

RESEARCH ARTICLE

Between pandemic and patriarchy: Gendered population impacts of COVID-19 in Iraq

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Abstract

The COVID-19 pandemic exposed and intensified pre-existing gender inequalities in Iraq. This study examines the gendered consequences of the COVID-19 pandemic in Iraq, focusing on how entrenched patriarchal structures, alongside inequalities and tribal authority, heightened women's vulnerability during the crisis. Conducted in Baghdad, Anbar, and Salah al-Din governorates, the research utilized a mixed-methods design with stratified random sampling to survey 1,200 individuals through structured questionnaires and semi-structured interviews. The study explores the pandemic's impact on women's economic participation, access to education, exposure to gender-based violence, and healthcare use. Results show that 73.3% of women experienced job loss or major income decline, while 59.4% reported repeated domestic violence during lockdowns. Around 80% of households restricted girls from online learning, citing cultural taboos, digital gaps, and safety concerns rooted in patriarchal norms governing honor, mobility, and gender roles. Over half of the participants avoided healthcare services due to infection fears, familial restrictions, or financial hardship. Widespread emotional strain was reported, including anxiety, fear, and decision paralysis. These findings reveal that the pandemic magnified pre-existing gender disparities and exposed significant weaknesses in Iraq's crisis preparedness and gender-inclusive policy frameworks. Unlike global studies centered in higher-income or urban contexts, this research offers unique, field-based insights from a fragile Middle Eastern setting characterized by patriarchal governance, tribal authority, and institutional instability. The study calls for urgent gender-responsive strategies to address digital exclusion, economic resilience, healthcare access, and violence prevention. A combination of institutional reforms and localized, community-based engagement is crucial to ensuring that future emergencies do not perpetuate or exacerbate gender-based inequalities.

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1. Introduction

The social sciences have long played a crucial role in understanding social phenomena during times of crisis (Mohammed & Anas, 2020). The COVID-19 pandemic, which may have been the most significant global crisis of the 21st century, was far more than a health crisis; it also included new health measures, as well as changes in social

norms, institutions, and power structures. In post-conflict Iraq, an already fragile context, women and girls faced strict patriarchy, tribal authority, and global insecurity, heightening their vulnerability. At the same time, the pandemic made it even clearer that social cohesion in highly patriarchal settings is sustained through family solidarity, community practices, and gendered caregiving roles. These norms are not merely ethical ideals; they are institutionalized within the architecture of highly patriarchal societies. Ironically, lockdowns disrupted the community practices through which cohesion is enacted, gradually weakening these sources of social support.

In this paper, patriarchy is interpreted as a structural problem that exacerbates vulnerability for women, with empirical and theoretical analyses consistently showing that patriarchal governance, tribal norms, and gendered hierarchies of power exacerbated gendered impacts of the pandemic.

Moreover, these disruptions were not brief. For Iraq and similar societies, they reinforced structural inequalities, particularly gender-based inequalities affecting women. Economic vulnerability was exacerbated for women during the pandemic, with existing gaps in employment, income, and resources widening. In the Middle East and North Africa, women's employment levels declined at higher rates than men's, particularly in informal and low-wage sectors where job recovery is slow (Abdel-Rahman *et al.*, 2023; Organisation for Economic Co-operation and Development [OECD], 2024). While the lack of a social safety net created a context for such a regressive economic outcome in Iraq, this was exacerbated by a lack of long-term policy vision.

At a global level, feminist crisis sociology emphasizes that women are disproportionately affected by crises through increased unpaid labor, heightened exposure to violence, and exclusion from policy-making processes (Bradshaw & Fordham, 2013). Consistently, literature indicates that women and girls experienced the largest negative impacts along economic, social, and health axes, increased gender-based violence (GBV) during lockdown, and reduced access to education and healthcare (United Nations Development Programme [UNDP], 2020; World Health Organization [WHO], 2020). These gendered impacts were compounded in fragile political environments such as Iraq, by pandemic-induced dislocation, along with male guardianship and tribal power structures (PAX for Peace, 2022). In tribal contexts, the enforcement of gender roles and the ways in which customary law undermines formal legal protections further magnify these impacts.

Krafft *et al.* (2024) found that women's unpaid care work increased by nearly 30% due to school closures and health

system disruptions, while formal employment remained largely stagnant. This reinforces the structural argument that care burdens and economic vulnerability marginalize women from many processes that remain critical during crises.

Crisis theories often view disruption as the disruption of equilibrium within a society (Abdel Hamid, 2000; Barton, 1969; Dynes, 1970; Quarantelli, 1988); however, they do not adequately explain how power, identity, and gendered authority influence vulnerability and response. To remedy this misunderstanding, the present analysis brings together three theoretical models: feminist crisis sociology, intersectionality theory, and foresight governance. This analysis uses these perspectives to interpret the structural patriarchy, social complexities, and lack of anticipatory leadership that shaped Iraqi women's experiences during the COVID-19 crisis.

1.1. Feminist crisis sociology

The feminist crisis sociology framework provides the theoretical foundation for this study, as it examines how gender hierarchies are intensified rather than generated during times of crisis. Existing patriarchal structures, such as male guardianship, tribal authority, and gendered labor norms, collectively shape access to resources, mobility, and protection, thereby heightening women's vulnerability during instability (Bradshaw & Fordham, 2013; Hajji, 1998). In Iraq, these dynamics became more evident during COVID-19, as caregiving burdens increased, access to services further contracted, and risks of violence escalated. Additional supporting evidence regarding the rise in GBV, limited access to legal recourse, and the expansion of unpaid labor during lockdowns comes from vulnerable contexts in the Arab world (UNDP, 2020; WHO, 2020). This framework demonstrates how macro-level manifestations of patriarchy, including unequal household responsibilities and limited agency for women, were reproduced and intensified throughout the pandemic.

1.2. Intersectionality theory

In addition to the analytical perspective explored in this research, intersectionality theory (Crenshaw, 1989) explores the ways in which gender intersects with tribal identity, class, displacement, and location, resulting in particular types of risk. In Iraq, where social life is defined by tribal authority and inequality in space, the pandemic affected urban and rural communities in very different ways. Displaced and poor women faced many barriers in accessing healthcare, education, and basic safety. A regionally oriented study confirms these trends, showing rural and displacement women are more likely to be excluded digitally, are dependent on non-formal work, and

have less institutional support (UNDP Arab States, 2021; UNESCO, 2020). The intersectionality theory enables a more sophisticated interpretation of vulnerabilities as they arise across multiple layers and intersect with existing weaknesses, rather than viewing women as a single, universal social group.

1.3. Foresight governance framework

The foresight governance framework introduces a preventive, forward-looking approach that integrates gender sensitivity into crisis preparedness through a focus on anticipatory rather than reactive governance (Cornish, 1977; Feleih & Al-Zaki, 2003). Research shows that many governments responded to COVID-19 with short-term measures that overlooked significant structural risks to women's safety, labor participation, mobility, and access to services (UNDP & UN Women, 2021). This gap was particularly acute in a hybrid governance context of Iraq, where state institutions intersect with tribal authority. Foresight governance also emphasizes the necessity of gender-sensitive assessments and early warning systems, as well as continuous strategies for essential services such as education and GBV support. Applying this framework illustrates how the absence of anticipatory planning exacerbated gender inequalities during the pandemic.

1.4. Integrated conceptual model

The intersection of feminist crisis sociology, intersectionality theory, and the foresight governance framework creates a comprehensive analytical framework that combines structural patriarchy, intersectionally compounded vulnerabilities, and institutional preparedness. Under this model, patriarchal and tribal norms operate as structural factors that limit agency, mobility, and access to protection for women. Rurality, dislocation, class position, and other intersecting identities shape the impact of these conditions, leading to variation in educational and income security, access to healthcare, and vulnerability to violence. Foresight governance functions as a moderator; crises tend to have greater impacts where anticipatory, gender-sensitive plans are weak or absent, while their presence can substantially mitigate these impacts.

This theoretical framework situates the study's empirical findings within a broader analytical framework that connects micro-level dynamics with macro-level power relations. It draws on evidence demonstrating how customary authority in Iraq controls access to justice and social services, how gender norms intersect with displacement to exacerbate precarity, and how institutional fragility limits the state's capacity to protect women during crises (UNDP, 2020; UNDP Health Cluster, 2021; UNDP Iraq, 2020; WHO, 2020). The model frames COVID-19

as an event that interacted with pre-existing sociopolitical structures rather than producing new inequalities. Anchoring the analysis within this framework enhances the study's overall contribution to social science literature on crisis, gender, and governance, and provides a strong rationale supporting the mixed-methods findings.

1.5. Empirical and contextual justification

This study seeks to fill the gap in empirical knowledge of the impact of COVID-19 on the lives of women in patriarchal tribal societies with fragile institutions. While global studies have documented the rise in GBV and economic insecurity, few have explored the ways in which tribal identity, displacement, and regional inequality intersect with gender to shape crisis outcomes.

However, much of the existing scholarship relies on humanitarian assessments rather than systematic field data, despite an increasing awareness of these issues. The majority of the literature specific to Iraq, such as the UNDP Arab States (2021) and UNDP Iraq (2020), highlights the implications of gendered impacts, but does not provide detailed statistics or qualitative analysis. This research addresses this gap by offering new mixed-methods evidence from Baghdad, Anbar, and Salah al-Din, combining empirical evidence and theories of feminist and foresight thinking to understand how structural and cultural forces converged during the pandemic.

The study has five interrelated goals: first, to identify the most pressing social impacts of the COVID-19 pandemic in Iraq on women, particularly in fragile and marginalized contexts; second, to understand the patterns of gender discrimination evident not only in state-level policies but also in community-centric responses to the pandemic; third, to assess how various barriers affect women's ability to engage with e-learning platforms, particularly in conservative/tribal regions; fourth, to examine the sociocultural and economic dynamics that contributed to a spike in domestic violence during lockdown; and fifth, to uncover how women coped, adapted, and accessed resources based on their various intersecting identities within a high-stress context.

2. Methodology

This study employed a cross-sectional, mixed-methods design integrating qualitative and quantitative approaches to explore individual experiences during the COVID-19 pandemic in Iraq and develop a holistic understanding of its gendered social impacts. The selection of a mixed-methods design was informed by crisis feminism, intersectionality, and foresight governance theory, as discussed in the previous section. The qualitative and quantitative data not

only provided statistical insights into prevalent patterns of vulnerability but also contextualized women's experiences within patriarchal and tribal social structures.

2.1. Research design and setting

This cross-sectional design enabled a reflection on the social and psychological impacts of the pandemic, which were considered to be at their peak in 2021. The study was conducted in three Iraqi governorates, Baghdad, Anbar, and Salah al-Din, which were chosen for the varying sociocultural and geographic contexts they represent.

Baghdad is an urban administrative center with greater institutional capacity and civil society engagement than the more rural, tribal environments of Anbar and Salah al-Din, where conservative gender norms and weak infrastructures were more prominent. This variation enabled the analysis to account for urban and tribal aspects of women's experience during the pandemic.

During the fieldwork, Iraq had reported more than 1.2 million COVID-19 cases and over 16,000 deaths, with significant variation by governorate and gender. National surveillance data revealed that women in rural and tribal communities were significantly less likely to receive timely testing or medical follow-up than men and their counterparts in urban communities. Baghdad had the highest number of infections due to population density and mobility, whereas Salah al-Din and Anbar reported the lowest numbers but had a higher percentage of deaths due to the difficulty in accessing hospitals or delays in receiving support. These differences in epidemiology are further illustrated by regional differences in women's ability to access healthcare, economic vulnerability, and gender gaps in the pandemic. Additional disaggregated surveillance data from the Ministry of Health, Iraq, and WHO revealed that, among confirmed cases, nearly 48% were females, and over 56% of hospital delays during the second wave involved women, indicating significant gender gaps in testing and treatment access during the initial phase of the second wave (WHO, 2025). This is also related to the gender disparity in mortality, with men dying more often than women in rural and displacement settings where mobility is limited and male consent for care is required. Similarly, these patterns also reflect structural and cultural factors that affect women's knowledge, disease diagnosis, and healthcare experiences across the governorates.

2.2. Population and sampling

The sample population consisted of 1,200 individuals aged 18 and over who had ties to or received support from civil society organizations in the fields of gender, development, or humanitarian services. Men accounted for 33.3% of the

total respondents, providing a broader, community-level understanding of gender roles and household decision-making.

Stratified random sampling was employed within a purposive framework. A list of 600 non-governmental organizations (NGOs) was compiled, comprising 300 from Baghdad, 150 from Anbar, and 150 from Salah al-Din. From this list, participants were randomly selected at a 1:10 ratio, resulting in approximately 60 NGOs included in the study.

Access to participants was influenced by patriarchal and tribal norms governing movement and contact with outsiders. In rural and tribal areas, interview teams required permission from male heads of households or mukhtars before interviewing women, which affected the willingness and comfort levels of participants. This cultural gatekeeping was evident in the recruitment process, as women within or affiliated with NGOs were easier to reach than women in very conservative households. Thus, the sampling frame captured the sociocultural limitations to women's public visibility, as well as the gendered power hierarchies that shaped the researcher's access to the field.

While this approach ensured both regional and thematic relevance, it also likely introduced bias toward women with some level of connection to these civil society networks. As a mitigation strategy, interviewers additionally recruited participants living in informal settlements and displacement camps accessible through the local humanitarian agencies. Future studies could improve the representativeness of this sample by employing snowball or respondent-driven sampling in more conservative areas with minimal NGO outreach.

2.3. Data collection

Data collection took place between March and May 2021, when Iraq was still under intermittent lockdowns. Field teams, comprising predominantly trained female enumerators to facilitate participant comfort and respect for cultural norms, collected data through questionnaires and semi-structured interviews in Arabic.

The quantitative survey consisted of 42 questions, organized into modules covering demographics, education, health, family dynamics, GBV, technology access, and economic status. Questions were designed in Likert-scale, multiple-choice, and dichotomous formats, and data were analyzed using both descriptive and inferential methods.

The qualitative data were collected through semi-structured interviews exploring the narratives of coping, constraints, and perceptions of institutions. Questions were open-ended to allow women to describe experiences

beyond numeric categories and provide cultural depth through narrative accounts.

Interviews were conducted orally as needed, and research staff recorded data as required for each literacy level. Data collection was conducted in respondents' homes, at NGO offices, and in neutral public spaces, all in accordance with COVID-19 safety guidelines that included wearing masks, maintaining social distancing, and practicing sanitation. The instrument was also piloted among 30 people in Baghdad to ensure clarity and cultural appropriateness. The final version was slightly modified based on feedback, and internal reliability was calculated using Cronbach's alpha ($\alpha = 0.89$). Subject-matter experts reviewed the instrument for content validity and thematic consistency.

2.4. Data analysis

Quantitative data were analyzed using the Statistical Package for the Social Sciences software version 26. Descriptive statistics (frequencies, means, and standard deviations [SDs]) were used to describe the sample. Inferential analyses included chi-square tests and multivariable binary logistic regression to identify significant predictors of healthcare avoidance, insufficient income, and experience with GBV. The significance level threshold used in this study was $p < 0.05$.

Although the cross-sectional nature of the data precludes any causal inferences, the patterns identified here were consistent with theoretically anticipated types of vulnerability and resilience as proposed in the integrative model. Such baselines may serve as a benchmark for future longitudinal or panel studies examining recovery trajectories in the post-pandemic era.

Qualitative data were transcribed and thematically analyzed according to Braun & Clarke's (2006) six-phase approach to thematic analysis. Applying an inductive coding approach, codes highlighting key themes pertaining to gendered work, domestic conflict, digital exclusion, and emotional well-being were recorded. All codes were checked for intercoder reliability by three researchers. The NVivo software (version 12) was used to organize the data and triangulate across qualitative and quantitative strands.

Five broad thematic categories shaping women's stories across governorates emerged from the synthesis of the coded data. The first theme, digital exclusion and gendered barriers to e-learning, detailed women's access to education during lockdown, with cultural limitations, availability of technology, and fear of being exposed online, restricting opportunities for education. The second theme, domestic conflict and escalating GBV, captured rising tensions and arguments within the home, as well as intensified verbal,

physical, and psychological abuse during lockdown. The third theme of healthcare gatekeeping and mobility restriction highlighted how patriarchal authority, tribal expectations, and fears of reputational damage restricted women's access to medical care. The fourth theme, economic precarity and loss of livelihoods, illustrated the widespread loss of jobs or incomes and reliance on informal aid networks. The fifth theme, emotional and psychological strain, included a general sense of anxiety, fear, and paralysis of decision-making that was associated with spatial marginalization, economic hardship, and uncertainty about institutional support. These themes collectively formed a framework to triangulate quantitative data and inform the analysis in the results and discussion sections that follow.

2.5. Reflexivity and positionality

Reflexivity and positionality were inherent to the research process. The field team was predominantly composed of female researchers from Baghdad and Anbar, and the gender and regional identity of the research team influenced both the way women respondents communicated with female researchers and the narratives they felt comfortable sharing. The composition of the research team, highly educated women from urban or peri-urban backgrounds working in civil society, may also have influenced understandings of tribal norms, conceptions of gendered roles, and informal power structures. As a countermeasure, systematic reflexive note-taking (defined as the practice of writing analytic notes to document researchers' reflections, assumptions, and evolving interpretations) and team debriefings were held following each field visit to capture these biases, provide transparency, and ground data interpretations in the lived experiences of participants rather than researcher assumptions.

2.6. Ethical approval

The study received ethical approval from the College of Arts, University of Anbar Ethics Committee (Approval ID: Ref. 1120). All participants provided verbal consent after being informed of the nature of the study, confidentiality procedures, and their right to withdraw at any time.

Written consent was waived due to literacy issues, as well as the sociocultural sensitivity of the research context, particularly for those displaced or from a tribal population where written records could be used as a weapon or perceived as a risk. This method was considered appropriate from an ethical perspective and in accordance with the Declaration of Helsinki (2013 revision).

No personally identifiable information was collected, and all transcripts were de-identified. Operating under

the research protocol, the data collection team was trained to respond sensitively to the disclosure of violence and provide referral to the partner NGOs that offer psychosocial support.

3. Results

The survey included 1,200 respondents in Baghdad, Anbar, and Salah al-Din governorates. A total of 66.7% of the sample was women. The mean age was 36.2 years (SD = 10.2), and 83.3% of the participants were married. There was also an important urban bias, with 81.7% residing in urban centers, primarily in Baghdad.

3.1. Educational attainment and structural vulnerability

Educational levels were relatively high, with 53.5% holding a bachelor's degree and 12.5% possessing postgraduate qualifications. However, education was not an absolute bulwark against economic hardship. The frequency and percentage distribution revealed that although Baghdad had the highest number of women with university education at 54.0%, the more rural governorates, Salah al-Din and Anbar, also showed a significant level of educational attainment despite higher income loss. For all levels of education completion, women in rural areas completed 3–8 percentage points lower than women in urban areas. A significant association was found between education and region using a chi-square test (χ^2 [10, n = 1,200] = 21.82; p < 0.01; Cramer's V = 0.14). These findings imply that despite growth in women's educational attainment, its protective role is still limited by patriarchal labor division and limited mobility, aligning with feminist crisis sociology.

3.2. Housing insecurity

Housing conditions showed clear spatial inequality (Table 1). Half of the households interviewed (n = 600; 50%) reported owning the house they were living in, 15% lived in a displacement camp, and another 5% resided in clay or temporary housing. The newly developed Displacement Index (0–1 scale; lower values indicate greater precarity) indicates increasing levels of precarity, ranging from 0.40 to 0.29, with Salah al-Din exhibiting the highest risk. Chi-square analysis confirmed the significance of the variation (χ^2 [10, n = 1,200] = 39.76; p < 0.001; Cramer's V = 0.34) and revealed that displaced women were overrepresented in terms of exposure to housing instability and economic precarity. These examples illustrate an important insight offered by the intersectional perspective, namely, that geographic and identity hierarchies combine to reinforce vulnerabilities.

3.3. Income adequacy and educational attainment

Income adequacy showed a moderate correlation with education. Although 58.3% of the total participants' monthly incomes were rated as "insufficient," the mean adequacy scores were 1.20 (SD = 0.41) for participants with primary education and 1.96 (SD = 0.62) for postgraduates, corroborating a monotonic gradient (Figure 1).

The chi-square test (χ^2 [10, n = 1,200] = 42.10; p < 0.001; Cramer's V = 0.27) showed a statistically significant association with a moderate effect size range. However, even among this highly educated group, one-third were still living with insufficient income, indicating that the nature of precarity is structural rather than individual.

3.4. Informal aid and institutional absence

In the face of reduced income, informal assistance was the first source of support sought by households. Urban women in Baghdad were significantly more likely to have

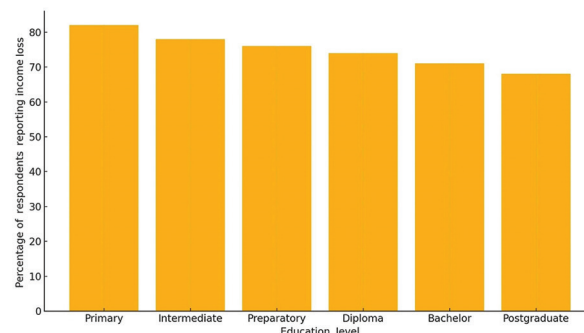


Figure 1. Income loss by education level

Table 1. Housing type by governorate

Housing type	Baghdad	Anbar	Salah al-Din	Displacement index (0–1)
Owned	330 (55.0)	270 (45.0)	240 (40.0)	0.40
Rented	180 (30.0)	150 (25.0)	120 (20.0)	0.20
Clay houses	12 (2.0)	48 (8.0)	36 (6.0)	0.08
Slums	12 (2.0)	18 (3.0)	12 (2.0)	0.03
Temporary structures	18 (3.0)	24 (4.0)	18 (3.0)	0.04
Displacement camps	48 (8.0)	90 (15.0)	174 (29.0)	0.29
Total	600 (100)	600 (100)	600 (100)	-

Notes: Data presented as n (%). Percentages and totals are calculated within each governorate separately (Baghdad n = 600; Anbar n = 600; Salah al-Din n = 600). Governorate subsamples are used for comparative analysis and are not summed to derive the overall study sample (n = 1,200). The Displacement Index ranges from 0 to 1, with lower values indicating greater housing precarity. Statistics: χ^2 (df = 10) = 39.76; P < 0.001; Cramer's V = 0.34. Salah al-Din exhibited the highest housing insecurity and displacement, consistent with post-conflict instability.

received aid from NGOs (32%) or wealthy benefactors (28%) during periods of need, while women in Anbar and Salah al-Din were much more likely to rely on religious leaders or their neighbors. The tribal–urban relationship reflects an 8–15% point increase in access to communal and religious sources compared to urban centers.

The overall interaction was significant ($\chi^2 [14, n = 1,200] = 36.44; p < 0.001$; Cramer's $V = 0.22$). From the perspective of foresight governance, these data reveal a lack of state contingency systems and a gendered overreliance on communal networks in times of crisis.

3.5. Healthcare exclusion and gender constraints

Access to healthcare was highly uneven (Table 2). More than half of women (52.5%) did not attend clinics during the pandemic; non-attendance was 11 percentage points higher among women than men (58% vs. 47%) and 19 percentage points higher among rural than urban women (64% vs. 45%). The chi-square test ($\chi^2 [4, n = 800] = 16.54; p < 0.01$; Cramer's $V = 0.16$) indicated that location and gender had an effect on the frequency with which women accessed health services across communities. Qualitative interviews corroborated these trends, with many women reporting the need for male permission to visit health facilities or fearing reputational damage. The lower attendance by women further supports the argument that it was not logistics alone, but patriarchal gatekeeping that determined access even in the urban environment.

Women's narratives consistently reinforced these quantitative patterns. One Anbar respondent remarked, "Even if I could not breathe, I did not leave the house without my husband's permission. They would say we disrespected him if I went without him." Another woman from Salah al-Din expressed the same limitation, saying that "I knew the clinic was opening, but my brothers said it was inappropriate to be seen outside during the lockdown." These narratives show how cultural gatekeeping, rather than medical risk alone, limited access to vital health services.

3.6. Reasons for healthcare avoidance

Specific reasons related to avoidance behaviors were also identified. Fear of infection (30.5%), objection by family members (21.0%), and objection by husbands (14.2%) were the most common and differed significantly by region ($\chi^2 [8, n = 420] = 17.90; p < 0.05$; Cramer's $V = 0.14$). Mean barrier scores (1–5 Likert scale) revealed that fear of infection was the highest psychological deterrent, at 4.3 (SD = 0.6). The level of financial difficulty was relatively low (3.2 ± 0.9), supporting our hypothesis that, beyond economic barriers, cultural norms were the strongest constraining factor in women's mobility during lockdowns.

3.7. GBV and compound precarity

Overall, 80% of women reported experiencing GBV across all settings combined, and 59.4% reported multiple occurrences. Table 3 indicates that GBV, income insecurity, and avoidance of healthcare all increased along the continuum from urban to rural to displacement settings. The Economic Precarity Index captured this compounding process (Urban = 0.42; Rural = 0.67; Displacement = 0.73). The association between region and GBV was significant ($\chi^2 [2, n = 800] = 31.54; p < 0.001$; Cramer's $V = 0.19$).

These findings reinforce the logic of layered disadvantages associated with intersectionality; spatial, economic, and patriarchal disadvantages reinforce one another within the specific community context.

In interviews, respondents highlighted the escalation of violence in private spaces. One woman from Baghdad explained, "Home had become a prison. Every argument turned to screaming or hitting, because no one could leave, not even for a walk." A displaced participant from Salah al-Din remarked, "We were in one tent with no privacy. My husband had become increasingly violent since he lost his job." These testimonies complement the statistics that correlate displacement and the subsequent loss of income with heightened vulnerability to violence.

Similar studies indicate a spike in domestic violence murders in Iraq throughout the pandemic, a further sign

Table 2. Visits to health institutions by region and gender

Visit frequency	Urban	Rural	Δ (Urban–rural %)	Female	Male	Δ (Female–male %)
None	180 (45.0)	256 (64.0)	–19.0	232 (58.0)	188 (47.0)	+11.0
Once	88 (22.0)	72 (18.0)	+4.0	76 (19.0)	84 (21.0)	–2.0
Twice	52 (13.0)	40 (10.0)	+3.0	44 (11.0)	48 (12.0)	–1.0
Thrice	48 (12.0)	24 (6.0)	+6.0	32 (8.0)	40 (10.0)	–2.0
Four times	32 (8.0)	8 (2.0)	+6.0	16 (4.0)	24 (6.0)	–2.0

Notes: Data presented as n (%), unless stated otherwise. Statistics: χ^2 (df=4) = 16.54; $p < 0.01$; Cramer's $V = 0.16$. Rural women had the lowest health-service utilization, indicating mobility restrictions and patriarchal constraints.

Table 3. Gender-based violence, income insecurity, and healthcare avoidance by region

Area	Gender-based violence	Income insecurity	Healthcare avoidance	Economic precarity index (0–1)
Urban	450 (75.0)	306 (51.0)	254 (42.3)	0.42
Rural	528 (88.0)	396 (66.0)	382 (63.8)	0.67
Displacement camps	108 (90.2)	86 (72.0)	81 (68.1)	0.73

Notes: Data presented as *n* (%), unless stated otherwise. Statistics: χ^2 (df=2) = 31.54; $p < 0.001$; Cramer's $V = 0.19$. Intersecting economic and healthcare vulnerabilities were most severe in displacement contexts, confirming intersectional exclusion.

of patriarchal impunity (Yousif, 2025). Rapid reviews from around the globe suggest a relatively consistent increase in family violence during the 1st year after lockdowns and insufficient protection for women in closed domestic environments (Letourneau *et al.*, 2022).

3.8. Emotional and psychological toll

Psychological distress was a nearly universal phenomenon, with patterns varying according to income at both the bivariate and multivariate levels (Table 4). All negative-emotion domains increased consistently with worsening income security, showing a +1.2-point difference between the “Enough and more” and “Insufficient” groups. Chi-square analysis confirmed the significant association (χ^2 [12, *n* = 800] = 26.33; $p < 0.001$; Cramer's $V = 0.27$).

Refugees and those with low socioeconomic status reported the highest mean distress levels (mean = 3.7 ± 0.9), indicating the psychological manifestation of structural inequality.

Interviewees frequently described the psychological toll of prolonged confinement and economic instability. As one Baghdad respondent articulated, “Every day was a heavier day. I woke up afraid we would not have food, or that someone would get sick and we would not be able to reach a hospital.” Another woman from Anbar reported, “I could not sleep for weeks. Constant arguments in the house and the pressure of caring for everyone, I felt I was drowning.” These stories highlight the psychological suffering that arises at the intersection of economic hardship, restricted mobility, and domestic tension.

A parallel household survey in Baghdad found a near-identical emotional distress profile, with fear and anxiety levels being high among women and within multi-generational households, as lockdown continued (Lafta *et al.*, 2023). This study highlights the social psychological component of these forms of social inequality during a health crisis. Only 4% of those with economic insufficiency reported “no distress” compared to 45% among the financially secure.

3.9. Synthesis of findings

Across all domains of education, housing, income, healthcare, and violence, the data demonstrate statistically

Table 4. Emotional responses by income adequacy

Emotion	Enough and more	Sufficient	Insufficient	Δ (Insufficient–enough)
Anxiety/Tension	2.6±0.7	3.1±0.8	3.8±0.9	+1.2
Fear	2.4±0.6	2.9±0.8	3.6±0.8	+1.2
Decision difficulty	2.5±0.8	3.0±0.8	3.7±0.9	+1.2
Confusion	2.3±0.7	2.8±0.8	3.5±0.8	+1.2
None (resilience indicator %)	45	18	4	–41

Notes: Data presented as mean±standard deviation, unless stated otherwise. Statistics: χ^2 (df=12) = 26.33; $p < 0.001$; Cramer's $V = 0.27$. Emotional distress intensified as income adequacy declined; mean scores show a linear gradient of psychosocial strain.

significant relationships between structural position and gendered outcomes. Higher levels of education were correlated with the likelihood of sufficient income for women, although this relationship weakened when controlling for household dependency on income, mobility, and exclusionary discrimination within sectors. Higher education, in reality, offered women protection that was more symbolic than substantive, as it highlighted persistent structural barriers within the female labor market in a patriarchal, tribal system. This was also true for the issues of housing insecurity and forced relocation, which increased economic suffering and demonstrated that spatial marginalization had a dual function as both a social and financial disadvantage.

This dynamic also appeared in healthcare avoidance, which constituted another form of gender control, but where the force behind the control was patriarchal authority rather than logistical or financial barriers. Rural and tribal women stated that they did not go to the doctor, not because of fear or lack of funds, but because their husband or family member objected, thus corroborating that gendered gatekeeping was a barrier to accessing even the most basic of health services during a national crisis. GBV presented another distinct spatial pattern; GBV increased in rural settings and was highest in displacement areas, alongside increasing income insecurity and healthcare avoidance. This intersection of violence, poverty, and social exclusion is the compounded vulnerability described

in intersectionality theory, where identity and contexts combine to create a heightened likelihood of harm.

The behavioral and psychological effects of these social inequalities were equally visible. Symptoms of emotional distress discussed in the findings, including anxiety, fear, and decision-related confusion, increased in the group of women living with reduced income or experiencing housing loss. The analysis concludes that the emotional suffering of women exists both as an unseen individual psychological burden and as an embodied response to structural violence, revealing systemic injustices and social hierarchies.

Given the overall picture provided by the quantitative data, the results align with the mixed-methods model employed in this study. Male-dominated politics, tribal power, and tepid institutions combined to create a system of government in which education did not mitigate poverty, healthcare exclusion, or violence in the absence of anticipatory gender-sensitive planning. As the foresight-governance framework suggests, these gaps were neither addressed nor abated but continued to grow during the crisis. This proves that the pandemic was not an isolated event for women in Iraq, but that their experience was mediated by the hierarchies that were embedded in the sociocultural and institutional milieu.

Recent clinical data support this claim, reporting high rates of psychological morbidity among Iraqi women during the time of COVID-19, including depression and post-traumatic stress associated with economic and domestic instability (Ahmed *et al.*, 2025). These results highlight the intersection between public health and gender inequality within a fragile governance system.

3.10. Binary logistic regression results

Three logistic regression models were estimated to examine the predictors of healthcare avoidance, income inadequacy, and exposure to GBV. Each model incorporated age, education, governorate, household size, income category, and displacement status. The model predicting healthcare avoidance was statistically significant (χ^2 [$6, n = 1,200$] = 22.41; $p < 0.01$), with a Nagelkerke R^2 of 0.07, indicating that displaced women were more than twice as likely to avoid healthcare (odds ratio [OR] = 2.14, $p = 0.008$), while rural residence also increased avoidance likelihood (OR = 1.62, $p = 0.031$); age and education were not significant predictors. The income inadequacy model was also significant (χ^2 [$6, n = 1,200$] = 31.03; $p < 0.001$, Nagelkerke $R^2 = 0.11$), where being less educated (OR = 2.46, $p = 0.002$) and having a larger household size (OR = 1.71, $p = 0.014$) increased the likelihood of an inadequate income, while age and governorate were not

significant. The model predicting GBV exposure was also significant (χ^2 [$6, n = 1,200$] = 18.22; $p < 0.05$; Nagelkerke $R^2 = 0.066$), as income inadequacy (OR = 2.83, $p < 0.001$) and displacement status (OR = 1.94; $p = 0.017$) emerged as key predictors, while education, age, and governorate did not have a significant effect. In summary, the key lessons from the regression analyses indicate that structural factors, including displacement, living in a rural area, larger household size, and material insecurity, outweigh the impact of individual-level characteristics on women's vulnerability in the context of the pandemic.

4. Discussion

This research examined how the COVID-19 pandemic impacted the lives of Iraqi women, creating an environment of persistent inequality rather than one of globalization. These findings consistently demonstrate the growing gender hierarchies that have developed as a result of the crisis through economic insecurity, educational marginalization, limited access to healthcare, and a corresponding increase in GBV (Yin & Gu, 2025).

These results complement data in fragile countries, such as Afghanistan, Yemen, and Syria, where institutional fragility and firmly embedded patriarchal norms led to gendered vulnerabilities during the pandemic (Azcona *et al.*, 2020; ReliefWeb, 2021). The logistic regression findings also highlight that displacement, rural residence, larger households, and inadequate incomes were the strongest predictors of healthcare loss, hardship, and exposure to GBV (Lok & Zhuang, 2025; Wang & Kolano, 2025). Despite the lack of significant age and education-related effects, feminist crisis sociology has emerged as a structural interpretation of the failures of government, spatial marginalization, and patriarchal power that shaped women's lives during the pandemic.

Economic insecurity was among women's greatest problems, with many of them describing difficulty in finding food, paying rent, or obtaining reliable assistance. This is consistent with evidence from the Middle East and North Africa region, where labor market shocks have particularly affected women in conditions of patriarchal division of labor and ineffective welfare systems (Kabeer *et al.* 2021; Md Nor *et al.*, 2025; OECD, 2024; UN Women Arab States, 2020). While women with higher education faced financial difficulties amid high tuition costs, many women suffered financially regardless of education level, suggesting that education did not prevent women from lower-income backgrounds from being excluded from the labor market in an environment where mobility, gender norms, and tribal authority constrain female workers. Prior research on war-torn areas also highlights the limitations

of education alone in addressing structural patriarchies (Abdel-Rahman *et al.*, 2023). This research extends the literature through an analysis of field data in Iraq, providing evidence that economic vulnerability persisted even among highly educated women. Unpaid caregiving also increased significantly during the pandemic (van der Gaag *et al.*, 2023). Interviewees described their increased domestic workload due to the closure of schools, illness, and the collapse of external support networks. These narratives follow regional patterns that suggest a nearly 30% increase in unpaid care work for women during the COVID-19 pandemic (De Henau & Himmelweit, 2021; Krafft *et al.*, 2024). Similar increases were observed in Lebanon and Iran as women assumed far more caretaking responsibilities than men (Ahorsu *et al.*, 2020; UN Women, 2020).

The Iraqi case contributes to a regional understanding of these dynamics, showing that the expansion of caretaking positions placed special burdens under the predictable asymmetry of tribal norms and displacement-related stressors, thereby increasing the economic dependence and emotional strain on women. This dynamic translates into the gendered organization of care labor, which puts women at a particularly high risk of crisis, as described in Connell's (2009) theory of gendered institutions. These findings also revealed significant spatial inequalities in access to healthcare. Most women in the survey did not visit health centers during the pandemic because they feared infection, financial hardship, and most importantly, pressure from husbands or male relatives. Previous research in Yemen and Syria has shown similar declines in women's access to healthcare services in response to healthcare system collapses or freedom of movement (ReliefWeb, 2021; WHO, 2020). However, this Iraqi case reveals a different mechanism: patriarchal gatekeeping was more important in restricting access to healthcare than logistical or economic barriers. This suggests that the norms of gender, space, and mobility influence health exclusion in mutually reinforcing ways, complementing the effects of gender, space, and mobility on healthcare exclusion (Rampaul & Magidimisha-Chipingu, 2025; UNDP Health Cluster, 2021).

It also demonstrates Galtung's conception of structural violence, with social structures and patriarchy preventing women from accessing essential services. GBV increased dramatically during lockdown, with 80% of women stating that they were experiencing violence, and over half of women reporting that they were experiencing violence at least once. These results are consistent with a pattern observed in Turkey, Brazil, and India, where the placement of women in houses and economic constraints

increased the threat to domestic violence among women (Letourneau *et al.*, 2022; Piquero *et al.*, 2021). This pattern of migration, tribal law, and state institutions complicates the context of Iraq, where women had limited access to legal protection, limited institutional support, and few options from unsafe homes (Shcherbak *et al.*, 2025). In addition to explaining this dynamic, Butler's (1990) theory of gender performativity demonstrates how cultures that legitimize masculine authority through violence function without public scrutiny. GBV, income insecurity, and healthcare avoidance are other signs of the intersection of economic and patriarchal subordination presented in this paper.

Educational exclusion also emerged as a major theme (UNICEF Iraq, 2021). A total of 84% of women indicated that girls in their households did not participate in online learning due to concerns about online visibility, family honor, or perceived irrelevance of girls' education within tribal or conservative contexts. These concerns align with findings from the United Nations Children's Fund (UNICEF, 2021), which reported that sociocultural constraints, rather than technological barriers, were the main obstacles to girls' digital engagement in emergencies. From a foresight governance perspective (Cornish, 1977; Feleih & Al-Zaki, 2003), ignoring anticipatory planning for inclusive digital education in Iraq during the pandemic exacerbated educational inequality and reduced long-term human capital for girls. Mental health outcomes were closely tied to structural inequality. Most women, at the highest risk, reported anxiety, fear, and decision paralysis under conditions of income insufficiency or displacement.

These data are parallel with research in Iran and Lebanon, where economic uncertainty and domestic tension significantly increased women's psychological distress (Ahorsu *et al.*, 2020; UN Women, 2020). Stigma about mental health and the lack of psychological services in Iraq further contributed to these effects. The findings thus show how emotional distress was both a personal experience and an expression of structural violence, a reflection of economic, spatial, and gender differences. Together, quantitative and qualitative data support the conceptualization of the study as an integrative theoretical framework. These principles draw on feminist crisis sociology, intersectionality theory, and foresight governance, highlighting how the gendered effects of the pandemic are directly associated with patriarchal authority, tribal power, and institutional fragility. These findings suggest that a crisis does not create new inequality, but rather amplifies existing structural hierarchies in hybrid political systems, where weak institutions and powerful social norms reinforce each other. Similarly, comparisons

with Afghanistan, Yemen, and Lebanon reveal broadly diverse patterns of structural inequality that transcend symptoms (Pitoyo *et al.*, 2025).

This research has some limitations. Women from highly conservative or remote communities may have been underrepresented in NGO networks, limiting the extent to which their experiences were captured. The ongoing trauma associated with GBV and mental illness may have caused an underreporting of sensitive experiences. The cross-sectional model captured a particular moment in the pandemic, but it is not necessarily indicative of long-term recovery or decline. However, the multifaceted interpretation of the data, the integration of quantitative and qualitative analyses, the use of a stratified sampling procedure across three governorates, and the application of multiple theories offer strong interpretive value and improve the validity of this investigation.

The results suggest that gender sensitive crisis management in Iraq is needed. The right to legal protection against GBV, psychosocial support, and access to quality health care and digital education is essential. Depending on the focus of crisis planning, this approach would enable policymakers to shift emergency response from short-term to anticipatory planning that significantly reduces harm and protects vulnerable groups in future crises. Integrating gender justice into crisis governance is essential for social resilience, ensuring that social solidarity, economic security, and sustainable recovery remain fundamental principles of equitable systems.

These findings carry important implications for policy and crisis management. First, gender-responsive planning must be integrated into national preparedness strategies to prevent the uncontrolled widening of inequalities in the future. In rural and displacement contexts, access to medical services is critical. In addition, digital infrastructure and culturally grounded strategies must be strengthened to support girls' online education and narrow the digital and educational gaps highlighted in this study. Furthermore, national priorities should include stronger enforcement of protections and services for survivors of GBV. Strengthened coordination between state institutions, NGOs, and community leaders may enhance the reliability and effectiveness of such interventions.

5. Conclusion

This study examined the gendered implications of COVID-19 in Baghdad, Anbar, and Salah al-Din, revealing how structural differences shaped women's experiences during the crisis. The vulnerability of women to economic insecurity, healthcare avoidance, digital exclusion, and

GBV was consistent with the overarching finding that social, institutional, and personal histories contributed significantly to women's risk profiles compared to individual characteristics alone. Most logistic regression models identified displacement status, rural residency, larger household size, and low income as the strongest predictors of risk. These patterns indicate that crises intensify existing forms of inequality. Furthermore, the results suggested that space, class, tribal authority, and displacement shaped dissimilar experiences for women across regions. Rural and displaced women faced a higher risk for violence, a worse economic situation, and more barriers to healthcare than other women. Unpaid caregiving and domestic labor burdens weighed down the mobility and economic engagement of women during lockdowns, further exacerbating the gender gap in labor-force participation.

Overall, the research emphasizes the importance of gender equality as a fundamental human right and a crucial component of crisis preparedness. This integration of gender as part of national reconstruction and preparedness is a suitable solution that would ensure future crises do not reproduce or exacerbate the structural inequalities that emerged as a consequence of the COVID-19 pandemic.

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Conflict of interest

The authors declare that they have no competing interests.

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Ethics approval and consent to participate

This study received ethical approval from the Ethics Committee of the College of Arts, University of Anbar (Approval ID: Ref. 1120). Written informed consent was not required due to the cultural and logistical context of the study. Literacy levels varied among the study population, and formal documentation could raise fear or mistrust, particularly among women from tribal or displaced communities. Instead, verbal informed consent was obtained from all participants following a clear explanation of the study's aims, their voluntary participation, confidentiality of responses, and their right to withdraw at any time without consequence. No personally identifiable data were collected or published. The procedure was approved as ethically appropriate and in accordance with international ethical standards and the principles of the Declaration of Helsinki.

Consent for publication

All participants provided verbal informed consent before participation, following a clear explanation of the study's aims, confidentiality procedures, and their right to withdraw at any time without consequence. No personally identifiable data, photographs, or images were collected or published. All responses were anonymized to ensure the privacy and dignity of participants.

Availability of data

The data are not publicly available to protect participant privacy, but may be obtained from the corresponding author upon reasonable, ethically approved request.

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