

**GUIDANCE FOR THE  
CARIBBEAN REGION**

# **Integration of Sexual and Reproductive Health and Gender-Based Violence Considerations in Emergency Shelters**



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# Acronyms

Adolescent Sexual and Reproductive Health (ASRH)	Ministries / Ministry of Health (MoH)
Antenatal Care (ANC)	National Gender Machineries (NGM)
Antiretroviral Treatment (ART)	Norethisterone Enanthate (NET-EN)
Antiretroviral (Drugs) (ARV)	Non-Food Item (NFI)
Child Friendly Spaces (CFS)	Non-Governmental Organization (NGO)
Clinical Management of Rape (CMR)	Pan American Health Organization/ World Health Organization (WHO / PAHO)
Civil Society Organization (CSO)	People Living with HIV (PLHIV)
Emergency Contraception Pill (ECP)	People Living with Disabilities (PLWD)
Emergency Obstetric Care (EmOC)	Post-exposure Prophylaxis (PEP)
Emergency Obstetric and Neonatal Care (EmONC)	Post-abortion Care (PAC)
Family Planning (FP)	Post-abortion Contraception (PAC)
Gender-Based Violence (GBV)	Pre-Exposure Prophylaxis (PrEP)
Gender-Based Violence Information Management System (GBVIMS)	Prenatal Care (PNC)
Health Management Information System (HMIS)	Prevention of Mother to Child Transmission (PMTCT)
Human Immunodeficiency Virus (HIV)	Protection from Sexual Exploitation and Abuse (PSEA)
Inter-Agency Standing Committee (IASC)	Psychological First Aid (PFA)
Information, Education and Communication (IEC)	Reproductive Health (RH)
Information Sharing Protocol (ISP)	Sexual and Reproductive Health (SRH)
Intrauterine Device (IUD)	Sexual and Reproductive Health and Rights (SRHR)
Infection Prevention and Control (IPC)	Sexual Exploitation and Abuse (SEA)
Intimate Partner Violence (IPV)	Sexually Transmitted Infection (STI)
Lesbian, Gay, Bisexual, Transgender, Queer and Intersex + (LGBTQI+)	Trafficking in Persons (TiP)
Medical Eligibility Criteria (MEC)	United Nations Population Fund (UNFPA)
Medroxyprogesterone Acetate (DMPA)	Ulipristal Acetate (UPA)
Minimum Initial Service Package (MISP)	

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# Introduction

## A. PURPOSE OF THE GUIDE

**T**he purpose of this guide is to support shelter managers and coordinators as well as Health Providers, National Ministries of Health (MoH), National Gender Mechanisms (NGM), National Bodies for Disaster Management and Humanitarian Coordination bodies to reduce the risks of Gender-Based Violence (GBV) and integrate essential actions for the provision of lifesaving Sexual and Reproductive Health (SRH) and GBV response services in emergency shelters through improved planning and response actions. This guidance should be used before the onset of an emergency for planning purposes, and also serves as a technical guidance that should be used when responding to an emergency. Each country is encouraged to adapt it based on the nature of the emergency and particular national policies and protocols around SRH and GBV.

This guidance is structured around the Minimum Initial Service Package (MISP) for the delivery of SRH services in humanitarian emergencies, as well as the Inter-Agency Standing Committee (IASC) Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action, which is a priority set of lifesaving activities to be implemented at the onset of every humanitarian crisis to mitigate, prevent and safely respond to all types of GBV among a wide range of humanitarian sectors of work. Actions within the MISP are designed to prevent sexual violence and respond to the needs of survivors; prevent and reduce morbidity and mortality due to transmission of human immunodeficiency virus (HIV) and other sexually transmitted infections (STIs); prevent excess maternal and new-born morbidity and mortality; prevent unintended pregnancies; and plan for the provision of lifesaving SRH and GBV response service provision, until a transition to a more stable and comprehensive solution is planned. This guidance is geared toward general

emergency response; specific guidance around the COVID-19 pandemic is provided succinctly in Annex 8.

This guide will introduce key concepts and provide guidance and tools around actions shelter managers should take during emergency planning and response to mitigate GBV and poor SRH outcomes and integrate SRH and GBV response into shelter services.

## B. CARIBBEAN CONTEXT & HUMANITARIAN EMERGENCIES IN THE REGION

GBV is a persistent problem across the Caribbean. Intimate partner violence (IPV), domestic violence, sexual violence (rape is also used as reprisal/ community warfare), trafficking in persons (TiP), sexual exploitation and abuse (SEA), femicide and incest are the most common forms of GBV. Those identified as being at highest risk of GBV in the Caribbean are women and girls, LGBTQI+<sup>1</sup> persons, sex workers, persons living with disabilities (PLWD) and migrants/refugees. It is well documented that often during crises, needs for SRH services are overlooked and incidents of GBV increase, and during 2020 and well into 2021 the Caribbean has been affected by three overlapping emergencies: the Venezuelan displacement crisis, the Atlantic hurricane season, and the COVID-19 pandemic.

The Venezuelan displacement crisis is the largest in Latin America's history, and since its start, several Caribbean countries have received a large influx of migrants/refugees escaping the humanitarian emergency. The Caribbean also faces persistent threats from natural hazards; mainly hurricanes, earthquakes, volcanic eruptions and flooding, and the region is annually affected by the Atlantic hurricane season from June to November. In addition to these two

1 LGBTQI+ : Lesbian, Gay, Bisexual, Transgender, Queer and Intersex +

emergencies, the Caribbean is also coping with the emergency caused by the COVID-19 pandemic, which has had specific gendered impact on women and girls, increased the risk of GBV, and has disrupted access to lifesaving SRH and GBV response services.<sup>2</sup> The COVID-19 pandemic is placing migrants and refugees from Venezuela at particularly heightened risk as the virus spreads in the Caribbean, and it is likely that irregular border crossings, risks at sea as well as smuggling and human trafficking will continue to increase. In addition, the Venezuelan community will experience even higher levels of discrimination and xenophobia, and a lack of access to lifesaving SRH and GBV response services.

**Humanitarian emergencies, including natural disasters, disproportionately affect women and girls, and increase GBV.**

During humanitarian emergencies, GBV dramatically increases, as national systems, including health, justice and social welfare breakdown, and community and social support networks weaken. The latter will reduce access to lifesaving services, such as SRH, social protection and legal services, which leads to an environment of impunity where perpetrators of GBV are held accountable even less frequently and survivors are even more unprotected. GBV “has significant and long-lasting impacts on the health, and psychological and economic well-being of women and girls, and their families and communities.”<sup>3</sup>

**COVID-19 Pandemic:** Women’s rights activists around the world have reported dramatic increases in GBV during the COVID-19 pandemic, creating more demand and greater need for services. The COVID-19 measures imposed by national authorities to slow the spread of the virus have severely impacted women and girls at risk of GBV as well as GBV survivors. This has particularly increased IPV, as quarantine and movement restriction measures often force survivors to isolate with their perpetrators, losing their social support networks, and making it even more difficult for them to reach out for help and access life-saving SRH and GBV response services. Placement in emergency shelters following humanitarian emergencies will pose additional risks to women and girls as their freedom of movement and capacity to adapt are reduced, as is their access to lifesaving services.

**Care-giving burden:** As primary caregivers, who often have greater responsibilities related to household work, women tend to have less access

to resources for recovery. In the context of natural disasters in the Caribbean region, women and girl’s dependence on climate-sensitive work, such as agriculture and tourism, and their limited access to economic resources, makes them more vulnerable to experiencing GBV. Women perform most of the unpaid care work—more than three times as much as men. During public health crises such as the COVID-19 pandemic, this labour will often involve taking care of sick family members, and in the case of school closures, looking after children.

**Women health and frontline workers:** Female health and frontline workers face a double caregiving burden—one at work, and one at home. In the workplace women are, on average, paid less than their male counterparts and are less likely to be in a management position. They also risk stigmatization due to caring for COVID-19 patients and survivors of GBV.

**Access to health care, specifically SRH services:** The redirecting of health care resources to emergency response, for example COVID-19 prevention and response efforts, may increase maternal morbidity and mortality and other poor sexual and reproductive health outcomes. School closures also often lead to increased sexual activity, and with COVID-19 likely to increase barriers for accessing contraception, this can result in a spike in adolescent pregnancy, which in turn will lead to school dropouts that will disproportionately affect adolescent girls.

## C. THE ROLE OF EMERGENCY SHELTERS IN MAINSTREAMING SRH AND GBV RESPONSE SERVICES, AND MITIGATING GBV RISKS

The work of emergency shelters is critical to the survival of populations displaced by humanitarian emergencies, whether the displacement occurs within or across national borders. Humanitarian emergencies greatly affect people’s health and increase the risk of violence and exploitation, especially for vulnerable populations. Women and girls are disproportionately affected by natural disasters specifically as primary caregivers who generally have a greater responsibility for unpaid domestic labour, caring for sick family

2 CARE and IRC (2020). Global Rapid Gender Analysis for Covid-19.

3 The Interagency Minimum Standards for GBV in Emergencies Programming, GBV AoR, Copyright UNFPA, 2019

members, as well as children and the elderly. It is recognized that during disasters there is an increased risk of GBV, as well as increased risk of transmission of HIV and other STIs.

In acute emergencies SRH services are often neglected and unavailable, yet the demand for SRH services often increases during an emergency. Lack of access to family planning (FP) services can increase unplanned pregnancies, unsafe abortions and the transmission of STIs including HIV; childbirth can occur during evacuation and displacement; and lack of access to basic and comprehensive emergency obstetric and neonatal care (EmONC) can increase the risk of maternal and neonatal death; untreated trauma from sexual violence can lead to poor sexual and reproductive health (including unplanned pregnancies and unsafe abortions) and poor mental health outcomes including depression and suicide. Overcrowding can exacerbate family tensions which in turn can contribute to IPV and other forms of domestic violence. Poorly designed shelters that provide inadequate privacy, locks, and insufficient lighting can increase the risk of sexual harassment and

assault. Inadequate distribution of food and shelter-related non-food items (NFI)<sup>4</sup> increases the vulnerability for women, girls, and other at-risk groups, who might be forced to trade sex or other favours in exchange for these items. At-risk groups including the elderly, adolescent girls, PLWD, the LGBTQI+ community, People Living with HIV (PLHIV), and religious and ethnic minorities are at heightened risk of GBV and often have greater unmet needs for SRH services. The timely provision of SRH and GBV response services can prevent death, disease, and disability related to unintended pregnancies, obstetric complications, STIs including HIV, and a range of other poor sexual and reproductive health outcomes.

Emergency shelters are understood to be more than ‘four walls and a roof,’ and therefore emergency shelter managers play a critical role in protecting the health, security, privacy, and dignity of vulnerable individuals and families who are affected by crisis. The continuation of SRH and GBV response services during a crisis through emergency shelters, including referral to health facilities and other essential services, is a critical strategy to save lives.

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4 Non Food Items (NFI) are items other than food distributed to those affected by emergencies, these commonly include clothing, hygiene items (hygiene or dignity kits), and essential household items such as blankets, cooking utensils and lights.

# Definitions and Terms

## WHAT IS REPRODUCTIVE HEALTH?

**R**eproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. It implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so (Cairo, ICPD Programme of Action, paragraph 7.2).

The Minimum Initial Service Package (MISP) for Reproductive Health is a priority set of lifesaving activities to be implemented at the onset of every humanitarian crisis. The MISP is designed to prevent and manage the consequences of sexual violence; reduce transmission of HIV and other STIs; prevent new-born and maternal morbidity and mortality; prevent unplanned pregnancies and to plan for comprehensive reproductive health services.

**TABLE 1**

<b>SRH SERVICES SHOULD BE PROVIDED BASED ON THE FOLLOWING PRINCIPLES</b>	
<b>AUTONOMY</b>	The ability of an individual to be her/his/their own person, to make her/his/their own choices based on her/his/their own motivations, without manipulation by external forces
<b>EQUALITY</b>	The state of being equal, particularly with respect to rights, status, and opportunities
<b>EQUITY</b>	Fairness or justice in the way people are treated

5 UN Inter-Agency Standing Committee and Global Protection Cluster (2015). IASC Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action (Section 3.11: Shelter, Settlement and Recovery).

6 Global Shelter Cluster Working Group on Gender-Based Violence (2016). Good Shelter Programming - Tools to Reduce the Risk of GBV in Shelter Programmes.

## WHAT IS GENDER-BASED VIOLENCE (GBV)?<sup>5,6</sup>

‘Gender-based violence’ (GBV) is an umbrella term for any harmful act that is perpetrated against a person’s will and that is based on socially ascribed (i.e. gender) differences between males and females. It includes acts that inflict physical, sexual, or mental harm or suffering, threats of such acts, coercion, and other deprivations of liberty. These acts can occur in public or in private’ (IASC 2015). GBV can affect women, girls, men, and boys, although the overwhelming majority of survivors worldwide are women and girls. GBV includes physical violence, sexual violence, emotional and psychological violence, and economic violence. Forms of GBV most often reported in the Caribbean region include rape and sexual assault, IPV and domestic violence, sexual exploitation/trafficking and forced and/or coerced prostitution. These are some examples of GBV:

- **Inflicting physical harm:** I was attacked when I left the shelter and tried to find food for my family.
- **Inflicting sexual harm:** I have been sexually abused by my uncle ever since they placed our families in one shelter.
- **Inflicting mental harm:** Men insult me and tell me to use the women’s bathroom because I’m gay.
- **Threats:** I am scared to go to the clinic because someone threatened to rape me last time I went.



- **Exclusion (denial of rights):** My husband died and now I can't inherit the land or the house.
- **Coercion:** I do not speak the language of this country, and I am forced to sell sex to feed my family.
- **Sexual Exploitation and Abuse:** A member of the shelter team told me that I would receive more clothes and food if I had sex with him.

## WHAT IS SEXUAL EXPLOITATION AND ABUSE (SEA)?

Sexual Exploitation and Abuse (SEA) is a form of GBV committed against the crisis-affected population in which the perpetrators of violence are humanitarian actors, including government staff, non-governmental organizations (NGOs), United Nations, volunteers, security guards, police and/or military personnel. The term 'sexual abuse' means the actual or threatened physical intrusion of a sexual nature, whether by force or under unequal or coercive conditions. The term 'sexual exploitation' means any actual or attempted abuse of a position of vulnerability, differential power, or trust for sexual purposes, including, but not limited to, profiting monetarily, socially or politically from the sexual exploitation of another. Some types of forced and/or coerced prostitution can fall under this category. Protection from Sexual Exploitation and Abuse (PSEA) relates to the responsibilities of ALL humanitarian actors to prevent SEA through setting up confidential reporting mechanisms; and taking safe and ethical action as quickly as possible when incidents do occur.

## WHAT ARE SOME OF THE CONSEQUENCES OF GBV?<sup>7</sup>

GBV impacts survivors immediate sexual, physical and psychological health, and contributes to greater risk of future health problems. GBV is life-threatening, some possible consequences are outlined in Table 2.

TABLE 2: GBV CONSEQUENCES

PHYSICAL CONSEQUENCES	PSYCHOLOGICAL CONSEQUENCES	SOCIAL CONSEQUENCES
Physical injury	Depression and sadness	Victim-blaming
Disability	Fear and anxiety	Stigmatisation
Sexually Transmitted Infections (STIs) including HIV	Self-blame, guilt and shame	Rejection and isolation by family and/or community
Unwanted Pregnancy	Re-experiencing the trauma, flashbacks	Forced marriage
Unsafe abortion, miscarriage	Avoidance of places or situations, isolation	Decreased earning capacity / contribution
Fistula	Anger	Increased poverty
Chronic pain	Trouble concentrating or remembering	Risk of re-victimization
Sleeping and eating disorders	Self-harm	Death / honour killings
Death, including suicide	Suicidal thoughts / actions	

7 UN Inter-Agency Standing Committee and Global Protection Cluster. GBV Pocket Guide - How to Support Survivors of Gender-Based Violence When a GBV Actor is Not Available in Your Area.

# GBV Guiding Principles

**T**he GBV Guiding Principles and survivor centered approach underpin all aspects of GBV programming<sup>8</sup>, and therefore all the recommendations listed in this guidance. Adhering to and implementing the GBV Guiding Principles across the design, implementation and management of emergency shelters will contribute to minimizing harm to survivors and women and girls at risk of GBV. It is strongly recommended that shelter actors receive proper training and guidance and follow the recommendations described below, as this will also increase the efficacy of their efforts to mitigate GBV risks and prevent and safely respond to GBV incidents in their shelter.

## THE GBV GUIDING PRINCIPLES:<sup>9</sup>

<p><b>SAFETY</b></p> <hr/> <p>The safety and security of the survivor and others, such as her/his children and people who have assisted her/him, must be the number one priority for all actors. Individuals who disclose an incident of GBV or a history of abuse are often at high risk of further violence from the perpetrator(s) or from others around them.</p>	<p><b>CONFIDENTIALITY</b></p> <hr/> <p>Confidentiality reflects the belief that people have the right to choose to whom they will, or will not, tell their story. Maintaining confidentiality means not disclosing any information, at any time, to any party, without the informed consent of the person concerned. Confidentiality promotes safety, trust, and empowerment.</p>
<p><b>RESPECT</b></p> <hr/> <p>The survivor is the primary actor and the role of helpers is to facilitate recovery and provide resources for problem-solving. All actions taken should be guided by respect for the choices, wishes, rights, and dignity of the survivor.</p>	<p><b>NON-DISCRIMINATION</b></p> <hr/> <p>Survivors of violence should receive equal and fair treatment regardless of their age, gender, race, religion, nationality, ethnicity, sexual orientation, or any other characteristic.</p>

<sup>8</sup> UNFPA and the Global Gender-Based Violence Area of Responsibility (2019). The Inter-Agency Minimum Standards for Gender-Based Violence in Emergencies Programming.

<sup>9</sup> Excerpted from the IASC GBV Guidelines, 2015.

## THE SURVIVOR CENTERED APPROACH<sup>10</sup>

The Survivor Centered Approach is based on the above-mentioned GBV Guiding Principles, and it “creates a supportive environment that promotes the survivor’s empowerment. It puts them at the center of the helping process so that they direct the course of their recovery”<sup>11</sup>. This approach aims at providing survivors with a regained sense of control by acknowledging and respecting their agency as the primary decision maker throughout their recovery and helping process. The survivor centered approach ensures that the survivors’ rights and wishes are respected, their safety is ensured, and they are treated with dignity and respect, without any discrimination. Because of the many consequences of GBV listed above, survivors have multiple and diverse needs. Not all survivors react in the same way or have the same needs, so the first thing to do is LISTEN to the survivor and ask them what they need and how they would prefer to receive services available, rather than making assumptions about how their case should be dealt with and what kind of services they should be receiving.

Physical and emotional safety of the survivor, and the service providers, should be a priority whenever a case of GBV is disclosed. When basic health services are available, these can sometimes help mitigate some of the physical consequences of GBV, but psychological health and social consequences are often harder to address. Please refer to the pocket guide for further details about services that might support survivors of GBV in the absence of specialized GBV health, psychosocial or legal services.

This illustration contrasts survivors’ rights (on the left) with the negative impact a survivor may experience when the survivor-centred approach is not employed (on the right).

TABLE 3: SURVIVOR-CENTRED APPROACH<sup>12</sup>

To be treated with dignity and respect	<b>VS.</b>	Victim-blaming attitudes
To choose		Feeling Powerless
To not be discriminated against		Not being able to access services due to specific gender identity, ethnicity, nationality, etc.
To receive all available information		Being told what to do

In addition to the survivor-centered approach, the following two approaches should also underline all work with the affected population, including survivors of GBV.

**“Do no harm” approach:** A “do no harm” approach involves taking all measures necessary to avoid exposing people to further harm as a result of the actions of humanitarian actors.

**Rights-based approach:** A rights-based approach seeks to analyse and address the root causes of discrimination and inequality to ensure that everyone has the right to live with freedom and dignity, safe from violence, exploitation and abuse, in accordance with principles of human rights law.

10 UN Inter-Agency Standing Committee and Global Protection Cluster. GBV Pocket Guide - How to Support Survivors of Gender-Based Violence When a GBV Actor is Not Available in Your Area.

11 UNFPA and the Global Gender-Based Violence Area of Responsibility (2019). The Inter-Agency Minimum Standards for Gender-Based Violence in Emergencies Programming.

12 Excerpted from the GBV AoR.2010 GBV Coordination Handbook p.20.

# Key Preparedness Actions

**U**nderstanding why emergency shelters can exacerbate GBV risks and what shelter managers can do about them, as well as being clear on the services that can be provided in the shelter, are the first steps in the preparedness actions to avoid poor SRH outcomes and ensure safe responses to GBV incidents and protection.

When we talk about GBV, we are essentially referring to structural and systemic power imbalance and gender inequalities as the root causes of this violence, which by default puts women and girls at higher risks of GBV and impedes their access to safe and equitable humanitarian assistance. Women and girls face additional barriers in accessing services, particularly humanitarian services, and these are oftentimes designed in generic ways that do not take their particular needs into consideration, where they do not feel entirely safe and where they can also be exposed to additional risks, including GBV.

Emergency shelters are not the exception, and GBV risks can be exacerbated by actions and programmes within the shelter. When the general layout of the shelter is not centered on special needs of the affected population, issues such as lack of privacy, overcrowding, lack of gender-sensitive sanitation facilities, and a lack of lighting around the space, among others, will increase the likelihood of GBV incidents because those situations provide perpetrators of GBV with an easier way of targeting their next “victim”. These conditions allow for the spontaneous set up of “GBV hotspots” around the shelter, especially after some time has passed and the population settles. When emergency shelters do not provide special areas ensuring privacy and access to key services to the most vulnerable, such as single women, female heads of household, unaccompanied girls, LGBTQI+ persons, PLWD, and pregnant and lactating women and girls, these individuals will become the main targets for GBV perpetrators. This is particularly true if they do not have support systems (which are formed and encouraged by setting up special areas for these persons).

As mentioned above, power dynamics are an important consideration related to GBV risks, including within emergency shelters. Globally, men are seen as the power holders and are therefore automatically assigned as the heads of the household. Challenging this is important when considering decision-making authority among households in the shelter. Choosing female heads of household instead of male heads of households as the decision-makers when preparing for the registration of individuals and the provision of ration cards, cash and voucher assistance plays an important role in challenging these preconceptions, and also allows for the empowerment of women and girls and meeting their specific needs, many of which are usually overlooked (menstrual health needs, for example).

Another risk can be associated with the location of service providers, distribution/registration points, water, hygiene, and sanitation facilities. If these are not professionally designed, and the design is not developed in consultation with the affected population (including women and girls) in advance, they can become hotspots for GBV incidents. The distribution of food and NFI items such as clothing and hygiene products etc., can also pose GBV risks within shelters. Distribution of food and essential items can exclude women and girls and at risk-groups, not meet their needs, or put them at risk of harm and exploitation during the distribution process (i.e. transactional sex). Special services aimed at meeting the needs of women and girls should be a priority during both preparedness and response, and these include the set-up of women and girls’ safe spaces where services such as case management and psychosocial support, family planning, syndromic treatment of STIs and clinical management of rape, among other SRH interventions, can be offered in a private and secure space.

As such, shelter managers play a particularly important role in the mitigation of GBV risks and other sexual and reproductive health risks in the shelters they manage, and it is crucial to understand how the set-up of emergency

shelters can allow perpetrators of GBV easier access to potential survivors. During the preparedness phase, many of these considerations can be put in place ahead of a disaster, and this will have an enormous impact, aside from facilitating key actions specific to the response phase. Below you will find specific guidance to apply during the preparedness phase, which will also be available in the form of a checklist.

## 1. UNDERSTAND NATIONAL LEGISLATION, POLICIES AND PROCEDURES

In close collaboration with the MoH and NGM, understand national legislations related to availability and access to SRH and GBV response services, protocols, and standards of all SRH/GBV interventions which can be provided in the shelter and how GBV survivors can safely continue to access key lifesaving services when they are in the shelters (including Clinical Management of Rape (CMR) procedures and Mandatory Reporting Laws)<sup>13</sup>. Understanding procedures that have been put in place for the set-up of shelters will also provide shelter managers with key information around the facilities they will be managing (i.e. whether there are specific facilities designed and built as emergency shelters, whether other facilities will be repurposed as emergency shelters, such as schools, churches, community centres, etc). This is key in order to have information around the actions that will be needed in order to ensure a safe overall layout of the shelter and the possible services that may be offered.

### Key preparedness actions

- All service providers in the shelter should have on hand the national protocols/standards of all SRH interventions (including CMR) to be provided at the shelter. All health providers operating at the shelter must be aware of the legal framework, especially regarding adolescents' access to sexual and reproductive health services, including contraception (especially if providers are international organizations deployed in the context of the emergency and have never operated in the country).
- All health providers must have knowledge of national mandatory reporting laws around GBV, child sexual abuse, and SEA.

- All service providers must understand and have at hand national legislation regarding the response to GBV incidents in their countries, and any protocols developed for emergency settings. These include standard operating procedures and any measures referring to the emergency set up of operations following a disaster and system's collapse.

## 2. SHELTER POLICIES – DESIGN & MANAGEMENT OF EMERGENCY SHELTERS

Prioritize GBV risk reduction in shelter design, site preparation and planning. Design shelters for privacy and safety, and include the active participation of women, girls, at-risk groups, as well as community groups and NGOs. Engage GBV response service providers to understand and mitigate GBV risks in shelter site planning and preparation.

### Key preparedness actions related to shelter design & policies

- During site preparation and planning, shelters should be designed for privacy and safety, with GBV risk mitigation in mind, to limit overcrowding and prioritize the safety of at-risk groups.
- Ensure all shelters will have a specially protected, private and safe area for most vulnerable individuals such as single women, unaccompanied children, female heads of household, LGBTQI+, PLWD, etc. If this is not possible, an alternative could be to plan for completely separate shelters only for these individuals (ensuring adequate protection and safeguarding measures in advance, in collaboration with and consulting GBV Specialists).
- WASH facilities should be sex disaggregated and separated by a distance from each other, including working locks from the inside, which will avoid generating GBV hotspots and contributing to women and girls feeling safer in accessing them. Lighting should be ensured in all corridors and around WASH facilities, and please consider back up plans in the event of power outages.
- A private exam room at the shelter should be dedicated to first aid and the

<sup>13</sup> Mandatory reporting laws refer to legislation passed by some countries that requires individuals such as health-care providers or teachers to report to the police or legal system any incident of known or suspected GBV or child abuse. In most countries mandatory reporting applies primarily to child abuse and maltreatment of minors, but in others it has been extended to the reporting of GBV. More information [here](#).

provision of certain SRH services, and where GBV survivors can feel safe to disclose an incident, if they so wish, in a confidential, safe, respectful, and non-discriminatory environment.

- Proper warehousing such as secured rooms should be identified for the storage of commodities and medical/personal records (if these are to be stored in the shelter).
- Processes should be in place to identify needs and prioritize shelter assistance for at-risk groups using vulnerability criteria, including criteria and processes for emergency re-housing for at-risk groups facing safety concerns.
- An SEA Code of Conduct should be adapted and signed by all staff operating the shelter.
- Shelter managers should be aware of local SEA focal points and agency procedures to report, investigate and take disciplinary action in cases of SEA.

### Key preparedness actions related to shelter management

- Ensure that every single person in the shelter is registered and data is disaggregated by gender (or at least by sex), and age groups. This should be coordinated with national coordination structures to ensure all shelters follow the same procedures. Please avoid only registering heads of households (by default, men), as this increases GBV risks.
- Ration cards should be provided to every adult and unaccompanied child in the shelter. If this is not possible and the decision is to provide one ration card by family, please make sure these are provided to female heads of household instead of males. This ensures women are provided with decision-making power over resources in the household.

## 3. STAFFING AND CAPACITY BUILDING OF STAFF WORKING IN THE SHELTERS

In collaboration with Health and GBV Specialists, advocate for the provision of training for shelter staff to be able to understand SRH and GBV, and their role in mitigating GBV and poor SRH outcomes, as well as responding to

the needs of the affected population in their shelters. These trainings should be provided by relevant national authorities and are usually facilitated in collaboration with UNFPA. In addition, it becomes increasingly important for shelter managers to advocate for the deployment of specialized staff to directly work in their shelters, which will ensure a more comprehensive response and direct service provision onsite.

### Key preparedness actions

- Ensure all staff working in the shelter understand and have been trained on PSEA. Ensure the shelter has adopted an SEA Code of Conduct (including specific SEA prohibition and zero tolerance policies are clear), which all current staff have signed (see Annex 7).
- It is recommended a cadre of health providers be available to provide SRH interventions at the shelter. Depending on what is most feasible for the specific context, this could take the form of health providers setting up a temporary clinic at the shelter, or through mobile clinics that recurrently visit the shelter. However, the specific categories of health providers will depend on which competencies are assigned for these different cadres, namely nurses, midwives, and doctors within the country.
- It is proposed that a trained GBV point-person be assigned to the shelter, and that the shelter manager work with GBV specialists to provide additional support. It is strongly advised that social protection workers (specialized in the provision of GBV response services) be deployed to work in the shelter, and when this is not feasible, these services are set up as mobile.
- Attention is given to hiring and retaining female staff, especially in positions of leadership within the shelter. This refers also to ensuring presence of female law enforcement actors for security in the shelters. Having only male law enforcement actors creates additional GBV risks.
- Translators should be available on site for the main co-existing languages and the languages of the main migrant groups. If they are not available a list of approved translators should be provided to staff.
- Health providers should be trained in the MISP for SRH, and all shelter staff and managers should be sensitized on issues relating to SRH including Adolescent Sexual and Reproductive Health and Rights (ASRH).

- All staff should also be trained in how to safely respond to GBV incidents including the GBV Pocket Guidelines for Safe Referrals, and PSEA. If possible, staff should be trained in Psychological First Aid (PFA).

**TABLE 4:**

<b>RECOMMENDED TRAININGS FOR FRONTLINE PROVIDERS</b>
* International Shelter Standards such as Sphere and the IASC
* Minimum Initial Service Package (MISP) for Reproductive Health
* GBV Pocket Guide for Safe Referrals
* Psychological First Aid (PFA)
* Prevention of Sexual Exploitation and Abuse (PSEA)

## 4. REFERRAL PATHWAYS

Advocate for updated SRH and GBV referral pathways to be in place and widely disseminated among shelter staff and managers. Contact the NGM and GBV specialists to access referral pathway documentation (including GBV Pocket Guide and GBV Constant Companion for non-GBV specialists), and advocate for shelter staff to be briefed on how to use them without putting survivors at risk.

### Key preparedness actions

- Shelter managers should advocate with health providers and GBV specialists to update existing referral pathways so that shelter managers and frontline staff can have proper guidance around the safest way to respond to GBV incidents and support survivors of GBV. When these are not available, SRH and GBV Specialists, along with relevant national authorities, should establish a referral pathway linking the shelter with health facilities, and routinely update it through SRH and GBV service mappings. A simple version outlining key emergency services and GBV focal points (such as the GBV constant companion) should be easily available to shelter staff and residents.

- This list of health facilities that geographically cover the shelter should include the contact information, opening hours, type of services provided, documentation required to be attended, and alternative solutions for service provision (i.e., whether remote services are available and if so, phone numbers of the hotlines.). NGOs that are able to provide SRH services should also be listed.
- It is critical that shelter staff have up-to-date information about contacts for emergency transportation, to be able to make timely referrals 24/7, for SRH and GBV response services that are not available at the shelter.
- Shelter staff should always inform the population hosted in the shelter about the available SRH and GBV response services inside and outside the shelter through announcements and IEC materials in a format that reaches PLWD, in both local languages and the main foreign language (targeting most vulnerable groups among migrant populations such as women, pregnant women and lactating mothers, adolescents, LGBTQI+, sex workers etc.), and this should be done with support and guidance from SRH and GBV Specialists.

## 5. GENERAL PROGRAMMING AND SERVICE PROVISION IN THE EMERGENCY SHELTERS

During the stage of preparedness, shelter managers are encouraged to engage with other service providers and have a clear understanding of the types of interventions that could be implemented in their shelters. Interventions range from different areas of work such as food distribution, non-food items distributions, health (especially Sexual and Reproductive Health, Mental Health and Psychosocial Support), child protection, education, etc. Coordination between the different areas of work is key, ensuring that service provision is in line with specific programmes planned according to these areas of work and that they complement each other as much as possible. In terms of SRH and GBV prevention and response service provision interventions that can be planned for the shelters ahead of an emergency, please take into consideration the following recommendations.

### Key preparedness actions

- Ensure the active participation of women, girls and other at-risk groups is promoted in the planning of shelter programming

- The package of SRH interventions to be offered at the shelter should be discussed and agreed by the MoH as part of the preparedness actions. Depending on what is most feasible for the specific context and the size of the shelter, SRH services could be provided at the shelter itself, through mobile SRH services that recurrently visit the shelter, or through transporting persons from the shelter to the health facilities.
- It is proposed a number of SRH commodities should be offered at the shelter, the specific type of commodities that can be stocked at the shelter will depend on national protocols. A list of the necessary commodities for hygiene/dignity kits and IEC materials should be created, as mentioned above, and key items sourced and stocked when possible.
- The shelter should coordinate and link with the NGM, local community groups and NGOs that provide specialized GBV response services, to ensure programming at the shelter and support in designing shelter spaces and service provision with GBV risk mitigation in mind. In line with the above, feasibility of the type of service provision needs to be discussed and adapted to each specific context, as static and mobile service provision can both be feasible.
- Processes are in place to determine which NFIs are the priority of the shelter to distribute such as hygiene kits, lighting, and cooking utensils.
- Vulnerability criteria is clearly defined to prioritize distribution of NFIs especially for at-risk groups.
- GBV risk mitigation measures are understood, specifically in reducing the risk of SEA during distribution

## 6. COMMODITIES, INFORMATION, EDUCATION AND COMMUNICATION MATERIALS

Once national legislation, protocols and procedures have been understood, shelter managers will be able to work in close collaboration with the MoH and NGM in planning for the commodities needed to be prepositioned ahead or immediately at the onset of an emergency, to be offered in the emergency shelters. Planning for this will be key to ensure lifesaving services are available in shelters as soon as possible.

### Key preparedness actions:

- Understand and list what commodities of the Inter-Agency Reproductive Health (IARH) Kits are in line with national protocols and/or the National Essential Medical List that can be stored in the shelter during an emergency.
- In close collaboration with NGM and GBV programme Specialists, source, and stock Dignity Kits (see table 10 – dignity kits) to be prepositioned and in the event of an emergency, be distributed in the shelters by specialized staff.
- IEC materials should be gathered or otherwise designed in coordination with SRH and GBV specialists and printed to be rapidly shared within the shelter.
- Mechanisms are in place for the supply of commodities to the shelter, as well as guidance on proper warehousing (identify a secured room, responsible staff etc.) and safe distributions of items such as the dignity kits, in collaboration with the NGM and UNFPA.

## 7. INFECTION PREVENTION AND CONTROL (IPC) MEASURES

Use of IPC measures by all shelter staff and residents in the context of the COVID-19 pandemic is critical to prevent exposure and transmission of the virus (see Annex 8).



# Key Response Actions

In the best-case scenario, preparedness key actions outlined above would have been considered and implemented in advance of a disaster. But when this is not possible, it is important to consider them before implementing the key response actions. In any case, it is still crucial to closely coordinate and collaborate with specialized Health and GBV response service providers who will be able to provide guidance around the best ways to prioritize specific actions and adapt accordingly to the context. The actions below provide an overview of key response actions that will, in addition to mitigating GBV risks, guide shelter managers on key SRH considerations and possible service provision as well as ways in which the prevention and response to GBV can be ensured within the shelters.

## 1. ENSURING CONTINUITY OF SRH SERVICES: MISP INTERVENTIONS TO BE DELIVERED AT SHELTERS <sup>14,15</sup>

During the emergency preparedness phase there are certain actions shelter managers should take to prepare to integrate SRH response into shelter services. The guidance below suggests minimum interventions to be offered at the shelter to provide SRH services, including necessary commodities and guidance on referral. Please see the SRH Rapid Service Mapping Tool (see Annex 2) and Sample Referral Flowchart for guidance (see Annex 4).

### 1.1. Preventing Unintended Pregnancies

#### Contraceptive Counselling

During the emergency, do not promote any new method that has not

previously been introduced in the country. The person in charge of providing counselling will sometimes offer an alternative method if the user's method of choice is not available or conditions are not in place to offer such a method<sup>16</sup>. Counselling for women who want to stop using their current contraceptive method because they want to get pregnant should also be offered, however, women should also be informed about the risks of getting pregnant in the aftermath of an emergency if the disruption of health services is severe. It is important to provide counselling on safer sex practices including dual protection.

- **Access:** to the widest range of methods possible from which to choose.
- **Free choice:** the decision whether to use FP and what method to use, made voluntarily, without barriers and coercion.
- **Informed choice:** a decision based on complete, accurate, unbiased information about all FP options, including benefits, side effects and risks, and information about the correct use of the method chosen, as well as the risks of non-use.

**Adolescents:** If the law is clear, and providers are not allowed to provide contraceptive methods for adolescents, methods cannot be provided. In these cases, the counsellor should explain that the only solution is to obtain parental/legal guardian consent.

**IEC materials (brochures, posters, leaflets):** Check with the unit within the MoH in charge of health education (such as the Health Education Unit or any other relevant unit) to see if they have developed or are able to develop IEC materials such as flyers, brochures and posters. These materials should include information about the benefits of using condoms and correct

14 IAWG (2018). Minimum Initial Service Package (MISP) for sexual and reproductive health (SRH) in crisis situations.

15 UNFPA (2019). Manual - Inter-Agency Emergency Reproductive Health Kits for use in Humanitarian Settings, 6th edition. *\*please note this is the new manual\**

16 Keep in mind that introducing new contraceptive methods in contexts where a high standard of care cannot be guaranteed may violate the principle of "do no harm".

use (including dual protection) and provide information on the method mix available in the country along with basic instructions.

**By Whom:** Health providers from the public health sector or staff of international or national NGOs with prior agreement/approval by the MoH. Providers may include medical doctors, nurses, midwives, and health educators, translation as needed. Counselling and service provision can be provided by health providers assigned to the shelter or through mobile teams organized at the shelter in coordination with health authorities.

#### Referral to a hospital or clinic may be needed if:

- The preferred method is not available at the shelter
- For long lasting methods like the Intrauterine Device (IUD), implant, or if a check-up is needed prior to initiating one of these methods

## FP Commodities Include:

### CONDOMS

Male and female condoms. Condoms should be accessible for all in need. Discuss with the population in the shelter the best distribution points and check regularly that there are condoms at the shelter. It is recommended to provide: 12 male condoms per user/month and 6 female condoms per user/per month and to the extent possible, offer at least a two-month supply if there are no free distribution points at the shelter.

**By Whom:** Nurse, Midwives, Health educators, free access .

**Commodities:** Male and Female condoms.

**Note:** Inter-Agency Emergency Reproductive Health (IARH) Kit 1A (male condoms) and Kit 1B (female condoms, complementary kit) can be made available if needed.

### ORAL PILLS

For continuing users, to the extent possible offer a 3-month supply of methods. For new users, first rule out pregnancy and check Medical Eligibility Criteria (MEC) of the World Health Organization (WHO/PAHO). Important to note that some countries will require a medical appointment first.

**By Whom:** Nurse, Midwives, doctors

**Commodities:** Combined oral contraceptives, Progestin-Only Pills

**Note:** IARH Kit 4 (Oral and injectable contraception) could be made available if needed.

### INJECTABLES

Provide to continuing users. For new users, first rule out pregnancy and check the MEC from the WHO. Important to note that some countries will require a medical appointment first.

**By Whom:** Doctor, Nurse, Midwives

**Commodities:** Progestin-Only Injectables (the injectable contraceptives depot, medroxyprogesterone acetate (DMPA) and norethisterone enanthate (NET-EN) each contain a progestin like the natural hormone progesterone in a woman's body. Monthly Injectables (contain 2 hormones—a progestin and an estrogen).

**Note:** IARH Kit 4 (oral including emergency contraception pills and injectable contraception) can be made available if needed. Please note that Medroxyprogesterone acetate subcutaneous is a complementary Kit (DMPA-SC) that can be self-injected by women.

### EMERGENCY CONTRACEPTIVE PILLS (ECP)

ECP should be provided as soon as possible after unprotected sex. The sooner ECPs are taken after unprotected sex, the better they prevent pregnancy and always up to 5 days after unprotected sex. Use the opportunity to explain the ECP is to be used only in emergencies.

**By Whom:** Nurse, Midwives, doctors

**Commodities:** What Pills Can Be Used as Emergency Contraceptive Pills (Please note that the options would depend on national protocols)

- A special ECP product with levonorgestrel only, or ulipristal acetate (UPA)
- Progestin-only pills with levonorgestrel or norgestrel
- Combined oral contraceptives with estrogen and a progestin—levonorgestrel, norgestrel, or norethindrone (also called norethisterone)

**Note:** IARH Kit 3 (Post-rape treatment) contains Emergency Contraception and can be made available if needed. As indicated above, ECP is also part of IARH Kit 4.

**Referral:** Refer if the following methods are chosen: Copper-bearing IUD, Levonorgestrel IUD, Subdermal implants

## PREGNANCY TEST

Provide pregnancy test. If not available, a pregnancy checklist should be used to rule out pregnancy (see Annex 5).

**By Whom:** Nurse, Midwives

**Referral:** If pregnancy test is positive, refer to health facility for antenatal care services

## WORKING WITH ADOLESCENTS

During crisis adolescent girls are at greater risk of sexual assault, sexual exploitation and abuse, child or forced marriage, and lack of access to education. These factors place adolescent girls at heightened risk of unintended pregnancies and maternal morbidity and mortality. Factors which contribute to these risks include vulnerability to poverty, family separation and erosion of support structures, increased domestic responsibilities, engagement in unsafe livelihoods, and dependence on exploitative relationships or transactional sex for survival.

Shelter staff should ensure adolescents can access understandable SRH information and have full access to SRH services including contraception in line with national legislation. Shelter managers should establish relationships with national Child Protection agencies to support in the adaptation of programming to serve adolescents, and in referring child protection incidents.

See [MISP Chapter 6 - Adolescent SRH](#) for more information.

## 1.2. Prevent the transmission of and reduce morbidity and mortality due to HIV and other STIs

### SEXUALLY TRANSMITTED INFECTIONS (STI)

In case of a suspected STI, the user should be referred to a health facility for clinical examination, counselling and taking of samples and complementary tests. If referral is not possible and/or the test cannot take place or it is necessary to wait for sample results, the provider must opt for syndromic

treatment and provide condoms. Explain the importance of treating the sexual partner; promote and explain the use of condoms.

**By whom:** Doctor; nurse; midwife; health educator; translator as needed

**Commodities:** Treatment protocols may vary across countries. Could be provided at the shelter, yet health personnel should have been trained to diagnose and treat STIs according to the syndromic approach.

**IEC:** Wallchart on the syndromic treatment of STIs

**Referral:** If service is not provided at the shelter

### HIV

It is recommended that the shelter personnel create a secure and confidential environment to allow PLHIV to request help and easy access to their treatments. The shelter should also provide information about existing peer support groups and organizations that can provide support. To reduce the transmission of HIV during emergencies it must be:

- Guaranteed the availability of free lubricated male condoms and lubricants, where applicable (e.g., already used by the population), ensure provision of female condoms (see above)
- Supported the provision of Antiretroviral drugs (ARVs) to continue treatment for people who were enrolled in an Antiretroviral treatment (ART) program prior to the emergency, including women who were enrolled in Prevention of Mother to Child Transmission (PMTCT) programs
- Provided post-exposure prophylaxis (PEP) to survivors of sexual violence as appropriate and for occupational exposure: if not possible at the shelter ensure timely referral (less than 72 hours)

**By Whom:** Nurse/Physicians - in partnership with ARV clinics (phone consultation)

**Commodities:** ARV for patients on these medications: the medical personnel at the shelter should make the necessary arrangements with the referral health facilities to ensure that displaced persons would have access to ARVs. Rapid HIV tests only if counselling is provided.

**IEC:** Focus on HIV primary prevention, treatment, Prevention of Mother to Child Transmission (PMTCT), information related to PLHIV peer support groups and Civil Society Organizations (CSO) working with PLHIV

**Note:** IARH kits in support of STIs and HIV prevention which can be made available include: **Kit 1A** (Male condoms), **Kit 3** (Post-Rape Treatment), **Kit 5** (Treatment of STIs) - all 3 kits to be provided at the community level/health post level including shelters; and **Kit 12** (Blood transfusion) to be provided at the referral hospital level. Also, complementary Kit 1B (female condoms)

**Referral:** For HIV counselling and testing, uncomplicated asymptomatic patients doing well on therapy if follow up visit is needed, infectious diseases clinic for complicated cases, symptomatic or with virologic, immunologic or clinical failure, PMTCT, and PEP

### INTER-AGENCY REPRODUCTIVE HEALTH KITS

UNFPA maintains stock of reproductive health kits (RH Kits), ready to ship for urgent and emergency requests. The kits are designed to respond to three month's need for various population sizes. The individual kits are small enough and have convenient packaging, enabling them to be handled by one or two people. All boxes are clearly marked on the outside with the kit number, a distinct color for each kit, as well as a description of contents, consignee and other relevant information. Speak with UNFPA and the Ministry of Health within your context for guidance on what kits have been procured as well as timelines for delivery.

For more guidance on what is included in each kit see **UNFPA's 2019 Inter-Agency Emergency Reproductive Health Kits for use in Humanitarian Settings, 6th edition.**

## 1.3. Prevent excess maternal and new-born morbidity and mortality

Provision of information to the individuals about prenatal care, obstetric emergencies, safe delivery practices and new-born care.

**By Whom:** Nurse; midwives; doctor

**Referral:** All pregnant women are to be referred to a health facility for antenatal care and safe delivery (the level of Health Facility will depend on the model of care of each country)

## Antenatal Care

Ensure all pregnant women receive an appointment to attend Antenatal Clinic at the Health Facility. Ensure that if the woman is not in possession of an antenatal card she is provided with a replacement. It is important that pregnant women are aware of danger signs and have a delivery plan.

**Commodities:** At the discretion of the shelter. If commodities have been prescribed at the antenatal clinic continuation should be ensured at the shelter, key commodities include: Prenatal vitamins, Folic Acid, Iron Sulphate.

## Safe Delivery

Assist clients to plan for safe delivery. Counsel women on the importance of labour and delivery in a health facility. Provide individuals with information about health facilities operating 24/7 and methods of transportation for timely referral in case of pregnancy complications and/or onset of delivery. Provide information about financial aid available/social services to facilitate transfer to the health facility if emergency transportation is not free of costs.

## Post-partum

In case of delivery at the shelter, or where timely referral was not possible, or in the case of an incomplete abortion, women should be immediately referred to the referral health facility for urgent assistance.

**Post-partum and post-abortion contraception (PAC):** Respecting free and informed choice, women should initiate a contraceptive method early after the delivery. Please refer to the health facility.

## 1.4. Clinical Management of Rape

All survivors of sexual violence should be immediately referred to the health facility for additional care for physical health after the sexual assault, always ensuring that survivors themselves are informed of the services they will be receiving, and for referrals to be made only following informed consent unless life-threatening conditions are present (which would prevent the survivor from giving informed consent). Please see the referral pathway in Annex 3 as well as responding to incidents of GBV in the Sample SRH and Sexual Violence Referral Flowchart (see Annex 4).

**Note:** IARH kits in support of managing the consequences of sexual violence

which can be made available are: Kit 3 (Post-rape treatment) to be provided at the community/primary health level, and Kit 9 (Repair of cervical and vaginal tears) to be provided at the primary health-care facility level.

### Work with SRH health providers to conduct SRH rapid assessments

It is the role of shelter managers to advocate for SRH providers to be deployed to work in the shelter or visit the shelter regularly through mobile health teams and support them in conducting SRH Assessments at the shelter. This includes SRH risk assessments and assessments of the access

to SRH information and services by residents of the shelter, and especially by most vulnerable groups. This assessment will also include aspects such as to what extent health facilities that provide geographical coverage to the shelter have been identified (See Annex 2 for the SRH Rapid Service Mapping Tool), whether there are referral mechanisms in place including transportation to health facilities 24/7, whether shelter personnel are being sensitized in SRH and other relevant information that will inform what interventions need to be put in place to ensure that affected population has continuous access to the MISP for RH.

## 2. KEY GBV RISK MITIGATION, PREVENTION AND RESPONSE ACTIONS

It is not the role of shelter managers and untrained staff to directly provide GBV prevention and response services. The latter should always be done in coordination with national relevant authorities and the technical assistance of actors specialized in this area of work, such as UNFPA, in order to receive proper guidance during the implementation phase. It is highly recommended for shelter managers to support GBV Specialists to conduct assessments and set up programming interventions within the shelter.

However, shelter managers should be able to mitigate GBV risks within their shelters by following this guidance and advocating for the hiring of specialized personnel to work in their shelters, as well as ensuring their staff are aware of how to safely respond to GBV incidents within the shelters.

The following key actions must always be complemented with the key activities outlined in the section related to preparedness actions, and in line with the checklist provided below in this guidance.

### 2.1. Understand and Mitigate GBV Risks<sup>17,18</sup>

In line with what was mentioned under key preparedness actions (please refer to that section to understand how emergency shelters can increase GBV risks), it is important to remember that even if key preparedness actions have been undertaken ahead of an emergency, each context and each shelter is

different and will therefore give place to different types of risks for women

#### KEY CONSIDERATIONS FOR GBV RISK MITIGATION IN EMERGENCY SHELTERS:

- Use shelter interventions to mitigate GBV risks associated with the emergency and/or local context
- Mitigate GBV risks posed, or exacerbated by, shelter interventions themselves

and girls, and further possibilities for perpetrators of violence to inflict GBV. As such, aside from following preparedness guidance, there continues to be a need to constantly assess GBV risks in the shelters and adapt to mitigate new identified risks.

### Understand the population in your shelter

Collect general demographic information, disaggregated by gender (or at least by sex) and age, to understand the population that is residing in the shelter, including at-risk groups (see general and demographic information tool - Annex 1). Identifying the number of sex-disaggregated persons and at-

<sup>17</sup> Global Shelter Cluster Working Group on Gender-Based Violence (2016). Good Shelter Programming - Tools to Reduce the Risk of GBV in Shelter Programmes.

<sup>18</sup> Global Shelter Cluster Working Group on Gender-Based Violence (2018). Distribution: Shelter Materials, NFI & Cash.

risk groups will help shelter managers in accounting for those groups' special needs and specific GBV risks that can be mitigated already at the planning stages.

### General set up of the shelter, including special considerations to increase security and privacy

Security and privacy interventions such as providing lockable doors, partitions, segregating toilets and washing facilities by sex, adequate accommodation and respect of minimum standards have a great impact on GBV risk reduction. This is due both to general protection / good shelter programming, and to the fact that inadequate shelter can increase tensions. The shelter should adhere to the humanitarian recommendation of respecting 3.5 m<sup>2</sup> per person and consulting at-risk groups on shelter arrangements which make them feel safest and are intentionally located within the shelter facility to minimize risk (e.g. unaccompanied children, PLWD, female or child-headed households, older persons, LGBTQI+ etc.). Please see the Sphere Standards, and the Global Shelter Cluster for guidance.

- Ensure every single person in the shelter is accounted for and is properly registered, regardless of their marital status
- Ensure lighting across all corridors and WASH facilities of the shelters are not only available but properly working and there is a plan in place in case of power outages (i.e. providing lanterns through specific distributions)
- Ensure WASH facilities are all separated by sex, and also as far away from each other as possible
- Ensure law enforcement actors include female personnel in all emergency shelters
- Ensure all law enforcement personnel and service providers have signed a Code of Conduct highlighting a zero tolerance for PSEA

### Mitigate GBV risks around procurement and distribution of food and NFI items

Being unable to meet their needs through NFIs can greatly limit women's freedom of movement and exposes them to risk of violence and exploitation as they may be forced into negative coping mechanisms, such as transactional

sex, to meet their needs. These specific actions should be taken to mitigate risks when distributing food and NFIs:

- Provide ration cards, information and aid distribution to female heads of households, shifting power dynamics and empowering potential GBV survivors to have the means to leave an abusive relationship.
- Consult with shelter residents in the sourcing and distribution of food, NFIs to ensure items are appropriate in selection and quantity and meet the needs of residents in relation to their roles and responsibilities. Discussions should be led by trained personnel, separated by gender and age groups, and include GBV specialists to provide support in the event of a GBV disclosure.
- Consult women and girls about locations and times of distributions to ensure access and consult where they feel safest.
- Provide at risk groups a 'priority line' for distributions (persons at risk of violence, elderly, lactating women, LGBTQI+, persons with disabilities, unaccompanied children etc.)
- Provide those with mobility restrictions or fear of violence a direct distribution and support in returning to their site / bed location.
- Prioritise household-level water sources as well as sex disaggregated WASH facilities. If the latter is not possible, ensure consultation with women and girls on how they would feel more comfortable, in collaboration with GBV actors, including UNFPA.
- Ensure coordination with GBV actors in the distribution of Dignity Kits and Hygiene Kits, clearly understanding the differences between these two interventions and complementing the items being distributed to women and girls with recommendations provided by UNFPA.

The distribution of relief items introduces powerful resources into the community that can be misused and abused. Distributions can increase the protection risks to vulnerable groups - in particular, a heightened risk of SEA and other forms of GBV. Perpetrators of SEA are usually humanitarian workers and other service providers, as well as individuals who are also affected by the emergency who hold a position of power linked to the provision of services or benefits to the affected communities, such as community/religious leaders, national staff and community volunteers. As such, appropriate measures must be put in place to mitigate the risks of SEA.

### Actions to reduce the risk of SEA perpetrated by the humanitarian staff include:



Ensuring the distribution is done by a gender-balanced team



Informing the community that all assistance is free of charge and does not require favours in return



Ensuring a monitoring system is in place

See additional guidance on distribution of shelter materials and NFIs [here](#); watch a video on NFI distribution in shelters [here](#).

## 2.2. Strengthen partnerships with GBV Specialists to set up GBV prevention and response services in emergency shelters

Shelter managers should always advocate for the support of GBV Specialists who will help them plan for and implement specific activities to mitigate GBV risks, and also ensure the shelters are able to prevent and respond to GBV, through the direct provision of GBV response services by specialized actors. Shelter programmes should thus aim to ensure the following four areas of work to mitigate GBV risks, and allow for the provision of specialized services in the shelters:

### Work with GBV Specialists to ensure distribution of Dignity Kits for women and girls, as part of their GBV response services within the shelter and/or linked to related service provision outside of the shelter premises

Shelter managers should aim to work with GBV specialists in order to ensure Dignity Kits will be distributed to women and girls, and that the activity is strongly linked to lifesaving GBV response services. In the aftermath of an emergency, women and girls need basic items to maintain their hygiene, and the provision of dignity kits is meant to support them in seeking basic services and fully participate in their public and private life with dignity. The selected items in the dignity kits must be informed by conversations with affected

women and girls, as they can increase their protection and avoid that they spend their limited income (if any) procuring these items. They also contain key information on services available for women and girls who could be at risk of (or suffering) GBV, offering an opportunity to enter in direct contact with service providers, which is in itself a lifesaving activity. It is extremely important to note that distribution of dignity kits is not a standalone activity, nor should it be done as a general blanketed distribution - it is a part of GBV programming activities and should be led by GBV specialists, and/or local partners who can also receive technical guidance and support from agencies such as UNFPA.

### Work with GBV Specialists to conduct GBV Assessments

It is the role of shelter managers to advocate for trained GBV Specialists to be deployed to work in the shelter, such as Case Workers and Social Workers, through UNFPA and the National Gender Mechanisms within your context and support them in conducting GBV Assessments within the shelter. This includes assessments such as the GBV Safety Audit and GBV Risk Mitigation Tools, which are conducted prior to and after the establishment of the shelter to understand the risks that exist within the facility and its programming and ensure the shelter is set up taking them into consideration. These assessments will also inform the need to include GBV response programming and coordination activities within the shelter, providing key information to shelter managers around the staff needs, spaces needed for the establishment of the activities and services, funding needs, etc.

**DIGNITY KITS<sup>19</sup>**

Dignity Kits are not just hygiene kits, they are used as an entry point to begin working with women and girls, understanding GBV risks in their shelters and providing a safe entry point for possible disclosures of GBV incidents and referrals. Dignity kits comprise basic items that women and girls need to protect themselves and maintain hygiene, respect and dignity during a crisis. Menstrual sanitary items, such as sanitary pads and tampons, or any other items preferred by the women and girls, should be available and free for all women and girls at all times. Dignity kits should be distributed by GBV staff as part of programming, and not part of general NFI distributions. Items recommended by UNFPA for inclusion in Dignity Kits for women and girls in the Caribbean region include:

- Toothbrush and toothpaste + Comb + Deodorant + Soap + Shampoo + Lotion (body and/or face)
- Sanitary pads and tampons + Undergarments (bra and underwear)

### **Partnering with local organizations that have GBV expertise, and engaging men and community gatekeepers in programme planning**

It is the role of shelter managers to ensure GBV specialists are supported and able to train and guide staff in mitigating GBV risks when designing programmes, and that those same specialised actors are allowed to set up activities within the shelter. Work with local organizations, governmental entities, and UN Agencies (such as UNFPA) specializing in GBV response, to ensure GBV-related trainings for staff, and to facilitate single-sex safe spaces for critical reflection on men's/women's own experiences of gender norms and expectations. Engaging existing community groups in shelter program design can also address potential unintended effects of a programme and the gender and GBV related barriers that need to be considered. Shelter managers should engage extension workers, health workers, and other existing development actors who might have already received gender training, about who will be allies in all the various levels at which the programme work will take place and who can partner with your project to mitigate or prevent

any potential unintended GBV effects.

If programmes in the shelter engage the participation of women and/or girls in different activities by inviting them, for example, to attend meetings or groups, men can often become suspicious. To reduce the risk of violence that may result from this suspicion, shelter staff should inform men and gatekeepers of the community of the project's goals and expectations for female programme participation. This will help to reduce the risk of violence.

### **Ensure all staff have signed and been trained on the PSEA Code of Conduct**

In humanitarian emergencies while states have the primary responsibility to protect persons under their control, all humanitarian actors including shelter staff have the responsibility to protect shelter residents. Prevention of Sexual Exploitation and Abuse (PSEA) therefore is the responsibility of ALL humanitarian actors, yet shelter managers play a critical role in the training and management of staff and in setting up PSEA systems. All staff, volunteers, support personnel and security guards should be trained on the respective government agencies and NGOs' Codes of Conduct and relevant national legislation and will have signed such Code of Conduct prior to working in the shelter. For a sample Code of Conduct Please see Annex 7. It is the responsibility of the shelter manager to ensure that staff have signed the Code of Conduct, that they are trained on PSEA, and to monitor adherence. Copies of the Code of Conduct should include values and responsibilities, and safe contact information (e.g. dedicated phone lines and email addresses) for reporting Sexual Abuse and Exploitation and other forms of abuse or negligence should be prominently displayed at the shelter.

Shelter managers must be aware of the national authorities responsible for responding to SEA, as well as the mechanisms for reporting when incidents are reported. Please contact UNFPA and the National Gender Mechanisms within your context for further guidance on reporting and response mechanisms, including PSEA focal-points. Shelter managers should work with GBV specialists to ensure communities are engaged in discussions regarding the safest way to report SEA incidents and identifying community-based reporting mechanisms. More guidance on SEA can be found through the PSEA task force, including setting up Community-Based Complaints Mechanisms.

<sup>19</sup> More guidance from UNFPA on dignity kits can be found [here](#).



## 2.3. Following the GBV Guiding Principles and a Survivor-centered approach when GBV incidents are reported to non-specialized personnel

### Key consideration when responding to GBV incidents in the shelters:

- Follow the GBV Guiding Principles and a Survivor-centered approach when GBV incidents are reported to non-specialized personnel.

### Safely responding to GBV Incidents (GBV Pocket Guide and Constant Companion)

Even when GBV Referral Pathways have been developed and disseminated prior to a disaster, an emergency usually disrupts these services and there will be a need to update them. GBV Referral Pathways are used by case workers to provide case management services, but there are simplified tools that are created specifically for persons who are not specialized in the provision of services to survivors, but that ensure care and referrals are provided in a manner that upholds a survivor-centered approach and adheres to the GBV Guiding Principles.

- If the specific country has GBV services in place and there are GBV focal points, shelter managers can use the GBV Constant Companion, which provides basic information on the specific steps they can take to safely refer a survivor to specialized services, if the survivor provided specific consent to it<sup>20</sup>.
- If there are no GBV services available in the country, or those services have been completely disrupted by the emergency, shelter managers can use the GBV Pocket Guide (see Table 3 for recommended training for frontline workers)<sup>21</sup>.
- All response activities should be closely coordinated with GBV Specialists, who can also provide tailored training for shelter managers and other staff working in the shelters.
- Contact the NGM and GBV specialists if you do not have access to referral pathway documentation.
- See Annex 3 for the GBV Rapid Service Mapping Tool, which GBV specialists should be asked to lead, and contains key information on providers in your area, what services are available and how they can be reached.
- For additional guidance on referral see Annex 4 which provides a Sample SRH and Sexual Violence Referral Flowchart.

<sup>20</sup> Annex 6, referencing the GBV Pocket Guide and the GBV Constant Companion, provides shelter staff with practical step-by-step advice on how to respond if they are faced with a disclosure of GBV, including clear Do's and Don'ts and a decision tree to guide in how to respond when a disclosure is made.

<sup>21</sup> Idem

# Checklist for Emergency Shelters

SERVICE	PREPAREDNESS CONSIDERATIONS	RESPONSE CONSIDERATIONS
<b>1. National Protocols &amp; Shelter Policies</b>	<ul style="list-style-type: none"> <li><input type="checkbox"/> National protocols and standards of all SRH interventions to be provided at the shelter, including CMR and adolescents' access to contraception, have been reviewed and are easily available at the onset of an emergency</li> <li><input type="checkbox"/> National mandatory reporting laws in regard to GBV, child sexual abuse, and SEA have been reviewed and are easily available at the onset of an emergency</li> <li><input type="checkbox"/> National protocols and standard operating procedures regarding the response to GBV incidents and additional protocols prepared in cases on emergency, are reviewed and easily available at the preparedness stage</li> <li><input type="checkbox"/> Understand national plans for the facility set up of the emergency shelters (will facilities be repurposed to fill the gap, are there facilities ready for the purpose?)</li> <li><input type="checkbox"/> Shelter policies and guidelines are updated to ensure the below checklist is actionable (e.g. equal employment of females, zero tolerance for SEA)†</li> <li><input type="checkbox"/> Plan for registration processes that are gender (or at least sex).</li> <li><input type="checkbox"/> Plan for ration cards to be distributed to every individual in the shelter, and when this is not possible, to female heads of household.</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> All service providers in the shelter understand and have on hand the national protocols and standards of all SRH interventions to be provided at the shelter (especially if providers are INGOs that have never operated in the country before)</li> <li><input type="checkbox"/> All service providers at the shelter are aware of mandatory reporting laws and where to report (police, legal system)</li> <li><input type="checkbox"/> Data collection tools are available in line with national health management information system (HMIS)</li> <li><input type="checkbox"/> Shelter policies, standards and guidelines have been communicated to women, girls, boys and men†</li> <li><input type="checkbox"/> Registration processes that are gender (or at least sex) disaggregated, and every person at the shelter will be registered.</li> <li><input type="checkbox"/> Ration cards will be distributed to every individual in the shelter, and when this is not possible, to female heads of household.</li> </ul>

SERVICE	PREPAREDNESS CONSIDERATIONS	RESPONSE CONSIDERATIONS
<p><b>2. Shelter Design &amp; Safety</b></p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> GBV risk reduction is prioritized in shelter design, site preparation and planning: shelters are built and designed for privacy and safety, and include the active participation (through consultations) of women, girls and other at-risk groups as well as community groups and NGOs that provide specialized GBV services†</li> <li><input type="checkbox"/> Processes are in place to identify needs and prioritize shelter assistance for at-risk groups (using vulnerability criteria),<sup>14</sup>including emergency housing for at-risk groups facing safety concerns†</li> <li><input type="checkbox"/> Shelters will have a specially protected, private, and safe area for most vulnerable individuals and when this is not possible, completely separate shelters specific for these vulnerable groups will be planned.</li> <li><input type="checkbox"/> GBV specialists are invited to the shelter to assess safety and to identify associated GBV risks. If shelters are not yet set up, they are included in the planning process. †</li> <li><input type="checkbox"/> <b>Consultation:</b> At-risk groups are consulted on which shelter arrangement makes them feel safest and intentionally located within the shelter facility to minimize risk (e.g. unaccompanied children, PLWD, female- or child-headed households, older persons, LGBTQI+)</li> <li><input type="checkbox"/> <b>Safety and Privacy:</b> Shelters are designed to be safe and private - locks on windows and doors, and distance is provided between ages and sexes as culturally appropriate (e.g. privacy partitions between spaces)†</li> <li><input type="checkbox"/> <b>Accessibility:</b> Reasonable accommodation considerations are in place to ensure accessibility for all persons, including PLWD (e.g., physical disabilities, injuries, visual or other sensory impairments, etc.) to all facilities in the shelter.</li> <li><input type="checkbox"/> <b>Cooking Spaces:</b> Sufficient cooking spaces are planned to be set up if prepared food is not provided.</li> <li><input type="checkbox"/> <b>Lighting:</b> Sufficient lighting is provided in and around shelters including restrooms and common areas, at the entrances to the shelter, and on the street where entrances are located (e.g., alternative lighting during periods with no power, adequate light bulbs etc.)†</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> <b>GBV specialists:</b> GBV specialists are invited to the shelter to assess for safety and to identify associated risks of GBV†</li> <li><input type="checkbox"/> <b>Overcrowding:</b> The shelter respects the humanitarian recommendation of 3.5 m2 per person and limits overcrowding ±</li> <li><input type="checkbox"/> <b>Consultation:</b> At-risk groups are consulted on which shelter arrangement makes them feel safest and intentionally located within the shelter facility to minimize risk (e.g. unaccompanied children, PLWD, female- or child-headed households, older persons, LGBTQI+)</li> <li><input type="checkbox"/> <b>Safety and Privacy:</b> Shelters are designed to be safe and private - locks on windows and doors, and distance is provided between ages and sexes as culturally appropriate (e.g. privacy partitions between spaces)†</li> <li><input type="checkbox"/> <b>Movement:</b> Women and girls including vulnerable persons (adolescents, pregnant women, PLWD, LGBTQI+, migrants etc.) can safely move around the shelter alone, including corridors and walkways to safely access communal spaces and service points†</li> <li><input type="checkbox"/> <b>Accessibility:</b> Reasonable accommodation to ensure accessibility for all persons, including PLWD (e.g., physical disabilities, injuries, visual or other sensory impairments, etc.) to all facilities in the shelter; if women and girls need to leave the shelter for work, food, or other services measures are in place to improve safety†</li> <li><input type="checkbox"/> <b>Cooking Spaces:</b> Sufficient cooking spaces are provided if prepared food is not provided <b>Lighting:</b> Sufficient lighting is provided in and around shelters including restrooms and common areas, at the entrances to the shelter, and on the street where entrances are located (e.g., alternative lighting during periods with no power, adequate light bulbs etc.)†</li> <li><input type="checkbox"/> <b>Safe bathroom facilities/water access:</b> Adequate toilets, bathing facilities, sinks and water points placed at appropriate distances from sleeping structures (according to humanitarian standards) and toilets are gender separated and have safety locks, showers are gender separated and have safety locks, potable drinkable water is available, and adequate water and soap is provided for menstrual health management†,‡</li> </ul>

14 There is currently no agreed upon methodology to classify the nature and severity of vulnerability within shelters at the global level, different countries will have various vulnerability criteria and indexes.

SERVICE	PREPAREDNESS CONSIDERATIONS	RESPONSE CONSIDERATIONS
	<ul style="list-style-type: none"> <li><input type="checkbox"/> <b>Safe bathroom facilities/water access:</b> Adequate toilets, bathing facilities, sinks and water points placed at appropriate distances from sleeping structures (according to humanitarian standards) and toilets are gender separated and have safety locks, showers are gender separated and have safety locks, potable drinkable water will be available, and adequate water and soap will be provided for menstrual health management †, ‡</li> <li><input type="checkbox"/> <b>Private exam room:</b> A private consultation / exam space at the shelter is dedicated to first aid and the provision of SRH services as well as confidential/private disclosure of a GBV incident, basic commodities are in stock and a first aid kit is available*</li> <li><input type="checkbox"/> <b>Connectivity:</b> Free phone calls, free Wi-Fi, device charging stations, and if conditions allow, devices available for use free of charge †</li> <li><input type="checkbox"/> <b>Safe re-housing:</b> shelters for GBV survivors will be included in the planning process, to make sure protocols are in place in case there needs to be referrals. These will not be opened for the general population, even during an emergency.</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> <b>Private exam room:</b> A private consultation / exam space at the shelter is dedicated to first aid and the provision of SRH services as well as confidential/private disclosure of a GBV incident, basic commodities are in stock and a first aid kit is available*</li> <li><input type="checkbox"/> <b>Connectivity:</b> Free phone calls, free Wi-Fi, device charging stations, and if conditions allow, devices available for use free of charge †</li> <li><input type="checkbox"/> <b>Safe re-housing:</b> GBV Survivors and other at-risk groups which need to be moved for safety reasons are safely referred to alternative emergency housing †</li> </ul>
<p><b>3. Staffing: Hiring, Capacity Building and PSEA</b></p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Attention is given to hiring and retaining female staff, especially in positions of leadership within the shelter †</li> <li><input type="checkbox"/> Staff are trained on international shelter standards such as Sphere and the IASC, and trainings and workshops on PSEA, GBV, Child Protection, and MISP-SRH are carried out regularly for all staff †</li> <li><input type="checkbox"/> Shelter managers are aware of local SEA focal points and agency procedures to report, investigate and take disciplinary action in cases of SEA</li> <li><input type="checkbox"/> SEA Code of Conduct has been adapted and endorsed by the agency (see annex 7)</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> SRH point person, and trained GBV point person are assigned at the shelter</li> <li><input type="checkbox"/> A cadre of health providers are available to provide SRH interventions at the shelter (specific categories will depend on which competencies are assigned for these different cadres, namely nurses, midwives, and doctors), this could be through static teams or mobile teams.</li> <li><input type="checkbox"/> Attention is paid to the ratio of female to male staff including those in leadership positions</li> <li><input type="checkbox"/> Cultural or security issues related to the employment of women and an increased risk of GBV is mitigated †</li> <li><input type="checkbox"/> Translators are available on site; if they are not available a list of approved translators is provided to staff</li> <li><input type="checkbox"/> New staff are trained, and staff are provided refresher trainings on shelter standards, PSEA, GBV, Child Protection, and SRH</li> <li><input type="checkbox"/> All shelter staff (contractual or volunteer) have signed the Code of Conduct, and the SEA Code of Conduct is posted and visible at the shelter †</li> </ul>

SERVICE	PREPAREDNESS CONSIDERATIONS	RESPONSE CONSIDERATIONS
<p><b>4. Referral Pathways</b></p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Shelter management have consulted with specialists to map SRH and GBV response services (medical, psychosocial, legal, temporary shelter/housing, GBV case worker/social worker etc.), and referral pathways are updated/established.</li> <li><input type="checkbox"/> Shelter managers have been trained on the use of GBV Pocket Guide or GBV Constant Companion</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Shelter managers consult with GBV and SRH Specialists on available and updated Referral pathways in the specific context, in order to receive updated information - such as the GBV constant companion.</li> <li><input type="checkbox"/> If no GBV services are available in the country, shelter managers consult with GBV Specialists and NGM in organising a GBV Pocket Guide training for themselves and their staff, ensuring safe referrals.</li> <li><input type="checkbox"/> Shelter staff know the opening hours, contact information, services provided and modality (phone, remote), and are aware of the necessary documentation required for persons to access these services*</li> <li><input type="checkbox"/> Referral pathway information is printed and visible within the shelter and easily accessible to shelter staff and those sheltering (in multiple languages, and adapted to the needs of persons living with disabilities)</li> <li><input type="checkbox"/> Persons in need of urgent medical care are referred to medical facilities in a timely fashion and only following informed consent unless life-threatening conditions are present (which would prevent the survivor from giving informed consent), and persons are provided with free transportation 24/7. Information regarding free transportation services (and contact numbers) for referrals to the health facilities is available and visible to all.</li> <li><input type="checkbox"/> Staff understand confidentiality and no data or information on GBV cases is kept by shelter managers or staff.</li> </ul>
<p><b>5. General programming</b></p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Active participation of women, girls and other at-risk groups is promoted in the planning of shelter programming †</li> <li><input type="checkbox"/> Coordinate and partner with community organizations and NGOs that have gender and GBV-specific expertise.</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Women, girls and other at-risk groups are included in shelter programming, and their participation and leadership are promoted and encouraged †</li> <li><input type="checkbox"/> Women and Girls Safe Spaces established and other relevant community and protective spaces according to age and need.</li> <li><input type="checkbox"/> In partnership with community organizations and NGOs, gender equality programmes could take place within shelter interventions†</li> </ul>

SERVICE	PREPAREDNESS CONSIDERATIONS	RESPONSE CONSIDERATIONS
<p><b>6. SRH Services at the Shelter</b></p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> The package of SRH interventions to be offered at the shelter is discussed and agreed by the MoH.</li> <li><input type="checkbox"/> Health providers are trained in the provision of the MISP for SRH and staff at the shelter are sensitized in SRHR</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Health providers at the shelter provide the MISP for SRH and are able to provide timely referrals*</li> <li><input type="checkbox"/> Staff at the shelter is sensitized in SSR</li> <li><input type="checkbox"/> Access to contraceptive counselling and referrals is available to all *</li> <li><input type="checkbox"/> Adequate supply of condoms is provided and distributed through various free distribution points (including male and female condoms based upon context). Distribution mechanisms inclusive of sex workers, youth, PWD, PLHIV and LGBTQI+ community**</li> <li><input type="checkbox"/> Condom distribution/uptake is monitored and resupplied when needed**</li> <li><input type="checkbox"/> PLHIV are aware of where to get access to ART treatment and where to get confidential counselling *</li> <li><input type="checkbox"/> Pregnant women have access to antenatal care (WHO recommends 8 visits) or referred Survivors of rape are compassionately and quickly referred to CMR services, including but not limited to: Wound care, PFA, access to EC, PEP for HIV within 72 hours, STI treatment, safe abortion to the fullest extent of the law, post-exposure prophylaxis against Hepatitis B and Tetanus toxoid **</li> <li><input type="checkbox"/> Free sanitary napkins are available for women and girls</li> </ul>
<p><b>7. SRH and GBV Commodities</b></p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> A list of the necessary SRH commodities to provide MISP- SRH in line with national protocols and/or the National Essential Medical List is created and easily available at the onset of an emergency</li> <li><input type="checkbox"/> A list of the necessary commodities for hygiene/dignity kits and IEC materials is created; key items sourced and stocked when possible</li> <li><input type="checkbox"/> Mechanisms are in place for the supply of commodities to the shelter, as well as guidance on proper warehousing (identify a secured room, responsible staff etc.)</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> All commodities required for SRH services to be provided at the shelter are in stock<sup>15</sup></li> <li><input type="checkbox"/> All commodities required for hygiene/dignity kits and IEC materials at the shelter are in stock</li> </ul>

<sup>15</sup> The list of commodities and services to be provided at the shelter during the response will depend on each country and context. In some cases, countries might opt for organizing mobile clinics to the shelters for the SRH service provision. However, regardless of the delivery modality (whether static teams or mobile clinics), shelter managers and health teams should ensure that all commodities required for SRH service provision at the shelter are available.

SERVICE	PREPAREDNESS CONSIDERATIONS	RESPONSE CONSIDERATIONS
<p><b>8. GBV Response Services at the Shelter</b></p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Map and consult GBV Actors in the types of services they can provide in the shelter, their capacity and needs of space, staff, and general support needed from the shelter manager</li> <li><input type="checkbox"/> Specialized medical staff are trained in how to respond to GBV incidents, all staff who engage with affected populations are trained in the use of the GBV Constant Companion, ensuring safe referral of GBV survivors</li> <li><input type="checkbox"/> Mechanisms for safe and confidential reporting of GBV within and outside the shelter are understood by shelter manager</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> GBV Constant Companion is printed and provided to all staff when hired *</li> <li><input type="checkbox"/> All persons who disclose an incident of GBV are provided with safe and timely referrals Engage with local partners to deploy case workers/social workers to ensure case management services are provided in the shelter and survivors continue to be referred (e.g. psychological services) - If a case worker/social worker is not on site or provided to the GBV survivor through the referral pathway contact UNFPA or the National Gender Machineries within your context</li> <li><input type="checkbox"/> Engage with local partners to deploy case workers/social workers to ensure case management services are provided in the shelter and survivors continue to be referred (e.g. psychological services) - If a case worker/social worker is not on site or provided to the GBV survivor through the referral pathway contact UNFPA or the National Gender Machineries within your context</li> <li><input type="checkbox"/> GBV actors provide GBV programming at the shelter, including the Distribution of Dignity Kits (see table 10)</li> <li><input type="checkbox"/> To ensure confidentiality and survivor safety no data or information on GBV cases should be kept by or shared with shelter managers (If GBV practitioners are present in the shelter data must be collected and stored in line with ethical standards, see the GBVIMS guidance<sup>16</sup> - including Information Sharing Protocols (ISP))</li> </ul>
<p><b>9. NFI distribution</b></p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Processes are in place to determine which NFIs are the priority of the shelter to distribute such as hygiene kits, lighting, and cooking utensils</li> <li><input type="checkbox"/> Vulnerability criteria is clearly defined to prioritize distribution of NFIs especially for at-risk groups</li> <li><input type="checkbox"/> GBV risk mitigation measures are understood, specifically in reducing the risk of SEA during distribution †</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> GBV mitigation measures in place to ensure safety of distributions †</li> <li><input type="checkbox"/> Equal and impartial distribution of NFIs ensuring women, children and at-risk groups have the same access †</li> <li><input type="checkbox"/> Vulnerability criteria used to prioritize women, girls and at-risk groups in distribution processes – direct distribution, priority lines, and assistance with carrying or transport of items given to at- risk groups (e.g. unaccompanied children, pregnant women, persons with disabilities, survivors of GBV, etc.)†</li> <li><input type="checkbox"/> Distribution routinely monitored for safety including assessing if items meet needs of women, children and at-risk groups and for GBV risks (e.g. sexual exploitation or forced and/or coerced prostitution in exchange for NFI etc.)†</li> <li><input type="checkbox"/> Hygiene kits for women and men are differentiated by gender needs ,and are distributed using clearly defined prioritization</li> </ul>

<sup>16</sup> The Gender-Based Violence Information Management System (GBVIMS) is a system that enables GBV specialists responding to incidents of GBV to effectively and safely collect, store, analyze and share data reported by GBV survivors. Tools include the GBV classification Tool, Intake and Consent Forms, Incident Recorder, and sample inter-agency Information Sharing Protocol (ISP). More information here.

SERVICE	PREPAREDNESS CONSIDERATIONS	RESPONSE CONSIDERATIONS
<p><b>10. Information &amp; Outreach</b></p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> IEC materials are designed in collaboration with GBV/SRH specialists, and printed to be rapidly deployed within the shelter</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Shelter staff inform those sheltering about the SRH and GBV services available at the shelter as well as external services, this information should also be in the form of printed materials (including hours, location, contact, services provided, and documentation required)‡</li> <li><input type="checkbox"/> IEC material including information boards, banners, and leaflets display information on services available on site in a format that reaches PLWD, in both local languages and the main foreign language (targeting migrants, adolescents, LGBTQI+, sex workers etc.)*</li> <li><input type="checkbox"/> Outreach to shelter residents utilizing various communication modalities such as SMS, WhatsApp and radio messaging†</li> <li><input type="checkbox"/> Key IEC and outreach campaigns include:             <ul style="list-style-type: none"> <li><input type="checkbox"/> <b>FP:</b> Information about pregnancy prevention with a focus on modern contraceptive methods</li> <li><input type="checkbox"/> STIs and HIV prevention, information targeting PLHIV about where to access ART treatment and where to receive confidential counselling †</li> <li><input type="checkbox"/> Danger signs of pregnancy and where to go in case of an emergency †</li> <li><input type="checkbox"/> Awareness on safety and GBV risk reduction (including where to report risk and how to access care), survivor’s rights including confidentiality as well as trafficking risks †</li> </ul> </li> </ul>

**General comments:**

If you have general comments you would like to raise in either the preparedness or response phase, feel free to include them in here:

† UN Inter-Agency Standing Committee and Global Protection Cluster (2015). IASC Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action.

‡ Response for Venezuelans (R4V) Support Spaces Working Group. Support Spaces Toolkit.

\* UNFPA Sub-Regional Office for the Caribbean - Guidance and Assessment Tools.

\*\*IAWG, MISP Sub-Working Group (2018) Minimum Initial Service Package (MISP) for sexual and reproductive health (SRH) in crisis situations: A Distance learning module; and IAWG, MISP Sub-Working Group (2020). MISP Considerations Checklist for Implementation During COVID-19.

± Sphere Project (2018). The Sphere Handbook: Humanitarian Charter and Minimum Standards in Humanitarian Response.



# Bibliography

- CARE and IRC (2020). Global Rapid Gender Analysis for Covid-19. Available [here](#).
- GBV Constant Companion (2016). Global Shelter Cluster, GBV in Shelter Programming Working Group.
- Available [here](#).
- Global Shelter Cluster Working Group on Gender-Based Violence (2018). Distribution: Shelter Materials, NFI & Cash. Available [here](#).
- Global Shelter Cluster Working Group on Gender-Based Violence (2016). Good Shelter Programming - Tools to Reduce the Risk of GBV in Shelter Programmes. Available [here](#).
- IAWG (2018). Minimum Initial Service Package (MISP) for sexual and reproductive health (SRH) in crisis situations: A Distance learning module. Available [here](#).
- IAWG, MISP Sub-Working Group (2020). MISP Considerations Checklist for Implementation During COVID-19. Available [here](#).
- ICRC (2020). Prevention and Response to Sexual and Gender based Violence in Covid-19 Quarantine Centres Recommendations and Best Practice. Available [here](#).
- PAHO (2020). Caribbean Shelter Guide : Covid-19 considerations, Preparatory measures to be taken in Emergency Shelters during hurricane season inclusive of Basic Infection Control, Hygiene, Space Management and COVID-19 Precautions. Available [here](#).
- PAHO (2020). COVID-19 Infection Prevention and Control in Shelters for Women and Children Survivors of Domestic and Family Violence in the Caribbean, 4 June 2020. Available [here](#).
- Response for Venezuelans (R4V) Support Spaces Working Group. Support Spaces Toolkit. Available [here](#).
- Sphere Project (2018). The Sphere Handbook: Humanitarian Charter and Minimum Standards in Humanitarian Response. Available [here](#).
- UN Inter-Agency Standing Committee and Global Protection Cluster. GBV Pocket Guide - How to Support Survivors of Gender-Based Violence When a GBV Actor is Not Available in Your Area. Available [here](#).
- UN Inter-Agency Standing Committee and Global Protection Cluster (2015). IASC Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action (Section 3.11 - Shelter, Settlement and Recovery). Available [here](#).
- UN Inter-Agency Standing Committee and Global Protection Cluster (2012). IASC Minimum Standards for Child Protection in Humanitarian Action. Available [here](#).
- UN Inter-Agency Standing Committee and Global Protection Cluster (2020). Identifying & Mitigating Gender-based Violence Risks within the COVID-19 Response. Available [here](#).
- UN Women, PAHO and UNFPA (2020). Guidance for GBV Shelters in the Context of COVID 19. Available [here](#).
- UNFPA (2019). Manual - Inter-Agency Emergency Reproductive Health Kits for use in Humanitarian Settings, 6th edition. Available [here](#).
- UNFPA and the Global Gender-Based Violence Area of Responsibility (2019). The Inter-Agency Minimum Standards for Gender-Based Violence in Emergencies Programming. Available [here](#).

# Annexes

1. General / Demographic Information
2. SRH Rapid Service Mapping
3. GBV Rapid Service Mapping
4. Sample SRH and Sexual Violence Referral Flowchart
5. Pregnancy Checklist
6. GBV Pocket Guide and Constant Companion
7. Sample Code of Conduct on Sexual Exploitation and Abuse (SEA)
8. COVID Specific Guidance

## 1. GENERAL / DEMOGRAPHIC INFORMATION

Collecting demographic information (disaggregated by sex and age and including at-risk groups) will help shelter managers understand the population that is residing in the shelter in order to best meet their special needs and mitigate GBV risks.

### GENERAL INFORMATION

Date of Assessment: \_\_/\_\_/\_\_ (dd/mm/yy)

Name of Assessor:

Location of Assessment:

Country/territory \_\_\_\_\_ City/Community \_\_\_\_\_ Rural  Urban

Emergency Shelter \_\_\_\_\_ Other location \_\_\_\_\_

### DEMOGRAPHIC INFORMATION

Total Estimated Affected Population of Site  
(disaggregated by gender and age)

Number:

#### Characteristics - Host Community

- Women
- Men
- Adolescents girls
- Adolescents boys
- Girls
- Boys
- LGBTQI+ members
- Persons with physical or mental disabilities
- Elderly
- Chronically ill persons (HIV/AIDS, TB)
- Migrants
- Others (please specify)

#### Characteristics - Displaced Persons

- Women
- Men
- Adolescents girls
- Adolescents boys
- Girls
- Boys
- LGBTQI+ members
- Persons with physical or mental disabilities
- Elderly
- Chronically ill persons (HIV/AIDS, TB)
- Migrants
- Others (please specify)

If there is information suggesting that some groups are under- or over-represented, or particularly affected (i.e. women or girl children, ethnic minorities, etc) explain here:

## 2. SRH RAPID SERVICE MAPPING

List of Agencies/Organizations currently providing SRH services.

WHO		WHERE	WHEN	WHAT	FOR WHOM	
Organization Name	Contact Details		Address / Location (City) /Parish/Region (depends of the administrative division)	Days and opening hours	Specify type of SRH services: FP; ANC & PNC, <sup>24</sup> Delivery Care, syndromic treatment STIs, ART, CMR and referrals (please specify for each intervention whether is prevention, care or both including supplies)	Specify: women, adolescents, PLHIV, LGBTQI+, sex workers, PLWD, rural, migrants, refugees, etc.
	Name (Focal person)	Email / phone				

Emergency transportation 24/7 contact numbers should also be available and visible to all:

## 3. GBV RAPID SERVICE MAPPING

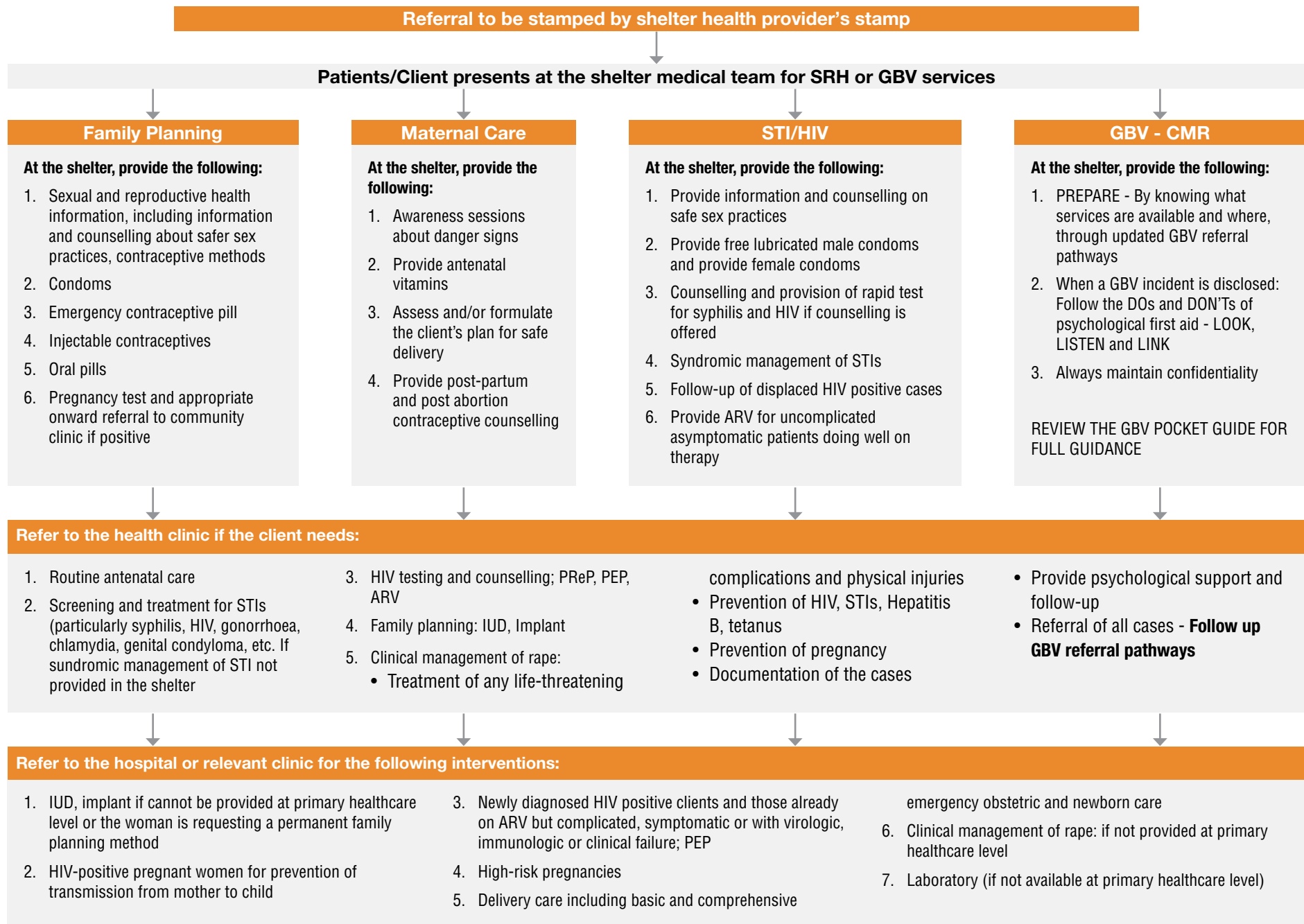
List of Agencies/Organizations currently providing services related to GBV.

WHO		WHERE	WHEN	WHAT	FOR WHOM	
Organization Name	Contact Details		Address / Location (City)	Days and opening hours	Specify type of service: Health, Psychosocial, Legal, Security, Training; details related to activities	Specify: women, adolescents, PLHIV, LGBTQI+, sex workers, PWLD, rural, migrants, refugees, etc.
	Name (Focal person)	Email / phone				

Emergency transportation 24/7 contact numbers should also be available and visible to all: .

<sup>24</sup> Antenatal Care (ANC) and Prenatal Care (PNC)

## 4. SAMPLE SRH AND SEXUAL VIOLENCE REFERRAL FLOWCHART



## 5. PREGNANCY CHECKLIST

Ask the client questions 1-6 if a pregnancy test is not available. As soon as the client answers “yes” to any question, stop and follow the instructions below:

NO	PREGNANCY CHECKLIST	YES
	Did your last monthly bleeding start within the past 7 days? In the last 12 days if the user has the intention to use an IUD	
	Have you abstained from sexual intercourse since your last monthly bleeding, delivery, C-section, abortion or miscarriage?	
	Have you been using a reliable contraceptive method consistently and correctly since your last monthly bleeding, delivery, abortion or miscarriage?	
	Have you had a baby in the last 4 weeks?	
	Did you have a baby less than 6 months ago, are you fully or nearly-fully breastfeeding, and have you had no monthly bleeding since then?	
	Have you had a miscarriage or abortion in the past 7 days? In the last 12 days if the user has the intention to use an IUD	

**\* If the client is planning to use a copper-bearing IUD, the 7-day window is expanded to 12 days**

If the client answered **NO** to all of the questions, pregnancy cannot be ruled out using the checklist. Rule out pregnancy by other means

If the client answered **YES** to at least one of the questions, you can be reasonably sure she is not pregnant

## 6. GBV POCKET GUIDE AND CONSTANT COMPANION

### Responding to a GBV Incident - Incident Referral Decision Tree and Do's and Don'ts of Psychological First Aid

The material in this section provides shelter managers and staff with practical step-by-step advice on how to react if they are faced with a disclosure of GBV when there is no GBV actor available at the shelter. Find the full guidance, the '[GBV Pocket Guide](#)' here, which is also available as a phone [App](#). Here is also a [video](#) which provides guidance on responding to a disclosure of a GBV incident. Contact UNFPA and the National Gender Mechanisms within your context to train your staff on the GBV Pocket Guide and Safe Referrals.

Shelter managers and staff should **prepare** by knowing what services are available by completing the GBV and SRH Rapid Service Mapping Tools (Annex 2 and 3, also see incident referral decision tree below) and when an incident is disclosed to shelter managers and staff follow the steps below - Follow the **DOs and DON'Ts of Psychological first Aid: LOOK & LISTEN and LINK.**

#### DO'S AND DON'TS OF PSYCHOLOGICAL FIRST AID

**1. LOOK:** Introduce your name, your role and who you are. Ask how you can help. Each person will have different basic needs, which may include urgent medical care, water, finding a loved one or blanket or clothes if lost, torn, stained or removed. Especially for GBV survivors, clothes may be the primary urgent need for them to feel more comfortable and dignified. Let the survivor tell you how s/he feels about their personal safety and security. Take care to not make assumptions based on what you are seeing.

**2. LISTEN:** After ensuring the survivor's basic needs are met, and that s/he is not in immediate danger, LISTEN. The survivor may be very upset and/or confused, but as a helper it is important to stay as calm as possible. Allow the individual to share as much or as little information as s/he would like to. It is not your role to provide counselling, take the individual to services or conduct a detailed interview about what happened to them. Rather than asking detailed questions about the incident itself, focus on providing them with information about the services you know are available.

**3. LINK:** Ask the survivor if there is someone s/he trusts to go to for support. If asked what your opinion is, encourage the survivor to make the decisions on who to go to, when and why. Do not give your own opinion of the situation. If any services do exist, provide accurate information to the survivor on the available services or options for more comfort. If you are not sure a specific service exists, say you are not sure. **ALWAYS maintain confidentiality.**

## 7. SAMPLE CODE OF CONDUCT ON SEXUAL EXPLOITATION AND ABUSE (SEA)

The below Code of Conduct has been adapted from UNFPA and can be further amended by the shelter lead agency. It is the responsibility of the shelter manager to ensure that staff, volunteers, support personnel and security guards have signed the Code of Conduct, that they are trained on PSEA and relevant national legislation, and to monitor adherence. Shelter managers must be aware of the national authorities responsible for responding to SEA, as well as the mechanisms for reporting when incidents are reported. Guidance on SEA can be found through the [PSEA task force](#), and further guidance on reporting and response mechanisms through UNFPA and the National Gender Mechanisms within your context.

All [insert organization / agency name] personnel must uphold the highest standards of professional and personal conduct. At all times, [organization / agency name] staff and affiliated personnel must treat the local population with respect and dignity. Our mandate includes [insert text regarding your organizations role in protecting community members, including vulnerable populations such as women and children].

Sexual exploitation and abuse (SEA) are acts of unacceptable behaviour and prohibited conduct for [organization / agency name] staff and affiliated personnel. SEA damages the integrity and image of [organization / agency name] and erodes confidence and trust in our organization.

I will strictly comply with all of the provisions of the Secretary-General's Bulletin: Special measures for protection from sexual exploitation and sexual abuse (ST/SGB/2003/13), and [include any relevant national legislation]<sup>25</sup>

I acknowledge that it is strictly prohibited for all [organization / agency name] staff and affiliated personnel to engage in:

- Any act of SEA, or other form of sexually humiliating, degrading or exploitative behaviour.
- Sexual activity with children (persons under the age of 18) regardless of the age of majority or age of consent locally or in my home country.

Mistaken belief as to the age of the child is no excuse.

- Sexual activity with anyone including sexual favours or other forms of humiliating, degrading or exploitative behaviour, in exchange for money, food, employment, goods (including programme supplies) or services. This includes any exchange of assistance that is due to beneficiaries of assistance.
- The above bullet also applies to any sexual activity with prostitutes, whether or not prostitution is legal in my country or the host country.
- Sexual activity that is forced upon another individual.
- Use of a child or adult to procure sexual activities for others.

All [organization / agency name] staff and affiliated personnel must contribute to an environment that prevents SEA. [organization / agency name] staff and affiliated personnel are obligated to report allegations of SEA through the established reporting mechanisms.

Any SEA will be considered as serious misconduct. Allegations of SEA will be investigated and may lead to disciplinary measures, including termination, and referral for prosecution.

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

<sup>25</sup> ST/SGB/2003/13 and can be found here. Please also include relevant national legislation.



## 8. COVID SPECIFIC GUIDANCE <sup>26, 27, 28</sup>

This annex is intended to support non-GBV specialist humanitarian actors to identify COVID-19, GBV- specific risks in their sectors, and take actions to mitigate those risks. COVID-19 is an acute respiratory illness caused by a novel human coronavirus (SARS-CoV-2, called COVID-19 virus), which causes higher mortality in people aged  $\geq 60$  years and in people with underlying medical conditions such as cardiovascular disease, chronic respiratory disease, diabetes and cancer. The COVID-19 virus spreads primarily through droplets of saliva or discharge from the nose when an infected person coughs or sneezes, so it is important to practice respiratory etiquette (for example, by coughing into a flexed elbow). Most shelters in the Caribbean are community centres, schools or churches that are limited in size. COVID-19 distancing requirements will subsequently reduce the number of persons a shelter can accommodate during the hurricane season. We also know that COVID-19 will have specific gendered impacts, increases the risk of GBV, and hinders access to lifesaving SRH services for women and girls.<sup>30</sup>

### Key considerations for emergency shelters: <sup>31,32</sup>

In the context of the COVID-19 pandemic, providers in charge of providing services should always wear personal protection equipment in accordance with international standards and country norms. They should also follow all applicable infection prevention control measures including social distancing.

- **Staffing:** Strive for the **inclusion of female staff** - if there is no gender balance in the team, consider collaborating with other sectors or organizations to ensure that female staff are present, particularly during distributions or other activities involving direct contact with the affected population. Ensure all staff are **aware of the PSEA policy** and have signed the Code of Conduct, apply a zero-tolerance policy to SEA. Ensure all staff are **aware of the most up to date SRH and GBV referral pathways** in light of the COVID-19 pandemic.

- **Communication:** Plan for adaptations to communication and information sharing mechanisms for situations where large gatherings, access to communal buildings and community meetings may be restricted or suspended. Particular care should be taken to ensure that timely, reliable and objective information about COVID-19 and any changes in the availability or delivery of essential services reaches women and girls, so their access is not compromised, and they are not at increased risk of marginalization. Suggested adaptations can include text messages/SMS/WhatsApp messages, radio messages, and/or announcements in the site. Involve women and girls in the development of IEC materials on COVID-19 to ensure they are effective, appropriate and proactively address misinformation and disease-related stigma.
- **SRH:** Recognizing the strains that the pandemic response has put on existing primary and SRH care resources, take all possible steps to NOT divert resources from SRH services and to ensure continuation of lifesaving services in line with the MISP for SRH in crisis-settings at the shelter or through referral.
- **GBV:** Plan for an increase in GBV cases (specifically domestic violence), and an increase in vulnerability and needs of GBV survivors. Ensure that staff are aware of GBV risks and health consequences and are able to help survivors who disclose by offering first-line support or referral to medical treatment. In coordination with GBV actors, identify contingency measures to provide support to survivors in case access to services outside the shelter is restricted. Explore how technology can support those in quarantine who need access to GBV services. For those at increased risk of intimate partner violence or domestic violence, work in close collaboration with GBV actors to identify alternative shelter options, wherever possible. Closely monitor GBV trends and emerging protection risks.

26 UN Women, PAHO and UNFPA (2020). Guidance for GBV Shelters in the Context of COVID-19.

27 PAHO (2020). Caribbean Shelter Guide : COVID-19 considerations, Preparatory measures to be taken in Emergency Shelters during hurricane season inclusive of Basic Infection Control, Hygiene, Space Management and COVID-19 Precautions.

28 UN Inter-Agency Standing Committee and Global Protection Cluster (2020). Identifying & Mitigating Gender-based Violence Risks within the COVID-19 Response

29 At time of writing this was understood by scientists to be true, yet as this is a new novel virus evidence around COVID-19 will continue to evolve over time.

30 CARE and IRC (2020). Global Rapid Gender Analysis for COVID-19.

31 Ibid.

32 UN Inter-Agency Standing Committee and Global Protection Cluster (2020). Identifying & Mitigating Gender-based Violence Risks within the COVID-19 Response

- **GBV Risk Mitigation / NFI Distribution:** Ensure that any changes in modalities for NFI distributions integrate measures that maintain effective access for at risk groups/individuals, particularly those at increased risk of COVID-19 complications or those facing specific mobility issues such as older persons, persons with disabilities, single/child-headed households, pregnant/lactating women or unaccompanied children. Consider how to adapt modalities for consulting with women and girls on their shelter/NFI needs in light of COVID-19 infection prevention control measures (WhatsApp/Text). Also consider that women and girls may face increased burden of domestic chores or caring for HH members in case schools/community centres etc. are closed, and they may not be able to wait for a long time in distribution lines. Consider establishing a priority lane to reduce wait times. Provide clear communication to the affected population on prioritization criteria.

Assure the prospective resident they will get support regardless of how they answer the questions:

- Have you or anyone in your family travelled recently?
- Have you been in contact with someone who has displayed symptoms of COVID-19?
- Have you had any COVID-19 symptoms?

This document is not exhaustive. For additional guidance see the PAHO Caribbean Shelter Guide Covid-19 considerations, COVID-19 Infection Prevention and Control in Shelters for Women and Children Survivors of Domestic and Family Violence in the Caribbean, Guidance for GBV Shelters in the context of COVID-19 from UN Women, and Prevention and Response to Sexual and Gender based Violence in COVID-19 Quarantine Centres Recommendations and Best Practice from the ICRC. For technical guidance on adapting the MISP see the MISP considerations checklist for implementation during COVID-19.

## Questions to ask new residents upon entry to the site:



