REVIEW ARTICLE

COVID-19 impact on gender-based violence among women in South Africa during lockdown: a narrative review

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Abstract

COVID-19, first detected in Wuhan, China, in December 2019, was declared a global pandemic by the WHO following the rapid spread of cases worldwide. The pandemic resulted in governments enforcing nationwide lockdowns, halting economic activities except for essential services. This review aims to explore the impact of the COVID-19 pandemic on gender-based violence (GBV) among women in South Africa. The literature search for this review was limited to African peer-reviewed articles and studies published in English between March 2020 and July 2021. EBSCOhost (PubMed, EBSCOhost, APA PsycArticles, APA PsychINFO, Academic Search Ultimate, Africa-Wide Information, Sociology Source Ultimate, CAB Abstracts, CINAHL with full text, and MEDLINE) electronic database platforms and the Google Scholar search engine and bibliographies of identified sources were used to identify studies that are included in the review. 82 studies were identified for this review and 18 were included in the synthesis. Multiple factors contributed to the surge in GBV cases in South Africa, including alcohol availability and consumption, job losses, financial dependence, psychological distress, and emotional imbalances. Effective intervention strategies are proposed, calling for more research to better understand women's experiences of GBV during the COVID-19 pandemic. *(Afr J Reprod Health 2022; 26[7]: 59-71).*

Keywords: COVID-19; pandemic; gender-based violence; GBV; lockdown

Résumé

Le COVID-19, détecté pour la première fois à Wuhan, en Chine, en décembre 2019, a été déclaré pandémie mondiale par l'OMS suite à la propagation rapide des cas dans le monde. La pandémie a conduit les gouvernements à imposer des confinements à l'échelle nationale, interrompant les activités économiques, à l'exception des services essentiels. La recherche documentaire a été limitée aux articles africains évalués par des pairs et aux études publiées en anglais entre mars 2020 et juillet 2021. EBSCOhost (PubMed, EBSCOhost, APA PsycArticles, APA PsychINFO, Academic Search Ultimate, Africa-Wide Information, Sociology Source Ultimate, CAB Abstracts , CINAHL avec texte intégral et MEDLINE), les plateformes de bases de données électroniques et le moteur de recherche Google Scholar et les bibliographies des sources identifiées ont été utilisés pour identifier les études incluses dans cette revue. 82 études ont été identifiées pour cette revue et 18 ont été incluses dans la synthèse. Plusieurs facteurs ont contribué à l'augmentation des cas de VBG en Afrique du Sud, notamment la disponibilité et la consommation d'alcool, les pertes d'emploi, la dépendance financière, la détresse psychologique et les déséquilibres émotionnels. Des stratégies d'intervention efficaces sont proposées, appelant à davantage de recherches pour mieux comprendre les expériences des femmes en matière de VBG pendant la pandémie de COVID-19. *(Afr J Reprod Health 2022; 26[7]: 59-71).*

Mots-clés: COVID-19; pandémie; la violence sexiste; VBG ; confinement

Introduction

December 2019 saw the world being introduced to the novel coronavirus, 2019-nCoV as abbreviated by the World Health Organization (WHO), which was renamed 'severe acute respiratory syndrome coronavirus 2' (SARS-CoV-2) in Wuhan City, Hubei Province, China, where the first case was detected[1–4]. Subsequently, SARS-CoV-2 was renamed coronavirus disease 2019 (COVID-19). By March 2020, COVID-19 had spread globally, with the first case outside China reported in Thailand[5]. In January 2020, the WHO declared SARS-CoV-2 a public health emergency of international concern[6] before declaring it a pandemic on 11 March 2020[1,2,7]. Although COVID-19 is moderately contagious, a high mortality rate has been reported, making it one of the most dangerous and widespread diseases in the world[1,8,9].

The disease has severely affected both developed and developing nations, with African countries predicted to be among the hardest

hit[2,10–12]. The first reported case of COVID-19 in Africa was in Egypt in February 2020[2]. Currently, South Africa has among the highest number of overall COVID-19 cases in Africa[13]. The first case of COVID-19 in South Africa was reported on 5 March 2020. The patient was a 38-year-old man who had travelled to Italy with his spouse[14,15]. As of 13 June 2022, the country has performed 25.5 million COVID-19 tests; 3.97 million (15.6%) were positive cases out of which 101,509 died (2.6%); a total of 536,565 hospital admissions have been reported to date[16].

The COVID-19 pandemic outbreak necessitated governments to act quickly to derive prevention strategies and curb the spread of the disease. As a result, China and many countries across the globe implemented country-specific nationwide lockdowns, halting most economic activities, and restricting individuals' movement, which negatively impacted the healthcare system[17,18]. Lockdown does not have a universal definition as it was context-dependent[19], but it refers to circumstances where mobility and action are limited during the pandemic to contain the spread of the disease[20]. Though South Africa had a low number of confirmed cases compared to other parts of the world in March 2020, the country led other countries in the sub-Saharan Africa region to apply lockdown regulations, requiring self-quarantine and restricting gatherings and movement of people to contain the outbreak[21].

South Africa's President, Honourable Cyril Ramaphosa, implemented a national level 5 lockdown on 27 March 2020 after recording about 1 000 COVID-19 cases and one fatality. The government introduced five alert status levels that needed to be complied with in fighting the pandemic in the country. The alert status level 5 translated into a complete shutdown of economic activities across the country, including the closure of all primary, secondary, and higher education institutions of learning, except for essential services, such as access to healthcare, financial services, media, and food-related retail. There was a non-negotiable government directive of wearing masks, social distancing, and sanitising of hands[15,22,23]. In addition, these measures prohibited travel (international, inter-provincial, and non-essential travel), and mass gatherings (only funerals were an exception with up to 50 people allowed at the funeral and ensuring compliance with COVID-19 regulations), as well as the banning of alcohol and cigarette sales[15]. The government's decision to embark on a strict nationwide lockdown resulted in a sharp decrease in economic productivity in all spheres while consultations were underway to derive a way forward[24]. COVID-19 lockdown was a public health measure implemented by governments to combat the spread of COVID-19[15]. Not only has the pandemic put a strain on the economy of the country, but it is noteworthy that during the hard lockdown level 5, COVID-19 cases increased dramatically, and this further disrupted the country's healthcare system due to inadequate resources and infrastructure to contain the pandemic[24–26].

It is important to note that although gender-based violence (GBV), domestic violence (DV), and intimate partner violence (IPV) are often used interchangeably, there are subtle differences between them[27]. The United Nations (UN) defines GBV as "any act of gender-based violence that results in or is likely to result in physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or private life"[28]. Domestic violence is termed as "any incident of threatening behaviour, violence (psychological, physical, sexual, financial, emotional), or abuse between adults who are or have been an intimate partner or family member, regardless of gender or sexuality"[29] against their will, impacting their daily functioning, psychological health, and identity[30,31.] Moreover, IPV is termed as "abuse or aggression that occurs in a romantic relationship"[32]. DV remains one of the global public health concerns[33,34] and priority, given the prevalence and incidence of violence in several countries[35]. This review aimed to explore the impact of the COVID-19 pandemic on GBV among women since there is inadequate established literature on this topic, particularly in South Africa.

Methods

A trained Librarian conducted the literature search for all the articles that met the inclusion criteria. PubMed, APA PsycArticles, APA PsychINFO, Academic Search Ultimate, Africa-Wide Information, Sociology Source Ultimate, CAB Abstracts, CINAHL with full text, and MEDLINE electronic database platforms and Google Scholar

search engine were searched to identify studies that are included in this review using the terms "COVID-19, gender-based violence, domestic violence, intimate partner violence, south Africa, sub-Saharan Africa, Africa, lockdown" from March 2020 to July 2021. Boolean operators (COVID-19 OR coronavirus OR sars-cov-2) and ("domestic violence" OR "intimate partner violence" OR "gender-based violence") AND Africa* were also used to source literature. Peer-reviewed journal articles and reports were sourced, reviewed, and analysed. Also, bibliographies of identified sources were used to identify relevant references for this review. All articles that are included in this review needed to satisfy the following inclusion criteria: original research conducted in Africa, particularly in sub-Saharan Africa and South Africa; they were on COVID-19 and violence among women; published in and translatable to English. Also, the articles needed to be available in full text and within the described period. Articles published before and after the mentioned period, those on COVID-19 but not about GBV, DV, and IPV, and non-African, particularly sub-Saharan Africa were excluded in this review. The primary author listed and cited all references used in this review. Peer-reviewed journal articles and reports were sourced, reviewed by all the authors, and analysed prior to including them in the study.

Results

Literature searches that were sourced from PubMed, APA PsycArticles, APA PsychINFO, Academic Search Ultimate, Africa-Wide Information, Sociology Source Ultimate, CAB Abstracts, CINAHL with full text, and MEDLINE electronic database platforms by the Librarian yielded 38 literature studies. Google Scholar search engine by the primary author yielded 44 literature studies. All studies were screened for prospective duplication, whereby 5 studies were identified as duplicates and thus excluded, and 77 remained after screening. A further 48 studies were excluded due to unspecified geographical location, outside of the topics of interest (GBV, IPV, and DV), non-African countries, non-English, and a different population. To assess for eligibility, 25 full-text articles were assessed, with 7 full-text articles excluded due to unclear methodology, unspecified target population, and insufficient GBV/DV/IPV knowledge in the articles. A total of 18 studies were included in the synthesis. The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flow diagram was applied to indicate the screening of the literature studies, as shown in Figure 1.

Discussion

Violence as a result of restricted movement during COVID-19

Globally, government authorities and numerous organisations have warned about the possibility of the COVID-19 pandemic's negative impact on gender-based violence (GBV) due to individuals, especially women, being confined in environments and settings that are likely to trigger violent acts from their intimate partners[17,36–40,] and increased exploitation and neglect[41]. It has been reported that some governments had insufficient resources to address COVID-19. As a result, civil, non-government, and international organisations, including the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the United Nations Population Fund (UNFPA), availed themselves by providing much-needed support to the victims of violence[42].

An increase in global evidence of reported GBV during the COVID-19 pandemic has been reported in several publications[33,41,43–47]. Contributing factors to IPV include discrepancies in income, a high unemployment rate, and a range of psychological distress. Evans proclaims that these contributing factors may be exacerbated during the COVID-19 pandemic[37]. Domestic violence in family settings would be associated with a change in income and existing income gap, more time spent at home, and frustrations because of lockdown restrictions, which could result in various negative psychological effects[17,48]. The restrictions and limitations during the COVID-19 pandemic increased the risk of women and girls being victims of GBV[49].

Domestic violence (DV) cuts across racial and socioeconomic lines[43]. An estimated one in three women globally will become victims of GBV in their lives[35,50], more than 40% of these cases being physical assault and about 38% related to IPV[51]. Women always bear the brunt of DV during crises, mainly physical and sexual violence[12,52].

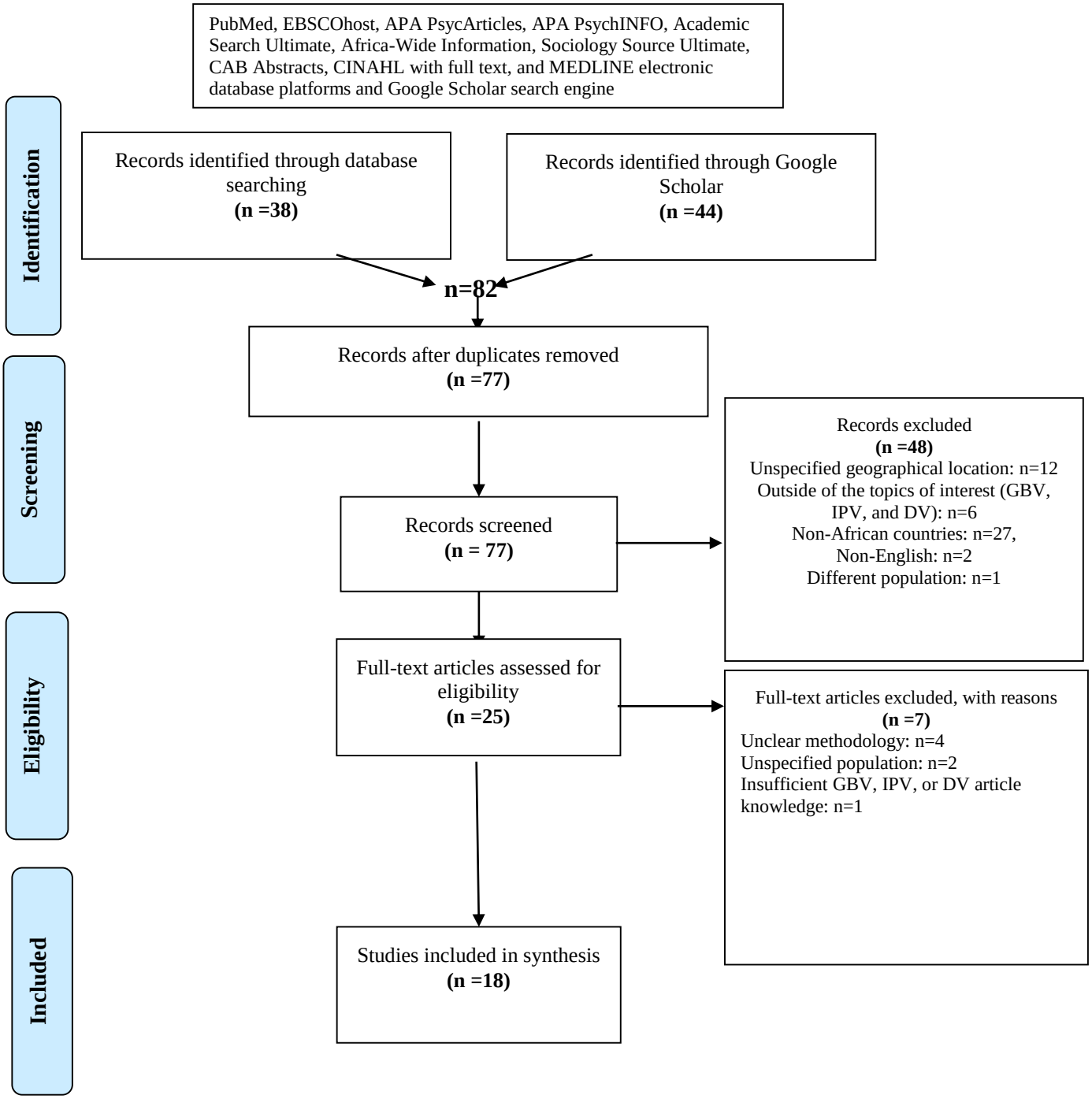

Figure 1: PRISMA flow diagram illustrating the process of article selection

The COVID-19 pandemic has seen numerous media coverage on the increased number of DV amid lockdowns across the world[17,18]. The restriction of economic, social, health, and education activities due to the nationwide lockdown gave rise to a range of psychological distress among individuals and their families, increasing the likelihood of GBV, particularly DV, also referred to as intimate partner violence (IPV). Restrictive lockdown, including isolation and quarantine, has a more significant potential to reduce the spread of COVID-19; however, it can also lead to potential exposure to IPV, especially as women are more exposed to the aggressors at home, where varying hostile power dynamics prevail, leaving the victims with limited opportunity to find any potential help and support due to limited mobility[40,42,43,53,54].

There are also significant social, economic, and psychological consequences in which lockdown restrictions limit family support services[46]. Furthermore, victims may not be able to access services for help due to fear of retribution by the aggressor, unfamiliarity with these services, and fear of disease exposure due to in-person consultations[18,36]. Women are more susceptible to persistent DV in countries where barriers such as language and lack of access to services exist[34]. In South Africa, COVID-19 also reduced access to services due to clinic closures, shortage of healthcare workers, and limited or lack of public transport.

A study conducted in Argentina by Carreras found that more than 30% of DV-related hotline calls were reported, compared to calls before enforcing countrywide lockdown restrictions[17]. This study further revealed a positive correlation between lockdown and IPV and that most of the calls were made by victims, not third parties. Authors can argue that quarantine and strict lockdown played a considerable role in the increase in violence since intimate partners who stayed together spent more time in the same setting. COVID-19 lockdown also resulted in retrenchments[17]. Although the Argentina government was victorious in reducing the number of COVID-19 in their country, the media reported an increase in the reporting of family harm calls during the lockdown, including sexual and/or physical violence as well as harassment[55]. However, the newspaper article did not specify whether these calls were between intimate partners or general family violence. Consistent with the above, the impact of COVID-19 on IPV or DV is seen through various relationships, including social, peer and family relationships, and colleagues[56].

Other studies conducted during lockdown reported similar findings on the increased number of reported GBV-related calls. For instance, 90% of the reported IPV cases to law enforcement in China could be linked to the COVID-19 pandemic, while France reported an increase of almost 40% in IPV-related cases[37,57]. The Italian National Institute of Statistics (INIS) revealed that the calls to the GBV hotline increased nearly 60% between March and April 2020 compared to 2019[50]. In Australia, although there was a reported decline in the number of reported crime rates. Overall, there was an increase in IPV cases by 5%[58]. The above paints a relatively clear picture of the severity of the increased COVID-19-related cases of violence across the world, and in this context, in developed nations.

There is less attention on the COVID-19 pandemic and the consequences of social distancing and interpersonal relations during lockdown that point out the effects of COVID-19 and the appropriate, effective interventions amid the pandemic[18,37,59,60]. The UNFPA approximates a global increase of 20% of IPV cases because of isolation, quarantine, and strict lockdown[60]. A review by Mittal and Singh revealed that the aspect of GBV remains a neglected area of exploration because of COVID-19[42]. Also, there remains a gap in exploring how quarantine and other disasters contribute to a surge in GBV cases[42,61]. There is a lack of literature regarding age-segregated data on women who experience GBV. It is deducible that developing countries, particularly in Africa, suffer the same fate, probably worse due to limited resources.

Sub-Saharan Africa (SSA) has significantly suffered from COVID-19, and there has been an observed increase in GBV cases across the region[44]. It is important to note that COVID-19 and GBV in the SSA region correlate[62]. It is important to acknowledge and understand the association between GBV and pandemics, particularly COVID-19 in the SSA and the subsequent impact[49]. Although Uganda had a few COVID-19 cases when most countries enforced a nationwide lockdown, the government decided to embark on a national lockdown in March 2020 to

combat any potential spread of the disease across the country[49,52]. Around April 2020, Uganda had seen a rise in the number of GBV cases where more than 300 cases were reported amidst lockdown, with the increase observed in rural and urban settings[63,64]. However, there is a lack of data on aggregated number of cases reported between March 2020 and March 2021. These findings are consistent with a cross-sectional study by Gebrewahd, Gebremeskel, and Tadesse on IPV and women during COVID-19, which revealed an upsurge of IPV cases in Aksum, Northern Ethiopia[65]. Existing violence cases are estimated to be around 25%, with more cases of psychological violence, especially among housewives[65]. About 40% of the participants reported having aggressive spouses[65]. The study did not specify potential reasons for the aggression.

The relationship between COVID-19 and GBV is attributed to a multitude of factors in Uganda, such as lack of support services, lack of prioritisation of GBV by the government, fear of a COVID-19 positive result where a partner starts to think they could be a positive case, financial insecurity and uncertainties, adverse psychological effects as a result of stress, women not able to escape abusive households, and quarantine and isolation as these are not the usual routes to circumnavigate their lives daily[49]. Exposure and experience of GBV among women in the SSA bring about a range of socioeconomic, psychosocial, and psychological impacts. These include food insecurity due to job losses, heightened anxiety because of social isolation and quarantine alongside strict curfew periods, stress due to closure of economic activities, particularly for informal traders[52], and other impacts on women's "physical, mental, sexual, and reproductive health"[65]. An Ethiopian study on married couples also portrayed a rise in GBV cases during lockdown[66]. The Democratic Republic of Congo (DRC) government's efforts to reduce GBV remain insufficient, posing a threat to increased GBV cases if not addressed adequately[62]. In response to COVID-19 and healthcare workers in Africa, a study by Bukuluki *et al.* in Uganda found that it is crucial to capacitate essential healthcare workers to respond effectively and support victims of GBV[52].

Over time, as determined by the statistics, there have been the easing and re-instating of alert levels. When writing this paper, President Ramaphosa announced that South Africa moved to level 4 lockdown for 14 days, which commenced on 27 June 2021, until 10 July 2021 due to a surge in new confirmed cases. On 11 July 2021, he extended the level 4 lockdown for another 14 days until 25 July 2021, with some of the restrictions, such as social distancing, wearing of masks, sanitising, and banning some international travels, still in place. As a developing country, South Africa is no stranger to heightened cases of GBV as it remains one of the countries with higher prevalence and incidence of GBV cases in the world under normal circumstances[12,23].

As with many countries, the COVID-19 lockdown impacted the abuse against women, particularly physical and sexual violence. GBV is a pandemic perpetuated by toxic masculinities and gender disparity unities, and the COVID-19 outbreak largely contributed to such inequality and toxicity[12]. These findings are consistent with Stark *et al.* that masculine gender norms perpetuate abuse against women[63]. In South Africa, women remain more prone to violence by their male counterparts during the COVID-19 local epidemic[67]. There is insufficient literature on the extent of violence among males, including the context of gay relationships during COVID-19 in South Africa.

In South Africa, at the start of lockdown in March 2020, 87 000 cases of GBV and interpersonal violence were reported, a significant increase compared to pre-COVID-19[23,68–70]; however, the reports did not specify the type of interpersonal violence and GBV reported as well as the gender of the aggressor, although it has been widely reported that most IPV is perpetrated by males[67]. To highlight this, President Ramaphosa, during one of the COVID-19 progress update meetings, spoke about the seriousness of GBV and femicide in South Africa and stated that every 3 hours, a woman loses her life due to GBV in the country. On the contrary, the Institute for Security Studies (ISS) revealed a decline of about 69% in the number of cases reported to the South African Police Services (SAPS) in March and April 2020[71]. From this, although there were 87 000 cases reported, the number was lower than before the COVID-19 pandemic. Noteworthy is that the administration data reported by the SAPS does not represent the prevalence of GBV in South Africa, as there is a possibility of underreporting by the victims of violence[71]. The decline in reporting

(underreporting) to SAPS during the COVID-19 pandemic could be partly due to fear of going to a police station during the lockdown, fear of repercussions of reporting an aggressor whom the victim is in lockdown with, or lack of privacy to report to the incident during the lockdown. These findings are consistent with Ditekemena et al., who found that underreporting of domestic violence during COVID-19 in the DRC[72].

The introduction of COVID-19 lockdown also poses a threat to GBV for couples that were not violent before the pandemic[73]. These findings are consistent with the report by Nakyazze, which further highlighted the threat to women's safety in their households[43]. Nationwide lockdown presented a significant increase in cases of DV[43]. Vulnerable individuals are at the mercy of their aggressors, and their coping mechanisms may not be as effective[43,56,74]. Also, national lockdown presented an environment where every minor matter within a household had the potential to trigger the male partners to be violent towards their spouse[75]. Persistent GBV experiences result in irreversible harm to victims[76]. Although social services may be available, they remain limited and hard to reach. There is a shortage of personnel, such as social workers, to intervene and address the reported cases, which subsequently presents challenges to following up on the cases[76]. Some social services have resorted to web-based and telephonic interventions[62]; however, there is an additional risk to victims who cannot make telephone calls due to the aggressor's presence at home, and for some, internet access and affordability to make calls are additional barriers. In this regard, one can argue that there is a possibility of continuous underreporting of GBV cases because of the lack of access to available services. Most African countries, including South Africa, mainly prioritise the resources to combat COVID-19, not GBV, and as a result, GBV-related interventions are neither taken seriously nor prioritised[15,43]. The discrepancy in the allocation and prioritisation of much-needed resources to support the victims of GBV during the COVID-19 pandemic is also a factor in the inability to escape violence by the victims in South Africa[69].

Factors contributing to GBV against women during the COVID-19 pandemic

Various factors contribute to persistent GBV against women in South Africa and the impact of COVID-19 on GBV during the lockdown. South Africa is one of the countries with the highest level of alcohol consumption in the world, and the availability and sales of alcohol were one of the main contributors to GBV in households[78]. Although the government implemented a ban on alcohol sales, there were still numerous places where the consumption and sale of alcohol could not be monitored, including households[69,79]. Although few countries have addressed the impact of alcohol during the COVID-19 lockdown, the South African government has addressed it, with the banning of alcohol sales countrywide, with a few easing of this restriction over time, which resulted in alcohol being sold at regulated times at specific establishments[80]. Various studies have revealed that alcohol consumption at above moderate levels is significantly associated with high GBV against women[31,71,79], and an increase in road accidents[15]. This is consistent with the United Nations Women's report that harmful use of alcohol during COVID-19 lockdown was positively associated with a rise in IPV cases[81]. Although alcohol consumption may be one of the main contributing factors to a surge of GBV cases in South Africa, there may be other causes[67]. Still, alcohol consumption is a catalyst of violence, given that intimate partners may have already been at each other's loggerheads even before the lockdown was implemented[67]. To further account for the above, if alcohol consumption was the leading cause, female learners and students would be free and safe from violence within the school and university premises where alcohol is not allowed[82]. In this regard, women's safety is compromised in the absence of pandemics and the availability of alcohol, but pandemics exacerbate the situation[69]. There are instances where the women who were victims also consume alcohol to gather strength and courage to defend themselves during the violent acts perpetrated by their spouses or intimate partners[67]. There is a need to explore the contributing factors of violence that trigger women to resort to alcohol consumption and acts of violence in intimate relationships. From examined literature, it is not clear whether many GBV cases are prevalent in married, cohabiting, or casual relationships.

Researchers have reported that psychological distress among GBV victims is exacerbated mainly by social isolation, which is the primary preventative regulation enforced by

governments[18,42,49,61,74]. One of the main reasons for social isolation being the facilitator of DV, is the increased amount of time that the women who were victims of violence spend in the presence of their violent partners[18,34]. Women who experience violence are left without a choice but to remain in the households where violence is perpetuated due to restricted travels[53], to travel to places where their safety is ensured, such as their maiden homes. Being confined in their houses increases and worsens their experiences[34].

Other factors that have been found to aggravate violence are economic-related. For instance, since several employers resorted to working from home, they are in the constant presence of their abusive partners. In addition, those in informal trade depended on their male partners for financial support. As a result, they feel obligated to remain in abusive relationships due to co-dependency[18,42,43,49]. Financial stress seen through potentially reduced family income and a bleak future because of retrenchment is noted as a potential catalyst to violence against women in their homes. Emotional and financial stress due to isolation, unemployment, and the inability to afford basic needs can be attributed to the COVID-19 pandemic[34,46]. Knowing that patriarchy is one of the leading cultural aspects where men are heads of their households, thus controlling their spouses and finances, it would be interesting to further explore the prevalence and incidence of GBV during the COVID-19 pandemic in South African households where the male spouse has been laid off work and the wife and/or children are employed.

Interventions and recommendations to support victims of gender-based violence during the COVID-19 pandemic

This section provides authors' recommendations and does not provide a strong literature review on existing recommendations. With research and other reporting channels highlighting the prevalence of GBV in households during COVID-19 lockdown, the government needs to derive interventions that will effectively address the issue of GBV in South Africa. There remains a need to adequately develop strategies, measures, and interventions to address violence and, at the same time, ensure that victims are protected from their aggressors and that aggressors are held accountable for the abuse[50]. The South African government is among a few countries in Africa that have derived interventions from combating GBV through the introduction of support services through media communication; however, there is inadequate research or evaluation from examined literature that speaks to the effectiveness of such interventions[43]. Also, it is not clear what media communication has been implemented countrywide. Although the World Health Organization (WHO) and United Nations (UN) have derived strategies to address GBV[50], it should be noted that in South Africa, as an upper-middle-income country, some of the interventions developed and/or adopted by the developed nations may not be applicable in the South African context due to affordability and varying socioeconomic statuses, where there is a significant number of individuals living in poverty. In South Africa, access to services, mainly healthcare services in the rural and peri-urban settings, differ and remain a challenge.

It is also of utmost importance that the government prioritises GBV and monitors the damage caused by GBV against women, men, and children due to the COVID-19 pandemic and subsequent lockdown[41]. The South African Ministry of Justice and Correctional Services recently drafted a Domestic Violence Amendment Bill (herein amendment to the Domestic Violence Act 116 of 1998); however, implementation on the ground needs to be ensured to track the progress of activities and to respond effectively. Immediate interventions are required where the government partners with pharmacies and uses coded terms to enable victims of GBV to access support services without being identified[37]. It is vital also to have national, provincial, and district databases of the reported violence cases to be able to monitor and evaluate for intervention purposes[41]. In partnership with various organisations, the national government should develop a free mobile application that offers free mental health counselling for the victims of GBV[41].

In the South African context, there needs to be free mental health counselling services for victims with mobile phones that do not have the internet to ensure inclusivity. Also, the government could subsidise the unemployed victims and those earning minimum wage for them to be able to access these services One of the ways to ensure that GBV is prioritised in South Africa lies with the

government and medical aid companies. They need to categorise psychological treatments as necessary and capacitate existing community health workers in tracking the victims of GBV in hard-to-reach communities and those with little to no existing counselling services[74,83]. In the above implementation, the government might need to subsidise individuals who cannot afford the services. The training will also need to be extended to medical doctors, allied health professionals, as well as other workers in the health fraternity to best identify and protect survivors of GBV[84–86]. South Africa is well-known for community dialogues, which have raised awareness about Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) and tuberculosis (TB) in communities for decades[46]. In this instance, the discussions could be held with women to understand better their lived experiences and concerns about safety in their homes and communities. There is also a need for dialogues with men to understand what drives them to GBV. This will help to define the prevention strategies.

Also, public awareness campaigns on GBV and access to support services need to be conducted where the importance of reporting cases should be highlighted[46,73]. These support services must speak to the services required for each respective community. There needs to be increased surveillance of reported GBV cases, which necessitates effective systematic working relationships between various government departments, such as the Department of Social Development (DDS) and the Department of Health (DoH)[50] and the SAPS. Additionally, further research is needed to support victims of GBV during the pandemic[50].

Key intervention strategies in combating GBV and ensuring that victims are supported adequately include dialogues and interventions around high-level communication and behaviour change programs, prioritisation of reported cases, and developing interventions tailored to respond to the economically vulnerable circumstances women encounter[12]. There should be an emergency strengthening of the support systems that could be utilised by women experiencing violence and who are planning to escape the violent environment during regulated lockdown curfew periods in South Africa[67]. Interventions should also include de-normalising violence against women by their male counterparts and men in general[68]. This could be implemented through educational programs in communities, including schools where violence is prevalent. In this regard, an evaluation study on a school violence program in Tshwane, South Africa, found that the programme increased positive knowledge of violence and attitudes toward violence[87]. The recommended services must also be offered in all South African official languages to ensure that information is received and understood extensively. GBV-related programs need to be prioritised in every sector and government department. This would necessitate realistic measures and activities to ensure impact. Governments must collaborate with various organisations to derive interventions by eliminating factors contributing to a surge in GBV cases. Lastly, for governments in the SSA region, particularly South Africa, to adequately address the GBV and COVID-19 pandemic impact on women, countries should conduct research studies on experiences of GBV during COVID-19.

Limitations

This review only included studies published in English; as a result, this limited the possibility of finding studies that can be transferred in other similar settings and the ability of the reviewer to find other relevant studies published in a different language. The period was limited between March 2020 to July 2021 only, thus excluding studies before and beyond the stipulated period. The literature was limited to African peer-reviewed articles, excluding other similar settings beyond Africa.

Conclusion

COVID-19 has changed how individuals live, and the introduction of nationwide lockdowns has limited the opportunity to address GBV. A growing body of literature has documented the prevalence of GBV cases against women during the COVID-19 pandemic globally, including in South Africa. Experiences of GBV bring about several psychological and emotional stressors in the lives of individuals. As such, it remains vital for the South African government to prioritise and respond proactively to the reported and increased number of GBV-related cases to support the victims. Women

who are victims of GBV bear the brunt of the violence in pandemics. Without proper and accessible support during the lockdown, there is an increased risk of victimisation, even in households where there was no violence before the lockdown. Multi-pronged and all-inclusive intervention strategies are needed to address the prevalence of GBV cases effectively and sufficiently in South Africa during the lockdown. Also, there is a need for a qualitative inquiry, especially in rural and peri-urban areas, to determine the extent to which GBV and COVID-19 impact where knowledge of and access to support services remain limited compared to urban areas.

Conflict of interest

The authors declare no competing interests.

Ethical approval

The project was approved by the University of the Free State Health Sciences Research Ethics Committee (HSREC) (reference number UFS-HSD2021/0520/2906).

Data availability

Due to the nature of this review, no new data were generated.

Authors' contributions

SN, MM, JTG and JN were involved in finalising the concept, additional literature search, and critical revision and proofreading of the write-up. SN led the writing process of the review. All authors read and approved the final version to be published.

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