Monitoring SRH-GBV integration in emergencies

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1. Introduction

Sexual and reproductive health (SRH) and gender-based violence (GBV) services are inherently interconnected, particularly in humanitarian settings where crises exacerbate health and protection risks. Coordinated monitoring of SRH and GBV programmes helps ensure that life-saving services are available, accessible and meet minimum standards of quality, and that patients and GBV survivors receive the care and support they need in a timely, confidential and survivor-centred manner.

This note provides practical guidance for SRH and GBV specialists on monitoring the integration of SRH and GBV services in emergencies. It complements the *Entry Points for Integrating SRH and GBV Services in Emergencies* guidance and draws on existing global frameworks, including the **Minimum Initial Service Package (MISP) for SRH in Crises (IAWG, 2023)**, the **Inter-Agency Minimum Standards for GBV in Emergencies Programming (GBV Area of Responsibility (AoR), 2024), UNFPA core indicators and humanitarian response monitoring frameworks**, and the **Gender-based violence information management system** (**GBVIMS+) and SRH health-information systems** such as **District Health Information Software (DHIS2)** or national SRH dashboards.

The purpose of this note is not to introduce new indicators but to show how practitioners can use existing monitoring systems to capture progress, identify challenges and strengthen coordination between SRH and GBV services. The emphasis is on practical approaches that can be implemented at field level within existing reporting structures.

2. Objectives of monitoring SRH–GBV integration

Monitoring the integration of SRH and GBV services serves multiple purposes. It enables SRH and GBV humanitarian actors to track how effectively the entry points identified in the *Entry Points for Integrating SRH and GBV Services in Emergencies* guidance are being implemented and whether they translate into tangible benefits for crisis-affected populations, particularly women and girls. Through systematic monitoring, teams can assess the quality, safety and accessibility of patient and survivor-centred SRH and GBV services and identify barriers that prevent people in need from receiving care.

Monitoring also plays a crucial role in strengthening coordination and accountability between sectors. When SRH and GBV actors regularly review shared data and experiences, they are better able to align objectives, avoid duplication and fill service gaps. Finally, integrated monitoring supports programmatic learning and advocacy. Evidence on what works, such as successful referral systems, effective training or improved service uptake, can guide adaptation of interventions and inform advocacy for sustained funding and institutional support for integrated service delivery.

3. Core monitoring questions

Monitoring should focus on how effectively systems and services link SRH and GBV interventions. Existing data can help to indicate:

Monitoring area	Illustrative questions	Data sources
Availability of integrated/linked services	Are SRH and GBV services co-located or linked through functional referral pathways? Are SRH and GBV services designed to meet the specific needs of survivors of SEA?	Service mapping tools
Functionality of referral systems	Are referral pathways updated, available to staff and in use? What proportion of referrals between SRH and GBV services are completed safely and confidentially?	Referral tracking logs, GBVIMS+ aggregate data, supervision reports
Access and utilization	Are GBV survivors (including survivors of SEA) able to access SRH and GBV services (i.e. for clinical management of rape)? Are adolescent girls, persons with disabilities and other at-risk groups being reached (i.e. by services and information)?	Facility registers, outreach reports, GBV case management data and exit interviews
Quality and safety	Are survivor-centred principles (confidentiality, informed consent, Do No Harm) applied during referrals and service delivery?	Quality assurance tools, supervision checklists, joint monitoring visits
Coordination and information-sharing	Do SRH and GBV coordination mechanisms exchange monitoring data and jointly analyse trends? Are SOPs in place for appropriate data sharing related specifically to cases of SEA?	Cluster/ Working group meeting notes, joint analysis reports PSEA Network and/or GBV WG SOPs for data sharing and reporting

4. Relevant indicators from existing frameworks

Practitioners should rely on established global and national indicator sets. The examples below illustrate how existing indicators can be used to monitor SRH–GBV integration.

Area	Sample indicator	Source / framework
Service availability	Number or percentage of health facilities providing CMR services according to national/inter-agency standards	MISP Objective 2; UNFPA Core Indicator
Referral pathways	Percentage of SRH and GBV service points with updated, functional referral pathways between the health and protection sectors	GBV Minimum Standards 4 and 7
Provider capacity	Number and percentage of healthcare providers trained in CMR and intimate partner violence (IPV) practices	MISP monitoring framework
Access and use	Number of GBV survivors receiving timely SRH care. CMR indicators can also be used, such as timely post-exposure prophylaxis for HIV (within 72 hours) and emergency contraceptives (within 120 hours); number of SRH patients referred to GBV case management services	Joint SRH–GBV data review
Information-sharing and coordination	Frequency of joint SRH–GBV data review meetings or joint supervision visits	Coordination indicators
Quality and ethics	Percentage of facilities meeting minimum standards for privacy and confidentiality in GBV-related care	Facility supervision checklists

Indicators should always be **disaggregated by sex, age** and where feasible and relevant **disability**, and data should remain aggregated to protect confidentiality.

5. Data collection and coordination mechanisms

Effective monitoring depends on using and strengthening existing information systems rather than creating parallel tools. SRH data are typically captured through health-information systems such as facility registers and the MISP progress checklist, while GBV data are gathered through the GBVIMS/GBVIMS+ and complementary service-level tools. Referral tracking forms can help both sectors understand whether survivors referred from one service to another successfully receive care.

Regular joint supervision and quality-monitoring visits by SRH and GBV focal points allow teams to observe services directly, identify gaps and agree on corrective actions. These visits should be accompanied by systematic documentation and follow-up. Community feedback mechanisms – such as complaint desks, helplines or participatory community reviews – also provide important insights into whether integrated services are perceived as safe, respectful and accessible.

Monitoring processes should be coordinated through existing health and protection mechanisms. Joint data-review meetings held quarterly or biannually can bring together SRH and GBV programme staff, data managers and coordination leads to analyse trends, identify bottlenecks and agree on programmatic adjustments. Such discussions are most effective when embedded within established coordination structures, clusters and working groups. In the context of GBVIMS, SRH and GBV actors need to ensure that the existing GBVIMS Information Sharing Protocol (ISP) permits the sharing/use of analysed trend data with SRH actors for trend analysis to inform programmatic adjustments.

6. Safe and ethical data management

Monitoring the integration of SRH and GBV services must always uphold the principles of safety, dignity and confidentiality. Because information related to GBV and SRH can be highly sensitive, data collection and sharing should follow the ethical standards outlined in the *WHO Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence* and the *GBVIMS Data Protection Protocols*.

All monitoring activities should adhere to four key principles. Do No Harm means that information-gathering must never increase risks for survivors, service providers or communities. Informed consent or informed assent require that any information collected about individuals or service use is obtained voluntarily and with a clear understanding of how the data will be used. Respecting confidentiality requires that data be stored securely, access be restricted to authorized personnel, and only information that does not identify individuals be shared between partners. Finally, purpose limitation ensures that data are used solely to strengthen services, coordination and protection outcomes – not for investigative, punitive or non-programmatic purposes.

SRH and GBV coordination mechanisms should formalize safe information-sharing procedures, including clear guidance on how joint analysis can take place without breaching confidentiality. Developing a shared understanding of these protocols during preparedness and training activities will help ensure consistency and trust between partners.

7. Using monitoring data for programme improvement

The true value of monitoring lies in how the findings are used. SRH and GBV data should feed into regular programme reviews and coordination discussions so that lessons learned translate into tangible improvements in service delivery. For example, analysis of referral data might highlight that survivors face delays in reaching health facilities, prompting actors to revise transportation support or service hours. Likewise, data showing low uptake of SRH services among adolescent girls could lead to targeted outreach or adapted communication strategies.

Monitoring results can also inform capacity-building priorities. If supervision data reveal weak adherence to trauma-informed care standards, additional training or mentoring may be organized for healthcare and protection staff. Over time, these iterative adjustments enhance the quality and responsiveness of integrated programming.

At a broader level, joint analysis of SRH and GBV monitoring data supports evidence-based advocacy. Documented improvements in referral systems or increases in service coverage can strengthen funding proposals and policy dialogue, while persistent gaps can guide advocacy for additional resources or policy reform. By embedding these feedback loops into coordination structures, humanitarian actors can ensure that monitoring contributes directly to improved outcomes for women, girls and other crisis-affected populations.

8. Key resources

- IAWG, *Minimum Initial Service Package (MISP) for SRH in Crises* (2023). Available at https://iawg.net/resources/minimum-initial-service-package-misp-resources.
- UNFPA, WHO, UNHCR, *Clinical Management of Rape and Intimate Partner Violence Survivors: Developing Protocols for Use in Humanitarian Settings* (2020). Available at https://www.who.int/publications/i/item/9789240001411.
- GBV AoR, *Inter-Agency Minimum Standards for Gender-based Violence in Emergencies Programming* (2024). Available at https://gbvaor.net/sites/default/files/2023-07/Standards_revised.pdf.
- UNFPA, *Programmatic guidelines: Cash and Voucher Assistance in Sexual and Reproductive Health programming in Emergencies* (2025). Available at www.unfpa.org/publications/programmatic-guidelines-cash-and-voucher-assistance-sexual-and-reproductive-health.
- Guidance Note on Safe and Ethical Management, Analysis, and Sharing of GBV Service Data (2025).
- WHO, *Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence* (2007). Available at https://www.who.int/publications/i/item/9789241595681.
- Guidance to Support the Mental Health and Psychosocial Well-Being of GBV and SRH Service Users in Humanitarian Settings (2024).
- UNFPA, *Entry points for integrating SRH and GBV services in emergencies* (2025).

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