Prevention and response to

Sexual and Gender-Based Violence in COVID-19

-A Protection, Gender & Inclusion (PGI) Technical guidance note

This document explains ***why*** there is an elevated risk of sexual and gender-based violence (SGBV) in the face of the COVID-19 pandemic, ***who*** is likely to be most affected and ***what operational approaches*** can be adopted to prevent, mitigate or respond to SGBV by Movement actors. The guidance also includes ***diplomatic messages*** to support decision-makers in preventing and responding to SGBV and brief guidance on how to ***ensure staff and volunteers*** are protected in their SGBV prevention and response efforts.

It is important that all Movement components, other humanitarian agencies and authorities:

Understand and monitor the increased risks of SGBV associated with the pandemic, and identify persons more at risk

Reduce risk of SGBV and sexual exploitation and abuse activities

Provide information in accessible formats about available SGBV support services and support at-risk individuals to access those services

Adapt approaches in line with COVID-19 contagion measures while also focusing on ensuring continued lifesaving SGBV support such as healthcare or livelihoods

1) SGBV situation analysis: higher risk of SGBV due to COVID-19

The 32nd International Conference Resolution "Sexual and gender-based violence: Joint action on prevention and response" (2015) makes clear that all emergencies lead to increased levels of SGBV. Research by IFRC has further demonstrated the ways in which this occurs[1]. COVID-19 is no different. Worldwide preliminary evidence[2] from the impacts of the pandemic show that SGBV is rising rapidly, and that access to services and modes of delivery of services for victims/survivors of this type of violence are changing quickly due to measures to contain the virus at the international, national and local levels[3].

[1] Unseen, unheard (IFRC, 2015) and The responsibility to protect (IFRC, 2018)
[2] https://gbvguidelines.org/wp/wp-content/uploads/2020/03/vawg-helpdesk-284-covid-19-and-vawg.pdf
[3] https://www.thelancet.com/journals/lanres/article/PIIS2213-2600(20)30128-4/fulltext

SGBV-risks of urgent concern due to the pandemic are:

Increased prevalence of **violence in the home** or family, including intimate partner violence (IPV) and **child- or elder sexual abuse** owing to forced coexistence and isolation with abusers, or new abuse triggered by fear, stress, loss of household income and livelihood; prolonged confinement and negative coping mechanisms such as substance abuse, discriminatory, abusive or selective behavior towards close relations;, increased **violence against health care workers** who are predominantly women[4]; and the **increased risk of sexual exploitation and abuse**, such as sexual violence while accessing help, for example, from healthcare and humanitarian aid.

In **Sierra Leone**, community members responsible for enforcing quarantine were accused of sexually assaulting girls during the Ebola epidemic (The Alliance for Child Protection in Humanitarian Emergencies, 2018). Research found that more than 65% of female respondents reported manipulation and exploitation by guards; women and girls quarantined were financially and sexually exploited by guards in exchange for permission to leave the house for water and firewood (IRC, 2015)

Further, increased SGBV-risks due to secondary impacts of COVID-19 include **child- and forced marriage** with related early pregnancies that might lead to health complications and heightened **maternal mortality**. In the short-medium and longer term, the anticipated global socio-economic consequences of pandemic control may result in reduced economic growth, widespread loss of income, particularly for women and un- or underpaid workers, and an overall **increase in inequality** levels and marginalization of the poor, those migrating and especially: women, children and sexual and gender minorities. All this is known to increase the **risk of human trafficking to sexual services, engagement in transactional and survival sex, engaging in unsafe sex work**, and forced marriage (this is especially true for women and children who are migrants or undocumented). Furthermore, the risk of **racialized sexual harassment** is already being seen, due to COVID-19 being attributed to a particular ethnic groups or geographic locations.[5]

Regular health, psychosocial and safe-house services are being overwhelmed, traditional walk-in services are harder to access or not operating, and phone lines can be unsafe for survivors to access due to abusers controlling information-communication-technology. Critical services such as clinical management of rape, healthcare services for survivors of violence in the home or family, sexual and reproductive healthcare, as well as mental health and psychosocial support, may be interrupted, resulting in unplanned or **forced pregnancy, unsafe abortions, inadequate prenatal and post-natal care** for pregnant and lactating women, physical injuries going untreated, **increase in STIs including HIV, self-harm and suicide**.

The health-, protection- and socio- economic impacts of COVID-19 are being felt deeply across the world, and many people no longer have access to basic services, safety or livelihoods. These are our essential safety nets, and their compromise heightens the risk of abuse.

[4] https://www.nytimes.com/2020/04/27/world/coronavirus-world-pandemic.html?type=styln-live-updates&label=global&index=1&action=click&module=Spotlight&pgtype=Homepage#link-2efc59ae

[5] ibid

Lessons learnt from the Ebola outbreak in **West Africa**, showed great economic impact on women, including reports of sexual exploitation, transactional sex and sexual violence and increase levels of early/forced marriages and teenage pregnancy due to socio-economic factors imposed by the outbreak and increase in complications and deaths related to pregnancy. (Save the Children, 2016)

At the time of writing, **emerging data** shows risk of heightened or new forms of SGBV, where residential confinement policies are in place:

- In the **UK**, initial reports from domestic violence advocacy groups show a spike in domestic homicide: an increase from two deaths per week to five deaths per week. The UK's largest domestic abuse charity, Refuge, has reported a 700% increase in calls to its helpline in a single day, while a separate helpline for perpetrators seeking help to change their behaviour received 25% more calls after the start of the Covid-19 lockdown[6]
- According to a tally combined by Tal'at, an independent feminist movement in **Palestine**, domestic homicide has also drastically increased in this country, with 5 deaths in just over a months' time from when lockdown was enforced[7]
- **Online sexual harassment** against women and girls has become prevalent amid the enhanced community quarantine due to COVID-19, and according to sources from several different contexts such as Europol, the U.K.'s National Crime Agency, the **Swedish Police Authority** and others there is already an increase in **online child sexual exploitation** since COVID-19 lockdowns.[8]
- In **Canada** federal consultations show 20 to 30 per cent increase in violence rates in certain regions following the imposition of a national lock down[9]
- A police station in Central Hubei, **China**, reported in February 2020 a three-fold increase in cases of domestic violence compared to the same period in 2019, and according to police statistics, 90% of the cases of violence were related to the COVID-19 pandemic.[10]
- In **Kenya**, the National Council on Administration of Justice reported a "significant spike in sexual offences in many parts of the country [since end of March 2020][11].

2) Who is likely to be most affected by SGBV during the COVID-19 pandemic?

The COVID-19 pandemic is affecting the entire world population, but in all societies, certain individuals, groups or communities, face greater marginalization, inequality and violence than others. These differences are linked to existing socially constructed and ascribed factors: legal, cultural, gender-based or economic, that define peoples' differences in status, access and influence over their own lives.

[6] https://www.theguardian.com/society/2020/apr/12/domestic-violence-surges-seven-hundred-per-cent-uk-coronavirus
[7] https://www.aljazeera.com/news/2020/04/domestic-abuse-palestinian-women-soars-200420175924348.html
[8] https://www.npr.org/sections/coronavirus-live-updates/2020/04/08/828827926/child-sex-abuse-livestreams-increase-during-coronavirus-lockdowns?t=1588059672551 and https://www.gmanetwork.com/news/news/nation/734922/condemns-rising-online-sexual-harassment-vs-women-amid-covid-19-pandemic/story/
[9] https://www.cbc.ca/news/politics/domestic-violence-rates-rising-due-to-covid19-1.5545851
[10] https://theaseanpost.com/article/virus-lockdown-causing-rise-domestic-abuse
[11] https://www.hrw.org/news/2020/04/08/tackling-kenyas-domestic-violence-amid-covid-19-crisis

The consequence of this is that some people are more vulnerable to the immediate health effects of the virus, some more to the increased risks of violence and discrimination, while some are more vulnerable to the socio-economic impacts. Many have a combination of these vulnerabilities and face multiple severe threats and consequences due to the pandemic. Women and girls as well as sexual- and gender minorities often face a disproportionate compound of barriers and increased risks based on these factors.

The individuals and groups most at risk of contracting COVID-19, getting seriously ill or dying include: older adults, people with underlying health conditions or those receiving treatment/care for other health conditions; those living in closed environments; people residing in areas with poor access to basic health and sanitation services, such as clean water for hand washing; and those with limited or no access to communication and information channels, including language minorities, persons with sensory impairments, people with low literacy and people whom communication campaigns do not reach with their messages.

Women of all ages face particular risks of contracting the virus because they are often primary caretakers of the sick and the older members of the family/community during emergencies. Additionally, women are overrepresented in the frontline of a pandemic response as nurses and health-care workers. Therefore, women and girls are most likely to face the stigma, isolation, exclusion and discrimination that are known risks to members of the community who are bearers of contagious diseases.

In **Liberia**, a study found that during the Ebola crisis more than 80% of GBV survivors were denied access to basic health services out of fear that health workers could contract Ebola through contact with bodily fluids (IRC, 2015). Research also found that 27% of people thought that the courts and police had not been working properly to handle GBV cases since the Ebola crisis began – this figure varied geographically and was as high as 87% in Lofa County (Korkoyah and Wreh, 2015).

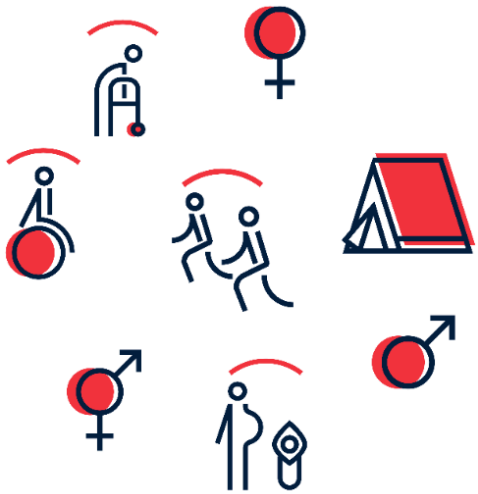
Women, girls and sexual- and gender minorities tend to face heightened job insecurity, reduced work hours and reduced income. Lack of regular access to schools, and the burden of household chores that often fall to them, put girls at greater risk of missing education, which can lead to child marriage, survival sex, or to sexual exploitation, abuse and human trafficking. Women tend to have professions that are more impacted during outbreaks, which can lead to loss of financial independence, putting them more at risk to SGBV.

Men, boys, sexual and gender minorities and people living in protracted periods with other people in close quarters (including people in humanitarian settings) are also at heightened risk of SGBV as their basic social protection mechanisms are compromised and barriers such as shame, stigma and unhealthy gender-expectations prevent them from seeking or getting help.

Due to the different impacts of COVID-19 and increased risks of SGBV, it is therefore necessary to develop contingency plans to shift the modalities of service provision for SGBV survivors to ensure continuity in adequate and safe SGBV services.

The IFRC Protection, Gender and Inclusion technical guidance note as well as the ICRC Covid-19: Inclusive Programming – ensuring assistance and protection addresses the needs of marginalised and at risk people (and its accompanying video) outlines the following groups as facing particular risks of SGBV due to the COVID-19 pandemic:

- People living in existing humanitarian emergency settings
- Women and adolescent girls
- Children
- Older people
- Persons with disabilities
- Sexual and gender minorities
- People deprived of their liberty
- SGBV survivors
- Migrants, including refugees and asylum seekers
- Domestic workers
- Ethnic minorities



Meaningful participation of groups at risk of SGBV through consultations is essential to maintain *during the COVID-19 crisis, where social distancing measures are prevailing and necessary throughout the response. Design, planning and response monitoring should be tailored to follow the COVID-19 guidance on social distancing and still ensure the dignity, access, participation and of the community. Usual ways of seeking participation of groups, such as focus group discussions, may not be feasible due to social distancing; it is therefore important to consult with existing partner community-based groups, such as women's groups, groups representing sexual and gender minorities or others, to identify relevant ways to consult with at-risk groups adapted to local contexts. It is also important to work closely with Community Engagement and Accountability (CEA) teams to use their existing community networks. and ensure all vulnerable groups/groups at risk of SGBV are consulted in a meaningful way and none is left behind. It is important to note this does not mean seeking to consult*

3) Adapting programming to meet the needs of those at risk

Three key issues have been identified as the main challenges to SGBV prevention and response programming in the context of the COVID-19 crisis:

- **Availability and access** to SGBV services due to the changed operational environment
- **Lack of updated information** about available SGBV services during the crisis
- **SGBV prevention and response not prioritized** by all States and declared a priority to be addressed as part of national response plans.

This guidance aims at providing Red Cross and Red Crescent staff, volunteers and partners with concrete recommendations to address these challenges and adapt their programming and messaging accordingly.

Mainstreaming SGBV prevention and response into all activities

Overall, all actors within the Red Cross Red Crescent Movement should **mainstream SGBV prevention and response measures into activities** and support non-Movement actors to also do so. The following key actions support this approach:[12][13]

Minimum Standards for Protection, Gender and Inclusion; *Do no harm*

To ensure the specific protection needs of at-risk groups are met throughout the humanitarian programming cycle, the Minimum Standards for PGI in Emergencies should be integrated in the work of all sectors, with a focus on prevention and response to SGBV. This includes:

Needs assessment and analysis

Collect and **analyse sex-, age- and disability disaggregated data** and analyse the differential impacts, barriers and risks being faced by different groups to ensure current SGBV programming best meets the needs of the affected population[14]

Develop and rollout **rapid SGBV analysis** specific to the country context[15] using NS and local knowledge and experience, news reports, secondary data, information from the GBV AOR, etc. and share these with Movement teams and government stakeholders

Strategic response planning

Include SGBV prevention and response into Covid-19 **National Society Response Plans** and the continuity and adaptation of SGBV life-saving services into Business Continuity Plans

Ensure SGBV prevention and response **indicators** are included in response plans

Resource mobilization

Ensure that **earmarked funding for SGBV** is integrated in regional and country appeals

[12] https://gbvguidelines.org/wp/wp-content/uploads/2020/03/GiHA-WG-advocacy-brief-final.pdf
[13] https://gbvguidelines.org/wp/wp-content/uploads/2020/03/COVID-19_CommunityEngagement_130320.pdf
[14] https://gbvguidelines.org/wp/wp-content/uploads/2020/03/guidance-on-gbv-case-management-in-the-face-of-covid-19-outbreak-final-draft.pdf
[15] *Global Rapid Gender Analysis for COVID-19*. CARE, International Rescue Committee, 2020.

Implementation and monitoring

Ensure the minimum standards are applied by all sectors and that the participation and feedback of at-risk groups is done in a meaningful way.

Regularly monitor progress and adherence to the minimum standards for PGI in Emergencies

Operational review and evaluation

Ensure that **feedback** received from women, girls and other groups is used to adjust programming

Capacity building

Internal capacity building of RCRC staff and volunteers is an essential component of prevention. To be able to respond to the COVID-19 crisis without creating further harm, staff from other sectors must be supported and trained on the following:

1. **Minimum Standards for PGI in Emergencies**
2. **SGBV core concepts, safe referrals and Psychological First Aid (PFA)**
3. **PSEA**

It is crucial to provide **appropriate remote training** on core competencies for **Protection, Gender and Diversity, Inclusion, SGBV, the survivor-centred approach, safe referrals, and psychosocial support** (PSS) for all staff and volunteers, and refresher trainings, as necessary. Although staff and volunteers may have been trained on SGBV and PSEA, it is advisable to provide additional refresher trainings due the current increase in risk and occurrence of SGBV globally, and reduced access to services. Additionally, because of the significant increase in recruitment of staff and volunteers to respond to the COVID-19 crisis, building their capacities to safely handle disclosures and ensure they do not cause harm is critical and time-sensitive.

The following actions are therefore recommended:

- Ensure all staff and volunteers are trained on Minimum standards for PGI, SGBV (the survivor-centred approach, safe referrals, and PSS) and PSEA.
- Plan and facilitate refresher trainings as necessary.
- For staff and volunteers newly recruited for the COVID-19 response, ensure Management and HR includes PGI and SGBV prevention and response in their onboarding package and induction within the first week.

- All staff and volunteers should sign the Code of Conduct, including Prevention of Sexual Exploitation and Abuse (PSEA) and Child Protection/Safeguarding policies, if they exist within the National Society. In the case that an NS does not have these policies, IFRC policies can serve as a guide or function as interim policies.

During the cholera outbreak in **Yemen** in 2017, there were reports of children being left alone to sleep outside the cholera treatment centres while their sick caregivers were admitted for treatment. The lack of supervision exposed children, especially girls, to risks of harassment, sexual violence, and abuse (The Alliance for Child Protection in Humanitarian Emergencies, 2018).

Community messages

The two primary purposes of community messaging should be to **1.) inform at-risk community members** about their right to participate in decision-making and to receive humanitarian services, including SGBV services and other support services, without condition and **2.) inform all community members, and especially those at risk of resorting to violent behavior** about the harmful effects of violence (physical, emotional, psychological and sexual), as well as healthy coping mechanisms to deal with stress, fear, grief, anger, substance abuse/addiction and trauma. It is important to share if applicable, where or how these skills can be further developed.

Community messages should be used to develop awareness of the importance of supporting those at risk or victimized of SGBV and to promote behavior change with alternate ways to manage stress and difficult emotions triggered by the pandemic and pandemic response. Referral pathways should be tested, updated and checked for quality and coherence with the [IFRC Guidance on SGBV and Referral Pathways]. When in doubt, personnel should reach out to the NS or IFRC PGI focal point or SGBV Advisor for support. Community messages should be developed or adapted locally, and in collaboration with at-risk groups to ensure their appropriateness and relevance. It is critical to engage with existing community groups such as women's groups, persons of diverse SOGIESC[16]- groups, in development and dissemination. Continued feedback should be sought in order to adapt the messages to the evolving situation. Community messages should be disseminated through different channels and must be accessible for all segments and individuals of the community. It is important to consider dissemination channels that will not contribute to further spread of the virus.

DO: Collect accurate, safe and up-to-date information about available services that are functional during COVID-19 and provide this in a user-friendly format that is monitored and regularly updated.	**DO NOT:** disseminate information about services that have not been verified. Inaccurate information can cause further harm. It is better to provide no information rather than information that is incorrect or has not been verified to be survivor-centred.

[16] Sexual Orientation, Gender Identity and Expression, and Sex Characteristics

DO: Ensure referral pathways are incorporated in other sectors (Health, WASH, Livelihoods, CEA, DRR, etc.) and that management are well informed on their function and limitation.	**DO NOT:** disseminate referral pathways to RCRC staff, volunteers, and partners without providing sensitization on SGBV core concepts and safe referrals.
DO: Ensure community messages are survivor-centred and promote the safety, dignity, and confidentiality, of survivors. Develop messaging to be appropriate for all genders and ages, people with disabilities, different backgrounds and belief-systems	**DO NOT:** use language that further discriminates against survivors or at-risk groups. Do not "speak" or target your messaging to only one/a homogenous group of people as it may further stigmatise others who are not part of that group but still at risk of SGBV
DO: Ensure messages on PSEA are disseminated responsibly. Continuously remind the community and all RCRC staff, volunteers, and partners that humanitarian aid is free and that no sexual act or other favour should be requested in exchange. Provide information on how to report breaches by any RCRC staff or volunteer to all people in the community on a regular basis.	**DO NOT**: work in a silo! Ensure messages are developed and disseminated in collaboration and coordination with CEA/AAP, communications, security and management and all sectoral colleagues, as well as with other local and regional actors.

Dignity kits

Dignity kit distribution is a key emergency response activity. And indeed, the COVID-19 environment may exacerbate immediate/acute needs for underserved communities and women and adolescent girls at increased risk of SGBV due to heightened barriers to access to basic services or necessities. The content of the kits and the modality of distribution may need to be adapted to respond to the needs of the women and girls in the Covid-19 context and to avoid spreading further the virus. Women and girls in quarantine and isolation centres may need to be prioritized in the distribution of dignity kits in the acute phase of the emergency. Key messages on SGBV and PSEA as well as referral pathways should be distributed along the dignity kits. This guidance from UNFPA provides advise on DK distribution adaptation during COVID-19.

Specialized measures to prevent and respond to SGBV

All staff and volunteers must assume that SGBV is happening and increasing (even without existing data) and plan for increased support to survivors and to services supporting them. The survivor-centred and multi-sectoral approach must be maintained although the modality of service provision and its frequency may be adapted to comply with the measures taken by governments in containment, delay, and mitigation.

Each strategy carries various levels of risks and restrictions which make some modes of service delivery more possible than others. Containment strategies enable public life to be minimally affected and as such, face-to-face SGBV specialized services (case management, PSS, legal assistance) can largely continue. Delay- and mitigation/suppression strategies see tougher restriction on movement and assembly, making face-to-face service provision challenging without high-level official permissions and adequate resources for protective equipment for caseworkers. The table below provides recommendations for provision of specialized services (case management, PSS, legal assistance) for different national strategies, noting that

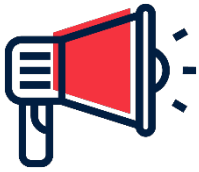
countries can shift from one strategy to another rapidly, and, therefore, contingency plans for both strategies are needed[17]:

Containment strategy: Static face to-face case management continues. Social/physical distancing measures can be implemented in institutions to ensure safety of staff and survivors. Infection, prevention and control procedures can be implemented in the sites where services are provided.
• **Train** staff handling NSs hotlines on handling disclosures and safe referrals in preparation for possible interruption of service provision • **Prepare** for shifting to phone-based specialized services provision and assess whether caseworkers are prepared to handle SGBV disclosures and if they have up-to-date referral pathways. • Put a **plan** in place in preparation to shift to phone-based case management, procure mobile phones and credit (including data bundle) for SGBV caseworkers / supervisors, and if needed also procure charging devices for use in settings with poor/unreliable power. • Draft / update an internal organizational communication tree to ensure support for caseworkers in the interests of **duty of care**. • Caseworkers **review safety plans with survivors** in case of a lockdown, especially those living with their abusers, considering the risks to shifting to phone-based case management. • Discuss **safe storage** for existing paper files in the crisis center in case of lockdown and data storage protocols for remote SGBV case management • **Obtain informed consent** of survivors to potentially shift to phone-based case management.
Delay and Mitigation/suppression strategy: Static face-to-face case management cannot continue; operate remotely via phone-based case management from caseworkers' homes
• Caseworkers have a **private and confidential space** available in their homes to speak to survivors over the phone. • Caseworkers have **obtained informed consent** from survivors to conduct phone-based case management. • Caseworkers **shift to emergency case management** and focus on safety planning, especially for IPV survivors.
If the prerequisites mentioned in this table cannot be upheld to ensure the safety of the survivors, it is recommended to shutdown services temporarily.
• **Caseworkers refer survivors, upon their informed consent, to services that are still operational. Alternatively, they inform survivors who to contact if they need help.**

[17] Adapted from Case Management, GBVIMS/GBVIMS+ and the COVID-19 pandemic

4) Diplomatic Measures

National Societies can play a key role as auxiliary to governments in advocating for a more comprehensive and better coordinated prevention and response approach to SGBV during the pandemic and in highlighting the increased protection risks and gendered impacts of the crisis.



Suggested Interventions[18][19]

- Ensure that **authorities understand the increased risk** of SGBV and other forms of violence and abuse during the pandemic as well as the gendered impact of the crisis.
- Ensure that all data from Ministry of Health and key line Ministries responding to Covid-19 is **disaggregated by sex, age and disability**.
- Ensure that national COVID-19 cells/taskforces have **trained SGBV focal points** working on integration of SGBV into national response plans to COVID-19.
- Short and long-term SGBV services should be prioritized and **categorized as life-saving** due to the negative and often life-threatening impacts of SGBV on individuals, their families, social cohesion and economic stability.
- Ensure that emergency preparedness and response plans are based on thorough gender analyses, **considering gendered roles, risks, responsibilities, and social norms**, and accounting for the unique capabilities and needs of other vulnerable populations. This includes ensuring that prevention and response measures address women's and girls' caregiving burdens and heightened SGBV risks.
- Refer to the **IFRC Disaster Law Checklist** for guidance on SGBV and Disaster Law. [20]
- Advocate for leadership and **meaningful participation of local women and girls, sexual and gender minorities and persons with disabilities** in all decision-making processes in addressing the COVID-19 outbreak.
- Advocate for **continued government funding** to support local and existent SGBV response services during outbreaks, adjusted to be provided remotely as required and to complement other available services.
- Advocate for **coordination of government services** to respond to SGBV, including for continued coordination groups such as sub-clusters and working groups.
- **Offer trainings** (with modifications to be attended remotely or online) on risks of SGBV and how to handle disclosures and share the services available in a survivor-centred way.
- Ensure that those at risk/survivors of SGBV are engaged in the design/selection of **quarantine/isolation centres and that centres preserve the Dignity, Access, Participation and Safety** of all. Ensure that the centres follow all standards outlined in the IFRC Minimum Standards.

[18] https://www.care-international.org/files/files/Gendered_Implications_of_COVID-19-Executive_Summary.pdf
[19] https://gbvguidelines.org/wp/wp-content/uploads/2020/03/GiHA-WG-advocacy-brief-final.pdf
[20] https://media.ifrc.org/ifrc/document/checklist-law-disaster-preparedness-response/

- In contexts where curfews are or will be implemented, persons at risk/survivors of SGBV fleeing their homes during curfew times should be supported and not put at further risk. **Clear guidance for security forces** can be developed (such as sharing of SGBV referral pathways).
- Work with government authorities and local organizations to develop and **disseminate a revised referral pathway**.

5) Staff and volunteer care

Staff and volunteers of the Red Cross Red Crescent Movement, like the communities they support, are equally impacted by the outbreak of COVID-19 and at increased risk of SGBV, and need adequate support during outbreaks to ensure their safety, welfare, and physical and MHPSS needs. Many staff have been asked to work from home, and it is notable that, for example, women do four times as much housework as men and are often primary caretakers in the family. Work from home can put extra financial, emotional and physical burdens on staff and their families increasing incidents of domestic violence and other forms of SGBV. Active engagement with staff about what sort of feasible flexible work arrangements and environments will work for them, and trust in staff at this time, will promote a well-functioning and supportive workforce.

Suggested Interventions
As an organization, it is suggested that Red Cross Red Crescent Movement:

- **Consult with staff** about their work needs and provide flexibility in work hours, location, and deadlines.
- Ensure staff have **at least one non-working day** per week.
- Create space for staff to **discuss quality of life and safety concerns**. This can be done online if proper safeguarding measures are in place and guiding principles, such as confidentiality, are upheld.
- Map and provide a list of available **referral services for SGBV to staff and volunteers**, noting which services are provided in relevant languages. Make a point to note confidentiality in the organization in case any staff members need to reach out to HR or the PGI Officer/ SGBV Advisor for additional support.
- Obtain additional, **comprehensive insurance** for COVID-19 for staff and volunteers, including free and easy to access mental health support, with the choice of counselors of at least two genders.

For additional information or support please contact the Protection, Gender and Inclusion team at pgi.support@ifrc.org, or visit the IFRC GO platform, the IFRC extranet FedNet, or the IFRC Sokoni platform.