Guidance note on
SRH-GBV integration models

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1. Introduction

Humanitarian crises fundamentally disrupt the social structures, institutions and community networks that ordinarily provide protection, access to life-saving services such as healthcare, to justice and information, and disrupt solidarity for affected populations.[1, 2, 3] In these contexts, humanitarian responses frequently fail to adequately address how women and girls experience crises differently and more severely than their male counterparts, or recognize the additional barriers women and girls face in accessing essential services and resources, including basic survival needs. Gender-based violence (GBV) becomes increasingly prevalent during humanitarian emergencies, rooted in gender inequality and exacerbated by patriarchal systems that systematically restrict women and girls' autonomy through limited access to sexual and reproductive health (SRH) and GBV response services. The consequences of GBV extend far beyond immediate physical harm, encompassing severe emotional and social impacts including unwanted pregnancies, community stigmatization, depression and, in extreme cases, death. Concurrently, SRH-related complications represent the leading cause of mortality and morbidity among women and girls of reproductive age globally, with humanitarian settings presenting particularly acute risks with maternal mortality rates of 504 deaths per 100,000 live births compared with fragile settings (368) and non-conflict and non-fragile settings (99).[4]

Current humanitarian programming is guided by established frameworks including the GBV Minimum Standards,[5] the Minimum Initial Service Package (MISP)[6] and UNFPA-UNHCR-WHO's Clinical Management of Rape and Intimate Partner Violence Survivors.[7] However, ensuring meaningful access to quality services that align with these standards for women and girls in all their diversity remains challenging when interventions operate in silos. Recent years have witnessed growing recognition of the benefits of humanitarian programming that prioritizes shared, collective outcomes for the health and safety of diverse women and girls rather than sector-specific approaches.[8] In combination with the 2025 humanitarian reset and sector-wide funding cuts, these shifts have illuminated the significant advantages of integrated, women and girl-centred SRH and GBV programming and the necessity to work more efficiently with the limited resources available.

This technical guidance aims to provide implementers with an overview of a variety of field-tested integrated SRH and GBV programming. It also touches briefly on the rationale for integrating SRH and GBV programming in humanitarian settings and ensuring programming remains accountable to the women and girls it seeks to serve. For more ideas from the Arab states region on implementing GBV or Child Protection-SRH Integration, see the tool, "*Stronger Together: Integrating Gender-based Violence and Sexual and Reproductive Health Approaches in Humanitarian Settings*" (UNFPA, 2024).

1 IRC, *Our lives are integrated, our needs are integrated, our program and work should be integrated* (New York, 2022). Available at https://gbvresponders.org/wp-content/uploads/2023/12/IRC_GAC_External_Assessment_of_SRH_WPE_Integration_Programming_ENG.pdf (accessed on 12 July 2025).

2 Global Health Cluster, *Best practices linking SRH GBV coordination in emergencies*, no date. Available at https://healthcluster.who.int/docs/librariesprovider16/meeting-reports/best-practices-linking-srh-gbv-coordination-in-emergencies--report-april-2025.pdf (accessed on 12 July 2025).

3 IRC, *Research Report on Integrated GBV and SRH Approaches from Women in Pakistan and South Sudan* (2024).

4 Cresswell JA, Alexander M, Chong MYC et al. Global and regional causes of maternal deaths 2009-20: a WHO systematic analysis. *Lancet Glob Health*. 2025 Mar 7:S2214-109X(24)00560-6. doi: 10.1016/S2214-109X(24)00560-6.

5 GBV AoR, *Minimum standards for Gender-Based Violence in Emergency Programming* (2019). Available at https://www.unfpa.org/minimum-standards (accessed on 12 July 2025).

6 IAWG, *Minimum Initial Service Package for Sexual and Reproductive Health* (no date). Available at https://www.unfpa.org/resources/minimum-initial-service-package-misp-srh-crisis-situations (accessed on 12 July 2025).

7 UNFPA-UNHCR-WHO, *Clinical management of rape and intimate partner violence survivors* (2020). Available at https://www.who.int/publications/i/item/9789240001411 (accessed on 12 July 2025).

8 UNFPA, *Stronger Together: Integrating Gender-based Violence and Sexual and Reproductive Health Approaches in Humanitarian Settings* (New York, 2024) Available at https://arabstates.unfpa.org/en/publications/stronger-together-integrating-gender-based-violence-and-sexual-and-reproductive-health (accessed on 12 July 2025).

This document refers to women and girls as the primary targets of integrated SRH and GBV services. This is due to structural and systemic gender inequality and discrimination, which leads to significantly higher risks of GBV and to a lack of safe and equitable access to SRH services for women and girls compared with men and boys. People with diverse sexual orientation, gender identity, gender expression, and sex characteristics (SOGIESC) also face heightened risks and have the right to comprehensive SRH and GBV services and programming during crises and displacement. Finding safe and appropriate entry points should be explored as part of integrated SRH and GBV programming.

In this Guidance note, the term SRH includes Sexual and Reproductive Health and Rights (SRHR). The rights aspect is crucial because it frames sexual and reproductive health not merely as services or needs, but as fundamental human entitlements grounded in dignity, equality and autonomy.

1.1 Methodology

This technical guidance was developed through consultations with 16 International Rescue Committee (IRC) country programmes, two pilot countries (Mali and Tanzania), and an online desk review. It builds on IRC's experiences of more than a decade of intentionally integrating SRH and GBV programming in various humanitarian contexts combined with existing research, case studies, guidance notes, website content, presentations and policy documents (published and unpublished) by international non-governmental organizations (INGOs), the United Nations Population Fund (UNFPA), the GBV Area of Responsibility (AoR), and humanitarian consortia in the period from 2019 to 2025. Inclusion criteria were mainly resources containing models for integrated SRH and GBV programming for women and girls in humanitarian settings. Most of the resources used focus on SRH-GBV integration but also wider health and protection efforts. Specific text and illustrations on integration models, their rationale and ways of centring women and girls were compiled and analysed, and artificial intelligence was used to refine the final language. The document underwent a final, comprehensive review by IRC and UNFPA technical staff.

2. Rationale for SRH-GBV integration

SRH and GBV outcomes are intrinsically linked, as both are underpinned by gender inequality, discrimination and harmful social norms.[9, 10] In humanitarian contexts, these inequalities deepen, driving increases in multiple forms of GBV while simultaneously heightening risks of SRH-related complications. The same women and girls who require GBV prevention and response services often also need timely, safe, and confidential access to SRH care. Addressing these needs in isolation can result in missed opportunities for life-saving interventions and reduced overall impact.

Integrated SRH and GBV services and programming offer significant benefits for women and girls' safety, health and well-being. Well-designed models can: 1) reduce barriers to access and ensure timeliness of critical services, particularly in highly insecure settings; 2) improve service uptake, adherence to follow-up care and continuity of support across SRH and GBV services; 3) increase efficiency by reducing the need for multiple service visits and strengthening referral pathways and 4) enhance cross-sector responsiveness for specific populations through shared objectives, feminist principles[11] and women-centred approaches.

Kwizera Zefrine, a 34-year-old mother of six, fled Burundi to Nduta Refugee Camp in Tanzania after being abandoned by her husband. Life in the camp was marked by extreme hardship, dependence on food distributions and exposure to cultural barriers that discouraged women from seeking SRH services or challenging GBV. After facing further abuse from a new partner, she sought help through IRC's Women's Empowerment and Protection (WPE) activities, supported by the United Nations High Commissioner for Refugees (UNHCR) and the European Civil Protection and Humanitarian Aid Operations (ECHO), which offered her legal assistance, SRH and GBV awareness, and a chance to participate in livelihood programmes such as basket weaving. These opportunities allowed her to build friendships, gain confidence in her reproductive choices and break free from cycles of violence and dependency.

Through economic empowerment and skills training, Kwizera transformed her life from one of survival to self-reliance. Selling baskets provided her with a steady income to support her children and reduced her dependence on aid distributions, while SRH and GBV awareness enabled her to safeguard her rights and make informed decisions about her body and future. Her story reflects the wider impact of the integrated SRH and GBV programming in Nduta Camp, which has equipped hundreds of women with knowledge, skills and collective solidarity. By combining economic empowerment with health and rights awareness, the programme has created lasting change, enabling women to resist abuse, secure independence and build sustainable futures for themselves and their families.

SRH interventions inherently uphold the rights to bodily autonomy, informed decision-making about sexuality, reproduction, and freedom from coercion, violence and discrimination. These rights are firmly linked to GBV, making GBV prevention and response essential components of comprehensive SRH, just as SRH services are a critical entry point for identifying and supporting GBV survivors and upholding women and girls' empowerment. Integrated models build on the strengths of both sectors and provide a more holistic, woman-centred continuum of care. Moreover, integrated SRH and GBV programming reinforces service sustainability during emergencies when women- and girl-focused services often struggle to survive independently. By combining resources, expertise and delivery mechanisms, integration has the potential to increase resilience, cost-effectiveness, and reach.[12]

9 UNFPA, *Delivering integrated services for gender-based violence and sexual reproductive health and rights* (2019). Available at https://myanmar.unfpa.org/en/publications/case-study-delivering-integrated-services-gender-based-violence-and-sexual-reproductive#:~:text=This (accessed on 12 July 2025).

10 Countdown 2023 Europe, *Sexual and Reproductive Health and Rights (SRHR) must be part of the Women, Peace, and Security (WPS) agenda* (New York, 2024). Available at https://www.countdown2030europe.org/wp-content/uploads/2024/04/FACTSHEET-WPS-SRHR-factsheet_v4.pdf (accessed on 12 July 2025).

11 "Feminist principles" refers to approaches that recognize and address unequal power relations and structural barriers to gender equality, promote the meaningful participation and leadership of women and girls, apply an intersectional analysis of discrimination and exclusion, and strengthen accountability to affected populations. In this guidance note, these principles complement survivor-centred, rights-based, gender-responsive and women-centred programming.

12 Global Health Cluster, *Joint Operational Framework* (2023). Available at https://healthcluster.who.int/publications/m/item/health-and-protection-joint-operational-framework (accessed on 12 July 2025).

3. The role of women and girls when setting up integrated SRH and GBV programming

The meaningful involvement of women and girls, and the women-led organizations (WLOs) that represent them, is essential to the design, delivery, and monitoring of integrated SRH and GBV programming in humanitarian settings.[13] Women and girls hold unique, context-specific knowledge of the risks, barriers, and social norms shaping their access to services. Their insights ensure interventions are women-centred, culturally relevant and responsive to diverse needs, rather than replicating externally driven models.[14, 15, 16, 17, 18]

Lesson learned

In Tanzania, the Women and Girls Safe Space (WGSS) had a room labelled SRH, which women and girls gave feedback to change as the title was stigmatizing. Be sure to not label rooms or buildings as "GBV" or using other potentially stigmatizing language which may prevent clients from seeking services.

Humanitarian contexts often restrict women's mobility and expose them to physical and emotional risks when seeking services, particularly where male staff, male relatives or public exposure could reveal their need for family planning, safe abortion care or GBV support.[19] Integrated service delivery, when informed by women, offers safer, more confidential pathways to care, reducing the need for multiple visits and improving access to women-centred support.[20] WLOs are well placed to facilitate such engagement, with deep contextual understanding, trusted relationships and the ability to navigate complex local power structures.[21] They are especially effective in reaching those facing intersecting discrimination, including women with disabilities, older women, women and girls who can neither read nor write, widows, and people with diverse SOGIESC. Their leadership strengthens cultural relevance, community acceptance, sustainability of integrated interventions and efforts to address harmful gender norms that external actors may struggle to confront.

13 GBV AoR, *One Stop Centers – Models, Standard Operating Procedures (SoPs) And Guidance* (2022). Available at https://gbvaor.net/node/1554 (accessed on 12 July 2025).

14 IRC, *Why not local? Gender-based violence, women's rights organisations, and the missed opportunity of COVID-19* (New York, 2021). Available at https://www.rescue.org/report/why-not-local-gender-based-violence-womens-rights-organisations-and-missed-opportunity-covid (accessed on 12 July 2025).

15 GBV AoR, *Promising practices for partnerships supporting national and local women's organisations and groups undertaking GBV prevention and response programming in emergencies* (no date). Available at https://gbvaor.net/sites/default/files/2019-11/Partnerships%20Supporting%20National%20and%20Local%20Women%E2%80%99s%20Organisations%20Undertaking%20GBV%20Prevention%20and%20Response%20Pograming.pdf (accessed on 12 July 2025).

16 CARE, *Enhancing women's participation and leadership in humanitarian action* (2024). Available at https://www.jstor.org/stable/resrep58493?seq=1 (accessed on 12 July 2025).

17 GBV AoR, et al., *Women-led organizations; Leadership in GBV coordination resource package* (no date). Available at https://gbvaor.net/node/1834 (accessed on 12 July 2025).

18 CARE, *Gender-based Violence Localization: Humanitarian Transformation or Maintaining the Status Quo?* (2019). Available at https://resourcecentre.savethechildren.net/document/gender-based-violence-gbv-localization-humanitarian-transformation-or-maintaining-the-status-quo (accessed on 12 July 2025).

19 IRC, *Being more responsive to the needs, concerns and wishes of women and girls through our WPE-SRH collaboration and shared outcomes* (2024).

20 IRC, *Practitioner Guidance Note for Integrated GBV–SRH Services: Based on Voices of Women from South Sudan and Pakistan* (2024).

21 COFEM, *Feminist movement building: Taking a long-term view* (2018). Available at https://cofemsocialchange.org/wp-content/uploads/2018/11/TS10-Feminist-movement-building-Taking-a-long-term-view.pdf (accessed on 12 July 2025).

Genuine participation must go beyond tokenistic consultation.[22] Programmes should establish ongoing feedback mechanisms through women's groups or WLO-led fora, which allow women and girls to voice concerns, suggest improvements and see their input reflected in programme changes.[23] This process must be inclusive of adolescents, women with disabilities, ethnic minorities and other groups with less voice, and hold organizations and agencies accountable for their actions by the people they support.

At its core, integrated SRH and GBV programming must be grounded in a sustained commitment to listen to, learn from, and be accountable to women and girls in all their diversity. Their expertise is central to achieving safe, effective, and transformative humanitarian outcomes.

Promising practice

In Mali, there was a hesitation by women and girls to seek support services for rape. The SRH and GBV teams discussed the hesitancy with women and girls and found they felt they would be forced to go to court. The teams conducted awareness-raising together to address the fear and explained that seeking support does not mean going to court, that confidentiality is ensured at the sites and informed the women that seeking support is important for reducing the consequences of rape.

Promising practice

Learning from implementers suggests that a baseline beyond referrals for collaboration could include mobile outreach SRH and GBV, safety audits in collaboration with women and adolescent girls, GBV screening in health facilities, Girl Shine life skills SRH sessions, awareness and education sessions on identified areas of concern.

22 CARE, *Women responders; Placing local action at the centre of humanitarian protection programming* (2018). Available at https://resourcecentre.savethechildren.net/document/women-responders-placing-local-action-at-the-centre-of-humanitarian-protection-programming (accessed on 12 July 2025).

23 IRC, *Contextualising GBV prevention and response; Rhetoric or Reality for WROs and WLOs in humanitarian contexts* (New York, 2024) Available at https://gbvresponders.org/wp-content/uploads/2025/02/WPE-Policy-Report-EN-1.pdf (accessed on 12 July 2025).

4. SRH-GBV integration models

Over the years, the integration of SRH and GBV programming has been described using many terms. At its core, SRH-GBV integration is a deliberate, strategic effort to design programming across sectors to meet the specific needs and priorities of diverse groups of women and girls, with the ultimate aim of improving their safety, health and rights.

Before exploring the different models of integration, it is important to clarify several points. **First**, coordination of services in humanitarian settings is a global requirement. Activities such as developing or updating referral pathways that link multiple sectors, or coordinating GBV/clinical management of rape (CMR) training, are not in themselves examples of integration – they are baseline humanitarian standards. **Second**, the models of SRH-GBV integration described here can be viewed as a continuum, as one often is an expansion of the previous, but there is no hierarchy. The model selected in any given context will depend on a range of factors, including available services and sectors, the strength of cross-sector partnerships, the availability of physical spaces, safety considerations, funding availability, engagement with local authorities and, most importantly, consultations with women and girls. **Third**, the health sector, even in emergencies, is structured and institutionalized differently compared with the protection sector and it is important that all health services are linked to (and supervised by) an established and functional health facility. When SRH services are provided through WGSSs or community centres it is important that handing over to WLOs is part of the exit strategy and that GBV response actors keep in mind sustainability with women's associations or WLOs. **Finally**, while GBV (protection) and SRH (health) address the needs of overlapping populations, they are fundamentally different sectors with distinct mandates, approaches, and ways of working. Integration can bring tensions, and in already high-pressure humanitarian contexts, it may feel easier to remain siloed. However, effective integration requires both sectors to build on the agreement that persons, women and girls, seeking support should not need to know if their needs correspond to protection or to health services. The services should be tailored to their needs.

Promising practice

In Yemen, teams reviewed aggregated service data and programme observations on adolescent pregnancy to inform joint programming on the risks and consequences associated with child marriage.

4.1 Overview of SRH-GBV integration models

SRH-GBV integration can be and has been described using different categories by different agencies over the years. Examples of such categories are service delivery point, level of integration (provider, facility, system) and activities. The overview below focuses on a combination of service delivery points and to some degree, also the comprehensiveness of the integration. It is important to keep in mind that within the models presented in this resource, those other categories co-exist.

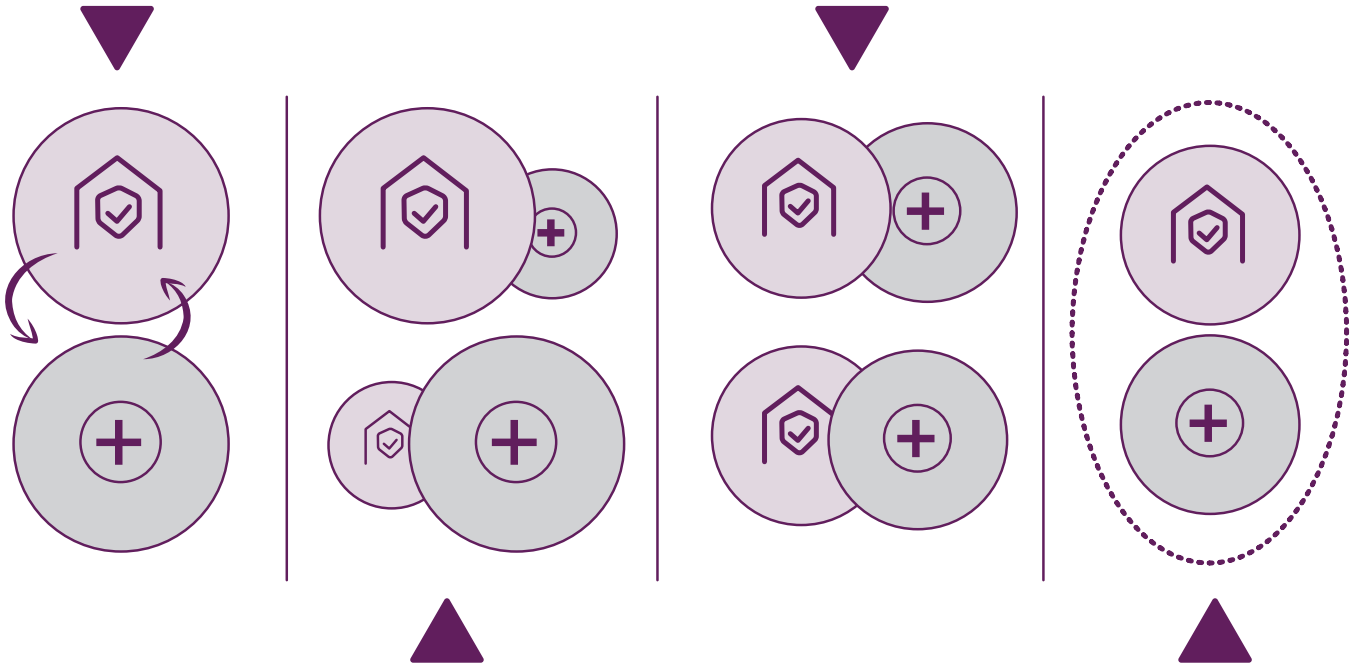
Furthermore, the models are meant to provide ideas and insight on coordination, collaboration and integration that extend beyond referrals. Models are not meant to be rigid but rather always informed by the preferences of women and girls and the practicalities of service delivery. Integrated models of SRH and GBV services have been shown to increase uptake of these often culturally sensitive services that hugely affect women and girls' protection and health outcomes.

Model 1

GBV and SRH services are located at separate delivery points. A focal point or staff member roves between the sectors for joint activities. Model 1 focuses on collaborative and coordinated outreach messages and community engagement.

Model 3

A health facility or WGSS* as the primary service delivery point (host) with dedicated/private space to provide expanded services from the other sector (visitor). This model is women- and girl-focused and has an expanded scope of core services from both sectors.
The specific services are selected in consultation with women and girls. Services are static (always available during opening hours).
3a – A health facility with GBV response services (CM, PSS)
3b – A WGSS with SRH services (e.g. STI treatment, contraception, comprehensive abortion care, CMR)



Model 2

A health facility or WGSS* as the primary service delivery point (host) with dedicated/private space to provide limited services from the other sector (visitor).
This model is survivor-focused and the visiting sector focuses on GBV core services (case management (CM) /clinical management of rape (CMR) only. Services are static (always available during opening hours).
2a – A health facility with a dedicated/private room for CM
2b – A WGSS with a dedicated/private room for CMR

Model 4

A co-owned service delivery point that hosts both sectors. Each sector provides GBV/SRH core services and interventions/activities. The space is guided by WGSS principles and while technical staff is sector specific there may be staff members that are non-sector specific. Other (sub-) sectors can 'visit' based on the needs and wishes of women and girls (e.g. nutrition, education, etc.). Model 4 is mainly used in acute emergencies or camp settings.

* WGSS are the recommended modality for GBV service provision by GBV actors. However, other protection hubs such as youth centres could also be applied.

More than one model may exist in a location to meet the SRH and GBV needs of women and girls. When SRH and GBV services are integrated successfully (regardless of the model) and sensitive services become more accessible to diverse groups of women and girls, there is a tendency for demand to increase, for referrals to be more efficient, and for the collaboration between sectors to improve. Unpublished data from UNFPA/IRC programming in Bangladesh showed that services such as contraception, safe abortion care and treatment for sexually transmitted infections (STIs) increased by 4, 28, and 53 times when offered in WGSSs compared with traditional health facilities. It is important that implementers are aware of the possible need to increase staffing to meet the demand for services.

Model 1: GBV and SRH services are located at separate delivery points. A focal point or staff member roves between the sectors for joint activities. Model 1 focuses on collaborative and coordinated outreach messages and community engagement.

Advantages	Considerations
• *For actors with existing separate sector-specific service delivery points for SRH and GBV, this may help with further integration with minimal financial input.* • *Overlapping activities with the aim of achieving overall outcomes for women and girls.* • *Improved referrals for survivors.* • *May allow SRH and GBV service providers who may not want to share their structures to improve referrals for women and girls.*	• *Women and girls have to seek comprehensive services from each sector separately, which may reduce access to services that they deem in high demand but are difficult to access due to gendered barriers (i.e. GBV case management, comprehensive abortion care and family planning). This exemplifies the need for consultation with women and girls on creating safe referrals for services with gendered barriers and for services to be responsive to women and girls' feedback.* • *Roving providers are sometimes delayed when they are asked to provide services outside of usual roving hours; service providers will need clear referral pathways for nighttime services.*

Example: Integration through GBV (IRC) and primary health care (local partner) in Lebanon:

Introduction of GBV mainstreaming in primary health facilities, which has included GBV core concept training, understanding of survivor support, and joint SRH and GBV community awareness and advocacy campaigns. Midwives also occasionally visit community centres to educate women and girls about their SRH and rights.

Examples of other activities that could be considered: combined mobile outreach, joint project development based on outcomes, safety audits in collaboration with women and adolescent girls, engagement of men and boys, Girl Shine life skills interventions, Menstrual Hygiene Management (MHM), etc.

***Promising practice:** In Tanzania, a roving SRH and GBV focal point went between the health facility and the WGSS. At the WGSS, she facilitated the SRH sessions within the Girl Shine* intervention and took the opportunity to introduce herself and the available SRH services for adolescent girls. This enabled older adolescent girls to access SRH services and health service providers noted the uptake in services and referrals in the age group.*

After holding a multi-stakeholder inception meeting with key health and protection service providers, focus group discussions were conducted with women and girls to improve access. After the marked improvement of referrals from WGSSs to SRH services, health providers from other facilities decided to replicate this model, and became involved in monthly SRH-GBV integration meetings.

** Girl Shine is a life skills intervention for adolescent girls in humanitarian settings.*

Model 2: A health facility or WGSS as the primary service delivery point (host) with dedicated/private space to provide limited services from the other sector (visitor). This model is survivor- and patient-focused and the visiting sector focuses on GBV core services (CM/CMR only). Services are static (always available during opening hours).
2a - A health facility with a dedicated/private room for CM.
2b - A WGSS with a dedicated/private room for CMR.

Advantages	Considerations
• *Easy access to GBV case management and CMR services for survivors in one place.* • *Improved referrals and follow-up with survivors.* • *Facilitates discussion on CMR-Intimate Partner Violence (IPV) care for individuals and advocates for survivors when needed.* • *Increases uptake of GBV services.*	• *One sector will provide a full range of services while the other is limited to GBV/CMR-IPV care, which may require survivors to seek comprehensive SRH and GBV services by referral.* • *For health facilities hosting GBV case management, health actors will need to ensure the room is labelled appropriately and not identified as GBV.* • *For a WGSS hosting CMR services, need to ensure the room is not labelled as CMR and seek permissions from the Ministry of Health (MoH) as needed.* • *Ensure mandatory reporting legislation does not put survivors and providers at risk.*

Example: One Stop Centres (OSCs) in Somalia (UNFPA):

The OSCs are most often affiliated with existing secondary health facilities in host community locations and in sites which are more temporary in nature. GBV survivors can access the full package of CMR services, mental health and psychosocial support and GBV case management at a single location. The physical location and connection to health facilities remove access barriers and risks of stigmatization. Given that the OSC is located within health facilities owned by the government, GBV OSCs are able to leverage the expertise of specialized health workers. (Link to Somalia case study)

Model 3: A health facility or WGSS as the primary service delivery point (host) with dedicated/private space to provide expanded services from the other sector (visitor). This model is women and girl-focused and has an expanded scope of core services from both sectors. Specific services are selected in consultation with women and girls. Services are static (always available during opening hours).
3a - A health facility with GBV response services (CM and psychosocial support).
3b - A WGSS with SRH services (e.g. STI treatment, contraception, comprehensive abortion care and CMR).

Advantages	Considerations
• *Easy access to comprehensive SRH and GBV services for women and girls in one place.* • *Improved referrals between sectors and follow-up with a wider range of SRH and GBV services.* • *Facilitates service providers to discuss a wide range of barriers women and girls may face and space to address them together in consultation with service users.* • *Increases uptake of perceived sensitive services.* • *Opportunity to create an environment that is non-sector specific and defined by women and girls.*	• *Sharing a service delivery point needs to be intentional and respectful of sectoral needs.* • *High degree of buy-in and commitment needed from all partners at all levels, including leadership.* • *Requires understanding of each sector's aims and attitude change from service providers.* • *Services provided need to align with the wishes of women and girls, global standards and funding available.*

Example: Integrated Women's Centres (IWCs) in Cox's Bazar in Bangladesh (IRC):

The women in Cox's Bazar call the IWCs 'Peace Centres'. They are essentially WGSSs where women and girls can enjoy each other's company, build networks, learn new skills while receiving GBV (response and prevention) and SRH services (CMR, contraception, STI treatment, menstrual regulation (MR), and post-abortion care (PAC). Women and girls state that they feel respected and empowered to define for themselves what kind of services they need and they are more comfortable accessing SRH services in IWCs than health facilities.

Promising practice: *In Mali, as a result of SRH-GBV integration, women made explicit requests for STI care directly to the nurse and service providers saw an influx of girls seeking STI treatment after the initial awareness-raising sessions. In addition, integration of SRH and GBV at the WGSS improved trust between providers and clients. As a result, women and girls used WGSSs as an additional entry point for SRH services.*

Model 4: A co-owned service delivery point that hosts both sectors. Each sector provides SRH/GBV core services and interventions/activities. The space is guided by WGSS principles and while technical staff are sector specific, there may be staff members that are not. Other (sub)sectors can 'visit' based on the needs and wishes of women and girls (e.g. nutrition, education, etc.). Model 4 is mainly used in acute emergencies or in camp settings.

Advantages	Considerations
• *Easy access to comprehensive SRH and GBV services for women and girls in one place.* • *Improved referrals between sectors and follow-up with a wider range of SRH and GBV services.* • *Facilitates case conferences when needed.* • *Increases uptake of perceived sensitive services.* • *Opportunity to create an environment that is non-sector specific and defined by women and girls.* • *Encourages teams to put women and girls before narrow programmatic priorities.*	• *Finding a space that can equally accommodate both SRH and GBV services and activities.* • *Sharing a service delivery point needs to be intentional and respectful to the different sectors' aims and ways of working.* • *Services provided need to align with the wishes of women and girls, global standards and funding available.* • *High degree of buy-in and commitment from all partners at all levels, including leadership.* • *Requires understanding and attitude change from service providers.* • *When the INGO leaves, considerations around handover. If handed over to the MoH, empowerment activities and women and girl focus may cease. If handed over to the WLO, SRH services may no longer be available. Need to work with WLO and MoH on how to operationalize cooperation in line with feedback from women and girls' priorities.*

Example: Comprehensive Women's Centre (CWC) in North-Eastern Nigeria (IRC):

Given the reality of restricted movement, discrimination and male control that many women and girls face in the protracted crises in Borno, it is difficult and at times dangerous for women and girls to access GBV and SRH services confidentially. GBV and SRH service providers in Borno are working under the same roof with joint objectives and a spelled out standard operating procedure (SoP), providing a full range of GBV and SRH services and activities. The CWC is managed by a non sector-specific centre manager, while technical staff have dual reporting lines that also include technical support. (Link to CWC case study)

5. Choosing an integrated SRH-GBV model

Promising practice

In Mali, consulting women and girls on the layout of the facilities informed the refurbishment to meet the need for comfort and confidentiality. Now that they have a well-equipped, confidential consultation room, women and girls have started frequenting the space.

In some contexts, SRH-GBV integration develops organically, driven by the practical need to combine efforts and improve outcomes for women and girls. As implementers become more deliberate and strategic in their integration approach, it is essential to take the right steps in the right sequence. In acute emergencies, integration can be undermined by false assumptions and the absence of meaningful consultations, resulting in programming that is less efficient and less responsive to the needs of women and girls. Stakeholders at many levels need to be included in the decision-making process (providers, coordinators, technical advisors and partners) to understand the context, increase buy-in and facilitate understanding of what value an integration model will add. The questions below are designed to guide decision-making when selecting an appropriate SRH-GBV integration model, ensuring that the chosen approach is both context-specific and women-centred:

What are the SRH-GBV needs of diverse groups of women and girls in the context?

How would women and girls want services to be delivered?

What SRH-GBV services are most important/difficult to access for women and girls?

How do women and girls want to be engaged throughout the project cycle (including accountable community-led feedback mechanisms)?

These questions can only be answered by the women and girls or the WLOs that represent them!!

What sectors/services are available in the context and how does this align with the voices of women and girls?
Who are the SRH and GBV actors in the community?

What spaces for service delivery are available?
(Health facilities, WGSSs, community centres, spaces identified by women and girls)

What funding is available? Which donors should be engaged?
Is the project funding long term?

It is important to recognize that SRH-GBV integration models are not static; they may evolve as humanitarian contexts and operational environments shift. Transitioning from one model to another is not uncommon, and such changes may be influenced by factors such as security dynamics, fluctuations in funding, the arrival or departure of implementing partners (handing over to local partners), or programme scale-up and scale-down processes. Flexibility in adapting the integration model ensures continued relevance and effectiveness in meeting the needs of women and girls.

5.1 Enablers and barriers for SRH-GBV integration

Increased awareness of the factors that facilitate or hinder SRH-GBV integrated programming is essential when selecting an appropriate integration model. If the broader environment, whether at the level of community or staff attitudes, staff capacity, organizational leadership or donor priorities is resistant to change, it may be necessary to address these barriers before implementation begins. The first enabler is clearly both SRH and GBV sectors a) working together with the common goal of gender equality and b) seeking consultation and being responsive to women and girls.

Promising practice

In both Mali and Tanzania, a number of topics were identified for cross-team training in a bid to foster integrated interventions, ensuring each team understood each other's basic concepts and work in order to provide appropriate support to each other on the common goal of facilitating access to women and girls to integrated service provision. Teams appreciated each other's support more after the series of training sessions, resulting in increased confidence in explaining the referral pathways and what services were offered by each team.

An enabling environment is characterized by dedicated and passionate staff, backed by strong technical support, who regard integration as essential to improving the safety and health outcomes of women and girls. The presence of integration focal points from each sector, supported by technical expertise on integration methodologies, ensures that coordination is not left to chance. Joint planning processes are critical. Regular integration meetings, shared work plans, aligned training calendars, joint outreach strategies, clearly defined roles and a common theory of change all contribute to creating a shared language and purpose across sectors. This coordinated approach enables the development of seamless, detailed referral pathways through regularly updated multisectoral engagement that women and girls experience as a single, coherent service rather than a series of disconnected interventions.

Perhaps most compellingly, early and continuous success stories serve as powerful catalysts for change. Tangible improvements in service uptake, safety and dignity can persuade staff, communities, and donors alike that SRH-GBV integration is not only feasible but vital. These visible gains build confidence, encourage replication, and strengthen commitment by all stakeholders to integrated models over time.

The most common integration barriers as experienced by GBV and SRH providers and programme managers are:

Staff attitudes and capacity: Gaps in staff capacity can inadvertently cause harm, often seen when health or protection staff are not adequately trained in survivor- or patient-centred approaches and feminist principles, or object to offering comprehensive abortion care to the full extent of the law. A chronic shortage of qualified female staff and fear of additional workload, combined with negative attitudes to integration and high turnover, undermines both the clinical quality of care and women's trust in services. Without consistent investment in cross-sector skills and survivor-sensitive practices, integration efforts risk falling short of their intended impact.

Organizational structure: Many organizational structures remain ill-suited to integrated programming and donor preferences for vertical funding streams reinforce these silos. Programmes that are designed without integration from the outset often generate conflicting indicators, experience procurement bottlenecks and lack the flexibility needed for cross-sector integration. Furthermore, monitoring and evaluation (M&E) systems that do not use harmonized outcome indicators limit the ability to measure and demonstrate the real impact of integrated SRH and GBV interventions.

Sector-specific terminology and culture: Differences in language, professional culture and power structures between sectors can hinder collaboration. Examples are regulations on mandatory reporting and information management systems. Diverging approaches can also lead to differing degrees of control, autonomy and decision-making power afforded to women and girls, creating friction in integrated programming.

Promising practice

Countries that have implemented SRH-GBV integration, such as Mali and Tanzania, have noted that training service providers on SRH and GBV core concepts and training safeguards at the WGSS or health facility on confidential referrals/receiving disclosures improved provider attitudes and access for women and girls to services.

Promising practice

During an SRH-GBV integration inception workshop in Tanzania, all stakeholders came together to analyse possible barriers and enablers. Stakeholders committed to integrated interventions and continued monthly meetings to discuss the evolution of the SRH-GBV integration.

Senior-level buy-in: Internal competition for resources, shifting priorities at senior management levels and short funding cycles frequently derail integration before it can take root. Without sustained commitment from leadership, integrated models are difficult to institutionalize and even harder to maintain over time.

External engagement: Externally, integration is often constrained by limited government capacity or understanding of cross-sector services, as well as by competition or reluctance among NGOs to collaborate. A lack of sustained dialogue with external partners and insufficient alignment with government priorities weaken the social licence and political support needed for integration. Community-level barriers are also significant. Conservative social norms, survivor stigma and low literacy levels can lead to rejection of integrated service entry points.

6. Conclusion

Integrating SRH and GBV programming represents both a strategic imperative and moral obligation in humanitarian contexts where women and girls face compounded vulnerabilities. This guidance has outlined four distinct integration models, from coordinated sector-specific programming to integrated women's centres providing holistic care under one roof.

Well-designed integrated approaches consistently deliver superior outcomes, improving access to life-saving services, enhancing safety and dignity, and creating efficient pathways to comprehensive care. However, successful integration requires genuine commitment to feminist principles, meaningful participation of women and girls, and sustained investment in addressing systemic barriers that perpetuate fragmented service delivery.

Most critically, there is no universal integration model. Context-specific factors, including security dynamics, community attitudes, partnerships, and the voices of women and girls must drive the selection and adaptation of approaches. Flexibility to evolve between models ensures programming remains responsive to shifting needs.

For humanitarian practitioners, the path forward requires moving beyond coordination toward deliberate integration that places women and girls at the centre of decision-making. This means investing in enabling environments with dedicated staff, technical support and collaborative cultures, while systematically addressing barriers from capacity gaps to vertical funding preferences.

Ultimately, SRH-GBV integration represents a fundamental shift towards recognizing the interconnected nature of women's experiences in crisis. When implemented with women-centred principles and accountability to women and girls, integrated programming can transform fragmented humanitarian responses into coherent, rights-affirming systems of care.

Annex 1: Abbreviations and Glossary of terms

CM	*Case management*
CMR	*Clinical management of rape*
CWC	*Comprehensive women's centre*
GBV	*Gender-based violence*
GBV AoR	*Gender-based violence Area of Responsibility*
INGO	*International non-governmental organization*
IRC	*International Rescue Committee*
IWC	*Integrated women's centre*
LGBTI	*Lesbian, gay, bisexual, transgender and intersex*
M&E	*Monitoring and evaluation*
MISP	*Minimum initial service package*
MR	*Menstrual regulation*
NGO	*Non-governmental organization*
OSC	*One-stop centre*
PAC	*Post-abortion care*
SAC	*Safe abortion care*
PSS	*Psychosocial support*
SOGIESC	*Sexual orientation, gender identity, gender expression and sex characteristics*
SRH	*Sexual and reproductive health*
SRHR	*Sexual and reproductive health and rights*
STI	*Sexually transmitted infection*
UNFPA	*United Nations Population Fund*
WGSS	*Women and girls' safe space*
WHO	*World Health Organization*
WLO	*Women-led organization*
WPS	*Women, Peace and Security*

Glossary of terms

GENDER-BASED VIOLENCE (GBV): Any harmful act that is directed at an individual based on their gender, including physical, sexual, emotional and economic violence. GBV is rooted in unequal power dynamics and gender-based discrimination and can occur in many settings, including family, community and workplace environments.

SRH-GBV INTEGRATION: SRH-GBV integration is a deliberate, strategic effort to design programming across sectors to meet the specific needs and priorities of diverse groups of women and girls, with the ultimate aim of improving their safety, health and rights.

LOCALIZATION: Empowering local responders in affected countries to lead and deliver humanitarian aid. It aims at strengthening the capacity and resources of local organizations to respond to crises and promote long-term sustainability. It recognizes the importance of local knowledge and cultural understanding in providing effective and culturally appropriate aid. By empowering local actors, localization aims to improve the relevance, efficiency and impact of humanitarian interventions.

ONE-STOP CENTRES (OSC): The purpose of OSCs, mostly hospital based, is to provide a direct targeted response to a GBV survivor, and usually focuses on survivors of sexual violence. They provide multi-disciplinary services for intake, typically within tertiary care facilities, while others are standalone centres that provide basic health services on-site and referrals for specialized and emergency services. Some OSCs are more strongly linked to the judicial system. OSCs typically have a wide range of specialized services for initial care (sometimes including police, prosecutors, social workers, counsellors and psychological support) for survivors. They are particularly suited for urban settings where the client load is high and survivors can remain anonymous.

If choosing an OSC model (typically under model 2), it is worth being mindful that OSCs are often highly medicalized or police focused and there are forms of GBV that do not require medical attention and may not want contact with the police. It is equally important to emphasize the need for a WGSS that provides additional counselling, peer support, creating space for solidarity and support among women and girls with gender-transformational approaches.

SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS (SRHR): A state of physical, emotional, mental and social well-being in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction or infirmity. Achieving sexual and reproductive health rests on realizing sexual and reproductive rights, such as the right to control one's own body, define one's sexuality, choose one's partner and receive confidential, respectful and high-quality services.

WOMEN-LED ORGANIZATIONS (WLOs): NGOs primarily led by women that advocate for and implement programmes to address issues affecting women, including GBV prevention and response. These organizations often have a deep understanding of the local context and are key to the contextualization of interventions. This resource uses the term WLO to also include Women's Rights Organizations (WROs) and other national or local organizations guided by feminist principles or which are women-focused.

WOMEN AND GIRLS SAFE SPACE (WGSS): In the humanitarian context, WGSSs are defined as "A structured place where women and adolescent girls' physical and emotional safety is respected and where women and adolescent girls are supported through processes of empowerment to seek, share and obtain information, access services, express themselves, enhance psychosocial well-being, and more fully realize their rights." In the context of SRH-GBV integrated programming, this refers to a service delivery/activity environment with absence of trauma, excessive stress, violence (or fear of violence), or abuse. It is a space built on feminist and woman-centred principles of empowerment, solidarity, accountability, inclusion and collaboration, where women and girls feel comfortable and enjoy the freedom to express themselves without the fear of judgment or harm.

The WGSS principles are non-negotiable if SRH services are integrated into WGSSs, which needs to be carefully considered when choosing a model. In practical terms, it means that service providers must be female and that men will not be able to accompany their female partners for services. It also means that the WGSS will remain a community centre for women and girls as opposed to a health facility, which may have an impact on the exit strategy after the acute phase of the emergency.

Annex 2: Checklists for SRH-GBV integrated service delivery points (adapted from IRC)

Checklist for Model 1

Checklist for Model 2

Checklist for Model 3

Checklist for Model 4

Guidance note on
SRH-GBV integration models

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