Ethical Considerations for Rapid Gender Analysis - COVID-19

Purpose: This guidance note highlights ethical considerations for conducting Rapid Gender Analysis during COVID-19. While this is a key guidance note developed as part of the Adapted RGA for COVID-19 toolkit, this guidance can be used for all needs assessments and surveys. There will be context-specific social and cultural considerations that are not covered in the guidance note but should be considered when conducting RGA's during the COVID-19 crisis.

Prioritise Secondary Data Review. Regulations around social distancing, isolation and quarantines[1] not only raise practical and logistical challenges with in-person data collection, but also ethical considerations. As such, initial RGA's for COVID-19 are **strongly encouraged** to take a secondary data analysis approach. Where feasible and necessary, remote Key Informant Interviews could be conducted where this adds value and fills an information gap specifically for at-risk / hidden groups, to gather information necessary to inform preparedness and response efforts, to ensure we do no harm and address the specific needs of these groups through our programmes and services.

A key first step: Share CARE's RGA plans with existing NGO coordination bodies and gender/GBV/protection clusters or working groups. Check if other agencies would like to develop a joint RGA, and map initiatives to ensure that multiple agencies (including CARE partners) are not conducting assessment/surveys in the same locations.

Remote data collection: With all forms of data collection including those using modern forms of technology, it is important to consider data protection, confidentiality and the safety of respondents. To minimize risk as part of the RGA process:
● Any questions regarding safety and protection should be reviewed and adapted based on the known location of the respondent and the means of communication used.
● Limit the identifiable data being collected and do not store information on staff's personal mobile phones/devices.
● Ensure confidentiality of the respondent and only use the information collected in ways indicated and consented to by the respondent.

Informed consent: It is important to keep the informed consent script short and use simple, clear language**.** Include the purpose of the call, who is calling (e.g. CARE and your name), explain confidentiality, and expected duration of the survey. Log when verbal consent is given.[2] The survey should not continue unless consent is explicitly given. All consent forms and interviews, need to be in the primary language of the respondents.

Primary data collection: Field data collection is strongly discouraged at this stage of the crisis, to avoid direct risks associated with the virus for staff and the community, as well as ensuring essential human, financial and logistical capacity is not diverted away from the immediate needs and direct response to COVID-19. Where information gaps persist, that are likely to have negative consequences for particular groups, remote primary data collection can be conducted. To minimize risks as part of the RGA process:
● Identify, from the Secondary data collection, **essential, need-to-know** information gaps only.
● Prioritise remote data collection by telephone, internet and apps. Analyse this data before considering field assessments.
● Integrate with other assessments teams (within CARE or with external partners) to ease the burden on staff and the community.
● If in-person field data collection is conducted, ensure appropriate Personal Protective Equipment (PPE). Ensure the assessment is not taking away limited PPE or logistics support from the emergency response. Further information can be found in [CARE's Program Guidance on Personal Protective Equipment (PPE) During COVID-19 Emergency Response](#).
● Conduct individual interviews (instead of group discussions), in alignment with physical-social distancing policies.
● Ensure time is allocated at the end of interviews for the respondent to feedback and ask questions. This is also an opportunity to provide updated essential information on: feedback and accountability mechanisms in that context; information on services and programmes; or updated prevention and response key messages.

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[1] The World Health Organisation guidance requires people to maintain at least 1 metre (3 feet) distance between yourself and anyone who is coughing or sneezing, with some Governments requesting that all persons should maintain a required distance from one another, and completely self-isolate should they be showing symptoms. https://www.who.int/emergencies/diseases/novel-coronavirus-2019/advice-for-public

[2] Sourced from https://www.povertyactionlab.org/blog/3-20-20/best-practices-conducting-phone-surveys. This source will be regularly updated with best practices for conducting remote surveys during COVID-19, whilst practicing social distancing.

- If field data collection is identified as not appropriate or feasible, pre-positioning of resources could be organised, in the case of changes in the crisis, e.g. pre-train teams; develop materials for assessments; update outreach messaging or GBV referral information; pre-identify transport/logistics support.

Do no harm: CARE's priority is a) its staff members' health and wellbeing; we do not want to ask staff to engage in activities beyond their risk appetite level and b) the communities we work with; we need to ensure that all contact with communities (if any) is absolutely necessary. If specific National Government guidance is in place, this should be prioritised. Review assessment tools and questions periodically as the crisis develops; if concerns are raised over questions/topics/methods potentially causing harm to respondents, these should be removed and/or the process ceased. If our assessment does inadvertently cause harm to the respondent, we should ensure that support information is on hand e.g. psychosocial support or other referral services. At this stage, the interview should be stopped.

Protection of Sexual Exploitation and Abuse (PSEA): The use of isolation measures may limit access to information on PSEA, and restrict access to reporting channels and gender-based violence and sexual and reproductive health services.[3] Ensure you know the updated PSEA mechanisms for the context to ensure timely, safe and confidential reporting.

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[3] IASC, Interim Technical Note, Protection of Sexual Exploitation and Abuse (PSEA) during COVID-19 response. Version 1.0 March 2020. https://interagencystandingcommittee.org/system/files/2020-03/IASC%20Interim%20Guidance%20on%20COVID-19%20-%20Protection%20from%20Sexual%20Exploitation%20and%20Abuse.pdf