

Integration of Sexual Reproductive Health and Gender-Based Violence Programs

Cox's Bazar, Bangladesh

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Cover page photo: Refugee Camp 14, Ukhiya, Cox's Bazar District

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Objective

As an organization centered around women and girls, CARE is committed to providing technical leadership on integration of sexual and reproductive health and gender-based violence programs. Contexts such as Cox’s Bazar highlight the critical importance of addressing exacerbated needs of women and girls affected by crisis. This case study serves to share key practices and lessons learned to inform the implementation of integrated approaches in this and other humanitarian programs.

Executive Summary

Service provision through health posts, mobile outreach spots, and women and girls' safe spaces coupled with community engagement activities through household visits and outreach platforms have enabled access to integrated SRH/GBV services among women and girls in Cox's Bazar.

This case study highlights key learnings from CARE's integrated implementation of sexual and reproductive health (SRH) and gender-based violence (GBV) interventions within CARE's programs in Cox's Bazar (CxB). While CARE has included gender considerations within its sectoral approaches, we focus on the intentional integration of SRH and GBV as a merged sector.

This case study was completed between January and March 2020 using the following **methods**:

- secondary review of key strategy documents (2020 JRP, CARE's CxB Strategy, CARE's SRH-E Strategy, Rapid Gender Analyses from 2017 and 2019, 2018 CARE Bangladesh SRH/GBV trip reports, 2019 Rapid Action Review) to understand the alignment of integrated programs with identified needs in this response
- discussions with staff at CARE's CxB office, Ukhiya field office, Dhaka office (CARE Bangladesh headquarters), and CARE's global humanitarian team to understand the implementation of integrated programs
- site observations in refugee camps where CARE has integrated SRH/GBV activities (Camps 12, 14, 13, and 16) to observe the implementation of key interventions per standards
- interactions with program staff to identify core activities that contribute to an integrated SRH/GBV approach
- discussions with program beneficiaries (women separately, men separately, and adolescent girls and boys separately) at each service platform to understand perceptions and feedback on services received
- interviews with selected sector leaders and external partners for input on CARE's response per standards

Lessons learned and challenges were discussed with all key stakeholders. In this document, we detail the implementation of the integrated SRH/GBV approach, discuss the alignment with key frameworks and programming principles, and conclude with key lessons and recommendations.

CARE conducted a rapid gender analysis in CxB in October 2017, immediately highlighting the need for humanitarian response programming to be gender-responsive. A mid-term review conducted in September 2018 reflected on the opportunity for sectoral integration of SRH and GBV as a move towards holistic programming. Since 2018, CARE has implemented static health services at four health posts in CxB, GBV case management at 12 women and girls' safe spaces (WGSS), household and sub-block level sensitization for awareness on service availability through 14 outreach teams, and provision of basic health services at mobile outreach spots at the sub-block level. These comprehensive service and demand-side components addressing individual, household, and community barriers to accessing services have enabled a gender-responsive integrated approach to reach women and girls. (See **Table 1** for successful practices that have been key to the integration of SRH/GBV services).

Table 1. Key practices for implementing integrated SRH/GBV programming

- **Multi-component, comprehensive approach:** In CxB, CARE’s humanitarian response is centered on addressing supply-side and demand-side factors that affect uptake of SRH and GBV services, including activities at the individual, household, and community level to address gender norms and attitudes as well as myths and misconceptions around health and family planning practices.
- **Participatory inclusion of affected populations:** For effective household outreach, rapport building, and community harmony, it has been crucial to involve Rohingya volunteers. Volunteers work in teams with host community staff to connect with communities in a language understandable to beneficiaries and in a manner deemed acceptable by affected populations.
- **Standardized messaging:** Messaging for household visits and community courtyard sessions is limited to simple, accurate messages on topics ranging from handwashing and healthy timing and spacing of pregnancy to gender issues, GBV, and safety and security. The materials, messages, and job aids utilized by outreach teams have been standardized to ensure harmonization.
- **Monitoring checklists:** To ensure delivery of key messages, supervisors conduct spot checks and volunteers submit daily pictorial reporting formats used to assess coverage of key interventions.
- **Joint workplans:** At the beginning of each month, the SRH and GBV implementation teams co-develop a workplan in which they identify sessions that will be delivered jointly by their teams at each platform, including WGSS, courtyard sessions, and outreach groups.
- **Risk mitigation:** To ensure security of outreach teams, household and outreach visits are always conducted in pairs, with a mix of male and female staff, with discussion with local leaders including *majhis*, and under the knowledge of site management committees.
- **Adaptive management:** As one management unit, the SRH and GBV teams meet on a monthly basis to discuss key content, challenges, and identify solutions to barriers faced.

Ongoing efforts to strengthen programming

Focus has been placed on staff and partners at all levels to have accurate and updated knowledge on referral points for SRH/GBV services, specifically for clinical management of rape, menstrual regulation, and post-abortion care, recognizing that the US government’s Protecting Life in Global Health Assistance policy does not restrict passive referrals in a context where menstrual regulation is a part of essential health services.

Staff identified the need to include discussion and staff reflection on harmful gender norms and practices in monthly meetings conducted by project staff, integrated teams, and leadership. The ability of staff to question critical gender norms and attitudes is an ethical obligation given work with vulnerable populations as staff hold power over beneficiaries’ access to services (SRHiE Minimum Principles, GBV Minimum Principles).

The opportunity to include messaging within outreach activities on underutilized services (including IUDs and postpartum IUDs) can help address latent demand for family planning. Leveraging CARE’s integrated outreach model to help address questions and concerns can advance community awareness and acceptance of a wider range of services to meet women’s health needs.

Context

“On 25 August 2017, violent attacks against the Rohingya population in Myanmar triggered a huge influx of nearly 1 million refugees into Cox’s Bazar in Bangladesh, requiring substantial humanitarian assistance” (2019 CARE Rapid Action Review).

“Some 855,000 Rohingya refugees currently reside in 34 extremely congested camps formally designated by the Government of Bangladesh in Ukhiya and Teknaf Upazilas [sub-districts] of Cox’s Bazar District” (2020 Cox’s Bazar Joint Response Plan).

“The Government of Bangladesh refers to the Rohingya as ‘Forcibly Displaced Myanmar Nationals’. The UN system refers to this population as Rohingya refugees, in line with the applicable international framework. In this document, we use the phrase Rohingya refugees, and host community to refer to affected Bangladeshi nationals” (2020 Cox’s Bazar Joint Response Plan).

The 2020 JRP targets 1.3 million people in need, including

- 855,000 Rohingya refugees
- 444,000 host community Bangladeshi nationals residing in Cox’s Bazar

Specific sector objectives (SOs) outlined in the 2020 Joint Response Plan include:

- SO1: Strengthen the protection of Rohingya refugee women, men, girls and boys
- SO2: Deliver quality, life-saving assistance to populations in need
- SO3: Foster the well-being of communities in Ukhiya and Teknaf Upazilas
- SO4: Work towards achieving sustainable solutions in Myanmar

Enabling environment/Policy context

CARE CxB staff who have worked in other humanitarian contexts noted that this response differs from other responses due to scale and intensity of govt scrutiny. Bureaucratic (FD7) approval is required from the Government of Bangladesh on each activity implemented, and approval is given for six months only. The government approves and audits expenditures at the line item level. These requirements place a high bureaucratic and administrative burden for all activities regardless of funding size (CARE CxB staff).

As the Government of Bangladesh (GoB) lacks capacity in the sectors of social protection and cohesion, there is a heavy reliance on INGOs. At the same time, the government places increasing scrutiny on NGO activities, particularly around government restrictions regarding livelihoods and cash for work, with a cap on rates provided to volunteers and number of days they can work per month. Given this policy environment, many INGOs have stepped back from advocacy on programming restrictions within the camp context, which remains a collective issue for INGOs (CARE CxB staff).

Recently, in January 2020, the GoB announced changes in policies regarding education in the camp setting, announcing that schools would now teach in the Myanmar language (previously teaching had been in English or Rohingya languages only). Yet sensitivities remain around programming on livelihoods, women’s empowerment, and cash-based programming. These restrictions, particular to this context, limit the prospects of programming on income generation. However, programming on life skills and skills building remains permitted and provides opportunities to strengthen the capacity of women and girls.

In the advocacy space, CARE had worked with the GoB to expand the method mix and contraceptive options within the camp setting. Prior to 2018, long-acting reversible contraceptive (LARC) services, specifically implants and IUDs, were not available in the camps due to a GoB policy that required women to have a permanent address in order to be eligible for long-acting and reversible methods. In order to ensure contraceptive choice and access to a range of methods, CARE worked with other organizations (including donors and multilateral agencies) at multiple levels to advocate the GoB to waive this policy. This GoB policy shift in April 2018 permitted CARE and one other organization to provide LARCs initially before wider expansion throughout the health sector. The GoB entrusted CARE with the rollout of LARCs due to CARE's existing provision of similar services within development programs throughout the country (CARE CxB Emergency Brief).

In line with GoB guidelines, doctors are the only providers authorized to insert implants, which is a more stringent requirement than in neighboring countries including Nepal, where nurses and midwives are permitted to provide them (external stakeholder interviews). Sterilization is not a permitted method within the camp setting as a protection issue. To avoid the risk or perception of coercion, permission is not given for permanent methods in the camp setting (external stakeholder interviews).

CARE's SRH/GBV Response

"CARE's first phase response (initial 6 months) reached 177,193 refugees with multi-sectoral programming and had a total budget of almost \$2.5 million, while the second (6-12 month) and third phases (12 months onward) brought a scale up in services and support for both refugees and host community. The response strategy and scope were adjusted as needs and context evolved" (from Sept 2019 Rapid Action Review of CARE's Response).

CARE was one of the first humanitarian organizations on the ground to provide SRH services during the initial phase of an emergency, with health services started in Sept 2017. Based on internal review, CARE chose to expand its role as site management to three camps (Camps 13, 14, and 16) with the provision of holistic programming, including integrated SRH/GBV programming (2018 Mid-Term Review). CARE had existing programming on resilience within the CxB District through its Shouhardo program (CARE Bangladesh staff).

Host community programming

"Host communities in the CxB District, especially those residing in close proximity to Rohingya refugee camps have unaddressed basic needs and are also exposed to serious protection risks due to a combination of factors, including poverty, limited access to livelihood opportunities, limited availability of public services (especially healthcare and education) and inadequate infrastructure and markets. The Rohingya influx has resulted in competition for scarce resources, such as land, and livelihoods opportunities. The Rohingya refugee presence has impacted the environment in host communities, further straining relations between the communities. Criminal elements exploit both communities, while access to formal and informal justice systems and legal remedies is limited. These factors contribute to heightened humanitarian and protection needs among vulnerable segments of host communities." (2020 JRP)

"Based on assessment findings, host communities are particularly concerned by a perceived deterioration in the security environment. They attribute this to the presence of criminal groups engaged in violence, harassment, and abductions for ransom; which create barriers to accessing basic services. Particularly vulnerable host community families are also adopting negative coping mechanisms, including incurring mounting debts to pay for urgent medical treatment, engaging in child labor and child marriage, and resorting to smuggling and

trafficking networks. Host communities perceive their urgent needs to have been overlooked by humanitarian actors and, at the same time, have very limited knowledge of community-based strategies to mitigate and respond to protection risks. These assessments highlight the importance of enhancing assistance and services to host communities, in order to address their concerns, while at the same time effectively communicating with communities to inform them of humanitarian and development assistance provided” (2020 JRP).

Funded by UNFPA, CARE supported capacity building for sexual and reproductive health in emergencies. These activities included support for two training of trainers (including government health personnel from the Directorate General of Health Services (DGHS) and Directorate General of Family Planning (DGFP) at the national level, INGOs and national NGO staff) and four district-level trainings (including public medical doctors, nurses, midwives and NGO personnel) for creation of trained personnel on the Minimal Initial Service Package for Reproductive Health in Crisis (MISP) with particular competencies in SRH in emergencies at the district level. CARE led these trainings and customized the MISP module to the CxB context (CARE CxB team). CARE also led trainings on long-acting reversible contraception conducted through the Inter Agency Working Group on Reproductive Health in Crises (IAWG) and assisted with the rollout of the training among government doctors and NGO workers (CARE CxB team). CARE conducted an assessment to explore facility and service provider readiness to appropriately respond to SRH in emergencies in 22 disaster-prone districts in Bangladesh (*char, haor, coastal and hilly areas*) where the MISP has not been implemented by UNFPA partners or other humanitarian actors (Learning Brief).

With funding from the USAID Office of Disaster Assistance (OFDA), CARE supports disaster risk reduction, shelter, and WASH/protection efforts through a program called Ashar Alo. Gender is integrated through consideration at the design phase for vulnerable, person with disability, and widowed households and identification of vulnerable people through surveys using vulnerability ranking to inform implementation of activities (CARE Bangladesh team). In July 2019, monsoon flooding impacted 28 districts in the north, northeast, and southeast of Bangladesh, affecting 7.6 million people, of which nearly 800,000 people were displaced (UNRCO, July 2019). CARE Bangladesh, with technical expertise from UNFPA Bangladesh and funding from Central Emergency Response Fund (CERF), implemented a project that addressed the needs of flood-affected adolescent girls and women in these three districts from September 2019 to January 2020. CARE set up Women-friendly spaces (WFS) (involving women and girls to identify appropriate locations) in the three most affected districts as a safe space for provision of GBV (case management and psychosocial services), as well as SRH midwifery services with referral and outreach. These WFSs served as the first entry point to facilitate referral to multi-sectoral GBV services or facility-based SRH services. CARE mapped and validated a referral pathway with key stakeholders (doctors, nurses, legal aid, police, etc). For sustainability, community leaders suggested that the WFS should be set up inside community clinics for future integration into existing service platforms (Learning Brief).

Specific to GBV, UNFPA funds a multi-sectoral intervention through multiple implementing partners in CxB among host communities. CARE is implementing GBV response and prevention interventions, with Save the Children implementing SRH services and Concerned Women for Family Development implementing education curriculum development. CARE’s approach includes supply-side considerations to ensure and improve GBV service availability at 18 health facilities (family welfare centers and community clinics) and demand-side factors to address community attitudes on GBV. Activities are underway to renovate family welfare centers, community clinics to establish safe and confidential spaces for case management with the objective of placement of case workers to provide GBV case management and psychosocial support at these centers. Renovation is underway in two police stations to include woman’s help desks to ensure support to GBV survivors. In 12 villages of six unions in CxB, CARE will implement a tool on community mobilization for health and GBV (SASA Together!, identified as a [high-impact practice](#) to address social norms through community mobilization). A training of

trainers on SASA Together! has been provided by UNFPA. Community mobilization activities will include tea stall meetings with men and boys, women’s groups, existing other community groups, Nari Nirjaton Protirodh Committee members, and other local government committees including union parishad chairpersons (CARE CxB team). Inception, recruitment of staff and preparation of the project implementation started from July 2019 and field implementation have started from October 2019. As services were not underway during the time of this case study, field observations for host community activities were not included.

SRH/GBV integration approach

Here we detail the core components of CARE’s integrated SRH/GBV approach, including key components of **service delivery, outreach services, monitoring and capacity building.**

SRH/GBV model

Service delivery: 75 staff work on SRH across 4 camps and 50 staff (~30 female, 20 male) provide GBV services and outreach across 5 camps. CARE provides services through the following platforms:

- **Static health posts (4)**, each covering a population of ~10,000 people. Services provided include curative, maternal/child health, and immunization services with referrals to safe spaces for GBV case management and to primary health centers (PHCs) for safe delivery, clinical management of rape, and menstrual regulation (see box). Staff at each health post include a doctor, paramedic with midwifery training, and counselor.
- **Outreach mobile spots (40)** at the sub-block level based at four satellite spots per health post. Services are provided by a paramedic (with midwifery training) with a doctor on call and referral for services beyond family planning (contraceptive Depo injections, oral contraceptive pills, condoms, counseling and referral for implants), antenatal care, RTI/STI, pregnancy tests and hemoglobin test. These mobile spots include limited commodity distribution (general medicines, medical supplies, testing kits (blood sugar, hemoglobin, pregnancy) and condoms, oral contraceptive pills, and Depo injections.
- **Women and Girls’ Safe Spaces (12)**, each staffed by a case worker, psychosocial counselor (with honors or master’s degree in psychology), prevention officer, response officer, and facilitator (with honors or master’s degree). Services provided include GBV case management and psychosocial support. Referrals are made to health posts for health services not provided by paramedic, to IOM for safe shelter, to TAI for legal services, and to health posts for clinical management of rape, menstrual regulation, and post-abortion care. In addition to GBV case management, these safe spaces provide group sessions (*see Table 2*), life skills training and recreational activities for adolescent girls, sewing training for women, individual and group counselling sessions for women and girls, and Girl Shine curriculum for adolescent girls.
- **Co-location and co-service provision:** The psychosocial counselor from the WGSS visits the health post weekly for client referral and group discussion with clients waiting for SRH services. The paramedic from the health post provides health services at WGSS once a week.

Health posts, WGSS, outreach teams provide:

- Family planning
- Antenatal care
- Postnatal care
- Psychosocial support for GBV
- STI treatment
- Menstrual health
- Immunization
- General treatment
- Referral to health center for:
 - Safe delivery
 - Clinical management of rape
 - Menstrual regulation and post-MR care

(from CARE CxB Emergency Brief)

Outreach services at sub-block level: These activities are conducted by host community organizers and Rohingya volunteers. Rohingya volunteers are over 18 years old and were selected for their literacy, communication skills, and previous community mobilization work (such as traditional birth attendants).

- **Courtyard sessions** – these aim to cover all households in assigned blocks each month for discussions on gender, SRH, GBV and for awareness on where to seek care and services (health posts and WGSS) (see **Table 2**). Sessions are delivered by host community organizers and Rohingya volunteers (mix of male and female depending on whether sessions are being delivered to men, women, or adolescents) in a participatory, interactive manner. At the end of each session, the organizers reiterate key messages, remind participants about dates and locations of service availability, and tell participants to come to volunteers for any issues
- **Community outreach groups** – group discussions at sub-block with men, women, and adolescents (separate groups) on topics such as dengue, coronavirus, polygamy, trafficking. Through outreach groups, those interested in GBV services are issued referral slips with information on WGSS. The outreach groups are led by a member of SRH and GBV teams including a mix of host community organizer and Rohingya volunteers.
- **SRH outreach group** – conducted per mobile outreach spot and includes community leaders such as *majhis* to encourage acceptance of females seeking services for GBV and SRH.
- **Household visits** – Rohingya volunteers cover 100-400 households per month with host community organizers to discuss integrated messages. The day before mobile spot services are scheduled, outreach teams visit households to inform clients about the services to be provided.

Table 2. Topics covered in integrated SRH/GBV outreach

Topics for group sessions (courtyard sessions, group sessions conducted at WGSS)	Topics Covered in GBV/SRH outreach (courtyard sessions, community outreach groups, SRH outreach groups)	Key messages for SRH/GBV household visits
<ul style="list-style-type: none"> • Types of GBV/causes/consequences • Menstrual hygiene management • Personal hygiene • Trafficking • Polygamy • Family planning • Nutrition • Depo Provera injection • Latrine use and hygiene practices • Dengue prevention • Hand washing feedback and feedback/complaint mechanism • Mental health/psychosocial support • Antenatal care, safe delivery, postnatal care • Child rights/child labor • Dowry • Breastfeeding • Water-borne diseases • GBV reporting • General checkups for pregnant mothers • HIV • GBV Safety Advice and how to get support • Child/early marriage • Personal hygiene 	<ul style="list-style-type: none"> • Community outreach group responsibilities • Family planning • Menstrual hygiene management • Types of GBV/causes/consequences • Counseling, mental health, and psychosocial support • Polygamy • Dowry • Drug addiction • Dengue • Trafficking • Health and hygiene • Communication/feedback mechanism for persons with disabilities • Child marriage • Volunteers’ responsibilities • Sexual and reproductive health • Sexually transmitted diseases • Maternal health • Child health • Food and nutrition • Health services for adolescents 	<ul style="list-style-type: none"> • Family planning • Menstrual hygiene management • Types of GBV/causes/consequences • Counseling, mental health, and psychosocial support • Early marriage • Polygamy • Dowry • Drug addiction • Dengue • Trafficking • Coronavirus • Communication/feedback mechanism with persons with disabilities • WGSS service information • Referral pathways • Child marriage • Antenatal care • Danger signs of pregnancy • Safe delivery • Birth planning • Newborn care • Breastfeeding • Neonatal danger signs • Newborn nutrition and feeding • Handwashing • Latrine use /hygiene practices • Safe water

Key Practices Enabling SRH/GBV Integration

Monitoring, management, and capacity building: SRH and GBV are considered as one sector and aligned under one management structure in the following ways.

- **Standardized messaging:** Visual job aids are aligned with standardized key messages covering core topics during for household visits and group outreach sessions (Table 2).
- **Capacity building and training of staff:** All volunteers meet on a monthly basis with project staff, and organizers meet on a quarterly basis. The purpose of these meetings are to discuss key content, challenges, identify solutions to barriers faced, and problem solve. The sector leaders and program teams have a monthly **SRH/GBV integration meeting** to discuss challenges and improvements in ongoing areas of challenge including referral between platforms for services.
- **Monitoring checklists:** Volunteers use pictorial reporting forms, with supervisors filling out supervision checklists which are reviewed on a monthly basis for key areas such as coverage.
- **Joint workplans:** At the beginning of each month, the SRH and GBV implementation teams co-develop a monthly workplan in which they identify which sessions will be delivered jointly by their teams at each platform, including WGSS, courtyard sessions, and outreach groups.
- **Risk mitigation:** To ensure security of outreach teams, planning is done to ensure that household and outreach visits are always conducted in pairs, with a mix of male and female staff, with discussion with local leaders including *majhis*, and under the knowledge of site management committees.



Figure 1. CARE's Visual outreach job aids

Lessons learned

- When identification of GBV was introduced at health posts, the intention was for universal screening, with a psychosocial worker posted at the health posts. However, clients screened for GBV remained a percentage of total clients and capacity for GBV identification remained low given other health priorities. Recognizing the need for privacy and psychosocial support, health posts instituted referral to WGSS for GBV case management, with the psychosocial counselor coming once a week to the health post. If the health cluster introduces GBV screening for antenatal care patients, further discussion with CARE's service providers on challenges faced for universal identification of GBV can help to identify solutions.
- The outreach model had many trials and errors. Initially volunteers were not included, but only paramedics. The sub-blocks to be covered varied widely in population given variation in camp populations. The model was mixed and matched for optimal team composition and size. The idea of including a host community organizer was included after participation of Rohingya volunteers in the model to ensure quality control and a reference point for technical health knowledge. A terms of reference was developed for outreach, job aids, and checklists.

Within the outreach approach, core learnings led to the evolution of a model in which "Each team have one health care provider and two organizer who pairs with 5 Rohingya volunteers to provides SRH services at 5 satellite spots on rotational basis, organize courtyard meetings and birth preparedness discussion for awareness and service promotion, conduct doorstep visits for identification of pregnant women and adolescents with limited commodity distribution." (From SRH-E Sector Strategy).

Feedback from program participants

We interacted with program participants at the four camps in which CARE implements integrated SRH/GBV services (at various health posts, WGSS, and mobile outreach sites). Participants told us that they knew about the SRH/GBV services provided at these platforms through a wide range of sources including other people in their blocks, volunteers going door-to-door, from leaders in their mosque, and from their friends. The fact that many heard about services by word-of-mouth indicates wide reach of outreach messaging on service availability.

- Clients mentioned that they would prefer that the health post provide all health services they require, including delivery services. However, per response [health sector standards](#) delivery services are to be provided at the PHC level and not the health post level.
- If cases of violence happen in the community, beneficiaries who are members of outreach groups mentioned that they go to WGSS, report to the *majhi*, or to the camp-in-charge. Respondents mentioned that *majhis* are not always helpful, as they themselves often engage in practices such as multiple marriages which underlie key gender disparities (male respondents, SRH Outreach Group, Camp 13).
- Women and adolescent girls at WGSS reflected on the ability to have a peaceful space to be with their friends. Adult women appreciated the ability to discuss topics (*see Table 2*) with their friends in their sessions led by organizers. Adolescent girls involved in the Girl Shine curriculum enjoyed the participatory nature of the approach engaging them in negotiation and self-awareness.

Integration across other sectors

Across other sectoral programming (WASH, site management and camp management, nutrition), CARE has implemented mitigation efforts to include gender considerations in the design, implementation, and measurement of programs have been implemented (CARE CxB staff). Across host community and refugee programming, gender analyses are used to inform activities. For example, site management and in disaster risk reduction activities in host communities have incorporated considerations for shelters to meet the specific needs of vulnerable sub-groups (such as people with disabilities) and ensuring access and participation. Workshops have been conducted for SRH and site management teams regarding GBV referral pathways including non-GBV actors and maintaining programming principles such as confidentiality. Site management activities include GBV risk mitigation activities such as installation of solar lights for areas that are risk (based on safety audits) and distribution of dignity kits to vulnerable groups (CARE CxB team).

For 330 staff and partners, GED and PSHEA training has been conducted to address staff understanding of concepts of gender, sexual harassment, and sexual exploitation. The need for an ongoing forum to critically engage and discuss staff attitudes underlying gender practices was identified (CARE CxB team). Beyond the integration of gender into sectoral work for gender-responsive programming across sectors, the CARE CxB team recently completed an integration analysis to look at the potential for cross-sectoral integration (different from gender integration). This integration analysis is available separately (CARE CxB Integration Analysis).

Areas of Ongoing Improvement

Issue	Suggestion	Resources
In camps visited, CARE’s SRH/GBV staff at health post, safe spaces, and outreach teams did not share a uniform understanding of referral points for key SRH services including clinical management of rape (CMR), menstrual regulation (MR), and post-abortion care (PAC). While these services are not provided at health posts per sector standards, sector standards require staff to accurately refer.	<p>Use ongoing monthly staff and coordination meetings to clarify staff understanding on referral and information procedures for life-saving emergency health services which are not provided at the health posts themselves.</p> <ul style="list-style-type: none"> Emphasize responsibility of CARE’s SRH/GBV staff and team members to have accurate and updated knowledge on referral points for SRH/GBV services, specifically for clinical management of rape, menstrual regulation (MR), and post-abortion care. Emphasize shared responsibility across sectoral teams (site management, WASH, etc) to understand availability and location of key SRH/GBV services, especially MR, CM, and PAC. Clarify staff understanding of Protecting Life in Global Health Assistance (PLGHA)/Gag Rule: Passive referrals are allowed (meaning that if a client asks about MR, providers are required to provide information on where MR service is provided). Allow time for discussion of scenarios to role play practical difficulties and areas of confusion between passive and active referral and for staff to question and completely understand their responsibilities as providers and the limits of the policy. 	<ol style="list-style-type: none"> Package of Essential Health Services for CxB Response https://www.kff.org/global-health-policy/fact-sheet/mexico-city-policy-explainer/
In health posts, IUDs are not functionally being provided. Perception among interviewed CARE staff is that demand is low and significant infrastructure would be required to equip health posts for sufficient space for IUD insertions.	<p>Include IUD and postpartum IUD as part of comprehensive outreach messaging conducted at community and household level on family planning and pregnancy-related messaging for postpartum care as part of basket of choices. Orient outreach teams on IUD so that they know details of the method and can answer questions that communities may have.</p> <ul style="list-style-type: none"> Currently clients can be referred to PHCs and other health posts where partners are inserting IUDs. If demand for IUDs is increased, at a future point CARE could consider exploring additional funding to equip health posts for IUD provision, including postpartum IUD. 	Resource for messaging: CxB SRH WG sub-sector flipbook on basket of choices
The mobile outreach approach and provision of health services at community spots has increased access and uptake of services. Key to maintaining quality at this level is keeping the referral chain of doctors for questions and referral of higher-level or complicated cases.	<p>CARE is one of the only actors providing health services through mobile outreach, and the health sector lead emphasized that maintaining quality assurance by ensuring that each outreach team works under the supervision of a doctor is key (external stakeholder interviews). If additional outreach teams are implemented in new projects, it is imperative that this teams continue to have a doctor on call for questions that may arise from paramedics and staff regarding medical concerns. Strongly recommend that any doctor vacancies be filled with female doctors as women may feel more comfortable in disclosing sensitive issues. As the CxB Health Sector has rationalized its health posts per population, CARE should prioritize continuity of services at health posts throughout funding gaps given the commitment to the health sector.</p>	
Access to SRH and GBV services is affected by staff attitudes and prevailing norms on gender. Interviewed staff mentioned a general lack of deep understanding among staff regarding perceptions of gender.	<p>Leverage Social Analysis and Action (SAA) conducted among all health providers in the beginning of the response (Nov 2017) (as well as GED and PSHEA trainings conducted for all staff and partner) to designate time within monthly coordination and staff meetings for staff at all levels to discuss gender norms such as:</p> <ul style="list-style-type: none"> Violence against women depends on the way a woman is dressed It is okay for unmarried adolescents and LBGTQ clients to access family planning services 	<p>SAA reflective dialogue</p> <p>SRHRiE Minimum Commitments to Gender and Inclusion</p>

Alignment with Key Standards

In this section, we explore the alignment of CARE's SRH/GBV integrated approach with key standards.

Sector standards (adapted from MISP and Core Humanitarian Standards)

According to the health sector standards set by the GoB for the CxB response:

Health post (comparable to the MOHFW Community Clinic)

- Proposed: 1 health post per 10,000 population and within 20 minutes walking distance from patients' home.
- Deliver simple curative, maternal/child health, and immunization services with referrals to PHC facilities.
- Normally operational during the daytime only.

Primary health centre (PHC, comparable to the MOHFW union-level health facility)

- Proposed: one PHC per 30,000 population and within 30 minutes walking distance from patients' home.
- 24-hour operational facilities that deliver the essential PHC services.

In 2019, rationalization was completed in the health sector with decommissioning of PHCs and health posts not up to standards or exceeding population catchment sizes.

SRH service package (from CxB SRH Sector Standards):

- Safe motherhood: antenatal care, postnatal care, safe delivery, essential obstetric care.
- Family planning: comprehensive education, counseling, contraceptive methods
- Neonatal and child care: 0 – 6 months service for the newborn child
- Prevention and mitigation of HIV and STIs
- Prevention and mitigation of infections and cancers of the reproductive system (e.g., breast cancer)
- Prevention and mitigation of infertility and fertility
- Adolescent SRH
- GBV screening, counseling and referral for treatment
- Problems related to aging: post-menopausal syndrome for women
- Information and counseling: right-based, user-centered, judgment-free approach
- Menstrual regulation up to 32 weeks by medical officer (up to 8 weeks by paramedic). No government restriction on MR per GoB standard health guidelines. (SRH sub-sector leader)

GBV sector guidelines per the Interagency Standing Committee on GBV in Humanitarian Action:

- Psychosocial support
- Referral pathways (clinical management of rape: refer to PHC 24/7 as a life-saving service as part of MISP), basic and emergency obstetric services with initial stabilization, safe delivery, post abortion care, and menstrual regulation

From March 2019, cervical cancer screening and screening for obstetric fistula and uterine prolapse was introduced with referrals to Hope Hospital (SRH sub-sector leader).

CARE's frameworks

The alignment of CARE's integrated SRH/GBV response with key CARE frameworks including GBVIE Framework,

GBViE and SRHiE minimum commitments, and CARE’s Gender marker are summarized below.

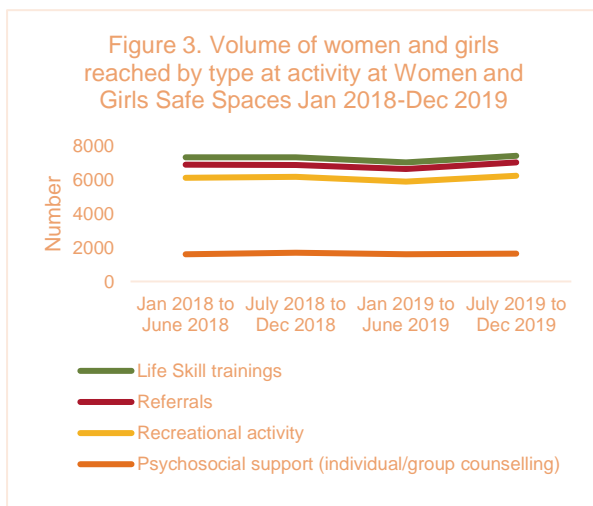
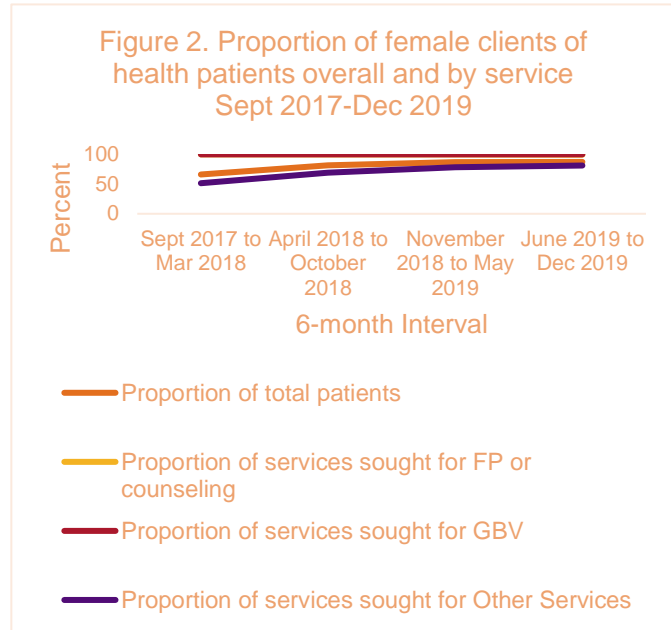
Table 3. Alignment by level of intervention and selected programming priorities

Level of Intervention	Alignment of response with frameworks
Response	
GBV Programming Principle #4: Provision of comprehensive SRH services at health posts per sector standards and SRH service provision at WGSS	Interventions are gender-responsive in meeting the particular needs of vulnerable groups, including females. Host community clients are also seen, including NGO workers per standards. Clients are not asked for identification, meeting current sector recommendations for inclusive care. (site observations, staff interviews).
GBViE Programming Principle #3: GBV case management at WGSS integrated with psychosocial counselor visiting health posts	Case management is provided including psychosocial counseling and referral for medical treatment or safe shelter.
Referral system for GBV survivors and SRH services and integrated SRH/GBV outreach for awareness of service availability	CARE’s outreach model is a key strength to address norms restricting women’s ability at individual and community. Per GBV minimum commitments, knowledge of referral services can be strengthened and standardized across project staff. The need for an ongoing platform to question staff attitudes to provide non-stigmatizing support was identified per SRHiE Minimum Commitments (CxB staff interviews).
Prevention (Primary Prevention)	Provides potential for gender-transformative interventions
GBV Programming Principle #5: Engage men and boys	Meeting GBV Minimum Standard 2: Specific strategies, informed and led by women and girls, should be designed and implemented to engage male leaders and gatekeepers, especially religious and community leaders, to identify strategic allies for prevention of and response to GBV. These practices help ensure acceptance of female mobility as well as safety and security of outreach teams. For a gender-transformative approach per CARE’s gender marker, empowerment of female leaders can be considered.
GBV Programming Principle #2: Shift social norms to address root causes of GBV as well as impact on access to SRHR	Per CARE’s gender marker, a gender-transformative intervention seeks to make changes at 3 levels of individual agency, enabling structures, and power relations: CARE recognises the interlinking issues of agency – a person’s own aspirations and capabilities; structures - the legal and institutional environment, including harmful social and gender norms, that surrounds and conditions a person’s choices; and relations - the power relations, including harmful social and gender norms, through which crisis-affected people negotiate their path – that together prevent harmful patriarchal social norms from occurring. Empowering female leaders and building on activities for livelihoods can strengthen gender-transformative approaches.
Mitigation	
GBViE Programming Principle #1: Mainstreaming/ integrating GBV risk mitigation/prevention measures across all sector/multi-sector	Per SRHiE and GBViE minimum commitments, explicit activities and objectives on gender, diversity and GBV prevention and risk mitigation in all sectorial and multi-sectorial activities.
GBViE Programming Principle #6: Advocacy and scale up on SRHR/GBV	Following the do no harm principle, ensure that CARE staff in all programming as well as Save the Children for host community programming are informed of the obligation to provide passive referrals for MR

The CARE team analyzed service data from the first phase of programming (September 2017 to March 2018) was analyzed for proportion of services accessed by female clients. Intentional efforts to reach women and girls through outreach efforts were implemented. Over time, the proportion of female clients accessed by health services (either at health post or mobile outreach) increased from 66% in the first six months to 87% in the

second half of 2019 (see **Figure 2**). Between phases of the response, data was analyzed on service statistics to understand client profiles of whether those accessing services matched targeted beneficiaries (particularly females). This ongoing data analysis was used to inform the need for an outreach strategy to improve service uptake among females.

- Each health post provides 70 to 100 Health services/day. Each health post provides 50 to 70 health services a day, including SRH, GBV and general health services and referral. Approximately 70% of services are provided to women or girls.
- Each outreach team provides about 25-30 SRH services per day including antenatal care, postnatal care, and family planning services.
- Every WGSS serves an average of 20-30 GBV cases monthly. Every WGSS has a requirement of serving 50 cases over three months as a minimum threshold for active service point. (GBV sector standards)
- Besides case management, women and girls in WGSS are reached by awareness sessions, life skills trainings, recreational activities, and psychosocial support (see **Figure 3**). Bi-annually, the WGSS have constantly reached more than 1600 females with psychosocial support (6583 to date), approximately 400 females with life skills training (1672 to date) and referred more than 700 clients for SRH services (more than 3000 to date).
- Health posts have been providing an average of 947 contraceptive services per each month with nearly half of all family planning clients choosing an injectable method.
- Mobile outreach teams have been providing 350 contraceptive services per each month with nearly four in 10 clients choosing an injectable method.



- As of January 2020, CARE provided 139,448 service contacts through the static health post and the SRH outreach mobile clinic teams and reached more than 70,000 people. Almost 5% of the ANC service users were adolescents. In an average, a total of 9285 users seem to have receive the FP service from the health post per month which is 16% of the total services. Four percent (2208) of the total service recipients chose injectable methods.
- Through outreach services, 96% of the clients were females and 15% are adolescents. Almost 20% of the antenatal service users were adolescents. In an average month, a total of 4853 users seem to have received family planning services. Four percent (1080) of the total service users chose injectable methods.

Future Programming Directions

The 2020 Cox's Bazar joint response plan (JRP) lays out a clear vision for programming consolidated for both Rohingya and host community populations and builds on CARE's 2019-2022 CxB response strategy, a programming framework that integrates interventions, objectives, and indicators across Rohingya and host community programming could assist in the articulation of a consolidated approach.

To achieve gender-transformative programming, efforts can focus on at the levels of individual agency, structure, and power relations. Opportunities for joint discussion between males and females on practices and underlying gender issues can deepen primary prevention approaches. Appropriate forums and approaches for these joint discussions should involve communities to identify acceptable platforms.

As a move from gender-responsive to gender-transformative programming, CARE can strengthen opportunities to empower female leadership within integrated sectoral approaches. CARE can leverage the Women Lead in Emergencies grant to support formal and self-elected female leaders as an alternative power structures to male *majhis* within camp governance. The 2020 JRP discusses the need to expand protection-oriented alternative dispute resolution mechanisms that to enhance access to justice, as well as protection monitoring through the network of focal points in each camp. As CARE works as site manager and implements comprehensive programs, the ability to leverage existing partner programs to empower female leaders can be explored.

In the women's and girls' safe spaces led by CARE, sewing machines and lessons on sewing are currently provided in response to a needs assessment asking what females wanted to learn. These opportunities can be strengthened for income generation for women in refugee and host communities. UNFPA's implementation of voucher assistance programs for nutrition support of pregnant woman has shown uptake in SRH services (Cash and Voucher Assistance Compendium for Humanitarian Practitioners). CARE could explore opportunities to leverage voucher assistance for SRH/GBV access. Given government restrictions on livelihoods, economic empowerment, and cash-based programming, these area of programming require substantial advocacy.

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