PLAN INTERNATIONAL CANADA'S GUIDANCE FOR MAINSTREAMING GENDER EQUALITY ACTIONS IN COVID-19 RESPONSE

APRIL 17, 2020

As noted in our COVID-19 special edition newsletter released on 02 April, 2020, this pandemic has often invisible and egregious consequences specifically on women and girls both in the short and long term with far-reaching and wide-ranging devastating impacts with the potential to derail and indeed reverse the tenuous global gains made towards gender equality and the rights of women and girls – if not addressed head-on through gender-responsive and increasingly gender transformative approaches.

Every pandemic, disease outbreak or crisis of any kind affects women, men, boys, girls and individuals of diverse gender identities differently. These effects are further compounded with several intersectional factors of exclusion such as disability or ethnicity. Gender norms, values and practices affect everyone, at all times and in every walk of life. COVID-19 is no different. It will intensify gender issues and considerations but is also an opportunity to improve gender power relationships (such as male engagement as everyone is at home!). A quick glimpse of the known and expected socio-economic, health and gender specific impacts of COVID-19. Are given below

COVID-19 and the gendered distribution of work: Women and girls already do most of the world's unpaid care work. According to the International Labour Organization (ILO), globally, women perform 76% of total hours of unpaid care work, more than three-times as much as men. The existing gender roles and responsibilities of women and girls as primary caregivers responsible for cleaning, cooking and caring for children, elders, or the sick, will undoubtedly impact women and girls further across the globe as schools and childcare services have closed indefinitely and as family members become ill. This will not only increase their existing burden of work, especially those also working from home, but also expose them greatly to contracting the virus. Women in essential services, especially healthcare workers face increased time poverty and mental distress as their care work burden remains the same.

Gender barriers and access to healthcare: Around the world, often due to the lower literacy or educational status of women and girls relative to men and boys, their access to critical health information is limited. In addition, women and girls often have limited decision-making power due to unequal power relationships in homes and communities, are financially dependent and face mobility restrictions to autonomously seek health care. As the pandemic progresses, this existing lack of access to resources will be further compounded when further impoverished families need to make critical decisions about who receives healthcare, and too often, due to prevailing patriarchal norms, male preference, and the lower social status and value of women and girls can prevent them from accessing care. This is further complicated by the invariable stigma families and communities face dealing with any outbreak where more often than not ill women and girls are hidden by families compared to men and boys. Furthermore, as health systems become overwhelmed with COVID-19 cases, the expected knock-on effects for women and adolescent

girls' reduced access to critical SRHR services will place them at greater risk of unwanted pregnancies, untreated STIs, and other risks.

Gender based violence: Incontrovertible evidence points to an escalation of all forms of gender-based violence (GBV) during crises, including domestic violence, intimate partner violence, sexual violence and violence against children, particularly girls. Lessons from Ebola as well as reporting from the Chinese and European outbreak of COVID-19 indicate the most harmful risk for women and girls for sexual and gender-based violence (SGBV) and Intimate Partner Violence is during self or home quarantine. Confinement in the home along with other stressors related to the COVID-19 pandemic increases tensions that can promote violence and harm to many women and girls who are already at risk. In addition to this, as the need for households to maintain hygiene and preventative measures against COVID-19 increases, women and girls will face greater demand and walk further distances to fetch water, thereby putting them at heightened risks related to protection, SGBV as well as exposure to COVID-19. Furthermore, in any crisis, and COVID-19 is no different, the risk of child early and forced marriage (CEFM) increases for girls. It is highly likely that girls now out of school will probably not return to school once communities normalize, and will likely be married earlier than expected; as is the risk of girls, young women and women engaging in survival sex and other forms of exploitation and abuse.

COVID-19 and economic impacts on women: The economic crisis as the result of national lockdowns, closures of markets and physical distancing measures will have a pronounced impact on those already living in poverty, but with far greater effects on women who are already employed in informal, unprotected, precarious work or self-employed. During the Ebola outbreak, the social and economic impacts disproportionately affected women, because of various overlapping socio-economic vulnerabilities and pre-existing gender inequalities. Self-employment was the most important source of livelihood for female-headed households. The breakdown in small businesses because of the Ebola crisis meant that many women lost an important source of income. Additionally, the loss of cross-border trade had serious impacts on women's livelihoods. With many governments imposing border closures and movement restrictions, the COVID-19 pandemic is likely to cause very similar consequences to women's livelihoods. Furthermore, as deepening poverty, income and food insecurity threatens overall family health, wellness and nutrition and when household resources such as food become scarce, their distribution amongst families can be heavily gender biased resulting in an elevation of the already poorer nutrition status of women and girls as they eat last and leftover food.

Frontline healthcare workers are predominantly women: Around the world, women make up the majority of frontline health care workers, almost 70 percent according to WHO, at the helm of efforts to combat and contain outbreaks of the pandemic. COVID -19 threatens to further strain already understaffed, poorly equipped and poorly resourced health systems in many developing countries. The insufficient quantity of essential equipment and supplies, including Personal Protective Equipment (PPE) for health workers and support staff, and other infection prevention and control (IPC) measures in many health facilities could lead to significant morbidity and mortality amongst the population and the already strained health workforce, that are predominantly women. In addition, gender related norms and expectations further add stresses for women health workers, as they work long shifts with little recourse to childcare for their children, additional domestic care work and family and community stigma they may face in relation to their exposure to the disease.

Chronic data and accountability deficit: While globally age and sex disaggregated data is emerging in some parts of the world, it is by and large incomplete. We don't know who is tested and who is brought to health facilities for care. These are very much gendered questions. What

we do know is that COVID-19 poses greater risks for people over the age 60, and those with underlying medical conditions. From the insufficient sex-disaggregated data available, it appears that men comprise a slightly greater proportion of those infected and are at a slightly higher risk of morbidity and mortality than women.

However, flow of accurate, complete and timely health information to and from community and health facilities and the ability of health planners and managers at various levels to collect gendered data and act on the information is limited. Furthermore, most national COVID-19 responses lack the voices of women and girls or any gender expertise to ensure relevant and gender-responsive responses.

This short guidance note sets out minimal and practical standards to be applied through all our programming to mitigate and address those gendered impacts. As we repurpose existing programs and develop new ones regardless of thematic or programming channel. For us, the key lies in continuing to amplify the agency of women and girls in this pandemic; foster equitable social environments; and ensure COVID-19 health, education, WASH and other ancillary responses are gender-responsive, all premised on contextual evidence, generated on an ongoing basis.

The programmatic framework is reproduced below with guidance.

<table>
<tr><td colspan="3">RAPID GENDER ASSESSMENT FOCUSING ON GENDER BARRIERS TO COVID-19 PREVENTION AND CARE
Access and control of COVID -19 resources; roles and responsibilities-burden of work, in households/communities, decision-making power, social norms, service responsiveness</td></tr>
<tr><td>↓</td><td>↓</td><td>↓</td></tr>
<tr><td>Enhancing the inherent individual and collective agency of women and girls</td><td>Building an enabling social environment for gender responsive COVID-19 response</td><td>Gender-responsive, child and adolescent friendly COVID-19 service delivery and response</td></tr>
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<tr><td colspan="3">Ongoing gender specific learning documentation, dissemination and feeding back into programs</td></tr>
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CNOS GENDER SPECIFIC RESPONSE TO COVID-19

1) RAPID GENDER ASSESSMENT

It is critical that we have the evidence base to be able to carry out effective and relevant programming to avoid making assumptions and ensure our “do no harm” principles are applied. To this end a rapid gender assessment is mandatory; whether questions are embedded in a broader rapid assessment, or the data is collected through a separate exercise. This does not have to be a massive endeavor and it is not meant to be perfect from the beginning or to cover all the questions altogether. Rapid Gender Assessments are built over time using primary (if possible to collect) and secondary data. Key considerations are provided below that should be investigated as far as possible and as early as possible:

1.1: What do we have to know within the gender equality domains of access and control; roles and responsibilities; decision-making patterns; social norms and systemic responsiveness. Minimal content required within the COVID-19 context includes:

Access and control over resources – key questions

- What are the differences between women/girls, men/boys in access to accurate information about the pandemic, hygiene, myths, symptoms, social/physical distancing, availability of health care services and how to access these?
    - How is that information received?
    - Who has and controls the technological means such as ICTs, FM Radio, local public announcement?
    - Who conveys information in the home and community?
- What are the barriers to accessing information for women/girls, men/boys? Personal barriers (e.g. literacy, disability, time-constraints); external barriers (means of communication, ICT barriers including signal, internet access, data, low literacy, permission to use ICTs and surveillance by a partner/elder member of the family), Is the information provided through any electronic/print/cultural media accessible? i.e. easy to understand formats, timing etc.
- Who gets what in terms of nutrition, money to purchase goods, medicine, PPE, health care, who decides how resources will be distributed in the home?
    - Who eats first, what and why?
    - Who gets to go to a health facility if ill? Who decides?
    - Who is able to access contraceptives and SRH services?
    - Who determines hygiene norms at home?
    - Who controls and decides how to use household finances?
- How has mobility been impacted for girls, boys, women and men?
    - Who is enforcing lockdowns in communities and within homes?
    - Who decides who will/can go out and for what?
- Are there any local women's rights organizations (WRO), youth groups (YG), CBOs working on the rights of the disabled, and minority groups as relevant to the local context?
    - What services/initiatives do they carry out?
    - What are their ideas on response strategies using safe and appropriate methods?
    - What is the nature/possibility of WRO/YG collaboration with national, local state actors and UN System providing emergency services (food, health, cash, information etc.) to women/men, and girls/boys?
    - Are there any groups who are at particular disadvantage, for example migrant women workers (urban based women daily wage earners, women domestic workers away from their support systems at home)?

Distribution of roles and responsibilities post-pandemic – key questions

- How have gender roles shifted in response to the pandemic or lockdown?
    - Who is more or less active and what new responsibilities are they taking on?
    - How has scarcity of resources impacted roles and responsibilities? (e.g. women and children spending more time searching for water)
- Who does the household chores-cooking, washing etc.?
- Who is responsible for water and sanitation? Specific question
- Who takes care of children?
- Who takes care of the sick?
- Who takes care of elders?
- Who takes care of disabled?
- Who goes out to purchase goods (food, medicine, PPE, dignity kits etc.)

- Who goes out or does home-based work to earn money?

Norms and practices – key questions

- SGBV - Please note a detailed SGBV Risk Assessment must be done in all cases covering existing SGBV and potential risks-additional programmatic questions:
    - How have SGBV patterns been impacted by social distancing directives?
        - How is social distancing impacting women and girls' support networks?
        - What has lockdown meant for living arrangements and daily activities and what kinds of risks are being introduced or elevated and for whom?
    - In the community do you know if SGBV is prevalent? What types?
        - Intimate partner violence/domestic violence
        - Physical abuse
        - Verbal abuse
        - Violence against children
        - Rape or sexual abuse
        - Harassment/threat of violence
        - Neglect
        - Harmful Traditional Practices (HTP) such as CEFM, FGM
    - Who is it directed at mostly?
    - If cash transfers or goods distribution are part of program directed at women, do you think it can create conflict and/or SGBV risks?
        - If yes, what types?
        - What is a safe way to transfer these commodities?
    - What key messages and modalities are being promoted by SGBV cluster leads to prevent SGBV escalation in communities and households under social distancing or lockdown orders?
- If men/boys and women/girls and elderly man/woman, or person with disability fall ill because of COVID-19, how is it dealt with?
    - Is anyone hidden? If yes, who? Why?
    - Is there community censure? If yes, what type?
    - Do they face stigmatization? Does the type of stigmatization differ based on the sex, age, and ability of the infected person?

Systemic responsiveness – key questions or observations

- Does the facility keep sex and age disaggregated data of COVID-19 patients and deaths?
- Do you see/are facilities noting sex-age balance in in-coming patients seeking care?
- Are all patients treated equally?
    - Given the same priority (based on case severity and individual risk assessment)
    - Respect/behavior of service providers?
    - If and how is privacy ensured?
    - How are ethical decisions made on who gets critical care/ICU given limited provisions?
    - Who gets referred to higher facilities?
    - Are health facility and community staff sensitized/trained on gender equality or gender responsive health service delivery?
    - Are health facility and community staff sensitized/trained on child safeguarding or child friendly health service delivery?

- Is there government advice to give preference to priority groups for COVID-19 treatment? (Probe: pregnant and lactating women and girls, children (0-5 years), elderly, people with underlying medical conditions, any discrimination if at all)
- Human resources for health:
    - What is the sex ratio of health services providers? (e.g. almost same sex ratio, more women, more men)
    - Are all frontline (community and facility) well equipped with PPE and trained in self-care?
    - Are any special measures in place for healthcare workers such as mental health resources, childcare? Can male and female health workers access these resources equally?
- Are staff (community and facility) aware of SGBV risks, identification and referral pathways? Have they received training on supporting SGBV survivors?
- Alignment with national response and SGBV and Health cluster/coordination bodies:
    - What SGBV referral services are functioning?
        - Have they been adequately adapted with infection prevention and control (IPC) measures?
        - Is access to emergency health services facilitated for SGBV survivors in line with IPC protocols, and how can access to basic services (e.g. rape kits) continue if services become remote?
    - What safety precautions are being advised for women, girls and boys and vulnerable individuals for whom lockdown is not safe?
    - What are the ways that women and adolescent girls can confidentially communicate and seek help if they do not feel safe or for survivors who require urgent health support? (Contextualized according to ICT, access and control, and cultural considerations and preferences of women and girls).
- Are community-based health, education, child protection committees in place and functioning?
    - What is the representation and leadership of women in these structures? Has COVID-19 impacted the level of representation and leadership of women in these structures? If yes, how?
    - Has COVID-19 caused any adaptation in the working procedures of these committees? If yes, what are the adaptations?

1.2: How do we carry out an RGA on-ground? Understanding completely that a fulsome exercise may not be possible in all contexts, a flexible and graduated approach is suggested, over time as follows:

- Desk review, secondary information, sector/cluster group data/information to get a fuller picture including SGBV mappings etc.
- Get the information that you are able to get and build it up over time keeping in mind the imperfection principle.
- Make use of phone calls or have small FGDs and KIIs with women/girls, men/boys with physical distancing if not in lockdown in compliance with local government rules.
- Contact local health and relief service providers (both government and non-government actors, private sector) to determine who is seeking/not seeking, and getting/not getting health and relief services and why?

- Connect and confer with local women's rights organizations (WROs), youth groups (YGs), CBOs and other organizations such as disability focused, LGBTIQ focused to get their expert opinions
- Look at demographic and health surveys
- Education data, census data
- MICs data
- GBV IMS data, if CO has access
- Look at CEDAW and CRC shadow reports from NGOs and Concluding Observations of committees
- Ensure as many questions as possible are integrated in the broad rapid assessment that the UN System or others are carrying out, if possible.
- Share information with other actors on the ground on a regular basis

2) PROGRAMMING

2.1: Enhancing the inherent individual and collective agency of women and girls with accurate, empowering and lifesaving COVID-19 knowledge and information; decision-making skills and financial support **in the immediate term**. Further actions will be delineated for longer-term recovery. NOTE: Flexibility, adaptation to outbreak evolvement/stages, contextualization, innovative thinking is absolutely critical, without exception.

Information on COVID-19 prevention and care developed in simple and accessible language and formats. Too often, IEC material developed can be complex and text heavy or the imagery used can be gender stereotypical, which can, not only be inaccessible especially when literacy is a challenge and particularly from a child-friendliness perspective but can inadvertently reinforce gender stereotypes. Make sure:

- As many images, illustrations and pictorials as possible are used
- Absolutely no image portrays or reinforces gender stereotypes especially relating to hygiene management (e.g. women and girls washing, cleaning etc.). Use images of women and men equally carrying out non-traditional roles
- All IEC mainstreams gender equality messaging including on:
    - Time poverty and redistributing equal unpaid care and household responsibilities
    - Shared decision-making
    - Equal right to access healthcare
    - Equal distribution of resources, food, nutrition in homes
    - Positive masculine behaviors in nurturing/caring roles
    - SGBV prevention including CEFM and other contextually relevant HTP
- Distribute IEC materials in health centres, put in food parcels, include in hygiene kits, leave by food shop checkouts, etc.

Channels of information dissemination – (radio/TV/ICT) and media products most used/viewed by women and girls and messaging with appropriate timing for maximum reach. Too often, ICTs are controlled by men in households limiting women's and girls' access to them or men and boys by and large have greater access to these resources. Therefore, it is critical to know these limitations and program accordingly as suggested below:

- Create and/or leverage separate radio/TV programming timing for women and girls based on the burden of work they face and their media products preference

- Identify women/girls leaders that have cell phones and data so they can relay information directly (see group action below)
- Public service announcements (radio, TV, print, cultural PA practices etc.) highlight the importance of inter-generational dialogues, family discussions, and creating safe spaces within the home to discuss COVID-19, gender equality, child protection, and other topics
- Utilize technology platforms where accessible to help girls and women to establish and moderate information sharing groups, such as the PII Girls Out Loud platform (secured Facebook).
    - Girls and women may not individually own phones but may share access and information with each other; IPC measures should therefore be part of messaging in setting up networks
    - Household/community buy-in must be generated for girls to have safe access
    - Groups can facilitate information sharing via video or text on infection prevention and control, symptoms and actions to keep everyone safe, as well as on the practicalities of social distancing, and managing the social and mental health impacts of the pandemic and response, including coping with increased mental, emotional, physical loads.
    - Platforms can be moderated to provide a confidential place for SGBV survivors to seek help, to receive emotional support and to be linked to referral services.

Identify actions to mitigate SGBV risks to women and girls and measures to respond to SGBV protection concerns that support the individual and collective agency of women and girls, and that are locally contextualized (ITC environment, to level of female access and control, to cultural context, to female preference).

- GBV risk mitigation measures:
    - Establish WhatsApp groups for social connectivity and support (see group action below) and to promote individual and collective agency among women and girls
    - Engage young influencers using social media (e.g. TikTok (popular video sharing service), Facebook, Instagram etc.) to develop and disseminate content promoting abhorrence among youth against SGBV
    - Outline helplines for those experiencing SGBV, or hotlines for parents/families to provide support to their children or elderly
    - Identify WROs & trusted women and girls to act as resource people for survivors (to listen confidentially, to provide emotional support and possibly to be stewards of SRH and SGBV materials in line with agreed IPC protocols).
- Support girls and women to access secure communication channels for confidential signaling SGBV protection concerns and requests for help
    - Agree pathways for confidential communication with women and girls in lockdown, in line with ICT capabilities/low-tech settings
    - Communicate key messages on staying safe to vulnerable women and girls, in line with SGBV coordination mechanisms and lead actors
    - Support girls and women in establishing their own secret distress signals and responses that can be used through ICT-based messaging by text message or through social media groups. Sending agreed questions and answers or sending specific images can be understood to signal that someone is feeling safe or unsafe, or to signal a request for emotional support or intervention. (e.g. taking a picture of the top of one's hand to signal the situation is under control, or the open palm to

signal a request for help; requesting a hair appointment and a specific style; placing an order for an item that requires sending an address where help is needed)
    - Creating direct communication linkages between health sector actors in the referral system and trusted girls and women who can send and receive messages (with protocols to ensure confidentiality)
    - Utilizing MHM distributions as a vehicle to confidentially share safety information and materials (hotline numbers, phone credit, emergency whistle), or for female staff to assess protection concerns among women and girls as a pretext for private and confidential conversations. Conversations can be adapted for social distancing and privacy, for example using visual cards focused on menstrual health and hygiene to elicit yes and no responses, inserting images to assess feelings of safety or requests for intervention).

Large group activities avoided for safe physical distancing or organized as allowed by governments.

- Members of existing women's and girls' groups established under projects e.g. Women's Support Groups, adolescent girls' groups, grannies clubs provided guidance and data on continuing collective action through WhatsApp groups, social networks, ICT technologies.
- Where and if only possible, new groups are formed, identify key female leaders in communities to establish them via social media
- Provide these groups with all IEC materials for dissemination in groups
- Provide these groups with SGBV including CEFM specific information
- Create linkages between these groups and local women's right organization (see below) for support.

Local women's rights organizations (WROs) supported for SGBV, WASH, SBCC and other COVID-19 response work.

- Identify and engage with local WROs and youth led organizations to:
    - Form social networks with project women's/girls' groups (see above) and provide remote advice and support for SGBV and other resilience building supports
    - Engage WROs in COVID-19 clusters and coordination groups
    - Develop and implement (provide funding) projects and initiatives building on their existing programs or adding new ones
    - Carry out advocacy/influencing with health and relief service providers (government, non-government, private sector) for gender responsive adolescent friendly and inclusive service delivery.

Cash and or other resources transfers (e.g. food distribution, or WASH kits) to women in households for preparedness for COVID-19 isolation, costs for transportation to clinics and other contingencies.

- To mitigate risks associated with cash and resource transfers:
    - Establish means of transfer based on rapid gender assessment in terms of timing, method, venue, e-transfers of cash etc.
    - Raise broader community awareness through social and behavioural change communication (SBCC).

- Value of cash transfers established by recommended Minimum Expenditure Basket (MEB) value and coordinated with governments and other agencies to ensure consistency and avoid negative social consequences.

Remote Education programs for continuing education for children are to:

- Ensure that both parents are involved in children's remote education being mindful of the burden of work on women and girls
- Disseminate messaging regarding the equal rights of girls in education so they are not left out as programs are rolled out via ICTs. Particularly:
  - Advocate for equal sharing of domestic chores and care duties amongst male and female siblings/household members, so each has time to participate in alternative education initiatives
  - Mainstream gender equality messaging in remote education programs including communicating how to prevent/avoid SGBV/SEA
  - Support teachers in ensuring girls' classwork/homework is especially solicited from parents through phone and sensitize teachers on increased risk of SGBV/SEA for children and on tools for children to prevent and report it.

WASH programs are to:

- Ensure all IEC materials and SBCC activities are devoid of gender stereotypes and mainstream gender equality messaging (see IEC above in 2.1)
- Women and men are equally targeted for any direct messaging/activities
- Ensure men and boys are encouraged to share hygiene management responsibilities
- The gender specific needs of women and girls especially MHM are addressed in distribution activities adequately and include age-appropriate information for adolescent girls
- Use inputs and feedback from women, girls, men and boys in a participatory manner to increase hygiene and encourage measures such as hand-washing in ways that resonate with the community
- Consider the distance and the route that women and girls have to cover to collect water if distributing water. This has implications in terms of a time burden and potential protection risks if it becomes known that they regularly take that route unaccompanied

Further information can be found in Table in Annex 1 of the COVID-19 Gender Equality Global Adaptation and Response Framework which describes suggested key activities for cross cutting issues (including on gender and inclusion) and for each of the Intervention Pillars across the four phases of the crisis (Preparedness, Initial Response, Mitigation and Recovery).

2.2: Building an enabling social environment for gender equality and gender responsive COVID-19 response

Additional or integrated SBCC with age and gender-specific messaging relating to the impacts of COVID-19 on women and girls (see 2.1 above) including: the disproportionate workloads of women and girls focusing on shared household and care responsibilities, decision-making relating to COVID-19, women's and girls' increased risks for contracting the virus, opportunities for women's and girls' empowerment, SGBV prevention. Messaging to be delivered through:

- Radio, ICTs, Public Address Systems
- Pre cash, food or WASH resources distribution
- Door to door visits by community health workers/volunteers (where this is happening)

Identify messages and social actions to mitigate SGBV risks to women and girls and to promote response to SGBV incidents.

- Develop sex and age-adapted strategies to sensitize women, men, adolescent girls and boys about the risks to girls and women of escalating violence, including sexual exploitation, during lockdown/quarantine, and the responsibility to take action to prevent or intervene
- Develop and carry out ICT based, radio/TV based PSAs on SGBV including CEFM prevention
- Use educational radio programs and sex and age-targeted PSS activities to sensitize women, men, girls and boys about stress responses to the pandemic and quarantine measures and share coping techniques for grounding and mindfulness, discharging difficult emotions, de-escalation and non-violent communication as part of SGBV risk awareness and mitigation
- Promote bystander intervention. In areas where there are no or limited connectivity consider the “ring the bell” approach to alert an SGBV incident (CNO GEA to facilitate the delineation of this approach where feasible and contextually relevant) (e.g. banging a pot, beating a drum).
- Integrate messaging on how to access hotlines and key SGBV services in radio and IEC messaging across all sectors for broad public awareness

Male engagement messages integrated in SBCC for positive masculinities, SGBV prevention, positive parenting, equitable distribution of resources, equitable distribution of unpaid care and household responsibilities, shared decision-making and gender equality.

- Discussion of the impact of the pandemic, lockdown measures and knock-on effects upon stress levels, feelings of fear, powerlessness, and trends of increased male violence towards women and children; share stress management techniques tied to positive masculinities
- Specific and targeted messaging through WhatsApp and other ICT channels such as radio/TV, PSA

Community religious, traditional and other leaders/influencers such as artists, journalists, teachers etc. provided with messaging for SGBV prevention and gender equality promotion.

- Targeted through WhatsApp and create WhatsApp groups
- Engage leaders for radio/TV, PSA messaging
- Engage influencers (singers, celebrities, etc.) to develop messaging on COVID-19 prevention and response (where relationships already exist)
- Engage young social influencers (e.g TikTok stars!) by developing and disseminating gender equality messaging using infotainment approach

Group work with men and boys in ongoing programs re-oriented to COVID-19 response through group leaders provided with guidance to continue discussions on gender equality and its relevance in COVID-19 using ICT outreach and smaller groups as allowed by governments.

- If new groups established, where possible, provide them with remote male engagement training and resources applying CNO’s Fathers Clubs manual

Family-based intergenerational dialogue for gender equality noting that while COVID-19 poses serious challenges, it provides opportunities also as families are at home. As relevant, ensuring "do no harm" leverage:

- Leaders of men's groups (see above) to promote intergenerational dialogues and gender equality messaging sharing in families
- Leaders of adolescent boys' and girls' groups to facilitate dialogue and share messaging (making sure that no harm is done or risks accrue)
- Members of women's groups to promote intergenerational dialogue and gender equality messaging
- Community religious, traditional and other leaders/influencers promote intergenerational dialogue on COVID-19 prevention and response and the importance of creating safe spaces at home

2.3: Gender-responsive, child and adolescent friendly COVID-19 service delivery and response:

- Align SGBV risk mitigation and response protocols with the CO and national response
    - Ensure local multi-sector referral pathways (for children, adolescent girls and women) are frequently updated in accordance with SGBV, Health, CP and MHPSS clusters or coordination bodies to reflect currently available services (with IPC adaptations), including remote services such as hotlines.
        - Explore ways of ensuring continuity of access to critical SGBV and SRH services and materials if regular service provision is no longer possible (e.g. with the assistance of WROs, community- based protection systems (if active) or women and girls acting as community focal points that can be linked up to hotlines with health staff)
    - Sensitize all frontline workers on existing and expected protection risks including SGBV and elder abuse and train them to respond to disclosures of SGBV, including IPV and elder abuse, as well as to guide individuals through the existing referral mechanisms using survivor-centered care
    - Secure training (e.g. through SGBV Cluster) for focal points who can operate at community level to be able to provide psychological first aid and confidential survivor-centered support, linking to appropriate services in accordance with SGBV and CP referral protocols and infection prevention and control protocols
- Engagement in cluster system/coordinating mechanisms to further action on the gendered implications of COVID-19 especially access to care, disease related stigma, SGBV services, nutrition, SRHR, economic recovery and engaging women and girls in response plans.
- Community and facility health workers sensitized and provided resources on the gendered implications of COVID-19 – SGBV, child protection and gender equality messaging.
- Community Health Committees, education, protection and WASH structures oriented on the gendered implications of COVID-19, links to SGBV supports and the continued participation and leadership of women in these structures.
- Governments/health systems supported in collecting sex and age disaggregated data for COVID-19 incidence, morbidity and mortality rates.
- Education ministries supported in integrating gender equality and child protection messaging in online education continuation programs. Utilize partnerships with schools/Ministry of Education and disseminate IEC messaging on COVID-19 prevention and response for

school management, teachers, and students through educational structures or e-learning initiatives.

- Governments supported in carrying out gender analysis of data and project learnings for gender responsive action.
- Collaborating with local/national advocacy and influencing groups, particularly Women Rights Organization and Youth Lead Organizations, to create opportunities to address gender equality and SGBV in press conferences and other actions.
- Support Women Rights Organization and Youth Lead Organizations to influence government and private sector led relief programs to respond to unique needs of women and adolescent girls.
- Regularly inform communities in inclusive, gender and age friendly formats about changes to Plan International's programming, adaptations and how they can access information or contact Plan. Ensure methods take into account differences in literacy levels and access to information
- Adapt feedback response mechanisms to function with remote strategies and limit direct contact while ensuring they remain accessible to different age and gender and vulnerable groups, particularly adolescent girls.
- Maintain closing off the feedback loop with adapted remote strategies and using feedback to inform programming in collaboration with Plan sector teams

3) ONGOING GENDER SPECIFIC LEARNING DOCUMENTATION, DISSEMINATION AND FEEDING BACK INTO PROGRAMS

- All programs are to set sex and age disaggregated targets
- All indicators to gather sex and age disaggregated data, and other variables as relevant
- Key gender equality indicators from CNO's Women and Girls' Empowerment Index-WGEI to assess:
    - Access and control (Percentage of women/girls with adequate access and control over resources (to be customized by sector of the COVID Response program)
    - Gender roles and responsibilities (Average time women/girls spend in unpaid work (productive, reproductive and community)
    - Women's/girls' participation and decision making (Level of involvement in HH decision making (to be customized by sector and/or Level of community/public engagement of women/girls in COVID-19 response)
- Ongoing learning documentation to be carried out mid-intervention and at the end regarding:
    - What works, doesn't work across the three programming streams
    - Impacts including spin-off and unintended consequences