GBV Case Management and the COVID-19 Pandemic

Robyn Yaker and Dorcas Erskine

Overview

This note aims to provide practical support to Gender-Based Violence (GBV) practitioners to **adapt GBV case management service delivery models quickly and ethically during the current COVID-19 pandemic**. It does not address all aspects of a gendered analysis that are necessary to create a robust response, nor is it a definitive set of guidelines. Rather, it is designed to be a *"living"* document, that will continue to draw upon the expertise of the global community in this new and evolving field. It assumes that users of this note already understand and are familiar with GBV case management.

Whilst the pathology of COVID-19 presents some unique challenges, GBV programming from other contexts of severely restricted access, such as conflict and natural disaster, offer important insights into how the provision of remote GBV case management support may be adapted to continue to offer a critical avenue of support to vulnerable women and girls.

GBV and COVID-19

There are reports of increases in GBV incidents in the countries most affected by the COVID-19 outbreak. For example, domestic violence organisations have observed that extended quarantine and other social distancing measures have increased the reports of domestic violence, as a result of household stress over economic and health shocks combined with forced coexistence in narrow living spaces (VAWG Helpdesk report, March 2020). There are also reports of a growing number of attacks on female healthcare workers, which have the potential to increase as health facilities struggle to provide adequate care to everyone who requires medical assistance (VAWG Helpdesk report, March 2020).

Given the increase in reports of GBV, ensuring that women and girls can access GBV support services remains a critical and lifesaving activity. At the same time, maintaining the health and wellbeing of GBV case workers and contributing to rigorous efforts to stop the pandemic are of critical concern, presenting a challenge to traditional modes of GBV service delivery. A flexible and adaptive approach is needed to ensure that life-saving services continue to be made available without compromising the safety of GBV caseworkers.

Case Management Services During COVID-19: A layered approach to risk management

While some past infectious disease outbreaks provide valuable insights into how to maintain GBV case management, such models are not always directly transferable, given the unique pathology of COVID-19. Unlike Ebola, COVID-19 is an airborne/respiratory virus, and although it has a much lower mortality rate than Ebola, it is in fact more contagious[1], harder to detect and many carriers of the virus are asymptomatic[2]. The way in which the virus is transmitted, its level of potency in a country at a particular time, the stark differences and exponential changes in national government responses all demand a higher level of flexibility, and a more layered approach to GBV case management service delivery than in past epidemics.

During the Ebola crises in West Africa and the Democratic Republic of Congo (DRC) for example, static case management services were largely maintained - more so when they were integrated within healthcare services. Humanitarian agencies and local women's groups[3] were also able to provide limited outreach and case management through static safe space programmes to varying degrees by generally adhering to strict Infection, Prevention and Control (IPC) measures. Providing similar static case management services during all stages of the COVID-19 outbreak is likely to be significantly more challenging, and at certain stages, the risks might be too great or restrictions may make it impossible to do so.

This is not to suggest that case management is not possible within all stages of the COVID-19 outbreak; on the contrary, **case management remains a critical service that is possible to continue in most cases** as long as sufficient modification and adaptations are made to uphold public health guidelines. Decisions about whether to continue static, face-to-face case management services, scale down, or dramatically change in favour of other modalities such as remote case management, will depend on a number of factors including:

- **The strategy of national response to the coronavirus, i.e. containment, delay or mitigation**. Each carry various levels of risks and restrictions which make some modes of service delivery more possible than others.

- **Resources (including donor flexibility)** for the service provider to maintain stringent IPC standards at all stages of the pandemic, and in preparation for more advanced stages.

- **National government guidance and policies** that affect freedom of movement and the ease of obtaining official permissions including formal exceptions required to operate static services in the event of national lockdown.

- **Risks and *perceived* risks for staff and others**. It is critical to weigh actual risks not only to the health of staff, but to the health of others whom you may be exposing by carrying out your services (including movement to and from). In addition, *perceived* risks also affect staff and clients.

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[1] Zhanwei Du, Xiaoke Xu, Ye Wu, Lin Wang, Benjamin J. Cowling, Lauren Ancel Meyers. Serial Interval of COVID-19 from Publicly Reported Confirmed Cases. *Emerging Infectious Diseases*, April 2020
[2] Infection Control Today, Asymptomatic carriers of COVID-19 Make it Tough to Target. Accessed 18/3/2020
[3] Discussions with GBV practitioners

- **Location of static services:** GBV case management services situated within official clinical settings are more likely to be able to provide static, face to face services for the duration of the pandemic.

- **Organizational policies.** Service providers interpret government guidance and policies in a more or less flexible manner which can influence service provision.

Understanding National Response Strategies

Current national responses to COVID-19 can be roughly classified into three strategies: containment, delay, and mitigation[4]. It is important to note that all three strategies can run concurrently in any one territory, and that changes from one to the other might change in as little as 24-48 hours. Therefore, a **high- level of preparedness is necessary in all countries, even those with zero or few confirmed cases**. Given how rapidly responses are changing, service providers should put contingency plans in place immediately for each of the strategies.

Below is a quick description of each strategy and the type of impact that can be expected on case management services:

- **Containment**: Normal public life is minimally affected as governments focus on early detection, isolation and care of people already infected with careful tracing and screening of their contacts. Static, face-to-face case management, with strict adherence to IPC protocols, is possible under this strategy. However, plans must be in place for a rapid escalation in number of virus cases which may prompt governments to quickly change strategy and take more aggressive action to reduce the spread of infection. This includes identifying alternative models and beginning to train staff and actively communicating with clients about possible changes to come.

- **Delay:** the aim is to slow the spread of the virus and push the impact away till a time when a country's health service can cope with the spread. Social distancing strategies, closure of education institutions, prohibitions on large gatherings, and reduction in the use of public transport are common and are implemented with varying degrees of enforcement. Static, face-to-face case management may be possible depending on the location of the service, the ability to resource and provide effective protection of case workers, and the severity of national policies on freedom of movement and assembly. Action should be taken at this stage to include other modalities of delivering case management, and to train staff and clients alike for continued changes.

- **Mitigation planning for widely established infection**: As seen in China, Italy and Iran, this strategy is deployed by governments seeking to stem widespread infection during a prolonged pandemic in which high levels of the population are infected. This may involve more directive "lockdowns" or "sheltering in place", where movement is more tightly restricted and monitored, transport arteries may be blocked, and possibly permissions required. Maintaining static, face-to-face case management services outside health care facilities will be extremely challenging, or even impossible.

[4] Lancet, COVID-19: delay, mitigate, and communicate, March 2020

Table 1 below summarises the common national strategies that are emerging, the features of each, their impact on GBV case management and possible modalities for delivering case management services. These are not directive for every context. In each context, teams must weigh their specific circumstances and current public health guidance.

National Strategy	Features of Strategy	Impact on GBV Case Management	Possible Case Management Modalities
Containment	Relatively low numbers of infected cases. Tracking and isolation policies in place for infected individuals and their contacts. Limited impact on freedom of movement and assembly.	Introduction of IPC protocols, contingency planning and community dialogues about the novel coronavirus. Services may generally continue, with slight modification based on IPC protocols.	Static face-to-face can likely continue. Stringent IPC protocols must be established. Widespread communication on virus and hygiene protocols must be shared with survivors, case workers and wider community, including dialogue about their thoughts and concerns. Preparedness and contingency planning for remote case management (including safety considerations in choice of hotlines and use of mobile technology; referral pathway review; budget forecasting, re-allocation and alignment for procurement of unanticipated needs, e.g. telephones and IPC supplies; revision of staff health and wellbeing policies. Consider offering remote case management to a few survivors who may be interested and begin to test the system. Ensuring that survivors have all information needed to access remote support and brainstorming safe ways to do this (e.g. storing phone numbers under code names in their phone, printing tiny information cards that can easily be hidden). Comprehensive review of safety plans must be undertaken with survivors in case of rapid change in national strategy. Coordinate with others- especially local women's organisations, on their plans. Update contact lists, referral pathways and communication trees to include newly relevant information, e.g. neighborhood focal points, and build connections with case workers.
Delay	"Social distancing" is put in place. This may include some or all of the following: prohibitions or restrictions on large gatherings, closure of schools and other institutions, restrictions or closure on restaurants and bars, and closure of non-essential enterprises. Reduction in the use of public transport encouraged. Possible border closures. Individuals advised not to be closer than 2 meters to others.	Stringent restrictions on movement of staff and survivors highly likely. Movement could create risk of exposure. Very high levels of IPC practice expected and enforcement and monitoring by national agencies possible. High level permission and clearance may be needed to operate case management services based in and outside of official health care settings. Survivors likely to begin being more confined at home. Resources needed to create a protective environment for staff, if face-to-face services continue.	Case management within health centers may be feasible (or may not). Primarily rely on remote case management services- via phone or other technology- with limited or no face-to-face case management services outside of healthcare settings. Training of frontline workers. Highly stringent IPC protocols and monitoring in place. Referral linkages and partnerships in place with health care providers, existing GBV hotline services, law enforcement, women's organizations and other actors still providing services. Train other service providers using the GBV pocket guide. Regular monitoring of staff safety in use of mobile technology. Continual review of survivor safety plans. Use of GBVIMS for remote supervision. Possible inclusion of GBV caseworker in rapid response teams. Regular wellbeing check-ins for staff
Mitigation	Extremely high levels of social distancing in place including closure of schools, institutions and non-essential enterprises. Prohibitions on all gatherings, reduction in the use of public transport. Possible border closures	High level permission and clearance may be needed to operate case management services both in and outside of healthcare settings. Stringent restrictions on movement of staff and survivors. Home confinement for survivors highly likely. Very high levels of IPC practice expected and enforcement and monitoring by national agencies possible. If static, face to face case management is permitted, resources will be needed to create a protective environment for staff.	Remote case management services with limited or no face-to-face case management services outside healthcare settings. Highly stringent IPC protocols and monitoring in place. Referral linkages and partnerships in place with health care providers, existing GBV hotline services, women's organizations and other actors still providing services. Regular monitoring of staff safety in use of mobile technology. Continual review of survivor safety plans. Use of GBVIMS or other tools for remote supervision. Possible inclusion of GBV caseworker in rapid response teams. Regular well-being check-ins with staff.

Immediate Key Actions

1. **Immediately put in place Infection, Prevention and Control (IPC) measures in accordance with standards at all service delivery points. Coordinate with Water, Sanitation and Hygiene (WASH) and other relevant sectoral teams.**
   a. In places where you are meeting clients face-to-face, set up hand-washing stations and/or make hand sanitiser available immediately upon entrance.
   b. If "thermoflash" thermometers are accessible, it may be appropriate to use them to check temperatures of those accessing services. Consult with health programmes about whether this protocol is suggested in your context. Note that the use of thermoflash can be scary to those who have never seen them before, and particularly to children. It might be necessary, therefore, to conduct some awareness-raising and communication about thermoflash so that people know what to expect and are not scared away.
   c. Ensure adequate distancing in activities so that women and girls can access services and be kept 2 meters apart, and without large crowds forming (follow the guidance in your area for limiting numbers).
   d. Put in place measures to ensure that Women and Girls' Centers or other spaces where caseworkers operate are not crowded and are able to adhere to distancing guidance. This may include putting a cap on the number of women and girls accessing the service at one particular time, and/or marking spaces for mats on the floor/ chairs on the ground, etc.
   e. Do not send caseworkers into crowded areas or situations where they cannot maintain the suggested IPC protocols or suggested distancing.
   f. Ensure all caseworkers have access to hand-washing stations, hand sanitiser, and all the tools they need to continue to provide support, for example mobile phones and mobile phone credit.

2. **Communicate openly with women and girls about COVID-19 and any changes or potential changes in your methods of service delivery.**
   a. 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.
   b. Develop quick discussion guides and communication materials for discussing COVID-19 with your clients and women and girls in your programmes:
      i. Emphasise the importance of listening to clients, as well as giving out messages. Use your space to *listen* to women and girls and to *ask questions* to better understand what they know about COVID-19, as well as what their concerns and fears are and their suggestions for how we improve our response.
      ii. Make sure that messages around COVID-19 and IPC measure evolve over time and meet the needs of your clients, women and girls.

      iii.   Share any relevant information such as changes in services, hotline numbers, and how to reach relevant service providers in case of a change.

3. **Meet with your team to discuss best options for *remote support to survivors* and *remote support to staff*.** It is possible to maintain some level of support for survivors and staff alike, even under extremely restricted circumstances. It is important that staff are engaged actively in decision-making so that they feel a sense of ownership, control, and connectivity during the rapidly changing crisis. This is about more than supervision, it is about support. Discuss with staff what more you can do support them personally, as well as professionally. Check in regularly as the situation evolves.

4. **Keep up to date on the latest guidance in your region.** It is essential to keep up-to-date with the latest guidance being given in your specific context and also to recognise that this will change on a day-to-day basis. Planning ahead is important, as is making sure your actions are aligned with what is happening in your particular communities. For example, if no restrictions have been placed on movement or gatherings in the areas where you work and suddenly your team stops all programming entirely, you might cause further fear and uncertainty. However, if you are ready to take certain steps based on public health guidance and feel that others are moving too slowly, do what your team believes is best for the safety of your clients and each other. Follow protocols for infection, prevention and control at each stage and be ready for the situation to change quickly.

Preparing for Sudden Changes, Including "Lockdown" or "Quarantine."

Government responses to COVID-19 are changing rapidly and dramatically, perhaps more so than any other outbreak. Therefore, even countries which do not currently have confirmed cases, should consider the following:

1. **Begin safety planning with current clients for situations of quarantine, lockdown, or "shelter-in-place".** Help your clients to prepare for the possibilities. Help them to feel a sense of control in a chaotic moment. Key issues and measures to explore include:
   a. Do they have someplace safe to stay that is not with the abuser?
   b. If not, are there any steps they can take to help minimise harm at home?
   c. Provide them with phone numbers of caseworkers, hotline, or other support providers that they can keep safely. If they have phones, they may store the number under a code name, or you may print tiny cards that can easily be hidden.
   d. Brainstorm ways that they can safely call for help and access support.
   e. Explore ways that they can plan with their neighbors to signal that they need support.

2. **Ensure continued safe storage of sensitive documentation**. In the event that your offices shut, consider the safest ways to store documentation without putting anyone at risk. Primero/GBVIMS+ for case management offer options for digital storage, including on mobile phones. Ensure that organisations have developed and implemented data protection

protocols with paper and electronic file evaluation provisions[5]. Key issues and measures to explore include:

    a. If leaving your office, will that documentation be locked and safely stored? Is it possible that someone might gain unauthorized access?

    b. If moving to remote support, how will you document cases? Is it safe to store information on phones, tablets, or paper?

3. **Develop quick and clear new case management protocols with staff.** If you move to remote support, how will it work? For example:

    a. Which phones and phone numbers will be used for case management?

    b. How often will staff contact current clients? How will staff be reachable to clients?

    c. Will you be accepting new calls/clients in addition to following up with current clients?

    d. How will calls be documented and followed upon?

    e. Will there be a staff rotation to ensure coverage?

    f. Will this be safe for staff?

4. **Consider modalities for remote supervision**. This refers to supervision of case management. This may include remote individual supervision and peer-to-peer or group supervision through online platforms and/or phones. Case file review can be enabled for remote supervision through rollout of digital case management tool, such as Primero/GBVIMS+ which includes functionality such as flags, case plan/closure approval, remote case file review and automated production of key performance indicators (KPIs). Remember: supervision is not the same as support. Supporting the overall wellbeing, health, and stress management of staff is of utmost first priority. This must be in place before you can introduce new forms of staff supervision.

5. **Strengthen capacity and confidence to provide remote support**

    a. **Review guidelines on supporting survivors through digital and remote support.** There are various types of guidance around using technology to communicate with survivors during a public health crisis, including text messaging, calls, online support, to ensure safe and ethical connections. Examples can be found below in the resources section. Review as needed to ensure ethical programming.

    b. **Conduct rapid training/skills-building for staff on any new technology to be used for support.** Teams may need to get acquainted with systems used for hotlines, online service provision, and apps (e.g. Primero/GBVIMS+). Reach out for support to relevant actors who are managing or have experience with the platforms being used e.g. GBVIMS global team, etc.

6. **Prepare for possible closure (temporary or long-term) of physical locations for case management.** It may be necessary to close Women and Girls' Centers or other physical

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[5] See template of the GBVIMS Data Protection Protocol: http://www.gbvims.com/wp/wp-content/uploads/DATA-PROTECTION-PROTOCOL.pdf

spaces where you are providing case management services. This may be temporary or for an indefinite term. You may need to take steps similar to programme exit in this case (resources around exit strategies can be found in the Resources section below). Consider questions such as:

    a. Are there any outstanding payments that need to be made for the space?
    b. Can items be left there safely, or is it necessary to remove them?
    c. Will anyone access the space for any reason during closure?
    d. Are there any risks involved to closing the space? How can you mitigate these?

7. **Coordinate with other services providers.** Solidarity is critical in adapting to the new situation. Information is also crucial on what will be available to survivors and how to ensure coordinated and safe access to shelters and law enforcement authorities.

8. **Inform communities of possible changes ahead.** Be sure to communicate possible changes with clients as well as communities, in order to maintain trust.

9. **Communicate with donors about changing needs.** Begin communicating with donors immediately about changes in case management programming and funding needs, including preparations for worst-case scenarios. Request greater flexibility of resources and rapid mechanisms for ensuring you have the resources you need.

Modalities of Adapted and Remote Case Management:

In situations of containment, when limited movement and contact is a viable option, you may be able to continue face-to-face support, while observing IPC protocols. You may also consider switching to a health-center based caseworker model described below. This is also the opportunity of train all frontline workers on the GBV Pocket Guide as they may face disclosures of violence.
In situations of delay, mitigation, or any severe restriction of movement and access, the following are options for continuing case management support remotely:

1. **Health-centered based caseworkers.** When movement of people is limited, and the majority of efforts are focused on supporting healthcare systems, basing a caseworker at a health center might be a good option. The caseworker could be available to support both women and girls who are infected with Coronavirus and survivors who report to the hospital. This model was used during the Ebola response in DRC by GBV actors. There is a need to work closely with health teams to ensure that this is a safe and viable option. You need to be careful not to be seen to be creating an extra burden for staff, but rather GBV should be framed and recognised as a life-saving service in itself.

2. **Mobile phone case management.** Caseworkers may be able to provide case management support by mobile phone. In this case, consider the following:

    a. Provide additional sim card and/or mobile phone to caseworkers solely for the purpose of providing support.

b. Electricity sources: What kind of access to electricity do they have? Is maintaining charged phones a challenge? Can you provide battery packs or solar chargers?

c. Consider the safety of making and receiving calls for staff, as well as safety of making and receiving calls for clients. **There is a risk that conversations might be overheard and confidentiality breached.**

d. How is data collected? We want to avoid caseworkers storing paper forms at home or in locations that are unsafe. Consider rolling our digital case management tools such as Primero/GBVIMS+.

3. **Hotlines.** If a hotline exists already, discuss with that provider how you may link into that by offering staff support, sharing their number, etc. If there is not, you may consider buying additional mobile phones and creating a shift schedule for caseworkers. Remember that if caseworkers are also on lockdown, they will have duties at home and stress of their own. Therefore, it is important to discuss what is feasible and safe.

4. **WhatsApp communication.** This may be the preferred option for communication both by survivors and case workers. You need to take into account staff stress, home duties, safety, access to electricity and internet, as mentioned above.

5. **Limited rapid or mobile response team.** Your organisation may maintain a rapid response team during the outbreak with limited staff involved in providing essential services, in accordance with national strategies and IPC protocols. If this is the case, you may advocate for a caseworker to be on that team, if the benefits outweigh the actual and perceived risks.

Shelters and COVID-19
If you are running case management services out of a shelter for women, it is important to follow all IPC protocols and emerging guidance. Specific guidance for managing shelters during the outbreak is available at: https://vawnet.org/news/preventing-managing-spread-covid-19-within-domestic-violence-programs

Prioritising Duty of Care to Staff
Caring for staff and prioritising their wellbeing is the foundation of any other action. Put systems in place to ensure that staff are getting the support they need and to prioritise this as the outbreak continues. This includes:

1. Creating space to ask staff about their concerns, their needs, and their ideas for moving forward. Give time to talk freely, whether about work, or the situation more generally. Do this at every stage of the outbreak, whether in-person or continuing remotely.

2. Observing IPC protocols; work to reduce risk as well as *perception* of risk.

3. Sharing resources for managing stress and maintaining emotional wellbeing. This can be documents with links to resources, sharing one simple self-care exercise per day via text/WhatsApp group, phone numbers for accessing psychological support, etc.

4. Ensuring that staff have phone numbers and information about support services that are available to them.

5. Checking in regularly by phone or WhatsApp as a form of emotional support (different from supervision). Creating chat groups or other relevant fora for staff to connect and support each other.
6. Sharing resources online that staff can use to continue to build their skills. e.g. the Rosa App by International Rescue Committee (IRC), GBVIMS podcasts and videos, etc.

Key Principles and Considerations

1. **Prioritise the safety and wellbeing of all staff and clients.** This is true in any GBV programme and remains true during the COVID-19 response.

2. **Solidarity with the most vulnerable.** Some clients will be more vulnerable than others, and some community members more vulnerable. Remember that social distancing and other measures are not just about protecting clients, but about everyone doing their part to protect others. Keep this in mind when making decisions. For clients who are particularly vulnerable, prioritise early safety planning for changing conditions and regular follow-up.

3. **Focus on humanity over productivity.** Remember that these are stressful times, and that the changes and uncertainty add to that stress for staff, their families, clients and communities. As you make changes to programming, do not over-emphasise the need for seamless transition and continued productivity. Staff will likely need time to slow down, to figure out what the next days and weeks look like and to manage stress alongside continuing work. Help everyone to take a breath and assure them that this is ok.

4. **Be prepared, not panicked.** This paper highlights the importance of preparing for all scenarios urgently, expecting the possibility of rapid changes. However, changes should be planned for as calmly as possible, and presented as proactive steps rather than panicked reactions.

5. **Advocate for increased gendered analysis across the response.** This paper focuses on GBV case management. However, a gendered analysis is essential to a strong response for all communities and in particular to women and girls. Advocate in relevant fora and provide guidance as needed to build a more gendered response in your area.

Resources

Resources on GBV Remote Support:

How to Support Survivors of Gender-Based Violence When a GBV Actor Is Not Available in Your Area: A Step-by-Step Pocket Guide for Humanitarian Practitioners
https://bit.ly/2WqrT9f

Guidelines for Mobile and Remote Gender-Based Violence (GBV) Service Delivery
https://bit.ly/2xKsFUe

Using Technology to Communicate with Survivors During a Public Health Crisis
https://bit.ly/3b6LMX5

Chat with Survivors: Best Practices
https://bit.ly/3deRXu8

Texting and Messaging with Survivors: Best Practices
https://bit.ly/33vOK4G

Communicating with Survivors using Video: Best Practices
https://bit.ly/3a553rI

Guidance Note on Ethical Closure of GBV Programmes
https://bit.ly/2Wye4pz

Resources on GBV and Infectious Disease Outbreaks:

Overcoming the 'Tyranny of the Urgent': Integrating Gender into Disease Outbreak Preparedness and Response
https://doi.org/10.1080/13552074.2019.1615288

The Effect of the 2014 West Africa Ebola Virus Disease Epidemic on Multi-level Violence Against Women
https://www.researchgate.net/publication/306902936_The_effect_of_the_2014_West_Africa_Ebola_virus_disease_epidemic_on_multi-level_violence_against_women

Ebola Publications: Case management, Infection Prevention and Control
https://bit.ly/2vxEqN6

Resources Specific to COVID-19:

GBV Guidelines Resource Hub
https://gbvguidelines.org/en/knowledgehub/covid-19/

Technical Note on Protection of Children During the Coronavirus Pandemic
https://alliancecpha.org/en/system/tdf/library/attachments/the_alliance_covid_19_brief_version_1.pdf?file=1&type=node&id=37184

Staying Safe During COVID-19
https://www.thehotline.org/2020/03/13/staying-safe-during-covid-19/

The COVID-19 Outbreak and Gender: Key Advocacy Points from Asia and the Pacific
https://bit.ly/2WtyC2i

Coronavirus: Five Ways Upheaval is Hitting Women in Asia
https://bit.ly/2xc4JZz

COVID-19: The Gendered Impacts of the Outbreak
https://bit.ly/2xTfsJ1

The COVID-19 Pandemic & Digital Services
https://bit.ly/2xJG3rJ

Gender and the Coronavirus Outbreak
https://bit.ly/394ZDvD

Gender Implications of COVID-19 Outbreaks in Development and Humanitarian Settings: Executive Summary
https://bit.ly/2QtFfxP

Gender Implications of COVID-19 Outbreaks in Development and Humanitarian Settings
https://bit.ly/2U1UbVV

COVID-19: Coalition Guidance for Programmes
https://bit.ly/3a6iWWH

COVID-19: The Gendered Impacts of the Outbreak
https://bit.ly/2IXNduT

Impact of COVID-19 Pandemic on Violence Against Women and Girls
https://bit.ly/2xbcM92

The GBV AoR Help Desk

The GBV AoR Helpdesk is a technical research, analysis, and advice service for humanitarian practitioners working on GBV prevention and response in emergencies at the global, regional and country level. GBV AoR Helpdesk services are provided by a roster of GBViE experts, with oversight from Social Development Direct. Efforts are made to ensure that Helpdesk queries are matched to individuals and networks with considerable experience in the query topic. However, views or opinions expressed in GBV AoR Helpdesk Products do not necessarily reflect those of all members of the GBV AoR, nor of all the experts of SDDirect's Helpdesk roster.

Contact the Helpdesk

You can contact the GBViE Helpdesk by emailing us: enquiries@gbviehelpdesk.org.uk, and we will respond to you within 24 hours during weekdays.

The GBViE Helpdesk is available 09.30- 17.30 GMT, Monday to Friday.