GENDER-BASED VIOLENCE DURING COVID-19 PANDEMIC IN THE MALDIVES: AN ANALYSIS OF REPORTED CASES

A study undertaken by
Institute of Research and Development Pvt Ltd

UNFPA

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ON BEHALF OF UNFPA

At the onset of the COVID-19 pandemic, increasing evidence pointed that alongside the measures and restrictions placed to control the pandemic, existing inequalities compounded and increased women's vulnerabilities, with a surge in incidences of violence . To safeguard the progress that has been achieved, United Nations Population Fund (UNFPA) in collaboration with the Ministry of Gender, Family and Social Services commenced an analysis of the reported cases in order to seek an evidence based roadmap that encompasses a human-rights based and survivor centered approach.

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Executive Summary

Gender based violence (GBV), including domestic violence (DV) and violence against women (VAW) in particular, is indicative of deep-rooted gender inequalities that is predominant in most societies, including Maldives. In most countries across the world, including the Maldives, 1 in 3 women experience some form of violence which is intensified by their gender. VAW results in women's physical and psychological distress and imperils the autonomy of women to claim and to enjoy their human rights. During the COVID-19 pandemic, occurrence of GBV has been reported as increasing throughout the world, especially in developing countries such as the Maldives. The current study explores the prevalence of GBV during the pandemic-related lockdown period in the Maldives (January 2020 to September 2020).

The purpose of this study is to create an evidence-based roadmap for reorienting the existing GBV/DV programme to encompass a human rights-based and survivor-centred approach. As such, the study will also inform the design and delivery of the national GBV/DV response programme, including the campaign to change public perceptions and attitudes towards GBV/DV. In particular, this study is designed to:

1. Provide a desk review of relevant national strategies and legislation on GBV/DV and other available guidelines on the GBV/DV programme in the Maldives.
2. Analyse cases and administrative records of GBV/DV-related issues reported during January to September 2020 to MoGFSS/FPA.
3. Determine the current service and communication gaps, covering urban and rural settings, and inform suitable communication preferences to address gaps and myths regarding GBV/DV.

This study utilised a mixed-method approach included collection of qualitative data through key informant interviews (relevant authorities) and gathering of quantitative data from the reported cases from January to September 2020, available from MoGFSS and FPA. The document analysis revealed that in the Maldives, while there exists a good legal framework, which include Gender Equality Act (Law no. 18/2016), Domestic Violence Prevention Act (Law no. 3/2012), Prevention of Sexual Abuse and Harassment Act (Law no: 16/2014), and Sexual Offences Act (Law no: 17/2014), and related policies to promote gender equality and address GBV/DV, both their implementation and awareness amongst the public are limited. Further, the traditional patriarchal system ingrained in Maldivian society remains powerful, negatively impacting women's lives as these cultural and social norms tend to be a basis for GBV/DV against women. According to this study, female adolescents are more likely to suffer from GBV/DV than their male counterparts. Further, during the lockdown period, women aged between 19 to 40 years were more than four times more likely to report as a survivor of GBV/DV than their male counterparts. This study has shown that the risk of violence have been magnified during the lockdown period, when survivors had to live in close proximity to their perpetrators or when families experienced financial strain. Finally, public's awareness of laws and the availability of services are limited, and lockdown situations had further negatively impacted communication about both these services and how survivors may seek help from the respective institutions.

Based on these findings, we make five practical recommendations as a way forward in mitigating GBV/DV in the country, which are:

1. Make available comprehensive sexuality education both within and outside schools;
2. Establish women's economic empowerment as a strategy for prevention of GBV;
3. Change social norms that perpetuate violence against women and children;
4. Ensure that adequate services for the rehabilitation of perpetrators are introduced and are made accessible at all levels; and
5. Strengthen the national capacity to use and analyse data for policy advocacy.

Section A: Introduction

Gender-based violence (GBV), and violence against women (VAW) in particular, is one of the most significant social problems in our society today, as the World Health Organisation (WHO) reports that globally, 1 in 3 women experience physical or sexual violence in their lifetime (WHO, 2017). Prevalent estimates of intimate partner violence range from 23.2% in high-income countries and 24.6% in the WHO Western Pacific region to 37% in the WHO Eastern Mediterranean region, and 37.7% in the WHO South-East Asia region (ibid). According to UN Women (2020), globally in 2019, 243 million women and girls were abused by an intimate partner. However, only a mere 40% of women who experience violence report it or seek help (ibid).

According to the WHO (2020), the health impacts of GBV and domestic violence (DV) on women and their children are significant. VAW can result in serious injuries such as physical, mental, sexual and reproductive health problems, including sexually transmitted infections and unplanned pregnancies (ibid). These acts of violence negatively impact human rights as well as the country's national development. GBV results from an imbalance of power between women and men, and the structural inequities and discrimination that exist in our societies further aggravate this inequality. The Maldives Study on Women's Health and Life Experiences shows that even in the Maldives, 1 in 3 women aged 15-49 years have experienced at least one form of physical or sexual violence, or both, during their lifetime (Fulu, 2007). Further, 1 in 5 women aged 15-49 years who had been in a relationship reported experiencing physical and/or sexual violence by an intimate partner (ibid). Significant efforts have been put in place in the Maldives since the publication of this report to address the issue of VAW and GBV. One significant step was the legislative reform that saw the introduction of the 2012 Domestic Violence Prevention Act, the Gender Equality Law (Attorney General's Office, 2016), the Prevention of Sexual Abuse and Harassment Act (16/2014; Attorney General's Office, 2014a), and the Sexual Offences Act (Attorney General's Office, 2014b).

Further, through the mandate of the Domestic Violence Prevention Act (DVA), a Family Protection Authority (FPA) was established to oversee and coordinate the response to DV in the Maldives.

In the Maldivian society, GBV has been a taboo subject and matters arising from it are considered a private family affair; however, reporting of these cases have increased since the introduction of these laws and the associated awareness programmes that have been conducted by the government and non-government authorities. These awareness programmes work on addressing these issues of GBV/DV through community awareness on the detrimental effects on women's health and wellbeing, and that of their families and the community in general, together with educating the public about individual rights in reporting these cases on their own behalf or on the behalf of a family member. These awareness programmes are a first step, paving the way for evidence-based planning by all the concerned authorities in finding solutions to address and eliminate GBV/DV acts in the community and the country.

Despite these positive steps, the lived reality for women in the Maldives still remains dire. The Demographic Health Survey (DHS; Ministry of Health, 2016) shows that 1 in 4 ever-partnered women have experienced physical and/or sexual violence from an intimate partner in their lifetime, indicating an increase from 1 in 5 women in 2007. Further, according to the study undertaken by the UNDP, Women in Public Life - Situational Analysis/Baseline Assessment, the national prevalence rates of different forms of intimate partner violence was such that all Maldivian women have experienced some form of violence at least once in her life (Quinn, 2011). Emerging issues such as increasing religious extremism have aggravated negative impacts and erased gains made in the rights and empowerment of women (United Nations, 2019; Uthema, 2020).

The global COVID-19 pandemic brought about various levels of lockdowns, curfews, and restrictions in movements in countries worldwide. These measures have created conditions that have significantly increased VAW, GBV, and DV all around the world, evidenced by the increase in calls to DV helplines in many countries (UN Women, 2020). According to UNFPA (2020), the COVID-19 pandemic has exposed inherent and systemic gender inequalities and forms of discriminations that exist in our communities. The lockdown conditions have placed vulnerable women in an environment where the risk factors were high and where they had limited opportunities to escape from any violence they faced. The United Nations has called GBV/DV during the COVID-19 pandemic the 'Shadow Pandemic' (UN Women, 2020). In the Maldives, statistics from MoGFSS and FPA shows that the reporting of GBV, including DV, were initially limited during the first weeks of the pandemic-related lockdown period; however, reporting increased with the easing of the lockdown, as well as with the lifting of the restrictions that were in place to prevent the spread of the infection.

However, in the Maldives, it is not yet clear the overall trends of the GBV/DV cases that were reported during the pandemic period, nor are the causes for these reports. Thus, a thorough analysis of the cases triangulated with key informant interviews, together with the statistics on reported GBV/DV cases can provide a much-needed set of evidence to shape the recovery and long-term plans to prevent and respond to GBV/DV in the Maldives. Such an analysis also stands to identify ways to address this Shadow Pandemic in the country alongside recovery from the COVID-19 pandemic itself. Moreover, the analysis will engage with broader elements to help us understand any existing communication gaps in reporting and addressing GBV/DV; therefore, all concerned authorities can work together to provide better and concerted means to address these dual pandemics.

PURPOSE AND SCOPE OF THE PROJECT

The purpose of this research is to create an evidence-based roadmap for reorienting the existing GBV/DV approach to encompass a human rights-based and survivor-centred approach. As such, the study will also inform the design and delivery of the national GBV/DV response programme, including the campaign to change public perceptions and attitudes towards GBV/DV. This research will lead to achieving the specific objective of the programme, which is that by 2023, women and young people will have improved access to GBV/DV information and services and will be able to counter myths and prejudices related to GBV/DV.

The scope of work includes the following:

i. Desk review of relevant national strategies and legislation on GBV/DV and other available documents, including survey and research reports, and guidelines on the GBV/DV programme of the Maldives;

ii. Analysis of the summary of cases and administrative records of GBV/DV-related issues reported to MoGFSS/FPA during 2020;

iii. Conducting key informant interviews across different sectors and levels to determine the current services and communication gaps, covering urban and rural settings; and

iv. Conducting discussions with relevant key informants to inform suitable communication preferences to address gaps and myths regarding GBV/DV.

The research questions guiding this study are:

1. Is there evidence for a change in the nature, forms, or severity of reported violence during the COVID-19 pandemic-related lockdown period?
2. Was there an increase or decrease in service use?
3. During the lockdown period were the services being accessed and/or delivered, and was it safe and effective?
4. What is the nature of the challenges to service delivery during the pandemic, including communication of the availability of services and referral pathways?
5. Which age group was most affected due to GBV/DV?
6. What types of violence was most reported as GBV/DV?

Section B Conceptualising Gender-Based Violence and Domestic Violence

In 1979, the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW) was adopted by the United Nations General Assembly and a committee named Committee on the Elimination of Discrimination against Women was established to monitor the implementation of the convention. The countries who have adopted this convention are required to report every four years on country implementation. Gender-based violence (GBV), especially violence against women (VAW), as an issue of human rights was placed on the agenda of the World Conference on Human Rights, held in Vienna in 1993 (Johnson, Ollus, & Nevala, 2007). This conference provided a turning point for GBV, as it not only led to the broadening of the definitions of GBV and VAW, but it also focused global attention on the discrimination and inequalities that are tolerated by any state and lead to women's increased vulnerability to violence (ibid).

In 1993, through the Declaration on the Elimination of Violence Against Women, the United Nations put forward the first official and comprehensive definition of VAW. According to the United Nations, VAW is "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 deprivation of liberty, whether occurring in public or in private life" (United Nations, 1993 p. 2). Article 2 of the Declaration on the Elimination of Violence Against Women states that violence against women shall be understood to encompass, but not be limited to, the following:

1. Physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation;
2. Physical, sexual and psychological violence occurring within the general community, including rape, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution;
3. Physical, sexual and psychological violence perpetrated or condoned by the state, wherever it occurs.

(United Nations, 1993, p. 2)

The terms 'gender-based violence' and 'violence against women' are often used interchangeably in the literature. The European Commission states that the term GBV refers to violence directed against a person because of his or her gender and expectations of his or her role in the respective society. GBV highlights the gender dimension of these types of violent acts, and the relationship between females' subordinate status in society and their increased vulnerability to violence. It is important to note that men and boys may also be survivors of GBV, especially sexual violence; however, incidence of GBV against women and girls is disproportionately higher all over the world. Given the disproportionate numbers of women and girls that experience and report cases of such violence, the focus of this study is on women and girls. Therefore, the term GBV will be used throughout this study referring to VAW and other forms of gender-based domestic violence (DV), and thus this study conceptualises VAW as one form of GBV. In conflict/post-conflict and emergency settings (such as the COVID 19 situation facing the world right now), the term sexual and gender-based violence (SGBV) is also a commonly used term. Sexual violence is also perpetrated primarily against women and girls.

In the Maldives, according to the Gender Equality Act (Law no. 18/2016), GBV is defined as "any violence towards women, for the reason of her

being a woman, shall be considered, as gender-based discrimination" (Republic of Maldives, 2016, Chapter 3). Further, the Domestic Violence Prevention Act (DVPA) (Law no. 3/2012), defined DV as "domestic acts by a perpetrator where such conduct harms, or may cause imminent harm to, the safety, health or wellbeing of the survivor(s) and provided the survivor(s) and the perpetrator(s) are in a domestic relationship" (Republic of Maldives, 2012, Article 4(a)).

Research suggests that adhering to gender roles at individual and societal levels increases the likelihood of VAW (Heise, 1998) in the community. Gender differences exist in the Maldives in all aspects of life.However, in sexual and reproductive health (SRH) provision, gender-based discriminations are more visible and profound (Uthema, 2020). Due to such disparity of fundamental human rights, women's wellbeing is diminished, whereby the social, cultural, and gendered restrictions on women's roles at home and outside may increase (El-Horr & Pande, 2016). Throughout their lives and in different settings such as in the family, the community, and the broad society, women experience violence, mostly by their partners (UN Women, 2012; UN Women, 2020), and this pattern of VAW is also evident in the Maldives (Fulu, 2007; Ministry of Health, 2016). The first Maldivian CEDAW report of 2002 prepared by the Ministry of Women's Affairs and Social Security highlighted concerns of VAW including DV being under-reported, the absence of laws and law enforcement and a lack of support systems for women survivors of violence. One of the main concerns of this report was that VAW in the community and in the legal system is seen as a private matter rather than an infringement of human rights and a violation of the convention. Thus, the 2002 report urged the government to improve law enforcement measures and enact laws on VAW, including DV and marital rape, evident in the CEDAW General Recommendation 19 on VAW (Ministry of Women's Affairs and Social Security (2002), as cited in Alder and Polk, 2004 p.3).

According to the Maldives demographic and health survey (DHS; Ministry of Health, 2016) from 2016-2017, the main findings regarding GBV and DV are as follows:

- **Experience of Violence**: Among women age 15-49, 17% have experienced physical violence and 11% have experienced sexual violence. 41% of women have experienced physical violence during a pregnancy.
- **Marital control**: 6% of women who have been or are married have experienced at least three types of marital control behaviours from their husbands or partners. 62% have never experienced marital control behaviours by their husbands or partners.
- **Spousal violence**: 24% of ever-married women age 15-49 have experienced physical, sexual, or emotional violence from their current or most recent husband/partner. 19% of women have experienced emotional violence, 12% have experienced physical violence and 2% have experienced sexual violence from a husband or partner.
- **Injuries due to spousal violence**: 41% of ever-married women reported injuries due to experience of spousal physical or sexual violence.
- **Help-seeking**: 42% of all women who have ever experienced physical or sexual violence have sought help. 1 in 5 women aged 15-49 (19.5%) who had ever been in a relationship reported experiencing physical and/or sexual violence by an intimate partner. Women in the South region (51%) are most likely to seek help and women in North Central region are least likely to do so (29%).
- Approximately **1 in 8 women aged 15-49** (13.2%) reported experiencing physical and/or sexual violence by someone other than an intimate partner since the age of 15.
- Combining physical and/or sexual violence by partners and non-partners, since the age of 15, more than **1 in 4 women** (28.4%) has experienced partner or non-partner violence, or both.
- Approximately **1 in 8** women aged 15-49 (12.2%) reported that they had been sexually abused before the age of 15 – that is, they had experienced childhood sexual abuse.

Further, the sixth CEDAW report compiled in 2019 also highlights the significant advances made in the Maldives from 2013-2018, demonstrating the alignment between the country's national legal and regulatory frameworks with the overall obligations in the CEDAW. Since the initial report of the CEDAW committee in 2002, the status of reporting GBV has changed in the Maldives. For example, in 2007 a national-level study on VAW revealed that 19.5% of women reported intimate partner violence, 13.2% reported non-partner violence, and 12.2% reported childhood sexual abuse (Fulu, 2007). Further, this study showed that overall prevalence rate for VAW in the Maldives was 34.6% (ibid). However, with the introduction of various laws such as the Domestic Violence Prevention Act (Law no. 3/2012; Attorney General's Office, 2012), the Sexual Harassment Act (Law no: 16/2014; Attorney General's Office, 2014a), the Sexual Offences Act (Law no: 17/2014; Attorney General's Office, 2014b), and the Gender Equality Act (Law no. 18/2016; Attorney General's Office, 2016), these statistics are changing. Following these laws, there have been positive developments in providing support for GBV/DV survivors. With the implementation of security to survivors through laws such as the 2016 Gender Equality Act and the 2012 Domestic Violence Prevention Act and the awareness programmes that have been conducted countrywide, there have been an increase in the reporting of cases and subsequent number of reported cases of GBV/DV in the Maldives. Further, the MOGFSS has established four shelters for survivors of DV (H.Dh. Kulhudhufushi, SH.Fonadhoo, Th.Veymandoo and GDh Thinadhoo) and there are plans to extend these services to other atolls. Further, 19 Family and Children Service Centres (FCSCs) have been established covering all atolls of the country and conduct a 'Service Mapping' by FPA helps to identify the available current services in the country (UN, 2019).

Additionally, respective government and non-government agencies have made many efforts in the past years to reinforce and secure women's rights. These measures include the above-mentioned changes to the legal framework, but also are evident in the reviews of existing laws and/or establishment of new ones, together with the implementation various community awareness programmes. For instance, a report prepared by Alder and Polk (2004) proposed recommendations on the gender issues for the Criminal Justice System of the Maldives and the government of the Maldives have addressed most of these. These amendments include Article 34 and 52 of the Constitution of the Maldives which counteracts previous measures which prevented women from the office of the President and Vice president. Further, the recent amendments made to the Penal Code criminalise rape in all scenarios, including marital rape, via the 2020 Criminal Procedure Act.

Despite these legal changes and an increased awareness of GBV/DV reporting in the communities, the traditional beliefs around gender roles and patriarchal norms still exist in Maldivian society, maintaining the gender-related power imbalance. Further, although equal opportunities are available at primary and secondary schooling and the life expectancy of women (85.7 years) is higher than men (79 years) in the Maldives, in private life women face an increased risk of DV, which significantly impacts their health and wellbeing, and may potentially decrease their life expectancy. VAW is perceived as a shameful issue, and the acknowledgement of being a survivor may bring dishonour to the survivor and family, consequently harming the survivor's well-being and readjustment into society (Alder & Polk, 2004). The stigma attached to GBV/DV results in significant under-reporting of GBV/DV and sexual assault and a lack of gender sensitivity in the reporting mechanisms, along with limited access to legal and healthcare information and services (ibid). Hence, many cases regarding sexual violence against women may go under-reported, and these cultural challenges indicate some of the reasons why few perpetrators of GBV/DV are convicted for their offences. These reasons for limited reporting of GBV/DV is also applicable during the COVID-19 pandemic period, when women experiencing violence were more vulnerable, for example in having to live in confined spaces for prolonged periods with their perpetrators, unaware of the

services available or their fundamental rights to ask for help to escape an abusive environment.

For people who were living under these conditions, it is vital to address GBV as it is a significant factor hindering women's participation and engagement in society. Hence, all forms of VAW must be addressed and there is work needed to create a gender-equitable society that will enable us to attain the global Sustainable Development Goals (SGDs). Even with the limited resources that exist in the Maldives, the MoGFSS plays an active role to address some of these issues, but there is more to do in minimising GBV/DV beyond simply providing supports such as temporary shelter, counselling and economic empowerment to women so that we can address deep-seated cultural beliefs about women.

OVERVIEW OF THE NATIONAL LAWS AND REGULATIONS ON GBV/DV

In this section, a brief overview of the four laws that impact GBV and DV are provided. The laws are the Law on Gender Equality (Law no. 18/2016), the Law on Domestic Violence Prevention (Law no. 3/2012), the Sexual Harassment Act (Law no: 16/2014) and the Sexual Offences Act (Law no: 17/2014). However, there are other laws such as the Family Law 2001 and supplementary guidelines, the Special Provisions Act to Deal with Child Sex Abuse Offenders (Law no: 12/2009), the Anti-Human Trafficking Act (Law no: 12/2013) and also the new CRPA ACT (Law no: 19/2019), which also contribute to the prevention of violence. In this overview, we rely upon the terminologies that are used in those documents.

Gender Equality Act (Law no. 18/2016)

This act (Attorney General's Office, 2016) provides general principles to achieve gender equality in the Maldives, identifying policies to prohibit discrimination based on gender and the duties and responsibilities of State institutions and other relevant parties to achieve gender equality in the Maldives. This law is divided into nine main chapters in which Chapter 3 defines GBV and its characteristics as:

Any violence towards women, for the reason of her being a woman, shall be considered, for this Act, as gender-based discrimination.

According to this law, GBV against women, as stated in subsection (a) of this act, involves the following acts against women for reason of her being a woman:

a. an act of domestic violence as stipulated in Act number 3/2012 (Domestic Violence Prevention Act);

b. an act of rape or sexual assault as stated in Act number 17/2014 (Sexual Offences Act), or a threat thereof;

c. physical, sexual or psychological harm;

d. threatening to commit acts of nature stated in subsection (a) (3) of this Section;

e. detention in a certain place without consent; denial of dignified economic and social life;

f. denial of opportunity to earn for self-sustenance;

g. acts of sexual abuse and harassment as stated in Act number 16/2014 (Sexual Abuse and Harassment Act);

h. trafficking of girls and women or obtaining benefits through the trafficking of girls and women; and

i. carrying out an act against women prohibited by another law.

According to this law, the steps taken where GBV occurs against women include "penalties prescribed in such laws or the application of social responsibility as defined in such laws or the application of criminal charges specified in such laws for the acts stipulated in this Act".

Domestic Violence Prevention Act (Law no. 3/2012)

The Domestic Violence Prevention Act (DVPA; Attorney General's Office, 2012) was passed and enacted in 2012. The DVPA defines "domestic

violence" as "acts by a perpetrator where such conduct harms, or may cause imminent harm to, the safety, health or wellbeing of the survivor(s), and provided the survivor(s) and the perpetrator is in a domestic relationship" (Domestic Violence Prevention Act, 2012, Article 4(a)).

The Act is divided into ten parts; Parts 1 to 3 cover introductions and definitions. Within the section on reporting (Part 5), the Act specifies that any person who has reason to believe that an act of domestic violence has been, or is being, or is likely to be committed, must give information about it to the police. The role of the police, health professionals, and social workers is identified in detail in Part 6. Part 7 outlines the process for protection orders (POs). The DVPA is a semi-criminal law in the sense that it only allows punishment if there is a violation of the protection order issued under the Law. The Law itself does not provide a pathway to hold offenders accountable within the criminal justice system for the offence of Domestic Violence.

The last part of the law outlines how it will be implemented, with the Minister of Gender, Family and Social Services being the highest authority responsible for the implementation and enforcement of the provisions in this Act as respects to the stopping of DV. The establishment of a Family Protection Agency and the responsibility of the authority is also determined in this Act.

According to this law, domestic relationships include:

a. Persons who are or were married to each other;

b. Persons who share or have recently shared the same residence;

c. Persons who are the parents of a child or a person who has or had parental responsibility for that child;

d. Persons who are family members related by consanguinity, affinity or marriage;

e. Persons who are domestic child caretakers or domestic workers; or

f. Persons who are in an intimate relationship.

Furthermore, the DVPA recognises the following acts as domestic violence:

1. physical abuse;
2. sexual abuse;
3. verbal abuse and psychological abuse;
4. economic or financial abuse;
5. impregnating the spouse, without concern to her health condition and against any medical advice to refrain from impregnation for a specified period;
6. impregnating a woman, who is trying to remove herself from a harmful marriage, against her will;
7. deliberately withholding the property of a person;
8. intimidation;
9. harassment;
10. stalking;
11. damage to property;
12. entry into, and being present thereafter at the survivor's residence without consent, where the parties do not share the same residence;
13. any other act which may be described as controlling or abusive behaviour towards the victim;
14. coercing, intimidating or forcing the survivor to commit an act which such person would not have consented to or committed by their own volition;
15. confining the victim to a place or restricting their movement against their will;
16. attempting to commit any of the foregoing acts or causing apprehension of such acts; and
17. causing a minor to witness or hear an act of domestic violence or presenting or placing a minor in such a situation where such minor may witness or hear an act of domestic violence.

While the DVPA covers some elements of hate crimes, as seen above regarding when there is an existing domestic relationship between offender and survivor. However, there is no framework or law to criminalise hate crimes, which make it difficult for the state to prosecute individuals for the underlying issues, such as cyberbullying and domestic violence against and by those with mental health problems and persons with disabilities.

Prevention of Sexual Abuse and Harassment Act (Law no: 16/2014)

This Act (Attorney General's Office, 2014a) was passed and enacted in 2016. This law covers all forms of sexual harassment at the workplace, such as educational institutions, healthcare providers, and other forms of service providers. It indicates the responsibilities of these service providers in ensuring a sexual-harassment free workplace and their obligations if such issues are reported. The first chapter of this Act defines their terminologies, and it defines sexual harassment as any form of sexually-motivated action (written, verbal and other forms) without consent.

In the ensuing chapters in this Act, the responsibilities of the employers with regard to ensuring a safe work environment are stipulated, identifying their courses of action if such an incident is reported. For example, in workplaces where more than 30 staff members are employed, a committee called the 'Committee on preventing and stopping sexual harassment at the workplace' should be established to ensure that this Act is practised in the workplace. The Act goes onto explain how the committee will be structured and run, and its roles and responsibilities in providing a safe workplace, such as investigating incidences within a maximum of 60 working days. Further, how a survivor can go about reporting such forms of harassment is also clearly described in this Act.

Sexual Offences Act (Law no: 17/2014)

The Sexual Offences Act (Attorney General's Office, 2014b) was passed and enacted in 2014. It is an Act that provides security for the survivors of a sexual offence, and it also states what constitutes a sexual offence in the Maldives and the procedure related to these offences. The Act is divided into seven chapters: Chapter 1 covers introduction and purpose, Chapter 2 contains definitions and terminology, Chapter 3 explains the offences, Chapter 4 is regarding establishing a sex offenders' registry, Chapter 5 is on collecting evidence, Chapter 6 is on recovery of damages, and Chapter 7 explains some general provisions.

The purpose of this Act is for amending and enhancing the legal procedures relating to sexual offences, such as:

1. Determination of sexual offences and penalties thereof;
2. Determining the acceptable defences about sexual offences;
3. Determining the standards for defining consent concerning sexual offences;
4. Introducing a mechanism for recovery of damages for survivors of sexual offences; and
5. Enabling the publication of persons convicted for sexual offences.

Additionally, under this Act, the family protection agency needs to keep a proper record of sexual offenders.

GBV/DV AND THE COVID-19 PANDEMIC

The COVID-19 disease that grew to become a worldwide pandemic in the beginning of 2020 brought about instantaneous, life-changing measures across global populations. Countries were forced to restrict the movements of the public through lockdown or curfew measures to prevent the spread of COVID-19, reduce casualties, and minimise loss of life due to the disease. The unprecedented nature of the pandemic and the ensuing lockdown has revealed some of the inherent and systemic gender inequalities, exacerbating pre-existing and toxic social-norms that underlie our communities (UNDP, 2020; UNFPA, 2020). According to UNDP (2020), during

the pandemic, these social norms and practices, coupled with the economic and social stress of the pandemic, the associated restrictions in movement, and isolation measures, have led to an exponential increase in GBV and DV all over the world. Further, the WHO (2020) has also expressed concern that during the pandemic, the likelihood of women being exposed to abusive relationships and forms of violence has dramatically increased. Incoming reports and research reveal that in both developed countries such as the United Kingdom and the United States, and developing countries such as South Africa, there are significant increases in GBV and DV cases since the COVID-19 outbreak began (Raj, Johns, Barker, & Silverman, 2020; CommonAge, 2020; WHO, 2020). UN Women (2020) reports that in some countries during the COVID-19 related lockdown periods, calls to GBV/DV helplines had increased five-folds. On 2020's International Day for the Elimination of Violence against Women, the United Nations labelled all forms of violence happening against women and girls happening at the wake of COVID-19 as the 'Shadow Pandemic' (ibid). According to the United Nations, the collective focus on GBV and DV against women as a Shadow Pandemic will enable worldwide attention to focus on that global increase and provide it a level of seriousness and attention commensurate with the broader COVID-19 health crisis. Under these global circumstances, the situation in the Maldives is similar, and yet needs further exploration to understand how service delivery and support systems to the survivors of GBV and DV can be provided. As such, a comprehensive national study has not been conducted to understand the situation within the country, and so this study provides a first step in exploring the situation of the Shadow Pandemic in the Maldives.

THE THEORETICAL FRAMEWORK FOR THE STUDY

Violence is complicated and results from a combination of multiple influences upon behaviour, which involve how individuals relate to those around them and their broader environment. The theoretical framework driving this study is the socio-ecological framework (Heise, Ellsberg, & Gottmoeller, 2002, see Figure 1). This framework allows us to address the factors that put people at risk for or protect them from experiencing or perpetrating violence, labelled here as risk and protective factors, along with the prevention strategies that can be used at each level to address these factors (Heise et al., 2002). Further, this framework is commonly used for GBV/DV studies. In this study, the framework helps us to explore GBV/DV at four different but interconnected levels (individual, relationship, community and the societal context levels), thus enabling an understanding of how these distinct levels interact in the manifestation of GBV/DV, its causality, and its reporting and communication mechanisms (ibid). A brief description of each of these levels, as they are pertinent to this study, follows.

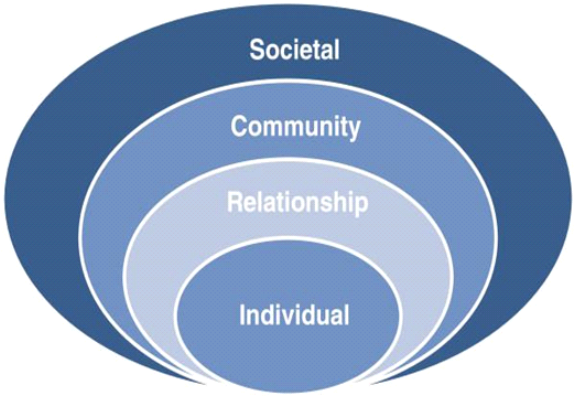

Figure 1 Socio-ecological framework

Individual: This level identifies biological and personal history factors that increase the likelihood of becoming a survivor or a perpetrator of violence; factors include age, education, income, substance use, or history of abuse. This level can also take into consideration the beliefs, values, and actions that can either make an individual a survivor or a perpetrator.

Relationship: This level examines the relationships that may increase the risk of experiencing violence as a survivor or perpetrator. A person's closest social circle, peers, partners, and family members all influence their behaviour and contribute to their range of experience.

Community: This level explores both the formal and informal settings, such as schools,

workplaces, and neighbourhoods, in which social relationships occur and seeks to identify the characteristics of these settings that are associated with becoming survivors or perpetrators of violence.

Societal: This level looks at the broad societal factors, such as health, economic, educational and social policies, that help create a climate in which violence is encouraged or inhibited; this climate also helps to maintain existing economic or social inequalities between groups in society (Heise, 1998). This level also considers the "general views and attitudes that permeates the culture at large" (Heise et al., 2002, p. 264)

How does the socio-ecological framework apply to this study?

The current study addresses each level of the socio-ecological framework as a level of influence and also a key point for the prevention of GBV/DV. This breakdown offers opportunities for programme planners and policy makers to determine how and where to focus on prevention activities. With the application of this framework, we can gauge the communication gaps and what activities, policies, and or programmes are required to fill these gaps.

RESEARCH CONTEXT

Although there are few studies undertaken to suggest that there is an increase in DV and GBV since the COVID-19 outbreak began, reports from China, the United Kingdom, the United States, and other countries indicate an increase in DV cases (Godin, 2020; Women's Aid, 2020). In the Maldives, due to the disruption of livelihoods and earning potential, many people who were working in the tourism industry and small businesses experienced decreased access to basic needs and services. During this time, there was also an increased burden of care work for women. This abrupt change, in turn, increased the stress on and within families, with the potential to intensify conflicts and violence. Further, at the onset of the pandemic, all the economic and human resources in the country were focussed on the containment of COVID-19 and related health services, consequently disrupting other essential services such as sexual and reproductive health (SRH) and GBV support and help-lines. Thus, it is important to explore how these factors have affected GBV/DV reporting in the country.

ADDED-VALUE OF THIS STUDY

This study examined how the current social support systems were able to cope with issues of GBV and DV during the pandemic, particularly if the services that were accessible to the public were safe and effective, and catalogues the challenges of reporting during the pandemic, and what age cohorts of the population were the most affected. It additionally examined if there is an increase or decrease in cases during the pandemic and if there have been any communication barriers within the reporting process. This study shows that there has been an increase in reported cases, and there was a time in strict lockdown where the numbers decreased due to communication barriers as perceived by the reporting authorities. Further, this study also shows that the spouses of drug offenders were more at risk to be subjected to partner violence, suggesting the potential value of strengthening the communication and social support systems and reimagination of communication channels in order to be more effective.

IMPLICATIONS OF ALL THE AVAILABLE EVIDENCE

As COVID-19 impacts continue around the world, it will be essential to focus on breaking down communication barriers, correcting myths, and reimagining the support networks and other support organisations to ensure the availability of services for affected community members, and especially for those members of vulnerable populations.

Section C
The methodology of the study

This study utilised a mixed-method approach for research. In particular, a concurrent-triangulation design of mixed-method research (Matthews & Ross, 2014) was adopted. The study's application of this methodology included the collection of qualitative data through key informant interviews (relevant authorities) and the gathering of quantitative data for the cases reported from January to September 2020; this data as collected from MoGFSS and FPA. Collection of both types of data enriches the findings of the study in understanding the prevalence of GBV/DV during the COVD-19 pandemic, and these data would also enrich our understanding and knowledge of availability and challenges in providing service delivery to survivors of GBV/DV, including any gaps in communication and service delivery. The data collection methods are explained in detail below.

QUANTITATIVE DATA COLLECTION METHODS

The quantitative data involved collecting the information on reported cases of GBV/DV in the country from January to September 2020. This duration of data provided a picture of the reported cases during the pandemic and the type of GBV/DV cases reported so that we could examine trends in the cases during this period.

These data were collected through a specific data collection form that was designed for this study; the bespoke form was designed to capture vital aspects of GBV/DV, including each survivor's demographic background, such as age, gender and location, how and when the case was reported, and any outcomes of the case (if known). The quantitative data collection template is in Appendix A. The template was sent to MoGFSS and FPA who provided the information they have on the cases reported from January 2020 to September 2020.

QUALITATIVE DATA COLLECTION METHODS

For the qualitative data collection, an open-ended semi-structured interview guide was developed based on the literature reviewed on GBV/DV research. The interview guide can be found in Appendix B. MoGFSS identified 14 key informants to be interviewed (see details in Table 1).

These interviews were conducted in Dhivehi, and they were audio-recorded and translated into English during the transcription process. The interviews provided vital information regarding the situation of GBV/DV during the pandemic as perceived by the key informants and based on their first-hand experience in working on the reported cases.

Table 1 Key informants interviewed

#	Organization	Position
1	Family Protection Authority (FPA)	Official
2	HOPE for Women (an NGO)	Official
3	Famliy Legal Clinic (FLC; an NGO)	Official
4	Ministry of Gender, Family and Social Services (MoGFSS)	Caseworkers/ Supervisors
5		
6		
7		
8	Prosecutor General Office (PGO)	Official
9	Maldives Police Service	Chief Station Inspector
10		Staff Sergeant
11		Chief Station Inspector
12		Chief Station Inspector

DATA ANALYSIS

As per a concurrent-triangulation approach to mixed-method research, the qualitative data and quantitative data were analysed concurrently but separately from each other (Matthews & Ross, 2010). This method of data analysis was possible because each member of the research team was involved in a different element of data analysis. In the analysis of quantitative data, at first, the data provided by MoGFSS and FPA were cleaned independently and checked for missing values, and multiple submission of the same case were

identified and confirmed with data providers. The data cleaning phase showed some instances of vital information missing from both data sets, such as sex and age. Further, the data from FPA showed that the same case number had been assigned for GBV/DV cases that reported as a family or that for the same person even if reported from different sources. Once these two data sets were cleaned, they were individually transferred into the Statistical Package for Social Science (SPSS 26). In the analysis, both descriptive and inferential statistics were run on the data to help us answer the research questions. The data from each of these institutions are reported both individually and simultaneously, depending on the theme of analysis.

For the qualitative data analysis of the key informant interviews, the translated and transcribed interviews were analysed for content; the different forms of GBV/DV cases reported during the lockdown period and the different practices each key informant and their institutions prescribed to were also noted. This analysis was driven by the research questions and informed by the socio-ecological framework (Heise et al., 2002) to understand how each of the different levels of the socio-ecological dimensions impacted the reporting and communicating of the GBV/DV cases.

The findings from each type of data collection method were then triangulated to identify collective themes that would help the research questions of this study. Through data triangulation and application of the socio-ecological framework, we were able to identify a picture of GBV/DV cases in the Maldives during the COVID-19 pandemic period, in particular from January 2020 to September 2020.

Section D
Results and Findings

In this chapter, we present the results from the quantitative data analysis together with the findings from qualitative data. The quantitative data set consists of reported cases of GBV/DV from January to September 2020, used to explore different aspects of GBV/DV during COVID- 19 pandemic in the Maldives. The qualitative data collection was based on interviews with key informants from the following authorities: the Ministry of Gender Family and Social Services (MoGFSS), the Family Protection Authority (FPA), the Family Legal Clinic (FLC), the Maldives Police Services (MPS), the Prosecutor General Office (PGO), and HOPE for Women. The data are presented below according to the themes that were triangulated from these both data sets.

REPORTED CASES FROM JANUARY 2020 TO SEPTEMBER 2020

Analysis of the data reported to FPA from January to September 2020 showed that 600 cases of GBV/DV were reported to FPA. This number was reduced to 569 when multiple reported cases were excluded from the analysis. Table 2 illustrates that the percentage of multiple reporting cases were highest (10.3) in January 2020, but there are instances of multiple reporting of GBV/DV cases in all the months except March 2020. Reporting from various sources was high at the beginning of the year. Reporting of GBV/DV was lower in March to May, with no cases of multiple reporting in March. The decrease in reporting could be due to the first instances of community spread of COVID-19 and the sudden lockdown of Male' at the beginning of the pandemic. A similar trend is evident in the data reported to MoGFSS.

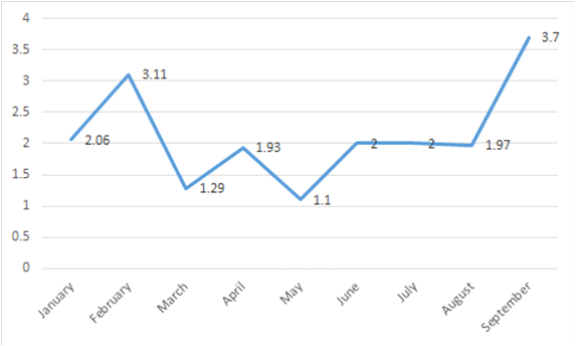

Figure 2 Daily average reported cases of domestic violence to FPA

The average daily cases of DV reported to FPA increased from January (2.06) to February (3.11). However, this average decreased and fluctuated-rom March to August. The lowest average of cases was for March and May (Figure 2). The data showed that daily reported cases increased in September, at the time when the COVID-19 restrictions on movement were eased in the Maldives. The increase in reported GBV/DV cases with the ease of lockdown measures indicates that

Table 2 Domestic violence cases reported to FPA and MoGFSS

	FPA						MoGFSS	
	All the Cases		Repeated excluded cases		Multiple reported cases		All the cases	
Month	F	P	F	P	F	P	F	P
January	65	10.8	*58	10.2	6	10.3	33	10.9
February	93	15.5	87	15.3	6	6.9	40	13.2
March	40	6.7	40	7	0	0	25	8.3
April	60	10	58	10.2	2	3.4	25	8.3
May	36	6	34	6	2	5.9	31	10.2
June	65	10.8	60	10.5	5	8.3	45	14.9
July	64	10.7	62	10.9	2	3.2	30	9.9
August	64	10.7	61	10.7	3	4.9	28	9.2
September	113	18.8	109	19.2	4	3.7	46	15.2
Total	600	100	569	100	30	46.7	303	100

Note: * one case was reported from 3 different institutions. F denotes Frequancy and P represents a percentage. The total percent may be more than 100 due to rounding.

there was an increase in service usage around GBV/DV.

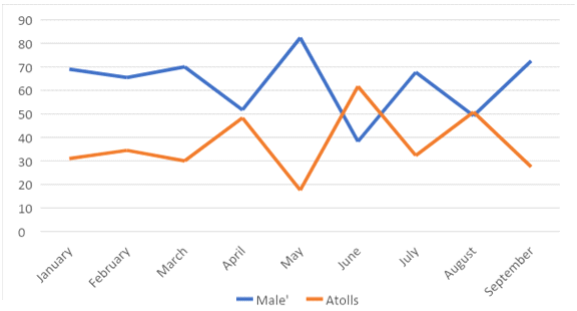

Figure 3 Percentage of GBV/DV cases reported to FPA by month, from Male' and the Atolls

The trend of GBV/DV cases reported to FPA from Male' versus the atolls appears as an opposing reflection of each other (Figure 3). It is interesting to note that as there was an increase of reported cases from Male', there was a corresponding decrease in reporting of GBV/DV in the atolls.

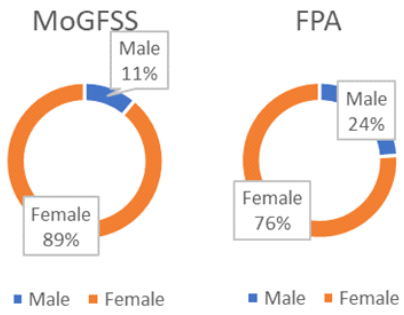

Figure 4 Survivors of domestic violence by gender

The characteristics of reported cases of DV revealed that more than 75 percent of the survivors reported to FPA were female, and this number increased to almost 90 percent in the cases reported to MoGFSS (Figure 4).

One of the key informants interviewed indicated that during the pandemic period, DV cases reported by men have increased when compared to the cases reported in previous years:

> *Mostly these increases are also cases of men. From my experience I have worked here for four years and then I would get two per year but now I have six cases of men here. So now men's cases are on the rise too,*
>
> *(Key Informant Interview 5)*

The reported cases of DV from January to September 2020 showed that DV survivors are evident across all the age groups, from infants to the elderly. The data from FPA revealed that female adolescents are more likely to suffer from domestic violence than their male counterparts. Women aged between 19 to 40 years are more than four times more likely than other age groups to report as a survivor of DV (Figure 5). However, reported cases showed that DV against male infants (3.1%) was higher than female infants (0.5%). Also, boys within the age of 6-10 years were three times more likely to be reported as DV survivors than girls in that same age group. From the reported cases, it was revealed that more females (4.9%) had unidentified age than males (1.6%). In addition to these unspecified ages, the

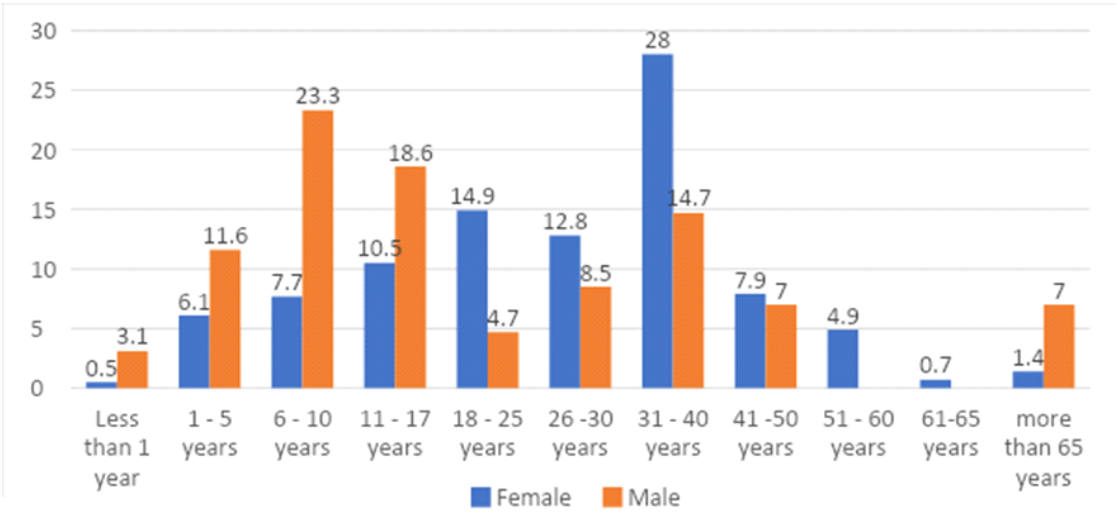

Figure 5 Percentage of domestic violence cases reported to FPA by gender and by age groups

data set has 11 cases where both the age and gender of survivors are unknown.

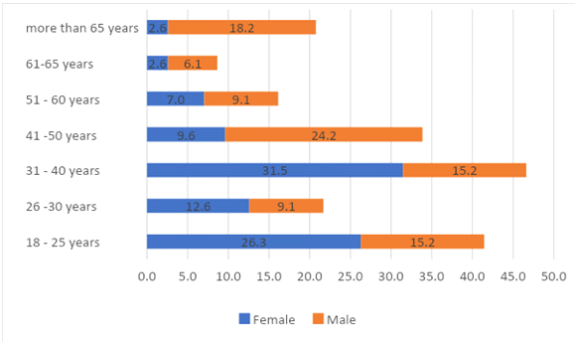

Figure 6 Percentage of domestic violence cases reported to MoGFSS by gender and age groups

The reported cases of DV to MoGFSS showed only adult survivors, and so data on violence against children (VAC) cases are not included here. The adult DV cases reported to MoGFSS revealed that more than 70 of the reported female survivors are aged between 18 and 40 years old. The highest reported male survivors age group was 41 to 50 years (24.2%) (Figure 6). The data set has age unidentified for 7.8 percent of females and 3 percent of males.

Forms and characteristics of reported cases of DV

The data reported to FPA are classified into 17 types of DV according to the Domestic Violence Prevention Act (see the overview of the national laws and regulations on GBV/DV in Section B). However, cases reported to MoGFSS were classified into 11 categories: physical violence; sexual violence; emotional abuse; rape; controlling behaviour; neglect; intimidating; economic and financial abuse; sexual harassment; stalking; and withholding and property damage.

The cases reported to FPA from January to September 2020 did not have any reported incidence of 'impregnating a woman, who is trying to remove herself from a harmful marriage against her will', or 'deliberately withholding a person's property' (see discussion of Domestic Violence Prevention Act, Section B). In the analysis, cases which have lower frequency were combined and formed a category called 'other'. The other category includes deliberately withholding the property of a person; stalking; entry into, and being present after that at the

Table 3 Reported cases of DV by type to FPA

Month	Total	Percentage of cases										
		Physical	Sexual	Verbal and psychological	Financial	Intimidation	Harassment	Damage to property	Any other controlling behavviour	Attempting to commit at act	DV in front of children	Other (7, 10, 12, 14 and 15) *
January	61	49.2	18.0	42.6	11.5	31.1	23.0	8.2	6.6	13.1	16.4	13.1
February	87	40.2	17.2	48.3	6.9	34.5	16.1	8.0	9.2	13.8	20.7	8.0
March	40	42.5	7.5	47.5	7.5	32.5	20.0	5.0	0.0	15.0	20.0	10.0
April	58	50.0	15.5	46.6	3.4	34.5	6.9	8.6	3.4	8.6	20.7	6.9
May	34	55.9	20.6	64.7	2.9	38.2	23.5	2.9	17.6	17.6	41.2	14.7
June	60	50.0	21.7	66.7	15.0	40.0	31.7	11.7	10.0	21.7	25.0	15.0
July	62	30.6	21.0	64.5	4.8	45.2	9.7	6.5	11.3	11.3	16.1	9.7
Aug	61	50.8	16.4	55.7	8.2	26.2	11.5	21.3	1.6	11.5	11.5	8.2
September	111	55.9	18.9	57.7	10.8	33.3	12.6	9.9	5.4	11.7	12.6	10.8

Note: * As per the numbering of DV acts in the DVPA, see SectionB

Table 4 Reported cases of DV by type to MoGFSS

Month	Total	Percentage of cases										
		Physical	Sexual	Verbal and psychological	Financial	Intimidation	Harassment	Damage to property	Any other controlling behavviour	Attempting to commit at act	DV in front of children	Other (7, 10, 12, 14 and 15) *
January	33	39.4	15.2	24.2	9.1	3.0	3.0	6.1				
February	40	52.5	10.0	15.0	5.0		2.5	5.0	2.5		5.0	
March	25	40.0	16.0	20.0		4.0	4.0	16.0				
April	25	60.0	4.0	24.0	4.0		4.0	4.0				
May	31	58.1	6.5	29.0	3.2			3.2				
June	45	37.8	11.1	15.6	13.3	4.4	2.2	8.9	2.2	2.2		
July	30	40.0	10.0	40.0		3.3		3.3				3.3
Aug	28	35.7	7.1	35.7	10.7		3.6				3.6	3.6
September	46	63.0	6.5	17.4		4.3	6.5				2.2	

Table 5 Result of Chi-square test

	Female frequency (%)	Male frequency (%)	Significant Value
Physical	214 (49.9)	54 (41.9)	0.0670
Sexual	90 (21.0)	10 (7.8)	0.0000*
Verbal and psychological	247 (57.6)	64 (49.6)	0.0640
Financial	43 (10.0)	5 (3.90	0.0170*
Withholding property	9 (2.1)	2 (1.6)	0.6870
Intimidation	166 (38.7)	33 (25.6)	0.0050*
Harassment	76 (17.7)	17 (13.2)	0.2150
Stalking	29 (6.8)	1 (0.8)	0.0020*
Damage to property	45 (10.5	9 (7)	0.2210
Entry to a residence without consent	8 (1.9)	0	0.0390*
Any other -controlling behaviours	33 (7.7)	7 (5.4)	0.3680
Coercion	13 (3)	1 (0.8)	0.1060
Restricting movement	8 (1.9)	0	0.0390*
Attempting to commit an act	63 (14.7)	14 (10.9)	0.2570
DV in front of children	55 (12.8)	41 (31.8)	0.00001*

Note: Significant results

survivor's residence without consent, where the parties do not share the same home; coercing, intimidating, or forcing the survivor to commit an act which such person would not have consented to or committed by their own volition; and confining the survivor to a place or restricting their movement against their will.

The most reported cases involved physical abuse and both verbal and psychological abuse. The highest cases of DV reported were verbal and psychological abuse. From the cases reported each month, more than 40 percent of the cases involved verbal and psychological abuse, and in some months, more than 60 percent. The second most prevalent form of DV during this period was physical abuse. Compared to the other months' percentage of reported cases, physical abuse was least evident in July (Table 3). The third most common type of DV reported during this period was intimidation.

Similar to FPA data, the cases reported to MoGFSS (Table 4) also had the highest reported number of cases categorised as physical violence. The second highest reported case numbers involved emotional abuse. Unlike the FPA data, MoGFSS had separated rape from sexual violence, and there were reported cases of rape in each month except March, July and September.

A chi-square test of independence was performed to examine the relationship between gender and the reported cases of DV (Table 5). The chi-squared test revealed a significant association between gender and reported cases of DV. The significant results were found for sexual abuse, financial abuse, intimidation, stalking, restricting movement, entry to a residence without consent, and DV in front of female children were more likely to report as a survivor.

These quantitative findings were corroborated through the qualitative findings, verifying this increase in trend in reported GBV/DV cases during this period. However, it should also be noted the number of reported cases was fewer during the strict lockdown phase in the country than in non-lockdown months.

Trends in reported cases of GBV

GBV cases reported to MoGFSS and FPA illustrated that there was an increase in GBV cases from January to February 2020. However, there was a decreasing number of GBV cases from March to May. This change could be due to COVID-19 precautions and the strict lockdown of Male' city during this period. Figure 7 demonstrates that with easing of lockdown restrictions, the number of reported cases of GBV increased in September.

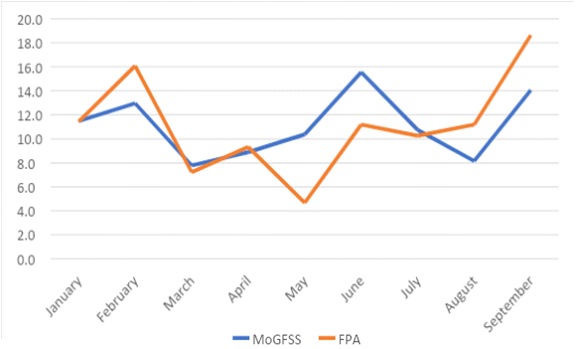

Figure 7 Percentage of GBV cases reported by month

REPORTED CASES BY INSTITUTIONS

In 30 per cent of the cases reported to MoGFSS, the source of reporting was not stated. There was a higher percentage of cases directly reported by the survivor herself to the MoGFSS (17.8%) than were directly reported to FPA (4%). From the instances of GBV/DV reported to FPA, almost 50 percent were reported by the Maldives Police Services (MPS), whereas the cases reported by the Social Service Division (SSD) of MoGFSS included less than one-fifth of the survivors. The Family and Children Service Centres (FCSCs) placed in the atolls reported more than 17 percent of the DV cases, and only about six percent of the reported cases were from the hospitals or health centres.

Table 6 below shows the DV cases reported to both FPA and MoGFSS by the institution. Domestic violence cases are reported to two departments in MoGFSS, namely SSD mentioned above and the Child and Family Protection Service (CFPS). GBV/DV related to children under 18 years of age is reported to CFPS and all other cases are handled by SSD. The data revealed that the cases reported to FPA include all of the GBV/DV cases reported from January to September 2020. In contrast, the cases reported to SSD include only the cases where the survivor is aged 18 years and over.During the

Table 6 Domestic Violence cases reported by institution

	FPA		MoGFSS	
Institution	Frequency	Percent	Frequency	Percent
Hospital/Health Centres	35	6.2	10	3.3
MoGFSS	110	19.3	54*	17.8
Family and Children Service Centres (FCSC) - Atolls	100	17.6	52	17.2
Child and Family Protection Service (CFPS)- MoGFSS	40	7	3	1.0
Maldives Police Services	126	22.1	24	7.9
Family and Gender Affairs Department (FGAD)- Police	154	26.9		
FPA	4*	0.7	1	0.3
Family			3	1.0
NGO			48	15.8
Reported to child helpline			2	0.7
Self-reported			4	1.3
Self-reported to child helpline			10	3.3
Social media			1	0.3
Reported source not identified			91	30.0
Total	569	100	303	100

Note: *directly reported

period of January to September 2020, a majority of the DV cases were reported in Male' (62.7%), Seenu Atoll (10.4%), and HDH Atoll (4.7%), respectively. During this period, there were no reported cases of DV from Meemu Atoll found in the data reported by FPA. A similar trend can be observed in the MoGFSS data where the cases of adult survivors were reported (see Table 7). This trend is somewhat different than that what was previously reported by the 2016-2017 DHS. In that report, the Northern most atolls had the lowest rates of reporting GBV/DV cases while during the pandemic period in HDH, one of the northernmost most atolls, is reporting an exceptionally higher number of GBV/DV cases, unlike the neighbouring atolls in this region. The trend of more reported cases in the Southern atolls and Male' are similar to data reported by the DHS of 2016-2017.

In reporting the cases, a MPS email account and helpline were available to report during the pandemic. In MoGFSS, the regular, 24/7 child helpline 1412 was in service, and a special social helpline was established, which attended to DV and GBV cases.

According to one key informant, many families experiencing GBV/DV were also in need of financial support. The MoGFSS has actively worked with various institutions to provide this relevant support.

> *I had a woman who lived in a deteriorated house, that was very hot, her kids wore only nappies. So, we checked to see what they need most. The woman was not working, and the husband (a drug-addict) cannot provide any support. We cannot provide any financial support, and the woman cannot get 'ekani veri mainge' support (state allowance for single mothers) because she is married. So, through EHEE NGO, we managed to provide some materials (nappies and food) for them for three months. We had also directly worked through the IGMH mental support though, rather than us trying to offer mental support.*
>
> *(Key Informant Interview 5)*

Table 7 Domestic Violence cases reported to FPA and MoGFSS by Male' and atolls

	FPA		MoGFSS	
	Frequency	Percent	Frequency	Percent
HA	3	0.5	4	1.3
HDH	27	4.7	20	6.6
SH	5	0.9	8	2.6
N	5	0.9	2	0.7
R	4	0.7	7	2.3
B	10	1.8	7	2.3
LH	3	0.5	1	0.3
K	4	0.7	1	0.3
AA	7	1.2	6	2.0
ADH	12	2.1	9	3.0
V	3	0.5	3	1.0
M	0	0	1	0.3
F	4	0.7	3	1.0
DH	11	1.9	3	1.0
TH	3	0.5	3	1.0
L	3	0.5	15	5.0
GA	2	0.4	6	2.0
GDH	23	4	20	6.6
GN	24	4.2	11	3.6
S	59	10.4	44	14.5
Male'	357	62.7	126	41.6
Reported place not stated			3	1.0
Total	569	100	303	100

PROCEDURES FOLLOWED BY THE AUTHORITIES IN DEALING WITH GBV/DV CASES

In this section, we describe the procedures each of the interviewed authorities follow regarding reported GBV/DV cases. The authorities that were interviewed are MoGFSS, FPA, PGO, MPS, FLC and HOPE for Women.

The role of the **Ministry of Gender, Family and Social Services (MoGFSS)** is to coordinate and monitor gender equality commitments; for GBV/DV cases, it provides social support for the GBV/DV survivors, creates public awareness, and undertakes gender equality sensitization initiatives (UN, 2019). The caseworkers at MoGFSS in particular highlighted how they provide psychosocial and psychological support to GBV/DV survivors. For example, the caseworkers closely liaise with hospitals (such as IGMH mental health centre) and other clinics, or with NGOs such as Family Legal Clinic (FLC) to provide the support that survivors need. Further, the MoGFSS also will offer help in filing a Protection Order (PO), if requested by the survivor. The procedure followed by MoGFSS caseworkers when they reported a GBV/DV case is as follows. First, Ministry officials ensure the safety of the survivor and if children are involved, they lodge the case separately to attend to the minors accordingly. As a next step, the Ministry ensures the protection of the survivor while investigation is carried out by MPS.

> *First, we physically attend to the case as soon as we get it and then collect the necessary information, liaise with MPS, and then send referrals to the concerned authorities where necessary. Then we try to provide psychosocial support, and if a PO (protection order) is needed, we provide support in the process and if the*

perpetrator is pressing more problems, we offer a temporary removal of them, and explore safety nets for the survivor through their immediate family and friends. If it is prolonged, we try to provide professional support to the survivor. We connect them to SHE and Family Legal Clinic. We also connect them to other clinics; we try to expedite their appointments. We concurrently do all these supports. Also, depending on the case, we even have a conference with other institutions to offer other forms of support to the survivor.

(Key Informant Interviewee 4)

Under the DVPA, the **Family Protection Authority (FPA)** was established in 2012, and is responsible for the oversight, monitoring and coordination of authorities under the Act, as well as generation of research, awareness and capacity development" (UN, 2019, p. 6). Within this capacity, according to key informants from FPA, they also support in sending referrals to other institutions.

When the **Prosecutor General's Office (PGO)** receive a case from the police, their role is in initially assisting in obtaining any necessary court order for the survivor for the duration of the investigation. The PGO also provides legal advice to the police during any police investigations of a GBV/DV case. According to the PGO office, any case they receive from the police is sent to the criminal court within 2 to 3 days, depending on the amount of evidence available for the case. Currently, both DV and GBV cases are not considered a severe criminal offence; as a result, standard regular procedures are followed, and if enough evidence exist, such cases are also sent to the court.

However, with recent amendments to the Penal Code, DV acts such as marital rape are considered a severe criminal offence (UN, 2019).

When a case of GBV/DV is reported to the **Maldives Police Service (MPS)**, statements are taken from witnesses and from the perpetrators (if relevant). In circumstances where the perpetrators are seen as a threat, they are removed from the environment immediately and held under police custody. Otherwise, perpetrators are warned not to repeat the case, and the warning is considered as a mechanism to minimise the threat of this person: if they repeat the GBV/DV act, they can be prosecuted based on the warning issued. For the MPS, it usually takes on average a month to investigate a case, provided there are no issues in obtaining witness statements and cooperation. In the most urgent cases, it takes about 15 days to investigate a case and send it to PGO. However, an MPO informant expressed that there are also hindrances in terms of human resources for investigating these cases:

Sometimes a case may take a long while to investigate for us because we are not only dealing with one case alone, but we also have plenty of cases under investigation for each section, and for each investigating officer.

(key informant interview 8)

As an NGO, the **Family Legal Clinic (FLC)** provides support to survivors on a pro bono basis. When FLC receive a case, they educate the survivor about their legal rights and what actions are available for them in reporting the case; they also support the survivor in filing a court case and offer any representation for the survivors at court. Further, they also offer support groups, a mechanism that was been piloted in 2019 for survivors of domestic violence. FLC is also planning to establish a similar support group for GBV and sexual harassment survivors. During the pandemic-related lockdown period, FLC was reaching out to the public, especially to those experiencing financial pressure due to the COVID-19 pandemic and those being evicted from their homes; they also provided a support group for people suffering from mental illnesses. Another NGO is **HOPE for Women**; as an NGO, they are not a reporting authority but are focussed on creating awareness of GBV and DV cases and establishing support groups during the pandemic:

We are not a reporting authority, so they don't directly report to us. We as HOPE are not acknowledged much, we work with the authority and convey the information when we get information.

(Key Informant Interview 2)

REASONS BEHIND THE INCREASE IN GBV/DV DURING THE COVID-19 PANDEMIC

Instances of GBV and DV have been reported during the pandemic lockdown period, and all of the key informants expressed that there has been

an increase in these cases during the pandemic period. Their responses indicate that some of the reported cases of GBV/DV that had been reported during the pandemic included instances of verbal abuse, physical abuse, and sexual abuse.

However, as noted in the quantitative data, during the COVID-19 lockdown, there was a reduction in reporting of cases , especially from March to mid-May 2020. Once lockdown was eased, a surge in reporting was indicated. From the interviews, there are five primary reasons identified to explain the changes during this period (January 2020 to September 2020) as perceived by the key informants. These reasons are presented below.

Loss of jobs and financial security

Many people lost their jobs because of the pandemic-related business shutdowns. Job loss has adversely affected many people's incomes and lifestyles, and the loss of financial security has triggered many of the domestic issues and factored into the DV cases reported during the pandemic.

> *A lot of people lost jobs, and husbands lost jobs so that pressure was felt on the wives who were at home. We noticed that this was a common cause, the associated financial pressure was a heavy precedent, and many had to find alternatives, and it was a massive pressure for the wives, on top of them managing the kids and schooling.*
>
> *(Key Informant Interview 1)*

> *The cases that have increased are mostly for reasons because people have lost their jobs during the pandemic, many people's income has been negatively affected, and because of this, many issues have arisen, DV cases have also occurred because of that. Because most people have lost their jobs and their basic need can't be sufficed… these have been some reasons for the cases that had been reported.*
>
> *(Key Informant Interview 8)*

Repeat Drug Offenders

Usually, repeated cases are common with substance abuse users. Most cases of verbal abuse reported to the police during this pandemic were related to drug users living in the same household. As suggested by the police authorities in the key informant interviews, the reason might have been that addicts, who usually spend time outside the home, are restricted inside the four walls of the home. This confinement is worsened by the effects of drug addiction, and the user may become loud and violent, which may then lead to physical abuse.

> *Drug addicts were home, and then they quarrelled with family members, leading to acts of violence.*
>
> *(Key Informant Interview 11)*

Child custody and welfare

Alongside both DV and GBV cases, there were also child abuse cases, mostly related to child custody. In these cases, even when various forms of DV had occurred, the survivor might only want to go forward with child custody proceedings and would not want to press charges for the DV they had experienced. In these cases during the lockdown especially, institutions such as FLC had facilitated the child custody proceedings for these survivors through the courts. Further, despite the courts being open during the lockdown period, many people assumed that the courts were shut down, like most of the services in the country. Such assumptions led to a decline in the number of reported cases during the lockdown. Some of the key informants indicated that usually, a parent will approach the authorities in seeking support to collect their alimony through the courts because of the parents' financial needs. These needs were exacerbated during the pandemic due to job loss and the other financial difficulties that families faced.

Some of the key informants also conveyed examples where the wife was not allowed to come into the home, or was forced out of the home; both instances were seen as leading to GBV/DV during the pandemic. Further, women as caregivers were identified as 'in the line of violence' and targeted for GBV/DV,

> *There are also women who as primary caregivers, are also in the violence line. But sometimes these women also are reluctant to, or they may not want to report these cases of abuse they have against them.*
>
> *(Key Informant Interview 3)*

Living under confined spaces for a prolonged period

During the pandemic one of the challenges faced by survivors was living under the same roof as their perpetrator for prolonged periods ; this aspect was identified as one of the causes for the increase in violence during the pandemic. A large population of men work in the tourism industry, spending long periods away from home and visiting their families for only a day or two per month. With the resorts closed, resort workers were forced to stay home, and various family matters became more prominent in their views. Such views, together with substantial financial loss, exacerbated the pressure they felt. These frustrations had often resulted in physical and verbal abuse directed at their spouse and/or children.

> *In the pandemic, resorts were closed and people were at home for prolonged periods. In the past, people got a few days off and that way they are not aware of most family matters. In most of our cases, this is the case. Then when the resorts were locked down, they had to stay home, and huge financial issues started leading to lots of violent cases.*
>
> *(Key Informant Interview 5)*

> *Reason (for prevalence) can be lack of awareness and also due to the living situation. Sometimes the financial support provider in the family can also be the perpetrator themselves, so living under the same roof with the perpetrator makes reporting difficult.*
>
> *(Key Informant Interview 8)*

The prevalence of DV/GBV perpetrated by out-of-work spouses was highlighted by one of the key informants as a reason why survivors sought support from institutions:

> *During lockdown, there were few PO cases we got, what we got were mostly survivors trying to move away from the perpetrators, trying to find a safe shelter.*
>
> *(Key Informant Interview 3)*

Inappropriate use of technology and mobile phones

According to MPS, blackmail and sexual harassment cases have risen during the pandemic period. Most of the cases that have been reported are from persons who are in a close intimate relationship. These cases of blackmail have been either for monetary purposes or to stop a relationship from ending.

> *During the pandemic, we have had 3-4 cases per week of blackmail cases. In total, the blackmail cases have increased. Women usually report blackmail. Usually, when she wants to break up (divorce or end the relationship) is when this happens. It can also be due to financial reasons. There have also been planned cases just to harm someone.*
>
> *(Key Informant Interview 12)*

> *Many were at home, then spending too much time on social media, and many spent a lot of time together, sharing photos; as a result, there was blackmail and threatening cases on the rise.*
>
> *(Key Informant Interview 9)*

PERPETRATOR CHARACTERISTICS

The data collected from January to September 2020 revealed that more than 80 percent of the perpetrators were male, whereas only 16 percent were female (see Figure 8). Further, the age groups of perpetrators showed that close to 50 percent were of 31 to 50 years old. Less than one percent of the perpetrators were children and about 2 percent of them were above 66 years of age. More than 20 percent of the perpetrators' age were missing from the records, which shows that there is a need for strengthening data collection procedures especially for GBV/DV reporting (see Figure 9).

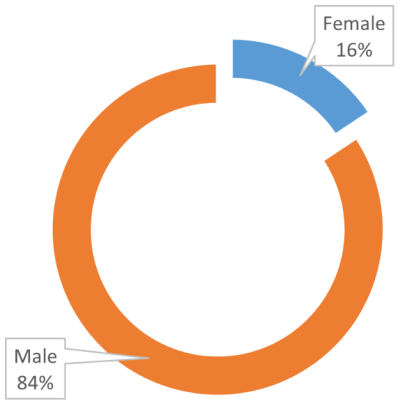

Figure 8 Perpetrators of reported cases by gender

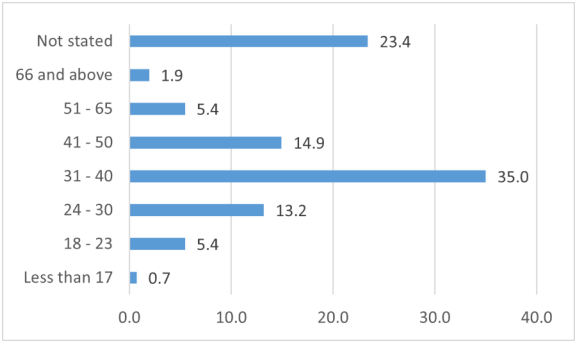

Figure 9 Perpetrators' age

TYPE OF SUPPORT PROVIDED TO THE SURVIVORS

The data collected by MoGFSS showed that the types of support provided to GBV/DV survivors were counselling services, psycho-social support and shelter. However, according to the data from MoGFSS, 54.8% of the support they provided was classified as 'other' and for 22.8% of the cases, the support provided was not mentioned (Figure 10). Thus, it can be said in more than 75% of the GBV/DV cases, support services were not provided or were not required.

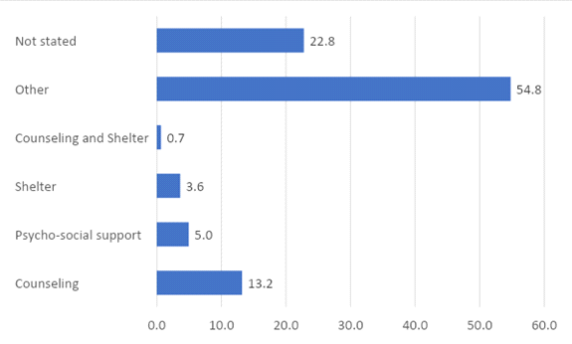

Figure 10 Support provided by MoGFSS

THE OUTCOME OF GBV/DV CASES REPORTED TO MOGFSS

From the reported cases of GBV/DV, less than 50 percent of the cases were sent to police for further investigation and close to 40 percent of the cases did not have the outcome stated. The outcomes of the cases reported to MoGFSS are illustrated in Figure 11.

Further, of the GBV/DV cases reported to MoGFSS, about 10 percent were dismissed for various reasons, as illustrated in Figure 6. Of the cases that reported GBV/DV to MoGFSS and were investigated by police from January to September, only 7.6 percent were sent to the Prosecutor General Office. The data collected from the MoGFSS shows that from the cases investigated by the police, nearly 50 percent had the outcome not stated. After police investigations, about six percent of the cases were dismissed due to inadequate evidence (Figures 12 & 13).

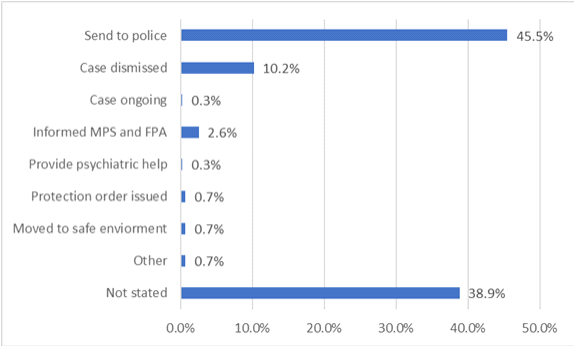

Figure 11 Outcome of the cases reported to MoGFSS

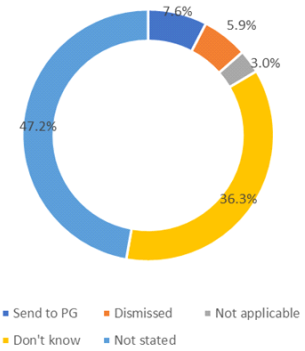

Figure 12 The outcome of reported cases that were police-investigated

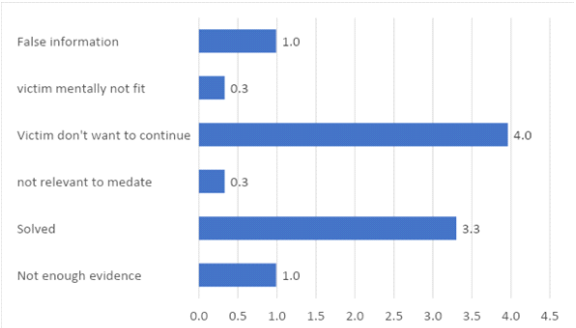

Figure 13 Reasons for dismissing the cases reported to MoGFSS

The data from MoGFSS revealed that about 16 percent of the reported DV cases were dismissed for various reasons. It is interesting to note that four percent of the survivors did not want to continue with their cases. According to the key informant interviews some reasons for not continuing could be due to lockdown restrictions and difficulty in getting access to help, or the survivor's economic dependency on the perpetrator.

MYTHS REGARDING GBV/DV IN THE MALDIVES FROM THE PERSPECTIVE OF THE KEY INFORMANTS

Most of the key informants indicated that in our society, many people believe that DV and GBV are private family affairs which have been going on for a very long time, especially in small island communities. There, it is assumed that community members do not intervene because to do so might hinder the relationships that have been forged among the different families and the broader community. It is a belief among many people that if the abuse occurs in someone else's relationship or someone else's home, it is not their problem. However, abuse and domestic violence are problems that affect and impact the community at large. All of the key informants interviewed agreed that many people in our communities do not understand that DV/GBV are a crime and against the law.

> *Family issues are another problem. Safeguarding family becomes more of a priority than the case itself, so they try to hide this violence they face because the family bond is their priority, and they don't want to talk about it.*
>
> *(Key Informant Interview 3)*

Most key informants acknowledged that the widespread belief of violence as a 'women's issue' is a myth. It is a men's issue as well, because the survivors are either wives, mothers, sisters, daughters, and friends. A minority of men treat women and girls with contempt and violence, and it is up to the majority of men to advocate for the eradication of DV/GBV and help create a culture in which this behaviour is unacceptable. Policymakers need to develop and fund programmes to eradicate GBV/DV:

> *When we identify issues in a given policy, we try to turn it around, but the guidelines need to be more focused on eradicating and minimising DV/GBV. While we want advice from our government counterparts and other institutions on improving systems, we want to provide more support in mediating, marriage counselling courses through FLC, investing in people, and making girls and boys more resilient. We also want to run programmes for survivor empowerment to provide the skills they need, such as psychosocial support and other forms of support, too.*
>
> *(key informant interview 4)*

The prompts listed in Table 8 were provided to interviewees, and they provided responses, as recorded in the table.

All the respondents believed that our religion does not advocate for abuse, and some did not think that this myth was prevalent among the younger generations in our community because it is changing with awareness and education. One respondent noted that these beliefs are ingrained because we live in a patriarchal society and some abusers misinterpret or intentionally misuse religious writing to justify violence against their partners and children or to prevent the breakdown of marriage.

> *But now with social media, campaigns, and the amount of world news, people are watching and awareness of women's empowerment is changing, but in the Maldives, this is still a taboo subject. In educational institutions, and in schools this is not something that is easily talked about.*
>
> *(Key Informant Interview 3)*

Some of the key informants perceived that many people in the community think that men are born that way and so DV and GBV cannot be prevented. However, research shows that VAW is the product of learned attitudes, norms, and social inequalities (UN, 2019). Just as violence-supportive attitudes can be learned, they can be unlearned. Likewise, communities and governments can change the social conditions that feed violence, replacing them with social conditions that encourage respect and non-violence.

Most of the key informants stated that women and girls are more likely to experience violence by someone they know. Among all ever-married women aged 15-49 who have experienced physical violence since age 15, 47% report their current husbands/partners as perpetrators of physical violence, and 41% report former husbands/partners as perpetrators (MDHS 2016-2017). The 2016-17 MDHS also shows that sexual violence is most often committed by former husbands or partners (27%) or by other relatives (25%). Just one in seven women who have experienced sexual

Table 8 Key informant responses to common myths regarding GBV/DV

Prompts	1	2	3	4	5	6	7	8	9	10	11	12	13
Violence against women is a women's issue.	Y	Y	Y	Y	M	N	Y	Y	S	Y	N	Y	N
There is nothing we can do to stop GBV/DV	Y	S	Y	Y	Y	Y	N	N	N	N	Y	N	N
Men cannot control their anger	S	Y	M	Y	Y	Y	N	N	N	Y	N	N	N
GBV/DV does not affect me	Y	NS	Y	M	Y	N	Y	N	N	S	N	N	N
Men have no role in ending GBV/DV	Y	S	S	M	M	N	N	N	N	N	N	N	N
It is in the religion	S	Y	S	NA	NA	N	N	N	Y	Y	N	N	Y
It is a private family affair	Y	Y	Y	Y	Y	N	Y	N	Y	Y	N	N	Y
Sexist jokes are okay	Y	Y	S	Y	Y	N	N	N	N	N	N	N	Y
Survivors are unable to break the cycle	Y	Y	Y	Y	Y	Y	Y	N	S	Y	N	N	N
A stranger commits violence	Y	S	N	N	N	S	N	N	N	S	N	N	S

Note: Y=yes, N=no, S=some, M=most, NS= not sure and NA=not applicable

violence said the perpetrator was a stranger (14%) or a family friend (14%).

> *We have noticed that harassment is an issue in the workplace. Some of these workplaces are significant organisations in the country. Being an ex-worker in such an organisation, I have experienced these issues in the workplace. There was physical and verbal abuse in the workplace. The fear for these survivors then is how their reporting of these harassment cases will affect their opportunities for promotions and other job-related professional development. Even in private companies, these things are happening. If the HR head could be the perpetrator, how should one go with this reporting process? People in power and authority use these [being in the sexual harassment investigation committee] for their gains and they use this power to inflict and perpetuate workplace harassment and violence towards the junior staff members.*
>
> *(Key Informant Interview 5)*

This respondent highlighted issues in the sexual harassment policy and procedures followed in the workplace. A committee to investigate workplace sexual harassments is compulsory for all workplaces to have, but currently, there are issues of how independent these committees are. When the committee is formulated from personnel in the workplace and is not independent, they do not investigate these sexual harassment reports. Even the personnel in these committees are not aware of their mandate, and they are not sensitised on how to manage these reports and investigations. There are also cases where the harassment cases are investigated outside the law. The law has to be used and practised by all.

Currently, as discussed in Section B, the Sexual Harassment Law is also limited in scope because it only defines harassment in the workplace. In public, if anyone faces harassment, the law does not cover this element. So, when people experience such harassment outside the workplace, it is not easy to try these perpetrators under the existing law.

Another critical issue regarding this law is that people in the offices and workplace are not even aware of the existence of the anti-harassment committee. This law was mandated in 2014, and it is unclear how many offices and workplace are implementing it and making their employees aware of its contents and mandates. According to this Law, the forms employees need to fill to report a case have to be readily available in both soft copy and hard copy (even at places like the reception desk). There are various ways in which people are taking advantage of limited scope of the law. Given the inadequacy of the policy, and the barriers in implementing it, there are many challenges in getting justice for the survivor.

BARRIERS IN THE COMMUNICATION PROCESS

In reporting GBV/DV incidents, there are barriers for communicating and obtaining support and relief. The barriers identified are three-fold and include the following: lack of awareness of the laws and rights of the survivor, lack of trust in the system and understanding of how the system works, and limited staff providing support. During the initial months of the COVID-19 pandemic, these factors were exacerbated due to restricted movement and shutdown of most government offices and services.

> *We had difficulty in limited staff providing the support. Only a few staff were there to attend, so urgent cases were dealt with and not urgent ones were dealt with later when lockdowns were eased.*
>
> *(Key Informant Interview 6)*

> *There was a period where there were some issues in reporting these cases during the pandemic. This can be seen as a hindrance to reporting and communicating these issues experienced by the survivor. Initially, all the staff from FPA was involved in crisis management, and the hotlines may not have been managed as it was before due to lack of personnel and most of them were being required to help at the disaster management. Regarding service reporting, a recent study done by FPA has identified that during that time, geographical barriers played a significant role in how these cases were managed. Due to lack of transport during the lockdown period, it was challenging to take the survivor away from the perpetrator to safe shelters as travelling to other islands was restricted.*
>
> *(Key Informant Interviewee 1)*

Some of the barriers to reporting, as mentioned by the key informants above, were rooted in people's belief that the system cannot do much and that the legislative process will be too slow. Further, many people also believe that family conflicts can be solved within the family itself. In most cases, there is a fear emanating from the survivor of GBV/DV that if they report the case, the financial support they were receiving from their spouse/family will be discontinued. Hence, the survivor's financial dependence on the perpetrator forces them to continue living under abusive conditions without seeking support or reporting the violence. Stigma suffered by survivors especially in small island communities is yet another barrier to reporting:

> *In one case I had, the woman wanted to divorce, but because her concern was about what the family may think and associated labels they might think, she had thought to herself I will go through it, so in cases like this, they don't want to report. So, they are even hesitant to file for divorce.*
>
> *(Key Informant Interview 7)*

One of the key informants stated that due to lockdown associated with the initial stage of the pandemic, there were fewer cases in GBV, DV, and sexual abuse reported. One reason identified was due to the limits on physical movement: survivors were unable to come and report in person. In the GBV cases especially, reporting was limited because the survivors were living in the same household with the perpetrator and might lack privacy to report. Also, public perceptions of government closures meant that many assumed that the gender ministry was closed. When the lockdown eased, reporting began slowly increasing, where a subtle increase was noticed from July onwards. DV as physical abuse has increased from its already prevalent status before the pandemic.

REIMAGINING SUPPORT NETWORKS

To combat domestic violence in the Maldives, on the 15th of July 2020 the MoGFSS launched a campaign called Geveshi Gulhun (MoGFSS, 2020), which MOGFSS plans will be in implementation for two years. According to MoGFSS, the objectives of this campaign are to raise awareness on DV, create communities which are safe from DV, strengthen the support provided to survivors of DV, and ensure the quality of the services provided to the survivors.

The campaign is comprised of different components, including a theme song and animated video clips, along with the provision of police and social worker training to upgrade their efficiency in dealing with GBV/DV (MoGFSS, 2020). Through this campaign and in accordance with the DVPA, five regional DV shelters will also be established and a mobile phone app will be introduced for ease of reaching out to the survivors.

During the pandemic, the NGO HOPE for Women had planned to create peer-support groups for survivors of GBV/DV, which they communicated via social media. As an interview reported, many people supported this idea and volunteered to be part of this support group.

> *We wanted to establish a peer support group because we thought that this way, an alternative form of reporting and a supportive mechanism can be provided. Other than that, we do conduct awareness programmes...through these, we wanted to say that it is okay to talk about it (GBV/DV) cases from a survivors' perspective and be blunt about it.*
>
> *(Key Informant Interview 2)*

Further, HOPE for Women also conducted webinars aimed at creating more awareness, which were offered live on Facebook as well. One of the topics for the webinars was 'Women in Contemporary Maldives', with a focus on women's role in jurisprudence and delivered by Sheikha Aisha Hussain Rasheed, Inspector Rifaan Ahmed, Ms. Aishath Shahuda and Ms. Aneesa Ahmed, and was moderated by Mr. Hamdun A. Hameed. All HOPE webinars were conducted in both Dhivehi and English and were held during September of 2020. According to HOPE for Women, the response received from the public for these webinars was very positive, and since, the public has been requesting more similar webinars.

Some of the key informants identified that we need to strengthen our current mechanisms to establish a nation-wide, consistent, and harmonised mechanism to provide the needed support and awareness for survivors of GBV/DV:

> *When our institution was first established, there were minimal human resources and personnel trained on this matter in the country. So, everyone had to learn from scratch, use personal resources and investment to understand these matters, and see what is working or not. Also, in our context, small islands are very unique and different from most other countries in the world and how we have to harmonise and coordinate these activities are very different.*
>
> *(Key Informant Interview 1)*

Other forms of awareness that key informants identified include the use of various forms of social media or mass media to share videos, sketches, and survivors' stories. Similarly, there were suggestions for using public billboards to share the message to members of the public who may not have access to social media. A heavy emphasis that was made by one of the key informants include approaching the public door-to-door:

> *A seminar or a TV advertisement is not enough, because people won't be aware of these things just by a seminar. We need to go closer to the people and provide this type of legal education. We need to go to their doorsteps to provide this awareness and the information and explain the opportunities they have via the law. We previously did a lecture at an island, following that we went door to door. From this programme, we learnt a lot about what works in the community. There was immediate increase in reporting of these cases on the island. That made us realise there are very many cases here on the island (an island previously known as a place where fewer cases were reported). This showed us that people come out and report when they are aware these are crimes.*
>
> *(Key Informant Interview 1)*

Further, alongside operationalising and strengthening services such as shelters, additional changes need to be put in place, such as creating a conducive environment for survivor support and a survivor-oriented health sector response to GBV, drafting a comprehensive social protection protocols, and instituting legal changes, as pointed out by one key informant:

> *In the GBV Act, the PO procedure is very weakly laid out. To get a PO, there needs evidence according to the Law, but in our context, this evidence is hard and difficult to get; thus, we need to tailor these laws to fit our context. For example, the current mechanism for getting a PO enforcement is set up for failure and discouraging people from applying for it. The support state has to provide, such as the safe homes and safe havens for the survivors are not there, and the current system was set for failure during a time like the pandemic. There were many instances where threats to life existed for the survivors, and even then, we could not provide that support and keep them safe. So, the system needs to work towards a more survivor-oriented model. We need to flip the system... it is the perpetrator who has to be removed, not the survivor. The design has to change because it is not working for us now. If we look at the sexual offence act, these issues are much weaker for the survivor. At the moment this Law is being discussed at the parliament, things such as the rights of the survivor, providing a rape-kit as a right for the survivor, the state bearing cost for taking her to a doctor – they are all in the discussion stages.*
>
> *(Key Informant Interview 5)*

STUDY LIMITATIONS

Various limitations have impacted the shape and trajectory of this study, and a few of these are identified here. Firstly, the time frame for this study was limited, with fewer than three months

provided to undertake the study; at the time of writing, with the COVID-19 pandemic still in effect, staff from the relevant key informant authorities were not always available as the institutions were not fully functional. It was challenging to set up interviews because the caseworkers in the MoGFSS were extremely busy during the study period. Further, it was also difficult to acquire the quantitative data because of the different methods and procedures in which FPA and MoGFSS recorded data.

Additionally, this is not a comprehensive national study. Due to limited time and other factors, all the national institutions and agencies relevant to providing services around GBV/DV were not accessed: for example, quantitative data were only collected from MoGFSS and FPA. Agencies such as Maldives Police Services (MPS), Prosecutor General's Office (PGO) and the courts also maintain records regarding GBV/DV cases, especially those that have been investigated. However, this study was not able to consider these data.

Thirdly, this study was developed based on the reported cases of GBV/DV. As has been highlighted by various key informants, the reporting of these cases in the country is quite limited and may not represent the true prevalence of these cases in our society.

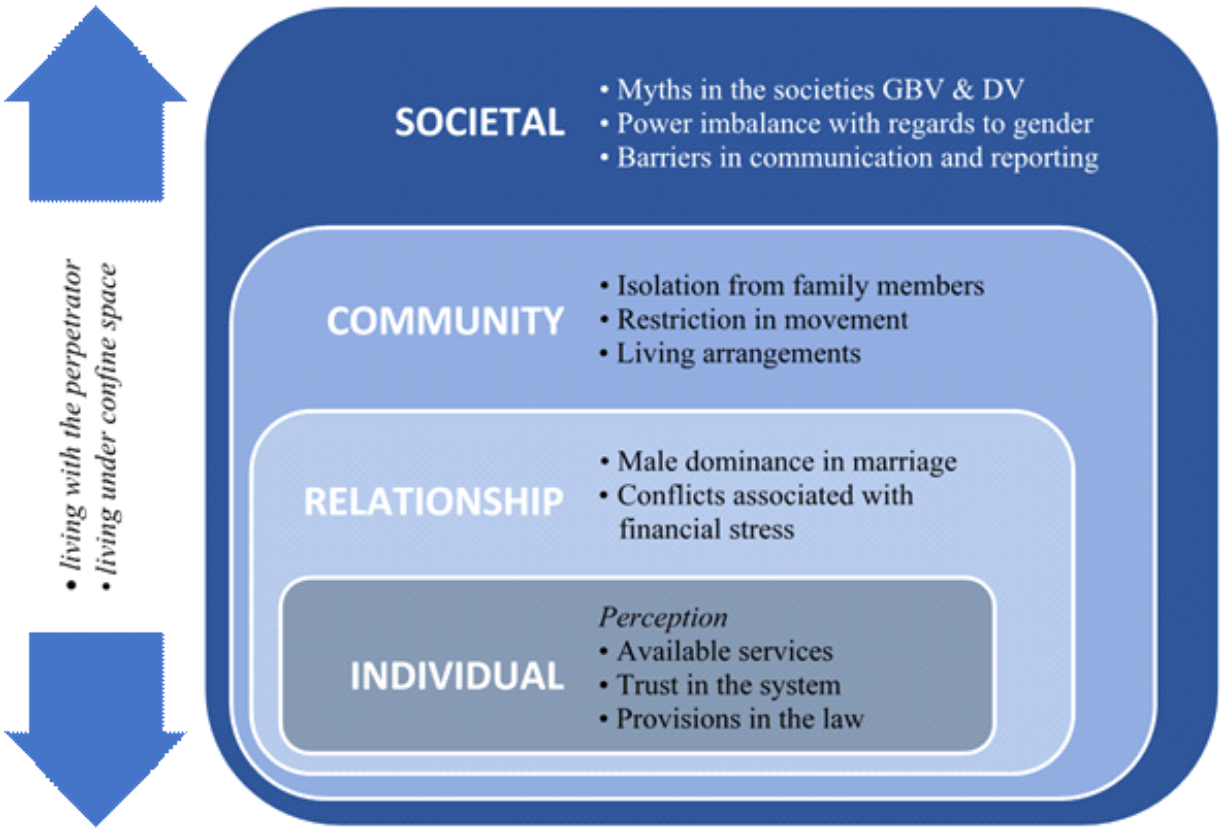

Figure 14 Factors associated with GBV/DV at different levels of the socio-ecological framework.

Section E Discussion

Overall, in order to understand and analyse the prevalence of GBV/DV during the pandemic, we applied a socio-economic framework (Figure 1). In doing so, we can see that all socio-economic levels have played a significant role in the increase of GBV/DV cases during the pandemic. Further, each of these levels have operated in conjunction with the others, magnifying the increase in GBV/DV cases during the pandemic. Individual's perceptions about available services, their rights as a GBV/DV survivor, and the provisions in the law are factors that affect the reporting of GBV/DV cases. Similarly, relationships matter, and those familial and spousal relationships play an especially significant role in how a survivor of violence seeks support from the authorities for the different forms of violence they may be experiencing. The relationship aspect was exacerbated during the lockdown period because the survivors were forced to live in confined spaces with the perpetrators for prolonged periods of time, and there, frequent verbal disagreements can often lead to physical, verbal, and even sexual violence (Heise et al., 2002).

The individual and relationship levels operated directly in leading to DV/GBV as well as how the cases were reported. For example, financial issues and frustrations of job-loss and lifestyle changes led to a large number of DV/GBV cases during the lockdown. In Maldives' patriarchal society, many men who are the breadwinners lost this status due to the pandemic. According to Heise et al. (2002), often in societies where the male controls the family wealth and divorce restrictions are placed on women, DV tends to be common. Further, several studies have reported that in families where such power imbalance exists,

women are often at high risk of violence (Heise et al., 2002). Such imbalances are exacerbated in families where husbands are drug or alcohol addicts. According to Heise et al. (2002), isolation from social networks and community can further be linked to violence against women. The response to the COVID-19 pandemic exacerbated these factors at an unprecedented level in many Maldivian families.

Community belief in myths regarding GBV/DV (as presented in the previous section) also play a significant role in how confident and comfortable survivors are in reporting the violence they are experiencing. Additionally, there are various barriers in the society that exists for survivors to report and communicate about the violence they are experiencing. One such barrier is the perpetrator-oriented nature of the current laws and the current mechanism for investigating these cases, where survivor-shaming is quite common. Additionally, there are also barriers in the society for survivors of violence being able to live a respectful life after experiencing different forms of violence. Thus, a reconceptualised and contextualised version of the socio-ecological framework based on this study is presented in Figure 14.

RQ1: IS THERE EVIDENCE FOR A CHANGE IN THE NATURE, FORMS OR SEVERITY OF REPORTED VIOLENCE?

The data available was from January to September 2020. Based on this data and the key informant interviews, it can be said that the average daily reported cases of GBV/DV increased from January to February. However, this average decreased and fluctuated from March to August. The lowest average reported cases were between March and May, the full-lockdown period in the Maldives. However, the daily reported cases increased in September, which coincided with the easing of the lockdown restrictions throughout the country. It is important to note here that throughout the lockdown period, DV support services were provided by MoGFSS caseworkers, though they were operating with significantly limited resources. The increase in reported GBV/DV cases that occurred with the easing of lockdown restrictions indicate that there was an increase in service usage for GBV/DV cases after July. Thus, it can be argued that this represents an increase in these cases throughout the lockdown period.

There is a significant association between gender and reported cases of DV. Significant results were found that survivors were most likely to report sexual abuse, financial abuse, intimidation, stalking, restricting movement, entry to a residence without consent, and DV in front of female children. The number of females survivors of DV are significantly represented than males, though informants indicated that the rate of cases of DV being reported for men have increased during the pandemic period when compared to the number of cases that were reported in previous years.

The key informants reported that during the full lockdown period, due to restrictions in movement, misconceptions about available services, and limited privacy in confined quarters, people had difficulty in reporting GBV/DV cases. According to the key informants from the MoGFSS, they had informed the general public about the available services during the lockdown period through TV, radio and other social media.

The key informants identified five main reasons for the increase in GBV/DV cases: loss of jobs and financial security, repeat offenders (often associated with drug-abuse), child custody matters, living under confined conditions often with the perpetrators, and inappropriate use of technology such as mobile phones. The latter has led to an increase in GBV/DV cases of intimidation and blackmail during the COVID-19 lockdown period.

Across the data from this report, the reasons for curtailed reporting are similar to the trends reported worldwide. According to WHO (2020), in global reporting, reasons for an increase in GBV/DV have included spending more time at home with perpetrators, rising stress, isolation from social-support networks, and limited access to critical services. It is evident that in the Maldives, too, the reasons are similar; however, the most common stress factor in the Maldives was associated with financial loss.

RQ2: WAS THERE AN INCREASE OR DECREASE IN SERVICE USE?

The service use reflected the reported cases, as discussed above in response to Research Question 1. However, as noted by most of the key informants, there was a significant constraint due to the nature of lockdown and restrictions in movement. As a result, only a limited number of personnel could attend to these reported cases, including responding to hotlines. Further, there were also misunderstandings regarding the services available during the lockdown period which may have impacted how people sought these services.

RQ3: DURING THE LOCKDOWN PERIOD WERE THE SERVICES BEING ACCESSED AND/OR DELIVERED, AND WAS IT SAFE AND EFFECTIVE?

Despite the trends in case reporting during the lockdown period, there is evidence to suggest that the public did seek social services and legal services from the respective authorities regarding GBV/DV, with most of these cases were filed as DV, according to the data from FPA and MoGFSS. Concerning the safety of the services being offered, there are elements such as survivor-shaming associated with the investigation of the GBV/DV cases that may negatively affect the survivors. Further, it seems that there may be several issues and challenges that impact the effectiveness of the support systems currently available. One significant challenge faced during the lockdown period was related to the wide geographical dispersal of the islands in the Maldives, and the restricted movement of people hindered their access to safe shelters for survivors of DV and GBV. This challenge was further exacerbated by the limited number safe houses available in the country and the limited provisions of both psychosocial and mental support available for these survivors under the same roof of these shelters.

RQ4: WHAT IS THE NATURE OF THE CHALLENGES TO SERVICE DELIVERY DURING THE PANDEMIC, INCLUDING COMMUNICATION OF THE AVAILABILITY OF SERVICES AND REFERRAL PATHWAYS?

Various forms of support services were considered in this study, including psychosocial support services, legal support services, investigative support services, and court services. One of the greatest changes for these services was shifting their services to online platforms, which were not available before the pandemic. However, while this change may be positive, people were not familiar with using the online modality, nor were they aware of online service provisions nor had the devices, data connections, or technical literacy to access them. There were further challenges to relying on online services, such limited privacy in accessing these services. Additionally, the public was also not aware of the different levels of services (island, atoll and central) that were available.

Additionally, the nature of the pandemic and the lack of readiness for such an emergency meant that energy and resources were directed to responding to the pandemic rather than the welfare of its public for the first three months of the lockdown. Such a crisis response has been reported in many countries as one reason for the limited provision of social services for GBV/DV cases (UN Women, 2020). Emphasis on the pandemic meant that only a limited staff was available to respond to the GBV/DV cases that were reported.

RQ5: WHICH AGE GROUP WAS MOST AFFECTED?

The data from FPA revealed that adolescent females are more likely to suffer from domestic violence than their male counterparts. Women aged between 19 to 40 years are more than four times more likely to report as a survivor of DV than other age groups. However, reported cases also showed that the rate of male infants exposed to DV (3.1%) was higher than female infants (0.5%). Also, boys in the age group of 6 to 10 years are three times more likely to be reported as DV survivors than girls of this age group.

According to Heise et al. (2002), such exposure to violence at younger age can be a common causal factor for boys to grow up and become perpetrators of violence. The data revealed that more of the females reported cases (4.9%) had an unidentified age than that the reported cases for males (1.6%); however, we cannot conclude from this fact that the reported cases of females were not given seriousness.

The characteristics of DV reported cases revealed that more than 75 percent of the survivors reported to FPA were female, and this number increased to almost 90 percent for the cases reported to MoGFSS.

RQ6: WHAT TYPE OF VIOLENCE WAS MOSTLY REPORTED?

The most commonly reported cases involved physical abuse, verbal abuse, and psychological abuse, and the highest rates of DV reported were for verbal and psychological abuse. In some months during the lockdown period, more than 60 percent of the cases involved verbal and psychological abuse. The second most prevalent form of DV during this period was physical abuse. The third most common type of DV reported during this period was intimidation. Forms of intimidation also increased during this period, include blackmail cases and child custody related cases. Blackmail was often associated with monetary ransoms or forcing unwilling individuals to continue intimate relationships.

Section F Recommendations

As the situation of the COVID-19 pandemic is still unfolding with the shadow pandemic of GBV and DV alongside it, UN Women (2020) argues that ending VAW will require more investment, leadership, and action: "it cannot be side-lined; it must be part of every country's national response, especially during the unfolding COVID-19 crisis" (UN Women, 2020). In this section, we make some recommendations based on the findings from the data to identify ways forward in enhancing the communication and reporting mechanisms for DV and GBV in the Maldives. Five key recommendations are presented below

MAKE COMPREHENSIVE SEXUALITY EDUCATION AVAILABLE BOTH WITHIN AND OUTSIDE SCHOOLS

Currently, comprehensive sexual education (CSE) is very limited in formal and informal school curricula. We recommend that all education service providers implement high-quality, sustainable programmes that encompass information and education about sexual and reproductive health, and positive aspects of sexuality, gender, rights, and empowerment principles; such programmes should further encourage critical thinking in young people. In particular, this study strongly recommends that the Health and Physical Education (HPE) subject to be re-introduced to grades 9 and 10 students with age-appropriate CSE topics.

Further, we also recommend that all service providers involved in informal education use their platforms to create awareness of CSE among their beneficiaries. For example, a study undertaken by SHE (2019) showed that the Siththaa App has been a successful tool in reaching out to the youth, with 2484 downloads within one year. Therefore, this study recommends the use of social media platforms by both education institutions and health service providers to reach out to young people for CSE.

CHANGE SOCIAL NORMS THAT PERPETUATE VIOLENCE AGAINST WOMEN AND CHILDREN

This study has shown that there are various awareness programmes that are currently being run to create awareness on GBV/DV and VAW in particular. However, these awareness programmes need to be more accessible, contextually-oriented, and rigorous in order to bring social norm changes within our communities. These awareness programmes also need to consider that women in our society is not a homogenous group, but there is diversity of experiences, backgrounds, aspirations and futures amongst women and girls in our society. Thus, acknowledging these diversities and intersectionality in creating awareness towards reporting and preventing GBV/DV among the public is critical.

Further, this study recommends reorienting existing laws such as the Gender Equality Act (Law no. 18/2016) and the Domestic Violence Prevention Act (3/2012) to make them more survivor-oriented rather than simply criminalizing perpetrators. As such, it is strongly recommended that the laws on GBV and DV, including the 2000 Family Law, needs to be reviewed to take a human-rights-based approach, rather than focusing on just criminalising GBV/DV acts.

MAKE WOMEN'S ECONOMIC EMPOWERMENT A KEY STRATEGY FOR PREVENTION OF GBV

The survivors of GBV/DV may not be financially able to start a new life and so may remain with a perpetrator of violence; thus, it is important that the state support them to establish financial independence and reintegrate into the society. This study recommends that when a case is classified as GBV/DV in the MoGFSS or any other government/ non-government authority, there needs to be a regulation whereby the state can provide the survivor with financial assistance to start over. As such, GBV/DV legislation needs to be reviewed to establish such support systems that

would require the state to provide for the survivors for a reasonable duration.

ENSURE ADEQUATE SERVICES FOR REHABILITATION OF PERPETRATORS ARE INTRODUCED AND ACCESSIBLE AT ALL LEVELS

There exists a need to establish proper rehabilitation and support mechanisms for perpetrators. It is critical to empower both survivors and perpetrators to rehabilitate in order to efficiently minimise GBV/DV in the country. As such, the existing legislations needs to be reviewed to establish guidelines to rehabilitate the perpetrators, which would further act as potential prevention from them becoming repeat offenders. Further, we recommend setting up healthy relationship development programmes aimed at changing perpetrators' aggressive behaviour by identifying and addressing the root cause of their aggressive nature. This education and rehabilitation can play a significant role in helping to break the cycle of violence.

STRENGTHEN NATIONAL CAPACITY TO USE AND ANALYSE DATA FOR POLICY ADVOCACY

Currently, the national practices of record-keeping for GBV/DV are fragmented. As such, this study recommends undertaking a national study on GBV/DV to document the prevalence of it in our communities. This comprehensive study can be conducted through a central government or non-government institution, and the data can then be used to catalyse and inform the development and implementation of an evidence-based, nationally-led multi-sector policy and programmatic response to violence against children (VAC) and women (VAW) in the Maldives. Further, the current data recording process also needs to be revisited and harmonised to capture the essential data for future use from the all the stakeholders so as to streamline services.

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Appendix A

A study on reported GBV/DV cases at MoGFSS/FPA during Covid-19 pandemic in the Maldives

Data Source:

Note: For cases reported in Male' area (Male', Villimale' and Hulhumale'), for atoll please select Male' from the list.

Month	Case No (*For each new month pls start with 1*)	Type of Incident or Offense (*as listed in records*)	Age (*Age in completed years*)	Gender	Reported Atoll	Reported Island	First reported by	What type of support was provided to the victim?(*choose from the list, if it is other write it in Remarks column*)	Outcome of reported case	If case dismissed please provide reason for dismissal: For Eg: Not enough evidence or any other specific reason	What was the police investigation outcome?	Remarks

Appendix B

A study on reported GBV/DV cases at MOGFSS/FPA during Covid-19 pandemic in the Maldives

Questions for stakeholders

Do you know of cases of GBV/DV in your island/community during the COVID pandemic?

1. What are the most frequent types of GBV/DV that you have already recorded during the COVID pandemic?
2. What are their causes?
3. Have the number of cases reported during the pandemic increased? If so, what types of cases are more, DV, GBV or both? What evidence is there for this?
4. What kind of support do you provide to the GBV/DV survivors?
5. Are you aware of the law in force concerning the control of GBV/DV in Maldives?
6. If yes, which laws are you most familiar with and how do you enforce it?
7. What are the myths surrounding GBV/DV in the island community that you work in?
8. In your opinion, what are some communication gaps in reporting GBV/DV cases? Is it because it is a taboo subject? Are there family pressures? Is it because victims will be labelled? Is it to save the reputation and dignity of their family members?
9. Has there been any difficulty in reporting GBV/DV cases to the authority during the pandemic? If yes, what are those difficulties?
10. Has there been any difficulties in the provision of your services during the pandemic? If so, what are those difficulties?
11. What are the procedures that you follow as an institution, when you have a case of GBV/DV reported to you? (Ask for any of these internal policies, SoPs they have)
12. Do you think there have been instances where you received overwhelmingly more cases to the point where you could not properly address them?
13. Where can we identify the survivors and the perpetrators of the GBV/DV in your area of operation (community, prisons, relevant authorities, etc.)?
14. Apart from your organization, can you name various organizations involved in the control of GBV/DV in your island or community?
15. What kind of support do they provide to the GBV/DV survivors?
16. What are some of the strategies you and your organisation use and practice against GBV/DV?
17. Is there any framework of cooperation between your organizations (network) and other organisations doing similar work?
18. What strategies do you recommend for the effective eradication of the GBV/DV in your island or community?

Delivering a world where every pregancy is wanted, every childbirth is safe and every young person's potential is fulfilled.

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