

What can humanitarian innovation do for GBV programmes?

Since 2015, at Elrha we have directed some of our support for humanitarian innovation specifically towards innovation that addresses gender-based violence (GBV) in emergencies. We've produced analysis of [opportunities for innovation](#) and of [persistent gaps, based on a global consultation](#), and have funded over 50 projects related to humanitarian research and innovation on gender-based violence.

Here, we're sharing insights from some of our current and past grantees and other members of the GBV innovation community. We want to spark interest, conversation and ideas about what innovation has contributed to best practices and what could be or should be on the horizon. If you've any follow-up questions, get in touch with Elrha's GBV Innovation lead, Ian Brightwell i.brightwell@elrha.org

Introduction: In this extended edition of GBV Innovation Insights, we hear insights from three people, all working with the same innovation, addressing intimate partner violence (IPV) in Bangladesh. Taken together, the three perspectives demonstrate different roles and experiences in the adoption process, and they highlight the value of ensuring input from and ownership by diverse community members, frontline workers, managers and support staff.

Who are you?

I'm Mehenaz Zaman, Research Coordinator at Ipas Bangladesh.

I've always been drawn to the challenge of translating research into real, on-the-ground change – helping women to

reclaim control over their bodies and lives when so many forces try to take that away.



What've you been working on?

In Cox's Bazar's refugee camps, reproductive coercion (RC) is a hidden but widespread form of violence. On top of displacement and trauma, women suffer coercive control over their reproductive choices by partners or family members.

At Ipas, we've been adapting an established intervention called ARCHES (Addressing Reproductive Coercion in Health Settings). Adaptation has included translating and contextualising information materials for the Rohingya population in Bangladesh. Now we are also adapting the design of our programme delivery, to better suit the humanitarian context of densely packed refugee camps.

We train frontline workers to deliver ARCHES counselling using an adapted GATHER approach focusing on respectful, client-centred service delivery. GATHER means to Greet, Ask about needs, Talk about family planning options, Help select a method, Explain its use and make a Referral if needed. Part of the ARCHES adaptation is to add a second "T" of also talking about RC and IPV.

For me, ARCHES is more than just a programme, it's a response to the silent crisis of reproductive coercion. The result we see is an increase in women's self-efficacy to use contraception and abortion services.

How is it an innovation?

The innovation of ARCHES lies in its integrated, empathetic and adaptive design. We didn't just translate a clinic-based model into a new setting; we transformed it by deeply embedding the GATHER counselling approach into provider training, emphasising empathy, privacy, confidentiality and non-judgmental support.

Beyond the clinic walls, we recognised the need to reach women who haven't even been to health facilities. So, embracing a user-centred design method, we developed tools that are adaptive to the context, and for use by midwives and community health workers, who we trained to deliver nuanced messages – at community centres and in the home – about reproductive coercion, safety planning and contraceptive options. The iterative feedback loops of adapting to the views of clients and service providers have ensured the intervention is culturally sensitive and grounded in lived realities. The new community-based approach does more than increase outreach, it builds

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trust with clients and offers early intervention in a context where access is often limited and stigma is high. The holistic, community-based facility integration sets ARCHES apart as a pioneering innovation in humanitarian reproductive health.

It can't have been easy, can it?

It's been incredibly challenging. At first, the very concept of reproductive coercion was new and sometimes hard to discuss openly, both for clients and providers. Some providers struggled to shift from routine, transactional care to a counselling style that required more patience and empathy. We encountered silence, shame, tears and fear. It was a steep learning curve to embed the GATHER approach into everyday practice, especially in a setting overwhelmed by humanitarian crisis and resource constraints. The high prevalence of IPV made it even harder.

The stories that surfaced were often overwhelming. I remember during one of my monitoring visits, in the evaluation phase, sitting with a woman who was struggling to open up about her vulnerabilities. She held her pain so tightly inside, terrified of what might happen if anyone found out. And then there were the young girls, recently married, already carrying the weight of caring for a child while trying to meet their husband's expectations, with little space to think about their own needs and futures. On the community side, our outreach workers had to overcome scepticism and build trust carefully; in close-knit refugee

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communities, privacy is scarce and discussing family or intimate issues can carry serious social risk. There were moments when logistical hurdles, like flooding or security lockdowns, disrupted activities and morale.

What helped us persist was the constant reminder from survivors and community members that this work mattered – that our efforts were giving women something as precious as agency and hope in the face of adversity.

Was there a most meaningful moment?

There's one particularly vivid memory I carry with me from an evaluation interview. A young woman quietly shared how the ARCHES intervention changed her life.

Previously her husband's control over her contraception choices felt normal, invisible, and she hadn't realised that this was coercion. But through conversations with community health workers and a confidential visit to a trained midwife at a Women's Friendly Space (WFS) in the camp, she found the confidence and support to claim her own reproductive choices and to seek support if she faces violence from her partner. She said that she wanted her choices to be for her wellbeing, as well as her child's and her family's. That story crystallised everything we'd worked for: the power of combining respectful, confidential care at the clinic with trusted, empathetic outreach in the community. It was a reminder that humanitarian innovation isn't just about new tools or models it's about transformation of human lives.



When we saw the data come in from our research, we saw this story reflected in so many others, telling us that our work with ARCHES isn't just effective, it's essential. It reaffirms my belief that women have a right to agency, dignity and choice, and that with the right support, they have the strength and courage to claim it.

Image: ARCHES educational materials were co-designed with Rohingya refugees to provide culturally appropriate, low literacy representations of gender-based violence. Source: [Ipas Bangladesh ARCHES Resources](#)

What's on the horizon for GBV innovation in the next few years?

Looking forward, I see huge potential for merging technology with user-centred approaches, to see confidential mobile apps and AI-driven risk assessments that could increase access and personalisation. Yet, technology can never replace the essential role of community trust and culturally grounded care.

We have to continue investing in training providers on trauma-informed, empathetic approaches and strengthening community networks for early identification and support of survivors. And we need to keep engaging men and boys as partners in change, as we will only end violence against women if we address the social norms that sustain coercion and violence.

Critical for ARCHES as a humanitarian innovation is how we scale up. Our data and experience points to the urgent need for this scale-up and long-term integration. This is not a one-off intervention; it's a foundational shift in how reproductive health and GBV services must be delivered in crisis settings. We need partners, donors and advocates to walk alongside us — to help expand this work, adapt it to new contexts, and continue refining approaches based on what women and girls tell us they need. Because iterative innovation is about deepening what works, listening better and ensuring no one is left behind.

Do you recommend any resources on your work or innovation more broadly?

For those interested in the nuts and bolts of ARCHES, [the intervention overview](#) and research briefs from [2022](#) and [2025](#) available through Ipas are invaluable resources. They offer detailed guidance and solid evidence. The [Elrha innovation case studies](#) also provide excellent inspiration for designing solutions with communities in crisis settings.

And for those new to innovation in humanitarian or SRHR contexts, the [Design for Change toolkit](#) is an accessible, hands-on way to learn how to centre human experiences in problem-solving. Ultimately, though, the best resource we have is the people we work with. Deep, intentional listening to communities is

where meaningful, lasting innovation truly begins.

Who are you?

I'm Shamim Sarder, GBV Programme Manager for Mukti, which is a local organisation in Cox's Bazar. I have been part of the Technical Advisory Group (TAG) for the projects adapting ARCHES for use in the Rohingya camps.



What've you been working on?

I have been with Mukti for seven years, and in our protection programme we run a Women-Led Community Centre (WLCC) and 37 Women-Friendly Spaces (WFS) with the support of UNFPA. As part of the TAG for ARCHES, I have really supported the community-based adaptation which has been piloted in three of our WFS.

As a local organisation, our GBV programme has steadily evolved through context-driven innovation. Initially we focused on GBV response in this crisis setting, and by 2020, we adopted an integration approach to embedding services for sexual and reproductive health rights (SRHR) within the WFS, drawing on expertise in family planning from partners like IRC and Ipas Bangladesh. Around the same time, we adopted the [SASA! Together](#) approaches, to engage men and boys in community mobilization against GBV.

We've also piloted legal aid service provision through female legal professionals. We've formed women's support groups and community watch groups in each WFS, and mobilized over 1,750 changemakers, community leaders, institutional allies and religious figures. These structures helped create a strong community-led response system and has shifted our entire approach in Mukti. We became less organisation-driven and more community-owned.

ARCHES is one of the approaches integrated into our community mobilisation and our work

through the WFS. Community health workers and volunteers are involved in the door-to-door community-based intervention model. By linking facility-based SRHR counselling with community outreach, ARCHES ensured services reached women unable to access WFS — a major innovation in our context.

Along with other TAG members including staff from UN agencies, NGOs and government departments, I have participated in the co-design and provided technical guidance. And through my role in Mukti I have supported the roll out to our WFS.

How is it an innovation?

Adopting ARCHES was a natural progression in our evolution. And adapting it for the first time from a clinic-based to a community-based intervention has made it a true innovation.

Previously, ARCHES interventions had only been delivered in medical facilities. But in the TAG we recognised that many women and girls don't typically visit clinics.

The new community model not only involved WFS and its midwives in one-on-one and group counselling but also enabled light-touch ARCHES counselling at the household level by community health workers and volunteers, which has increased outreach and awareness far beyond the formal service points. With minimal additional resources — just intervention materials, midwife training, and a smart use of existing infrastructure — it's possible to expand SRHR access in difficult, resource-constrained settings.

ARCHES stands out for its approach to addressing highly the sensitive issues of RC and IPV, with the user-centred design process making the significant difference in how well

the intervention was received. This has underpinned the capacity to implement ARCHES safely, sensitively and sustainably.

In recent years, our programmes have increasingly shifted toward integrating technology-based awareness and cost-effective innovations, and ARCHES has become a prime example of what's possible when partners come together, build on existing systems and infrastructure, and centre the needs of the community in every step of the design and delivery process.

It can't have been easy, can it?

Challenges have been constant. Every day brings new challenges and mitigating them is part of the job. One of the big challenges regarding ARCHES implementation relates to women and girls who are using contraceptives without their partner or family knowing — what we call covert use. There's always the risk of them being found out, which could lead to serious harm, especially in abusive or controlling situations.

When our community health workers used SRHR-specific or ARCHES tools, I felt some risk. That's why the ARCHES approach to client-centred care is so important. As a harm reduction intervention, we need to ensure that clients are supported in making decisions that are not only right for their health, but also safe given their circumstances. We have had to maintain community engagement, manage individual and collective risks, and ensure thorough training for all the community health workers and volunteers involved. Updates to materials and routine refresher training are so important to mitigate the risks, and to continue learning as we go.



Image: ARCHES provides education on diverse reproductive coercion experiences, such as a husband interfering with his wife's contraceptive use (left) or blocking abortion access (middle) or forcing her to have an abortion (right). Counsellors provide information on strategies to address reproductive coercion. Source: [Ipas Bangladesh ARCHES Resources](#)

Was there a most meaningful moment?

For me, it's when I saw our local women volunteers move beyond their previous roles in supporting survivors and instead begin to also lead conversations about prevention. It's been really striking seeing them speak about complex issues like RC and IPV, using the co-designed materials from the ARCHES intervention.

In the early days of our response work, these community volunteers primarily linked survivors to support, or quietly supported survivors. Through the ARCHES community intervention – with the orientation, tools and confidence they gained – they now can create safe, confidential spaces where women can discuss the challenges they face, and can hear how to connect to the services they need.

Seeing this change reaffirms for me why integrating community structures and interventions like ARCHES matters. It's not just about service delivery — it's about supporting reproductive autonomy, fostering leadership, and creating lasting, community-driven change.

The full success of implementing ARCHES in the community isn't measured in numbers alone, but in the way it has shifted power, confidence and agency to the women and girls at the centre of it all. Every afternoon, when the community centres close their doors, these volunteers continue to provide information and support within their neighbourhoods and families.

What's on the horizon for GBV innovation in the next few years?

The future of GBV programming is definitely moving toward more technology-based education and awareness. We've already introduced tablets with video content at our WFS, and I see that expanding further. But we still need to focus on cost-effective, integrated approaches like ARCHES. It's been a great example of how an intervention can use existing infrastructure and community platforms to deliver real impact.

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Do you recommend any resources on your work or innovation more broadly?

[ARCHES tools](#) have been very effective, and alongside the [SASA! Together](#) methodology, they have proven invaluable for structured community engagement.

These approaches have enabled us to develop consistent, context-specific interventions that genuinely resonate with the community's needs. ARCHES, in particular, stands out due to its practical design and the direct impact it has had on our programming.

In addition to these, I regularly rely on the [Inter-Agency Minimum Standards for GBV in Emergencies](#), which remain foundational for planning and reviewing our interventions.

Who are you?

I'm Hosna Begum, a paramedic based at Leda Health Clinic in Camp 24, Cox's Bazar. I work on sexual and reproductive health (SRH) addressing issues including GBV, FP, menstrual regulation (MR) and post-abortion care (PAC). I also help refer patients to other services such as GBV case management, mental health support and legal counselling. My aim is that women in the camps can access GBV and SRH services safely and confidentially. I want to help *them* make choices about their own lives, even in very difficult circumstances.



What've you been working on?

For the last six years, I've been providing services in Leda Health Clinic, Camp 24. Every day, when a client comes in, we counsel them on the options available — both their advantages and disadvantages — and on when they should seek services. A big part of our work is about confidentiality. For example, if a patient wants to secretly use a method like injectable contraception, we counsel them on how to do that safely.

We conduct health check-ups to confirm that a given FP method is right for someone, and if it

is, then we provide it and explain how to use it discreetly. We also talk about domestic violence and let clients know they can come to our centres if they or someone they know faces such issues.

At our centre, we provide a wide array of SRH services, and we can make referrals to other specialised service providers, for example for mental health and psychosocial support.

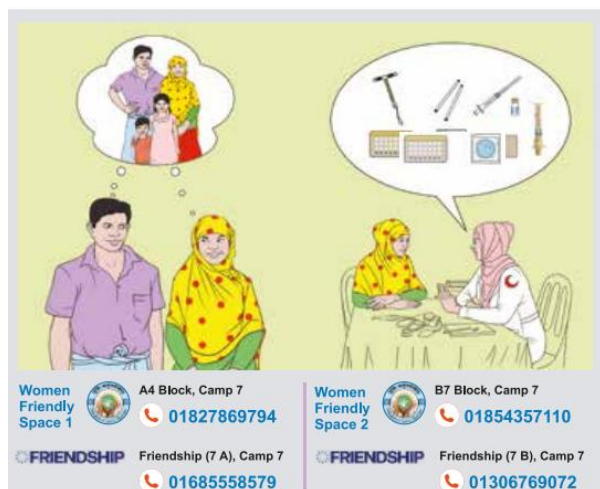


Image: ARCHES clients are given information cards with service provider contact details that can be shared with others. Source: [Ipas Bangladesh ARCHES Resources](#)

For me, one of the most significant innovations was the training we received on the ARCHES intervention. A lot of this was new to me, including details relating to confidentiality. For example, if a woman is pregnant unwillingly, we can now support her confidentially in seeking care, ensuring that no one else, including family members, finds out.

We also learned how to help women keep their contraceptive use secret and to advise them on post-care measures.

Another important aspect that we have now introduced is how we counsel women who are forced to continue a pregnancy. In these cases, we have had training on ways that we can counsel both the woman and her family, especially husbands, and help support her decision to continue or not continue the pregnancy.

Through adopting the ARCHES intervention, we now have information and education tools that

we never previously had. Creating these tools was difficult at first, as we've had nothing like this before. But through a co-design process we found success, and now we've developed a range of materials – simple visual aids, colourful images, flow charts and so on – which are really helpful in our counselling sessions.

Along with this, we received a pocket-sized information card that is part of the ARCHES intervention. We give clients the information cards and advise them on how to keep the card discreetly if need be.

How is it an innovation?

The innovative part for me was learning to counsel clients about keeping their care choices confidential, especially around birth control and menstrual regulation. These skills were new to me — before, we didn't know how to guide women on how to keep this information private from their families or husbands.

Through ARCHES training, I learned techniques for ensuring confidentiality, providing aftercare advice, and dealing with sensitive family situations where a woman might want to continue a pregnancy despite pressure to terminate. Another key component was how we developed the counselling materials, which was a new experience for me.

This innovation was also about trust-building. In a setting where stigma is high and privacy is scarce, being able to offer discreet, rights-based care is a huge step forward.

It can't have been easy, can it?

Honestly, learning the new information at first was difficult — especially around confidentiality, counselling

techniques, and using the new tools. But with time, I learned how to apply it in my work.

There were challenges in creating the counselling tools, like the family planning wheel chart and the other visual aids. Since we weren't used to using tools like this, it took effort and adjustment to get them right.

I know that for some of my colleagues in other camps, they faced resistance from community members about women making their own

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reproductive decisions in private. Apparently there were some people who said it was wrong for a woman to keep her pregnancy status a secret or to seek MR without family knowledge. While I didn't face that barrier myself, I was aware it could happen.

Was there a most meaningful moment?

Yes — there's one story I will never forget. A young woman came to me after one of our door-to-door community representatives visited her home. The patient was initially hesitant and said she was inquiring for a friend.

During our conversation, I opened up about the services we offer and slowly gained her trust. She eventually shared that she was pregnant from a relationship, hadn't had her period in over one-and-a-half months, and the man had left for another of the camps. She was terrified about her life, her future, and her child.

I reassured her, explained the available services, and supported her through MRM care. She successfully regularised her menstruation, and six months later she married and had a child within marriage. This intervention changed her life. But it also did more than that. I think every success we have in case like this, helps to build confidence in our services among others, and has a positive ripple effect in the community.

What's on the horizon for GBV innovation in the next few years?

From my perspective, going forward, I think we should integrate direct GBV case management

services and services like ARCHES and FP counselling. Right now, when a woman needs protection services, we have to refer them to other service providers. It would be better if we could provide GBV case management through a one stop shop housed within our centres.

Also, I dream of a future where women can live life on their own terms and receive the care they need when they need it. I believe increasing the number of trained community health workers would help tackle these issues better. And above all, even though current funding for the community adaptation of ARCHES has ended, we need to keep counselling services active for GBV survivors and for people who don't yet know about ARCHES. Doing this would stop us from going back to the difficult situation we faced before we adapted and introduced ARCHES.

Do you recommend any resources on your work or innovation more broadly?

Yes — the ARCHES training materials are invaluable, especially those on confidential counselling and post-care advice. And the FP [counselling tools](#) we use — like the [WHO wheel chart](#), GBV referral pathway, FP checklist, flipchart and flowchart — have made a significant difference to how well we support clients.

I'd also recommend the [FP, MR/PAC manual produced by Ipas](#) (and the [Bangla version](#)) which has been essential resources in my work.

Elrha is a global organisation that finds solutions to complex humanitarian problems through research and innovation. Through our Humanitarian Innovation Fund (HIF) we identify, nurture and share more effective and scalable solutions to some of humanity's most difficult challenges. The HIF is funded by the UK Foreign Commonwealth and Development Office (FCDO) and Norway.

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