Entry points for integrating SRH and GBV services in emergencies

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DISCLAIMERS:

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Introduction

Sexual and reproductive health (SRH) and gender equality are closely linked. The power imbalances stemming from gender inequality not only underlie gender-based violence (GBV) and increase the risk of poor SRH outcomes, but they also create obstacles that prevent women and girls from accessing SRH and GBV response services. The risks of poor SRH outcomes and GBV are increased in humanitarian contexts due to many intersecting factors, including existing patriarchal norms, the disruption of social safety nets and institutions that protect women and girls, the disruption of protective social norms, and the exacerbation of existing gender-based stereotypes, stigma and bias. In addition, the disruption of health and social work services that occur during times of crisis increases barriers to accessing life-saving SRH and GBV response services.

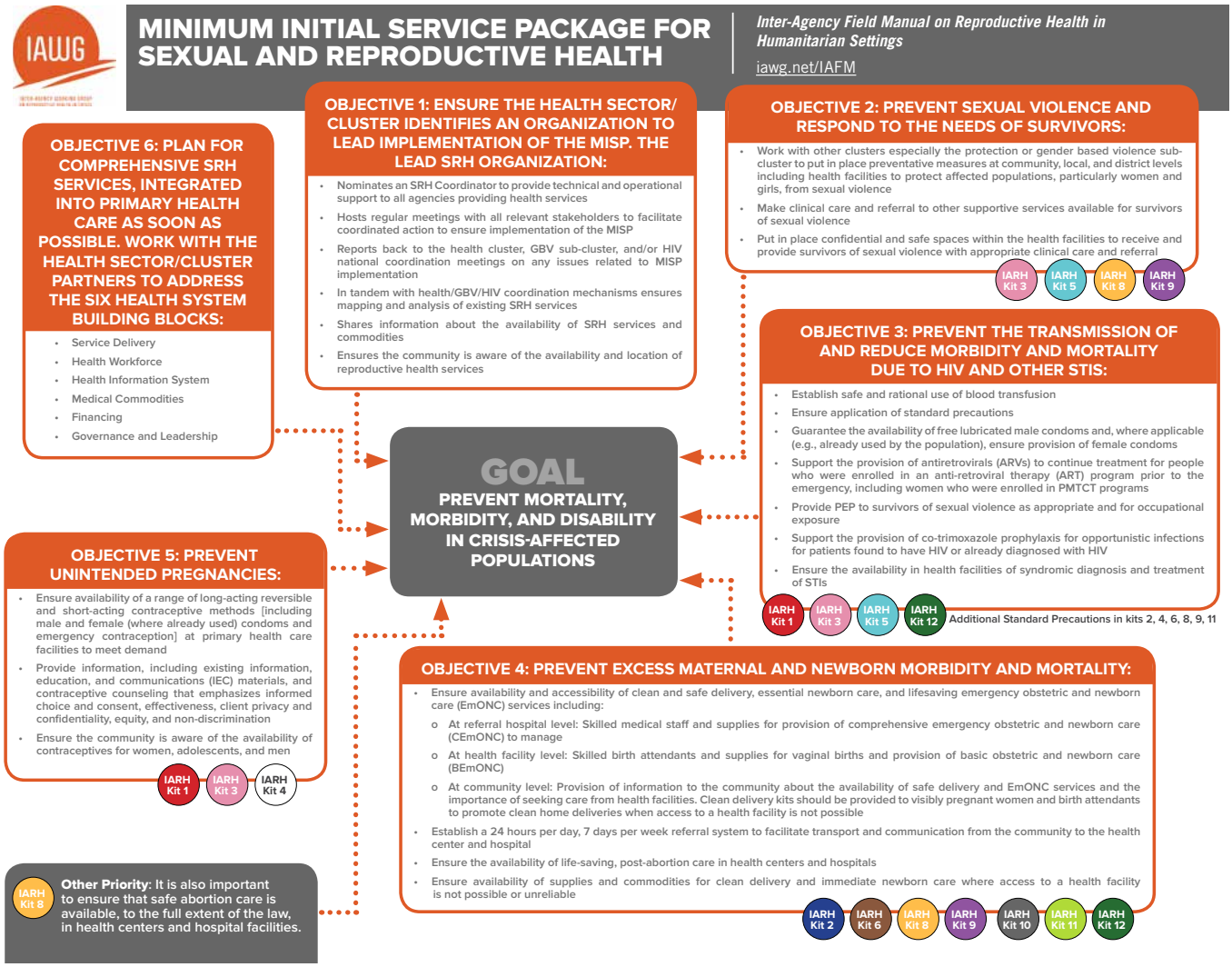
Clinical services at the community or health facility level may be the first point of entry for survivors of GBV, and healthcare providers must be attuned to signs of GBV among patients, even when they do not specifically mention this as part of their clinical history, to ensure that they receive timely and appropriate GBV case management services. On the other hand, survivors of GBV may initially seek support through shelters or women's and girls' safe spaces (WGSS), and GBV programme personnel should ensure that they are safely and confidentially linked to the healthcare system for appropriate, and at times life-saving, SRH, mental health and psychosocial support (MHPSS) and other services, in order to prevent long-term health consequences.

SRH and GBV actors should regularly review and update referral pathways and liaise with other sectors, to ensure that they remain relevant and effective in changing humanitarian contexts.

This guidance note aims to raise awareness among healthcare providers, protection staff, and SRH and GBV programme managers on the **key points where survivors of GBV may present for services**, through the health and protection systems, or through other entry points; sensitize front-line service providers on the **importance of interlinking SRH and GBV needs of survivors;** and demarcate the steps that can be taken to **support their entry into and survivor-centred referrals** within the healthcare and protection systems.

Entry points through the Minimum Initial Service Package for SRH

The Minimum Initial Service Package (MISP) for SRH in Crises is a set of essential, life-saving interventions designed to reduce maternal and newborn morbidity and mortality, and ensure access to critical SRH services during the initial stages of a humanitarian crisis.[1] Five of the six MISP objectives and the "other MISP" priority[2] focus on service delivery, and are relevant to the discussion here. While the MISP Objective 2 specifically addresses GBV (see table below), there are other MISP services where GBV survivors may present. It is important that healthcare providers are aware of the risks among their patients and have a low threshold for asking questions using trauma-informed approaches[3] to identify survivors and explore the need for safe referral to GBV case management.



Source: IAWG.

1 Inter-Agency Working Group. *Minimum Initial Service Package (MISP) for Sexual and Reproductive Health in Crisis Situations*. IAWG, 2018. Available at https://iawgfieldmanual.com/.

2 Refer to Disclaimer on page 2 (ICPD paragraph 8.25).

3 In humanitarian contexts, trauma-informed approaches take into consideration the various forms of trauma experienced by crisis-affected individuals and aim to provide sensitive, safe and dignified care that does not re-traumatize or cause further harm. For more information on trauma-informed care, see Denise E. Elliott and others. Trauma informed or trauma denied: Principles and implementation of trauma informed services for women. *Journal of Community Psychology*, vol. 33, No. 4 (July 2005). Available at https://onlinelibrary.wiley.com/doi/10.1002/jcop.20063.

MISP Objective 2: Prevent sexual violence and respond to the needs of survivors

As noted above, MISP Objective 2 is the clearest entry point for GBV survivors, as it specifically encompasses clinical management of rape and intimate partner violence (CMR-IPV) services through the health system. Health facilities should ensure that staff are trained and available 24/7 to provide clinical care for survivors of sexual assault, that equipment and supplies are available (IARH kit 3)[4] on site, and that referral networks, including for girls, men and boys, are up-to-date and functional so that survivors receive timely and appropriate care and support that they need.

In addition to ensuring safe, confidential and stigma-free access to CMR-IPV services, which includes trauma and wound care, post-exposure prophylaxis for sexually transmitted infections (STIs) and HIV, prevention of unintended pregnancies, hepatitis B and tetanus vaccinations, and psychological first aid, healthcare providers must ensure that survivors are informed of GBV case management and other available services (WGSS, MHPSS, legal, etc.) and receive appropriate referrals according to their needs and preferences. GBV case workers provide individual psychosocial support, and will assess additional needs and facilitate further survivor-centred referrals to other services, including protection and legal support and specialized MHPSS, in accordance with the individual survivor's needs, decisions and choices. In some locations, GBV case workers may be able to support with cash assistance to improve access and reduce risks.[5]

Information and sensitization on sexual violence, IPV and other forms of GBV, and where and how to access available services, including CMR-IPV and GBV case management services, can be provided through both static and mobile health services and through community outreaches coordinated with GBV response actors.

Additional information about CMR-IPV services and referrals can be found in the 2020 inter-agency guidance document *Clinical Management of Rape and Intimate Partner Violence Survivors: Developing Protocols for use in Humanitarian Settings*.[6]

MISP Objective 3: Prevent the transmission of and reduce morbidity and mortality due to HIV and other STIs

Individuals may present for clinical services with STIs or new diagnoses of HIV as a result of coerced or forced sexual encounters. People newly diagnosed with HIV or other STIs may also face increased risks of GBV during the partner notification process. While universal GBV screening is not recommended[7], healthcare providers should use trauma-informed approaches to ask patients whom they suspect of having experienced GBV, particularly adolescents and other vulnerable people, about their safety, forced or coerced sex, trafficking and other forms of GBV, and offer referrals to GBV specialists and services, such as WGSS, if survivors agree to be referred.

4 The Inter-Agency Reproductive Health (IARH) kit 3 contains equipment and supplies needed to provide CMR-IPV services for a population of 10,000 people for a period of three months. For more information on IARH kits, see United Nations Population Fund. *Inter-Agency Emergency Reproductive Health Kits for Use in Humanitarian Settings*. New York, UNFPA, 2019. Available at https://www.unfpa.org/resources/manual-inter-agency-emergency-reproductive-health-kits-use-humanitarian-settings.

5 United Nations Population Fund. Guidance: *How to Design and Set Up Cash Assistance in GBV Case Management*. New York, UNFPA, 2023. Available at https://gbvaor.net/node/1811.

6 World Health Organization. *Clinical Management of Rape and Intimate Partner Violence: Developing Protocols for Use in Humanitarian Settings*. Geneva, WHO, 2020. Available at https://www.who.int/publications/i/item/9789240001411.

7 Lara Quarterman. Review of available evidence and conditions necessary for screening for gender-based violence in antenatal healthcare settings. Geneva, Gender-Based Violence AoR, 2020. Available at https://gbvaor.net/sites/default/files/2020-07/GBV%20Screening%20in%20Antenatal%20Settings%20 29.06.20.pdf

MISP Objective 4: Prevent excess maternal and newborn morbidity and mortality

Pregnant women are at increased risk of GBV, particularly IPV, and delivery services may be the first time that a pregnant survivor is able to access the healthcare system.[8] MISP Objective 4 addresses both safe delivery and emergency obstetric and newborn care (EmONC) services. Skilled birth attendants, including midwives, nurses, medical assistants, clinical officers and doctors, should be sensitized to the risks of GBV in pregnancy and ensure clinical inquiry 9 of at-risk women and offer appropriate referrals for survivors of GBV, including IPV, based on the needs and preferences of the survivor. Healthcare workers providing maternity services should also be sensitized to the risks of other forms of GBV – including early, child or forced marriage, and forced or coerced sex – particularly among adolescents and girls, and have the skills and capacities to provide front-line support and to offer safe, client-centred referrals to GBV services to young patients who present for safe delivery, emergency obstetric care or abortion-related services[9].

While respectful maternity care (RMC)[10] is the expected standard, many women experience obstetric violence or mistreatment during childbirth. Healthcare providers should be trained on RMC and referral systems should be established to link women who have experienced obstetric violence with GBV services. The provision of cash and voucher assistance (CVA) to pregnant women as part of EmONC and safe delivery services can also be an entry point to share information about GBV and health services and to make referrals.[11] Values clarification and attitude transformation (VCAT) training is recommended to identify and address stigma and biases among front-line health workers (both clinical and non-clinical), protection workers, and SRH and GBV programme managers that may pose barriers to access.[12]

MISP Objective 5: Prevent unintended pregnancies

MISP Objective 5 focuses on ensuring that crisis-affected populations have information about and access to a mix of both short- and long-acting modern contraceptive methods to meet their demands. While routine screening for GBV is not recommended, front-line health workers working in humanitarian settings have been trained to discuss IPV, reproductive coercion and other forms of GBV, providing openings for survivors who wish to receive more information or referrals.[13] Using trauma-informed approaches during family planning counselling presents a valuable opportunity for healthcare workers to provide information on various forms of GBV, including sexual violence and IPV, and on safe and consensual sex, particularly with at-risk individuals, and, with the client's informed consent, facilitate referrals to GBV-related services as needed.

8 Ibid.

9 Refer to Disclaimer on page 2 (ICPD paragraph 8.25).

10 RMC calls for the prevention and elimination of disrespect and abuse during childbirth. It emphasizes that every woman is entitled to the highest attainable standard of health, which includes dignified and respectful care throughout pregnancy and childbirth.

11 United Nations Population Fund. *Programmatic Guidelines: Cash and Voucher Assistance (CVA) in Sexual and Reproductive Health Programming in Emergencies*. Available at https://www.unfpa.org/publications/programmatic-guidelines-cash-and-voucher-assistance-sexual-and-reproductive-health

12 Ipas. *Abortion Attitude Transformation: A Values Clarification Toolkit*. Chapel Hill, Ipas, 2018. Available at https://www.ipas.org/resource/abortion-attitude-transformation-a-values-clarification-toolkit-for-humanitarian-audiences/.

13 Ipas. Effectiveness of ARCHES in improving reproductive autonomy in humanitarian settings: Results from a pre-post study with forcibly displaced Myanmar nationals in Bangladesh. Chapel Hill, Ipas, 2022. Available at https://www.elrha.org/docs/document/2022-12-01-annex-a_research-brief_effectiveness-of-arches-in-improving-reproductive-autonomy-in-humanitarian-settings.pdf?file_url=document/16q0366q9d0af94e70csvc0350/ckzfk70e0qku1nfzj1hlehu_ylk/original?content-type=application%2Fpdf&name=2022-12-01-annex-a_research-brief_effectiveness-of-arches-in-improving-reproductive-autonomy-in-humanitarian-settings.pdf.

Other MISP Priority:
Ensure access to safe abortion care services to the full extent of the law

Ensuring access to safe abortion care (SAC) to the full extent of the law[14] in health facilities and hospitals is a priority under the MISP. Healthcare providers in humanitarian settings should be alert to the increased risk of unintended pregnancy as a result of sexual violence or forced, coerced or transactional sex and ask women and adolescents who present requesting SAC services about the need for referral to GBV prevention and support programmes using trauma-informed approaches.[15] VCAT training is recommended to identify and address abortion-related stigma and biases among front-line health workers (both clinical and non-clinical), protection workers, and SRH and GBV programme managers.[16]

14 Refer to Disclaimer on page 2 (ICPD paragraph 8.25).

15 Lara Quarterman. Review of available evidence and conditions necessary for screening for gender-based violence in antenatal healthcare settings. Geneva, Gender-Based Violence AoR, 2020. Available at https://gbvaor.net/sites/default/files/2020-07/GBV%20Screening%20in%20Antenatal%20Settings%2029.06.20.pdf.

16 Ipas. Abortion Attitude Transformation: A Values Clarification Toolkit. Chapel Hill, Ipas, 2018. Available at https://www.ipas.org/resource/abortion-attitude-transformation-a-values-clarification-toolkit-for-humanitarian-audiences/.

Entry points through non-MISP health services

Antenatal and postnatal care

Because the risk of GBV is increased during pregnancy, and because many women have their only interactions with the health system during pregnancy and childbirth, healthcare workers should be trained on GBV, which enables them to identify, screen and be able to support a disclosure of GBV, including IPV, during antenatal care (ANC) and postnatal care (PNC) visits,[17] and make appropriate referrals as necessary and desired by the survivor, including when providing CVA, to facilitate access to ANC and PNC.[18] ANC and PNC also provide opportunities for healthcare workers to raise awareness about GBV, provide information about GBV prevention and response services available within the community, camp, etc., and facilitate referrals to services, based on the individual's consent.

Immunization and child health services

Mothers may not seek healthcare for themselves, but may seek immunization and child healthcare services, where they can be reached with information and provided with referrals for SRH and GBV services. Static and outreach teams can be trained to deliver SRH and GBV messaging, and safe referrals, while discreetly providing referrals for those who require further support, based on existing referral pathways.

Nutrition services

GBV, and particularly IPV against mothers, is associated with low birthweight, poor breastfeeding practices and poor growth indicators, such as stunting, among their children.[19] Girls and adolescents who have experienced childhood sexual abuse, sexual assault and IPV may develop obesity in adolescence or early adulthood, while child marriage and early age at first pregnancy may be linked to undernutrition.[20] Healthcare workers providing nutrition services should be aware of the associations between GBV and nutritional outcomes, and use survivor-centred approaches to identify and safely refer survivors to GBV case management and SRH services. In turn, GBV actors should collaborate with nutrition teams in the design and monitoring of programmes in order to minimize risks to women and girls, meet the needs of survivors (particularly in regards to timing and location of services and reducing missed opportunities, and survivor-centred referrals).

17 World Health Organization. *Responding to Intimate Partner Violence and Sexual Violence Against Women: WHO Clinical and Policy Guidelines*. Geneva, WHO, 2013. Available at https://iris.who.int/bitstream/handle/10665/85240/9789241548595_eng.pdf.
Lara Quarterman. Review of available evidence and conditions necessary for screening for gender-based violence in antenatal healthcare settings. Geneva, Gender-Based Violence AoR, 2020. Available at https://gbvaor.net/sites/default/files/2020-07/GBV%20Screening%20in%20Antenatal%20Settings%2029.06.20.pdf.

18 United Nations Population Fund. *Programmatic Guidelines: Cash and Voucher Assistance (CVA) in Sexual and Reproductive Health Programming in Emergencies*. Available at https://www.unfpa.org/publications/programmatic-guidelines-cash-and-voucher-assistance-sexual-and-reproductive-health

19 United Nations Children's Fund. *A rapid evidence assessment on exposure to gender-based violence and children's nutrition*. New York, UNICEF, 2022. Available at https://www.unicef.org/media/132166/file/A%20RAPID%20EVIDENCE%20ASSESSMENT%20ON%20EXPOSURE%20TO%20%20GENDER-BASED%20VIOLENCE%20AND%20CHILDREN%E2%80%99S%20NUTRITION.pdf.

20 Luissa Vahedi and others. Childhood and adolescent nutrition outcomes among girls exposed to gender-based violence: A rapid evidence assessment of quantitative research. *PLOS One*, vol. 18, No. 2 (February 2023). Available at https://pmc.ncbi.nlm.nih.gov/articles/PMC9934406/.

Community health services

Community health workers (CHWs) are generally trusted individuals within the community and may be first responders during emergencies.[21] In some contexts, CHWs provide basic SRH services, such as family planning methods and basic antenatal care, and may be the first point of contact for individuals experiencing GBV or needing SRH services. CHWs should be aware of signs of GBV, including IPV, and know how and where to make safe, confidential and timely referrals to specialized services.[22]

Health outreaches and mobile health service providers should incorporate messaging to raise awareness on both SRH and GBV, including where and how to seek services.[23]

21 Maryse Kok. The role of CHWs in fragile and conflict-affected settings, 15 January 2021. *CHWCentral*. Available at https://chwcentral.org/twg_article/the-role-of-chws-in-fragile-and-conflict-affected-settings/.

22 Kalin Werner and others. The role of community health worker-based care in post-conflict settings: a systematic review. *Health Policy and Planning*, vol. 38, No. 2 (September 2022). Available at https://pmc.ncbi.nlm.nih.gov/articles/PMC9923383/.

23 Inter-Agency Standing Committee. *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action*. Geneva and New York, IASC, 2019.
Available at https://gbvguidelines.org/wp/wp-content/uploads/2015/09/2015-IASC-Gender-based-Violence-Guidelines_lo-res.pdf.

Entry points through GBV response services in the Minimum Standards for GBV in emergencies

The Inter-agency Minimum Standards for Gender-Based Violence in Emergencies is a set of 16 standards that guide agencies implementing specialized GBV programmes for prevention and response to GBV and the delivery of multisectoral services.[24]

Standard 4: Healthcare for GBV survivors

GBV Standard 4 requires that *GBV survivors access quality, survivor-centred health care, including health services for sexual and intimate partner violence and other forms of GBV, and referrals to prevent and/or reduce the effects of violence*.[25] As such, any survivor who receives GBV services should be offered access to appropriate, survivor-centred healthcare services, including SRH services.

Standard 5: Mental health and psychosocial support (MHPSS)

SRH providers can support semi- and structured psychosocial support sessions offered through GBV programmes by answering SRH-related questions that arise during the sessions and facilitating referrals to survivor-centred SRH services.

Individuals seeking mental health services can also be identified as GBV survivors requiring SRH and GBV services. Mental health service providers should collaborate closely with both SRH and GBV service providers to support safe, timely, survivor-centred referrals of survivors. More information on integrating MHPSS into SRH and GBV services can be found in the *Guidance to support the mental health and psychosocial well-being of GBV and SRH service users in humanitarian settings*.

Standard 6: Gender-based violence case management

GBV case management is a collaborative process that engages a range of service providers to meet a survivor's immediate needs and support long-term recovery.[26] A GBV survivor's first point of contact may be through GBV case management services, and the GBV caseworker should refer the survivor to SRH or other prioritized services if the survivor so wishes, while ensuring informed consent, confidentiality and non-discrimination.[27] Cash assistance may be

24 Gender-Based Violence Area of Responsibility (UNFPA). *16 Inter-agency Minimum Standards for GBV in Emergencies Programming*. 2019. Available at https://gbvaor.net/gbviems.

25 Gender-Based Violence Area of Responsibility (UNFPA). *The Inter-Agency Minimum Standards for Gender-Based Violence in Emergencies Programming*. Geneva, GBV AOR, 2019 https://gbvaor.net/sites/default/files/2019-11/19-200%20Minimun%20Standards%20Report%20ENGLISH-Nov%201.FINAL_.pdf.

26 Gender-based Violence Information Management System Steering Committee. *Inter-agency Gender-Based Violence Case Management Guidelines: Providing Care and Case Management Services to Gender-Based Violence Survivors in Humanitarian Settings*. 2017. Available at https://www.gbvims.com/wp/wp-content/uploads/Interagency-GBV-Case-Management-Guidelines_Final_2017.pdf.
Gender-based Violence Information Management System Steering Committee. eLearning Inter-Agency GBV Case Management Guidelines, no date. Available at https://www.gbvims.com/inter-agency-gbv-case-management-guidelines-e-learning/.

27 Gender-Based Violence Area of Responsibility (UNFPA). *The Inter-Agency Minimum Standards for Gender-Based Violence in Emergencies*

provided as part of an individual case plan to facilitate access to relevant GBV and SRH services.[28]

Standard 7: Women and girls' safe spaces

WGSS are considered a minimum component of GBV programming in emergency settings, and have been used for decades as a secure environment for women and girls to report protection concerns, express their needs, receive services, engage in empowerment activities and connect with the community.[29] Although not all WGSS users have experienced GBV, WGSS provide an entry point where GBV survivors may present for survivor-centred services, including GBV case management and SRH services. Integrating SRH services into WGSS can also provide women and girls the opportunity to discreetly receive SRH information and services, such as contraception and treatment of STIs, reducing barriers to access and promoting a more holistic approach to women's health and safety.

Programming. Geneva, GBV AOR, 2019. Available at https://gbvaor.net/sites/default/files/2019-11/19-200%20Minimun%20Standards%20Report%20ENGLISH-Nov%201.FINAL_.pdf.

28 United Nations Population Fund. *Guidance: How to Design and Set Up Cash Assistance in GBV Case Management*. New York, UNFPA, 2023. Available at https://gbvaor.net/node/1811.

29 International Rescue Committee and others. *Women and Girls Safe Spaces: A Toolkit for Advancing Women's and Girls' Empowerment in Humanitarian Settings*. 2020. Available at https://gbvaor.net/sites/default/files/2020-02/IRC-WGSS-Toolkit-Eng.pdf.

Entry points through cash and voucher assistance (CVA)

CVA is an assistance modality – not a standalone intervention – for advancing GBV and SRH programme outcomes[30] that can complement essential services by addressing financial barriers and enabling access to services.[31] For SRH, cash and vouchers can help cover out-of-pocket costs related to accessing SRH services, including transport, accommodation, lodging and food, as well as the costs of relevant SRH items such as medications and menstrual pads. Conditional CVA can also serve as an incentive to accessing SRH services such as ANC, PNC and facility-based deliveries.[32] Details on how CVA can contribute to MISP objectives is found in the Programmatic Guidelines: CVA in Sexual and Reproductive Health Programming in Emergencies. For GBV survivors and those at high risk of GBV enrolled into GBV case management services, cash given within the context of a one-to-one case management process can support urgent needs such as shelter, legal or health services, and can help survivors' recovery.[33]

When well integrated into other comprehensive SRH and GBV programming, CVA can serve as a valuable entry point for sharing information on GBV and SRH, and making referrals to key services.[34]

Entry points through other sectors

Entry points for SRH and GBV services can be found in other humanitarian sectors such as camp management, education, child protection, water and sanitation, food distribution, shelter, livelihoods, etc. These sectors often have regular contact with women, girls and vulnerable populations, allowing for the possibility of sensitizing about SRH and GBV-related issues, and in some cases identifying survivors, as well as providing confidential referrals to appropriate care and support services through established referral pathways.

Integrating GBV and SRH messaging and response across these sectors enhances early identification, reduces stigma, and promotes timely referrals and access to life-saving care. The IASC GBV guidelines provide important insights on how to integrate both GBV and SRH responses effectively. WASH actors, for example, can incorporate SRH and GBV education into hygiene promotion; emergency shelter staff can provide discreet referrals for SRH and GBV services; education staff and child protection workers can guide adolescents and caregivers to appropriate services; and livelihood initiatives and cash assistance also help GBV survivors access life-saving support. When these sectors are well coordinated and linked to functional referral pathways, they can be powerful entry points to improve awareness of and access to life-saving SRH and GBV services for women and girls.

30 Royal Tropical Institute. *Literature Review: Evidence and Feasibility of Cash and Voucher Assistance for Sexual Reproductive Health Services in Humanitarian Emergencies*. Amsterdam, Royal Tropical Institute, 2020. Available at https://www.kit.nl/wp-content/uploads/2020/11/CVA-for-SRH-in-Humaniarian-Settings-Literature-Review.pdf.

31 United Nations Population Fund. *Stronger Together: Integrating Gender-based Violence and Sexual and Reproductive Health Approaches in Humanitarian Settings*. New York, UNFPA, 2024. Available at https://arabstates.unfpa.org/sites/default/files/pub-pdf/gbv_srh_strong_together_33_b_pages.pdf.

32 United Nations Population Fund. Programmatic Guidelines: Cash and Voucher Assistance (CVA) in Sexual and Reproductive Health Programming in Emergencies. Available at https://www.unfpa.org/publications/programmatic-guidelines-cash-and-voucher-assistance-sexual-and-reproductive-health

33 Gender-Based Violence Area of Responsibility (UNFPA). *The Inter-Agency Minimum Standards for Gender-Based Violence in Emergencies Programming*. Geneva, GBV AOR, 2019. Available at https://gbvaor.net/sites/default/files/2019-11/19-200%20Minimun%20Standards%20Report%20ENGLISH-Nov%201.FINAL_.pdf.

34 United Nations Population Fund. *Guidance: How to Design and Set Up Cash Assistance in GBV Case Management*. New York, UNFPA, 2023. Available at https://gbvaor.net/node/1811.

Conclusion

Ensuring access to SRH and GBV services in humanitarian settings is essential to safeguarding the health, rights and dignity of people affected by crises. Identifying key entry points across both clinical and non-clinical services and regularly reviewing and updating referral pathways support survivors in receiving life-saving, survivor-centred care, and help reduce missed opportunities for intervention. Cross-sectoral collaboration – including the sensitization of clinical and non-clinical teams, as well as the establishment of functional referral systems – is vital to ensuring that individuals in need of GBV or SRH services do not fall through the cracks. This integrated approach not only enhances health outcomes, but also mitigates the risk of violence, thereby empowering women and girls in some of the most vulnerable contexts.

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