SPACE Social Protection Approaches to COVID-19: Expert advice helpline

Gender and Inclusion in social protection responses during COVID-19

REBECCA HOLMES, AMBER PETERMAN, ELAYN SAMMON, COURTNEY CABOT VENTON, LAURA ALFERS AND INPUT FROM EXPERTS ON THE SOCIAL PROTECTION APPROACHES TO COVID-19: EXPERT ADVICE HELPLINE (SPACE) - CONTACT: SPACE@DAI.COM

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This document provides key considerations and examples of **how gender and social inclusion (GESI) can be integrated into potential COVID-19 response options/strategies via existing social protection and / or humanitarian programmes (or a hybrid approach, leveraging social protection delivery systems and capacity)**. It aims to highlight key considerations for integrating GESI into social protection design and operation, in an effort to increase wellbeing and dignity, while minimising potential negative effects on vulnerable populations.[1]

This document links to the SPACE Strategy Decision Matrix and Delivery Systems Matrix, providing further detail on GESI issues for both documents.

There are potential trade-offs between design and implementation options that will need to be decided in each context according to programming objectives and priorities. In addition, not all options will be feasible or desirable in every context.

However, the aim is to build on existing gender-sensitive social protection features and ensure that i) GESI issues have been strategically considered across all the potential options, ii) that all social protection responses will, at a minimum, be GESI-sensitive and not exacerbate gender and social inequalities, and iii) that longer-term objectives of equality and empowerment are considered and, where possible, factored in to immediate responses, as well as considering how to ensure inclusive medium-to longer-term recovery.

The document is divided into two parts:

1. Impacts of the COVID-19 crisis on vulnerable groups.
2. Social protection strategy decision matrix – considerations for integrating GESI into social protection responses.

[1] This guidance draws closely on material and narrative presented in Hidrobo, M., Kumar, N., Palermo, T., Peterman, A., and S. Roy (2020). "Gender-sensitive social protection: A critical component of the COVID-19 response in low- and middle-income countries" International Food Policy Research Institute, Washington, D.C.

IMPLEMENTING PARTNERS

1 IMPACTS OF THE COVID-19 CRISIS ON VULNERABLE GROUPS

It is already widely recognised that the primary and secondary impacts of COVID-19 are likely to affect men and women differently owing to biological differences, as well as existing inequalities, roles and responsibilities, that differ by gender. Initial evidence indicates that the pandemic is likely to widen existing inequalities, including by gender, socio-economic status and race, among others. In addition, as women and other vulnerable groups are typically marginalised in terms of decision-making power and agency at the household, community and institutional-level, this may reduce the likelihood that their needs will be visible and met in the pandemic response effort.

1.1 What are the key risks and impacts of the crisis on vulnerable groups?

1.1.1 Increase in health and nutrition risks (direct and indirect) by gender and other intersectional risks

- Elderly women and men are at a higher health risk from direct COVID-19 infection. While men appear to be at higher risk for direct mortality, there is a higher number of elderly women (over the age of 80) around the world. Women also tend to have lower pensions (if any) and more limited access to care and other services, constraining their ability to seek care and treatment while sick.
- Emerging data in some countries shows that racial and ethnic minorities account for a disproportionate share of COVID-19 mortality, potentially due to disparities in socio-economic status, treatment discrimination and co-morbidities.
- People with disabilities may also be at greater risk of contracting COVID-19 and developing serious illness or dying as a result of COVID-19 because of underlying health conditions and accessibility barriers; and women and girls with disabilities are likely to face discrimination which limits access even further, because of their gender.
- Women represent 70% of workers in the health and social sectors and therefore, women working in the health sector face a high risk of direct infection from COVID-19.
- As health resources are diverted towards emergency response and health systems are overburdened in the crisis there is risk of indirect health risks, including increases in maternal mortality and other negative effects on women's health needs including sexual and reproductive health; women and girls with disabilities already have the least access to reproductive, maternal, new born and child health and are likely to see access further eroded. Similarly, access to essential medicines and therapeutic programmes to meet the additional health needs of women and girls with disability, including can be at risk. Women and girls in rural and marginalised communities are already less likely to have adequate access to quality health services, essential medicines, maternal and reproductive health care, or coverage for health costs.
    - E.g. During the Ebola outbreak in Sierra Leone, studies show that the "decrease in utilisation of life-saving health services translates to 3,600 additional maternal, neonatal and stillbirth deaths." The disproportionate loss of health workers in areas with low pre-crisis coverage are likely to lead to higher maternal mortality for years to come.

- Indirect risk of food insecurity and malnutrition exist, particularly for women and children who may be the first to reduce food consumption in times of food insecurity due to intra-household inequalities. The risk of malnutrition is particularly acute for pregnant and lactating women and can have long-lasting impacts on infants and young children. Women and girls with disabilities may also face increased risk of exposure to harmful practices involving restrictions on food and nutrition.
- Menstrual hygiene products may become less available or not prioritised for household expenditure because of loss of income, putting women and girls at increased risk of health conditions, and girls and women with disabilities are disproportionately affected.

1.1.2 Increase in poverty, loss of jobs and livelihoods

- The economic impacts of the crisis will have long-lasting effects. Women in the informal economy are especially vulnerable, as are people with disabilities, as they are overrepresented in low-paid work, more likely to work part-time, earn less, work in non-standard employment and have less access to social security. Travel restrictions imposed by COVID-19 are likely to cause financial challenges and uncertainty for migrant informal workers, such as domestic workers. Disruptions to supply-chains originating in developed countries will mean that many women who are homeworkers will no longer earn.
- Women and other vulnerable groups, including people with disabilities, living in poverty, without savings or access to financial services and an independent source of income face significant risks. Poor populations are unlikely to be able to stock-up on basic necessities, including bulk purchases to facilitate social distancing, and cannot afford to stay home or quarantine. More women live in poverty than men: 50 million women aged 25–34 compared to 40 million men of the same age. The poverty gap between women and men with disabilities is also substantial. For example, women in the United States are 25 percent more likely to live in poverty than men with disabilities, and women with disabilities in the United Kingdom earn 12 per cent less than disabled men. Working-age women, especially those in a relationship and with children, are also less likely to have a job as compared to men.
- While female headed households may have similar or even lower levels of poverty across different countries, per-capita poverty measures do not take into account marital status, economies of scale, higher time poverty and reduced access to services faced by female headed households—all of which may put them at a disadvantage during COVID-19.

1.1.3 Increase in unpaid and care burden

- The impacts of COVID-19 are likely to increase women's unpaid and care time, as schools close and women are more likely to provide care for family members if they fall ill. This also increases women's risk of exposure. Women are also more likely to carry out household tasks, including cooking and cleaning, which increase with more people staying at home during a quarantine.
- Longer-term care burdens are also likely to fall upon women, as men are more affected by COVID-19 related mortality, leading to higher rates of female headed households.
- School closure and stay-at-home orders can also exacerbate burden of care for women looking after children with disabilities, who may require a higher level of care and educational instruction and may experience additional difficulties coping.

1.1.4 Increase in violence, protection and social risks

- There is an increased risk of frequency and severity of violence against women and violence against children, as families cope with stressors of economic insecurity, quarantines and isolation, and women are unable to or unwilling to access legal, health and first responders to prevent violence and mitigate against severe effects.

- Evidence shows that past crises can result in negative coping strategies such as early marriage, school drop outs and pregnancy among adolescent girls, which have long-lasting adverse effects.
    - E.g. when schools were closed in Sierra Leone during the Ebola outbreak, studies found an increase in adolescent pregnancies largely attributed to increased time spent with men, and exploitative relationships, facilitated by the closure of schools.
- School closures also have multiple adverse effects, beyond loss of learning and education opportunities, particularly for disadvantaged children, as free school meals are an important source of nutrition for children. In fragile states, school closures can be particularly harmful, leaving children at risk of child labour, early marriage, sexual exploitation, and even recruitment into militias. Before the crisis, UNICEF estimated that approximately 32 million girls of primary school age were out of school compared to 27 million boys – once schools are closed there is a risk that girls in particular may not return and that efforts on inclusive education are deferred.
- Violence and protection risks may be particularly acute for refugees, undocumented migrants and asylum seekers who may be living in precarious and unsecure locations, and may be at risk for xenophobic attacks or exploitation; and for people, especially women and girls, with disability who may face increased stigma, discrimination and abuse.

1.2 Are there any opportunities?

The COVID-19 crisis also provides an opportunity for stakeholders to recognise existing inequalities and strengthen GESI both within the immediate response and early to longer term recovery. In particular, opportunities for leveraging responses include:

- With families staying at home together, there is an opportunity for increased dialogue around the importance of more equal division of labour in the household and more equitable gender socialisation of boys and girls;
- With increasing distance and online education, there is opportunity for investment in IT infrastructure and connectivity for all household members;
- With increasing efforts to perform rapid registration of individuals and households, there is a chance to leverage these efforts to address current documentation (ID) and civil registration gaps that are often a source of social protection exclusion;
- With increasing use of e-payments and mobile money, there is opportunity for investment in financial inclusion, particularly for women;
- With the reliance on frontline health and care workers (primarily carried out by women) for primary response to the crisis, there is an opportunity to change the narrative around low and unpaid care and health work.
- With expansion of social protection caseloads in many countries, including to the 'missing middle' and previously uncovered groups such as informal workers, there is the opportunity to a) retain some of those caseloads in the aftermath of the crisis or b) at a minimum ensure being previously covered enhances the potential for future access (e.g. registration for simplified/low-tax social security measures for informal workers). Also, a movement towards the integration of social assistance and social insurance measures, towards a more coherent social protection system.
- Greater funding to local/women's organisations. With the repatriation of most international staff, as well as local restrictions on movement, localisation of response has become imperative. This presents an opportunity to position and channel greater amounts of funding to local women's organisations, groups, and networks, those supporting disabled and other vulnerable groups, placing their voice and decision making at the core of the response.

1.3 What further data and resources are there on the impacts of COVID-19 on vulnerable groups?

This list is growing and will continue to be updated.

1.3.1 Gender

- UN Women (2020) COVID-19: Emerging gender data and why it matters (compilation of resources)
- Gender and COVID-19 Working Group (2020) List of Resources (living document)
- Gender and Development Network (GADN) List of resources: Feminist Responses to COVID-19 (compilation of resources)
- World Bank (2020) Gender dimensions of the COVID-19 pandemic (policy note)
- UNFPA (2020) COVID-19: A Gender Lens (brief)

1.3.2 Disability

- International Labour Organization (2020) Disability Inclusive Social Protection Response to the COVID-19 Crisis (brief)
- WHO (2020) Disability considerations during the COVID-19 outbreak (brief)
- The Lancet (2020) The COVID-19 response must be disability inclusive (commentary)

1.3.3 Other/mixed

- INCLUDE (2020) How COVID-19 affects inequality in Africa
- SDDirect (2020) COVID-19 Blog Series (covering issues of gender, disability and LGBTIQ)

2 CONSIDERATIONS FOR INTEGRATING GENDER AND SOCIAL INCLUSION INTO SOCIAL PROTECTION RESPONSES

2.1 The Strategy decision matrix: what are the main GESI considerations?

This matrix complements the SPACE Strategy Decision Matrix, providing more detail on the GESI considerations in its three main components: coverage, adequacy and comprehensiveness. Further gender considerations are also integrated within the main Matrix.

Strategy decision matrix: what are the main GESI considerations?		
(Examples or considerations in gray)	Key GESI considerations and implications for social protection responses	Country / programme examples
1. Coverage (reaching all those in need and minimising exclusion)		
Level of coverage and appropriateness of targeting Is the response supporting those that are most likely to be affected by COVID19 (this often does not correspond to routine caseloads, i.e. potentially different eligibility criteria, urban rather than rural focus, etc)	Considerations: GESI analysis is required to identify the most vulnerable groups in each context and the potential impacts of the crisis on them. Consideration needs to be taken on whether household or individual targeting is required to meet their needs. Examples of groups likely to be severely affected by COVID-19 (directly or indirectly) include: • Women workers in the informal economy • Single parents (majority of whom are women) • Pregnant and lactating women • Young children (e.g. first 1000 days) • Older persons, particularly those without access to services and resources • Health sector and care workers	• COVID-19 response programmes specifically target pregnant women or women receiving maternity benefits (Argentina, Armenia, El Salvador, Hungary, Russia, Sri Lanka) • COVID-19 response programmes targeting women specifically, due to various criteria (at nutritional risk, lacking a spouse, women leaders, pre-existing female beneficiaries, or top-ups to programs for women -- Argentina, Brazil, Colombia, Egypt, India, Italy, and Pakistan). • COVID-19 response programmes are targeted specifically to health care workers

	• Adolescent girls (if out of school and vulnerable to early pregnancy, marriage and exploitation)
	• People living with disabilities (and their carers)
	• Individual's with underlying health co-morbidities (including people living with HIV/AIDS)
	• Children outside of stable care environments (including street children, children in institutional care or orphans)
	• Refugees and migrants living in camps/temporary unsafe settings.
	Implications for social protection responses:
	• Informing social protection coverage and design:
	  ○ conduct rapid GESI analysis
	  ○ draw on existing GESI analyses (including from humanitarian crises where relevant)
	  ○ engage with GESI-focused organisations (gender, disability, youth etc) throughout the process of planning, evaluation and M&E
	• Provide social protection to groups who are vulnerable during the crisis
	• Focus on minimising exclusion errors – inclusion errors are NOT a problem in the COVID-19 context (pay now, verify later). This will involve simplified targeting criteria and more universal approaches to provision.
	• Engage local organisations to help with the design of coverage and ensure inclusion of those who many not be registered/have access to mobile money
		(who are primarily women), including covering exposure or injury-related costs and compensation for infection (Philippines) and higher levels of childcare vouchers as compared to the rest of the population (Italy).
		• COVID-19 response programmes target informal workers, who are likely to be disproportionately women, through instruments including vouchers for skills training (Indonesia), wage subsidies (Australia), utility subsides (Vietnam), public works for those who lost livelihoods (Philippines), food vouchers (Jordan), and cash transfers (Argentina, Australia, Cabo Verde, Colombia, Ecuador, Morocco, Namibia, North Macedonia, Peru, Philippines, Tunisia).

Named recipients Who in the household should be the target (named) recipient? Should household level transfers be targeted to men or women (or should households be allowed to choose?); In what cases	Considerations: If household level transfers are used, there are named recipients within the household and this can have gender implications. Evidence is mixed on the advantages and disadvantages of naming women as recipients in terms of overall household economic and child-level outcomes. However, consider the following: Potential advantages of targeting women include: • Economic benefits for women (who typically have lower existing levels of economic status and financial agency) • Improvements in women's empowerment and decision making within the household	• Programmes (non-COVID) in Jordan, Egypt, Mali and Rwanda where multiple persons within a household are authorised to carry out transactions diffuse control and support a shared workload; In Bangladesh, multiple persons within the household are authorised to use the cash-based transfers • Cash-based programming (non-COVID) in Bangladesh, Egypt, El Salvador, Rwanda, Mali used a variety of 'awareness raising' messaging around equitable intra-

should individual-level benefits be prioritised?	• Increased wellbeing for women (including mental health and decreases in violence) Potential disadvantages include: • Risk of backlash against women (from inside and/or outside the household – although there is little rigorous evidence of this occurring, it is still an important consideration in diverse settings) • Risk of increasing women's time burden and security or health risks if collecting manual payments Overall, guidance suggests that if women were assessed to be target recipients in pre-COVID-19 programming, it is a likely feasible strategy for new programming as well. In contrast, if context suggested risks or logistical barriers outweighed benefits of targeted women pre-COVID-19, the added challenges during COVID-19 point against using this period to explicitly program to change gender norms. Even where women can be considered as named recipients where, consideration needs to take account of: • Crisis context and levels of violence – acknowledging that household tensions may be higher in lockdown or economic downturns; • Existing evidence from gender analysis, including feasibility and acceptability of targeting women in the past – in order to monitor areas of past tension and risk. Implications for social protection response: Strategies to maximize benefit and minimise risks include: • Authorising multiple people in a household to carry out transactions; • If explicitly targeting women is deemed not to be feasible, asking households to nominate a named recipient rather than assigning a household head; • Providing relevant information to both men and women on the transfer modality, access, use etc. • Provide accompanying messaging on importance of equitable gender relations, emphasising the benefit is for the entire family, and meant to increase household harmony and wellbeing; • Consider targeting multiple beneficiaries (e.g. co-wives) in diverse household structures such as polygamous households, which may be at increased need for resources.	household decision-making, meeting nutrition needs of different household members and other gendered topics (e.g. gender roles, harmful practices, etc.) – which was perceived to be meaningful for ultimate outcomes. • Programmes across settings in sub-Saharan Africa (non-COVID) have demonstrated that considering local acceptable accommodations to targeting polygamous households are needed. In some settings, not allowing co-wives to be considered as eligible for separate transfers has caused conflict (e.g. Somalia) —while in others, polygamous households are considered one family unit (e.g. Malawi).

Minimising gaps in provision Is anyone (e.g. population group) being left out – either because eligible groups may face challenges accessing schemes, or because one programme cannot achieve adequate coverage and requires a coordinated set of programmes that, together, ensure universal coverage of those in need)	Considerations: *Reducing exclusion errors of eligible beneficiaries* Existing coverage of social protection, particularly contributory schemes linked to formal employment may be biased towards men and able-bodied individuals, and women may face particular barriers to accessing social assistance programmes. Ensuring that women and other vulnerable groups are able to access existing or new programmes may require specific measures to eliminate the barriers they face, such as mobility constraints, limited access to information, illiteracy or minority language, limited social networks, less access to and ownership of mobile phones, bank accounts, IDs and civil registration. *Coordinating for higher coverage of groups in need:* Given that it is unlikely social protection will be able to cover all affected groups, it will be important to coordinate with other actors in the country, including humanitarian actors. Implications for social protection response: • removing or proactively resolving physical and administrative access, registration and enrolment barriers (distance, documentation requirements, etc) • removing conditionalities • consider automatic enrolment and waiving co-payments for health and other insurance schemes • ensuring information is in appropriate languages and utilise various communication channels that are known to reach women, people with disability and marginalised communities (e.g. local media, television, radio, text messaging, voice messages, community postings, utilising local leaders and groups such as women's collectives and Membership Based Organisations (MBO) • Provision of mobile phones, access to bank accounts, access to ID etc. coupled with appropriate messaging / training if using new delivery methods • Coordinating and working with existing gender-and inclusion-focused organisations (including member-based organisations, disability-focused organisations, informal worker organisations) who may have the ability to deliver social protection and also extend coverage to hard-to-reach groups.	• Non-COVID modification of systems to support the rapid identification and enrolment of households in Kyrgyzstan in areas by crisis. • Women self-help groups in India are responding to COVID crisis by running community kitchens, awareness raising and providing banking and pension services • Innovative approaches to increasing coverage of women, e.g. by leveraging financial inclusion programmes. In India, 200 million women with a Jan Dhan Bank Account were provided with a 3 month transfer.

2. Adequacy		
Adequacy of support (meeting needs) For many the amount will not be an add-on for existing income but may need to be a full income replacement, aiming to cover all basic needs	Considerations: There may be trade-offs to consider and gender implications of "lumpy (larger)" versus smaller and regular transfers: • Whilst "large and lumpy" transfers may be preferred early in the COVID-19 onset, to support supply chains and systems before they are overwhelmed, as well as reducing contact at payment distribution points, smaller and more regular transfers may help to reduce stock-piling and spread need over a longer period of time. • Evidence suggests that smaller transfer values targeted to women may play a role in increasing women's control of resources. However, larger transfer values may result in comparatively higher wellbeing outcomes – both for households and women specifically. Although there is little rigorous evidence on the effect of smaller vs. larger transfers on women's control of transfers, or on intra-household tensions, it is important to plan for and mitigate against unintended effects. This is particularly important in emergency contexts when intra-household tensions are likely to be heightened or in settings with restrictive gender norms. • Ensuring benefit levels are sufficient in value to cover the duration of the COVID-19-related crisis and mitigate against unintended negative effects due to economic insecurity, should be prioritised – noting that with COVID transfer values are not an add-on to regular income, but often a complete substitute to income. Implications for SP response: gender-and inclusion specific needs in calculating the value (and type) of support: • Care responsibilities are disproportionately taken on by women, so consider whether additional top-ups can be given to households caring for sick members, or children who may require additional resources (meals at home, home tutoring, school supplies). • Consider the additional financial needs of people with disabilities. • If computing benefit levels on per-capita or pre-crisis earning levels, consider that although female headed households are likely to be smaller and may appear better off, they may still be more disadvantaged	• COVID-response programmes specifically consider childcare duties or provide benefits related to childcare (Austria, Cook Islands, Czech Republic, France, Germany, Italy, Norway, Poland, Romania, Serbia, Slovenia, South Korea, Spain, and the United States) • Evidence (non-COVID) from cash transfer benefit levels which were randomized in Kenya and Rwanda suggests that larger cash transfers result in comparatively higher wellbeing impacts, for households and women specifically. Qualitative studies in Somalia and across countries (Bangladesh, Egypt, El Salvador, Jordan, Mali, and Rwanda) indicate that smaller transfer values targeted to women may have allowed them to retain control of funds (however no variation allowed comparison across values).

	due to reduced access to markets and services and economies of scale, among others. • Engage with GESI-focused organisations (gender, disability, youth etc) to inform appropriate types of response.	
Relevance of type of support	Considerations: As summarised in the section above, the impact of the crisis will have different and disproportionate effects on women and girls across age, disability, ethnicity, etc. Implications for social protection response: Whilst cash transfers will often be the preferred modality of response, consider other / additional options to support which will also support women and girls across age, disability and other intersections: • Access to health care, ideally maintained via individual schemes, including fee waivers, automatic health insurance enrolments to support care for critical, routine maternal and child health services (including access to family planning and reproductive health) and to counteract inequalities in health seeking behaviour – otherwise, expanded via individual prioritisation for vulnerable groups or household level enrolments. • Provision of in-kind transfers (including bulk, storable, fortified food or hygiene supplies, including soap), if mobility is restricted (providing from accessible locations or delivered to people's homes), when markets are not functioning or when price volatility undercuts the value of cash transfers; • If public works are deemed appropriate in recovery stages, ensure that wages are fair, work is dignified, and women are safe/able to participate, including through exemptions for lactating and pregnant women, and people with disability – see considerations for gender-sensitive public works here; • Provision of productive inputs to support women farmers, including consideration of digital extension service provision; • When schools are re-opened, provision of school fee waivers, cash for education top-ups, particularly for adolescent girls who may be at heightened risk for drop-out in the short and long term;	• COVID-19 response programmes specifically target pregnant women or women receiving maternity benefits (Argentina, Armenia, El Salvador, Hungary, Russia, Sri Lanka) • COVID-19 response programmes targeting women specifically, due to various criteria (at nutritional risk, lacking a spouse, women leaders, pre-existing female beneficiaries, or top-ups to programmes for women -- Argentina, Brazil, Colombia, Egypt, India, Italy, and Pakistan). • COVID-19 response programmes target informal workers, who are likely to be disproportionately women, through instruments including vouchers for skills training (Indonesia), wage subsidies (Australia), utility subsidies (Vietnam), public works for those who lost livelihoods (Philippines), food vouchers (Jordan), and cash transfers (Argentina, Australia, Cabo Verde, Colombia, Ecuador, Morocco, Namibia, North Macedonia, Peru, Philippines, Tunisia).

	• Some groups of informal workers are considered "essential workers" – many of whom will be women. They require hygiene protections – protective equipment, handwashing stations, access to running water in their places of work.	
3. Comprehensiveness		
Fully supporting different multidimensional needs Given the types of needs emerging from COVID19, can additional measures be layered on or linked to (e.g. to meet health needs, behavioural change objectives, psychosocial support needs, protection needs etc).	Considerations: One single response will not be able to support all the needs that vulnerable groups face, and complementary activities that often accompany social protection – such as group trainings, group savings, home visits etc. may not be possible. Key consideration is therefore needed on how social protection platforms can explore linkages to existing services or explore options to integrate messaging which are most relevant and important for women, girls and people with disability. This is likely to best be achieved via leveraging existing networks/organisations such as women's groups, informal worker organisations, etc. Implications for social protection response: Assessing what *type of messaging, information, support, and services are most needed and relevant* are likely to include: • food and nutrition, including ways of accessing or growing nutritious foods when markets and supply chains are down; • water and sanitation, as information about hygiene and social distancing are critical for safety and COVID-19 spread; • maternal health, as travel may be restricted, and health services stretched; • sexual and reproductive health, as access to routine family planning and menstrual hygiene products may be interrupted; • parenting and learning as many schools are closed, and parents need extra support for home education during stressful periods; • mental health and psychosocial support for both men and women, given that many may experience depression from isolation or loss of employment/income; • Protection resources, including access to helplines, referrals and other violence-related services; On a country-level basis, social protection actors are encouraged to liaise with and explore options for innovative linkages and programming to mitigate against GBV. This could include, at	• Within pre-COVID programming, a variety of different gender-sensitive plus components have been integrated, related to health, nutrition, GBV, and economic empowerment of women (see e.g. review of cash-plus models, including examples of adolescent cash-plus, review of social safety nets and gender in Africa). • Within emergency programming (pre-COVID), GBV has been a focus, including cross-country operational learning undertaken by the Women's Refugee Commission (WRC) – integrating cash-based programming and GBV in Ecuador, Jordan, Niger, Somalia. • Women's groups have been utilised not only for targeting and spreading informational messages related to COVID-19, but also for complementary programming. In India, self-help groups have started production of protective equipment, running community kitchens, fighting misinformation and providing banking solutions for remote communities.

	a minimum, having explicit protocol for GBV concerns in grievance mechanisms and post-distribution monitoring (some example tools across were developed by the WRC) – and advertising the availability of assistance for protection concerns. In addition, providing information on support services at any touch-points with beneficiaries. This could also include providing flexible funds for additional services, including housing stipends for temporary safe shelter for women and children. Dedicated resources on GBV and COVID-19 have been compiled by various organizations with information on: • Identifying & Mitigating Gender-based Violence risks during the COVID-19 response provides information on how to identify risks and integrated programming into sectoral response efforts. This is accompanied by the GBV Pocket Guide (how to support survivors for non-GBV specialists, available in mobile app form in seven languages). • GBV case management series via the GBVIMS steering committee, which is a series of podcasts, informational guides and videos on how to conduct remote case management within the COVID-19 response. • Contingency planning for GBV coordination groups via the GBV AoR Global Protection Cluster. • Mental health & Psychosocial Support for staff during COVID-19 via the GBV AoR Global Protection Cluster. • Prevention and Response to GBV in COVID-19 Quarantine Centres, via ICRC. • Promoting equitable social relations, messaging on sharing childcare and domestic responsibilities, reducing violence; **Embed support for gender transformative programming**. Social norms are one of the biggest barriers for women, people with disabilities and other vulnerable groups to access social protection programming. Whilst typically seen as longer-term programming, a lack of focus on social norms/behaviour change can fundamentally undermine the ability of programming that benefits vulnerable groups, by holding them locked in a system whereby their needs are deprioritised. Programming in this space can be a critical complement to some of the more standardised programming around cash transfers and additional measures.	

	Ensuring access to information, support and services in the context of COVID-19: • Reducing physical contact and providing services and information through phone, internet, television and radio; • Provision of one-on-one support services for maternal health or mental health could be in the form of "tele-visits" either online or via phone calls from experts or hotlines (WhatsApp messages) where women or men to call in to speak with an expert (although challenges to the mobile phone service include women's lower access to mobile phones, and financial barriers to paying for a service so fees should be waived); • For more generalised messages in accessible formats, television, radio, SMS or voice messages including in local languages are another way to reach people at scale, the latter especially where women's literacy is low; • Consider the best time of day for a woman to receive the messages via phone or radio, given the multiple demands on a woman's time. • Support existing frontline organisations/networks, including women's groups (e.g. through capacity building, funding etc) for delivering additional services and information (e.g. relevant messaging, screening for violence and set up hotlines, mitigating child protection issues etc.)	
Final considerations: Achieving some of these objectives discussed above may present trade-offs with regards to some of the other dimensions within the Strategy Decision Matrix: for example, achieving timeliness and lowering costs of delivery. Further considerations on gender and inclusion can be found within the main Matrix. Nevertheless, it should be stressed there are clear long-term benefits to be gained from a response which, from its inception promotes inclusion and works towards the building of a stronger social contract between the state and its most vulnerable citizens.		

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