Gender-Based Violence AoR
Global Protection Cluster

COVID-19 CONTINGENCY PLANNING: GUIDANCE FOR GENDER-BASED VIOLENCE (GBV) COORDINATION GROUPS

Version as of 18 March 2020

Contingency plan

A contingency plan put in its simplest terms is a snapshot of a humanitarian partner's capacities and approaches to meet the immediate needs of affected communities during the early phases of an emergency. Contingency planning is a tool to anticipate and solve problems that typically arise during humanitarian response.[1]

Role of GBV coordination group[2] in inter-agency contingency planning

- Defines how different agencies that are sub-cluster members will work together to achieve sector-specific objectives in a COVID-19 response.
- The coordination group's contingency plan provides the overarching framework for GBV actors to deliver a response together. It may be part of an inter-agency plan of the Humanitarian Country Team (HCT) in cluster contexts[3], a United Nations Country Team (UNCT)-led exercise or part of another inter-agency contingency planning framework in countries where the humanitarian response is led by government disaster coordination structures.
- A GBV coordination group's contingency plan is distinct but complementary to individual organisation's contingency plans, which describe how organisations will deliver their programmatic response.
- In many cases, OCHA, the UNCT or a national disaster risk reduction and management agency will provide the scenarios for the contingency planning exercise to ensure there is consistency in the planning across all the clusters of the response. In the case of COVID-19, it is important to clarify the specific planning assumptions and phases/risk-level of the COVID-19 response that are relevant for your areas of coverage for the GBV response.
- The contingency plan provides detailed information about what **combined resources and capacities** are available from all the GBV coordination partners; and maps out **a collective and specific plan for which organisation will do what during the anticipated crisis.**
- The contingency plan should **identify gaps in preparedness and identify ways to address the gaps**.
- The coordination group should engage in **resource mobilization to implement the preparedness actions in the plan**.
- Apply a human rights-based approach in the planning of the GBV response throughout the cycle of the COVID-19 response**.**
- **Gender equality and the empowerment of women and girls should remain at the heart of the planning process and implementation of a response.**
- The Protection Cluster may develop a more detailed contingency plan, which integrates or references the GBV coordination group's planning.
- Other clusters will also develop contingency planning documents, which may require technical advice or support to integrate GBV risk mitigation.

Participatory process

- Encourage the input and participation of the Red Cross/Red Crescent Movement (IFRC and ICRC), UN agencies and NGOs, including national Red Cross organisations, local women's rights organizations, organizations of persons with disabilities (OPDs), LGBTI and Older Persons Organisations that are active in the country, to ensure that their humanitarian capacities and expertise are recognized and that they can contribute fully.
- In most contexts where the COVID-19 response has already been activated, it is national authorities who lead the response. This scenario may be the case in many other contexts where public health and other government actors are leading the coordination of a holistic response. The extent of involvement of national and subnational authorities in the inter-agency contingency planning process depends on the context and the coordination bodies and its members in that context. In all situations, emergency response preparedness should be based on knowledge of the planning, capacities and systems of national and local authorities.

- This should be complemented with a knowledge of the underlying inequalities and vulnerabilities influencing risk susceptibility and resilience of women, men and their communities in a given context and guided by the principles of neutrality and impartiality.
- Consultation methods may need to shift to limit exposure to vulnerable groups: online/webinar/telephone consultations; written inputs; speaking with panels of nominated representatives rather than large public gatherings; and providing spaces for consultations with COVID-19 screening services at entry.

Planning assumptions

- Response will be delivered with locally available resources due to international travel and border entry restrictions
- Access to large volumes of external/imported commodities such as dignity kits, medicines, sanitizers, masks, and other personal protective equipment (PPE) may be significantly

delayed or unavailable due to disruptions in and high demand on global supply chains.

- There may be a decrease or shifts in how populations access public facilities, such as safe spaces, due to quarantine and other restrictions on public space gatherings.
- High demands on public health services may disrupt or significantly shift GBV-related services previously available in health and other sectors.
- Harmful gendered social norms may significantly increase women and girls' vulnerability to infection and many forms of GBV, including intimate partner violence (IPV).
- Confinement at home or other measures obliging women and girls to stay home in an unprotected situations might increase the risk of GBV, including sexual harassment, abuse and IPV.
- Restrictions of movements and confinement in camp settings may be particularly strict and health systems fragile. Displaced populations may be particularly vulnerable to simultaneously experiencing the harmful effects of GBV and COVID-19.

Helpful data for the planning process

- **Updated secondary data review**, including any information available from previous in-country responses to GBV in the context of health emergencies, such as cholera, SARS, Ebola, measles or others.
- **Remote response capacity**: How many GBV support hotlines/online counselling services are operational? How many hotline staff are trained in PFA and GBV referrals?
- **SGBV service points mapping** including number and locations of health centres and Women and Girl Friendly Spaces or percentage of coverage of GBV services for a particular area
- **Commodity stocks**:
  - Number of dignity kits
  - Number of post-rape kits available with prepositioned locations (liaise with Health Cluster/Sexual and Reproductive Health Working Group)
  - Number of hygiene commodities for GBV service provision staff such as alcohol, hand sanitizers, masks, etc.
- **Human resource availability**: Number of healthcare workers, social workers, police officers trained in GBV referrals
- **Cash and Voucher Assistance (CVA) mapping and evaluations:** Number or availability of CVA related to GBV or other sectors; Compiled assessment or evaluation data on CVA in the context
- **MHPSS resources for GBV and health responders:** Number or percentage of member organisations with remote or in-person staff counselling/well-being services available)
- **PSEA preparedness:** Information on PSEA task force or measures in place in your context; percentage of member organisations with PSEA Code of Conduct and/or training.

Key points to consider for response planning and analysis

- **Gender and access to technology:** Do women and girls have independent and safe access to internet, phones or other communication methods that would allow basic services to

continue if freedom of movement was restricted/quarantines? If not, what are alternative delivery modalities, including for access to prevention information?

- **Impact on health facilities,** including availability of staff to provide GBV response services.
- **Impact on security/justice sector,** such as availability of services to obtain protection orders and assistance available to provide immediate safety/justice response to survivors.
- **Impact on Women and Girl Safe Spaces (WGSS) and Safe Houses:** How will restrictions of movement and on gatherings, as well as quarantine policies, limit or change the operations of these services? What health and prevention measures need to be put into place in these locations?

- **Role of Cash and Voucher Assistance (CVA):** In several countries, CVA is already being used to provide financial support to persons infected with the virus. What are the potential advantages/risks of CVA for GBV and other programming during a COVID-19 response?
- **Intersectionality and targeting:** Which groups may need to be targeted or prioritized for assistance based on vulnerabilities and need? For example, elderly women living alone or without any support systems or women migrant workers who may have particular vulnerabilities and require specific outreach and assistance.

Key points to incorporate into the narrative of the inter-agency risk analysis

- **GBV risks are already rising** due to restricted movements; increased demand and limited access to public services and basic commodities; and an increase in the gendered demand for women to act as caregivers while still performing other domestic and income-earning roles. These risks will magnify in relation to the degree to which an outbreak affects a particular context and country, and the fragility of the public health systems.

- **Domestic/intimate partner violence is likely to increase**. Evidence of significantly increased domestic violence in COVID-19 affected areas of China is already emerging and evidence from previous public health crises.[4]
- **Reduction in availability/access of women and girls to GBV services** may jeopardize immediate health and physical safety of survivors, and result in impunity for perpetrators if the health and justice sectors are unable to adequately respond.
- **Sexual Exploitation and Abuse (SEA) risks**: In the Ebola crisis women and girls have faced increased exposure to sexual exploitation and abuse.[5] Increase in persons responding to crisis (maybe non-traditional humanitarian responders) and high demand and unequal supply of food and health supplies increase risks of sexual exploitation.
- **Analysis of other GBV risks that may be impacted by the dynamics of response in your context.**

Menu of possible actions

- Create plans to shift or expand some direct delivery modalities for prevention, risk mitigation and GBV response to remote modalities (i.e. online counselling, telephone counselling, increased online/radio communication campaigns, creating online chats/peer support groups).
- Assess and revise GBV referral pathways to reflect any changes in service operation hours or access points. Disseminate rapidly and continue to monitor and update regularly.
- Position IEC materials related to GBV prevention and services at COVID-19 screening desks. Incorporate Protection-trained staff into these screening areas.
- Recruit and/or train more GBV response staff who are in-country, including hotline operators.
- Conduct remote trainings for staff on Psychological First Aid (PFA) and GBV referrals.
- Train remotely frontline health staff on safe referrals and referral pathways.
- Create guidelines on safe operations and management of women and girls safe spaces, child-friendly spaces, safe houses, one-stop crisis centers and other collective safe spaces specific to COVID-19.
- Integrate GBV risk-related questions into COVID-19 needs assessments.
- Revise and disseminate "lifesaving" GBV messages in coordination with other sectors.
- Dignity kit pre-positioning and distributions, including incorporating COVID-19 IEC materials and remote/hotline information into kits.
- Localize commodity and IEC production: Produce adjusted dignity kits with locally sourced and available items; engage women in girls in making masks or COVID-19 prevention IEC materials.
- Integrate Protection staff into COVID-19 health response teams.
- Ensure quarantine facilities or spaces adhere to IASC GBV guidelines/risk mitigation measures.
- Increase availability of remote services for staff well-being.

Endnotes

[1] Inter-Agency Standing Committee. (2007). Inter-Agency Contingency Planning for Humanitarian Assistance. Retrieved from
https://interagencystandingcommittee.org/system/files/legacy_files/ia_cp_guidelines_publication_final_version_dec_2007.pdf

[2] GBV coordination group is a blanket term that can apply to GBV Sub-Clusters, Working Groups, sub-sectors, sectors, or other similar groups that combine coordination of the humanitarian response for the protection of women and girls or child protection.

[3] In some contexts, the Humanitarian Country Team may have a Working Group dedicated to the inter-agency contingency planning.

[4] Owen, L. (2020, March 8). Coronavirus: Five ways virus upheaval is hitting women in Asia. *BBC News*. Retrieved from https://www.bbc.com/news/world-asia-51705199

National Domestic Violence Hotline. (2020, March 13). Staying safe during COVID-19 [Blog post].
Retrieved from https://www.thehotline.org/2020/03/13/staying-safe-during-covid-19/

[5] CARE. (January 2020). *Gender Analysis: Prevention and Response to Ebola Virus Disease in the Democratic Republic of Congo*. Retrieved from https://www.care-international.org/files/files/Ebola_Gender_Analysis_English_v2.pdf