



**“Our lives are integrated,
our needs are integrated,
our program and work
should be integrated.”**

External Assessment of IRC's SRH/WPE
Integration Programming

International Rescue Committee | January 2022



List of Acronyms

CCSAS	Clinical Care of Sexual Assault Survivors
GAC	Global Affairs Canada
GBV	Gender-Based violence
IGA	Income Generating Activities
IRC	International Rescue Committee
M&E	Monitoring & Evaluation
PM	Programme Manager
SOP	Standard Operating Procedure
SRH (R)	Sexual and Reproductive Health (and Rights)
TA	Technical Advisor
VAWG	Violence Against Women and Girls
WGSS	Women and Girls' Safe Spaces
WPE	Women's Protection and Empowerment
WASH	Water, Sanitation and Hygiene

When integrated with health, Women and Girls' Safe Spaces (WGSS) are called different things depending on location. They are also known as Women and Girls' Wellness Centres, Comprehensive Women's Centres and Integrated Women's Centres. For clarity, this report uses only the term WGSS.

This assessment report is written in British English.

Image on cover page – South Sudan Global Affairs Canada Programme. *Adrienne Surprenant*.

This assessment was funded through IRC's partnership with Global Affairs Canada (GAC), through the project, Women and girls' health and safety needs in Chad, Nigeria, Pakistan, South Sudan, Ethiopia, and DRC are addressed and met during COVID-19 in 2021/22.

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1. Summary

To explore IRC staff experiences and perceptions of SRH/WPE integrated programming, a quantitative and qualitative survey was sent to staff who are either working on the GAC project or staff with integration experience from other integration projects, in December 2021, and 48 responses were received. A further 10 key staff members participated in semi-structured interviews during January 2022.

The survey showed staff perceptions of their belief in and enthusiasm for integration has grown significantly since they joined IRC. They feel their knowledge grew less than their belief and enthusiasm, which might mean they are underestimating their knowledge or they felt knowledgeable from the outset, or could suggest that a high level of knowledge isn't necessary for staff to gain belief in and enthusiasm for integration.

Another survey finding was that staff feel collaboration between SRH & WPE is essential – more so than collaboration with other sectors, such as WASH and nutrition.

When staff gave examples of challenges, (59%) were within IRC, followed by external organisations (18%), community (13%), then accessibility/ infrastructure (8%) and finally Covid-19 (2%). Successes had been mainly around service delivery (44%), followed by staff, training and ops (28%), then community (16%), value (7%) and collaboration with partners (5%). So it looks like a lot of the issues staff face are located in the same spheres as the successes. For example, challenges within IRC are 59%; successes in service delivery together with staff, training and ops add up to 72%. On the other hand, working with external organisations brings a significant proportion of the challenges, and the least successes. This could suggest that challenges within IRC are easier to resolve than those with external organisations.

The final qualitative question in the survey asked how staff would respond if a colleague said they thought integration didn't make sense. 24 responses (50%) were helpful and indicated that the staff member not only sees the value and role of integration but also can describe it well. For example; “SRH/WPE integration is the bedrock of any meaningful programming which prioritises woman-centred programming and seeks to empower marginalised groups as far as their health and socio-economic wellbeing is concerned.”

The interviews explored challenges and successes (which largely reflected challenges and successes in the survey responses) as well as needs and suggestions of SRH and WPE Programme Managers (PMs) in Nigeria, Pakistan, Democratic Republic of Congo (DRC) and South Sudan. A large proportion of the challenges PMs had faced had

been resolved by themselves and their teams, with great success. For example, communities had gone from having no understanding of integration and being very hostile to any SRH or WPE services, to embracing integration and helping teams identify new locations for implementation.

The interviews showed powerfully that no matter the context, challenges or newness of integration to any given location, staff experiences of SRH/WPE integration and its benefits for women and girls have demonstrated to them the value of integration.

Enablers include the great enthusiasm for and belief in integration of staff, support from dedicated SRH/WPE integration Technical Advisors (TAs), shared/ joint resources and work, strong relationships with communities, strong relationships with external organisations, and successful integration itself, with positive outcomes being a powerful enabler of further integration.

Fundamental barriers that would be difficult for staff to resolve, included: integration not being prioritised by senior managers in either sector in some locations; integration not being prioritised by service providers and governments (although this is actively addressed with engagement and advocacy work); and the short timeframe of the GAC project. The timeframe isn't a barrier to integration per se, but staff are worried about what will happen to the women and girls they serve and all their work on integration when the project ends in March 2022

IRC's SRH/WPE integration is progressing at different paces depending on the location, but in every context it is making an immense difference to health and safety outcomes for women and girls. In some locations, dramatic progress has been made, and staff are all hopeful that this work be able to continue..

A central integration toolkit, advocacy at a national level and deepening of the women-centred approach by making programme design participatory are some of the suggestions from staff on what would help them with their work on SRH/ WPE integration, and would maximise the future role of integration.

2. Introduction & background

Humanitarian settings and the Covid-19 pandemic affect women and girls differently and more fundamentally to men and boys. Intimate partner violence and sexual violence increase during times of social pressure and during any kind of lockdown, whether it's due to Covid or Ebola, women and girls are confined with their abusers and cannot get to places of safety. In humanitarian settings, the social structures, social norms and institutions that might normally provide protection, access to justice, information and solidarity have fallen away. Humanitarian responses tend not to take into account a) how women and girls are affected differently and more severely by the crisis, and b) that women and girls are often less able to access what they need (including basic survival needs) than men and boys. Additionally, responses and services focus on the crises at hand, and the needs of women and girls are neglected. For example, the health sector during Covid pandemic has focused on providing treatment for Covid patients, infection prevention and delivering vaccination programmes, leaving women and girls in need of urgent medical and other services for anything other than Covid out in the cold.¹

Sexual and Reproductive Health (SRH) services and International Rescue Committee's (IRC) Women's Protection and Empowerment (WPE) services are provided in humanitarian settings under two separate sectors – SRH within Health and WPE within Protection. In deeply patriarchal societies where women and girls face early forced marriage, adolescent pregnancy and high levels of gender-based violence (GBV), their SRH and WPE needs are intrinsically linked. SRH and WPE serve the same people, have highly aligned intended outcomes, a lot of crossover and women and girls often need access to both simultaneously for the same issue, so require efficient referral pathways. SRH and WPE are not only complementary, but inseparable if they are to be effective.

In response, and guided by feedback from women and girls, IRC began a programme of SRH/WPE integration, starting in South Sudan 2012 and expanding to other locations. By 2021, integration work was ongoing in South Sudan, Nigeria, Ethiopia, Democratic Republic of Congo (DRC), Bangladesh, Pakistan, Chad, Yemen, Myanmar and Kenya with more comprehensively in some locations than others, depending on when it started and individual contexts.

Due to the Covid-19 pandemic, pressures on the health and protection sectors increased exponentially, with government-controlled country-wide lockdowns that often led to reduced service provision and impacted women's ability to seek care and help. Meanwhile, we saw the corresponding increase in need for integrated SRH and WPE services. Global Affairs Canada (GAC) recognised the importance of IRC's integrated SRH/WPE provision, especially during Covid, and provided emergency funding to help address the gaps left in services for women and girls.

The GAC-funded project is entitled '*Women and girls' health and safety needs in Chad, Nigeria, Pakistan, South Sudan, Ethiopia and DRC are addressed and met during Covid-19 in 2021/22*'. It started on 1st April 2021 and will run until 31st March 2022, so this assessment began at the end of the project's third quarter. The purpose of the assessment is to explore how integration of SRH/WPE programming is progressing as perceived by staff on the ground, what factors are enabling success and what factors are preventing integration, as well as the perceived value of integration in improving health and safety outcomes for women and girls. In addition, there is a lack of evidence on the benefits and risks of integration in community-based integration versus traditional health facilities and Women and Girls' Safe Spaces (WGSS), so the data gathered for this assessment could provide more of such evidence. IRC technical staff had some idea of the barriers to- and enablers of- integration, but realised that their own positionality may prevent objective research, and therefore appointed an independent consultant (Gemma Driver) to undertake this assessment.

Humanitarian settings and the Covid-19 pandemic affect women and girls differently and more fundamentally to men and boys. Intimate partner violence and sexual violence increase during times of social pressure and during any kind of lockdown, whether it's due to Covid or Ebola, women and girls are confined with their abusers and cannot get to places of safety.

1. International Rescue Committee; What Happened? How the Humanitarian Response to COVID-19 Failed to Protect Women and Girls; October 2020

3. Methodology

This small, straightforward informal study employed a mixed methods approach to explore the following research questions:

- 1. What are the experiences with SRH/WPE integration as perceived by IRC staff?**
- 2. What are the enablers and barriers to successful SRH/WPE integration as perceived by IRC staff engaged in integration programming?**
- 3. What is the role of SRH/WPE integration in terms of improving health and safety outcomes for women and girls in humanitarian settings?**

SURVEY

A quantitative and qualitative survey was sent to 54 IRC staff who are either working on the GAC project or staff with integration experience from other integration projects. 48 responses were received.

Survey data in separate English and French language batches was collated for analysis. The quantitative data was analysed using a Google Sheets spreadsheet.

For the qualitative data, answers under each survey question were listed according to the research questions (experiences, barriers, enablers, perceptions); those that are very similar to each other will be counted, and then those that would be coded into groups. For example, under barriers the groups included 'community/ cultural/ context', 'IRC', 'external agencies/ service providers', 'Covid-19'.

It was then possible to quantify the types of experiences, barriers, enablers and perceptions, effectively conducting quantitative analysis of the qualitative data, as well as exposing patterns and outliers.

See the [Appendices](#) for the survey (and interview) questions and a list of the qualitative survey responses.

INTERVIEWS

Eight semi-structured key informant interviews (KIs) with 10 GAC project staff, conducted by the consultant, took place between the 7th and 17th January 2022.

Interviews were conducted via online video calls, reverting to messages when internet connectivity difficulties became insurmountable. Interviews were in English or French depending on the informant's preference. Participants consisted of one SRH Programme Manager (PM) and one WPE PM working in Democratic Republic of Congo, Nigeria, Pakistan and South Sudan, plus two Technical Advisors – one in SRH and one in WPE. One of the interviews was with the two TAs, including Sanni Bundgaard (SRH), who collaborated with the consultant throughout the assessment. The questions for this interview were different from the other KIs.

The interviewer took notes during the interviews and also recorded the audio, so that they could be transcribed if necessary and any pertinent quotes extracted.

Analysis of individual interviews was done immediately after they took place, with comparative analysis as an ongoing process throughout the interviews and following the final one.

Analysis of such a small number of interviews centred around drawing out key information and insights, and helpful quotes. They were also coded for barriers to- and enablers of integration, and these along with suggestions were grouped according to theme.

ETHICS

There were no ethical concerns attached to this research project, in terms of the interviews or assessment causing harm to IRC staff who were interviewed or to beneficiaries. It will hopefully have been beneficial for informants to express their experiences and views confidentially.

However, there were some safeguards in place to protect informants. At the start of each interview, they were asked to give formal informed consent to be interviewed and for the interview audio to be recorded. They were given the option for their interviews and quotes to remain anonymous or to have their name attached to their data. They could change their mind on their choice until the report was drafted.

It was made clear that any suggestions made by informants were just that, and may not be acted on by IRC. No promises were made, other than that the final report would be shared with them and they would be invited to the presentation of findings.

4. Findings

4.1.1. SURVEY

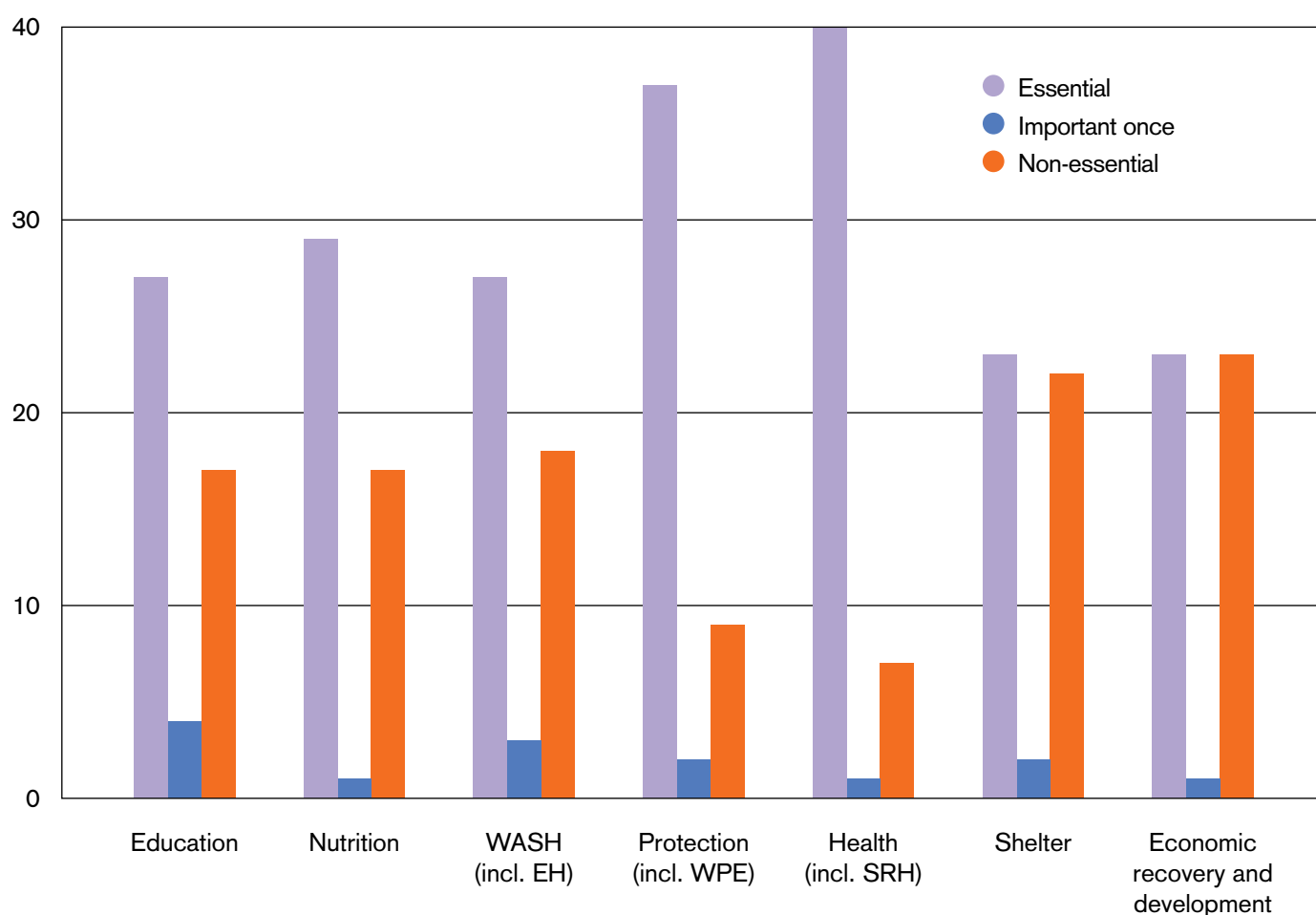
There were 48 responses to the survey; 26 from staff working in WPE or other sub-sector, 20 from staff working in SRH or other sub-sector, one from a staff member from a community health programme, and one from a staff member working in ‘Humanitarian Health Program (HHR)-Emergency Response’. The survey responses produced the following data:

QUANTITATIVE

- There was a pretty even spread of length of service, with the most respondents (8) working for IRC for 10+ years.
- More respondents felt they have a medium to large amount of experience in SRH/WPE integration. Only one selected ‘very little’ – the lowest option.
- The most agreement on the question of which sectors/sub-sectors respondents felt were most important to collaborate with for better overall outcomes for women and girls in humanitarian setting was on Protection (including WPE) and Health (including SRH) – most respondents felt that collaboration with both these sectors were essential – 77% for Protection and 83% for Health.

This indicates that most respondents view integration as essential. As all respondents work in Health and Protection, they are bound to have a biased viewpoint, but this result does demonstrate belief in SRH/WPE collaboration over collaboration with other sectors.

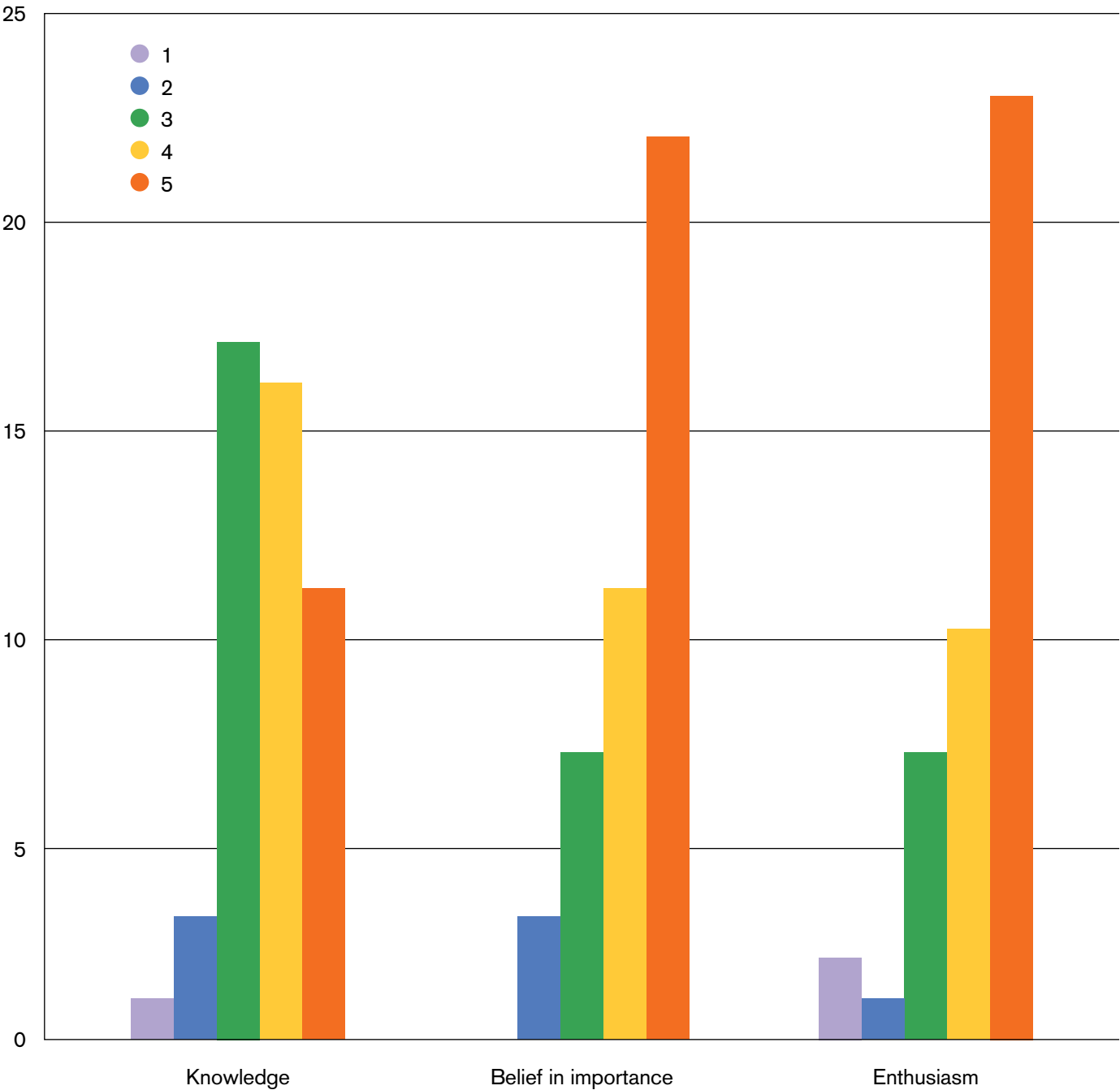
- There was most disagreement on Shelter and on Economic Recovery & Development, with almost equal numbers of respondents who felt that collaboration with these sectors is essential and non-essential. For Education, Nutrition and WASH, there were a few more respondents who felt these are essential than non-essential. Very few selected ‘important once services are established’ for any sector.



- For the question, ‘During your time with IRC, to what degree have you increased your knowledge of WPE/SRH integration?’, most selections on the 0 (‘Not really’) to 5 (A lot) scale were for 3 (17 selections) or 4 (16 selections), with 5 getting 11 selections, 1 was selected once and 2 got three selections. This indicates that respondents felt their knowledge of integration increased from a middling amount to a lot.
- For both the question, ‘During your time with IRC, to what degree have your belief of how important WPE/ SRH integration is increased?’ and ‘During your time with

IRC, to what degree have you increased your enthusiasm about WPE/SRH integration?’ the most selections were for 5 followed by 4 and a reduction down the scale. This suggests that belief in the importance of integration and enthusiasm for integration had increased significantly during staff’s time with IRC – somewhat more so than their knowledge of integration. This could imply that staff don’t feel they need huge amounts of knowledge to be convinced of the importance of integration, but staff may be underestimating the amount of knowledge they have gained – or their knowledge was high from the onset.

Knowledge of, belief in importance of, and enthusiasm for integration



QUALITATIVE

There was significant range in the answers for each of the qualitative questions, reflecting the diverse contexts represented and variations in integration success. However, overall, the responses demonstrated a good understanding of integration and its purpose, as well as providing lots of useful insights into barriers to and enablers of integration, and examples of telling experiences. Quoted responses have been corrected for spelling and grammar; the original, unedited versions can be found in [Appendix 2](#).

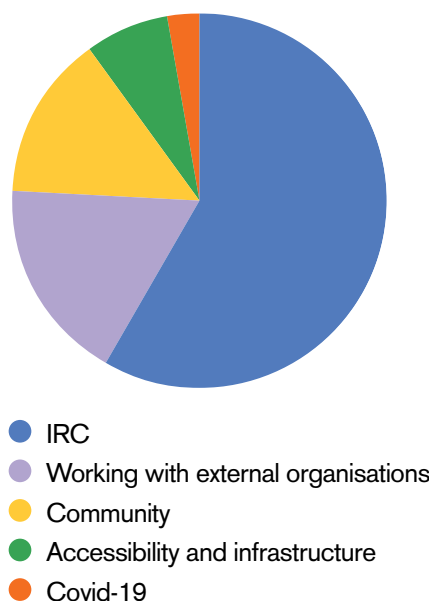
When asked to describe SRH/WPE integration, 35 (73%) respondents demonstrated a good understanding of it – for example, *“It’s amazing, especially in the Nigerian context. Full package of services, it eases a lot of stress and ignorance about life. It helps prevent and respond to GBV. It paves way for women and girls to understand their rights and make appropriate decisions. Integration helps strengthen our relationships with community which led to community participation.”*

10 (21%) respondents did not seem to have understood what was being asked of them (*“Great!”*), and five responses could indicate a possible lack of understanding of integration – *“Enabling women, girls, boys and men on accessing essential SRH services in humanitarian settings and hard-to-reach areas.”*

The question on challenges encountered on integration essentially elicited responses describing 97 barriers staff faced. The majority of the barriers mentioned – 57 (59%) – were located within IRC, which means they can be addressed internally. This percentage might sound high, but it is perhaps not surprising that staff working within IRC and asked to think of challenges they have faced will identify difficulties in their daily working lives at IRC. Additionally, when analysing the challenges themselves, we can see that they are known issues, some of which may have been resolved. Other than these:

17 (18%) to working with external organisations
13 (13%) related to community-based context
8 (8%) related to accessibility (external to IRC) and infrastructure
2 (2%) to Covid-19

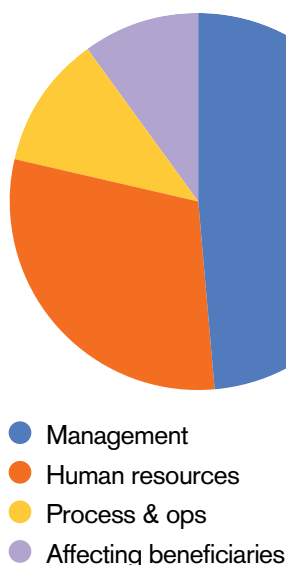
Challenges/barriers



Notably, five respondents (i.e. 10%) said they hadn't encountered any challenges. It is quite astonishing that even when asked to think about challenges, five staff members couldn't identify any, especially considering the challenging and complex contexts in which they are implementing integration. Given these contexts, zero challenges would be practically impossible, so it may be that the question wasn't understood or answered properly.

To explore the challenges located within IRC, they were further split into the categories of management (28 responses or 49%), human resources (17, i.e. 30%), process and operations (7, i.e. 12%), and directly affecting beneficiaries (6, i.e. 11%).

IRC challenges



Some examples of common responses for each of these 'locations' for barriers:

IRC – Power tussle between managers or coordinators; lack of universal management approach/ universal planning at all levels; poor M&E (data not comparable) lack of clarity; competition between the sectors at expense of beneficiary; duration of project; focus on outputs rather than outcomes; lack of training, skills, staff, qualified (female) staff; operations systems causing delays; service providers footing the bill for bank charges; lack of privacy/ confidentiality in services.

External organisations – Government health staff lacking capacity, skills, understanding integration and preventative services etc in government; government policy ambiguity or insufficiency; lack of prioritisation by government; SRH delivered by other organisations; need for clinic licence/ registration; discrimination => some centres refuse treatment.

Community-based context – Lack of community awareness or acceptance; conservative beliefs/ misconceptions; stigma for survivors of GBV; weak literacy; community court/ family agreements; lack of access to community.

Covid-19 – Procurement of drugs, access to cash and travel authorisations more difficult => delays in service; prevention of community engagement work – this is significant despite only getting one mention, because of the enormous importance of community engagement, as found through the survey and particularly the interviews.

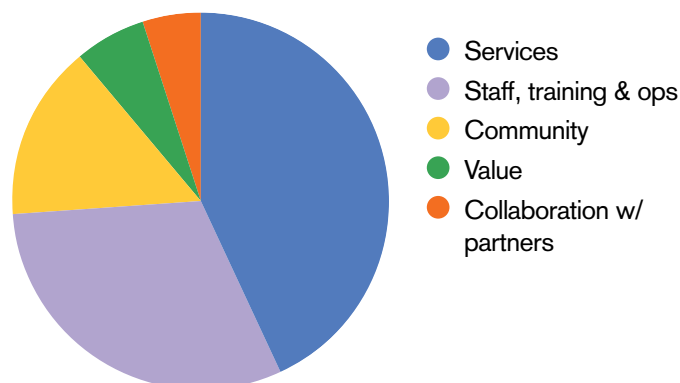
When asked for experiences of integration successes, staff gave a total of 75² examples, and answers demonstrated that respondents understood what successful integration looked like and that they are seeing the positive impacts of successful integration on outcomes for women and girls, for example; *“Improved acceptance and access for women and girls to both SRH/WPE services in IRC programming. Availability of a wide range of services within close range and in a timely and confidential manner. Improved referral system which is client centred and women/girl friendly.”*

Successes were categorised as services (33, i.e. 44%); staff, training and operations (21, i.e. 28%); community (12, i.e. 16%); value (5, i.e. 7%); and collaboration with partner organisations (4, i.e. 5%).

All successes were due to the work of IRC staff, whether on the ground or through high level management or support. They also correlate neatly with the challenges – staff overcame challenges such as lack of community understanding through successful community engagement. This means that lack of access to communities, either due to Covid restrictions or other

factors, will have made it difficult for staff to engage with and get vital approval and support from communities.

Successes/enablers



Examples of common types of responses by grouping:

Services – “One stop shop”; increased access to services at safe spaces, integrated centres or with integrated teams; common/ clear referral pathway [lack of one was listed as a challenge]; SRH awareness sessions at WGSSs; holistic care; all staff able to provide SRH care; SOP [lack of one was listed as a challenge]; GBV rooms/ services in hospitals (called ‘women’s rest room’)

Staff, training and operations – Collaboration/ synergy of staff; joint training; shared knowledge, capabilities, understanding and guidelines; joint campaigns; training, coaching, capacity building of staff [lack of these were listed as challenges]; improved outcomes (due to integrated design) and long-term protection for beneficiaries; enthusiasm/ buy-in from staff in both sectors.

Community – Increased community understanding/ engagement on harmful norms affecting SRH rights and needs; stakeholder coordination meetings; peer support, peer educators, community advocates and health volunteers delivering sensitisation, and capacity building for these groups.

Value – Integration of activities, resources, fundraising (adds weight and impact); maximum utilisation for HR and supplies; harmonisation of data => work not duplicated [duplication of work was a challenge].

Collaboration with partner organisations – joint discussions with implementing partners; coordination/ collaboration with donors => donors’ activities adjusted; healthcare providers’ attitudes transformed.

2. A note on weighting of challenges and successes, of which there were 97 and 75 identified respectively: Challenges are often an intrinsic part of integration work and are often resolved by staff. They also tend to be very specific. Successes can be more fundamental and broad - “Holistic care delivered”, i.e. integration delivered, and integration can progress despite challenges. It is therefore not helpful to compare the number of challenges and successes.



Courtesy of IRC Nigeria. KC.

One response included seven bullet points describing joint coordination meetings, capacity building of partner organisations and multiple community engagement activities. The community engagement activities were only counted once, but it should be noted that work with the community carried a lot of weight in this response and others.

It is clear that the successes of integration described in the survey responses act as enablers for further integration success, meaning that successful integration is an enabler for deeper integration; the outputs and outcomes of successful integration demonstrate the importance and role of integration to staff, beneficiaries, communities and partner organisations. Successful integration is a feedback loop.

The final qualitative question asked how staff would respond if a colleague said they thought integration didn't make sense. 24 responses (50%) were helpful and indicated that the staff member not only sees the value and role of integration but also can describe it well. For example;

“SRH/WPE integration is the bedrock of any meaningful programming which prioritises woman-centred programming and seeks to empower marginalised groups as far as their health and socio-economic wellbeing is concerned. The advantages and success is clear and in North-East Nigeria where the patriarchal nature of the culture creates power imbalance, SRH/WPE through the WGSS approach has created a safe niche to access stigmatised and sidelined services, especially women-centred services, without the watchful eye of men in the community.”

“Much of the consequences of GBV affect SRH... SRH education and services are a huge component of GBV prevention. In many contexts we work in, societies are more conservative or religious, where SRH information and services are stigmatised and taboo. If SRH and WPE integrate in safe spaces, where women and girls can receive different types of services, information, and activities, there is more confidentiality and protection on who is receiving/doing what at the centres. Whereas an ‘SRH centre’ or ‘SRH room’ is more visible and there is less privacy for women and girls to receive services. Furthermore, it is more effective for units to be integrated where we can work with the same target population, provide more effective referrals, use the same facility for services.”

“Our lives are integrated, our needs are integrated, our program and work should be integrated.”

The other 24 respondents' answers were not necessarily 'wrong' in any sense, simply not useful for this assessment as they didn't provide insight into their level of understanding or how they value integration. For example, “It makes sense”; “It is essential”; “No”.

A few of the responses were defensive and not constructive, as the staff member would simply tell their colleague that the colleague had not understood or clearly didn't have all the proper information (or even that they were ignorant of the benefits), without qualifying it by providing more information or their own understanding of why integration makes sense. This isn't necessarily relevant to this assessment, but it may be something to note for supporting staff with how they communicate, and equipping them to advocate for their important work. These types of responses made up the majority of answers supplied in French.

4.1.2. SURVEY FINDINGS CONCLUSIONS

In analysing the survey responses according to the research questions;

1. What are the experiences with SRH/WPE integration as perceived by IRC staff?

Overall, staff experiences and perceptions of integration are very positive. Joint training on integration convinced staff of its importance, enabling successful integration. Experiences of successful integration propelled staff's enthusiasm for- and commitment to it, whereas feeling highly knowledgeable about integration was not necessary for gaining belief in its importance. Challenges relating to the context (community, government, partner organisations) are dealt with effectively and seen as part of the work of integration. Challenges located within IRC are frustrating and can impact the success of integration, but they do not curb staff conviction in it.

2. What are the enablers and barriers to successful SRH/WPE integration as perceived by IRC engaged in integration programming?

Enablers:

- Joint SRH/WPE training
- Regular joint meetings
- Joint community and partner organisation engagement
- Successful integration itself

Barriers:

- Lack of understanding and prioritisation of integration by external organisations including government agencies. [Can be mitigated to some degree by enablers]
- Lack of community understanding and support for integration; community resistance. [Can be mitigated effectively by enablers]

- Lack of staff, lack of qualified female medical staff, lack of training and lack of skills, within IRC and other organisations.
- Lack of integration at higher levels within IRC creating conflicting interests
- Focus of IRC management on outputs/ indicators rather than outcomes for women and girls.
- Delays caused by IRC operational processes including procurement
- Covid-19 affecting procurement, travel and access to communities.

The first two barriers concerning partner organisations and communities can be at least partially mitigated by staff on the ground, if all the enablers are in place. (Government agencies present more of a challenge depending on the context.) The remainder of the barriers can compromise the enablers and therefore the ability of staff to implement successful integration.

3. What is the role of SRH/WPE integration in terms of improving health and safety outcomes for women and girls in humanitarian settings?

Staff on the ground see the role of integration in improving outcomes as primarily giving women and girls access to all the services they need, as well as ongoing protection from GBV, via a woman-centred approach. For this role to be achieved, they feel integration is needed at every level (including management and coordination) and every stage of programming, starting with planning and fundraising.



South Sudan Global Affairs Canada Programme. Adrienne Surprenant.

4.2.1. INTERVIEWS

Staff were all keen to participate in their interviews and have their contributions linked to their names, but – apart from some quotes – they have been kept anonymous.

The interviews demonstrated that staff experiences and perceptions of integration differed enormously, even between people working in the same project areas. Differences were down to the length of time integration had been implemented in participants' locations, length of time staff had been with IRC and/ or working on integration, informants' backgrounds and context.

However, although each interview provided unique insights, there were a number of common barriers, enablers, experiences and suggestions, which will be examined according to the theme, below.

All informants expressed passionate belief in the value of SRH/WPE integration, and commitment to implementing it, including the one interviewee who described a backsliding of integration that amounted to abandonment of it – they vehemently voiced a desire to reinstate integration and a call for collaboration and unity:

"I would like it to come back to life and even better! [...] If this leadership can come together and say 'OK maybe we don't understand. How can we understand this thing?' [it could be brought back to life]. This thing is not a tussle for power! This thing is just because of common interests. It has worked before! [...] It is adding value and quality to our programming."

IRC LEADERSHIP

All non-TA informants said that a big help in implementing integration has been the highly collaborative and regular support and guidance from TAs, via online video calls. Challenges included the lack of field visits from TAs (to identify areas for improvement and see whether work is in line with GAC/ IRC standards) and lack of in-person training from TAs, both of which were seen as out of IRC's control due to security problems and Covid. Frequent suggestions for improvements included visits from TAs and training by TAs. More mentorship from TAs was also suggested, as was TAs supporting continuation of thinking about integration and implementation.

"Patty, [Patricia/ Patty Gray, WPE TA] [...] every two weeks I have a meeting with her to discuss challenges and get guidance. [...] She's there all the time to provide support and guidance at any level if I need it. So it's been good that [...] all of them [TA, Team Lead, Protection Coordinator, Health Coordinator and Head of Technical Excellence] are available – they are just one message or email away if I need support at any time, so I think that helps a lot. [...] And new ideas are very much welcomed by them" – Mehvish Bibi, Pakistan

One staff member in Pakistan had no knowledge of integration until they were recruited in August, but following their initial training, became utterly dedicated to it. This could suggest (like the survey responses) that even a basic level of knowledge of SRH/WPE integration is sufficient for staff to be thoroughly convinced by its benefits to women and girls and therefore its importance.

Managers on the ground also wish they could carry out a lot more 'deep field' visits. Just as they recognise how beneficial TA visits would be, so they are aware of how detrimental their own lack of visits to project locations can be, and what problems are caused by this. Staff felt that not being able to visit due to conflict, risk of kidnapping, poor roads during rains and inability to get the required government permissions is out of their and IRC's control. However, one manager's planned visits were not going ahead due to their supervisor not prioritising them. Road closures and security risks mean that travelling by plane is the only option and seats are very difficult to secure. They are not impossible to get hold of, though, so the determining barrier here seems to be lack of prioritisation of higher level staff.

This lack of prioritisation of integration by senior staff other than TAs was a common barrier to implementing integration in most locations, with supervisors and technical coordinators based in the health and in the protection sectors not prioritising integration or – it was felt – women and girls. Country managers were also described as not prioritising integration. A power struggle or competition between management in the two different sectors was also frequently mentioned by staff. Resources and staff being funded by different sectors was mentioned as a barrier, and may be part of this issue.

Pakistan seems to have buy-in and support at senior levels of IRC. This could be due to a smaller programme with less staff and therefore a flatter, simpler structure, although the hierarchical structure was mentioned as an enabler here – and a barrier in other locations.

PROGRAMMING & SERVICES

All the interviews supported the survey findings that joint meetings, work plans, engagement strategies, training (their own training and training they give to other organisations), workshops, outreach and sensitisation and shared materials and resources are all key to successful integration. As soon as SRH or WPE teams start any work separately, integration is degraded and segregation begins to take hold. Permanently reinstating the post of integration officer was a suggestion to reverse this situation. All informants mentioned the importance of very regular joint meetings, for sharing ideas and identifying and dealing with issues, and the importance of joint community sensitisation sessions and outreach work. Interviewees frequently described deep collaboration between SRH and WPE teams and mutual respect for each other's areas of expertise.

"One thing that worked well is the two managers having joint meetings and supervision to the field sites [...] such visits have really made the team implementing the project understand the importance of integration because it is never just a single manager going to see what the teams are doing but it's more like jointly doing it. [...] There is a oneness that the team has built, and you can hardly tell who is who; there is a oneness and togetherness, and a flow of trust." – Zarah Garba Geidam, Nigeria

One TA mentioned that the regular coordination meetings that had been included in the GAC budget had been very helpful in Pakistan, because, *"it flags to us where integration is or isn't happening by the way they're talking and then we're able to work with the teams a bit more concentrated on what is integration, and I've seen a change with that team over the past year."*

Staff in South Sudan found – upon the establishment of joint premises – how important it is for successful integration to have a central place for both teams to be based together. Informants in other locations also stated the need for joint facilities, for both integration coordination and integrated service delivery.

If any staff or service providers do not receive training on integration and therefore do not understand it, do not understand how WPE relates to SRH, implementation is compromised. However, basic training is very effective and new staff quickly grasp integration and become enthusiastic about it.

Logistics were often mentioned as a problem for integration programming, including tensions over which sector should provide which vehicles. Some issues were resolved through meetings. Suggestions for tackling ongoing problems were to include logistics at the planning stage, and to partner with development NGOs to improve roads and network connectivity. Another suggestion was for TA support and management for development work more generally, i.e. working with partners to improve infrastructure and develop

permanent services for women and girls rather than purely short-term urgent care delivery.

Informants feel that services should be delivered where the greatest need is, not just according to where there is existing healthcare provision, implying that there may need to be a shift in how outreach work and programme expansion are planned.

Staff in Pakistan, where there is better network connectivity, find social media a powerful communications, sensitisation and engagement tool for integration – a "main road" – and recommend tapping into it as much as possible. They have a WhatsApp group on which psychologists advise SRH and WPE staff on case management. The 'Lady Health Visitors' (an important component of the Pakistan programme) dealing with SRH cases communicate with IRC WPE staff via WhatsApp, using shared client numbers to ensure confidentiality, consistency and rapid, seamless referrals, and avoid duplication and confusion.

It is clear from the interviews that gathering client feedback on integration in every context is prioritised by IRC as an organisation and by staff, so although it may currently be difficult to evidence the case for integration using quantitative data, there should be plenty of evidence of both risks and positive experiences and outcomes from beneficiaries of community-based integration. Interviewees described overwhelmingly positive feedback but also that action is taken in terms of programming in response to negative feedback, and individual cases are followed up. Suggestions and requests are solicited, listened to and acted upon.

"One of the main things I love at IRC is that they are [...] very much serious about clients' feedback. They have multiple proactive and interactive channels through which they can receive feedback from clients. It can be around anything; around the service delivery part or the outreach activities and they have virally distributed the accountability contact details [...] and it was very encouraging to see that we have been receiving a lot of feedback from the clients on that hotline [...] – that includes positive and negative feedback. And then they work on that feedback and they get back to the client; if the issues were resolved or not and to keep follow up on that feedback, so it is very good." – Mehvish

"[Integration] is actually working very well, because we have seen a great impact in terms of the number of beneficiaries we are reaching. Within the GAC project we are also doing quarterly awareness just to see the level of awareness for the beneficiaries that we are targeting and we are getting very positive feedback from our beneficiaries in terms of the services we are offering." – Kadra Noor Abdullahi, South Sudan



South Sudan Global Affairs Canada Programme. *Adrienne Surprenant.*

The Technical Advisors recognise the need for teams to see outcomes being met and hear from women and girls how integration is making a positive difference to their lives.

At least two locations have experienced trying to roll out integration without understanding or engaging the local community first, which inevitably created hostility – communities had no understanding of what SRH/WPE integration is or how it could benefit them, and were worried that IRC was going to make “their women stubborn”, among other things. However, it seems these situations occurred in the locations where integration was first introduced (Nigeria and South Sudan), so there was bound to be learning to start with. Tensions were thoroughly resolved through enormous efforts and initiative of the teams on the ground. All informants described (joint SRH/WPE) community sensitisation and engagement as a major component of their work on integration.

Some examples of common engagement successes, all carried out jointly:

- Establishment of community support groups (mens' and womens')
- Engaging with religious and community leaders; showing them what an important role they can play in outcomes for women, men and children.
- Engaging women leaders
- Training community groups and leaders to be advocates (e.g. they convince parents at household level)
- Engaging with teachers
- Providing learning sessions for children and adolescents on menstrual hygiene, early forced marriage, how to report rape and healthy choices
- Messaging via local radio, social media and safe spaces.
- Weekly comprehensive sexuality education for women and girls at safe spaces
- Engaging men and boys.

All this work has resulted in community leaders insisting and enabling IRC to stay in their area and continue delivering integrated programming when facilities had to be vacated, and working with SRH/WPE teams to identify which areas they think are most in need of mobile outreach units next.

An example of engaging men was in response to the common problem of women needing consent from their male partners to access contraceptives. Using ‘Engaging Men in Actionable Practice’ (EMAP) groups located in WPE programming, that normally learn about GBV, activism and accountability, the health team are “reaching out to men and educating them” about SRH, family planning, consent, forced marriage and teen pregnancies. This is a new initiative and there was some resistance at first, especially at one site, but the team resolved this and are taking “baby steps” (with community leaders initially), and feel progress is being made.

Two informants suggested engaging women, including community leaders, in planning, design and implementation of integration, essentially proposing a more participatory approach, to foster greater support for services and higher quality services. One informant suggested monthly meetings with women and girls to get their input on the programming, discuss how to address challenges and understand what beneficiaries want rather than simply delivering what has been decided already. Being listened to and having their views incorporated into programme design will make women and girls feel valued, and the informant thinks that they will feel more comfortable accessing safe spaces.

Confidentiality and privacy of services as an enabler (and lack of them as a barrier) to integration was mentioned regularly in the survey responses and interviews. The interviews shed more light on the various ways confidentiality and privacy can be compromised and the impact of that. For example, the mobile units in Nigeria only have screens to protect survivors of GBV who are trying to access services. They need tents but can't access funding for them from either sector.

Another example, also from Nigeria, is girls and young women accessing SRH services at centres feeling uncomfortable and stigmatised due to being 'judged' by other and older women. Meanwhile, women accessing family planning services were uncomfortable due to invasions of "rowdy" girls attending economic empowerment workshops – this particular problem was resolved through joint meetings to find solutions, but services clashing is clearly an ongoing issue that needs managing. To improve solidarity and understanding between different groups of women, one informant suggests:

"Hold awareness seminars to educate women and girls on the importance of SRH services for girls and the consequences of not receiving such assistance when a girl is abused. Space for adolescent girls should be considered in future WGSS designs for clinical treatment."

The surveys and interviews highlight the need for smooth, clear, simple referral pathways to ensure integrated service delivery. Issues with referrals either not being made consistently or pathways being too muddled to systematically follow have been ironed out through joint SRH/WPE coordination meetings, with staff developing the simpler systems they need. One suggestion from country staff in Nigeria is to make it mandatory to refer all GBV cases to the SRH team.

To meet the needs and requests of women and girls, another suggestion from Nigeria is to provide services 24 hours a day. This is needed because, a) large proportion of GBV cases occur at night when centres are closed, and b) women and girls can find it difficult to access centres during the day, due to work and unpaid care duties, and also due to feeling stigmatised – it would be easier for them to visit a centre under cover of darkness.

Informants reported that one area that has been difficult to integrate and which is itself a barrier to SRH/WE integration, is reporting. It should be noted that staff in Pakistan have found the dedicated IRC Monitoring & Evaluation (M&E) team to be not only highly effective but also very supportive in offering help and feedback. However, the reporting that the SRH and WPE teams do has not always been integrated. This causes duplication of work, double-counting and multiple records of beneficiaries, confusion about roles and significant discrepancies, and produces data sets with different metrics to each other that are consequently not comparable.

Reporting is a source of friction between teams – as illustrated by the very first interview quote – each wanting to claim credit for meeting targets or achieving indicators. Survey responses and interviews frequently mention the importance of clarity of roles, responsibilities, accountability (and what success looks like), and M&E is an example of how a lack of these elements negatively impacts integration and the teams. It also of course doesn't help the quest for evidence of benefits and risks, making fundraising more difficult.

Some staff feel that supervisors are too focussed on indicators and not enough outcomes for women and girls or on what women and girls want and need. The M&E systems may be encouraging this culture, but if they were designed as integrated and measured indicators of woman-centred programming, they could reverse it.

SRH/WPE teams have in some instances been able to resolve M&E problems themselves through their joint meetings and due to their motivation to fully integrate their work.

Several staff -both country staff and Technical Advisors – talk about the need to maintain focus on what women and girls want from safe spaces. It might simply be to chat with each other, which they may not otherwise have any opportunity to do. In any case, it should not be the two sectors "preying on" (TA) women and girls.

One enabler of integration mentioned only by one TA is the GAC project Theory of Change for SRH/WPE integration. She describes it as "totally integrated including the outcomes". In which case, it could be useful to examine whether and to what extent the reporting systems have been designed according to the Theory of Change.

Staff frequently suggest that projects should be integrated from the design and planning phase, and that they should "come in" in an integrated fashion", rather than as separate SRH or WPE projects. Theories of Change are usually sector specific (for example, one for GBV prevention and response, and one for SRHR), but according to the same Technical Advisor, they are fully aligned in their sub-outcomes so that integrated programming is obvious and straightforward. It is therefore important that the Theories of Change are used for designing projects, which should result in more projects that are more integrated from the outset.

Interviewees did not demonstrate much or any awareness of integration work in other countries. This is not surprising, because they are immersed in the daily challenges of their own work and environment. But as they have learning in common, there are wasted opportunities to learn from each other, avoid making the same mistakes and maximise effectiveness. The Technical Advisors recognise the need for a more structured toolkit of guidelines for TAs and country staff, so they can start new integration programming without "reinventing the wheel" and without making the same mistakes. Such a resource would contain different integration models and case studies to illustrate them. This would enable programme staff to learn from each other without going through the TAs.

The Technical Advisors feel this toolkit needs to be "scientific and systematic", possibly produced by a dedicated team, and that it could then be made available for other organisations to use.

Another purpose of the toolkit could be fostering solidarity across IRC and beyond. As Patty said, *"It is tough working on anti-oppression work, right? Which includes making sure there are services for women and girls. So I think as the integration approach grows, realising we have allies together, we're not working on this alone is actually a huge benefit as well. Especially as we begin to respect each other's work and understand and support women and girls together."*

The GAC SRH/WPE project was aimed at mitigating the impacts of Covid specific to women and girls, including the reduced prioritisation of non-Covid-related health services. It is therefore no surprise that some barriers to integration were due to Covid, and informants regularly reported that health services were focussed on preventing transmission and treating Covid patients. South Sudan seemed to be the hardest hit by the impacts of Covid. Restrictions on numbers allowed at health centres and safe spaces (and queuing up for them) meant that women couldn't always access services when they needed them. Less people were

allowed in vehicles at once – even wearing masks – so joint outreach work became very difficult to manage logistically. A successful solution was to incorporate integration work with dissemination of information on Covid and vaccinations, and distribution of materials such as masks and sanitiser. It should be noted that before the GAC project began in April there were no community services at all.

"Every time something has been labelled Covid-specific money like this it goes to health and it goes to infection prevention [...] The fact that GAC was bold enough to say that this was specific Covid money and it was a fairly big amount of money and that they wanted that to be spent on women and girls increasing availability of services, that was pretty cool. We are honoured that they came to us with that pot of money. [...] The fact that they recognised that we have a specific focus on women and girls and that we do it well, I think that was something people were really motivated by." – Sanni



South Sudan Global Affairs Canada Programme. Adrienne Surprenant.



Muna and her older sister Kumis fled their home in the Nuba mountains in 2016. Today, they attend the IRC's classes on how to prevent gender-based violence, which tends to spike during times of crisis. *Adrienne Surprenant.*

EXTERNAL ORGANISATIONS

Informants noted challenges in working with external partner organisations on integration – government agencies, service providers, UN agencies, other NGOs and community structures – but also gave lots of examples of really successful partnerships. As with community engagement, staff put a huge amount of work into building relationships with other organisations, as it is a major strand of integration. They are in constant communication with other organisations and hold regular meetings with them to exchange ideas and iron out issues. When a healthcare provider in South Sudan felt threatened by IRC's integration work when the mobile facility came to their area;

“We were able to have a meeting with them [the other organisation's leadership] and we were also able to have a meeting with that primary healthcare unit so they could understand exactly what we were doing; ours is more of an outreach service, providing actually a helping hand to the services they are providing and it doesn't involve their staff losing their job. And was until [sic] they understood that we started working very well [together].” – Longa Luis Sylvester, South Sudan

Immaculée Masika, DRC; “It starts with the IRC team. It's the IRC team that needs to understand integration. Once the team understands integration we don't have any problems. We need to start with us first of all [...]

Lucien Biral, DRC; “[...] Once the team understands the importance of integration, it will be very easy to implement an integrated project. And even our clients and our partners will understand the importance of integration.”

Immaculée; “[...] Training regular meetings with service providers helps everyone understand and know what each other is doing and understands the value of each other's work. [Translated from French]

Excellent relationships with local government organisations are built through joint IRC SRH/WPE training of government staff, regular joint meetings to coordinate efforts and continuous communication.

Frustrations with government organisations include lack of prioritisation of integration (or even recognition of its merits by policy makers in Pakistan, although on a local level there are collaborative relationships and buy-in), and work being considered 'complete' and therefore the need is not recognised in a few locations. Difficulties in Pakistan stem from the complex structure of ministries and departments that overlap and are under-resourced. For example, the Health Department and the Population Welfare Department both provide family planning and are both short of contraceptives;

“I think this should be only the one department, not two separate departments, then integration will come. [...] All the departments should be integrated with each other, on the same goals for the same outcomes.” – Dr Mohammad Amal Khan, Pakistan

Solutions to issues of working with government organisations suggested by country staff in various locations centre around high level advocacy (in collaboration with other organisations), including training for staff at every level in government, especially policy makers.

IRC in Pakistan teams up with other NGOs (Save the Children, World Vision) and is working in close partnership with UNICEF and UNFPA on integration, all in collaboration with provincial government departments.

Some quoted successes/ enablers were the establishment of GBV units in hospitals and mobile government psychologists, as well as psychologists permanently stationed at health centres throughout opening hours, and young, energetic staff being recruited in government departments and IRC.

Informants additionally find collaboration and even integration with government agencies, NGOs and IRC teams serving other sectors is helpful when focussing on improving outcomes for women and girls, namely WASH, nutrition and child protection.

GAC & FUNDING

It was sometimes difficult to separate GAC-funded integration work from other integrated programming for this assessment, because the project was incorporated into existing activities. However, there were some specific findings on the impact of GAC funding.

In South Sudan, GAC funding enabled capacity development and training of teams, which an informant there felt had been key for successful implementation.

The most common comment on the GAC project in interviews was the short timescale. In Pakistan, for example, recruitment, MoUs with the government and other agreements were not completed until August. It is incredible what has been achieved in such a short time, but;

"This was an emergency project due to Covid. [...] It took two or three months to get [started] [...] so the time duration of this project was very short. Now things are streamlined, the processes are streamlined, people are getting services at each level but very few [sic] time is left. So now women [and girls] are even requesting to extend the project, because we have had very positive feedback from [them] at the safe spaces, because they have got a place, a space where they can have some time for themselves. I have been visiting the spade spaces and it is very encouraging to see the energy levels among the women and girls at the safe spaces. They are talking with each other, sitting with each other, they are playing games, they are learning new skills and I can see the happiness on their faces – all of them have a big smile on their faces." – Mehvish

Staff and beneficiaries are asking for the extension of the project well beyond March 2022, and also the expansion of it to more locations.

"The GAC project has been one [...] of the very good projects that has come in an integrated fashion from the design to implementation phase. Sadly enough it is a one year project that is ending. And I must say [...] that we just started, especially for the host community, conducting outreaches – it is something that we are seeing a lot, a lot, a lot of great impact that we have been doing for the last, let me say, nine months. It would be good to ensure that we have a continuity of the same. Support – not just for that specific field site but also extended to other field sites within South Sudan. This would ensure that for the gains we have already made we are able to sustain them and also have a lasting impact in the longer [term] future" – Kadra

"It is moving on well, however [...] it does not look here very clear that this integration programme might go a long way. The starting is OK but now the sustainability component is another thing that we are looking at. [...] We are little a bit worried that we have started this, how does the future look today? Are we able to sustain this within this community who are benefitting from the services being provided? That is a question we move with in our minds, and I feel like this kind of integration should not be only one year, it should be for example a period of 2,3,4, 5 years so you know that even within the community we should be able to empower the community themselves to know that this is what we need to go with." – Longa

One Technical Advisor feels it is important to understand the SRH/WPE relationship "takes time to be built and needs to be maintained". If something goes well there maybe a tendency to think that piece of work is complete, but it is a permanent process.

Funding is unsurprisingly seen by staff as an enabler of integration, and the "need is enormous" (country staff in DRC); lack of funding (and staff and materials) is noted as a barrier, while value is frequently quoted as one of the benefits of integration. Integration means that funding is maximised because resources, materials and premises are shared.

It is evident from the interviews that support, guidance and collaboration from the Technical Advisors has been absolutely vital for integration. GAC funding allowed the TAs to focus exclusively on integration, and this is the single most significant reason that SRH/WPE teams were able to channel their enthusiasm and expertise to deliver integration, despite more senior management often not prioritising it. One TA said that at HQ and country levels, IRC has "dedicated people who believe this is the right thing to do and want to push this forward. It is a message that they decided to have technical staff that are allowed to focus on it."

"And what enabled [progress] also was GAC allowing us to focus on women and girls. If it had been a broader project that just did integration, I don't think this would have been possible. Having dedicated funding actually does matter." – Patty

"Every country programme has moved forwards at its own pace, and it's nice to see with something that takes a long time and we only had a 12 month project to do that, but to see that even taking the initial steps and learning from that has been very inspirational." – Sanni

4.2.2. INTERVIEW FINDINGS CONCLUSIONS

1. What are the experiences with SRH/WPE integration as perceived by IRC staff?

The interviews showed powerfully that no matter the context, challenges or newness of integration to any given location, staff experiences of SRH/WPE integration and its benefits for women and girls have demonstrated to them the value of integration.

The interviews added weight to some enablers and barriers that were only mentioned once or twice in the survey responses, such as the length of the programme and lack of privacy/ confidentiality.

2. What are the enablers and barriers to successful SRH/WPE integration as perceived by IRC engaged in integration programming?

Enablers:

- Dedicated, passionate staff on the ground
- TAs focussed entirely on integration
- Staff desire to identify issues with support from TAs and address them
- Joint meetings, work plans, engagement strategies, training (their own training and training they give to other organisations), workshops, outreach and sensitisation and shared materials, premises and resources.
- Strong community engagement
- Strong engagement with external organisations
- Confidential services with smooth, integrated referral pathways.
- Clarity of roles and responsibilities
- Integrated Theory of Change
- Maintaining a woman-centred approach, so that focus does not drift from outcomes for women and girls to meeting targets.
- Projects that are integrated from the planning stage, like the GAC project.
- Beneficiary feedback
- Funding exclusively for SRH/WPE integration and exclusively for women and girls.

Barriers:

- Senior staff in health and protection not prioritising integration or women and girls
- Lack of physical visits from TAs
- Logistics problems
- M&E and reporting systems
- Covid and Covid restrictions
- Short timeline of the project
- Projects that are not integrated from the planning and fundraising stages

3. What is the role of SRH/WPE integration in terms of improving health and safety outcomes for women and girls in humanitarian settings?

SRH/WPE integration is evidently vital for improving health and safety outcomes for women and girls. Successful integration means that women can have physical and psychological needs met in safety, in one place. In humanitarian settings, and with its own funding, it also serves to protect services for women and girls that would otherwise be sidelined. Further, all of the many important services and functions SRH/WPE integration encompasses struggle to survive in humanitarian settings individually. When they are all held together as integrated programming, their future becomes secure.

A central integration toolkit, advocacy at a national level and deepening of the women-centred approach by making programme design participatory would maximise the future role of integration.



Tabetha, IRC case manager at the Women and Girls Safe Space in South Sudan. Adrienne Surprenant.

5. Conclusion & recommendations

Many of the challenges of integration – community resistance, service providers not understanding it, unclear referral pathways et cetera – can be and have been addressed by the distilled list of enablers below. The barriers listed are fundamental issues that would be difficult or impossible to resolve by programme staff.

Enablers:

- Enthusiasm and belief in integration of staff
- Support from TAs
- Shared/ joint everything
- Strong relationships with the community
- Strong relationships with external organisations
- Successful integration and its outcomes

Barriers:

- Integration not prioritised by senior managers in either sector
- Integration not prioritised by service providers and governments
- Short timeframe of the GAC project

IRC's SRH/WPE integration is progressing at different paces depending on the location, but in every context it is making an immense difference to health and safety outcomes for women and girls. In some locations, dramatic progress has been made, and staff are all hopeful that this work be able to continue beyond March 2022.



Veronica, above with her mother, Amou Makuei. *Adrienne Surprenant.*



Courtesy of IRC Democratic Republic of Congo. O. Acland.

RECOMMENDATIONS

- **Secure multi-year funding to sustain and deepen integration in all areas where it has already been established.** It is vital that once integration has been established in any location, funding is sought to ensure that all the activities underway can continue uninterrupted and sustainably. Leverage the GAC project to attract other donors to invest in projects that are integrated from the outset.
- **Take participatory and feminist driven approaches to program design and implementation of projects focused on women and girl outcomes from the proposal-writing stage and throughout.**
- **Implement integration at all levels of hierarchy and all project stages with close reference to Theories of Change and their aligned sub-outcomes.** Include common woman-centered indicators throughout the project cycle.
- **Increase hands-on in-person support for PMs from TAs (Covid restrictions allowing).** Continue ring-fenced funding for specialized TAs to focus on supporting integration efforts. Provide training for staff on the long-term benefits of integration, beyond service provision. i.e. social change, and on the guiding intersectional feminist principles of integration – If integration is only about effective service delivery (measured in outputs), there is a danger that the women-centred approach will be eroded.
- **Harness the expertise of PMs and supporting them to share learning across IRC.** Explore the provision of forums and opportunities for integration program staff globally to communicate with each other.
- **Develop a toolkit containing models of integration and case studies.**

6. Appendices

6.1. APPENDIX 1 – SURVEY QUESTIONS

1. Which sector are you currently working in?

- Protection (WPE or other sub-sector)
- Health (SRHR or other sub-sector) community health program
- Humanitarian Health Program(HHR)-Emergency Response

2. How long have you been working at IRC?

Options to select 0 – 10 years

3. How much experience do you, in your own opinion, have with WPE/SRH integration?

Options 1 (very little) to 5 (a lot)

4. In order to achieve better overall outcomes for women and girls, which sectors (or sub-sectors) do you find most pertinent to collaborate with in humanitarian settings?

Option to select 'Essential', 'Non-essential' or 'Important once essential services are established' for Education, Nutrition, WASH (incl. EH), Protection (incl. WPE), Health (incl. SRH), Shelter, Economic recovery and development.

5. During your time with IRC, to what degree have you increased your knowledge of WPE/SRH integration?

Options 0 (Not really) to 5 (A lot)

6. During your time with IRC, to what degree have your belief of how important WPE/SRH integration is increased?

Options 0 (Not really) to 5 (A lot)

7. During your time with IRC, to what degree have you increased your enthusiasm about WPE/SRH integration?

Options 0 (Not really) to 5 (A lot)

8. How would you describe SRH/WPE integration in your own words?

Free text

9. Some of the challenges I have encountered with WPE/SRH integration are...

Free text

10. Some of the successes I have encountered with WPE/SRH integration are...

Free text

11. If a colleague says that SRH/WPE integration doesn't make sense, I say...

Free text

6.2. APPENDIX 2 – LIST OF QUALITATIVE SURVEY RESPONSES

CHALLENGES (i.e. OFTEN BARRIERS) TO INTEGRATION (total)	97
IRC	57
Management	28
• Providers/ managers inflexible and resistant to integration [includes staff at other organisations]	5
• Lack of universal approach in management or care providers and planning at all levels	4
• Lack of coordination (e.g. meetings)	4
• Poor M&E due to different tools (incomparable data) or 'bad' indicators	2
• Power tussle between managers/ coordinators	1
• Lack of accountability on integrated activities	1
• Unclear roles	1
• => Both sectors try to get credit at expense of beneficiary	1
• Staff forget they're all serving the same person with the same purpose and objectives	1
• Some project areas not reached	1
• Low rate of referrals between health and protection	1
• Providers/ managers focus on outputs not outcomes	1
• Nutrition not included in WGSS	1
• Sharing knowledge => duplication of roles	1
• Staff not assigned roles in partnership => lack of synergy	1
• Lack of coordinating body	1
• Duration of project	1
Human resources	17
• Lack of training	2
• Lack of skills	1
• Lack of staff	1
• Staff time stretched	1
• Lack of qualified staff	1
• Lack of WPE staff qualified in SRH and GBV	1
• Lack of female SRH staff	1
• Requirement of staff to find female medical professionals	1
• SRH staff need training on case work for VAWG and confidentiality	1
• Staff need trauma counselling	1
• Staff not empowered to be creative/ use initiative	1
• Lack of understanding from health colleagues on risks and challenges of CCSAS	1
• Poor understanding of 'why' integration => lack of enthusiasm	1
• Lack of SOPs and job aids	1

• Not enough information on handling GBV cases	1
• When IRC health team aren't available to provide medication to survivors. We refer survivors for medical services to other actors instead of our own health colleagues.	1
Process and operations	7
• Non-involvement at proposal writing/ lack of planning	1
• Funding [lack of]	1
• IRC systems	1
• Bank charges taken from funds transferred to service providers => don't receive full expected (budgeted) funds	1
• Long IRC procedures cause long waits for suppliers and payments to service providers	1
Affecting beneficiaries	6
• Privacy/ confidentiality [lack of] at centres, e.g. SRH clinic with 'intrusion' of adolescent girls attending workshop	2
• Lack of clear/ smooth referral system	1
• => Delay in responding to emergency SRH	1
• Repetition of survivors' stories	1
• Commitment [lack of] to ensuring survivors have services	1
WORKING WITH EXTERNAL ORGANISATIONS	17
• Government health staff lack capacity, skills, and knowledge on integration and preventative services for survivors of GBV	2
• Government not prioritising	2
• SRH implemented by other organisations	2
• Collaboration/ coordination with local authorities	1
• Advocacy to local authorities due to need for clinic licence	1
• Government policy ambiguity	1
• Some centres refuse to provide services	1
• [Due to] Discrimination	1
• Requirement of clinic registration	1
• Authorisation of activities by health authorities that consider previous IRC services (overlapping) as delivered and good.	1
• Managing integration via different organisations	1
• Medicine provided under policies often not sufficient [presuming government policies but could by IRC?]	1
• Government staff and other stakeholders thinking SRH is separate, with no link to empowerment.	1
• Samples should legally be done by police – not practiced.	1
COMMUNITY	13
• Community awareness [lack of]	3
• Conservative beliefs/ misconceptions	2
• Stigma of survivors	2
• Weak literacy	1

• Community acceptance	1
• Access to communities	1
• Perceived to be 'women's problems' but men are the problem/ cause	1
• Community court/ family agreements	1
• Male intimate partners not accepting contraception	1
ACCESSIBILITY (EXTERNAL TO IRC) & INFRASTRUCTURE	8
• Access to services at night	1
• Starting from scratch in community settings	1
• Weak health infrastructure	1
• Lack of quality SRH or WPE services in places where women are vulnerable [this could also come under IRC]	1
• Infrastructure	1
• Sectors located at different sites	1
• Not linked to police, legal or children's services.	1
• Services don't exist/ are bad quality due to economic, geographic, socio-cultural reasons.	1
COVID-19	2
• Covid has made procurement of drugs, access to cash and travel authorisations more difficult, leading to delays in service.	1
• Covid has prevented community engagement work	1
SUCCESSES/ ENABLERS THAT ACT AS FURTHER ENABLERS OF INTEGRATION (total)	75
SERVICES	33
• “One stop service” at integrated locations	9
• Increased access to SRH at safe spaces/ integrated centres, including in areas where there was a WPE centre but no health centre, or there was a health centre but no WPE centre	8
• Double/ common/ clear referral pathway for sexual and gender-based violence	6
• SRH awareness sessions at WGSSs	2
• Holistic care	1
• Specialist doctors, midwives and WPE team all able to provide SRH	1
• Free services	1
• SRH increasingly prioritised in WPE	1
• Health staff have SOP	1
• GBV room establish in a hospital	1
• GBV room in another hospital previously called 'rape detection room' is now called 'women's rest room'	1

• Integration with IGAs	1
STAFF, TRAINING AND OPERATIONS	21
• Collaboration/ synergy of staff	3
• Joint training of both sectors	3
• It's easy to link the issues, needs and crosscutting agenda	2
• Shared knowledge, capabilities, understanding and guidelines	2
• Enthusiasm of SRH and WPE staff	1
• Training, coaching and capacity building of staff	1
• Joint campaigns	1
• Effective dissemination of information to staff	1
• Health staff trained on CCSAS	1
• Case review meetings with case workers	1
• Regular checking of compliance	1
• Buy-in from health colleagues on integration	1
• Support from clinical management	1
• Successful integration = long-term protection for beneficiaries	1
• Improved outcomes due to integrated programme design	1
COMMUNITY *	12
• Increased community understanding/ engagement on harmful norms affecting SRH rights and needs	6
• Community advocates, peer educators and health volunteers disseminating sensitisation.	2
• Stakeholder coordination meetings	2
• Peer support and educators (e.g. girls and mothers)	1
• Capacity building for peer support groups	1
VALUE	5
• Integration of activities and resources	2
• Fundraising for both adds weight/ impact	1
• Maximum utilisation of HR and supplies	1
• Harmonisation of data => work not duplicated	1
COLLABORATION WITH PARTNER ORGANISATIONS	4
• Discussions with SRH and WPE teams during field visits for integration implementing partners	2
• Coordination/ collaboration with Access to Health Fund guided the adjustment of their SRH and GBV activities	1
• Healthcare providers' attitudes transformed	1

SIGNIFICANT OR STAND-OUT EXPERIENCES AND VIEWS

Copied-and-pasted (unaltered) from the survey responses

HOW WOULD YOU DESCRIBE SRH/WPE INTEGRATION IN YOUR OWN WORDS?

Its amazing, especially in the Nigerian context. Full package of services, Its ease a lots of stress and ignorant about life. Its helps prevent and response to GBV. It paved way for women and girls to understand their right and make appropriate decision. The integration helps strengthen our relation with community which led to community participation

the current integration SRH/WPE is good but it requires to strengthen more than this

SRH/WPE integration is paramount to the success of the WPE/HEAL programs and wellbeing of girls and women. SRH/WPE integration resolves many barriers such as cultural, societal and religious barrier that impacts negatively the success of the program and therefore yields a conducive space for women and girls to access SRH/WPE services. For instance , For the last 4 years with IRC Health , we have work collaboratively with WPE right from the planning process of key activities such as Comprehensive sexuality education to in school and out of school adolescents, clinical management of rape, and all forms of violence against girls and women, provision of support in terms of material and Psycho social support. Training of program staffs from both Health and WPE as TOT, health educators and case managers. This has led into overall success of the HEALTH(SRH and WPE) programs.

SOME OF THE CHALLENGES I HAVE ENCOUNTERED WITH WPE/SRH INTEGRATION ARE...

When health is not available to provide medication to survivors. We refer survivors for medical services to other actors instead of our own health colleagues.

SOME OF THE SUCCESSES I HAVE ENCOUNTERED WITH WPE/SRH INTEGRATION ARE...

With the help of IRC interventions (VCAT) debate on WPE/SRH has been initiated with all the stakeholders HCPs, religious clerics, Community Leaders, politicians and relevant departments. We as IRC Team are working with GoP partners within their mandate.

– women and girls feel safe accessing both WPE/SRH services at the safe space. – the integration has improved prevention and response to GBV against women and girls. Most especially on the adolescent girls. – They have access to accurate information and the safe, effective, free and acceptable contraception method of their choice. – Girls have increased knowledge on how to have a satisfying and safe sex life, free from STDs and unwanted pregnancy as its one of the most prevalent cases before. – Feel more comfortable and safe at the WPE/SRH safe space because they are not being judged or blamed.

Improved care given to survivors after WPE, SRH and Clinical services established a common client referral pathway. Joint trainings between SRH/WPE on Clinical Care for Sexual Assault Survivors, with shared knowledge and guidelines clients are able to receive standardized care.

– Changing the idea of the name of the GBV room from the rape detection room to the name of a rest room for women in Aden city, Al-Sadaqa Hospital – Accept to sit in the room and listen to the awareness – Establishment of a room (GBV) in Abyan city in Al-Razi Hospital

Community awareness to some extent, Value clarification & attitude transformation of health care providers.

Improved acceptance and access for Women and girls to both SRH/WPE services in IRC programming, Availability of wide range of services within close range and in a timely and confidential manner. Improved referral system which is client centered and women/girl friendly.

Quick and timely access to services, coordinated activities and information sharing at the same time. Survivors feel they are given top priorities and they don't need to move from one place to another to get medical services. Easy and quick referrals. Follow up sessions can easily be done.

Mise en place des circuits de référence en intégrant la santé; conduite des activités intégrées VBG et santé

[Translation: Referral pathways put in place that integrate health; implementation of integrated GBV and health activities]

– Répondre aux besoins des femmes en leur offrant un service intégré SSR/PAF de qualité. (Un exemple une jeune fille de 19 ans qui était victime d'un viol avait bénéficiée d'un service de SAC après s'être rendu compte qu'elle était enceinte) – Amener les femmes à cerner l'importance des services de SSR/PAF malgré les us et coutumes

[Translation: – Respond to the needs of women by offering a quality integrated SRH/WPE service. (An example a young girl of 19 who was a rape victim benefitted from a comprehensive abortion care service after she realised she was pregnant) – Support women to understand the importance of SRH/WPE services regardless of norms and customs]

Les femmes qui accouchent gratuitement dans des structures appuyées par IRC. Les prestataires qui bénéficient des renforcements des capacités à travers plusieurs formations de la part des experts des IRC. Les structures qui bénéficient des équipements de bonne qualité qui facilitent une bonne prise en charge des malades dans de bonnes conditions. Les femmes et filles qui ont des grossesses issues du viol et incestes qui bénéficient des soins et des avortements sécurisés.

[Translation: Women who give birth for free within the structures established by IRC. The service providers that benefit from capacity building via several training sessions from IRC experts. The teams that benefit from good quality equipment that help good treatment of patients under good conditions. Women and girls carrying pregnancies that are the result of rape or incest who benefit from safe/ confidential care and abortions.]

Les femmes sont autodéterminées, se sentent protégées et les services sont disponibles et fréquentés.

[Translation: Women achieve self-determination, feel protected and services are available and used.]

IF A COLLEAGUE SAYS THAT SRH/WPE INTEGRATION DOESN'T MAKE SENSE, I SAY...

SRH/WPE integration is the bedrock of any meaningful programming which prioritizes Women centered programming and seeks to empower marginalized groups as far as their Health and Socio-economic well being is concerned. The advantages and success is clear and in North East Nigeria where Patriarchal nature of the culture creates power imbalance, SRH/WPE through the WGSS approach has created a safe Niche to access stigmatized and sideline services especially women centered services without the watchful eye of Men in the community.

Much of the consequences of GBV affect SRH... SRH education and services are a huge component of GBV prevention. In many contexts we work in, societies are more conservative or religious, where SRH information and services are stigmatized and taboo. If SRH and WPE integrate in safe spaces, where women and girls can receive different types of services, information, and activities, there is more confidentiality and protection on who is receiving/doing what at the centers. Whereas an 'SRH center' or 'SRH room' is more visible and there is less privacy for women and girls to receive services. Furthermore, it is more effective for units to be integrated where we can work with the same target population, provide more effective referrals, use the same facility for services.

Our lives are integrated, our needs are integrated, our program and work should be integrated.

6.3. APPENDIX 3 – INTERVIEW QUESTIONS

- How do you see the value of integrating SRH/WPE?
- Do you have any concerns about the value of integration?
- Please describe to me your work on integration and the context you're working in?
- What are your experiences of working with IRC colleagues and management, staff from other organisations and other stakeholders (government agencies, religious leaders, community members) on integration?
- How do you think the programme is going in your area and more generally at IRC?
- What are some of the difficulties you've experienced in implementing integration?
- And [for those who have worked on integration in more than one location] what are some impacts you've noticed of differences in approaches to integration?
- What are some things that have helped with implementation?
- Do you have any suggestions for how things could be done differently to overcome barriers to integration?
- What kind of support you would like from the technical units (awareness, technical resources, TA support)? What would make your work with integration easier?

Technical Advisor interview questions:

- How do you feel SRH/WPE integration is going?
- What will or won't be 'complete' by 31st March 2022?
- What challenges have you faced in supporting staff with implementation?
- What do you think are the main barriers and enablers that staff experience?
- Are there any measures you think should be put in place immediately to aid integration, either across IRC or in specific contexts?
- Is there anything else you would like GAC to be made aware of?

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