Learning to respond

Good practices and lessons learned on sexual reproductive health (SRH) and gender-based violence (GBV) in emergency settings in Latin America and the Caribbean

UNFPA

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Acronyms and abbreviations

AoR	Area of Responsibility
CAP	Consolidated Appeal Process
CBO	Community-Based Organization
CCCM	Camp Coordination and Camp Management
CERF	Central Emergency Fund
CHAP	Common Humanitarian Action Plan
ECAP	Equipo de Estudios Comunitarios y Acción Psicosocial (Guatemala)
GBV	Gender-Based Violence
GBVIMS	Gender-Based Violence Information Management System
GRT	Grupo de Trabajo Regional para la Reducción de la Mortalidad Materna
HFCB	Humanitarian and Fragile Contexts Branch
ICPD	International Conference on Population and Development
IEC	Information, Education and Communication
INE	Instituto Nacional de Estadística (Bolivia)
INIM	Instituto Nicaragüense de la Mujer
IOM	International Organization for Migration
ISDEMU	Instituto Salvadoreño de la Mujer
LAC	Latin America and the Caribbean
LACRO	Latin America and the Caribbean Regional Office
LGBT	Lesbian, Gay, Bisexual and Transgender
MISP	Minimum Initial Service Package
NGO	Non-Governmental Organization
PEP	Post-Exposure Prophylaxis
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
PoA	Programme of Action
REDLAC	Inter-Agency Working Group on Risk, Emergency and Disasters for Latin America and the Caribbean
SE-SINAPRED	Secretaría Ejecutiva del Sistema Nacional para la Prevención, Mitigación y Atención de Desastres
SINAPRED	Sistema Nacional para la Prevención, Mitigación y Atención de Desastres (Nicaragua)
SitRep	Situation Report
SPRINT	Sexual and Reproductive Health Programme in Humanitarian Settings
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNETE	Equipo Técnico de Emergencias de Naciones Unidas
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children Fund
UNV	United Nations Volunteer
USD	United States Dollar
WASH	Water Sanitation and Hygiene
WHO	World Health Organization

1 Introduction .....

1.1 Background

Latin America and the Caribbean cover 8.1 million square miles of the globe (21 million square kilometres) and encompass vastly different climates and terrains. The region is therefore prone to natural disasters and emergencies that require a humanitarian response. UNFPA has taken a leadership role in ensuring that emergency response in this region respects the rights of the most vulnerable and incorporates the latest research on issues that have traditionally been ignored in times of emergency, such as sexual and reproductive health (SRH) and gender-based violence (GBV). From 2008 to 2012, UNFPA was able to mobilise over US 5 million in Central Emergency Response Fund (CERF) funds to respond to the humanitarian needs of more than 2.3 million people in the region, including the SRH and GBV-related needs of more than 1.8 million women.[1]

The International Conference on Population and Development Programme of Action (ICPD PoA) has affirmed that all people shall enjoy their SRH rights and live free from sexual violence and other forms of GBV, including during emergencies. SRH and GBV are inextricably linked, and UNFPA's strengths on both of these issues position it to provide in-depth analysis of these issues in emergency settings. SRH is one of the core areas of intervention for UNFPA, and includes the provision of a wide range of services across all stages of crisis and recovery, such as health care, contraceptives, hygiene kits, psychosocial counselling for individuals in the affected population and health system restoration.

The leadership that UNFPA provides on SRH also gives it a strategic entry point to address GBV, including within the framework of SRH services. Prevention of, and response to, GBV, with an emphasis on sexual violence, is one of the subject areas of the Minimum Initial Service Package (MISP) [2] for reproductive health services in humanitarian settings. The consequences of sexual violence on the health of the survivors are already well documented,[3] and much of the work to address GBV in humanitarian contexts is in fact in the health sector.[4] This explains why prevention of sexual violence and assistance to survivors is one of the objectives of the MISP. By seizing on the linkages between SRH and GBV, and by seizing on opportunities for collaboration with other actors, UNFPA can make better use of available resources and maximize effectiveness.

Yet evidence still suggests that SRH services have not been systematically implemented in humanitarian emergencies mainly due to lack of qualified staff and poor coordination.[5] UNFPA's humanitarian mandate was enshrined in the organizations' humanitarian strategy for 2007 to 2009, [6] and then reaffirmed in the Second Generation Humanitarian Response Strategy. [7]

[1] UNFPA LACRO analysis on UNFPA CERF fund allocations 2008-2012 in the LAC region.

[2] The MISP is a set of priority interventions that is designed to 'reduce mortality, morbidity, and disability among populations affected by crises, particularly women and girls.' It contains guidelines for coordinated SRH services in the early phase of an emergency, and planning for comprehensive SRH services when the situation has stabilized. UNFPA et al. (2008). *Training on the Minimum Initial Service Package (MISP) for Sexual and Reproductive Health in Crises - A Course for SRH Coordinators*. New York: UNFPA. In 2007, MISP was included among the CERF life-saving interventions.

[3] These include gynaecological complications, problems of sexuality, urinary tract infections, unwanted pregnancies, sexually transmitted infections (STIs), HIV and unsafe abortions.

[4] Since 2005 UNFPA and UNHCR have partnered to conduct trainings for health care providers in refugee and displacement settings on the clinical management of rape survivors.

[5] Cfr. Inter-Agency Working Group on Reproductive Health in Crises (2010). *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*. New York: Inter-Agency Working Group on Reproductive Health in Crises ; UNFPA et al. (2008), *op. cit.*; and WRC (2007). *Minimum Initial Service Package (MISP) for Reproductive Health in Crisis Situations*. New York: WRC.

[6] UNFPA (2006). Integrating the Programme of Action of the International Conference on Population and Development into Emergency Preparedness, Humanitarian Response, and Transition and Recovery Programmes: a Strategy to Build Commitment and Capacity. New York: UNFPA.

[7] UNFPA (2012). Humanitarian Response Strategy "Second Generation". New York: UNFPA.

Thus, since 2008, the UNFPA Latin America and the Caribbean Regional Office (UNFPA LACRO) has been systematically engaged in supporting country offices in the region in the design, resourcing and implementation of SRH and GBV programmes in both emergency preparedness and response. There is still little knowledge on the extent, quality and impact of programming in these subject areas, however, and this study aims to fill that gap.

1.2 Purpose of the study

The purpose of this study is to document SRH and GBV programmes implemented by UNFPA as part of preparedness and response efforts for humanitarian settings in the LAC region for 2008 to 2012. More specifically, the study is intended to map programmes on SRH and GBV in humanitarian contexts in the region, covering both preparedness and response; to look into the role played by UNFPA LACRO; and to select and document good and promising practices and related lessons learned.

Research can be a powerful advocacy tool and often it is only through research and documentation that the effectiveness of certain practices can be known, and their replication advocated for. This stocktaking study is meant to provide UNFPA with useful information on past and current implementation in humanitarian settings in the region, what has worked and what has not worked, challenges and opportunities, for use with other agencies and donors alike.

By documenting these practices[8] over the past five years, and by distilling the key elements that define good practices, this study strives to provide inspiration as well as practical tips for future SRH and GBV programming in the region.

Chapter 2 of this study outlines the framework of analysis used, including the criteria for the selection of good practices and lessons learned, and the methodology. Chapter 3 presents the main findings from the mapping exercise as well as the good practices and lessons learned. Finally, Chapter 4 offers concluding remarks and recommendations.

2 Framework of analysis

This section explains how the mapping and selection of projects and programmes was carried out by the study team. It sets out the criteria that were agreed for the selection of good practices and lessons learned as well as the rationale behind them.

2.1 Conceptual framework

2.1.1 Definitions

The UNFPA Guidance Note on Sharing Good Practices in Programming distinguishes between "best practices", "good practices" and lessons learned. Increased caution has been used in the last decade in labelling a practice as "best", as suggesting a strong claim about its universal applicability and relevance for all. This is why the terms "good" and 'promising' are generally preferred, including in this study. UNFPA's, definition of "good practice" is "experience acquired during programme implementation, which demonstrates proven methods, techniques, or practices." "Lesson's learned" is defined as "a work practice that identifies procedures and methodologies that facilitated or hindered the implementation of a project/programme and the achievement of expected results."[9]

2.1.2 Strategic framework

As an international development agency, UNFPA is often already present in a country during an emergency situation. This places the organization in a unique position for the provision of life-saving SRH services and GBV response. These facts are also reflected in UNFPA's mandate, which assigns

[8] Typically, UNFPA's partners include government entities in the areas of health, justice, security, education, women's and/or gender mechanisms, planning and protection organizations and civil defense; national and international NGOs, community groups, academia; as well as other UN agencies and donors.

[9] Definitions taken from UNFPA (2010)b. *Guidance Note on Sharing Good Practices in Programming.* New York: UNFPA, p. 4.

the organization the leadership on SRH within the United Nations, and co-leadership of the GBV Area of Responsibility (GBV AoR), with key responsibility for coordinating GBV and SRH in crisis situations.[10] UNFPA carries out this work under its "second generation" humanitarian response strategy, which represents an operational shift from headquarters to regional, sub-regional and country offices in the leadership of humanitarian preparedness and response, as well as recovery programmes. The objective is to strengthen disaster preparedness within development programming at the country level to better respond in the event of an emergency.[11] In accordance with UNFPA's mandate, GBV and SRH are part and parcel of the Second Generation humanitarian strategy.

UNFPA's LAC Humanitarian Strategy[12] and the Regional Strategy to Prevent and Address Sexual Violence against Women[13], as well as the MISP for reproductive health services in humanitarian settings, thus provide the general framework within which to analyse practices. The organization's Regional Strategy to Prevent and Address Sexual Violence against Women provides for a set of actions in critical areas to eradicate sexual violence.[14] It places sexual violence at the centre of the human rights agenda in order to face existing challenges and advance institutional responses to sexual violence, and it is this strategy that is the main framework for GBV programmes in the region.

With UNFPA's Strategy and Framework for Action on Addressing GBV (2008-2011, now extended to 2013), emergency, conflict and post-conflict response is among five strategic areas that have been prioritized. More specifically, this includes strengthening the protection and health systems in humanitarian, conflict and post conflict situations. In Latin America and the Caribbean, UNFPA has considerable experience with both issues and has developed solid "cross-sector" alliances for comprehensive prevention and treatment. Examples of this are the Regional Working Group for the Reduction of Maternal Mortality (*Grupo de Trabajo Regional para la Reducción de la Mortalidad Materna - GRT*), a regional mechanism comprising different UN agencies, bilateral actors, multilateral actors, professionals and civil society organizations to reduce maternal morbidity and mortality.[15] This work also includes a cooperation fund between UNFPA and the Spanish International Cooperation Agency for Development (*Fondo de Cooperación UNFPA/Agencia Española de Cooperación Internacional para el Desarrollo* - AECID) to promote and protect SRH and rights, including protection from sexual violence.[16]

2.1.3 Criteria for selection: good practices and lessons learned

Whether a practice is considered as promising, innovative or successful depends also on the standards and criteria used to evaluate it. In the absence of specific assessments of programmes and approaches, these hallmarks below were used for the identification of good practices. Criteria were defined jointly among UNFPA LACRO and its partners and stemmed from review of existing documentation, methodological approaches and tools for data collection and reporting, as well as from the reality of SRH and GBV programmes as derived from the mapping exercise.

To be considered a "good practice", programmes had to be evidence-based and had to build on, and contribute to, current knowledge in their field

[10] Within IASC, UNFPA holds lead responsibility for GBV, reproductive health and gender mainstreaming.
[11] UNFPA (2012), *op. cit.*, p. 12.
[12] UNFPA (2009). Emergency Preparedness, Response and Recovery in Latin America and the Caribbean 2009-2013. New York: UNFPA.
[13] UNFPA LACRO (2013). UNFPA Latin America and the Caribbean Regional Strategy to Prevent and Address Sexual Violence against Women, 2011-2013. Panama: UNFPA.
[14] Among the many forms of GBV, priority is given to sexual violence as a key human rights violation, a barrier to the human, economic and social development of women and a public health priority, with broad dimensions in the region. UNFPA LACRO (2011). *UNFPA Latin America and the Caribbean Regional Strategy to Prevent and Address Sexual Violence against Women, 2011-2013*. Panama: UNFPA LACRO, p. 10.
[15] For more information on the GRT visit http://lac.unfpa.org/public/pid/4101, accessed 10 September 2013.
[16] For more information on the UNFPA/AECID Fund visit http://lac.unfpa.org/public/pid/5032, accessed 10 September 2013.

of intervention. And given the areas of focus of this study, programmes had to be rooted in the principles of gender equality, women's empowerment, human rights and the use of culturally-sensitive, diversity-based, population-based and life cycle approaches, such as age, gender and diversity mainstreaming. Taken together, these principles underpin UNFPA's work and should be reflected in all projects and programmes.

Below is a table describing each criterion and key questions to help assess applicability of each to projects and programmes.

Table 1: Criteria for the selection of good practices and lessons learned.

Criteria	Description, why and what matter	Key questions
Relevance[17]	Alignment and consistency with: • UNFPA Humanitarian Response Strategy - Second Generation. • UNFPA LAC Humanitarian Strategy. • UNFPA Regional SV Strategy. • SRH Strategy and Policies (MISP). • Other priority areas if relevant.	To what extent were the activities, and outputs/outcomes consistent with the strategies and priorities of UNFPA LACRO for both GBV and SRH?
Replicability	• Potential to be applied in other humanitarian settings. • The project/programme serves as an effective model for other countries/organizations.	• What is the project/programme's potential applicability to other settings? • What are the key elements for replication?
Impact	• Accurate data collection and analysis have informed programme design and have established a baseline against which progress can be measured. • Significant progress has been made and results achieved. • Beneficiaries, particularly women, feel "remembered, prioritized and taken good care of".	• To what extent did the activities attain their objectives? • What are the results of the programme? • What real difference has the activity made to the beneficiaries? • Was the initiative timely[18] and instrumental to, or functional in, the achievement of the proposed objectives?
Partnership and coordination	• The project/programme has a multi-sectoral, multi-level approach, to provision of services and to policy development, for example, that integrates and coordinates a wide range of professionals and services across various sectors of intervention. • Links and integration among different sectors, work areas and actors is fostered. • Coordination, monitoring and oversight is embedded in the project design and maintained throughout the programme.	• Was the initiative coordinated with other agencies (government, UN, NGOs)? • Were relevant partnerships established and maintained? • To what extent did UNFPA create synergies and advocate for attention to women's concerns in emergency response? • To what extent did UNFPA exercise a coordinating role?
Sustainability	• The project/programme builds on the idea of a continuum from emergency	• To what extent are the benefits of the programme sustainable over

[17] Generally refers to the overall goal and purpose of a programme.
[18] While timeliness is usually implicit within the concept of effectiveness, it still needs to be mentioned, especially for its importance in emergency programmes. Similarly, issues such as resourcing, preparedness and coordination (the latest included with partnership), while not considered as separate criteria, should be kept in mind.

	to transition to recovery. • The project/programme considers intersections between SRH and GBV, as well with other relevant fields of work, HIV/AIDS for example, and builds on available opportunities for programming and resourcing. • There is potential for an on-going impact, through support to local capacity development, institutionalization of work and identification of opportunities for continuous resourcing.	time and after the programme ceases? • Is the initiative contributing to support/build local capacities and opportunities? • Were durable solutions proposed/implemented?
Transformative	• Change is promoted at the individual, collective, legislative and social levels. • The project/programme aims to transform power relationships through comprehensive analysis of the context. • Individual and collective capacity for sustainable change is facilitated and supported. • The project/programme's approach highlights, challenges and ultimately changes harmful gender norms.	• Is the transformational approach appropriate and culturally sensitive? • What has changed as a result of the programme? • Is there any sign of change that can be attributed to the project/programme?
Community ownership and responsibility	• Understanding and analysis of the local context. • The project and the way it is implemented are culturally and socially acceptable. • Community acceptance is sought, nurtured and monitored, and is an essential component of the programme. • A functioning, two-way system for communication, transparency, participation of aid recipients, and complaints is in place to engage with local communities and to ensure information about the risks facing populations. • Beneficiaries/communities are aware of, and understand, the project, objectives and activities implemented. • Information sharing and skill building are in place for service providers, law enforcement, the legal and health sectors and policy makers at the local level.	• Is the project grounded in a deep understanding of the local context? • How much active consultation and engagement of people at the local level has been sought and at what level was this conducted? • Are capacities built and transferred? • Are formal systems for beneficiaries' complaints and feedback established and used? • Is time allocated to periodically reflect, reassess and make the necessary adjustments based on beneficiaries' feedback and consultation? • •

In addition, lessons from implementation of projects and programmes that can potentially contribute, or have already contributed, useful knowledge and understanding - both positive and negative - to the learning process, have been considered. Lessons learned were identified according to the following criteria:

1. Value/significance: something important to retain for future use, or something that can be relevant for other countries/organizations, including undesirable results to be avoided or factors that hindered the implementation process;
2. Accuracy: extent, quality and exactness of information and reflection;
3. "Newness": an innovative aspect to be captured and shared for replication.

For ease of decision making, and to avoid any subjectivity in the selection of practices to be documented, it was agreed that satisfaction of five or more criteria defines a "good practice" while fulfilment of three to four criteria out of the seven selected indicates a promising practice. However, it is important to note that, as the appraisal is based largely on the information provided by those who found the time to respond, selected interviewees, and a limited number of project documents, it is far from exhaustive. A table with a description of how each practice matched the criteria can be found in Annex 5.3.

2.2 Methodology

2.2.1 Desk review

A review of available literature was conducted throughout the first phase of the study, in May to June 2013. This covered policy, guidance and project documents, reviews and evaluations. The resources shared by UNFPA LACRO formed a substantial part of the desk review and included project proposals drafted as part of the response to emergencies for mobilization of resources. These included Emergency Fund proposals, CERF and Flash proposals, and progress reports.

The desk review provided for the identification of key actors, programmes and resources on both SRH and GBV in the region, as well as for the parallel development of the survey questionnaire used for data gathering and of criteria for the identification of good practices and lessons learned.

2.2.2 Regional survey

A regional online survey with information on implemented projects and programmes complemented the desk review. This survey drew on the UNFPA Guidance Note on Sharing Good Practices in Programming and on the UNFPA Good Practices in Programming Template[19] as well as on other similar exercises identified during the desk review. It included open-ended questions and space for respondents to add information, when relevant. (See Annex 6.2 for the survey questionnaire).

Respondents included UNFPA programme officers, humanitarian focal points, gender focal points, SRH focal points, education focal points and members of the indigenous community. Country offices were asked to select one to three projects or programmes in the areas of SRH or GBV among all those implemented from 2008 to 2012. [20] A general description of the good practices criteria was shared with them to help with selection.

The purpose of the survey was to:

- Compile country-specific practices and lessons learned on SRH and/or GBV covering both emergency preparedness and response;
- Identify enabling and hindering factors, as well as keys for success in implementing SRH and GBV programmes;
- Compile information on capacity among UNFPA and its partners on SRH and GBV

[19] UNFPA (2010)b, *op. cit.*
[20] See Annex 5.2 for the regional survey.

programming for emergency preparedness and response;

- Validate and complement findings of the desk review.

Following the survey and mapping exercise, six countries were selected for in-depth interviews[21]. And as humanitarian action is seldom properly documented, interviews with key informants are often one of the best ways to understand results.[22] Together with the desk review, the in-depth interviews complemented the information collected through the survey, especially in relation to past experiences for which knowledge may have been lacking, and helped expand on existing good practices and lessons learned.

The survey team worked closely with UNFPA LACRO throughout the process. As well as share relevant information and documentation, the Regional Office was instrumental in facilitating communication with country offices and consolidating feedback from stakeholders during the reviews of various parts of the study.

2.3 Scope and limitations

The study was conducted in two phases between May and October 2013 to glean information from various sources and through various methods. In the first phase, a thorough review of project documents, including proposals, reports and responses by country offices to the online survey allowed the team to map out all the initiatives implemented in the region between 2008 and 2012. The online survey was sent to all UNFPA Country Offices in Latin America and the Caribbean, asking them to contribute one to three experiences. Out of 21 country offices, however, only seven responded to the online questionnaire, sharing only one experience each.[23] Among those that did not respond, some said they had not experienced any emergencies in the past five years and therefore did not have anything to contribute to the survey. Others did not have comprehensive and reliable information to contribute due to the high turnover of staff during the emergency response.[24]

Desk review was also an integral part of this survey, and based on that, the online survey and some in-depth interviews with some selected country-based informants, a number of good and promising practices and lessons learned were ultimately identified (second phase).

This study did not benefit from any site visits to specific projects or programmes, however. This, coupled with the weak documentation of practices across the region, was among the challenges to a more comprehensive record of experiences. This is also why the study focused primarily on activities, and why it contains only selected specific analyses of the results. Similar to what happens in general in humanitarian situations globally, evaluations are limited in this region, and when they are carried out at all they are often focused on outputs rather than on the impact on the target population.[25] Yet the combination of online survey and interviews with field-based staff from selected country offices has provided the opportunity to expand this analysis to examine aspects that were not that clear or would not have emerged otherwise.

Only initiatives led or directly supported by UNFPA were profiled in this study. As mentioned earlier, given the limited number of evaluations documenting SRH and GBV programmes in humanitarian settings in the region, the study primarily relies on information provided by UNFPA staff both at the regional and country levels.[26] Among all the information gathered, that stemming from surveys and in-depth interviews was crucial for the selection and analysis of good practices.

[21] Bolivia, Ecuador, El Salvador, Guatemala, Nicaragua and Panama were targeted with in-depth interviews. Information about the Caribbean sub-regional office was collected only through an in-depth interview.
[22] Cfr. ALNAP (2013). Evaluation of Humanitarian Action - Pilot Guide. London: ALNAP.
[23] More precisely, Bolivia, Ecuador, El Salvador, Guatemala, Nicaragua, Panama and Peru.
[24] This was specifically the case in the Dominican Republic which, when contacted, said that the majority of staff that responded to the only relevant emergency in the past five years, namely the 2010 Haiti earthquake, had departed, taking with them the most qualitative information on the emergency response.
[25] Cfr. Hoffmann C. et al. (2004). Measuring the Impact of Humanitarian Aid - A Review of Current Practice. London: HPG-ODI.
[26] Please see Section 2.2 for a description of the methodology.

The methodology adopted, while helping to delimit the scope of the study and to make the voice of those involved in the implementation of the emergency response more prominent, did have a few limitations.[27] First, voluntary participation of respondents could have meant that some valuable experiences may have simply not been reported and analysed. Lack of mention in this study therefore does not necessarily reflect the lack of noteworthy experience in a given country. Second, leaving room for the respondents themselves to select what to report may have led to subjectivity biases on both the experience and the information reported therein. To provide one example, Bolivia, Colombia and Peru implemented activities with approaches similar to those of other countries in the areas of SRH and work with indigenous populations, [28] yet they decided to give priority to other experiences.

This study may therefore suffer from potential selection bias in some cases due to the non-random selection of participants and practices, and the information provided here certainly does not exhaust the richness of UNFPA's initiatives in the region. Nevertheless, it is the opinion of the research team that this report does reflect the level of documentation and information sharing that exists within the region, while providing an accurate account of what country offices decided to report on.

Finally, though individually documented, and covering a specific timeframe, practices and lessons that emerged from this study should not be considered in isolation. Rather, they are the result of an on-going process of experimentation, learning, and knowledge transfer that this study is designed to contribute to.

3 Main findings

Findings are arranged according to the two phases that characterized the study, the mapping/selection of study targets, and analysis of good practices on SRH and GBV in emergency contexts in the region.

Findings consist of:

1. General considerations drawn from the analysis of the mapping of SRH and GBV practices in humanitarian settings in LAC;
2. An overview of selected practices organized around key aspects found in different countries. An overview of all practices and their rating, such as how they fulfilled the criteria for selection, replicability, impact, partnership and coordination among implementers, sustainability, transformative power, community ownership and responsibility (Please see Annex 6.3);
3. A more in-depth description of selected practices per available information and relevance;
4. Lessons drawn from experiences in implementing specific projects;
5. An overview of challenges in SRH and GBV programming in humanitarian settings in the region over the past five years.

It was found that, for the majority of the projects considered for this study, and these were chiefly CERF and Flash Appeals, only the proposals were available, followed by little or no information about their actual implementation.

While mapping proceeded equally for all projects, for the selection and analysis of good practices, a decision was made to prioritize those reported through the survey or through other reports and documentation.

It is also important to bear in mind that many of the findings presented here reflect the opinions and perceptions of informants by methodology adopted. In the absence of any fieldwork, the research team had to rely on inputs of UNFPA staff as well as review of existing documents.

[27] See section 2.2 for a more detailed description.
[28] This information was shared with the research team by UNFPA LACRO.

3.1 Mapping of SRH and GBV humanitarian initiatives in LAC

The desk review and regional survey allowed for the mapping of 55 projects implemented in emergency settings in the LAC region in the past five years (Figure 1).[29]

Figure 1: Total SRH and/or GBV programmes mapped out, organized per country.

Among them, Haiti and Guatemala had the greatest number of projects on either GBV or SRH, or both. Both countries have a long history of emergencies. Haiti has been in a protracted crisis for the past 20 years[30] and that crisis was further aggravated by the 2010 earthquake. Guatemala has endured six natural disasters in the past five years. For Chile, Ecuador, Honduras, Panama and Venezuela, the study looked at one humanitarian project on SRH and/or GBV per country in the period under consideration and most of these projects were in the area of emergency preparedness.

UNFPA LACRO has been systematically engaging country offices on addressing SRH and GBV needs in emergency situations since 2008 and attention to these two issues was focused particularly between 2008 and 2011 with a series of *ad hoc* interventions to respond to immediate emergencies. There was then a slight increase in the interventions in 2012 (see Figure 2).

It was found that, while on average the number of projects designed to respond to a specific emergency in 2012 was more or less the same as previous years, Bolivia, Peru and Venezuela had also begun implementing emergency preparedness measures that included aspects of SRH or GBV.

In addition to *ad hoc* interventions, Colombia, El Salvador, Panama and the UNFPA Sub-Regional Office for the Caribbean implemented longer-term interventions as well, mainly aimed at building the capacity of local actors to address SRH and GBV in emergency contexts.

Other projects, though *ad hoc* as well, also did establish foundations for further activities in the future. One example was Ecuador, where, in 2008, an intervention to protect women, young people and children from GBV in shelters particularly in the cold season set the basis for the development of a national strategy implemented in 2012 to respond to GBV-related issues during emergencies. Similarly, a project in Haiti in 2008 to build capacity among youth groups to respond to SRH and GBV in emergencies allowed these youth to be mobilized after the 2010 earthquake.[31, 32]

[29] Projects reviewed were implemented in 14 countries plus the Dutch and English speaking countries that are part of the Caribbean sub-region, for a total of 36 countries.

[30] Harmer A. et al. (2004). Beyond the Continuum - The Changing Role of Aid Policy in Protracted Crises. London: HPG-ODI.

[31] UNFPA (2010)a. *Good Practices - Global Meeting 2010*. New York: UNFPA, p. 61.

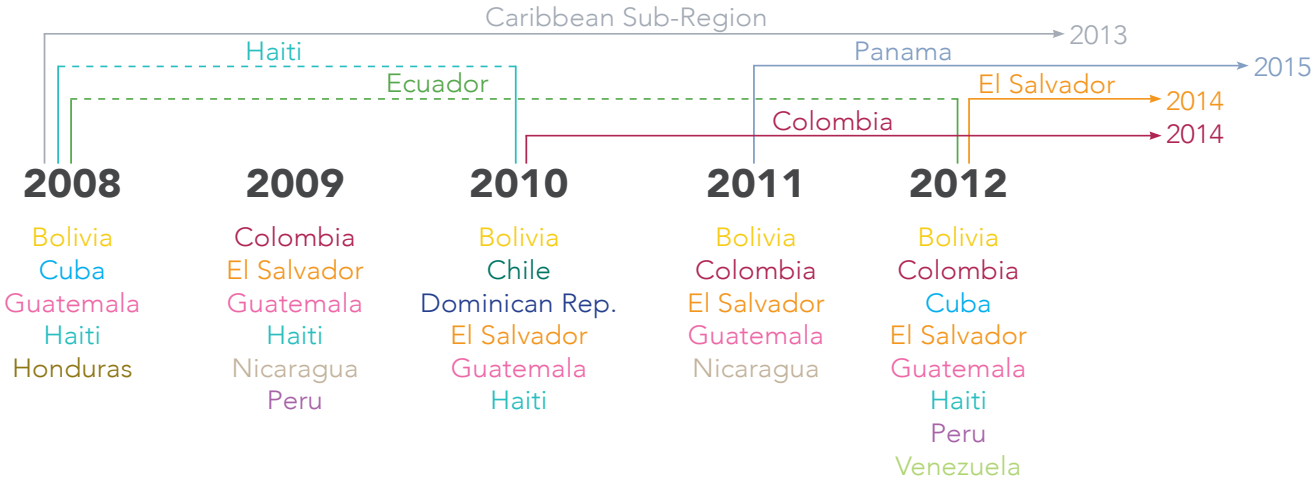

Figure 2: SRH and/or GBV projects implemented since 2008.

In evaluating capacity in general, the research team found that all country offices in the region did have humanitarian affairs focal points, but that this was often an add-on responsibility on top of many other responsibility rather than a full-time position. Only two countries were found to have had a full-time humanitarian affairs officer. Colombia had one local United Nations Volunteer (UNV) and Haiti had previously had this position.

Below are the percentages for the mapping carried out in this study. They represent the weight of each value describing a variable out of the total number of projects analysed.[33] This way of counting was necessary since, in each project, certain variables, such as type of activity, sectors of intervention or targeted population, could be described by a multiplicity of values. For example, since projects often entail more than one type of activity (variable), each activity (value) was accounted for separately in the analysis. Thus percentages do not always add up to 100.

Throughout these areas, CERF is the main funding mechanism used by UNFPA to implement SRH and GBV humanitarian interventions in the region.[34] As Figure 3 demonstrates, half of all projects analysed in the study were financed through CERF, 25.5% were through the Flash Appeals in response to specific crises and 23.6% were implemented directly by UNFPA outside the framework of specific appeals. And where CERF and Flash Appeals are responsive in nature, UNFPA mostly funded projects on preparedness. Exceptions to this include those projects implemented in the Dominican Republic in response to the 2010 Haiti earthquake, in Ecuador

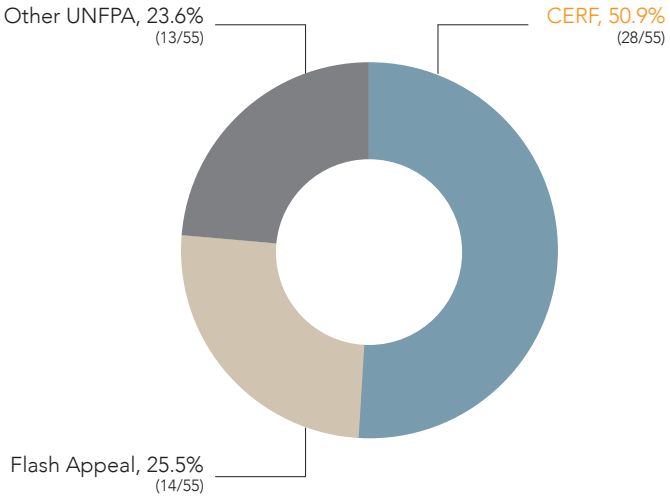

Figure 3: Frameworks used to implement SRH and/or GBV projects.

[32] There was no evidence of projects on SRH or GBV in the appeals activated in response to emergencies that affected Honduras and Paraguay during the years 2008, 2009, 2010 and 2012.

[33] More specifically, a calculation was made of the number of times different values were mentioned in projects. This was divided by the total number of projects.

[34] The CERF grant is intended to complement - not replace - funding made available through mechanisms such as Consolidated Appeal Process (CAP)/Common Humanitarian Action Plan (CHAP), Flash Appeals and Pooled Funds. Thus in practice, even CERF-funded projects are also supported by other sources of funding, which can include UNFPA funds or other pooled funds.

in 2012, in Haiti from 2008 to 2010 and in Peru in 2009, which were also responsive.

Following these events, the majority of interventions, reviewed (87.3%) were implemented in the **response phase**, and were normally short-term, of six months to one year. Just over 7% of these projects also contained a medium-to-long-term vision and combined response with recovery and rehabilitation activities.

One-fifth of the initiatives mapped were on preparedness while in only four projects (7.3%), activities covered both preparedness and response. These were the Gender-Based Violence Information Management System (GBVIMS) implemented in Colombia to collect GBV-related information in a systematic and uniform manner,[35] the integration of GBV in emergency response plans in Nicaragua in response to the Tropical Depression 12 E, and the two projects in Ecuador and Haiti described above.

Because SRH and GBV are key **areas of focus** for UNFPA, attention to them is roughly equal in the projects reviewed. Just over 69% of initiatives addressed SRH and 65.5% addressed GBV. Just over 34% of initiatives addressed SRH exclusively and 27.3% addressed GBV exclusively, while 34.5% considered them together. Mental health was specifically cited in 9.1% of cases, though always in association with either GBV alone or both SRH and GBV. Mental health-related activities were typically limited to psychosocial assistance to GBV survivors, yet an exception to this was Guatemala, where assistance did not focus exclusively on GBV but was also extended to the distress caused by the loss of family members, property and livelihoods.

It was also found that while SRH projects typically focus on the health-related needs of the affected population, 50% projects analysed were implemented from a health perspective and 50% from a protection perspective.[36] Health-related GBV projects included, for example, the clinical management of rape and the distribution of post-exposure prophylaxis (PEP) kits.

Yet the protection-related projects included a very diverse set of activities that ranged from raising awareness on GBV, to properly lit toilets, to capacity building on prevention of, and response to, GBV in emergencies.

Figure 4 below provides an overview of the main **sectors of intervention**. These sectors mostly reflect the type of activities implemented rather than a formal classification.[37] This is partially due to the fact that humanitarian clusters[38] have not been activated universally. For instance, Nicaragua had no protection cluster so protection instead fell under the health and shelter clusters, even when they had a clear protection component.

Health was by far the most common sector of intervention and this is consistent with the facts that the majority of UNFPA humanitarian interventions mapped were on SRH, and that half of GBV projects were health-related. Similarly, given that the other half of GBV projects were protection-related and that UNFPA is co-leader of the GBV AoR,[39] it follows that protection is the second most common sector of intervention. Just over 12% of projects analysed were within the shelter sector, while the remaining were in the early recovery, camp coordination and camp management (CCCM), water sanitation and hygiene (WASH), and education.

The study found that Capacity building was by far the most common activity implemented: 67.3% of the projects emphasized this need. Examples of capacity building activities included training of

[35] The implementation of the GBVIMS can be considered as a preparedness activity since local actors dealing with GBV survivors are trained and prepared on the use of the tool, and at the same time as a response activity since it helps the improvement of the response to GBV.

[36] The project implemented in Nicaragua in 2011 was in response to Tropical Depression 12E addressed GBV from both a health and protection point of view but without emphasis on either. The GBVIMS project in Colombia is just a tool to collect data.

[37] Though CERF and Flash Appeals are classified according to the UN humanitarian cluster system, formal classification was not maintained in the analysis because the intent was to highlight the type of activities actually implemented. It was not uncommon that projects classified under the Shelter cluster included also protection or health activities.

[38] For an overview of the clusters of the humanitarian response see http://www.humanitarianresponse.info/clusters, accessed 1 August 2013.

[39] Together with UNICEF.

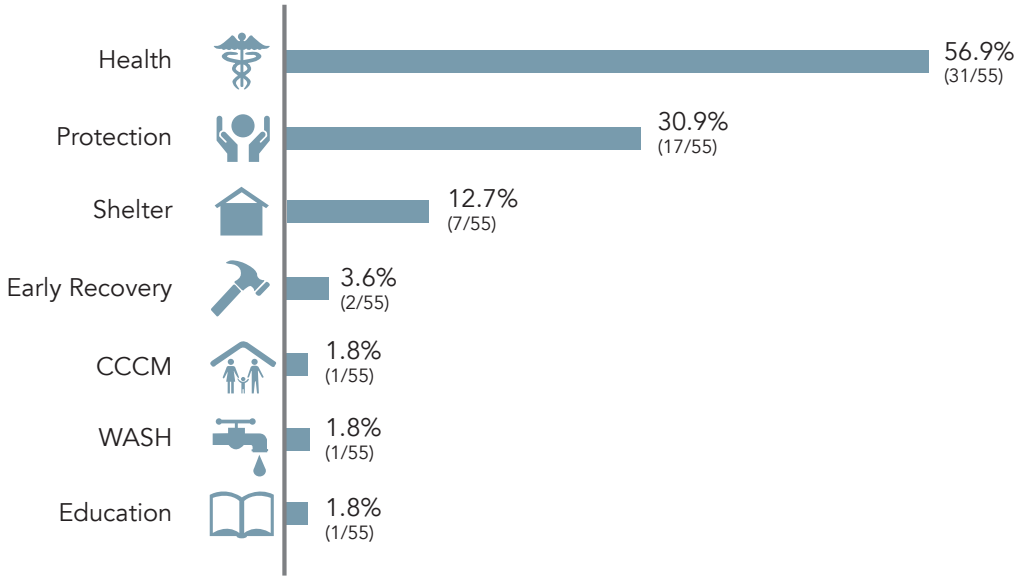

Figure 4: Main sectors of intervention of SRH and GBV projects.

trainers, strengthening or building outright the capacities of national actors such as the Ministry of Health or Women's and Social Affairs, and development of manuals and guidelines to support the implementation of SRH and GBV responses in humanitarian situations.

Capacity building is part and parcel of UNFPA's mandate and was the most commonly cited activity in the study.[40] Distribution of items was the second-most cited, being present in 54.5% of humanitarian interventions. Items cited in association with distribution include sexual and reproductive health kits as part of the MISP, dignity kits, flashlights and tents. Provision of services and awareness raising followed this, mentioned in 47.3% of initiatives. "Provision of services" included psychosocial support, medical treatment and family planning services to the affected population while "awareness raising" encompassed activities such as broadcasting of radio advertisements, development of information and sensitization material in various languages, including indigenous languages, as well as information, education and communication (IEC).

Slightly more than one-quarter of the projects included activities on data collection and analysis, for example the mapping of available services and resources, or assessment of protection risks. Technical assistance was included in 12.5% of projects, policy and strategy development in 7.3%, and coordination in 3.6%. Technical assistance provided by UNFPA consisted of support to national governments to procure and manage SRH supplies to respond to emergencies, strengthening of mechanisms on SRH and GBV in emergency situations, and development of data collection and rapid needs assessment tools.

For **population affected** by emergencies, specific groups were defined by their specific needs and vulnerabilities. Women were specifically targeted in 58.2% of projects, and young people and adolescents, mostly girls but also boys, in 30.9% of the projects. This was consistent with recent policy direction for UNFPA to expand and improve access to SRH for young people, also in humanitarian settings.[41] Men were also targeted, though in just 9.1% of cases. Yet in just a few cases were groups with specific needs and vulnerabilities targeted. These included persons with disabilities (3.6%), older people (3.6%) and indigenous people (1.8%).

Other activities were targeted to service providers (36.4%), which included nurses and midwives, including traditional birth attendants. In these cases, activities were meant to build their capacity on SRH and GBV-related tasks. Traditional birth attendants were trained on how to ensure safe labour for women giving birth in emergency situations and in the use of the delivery kits, while healthcare workers were trained on how to deal with GBV survivors in a safe and ethical manner. Other important target groups were government

[40] Part of UNFPA's mandate is to "build the knowledge and the capacity to respond to needs in population and family planning".http://www.unfpa.org/public/about/faqs#mandate.

[41] This is outlined in Outcome 6, 'Improved access to SRH services and sexuality education for young people (including adolescents)' of the Fund's Second Generation Humanitarian Strategy. UNFPA (2012), *op. cit.*, p. 19.

entities (23.6%), including civil defence mechanisms (5.5%); local NGOs (7.3%); and community leaders (9.1%).

For **implementation,** UNFPA relies on a wide range of local actors in the majority of projects (65.4%). In the survey, these included NGOs, National Red Cross Societies, community-based organizations (CBOs) and research institutes (34.5%). Individual actors from civil society, such as volunteers or healthcare providers, were included as well (3.6%). In 27.3% of the projects reviewed, the nature of local actors was not specified. Other local actors included various government entities. Ministries or local authorities were represented in 38.2% of cases, national civil defence mechanisms in 9.1% and armed forces in 1.8%. UNFPA was direct implementer in 61.8% of the projects considered and these activities included procuring supplies, building the capacity of local actors and raising awareness on SRH and GBV issues. Other UN agencies were mentioned as implementers in 14.5% of projects.

In 14.5% of cases, partners in the implementation of SRH and GBV interventions in humanitarian settings were other UN agencies, including the United Nations Children Fund (UNICEF), the Joint United Nations Programme on HIV/AIDS (UNAIDS), the World Health Organization (WHO) and the International Organization for Migration (IOM). Governmental entities, especially ministries of health or ministries of women's affairs, were partners in 30.9% of cases, including civil defence mechanisms in 3.6%; local actors were partners in 10.9% of cases, mainly CBOs.

Collaboration with these partners focused on several issues, including better coordination between UNFPA and partners to ensuring a more concerted, comprehensive and effective humanitarian response to the needs of affected population, while avoiding overlaps and waste of resources; the provision of technical inputs to UNFPA programmes; information sharing to enhance the planning of interventions; logistics for materials and personnel; managing the funds received through pooled funds; to monitoring implementation of projects.

UNFPA LACRO also plays a key role in the implementation of SRH and GBV initiatives in humanitarian contexts in the region. In 90.9% of cases, UNFPA provided technical and programmatic assistance, offering support for the development of project proposals, calculating number of RH and dignity kits needed, estimating number of beneficiaries, developing data collection and rapid needs assessment tools and supporting development of situation reports (SitReps). In 23.6% of cases, LACRO supported the response with direct operations.

In 20% of cases reviewed, LACRO had also facilitated coordination between country offices and the United Nations Office for the Coordination of Humanitarian Affairs (OCHA) or other humanitarian actors through the Inter-Agency Working Group on Risk, Emergency and Disasters for Latin America and the Caribbean (REDLAC).[42] REDLAC is the regional inter-agency working group on disaster reduction, preparedness and response. And UNFPA LACRO also directly funded a significant number of interventions on SRH or GBV (16.4%).

Table 1[43] shows the **sources of funding** and coverage of SRH and GBV projects included in the mapping. CERF, Flash Appeals, UN agencies other than UNFPA and affected governments are indicated as sources of funding external to UNFPA while funds coming from UNFPA LACRO, country offices and the Humanitarian and Fragile Contexts Branch (HFCB) are considered as internal to UNFPA. For each year and source of funding, the table below gives an average of how much has been covered out of the total amount of funds requested for the projects, as well as a breakdown of that funding. This provides an overview of trends and of the differences among different projects.

[42] Created in 2003, REDLAC is a platform for the exchange of information, joint planning and common activities to prepare for, mitigate and respond to natural disasters in the LAC region.

[43] Long-term projects that were ongoing at the time of writing were included in the analysis of the sources of funding, since these can vary during implementation. For those that had already concluded, the first year of the project was considered for the analysis. For six of the projects, this type of information was missing and hence not included.

Table 2: Sources of funding and coverage of SRH and GBV projects per year, 2008 to 2012.

		2008 (%)	2009 (%)	2010 (%)	2011 (%)	2012 (%)
External	CERF	72.1; 11.3	79.9; 42.7; 84.5; 58.3	47.9; 26.2; 71.5; 16.7; 19.9; 3.2; 5.7; 61.2	16; 7.6; 66; 50.3; 59.5; 78.2; 58.2; 55.6	92.4; 22.5
		Average: 41.7	Average: 66.4	Average: 31.5	Average: 48.9	Average: 59
	Flash Appeals	100; 42; 71	39.5; 43; 5.8	42; 100; 25; 69; 107; 100; 73; 9; 88; 9		53; 100
		Average: 71	Average: 29.4	Average: 62.2		Average: 76.5
	UN agencies	12.5			3.8	
		Average: 12.5			Average: 3.8	
	Government	25				71.4
		Average: 25				Average: 71.4
UNFPA	LACRO	62.5			44.4	90.2; 7.5; 19.1; 100; 29.3
		Average: 62.5			Average: 44.4	Average: 49.2
	Country Offices				22.6; 21.8; 41.8	9.8; 28.6; 80.9; 70.7
					Average: 28.7	Average: 47.5
	HFCB		21.1; 17.8; 41.7	131.4		19.9
			Average: 26.9	Average: 131.4		Average: 19.9

CERF appeared to be the most consistent source of funding. Flash Appeals were also common, but with varying intensity. The majority of Flash Appeals funds were received in 2010, at the time of the earthquake in Haiti, which remains the most funded emergency in the region over the past five years.[44] Apart from this, the Government of Ecuador contributed funds to the two-phase project described above together with UN Women, while UNICEF financed a small part of the project implemented in Bolivia in response to the 2011 floods caused by "*La Niña*". UNFPA LACRO and country offices have contributed funding over the past two years, while HFCB contributed to the project implemented in the Dominican Republic, again in response to the 2010 Haiti earthquake.

[44] To see funding trends in the region by year, see the Financial Tracking Service Trend Analysis at http://fts.unocha.org/pageloader.aspx?page=Trend-TrendAnalysis. In addition, in 2010, Haiti was the leading recipient of worldwide official humanitarian aid, http://www.globalhumanitarianassistance.org/countryprofile/haiti, accessed 1 August 2013.

Ultimately, funds 'external' to UNFPA have represented a regular and reliable source of financial support while UNFPA funds for SRH and GBV interventions at the country and regional levels have become more significant in recent years.

Getting results

While this study looks mostly at activities, it also looks at **results** achieved with SRH and GBV activities in emergency settings during the past five years, activities that had either a direct impact on beneficiaries or an institutional impact on the actors involved in the emergency response.

Though populations affected by emergencies are the target audience of UNFPA humanitarian initiatives in the region, the actual impact on these populations is rarely documented. Exceptions to this are the GBVIMS project in Colombia, where improvements in the lives of GBV survivors and in GBV services have been achieved; the psychosocial support project implemented in Guatemala in response to Tropical Depression 12E, where women became aware of GBV prevention and response mechanisms thanks to the sensitization sessions implemented; and the improvements observed in the shelters in Nicaragua specifically with regard to protection against GBV.

The impact on institutions and actors involved in the emergency response is in turn better documented. The result cited most often was the inclusion of SRH and GBV in national emergency preparedness and response plans, both when it was the actual objective of the activity and when it resulted from capacity building and awareness

Figure 5: Countries in which good practices were identified, highlighting their area of focus.

raising activities implemented by UNFPA. In Bolivia, state actors, in partnership with UNFPA and other humanitarian actors, developed a strategy for GBV in both preparedness and response together with an 'engagement act' for its operationalization. Five countries in the Caribbean sub-region that had been the focus of capacity building activities also included SRH protocols in their national contingency plans. In Nicaragua as well, GBV prevention and response was accounted for in national preparedness activities thanks to UNFPA's long-term engagement with both GBV and humanitarian actors in the country.

Another common result found was change of mind-set and perception of SRH and GBV. After systematic capacity building and sensitization activities, some countries in the Caribbean sub-region recognized SRH as a lifesaving issue worth particular attention in disaster preparedness and response, and acknowledged the leading role of UNFPA on this. In El Salvador, participants in the response to Tropical Depression 12E are now asking to be trained on SRH and GBV, and some of the participants in trainings for service providers have stated that the training also had a positive impact on their personal life, changing the way they look at SRH and GBV.

3.2 Good practices and lessons learned

This section presents and analyses good practices and lessons learned on GBV and SRH in emergency contexts. Findings are grouped according to key aspects and are presented qualitatively. Figure 5 below shows the countries from which the analysis of good practices and lessons learned were derived.

Table 3 below also provides an overview of how practices have been rated, while a more detailed description of the key aspects that formed the basis of the analysis and selection of good practices can be found in the matrix for selection of good practices attached as an annex.

Table 3: Rating of selected practices.

Project	Criteria		# satisfied criteria	Classification
Bolivia "The consultants left the wording of the projects without translation to respect the reference, but you're right… I have included translation – let me know what you think… maybe we can keep both? Some read very weird in English" National strategy to prevent and respond to gender based violence, with emphasis on sexual violence, in emergencies	Relevance	✔	5 out of 7	**Good practice**
	Replicability	✔		
	Impact	✔		
	Partnership and coordination	✔		
	Sustainability	✔		
	Transformative			
	Community ownership and responsibility	✔		
Caribbean sub-region "Capacity building on the integration of SRH through MISP and SPRINT training in the emergency response of 22 countries in the sub-region"	Relevance	✔	6 out of 7	**Good practice**
	Replicability	✔		
	Impact	✔		
	Partnership and coordination	✔		
	Sustainability	✔		
	Transformative	✔		
	Community ownership and responsibility			
Colombia "Sistema de gestión de datos sobre violencia basada en género (GBVIMS)" "Gender-based violence Information Management System"	Relevance	✔	6 out of 7	**Good practice**
	Replicability	✔		
	Impact	✔		
	Partnership and coordination	✔		
	Sustainability	✔		
	Transformative			
	Community ownership and responsibility	✔		
Ecuador "Convivir en emergencias sin violencia, de la practica a la política" "Living in an emergency together, without violence"	Relevance	✔	6 out of 7	**Good practice**
	Replicability	✔		
	Impact			
	Partnership and coordination	✔		
	Sustainability	✔		
	Transformative	✔		
	Community ownership and responsibility	✔		
El Salvador "Integración de SSR en la respuesta ante situaciones de emergencia mediante la implementación del PIMS" "Integrating sexual and reproductive health into emergencies through MISP implementation"	Relevance	✔	6 out of 7	**Good practice**
	Replicability	✔		
	Impact	✔		
	Partnership and coordination	✔		
	Sustainability	✔		
	Transformative	✔		
	Community ownership and responsibility			

El Salvador "Integración de SSR, igualdad de género y prevención de violencia por razón de género en planes de atención por desastres" “Integrating sexual and reproductive health, gender equality and prevention of gender-based violence into disaster assistance plans”	Relevance	✔	4 out of 7	**Promising practice**
	Replicability			
	Impact	✔		
	Partnership and coordination	✔		
	Sustainability	✔		
	Transformative			
	Community ownership and responsibility			
Guatemala "Promoción de espacios seguros y libres de violencia y atención psicosocial y cultural a mujeres, adolescentes y niñas en situación de albergues y comunidades afectadas por el terremoto del 7 de noviembre de 2012, Guatemala" “Promotion of spaces that are safe and free from violence that provide psychosocial and cultural support to women, adolescent and girls in shelters and communities affected by the earthquake of 7 November 2012”	Relevance	✔	6 out of 7	**Good practice**
	Replicability	✔		
	Impact	✔		
	Partnership and coordination	✔		
	Sustainability	✔		
	Transformative			
	Community ownership and responsibility	✔		
Haiti "Youth mobilization and participation to UNFPA humanitarian response"	Relevance	✔	6 out of 7	**Good practice**
	Replicability	✔		
	Impact	✔		
	Partnership and coordination			
	Sustainability	✔		
	Transformative	✔		
	Community ownership and responsibility	✔		
Nicaragua "Prevención y atención de la violencia basada en género en situaciones de emergencias" “Prevention and response to gender based violence in emergency situations”	Relevance	✔	7 out of 7	**Good practice**
	Replicability	✔		
	Impact	✔		
	Partnership and coordination	✔		
	Sustainability	✔		
	Transformative	✔		
	Community ownership and responsibility	✔		
Panama "Atención en situaciones humanitarias" “Assistance in humanitarian settings”	Relevance	✔	5 out of 7	**Good practice**
	Replicability	✔		
	Impact	✔		
	Partnership and coordination	✔		
	Sustainability			
	Transformative			

	Community ownership and responsibility	✔		
Peru "CERF: Support for collective centre management, shelter and NFIs"	Relevance	✔	6 out of 7	**Good practice**
	Replicability	✔		
	Impact			
	Partnership and coordination	✔		
	Sustainability	✔		
	Transformative	✔		
	Community ownership and responsibility	✔		
Venezuela "Formación del personal de protección civil y administración de desastres en violencia de género y salud sexual y reproductiva y fortalecimiento de la mesa técnica para la recolección de información en emergencias" "Training on gender based and sexual violence and sexual and reproductive health for civil protection and disaster administration staff and strengthening of the technical table for data gathering in emergencies"	Relevance	✔	3 out of 7	**Promising practice**
	Replicability	✔		
	Impact			
	Partnership and coordination	✔		
	Sustainability			
	Transformative			
	Community ownership and responsibility			

Multi-sectoral and multi-institutional approach

This study revealed that UNFPA's role across the region is largely that of a facilitator and catalyser that brings together and promotes coordination and partnership among diverse actors from various sectors and levels of intervention. This is further strengthened by UNFPA's role as advocate for the creation and enforcement of SRH and GBV policy, including in emergency situations.

Linking levels, actors and sectors of intervention creates the conditions for both GBV and SRH issues to be understood and addressed from different angles, depending on the context and the interactions between relevant cultural, social and political factors. It allows for the optimization of existing resources and expertise through joint programming, collaboration and coordination. It also ensures an integral approach to GBV and SRH. For example, in El Salvador the collaboration between the Ministry of Health and the Instituto Salvadoreño de la Mujer (ISDEMU) enhanced the exchange of knowledge between SRH and GBV actors, ensuring that the two issues were integrated into the national contingency plans and also ensuring that all actors acknowledged that they had to contribute. In Ecuador, ministries, local NGOs and civil society all worked together on policy for GBV prevention and response in emergency shelters and for the protection of SRH rights of affected populations. They established inter-sectoral teams for emergency response that comprised both governmental entities and civil society organizations. Bolivia also had a similar experience, where national policy to address GBV in emergencies was a joint effort between different ministries, UN agencies, a consortium of NGOs operating in Bolivia and the national Red Cross Society.

In Nicaragua, this multi-sectoral and multi-institutional approach translated into the creation

of linkages between long-term actors on GBV prevention and response and humanitarians. There, UNFPA played a significant role, first in the establishment of an inter-ministerial committee on GBV (2010), which later included the variable of GBV in emergencies, and then in the incorporation of GBV in the Sistema Nacional para la Prevención, Mitigación y Atención de Desastres (SINAPRED) response to emergency situations. As the *trait d'union* between the two entities, and working closely with both over the years, UNFPA was able to promote the development of a common vision on SRH and GBV as well as to identify synergies and common areas of work. Respondents in Nicaragua also cited regular and systematic engagement on GBV with local actors and institutions, as well as concrete opportunities for implementation through CERF funds, as key factors of success.

This is of particular interest, as a study on the linkages between GBV and emergencies caused by natural disasters in the LAC region conducted in 2010 and 2011 found an absence of intersections between traditional GBV actors and those in charge of disaster management.[45] More specifically, with reference to Nicaragua, the study pointed to the lack of references to GBV in SINAPRED judicial instruments, coupled with a general lack of representation of women's issues among the members of SINAPRED.

This "multi-dimensional" approach also helps to integrate mental health concerns into emergency response. El Salvador has already provided one example of how integrating family planning, HIV, maternal care and neonatal care with GBV and mental health ensures that these issues will be properly addressed during an emergency. For example, during Tropical Depression 12E, mobile clinics equipped with a gynaecologist/obstetrician and an educator allowed emergency teams to respond to the multiple needs of the affected communities, including prevention of maternal and neonatal mortality and morbidity, prevention of HIV, GBV prevention and response, promotion of SRH and GBV referral systems, and data collection on SRH. This experience also demonstrates how coordination among different levels is essential for the effective integration of SRH and GBV in humanitarian response. Lessons learned from the El Salvador country office highlight that the close collaboration between the political and technical levels of the Ministry of Health and the central, regional and local levels guaranteed the success of the intervention.

The adoption of an integral approach through partnership and coordination with other organizations on the ground has also been a key factor of success in Guatemala, where UNFPA provides emergency kits for women, UNICEF provides emergency kits and services to children and pregnant women and IOM supports men in restarting work.

[45] UNFPA (2011). Gender-based Violence and Natural Disasters in Latin America and the Caribbean. UNFPA LACRO: Panama.

Box 1. Nicaragua - "Preventing and addressing gender based violence in emergency situations"

In 2011, Tropical Depression 12E affected almost 150,000 people in Nicaragua.[46] Working in close collaboration with the Secretaría Ejecutiva del Sistema Nacional para la Prevención, Mitigación y Atención de Desastres (SE-SINAPRED), the Ministerio de la Familia (Ministry of Families) and the Instituto Nicaragüense de la Mujer (INIM), UNFPA set up an initiative to protect women and children from GBV in temporary shelters.

UNFPA Nicaragua was instrumental in providing relevant information and technical inputs to the inter-ministerial committee on GBV, while advocating for the inclusion of the issue in the national emergency response plans. Building on the trust gained by systematically working on GBV over the years, the office in Nicaragua accompanied negotiations over a period of six months between SINAPRED and the Ministry of Family and INIM to incorporate GBV into SINAPRED's contingency plans. CERF funding provided an opportunity to put this into practice.

One key element of success was the selection of certain key actors in both GBV and humanitarian response with the capacity and willingness to engage a much larger group of actors for an integrated response. In the words of one respondent to the survey in Nicaragua, "Three institutions engaged eleven other institutions on the issue, ensuring an integral approach between GBV actors and those focusing on humanitarian response".

The experience of Nicaragua fulfils all seven good practice criteria, with **partnership and coordination** being particularly prominent. The sensitization and capacity building work targeted at SINAPRED as well, as at GBV actors, exemplify the **transformative** nature of the project. Here, GBV was integrated into emergencies as well as into national legislation and national processes, and a new manual helped systematize the experience in the shelters. This formed the basis for interventions to be **sustainable**. A data collection and management tool developed in response to Tropical Depression 12E is available now and could be re-circulated if necessary, as could the experiences shared with other country offices (**replicability**).

It was also found that involving the local population in the promotion of GBV prevention addresses the need for **community ownership and responsibility**. As one example of the **impact** of this work, temporary shelters were improved with community involvement to ensure privacy and safety through adequate lighting and allocation of more space. The initiative is now in line with Outcome 5[47] of UNFPA's Humanitarian Response Strategy 'Second Generation' and LAC Aligned Humanitarian Strategy (**relevance**).

[46] CEPAL (2011). Resumen Regional del Impacto de la Depresión Tropical 12-E en Centroamérica. Cuantificación de Daños y Pérdidas Sufridos por los Países de la Región en el Mes de Octubre de 2011. UN: Ciudad de México.
[47] Outcome 5 of the Second Generation Humanitarian Strategy reads, "Gender equality and reproductive rights advanced particularly through advocacy and implementation of laws and policy".

Enhanced data collection and management on GBV and SRH

Colombia and Haiti are the only countries in the region to have adopted the Gender-Based Violence Information Management System (GBVIMS).[48] However, while Colombia has had a positive experience with implementation of the GBVIMS, Haiti experienced problems in the rollout of the tool after the 2010 earthquake. According to informants from UNFPA Haiti, the large number of actors working in the country posed then, and still poses, a challenge to GBVIMS because there are too many different data collection systems already in place and resistance to a standardized approach.[49]

The experience of Colombia is in line with the purpose of the GBVIMS. By using standardized tools and definitions, the system has allowed for safe and "ethical" information sharing among stakeholders. In addition, the survey found that systematic collection and analysis of GBV data served to improve GBV services. Sharing of a common system of collection and analysis created the opportunity for the establishment of new partnerships and joint activities.

Standardization was also found to have brought to light gaps and challenges in existing GBV data collection and management, and contributed to more informed and focused efforts toward strengthening and improvement. (See Box 3 for a comprehensive list of results.)

[48] The GBVIMS is an initiative by UNHCR, UNFPA, IRC, WHO and UNICEF to harmonize data collection on GBV in humanitarian settings. The intention is to enable humanitarian actors responding to incidents of GBV in the areas of health, justice and psycho-social assistance to collect, store and analyse GBV incidents as well as to share data both internally and externally for trend analysis and improved coordination. Thus far, GBVIMS has been implemented in 18 countries. In the LAC region, the system has been implemented in Colombia and Haiti. More information on the initiative can be found at: http://www.gbvims.org/what-is-gbvims/.

[49] No public information was found on the implementation of GBVIMS in Haiti. The information included in the study was derived from a phone meeting on 29 August 2013.

Box 2. The need for structured data collection and management systems on GBV and SRH

Healthcare workers are often the first providers of help to GBV survivors. For women, a visit to a health clinic may be the only chance to end abuse. Yet service-based data, typically compiled by healthcare facilities, police stations, courts, housing, and social welfare services, hotlines and shelters, tell only a part of the story, as only those who are severely injured and have the resources end up travelling to a hospital. Similarly, only those who seek redress, or who have received more, tend to resort to the police or human rights organizations. In the absence of other data however, existing studies and research on these subjects draw on hospital and police records,[50] thus missing part of the reality.

Ultimately, data on SRH are collected by a variety of actors, including government entities, public health services and humanitarian actors, each with their own system and their own priorities. Data therefore tend to respond to the needs of the data collectors rather than reflect the needs of those affected. SRH data, in particular, depend on the attention given by the collecting actors to specific SRH issues, and the availability of services to collect them.

In the words of the UNFPA Executive Board, "accurate demographic and health data are the cornerstone of effective humanitarian response."[51] Hence the need for a structured approach to SRH and GBV data collection and management to allow a concerted and effective response in crisis situations.

[50] USIP (2013). Special Report: Wartime Sexual Violence, Misconceptions, Implications, and Ways Forward. Washington, DC: USIP.
[51] UNFPA (2010)c. Guidelines on Data Issues in Humanitarian Crisis Situations. New York: UNFPA, p. 11.

The research team found that UNFPA Nicaragua has also started working on standardizing GBV data collection and management in the framework of the 2011 response to the Tropical Depression 12E. Recognizing that information on GBV was highly scattered among actors, and that different databases and data collection systems were being used, the office started working on the creation of a common database on GBV in emergency shelters. To overcome the resistance of some government ministries to GBVIMS, UNFPA Nicaragua worked with them on the development of a new database inspired by GBVIMS and designed for use in the emergency shelters. Although by the time it was approved, most of the people in the shelter had left and the system was never implemented. Yet this should not be seen as a vain effort. The experience and the knowledge acquired, as well as the interest in the implementation, are significant.

Unfortunately, similar efforts have not been made in relation to SRH elsewhere. Evidence shows that country offices and humanitarian actors rely heavily on data provided by the national ministries of health or other institutions, such as national institutes for statistics or civil defence mechanisms. This is the case in Cuba, Guatemala, El Salvador, Ecuador, Bolivia and Haiti. One problem with these national databases is that they do not always include sex and age-disaggregated data on SRH, such as in Guatemala and Bolivia, or do not differentiate between emergency and non-emergency settings, such as in Ecuador and Guatemala. UNFPA Country Offices did make some effort to strengthen the capacity of ministries and health institutions to collect SRH data for emergency preparedness or in times of emergency, and UNFPA Bolivia did advocate with the Instituto Nacional de Estadística (INE) and the World Bank for an SRH database to be used in humanitarian crises, although it was not implemented and this undermined the success of the initiative. Through SPRINT and MISP trainings meanwhile, UNFPA Ecuador is continuously advocating the importance of SRH data collection in emergencies and UNFPA Guatemala has made efforts to get SRH included in the work of the National Institute for Statistics, for both emergency and non-emergency purposes. Cuba has also worked to build capacity on the collection of SRH data, though not with a focus on emergencies. UNFPA Haiti did fund an SRH survey after the 2010 earthquake and supported the 2012 Mortality, Morbidity and Service Utilization Survey (EMMUS-V), which included data on SRH, GBV and HIV. These studies could be used as a baseline for the implementation of a standardized tool for the collection of SRH data.

In the framework of the national Equipo Técnico de Emergencias de Naciones Unidas (UNETE),[52] UNFPA El Salvador has also begun to include SRH and HIV in forms used by civil defence organs to assess the impacts of disasters and the needs of the affected population, called 'Evaluación de Daños y Análisis de Necesidades' (EDAN). Yet EDANs change every time there is an emergency, thus there has been no standardization of the system.

Among the other challenges to standardization of SRH data collection is the fact that SRH is still not prioritized in emergencies. Material damages and loss of livelihoods are prioritized, and a lingering lack of collaboration among humanitarian actors, as well as difficulty agreeing a common approach, also hamper data collection.[53]Honduras, Peru and the Caribbean sub-region have also reported that no standardized tool to collect SRH data in emergencies currently exists, and there appear to be no plans to put it in place in the near future.

[52] UNETE is an inter-agency working group present in almost every LAC country, with the purpose of supporting the UN system to prevent and respond to natural disasters and humanitarian emergencies.

[53] When enquiring on a standardized tool for the collection of SRH data in emergencies, the research team did not ask for the challenges encountered. The findings here therefore only refer to Guatemala, which voluntarily recounted them. However, from the overall analysis of the findings, it is reasonable to think that these obstacles could be similar to other countries in the region.

Box 3. Colombia - "Gender Based Violence Integrated Management System (GBVIMS)"

Colombia has a national database that includes GBV (SIVIGILA),[54] under the auspices of UNFPA and the United Nations High Commissioner for Refugees (UNHCR). It has also adopted GBVIMS to standardize and compare data on GBV and to allow the access to, and exchange of, information. The objective is to improve GBV response.

The implementation of this system demonstrates some good practices. Where many countries in the region rely mainly on local NGOs for implementation, in Colombia, **partnership and coordination** is mainly with state authorities, especially municipalities, as well as civil society, such as women's organizations, as well as with UNHCR. This fosters the understanding that GBVIMS is a tool for, and owned by, the municipalities rather than the UN. This contributes to the **sustainability** of the system as well as to **community ownership and responsibility**, especially considering that initial implementation was only in those municipalities where services for the response to GBV were already present. Colombia has also adopted an innovative approach to registering GBV cases, developing a web platform that allows quick and safe information sharing while avoiding the re-victimization of GBV survivors. Protection and confidentiality of this data collected is also of primary concern, as demonstrated by a protocol on the ethical and safe exchange of data that all actors using the GBVIMS have to sign.

Three years into the project, there have been multiple positive **impacts.** There has been positive change in the lives of GBV survivors and this is chiefly owing to the improvement in services provided and to the empowerment of communities and women's organizations, which are also more active now in denouncing GBV.

This successful implementation in Colombia is now paving the way for the GBVIMS to be **replicated** in other countries in the region. This initiative is also in line with Outcomes 2[55] and 5 of UNFPA Humanitarian Response Strategy 'Second Generation' and LAC Aligned Humanitarian Strategy (**relevance**).

[54] UNFPA and UNHCR (2012). Implementación del Sistema de Gestión de Datos sobre Violencias Basadas en el Género - GBVIMS en Colombia 2011-2012. New York, Geneva: UNFPA and UNHCR.

[55] Outcome 2 of the Second Generation Humanitarian Strategy reads, "Increased access to and utilization of quality maternal and newborn health services." However, reference is also made to services for the prevention and response to GBV.

A truly culturally sensitive approach

Operating in contexts characterized by diverse social and cultural realities creates both challenges and opportunities for SRH and GBV. Dealing with, and changing, attitudes, behaviours, and mind-sets on such sensitive issues can therefore be a complex task.

Viewing the issue through a cultural lens helps to clarify the realities of societies in which these programmes are delivered, and thus increases the chance that they will be effective. It is also only through this culturally sensitive approach that the beliefs and practices that could facilitate the acceptance of a specific intervention can be identified and leveraged.

Guatemala provides a good example. There the research team found that a key factor of success was a partnership established with the local NGO, Equipo de Estudios Comunitarios y Acción Psicosocial (ECAP), for their presence in targeted communities. They offered knowledge of the indigenous language and facilitated long-term work on building the capacity of local therapists on GBV with due attention to the local culture, spirituality and beliefs.

Working with people with an expertise from a particular context and community facilitated interactions with the affected community, especially if they are of indigenous origin.[56] Their knowledge of customs and traditions as well as of the spirituality and rituals not only facilitated the provision of psychosocial support but also constituted a fundamental gateway to better communication with the affected populations. The project team was better able to understand their needs and how to better address them, and their approach also allowed connection with other humanitarian actors. This experience is even more relevant when we consider that psychosocial support is not particularly common in these contexts.

UNFPA Panama also integrated an intercultural dimension when building capacity among indigenous people. The Panama country office included a session where indigenous community leaders were taught how to perform a puppet show on SRH and GBV. This approach was chosen for its potential to involve all members of the indigenous community through a common language that allowed talk on sensitive matters in a simple way, and also encouraged the audience to identify with the issues represented.

[56] An example of working with traditional birth attendants from indigenous communities to integrate them in the official health system was found in UNFPA (2010)a, *op. cit.*, p. 55. In addition, one reference to this was found in a CERF project proposal from Guatemala in 2009. There, traditional birth attendants were the target audience for capacity building activities on emergency delivery. This should help guarantee that SRH rights are respected and well taken care during emergencies, when indigenous people may become even less accessible.

Box 4. Guatemala - "Promotion of spaces that are safe and free from violence and that provide psychosocial and cultural support to women, adolescents and girls in shelters and communities affected by the earthquake of 7 November 2012."

After Tropical Storm Agatha, which hit Guatemala in 2010, UNFPA started working with ECAP, a Guatemalan NGO specializing in psychosocial support to affected populations, and which employs women therapists from different indigenous communities. All ECAP therapists are bilingual in Spanish and one indigenous language, in this case *Man*, and have a deep understanding of cultural norms that underpin Maya spirituality. This allowed ECAP therapists to agree with affected women on the most culturally appropriate psychosocial support needed to overcome the distress caused by the 2012 earthquake. Through an individual approach, but also in collective meetings, the therapists organized '*jornadas del susto*' (days of the shock) and other traditional Maya ceremonies to help affected women rebuild their lives after the trauma. The objective was to minimize trauma, to repair the social fabric and to regain trust. Though initially only women were targeted by this intervention, later the project also addressed shelter leaders and national institutions working closely with the affected population to make them aware of GBV risks and responses.

This approach was found to have a high degree of **sustainability** and to rely greatly on **community ownership and responsibility**. The project made affected women aware of their rights and of existing mechanisms for the prevention of, and response to, GBV (**impact**). This, together with the cultural sensitivity that characterized the project, was indicated by respondents as key aspects for **replicability**. The project is also an example of effective **partnership and coordination** among ECAP, UNFPA, UNICEF and IOM.

As well as being in line with outcomes 2 and 5 of UNFPA's Humanitarian Response Strategy 'Second Generation', and with LAC's Aligned Humanitarian Strategy, this initiative is also in line with the LAC Aligned Humanitarian Strategy for "Participation of vulnerable populations in emergency preparedness, response and recovery planning and implementation" (**relevance**).

Making disaster preparedness and relief inclusive

Evidence from emergencies has also shown that gender and sexuality concerns are often sidelined due to lack of understanding and feeling of unease in dealing with them. There is also lingering discrimination and stigma. Emergency situations also often exacerbate prejudices and make marginalized people even more vulnerable. The distress caused by emergency situations can bring this discrimination out or can cause it to intensify. Moreover, traditional ways of providing assistance, such as through family units for example, do not necessarily work for all those affected. For example, lesbian, gay, bisexual and transgender members of the community (LGBT) may be left out.

The research team found that these issues above are echoed in most of the disaster documentation and protocols. For example, shelter protocols are generally silent on how to care for LGBT.

Thus, in the absence of protocols and guidance on this, UNFPA El Salvador has been dealing with the issue from a human rights perspective while trying to build on and systematize their experience. The issue of sexual diversity came out strongly in capacity building activities that they organized on the MISP, including reference to practical aspects, such as where to place LGBT in emergency shelters and which bathrooms they should be using.

Attention to, and active engagement of, young people on SRH and GBV

Young people often form a large proportion of those affected by crises and reaching out to youth is key in emergency situations, not only for their specific vulnerabilities but also for their ability to

act as agents of change in their communities, to influence their peers, and for the help they can provide. Youth are also best positioned to "sustain" gender transformation given the influence on future generations.

Still, while almost one-third of the projects analysed mentioned youth as a specific target, information on implementation was only available in a few cases. One such project was youth mobilization and participation in UNFPA's humanitarian response efforts in Haiti in 2008. Regular engagement of the 150 young people that were mobilized to distribute dignity kits after the 2008 hurricane season allowed UNFPA to easily mobilize them again when the earthquake hit in 2010. Following this, UNFPA Haiti included a list of ready-to-be-deployed young people in its contingency plans. Engagement of young people also resulted in activities being adapted to the needs and capacities of the youth, while having strong transformative potential, particularly on how the next generation will look at GBV or SRH.

Active engagement of young people and adolescents was also found in Ecuador in the response to the intense rain during the 2008 winter season that displaced almost 15,000 people, 70% of whom were women, adolescents and children. Owing to the educational and pedagogical sway they held over their peers,[57] youth organizations such as Ponte Once were involved in peer-to-peer capacity building and sensitization activities on SRH and rights, and on GBV prevention and response directed at adolescents living in temporary shelters. Efforts targeted not only girls but also boys for their potential as agents of change. This was possible also thanks to the long-standing engagement of UNFPA with capacity building for the youth on SRH and rights and GBV. Young people were also involved in the development of key awareness raising messages addressing the affected populations as well as national authorities on the unacceptability of GBV as a 'normal' feature in emergency situations and on the rights of the affected population, according to a human-rights based approach.[58]

The need for a transformative approach

One key aspect highlighted in relation to various practices in the region was the need for a profound transformation in the mind-set of those engaged in actually providing the assistance, for a truly integral approach to SRH and GBV in emergency situations. Hence, the need for GBV and SRH programmes to embed a transformative approach or to build on changes in attitudes and behaviours that already occurred in the past.

Such transformation is often the result of the internalization of positive gender norms and understanding of the root causes that underpin GBV, just to provide an example, and how they can be changed, or how gender dynamics can affect maternal and new-born mortality and morbidity.

Examples of transformative actions range from changing the perception of communities and aid providers alike that GBV is acceptable and inevitable in emergencies, and changing the perception of affected populations as beneficiaries of the state's charity rather than rights holders (Ecuador). This also involves sensitizing decision makers on the importance of integrating SRH and GBV among lifesaving concerns in emergencies (Caribbean sub-region, Nicaragua) as well as challenging the perception that these issues are taboo (Ecuador). It involves engaging men and youth as agents of change against GBV as well (El Salvador, Haiti, and Ecuador) and also involves adopting a culturally sensitive approach to social structures and dynamics, such as 'machismo' in Nicaragua, Ecuador and El Salvador. These lingering norms perpetuate discrimination and violence not only against women but also against homosexuals and transsexuals, including in times of crises.

[57] Phone interview with a UNFPA Ecuador officer responsible for the implementation of the initiative, 10 September 2013.

[58] Examples of key messages are: 'La violencia no es natural', 'La violencia no es una situación que se presenta solo en condiciones de emergencia', 'Nada justifica la violencia', 'La persona violentada y que vive situaciones de emergencia no está sola, tiene derechos'.

Some respondents noted that systematic sensitization on the importance of integrating GBV and SRH issues into emergency preparedness and response is needed for this transformation to take place, again because of a lingering lack of common understanding of these issues among the various humanitarian actors. In Ecuador, following the discovery of resistance among personnel from various services to SRH and GBV (health, shelter, protection), sensitization was conducted for the implementing teams from various sectors. And sensitization on these issues is often needed not only for local actors, but also for personnel within UNFPA.

Building institutional capacity on GBV and SRH

Systematic investment in the integration of GBV and SRH across the disaster management cycle is essential for these issues to be taken into consideration when an emergency occurs. This includes strengthening the capacity of decision makers across key sectors of intervention, including in political, legislative, judicial, social, security, and health sectors to increase their effectiveness and accountability. It involves capacity building for relief staff and service providers in general to address GBV and SRH in disaster risk reduction and response policies, strategies and practices.

As the experience in Nicaragua demonstrates, integration of GBV in SINAPRED response plans and procedures was only possible after months of joint collaboration and systematic sensitization on these issues. Also, SRH and GBV can be effectively integrated into national strategies only if those in charge of the response are aware of, and familiar with, the issues. For example, in Ecuador capacity building and awareness raising conducted with personnel of the Ministry of Health and Ministry of Social and Economic Inclusion on SRH rights and GBV prevention and response were instrumental for the inclusion of both SRH and GBV in the national emergency response plans. Similarly, in El Salvador, a training-of-trainers approach was adopted to strengthen the institutional capacity of key actors to address SRH and GBV needs in emergencies.

The effort undertaken by the Caribbean sub-regional office to train government personnel, service providers and UNFPA staff on the MISP (2008-2013) in all 22 countries of the sub-region was also instrumental in the recognition of SRH as a life-saving concern. As a result, five countries included an SRH protocol in their contingency plans while three countries have requested the pre-positioning of the MISP kits.

In Bolivia and Ecuador, efforts focused on the institutionalization of GBV and SRH in emergency preparedness and response through development of national strategies and plans. More importantly, participation and consultation with a wide range of stakeholders in the development of the strategies contributed to increasing the visibility of GBV and SRH as well as to the creation of synergies and collaborative efforts on GBV prevention/response and on attention to SRH and rights across the disaster management cycle.

Community ownership and participation

Evidence from previous studies shows that GBV is often considered to be justified, and is sometimes even nurtured, by the culture, social practices, attitudes and beliefs that place women in a subordinate position. Legislation, regulations and policies at times also legitimise particular forms of violence. Similarly, SRH and rights are not considered as a priority and are often considered as an add-on in emergency contexts by authorities, governments and relief actors.

Changes in this regard could only happen from within and through wide mobilisation of key constituencies, as no outside views and perspectives could ever work unless people themselves perceived them as beneficial. Thus, projects that encourage people to find new ways of looking at reality, and mobilise communities towards change, have greater potential to be effective. Engagement of relevant stakeholders, including police, health providers, decision makers, media, religious leaders and traditional

leaders, particularly at the local level, is also essential for projects to be effective.

It is also only through consultations and understanding of the realities on the ground that it is possible to identify those who have the capacity to motivate communities to accept ownership of programmes.

UNFPA Panama provided a good example of how community ownership and mobilization can be promoted and sustained. There, indigenous community leaders were targeted with capacity building activities on both SRH and GBV, though it was up to them to decide what key messages and issues to prioritize in their communities. The result was that priority was given to GBV and HIV prevention in emergency shelters, since it was considered particularly problematic in crisis situations for the indigenous population.

Participation of vulnerable populations in emergency preparedness, response and recovery is also a priority in the LAC emergency response strategy. In Peru, for example, beneficiaries participated in the design of the intervention by outlining their needs and concerns. Moreover, work with community leaders led to the identification of the most common forms of GBV to be addressed through radio advertisements. Other examples of activities in this regard were consultations and participatory approaches with adolescents, youth and women for the development of a GBV strategy and awareness-raising messages on GBV in Ecuador, as well as engagement of young people to increase understanding of, and access, to SRH services by youth in Haiti. A similar experience was also found in Panama, where youth and women's groups established through the support of a joint UN programme called 'Ventana de Paz' [59] were sensitized on GBV and SRH, also with a view to their mobilization in case of emergencies.

3.3 Challenges

The survey questionnaire also provided country offices with the opportunity to report on challenges, both internal and external, that they encountered during implementation.

Challenges experienced internally mostly related to the way UNFPA is structured and how it works in emergencies. Bureaucracy was indicated as an obstacle to a timely and effective emergency response in both Guatemala and Panama, and in Nicaragua, delays were reported in relation to the disbursement of funds for the response to Tropical Depression 12E. Limited financial resources in general for GBV and SRH programming in emergencies were also often reported, chiefly in Panama and Ecuador.

External challenges, in turn, refer to issues related to other actors involved in the emergency response or situations that are outside UNFPA's control. Among them, limited priority given to SRH and GBV in emergency situations was a common theme. UNFPA Ecuador lamented the lack of attention given to SRH and rights during emergencies, as well as the resistance of other actors to these issues. In El Salvador, during Tropical Depression 12E, priority was given to the dengue epidemic over SRH and GBV.

Activities by UNFPA to address the general lack of priority given to these issues include advocacy for the integration of SRH and GBV into the emergency response (Peru), awareness raising and sensitization of relevant actors through capacity building on SRH and gender rights, also through SPRINT (Ecuador), and negotiation with those responsible for emergency response for a re-prioritization of issues to include also GBV and SRH (El Salvador).

Coordination with actors across different sectors of and at different levels in emergency response was another commonly cited challenge. Among the solutions found, in El Salvador, a facilitation team comprising representatives of national bodies responsible for SRH, GBV and mental health was created to allow members to get a deeper understanding of each other's work and to plan and coordinate activities to meet the needs of the affected population in a holistic manner. In Ecuador, lack of dialogue between those operating at the central and local levels as well as lack of consideration of SRH in emergency response plans was solved through the creation of

[59] Other participating UN agencies were UNDP, UNODC, UNESCO and UNICEF. The objective was to have safer communities in Panama.

a coordination mechanism comprising both actors responsible for disaster risk management and those working on SRH issues to facilitate coordination, also at the local level.

Respondents finally listed limited access to reliable and accurate information on those affected and their SRH and GBV needs as another key challenge, chiefly in Nicaragua and Panama.

4 Conclusions and recommendations .....

The recommendations of this study relate to both programmatic aspects and internal, organizational issues that would need to be addressed for better programming and continuous monitoring of GBV and SRH interventions in humanitarian settings. Specific effort was made identify good and promising practices throughout the study.

4.1 Conclusions

First, the **scope of the study and the opportunities and limitations of the methodology adopted**, most of which were already anticipated at the beginning of this study (see Section 1.3). An analysis that is based solely on desk review, online survey and selected phone interviews, albeit comprehensive, is inevitably limited. This issue arose during phone interviews with some country-based representatives, during which previously unknown information was revealed or relevant aspects of the projects surveyed became more prominent. And as detailed and lengthy as the research might have been, there is no substitute for direct observation and fieldwork to achieve an understanding of projects on the ground: information gaps are still likely.

This report is unique, however, in the type and breadth of information and analysis on SRH and GBV practices provided, and it lays the foundations for a systematic and more long-term process of information sharing, documentation and learning on these issues. As the first comprehensive analysis of SRH and GBV projects in emergencies ever conducted in the region, though far from exhaustive, this report can be a starting point for further collection and analysis.

A second conclusion regards the poor level of knowledge management that was found across the region. Despite a few exceptions, most of the SRH and GBV activities implemented in the past five years have not been adequately documented and shared across the region.[60] Most of the activities discussed above are in fact taken from project proposals rather than progress reports, thus reflecting plans rather than actual programme realities.

Information on the impact that activities had on beneficiaries are even harder to find, also due to gaps in the internal reporting system. Therefore, this study mostly accounts for activities (and planned ones therein), rather than outputs and outcomes. This is also mirrored in external reporting systems, such as those for CERF and Flash Appeals. Lack of monitoring and documentation on impacts and results not only negatively impacts UNFPA's chances for learning and improvement, but also undermines the organization's accountability to governments and affected populations.

Another general consideration that emerges from this analysis relates to the **importance of investing in preparedness building to avoid wastage or underutilisation of resources**[61] in an emergency as well as to ensure effective and efficient responses. In the words of UNFPA informants,

> *"'UNFPA has the tendency to work on an ad hoc basis. Then, by the time we are ready to respond, the emergency is over.' And again, 'UNFPA is mainly reacting to emergency, there is not much preparedness - we don't do anything until*

[60] Those who documented their activities on SRH and/or GBV in emergencies include Bolivia, Colombia, Dominican Republic, Ecuador, El Salvador, Haiti and Venezuela.

[61] See the case of Nicaragua described in the section, 'Enhanced data collection and management on GBV and SRH'. UNFPA Nicaragua used the funds for the emergency response to develop a GBV data collection system but that system was never implemented. If it had been developed before, the intervention would have benefited from it.

something happens, we are not prepared and we are literally wasting resources. This is a continuity issue, without preparedness the effectiveness of our actions is limited."[62]

This means not only that important investment to step up preparedness should be ensured, but also that continuity should be guaranteed when working to strengthen the local capacity for emergency preparedness and response for these efforts to start yielding results, as the experience in Nicaragua clearly exemplifies.

Far from being solely a matter of finances, findings on funding indicate that investment on preparedness is neither sufficient nor regular enough for continuity. For instance, CERF has been the most reliable source of funding over the years and across countries and emergencies in the region. However (and without undermining their relevance), CERF funds are not enough to ensure the maintenance of GBV and SRH programmes beyond the initial emergency phase. Effectiveness of the response cannot be ensured unless there are pre-existing conditions, such as installed capacities and partnerships to be easily and quickly activated as soon as the emergency strikes.

This can only be guaranteed if significant investment is made in preparedness. CERF is intended to complement, not to substitute, existing humanitarian funding mechanisms. As is evident in the project in Nicaragua, funds came in very useful to test and consolidate the linkages between traditional GBV actors and humanitarian response, which were themselves the results of a long process of sensitization and synergies' creation between the two.

On youth **and the engagement of men and boys in SRH and GBV initiatives**, almost one-third of the projects analysed refer to youth as a specific target group, but the research team could find information on implementation for a only few of them, such as in Haiti and Ecuador. Given the high priority that UNFPA places on young people's wellbeing, including in emergency contexts,[63] this is therefore an area that demands more attention.

Since the 1994 ICPD PoA, UNFPA has also been active in work on men and boys as partners in the achievement of gender equality and in work to prevent violence against women.[64] The ICPD PoA notes that "special efforts should be made to emphasize men's shared responsibility and promote their active involvement in responsible parenthood, sexual and reproductive behaviour, including family planning; prenatal, maternal and child health; prevention of sexually transmitted diseases, including HIV; [and] prevention of unwanted and high risk pregnancies […]"[65] Yet, while praising the few initiatives targeted to the men, and recognizing that there are still gaps and that lack of precision and details in the documents reviewed might have constrained a more thorough analysis, the inclusion and active engagement of men should be sought more systematically also in emergency situations.

Finally, a general look at the study reveals an imbalance between GBV and SRH initiatives, in favour of GBV. Whether this is a reflection of the reality in programming or a bias due to the methodology adopted and the available information is unclear.

4.2 Recommendations

Recommendations in this study are organized around the seven criteria used for the identification and selection of good practices.

Relevance

1. Ensure a **common understanding and appreciation of the UNFPA mandate in emergencies among** staff and partners across the region, including roles and responsibilities on SRH and GBV. Messages on this should be targeted to all staff at different levels, including senior managers, and ways should be found to overcome remaining resistance.
2. In line with the above, ensure **adequate capacity** (human resources, time and seniority/accountability) in country offices

[62] Phone meeting with UNFPA LACRO, 29 August 2013.
[63] UNFPA (2012), *op. cit.*, p. 19.
[64] UNFPA (2013). Engaging Men and Boys: A Brief Summary of UNFPA Experience. New York, UNFPA, p. 3.
[65] Para 4.27. UN (1995). Report of the International Conference on Population and Development. New York: UN.

for emergency preparedness and response.

Replicability

3. **Identify and promote more structured ways to regularly share experiences, document practices** and keep the learning loop within UNFPA moving. While this study is a good starting point, other activities need to be considered to ensure that this knowledge and experience are used. Examples of how this could be done include: a workshop to discuss, review and disseminate good practices on SRH and GBV; after action reviews for staff and storytelling; regular calls among those responsible for GBV and SRH programmes to draw and build upon experience and know-how, share concerns as well as ideas and possible solutions; and visits to projects' sites to encourage learning and ensure knowledge transfer across teams and countries as a way to enhance performance. Internal efforts such as 'Evidence and Action' brochures and good practices competitions could serve this purpose.
4. Closely monitor experiences in implementation of the GBVIMS in Colombia, as well as similar attempts for systematic collection and analysis of data on GBV and SRH, where they exist, to identify lessons and opportunities for replication in other countries in the region, including during emergencies. UNFPA LACRO should consider promoting the development of standardized methods and tools for the collection of SRH data in emergencies and for preparedness purposes, in partnership with relevant actors and under the auspices of coordination mechanisms such as REDLAC.
5. **Select a handful of practices and experiences for more in depth exploration and documentation** from which to draw lessons from and upon which to build. Ideally, the first issues to be further researched should be those for which information is generally missing, either because they are new, because they are particularly challenging or because they are more innovative.[66] Some initiatives for further analysis are El Salvador on the inclusion of LGBT in emergency response; the experience of involving youth in Haiti and/or Ecuador on; and the culturally sensitive approach to emergency preparedness and response in Guatemala.

Impact

6. UNFPA should move away from merely documenting **number** of activities implemented or items distributed and move toward a **more in-depth analysis and reporting of results and impacts**. In addition to the integration of indicators at the outcome and impact levels, if relevant, a selected number of in-depth studies may be considered to specifically document results.
7. Keep better track of the effectiveness of projects targeted at young people and encourage country offices **to better document their experiences in working with, and for, youth in humanitarian settings**. More evidence needs to go into proposals on youth so that reference to them is more than a mere exercise in style. This would also ensure learning on this relatively new field of work.

Partnership and coordination

8. Strengthen and standardize UNFPA's role as facilitator in bringing together and promoting coordination and partnership among diverse actors. Throughout the region, systematic efforts should be made to link actors across from different sectors to ensure that GBV and SRH are adequately understood and addressed in emergency preparedness and response,

[66] Colombia will be one of four countries receiving in-depth evaluation of the GBVIMS within the framework of a five-year evaluation process. (https://www.ungm.org/Notices/Item.aspx?Id=27311.

and to optimize resources and expertise through joint programming, collaboration and coordination. Particular attention should be paid to linking up traditional GBV and SRH actors as well as those in charge of disaster management and humanitarian response in general. One suggestion on this is to collect information about existing coordination mechanisms in other areas of emergency response, such as shelter, where reproductive health care and GBV issues can be integrated.

Sustainability

9. **Ensure adequate funds for emergency preparedness and response**, complementing the funds made available through CERF and other emergency response funding mechanisms. This will serve to ensure continuity of the activities implemented and will ensure capacity and coordination among local actors when emergencies strike. Investments can be directed at wide-ranging trainings and capacity building activities for national actors; UNFPA-specific surge capacity for direct support within the region can be developed to provide direct qualified support whenever needed; and support for national preparedness planning activities could be provided.
10. Provide training on MISP and the use of related UNFPA kits [67] for UNFPA and partner organizations across the region and **ensure that efforts will continue to sustain the capacities that have been created and to mobilize capacity when needed**.
11. Develop a **roster of trained and qualified reproductive health coordinators and GBV experts** at the regional level for deployment at the onset of an emergency to work closely with both local personnel and humanitarian response personnel to sustain reproductive health and GBV coordination. Participants in the on-going MISP training in the Caribbean sub-region, as well as those who have participated from other countries, can provide a first pool of candidates.
12. Advocate for a **GBV AoR Rapid Response Advisor** to be posted in the LAC region.

Transformative

13. In addition to training, systematic sensitization is needed for personnel of both UNFPA and partner organizations on both GBV and SRH and rights to avoid stigma and discrimination, and to avoid perpetuating prejudice.
14. Ensure that sexual diversity for example in relation to LGBT, is integrated into UNFPA's emergency preparedness and response. The **experience of El Salvador should be further examined and documentation developed for use by other countries in the region**.

Community ownership and responsibility

15. **More evidence is needed on 'how' things are done, and the implications, both positive and negative, of different approaches**. The use of a consultative and participatory approach should be examined because this method is inclusive of all those in need, and it has potential to address the needs of all. This is integral to shifting the mind-set of both affected populations and humanitarian actors from "recipients of aid to actors of their own well being", consistently with a human rights-based approach where the rights holder is involved in the humanitarian process.
16. Continue advocating for the inclusion of SRH and GBV as key concerns in national contingency and emergency preparedness and response plans,

[67] Reproductive health kits contain medications, supplies and equipment to facilitate the implementation of reproductive health services in the early stage of an emergency (three months maximum). They have been specifically created to respond to a particular reproductive health need, such as clinical delivery and medical treatment of rape, and sexually transmitted infections, including HIV. One kit can serve from 10,000 to 150,000 people.

policies and protocols. In addition to the opportunities provided by training on MISP, and other capacity building initiatives that typically fall under UNFPA's mandate, another activity that proved successful on this was the systematic engagement with national disaster preparedness and response mechanisms in both emergency and non-emergency situations.

5 References

ALNAP (2013). *Evaluation of Humanitarian Action – Pilot Guide*. London: ALNAP.

CEPAL (2011). *Resumen regional del impacto de la depresión tropical 12-E en Centroamérica. Cuantificación de daños y pérdidas sufridos por los países de la región en el mes de cctubre de 2011*. Naciones Unidas: Ciudad de México

Harmer A. et al. (2004). *Beyond the Continuum – The Changing Role of Aid Policy in Protracted Crises*. London: HPG-ODI

Hoffmann C. et al. (2004). *Measuring the Impact of Humanitarian Aid – A Review of Current Practice*. London: HPG-ODI

Inter-Agency Working Group on Reproductive Health in Crises (2010). *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*. New York: Inter-Agency Working Group on Reproductive Health in Crises

UN (1995). *Report of the International Conference on Population and Development*. New York: UN

UNFPA (2013). *Engaging Men and Boys: A Brief Summary of UNFPA Experience*. New York, UNFPA

UNFPA (2012). *Humanitarian Response Strategy "Second Generation"*. New York: UNFPA

UNFPA (2011). *Gender-based Violence and Natural Disasters in Latin America and the Caribbean*. UNFPA LACRO: Panama

UNFPA (2010)a. *Good Practices – Global Meeting 2010*. New York: UNFPA

UNFPA (2010)b. *Guidance Note on Sharing Good Practices in Programming.* New York: UNFPA

UNFPA (2010)c. *Guidelines on Data Issues in Humanitarian Crisis Situations*. New York: UNFPA

UNFPA (2009). *Emergency Preparedness, Response and Recovery in Latin America and the Caribbean 2009-2013*. New York: UNFPA

UNFPA (2006). *Integrating the Programme of Action of the International Conference on Population and Development into Emergency Preparedness, Humanitarian Response, and Transition and Recovery Programmes: a Strategy to Build Commitment and Capacity*. New York: UNFPA

UNFPA y UNHCR (2012). *Implementación del Sistema de gestión de datos sobre violencias basadas en el género – GBVIMS en Colombia 2011-2012*. Nueva York, Ginebra: UNFPA y UNHCR

UNFPA et al. (2008). *Training on the Minimum Initial Service Package (MISP) for Sexual and Reproductive Health in Crises – A Course for SRH Coordinators*. New York: UNFPA

UNFPA LACRO (2011). *UNFPA Latin America and the Caribbean Regional Strategy to Prevent and Address Sexual Violence against Women, 2011-2013.* Panama: UNFPA LACRO

UNFPA LACRO (2013). *UNFPA Latin America and the Caribbean Regional Strategy to Prevent and Address Sexual Violence against Women*, *2011-2013*. Panama: UNFPA

USIP (2013). *Special Report: Wartime Sexual Violence, Misconceptions, Implications, and Ways Forward*. Washington, DC: USIP

WRC (2007). *Minimum Initial Service Package (MISP) for Reproductive Health in Crisis Situations*. New York: WRC