NATIONAL HUMANITARIAN ASSISTANCE STANDARDS

for The Bahamas

2025 Edition

DRM AUTHORITY

IDB

NATIONAL HUMANITARIAN ASSISTANCE STANDARDS
for The Bahamas

THE CORE STANDARDS

SHELTER

WATER, SANITATION AND HYGIENE (WASH)

FOOD SECURITY AND NUTRITION (FSN)

HEALTH

LOGISTICS

ANNEXES

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The Disaster Risk Management Authority was established by the Disaster Risk Management Act 2022 and came into being in June 2024. The National Humanitarian Assistance Standards for The Bahamas (NHAS), was inspired by the Sphere Handbook, developed to provide a set of national minimum standards in core areas of humanitarian response. The aim of the NHAS for The Bahamas is to improve the quality of humanitarian response in disaster situations, and to enhance the accountability of humanitarian actions to crisis-affected people.

The NHAS for The Bahamas is the product of the collective experience of many people and agencies. They should therefore be seen as representing the views of the collective of Bahamian agencies. This edition of the NHAS for The Bahamas is the result of a broad consultation process. The DRM Authority gratefully acknowledges the contributions made, including from national and international NGOs, national authorities and ministries, the Red Cross Society, UN organization and individual practitioners. The drafting, consultation and revision process was coordinated and facilitated by lead author Aninia Nadig with thematic experts and resource persons from across the relevant sectors. The DRM Authority acknowledges the valuable contribution of all individuals and experts put forward by their agencies who dedicated time and effort to contribute to this publication.

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Lead Author: Aninia Nadig

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Aarone Sargent
Alex Storr
Andrea Newbold
André Thurston
Aneesah Abdullah
Anne Edwards
Angela Bowleg
Anglican Diocese of The Bahamas
Annouch Armbrister
Antoinette Cumberbatch
Arthurea Outten
Barrise Griffin
Beryl Armbrister
Camelta Barnes
Chapell Whyms
Chauntez Dillet-Wilson
Chequita Johnson
Christina Johnson
Christine Lightbourne
Colin Higgs
Demetrius Emmanuel
Dominique Martin
Dwayne Rolle
Dwight B. King
Erica Cox
Etoile Pinder
Fantella Davis
Franklin Espiga
Gabrielle Hudson
Gayle Moncour
Geoffrey Greene
Henry Moxey
Hori Tsuneki
Jessie Jordan
Judie Simmons
Juliette Deal
Keisha Ellis
Kendria Ferguson
Kennita Saunders
Lauren Riviere
Lavado Duncanson
Lapisha Gray
Lisa Pinder
Marcellus Taylor
Mary Walker
Matt Aubry
Maurissa Davis
Megan Johnson
Melissa Ingraham
Melvelyn Symonette
Michael Fontain
Michael Wright
Monica Rodriguez
Monique Johnson
Monique Mitchell
Natalie Bethel
Niko Davis
Pandora McKinney-Smith
Ronnie Stevenson
Rosalie Foulkes
Ruth Munnings
Samuel Dean
Sergio Lacambra
Shaloma Carroll
Shanishka Cambridge
Shanty Richards
Sherlin Brown
Sonia Miller
Sophie Teyssier
Steffon Evans
Stephanie Barr
Stephenique Davis
Stephen Russell
Suzanne Russell-Dorset
Syreta Roberts
Tanya Douglas
Te'Neill Francis
The National Trust
Timyka Davis
Trevor Johnson
Vincent Williams
Xavier Genot

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Abbreviations

CHS	Core Humanitarian Standard
CHW	Community Health Worker
BRCS	Bahamas Red Cross Society
BUC	Bahama Utility Company
CDEMA	Caribbean Disaster Emergency Management Agency
DMU	Disaster Management Unit
DRA	Disaster Reconstruction Authority
DRM	Disaster Risk Management
DRM Authority	Disaster Risk Management Authority
EOC	Emergency Operation Centre
EPI	Expanded Program in Immunization
ESF	Emergency Support Function
EWAR	Early Warning, Alert and Response
FI	Family Island(s)
FSN	Food Security and Nutrition
GB	Grand Bahama
GBV	Gender-based violence
GoBH	Government of The Bahamas
HLP	Housing Land and Property
ICC(s)	Incident Command Centre (s)
ICCM	Integrated Community Case Management
IDP	Island Disaster Plan
IMCI	Integrated Management of Childhood Illness
IPC	Infection Prevention and Control
MEDS	Medical Emergency Distribution System
MHPSS	Mental Health and Psycho-Social Support
MoHW	Ministry of Health and Wellbeing
MoW	Ministry of Works and Family Island Affairs
MoU	Memorandum of Understanding
NCD	Non-Communicable Disease
NDRMP	National Disaster Risk Management Plan
NDEP	National Disaster Emergency Plan
NEMA	National Emergency Management Agency
NEMS	National Emergency Medical Services
NDEOC	National Disaster Emergency Operating Centre
NGCC	Non-Governmental Consultation Committee
NGO	Non-Governmental Organization
NP	New Providence
NPO	Non-Profit Organization
RRM	Regional Response Mechanism
SGBV	Sexual and Gender-Based Violence
SOP	Standard Operating Procedures
UBD	Unsolicited Bilateral Donations
WASH	Water, Sanitation and Hygiene
WSC	Water and Sewerage Company

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Foreword

The archipelago of The Bahamas is situated in a disaster-prone region. The particularly heavy destruction caused by Hurricane Dorian in September 2019 and the challenges faced during the response, recovery and reconstruction phases prompted the Government of Bahamas (GoBH), with the support of the Inter-American Development Bank (IDB) to review and reform its disaster risk management strategy and policy framework. As a result, the Disaster Risk Management Act (DRM Act) was adopted and enacted in December 2022, and enforced as of April 2024. It provides a state-of-the-art legal, institutional and budgetary framework for the implementation of comprehensive DRM informed by the blueprint of CDEMA, international best practices and lessons learned.

Among a range of key DRM policy instruments, the DRM Act also calls for the establishment of **National Humanitarian Assistance Standards.** The "National Standards" outline the minimum standard for any humanitarian response and give due consideration to the needs of vulnerable persons, groups and communities. The National Standards in this Handbook were adapted to the Bahamian context from the Sphere Standards, a globally agreed framework of humanitarian standards designed to ensure a principled, accountable and high-quality response, that places people's dignity at the centre of the response.

The National Standards help create a jointly agreed basis to define what such principled, accountable and high-quality disaster response should look like. They support a Whole of Community approach, aiming at empowering and connecting with communities and local authorities, recognizing communities' capacities as first responders and their active involvement in the response and recovery processes, acknowledging the importance of overall coordination, including with international aid suppliers, and supporting the sense of unity and solidarity in the extraordinary situation of post-disaster recovery.

All DRM Stakeholders consulted on draft versions of these standards agreed that it was important to work towards well-planned and coordinated disaster preparedness and response, which actively involves affected communities and recognized the key role of the National Standards in this endeavour.

The present Handbook is a living document, the content of which will be integrated into, and inform all relevant disaster policies, plans and frameworks. Based on the learnings from working with them, the Standards themselves will be reviewed and updated in due course.

We trust that these National Standards will provide a meaningful contribution towards improving the coordination between international, national and local humanitarian, community and private sector actors and to ensuring that the assistance provided is principled, accountable, adequate and timely, fully involving people and communities during response and recovery and respecting their dignity and agency.

H. Alexander Storr
Chairperson of the Board

Aarone Sargent
Managing Director

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Introduction

The National Humanitarian Assistance Standards (in short "National Standards") established by the Disaster Risk Management Authority provide the building blocks for a principled, accountable and high-quality humanitarian assistance framework following a Whole of Community approach. They support the 2022 DRM Act's objectives of a holistic, comprehensive, integrated and proactive DRM approach focusing on the most vulnerable and promoting "the involvement and participation of all relevant sectors and stakeholders, at all levels of the society". According to the DRM Act, the National Standards are to ensure the immediate provision of humanitarian assistance and to lead towards the restoration of basic services, physical assets, natural capital and livelihoods. They focus on people's needs and dignity.

The National Standards are based on the Sphere Standards, the 2024 Core Humanitarian Standard and the Universal Logistics Standards.[1] As such, they are based on Sphere's two core beliefs: the right to life with dignity and therefore the right to assistance; and that all possible steps should be taken to alleviate human suffering arising out of disaster or conflict.

During humanitarian assistance, these **National Standards will serve as a key tool for a coordinated humanitarian response at all levels** and include all key stakeholders, in particular Government agencies, national and international NGOs, UN agencies, the International Federation of Red Cross (IFRC) private sector actors, community-based organizations and affected people and communities. They can serve as a monitoring and benchmark tool to understand how aid is being designed and distributed, and what its impact is on people and communities.

Who are the National Standards for and when should they be used

These Standards "are to be met by any humanitarian assistance provided by the Government, to the Government or by humanitarian aid organizations" (DRM Act Article 21). This includes all national and international humanitarian actors and donors operating in The Bahamas. The Standards ensure a complementary, coordinated approach to disaster preparedness, planning, response and recovery. These Standards also support communities and their leaders, local volunteers and private sector actors.

This Handbook includes a chapter with nine Core Process Standards and five chapters covering Shelter, Water supply, sanitation and hygiene promotion, Food Security and Nutrition (FSN), Health and Logistics.

[1] 2018 Sphere Handbook, the 2024 Core Humanitarian Standard and the 2021 Universal Logistics Standards.

Coordination of national and international response and support of local first responders:

The National Standards provide a common assistance framework which supports response coordination between government agencies and national and international aid actors from regional and UN bodies, civil society and the private sector. The National Standards also aspire to help the local, national and regional response structure to better support community-based first responders and community leaders. Public awareness and education initiatives are essential in disaster preparedness plans, empowering individuals to take appropriate actions before disasters strike.

Bringing the Standards to life

The National Humanitarian Assistance Standards are to be implemented through existing response mechanisms, in particular the National Disaster Emergency Plan, Local Disaster Emergency Plans, and the Emergency Support Functions' Standard Operating Procedures set up by the National Emergency Operation Centre and Family Island Incident Command Centres. **The Standards must be adapted to each Family Island context and all DRM Stakeholders are required to integrate them into their disaster planning and response guidelines and frameworks.**

Long-term vision:

The National Humanitarian Assistance Standards strive to reach a situation in which people can survive and recover from a disaster with dignity. The Standards inform preparedness and planning activities (e.g. pre-positioning of goods and emergency trainings) and can feed into longer-term recovery. The Standards can be institutionalized through a variety of processes, including, for example, the National and Local Body Disaster Emergency Plans and The Bahamas National Development Plan. The latter refers to disaster planning across most strategies.

Links to the Emergency Support Functions (ESF):

The National Humanitarian Assistance Standards are to be implemented through existing response mechanisms, in particular the Emergency Support Functions (ESF), activated in the case of a disaster emergency by the National Disaster Emergency Operations Centre (NDEOC), and the auxiliary Public Body Emergency Operating Centres (EOC) and Family Island Incident Command Centres. They are also to be implemented through other arms such as guiding the Non-Governmental Consultation Council, and in mechanisms for requesting International Assistance. They also apply to international responders (UN agencies, inter-governmental organizations, INGOs and the International Federation of Red Cross (IFRC)).

Principles and values

Humanitarian assistance is based on principles and values, which is intended to ensure that humanitarian action is impartial, independent and neutral. **The four Humanitarian Principles are Humanity, Impartiality, Independence and Neutrality.** The Humanitarian Charter, a cornerstone document supporting all humanitarian standards, builds on these principles and outlines the rights to protection and assistance reflected in the provisions of international humanitarian law, human rights, international disaster relief law, and refugee law.

The Charter summarises these rights as follows:

1 **The right to life with dignity.**

2 **The right to receive humanitarian assistance.**

3 **The right to protection and security.**

These rights are the same for all people. Humanitarian assistance is impartial and needs-based. This means that people receive aid according to their needs and without discrimination, to ensure equal access to dignity, assistance, protection and security for all.

The National Humanitarian Assistance Standards support these rights by focusing on protecting and improving people's physical, mental and emotional security before, during and after a disaster event. The Humanitarian Charter acknowledges that it is firstly through their own efforts, and through the support of community and local institutions, that the basic needs of people affected by disaster are met. It goes on to recognize the primary responsibility of the state – i.e. The Commonwealth of The Bahamas – to provide timely assistance to those affected on its territory, to ensure people's protection and security and to provide support for their recovery.

A Whole of Community Approach

Whole of Community is a concept in which all actors involved in DRM (from individuals to local community leaders, non-governmental and private actors to government bodies and officials) have been consulted and embrace their role in preparing for and responding to a disaster. This complementary approach can lead to better resilience and cohesion in communities and society. It recognizes that each community is unique and has specific needs and capacities to prepare for and respond to a disaster. These differences must be considered by national disaster management mechanisms, to ensure that local contexts are understood.

Involving and supporting local communities in efforts already undertaken by them can empower them to become more engaged in local and national disaster preparedness processes.

Vulnerabilities and Capacities

Not all people have equal control of power and resources. Individuals and groups within a population have different capacities, needs and vulnerabilities, which change over time. Individual factors such as age, gender, disability and legal or health status can limit access to assistance. It is important to identify people's capacities to contribute to their own recovery, as well as potentially vulnerable and marginalized population groups that may be particularly vulnerable to the effects of a hazard. The DRM Act 2022 mentions "age, disability, poverty, lack of resources, physical displacement or gender" (Art 58(2)).

Vulnerabilities change in the wake of a disaster. Pre-disaster vulnerabilities, which may aggravate the impact of a disaster and capacity to recover include being part of the following groups: female-headed households, children and youth, elderly people, people with disabilities – in particular women and girls with disabilities, exposed to heightened risk of sexual violence, people living with stigmatizing conditions (for example HIV), undocumented migrants, shantytown dwellers, people living in remote locations or in aged, unsafe homes, people without access to private vehicles or public transport, people in situations of economic hardship and dependency, and homeless people. Special attention must be given to the community needs on each of the Family Islands, through specific disaster response plans for each of them.

Post-disaster vulnerabilities include protection concerns for sexual and gender-based violence in shelter settings, child protection (including migrant children), being victims of violence and looting, and the exacerbation of existing situations of vulnerability during and in the aftermath of a disaster, and economic vulnerabilities through loss of income and security of tenure during extended shelter or temporary housing.

Environmental considerations

The Bahamas' natural beauty and environmental stability ensure quality of life and livelihoods for Bahamians and the country's important tourist industry. While environmental considerations are specifically covered in Core Standards 3 and 9, Shelter Standards 7 and 8, they must be kept in mind throughout all preparedness, response and recovery activities. Environmental considerations ensure that humanitarian assistance and recovery activities do not further damage the environment. Ideally, these activities ensure that environmental damage caused by the disaster is addressed as part of the response, and that response activities limit additional damage to the environment.

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How to work with the National Standards

Working with standards is a process. It is rare that standards are reached immediately. Rather, they are formulated as outcome statements, describing a situation that all actors involved have agreed to work towards. Working with standards means committing to a long-term process of planning, implementing, evaluating, learning and improving.

To fully capture the potential of the National Standards, it will be important to implement trainings on humanitarian principles and the national approach to humanitarian assistance. It will also be important to ensure that communication on the National Standards reaches local communities through adapted information and dissemination materials.

The Core Standards: Processes

The Core Standards describe essential processes aiming to ensure that the Bahamian humanitarian response supports people and communities affected by crises in ways that respect their rights and dignity and promote their primary role in finding solutions to the crises they face. The Core Standards are based on the Core Humanitarian Standard.

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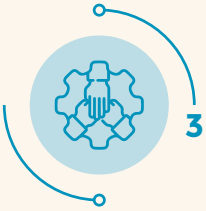
THE NINE CORE STANDARDS

1 PARTICIPATION AND TWO-WAY COMMUNICATION

2 IDENTIFICATION OF NEEDS AND PRIORITIES



3 PREPAREDNESS AND RESILIENCE

4 WORKING WITH AFFECTED PEOPLE

5 FEEDBACK AND COMPLAINTS

6 COORDINATION

7 MONITORING, EVALUATION AND LEARNING

8 HUMANITARIAN WORKERS' COMPETENCIES AND WELLBEING

9 RESPONSIBLE MANAGEMENT OF RESOURCES

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The Technical Standards chapters

The technical chapters cover five humanitarian response sectors. **As is the case with the ESF areas, the Humanitarian Standards chapters are all closely interlinked and should always be considered in conjunction with each other.** For example, water supply for temporary shelters is covered in the WASH chapter, while transporting the water to the shelters is covered in the Logistics chapter.

What's in a Standard?

The National Standards share a common structure:

- **The Standard:** Each standard is a practical expression of the right to life with dignity in a humanitarian response setting. Together, the Standards describe what needs to be in place for an affected person or community to survive and recover with dignity.
- **Key actions** outline practical steps to attain the standard. They support all humanitarian actors and should be considered when developing the National Response Plans and Standard Operating Procedures for the relevant ESFs.
- **Guidance notes** provide contextual information to support the key actions, with cross-references to other chapters where needed.

Annex: Assessment lists and Indicators

For each chapter, the Annex lists assessment questions and useful indicators for planning, monitoring and evaluating a response. **These indicators serve as signals to measure whether the standard is being attained.** They should not be mistaken as "pass or fail". As mentioned above, working with standards is a process. Indicators should be used in that sense. Metrics (quantitative minimum requirements) are only included where there is sectoral consensus or for certain nutrition and health standards.

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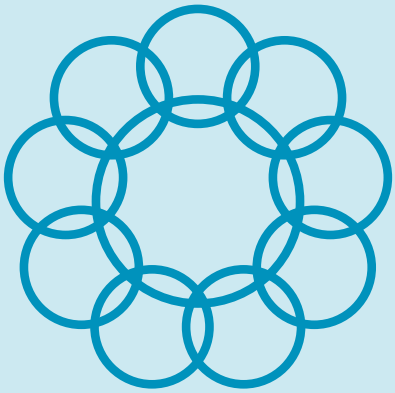

THE CORE STANDARDS

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THE CORE STANDARDS

The Core Standards aim to ensure that the Bahamian humanitarian response supports people and communities affected by crises in ways that respect their rights and dignity and promote their primary role in finding solutions to the crises they face. The Core Standards are instrumental in respecting a Whole of Community approach. They include key elements such as participation, communication and coordination, as well as staff and volunteers' competencies, accountability and wellbeing. The Core Standards are based on the Core Humanitarian Standard.

Structure: Each Standard is formulated as a qualitative outcome statement from a people and community perspective, followed by key actions for reaching the standard, and Guidance Notes providing additional context and explanations. All Actions can be re-formulated into indicators to support planning, monitoring and evaluation.

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There are nine Core Standards:

1. PARTICIPATION AND TWO-WAY COMMUNICATION
People and communities can participate in actions and decisions that affect them.

2. IDENTIFICATION OF NEEDS AND PRIORITIES
People and communities have timely access to effective support, in accordance with their specific needs and priorities.

3. PREPAREDNESS AND RESILIENCE
People and communities are better prepared and more resilient to current and future crises.

4. DO NO HARM
People and communities access support that does not cause harm to them or their environment.

5. FEEDBACK AND COMPLAINTS
People and communities can safely report concerns and complaints and get them addressed.

6. COORDINATION
Humanitarian assistance is coordinated and complementary.

7. MONITORING, EVALUATION AND LEARNING
Support is continually adapted and improved based on feedback and learning.

8. HUMANITARIAN WORKERS' COMPETENCIES AND WELLBEING
Staff and volunteers are respectful, competent and well-managed.

9. RESOURCE MANAGEMENT
Resources are managed ethically and responsibly.

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CORE STANDARD 1

Participation and two-way communication

People and communities can participate in actions and decisions that affect them.

KEY ACTIONS

1.1 Recognize people's role as first responders and proactively ensure that their participation in decisions and actions is meaningful for them and corresponds to their preferred ways of engaging.

1.2 Integrate considerations of diversity, equity and inclusion into all response activities with people and communities, with attention to the most vulnerable.

1.3 Ensure that instructions for safeguarding against the effects of hurricanes and other disasters are shared regularly with people and communities before, during and after a disaster, and that they clearly outline the roles and responsibilities of different response actors.

1.4 Transparently communicate about DRM decisions made before, during and after a disaster.

1.5 Ensure year-round programs to educate the public on overall DRM goals, communicating in formats and languages that are easily accessible and understandable, (also for people with auditory or visual impairments) respectful, and contextually appropriate for people and communities – adapt communication accordingly.

1.6 Engage local groups to assist with knowledge distribution. Door to door, TV/radio ads, Social Media.

1.7 Ensure the National Disaster Risk Management Plan and National Disaster Emergency Plan, and subsequent Local Plans include a coherent approach to effective information-sharing and communication, as well as to meaningful participation of people and communities in all activities that affect them.

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Guidance Notes:

People and communities as first responders: It is important to recognize that affected people and communities are the first to work on preparations before a storm, survival and recovery of themselves and others. Official support for, and recognition of these efforts will empower people taking interest in broader disaster response efforts. This will help strengthen the link between local and national efforts. Core Standard 6.

Understanding and supporting community leadership: Consider establishing lists of community leaders, key volunteers, community workers and other important members of the community. This will help reinstall community leadership. Support them post-disaster, so they can resume/ take on their roles within the communities.

Participation means considering community realities and structurally turning one-way communication into meaningful dialogue. Meaningful participation will support preparedness, response and recovery. People can be directly involved in preparing their communal shelters. They can understand the logistics of pre-positioning goods and formulating family contingency plans. As outlined in the Shelter chapter, communal shelters should ideally serve multiple functions, ensuring they are seamlessly integrated into community life. Consider compensation or incentives for community level participation in disaster planning.

For recovery, reconstruction and rehabilitation, active participation is of utmost importance. It can be reinforced when integrated into all aspects of disaster management.

Ways to ensure active participation include:

- **National and local response plans** specifically include proactive consultation meetings with local populations to discuss the response plans.
- **People's suggestions and feedback are fully considered** when adjusting emergency and disaster response plans and they are informed about how community inputs are reflected in the plans.
- Any after-action review **includes discussions with affected people** (including marginalized groups) to understand how they experienced the disaster and the response.

Disaster mitigation planning: Actively engage women, children and other potentially marginalized groups in disaster preparedness and management, and in community disaster plans. Ensure national and local disaster plans appropriately address gender issues to avoid gender-based discrimination. References: UNISDR: Making DRR Gender-Sensitive.

Diversity, equity and inclusion: It is important that vulnerable groups and individuals, in particular elderly people, people with disabilities, Family Island communities and undocumented migrants are identified and measures put in place to ensure they can access the support needed. This can happen in a variety of ways, including approaching them directly or ensuring that they can rely on trusted neighbors, family, and friends to receive relief and support on their behalf. Consider community-based inclusion training.

Detailed DRM instructions are provided in the DRM Act 2022 and will be updated in the related National and Local Body Disaster Emergency Plans.

Inclusive and contextualized disaster communication: To ensure public preparedness, ensure long-term and effective pre-disaster communication and exchange – in appropriate formats – with Family Island inhabitants about identified communal shelters, Coordination Centers and other important infrastructure. Information should also include tips and tools to ensure a safe shelter experience during a disaster. Schools and Faith-Based Organizations can be used to teach and relay critical preparedness information to families. National telephone broadcasting blast, existing community groups and online social networks such as WhatsApp groups, can be identified and integrated in public awareness communications. Core Standard 2; Core Standard 3; Shelter standards.

Adapt disaster communication to Family Island contexts, and ensure that within each Family Island, all communities are reached. Include radio messages or pictograms for people who cannot read and those with hearing deficits.

Communication formats: Every effort should be made to ensure communication is accessible to all residents of The Bahamas. This can be done by using various formats. To reach remote populations (in particular Family Island residents), additional Early Warning communication such as sirens, as well as cell phone or social media blasts, should be in place and functioning (tested).

Information sharing with communities should include information about the agency's or organization's mandate, mission, values and principles, the aid to be delivered and how it intends to involve the community. This is a key element of protection and accountability and helps manage expectations from communities.

Evaluation: Ensure disaster warnings, evacuation orders and post-disaster safety measures are received, understood, and acted upon by all communities, and evaluate if the information provided had the necessary effect.

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CORE STANDARD 2

Identification of needs and priorities

People and communities have timely access to effective support in accordance with their specific needs and priorities.

KEY ACTIONS

2.1 Plan and implement disaster response which respects and builds upon local knowledge, capacities and existing actions, and people's own understanding of their needs.

2.2 Carry out post-disaster needs assessments as soon as possible, based on relevant instructions in the National and Local Body Disaster Emergency Plans.

2.3 Set up, use and curate the National Disaster Risk Information system as the central database for pre-disaster risk assessments, post-disaster needs assessments, activity reports, National and Local Body Disaster Plans and any data collected during and after a response.

2.4 Ensure any official or organizational assessments and response plans are regularly communicated to DRM Authority and made available on the online platform, respecting data protection.

2.5 Use fair, impartial and transparent criteria to define programs and the people or groups supported.

2.6 Refer any unmet priority needs to relevant stakeholders with the technical expertise and capacity to address them.

2.7 Regularly monitor and adjust programs to ensure actions are timely and accessible, and address the priority needs of people and communities.

2.8 Ensure clear and transparent communication around rights during the relief and recovery phases, possible end points to those rights and the consequences.

2.9 Ensure the National Disaster Emergency Plan addresses the diverse island contexts and capacities, vulnerabilities, needs and risks faced by people and communities on each island.

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Guidance Notes:

Understanding pre-disaster context, risks and vulnerabilities: The response is based on up-to-date context analysis and disaster risk assessments for each island, including local knowledge, vulnerabilities and capacities, current response strategies and actions at the community level. Existing informal local response structures are understood. Risk assessments include socio-economic risks of remote communities and marginalized groups. Early warning information should also contribute to the understanding of context and risk.

Include information on gender and vulnerable groups as they were identified in risk and vulnerability assessments, as well as data relating to household composition, into national and local emergency planning efforts.

Pre-disaster information collection should strive to include the number of inhabitants on each Family Island, including the number of children, elderly, people with disabilities and pre-disaster vulnerabilities (such as identifying pregnant women).

Data storage and information sharing: Disaster response related information must be shared with the DRM Authority, which ensures that this information is accessible to all relevant stakeholders in a systematic manner, and that key assessment outcomes are linked to post-disaster decision making processes and protocols.

Planning: Ensure sufficient national and local disaster response planning capacities and structures. Any national or island plans and implementation activities should be carried out either under a functioning Incident Command Structure (ICS) or communicated to the DRM Authority and the NDEOC. Island-level Disaster Plans should be updated regularly in collaboration with the Family Island Administrators and the DRM Authority. This will ensure that they are linked to the NDEP and the ESF structure. The various plans should also be tested.

Post-disaster damage and needs assessments (DRM Act art.58 (2) will determine the disaster response and help understand the specific needs of individuals and communities. The assessments are coordinated by the DRM Authority in coordination with an Administrator, and should be supported by private sector actors as needed (for example for airplanes, drones etc). Specific instructions must be obtained from / shared by the DRM Authority or the relevant authority.

The assessment categories are:

- **Initial Situation Overview (ISO) – within the first 8 hours.**
  Focus on casualties, displacement of the population and damage to lifelines and critical facilities.
- **Initial Damage Assessment (IDA) – within the first 48 hours.**
  After clearing airports and seaports. Deployed by DRM Authority.
  Initial evaluation of damage for each sector.

- **Damage Assessment and Needs Analysis (DANA) – after 48 hours, can last several weeks.**
  Deployed by DRM Authority and carried out by technical/sector specialists.
- **Damage and Loss Assessment (DaLA) and Agency Specific Assessments** of status of infrastructure and personnel. Liaise with relevant authorities to assess damage to public infrastructure.
- **Social and Physical Assessments.**
  The results of these door-to-door rapid needs assessments will help share information to local, regional and international partners and organizations.

If possible, **food security and nutrition assessments** should be integrated into these various assessments, including into DANA, DaLA and Social and Physical Assessments.

Continuous needs assessments should be carried out during response, recovery and reconstruction, to adapt response measures to evolving needs. This applies to all response activities and all actors and coordination mechanisms involved.

Sensitivity training for those doing assessments is important, as many people may be traumatized. It is important to deliver on promises made during assessment visits.

CORE STANDARD 3

Preparedness and resilience

People and communities are better prepared and more resilient to current and future crises.

KEY ACTIONS

3.1 Support formal and informal community leadership, island-level disaster preparedness and response capacities, including local staff and volunteers. Core Standard 8.

3.2 Ensure that disaster response contributes to long-term recovery of livelihoods, the local economy and the environment. Shelter: Livelihoods; Logistics: Procurement.

3.3 Establish a coherent approach to ensure disaster response reinforces locally led actions and decision-making.

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Guidance Notes:

Preparedness assessments: For assessing preparedness levels, conduct household surveys with the help of volunteer organizations. Share results with all aid providers. Such assessments and results sharing should be coordinated by the DRM Authority.

Local capacities: Support for local preparedness and resilience should contribute to increasing Family Islands' capacity to respond before the arrival of the external response, which can be delayed, depending on circumstances and logistical limitations.

- Local volunteer recruitment on all Family Islands. Volunteer training should focus on their capacity to respond to emergency situations independently if needed. It should also focus on disaster preparedness and response needs tailored also to the geographic specificities of each island, including First Aid. Core Standard 8, Health: Injury and Trauma Care Standard.
- Local community networks, such as community preparedness committees, non-profit and faith-based organizations and voluntary response groups, led by Family Island Administrators, should be set up on all Family Islands and receive support for regular disaster response training. These groups should be resourced to carry out training and emergency drills for any disaster with the entire population, including in schools. Information to communities should include the importance of family plans and homes as first safe spaces. Shelter standards.
- Develop a Family Islands exercise plan to ensure exercises are carried out regularly.
- Work to develop training relationships among the Family Islands to foster the ability of nearby islands to support each other in times of disaster. This includes additional staffing support for EOCs, logistics, sheltering and supplies.
- Encourage preparedness programs in schools, empowering children to work towards their own preparedness at home.
- Consider incentives to people and communities for active participation in disaster preparedness and training.

Anticipating and reducing risks: Require and incorporate pre-disaster risk assessments into disaster management planning. Include in these risk assessments, climate change, local knowledge and vulnerabilities, and include vulnerability assessments in planning. Ensure risk assessments are available to all relevant stakeholders.

Environmental considerations must be taken into account for all activities related to disaster response and humanitarian assistance. Ensure all related activities are conducted in an environmentally responsible manner and that they do not contribute to environmental degradation. Shelter Standard 7 (Environmental Sustainability) applies beyond Shelter activities.

Nature-based solutions should be considered wherever possible. Nature-based solutions (NbS) are actions that hold the twin objectives of providing for **human wellbeing** and protecting the environment. They are a tangible solution that can build immediate and long-term resilience for those affected by crisis. Sphere NbS Guide.

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CORE STANDARD 4

Do-no-Harm

People and communities access support that does not cause harm to them or their environment.

KEY ACTIONS

4.1 Identify, prevent, mitigate and address potential and actual negative impacts of programs on people, communities and the environment.

4.2 Ensure safe, ethical and effective management of data and information to minimize risks for people and communities in line with recognized good practice for data protection.

4.3 Conduct surveys to understand people's concerns and specific definition of harm.

4.4 Provide sensitivity and risk training to staff and volunteers – including focus on compliance of behavior and an understanding of expectations and consequences in case of non-compliance.

4.5 Work in ways that protect the safety, security, rights and dignity of people and communities and prevent all forms of exploitation and abuse, including sexual exploitation, abuse and harassment, by staff and volunteers in line with recognized good practice. Core Standard 8.

4.6 Follow the Child Protection Protocols to prevent all forms of abuse, particularly as it pertains to unaccompanied minors. Such minors should be referred to the Child Protection Unit (CPU) which will seek to relocate them as soon as possible.

Guidance Notes:

Organizational policies to prevent negative effects and strengthen local capacities: Policies and procedures should reflect a commitment to the protection of vulnerable people and outline ways to prevent and investigate the abuse of power by staff. Careful recruitment, screening and hiring practices can help to reduce the risk of staff misconduct, and codes of conduct should make it clear what practices are forbidden. Staff should formally agree to adhering to these codes and be made aware of the sanctions they will face if they fail to do so. Core Standard 5; Core Standard 8.

Staff and volunteers training on staff behavior and risks of misconduct should regularly be carried out.

Data protection: All personal information collected from individuals and communities must be treated as confidential and comply with the 2003 Data Protection Act. This applies in particular to protection-related data, reported violations, complaints of abuse or exploitation, and gender-based violence. Systems that ensure confidentiality are essential to prevent further harm.

Child protection: Follow the Child Protection Unit Protocols to prevent all forms of child abuse, particularly as it pertains to unaccompanied minors. Such minors should be referred to the Child Protection Unit (CPU) which will seek to relocate those minors as soon as possible. The CPU sits under the Department of Social Services (DOSS).

CORE STANDARD 5

Feedback and complaints

People and communities can safely report concerns and complaints and get them addressed.

KEY ACTIONS

5.1 Ensure community leaders and local authorities are leading on the design, implementation and monitoring of complaints processes.

5.2 Plan and implement safe, accessible and appropriate ways for all groups in a community to provide feedback, report concerns and complaints in line with established international practice. Core Humanitarian Standard.

5.3 Regularly monitor that people and communities understand how staff and volunteers are expected to act to prevent harmful behaviors, including sexual exploitation and abuse, harassment and further psychological distress independent of the disaster.

5.4 Regularly monitor that people, communities and other relevant stakeholders understand how to report concerns and complaints, and how they will be addressed.

5.5 Manage, investigate, address and/or appropriately refer complaints in a timely manner and in line with recognized good practice. Core Standard 2.

5.6 Apply appropriate victim/survivor-centered approaches to investigate and address complaints and reports of any misconduct, including sexual exploitation, abuse, and harassment and psychological harm.

5.7 Establish coherent local and national approaches to ensure any concerns and complaints are welcomed and acted upon in a timely and appropriate manner.

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Guidance Notes:

Harmful behavior can also cause psychological harm, especially in the face of a current crisis. Harmful behaviors can also include criticism, cynicism and invalidation.

Feedback mechanisms: A Whole of Community Approach requires full inclusion of affected people. Feedback should be welcomed regarding all aspects of a humanitarian response, and to ensure the goods and services delivered correspond to people's needs and expectations. WASH: Hygiene Promotion; FSN: Food assistance.

Designing a complaint handling process: Social and power dynamics must be assessed before deciding on the best way to interact with communities. Pay attention to the needs of potentially marginalized groups. Encourage participation in the design and implementation of complaints systems.

Raising awareness about how to make a complaint: Time and resources will be needed to ensure that affected people know what services, staff attitudes and behavior they can expect from agencies and NGOs. They should also know what to do and where to make a complaint if an agency or NGO has failed to meet these commitments.

Managing complaints: When the complaint falls outside the control and responsibility of an agency or NGO, refer the complaint to the appropriate organization, when possible, with their agreement.

Protecting complainants: A mechanism which ensures that complaints will be treated confidentially should be a priority. A whistleblowing policy should be in place to protect staff who highlight concerns about programs or the behavior of colleagues. Data protection policies should cover how long specific types of information should be kept, in accordance with relevant data protection laws.

Organizational culture: Managers and senior staff should model and promote a culture of mutual respect between all staff, partners, volunteers and people affected by the crisis. Their support for the implementation of community complaints mechanisms is vital.

Staff behavior and codes of conduct: Agencies and organizations should have a staff code of conduct that is endorsed by senior management and made public. A child safeguarding policy should apply to all staff and partners, and inductions and training should be provided on expected standards of behavior. Staff should know and understand the consequences of breaching the code of conduct. Core Standard 8.

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CORE STANDARD 6

Coordination

Humanitarian assistance is coordinated and complementary.

KEY ACTIONS

6.1 Communicate the National Humanitarian Assistance Standards with all key DRM Stakeholders and partners, through an engagement plan including communities (for example town hall meetings) and through social media.

6.2 Establish a policy and clear procedures for requesting regional or international aid.

6.3 Ensure National and Local Body Disaster Plans are up-to-date and foresee coordinated response activities, which allow for clear distinction between nationally led and locally led activities, and those of other relevant stakeholders, including international aid actors.

6.4 Identify key humanitarian assistance partners and their assistance capacities (UN and Clusters, Red Cross, regional organizations, NGOs, NPOs, faith-based organizations, and private sector) and establish formal agreements to support disaster management efforts through the Non-Governmental Consultation Council.

6.5 Ensure the response structure is implemented and tested, and sufficient staff are trained to run a disaster response. Core Standard 8.

6.6 Ensure island-based coordination structures are in place, staffed, equipped and tested and aligned with the NDEP.

6.7 Ensure a national coordination mechanism is in place and tested, including, for national and international actors, clear requirements and guidance on planning and engagement with other actors.

6.8 Maintain an up-to-date common operational platform for efficient information access and sharing among all identified disaster management stakeholders.

6.9 Establish a national approach through the Non-Governmental Consultation Council to continuously ensure that all providers of humanitarian assistance fulfil established quality criteria for working in The Bahamas during a disaster response.

6.10 Encourage civil society actors to advocate for updating DRM plans and align these with national policies and procedures, to ensure a collaborative approach to DRM.

6.11 Support local ownership of resources and decision-making from the outset.

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Guidance Notes:

National Humanitarian Assistance Standards as key coordination tool: The standards in this Handbook are key to a coordinated humanitarian assistance and recovery. They should be continuously communicated, and training provided as appropriate and needed. Ensure the Standards are solidly embedded in all national emergency preparedness and response guidance.

Coordination: DRM Act Article 57 sets out the coordination principles, responsibilities and instructions relevant for disaster response, and outlining the coordination responsibilities of the Prime Minister, the DRM Authority and the Administrator of the affected area. All actors (gov. and non-gov / national and international) within the DRM system involved in the response must know their roles and responsibilities as set out in the 2022 Act, and act accordingly to ensure an articulated, effective and timely response avoiding duplication of efforts, unsolicited donations and delays.

Coordination includes allocation of competencies among government agencies, a strong link between national and island response, strong coordination mechanisms at island level, and incorporation of non-governmental and private sector actors (national and international) into the national disaster management framework.

A review and update of existing coordination mechanisms with national and international partners should happen annually.

The coordination mechanisms need to be well documented and effectively tested during exercises. Learnings from exercises and actual disaster response must be captured and included in the NDEP.

Coordination of international assistance may be requested based on the assessment of humanitarian needs and damages and the availability of domestic resources to meet the identified needs. A clear list of aid required must be established and published and travel clearance for international aid workers given as needed. The DRM Authority will act as the liaison between the international aid actors and the Government and is responsible for ensuring that international humanitarian actors are well informed about the policy, institutional and legal environment in The Bahamas, as well as the operational context.

CDEMA is a key actor for mobilizing and coordinating disaster relief to affected Participating States. Logistics chapter.

The International Cluster System coordinates international disaster relief support. It is important for Bahamian NDEOC and ESF leads to understand the Cluster system and how best to liaise with it to ensure that international assistance, when requested, will be able to support national and local efforts in a coordinated and effective manner.

The National Disaster Emergency Plan and Instructions for Emergency Operations are the place where all coordination efforts come together. The NDEP lists the EOCs on each Family Island. It also lists key tasks and Standard Operating Procedures (SOP) for each ESF.

Information exchange: The central information platform includes early warning information and is fully integrated into the National and Local Body Emergency Response Plans. Core Standard 2.

Ensure that key planning documents, including government planning documents, are updated and available online.

> **Note:** International assistance, including customs clearance, is covered in the Logistics chapter.

The Non-Governmental Consultative Council: will contribute to integrating private sector, international NGO and local NPO and faith-based organization capacities and staff into NDEP along clear plans and procedures. Private sector resources and personnel are integrated into the NDP and topical ESFs through ESF13 (Volunteers) or based on expertise and roles in prior disasters.

ESF13 maintains and updates standardized procedures for identifying, providing, accepting and distributing NGO and private sector capabilities, capacity, equipment and commodities, so they can be activated/mobilized easily and rapidly during response operations. This includes minimum staff competencies needed to support each ESF. Core Standard 8.

DRM Authority maintains updated resource inventories and mobilization information for both the public and private sectors, as well as a personnel roster.

Registration of NGOs and NPOs: National NPOs must sign up through a Non-Profit Organizations Registration procedure. As possible, international NGOs and agencies should operate through local or national branches.

Agreements with private sector actors: Partnerships between GoBH and private sector actors must be concluded through a signed MoU or Mutual Aid Agreement, which is to be reviewed annually. Logistics standards: Procurement.

Becoming a vendor or partner for disaster response must follow clear and transparent processes, which ensure fair and transparent treatment of all providers of humanitarian assistance. These agreements should be reviewed and updated regularly and integrated into a dynamic roster. Logistics.

Family Island-level disaster preparedness and management: Family Island Administrators have a key role in convening Family Island-level actors (Government, NGOs, private sector actors). Island-level disaster plans should be updated and submitted regularly to DRM Authority for review, uploading, testing and operationalization.

Ensure strong links between NEOC and Family Island EOCs. Local emergency plans must exist, be communicated, and linked to the ESF/NEOC system to ensure synergies between them and with the national level.

To be operationalized, the Incident Command Structures and Systems (ICS) need to be structured, up-to-date and with a well-functioning governing mechanism. This includes a sufficient number of well-trained NEOC managers and ESF staff. Core Standard 8.

Family Island Coordination Centers and ICCs should be staffed and equipped. For small islands with limited facilities, a dual-use location should be envisaged (for example police stations, government buildings or public libraries). Functioning and tested communication equipment

(as a minimum radio communications and satellite phones) for the coordination center must be provided by the Family Island Administrator.

Island Coordination Centers should be identified well ahead of hurricane season, their existence should be well known to island inhabitants. The same goes for EOCs, which should be identified early on, equipped, configured and tested.

Mutual Aid and Support Agreements across Family Islands: The unique geographic setup of The Bahamas calls for strong local disaster management mechanisms and capacities. It is important to empower Family Island Administrators should be empowered through training, equipment and resources. These should be clearly outlined in the annual disaster plans and budgets submitted to the DRM Authority.

Ensure that there is a formal mechanism for setting up and enforcing mutual aid agreements between Family Islands. These should be regularly reviewed and updated.

CORE STANDARD 7

Monitoring, evaluation and learning

Aid and assistance are continually adapted and improved based on feedback and learning.

KEY ACTIONS

7.1 Regularly collect and respond to feedback and inputs from people and communities about the disaster response. Core Standards 4 and 5.

7.2 Collect disaggregated monitoring data (including from local private sector actors and NPOs) for decision making that reflects the diversity of people and communities and in ways that minimize demands on them.

7.3 Use data from monitoring, feedback and learning to guide decision making, and to improve ongoing interventions and the National Disaster Management approach, including ESF instructions/guidance and disaster communication with people. Core Standard 1.

7.4 Systematically share the analysis and learning from feedback and monitoring and any related changes with the affected people and communities, and via the national database.

Guidance Notes:

Evaluations: Ensure that timely post-disaster evaluations are carried out, and learning is integrated into preparedness, response planning and recovery activities. Consider making such evaluations/ After Action Reports required. Ensure that Plans, policies and procedures are regularly reviewed.

Evaluate and update the National, Local and Public Body Disaster Plans. Monitoring the implementation and learning from the findings should be fully integrated into disaster management processes.

Data disaggregation should be carried out along relevant protection criteria, but as a minimum by gender, age and disability.

Collaborative learning and sharing of lessons: Collaborative learning with other agencies, NGOs, private sector partners and academia can introduce fresh perspectives and ideas, avoid future mistakes and maximize the use of limited resources. Collaboration also helps to reduce the burden of repeated evaluations in the same community. Core Standard 8.

Planning, monitoring and evaluation indicators: Annex 2 in this Handbook includes planning, monitoring and evaluation indicators.

CORE STANDARD 8

Humanitarian workers' competencies and wellbeing

Staff and volunteers are respectful, competent and well-managed.

KEY ACTIONS

8.1 Maintain a safe and inclusive working environment, taking measures to protect the safety, security, wellbeing and dignity of all staff and volunteers.

8.2 Ensure all staff and volunteers have the necessary support, skills and competencies to fulfil their roles and responsibilities effectively and with accountability.

8.3 Ensure procedures are in place that allocate support staff and volunteers to ESFs.

8.4 Ensure all staff and volunteers understand and adhere to their agency's or organization's code of conduct, the National or Local Body Disaster Response Plans, and that they know about and understand the National Standards.

8.5 Ensure there are safe, confidential, and accessible ways for all staff and volunteers to raise concerns and report misconduct, with appropriate protection for those reporting.

8.6 Take timely, appropriate actions to address misconduct of all staff and volunteers in line with recognized good practice.

8.7 Establish a coherent organizational approach to ensure that human resources are managed effectively in a fair, non-discriminatory, and transparent manner, in line with recognized good practice.

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Guidance Notes:

Job descriptions and staff development: Ensure staff job descriptions are accurate and kept up to date, including staff responsibilities, to ensure they have a clear understanding of what is required of them in an emergency situation. Job descriptions should also be subject to development plan with objectives for work aspirations and competencies. Support staff to attain these objectives. Do the same, as much as possible, for volunteers who are not employed by another agency or organization.

Adherence to humanitarian values and principles: Humanitarian aid must be based on need alone. Ensure that staff and volunteers understand the importance of this principle and work reliably and without bias towards the people they serve. Core Standard 9.

Staff and volunteer security and wellbeing: During disaster response, staff often work long hours in risky and stressful conditions. Ensure staff and volunteers can take personal responsibility for managing their wellbeing. Promote and implement actions to ensure mental and physical wellbeing and avoid long term exhaustion, burnout, injury or illness.

Psychological first aid should be immediately available to workers who have experienced or witnessed extremely distressing events. If possible, provide longer-term psychological support as needed.

Train staff to receive information on incidents of sexual violence experienced by their colleagues. Provide access to robust investigative and deterrence measures that promote trust and accountability.

Harassment and abuse: Establish an agency/organizational policy that expresses zero tolerance for harassment and abuse, including sexual harassment and abuse, in the workplace. Establish holistic prevention and response strategies to address incidents of sexual harassment and violence as experienced or perpetrated by their staff. Core Standard 5.

Staff capacity: Build HR capacities across the nation to support DRM activities, and to be ready to increase staffing in support of Disaster Emergency Operation Center (DEOC) operations. Ensure staffing support to affected Family Islands and to the NDEOC.

Surge capacity: Formalize a process to identify and recruit surge staff within the disaster management stakeholder community, including NGOs, the private sector and other government agencies. Develop and use island pairing and mutual aid arrangements. Core Standard 6.

Staff and volunteer competencies: Ensure a structural, long-term national approach to disaster management capacity building, led by the DRM Authority. The approach includes all levels of disaster management and response. Support ESF leads so they can train their staff consistently and report on the training.

Ensure staff and volunteers are trained in first aid and psychological first aid, to ensure they are ready to deal with disasters and to support disaster victims. Core Standard 3; Health Standards for Injury Care and Mental Health.

Training plan: Develop a multi-year disaster management training plan. DM training should be compulsory at agreed levels and frequencies. Approved training materials should be used as references for new personnel or refreshers, including for personnel of the DRM Authority, NEOC, ESFS and DDC, as well as Family Island Administrators. Ensure accredited NGOs and private sector partners administer the same or similar training to their staff and to volunteers deployed to disaster response. Core Standard 3.

Training on humanitarian principles and standards should be provided to all individuals involved in humanitarian assistance.

Disaster simulation exercises: Consider broad yearly disaster exercises involving multiple Disaster Management actors, to increase awareness of the importance of coordination and collaboration. Use that occasion for sharing and jointly reviewing National, Island and Sectoral Disaster Response Plans. Incorporate lessons learned from these exercises into further disaster response planning. Develop and support island-level exercise planning and execution capabilities. Maintain electronic training and exercise records.

Collaborative training and links to learning: Consider partnerships with academic and non-governmental organizations, to address comprehensive training and education requirements that will meet current and emerging disaster management and disaster risk reduction requirements. Ensure training reports are filed for the record and for learning. Core Standard 7.

Volunteers are a valuable resource in humanitarian response in The Bahamas. The term "volunteer" refers to a range of individuals working for a variety of non-profit and private sector actors who are deployed in case of a disaster. It is therefore important to have procedures in place to integrate them into the response structure. ESF13 is dedicated to ensuring this and aligning work with volunteers to any relevant national regulation.

CORE STANDARD 9

Resource management

Resources are managed ethically and responsibly.

KEY ACTIONS

9.1 Ensure adequate capacity and resources to meet humanitarian assistance commitments.

9.2 Manage financial resources responsibly, including monitoring expenditure and reporting it against budget.

9.3 Ensure fundraising, resource mobilization and fund allocations are transparent and ethical and do not compromise any commitments and values.

9.4 When using local and natural resources, consider their impact on the environment.

9.5 Identify, prevent and manage risks at all levels, including corruption, fraud, misuse of resources and conflicts of interest, and take appropriate action if these are identified.

Guidance Notes:

National Development Plan - Capacities and resources: Allocate funding specific to DRM programs and response activities. Work with Family Island administrators to identify priorities of disaster management and mitigation projects. Regularly budget for formal training and exercise programs for disaster management personnel and volunteers, particularly at community and island levels.

Transparent resource allocation at the government level is important, with independent controls of flows of funding for humanitarian and recovery assistance.

Organizational risks: Establish transparency, accountability and monitoring mechanisms in relation to disaster recovery programs and activities, including civil and criminal sanctions for non-compliance.

Corruption: A definition and understanding of corrupt practices are reflected in national anti-corruption and anti-bribery laws. It is important to have clear definitions of staff behavior and communicate them transparently with all partners (NGOs and private sector actors) and with affected communities. The Bahamas Ombudsman Act 2024 is a good tool for raising corruption concerns.

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SHELTER

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SHELTER

The Shelter standards are a practical expression of the right to adequate housing in humanitarian contexts. People's primary shelter is their own home. However, due to the increased severity of hurricanes and other natural hazards in the region, various kinds of communal shelter response must be planned for to address short-term, mid-term and long-term shelter needs.

Disaster emergency and community evacuation shelters to accommodate people during and right after a disaster emergency are set up on all islands. They offer protection from the disaster and are also the place where people will find clean water, food, emergency medical assistance, psychological support and overall security in a way that is sensitive to gender and disability issues, and that protect particularly vulnerable groups.

The contexts vary enormously between islands and within islands and depend on the nature and severity of a natural hazard. Having a variety of shelter options available will contribute to ensuring an appropriate shelter response.

Transitional shelters and temporary housing options are important to ensure people have time to recover and reconstruct their homes and livelihoods.

ESF6 (Mass Care and Shelter Services) is led by the Disaster Management Unit (DMU) of the Department of Social Services, in partnership with the DRM Authority and in compliance with the National Disaster Emergency Plan.

- The DRM Authority checks the overall appropriateness of the facility as an emergency shelter.
- The Ministry of Public Works ensures the shelter's strength, maintenance and structural integrity.
- The Department of Environmental Health Services checks for adequate and gender-sensitive sanitation, toilets, showers and sewage treatment capabilities.
- The Department of Social Services focuses on shelter coordination personnel, gender-sensitive shelter layout, disability access, provision of equipment and services that ensure the physical and mental safety of shelter residents. Its Disaster Management Unit (DMU) is primarily responsible for shelter management.

There are nine Shelter Standards:

1. LONG-TERM PLANNING
Shelter interventions are planned and coordinated to contribute to the safety and wellbeing of affected people, and to promote recovery.

2. SITE AND SHELTER PLANNING
Disaster emergency shelters are located in safe and secure areas, offering adequate space.

3. LIVING SPACE
People have access to safe and adequate living space for disaster emergency and transitional shelters.

4. NON-FOOD ITEMS
Essential non-food items support health, dignity and safety.

5. TRANSITIONAL SHELTER AND HOUSING OPTIONS (not including reconstruction)
People have timely access to appropriate assistance for transitional shelter and housing options.

6. SECURITY OF TENURE
Affected people have security of tenure in their transitional shelter and housing options.

7. LIVELIHOODS
Women and men receive equal access to appropriate income-earning opportunities where income generation and employment are feasible livelihood strategies.

8. ENVIRONMENTAL SUSTAINABILITY
Humanitarian assistance, including shelter and housing assistance, minimize any negative impact on the natural environment.

9. DEBRIS MANAGEMENT
Debris is managed in a safe and timely manner and minimizing impact on communities and the environment.

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SHELTER STANDARD 1

Long-term planning

Shelter interventions are planned and coordinated to contribute to the safety and wellbeing of affected people, and to promote recovery.

KEY ACTIONS

1.1 Together with all relevant stakeholders involved in shelter planning, and particularly the affected communities, assess the shelter needs and capacities on a yearly basis.

1.2 Support communities and individual households to be better prepared in terms of emergency shelters.

1.3 Work with all relevant stakeholders and communities to identify the most appropriate shelter options and selection – including both emergency and transitional shelters and considering needs of elderly persons and persons with disabilities.

1.4 Develop a shelter plan together with all stakeholders, including Family Island ICCs, Coordination Centers and communities.

1.5 Develop an ongoing shelter communication plan with all stakeholders, and in particular local communities, and publicize updated lists of available shelters.

1.6 Plan for long-term evacuation shelters at the locations where people may be evacuated.

1.7 Develop mass evacuation plans for each Family Island or island group.

1.8 Include in the shelter plans, environmental considerations as outlined in Shelter Standard 8.

Guidance Notes:

Assessment of disaster emergency and transitional shelters: Between February and April of each year, compile and update shelter lists and inspect existing shelters used for disaster emergencies. Identify new shelter buildings as needed. Ensure these activities take place well ahead of hurricane season and other recognized seasonal natural hazards, to allow for any repairs to be carried out. Allocate sufficient funding and time to ensure that dual-use buildings like schools or churches are upgraded to hurricane proof and then routinely serviced. Actively support Family Island administration, communities and professionals in the building and/or securing process of storm-resistant buildings that can serve as emergency shelters. Ensure shelter suitability assessments are completed, documented and widely distributed.

Shelter occupancy: Determine for each island, the approximate number of people who will need a disaster emergency or transitional shelter solution and ensure sufficient structurally sound shelter options are available and accessible to communities, so people have options to relocate.

Community preparedness: Through schools, churches, the Bahamas Red Cross and community-based groups, support preparedness at the household level through adapted communication campaigns (Core Standard 1). Support communities with information on reinforcement measures to secure homes and properties including climate resilient and adaptive design options where appropriate.

Shelter location planning should be done collaboratively between the DRM Authority, the Ministry of Works and the Department of Social Services. It should consider vulnerability to relevant hazards and appropriateness of a place and the environment surrounding the shelter, including topography of the site, proximity to watercourses, access paths, nearby hazardous materials, trees, power cables and potential landslides. Having more than one shelter available will increase preparedness. Make sure new shelters are in areas with low risk regarding storm surges, flooding and other relevant hazards.

Access and inclusion: Some shelters may be difficult to reach for remote communities. Where this is the case, efforts should be made to identify these areas and prepare additional community shelters, which are in or near population centers, so they can be reached easily and quickly, in the event conditions change rapidly. All people should be able to reach a shelter within a reasonable time span, determined according to context. Particular attention must be paid to isolated communities.

Shelter plans should be culturally appropriate and gender-sensitive and support groups with special needs, including the elderly, people with disabilities and chronic illnesses, and people who do not have access to transportation in an evacuation situation. Shelters should have areas for parking. Where needed, allow guide dogs and other recognized service animals.

There should be shelters near or within reach of marginalized communities, and adapted communication with these communities should ensure that women and children and vulnerable persons feel safe to seek shelter if needed. Core Standard 1.

Health-related hazards: Have protocols at hand in case of health-related hazards such as epidemics or pandemics. Consider the ease of access to the shelter for supplies. Health Standards.

Dual use: Consider dual-use buildings rather than building sole-purpose shelter buildings. This also ensures that buildings are maintained and are well known to the local community. Dual use should not include hospitals and EOCs, or other spaces for critical community lifeline services.

Shelter options and surge capacity: Due to the unpredictability of a disaster, shelter options should be varied in terms of numbers and duration. Consider hotels and other private structures. Additional surge capacity or secondary shelter locations should be identified, evaluated and resourced appropriately before landfall. This includes plans and processes for evacuations and sheltering people on neighboring islands. Such scenarios, as well as roles and responsibilities of a host island, must be prepared in advance for host islands to be able to provide shelter and mass care to evacuees. Evacuation plans should include the evacuation and sheltering of Grand Bahama and New Providence residents among the Family Islands where possible.

Mutual support agreements and MOUs should be set up among neighboring islands and Public-Private Partnerships to support evacuation and shelter plans. These MoUs should be reviewed annually to strengthen partnerships and clarify expectations from both the government and partners, for example regarding the use of a building as a shelter. The DRM Authority should provide clear guidance and SOPs for equipping existing facilities.

Shelter inspections should lead to the facility representatives/owners being able to carry out the identified improvements to maintain and enhance the safety and functionality of the shelter facility.

Schools and curricula: Use school buildings for short-term shelters, plan to transfer longer-term shelter residents to appropriate shelters and to restore school buildings to their main function as soon as possible and resume school. For pupils unable to attend school for a prolonged amount of time after a disaster, the Ministry of Education may consider alternative instructional methods, including virtual platforms.

Scenario-based planning and community drills and trainings should be carried out regularly with all community members, including vulnerable and marginalized groups. Regularly conduct shelter manager and staff trainings. Participation should be mandatory for all shelter managers. Shelter manager and staff should be trained in first aid and psychosocial first aid.

Mapping of population: Drills and trainings should facilitate the mapping of vulnerable persons in the community particularly persons with disabilities, those that may require specialized medical or mental health intervention, people with mobility issues, shut-ins and elderly persons living alone. Curated resource listings should be established to ensure appropriate referral where necessary. Community human and transportation resources should also be identified to support the shelter plan.

Emergency provisions and important documents: Ensure awareness of minimum emergency provisions at the community and individual levels including items to take to the shelter and supplies for the first 72 hours. Ensure people understand they need to secure important identification documents.

Long-term public shelter communication: The DRM Authority should inform the public about evacuation and shelter plans and provide information resources to ensure a safe shelter experience during a disaster event (both for private and public sheltering communities). Shelter communication should include a long-term perspective of information sharing and building trust, in order to adequately prepare communities for a storm and to ensure they seek shelter or follow evacuation orders before a storm hits. Core Standard 1.

Mass evacuation plans should exist for every location in The Bahamas, including remote Family Islands, developed in collaboration with identified local and external transportation resources, so they can be activated efficiently. Have shelter options in place to receive higher numbers of evacuees than anticipated. Evacuations from New Providence and Grand Bahama will entail particular challenges that should be planned accordingly. The possibility that people may leave the country and any linked issues should be considered as well.

Identification documents: Develop a protocol to facilitate and process persons who may have lost their identification documents to be evacuated under specific conditions.

Transitional shelter occupation: Persons that may have lost their homes may not have the option to leave the shelter. Discuss changes in the local situation and any new or extended shelter needs with the Family Island Administration and representatives of the local communities. Ensure that any specific protection or accessibility needs are taken into consideration. Some shelters should be equipped for longer-term stay as part of the Shelter Plan, which should also consider, as needed, building dedicated structures for extended sheltering. Shelter Standard 5.

Shelter repairs: After the hazard phenomena has ceased, assess damage and determine a shelter repair plan, prioritizing those repairs that will have the greatest impact on shelter safety. Prioritize schools used as shelters, so they can return to their primary purpose as soon as possible. Ensure that shelter owners and the authorities have sufficient funding allocated for shelter repair activities. Core Standard 9 and Shelter Standard 5.

SHELTER STANDARD 2

Site and shelter planning

Disaster emergency shelters are located in safe and secure areas, offering adequate space.

KEY ACTIONS

2.1 To prepare identified shelters, work according to zoning plans, the National Building Code and in agreement with local communities and authorities.

2.2 Plan the emergency shelter space for a variety of functions in line with its intended purpose, including water and sanitation facilities and communal cooking facilities, private spaces for breastfeeding and child-friendly spaces.

2.3 For each communal shelter listed, have shelter coordination teams trained continuously and ready for mobilization.

2.4 Ensure that the placement of essential functions and facilities in the shelter ensures safety, protection and dignity.

2.5 Ensure that all personal information collected from shelter occupants is appropriately gathered, securely stored and used for security and protection.

2.6 Plan for rainfall or floodwater drainage and ensure that drains in existing shelters are cleaned every year ahead of hurricane season. Identify leaks and ponding to anticipate and manage potential breeding sites of disease vectors.

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Guidance Notes:

Planning processes and principles: Provide a detailed set of requirements for a shelter to be added to the list. Ensure that shelters on all islands, including remote Family Islands, are equally included in the shelter planning process.

Ensure that shelters, hospitals, fire stations and the ICCs are built to withstand category 5 winds, storm surges and floods. This means they adhere to the National Building Code and are in designated safe zones, with safety protocols and appropriate levels of emergency equipment and supplies. The Royal Bahamas Defence Force (RBDF), with the DRM Authority, will check for shelter security (windows and doors, safety hazards, restricted areas, perimeter safety, and overall property security and staging areas).

Shelter planning should always include:

- **Shelter infrastructure preparation** according to The Bahamas National Building Codes.
- **Minimum emergency equipment** (fire extinguishers, medical kits, generators, water supplies, septic tank or other sewage system).
- On some Family Islands, **water purification system**.
- **Minimum supplies** in place or available at short notice Logistics.
- **A core shelter team,** consisting of a manager, a medical professional and RBPF or RBDF representative.
- **An evacuation plan** in the event the shelter is compromised Shelter Standard 1.
- **A defined maximum capacity level.** Catchment number should be adjusted to context.
- **A defined catchment population,** with maximum distance from a catchment population Shelter Standard 1.
- **Elevation above storm surge flooding,** based on existing hazard maps and assessments.
- **Documentation permanently in place** at each shelter for registration, shelter management and information for evacuees.
- The option to **accommodate individuals who need to bring animals,** in particular service animals like guide dogs.

Communal shelter management team: Ensure shelter management teams are well-trained, including on first aid and psychological first aid. Ensure the teams have adequate composition and operational and technical capacity to manage the shelter. Pay particular attention to ensuring volunteers understand and can take on responsibilities.

A shelter management team should consist of, at a minimum:

- **A manager** to manage registration and communication with evacuees. Normal occupants of the shelter (school or church members) support the manager.
- **One medical professional,** trained also in psychological first aid.
- **One person from RBPF or RBDF** to ensure protection and security.

Ideally, a Shelter management team will include more people, in particular Interpreters (including for sign language), personnel for medical and psychological support, people carrying out repairs in the shelter and sanitation support.

Search and Rescue: The Shelter management team should be ready to receive individuals handed over by Search and Rescue teams and support them with registration, medical aid, psychological first aid, food, water and shelter supplies.

Registration process and data protection: A pre-defined registration process is in place to process all individuals ensuring all personal data is secure. Consider how to accommodate requests for bringing animals to the shelter.

Essential services for emergency shelters: People in public shelters require safe, secure and equitable access to essential services and facilities, which are:

- Emergency water supply WASH.
- Toilets.
- Functioning septic tanks or other sewage systems.
- Fire extinguishers.
- Safe solid waste disposal.
- Emergency power supply for lighting.
- Food supplies, storage and processing facilities (including fuel).
- Basic medical supplies.
- Safe sleeping space (cots, blankets – including for infants and small children).
- Where possible, social spaces such as meeting points and recreational areas, particularly for children, and persons needing psychological support.
- Clean cooking and eating facilities.
- Showers.

Personal data collection should allow for anonymizing the data later, to ensure all population groups come forward to seek shelter.

Drainage of rainfall and floodwater: Avoid selecting a shelter site that is prone to flooding and storm surges. Protect toilets and sewers from flooding, to avoid structural damage and leakage and increased exposure to diarrheal diseases from contact with contaminated water. Annual maintenance should prioritize drainage conditions and appropriate solutions. Flood Mitigation Measures: Any buildings situated in flood-prone areas should seek guidance from the DRM Authority on effective mitigation measures to minimize risk.

Communication systems: Have an emergency communications system in place.

Warehousing: Pre-positioning key emergency goods must be as planned as possible. This includes water purification systems, non-perishable foods and essential medicines. Logistics.

SHELTER STANDARD 3

Living space

People have access to safe and adequate living space for disaster emergency and transitional shelters.

KEY ACTIONS

3.1 Ensure that each affected person has safe and adequate living space, considering protection and psychosocial wellbeing.

3.2 Ensure basic communal spaces for social gathering and child-friendly spaces.

3.3 Ensure that the space immediately surrounding the living space supports safe access to fundamental activities.

Guidance Notes:

Safe and adequate living space: Living space is a core human need and right. It means having a space for an individual or family to dwell, feel safe, and perform a variety of essential domestic activities. This should be provided in transitional shelters. In a disaster emergency shelter, living space will be limited. As a minimum, people should be able to group together as families and feel safe. Provide child-safe spaces and breastfeeding spaces as a minimum.

Toilet facilities should be accessible without having to step outside. Women, girls and people needing assistance with personal hygiene often require additional space and support. WASH Standards 2 and 6.

Protection: Ensure adequate lighting in the shelters, and that there are safe sleeping arrangements for women, girls and boys, as well as safe access to toilets and bathing facilities. WASH Standard 6.

Ensure that staff know how to refer any protection concerns (including domestic violence or abuse, violence, exploitation, sexual discrimination or neglect of children).

Psychosocial considerations: During an emergency, people will be exposed to high levels of stress. Ensure that the shelter allows for communal and child-friendly spaces to gather, but also enough safe spaces to retreat and have a sense of privacy.

Animals: Dual-use buildings are often not appropriate for accommodating animals, be they service animals like seeing dogs, or emotional support animals. Consider planning for accommodating animals, for example by providing designated rooms for persons with animals.

SHELTER STANDARD 4

Non-food items

Essential non-food items support health, dignity and safety.

KEY ACTIONS

4.1 Assess and ensure access to items that enable households and shelter dwellers to restore and maintain essential domestic activities.

4.2 Monitor the availability, quality and use of household items, and adapt as needed.

4.3 Decide how to deliver the household item assistance effectively and appropriately with consideration for:

1. What can be sourced locally through **cash or voucher-based assistance** and through local, regional or international procurement for in-kind distribution.
2. Environmental issues related to how items are packaged or delivered.

Guidance Notes:

Essential household items should be available in sufficient quantity and quality for:

- Sleeping and personal clothing.
- Water storage, food preparation and storage, eating and drinking.
- Lighting.
- Cooking and boiling water.

- Hygiene, including menstrual hygiene or incontinence items.
- Protection from vectors; for example, mosquito nets, repellents, etc.
- Fire and smoke safety.
- Sanitation products, for example disinfectants, hand sanitizers, etc.

Selecting appropriate household items: Post-disaster, household items should be provided as part of the overall shelter plan. When specifying the type, quantity and quality of the items, prioritize items that are lifesaving.

Consider:

- Essential daily activities at the individual, household and communal levels.
- Cultural norms and traditions.
- Safety and ease of use (with minimal additional instruction or technical guidance).
- Durability, rate of consumption and need for replenishment.
- Current living conditions and arrangements.
- Local availability.
- Specific needs according to categories of the affected population, including women, girls, men, boys, infants, elderly people, persons with disabilities and other vulnerable individuals and groups.
- Environmental impact of the selected items.
- Storage of items; consider if some items require specific conditions for safe storage.

Distribution of goods: Plan and consult with local authorities and communities to implement efficient and equitable distribution methods to individual homes and transitional shelters. Ensure that, as much as possible vulnerable individuals, households and communities are included in distribution lists and can access both the information and the distribution itself.

Locally sourced goods and services should be encouraged through cash or voucher-based assistance and through local, regional or international procurement for in-kind distribution.

Packaging should be limited or recyclable. Logistics Standards.

Food preparation: Individual cooking facilities per family may not be foreseen in communal shelters. A central kitchen for food preparation or an area for food distribution should be available. During a storm, cooking may not be possible. Food items should be selected accordingly.

Energy supply: Electricity should be made available for charging mobile phones, lighting and storage of medication.

Post-distribution monitoring and evaluation will assess the appropriateness of the distribution process and the items themselves. Integrate the learnings from the PDM into the following year's disaster preparations.

SHELTER STANDARD 5

Transitional shelter and housing options

People have timely access to appropriate assistance for transitional shelter and housing options.

KEY ACTIONS

5.1 Understand the pre-crisis planning and building practices.

5.2 Develop and implement a transitional shelter and reconstruction strategy at both national and Family Island / New Providence / Grand Bahama levels.

5.3 Establish appropriate project management of materials, finance, labor, technical assistance and processes for regulatory approval in support of home and shelter repairs.

5.4 Where transitional housing is provided, ensure that this is done in a dignified and environmentally responsible manner, and that materials and building elements can be reused.

5.5 Ensure that people have access to adequate technical assistance for repair and reconstruction of homes and shelters (both emergency and long-term).

5.6 Support homeowners in their reconstruction efforts according to established, agreed and transparent criteria and through adequate technical assistance.

Guidance Notes:

Building practices and related regulatory frameworks should be well understood, in particular by foreign aid organizations. This information should be provided by the government.

Shelter and home repair and reconstruction are carried out during the year and in preparation for the next hurricane season. Communities should be actively involved. Support to communities and individual households should include materials where needed and technical assistance and training.

Resilient recovery: Ensure that all minor and major reconstruction efforts (including shelter repairs and constructions) respect the Zoning Plans to ensure safe location, that they apply the

Bahamas Building Codes and safety standards for essential infrastructure, and that they use adequate materials and construction methods. Ensure funds for maintenance of key infrastructure.

Community empowerment: Avoid disbursement of public funds for works that could reproduce disaster risks, especially in the housing sector. Empower communities and promote local networks as first line of action.

Environmental considerations: Transition to decentralized utilities and boost the use of renewable energy, especially in the power, telecommunications and water and sanitation sectors. Protect, recover and promote healthy ecosystems as first defense mechanisms. Shelter Standard 7; Nature-based Solutions Guide.

Looting and criminal activities: Transitional shelters may be confronted with gang and criminal activities. Guidelines should be developed for the Shelter Management teams to understand their options to address these issues and what legal and security support they can expect.

Shelter closure: Consider a minimum number of shelter occupants at which a shelter should be declared closed. Combine multiple shelters to minimize the number of open shelters. Put a plan in place on how to meet the needs of the remaining shelter residents by exploring other temporary housing options provided by the Department of Social Services. Avoid evictions Shelter Standard 6 – Security of tenure.

Reconstruction should be supported in clear and transparent ways as set out by the relevant government agencies. While it should be planned as part of shelter preparedness, it does not fall within the scope of the National Humanitarian Assistance Standards.

SHELTER STANDARD 6

Security of tenure

Affected people have security of tenure in their transitional shelter and housing options.

KEY ACTIONS

6.1 Plan transitional shelter and housing options ahead of hurricane season, including a clear understanding of the legal frameworks needed and the limitations to security of tenure.

6.2 Undertake due diligence in designing and implementing extended shelter and temporary housing programs, with as much legal certainty about the options as possible, and in coordination with local authorities.

6.3 Implement extended shelter and temporary housing programmes to support house owners before they can return or find a new permanent home.

6.4 Have guidelines for rental support as a temporary housing option.

6.5 Support protection from forced eviction, and in case of eviction, identify alternative shelter solutions and other assistance as needed.

6.6 Conduct the closing of shelters and temporary housing programs according to clearly defined criteria and supporting people to find solutions to their housing situation. Minimum Standards for Camp Management.

Guidance Notes:

Tenure: There are many forms of tenure arrangements, ranging from full ownership and formal rental agreements to emergency housing and occupation of land in informal settlements. Security of tenure means that people can live without fear of forced eviction, whether in public shelters, informal settlements, host communities or after return from shelters. It is an integral part of the right to adequate housing and guarantees legal protection against forced eviction, harassment and other threats, enabling people to live in their (temporary) home in security, peace and dignity. All people, including women and children, should possess a degree of security of tenure. Tenure insecurity mostly concerns poor and isolated communities with irregular status, and informal settlements.

Post-disaster tenure issues: A number of households may be in need of temporary shelter assistance, for example through rental support. Lacking house insurances for reconstruction may be an issue. A strategy should be in place to address homelessness and to find long-term solutions where return is not an option.

Extended shelter and temporary housing options should be planned ahead to respond to shelter needs after a mass evacuation. Building dedicated shelters for extended stays should be considered as one option. Standards for building and running transitional shelters should go beyond the National Humanitarian Assistance Standards.

Ensure that documentation, such as tenure agreements, is properly prepared and reflects the rights of all parties. Reduce the risk that the shelter programme may cause or contribute to tensions within the community and with surrounding communities.

Legal framework and time limitations: As part of disaster preparedness, achieve as much legal certainty about tenure as possible. Work with local authorities to understand which regulations will be enforced and which will not, and the related time frames. Understand how tenure relations are managed and disputes resolved, and how this may have changed since the onset of the crisis. This information, for example in form of practical and legal guidelines, should be provided in advance by the Government (relevant website). Core Standard 6; Shelter Standard 1.

Security of Tenure for at-risk groups: Include security of tenure as an indicator of vulnerability. Understand what documents may be required by people participating in a tenure program, noting that some people may not have, or be able to access, these documents. Ensure that the response is not biased towards owner-occupier.

Evictions and relocation: People should feel safe to be sheltered for the time they need to find a solution to their living situation. There should be no threat of evictions from shelters and deportation during a declared emergency or disaster event. A **non-eviction period** should be clearly communicated and – if needed – extended.

SHELTER STANDARD 7

Livelihoods

Women and men receive equal access to appropriate income-earning opportunities where income generation and employment are feasible livelihood strategies.

KEY ACTIONS

7.1 Give priority to local government and community leaders to ensure they can resume their leadership roles.

7.2 Base decisions regarding income-earning activities on a gender-sensitive market assessment.

7.3 Choose types of payment (in-kind, cash, voucher, food or a combination) based on a participatory analysis.

7.4 Base the level of payment on the type of work, local rules, objectives for livelihoods restoration and prevailing approved levels of payment.

7.5 Consider safety-net measures such as unconditional cash and food transfers for households that cannot participate in work programmes.

7.6 Adopt and maintain inclusive, safe and secure working environments.

7.7 Promote partnerships with the private sector and other stakeholders to create sustainable employment opportunities.

7.8 Include security of tenure and temporary housing into livelihood strategies.

7.9 Choose environmentally sensitive options for income generation whenever possible.

Guidance Notes:

Local government and community leaders: It is important that local government is respected and can resume its role as soon as possible. It should receive the necessary support.

Care of children and the elderly: When proposing cash-for-work programmes, ensure that participants can rely on care for their children or elderly people who rely on them, for the duration of the work.

Safe and secure work environments: Monitor the risk of sexual harassment, discrimination, exploitation and abuse in the workplace and respond quickly to complaints.

Private sector engagement: Create lists of local contractors and businesses on the Family Islands. This will facilitate post-disaster outreach, giving them, whenever possible, the first right of refusal for government contracts related to recovery efforts, including debris removal. This approach contributes to supporting local livelihoods.

Security of Tenure as part of a broader livelihoods approach: Security of tenure includes ways to ensure homeowners can continue to pay their rent and other related continued expenses. Government support plans should be developed and ready for implementation.

Transitional shelter and livelihoods assistance must be planned, and funds set aside accordingly. It is provided to people who need continued support because they have not yet been able to find a durable solution. This can happen, for example, through supporting the payment of rent and related continued expenses. Cash and voucher assistance for livelihoods are another option. At-risk individuals and communities should receive particular consideration.

SHELTER STANDARD 8

Environmental sustainability

Humanitarian assistance, including shelter and housing assistance, minimize any negative impact on the natural environment.

KEY ACTIONS

8.1 Make available, be aware of, and comply with, relevant national environmental laws.

8.2 Integrate environmental impact assessments and management in all shelter options planning.

8.3 Select the most sustainable materials and techniques among the viable options of shelter construction, repairs etc.

8.4 Manage storm debris in a safe, timely and environmentally sustainable way: salvage and reuse, recycle or re-purpose available materials where possible.

8.5 Establish, restore and promote safe, reliable, affordable and environmentally sustainable energy supply systems.

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Guidance Notes:

Environmental Sustainability: Shelters and temporary housing carry one of the highest risks of negative environmental impacts, and when constructed without considering the natural environment, can place vulnerable populations at greater exposure to hazards. There is opportunity for transformative change by integrating environmental considerations across shelter responses, as well as any other aspects of humanitarian assistance. Core Standard 3; WASH; Food security; Logistics.

Key National Environmental Laws are listed below. They should be made available in an accessible way (e.g. through related guidelines) to national and international actors supporting disaster response, recovery and rehabilitation, to ensure these efforts are coordinated and support existing national efforts.

- **National Environmental Management Act:** Empowers the relevant agencies to enforce environmental regulations, conduct inspections, and address activities harming the environment.
- **Hazardous Chemicals and Pesticides Control and Management Act (HCPCMA):** Regulates the use, production and disposal of hazardous materials.
- **Environmental Quality Standard Regulations** define environmental quality standards.
- **Discharge Permitting Regulations:** Regulate the discharge of waste into the environment.

These laws and the agencies responsible for executing them provide the framework for achieving environmentally sustainable practices in The Bahamas, including within the context of shelter and housing.

Environmental Impact Assessments are important to include in shelter planning, to ensure shelter activities don't do further damage to the environment. They should be carried out in close coordination with the local authorities and the Ministry of the Environment. Shelter Standard 1.

An Environmental Impact Assessment consists of three elements: a **baseline** description of the local environment against which the assessment is occurring; an understanding of the **proposed activity** and its potential threat to the environment; and an understanding of the **consequences** if the threat occurs.

Key points to consider in the assessment include:

- **Pre-crisis access** to and use of local natural resources, including fuel and construction materials, water sourcing and waste management.
- The extent of **locally available natural resources** and the impact of the crisis on these assets.
- **Social, economic and cultural issues** (including gender roles) that may influence the sustainability of the response and improve its overall effectiveness and efficiency.

- Integration of an **environmental management plan** into operations and monitoring procedures.
- Comply, as appropriate, with the national **Environmental Impact Assessment Regulations,** which mandate these assessments for certain projects.

Energy supply systems: Determine whether existing energy supply systems have a negative environmental impact on localized natural resources, pollution, health and safety. Ensure any new or revised energy supply options meet user needs; provide training and follow-up as needed.

Responsible Ministry and Departments: The following two departments are placed within the Ministry of the Environment and Natural Resources:

- The Department of Environmental Planning and Protection (DEPP) leads environmental management.
- The Department of Environmental Health Services (DEHS) is responsible for waste management and regulating hazardous chemicals.

SHELTER STANDARD 9

Debris management

Debris is managed in a safe and timely manner and minimizes impact on communities and the environment.

KEY ACTIONS

9.1 Prior to a hurricane, communities identify the safest places to store moveable objects to avoid them becoming debris.

9.2 Have community debris management plans in place that consider recycling, communication and outreach methods, equipment and supplies, collection and storage sites, and hazardous waste.

9.3 Initiate debris management immediately after the crisis.

9.4 Develop a strategic plan to mobilize debris management as soon as possible and into the recovery phase.

9.5 Between hurricane seasons, and for repairing shelters and communal buildings, consider salvaging, recycling, or re-purposing available materials, including debris.

9.6 Work with professionals on debris management, prioritizing local contractors.

9.7 Do not dispose of debris in unsafe ways (e.g. into the sea).

9.8 Reuse, recycle or compost as much of the debris as possible.

Guidance Notes:

Debris management and reuse or re-purposing: Debris consists of the remains of destroyed buildings, port structures, power lines, trees and rubble. It needs to be managed efficiently in order to regain and maintain a healthy living environment. This standard does not cover treatment or disposal of hazardous waste. Debris clearing falls under ESF3. Debris removal falls under ESF7 (Supplies and Distribution).

Debris management planning immediately after the crisis promotes the salvaging of debris for reuse, re-purposing or safe disposal. Humanitarian settings provide opportunities for innovative reuse of materials.

Debris removal: Debris can be reused, recycled or identified for separation, collection and/or treatment. It may provide opportunities for cash-for-work programmes. Key issues include the presence of human bodies, structurally dangerous locations and hazardous materials. Removal of debris may require specialised expertise and equipment, so must be planned with other sector specialists. Coordinate with WASH, Health, Public Works and other authorities.

Private sector actors should be involved actively for their support in debris removal and to (re) establish sustainable debris and waste management practices.

Dumping debris into the sea should be avoided at all cost, since they may contain gasoline, motor oil and other substances damaging to the environment.

Protection for debris handlers: Debris may contain hazardous substances such as asbestos. Provide Personal Protection Equipment for everyone involved in debris removal. When necessary, provide immunization against tetanus and hepatitis B. Ensure that soap and water is available for washing hands and face. Inform and train staff on the correct ways to transport and dispose of debris and of the risks associated with improper management.

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WATER, SANITATION AND HYGIENE (WASH)

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WATER, SANITATION AND HYGIENE (WASH)

The standards covering **W**ater, **S**anitation and **H**ygiene promotion (WASH) are a practical expression of the right to access water and sanitation in humanitarian contexts. They aim to reduce public health risks linked to illness and death from diarrheal and infectious diseases related to inadequate sanitation and water supplies and poor hygiene. Community engagement in WASH is therefore very important. It is a dynamic process that links communities and response teams.

WASH interventions fall under more than one Emergency Support Function (ESF):

- ESF3 (Public Works and Engineering) covers water and sanitation, led by the Water & Sewerage Corporation (WSC) under the Ministry of Public Works.
- ESF7 (Relief Supplies and Distribution,) covers distribution of water and hygiene items. It is led by the DRM Authority.

Furthermore, WASH activities support ESF6 (Shelter) and ESF8 (Health).

There are nine Water, Sanitation and Hygiene (Wash) Standards:

1. HYGIENE PROMOTION
People are aware of key public health risks related to water, sanitation and hygiene, and can adopt individual, household and community measures to reduce them.

2. HYGIENE ITEMS
Appropriate items to support hygiene, health, dignity and wellbeing are available and used by the affected people.

3. ACCESS TO WATER AND WATER QUANTITY
People have equitable and affordable access to a sufficient quantity of safe water to meet their drinking, cooking and hygiene needs.

4. WATER QUALITY
Water is palatable and of adequate quality for drinking and cooking, and for personal and domestic hygiene, without causing a risk to health.

5. EXCRETA-FREE ENVIRONMENT
All human excreta are safely contained on-site to avoid contamination of the natural and living environments.

6. ACCESS TO AND USE OF TOILETS
People have adequate, appropriate and acceptable toilets to allow rapid, safe and secure access at all times.

7. EXCRETA MANAGEMENT
Excreta management facilities, infrastructure and systems are safely managed and maintained to ensure service provision and minimum impact on the surrounding environment.

8. VECTOR CONTROL
Vector breeding and feeding sites are targeted at community and household levels to reduce the risks of vector-related problems.

9. SOLID WASTE MANAGEMENT
Solid waste is safely contained to avoid pollution of the natural, living, learning, working and communal environments.

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WASH STANDARD 1

Hygiene promotion

People are aware of key public health risks related to water, sanitation and hygiene, and can adopt individual, household and community measures to reduce them.

KEY ACTIONS

1.1 Identify the main public health risks and the current hygiene practices that contribute to these risks.

1.2 Work with communities to design and manage hygiene promotion and the wider WASH response.

1.3 Use community feedback and health surveillance data to adapt and improve hygiene promotion.

Guidance Notes:

Public health risks related to WASH should be identified and checked yearly, for both national level and for each island individually, and responses adapted accordingly. It is important to have community profiles to determine which individuals and groups are vulnerable to which WASH-related risks and why.

The Department of Environmental Health Services (DEHS) addresses public health risks around water quality and the management of solid waste, debris and excreta, mainly on New Providence. It is important to ensure appropriate public health approaches on all islands.

Prioritizing and reducing WASH risks in the initial phase of disaster response, which is likely to include flooding, can be challenging. Focus on the access to **safe water, excreta management and handwashing**, as these are likely to have the greatest impact on preventing disease transmission. Facilities should be convenient and accessible for all users, safe, dignified and clean. Include both men and women in hygiene promotion activities.

Hygiene promotion that supports behaviors, community engagement, and actions to reduce the risk of water-borne disease is fundamental. Identify factors that can motivate positive behaviors.

Community mobilization can be done through existing structures, such as churches or youth groups. Plan for one outreach worker per 1,000 people.

Schools: Children can promote healthy behaviors to their peers and family. The Department of Education or the Department of Social Services can identify opportunities to promote hygiene in schools. Involve the children in developing the messages.

Sanitation facilities in communal shelters: Handwashing with soap is an important way to prevent transmission of diarrheal diseases. Handwashing facilities in communal shelters must be prepared so that they have a regular supply of water, soap and safe drainage. Position facilities so that handwashing happens before touching food (eating, preparing food or feeding a child) and after contact with excreta (after using the toilet or cleaning a child's bottom).

Collecting, transporting and storing drinking water safely is key to reducing contamination risks. Ensure that a good understanding of communities' preferred ways to receive and store drinking water, both as a preparedness measure and during disaster response and recovery. Ensure island-specific approaches to drinking water are included in Local Body Disaster Risk Management and Disaster Emergency Plans.

WASH STANDARD 2

Hygiene items

Appropriate items to support hygiene, health, dignity and wellbeing are available and used by the affected people.

KEY ACTIONS

2.1 Understand the practices and social norms concerning menstrual hygiene and incontinence management and adapt hygiene supplies and facilities accordingly. Shelter Standards 2 to 4.

2.2 When designing and outfitting disaster emergency and transitional shelters, consult women and girls, as well as people with incontinence on the design, siting and management of facilities (toilets, showers, laundry, disposal and water supply).

2.3 Identify and provide access to the essential hygiene items that individuals, households and communities need.

2.4 Seek feedback from affected people on the appropriateness of the hygiene items chosen and their satisfaction with the mechanism for accessing them.

Guidance Notes:

Identify essential items: Adapt hygiene items and hygiene kits to context, response phase and needs of target groups. Decide which items are essential in the initial phase (such as soap, water containers, and menstruation and incontinence materials). Keep in mind any other specific requirements, and that people are expected to bring their own hygiene items to the emergency shelters.

Suggested essential items for individual households

(to be adapted according to duration):

- Two **water** containers per household (2 to 4.5 US gallons minimum; one for collection, one for storage).
- 8.8 ounces (250 grams) of **soap for bathing** per person per month.
- 200 grams of **soap for laundry** per person per month.
- **Hand sanitizer.**
- Soap and water at a **handwashing station** (one station per shared toilet or one per household).
- **Potty, scoop or diapers** to dispose of children's feces.

Suggested essential items to bring to emergency shelters:

- 8.8 ounces (250 grams) of **soap for bathing** per person per month.
- **Soap and water** at a handwashing station (one station per shared toilet or one per household).
- **Hand sanitizer.**
- **Potty, scoop or diapers** to dispose of children's feces.
- A **dedicated container** with lid for soaking cloths and storing sanitary pads/cloths.
- **Rope and pegs** for drying.

At-risk groups: Some people will need different or greater quantities of personal hygiene items because of their age, health status, disability, mobility or incontinence. Ask people or their care givers if they need help collecting and disposing of their waste in a way that respects their dignity. Consult with them and their families or carers on the most appropriate support.

Distribution: While people are expected to bring their own hygiene items to disaster emergency shelters, it is important to make sure all population groups have access to the hygiene items they need while in post-disaster transition shelter situations. This includes elderly people, people with disability, people living in informal settlements and other identified groups.

Addressing menstrual hygiene management and incontinence in crises: Successfully managing menstrual hygiene and incontinence helps people to live with dignity and engage in daily activities, as both can be associated with stigma. It is important to consult with users about disposal mechanisms at home, as well as in emergency and transitional shelters. For planning purposes, establish minimum supplies for both menstrual hygiene and incontinence needs.

Poor incontinence hygiene management can be a major source of disease transmission in emergencies. Access to higher amounts of water and soap is critical.

Shelters: Ensure there is adequate privacy for menstrual hygiene and incontinence management in shelters. This may include using privacy screens or separate areas for changing.

WASH STANDARD 3

Access to water

People have equitable and affordable access to a sufficient quantity of safe water to meet their drinking, cooking and hygiene needs.

KEY ACTIONS

3.1 Where available, identify the most appropriate groundwater or surface water sources, taking account of potential environmental impacts of a hazard and the effects of flooding.

3.2 Determine how much water is required and the systems needed to deliver it.

3.3 For bottled water, ensure that water depots are functional, structurally safe and appropriately stacked.

3.4 Ensure that bottled water distributed post-disaster (5-gallon bottles) can be re-used and eventually safely recycled or disposed of.

3.5 Ensure appropriate waterpoint drainage at household and communal washing, showering and cooking areas, and handwashing facilities.

Guidance Notes:

Water source selection: On some Family Islands, fresh water sources include surface and ground water. These water sources may be affected by salt water after a storm surge and be unfit for consumption.

Preparing for access to water: The challenge of accessing water revolves around the ability to preposition or secure an adequate supply of drinking water on any Family Island at risk of a disaster, ensuring availability for both emergency shelters and household distribution. The suggested quantities of safe drinking water vary according to needs and the response phase. In the immediate aftermath of a disaster, the priority is to provide an adequate quantity of drinking water, even if it is of intermediate quality.

Water depots provide drinking water throughout The Bahamas. They are very important sources of clean water after a disaster when the quality of tap and source water may have become compromised. These depots should be prepared to cover post-disaster demands. They should be built to withstand hurricanes. A list of certified water depots available should be regularly communicated.

Livelihoods support: As much as possible, bottled water distribution, including of international water supplies, should be carried out through existing Bahamian water depots and local businesses, to support the local economy to recover after a disaster.

Short-term and long-term water needs: Emergency water quantities cover survival needs. Where longer-term assistance is needed, quantities will be higher over time. Water needs will also vary within the community and must be understood. Persons with disability or lactating women are just two examples of individuals needing more water.

During the preparedness phase, data on actual water use and consumption can be obtained through surveys and from companies on the ground (differs between NP, GB and FI).

Below is a list of water uses **per person per day** for three distinct phases. Amounts of water are for shelter response **planning** and must be reviewed and adapted for each shelter situation. Pre-positioned quantities may be needed either to cover the entire water needs, or to fill the planning gap where some reliable local water sources are available.

Higher amounts of water are always preferable if possible. Where people remain in shelters for longer time, water quantities will quickly need to be adapted upward. Include the affected people themselves in these deliberations.

Use of bottled water: Treated water is more cost-effective, appropriate and technically sound than bottled water, because of transport, cost, quality and waste generation. If bottled water is preferred for logistical or cultural reasons, establish an appropriate plastic waste management system. Continuously inform communities of the advantages of treated water, in information campaigns or simulation exercises.

Drainage from waterpoints, laundry areas, shower facilities and handwashing stations: Ensure that wastewater does not pose a health hazard or breeding ground for problem vectors (disease-bearing insects, rodents and other animals). Establish an overall drainage plan in coordination with shelter managers, municipal authorities and community leaders.

Water Needs per person per day	**Immediate disaster response** (up to 4 weeks): minimum 2.5 US gallons	**Early recovery phase** (1 to 3 months) – adjust according to needs): minimum X US gallons	**Late recovery phase** 3 months to 1 year (adjust according to needs): minimum X US gallons
Survival needs: water intake (drinking and cooking)	1 US gallon	Define	Define
Basic hygiene practices	1 US gallon	Define	Define
Basic cooking needs	0.5 US gallons	Define	Define
Total	2.5 US gallons		

WASH STANDARD 4

Water quality

Water is palatable and of adequate quality for drinking and cooking, and for personal and domestic hygiene, without causing a risk to health.

KEY ACTIONS

4.1 Identify public health risks associated with the water available and the most appropriate way to reduce them.

4.2 Determine the most appropriate method for ensuring safe drinking water at point of consumption or use (see guidance notes).

4.3 Minimize post-delivery water contamination at point of consumption or use.

Guidance Notes:

Maintaining a safe water chain throughout the country is essential regardless of the entity which has responsibility for it on the various islands. These responsibilities should be communicated clearly to all of those entities. A safe water chain helps avoid water-related diseases.

A risk assessment of the water chain, from the water source to the drinking water storage container, includes:

- Sanitary survey of the water collection point.
- Observation of use of separate containers for water collection and storage.
- Observation of clean and covered drinking water containers.
- Water quality testing.

Where there is a high likelihood of unsafe water, these actions can highlight apparent risks without carrying out labor-intensive household water-quality testing.

A sanitary survey assesses conditions and practices that may constitute a public health risk at the water collection point. It considers the structure of the water point drainage, fencing, defecation practices and solid waste management practices as possible sources of contamination. If applicable, the survey also examines water containers in the household.

Water quality: Tap water is unsafe for consumption in parts of The Bahamas. People are accustomed to drinking bottled water and may be suspicious to open water distribution,

which may need to be accompanied by an information campaign. Water must be distributed to individual households and shelters.

Use guidance from the Bahamian government to determine water quality.

The taste of drinking water: Safe drinking water may not always taste good (due to salinity, hydrogen sulphide or chlorine levels that people are not used to), but it is preferable to better-tasting but unsafe sources. Use community engagement and hygiene activities to promote safe drinking water.

Water disinfection: Water should be treated with a residual disinfectant such as chlorine if there is a significant risk of source or post-delivery contamination. The risk will be determined by population density, excreta disposal arrangements, hygiene practices and the prevalence of diarrhoeal disease. Turbidity should be below 5 NTU. If it is higher, train users to filter, settle and decant the water to reduce turbidity before treatment. Consider short-term double-dose chlorination if there is no alternative. Be aware that chlorine dissipation varies depending on the length of storage and temperature range, so factor this into dosing and contact times.

Quantity versus quality: If it is not possible to meet Minimum Standards for both water quantity and quality, prioritize quantity over quality. Even water of intermediate quality can be used to prevent dehydration, decrease stress and prevent diarrheal diseases.

Post-delivery contamination: Water that is safe at the point of delivery can become contaminated during collection, storage and drawing of drinking water. Minimize this through safe collection and storage practices. Ensure the community knows how to clean household or settlement storage tanks and does so regularly.

Household-level water treatment and safe storage (HWTSS): Use HWTSS when a centrally operated water treatment system is not possible. HWTSS options that reduce diarrhea and improve the microbiological quality of stored household water include boiling, chlorination, solar disinfection, ceramic filtration, slow sand filtration, membrane filtration, and flocculation and disinfection. Work with other sectors to agreed household fuel requirements and access for boiling water. Avoid introducing an unfamiliar water treatment option during a crisis. Effective use of HWTSS options requires regular follow-up, support and monitoring, and is a prerequisite to adopting HWTSS as an alternative water treatment approach. For more information see IFRC guidance for household water treatment and safe storage in emergencies.

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WASH STANDARD 5

Excreta-free environment

All human excreta are safely contained on-site to avoid contamination of the natural and living environments.

KEY ACTIONS

5.1 Establish facilities in all disaster emergency and transitional shelters (whether newly constructed or retrofitting existing structures) to immediately contain excreta.

5.2 Decontaminate any feces-contaminated living, learning and working spaces or surface water sources immediately.

5.3 Design and construct all excreta management facilities based on a risk assessment of potential contamination of any nearby surface water or groundwater source.

5.4 Contain and dispose of children's and babies' feces safely.

5.5 Design and construct all excreta management facilities to minimize access to the excreta by problem vectors. WASH Standard 8: Vector Control.

Guidance Notes:

An environment free of human excreta is essential for people's dignity, safety, health and wellbeing. This includes the natural environment as well as the living, learning and working environments. In crisis situations, safe excreta management is as important as providing a safe water supply.

Toilets, showers and sewage treatment: All people should have access to appropriate, safe, clean and reliable toilets. Uncontrolled human defecation constitutes a high risk to health, particularly where population density is high, as for example in a communal shelter, and in wet or humid environments. Containment of human excreta away from people reduces the possibility of transmitting excreta-related diseases such as cholera. Excreta containment includes collection, transport, treatment and disposal of excreta.

Planning and phasing: Plan and install appropriate equipment in all identified communal shelters ahead of hurricane season, and repair damaged installations yearly. Engage in continued hygiene promotion campaigns as part of hurricane information and training activities. Shelter standards 1 and 2.

Immediately after a crisis, control indiscriminate open defecation as a matter of urgency. If needed, build additional communal toilets, and start a concerted hygiene campaign.

Prevent defecation near all water sources (whether used for drinking or not) and water storage and water treatment facilities. Do not establish defecation areas uphill or upwind of settlements. Do not establish them along public roads, near communal facilities (especially health and nutrition facilities) or near food storage and preparation areas.

Assess the extent of damage to existing sewage systems. If damaged, consider alternatives such as portable toilets, septic tanks or containment (cesspit) tanks that can be regularly desludged. Provide appropriate guidance to households with septic tanks or cesspits.

Children's feces: Infants' and children's feces are commonly more dangerous than those of adults. Excreta-related infection among children is frequently higher, and children may not have developed antibodies to infections. Provide parents and caregivers with information about safe disposal of infants' feces, laundering practices and the use of diapers, potties or scoops to manage safe disposal.

Protection: Evidence of human feces in the living, learning and working environment can indicate protection issues. People, especially women and girls, may not feel safe using facilities. Make sure all people have safe and dignified access to facilities. WASH Standard 6: Access to and use of toilets.

WASH STANDARD 6

Access to and use of toilets

People have adequate, appropriate and acceptable toilets to allow rapid, safe and secure access at all times.

KEY ACTIONS

6.1 Determine the most appropriate design and construction options for toilets.

6.2 Determine the number of toilets needed per communal shelter based on the occupancy rate of the shelter, public health risks, and water collection and storage capacity.

6.3 During preparation phase, consult representative stakeholders about the siting, design and implementation of any shared or communal toilets.

6.4 Provide appropriate facilities inside toilets for washing and drying or disposal of menstrual hygiene and incontinence materials.

6.5 Ensure that the water supply needs of the chosen toilet facilities can be feasibly met.

Guidance Notes:

The chosen **design and construction options for toilet facilities** should ensure that toilet facilities are adequate, appropriate and acceptable for users and for maintenance workers.

Toilets are adequate, appropriate and acceptable if they:

- **Are safe to use for all,** including children, elderly people, pregnant women and persons with disabilities.
- **Are located to minimize security threats** to users, especially to women and girls and people with other specific protection concerns.
- **Are segregated by gender** (and by age if appropriate).
- **Are directly accessible** within the communal shelter, without having to go outside.
- **Provide privacy** in line with users' expectations.
- **Are easy to use** and to keep clean.
- **Do not present a hazard** to the environment; WASH Standard 7: Excreta Management.
- **Have inside locks** and adequate overall lighting.
- **Are provided with easy access** to water for handwashing and flushing.
- **Allow for the dignified cleaning, drying and disposal** of women's menstrual hygiene materials, and child and adult incontinence materials.
- **Minimize fly and mosquito breeding;** WASH Standard 8: Vector Control.
- **Minimize foul or unpleasant smell.**

Safe and secure communal facilities: All people should feel safe using communal toilet facilities. If these are inappropriately located, at-risk groups, including women, girls and boys, older people and others with specific protection concerns may feel uncomfortable using the facilities, or get harassed or attacked, especially at night. Adequately illuminate facilities. Ask the community, especially those most at risk, how to enhance their safety.

Water and toilet paper: In designing the facility, ensure enough water and toilet paper are available. Consult users about the most appropriate cleansing material and ensure safe disposal and sustainability of supply.

Handwashing: Ensure that the facility allows for handwashing, including water and soap after using toilets, cleaning the bottom of a child who has defecated, and before eating and preparing food.

Menstrual hygiene management: Toilets should include appropriate containers for the disposal of menstrual materials to prevent blockages of sewerage pipes or difficulties in desludging pits or septic tanks. Consider needs of women and girls when designing toilets to provide space, access to water for washing, and drying areas.

Minimum number of toilets in communal shelters: in the short- and medium-term (up to 3 months), strive for 1 toilet per 20 persons, if possible 3:1 female to male ratio.

Household toilet facilities should correspond to the relevant criteria above. Sufficient water, hygiene items, soap, toilet paper and other basic items must be available to individual households. Excreta containment must extend to individual houses where needed.

WASH STANDARD 7

Excreta Management

Excreta management facilities, infrastructure and systems are safely managed and maintained to ensure service provision and minimum impact on the surrounding environment.

KEY ACTIONS

7.1 Plan and establish collection, transport, treatment and disposal systems that align with local systems, by working with local authorities responsible for excreta management.

7.2 Define systems for short- and long-term management of toilets, especially sub-structures (pits, vaults, septic tanks, soakage pits) and ensure these systems are designed for short- to medium-term intensive use (while the collective shelter is fully occupied).

7.3 Dislodge the containment facility safely, considering those doing the collection and those around them.

7.4 Ensure that people have the information, means, tools and materials to construct, clean, repair and maintain their toilets.

7.5 Confirm that any water needed for excreta transport can be met from available water sources, without placing undue stress on those sources.

Guidance Notes:

Aligning with national and local systems, adapted to NP, GB or FI contexts, and ensure that any extra load placed on existing systems does not adversely affect the environment or communities.

Planning: Initially, plan for an excreta volume of around half a US gallon per person per day. Long term, plan for 9 to 20 US gallons (40 to 90 liters) per person per year (adapt to actual planned duration); excreta reduce in volume as they decompose. Actual volume will depend on whether water is used for flushing or not, and whether water is used for any other activities (anal cleansing, cleaning toilets), and the diet of the users. Ensure that household water from cleaning and cooking or from laundry and bathing does not enter the containment facilities, as the excess water will mean more desludging. Allow 20 inches (50 cm) at the top of the pit for backfill.

Excreta containment after flooding can be especially difficult. In these situations, consider raised toilets, urine diversion toilets, sewage containment tanks and temporary disposable plastic bags with appropriate collection and disposal systems. Support these different approaches with hygiene promotion activities.

WASH STANDARD 8

Vector control

Vector breeding and feeding sites are targeted at community and household levels to reduce the risks of vector-related problems.

KEY ACTIONS

- **8.1** Assess vector-borne disease risk for a defined area.
- **8.2** Conduct a local market assessment of relevant and effective preventive measures.
- **8.3** Train communities to monitor, report and provide feedback on problem vectors and the vector control program.
- **8.4** Align humanitarian vector control actions with local vector control plans or systems, and with national guidelines, programs or policies.
- **8.5** Determine whether chemical or non-chemical control of vectors outside households is relevant based on an understanding of vector life cycles.
- **8.6** Assess current vector control practices at the household level as part of an overall hygiene promotion program.
- **8.7** Use participatory and accessible awareness campaigns to inform people of problem vectors, high-risk transmission times and locations, and preventive measures.

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Guidance Notes:

A **vector** is a disease-carrying agent. Vectors create a pathway from the source of a disease to people. Vectors include insects, wild hogs and birds. Their presence can be symptomatic of solid waste, drainage or excreta management problems, inappropriate site selection or broader safety problems.

Vector control programs should aim to reduce vector population density, vector breeding sites and contact between humans and vectors across multiple response sectors. In The Bahamas, the Ministry of Health and Wellness addresses vector control and will engage vaccination programs as appropriate. Health standard 6: Communicable diseases.
Breeding grounds: Low-lying areas, debris and vacant buildings can provide breeding grounds for vectors that can pose public health risks. For communal shelters, site selection and the active mitigation of vector risks are key to reducing the impact of vector-borne diseases. Shelter Standard 9: Debris Management.

Removing or modifying vector breeding and feeding sites: Many WASH activities can have a major impact on breeding and feeding sites, including eliminating stagnant water or wet areas around water distribution points, bathing areas and laundries or managing solid waste storage and transportation.

Other solutions include e.g. providing lids for water containers, managing excreta, sealing offset toilet pits, running hygiene promotion programmes on general cleanliness; and keeping wells covered and/or treating them with larvicide, for example where dengue fever is endemic.

National and international protocols: The WHO has published clear international protocols and norms that address both the choice and the application of chemicals in vector control, as well as the protection of personnel and training requirements. Vector control measures should address two principal concerns: efficacy and safety. If national norms regarding the choice of chemicals fall short of international standards, then consult with and lobby the relevant national authority for permission to adhere to the international standards.

Climate change and related changes in temperature and drier conditions may create favorable conditions for invasive species, potentially leading to the spread of diseases and competition with native species.

High-risk groups: Some sections of the community will be more vulnerable to vector-related diseases than others, particularly babies and infants, older people, persons with disabilities, sick people, and pregnant and breastfeeding women. Identify high-risk groups and take specific action to reduce that risk. Include any unofficial settlements to ensure comprehensive vector control.

Social mobilization and communication: To achieve behavioral change at both individual and community levels, social mobilization and communication activities should be fully integrated into vector prevention and control efforts, using a wide variety of channels. Core Standard 1: Communication and participation.

Individual protection measures for other vectors: Good personal hygiene and regular washing of clothes and bedding are the most effective protection against body lice. Control infestations by personal treatment (powdering), mass laundering or delousing campaigns. A clean household environment, effective waste disposal and appropriate storage of cooked and uncooked food will deter rodents and insects (such as cockroaches) from entering houses or shelters.

WASH STANDARD 9

Solid waste management

Solid waste is safely contained to avoid pollution of the natural, living, learning, working and communal environments.

KEY ACTIONS

- **9.1** Design the solid waste disposal approach based on public health risks, assessment of waste generated by households and institutions, and existing practice.
- **9.2** Work with local government authorities and service providers to make sure existing systems and infrastructure are not overloaded, particularly in urban areas.
- **9.3** Organize periodic or targeted solid waste clean-up campaigns with the necessary infrastructure in place to support the campaign.
- **9.4** Provide protective clothing for and immunize people who collect and dispose of solid waste and those involved in reuse or re-purposing.
- **9.5** Ensure that treatment sites are appropriately, adequately and safely managed.
- **9.6** Minimize packing material and reduce the solid waste burden by working with organizations responsible for food and household item distribution.

Guidance Notes:

Solid waste management is the process of handling and disposing of organic and inorganic solid waste generated mostly by households, schools, hospitals or administrative buildings.

It falls under ESF3. Solid waste management includes:

- → Planning solid waste management systems.
- → Handling, separating, storing, sorting and processing waste at source.
- → Transferring to a collection point.
- → Transporting and final disposal, reuse, re-purposing or recycling.

Waste can be generated at the household, institutional or community level and includes medical waste. It may be hazardous or non-hazardous. Inadequate solid waste management poses a public health risk as it can attract insects, rodents and other disease vectors.

Untreated waste can pollute surface water and groundwater. Children may play in poorly managed solid waste, risking injury or sickness. Waste pickers may be at risk of injury or infectious disease. Solid waste can block drainage systems, generating stagnant and polluted surface water, which may be a habitat for vectors and create other public health risks.

Protection for waste handlers: Provide protective clothing for everyone involved in solid waste management. At a minimum, provide gloves. Ideally, also boots and protective masks. When necessary, provide immunization against tetanus and hepatitis B. Ensure that soap and water is available for washing hands and face. Inform and train staff on the correct ways to transport and dispose of waste and of the risks associated with improper management.

Communities in remote areas: Household solid waste disposal may be possible, and even preferred, in remote communities and areas with lower population densities. Base the size of domestic solid waste burial or burning pits on household size and an assessment of the waste stream. Household pits should be properly fenced to prevent children and animals accessing them.

Reuse, re-purpose and recycle: Encourage reuse, re-purposing or recycling of solid waste by the community, unless doing so presents a significant public health risk. Consider the potential for small-scale business opportunities or supplementary income from waste recycling, and the possibility of household or communal composting of organic waste.

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FOOD SECURITY AND NUTRITION (FSN)

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FOOD SECURITY AND NUTRITION (FSN)

The standards for Food Security and Nutrition are a practical expression of the right to adequate food in a humanitarian context.

In a sudden-onset natural disaster such as a hurricane, people's access to food and water must be addressed immediately. At the same time, food security and nutrition assessments can help identify and address longer-term potential malnutrition and food insecurity.

The FSN Standards support the area of ESF11 (Food and Nutrition Security) that covers rapid response to the nutritional needs of persons in affected areas. As ESF11 covers a broad range of response areas, it will be important to ensure adequate focus on human nutrition and food security.

With most food in The Bahamas being imported, the identification, storage capacity, coordination of the overall supply chain including procurement and delivery of food, water and ice are critical. Close collaboration between the relevant ESFs is important to include nutritional considerations, in particular ESFs 1 and 7 (Logistics) and ESF6 (Mass Care and Shelter).

The National Disaster Emergency Plan (NDEP) includes a detailed FSN policy, the current nutritional status of the population and list of SOPs to be carried out prior to the start of the hurricane season and during disaster response.

In The Bahamas, there are various forms of malnutrition, including overweight, with above regional average obesity and hypertension prevalence in 2019[2]. Diabetes and pre-diabetic prevalence is high. Poor nutrition management can adversely affect disease management and increase morbidity, which will have an impact on individuals' resilience and livelihood. Also, due to the high prevalence of non-communicable diseases (NCDs), in The Bahamas, nutrition management of NCDs in emergencies is important and should be included in ESF11 Nutrition SOPs for a minimally adequate response. Equally, nutrition considerations should be included in SOPs for addressing NCDs during and following disasters. Health: NCD Standard.

[2] Bahamas STEPS Report 2019.

There are eight Food Security and Nutrition (FSN) Standards:

1. FOOD SECURITY AND NUTRITION ASSESSMENTS

Where people are at risk of food insecurity, assessments are conducted to determine the degree and extent of food insecurity and nutritional status, identify those most affected and define the most appropriate response.

2. MODERATE ACUTE MALNUTRITION (MAM) AND MICRONUTRIENT DEFICIENCIES

Moderate Acute Malnutrition micronutrient deficiencies are addressed.

3. IYCF: POLICY GUIDANCE AND COORDINATION

Policy guidance and coordination ensure safe, timely and appropriate infant and young child feeding in emergencies (IYCF-E).

4. MULTI-SECTORAL COORDINATION OF INFANT AND YOUNG CHILD FEEDING

Mothers and caregivers of infants and young children have access to timely and appropriate feeding support that minimizes risks, is culturally sensitive and optimizes nutrition, health and survival outcomes.

5. GENERAL NUTRITION REQUIREMENTS

The basic nutritional needs of the affected people, including the most vulnerable, are met.

6. FOOD QUALITY, APPROPRIATENESS AND ACCEPTABILITY

The food items provided are of appropriate quality, are acceptable and can be used efficiently and effectively.

7. TARGETING, DISTRIBUTION AND DELIVERY

Food assistance targeting and distribution is responsive, timely, transparent and safe.

8. FOOD USE

Storage, preparation and consumption of food is safe and appropriate at household, shelter and community levels.

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FSN STANDARD 1

Food security and nutrition assessments

Where people are at risk of food insecurity, assessments are conducted to determine the degree and extent of food insecurity and nutritional status, identify those most affected and define the most appropriate response.

KEY ACTIONS

1.1 Have a food security assessment protocol prepared and ready to use, which includes roles and responsibilities for the assessment process.

1.2 Compile pre-crisis information and baseline data and conduct initial assessments to establish the nature of the nutrition situation.

1.3 Coordinate with Ministry of Finance in Budget Circular of prior fiscal year to ensure allocation based on expenditure needs, and to define expenditure categories.

1.4 Train people living and working on each Family Island to use the assessment protocol immediately after a disaster to determine an appropriate response based on the findings.

1.5 For the nutrition aspects of the assessment, use standardized protocols based on UNICEF's protocols to assess malnutrition and identify causes.

1.6 Ensure coordination between Ministry leads and NGOs and civil society groups already present on the affected Family Island(s) to collect and analyze information on food security at the initial stage and during the crisis, both at individual household level and in communal shelters.

1.7 Identify groups that have the greatest need for nutritional support.

1.8 Analyze the impact of food security and other factors (healthcare etc) on the nutritional status of the affected population.

Guidance Notes:

Focal points for each island: For many of the Key actions, it will be important to identify a Nutrition Focal Point, ideally in coordination with FI administrators. Furthermore, the Non-Governmental Consultation Council can be mobilized to ensure that assessments are carried out in an efficient and effective manner.

Food security and nutrition assessments provide important information on food needs and contribute to overall needs assessments. Consecutive FSN assessments show how the context

evolves and enable responses to be adjusted appropriately. After a natural hazard such as a hurricane, which impacts the entire nation, the objective of food security and nutrition assessments is to:

- Understand the situation, current food needs and how to meet those needs.
- Estimate how many people need assistance.
- Identify groups at highest risk.
- Provide a baseline for monitoring the impact of the overall disaster response.

Assessment sources, tools and information systems: Information sources include satellite or drone images, household assessments, focus group discussions and interviews with key informants. Useful tools include the Food Consumption Score, Household Dietary Diversity Score and Reduced Coping Strategies Index for rapid measurement of household food security. The design of food security programmes should be based on a clear response analysis using the findings of assessments.

Training: Provide training to key stakeholders and partners to ensure these tools can be used when needed.

Food security and nutrition assessments must be planned to ensure roles and responsibilities are clearly identified among agencies and local actors. This requires preparation throughout the year, including the development of assessment protocols and appropriate training of the people who will carry out the assessments.

Pre-crisis information should be digitized as much as possible and be made available to all key stakeholders. The DRM Authority may consider a cloud platform with the Digital Transformation Unit. Core Standard 1.

Assessment stages: FSN Assessments can be divided into two phases: a) Initial assessment to identify critical emergency needs; b) rapid assessment within two to three weeks; c) detailed assessments to identify long-term sustained needs during the recovery period. Responsibilities for these assessments should be clearly assigned for each phase.

Collecting assessment information: Ensure that trained individuals are present on the affected Family Island(s) to carry out FSN assessments. Ensure different ministry leads are well coordinated, and the data collected widely shared. Department of Social Services and Ministry of Health and Wellness have particularly important roles, so do NGOs and community-based organizations.

Complex underlying causes of all forms of malnutrition (under- and over-nutrition): Beyond post-disaster survival food and water, humanitarian food security and nutrition response should also plan and adopt a multi-sectoral approach to work towards longer-lasting improvements to avoid malnutrition and food insecurity, beyond the first few months of recovery. This may contribute to people's resilience and reduce the need for intervention at a later stage.

Groups in need of nutritional support: Data should be disaggregated, as a minimum, by gender and age, with further considerations for disability, poverty and other relevant factors.

Women and men may have different and complementary roles in securing household nutritional wellbeing. Consult with both, separately, if necessary, about practices related to food security, food preparation and household resources.

People with non-communicable diseases such as diabetes and heart disease have special nutritional needs. The same goes for people living with HIV and other acute conditions.

Be aware that older people and people with disabilities may be excluded in intra-household distribution of food assistance. Assess the needs of girls and boys, especially child-headed households, separated or unaccompanied children, children with disabilities and children living in alternative care. Ensure that undocumented people and people who do not speak English are included.

Coping strategies: Assess the different types of coping strategy, their effectiveness and any negative effects.

Infant and young child feeding assessment questions can be included in other sectoral assessments or conducted as stand-along surveys. Annex 1 to this chapter: Nutrition assessment checklist.

Interpreting levels of undernutrition: Certain communities may be confronted with situations of undernutrition. It takes detailed analysis and trained staff to decide whether levels of undernutrition require intervention. A combination of complementary information systems may be the most cost-effective way to monitor trends. Decision-making models and approaches that consider several variables, such as food security, livelihoods, and health and nutrition may be appropriate.

Proxy measures can be useful for an initial food security assessment, e.g. changes in the daily number of meals consumed and dietary diversity.

FSN STANDARD 2

Moderate acute malnutrition (MAM) and micronutrient deficiencies

Moderate acute malnutrition and micronutrient deficiencies are prevented and managed.

KEY ACTIONS

2.1 Collect information on the pre-crisis situation to determine the most common areas of malnutrition and/or micronutrient deficiencies.

2.2 Continuously train health staff in identifying and treating MAM and micronutrient deficiencies.

2.3 Establish clearly defined procedures, strategies and objectives to respond to MAM and micronutrient deficiencies.

2.4 Maximize access to coverage of MAM and micronutrient interventions through community engagement and involvement from the beginning, and include FSN messaging in pre-designed communications materials.

2.5 Link the management of MAM and micronutrient deficiencies to existing health services and public health responses and treatment protocols established by MOH to reduce diseases commonly associated with crises, such as vitamin A to manage measles and zinc to manage diarrhoea. ESF8; Health chapter.

2.6 Ensure that existing micronutrient prevention and health services are not interrupted.

2.7 Emphasise the importance of nutritional needs for people living with non-communicable diseases. Health: NCD Standard.

2.8 Emphasise the importance of protecting, supporting and promoting breastfeeding, complementary feeding, hygiene promotion and good mother-child interaction.

Guidance Notes:

Acute malnutrition – which may be triggered during a crisis – can be prevented and treated with the right nutrition responses. Nutrition responses are key in reducing morbidity and mortality in affected populations. They require an understanding of the complex underlying causes of malnutrition. A multi-sectoral approach is essential to addressing all the causes and their interactions.

In crises, supplementary feeding is often the primary strategy for preventing and treating moderate acute malnutrition.

Pre-crisis malnutrition information should be made available in digital format.

Program design: Design programs that build on and support existing health system capacity and consider access to health facilities, the geographical spread of the population and security. Supplementary feeding programs are not meant to replace the diet but to complement it. Integrate MAM and micronutrient programs into multi-sectoral approaches, with particular attention to WASH programs. WASH chapter, Hygiene promotion, access to water.

Prevention or treatment: The decision whether to adopt a blanket approach to prevent malnutrition, or a targeted approach to treat it will depend on the levels of malnutrition, the severity of the crisis and other contextual factors. Here again, it is important to refer to national nutritional status data.

Effective community mobilization: Community mobilization and involvement, in particular through church and volunteer groups, will improve people's understanding of the programme and its likely effectiveness. Work with the target population in deciding where to locate programme sites and how to make them accessible for all. Share clear and comprehensive information on the available support in accessible languages using multiple information-sharing channels, including audio, visual and written forms. Emphasize that food support focuses on **supporting** existing diets.

Links to health and other sectors: Both targeted and blanket supplementary feeding programmes can be used as a platform for delivering complementary services, such as community screening or child survival interventions such as: anthelmintics; vitamin A supplementation; iron and folic acid; zinc for treatment of diarrhoea; and immunizations.

Ensure full attention is given to people suffering from NCDs and understand their specific nutritional needs. Health chapter: NCD Standard.

Micronutrient deficiencies have a great impact on people's health, learning ability and productivity. These deficiencies contribute to a vicious cycle of malnutrition, underdevelopment and poverty, affecting already underprivileged groups. Micronutrient deficiencies are often difficult to identify.

Controlling micronutrient deficiencies can be done in three ways and should always be accompanied by public awareness raising on the importance of micronutrients and their sources:

- Supplementation, e.g. iron monitoring and potentially supplementation should be considered.
- Fortification of food products with micronutrients, e.g. iodised salt, micronutrient powders or vitamin A fortified vegetable oil.
- Food-based approaches: Ensure that micronutrient-rich foods are broadly accessible year-round.

Public health measures to control micronutrient deficiencies include:

- **Providing vitamin A** supplementation with vaccination for children aged 6–59 months.
- **De-worming** all children aged 12–59 months.
- **Adding iodised salt and other fortified commodities** such as vitamin A and D fortified vegetable oil in the food basket and providing micronutrient powders or iodised oil supplements.
- **Providing iron-containing multiple micronutrient products** for children aged 6–59 months.
- **Providing daily iron-containing multiple micronutrient supplements,** including folic acid, for pregnant and lactating women.

Breastfeeding: Ahead of disasters and in a continuous manner, provide clear information on the importance of exclusive breastfeeding in children up to six months, and continued breastfeeding for children from 6 to 24 months, for both the physical and psychological health of mother and child.

FSN STANDARD 3

IYCF: Policy Guidance and Coordination

Policy guidance and coordination ensure safe, timely and appropriate infant and young child feeding in emergencies (IYCF-E).

KEY ACTIONS

3.1 Ensure that IYCF-E is included within ESF 8 (Health), promoting collaboration across sectors, and in particular with municipalities, FI administrators and Shelter coordination teams.

3.2 Include the specifications of the Operational Guidance in relevant national and humanitarian policy and preparedness guidance.

3.3 Support strong, harmonized, timely communication on IYCF-E at all response levels, including ESFs as appropriate, including ESF6 and ESF8, and directly with affected communities (have feedback mechanisms in place).

3.4 Ensure that accepting or soliciting donations of breastmilk substitutes, other liquid milk products, feeding bottles and teats **does not undermine breastfeeding practices**. Donations that do arrive should be managed by the designated authority, in accordance with the Operational Guidance and the Code. (see Guidance Note 1).

3.5 Follow WHO/UNICEF indicators for IYCF assessment (2021).

Guidance Notes:

Infant and Young Child Feeding in Emergencies (IYCF-E) addresses actions and interventions to protect and support the nutritional needs of both breastfed and non-breastfed infants and young children aged 0–23 months. Priority interventions include breastfeeding protection and support; appropriate and safe complementary feeding; and management of artificial feeding for infants with no possibility to breastfeed.

The key actions in this section reflect two key guidance frameworks for IYCF:

- The Operational Guidance on Infant and Young Child Feeding in Emergencies (Operational Guidance), which provides concise, practical guidance for appropriate IYCF-E.
- The International Code of Marketing of Breastmilk Substitutes ("the Code").

Public health emergencies: In public health crises, take steps to prevent any interruptions in access to health and feeding support services, to ensure continued household food security and livelihoods, and to minimize disease transmission risks via breastfeeding, as well as to minimize maternal illness and death. Refer to WHO guidance where needed for cholera, Ebola and Zika virus guidance.

FSN STANDARD 4

Multi-Sectoral Support to IYCF in Emergencies

Mothers and caregivers of infants and young children have access to timely and appropriate feeding support that minimizes risks, is culturally sensitive and optimizes nutrition, health and survival outcomes.

KEY ACTIONS

4.1 Prioritize pregnant and breastfeeding women for access to food, cash or voucher transfers and other supportive interventions.

4.2 Consistently and continuously target mothers of all newborns with support for early initiation of exclusive breastfeeding.

4.3 Provide appropriate breastmilk substitutes, feeding equipment and associated support to mothers and caregivers whose infants require artificial feeding.

4.4 Provide feeding support to particularly vulnerable infants and young children.

4.5 Provide micronutrient supplements as necessary.

Guidance Notes:

Multi-sectoral collaboration: Sectoral entry points to identify and support IYCF-E include:

- Health services: ante-natal and post-natal care; immunization points; growth monitoring; early childhood development; HIV treatment services (including prevention of mother-to-child transmission); community health; mental health; psychosocial support.
- Nutrition and hygiene interventions.

Target groups: All assessment and programme data for children under five years should be disaggregated by gender and by age 0–5 months, 6–11 months, 12–23 months, and 24–59 months. Disaggregation by disability is recommended from 24 months.

Registering pregnancies: In order to provide appropriate assistance during or in the aftermath of a disaster emergency, public clinics' records on pregnant women could be shared with the DRM Authority Database, with the women's explicit agreement for that information to be shared.
Pregnant and breastfeeding women: If the needs of pregnant and breastfeeding women are not met in food, or cash or voucher assistance programmes, target them with fortified food. Give micronutrient supplements in accordance with WHO recommendations. Organize psychosocial support for distressed mothers. Arrange appropriate support for mothers with disabilities. Create safe places in shelters for women to breastfeed, such as baby friendly spaces with exclusive breastfeeding areas. Shelter Standards.

Breastfed infants: Planning and resource allocation should allow for skilled breastfeeding support and counselling in difficult situations, including for the duration of staying in shelters. This could include for acutely malnourished infants aged 0–6 months, populations where mixed feeding is common, and infant feeding in the context of HIV.

Non-breastfed infants: In all crises, protect infants and young children who are not breastfed and support them to meet their nutritional needs. The consequences of not breastfeeding vary by the age of the child. The youngest children are most vulnerable to infectious diseases. They depend on access to assured supplies of appropriate breastmilk substitutes, fuel, equipment and WASH conditions.

Gender-based violence, child protection and nutrition: Gender-based violence, gender inequality and nutrition are often inter-related. Domestic violence can pose a threat to the health and wellbeing of women and their children. Nutrition staff should provide supportive and confidential referral for caregivers or children exposed to gender-based violence or child abuse. Other elements to integrate include counselling, working to establish women- and child-friendly treatment sites, and regular monitoring of default rates and failure to respond to treatment. Consider including specialized gender-based violence and child protection caseworkers as part of nutrition staff.

Food security and food assistance

Food security exists when all people have physical and economic access to sufficient, safe and nutritious food that meets their dietary needs and food preferences for an active and healthy life.

Food assistance is required when the quality and quantity of available food or access to food are not sufficient to prevent excessive mortality, morbidity or malnutrition. Food assistance is an excellent opportunity to improve food availability and access, nutrition awareness and feeding practices.

This section on food assistance corresponds to **ESF11: Food and Nutrition Security.** More information on the various tasks of both the lead and supporting ESFs can be found in the National Disaster Emergency Plan. The Ministry/Department of Social Services & Urban Development plays an important role in issuing food vouchers in disasters.

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FSN STANDARD 5

Food Security and Food Assistance

The basic nutritional needs of the affected people, including the most vulnerable, are met.

KEY ACTIONS

5.1 Based on pre-disaster preparations and food security assessment data, design the response to meet immediate needs, and restore food security.

5.2 Measure the levels of access to adequate quantity and quality of food and assess it on a yearly basis, especially ahead of hurricane season, to see whether it is stable or likely to decline.

5.3 Design food and cash-based assistance to meet the standard initial planning requirements for energy, protein, fats and micronutrients. Plan rations to make up the difference between the nutritional requirements and what people can provide for themselves.

5.4 Monitor market prices for food and consider corrective actions as needed to ensure that food remains accessible to all.

5.5 Protect, promote and support affected people's access to nutritious foods and nutritional support.

Guidance Notes:

Food security: Directly after a disaster, food security responses should aim to meet short-term needs and reduce the need for the affected population to adopt potentially damaging coping strategies, until longer term food security can be restored.

Cash-based assistance: Food is the major expenditure for vulnerable households. Cash-based assistance can enable people receiving assistance to better manage their overall resources, although this depends on the transfer value provided. Collaborative analysis and program objectives will guide the targeting, transfer value and any potential conditions placed on the transfer.

Market-based programming: Food security responses should progressively aim to work through or support local markets. Decisions on local, national or regional procurement should be based on an understanding of markets, including market and financial service providers. Market-based programming, such as grants to traders for restocking, can also support markets. Sphere Handbook: Delivering assistance through markets.

Coordination during preparedness, emergency phase and recovery is covered in the Logistics chapter.

Tools to work towards food security: Work with the Food Consumption Score, the Dietary Diversity Score and the Coping Strategy Index (see also FSN Standard 1: Assessment).

Monitoring access to food: Consider variables including levels of food security, access to markets, livelihoods, health and nutrition. This will help determine whether the situation is stable or declining, and whether food interventions are necessary. Use proxy indicators such as the Food Consumption Score or dietary diversity tools.

Forms of assistance: Use appropriate forms of assistance (cash, vouchers or in-kind) or a combination to ensure food security. Where cash-based assistance is used, consider complementary food distributions or supplementary food distributions to meet the needs of specific groups. Consider the adequacy of markets to serve particular nutritional needs and use specific methodologies including 'the minimum cost of a healthy diet' assessment tool. This process should be led by ESF 11 (Food and nutrition security) and ESF 8 (Medical Services).

Design of food rations and nutritional quality: A number of ration planning tools are available, for example NutVal.

Targeting at-risk groups: When setting eligibility criteria for food assistance, consult with different groups to identify any particular needs that might otherwise be overlooked. Include adequate and acceptable food such as fortified blended food for young children (aged 6–59 months) in the general ration. Specific population groups that may need attention include older people, people living with HIV, and persons with disabilities.

Feedback mechanisms are important for all food assistance interventions, to ensure the measures were accepted by the targeted people and had the expected effect.

Link with health programmes: Food assistance can prevent the deterioration of the nutrition status of the affected population, especially when combined with public health measures to prevent diseases such as measles and parasitic infection. Health standards.

FSN STANDARD 6

Food quality, appropriateness and acceptability

The food items provided are of appropriate quality, are acceptable and can be used efficiently and effectively.

KEY ACTIONS

6.1 Select foods that conform to The Bahamas national food quality standards and other internationally accepted quality standards.

6.2 Ensure foods are culturally acceptable and conform with existing food consumption patterns. FSN Standard 3: Malnutrition and micronutrient deficiencies.

6.3 Choose appropriate food packaging with food use information labels as needed, and the possibility to recycle.

6.4 Assess access to water, electricity, fuel, stoves and food storage facilities and provide ready-to-eat foods when crises prevent access to cooking facilities.

6.5 Transport and store food in appropriate conditions.

Guidance Notes:

Food quality: Foods must conform to the National Food Standards (BAHFSA and BH Bureau of Standards) and to the Codex Alimentarius standards about quality, packaging, labelling and fitness for purpose. For information on supply, warehousing and distribution, see Logistics chapter.

Food packaging and littering are covered in the Logistics chapter. If possible, packaging should allow direct distribution without requiring re-measuring or repacking. Dispose of waste packaging in a way that prevents environmental degradation. Where litter occurs, organize regular community clean-up campaigns. These campaigns should be part of community mobilization and awareness-raising. WASH Chapter.

Food choice: While nutritional value is the primary consideration in providing food assistance, the commodities should be familiar to the recipients and consistent with religious and cultural traditions.

Food storage and preparation: Household storage capacity should inform the choice of foods offered. In the immediate aftermath of a storm, when electricity and cooking gas lines might be damaged, prioritize ready-made foods and non-perishable foods that does not need to be refrigerated nor cooked. Ensure that people receive sufficient information to understand how to avoid public health risks associated with food preparation.

FSN STANDARD 7

Targeting, distribution and delivery

Food assistance targeting and distribution is responsive, timely, transparent and safe.

KEY ACTIONS

7.1 During pre-hurricane season, and in consultation with local communities, including at-risk groups, design and plan food distribution methods for various Family Island contexts.

7.2 Identify and target food assistance recipients based on assessed need and consultations with appropriate stakeholders. FSN Assessment Standard.

7.3 Locate distribution and delivery points where they are accessible, safe and most convenient for the recipients.

7.4 Provide recipients with advance details of the distribution plan and schedule, the quality and quantity of the food ration and what it is intended to cover.

Guidance Notes:

Food distribution methods should be planned well before hurricane season and other recognized seasonal natural hazards, involving the relevant Ministries, ESFs, NGOs and food/water/ice providers. Individual Family Island contexts should be considered, including local infrastructure and accessibility. Distribution methods should be efficient, equitable, secure, safe and accessible. Logistics Standards 18 to 23: Logistics.

Targeting: and registration: Provide clear, publicized details of targeting approaches that are accepted by both recipient and non-recipient populations. Initiate formal registration of households to receive food as soon as it is feasible and update as necessary. More details can be added to address at-risk groups, to include targeting committees in communities and to avoid community gate keepers. Where advisable, collect contact details and GPS locations in the event of a power outage.

Distribution and delivery points: Minimize risks to people reaching distributions, especially in the immediate aftermath of a disaster, or due to debris blocking roads and paths. Anticipate and mitigate safety issues (threats of theft or violence) that may be associated with the receipt of food and/or cash.

Advanced notice: Schedule distributions in a way that allows people to adapt their daily schedules accordingly and that prioritizes at-risk groups as appropriate.

Feedback mechanisms: Define and establish feedback mechanisms with the community before distribution.

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FSN STANDARD 8

Food use

Storage, preparation and consumption of food is safe and appropriate at household, shelter and community levels.

KEY ACTIONS

8.1 Ensure people receiving assistance understand how to handle and prepare food appropriately and safely.

8.2 Consult with and advise people receiving assistance on storage, preparation, cooking, and consumption of food.

8.3 Ensure that households have safe access to appropriate cooking utensils, refrigeration (storage), electricity, fuel, stoves, clean water and hygiene materials.

8.4 Ensure that individuals who cannot prepare food or feed themselves have access to caregivers who can support them where possible and appropriate.

8.5 Monitor how food resources are used within the household.

Guidance Notes:

Food hygiene: Crises may disrupt people's normal hygiene practices. Inform people of the importance of food hygiene and promote food hygiene practices that are adapted to local conditions and disease patterns. Stress the importance of avoiding water contamination, controlling pests and always washing hands before handling food. Inform people receiving food about storing food safely at the household level. Adopt hygiene promotion messages around personal hygiene at family level. Ensure families have cleaning products for personal hygiene and their home WASH: Hygiene promotion.

Food storage: Where perishable food items are offered, consider appropriate facilities to store these. Outreach programmes or additional support may be necessary for people who have difficulty providing food to their dependants, such as parents with disabilities.

Intra-house food use monitoring: Humanitarian organizations should monitor and assess intra-house use of food and its appropriateness and adequacy. At the household level, food commodities can either be consumed as intended or be traded or bartered. The goal of the barter could be to access other more-preferred food items, non-food items or payment for services such as school fees or medical bills. Intra-household allocation assessment should also monitor food use by gender, age, and disability.

Food use should be monitored at household level.

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HEALTH

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HEALTH

The Health standards are a practical expression of the right to healthcare in humanitarian contexts. In the wake of a disaster, existing health care infrastructure may be compromised, while at the same time the needs for medical care are high. This chapter focuses on actions of disaster preparedness and immediate response to ensure impartial access to life-saving healthcare and wellbeing of all members of affected communities. Many of them will remain relevant for longer-term recovery.

The Health Standards support ESF8, which provides coordination of national medical assets to assist local communities. There is also a strong link with ESF1 (Transportation) and with Customs, to ensure that foreign medical aid can reach The Bahamas without undue delays in case of an emergency response. Links to the Logistics standards include pre-positioning of emergency medical kits and cold chain.

The Health standards are referenced in the All-Hazards Health Disaster Preparedness and Response Plan by the Ministry of Health and Wellness, which is also the basis for facility and institutional guidelines.

There are thirteen Health Standards, divided into two broad sections: Health Services and Essential Healthcare

Health Services

1. ACCESS TO HEALTHCARE
People have access to integrated quality healthcare that is safe, effective and patient-centred.

2. HEALTHCARE WORKFORCE
People have access to healthcare workers with adequate skills at all levels of healthcare.

3. ESSENTIAL MEDICINES AND MEDICAL DEVICES
People have access to essential medicines and medical devices that are safe, effective and of assured quality.

4. FREE PRIORITY HEALTHCARE DURING CRISIS
People have access to free priority healthcare for the duration of the crisis.

5. HEALTH INFORMATION
Healthcare is guided by evidence through the collection, analysis and use of relevant public health data.

Essential Healthcare

6. COMMUNICABLE DISEASES
Systems are in place nation-wide to prevent, survey and detect communicable diseases, and to respond adequately in the case of a disease outbreak during an emergency.

7. VACCINE-PREVENTABLE CHILDHOOD DISEASES
Children aged six months to 15 years have immunity against disease and access to routine Expanded Program on Immunization (EPI) services in the aftermath of a disaster and during recovery.

8. MANAGEMENT OF NEWBORN AND CHILDHOOD ILLNESS
In long-term recovery phases, children have access to priority healthcare that addresses the major causes of newborn and childhood morbidity and mortality.

9. REPRODUCTIVE, MATERNAL AND NEWBORN HEALTHCARE
Healthcare prevents excessive maternal and newborn morbidity and mortality.

10. MENTAL HEALTH CARE
People of all ages have access to healthcare that addresses mental health conditions and associated impaired functioning.

11. CARE OF NON-COMMUNICABLE DISEASES (NCD)
People have access to preventive programmes, diagnostics and essential therapies for acute complications and long-term management of non-communicable diseases.

12. INJURY CARE
People have access to safe and effective injury care during crises to prevent avoidable mortality, morbidity, suffering and disability.

13. PALLIATIVE CARE
People have access to palliative and end-of-life care that relieves pain and suffering, maximizes the comfort, dignity and quality of life of patients, and provides support for family members.

Section One: Health Systems

The Bahamas' health system and ESF8 (Medical Services) are led by the Ministry of Health and Wellness (MoHW).

The standards in this section address five interdependent core aspects of a well-functioning health system, which are particularly important for disaster preparedness.

Coordination should occur at and between all levels of healthcare from national to community and with other sectors such as WASH, nutrition, and education, and with cross-sectoral technical working groups focusing on e.g. Mental Health and Psychosocial Support (MHPSS) or gender-based violence (GBV).

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HEALTH STANDARD 1

Access to healthcare

People have access to integrated quality healthcare that is safe, effective and patient-centred.

KEY ACTIONS

1.1 Understand, follow and support actions and instructions from the National Emergency Medical Services (NEMS) and ESF8.

1.2 Have in place a Mass Casualty Incidence Response plan, to be activated with ESF8, and supported by EMS services and providers.

1.3 Provide sufficient and appropriate healthcare at the different levels of the health system and with particular focus on Family Island healthcare.

1.4 Establish or strengthen triage mechanisms and – if possible – referral systems.

1.5 Use standardized national protocols for healthcare, case management, rational drug use and essential medicines lists, and adapt them to the disaster emergency context.

1.6 Provide healthcare that guarantees patients' rights to dignity, privacy, confidentiality, safety and informed consent – in particular people with conditions that may be associated with stigma.

1.7 Use appropriate infection prevention and control (IPC) measures, including minimum WASH standards and medical waste disposal mechanisms, in all healthcare settings.

1.8 Manage or bury the dead in a safe, dignified, culturally appropriate manner, based on good public health practice.

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Guidance Notes:

Medical standard operating procedures (SOP) and guidelines should be made available as possible, to ensure that emergency health care is aligned, and that external aid actors understand expected procedures and can support accordingly. These guidelines include the National Emergency Medical Services, ESF8 guidance and the Mass Casualty Incidence Response Plan.

Foreign medical personnel: As needed, consider establishing expedited procedures for temporary recognition of professional qualifications of foreign medical personnel for the time necessary to carry out disaster relief and/or initial recovery activities. These personnel should be certified as genuine by the concerned assisting State or assisting humanitarian organization.

Adapting healthcare protocols to disaster response should be done in pre-disaster periods. This allows for specific adaptation to each island context, considering remoteness, population density and existing healthcare infrastructure and logistics options for transporting items ahead of a disaster. Use the guidelines available from MoHW.

Different levels of the healthcare system: Prioritize health services at FI level, whether at a healthcare facility or care at household and community levels.

Mobile units: Prepare for bringing mobile units to affected areas/islands, if the local medical infrastructure is damaged after a disaster.

Referral may not be possible at early stages of a disaster, due to limited air and sea transport possibilities.

IPC: National IPC standards for The Bahamas were under development in 2024.

Management of the dead: Dead bodies rarely represent an immediate health risk. Certain dis eases (for example cholera) require special management. Recovery of the dead may require personal protective equipment (PPE), equipment for recovery, transportation and storage, as well as documentation.

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HEALTH STANDARD 2

Healthcare workforce

People have access to healthcare workers with adequate skills at all levels of healthcare.

KEY ACTIONS

- **2.2** Review existing staffing levels and distribution against national classifications to determine gaps and under-served areas and Family Islands.
- **2.2** Train staff and volunteers for their roles according to national standards or international guidelines, including for responding in acute emergencies, and offer refresher trainings.
- **2.3** Support healthcare workers to operate in a safe working environment: Provide occupational health training and immunizations for hepatitis B and tetanus for clinical workers and supply adequate IPC and PPE to carry out staff duties.
- **2.4** Share healthcare workforce data and readiness information with MoHW/ESF8.
- **2.5** Consider requesting skilled healthcare workers internationally Health Standard 1.

Guidance Notes:

Availability of healthcare workers: The number and profile of workers should match the population and service needs. Understaffing can result in excessive workloads and unsafe healthcare. When recruiting and training local staff, follow national guidelines. International staff recruitment should follow national and MoHW regulations. As needed, consider rapid clearing mechanisms for certain international medical staff to ensure that the needed medical assistance can reach the affected communities without unnecessary delay. Health Standard 1.

Develop strong referral mechanisms, including from remote Family Islands, coordinated nationally and with other regional partners as possible.

Community health workers (CHWs): Community programming with CHWs (including volunteers) increases access to hard-to-reach communities, including marginalized or stigmatized populations. CHWs may be trained in first aid or case management or may conduct health screening. They must be linked to the nearest healthcare facility to ensure appropriate oversight and integrated care. Community health workers can gain the trust of special populations and communities, which may have less access to health care.

Quality: All health staff, whether from MoHW or non-profit organizations, local, national or international, have up-to-date knowledge and safe practice. Align training programs with national emergency guidelines.

Include training on:

- → **Healthcare** in communal shelters.
- → **Clinical protocols** and case management.
- → **Standard operating procedures** (such as IPC, medical waste management).
- → **Security and safety** (adapted to the level of risk).
- → **Codes of conduct** (such as medical ethics, patients' rights, humanitarian principles, child safeguarding, protection from sexual exploitation and abuse).

Regular supervision and quality monitoring will encourage good practice. One-off training will not ensure good quality. Share records of who has been trained, in what, by whom, when and where with MoHW.

HEALTH STANDARD 3

Essential medicines and medical devices

People have access to essential medicines and medical devices that are safe, effective and of assured quality.

KEY ACTIONS

3.1 Establish standardized essential medicine and medical device lists for priority healthcare.

3.2 Establish effective electronic management and monitoring systems to ensure availability of safe essential medicines and medical devices. Logistics.

3.3 Accept donations of medicine and medical devices only if they follow internationally recognized guidelines.

Guidance Notes:

Managing essential medicines: Essential medicines include drugs, vaccines and blood products. Good medicine management ensures availability but also prohibits unsafe or expired medicines. The main management elements are selection, forecasting, procurement, storage and distribution.

Selection should be based on the national essential medicines list.

Forecasting should be based on consumption, morbidity data and context analysis. Foresee actions in the event warehouses are damaged or international procurement is delayed, among other factors.

Procurement methods should adhere to national laws, customs regulations and quality assurance mechanisms for international procurement. Work with Customs to ensure emergency procedures are agreed and implemented to avoid delays for international medical aid provisions.

Storage: Medicines should be safely stored throughout the drug supply cycle. Requirements vary between products and are available from MoHW.

Distribution: Establish safe, protected, predictable and documented transport mechanisms from central stocks to healthcare facilities on all Family Islands.

Safe disposal of expired medicines: Prevent environmental contamination and hazards to people. Comply with national regulations adapted to the particular disaster emergency and Family Island situation.

Essential medical devices: Define and procure necessary devices and equipment at each level of healthcare that are nationally or internationally compliant. Include assistive devices for persons with disabilities. Ensure safe use of devices and decommission devices safely.

Prequalified kits/essential health packs should be defined by MoHW for use in the immediate aftermath of a disaster. They should be pre-positioned for preparedness. The packs/kits contain prequalified essential medicines and medical devices, including NCD kits (glucometer, strips). Medicines for pain relief, mental health and post-partum bleeding are usually controlled. MoHW should ensure they are available in sufficient quantities and for all Family Islands.

Internationally, WHO is the lead provider for Interagency Emergency Health Kits and non-communicable disease kits, in addition to kits to manage diarrhea, injury and others. The United Nations Population Fund (UNFPA) is the lead provider of sexual and reproductive health kits.

Blood products: Coordinate with the national blood transfusion service. Only collect blood from volunteers. Test all products for HIV, hepatitis B and C, and syphilis as a minimum, with blood grouping and compatibility testing. Store and distribute products safely. Train clinical staff in the rational use of blood and blood products.

Accepting medications: Assisting States and eligible assisting humanitarian organizations should take all reasonable steps to ensure the quality, appropriateness and safety of any medications and equipment and in particular following best practices around approval of medications by both sending and affected State; safe transport and storage of medication. Logistics Standards.

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HEALTH STANDARD 4

Free priority healthcare during crisis

People have access to free priority healthcare for the duration of the crisis.

KEY ACTIONS

4.1 Plan for user fees to be abolished or temporarily suspended where they are charged through government systems.

4.2 Reduce indirect costs or other financial barriers to reach and use health services.

4.3 Communicate end dates for free priority healthcare.

Guidance Notes:

User fees: Requiring payment for services during an emergency impedes access and may prevent people from seeking healthcare. If user fees are temporarily suspended, ensure users get clear information about the timing and reasons, and monitor accessibility and service quality.

Indirect costs can be minimized by providing adequate services in communities and using planned mechanisms for transport and referral.

HEALTH STANDARD 5

Health information

Healthcare is guided by evidence through the collection, analysis and use of relevant public health data.

KEY ACTIONS

5.1 Strengthen or develop a health information system that provides sufficient, accurate and up-to-date information for effective and equitable health response.

5.2 Ensure the MoHW Alert Network is operational (see NDP – ESF8) and working with disease Early Warning, Alert and Response (EWAR) mechanisms for all hazards that require an immediate response.

5.3 Support ESF6 to activate and run the Medical Emergency Distribution System (MEDS).

5.4 Agree standard operating procedures for all health actors when using health information.

5.5 Ensure mechanisms to protect data to guarantee the rights and safety of individuals, reporting units and/or populations.

5.6 Support the MoHW to compile, analyze, interpret and disseminate health information to all stakeholders in a timely and regular manner, and to guide decision-making for health programs. Core Standard 1.

Guidance Notes:

Health information system: A well-functioning health information system ensures the production, analysis, dissemination and use of reliable and timely information on health determinants, health systems performance and health status. ESF8 Information will identify problems and needs at all levels of the health system. Collect missing information through further assessments or surveys. Consider cross-border movement of people, and the information needed or available. Provide regular analysis on who is doing what and where.

Health surveillance is the continuous and systematic collection, analysis and interpretation of health data. Disease surveillance specifically monitors different diseases and patterns of progression. This is a key task of ESF8.

EWAR is part of a routine health surveillance system. It detects and generates an alert for any public health event that needs an immediate response.

Standard operating procedures: Establish common definitions and ways of conveying information across geographical locations, levels of care and health actors. As a minimum, agree on:

- Case definitions.
- Indicators of what to monitor.
- Reporting units (such as mobile clinics, field hospitals, health posts).
- Reporting pathways.
- Frequency of data submission, analysis and reporting.

Disaggregation of data: Health information data should be disaggregated by gender, age, disability, displaced and host populations, context and administrative level to guide decision making and detect inequity for at-risk groups. For EWAR, disaggregate mortality and morbidity data for children under and over age five years. The aim is to quickly generate an alert; less detailed data is acceptable. Outbreak investigations data, contact tracing, line listing and further monitoring of disease trends must have disaggregated data.

Data management, security and confidentiality: Take adequate precautions to protect the safety of the individual and the data. Staff should never share patient information with anyone not directly involved in the patient's care without the patient's permission. Give consideration to persons with intellectual, mental or sensory impairment that may affect their ability to give informed consent.

Treat data that relates to injury caused by human rights violations, including sexual assault, with care. Consider passing such information to appropriate actors or institutions if the individual gives informed consent.

Section Two: Essential Healthcare

Essential healthcare addresses the major causes of mortality and morbidity in a crisis-affected population. Coordinate within ESF8 and MoHW to agree which services to prioritize, when and where.

HEALTH STANDARD 6

Communicable diseases

Systems are in place nation-wide to prevent, survey and detect communicable diseases, and to respond adequately in the case of a disease outbreak during an emergency.

KEY ACTIONS

6.1 Implement disease prevention nation-wide, following national standards and protocols, and covering vaccination and IPC measures at all levels of healthcare according to risk.

6.2 Strengthen or establish a context-specific disease EWAR mechanism.

6.3 Develop clear messages that encourage people to seek care for symptoms such as fever, cough and diarrhoea.

6.4 Coordinate with other sectors/ESFs as appropriate.

Guidance Notes:

Risk assessments: Conduct risk assessments with the affected population, local leaders and health professionals. Analyze risks posed by the context and environment, such as in crowded communal shelters. Actively consider different segments of the population for disease-specific factors, low immunity or other risks.

Inter-sectoral disease prevention: Develop general prevention measures such as appropriate hygiene, waste disposal, safe and sufficient water and vector management and adequate shelter space. Exclusive breastfeeding and access to adequate nutrition contribute directly to health status WASH; Shelter; FSN.

Health promotion: Engage communities to provide information in formats and languages that are accessible for elderly people, persons with disabilities, women and children and migrant communities. Take the time to test and validate messages on sensitive issues, so that health interventions are accepted after a disaster strikes.

Vaccination: The decision to implement a vaccination campaign will be based on an **assessment of general risk factors, the feasibility of a campaign** and other contextual considerations.

EWAR: In coordination with all stakeholders, including MoHW, partners and communities, strengthen or establish an EWAR system representative of the affected population. The system should be able to capture rumors, unusual events and community reports. Health Standard 5.

Surveillance and early warning: Strengthen the EWAR system with partners, and agree on reporting units, data flow, reporting tools, data analysis tools, case definitions and frequency of reporting.

From Alert generation to outbreak detection and response: These crucial steps are covered by national and global health protocols and standards and should be further strengthened as possible.

More detailed information can be found here:

- Sphere: Health – Communicable Diseases Standards.
- Bahamas Surveillance Manual and disease-specific response plans.
- CARPHA Communicable Disease Surveillance Manual.
- WHO: Emergency Risk Management for Health: Communicable Diseases.

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HEALTH STANDARD 7

Vaccine-preventable childhood diseases

Children aged six months to 15 years have immunity against disease and access to routine Expanded Program on Immunization (EPI) services in the aftermath of a disaster and during recovery.

KEY ACTIONS

7.1 Determine whether there is a need for vaccinations, and the appropriate approach for the emergency.

7.2 If measles vaccination campaign for children aged six months to 15 years falls within a disaster recovery phase, and regardless of measles vaccination history, ensure all children are covered, when estimated measles coverage is less than 90 per cent or unknown.

7.3 Re-establish the defined EPI as soon as possible.

7.4 Screen children attending healthcare facilities or mobile clinics for vaccination status and administer any needed vaccinations.

Guidance Notes:

Vaccination: Vaccines are vital in preventing excess deaths in acute crises. National guidance should cover emergencies and undocumented populations.

Measles vaccination: Measles immunization is a priority health intervention in crises that can become important if the recovery process after a disaster is drawn out for significant sections of the population.

- Coverage: Review coverage data for all populations to assess if routine measles immunisation coverage or measles campaign coverage has been higher than 90 per cent for the preceding three years. Carry out a measles campaign if vaccination coverage is less than 90 per cent, unknown or in doubt. Administer vitamin A supplementation at the same time. Ensure that at least 95 per cent of newcomers to a settlement aged between six months and 15 years are vaccinated.
- Age ranges: Vaccinate up to the age of 15 years. If this is not possible, prioritize children aged 6–59 months.
- Repeat vaccinations: All children aged nine months to 15 years should receive two doses of measles vaccine as part of standard national immunization programs. Children between six and nine months who have received the measles vaccine should receive a further two doses at the recommended ages according to the national schedule.

National EPI program: Re-establish EPI promptly to protect children against measles, diphtheria and pertussis and reduce the risk of respiratory infections. National EPI programs may need supplemental vaccines.

Vaccine safety: Ensure the safety of vaccines at all times. Follow the manufacturer's instructions for storage and refrigeration.

Informed consent: Obtain informed consent from parents or guardians to administer vaccine. This includes an understanding of risks and potential side effects.

HEALTH STANDARD 8

Management of newborn and childhood illness

In long-term recovery phases, children have access to priority healthcare that addresses the major causes of newborn and childhood morbidity and mortality.

KEY ACTIONS

8.1 Provide appropriate healthcare at different levels (facility, mobile clinics or community programs).

8.2 Establish a standardized system of assessment and triage at all facilities that provide care for sick newborns or children.

8.3 Make essential medicines available in the appropriate dosages and formulations for treating common childhood illnesses at all levels of care.

8.4 Screen children for their growth and nutritional status.

8.5 Design health education messages to encourage families to engage in healthy behaviour and disease preventive practices.

8.6 Design health education messages to encourage people to seek early care for any illness such as fever, cough or diarrhoea among children and newborns.

8.7 Identify children with a disability or developmental delay.

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Guidance Notes:

Essential newborn care[3]:

Whether the birth takes place with or without skilled care, essential newborn care consists of:

- **Thermal care** (delay bathing, and keep the baby dry and warm with skin-to-skin contact).
- **Infection prevention** (promote clean birth practices, handwashing, clean cord, and skin and eye care).
- **Feeding support** (immediate and exclusive breastfeeding, not discarding colostrum).
- **Monitoring** (assess for danger signs of infections or conditions that may need referral).
- **Post-natal care** (provide it at or close to home in the first week of life).

Integrated management of childhood illness (IMCI) focuses on the care of children under age five years at a primary healthcare level. After establishing IMCI, incorporate clinical guidelines into standard protocols and train health professionals properly.

Integrated community case management (iCCM) is an approach to provide timely and effective treatment of malaria, pneumonia and diarrhoea to people with limited access to healthcare facilities, especially to children under age five years.

Management of diarrhoea: Treat children with diarrhoea with low osmolality oral rehydration salts (ORS) and zinc supplementations. Zinc shortens the duration of diarrhoea, and ORS prevents dehydration. Encourage caregivers to continue or increase breastfeeding during the episode, and to increase all feeding after.

Management of pneumonia: If children have a cough, assess for fast or difficult breathing and chest indrawing. If present, treat with an appropriate oral antibiotic. Refer those with danger signs or severe pneumonia for priority care.

Feeding separated children: Arrange supervised feeding for separated or unaccompanied children.

Child protection concerns: Use routine health services to identify child neglect, abuse and exploitation. Refer cases to child protection services. Integrate identification and gender-sensitive case management procedures into routine health services for mothers and infants, children and adolescents.

[3] Integrated Management of Pregnancy and Childbirth' (IMPAC) and 'Newborn Health in Humanitarian Settings' guidelines.

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HEALTH STANDARD 9

Reproductive, maternal and newborn healthcare

Healthcare prevents excessive maternal and newborn morbidity and mortality.

KEY ACTIONS

9.1 Ensure that clean and safe delivery, essential newborn care, and emergency obstetric and newborn care services are available at all times.

9.2 Provide all visibly pregnant women with clean delivery packages when access to skilled health providers and healthcare facilities cannot be guaranteed.

Guidance Notes:

Emergency obstetric and newborn care services should be available at all times. Details and procedures are available in relevant national guidelines. Some details can also be found in Sphere: Health – Reproductive, maternal and newborn healthcare Standard.

Other services: Initiate other maternal and newborn care as soon as possible, including ante-natal and post-natal care. Coordinate with the nutrition sector to ensure that pregnant and breastfeeding women are referred to nutrition services as appropriate, such as for targeted supplementary feeding.

Prepositioning delivery packages in emergency shelters should be considered.

HEALTH STANDARD 10

Mental health care

People of all ages have access to post-disaster psychological support and to healthcare that addresses mental health conditions.

KEY ACTIONS

10.1 During pre-disaster preparedness period, train community leaders, staff and volunteers on psychological first aid and work with community members, including marginalized people, to strengthen community self-help and social support.

10.2 In the immediate post-disaster relief phase, identify and support people having lived through traumatic experiences.

10.3 Provide psychological support to community leaders, aid workers and volunteers working with disaster survivors.

10.4 Make psychological first aid available at every healthcare facility.

10.5 Rely on community-based psychological support, provided by qualified lay persons, faith-based organizations, churches and other actors.

10.6 Identify and support the setting up of community spaces by – for example faith-based organizations and churches.

10.7 Coordinate mental health and psychosocial supports across sectors and ESFs as appropriate.

10.8 Make psychological interventions available where possible for people with chronic conditions and prolonged distress.

10.9 Protect the rights of people with severe mental health and neurological conditions in the community, hospitals and institutions.

10.10 For work done around minimizing harm related to alcohol and drugs, consider consulting the Bahamas National Drug Council.

10.11 Make available resources to minimize the increase in incidences of GBV and child abuse.

Guidance Notes:

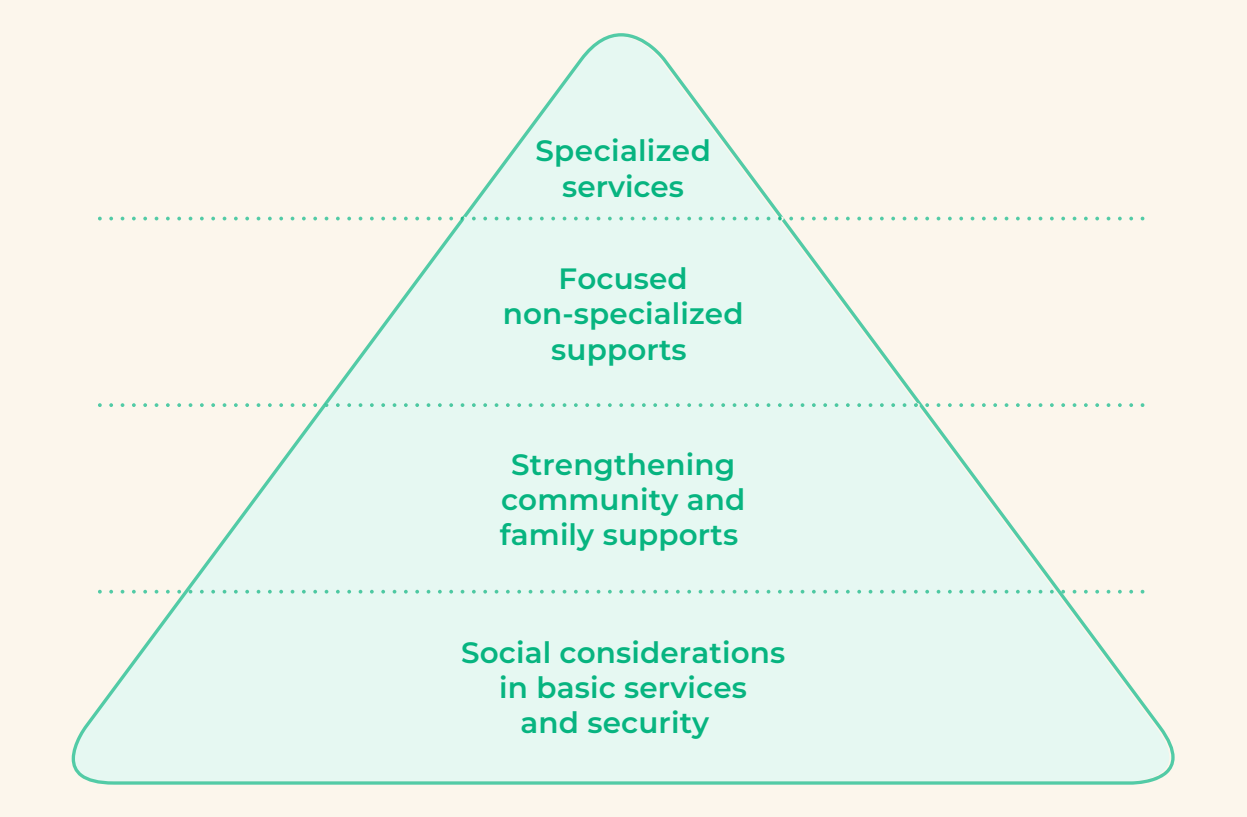
Multi-level support: Crises affect people in different ways, requiring different kinds of support. A key to organizing mental health and psychosocial support is to develop a layered system of complementary supports that meets different needs as illustrated in this diagram, which shows how different actions complement each other. All layers of the pyramid are important and should ideally be implemented concurrently.

Assessment: Rates of mental health conditions are substantial in any crisis. Use rapid participatory approaches and, where possible, integrate mental health in other assessments.

Support to community leaders and volunteers should be provided with priority, to ensure they can continue their roles within their communities.

Community self-help and support: Engage community leaders, health workers, and volunteers to enable community members, including marginalized people, to increase self-help and social support. Activities could include creating safe spaces and the conditions for community dialogue.

Pyramid of multi-layered services and supports



Source: IASC Reference Group for Mental Health and Psychosocial Support in Emergency Settings (2010).

Psychological first aid: Psychological first aid needs to be available to people who have been traumatized by the disaster and its effects. It is a basic, humane and supportive response to suffering. It includes listening carefully, assessing basic needs and ensuring they are met, encouraging social support, and protecting from further harm. It is non-intrusive and does not press people to talk about their distress. After brief orientation, community leaders, healthcare workers and others involved in the humanitarian response can provide psychological first aid to people in distress.

Single-session psychological debriefing should **not** be used. It promotes venting by encouraging people to briefly but systematically recount perceptions, thoughts and emotional reactions experienced. It is at best ineffective.

Other psychological interventions: Non-specialized healthcare workers can deliver certain psychological interventions for depression, anxiety and post-traumatic stress disorder when they are well trained, supervised and supported. This includes cognitive behavior therapy or interpersonal therapy. PAHO provides Brief Interventions to prevent alcohol and drug problems.

Clinical mental healthcare: Brief all health staff and volunteers about available mental healthcare. Train health providers according to evidence-based protocols such as Mental Health Gap Action Program (mhGAP). Where possible, add a mental health professional such as a psychiatric nurse and mental health therapist to general healthcare facilities. Arrange private space for consultations.

The most frequent conditions presented to health services in emergencies are psychosis, depression and a neurological condition, epilepsy. Maternal mental health is of specific concern because of its potential impact on care for children. Integrate mental health categories into the health information system.

Essential psychotropic medicines: Organize an uninterrupted supply of essential psychotropic medicines with at least one from each therapeutic category (anti-psychotic, anti-depressant, anxiolytic, anti-epileptic, and medicines to counter side effects of anti-psychotics. Health systems standard 3: Essential medicines and medical devices.

Protecting the rights of people with mental health conditions: During humanitarian crises, people with severe mental health conditions are extremely vulnerable to human rights violations such as abuse, neglect, abandonment and lack of shelter, food or medical care. The rights of people in institutions are particularly fragile. The Mental Health Bill (2022) upholds these rights, supported by the National Adult Safeguarding Task Force.

Transition to post-crisis: A disaster increases the long-term rates of many mental health conditions, so it is important to plan for sustained increased treatment coverage across the affected area. As a longer-term measure, steps should be taken to develop a sustainable mental health system at Family Island levels that is ready to supporting communities in the immediate aftermath of a disaster and during recovery.

Psychological help for aid workers must be provided as needed, as they may have traumatic experiences supporting disaster survivors and dealing with stress and exhaustion. Additional guidance provided in Core Standard 8.

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HEALTH STANDARD 11

Continued Care of Non-Communicable Diseases (NCD)

Post-disaster and during recovery, people have access to preventive programs, diagnostics and essential therapies for acute complications and long-term management of noncommunicable diseases.

KEY ACTIONS

11.1 For each Family Island, identify the NCD health needs and analyse the availability of services and medicines pre-crisis.

11.2 Consider pre-positioning pain medicines and insulin on Family Islands ahead of hurricane season, to support identified needs for at least one month, based on the island communities' profiles.

11.3 Establish national disaster preparedness protocols for NCDs, including focus on people living in long-term care facilities.

11.4 Implement phased-approach programmes based on life-saving priorities and relief of suffering.

11.5 Ensure NCD care includes a focus on adequate and adapted nutrition requirements, in particular for patients suffering from diabetes.

Guidance Notes:

Prevention and preparedness plans: Include NCD management in national disaster and emergency plans, ensuring it is specific to the different types of healthcare facilities. Health centers in disaster-prone contexts should be prepared for NCD service delivery.

A registry of patients with complex and critical NCDs should be developed for each Island. Create standardized operating protocols – including nutritional requirements – for referring them if a disaster occurs.

NCD patients and services should be identified regularly at the beginning of hurricane season. Plan for care or evacuation of complex cases such as cancer or chronic renal disease. Identify people with diabetes.

Complex treatment needs: Provide continuity of care for patients with complex needs such as renal dialysis, radiotherapy and chemotherapy. Ensure people living in long-term care facilities are integrated into any emergency health plan. Give clear and accessible information about referral pathways. Provide referrals to palliative care support if available.

Integration of NCD care into the health system: Provide basic treatment for NCDs at primary healthcare level in line with national standards.

Work with communities to improve early detection and referrals. Integrate Community Health Workers into primary care facilities, and engage with community leaders, traditional healers and the private sector. Outreach services can provide NCD health services to isolated populations. Adapt the existing health information system for the disaster setting, to include monitoring of main NCDs, and in particular diabetes, followed by hypertension, asthma and other respiratory diseases, heart diseases and epilepsy.

Medicines and medical devices: Review the national list of essential medicines and devices, including technologies and core laboratory tests, to manage NCDs. Focus on primary healthcare. Provide access to essential medicines and medical devices at the appropriate levels of care. NCD kits may be used in conjunction with inter-agency emergency health kits at immediate post-disaster stage. Do not use these kits to provide long-term supplies.

Training: Train all levels of clinical staff on case management of NCD conditions and train all staff in priority NCD management, including standard operating procedures on referral.

Health promotion and education: As a long-term measure, work with community leaders and representatives to develop and provide information about NCD services and where to access care. Information should be accessible to all, including elderly people and persons with disabilities, to promote healthy behaviors, modify risk factors, and improve self-care and adherence to treatment. Focus on nutrition education.

HEALTH STANDARD 12

Injury Care

People have access to safe and effective injury care during crises to prevent avoidable mortality, morbidity, suffering and disability.

KEY ACTIONS

12.1 Provide injury care on Family Islands as the post-disaster state of facilities allows.

12.2 Plan for the option of immediate post-disaster emergency evacuations to NP or GB.

12.3 Establish or strengthen standardized protocols for triage and injury care.

12.4 Pre-position tetanus shots on Family Islands and provide tetanus prophylaxis to anyone at risk of injury, to injured people with open wounds and those involved in rescue and debris removal operations.

12.5 Ensure timely access to rehabilitation services, priority assistive devices and mobility aids for injured patients.

12.6 Ensure timely access to mental health services and psychosocial support.

12.7 Strengthen the health information systems to include injury data.

Guidance Notes:

Training and skills development for injury care should include early recognition, resuscitation, wound management, pain control and time-sensitive psychological support.

Standardized protocols exist to cover acuity-based triage classification for routine and surge situations, emergency care and referrals for emergency and advanced care.

Minimum safety and quality standards include the safe and rational use of medications, devices and blood products, including supply chain; IPC; sufficient power supply for lighting, communications and operating essential medical devices such as emergency resuscitation equipment and sterilization autoclaves; and medical waste management.

Community-based first aid: Timely and appropriate first aid by non-professionals and volunteers saves lives if done in a safe and systematic manner. Basic wound management training, such as in cleaning and dressing, is vital. Include household- and community-level first aid, and guidance on when and where to seek medical help. Raise awareness of context-specific risks such as unstable infrastructure or risk of injury during rescue attempts or debris management.

Anesthesia and surgical care: Emergency, operative and rehabilitative care should be undertaken only by organizations with appropriate expertise. Inappropriate or inadequate care may do more harm than doing nothing. Surgery provided without appropriate pre- and post-operative care and ongoing rehabilitation can result in a failure to restore functional capacities of the patient.

Mobile clinics: The use of temporary mobile clinics may be necessary and should be coordinated with MoHW and community leaders and health actors. Standards and safety of care should meet the existing standards in The Bahamas and international standards.

Rehabilitation and social reintegration: Early rehabilitation can increase survival and enhance quality of life for injured survivors. Establish links with local rehabilitation centers or community-based rehabilitation organizations for ongoing care.

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HEALTH STANDARD 13

Palliative care

People have access to palliative and end-of-life care that relieves pain and suffering, maximizes the comfort, dignity and quality of life of patients, and provides support for family members.

KEY ACTIONS

12.1 Establish guidelines and policies to support consistent palliative care.

13.2 Develop a care plan and provide palliative care to patients who are dying.

13.3 Integrate palliative care into all levels of the health system.

13.4 Train healthcare workers to provide palliative care, including pain and symptom control, and mental health and psychosocial support.

13.5 Provide essential medical supplies and equipment.

13.6 Work with local systems and networks to support patients, caregivers and families in the community and at home.

Guidance Notes:

Preparedness: For each Family Island, identify individuals requiring palliative care and, at family and community levels, be prepared for the case of a disaster (for example plan for early evacuation).

Developing a care plan: Identify relevant patients and respect their right to make informed decisions about their care and about actions to be taken for disaster preparedness. Provide unbiased information and take account of their needs and expectations. The care plan should be agreed and based on patient preferences. Offer access to mental health and psychosocial support.

Availability of medicines: Some palliative care medicines, such as pain relief, are included in the basic and supplementary modules of the inter-agency emergency health kit, and in the Essential Medicines List – while useful for immediate post-disaster care, more sustainable systems should be established for the weeks and months after a disaster. Consider pre-positioning certain medicines.

Family, community and social support: During the post-disaster recovery and reconstruction phase, coordinate with other sectors to agree a referral pathway for patients and their families to have integrated support. This includes assistance in shelter, hygiene kits, cash-based assistance, mental health and psychosocial support, and legal assistance if needed. Work with existing networks of community care to provide additional support for patients and family members.

Spiritual support and burial practices: All support should be based on patient or family requests. Spiritual care providers can act as a resource for patients, carers and humanitarian actors. Orient local faith leaders on key principles of psychosocial support for patients facing major health issues. Establish reliable mechanisms for bilateral referral between the healthcare system and spiritual leaders for any patient, caregiver or family member who requests it.

Ensure support for safe, respectful and dignified burial practices in collaboration with the local community.

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LOGISTICS

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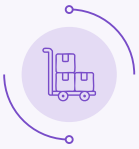
LOGISTICS

The Logistics standards[4] support the humanitarian standards. They are key to the success of any humanitarian response and are intended to address the particular logistical challenges related to The Bahamas' archipelagic setting. These standards focus mainly on the transportation of goods, while the transport of aid workers and evacuation of people are included as well.

[4] The standards are based on the Universal Logistics Standards.

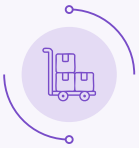
The Logistics Standards are grouped into four sections:

Section 1: Procurement



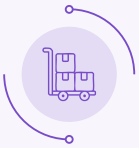
STANDARD 1: Procurement planning
STANDARD 2: Procurement decisions
STANDARD 3: Procurement process
STANDARD 4: Supplier relationships
STANDARD 5: Procurement practices

Section 2: Transport



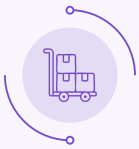
STANDARD 6: Transport strategy
STANDARD 7: Transport – Timely and efficient delivery
STANDARD 8: Transport information
STANDARD 9: Transported goods
STANDARD 10: Legal and regulatory transportation requirements
STANDARD 11: Minimizing harm
STANDARD 12: Fleet management

Section 3: Warehouse and storage



STANDARD 13: Warehouse management
STANDARD 14: Storage facility
STANDARD 15: Warehouse processes documentation
STANDARD 16: Storage with minimal losses
STANDARD 17: Warehouse impact on environment

Section 4: Distribution



STANDARD 18: Distribution planning
STANDARD 19: Distribution effectiveness and transparency
STANDARD 20: Distribution monitoring
STANDARD 21: Safe and secure distribution
STANDARD 22: Distribution and environmental impact

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Section 1: Procurement

Procurement is the process of sourcing and agreeing to terms and purchasing goods, services or other works from an external source, often implemented via an official procurement and tendering process.

Procurement and management of warehoused goods fall under the responsibility of ESF7 (Relief Supplies and Distribution). Procurement is also covered in ESF1 (Transportation) and ESF4 (International Assistance).

LOGISTICS STANDARD 1

Procurement planning

Procurement planning supports the timely delivery of goods and services.

KEY ACTIONS

1.1 Assess the goods and services (including cash transfers) needed in terms of type, quality, quantity and date required.

1.2 Consult communities on their expected needs in case of a disaster.

1.3 Define the specification of goods and services based on market availability and context.

1.4 Evaluate and plan the appropriate procurement process. As a first step, seek to procure from local / Family Island businesses. Prices from local businesses should be negotiated prior to disaster.

1.5 Ensure that product specifications respond to identified Family Island needs and allow for quick delivery, best value for money, and market availability.

1.6 Develop a risk matrix with possible mitigating measure for each risk identified.

1.7 Cooperate with CDEMA during procurement planning and align planning with their Regional Disaster Response Support (RDRS) strategy.

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Guidance Notes:

Procurement planning: While the procurement of goods and services follows strict rules of scoping, tendering and awarding contracts, preparations for a natural disaster include a pre-negotiated inventory of all items to be procured and all services to be provided. This will save time and control prices. Involve communities in identifying inventory items.

Water, food and medicines: Coordinate and consult with the Ministry of Health and Wellness, Ministry of Social Services, (possibly Ministry of Agriculture), as well as Food and Nutrition focused NGOs to determine their procurement needs and processes.

Local providers: prioritize national and local providers of goods and services, especially from affected areas, to support local recovery.

CDEMA's Regional Disaster Response Support (RDRS) strategy provides for technical and operational assistance through units of the Regional Response Mechanism (RRM), including the co-ordination of regional in-kind support through CDEMA. This cooperation must be considered during preparedness and integrated into logistics procedures in times of disaster response.

LOGISTICS STANDARD 2

Procurement decisions

Procurement decisions add value to interventions through best value for money.

KEY ACTIONS

2.1 Have available pre-identified procurement needs.

2.2 Match procurement needs with available budgets and funding.

2.3 Allow time at the start of an intervention for an assessment of procurement needs, ensuring that affected communities can participate meaningfully in decision-making.

2.4 Adapt eligibility and selection criteria of suppliers to ensure that local / Family Island businesses can fully engage in the bidding process, prioritizing bidders from disaster-affected Family Islands to support recovery of local livelihoods.

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Guidance Notes:

Needs lists development is the responsibility of the Government. These lists are developed after initial situation overviews and initial damage assessments Core Standard 2. Ensure clarity about which agency is responsible for developing and sharing these lists. Ensure procurement planning is involved from the beginning of establishing these lists.

Lists include goods, services and equipment required for the disaster operation. Be specific in terms of quantities, volumes, etc. needed. Expressly exclude problematic items from these lists, such as fresh food or medicines. Procure those through pre-established trusted channels.

Make sure that these lists are publicly available (e.g. on websites of DRM Authority, MoFA and CDEMA) in addition to their sharing through official channels by the MoFA.

During disaster response, recovery and rehabilitation, review needs lists weekly to reflect changing needs and the evolving response.

Sharing needs internationally: The DRM Authority should maintain strong links with MoFA to share the needs lists and key communication messages through diplomatic channels. Do the same through CDEMA's Regional Response Mechanism (RRM) and share the needs list with CDEMA's donor groups within the RRM. Furthermore, share needs lists on DRM Authority website to avoid unsolicited bilateral donations.

International assistance must respond to the needs expressed by Government through the needs lists. It must be coordinated between MoFA and the DRM Authority, in alignment with the procedures and standards outlined in the (forthcoming) National Disaster Coordination Protocols. For further details on international assistance, see Core Standard 6.

Customs clearance: Work with the Customs Department to develop clearance procedures (consult IDRL Guidelines). Ensure timely customs clearance, VAT exemption etc. of pre-authorized humanitarian goods from pre-identified and approved providers in times of disaster response, recovery and rehabilitation. Consider not extending this option to all international donations to avoid unsolicited donations.

Unsolicited Bilateral Donations (UBDs): Clearly communicate that aid and assistance can reach The Bahamas and be delivered **only if** it is requested and/or accepted by MoFA and if it responds to the published needs list.

Publicize the criteria for welcoming international aid. Consider not accepting help from un-registered organizations. Review the list of registered and authorized organizations annually. Include messages around UBDs in the national communications strategy. To avoid UBDs, suggest alternative forms of aid, such as cash, and provide a website through which donations can be easily made.

LOGISTICS STANDARD 3

Procurement process

The procurement process is designed to be responsive and proportional while ensuring a transparent and efficient use of resources.

KEY ACTIONS

3.1 Design / adapt procurement procedures and the documentation required for the different methods of supplier selection, including value thresholds for tendering processes.

3.2 Incorporate mechanisms to allow flexible procurement strategies in situations of emergency and define the rules and conditions for the application of these mechanisms (for example, waivers/derogation and simplified procedures).

3.3 Put in place mechanisms to ensure that procurement procedures are used appropriately and in proportion to the size of the intervention.

Guidance Notes:

The procurement of goods and services requires a clear definition of what is to be achieved at the end of the process. For goods, a listing of the items to be procure along with the specification of each item is needed. For services, a detailed scope of services must be developed. Next, the appropriate tendering process must be determined (sole sourcing, selective bidding, competitive bidding). Each of these tendering processes are time specific. Tenders received are then assessed and the contract is awarded.

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LOGISTICS STANDARD 4

Supplier relationships

Supplier relationships are transparent and built on fair competition.

KEY ACTIONS

4.1 Ensure equal opportunities for all potential suppliers, through equal information and allowing enough time for them to provide offers. Check that all suppliers being considered are legitimate and comply with all legal, financial and statutory requirements.

4.2 Prepare procurement solicitation documents to share, which provide all the necessary specification and detail to potential bidders or vendors.

4.3 Mitigate supplier selection bias by working proactively to prevent conflicts of interest, collusion, fraud, bribery or coercive practices.

Guidance Notes:

Non-Profit Organizations registration and Evaluation: Non-Profit Organisations Registration - Government - Services (bahamas.gov.bs). All NPOs wishing to work in The Bahamas are required to register. These NPOs are also required to undergo an evaluation process to determine if they are legitimate and in good standing with The Government or other Government Entities, and they should be vetted with the support of regional and international organizations before being allowed to enter the country. NPOs should be encouraged to register throughout the year, to make sure their application is processed at the beginning of hurricane season. Core Standard 6.

Exceptions to this rule might be considered for certain international humanitarian actors deemed “eligible”, e.g. relevant intergovernmental organizations (including UN and CDEMA), The Bahamas Red Cross Society and Foreign Components of the International Red Cross and Red Crescent Movement.

Bahamian and Family Island companies: All things equal, give preference to Bahamian companies, and where possible to companies based on affected Family Islands, to support local economic recovery.

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LOGISTICS STANDARD 5

Procurement practices

Procurement practices minimize harmful impact on the environment, communities and markets.

KEY ACTIONS

5.1 Carry out procurement activities in knowledge of, and compliance with, the most up-to-date Public Procurement Act of The Bahamas (currently 2023).

5.2 Ensure sustainable and ethical procurement policies that inform both decision makers and suppliers about conditions for engaging in procurement opportunities.

5.3 Ensure that procurement practices and organizational purchasing power do not negatively affect local business or else impact market prices or product availability.

5.4 Assess the effects of procurement and its outcomes on the environment, and implement the necessary measures to minimize negative impacts, including long-term impact on the community, environment and market.

Guidance Notes:

Procurement: Potential suppliers should be familiar with The Bahamas Public Procurement Act and the website Bahamas.bonfirehub.com, where the Government of The Bahamas publishes procurement opportunities.

Approval process: It is important to map capacities and resources available to support the national response. Establish and regularly review lists of reliable suppliers. As possible, draw up public-private partnerships in key areas such as warehousing and logistics, to build overall preparedness and support local businesses. Make sure the approval process is clearly stated in the adopted procurement procedure.

International companies can register following instructions and providing relevant documentation, including a letter of incorporation.

Approved suppliers: The Government of The Bahamas often conducts business with companies that have current business licensing and Tax Compliance Certificates. This can include international companies.

Section 2: Transport

LOGISTICS STANDARD 6

Transport strategy

A transport strategy is clearly defined to best support relief operations.

KEY ACTIONS

6.1 Assess the operational requirements, infrastructure and access difficulties, in particular assessing damage to affected Family Island airports, seaports, roadways and access to remote Family Islands.

6.2 Determine what supplies need to be moved from origin to destination, how long it will take for them to arrive, and when these supplies should be available.

6.3 Elaborate a detailed plan for each step of the transport process and stage of the journey, matching operational requirements with needs and capacity, and forecasting the time and costs involved.

6.4 Ensure cold goods supply chain logistics for storing and transporting essential medicines, vaccines and medical devices, and for collection and storage of blood. Health Standard 3.

6.5 Coordinate with Shelter actors to ensure available mass evacuation plans are ready and can be implemented.

6.6 Prepare for transporting aid workers safely to the affected island(s), including food, water and shelter for the aid workers.

6.7 Assess that transport services are available along with other agencies' transport requirements and capacity.

6.8 Collaborate with relevant stakeholders at all levels in the development of the transport plan, ensuring it fits in with an overall supply chain strategy.

Guidance Notes:

Inter-island and Intra- Island transport strategies: In the context of disasters, inter-island and even intra-island transport infrastructure plays an essential role for providing access to critical goods and services such as medical goods and services, power generation facilities and food and water provision to shelters. Inter-island maritime logistics channels can be planned by establishing transport routes which consider reefs and potential debris.

These channels can support inter-island and intra-island support and can be particularly important for planning more decentralised warehouses. Involve FI administrators, Local Government councils, and other relevant actors to develop and implement a variety of such strategies, to create a more decentralised approach to DRM activities in the immediate aftermath of a natural hazard or disaster event.

Note: that such approaches should remain in line with National plans.

Transporting early essential relief items: Two possibilities are listed here:

- Pre-deployment: Royal Bahamas Defence Force vessels have the possibility to pre deploy with essential supplies prior to impact with initial relief supplies, and go to impacted area once the "all clear" is given.
- Assessment flights to an impacted island can carry some essential supplies.

Identifying transport options from the US East Coast: Most of the sources to The Bahamas, come from the US East Coast. Therefore, a detail evaluation of the potential constrains and bottle necks that may be in these areas will be useful.

Evacuation plans for NP, GB and all FI must be developed, updated, and tested on a yearly basis, ahead of hurricane season. The plans should clearly cite the frequency of testing and drills. Plan for significant evacuation numbers and at the same time sufficient shelters, to offer shelter options as needed. Consider that if an airfield is damaged, marine-based evacuations may be the better option. Shelter Standards 1 and 2.

Aid workers: Safely transporting aid workers to affected islands and ensuring accommodation, food and water for them in a situation of general need is important, so aid workers don't use up the affected population's scarce goods and services.

Suitability of transport services: Assess suitability of available transport services for the specific terrain and weather conditions. Consider if they can pass through flood waters, consider electric or non-electric vehicles and similar transport.

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LOGISTICS STANDARD 7

Transport – Timely and efficient delivery

Goods are delivered in the right time while optimizing costs and the use of resources.

KEY ACTIONS

7.1 Define the roles and responsibilities of all parties involved in each phase of the transport process.

7.2 Organize the means of transport according to availability, the type of goods that are being shipped, the timing required for delivery, the load to be transported (dimensions and weight), the distance to be travelled, the cost per transported unit and the related risks.

7.3 Anticipate, plan, and consolidate cargo, minimizing transport service costs and maximising vehicle payload and the number of loaded journeys.

7.4 Ensure that every step in the transport chain is selected to react to any associated transport risk.

7.5 Consider diversifying service providers, subcontractors, transport methods, and in-country routes where possible, contributing to transport service sustainability and risk mitigation.

Guidance Notes:

International assistance for The Bahamas is coordinated by the Ministry of Foreign Affairs (MoFA) and according to Part XIII of the DRM Act, 2022. This includes customs, civil aviation, port authorities and the Department of Immigration. MoFA will collaborate with the DRM Authority and regulate the acceptance and termination of assistance and manage the protocols and procedures in making requests to countries, territories, or organizations outside of The Bahamas for monetary assistance, whether donations or funds. International assistance includes goods, equipment, and services, which includes, but is not limited to boats, airplanes and other transport resources.

Importing supplies: The majority of sources come from the US East Coast (Florida and Texas). A detailed evaluation of potential constraints and bottle necks affecting transporting goods is important.

International air support: The DRM Authority liaises with the National Airport Development (NAD) and the Bahamas Civil Aviation Authority (BCAA) for tarmac spacing for disembarking of relief supplies.

Disembarking of supplies: The DRM Authority liaises with port officials to confirm berthing space for disembarking of supplies.

LOGISTICS STANDARD 8

Transport information

Transport is supported by clear communication channels, visibility into cargo movement and handover, and access to relevant information.

KEY ACTIONS

8.1 Establish clear communication channels with each party involved in the transportation process, agreeing what information or reporting is required and the documentation that should be delivered for each step in the process.

8.2 Use a common language, terminology and templates to enable sharing of information and to facilitate opportunities to consolidate cargo or mutualise services.

8.3 Establish a monitoring mechanism, both procedural and physical, for obtaining and providing regular feedback about the cargo location and condition and adapt operations accordingly.

Guidance Note:

Clear lines of communications are essential when transporting relief goods via land or sea to multiple Family Islands. Times of departure, noted delays and arrival times of carriers in the islands is essential to avoid cargo being abandoned at air or sea ports.

LOGISTICS STANDARD 9

Transported goods

Well-implemented transport minimizes financial and material losses and guarantees the preservation of transported goods.

KEY ACTIONS

9.1 Carry out a risk analysis in relation to the shipment, identifying potential bottle necks, threats and cargo vulnerabilities and implementing the necessary actions to minimize risks.

9.2 Evaluate the need to ensure the freight and assess the options for doing this.

9.3 Ensure that the transport operations and conditions are not harmful for the cargo.

9.4 Monitor the movement and condition of the cargo, taking the required actions to minimize delays, damages or losses.

9.5 When receiving a consignment, inspect the quantity and the quality, and notify the transporter of any discrepancy.

LOGISTICS STANDARD 10

Legal & regulatory transportation requirements

Well-implemented transportation complies with legal and regulatory requirements.

KEY ACTIONS

10.1 Check import restrictions and requirements and fulfil all opportune clearance actions.

10.2 Ensure that the appropriate transport documents are provided in time and are accurate.

10.3 Ensure that both the chosen transport mode and how the cargo is packaged, loaded and confined complies with national legislation and all regulatory frameworks.

10.4 Verify the identification of the carrier and registration of the vehicle. This is especially important for contracted transport.

10.5 Ensure all procedures, documents, personnel and carriers are following maritime rules, protocols and regulations.

Guidance Note:

For more details, consult the IDRL Guidelines, in particular sections 16 to 19.

LOGISTICS STANDARD 11

Minimizing harm

Well-implemented transport minimizes harm to people and the environment.

KEY ACTIONS

11.1 Ensure that risks affecting personnel, communities and the environment are included in the risk analysis. Implement the measures required to minimize such risks.

11.2 Assess the transportation in terms of its environmental impact and consider environmental considerations when selecting options. Minimize any potential negative impacts of the transportation on the environment.

11.3 **Food:** Minimize packaging, while ensuring direct distribution without requiring re-measuring or repacking. Packaging should be sturdy and convenient for handling, storage and distribution. It should be accessible for older people, children and persons with disabilities. FSN Chapter.

11.4 Minimize harm for transporting goods like water treatment plants, chemicals for water treatment, generators, and diesel and gasoline.

11.5 Organize briefing sessions and training for transporters to sensitize them to environmental and protection topics.

11.6 Plan for reverse logistics when required, contributing to properly dealing with hazardous materials, recycling of goods, obsolete equipment or unused commodities.

LOGISTICS STANDARD 12

Transport - Fleet management

Fleet management follows existing guidance and standards and is planned and managed in a cost-effective, compliant and environmentally responsible way, to meet operational needs.

KEY ACTIONS

12.1 Ensure fleet management supports the objectives set out by the transport strategy.

12.2 Assess availability of fleet, focusing on local transport options, collaboration with private actors, and various acquisition methods, such as renting, leasing or purchasing.

12.3 Ensure fleet is managed in a cost-effective manner.

12.4 Ensure fleet drivers and pilots are trained and experienced.

12.5 Ensure fleet vehicles, boats and planes are operated safely and securely.

12.6 All vehicles are operated in compliance with national regulations and stakeholder policies and procedures.

12.7 Ensure fleet reduces its environmental impact.

Guidance Notes:

Access: The DRM Authority establishes MoUs with local shipping and airline companies to gain access to their assets in times of emergency. The same is the case for MoUs with trucking companies to assist with the rapid transport of supplies from aircraft or ships delivering to warehouses.

Fleet management cost: Establish procedures for effective vehicle and transport service management. Ensure regular vehicle checks and routine maintenance in line with manufacturer recommendations. Record and regularly monitor trips, fuel consumption and mileage for each vehicle and cross-check logbook entries with original trip plans. Record vehicle costs for fuel, tyres, maintenance, repair and miscellaneous expenses. Consider using an electronic vehicle management system if budget allows. Ensure that subcontracted transport services are meeting the agreed standards for vehicles and drivers. Review supplier performance (maintenance, fuel, rental vehicles) on a regular basis.

Fleet drivers: Ensure that all drivers are appropriately trained, have experience and valid driving licences and all the important information to operate their vehicle. Consider annual medical checks for all drivers, which will include hearing and eyesight tests. Ensure that all drivers

receive training on workplace safeguarding policies, including code of conduct provisions. Actively encourage female drivers to apply for fleet and transport positions.

Fleet safety: Clearly define roles and responsibilities for the safety of vehicle users, drivers and outsourced personnel transport services. Establish trip approval and security protocols, where appropriate. Establish incident and crash reporting procedures. Empower staff to refuse to travel in unsafe vehicles or with drivers who exhibit poor driving or otherwise behave unacceptably. There should be zero tolerance for harassment and sexual exploitation and abuse. Ensure that essential equipment is always available in each vehicle.

Operating regulations: Ensure that all vehicles are registered and have valid third-party liability insurance, and up-to-date required documentation, such as confirmation of registration.

Environmental impact: Ensure that vehicle types used are appropriate for the trip and task requirements. Report fuel consumption data for each of the fleet vehicle classes. Environmental considerations should be a criterion when selecting the make-up of the fleet vehicle classes.

Section 3: Warehouse & Storage

LOGISTICS STANDARD 13

Warehouse management

Warehouse management supports as appropriate the organization and purpose of the intervention.

KEY ACTIONS

13.1 Define the purpose of the warehouse according to needs and context, and ensure it is an integral part of a global, regional, national or local supply chain strategy.

13.2 Compare, analyse and document the benefits of holding stock against the organization's capacities, cost and risks of doing so.

13.3 Assess and study current and past warehousing operations of other agencies, private sector and local government bodies in terms of 'preparedness and response'. Consider what other agencies store and what the local market offers to ensure coherence and complementarity.

13.4 Regularly consult key stakeholders to adapt the warehouse plan to intervention requirements.

Guidance Notes:

Warehouse planning: Develop a national warehouse plan and a plan for each Family Island and groups of islands. Consider a phased, sub-regional approach to add a few decentralised warehouse sites, to ensure remote Family Islands can be reached on time, depending on where a hurricane makes landfall. Consider additional logistics approaches to ensure aid reaches all Family Islands and understand how much time this may take. Identify storm-resistant structures on each island that can be used temporarily as warehouses to receive, store and distribute aid, and from where aid can be delivered.

Warehouse managers need specialized training for warehouse management and inventory control.

Mobile warehouses (tents) should be considered for setting up near airports and seaports, particularly in Family Islands.

Warehouse stocks should be replenished continuously, if necessary, during an emergency response, and in particular during the months right after a disaster. Check expiration dates and shelf life of products.

LOGISTICS STANDARD 14

Storage facility

The storage facility accomplishes its expected functions and contributes to the best use of resources, including a layout that maximizes space utilisation with the minimum necessary handling effort.

KEY ACTIONS

14.1 Assess available storage options against specific functions and requirements depending on the type of products or goods to be stored.

14.2 Assess the location and size of the storage facility and its proximity to demand and supply points, and its location relative to potential hazard impacts.

14.3 Confirm warehouse accessibility by the required means of transportation and its access to the labour and assets required for its operation.

14.4 Define the resources necessary to properly operate the warehouse based on expected intervention needs and stock management strategies.

14.5 Verify that the site is safe and secure and that it complies with all administrative and legal requirements.

14.6 Plan the warehouse layout and the material handling requirements, based on its expected functions. Consider accessibility for persons with disabilities (mobility, vision or hearing).

14.7 Define a clear and logical layout focusing on maximising space utilisation and minimizing handling effort based on the characteristics of goods and stock turnover.

14.8 Ensure the layout is designed with due consideration for staff safety.

14.9 Determine and make available the best storage solution: shelving, pallets, racking.

LOGISTICS STANDARD 15

Warehouse processes documentation

Warehouse processes ensure traceability and transparency while supporting planning and forecasting through accurate and up-to-date documentation.

KEY ACTIONS

15.1 Identify all goods kept in the storage facility based on critical characteristics including type, volume, ownership, expected usage, and specification.

15.2 Ensure that all stock movements and warehouse activities are planned, tracked and documented.

15.3 Maintain accurate and updated stock level information and make it available to all staff for activity planning and other logistics processes.

15.4 Periodically confirm the accuracy of activity records by running physical inventories of goods and reconciling stock documentation.

15.5 Ensure all movements of goods are performed by appropriate authorised staff, segregating duties to ensure compliance and accuracy of stock records while minimizing losses and human error.

15.6 Provide training to warehouse staff and partners to support safe, efficient operations and respect for your code of conduct.

LOGISTICS STANDARD 16

Storage with minimal losses

Management processes and storage conditions preserve stored items by minimizing losses and deterioration.

KEY ACTIONS

16.1 Perform a warehouse risk assessment to determine likely hazards that stocks may be exposed to, including fire, floods, looting, etc.

16.2 Put in place and maintain the necessary physical and procedural mitigation measures.

16.3 Regularly monitor and control storage conditions to minimize the deterioration of stored goods.

16.4 Perform regular inspections and maintenance, including ventilation and cleaning of the storage facility and its equipment.

Guidance Notes:

Standing Operating Procedures (SOPs) must be developed for the activities in this standard.

Regular inspections of the goods in storage and condition of the facilities should be carried out by Warehouse teams who are on location on a daily basis.

LOGISTICS STANDARD 17

Warehouse impact on environment

Warehouse management minimizes impact on the environment while supporting people and communities.

KEY ACTIONS

17.1 Assess and consider any potential environmental impact when designing or updating the warehouse layout and management processes.

17.2 Regularly train staff (including casual labour) to correctly handle goods, manage specific product categories, and use and maintain safely equipment.

17.3 Make sure that the warehouse does not increase the exposure of any neighbouring communities to human or environmental threats.

17.4 As necessary, develop and implement a spill contingency plan when handling hazardous materials.

Section 4: Distribution

Distribution refers to the 'handover' of assistance to the affected communities who are the recipients. Dispatch or transport of goods to the distribution point is addressed in the Transport section above.

Distribution must take into account the following:

- As the final step in meeting end-user needs, this is the last **link in the supply chain,** where goods have the highest value.
- Risks associated with **loss and lack of security** tend to be high.
- Many stakeholders are involved where **a lot of activities are running simultaneously,** while at the same time communication can be sporadic and monitoring difficult.
- Recipients are extremely vulnerable and there is an **imbalance of power** between those delivering and those receiving.
- There is a **need for a high level of coordination,** efficiency and timeliness.
- The **safety and protection of all people** involved is essential along with monitoring to enable process adjustments.

Affected communities must be able to participate in the distribution design and implementation. Feedback and complaints mechanisms should be understandable and accessible to all stakeholders, and they should be encouraged to use them. Monitoring and learning are key to achieving optimal results and to enabling any corrective action in a timely manner. Core Standards.

Note: this chapter is complementary to the FSN standard on Targeting, distribution and delivery.

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LOGISTICS STANDARD 18

Distribution planning

The distribution is collaboratively designed and planned to best serve the population in need; it is adapted to the operational environment, and to the type and nature of the assistance that will be distributed.

KEY ACTIONS

18.1 Clearly define the distribution details (what is to be delivered, to whom, where and when).

18.2 Evaluate the logistics requirements, viability and risks in the local context for the different distribution modalities (cash, vouchers, goods), as well as the logistics capacities of all stakeholders, the available infrastructure and the accessible resources.

18.3 Ensure that the distribution plan is part of general supply planning.

18.4 Ensure relevant representatives of stakeholders are consulted during the design and planning of the distribution.

18.5 Design the delivery network detailing how goods will reach recipients and agreeing on the number and location of distribution sites.

18.6 Adapt the means for recipient identification and registration according to Family Island realities and to the distribution process itself.

Guidance Notes:

Clean water distribution: The Bahamas has serious challenges to provide uncontaminated water due to its geographical spread, population size, remote locations, topography and climatic conditions. In order to anticipate water distribution where it is needed, maintain an updated full inventory of available water production, transport and distribution systems. This includes water trucks transporting water from production site to distant communities, portable water production systems and Reverse Osmosis water purifiers, as well as collapsible plastic water bottles and how to integrate it to the existing (not damaged) water infrastructure. The Royal Bahamas Defence Force, Water and Sewerage Corporation and others, including NGOs, have equipment available. WASH Standards 3 and 4.

Design of site setup and distribution process: Fully integrate all Family Islands in this process, ensuring distribution will reach them within a reasonable amount of time. Make the process inclusive. Women, girls, boys, men, and persons with disabilities should all take part in the

design process to ensure there is local knowledge of risks, preferences, barriers etc. Locate the distribution sites in suitable, accessible and safe places.

Food distribution: See FSN chapter.

Distribution of medical devices and essential medicines: See Health chapter.

Eligibility: Consider checking with government social programs which may have lists available of eligible people. During distribution, include a plan for dealing with eligible but unregistered recipients and any no-shows.

LOGISTICS STANDARD 19

Distribution effectiveness and transparency

People receive the distributed assistance in an effective, accurate, safe and transparent manner.

KEY ACTIONS

19.1 Coordinate with all stakeholders to ensure that all prerequisites are in place and goods are delivered on time.

19.2 Spend time in advance to streamline and verify your targeted population list, where possible.

19.3 Define clear responsibilities and accountability mechanisms among the different participating agencies, service providers and community groups.

19.4 Make sure that the distribution team and community representatives are aware of the tasks that they are expected to fulfil so they perform them correctly and safely. Adjust their duties to their capacities. Set up staff to act as coordinators.

19.5 Establish a simple communication and reporting mechanism to communicate with other team members and key stakeholders.

Guidance Notes:

Defining responsibilities: Ensure segregation of duties between a) teams identifying both needs and affected communities; b) teams distributing the goods; and c) those carrying out verification. Avoid one person or team participating in more than one of those duties.

Reporting mechanism, feedback and complaints: Ensure the reporting mechanism allows for collecting feedback from communities and complaints, identifying uncovered needs and issues around targeting and quality of distributed goods. Ensure that complaints are managed by someone without any conflict of interest.

LOGISTICS STANDARD 20

Distribution monitoring

The performance and impact of the distribution are monitored to achieve optimal results and to enable any corrections in a timely manner.

KEY ACTIONS

20.1 Develop an information system that provides sufficient, accurate and up-to-date information to enable effective assistance delivery.

20.2 Provide the means and train people for data to be correctly collected, monitored and shared.

20.3 Monitor distribution activities and the impact of the distribution on the population.

20.4 Regularly analyse data and provide feedback on quality, efficiency and impact to improve planning for the next distribution cycle. Consider supply tracking, distribution performance monitoring and end user monitoring.

20.5 Determine whether assistance should continue, be amended or be stopped.

LOGISTICS STANDARD 21

Safe and secure distribution

The distribution is safe, secure and grants protection and dignity to affected people and aid workers.

KEY ACTIONS

21.1 Undertake safety, security, safeguarding and corruption risk assessments to integrate specific prevention and mitigation strategies in all distribution phases, with special emphasis on risks to vulnerable groups and individuals. Core Standard 9.

21.2 Put in place feedback and complaints mechanisms which are appropriate, safe, confidential, known and accessible Core Standard 5.

21.3 Establish the necessary measures to ensure that the distribution is used only for intended purposes.

21.4 Collect and manage data without exposing affected communities or any stakeholder.

21.5 Ensure that affected communities understand why they have been selected and what this entitles them to.

21.6 Engage with relevant communities and groups to ensure their viewpoints, both positive and negative, are considered.

21.7 Establish anti-corruption and safeguarding policies and procedures, including a staff code of conduct.

LOGISTICS STANDARD 22

Distribution and environmental impact

The distribution is organized and carried out in such a way to minimize environmental impact.

KEY ACTIONS

22.1 Assess past interventions in terms of environmental impact to evaluate potential future consequences, and use lessons learnt to minimize impact, where possible.

22.2 Incorporate environmental considerations into the distribution design and planning, including reverse logistics where the community does not have the resources to deal with the waste in an environmentally friendly way.

22.3 Define environmental impact indicators to track the environmental performance of your distribution activities.

22.4 Assess contractor contributions to the total environmental impact and encourage and support contractors to minimize their environmental impact, such as by optimizing packaging or using more environmentally friendly materials.

22.5 Comply with local and national environmental regulations, particularly any related to waste management. WASH: Solid Waste Management Standard.

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ANNEXES

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Annex 1 – Needs assessment checklists for Shelter, WASH, Nutrition, Food security and Health

These checklists are taken from the Sphere Handbook (2018 edition). They should be seen as suggestions and should be adapted as needed.

Shelter and settlement assessment checklist

This list of questions serves as a checklist to ensure that appropriate data is obtained to inform the post-crisis shelter and settlement response.

Information on the underlying causes of the crisis, the security situation, the basic demographics of the displaced and any host population, and the key people to consult and contact, will need to be obtained separately.

Assessment and coordination

- ☐ Has an agreed coordination mechanism been established by the relevant authorities and humanitarian organizations?
- ☐ What baseline data are available on the affected people and what are the known hazards and shelter and settlement risks and vulnerabilities?
- ☐ Is there a contingency plan to inform the response?
- ☐ What initial assessment information is already available?
- ☐ Is an interagency and/or multi-sectoral assessment planned and does this include shelter, settlement and household items?

Demographics

- ☐ How many people comprise an average household?
- ☐ How many affected people are living in different types of households? Consider groups living outside of family connections, such as groups of unaccompanied children, households that are not average size, or others. Disaggregate by gender, age, disability.
- ☐ How many affected households lack adequate shelter, and where are these households?

- ☐ How many people, disaggregated by gender, age and disability, who are not members of individual households have no or inadequate shelter, and where are they located?
- ☐ How many affected households that lack adequate shelter have not been displaced and can be assisted at the site of their original homes?
- ☐ How many affected households that lack adequate shelter are displaced and require shelter assistance with host families or in temporary settlements?
- ☐ How many people, disaggregated by gender and age, lack access to communal facilities such as schools, healthcare facilities and community centres?

Risks

- ☐ What are the immediate risks to life, health and security resulting from the lack of adequate shelter, and how many people are at risk?
- ☐ What are the less immediate risks to people's lives, health and security resulting from the lack of adequate shelter?
- ☐ How do tenure systems, arrangements and practices affect security of tenure for vulnerable and marginalized populations?
- ☐ What are the particular risks for vulnerable people, including women, children, unaccompanied minors, and persons with disabilities or chronic illnesses, due to the lack of adequate shelter, and why?
- ☐ What is the impact on any host populations of the presence of displaced people?
- ☐ What are the potential risks for conflict or discrimination among or between groups within the affected population, particularly for women and girls?

Resources and constraints

- ☐ What are the material, financial and human resources of the affected people that are available to meet some or all of their urgent shelter needs?
- ☐ What are the issues regarding land availability, ownership and usage that affect people's ability to meet urgent shelter needs, including temporary communal settlements where required?
- ☐ What risks may potential host populations face in accommodating displaced people within their own dwellings or on adjacent land?
- ☐ What are the opportunities and constraints affecting the use of existing available and unaffected buildings or structures to accommodate displaced people temporarily?

- ☐ Is accessible vacant land suitable for temporary settlements, considering topography and other environmental constraints?
- ☐ What regulatory requirements and constraints may affect the development of shelter solutions?

Materials, design and construction

- ☐ What initial shelter solutions or materials have the affected people, affected populations or other actors provided?
- ☐ What existing materials can be salvaged from the damaged site for use in the reconstruction of shelters?
- ☐ What are the typical building practices of the affected people and what materials do they use for the structural frame, roof and external wall enclosures?
- ☐ What alternative solutions for design or materials are potentially available and familiar or acceptable to the affected people?
- ☐ What design features will ensure safe and ready access to and use of shelter solutions by all affected people?
- ☐ How can the identified shelter solutions minimize future risks and vulnerabilities?
- ☐ How are shelters typically built, and by whom?
- ☐ How are construction materials typically obtained, and by whom?
- ☐ How can women, youths, persons with disabilities and older people be trained or assisted to participate in the building of their own shelters, and what are the constraints?
- ☐ Where individuals or households lack the capacity or opportunity to build their own shelters will additional assistance be required to support them? Examples include the provision of voluntary or contracted labour or technical assistance.

Household and livelihood activities

- ☐ What household and livelihood support activities typically take place in or near the shelters of the affected people, and how does the resulting space provision and design reflect these activities?
- ☐ What legal and environmentally sustainable livelihood support opportunities can be provided through the sourcing of materials and the construction of shelter and settlement solutions?

Essential services and communal facilities

- ☐ What is the current availability of water for drinking and personal hygiene, and what are the possibilities and constraints in meeting the anticipated sanitation needs?
- ☐ What is the current provision of social facilities (such as health clinics, schools and places of worship), and what are the constraints to and opportunities for accessing these facilities?
- ☐ Where communal buildings, particularly schools, are used for sheltering displaced people, what is the process and timeline for returning them to their intended use?

Host population and environmental impact

- ☐ What are the issues of concern for the host population?
- ☐ What are the organizational and physical constraints related to accommodating the displaced people within the host population or within temporary settlements?
- ☐ What are the environmental concerns regarding the local sourcing of construction materials?
- ☐ What are the environmental concerns regarding the needs of the displaced people for fuel, sanitation, waste disposal, and grazing for animals, among others?

Household item needs

- ☐ What are the critical non-food items required by the affected people?
- ☐ Can any of the required non-food items be obtained locally?
- ☐ Is the use of cash or vouchers possible?
- ☐ Will technical assistance be required to complement the provision of shelter support items?

Clothing and bedding

- ☐ What types of clothing, blankets and bedding do women, men, children and infants, pregnant and lactating women, persons with disabilities and older people typically use? Are there particular social and cultural considerations?
- ☐ How many women and men of all ages, children and infants have inadequate or insufficient clothing, blankets or bedding to provide protection from the negative effects of the climate and to maintain their health, dignity and wellbeing?

- ☐ What are the potential risks to the lives, health and personal safety of the affected people if their need for adequate clothing, blankets or bedding is not met?
- ☐ What vector-control measures, particularly the provision of mosquito nets, are required to ensure the health and wellbeing of households?

Cooking and eating, stoves and fuel

- ☐ What cooking and eating utensils did a typical household have access to before the crisis?
- ☐ How many households do not have access to sufficient cooking and eating utensils?
- ☐ How did affected people typically cook and heat their dwellings before the crisis, and where did the cooking take place?
- ☐ What fuel was typically used for cooking and heating before the crisis, and where was this obtained?
- ☐ How many households do not have access to a stove for cooking and heating, and why?
- ☐ How many households do not have access to adequate supplies of fuel for cooking and heating?
- ☐ What are the opportunities and constraints (in particular environmental concerns) of sourcing adequate supplies of fuel for the crisis-affected and neighbouring populations?
- ☐ What is the impact on affected people, and in particular women of all ages, of sourcing adequate supplies of fuel?
- ☐ Are there cultural issues regarding cooking and eating to take into account?

Tools and equipment

- ☐ Which basic tools to repair, construct or maintain a shelter are available to the households?
- ☐ What livelihood support activities can also utilise the basic tools for construction, maintenance and debris removal?
- ☐ What training or awareness-raising activities will enable the safe use of tools?

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Water, Sanitation and Hygiene promotion (WASH)

This list of questions is primarily for use to assess needs, identify resources and describe local conditions. It does not include questions that will determine the external resources needed to supplement those immediately and locally available.

General

- ☐ How many people are affected and where are they? Disaggregate the data by gender, age, disability and so on.
- ☐ What are people's likely movements? What are the security factors for the affected people and for potential relief responses?
- ☐ What are the current, prevalent or possible WASH-related diseases?
- ☐ Who are the key people to consult or contact?
- ☐ Who are the vulnerable people in the population and why?
- ☐ Is there equal access for all to existing facilities, including at public places, health centres and schools?
- ☐ What special security risks exist for women, girls, boys and men? At-risk groups?
- ☐ What water, sanitation and hygiene practices were the population accustomed to before the crisis?
- ☐ What are the formal and informal power structures (for example, community leaders, elders, women's groups)?
- ☐ How are decisions made in households and in the community?
- ☐ Is there access to local markets? What key WASH goods and services were accessible in the market before the crisis and are accessible during the crisis?
- ☐ Do people have access to cash and/or credit?
- ☐ Are there seasonal variations to be aware of that may restrict access or increase demands on labour during harvesting time, for example?
- ☐ Who are the key authorities to liaise and collaborate with?
- ☐ Who are the local partners in the geographical area, such as civil society groups that have similar capacity in WASH and community engagement?

Hygiene promotion

- ☐ What water, sanitation and hygiene practices were people accustomed to before the crisis?
- ☐ What existing practices are harmful to health, who practises these and why?
- ☐ Who still practises positive hygiene behaviour and what enables and motivates them to do this?
- ☐ What are the advantages and disadvantages of any proposed changes in practice?
- ☐ What are the existing formal and informal channels of communication and outreach (such as community health workers, traditional birth attendants, traditional healers, clubs, cooperatives, churches and mosques)?
- ☐ What access to the mass media is there in the area (for example, radio, television, video, newspapers)?
- ☐ What local media organizations and/or non-governmental organizations (NGOs) are there?
- ☐ Which segments of the population can and should be targeted (for example, mothers, children, community leaders, religious leaders)?
- ☐ What type of outreach system would work in this context (for example, community hygiene volunteers or workers or promoters, school health clubs, WASH committees) for both immediate and medium-term mobilization?
- ☐ What are the learning needs of hygiene promotion staff and community outreach workers?
- ☐ What non-food items are available and what are the most urgently needed based on preferences and needs?
- ☐ Where do people access markets to buy their essential hygiene items? Has this access (cost, diversity, quality) changed since the crisis?
- ☐ How do households access their essential hygiene items? Who makes the decisions regarding which items to buy and prioritize?
- ☐ How effective are hygiene practices in healthcare settings (particularly important in epidemic situations)?
- ☐ What are the needs and preferences of women and girls for menstrual hygiene practices?
- ☐ What are the needs and preferences of people living with incontinence?

Water supply

- ☐ What is the current water supply source and who are the present users?
- ☐ How much water is available per person per day?
- ☐ What is the daily and weekly frequency of the water supply availability?
- ☐ Is the water available at the source sufficient for short-term and longer-term needs for all groups?
- ☐ Are water collection points close enough to where people live? Are they safe?
- ☐ Is the current water supply reliable? How long will it last?
- ☐ Do people have enough water containers of the appropriate size and type (collection and storage)?
- ☐ Is the water source contaminated or at risk of contamination (microbiological, chemical or radiological)?
- ☐ Is there a water treatment system in place? Is treatment necessary? Is treatment possible? What treatment is necessary?
- ☐ Is disinfection necessary? Does the community have problems with water palatability and acceptance associated with chlorine taste and smell?
- ☐ Are there alternative sources of water nearby?
- ☐ What traditional beliefs and practices relate to the collection, storage and use of water?
- ☐ Are there any obstacles to using the available water supply sources?
- ☐ Is it possible to move the population if water sources are inadequate?
- ☐ What are the alternatives if water sources are inadequate?
- ☐ Are there any traditional beliefs and practices related to hygiene (for example, during the Haiti cholera outbreak the disease was associated with voodoo culture)? Are any of these beliefs or practices either useful or harmful?
- ☐ What are the key hygiene issues related to water supply?
- ☐ Do people buy water? If so where, at what cost and for what purposes? Has this access (the cost, quality, regularity of delivery) changed?
- ☐ Do people have the means to use water hygienically?
- ☐ Are waterpoints and laundry and bathing areas well drained?
- ☐ Are soil conditions suitable for on-site or off-site management of problem water from waterpoints and laundry and bathing areas? Has a soil percolation test been carried out?
- ☐ In the event of rural displacement, what is the usual source of water for livestock?

- ☐ Will there be any environmental effects due to possible water supply intervention, abstraction and use of water sources?
- ☐ What other users are currently using the water sources? Is there a risk of conflict if the sources are utilised for new populations?
- ☐ What opportunities are there to collaborate with the private and/or public sector in water provision? What bottlenecks and opportunities exist that could inform the response analysis and recommendations?
- ☐ What operation and maintenance duties are necessary? What capacity is there to fulfil them in the short and long term? Who shall be accountable for them?
- ☐ Is there an existing or potential finance mechanism or system that can recover the operation and maintenance costs?
- ☐ How does the host population access water and ensure that its water is safe at the point of use?

Excreta disposal

- ☐ Is the environment free of faeces?
- ☐ If there is open defecation, is there a designated area?
- ☐ Are there any existing facilities? If so, are they used? Are they sufficient? Are they operating successfully? Can they be extended or adapted?
- ☐ Are the facilities safe and dignified: lighted, equipped with locks, privacy screens? Can people access the toilet facilities during the day and night? If not at night, what are the alternatives?
- ☐ What excreta management practices does the host population practice?
- ☐ Is the current defecation practice a threat to water supplies (surface or groundwater) or living areas and to the environment in general?
- ☐ Are there any social – cultural norms to consider in the design of the toilet?
- ☐ Are people familiar with the design, construction and use of toilets?
- ☐ What local materials are available for constructing toilets?
- ☐ Is there an existing acceptance of and practice for composting?
- ☐ From what age do children start to use the toilet?
- ☐ What happens to the faeces of infants and young children?
- ☐ What is the slope of the terrain?
- ☐ What is the level of the groundwater table?

- ☐ Are soil conditions suitable for on-site excreta disposal?
- ☐ Do current excreta disposal arrangements encourage vectors?
- ☐ Are there materials or water available for anal cleansing? How do people normally dispose of these materials?
- ☐ Do people wash their hands after defecation and before food preparation and eating? Are soaps or other cleansing materials with water available next to the toilet or within the household?
- ☐ How do women and girls manage menstruation? Are there appropriate materials or facilities available for this?
- ☐ Are there any specific facilities or equipment available for making sanitation accessible for persons with disabilities, people living with HIV, people living with incontinence or people immobile in medical facilities?
- ☐ Have environmental considerations been assessed: for example, the extraction of raw materials such as sand and gravel for construction purposes, and the protection of the environment from faecal matter?
- ☐ Are there skilled workers in the community, such as masons or carpenters and unskilled labourers?
- ☐ Are there available pit emptiers or desludging trucks? Currently, is the collected faecal waste disposed of appropriately and safely?
- ☐ What is the appropriate strategy for management of excreta – inclusive of containment, emptying, treatment and disposal?

Vector-borne diseases

- ☐ What are the vector-borne disease risks and how serious are they?
- ☐ What daily or seasonal patterns do local vectors follow in relation to reproduction, resting and feeding?
- ☐ Are there traditional beliefs and practices (for example, the belief that dirty water causes malaria) that relate to vectors and vector-borne disease? Are any of these beliefs or practices either useful or harmful?
- ☐ If vector-borne disease risks are high, do people at risk have access to individual protection?
- ☐ Is it possible to make changes to the local environment (especially by, for example, drainage, scrub clearance, excreta disposal, solid waste disposal) to inhibit vector breeding?

- ☐ Is it necessary to control vectors by chemical means? What programmes, regulations and resources exist regarding the use of chemicals for vector control?
- ☐ What information and safety precautions need to be provided to households?

Solid waste management

- ☐ Is accumulated solid waste a problem?
- ☐ How do people dispose of their waste? What type and quantity of solid waste is produced?
- ☐ Can solid waste be disposed of on-site or does it need to be collected and disposed of off-site?
- ☐ What is the normal solid waste disposal practice for affected people (for example, compost and/or refuse pits, collection system, bins)?
- ☐ Are there medical facilities and activities producing waste? How is it disposed of? Who is responsible?
- ☐ Where are disposable sanitary materials disposed of (for example, children's nappies, menstruation hygiene materials and incontinence materials)? Is their disposal discreet and effective?
- ☐ What is the effect of the current solid waste disposal on the environment?
- ☐ What solid waste management capacity do the private and public sectors have?

Nutrition assessment checklist

Below are sample questions for assessments examining the underlying causes of undernutrition, the level of nutrition risk and the possibilities for response. The questions are based on the conceptual framework of the causes of undernutrition. See Figure 7 Food security and nutrition: causes of undernutrition. The information is likely to be available from a variety of sources. Gathering it will require various assessment tools, including key informant interviews, observation and review of secondary data.

PRE-EMERGENCY SITUATION

What information already exists on the nature, scale and causes of undernutrition among the affected people? See Food security and nutrition assessments standard 1.1.

THE CURRENT RISK OF UNDERNUTRITION

What is the risk of undernutrition related to infant and young child feeding and care practices?

- ☐ Is there a change in work and social patterns (due to factors such as migration, displacement or armed conflict) affecting the roles and responsibilities in the household?
- ☐ Is there a change in the normal composition of households? Are there large numbers of separated children?
- ☐ Has the normal care environment been disrupted (for example, through displacement), affecting access to secondary caregivers, access to foods or access to water?
- ☐ Are any infants not breastfed? Are there infants who are artificially fed?
- ☐ Has there been any evidence or suspicion of a decline in infant feeding practices in the crisis? In particular, has there been a decrease in breastfeeding initiation or exclusive breastfeeding rates? Has there been an increase in artificial feeding rates and/or any increase in the proportion of infants not breastfed?
- ☐ Are age-appropriate, nutritionally adequate, safe complementary foods, and the means to prepare them, hygienically accessible?
- ☐ Is there any evidence or suspicion of general distribution of breastmilk substitutes such as infant formula, other milk products, bottles and teats, either donated or purchased?
- ☐ In pastoral communities, have the herds been away from young children for long? Has access to milk changed from normal?
- ☐ Has HIV affected caring practices at household level?

- ☐ Has the general food ration been adapted to the needs of older people and people with difficulties feeding? Evaluate its energy composition and micronutrient content. Assess the acceptability of the food products (palatability, chewability and digestibility).

What is the risk of undernutrition related to poor public health?

- ☐ Are there any reports of disease outbreaks that may affect nutritional status, such as measles or acute diarrhoeal disease? Is there a risk that these outbreaks will occur?
- ☐ What is the estimated measles vaccination coverage of the affected people?
- ☐ Is vitamin A routinely given with measles vaccination? What is the estimated vitamin A supplementation coverage?
- ☐ Are there any estimates of mortality rates (either crude or under-five)? What are the estimates and what method has been used to make them?
- ☐ Is there, or will there be, a significant decline in ambient temperature that is likely to affect the prevalence of acute respiratory infection or the energy requirements of the affected people?
- ☐ Is there a high prevalence of HIV?
- ☐ Are people already vulnerable to undernutrition due to poverty or ill health?
- ☐ Is there overcrowding or a risk of or high prevalence of tuberculosis?
- ☐ Are there reported cases of non-communicable diseases such as diabetes, arthritis, cardiovascular diseases and anaemia?
- ☐ Is there a high incidence of malaria?
- ☐ Have people been in water or in wet clothes or exposed to other harsh environmental conditions for long periods of time?

What formal and informal local structures are currently in place through which potential interventions could be channelled?

- ☐ What is the capacity of the Ministry of Health, religious organizations, community support groups, breastfeeding support groups or NGOs with a long- or short-term presence in the area?
- ☐ What nutrition interventions or community-based support were already in place and organized by local communities, individuals, NGOs, government organizations, UN agencies or religious organizations? What are the nutrition policies (past, ongoing and lapsed), the planned long-term nutrition responses, and programmes that are being implemented or planned in response to the current situation?

Food security assessments often broadly categorize the affected people into livelihood groupings according to their sources of, and strategies for, obtaining income or food. This may also include a breakdown of the population according to wealth groups or strata. It is important to compare the current situation with the history of food security before the crisis. Use "average normal years" as a baseline. **Consider the specific roles and vulnerabilities of women and men, and the implications of these for household food security.**

Food Security and Livelihoods needs assessment checklist

The following checklist questions cover the broad areas to consider in a food security assessment.

Food security of livelihood groups

- ☐ Are there groups in the population who share the same livelihood strategies? How can these be categorized according to their main sources of food or income?

Food security before the crisis (baseline)

- ☐ How did the different livelihood groups acquire food or income before the crisis? For an average year in the recent past, what were their sources of food and income?
- ☐ How did these different sources of food and income vary seasonally and geographically in a normal year? Constructing a seasonal calendar may be useful.
- ☐ Were all groups getting enough food of the right quality to be well nourished?
- ☐ Were all groups earning enough income by non-harmful ways to afford their basic needs? Consider food, education, healthcare, soap and other household items, clothing, and productive inputs such as seeds and tools. (The last two questions will indicate whether there were chronic problems. Existing problems may be worsened by a crisis. The appropriate response is influenced by whether the problem is chronic or acute.)
- ☐ Looking back over the past five or ten years, how has food security varied from year to year? Constructing a timeline or history of food security may be useful.
- ☐ What kind of assets, savings or other reserves do the different livelihood groups own? Examples include food stocks, cash savings, livestock holdings, investments, credit and unclaimed debt.
- ☐ Over a period of a week or a month, what do household expenditures include? What proportion is spent on each item?
- ☐ Who is responsible for the management of cash in the household and on what is cash spent?
- ☐ How accessible is the nearest market for obtaining basic goods? Consider factors such as distance, security, ease of mobility, availability and accessibility of market information, and transport.
- ☐ What is the availability and price of essential goods, including food?
- ☐ Before the crisis, what were the average terms of trade between basic needs (food, agricultural inputs, healthcare, etc) and income sources (cash crops, livestock, wages, etc).

Food security during crises

- ☐ How has the crisis affected the different sources of food and income for each of the livelihood groups identified?
- ☐ How has it affected the usual seasonal patterns of food security for the different groups?
- ☐ How has it affected access to financial service providers, markets, market availability and prices of essential goods?
- ☐ For different livelihood groups, what are the different crisis coping strategies and what proportion of people are engaged in them? How has this changed compared with the situation before the crisis?
- ☐ Which group or population is most affected?
- ☐ What are the short- and medium-term effects of coping strategies on people's financial and other assets?
- ☐ For all livelihood groups, and all people at risk, what are the effects of coping strategies on their health, general wellbeing and dignity? Are there risks associated with coping strategies?

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Health assessment checklist

Preparation

- ☐ Obtain available information on the crisis-affected population.
- ☐ Obtain available maps, aerial photos or satellite images, and geographic information system (GIS) data of the affected area.
- ☐ Obtain demographic, administrative and health data.

Security and access

- ☐ Determine the existence of the ongoing natural or human-made hazards.
- ☐ Determine the overall security situation, including the presence of armed forces.
- ☐ Determine the access that humanitarian organizations have to the crisis-affected population.

Demographics and social structure

- ☐ Determine the size of the crisis-affected population, disaggregated by gender, age and disability.
- ☐ Identify groups at increased risk, such as women, children, older people, persons with disabilities, people living with HIV or marginalized groups.
- ☐ Determine the average household size and estimates of the number of female- and child-headed households.
- ☐ Determine the existing social structure and gender norms, including positions of authority and/or influence in the community and the household.

Background health information

- ☐ Identify health problems that existed in the crisis-affected area before the emergency.
- ☐ Identify pre-existing health problems in the country of origin for refugees, or the area of origin for internally displaced persons.
- ☐ Identify existing risks to health, such as potential epidemic diseases.
- ☐ Identify pre-existing and existing barriers to healthcare, social norms and beliefs, including positive and harmful practices.
- ☐ Identify previous sources of healthcare.
- ☐ Analyze the various aspects of the health system and their performance.

Mortality rates

- ☐ Calculate the crude mortality rate.
- ☐ Calculate the age-specific mortality rates (such as under-five mortality rate).
- ☐ Calculate cause-specific mortality rates.
- ☐ Calculate proportional mortality rate.

Morbidity rates

- ☐ Determine incidence rates of major health conditions that have public health importance.
- ☐ Determine age- and gender-specific incidence rates of major health conditions where possible.

Available resources

- ☐ Determine the capacity of the MoH of the country affected by the crisis.
- ☐ Determine the status of national health facilities, including total number by type of care provided, degree of infrastructure damage, and access.
- ☐ Determine the numbers and skills of available healthcare staff.
- ☐ Determine the available health budgets and financing mechanism.
- ☐ Determine the capacity and functional status of existing public health programmes such as Extended Programme on Immunisation.
- ☐ Determine the availability of standardized protocols, essential medicines, medical devices and equipment, and logistics systems.
- ☐ Determine the status of existing referral systems.
- ☐ Determine the level of IPC standards in health facilities.
- ☐ Determine the status of the existing health information system.

Data from other relevant sectors

- ☐ Nutritional status.
- ☐ Environmental and WASH conditions.
- ☐ Food basket and food security.
- ☐ Shelter – quality of shelter.
- ☐ Education – health and hygiene education.

Annex 2 – Indicators for planning, monitoring and evaluation

Each standard is accompanied by a few indicators. They can be used for planning purposes, for monitoring during the response, and for evaluation. If needed, any key action in the Handbook can be re-formulated as an indicator.

The indicators will need to be contextualized to the situation they are used in. Percentages and amounts chosen are likely to evolve over time, which can be tracked in indicator tracking tables.

Shelter indicators

Where not specifically indicated, the standards apply to both emergency and transitional shelter situations.

Shelter Standard 1 – Long-term planning

- The shelter plan provides for the essential needs of the target population and is agreed with community leaders and relevant authorities.
- Percentage of shelters sites that are located in areas with no or minimal known natural or man-made threats, risks and hazards.
- Percentage of affected people indicating that shelter assistance reflects their needs and priorities.

Shelter Standard 2 – Site and shelter planning

- Percentage of communal shelters that have a trained and functioning shelter coordination team in place during a disaster.
- Percentage of shelters that have safe access to essential facilities and services within an acceptable amount of time and distance.

Shelter Standard 3 – Living space

- Percentage of the affected communities who have adequate emergency shelter space for 2-5 days.
- Percentage of the affected communities who have adequate transitional shelter space for a duration of several weeks or months.
- Percentage of people receiving shelter assistance that feel safe in their emergency or transitional shelter.

Shelter Standards 4 – Non-food items

- People have sufficient and appropriate quality items for safe, healthy and private sleeping.
- People have sufficient and appropriate hygiene items.
- People have sufficient and appropriate items to prepare, eat and store food.
- Percentage of the affected population who have access to a sufficient, safe and affordable energy supply to prepare food and provide lighting (Consider this integrated into the KA and GN).

Shelter Standard 5 – Transitional shelter and housing options

- Percentage of programs where local authorities are involved in monitoring construction activities.
- Percentage of construction activities that demonstrate active involvement of the affected population.
- Percentage of homes and shelter units that are constructed, repaired, retrofitted, upgraded or maintained according to the agreed Building Code.
- Percentage of households that report having received appropriate technical assistance and guidance for repairing and retrofitting their homes.

Shelter Standard 6 – Security of tenure

- Percentage of transitional shelter residents that have security of tenure for their shelter and settlement option at least for the duration of a particular assistance program or during their agreed stay in a transitional shelter.
- Percentage of shelter recipients that have an appropriate agreement for security of tenure for their transitional shelter option.
- Percentage of transitional shelter recipients with tenure challenges that have accessed, independently or through referral, legal services and/or dispute resolution mechanisms.

Shelter Standard 7 - Livelihoods

- Percentage change in the targeted population's production (food or income source) compared with a normal year.
- Percentage of targeted households with improved physical access to functioning markets.
- Percentage of the target population who improve their net income during a defined period.
- Percentage of households with access to credit.
- Percentage of the target population who diversify their income-generating activities.

- Percentage of the target population employed (or self-employed) in sustainable livelihoods activities.

Shelter Standard 8 – Environmental sustainability

- Percentage of shelter activities that are preceded by an environmental impact assessment, and recommendations implemented.
- Number of recommendations from the environment management and monitoring plan that have been implemented.
- Percentage of shelter constructions using low carbon emission construction materials and procurement methods.

Shelter Standard 9 – Debris management

- All debris is disposed of safely.
- Percentage of debris that is reused, re-purposed or recycled (target > 70 per cent by volume).

WASH indicators

WASH Standard 1 – Hygiene promotion

- Percentage of affected households who correctly describe three measures to prevent WASH-related diseases.
- Percentage of target population who correctly cite two critical times for handwashing.
- Percentage of affected households and shelters where soap and water are available for handwashing.
- Percentage of affected population who collect water from improved water sources.
- Percentage of households and shelters that safely store drinking water.
- Percentage of carers who report that they dispose of children's excreta safely.
- Percentage of households using incontinence products who report that they dispose of excreta from adult incontinence safely.
- Percentage of affected households who dispose of solid waste appropriately.
- Local environment is free of human feces.

WASH Standard 2 – Hygiene items

- All affected households have access to the minimum quantity of essential hygiene items.
- Percentage of affected people who report using hygiene items regularly after distribution.
- Percentage of women and girls of menstruating age with access to appropriate materials for menstrual hygiene management.
- Percentage of recipients who are satisfied with menstrual hygiene management materials and facilities.
- Percentage of people with incontinence that use appropriate incontinence materials and facilities.
- Percentage of recipients that are satisfied with incontinence management materials and facilities.

WASH standard 3 – Water quantity

- Average volume of drinking water per person.
  - » Minimum of 1 US gallon per person per day for up to 4 weeks for drinking water.
  - » Minimum of 2 US gallons per person per day for early recovery phase.
- Percentage of targeted households and shelter residents who know where and when they will next get their water.
- Percentage of communal water distribution points free of standing water.
- Percentage of water systems/facilities that have functional and accountable management system in place.

WASH Standard 4 – Water quality

- Percentage of affected people who collect drinking water from protected water sources.
- Percentage of households and shelters that store water safely in clean and covered containers at all times.
- Percentage of water quality tests meeting minimum water quality standards.
  - » <10 CFU/100ml at point of delivery (unchlorinated water).
  - » ≥0.2–0.5mg/l FRC at point of delivery of delivery (chlorinated water).
  - » Turbidity of less than 5 NTU.

WASH Standard 5 – Excreta-free environment

- There are no human feces present in the environment in which people live, learn and work.
- All excreta containment facilities are sited appropriately and are at an adequate distance from any surface or groundwater source.

WASH Standard 6 – Access to and use of toilets

- Ratio of shared toilets: Minimum 1 per 20 people.
- Distance between dwelling and shared toilet: In emergency shelters, toilets must be accessible within the shelter.
- Percentage of toilets that have internal locks and adequate lighting: Aim for 100%.
- Percentage of toilets reported as safe by women and girls: Aim for 100%.
- Percentage of women and girls satisfied with the menstrual hygiene management options at toilets they regularly use: Aim for 100%.

WASH Standard 7 –Excreta Management

- All human excreta is disposed of in a manner that is safe to public health and the environment.

WASH Standard 8 – Vector control

- Percentage of identified breeding sites where the vector's life cycle is disrupted.
- Percentage of affected people who can correctly describe modes of transmission and effective vector control measures at the shelter or household level.
- Percentage of people who have taken appropriate action to protect themselves from relevant vector-borne diseases.
- Percentage of households and shelters with adequate protection for stored food.

WASH Standard 9 – Solid waste management

- Percentage of solid waste that is reused, re-purposed or recycled (target > 70 per cent by volume).
- There is no solid waste accumulating around designated neighborhood or communal public collection points.

Food security and nutrition (FSN) indicators

FSN Standard 1 - Food security and nutrition assessment

- Standardized protocols are used to analyze food security and coping strategies, and to assess malnutrition and its causes.

FSN Standard 2 – Moderate acute malnutrition (MAM) and micronutrient deficiencies

- Percentage of malnutrition cases with access to treatment services (coverage): aim for 100%.
- There are no cases of malnutrition-related illnesses (scurvy, pellagra, beriberi or riboflavin deficiency).

- Rates of xerophthalmia, anaemia and iodine deficiency are not of public health significance.
- Special attention is given to elderly persons and persons with special needs, in particular non-communicable diseases.

FSN Standard 3 – IYCF: Policy Guidance and Coordination

- Percentage of adopted IYCF policies in emergencies that reflect the specifications of the Operational Guidance.
- No Code violations reported.

- Percentage of Code violations donations of breastmilk substitutes (BMS), liquid milk products, bottles and teats dealt with in a timely manner.

FSN Standard 4 – Multisectoral Support to IYCF in emergencies

- Percentage of breastfeeding mothers who have access to skilled counselling.
- Percentage of caregivers who have access to Code-compliant supplies of appropriate breastmilk substitutes (BMS) and associated support for infants who require artificial feeding.
- entage of caregivers who have access to timely, appropriate, nutritionally adequate and safe complementary foods for children aged 6 to 23 months.

FSN Standard 5 – Food Security and Food Assistance

- Percentage of emergency and transitional shelters and targeted households with acceptable.
- Food Consumption Score: >35 per cent; if oil and sugar are provided, >42 per cent.

- Percentage of targeted households with acceptable Dietary Diversity Score: >5 main food groups regularly consumed.
- Percentage of targeted households with acceptable Coping Strategy Index.
- Percentage of people receiving assistance that report complaints or negative feedback related to their treatment with dignity: All complaints are regularly monitored and quickly responded to.
- Percentage of transitional shelters and targeted households that receive the minimum food energy requirements (2,100kCal per person per day) and recommended daily micronutrient intake: aim for 100%.

FSN Standard 6 – Food quality, appropriateness and acceptability

- Percentage of affected people, including in emergency and transitional shelters, who report that food provided is of appropriate quality and meets local preferences.
- Percentage of affected people, including in emergency and transitional shelters, who report that the mechanism to receive food was appropriate.
- Percentage of emergency and transitional shelters and households that report that received food items were easy to prepare and store.
- Percentage of people receiving assistance that report complaints or negative feedback related to food quality.
- Percentage of food losses reported: aim for >0.2% of total tonnage.

FSN Standard 7 – Targeting, distribution and delivery

- Number of cases reported on bias, favoritism and discrimination related to food delivery and distribution.
- Percentage of follow-up on these cases: 100%.
- Percentage of assisted people (disaggregated by gender, age and disability) who report experiencing safety problems travelling (to and from) and at distribution sites.
- Number of cases reported of sexual exploitation or abuse of power related to distribution or delivery practices.
- Percentage of cases of sexual exploitation or abuse of power related to distribution or delivery practices that are followed up: 100 per cent.
- Percentage of targeted people that correctly cite their food assistance entitlement • Target: >50 per cent.

FSN Standard 8 – Food use

- Number of cases reported of health hazards from food distributed.
- Percentage of shelter residents and households able to store and prepare food safely.
- Percentage of targeted households able to describe three or more hygiene awareness messages .
- Percentage of targeted households that report having access to appropriate cooking utensils, fuel, drinking water and hygiene materials.

Health indicators

Many of these indicators must be adapted to the concrete situations, for example to specific Family Islands contexts.

Health Standard 1 – Health Service Delivery

- Percentage of population that can access primary healthcare within a reasonable time from dwellings: Minimum 80 per cent.
- Percentage of healthcare facilities that deliver prioritized health services: Minimum 80 per cent.
- Number of inpatient beds (excluding maternity beds) per 10,000 people: Minimum 18 (adapt to situation on each Family Island).
- Percentage of population requiring a referral seen at the next level of healthcare.
- Percentage of patients referred in adequate time.

Health Standard 2 – Healthcare Workforce

- Number of community health workers per 1,000 people: Minimum 1–2 community health workers.
- Percentage of births attended by skilled personnel (doctors, nurses, midwives): Minimum 80 per cent.
- Number of skilled birth attendant personnel (doctors, nurses, midwives) per 10,000 people: Minimum 23.
- All health staff performing clinical work have received training in clinical protocols and case management.

Health Standard 3 – Essential medicines and medical devices

- Number of days essential medicines are not available: Maximum 4 days out of 30 days.
- Percentage of health facilities with essential medicines: Minimum 80 per cent.
- Percentage of health facilities with functional essential medical devices: Minimum 80 per cent.
- All medicines dispensed to patients are within the expiry date.

Health Standard 4 – Free priority healthcare during crisis

- Percentage of healthcare facilities that do not charge user fees for priority healthcare during determined time period (including consultations, treatment, investigations and provision of medicines): Target 100 per cent.
- Percentage of people not making any direct payment when accessing or using healthcare during determined time period (including consultations, treatment, investigations and provision of medicines): Target 100 per cent.

Health Standard 5 – Health information

- Frequency of health information reports produced by MoHW: Minimum monthly.

Health Standard 6 – Communicable diseases

Prevention:

- Percentage of affected households who report that they have received appropriate information on communicable disease-related risks and preventive action.
- Percentage of affected households who can describe three measures they are taking to prevent communicable diseases.
- Incidence of major communicable diseases is stable or not increasing against pre-crisis level.

Surveillance, Outbreak Detection and Early Response

- Percentage of alerts being reported within in 24 hours: 90 per cent.
- Percentage of reported alerts being verified within 24 hours: 90 per cent.
- Percentage of verified alerts being investigated within 24 hours: 90 per cent.

Diagnosis and Case Management

Percentage of health centers supporting a crisis-affected population using standardized treatment protocols for a specified illness: Use monthly record review to monitor trends.

Percentage of suspected cases confirmed by a diagnostic method as determined by an agreed protocol.

Outbreak Preparedness and Response

Percentage of health staff in high-risk areas trained on outbreak response plan and protocols Case fatality rate is reduced to an acceptable level for all communicable diseases. Disease Surveillance Thresholds.

Health Standard 7 – Vaccine-preventable childhood diseases

- Percentage of children aged six months to 15 years who have received measles vaccination, on completion of a measles vaccination campaign: >95 per cent.
- Percentage of children aged six to 59 months who have received an appropriate dose of vitamin A, on completion of measles vaccination campaign: >95 per cent.
- Percentage of children aged 12 months who have had three doses of DPT: >90 per cent.
- Percentage of primary healthcare facilities that offer basic EPI services: at least 20 days/month.

Health Standard 8 – Management of newborn and childhood illness

- Under-five crude mortality rates: Fewer than 2 deaths per 10,000 per day.
- Appropriate care provided in a timely manner to all children under age five years presenting with pneumonia: Within 24 hours of the onset of symptoms.

Health Standard 9 – Reproductive, maternal and newborn healthcare

- Skilled care available for emergency obstetrics and newborn care at all times.
  - » Basic emergency obstetric and newborn care: minimum five facilities per 500,000 people.
  - » Comprehensive emergency obstetric and newborn care: minimum one facility per 500,000 people.
- Percentage of births attended by skilled personnel: Minimum target: 80 per cent.
- Referral system for obstetric and newborn emergencies available: Available 24 hours/day and 7 days/week.
- Percentage of deliveries in health facilities by caesarean section: Target: 5–15 per cent.

- All primary health centers report availability of at least four methods of contraception between three and six months after the onset of the crisis.

Health Standard 10 – Mental health care

- Percentage of secondary healthcare services with trained and supervised staff and systems for managing mental health conditions.
- Percentage of primary healthcare services with trained and supervised staff and systems for managing mental health conditions.
- Number of people participating in community self-help and social support activities.
- Percentage of health services users who receive care for mental health conditions.
- Percentage of people who have received care for mental health conditions who report improved functioning and reduced symptoms.
- Number of days for which essential psychotropic medicines were not available in the past 30 days: Less than four days.

Health Standard 11 – Continued care of non-communicable diseases (NCD)

- Percentage of primary healthcare facilities providing care for priority NCDs.
- Number of days essential medicines for NCDs were not available in the past 30 days: Less than four days.
- Number of days for which basic equipment for NCDs was not available (or not functional) in the past 30 days: Less than four days.
- All healthcare workers providing NCD treatment are trained in NCD management

Health Standard 12 – Injury care

- Percentage of health facilities that have a disaster plan including management of mass casualties, reviewed and rehearsed on a regular basis.
- Percentage of health facilities with protocols for the acutely injured including formal triage instruments.
- Percentage of health facilities with staff that have received basic training in the approach to the acutely injured.
- Percentage of health facilities implementing quality improvement measures to reduce baseline morbidity and mortality according to available data.

Health Standard 13 – Palliative care

- Number of days for which essential palliative care medicines were not available in the past 30 days: Less than 4 days.

- Percentage of staff trained in basic pain and symptom control or palliative care in each health centre, hospital, mobile clinic and field hospital.
- Percentage of patients identified by the healthcare system as in need that have received end-of-life care.

Logistics indicators

Procurement

- Percentage of interventions with updated, adapted and flexible procurement plans that reflect the diverse needs, preferences and priorities of affected people.
- Percentage of orders where the total time between placing an order and final (complete) delivery is in line with original expectations.
- Supplier capacity assessments provide information on the supplier's capacity to deliver according to the intervention needs.
- Percentage of orders where procurement criteria include equity and environmental considerations.
- Procurement procedures fulfil operational requirements, provide for equitable procurement and adapt to allow the selection of different types of suppliers depending on the context.
- Percentage of orders processed based on waivers/derogations.
- Percentage of procurements with records showing procurement processes have been followed.
- Percentage of orders fully delivered in compliance with the predefined terms and conditions.
- The procurement procedures and functions provide for the actions needed to prevent and mitigate corrupt practices.
- Percentage of actions to prevent and mitigate corruption that have been implemented.
- Procurement impact assessments of communities, markets and the environment provide essential information about potential negative effects and recommended mitigation measures.
- Percentage variation in prices of relevant goods and services in the local market during an intervention.
- Percentage of supplier selection processes where protection and environmental criteria are considered.

Transport

- The transport plan provides for the essential needs of the intervention and is agreed with the relevant stakeholders.
- Deviation in cost from the original transport budget.
- Percentage of transport movements whose lead times remain within the range of forecasted expectations.
- Percentage of transportations that arrive on or before the scheduled delivery date.
- Percentage deviation from the initial transport service quotes.
- Average loaded volume against total available capacity.
- Communication and monitoring systems are available for every transport operation.
- Percentage of handover and shipment events with timely confirmation according to the nature of the cargo.
- Percentage of cargo delivered with accurate information on content, schedule, consignee, consignor and transporter.
- Percentage of shipments with functioning monitoring mechanisms allowing goods to be located whenever necessary.
- A mechanism to handle complaints raised by key stakeholders, staff or local communities is available.
- An updated transport risk analysis is available, including essential information about the main risks posed to personnel, communities and the environment.
- Percentage of cargo lost or damaged during transport.
- Percentage of shipments suffering an undesired event affecting the transported goods; percentage of such events not contemplated in the risk analysis.
- All documentation required for specific transport operations is available.
- Percentage deviation from the expected time to clear goods from customs.
- Amount spent on demurrage charges, penalties and detention.
- Percentage of carbon footprint reduction due to best practice transport operations.
- Percentage of round trips where reverse logistics contributed to minimizing environmental burden.
- Number of events harming the population due to transport operations.
- An appropriate local community complaints mechanism is available.
- Clear specifications exist for any vehicles, boats and airplanes that are required.
- Fleet management plans and procedures are available, including environmental criteria for vehicle selection.
- Vehicle acquisition procedures are in line with regulations, budget and purchasing policy.

- Percentage of drivers and pilots (male and female) tested and trained annually against requirements (with records of training and briefing sessions).
- A complaints mechanism for both passengers and local communities is available.
- Incident reports (including any protection or safeguarding issues) and crash reports are available.
- Number of incidents of all kinds and crashes, whether at fault or not at fault.
- Number of insurance claims per reporting period.
- Vehicle utilization records are available.

Warehousing

- Clear warehouse specifications fulfilling operational requirements are available.
- An updated analysis of the risks, costs and benefits of holding stock is available.
- Percentage of stakeholders' requests satisfied through warehouse services.
- Percentage of stock fulfilling planned purposes.
- Criteria laying out the elements for adequate warehouse selection are available along with a definition of the resources required (workforce, equipment, etc).
- Percentage of time where the warehouse operations are disrupted due to disturbances.
- Percentage of goods transiting through the warehouse respecting the expected time of receipt and dispatch.
- Level (or percentage) of compliance with site safety criteria (checklist/policies).
- A layout plan of the storage facility provides key information on the use of space.
- Percentage of warehouse space which is currently occupied.
- Percentage of staff trained in health and safety procedures and in the use of equipment.
- Percentage of stored goods with properly documented records.
- Percentage of stock movements (receipt and dispatch) with available, accurate records.
- Discrepancies between physical inventory and stock records.
- Percentage of staff trained on required warehouse management skills.
- An updated risk analysis is available providing essential information about the key risks affecting stocks.
- Value of damaged, expired or lost goods.
- Recommendations on how to minimize the human and environmental impact of warehouse management and processes are available.
- Percentage of waste that is reused, repurposed or recycled.
- Percentage of energy, material and equipment coming from sustainable sources.

Distribution

- Distribution plan with the essential information for the logistics implementation, agreed with relevant stakeholders, including the affected population.
- Percentage of distribution sites reporting shortages of goods.
- Deviations in time and cost from the original distribution plan.
- Distribution site plan with essential information on the site layout and use of space.
- Average time that a person is waiting from the beginning of the distribution to receiving assistance.
- Percentage of sites which report problems with safe access for recipients and other stakeholders.
- Percentage of sites which report problems with distribution related to the location and organization of the site.
- Percentage of items that are delivered in good condition and in an appropriate manner.
- Percentage of deviation between distribution records and quantity of items consumed.
- Percentage of unregistered recipients and of recipients not showing up.
- Percentage of sites with staffing shortages.
- Distribution monitoring system with essential information on the distribution process.
- Percentage of reconciliation records with no discrepancy at the end of each distribution day.
- Frequency of distribution reports produced and shared.
- Percentage of relevant staff and volunteers trained on data collection means and methods.
- An appropriate complaints and feedback mechanism is available.
- Number of complaints recorded as a percentage of total respondents.
- Percentage of complaints addressed.
- Percentage of distribution events reporting safety and security incidents.
- Percentage of staff trained in anti-corruption and safeguarding policy and procedures.
- An updated environmental impact review for the distribution is available.
- Percentage of waste on the site that is reused, repurposed or recycled.
- Percentage of distribution sites that are restored to similar or better environmental conditions than before use.

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Annex 3 – Glossary

For the National Humanitarian Assistance Standards, the following definitions apply:

Accountability: the process of using power responsibly and being held accountable by different stakeholders, primarily those who are affected by the exercise of such power. Accountability means putting people and communities at the centre of decisions on issues that affect them.

Coordination: the process of working together and keeping each other informed across all levels of stakeholders involved in humanitarian assistance, ranging from community-based organizations and NGOs to private sector actors and all the way to government Ministries, to ensure that humanitarian assistance is tailored to the specific needs of the Bahamian people and communities.

Complementarity: means that every actor involved in DRM knows their role and their specific contribution to the response as a whole.

Diversity: the presence of differences among people in terms of their identities, backgrounds, experiences, perspectives and characteristics. These differences can include, but are not limited to, factors such as race, ethnicity, gender, age, sexual orientation, socioeconomic status, physical abilities, religious beliefs and cultural backgrounds.

Equity: a situation where individuals or groups are treated fairly according to their specific needs.

Family Islands Context: The understanding and recognition of unique circumstances and communities on each Family Island, the key prerequisite for context-based preparedness, planning and response.

Inclusion: the deliberate and proactive effort to create environments and practice that respect, value and support the full participation of individuals from diverse backgrounds and with different identities.

Marginalized: any individual in any context at risk of being subjected to or experiencing discrimination due to their identities, backgrounds, experiences, perspectives and characteristics.

Participation: the processes and activities that allow people and communities to play an active role in all decision-making processes that affect them. Meaningful participation involves all groups, including the most vulnerable and marginalized and is organized in accordance with people's specific needs and preferences. Participation is voluntary.

People and communities in situations of crisis and vulnerability: the totality of women, men, girls and boys with different needs, vulnerabilities and capacities who are affected by disasters, conflict, poverty or other crises and challenges.

Quality: a set of characteristics that ensures that the support provided to people and communities meets their implied or stated needs and expectations and respects the dignity of people.

Resilience: the ability of an individual or community exposed to hazards to resist, absorb, accommodate and recover from the effects of a hazard in a timely and efficient manner.

Resources: what aid actors need to deliver their mission, including but not limited to, natural, human, financial, capital, technological and informational.

Rights: people's right to life with dignity, their right to receive support and assistance and their right to protection and security, as described in the Humanitarian Charter.

Whole of Community Approach embraces both formal and informal institutions in seeking a generalized agreement across society about policy goals and the means to achieve them. Whole Community includes individuals and families, businesses, faith-based and community organizations, nonprofit organizations, schools and academia, private sector, and all levels of government. Whole of Community means involving people in the development of national preparedness documents, and ensuring their roles and responsibilities are reflected in the content of the materials.

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Annex 4 – References

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CORE STANDARDS

Core Humanitarian Standard (2024): https://www.corehumanitarianstandard.org/

Data Protection Act (2003)

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IDRL Guidelines for the domestic facilitation and regulation of international disaster relief and initial recovery assistance.

National Gender Equality and Equity Policy (in drafting process).

Ombudsman Bill (2024 – forthcoming).

Pacific Disaster Center (2001): National Disaster Preparedness Baseline Assessment https://www.pdc.org/wp-content/uploads/NDPBA_BHS_Final_Report.pdf

Persons with Disability Act (2014).

Persons with Disabilities Equal Opportunities Bill (2014) https://www.bahamas.gov.bs/wps/wcm/connect/678cadc1-08d9-43d3-bc55-d10c99f9064c/Final+Clean+1+July+2014+Persons+With+Disabilities+(Equal+Opportunities)+Bill.pdf?MOD=AJPERES

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FEMA: National Incident Management System – guidelines for MAA

Making Disaster Risk Reduction Gender Sensitive – Policy and Practical Guidelines https://www.unisdr.org/2022/dipecholac.net/docs/files/62-makingdisasterriskreductiongendersensitive.pdf

Mutual aid agreements: example of FEMA: Ntl Incident Mgt System – guidelines for MAA

SHELTER

CDEMA: Hurricane preparedness https://weready.org/hurricane/index.php?option=com_content&view=article&id=3&Itemid=3

Collective Centre Guidelines: https://sheltercluster.org/resources/documents/collective-centre-guidelines-2010

FEMA: Commonly used sheltering items catalog https://www.fema.gov/sites/default/files/documents/fema_commonly-used-sheltering-items-catalog.pdf

Nature-based Solutions Sphere Unpacked Guide: https://spherestandards.org/resources/nbs-guide/

Deal, Juliette (2020): Environmental Impact of Debris – Dorian's Response.

Minimum Standards for Camp Management: https://handbook.spherestandards.org/en/camp/#ch001

The National Environmental Policy for The Commonwealth of The Bahamas: https://www.depp.gov.bs/wp-content/uploads/2020/03/Bahamas-National-Environmental-Policy-2005.pdf

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Caribbean Vector-borne disease network: https://carivecnet.carpha.org/Working-Groups/Vector-Control-Technical-Working-Group

IFRC guidance for household water treatment and safe storage in emergencies. Deal, Juliette (2020): Trash to Cash Resource Recovery, DRA.

Sphere Handbook: Delivering assistance through markets

https://disabilitiescommissionbahamas.org/ has an app (ORG comment on CS1).

Medical waste disposal: *Sphere WASH standard 6: WASH in healthcare settings*. https://handbook.spherestandards.org/en/sphere/#ch006

FOOD SECURITY AND NUTRITION

Bahamas Steps 2019 Report: Non-communicable Diseases and Risk Factors in the Bahamian Society

Codex Alimentarius

Food Consumption Score

Household Dietary Diversity Score

Reduced Coping Strategies Index

Sphere Handbook: Delivering assistance through markets

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HEALTH

Bahamas National Drug Council

Bahamas Steps 2019 Report: Non-communicable Diseases and Risk Factors in the Bahamian Society

Emergency Risk Management for Health: Communicable Diseases www.who.int/docs/default-source/documents/publications/information-sheet-communicable-diseases.pdf?sfvrsn=384d78b2_1

Guidelines and protocols via Surveillance Manual and disease-specific response plans.

CARPHA Communicable Disease Surveillance Manual: www.carpha.org/Portals/0/Publications/Communicable%20Disease%20Surveillance%20Manual.pdf

IDRL Guidelines for the domestic facilitation and regulation of international disaster relief and initial recovery assistance.

Integrated Management of Pregnancy and Childbirth' (IMPAC) and 'Newborn Health in Humanitarian Settings' guidelines.

Mental Health Gap Action Programme (mhGAP): https://www.who.int/teams/mental-health-and-substance-use/treatment-care/mental-health-gap-action-programme

PAHO Brief Interventions to prevent alcohol and drug problems: https://www.paho.org/en/events/lets-talk-about-brief-interventions-prevent-alcohol-and-drug-problems

LOGISTICS

IDRL Guidelines for the domestic facilitation and regulation of international disaster relief and initial recovery assistance.

The Bahamas Public Procurement Act 2023

Universal Logistics Standards: https://www.ul-standards.org/

DRM AUTHORITY

IDB