HEALTH CLUSTER
GHC SRH Task Team

REPORT

Best practices in linking sexual and reproductive health and gender-based violence coordination in emergencies

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Acronyms

AoR	area of responsibility
CMR	clinical management of rape
CMR-IPV	clinical management of rape and intimate partner violence
EmONC	emergency obstetric and newborn care
FGD	focus group discussion
GBV	gender-based violence
GBV AoR	Gender-based Violence Area of Responsibility
GBVIMS	Gender-Based Violence Information Management System
GHC	Global Health Cluster
HCT	humanitarian country team
HIS	health information system
HNO	Humanitarian Needs Overview
HRP	Humanitarian Response Plan
IARH	Inter-Agency Emergency Reproductive Health
IASC	Inter-Agency Standing Committee
IAWG	Inter-Agency Working Group for Reproductive Health in Crises
IEC	information, education and communication
IPV	intimate partner violence
IRC	International Rescue Committee
KII	key informant interview
MHPSS	mental health and psychosocial support
MISP	Minimum Initial Service Package (for sexual and reproductive health in crisis situations)
OCHA	Office for the Coordination of Humanitarian Affairs
OSC	one stop centre
REGA	Regional Emergency Gender Based Violence Advisors
SOGIESC	sexual orientation, gender identity and expression, and sex characteristics
SOP	standard operating procedure
SRH	sexual and reproductive health

SRH-TT	Sexual and Reproductive Health Task Team
SRH-TWG	Sexual and Reproductive Health Technical Working Group
SRHWG	sexual and reproductive health working group
STI	sexually transmitted infection
TAG	Technical Advisory Group
UNFPA	United Nations Population Fund
UNHCR	Office of the United Nations High Commissioner for Refugees
VCAT	values clarification and attitude transformation
WHO	World Health Organization

Executive summary

The intersection of sexual and reproductive health (SRH) and gender-based violence (GBV) in humanitarian emergencies presents both challenges and opportunities for coordinated action. The complex nature of crises exacerbates vulnerabilities, particularly for women and girls, making it imperative that SRH and GBV actors work together to deliver comprehensive care. This report, commissioned by the Sexual and Reproductive Health Task Team (SRH-TT) under the Global Health Cluster (GHC), documents best practices for linking SRH and GBV coordination in emergencies, drawing on lessons learned from diverse humanitarian contexts. This report is the first part of a two-part project, and will be followed by the development of guidelines and tools for linking SRH and GBV coordination at the global and national levels. The report was developed through an online desk review, key informant interviews, focus group discussions and the development of case studies. In total, 32 people from 13 institutions, including SRH and GBV experts and donors, were interviewed for the purpose of this paper.

The increase in violence, collapse of infrastructure such as the health system, and disruption of the social fabric that occur during humanitarian emergencies heighten SRH and GBV risks. In crises, SRH and GBV actors must work together to align and ensure a cohesive and comprehensive response, as SRH services are an important entry point and lifeline for GBV survivors, and GBV services are an entry point for survivors to access SRH services.

Under the humanitarian response architecture, the newly created SRH-TT falls under the GHC and the Gender-based Violence Area of Responsibility (GBV AoR) falls under the protection cluster. Systematization and strengthening of linkages between SRH and GBV in emergencies was identified as a priority when the SRH-TT was developed, and the Baseline Assessment on Sexual and Reproductive Health Coordination (GHC, 2024) conducted by the SRH-TT in 2023 highlights the need to strengthen linkages between SRH and GBV coordination, to clarify roles and responsibilities in ensuring care for survivors and patients, and to streamline and align service mapping and indicators.

While the humanitarian architecture is well established, the involvement of multiple agencies in coordination leads some informants to perceive it as fragmented. The United Nations Population Fund is the lead United Nations agency for both SRH and GBV in emergencies and, as such, is responsible for the coordination of both SRH and GBV and plays an important role in encouraging linkages and in clarifying and promoting the roles and mandates of different actors involved. The SRH-TT should further advocate for dedicated space within the humanitarian coordination mechanisms to ensure that SRH is systematically prioritized in emergency preparedness and humanitarian response. For collaboration between SRH and GBV to be successful, it must be prioritized at all levels of coordination, from global to subnational, and a feedback mechanism must ensure that the levels communicate and work towards the same objectives. Introducing these linkages can be challenging with the competing priorities in an acute emergency. Therefore, working with SRH and GBV teams to introduce these concepts as part of preparedness planning ensures teams are ready to work together from the onset of a response, streamlining interventions.

Both the GBV and SRH communities reported having to fight for space and funding within their own clusters, limiting time and energy to collaborate. While tensions and competition exist, silos can be overcome through dialogue and bringing teams together.

Clear guidelines on linking SRH and GBV coordination at both the global and national levels, and tools to support national and subnational coordination would support collaboration by defining the clear roles and responsibilities of the different parties, including the GBV AoR, the SRH-TT and the GHC; SRH and GBV Coordinators; and leadership, partners and service providers. Both coordination bodies should align their requirements and training of Coordinators, and investigate ways to harmonize systems such as data management and referral mapping to ensure that linkages are prioritized.

While clinical management of rape (CMR) is an obvious area of intersection between SRH and GBV, other areas of focus are also important, including intimate partner violence (IPV), mandatory reporting, and services for pregnant children and adolescents. Development of joint curricula and co-facilitation of training to encourage better collaboration are good practices that were highlighted by informants, alongside aligned messaging and coordinated advocacy around issues relevant to SRH and GBV.

Joint efforts by SRH and GBV Coordinators to establish and update referral pathways will improve access to services, and collaboration on mapping of commodities and supplies (in-country and in the pipeline), particularly for CMR, will improve distribution, avoid gaps and reduce wastage.

While donors prioritize SRH-GBV integration, their internal processes do not facilitate joint funding proposals or development of common indicators, and funding specific to linking SRH and GBV coordination is not prioritized.

To move forward, the report recommends a strategic approach that prioritizes SRH-GBV linkages at all levels of coordination, including in global frameworks, encourages joint funding mechanisms, and supports capacity-building efforts that bring SRH and GBV teams together. By implementing these recommendations, humanitarian actors can ensure that every survivor receives the comprehensive care they deserve, ultimately leading to more resilient and responsive systems in crisis situations.

Introduction

Background

The World Health Organization (WHO) defines sexual health as "a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled" (WHO, n.d.). Women and girls in humanitarian settings face increased risk of unintended pregnancies, obstetric complications, sexually transmitted infections (STIs), including HIV, and unsafe abortions. During emergencies, sexual and reproductive health (SRH) services may be deprioritized as other health needs increase, e.g. the response to outbreaks and epidemics, malnutrition and trauma care (READY Initiative, 2022, pp. 10, 17; Inter-Agency Working Group for Reproductive Health in Crises [IAWG], 2020). This, along with overwhelmed or weakened health systems and, in some contexts, restrictive governmental regulations mean that women, girls and vulnerable populations face reduced access to life-saving obstetric services, contraception, safe abortion care, and prevention and treatment of STIs and HIV.

To draw attention to these underserved SRH needs, the IAWG was established in 1995 to strengthen reproductive health services for crisis-affected populations. While the IAWG has led many of the most critical SRH discussions, such as the development of the Inter-Agency Field Manual for Reproductive Health in Humanitarian Settings and the Minimum Initial Service Package (MISP) for SRH in crisis situations, the coalition does not hold a formal space within the humanitarian coordination architecture. Although the first MISP objective is to establish coordination for SRH, without a formal structure to standardize and systematize SRH coordination in humanitarian emergencies, SRH coordination has historically been inconsistent at the field level. In some contexts, the health cluster creates a sexual and reproductive health working group (SRHWG) to coordinate the SRH response, but this is not systematically set up in all responses and SRH is often under-represented and under-prioritized in humanitarian coordination. To address this gap, the Sexual and Reproductive Health Task Team (SRH-TT) was established as a temporary entity within the Global Health Cluster (GHC) in November 2022, with the aim of ensuring that SRH priorities are systematically addressed in all phases of humanitarian response and that SRH coordination is consistently included in cluster coordination at both the global and national levels (GHC, 2024). The SRH-TT is co-led by the United Nations Population Fund (UNFPA) and the International Rescue Committee.

"Gender-based violence (GBV) is an umbrella term for any harmful act that is perpetrated against a person's will and that is based on socially ascribed (i.e. gender) differences between males and females. It includes acts that inflict physical, sexual or mental harm or suffering, threats of such acts, coercion and other deprivations of liberty. These acts can occur in public or in private" (Inter-Agency Standing Committee [IASC], 2015, p. 5). It is estimated that approximately 30 per cent of women will experience physical and/or sexual violence in their lifetime (WHO, 2021). This risk may increase to up to 70 per cent in humanitarian contexts (ActionAid, 2016, p. 10) and affects not only women and girls, but also men, boys, people of diverse sexual orientation, gender identity and expression, and sex characteristics (SOGIESC) (ibid.) and other vulnerable populations. The coordination of GBV in humanitarian settings is led by the Gender-based Violence Area of Responsibility (GBV AoR), which is headed by UNFPA and falls under the Global Protection Cluster, chaired by the Office of the United Nations High Commissioner for Refugees (UNHCR).[1]

GBV is a public health issue and has complex consequences, many of which may impact a survivor's SRH and rights. From a gynaecological perspective, women who have experienced intimate partner violence (IPV) are three times more likely to suffer from chronic pelvic pain, vaginal infections, dysmenorrhoea and dyspareunia. Additionally, those subjected to sexual violence face heightened risks of STIs, including HIV. IPV complicates a woman's ability to refuse sexual intercourse or use contraceptive methods. Forced sexual intercourse can result in vaginal trauma and increase the risk of HIV transmission. Furthermore, childhood sexual abuse may lead to high-risk sexual behaviours in adulthood, such as reduced condom use, multiple partners and subsequent violence (Shalak, Markson and Nepal, 2024). GBV is also linked to increased likelihood of miscarriage, stillbirth, preterm delivery and low-birth-weight babies (WHO, 2024). Further, the lack of respect for rights within SRH service delivery itself constitute situations of GBV. These include, but are not limited to, denial of service and obstetric and reproductive violence.

Both SRH and GBV interventions target similar populations, including women, girls, adolescents, people of diverse SOGIESC, people with disabilities, and people who sell or exchange sex, who might otherwise be overlooked. The GBV subcluster (as part of the protection cluster) focuses on a multisectoral and

1 UNFPA chairs the GBV AoR in internally displaced person settings, while in refugee settings, GBV working groups are chaired by UNHCR. In some cases, at the invitation of UNHCR, UNFPA can co-chair the GBV working group, such as in the context of Lebanon or the Regional Inter-Agency Coordination Platform for Refugees and Migrants from Venezuela in the Latin America and Caribbean Region.

survivor-centred response to ensure a holistic and coordinated approach, focusing on prevention, risk mitigation and the provision of response services through psychosocial welfare, law enforcement and referrals to appropriate health services, including SRH. The Health Cluster is responsible for coordinating the health response to all forms of GBV and ensuring that both the physical and psychological needs of survivors are addressed. Within the health response, SRH services for GBV survivors, including survivors of sexual assault and intimate partner violence, are specifically prioritized under the MISP and are a priority of SRH coordination. Clinical management of rape and intimate partner violence (CMR-IPV) addresses prevention and management of unintended pregnancies; prevention and management of STIs, including HIV; provision of psychological first aid; and appropriate referrals to other health and protection services. The health response to GBV also includes prevention of GBV committed through health services, especially SRH services. SRH services are an important entry point and lifeline for GBV survivors, and GBV may be identified through SRH services in the same way that SRH needs can be uncovered in GBV services (Neha and others, 2018). As a result, both communities have a responsibility to work together to align and ensure a cohesive and comprehensive response, especially in humanitarian settings.

The SRH-TT, structured under seven subgroups, identified the collaboration between SRH and GBV Coordinators as a priority and delegated Sub-group 7 to systematize and strengthen SRH-GBV linkages in emergencies. Little has been documented in terms of collaboration between SRH and GBV at the humanitarian coordination level, but the SRH-TT's 2024 Baseline Assessment on Sexual and Reproductive Health Coordination highlights the need to strengthen the linkages between both coordination systems, to clarify roles and responsibilities in providing care for survivors, and to streamline and align service mapping and indicators.

Objectives

This report aims to document best practices and lessons learned in linking coordination for SRH and GBV in crises at subnational, national and global levels, highlighting practices that have worked (and those that have not) as well as the challenges that must be addressed to establish, strengthen and systematize linkages between SRH and GBV.[2] The recommendations of this report will inform the SRH-TT's next steps to develop and pilot guidelines for linking SRH and GBV coordination, in collaboration with the GBV AoR.

Methodology

This report was developed in several phases:

An **online desk review** of key documentation pertaining to SRH and GBV coordination, focused primarily on the SRH-TT's Baseline Assessment on Sexual and Reproductive Health Coordination (GHC, 2024), the "Stronger Together" report, developed by the UNFPA Arab States Regional Office (UNFPA, 2024), and other guidance such as the "Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action" (IASC, 2015); the MISP for SRH in crisis situations; "Clinical Management of Rape and Intimate Partner Violence Survivors: Developing Protocols for Use in Humanitarian Settings" (WHO, UNFPA and UNHCR, 2020); the 2023

2 Note that this report is specific to strengthening linkages between coordination for SRH and GBV and, as such, is not intended to address broader inter-cluster linkages. Existing collaborative frameworks, for example, between the health cluster and the protection cluster, are referenced and have been considered in the identification of best practices.

GBV AoR external review (Ward, Tong and Voss, 2023); the Health and Protection Joint Operational Framework (GHC and Global Protection Cluster, 2023); and the "Health Cluster Guide: A Practical Handbook" (GHC, 2020). Further resources were identified based on a Google search, a Google Scholar search, and recommendations by the SRH-GBV Coordination Technical Advisory Group (TAG) and key informants. Reviews of these documents identified several common themes, which informed the interview questionnaires and the initial analysis of the information collected.

Key informant interviews (KIIs): A list of key informants was developed by the consultant based on recommendations and referrals from the TAG and SRH-TT and GBV AoR members. Respondents were identified based on multiple criteria, including:

- Regional representation: Sub-Saharan Africa, Arab States, Asia and Pacific, and Latin America and the Caribbean
- Technical specialty: SRH, GBV
- Level: Global, regional, national
- Type of partner: United Nations, local NGO, international NGO, Donor

A total of 32 SRH and GBV experts from 13 institutions were interviewed through KIIs and focus group discussions (FGDs).[3]

United Nations	UNFPA, UNHCR, WHO[4]
Local NGOs	Profamilia (Colombia), Women's Health and Family Planning Ukraine
International NGOs	CARE International, International Committee of the Red Cross, International Medical Corps, Ipas, International Planned Parenthood Federation, International Rescue Committee
Donor	United States Agency for International Development Bureau for Humanitarian Assistance, European Commission Directorate-General for European Civil Protection and Humanitarian Aid Operations
Other	Independent experts

Interview questionnaires for informants and donors were developed and reviewed by the TAG (see annex 2). After informed consent was obtained, all interviews were conducted via video conferencing; interviews were recorded and transcribed. Transcriptions were reviewed to identify content, patterns and themes around GBV and SRH linkages, which were progressively adapted to inform the "Findings" section of this report.

3 At the request of some key informants who wished to contribute without being identified by respondent type, attribution of quotes was omitted throughout this report.

4 Health Cluster Coordinators were not engaged during this process, which was limited to SRH and GBV experts. Their contributions to the SRH-TT Baseline Assessment are included in the SRH-GBV linkages recommendation, which contributed to this report. SRH, GBV and Health Cluster Coordinators will be engaged during the next phase of this project, in the development of specific guidelines and tools for linking SRH and GBV coordination.

Case studies were developed from north-west Syria, Honduras and Ethiopia following recommendations from field-based informants, including SRH and GBV Coordinators, Regional Emergency Gender-Based Violence Advisors (REGAs), and UNFPA regional offices. The case studies were compiled following KIIs and FGDs.

The report was reviewed by the TAG, the SRH-TT and representatives from the GBV AoR and the GHC, and relevant additional inputs were incorporated prior to finalization.

Findings

The findings of the interviews and FGDs are structured under three broad themes:

1. Fostering a collaborative environment between SRH and GBV
2. Identifying and encouraging ways of working jointly
3. Fostering a common outlook on cross-cutting areas

Under each theme, challenges that were identified by the key informants are described and are followed by best practices, accompanied by field-based examples and case studies when available.

Fostering a collaborative environment between sexual and reproductive health and gender-based violence coordination

Working within the coordination structure

Challenge: Fragmented and confusing coordination

Despite the well-established humanitarian architecture, the involvement of multiple agencies in coordination for GBV (such as UNFPA, UNHCR, the United Nations Children's Fund, International Organization for Migration and WHO) and the inconsistent establishment of SRH coordination under health clusters has contributed to a fragmented, confusing collaboration landscape and tensions between the two areas. Although the Health and Protection Joint Operational Framework exists, it was not well known among respondents and does not offer guidance on how GBV and SRH coordination can and should collaborate. A framework specific to SRH and GBV coordination does not currently exist, which further exacerbates inefficiencies and misunderstandings.

> **Best Practice 1: Strengthen linkages between SRH and GBV through formal frameworks**
>
> To enhance collaboration, it is essential to build on existing frameworks such as the Health and Protection Joint Operational Framework, which highlights areas that both clusters should focus on jointly, structured under the six core functions of cluster coordination. The SRH-TT and the GBV AoR should work together to develop clear, formal guidance that outlines joint SRH-GBV objectives, roles and responsibilities for collaboration. This approach will help ensure that both areas work together effectively and avoid the fragmentation and confusion currently observed.

Challenge: Dependence on political will and strategic leadership

Effective coordination between SRH and GBV requires strong political will and strategic leadership. SRH and GBV respondents at all levels mentioned having to fight for space and funding within their own clusters to gain visibility and have their priorities heard, leaving little energy or time to work with the other sector. Many respondents from both the SRH and GBV fields feel they sometimes need to lobby or advocate with their respective clusters to demonstrate the value of working together, with some at the national protection or health cluster level not understanding how the other cluster or AoR works, the needs of the other sector, and how GBV and SRH interlink.

Respondents mentioned the importance of a top-down process, noting that coordination requires political will from leadership at the strategic level to set the pace and establish accountability and momentum for both sectors to work together. When linkages are discussed and agreed upon, these must be communicated and promoted from global to national and national to local levels, but without leadership driving the collaboration from the top, efforts to work together may falter. The momentum and flow of information can also happen from the bottom-up, however, and respondents cited the importance of fostering both types of approaches to strengthen collaboration.

> "Coordination ... remains very much a top-down approach."

Best Practice 2: Establish both top-down and bottom-up coordination

Collaboration between SRH and GBV should be prioritized at all levels of coordination – from global to local. This requires both top-down support and directives from leadership, and bottom-up initiatives that address issues identified at the local level. For example, in, north-west Syria, a bottom-up process led to closer collaboration between SRH and GBV at the regional and national levels. As one respondent noted, "the momentum and flow of information can also occur through a bottom-up process", indicating that both approaches are necessary to ensure effective collaboration.

Case study: North-west Syria

In 2022, UNFPA identified significant challenges in the response to GBV within medical facilities in north-west Syria. The challenges included poor response practices, negative staff attitudes and a lack of confidentiality, leading to negative outcomes for survivors, including two cases of femicide. These issues highlighted the urgent need for better integration of SRH and GBV services to ensure that survivors received dignified and safe care.

To address these challenges, UNFPA launched an SRH and GBV integration initiative, which aimed to improve access to integrated SRH and GBV services for women and girls in health facilities across the region. The initiative was a collaborative effort led by both the GBV AoR and the Sexual and Reproductive Health Technical Working Group (SRH-TWG) within the health cluster, in coordination with 21 local organizations.

The initiative took a comprehensive approach to improving the GBV response within medical facilities:

- **Baseline assessments (UNFPA, 2022)**: Baseline assessments were conducted at 50 emergency obstetric and newborn care (EmONC) facilities to evaluate their readiness to provide health care for GBV survivors. These assessments revealed significant gaps:
  - Only 26 per cent of facilities had sufficient staff to provide clinical management of rape (CMR) services 24/7.
  - Only 24 per cent adhered to the minimum standards for providing CMR services.
  - Only 32 per cent used CMR kits appropriately.
  - Training gaps were also identified, with only 41 per cent of medical staff and 27 per cent of non-medical staff trained on GBV fundamentals and standard operating procedures (SOPs), and only 19 per cent of medical staff trained on the safe identification and referral of GBV survivors.
- **Capacity-building:** In response to these findings, the GBV AoR and the SRH-TWG collaborated to provide comprehensive training and support to 3,967 staff members. The training focused on fostering a culture of respect, empathy and understanding, and prioritizing services delivered with dignity and sensitivity.
- **Joint supervision and monitoring:** The initiative included 945 joint supervision and monitoring visits, during which facilities were assessed using GBV integration checklists. These checklists considered factors such as accessibility, staff capacity, readiness of health facilities to deliver CMR, policies and protocols, and GBV messaging.
- **Revising materials and advocacy:** The initiative also involved revising training materials, information, education and communication (IEC) materials, and awareness materials, as well as advocacy messages to ensure that they addressed the needs of GBV survivors effectively.

Outcomes (UNFPA, 2023): One year after the launch of the initiative, significant improvements were observed:

- 85 per cent of facilities had CMR-trained staff available 24/7.
- 53 per cent of facilities adhered to the minimum standards for providing CMR services.
- 87 per cent of facilities were using CMR kits appropriately.
- 80 per cent of medical staff and 74 per cent of non-medical staff were trained on GBV basics and SOPs.
- 62 per cent of medical staff and 64 per cent of non-medical staff were trained on the safe identification and referral of GBV survivors.

Expansion and sustainability: The initiative expanded to include 117 facilities, with the involvement of 100 technical members from 41 different national and international organizations. This expanded effort addressed additional areas such as advocacy, attitudes, reporting mechanisms, community-based GBV, and integrated IEC materials and messages.

Recommendations:

- At the global and national levels, the health and protection clusters should enable the SRH-TT/SRHWGs and the GBV AoR to systematize and strengthen SRH-GBV linkages in alignment with the Health and Protection Joint Operational Framework, recognizing the interlinkages between these sectors and the urgent need to prioritize the specific needs of women and girls in humanitarian crises.
- The relationships and ways of working among the GBV AoR, the SRH-TT/SRHWGs and the health and protection clusters should be further clarified and promoted to avoid confusion.
- The SRH-TT and the GBV AoR should develop guidance formalizing the collaboration between SRH and GBV Coordinators that provides concrete direction on the joint objectives, roles and responsibilities of different actors, and defining ways of working together.
- Collaboration should be prioritized at all levels of coordination, combining top-down directives with bottom-up initiatives to address both strategic and operational needs effectively.

Reconciling differences

Challenge: Perceived power imbalances and sectoral resentment

Real or perceived power imbalances between SRH and GBV actors have created tensions that hinder collaboration. The health community, which includes SRH, is often seen as more institutionalized, better funded, and receiving preferential treatment from (UNFPA) leadership, leading to resentment from GBV actors who feel undervalued. While members of the health profession, including SRH practitioners, have close affiliations to governments through their ministries of health, GBV professionals, who also interface with many ministries, often have closer ties with grass-roots women's organizations, which have less power and influence.

> "They (the 'SRH people') see themselves as superior. I think, compared to the GBV people, they can see themselves as being more educated. I think they can have a more top-down attitude in some cases."

Challenge: Lack of shared objectives and competition for resources

Within their respective clusters, both SRH and GBV coordination face intense competition for resources, visibility and influence, which can disincentivize collaboration. For example, informants from both SRH and GBV reported having to fight for space and funding within their own clusters to gain visibility, leaving little time or energy for joint SRH-GBV initiatives.

Collaboration between SRH and GBV has often been piecemeal, with a focus on ad hoc activities rather than alignment around clear, joint objectives. Respondents emphasized that when collaboration is focused on ad hoc activities (usually led by one area over the other), it fails to build meaningful linkages. Instead, aligning both SRH and GBV interventions around a few clear objectives is more likely to inform strategy, workplans and approaches.

> **Best Practice 3: Advocate for shared objectives**
>
> Both SRH-TT and GBV AoR should centre their collaboration around shared objectives rather than separate activities. Focusing on common goals, such as improving the health and well-being of survivors, can help prevent division and competition between the sectors. It is important to highlight the added value of collaborating at the coordination level, not only to avoid duplication and increase efficiencies, but also to potentially reduce workloads for both SRH and GBV actors. When SRH and GBV teams are aligned around clear, shared objectives, their collaboration becomes more effective and impactful, prevents the sectors from working in silos, and encourages joint ownership of outcomes, leading to more sustainable and integrated solutions.

Challenge: Lack of understanding and communication

The lack of mutual understanding and communication between SRH and GBV actors was identified as a significant challenge. For instance, in some national contexts, health clusters have collected and reported sensitive GBV data that could have serious safety implications for survivors, underscoring the critical need for better coordination and communication.

This lack of understanding was also evident in the different operational approaches and terminologies used between SRH and GBV, which often led to misunderstandings and a lack of trust. While SRH actors might focus on clinical management and health outcomes, for example, GBV actors are guided by principles centred on survivor protection, confidentiality and informed consent. These differing priorities and frameworks can create tension, as each sector may not fully appreciate the other's perspective or operational constraints. While GBV survivors are asked if they would like to opt out of having their data used as part of GBV data collection and monitoring, the health system does not allow a patient to opt out of being counted as having received a service (one cannot opt out of being counted as having had a caesarean section, for example). The discrepancies in understanding are also evident in how certain services are perceived and delivered. For instance, SRH services such as safe abortion care or emergency contraception may be controversial in some contexts and could pose protection risks for clients. When these services are not aligned with GBV principles or are poorly understood by GBV actors, it can lead to inadequate or even harmful service delivery.

> "Yeah, we are together, but there's not so much cohesion yet."

Challenge: Different languages and approaches

The two communities speak different languages, with different understandings of concepts such as "case management", "rights", "survivor-" versus "human-" or "patient- centred" approaches (UNFPA, 2024) and differing definitions of "integration". These differences can cause confusion and hinder collaborative efforts.

> **Best Practice 4: Strengthen understanding and communication between SRH and GBV**
>
> Regular joint training, cross-representation in meetings, and dialogue sessions are essential to bridge the gap between SRH and GBV teams and create strong linkages between sector coordination. These activities also help align the languages and approaches, fostering trust and respect.

In **Cox's Bazar, Bangladesh**, SRH and GBV sector coordination teams successfully advocated to remove the indicator "number of GBV survivors" from the data collected by the national health cluster. This decision was made to avoid the safety risks associated with collecting sensitive data. The effectiveness of this intervention underscores the importance of working collaboratively to address specific challenges, and for each sector to have a clear understanding of the others' priorities, to prevent the mishandling of sensitive issues.

Despite the politics, most key informants agreed that good intentions exist, but that the pressures and demands of humanitarian response and coordination leave little time or energy for anything not perceived as a top priority.

"Coordinators are more and more engaged in reporting rather than thinking and strategic work."

Recommendations:

- Emphasize the importance of aligning SRH and GBV efforts around shared objectives rather than separate activities to foster a more unified response.
- Identify opportunities for dialogue at the country level, such as through joint meetings, training and activities, to overcome prejudice, competition and resentment.
- Encourage joint funding initiatives for SRH and GBV collaboration, and promote the integration of both sectors in proposal processes and indicators to prevent division and competition.
- Improve coordination among donors to support a unified approach to creating linkages between SRH and GBV coordination, holding coordinating agencies accountable to shared objectives.

Working together across the nexus

Challenge: Competing priorities during the acute phase of a crisis

Although linking SRH and GBV coordination from the onset of a crisis was recognized as an enabler of successful coordination, actors are focused on delivering essential life-saving services during the acute phase of a crisis, making it difficult to prioritize collaboration between SRH and GBV.

"I think in acute crisis, where your primary focus is on delivering essential, life-saving (services), often the coordination is not very well defined at this point."

To lessen the burden during the acute phase of a crisis, some partners highlighted the need to introduce linkages between SRH and GBV as part of joint planning during the preparedness phase of the Humanitarian Programme Cycle (Office for the Coordination of Humanitarian Affairs [OCHA], n.d.). This could include joint readiness assessments, joint advocacy, joint resource mobilization and protection risk analysis in health assessments, processes, propositions and interventions. This was successfully done in the Asia/Pacific Region, where GBV and SRH teams worked jointly to train members on the MISP in preparation for the cyclone season. It was also highlighted that in contexts where the cluster system has not been activated, introducing the linkages between SRH and GBV with governments can have a significant impact. In Egypt in 2023, for example, the Government implemented a comprehensive GBV strategy to respond to the influx of Sudanese refugees, with technical and logistic support from WHO, UNFPA and UNHCR. In contrast, in the Republic of Moldova, the government response to Ukrainian refugees included registration and immediate health services at the border, but longer-term health needs, including for GBV, were not considered, despite support from United Nations agencies. Working across the humanitarian-development-peace nexus requires working with development actors, opening another avenue of collaborative work to break down silos.

> "These things have to be embedded as part of emergency preparedness because otherwise in the midst of an active (response), it doesn't really work."

Best Practice 5: Joint planning during preparedness phases

Introducing SRH and GBV linkages during the preparedness phase of the humanitarian programme cycle can establish these connections before a crisis hits, making it easier to coordinate during the acute phase. Joint readiness assessments, advocacy and resource mobilization are key components of this approach.

In the **Asia/Pacific Region**, International Planned Parenthood Federation GBV and SRH teams worked jointly to train members on the MISP in preparation for cyclone season. While not driven by the coordination bodies, this proactive approach during the preparedness phase established strong linkages between the sectors, supporting better coordination of response interventions during emergencies.

Best Practice 6: Ensuring joint representation in national disaster plans

Proactive advocacy at the national level is essential for integrating SRH and GBV into disaster preparedness and response plans. By advocating for SRH and GBV considerations in national disaster plans and anticipatory action frameworks, the sectors can secure their place in emergency responses, ensuring they are not sidelined during critical moments.

In **Egypt**, a comprehensive GBV strategy was successfully implemented with technical and logistic support from WHO, UNFPA and UNHCR in response to the influx of Sudanese refugees. This integration into the national disaster response highlights the effectiveness of embedding SRH and GBV considerations into broader emergency frameworks.

Recommendations:

- Introduce SRH and GBV linkages during the preparedness phase of the humanitarian programme cycle to establish these connections before a crisis hits, ensuring smoother coordination during emergencies.
- Proactively advocate for the inclusion of SRH and GBV considerations in government-led national disaster response plans and anticipatory action frameworks.

Ensuring prioritization of sexual and reproductive health and gender-based violence during public health emergencies

Challenge: Lack of integration into public health emergencies

In public health emergencies, separate coordination mechanisms often operate in parallel with existing cluster systems, leading to the deprioritization of crucial SRH and GBV interventions within the public health response. An example of this was seen during the 2018 Ebola response in the Democratic Republic of the Congo, where SRH needs were not integrated into Ebola services, and GBV survivors did not seek CMR services for fear of being referred to Ebola treatment centres (McKay and others, 2020). This lack of integration underscores the need not only for better coordination between SRH and GBV in public health emergencies, but also for better alignment of coordination of outbreaks with the existing humanitarian architecture.

> **Best Practice 7: Integrate SRH and GBV into public health emergency responses**
>
> SRH and GBV considerations should be integrated into government-led disaster response plans and public health emergency preparedness efforts.

Recommendations:

- Discussions around coordination linkages need to occur beyond the AoR and the SRHWG, and to be integrated into discussions with national counterparts, including governments, development actors and local partners. This will ensure that linkages between SRH and GBV are introduced as part of emergency preparedness and prioritized at every stage of the humanitarian programme cycle.
- The SRH-TT and the GBV AoR should introduce and advocate for SRH and GBV considerations in government-led national disaster response plans, anticipatory action, and outbreak prevention and preparedness forums when the health cluster is supporting an epidemic/outbreak response, to ensure that SRH and GBV are prioritized from the onset of different types of emergencies, such as public health emergencies.

The role of the United Nations Population Fund

Challenge: Internal silos within UNFPA

Although coordination of both SRH and GBV fall under the mandate of UNFPA, internal silos exist within the agency, limiting collaboration. Competition for funding and resources is a common issue, with respondents expressing concerns that one area is often under-prioritized compared to the other. The lack of alignment around common objectives further contributes to these internal divisions.

> "There is so much potential that remains unexplored between the two (SRH and GBV)."

Best Practice 8: Institutionalize collaboration within UNFPA

The fact that UNFPA is the lead United Nations agency for both SRH and GBV is a significant advantage and enabling factor for collaboration between them to take place. To overcome internal silos, UNFPA should focus on fostering a culture of collaboration by increasing opportunities for dialogue, ensuring transparent allocation of resources and providing strong management support.

Simple measures, such as locating SRH and GBV offices close to each other at various levels of coordination, are best practices that facilitate spontaneous interactions and joint participation in meetings. Such proximity fosters a more collaborative environment and improves communication between the sectors.

> "UNFPA should work to overcome the silos that exist internally between SRH and GBV."

In **Bangladesh** and **South Sudan**, SRH and GBV offices are located next door to each other, making it easier to ask spontaneous questions and attend each other's meetings. This physical arrangement has allowed for more frequent and informal exchanges between teams, helping to build stronger relationships and a deeper understanding of each other's work.

Recommendations:

- UNFPA holds a crucial role in promoting the linkages between SRH and GBV and should work to overcome internal silos between SRH and GBV through culture change, increased opportunities for dialogue, transparent allocation of resources and strong management support.
- Simple measures, such as the co-location of SRH and GBV offices, to facilitate spontaneous interactions and joint participation in meetings, should be encouraged to facilitate better collaboration.

- A recommendation made in the 2023 GBV AoR review highlights the need for UNFPA to "institutionalize its CLA [cluster lead agency] mandate", be more "active and visible in the … HCT [humanitarian country team] … in representing the GBV AoR" and ensure the "level of GBV programming … is commensurate with needs" (Ward, Tong and Voss, 2023). These recommendations can further be extrapolated to the SRH-TT and SRH and will strengthen the GBV AoR and the SRH-TT's ability to work meaningfully and consciously together.

Best practices to create linkages between sexual and reproductive health and gender-based violence teams

Bringing sexual and reproductive health and gender-based violence teams together

Challenge: Fragmented coordination and inconsistent representation

One of the most significant challenges in creating linkages between SRH and GBV teams is the fragmented nature of coordination and the inconsistent representation of SRH in strategic coordination platforms. In-country inter-agency coordination meetings held by the humanitarian country team (HCT) are key platforms to make initial contact, exchange findings and identify touchpoints for further conversations. While the GBV AoR has dedicated sections in the Humanitarian Needs Overview (HNO) and the Humanitarian Response Plan (HRP), SRH often lacks this level of representation and is subsumed under the broader health response. This leads to critical SRH priorities being deprioritized, overshadowed or lost in broader health discussions.

> "… because these (joint meetings) can help us to maintain that solid communication and that solid articulation to work together and provide a better, more effective and quality response across the country."

Best Practice 9: Joint planning and advocacy

Joint planning between SRH and GBV teams is a critical best practice for strengthening and prioritizing linkages. This includes developing combined workplans, engaging in joint advocacy efforts and ensuring that each sector's issues are included in needs assessments and community outreach. By working together, both sectors can increase their visibility and secure more funding. WHO and UNFPA representatives present in the HCT have a responsibility to ensure that SRH needs are represented and to advocate for SRH and GBV linkages to be prioritized in these plans. Ensuring that an SRH partner sits in the national health cluster's Strategic Advisory Group would help to ensure that SRH priorities are represented in the HRP and other decision-making processes.

Case study: Honduras

For several years, Honduras has been grappling with a growing humanitarian crisis, with its population increasingly vulnerable to violence, migration, forced displacement and the impacts of climate change. The Government has struggled to adequately address the social, economic and health needs of its people, leading to rising poverty and exacerbating the challenges faced by communities.

Within the UNFPA Honduras office, SRH and GBV Coordinators have established a strong collaborative relationship, agreeing to regularly attend each other's coordination meetings. When direct attendance is not possible, they ensure ongoing communication to keep each other informed of discussions and emerging issues. This close coordination is further strengthened by the participation of representatives from other agencies in both sets of meetings, creating a robust linkage between the sectors.

The GBV Coordinator, who originally focused on SRH within UNFPA before transitioning to GBV, brings a deep understanding of both sectors' mandates. This unique background has facilitated a more integrated approach to addressing the interconnected needs of SRH and GBV, recognizing their critical interdependencies.

This close collaboration has led to several significant joint initiatives:

- **Training initiatives:** The GBV AoR and the SRHWG joined forces to train 80 service providers on CMR and 86 service providers on the MISP. These trainings were essential in building the capacity of local health providers to respond effectively to both SRH and GBV needs, especially in crisis situations.

- **Integrated protocol development:** An integrated GBV protocol and referral pathway, tailored to the specific context of Honduras, was developed and disseminated through both the SRHWG and GBV AoR platforms. This protocol was promoted through joint events and activities, ensuring widespread awareness and adoption. One of the key achievements of this collaboration was the coordinated advocacy for the legalization of emergency contraception, which was successfully approved on International Women's Day, 8 March 2023. Both the GBV AoR and the SRHWG played crucial roles in the dissemination and promotion of this new policy, marking a significant step forward in women's health and rights in Honduras.

- **Collaborative proposal development:** The SRH and GBV teams worked together on Central Emergency Response Fund (CERF) proposals to harmonize activities and indicators between the two sectors. This collaboration enabled integrated programming opportunities for both local and international organizations, effectively addressing the complex migration crisis in Honduras. By aligning their efforts, they ensured that the needs of vulnerable populations were met in a more coordinated and comprehensive manner.

These initiatives demonstrate the power of collaboration between SRH and GBV sectors in responding to complex humanitarian challenges. The strong linkages established between these teams in Honduras have not only enhanced the effectiveness of their interventions but also provided a model for how integrated approaches can lead to significant policy and programmatic achievements.

Challenge: Attending each other's meetings – competing priorities and overwork

Although attending each other's meetings was almost unanimously mentioned as a best practice, the culture of overwork and competing priorities among humanitarian workers poses another significant challenge to effective collaboration between SRH and GBV teams. The heavy workload and the large number of meetings that staff members are expected to attend make it difficult to maintain regular communication and alignment between the two sectors. This challenge often results in missed opportunities for collaboration and joint planning, which are crucial for integrating SRH and GBV efforts.

> "You can't expect everyone to go to every meeting because it's just too many meetings … but if you can make sure that there is someone designated to be responsible for attending and sharing the information, it is important."

Best Practice 10: Cross-representation in meetings

Regularly attending each other's coordination meetings is essential for promoting synergies and ensuring that both SRH and GBV teams are aware of common issues. Including SRH and GBV as standing agenda items in each other's meetings can help normalize integrated approaches. However, due to the challenge of attending multiple meetings, designating a focal person or delegating this task to a partner organization can ensure that information is shared and linkages are strengthened.

Challenge: Irregular and operationally focused meetings

Joint meetings between SRH and GBV teams tend to be irregular and often focus primarily on operational issues such as CMR. While these meetings are important, they limit the scope of collaboration to immediate operational concerns, preventing the sectors from exploring and expanding their linkages into broader areas and restricting the potential for deeper, more strategic collaboration.

Best Practice 11: Hold regular or punctual joint meetings

Holding regular or ad hoc joint meetings between SRH and GBV teams to address specific cross-cutting issues is a best practice that significantly enhances collaboration. These meetings ensure that both sectors remain aligned, addressing shared challenges and working towards common goals. Regular joint meetings facilitate ongoing communication, help identify emerging issues and allow for the coordination of responses that leverage the strengths of both sectors. To maximize their impact, these meetings should be structured to not only tackle operational issues but also to explore and develop strategic linkages between SRH and GBV.

> "… because these (joint meetings) can help us to maintain that solid communication and that solid articulation to work together and provide a better, more effective and quality response across the country."

In various contexts, joint meetings have been used effectively to overcome barriers to collaboration. For instance, in Cox's Bazar, regular joint meetings between SRH and GBV teams focus on advocacy challenges, allowing both sectors to coordinate their efforts in addressing the complex needs of the population. Similarly, in Lebanon and Somalia, task forces have been established to specifically address issues related to CMR, helping to standardize protocols and improve service delivery. One international NGO holds compulsory monthly meetings between SRH and GBV, which are monitored through indicators and hosted and documented by each sector in turn to ensure engagement and ownership. While this occurs at the programmatic level, lessons and best practices from this type of collaboration could be extrapolated to the coordination level.

"The main point is to see people around the same table. The first phase is being able to identify the issue that we want to work on, prioritize it, and then once it is prioritized between the 15,000 things that the Coordinator needs to look at, it's a matter of putting people around the same table and talking."

Recommendations:

- The SRH-TT/national SRHWGs should advocate with the health cluster to have dedicated SRH representation in strategic forums and documents, while also working closely with the GBV AoR to ensure that SRH is integrated into the GBV sections.
- Given its position, the GBV AoR has the responsibility, together with UNFPA country representatives and the health cluster, to support better inclusion of SRH in humanitarian response and take opportunities to advocate for common messages and strategically mainstream SRH in platforms where the SRH-TT cannot be represented (GHC, 2024).
- SRH and GBV Coordinators should attend inter-agency coordination meetings at the country level to identify opportunities for linkages. However, interactions must take place beyond these meetings, and bilateral discussions must be prioritized.
- Encourage and institutionalize joint meetings to address cross-cutting issues, ensuring that both sectors remain aligned, and explore collaborative opportunities beyond operational issues.
- In-country SRH and GBV Coordinators should prioritize attending each other's coordination meetings. When possible, other individuals attending both meetings can be drawn upon to strengthen the linkages between both coordination mechanisms.
- Designate focal points or delegate responsibilities to attend both SRH and GBV meetings, ensuring continuous information-sharing and alignment.

Linking sexual and reproductive health and gender-based violence coordination at the country level

Challenge: Lack of clear roles and responsibilities of Coordinators

Confusion around the roles and responsibilities of SRH and GBV Coordinators, especially at the national level, is another significant barrier to effective collaboration. Personality traits such as proactivity, leadership and strong communication skills were identified as crucial enablers for good relations between SRH and GBV teams, but without clearly defined roles and responsibilities, collaboration can become dependent on individual personalities rather than institutionalized processes, leading to inconsistency and inefficiency.

> "You'll also have some partners for whom it's [attending coordination meetings] not a priority for and they won't necessarily attend. So it depends on how the subcluster Coordinator can draw the team members together."

> **Best Practice 12: Define clear roles and responsibilities**
>
> Establishing and promoting clear roles and responsibilities between SRH and GBV Coordinators is crucial for successful collaboration. This includes prioritizing skills and personality traits that support collaboration during recruitment processes, and ensuring that Coordinators are supported by their respective leaderships.

Challenge: Lack of systemized coordination and support

SRH and GBV Coordinators hold crucial positions that face differences in structure and resources. At the onset of a crisis, a GBV Coordinator can request support from the REGAs for GBV coordination, but a similar system is not yet in place for SRH. Therefore, when a crisis erupts, existing SRH staff in the UNFPA country office who may be more development-focused suddenly have to lead an SRHWG without necessarily having the knowledge, skills or experience to immediately take on the role of SRH Coordinator.

The SRH-TT Baseline Assessment confirmed that SRH Coordinators also frequently find themselves "double hatting", covering SRH coordination responsibilities as well as their normal development-focused roles, which limits their ability to fully address the responsibilities of coordination.

Finally, instances in which the SRH and GBV Coordinators reported to different supervisors (such as in Colombia) or where one Coordinator reported to the other were mentioned as poor practices.

In **Venezuela**, the clear separation between Coordinators and Programme Managers has been identified as a best practice. This separation allows Coordinators to focus on their coordination responsibilities without being overburdened by programmatic duties. In this context, SRH and GBV Coordinators who report to different supervisors or who report to each other have been found to be less effective.

In **Honduras**, the SRH and GBV Coordinators are both employed by UNFPA and report to the UNFPA Humanitarian Coordinator. This ensures harmonized expectations, management and support for both SRH and GBV coordination.

Best Practice 13: Systematize SRH coordination and support

Supportive leadership and management were noted as key for SRH and GBV Coordinators to prioritize collaboration. Systematizing SRH coordination means not only eliminating, to the extent possible, "double hatting" to allow Coordinators to prioritize coordination of SRH response, but also ensuring that technical support and backstopping are available.

Supervision of SRH and GBV Coordinators should be streamlined to ensure consistency in expectations, management and support for coordination. Management at all levels has a responsibility to ensure that there is time and space for SRH and GBV Coordinators to work together and address challenges.

"Management [needs to] make sure there is the space for them to think things through and work together, not overloading teams, and making sure there's room for creativity."

Challenge: High staff turnover and inadequate humanitarian preparation

High staff turnover, particularly during the acute phase of a crisis, presents a significant challenge to effective collaboration between the SRH and GBV sectors. Building relationships and trust, which are crucial for coordinated efforts, takes time. When coordinators leave, the process of establishing these essential connections must often start over, leading to disruptions in service delivery and collaboration.

"Because any time you have a change in the person that is assuming the coordination role, you have to start all over again."

Challenge: Governmental silos and local sensitivities

Governmental silos that separate health and GBV issues across different ministries can also hinder collaboration between SRH and GBV teams. In many contexts, government institutions have similar silos between SRH (often falling under the Ministry of Health), GBV prevention, risk mitigation and response (often falling under the Ministry of Women or a similar institution), and humanitarian response, which might fall under a third institution.

In many contexts, these silos reflect broader societal and cultural sensitivities that complicate open discussions and coordination around SRH and GBV. This challenge is particularly acute in conservative or restrictive environments where openly addressing SRH or GBV issues can be politically or culturally sensitive. In some conservative country contexts, linking SRH and GBV coordination can be hindered by local sensitivities around one area or the other. GBV services may not be explicitly offered, for example, but are provided as part of health or SRH service delivery and referred to as "family services" or "women's diseases". In other

contexts, SRH is considered sensitive, and services are offered under the umbrella of GBV. Open discussion and coordination around GBV or SRH are difficult in these situations, and this can hamper simple coordination activities such as service mapping and development of referral pathways.

> "We do want to coordinate but, because of the restrictive environment and the draconian mindset of the authorities, we cannot openly do that level of coordination."

Best Practice 14: Engage governments

Working jointly with national and local governments is crucial for strengthening the linkages between SRH and GBV, particularly in contexts where governmental silos exist, and crises may lead to opportunities to jointly engage governments on issues relevant to both SRH and GBV. Collaborative efforts with government entities can help align strategies, create unified protocols and ensure that both sectors are prioritized in national policies and emergency response plans.

In both **Somalia** and **Ukraine**, SRH and GBV coordination teams worked closely with their respective Ministries of Health to review and align national CMR protocols. This collaboration helped to standardize care, avoid the development of parallel protocols, and ensure that survivors received consistent and effective services.

Challenge: Lack of engagement of national and local partners

National and local partners are critical to any response. With close relationships to and deep understanding of the communities, they are best able to advise on approaches and strategies to address GBV and SRH and to bridge the gap between the sectors. Local partners may be unaware of the coordination space or see United Nations agencies as disconnected and ineffective (as mentioned by one informant who did not see the United Nations as able to have a consistent presence in the sensitive areas where they work).

Best Practice 15: Engage local actors in coordination

Engaging local partners, especially women-led and women's rights organizations, and building on existing local structures is important for connecting SRH and GBV at the community level. Local organizations have deep contextual understanding, and they are often best positioned to navigate cultural sensitivities and build trust within communities. As noted by a respondent, however, "local partners might be unaware of the coordination space or might see United Nations agencies as disconnected and ineffective", highlighting the need for meaningful engagement with these groups. Involving local partners not only enhances the effectiveness of these efforts but also ensures that SRH and GBV services are culturally appropriate and accessible at the community level. This approach fosters a more inclusive and holistic response, which is essential for addressing the multifaceted challenges faced by vulnerable populations in humanitarian settings.

> "We are the voice of the communities."

Challenge: Inconsistent levels of engagement of partner organizations

Coordination cannot occur without the active participation of the partners, and difficulties arise when there are varying levels of engagement between clusters. Lack of trust and competition among agencies can inhibit collaboration across stakeholders.

> **Best Practice 16: Ensure engagement of partner organizations in coordination**
>
> While UNFPA plays a leadership role in ensuring collaboration between SRH and GBV coordination, the engagement and proactivity of other member agencies are also crucial for effective teamwork. Trust between partners and breakdown of competition among agencies are key to ensuring open and transparent discussions at the coordination level. SRH and GBV Coordinators should actively engage partner organizations to foster broad representation and collaboration in coordination.

Recommendations:

- The GBV AoR, the SRH-TT and national health clusters must systematize the emphasis on linkages between SRH and GBV in their recruitment of and support to country-level Coordinators:
  - Prioritize skills and personality traits that support collaboration in the recruitment processes (e.g. terms of reference) when selecting SRH and GBV Coordinators.
  - The GBV AoR should integrate language on linking SRH and GBV coordination into the GBV Coordination Handbook.
  - The SRH-TT should integrate similar language into the guidance for SRH Coordinators, which is under development.
- The SRH-TT should establish clear criteria and competencies for SRH Coordinators and build their capacities through competency-based training and provision of technical support or backstopping.
- UNFPA should standardize the roles and positions of both SRH and GBV Coordinators, and ensure these are supported by country office leadership, allowing for stronger collaboration.
- To the extent possible, "double hatting" of Coordinators should be eliminated to allow fulfilment of coordination roles and obligations.
- All GBV or SRH actors have the responsibility to engage with their respective clusters and build their members' capacity to ensure the roles and responsibilities of both sectors are understood.
- Both sectors should strengthen staff retention for continuity of collaboration that is not solely dependent on personalities and goodwill.
- Continuous capacity-building for SRH and GBV Coordinators should be ensured to address high staff turnover and ensure consistent service delivery.

- SRH and GBV Coordinators should engage national and subnational governments through joint initiatives, such as updating of SOPs, training of health workers on the MISP and CMR-IPV, joint advocacy for better recognition of SRH and GBV (in conservative contexts), and revision of policies around topics relevant to SRH and GBV to make them more survivor-centred.
- SRH and GBV Coordinators should actively engage partner organizations to foster broad representation and collaboration in coordination.
- SRH and GBV Coordinators should meaningfully engage local partners (particularly women-led and women's rights organizations) and support their role in linking SRH and GBV at the community level and to ensure that services are culturally appropriate and accessible.

Best practices to create linkages on cross-cutting areas of work

Beyond clinical management of rape

Challenge: Overlooking other entry points for linking SRH and GBV

While CMR is included in Objective 2 of the MISP[5] and is a clear entry point for collaboration, other SRH services, such as those for IPV, maternal health, contraception, STI treatment and menstrual hygiene management, are often overlooked as intersections between SRH and GBV, resulting in missed opportunities for broader collaboration and potentially affecting access to and quality of care for survivors.

> **Best Practice 17: Expand clinical entry points for linking SRH and GBV**
>
> Ensuring quality clinical care not only for survivors of sexual assault and IPV, but also for patients seeking other SRH-related services, including contraception, STI treatment, maternal health services and menstrual hygiene management, is a firm responsibility of SRH actors and falls under the SRHWGs while, as with all GBV response, CMR-IPV services must adhere to the GBV guiding principles (the Inter-Agency Minimum Standards for GBV in Emergencies Programming [UNFPA, 2019]). Collaboration between SRH and GBV to ensure that health facilities are prepared to deliver GBV services, as per the case study in north-west Syria, results in improved access and quality of services for survivors.
>
> Certain SRH services may be considered controversial in some contexts and, as such, may pose protection and safety risks for both patients and providers. SRH and GBV actors should work jointly to promote the creation of different and private entry points, and reinforce confidentiality to strengthen the quality of and access to SRH services alongside broader advocacy to improve the SRH and GBV environment.

5 For information on the MISP, see https://iawg.net/resources/misp-reference.

Best Practice 18: Identify and strengthen non-clinical entry points for linking SRH and GBV

Respondents identified multiple non-clinical issues to be tackled jointly by the SRH and GBV sectors, including risk mitigation, GBV risk mitigation in the health sector, intersectoral SRH and GBV mobile responses, prevention work, support for women's access to rights, protection of SRH and GBV front-line workers, standardization of delivery models, targeting of specific populations (e.g. people who sell or exchange sex) or forms of GBV (e.g. child marriage), sustainability of programmes beyond the immediate acute response, mainstreaming of inclusion and adoption of a gender-neutral focus in GBV. Many of these topics will be context-dependent, and will require national and subnational coordination teams to address them together with programming teams.

Mandatory reporting requirements are known to discourage survivors from seeking support (UNFPA, 2019) and may increase risks to survivors, their families and health-care providers who assist them. SRH and GBV Coordinators should develop joint advocacy approaches and aligned messaging against mandatory reporting to mitigate risks.

Recommendations:

- GBV and SRH Coordinators should assess facilities' CMR capacity and build actors' capacity to offer the full CMR-IPV package.
- GBV and SRH Coordinators should identify and build capacities to ensure that other areas for integration of SRH and GBV, including maternal health services, contraception, STI treatment and menstrual hygiene management, are not overlooked.
- SRH and GBV Coordinators should have a clear understanding of the legal and practical parameters of broader SRH services and non-clinical issues such as mandatory reporting to improve care for survivors.
- SRH and GBV Coordinators should collaborate to ensure that non-clinical entry points for linking SRH and GBV are identified and addressed.
- SRH and GBV Coordinators should develop joint advocacy approaches and align messaging around issues common to SRH and GBV.

Training and capacity-building

Challenge: Lack of common understanding and capacities between SRH and GBV

SRH and GBV actors have not been systematically trained on essential topics that are common to both sectors. Informants mentioned that SRH service providers need more exposure to case management, informed consent and referral to protection and other GBV services, and that GBV actors require a better understanding of SRH services beyond CMR.

Best Practice 19: Identify opportunities for joint training and capacity-building

Joint capacity-building activities are particularly effective in developing a holistic approach to survivor care, as they integrate the diverse expertise from both sectors. These trainings ensure that all staff, regardless of their primary focus, are well equipped to handle the complex and overlapping needs of SRH and GBV, especially in humanitarian settings. Moreover, these joint sessions can help mitigate the impact of staff turnover by standardizing knowledge and practices across teams, making it easier to maintain continuity even when personnel changes occur.

Working together to develop and deliver training supports better understanding of roles and responsibilities, and promotes collaboration in programming. The joint delivery of the CMR-IPV training, with GBV experts covering gender-specific topics and SRH experts addressing the clinical components of care, was recognized as a best practice that fosters better quality of care and holistic approaches to providing care for survivors of sexual assault and IPV.

The GHC training for Health Cluster Coordinators incorporates the Inter-Agency Minimum Standards for GBV in Emergencies Programming into its core curriculum and in simulation exercises, ensuring that Health Cluster Coordinators are familiar with the basic priorities of GBV humanitarian response and the roles and responsibilities of health actors in the health response to GBV.

"Training can be one of the few activities that bring the [SRH and GBV] sectors together."

Recommendations:

- SRH and GBV coordination should lead on joint capacity needs assessments and organize and conduct joint training using inter-agency standard curricula that recognize both areas of expertise. Similarly, coordination should lead on joint post-training monitoring, to further support service quality and collaboration.
- Coordination should also address joint capacity-building for other populations, such as community-based front-line workers, community health workers, police, government officials, border authorities, and local and/or women's organizations, to highlight the linkages between SRH and GBV, and to support effective referrals of survivors to appropriate services.
- SRH and GBV should work together on curricula for topics beyond CMR and IPV, and place more emphasis on bringing SRH and GBV teams together in trainings focused on: the MISP, GBV data, protection mainstreaming, provider attitudes, mental health and psychosocial support (MHPSS), legal frameworks, values clarification and attitude transformation (VCAT) and referral pathways.

Case study: Ethiopia

The conflict in Tigray, accompanied by droughts, floods and other natural disasters, has resulted in the displacement of over 4.4 million people, a situation compounded by the 942,000 refugees entering Ethiopia from neighbouring countries. The impacts of these crises go beyond displacement, affecting local communities' access to social services, disrupting markets and hindering humanitarian operations.

The GBV AoR documented over 2,000 survivors of sexual violence who received services through one stop centres (OSCs), health facilities and mobile health teams in Tigray between November 2020 and June 2021. Survivors experienced unintended pregnancies, trauma-related fistulas and prolapse of pelvic organs, as well as increased risk of HIV and STIs, and other health consequences. The majority of survivors sought services after the 72-hour window for emergency contraception, and high numbers sought safe abortion care services. As a result, the GBV AoR joined forces with the SRHWG, which works within the health cluster, to adopt an integrated GBV and SRH response.

A technical working group was established to specifically focus on the SRH needs of survivors of sexual violence and to provide coordinated support to health facilities, including 78 OSCs. The technical working group conducted joint assessments to understand the magnitude of GBV in different regions, and their results informed planning and advocacy.

The GBV AoR and the SRH-TWG worked closely on the HNO and HRP, aligning response needs. They provided IARH kits to 389 health facilities, deployed 378 midwives in GBV service delivery points to offer SRH services and reached over a million individuals with SRH and GBV awareness-raising, information and education activities. To ensure integration across the coordination levels, UNFPA adapted staff profiles to include integrated SRH-GBV Specialists in 10 of 14 regions, to ensure coverage of programming and coordination of GBV and SRH.

Using a common service mapping and availability tool to map partner presence, they developed a Service Referral Directory that brought together information about services, geographic distribution and target populations, as well as the contact details of providers, to better help front-line workers refer survivors to the appropriate services.

They adapted training materials to include both GBV and SRH subjects and conducted joint trainings to 2,132 health professionals on MISP, CMR and GBV in emergencies, ensuring that GBV best practices and referral mechanisms were included.

Together, they adapted the national policy and legislative environment in humanitarian response by developing overarching national SOPs for GBV response and prevention and aligning subsequent service guidelines and training manuals to the SOPs. The medical management manual for sexual violence and post-rape treatment guidelines was jointly revised, and the national strategy and service delivery guidelines were adapted to humanitarian response, formalizing the integrated GBV and SRH response approach. Faced with reduced funding for SRH, all funding requests to country-based Pool Funds and traditional donors advocated for GBV, SRH and coordination outcomes, and joint funding from multiple bilateral and multilateral donors was secured.

Data

Challenge: Data collection and analysis are not aligned

Humanitarian data is challenging, and the sharing of data between SRH and GBV, particularly those related to GBV case numbers, poses further challenges, as their use has safety implications for survivors and those who provide response services. Additionally, SRH and GBV use different data management systems: the health information system (HIS) is used for health/SRH data, and the Gender-Based Violence Information Management System (GBVIMS) is active in many (but not all) countries to collect data on GBV. These systems do not interact, which results in one sector missing survivors that enter through the other without being referred and double counting of survivors who access both services independently. The data produced by these systems are usually analysed separately, which misses the opportunity for more comprehensive assessment of issues related to the accessibility, uptake and quality of services, and the effectiveness of referral pathways.

To protect the anonymity and safety of GBV survivors, GBV data is rigorously safeguarded, and agencies participating in the GBVIMS sign a GBV Information Sharing Protocol (Gender-based Violence Information Management System, n.d.)[6] to access non-case specific GBV data. Since many health and SRH actors are not part of these agencies, they do not have access to this GBV data. However, health/SRH providers also report GBV data through their own health service delivery points and require numbers of cases to forecast commodities for CMR-IPV. This disconnect can create tensions.

On the other hand, it was also mentioned that health/SRH actors have easier access to GBV-related data (from primary health interventions) because they may be more trusted by health-care professionals than GBV practitioners and, especially in contexts where GBV services are restricted, they can gather more controversial information under the cover of other health-related data collection.

> "The [GBV] case management side is disconnected from the health system side."

Best Practice 20: Identify common indicators and explore opportunities for data-sharing and joint analysis

Working together to develop joint assessment, monitoring and data-collection tools reflects the IASC approach and can help identify service gaps, improve quality and inform strategic decisions.

While joint data collection for SRH and GBV may or may not prove feasible or advisable since the data are used for different purposes, and given the sensitivities, confidentiality concerns and potential risks to survivors and providers, it was frequently mentioned as a good practice by respondents from both SRH and GBV respondents. Alignment of data-collection parameters has been attempted in Lebanon by the Danish Refugee Council with the Referral Information Management System, but this has not yet been put into practice.[7]

6 The GBV Information Sharing Protocol offers ground rules and guiding principles on procedures for sharing non-identifiable data on reported cases of GBV, so that GBV service providers adopt and adhere to information-sharing protocols that ensure the security of the client and those involved.

7 For more information about the Referral Information Management system, see https://www.referral-ims.org/.

The UNFPA report "Stronger Together: Integrating Gender-based Violence and Sexual and Reproductive Health Approaches in Humanitarian Settings" suggests the use of "trigger indicators" to track trends and outliers that would alert GBV and SRH Coordinators to specific issues that need to be addressed. For example, monitoring of the rise in antenatal care visits by very young adolescents should trigger investigation and action by the SRH and GBV sectors (UNFPA, 2024).

Identifying common indicators that measure SRH-GBV linkages at both the coordination and programming levels and investigating ways for SRH and GBV information management systems to communicate with each other are areas that can be investigated further. Joint analysis and sharing of data between SRH and GBV teams should be undertaken to identify gaps and potential areas for collaboration between SRH and GBV.

"I don't see analysis being done together. I don't see that identification of barriers and then a joint effort at the strategic [level] to tackle these barriers to ensure access of GBV survivors to services."

Recommendations:

- Sensitize health actors on the use of sensitive GBV data to enable trust and transparent exchange of information.
- Review existing data and harmonize what is being collected, and how it is collected and analysed (which could lead to joint guidance on survivor data management).
- Assess data management systems and investigate alignment of GBV case reporting to avoid duplication.
- Pursue joint analysis, data-sharing, and comparison of trends to better inform strategic decision-making, programming and advocacy.
- Align and update service mapping and referral pathways to reflect the integrated data to support better service delivery.
- Identify and introduce "trigger indicators" to track trends and outliers that would alert SRH and GBV Coordinators to issues that need to be addressed.

Advocacy and messaging

Challenge: Lack of alignment of advocacy and messaging

While many agencies undertake advocacy, few coordinate their messaging. Even within organizations, SRH and GBV do not always align their own messages, which can lead to fragmented or contradictory communication and missed opportunities for increased visibility and funding.

> **Best Practice 21: Align SRH-GBV advocacy and messaging**
>
> Aligning messages for advocacy, communication and IEC materials was strongly encouraged as a key area for collaboration, to capitalize on the strengths and expertise of each sector. Coordination can steer the development of aligned messaging, which would ensure that the targets of advocacy efforts (e.g. donors, governments) receive coherent and consistent information aligned with humanitarian priorities related to both SRH and GBV. This would not only increase visibility, but also foster joint funding and programming, and more holistic and comprehensive approaches to supporting these underserved sectors.

Recommendations:

- Create global advocacy strategies that align SRH and GBV messaging, and increase visibility to donors, governments and other stakeholders to increase awareness and secure resources.
- Work with national stakeholders, including governments, to reflect aligned SRH-GBV advocacy efforts in national health and protection policies, ensuring consistency across different levels of coordination.

Referrals

Challenge: Inconsistent referral pathways

Referrals are another obvious area of collaboration between SRH and GBV sectors, but service mapping is often conflated with referral pathways, which can result in gaps in service delivery for survivors and undermine the effectiveness of coordinated efforts. While service mapping identifies what services are available, where and by whom, and thereby highlights gaps in services (including commodities, trained staff, staff with the right attitudes, etc.), referral pathways provide the information needed by a first-line provider to ensure effective, timely and appropriate referral of survivors.

> **Best Practice 22: Align service mapping to contribute to effective referral pathways**
>
> SRH and GBV coordination should work jointly to map facilities, providers and commodities, in order to then develop referral pathways that ensure both service quality and availability. Regular updates of mapping and referral pathways (especially in fluid security contexts that result in infrastructure damage and population movements) have an ethical impact on survivors, ensuring that they are referred to existing quality services.

Agreed roles and responsibilities between SRH and GBV actors are essential to maintain a quality referral pathway. This worked well in several contexts, including Ukraine, where UNFPA took a clear leadership role, and in Cameroon and Cox's Bazar, Bangladesh, where the GBV subclusters compiled service information received from the SRHWG.

SRH coordination maps EmONC facilities where CMR services could potentially be offered. Ensuring the link between EmONC and CMR service mapping can ensure that CMR services are offered across as many facilities as possible. While joint referral pathways often implicitly refer to referral pathways for survivors of sexual assault and IPV, SRH and GBV Coordinators should work together to ensure that pathways include other GBV and SRH services, such as GBV case management, MHPSS or contraception.

Finally, for referral pathways to be effective, they must be kept up to date and shared across both SRH and GBV networks.

Recommendations:

- The SRH-TT and GBV AoR should streamline and systematize the service mapping (in line with the 4Ws[8]) and referral systems to ease the work of staff at the national and subnational levels. Mapping should include information such as clear focal points, contacts and health facility opening times.
- Country-level coordination should regularly update and align service mapping and referral pathways, including at the subnational level, and communicate these to relevant stakeholders, to ensure that survivors are directed to the appropriate services. They should also establish clear roles and responsibilities between SRH and GBV teams to keep referral pathways up to date.

Commodities

Challenge: Lack of formal guidance on responsibility for leading on procurement of Inter-Agency Emergency Reproductive Health kits

UNFPA is the custodian of the Inter-Agency Emergency Reproductive Health (IARH) kits, which provide health facilities with the SRH commodities and supplies needed to provide MISP services for a period of three months. IARH Kit 3 is the most widely recognized kit related to providing clinical care for survivors of GBV,[9] and contains medications and supplies required for CMR services, including treatment of injuries, post-exposure prophylaxis of HIV, prevention of STIs and prevention of pregnancy (emergency contraception). These commodities, as well as those provided through IARH complementary kits, such as misoprostol and mifepristone to support safe abortion care, can be heavily politicized and restricted in some countries. Commodities are expensive, lead times from order to receipt are long, and managing stock-outs and wastage of these kits is difficult, especially as different drugs within the kits have different expiry dates.

8 Who does What, Where and When (see https://www.ochaopt.org/page/who-does-what-where-and-when).

9 For more information on Kit 3, see the UNFPA manual on IARH kits for use in humanitarian settings (UNFPA, 2021).

In some instances, the GBV sector submits funding proposals for IARH kits, creating confusion around supplies' availability and gaps. Lack of formal guidance on who is responsible for these kits between the GBV AoR and the SRH-TT results in different sectors leading in different contexts, although some informants agreed that the best practice is for the SRHWG to take the lead.

Best Practice 23: Conduct joint SRH-GBV mapping of supplies (in-country and in the pipeline); streamline procurement processes to avoid duplication and gaps

SRH and GBV Coordinators should work together to map service delivery points and supplies that are available/in the pipeline, monitor CMR commodities, and pool information on the availability of Kit 3 for more efficient, effective programming and better resource management.

In the **Democratic Republic of the Congo**, the SRHWG led mapping of commodities, which helped to identify gaps and inform forecasting, and allowed partners to ensure that they were referring survivors to facilities equipped with the appropriate drugs and supplies.

Recommendations:

- SRH and GBV Coordinators should work together to map service delivery points and supplies that are available/in the pipeline, monitor CMR commodities, and pool information on the procurement and availability of Kit 3 and other kits for more efficient, effective programming and better resource management.
- When established, the in-country SRHWG should lead on funding proposals for procurement of IARH kits. In contexts where the GBV sector submits funding proposals for kits, this information should be communicated to the SRHWG or the health cluster (as appropriate), to facilitate tracking of supplies and identification of gaps, and to avoid duplication.
- Country-level coordination should work together to train staff and ensure they are able and supported to monitor and manage utilization of these kits to avoid wastage and ensure adequate forecasting and timeliness of procurement.

Funding and resource mobilization

Challenge: Competition for resources, short-term funding, and limited opportunities for joint funding

Both SRH and GBV are underfunded humanitarian areas (International Rescue Committee, 2019) that may be under-prioritized, especially during periods of restricted funding. While some respondents mentioned that collaboration and dialogue does not require resources, going beyond that to implement joint initiatives requires funding (and coordination and collaboration can support better use of these resources). When SRH and GBV actors are not working together, giving funding to one can be seen as limiting funding to the other, creating unnecessary competition between SRH and GBV.

While donors promote integration of SRH and GBV programming, proposal processes often separate SRH and GBV and require separate indicators, which introduces divisions in the planning phase before a programme even starts. While donors may support linking SRH and GBV coordination, they may be unwilling to prioritize this collaboration over other areas they fund.

Finally, the short-term nature of humanitarian funding limits meaningful sustainable efforts to link coordination and may make it difficult to maintain momentum and continuity in joint initiatives.

> "It's not that we do not have resources. It's just that … since everyone wants to be the protagonists and have the leadership or wants to have the last word, then the resources are not used as they should [be]."

Best Practice 24: Prioritize joint funding

Joint funding initiatives are crucial for supporting the linkages between SRH and GBV and reinforce the need for collaboration between sectors. Coordinated planning and joint funding applications can help avoid duplication and ensure that resources are used effectively to address the needs of both sectors. Donors have a critical role to play in advocating for longer-term joint funding opportunities to support linkages between SRH and GBV coordination.

> "Their engagement with the topic depending on its administration also has an impact on how much the donors can coordinate together on this."

Recommendations:

- Donors should continue to explicitly encourage linkages between SRH and GBV. These linkages will be reinforced if resource mobilization processes are reviewed to better encourage collaboration from the strategic and planning stages.
- Increasing dialogue and coordination among donors will help initiate a unified approach to creating these linkages and hold agencies accountable to the same requirements.
- SRH and GBV actors should advocate for longer-term funding commitments that sustain linkages between SRH and GBV coordination and the integration services, reducing competition and fostering collaboration.

Conclusion

Stronger links between SRH and GBV coordination in humanitarian crises will ensure more effective and efficient use of economic and human resources, and wider coverage of more holistic and better quality services for survivors of GBV.

Coordination requires commitment and effort, especially when the other sector has different, albeit complementary, priorities and "speaks a different language." The SRH and GBV communities face a common struggle to make their own mandate heard within their own clusters. If the clusters struggle to acknowledge the different needs of women, girls and marginalized communities internally – be it GBV within the protection cluster or SRH within the health cluster – it is difficult to go a step further to acknowledge these needs in another sector. UNFPA therefore has an important responsibility to ensure that the health and protection clusters support the remits of the GBV AoR and the SRH-TT, and advocate for their strategic importance in the humanitarian space.

Increasing opportunities for dialogue between SRH and GBV improves tensions and decreases competition, allowing for stronger synergies to be created. Joint training and capacity-building exercises that bring teams together ensure alignment of language and messages, and creates common objectives. Reinforcing the need for collaboration and promoting the mandate of the other sector in meetings, from global conferences to subnational coordination meetings, will also overcome power dynamics and improve relations.

The creation of the SRH-TT opens a new opportunity to strengthen ties and linkages with the GBV community, and the best practices from the field demonstrate a willingness to work together. As we move forward, fostering a collaborative environment, encouraging joint efforts and adopting a common outlook on cross-cutting areas will be not just beneficial, but essential activities. By adopting the best practices identified, we can pave the way for more resilient and responsive systems that better serve the needs of vulnerable populations in crisis situations. The success of these initiatives will hinge on our ability to transcend silos, bridge gaps and work together towards a unified goal: ensuring that every survivor receives the comprehensive care and support they deserve.

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Annexes

Annex 1: Best practices for national SRH and GBV Coordinators to create and strengthen linkages between SRH and GBV coordination (as identified by key informants)[10]

	Preparedness	Response		Recovery
		Acute	Protracted	
• Joint planning based on common objectives (HNO, HRP and combined workplans)	X		X	
• Inclusion of SRH and GBV in data-collection tools (e.g. needs assessments) • Joint data review and analysis	X	X	X	X
• Joint memorandum of understanding with government	X			
• Ensure close physical proximity of offices	X			
• Cross-representation in coordination meetings		X	X	
• Regular or punctual meetings to tackle specific joint issues	X	X	X	X
• Address services beyond CMR	X	X	X	X

10 This is intended as a quick reference tool for SRH and GBV Coordinators and was developed based on the best practices identified by key informants.

• Joint trauma-informed and survivor-centred trainings (e.g. on CMR/IPV, MISP, protection mainstreaming, provider attitudes, MHPSS, legal frameworks, VCAT or referral pathways) • Joint post-training monitoring	X		X	X
• Joint proposal development	X	X	X	X
• Joint advocacy, aligning messages for donors, governments and other stakeholders	X	X	X	X
• Include SRH considerations in GBV SOPs	X		X	
• Plan jointly for procurement and delivery of IARH Kit 3 • Ensure staff using kits are trained on monitoring and managing utilization of commodities to avoid wastage and stock-outs	X	X	X	
• Inclusion of SRH and GBV issues in community outreach	X	X	X	X
• Engage development colleagues to create linkages in the preparedness phase	X			X

Annex 2: Recommendations (by stakeholder)

Stakeholder	Recommendation
GHC and/or Global Protection Cluster	• The health and protection clusters should enable the SRH-TT and the GBV AoR to systematize and strengthen SRH-GBV linkages in alignment with the Health and Protection Joint Operational Framework, recognizing the interlinkages between these sectors and the urgent need to prioritize the specific needs of women and girls in humanitarian crises. • The relationships and ways of working among the GBV AoR, the SRH-TT and the health and protection clusters should be further clarified and promoted to avoid confusion.
Global level: GBV AoR and/or SRH-TT	**Recommendations for fostering collaborative environments between SRH and GBV coordination** • The SRH-TT and the GBV AoR should develop guidance that formalizes the collaboration between SRH and GBV Coordinators and provides concrete direction on joint objectives, roles and responsibilities of different actors, and defines ways of working together. • Collaboration should be prioritized at all levels of coordination, combining top-down directives with bottom-up initiatives to address both strategic and operational needs effectively. • The SRH-TT and the GBV AoR, and national-level coordination should centre SRH and GBV collaboration around objectives rather than activities with a common focus on the well-being and improved health of survivors to avoid division and competition. • The SRH-TT should establish clear criteria and competencies for SRH Coordinators and build their capacities through competency-based training and provision of technical support or backstopping. • Continuous capacity-building for SRH and GBV Coordinators should be ensured to address high staff turnover and ensure consistent service delivery. **Recommendations for creating linkages between SRH and GBV teams** • While the GBV AoR is a member of the HCT and has dedicated sections in the HNO and the HRP, the SRH-TT does not yet have the same representation and is integrated into the health cluster's section. The SRH-TT should advocate with the health cluster to have a dedicated SRH section in strategic forums and documents, while also working closely with the GBV AoR to ensure that SRH is integrated into the GBV sections.

- The GBV AoR, the SRH-TT and the health cluster must systematize the emphasis on linkages between SRH and GBV in their recruitment of and support to country-level Coordinators:
    - The GBV AoR should integrate language on linking SRH and GBV coordination into the GBV Coordination Handbook.
    - The SRH-TT should integrate similar language into the guidance for SRH Coordinators, which is under development.

Recommendations for creating linkages on cross-cutting areas of work

Training/capacity-building

- The SRH and GBV sectors should work together on curricula for topics beyond CMR and IPV, and place more emphasis on bringing SRH and GBV teams together in trainings focused on: MISP, GBV data, protection mainstreaming, provider attitudes, MHPSS, legal frameworks, VCAT and referral pathways.

Data

- The health cluster (both SRH and broader health actors) must be sensitized regarding the use of sensitive GBV data to enable trust and transparent exchange of information.
- The SRH-TT and the GBV AoR must review existing data and harmonize what is being collected, and how it is collected and analysed (which could lead to joint guidance on survivor data management).
- Data management systems must be improved to align how GBV cases are reflected in both systems and to avoid duplication, which will ensure that more accurate data is used.
- Joint analysis and comparison of service delivery, data trends and so on will better inform strategic decision-making, programming and advocacy.

Advocacy/messaging

- The SRH-TT and the GBV AoR (including national-level coordination) should advocate for the importance of SRH and GBV linkages externally. Aligning messages and pushing for increased visibility to donors, governments and other stakeholders, and maintaining sustained advocacy messages will increase awareness and resources.
- Create global advocacy strategies that align SRH and GBV messaging, increase visibility and secure joint funding. Use global platforms to advocate for the inclusion of SRH and GBV linkages in international policy frameworks.

	Referrals • The SRH-TT and the GBV AoR should streamline and systematize service mapping (in line with the 4Ws[11]) and referral systems to ease the work of staff at the national and subnational levels. Mapping should include information such as clear focal points, contacts and health facility opening times. Commodities • The SRH-TT and the GBV AoR should clarify and systematize roles and responsibilities around supply chain processes for commodities (forecasting, procurement, warehousing and last-mile distribution).
Country level: SRH and/or GBV coordination	**Recommendations for fostering collaborative environments between SRH and GBV coordination** • The GBV AoR, the SRH-TT and the health cluster must systematize the emphasis on linkages between SRH and GBV in their recruitment of and support to country-level Coordinators: • Prioritize skills and personality traits that support collaboration in recruitment processes (e.g. terms of reference) when selecting SRH and GBV Coordinators. • The SRH-TT/national SRHWGs should advocate with the health cluster to have dedicated SRH representation in strategic forums and documents, while also working closely with the GBV AoR to ensure that SRH is integrated into the GBV sections. • Given its position, the GBV AoR has the responsibility, together with UNFPA country representatives and the health cluster, to support better inclusion of SRH in humanitarian response and take opportunities to advocate for common messages and strategically mainstream SRH in platforms where the SRH-TT/SRHWG cannot be represented. • Collaboration should be prioritized at all levels of coordination, combining top-down directives with bottom-up initiatives to address both strategic and operational needs effectively. • Emphasize the importance of aligning SRH and GBV efforts around shared objectives rather than separate activities to foster a more unified response.

11 Who does What, Where and When (see https://www.ochaopt.org/page/who-does-what-where-and-when).

- Identify opportunities for dialogue at the country level, such as joint meetings, training and activities that will work to overcome prejudice, competition and resentment.
- Encourage joint funding initiatives for SRH and GBV collaboration, and promote the integration of both sectors into proposal processes and indicators to prevent division and competition.
- Systematize the linkages between SRH and GBV and roll these out at all levels of coordination to ensure that joint opportunities and initiatives are communicated, and that joint objectives are met at all levels of coordination.
- Encourage and institutionalize joint meetings to address cross-cutting issues, ensuring that both sectors remain aligned, and explore collaborative opportunities beyond operational issues.
- Include national counterparts including governments, development actors and local partners, ensuring that linkages between SRH and GBV are introduced as part of emergency preparedness and prioritized at every stage of the humanitarian programme cycle.
- SRH and GBV coordination should meaningfully engage local partners (particularly women-led and women's rights organizations) to foster broad representation and collaboration in coordination and to support their role in linking SRH and GBV at the community level to ensure that services are culturally appropriate and accessible.
- Discussions around coordination linkages must occur beyond the AoR and SRH-TT and be integrated into discussions with national counterparts, including governments, development actors and local partners. This will ensure that linkages between SRH and GBV are introduced as part of emergency preparedness and prioritized at every stage of the humanitarian programme cycle.
- The SRH-TT and the GBV AoR should introduce and advocate for SRH and GBV considerations in government-led national disaster response plans, anticipatory action, and outbreak prevention and preparedness forums when the health cluster is supporting an epidemic/outbreak response, to ensure that SRH and GBV are prioritized from the onset of different types of emergencies, such as public health emergencies.

Recommendations for creating linkages between SRH and GBV teams

- SRH and GBV Coordinators should attend inter-agency coordination meetings to identify opportunities for linkages. However, interactions must take place beyond these meetings, and bilateral discussions must be prioritized.
- SRH and GBV Coordinators should prioritize attending each other's coordination meetings. When possible, other individuals attending both meetings can be drawn upon to strengthen the linkages between both coordination mechanisms.
- Encourage and institutionalize joint meetings to address cross-cutting issues, ensuring that both sectors remain aligned, and explore collaborative opportunities beyond operational issues.
- Designate focal points or delegate responsibilities to attend both SRH and GBV meetings, ensuring continuous information-sharing and alignment.
- Both sectors should strengthen staff retention for continuity of collaboration that is not solely dependent on personalities and goodwill.
- SRH and GBV Coordinators should engage national and subnational governments through joint initiatives, such as updating of SOPs, training of health workers on MISP and CMR-IPV, joint advocacy for better recognition of SRH and GBV (in conservative contexts), and revision of policies around topics relevant to SRH and GBV to make them more survivor-centred.

Recommendations for creating linkages on cross-cutting areas of work

- GBV and SRH Coordinators should assess facilities' CMR capacity and build actors' capacity to offer the full CMR-IPV package.
- GBV and SRH Coordinators should identify and build capacities to ensure that other areas for integration of SRH and GBV, including maternal health services, contraception, STI treatment and menstrual hygiene management, are not overlooked.
- SRH and GBV Coordinators should have a clear understanding of the legal and practical parameters of broader SRH services and non-clinical issues such as mandatory reporting to improve care for survivors.

- SRH and GBV Coordinators should collaborate to ensure that non-clinical entry points for linking SRH and GBV are identified and addressed.
- SRH and GBV Coordinators should develop joint advocacy approaches and align messaging around issues common to SRH and GBV.

Training/capacity-building

- SRH and GBV Coordinators should lead on joint capacity needs assessments and organize and conduct joint training using inter-agency standard curricula that recognizes both areas of expertise. Similarly, coordination should lead on joint post-training monitoring, to further support service quality and collaboration.
- Coordination should also address joint capacity-building for other populations, such as community-based front-line workers, community health workers, police, government officials, border authorities, and local and/or women's organizations, to highlight the linkages between SRH and GBV, and to support effective referrals of survivors to appropriate services.
- SRH and GBV should work together on curricula for topics beyond CMR and IPV, and place more emphasis on bringing SRH and GBV teams together in trainings focused on: MISP, GBV data, protection mainstreaming, provider attitudes, MHPSS, legal frameworks, VCAT and referral pathways.

Data

- The health cluster (both SRH and broader health actors) must be sensitized regarding the use of sensitive GBV data to enable trust and transparent exchange of information.
- Assess data management systems and investigate alignment of GBV case reporting to avoid duplication.
- Pursue joint analysis, data-sharing, comparison of trends and so on to better inform strategic decision-making, programming and advocacy.
- Align and update service mapping and referral pathways to reflect the integrated data to support better service delivery.
- Identify and introduce "trigger indicators" to track trends and outliers that would alert SRH and GBV Coordinators to issues that need to be addressed.

Advocacy/messaging

- Advocate for the importance of SRH and GBV linkages externally. Aligning messages and pushing for increased visibility to donors, governments and other stakeholders, and maintaining sustained advocacy messages will increase awareness and resources.
- Work with national stakeholders, including governments, to reflect aligned SRH-GBV advocacy efforts in national health and protection policies, ensuring consistency across different levels of coordination.

Referrals

- Country-level coordination should regularly update and align service mapping and referral pathways, including at the subnational level, and communicate these to relevant stakeholders, to ensure that survivors are directed to the appropriate services. They should also establish clear roles and responsibilities between SRH and GBV teams to keep referral pathways up to date.

Commodities

- SRH and GBV Coordinators should work together to map service delivery points and supplies that are available/in the pipeline, monitor commodities, and pool information on the procurement and availability of Kit 3 and other kits for more efficient, effective programming and better resource management.
- When established, the in-country SRHWG should lead on funding proposals for procurement of IARH kits. In contexts where the GBV sector submits funding proposals for kits, this information should be communicated to the SRHWG or the health cluster (as appropriate), to facilitate tracking of supplies and identification of gaps, and to avoid duplication.
- Country-level Coordinators should work together to train staff and ensure they are able and supported to monitor and manage utilization of these kits to avoid wastage and ensure adequate forecasting and timeliness of procurement.

Funding and resource mobilization

- SRH and GBV actors should advocate for longer-term funding commitments that sustain linkages between SRH and GBV coordination and the integration services, reducing competition and fostering collaboration.

UNFPA	• UNFPA has a crucial role in promoting linkages between SRH and GBV, and should work to overcome the silos that exist internally between SRH and GBV, through culture change, increased opportunities for dialogue, transparent allocation of resources and strong management support. • UNFPA should systematize the roles and positions of both SRH and GBV Coordinators and ensure that these are supported by country office leadership, allowing for stronger collaboration. • To the extent possible, "double hatting" of Coordinators should be eliminated to enable fulfilment of coordination roles and obligations. • Simple measures, such as co-location of SRH and GBV offices, to facilitate spontaneous interactions and joint participation in meetings, should be encouraged to facilitate better collaboration.
Donors	• Encourage joint funding initiatives for SRH and GBV collaboration, and promote the integration of both sectors in proposal processes and indicators, to prevent division and competition. • Increase dialogue and improve coordination among donors to support a unified approach to creating linkages between SRH and GBV coordination, holding coordinating agencies accountable to shared objectives.
Other actors involved in SRH and GBV coordination	• All humanitarian GBV or SRH actors have the responsibility to engage with their respective clusters and build their actors' capacity to ensure the roles and responsibilities of both sectors are understood.

Annex 3: Key informant interview questionnaire (stakeholders)

My name is XXX. I am a consultant working with the SRH-TT to compile a paper on best practices for SRH and GBV linkages to make recommendations to improve SRH and GBV coordination in humanitarian contexts.

I would like approximately an hour of your time to discuss your experience and thoughts on the topic. Your organization will be named in the methodology section of the report, and the country you represent may be linked to your feedback. However, do specify anything you would like to be kept anonymous and I will accommodate that in the final report. You are of course free to stop the interview at any time.

Do you consent to taking part in this interview?

Are you happy for me to record and transcribe this interview, for the purpose of writing the report? (No one else will listen to the recording.)

1. Tell me about your experience with SRH/GBV coordination.

2. What are areas that SRH and GBV coordination should work together on? *(Prompt: training/capacity-building, data, advocacy, referral, working with local governments, commodities, funding)*

3. Can you tell me about coordination modalities (ways of working together) that you have seen successfully breach the silos existing between SRH and GBV? Any examples of coordination modalities that did not work?

4. What do you think are some of the enablers for both sectors working well together?

5. Can you tell me about any success stories where SRH and GBV coordination mechanisms worked together for a positive outcome, and why it worked well?

6. What do you think are some of the barriers to both sectors working well together?

7. Can you give me any examples where SRH and GBV coordination mechanisms did not work well together, and why?

8. Can you give me any examples where coordination challenges between SRH and GBV were overcome, and how?

9. Do you have any other thoughts or examples of good practice in terms of integrating or linking SRH and GBV coordination that you would like to share?

Annex 4: Key informant interview questionnaire (donors)

My name is XXX. I am a consultant working with the SRH-TT to compile a paper on best practices for SRH and GBV linkages to make recommendations to improve SRH and GBV coordination in humanitarian contexts.

I would like approximately an hour of your time to discuss your experience and thoughts on the topic. Your donor organization will be named in the methodology section of the report and may be linked to your feedback. However, do specify anything you would like to be kept anonymous, and I will accommodate that in the final report. You are of course free to stop the interview at any time.

Do you consent to taking part in this interview?

Are you happy for me to record and transcribe this interview, for the purpose of writing the report? (No one else will listen to the recording.)

1. Tell me about your experience with SRH/GBV coordination.

2. What areas should SRH and GBV Coordinators work together on? *(Prompt: training/capacity-building data, advocacy, referral, working with local governments, commodities, funding)*

3. Can you tell me about coordination modalities (ways of working together) that you have seen successfully breach the silos existing between SRH and GBV? Any examples of coordination modalities that did not work?

4. Can you give me any examples where SRH and GBV coordination worked well, and why?

5. Can you give me any examples where SRH and GBV coordination did not work well, and why?

6. From a donor or funding perspective, what is the value of SRH and GBV working together at the humanitarian coordination level?

7. From a donor or funding perspective, are there disadvantages of SRH and GBV working together at the humanitarian coordination level?

8. If you were to make a recommendation to the SRH Task Team, the GBV AoR or the field, what would you like to see in terms of linkages between SRH and GBV coordination? Is there anything you might not want to see anymore?

9. How should the donor community be engaged in SRH and GBV coordination linkages?


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