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gender section

unrwa experience in gbv programming

lessons learned from the first five years

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unrwa experience in gbv programming: lessons from the first five years

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Acknowledgments:
This document is the product of the learning workshops organized by UNRWA between 2010 and 2014. It summarizes the discussions held by the community of practitioners that gathered during these learning events. It is coordinated and written by UNRWA HQ Gender Unit that defined the learning process, namely Sana Jelassi, Tamara Abu Nafiseh and Stefania Chirizzi. From the Gender Unit Joely Thomas, Zahra Shah and Sophia Schall edited the document. Data, inputs, and feedback were provided by the teams leading the implementation of the GBV interventions in the Agency's five fields of operation: Lumi Young and Dr Iyad Zaqout in Gaza, Nada Hamdan in Jordan, Helene Skaardal in Lebanon, Aysheh Takhzent in Syria, Amal Ghanem and Maha El Sheikh in the West Bank.

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forward

Palestine refugees are at increasing risk of violence, abuse, exploitation and neglect across the region. Conflict, displacement and ongoing occupation are all factors that increase their vulnerability and compound their protection concerns. Gender-based violence (GBV) affects thousands of Palestine refugees and requires a multisectoral response from a range of different actors. The UN General Assembly acknowledges the protection mandate of UNRWA and specifically "encourages the Agency, in close cooperation with other relevant UN entities, to continue making progress in addressing the needs and rights of children, women and persons with disabilities in its operations, including through the provision of necessary psychosocial and humanitarian support, in accordance with the Convention on the Rights of the Child, the Convention on the Elimination of All Forms of Discrimination against Women, and the Convention on the Rights of Persons with Disabilities, respectively".[1] Preventing and responding to GBV is a central pillar of the implementation of this protection mandate.

In 2006, the UN Secretary General published a study on Violence against Women (VAW)[1] which called for action and coordination within the UN system to improve the efficacy and efficiency of all interventions developed to address VAW. It also called on UN Member States to comply with the international legal and policy framework on discrimination and VAW.

Consequently, an increasing number of structures were built to end VAW globally and in the region. In February 2009, the League of Arab States organized the second Arab Regional Conference for Family Protection from Family Violence. During this conference, experts from 18 Arab countries drafted a unified strategy for safeguarding families from domestic violence.

In order to contribute to this broader agenda to support gender equality and women's rights in conflict and post-conflict settings,[2] UNRWA has strengthened its efforts to address GBV both in the sphere of prevention and response across all five fields of operation. In 2009, UNRWA adopted a multisectoral approach to GBV, which has been informed by the Inter-Agency Standing Committee (IASC) *Guidelines for GBV Interventions in Humanitarian Settings*. Based on this multisectoral approach, context-adapted models of referral systems were developed in each of the Agency's five fields of operation.

As this learning document shows, the Agency's work to address GBV in the last few years has involved the establishment of referral pathways, training and capacity-building of staff, awareness-raising activities among Palestine refugee communities as well as prevention activities. Between 2011 and 2014, UNRWA has assisted 6,972 survivors of GBV.

Building on the lessons learned to date and documented in this report, UNRWA will continue in the coming years to consolidate the work to respond to GBV, systematize its prevention initiatives to better measure their impact and build capacities to strengthen GBV prevention and response from the onset of emergencies.

Furthermore, gender will also form an integral part of UNRWA's new Protection Unit to be established as of January 2016. This is an important move for the Agency in its efforts to ensure that gender issues are streamlined in all of our activities as an integral part of our mandate in serving Palestine refugees.

Sandra Mitchell
Deputy Commissioner-General

1 OP14, UN General Assembly resolution 68/88, adopted 5 December 2014.
2 Reference is made to United Nations Convention on the Elimination of all Forms of Discrimination against Women (CEDAW, 1979), the Beijing Platform for Action (1995); the United Nations Declaration on the elimination of Violence Against Women (UN DEVAW, 1993); UNSC resolutions 1325, 21061820, 1888, 1889, 1960, and 2122.

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glossary

Case Management
It is a collaborative, multidisciplinary process promoting quality and effective outcomes through communication and the provision of appropriate resources to meet survivors' needs. The goal of case management is to empower the survivor and, where appropriate, their caregiver, by giving her/him increased awareness of options available and assisting her/him in making informed decisions.[3]

Child
Any person below the age of 18.[4]

Child Sexual Abuse
Child sexual abuse is defined as any form of sexual activity with a child by an adult or by another child who has power over the child. By this definition, it is possible for a child to be sexually abused by another child. Child sexual abuse often involves body contact. This could include sexual kissing, touching and oral, anal or vaginal sex. However, not all sexual abuse involves body contact. Forcing a child to witness rape and/or other acts of sexual violence, forcing a child to watch pornography or show their private parts, showing a child private parts ("flashing"), verbally pressuring a child for sex and exploiting a child as a prostitute or for pornography are also acts of sexual abuse.[5]

Child Survivor
A person under the age of 18 who has experienced any form of gender-based violence.[6]

Collective Shelters
They refer to shelters facilities used by UNRWA to house internally displaced persons during or in the aftermath of a crisis or emergency.

Domestic Violence
All acts of physical, sexual, psychological or economic violence that occur within the family or domestic unit or between former or current spouses or partners, whether or not the perpetrator shares or has shared the same residence with the victim.[7]

Gender
Refers to the social differences between men and women that are learned, and though deeply rooted in every culture, are changeable over time and have wide variations both within and between cultures.[8]

Gender-Based Violence
GBV is an umbrella term for any harmful act that is perpetrated against a person's will, and that is based on socially ascribed (gender) differences between males and females.[9]

Identification
The number of GBV survivors recorded in the system (via forms or database), identified by UNRWA frontline staff or self-identified.[10]

Internally Displaced Persons
Persons or groups of persons who have been forced, or are obliged to flee, or to leave their homes or places of habitual residence in particular as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognized border.[11]

Intervention
Any action undertaken with the aim of eliminating GBV. Interventions can be preventive or reactive and can have different formats such as laws, policies, large-scale programmes or single projects. In the context of health system responses to GBV, interventions are understood as any action set by health care professionals vis-à-vis a survivor of GBV, aimed at identifying GBV, providing first-line support and other medical care as well as referring the survivor to other services.[12]

Mandatory Reporting
Refers to legislation passed by some countries or states that requires individuals or designated individuals such as health-care providers to report (usually to the police or legal system) any incident of actual or suspected domestic violence. In many countries, mandatory reporting applies primarily to child abuse and maltreatment of minors but in others it has been extended to the reporting.[13]

3 NCFA/Child Protection and GBV Sub-Working Groups. Interagency Emergency Standards Operating Procedures for Prevention of and Response to Gender-based Violence and Child Protection in Jordan. 2013.
4 United Nations. General Assembly. Convention on the Rights of the Child. Article 1. New York: United Nations, 1989.
5 IRC and UNICEF. Caring for Child Survivors of Sexual Abuse: Guidelines for health and psychosocial service providers in humanitarian settings. First Edition. 2012.
6 Ibid.
7 Council of Europe. Council of Europe Convention on preventing and combating violence against women and domestic violence. Istanbul: Council of Europe, 2011.
8 Inter-Agency Standing Committee. Guidelines for Gender-Based Violence Interventions in Humanitarian Settings: Focusing on Prevention of and Response to Sexual Violence in Emergencies (Field Test Version). Geneva: Inter-Agency Standing Committee, 2005.
9 Ibid.
10 UNRWA. Building Referral Systems for Survivors of Gender-based Violence: Framework of Indicators. UNRWA, 2013.
11 United Nations. Economic and Social Council. Commission on Human Rights. Guiding Principles on Internal Displacement. E/CN.4/1998/53/Add.2, 1998.
12 UNFPA and WAVE. Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia. 2014.
13 WHO. Responding to Intimate Partner Violence and Sexual Violence against Women: WHO Clinical Guidelines. WHO, 2013.

Perpetrator

Person, group or institution that directly inflicts or otherwise supports violence or other abuse inflicted on another against his/her will.[14]

Referral

The number of GBV survivors directed internally (within UNRWA services –including intra-departmental referral) or externally (to outside service providers) for further action. It is the number of survivors experiencing the act of referral; it does not necessarily involve survivors accessing the services through the referral.[15]

Referral System

A comprehensive institutional framework that connects various entities with well-defined and delineated (albeit in some cases overlapping) mandates, responsibilities and powers into a network of cooperation. Its overall aim is to ensure the protection of and assistance to survivors, to aid survivors in their full recovery and empowerment and to work towards the prevention of GBV and the prosecution of perpetrators (the so-called 3 p's). Referral mechanisms work on the basis of efficient lines of communication and establish clearly outlined referral pathways and procedures, with clear and simple sequential steps.[16]

Services Accessed

This denotes the number of services which have been accessed at least once by survivors of GBV (whether provided by UNRWA or by an external service provider).[17]

Sexual Violence

Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic a person's sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship to the victim, in any setting, including but not limited to home and work.[18] For the purposes of this document, sexual violence includes both sexual assault and rape.

Survivor

Person who has experienced gender-based violence.[19] UNRWA uses the term 'survivor' as opposed to 'victim' because it focuses on the potential and resilience that individuals can channel as they seek to address and overcome the violence they face in life.

Training

UNRWA has implemented three different levels of trainings with varying degrees of specialization, which are:

- Basic training: GBV basic concepts training, focusing on sensitising staff to GBV, including identification and referral.
- In-depth training: training for service providers to strengthen non-specialised capacities to respond to GBV within different functions, such as primary healthcare, social services and education. In-depth training focuses primarily on non-specialised first-line/psychosocial support and GBV guiding principles.
- Specialised training: Profession-specific training to build capacities for specific GBV interventions (such as GBV case management, mental health services for GBV survivors, provision of legal aid to GBV survivors, medical care for survivors of sexual violence etc.)[20]

Types of Violence

- Rape: non-consensual penetration (however slight) of the vagina, anus or mouth with a penis or other body part. Also includes penetration of the vagina or anus with an object.
- Sexual assault: any form of non-consensual sexual contact that does not result in or include penetration
- Physical assault: any act of physical violence that is not sexual in nature.
- Forced marriage: the marriage of an individual against his or her will. This also includes 'child marriage' which is any marriage under the age of 18.
- Denial of resources: denial of rightful access to economic resources/assets or livelihood opportunities, education, health or other social services.
- Psychological/Emotional abuse: infliction of mental or emotional pain or injury. [21]

Violence against Women

According to the Declaration on the Elimination of Violence against Women, violence against women "means any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life".[22]

14 Inter-Agency Standing Committee. Guidelines for Gender-Based Violence Interventions in Humanitarian Settings: Focusing on Prevention of and Response to Sexual Violence in Emergencies (Field Test Version). Geneva: Inter-Agency Standing Committee, 2005.
15 UNRWA. Building Referral Systems for Survivors of Gender-based Violence: Framework of Indicators. UNRWA, 2013
16 Chitashvili, Marina et al. National Research on Domestic Violence against Women in Georgia. UNFPA, 2010.
17 UNRWA. Building Referral Systems for Survivors of Gender-based Violence: Framework of Indicators. UNRWA, 2013
18 WHO. World Report on Violence and Health. WHO, 2002.
19 Inter-Agency Standing Committee. Guidelines for Gender-Based Violence Interventions in Humanitarian Settings: Focusing on Prevention of and Response to Sexual Violence in Emergencies (Field Test Version). Geneva: Inter-Agency Standing Committee, 2005.
20 Definitions of the different types of trainings are taken from the indicator framework developed by UNRWA for the GBV referral system project, 2013.
21 For GBVIMS definitions see: UNFPA, IRC and UNHCR. Gender-Based Violence Classification Tool. Web. 4th Nov. 2015. <http://gbvims.com/wp/wp-content/uploads/Annex-B-Classification-Tool.pdf>
22 United Nations. General Assembly. Declaration on the Elimination of Violence against Women. A/RES/48/104, 1993.

list of acronyms

ARDD	Arab Renaissance for Democracy and Development
BCC	Behavioural Change Communication
CBO	Community-based Organization
CEDAW	The Convention on the Elimination of all Forms of Discrimination against Women
CMHP	Community Mental Health Programme
CoP	Community of Practice
CMR	Clinical Management of Rape
CSA	Child Sexual Abuse
FCPP	Family and Child Protection Programme
FCPC	Family and Child Protection Committees
FSOs	Family Support Offices
GEM	Gender Equitable Men
GBVIMS	Gender-based Violence Information Management System
GBV	Gender-based Violence
GFO	Gaza Field Office
GUVS	General Union of Voluntary Societies
IASC	Inter-Agency Standing Committee
IDP	Internally Displaced Person
IFH	Institute for Family Health
IRC	International Rescue Committee
JNCW	Jordanian National Commission for Women
JFO	Jordan Field Office
JRF	Jordan River Foundation
LFO	Lebanon Field Office
MENA	Middle East and North Africa
MOU	Memorandum of Understanding
MOWA	Ministry of Women's Affairs
NCFA	National Council for Family Affairs
NGOs	Non-governmental Organizations
PBA	Palestinian Bar Association
PRS	Palestine Refugees from Syria
RSSP	Relief and Social Services Programme
SGBV	Sexual Gender-based Violence
SIGI	Sisterhood Is Global
SFO	Syria Field Office
SOP	Standard Operating Procedures
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
UNRWA	United Nations Relief and Works Agency for Palestine refugees in the Near East
USG	United States Government
VAW	Violence against Women
WBFO	West Bank Field Office
WCLAC	Women's Center for Legal Aid and Counselling
WPCs	Women Programme Centres

introduction

The Gender Unit in UNRWA works to embed learning in its practice to ensure quality of the services provided to Palestine refugees and their compatibility with a changing context. In this perspective, the Agency's work to address gender-based violence (GBV) included building a framework to measure results, developing lessons learned from field practices and providing space to exchange best practices, challenges and successes with key partners.

UNRWA sought to embed learning in GBV programming in two main ways: i - staging official learning events in the form of learning workshops and, ii- opening up boundaries for participation, beyond the gender taskforce and the GBV focal points, by establishing a Community of Practice (CoP).[23] The GBV CoP met on a bi-annual basis to reflect with others on practices, successes and challenges. The approach to gain insights goes beyond a single linear lecture of the outcomes of the referral. It looks at combined variables, indicators and results and brings different perspectives and multi-layered analysis together to find the best context-fitting solution to challenges.

UNRWA organized the first workshop in March 2010 that drew on regional experiences in addressing GBV and specifically on building referral systems,[24] as well as the processes involved and the challenges met. The development of an indicator framework for the Agency's referral systems was another step in the learning process and that allowed the definition of common measures for results across all UNRWA field offices.

The eight learning workshops organized between 2010 and 2014 continued to bring together staff from all UNRWA field offices with practitioners and experts on GBV from different organizations. This community of practitioners had flexible boundaries but involved a constant nucleus of UNRWA staff working on GBV and was open to national, regional and international organizations involved in GBV programming in the Middle East.

Learning from Others

Learning from others was particularly valuable for UNRWA, it contributed to building the Agency's approach in three ways:

- It contributed to the Agency's reflection bringing increased and nuanced evidence to results. For example, the lessons shared from the Palestinian framework to address violence against women (VAW) highlight the need to focus on the health system in responding to GBV survivors which corroborates UNRWA results.
- It brought practical examples from other organizations on how challenges are tackled mainly when resistance from staff and community made the challenge seem insurmountable. This is clearly demonstrated in how UNRWA partnership with ARDD Legal Aid in Jordan has helped the Agency overcome challenges related to mandatory reporting laws in Jordan which had made staff reluctant to report GBV cases fearing that they would have to go to the police and possibly court.
- It allowed bringing and discussing innovative approaches that could be adapted by UNRWA. This is the case for the prevention section where UNRWA is looking into systematizing its interventions and building a comprehensive framework addressing the different levels of prevention.

This learning document highlights UNRWA experience in addressing GBV between 2009 and 2014. UNRWA has put in place referral pathways in 114 locations within its five fields of operation by the end of 2014; training was provided to 7,499 staff between 2011 and 2014. This resulted in 6,972 survivors identified and 7,677 services accessed by the 3,778 survivors who gave consent to referrals.

Further, the document brings together the various discussions and reflections on the data and processes that took place during these years through the learning workshops. The discussions focused not only on practical challenges and successes in addressing GBV, but also integrated more strategic questions based on a combination of the results achieved by UNRWA, measured through the indicator framework, and compared to the practice of others at the level of processes. The questions raised addressed differences in the number of identified survivors across UNRWA

23 Garvin, D. "Building the learning organization." Harvard Business Review. 71. 4 (1993): pp. 78–92.
24 UNRWA. Community of Practice in Building Referral Systems for Women Victims of Violence. UNRWA, 2010. Web. 4th Nov. 2015. <http://www.unrwa.org/userfiles/2010081854458.pdf>

fields of operation and their links to the field context, to the model of referral and to previous work on GBV. Another issue was to what degree was there resistance from UNRWA frontline staff to address GBV as compared to staff in large public service-providing institutions and what has been the impact of this on the roll-out of the referral system. Furthermore, another issue discussed was the effect of threats from members of the community and staff's legitimate concerns towards their safety and security on their readiness to address GBV as part of their work as health care providers, social workers or educators.

The document provides elements of discussion and pragmatic solutions to challenges in addressing GBV in the context of resistance. It does not provide clear cut answers to all questions, but intends to bring together evidence from UNRWA and results from other agencies. It documents lessons learned around challenges and successes in addressing GBV to be shared with the wider CoP working on GBV.

The document is structured around four chapters. The first chapter recalls the overarching multisectoral approach and presents the process of building referral systems in UNRWA through the different field-specific models and ends with a review of experiences in the region and the challenges faced. The second chapter provides a snapshot of the data collected through the Agency's tracking systems in the fields and the indicator framework. The chapter offers insights to better understanding the typology of violence experienced by Palestine refugee survivors, survivors' needs and the services accessed. The data also provide opportunities to identify gaps in services for GBV survivors and to look into the adequacy and efficiency of the processes that make up the Agency's response to GBV. The chapter ends with an analysis of the challenges experienced during the last four years of implementation. The third chapter looks into the various GBV prevention efforts pursued by UNRWA and the need for systematization as well as the need for building evidence to show the results and impact of prevention activities. It provides examples from interventions implemented by UNRWA and others and reflects on the need to develop a theory of change (TOC) and a chain of results that will allow for the tracking of pursued and generated changes. The document concludes with a summary of the lessons learned during this whole process and defines the way forward for the coming years.

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unrwa experience in gbv programming: lessons from the first five years

Chapter I: Building Referral Systems as a Response to GBV

chapter i:
building referral systems as a response to gbv

1. A MULTISECTORAL APPROACH TO END GBV

In 2009 in view of addressing GBV holistically, UNRWA adopted a multisectoral approach to address GBV, which was informed by the Inter-Agency Standing Committee (IASC) Guidelines for GBV Interventions in Humanitarian Settings.[25] The multisectoral approach is a best practice model in responding to and preventing GBV. It is a co-ordinated approach based on the recognition that GBV can only be adequately addressed through a holistic effort, bringing together several organizations, actors and structures. It is an approach which cuts across several sectors including health, psychosocial and mental health, social services, legal/justice, security/protection and education.

One of the core aspects of the multisectoral approach is the centrality of survivors' rights and needs, such as ensuring survivors' access to adequate services, confidentiality and safety. Furthermore, the multisectoral approach promotes community involvement in GBV prevention and response, particularly of women and girls in the design of interventions, their implementation, and follow-up.

The Agency's comprehensive approach focused on response to enhance survivors' access to services and prevention in order to address the root causes of GBV. UNRWA started with addressing GBV by providing survivors with access to services through referral systems in each of the five fields of operation, coordinating available resources and reducing gaps in its response.

Funding from the United States Government (USG) in 2011 enabled UNRWA to accelerate the operationalization of this approach which focused on four main areas of intervention: (i) training UNRWA staff to identify, refer and provide first-line support to GBV survivors; (ii) developing referral pathways; (iii) building partnerships with external service providers; and (iv) raising awareness on GBV, including prevention and response, within the Palestine refugee communities.

"GBV is an umbrella term for any harmful act that is perpetrated against a person's will, and that is based on socially ascribed (gender) differences between males and females"

IASC Guidelines on Gender-based Violence Interventions in Humanitarian Settings

The establishment of the referrals by UNRWA followed the below steps:

- Assessment of internal resources, capacities and competencies;
- Mapping of external actors;
- Negotiation and establishment of a coordination mechanism;
- Developing a pathway;
- Building internal capacity, including staff training;
- Outreach and communication about the referral;
- Establishment of an information management system;
- Establishment of a follow-up system;
- Development of a learning system.

25 IASC, Guidelines for Gender-based Violence Interventions in Humanitarian Settings: Prevention of and Response to Sexual Violence in Emergencies (2005), (reviewed in 2015).

Multisectoral Framework for the Prevention and Response to GBV[26]

26 UNHCR. Action Against Sexual and Gender-Based Violence: An Updated Strategy. UNHCR, 2011. Web. 4th Nov. 2015. <http://www.unhcr.org/4e1d5aba9.pdf>.

2. MODELS ADAPTED TO FIELD CONTEXTS

UNRWA established referral systems as a response to GBV in each field of operation, based on field context and available resources, while also mindful of the need to ensure the sustainability of the referral system. The resources available informed the approach to response, which involves identification, case management, offering in-house services to the extent possible and referring externally as needed.

a. Gaza

In Gaza, the Agency's model revolved around the establishment of one-stop centres in all UNRWA health centres, which offer psychosocial services and legal counselling besides primary healthcare.[27] The 21 one-stop centres established since 2011 exemplify an effective service approach to GBV. They provide necessary and coordinated services in one easily accessible location to survivors, which is a recognized best practice by the Secretary General's 2006 Study on VAW.[28] However, it is important to note that UNRWA experience in developing one-stop centres lacks certain critical services often available in these type of centres such as forensic facilities and adequate temporary protective shelters. As such, UNRWA works with other organizations to address these gaps. The Agency has established referral pathways with the Network of Legal Aid Providers that bring together the Palestinian Bar Association (PBA), three schools of law and a number of local civil society and community-based organizations (CBOs) providing access to justice for poor and vulnerable individuals, including survivors of GBV.[29] In the health centres, psychosocial counselors function as case managers for survivors. They assess survivors' needs and recommend intervention plans ensuring the provision of inclusive and appropriate care, whilst coordinating services across the different sectors within the health centre and and also outside of it. Frontline staff in health centres, Relief and Social Services (RSS) offices and independent Women Programme Centres (WPCs) all participate in the identification and referral of survivors to the case managers.

Relevant staff at the centres meet regularly for the purpose of coordination. They review the efficiency of the referral system centre and the quality of the services provided to GBV survivors.

b. Jordan

The work of UNRWA on GBV in Jordan is framed by the Jordanian National Strategic Plan for Family Protection against Family Violence and the Family Protection Law No. 6 (2008). The National strategic plan was developed in 2005 under the umbrella of the National Council for Family Affairs (NCFA) and provides protection for all survivors present in Jordan.[30]

UNRWA referral system in Jordan is based on a survivor-centred approach, operating through what is referred to as GBV multi-disciplinary teams, which include staff from UNRWA core programmes who use the national referral system and refer survivors to partners including public institutions and NGOs when needed. At the time of writing this document, the GBV referral system is operational in all four areas in Jordan, covering eight out of ten camps.

GBV multi-disciplinary teams are made out of UNRWA education staff (school and teacher counselors or school supervisors), RSS staff (social workers), health staff (nurses) and also volunteers from the WPCs and community based rehabilitation centres and they all act as case workers. Caseworkers provide services as needed, refer internally or externally for services which they are unable to provide themselves and follow-up on the situation of the cases after referral. Finally, they keep track of the cases and ensure the adequacy of the services provided to survivors.

Internal coordination takes place through monthly meetings where data management and difficult cases are discussed without disclosure of names or details to protect confidentiality. The teams improved the follow-up and feedback mechanisms for referred cases through periodic meetings held with external service providers to ensure survivors' access to quality services and to build trust between UNRWA frontline staff and external service providers. UNRWA maintains eight partnerships in Jordan with Bright Future, Jordanian Women's Union, ARDD Legal Aid, Justice Center, Noor Al Hussein Foundation, Jordanian National Commission for Women (JNCW), Jordan River Foundation (JRF), and SIGI (Sisterhood Is Global). These partnerships allow survivors to access legal aid and court representation,

27 It is noteworthy that UNRWA does not legally represent survivors, but offers some legal counselling through projects and specialized project personnel or refers cases to legal aid partners for legal representation and litigation.
28 UN General Assembly. In-depth study on all forms of violence against women: report of the Secretary-General. A/61/122/Add.,2006. Web. 4th Nov. 2015. <http://www.refworld.org/docid/484e58702.html>
29 "Building new lives with legal aid support in Gaza." UNDP. Web. 4th Nov. 2015. <http://www.ps.undp.org/content/papp/en/home/ourwork/democraticgovernance/successstories/building-new-lives-with-legal-aid-support-in-gaza.html>
30 Please refer to page 17 for details on Jordan's National Strategic Plan for Family Protection against Family Violence 2005-2009.

psychosocial counseling as well as more specific services such as psychiatric care.

c. Lebanon

In Lebanon, a GBV case management approach has been adopted recently, housed within the RSS programme. The GBV caseworkers are community development social workers who have received specialized GBV case management training.[31] The caseworker and the client work together on various aspects of the required interventions to meet the needs in a survivor-centred, holistic manner. The interaction between the social worker and the GBV survivor is a collaborative process that assesses plans, implements, coordinates, monitors, advocates and evaluates available resources, options and services. An agreed upon intervention plan with the survivor is the outcome of this process. UNRWA ensures that appropriate care is provided and coordination of services across the organization and with external providers is facilitated. UNRWA has one GBV caseworker in each of its areas of operation in Lebanon.

These caseworkers are managed by the Women Programme Officer with the support of the Gender Protection Coordinator who ensures technical supervision, follow-up and peer-support to the caseworkers. Specific guidelines have been developed for both caseworkers and supervisors, detailing the steps of case management, the survivor-centred approach and the key components of the supervision of GBV case management.

UNRWA is able to assist survivors to access available resources and services internally, such as primary healthcare, special hardship assistance, emergency cash assistance, psychosocial support and mental health services and legal counselling and representation (apart from criminal cases). In situations where required services are not available within UNRWA nor offered by local camp-based service providers, UNRWA refers survivors externally to international and Lebanese NGOs. This includes specialized women's safe spaces and empowerment centres, protective shelters for survivors and women at risk, specialized mental health and child protection services as well as specialized medical care, such as clinical management of rape (CMR).

Palestine refugee survivors can generally access services such as the above at other organizations, usually offered through the Inter-Agency SGBV Taskforce and Child Protection in Emergencies Working Group in Lebanon while some services remain inaccessible to Palestine refugees, including Palestine refugees from Syria (PRS).

d. Syria

The model in Syria was initiated through the RSS programme with the creation of what is referred to as the 'Family Support Offices' (FSOs) where lawyers from the community provide legal counselling, while social workers act as case workers. In 2010, Legal Advice Bureaus, which had been set up in Yarmouk in 2007 and later in Deraa in 2008 to provide legal counselling to the community members, were changed to FSOs. They began focusing on addressing GBV using the community expertise and referring to the few available civil society organizations such as the Good Shepherd Foundation and the Association for Women's Role in Development that provided psychological and legal counselling as well as shelter.

The project came to a halt following the outbreak of hostilities in 2011 to re-start a year later. The model in Syria continues to operate through RSS with the re-opening of the FSO in the Alliance area of Damascus and the re-activation of the Deraa office. Further plans are underway to open another FSO in Homs by the end of 2015. In the newly-opened FSO in Damascus, there is increased involvement from social workers as case managers who are able to refer survivors to the lawyers in case of need. In the collective shelters, social workers identify GBV survivors and make a primary assessment of their needs. Subsequently, survivors are referred to the FSO where they can access psychosocial counselling and legal services. In case there is a need for more specialized services such as mental health care, survivors are referred to external service providers such as the Syrian Red Cross.

In some cases, identification occurs through partner NGOs, which either refer directly to UNRWA services or to the FSO, which in turn refers survivors internally according to need. As a result of the continuous displacement of the community and the restrictions on movement, lawyers from the FSO frequently visit collective shelters to meet with survivors. Volunteers continue to play an important role in facilitating referrals to lawyers and operating helplines for survivors.

31 The training was carried out in partnership with International Rescue Committee.

The conflict and unstable conditions in Syria continue to challenge the resilience of the referral system since mass and repeated displacements have compounded the situation for a population group that was already vulnerable prior to the conflict. Moreover, the conflict affected civil society and community organizations resulting in decreased levels of human resources for service provision. The referral model in Syria has thus had to adapt, developing into a more flexible model that can respond to changes in community organizations and available resources.

e. West Bank

In the West Bank, UNRWA adopts a multisectoral, community, and family-based approach to addressing GBV which bridges gaps, links core programmes and coordinates with several partner organizations. UNRWA health, RSS and education programmes established the Family and Child Protection Programme (FCPP) in 2009. The FCPP is housed in the Community Mental Health Programme (CMHP) and aims to protect the rights of vulnerable groups in refugee camps—children, youth, women, the elderly and persons with disability—from all forms of violence, injury, abuse, neglect and discrimination.

UNRWA has since expanded the FCPP and GBV referral system in the West Bank to all 19 camps. UNRWA health centres' psychosocial counsellors, school counsellors and social workers play the role of case managers of GBV survivors when identified in their respective programmes. Case managers were trained on developing protection plans with any individual or family suffering from GBV. In addition, each UNRWA health centre and school has created a Family and Child Protection Committee (FCPC). Committees conduct case management conferences in the event of urgent and difficult cases and coordinate with social workers. The committees convene with the written consent of the survivor or the guardian if the survivor is under 18 years old.

For high-risk/emergency cases, Critical Case Management Committees convene when rapid and direct intervention at the camp-level is needed. The Critical Case Management Committee may be called upon to provide protective support to the survivor, work with the family members to ensure support and social acceptance and ensure that the survivor receives protection from further physical, psychological, or community violence.

UNRWA developed partnerships that permit the referral of clients needing specialized services. For mental health services, survivors are referred to the Ministry of Health or Palestinian Centre for Counselling. Cases requiring legal services are referred to the Women's Centre for Legal Aid and Counselling (WCLAC). Specialized NGOs, such as Al-Mada Association for Arts-Based Community Development, provide UNRWA with technical support on the use of music and art therapy in preventing GBV, while Birzeit University, Juzoor for Health and Social Development, and the Women's Studies Association provide technical support and research capacity to UNRWA.

In addition, UNRWA works with the Ministry of Women's Affairs and the Ministry of Social Affairs to operationalize the National Strategy to Combat Violence against Women (2011-2019). UNRWA Standard Operating Procedures and GBV protocols for health, education and RSS programmes were developed in line with the Palestinian referral system. The guidelines define the roles and responsibilities of staff and programmes and provide forms for assessment and case management, referral, protection plans and informed consent.

Models of the Referral System

Fields	Models	Strengths	Challenges
Gaza	One-stop centres located in health centres, which offer psychosocial services and legal counselling besides primary healthcare	Enhanced efficiency and easier access to all services in one location	One-stop centres often face challenges in guaranteeing sustainability because it is demanding in terms of human resources
West Bank	Community-based approach with core management committees made up of social workers from RSS and psychosocial counsellors from Health	System is fully integrated and supported by the community; a community based prevention framework has been developed	Demanding in terms of coordination, putting systems in place, and systematising work
Lebanon	GBV case management housed in the relief and social services Women's Programme	Survivor-centered approach focused on the immediate and long-term needs of survivors	The focus on case management makes it demanding in terms of human resources, and also poses some challenges in looking at GBV holistically, by focusing on individual cases rather than the community level to ensure that GBV risks are prevented and addressed
Jordan	Builds on national framework of responding to GBV and works closely with external partners	Guaranteed sustainability because it is reliant on integrated efforts at the national level	Demanding in terms of coordination, putting systems in place, and systematising work
Syria	Initiated through Women Programme Centres (WPCs) and based on family support offices, which are located inside WPCs and where lawyers from the community provide legal counseling, while social workers act as case workers	Integrated in the community through WPCs and through the active involvement of volunteers from the community in addition to UNRWA staff	Flexibility in responding to needs may be limited; sustainability of CBOs not guaranteed given the security situation

3. LEARNING FROM OTHERS: NATIONAL FRAMEWORKS TO ADDRESS GBV IN THE REGION

After outlining the key strengths and the challenges pertaining to each UNRWA field referral system, highlighting other experiences of referral systems addressing GBV or VAW in the region was a useful learning experience in identifying corresponding features and dissimilarities with the Agency's experience. The selected models – which are the Palestinian and the Jordanian national frameworks to address GBV and the experience of the Institute of Family Health in Jordan – provide a diverse range of approaches and operational modalities with their own lessons to share.

a. The Palestinian Framework: A Multisectoral Approach

The Juzoor Foundation for Health and Social Development and the Women's Centre for Legal Aid and Counselling (WCLAC) jointly implemented the Takamol project which developed a sustainable legal-health-social services referral system for women survivors of violence in Palestine. The three-year project (2009-2011) created a referral system with operational protocols, organized awareness-raising activities and trained service providers.

In 2011, after piloting the system in two Palestinian governorates, it was submitted to the Ministry of Women's Affairs (MOWA). During this time, a National Strategy for Combating Violence against Women (2011-2019), which called for ending GBV through intervention at three levels: prevention, protection and law enforcement, was also adopted by the Palestinian Authority.[32]

The Palestinian government approved the referral system in 2013 and took over the implementation of the mechanisms and tools designed to improve service provision for GBV survivors.

Lessons to Share

The Palestinian national referral system is still in the early stages, however, a number of issues aimed at strengthening its impact have been identified:[33]

- Expanding the referral system targeting all ages and sexes of survivors and reaching more isolated areas;
- Standardizing measures and tools with effective criteria for regulatory bodies as well as standards of operation for all service providers involved in the referral system;
- Creating an enabling environment with a system which enforces the legal framework;
- Continuing the training of service providers on the use of the referral system for more compliance;
- Increasing outreach to potential survivors with more focus on the health system;
- Consolidating prevention and putting interventions in place at three levels: policy level, institutional and community level and individual level.

32 Palestinian National Authority. Ministry of Women's Affairs. National Committee to Combat Violence Against Women. Strategic Plan for Combatting Violence Against Women. (VAE) 2011-2019. 11 January 2011. Web. 4th Nov. 2015. <http://reliefweb.int/sites/reliefweb.int/files/resources/D3E990A06959C3B34925781D000E0D58-Full_Report.pdf>

33 Based on the presentation by Mr. Ismail Hammad from the Palestinian Ministry of Women's Affairs at the 9th GBV Learning Workshop in Amman in September 2014, and the discussion which followed. In addition to various other reports. For more information see: "Implementing the National Referral System for Battered Women." Miftah. Web.<http://www.miftah.org/Doc/PolicyPapers/Policy270715.pdf> ; Council of Europe. Parliamentary Assembly. Evaluation of the partnership for democracy in respect of the Palestinian National Council. 27 January 2014. Web. 4th Nov. 2015. <http://www.assembly.coe.int/nw/xml/XRef/X2H-Xref-ViewPDF.asp?FileID=20370&lang=en>.

b. The Jordanian Framework to Address Domestic Violence: A Right Based Approach

The Jordanian National Women's Commission (JNWC) established in 2009 a complaint office providing legal and social counselling for GBV survivors. Furthermore, memoranda of understanding (MOU) were signed with 82 relevant institutions for referral and a data base was established to follow-up on cases.

Building on the work by JNWC, a national framework for addressing domestic violence was developed in 2005 under the umbrella of the National Council for Family Affairs (NCFA). The framework which is centred around the protection of the family, identifies five strategic objectives.[34] It was followed by the Law on Protection from Domestic Violence in 2008 which lays out processes and protocols for family protection from domestic violence.

Guided by this legal framework, a growing number of Jordanian structures, including NGOs, provide extensive services to GBV survivors such as shelter, hotlines and outreach programmes, which entail household visits that are important in identifying survivors of VAW.[35] While gaps exist in the law and its implementation, the existence of this national framework has created further opportunities for UNRWA to partner with external service providers.[36]

The Jordanian National Plan includes the following strategic objectives:

- Prevention: aiming at adopting the necessary measures to curb violence through awareness and education programs.
- Protection: aiming at raising the efficiency of the response to domestic violence through quality services and standardised procedures.
- Human and material resources: aiming at enhancing the institutional capacities of the parties involved in family protection and security.
- Legislation, policies and legal issues: commitment to developing legislation and laws that harmonise with the principles of prevention of, and protection from domestic violence.
- Partnership and coordination: Ensuring that programs, policies and legislation are comprehensive and integrative.
- Studies and research: Promoting research on domestic violence, its consequences and costs and the efficiency of the programs.

Lessons to Share

The Jordanian national referral system brings together actors from governmental and non-governmental sectors in the public and private spheres and in providing a clear system of legal support for survivors. Yet, a number of areas require further attention:[37]

- Coordination and follow-up mechanisms are needed to reinforce the efficiency of the referral system;
- Harmonization of approach is required to ensure shared knowledge among service providers;
- Improvement of specific services such as psychosocial and family counselling is needed.[38]

34 "Family Protection against Violence Program." National Council for Family Affairs. Web. 4th Nov. 2015. <http://www.ncfa.org.jo/Default.aspx?tabid=75&language=ar-JO>
35 United Nations Jordan. Violence Against Women: Assessing the Situation in Jordan. 2008. Web. 4th Nov. 2015. <http://www.un.org/womenwatch/ianwge/taskforces/vaw/VAW_Jordan_baseline_assessment_final.pdf>
36 For more information on Jordanian policies and legislation on violence against women, please see: National Council for Family Affairs. Status of Violence against Women in Jordan. National Council for Family Affairs, 2008.
37 Based on the outcomes of the surveys presented in: Abu-Dayyeh, Suad. Challenges and Obstacles: Women Breaking the Cycle of Violence in Jordan. Alianza por la Solidaridad, 2012-2013. Web. 4th Nov. 2015. <http://www.alianzaporlasolidaridad.org/wp-content/uploads/Research-Eng-Violence-challenges-and-obstacles.pdf>
38 United Nations Jordan. Violence Against Women: Assessing the Situation in Jordan. 2008. Web. 4th Nov. 2015. <http://www.un.org/womenwatch/ianwge/taskforces/vaw/VAW_Jordan_baseline_assessment_final.pdf>

c. The Institute for Family Health in Jordan: a Health-Centred Approach Supplemented by Multidisciplinary Services

The Institute for Family Health (IFH) in Jordan began providing services for GBV survivors in 2007, expanding from sexual violence and child abuse to VAW. IFH is now an internationally recognized national and regional centre providing prevention and rehabilitation services for survivors of GBV.[39]

IFH centres systematically screen for GBV through a self-administered screening tool handed to all patients. Each identified survivor enters a case assessment stage and a case plan for intervention is established and agreed upon by both parties. The plan usually begins with individual counselling, though group and couple counselling is also available. In some cases, a male counsellor may approach and provide counselling to the perpetrator alone. Depending on the assessment of the survivors' security, cases can be classed as 'urgent' where action is taken within 24 hours. If there are immediate protection concerns, the survivor is also referred to the Family Protection Department and shelter services are offered if needed. IFH also conducts outreach sessions on GBV in the community and has also implemented a capacity-building programme for health providers and developed the medical care providers' training manual.

Lessons to Share

The IFH provides a committed and comprehensive service in supporting and referring survivors of GBV, yet it has encountered some challenges in integrating a referral system:[40]

- Staff well-being and security were initially a major concern and some staff resigned because of the stress of dealing with GBV. A stress-management plan is now in place for all staff.
- Quality assessment was measured through client satisfaction forms, however, it should be interpreted cautiously since the situation of some beneficiaries may deteriorate following a successful initial assessment. This is due to the client's personal situation which could require additional methods for quality assessment.
- Follow-up on referred cases is not always successful, especially when liaising with government bodies, which have lengthy procedures that result in delaying the sharing of information on survivors referred to them.

39 "Institute for Family Health." Noor al Hussein Foundation. Web. 4th Nov. 2015. <http://www.nooralhusseinfoundation.org/index.php?pager=end&task=view&type=content&pageid=35>
40 Based on IFH participation and discussion in the GBV learning workshop, organized by UNRWA, which took place in June of 2012.

unrwa experience in gbv programming: lessons from the first five years

Chapter II: Implementation, Achievements and Challenges

chapter ii: implementation, achievements and challenges

The referral systems that UNRWA has put in place in its five areas of operation allow the Agency to collect non-identifiable data on GBV trends, survivors and service provision to survivors. UNRWA has developed an indicator framework for the purpose of assessing the utility of the referral systems and their ability to deliver expected outcomes. This chapter provides an analysis of the results and achievements of the systems in place, their approaches and outcomes for survivors. The analysis uses data from the tracking systems and the tools developed to monitor progress and measure impact of the various components of the GBV interventions and the referral systems established.

It is important to note that because this data is gathered through the referral systems established by the Agency, UNRWA is mindful of the limitations of drawing conclusions on the prevalence and trends of GBV among Palestine refugees using service-based data. In this light, the data can be utilized to gain insights to the response of UNRWA, the trends in service provision and the identification of challenges and gaps in services for GBV survivors across its areas of operation.

Prevalence of GBV among Palestine Refugees

Data collection is integral to the development of evidence-based programming to address GBV. UNRWA has made strides in the development of tracking systems which collect data on the number of survivors. It is important to remember though that one of the inherent limitations of service-based data is that it only scratches the surface in representing the prevalence of GBV among the population.

The following are the numbers of GBV survivors identified by UNRWA in the period between 2011–2014.

Gaza 3,160 survivors

West Bank 1,803 survivors

Syria 1,347 survivors

Jordan 485 survivors

Lebanon 204 survivors

In **Jordan**:[41]

87% of women reported domestic violence

According to the study, of those women:

48% reported psychological violence

20% reported physical violence

In **Lebanon**, GBV was described as **'rampant'** among Palestinian refugees in Lebanon and that women suffer specifically from domestic violence.[43]

In the **Occupied Palestinian Territories**:[42]

51% of women in Gaza experienced GBV

30% of women in West Bank experienced GBV

According to the study, of the women respondents:

59% suffered psychological violence

55% suffered economic violence

55% suffered social violence

24% suffered physical violence

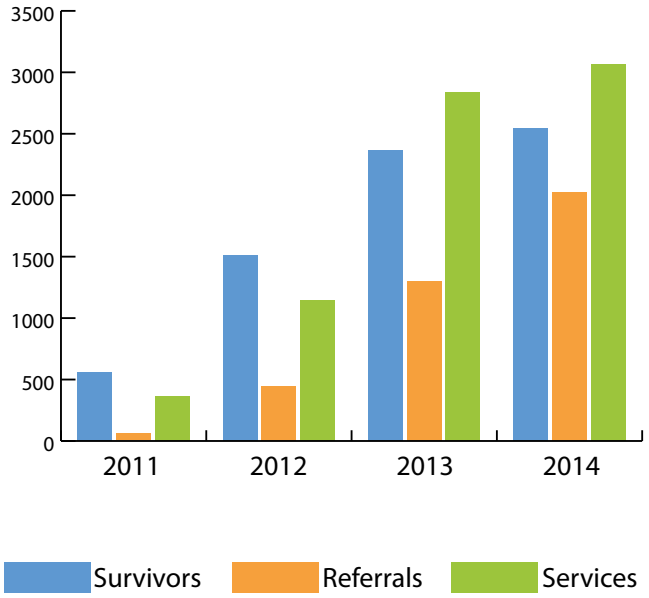
12% suffered sexual violence

41 Al-Nsour, M., Khawaja, M., and Al-Kayyali, G. "Domestic violence against women in Jordan: Evidence from health clinics." Journal of Family Violence, 24 (2009): 569–575.
42 Palestinian Central Bureau for Statistics. Main Findings of Violence Survey in Palestinian Society. N.p., 2011: 17. Web. 4th Nov. 2015.<http://www.pcbs.gov.ps/Portals/_pcbs/PressRelease/el3onf2011_E.pdf>
43 Khalidi, Aziza, comp. Breaking Through Layers of Discrimination: Report on the Implementation of CEDAW for Palestinian Refugee Women in Lebanon. Rep. 2008: 48.

1. RESULTS AND FINDINGS

a. Identification of GBV Survivors

Between 2011 and 2014, UNRWA frontline staff identified 6,972 survivors of GBV in Gaza, Jordan, Lebanon, Syria, and the West Bank, while 7,677 documented services have been accessed with a steady increase yearly in each field of operation.



i. Identification by Field of Operation

Gaza and West Bank fields have identified the highest numbers of survivors throughout the four years of implementation. This could be related to numerous factors and should not be interpreted as indicating that GBV is more prevalent in the oPt than elsewhere in UNRWA areas of operation. Organizational capacities such as the existence of the CMHP in Gaza and the West Bank have played a central role in the high levels of identification, referral and interventions in both fields. The CMHP houses a large number of psychosocial counsellors who have consistently functioned as primary identifiers and responders to GBV.

Furthermore, in Gaza, the Equality in Action[44] programme has implemented large-scale community-based GBV awareness activities, in addition to basic GBV training and awareness-raising activities targeting UNRWA frontline staff. Several activities were implemented prior to the establishment of the referral system which laid the foundation for the sensitization of both community members and frontline staff. This has proven an important enabler for the implementation of the referral system there, particularly in relation to strengthening staff's readiness to address GBV as part of their work.

In Syria, the identification of GBV survivors has seen a dramatic increase following the outbreak of hostilities and the crisis. The number of survivors identified in 2011 before the start of the crisis was 44, compared to 516 reported cases in 2013 after the re-activation of the referral system by UNRWA in Syria. The more than 10 fold increase in survivors identified corroborates the link between emergencies and the increase in the occurrence and reporting of GBV.

Identification and referral in Lebanon and Jordan fields remain lower than other fields. This is due to several factors. In addition to the lack of an integrated CMHP, it is also a result of lower numbers of staff trained on GBV identification and safe referrals compared to other fields primarily due to lower levels of funding for GBV programming. In the case of Lebanon, the limited initiatives for GBV community outreach and awareness prior to setting up the referral system also posed some challenges. These challenges were compounded by the resistance to the programme experienced in the pilot phase which caused major delays in the roll-out and anchoring of the programme.

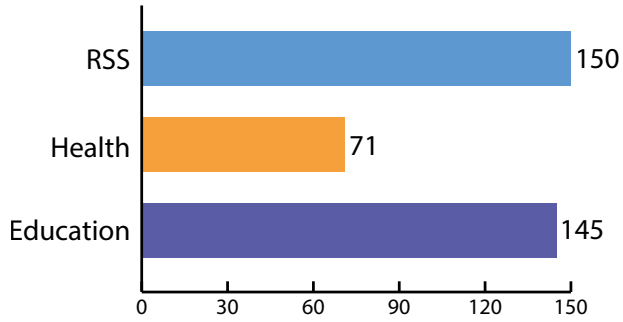
44 Kindly see box on page 33.

ii. Identification by Programme

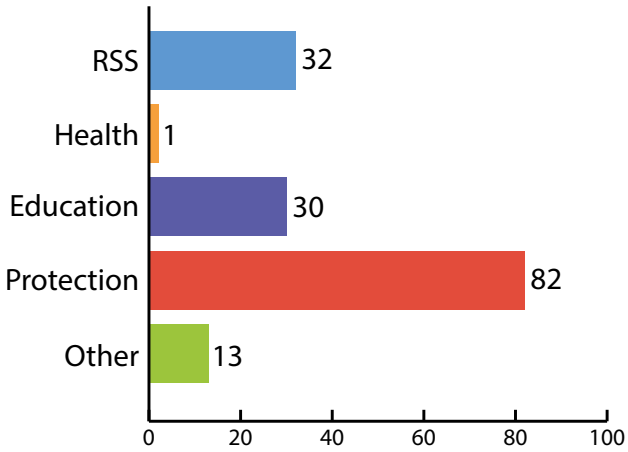
While UNRWA was concerned with ensuring consistency among fields in applying a mutlisectoral approach to GBV through bringing together all the different programmes within the Agency, it had to rely on a degree of flexibility in the implementation of the approach depending on the context and resources in each field. This has led to different programmatic leadership in each field. In Gaza and the West Bank the CMHP and the Department of Health respectively managed the implementation. In Lebanon, coordination of the GBV referral system is housed within the OSO/Protection Unit (until it can be fully managed by the RSS programme), while in Syria RSS is managing the referral system. In Jordan, the GBV referral system was initially housed in the Programme Support Office but has recently come under the Protection Unit.

Numbers of identified survivors, disaggregated by programme indicate a clear correlation between programmatic leadership and increased number of identification and referrals (Please refer to charts by field and programme on identification for the two year period 2013-2104). In the case of Gaza most identifications are made through CMHP counsellors, which have the highest readiness rate for GBV identification at 81 per cent.[45] Similarly, in Lebanon and Syria the majority of identifications are made by Protection and RSS staff respectively, both coming from the programme/unit leading the response. The impact of programmatic leadership on the number of identifications further points to the importance of managerial commitment to strengthen the level of engagement and accountability of staff to address GBV.

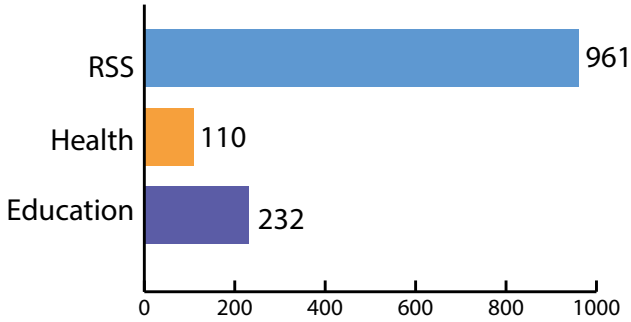
Jordan



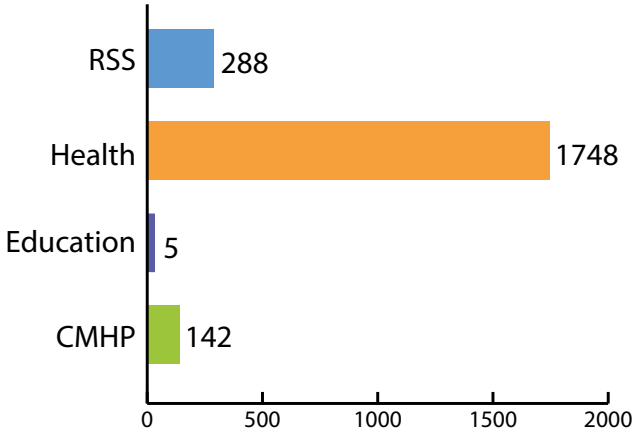
Lebanon



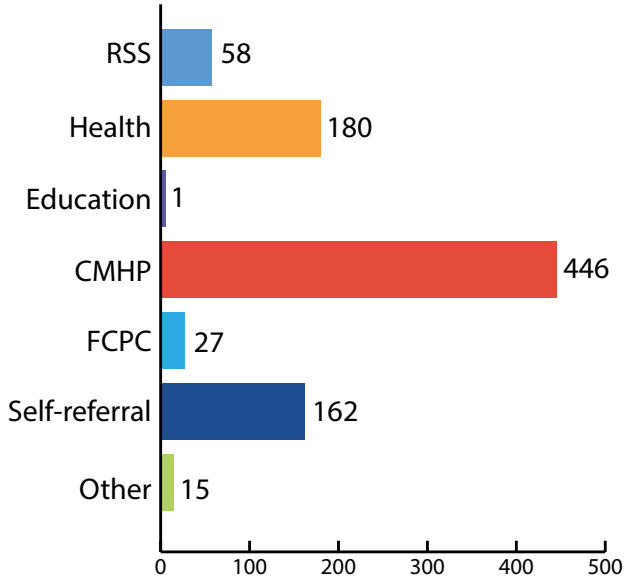
Syria



Gaza



West Bank



45 This is based on questionnaires administered December 2014 in Gaza Field Office.

Further, the leading program was able to institutionalize this commitment through revisions in staff terms of reference which took place SFO. For example, the leading Department of RSS amended the terms of reference of social workers, embedding GBV identification and referral in their core responsibilities. Furthermore, in the West Bank, the leading Department of Health developed health-specific guidelines for GBV response as a first step and then moved to the development of education and relief specific guidelines on GBV, leading to more involvement from all programmes. These experiences demonstrate the importance of developing tools as well as follow-up in building institutional capacity to respond to GBV.

b. Referral and the Quality of Services

As part of the monitoring framework, UNRWA follows up on referrals as well as the services accessed by survivors. This helps the Agency in identifying survivors' needs and also informs the development of partnerships with external service providers to fill gaps in service delivery.

Data collected for the year 2014 indicates that psychosocial counselling is the most accessed service by survivors, which is due to a number of reasons. All types of GBV, be it physical, sexual, or psychological result in psychological trauma for survivors who often experience feelings of fear, guilt, shame and anger among others. This could lead to depression, anxiety and somatic problems which explains the centrality of psychosocial support to GBV survivors.[46] Further, as previously noted, the most widely prevalent form of GBV is domestic violence by husbands and fathers of survivors and thus survivors fear retaliation and are reluctant or afraid to pursue more formal action towards perpetrators, while psychosocial counselling is seen as more acceptable and less consequential. The need for legal services by survivors due to issues such as divorce, custody of children and inheritance is also reflected in the data, as survivors need clarification on relevant procedures, legal consultation and litigation in some cases.

In addition to following up on services accessed, the Agency looks into survivors' satisfaction with GBV services through one of the indicators in the monitoring framework. Measuring survivors' satisfaction is based on a survey tool with close-ended questions on satisfaction with UNRWA and external service providers. All survivors who received follow-up from case managers for four months or longer were asked to respond to the survey.

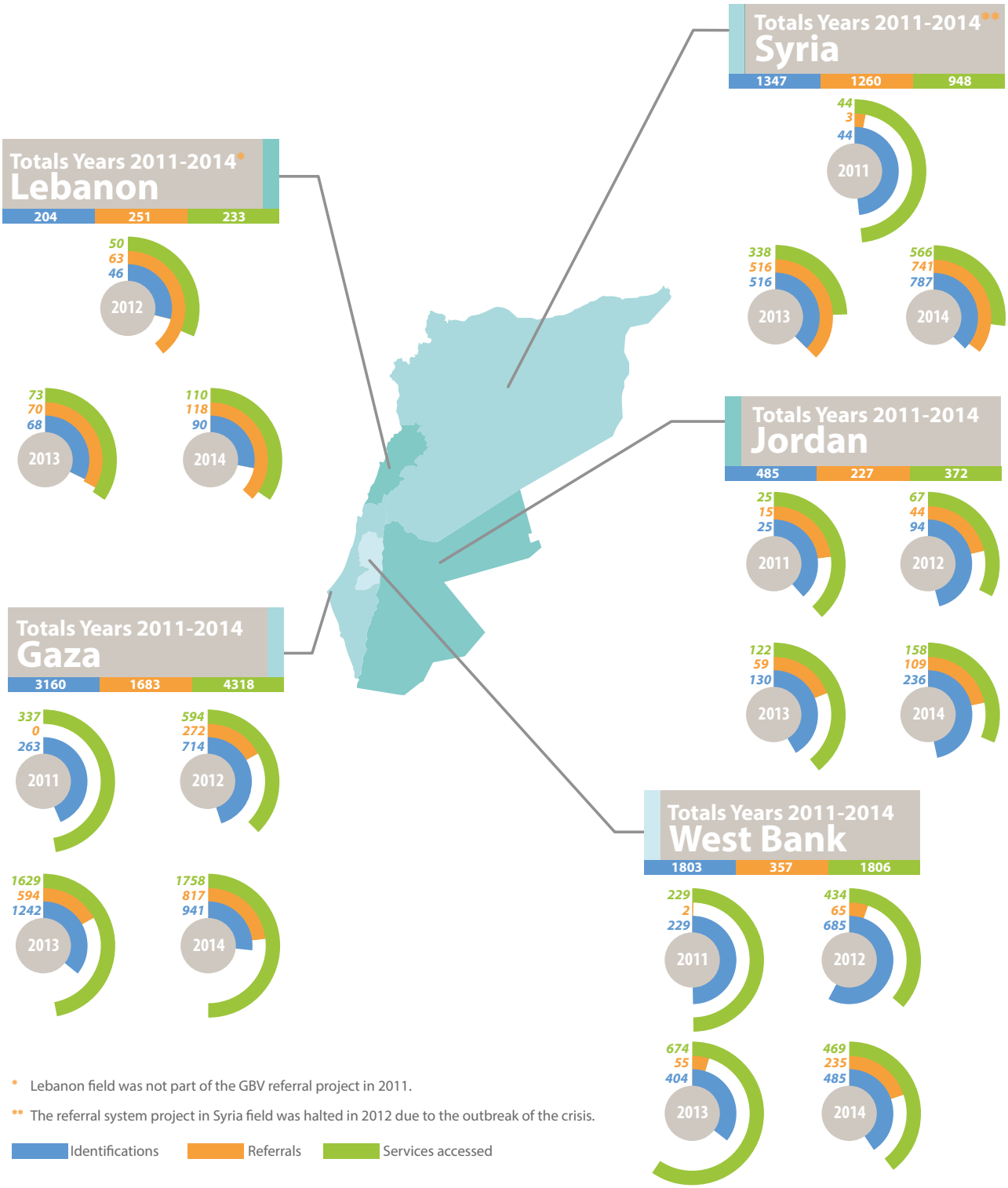
The following table shows the percentage of survivors satisfied with services for 2013 and 2014:

Field	2013	2014
GFO	90.7%	96.8%
JFO	80.0%	100%
LFO	83.3%	80.0%
SFO[47]	NA	NA
WBFO	NA[48]	98.0%

This indicator has consistently shown high levels of survivor satisfaction with GBV services. However, based on experiences in other areas, it is challenging to establish the accuracy of client satisfaction surveys because the results could be linked to wider issues related to UNRWA or referral partners' services as well as the survivors' own expectations about the support provided. Moreover, the way in which the client satisfaction surveys are implemented has an impact on the results. Since the key service providers (i.e. UNRWA case managers) are asking the clients to do the survey, clients are likely to feel uncomfortable in being honest in their assessment. An anonymous survey would likely offer a more accurate result, however, that has proven difficult to implement.

46 UNFPA, WHO and UNHCR. Reproductive Health in Refugee Situations, an Interagency Field Manual. UNHCR, 1999.
47 Syria Field Office was unable to administer the survey due to the continuous displacement of the Palestine refugee population in Syria as a result of the hostilties.
48 WBFO could not administer the survey at the end of 2013 due to an UNRWA staff strike.

Identification, Referrals, and Services Accessed



* Lebanon field was not part of the GBV referral project in 2011.

** The referral system project in Syria field was halted in 2012 due to the outbreak of the crisis.

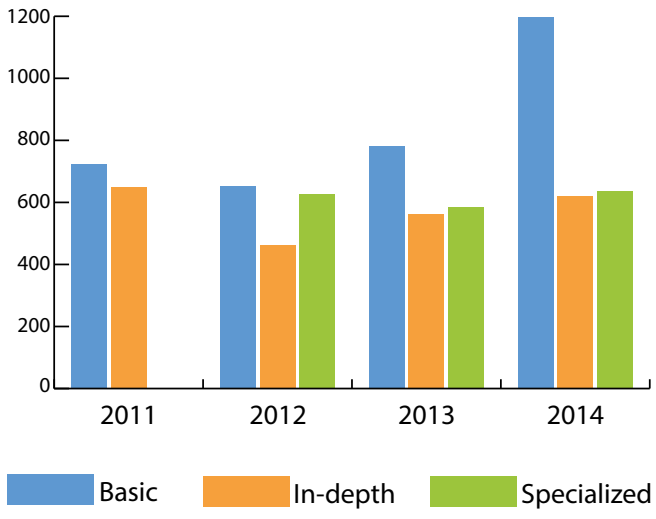
Identifications | Referrals | Services accessed

c. Capacity-Building and Staff Readiness to Respond to GBV

Training and capacity-building have been a central component in embedding GBV response in the Agency's core programmes and services. Between 2011 and 2014, UNRWA trained around 7,000 staff members including teachers, social workers, psychosocial counsellors, medical officers and nurses. Trainings were organized around three main categories: basic, in-depth and specialized trainings defined as follows:

- Basic training: GBV basic concepts training, focusing on sensitizing staff to GBV, including identification and referral.
- In-depth training: training for service providers to strengthen non-specialized capacities to respond to GBV within different functions, such as primary healthcare, social services and education. In-depth training focuses primarily on non-specialized first-line/psychosocial support and GBV guiding principles.
- Specialized training: Profession-specific training to build capacities for specific GBV interventions (such as GBV case management, mental health services and legal aid to GBV survivors, medical care for survivors of sexual violence etc.)

Both basic and in-depth trainings are using the Agency's manual for frontline staff 'Working with GBV survivors'[49] that was developed in 2012.



GBV capacity-building has proven instrumental not only in increasing staff ability to respond to GBV, but also in raising awareness and changing perceptions. GBV was previously considered a private issue but the Agency has achieved strides in changing perception on GBV to be understood as a public health and social problem. In turn, this has reinforced the understanding of the staff's roles in responding to GBV, as well as their readiness to use the referral system. However, by looking at the return on trainings through identification[50] and referral, it is clear that even within programmes which have received high levels of trainings there have been persistent obstacles to reporting the identification of GBV survivors and referring them to appropriate services. This shows that while trainings have been crucial, it has not been sufficient on its own. Supporting mechanisms, such as revisions to staff terms of references, accountability frameworks and reference tools and guidelines to support staff in implementation, are necessary to improve the effectiveness and efficacy of the response and to ensure sustainability. Furthermore, some fields reported structural obstacles that impede identification, such as the lack of confidential spaces that are key for identification and for survivors to disclose information.

On the other hand, training of staff has been contributory in increasing frontline staff's embracement of their roles and responsibilities to respond to and address GBV. This was essential to embed the referral system in the Agency's core programmes and ensure its sustainability over the long term. In order to monitor to what extent staff understand and acknowledge their roles and responsibilities to address GBV, UNRWA carried out bi-annual readiness assessment questionnaires in all core programmes. Further, these questionnaires have also been integral to assess resistance among frontline staff in addressing GBV which has helped the Agency identify where to focus its training and capacity-building efforts.

49 Al Usta, Jinan. Working with Gender Based Violence Survivors Reference Training Manual for Frontline Staff. UNRWA, 2012. Web. 4th Nov. 2015. <http://www.unrwa.org/sites/default/files/2012061162152.pdf>

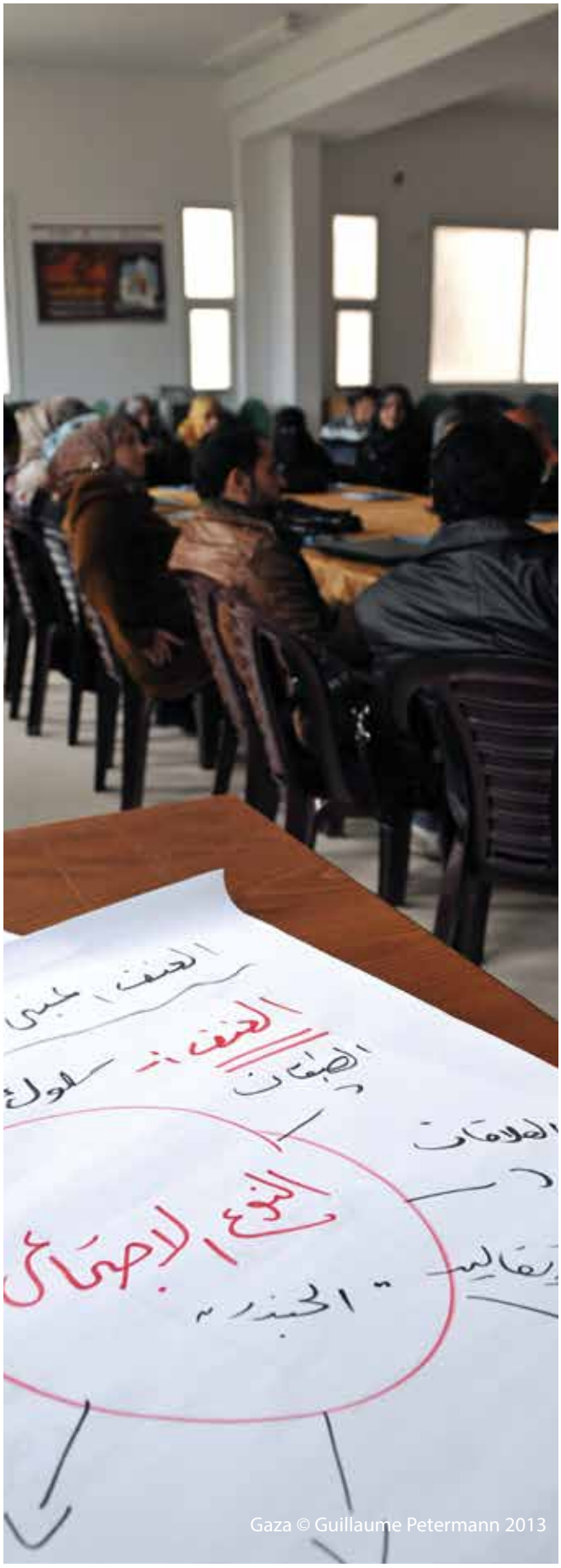
50 UNRWA measures return on trainings by using this formula: Number of identification for a given period/ Number of trainings for the same period. The rate of return on trainings is done for each programmes separately. This has been used by UNRWA to get an indication of the correlation between trainings and detections as well as some insights on obstacles to detection which face some programmes, including at times staff's own resistance to address GBV, either due to a lack of know-how or due to personal attitudes and beliefs.

Staff embracement of their GBV roles in identification and referral for December 2014:

	GFO	JFO	LFO[51]	SFO	WBFO
Education	na	80%	62%	77%	65%
RSS	82%	78%	61%	87%	90%
Health	50%	25%	68%	44%	75%
CMHP	81%	NA	NA	NA	90%

While these questionnaires were useful in shedding light on staff's readiness to address GBV, challenges remain in ensuring representative samples, follow-up, and consistency in sampling across the different fields. In 2014, UNRWA reviewed the indicator framework and the tools used in indicators measurement to further clarify these issues.

UNRWA has made use of the results of the readiness assessment surveys to identify gaps in programmes' involvement in the GBV referral system. In 2014, with the aim of enhancing the integration of health staff in the GBV referral system due to the noticeably low embracement levels (as shown in the above table), UNRWA has drafted GBV guidelines for Health staff. These guidelines form a basis on which the different fields are building a more systematic approach to address GBV within the Agency's primary healthcare setting that is adapted to the context and approach of the referral system across the different fields.

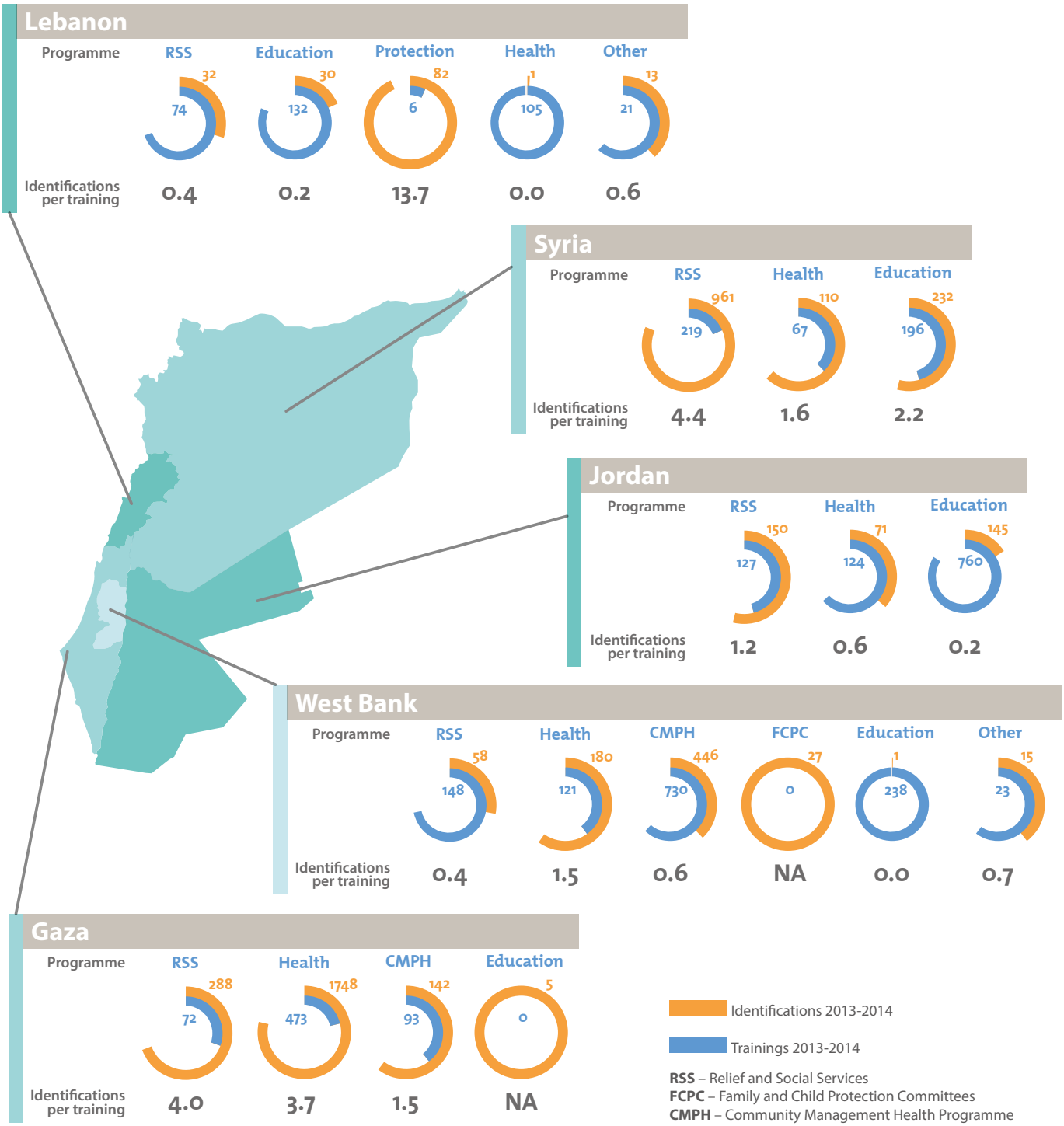


Gaza © Guillaume Petermann 2013

51 For LFO, the questionnaire was administered for Education and RSS departments in June 2014.

Trainings by Field of Operation

Trainings have been one of the main ways in which UNRWA has sought to embed addressing GBV in the roles and responsibilities of all frontline staff. This graphic explores the correlation between trainings and the identification of survivors for each Programme in UNRWA fields of operations. Understanding this correlation between trainings and identification highlights gaps in training provision as well as helps reflect on the possibility of other factors which play a role in the identification of survivors aside from technical know-how. The period covered in this graphic is 2013-2014.



2. TRENDS IN GBV IN UNRWA FIELDS OF OPERATION

Understanding and analyzing GBV trends are essential for adapting interventions and services to better meet the needs of survivors. Based on the analysis of data collected over 2013 and 2014, UNRWA has been able to identify gaps in services and capacity-building, particularly in relation to enhancing capacities to respond to sexual violence and child sexual abuse (CSA).

Damascus Training Centre, Damascus. ©UNRWA/Taghrid Mohammad 2015.

Core Types of GBV [52]

Rape

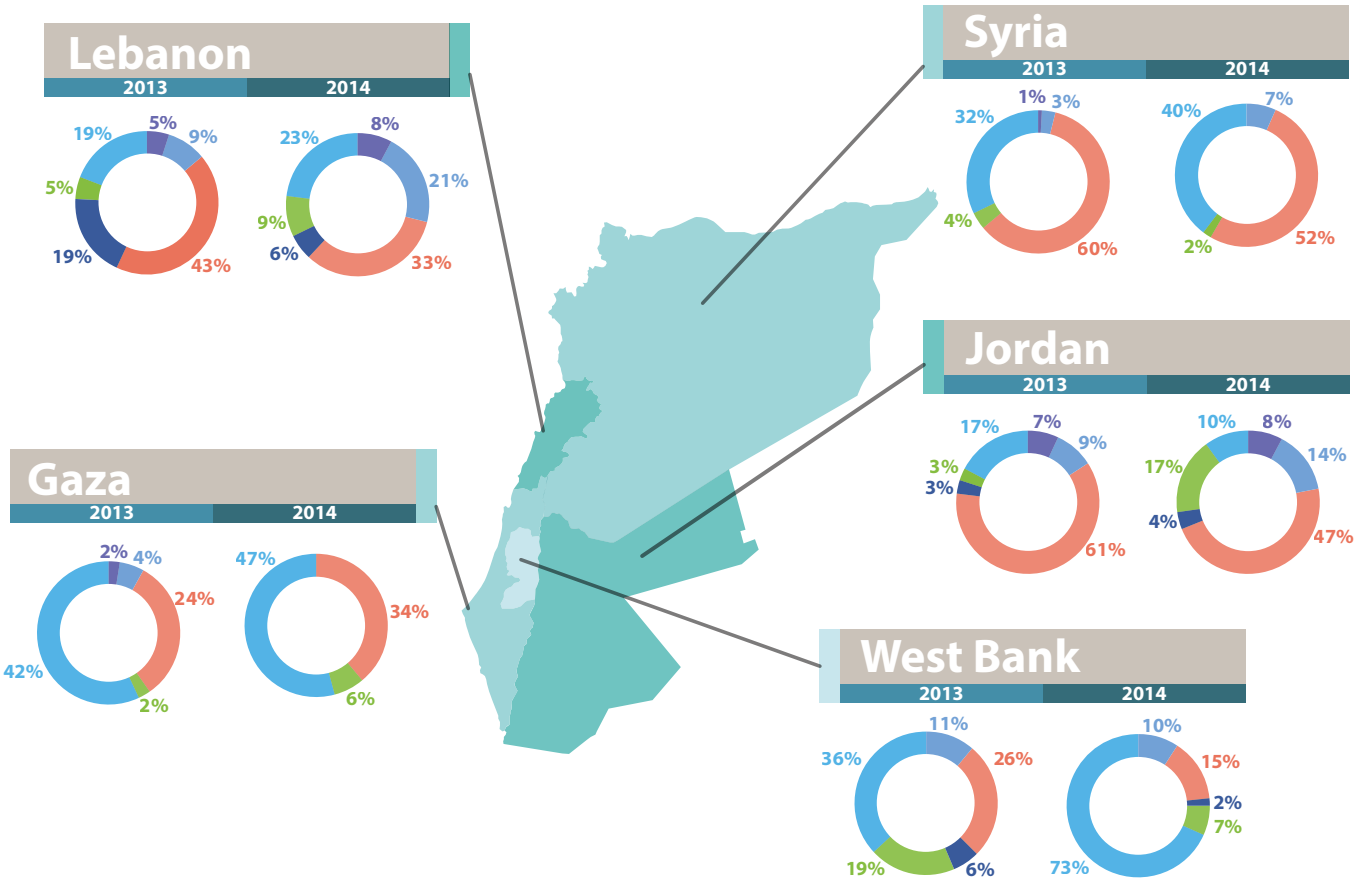
Sexual Assault

Physical Assault

Forced Marriage

Denial of Resources, Opportunities or Services

Psychological, Emotional Abuse



Rape: non-consensual penetration (however slight) of the vagina, anus or mouth with a penis or other body part. Also includes penetration of the vagina or anus with an object. They should be used only in reference to GBV even though some may be applicable to other forms of violence which are not gender-based.

Sexual Assault: any form of non-consensual sexual contact that does not result in or include penetration. Examples include attempted rape, as well as unwanted kissing, fondling, or touching of genitalia and buttocks. FGM is an act of violence that impacts sexual organs and is classified as sexual assault.

Physical Assault: an act of physical violence that is not sexual in nature. Examples include hitting, slapping, choking, cutting, shoving, burning, shooting or use of any weapons, acid attacks or any other act that results in pain, discomfort or injury. This incident type does not include FGM/C.

Denial of rightful access to economic resources/assets or livelihood opportunities, education, health or other social services. Examples include a widow prevented from receiving an inheritance, earnings forcibly taken by an intimate partner or family member, a woman prevented from using contraceptives, a girl prevented from attending school, etc.

Psychological / Emotional Abuse: infliction of mental or emotional pain or injury. Examples include threats of physical or sexual violence, intimidation, humiliation, forced isolation, stalking, verbal harassment, unwanted attention, remarks, gestures or written words of a sexual and/or menacing nature.

Forced Marriage: the marriage of an individual against her or his will. Child Marriage is included in this category by analysis of the age of the survivor at the time of the incident of forced marriage.

52 This classification was developed by the GBV Information Management System (GBV IMS), as part of a project initiated in 2006 by OCHA, UNHCR, and the IRC. For further information see: http://www.gbvims.com.

a. Data by Field of Operation

i. Gaza

The type of GBV most commonly identified by UNRWA staff in GFO is psychological and emotional abuse, followed by physical abuse. Noteworthy are the low levels of reported incidents of sexual violence in 2013, with sexual abuse at 4 per cent and rape 2 per cent, and the fact that no sexual abuse or rape survivors were reported in 2014. This prompted UNRWA to initiate discussions around the challenges of identification of sexual violence. In 2014, Gaza field reported that 96 per cent of their caseload are survivors of domestic violence and out of the total caseload, the perpetrator was the spouse in 65 per cent of the cases identified while violence perpetrated by the father accounted for 10 per cent. In 93 per cent of all cases reported survivors were women and girls, whereas 7 per cent of survivors were children.

ii. Jordan

In Jordan, physical abuse is the most identified type of violence in the past two years. There has been an increase in the identification of sexual abuse from 9 per cent in 2013 to 14 per cent in 2014. A change in the way of recording the type of violence in Jordan field as per GBV IMS guidelines, where only the primary type of violence is recorded, has significantly affected the data reporting. In the first report for 2014, Jordan had recorded psychological violence as the most reported type of violence at 51 per cent, whereas after the change in the way the data is collected, psychological abuse accounted for 10 per cent of the cases. This indicates that along with psychological abuse, survivors were subjected to much more severe types of violence.

In Jordan, 85 per cent of the cases identified were domestic violence survivors. Perpetrators were husbands in 36 per cent of the cases, fathers in 27 per cent, and 8 per cent were other family members.

The majority of the survivors identified were women and girls at 82 per cent. Of the remaining 18 per cent who were male survivors, 96 per cent were boys. Out of the entire caseload, 52 percent were child survivors involving both girls and boys.

iii. Lebanon

Even though physical abuse continues to be the most reported type of violence in Lebanon, the year 2014 has seen a significant increase in the identification of sexual assault cases reaching 21 per cent compared to 9 per cent in 2013. Reported cases of rape also increased in the same period from 5 per cent in 2013 to 9 per cent in 2014. In 2014, PRS accounted for 38.8 per cent of all reported incidents of GBV. According to UNRWA reports in Lebanon field, 62 per cent of all sexual assault survivors and 65 per cent of all rape survivors were children.

In 2014, 80 per cent of the caseload were survivors of domestic violence. The perpetrators for 46 per cent of the survivors were the spouses and for 22 per cent the parents. The majority of survivors identified in 2014 were women and girls at 88 per cent while 33 per cent were child survivors.

iv. Syria

Domestic violence accounted for 72 per cent of the caseload reported by Syria Field in 2014. Further, UNRWA has noted an increase in reporting incidents of sexual assault from 3 per cent in 2013 to 7 per cent in 2014. This could be related to increased staff capacity in identifying sexual violence, as well as other factors related to the crisis. The link between displacement and increased vulnerability to sexual violence, including both sexual assault and rape, is an issue that UNRWA has been following up on in recent years. It is noteworthy that with the establishment of the referral system, and the outbreak of the Syria crisis. Reports from Jordan, Lebanon and Syria field offices showed increased identification of sexual violence and a growing capacity to identify it.

Within the 72 per cent of domestic violence accounted for in 2014, 65 per cent were perpetrated by the spouses, while 35 per cent were perpetrated by a parent or a sibling. The majority of survivors were women and girls at 87 per cent while child survivors represented 25 per cent.

v. West Bank

The majority of cases identified in 2014 reported psychological abuse reaching a rate of 73 per cent, followed by physical abuse at 15 per cent. Noteworthy are the difficulties in identifying rape survivors, as no survivors have been identified in the past two years.

In 2014, 82 per cent of the cases identified were domestic violence survivors, women and girls accounted for 79 per cent of all cases identified, while children represented 14 per cent of all cases.

Effects of GBV [53, 54]

GBV has consequences affecting not only survivors, but also their families, children and society at large. The consequences of violence on survivors may vary widely depending on the nature of the abuse, relationship with the abuser and the context in which it took place. GBV typically has physical, psychological, and social effects. For the survivors, these are all interconnected.

Family & Dependents

- Divorce or broken families;
- Lower economic development for the family;
- Increased likelihood of violence against children;
- Compromised ability of survivor to care for the children.

Society

- Economic burden on the health and judicial systems;
- Increase in the rates of crime, addiction, and prostitution;
- Further entrenches gender inequality, and as a results hinders economic growth through the loss of women's productivity;
- Hinders women's participation in the development processes and lessens their contribution to social and economic development.

Economic and Social

- Medical costs, including treatment expenses, emergency room visits, external consultations, laboratory tests and x-rays, medicine and use of transport;
- Non-medical costs such as legal fees, such as court expenses, legal consultations;
- Negative impact on women's income generating ability, including inability to benefit from opportunities, low productivity, and job loss due to absenteeism;
- Rejections, ostracism, and social stigma at the community level;
- Increased vulnerability to other types of gender-based violence.

Physical

- Injuries (bruises, cuts, burns);
- Functional impairment;
- Permanent disability;
- Sexual and reproductive health problems such as sexually transmitted diseases, unwanted pregnancy, pregnancy complications, miscarriage;
- Death.

Psychological

- Post-traumatic stress disorder (PTSD);
- Depression, anxiety, panic attacks, paranoia;
- Desire to die and thoughts of suicide;
- Abuse of pain killers and sedatives;
- Eating disorders;
- Volatile emotions and feelings;
- Lack of self-confidence;
- Sleep disorders.

Child Survivors

- Poor health;
- Sleeping disorders;
- Exposure to violence in early stages of infancy could impair or alter brain development;
- Shows signs of fear, terror, emotional distress, anxiety, agitation;
- Attribution to self of problems happening in the household;
- Poor peer relationships;
- Poor academic performance, risk of dropping out of school;
- Child marriage imposed by the family based on the belief that it would save the "family's honour"
- Use of aggression to solve problems;
- Delinquent behavior;
- Social withdrawal.

53 UNRWA.Working with Gender-Based Violence Survivors: Reference Training Manual for Frontline Staff. UNRWA, 2011: 43-45
54 UNFPA and Wave. Strengthening Health System Responses to Gender-Based Violence in Eastern Europe and Central Asia: A Resource Package. UNFPA and Wave, 2014. Web. <http://www.healthgenderviolence.

b. Responding to Sexual Violence

While reporting on sexual violence has varied from one field to another, all fields have reported increased awareness among staff on the identification of sexual assault and rape and the need for specialized training to address the specific needs of survivors of sexual violence, including child survivors. Importantly, the increase in reporting for some fields does not necessarily reflect an increase in incidents of sexual violence. It rather shows that training and sensitization of staff on sexual violence has increased the institutional capacity to report and support survivors of sexual violence.

The complexity of addressing sexual violence is compounded in the case of children. This has particularly come to light in fields such as Lebanon where the majority of survivors of rape and sexual assault identified by UNRWA were children. Fields have also raised issues of consent prior to referrals and questions regarding mandatory reporting in the case of child survivors. It is also important to note that in Syria, Lebanon and Jordan, the identification of sexual violence has increased after the integration of PRS into the referral systems.

In Gaza, where reporting on sexual violence continues to be low, UNRWA is mindful that rather than this being an indication that it is not prevalent in Gaza, it is estimated that most sexual violence and rape occurs within marriage and, as such, might not be recognized as GBV by survivors and staff. Therefore, workshops were organized to increase senior staff nurses and medical officers' understanding of treating sensitive and high-risk cases of GBV, including sexual violence, as well as to clarify their role regarding the process.

As for Jordan, a five-day training was organized in May 2014 for health staff on how to respond to rape and sexual assault as well as referral options.

Further to this, Lebanon field office has introduced coverage of Clinical Management of Rape (CMR) as part of its hospitalization programme in order to ensure survivors' access to life saving medical care. Steps such as these are instrumental in encouraging staff to address rape and refer survivors to receive specialized medical care.

In Syria, reports have seen an increase in sexual violence against boys in the community and in schools. Furthermore, the reports point to the difficulty of preventing sexual violence in overcrowded collective shelters with little or no privacy.

In the West Bank, UNRWA has begun to organize trainings to staff on sexual violence. In addition to this and as part of prevention, UNRWA has been raising awareness among parents, children, adolescents and community members on sexual and reproductive health and rights, as well as the different forms of sexual violence that included risks associated with internet use and online abusers. The latter was identified as a mode of harassment by some FCPC.

3. CHALLENGES TO RESPONDING AND PREVENTING GBV

a. Resistance among Staff to Report and Address GBV

Resistance to address GBV continues to be one of the main challenges in developing response and ensuring referral pathways are utilized by staff and communities. Given the nature of UNRWA as an organization in which most of its staff members belong to the Palestinian refugee communities that they serve, and the crucial role they played in guaranteeing the successful implementation of the GBV referral system, UNRWA strives to work at two levels to tackle resistance: at the staff and community levels. Building the acceptance of both the staff and the community was taken into account from the initial phase of the project, specifically through initiatives of awareness raising of the community and building the capacity of staff. Partnerships established with non-governmental, community-based, and civil society organizations also constitute bridges for mutual support to address GBV and trigger community participation and acceptance for this work.

Gaza provides an excellent example of how awareness-raising was used to promote community acceptance of GBV response and prevention programmes. UNRWA in Gaza largely succeeded in opening up spaces for dialogue on domestic violence prior to the establishment of the GBV referral. Conducted through the "Equality in Action" programme, initial activities included discussion groups for women and girls, families and men and boys, in addition to sensitization workshops for health-care practitioners, including UNRWA staff. The discussion groups contributed significantly to reducing community resistance to the establishment of the GBV referral system. Work continues with communities to raise awareness on GBV and the referral system.

Equality in Action in Gaza

In 2008, UNRWA in Gaza pioneered a large programme addressing gender inequality in the Gaza Strip by promoting Palestinian women's social and economic empowerment, ensuring that women and girls have access to educational and recreational activities outside the home, increasing women's income-generating opportunities and building knowledge of and means to protect women and girls from GBV. The programme was established through a community-based and participatory approach directly responding to the self-stated needs of girls and women.

The implementation process has faced greater difficulties in other fields, due to misunderstandings and misinterpretation of the work to address GBV. In Lebanon and in spite of focus group discussions organized with frontline staff at the different stages of planning and implementation, limited acceptance and even opposition was experienced from some frontline staff, political factions and segments of camp leadership. Though issues were raised on how UNRWA approached the community on these matters, other problems unrelated to the Agency's efforts to address GBV also played a role, such as wider community grievances in relation to UNRWA services. Therefore, UNRWA was forced to freeze the project five months into its implementation in 2011. An internal review of lessons learned, the Agency's approach and how to engage the communities on GBV prevention and response led to a change in the way in which outreach was conducted and enabled UNRWA to reinitiate the programme.

b. Staff Safety, Security and Self-Care

Related to the resistance to address GBV are questions on staff safety and legal considerations as UN staff which will particularly arise when Agency staff, such as health practitioners, are required to provide testimony in connection with allegations of GBV they have reported or witnessed. However, noteworthy is that processes have been established to manage staff safety and security concerns as well as legal considerations, including through conducting proper risk-assessments and mitigation measures as well as the solicitation of limited waivers to allow staff members to testify, where this can be done without prejudice to the interest of UNRWA, including staff safety and security, while preserving their privileges and immunities.

Jordan field has faced this challenge in the past years, specifically due to national mandatory reporting requirements.

Family Protection Law in Jordan:

Article 8 of the Law obliges service providers to report cases of violence: "Providers of health care, social and education services from both public and private sectors shall inform competent authorities once they learn about the incident of domestic violence or see traces or marks they feel associated with domestic violence".[55]

Article 10 of the same law also stipulates that 'Officers in charge shall be under the liability of guaranteeing the protection of the reporter and not disclosing their name or identity unless judicial procedures require otherwise'.[56]

Responding to these concerns, UNRWA in Jordan and the West Bank has provided legal training to familiarise staff with the legal framework, including that applicable to UNRWA as a UN entity, and their rights and obligations in the context in which they work. In Jordan, UNRWA has partnered with ARDD Legal Aid, to which it refers survivors needing police intervention and legal aid. ARDD reports cases to the Family Protection Department and follows up on these referrals.

55 "Family Protection Law No. 6 of Jordan (2008)" Family Protection Law No. 6 of Jordan (2008). The Official Gazette of the Hashemite Kingdom of Jordan. Issue 4892 (2008): 821. Web. 4th Nov. 2015. <http://corpus.learningpartnership.org/family-protection-law-no-6-of-jordan-2008>

56 Ibid.

c. Protecting Child Survivors

With the support of UNICEF, UNRWA is working on developing a Child Protection Framework that will seek to delineate the Agency's longer term vision and organizational commitment to child protection and provide clarity as to what is its role and function with regards to child protection. While child protection issues have been a longstanding concern of UNRWA, the introduction of the GBV referral systems has resulted in heightened attention to specific child protection issues, most notably child sexual abuse and child marriage. This is linked to the increased reporting of, and systematic data collection of GBV, including incidents involving child survivors. Consequently, UNRWA staff have also increasingly highlighted the gaps in services for child survivors.

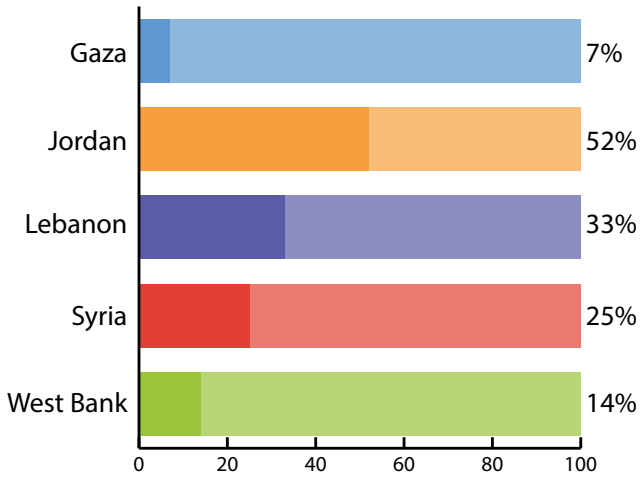
> UNICEF defines 'child protection' as preventing and responding to violence, exploitation and abuse against children.

UNRWA staff have at times encountered major challenges in ensuring timely response to high-risk child protection cases, including child sexual abuse, sometimes with parents and caregivers unwilling to accept referral to medical and other critical services. These challenges are exacerbated in cases where it is suspected that the perpetrator is a family member or when the case is perceived to involve high profile individuals in the community. Furthermore, UNRWA continues to operate in environments, where specialized child protection services are lacking. In Lebanon for example, the identification of high-risk child protection cases, including those that relate to sexual abuse of children, have highlighted major gaps in national child protection services. The few numbers of social workers mandated by the Ministry of Justice to obtain protective orders for urgent and high-risk child protection cases causes delays in the referral process. In many instances the access of these social workers to some Palestine refugee camps due to safety and security concerns pose further difficulties in responding to child protection cases. Furthermore, the availability of specialized institutions for alternative care particularly for Palestine refugee children in Lebanon, remains substantially insufficient.

The issue of obtaining informed consent/assent is particularly complicated when dealing with child survivors. UNRWA staff remain reluctant to refer child survivors to child protection or other services without parental consent. When informed consent from parents or other guardians cannot be obtained, UNRWA lacks the capacity to adequately work with children to obtain such informed consent/assent from them, since the Agency does not have specialized child protection capacities.

While the issue of consent with minors is a common challenge in addressing GBV among child survivors, UNRWA has been trying to integrate learning from others in this area, specifically UNICEF, on the best approach to obtaining consent in the case of child survivors mindful of the potential tension between the principle of do no harm and reporting requirements.

Percentage of child survivors identified out of total case (2014):



learning from others:

UNICEF has developed a framework for obtaining the consent of children, depending on their age, which is a valuable tool for case management with child survivors.

AGE GROUP	CHILD	CARE GIVER	IF NO GAREGIVER or NOT IN CHILD's BEST INTEREST	MEANS
0 - 5	-	Informed consent	Other trusted adult's or caseworker's informed consent	Written consent
6 -11	Informed assent	Informed consent	Other trusted adult's or caseworker's informed consent	Oral assent, Written consent
12 -14	Informed assent	Informed consent	Other trusted adult's or child's informed assent. Sufficient level of maturity (of child) can take due weight	Written assent, Written consent
15 - 17	Informed consent	Obtain informed consent with child's permission	Child's informed consent & sufficient level of maturity takes due weight	Written consent

Promising Practices on Child Protection in UNRWA

- **Lebanon: Training for UNRWA counsellors in the education programme on caring for child survivors**
  UNRWA initiated the Caring for Child Survivors Training in partnership with Abaad Resource Centre for Gender Equality to build the capacity of counsellors in the Department of Education to identify and respond to child sexual abuse through prevention, primary support and referral. The training has been rolled out to all counsellors as well as PRS psychosocial counsellors. Based on this training, and supported by a child protection expert, UNRWA in Lebanon has developed a reference manual titled "Responding to Child Sexual Abuse: a guidance to counsellors in UNRWA education setting in Lebanon". The manual provides basic guidance for counsellors who may encounter children who have experienced or are at increased risk of sexual abuse. The manual draws on the Caring for Child Survivors' Guidelines for Health and Psychosocial Service Providers in Humanitarian Settings developed by IRC and accompanies existing reference documents in UNRWA's education programme. It is also adapted to UNRWA's non-specialized psychosocial support and counselling in education.

- **The West Bank: Peer Groups and child information points**
  Through peer groups, refugee youths serve as advocates and educators to their peers on child rights, gender equality, GBV, discrimination and other family and child protection issues. The West Bank FCPP also manages ten child information points and a mobile library that provides resources, educational games and material for children, adolescents and their parents on gender discrimination, sexual and reproductive health and rights, GBV, abuse and child marriage.

  In addition, through its child to child methodology, children and youth conduct advocacy conferences to express their hopes and dreams for the future. Out of one of the advocacy conferences came a letter to the Chief of Education in the West Bank asking for education on sexual and reproductive health and rights, including abuse and ways of protecting children and youth. As such, the Chief of Education and the FCPP have developed sexual and reproductive health and rights modules to be integrated into the curriculum, which will be piloted in three camps. Teachers and parents will be trained on these modules.

d. Information Management and Establishing Data Management Systems

UNRWA has developed GBV databases and tracking systems for the purpose of tracking services accessed by survivors and ensuring follow-up. Furthermore, the databases are aimed at ensuring the safety of survivors and the confidentiality of data as well as eliminating the risk of double reporting and harmonizing data collection in all fields of operation. The establishment of databases and tracking systems faced different challenges depending on the context of each field.

Recommendations from the GBV Database Evaluation Report:

There is a need for systemizing forms, the data collected and the classification used by the fields for types of violence, perpetrators and other classifications.

The lack of computers in all areas where UNRWA frontline staff are involved in identification, referral and service provision, as well as poor internet connection due to frequent power outages pose significant infrastructural challenges to the establishment and consistent use of functioning and viable computerised information management systems for UNRWA.

The different models implemented in each of the five fields as well as different programmes leading the implementation of the GBV referral systems, has resulted in different tracking systems being developed in each field with varying degrees of complexity. This has also caused discrepancy in the forms used and the data collected and generated through these systems. UNRWA continues to work on overcoming these challenges based on the recommendation of an evaluation of GBV databases across the fields which was carried out in 2013.

Homs. ©Taghrid Mohammad 2015.

unrwa experience in gbv programming: lessons from the first five years

Chapter III:
GBV Prevention towards Systematization

Chapter iii:
gbv prevention towards systematization

1. UNRWA's EXPERIENCE IN PREVENTION

The work done by UNRWA in the last few years on building referral systems and creating an enabling environment to address GBV has required an increased focus on prevention and community outreach. As seen in the challenges section, the community outreach approach has played a crucial role in ensuring staff and community acceptance of the GBV programmes and the engagement of different community and institutional stakeholders in these processes. UNRWA has developed context-specific prevention initiatives in all five fields of operation, building on local partnerships and working with community structures. These initiatives have focused on developing effective approaches to tackle root causes of GBV, addressing power imbalances and gender inequality and engaging communities in the effort to combat GBV. Progress has also been made in involving men and boys in awareness-raising activities and key services, such as involving men in preconception care and family planning counselling in health centres.

As part of the global 16 Days Campaign against GBV, a broad range of initiatives are organized each year by UNRWA and partners. Each field is increasingly engaged in marking the campaign each year, sponsoring advocacy and outreach events related to it in order to mobilize community support to combat GBV. The activities include thematic events, such as lectures, workshops, discussion groups, and large events, such as theatrical performances, puppet shows, exhibitions, involvement in public campaigns, etc.

Change towards GBV: A Man's View

"When I was first invited to attend a session on GBV awareness raising I wondered why I was there. Things changed when I became part of the dialogue. Session after session I heard many real stories, which made me think about my behaviour. I also learned about CEDAW and I asked my son to search the internet about it. I wanted to show my wife that I am a good husband who understands this agreement. During a session I talked to the trainer about CEDAW, she was really happy with me and asked the audience to clap for me. At that moment, I really wished I could have completed my university studies because I felt different from inside."

A man attending awareness raising sessions in Gaza

a. Gaza

In Gaza, UNRWA has a long experience in implementing discussion groups for families and individuals, aimed at educating Palestine refugee women and men about GBV and domestic violence specifically and equipping them with the skills needed to address GBV experienced within their homes and communities. Community awareness-raising on gender issues is a priority for Gaza, typically taking place through both the Equality in Action Programme and the CMHP, which have been implementing a domestic violence awareness programme since 2008. The awareness-raising sessions also proved useful in creating spaces where people could openly discuss the stress, grief and anger they had suffered during the most recent summer hostilities in 2014. Based on the results of questionnaires handed out at awareness-raising sessions, there has been significant progress in changing perceptions around GBV, as well as in raising refugees' awareness on available services for survivors.

In Gaza, awareness-raising discussion groups carried out in partnership with implementing partners which are commonly local NGOs target youth, such as university students and recent graduates in addition to other community members. The aim of the discussion groups is to build the capacity of youth to implement awareness-raising as well as to become agents of change within their communities. As part of this, 30 recent graduates with backgrounds in psychology and legal studies participated in the preparation and implementation of the Agency's activities within the 16 days campaign against GBV in 2014.

b. Jordan

In Jordan, UNRWA implements awareness-raising initiatives aimed at women, men, girls and boys from camp communities, in cooperation with WPCs, United Nations agencies and institutional actors and covering a multitude of topics related to GBV and its roots.

An important experience in Jordan is the involvement of community religious leaders in prevention activities. The community religious leaders are firstly involved in building knowledge on themes related to GBV. In coordination with the trainers and the GBV focal points, the community religious leaders become actively engaged in awareness-raising activities, such

as discussion groups held with women and men in their own communities. These initiatives have proven effective in changing the misperceptions and gender stereotypes that feed gender discrimination and GBV, both at the individual and community levels.

Another interesting initiative concerns the involvement of student parliaments from UNRWA schools in capacity-building activities on GBV. These sessions aim at raising awareness on GBV among student parliament members (grades 6-10) who then pass on the information to the rest of their classmates within their various activities.

c. Lebanon

In Lebanon, UNRWA established community-based support groups for PRS and Palestine refugees from Lebanon as a forum to represent women's interests and to help identify and protect those most vulnerable to GBV. Additionally, UNRWA initiated discussion groups with women and men to explore coping mechanisms available for both of them in situations where trauma, stress and isolation translate into strained family relations, consequently increasing the likelihood of gender-based and other forms of violence, including violence between PRS and the host community.

Another valuable initiative that brought together displaced PRS and Palestine Refugees in Lebanon was carried out by UNRWA in partnership with Abaad Resource Centre for Gender Equality in 2014. Sixteen young girls and boys between the ages of 15 and 18 participated in a gender awareness programme in Burj Shemali Camp in South Lebanon. The young participants were introduced to different concepts and issues relating to gender roles, gender inequality and GBV through discussion and group work. The workshop provided a space for youth to come together to discuss an issue that affects individuals, families and communities, and is also one of the hidden impacts of the Syrian crisis. Assisted by a professional photographer, the youth made their own pinhole cameras and were trained on how to take photographs using a camera made out of a paper box. Equipped with new knowledge and ideas, the youth set out in their communities to document, through photography, how they perceive gender relations, gender inequalities and gender differences in their communities. The resulting series of photographs, which is a collection of images from Burj Shemali Camp, were reworked with captions that tell three fictional stories narrated by the youth themselves.[57] The stories describe the lives of three different individuals, both male and female, experiencing gender inequality and GBV in different ways.

d. Syria

In Syria, UNRWA has continued to raise awareness for, and address GBV despite the difficulties posed by the deteriorating security situation, accompanied by capacity-building in an attempt to address such difficulties. Women and men attend trainings and awareness-raising initiatives on psychosocial support activities, human rights sensitisation, as well as recreational activities by social workers working with the CBO and in the collective shelters. A crucial role in the prevention of GBV is played by the community committees and volunteers, who are actively engaged in trainings, awareness-raising activities and discussion groups on gender and GBV.

UNRWA in Syria has also established working relations with local Palestinian NGOs in the community, which is another important aspect in promoting GBV prevention activities. Special attention is also devoted to youth involvement through art activities, as a means to express themselves and create spaces to discuss gender norms which lead to GBV and discrimination against women. An important initiative called 'Women's Image in Art' was launched early 2014 which brought together twenty one refugees, both males and females, who have been displaced and are living in collective shelters aged between 15 and 35 to use their talents in painting and photography to reflect on GBV. This initiative culminated in an exhibition which opened for the occasion of the International Day for the Elimination of Violence against Women.

e. West Bank

Through the FCPP, UNRWA in the West Bank works to eradicate the root causes of violence and abuse through social transformation, which is at the core of the programme's prevention strategy with three main areas of programming that consist of (i) community based initiatives to prevent and mitigate GBV risks among children and their families; (ii) promoting good parenting and family management as well as positive and non-violent communication as a means

57 Shadows of Alleys: at the beginning we were happy. ABAAD and UNRWA, 2014.

to prevent and mitigate home and family violence; (iii) children and youth engagement and empowerment in GBV prevention. As part of the FCPP, FCPC have been established in 21 locations with the mandate of identifying risk factors and implementing coordinated services and awareness- raising activities for the prevention and protection of families and children. The committee members are trained on GBV, and develop quarterly action plans which serve as coordination tools for CBOs, UNRWA and other camp representatives.

The Programme works through support groups to promote prevention of GBV at the community level. UNRWA in the West Bank has so far established 18 mother-to-mother groups (consisting of 244 women), 22 peer groups (169 boys and 188 girls) and 15 support groups for UNRWA sanitation workers (162 males and 15 females). Through support groups, UNRWA psychosocial counsellors provide group counselling and education sessions on life skills, communication, teamwork, advocacy, gender, GBV, child marriage and other family and child protection issues of relevance to the group. Groups have reported improved relationships and communication within their families as well as feelings of confidence and worthiness. Members of the support groups are now advocates and leaders in their communities, and they conduct GBV awareness-raising and education sessions in their camps.

An innovative part of the programme focuses on engaging children and youth as advocates for child and human rights and against GBV. Using the child-to-child approach, the programme implements peer groups and summer camps as well as managing ten Child Information Points and a mobile library that provide space and materials for children, adolescents, and their parents to engage in discussions on gender discrimination, gender equality, sexual and reproductive health and rights, sexual abuse and GBV and child marriage. The child information centres work in close coordination with CBOs, community volunteers and health centres.

West Bank © Guillaume Petermann 2013

2. LEARNING FROM OTHERS

In view of building capacity and systematizing its prevention work, UNRWA continues to be interested in other organizations leading experiences. Various organizations were invited to learning workshops organized by UNRWA to present and discuss their interventions, their impact and to share lessons learned. Working on change and behavioural change, focusing on men and the accepted norms of manhood and developing research to inform campaigns aiming to target behavioural change as well as policy-making, emerge as key learning points from partners' and others' experiences.

a. Critical Research to Inform Policy Making on the Roots of GBV

El Karama is a regional network advocating for the elimination of GBV. It works from the ground up, emphasising local expertise to inform national policies, regional dialogues, and international advocacy. The network seeks to address the structural causes of GBV, considering the root of GBV as discrimination against women in six sectors: education, legislation, economy, culture, media and health.

In Jordan, El Karama worked with partners to identify patterns of violence at work, school and in the Jordanian society in general, bringing evidence from the studied sector and sharing it with policy makers and legislators. "Breaking the Circles of Silence: Violence against Women" for instance, is a case study which has been developed by the Arab Women Organization within El Karama network. The study aimed at:

- Bringing to light the discrimination experienced by women in Jordan despite ratified conventions;
- Assessing the social acceptance of VAW and identifying trends in VAW evolution;
- Providing recommendations to end VAW.

The report urges decision makers, opinion leaders and civil society to work together for "zero social tolerance" for VAW. It highlights the need to bridge gaps between national legislation and international conventions, between existing legislation on women's rights and its implementation, and between the general civil legislation and the Personal Status Law. The study concludes that important and urgent steps need to be taken. The main recommendations focus on changing legislation, raising awareness, involving more women in politics and supporting women's NGOs.

b. Conversations with Young Men and their Communities on Manhood

Programme H is a program designed to promote gender equitable norms with young men. In 2011, it was named as a good practice in the prevention of VAW by former UN Women Executive Director.

Programme H is a methodology developed to start conversations with young men and their communities on norms related to manhood. It focuses on group educational activities like dramatizations, games and debates that stimulate individual and collective reflection about how men and women are socialized. Among the themes addressed are sexual and reproductive health, mental health and GBV. These activities are often accompanied by youth-driven community campaigns and are assessed using an innovative evaluation tool called the Gender-Equitable Men (GEM) Scale. The centerpiece of the Programme H approach is same-sex group discussions, generally with male facilitators who serve as role models. The discussions focus on creating a safe space to allow young men to question traditional views about manhood and to reflect on injustices and rigidities related to gender.

The programme has been tested, implemented and adapted to local cultures in over 25 countries and results have shown that young men who participate in Programme H have shown more positive attitudes towards participating in domestic work, decreased rates of VAW and better relationships with friends and partners.[58]

ABAAD, in partnership with Promundo, is now implementing the project in Lebanon, thereby becoming the first organization to implement Programme H in the MENA region. The project will initially focus on youth and the influx of refugees from neighbouring countries. ABAAD will work with school administrators, religious and community leaders to expand the reach and increase the effectiveness of the intervention, building a model that can be replicated throughout the MENA region and elsewhere.[59]

58 For further information see: Promundo. "Programme H." Promundo. Web. 4th Nov. 2015. <http://promundoglobal.org/programs/program-h/>
59 Ford, Nina, Antonella Notari Vischer and Anthony Keedi. "Young men advocate for gender equality in Lebanon." Thomson Reuters Foundation, 2014. Web. 4th Nov. 2015. <http://www.trust.org/item/20141020203954-suvt6/?source=leadCarousel>

c. Behavioural Change Communication Campaign

The Behavioural Change Communication (BCC) Campaign was part of the IRC women's protection and empowerment project, 'Strengthening Protection: Preventing and Responding to Gender-Based Violence in Jordan' that focused on physical violence and psychological abuse. Working with the Family Protection Department and the General Union of Voluntary Societies (GUVS), it aimed to increase awareness of GBV in a way that encouraged a subsequent reduction in abusive behaviour and advocated for the rights of women and girls.[60] Staff from project partner bodies, GUVS and the Family Protection Department, were trained on campaign tools, such as design, message development and communication strategies. The campaign then used broadcasts, TV talk shows, taxi and bus publications and text messages to reach the community.

A study identifying the ramification of GBV is used for informing the campaign. It found that GBV is more likely to happen:

- If the male perpetrator had childhood experiences of GBV or marital conflict;
- If the family experiences male control of wealth and decision-making, poverty, low socio-economic status or unemployment and or associates with peers with similar attitudes towards GBV;
- If women are isolated from the community;
- If the society has norms granting men control over female behaviour, accepts violence as a way to resolve conflicts, has rigid social roles and/or links masculinity to dominance, honour and/or aggression.

Haifa School Collective Shelter, Damascus. ©UNRWA/Taghrid Mohammad 2015.

60 "Behavior Change Communication (BCC) Consultant, Amman." UN Jobs, A Swiss Association. Web. 4th Nov. 2015. <http://unjobs.org/vacancies/1330899580643>

3. BUILDING A COMMON VISION AND APPROACH

Past and current experiences of UNRWA on GBV, along with other experiences adopting similar modalities (see sections on learning from others), highlight that, within a multisectoral framework that is primarily geared towards response, the work on prevention is limited in its conception and challenges exist in ensuring multi-level engagement in both individual and systemic areas of intervention. Additional challenges are faced in defining ways to track changes and thus in measuring the impact of prevention efforts, mainly when the chain of results is not evident.

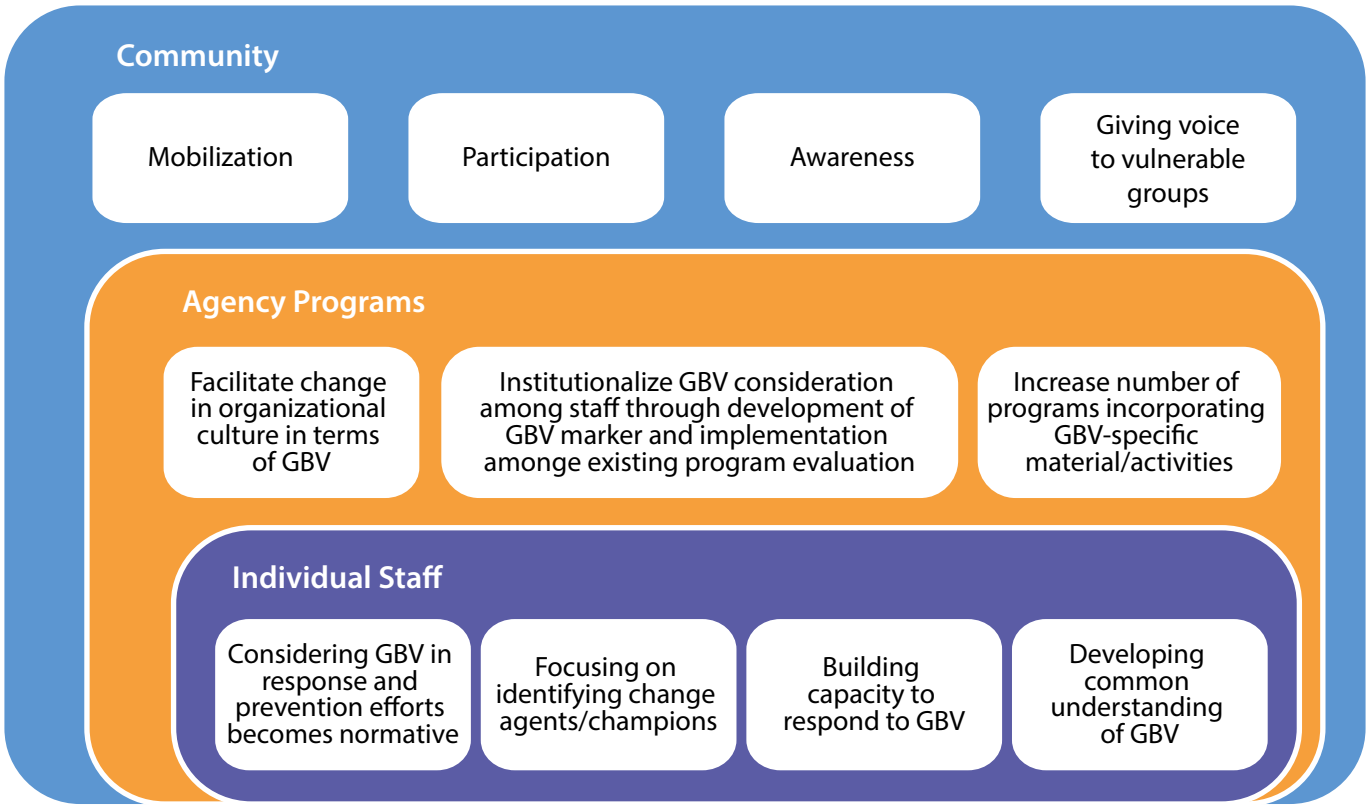
Taking into consideration these challenges, UNRWA has recently initiated a learning path that involves all fields of operation with a view to develop a theory of change on prevention. The process which solicits critical thinking on how to improve current strategies, approaches and interventions in relation to GBV prevention, includes the following objectives:

- Creating a common vision and understanding of GBV prevention and building on commonalities and expertise in the different fields;
- Moving from ad hoc GBV prevention activities that are in many cases awareness-raising initiatives, to a more comprehensive and systematic approach;
- Defining a clear chain of results that will lead to changes;
- Being able to track changes and measure the impact of UNRWA GBV prevention efforts.

As a first step and based on field experiences, UNRWA worked on classifying the changes, sought by the different activities that the fields are promoting, into individual or systemic change, and into informal and formal changes. The discussions were held with teams from all fields and programmes and with a variety of functions including staff involved in direct implementation of intervention, community development and policy making. Beyond the results of establishing a grid with the aims of the interventions, it was the discussions generated by the process that were most interesting and that led to an initial review of the level of changes that UNRWA practitioners were aiming at in the implemented interventions.

In a following stage, UNRWA structured the changes that the prevention activities are aiming to meet into 3 levels ranging from the individual to the community.

Damascus Training Centre, Damascus. ©Taghrid Mohammad 2014.



Building on this process and on the lessons learned from working and exchanging experiences with others, the Agency's theory of change will provide a foundation for building a renewed approach to GBV prevention, based on shared standards. This learning exercise is being undertaken at a critical time for GBV programming, while the Agency is in the process of widening its prevention programme through increasing efforts on preventing and mitigating GBV risks in emergencies.

Addressing the root causes leading to gender discrimination and GBV will continue to be a primary concern at the core of the GBV prevention programming, mindful that (i) gender realities in the region reflect traditional cultural value sets with regard to gender dynamics within the family and community, division of labour, social and economic power and decision-making and legal protection; (ii) in the context of conflict or humanitarian crisis, the exacerbation of inequities or stereotypes, already present within traditional gender dynamics, results in heightened exposure of vulnerable groups to GBV risks. In this perspective, efforts will need to frame the prevention work in a way that encourages equal engagement of women, men, girls and boys and mechanisms for accountability to the larger community will need to be in place.

Expanding the GBV prevention programming to increase efforts in times of emergencies entails that specific needs and vulnerabilities are taken into account and that resources, including local capacities, are in place to appropriately address them. In line with this, UNRWA is currently looking into the opportunity to strengthen its preparedness capacity to mainstream GBV interventions in emergency settings.

unrwa experience in gbv programming: lessons from the first five years

Lessons Learned and Conclusions

lessons learned and conclusions

1. WHAT DID WE LEARN?

UNRWA worked on addressing GBV through a wide range of interventions in the last five years (2009-2014). Throughout the process of building the referral systems, the Agency has consistently sought to embed learning to inform future planning. On some of the issues the reflection developed is more advanced while in others the Agency has only recently been able to conduct evidence-based reflection and efforts continue to have a better understanding. In many of these cases the main point for advancing the reflection is about building a measurement system that will allow for the collection of evidence while in others it will need to continue bringing different perspectives together, including other practitioners, policy makers, researchers and others depending on the issues and the best approach to address it in its specific context.

Assumptions	Variables	Lessons learned
The model of referral is significantly linked to the level of GBV identification and reporting	• Different models of referral in each field, most of them known as "best practice"; • Prevalence of GBV; • Protracted and acute emergencies depending on fields of operation; • Legal framework and national referrals; • Organizational capacity.	Two elements from the variables are making a difference: • Raising awareness and demystifying addressing GBV; • Organizational capacity (namely the existence of the psycho-social counselors in Gaza and the West Bank).
A strong programmatic leadership hinders the multi-sectoral approach	• Multisectoral approach to address GBV; • Variety of leadership in addressing GBV from a field to another; • Accountability and rewarding results; • Ownership; • Staff readiness to address GBV.	• A strong programmatic leadership is useful in the early stage of implementation mainly in resistant contexts, with no clear accountability mechanism. • It makes it difficult for a multi-sectoral approach in the long run. • Certain categories of staff have higher readiness to address GBV (example social workers show more readiness than medical care providers in UNRWA and within the Palestinian framework to address GBV).
The number of survivors identified is an indicator of the efficiency and efficacy of the training on addressing GBV	• Number of survivors identified; • Number of staff trained; • Staff readiness to address GBV; • Review of job descriptions; • The existence of guidelines and SOPs; • Clear lines of accountability.	• Basic GBV training is successfully used in raising awareness about GBV, its consequences and the need to address it. • The review of the job descriptions to include GBV in the terms of reference and the development of guidelines, increase the effectiveness. • The existence of accountability lines is being introduced as a promising mechanism for efficiency.

Assumptions	Variables	Lessons learned
Reported data does not always reflect the reality in terms of prevalence, forms of violence and sex and age disaggregation.	• Cultural and social norms; • Survivors resistant to talk about the "most painful"; • Staff reluctance to record certain forms of violence; • Gender stereotypes on what defines manhood and masculinity, womanhood and feminity.	• Psychosocial violence is more easily reported relative to other forms of violence. • Some forms of violence or discrimination are not identified by survivors and staff as GBV or discriminations. • For the survivor, social norms and possible prejudice influence whether an incident is reported or not. Also, sex and age as well as the type of violence experienced affect the level of reporting. It is very difficult to talk and or report sexual abuse and rape or even domestic violence against men.
The increase in reported sexual violence is linked to a surge in its prevalence in the context of the Syria crisis.	• Emergency context (Syria crisis) with displacement; • Existing system to identify and report; • Capacity to identify.	• It is undeniable that the Syria crisis was concomitant to the increase in sexual violence reporting but it is difficult to reveal the significance as it is still difficult to measure. • Both the referral system, as a system to identify, report and give access to services as well as the capacity created to identify sexual violence, are significant elements of contribution to the identification levels.
Raising awareness affected the acceptance of the referral system by the community	• Acceptance of the referral systems; • Community involvement; • Staff confidence and readiness to address GBV.	• Raising awareness and engaging the community played a clear role in the acceptance of the referral. • Tools for community involvement and communications are crucial for all interventions, specifically when it comes to possible "sensitive" interventions.
Addressing GBV might pose specific threats to staff safety and security	• Mandatory reporting; • Community threats; • Resistance to address GBV; • Considering GBV a private issue.	• In cases where staff were required to testify before the court, proper assessments were made involving the different concerned departments in the Agency to assess risks and see whether or not mitigating measures can be taken. • While mandatory reporting often reflects commitment from the state to address GBV, it can often be counter-productive and should be limited to clear cases where safety and security of survivors are threatened and in the case of minors. UNRWA is committed to respecting survivors' right to confidentiality and informed consent. As such, when mandatory reporting exists in our fields of operation, survivors should be made aware of these rules, the type of information which triggers them and consequences of reporting to allow survivors the opportunity to choose what kind of information to disclose. Services can still be provided based on the information shared and after obtaining survivors' consent.[61]

61 IASC Sub-Working Group on Gender and Humanitarian Action. GBV Response Tool: Establishing GBV Standard Operating Procedures (SOP Guide). ISAC, 2008.

Assumptions	Variables	Lessons learned
Data generated through information management systems provides a clear idea of the reality of GBV	• Standardized definitions and forms; • Reliability of data; • Confidentiality; • Resistance to record information; • Difference between prevalence, identification and reporting.	• A lack of standardization in terms of terminology used, forms, and data collection across fields; • Differences continue to exist between the number of survivors identified and those reported.
Areas for further reflection		
Measuring survivors' satisfaction and quality of services accessed	• Quality of services accessed; • Survivors' personal circumstances; • Difficulty of anonymously assessing the quality of services provided to survivors.	Various tools were used to measure the satisfaction of the survivors with the services accessed or with the case management. They are still providing limited information along with difficulties in initially defining the GBV survivors' satisfaction.
Child protection specifically from sexual violence and abuse	• Difficulties in assessing the "best interest" of the child in the current cultural context; • Limited capacity in services provision; • Lack of capacity within UNRWA	A child protection framework is being developed with the support of UNICEF. Capacity needs to be developed concomitantly with the framework.
Measuring prevention interventions	• Pilot experiences in the fields; • Levels of activities more widespreadly implemented; • No clear chain of changes identified.	• A Theory of change is being developed.

2. CONCLUSIONS

UNRWA has made significant strides in addressing GBV in the last five years. The establishment of referral systems in all five fields of operation, the number of GBV survivors benefiting from internal and external services and the increased capacity of staff to deal with GBV cases are tangible results of the Agency's work on GBV. These results have been accomplished through an inclusive process that relied on multi-disciplinary response, including the engagement of different sectors and a multi-layered approach, involving a combination of interventions at the individual, community and institutional levels.

Given the breadth and the peculiarity of the Agency's areas of operation, this process has succeeded in developing context-specific structures that are viable and durable in providing GBV responses based on local needs. The Agency's commitment to learning has solicited continuous exchange and reflection on the different field experiences, highlighting valuable practices and approaches in each context where the GBV referral systems are in place. This learning process has also brought up relevant aspects and emerging priorities for further consideration that have informed strategic thinking and planning on how to improve the Agency's approach to GBV.

Some of the core aspects are described in the following table providing an overview that shows progress made over the years and the way forward, based on collective inputs.

Key Issues	As raised in 2010	Situation by the end of 2014	The way forward
Standardized understanding of GBV	Need to standardise concepts on GBV for a common language within UNRWA.	A GBV manual based on the IASC GBV Guidelines was developed in 2011 defining types of violence and the role of staff in addressing it . Nonetheless, challenges still exist when it comes to consistent use of GBV incident classification.	More standardization will take place with: • Aligning the classification of GBV to GBVIMS • SOP for addressing GBV in emergencies • TOC is being developed to define the clear chain of changes and results for GBV.
Staff awareness at all levels	Training to target different professions and levels to ensure institutional response for survivors.	7,000 staff have been trained thus far and the Agency continues to be committed to organize training and learning workshops on GBV to increase both staff capacity and willingness to address GBV.	Training and raising awarenss will continue targeting the areas where needs are emerging: • Programmes will continue to use the readiness tool to track staff readiness to address GBV; • Identification of GBV survivors will continue to be disaggregated by programmes.
Confidentiality of survivors	Code of Ethics, along with coding of names discussed as options.	Names of survivors are coded in the GBV databases to ensure confidentiality. Further, when cases are discussed, it is done in small groups usually only involving caseworkers, social workers and/or psychosocial counselors.	Confidentiality will continue to be an issue requiring attention mainly with the emergence of sexual violence. • Discussions with concerned departments and units will continue to ensure a holistic approach and alignement of standards ; • Confidentiality will be part of the agency wide case management framework and database.
Respecting survivors' choices	Information and options provided by professionals but final decision left to the survivor.	UNRWA applies a survivor-centered approach based on providing survivors with information on available services, options for referrals and counseling. Provision of services and referrals are only made after obtaining written consent. However, challenges continue to exist in some fields to ensure that staff's personal attitudes, opinions and judgments do not interfere in the process of counseling survivors.	• UNRWA will continue to build capacity of staff and monitor staff response to GBV; • SOP for GBV in emergencies will take into account the possible interference of staff's attitudes, opinions and judgments; • The pilot practice of involving supervisors in following the practice of case managers in Lebanon will be followed up and built on in case of success.

Key Issues	As raised in 2010	Situation by the end of 2014	The way forward
Complementarity of services	Duplication of services should be avoided, whilst focusing on complementarity in order to broaden survivors' options.	All fields of operations have established partnerships with local organizations to ensure complementarity of services.	• Partnerships continue to be developed and monitored. • Regular meetings with partners will continue to ensure that survivors continue to access quality services that respond to their needs.
Follow-up with survivors	To ensure timely follow-up, focal points from partner organisations provide continuity and a level of confidentiality. Administrative transactions should be kept to a minimum.	Internal referrals are tracked through the intake and assessment forms, while external services are tracked through direct follow-up either with partner organisations, such as through coordination meetings, or through contact and follow-up with survivors themselves.	Follow up will continue and is part of the mechanisms established in the referral systems.
Community participation	Community solutions and sanctions are vital for sensitising communities to GBV, for referral pathways and for protecting survivors in the long-term.	Ensuring community participation has been integrated in each of the field models mainly through community-based awareness-raising activities in all fields on GBV and its consequences on the individual, family, and community. These activities contributed to the creation of a space for dialogue around GBV, bringing together the whole community, not only GBV survivors but also men and boys and community and religious leaders.	Community participation will be the focus of the work in the next 2 years: • An effort will be made on systematising the work with the communities; • Ensuring the participation of the different vulnerable groups; • Measuring the results and the impact of this work.
Institutionalizing the referral system	Sustained commitment, financially and of human resources, is needed. Systems, procedures and protocols may need revision.	Embedding the referral system within UNRWA's core service provision is crucial in sustaining the systems. As such, UNRWA has worked on a two-track approach: embedding GBV identification and referral in protocols, guidelines and staff Terms of Reference (ToR), while also building staff capacity to identify and refer GBV survivors.	Insitutionalising the work on GBV will reach another level in the next 2 years with: • Building institutional capacity to respond and prevent GBV from the onset of any emergency. • It will be done in fashion with the referral systems as a response to GBV.

The Agency's work to tackle GBV has come to a stage where further efforts are needed to consolidate response mechanisms and drive prevention interventions towards a systematized approach. Further, growing concern arises from contexts where acute humanitarian pressure and violent conflict constitute aggravating factors for GBV and particularly violence against women and girls, as the recent crises in Syria and Gaza showed. In these settings, it is important to ensure that GBV risks are identified and risks mitigation is mainstreamed across all sectors of operation and that wider emergency response sustains and facilitates interventions addressing GBV in emergencies. Strengthening preparedness of UNRWA to address GBV in emergencies is thus a key area of focus in the upcoming Agency's GBV programming.

The programme "Building Safety: Strengthening GBV Prevention & Preparedness" has recently started and is expected to last two years. This initiative is an important opportunity to integrate GBV into emergency preparedness and response both at the strategic and operational level in a systematic way. The project involves two main levels of action: (i) Establishing minimum emergency standard operating procedures on prevention and mitigation of GBV, while making sure that these procedures fit into the Agency's vision, for the elaboration of an Agency-wide emergency response framework and address field specific needs; (ii) Increasing the ability to recognize, understand and address GBV, including sexual violence, among key frontline staff operating in emergencies. Adding to these action levels, the programme contains two further objectives focusing on systematizing the Agency's prevention efforts on the basis of common criteria and reliable information and strengthening participation of target communities and beneficiaries in GBV prevention and risk mitigation processes.

Gaza © Guillaume Petermann 2013

UNRWA Work on GBV: The Way Forward

ADDRESSING GBV

RESPONSE

EMERGENCIES

PREVENTION

CURRENT

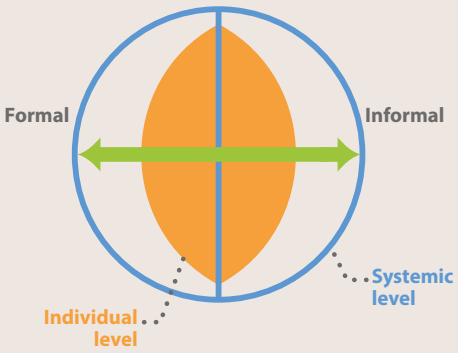
6,972 survivors identified

7,677 services accessed

114 Locations expanded to in Gaza, West Bank, Syria, Lebanon and Jordan

THEORY OF CHANGE

UNRWA has started working on developing a theory of change framework for GBV prevention in 2014 to both consolidate and frame its earlier work on prevention.



FUTURE

Development of common standards for GBV response and prevention, including emergencies

Strengthening the capacity of staff to address GBV, including emergencies

Systemizing GBV mitigation and prevention, including building an evidence-based approach

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