

UNITED NATIONS POPULATION FUND

COVID-19

GUIDANCE NOTE ON
GENDER-BASED VIOLENCE
SERVICE PROVISION

WHOLE OF SYRIA - APRIL 2020

Gender equality and women's rights are essential to getting through this pandemic together.

— ANTONIO GUTERRES
Secretary General of the United Nations



UNITED NATIONS POPULATION FUND
REGIONAL SYRIA RESPONSE HUB



GBV AoR
Whole of Syria

During the curfew period, I met many women who face violence at the hands of their husbands. It has clearly increased. One woman told me that she is consistently suffering from domestic abuse since her husband had lost his job. I also saw a wife being beaten in front of her children.

— Ghadeer, a woman from Homs, Syria

INTRODUCTION

This document aims to provide practical guidance to support front-line gender-based violence (GBV) service providers to ensure timely, dignified and safe GBV service provision during the COVID-19 pandemic.

This guidance note is a rolling document based on continually updated information and best practices. As such, information contained will be updated as necessary on a continuous basis as the situation evolves.

GBV RISKS AND COVID-19

There is increasing preliminary evidence from the countries most affected by the virus that indicates a negative impact on the trends, prevalence and intensity of GBV. For example, organizations have observed that extended quarantine and other social distancing measures have resulted in an increase in the number of domestic violence reports, driven by added household stress over health and economic risks, combined with forced coexistence in small living spaces.¹ There are also reports of a growing number of attacks on female healthcare workers, which in turn have the potential for increase as health facilities struggle to provide adequate care to everyone who requires medical assistance (VAWG Helpdesk report, March 2020).

Additionally, restrictions of movement, lockdowns, and forced quarantine measures may impede access to services for GBV survivors, in addition to significantly impacting their individual safety plans. Schools, community centres, Women and Girls Safe Spaces (WGSS), and places of worship may also have been closed, further impacting the ability of GBV survivors to cope with stressful situations. There have also been documented reports of sexual harassment and abuse against women in quarantine facilities.

There is growing concern about the potentially catastrophic impact on vulnerable displaced women and girls should the virus spread into IDP sites, where population densities are high; water, sanitation and hygiene provisions are poor; and self-isolation is virtually impossible. The inevitable increase in fear and tensions in IDP sites increases the risk of violence against women and girls as well as their vulnerability to sexual exploitation and abuse.

It should also be noted that the predominant health aspects of COVID-19 may also have the added effect of diverting attention away from the provision of life-saving GBV services (i.e. clinical management of rape and mental health and psychosocial support). GBV case workers may eventually be unable to meet and assist new survivors and will need to adopt new modalities to follow-up with old cases, as they, too, may be quarantined at home, either by choice or due to mandates by authorities. If confinement restricts the work of GBV case workers, this may have serious consequences for those who rely on this form of support.²

As primary caregivers to children, the elderly, and the ill, it is important to note that women face additional risks and exposure to COVID-19. Understanding this is crucial when attempting to address and mitigate — by programing appropriate measures — the multitude of risks that women caregivers face.

KEY POINTS OF CONSIDERATION

Life-saving critical GBV response services, including case management, individual structured psychosocial support (PSS), distribution of dignity kits/IEC materials, and referrals, should remain available to those who are in need at all times, while non-life-saving activities that typically feature large numbers of people (e.g. vocational training/ life skills and recreational sessions) can be temporarily suspended or otherwise reviewed (for example, to have fewer participants) in order to minimize the risk of infection. This guidance note builds on existing global and regional resources and focuses on key points of consideration for GBV programming, as follows:

GBV CASE MANAGEMENT³

Case management remains a critical service that, in most cases, is possible to continue as long as sufficient modification and adaptations are made to uphold public health guidelines. Decisions about whether or not to continue static, face-to-face case management services, scale them down, or dramatically alter them in favour of other modalities such as remote case management, will depend on a number of factors, including **national response strategies to COVID-19, i.e. containment, delay or mitigation**. Each carries various levels of risks and restrictions that may make some modes of service delivery more possible than others.

Containment: There is minimal disruption to public life, and the focus is on early detection, isolation and care for people infected with the virus. **Face-to-face case management can continue under this strategy, provided there is strict adherence to infection, prevention and control protocols** (Model 1).

Delay: There is significant disruption to public life and people are called upon to self-isolate and introduce social distancing strategies, such as asking people to work from home and closing recreational and leisure facilities. Face-to-face case management may only be possible in clinical facilities. If referrals to these static services are not possible or approved by the survivor, **providers should primarily rely on remote case management services with limited or no face-to-face services outside of healthcare settings** (Model 2).

Mitigation: Aggressive strategies are deployed seeking to stem widespread infection, which can include severe restrictions on freedom of movement. **Maintaining face-to-face support is likely to be impossible, so GBV service providers can switch entirely to remote service modalities through safe and secure forms of telecommunications, e.g. prepaid mobile phones.** Individual protection and cash assistance may be used in this scenario to ensure survivors are equipped with voice and data communication as needed. Prepare for possible closure (temporary or long-term) of physical locations of the WGSS/community centres (Model 3).

The following checklist highlights considerations to include in GBV response programming based on the different possible models. Organizations need to have a plan in place to rapidly adjust to these changes in their programmes.

3. Please refer to guidance for [GBV Case Management and the COVID-19 Pandemic guidelines](#) and [Case Management, GBVIMS/GBVIMS+](#) and the COVID-19 pandemic guidance for further info. The IRC's (2018) [Guidelines for Mobile and Remote Gender-Based Violence \(GBV\) Service Delivery](#) also provide useful examples and practical advice for remote and mobile GBV case management in both acute and protracted crises.

1. VAWG Helpdesk report, March 2020).

2. (GBV WG COVID-19 and GBV guidance note, Libya, March 2020)

MODELS	PREREQUISITES	RECOMMENDED ACTIONS
<p>Model 1: Static, face-to-face case management continues</p>	<ul style="list-style-type: none"> • Social/physical distancing measures can be implemented in the centre to ensure safety of staff and survivors. • Infection Prevention and Control (IPC) procedures can be implemented in the centre. 	<ul style="list-style-type: none"> • In places where you are meeting clients face-to-face, set up hand-washing stations and/or make hand sanitizer available at all entry points. • Continuously update your organization's services on the 4Ws and service mapping. Refer to the most recent referral pathways, updated with a focus on health facilities and medical service providers (particularly facilities with available CMR services). Ensure that caseworkers regularly verify the validity of service mapping and referral pathways, ideally on a weekly basis, as services provided might be suspended or have their modalities change within a very short timeframe, depending on the spread of the virus. • Develop quick and clear case management protocols with staff: • Prepare for shifting to phone-based case management (check: are caseworkers prepared to handle GBV disclosure and case management remotely? Are there any capacity building needs at this stage? Identify resources needed and revise data collection and storage protocols accordingly.). • Set up hotlines in preparation for possible interruptions of service provision and disseminate numbers within the communities. Inform clients in a timely manner about the shift in the approach. • Procure mobile phones and credit (including data bundles) for GBV caseworkers and their supervisors, and, if needed, charging devices for use in settings with poor/unreliable power. • If possible, put a plan in place for remote, phone-based coaching, technical support and regular supervision. • Identify GBV staff or focal points working within operating medical facilities who can provide survivors with crisis counselling and a more specialized response. • Update data protection protocols to ensure safe storage of files. • Ensure GBV case workers integrate COVID-19 prevention and response key messages during case management action plan discussions with survivors (see key messages included in this document for reference). Ensure that the messaging is tailored and that interventions consider gender, language, disability, literacy and local culture. • Ensure that a remote mechanism for staff care is set in place.
<p>Model 2: Static face-to-face case management from health centre(s)</p>	<ul style="list-style-type: none"> • A confidential and safe space is available in the health centre to provide GBV case management services. • Caseworkers are / can be deployed in health facilities. • Social/physical distancing can be implemented in the health facility to ensure safety of staff and survivors. • IPC procedures can be implemented in the centre. • Locked cabinets are available in the case management room in order to store consent forms and case files separately. • At least one female caseworker is available to provide case management services. 	<ul style="list-style-type: none"> • Train receptionists and medical staff on how to deal with GBV survivors (e.g. basic GBV concepts, confidentiality, a survivor-centred approach, and GBV guiding principles; referral to services that would still be functional, such as helplines, PFA, PSEA, etc.) • Set up internal operational procedures (internal referral pathways for health to protection services; safe and ethical data storage; etc.), and train involved staff in providing service provision on the processes and tools adopted. • Always use the most update referral pathways as, due to the escalation of the situation, some services might be closed as a mitigation measure to control the spread of the virus. • Disseminate information on the availability of services and referral pathways in health centres through all possible communication channels. • Train social workers and assistants in the health facilities on providing information on preventive measures related to COVID-19, allowing for the possibility to organize information sessions for women and girls. • Ensure the case workers are not only associated with case management to avoid stigmatizing survivors who access these services by engaging them in other activities, such as open space messaging.
<p>Model 3: Phone-based case management from caseworkers' homes</p>	<ul style="list-style-type: none"> • Caseworkers feel safe and comfortable offering case management services from their homes and over the phone. • Caseworkers have a private and confidential space available in their homes to speak to survivors over the phone. • Case workers have access to updated referral pathways and to mobile phones with sufficient credit 	<ul style="list-style-type: none"> • Define operational procedures that will guarantee the confidentiality and safety of the survivor. • Ensure that GBV caseworkers obtain informed consent from survivors to conduct phone-based case management. • Ensure that GBV caseworkers assess the safety of contacting survivors by phone for case management services based on their living conditions (e.g. do they live with an abusive partner? Do they have space to speak confidentially? What are their working hours? Etc.) • Ensure that GBV caseworkers shift to emergency case management and focus on safety planning, especially during quarantines, lockdowns, or "shelter-in-place" scenarios. • Strengthen capacity and confidence to provide remote supervision and/or support. • Ensure that GBV caseworkers have integrated COVID-19 prevention and response key messages during case management action plan discussions with survivors. • Ensure that caseworkers safeguard the integrity of sensitive data ⁴ (ideally, this should be achieved by adopting an online, password-protected system to avoid the use of paper. • Case management supervisors are encouraged to check in with caseworkers to monitor whether their living conditions allow them to provide specialized services from their homes. • Case management supervisors should regularly check on staff wellbeing and ensure that a remote staff care mechanism is in place.⁵

4. Caseworkers store survivors' phone numbers using survivors' codes. Phone numbers connected to survivors' codes can be saved in office or personal phones. Separate information on survivors' codes related to survivors' names & other identifying information should be stored in a paper in a locked cabinet/drawer or in password protected electronic form on desktop. No information related to a survivor's case should be documented in writing to ensure data confidentiality. Do not store case files information in caseworkers' homes.

5. Check the "Mental Health & Psychological Support Considerations for Staff During COVID-19 Crisis - GBV AoR"

GBV PROGRAMMING/SERVICE PROVISION

WGSS, COMMUNITY, AND COMMUNITY WELLBEING CENTRES:

WGSS should not close at the first sign of COVID-19 as they facilitate life-saving interventions. Rather, they should remain open as long as possible, with activities adjusted based on risk assessments within the context. WGSS should also be used as centres for preparedness actions and information sharing with women and girls.

- **WGSS can be used as a key entry and service point** for continuity of care for women and girls, including sexual reproductive health services when health services become overburdened.
- **Consult with women and girls** about protection risks that might increase or emerge during the COVID-19 response and its resultant restrictions on movement.
- **Share information on protection risks**, including increased risks of intimate partner violence, together with suggested mitigation recommendations, if applicable.
- **Involve women and girls in preparedness and response planning.** Consult with women and girls on their concerns and needs and help amplify their voices to decision-makers. Ensure that women are recruited to facilitate awareness sessions, rapid assessments, and other core operations.
- **Include dissemination of tailored COVID-19 IEC materials** during GBV awareness raising sessions.
- **Reduce the risk of transmission** by (i) improving hygiene practices and instituting cleaning/disinfecting measures and screening protocols; (ii) redesigning WGSS services or processes to avoid congestion (e.g. set an appointment system for women and girls to attend activities; and (iii) reducing both the volume of group activities and the number of participants to allow for enough space for recommended social distancing measures.

DIGNITY KITS DISTRIBUTION

Dignity kits should be used as a vehicle for supporting the dissemination of lifesaving information on GBV, sexual and reproductive health (SRH), and prevention of sexual exploitation and abuse (PSEA) awareness, in addition to serving as a means for promoting protection, physical and psychosocial wellbeing, mobility, and hygiene for women and girls at risk. They also provide a key entry point for women and girls to disclose GBV and to access specialized services. It is therefore recommended to involve social workers in the distribution processes to secure access to immediate care and disseminate hotline contacts.

Dignity kit distributions should include dissemination of COVID-19 infection prevention and control (IPC) IEC materials. Distributions of dignity kits should follow the [NFI distribution guidelines](#) developed by the Shelter/NFI cluster.

OTHER GBV PROGRAMMING

- **Localize commodity and IEC production** (e.g. engaging women and girls in making masks or distributing COVID-19 prevention IEC materials).
- When possible, **assist women and girls through IPA services** to address their basic needs.
- **Promote the integration of GBV risk mitigation actions** (as outlined in the Inter-Agency Standing Committee GBV Guidelines) in the interventions related to COVID-19 implemented by other clusters.
- **All funding proposals should contain comprehensive gender analyses** and protection mainstreaming provisions.
- **Regularly update your services** and the status of your GBV programming through the 4Ws and service mapping, and reflect any changes in operating hours or access points.
- Promote the integration of PSEA awareness raising and messaging within GBV programming.

CAPACITY BUILDING & STAFF WELLBEING

- **Conduct remote trainings for staff on Psychological First Aid (PFA) and GBV referrals.**
- **First responders must be trained on how to handle disclosures of GBV and referral pathways.** Health workers who are part of an outbreak response must have basic skills to respond — in a compassionate and non-judgmental manner — to disclosures of GBV that could be associated with or exacerbated by the epidemic, and to know to whom they can make referrals for further care in such situations.
- **Staff should be trained on the clinical management of rape (CMR)** and post rape treatment kits should be available in each health facility.
- In each health facility, it is essential to have staff trained on the clinical management of rape (CMR) and the availability of post-rape treatment kits.
- **Increase availability of remote staff well-being services.**⁶
- **Duty of Care:** Respect the decisions of female case workers who choose to work from home or part time to look after children and older family members.

INFORMATION SHARING:

With the understanding that women's access to information and available services during outbreaks is severely constrained and limited, it is key to plan and identify effective information dissemination channels.

- **Communicate openly with women and girls** about COVID-19 and any changes or potential changes to your methods of service delivery.
- **Re-assure clients that support services will still be available in some capacity**, even if the modality changes, and that they will not be alone. Be careful to listen to their fears, questions, suggestions, as well as what will work best for them.
- **Use every opportunity to engage with women and girls** to listen to them and to ask questions to better understand what they know about COVID-19, what their concerns and fears are, and their suggestions for how we improve our response.
- **Position IEC materials related to GBV and SEA prevention and available services** at COVID-19 screening desks (e.g. triage tents). Assign GBV-trained staff to these screening areas.
- Make sure that messages around COVID-19 and IPC measure evolve over time and meet the needs of your clients (see messages below as starting point).
- GBV staff are also encouraged to support GBV risk mitigation actions in other sectors, particularly those most affected by COVID-19 (e.g. healthcare, WASH, shelter, etc.)

6. Please refer to guidance for [GBV Case Management and the COVID-19 Pandemic guidelines](#) and [Case Management, GBVIMS/GBVIMS+](#) and the COVID-19 pandemic guidance for further info. The IRC's (2018) [Guidelines for Mobile and Remote Gender-Based Violence \(GBV\) Service Delivery](#) also provide useful examples and practical advice for remote and mobile GBV case management in both acute and protracted crises.

TARGET AUDIENCE	MAIN MESSAGE	SAMPLE MESSAGES TO BE USED BY HUMANITARIAN ACTORS ON GBV RISK MITIGATION, ACCESS TO SERVICES, AND PSS
Everyone	GBV	<ul style="list-style-type: none"> • Listen and Link: If someone experiences gender-based violence and asks for help, you can be a source of support; listen to their problem and link them to information about helplines and/or other social support services available in your area (INSERT contact and opening hours). Remember, it's not the survivor's fault. • During times of crisis, some families use negative coping mechanisms, such as child marriage or other harmful practices. These are not solutions! Protect every member of your family by saying no to these harmful practices. Don't feel ashamed to ask for help (INSERT contact and opening hours tailored to your specific response).
Women and Girls	GBV	<ul style="list-style-type: none"> • During the COVID-19 pandemic, you might find that you have more work and pressure on your shoulders. Please remember that it is fine to feel overwhelmed, stressed or scared. Don't feel ashamed to seek help via (INSERT contact and opening hours tailored to your specific response). • Do you feel unsafe in or around your home? Have you been harmed or feel threatened, intimidated or harassed? Please seek remote and confidential support from (INSERT contact and opening hours tailored to your specific response). You have the right to get help. You do not have to manage this on your own. Remember: it is not your fault. • In case of violence at home, and if you are fearing for your life or that of your family, try to organize an emergency safety plan, if possible. This plan should include a place where you can find refuge, in addition to the contact details of service centres or people who could support you, in addition to any other steps needed to ensure your safety.
Men and boys	GBV	<ul style="list-style-type: none"> • Quarantines and government lockdowns are no excuse for violence. Keep yourself, your family and community healthy and protected. Say NO to any form of violence. • Staying at home because of COVID-19 may cause tension among married couples and families. Uncertainty of the future and the impact on livelihoods can exacerbate your anxiety to safeguard and provide for your family. You may feel caged, crowded at home, or isolated from the world. If you find yourself reaching anger or frustration, or if you think tensions can turn into serious disagreements, allow yourself to take a break, if possible. Read, pray, meditate or do some physical activity. When things calm down, talk about the issue and express your feelings openly and calmly. Violence is never the solution. • With the measures set in place for COVID-19, your wife, daughters, sisters and mothers will likely have many more domestic responsibilities on their shoulders: let's help them! • If you know of any woman or girl who has been harmed, or who feels threatened, intimidated or harassed, support her by letting her know that she can seek remote and confidential support from (INSERT contact and opening hours tailored to your specific response).
Everyone	PSEA	<ul style="list-style-type: none"> • Remember that support and assistance are free. No one should ever ask for money, favours, or sex in exchange for assistance. You have the right to report anyone who attempts to exploit or abuse your situation (INSERT contact and opening hours + reporting modalities for complaints tailored to your specific response).
Everyone	MHPSS	<ul style="list-style-type: none"> • It is normal to feel sad, distressed, worried, confused, scared or angry during a major crisis. Taking care of yourself will benefit your family and is a sign of strength and responsibility. If you feel overwhelmed and anxious, seek help from (INSERT contact and opening hours tailored to your specific response). • Talk to people you trust. Contact your friends and family. • If you must stay at home, maintain a healthy lifestyle, including a wholesome diet, sufficient sleep, exercise, spiritual practices (if any), and contact with loved ones at home. Keep in touch with family and friends through email, phone calls and other forms of communication. • Don't rely on tobacco, alcohol or other drugs to cope with your emotions. • If you feel overwhelmed, talk to a health worker, social worker, or other similar professional. If none are available, seek help from a trusted person in your community (e.g., community elder or spiritual leader). • If necessary, have a plan in mind on where to go and seek help to address your physical and mental health needs. • When it comes to your risk of infection, only use credible sources to get information, such as the website of the World Health Organisation (www.who.int) or your local or state public health agency. Do not trust information provided by unofficial sources, even if it is forwarded by people you know. • Limit the time you and your family are exposed to negative media coverage. • Draw on the skills that you have used in the past during difficult times to manage your emotions during this outbreak.

FOR MORE INFORMATION

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