PLAN INTERNATIONAL

COVID-19

GENDER EQUALITY GLOBAL ADAPTATION AND RESPONSE FRAMEWORK

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1. ACRONYMS

BCP	Business Continuity Plan
CAY	Children, Adolescents and Youth
CBCPM/PC	Community-based Child Protection Mechanism/Committee
CEFM	Child, Early and Forced Marriage
CHW	Community Health Worker
CNW	Community Nutrition Worker
CVA	Cash and Voucher Assistance
FGM/C	Female Genital Mutilation/Cutting
FNS	Food and Nutrition Security
FNSiE	Food and Nutrition Security in Emergencies
FRM	Feedback Response Mechanism
GBV	Gender-Based Violence
IASC	Inter-Agency Standing Committee
IDP	Internally Displaced Person
IEC	Information, Education and Communication
IPC	Infection Prevention Control
IPV	Intimate Partner Violence
MCHN / MNCHN	Maternal and Child Health and Nutrition/ Maternal, Newborn and child Health and Nutrition
MHM	Menstrual Hygiene Management
MHPSS	Mental Health and Psychosocial Support
MIS	Management Information System
MoH	Ministry of Health

MUAC	Mid - Upper Arm Circumference
PII	Plan International Inc.
PPE	Personal Protective Equipment
PSEA	Protection against Sexual Exploitation and Abuse
PSS	Psychosocial Support
RCCE	Risk Communication and Community Engagement
SADDD	Sex-, Age-, Disability-Disaggregated Data
SGBV	Sexual and Gender - Based Violence
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infection
UASC	Unaccompanied and Separated Children
UNESCO	UN Educational, Scientific and Cultural Organization
UNHRD	UN Humanitarian Response Depot
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization
YAP	Youth Advisory Panel

2. EXECUTIVE SUMMARY

Type of document	*Adaptation and Response Framework*
Response name	*COVID-19 pandemic*
Target funding (euros)	**€100 million for six months**
Target beneficiaries	*Most vulnerable programme communities / refugees/ IDPs/ camps/ urban slums and sponsorship communities*
Planned response sectors	*Health, WASH, Education, Child Protection, Community Engagement and Accountability* *Modality of cash where feasible*
Response goal	**To contribute to the prevention of the transmission of COVID-19 and reduce the social impact on the most vulnerable communities particularly in refugee camps, displaced settings, urban slums and sponsorship communities across Plan International programme countries. We will work to ensure that we reduce the social impact on the status of women and girls who are normally disproportionately affected by crises.**
Date	*8 April 2020*

3. COVID-19 PROGRAMMATIC APPROACH

The world is facing an unprecedented crisis that has been described as the “greatest public health challenge in a generation”. It has the potential to crumple ordinarily functioning health systems, economies and social networks. As a girls’ rights and humanitarian organisation, Plan International has the responsibility to ensure that the communities we serve – both in our ongoing emergencies and our longer-term development programming – are supported to prepare, prevent and respond to the impacts of COVID-19. Humanitarian principles must underpin our approach, ensuring the basics of humanitarian action (humanitarian imperative, neutrality and impartiality) across our response.

Plan International will adopt a two-pronged approach to ensure that the most vulnerable communities we currently work with across 50 countries are prepared to prevent and respond to COVID-19. Within the response, the priority and focus will be on interventions in the sectors of WASH, Health, Community Engagement and Accountability, Education and Child Protection. The aim is to have the highest impact on prevention of transmission as well as to mitigate the subsequent negative sociological impacts. Plan International will mainstream gender equality throughout its response activities to curtail the likely deepening of gender inequalities as a consequence of the COVID-19 pandemic.

The first priority is to ensure that our **ongoing emergency responses** are integrating COVID-19 prevention and mitigation measures, with particular emphasis on refugee and displacement settings. These settings are at the forefront of our response to COVID-19 due to the fragility of the contexts and the impact that a double crisis will have on the most vulnerable.

The second priority is to target our **ongoing projects and programmes in high-risk areas with a particular focus on sponsorship communities**, using the programme guidance that outlines adaptations to current programmes to better prepare and mitigate the virus.

This adaptation and response plan emphasises four phases of the crisis – Preparedness, Initial Response, Mitigation and Recovery. These take into account the different scenarios and are inclusive of mobility restrictions and shutdowns of basic social services as a consequence of COVID-19. These phases are important to consider in our approach to ensure we adequately scale up life-saving activities at the right time and equally consider nexus programming as we move into recovery.

In addition to response and adaptation activities directed at communities, the foundation of our ability to respond effectively lies in strong coordination with local, regional and national governments. The aim of this is not only to enhance and support government-led responses to COVID-19 outbreaks but also to influence the inclusion and prioritisation of girls, women and vulnerable groups such as refugees and internally displaced persons (IDPs) into government policies to tackle the pandemic.

4. POTENTIAL IMPACT ANALYSIS

Although needs assessments have not been conducted, valuable insights into likely impacts of COVID-19 have emerged both from the early effects of the pandemic in China and Europe and from critical lessons learned during the Ebola virus and previous infectious disease outbreaks.

Health

The rapid spread of COVID-19, first seen in China and now in Europe, Asia, the Middle East, the Americas and across Africa, could destroy already fragile health systems in countries where skilled healthcare workers, resources and supplies are too scarce to cope with the influx of hospital patients, as seen in countries now experiencing the pandemic.

Countries with high rates of underlying respiratory and auto-immune diseases are particularly at higher risk, as are countries with pre-existing poor hygiene practices or infrastructure, high-density populations, and poor water and sanitation services. The diversion of funds, medical supplies and human resources from routine health services, including those for sexual reproductive health and rights (SRHR), gender-based violence (GBV), and maternal and child health and nutrition (MCHN), will heighten the vulnerability of populations where they are unable to continue receiving these services.

WASH

Global World Health Organization (WHO) guidance identifies washing hands and keeping areas as hygienic as possible, alongside social distancing measures. For many contexts where we operate, these guidelines are virtually impossible. Overcrowded refugee and IDP camps, townships and slums make social distancing unachievable. This is compounded often by poor sanitation, lack of access to adequate clean water supplies and insufficient antibacterial soap to aid prevention of transmission and spread of COVID-19. Incorporating and scaling up WASH (water, sanitation and hygiene) activities in our response is critical to support the curtailing of COVID-19 transmission.

Community Engagement and Accountability

Usual methods we use for two-way communication with communities, participation and feedback will become increasingly difficult and will be potential sources of infection. Those already facing access constraints to life-saving information, services and decision-making forums are at risk of further marginalisation and disproportionate impact. Remote solutions such as social media campaigns are not always accessible, particularly for adolescent girls. How people understand the disease is constantly changing and based on trusted sources they access. Already many rumours are circulating about causes and cures that are spreading misinformation. If these rumours go unaddressed, not only may people fail to take preventive measures, but there is also the potential for increased violence, discrimination, stigma and xenophobia – as was seen during the Ebola outbreak. Effective community engagement and accountability will be essential to promote the behaviour changes needed and to base decisions on the voices of community members. Remote solutions that limit contact should ensure inclusivity and should reach the most vulnerable. Local and national actors of course must play a critical role in building the resilience of local service providers, duty bearers and communities

to similar future shocks. However, our work in engaging and mobilising our community-based volunteers and frontline staff in sponsorship communities offers an opportunity to leverage our long-term, strong and trusted relationships to ensure that messages reach the most vulnerable.

Child Protection

The COVID-19 pandemic and the measures used to prevent and control the spread of the disease can disrupt children's daily routines, friendships, families, communities and services. Children and families who are already vulnerable due to humanitarian crises or socio-economic exclusion are particularly at risk. Home-based, facility-based and zone-based quarantines expose children to protection risks, especially children who have lost or are separated from primary caregivers. A failure to consider gender specific needs and vulnerabilities of girls can further increase their protection risks and lead to negative coping mechanisms. The closure of schools and recreational spaces, illness, isolation and stressors on parents, caregivers and community members increases physical and emotional maltreatment and creates obstacles to reporting incidents and to accessing mental health and psychosocial support (MHPSS) and child protection services. Quarantines can create fear and panic in the community and especially among children. Psychosocial distress can be exacerbated by death or separation from family members. The loss of household income, reduced family protection for children and girls' gender imposed responsibilities increase the risk of child labour and sexual and gender-based violence (SGBV), including sexual exploitation and child, early and forced marriages (CEFM).

Education

As the world faces a global health crisis, we are also witnessing an unprecedented education crisis that is rolling back decades of progress. UNESCO estimates that 1.54 billion children, including nearly 743 million girls, are currently out of school due to COVID-19. During crises, parents, children and young people frequently identify education as a priority need but as governments race to contain the virus, focus is being directed away from this essential service. Yet education presents opportunities to build resilience, tackle gender inequalities, nurture more cohesive and peaceful societies, and mitigate the impact of future disasters.

Many schools across the globe have closed, which reduces access to quality education and exacerbates vulnerabilities that existed prior to the COVID-19 crisis. Girls, particularly those in displaced settings, will be acutely affected. Even where schools remain open, there is a risk of increasing dropout rates among girls as domestic and caring responsibilities grow. As families face economic strains as a result of COVID-19, negative coping mechanisms including CEFM and child labour risk further dropouts. When schools do eventually reopen, some children and young people, including married and pregnant girls and young women, will find it difficult to return.

The overt focus on COVID-19 as a health crisis is eroding the protective structures of education systems and is putting children's wellbeing, development and learning at risk. Schools keep children safe from hostile environments and protected from risks including adolescent pregnancy, gender-based violence, trafficking, transactional sex, exploitation and recruitment into armed groups. They are also a space to disseminate life-saving messages and teach children the skills they need to thrive. The impact on learning outcomes is yet to be determined

but the crisis will likely set many children back, particularly if access to alternative learning opportunities is not supported. Critical services such as the provision of social protection, school meals and deworming programmes often stop when learning facilities close. Unless alternative mechanisms are put in place to reach children in their homes, lives will be lost.

Gender

Pandemics exacerbate existing gender inequalities and vulnerabilities. Lessons from the Ebola outbreak response as well as reporting from the COVID-19 outbreaks in China and Europe underline the myriad impacts on women, girls and excluded groups like children with disabilities.

The implications of quarantine or home isolation can increase tensions in the home which may in turn increase the likelihood of intimate partner violence, Child Early and Forced Marriage, or violence directed towards children. At a time when protection, justice and health services are critical, these may be curtailed as resources are diverted or shut down to support the COVID-19 response. In some contexts, where state powers of surveillance and/or military presence is increased as a result of forced isolation, this may lead to abuses of power, increased threats of SGBV, and fear and trauma for those in conflict and post-conflict settings.

Women and girls will face further pressures as the need increases for households to maintain hygiene and preventive measures against COVID-19. Given the gendered distribution of labour, roles and responsibilities in sourcing water for hygiene and sanitation, women and girls will face greater demand and walk further distances to fetch water, thereby putting them at heightened risks related to protection, SGBV, as well as exposure to COVID-19.

The burden of work is expected to increase disproportionately for women and girls in households due to their gendered role as primary caregivers for children, the sick and the elderly. This will exacerbate their time poverty to access information or services, exposing them to the virus and leading to fatigue that can heighten their susceptibility to the virus. This is likely to increase even further as schools and childcare services close indefinitely and as family members fall ill. Women in essential services face further time poverty as the care burden remains the same.

Access to healthcare, already limited for girls and women because of inadequate staffing and lack of knowledge on adolescent and gender friendly approaches, are likely to worsen through this crisis. Furthermore, critical SRHR services may be reduced as resources are diverted, placing women and girls at risk of unwanted pregnancies or other health risks.

In the COVID-19 situation, the prevailing inequitable distribution of household resources such as food and nutrition, lower access to supplies, decreased household incomes and increased workloads will all combine to further erode women’s and girls’ nutrition.

As quarantine regimes hamper economic activities for both women and men, the impact on women’s economic status will likely be more negative due to the higher proportion of women in informal and precarious work or self-employment with little recourse to social protection measures. During the Ebola outbreak, social and economic impacts disproportionately affected women, because of various overlapping socio-economic vulnerabilities and pre-existing gender inequalities. Self-employment was the most important source of livelihoods for female-headed

households. The breakdown of small businesses due to the Ebola crisis meant that many women lost an important source of income. Additionally, the loss of cross-border trade had serious impacts on women's livelihoods. With many governments imposing border closures and movement restrictions, the COVID-19 pandemic is likely to have very similar consequences for women's livelihoods. The economic impact of this crisis on many families may put pressure on caregivers to get children working, potentially leading to risks of sexual exploitation and an increase in CEFM and child labour.

For those girls and children from excluded groups who can access education, the closure of schools and other educational settings in response to the COVID-19 pandemic will present a further barrier to learning, depriving them of a protective environment and a source of life-saving information and psychosocial support. Where school feeding is disrupted, their nutrition may also be affected as preferential feeding patterns in resource-scarce contexts have shown that malnutrition rates are higher among girls.

As dropout rates rise following school closures, many girls may never return to school, further entrenching gender gaps in education, increasing the likelihood of child marriage and exploitation, and undermining girls' longer-term opportunities. This is particularly true for girls who become pregnant or get married during the period of school closures.

While the disease-related stigma will be high for everyone in communities, women and girls, due to gender norms and values are likely to face greater stigma within households and communities, as has been seen in other outbreaks globally.

Finally, globally some 70 per cent of community and health facility-based frontline health workers are women. With dwindling supplies of personal protective equipment (PPE) and inadequate protective training for health workers, the likelihood of women being impacted most adversely by the virus is high.

5. GENDER AND INCLUSION

Gender equality will be core to all of Plan International's work, reflecting that emergencies normally have a disproportionate negative impact on women, girls and children from especially vulnerable groups (e.g. children with disabilities, those from ethnic minorities). Country Offices must make use of any pre-existing gender analysis and any menstrual hygiene management (MHM) assessments for their context to embed gender awareness into their messaging and approach on community engagement. Lessons from Ebola as well as reporting from the Chinese and European COVID-19 outbreaks indicate that quarantine and lockdown measures will likely increase the risk of SGBV incidences towards women and girls. Additionally, women and girls will shoulder a disproportionate increase in their burden of work as families struggle with prevention and care in the home. Ensuring access to health, SRHR and community support services will be critical for women during the virus outbreak and must be considered in programme adaptation.

Key points for a gender aware response include:
Conduct a regularly updated, multisectoral rapid gender and inclusion analysis using primary and secondary data in order to understand the specific impact of the crisis on girls, boys, women and men, and vulnerable groups. Use this to inform and integrate these considerations into response plans. Make sure you identify and understand the specific gender norms (e.g. around household responsibilities, the value of girls and women) when developing your interventions to ensure that they are not increasing gender inequality and exclusion.

- Collect and analyse sex-, age- and disability-disaggregated data.
- Include targeted gender and inclusion indicators in sectoral assessments to ensure gender aware programming and advocacy during the crisis.
- Use the Inter-Agency Standing Committee (IASC) Gender Marker to assess and improve the quality of COVID-19 preparedness and response plans during design *and* implementation phases.
- Analyse and respond to the specific protection-related risks that COVID-19 can pose for children, especially girls and young women and other vulnerable groups (particularly on SGBV-related aspects), to be able to identify and refer children as well as set up safeguarding measures to protect those at risk. Make sure you keep in touch (online, via social media, phone, radio) with children and young people to collect their voices and direct them to helplines and referral mechanisms when necessary.
- Meaningfully engage with youth groups and organisations, including local girls' groups, women's organisations, organisations for those living with disability, on their specific needs, support structures and their ideas on response strategies using safe and appropriate methods. Use this data to inform needs assessments, response plans and implementation, and community engagement.
- Consider different methods of communication in order to overcome language divides and literacy levels, the gender digital divide and access to radio and internet etc.

- Ensure that the response teams are gender balanced and appoint or hire a gender adviser or gender focal point to cover this response. It is also important to consider how the needs and voices of other vulnerable or excluded groups are taken into account by the response teams.

- Track effects of this pandemic on girls and women (involve girls, women and other vulnerable groups in M&E and feedback mechanisms) and share lessons learned.

- Consider activities that redistribute equally unpaid care and household responsibilities that predominantly fall on women and girls by encouraging boys and men to contribute to reducing the gender divide burden.

- Consider existing projects like Girls Out Loud, Champions of Change and others that can be adapted to specific contexts.

6. PLANNED RESPONSE

5.1 Overall response goal

To contribute to the prevention of the transmission of COVID-19 and reduce the social impact within the most vulnerable communities, particularly in refugee camps, displaced settings, urban slums and sponsorship communities across Plan International programme countries. We will work to ensure that we reduce the social impact on the status of women and girls who are normally disproportionately affected by crises.

5.2 Strategic objectives

SO1: Adapt and extend existing programmes and humanitarian responses to support communities to adopt adequate COVID-19 prevention and mitigation activities, ensuring that negative social impacts and coping mechanisms within vulnerable communities are addressed.

SO2: Address specific negative issues affecting girls during the COVID-19 crisis, using windows of opportunity to advance gender equality and girls' rights.

SO3: Prioritise the protection and assistance of high-risk communities, particularly those vulnerable to rapid transmission of COVID-19 within our current portfolio including ongoing emergency responses and fragile settings such as refugee/displacement camps.

Priority intervention pillars

1) Health
2) WASH
3) Education
4) Child Protection
5) Community Engagement and Accountability

Priority cross-cutting pillars

1) Gender
2) Advocacy and influencing

To integrate the above priority intervention pillars, Country Offices should build on their existing thematic priorities within current programme areas as well as prioritise ongoing emergency response locations. Influencing and coordination with key sectoral government ministries in-country is critical to contribute to government and stakeholder efforts in prevention, control, response and recovery in a country.

Preparedness and contingency programme planning to integrate the priority intervention pillars across all ongoing projects needs to take place in all Country Offices. This will ensure rapid adaptations can be implemented should an outbreak occur in the country. The Business Continuity Plans (BCPs) completed by Country Offices are part of contingency planning in which mapping out programme-specific continuity is critical. Plan International should position itself as a partner of choice for local and national governments where possible to support national response strategies and to influence the adoption of gender aware approaches that address

specific vulnerabilities faced by women and girls. Safeguarding, protection against sexual exploitation and abuse (PSEA), and gender aware activities will be core to all programme activities in recognition of the potential increased risk to vulnerable individuals.

5.3 Geographical area of implementation

We will continue to operate in current programme countries. A priority focus and support will be provided to countries where we are working with highly vulnerable communities, such as refugee and displacement settings, sponsorship communities and urban settings.

Country Offices will identify priority target areas and beneficiaries based on criteria in areas where:

1) Plan International is implementing programmes that have the greatest potential to support prevention, control and response, and which can most readily be used as an entry point for community engagement and accountability (with a focus on WASH, health, child protection and education);

2) the capacities of health services are fragile: in such cases COs should prioritise activities for prevention in areas where health systems have very limited capacities to respond;

3) there are gaps in COVID-19 prevention and response activities by other actors; COs may want to prioritise locations where few other actors are supporting local authorities, as part of a coordinated interagency approach to prevention and response.

5.4 Operational modality

Plan International will work through a variety of modalities dependant on the structure of each Country Office's operation. We will work with partners such as youth groups and women's organisations, local and national government structures, UN agencies, national and international NGOs. In some circumstances we may need to implement a programme directly. We will work to ensure girls and boys have a voice in the design, implementation and monitoring of response activities. A core focus of our work will be on advocacy and influencing.

We will work to move away from the distribution of items wherever feasible to use instead cash and voucher modalities where the local markets are functioning effectively.

Recognising that many Country Offices are currently working remotely from home, we will need to explore how to continue operations and programmes based on the country context. Further work at the global level is being done on this to take into account varying operational contexts and to support Country Offices to work through this. Country Offices must ensure the adoption of humanitarian principles and the need to respond to humanitarian imperatives, based on need as part of our dual mandate as an organisation, in order to maintain and scale up life-saving services.

In-depth plans for Priority Intervention Pillars are in Annex 1.

7. ANNEX – PRIORITY INTERVENTIONS

This table describes suggested key activities for each of the Priority Intervention Pillars (WASH, Health, Education, Child Protection, Community Engagement and Accountability). Country Offices can use the information below to select activities that are best suited for the phase in which the country is currently in. A description of each phase is provided at the top of the table, under “Scenario”. These activities can be used in humanitarian response or in development settings to response to COVID-19.

	PREPAREDNESS (PREVENTION AND CONTAINMENT)	INITIAL RESPONSE (DELAY OF TRANSMISSION)	MITIGATION RESPONSE	RECOVERY
SCENARIO	No or few confirmed cases in-country and no community transmission. Normal public life minimally affected as governments focus on early detection, isolation and care of people already infected with tracing and screening of contacts. No general restrictions on mobility and no school closures.	Confirmed cases of community transmission in some parts of the country. Government institutes measures to slow the spread of the virus and the number of cases, to give time for the health service to prepare. Social distancing strategies and prohibitions on large gatherings. School closures Health services begin to reduce access to non-critical care.	Widespread, sustained community transmission: high levels of the population infected. High illness and potentially high death rates in some population groups. Parts or all of the population is under lockdown. Strict restrictions of movement between different parts of country. Widespread closure of schools, markets, transport systems, and reduced flow of goods. All but essential services and businesses closed. Lack of available essential food, water and supplies.	Decrease in community transmission. Government restrictions lifted or eased. Schools and public spaces begin to re-open. Access to camps re-opened and movement between different parts of the country possible. Markets re-open, essential goods more widely available. Likelihood of movement into another wave of COVID-19 infections, return to (initial) response phase.

			Healthcare system unable to meet demand: collapse of system possible. Public health and other critical service workforce reduced due to illness and fatigue. Disproportionate impact on the marginalised and deprived. Looting and a general breakdown of social order possible.	
CROSS-CUTTING, GENERAL INTERVENTIONS	Conduct a multisectoral gender analysis to identify the potential impact of the crisis on girls, boys, women and men, and to inform priorities for the response. As part of this, assess the protection risks of girls, boys, women and men (in particular to SGBV) in the event of an outbreak and lockdown. Ensure that when planning interventions, measures to safeguard the health and wellbeing of PII and partner staff are prioritised. Identify gender capacity gaps in response team and address them (including assigning a gender focal point to the response). Assess the protection risks of girls, boys, women and men (as well as people with disabilities and other vulnerable groups), regarding e.g. exposure of girls and women to SGBV, PSEA including in camps, in managing menstrual hygiene wastes when facilities are far from houses, the risks that boys and men face when they engage in equal gender	**As for preparedness, and:** • adapt any ongoing programmes immediately in order to ensure that risk of transmission is reduced to a minimum during programme activities; • incorporate risk communication and community engagement activities; • focus on preparing adolescents/youth, parents/caregivers and families, schools, health services and communities for the institution of social distancing measures and disruption of essential services; • consider the potential gender specific vulnerabilities of girls and women if the situation worsens, and what could be done to address these. Ensure that potentially infected staff are supported to take appropriate measures; • facilitate the safe and meaningful participation of girls and women in	Support the continuation of life-saving and life-sustaining measures and services in strict accordance with government/ MoH protocols. Institute distance approaches promoting the ongoing learning, psychosocial wellbeing and protection of children and adolescents, as well as support for parents/caregivers. Support community actions to mitigate the impact of the pandemic on community members/families. Maintain contacts with members of children's, girls' and adolescent/youth groups that we have worked with, to make sure they are safe and can report incidences of any forms of violence. Support children, adolescent and youth – especially girls and those from excluded/ vulnerable groups – to have their voices heard, and engage in	Resume all programme activities, adjusting these where relevant to prepare for a possible second wave of infections. Expand investments to support the livelihoods of youth (particularly young women), families and communities. Analyse where the biggest needs are for children, adolescents and youth (CAY), their families and communities; and identify differences in needs for different groups of CAY. Support safe returns to school, ensuring equal opportunities for girls and boys. Continue to support interventions for the mental health and wellbeing of children and their caregivers. Conduct research on the impact of COVID-19 on girls and women.

	roles with girls and women in care work, etc. Commence risk communication and community engagement activities. As part of this, work with leaders and existing groups to mobilise and form community support groups for the response, supporting the meaningful participation and representation of girls and women in these. Commence preparedness activities with adolescents/youth, parents/caregivers and families, schools, health services and communities. Consult with girls' groups, women's organisations, youth groups and fathers' groups with whom we are already working to identify how they wish to support their community's response and engage in advocacy to influence the government response – and the supports they will need to do this. Ensure that respiratory and hand hygiene measures are modelled and supported in all ongoing programmes. Assess risks linked with cash and voucher assistance (CVA) programming in case the modality will be used. Include gender indicators in sectoral assessments to ensure gender aware programming and advocacy during crisis. Use IASC Gender Marker to assess and improve the quality of COVID-19 preparedness and response plans.	programme activities and decision-making. Prepare programmes, staff and partners for large-scale disruption to come, and where feasible/appropriate, switch to distance modalities once quarantine and restrictions on movement are imposed. Work with the communities to ensure that at-risk groups are not stigmatised and excluded. Obtain parental consent to continue contact (for instance, by phone) with members of children's, girls' and adolescent groups with whom we are already working in the event of a lockdown. Collect at least sex-, age- and disability-disaggregated data. Use IASC Gender Marker and/or Plan International's institutional gender marker to assess and improve the quality of COVID-19 preparedness and response plans (Plan International's marker is for projects longer than six months). Ensure that all data collected is disaggregated by sex, age and disability during analysis.	producing messaging that reflects their experiences. Ensure that all data collected is disaggregated by sex, age and disability during analysis. Document lessons learned to inform ongoing and future preparedness and response activities.	

	Consult with youth groups and organisations, including local girls' groups and women's organisations on their specific needs, discuss their ideas on response strategies and continuation of their collective organising and advocacy within crisis support structures, as well as with existing initiatives for boys and male engagement (e.g. working on GBV and care work with boys and men).			
INTERVENTION PILLARS				
WASH	Participate in COVID-19 related WASH Cluster meetings and/or local WASH sector Technical Working Group meetings to inform multi-level, gender aware responses. Update/revise existing hygiene promotion messages and materials to incorporate information that is: COVID-19 specific, gender aware, age- and disability-appropriate, contextually adapted and universally inclusive (messaging to be in line with WHO/and local authority messages). Modify hygiene and sanitation promotion methodologies and activities to minimise transmission risk of COVID-19, including possible adaptations for also supporting people with disabilities. Train staff and partners on basic facts about COVID-19 including symptoms, modes of transmission, mitigation	**As for preparedness, and:** Intensify engagement with national WASH Clusters and other in-country key sectoral platforms, to ensure good coordination with other actors. Provide/offer technical support to WASH Cluster relevant government ministries for gender aware WASH service delivery. Continue and intensify hygiene promotion campaigns in communities, and public spaces, avoiding large gatherings and using alternative approaches e.g. digital platform and public announcements from vehicles. Engage community and traditional leaders, health workers, parenting groups, youth groups, women's and girls' groups, to help disseminate key	Support/address requests from national/provincial/district government for water, sanitation and hygiene promotion materials. Continue mass/multimedia COVID-19 Awareness and Handwashing Campaign; incorporate wider safe WASH promotion in campaigns including drawing attention to the impact of lockdown on girls e.g. MHM. Provide messaging targeted at women, girls on MHM. Provide remote support, training/refresher training and advice for staff, partners and WASH/Health/Education personnel engaged in public health and hygiene promotional work.	Ensure schools, health facilities and public spaces within Plan International operational areas have an adequate and reliable supply of water and age-appropriate handwashing facilities with soap prior to re-opening. Call on government to ensure infrastructure for piped water or boreholes are in place and issues of unclean water are resolved to ensure access for all, especially the poorest communities. Recommence hygiene promotion in schools and re-establish school WASH/Health Clubs. Continue mass/multimedia COVID-19 Awareness and Handwashing Campaign to reinforce messages.

	strategies, referral pathways, and combating myths. Commence COVID-19 risk communication and awareness-raising in communities, including modes of transmission, and prevention and control measures (appropriate hygiene practices, social distancing, especially at water points, markets and other public spaces etc.) Continue wider safe WASH promotion e.g. collection of drinking water from safe sources, water source safety, household water storage safety, safe sanitation, and safe management of wastewater and faecal waste. Work with technical teams to identify community-based groups already being engaged in Plan International's activities and quickly equip/train them to be community mobilisers and be involved in the management and maintenance of hygiene facilities where appropriate. Develop and test gender sensitive ICT-based Social and Behavioural Change Communication messaging campaign materials and channels (e.g. through community radio, social media influencers, text messaging). Promote and demonstrate regular handwashing and positive hygiene behaviours at home, in schools, healthcare facilities, work places, places of worship and other public places e.g. markets, transport hubs. Procure and pre-position handwashing kits/equipment, locally available household water treatment devices,	COVID-19/hygiene promotion messages. Intensify mass/multi-media COVID-19 Awareness and Handwashing Campaign coordinated with government partners where possible. Integrate messaging on the protection risks for children (particularly girls) and women when they are collecting water, where relevant. Develop joint messaging/ advocacy papers on required WASH actions for COVID-19 and for longer-term WASH services, with a focus on the specific needs of girls, including for MHM, children and reaching the most vulnerable. Call on government to ensure infrastructure for piped water or boreholes is in place and issues of unclean water are resolved to ensure access for all, especially the poorest communities. Conduct a rapid assessment of WASH infrastructure status in communities, health facilities, schools, public spaces within Plan International operational areas, paying attention to age- and gender appropriateness. Repair/install water supply, handwashing facilities and sex-segregated sanitation facilities at priority schools, health facilities, communities and public spaces in consultation with community members, including women and girls. Train local community groups in the management and maintenance of the facilities where appropriate. Consider protection risks for children, particularly girls and women, when installing water	Monitor and counter WASH-related misinformation and rumours about COVID-19 transmission, prevention and treatment. Continue engagement with national WASH Clusters and other in-country key sectoral platforms, as well as the provision of technical support as required. Support remote youth advocacy activities with a focus on the specific WASH needs of girls, children, on reaching the most vulnerable, and on priority WASH actions for the mitigation phase. Use project MIS to contribute sex-, age- and disability-disaggregated information to national WASH response monitoring systems. Ensure continued dialogue with the local WASH committees through established communication channels and provide (remote) support to continue work and address identified challenges. Promote the role of men in sharing unpaid care work (household and WASH chores such as water collection). Track and collect data disaggregated by sex, age and disability and other exclusion criteria.	Recommence COVID-19 awareness-raising in communities (where permitted) to reinforce messages. Recommence wider safe WASH promotion e.g. collection of drinking water from safe sources, water source safety, household water storage safety, safe sanitation and safe management of wastewater and faecal waste. Incorporate soap and menstrual hygiene material production in WASH programmes. Provide support to MOH/WASH sector lead agency in gender responsive and inclusive emergency planning and preparedness. Advocate to donors and government partners to prioritise investment in sustainable, gender responsive and socially inclusive water, sanitation infrastructure and hygiene promotion programmes in the long term. Stocktake pre-positioned handwashing kits/equipment, MHM supplies, child-friendly and gender sensitive IEC COVID-19 materials, water treatment equipment for WASH frontline workers, and procure replacement stocks as required.

	MHM supplies, child-friendly and gender sensitive Information, Education and Communication (IEC) COVID-19 materials for WASH frontline workers. Procure additional contingency stocks. Lobby the private sector to come in and support with supplies as part of their corporate social responsibility. Promote prevention and control measures across all working locations. In collaboration with Education and ECD colleagues, design a WASH e-curriculum for children to reinforce healthy behaviours. Advocate for child-friendly and gender sensitive handwashing stations in locations that children are likely to visit and ensure health facilities are child-friendly and gender responsive.	collection points and setting up water distribution activities. Prepare alternative (remote) programme modalities including online training for WASH staff and partners. Community distribution of soap, other hand hygiene-related materials and water treatment materials; ensure women are included as recipients and in the distribution process. Distribute MHM supplies accompanied with sensitisation and age-appropriate information for adolescent girls. Where feasible conduct training on local soap and menstrual hygiene material production. Regulate and timetable water distributions to avoid large crowds. Set up and train local communities (e.g. WASH/COVID-19 committees) to support the implementation of all WASH activities. If possible, use already organised and mobilised groups and CSOs. Promote gender parity for all groups, regardless of whether they are new or existing. Establish a communication stream/ system between the WASH committees and the responsible Plan International office / partner for ensuring continuous support. Where possible train local communities in making their own simple handwashing devices with locally accessible materials.		

HEALTH	**Adapt ongoing health programmes to prepare health services to prevent, control and respond to COVID-19 while ensuring continuity of essential life-saving MNCHN, SRH, HIV, TB, malaria and GBV response services in line with Ministry of Health objectives.** Participate in coordination meetings with health authorities and other actors, lobbying to ensure that the particular needs of urban and rural poor are considered in the health sector response to COVID-19 and for the continuity of essential services (as above) in the event of an outbreak. Support local health authorities with mapping health service capacity and with gender aware emergency planning and preparedness. Support health services to prepare to prevent, control and manage COVID-19: • Train healthcare workers (onsite coaching) in infection prevention and control – focusing on primary level and community health workers (CHWs). • Train healthcare workers on how to recognise and handle disclosures of GBV and the abuse of older people and the referral pathway. Train CHWs in case detection, referral and contact tracing. • Ensure all health staff/CHWs are trained and updated on key messages for risk communication.	**As for preparedness, and:** Pre-position COVID-19 supplies for health facilities (including for health workers, reception and cleaning staff) and with CHWs. Ensure all CHWs are equipped with phones, and set up emergency communications tree if this does not already exist. Support CHWs to conduct risk communication and community engagement activities (see below) and to guide families on what measures should be taken should a family member fall ill. Work with other sectors to plan how to meet the needs of female healthcare workers who will make up the majority of COVID-19 responders (family support, MHM) including clear measures to prevent and mitigate harassment, abuse or other forms of GBV. Work with other sectors to develop strategies to help mitigate psychosocial effects for all healthcare workers (men and women) and potential stigmatisation. Work with health authorities, CHWs and committees to set up services to accompany sick patients who may be self-quarantining. Support health facilities to set up separate areas for non-COVID patients in which emergency, life-saving health services can be conducted (including	Facilitate continued provision of COVID-19 supplies, as well as essential medicines and contraceptives to health facilities. Facilitate continued provision of COVID-19 supplies and drugs/supplies for essential MNCHN/SRH/TB/malaria/HIV care to CHWs. Work with other sectors to meet the needs of female healthcare workers who will make up the majority of COVID-19 responders (family support, MHM, protection from GBV). Link with Child Protection to offer psychosocial support (PSS) for all healthcare workers (female and male) where this is not offered by the Ministry of Health. (Where appropriate) connect with CHW networks regularly to encourage sharing/learning, assess ongoing needs, provide support. Document lessons learned to inform ongoing and future preparedness and response activities.	Support local health authorities to prepare for a second wave, including: • conduct an operational review to inform future response activities; • staff training to address skills deficits; • strengthening supply chains. Support CHWs and health facilities to continue case surveillance and contact tracing.

	• Support the provision of safe water, hygiene supplies and handwashing facilities in health facilities. • Print and distribute job aids including triage, case management and referral forms. Explore possible suppliers of PPE for health workers, including CHWs (including through global procurement). Support health and local/traditional authorities with efforts that contribute to community engagement and risk communication, especially through local radio networks, and digital/social media (see Community Engagement and Accountability below). Prepare for the continuity of essential services: • Prepare for task-shifting: train CHWs, auxiliary nurses, pharmacists, to provide essential MNCHN services, SRH services (post-abortion, STI treatment, clinical management of rape, modern contraception), HIV/TB/malaria care. • Train healthcare workers to recognise and handle disclosures of GBV and the referral pathways and on psychological first aid and PSS (see Child Protection below).	safe delivery, management of children with danger signs of severe illness). Support and train Community Health Committees on COVID-19 response and guidance on safe operation ensuring the quality and continuity of essential health care services. Pre-position essential MNCHN, SRH, TB/malaria drugs and supplies with CHWs /pharmacists. Where permitted, distribute clean and safe delivery kits to pregnant women, ensuring CHWs are trained in use. In collaboration with MoH prepare and support CHWs to adapt their routine community-level health promotion/disease prevention activities to ensure adequate IPC measures are taken during these activities. Provide on-the-job support to CHWs, auxiliary nurses as they begin to take over essential service provision (for instance, integrated case management of childhood illness). Identify and curate existing resources (radio programme recordings, flyers, SMS messages, [videos]) that can be used for ongoing awareness-raising around key family practices for MNCHN in the event of a lockdown. These should emphasise the importance of equal care and nutrition for girls and boys and of supporting the health and wellbeing of women, particularly when pregnant and lactating.		

	• Where relevant, support MoH in adapting/revising procurement plan and distribution of health programme supplies such as TB medicines, HIV supplies. • Collaborate with health actors to adapt existing assessment and monitoring tools to include child protection concerns, such as separation, psychosocial distress, etc. All of the above must be conducted only where Plan International is already implementing health projects in these areas, in strict alignment with MoH and WHO protocols, and ensuring all necessary measures are in place to prevent the continued spread of COVID-19 through our activities.	Support and train Community Health Committees on COVID-19 response and guidance on safe operation ensuring the quality and continuity of essential healthcare services. Work with other sectors to plan how to meet the needs of female healthcare workers (family support, MHM, protection from GBV) who will make up the majority of COVID-19 responders. Collaborate with health actors to adapt existing assessment and monitoring tools to include child protection concerns, such as separation, psychosocial distress, etc. Expand on SRHR education and services to contribute to the prevention of sexual violence and unwanted pregnancies. Ensure all data collected is sex-, age-, and disability-disaggregated and includes pregnancy status.		
FOOD AND NUTRITION	Seek additional funding to adapt and strengthen existing Food and Nutrition Security in Emergencies (FNSiE) interventions: Engage community members – including leaders, mothers, fathers – in planning how to adapt ongoing FNS interventions and support the most vulnerable individuals in case of an outbreak (see Community Engagement and Accountability below). Train, prepare and equip facilitators and staff of FNS interventions to integrate COVID-19 prevention and response	**As for preparedness, and:** Reduce the frequency of follow-up visits at nutrition facilities as well as of food distributions. Adapt the routine at nutrition facilities and distribution sites to minimise the risk of virus transmission: implement social distancing measures, screen beneficiaries for fever, ensure all people entering the site wash their hands. Suspend any planned nutrition assessments (e.g. mass MUAC	Facilitate and continue life-saving food security and nutrition programming, ensuring robust adherence to measures to minimise risk of transmission (as described in initial response). Adapt working routine through: • delivery of food to isolated communities; • communication with patients via phone, through project management committee or community leaders;	As social distancing measures are relaxed, support communities and FNS staff to prepare for a second wave, including, potentially: • conduct an operational review to inform future response activities; • staff training to address skills deficits; • strengthening of supply chains.

	activities into work with parents/caregivers including: how to prevent transmission; how to identify cases, and what families should do if a member falls ill. Prepare FNS facilitators/staff to give guidance on breastfeeding (in particular to breastfeeding adolescents and women who are confirmed to have COVID-19 or are under investigation) and to emphasise the importance of adequate nutritious food for young girls and boys, adolescent girls and pregnant and lactating women in the event of food shortages. Commence preparedness measures at nutrition treatment facilities/ distribution points. Pre-position and organise ratios of nutrition supplies and food rations at individual distribution sites. Reduce follow-up meetings and give double rations, ensure that female-headed households and families of children with disability are prioritised. Regulate and timetable distributions in order to manage the flow of traffic at the distribution site and avoid crowding. Install handwashing facilities at food distribution sites if not available yet. If MoH permits, support the continuity of essential services for the management of acute malnutrition by preparing for task-shifting: train CHWs in the	screening) as well as group nutrition counselling sessions in risk areas. Support continued community outreach and active case-finding of children with acute malnutrition. Community nutrition workers (CNWs) should be provided with the same PPE as other CHWs (if possible, hand sanitiser, masks and clothes). They should be trained to address questions, concerns of community members regarding COVID-19; model hygiene and social distancing behaviours; undertake MUAC assessments, minimising the risk of virus transmission. Prepare for the commencement of nutrition counselling at a distance, using telephone, radio etc.	• share Infant and Young Child Feeding (IYCF) messaging using radio. Provide financial and material assistance (cash or NFIs) to families whose income-generating opportunities are affected by the COVID-19 outbreak (i.e. through death, isolation or quarantine measures).	Resume conducting nutrition assessments and group counselling sessions. Continue with the implementation of hygiene measures in nutrition facilities and distribution sites.

	Community Management of Acute Malnutrition. Where Plan International has been supporting school-feeding programmes, engage with education authorities and the donor (usually WFP) to identify alternative food distribution measures in the event of school closures. Collaborate with CVA experts and partners to conduct a market analysis to ascertain whether a change from food distributions to cash/voucher distributions is a feasible option.			
CHILD PROTECTION	Conduct gender and protection risk analysis/audit – especially on GBV and sexual violence (including potential risks for girls and women in confinement, risk linked with MHM in camps, etc.). Analyse how the crisis will increase the protection risks for excluded and vulnerable groups (e.g. children with disabilities). Conduct community risk assessment and safety planning inclusive of community-based safe house arrangements for GBV survivors and their children, or safe alternative care arrangements (i.e. kinship care) for children separated from their parents/caregivers in quarantine or treatment centres. Develop COVID-19 child-friendly messages on protection risks and	Revise or develop age- and gender responsive SOPs and referral pathways with the health sector and other relevant actors to ensure children at risk of violence and women facing GBV as a result of the COVID-19 outbreak are identified (i.e. hospitals, health centres) and are referred to appropriate services amid the service provisions restrictions that may come as health systems become overwhelmed (see Health above). Work with service providers in COVID-19 affected areas to map available GBV response services. Identify and fill gaps in service provision to strengthen provision of local survivor-centred referral systems and services during crisis. Conduct and incorporate alternative PSS activities for all CAY (isolated for prevention measures; infected with COVID-19 in treatment centres or at home; in quarantine at home). This	Provide remote parenting sessions to families, parents and caregivers to support their children equitably, be responsive to age and gender needs emotionally and engage in appropriate self-care (see Education below). Provide online psychological support (e.g. through helplines, social media groups, online platforms) – ensuring all CAY have access to this support. Lobby for cash transfers to vulnerable families, particularly female-headed households affected by COVID-19 to improve health, protection and wellbeing. Work with Child Protection services to strengthen child-sensitive and gender responsive reporting mechanisms and referral pathways and to provide timely and effective gender responsive services and assistance for most vulnerable children (i.e. children without family care;	Advocate for social protection schemes supporting most vulnerable households, families and children, especially girls affected by COVID-19. Build capacity of child protection services and strengthen systems to support recovery and protection of children. Implement community-based psychosocial support recovery activities. Support consultation with children and lead documentation and dissemination of lessons learnt and good practices for the protection of children. Conduct community awareness/ mobilisation efforts to counter stigmatisation of individuals.

	conduct age- and gender appropriate awareness-raising activities. Incorporate messaging on the impact of pre-existing protection issues on girls and other excluded groups of children into COVID-19 communications. Develop campaigns and awareness-raising activities to address the risks of domestic violence and GBV, as well as related issues as early/forced pregnancy, CEFM, FGM/C, exploitation, online abuse which may have been pre-existing in the communities. Analyse existing referral systems, whether these will still work under lockdown situations; propose adaptations where necessary and special measures to support children's psychosocial wellbeing when under-going treatment. Sensitise and orient health workers, teachers and other professionals on existing and expected child protection and GBV risks, child-friendly and gender sensitive communication, child safeguarding, child protection concerns and safe referral practices. Conduct a mapping of existing girls' groups and women's empowerment initiatives and strategise on how to ensure the continuity of their work/ support to girls on gender-based violence. Coordinate with Protection partners and women's community groups/organisations to prepare for an increase in need for GBV, including	could include remote, home-based, peer-to-peer and one-on-one care using IEC materials, TV, social media, internet, radio or distance learning platforms. Consider the specific needs of excluded groups like children with disabilities. Keep in touch (online, social media, phone, radio) with the children and youth to collect their voices and direct them to helplines and referral mechanisms. Train Child Protection staff and CBCPMs, on protection-related risks that COVID-19 can pose for children, girls and young women (particularly on GBV-related aspects), so that they can identify and refer children as well as set up safeguarding measures to protect CAY at risk. Train health sector and humanitarian actors identified to provide MHPSS on IASC MHPSS Guidelines and CPMS Standard 10 on Mental Health and Psychosocial distress, family separation prevention and identification and referrals for children. Identify and quickly train frontline responders and community champions that handle disclosures of GBV and refer survivors in order to maintain and strengthen referral pathways when access to service centres becomes restricted. Ensure that they are familiar with minimum standards and national guidelines as relevant. Establish alternative mechanisms to ensure that communities facing restrictions on movement have continued access to child-friendly,	children who are refugees, internally displaced, migrant or stateless children; children living and/or working on the street; children with disabilities; etc.). Place CP staff in health centres or key facilities to identify and better protect most vulnerable children including UASC and support safe alternative care options. Support deployment of mobile and/or remote (online) GBV and SRHR services to hot spots as a short-term rapid response measure to provide information, psychosocial support, supplies and crisis support. This can be done as a stop-gap measure where access to services is restricted for a time or alongside mobile response measures. Advocate for GBV helplines and safe shelters to be classified as essential services; and support them to stay open and provide remote support and temporary shelter to women and girls who may be experiencing GBV. Support continuation of reporting hotlines and safe shelters, including local community shelters, for GBV survivors and their children or children separated from their parents in quarantine. Collect data disaggregated by sex, age and disability and other exclusion criteria to inform your activities.	Call on government to strengthen child protection and GBV response services. Analyse the data collected to understand the specific challenges different groups of CAY faced during the crisis and develop strategies to mitigate these in a possible new wave of the pandemic.

	intimate partner violence (IPV) and child marriage response. Ensure all staff are trained on Plan International's Safeguarding Children and Young People Policy, and PSEA. Analyse existing referral systems whether these will still work under lockdown situations, and propose adaptations where necessary. Closely monitor GBV trends and ensure integration of GBV risk mitigation actions, as outlined in the IASC GBV Guidelines, across sectoral interventions related to COVID-19. All staff and volunteers must be briefed on and sign institutional codes of conduct and PSEA obligations. PSEA reporting mechanisms for the local context must be understood and followed by all staff. Disaggregate data by sex, age and disability and other exclusion criteria to understand the specific challenges that CAY might face during the crisis.	holistic care for children experiencing violence, including child survivors. Collect data disaggregated by sex, age and disability and other exclusion criteria and based on that, identify the CAY most at risk so that you can develop mitigation strategies to protect them.		
EDUCATION (including ECD – parenting and early learning programmes)	**EDUCATION (inc. early learning):** Work with relevant sectors, authorities and community education committees (including School Management Committees and Parent–Teacher Associations) to develop gender responsive school emergency preparedness and contingency plans; work with the protection sector to take preventive measures to ensure that if schools are suspended that this does not expose children, girls in particular, to	**EDUCATION (inc. early learning):** Collect and analyse with a gender lens, education-relevant data disaggregated by sex, age and disability and other exclusion criteria to understand the most at risk groups in terms of access to education. Ensure key contacts within schools and community education committees (including School Management Committees and Parent–Teacher	**EDUCATION (inc. early learning):** Continue to collect education-relevant data disaggregated by sex, age and disability and other exclusion criteria. Support provision of relevant and flexible distance learning opportunities including radio, TV, online and paper-based methodologies; integrate key health and hygiene education messages, socio-emotional learning and PSS; and ensure content addresses the education	**EDUCATION (inc. early learning):** Coordinate with education cluster and authorities to organise "Back to School" campaigns; follow up on girls' access to education and ensure that girls and other excluded groups are going back to school. Mobilise communities, including women's groups/network, around Back to School messages. Ensure that

	protection risks (i.e. early, forced marriage, sexual exploitation and abuse, child labour etc.). Support continuation of critical services (such as school feeding programmes) that support vulnerable groups, including girls and children with disabilities. Analyse existing referral systems to determine whether these will still work under lockdown situations, and propose adaptations where necessary. Sensitise and orient community education committees and community leaders on the prevention and control of COVID-19 in schools/learning centres and avoiding stigmatisation of those exposed to the virus and who are unwell. Address issues such as the increased risk of GBV and sexual exploitation and abuse in the event of school closures and lockdowns. Support community education committees to develop risk communication and community engagement (RCCE) plans, including how to respond, protect, connect and support families in the event of a local outbreak, and what they need to support the community response (see Community Engagement and Accountability below). Develop age- and gender appropriate hygiene messages that encourage good health behaviours to mitigate transmission. Train teachers on the prevention and control of COVID-19 in schools/learning centres and to avoid stigmatisation of	Associations) have working cellphones and airtime/data. Work with the education sector, authorities and community education committees to map out existing alternative learning opportunities (including distance learning through radio and online platforms); consult communities to understand impact of COVID-19 on schools, on access to education for girls and boys, and viable alternative learning opportunities considering local context and specific challenges in particular for girls and children with disabilities. Work with relevant sectors, authorities and community education committees to develop gender responsive school emergency response plans. If physical distancing measures are put in place, ensure the locations and times of school do not place girls and boys at additional risk while commuting to school. Where schools are closed, work with the protection sector to mitigate exposure to protection risks for vulnerable groups including girls and children with disabilities (i.e. early, forced marriage, sexual exploitation and abuse, etc.). Support continuation of critical services (such as school-feeding programmes) that support vulnerable groups, including children with disabilities. Support schools to prepare alternative learning methods (also in local languages so ethnic communities can access them and considering different needs of girls, boys and children with disabilities) to ensure continued learning	continuity for all children, particularly girls and children with disabilities. In coordination with the education sector and authorities support teachers' skills and knowledge on distance learning modalities including: health and hygiene education, gender, socio-emotional learning and PSS. In coordination with education authorities and stakeholders, mobilise and support teachers/other education personnel for the provision of alternative learning opportunities; ensure female teachers are mobilised and supported. Support parents' and caregivers' awareness, knowledge and skills on distance learning opportunities and COVID-19 related prevention measures and child protection risks including risks for girls and children with disabilities. Ensure the provision of WASH, including access to an adequate and reliable source of water for drinking and handwashing, provision of hygiene kits to targeted households as well as menstrual hygiene kits for adolescent girls and women – work in coordination with the WASH and Health clusters. Provide learning equipment and materials for children, particularly to support home-based learning (pens and exercise books, solar lamps, radios and other electrical devices as required). In coordination with education authorities, focus support on children, girls in particular, who are preparing to sit exams – this may include distribution of digital or paper-based materials – and	specific messages on girls' education are included. Rehabilitate/construct WASH facilities in schools ensuring they are gender-separated and accessible. Procure and distribute cleaning and hygiene kits to schools and personal hygiene kits to children, along with guidance and IEC materials about handwashing. Support community education committees to prepare for a second wave, identifying the skills and resource gaps they encountered during the first wave and working to address these. Where teachers and other education personnel have been actively involved in community response and support to families, plan activities to review and share what they have done, to celebrate and acknowledge their achievements, and provide PSS. Work through the education sector to advocate with education authorities to ensure all schools/learning centres are equipped with an adequate and reliable water supply; have a sufficient number of child-friendly handwashing facilities and child-friendly and inclusive toilets; and incorporate hygiene promotion into curriculums and daily supervised activities. Work through the education sector to advocate with education authorities for the strengthening/development of accredited accelerated education curriculums with a strong focus on gender and inclusion to ensure relevant,

	those exposed to the virus and who are unwell. Procure and distribute cleaning and hygiene kits to schools/learning centres and personal hygiene kits to children, along with guidance and IEC materials about handwashing. Work with education sector and relevant authorities to ensure relevant health education (including disease prevention and control) and hygiene promotion is included in teacher training and incorporated into subject knowledge, such as science and social studies. Work through the education sector to advocate with education authorities to ensure all schools/learning centres are equipped with an adequate and reliable water supply, have a sufficient number of child-friendly handwashing facilities and child-friendly and inclusive toilets, and incorporate hygiene promotion into curriculums and daily supervised activities. **PARENTING:** Use parenting groups as an entry point for engaging parents/caregivers, recognising their key role in the response: 1) Use parenting interventions as entry point for RCCE, including identification by community leaders on how they will respond, protect, connect and support families in the event of a local outbreak, and what they need to support the	in the event of school closure; and provide guidance to parents on use of home learning materials and online platforms, especially where coordination around national-level provision is limited. Conduct community advocacy focused on education continuity for children, particularly girls and children with disabilities, and by equally sharing household chores and duties between girls and boys to ensure all children, especially girls can participate in alternative (e.g. online) education initiatives, making sure that girls can also access computers, and the internet where available. Work in conjunction with other sectors to ensure messages are aligned. Work with relevant sectors, authorities and community education committees to support the adaption of resources to the COVID-19 crisis, ensuring content and language are inclusive; do not discriminate against women, girls and children with disabilities or perpetuate negative stereotypes; coordinate with CP, WASH and Health sectors to identify and integrate resources and messages. Consult with teachers/education personnel to understand needs in terms of wellbeing as well as professional development, and skills and knowledge required to support children appropriately, particularly through distance learning modalities. Ensure that female teachers/education personnel are engaged and consulted in order to understand their specific needs. Work through the education sector to advocate with education authorities for	support the organisation of examinations which may be online or paper-based assignments. Support provision of unconditional cash for vulnerable households including refugees, IDPs, female-headed families, with school-age children, in particular girls and children with disabilities, who are currently out of school as a result of COVID-19. Document lessons learned and good practices to inform development of contingency and DRR plans and to inform future responses. Ensure referral systems are working under lockdown situations, and propose adaptations where necessary. **PARENTING:** 1) Use the different media (including radio parenting groups, internet, SMS and WhatsApp messages etc.) to regularly share: • updated and accurate information on what people should do if family members become sick; • the support (including PSS) services that exist for parents/caregivers and families with children; • play activities for young children in the home and how to support children's wellbeing; • self-care tips for parents/caregivers:	alternative pathways for re/integration into the formal system. **PARENTING:** 1) Support parenting programme facilitators to resume activities with parents/caregivers aimed at preparing families and communities for a possible second wave.

	community response (see Community Engagement and Accountability below). 2) Empower parenting group members to identify traditional and cultural practices that may promote or protect against transmission and to design local responses; to identify and lead community actions to support (young) children in their community, including maintaining hygienic practices. 3) Train and equip facilitators to adapt existing parenting interventions to strengthen caregivers' knowledge and skills on: how to prevent COVID-19; how to support children's wellbeing and continued learning; caregiver mental wellbeing and coping strategies; measures to take if family members fall ill; the importance of men's engagement in care and domestic work. 4) Work with VSLA/Revolving Funds attached to parenting groups to promote support for provision of hygiene kits for homes and pre-schools, and nutrition support to vulnerable families. 5) Prepare and disseminate printed materials for parents/caregivers on home-based play, learning and psychosocial support for (young) children – ensuring that these emphasise the importance of equal care and treatment for girls and boys. 6) If funds permit, purchase simple toys, children's books, arts and crafts materials that can be distributed as toy kits to families with young children, along with guidance on making and using toys.	continuity of education (including alternative learning opportunities) and to ensure schools/learning centres are not used as shelters or treatment units and, where possible, remain open for children to continue accessing quality education. **PARENTING:** 1) Identify and curate TV programmes, videos, online platforms, plus SMS messages that: are available in local languages; are aligned with recommended prevention measures; do not reinforce gender stereotypes/norms for girls and boys; and can be used to support caregivers and young children. 2) Develop new content in media that is accessible to target communities. Prepare to start radio parenting groups. 3) Distribute printed materials for caregivers/ toy kits to families with young children. 4) Distribute equipment/materials requested by communities for their response (see Community Engagement and Accountability below). 5) Ensure that facilitators use interactions with caregivers to discuss the importance of equal care and treatment of girls and boys; and of care work and health decision-making being shared between male and female household members in the event that the community and households are affected. 6) Support parenting group members (and other community residents) to set	• sanitation, hygiene and protection information; • messaging on the importance of supporting girls' continued learning and return to school once these re-open, on an equal basis with boys. 2) Provide virtual support to parenting facilitators in order that they can continue to link with members of their groups, provide guidance, and encourage family-to-family support. Link facilitators to virtual PSS services if needed.	

		up communication trees, WhatsApp groups and other mechanisms to ensure ongoing communication and peer support. 7) Ensure all parenting group facilitators have working cellphones and airtime/data.		
COMMUNITY ENGAGEMENT AND ACCOUNTABILITY	For all community consultation activities across all phases, follow adequate infection prevention and risk mitigation measures dependent on your context. Establish Gender and Age-Friendly Two-way Communication, Feedback and Participation that centres on the strength of youth and women's organising and collective power. Identify access barriers to reliable information, meaningful participation, and provision of feedback of different age, gender and vulnerable groups, particularly adolescent girls; and inform strategies based on existing and new analyses. Work with different age and gender groups and vulnerable groups to identify their trusted and preferred communication methods and feedback channels that observe infection prevention measures and can be done remotely. **Risk Communication and Community Engagement (RCCE)** Consult with different age, gender and vulnerable groups to design inclusive	Gender and Age-Friendly Two-way Communication, Feedback and Participation Regularly inform communities in inclusive, gender and age-friendly formats about changes to Plan International's programming, adaptations and how they can access information or contact Plan International. Ensure methods take into account basic differences in literacy levels and access to information, also for children with disabilities. Observing adequate infection prevention and risk mitigation, establish inclusive gender and age-friendly FRMs (based on the preferred channels) ensuring the feedback loop is closed and using information to inform Plan International's wider response. Safely consult gender and age groups on their experiences, understanding of, and impact of COVID-19 and share findings across Plan International teams for action and adaptation of activities. **Risk Communication and Community Engagement (RCCE)**	Gender and Age-Friendly Two-way Communication, Feedback and Participation Continue regular inclusive, gender and age-friendly information provision to communities on changes, including to communication channels, as activities shift and there is greater use of remote solutions. Adapt FRMs to function with remote strategies and limit direct contact while ensuring they remain accessible to different age, gender and vulnerable groups, particularly adolescent girls. Maintain closing of the feedback loop with adapted remote strategies and using feedback to inform programming in collaboration with Plan International sector teams. Disseminate children's and young peoples' voices on their experiences with the pandemic and its impact on their lives. Ensure that communication channels are available for CAY to communicate any potential rights violations.	Gender and Age-Friendly Two-way Communication, Feedback and Participation Continue regular inclusive gender and age-friendly communication with communities on changes to programming, phase-out of services, exit or transition strategies and who to contact for further information and feedback. Observing adequate infection prevention and risk mitigation measures, involve girls, boys, adolescent girls, adolescent boys and marginalised groups in decision-making for designing recovery and resilience programming and identify how they can lead and participate in its implementation. **Risk Communication and Community Engagement (RCCE)** Work with community champions and groups engaged throughout the response to identify how messaging and key practices can continue being reinforced in communities in preparation for future infections and for building resilience.

	RCCE messaging on COVID-19, and Plan International's response. Ensure messaging is localised, evidence-based, clear, and grounded in positive, social norm change stories that address the unique needs of sub-groups of affected populations. Identify community platforms, participation forums and other groups, including girls' and women's groups, which Plan International regularly engages with (for example YAPs, CBCPCs etc.) to determine potential community-led risk communication activities and support them to lead these safely. **Coordinating and promoting community voices** Work with Plan International sector teams to develop aligned and complementary inclusive gender and age-friendly RCCE and any information dissemination or community engagement strategies within their sectors. Coordinate with response actors and RCCE Working Group to access available materials, avoid duplication of efforts, and share gender and age-appropriate messaging and/or strategies. Meaningfully engage women, adolescent girls, and marginalised groups in leadership and decision-making roles throughout the COVID-19 preparedness and response by using quotas, targets, and other mechanisms at global, national, and local levels.	Refer identified issues, challenges or myths to relevant teams for action and follow-up, including updating of RCCE messaging (e.g. stigma, rumours, protection concerns, education difficulties etc.). Collaborate with community structures, including youth, children and women's groups, to enable safe community-led or supported delivery of RCCE and key messaging following adequate mitigation strategies. **Coordinating and promoting community voices** Coordinate with response actors and RCCE Working Group to access available materials, avoid duplication of efforts, and share gender and age-appropriate messaging and/or strategies.	**Risk Communication and Community Engagement (RCCE)** Continue delivery of inclusive gender and age-friendly RCCE. Modify strategies as needed to avoid direct contact and following infection prevention measures while ensuring the most vulnerable groups are being reached. Continue working with community groups to adapt strategies (e.g. use of community radios, phone trees etc.), ensuring the most vulnerable groups are being reached. Monitor trends and changes in perceptions or beliefs to adapt communications or activities (e.g. new rumours, reported confusion, rising tensions etc.) in collaboration with Plan International's sector teams. **Coordinating and promoting community voices** Coordinate with response actors and RCCE Working Group to access available materials, avoid duplication of efforts, and share gender and age-appropriate messaging and/or strategies for others to use.	**Coordination and promoting community voices** Share feedback, inputs and outputs of inclusive gender and age-friendly community consultations with local duty bearers and humanitarian actors to inform priorities for recovery and resilience strategies. Consult different age, gender and vulnerable groups to identify best practices and strategies that successfully responded to their needs to document and share lessons with communities, the Plan International federation and the wider humanitarian sector.

About Plan International

We strive to advance children's rights and equality for girls all over the world. We recognise the power and potential of every single child. But this is often suppressed by poverty, violence, exclusion and discrimination. And it's girls who are most affected. As an independent development and humanitarian organisation, we work alongside children, young people, our supporters and partners to tackle the root causes of the challenges facing girls and all vulnerable children. We support children's rights from birth until they reach adulthood, and enable children to prepare for and respond to crises and adversity. We drive changes in practice and policy at local, national and global levels using our reach, experience and knowledge. For over 80 years we have been building powerful partnerships for children, and we are active in over 75 countries.

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