

Guidelines for the Management of Safe Shelters for GBV survivors in the English and Dutch-speaking Caribbean

A SURVIVOR-CENTERED APPROACH



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Thank You

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Definitions & Terms

ADOLESCENT

Defined by the UN as those between 10 and 19 years old.

CHILD

is defined by the Convention of the Rights of the Child as every human being below the age of 18 years.

GENDER

The term gender refers to the economic, social and cultural attributes and opportunities associated with being male or female. It differs from sex as it does not refer to biology but to social and cultural norms.

GENDER-BASED VIOLENCE (GBV)

Gender-based violence 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. The term "GBV" is most commonly used to underscore how systemic inequality between males and females, which exists in every society in the world, acts as a unifying and foundational characteristic of most forms of violence perpetrated against women and girls. The term "gender-based violence" also includes sexual violence committed with the explicit purpose of reinforcing gender inequitable norms of masculinity and femininity¹.

GENDER NON-CONFIRMING GROUPS

Identifying with a gender or having a gender expression that is not in accordance with society's masculine or feminine gender norms.

INFORMED CONSENT

is a process in which a person grants permission before an intervention, service or treatment or before the disclosure of personal information. All relevant information and facts must be provided before giving consent.

LGBTQI+

Lesbian, gay, bisexual, transgender, queer and intersex.

MANDATORY REPORTING

is a legal requirement for service providers (such as police officers, social workers and teachers) who are obliged to report suspected abuse and neglect of vulnerable people (such as children, disabled, the elderly) to the police or to other governmental authorities. Mandatory reporting can result in legal requirements overriding the survivor's consent².

MIGRANT

An umbrella term, not defined under international law, reflecting the common lay understanding of a person who moves away from his or her place of usual residence, whether within a country or across an international border, temporarily or permanently, and for a variety of reasons. The term includes a number of well-defined legal categories of people, such as migrant workers; persons whose particular types of movements are legally-defined, such as smuggled migrants³⁴.

PERSONS LIVING WITH DISABILITIES

include “those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others”.⁵

PSYCHOSOCIAL SUPPORT (PSS)/MHPSS

Psychosocial support addresses the psychological and social needs of survivors. “The composite term mental health and psychosocial support (MHPSS) is used to describe any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorders”.⁶

REFUGEE

The 1951 Refugee Convention defines refugee as “someone who is unable or unwilling to return to their country of origin owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion.”⁷

SEXUAL AND EXPLOITATION ABUSE

Sexual Exploitation and Abuse refers to the “inappropriate conduct of a sexual nature committed by personnel against recipients of assistance” (UNFPA). Sexual Exploitation and Abuse includes: “an actual or attempted abuse of someone’s position of vulnerability (such as a person depending on you for survival, food

rations, school books, transport or other services), differential power or trust, to obtain sexual favours, including but not only, by offering money or other social, economic or political advantages. It includes trafficking and prostitution. Sexual abuse means the actual or threatened physical intrusion of a sexual nature, whether by force, or under unequal or coercive conditions. It includes sexual slavery, pornography, child abuse and sexual assault.”⁸

SEXUAL AND REPRODUCTIVE HEALTH (SRH) SERVICES AND COMPONENTS

includes the following: family planning information and services, maternal and newborn health care (including post abortion care), safe abortion care (where legal), STIs including HIV counselling, testing and treatment, prevention and treatment of infertility and services to prevent and treat reproductive cancers.

VIOLENCE AGAINST WOMEN (VAW)

The Declaration on the Elimination of Violence against Women, defined this term as “any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life” (Article 1). In addition, it described it as “a manifestation of historically unequal power relations between men and women, which have led to the domination over and discrimination against women by men and to the prevention of the full advancement of women”⁹.

A large, stylized number '2' is the central graphic element. It is composed of two overlapping shapes: a light orange '2' in the background and a darker orange '2' in the foreground. The number is positioned on the left side of the page, with its right edge overlapping a dark blue horizontal bar.

Introduction

2.1 GENDER-BASED VIOLENCE (GBV): THE EXPERIENCE OF THE DUTCH AND ENGLISH SPEAKING CARIBBEAN COUNTRIES AND THE IMPORTANCE OF SAFE SHELTERS IN ITS RESPONSE

Gender-Based Violence (GBV) affects primarily girls and women worldwide and hinders their ability to live a life free of violence. The World Bank¹⁰ has called GBV a global pandemic that impacts women and girls from all socio-economic backgrounds in society and, estimated that, 1 in 3 women will be affected by GBV or Violence Against Women (VAW) in their lifetime. In the Caribbean the most common forms of GBV are intimate partner violence (IPV)¹¹, domestic violence, rape, sexual harassment and other forms of sexual violence, including, but not limited to, trafficking in persons, sexual exploitation and abuse, femicides and incest.¹²

GBV tends to rise in emergency situations, while at the same time national systems and community ties are weakened. During emergencies, health, security and social services will be disrupted, which will usually further decrease access to sexual and reproductive health (SRH) and GBV response services, which in turn, make women and girls more exposed to and more vulnerable to GBV.

In the Caribbean region, the period of June 1 to November 30 is defined as the hurricane season. Besides hurricanes, the region is also vulnerable to volcanic eruptions, earthquakes, flooding and landslides caused by heavy rains, tropical storms, forest fires and droughts. These humanitarian emergencies increase women and girls' vulnerability to "sexual violence and coercion as well as to other forms of gender-based violence (GBV) such as sexual exploitation and abuse, domestic violence, physical violence, trafficking and femicide".¹³ Parallel to the natural hazards that threaten to affect the region every year, the Caribbean is also dealing with another humanitarian crisis: the unprecedented influx of Venezuelan refugees and

migrants, who are particularly vulnerable to loss of income, xenophobic behaviour and will often have very limited access to life saving services. Displacement increases the risk of being subjected to violence and, among Venezuelan refugees and migrants, women and girls are the most vulnerable as they are at disproportionate risk of all forms of GBV, particularly, but not limited to, rape, sexual harassment and violence, sex trafficking and sexual exploitation and abuse. The lack of socio economic opportunities and basic needs coverage such as safe shelter, food, and access to lifesaving Sexual and Reproductive Health (SRH) interventions, compounded by labour exploitation and discrimination, can force women and girls from Venezuela to engage in survival sex and other negative coping mechanisms, making them extremely vulnerable to GBV.

GBV takes place in both the private and the public sphere, and as COVID19 spreads throughout the world and strict lockdowns repetitively go into place, people around the globe are forced to stay at home. However, home is not a safe place for everyone and many women and girls are finding themselves locked in with perpetrators of violence. UN Women estimates that, globally, from April 2019 to April 2020, 243 million women and girls aged between 15-49 were subject to IPV, and GBV is expected to continue to rise as a result of persistent lockdown measures and ensuing loss of livelihoods¹⁴. Loss of income, financial pressure, stress, social isolation and decreased access to services contribute to women and girls becoming more vulnerable to GBV. Due to restrictions in mobility, disruptions in services and fear of being infected with Covid19, women and girls might not be able to access GBV response services and SRH services. The UNFPA (April 2020) estimates that

47 million women worldwide could lose access to contraception, leading to 7 million unintended pregnancies in the coming months¹⁵.

In light of these developments, it is paramount to offer effective and inclusive responses to GBV.

2.2 WHY ARE SAFE SHELTERS IMPORTANT?

Women and girls that are at risk or that have been subjected to GBV are often not able to afford housing and might also require assistance in navigating the judicial, police, health and social services systems¹⁶. Safe shelters offer protection while supporting and empowering survivors to become self sufficient and independent. It has been argued that safe shelters are not only a response but also a voice in the fight against GBV as they play a role in raising awareness and in generating social change.¹⁷ In the event of a lack of safe shelters, survivors and women and girls at risk of GBV will be left in situations that are a threat to their lives and will be more vulnerable to being pushed into situations of homelessness, of having to resort to survival sex, being forced to stay in abusive relationships, etc.

The first safe shelters created to respond to GBV were established by grassroots activists in England in the early 1970s and were directed particularly at women experiencing IPV. In the Caribbean, the first safe shelters were established in the 1980s by NGOs in Trinidad and Tobago and in the Bahamas. When safe shelters first appeared, their focus was to provide a safe house. Since then safe shelters have evolved, and now not only do they offer survivors a safe accommodation when escaping

One essential response to GBV is safe shelters and alternative accommodation for GBV survivors. The availability and accessibility of safe shelters is lifesaving and can turn the course of someone's life and well being.

imminent risk or actual harm, but also a myriad of services. These services can be either offered on site or by referrals, such as mental health and psychosocial support (MHPSS), SRH services, legal advice and representation, and vocational training. The focus is not only on providing a safe accommodation where women and girls won't be at risk of GBV, but also to promote a space for healing and recovery where the survivor's needs and strengths are at the centre, whilst supporting and empowering survivors towards living a life free of GBV.

GBV often strips survivors of confidence, dignity, self esteem and of the right to make their own empowered decisions. By adopting a survivor-centred approach, safe shelters and alternative accommodations put survivors at the center of the decision making process, making them feel empowered, respected and treated with dignity. Different survivors have different needs, but an active and fluid coordination among safe shelters and other actors can ensure that each survivor has access to the services they require. The mandate of safe shelters is to protect survivors, while adhering to the GBV guiding principles of safety, confidentiality, respect and non-discrimination, and thus ensuring that no one is left behind.

2.3 GBV GUIDING PRINCIPLES AND APPROACHES

These guidelines adhere to and are guided by the GBV guiding principles and approaches underpinning the Interagency Minimum Standards for GBV in Emergencies Programming¹⁸. By adhering to the GBV Guiding Principles throughout

all aspects of programming, stakeholders can minimize harm to women and girls, and maximize the efficacy of prevention and response interventions, including setting up and managing safe shelters for survivors of GBV.

2.3.1 SURVIVOR-CENTERED APPROACH

This approach seeks to empower survivors by putting them at the centre of the decision making process. This includes creating a supportive and safe environment in which the rights and wishes of the survivor are respected and where they are treated with dignity and respect. The survivor-centered approach creates a supportive environment that promotes the survivor's empowerment by putting her at the centre of all actions and services offered to her, so that she is the one directing the course of her recovery. At the core of the survivor-centered approach are the following principles:

❁ **SAFETY:** refers to both physical safety and security and to a sense of psychological and emotional safety. The safety and the security of the survivor and that of her/his children is the primary consideration and must be the number one priority for all actors. Women and girls who disclose an incident of GBV or a history of abuse are often at high risk of further violence and reprisal from the perpetrator(s), people protecting the perpetrators, or members of their own families or community due to patriarchal notions of honour and other factors. IPV and



conflict-related/politically motivated sexual violence may present particularly complex safety risks for the survivor and those around her.

- ❁ **CONFIDENTIALITY:** survivors have the right to choose to whom they will or will not tell their story and information should only be shared with the informed consent of the survivor. Confidentiality promotes and supports safety, trust and empowerment and it means that anyone who has access to information about a survivor must not share any of that information without the explicit permission and informed consent of the survivor. Breaching confidentiality can put the survivor and others at risk of further harm. If GBV service providers do not respect confidentiality, other women and girls may be discouraged from seeking help. For limits to confidentiality, please refer to Standard 6 of the GBViE Minimum Standards.

2.3.2 RIGHTS-BASED APPROACH

This approach seeks to analyse and address the root causes of discrimination and inequality in order to ensure that everyone, regardless of their gender, age and ethnicity or religion has the right to live with freedom and dignity, safe from violence, exploitation and abuse, in accordance with principles of human rights law.

2.3.3 HUMANITARIAN PRINCIPLES

The humanitarian principles of humanity, impartiality, independence and neutrality should underpin the implementation of the GBViE Minimum Standards and are essential to maintaining access to affected populations and ensuring an effective humanitarian response.

- ❁ **RESPECT:** all actions should be guided by respect for the choices, rights and dignity of GBV survivors, which requires that survivors are the primary actors in all aspects of service delivery. Respect for the survivor's dignity and self-determination requires actors to be non-judgemental of a survivor's choices and uphold her right to choose, including when she decides to decline support services.

- ❁ **NON-DISCRIMINATION:** staff should be equipped with knowledge, skills and attitudes on inclusive programming. Service provision should be tailored to the needs of all women and girls based on intersectional gender analyses that considers the increased risks to women and girls based on their age, disability, race, skin colour, religion, nationality, ethnicity, HIV status, social class, political affiliation or any other characteristic.

2.3.4 COMMUNITY-BASED APPROACH

A community-based approach ensures that affected populations are actively engaged as partners in developing strategies related to their protection and to the provision of humanitarian assistance. This approach involves direct consultation with women, girls and other at-risk groups at all stages in the humanitarian response, to identify protection risks and solutions and build on existing community based protection mechanisms.

2.3.5 'DO NO HARM' APPROACH

The 'Do no harm' principle refers to avoiding exposing survivors to further risks because of actions taken to intervene.

BEST PRACTICES FOR THE PROVISION OF ESSENTIAL SERVICES: HEALTH, POLICE, JUSTICE AND SOCIAL SERVICES

- ✿ Universally accessible
- ✿ Survivor-centered
- ✿ High quality
- ✿ Sufficient
- ✿ Free
- ✿ Non-discriminatory
- ✿ Linguistically accessible
- ✿ Physically accessible
- ✿ Geographically inclusive
- ✿ Non-judgmental
- ✿ Confidential (ensuring informed consent)



'Essential Services Package for Women and Girls Subject to Violence: Core Elements and Quality Guidelines' UN Women, UNFPA, WHO, UNDP and UNODC (2015)

2.4 THE ROLE OF THE STATE IN ADDRESSING GBV

Governments are ultimately responsible for protecting their citizens from all forms of violence. Gender inequality and abuse of power are two of the main root causes of GBV and it is thus crucial that governments are at the forefront of addressing GBV and gender inequality in its prevention, mitigation and response. To this end, the countries of the English and Dutch-speaking Caribbean region have made public commitments to eliminate violence against women and girls by ratifying international and regional conventions such as The Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) and the Inter-American Convention on the Prevention, Punishment, and Eradication of Violence against Women, also known as the Belém do Pará Convention.

However, governments are not only responsible for designing laws and other gender sensitive policies and practices to protect individuals from GBV. Governments are also responsible and accountable for ensuring that these are enforced. Part of addressing violence against women and girls is guaranteeing access to essential services such as Health, Social Services, Police and Justice. It is the

government's obligation to ensure that all essential services provided are of quality, widely available and sufficient. Access to these services must be safeguarded regardless of someone's age, gender, ethnicity, place of residence, income, migration status, sexual orientation, education/schooling/literacy level, marital status or disabilities¹⁹. Furthermore, governments are responsible for ensuring that essential services are provided with informed consent and that service provision is non-judgmental, confidential and adaptable to the needs of survivors,

To warrant an adequate and comprehensive provision of essential services, civil servants, particularly the ones in the frontline such as the police force, health care workers, social service providers and the justice system, should be trained on GBV, particularly around safely responding to incidents and always adopting a survivor-centered approach. Especially, in relation to the police force, it is paramount to form a police unit which specialises in GBV and that is capacitated to approach such cases in a respectful, unbiased, non-judgmental and informed manner.

With respect to offering an effective GBV response in which safety is prioritised, governments have the responsibility to ensure that all survivors and/or persons at risk of GBV have **immediate access to free, safe and secure accommodation**. Governments have to guarantee that safe shelters and alternative accommodations for GBV survivors provide quality services, which are available, free, geographically inclusive, non-discriminatory and physically and linguistically accessible. To safeguard universal access to essential services by GBV survivors, it is recommended not to impose mandatory reporting as it decreases the likelihood of survivors seeking help. Governmental departments should work on offering coordinated responses to GBV, while aiming at the standardisation and harmonisation of services. In order to secure the provision of quality in all essential services, ethical and safe monitoring and evaluation are also encouraged and recommended.

Adequate and stable funding is decisive in the quality of safe shelters' response and thus governments must ensure that they allocate and deliver sufficient and stable funding for safe shelters. While donation based funding may be an option, it should not be the only one. Donation based funding is more likely to be unstable and fluctuating and it should not cover regular costs as this compromises the ability of safe shelters to sustainably provide quality services.

RECOMMENDATIONS FOR GOVERNMENTS: RESPONSES TO GBV



- ✿ Allocate sufficient and stable funding to safe shelters
- ✿ Establish 24h Hotline(s) that serve all areas of the country
- ✿ Remove mandatory reporting
- ✿ Training of civil servants on GBV, particularly the ones in the front lines: Health, Police, Justice and Social Services
- ✿ Police unit(s) that specialise in the safe response to GBV incidents that are voluntarily reported to them
- ✿ Coordinated responses to GBV
- ✿ Gender-sensitive policies and practices
- ✿ Address workplace and institutional GBV
- ✿ Standardisation and harmonization of services
- ✿ Ethical and Safe monitoring and evaluation of services

2.5 THE PURPOSE OF THESE GUIDELINES

The purpose of these guidelines is to provide practical guidance for the management of safe shelters and alternative accommodations for GBV survivors in the English and Dutch-speaking Caribbean. Notwithstanding, these guidelines may also be of use to individuals that work in other services with GBV survivors and in GBV responses, such as NGOs and local governments and authorities.

Although there is extensive literature on setting up safe shelters in emergencies and on the response to GBV, UNFPA identified a general gap around the provision of guidelines to set up and manage safe shelters and alternative accommodation for survivors of GBV. These guidelines are the result of an extensive regional desk review, online survey and subsequent semi-structured interviews with safe shelter managers from the English and Dutch-speaking Caribbean countries. These countries are not homogenous and the different experiences shared by safe shelter managers in the region will undoubtedly contribute to a wider understanding of the situation regarding this segment of the GBV response. The guidelines are therefore to be adapted by safe shelters throughout the region in accordance to their reality. While these guidelines are directed at the Caribbean and were built taking into account the expertise and experience of

safe shelter managers in the region, safe shelter managers in other parts of the world are welcome to make use of them and to adapt them to their context.

These guidelines address the practical and functional aspects of setting up a safe shelter for GBV survivors, while focusing on a survivor-centred approach and on the principles of non-discrimination, respect, safety and confidentiality. Therefore, an important part of these guidelines concentrates on the accessibility of survivors and on the services to be provided in the safe shelters. Focus is also given to preparedness and response activities related to natural disasters and humanitarian emergencies as these increase the vulnerability of women and girls, further exposing them to GBV. It should be stressed that safe shelters should take all appropriate and possible steps to prepare for disasters and emergencies so that they are not caught off guard and do not have to resort to improvisation.

This work is also an invitation for other initiatives to be elaborated on safe shelters and alternative accommodations in other regions of the world. The sharing of experiences, findings, challenges and best practices will further enrich the literature and research around this topic.



Methodology



Core to UNFPA in the Caribbean is the support to policies and programmes that aim to prevent and respond to GBV. This document was developed as it emerged that there was a lack of structured guidelines for the setup and management of safe shelters and alternative accommodation for survivors of GBV from a survivor-centered approach. In response to this gap, UNFPA conducted an extensive desk review²⁰ of global relevant available literature and guidelines developed by UN agencies, INGOs and academics, as a first step in building a strategy to develop these guidelines for the Caribbean region.

Subsequently, and considering limitations due to COVID-19, safe shelter managers across the region were engaged in a consultation through an online survey. As such, between July and October 2020, safe shelter managers from the English and Dutch-speaking Caribbean were invited to answer an online survey about the safe shelters they manage and their experiences as safe shelter managers. The online survey covered a myriad of topics such as the types of safe shelters and their philosophies, capacity, accessibility, service provision and referrals, the staff as well as the safe shelter's preparedness to respond to disasters and covid19's impact. Safe shelter managers were also invited to share lessons learned and best practices. The survey was answered by 16 shelter managers from 16 different safe shelters in the following countries: Jamaica, Belize, St. Lucia, Trinidad and Tobago, St Vincent and the Grenadines, Barbados, Guyana and Suriname.

The online survey generated interesting results, mainly highlighting the need to engage in further conversations with shelter managers. Above all, however, the results of this survey evidenced the lack of clear technical guidance around best practices to be implemented when establishing and managing safe shelters and alternative

accommodation for survivors of GBV. This gap informed the need to hire an individual consultant who would be tasked with further engaging shelter managers across the region and compiling the results of the desk review and survey results, generating these guidelines in close collaboration with technical advisors at UNFPA's Sub Regional Office of the Caribbean.



Drawing from the online survey, and in order to gather more thorough information regarding the shelters, 9 semi-structured interviews were conducted online with 9 shelter managers from 9 different safe shelters. Interviews were conducted with shelter managers from Guyana, Suriname, Belize, Jamaica, Barbados and St, Vicent and the Grenadines. Below is a description of and an analysis of the main findings from the online surveys and the semi-structured interviews, around the management of safe shelters for survivors of GBV in the English and Dutch-speaking Caribbean region. The findings below reflect the surveyed and interviewed shelter managers but are not meant to be representative of the whole region.

3.1 THE EXPERIENCE OF SHELTER MANAGERS IN THE REGION: MAIN FINDINGS

Shelters in the region are deeply committed to provide an adequate and strong response to GBV. Despite facing several challenges they seek to adapt and to improve their support to survivors. It was noted by some shelter managers that if it was not for such a committed staff, it would not

be possible to respond on so many fronts. It is vital to highlight the existence of shelters for the LGBTQI+ population in the region, which are not state funded but that provide a pivotal response to one of the groups that is most vulnerable to GBV.

3.1.1 TYPES OF SAFE SHELTERS

The majority of safe shelters identified themselves as emergency safe shelters for GBV survivors²¹. One safe shelter that is due to open in December 2020 is a transitional shelter and one emergency shelter mentioned that they are in the process of opening another transitional shelter.

Emergency shelters provide short to medium-term secure accommodation and support for survivors of GBV. These safe shelters respond to situations in which immediate safety is the primary concern. The length of stay can go from 24 hours to a few days to up to a few months. On the other hand, transitional shelters provide long-term accommodation, which can go from six months up to one year or more.

3.1.2 LENGTH OF STAY

Emergency shelters managers referred to the fact that in some instances, survivors might only require a shelter for 24-48 hours as a first stop in situations of imminent risk, whereas in other situations, survivors might need support for a few weeks up to 3 or even 6 months. All shelters stated very clearly that no survivor would have to leave the shelter until a viable and safe solution was found. Transitional shelters offer lengthier programmes which can go from six to nine months up to one year or more.

LESSONS LEARNED: COMMITMENT TO GBV SURVIVORS

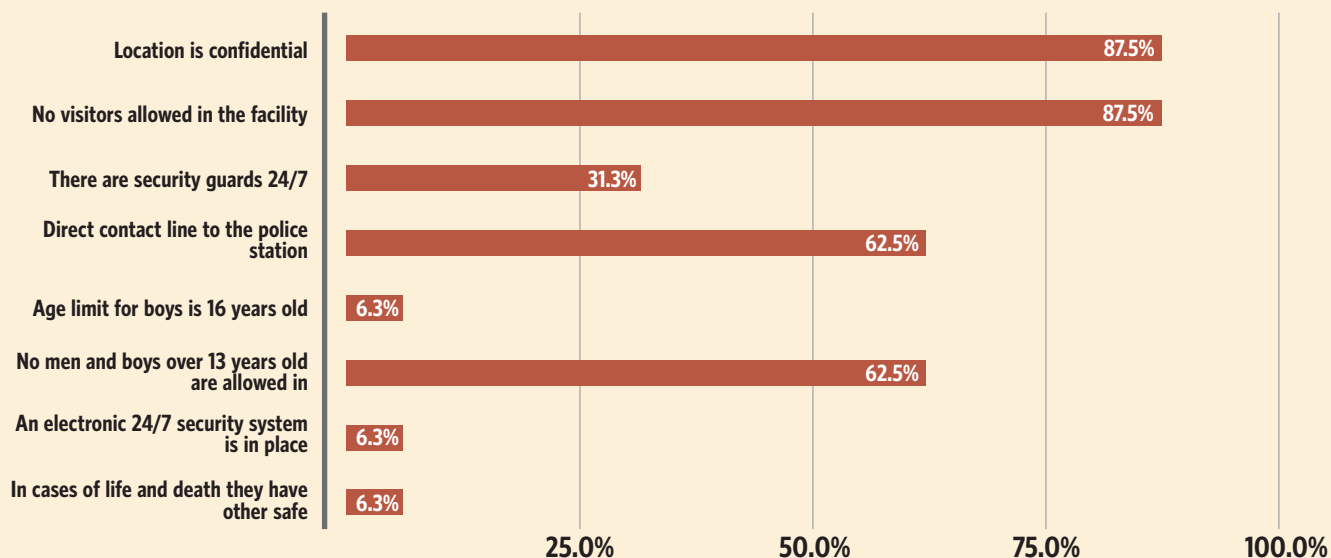


The majority of shelters are deeply committed to the safety and to the well-being of survivors and would never allow for a survivor to leave the shelter without a viable and safe solution in place, despite having exceeded the length of stay.

3.1.3 SECURITY

While the location of most shelters is confidential, only 31.3% of the surveyed shelters have security guards and not all have a direct contact line to a police station. It is recommended that security measures are reinforced.

SECURITY MEASURES IN PLACE



3.1.4 ACCESSIBILITY AND ELIGIBILITY

According to the shelter managers, accessing a shelter can occur in several ways. While shelters which are part of governmental departments work closely with the police and social services, other shelters have crisis centres which allow walk-ins, and/or 24h hotlines which will first assess and, if appropriate, will then refer the survivor to a shelter. While the majority of shelters are free of charge, two shelters have a fee in place. In the event of the survivor not being able to pay the fee, the shelter would try to find funding and, if that was not possible, they would refer the survivor to a different shelter.

The majority of shelters are directed at women with children. Despite this, it was pointed out by several shelter managers that they always make sure that

the survivor is not able to stay with family members or friends instead of accessing the shelter, in particular when the survivor has small or teenage children. Despite accepting women with children, shelters are not specifically designed for children or teenagers. Some shelter managers felt that due to this, the shelter was the last resort instead of the first choice when fleeing violence. Nevertheless, most shelters receive and accommodate children. In case the shelter cannot take the children of the survivor or if the child is above the age limit, alternative accommodation is arranged (usually with family or friends). Overall, shelters stated that they do their best to accommodate survivors and their families and adapt to the circumstances at the time of the intake.

The LGBTQI+ community relies on word of mouth regarding where to seek help and which shelters are friendly. According to one shelter manager, this community tends to be especially reluctant to go through official services as they fear negative experiences and stigmatisation, and only a small proportion of shelters are LGBTQI+ friendly. Most shelters had little or no experience with migrants and refugees, with the exception of a couple of shelters that receive victims of human trafficking. In relation to language barriers, most shelters are not able to conduct assessments, offer information or other services in other relevant languages.

Some shelters reported that they would not be able to adequately respond to certain cases such as women in advanced stages of pregnancy, survivors living with disabilities, survivors suffering from severe mental health issues and survivors with severe substance abuse issues. In all circumstances, shelters would activate referral pathways to ensure the survivor receives proper

CHALLENGES AND GAPS IDENTIFIED IN THE REGION: ACCESSIBILITY AND ELIGIBILITY



- ⦿ Not all shelters are free of charge
- ⦿ The majority of shelters are not prepared to receive women living with disabilities
- ⦿ Most shelters are not able to offer services or information in other relevant languages

BEST PRACTICES: INCLUSION



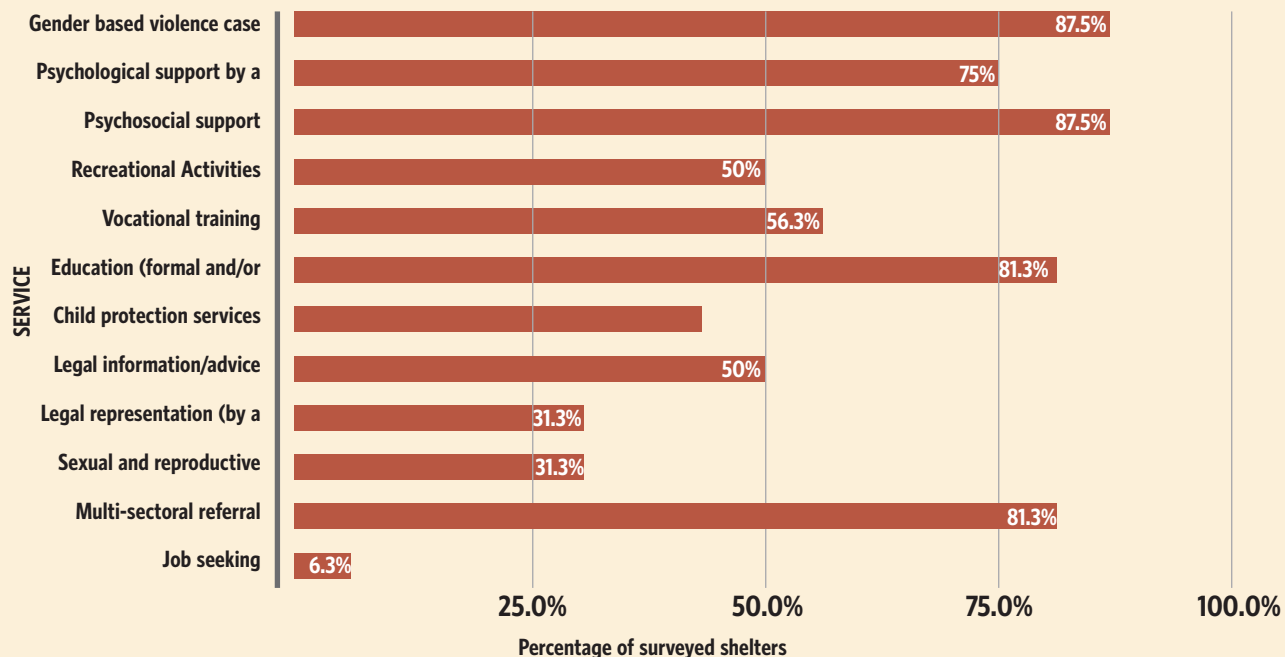
Guyana has two (non-state funded) shelters that are directed at the LGBTQI community.

care and attention. A few shelters also noted that they are often approached by individuals in need of housing who do not mention being survivors of GBV. All shelters have a written code of conduct for residents, and would expel a resident if the code was broken. Most shelters have strict policies of not taking back survivors that had been previously removed from the shelter for breaking the shelter's rules and putting other survivors and staff at risk.

3.1.5 SERVICES OFFERED

Most shelters are said to offer services such as GBV case management, psychosocial support, psychological support by a mental health specialist and recreational activities. In addition, as part of a successful transition to an independent and empowered life free of violence, shelters focus on assisting survivors in building skills, in job seeking, and in finding affordable housing. The majority of shelters offer cosmetology, baking, pastry making and sewing as vocational training.

SERVICE PROVISION BY SAFE SHELTERS



CHALLENGES AND GAPS IDENTIFIED IN THE REGION: SERVICE PROVISION

- ❁ Lack of GBV case management services adhering to international standards
- ❁ Lack of access to legal services and legal information/advice
- ❁ Slow and inefficient referral pathways
- ❁ Lack of programmes that focus on income generating skills and education to survivors
- ❁ Lack of child care services

With regards to immediate and long term medical care, shelters generally refer to public hospitals. In relation to SRH Services, most shelters work closely with Family Planning Clinics. Of the interviewed shelters, only one has a Polyclinic and is thus able to direct its residents there for most care and treatments. Nevertheless, all shelters rely on informal or formal referral pathways to guarantee that survivors access all the services they require.

The majority of shelters do not offer child care. Therefore child care takes place informally: either another resident minds the children of a survivor(s) or the staff does it if the carer needs to be absent.

BEST PRACTICES IN THE REGION: SERVICE PROVISION



- ☸ Parenting programme
- ☸ GBV prevention and response programmes for survivors that do not reside at the shelter

EXPERIENCES FROM THE REGION: BREAKING CYCLES OF VIOLENCE



Two shelters stated that they recognise the importance played by the perpetrator in breaking cycles of violence. To address this, one shelter has a programme for perpetrators and the other one is working with another organization that specialises in this target group, to establish a joint cooperation. However, many other shelters actively choose not to work with perpetrators as there is no balance of power or an equal relationship. If a shelter chooses to have programmes with perpetrators of violence, it is vital to uphold the safety of the survivor. It must be ensured that this takes place in a different location to protect the survivor and that it is provided by trained professionals.

3.1.6 STAFF

The majority of shelter managers are aware that they rely on deeply committed staff that often go above and beyond to provide survivors with the best possible service. Nevertheless, most shelter managers believe that their staff would benefit from receiving further training to develop professionally. Core recommended trainings for staff of shelters for GBV survivors (such as on the GBV basic concepts guiding principles) have not been attended by all staff, and other trainings (such as on GBV Case Management, GBV Referral Pathways, Child Protection, and Human Rights) have not reached the majority of shelter staff. It was also noted by some shelter managers that they are understaffed and/or heavily reliant on voluntary workers, which was perceived as having a negative impact on the functioning of the shelter and the provision of services of high quality and adherence to minimum standards. The shelters that reported being understaffed mentioned that this resulted in multitasking and in staff being involved in duties that do not correspond to their job description. Most shelter managers acknowledge the emotional distress that often accompanies staff in this line of work as a challenge, but only a small minority of shelters have a staff care plan in place.

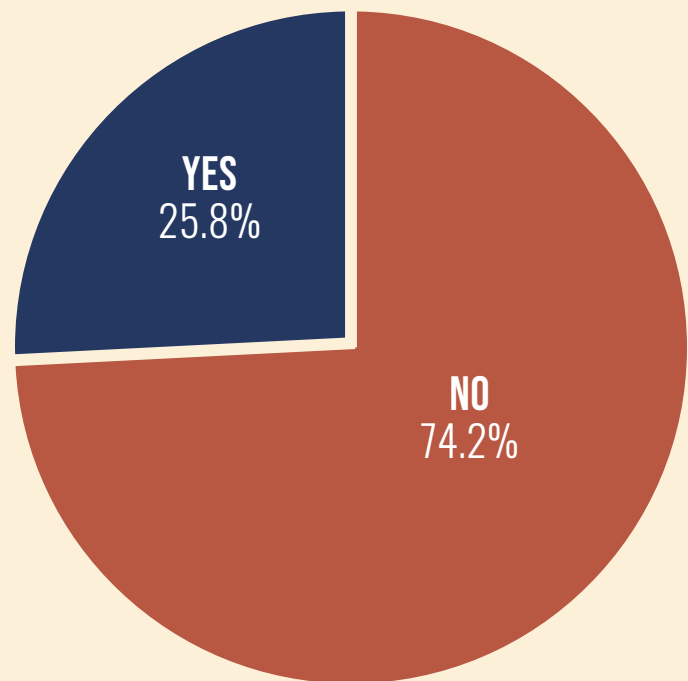
CHALLENGES AND GAPS IDENTIFIED IN THE REGION: STAFF

- ☸ No staff care plan in place
- ☸ Lack of training
- ☸ Lack of development opportunities for staff
- ☸ Understaffing

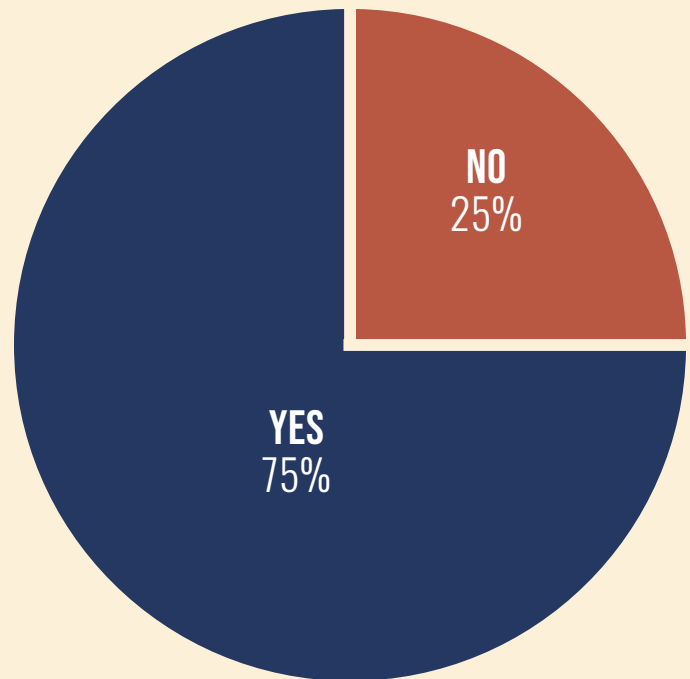
3.1.7 DISASTER PREPAREDNESS

Of the 16 shelters, only 4 have protocols in place to prepare for a disaster (hurricane, earthquake, pandemic, etc). Despite this, most shelters stated that as they follow government guidelines, they would be able to continue to operate in the event of a disaster.

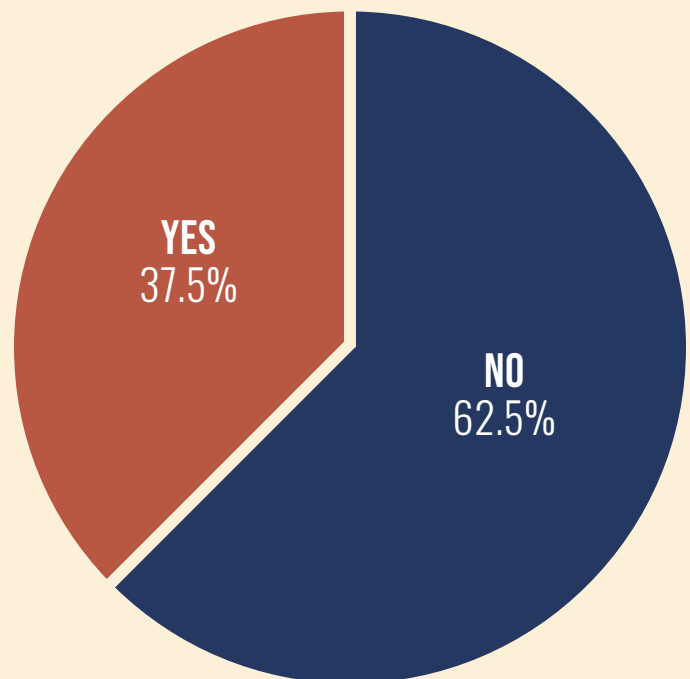
PERCENTAGE OF SAFE SHELTERS THAT HAVE PROTOCOLS IN PLACE TO PREPARE FOR A DISASTER (HURRICANE, EARTHQUAKE, PANDEMIC, ETC)



PERCENTAGE OF SAFE SHELTERS THAT WOULD CONTINUE TO OPERATE IN THE EVENT OF A DISASTER



PERCENTAGE OF SAFE SHELTERS THAT WOULD OPEN ITS DOORS TO OTHER INDIVIDUALS (NOT GBV SURVIVORS) IN NEED OF SHELTER IN THE EVENT OF A DISASTER



RECOMMENDATIONS FOR SHELTERS IN THE REGION: DISASTER PREPAREDNESS



It is extremely important to have protocols in place for a disaster. If protocols are not in place, safe shelters will have to resort to improvisation in the event of a disaster (hurricane, earthquake, pandemic, etc).

- ✿ Work along governmental guidelines for disaster preparedness
- ✿ Set up a disaster protocol
- ✿ Train the staff in disaster protocols
- ✿ Residents should be made aware of the relevant protocols in the event of a disaster
- ✿ Shelters directed at GBV survivors must not admit other individuals in need of shelter as this puts the security and confidentiality of their residents at risk

3.1.8 ADAPTING TO COVID19

In the early stages of the current COVID19 pandemic, shelters and alternative accommodations were informed that an increase in GBV was very likely. When lockdown restrictions went into place, most facilities had to close down, without being able to take in new referrals. Nevertheless, the COVID19 pandemic has affected shelters and alternative accommodation throughout the region in different ways:

- ✿ Lockdown measures related to COVID19 resulted in shelters closing down. While most were able to resume their activity, some were not, often due to a lack of funding which previously was obtained through fundraising;
- ✿ Shelters that rely heavily on donations have experienced either a cease or a decrease in donations. In some cases this has affected their ability to pay salaries to staff and to provide food to residents;
- ✿ Increase in GBV referrals after the lockdown that they have not been able to respond to. Several of the interviewed shelters had to reduce the number of intakes;
- ✿ One LGBTQI+ friendly shelter noted that cases of GBV against LGBTQI+ rose since the beginning of the pandemic;
- ✿ Several shelters reported general delays in the provision of services: one shelter manager pointed out that tubal ligations are either being postponed or suspended due to the current pandemic, thus putting women at risk of unintended pregnancies;
- ✿ Shelters have followed guidelines to COVID19 prevention: use of face masks, temperature screening, practicing distancing during group meetings and activities, having disinfectant available and practicing isolation when someone shows symptoms or has been in contact with someone who tested positive.

3.1.9 CHALLENGES

A concern shared among most shelters is funding. In most cases, funding from the government is either insufficient or non-existent, which means that the majority of shelters do not rely on stable and sufficient funding. Lack of funding can affect the conditions of the shelter, the professionalisation of the staff and the quality of the services that they offer.

One issue related to a general lack of funding is transportation. Transportation might be required to transport children to and from school and for survivors to access required services. As most shelters lack transportation, the shelter's staff often uses their personal vehicles for transportation. One manager of a shelter that is located outside an urban area, where public transport is scarce, shared that, due to this, there have been incidents in which survivors have resorted to family, friends

and even to the perpetrators of violence, to drive them to and from there.

An all-encompassing concern across all the shelters in the region is the transition to an empowered and independent life free of violence. Survivors' often lack skills and education to become financially independent and with a stable income, which in combination with a lack of affordable housing, poses a great challenge. In some reported instances, the government was able to provide support for rent for a period of time, but shelter managers pointed out that rents were often above the subsidy available. If a resident does not have a livelihood and is not able to afford their own place, the likelihood of them returning to the situation that they have sought to escape increases, putting them at further risk of violence.

Recommended Types of Safe Shelters and Alternative Accommodations

4.1 SAFE SHELTERS FOR GBV SURVIVORS

Different types of shelters respond to different levels of risk and needs. The definitions provided below are not absolute as most shelters are characterised for being highly adaptable and flexible. However, UNFPA considers it crucial

to adhere to the different types of safe shelter definitions across the region, to have a common understanding of the type of services they provide and how they should be managed on a day to day basis.

4.1.1 EMERGENCY SHELTERS/FIRST STAGE EMERGENCY HOUSING

Emergency shelters provide survivors of GBV with short or medium-term secure accommodation and support. These shelters respond to situations in which immediate safety is the primary concern. The length of stay can go from 24 hours to a few days to up to a few months as it depends on the situation of the survivor, the survivor's needs and the services available. Emergency shelters assist with the survivor's immediate needs, either onsite or through referrals, such as immediate medical care, GBV case management services (which include safety planning), sexual and reproductive health services, specialized psychosocial support, vocational training, etc.

4.1.2 TRANSITIONAL HOUSING/SECOND STAGE HOUSING

Second stage shelters provide long-term accommodation, which can go from 6 months up to 1 year or more. Support and referral services are available to the survivors in their transition from an emergency shelter to a permanent form of housing. The services, which can be available onsite or by referral, often include GBV case management services (which include safety planning), sexual and reproductive health services, vocational training, assistance in job seeking and in finding affordable housing.

4.1.3 THIRD STAGE HOUSING

The third stage housing is for women who have completed a second stage programme but that are still in need of housing and support. At this stage, the provision of services such as GBV case management, sexual and reproductive health services, assistance in job seeking and in finding affordable housing, are still available.

4.1.4 ALTERNATIVE ACCOMMODATION

Alternative Accommodation are settings that were not built specifically for the purpose of being shelters but which can be used in different situations and at different stages, linked to appropriate services to respond to the needs of GBV survivors. These guidelines do not provide specific guidance for the setup of alternative accommodations. As such, UNFPA recommends actors considering setting up such a programme, to contact UNFPA and relevant GBV Specialists in their contexts, to receive guidance and support in the process of establishing such service provision, and ensure it aligns with a survivor-centered approach. Nevertheless, the following section and guidance provided in this document, can serve as a basis to guide programming for alternative accommodations, and can be used as a backbone to the design of alternative accommodations for survivors of GBV.

4.1.5 **INDEPENDENT LIVING ARRANGEMENTS**

Survivors are housed in a separate accommodation such as independent flats or hotel rooms. This form of accommodation is particularly relevant for transitional periods and to develop independent living skills. Security risks must be assessed due to the presence of other individuals in the area and it is not recommended in high risk cases which require high security measures.

4.1.6 **COMMUNITY HOST SYSTEMS**

Survivors live in the private homes of pre-selected members of the community. This system has been used in Medellin, Colombia²², and it presents advantages as the survivor stays in a homely environment free of violence, with personalised attention. In these systems, healing and community networks will be strengthened. There are two main considerations regarding security in this system: the first one is regarding the suitability of the host family, as it is paramount to ensure that the survivor is placed in a safe and secure environment. The second concern regards the safety of the host family, as it is vital to guarantee they are not put at risk of violence by the perpetrator for hosting a survivor.

4.1.7 **PROTECTED AREAS**

Protected areas are used in refugee camps or in camps for internally displaced people (IDPs). Survivors are housed in a protected enclosed subsection of a camp for refugees or IDPs. In these situations, the shelters are managed by protection actors and the shelter location is kept confidential.

4.1.8 **ALTERNATIVE PURPOSE ENTITIES**

Survivors stay in a setting which is designed to provide services unrelated to safe shelter, such as a police station, hospital, church, clinic etc, in situations of emergency where nothing else is available.

HYBRID MODELS

Combines elements of different models.

A large, stylized number '5' in a light orange color is positioned on the left side of the page, partially overlapping the title text.

Guidelines for setting up a safe shelter for survivors of GBV: a survivor- centered approach

This section offers recommendations to GBV shelters and alternative accommodation from a survivor-centered approach. The chapter starts by addressing the functional aspects of setting up a shelter or an alternative accommodation for GBV survivors. Several functional aspects are to be considered at the set up stage, such as the importance of conducting a needs assessment, the location of the facility, and safety and security measures and concerns. These functional recommendations are centred in the right to safety, respect, confidentiality and non-discrimination of survivors as well as to their right to receive quality services.

The following section addresses the accessibility and eligibility criteria of individuals to be offered safe shelter, based on the GBV Guiding Principles and in ensuring that no one is left behind. The accessibility and eligibility criteria section is divided into 10 different points and each refers to specific needs and services recommended to ensure an optimal service provision to each group. The groups have been divided into the following categories of survivors: Women and children; adolescents and girls; migrant and refugee women; survivors living with disabilities; survivors who are no longer of reproductive age and those who are considered to be elderly; sex workers; survivors living with HIV; survivors identifying as LGBTQI+; survivors with severe mental health issues; and survivors dealing with substance abuse issues. This categorisation is meant to be general. A survivor might fall into several categories at the same time or might have needs that differ or that have not been contemplated in these guidelines. Nevertheless, it is imperative to approach all survivors of GBV in a non-discriminatory, non judgemental and inclusive manner. It is crucial to ensure that no survivor of GBV is denied access to services.

Recommendations have also been made in relation to the services provided on site and/or by referral as well as to the importance of referral pathways. In this section, the following services have been addressed: GBV case management, specialized mental health and psychosocial support (MHPSS), clinical management of rape (CMR), other SRH Services and commodities, child care, basic child protection, legal assistance and livelihood opportunities. As these guidelines are designed from a survivor-centred approach, survivors are the ones that decide which services they want to access or not. Still, it is paramount to provide them with adequate and timely information so that they are able to make informed choices.

Section 5.14 focuses on the staff working in safe shelters and alternative accommodation for GBV survivors. Professional and well trained staff will be better capacitated and more confident to deal with their tasks and duties and, overall, better prepared. Therefore, a better service provision can be ensured by the professionalisation and training of staff, ensuring core competencies for GBV service providers. This section recommends different training programmes that are deemed of high importance for the staff working at shelters and alternative accommodation. In addition, these guidelines also recognise the emotional burden carried by staff and the measures that can be taken to address this. Thus, designing and implementing a staff care plan is highly recommended for all shelters and alternative accommodation for GBV survivors.

All shelter staff have the duty to treat survivors with dignity and respect and to promote human rights. However, the shelter's staff is in a position of power in relation to survivors, and sexual exploitation and abuse (SEA) can take place. It is crucial to create an environment in which staff

and survivors and their children are safe and free from any SEA. The protection against sexual exploitation and abuse (PSEA) section addresses the steps that must be taken to prevent this, as well as the staff's duty, and anonymous and safe reporting mechanisms, to report any incidents. The following point in this section covers protocols on data collection and sharing. Regarding this, it is also highly recommended that shelter managers consult the articles and documentation mentioned for a more comprehensive approach on the matter.

As the Caribbean region is affected almost every year by natural hazards, being well prepared to respond to disasters and their aftermath is of benefit to all. Therefore we highly encourage shelters and alternative accommodation to design and establish Protocols on Disaster Preparedness and Response. Finally, we address the current COVID19 pandemic. Lockdown measures and loss of livelihoods due to the pandemic have the potential of increasing GBV cases, and it is thus vital that shelters and alternative accommodation are able to continue to operate whilst guaranteeing the safety of residents and staff.

5.1 STANDARD OPERATING PROCEDURES (SOPS)

SOPs are widely recognised as a best practice, which ensures a clear provision of instructions on how to conduct tasks, and that addresses roles and responsibilities, as well as referral mechanisms. In addition, SOPs guarantee that information is not lost with staff's turnover. SOPs can include, but are not limited to the following:

- ✿ Needs Assessment
- ✿ Mapping of services
- ✿ Location
- ✿ Financial Management: budgeting, funding; fundraising
- ✿ Safety and Security
- ✿ Infrastructure
- ✿ Food and Meals
- ✿ Dignity Kits and Non-Food items (NFIs)
- ✿ Accessibility and Eligibility Criteria:
 - ◇ Women with Children
 - ◇ Adolescents and Girls
 - ◇ Migrants and Refugee Women
 - ◇ Survivors Living with Disabilities
- ◇ Survivors who are no longer of reproductive age and those who are considered to be elderly
- ◇ Sex Workers
- ◇ Survivors Living with HIV
- ◇ Persons who identify as LGBTQI+
- ◇ Survivors with severe mental health issues
- ◇ Survivors dealing with substance abuse issues
- ✿ Admission Process
- ✿ Services Provided on Site:
 - ◇ Mental Health and Psychosocial Support
 - ◇ GBV Case Management Services
 - ◇ Clinical Management of Rape
 - ◇ Other Sexual and Reproductive Health Services and Commodities
 - ◇ Child Care and Schooling
 - ◇ Child Protection
 - ◇ Legal Assistance
 - ◇ Livelihood opportunities

- ❁ Coordination - Referral Pathways:
 - ❖ Coordination with other shelters and alternative accommodation
 - ❖ Coordination with other service providers
 - ❖ Coordination with the police and judicial systems
- ❁ Staff:
 - ❖ Organizational structure
 - ❖ Recommended training for staff
 - ❖ Self-care and Staff care
- ❁ Protection from Sexual Exploitation and Abuse
 - ❖ Confidential Reporting Mechanisms and Feedback
 - ❖ Codes of Conduct
- ❁ Protocols on data collection and sharing
- ❁ Disaster Preparedness and Response

5.2 ASSESSMENTS THROUGHOUT THE PROJECT CYCLE

The first step to take in order to understand the needs of the community, as well as to identify gaps and challenges, is to undertake a needs-assessment. Conducting a needs assessment will generate information on the type of safe shelter the community needs and wants, as well as if there are any survivors that are either being overlooked or excluded and if the safe shelter can cover their needs. Consider the following:

- ❁ What type of safe shelters for GBV survivors, if any, exist in the area
- ❁ If there are other safe shelters in the area, explore the following:
 - ❖ How many survivors and their families can they accommodate?
 - ❖ Are the existing safe shelters unable to accommodate all the cases that reach them due to lack of space?
 - ❖ Are the existing safe shelters oriented at receiving a specific group of survivors?

Conducting assessments is the first step in any project cycle. In the context of setting up projects to respond to GBV, such as establishing safe shelters for survivors, it is important to think about the

project cycle to design, monitor and evaluate the establishment of the intervention, clearly clarifying the purpose of the assessment first. We recommend that assessments be conducted throughout the cycle of the project, without limiting it to a needs-assessment, but conducting assessments to inform strategic planning, during implementation and during the monitoring and evaluation process.

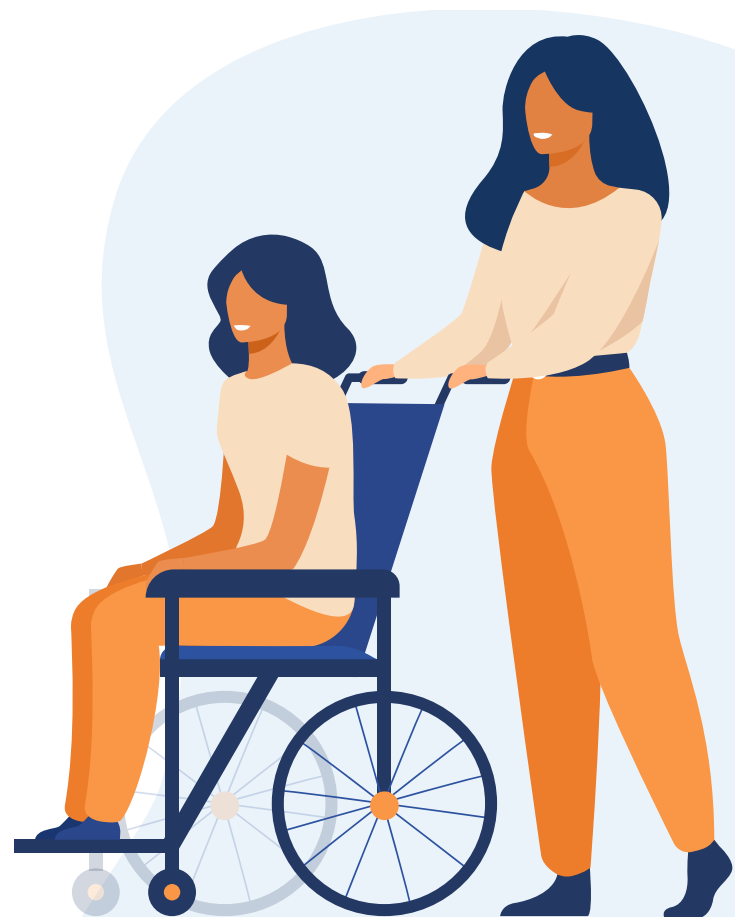
There are many different tools that can be adapted and used to conduct these assessments, depending on the stage of the emergency, the context and the specific information that is being searched for. A GBV service mapping gathers an overview of the services in the specific area, types of services provided, where these are provided, the modality and how to access them. This is a tool that informs the GBV referral pathway, which is a crucial tool for the use of shelter staff in order to ensure comprehensive service provision for survivors sheltering in their facilities. Most countries in the Caribbean have GBV referral pathways developed; please contact the local Gender Bureaus and/or UNFPA representatives in your countries in order to access them. If a specific country or area does not have GBV referral pathways available, then it is crucial to advocate for the tool to be completed as soon as possible.

Aside from understanding the services offered and the pathways to refer survivors to them, it is important to make sure the safe shelter is located in an area that will not be increasing risks for survivors, and that can keep them safe and protected. A safety audit can be conducted for this purpose. Aside from the safety audit however, feedback and engagement from the affected communities is necessary, and communities should be consulted in order to inform the design of the safe shelter for survivors. This can be done through Focus Group Discussions (FGD) and/or community mappings where a number of questions related to the setup and design of the shelter can be asked²³.

We particularly recommend conducting a mapping of the services provided in the area where you will operate (or are operating), as it will help you understand what is available in order to follow/update referral pathways, and will allow you to identify gaps in services. A mapping of services should include, but is not limited to, the following:

- ✿ Social protection services (including specialized response to GBV, such as case management services)
- ✿ SRH services (all levels of care)
- ✿ Mental health specialists (all levels of care)
- ✿ Security services (including emergency response to life-threatening GBV incidents)
- ✿ Lawyers and legal counselling
- ✿ General protection services
- ✿ International protection services for refugees and migrants (including family reunification agencies and legal advice and support in seeking asylum)
- ✿ Substance abuse support services
- ✿ Vocational training
- ✿ Formal and informal education
- ✿ Adult learning opportunities
- ✿ Child protection services

There are a number of resources available to guide service providers in conducting GBV assessments. UNFPA has put together a package of tools, adapted to the Caribbean Region, that can inform either a rapid assessment or a comprehensive one or "situational analysis". Please contact your local UNFPA representative to understand the support that can be provided. In addition, please also refer to the references where further guidance is given around GBV assessments.



5.3 LOCATION

A safe shelter should be located in an area that does not only provide maximum protection for survivors and their children, but which also promotes healing and recovery. If the safe shelter is located in a less busy area this might contribute to a quieter environment which, in turn, may bring benefits to the recovery of survivors. However, it is also necessary to take into account the safe shelter's accessibility to services, which might be compromised in more isolated areas. It is crucial to find a balance that allows survivors to enjoy a quiet environment, while also allowing accessibility to required services.

- ✿ **Confidentiality:** the location of the safe shelter should not be shared with anyone not working at the shelter, in order to guarantee the **safety** of the residents and the staff.
- ✿ If it is not feasible to keep the location a secret, it is recommended to take all other available security measures to prevent unwanted access (refer to section 5.6)
- ✿ **Identifying GBV Hotspots:** by doing so, it is possible to grasp which geographical areas are in need of safe shelter.
- ✿ Assessment of the **crime rates** in the area: being aware of the crime rates in the area where the safe shelter is located can ensure additional security measures are taken to prevent additional risks for survivors, if deemed necessary.
- ✿ **Convenient Location** for survivors to access services they might require such as psychological, medical and legal services. In instances where there is an identified need for a safe shelter, but the area is remote and/or

does not yet have basic services, either the safe shelter should ensure the provision of such, or remote service provision could be considered. You may also want to include a budget line for emergency transportation in case a survivor needs to be relocated to an area nearby for emergency services, i.e. medical.

- ✿ **Transportation** - Safe shelters should consider the availability of public or other affordable means of transportation (arranged taxi services, for example) to and from the shelter while ensuring the survivor's safety and the confidentiality of the shelter. In addition, children might also require transportation to and from school. It is important to have a safe affordable means of transportation available to prevent residents from resorting to friends and family to transport them to and from the safe shelter, thus disclosing its location and compromising the safety of residents and staff.
- ✿ If an **alternative** accommodation such as a hotel is being used, it is crucial to understand the risk that other individuals in the hotel or in the area may pose, as confidentiality and thus security may be compromised. Due to this, safety planning should not be overlooked in any type of accommodation, but special attention should be given to cases in which alternative accommodation is used.
- ✿ Alternative accommodation is not recommended for high-risk cases as security might be more easily compromised.
- ✿ **Rural vs Urban Areas** - traditional safe shelters tend to be more available in urban areas in contrast to rural areas. This can potentially leave survivors in rural areas unsupported or

may require them to travel to other parts of the country to seek refuge. Therefore it is important to ensure that survivors in rural areas are aware of the existence of safe shelters and the one closer to them. Consider an information campaign using the communication tools preferred in your area (radio, tv, flyers to be circulated virtually or physically, etc), targeting service providers and/or at-risk individuals, always ensuring confidentiality and their safety when receiving this information. It is also important to consider transport options for survivors in rural areas

who may need urgent access to safe shelters. If the shelter is to be located in an urban area and there is a lack of safe shelters in rural areas, consider the following:

- Arrange safe transportation for survivors coming from other parts of the country.
- Community outreach in the rural areas such as advertising 24 hotlines and ensuring that information on safe shelter services is available in churches, police stations and other relevant public offices

5.4 PHILOSOPHY OF THE SHELTER AND DESIRED OUTCOMES

It is recommended that the organization reflects upon and defines the philosophy of the shelter²⁴, its approach and desired outcomes in relation to survivors of GBV.

These guidelines recommend a survivor-centered approach that focuses on empowering survivors by putting them at the centre of the response.

Empowerment comes from making their own informed decisions and access to services can only occur with the survivor's informed consent. Survivors are respected and supported, in charge of making decisions that affect their lives so that they are able to transition to an independent life free of violence.

5.5 FUNDING

While the state is responsible for preventing and responding to GBV, most safe shelters are set up by women's organizations. To provide quality and secure services, safe shelters require stable and sufficient funding. Often funding that comes from the state is either insufficient or not stable, which means that shelters have to resort to other sources, such as private funding or donations from fundraising. The bulk of the safe shelter's funding should come from a stable and sufficient source and should ensure the functioning and maintenance of the shelter as well as its operationalisation. Different sources of funding that could be

considered, are the following:

- ✿ State funding
- ✿ International development partners - such as UN agencies, bilateral and other international non-governmental organizations
- ✿ Private Donors
- ✿ Civil Society Organizations
- ✿ Fundraising with the public and through private donations

5.6 SAFETY AND SECURITY PROTOCOLS

The safety and security of both residents and staff is paramount in safe shelters and alternative accommodation and all steps available must be taken to guarantee it. Shelters should design safety and security protocols while also contemplating safety and security in case of a fire or natural hazards. Take into account the following recommendations:

- ❁ Several entrances can be a safety hazard, have only one main entrance to ensure security and safety
- ❁ Safe entrances that cannot be opened or forced should be in place
- ❁ All entrances should be kept locked
- ❁ If there are ground floor windows, gratings are recommended
- ❁ If the location of the shelter is not confidential or confidentiality has been broken, ensure all other possible security precautions are being taken
- ❁ **Not allowing visitors** at the safe shelter will help guarantee survivors' safety and confidentiality
- ❁ Ensure there is a protocol in place for people entering and exiting the safe shelter
- ❁ Access to a **landline** and/or to a **direct emergency line** to the police
- ❁ If there is a **curfew**, include the residents in the establishment of these times - note that some shelters choose not to use the term 'curfew' and prefer to use other

terms such as 'safe times'. As UNFPA we would also recommend using this terminology and allowing residents to make their own choices, without forcefully limiting their freedom of movement. Please also take into account that some of them may have jobs and work at night, and they should be able to continue working, just ensure all safety and security concerns are met and make a plan with the survivors

- ❁ Plan and design safety and security protocols in case of security breaches which can endanger both staff and survivors
- ❁ Safety and evacuation protocols in case of fire and natural hazards
- ❁ Regularly review, evaluate and update safety and security protocols.



5.7 INFRASTRUCTURE

The safe shelter should be designed in a way to help survivors to overcome trauma by providing a safe environment where they can recover from a crisis. Ideally each survivor should have their own room, especially if the survivor is accompanied by children. This may not always be possible, but overcrowding should be avoided as it can potentially create stress and tensions. When planning the space, consider not only the number of survivors that will access the shelter, but also the number of children that will be accompanying the survivors. Include the needs of survivors that are single in the planning and designing of the shelter and allow space for individual and communal activities. As children are a considerable segment of shelter's residents, consider spaces designated only for children and for their activities.

5.7.1 ROOMS AND FACILITIES

- ✿ Rooms for residents
- ✿ Survivors of GBV are very likely to arrive at a shelter after experiencing distress and trauma. Privacy and having a space for themselves might positively contribute to their recovery.
- ✿ Individual bedrooms for residents - one bedroom to accommodate a single survivor or a survivor with children
- ✿ One bathroom shared by no more than two rooms
- ✿ If single bedrooms are not available or are not possible, the alternative is to have a big room with bunk beds: avoid overcrowding when planning the number of beds as many survivors will have children with them.
- ✿ Residents are in charge of cleaning their own room and bathroom

5.7.2 COMMON ROOMS FOR RESIDENTS

Shelters can promote communal living by having communal rooms where residents can engage with each other. Some shelters choose to prepare and provide meals, whilst others provide the food and the residents cook together, but in both situations residents can eat their meals together. Usually residents are in charge of cleaning the kitchen after using it, and it is recommended that clear instructions on the functioning and cleaning of common areas is provided. Consider the following common areas:

- ✿ Kitchen
- ✿ Laundry Room/Washing Area
- ✿ Dining Room
- ✿ Living/Sitting Room
- ✿ Reading Room/Studying Room
- ✿ Room for recreational activities
- ✿ Child-friendly spaces

5.7.3 SEPARATE ROOMS

- ✿ Individual rooms for counselling, case management, etc, where confidentiality and privacy is ensured
- ✿ Rooms for group meetings
- ✿ Secure storage of confidential information is mandatory

5.7.4 ROOMS FOR STAFF

- ✿ Rooms for the administration and management of the shelter
- ✿ Rooms for the staff that stays overnight

5.8 FOOD AND MEALS

Meals are an opportunity to foster communal living and safe shelters can either provide the residents with meals or provide groceries so that residents cook for themselves. Take into consideration the following:

- ✿ Specific diets: lactose intolerant, gluten intolerant, diabetes, vegetarian, vegan, etc.
- ✿ If the residents are provided groceries and are expected to cook, ensure the kitchen is fully equipped with appliances, cookware and utensils.
- ✿ If residents are expected to clean after using

the kitchen, ensure that is specifically stated in the code of conduct and/or in a sign in the kitchen stating the kitchen rules for a peaceful coexistence.

- ✿ Children are a steady presence in shelters, consider this when planning safety and access to the kitchen. If children are not allowed in the kitchen, make a plan with their carers so they agree on a way to ensure someone can mind them while they are busy with cooking and cleaning.

5.9 DIGNITY KITS AND NON-FOOD ITEMS (NFIS)

Survivors (and their children) often leave their homes without any of their possessions. It is highly recommended to have basic items in packages ready to be handed out on arrival and if required by the resident, during their stay. We highly recommend consulting with the communities during assessments and to continuously engage with residents to inform them of the items that they will need as per their arrival, and how often they will need to be replenished. Packages can contain, but are not limited to, the following:

- ✿ Sheets
- ✿ Towels
- ✿ One or two changes of clothes: t-shirts, pants, shoes (all contextually relevant)
- ✿ Pajamas
- ✿ Shower sandals

- ✿ Dignity Kits, which contain the following:
 - ✦ Toothbrush and toothpaste
 - ✦ Comb
 - ✦ Deodorant
 - ✦ Soap
 - ✦ Shampoo
 - ✦ Lotion (body and/or face)
 - ✦ Sanitary pads/tampons
 - ✦ Underwear (panties and bras)

CHALLENGES AND GAPS IDENTIFIED IN THE REGION: DIGNITY KITS AND NFIS

Shelters often depend on donations and could not ensure a stable supply. Frequently, they are forced to only provide Dignity Kits and NFIs to residents that either do not have their own or that cannot afford to buy their own.

- ◆ In addition to Dignity Kits, survivors and their children might also require clothing. If possible, safe shelters can also provide school supplies and toys for children. If the shelter is not able to provide clothing or school supplies, ensure that there is a referral path in place to connect the resident with another organization that does.

LESSONS LEARNED

One shelter in the region created a boutique of donated clothes so that residents can choose their clothes and have a similar experience to going to a shop.



5.10 ACCESSIBILITY AND ELIGIBILITY CRITERIA

The majority of shelters are oriented towards women and their children. However, not all survivors of GBV fit in this group. From a survivor-centred approach, it is vital to promote inclusive and non-discriminatory access to shelters for all survivors of GBV. While the points below draw

attention to particular concerns regarding specific groups, it is important to bear in mind that the survivors alluded to in each of the following groups are also not homogenous, and that factors such as age, gender and one's socio economic background also play a role.

5.10.1 WOMEN WITH CHILDREN

Women with children tend to represent the majority of survivors that enter safe shelters. While shelter and case management services are directed towards the survivor, it is vital to acknowledge the needs of the children too. Children might have witnessed or have been subjected to violence and thus might also experience **trauma or distress**. By entering the safe shelter, they might not be able to attend school or they might have to change schools, which will cause further disruption to their lives. Children may also be the target of violence by the perpetrator, and while the focus is on the survivor, child protection principles, namely the best interest of the child, must be applied in order to ensure that children are also protected and attended to. It is crucial for the safe shelter to partner with child protection agencies and governmental child protective services, to make sure proper protection services are available for children's wellbeing even



if outside the safe shelter. However, as children are a significant percentage of shelters' residents, it is important to plan for this by considering the following:

- ✿ Referrals to medical services if required
- ✿ PSS activities for children
- ✿ Recreational activities for children
- ✿ Child-friendly spaces
- ✿ Study Room - for children that are attending online school or/and need a quiet place to study and do their homework
- ✿ Child care options, particularly important in situations in which the carer is working and cannot attend to the child
- ✿ In case children are not able to stay at the shelter or there is an age limit, establish referral

pathways for alternatives

- ✿ Support the relationship between the child and the carer through parenting programmes

LESSONS LEARNED

A shelter manager noted that most shelters do not offer activities, child care nor spaces designated for children, which results in shelters that are not child-friendly but that accommodate children on a very frequent basis. Consequently, shelters become a last resort for women with children, instead of a first resort in case of violence.



5.10.2 ADOLESCENTS AND GIRLS

Adolescents are the 10-19 year old group, thus anyone under the age of 18 years old is under the umbrella of child protection. Adolescent survivors may also approach the shelter or be referred to it, and so it is crucial to understand the national legislations in terms of specific requirements when sheltering an adolescent, and whether there is an age group that can be covered by child protective services, while still being hosted in the safe shelter. However, please keep in mind that this entirely depends on the national context and regulations, and children, including adolescent survivors, might not be allowed to stay in a shelter for adults and might have to be referred elsewhere.

Safe shelter managers should be aware of the following:

- ✿ Child Protection Services in the country where the shelter is located: a referral system should be in place in case the safe shelter is approached by adolescents, unless this age group is under the safe shelter's mandate.
- ✿ Mandatory reporting laws: if an adolescent is a survivor of GBV and is under 18 years of age, there may be requirements where in a given country, it is mandatory to report it to the police or child protective services. Please urgently inform yourself and acquire the specific section of the national legislation where this mandatory reporting requirement is clearly stated, and inform your safe shelter's SOPs accordingly, clarifying what procedures will be followed for child survivors of GBV.

LESSONS LEARNED

One shelter interviewed in the Caribbean will soon be able to accommodate adolescent girls who have been subjected to the following: GBV, unfit parents, situations of family violence. The focus will be on the girls attending school, gaining skills to become independent as well as on emotional and psychological support for empowerment. The shelter will not mix the adolescent girls with the adult survivors of GBV, and they will be placed in separate parts of the shelter.



5.10.3 MIGRANT AND REFUGEE WOMEN

Migrant and refugee women are particularly vulnerable to GBV. Despite this, they are also more likely not to access safe shelters as they may not be aware of these services and how to access them and/or due to fear of being imprisoned or deported if they do not have legal asylum seeker statuses. Language poses an obstacle not only in learning about these services but also in accessing them and receiving all services that are offered in the facility. Migrant and refugee women are particularly vulnerable, as they are more isolated, have weak support networks and face an increased risk of GBV, in particular worsened socio-economic situation will expose migrant and refugee women and girls to increased risks of different forms of SEA such as resorting to survival sex (since it is extremely difficult for them to find alternative income-generating options), and of being subjected to discrimination and xenophobia. For safe shelters to be able to provide quality services to migrant and refugee women, please take into account the following recommendations:

- ✿ Training of staff on Refugee and Migrants Rights, to ensure that the safe shelter is able to provide an adequate and informed response

if approached by migrant and/or refugee survivors.

- ✿ Training on Trafficking in Persons, to guarantee that the staff is able to identify possible cases of trafficking in persons and to provide adequate response services using the referral pathways.
- ✿ Languages: if the survivor does not speak the language spoken by the staff, formal translation and interpretation services have to be made available to the survivor. For translation and interpretation purposes, it is not ethical to resort to assistance from another survivor, to a member of the community or to the survivor's child. This is a professional service that should be provided by a staff member, who will also benefit from capacity building activities. It is recommended to have this feature included in the mapping of services and budgeted in the shelter's finances to cover staff costs
- ✿ Information, Education and Communication (IEC) material, as well as the code of conduct and any other relevant materials available at the shelter, should be available in the different relevant languages.

- ❁ Advocacy, information and awareness raising around GBV directed at migrants and refugees must be offered in their languages. If hotlines and all the information available on GBV and on how to seek help are not available in a language known to survivors, the chances of the survivor seeking and getting help decrease.
- ❁ As mentioned under the assessment section, it is crucial to have an understanding of actors who provide protection services for refugees

and migrants, who can advice them on different options they may have due to their legal status, work with them in navigating the national system to either claim asylum or explore options for voluntary return to their home countries (this is especially important for Victims of Human Trafficking).

Availability of MHPSS services due to forced displacement.

5.10.4 SURVIVORS LIVING WITH DISABILITIES

The Interagency GBV Case Management Guidelines (2017), defines disabilities as such:

- ❁ **PHYSICAL IMPAIRMENTS:** includes persons who have mobility difficulties, and may resort to devices such as a wheelchair or a cane in their daily lives.
- ❁ **SENSORY IMPAIRMENTS:** this includes persons that are deaf or have hearing impairments, as well as individuals who are blind or have low vision (finding it difficult to see even when wearing glasses).
- ❁ **INTELLECTUAL IMPAIRMENTS:** includes individuals who live with neurodevelopmental disabilities (also referred to as cognitive or developmental disabilities). Intellectual impairments refer to intellectual functioning (such as learning, reasoning, problem-solving, etc.) and adaptive behavior (the conceptual, social, and practical skills that are learned and performed by people in their everyday lives)²⁵.
- ❁ **PSYCHOSOCIAL DISABILITIES:** encompasses individuals who do not have access to or are unable to participating in the community on an equal basis with other individuals, due to mental health difficulties combined with discrimination and other challenges in integrating into society.



Persons Living with Disabilities (PLwD) are highly vulnerable to GBV for a number of reasons such as being more likely to be socially isolated; being perceived as lacking the ability to defend themselves; are more likely not to be believed (especially if they have intellectual impairments), and depending on the disability they are living with, are many times unable to recognize when they are being subjected to GBV. When the caregiver is also the intimate partner, there is an even higher level of power imbalance in the relationship, and exertion of control over the PLwD may be aggravated. To be able to assist survivors living with disabilities, safe shelters can look into the following:

- ❁ Map the services that exist in the area that can provide support to PLwD (such as organizations that work with PLwD, but also sign language interpreters).
- ❁ When conducting assessments and when interacting with the communities to inform the main needs, always involve PLwD in discussions and take their recommendations into account at all times. Directly ask them how you can make the shelter accessible for them and how you can ensure services offered in the facility are tailored to their specific needs.
- ❁ Prepare the safe shelter to accommodate survivors living with physical disabilities: consider obstacles and barriers such as staircases, narrow doors and accessibility of toilets. Rooms, beds, kitchen facilities, common areas, and spaces to receive particular services, should be accessible for PLwD.
- ❁ When designing an emergency plan take into consideration PLwD: consult and involve them in the process of drafting the plans and make sure they are comfortable with it.

5.10.5 SURVIVORS WHO ARE NO LONGER IN REPRODUCTIVE AGE AND THOSE WHO ARE CONSIDERED TO BE ELDERLY

There is no consensus on when old age starts, and it varies greatly across cultures. Older survivors are often not taken into account in the designing of programmes for survivors of GBV as it tends to be an invisible phenomenon, and programmes usually target women and girls of reproductive age. However, older survivors are not only vulnerable to all types of GBV, but also to abuse and/or neglect by their caretakers. Consider the following:

- ❁ Access to mental health services
- ❁ Access to medical services and sexual health services (including, but not limited to, clinical management of rape services)
- ❁ Access to any other required services, such as the ones related to chronic illnesses (diabetes, arthritis, etc)
- ❁ Access to welfare services

LESSONS LEARNED

One shelter in the region perceived that older women were often skilled and were not in need of vocational training as many of the younger women, but were very much in need of emotional support and empowerment in order to make the transition to a dignified life free of violence.



5.10.6 SEX WORKERS

Sex workers are particularly vulnerable to GBV, and due to the nature of their work, they are also more likely not to go to the police or to seek help. Sex workers are often stigmatised due to their work, which can be challenging for the relationship with other survivors and with staff. In addition, curfew hours operated by safe shelters might be incompatible with their working hours. It is vital that the staff receives training on the relation between GBV and sex workers, but also that the shelter liaises with other organizations that work with sex workers as they might have complex needs. It is important that staff working in safe shelters receive general training on HIV, but it is also paramount that they are aware of the link between violence

against sex workers and HIV. The WHO has pointed out that 'violent or forced sex can increase the risk of transmitting HIV. In forced vaginal or anal penetration, abrasions and cuts commonly occur, thus facilitating the entry of the virus into the bloodstream'²⁶.

Access to SRH Services (including commodities) should be either facilitated on site or through referral, including the following:

- ✿ Clinical management of rape services
- ✿ HIV and STIs Counselling, testing and treatment
- ✿ Family Planning (modern contraception including female/male condoms and lubricants)

5.10.7 SURVIVORS LIVING WITH HIV

All persons receiving services have a right to confidentiality, and this includes the right not to have their HIV status disclosed. Maintaining the privacy of a person's HIV status is especially important because discrimination against people living with HIV is still pervasive, and survivors living with HIV are often stigmatized and alienated. Where the disclosure is necessary for providing appropriate services, please consider the following:

- ✿ Disclosure should only be made to a service provider or counsellor with training on HIV and on persons living with HIV and with prior consent of the survivor
- ✿ Service provider or counsellor should keep the information confidential at all times
- ✿ Ensure the availability of and access to care and ARV treatment for persons living with HIV
- ✿ Offer counselling on HIV where necessary



5.10.8 PERSONS WHO IDENTIFY AS LGBTQI+



Gender non-conforming persons are not only at a very high risk of experiencing GBV, but also at risk of experiencing discrimination when seeking shelter and support. The risk of discrimination and stigmatisation comes from the police, from service providers, and from society in general, which makes this group particularly vulnerable to GBV and creates a barrier to accessing essential services. Shelters frequently deny access to transgender women as they are perceived as disruptive and as a threat to other survivors²⁷. Not accommodating gender non-conforming groups can further put them at risk of GBV and of engaging in negative coping mechanisms such as survival sex. Consider the following:

- ✿ Provide training for all staff on LGBTQI+ groups to ensure an inclusive environment for gender non-conforming groups is created.
- ✿ The GBV guiding principles are guaranteed.
- ✿ Use gender inclusive language, including the use of gender-neutral pronouns: he/she/they/them/theirs/Ze/hir/hir (depending on preference). Gender inclusive language should be used in the intake forms, in Information, Education and Communication (IEC) material, as well as in the code of conduct and in any other relevant materials available at the shelter.
- ✿ A transgender person who seeks shelter and support is not, under any circumstances, obliged to disclose their gender identity. This is an individual choice and they should be able to do so if they feel comfortable, whenever they feel comfortable, and to whoever they want to share it with.
- ✿ Legal identity vs preferred identity: using a person's legal name and gender pronoun instead of their preferred name and gender pronoun can affect a survivor's mental health while also putting them at further risk of violence and exclusion. If a survivor identifies differently from their legal identity, it is important to respect it and address the survivor using their preferred name and gender pronouns.
- ✿ Sleeping arrangements: if private rooms are not available, and if a common room with bunk beds is not an adequate solution, consider placing survivors in alternative accommodation to ensure their confidentiality and safety (always make sure to ask them what their preferences may be).
- ✿ Always consult with the affected population identifying as LGBTQI+ to understand what their preferences would be for the setup of the shelter.

5.10.9 SURVIVORS WITH SEVERE MENTAL HEALTH ISSUES

Survivors with severe mental health issues, will require specialized services which can only be offered by professionals such as psychiatrists and psychiatric nurses. In the event of the safe shelter not being able to accommodate survivors with severe mental health issues, it is crucial to have active and functional referral pathways in place. The focus should be on ensuring that survivors that suffer from severe mental health issues are attended to in a respectful and confidential manner, that ensures their safety. It is paramount to note that “women living with severe mental illness are significantly more likely to fall victims to violence”, indeed, “they are six times more likely to experience sexual violence during their life”²⁸. Moreover, GBV can seriously further impact the mental health of survivors. The WHO (2018) states that the impacts of GBV in survivors include Post Traumatic Stress Disorder (PTSD), depression, anxiety, substance misuse, self-harm and suicidal behaviour, and sleep disturbances²⁹.

5.10.10 SURVIVORS DEALING WITH SUBSTANCE ABUSE

If during the initial assessment the survivor voluntarily discloses that they are abusing substances, it is important that the survivor gets immediate support. To that end, it is crucial to:

- ❁ Map the programmes that exist in the community for the support and treatment to persons engaging in substance abuse and desintoxication programmes, so this information can be given to the survivor for her to make a choice as to what services to receive.
- ❁ Depending on the level of addiction, the safe shelter might not be able to accommodate the survivor, and should therefore have a functional and updated referral pathway in place.
- ❁ If the above is the case, and there are other programmes available for desintoxication that include shelter, it is important that the shelter liaise with those service providers and they can make arrangements for the survivor to be able to receive GBV response services during the stay in another facility.
- ❁ If the survivor is going to engage in a desintoxication programme, please make sure that she knows she can always come back to the shelter once it is safe for her to do so, and the services available in the facility will remain available for her.

5.11 RECOMMENDATIONS FOR SERVICES PROVIDED ONSITE AND/OR BY REFERRAL

The following are some of the services commonly required by survivors of GBV. Shelter managers should put in place the necessary mechanisms to ensure access to these services by survivors whether within the shelter or by referral. Prior to setting services up at the shelter, map what exists in the community and in the area, including if these services are functioning, who can access them and how. If gaps are identified, safe shelter providers, along with the community, other service providers and local authorities can address them. Above all, services must be tailored to the needs of survivors.

The majority of shelters will not have a clinic, lawyers or educational programmes available inside the facility, but all these and other services should be accessible to survivors at least through referrals. The mapping of services in the community and the coordination and creation of referral pathways will ensure that the needs of survivors are effectively assessed and supported in a timely manner. All referrals must be confidential and made with the informed consent of the survivor.

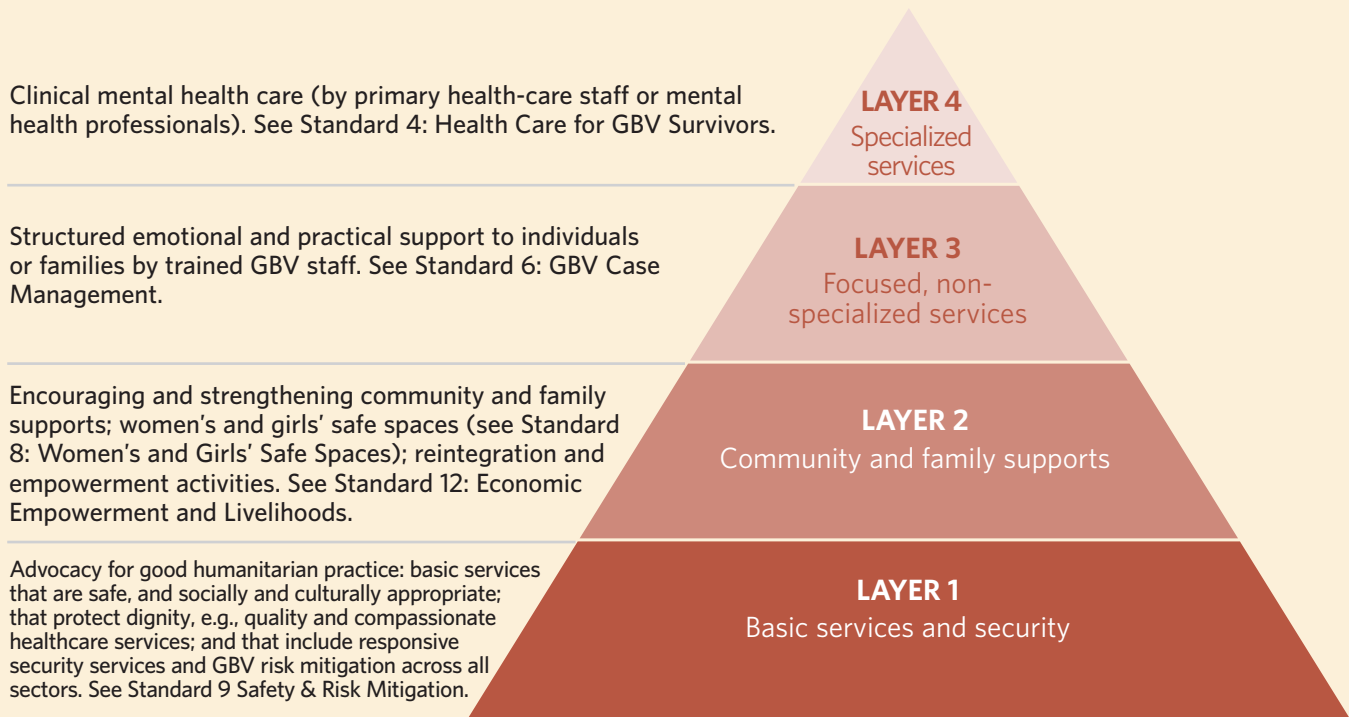
5.11.1 MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT

The impact GBV has on survivors will vary from person to person. Each person will experience different sorts of psychological and social consequences and effects “due to the silence and stigma surrounding GBV, a lack of family and community support and appropriate response services, internalized shame, and a lack of power and resources to escape continued perpetration of GBV. Psychosocial support is therefore a critical emergency intervention. It should be a central component of both short- and long-term GBV specialized programming”³⁰.

Psychosocial services of quality should be based on a survivor-centered approach that promotes resilience and supports positive coping mechanisms. Opportunities for social networking should be promoted, as well as solidarity-building activities among women and girls who access the services in the safe shelter. MHPSS describes the support that is provided to protect or promote psychosocial well-being and mental health, in this case for

survivors of GBV who enter the safe shelters. This guideline will mainly focus on the provision of psychosocial support, because it can be provided without specialized mental-health care services and is related directly to GBV response programming. Specialized and clinical mental health care is to be provided by specialized health care actors, and in cases of shelters for GBV survivors, this can be offered through referrals to the specific services.

Below you will find the IASC Intervention Pyramid for Mental Health and Psychosocial Support in Emergencies, and you will be able to identify the different services to be offered in the safe shelter, and the layer under which it will fall into. According to this, we recommend following specific recommendations highlighted in the Interagency Minimum Standards for GBViE Programming, where you will be able to clearly follow suggestions and identify the minimum standards of the services you can offer in your shelter.



Source: IASC 2007.

Survivors will require different levels of mental health and psychosocial support. As with every other level of intervention, staff at the shelter and other professionals that work with survivors should follow a 'Do no harm' approach. All shelter staff should be familiar with the services available to survivors in their area so that they are able to make safe and confidential referrals. Specialized MHPSS services should be available by referral and can include, but are not limited to the following:

- ✿ Psychological Assessment
- ✿ Psychiatric Assessment
- ✿ Psychological First Aid (PFA)
- ✿ Counselling
- ✿ Psychotherapy
- ✿ Support Groups

While some survivors might only require psychosocial support that focuses on "person-to-person services such as counselling, case management, and emotional and practical support provided by trained community or social workers". There will be survivors who experience specific mental health issues, may require specialized mental health services delivered by mental health professionals, such as a psychologist, a psychiatrist or a psychiatric nurse³¹

SIGNS THAT A SURVIVOR MAY NEED SPECIALIZED MENTAL HEALTH SUPPORT:

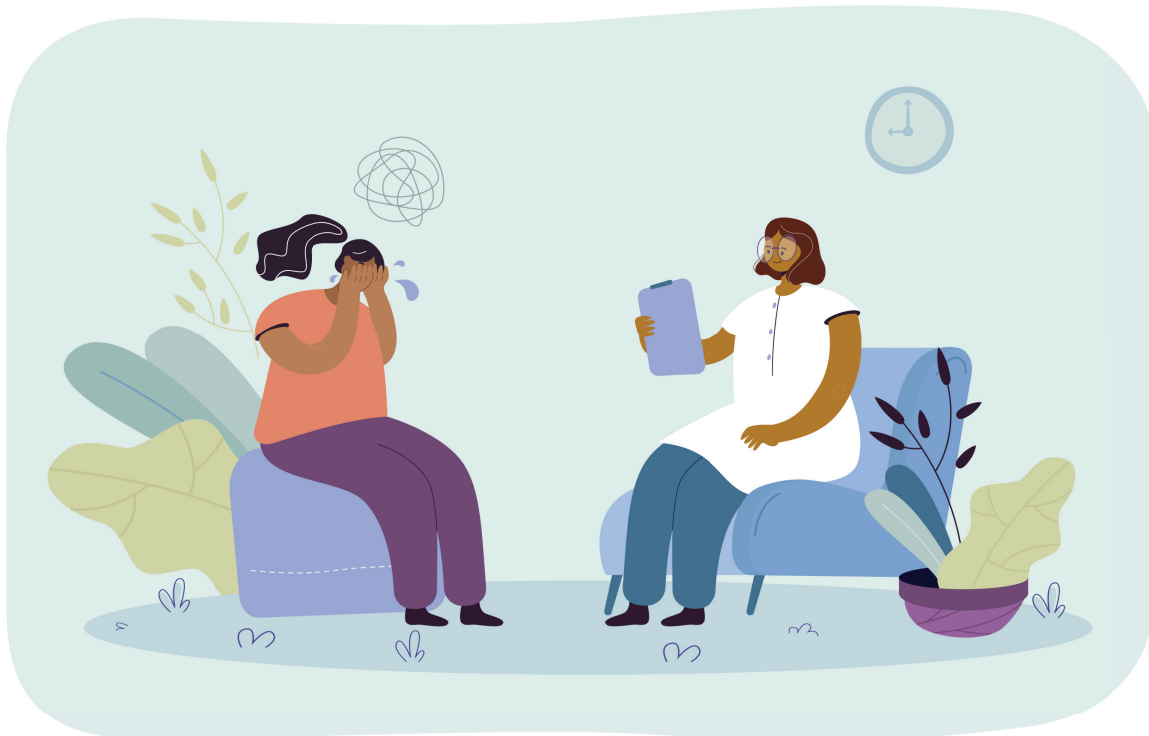
- ✿ Not showing signs of recovery or showing deterioration
- ✿ Not functional: not able to take care of oneself and/or their children
- ✿ It is known or perceived that the survivor has a mental health condition
- ✿ If the survivor is talking about self-harm (including suicide)
- ✿ If the survivor indicated that she/he/they can pose a risk to other
- ✿ If the survivor requests mental health specialized services



IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings (2007)

As the Caribbean region is afflicted by natural hazards, there is a risk of recurrent emergency situations. In emergency situations, mental health and psychosocial support should be layered so as to address the different needs of individuals. This has been developed by the IASC Guidelines on Mental Health and Psychosocial Support (2007),

which have been divided into four different layers, which offer different levels and different types of support, but that should take place simultaneously. The pyramid above and the table below address the multilayered supports that populations require in emergencies³²:



	LEVEL 1: BASIC SERVICES AND SECURITY	LEVEL 2: COMMUNITY AND FAMILY SUPPORTS	LEVEL 3: FOCUSED, NON- SPECIALIZED SUPPORT	LEVEL 4: SPECIALIZED SERVICES
FOCUS	Community Focused	Community Focused	Case focused	Case focused
DELIVERED BY	non-MHPSS Professional	non-MHPSS Professionals	Non-specialized support by case management;social and community workers	Specialized support qualified mental health professionals
TYPES OF SERVICES OFFERED	<p>Group based psychosocial support</p> <p>Preventive security and protection actions to identify and address environmental and situational GBV protection threats</p>	<p>Promotion of community acceptance of and support to survivors</p> <p>Community self-help and resilience strategies to support survivors and those at increased risk of GBV</p> <p>Support education and livelihoods Addressing GBV and the stigma attached to it through community awareness-raising and education</p>	<p>Group-based psychosocial support sessions</p> <p>Counselling: information and emotional support</p> <p>Livelihoods: focus on obtaining skills and on income generating activities</p>	<p>Specialized psychological interventions to individual survivors</p> <p>Continuity of access to services such as Case Management</p>
SERVICE PROVISION	Community level	Community level and shelter	Shelter/Referral	By referral

For the purpose of these guidelines, we want to make a special section for the GBV case management service provision in the safe shelters, as we consider this to be a specific need for survivors and a general gap in the region where we conducted the consultations with service providers from safe shelters for GBV survivors.

5.11.2 GBV CASE MANAGEMENT SERVICES³³

GBV case management is a structured method for providing help and support to a survivor of GBV. It involves one organization, usually a psychosocial support or a social services actor, who takes responsibility to ensure that survivors are informed of all options available to them, as well as that issues and problems the survivor is facing, are identified and followed up in a coordinated manner, providing the survivors with emotional support throughout the process.

GBV case management is a process that engages a range of individuals, organizations and services to support a survivor's immediate needs and longer-term recovery. An organization that provides GBV case management services needs a structure that allows for this specific service to be facilitated. First of all, they need to make sure they are able to financially support this service and can ensure continuity. Secondly, they will need to hire professional staff (such as case workers and technical supervisors) to be able to offer this service. Aside from this, they will need to have a system for information collection and the management of cases. They also need to be very clear as to where they are offering these services and how, and above all, the organization needs to draft policies and protocols for the provision of GBV case management of services, adhering to the GBV guiding principles, a survivor-centered approach and global best practices around the provision of this specific service.

UNFPA recommends that all safe shelters for GBV survivors ensure the provision of GBV case management services onsite, and make it a priority for the services they offer in the facilities. If the organization who will set up and manage the shelter is not specialized in this specific service, UNFPA strongly recommends partnering with another organization who is able to ensure this service is provided in the safe shelter.

The minimum infrastructure in order for an organization to provide GBV case management services, needs to ensure the following:

1. Data protection protocols: storage and sharing, and instructions on how data will be handled
2. Protocols to assign cases and clear understanding of mandatory reporting laws in the country
3. Forms to be used during the service provision, updated referral pathways/networks and available community groups active in the affected area
4. Protocols for the provision of the service in the safe shelter, ensuring these are staffed by female staff and community volunteers
5. Case workers should be female and speak the same language as the survivors, as well as have a good understanding of the culture
6. There need to be policies in place for the response to non-female cases (such as males and individuals identifying as LGBTQI+)

An assessment with the case worker should be conducted at the earliest opportunity, but taking into account that the survivor has the right to be informed of the service she is about to receive and subsequently provide her informed consent before engaging further in the process. The case worker is familiar with the range of services available and has the responsibility of ensuring that "survivors are informed of all the options available to them and that issues and problems faced by a survivor and her/his/their family are identified and followed up in a coordinated way"³⁴. GBV Case Management not only offers a survivor-centred approach, but it also places emphasis on the strengths of the survivor and offers support that is tailored to their needs. The case worker can provide the survivor with the following:

ASSESSMENT: After a first engagement and introduction of the services that will be provided, and ensuring an informed consent form has been signed by the survivor, the case worker will proceed with making an assessment of the case along with the survivor. This process aims at identifying the problems that the survivor is facing, how she sees her current situation, what support she has at that moment (including family/social networks), and finally, they will both explore the kind of assistance that the survivor wants to receive during (and even after) her stay in the safe shelter.

CASE ACTION PLANNING: Once the assessment of the specific case has been conducted, the case worker and the survivor will then work together on developing a case plan. Depending on the case, and particularly for IPV cases, a safety plan will be drafted between the case worker and the survivor. Developing a safety plan that takes into account the specific needs of the survivor and that recognises patterns of violence and identifies priorities to increase their safety. This can refer to safe shelters, police services, relocation, or in the case there are children involved, alternative care arrangements might be in order. The design of a safety plan should take place at the earliest possible opportunity.

IMPLEMENTATION: Once the steps above have been completed, the case worker can proceed with the provision of services within the scope of the case. This includes conducting referrals to specific services the survivor is interested in receiving as part of the case action plan - which include services such as medical care and/or SRH (inclusive of clinical management of rape), MHPSS services, legal assistance, and any other service that may be relevant, available and requested by the survivor. This is where the case worker will also make sure she advocates for the survivor to be provided with services following a survivor-centered approach and the four GBV guiding principles, and lead the coordination of the referrals made.

CASE FOLLOW UP: The case worker will continue the work with the survivor and will continuously follow up on the action plan, evaluating whether the survivor is reaching her goals and recovering. Oftentimes there will be challenges and setbacks, and the case worker will continue to work along with the survivor to either adjust the plan or assess whether the survivor is ready for a transition and to close the case.

TRANSITION PLANNING - often, when survivors reach the shelter they find themselves in situations in which they do not feel safe but, simultaneously, they are not able to support themselves due to a lack of livelihood options and are thus not able to leave their current situations. This increases the likelihood of them returning to situations where they are in danger. It is vital to plan for the transition with the survivor from the moment that they enter the shelter. Parallely, there is also a risk for dependency on the shelter if the survivor ends up staying much longer than what was initially planned. This is crucial to be included in the case action planning with the survivor, and even if it does not have to be included in the initial stages of the case management process, it should start to be added at a point where the survivor feels comfortable enough to start planning for her transition. Transition planning includes but it is not limited to:

- ✿ An income
- ✿ Vocational training and/or educational opportunities
- ✿ Safe and affordable housing
- ✿ Safety planning for the new situation
- ✿ Arrangements for the children

FOLLOW UP SERVICES - case management services can also include following up on the survivor after they have left the shelter. This can take place periodically over a determined period of time, as the shelter sees fit.

5.11.3 IMMEDIATE AND LONG TERM MEDICAL CARE

Medical treatment and healthcare refers to both immediate and long-term physical and mental health of survivors. This can include an initial assessment and treatment, continuing an existing treatment, follow up medical care, mental health care (including survivors that are at risk of self harm) and health-related legal services. Medical Treatment and Healthcare also includes clinical management of rape services as well as other sexual and reproductive health services. Unless the shelter has a clinic, all forms of medical treatment and healthcare shall be provided by official medical services through referrals facilitated by the shelter.

5.11.4 CLINICAL MANAGEMENT OF RAPE

Survivors must be granted confidentiality and be treated in a non-judgemental and non discriminatory approach at all times, but the event of a rape requires even more professionalism and discretion and female staff when possible. Clinical care must be available through referral to survivors that have been subjected to sexual violence, to address, at the minimum, the following:

- ✿ Immediate medical response to treat any injuries or any life-threatening condition
- ✿ Prevent sexually transmitted infections
- ✿ Post exposure prophylaxis to prevent HIV
- ✿ Prevention of unwanted pregnancies
- ✿ Mental health care related to the trauma

5.11.5 OTHER SEXUAL AND REPRODUCTIVE HEALTH (SRH) SERVICES AND COMMODITIES

It is recommended that survivors have access to sexual and reproductive health services through referral, which should cover the following interventions:

- ✿ Family planning services: information and modern contraceptives including female and/or male condoms
- ✿ Maternal/newborn healthcare (antenatal care, delivery care and postnatal care including Emergency Obstetric Newborn Care)
- ✿ Counselling and informative sessions on sexual and reproductive rights
- ✿ Counselling and informative sessions on HIV and STIs
- ✿ Services to prevent and treat reproductive cancers

5.11.7 CHILD CARE AND SCHOOLING

The provision of child care services on site or by referral can allow for the parent to work if that is a possibility. If the parent has to mind the child at all times, their commitment to the programmes offered at the shelter or by referral might be compromised. If the shelter does not provide child care services onsite, there should be a referral system in place for children to be able to access child care.

Entering a safe shelter with a parent, will disrupt the life of a child. If the child of the survivor is of school age, they should continue to attend school. If, for security reasons, it is not possible for the child of the survivor to continue to attend the same school, other arrangements should be made so that the child is able to continue to attend school.

5.11.8 CHILD PROTECTION

Children, a particularly vulnerable group in all circumstances, are a substantial percentage of the shelters' residents. Children may have been subjected to violence themselves and it might be necessary to involve Child Protection Services. All shelter staff should be trained on Child Protection and on mandatory reporting policies. In addition, updated and efficient referral pathways must be established and known to all staff. Please contact and coordinate with your local child protection agencies and specialists.

5.11.9 LEGAL ASSISTANCE

Legal counselling should be available so that the survivor is aware of their legal rights and protections. This includes supporting a survivor in the process of pressing charges if that is their desire, as well as any required legal support. Legal information and support includes, but is not limited to, the following:

- ✿ Police procedures
- ✿ Restraining orders
- ✿ Parental Rights
- ✿ Divorce laws
- ✿ Migration laws
- ✿ International Protection for asylum seekers and refugees

5.11.10 LIVELIHOOD OPPORTUNITIES

Supporting survivors in the transition to a safe, independent and dignified life can include referrals to existing programmes of vocational training, education, non-formal education, adult learning, counselling on livelihoods and income generating activities.

EXPERIENCES FROM OTHER COUNTRIES: COLOMBIA

Some shelters in Colombia provide cash assistance to survivors so they can pay for the first month's rent or pay for their transportation in case they relocate to another part of the country to be with family.

Safe Haven: Sheltering Displaced Persons from Sexual and Gender-Based Violence - Case study: Colombia (May 2013)

LESSONS LEARNED

Shelter managers in the Caribbean pointed out that the lack of affordable housing, lack of income and lack of vocational or formal skills present an immense challenge to a successful transition.



5.12 COORDINATION - REFERRAL PATHWAYS

Coordination with other safe shelters, health care services; police; schools, local authorities

Effective referral pathways can ensure that the needs of survivors are correctly assessed and supported in a timely manner. In order to provide an efficient, supportive and timely service, it is key to design and implement confidential referral mechanisms between and among other service providers and actors in order to facilitate the required multisectoral action. It is recommended to adhere to national GBV referral pathways, and if these are not available, create referral pathways for the following services:

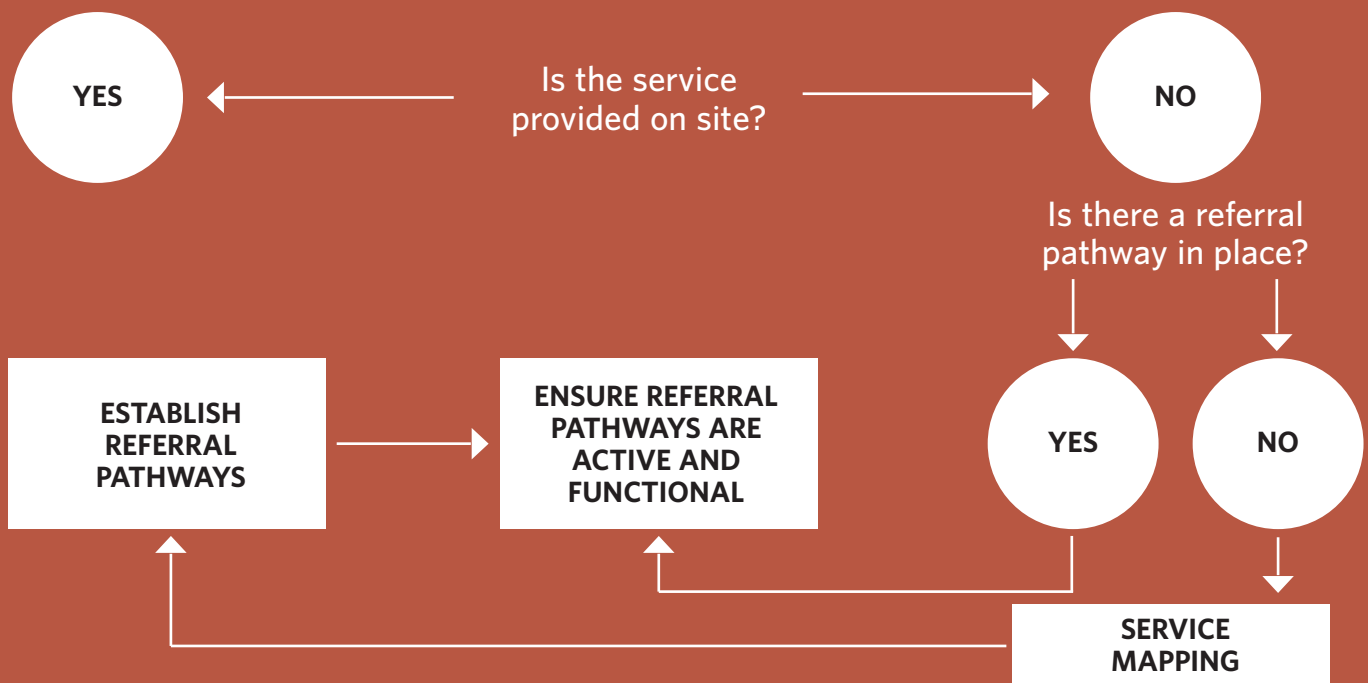
- ✿ Case Management
- ✿ Psychosocial Support Services
- ✿ Mental Health Services
- ✿ General Medical Services
- ✿ Sexual and Reproductive Health Services
- ✿ Legal Services

- ✿ Police/Law Enforcement Services
- ✿ Child Protection Services
- ✿ Vocational Training
- ✿ Formal Education
- ✿ Informal Education
- ✿ Adult Learning
- ✿ Income generating activities
- ✿ Housing services

REFERRAL PATHWAYS

- ✿ Refer to Generic Referral Pathways and adapt them locally
- ✿ Review and update Referral Pathways periodically to guarantee these are active and functional
- ✿ Update referral pathways to reflect the current Covid19 pandemic
- ✿ Train staff on existing Referral Pathways

SERVICE PROVISION: ENSURING SURVIVORS HAVE ACCESS TO SERVICES IN AN EFFECTIVE AND TIMELY MANNER



5.13 COMMUNITY ENGAGEMENT AND AWARENESS

Access to shelter programmes can be hindered if communities, local authorities and local governments are unaware of referral systems and/or hotlines. Coordinate and work alongside local authorities, local governments and other actors and service providers to increase timely and safe access to services, considering the following³⁵:

- ❁ Include women and girls in the design of services regarding GBV
- ❁ Include the population identifying as LGBTQI+ in the design of services regarding GBV
- ❁ How to access safe shelter services
- ❁ Inclusive messages that can reach different groups, different literacy levels and different languages

LESSONS LEARNED

In a study conducted on shelters for survivors of GBV and IDPs in Colombia, it emerged that there is a tension between the confidential nature of shelters and community engagement. This negatively impacts the creation of the programmes as there is no real consultation with the surrounding community. An absence of knowledge regarding shelters programmes for survivors of GBV among the general public and government officials prevents survivors from accessing the programmes and results in programmes not reaching capacity, which in turn sends the wrong message that there is low demand for these programmes and that they do not need to be expanded



5.14 STAFF

Staff working at safe shelters are often very committed; nevertheless it is essential to provide staff with multidisciplinary training that will allow them to provide quality, timely and efficient services. By receiving adequate training, staff is also likely to feel more confident and better equipped to perform their job. The staff should receive training on human rights and protection, in particular on the need for appropriate approaches which respect survivors

while taking into account the psychological impact of events they have been through³⁶. Shelters should consider hiring all female staff and reflect diversity by recruiting staff from different backgrounds. Moreover, it is important to bear in mind that shelter workers work in emotionally demanding environments and must be protected.

5.14.1 ORGANIZATIONAL STRUCTURE

This section addresses the recommended organizational structure of a safe shelter and alternative accommodation for GBV survivors in order to provide quality services. The staff should be multidisciplinary and the number of required staff will vary according to the number of survivors

and their children that the shelter is able to accommodate and according to financial resources. For a population of 8-15 women and 15 - 30 children and adolescents the recommendation is as follows³⁷:

Director - 1	Case Worker/Social Worker - 2	Child Care - 2
Shelter Manager - 1	Psychologist -1	Security staff - 3
Shelter Manager (night) - 1	Child Psychologist - 1	Cleaning / Cooking staff- 1
Administrator - 1	Staff Care - 1	
Facilitator - 3	Lawyer/Legal - 2	

Director - The director is in charge of planning, managing and executing strategies. The director will also be in charge of budgeting and funding. The director oversees the recruitment of staff as well as of advocacy and liaison with other organizations and with governmental departments.

Shelter Manager - Is in charge of the technical coordination of the safe shelter, such as the supervision and capacitation of the staff.

Shelter Manager (night) - The night shift manager is the person that has to respond during an emergency or to any situations that might arise during the night. Some safe shelters have this position on call and during the night rely on the security staff to reach out to the shelter manager.

Administrator - Is in charge of administrative tasks essential to the daily and optimal functioning of the safe shelter.

Facilitator - Are in charge of accompanying the survivors to and at the safe shelter and of ensuring a peaceful coexistence among residents. Also provide emotional support and support the organization of tasks and activities in the shelters.

Case Worker/Social Worker - Conduct an assessment to understand the needs of the survivors. Inform the survivors of the services they can access, and they are in charge of coordinating that access, as well as working on a safety plan for each survivor according to their needs and preferences.

Psychologist - To conduct individual and group counselling sessions.

Child Psychologist - Children of survivors might have been exposed to or been subjected themselves to violence. It is important to attend to the needs of children and adolescents as there is a risk of trauma.

Staff Care professionals - In charge of establishing and of conducting a staff care programme. It is recommended that this role is fulfilled by a psychologist.

Lawyer/Legal - To provide legal counselling and assistance to survivors of GBV.

Child Care - Due to the high number of children that often stay in shelters it is vital to have a role for someone that is exclusively in charge of the children. The staff-child ratio will depend on the shelter's capacity and available resources, but for 15-20 children, 2 workers are recommended..

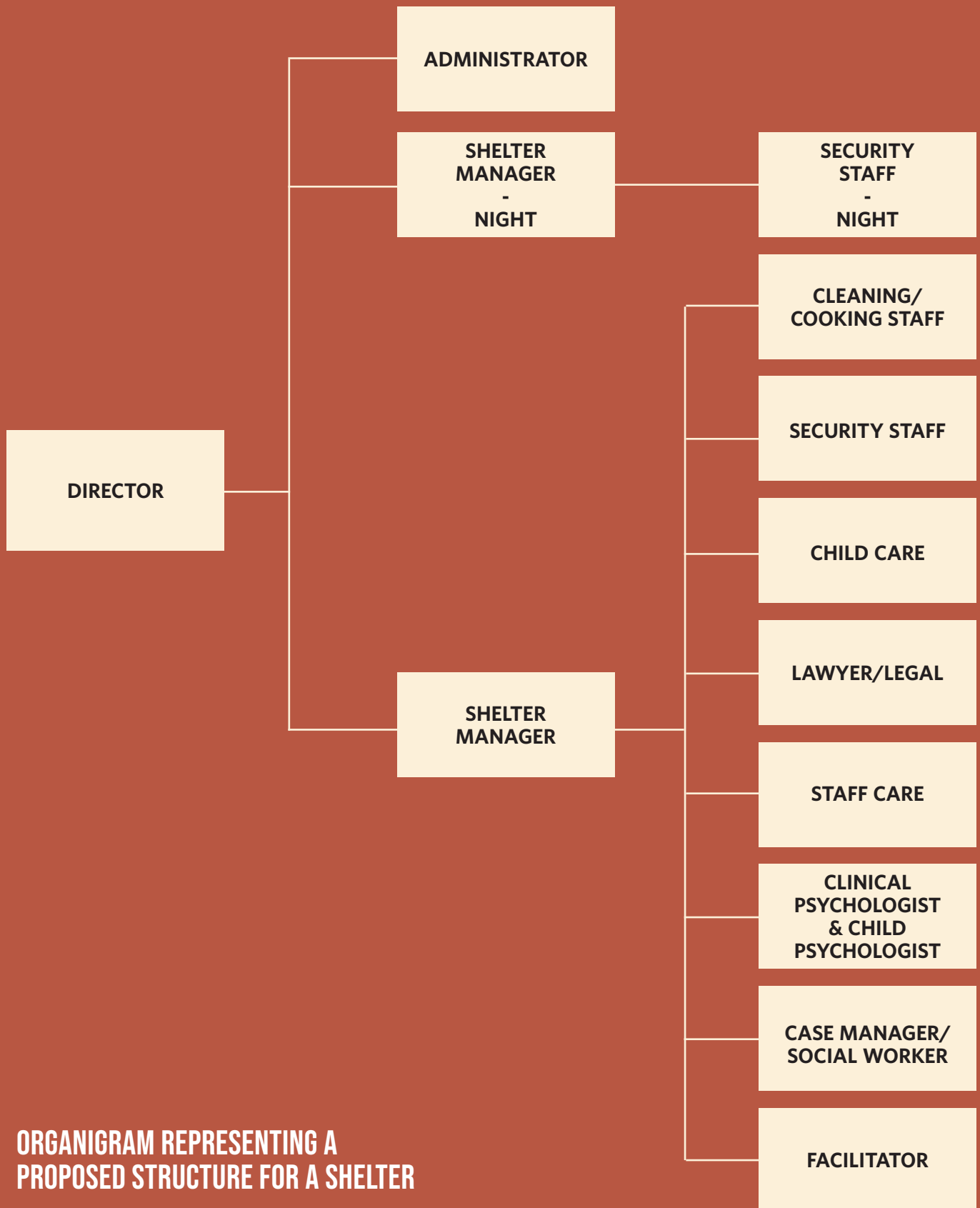
Security staff - Present 24h and 7 days a week. They must be able to respond to a threat or to incidents or any security breaches that may occur.

Cleaning / Cooking staff - In most shelters, residents are in charge of cleaning their own rooms and the kitchen after using it. The cleaning staff is in charge of the common areas and the outside (if it exists). If the residents do not receive groceries to cook their own meals, cooking staff is required.

LESSONS LEARNED

Many shelters in the Caribbean region count with the figure of the House Mother. The House Mother is usually an older lady who might live near the shelter and is in charge of welcoming survivors and of arranging day-to-day activities such as cooking, meals and recreational activities. Nevertheless the House Mother is usually not a professionalised role and UNFPA recommends that training is provided.





ORGANIGRAM REPRESENTING A PROPOSED STRUCTURE FOR A SHELTER

5.14.2 RECOMMENDED TRAINING FOR STAFF

The quality of service provision greatly depends on the professionalism of the staff. By being better prepared and properly trained, the staff will also be able to perform their duties more confidently. A highly trained staff is of benefit for the individual, the residents and for the organization as a whole. There is a wide range of training that is thus highly relevant, including but not limited to the following:

- ✿ GBV Core Concepts and Guiding Principles
- ✿ GBV Referral Pathways
- ✿ GBV Case Management
- ✿ Psychological First Aid (PFA)
- ✿ Child Protection
- ✿ Refugee and Migrant Rights
- ✿ International Protection: Asylum Seekers and Refugee
- ✿ Human Rights and Sexual and Reproductive

Health and Rights

- ✿ Human Trafficking
- ✿ HIV counselling and HIV basic knowledge
- ✿ GBV and people living with disabilities
- ✿ GBV and gender non-conforming groups and persons of diverse sexual orientation
- ✿ Conflict resolution
- ✿ Prevention of Sexual Exploitation and Abuse (PSEA)

A training plan should be developed for each staff member and according to their roles and responsibilities. While some training might be mandatory for all staff such as PSEA, GBV Core Concepts and Guiding Principles, other training is relevant according to the staff's functions.

5.14.3 SELF-CARE AND STAFF CARE

Shelter workers, social workers, humanitarian workers and anyone who works in an environment which is emotionally demanding and that deals with survivors who are experiencing different levels of trauma, mental health issues or addictions, as they are at greater risk of suffering from vicarious trauma (also known as secondary traumatic stress and compassion fatigue) and burnout. Vicarious/secondary trauma is a cumulative process that results from prolonged exposure to other's traumatic experiences. A change in the "staff member's ability to engage and empathise with survivors and a decreased ability to cope with stress might be signs of vicarious trauma"³⁸. The WHO³⁹ has defined burnout as resulting from chronic workplace

stress which has not been adequately managed. Vicarious trauma and staff burnout are realities which can result in poor retention, if not addressed effectively, meaning that shelters can lose workers that are an asset as they are experienced, capable, well-trained and familiar with the work and other services. If one individual suffers from burnout, the whole team can be affected. It is important to note that burnout can be aggravated by the current pandemic as most workers in this field are women, who are disproportionately affected by the social and economic impact resulting from the pandemic. In combination with this, a surge in GBV is expected as the pandemic and its consequences continue to hit countries hard.

SIGNS OF BURNOUT

- ✿ Feelings of energy depletion or exhaustion
- ✿ Increased mental distance from one's job
- ✿ Feelings of negativism or cynicism related to one's job
- ✿ Reduced professional efficacy



LESSONS LEARNED

- ✿ Developing self care strategies is critical to prevent vicarious trauma and burnout
- ✿ Learn to identify warning signs such as feeling disengaged, feelings of helplessness, decreased ability to cope with stress, feelings of constant exhaustion
- ✿ Examples of self-care: rest,
- ✿ exercising, spending time with your support network, recharging batteries, dedicating time to hobbies and to activities you find enjoyable

BEST PRACTICES: LOOKING AFTER YOUR STAFF'S MENTAL AND PHYSICAL HEALTH

- ✿ Clear job descriptions
- ✿ A balanced workload
- ✿ Regular meetings for debriefing (individually and as a team)
- ✿ Adequate supervision
- ✿ Regular staff care sessions: group and/or individual sessions
- ✿ Ensure that the staff is able to identify early signs of burnout
- ✿ Support the staff in developing self-care and coping strategies that they can incorporate in their lives
- ✿ Promote a work-life balance
- ✿ Check in on the well being of the staff
- ✿ Create a supportive work environment



5.15 PREVENTION OF SEXUAL EXPLOITATION AND ABUSE - PSEA⁴⁰

Sexual exploitation and abuse (SEA) refers to all forms of inappropriate conduct of a sexual nature committed by humanitarian workers (including UN workers, INGO, NGO, CSOs, etc) against recipients of assistance and other members of local communities who are in a particularly vulnerable position. Prohibited conduct includes, but is not limited to:

- ❁ Sexual activity with children (persons under the age of 18) regardless of the age of majority or age of consent locally. Mistaken belief in the age of a child is no defence
- ❁ Exchange of money, employment, goods or services for sex or sexual favors. This includes any exchange of assistance due to recipients of assistance
- ❁ Sexual activity with sex workers, whether or not sex work is legal in the host country
- ❁ Use of a child or adult to procure sex for others

Sexual relationships between humanitarian personnel and beneficiaries of assistance are strongly discouraged, as they are based on inherently unequal power dynamics and undermine the credibility and integrity of the work we do. All workers that provide assistance to vulnerable individuals, have a strong duty to promote human rights, while ensuring that survivors are treated with dignity and respect. In order to prevent SEA, all shelters are highly encouraged to develop a PSEA Policy and to declare a zero tolerance approach

directed at its staff, its partners, associates contractors and volunteers, by:

1. Ensuring all staff have signed a Code of Conduct that includes a strong component around PSEA, adhering to the zero tolerance policy.
2. Ensuring all staff working at the safe shelter complete mandatory training on PSEA.
3. Ensuring all staff understands and knows how to report SEA cases to a confidential mechanism provided by either the organization or the donor.
4. Ensure IEC materials containing SEA information and available reporting mechanisms are provided to the residents, so they are aware of the obligations of the staff working for them.

Safe shelters are highly encouraged to create an environment in which SEA is not tolerated and where survivors have available confidential reporting mechanisms, so that they can safely denounce. It is important to note that if the safe shelter is an implementing partner of a UN agency, they are bound to comply with the UN's code of conduct, the prohibition of harassment, sexual harassment, abuse of authority and discrimination and the duty to report incidents of abuse. In addition, all staff should receive training on PSEA provided by the UN Agency they work with. The organization should also take steps to prevent SEA prior to hiring someone, such as performing background checks and requesting a criminal record.

5.15.1 CONFIDENTIAL REPORTING MECHANISMS AND FEEDBACK

Establishing an effective, confidential reporting mechanism can help improve the programme's design and implementation as well as reducing the risk of harm and SEA to survivors and children that accompany them. It is therefore recommended for safe shelters to establish multiple anonymous reporting mechanisms and feedback both for staff and for survivors. Confidential reporting mechanisms and feedback should be inclusive and accessible to all regardless of any disabilities, language, level of literacy, job role, sexual orientation and gender. Staff and survivors should be consulted to ensure that the reporting mechanisms and feedback are appropriate. All staff and residents should be aware of when to report and how to report. Examples of reporting mechanisms and feedback include, but are not only limited to, telephone hotlines, feedback boxes, surveys and exit interviews.

5.15.2 CODES OF CONDUCT

CODE OF CONDUCT FOR RESIDENTS

Situations of violence often deprive survivors of the power of making their own decisions. It is essential that the shelter does not make the residents feel like they are locked up. To make this more inclusive of the survivors' needs, it is recommended that the code of conduct is drafted taking into account the resident's input. The code of conduct should be clear and straightforward:

- ✿ Ensure that residents are aware of, and understand and agree to, the code of conduct prior to being admitted to the shelter
- ✿ Available in other main co-existing languages and use gender inclusive language
- ✿ Provide a copy of the code of conduct to each resident and/or have copies available in common or in visible places
- ✿ If shelters establish curfew times, they might choose to call these 'safe times'.

BEST PRACTICES: EFFECTIVE COMPLAINTS MECHANISM



- ✿ Safe
- ✿ Confidential
- ✿ Transparent
- ✿ Accessible

InterAction Step by Step Guide to Addressing Sexual Exploitation and Abuse (2010), Page 15

- ✿ If residents do not follow the code of conduct, cause disruption or put other survivors and/or staff at risk, they might be given a warning or even expelled.

CODE OF CONDUCT FOR STAFF⁴¹

To ensure the safety of the survivors as well as their right to confidentiality, it is very important that the staff is aware of their duties and responsibilities as well as of behaviours that are not tolerated. The code of conduct should reflect the principles of the organization, should be drafted in a clear manner and should clearly forbid Sexual Exploitation and Abuse:

- ✿ Ensure that the staff understands and agrees to the code of conduct.
- ✿ Ensure that the staff has access to the code of conduct.
- ✿ Ensure that the staff understands the consequences of breaking the code of conduct.

5.16 PROTOCOLS ON DATA COLLECTION AND SHARING

Any personal information disclosed by survivors must be treated as confidential. While data collection is crucial, it is paramount that it is collected and stored in a safe and ethical manner as to ensure the confidentiality and safety of survivors. The WHO (2007) effectively addresses this topic and has drawn eight safety and ethical recommendations regarding the collection of information on sexual violence in emergencies:

- ❁ The benefits to respondents or communities of documenting sexual violence must be greater than the risks to respondents and communities.
- ❁ Information gathering and documentation must be done in a manner that presents the least risk to respondents, is methodologically sound, and builds on current experience and good practice.
- ❁ Basic care and support for survivors/victims must be available locally before commencing any activity that may involve individuals disclosing information about their experiences of sexual violence.
- ❁ The safety and security of all those involved in information gathering about sexual violence is of paramount concern and in emergency settings in particular should be continuously monitored
- ❁ The confidentiality of individuals who provide information about sexual violence must be protected at all times.
- ❁ Anyone providing information about sexual violence must give informed consent before participating in the data gathering activity.
- ❁ All members of the data collection team must be carefully selected and receive relevant and sufficient specialized training and ongoing support.
- ❁ Additional safeguards must be put into place if children (i.e. those under 18 years) are to be the subject of information gathering⁴².

In addition, GBVIMS (Gender-Based Violence Information Management System)⁴³ has developed a data protection checklist which addresses the following points:

- ❁ Safe storage of survivor records/files.
- ❁ Staff Data Protection Agreement.
- ❁ Training of staff on confidentiality, informed consent and the process for informed consent.
- ❁ Local mandatory reporting mechanisms.
- ❁ Protocol for the safe destruction of paper forms.
- ❁ Protection of electronic case management systems.
- ❁ Data back-up.
- ❁ Informing survivors of their rights in terms of data collection, storage and sharing.



LESSONS LEARNED

Suriname's Ministry of Justice launched a system for collecting and sharing data on GBV. However it is not mandatory and shelters can opt out.

5.17 DISASTER PREPAREDNESS AND RESPONSE: RECOMMENDATIONS

The Caribbean region is regularly affected by natural disasters such as hurricanes, flooding and landslides caused by tropical storms and earthquakes. Governments provide guidelines in the event of disasters, but it is recommended that each shelter has its own disaster and emergency plan. Safe shelters for GBV survivors serve a group that is highly vulnerable and that could be made even more vulnerable in the event of a disaster. When setting up a Disaster Preparedness and Response Protocol consider the following points:

- ✿ Design a disaster and emergency plan with the support of governmental agencies.
 - ✿ When designing a disaster and emergency plan, take into account that the shelter receives babies, children, people with mobility issues and people living with disabilities (physical and mental).
 - ✿ Allocate clear roles and responsibilities to all staff members.
 - ✿ Train the staff on the disaster and emergency plan.
 - ✿ Share the disaster and emergency plan with survivors when they enter the shelter and perform simulations regularly.
- ✿ Have instructions and signs for the event of a disaster and/or an emergency placed in visible places and accessible to all residents and staff.
 - ✿ In case of an emergency or disaster, opening the shelter to people in need that are not GBV survivors, puts at risk GBV survivors and their families.
 - ✿ Periodically review the disaster and emergency plan to adapt to any changes or to situations that had not been previously taken into account.

5.18 ADAPTING TO THE COVID19 PANDEMIC: RECOMMENDATIONS

The current COVID19 pandemic has the potential to affect safe shelters in several ways:

- ✿ Safe shelters might have to shut down and/or might not be able to receive survivors due to a disruption in funding as many shelters depend on private donations, which might cease or decrease due to economic instability.
- ✿ Decrease in the number of intakes due to distancing rules despite the increase in GBV cases.
- ✿ Disruption of services provided on site or by referral such as mental and physical care; psychological services; legal services; vocational training; formal and informal education.
- ✿ Disruption of Sexual and Reproductive Health Services including availability of commodities, which can hinder access to condoms and other modern contraceptives; and HIV and STI testing and treatment among other SRH interventions.



It is recommended that safe shelters and alternative accommodation facilities focus on how to prevent COVID19 from entering their facility, how to prevent it from spreading in the facility and how to prevent COVID19 from spreading outside the facility, so that they can continue to operate safely.⁴⁴ An extensive document with detailed recommendations regarding COVID19 Infection Prevention and Control in GBV shelters and alternative accommodation has been developed by PAHO, UNFPA and UN Women (2020). We recommend that shelter managers consult the named article which, among other points, invites them to consider the following recommendations⁴⁵:

- ✿ Create a crisis response team.
- ✿ Establish a focal point that handles all actions, measures and queries regarding preventing and controlling COVID19.
- ✿ Follow government guidelines and coordinate with the national emergency response team and other relevant health authorities.
- ✿ Define procedures for handling suspected COVID19 cases.
- ✿ Identify the most vulnerable among the staff and residents.
- ✿ Promote physical distancing at all times: plan group activities; meetings; meals or any other relevant activities or situations, in order to ensure that physical distancing is possible and thoroughly followed.
- ✿ Restrict the number of visitors.
- ✿ Administer the annual influenza vaccine to staff and residents according to local protocol.

- ✿ Ensure supplies of alcohol-based hand rub (ABHR) (containing at least 60% alcohol) and availability, for residents and staff, of soap and potable water. Place them at all entrances, exits, and points of care.
- ✿ Ensure supplies of protective face masks (surgical for staff and non-surgical for residents.)
- ✿ Ensure the sanitisation of the facility.
- ✿ Design a sanitation checklist for the shelter or alternative accommodation.
- ✿ Adequately ventilate the facility to prevent the spread of COVID19.
- ✿ All staff and residents should be trained on all the most up to date available information on preventing the spread of COVID19.
- ✿ Identify delays and disruptions in services.
- ✿ Update referral pathways in order to reflect the current reality and find alternatives for the ones that have been disrupted. It is also vital to continue to ensure timely access to clinical management of rape services.
- ✿ Coordinate and liaise with other shelters, service providers, local authorities and local governments in order to continue to provide vital services to survivors of GBV.

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- 5 The United Nations Convention on the Rights of Persons with Disabilities (2008)
- 6 IASC Guidelines for mental health and psychosocial support in emergency settings (2007)
- 7 The Convention Relating to the Status of Refugee (1951)
- 8 Protection from Sexual Exploitation, Sexual Abuse and Sexual Harassment, UNFPA (2019)
- 9 The Declaration on the Elimination of Violence Against Women (1993)
- 10 Gender-Based Violence (Violence Against Women and Girls), The World Bank (2019)
- 11 Refer to the annex 1 for more information on types of GBV and IPV
- 12 GBV In The Caribbean (UN Women <https://caribbean.unwomen.org/en/caribbean-gender-portal/caribbean-gbv-law-portal/gbv-in-the-caribbean>)
- 13 Gender-Based Violence and Natural Disasters in Latin America and the Caribbean, UNFPA
- 14 Violence against women and girls: the shadow pandemic' Statement by Phumzile Mlambo-Ngcuka, Executive Director of UN Women (2020) <https://www.unwomen.org/en/news/stories/2020/4/statement-ed-phumzile-violence-against-women-during-pandemic>
- 15 <https://www.unfpa.org/press/new-unfpa-projections-predict-calamitous-impact-womens-health-covid-19-pandemic-continues#:~:text=More%20than%2047%20million%20women,pregnancies%20in%20the%20coming%20months.&text=%E2%80%9CWomen's%20reproductive%20health%20and%20rights,must%20be%20protected%20and%20supported.%22>

- 16 Violence against women and girls: the shadow pandemic' Statement by Phumzile Mlambo-Ngcuka, Executive Director of UN Women (2020) <https://www.unwomen.org/en/news/stories/2020/4/statement-ed-phumzile-violence-against-women-during-pandemic>
- 17 Shelter for Women and Girls at Risk of or Survivors of Violence' (2013), Canadian Network of Women's Shelters and Transition Houses
- 18 'Essential Services Package for Women and Girls Subject to Violence: Core Elements and Quality Guidelines' UN Women, UNFPA, WHO, UNDP and UNODC (2015)
- 19 'Essential Services Package for Women and Girls Subject to Violence: Core Elements and Quality Guidelines' UN Women, UNFPA, WHO, UNDP and UNODC (2015)
- 20 Refer to the Bibliography section for a detailed list of the resources consulted
- 21 Please check section V for more information on the type of shelters
- 22 Safe Haven: Sheltering Displaced Persons from Sexual and Gender-Based Violence - Case study: Colombia (May 2013)
- 23 Always keep into account that it is NEVER recommended to actively look for survivors nor to interview them. This practice puts them at risk of GBV and goes against the survivor-centered approach. Additionally, there is no use in conducting individual interviews or conversations with survivors to inform an assessment, because everyone's experiences and needs are different. Which is why, it is always better to ask for general information and feedback from the communities instead.
- 24 UNICEF Helpdesk: Gender-Based Violence in Emergencies - Summary of Call on Somalia Safe Shelter' (2018)
- 25 The Interagency GBV Case Management Guidelines (2017) (P140)
- 26 Sexual Violence and HIV (WHO) - <https://www.who.int/svri/issues/hiv/en/>
- 27 'Are women's spaces transgender spaces? Single-sex domestic violence shelters, transgender inclusion and the Equal Protection Clause' Apsani, Rishita (October 2018)
- 28 'The silent health toll of gender-based violence' Linou, Natalia - UNDP (2018)
- 29 'Gender-Based Violence in Emergencies' WHO (2018) <https://www.who.int/health-cluster/about/work/task-teams/genderbasedviolence/en/#:~:text=Mental%20health%20impacts%20for%20survivors,from%20her%20community%20and%20family.>
- 30 The Interagency Minimum Standards for Gender-Based Violence in Emergencies Programming, GBV Area of Responsibility, Copyright: UNFPA, 2019
- 31 Source IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings (2007)

- 32 Idem, Page 12
- 33 For guidance on adapting Case Management services to the Covid 19 pandemic, consult 'Case Management, GBVIMS/GBVIMS+ and the COVID-19 pandemic' (2020) https://www.unfpa.org/sites/default/files/resource-pdf/GBV_Case_Management_GBVIMS_and_the_Covid-19_pandemic_v5_GBVIMS_March_2020_-_FINAL.pdf
- 34 Interagency Gender-Based Violence Case Management Guidelines: Providing Care and Case Management Services to Gender-Based Violence Survivors in Humanitarian Settings (2017)
- 35 ISC Guidelines for MHSS in Emergencies (2007)
- 36 IASC Guidelines for mental health and psychosocial support in emergency settings
- 37 Modelo de atención en Casas de Acogida para mujeres que viven violencia: cuatro años de trabajo colectivo a favor de una vida libre de violencia para las mujeres (2012)
- 38 Minimum Standards for GBV in Emergencies Programming UNFPA (2019)
- 39 Burn-out an "occupational phenomenon": International Classification of Diseases, WHO (2019)
- 40 Check <https://psea.interagencystandingcommittee.org/> for more resources on Prevention of Sexual Exploitation and Abuse
- 41 Annex 2 of these guidelines (Page 49) for a sample code of conduct
- 42 WHO Ethical and safety recommendations for researching, documenting and monitoring sexual violence in emergencies (2007)
- 43 Gender-Based Violence Information Management System (GBVIMS) - is a tool that allows those providing services to GBV survivors to effectively and safely collect, store, analyse and share data related to the reported incidents of GBV. Refer to <https://www.gbvims.com/> for more information
- 44 Refer to 'Covid19 - Infection Prevention and Control in Shelters for Women and Children survivors of Domestic and Family Violence in the Caribbean' PAHO, UNFPA, and UN Women (2020) <https://www2.unwomen.org/-/media/field%20office%20caribbean/attachments/publications/2020/covid19%20infection%20prevention%20and%20control%20in%20shelters%20for%20women%20and%20children%20survivors%20of%20dv%20fv.pdf?la=en&vs=3856>
- 45 'Covid19 - Infection Prevention and Control in Shelters for Women and Children survivors of Domestic and Family Violence in the Caribbean' PAHO, UNFPA, and UN Women (2020)
- 46 Consult <https://psea.interagencystandingcommittee.org/resources> for more x and resources



Annexes

ANNEX 1

TYPES OF GBV

The classification below stems from the one developed for the Gender-Based Violence Classification Tool (GBVIMS) . A key concept in the definitions of types of GBV presented below is consent and there is no consent when agreement is obtained through:

- the use of threats, force or other forms of coercion, abduction, fraud, manipulation, deception, or misrepresentation
- the use of a threat to withhold a benefit to which the person is already entitled, or
- a promise is made to the person to provide a benefit.

TYPES OF GBV:

SEXUAL - including rape and Female Genital Mutilation/Cutting (FGM/C) - refers to any form of non-consensual sexual contact. It includes the forms that result in or include penetration. Examples include: attempted rape, as well as unwanted kissing, fondling, or touching of genitalia and buttocks. Rape is a non-consensual penetration (however slight) of the vagina, anus or mouth with a penis or other body part, including penetration of the vagina or anus with an object. FGM/C is an act of violence that impacts sexual organs, and as such should be classified as sexual assault.

PHYSICAL - includes hitting, slapping, choking, cutting, shoving, burning, shooting or use of any weapons, acid attacks or any other act that results in pain, discomfort or injury.

PSYCHOLOGICAL/EMOTIONAL - infliction of mental or emotional pain or injury. include threats of physical or sexual violence, intimidation, humiliation, forced isolation, stalking, verbal harassment, unwanted attention, remarks, gestures or written words of a sexual and/or menacing nature, destruction of cherished things, etc.

DENIAL OF RESOURCES, OPPORTUNITIES OR SERVICES - refers to the denial of rightful access to economic resources/assets or livelihood opportunities, education, health or other social services. Examples include a widow prevented from receiving an inheritance, earnings forcibly taken by an intimate partner or family member, a woman prevented from using contraceptives, a girl prevented from attending school, etc.

9.2 INTIMATE PARTNER VIOLENCE (IPV)

A pattern of behavior in any relationship that is used to gain or maintain power and control over a current or former intimate partner. Includes physical violence, sexual violence and coercion, and emotional/psychological abuse and controlling behaviours, including, but not not limited to, the following:

- Physical violence: kicking, slapping, hitting, beating;
- Sexual violence: forced sexual intercourse, forced sexual touching
- Emotional/psychological abuse: insults, humiliation, threats
- Controlling behaviours: stalking; restriction of access to financial resources, employment, education and medical services; isolation from family and friends

ANNEX 2

SAMPLE OF A CODE OF CONDUCT⁴⁶

I, [Name of worker], am signing this Code of Conduct to confirm that I understand and commit to uphold the highest standards of professional and personal conduct. I understand that the Code of Conduct applies to me throughout the period that I am employed by or representing [Name of Organization], including when I am off duty, or away on leave. I understand that this Code of Conduct complements, but does not replace, any other policies, rules and regulations of the organization that I am working for.

I understand that I have a responsibility at all times to ensure that all survivors are treated with dignity, respect, and abide by non-discrimination principles and confidentiality. Therefore, I commit not taking part in any of the following:

- Engaging in any form of discrimination, harassment, abuse, intimidation or exploitation, or in any activity that undermines survivors' ability to exercise their human rights;
- Engaging in or facilitating any form of theft, fraud, corruption or abuse of power/authority;
- Asking for or inviting any personal payment, service or favour from others, without exception, in return for assistance, support, goods or services of any kind;
- Being in possession of, or profiting from the sale of, illegal goods or substances;
- Entering into any sort of business relationship on behalf of the organization with members of my own family without prior authorization;
- Viewing, downloading, creating or distributing pornography on the organization's computer/system;
- Engaging in or facilitating any unlawful activities such as child trafficking, human trafficking, drug trafficking, trafficking of weapons or any other illegal goods or substances.

PROTECTION FROM SEXUAL EXPLOITATION AND ABUSE

I understand that sexual exploitation and abuse is unacceptable behaviour which undermines the fundamental values and principles of an adequate response to GBV. In addition, it harms the credibility of [NAME OF Organization] and the trust of the community. I hereby fully commit to respect and abide by the following core principles:

- Sexual exploitation and abuse is serious misconduct and grounds for disciplinary measures;
- Sexual activity with children (persons under the age of 18) is prohibited, regardless of the age of majority or local age of consent. Mistaken belief in the age of the child is not a defence;
- Exchange of money, employment, goods or services for sex, including any humiliating, degrading, or exploitive behaviour is prohibited;
- Sexual relationships between staff and beneficiaries of assistance are strongly discouraged since they are based on unequal power dynamics;
- Workers are obliged to create and maintain an environment that prevents sexual exploitation and abuse. Managers at all levels have an additional responsibility to do so;

REPORTING ON INCIDENTS THAT MAY BREACH THE CODE OF CONDUCT

I understand that I have a responsibility to report on incidents that may be a breach of this Code of Conduct. In this regard, I commit to:

- Report any incident or concern that relates to, or may relate to, a breach of this Code of Conduct even if by a worker in an organization other than mine;
- Raise any matters that I believe are in breach of, or may be in breach of, the Code of Conduct through the appropriate channels, in line with the internal policies and procedures of the organization

By signing this Code of Conduct, I confirm that I have understood and that I hereby agree to uphold its principles.

{Name of worker}

Signature: _____

Date: _____

ANNEX 3 POSTERS

SHELTERS AND ALTERNATIVE ACCOMMODATION

GBV Guiding Principles



A SURVIVOR CENTRED APPROACH

Empower survivors by putting them at the centre of the decision making process. Create a supportive and safe environment in which the rights and wishes of the survivor are respected and where they are treated with dignity and respect. The survivor is the centre of all actions and services offered to her, so that she is the one directing the course of her recovery.

1 SAFETY

Physical safety and security as well as a sense of psychological and emotional safety. The safety and the security of the survivor and that of her/his children is the primary consideration and must be the number one priority for all actors.



2 CONFIDENTIALITY

Survivors have the right to choose to whom they will or will not tell their story and information should only be shared with the informed consent of the survivor. Confidentiality promotes and supports safety, trust and empowerment and it means that anyone who has access to information about a survivor must not share any of that information without the explicit permission and informed consent of the survivor. Breaching confidentiality can put the survivor and others at risk of further harm. If GBV service providers do not respect confidentiality, other women and girls may be discouraged from seeking help.



3 RESPECT

Respect for the choices, rights and dignity of women and girls and GBV survivors requires that survivors are the primary actors in all aspects of service delivery. All actions should be guided by respect for the choices, wishes, rights and dignity of the survivor. Respect for the survivor's dignity and self-determination requires actors to be non-judgemental of a survivor's choices and uphold her right to choose, including when she decides to decline support services.



4 NON-DISCRIMINATION

Staff should be equipped with knowledge, skills and attitudes on inclusive programming. Service provision should be tailored to the needs of all women and girls based on intersectional gender analyses that considers the increased risks to women and girls based on their age, disability, race, skin colour, religion, nationality, ethnicity, HIV status, social class, political affiliation or any other characteristic.



LEAVE NO ONE BEHIND

DISASTER PREPAREDNESS AND RESPONSE

Recommendations

Say no to improvisation. Be prepared.

In case of an emergency or disaster, DO NOT open the shelter to people in need that are not GBV survivors. This puts at risk GBV survivors and their families.

DESIGN A DISASTER AND EMERGENCY PLAN

Reach out to your governmental agencies

Periodically review the disaster and emergency plan to adapt to any changes or to situations that had not been previously taken into account



EVACUATION AND SAFETY

Take into account that shelters receive babies, children, people with mobility issues and people living with disabilities (physical and mental).



STAFF

Allocate clear roles and responsibilities

Train the staff on the disaster and emergency plan.



RESIDENTS

Share the disaster and emergency plan with survivors when they enter the shelter

Perform simulations regularly



VISIBILITY

Have instructions and signs for the event of a disaster and/or an emergency placed in visible places and accessible to all residents and staff



ANNEX 4

CHECKLISTS

CHECKLIST FOR THE DESIGN, SETUP AND MANAGEMENT OF SAFE SHELTERS FOR GBV SURVIVORS

Key Preparedness Actions

Please follow these guidelines during the planning phase of the safe shelter. These can also be used to evaluate safe shelters that have already been established and are up and running, to identify specific aspects of the safe shelter that need modification and improvement.

1	ASSESSING THE NEED TO SET UP A SAFE SHELTER AND KEY PREPAREDNESS ACTIONS	YES	NO	COMMENTS
	Have you conducted a GBV assessment in the area where you are locating the safe shelter for GBV survivors?			
	Have you conducted a GBV safety audit in the area where you are locating the safe shelter for GBV survivors?			
	Have you conducted/do you have access to a GBV service mapping?			
	Are there other safe shelters for GBV survivors in the area?			
	Are existing safe shelters for GBV survivors aimed only at one specific group of individuals? (i.e. only for women and girls, only for IPV survivors, etc)			
	Have you consulted with the communities around the need for a safe shelter for GBV survivors (including the most marginalized), and how it can best serve the needs of the communities?			
2	ESSENTIAL CONSIDERATIONS FOR THE DESIGN OF THE SAFE SHELTER			
	SAFETY AND SECURITY			
	The location of the safe shelter is confidential, and guarantees the safety and security of GBV survivors residing in the facility, based on the assessments conducted.			
	There is only one main entrance and at least one emergency exit.			
	The facility is surrounded by a security fence.			

There are clear protocols for visitors and entrance of external service providers.			
There is access to a landline and an emergency phone, as well as a direct communication line to the closest police station.			
Free transportation is provided for all residents and new referrals, as well as for emergency health incidents. This service could be provided by the safe shelter or through an external provider (in such case, clear protocols and safeguards must be ensured).			
INFRASTRUCTURE			
Individual bedrooms for residents can be assured and additional beds to be available if a resident has a child under their care.			
Shared bedrooms among no more than 3 persons and only if the residents feel comfortable in sharing with someone else. Not recommended for the first days after arrival.			
Bedrooms for staff who stay over night can be assured (no more than 2 persons per room)			
Toilets and showers to be shared among no more than 5 bedrooms			
Communal Kitchen is available for residents, outlining clear rules and responsibilities for each resident in the management of the space and available resources. If the kitchen is not provided, then catering services must be assured.			
Rooms for recreational group activities should be available in the safe shelter (these could also serve the purpose of a communal space when no activity is scheduled)			
At least one room dedicated solely for the provision of individual services for residents (MHPSS, case management, legal services, etc), ensuring privacy and confidentiality (ensuring ration of 1 room per 10 residents)			
Provide office space for staff working in the safe shelter, all of them including office equipment and lockable file cabinets.			

Essential Actions for Management and Service Provision

Please follow these guidelines after you have been able to guarantee the key preparedness actions. This section refers to the specific requirements that need to be in place for the administrative management of the safe shelter, and for ensuring a set of minimum services for survivors of GBV. These need to be guaranteed before the safe shelter starts being operational.

These are the staff positions that are required to be in place in a safe shelter for GBV survivors, as well as the required trainings they should receive ahead of starting their work in the safe shelter.

<p>Shelter Manager: This position is fundamental, so please make sure the person complies with the required skills, particularly in Project Management, experience working with survivors of GBV and leading teams.</p>			
<p>Security staff: Female security personnel must be in place 24 hours a day seven days a week. You will need at least three persons who can cover shifts and who have direct contact with the police in case there is any incident they may need support with.</p>			
<p>GBV case management supervisor: This position is essential if the shelter is offering case management services directly in the safe shelter (which is the general recommendation).</p>			
<p>GBV case workers: These positions are essential if the safe shelter provides this service directly in the facility. The ratio of case workers per survivors should be: 1 case worker per 15 survivors.</p>			
<p>Sexual and Reproductive Health Focal Point (or midwife): This person will have the required background to offer basic SRH services in the facility and to conduct referrals to specialized SRH services in medical facilities.</p>			
<p>Psychosocial support officer: This position is essential to ensure PSS activities in the safe shelter, and they can also be appointed as the MHPSS focal point, who can conduct referrals to specialized MHPSS services that are not offered in the shelter.</p>			
<p>Child care workers: This position is essential to support survivors who come into the shelter with their children, so they can make appropriate referrals to services if needed, ensure children can continue attending school and organize activities for them inside the facility.</p>			
<p>Translators/interpreters: This position is fundamental if the safe shelter receives referrals from survivors who do not speak the local language, such as refugees, migrants and even indigenous population. This also includes personnel who are fluent in sign language for survivors with hearing impairments.</p> <p>Depending on the need, you can also ensure this service to be provided by an external actor, but you need to make sure they adhere to the policies of the safe shelter and also receive appropriate training.</p>			

*Essential trainings to be made available for all personnel working in the safe shelter***Essential trainings for all staff:**

- Prevention from Sexual Exploitation and Abuse
- GBV Key Concepts and Guiding Principles
- GBV Safe referrals and basic provision of Psychological First Aid (PFA)
- Refugee and migrant rights
- Trafficking in persons
- Disability Inclusion

Essential service provision in the safe shelter

Food and water: food items or catering services to be arranged. You can also consider providing cash and voucher assistance for each resident to procure their own items and cook in the communicable kitchen.

Non food-items:

- Bed sheets, towels, cleaning supplies for each bedroom are essential.
- Change of clothes should be available for each resident.
- Dignity Kits: including toothbrush, toothpaste, comb/hairbrush, deodorant, soap, shampoo, lotion, sanitary pads/tampons, underwear).

Staff Care Plan: Developing a staff care plan is essential to ensure staff working in the facility have the required support, from a technical perspective and to ensure their wellbeing. If there are no psychologists in place, the recommendation is to outsource these services to a consultant who can support the shelter manager in establishing this plan, and ensuring all staff have access to a trained psychologist for free.

The following protection services must be in place in every safe shelter. If it is not possible to ensure the provision of such directly in the shelter, then a GBV Referral Pathway must be used and shelter staff must know how to safely use it.

Mental Health and Psychosocial Support Services

(MHPSS): Including access to psychological services, psychiatric services, and social support groups led by an accredited psychologist.

<p>GBV Case Management Services, including the following:</p> <ul style="list-style-type: none"> - All staff (supervisors and case workers) trained in GBV case management. - Clear SOPs around the provision of the service in the shelter (including data protection and storage protocols, and protocols for the response to cases and support to LGBTQI+ survivors and survivors living with disabilities). - Adherence to the GBV Guiding Principles and a survivor-centered approach. - Protocols to assign cases among case workers - Clear understanding of GBV referral pathways and mandatory reporting laws. - Clarity around the forms to be used for the provision of the services (either physical or electronic). - Clear ToRs for supervisors and case workers - Case workers are female and speak relevant languages. 			
<p>Essential trainings for personnel providing GBV case management services</p> <ul style="list-style-type: none"> - Interagency GBV Case Management Guidelines - GBV case management supervision (for supervisors) - Child protection and referrals - GBV Safe and Ethical Data collection 			
<p>Essential trainings for personnel providing SRH services:</p> <p>Clinical Management of Rape Services, including the following:</p> <ul style="list-style-type: none"> - Understanding of and adherence to the GBV Referral Pathways - Ensure female staff are trained in the provision of CMR. - Ensure stock containing STI prevention and treatment options. - PEP Kits available. - Emergency Contraceptives available. - Immediate medical response to treat injuries or life-threatening conditions <p>Sexual and Reproductive Health services and referrals, including:</p> <ul style="list-style-type: none"> - Family Planning services - Maternal and newborn healthcare (antenatal care, delivery care and postnatal care, including emergency obstetric newborn care) - Counselling and information about HIV and STIs - Services to treat reproductive cancers 			
<p>Child protection services or referrals, including referrals for children if not allowed to stay in the safe shelter, provision of GBV case management services for child survivors of GBV, and alternative measures for children to continue attending school.</p>			

Livelihoods and/or vocational training opportunities			
Legal assistance and/or referrals, including support for police procedures, restraining orders, parental rights, migration and asylum rights and international protection)			
PREVENTION AND PROTECTION FROM SEXUAL EXPLOITATION AND ABUSE			
The agency or organization running the safe shelter must develop and/or adhere to Zero tolerance policies around SEA, and ensure there are policies to protect against retaliation and victim assistance mechanisms in place.			
The safe shelter must have a Code of Conduct in place for all staff to sign and adhere to.			
All staff must receive training on PSEA			
Background and criminal records checks must be performed on every single staff working in the safe shelter before being hired.			
Confidential reporting mechanisms must be established, in consultation with the communities, ensuring inclusivity and accessibility.			
Multiple and anonymous feedback mechanisms must be available in the safe shelter, accessible for both residents and staff.			
PSEA IEC materials must be available around the safe shelter, containing information around responsibilities of the staff and available mechanisms to report wrongdoing.			
Recommendations for Disaster Preparedness and Response			
<i>Please follow these recommendations and ensure the safe shelter is prepared to remain operational during the onset of a disaster.</i>			
A detailed disaster emergency preparedness and response plan is in place, in line with national disaster agencies and NGM.			
All staff have been trained and understand their responsibilities within the plan, agreeing to them in advance.			
Emergency preparedness and response plan is shared with residents when they enter the facility			
The safe shelter guarantees the facility will not be repurposed during or after an emergency for any other purpose than to continue hosting and protecting survivors of GBV in the facility.			

Essential Considerations to ensure the safe shelters adapt to the needs of survivors with special needs

It is important for safe shelters to be inclusive and adapt to the needs of individuals with particular vulnerabilities, special needs, and

Essential considerations for Persons Living with Disabilities (PLwD)

Consult with PLwD, particularly women and girls, about the location and infrastructure, transportation services offered, IEC materials development and any other special needs they may have in order to tailor the services towards them and ensure accessibility to the safe shelter.			
Services for PLwD are mapped and included in GBV referral pathways			

Special Considerations for Elderly Survivors

Consult with elderly women around the design of the safe shelters, their location, infrastructure, special services and IEC materials on sexual health and available services.			
Services available for the elderly population are mapped and included in referral pathways (including particular medical considerations).			

Special considerations for survivors of sexual violence and individuals engaging in sex work

Ensure availability of CMR services in the facility			
Ensure HIV and STIs counselling services and treatment			
Ensure access to family planning alternatives inside the safe shelter			

Special considerations for persons identifying as LGBTQI+

Include persons identifying as LGBTQI+ in consultations around the design, set-up and services offered in these shelters.			
Promote the use of gender inclusive language and gender neutral pronouns in the safe shelters: he/she/they/them/theirs/Ze/hir			
Guarantee the use of the person's preferred identify and confidentiality/privacy of their gender identity if this is preferred by them			
Special services for the LGBTQI+ are mapped and included in referral pathways (including independent living arrangements)			

Special considerations regarding survivors engaging with substance abuse

Map services available for the support and treatment of survivors engaging with substance abuse and de-intoxication programmes			
If a person chooses to engage in such programmes, ensure they continue having access and benefit from all other services offered in the shelter, until they are able to and it is safe for them to transfer.			

Special considerations for refugee and migrant survivors

Translation and interpretation services are available at all times and/or specific services are offered in their native language.			
IEC materials, codes of conduct, relevant documents and information are translated and available in their native language.			
Specific services to respond to the needs of refugees and migrants are available and/or have been mapped, and referrals can be conducted for special protection measures.			

ANNEX

5

SURVEY

1. In which country do you work?
2. What type of Agency/Organization do you work for?
 - Government Agency
 - Civil Society Organization
 - Other
3. What is the name of the agency/organization you work for?
4. What is your name?
5. Is your Shelter accredited by your national government?
 - Yes
 - No
 - Not available
6. How many Shelters does your agency/organization manage in the country?
 - 1
 - 2
 - 3
 - More than 3
7. What is the maximum capacity of individuals the Shelter can host at once?
 - 5 or less
 - 10 or less
 - 15 or less
 - 20 or less
 - 25 or less
 - More than 25
8. Do you currently have space for new residents?
 - Yes
 - No
9. Do survivors have to pay any amount of money to stay in the Shelter and/or access any of the services available?
 - Yes
 - No
10. Are survivors able to stay in the Shelter with their children?
 - Yes
 - Yes, but there is an age limit
 - No
 - No but we find alternative solutions for their children

11. What type of Shelter is this?
- Emergency shelter (first stage emergency housing - short to medium secure accommodation, few days up to few months)
 - Second Stage/transitional housing (longer term accommodation 6-12 months or more, assistance for transition into permanent housing)
 - Third Stage Housing (those who have completed stage 2 but still need housing and support, either permanent housing or referrals for further specialized support)
12. Which of the following options would describe best the approach you use in your Shelter?
- Prioritise women empowerment and a survivor-centered approach, where you support women in finding alternative solutions.
 - Prioritise maintaining the family unit above all, where you promote temporary solutions until they can go back to their families.
 - Other
13. What services are offered in the facility?
- Gender based violence case management/social services
 - Psychological support by a mental health specialist (psychologist)
 - Psychosocial support
 - Recreational activities
 - Vocational training
 - Education (formal and/or informal)
 - Child protection services
 - Legal information/advice
 - Legal representation (by a lawyer)
 - Sexual and reproductive health services and/or education
 - Multi-sectoral referral mechanisms
14. Is there a GBV and multi-sectoral referral system in place, so residents can access services outside the facility?
- Yes
 - No
15. Does the Shelter have the following security measures in place?
- Location is confidential
 - No visitors allowed in the facility
 - There are security guards 24/7
 - Direct contact line to police station
 - No men and boys over 13 years old are allowed in the facility

16. Does the Shelter offer any of the following Sexual and Reproductive Health services?
- Prenatal care
 - Delivery care
 - Postnatal care
 - Family planning
 - Condoms (male or female)
 - Sexually transmitted infections care and treatment
 - Care and ARV treatment for persons living with HIV
 - Clinical management of Rape services
 - There is a referral mechanism in place to ensure access to the services
 - None
17. Has the Shelter established a referral mechanism in coordination with health facilities, so that women and girls can access the following sexual and reproductive health services?
- Prenatal care
 - Delivery care
 - Postnatal care
 - Family planning
 - Condoms (male or female)
 - Sexually transmitted infections care and treatment
 - Care and ARV treatment for persons living with HIV
 - Clinical Management of Rape
 - No
18. Does the Shelter have staff and/or interpreters of the following languages?
- English
 - Spanish
 - Portuguese
 - Creole
 - Local languages
 - Sign language interpreters
19. What is the main funding source, ensuring the operationalisation of the Shelter?
- Government funding
 - UN Agencies
 - International Non-Governmental Organization
 - Non-Governmental Organization
 - Private Sector
 - Donations form the public
 - Not available
20. What is the name of your donor(s)

21. For how long do you have the funding for?
- Less than one year
 - One year
 - Two years
 - Indefinitely
 - Undefined
 - Currently not funded
22. Please select staff positions that are currently working in the Shelter
- Shelter Manager
 - Security Staff
 - Case workers/social workers
 - Psychologist(s)
 - Lawyer(s)
 - Midwife(s)
 - Nurse(s)
 - Teacher(s)
 - Cleaner(s)
 - Cook(s)
23. Please select the training sessions you or your donor offer staff before and during their work in the Shelter
- GBV Core Concepts and Guiding Principles
 - GBV Case Management
 - GBV Referral Pathways
 - Security risk assessments
 - Psychosocial support
 - Child Protection
 - Human Rights
 - Prevention of Sexual Exploitation and Abuse
24. Is there a staff care plan in place?
- Yes
 - No
25. Does the Shelter have Standard Operating Procedures?
- Yes
 - No
- Attach a copy of your Shelter's Standard Operating Procedures here*
26. Is there a Code of Conduct for the staff working in the Shelter?
- Yes
 - No
- Attach a copy of the Code of Conduct for the staff working in the Shelter*

27. Is there a Code of Conduct and/or rules for individuals who stay in the Shelter?
- Yes
 No
28. Is there a way residents can provide anonymous feedback or complaints on anything related to the facility/staff/services offered in the Shelter?
- Yes
 No
29. If you answered yes on the previous question, can you please briefly explain how the feedback mechanism works?
30. Does your Shelter have protocols in place to prepare for a disaster (hurricane, earthquake, pandemic, etc)?
- Yes
 No
31. If you answered yes to the previous question, can you share these protocols with us?
32. If a disaster strikes, does the facility have the capacity to continue operating?
- Yes
 No
33. In the midst of a disaster, would the facility open its doors to other individuals (not GBV survivors) in need of Shelter?
- Yes
 No
34. What are the main gaps that you identify in terms of knowledge and capacity to respond to GBV incidents and survivor's needs?
35. Can you highlight some good practices around the management/functioning of your Shelter?
36. During emergencies such as hurricanes, refugee/migrant influxes or the COVID-19 pandemic, what are the main lessons learned that should be considered in guidelines for the management and operationalisation of Shelters for GBV survivors? (include constraining and facilitating factors) some good practices around the management/functioning of your Shelter?

Thank you for taking the time to answer this survey. Are there any additional comments you would like to highlight?

ANNEX 6

SEMI-STRUCTURED INTERVIEWS

The aim of these interviews is to understand a myriad of aspects, while it is paramount to understand how the provision of services, daily functioning and access to shelters is affected by the influx of Venezuelan migrants and refugees, the current covid19 pandemic and natural hazards, it is also crucial to identify gaps and challenges as well as good practices that are not directly connected with the above mentioned crises.

Name of shelter:

Country:

Name of Respondent:

Email of Respondent:

1 FEES

- 1.1 How much is the fee and what does it cover?
- 1.2 What is the procedure for survivors that are unable to pay the fee?

2 DIGNITY KITS AND NFIS

- 2.1 Are survivors given any Dignity kits and NFIs on arrival and/or during their stay?
 Yes No
- 2.2 What kind of NFIs?
- 2.3 Dignity kits
 Yes No

3. FOOD AND MEALS

- 3.1 Are meals provided?
 Yes No
- 3.2 Is food provided and access granted to the kitchen and its appliances so that women can cook?
 Yes No
- 3.3 Are survivors involved in the cleaning and cooking?
 Yes No
- 3.4 How has Covid19 affected this?

4. STAFF

- 4.1 What is the role and responsibilities of the House Mother?

5. LENGTH OF STAY

- 5.1 What is the average length of stay of survivors?
5.2 Is there a limit?

6. ACCESSIBILITY AND ELIGIBILITY CRITERIA

- 6.1 What is the current process for admission to the shelter?
6.2 Migrant/refugee women:
6.2.1 Does the shelter have experience in receiving migrant and refugee women?
 Yes No

6.3. Women with children:

- 6.3.1 Does the shelter allow for children to accompany their mothers?
 Yes No
6.3.2 What is the age limit for girls and the age limit for boys?
Girls:
Boys:
6.3.3 Do you provide child care services if necessary (in circumstances where the mother continues to go to work and the child is not in school or in formal child care)?
 Yes No
6.3.4 If the shelter is not able to accept children, what are the alternatives provided?

6.4 Adolescents and girls

- 6.4.1 What is the shelter's policy with adolescents and girls that are survivors of GBV?
6.4.2 Does the shelter offer any specific programmes for adolescents and girls?

6.5 Women living with disabilities

- 6.5.1 Is the shelter prepared to receive women living with disabilities or are there barriers such as staircases, narrow doors, inaccessible toilets?
 Yes No
6.6 Survivors who are no longer in reproductive age and those who are considered to be elderly
6.6.1 Does the shelter have experience with receiving older women?
 Yes No

6.7 Sex Workers

- 6.7.1 What is the shelter's experience with survivors that are sex workers?

6.8 People living with HIV-AIDS

- 6.8.1 Is ARV treatment and care for persons living with HIV available in the shelter?
 Yes No

6.8.2 Has the staff received training on providing care for people living with HIV?

Yes No

6.9 Gender non-confirming groups

6.9.1 Does the shelter integrate or is in the process of integrating gender non-confirming groups?

Yes No

6.9.2 If not, why?

6.9.3 If yes, are there any challenges or best practices which the shelter wishes to share?

6.10 Women living with severe mental health issues

6.10.1 Does the shelter have the ability to receive women living with several mental health issues?

Yes No

6.11 Substance abuse

6.11.1 What is the shelters' policy in relation to receiving cases where substance abuse is confirmed?

6.12 Are there any circumstances in which the shelter refuses admission?

7. ARE MANDATORY REPORTING LAWS IN PLACE IN YOUR COUNTRY? IF YES, PLEASE SHARE THE OFFICIAL DOCUMENT STATING THIS.

Yes No

8. SEXUAL AND REPRODUCTIVE HEALTH SERVICES

8.1 Does the shelter provide informative sessions on SRHS? (For example, family planning)

Yes No

8.2 HIV Counselling

Yes No

8.3 Is there access to female/male condoms in the shelter?

Yes No

8.4 Do survivors have access to other contraceptives?

Yes No

8.5 What is the shelter's procedure in case of rape?

8.6 Can survivors access clinical management of rape services? Where?

8.7 Have SRH services and components been disrupted or delayed amid the current pandemic? (Including referrals to other services)

Yes No

COVID 19: the impact of COVID 19 in service provision**9. ACCESS TO THE SHELTER AND TO SERVICES**

9.1. Intakes: have the number of intakes been reduced due to covid19 prevention measures?

Yes No

If yes, how many persons/families was the shelter admitting and how many is the shelter taking in now?

9.2 Referrals and self-referrals to the shelters:

9.2.1 Have there been any fluctuations (increase or decrease) in the number of referrals or self referrals?

Yes No

9.3 Have you had to refuse admittances due to lack of space related to covid 19 constraints?

Yes No

9.4 Provision of services

Has the shelter experienced disruption of any of the services that were usually provided prior to COVID19? Which services?

Yes No

9.5 Have referral pathways been updated since COVID19?

Yes No

9.6 Are referral pathways active and functional amid COVID19?

Yes No

9.7 Are there any services that used to be handled face-to-face and that are now being handled via telephone/email or in any other remote way?

Yes No

10. NATURAL HAZARDS

10.1 For the ones that do not have protocols in case of natural hazards but say they would continue to operate - please elaborate.

10.2 For the ones that have protocols and can continue to operate but did not share - please share.

11. IS THERE ANYTHING ELSE YOU WOULD LIKE TO SHARE (EITHER POSITIVE OR NEGATIVE)?

ANNEX 7

SAMPLE TOR SAFE SHELTER MANAGER

The purpose of the Shelter Manager is to ensure the survivors are receiving life saving quality support and are able to access the service needed to support their recovery. The Shelter Manager ensures the services provided in the shelter are survivor-centered and that the shelter is equipped with relevant materials, adequate spaces, technical guidelines, prepared staff and SoPs to ensure good quality and safe service provision. The incumbent will help plan, design, implement, monitor and report on the implementation of the Shelter for GBV survivor according to the national protocol.

RESPONSIBILITIES

Management:

- Develop and periodically update a suitable shelter approach taking into consideration area-based multi-sectoral approaches, age and gender, culture, climate, environmental protection and the availability of local resources, including materials, capacities and existing infrastructure.
- Prepare and maintain up to date work plans and expenditures plans.
- Ensure accurate budget forecasting and expense planning.

Human resources:

- Select, train and supervise shelter staff.
- Ensure capacity building of shelter staff and transfer key skills according to each technical profile. Identify the training needs of shelter staff and facilitate training to meet those needs,
- Ensure staff awareness and respect of code of conduct and Standard Operating Procedures.
- Ensure a positive working environment and positive and respectful environment within the shelter.
- Conduct regular planning and information sessions with team members
- Advise and support staff professional development and foster positive team spirit to encourage quality, innovative programming.

Quality assurance - Technical lead

- Ensure and reinforce adherence to GBV guiding principles in all shelter's activities
- Ensure that the services provided by the shelter, including case management and psychosocial interventions, adheres to best practice principles when working with survivors of GBV.
- Ensure the shelter has Standard Operating Procedure in place
- Ensure the shelter has a code of conduct for staff and a code of conducts for the guests in place
- Support the development and maintenance of a coherent Shelter strategy to ensure the shelter is supporting survivor's recovery and empowerment.
- Provide direct support and ongoing mentoring to GBV social workers and other staff members in providing services to women and girls who are survivors of GBV. This will include assessing the survivor's needs; basic crisis counseling (and in some contexts additional individual counseling); development of action plans with clients; support to survivors in accessing services.
- Ensure the shelter develops and implements a range of age-appropriate and specialized group emotional support services to be provided to vulnerable women and girls to meet the needs of GBV survivors.
- Guarantee the existence of a physical confidential space for case management and individual counseling.
- Supervise and guide age-appropriate and relevant psychosocial activities for women and adolescent girls.

Coordination:

- Liaise and collaborate with relevant local authorities and other key stakeholders.
- Ensure the Shelter is part of the local GBV referral pathways.
- Ensure coordination with service providers, including health, psychosocial support, livelihoods, protection and legal actors.

Monitoring

- Prepare and submit weekly, monthly and quarterly work plans in a timely manner
- Compile a monthly activity report for presentation.
- Ensure that all pertinent financial documentation is properly completed and submitted.
- Ensure attendance records and other reporting tools are implemented and

routinely provided to relevant personnel,

- Monitor data collection to ensure staff collect data in a safe and ethical manner.

Generic professional competencies for this position:

- Minimum five years of experience working with survivors of gender-based violence
- Minimum five years of experience in shelter sector (emergency, transitional and durable)
- Minimum of three years of experience supervising a multidisciplinary team
- Higher education, preferably in social sciences: economics, development, political science, gender.
- Documented results related to the position's responsibilities
- Proven communication and interpersonal skills
- Proven experience in budget management and financial literacy
- Experience in capacity building and training of staff
- Experience of coordination and advocacy works
- Planning skills
- Demonstrated leadership and teamwork skills.
- Knowledge of the survivor-centered approach



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