managed to galvanise some support including within the PHE team ... support for this really solidified”.⁷⁷ Despite previous regional office investment in GBV risk mitigation in humanitarian actions, the needed activities were not always automatically reflected in PHE preparedness and response plans. Participation in the GBV and PHE workshop and tool design, however, seemed to have positive continuity in terms of staff support with motivated participants feeling more able to implement and adjust their work practice accordingly, as one key informant reflected:

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When we were reviewing EPPs [Emergency Preparedness Plans], by the time I would get to it, somebody else would already have made a comment on it: ‘Have we considered these GBV risks here?’ Or, ‘Has this been incorporated?’ and so on. So I think there are those people that we've built, as we've supported them in capacity-strengthening and ... they are allies who will now advocate for this on their own ... So that's perhaps a work in progress, but you know the fact that it's in place, and then we can use that as leverage to try to advocate, I think is positive.⁷⁸

The investment helped create a solid foundation for GBV specialists, GBV champions and allies in the PHE team to further facilitate operationalizing the Key Considerations in PHE activities during their technical support deployments. While some key informants reported good GBV risk mitigation practice at the COs level in past and ongoing PHEs, this documentation is focused on efforts at a global level and is therefore limited in what it can report in terms of action at CO level. Exploring country-level work to implement the Key Considerations, especially when the context requires repeated responses to various PHEs, would also be worthwhile.

6.4 Ongoing efforts

The UNICEF PHE team recognizes institutionalizing GBV into PHE is probably a long journey, with continued effort needed to review and assess foundational documents so that mitigating, preventing, and responding to GBV in PHEs becomes “the standard way that we programme”. As one health sector interviewee asserted about GBV risk mitigation: “It’s good programming, it’s our mandate.”⁷⁹

In March 2023 UNICEF shared its long-term vision on PHE Preparedness and Response in the White Paper, ‘Putting the Best Interest of Children, Women and Their Communities at the Centre of Public Health Emergency Preparedness and Response’.⁸⁰ This external facing document is “UNICEF’s contribution to the global discussion for the global health architecture, for public health, for health, emergency preparedness and response”.⁸¹ It placed GBV risk migration and response as an essential component of the PHE response, encouraging more meaningful and actionable consideration of GBV in the ongoing global discussions regarding what works and what is best practice.

Internally, in 2024 UNICEF released the ‘Operational Response Framework for Public Health Emergencies’ which outlines the working strategies during PHE response and articulates what key activities will be undertaken. This Framework also includes prevention, risk mitigation and response to GBV, including PSEA as one of three key areas of response:

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*The risk of gender-based violence and sexual exploitation and abuse should be anticipated to increase as an emergency response continues for a protracted period. Therefore, **gender-based violence risk mitigation should be in place from the beginning of a response**. Gender-based violence response services should be available in communities. And front-line workers need to: be aware of the risks during public health emergencies; be sufficiently trained to recognize and respond to harm; be equipped with up-to-date information on response services, including mental health support; and support survivors of gender-based violence.*⁸²

The ‘Operational Response Framework’ further emphasizes the importance of considering GBV risks at the multi-sectoral coordination level of PHEs:

“

Effective multisectoral coordination draws on the understanding of the public health threat and specific country contexts, and the identification of appropriate cross-cutting support functions. For example, access to essential supplies and services, such as in health, nutrition, and education.

Coordination must also ensure that interventions do not exacerbate child protection and gender-based violence risks, including sexual exploitation and abuse.

To support COs to implement this plan, the PHE team is developing standard operating procedures (SOPs) including coordination and after-action reviews with plans to integrate the Key Considerations in those too. An interviewee expressed that embedding GBV in such routinely followed mandatory procedures will further accelerate risk mitigation measures within the standard way UNICEF responds. Such processes tend to “precede institutionalization” and “SOPs can help new actions become routinized behaviour.”⁸³

“

*When you have SOPs you just follow your SOPs and when we have gender-based violence integrated into the SOPs, that will encourage countries to follow them ... After a public health emergency ... we have the after-action reviews ... We can still evaluate the response based on the various points in the SOPs, and gender-based violence would definitely be one of them.*⁸⁴

7. Enablers for gender-based violence risk mitigation institutionalization

UNICEF’s experience in institutionalizing GBV risk mitigation in PHE points to several enablers relevant to other contexts. These include which functional areas in an organization might be best placed to lead changes to protocols and SOPs. There are also lessons about mobilising allies, the benefits of building on the history of previous work and linking up theoretically aligned areas of work (Gender, PSEA, GBViE), despite being potentially ‘siloe’d’ within organizational structures.

7.1 PHE team leadership, with GBV technical support

The PHE team remained in the driving seat of the process from the creation of the GBV and PHE workplan, to resource mobilization, to drafting the Key Considerations and related tools, to the PHE operation framework. This approach (rather than GBV specialists leading) allowed identification of the most strategic opportunities and entry points within the health sector’s evolving systems and processes. Together with specialist support, the PHE actors were best placed to identify key needs for integrating GBV considerations in PHE response, such as the type of messaging about actions, to effectively penetrate busy health response frameworks.

“

*There was a video [explaining GBV and GBV risk mitigation is an integral part of the PHE] from the webinar ... the fact that it was coming from the public health team colleagues, I think that was really a plus as I saw a positive reception in Uganda because there was a conversation with public health colleagues. This was coming from public health colleagues, and you could hear them [Uganda team responding to a PHE] talking about it [GBV risk mitigation in a PHE response].*⁸⁵

The deliberate intention to anchor GBV risk mitigation into the standards and strategies afforded a solid framework/foundation to ‘mandate’ GBV considerations as an integral part of UNICEF’s PHE response. GBV expertise within UNICEF was important to support the PHE team’s efforts to institutionalize GBV considerations at all levels as this facilitated best practice and technical alignment with the relevant current global guidance. A key informant expressed it as:



The fact that we have some expertise in gender-based violence in some regions ... I interacted a lot ... with the gender-based violence team [at the regional office]. So having those capacities, it definitely helps.⁸⁶

7.2 The right mix of expertise and allies

Interviews with those working in PHE response also pointed to having the right mix of expertise at the right institutional levels, in influential positions and at the right time as a critical success factor in getting GBV considerations integrated. While this was sometimes attributed to good luck, it also speaks to the benefit of messaging around GBV risk mitigation being ‘everyone’s business’ and essential for ‘good programming’.

It can also be attributed to the effort of health professionals leading a response to the mounting evidence and commentary around GBV and PHEs at the time. As leadership authorized the focus, use of resources, and time spent on GBV, the space at working level was therefore available to build up momentum and bring about sustainable change in what was becoming a standard PHE response.

During the formulation of foundational documents for the new PHE unit in UNICEF, the presence of GBV specialists alongside a well-established organizational commitment to GBV risk mitigation was particularly strategic. This early inclusion probably paved a way towards sustainable improvements in PHE response in terms of mitigating the risk of violence.

7.3 Building on existing efforts in humanitarian action

UNICEF’s inter-agency leadership role on GBV risk mitigation enabled the organization to act quickly to integrate GBV into a new PHE unit framework beginning in 2019, drawing upon existing policies, capacity, experiences and resources.⁸⁷

GBV risk mitigation was already included in the CCCs, which provided justification and the hook to create the Key Considerations, and evolving actions within and beyond UNICEF. Most professionals who had worked in emergencies were already exposed to the GBV risk mitigation efforts in UNICEF and inter-agency humanitarian responses across sectors and clusters, and understood the positive impact on results. Such “professionals often serve as powerful and persuasive agents” who help “actively socialize new members”.⁸⁸ They did not need to be convinced about why GBV risk mitigation was needed in PHE responses but rather how to integrate GBV risk mitigation in a PHE context. The GBV team had an established track record in working well with other programming sectors which was useful, relevant, and built confidence when approaching the PHE workstream.

7.4 Finding a common vision

The PHE team understood there was demand to unpack GBV requirements for PHEs in the CCCs for effective uptake in country programmes. The Key Considerations – the development process and final resources – helped to answer questions such as: what does GBV risk mitigation, GBV response and prevention look like in practice in the context of a PHE? And why and how is it different from other humanitarian responses?

UNICEF’s guiding principles on GBV and PHE (box 3) crafted at the beginning of the journey also forged a shared direction for the work. The process served a shared understanding of what are the most important things for UNICEF and partners to do in order to mitigate, respond and prevent GBV in these types of emergencies. The joint vision thus underpinned the documents and resources drafted by the PHE team, which are now available and ready to answer future queries from practitioners as they arise.

7.5 Linking up aligned workstreams (PSEA and gender)

At the beginning of the GBV and PHE work, PHE actors were mainly focused on sexual exploitation and sexual abuse (SEA). Gradually, the GBV and PHE joint activities began to spread the message that “SEA is a form of GBV and therefore GBV risk mitigation contributes to PSEA”. This approach worked effectively to broaden the narrower focus on PSEA in PHEs to consider, mitigate, prevent and respond to other forms of GBV as well.

UNICEF ‘set-aside’ funding for PSEA in PHE responses has assisted some COs to implement GBV risk mitigation measures. Such availability of dedicated resources elevated the status of GBV risk mitigation action from optional to a standard organizational commitment – with the expectation that COs will implement such action. Notably, however, there has been delay in funds allocation in the mechanism, which hinders immediate actions at the beginning of a PHE response and has knock on effects. Uptake of this funding portal has not been systematic.⁸⁹

Work on gender sensitivity and gender mainstreaming in health responses provided a good basis for mitigating the risk of violence in PHEs as well. For example, WHO’s ‘Taking sex and gender into account in emerging infectious disease programmes: An analytical framework’⁹⁰ helped to identify entry points for GBV risk mitigation in PHEs.

Some of the Key Considerations are directly related to gender mainstreaming standards and approaches already established and used in emergency response. In an effort to institutionalize GBV risk mitigation, the team found it useful to use ‘gender’ and ‘GBV risk mitigation’ considerations interchangeably to emphasize the point that the goal is good and safe programming. Similarly, initiatives labelled as PSEA had gained significant traction in the health interventions, due in part to fears arising out of the case in Democratic Republic of the Congo and similar high-profile violations and scandals. The sense of collective urgency as a result has been used to advance the GBV and PHE agenda.

8. Learning

UNICEF continues to learn and strengthen approaches to GBV risk mitigation institutionalization in PHEs. Some of the distinct characteristics of PHE responses have been important to consider, such as the role of governments, coordination and decision-making and specificity related to data and health threats.

8.1 Government role in a PHE response

All key informants emphasized working with the government as particularly important. While it is always important to anchor GBV risk mitigation in government systems, it is especially important for PHEs where government leadership is central. In PHE responses, government exercises the sole authority to declare a public health emergency, leads coordination and subsequent measures, and determines the acceptance or refusal of external support. As such, GBV risk mitigation needs to be prioritized within government preparedness and response plans for it to work well.



One specificity of a public health emergency response is ... it's ... genuinely and really led by the government. International organizations and national organizations support the governments. Government does not delegate this [lead role] to partners.⁹¹

UNICEF is well positioned given its relationship to multiple government ministries across a country programme of work. This includes Ministries of Health, Education, Social Services, Water, Women/Gender and other key government institutions, and departments. Existing partnerships and joint programming frameworks are in place in all country contexts, and many professionals interviewed considered that UNICEF's work across the nexus of humanitarian assistance and development was a key advantage in anchoring GBV risk mitigation in the government workplans. Critically, UNICEF also can play an important role in facilitating active participation in PHE coordination mechanisms of the ministry or authority responsible for gender or women (see box 6). This cooperation provides an opportunity for review and input in the PHE decision-making, planning and task forces at national level.⁹²

Box 5

Examples of involvement of relevant government authorities in public health emergency taskforces

Uniquely, in Uganda the Ministry of Gender, Labour and Social Development, and in the United Republic of Tanzania the Ministry of Community Development, Gender, Elderly and Children, have been brought into national PHE taskforces, in addition to health authorities.

UNICEF Tanzania, for example, applied the system-strengthening approach to PHE responses, for example to cholera, in 2023. A key informant explained the benefits of the approach being:

- Comprehensive, looking at everything from a system point of view
- Cross-cutting, requiring work with multiple ministries, including those with a GBV mandate
- Sustainable: the approach set up for one PHE could be used or adapted in the future. For example, the structure created for Risk Communication and Community Engagement for the COVID-19 response was used for the Ebola outbreak preparedness in 2022.

8.2 GBV data alongside other indicators in decision-making

The Key Considerations and related tools emphasize that PHE responders must put the health, safety and well-being of affected populations at the centre of any effective response, with particular attention to the needs of women and girls. The PHE response, if not considered, can exacerbate GBV, do more harm, and if risk mitigation against violence is not mainstreamed into the response it will also be less effective in controlling epidemics.

This work requires ongoing analysis, gender sensitive dialogue and situation monitoring to ensure that any time-sensitive or public health measure proposed considers the full picture of cost/benefits to all population groups and genders. Key informants discussed this challenge as knowing where the 'red line' is, namely when and how to decide and adjust a new measure if risk of harm to women and girls is in the detail. As one key informant attempted to articulate the dilemma:

“

There is a red line, but we don't know where it is ... It's an informed decision you make. That's why you need as much as possible ... integrated outbreak analysis to understand more the community perspective, to understand more the outbreak dynamics, the impact of the social measures. So, you can make the best-informed decision possible because it's not mathematic. The red line is not a mathematical model.⁹³

Lessons from lockdown and school closures during COVID-19 and the 2014–2016 Ebola response related to the gender-specific risks can now be integrated and considered in PHE responses. The risk of GBV must be routinely monitored and used to inform decision-making in PHE response by authorities and other responders.

While a full picture with data may not always be on hand when needed to adequately inform timely decision-making, capturing lessons and making necessary adjustments for better information and decisions in the future is a critical step. Anchoring GBV risk mitigation in the routine evidence generation from integrated outbreak analysis, rapid assessments to its inclusion in after-action reviews, and PHE evaluations is a key component of GBV risk mitigation work in these contexts – as it is in all emergencies. These reviews require evidence of impact as well as meaningful participation and leadership of women and girls in helping responders understand and weigh up risks.

The agreed objective of GBV risk mitigation in PHE is to make response systems and services safe, effective and responsive to the needs and rights of women and girls. This means (as outlined in the UNICEF PHE and GBV Toolkit) regularly scrutinising the measures, disease control and treatment interventions to inform decision-making by asking:

- Does it increase the likelihood of GBV occurring?
- Are we identifying and mitigating GBV risks?
- Are we conducting ongoing monitoring of access and barriers to services, particularly those faced by women and girls?

PHE decision-makers, working together with the different perspectives of GBV specialists, women-led organizations and other professionals with gender and GBV expertise, can and must be considered together when weighing up risk and benefit equations. Box 7 provides examples where this has worked in two UNICEF COs.

Box 6

Influencing decision-making of response actors, examples from country offices

Democratic Republic of the Congo, cellule d'analyse intégrée (CAI): The integrated analytics cell is an operational research unit that provides real-time integrated analysis to influence decision-making of response actors. It is led by **UNICEF DRC** and brings together different actors and data sources to provide a more comprehensive understanding of the dynamics of epidemics and public health outcomes in support of the Ministry of Health, national and international actors. Their research highlights potential impacts of outbreaks and emergency responses on community health, protection and socioeconomic security to facilitate operational decision-making. The issue of safe access for women and girls is a key consideration within public health response, and CAI's research. For example, when cases of cholera emerged in displacement sites in North Kivu, the CAI analysis was able to surface important gender dynamics.

A powerful insight was gained from evidence of a syndemic between cholera and GBV, highlighting that the incidence of cholera is significantly higher among women who, in order to avoid GBV risks, may expose themselves to the risk of cholera (for example, through unsafe defecation practices).

Rapid risk assessment of cholera outbreak in the United Republic of Tanzania: In 2023, **UNICEF Tanzania** supported the Ministry of Health to conduct a rapid risk assessment of cholera outbreaks in Arusha⁹⁴ in a way that integrated a gender dynamic and used gender disaggregated data in the analysis. The assessment identified gender-specific risks, access issues and behaviours as well as specific risks related to GBV. Like the CAI, it pointed to the syndemic between GBV and cholera: (i) gender disparities exist in access to clean water, sanitation facilities and hygiene practices, exacerbating vulnerabilities, particularly among women and girls; and (ii) cultural beliefs and living conditions contribute to the spread of waterborne diseases and GBV within communities, necessitating tailored interventions.

The assessment also had specific recommendations related to GBV and the cholera response: (i) implement GBV-inclusive water, sanitation, and hygiene programmes, addressing gender-specific needs and vulnerabilities; and (ii) promote community-led initiatives to raise awareness about the importance of proper sanitation and hygiene practices, with a focus on gender equality and women's empowerment.

8.3 Variation according to type of disease or public health threat

A review of UNICEF response and preparedness plans for Ebola and cholera outbreaks since 2021 shows a varying level of integration of GBV. The HAC for COVID-19 saw 84 countries had included GBV considerations. Out of the 6 cholera preparedness and response plans reviewed, 2 referenced GBV, as did 13 out of 17 preparedness and response plans for Ebola. This cursory review could not determine the actual level of GBV integration but can indicate a varying level of degree to which GBV has been considered. Given UNICEF's history of gender work in cholera responses one key informant mentioned:



... mainstreaming GBV considerations like ensuring we have a separate facility for men, women and children. That's part of the standard planning and implementation of isolation centres for cholera. So, there are elements which are already embedded within the standard cholera plan. We just do not call them GBV risk mitigation.⁹⁵

It should be noted that while it has been a successful strategy to adapt to the preferred language of a sector, it is also important not to assume that GBV risk mitigation is automatically being addressed, as mitigating GBV risks is a process of intentionally identifying and addressing safety concerns.

Some COs, such as UNICEF Malawi, integrated GBV into their cholera response and an evaluation is ongoing. However, most key informants agree that the level of GBV risk mitigation integration in cholera was likely less than in the Ebola and Marburg virus disease responses, citing reasons such as the acute nature of cholera with shorter periods of stay in isolation centres and that much of the forma-

tive work on the intersection of GBV and PHEs took place as a response to Ebola outbreaks. Because cholera is not always considered an emergency, there may be less application of emergency guidelines and tools on GBV risk mitigation by a range of actors. For example, UNICEF Kenya integrated GBV-related activities into the national cholera preparedness and response plan in 2023, however, the GBV prevention and response component of the plan was not funded.

Notably a PHE professional's perceptions of GBV risk related to a PHE response may differ from a response of GBV specialist's view. Key informants reported, for example, that PHE actors tended to strongly link GBV risks with treatment centres. However, GBV experts tended to stress that risks can be present in many aspects and locations of a PHE response, from access to toilets, safe water and hygiene materials, to vaccine delivery, to impacts related to loss of income and childcare challenges. Documenting or mapping the different GBV risks and corresponding mitigation measures in different infectious disease outbreaks was suggested to demonstrate the breadth of the issue to both cadres across different public health emergencies.

8.4 Role of key staff profiles

All key informants pointed to the role of UNICEF senior management at country level, in particular Deputy Representatives, as critical in seeing action on GBV risk mitigation. Within UNICEF's PHE response, the UNICEF Deputy Representative often plays a key coordination role. The role is influential as they coordinate, link up sections, and work across all programme areas and in operations. Key informants suggested increasing their knowledge and accountability through socializing existing resources such as the Key Considerations. Their role is pivotal in liaising with government and bringing together multi-ministerial committees around PHE decision-making tables, with potential to influence involvement and participation beyond traditional health actors.

9. Conclusion and future direction

There has been substantial progress in institutionalizing GBV risk mitigation in PHE in UNICEF at the HQ level. When the organization anchors GBV risk mitigation in foundational entry points such as programming standards, strategic documents, planning and reporting, it mandates everyone in its fold to act and can elevate GBV risk mitigation to an organizational accountability. UNICEF has achieved this within the PHE portfolio at the global level.

However, the journey is ongoing, and UNICEF continues to identify new entry points to further this agenda, finding ways to mitigate, prevent and respond to GBV in PHE response.

UNICEF is integrating the new GBV and PHE training modules to become part of the standard PHE capacity-building package. Ambition exists to involve wider health sector partners as well and to continue the progress to strengthening efforts in PHE preparedness activities as well. In addition to the global push, many promising practices are being generated in COs engaged in PHEs. These practices and lessons, when shared, can further enhance and demonstrate UNICEF's commitment and competencies in GBV risk mitigation, response and prevention.

Suggestions for future action include:

- Strengthening the operationalization of PHE strategies integrating GBV risk mitigation. UNICEF's ongoing efforts to institutionalize GBV risk mitigation within core PHE policies, strategies and guidance mark a significant achievement. The next crucial step involves supporting their effective implementation. The launch of the 'Operational Response Framework for Public Health Emergencies' presents a pivotal opportunity to bolster action against GBV within PHE contexts, given the framework's explicit focus on GBV risk mitigation. Senior management can play an important role to emphasize the importance of GBV risk mitigation during this roll-out, ensuring all PHE staff are well-informed and equipped with the necessary skills to implement its GBV components in the next phase.
- Advocating for and promoting GBV risk mitigation within PHE responses across agencies. UNICEF's important role in PHEs, particularly as the lead in community protection, combined with its role as the IASC-designated lead for the GBV Guidelines, positions it uniquely to drive the institutionalization of GBV risk mitigation across PHE systems. Leveraging UNICEF's experience in this area can influence broader PHE preparedness and response frameworks, including through collaborations with WHO and advocacy efforts targeting donors.
- Defining a research agenda on GBV in PHEs to address critical evidence gaps. This case study underscores remaining gaps in the literature concerning GBV and PHEs. Despite a growing body of evidence highlighting the link between GBV and PHEs, certain areas remain unexplored, such as GBV within cholera responses. Moreover, there are few studies establishing the effectiveness of GBV risk mitigation approaches within PHE contexts. Establishing a research agenda is essential to lay the groundwork for a more comprehensive integration of GBV risk mitigation into PHE strategies, leveraging existing knowledge to promote evidence-driven action.

Annex I. Timeline of Key Events

2015	IASC GBV guidelines revised edition released.
2019	A PHE unit is created in UNICEF Health Programme Division.
2020	- COVID-19 pandemic: breakthrough moment with heightened far-reaching visibility and experience of increased GBV risks related to a PHE response. - GBV received high-level policymaker attention as a 'shadow pandemic' to COVID-19. - UNICEF established the GBV and PHE working group at headquarters with the task of integrating GBV into PHE responses in the future. - An Operational Peer Review identified weaknesses in the response to DRC's largest Ebola outbreak (2018–2020). - International media publication of the investigations into sexual exploitation and sexual abuse in the Ebola response in DRC. - GBV considerations included in UNICEF's HAC for COVID-19 and 84 COs used the GBV-related indicator in the results frameworks.
2021	- WHO created an Independent Commission to establish facts, support survivors and hold perpetrators accountable for SEAs during the Ebola response in DRC. - UNICEF commissioned a consultant to facilitate and draft the Key Considerations: Mitigating, Preventing and Responding to GBV in PHE and a training package for staff capacity-building. - Inter-Agency Steering Committee for GBV and PHE work set up.
2022	- UNICEF conducted a pilot GBV and PHE training with its COs and ESARO. - UNICEF commissioned a consultant to develop the GBV and PHE training package and the GBV and PHE toolkit to support operationalizing the Key Considerations. - UNICEF MENARO conducted a GBV and PHE workshop with support from the PHE team. - Key Considerations published/released.
2023	- UNICEF GBV and PHE toolkit and the e-learning course in Agora released. - UNICEF White Paper, 'Putting the Best Interest of Children, Women and their Communities at the Centre of Public Health Emergency Preparedness and Response' published.
2024	The UNICEF 'Operational Response Framework for Public Health Emergencies' is published, placing prevention, mitigation and response to GBV in PHEs as one of the core actions for UNICEF.

Endnotes

- 1 Information was gathered by Tsunagu, an external consulting team, through review of 94 primary and secondary documents, including 45 organization-specific and/or inter-agency PHE response and preparedness plans from 2015 to 2023 as well as 7 interviews with selected practitioners involved in relevant processes and GBV response work.
- 2 UNICEF, 'Operational Response Framework for Public Health Emergencies', UNICEF, New York, 2024.
- 3 Violence against Women Prevalence Estimates, 2018: Global, regional and national prevalence estimates for intimate partner violence against women and global and regional prevalence estimates for non-partner sexual violence against women, World Health Organization, Geneva, 2021.
- 4 Refers to Ebola outbreaks in West Africa 2013–2016; and the Democratic Republic of the Congo in 2014, 2017, 2018–2020.
- 5 The disease outbreaks listed here are referenced from the following articles: Raftery, et al., 'Gender-based Violence (GBV) Coordination in Humanitarian and Public Health Emergencies: A scoping review', *Conflict Health* 16, 37, 2022; Stark, et al., 'Gender-based Violence against Adolescent Girls in Humanitarian Settings: A review of the evidence', *Lancet Child Adolescent Health*, 5(3), 2021, 210–222; Shukla, et al., 'Association between Public Health Emergencies and Sexual and Reproductive Health, Gender-based Violence, and Early Marriage among Adolescent Girls: A rapid review', *BMC Public Health* 23 (1), 1–14. 2023; Peterman, et al., 'Pandemics and Violence against Women and Children', *Working Paper* Vol. 528, Center for Global Development, 2020a; Peterman, et al., 'Framing the Issue: Pandemics and violence against women and children', in 'Report on Pandemics and Violence Against Women and Children', Center for Global Development, 2020; Meinhart, et al., 'Gender-based Violence and Infectious Disease in Humanitarian Settings: Lessons learned from Ebola, Zila and COVID-19 to inform syndemic policy-making', *Conflict and Health* 15:84, 2021.
- 6 Roy, C.M., et al., 'Impact of COVID-19 on Gender-based Violence Prevention and Response Services in Kenya, Uganda, Nigeria, and South Africa: A cross-sectional survey', in *Frontiers in Global Women's Health* Vol. 2, 2022; Decker, et al., 'Gender-based Violence during COVID-19 among Adolescent Girls and Young Women in Nairobi, Kenya: A mixed-methods prospective study over 18 months', *BMJ Global Health* 7(2), 2022; Shreeves, Rosamund. 'COVID-19: The need for a gendered response'. European Union (2021); Meinhart, et al., Gender-based Violence and Infectious Disease, 2021; Stark, et al., 'The Syndemic of COVID-19 and Gender-based Violence in Humanitarian Settings: Leveraging lessons from Ebola in the Democratic Republic of Congo', *BMJ Global Health* 5(11), 2020: e004194.
- 7 Roy, 'Impact of COVID-19 on Gender-based Violence Prevention', 2022.
- 8 Raftery, et al., 'Gender-based Violence (GBV) Coordination', 2022; Stark, et al., 'Gender-based Violence against Adolescent Girls', 2021; Stark, et al., 'The Syndemic of COVID-19 and Gender-based Violence', 2020; Shukla, et

al., 'Association between Public Health Emergencies', 2023; Peterman, et al., 'Pandemics and Violence against Women and Children', 2020a; Peterman, et al., 'Framing the Issue', 2020b; Meinhart, et al. 'Gender-based Violence and Infectious Disease', 2021; World Bank, "Policy Note: Gender dimensions of the COVID-19 pandemic", 26 April 2020; Shreeves, 'Covid 19: The need for a gendered response', Briefing for European Parliament Think Tank, 2020; Smith, et al., 'More Than a Public Health Crisis: A feminist political economic analysis of COVID-19', *Global Public Health*, 16(8-9), 2021: 1364-1380; Yaker, R., 'Securing the Safety and Wellbeing of Women Frontline Healthcare Workers in the COVID-19 Response', GBVguidelines.org, Emergency Support Query GBV Area of Responsibility, 2020; Decker, et al., 'Gender-based Violence during COVID-19', *BMJ Global Health* 7(2), 2022.

- 9 World Bank, 'Policy Note: Gender dimensions of the COVID-19 pandemic' (2020); Stark, et al., *The Syndemic of COVID-19 and Gender-based Violence*, 2020; Meinhart, et al., *Gender-based Violence and Infectious Disease*, 2021; Decker, et al., 'Gender-based Violence during COVID-19 among Adolescent Girls', 2022; Shukla, et al., 'Association between Public Health Emergencies', 2023; Shreeves, 'COVID-19: The need for a gendered response', European Union 2021; Smith, et al., 'More Than a Public Health Crisis', 2021; Yaker, 'Securing the Safety and Wellbeing', 2020.
- 10 International Rescue Committee, 'Everything on Her Shoulders: Rapid assessment on gender and violence against women in the Ebola outbreak in Beni, DRC', Report, IRC, 2019; Stark, et al., 'The Syndemic of COVID-19 and Gender-based Violence', 2020; Meinhart, et al., *Gender-Based Violence and Infectious Disease*, 2021; Decker, et al., 'Gender-based Violence during COVID-19 among Adolescent Girls', 2022; Shukla, et al., 'Association between Public Health Emergencies', 2023.
- 11 International Rescue Committee, 'Everything on Her Shoulders', 2019; Peterman, et al., 'Pandemics and Violence against Women and Children', 2020a; Stark, et al., 'The Syndemic of COVID-19 and Gender-based Violence', 2020; Meinhart, et al., *Gender-based Violence and Infectious Disease*, 2021; World Bank, 'Policy Note: Gender dimensions of the COVID-19 pandemic', (2020); Yaker, 'Securing the Safety and Wellbeing', 2020.
- 12 World Bank, 'Policy Note: Gender dimensions of the COVID-19 pandemic' (2020); Shukla, et al., 'Association between Public Health Emergencies', 2023.
- 13 Shreeves, 'COVID-19: The need for a gendered response', European Union, 2021; Decker, et al., 'Gender-Based Violence during COVID-19 among Adolescent Girls', 2022; Shukla, et al., 'Association between Public Health Emergencies', 2023.
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- 18 See for example: McDonald, et al., 'Quantifying the Impact of the COVID-19 Pandemic on Clinical Trial Screening Rates over Time in 37 Countries'. *Trials* 24, 254, 2023; Rancourt. N., 'Gender and Vulnerability to Cholera in Sierra Leone: Gender analysis of the 2012 cholera outbreak and an assessment of Oxfam's response', Oxfam, 2013; United Nations, Policy Brief: 'The Impact of COVID-19 on Women, 9 April 2020.
- 19 International Labour Organization, Women and Men in the Informal Economy: A statistical update, ILO, Geneva 2023.
- 20 Organisation for Economic Co-operation and Development, 'Women and Informality', OECD, website, 22 March 2024.
- 21 Smith, et al., 'More Than a Public Health Crisis', 2021; Korkoyah, D.T. and Wreh, F.F. 'Ebola Impact Revealed: An assessment of the differing impact of the outbreak on women and men in Liberia', UN Women, 2015.
- 22 In 'Quantifying the Impact of the COVID-19', 2023, McDonald, et al. outlined that during the COVID-19 pandemic, for example, women were more likely to report employment loss compared to men. "Between March, 2020, and September, 2021, women were more likely to report employment loss (26.0% [95% uncertainty interval 23.8 – 28.8], by September, 2021] than men 20.4% ([18.2-22.9])". In all regions, women report higher rates of employment loss than men, with the largest gender gaps seen in North Africa and the Middle East (ratio of women to men: 1.52), and Latin America and the Caribbean (ratio of women to men: 1.38). Also see Flor, L.S., et al., 'Quantifying the Effects of the COVID-19 Pandemic on Gender Equality on Health, Social, and Economic Indicators: A comprehensive review of data from March 2020, to September 2021', *The Lancet* 399.10344 (2022): 2381-2397.
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- 24 These definitions are from the Secretary General's Bulletin on Special Measures for Protection from Sexual Exploitation and Sexual Abuse, 2003: "Both sexual abuse and sexual exploitation can be committed by anyone in the position of power, but the international PSEA policies and frameworks refer specifically to SEA perpetrated by humanitarian/development actors. **Sexual abuse** is an actual or threatened physical *intrusion* of a sexual nature,

whether by force or under unequal or coercive conditions. This means it is not necessary for a sexual act to have occurred, it is sufficient if it has been threatened or an attempt has been made. **Sexual exploitation** is any actual or attempted abuse of a position of vulnerability, differential power, or trust, for sexual purposes, including, but not limited to, profiting monetarily, socially or politically from the sexual exploitation of another. It includes, for instance, the solicitation of a prostitute, and asking a beneficiary to have sex with you in exchange of a ‘promise’ of a job in your organization. If someone attempted to sexually exploit others, it is a sexual exploitation even if an actual act didn’t happen.”

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- 65 UNICEF website: Public Health Emergencies, www.corecommitments.unicef.org/phe.

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- 67** UNICEF, Mitigating, Preventing and Responding to GBV and PHE, September 2021 (UNICEF PowerPoint Presentation, internal).
- 68** On behalf of the GBV Area of Responsibility, UNICEF led the inter-agency revision of the IASC Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Actions (GBV guidelines). Since then, with funding from the Bureau of Population, Refugees, and Migration's *Safe from the Start*, UNICEF has led the GBV Guidelines Reference Group, the only global inter-agency mechanism dedicated to GBV risk mitigation.
- 69** Box 1 provides more information of specific characteristics of a PHE response, as defined by UNICEF.
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- 71** UNICEF, [Responding to COVID-19: UNICEF's 2020 Key Achievements](#), UNICEF, New York, April 2021.
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- 76** Key informant 803.
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- 80** See: UNICEF, '[Putting the Best Interest of Children, Women and Their Communities at the Centre](#) of Public Health Emergency Preparedness and Response', [UNICEF, 2023](#).
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- 88** Hagn, 'UNICEF: Caught in a Hypocrisy Loop', 2018: 87.
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- 94** Ministry of Health, UNICEF, and Tanzania Interfaith Partnership, 'Rapid Risk Assessment of Cholera Outbreak in Arusha Region Incorporating Gender-Segregated Data to Indicate Gender Dynamics' Report, July 2023.
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