STRONGER TOGETHER

Integrating Gender-based Violence and Sexual and Reproductive Health Approaches in Humanitarian Settings

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KNOWLEDGE SERIES

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FOREWORD

In a world where the well-being of women and girls is often overshadowed by the harsh realities of gender inequality and discrimination, understanding the intrinsic link between sexual and reproductive health (SRH) and gender-based violence (GBV) is not just critical but a critical step towards providing more effective and comprehensive care.

This knowledge product is an attempt to assist humanitarian organizations in understanding and mainstreaming this vital link. The guidance, insights, and data captured in the following pages are the culmination of years of experience in responding to humanitarian emergencies throughout the Arab region, in which women and girls overwhelmingly paid the steepest price. In addition to cataloguing strategies and approaches that have demonstrated their effectiveness, the information presented underscores the enormous impact humanitarians can make through integrated care that places the individual in need at the core of the response.

UNFPA firmly believes that every woman and girl has the right to access quality healthcare and protection services, even during the worst of circumstances. In the Arab region, with so many communities undergoing large-scale humanitarian crises, achieving this vital objective becomes ever more complex. Our approach goes beyond treating symptoms; it is about addressing the root causes of GBV and the barriers to SRH services. It is about recognizing the right of every woman and girl to make informed decisions about her body, her health, and her life, free from coercion, discrimination, and violence. This integrated approach is not just a strategy for more effective programming; it is a commitment to the fundamental human rights of women and girls.

The larger benefits of this integrated approach are manifold. By breaking down silos between SRH and GBV services, we not only enhance the effectiveness of our interventions but also create a more sustainable, cost-effective, and empowering environment for the beneficiaries of these services. This is particularly crucial in the Arab region, where resources are often stretched thin, and the needs are great.

This product is a step towards answering that call and providing humanitarians with the knowledge and tools they need to deliver the best possible care to those in need. I invite you to join us in this critical journey towards a future where every woman and girl lives a life free from violence and full of health and opportunity.

Sincerely,

Laila Baker

UNFPA Regional Director, Arab States

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KNOWLEDGE SERIES

The UNFPA Knowledge Series aims to provide all stakeholders in the humanitarian community with simple, effective, and replicable information or approaches that can aid humanitarian responses. These are based on lessons learned from UNFPA operations across the Arab region, informed by local organisations and by the population groups we serve: women, adolescent girls, men, and adolescent boys. The insights and recommendations provided by the Knowledge Series are intended to serve as practical tools for informing responses or enabling actors to adapt successful approaches to suit their specific contexts.

EXECUTIVE SUMMARY

Universal access to sexual and reproductive health (SRH) and the ability to live without any form of gender-based violence (GBV) are human rights that continue to apply in humanitarian contexts. To realise these rights in targeted communities and populations, it is essential that humanitarian actors take steps to address the root causes of gender inequality and discrimination, which underpin both GBV and poor SRH outcomes. Additionally, measures should be taken to ensure that women and girls have access to high-quality GBV and SRH services and information. It is therefore important to create an enabling environment that allows women and girls to make informed choices about their health, safety, and well-being, and to access specialised prevention and response services as needed. **The integration of GBV and SRH approaches can help increase women's and girls' access to high-quality GBV and SRH services in an effective and efficient manner, expanding the reach and impact of these lifesaving services.** GBV and SRH needs are best met by engaging women and girls within the affected communities at all phases of the programme cycle, from assessing needs and designing programs to the implementation and evaluation of the programme's impact.

This tool has been developed in the spirit of building on the strengths of two fundamentally intersecting fields: GBV and SRH. It is intended for use by GBV and SRH service providers and programme managers who wish to **start**, **strengthen**, or **scale up** integrated GBV and SRH **interventions** in humanitarian settings within the Arab region. **This can be undertaken through the development of new integrated programmes or by applying integrated GBV-SRH approaches to existing GBV and SRH activities**. This tool does not provide a 'standard way' of integrating GBV and SRH initiatives and activities, as **integrated approaches** will always need to be **tailored** to the specific **context**; instead, it aims **to support integrated GBV and SRH approaches in humanitarian settings** by:

- **Sharing promising practices** from existing integrated GBV and SRH approaches in humanitarian settings, both in the Arab region and beyond;
- **Highlighting possible challenges and barriers** associated with the integrated GBV and SRH approaches, **and providing practical tips for overcoming these barriers**;
- Suggesting **minimum actions for integrated GBV and SRH approaches** and practical tips for integrating existing GBV and SRH programming;

"UNIVERSAL ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH AND THE ABILITY TO LIVE WITHOUT ANY FORM OF GENDER-BASED VIOLENCE ARE HUMAN RIGHTS THAT CONTINUE TO APPLY IN HUMANITARIAN CONTEXTS."

- Encouraging consideration of **potential safety and confidentiality risks** associated with integrated GBV and SRH approaches, and identifying **ways to mitigate these risks**.
- **Providing references to existing resources** that can support the integration of GBV and SRH activities.

This document refers to women and girls as the primary targets of integrated GBV and SRH services. The integration of complementary GBV and SRH services is in line with the UNFPA Strategic Plan 2022-2025, which emphasises a commitment to achieving three transformative results: (a) fulfilling the unmet need for family planning; (b) ending preventable maternal deaths; and (c) ending gender-based violence and harmful practices, including female genital mutilation and child, early, and forced marriage, by focusing on "women and young people, especially adolescent girls." UNFPA's GBV and SRH response is centred on women and girls due to structural and systemic gender inequality and discrimination, which leads to higher risks of GBV and to a lack of safe and equitable access to SRH services. It is important to note that in the UNFPA's Strategic Plan, the organisation's outcomes have been structured and designed to break the programmatic siloes of SRH and GBV interventions; instead, the outcomes and outputs are organised by "services" and "policies," which demonstrates the intended organisational shift toward better integration and more holistic programming for women, girls, and young people.

This tool provides useful tips for integrating GBV and SRH activities in humanitarian settings, including summaries of essential actions and key considerations. It consists of five chapters: **Chapter One** covers the rationale for using an integrated GBV-SRH approach, the types of integration, and possible barriers; **Chapter Two** deals with the steps needed to introduce an integrated approach; **Chapter Three** includes details on how to design an integrated GBV-SRH approach, including targeting considerations when choosing a service delivery modality, funding for integrated approaches, and necessary capacity building; **Chapter Four** looks at how to strengthen collaboration for a successful integrated approach, both internally and at the inter-agency level; and finally, **Chapter Five** proposes monitoring and evaluation strategies for an integrated approach. Where available, the document outlines promising practices implemented by country offices and operations in the region.

While the tool focuses on humanitarian settings, the reality of emergency responses in the Arab region is changing, and country contexts are increasingly fluid, as protracted emergencies become more common and the average duration of forced displacement increases. UNFPA country teams and partners need to work flexibly across the humanitarian-development-peace nexus. This includes shaping GBV-SRH integration in a way that it can transition from the GBViE Minimum Standards to the Essential Services Package, and from the Minimum Initial Service Package (MISP) to comprehensive SRH programmes.

Finally, the tool focuses on the practicalities of integrating GBV and SRH activities, and should therefore be used alongside existing technical guidance on GBV and SRH in emergency programming. For each topic, these recommended resources – *manuals, checklists, reference documents* – are referenced as listed within **Annex H**. It is recommended that the tool be accompanied by existing relevant training to support teams with its implementation.

1. RATIONALE

1. RATIONALE

There is an intrinsic link between sexual and reproductive health (SRH) and gender-based violence (GBV). Gender inequality and power imbalances are the root causes of GBV, and, along with discrimination, also underpin the social, cultural, and structural barriers that prevent women and girls from accessing SRH services. GBV survivors are more likely to suffer from SRH risks, such as unintended pregnancies, sexually transmitted infections and HIV, and pregnancy or abortion complications. SRH health facilities and services can be a safe and non-judgemental entry point for women and girls to receive information, psychological first aid, and safe referral to GBV-specialised services. However, in some cases, women and girls may be subjected to violence while accessing health care, through tactics that can include forced sterilisation, forced pregnancy, non-consensual medical procedures, harassment, intimidation, verbal abuse, physical harm, and various other means of disempowerment and control.[1] In such scenarios, GBV actors can play a crucial role in helping health care providers to ensure the safety and dignity of women and girls seeking SRH services, with a focus on safeguarding agency, encouraging informed decision making, and guaranteeing bodily autonomy. At the same time, GBV actors can also use their platform as GBV service providers to raise awareness for SRH-related issues, and to support women and girls' access to SRH services.

Integrated GBV and SRH approaches offer opportunities to strengthen connections and facilitate collaboration between GBV programmes/services and SRH programmes/services, in an effort to maximise the impact on women's and girls' health and well-being. Across many UNFPA programmes, integration is likely already happening to some extent, given the intrinsic connections between SRH and GBV services; this is especially prevalent during the provision of clinical management of rape (CMR) services[2]. The framework employed in these instances can provide a systematic approach for further integrating both new and existing programmes. The key success factors for the successful development of integrated GBV-SRH models include strong collaboration and coordination between partners with a common understanding of the benefits of integration; a commitment to continuous learning and investment; and a realistic plan for sustainability.[3]

Integrated GBV and SRH approaches differ from single sectoral programming through the following traits and components:

- **A commitment to responding to GBV and SRH risks through a holistic lens** that recognises that both are caused by gender inequality and discrimination;
- **A common integrated goal that aims to improve the safety, health, and well-being of women and girls** through the implementation of complementary, inter-linked GBV and SRH activities;
- **A commitment to ensuring that GBV and SRH staff receive training** that will help them better understand the roles and responsibilities of each other's sectors;
- **Greater sustainability and potential for cost-effectiveness of the programmes** compared to the provision of stand-alone GBV or SRH services.

1 https://esaro.unfpa.org/en/publications/respectful-maternity-care
2 For the purpose of this document, we refer to CMR instead of CMR/IPV, given that intimate partner violence (IPV) is a type of GBV for which survivors will require tailored support, possibly including CMR, through case management and other services; CMR is linked specifically to the provision of clinical care following sexual assault.
3 UNFPA, 2020. An Analysis of the Evolution of Gender-Based Violence and Sexual and Reproductive Health in Syria 2017-2020

Essential Components for the Adoption of Integrated GBV-SRH Approaches

- Integrated GBV and SRH approaches should always **be implemented in line with GBV and SRH guiding principles, and in adherence to humanitarian principles** (see Annex B for definitions).
- **Support from senior management and heads of programme units** is a prerequisite for any successful integrated GBV-SRH approach.
- **Integration should happen on all levels**, across both new and existing GBV and SRH programmes.
- **All UNFPA programmes should include both GBV and SRH interventions**, unless there is a clear justification for not needing both, in the instance that certain needs and risks have already been addressed.
- **At a minimum, integrated GBV-SRH approaches should ensure that all staff are knowledgeable on basic GBV-SRH concepts and can provide safe, timely, and confidential referrals to people in need of GBV-SRH services.**
- An integrated approach **does not require all SRH staff to become GBV specialists, and vice versa**. Instead, it recognises that both sectors require a notable level of specialisation.
- **The roles and responsibilities of GBV and SRH teams must be clearly defined, in order to enable effective, timely referrals** for life-saving services, in line with the guiding standards and principles of emergency SRH and GBV responses.
- **Regular training and capacity building for GBV and SRH staff are key** to ensuring they understand the fundamentals of integrated approaches, and that they also understand each other's activities, programmes, and approaches.
- Identified methods of GBV and SRH **integration should be guided by available resources, staffing capacities, preferences of women and girls, and the specific contexts in which these programmes are being implemented**.
- **Joint collection and analysis of GBV and SRH information is important when it comes to identifying 'trigger indicators'** that demonstrate the possible need for an integrated approach. M&E frameworks should be designed accordingly.
- It is important for GBV and SRH teams to engage in **joint planning** when designing, scaling up, and delivering integrated GBV and SRH approaches.
- It is critical **to advocate for the benefits of integrated GBV and SRH approaches when communicating with donors,** and to underscore the need for multi-year funding in order to develop stronger connections between both sectors.

1.1 Types of Integration

GBV and SRH integration occurs in different ways, and integrated approaches can use one or more entry points to create stronger connections between the two sectors. **When choosing the types of integration, GBV and SRH actors should be guided by the available resources, staff capacities, preferences of beneficiaries, and the specific contexts in which the programmes are being implemented.**

Types of Integration	Description
Referrals	Strong **referral pathways** between new or existing GBV and SRH services to ensure that timely, confidential, and safe referrals occur in both directions
At Service Delivery Point	Delivery of GBV and SRH **services in one physical spac**e (e.g. comprehensive women's centres, Women and Girls Safe Spaces (WGSS), One Stop Centres, and other health facilities, including outpatient clinics, community centres, Integrated Mobile Units, etc.)
Staffing	Organisation of GBV and SRH staff into one **integrated team**
Capacity Building	Upskilling of GBV and SRH staff so that they can offer non-specialised services related to the other sector (e.g. SRH staff offering GBV awareness)
Activities	Design and delivery of integrated activities that include GBV and SRH services/components (e.g. programmes for young mothers, advocacy for national protocols on CMR)

1.2 Barriers to Integrated GBV and SRH Approaches

GBV and SRH practitioners may face a number of barriers when trying to implement integrated approaches. These include **gaps in staffing capacities that could lead to inadvertent harm** (e.g. if SRH staff are not well-versed in a survivor-centred approach), **organisational structures not suited to integrated programming, or donors' preference for vertical funding)**. Under no circumstances should integrated approaches be implemented if there is any risk of violating the Do No Harm principle (see **section 2.2** on risk assessment and analysis for more information). Other barriers may stem from the different ways in which GBV and SRH practitioners approach programming, such as:

Different language/terminologies - GBV practitioners refer to a survivor-centred approach, whilst health practitioners use human-centred approaches to refer to many overlapping principles, such as promoting a person's safety, dignity, and self-determination;

Survivor-centred versus clinical-based approaches - a workshop in Northwest Syria on integrated approaches revealed that SRH workers were confused about having to instantly believe everything a survivor tells them, rather than starting from an evidence-based, diagnostic perspective[4];

Differing levels of control, autonomy, and power given to programme participants - a key informant[5] noted that GBV practitioners prefer to have GBV survivors develop their case plans, whilst health practitioners tend to prefer a process that is led by health professionals, which can be narrower and more well-defined, when developing treatment plans.

In order to work effectively together, it is essential for teams to establish a common understanding and grounds for collaboration (i.e. terminology, guiding principles). Workshops, such as the one outlined in the box below, can help to achieve this, by providing space for open discussion. Chapter 4, 'Ensuring Strong Collaboration Between Sectors,' provides further examples of successful strategies for working effectively together on integrated approaches.

PROMISING PRACTICES

Unpacking Integrated GBV and SRH Approaches:
UNFPA Jordan has tried to define integrated GBV and SRH approaches. In a report outlining the lessons learnt from integrated approaches, UNFPA Jordan's SRH and GBV teams came up with multiple definitions that combine service delivery and policy considerations.[6] This process of openly debating is the definition of integrated programming, and identifying potential barriers, can be helpful for enabling GBV and SRH teams to clarify their combined strengths and identify complementary services of the two sectors. It also provides an opportunity to highlight potential differences in how the two sectors work and brainstorm ways of overcoming these differences.

"UNDER NO CIRCUMSTANCES SHOULD INTEGRATED APPROACHES BE IMPLEMENTED IF THERE IS ANY RISK OF VIOLATING THE DO NO HARM PRINCIPLE."

4 GBV and SRH Workshop, Afrin, March 2021. Organised by GBV and SRH WGs.
5 The key informant was consulted as part of the development of this document
6 Hanania, D., Curtis, J., and Meyer, K (2020), Charting the Path Forward: UNFPA Jordan and the Humanitarian-Development Nexus. UNFPA Jordan.

2. WHERE TO BEGIN

STEPS TOWARD INTRODUCING AN INTEGRATED GBV-SRH APPROACH

2. WHERE TO BEGIN: STEPS TOWARD INTRODUCING AN INTEGRATED GBV-SRH APPROACH

Whether dealing with the implementation of a new programme or an existing programme in which GBV and SRH services are already being provided, the decision to include an integrated GBV-SRH approach should be based on **an analysis of relevant GBV and SRH needs and risks, with the active engagement of people served (women and girls within the targeted community).** This can be achieved through **risk analysis** as well as other **detailed assessments**, and/or facilitated through the **use of 'trigger' indicators,** which build on existing information to alert GBV and SRH teams of the need to consider new or strengthened integration. Attention should also be given to partnership models that can facilitate the provision of integrated GBV-SRH services and to the capacities of UNFPA and its partners when it comes to safely implementing integrated GBV and SRH activities. However, the first step to introducing an integrated GBV-SRH approach is for the Country Office to adopt and commit to the integrated model, as part of an overarching effort to reduce the presence of work silos and enhance the impact of all interventions and operations.

2.1 Coordinated Country Office Plan

The decision to introduce an integrated GBV-SRH approach to programming at the Country Office level requires proper support from senior management and heads of departments. It is crucial that this decision is then followed by proper planning, which should follow the process enumerated below.

As a start, the minimum components for the planning of an integrated GBV-SRH approach include:

1. Providing a clear explanation of what GBV-SRH integration means;
2. Designating an SRH/GBV focal person who can ensure that the approach is properly introduced, implemented, followed up on, and evaluated;
3. Having a coordination mechanism in place between GBV and SRH actors/staff, as well as a functioning referral system;
4. Having all staff engaged in the integrated programme trained on the basic principles of both GBV and SRH;
5. Jointly developing the design of the model of integration that best fits the needs of the country office;
6. Conducting quarterly process evaluation to gain lessons learned from progress on implementation and to adapt accordingly.

2.2 Risk Assessment and Analysis

Prior to commencing an integrated GBV-SRH approach, whether for a new or existing programme, implementing partners are advised to conduct an assessment and analysis of the risks associated with the proposed integrated approach. This practice aims to ensure that the Do No Harm principle is upheld and that GBV risks are mitigated. Risk analysis is instrumental to:

- Ensuring that integration does not increase the risks of GBV;
- Ensuring that integration does not come at the expense of specialisation (i.e. dilution of service quality, increasing the risk that implementation will not align with minimum standards and guiding principles);
- Determining the capacity of the service providers, and assessing knowledge and attitudes that could affect service quality;

- Ensuring that integration does not reduce access to GBV and/or SRH programmes and services (e.g. in contexts where a specific activity is very sensitive, such as the provision of post-abortion care, integration with other services may actually reduce access to the integrated package of services);
- Ensuring that sufficient resources are available to uphold the confidentiality, dignity, and safety of all programme participants and beneficiaries.

Risk assessment should be repeated throughout project implementation, with the support of various tools that can re-assess existing or emerging risks. The tools used to conduct assessments vary depending on context-specific considerations, and there are a variety of methodologies that can be used that do not involve interviewing survivors about their experiences. Whatever the final methodology used, the goal should be to gather enough participatory feedback and information to allow for the implementation of effective GBV and SRH programming that is responsive to the needs of women and girls in the context. The promising practices box illustrates an example of UNFPA's use of safety audits to assess GBV and SRH risks for integrated approaches.

PROMISING PRACTICES

Safety Audits: *Safety audits are an important tool for identifying the knowledge and resources necessary to mitigate GBV risks across all implementation phases, including in emergency contexts.*[7] *UNFPA Syria and Türkiye Cross Border have adapted safety audit tools that focus on the broader challenges women and girls are facing within a humanitarian context, with a focus on both GBV and SRH risks.*

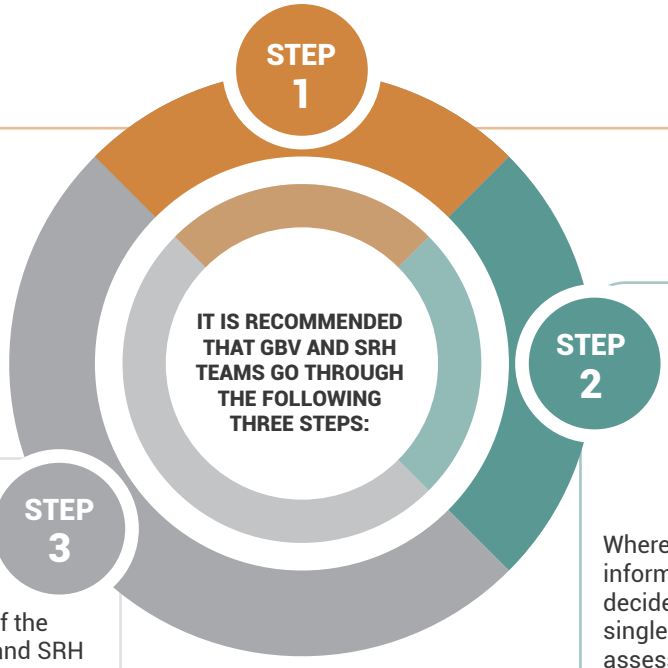
"IN SITUATIONS WHERE DIRECT IMPLEMENTATION IS NOT THE PREFERRED WAY OF WORKING OR IS NOT POSSIBLE, IT IS IMPORTANT TO DETERMINE WHICH TYPE OF PARTNERSHIP WILL BE MOST EFFECTIVE IN THE SPECIFIC CONTEXT."

7 UNICEF Helpdesk GBViE (2018), *Safety Audits: A How-To Guide.*

2.3 Assessing Integrated GBV and SRH Needs

Data on SRH needs and GBV risks and services can be derived from single-sector assessments or integrated assessments (using a tool that covers both GBV and SRH questions). The choice of assessment method is dependent on several factors, including available time and resources, existing data sources, and the breadth of information required. An integrated assessment tool has the advantage of gathering data on SRH needs and GBV risks and services from one specific sample of women and girls, strengthening insights into integrated needs. However, GBV and SRH teams do not always approach assessments from the same perspectives, which can pose a challenge when designing an integrated assessment tool. For example, a GBV lens assumes that GBV is happening and that the majority of cases are not reported; data can (and should) be collected on GBV risks and/or access/availability of services, but no data on GBV prevalence should be collected in humanitarian settings. The focus of these assessments should be on service gaps and GBV risks within the specific humanitarian context, rather than on GBV prevalence, as all women and girls are understood to be at risk of violence. SRH assessments, meanwhile, are traditionally used to identify gaps between SRH needs and SRH service delivery, and tend to focus only on women and girls of reproductive age. In order to overcome any potential obstacles, it can be helpful to establish an oversight group, inclusive of SRH, GBV and MEAL staff members, at the outset of the assessment, in order to discuss alternative approaches that may complement the pre-existing information available from each sector. In situations where GBV and SRH programmes are already being implemented and when information is available on GBV risks, SRH needs, and where and how to access GBV and SRH services, it is recommended that GBV and SRH teams go through the following three steps:

Jointly review existing GBV and SRH programme data and existing secondary data in order to determine if there are any integrated information gaps. Possible data sources include SRH and GBV Humanitarian Needs Overview (HNO) and programme data, patient satisfaction surveys, GBVIMS reports, Health Management Information System (HMIS) data, or external data, such as Demographic and Health Surveys (DHSs), or assessments and situational reports produced by NGOs or local- and women-led organisations. If no additional data is required, skip Step Two and proceed to Step Three.



Where additional information is required, decide whether to use a single-sector assessment or an integrated GBV and SRH assessment tool.

Conduct a joint analysis of the identified data, with GBV and SRH colleagues working together to identify possible 'trigger indicators' signalling that an integrated approach would be beneficial.

2.4 Trigger Indicators

Trigger indicators are trends or outliers that emerge during the analysis of programme or assessment data, and can be used to alert GBV and SRH teams that an integrated approach may be useful when addressing specific issues. Within the specific context, GBV and SRH teams can work together to define a set of trigger indicators that can then be regularly monitored, with pre-agreed values triggering a cross-sectoral discussion on how to respond to specific emerging needs through an integrated GBV and SRH response. Trigger indicators can also be developed during the implementation of existing programmes with GBV and SRH components, to better assess if an integrated approach is needed. The table below display a few examples of trigger indicators and the implications of these indicators on programme implementation:

TRIGGER INDICATORS	PROGRAMME IMPLICATION
Review of programme data reveals an increase in older women accessing Women and Girls Safe Space (WGSS) **Trigger indicators:** • # of women aged 60 years and above attending women's and girls' safe spaces, disaggregated by age	There is an identified need to deliver tailored women's health and post-menopausal messaging that addresses the reproductive health needs of this age group.
SRH assessment data finds that a barrier to married women accessing family planning services includes not being the primary decision-maker surrounding contraceptive modality use **Trigger indicators:** • % increase in reported cases of reproductive violence and denial of reproductive rights by husbands/other members of the family (e.g. brothers, mothers in law, etc.)	There is an identified need to address reproductive violence[8] through integrated programming (e.g. GBV case management, joint GBV and SRH awareness on reproductive violence, family planning counselling).
SRH data identify increasing rates of pregnant and/or lactating adolescent girls, births among adolescent girls, or maternal deaths of adolescent girls, all of which correlate to increases in early marriage **Trigger indicators:** • # of adolescent girls (10-14 and 15-19) presenting for ANC, disaggregated by age • # of adolescent girls (10-14 and 15-19) presenting for PNC, disaggregated by age • % increase in adolescent birth rate (disaggregated by age, still and live births) • % increase in maternal deaths among adolescent girls, disaggregated by age (10-14 and 15-19) • % of reported early marriage cases against other GBV reported cases provided with GBV case management	There is an identified need to refer these adolescent girls to GBV-specialised response services. There is also an identified need for GBV prevention and risk mitigation programming that addresses early marriage and its consequences.
GBV case management services are being provided to married adolescent girls, who may or may not already be pregnant **Trigger indicators:** • % increase in case management services provided to married adolescent girls	There is an identified need to support these adolescent girls via counselling related to family planning and/or ANC/PNC, and through awareness activities.
SRH data identify an increasing trend of survivors accessing clinical management of rape services **Trigger indicators:** • % increase in cases requiring clinical management of rape	There is an identified need to provide additional support services for these survivors, in the form of specialised GBV services, alongside CMR.

Consultations with Women and Girls: *Women and girls are best placed to know what services are needed, as well as where and how they can be delivered to have the most impact. A cross-section of women and girls should be consulted at regular intervals, during every stage of an integrated programme implementation, to ensure that the proposed approach is both culturally and socially appropriate and responsive to their needs. It is recommended to include a sufficient budget for consultations, including costs associated with transportation or childcare provisions during these consultations.*

8 See Annex B for a definition of this form of GBV

2.5 Partnership Models

In situations where direct implementation is not the preferred way of working or is not possible, it is important to determine which type of partnership will be most effective in the specific context. Based on previous experiences in the Arab world, **three main types of partnership modalities** have been identified for the delivery of integrated GBV and SRH approaches (see table below).

Type of Partner	
1**. One Partner** who is **experienced in implementing GBV and SRH services**, either in a siloed manner or as part of an integrated approach	
Pros	**Cons**
• Partner is proven in both GBV and SRH service delivery. • Capacity development may only be required on the integration of the two components. • Internal communication between GBV and SRH teams is likely to be easier than communication between two different organisations.	• Risk of overlooking partners with the potential to implement integrated GBV and SRH approaches in favour of partners who offer both services. This reduces the number of organisations trained to deliver integrated approaches. • Risk of overlooking partners who are delivering the highest quality programmes, in favour of the convenience of a partner offering both services. • Time and resources may be required to develop/amend SOPs to incorporate integration, train staff on integrated approaches, and adapt internal systems (e.g. MEAL) to suit these integrated approaches.
2. **One Partner** who is **experienced in offering either GBV or SRH services** and is **willing to add basic elements of the other sector** (non-core sector) as part of an integrated approach	
Pros	**Cons**
• Likely to offer a larger pool of partners from which to choose, allowing for the selection of a partner who has a proven track record of delivering high-quality programming in one of the two sectors, and is responsive to feedback and capacity development. • This model increases the number of partners who can offer integrated GBV and SRH approaches, even if they are not currently offering the full range of services.	• Considerable time is required to prepare a partner to understand and implement activities from a new sector, even if they will only be covering basic components (e.g. screening, information provision, referrals). This includes time required for hiring new staff (if necessary), developing SOPs, training staff on the new activities, and adapting internal systems (e.g., MEAL) to suit integrated approaches. • Time and resources are also required for regular follow-up over the course of the project, in order to reinforce the principles of integration and to provide on-the-job training. • Additional funding may be needed to set up new infrastructure or adapt existing infrastructure to accommodate the new activities, and to hire new staff and provide access to training opportunities. Where possible, multi-year funding and multi-year work plans are preferable, in order to allow the partner time to adapt to the integrated approach. • The partner's capacity to deliver activities in their non-core sector is not proven.
3. **Two Partners**: one who offers GBV activities and the other who offers SRH activities	
Pros	**Cons**
• Partners have a proven track record of either GBV or SRH service delivery. • Significant capacity development may only be required on the integration of the two components. • Allows for the selection of two partners who are each proven to deliver to a high standard within their specific sector.	• Increased risk of communication barriers and collaboration difficulties, since staff report to two different management structures. • Increased risk of programme management and oversight challenges, due to the need to negotiate with two separate organisations. • Reduced sustainability of the integrated approach(es), as this model relies on two organisations working together on a long-term basis.

When a one-partner model is used for implementation, it is advisable to conduct a partner capacity assessment, in order to ascertain their readiness to implement integrated GBV and SRH approaches. The questions below can be included in this capacity assessment:

Does the partner have a proven capacity to deliver high-quality GBV programming?	Yes	No	N/A
Does the partner have a proven capacity to deliver high-quality SRH programming?	Yes	No	N/A
Is the partner's management supportive of implementing integrated GBV and SRH approaches?	Yes	No	N/A
Is the partner willing and able to dedicate the time and resources needed to train all relevant staff on the Core Trainings for Integrated GBV and SRH approaches?	Yes	No	N/A
Does the partner have technical leads for both GBV and SRH who can ensure that activities are delivered in line with GBViE and SRHiE minimum standards?	Yes	No	N/A
Does the partner have sufficient resources to implement SRH and GBV activities in a way that protects the safety and confidentiality of women and girls?	Yes	No	N/A
Does the partner have adequate systems in place for safeguarding the confidentiality of health and GBV data?	Yes	No	N/A
Does the partner have robust systems for monitoring the quality of their GBV and/or SRH programming?	Yes	No	N/A
Can the partner's monitoring system capture integrated activities and indicators?	Yes	No	N/A
Does the partner have strong ties and relationships with the local communities and local women's organisations that can be leveraged to mitigate any community-level resistance to the introduction of new activities?	Yes	No	N/A
Does the partner have access to sufficient funding to cover the organisational changes needed to implement integrated GBV and SRH approaches?	Yes	No	N/A
Does the partner have access to the technical assistance necessary to enable them to develop the capacity required to deliver high quality integrated GBV and SRH approaches?	Yes	No	N/A

If NO is selected for any of these points, discuss with the partner whether they have the time, resources, and motivation to make the required change(s). If needed, a capacity strengthening plan can be developed to meet any of the resource or capacity gaps identified in the assessment.

PROMISING PRACTICES

Overcoming a Partner's Reluctance to Offer Services in Both Sectors.

When UNFPA Jordan approached one of their strong GBV partners to suggest they added SRH activities to their GBV portfolio, they were initially met with resistance. The partner felt that SRH activities were not part of their organisational mandate: this wasn't 'what they do.' However, after learning more about the possible added value of integrating GBV and SRH activities, and after gaining a better understanding of the linkages between GBV and SRH, they agreed to pilot an integrated approach at a couple of their locations. The integration of SRH activities with the existing GBV programme has been a huge success, with many more women attending their centres. The partner is now requesting additional support from UNFPA to expand their integrated activities and services. Thus, when proposing that a partner add new activities to offer integrated GBV and SRH services, the following steps and tactics are recommended:

- Clearly explain the benefits of integrated GBV and SRH approaches for both the organisation and the women and girls they serve;
- Be transparent about any cost or resource implications and potential challenges that they may face;
- Suggest a pilot phase;
- Provide a clear plan for technical support;
- Be respectful of the organisation's existing mandate and strategic priorities.

"THE INTEGRATION OF SRH ACTIVITIES WITH THE EXISTING GBV PROGRAMME HAS BEEN A HUGE SUCCESS."

3. DESIGNING AN INTEGRATED

GBV AND SRH APPROACH FOR NEW OR EXISTING PROGRAMMES

3. DESIGNING AN INTEGRATED GBV AND SRH APPROACH FOR NEW OR EXISTING PROGRAMMES

The following section highlights programmatic design considerations for new or existing GBV and SRH programming. This includes specific considerations for implementing integrated GBV and SRH approaches through different service delivery modalities and for specific target groups. It is recommended that all integrated GBV and SRH approaches introduce common integrated objectives, regardless of whether the approach has been designed as a new intervention or it is designed to link existing GBV and SRH activities. Integrated objectives should outline the purpose of integrating the chosen activities and can help staff to understand the aims of integration. Objectives can range from increasing access to GBV and SRH services to mitigating the risks of harmful practices that require both GBV and SRH interventions (Box below). A sample objective is outlined in the log frame table in Annex G.

PROMISING PRACTICES

Considerations for Integrated Approaches That Aim to Address Harmful Practices and the Root Causes of GBV

Early Marriage

The AMAL programme, targeting young and adolescent mothers, highlights the importance of addressing harmful practices at individual, family, and community levels, in order to begin initiating changes in attitudes and practices. Where possible, it is recommended that integrated GBV and SRH approaches establish linkages with other sectors and programmes, such as those related to education and livelihoods, that could be instrumental in reducing the risks of child marriage.

Female Genital Mutilation/Female Genital Cutting (FGM/C)

- ***In Somalia,*** *UNFPA identified a range of factors motivating trained medical professionals to continue the practice of FGM/C, including economic gain and social pressure. In response to this, UNFPA trained a number of 'health champions' to support with FGM/C programming. These 'health champions' are respected and listened to by individuals, families, and communities. They therefore have the potential to play a major role in the abandonment of FGM/C, particularly through counselling and by promoting education against the practice.*
- ***In Yemen,*** *a joint UNFPA and UNICEF FGM programme uses Communication for Behavioural Impact to support government authorities, implementing partners, and other stakeholders in their anti-FGM advocacy campaigns. The programme is implemented in partnership with the Ministry of Public Health to educate local communities about the harmful health-related consequences. The programme has successfully recruited religious leaders to join the campaign to delegitimise the religious pretexts for FGM. The programme also developed a manual on FGM for religious leaders that is being used to educate preachers on how to address FGM in their religious sermons. At the same time, in WGSSs, teams are educating and informing women and girls in the target communities about the consequences of FGM, and inviting women and girls who have undergone FGM to participate in awareness efforts. The WGSSs also engage with mothers and grandmothers to promote gender-transformative approaches and to encourage the abandonment of these practices.*

3.1 Targeting Considerations

When using integrated GBV and SRH approaches, particular attention should be given to the inclusion of marginalised or 'at-risk' groups of women and girls within the targeted communities. Not all at-risk groups will be exposed to—or experience—GBV in the same ways, nor will they have the same SRH needs.

As a broad demographic, women and girls experience gender inequality and discrimination, and are at risk of GBV and the denial of SRH rights. But each woman and girl may have different characteristics or aspects of their identity that will shape how they experience this discrimination, and will determine their individual risk of GBV and their access (or lack thereof) to SRH services. These factors can include age, ethnicity, sexual orientation, gender identity, disability, religion, socioeconomic status, civil status, and displacement or immigration status. An intersectional lens must be applied to every element of the integrated GBV and SRH approach. For example, an older woman living with HIV/AIDS will experience different forms of discrimination and GBV risk than a displaced adolescent from a minority group. By analysing and understanding the various, intersecting forms of structural oppression and discrimination that may affect different individuals' access (or barriers) to SRH services and their GBV risks, actors will be better equipped to design effective integrated GBV-SRH activities. This kind of intersectional approach can increase access to GBV and SRH programming for different groups, and can help tailor activities to their specific needs.

When quantifying the target population for an integrated GBV and SRH approach, estimates reported by the MISP calculator should not be the only measure used to make targeting decisions. For example, the MISP calculator calculates the "number of cases of sexual violence who will seek care," whereas the programme in question might include other types of GBV beyond sexual violence. Additionally, it is globally recognised that GBV is highly underreported, and that it can happen to women of all ages; as a result, the actual number of GBV survivors will likely be different (possibly higher) than what the MISP calculator estimates. The overall target should therefore be defined in collaboration with GBV and SRH actors, and should use a variety of information and data sources.

It is therefore recommended that additional considerations be made in order to increase the inclusion of potentially 'at-risk' groups in the context of integrated GBV and SRH approaches:

- **Older Women** (60 years and over) and post-menopausal women (50 years and over) may not be actively targeted through SRH programmes, which tend to focus on women of reproductive age. GBV programmes (e.g. WGSS) may offer a more effective entry point for this group. Consider developing tailored, integrated GBV and sexual health activities for older and post-menopausal women (e.g. integrated life skills programmes, tailored consultations, and information sharing on safety, PSS, and post-menopausal women's health).
- **Adolescent Girls** (aged 10-19) are already at a comparative disadvantage, even before humanitarian crises, but are all-too-often overlooked in humanitarian responses.[9] Adolescence, being the onset of puberty and sexual maturation, is a period of rapid physical, social, emotional, and cognitive changes. In some contexts, very young adolescent girls experiencing puberty are perceived as being old enough to begin sexual relations, marry, and bear children. This is also a time when gender norms shift and interpretations of what it "means to be a woman" begin to exert control over girls' lives. Harmful pre-existing gender norms are often used to exert power and dominance over adolescent girls. In some contexts, unmarried girls may face more challenges than married girls when GBV services are integrated into reproductive health settings, as it may not be considered socially acceptable for unmarried girls to access these healthcare services. In certain cases, Comprehensive Sexuality Education (CSE) programmes could be an appropriate and age-targeted entry point. It is therefore critical to tailor integrated services to meet the GBV and SRH needs of both married and unmarried girls.
- **Women and Girls with Disabilities** are often excluded from programmes and services designed to prevent and respond to GBV and SRH due to the multiple and intersecting forms of discrimination they experience on the basis of both gender and disability. These women and girls often face heightened risks, including increased incidence of reproductive violence, and have less access to services and information. Social isolation, loss of protective community networks, and changes in gender roles, particularly in households where a person may have a newly acquired disability, increase the vulnerability of persons with disabilities—as well as female caregivers—to violence both inside the home and in public spaces. [10] It is critical to ensure that integrated GBV and SRH awareness materials are available in formats accessible for women and girls with different disabilities[11] and that services and activities are tailored to their needs and respond to the specific risks they may face. This can include conducting home visits, home-based activities, and specialised case management services, accompanied by appropriate communication approaches.

9 For more guidance on working with adolescent girls in humanitarian settings, see the Whole of Syria Adolescent Girls Strategy, which combines GBV and SRH strategic objectives.

10 "I See That It Is Possible" Building Capacity for Disability Inclusion in Gender-Based Violence Programming in Humanitarian Settings, Women's Refugee Commission 2015

11 For more guidance, check UNFPA Global Guidelines for Providing Rights-Based and Gender-Responsive Services to Address Gender-Based Violence and Sexual and Reproductive Health and Rights for Women and Young Persons with Disabilities. The International Rescue Committee and the Women's Refugee Commission developed a toolkit for GBV practitioners, entitled "Building Capacity for Disability Inclusion in Gender-Based Violence Programming in Humanitarian Settings: A Toolkit for GBV Practitioners"

- **Men and Boys who Experience Sexual Violence:** While UNFPA provides clinical management of rape (CMR) services to men and boys who experience sexual violence, UNFPA's GBV response is centred on women and girls. This is due to structural and systemic gender inequality and discrimination that place women and girls at a significantly higher risk of sexual violence, often compounded by a disproportionate lack of safe and equitable access to humanitarian assistance.[12] Evidence shows that male survivors of sexual violence often do not want to receive the support of GBV-specific services or services primarily targeting female GBV survivors. Instead, they frequently seek support from other actors, such as health services, general MHPSS services, programmes supporting "survivors of torture" or, in the case of boy survivors, child protection actors. Providing SRH services to men and boys at the same locations where GBV services are provided to women and girls may also discourage or hinder service access to women and girls, increasing GBV and other risks, which is why expanding these services to men and boys is not recommended. Health facilities should guarantee the confidentiality of all individuals who access their services; for men and boys, these facilities should facilitate referrals to suitable providers of necessary services, such as CMR and counselling.
- **People with Diverse Sexual Orientation, Gender Identity, Gender Expression, and Sex Characteristics (SOGIESC)** also face increased risks of discrimination on the basis of gender, as well as an increased risk of gender-based violence. They often face challenges in accessing sexual and reproductive health services and may be subjected to stigmatising behaviours from service providers. For people with diverse SOGIESC, entry points to GBV and SRH services are often different from those of other groups. Therefore, integrated GBV-SRH service providers should invest in community-wide outreach and awareness efforts wherever possible. GBV and SRH staff should undertake training on SOGIESC knowledge, attitudes, and beliefs in order to increase the opportunities for these individuals to access GBV and SRH services in a safe and dignified manner. When developing referral pathways for integrated GBV and SRH activities, it is also important to include specific considerations and referrals for people with diverse SOGIESC, tailoring the response to the specific needs and risks of this demographic and increasing their access to GBV and SRH services.

PROMISING PRACTICES

The Adolescent Mothers Against All Odds (Amal Initiative):[13] *To date, one of the most successful integrated GBV and SRH initiatives in the Arab region has been the 'Adolescent Mothers Against All Odds' (AMAL) initiative. AMAL was designed to meet the immediate needs of pregnant adolescents and first-time mothers in crisis-affected settings, while simultaneously addressing community awareness and engagement on issues related to gender, power, and social norms. AMAL aims to facilitate young mothers' access to SRH services, GBV risk mitigation, and life skills training. One way that these goals are achieved is by working with health care providers and communities to create a more adolescent-responsive healthcare system. The programme has been very successful in increasing adolescent mothers' confidence in accessing health care and navigating their new lives as mothers and wives. The programme has also increased community support for adolescent girls to have equal access to services, and has demonstrated some impact on postponing cases of child marriage*[14]

TV Shows and Podcasts to Reach Young People: *In 2019, UNFPA **Jordan** initiated a strategic partnership with ROYA TV, a popular television channel in Jordan. The partnership aimed to leverage a new platform for disseminating SRH messages and stepping up awareness efforts. The objective was to provide a large population of women and youth with knowledge on sexual and reproductive health and rights and enhance their decision-making capacities. UNFPA developed 12 weekly television episodes under the name "Mesh Taboo" ("Not a Taboo") where experts tackled issues such as youth and adolescent changes, STIs, sex education in schools, and body image and its impact on one's sexual life. A range of stakeholders were consulted and engaged in the development of the sessions, including experts, youth, ministries of health and youth, and universities. Considering the success of this initiative in a very conservative environment, the partnership will continue via a youth-focused television segment and a podcast on sexual and reproductive health and rights*[15]

"AN INTERSECTIONAL LENS MUST BE APPLIED TO EVERY ELEMENT OF THE INTEGRATED GBV AND SRH APPROACH."

12 UNFPA's GBV Responsibility and Addressing the Needs of Male Survivors of Sexual Violence
13 For more information, please see CARE's description of the AMAL project.
14 CARE (2020), Adolescent Mothers Against All Odds Learning Report. CARE.
15 Taken from UNFPA Regional Syria Response Hub (2021), An Analysis Of The Evolution Of Gender-Based Violence And Sexual And Reproductive Health Services Within The Syria Crisis Response. 2017-2020; UNFPA.

"REMOTE AND ONLINE SERVICES CAN REACH WOMEN AND GIRLS WHO ARE UNABLE TO ACCESS INTEGRATED GBV AND SRH SERVICES IN PERSON DUE TO MULTIPLE FACTORS, INCLUDING SECURITY AND PUBLIC HEALTH CONCERNS."

3.2 Choosing a Service Delivery Modality

Within the Arab region, UNFPA and its partners currently use a range of static, mobile, and remote service delivery modalities to deliver integrated and single-sector GBV and SRH programming. These include Women and Girls' Safe Spaces (WGSS), health facilities (including primary, secondary, and tertiary facilities), mobile units, remote services, and youth centres.

An integrated GBV and SRH approach implies two different options of service delivery:

1. **Strengthening the linkages between two existing service delivery modalities**, one offering GBV activities and the other offering SRH activities. "It is not always possible to have integrated spaces. It is important that the referral systems work, [are] updated and [can be] easily accessed…so [service providers] know how to safely refer" (GBV Specialist, UNFPA). Having referral-related indicators (for examples) and monitoring systems is essential to knowing if the referral pathway is actually functioning, if it is functioning both ways (from GBV to SRH and vice versa), if women and girls are satisfied with the services they are receiving, and whether or not these services are meeting their needs. These indicators and monitoring systems are also critical to understanding whether service providers' attitudes are supportive of the integration of services.
2. **Integrated GBV and SRH activities are offered through one service delivery modality.** Wherever possible and safe to do so, a fully integrated GBV-SRH approach is recommended (e.g. the provision of GBV case management and CMR in a health facility, or family planning counselling provided through a WGSS). This modality limits the need for women and girls to travel to different sites, decreasing safety risks and transport costs, and reducing the risk of re-traumatisation from having to share their experiences several times. This does not mean that the recommended delivery type should be a one-stop centre for all GBV and SRH services, but rather that each service delivery modality offers some type of GBV-SRH integration. For a variety of reasons (including safety concerns, logistical considerations, and risks associated with reducing the quality of specialised services), it is not always possible to offer all SRH and GBV services in the same site. In Northwest Syria, for example, health facilities have a history of being targeted by armed attacks and shelling, so WGSSs are located in separate buildings.

The following table highlights key opportunities and issues to consider when deciding the type of service delivery modality or modalities to use for integrated GBV and SRH approaches.[16] This table covers only a few examples of service delivery modalities used by UNFPA and implementing partners in the Arab region and is therefore not an exhaustive or comprehensive list.

16 Decisions regarding which service modality/modalities to use for integrated GBV and SRH approaches should also take into account basic safety and logistical factors, including but not limited to: community acceptance, ease of access for women and girls (e.g. appropriateness of location, transport links, opening hours), affordability for women and girls (e.g. need for transportation or internet costs), and appropriateness of the physical space (e.g. availability of private spaces, secure areas for data storage, etc.).

STATIC FACILITIES

Women's and girls' safe spaces

Opportunities

WGSSs provide safe spaces for women and girls to access integrated GBV and SRH services, without the presence of men and boys. Prohibited male access to these spaces means that sensitive IEC materials on GBV and SRH topics can be displayed within the centre, particularly when compared, for example, to traditional health facilities.

WGSSs also enable service providers to have regular contact with women and girls and build trust before raising sensitive SRH and GBV issues (e.g. awareness on post-abortion care or safe abortion care).

WGSSs target a broader age range of women than many SRH facilities, which focus primarily on women of reproductive age.

WGSSs are particularly well-placed to address the SRH needs of married and unmarried adolescent girls who may feel uncomfortable accessing SRH services through health facilities, due to the stigmatisation of pre-marital sex and explorations of sexuality that may be happening in some contexts.

In contexts where access to health facilities is restricted, offering more specialised SRH services in WGSSs could be a valuable method of increasing women and girls' access to SRH services (e.g. family planning and counselling, post-natal care, maternal health, etc.).

Key considerations

Consider having a female SRH staff member based full-time or part-time in the WGSS (depending on service demand) to support awareness activities and undertake basic SRH counselling (if offered at the site). This would ideally be someone who can deliver both clinical services and awareness activities, such as a nurse or midwife. If this is not possible, consider arranging for female SRH staff members to participate in any planned activities that include elements of SRH (e.g. CSE sections of adolescent girls programming that cover reproductive development).

Consider including GBV staff and SRH/health staff (such as CHWs) in outreach teams linked to the WGSS. Where possible, outreach should be conducted jointly with GBV and SRH staff members, to ensure the high-quality delivery of both SRH and GBV messaging.

Youth centres

Opportunities

Youth centres could increase adolescent girls' access to SRH and GBV services and information, since girls may not be attending the same programmes and facilities as their mothers. Offering age-specific interventions can also increase access to these services. However, the presence of adolescent boys in the centres could reduce some adolescent girls' access to services and information.

Youth centres may help increase unmarried girls' access to SRH services, as they are sometimes perceived as less stigmatising than SRH clinics. This may increase adolescent and youth access to STI services.

Youth centres can be used to raise awareness on GBV, SRH, and MHM, and to disseminate information on GBV and SRH services and where to access them.

Youth centres may also provide an empowering space for adolescents and youth to lead activities that explore issues of sexuality, sexual health, and GBV.

Youth centres provide an excellent opportunity to deliver CSE activities as part of tailored, non-judgemental integrated GBV and SRH programmes. They can be good entry points for conducting awareness activities with adolescent boys and young men on SRHR, women's bodily autonomy, and GBV.

Consider working with youth to develop youth-led advocacy on integrated awareness and prevention topics (such as child marriage, MHM, virginity testing, FGM/C).

Key considerations

To facilitate safe and timely referrals, it is important to ensure that all staff working in the centre are trained on GBV and SRH basics, even if they themselves do not offer GBV or SRH services (e.g. youth staff).

Where possible, it is recommended to have at least one female SRH staff member on site to support SRH awareness activities and to conduct basic SRH counselling (if being offered at the site).

If planning to offer one-on-one services, such as GBV case management and family planning counselling, it is important to ensure the facility offers sufficient private space, a system for safe and ethical information management, and female staff available to provide these services, especially if access to the centres is not limited to females. These services should not be labelled and should be established only after a GBV risk analysis is conducted in consultation with women and girls from the community.

Primary, Secondary & Tertiary Health Facilities

Opportunities

Health facilities have the infrastructure necessary to provide a full range of clinical SRH interventions, and in some cases may also offer GBV services and information.

For unmarried girls, it may be more difficult to seek SRH or GBV services through general clinics due to socio-cultural barriers. SRH facilities can offer an entry point for information and referrals to specialised GBV services.

Men can be targeted at these facilities, through integrated GBV and SRH awareness and education activities (unlike at WGSSs and Youth Centres, it is more likely that women and girls may attend health facilities with their spouses or families).

Key considerations

Consider using integrated GBV and SRH awareness and IEC material that targets not just women and girls, but also sensitively targets their social networks (e.g, spouses and/or families).

Consider training outreach teams linked to health facilities (e.g. CHWs) on basic GBV awareness, which can be delivered alongside health messaging.

Consider the safety of the populations accessing integrated services in the different health care facilities. Prioritise the privacy and confidentiality of women and girls.

Consider having a GBV case manager based on-site at the health facility to support with survivor-centred care (implementation and training). If this is not possible, consider identifying female SRH staff members who have been comprehensively trained on GBV guiding principles, survivor centred-approach, health care for GBV survivors, and CMR, and who can be called upon to support a survivor from entry to discharge (e.g., explaining any procedures and making referrals to other services, including case management, if requested by the survivor).

Ensure all SRH and health staff are aware of referral pathways and are trained on how to provide safe referrals to GBV services.

When GBV activities are integrated within health services, it's important to ensure that private rooms are not labelled in a way that may expose the services being offered.

Ensure that all health facilities offering integrated GBV case management have secure places for storing both physical and electronic GBV case files.

Consider providing awareness sessions for adolescents and their mothers/guardians/family members on MHM as an entry point for learning about puberty and menstrual hygiene, and for providing information about delaying the age of marriage and pregnancy.

OTHER SERVICE DELIVERY MODALITIES

Mobile services

Opportunities

Mobile services can increase access to GBV and SRH services for women and girls living in remote areas.

Mobile services can support integrated GBV and SRH responses during new waves of displacement.

Men can also be targeted through integrated GBV and SRH awareness and education activities.

Key considerations

Demand should only be created for services that can be offered by the mobile unit or by a nearby static facility. This is particularly important when integrating GBV awareness activities into mobile health clinics.

A mobile response should only be considered when a static response cannot be implemented, or when mobile support can serve as a stop-gap until static services are established, either directly or through the capacity-building of a committed local partner.

Outreach services for SRH are sometimes conducted via home visits. This is not suitable for GBV activities, as it could increase the risk of violence.

Given the additional training required for integrated approaches, consider alternating teams between static and mobile facilities to reduce the risk of staff turnover, particularly in areas where long, difficult travel is required.

The staffing modality will vary depending on the type of integration being used. This can include adding a GBV specialist and GBV social worker to a mobile health unit or developing fully integrated mobile teams.

Consider training CHWs to provide GBV information and safe referrals during integrated outreach efforts.

Remote/online services

Opportunities

Remote and online services can reach women and girls who are unable to access integrated GBV and SRH services in person due to multiple factors, including security and public health concerns (e.g. COVID-19 has, at times, reduced access to in-person health facilities).

Online services may appeal to older women, adolescents, and youth, depending on their ability to access technology in a safe and confidential manner.

If internet or phone connections are good, remote services can provide a more efficient means of targeting certain groups with integrated awareness. Online services may provide an innovative way to target adolescents and youth, who are more accustomed to social media and other forms of online engagement.

Key considerations

Although online consultations have been used for basic health consultations, counselling, and GBV case management, this modality considerably limits the range of SRH activities that can be offered as part of an integrated GBV and SRH approach, due to the lack of in-person consultation.

Be mindful that privacy cannot be guaranteed for one-on-one online GBV or SRH services, as the women and girls may be monitored or overheard. Staff should be trained to check their whereabouts and ask who has use of the mobile device (especially if using apps) before engaging in more confidential discussions.

Ensure that GBV and SRH staff are trained to use online service delivery platforms and that they understand the risks associated with common online networking tools.

Ensure that staff have sufficient private space in which to offer the remote services. This is especially important if staff are offering services from their homes (e.g. during COVID-19 lockdowns).

Building on the above, the activities listed per modality of service delivery (table below) are suggestions for either adapting existing programming to include an integrated approach or designing an integrated programme from conception. Activities with a checkmark correspond to those that should be available at service delivery points that use an integrated GBV-SRH approach. The list does not include all single-sector GBV and SRH activities that are implemented as part of stand-alone programmes; it only highlights the activities suited for integrated approaches.

	Static facilities			Other service delivery modality	
	Women and girls safe spaces	Youth centres	Primary, Secondary & Tertiary Health Facilities	Mobile services	Remote/ online services
GBV awareness raising	✔	✔	✔	✔	✔
GBV prevention activities	✔				✔
GBV risk mitigation activities	✔	✔	✔	✔	✔
Justice and legal aid	✔				✔
GBV case management	✔	✔	✔		✔
GBV psychosocial support	✔	✔	✔	✔	✔
Information provision on available GBV services	✔	✔	✔	✔	✔
Referrals to GBV services	✔	✔	✔	✔	✔
Menstrual hygiene management	✔	✔	✔	✔	✔
Antenatal care awareness	✔	✔	✔	✔	✔
Antenatal care consultations			✔	✔	
Awareness on reproductive cancers	✔	✔	✔	✔	✔
Comprehensive sexuality education	✔	✔	✔		
Family planning awareness	✔	✔	✔	✔	✔
Family planning counseling			✔	✔	
HIV/STI awareness	✔	✔	✔	✔	✔
Information and counselling on infertility	✔		✔	✔	✔
Information provision on available SRH services	✔	✔	✔	✔	✔
Postnatal care awareness	✔	✔	✔	✔	✔
Postnatal care consultations			✔	✔	
Referrals to SRH services	✔	✔	✔	✔	✔
Respectful maternity care awareness	✔	✔	✔	✔	✔
Safe and post-abortion awareness	✔	✔	✔	✔	✔
CMR and Health Care for GBV Survivors			✔		

PROMISING PRACTICES

GBV Service Provision Through Health Facilities

In Yemen and Jordan, WGSS and SRH facilities are co-located in the same building or in close proximity to one another. This has helped reduce the stigma of visiting safe spaces in search of GBV services, because the arrangement has helped established the WGSSs as a part of a medical environment, making women and girls less nervous about visiting GBV facilities. Additionally, this setup has made it more convenient for women and girls who are accessing SRH services to learn about the WGSS, and has made potential referrals to the WGSS more convenient, eliminating transportation challenges. Another advantage is that the teams from both facilities can now hold regular, in-person joint meetings to discuss and refine integration issues.

Integrated Teams

- **In Syria,** many UNFPA partners have established safe spaces within health facilities, in order to facilitate timely referrals between health and GBV services. This might simply be a room where confidential services are offered. All the relevant teams (SRH and GBV) have been trained on GBV mainstreaming. Health care staff members were initially resistant to the integrated space, as the did not fully understand the objectives of integration, but after comprehensive training, they were able to grasp the importance and rationale behind the linkages, and internal referrals increased. At the same time, WGSSs in two camp settings in Syria also have an SRH clinic located inside the facility, which acts as an entry point for women who may need both SRH and GBV services. Similar to the experiences in Yemen and Jordan, the stigma of accessing GBV services is reduced when women and girls are seen to be seeking SRH services.
- **In Sudan,** UNFPA has established social workers inside health facilities to provide PSS for survivors; these facilities are also staffed with doctors who are trained in CMR services.
- **In Yemen,** UNFPA's partner has coordinated with the Taiz governorate health authorities in order to establish a WGSS in a local health facility. This was done with the aim of strengthening referral pathways between GBV and SRH services.
- **In Somalia,** WGSSs managed by UNFPA partners provide integrated services, with each facility staffed by a team of case managers, PSS workers, and nurses or midwives. Together, they provide GBV prevention and response services, coupled with SRH awareness activities and SRH-related consultations (family planning, antenatal care, and postnatal care). When clinical services are required, referrals are made to the nearest relevant health care provider.

Mobile Services

- **In Yemen,** UNFPA is experimenting with different staffing models for mobile units that offer integrated GBV and SRH services. For example, the mobile medical team now includes a psychologist to provide counselling, and there are plans to incorporate more GBV services. A midwife has also been added to the outreach teams, which were previously comprised of predominantly GBV staff. This has increased the reach of SRH services to areas that lack easy access to health facilities. Similarly, in Somalia, teams undertaking mobile outreach campaigns have included nurses, midwives, PSS counsellors, a case manager, and a doctor.
- **In Syria,** mobile teams have been integrated to include both GBV and SRH components, after realising that this integrated approach would be more cost-effective and would reduce duplication of services. As noted by one key informant: "We have two mobile teams at the same time: one for GBV and the other for SRH. Both are visiting the same community. In terms of cost-effectiveness and quality of services, we saw it is better to merge the mobile teams and provide unified services across all mobile teams, including SRH and GBV" (UNFPA SRH Specialist). Each mobile team consists of a midwife, a gynaecologist, a GBV case worker, a psychosocial support officer, and three community outreach assistants. These integrated GBV-SRH mobile teams provide the following services: antenatal and postnatal care, treatment of Reproductive Track Infections (RTIs) and Urinary Tract Infections (UTIs), early detection of breast and cervical cancers, individual and group information and awareness sessions for all targeted groups (men, women, and adolescent boys and girls), neonatal care, family planning, GBV awareness, psychosocial support, and referrals to more specialised services.
- **In Iraq,** UNFPA mobile teams were integrated in order to include both GBV and SRH, providing high-quality SRH services alongside GBV awareness and referrals to women and girls of reproductive age living in IDP and refugee camps. UNFPA Iraq's rapid SRH and GBV response to the Mosul crisis was internationally recognised as a promising framework for the provision of SRH and GBV services in emergency situations.

PROMISING PRACTICES

Reaching Adolescent Girls through Youth Centres

In October 2021, UNFPA **Jordan** launched a new Adolescent Girls Empowerment Programme. This is the combined effort of UNFPA's youth, GBV, and SRH teams, who worked together to develop an integrated programme that better targets the needs of adolescent girls. The programme is centred around the establishment of an adolescent girls' space, where girls lead the activities themselves, with older girls mentoring younger girls. The programme combines SRH services and basic GBV information with life skills training and financial education.

Remote and Online Services

Across the Arab region, promising practices that can be applied to remote integrated GBV and SRH approaches include:

- *Use of Apps to Raise Awareness of SRH and GBV Services: In **Jordan**, the Amaali App is a user-friendly tool established and supported by the GBV sub-working group, which aims to raise awareness and allow users to make self-referrals directly from their mobile device. In Yemen, UNFPA partners employed tele-counselling and the use of direct messaging apps such as WhatsApp to deliver awareness messages, provide basic GBV and SRH information, and conduct remote case management.*
- *Use of Local Radio to Share Awareness Messaging: In **Somalia**, partners used local radio services as a means of providing information on COVID-19. This is an approach that can be adapted for GBV and SRH awareness.*
- *Use of Hotlines to Provide GBV and SRH Information: During COVID-19, hotlines were used in countries across the region to provide information on how to access GBV and SRH services. It is important to provide staff with sensitivity training on the difference between hotlines and case management, in order to prevent 'ad hoc' case management being offered by hotline providers. UNFPA Iraq supported two GBV hotlines, with services available 24 hours a day, seven days a week. The call centres' staff were trained on how to deal with and safely record GBV cases.*
- *Tele-counselling and Remote Case Management: In **Syria**, partners reported offering GBV case management and SRH consultations over the phone (focusing on pregnancy and post-labour support). However, phone and online services only partially remove access barriers, as women and girls may lack access to the internet, mobile devices/computers, or private spaces. These approaches should not be used unless physical access and mobility is restricted.*
- *Telemedicine: In **Northwest Syria**, midwives and gynaecologists have been trained to provide virtual consultations, a practice initiated during the COVID-19 pandemic, and are on call to ensure service availability, including antenatal care, postnatal care, family planning, and others. The telemedicine system is combined with pre-existing mobile teams, who can deliver medication to patients if and when required.*
- *Referral Pathways Between In-person and Remote Services: In **Jordan**, WGSSs were closed during stricter periods of COVID-19 lockdowns, but health clinics were often able to stay open. This allowed SRH staff to continue having face-to-face contact with women and girls, to explain in person what remote GBV services were available, and to make safe referrals for online or tele-GBV services.*
- *Clear Guidance for Remote Service Delivery: In **Syria** and **Jordan**, partners highlighted the importance of having clear SOPs for delivering remote services. This can be achieved by adapting existing SOPs to include remote practices, or by developing new SOPs altogether.*
- *Increased Focus on Online Training Delivery: COVID-19 reduced opportunities for in-person training, forcing service providers worldwide to hone their online training methodologies. In Türkiye, GBV and SRH partners commented that access to online trainings had increased, meeting their need for continuous learning.*

For further information on best practices for remote work that emerged as a result of the COVID-19 pandemic, please see COVID-19: UNFPA Best Practices and Lessons Learned in Humanitarian Operations in Arab Region.

Key Considerations for the Adoption of an Integrated GBV and SRH Approach

When designing an integrated GBV-SRH approach for existing or new programmes, particular attention should be paid to the safe and ethical management of information throughout the project cycle. The programme design should also be informed by a careful analysis of the prevailing legal environment and the rights of women and girls within the specific context, particularly with regard to the mandatory reporting of sexual violence and abortions, as part of comprehensive and ongoing efforts to adhere to the Do No Harm approach.

Mandatory Reporting

Many countries in the Arab States region have laws that require service providers to report to police or other government authorities any acts that are believed to be criminal offences. In such situations, legal requirements may override the survivor's permission. Survivors of sexual violence or intimate partner violence (and their caregivers) should be made aware of these legal requirements as part of the informed consent process.

In humanitarian settings, all organisations are mandated to have protocols in place for responding to sexual exploitation and abuse by humanitarian workers. Organisations need to be clear on the inter-agency protocols and inform the survivor as to whom the case would be reported, what information would be shared, and what the expectations would be regarding the survivor's involvement once the case has been reported.

All response actors need to understand the laws and obligations on mandatory reporting as they relate to GBV cases, including the specific requirements for children. Although mandatory reporting is often intended to protect survivors (particularly children), in some situations, following mandatory reporting procedures may conflict with GBV Guiding Principles, including the principles of safety, confidentiality, and respect for self-determination. It can also result in actions that are not in the best interests of the survivor. For example, mandatory reporting of cases of sexual violence or intimate partner violence to the police can put the survivor at greater risk of harm from the perpetrator, family members, or community members.[17]

When mandatory reporting procedures are in place, survivors must be informed immediately upon reporting an incident. Service providers should not promise confidentiality; instead, from the very beginning, they should be clear about what confidentiality means and what the limits are within the specific context. In some contexts, service providers risk punitive action if they do not report cases that fall under mandatory reporting, such as sexual violence. This can lead to conflicts between GBV and health teams over the best course of action. During the introduction of an integrated GBV and SRH approach, it is critical that all staff (GBV and SRH) are familiarised with the mandatory reporting requirements and how to operate within the legal context. Health care providers should discuss how they can provide care to survivors without them needing to disclose violence that will mandate reporting, while at the same time providing relevant information that will allow survivors to access specialised GBV services.

GBV Survivor Data Management

As per the Inter-agency GBV Minimum Standards,[18] GBV survivor data—also referred to as GBV 'administrative data'—includes:

1. Personal or identifiable data about an individual survivor accessing the integrated GBV-SRH services, which are required in order to provide high-quality response services;

2. The details of the GBV incident: e.g. type of violence, location of the incident, relationship of the survivor to the perpetrator, *et cetera;*

3. Case management/service provision data: information about the support provided to an individual survivor through the GBV case management/service provision process.

Survivor data and information management—the collection, storage, analysis and sharing of data related to GBV survivors and their care—is a critical consideration for the provision of any GBV service or programme. Documentation of the services provided to survivors, as well as the monitoring and analysis of incidents of violence reported by survivors, can support service providers' efforts to monitor and understand the application and demand for these services. This data can also improve our understanding of who among the population accesses specific services and who does not, the types of GBV reported by the population, the risks and vulnerabilities faced by survivors, the types of responses provided, the nature of coordination between sectors, and, in some cases, the service outcomes. It can also support efforts to evaluate service capacity, resource allocation and costs, and can allow service

17 The Inter-Agency Minimum Standards for Gender-Based Violence in emergencies programming, UNFPA 2019
18 The Inter-agency Minimum Standards for Gender-based Violence Programming in Emergencies, UNFPA (2019)

providers to monitor the quality of services being provided, in addition to informing policy and programme priorities. It is important to note that GBV survivor data cannot be used to determine the prevalence of GBV, as it includes only data related to survivors who were able to access services, and therefore does not reflect the many unreported incidents of GBV.

When developing procedures for survivor data management in an integrated GBV-SRH programme, it may be helpful to consider how healthcare-sector actors and protection/social work-sector actors typically approach GBV survivor data management: these sectors may take different approaches and have differing imperatives regarding the classification, collection, and sharing of survivor data. When planning an integrated programme, it is important to ensure that discussions about data management happen early in the process, to ensure that a common understanding is established in terms of practices and minimum standards, standardisation of terminologies and classifications, identification of any capacity gaps, the promotion of consistent, survivor-centred approaches, and the safety and ethics of GBV survivor data management. Actors providing integrated GBV-SRH services should centre all of their GBV information management decisions around the guiding principles of safety, respect for the survivor's wishes (through informed consent), confidentiality, and non-discrimination.

Any type of survivor data collected as part of an integrated GBV-SRH programme should only be collected within the framework of direct service provision, and only when reported directly by the survivor or, when appropriate, by a caregiver in the presence of the survivor (depending on the survivor's age, maturity, and level of competence). It is important that service providers are able to provide survivor-centred services, and that they have clear protocols or standard operating procedures in place to guide the provision of these services, before establishing an information management system. Clear protocols for informed consent must be in place prior to collecting any data from survivors, as well as protocols for the protection and safe storage of data. Access to survivor data should be guided by the 'need to know' principle, and data management systems should be designed to reflect this—for example, by adopting a 'role-based' access approach to data systems. Service providers should limit the amount of data collected to only what is necessary to ensure the provision of high-quality care. Moreover, when collecting data for the purposes of analysis, service providers should set clear objectives for the data analysis and should plan to collect only the data that will be used.

Survivor data should only be shared when the following specific conditions are met:

- Safety, informed consent, and confidentiality must be respected; women and girls must remain the owners of the data they choose to share.
- Different approaches to data sharing must be taken for different purposes:
  - Identifiable case information (i.e. information that is collected through referral forms or, in situations of a case transfer, relevant portions of the case file) should only be shared within the context of a referral and with the consent of the survivor, and this type of data sharing should be guided by standard operating procedures.
  - Outside of these situations, it is not recommended to share any identifiable information; only anonymous, aggregate information should be shared. The sharing of anonymous, aggregate statistics for the purposes of analysis and reporting must be guided by clear information-sharing protocols and based on a comprehensive risk analysis, and should be carried out with the consent of the survivor.
  -

Unsafe and unethical management of GBV and SRH information can pose serious risks to the survivors, their families, the communities they live in, and service providers, and can hinder access to and trust in these services. Information should not be shared if these risks outweigh the benefits. The GBVIMS inter-agency initiative[19] recommends a number of tools, resources, and minimum standards for GBV survivor data management. Annex E contains a checklist that can help guide GBV survivor information management and best practices.

"ANY TYPE OF SURVIVOR DATA COLLECTED AS PART OF AN INTEGRATED GBV-SRH PROGRAMME SHOULD ONLY BE COLLECTED WITHIN THE FRAMEWORK OF DIRECT SERVICE PROVISION."

19 The Gender-based Violence Information Management System (GBVIMS): www.gbvims.com, UNFPA. UNICEF, UNHCR, International Rescue Committee, International Medical Corps.

3.3 Strengthening GBV and SRH Integration in Practice

The table below provides a few examples of ways in which GBV and SRH integration can be strengthened in practice, with several specific activities provided as examples.The following list of activities is not exhaustive, but rather designed to serve as a starting point for developing a new integrated approach, or to provide suggestions for how to better integrate two existing programmes.

What	How: GBV Service Providers	How: SRH Service Providers	Promising Practices
Integration of SRH activities into GBV Case Management	• Case managers are aware of basic SRH elements, related to family planning, postnatal and antenatal care, complete abortion care (where available), BASIC prevention and detection of early signs of pregnancy-related diseases (i.e bleeding, cramping, abdominal pain, dizziness, no urination, etc.), the importance of antenatal care services (including recommended frequency), and referral pathways and protocols. They are therefore able to identify the need for a specialised services and proceed with a referral, after providing the patient with relevant information on the available services. • GBV case managers are aware of and can provide adequate information on different contraceptive modalities (including emergency contraception and time frames for use), including myths and misconceptions and the benefits of family planning counselling; they also know the procedures for referring individuals for emergency contraception. Family planning services that require medical attention should only be provided by health care providers who meet local accreditation requirements. • GBV case managers are aware of the legal status of abortion in their context, can address any misconceptions, and know when and how to refer women and girls for safe abortion and/or post-abortion care. • Case managers and SRH staff are aware of how some forms of GBV can increase the risk of HIV, STIs, and unintended pregnancies, and are educated on the risks of reproductive violence.	• SRH staff understand and use the survivor-centred approach and the GBV guiding principles, and can handle safe disclosure. SRH staff are aware of GBV referral protocols, including GBV case management, and know how and where to refer survivors. • If conditions are met to ensure the safety and confidentiality of case management services, and these activities are happening in contexts where there is no mandatory reporting, GBV case managers should be situated in health facilities, so that they are on hand to provide case management and to refer women and girls to specialised services.	• One particularly effective practice is to ensure that case managers know key milestones for antenatal care, so that they can refer survivors for essential check-ups. These milestones could be displayed on a poster in the case management room.
Comprehensive sexuality Education (CSE)	• When CSE is covered as part of GBV programmes for adolescent girls, it is recommended to have sessions on sexuality, sexual reproductive health, and family planning delivered jointly with an SRH specialist (such as a midwife), to ensure that any health-related questions are answered accurately.	• When CSE activities are delivered by SRH teams, consider inviting GBV specialists to support in the design and/or delivery of the activities, to ensure that issues of sexual inclusion and power inequality within sexual relationships are clearly highlighted.	• Within the Arab region, UNFPA partners have implemented a range of life skills programmes for adolescent girls that include CSE components, including UNFPA's AMAL programme, IRC's Girl Shine and My Safety, My Well-being, and the Iraq Adolescent Girls Toolkit. These programmes allow for extended engagement with girls, enabling the beneficiaries to build trust in their facilitators and peers before tackling sensitive topics like sexuality and violence.

What	How: GBV Service Providers	How: SRH Service Providers	Promising Practices
Family Planning and Counselling	• GBV Staff (including WGSS and outreach staff) know when to refer women and girls to family planning services. • Consider inviting a nurse or midwife to a WGSS to provide family planning counselling, including services tailored to pregnant or postpartum adolescent girls.	• SRH staff understand the nature of reproductive violence, and women and girls who disclose violence are referred to GBV services. SRH staff should challenge the notion that reproductive violence represents 'normal' decision-making within families.	• Family Planning Counselling in WGSSs: Throughout the region, healthcare staff working through WGSSs have been able to address misconceptions surrounding contraception and its side effects, and have expanded the reach of family planning services to a larger cross-section of women and girls (e.g. unmarried and married adolescent girls). For example, in Somalia, UNFPA is offering basic family planning counselling in WGSSs (delivered by nurses), with a focus on highlight the health benefits of 'birth spacing' in order to make the service more culturally acceptable. This service is available for women and girls.
HIV/STI	• Case managers and GBV staff are aware of how GBV increases the risk of HIV, STIs, and unintended pregnancies. • GBV case managers are aware of basic protocols for integrated HIV/STI and SRH services, and when they are needed (i.e. for PEP treatments, disease progression of STIs, increased risk of violence, etc.).	• Health care providers know the correct referral pathways for populations at a high risk for HIV (i.e. women and girls engaged in sex work, etc.). • Health care providers deliver psychological first aid and safe referrals, in order to provide survivor-centred support to persons living with HIV who disclose GBV.	• In Somalia, SRH staff who are specialised in diagnosing and treating HIV are trained on GBV prevention and basic PSS. They are trained to refer any client to the GBV unit if necessary. This allows for improved service delivery and health outcomes for women and girls. Similarly, GBV staff are trained on HIV and its interlinkages with SRH. A similar approach is also being used in Sudan. Find an example here of how GBV staff can be sensitised to the risks associated with HIV and STIs.
Clinical Management of Rape and Health Care for GBV Survivors	• CMR should only be provided by staff who have been fully trained on CMR and health care for GBV survivors (including proper training on a survivor-centred approach). However, it is good practice to ensure that all staff working on GBV and SRH understand the basics of CMR and health care for GBV survivors, even if they are not expected to deliver these services. This equips them with the ability to provide a survivor-centred first response, including the ability to clearly explain the available services, and strengthens the bilateral referral pathways. • Deliver training on CMR and health care for GBV survivors using both SRH and GBV trainers, in order to emphasize the need for both clinical and psychosocial competencies in these circumstances. • All medical personnel, including midwives, should be trained on survivor-centred care and first-line response (LIVES/PFA), and on how to safely handle disclosure and referrals. • Consider having an on-call staff member (GBV case manager, social worker, PSS worker, or midwife) who has been trained on survivor-centred care and can provide dedicated practical support and LIVES/PFA to GBV survivors who are admitted for health care, from admission to discharge.		• Joint CMR Trainings: In Northwest Syria, UNFPA has provided joint CMR trainings for SRH and GBV staff that have resulted in relevant and useful knowledge exchange. Following these trainings, the number of reported and documented rape cases has increased due to the enhanced knowledge of GBV and SRH staff. The team noted that GBV staff also benefitted from greater knowledge about CMR, which has helped them provider better explanations of the services available to survivors.

What	How: GBV Service Providers	How: SRH Service Providers	Promising Practices
Clinical Management of Rape and Health Care for GBV Survivors			• The Türkiye Cross Border team developed a contextualised protocol on virginity testing, which included content and guidance relevant to both GBV and SRH staff.
Information and Education Activities	• The provision of information (signposting to available services) is a non-specialised service that can be offered by both GBV and SRH staff, even if the information being provided is outside the scope of their core sector. All staff working on integrated approaches should be educated on which GBV and SRH services are offered, so that they can effectively signpost to women and girls. It is also helpful to use a wide range of methods and communication channels (e.g. posters, television, social media) in order to provide information on the services available at these integrated delivery sites. • Awareness activities involve the dissemination of more technical and conceptual information. Awareness sessions on topics that require substantial medical knowledge (e.g. clinical aspects of safe abortion and post-abortion care, infertility treatments), cover more sensitive topics (e.g. rape), or are aimed at men (e.g. GBV prevention activities) should only be delivered by staff specialised in the relevant sector. However, less complex or potentially less sensitive topics (e.g. family planning, gender roles) could be delivered through cross-sectoral delivery methods, with GBV staff presenting basic SRH topics, and vice versa. • Awareness topics that have a strong GBV and SRH component (e.g. child marriage, virginity testing, reproductive violence) would ideally be offered through joint awareness sessions, led by a GBV specialist and an SRH specialist. It is recommended that GBV and SRH technical leads work together to develop new materials and/or review existing single-sector materials, and that they observe sessions to ensure that high-quality programming is being delivered. The language used in integrated sessions should be harmonised, with an emphasis on the common roots of GBV and SRH.		• UNFPA Myanmar found that the quality of awareness sessions offered as part of their integrated GBV and SRH approach was enhanced when staff emphasised the interconnectivity of SRH and gender equality—for example, by encouraging communities to reflect on issues of gender inequality, decision-making, and power in families when discussing family planning. • In the Türkiye Cross Border operation, UNFPA led the GBV and SRH working groups in developing integrated awareness materials on child marriage. The material was reviewed by members of both working groups so that both technical perspectives were reflected in the information.
Menstrual Hygiene Management	• The risks associated with inadequately addressing menstrual hygiene management (MHM) include greater vulnerability to gender-based violence (GBV) and negative consequences on women's and girls' sexual and reproductive health (SRH). Menstrual health and hygiene interventions not only support women's and girls' access to MHM, but can also serve as a gateway for gender-transformative programming. MHM programming in emergencies requires a multifaceted, interdisciplinary approach, and involves making adjustments and improvements to a number of sectoral interventions, including GBV, SRH, and youth programming. To set up an integrated programme, with components that cover all technical areas, it is critical to involve a mix of GBV, SRH, and youth-focused actors in the activity design process. The development of multi-sector MHM interventions can be done from scratch or by integrating MHM components into existing programmes. Key entry points for the integration of MHM activities into GBV and/or SRH programmes are numerous, and vary depending on the context; these can include WGSSs, Girls Safe Spaces (GSSs), GBV-PSS sessions, SRH service and information delivery.		• Through its partners and their facilities, UNFPA Syria provides integrated awareness sessions on GBV, RH, and MHM. UNFPA also supports MHM interventions by distributing sanitary pads to the beneficiaries of RH and GBV services across Syria, and by engaging in the capacity-building of health educators. Each beneficiary receives three packs of sanitary pads every two to three months. Facility staff and school health educators were also trained to disseminate information and key messages about menstrual hygiene to women and girls.

Intimate Partner Violence (IPV) during Pregnancies and GBV Screening in Antenatal Settings

Intimate partner violence (IPV) during pregnancy is known to have numerous detrimental consequences and adverse health effects on both the woman and, her unborn child, with an increased risk of complications and conditions like preterm birth, miscarriage, low birthweight, injury, depression, anxiety, and posttraumatic stress disorder.[20] In some countries, it has been documented that IPV during pregnancy increases a woman's likelihood of being killed by an intimate partner. Different types of IPV often overlap during pregnancy, such as physical, sexual, and psychological violence, and are associated with higher levels of depression, anxiety, and stress, as well as suicide attempts, lack of attachment to the child, and lower rates of breastfeeding.[21]

It is also noted that some women only seek medical support during ANC and delivery, meaning that, if protocols are in place, these can be opportune times to broach GBV-related topics, deliver information about available services, and, if requested, provide referrals to specialised GBV services. This doesn't mean that every single woman accessing ANC should be screened for GBV.

The GBV AoR Help Desk has published a report, titled '*Review of available evidence and conditions necessary for screening for gender-based violence in antenatal healthcare settings,*' which highlights that there is no conclusive evidence demonstrating any positive effects of IPV screening in antenatal healthcare settings, such as the reduction in IPV incidence or improved health outcomes for women or their babies. The report also mentions that literature on the topic identifies several potentially negative effects of IPV screening, but there are few studies that measure them. There are many calls for further investigation into the impact of IPV screening on both women, and healthcare providers involved in the screening process. However, the report does suggest certain ethical and safety-related considerations that should be weighed when designing and implementing IPV screening interventions, including how to improve detection and decrease the risks of unintended negative consequences. It includes a list of conditions that must be fulfilled prior to the establishment of IPV screening protocols, as part of a comprehensive system:

- Design intervention in consultation with women
- Ensure training of antenatal healthcare providers
- Pilot and contextualise screening protocols or standard operating procedures
- Allow sufficient time for screening and follow-up
- Guarantee safety, confidentiality, and privacy
- Respect the dignity and agency of women
- Ensure a functioning referral system
- Establish institutional support for IPV screening, including financing and leadership

In addition to the essential conditions enumerated above, there are further considerations to be addressed before establishing IPV screening protocols in antenatal care settings:

- Anticipate and be prepared to address the effect of screening on antenatal health care providers
- Ensure a shared understanding of the purpose and value of screening
- Incorporate multiple methods for screening
- Address social norms of both the antenatal institutions and the community
- Anticipate and be prepared to address the unintended consequences of screening

For further guidance on IPV screening, please refer to the *Clinical Management of Rape and Intimate Partner Violence Survivor: Developing Protocol for Use in Humanitarian Settings* (WHO, UNFPA, and UNHCR 2020)

The Use of CVA as Means of Fostering GBV and SRH Integration

Cash and voucher assistance (CVA) is not a distinct service or intervention in and of itself, but rather can serve as a tool or modality for supporting GBV and SRH programming. CVA should always be considered complementary to interventions focusing on the improvement of service provision, and not as a replacement for these services. CVA may have different protections and financial and fiduciary risks than other modes of assistance, which will be context-specific and should be analysed and compared with other methods of programme delivery.

It is important to carefully consider when and how to use CVA in SRH and GBV programming, in order to mitigate risks and avoid unintended negative consequences. CVA can be used to mitigate GBV risks as well as increase women and girls' timely access to GBV and SRH services. It can also be used to encourage and support access and uptake of referral services when GBV and SRH service are not provided in the same location and transport/cost is a barrier (e.g. SRH staff refer a case for specialised GBV services and provide a transportation

20 https://journals.sagepub.com/doi/full/10.1177/0886260517730029
21 https://apps.who.int/iris/bitstream/handle/10665/70764/WHO_RHR_11.35_eng.pdf

allowance, or CVA is provided within the context of GBV case management to provide for access to urgent SRH services, if these services come at a cost). CVA can also be used to provide access to menstrual hygiene materials, supplies, and pain relief medicines, within the framework of a comprehensive Menstrual Hygiene Management (MHM) programme. Conditional CVA could also be used to promote MHM education and awareness. For example, the receipt of CVA could be conditional on the beneficiary's participation in MHM and SRH awareness sessions. Note that the use of CVA in GBV response should always be unconditional.

When used by other sectors to support the needs of women and girls, CVA distributions can offer opportunities to educate women and girls on GBV risks and on how to access GBV and SRH services. Examples from the region include the Syria Pregnant and Lactating Women (PLW) voucher programme, through which women receive vouchers to purchase hygiene items. For this programme, UNFPA works in partnership with WFP, supporting the linkages and referrals to GBV and SRH services during voucher enrolment and distribution. Another example is the Individual Protection Assistance (IPA) programme in Northwest Syria, which facilitates access to GBV and SRH referrals, awareness sessions, and information about available GBV and SRH services. Within the context of GBV Case Management, CVA takes place in Jordan, Lebanon, and Northwest Syria in order to support access to urgent SRH services following GBV incidents. UNFPA Yemen provides cash for transport to facilitate referrals from GBV to SRH services.

3.4 Funding Integrated GBV and SRH Approaches

The table below outlines barriers faced when funding integrated GBV-SRH approaches, along with suggestions for overcoming them.

Barriers	Opportunities
Donors are not interested in integrated GBV and SRH approaches	• Conduct a thorough cost-effectiveness assessment of integrated GBV and SRH approaches to present to donors. • Advocate to donors about the benefits of integrated programming, using clear evidence. This could be through programme learning or specific research (e.g. impact assessments highlighting the impact of integrated approaches). The following box includes examples of evidence-based success stories that could be shared with donors. • Propose an integrated pilot programme with clear learning objectives and monitoring frameworks, to be used as a starting point for developing a more comprehensive evidence-based integrated approach. • See if existing SRH and GBV projects could be integrated, even if using separate funding sources. When integrated approaches employ simple linkages (such as providing cash assistance to pregnant women with integrated information-sharing on SRH services and GBV referral pathways), the cost of integration is not high. • Unpack what GBV and SRH integration means in practice, using case studies and concrete examples.
Donors only want one sector or the other (even after being educated on the benefits of integrated approaches)	• Consider using UNFPA core funds to add the 'missing' sector to a proposed integrated GBV and SRH approach. • The health component of GBV (e.g. health care for GBV survivors, CMR) can always be integrated into a single-sector GBV proposal (as per GBV minimum standards). Similarly, GBV components can always be integrated into an SRH proposal, as the MISP includes responding to sexual violence.
The prevailing humanitarian architecture positions GBV and SRH in separate sectors (Protection versus Health) making it hard to access response funding	• Advocate for integrated funding in GBV and SRH working groups/sub-clusters. • Advocate with OCHA and HC teams on the need to incorporate GBV-SRH integration in donor conversations, as well as throughout the HPC process. • Determine if the CERF call is sectoral or organizational; increasingly, it is the latter, which further supports integrated approaches.
Tensions between GBV and SRH teams over perceived funding prioritisation	• Promote a culture of transparency around funding calls and decisions. • Conduct project analyses at the country and regional levels in order to see the exact proportion of funding by sector.

PROMISING PRACTICES

Examples of the Evidence-Based Benefits of Integrated GBV and SRH Approaches

- *A UNFPA partner operating in **Northwest Syria** has implemented the AMAL programme for young mothers, which includes SRH and GBV awareness. The programme has increased adolescent girls' confidence in accessing health care, and has increased community-wide support for adolescent girls' equal access to SRH services. Some participants reported postponing their daughters' marriages because of the programme.*[22]
- ***In Northwest Syria,** UNFPA noticed a significant increase in reported GBV cases after GBV-specialised staff began to operate directly from the health facilities, in collaboration with midwives and gynaecologists.*[23]
- *In a review of evaluation studies, Haberland (2015) found that the inclusion of issues relating to gender, power, and GBV in sexuality and HIV education was associated with significantly lower rates of unintended pregnancy or STIs.*[24]
- ***UNFPA Jordan** has found that integrated programming tends to require fewer support staff (e.g. cleaners, guards) if one site is used for both sectors, cutting down on overall service delivery costs.*
- *Across the **Syria** response, UNFPA has consistently included both GBV and SRH components in its proposals, gaining buy-in from donors and successfully arguing that GBV cannot be provided without strong SRH systems in place.*

3.5 Training and Capacity-building for Staff Working on Integrated Approaches

Successful integrated approaches rely on GBV and SRH teams understanding each other's roles and services, so they can make effective, timely referrals to potentially life-saving services. As noted by a UNFPA SRH specialist, "We saw many cases coming to our SRH clinic to get either SRH emergency contraception or a check-up after sexual violence, but not referred by the social worker or case worker. The idea is to make sure that both areas have the same understanding about what should be done, and not work separately" (UNFPA, SRH Specialist). Integrated approaches require GBV and SRH staff to feel comfortable providing information about each other's services and programmes for women and girls, even if it means speaking about culturally sensitive topics. This requires regular, extensive, ongoing capacity development.

Core Competencies for Staff Working on Integrated GBV and SRH Approaches

Integrated GBV and SRH approaches require staff to possess additional skills and competencies linked to integration. However, these additional competencies do not replace the core competencies specific to their respective sectors. The GBV AOR has developed a framework with core competences for GBV Specialists, which can be consulted for further guidance on skills and competencies required for GBV practitioners. Similarly, WHO has developed core competencies for SRH providers and health staff.

In addition to the sector-specific **core competencies, the following core competencies are required for GBV and SRH staff working on integrated GBV and SRH approaches. These staff members should be able to:**

- Demonstrate knowledge of the common root causes and linkages between GBV and SRH;
- Demonstrate knowledge on how to apply GBV and SRH guiding principles and a survivor-centred approach;
- Demonstrate a willingness to listen to SRH/GBV colleagues in order to understand their perspectives, principles, and work, and to learn from their expertise;
- Demonstrate an ability to analyse the political, cultural, social, and economic factors that affect sexual and reproductive health and gender-based violence, and to identify possibilities for integrated support and action;
- Understand the principles of case management and how to use these principles to identify and address SRH needs and rights;
- Demonstrate knowledge of GBV prevention approaches and be able to identify and apply appropriate GBV prevention and behaviour change strategies, in order to address violence linked to SRH, such as reproductive violence;
- Demonstrate an ability to adapt and apply key GBV tools in SRH service delivery contexts;
- Demonstrate knowledge of their responsibilities in terms of the prevention of sexual exploitation and abuse within the integrated GBV and SRH approach;
- Facilitate a collaborative environment that promotes effective coordination between GBV, SRH, and MEAL stakeholders;

22 CARE (2020), Adolescent Mothers Against All Odds Learning Report. CARE
23 UNFPA Regional Syria Response Hub (2021), An Analysis of The Evolution of Gender-Based Violence and Sexual and Reproductive Health Services within the Syria Crisis Response. 2017-2020; UNFPA.
24 Haberland, N, 2015, The Case for Addressing Gender and Power in Sexuality and HIV Education: A Comprehensive Review of Evaluation Studies, International Perspectives on Sexual and Reproductive Health, 41(1):31–42, doi: 10.1363/4103115.

- Where relevant, demonstrate basic understanding of CVA and its potential to serve as an entry point for both GBV and SRH services, and to contribute to both GBV and SRH outcomes;
- Contribute to the identification of gaps and possibilities for increasing SRH beneficiaries' access to GBV case management services.

Core Trainings for Integrated GBV and SRH Approaches

It is recommended that all staff members who are implementing GBV and SRH approaches, whether working with UNFPA or with UNFPA's partners, should receive a core training package prior to or within the first three months of implementation. This training should be tailored to the specific context, and should include:

- GBV Basics (including the survivor-centred approach, GBV guiding principles, and multi-sector response);
- SRH Basics (including an introduction to the MISP and the comprehensive package of SRH interventions);
- Considerations for delivering an integrated GBV and SRH approach (including 'triggers' that can indicate when an integrated approach may be necessary).

It is also recommended that MEAL staff also receive the core package of training outlined in this section. This will enable them to understand the programmes they are monitoring, to support them in developing integrated MEAL tools (as required), and to make sure that they are well versed in safe and ethical GBV information management principles and practices.

PROMISING PRACTICES

Training on Integrated Approaches

Regular Refresher Trainings: In acute phases of an emergency, displacement can lead to a rapid turnover of staff. In contexts where high turnover is likely, it is advisable to plan for regular refresher trainings, in order to ensure that new staff members are given timely access to the required capacity development opportunities. For example, as part of the **Türkiye Cross Border** response into **Northwest Syria,** UNFPA is offering quarterly trainings on CMR and GBV basics in order to mitigate the impact of high staff turnover in the health care sector. Similarly, a UNFPA partner in **Syria** offers refresher trainings on GBV basics and safe referrals for its health staff every six months. Regular trainings ensure that health care providers are trained on how to use a survivor-centred approach which, in turn, may improve the quality of services received by GBV survivors who pass through these health facilities.

Partner-led Cross-training: Where training resources are scarce, or in cases where there are two partners with two different specialisations, a cross-training modality could be considered as a means of increasing local ownership of the integrated approach. For example, in **Myanmar,** UNFPA successfully supported two strong partners (one implementing GBV and one implementing SRH activities) to implement basic elements of the complementary sector as part of an integrated GBV and SRH approach.[25] Both partners trained each other on their respective sectors. This cross-training approach is potentially more cost-effective, increases sustainability, and strengthens local ownership of the integrated approach.

Training GBV and SRH Teams Together: A number of UNFPA offices in the Arab region have offered joint trainings to GBV and SRH staff, including MISP and CMR training. The teams noted that this gave staff a chance to better understand each other's roles and generated more fruitful discussions, due to the different experiences and expertise of those attending the session.

Training as Preparedness: It is advisable to view training as a preparedness exercise, in case access to staff is reduced or if it is necessary to prepare for new or recurrent acute emergencies. Consider developing a pool of qualified, vetted trainers who can provide face-to-face or remote training on GBV and SRH integration. For example, UNFPA **Syria** provided a GBV ToT and SRH ToT for UNFPA staff to establish a pool of trainers for GBV and SRH basics.

25 UNFPA Myanmar (no date), Case study: Delivering integrated services for gender-based violence, and sexual reproductive health and rights to conflict-affected communities in Myanmar. UNFPA.

INTIMATE PARTNER VIOLENCE (IPV) DURING PREGNANCY IS KNOWN TO HAVE NUMEROUS DETRIMENTAL CONSEQUENCES AND ADVERSE HEALTH EFFECTS ON BOTH THE WOMAN AND, HER UNBORN CHILD, WITH AN INCREASED RISK OF COMPLICATIONS AND CONDITIONS.

Developing and Delivering Trainings

In order to ensure that trainings for integrated activities (i.e. those including GBV and SRH components) are comprehensive, it is recommended that:

- Training materials for these types of activities are reviewed by both GBV and SRH technical specialists, to look for opportunities to:
  - Share varying expertise and different perspectives on a single topic;
  - Highlight potential disparities between how GBV and SRH technical teams may address a specific issue;
  - Ensure technical terms are clear and understandable for staff from each sector.
- Trainings on integrated activities are conducted by at least one GBV trainer and one SRH trainer, to ensure that cross-sector perspectives are effectively captured.
- The language used in the training sessions should be harmonised in a way that breaks down any technical language barriers between teams.
- Teams are trained on basic principles together, so that they can share ideas and perspectives.

4. ENSURING STRONG COLLABORATION

BETWEEN SECTORS

4. ENSURING STRONG COLLABORATION BETWEEN SECTORS

This section outlines promising practices for ensuring effective inter-agency and inter-team collaboration. Examples of best practices for working with governments are also highlighted in box below..

PROMISING PRACTICES

Working with Governments ***In Somalia,*** *UNFPA has undertaken successful integrated advocacy with governing authorities in order to address policy frameworks that reinforce harmful practices, such as child marriage. The team is currently working on an anti-FGM policy to prevent FGM/C practices being undertaken by health care staff. This work is being undertaken in close collaboration with the relevant line ministries. Similarly, in Yemen, UNFPA has been in discussions with the government since 2019 about rolling out a CMR protocol. Following extensive discussions and advocacy (based on standardised messages developed by the GBV and SRH teams), the protocol has now been approved by the government. The protocol is being rolled out in Northern Yemen and health care providers will be trained on CMR and the use of rape kits. In Iraq, UNFPA has also rolled out a CMR protocol in collaboration with the government.*

4.1 Promoting Collaboration through Inter-agency Coordination

UNFPA is strategically positioned to promote strong collaboration between the GBV and SRH sectors, due to its position as the global coordination lead on both these sectors in IDP contexts. At the coordination level, this can help strengthen integration, but also can ensure that promising practices and lessons learned relating to integrated GBV and SRH approaches trickle down to all partners (Box below). Where partners are in agreement, it is also recommended to include GBV and SRH integration activities in inter-agency sub-sector work plans, at least in terms of strengthening referrals between the two sectors.

PROMISING PRACTICES

Inter-agency Coordination

- *Joint In-Country Initiatives*: ***In Northwest Syria,*** *UNFPA is using its position as coordinator of both the GBV and SRH sub-working groups to promote integrated GBV and SRH approaches amongst working group members. Promising practices described by the cross-border team include the creation of a GBV-SRH integration initiative that includes:*

- *Attending each other's sub-working groups, attending joint coordination workshops to discuss the challenges of integrated GBV and SRH approaches, and creating a coordination team to lead the GBV-SRH integration initiative and provide technical advice. Different working groups have been established under the*

coordination team to contribute their respective technical inputs and recommendations to the response plan; these working groups include an integrated IEC materials and messages group, a GBV community-based group, an advocacy group, an attitude group, and a reporting mechanisms group;

- *Producing a joint guidance note and advocacy on cross-cutting topics (including a joint paper on virginity testing);*
- *Developing a guidance note to improve the provision of high-quality GBV services in SRH facilities;*
- *Developing joint recommendations on mandatory reporting;*
- *Conducting a comprehensive baseline assessment to map out 50 health facilities that provide emergency obstetric and newborn care (EmONC) services and understand the level of GBV integration. Within this framework, interviews with medical and non-medical staff have been conducted (see the following tools used: Facility Questionnaire, Medical Staff Questionnaire, Non-Medical Staff Questionnaire);*
- *Developing M&E tools for joint supervision during field visits, such as the GBV integration checklist to assess the accessibility, staff capacity, and overall preparedness to deliver CMR services, in line with existing policies and protocols and shared GBV messages. According to the score, the level of GBV integration of each facility is classified as inadequate, basic, or advanced;*
- *Developing joint awareness material on cross-cutting topics, such as child marriage.*

One coordinator noted that by developing tools and promising practices at the humanitarian coordination level, the impact in the field is greater, since all members of the working groups are exposed to learnings on the topic.

- *Joint Regional Initiatives: The 2017 **Syria** Humanitarian Needs Overview found that adolescent girls are particularly vulnerable to sexual violence and child marriage, leading to early pregnancy. Based on these findings, as well as consultations held by the Gender-based Violence (GBV) Area of Responsibility (AoR) and the Reproductive Health (RH) working groups of the **Whole of Syria (WoS),** it was agreed that a strategic framework was required to address the specific needs of adolescent girls in **Syria**, focusing on both SRH and GBV needs. A strategy was consequently developed, using a collaborative multi-country process that drew upon GBV and SRH expertise.*

4.2 Promoting Collaboration between GBV and SRH Teams

Improving collaboration between GBV, SRH, and MEAL teams is paramount to successful integrated GBV-SRH approaches. This can be achieved by:

- **Including stronger integrated GBV-SRH approaches within the country programme,** in line with the general direction of unifying SRH and GBV outputs in the strategic plan.
- **Introducing an Integration Focal Point to implement clear systems for overseeing teamwork,** including establishing clear roles and responsibilities, developing updated SOPs for integrated approaches, and creating inter-sectoral work plans. If a dedicated person cannot be hired, the GBV and SRH teams could each select a Focal Point, with these two personnel working together on the task at hand.
- **Gaining the commitment and buy-in of both GBV and SRH staff** towards the integrated approach and towards the collaborative implementation of this approach.
- **Engaging in joint planning and design processes** for integrated GBV and SRH approaches, including holding strategy meetings to discuss funding opportunities.
- **Conducting joint trainings and workshops,** where GBV and SRH staff can learn together and share lessons and experiences with each other. This can include formal training (including core training for GBV and SRH integration) and hypothetical case discussions.
- **Hosting monthly inter-sectoral team meetings** to discuss key content, highlight challenges, and identify solutions to collaboration barriers.[26] This can be supplemented with regular informal communication, quarterly/bi-annual troubleshooting workshops, and learning events.
- **Conducting joint team-building sessions** in order to establish strong relationships and further emphasise the importance of working collaboratively.
- **Using common language and terminologies,** so that GBV and SRH staff can understand both the commonalities and differences in their work, and to provide space for open dialogue between teams on language and guiding principles (e.g. in trainings on GBV and SRH integration, this could involve highlighting that 'human-centred care' and a 'survivor-centred approach' share a similar focus on respect, dignity, and promoting the wishes of women and girls).

26 CARE (2020), Integration of Sexual Reproductive Health and Gender-Based Violence Programs Cox's Bazar, Bangladesh. CARE

- **Demonstrating visible support from senior management** on integrated GBV and SRH approaches, including a clear message that integrated GBV and SRH approaches are a strategic priority, in line with the UNFPA Strategic Plan.
- **Introducing indicators that measure collaboration** across teams and identify areas where collaboration could be strengthened (Annex G).

Field-level Collaboration

Improving collaboration at the field office level can be achieved by:

- **Integrating staff at field offices,** to ensure that there is diverse personnel on field teams and/or that the head of the field office has an integrated role, with oversight and responsibility of both GBV and SRH sectors.
- **Conducting joint programming and monitoring visits** to the field office.
- **Conducting joint safety audits and safety assessments.**
- **Developing a joint advocacy strategy** for addressing the safety and health concerns of women and girls.
- **Conducting joint planning and distribution of dignity kits,** along with the provision of information on both GBV and SRH services.
- **Informing pregnant and lactating women about GBV services during ANC and PNC visits**—for example, through group antenatal information sessions or information shared in the waiting room.
- **Addressing the topic of early marriage and adolescent pregnancy together,** along with the associated GBV/SRH risks.
- **Emphasising the human rights aspect relevant to both GBV and SRH programming:** for example, women's right to access health services, including SRH services; bodily autonomy and freedom of choice regarding if, when, and how many children to have; the freedom to choose their partner and if or when to marry; and the right to be free from discrimination based on race, religion, ethnicity, or sexual orientation.
- **Establishing a clear referral pathway between SRH and GBV services,** as well as clearly defining how and where to seek advanced care, including PSS when needed
- **Implementing CMR,** including training selected GBV-SRH-MHPSS staff and **ensuring the procurement, distribution, and utilisation of RH Kit 3.** All staff should know what CMR is and how to refer survivors to trained specialists.

PROMISING PRACTICES

Promoting Strong Inter-team Collaboration

Development of an integrated GBV-SRH minimum response package: ***In Somalia,*** *UNFPA is scaling up support to ensure that minimum services for SRH and GBV are fully available to Somali women and girls who are displaced and affected by the drought. An integrated SRH and GBV minimum response package has been developed and adopted to address the exacerbated needs of women and girls during a crisis. The response is focused on existing emergency obstetric and newborn care (EmONC) facilities, one-stop centres, GBV shelters, and Women and Girls Safe Spaces.*

Troubleshooting Workshops: In ***Somalia****, UNFPA noted tensions between GBV case managers and health practitioners. The team therefore arranged a workshop where the different staff members could raise their concerns and challenges. The discussions proved very fruitful, especially in relation to GBV cases involving legal referrals. Health practitioners explained that cases requiring legal interventions concerned them. They worried about safety—not just the survivors' safety, but also the case managers' safety and their own safety—if cases that passed through the health clinic were referred for legal interventions. Neither team had previously had the chance to discuss each other's perspectives. The workshop concluded that there were clear misunderstandings over the roles of different team members, an area that required strengthening.*

Joint Supervision/Case Discussions: In one of the FGDs conducted as part of the research for this tool, staff from a partner organisation in ***Somalia*** *described a case of reproductive violence, in which a woman's family had fought for her to have an IUD inserted against her will, threatening her with divorce if she refused. The staff member noted that in cases like this, "there is a gap in the integration; we can't connect to the GBV [team]... it will be helpful if the mother can have all the services she needs." One way of handling such cases is through integrated work with the GBV team, such as referrals for case management. However, cases such as this can also be addressed through anonymised case discussions involving GBV and SRH field staff. This gives both teams a chance to discuss challenging cases that arise through either GBV or SRH activities, with each team bringing their unique expertise and insights to the discussion. Regular case discussions can also help to establish the expertise of both sectors and foster mutual respect; this, in turn, may start to address potential hierarchies between health and protection teams (where health teams may be viewed as 'more professional').*

Indicators to Measure Collaboration: Measuring the effects of collaboration may seem quite abstract, with the focus largely on qualitative assessments of communication and relationships. However, the impact of collaboration can be measured through various quantitative indicators, such as number of referrals between teams and number of inter-sectoral team meetings or workshops. Indicators such as these can help identify when parts of the integrated systems are not working as effectively as others, and can capture promising practices that can be applied at other field sites.

Tools for Assigning Clear Roles and Responsibilities

Given the nature of integrated GBV and SRH approaches, there are likely to be activities that require inputs from multiple teams and individuals. If roles and responsibilities are not clearly defined, this may lead to work duplication, work being overlooked, or tensions within and between teams.[27] Misunderstandings can be avoided by having clear, written guidelines that enumerate each team member's roles and responsibilities. This is helpful even when integrating existing GBV and SRH programmes, as team members will likely need to take on new and different responsibilities in an integrated approach (e.g. a midwife may provide services in a WGSS, not just a health facility). Clarity regarding team members' roles and responsibilities in an integrated approach can be achieved through:

- **Completion of a Roles and Responsibilities Matrix:** This would ideally be agreed upon at the onset of new integrated activities or during the initial integration of existing GBV and SRH activities, with inputs from all relevant staff. It is recommended that the matrix then be reviewed regularly, in order to address any challenges that emerge during implementation. It is important to pay particularly close attention to activities that include both GBV and SRH components (i.e. integrated activities), especially when allocating technical oversight responsibilities (see following box). A sample RACI[28] Roles and Responsibilities Matrix template is available in Annex F.
- **Inclusion of Responsibilities Relating to Activity Integration in all Staff Members' Yearly Objectives:** For an integrated GBV and SRH approach to be successful, staff need to not only feel accountable for the project components they are directly responsible for delivering—they should also feel a more general sense of responsibility for the successful integration of the GBV and SRH activities overall. This can be encouraged by incorporating targets related to integration into every team member's yearly objectives. This might include objectives like regular coordination with other teams or making cross-sectoral referrals.
- **Adaptation of Existing SOPs to Align with an Integrated Approach:** Where SOPs have been developed for existing single-sector GBV or SRH activities, they are unlikely to fully align with the Roles and Responsibilities Matrix developed for an integrated approach. To avoid confusion, it is advisable to update these SOPs to reflect the reality of delivering activities as part of an integrated approach. Existing SOPs can be amended by adding boxes or including an 'integrated approach' annex to highlight integrated activity adaptations.

Allocating Technical Oversight Responsibilities: *Some activities include both GBV and SRH components. For example, a life skills course for adolescent girls might include GBV awareness as well as sessions on menstruation, puberty, and family planning. In such cases, it is recommended that both GBV and SRH specialists be involved in the design and monitoring of the activity. It may be necessary to assign oversight responsibilities—not just at an activity level, but also to agree on how technical oversight of different activity components should be split between the technical teams. This helps to ensure that smaller complementary technical components integrated into the other sector's activities also receive the required level of technical oversight and monitoring.*

"IF ROLES AND RESPONSIBILITIES ARE NOT CLEARLY DEFINED, THIS MAY LEAD TO WORK DUPLICATION, WORK BEING OVERLOOKED, OR TENSIONS WITHIN AND BETWEEN TEAMS."

27 Hanania, D., Curtis, J., and Meyer, K (2020), Charting the Path Forward: UNFPA Jordan and the Humanitarian-Development Nexus. UNFPA Jordan.
28 RACI refers to the responsibilities allocated to each team or team member: Responsible, Accountable, Consulted, Informed. This makes the type of responsibility of each team or team member clear.

5. MONITORING AND EVALUATING

AN INTEGRATED GBV AND SRH APPROACH

5. MONITORING AND EVALUATING AN INTEGRATED GBV AND SRH APPROACH

The type of integration applied to a particular integrated GBV and SRH approach will influence which MEAL strategies and tools are needed to effectively monitor the programme's quality and impact (see following table).

Referrals between SRH and GBV teams

Monitor through existing single sectoral GBV and SRH MEAL tools and systems, with the following adaptations:

- Add integrated indicators to measure the combined impact of integrated GBV and SRH approaches (Annex G). Include these in your approach's Logical Framework(s), using harmonised language;
- Agree on overarching integrated objectives and how these will be measured (including means of verification);
- Add indicators to measure the success of inter-team collaboration;
- Educate GBV, SRH, and MEAL teams on activities and technical language used by each sector, and the different information management protocols used by GBV and SRH sectors;
- Have a joint MEAL plan that includes GBV and SRH MEAL activities. Arrange joint evaluation and learning events to reflect on the quality and impact of the integration;
- Ensure complaint and feedback mechanisms capture both GBV and SRH activities, and that responsibilities for closing the loop are clear, especially for integrated activities.

Cross-Sectoral Service Delivery (e.g. GBV and SRH staff offering non-specialised services of the other sector)

Take into account the tips listed above, plus:

- Agree on additional monitoring checks for activities offered by non-specialised staff of the other sector, particularly in the early stages of service delivery;
- Include outcome indicators measuring cross-sectoral capacity development and knowledge acquisition;
- Ensure IM systems for integrated approaches can be accessed by both GBV and SRH teams to record non-specialised service delivery (for more tips on IM systems, see Annex E).

Integrated Activities (e.g. life skills course for adolescent girls that includes both GBV and SRH components)

Take into account the tips listed above, plus:

- Develop specific MEAL tools for monitoring the quality of the integrated activities, so that quality markers for both sectors are included (e.g. checklists, programme participant feedback forms);
- Develop indicators to measure the impact of integrated GBV and SRH activities (Annex G).

Tracking the Journeys of Women and Girls through an Integrated Approach: It is possible to assess the success of team collaboration by mapping the actual journeys of women and girls throughout the integrated approach. This is done by conducting case studies that examine the different referral and service points through which a woman or girl passes, from registration to discharge/case closure. This approach is best used for women and girls who have received multiple services, but it may only be completed if the subjects consent to having their data reviewed for this purpose. Case studies can help identify referral bottlenecks (e.g. whether receptionists know how to signpost to women and girls in need) and check if staff are following agreed protocols (e.g. obtaining informed consent for all referrals).

5.1 Designing MEAL Tools for Integrated GBV and SRH Approaches

As noted above, if an integrated approach focuses on strengthening linkages between existing GBV and SRH programming, it is possible to continue using many of the same MEAL tools. However, when a specific activity includes both GBV and SRH components, it is recommended to develop specific integrated MEAL tools for the integrated activity. Ideally, these will be jointly designed by the GBV, SRH, and MEAL technical leads. An agreement should also be reached on how the GBV and SRH technical leads will split quality monitoring responsibilities.

Designing Integrated Indicators

It is advisable that all integrated approaches are assessed through indicators that capture the quality and impact of the integrated activities. These should cover output, outcome, and impact indicators, and might include:

- Indicators for overall programme impact (e.g. indicators that measure the integration objective);
- Indicators for measuring the impact of specific integrated GBV and SRH activities (e.g. % increase in girls' awareness of their SRH rights after participating in the AMAL programme);
- Indicators for measuring staff capacity to deliver integrated approaches (e.g. % of staff exhibiting increased understanding of GBV and SRH integration, % of SRH staff trained on a survivor-centred approach, % of staff trained on SRH/GBV);
- Indicators for measuring levels of collaboration during integrated approaches (e.g. number of monthly inter-team meeting conducted in a six-month period, % change in referrals from SRH to GBV services following the introduction of an integrated approach).

A list of sample integrated indicators is included in Annex G.

Harmonised Language: SRH and GBV programmes often use quite technical language that those operating in the other sector may not be familiar with. The two sectors also use different terms to refer to the same groups: for example, a person receiving CMR might be referred to as a 'patient' or a 'survivor' depending on the sector. It is important for the GBV, SRH, and MEAL technical leads to harmonise the language used in integrated approaches, especially when designing integrated indicators, so that the purpose of the indicators is clear. It is helpful to record all agreements regarding terminology in the MEAL plan. Where possible, it is recommended that indicators (including language and definitions) be standardised regionally to allow for cross comparisons of data.

PROMISING PRACTICES

Integrated GBV-SRH Indicators: **In Syria,** *UNFPA did not introduce new M&E tools developed specifically for the integrated services. However, to reflect the integrated approach,* ***Syria*** *CO started using two new indicators in the 2022 annual work plans of its implementing partners: 1) Number of functional integrated GBV/RH mobile teams, and 2) Number of beneficiaries reached with integrated services. Additionally, UNFPA* ***Syria*** *has also started reporting integrated services in its donor reports.*

6. ANNEXES

Annex A: **Acronyms**

AMAL	Adolescent Mothers Against All Odds
ANC	Antenatal Care
AoR	Area of Responsibility
ASRO	Arab States Regional Office
BEmONC	Basic Emergency Obstetric and Newborn Care
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CERF	Central Emergency Response Fund
CHW	Community Health Worker
CMR	Clinical Management of Rape
CVA	Cash and Voucher Assistance
DHS	Demographic and Health Survey
FGC	Female Genital Cutting
FGD	Focus Group Discussion
FGM	Female Genital Mutilation.
GBV	Gender-based Violence
GBVIMS	Gender-based Violence Information Management System
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
IASC	Inter-agency Standing Committee
IEC	Information, Education and Communication
IM	Information Management
IPA	Individual Protection Assistance
IPV	Intimate Partner Violence
IRC	International Rescue Committee
KII	Key Informant Interview

LGBTQIA+	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, and Asexual
MEAL	Monitoring, Evaluation, Accountability, and Learning
MHM	Menstrual Hygiene Management
MHPSS	Mental Health and Psychosocial Support
MISP	Minimum Initial Service Package
MoH	Ministry of Health
MoV	Means of Verification
NGO	Non-governmental Organization
NW	Northwest
PDM	Post-distribution Monitoring
PEP	Post-exposure Prophylaxis
PFA	Psychological First Aid
PLW	Pregnant and lactating women
PNC	Postnatal Care
PSS	Psychosocial Support Services
RACI	Responsible, Accountable, Consulted, and Informed
SoPs	Standard Operating Procedures
SRH	Sexual and Reproductive Health
STIs	Sexually Transmitted Infections
ToT	Training of Trainers
TRG	Technical Reference Group
UNFPA	United Nations Population Fund
WGSS	Women and Girls Safe Space
WHO	World Health Organization
WoS	Whole of Syria

Annex B: **Glossary of Terms**

NB: This glossary of terms defines the terminology as it is used within the tool.

Adolescent Girls	Refers to girls aged 10-19 years.
Cash and Voucher Assistance (CVA)	The provision of cash transfers or vouchers given to individuals, households, or community recipients—not to governments or other state actors. This excludes remittances and microfinance in humanitarian interventions (although microfinance and money transfer institutions may be used for the actual delivery of cash).
Confidentiality	The confidentiality of all programme participants should be respected, whether they are accessing GBV or SRH services. Respecting confidentiality involves ensuring there are clear data protection and information management protocols for referrals between GBV and SRH services that prioritise the wishes of women and girls at all times.
Cross-Sectoral Service Delivery	This refers to any GBV or SRH non-specialised service that is delivered by a GBV or SRH staff member whose primary expertise lies in the other sector. For example, the provision of basic SRH awareness services by GBV staff.
Do No Harm	This refers to the need to actively assess the impact and effects of integrated GBV and SRH approaches, to ensure that women and girls do not experience advertent or inadvertent harm. It involves ensuring that GBV and SRH staff are fully trained on practical as well as value-based competencies and can deliver services through a survivor-centred approach, wherever needed.
GBV Guiding Principles	These are principles that underpin any GBV response. They include ensuring the safety of GBV survivors, ensuring confidentiality, respecting the GBV survivor, and practicing non-discrimination.
Health Response to GBV	Includes survivor-centred care and first-line support (i.e. psychological first aid) to address basic emotional needs, as well as identification and care for survivors of intimate partner violence, clinical management of rape, mental health care, or referrals to additional services.
Health Care Facilities	This encompasses primary, secondary, and tertiary facilities, unless specified otherwise.
Humanitarian Principles	These are the core principles of humanity, neutrality, impartiality, and independence.[29] All humanitarian actors must abide by these principles.
Human-Centred Approach/Care	This refers to a means of working with health programme participants which places them at the centre of their care. A human-centred approach 'helps us understand the underlying drivers and barriers for desired health seeking behaviours and what we might do to improve uptake of services. The approach provides a structured process for working directly [across the health care system] to address demand-related challenges associated with the acceptability, responsiveness, and quality of services.'[30]
Integrated Activities	This refers to activities or services which include components of both GBV and SRH (e.g. a life skills programme for adolescent girls, delivered in a health facility, covering GBV and SRH awareness). Integrated activities are just one way in which GBV and SRH services and programmes can help improve the quality of provision and experience of care, while also enhancing continuity and cross-utilisation of services and promoting effective collaboration and coordination between the GBV and SRH sectors.

29 UNOCHA (2012), What are Humanitarian Principles.
30 Taken from UNICEF, https://www.hcd4health.org/

Mobile Units	This refers to mobile clinics, as well as mobile teams who may use temporary sites to deliver services. Mobile units 'move to where people are displaced, residing, or in transit, in order to provide services to those who cannot be easily reached with traditional (static) services. This model can be used in situations when the population is dispersed and/or displaced among host communities in rural or urban settings.'[31] Units usually work according to a predefined schedule. When providing integrated services, units include on-board GBV and qualified health staff, and provide a range of GBV and SRH activities. The level of clinical and GBV-specialised services will depend on the available space, equipment, and staff capacity within the unit.
Non-Discrimination	All humanitarian actors should provide inclusive services without discrimination based on age, sex, gender, religion, ethnicity, wealth, language, nationality, status, political opinion, culture, etc.
Older Women	Refers to women aged 60 years and above.
Women who are post-menopausal	Refers to women aged 50 years and above.
Remote or Online Service Delivery	This refers to services delivered over the phone, internet (e.g. Zoom, WhatsApp), and/or social media.
Reproductive violence[32]	Reproductive violence is a form of GBV that can be defined as actions that interfere with a woman's reproductive intentions and any actions that coerce a woman into initiating, preventing, or terminating a pregnancy. Reproductive violence can come in many forms, and it can include preventing someone from reproducing, as well as forcing them to reproduce. These range from persuasion to pressure (i.e. emotional blackmail, societal or family expectations, threats, and/or physical violence). Certain forms of reproductive violence, such as denying access to family planning methods (by the partner/family or health care provider), are linked to dominant cultural understandings about the right to control women's bodies, which sharply contrast with women's and girls' right to have full bodily autonomy and integrity.
Respectful maternity care (RMC)	This approach is centred on the individual, based on principles of ethics and respect for human rights, and promotes practices that recognise women's and girls' preferences, as well as the needs of women, girls, and newborns. It focuses on addressing disrespect and abuse as manifestations of the systemic failure to uphold women's dignity when accessing maternity care and treatment within the medical system.
Sexual and Reproductive Health Guiding Principles	The state of complete physical, mental, and social wellbeing in all matters relating to sexuality and the reproductive system. SRH principles outline that every individual has the right to make decisions governing their body and to access services that support that right. Every individual has the right to make his or her own choices about his or her sexual and reproductive health, which implies that people should be able to have a satisfying and safe sex life, the capability to reproduce, and the freedom to decide if, when, and how often to do so.
Survivor	A person who has experienced gender-based violence.
Survivor-Centred Approach	This approach creates a supportive environment in which survivors' rights and wishes are respected, their safety is ensured, and they are treated with dignity and respect. Although normally associated with caring for GBV survivors, this shares many similarities with human-centred care, including respect, empathy, and prioritising the wishes of women and girls.
Women and Girls Safe Space	This refers to a structured place where the physical and emotional safety of women and adolescent girls is respected, and where women and adolescent girls are empowered to seek, share, and obtain information, access services, express themselves, enhance their psychosocial well-being, and more fully realise their rights.[33]
Women and girls of reproductive age	Refers to women and girls between the ages of 15-49.

31 IRC: Guidelines for Mobile and Remote Gender-Based Violence (GBV) Service Delivery.
32 Rowlands, S., & Walker, S., (2019). Reproductive Control by Others: Means, Perpetrators and effects.
33 IRC and IMC (2020), Women and Girls Safe Spaces: A Toolkit for Advancing Women and Girls' Empowerment in Humanitarian Settings.

Annex C: Methodology for developing this document

The Programmatic Reference Tool was developed through a collaborative process involving UNFPA staff and partners from 11 UNFPA Country Offices implementing humanitarian programming across the Arab region.[34] To ensure that the tool was based on real-life examples of integrated GBV and SRH approaches in humanitarian settings, a research study was conducted that combined the following methods:

- Desk Review: This review focused on integrated SRH and GBV programme guidelines, case studies, and peer-reviewed research papers, with a predominant focus on the Arab region.
- Survey: This survey focused on the types of integrated GBV and SRH approaches being implemented in humanitarian and emergency settings across the region, as well as promising practices and lessons learned. The survey was sent to strategic staff in each of the 11 UNFPA Country Offices (i.e. staff focusing on humanitarian response, GBV, SRH, and MEAL), and one or two partners from each country. In total, it was completed by 24 UNFPA staff and 12 partner staff.
- Key Informant Interviews (KIIs): Eleven KIIs were conducted with a total of 27 UNFPA staff (GBV, SRH, MEAL, and humanitarian coordinators) from the regional office and five of the 11 country offices: Somalia, Sudan, Yemen, Syria (including cross-border response from Türkiye), and Jordan. These countries were strategically selected in order to cover a diverse range of humanitarian responses. The KIIs considered 'ideal' models of GBV and SRH integration, before exploring ways of strengthening existing integrated GBV and SRH approaches.
- Seven Focus Group Discussions (FGDs): These discussions were conducted with 40 field staff from partner organisations in each of the five selected countries listed above (Somalia, Sudan, Yemen, Syria, and Jordan). The FGDs explored field-level experiences with integrated GBV and SRH approaches in more detail, before validating the promising practices identified in the surveys and KIIs.

The data from the survey was analysed using SPSS, while the qualitative data was coded thematically using NVIVO. Across all the data, particular attention was paid to recurrent challenges and examples of promising practices for overcoming these challenges. The findings of the research and a desk review on integrated GBV and SRH approaches formed the basis of the Programmatic Reference Tool. This was supported with substantive feedback and reflection from a Technical Reference Group (TRG) set up to support the tool development process. The TRG comprised a group of UNFPA technical specialists from GBV, SRH, MEAL, and humanitarian coordination, all of whom had experience implementing integrated GBV and SRH approaches within the Arab region.

34 Somalia, Sudan, Libya, Syria, Jordan, Lebanon, Yemen, Egypt, Iraq, Palestine and Türkiye (Cross Border Response into North West Syria. All Country Offices were offering at least one form of humanitarian programming (preparedness, emergency, refugee response) in July 2021.

Annex D: Checklists for Non-Specialised Cross-Sectoral Service Delivery

Organisational Capacity

When deciding whether a non-specialised GBV or SRH service (such as information provision or awareness) can be offered by staff whose expertise lies in the other sector, the following standards should ALL be met. It is recommended that a separate checklist be completed for every non-specialised activity that is being proposed for cross-sectoral service delivery.

Name of Non-Specialised Activity:		
Organisation has the capacity to train staff on how to implement integrated approaches (see Annex K for core topics)	Yes	No
Organisation has training material that prepares staff members to deliver the specified activity in line with minimum standards	Yes	No
Organisation has trainers with sufficient technical expertise to offer high-quality training on the specified activity	Yes	No
Organisation has sufficient human resources to allow selected staff members to shadow a colleague while they deliver the specified activity (NB: colleague must have a technical background in the specified activity)	Yes	No
Organisation has sufficient human resources to allow selected staff members to be supervised by a colleague when they first deliver the specified activity (NB: colleague must have a technical background in the specified activity)	Yes	No
Organisation has technical staff with the relevant expertise to monitor the quality of the specified activity (NB: technical staff must have a technical background in the specified activity)	Yes	No

Individual Staff Capacity Checklist

When deciding whether a specific staff member is equipped to deliver a specific non-specialised service of the other sector, the following standards should ALL be met. It is recommended that all staff members being considered for cross-sectoral service delivery complete a separate staff capacity checklist with their supervisor for each non-specialised activity they are asked to deliver.

Name of Staff Member:		
Name of Non-Specialised Activity:		
Staff member has completed all the required core trainings for implementing integrated GBV and SRH approaches (see Annex K)	Yes	No
Staff member has received training on how to implement the specified activity, including when to complete referrals for specialised support	Yes	No
Staff member has shadowed a colleague as they deliver the specified activity (NB: colleague must have a technical background in the specified activity)	Yes	No
Staff member fulfils the core competencies required for delivering integrated GBV and SRH approaches	Yes	No
Staff member has passed any relevant value clarification exercises for the specified activity	Yes	No
Staff member has successfully delivered the specified activity in line with minimum standards while being supervised by a colleague (NB: colleague must have a technical background in the specified activity, period of supervision to be agreed upon by the organisation)	Yes	No

Annex E: Checklist for Ensuring Safe and Ethical Data Sharing and Information Management

Data Collection

- Are service providers trained to deliver survivor-centred services?
- Have staff been trained on confidentiality and informed consent? *NB: as part of this, staff should be made aware that intentional breaches of confidentiality are a code of conduct violation.*
- Are standard operating procedures in place to guide the provision of services?
- Has the organisation considered adopting a standardised, safe, and ethical approach to GBV data management, such as the GBVIMS/GBVIMS+?
- Have the risks associated with collecting different types of GBV data been fully and contextually analysed?
- Is there a standardised approach to data classification and a common understanding of terminology across service providers in the integrated programme?
- Has the organisation discussed and analysed which data it plans to collect and why?
- Is a full set of standardised forms (e.g. case management forms) used to document service provision?
- Are consent processes integrated into data collection? Is consent for information sharing always documented?
- Have staff been trained on coding processes to avoid the identification of survivors or service providers?
- Are programme participants informed of their rights in terms of data collection, storage, and sharing, including their right to access to their data and request deletion of data?

Data Storage

- Does the organisation have a Data Protection Policy?
- Is this policy compliant with data protection laws in the country of operation?
- Have staff been trained on the organisation's Data Protection Policy?
- Are programme participants' records/files stored in a safe location?
- Have staff all signed an agreement to comply with the organisation's Data Protection Policy? *NB: this should be shored in HR files per staff.*
- Is the organisation compliant with donor requirements on data protection?
- Is access of data limited to authorised staff and aligned with the need-to-know principle?
- Are there clear information-sharing protocols on who is authorised to access which pieces of information (i.e. GBV, SRH, and/or MEAL staff)?
- Are hard copies of programme participants' information stored in lockable filing cabinets, on computers that are password protected and locked when unoccupied, or on secure servers?
- Are electronic devices with programme participants' information locked in a safe location (this includes laptops, external hard drives, USB/flash drives)?
- Are computers, laptops, or programmes for storing information routinely password protected?
- Is there a protocol for evacuation and/or safe destruction of paper forms?
- Are staff aware of appropriate times and places to initiate evacuation and/or safe destruction of data?
- Does the organisation routinely back-up data?
- Does the organisation have protocols in place for determining the frequency of data back-up?
- Is data backed up to a safe, secure location, in line with the organisation's data protection protocols?

Data Analysis

- Are objectives for data analysis established prior to collecting data?
- Is data analysis carried out regularly?
- Are frontline service providers included in the data analysis process?
- Is the analysis of incidental data used to inform reporting, programming, policy, and advocacy efforts?

Data Sharing

- Is informed consent a condition for data sharing?
- Is the process of data sharing for the purposes of service provision/referrals guided by GBV standard operating procedures?
- Is there a standardised referral form at the organisational or inter-agency level?
- Has an information-sharing protocol been developed to guide the sharing of anonymised, aggregate statistics on reported incidents with other actors?
- Have all staff been trained on the information sharing protocol?

NB: If, after going through this checklist, you determine that your data is not safe or that the data collection or sharing processes do not follow minimum standards, contact your supervisor.

Annex F: **Roles and Responsibilities Matrix**

Sample Template. The following template is a basic example of a Roles and Responsibilities Matrix that could be used by teams implementing integrated GBV and SRH approaches. The letters in the columns reflect the type of responsibility allocated to each team member: R=Responsible, A=Accountable, C=Consulted, I=Informed

Activities Implemented in (insert service delivery site) *NB: Please see an example for filling the table in grey.* Project Manager/Coord. Position			Insert Staffing Positions (examples are suggested below, but will depend on the project)							
		Senior SRH Staff	Senior GBV Staff	CHW	GBV Officer	SRH Officer	Case Manager / Worker	Midwife	MEAL Staff	
Girl Shine or AMAL programme for adolescent girls	GBV-focused Sessions	A		C		R				I
	SRH-focused Sessions	A	C				C		R	I
Project Activity 1										
Project Activity 2										
Project Activity 3										
Project Activity 4										
Project Activity 5										
Project Activity 6										
Project Activity 7										
Project Activity 8										

Annex G: Sample Integrated Indicators and Log Frame

This annex contains a list of suggested indicators and sample components for a log frame. The integrated indicators listed below are non-exhaustive suggestions based on the findings of the survey, KIIs, and FGDs conducted as part of the tool development process. The indicators can be adapted to suit specific activities.

Indicator	Indicator Definition	Unit of Measurement	Possible Means of Verification (MoV)
Integration of GBV and SRH services			
Impact: Adolescent maternal mortality rates (for use in integrated programmes targeting adolescent girls, child marriage, etc.) *NB: This can also be adapted to cover adolescent girl birth rate or* child *marriage rates, both of which can also be used to measure the impact of integrated GBV and SRH approaches focusing on girls.*	(# of maternal mortality cases of girls under the age of 19 years) / (# of maternal mortality cases in catchment area)	Maternal mortality amongst girls under the age of 19 years	SRH patient records, maternal mortality surveillance systems
Outcome: % of pregnant women and girls accessing GBV activities who are referred for antenatal care (disaggregated by age) *NB: This can be used as a template for other SRH and GBV service integration (e.g. referrals for different types of service).*	(# of pregnant women and girls accessing GBV services referred for antenatal care) / (# of pregnant women and girls accessing GBV services) *100 *NB: Ideally, the numerator will be captured in women and girls' registration data. The indicator could also use 'successfully referred' for the denominator if the teams track whether women and girls attend at least one session.*	% increase in referrals to antenatal care by GBV staff	Referral records, case management records, registration records
Outcome: % of men who participated in (insert name) GBV prevention programme and reported increased knowledge of women's sexual and reproductive health rights *NB:Tthis can be adapted to also measure improved attitudes and practices, depending on the nature of the GBV programme being offered.*	(Post-test value – Pre-test value) / (Pre-test value)* 100 *NB: Set a minimum number of sessions participants must attend to qualify for the indicator.*	% change in knowledge regarding SRH	Pre-post tests (including value clarification and behavioural change indicators if these are offered)

Indicator	Indicator Definition	Unit of Measurement	Possible Means of Verification (MoV)
Outcome: % of service delivery points offering specialised GBV activities where GBV staff are also delivering non-specialised SRH services *NB: This can be adapted to cover other forms of cross-sectoral delivery and upskilling of staff.*	(# of service delivery points offering specialized[35] GBV services where GBV staff are also delivering non-specialised[36] SRH services) / (# of service delivery points offering specialised[37] GBV services) *100 *NB: 'Service delivery points' covers those service points offering only GBV activities as well as service points offering integrated GBV activities.*	% of service delivery sites offering specialised GBV activities where GBV staff have been trained and empowered to offer cross-sectoral service delivery for non-specialised SRH services	Mapping exercise, Capacity development plans of GBV Staff
Outcome: % of risk assessment(s) that include an assessment of both GBV and SRH risks affecting women and girls *NB: Can be adapted to other tools linked to integrated approaches, such as MEAL tools.*	(# of risk assessments that include GBV and SRH-related questions) / (# of GBV and SRH risk assessments) *100 *NB: Need to define a time frame for this indicator (e.g. assessment conducted in the past 12 months).*	% of risk assessment tools that have been designed as an integrated GBV and SRH tool	Risk assessment tools
Outcome: % of service delivery points that provide integrated GBV and SRH activities *NB: Can be adapted to focus on specific service-delivery modalities (e.g. % of youth centres that provide integrated GBV and SRH activities).*	(# of service delivery points that provide integrated GBV and SRH activities) / (# of SRH and GBV service delivery points) *100 *NB: 'Integrated activity' refers to an activity that includes both GBV and SRH components (e.g. AMAL programme) which are jointly conducted by GBV and SRH staff.*	% of service delivery points that implement at least one integrated GBV and SRH activity	Service mapping
Outcome: % of service delivery points that provide both GBV and SRH activities *NB: Can be adapted to focus on specific service delivery modalities (e.g. % of health facilities that provide both GBV and SRH activities).*	(# of service delivery points that provide GBV and SRH activities) / (# of SRH and GBV service delivery points) *100	% of service delivery points that offer both GBV and SRH activities	Service mapping

35 Specialised services refer to thematic services that are provided by accredited professionals within that domain (i.e. health care providers providing SRH, GBV providers providing case management)
36 Non-specialised services refer to services, information, and/or referrals that can safely be provided by a non-specialised staff (i.e. child marriage awareness sessions, antenatal care referrals, GBV awareness)
37 Specialised services refer to thematic services that are provided by accredited professionals within that domain (i.e. health care providers providing SRH, GBV providers providing case management)

Indicator	Indicator Definition	Unit of Measurement	Possible Means of Verification (MoV)
Output: # of CEmONC facilities offering GBV case management *NB: Can be adapted for other specific activities in specific service delivery points or modalities (e.g. % of WGSSs where SRH information and services are provided by SRH specialists).*	(# of CEmONC facilities that offer GBV case management)	# of CEmONC facilities which offer GBV case management	Monitoring checklists, staffing records
Output: # of women and girls who received integrated SRH and GBV IEC materials (disaggregated by age) *NB: Can be adapted for other specific types of integrated activities (e.g. life skills programmes for adolescent girls that cover SRH and GBV)*	(# of women and girls who received integrated GBV and SRH IEC materials) *NB: This refers to IEC materials that include both GBV and SRH messaging.*	# of women and girls who receive integrated GBV and SRH IEC materials (disaggregated by age)	Post-distribution monitoring (PDM)
Staff Capacity Development on Integrated Approaches			
Outcome: % of GBV and SRH staff who demonstrate improved knowledge of CMR after taking part in a training on this topic *NB: This can be adapted to cover other forms of training.*	(Post-test value – Pre-test value) / (Pre-test value)* 100 *NB: Set a minimum number of training sessions that must be completed before a staff member qualifies for this indicator.*	% of GBV and SRH staff who demonstrate improved knowledge of CMR	Pre and post-tests, training attendance records
Outcome: % change in survivor-centred values reported by SRH staff after completing the GBV basics training NB*: Can be adapted to cover other types of value change.*	(Post-test value – Pre-test value) / (Pre-test value) * 100 *NB: Set a minimum number of training sessions that must be completed before a staff member qualifies for this indicator.*	% change in survivor centred values reported by SRH staff	Pre and post-tests (value clarification exercises), Training attendance records
Outcome: % change in referrals from SRH teams to GBV activities after health staff have completed a safe referral training	(number of referrals from SRH teams to GBV activities in 3 months after safe referral training) / (number of referrals from SRH teams to GBV activities in three months before safe referral training) *100 *NB: Review whether other external factors may have affected any identified changes in the referral rate.*	% change in GBV referrals after safe referral training	Referrals records

Indicator	Indicator Definition	Unit of Measurement	Possible Means of Verification (MoV)
Output: # of GBV staff who participated in MISP or SRH basics trainings (disaggregated by sex and age)	(# of GBV staff who participated in MISP or SRH basics trainings) [Refer to the core package of training in Annex K]	# of GBV staff who are trained in MISP or SRH basics	Training records
Output: # of health facilities with SRH staff who are trained on delivering non-specialised GBV activities (disaggregate trained SRH staff by sex and age)	(# of health facilities with SRH staff trained on delivering non-specialised GBV activities)	# of health facilities with staff trained on delivering non-specialised GBV activities	Training records
Accountability			
Quality: % of the received complaints and feedback relating to integrated GBV and SRH approaches that were successfully closed within agreed time frames	(# of received complaints and feedback relating to integrated GBV and SRH approaches that were closed within agreed time frames) / (total # of received complaints and feedback relating to integrated GBV and SRH approaches) * 100	% of complaints and feedback relating to GBV and SRH integrated approaches that was closed within agreed time frames	Complaint and feedback tracker
Collaboration			
Outcome: % of proposals including GBV and SRH components that were jointly designed by the GBV, SRH, and MEAL teams	(# of proposals that have been designed jointly by GBV, SRH and MEAL teams) / (# of proposals which include both GBV and SRH components) *100 *NB: 'Jointly designed' includes having at least one integrated outcome indicator.*	# of proposals designed using integrated collaboration	Proposals
Output: # of joint learning workshops that include both GBV and SRH staff *NB: Can be adapted to measure other forms of collaboration, such as joint planning workshops, integrated team meetings etc.*	(# joint learning workshops that include both GBV and SRH staff)	# of joint learning workshops that include both GBV and SRH staff	Workshop attendance records

Sample Log Frame Components

Sample Objective for an Integrated Project	Adolescent girls have increased access to sexual and reproductive health and specialised GBV services free of discrimination and violence, improving their safety, well-being and reproductive health outcomes Sample Indicators (depending on activities): Adolescent Girls Birth Rate; Proportion of women aged 18-24 who were married before the age of 18		
Integrated GBV and SRH Programme Outcome	**Sample Programme Outputs**	**Sample Output Indicators, Baselines and Targets**	**Partner Contributions**
Sample Outcome: Strengthened integration of GBV and SRH services targeting adolescent girls. **Adolescent girls, especially the most vulnerable, have increased access to integrated SRH and GBV services. Integrated SRH and GBV services are provided in a timely, dignified, and confidential manner.** Sample Indicators: • % of SRH staff members who reported increased survivor-centred values after completing GBV Basics Training • % of service delivery points that provide integrated GBV and SRH activities for adolescent girls • Satisfaction rates of adolescent girls accessing programming that uses an integrated GBV and SRH approach • % increase in referrals from SRH teams to GBV activities, and vice versa, after GBV and SRH have received the core GBV and SRH trainings for integrated approaches • % of pregnant girls accessing adolescent girls' GBV programmes who are referred for antenatal care (disaggregated by age) • % of targeted national actors who demonstrate increased knowledge of integrated GBV and SRH approaches	Example One: Strengthened capacity of partners to deliver integrated, high-quality GBV and SRH activities targeting adolescent girls	• Sample Indicators • Number of partners trained on the core trainings for integrated GBV and SRH approaches (Annex K). *Baseline: 'XX'; Target: 'XX'* • Number of partners trained to deliver integrated GBV and SRH programmes targeting adolescent girls, such as the AMAL programme *Baseline: 'XX'; Target: 'XX'* Number of partner-led risk assessment(s) which include an assessment of GBV *and* SRH risks affecting adolescent girls *Baseline: 'XX'; Target: 'XX'* • Number of Youth Centres operated by partners which offer GBV *and* SRH services tailored for adolescent girls *Baseline: 'XX'; Target: 'XX'*	Different government entities, medical coalitions, GBV and SRH sub-working groups, international and national NGOs
	Example Two: Improved referral pathways between new or existing GBV and SRH services to ensure that timely, confidential, and safe referrals occur bi-directionally	Sample Indicators • Number of health facilities where 90% of staff have been trained on safe referrals *Baseline: 'XX'; Target: 'XX'*	

Integrated GBV and SRH Programme Outcome	Sample Programme Outputs	Sample Output Indicators, Baselines and Targets	Partner Contributions
		• Number of WGSSs where GBV case workers have been trained on referrals to adolescent SRH services • *Baseline: 'XX'; Target: 'XX'* • Number of integrated, inter-agency GBV and SRH service mappings focusing on services for adolescent girls *Baseline: 'XX'; Target: 'XX'*	
	Example Three: Strengthened capacities of national GBV and SRH actors to prevent and respond to child marriage and reproductive rights violations affecting adolescent girls through integrated advocacy, capacity-building, and coordination	Sample Indicators Number of integrated analytical GBV and SRH products to strengthen integrated response (policy briefs/advocacy documents/ reports) *Baseline: 'XX'; Target: 'XX'* • Number of national advocacy events on cross linking topics (e.g. child marriage, adolescent birth rates, etc.) *Baseline: 'XX'; Target: 'XX'* • Number of national actors trained on the reproductive health needs of adolescent girls *Baseline: 'XX'; Target: 'XX'* • Number of national actors trained on responding to child marriage *Baseline: 'XX'; Target: 'XX'*	Different government entities, women's rights organisations, justice organisations, GBV and SRH sub-working groups, national and international NGOs
	Example Four: Adolescent girls have increased access to GBV and SRH activities tailored to their age as part of an integrated GBV and SRH approach, with a focus on reducing child marriage and adolescent pregnancy	Sample Indicators • Number of GBV and SRH staff from partner organisations who are trained to jointly deliver child marriage awareness *Baseline: 'XX'; Target: 'XX'* • Number of adolescent girls who receive awareness sessions on family planning in WGSS, tailored to their age *Baseline: 'XX'; Target: 'XX'* • Number of adolescent girls who received integrated SRH and GBV IEC materials on child marriage, tailored to their age (disaggregated by age) *Baseline: 'XX'; Target: 'XX'* • Number of adolescent girls who participate in youth-led programming that aims to increase awareness of adolescent girls' reproductive rights *Baseline: 'XX'; Target: 'XX'*	

Annex H: **Additional resources and guidance**

Please note that this is not an exhaustive list of resources, but only a summary of key resources.

Guidance for GBV and SRH in Emergencies
Gender-Based Violence Minimum Standards
The Inter-Agency Minimum Standards for Gender-Based Violence in emergencies programming, UNFPA 2019 Minimum Standards for Prevention and Response to Gender-Based Violence in Emergencies, UNFPA 2015
GBV Case Management
GBVIMS website GBVIMS (Gender-based Violence Information Management System) Steering Committee, 2017. Interagency Gender-based Violence Case Management Guidelines: Providing Care and Case Management Service to Gender-based Violence Survivors in Humanitarian Settings.
Safe and Ethical Information Management
WHO Ethical and safety recommendations for researching, documenting and monitoring sexual violence in emergencies, WHO 2007 GBVIMS website
GBV Risk Mitigation
IASC (Inter-agency Standing Committee), 2015a. Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing risk, promoting resilience and aiding recovery GBV AOR Help Desk (2019), Mapping of Safety Audit Tools and Reports (including links to different tools). IRC (2013), GBV Assessment Tools: Safety Audit Tool
Consultation with Women and Girls
UN Women (2020), How to Promote a Gender Responsive Participation Revolution in Humanitarian Settings Plan (2021), Adolescent Girls' Consultation Toolkit.
GBV Core Concepts Training Material
IRC (2008), Core Concepts in GBV (Facilitation Guide) UNFPA (2017), Managing Gender-based Violence Programmes in Emergencies - Updated for 2017 (unfpa.org) (available in English and Arabic; self-learning) IRC (launched in 2018), Rosa Skill Building Application (self-learning)
FGM
UNICEF and UNFPA (2016), Manual on Social Norms and Change
WGSS
UNFPA (2021) Transcending Norms Gender Transformative Approaches in Women And Girls Safe Spaces In Humanitarian Settings IRC and IMC (2020), Women And Girls Safe Spaces: A Toolkit For Advancing Women's And Girls' Empowerment In Humanitarian Settings UNFPA (2015), Women and Girls Safe Spaces: A guidance note based on lessons learnt from the Syria Response.

GBV Prevention
IRC (2013), Empowering Men and Boys in Accountable Practice (EMAP) Raising Voices (different dates of publication), Sasa! programmes.
GBV and people with disabilities
Women's Refugee Commission and IRC (International Rescue Committee), 2015. Building Capacity for Disability Inclusion in Gender-Based Violence Programming in Humanitarian Settings: A Toolkit for GBV Practitioners. New York: Women's Refugee Commission. https://www. womensrefugeecommission.org/component/ zdocs/ document/download/1173 Humanity and Inclusion (2020), Disability data in Humanitarian action: an e-learning toolkit for collecting data for the inclusion of people with disabilities in Humanitarian Action. The e-learning includes practical guidance on how to use the Washington Group Questions, and can be accessed here. IASC Guidelines (2019), Inclusion of Persons with Disabilities in Humanitarian Action Women's Refugee Commission (2015), I See That It Is Possible: Building Capacity for Disability Inclusion in Gender-based Violence (GBV) Programming in Humanitarian Settings; Including Adolescent Girls with Disabilities in Humanitarian Programs Women's Refugee Commission (2016), Working to Improve Our Own Futures: Inclusion of Women and Girls with Disabilities in Humanitarian Action
Mobile Units Guidance
IRC (2018), Guidelines for Mobile and Remote Gender-Based Violence (GBV) Service Deliver: En, Ar
PFA
WHO (2011), Psychological First Aid: Guide for Field Workers: En, Ar IFRC (2018),Guide to Psychological First Aid: En, Ar IASC (Inter-agency Standing Committee), 2015b. Pocket Guide: How to support survivors of gender-based violence when a GBV actor is not available in your area En, Ar
Older Women
VOICE, HIF, ELRHA (2019), Disability and Older Age Inclusion in Gender-Based Violence (GBV) Humanitarian Interventions
Adolescent Girls
UNFPA (2017), Listen, Engage and Empower: A strategy to address the needs of adolescent girls in the whole of Syria Plan (2020), Adolescent Programming Toolkit, IRC (2016): My Safety, My Wellbeing: Equipping adolescent girls with key knowledge and skills to help them to mitigate, prevent and respond to gender-based violence. EN, AR UNICEF and UNFPA (2017): Adolescent Girls Toolkit IRC (2018), Girl Shine - a programme model and resource package that seeks to support, protect, and empower adolescent girls in humanitarian settings Women's Refugee Commission (2014): Strong Girls, Powerful Women: Programme planning and design for adolescent girls in humanitarian settings Girl Hub (2014), Girl Safety Toolkit Coalition for Adolescent Girls (no date), Girls in Emergencies and Humanitarian Settings Resource List IAWG (2020), Adolescent Sexual and Reproductive Health (ASRH) Toolkit for Humanitarian Settings: 2020 Edition UNFPA and CARE International (2020), Adolescent Mothers Against All Odds, https://www.care.org/our-work/disaster-response/health-in-emergencies/amal/

PSS
IRC (launched 2021), Women Rise: A Gender-Based Violence PSS Toolkit IASC (2007), Guidelines on Mental Health and Psychosocial Support in Emergency Settings.
Survivors And Children Born of Rape
UNICEF (2012), Research Toolkit: Understanding and addressing the needs of survivors and their children born of sexual violence in conflict
Menstrual Hygiene Management
UNFPA (2020) UNFPA Menstrual Hygiene Management in Emergencies. Perspectives and Practices from the Arab Region UNFPA (2021) Menstrual Hygiene Management In Emergencies Guidance Note For Integrated Programming In The Arab Region. Eng and Ara
CVA
UNFPA (2021), Guidance on Cash and Voucher Assistance (CVA)
Essential MISP Materials
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