MULTI-COUNTRY REAL TIME EVALUATION OF UNICEF GENDER-BASED VIOLENCE IN EMERGENCIES PROGRAMMES

LEBANON COUNTRY REPORT
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This report for Lebanon is one of seven country evaluations which form part of the Multi-Country Real Time Evaluation of UNICEF Gender-based Violence in Emergencies Programmes global evaluation. The Lebanon country report was prepared by Vine Management Consulting Ltd, an independent company recruited by the Child Protection Section of Programme Division to conduct this evaluation. A five-person internal UNICEF Evaluation Management Group was responsible for the management of this evaluation including inputs to quality assurance.

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The Evaluation Management Group whose responsibilities have included supervising and guiding the evaluation team; reviewing, commenting and approving the evaluation deliverables; approving the final report and supporting dissemination and management response process is comprised of Mendy Marsh, GBViE Specialist, CPS, Krishna Belbase, Senior Evaluation Specialist, Evaluation Office, Jennifer Keane, CP Specialist on Knowledge, Planning and Evidence, and Laili Irani, Senior Adviser, Gender & Evaluation, Gender Section and Sophie Read-Hamilton, GBViE Consultant with the CPS.
CONTENTS

ACKNOWLEDGEMENTS ........................................................................................................... i

CONTENTS ............................................................................................................................... ii

ACRONYMS ............................................................................................................................... iii

EXECUTIVE SUMMARY ......................................................................................................... v

1 INTRODUCTION .................................................................................................................... 1
  1.1 UNICEF’s Approach to GBViE ................................................................. 1
  1.2 Impact of Armed Conflict and Natural Disasters on GBV ....................... 1
  1.3 Background to the GBViE Evaluation .......................................................... 3

2 EVALUATION SCOPE AND METHODOLOGY ................................................................. 3
  2.1 Purpose and Objectives ..................................................................................... 3
  2.2 Evaluation Focus and Scope ............................................................................. 5
  2.3 Methodology ....................................................................................................... 6
  2.4 Evaluation Management ..................................................................................... 7

3 LEBANON MISSION OVERVIEW ....................................................................................... 7
  3.1 Mission Overview ............................................................................................... 7
    3.1.1 Data Collection ............................................................................................ 8
  3.2 Country Overview ................................................................................................ 8
    3.2.1 Country Context .......................................................................................... 8
    3.2.2 GBV Context ............................................................................................... 9
    3.2.3 General and GBV-specific Humanitarian Response .............................. 11
  3.3 UNICEF GBV Programme .................................................................................. 12
    3.3.1 GBViE Specific Programmes .................................................................. 13
    3.3.2 Integrated GBViE Programming ............................................................ 16
    3.3.3 Programme Funding ................................................................................. 18

4 EVALUATION FINDINGS ...................................................................................................... 18
  4.1 Relevance ............................................................................................................. 18
  4.2 Effectiveness ....................................................................................................... 21
  4.3 Sustainability / Connectedness ....................................................................... 25
  4.4 Coordination ....................................................................................................... 27
  4.5 Coverage ............................................................................................................ 29
  4.6 Efficiency ............................................................................................................ 30

5 PROTECTION OF SEXUAL EXPLOITATION AND ABUSE (PSEA) ................................. 32

6 GOOD PRACTICE CASE STUDIES .................................................................................... 32

7 CONCLUSIONS ................................................................................................................... 32
  Annex 1: Evaluation Questions .............................................................................. 37
  Annex 2: Interviews/Workshops participants ..................................................... 38
  Annex 3: Mission Itinerary ..................................................................................... 40
  Annex 4: Bibliography .......................................................................................... 41

ANNEX 5 ................................................................................................................................. 42
<table>
<thead>
<tr>
<th>ACRONYMS</th>
<th></th>
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</thead>
<tbody>
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<td>CSO</td>
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<td>DEVCO</td>
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<td>DV</td>
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<td>MoSA National Plan to Safeguard Children and Women 2014</td>
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<td>UNICEF Programme Cooperation Agreement</td>
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<td>Abbreviation</td>
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<td>Theory of Change</td>
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<td>British Aid Programme (formerly DFID)</td>
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EXECUTIVE SUMMARY

The Child Protection Section of UNICEF’s Programme Division, New York, is undertaking a multi-country real time evaluation (RTE) of UNICEF’s Gender-based Violence in Emergencies (GBViE) programming with the overall purpose of strengthening UNICEF’s current and future GBViE programming based on real time learning. The core of the evaluation is seven RTEs which are being conducted in Pakistan, Lebanon, Jordan, South Sudan, Somalia, Nepal and Central African Republic and a brief study of the GBViE programme the Democratic Republic of Congo conducted by telephone.

This report presents the findings, conclusions and recommendations of the mission conducted in Lebanon, between 16th and 22nd February 2016.

CONTEXT

Lebanon currently has the highest per capita concentration of refugees worldwide. With a population of 4.2 million, the country hosts just over 1 million registered Syrian refugees, 42,000 Palestinian refugees from Syria, 6,000 Iraqi refugees, and nearly 450,000 refugees from Palestine. As the refugee emergency was escalating (2011-2012), the UN took an early lead in highlighting GBV as a serious issue among refugees. Girls and women, particularly among Syrian communities, are vulnerable to forced and early marriage because of the imperative for families to ‘protect’ them from sexual harassment, rape and the social consequences. In addition to early marriage, the most commonly reported types of violence involve physical violence, mostly violence within the family/home and sexual violence (24% of reported cases, of which 8% are rape). Displacement increases the risk of GBV. 87% of incidents reported up to the second quarter of 2015 occurring after arrival in Lebanon. Child mothers, early married girls, unaccompanied girls and adolescents, women and girls with a disability and single heads of households are most at risk. Since 2014, in almost nine out of ten reported GBV cases, survivors have been women and girls, and one in four cases involve children.

CONCLUSIONS

Successes
1. The Child Protection team in the Lebanon Country Office (CO) initiated and achieved a very significant expansion of the UNICEF GBViE programme following the declaration of a level 3 (L3) emergency for the Syria crisis in January 2013.

2. The GBViE specific interventions in Lebanon are relevant to the needs of beneficiaries and are consistent with the UNICEF Strategic Plan, the UNICEF Gender Action Plan (GAP) (despite this not being well known in the CO) and the newly developed corporate Theory of Change for GBViE. They are also consistent with much of the draft GBViE Programme Resource Pack, which sets out UNICEF’s good practice programming for GBViE specific programming.

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1The data quoted in this document refer to reported cases and does not necessarily represent the total incidence of Gender-Based violence (GBV) in Lebanon. These statistical trends are based on data provided by six GBV service providers who use the GBV Information Management System (GBVIMS) across Lebanon and shared exclusively with the informed consent of survivors as per an interagency Information Sharing Protocol. These organizations provided different level of data based on which the above data has been produced. All organizations maintain the same standards and ethical processes for GBVIMS data collection. This information is confidential and must not be shared.

Should you like to use this data or access more information on GBV IMS, please contact the Lebanon inter-agency GBV IMS Coordinator and/or the SGBV Task Force Coordinator

2The order of the conclusions under Gaps/Challenges correspond to the order of the recommendations below.
3. From its inception, the GBViE programme has included service provision, prevention and capacity strengthening of national partners. This comprehensive approach addresses immediate needs of survivors and those at risk, while promoting sustainable approaches to GBV prevention and response.

4. The development of a standard programme for all implementing partners (IPs) to implement in safe spaces as a minimum, together with the policy of expanding the numbers of IPs delivering GBV programming, has ensured that basic GBV programming has been made available to vulnerable women and girls throughout Lebanon, with additional specialist response services being available to communities through referrals to facilities/NGOs offering those services.

5. The twin-track approach adopted throughout the GBViE response of supporting and building capacity of both government and civil society promotes the development of a broad base from which to support on-going expansion of GBV programming, notwithstanding the capacity constraints of the GoL, and the risk that government capacity may not increase significantly over the course of the new country programme.

6. The successful agreement, and current implementation, of the Ministry of Social Affairs (MoSA) National Plan to Safeguard Women and Children represents a major policy achievement; and UNICEF’s influence in its development demonstrates the close and productive relationship which the agency has with the GoL, and how it is using its influence to address GBViE.

7. UNICEF and its partners have developed a number of innovative approaches contributing to overall effectiveness of the programme, including the whole of facility clinical management of rape (CMR) training, engagement with religious leaders as champions and mobile safe spaces.

8. Success factors contributing to the Lebanon Country Office (LCO’s) ability to support quality GBV interventions include:
   - Recruitment of a dedicated, capable GBViE Specialist and National Officer level B who have been in post from the start of the L3 response. These staff positions will be continued into the new Country Programme Document (CPD) as part of a discrete GBV team;
   - Strong support by the Deputy Representative and Chief, Child Protection (CP), despite GBViE not being a UNICEF Middle East North Africa (MENA) regional priority for the Syria crisis response;
   - UNICEF having an established relationship of trust with the GoL, backed by funds available to implement programming;
   - The UNICEF response overall has been very well supported by donors throughout, which has allowed significant resources to be devoted to GBViE. Funds are being channelled through international agencies rather than to the GoL, which has strengthened UNICEF’s influence in shaping the humanitarian response. UNICEF has received by far the largest proportion of GBViE funding of any agency in Lebanon, demonstrating the high level of donor trust in the UNICEF Lebanon CO;
   - Availability in Lebanon of strong international and local non-government organisation partners with experience in GBViE programming;
   - The use of gateways as entry points for convergent multi-sector service provision which has reduced the stigma which would be attached to accessing dedicated GBViE services. The spaces are generally considered safe by women and girls and their male relatives.

9. The planned strengthening of social norms programming within the new CPD is highly appropriate for this stage of the GBViE response.
10. The LCO plans to conduct four evaluations over the next year, one of which will be of the whole CP programme. The findings from this report should inform that evaluation.

11. The LCO is fully aware that levels of funding are likely to be significantly reduced in the next few years. The CP team and the rest of the LCO is clear that the current GBViE programme includes a focus on leaving a significantly stronger system of service provision and real changes in attitudes towards the acceptability of GBV and its incidence in Lebanon among all communities. This goal will underlie the transition to non-crisis GBV programming.

**Gaps/Challenges**

12. The principle shortcoming of the programme is a lack of systematic integration of GBViE activities/approaches across all programme sections with the exception of the CP section. There are examples of cooperation between GBV and other sectors, such as the CMR-related activities under Health and Nutrition; but while the GBV Programme has supported GBV training with other sections (sometimes in response to their requests), there is a lack of ownership among other sections on taking responsibility to integrate GBV risk mitigation routinely across their programmes. Given UNICEF’s position as global lead of four clusters/AoRs in addition to GBViE, and the mitigation of GBV risks which can be achieved where all sectors implement GBViE activities, this represents a significant missed opportunity to meet global humanitarian standards with regard to GBV prevention and risk reduction.

13. Despite economic hardship being a key contributor to child marriage and increased levels of other types of GBViE, the GoL ban on refugees working has meant that economic strengthening needs of women and girls accessing safe spaces are not being met. Although existing socio-economic activities offer opportunities for social support, they do not address the severe economic hardship of many refugee households, a point of concern repeatedly raised by focus group participants. The GBV Unit has been coordinating with the LCO Social Cohesion and Livelihoods sector to strategize about how this area can be tackled, which is imperative to addressing a key contributing factor to GBV among Syrian refugees.3

14. UNICEF Lebanon is using relatively sophisticated information management and programme monitoring systems, including Equitrack and ActivityInfo. However, it remains a challenge to demonstrate programme results (beyond delivery of activities) in terms of levels of enhanced protection of children and women from GBV and changes in their wellbeing through GBViE service delivery. The CP team is aware of this and has sought help from external institutes and UNICEF HQ to develop/adapt tools.

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3 Of potential relevance to addressing the issue of refugee livelihoods, the LCRP includes provision for a livelihoods response with a MoSA-led Livelihoods Strategy, which it might be possible for UNICEF to explore further. The LCRP states: “The livelihood response will deliver, in full accordance with Lebanese labour laws and regulations, rapid-impact job creation initiatives targeting vulnerable groups, MSMEs, small farmers, and invest in the skills of young people and adolescents based on the Making Markets Work for the Poor (M4P) approach. It will also promote national economic and social safety-net reforms, an SME strategy, social protection reforms, and a MoSA-led National Livelihoods Strategy. Under the auspices of this strategy further creative solutions around livelihoods for de facto refugees from Syria will be explored during Phase I of the LCRP, through a consultative approach between with Ministry of Social Affairs, Ministry of Economy and Trade, Ministry of Foreign Affairs, Ministry of Labour, other line ministries, response partners and international experts.” (p23) Which suggests that there will be space for UNICEF to work with the MoSA and other ministries to augment livelihoods opportunities for refugees and poorer Lebanese.
15. UNICEF Lebanon is highly valued as a partner. However, some administrative practices are challenging for Implementing Partners. These include the numbers and frequency of programme changes and demands for additional information, and the emphasis on reaching targets for first-time beneficiaries reached which, several partners consider, do not support quality programming. (These practices are common to UNICEF as a whole and not specific to the GBV programme).

16. UNICEF’s withdrawal from co-chairing the SGBV Task Force has caused real concern to partners, (which the evaluation team shares). There is a perception that this change will negatively impact the sector, given that UNICEF has the largest GBV programme and considerable influence with the GoL.

RECOMMENDATIONS

Recommendation 1: Strengthen integration of GBViE activities/approaches across all UNICEF sectors in line with 2015 IASC GBViE Guidelines recommendations, including in the new CPD.

a. All UNICEF sectors adopt appropriate recommendations for each part of the programme cycle from 2015 IASC GBViE Guidelines, with one indicator per sector to be monitored regularly, and Chiefs of Sections take personal responsibility for ensuring that these are systematically integrated across their programming.4

b. Ensure that all technical sections are briefed and helped to understand the relevant sections of the GBViE Guidelines to help improve understanding across the office that practical achievable solutions to reducing GBV risks are available, and will add value to existing programmes. This could take the form of a support mission from UNICEF HQ for an external expert to visit LCO, provide initial trainings on the revised IASC GBViE Guidelines, and develop a training plan for on-going and sustained integration of GBViE across all sections of the new LCO country programme.

c. As part of this integration, identify and use entry points strengthening GBViE components, eg WASH programme, RACE 2, Youth sections programmes and No Lost Generation for Education sector.

d. Identify a few GBV specific indicators for monthly review during Programme Group Meetings by LCO Senior Staff.

Lead Responsibility: Senior CO staff (Deputy Representative and Chiefs of Sections), sustained support from GBViE Specialist in CPS, PD, HQ; MENARO CP Advisor and LCO GBViE Specialist for introduction of the 2015 GBViE Guidelines5 as required

When: 2016, to ensure each sector takes GBViE into account in the new CPD.

Recommendation 2: Building on current best practice, and in the likely context of greatly reduced funding over the next few years, contextualise established models for transitioning from emergency to post-emergency GBV programming, with the aim of developing high impact programmes which are also taken to scale to address the level of need.

a. Service delivery: Taking the Government of Lebanon (GoL) ban on refugees working into account, consider additional creative ways (including within the MoSA Livelihoods Strategy) to support livelihoods and economic strengthening programmes as key contributors to reducing GBV.

b. Prevention: As planned, expand existing social norms programming, informed by assessments of the specifics relevant for different communities and age groups, to tackle the deep social attitudes underlying the many forms of GBV faced by women and girls.

4 See respective sectors of the 2015 IASC GBViE Guidelines for suggested indicators
5 NB Lebanon has not been selected as a designated CO for rolling out the 2015 GBViE Guidelines under the Implementation Plan. However, UNICEF HQ have indicated that they will support the LCO in this process.
c. Capacity strengthening: Continue to ensure a balance of NGO and GoL capacity strengthening going forward, with a particular emphasis on expanding support to civil society women’s groups who can be empowered to create and lead on social change within Lebanon.

**Lead Responsibility:** GBViE team, Chief CP

**When:** During life of new CPD

**Recommendation 3:** Maintain a distinct GBViE sub-team under the leadership of the GBViE Specialist in order to facilitate UNICEF’s leadership on GBV at the national level, and ensure GBV specialist capacity within UNICEF at the sub-national level.

a. Maintain the position of GBViE Specialist in the new LCO CP structure, who will lead and have oversight over all aspects of the GBViE programme to ensure that the programme retains coherence across all interventions, (including prevention, service delivery, capacity development, social norms programming, justice and legal inputs).

b. Ensure sub-national offices have staff with GBV expertise as part of the transition from the immediate response to longer-term programming.

**Lead responsibility:** Chief, CP

**When:** Implementation of the CPD

**Recommendation 4:** Strengthen evidence base to demonstrate programme effectiveness and collate and disseminate good programme practice regionally and globally.

a. Dedicate capacity within and outside the CP team to document innovative and best practice programmes while the current staff with institutional memory (Deputy Representative, Chief CP and GBViE Specialist) remain in position.

**Lead responsibility:** Chief, CP to designate. Staff members to ensure dedicated time.

**When:** ASAP to capture the institutional memory of current staff

b. Disseminate collated good practice and innovative programmes within the country, regionally and globally so that other COs and partners can benefit. Proactively seek opportunities to share learning and successes from this flagship GBViE programme within MENARO and at HQ, and at workshops and learning events outside UNICEF. Proactively seek opportunities to share experience of this flagship GBViE programme, within Lebanon, regionally and globally.

**Lead responsibility:** CO Representative, CO Deputy Representative, Chief CP, GBViE Specialist.

**When:** Ongoing

c. Once developed and tested, share the new M&E and IM tools being developed for GBV by UNICEF and by the SGBV Task Force across UNICEF and more widely with partners, to address the general challenge of demonstrating effectiveness of GBViE programming in contributing to reduced risk of GBV and increased safety for those most at risk of GBV. As necessary, draw on support from HQ and MENARO, work with local and regional institutes, and build IP capacity on data collection, analysis and reporting as necessary to be able to report on outcome and impact level results.

**Lead responsibility:** GBViE team, CP Chief, SPPME team, MENARO CP Advisor, GBViE Specialist, CPS, HQ

**When:** Once tools are developed and have been tested and proven

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6 This recommendation has been formally endorsed under the new PBR for the new CPD starting 2017 with an enlarged dedicated GBV as a separate unit.

7 With the planned recruitment of additional staff being recruited who will engage with both CP and GBV programmes
Recommendation 5: While continuing to build LNGO capacity to deliver high quality programmes and enhance their management skills, as far as possible within existing UNICEF procedures/systems, take action to reduce unnecessary reporting and administrative demands and activities for partners:

a. Review targets to include existing course participants and also new participants. This will support longer-term relationships between service providers as well as seeking to engage new beneficiaries and expand the reach of programming.

b. Where possible, agree multi-year agreements for GBV services to allow partners the necessary time to establish trust with communities on issues pertaining to GBV, even if budgets can only be confirmed year by year. Provide as much clarity as possible re PCA termination and try and eliminate contract gaps in renewals so that expertise is not lost.

c. Continue with capacity strengthening/mentoring of LNGOs by INGOs as part of a long-term plan for transition to national ownership, reviewing whether the transition time to handover is realistic for local NGOs to be fully competent to deal with survivors, case management and capacity strengthening for other service providers.

Lead responsibility: LCO Deputy Representative (responsible for LCO procedures/systems), Chief CP, GBViE Specialist, SPPME, Reporting and Partnership staff in LCO

When: Immediately and renewal of PCAs

Recommendation 6: Review current coordination arrangements of the SGBV\(^8\) Task Force, to ensure a continued, effective response at national and sub-national levels with current coordination arrangements, and consider whether UNICEF should take up co-chair again if current arrangements are compromising the strength of the programme.

Review nationally and at field level at mid year 2016, to ensure that interagency coordination at national and field levels continues to support effective GBViE response and revisit the decision to relinquish leadership if it is not.

Lead Responsibility: Representative, Deputy Representative

When: Mid 2016

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\(^8\) As UNICEF addresses GBV this is the term used throughout the report with the exception of the Sexual and Gender-based Violence (SGBV) Task Force
1 INTRODUCTION

1.1 UNICEF’s Approach to GBViE

UNICEF defines Gender-based Violence (GBV) as an umbrella term for any harmful act that is perpetrated against a person’s will and that is based on socially ascribed (i.e., gender) differences between males and females. It includes acts that inflict physical, sexual or mental harm or suffering, threats of such acts, coercion, and other deprivations of liberty. These acts can occur in public or in private.9 This definition draws on UNICEF’s core mission to protect the health and well-being of children and women and its mandate to support states and other duty bearers, civil society and communities to prevent all forms of violence against children and women in emergencies, including GBV, and to ensure availability of appropriate systems and services for children and women survivors.

UNICEF is committed to providing comprehensive and coordinated programming across sectors to address the rights and needs of girls and women at risk of GBV holistically, leveraging UNICEF’s leadership and programming across humanitarian response, especially in Child Protection (CP), Education, Health, HIV/AIDS, Nutrition and WASH sectors. In addition to a programme response, UNICEF is global co-lead of the GBV Area of Responsibility (AoR), part of the Global Protection Cluster, with associated responsibilities for coordination and as a provider of last resort.

The Theory of Change (ToC) for UNICEF GBViE programming (see below) has been developed by the evaluation team and the Child Protection Section (CPS) Gender-based Violence in Emergencies (GBViE) Specialist based on the Resource Pack and other UNICEF GBViE guidance and strategies. The ToC was used to inform the evaluation approach and tools and is discussed during country evaluations with CO colleagues. As relevant the ToC will be updated to reflect evaluation findings.

1.2 Impact of Armed Conflict and Natural Disasters on GBV

GBV occurs in all societies in the world. However, conflict situations and disasters typically intensify many forms of GBV with which children and women live, even in times of peace and stability. Tensions at household level can increase intimate partner violence (IPV) and other forms of domestic violence (DV) specifically aimed at females and affecting all children. The pervasive impunity which characterizes conflict settings can exacerbate sexual violence, including its use as a weapon of war. Poverty, displacement and increased dependency resulting from crises may increase the risk for women and girls of being forced or coerced to engage in sex in return for safe passage, food, shelter or other resources.10 Insufficient security in camps and informal settlements increases the risk of sexual and physical assault, as well as trafficking.

The consequences of exposure to violence are as extensive as the scope of violence itself, in terms of the myriad acute and chronic health problems that accompany many types of GBV, and because victimization can increase risk of future ill-health for survivors. In humanitarian settings, where community support systems and formal health and psychosocial services are often severely compromised, the results can be even more profound than in peacetime.

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9 UNICEF programmes to address GBViE generally focus on the rights and needs of women and girls given their high vulnerability to violence rooted in systemic gender-based inequality in all societies and the importance of developing targeted programming to address violence against them. While prioritizing the protection of women and girls within UNICEF’s GBViE programmes, UNICEF’s CP programmes may target specific protection-related rights and needs of boy survivors and those at risk, promoting their access to care and support.

**PROBLEM:** GBV is exacerbated in an emergency environment (women and girls are more vulnerable to GBV in an emergency)

**DRIVERS:** Conflict drives violence against women and girls; social systems break down; existing power imbalances increase vulnerability and lack of information for women and girls; adequate care and support is limited

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**SUPER IMPACT:** Women and girls are able to access their rights and live with equal value and dignity to men

**IMPACT:** Improve the safety and wellbeing of women and girls in emergencies

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### THE LIKELIHOOD OF GBV OCCURRING IS REDUCED

**OUTCOMES**

- **Ongoing response and recovery:** Sector programmes mitigate risk and build resilience to GBV; women and girls are meaningfully engaged in humanitarian programming; violations of IHL are identified and actions taken to address them.
  - **Immediate:** Humanitarian actors recognize the urgency of addressing GBV; GBV risks, vulnerabilities and threats are identified and actions taken to address them; resources and services are available taken to meet women and girls’ specific safety, dignity and protection needs.

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### SURVIVORS BENEFIT FROM APPROPRIATE CARE

**CONCLUSIONS**

- **Ongoing response and recovery:** Women and girls are safely accessing appropriate and coordinated response services; referral systems in place for all GBV survivors; coverage and quality of services strengthened; actions taken to improve access to services.
  - **Immediate:** Life-saving services are put in place (health, psychosocial, safety) and communities are informed about them.

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### CONDITIONS THAT FOSTER GBV ARE TRANSFORMED

**LAY THE FOUNDATION FOR LONG-TERM CHANGE**

- Economic and social empowerment interventions for women and girls
- Programming to shift harmful social norms
- Support legal, land policy reform and build capacity of government to implement and enforce them

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**STRATEGIC INTERVENTIONS**

- **MITIGATE RISKS**
  - Advocate for prioritization of GBV
  - Implement and monitor essential actions outlined in the IASC GBV Guidelines across clusters/sectors

- **BUILD RESILIENCE**
  - Community safety assessments
  - Distribute dignity kits
  - Establish safe spaces
  - Integrate GBV into DRR efforts

- **PROTECT ACCOUNTABILITY**
  - Monitor CRGV
  - Engage and advocate with duty bearers to comply with IHL
  - Advocate for PSEA

- **PROVIDE QUALITY SERVICES TO SURVIVORS**
  - Make health, psychosocial and safety services available
  - Identify and addressing barriers to accessing services
  - Strengthen quality of available services
  - Publicize information about availability and benefits of services
  - Establish/strengthen referral systems, including for victims of PSEA

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**This facilitates strategic interventions in the following areas**

- Leverage resources and supplies (procuring PEP kits, dignity kits, donor support)
- Promote accountability for PSEA
- Develop capacity
- Provide TA across sectors and clusters
- Promote GBV Guidelines and uphold standards across all sectors
- Facilitate knowledge generation and exchange
- Coordinate humanitarian actors at national and sub-national levels
- Advocacy across humanitarian system to ensure prioritization of and action around GBV prevention and response

- Take on responsibilities when government cannot
- Advocate for and monitor compliance with international laws and norms
- Advocacy and technical support for enactment and enforcement of appropriate laws, policies, and protocols
- Leverage connections
- Fund services and programmes
- Develop capacity

- Promote accountability for PSEA
- Fund programmes/partners
- Develop capacity
- Providing TA to enhance programmes quality
- Promote GBV Guidelines and uphold standards across all sectors
- Facilitate knowledge and learning exchange

**UNCOLLECTED TASKS**

- Strengthen HUMANITARIAN ACTION on GBV
- Support STATE and other duty-bearers to uphold responsibilities to address GBV

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**Support CVL SOCIETY to address GBV**
The extent and impact of GBV not only affects survivors, it also limits the ability of entire societies to heal from conflict. Violence may affect child survival and development, raising infant mortality rates, lowering birth weights and affecting school participation. GBV can limit women’s access to reproductive health services including family planning, leading to unwanted pregnancies and unsafe abortions, and increasing women’s risk of HIV infection. At the same time that GBV increases costs to public health and social welfare systems, it decreases women and children’s abilities to participate in social and economic recovery.

While the primary responsibility to ensure people are protected from violence rests with the State, humanitarian actors play an important role in supporting measures to prevent and respond to GBV. According to the *IASC Guidelines for Integrating Gender-based Violence Interventions in Humanitarian Action, 2015*, (‘2015 IASC GBV Guidelines’) “All humanitarian actors must be aware of the risk of GBV and—acting collectively to ensure a comprehensive response—prevent and mitigate these risks as quickly as possible within their areas of operation” (p 14). This responsibility is supported by a framework that encompasses international and national law, UN Security Council Resolutions, Humanitarian Principles and Humanitarian Standards and Guidelines.

### 1.3 Background to the GBViE Evaluation

In the past decade, UNICEF has been at the forefront of efforts to prevent and respond to GBV in emergencies, both globally and at country level. UNICEF HQ is committed to supporting Regional and Country Offices (ROs/COs) to continue to deliver on UNICEF’s mandate to protect children and women from GBV, and ensure the well-being of all children, through consistent and effective GBV prevention and response in emergencies. The Child Protection in Emergencies Team (CPiE), is currently developing a range of resources for COs to use for designing, monitoring and evaluating stand-alone GBV programmes and integrated approach to GBV prevention and response across all sectors of UNICEF’s humanitarian response, in line with the Core Commitment’s for Children (CCCs) and other humanitarian standards. This includes the development of the new UNICEF GBViE Programme Resource Pack (‘Resource Pack’).

To facilitate continuous learning and improvement within UNICEF’s ongoing GBV response in emergency-affected countries and to inform the development of the Resource Pack, the CPiE Team of the CPS, in collaboration with ROs and COs, is undertaking this multi-country evaluation of UNICEF’s GBViE programming.

The evaluation is being conducted between November 2015 and August 2016.

### 2 EVALUATION SCOPE AND METHODOLOGY

#### 2.1 Purpose and Objectives

The overall purpose of the multi-country GBViE evaluation is to strengthen UNICEF’s current and future GBViE programming based on real time learning.

The objectives are to:

1. Assess GBViE programming in UNICEF country programmes using standard criteria for evaluating humanitarian action to generate learning that informs future UNICEF GBViE programming.
3. Develop a real-time GBViE programming evaluation methodology that can be used by UNICEF and other GBViE actors.
Develop recommendations to help UNICEF operationalise its organizational commitments to GBViE at HQ, regional and country levels.

During the country missions, the evaluation team focused primarily on objective 1 (above), but has also addressed objective 2, especially through the short case studies and the longer comparative Intervention Specific component of the evaluation. Objective 3 was addressed through the inception phase when the evaluation tools were developed, and was also a particular focus of the first two missions (to Pakistan and Lebanon), after which some tools were revised. But through each of the country missions the team has been aware of minor revisions which were required in the evaluation tools in the light of the particular context. The final version of the tools is included in the final overall evaluation report as well as in the Resource Pack (see below). Objective 4 has been addressed in the country reports with recommendations developed for the specific countries visited. The recommendations in the final evaluation report focused on agency-wide and some regional level recommendations.

This evaluation assesses UNICEF’s programming response to GBV in seven current emergencies against standard criteria for evaluating humanitarian action, namely: relevance, effectiveness, connectedness/sustainability, coordination, coverage and efficiency. Evaluation questions to be addressed under each of these criteria are included in Annex 1.

For this RTE, guidance on good programming practice from two documents is being used as the benchmarks on which UNICEF GBViE programmes should be modelled, representing current thinking on best practice for GBViE programming for specialised and integrated programming respectively:

(i) The GBViE Programme Resource Pack (the ‘Resource Pack’) currently being developed by the Child Protection Section of Programme Division, (CPS) provides detailed guidance for conducting assessments and designing and implementing specialised GBV programmes relevant to UNICEF’s operations. The Resource Pack (due to be finalized in 2016) includes information and resources for implementing a minimum package of essential services for GBV protection and response in the aftermath of an emergency or population displacement. It also contains guidance for expanded programming to strengthen structures, systems and services and institutionalize prevention, protection and response to GBV during ongoing response and throughout recovery.


11 This component will provide a comparative study across several of the evaluation mission countries, in more depth than the short case studies, of three types of intervention: child marriage, safe spaces and capacity strengthening activities and strategies which will inform the Resource Pack and provide examples of good practice for these GBV interventions.

12 To clarify programming terms being used in the evaluation as well as the nature of GBViE programmes to be evaluated:

‘GBV specific programmes’ are understood to be:
(a) Multi-sectoral response and referral services for survivors focusing on health care; security (including safe spaces) and psychosocial support (including within schools);
(b) Dignity kits (distributed by Child Protection (CP) and Water, Sanitation and Hygiene (WASH) teams or just CP teams), economic strengthening for adolescent girls, community based protection activities;
(c) Prevention programming including work on social norms, economic and social empowerment of women and girls, legal and policy reforms.

‘Integrated’ programming refers to the mainstreaming of GBV prevention and risk mitigation approaches/activities across other sectors.
2.2 Evaluation Focus and Scope

The evaluation includes data gathering at global, regional and country levels.

The core of the evaluation is seven real time evaluations (RTEs) which are being conducted in Pakistan, Lebanon, Jordan, South Sudan, Somalia, Nepal and Central African Republic, with missions lasting one to two weeks each and one brief country assessment conducted remotely for the Democratic Republic of Congo. The primary focus of the evaluation is on learning:

- To promote learning in each of the RTE COs on how existing programmes can be enhanced in the light of good and emergent practice as captured in the 2015 IASC GBV Guidelines and in the Resource Pack; and,
- To promote learning at HQ and ROs through the CO reports and the final evaluation, as well as short case studies of good practice and a detailed comparative review of three GBViE specific interventions across three to four of the mission countries which will inform the development of the GBViE Resource Pack.

To provide an overall picture of UNICEF’s GBViE programming, a mapping exercise will be conducted by electronic survey of 39 UNICEF COs which are reporting against corporate targeted priorities within the Gender Action Plan (GAP).

Implementing Partners

Any evaluation of UNICEF programming means, de facto, an evaluation of the programming of their implementing partners (IPs). The country missions will clarify UNICEF’s role vis à vis their IPs and how these roles may differ in different contexts and in different types of emergencies. This will include clarification of the nature of support UNICEF staff are offering their partners, (national and international); and how UNICEF staff are overseeing partnerships and ensuring programme quality.

GBV Sub-clusters

The evaluation will not include an assessment of the global GBV Area of Responsibility (AoR), or of country level GBV sub-clusters (or other GBV coordination mechanisms) per se, as it is focused on the GBV programming function of UNICEF. It will, however, consider the extent/nature of UNICEF’s programming contribution in realizing sub-cluster strategy/plans for addressing identified gaps/priorities, and will address how the agency has added value to the whole GBV response (including leadership and advocacy activities) within the CO and across the response as a whole.

GBV and Sexual Exploitation and Abuse (SEA)

The evaluation ToR doesn’t specifically include SEA within the scope of this evaluation. However, in the light of the recent report on the UN response to allegations of SEA in CAR, several donor interviewees have indicated that UNICEF, in common with all UN agencies, needs to have clear policies and guidelines in place to implement the UN Secretary-General’s October 2003 bulletin: Special Measures for Protection.

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13 The length of each mission is dependent on the extent of the GBV programme and access to programme areas. The mission in Somalia was longer than the others, being 15 working days.
14 An evaluation of the coordination function was not included in the ToR. Additionally, the UNICEF, via the Cluster Management Unit of UNICEF EMOPS and UNFPA HQ are undertaking a Review of the GBV AoR leadership function.
from Sexual Exploitation and Sexual Abuse.\textsuperscript{16} The evaluation scope therefore includes questions on the existence of protection from SEA (PSEA) policies and action plans, and familiarity with them by CO staff, and whether alleged victims of SEA are referred to for care and support services.\textsuperscript{17,18}

\textbf{Audience}

The primary audience for the overall evaluation findings and collated good practice is the CPS, (who commissioned the evaluation and will use the findings to inform future priorities as well as the GBViE Resource Pack). Findings will also be used by GBV specialists, CP specialists and Gender Advisors in Regional and Country Offices (CO) who are implementing, managing and providing support to GBV programmes. The secondary audience includes other sectors and UNICEF senior management at headquarters (HQ), Regional Offices (RO) and COs.

Given the paucity of evaluations on GBViE programming, it is hoped that the final evaluation report will also be of interest and use to non-UNICEF actors implementing and/or resourcing GBViE programmes.

\textbf{2.3 Methodology}

The evaluation is based on collection and analysis of primary\textsuperscript{19} and secondary data. Data collection includes document review (at global level and for each mission country); key informant interviews (KIIs) with stakeholders at global, regional and country levels; focus group discussions (FGDs) with programme beneficiaries in country; and field observation by the evaluation team. As a learning tool for country office personnel, staff are being asked to assess their programming against good practice checklists based on the 2015 IASC GBV Guidelines and the Resource Pack that were distributed prior to and during the field trips. National consultants are recruited to support the evaluations in each country to ensure that approaches and tools used are culturally sensitive and appropriate, and to support the team with language translation.

The evaluation team are visiting a selection of projects in each mission country to make field observations, interview IP staff and conduct FGDs with different groups of beneficiaries. Criteria have been developed for the selection of projects to be visited, but, in practice, final decisions have been taken by the CO evaluation focal point and CP Chief in advance of the evaluation team mission in light of accessibility, willingness of IPs to host visits and arrange FGDs, those projects with the most learning potential, and safety of beneficiaries, in-country staff and partners and the evaluation team.

\textsuperscript{16} ST/SGB/2003/13, 9 October 2003
\textsuperscript{17} UNICEF and all other protection actors are obliged to mainstream prevention of GBV within all programmes. Along with mainstreaming GBV prevention, UNICEF also delivers targeted programming where possible to address identified risk factors for GBV. All of these efforts will contribute to protection against SEA.
\textsuperscript{18} SEA committed by UN/UNICEF staff or related personnel against any persons of concern is based on abuse of power and—in the case of women and girls, who are the primary victims of SEA—gender inequality and gender discrimination. The SG’s Bulletin requires that all humanitarian personnel ensure action is taken to prevent SEA in their areas of operation, and report it when they observe any risks or abusive behaviour. PSEA should link with GBV programming to ensure survivors’ rights are respected and to improve victim assistance and the development of community-based complaints mechanisms. SEA agency focal points should link with GBV actors to develop referral systems that support survivor-centred care. While CP and GBV staff in UNICEF country programmes should know and promote the key principles and standards of conduct outlined in the Secretary-General’s Bulletin, the accountability for PSEA lies with senior management (Country Representatives) and human resources (Heads of Human Resource Departments). The IASC GBV Guidelines fully support the mandate of the SG’s Bulletin and provide several recommendations within each sector guidance chapter on programming that mitigates SEA, including incorporating PSEA strategies into agency policies and community outreach.
\textsuperscript{19} Including both self-reported data by mission CO staff and data gathered by the evaluation team.
Tools developed by the evaluation team guide country mission preparation and data collection and analysis. These tools were reviewed the Evaluation Management and Reference Groups and were tested and refined during the first two missions. The final versions of the evaluation tools will be included in the Resource Pack to support future GBViE evaluations.

In line with RTE methodology, a workshop is held at the end of each country mission to share and validate the initial findings and reflect, with CO colleagues, about how the findings can be used to enhance GVBiE programming in that setting.

A country mission report, based on the workshop presentation and discussion is drafted by the evaluation team, and reviewed by the COs and the Evaluation Management Group. The findings section of the country mission reports addresses the evaluation questions relating to each of the evaluation criteria. The country reports will inform the final, overall evaluation report.

### 2.4 Evaluation Management

The evaluation has been commissioned by the Child Protection Section of UNICEF Programme Division, who also selected the case study countries and has closely overseen the process throughout.

A five-person UNICEF Evaluation Management Group (EMG) was formed with responsibility for ‘daily management of the evaluation’ including supervision of the evaluation team, review of all products (Inception Report, tools, workplan, country and final reports, coordinate with the Evaluation Reference Group (ERG) and disseminate the final evaluation findings).

The ERG is composed of internal and external experts who provide quality oversight to the evaluation. The ERG includes the following individuals: Mary Ellsberg, Director, Global Women’s Institute at George Washington University; Mazeda Hossain, Social Epidemiologist, London School of Hygiene and Tropical Medicine (LSHTM); Jina Krause-Vilman, Senior Area Practice Lead, Refugees, Gender and Livelihoods, Near East Foundation; Maha Muna, Regional Gender Advisor, UNICEF CEE-CIS; Michael Copland, Regional Child Protection Advisor, UNICEF ESARO; Laurent Chapuis, Regional Child Protection Advisor, UNICEF MENARO; and Kate Alley, Emergency Specialist: Assessment, Planning, Monitoring and Evaluation, Humanitarian Policy Section, UNICEF EMOPS. Responsibilities include reviewing and commenting on the Inception Report, two early country reports and the draft final report, and sharing the final report with partners and networks. ERG responsibilities include reviewing and commenting on the Inception Report, two early country reports and the draft final report, and sharing the final report with partners and networks.

### 3 Lebanon Mission Overview

#### 3.1 Mission Overview

The country mission to Lebanon was conducted between 16th and 22nd February 2016 by all five consultants from the evaluation team supported by two national consultants. The whole team was present in order to test and refine the methodology and tools for use in subsequent country missions. The final workshop was attended by nine UNICEF staff members, including the Representative, the Chiefs of Child Protection, WASH and Field Operations and representatives from CP, Education and Health & Nutrition sections, one national consultant and the evaluation team. The mission was timely given that the LCO is in process of drafting its new Country Programme Document (CPD), 2017-2020.

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20 EMG Terms of Reference
3.1.1 Data Collection
A country document review was compiled by the evaluation team before the mission, to provide background on the Lebanese and CO contexts as well as the emergency response and the current GBViE programme. During the mission additional documentation was received from the country office (CO).\textsuperscript{21}

A total of 52 interviews (77% female, 23% male) were conducted with UNICEF staff and partners in government, UN agencies, INGOs, civil society organisations (CSOs)/Implementing Partners (IPs). Twelve FGDs were conducted in Bekaa, Bakhoun, Akkar and Tripoli with women, adolescent girls and adolescent boys. Self-assessments were received from the CP and Health and Nutrition sections.

Findings from all these sources have been triangulated and inform the findings in this report. Key informant interviewees were assured that their responses would be anonymised.\textsuperscript{22}

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\*Note, a few of the 15-24 youth group participants were under the age of 15

3.2 Country Overview

3.2.1 Country Context
Lebanon is an Upper Middle Income Country (MIC),\textsuperscript{23} ranking 67/189 on the 2015 Human Development Index scale, and consists of four provinces (Bekaa, South, North, Mount Lebanon). However, within and between the different regions, there are significant discrepancies in terms of poverty, levels of violence and education which mean that different communities have different vulnerabilities. Despite high social capital, effective government is compromised because Parliament has been unable, since 2014, to agree on a presidential candidate, leaving a vacuum which has impacted on all areas of life in Lebanon.\textsuperscript{24, 25} The private sector in Lebanon is much stronger than the public sector and many public services are delivered via private sector or NGO channels, creating an unusual ‘hybrid’ state with NGOs mandated to work within public structures.

\textsuperscript{21} See Annex 4 for bibliography
\textsuperscript{22} Hence the references to generic groups of KII informants rather than specific organisations and roles.
\textsuperscript{23} World Bank 2014
\textsuperscript{24} https://lb.boell.org/en/2014/07/04/caught-between-constitution-and-politics-presidential-vacuum-lebanon
\textsuperscript{25} Lebanon is a Parliamentary democratic republic. The constitution stipulates a balance of power among the major religious groups (‘confessions’), with the president, prime minister, and speaker of parliament being Maronite Christian, Sunni Muslim and Shia Muslim, respectively. (\textit{International Religious Freedom Report for 2011 United States Department of State, Bureau of Democracy, Human Rights and Labor})
Lebanon currently has the highest per capita concentration of refugees worldwide. Of a population of 4.2 million, the country hosts just over 1 million registered Syrian refugees, 42,000 Palestinian refugees from Syria, 6,000 Iraqi refugees, and nearly 450,000 refugees from Palestine. More than 600,000 Syrian and Lebanese children live under the poverty line. The influx of refugees since the outbreak of the Syrian civil war in 2011 has strained Lebanon’s economy and infrastructure, with pressure felt in all sectors including education, health, housing, water and electricity supply. Security challenges along border areas, particularly in Akkar and the northern Bekaa Valley, make humanitarian access and delivery of assistance to refugees and vulnerable Lebanese very challenging. The Government of Lebanon (GoL) has a stated intention to reduce the numbers of Syrian refugees in the country in order to enhance security and ease the burden on the people and the economy. In addition to refugees, Lebanese returnees from Syria represent a largely under-assisted and invisible group. In a recent survey, 40% of returnees said they intended to move back to Syria.

There are no formal refugee camps in Lebanon, as a result of the GoL “no camp” policy. An estimated 82% of refugees live among host communities in 1,700 locations across the country. The remaining refugees live in informal collective and tented settlements. Almost 9 out of 10 refugees live in the 251 poorest and most vulnerable localities in Lebanon, which are prioritised in the Lebanese Crisis Response Plan 2015-2016 (LCRP). On January 13, 2015, the GoL announced that all Syrian refugees wishing to enter Lebanon have to justify the purpose of their visit, significantly reducing access to the country.

Since the beginning of the crisis, Syrian refugees have not, officially, been allowed to work in Lebanon. In January 2015 this regulation was tightened, with a GoL requirement for refugees to sign a pledge that they will not seek to work as a condition of renewing residency permits. The combination of high fees, complicated administrative procedures, and unwillingness to commit to not work in light of decreasing savings for many refugee families, has led to an increasing number of undocumented refugees. This, in turn, restricts their ability to access services, and exposes them to abuse and harassment. A recent study found that approximately 90% of Syrian refugees believed that the lack of legal residency negatively impacted on their safety.

3.2.2 GBV Context

There was little recognition of GBV in Lebanon pre-crisis. The legislative framework relating to GBV is not strong. For example, the annulment of article 562 of the criminal code in August 2011, which mitigated sentences for honour crimes, did not deal with discrimination against women in the penal code that

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27 Ibid.
29 UNICEF Lebanon COAR, 2015
30 To address the dearth of school places for refugee children, UNICEF – the largest international actor in the education sector – is paying the GoL USD600 per Syrian child in school. 157,000 Syrian children are enrolled in Lebanese schools this academic year, using a double shift system (Lebanese children in the first shift and Syrian children in the second).
31 Fighting in Arsal in August 2014 was a turning point, crystallizing tensions between Lebanese and Syrian refugees and has led to increased numbers of evictions, police raids, mistreatment of refugees and restrictions on refugee movement.
33 UNHCR Sexual and Gender-based Violence Update, June 2014.
34 These settlements consist mainly of extended families who came from the same areas of Syria.
35 UNICEF is also focused on these same locations. UNICEF Lebanon COAR, 2015.
36 Before the emergency, there were no visa restrictions between Syria and Lebanon.
37 USJ Study on perceptions of Syrian refugees in Lebanon, 2015.
imposes harsher penalties for adultery on women than on men.38 On April 14, 2014, the Parliament passed the country’s first Law on the Protection of Women and Family Members from Domestic Violence (DV). According to Human Rights Watch, while the law covers some protection concerns for women and related policing and court reforms, it leaves women at risk of marital rape and other abuse.29

Service provision for GBV survivors was very limited pre-crisis, with most services concentrated around Beirut.40 Two main civil society organizations41 addressed intimate partner violence (IPV) and other forms of DV as part of a broader focus on women’s equality programming.42

A National Technical Task Force on GBV led by the Ministry of Social Affairs (MoSA) existed pre-crisis but was reputedly not effective,43 although a GBV case management toolkit was developed which UNICEF will support in revising in 2016 to reflect good practice including provision of services for child survivors. In May 2012, The National Ten-Year Strategy for Women’s Affairs in Lebanon (2011-2021) was launched,44 but operationalisation depends on an action plan being developed and funded.

As the emergency was escalating (2011-2012), the UN took an early lead in highlighting GBV as a serious issue among refugees. Girls and women, particularly among Syrian communities, are vulnerable to forced and early marriage because of the imperative for families to ‘protect’ them from sexual harassment, rape, and the social consequences as well as because of economic drivers. A UNICEF survey on early marriage among Syrian refugees and Lebanese communities, conducted in 2015, found that of those surveyed, 11.5% of Lebanese girls and 23% of Syrian girls were married before the age of 18.45,46 In addition to early marriage, the most commonly reported47 types of violence involve physical violence, mostly within the family/home, and sexual violence (24% of reported cases, of which 8% are rape). The data highlights how

38 A married woman who had an extramarital affair could be imprisoned from 3 months to 2 years, whereas punishment for men committing the same crime was 1 month to 1 year. A married man could only be tried for adultery if he engaged in extramarital sex in the conjugal home, or if he had a “stable” extramarital relationship (articles 487, 488, 489). [https://www.hrw.org/news/2011/08/11/lebanon-law-reform-targets-honor-crimes]
40 Notably, the introduction of services in rural and remote areas of Lebanon as part of the emergency response has confirmed that GBV has always been an issue, albeit hidden (KII with UNICEF CP staff).
41 ABAAD (Arabic for ‘dimensions’) Resource Centre for Gender Equality (ABAAD) and KAFA (Arabic for ‘enough’). National civil society experience on GBV is concentrated in these two larger NGOs.
42 KIIs with UNICEF staff and partners.
43 KII with CP team.
44 The strategy was developed by the National Commission for Lebanese Women in cooperation with line ministries, organizations and institutions involved in women empowerment and rights advocacy; and aims to provide a national framework to promote the state of law and equal treatment of women, including increasing women’s participation in political and economic life as well as eliminating all forms of discrimination against women. (Lebanon COAR, 2012)
45 PowerPoint: Early Marriage: Illusion or Reality: Survey on Early Marriage in Lebanon Among Syrian Refugees and Lebanese Population
46 There are differences of opinion among those interviewed about whether early marriage was widespread enough to be considered a cultural practice in Syria before the refugee crisis among some (mainly poorer, rural) communities, leading to a lack of consensus as to whether the escalating rates of early marriage associated with the displacement constitutes a genuine deep social norm for Syrians or is a negative coping mechanism in a situation where social norms have begun to change as result of poverty and other crisis factors. Either way, early marriage was recognised as a significant and growing protection issue among the Syrian refugee populations as the emergency escalated.
47 Based on data collected over the past two year from the Gender-based Violence Information Management System (GBVIMS), FGD conducted as part of GBV programmes, reports and assessments which refers to reported cases and FGD and activities with communities and doesn’t necessarily represent a comprehensive overview of GBV in Lebanon, nor of violence experienced by Syrian refugees. Statistical trends are based on data provided by 8 GBV service providers using the GBVIMS (i.e. incidents reported by those seeking services). Only reported incidents with survivor’s informed consent are included. The total number of cases is likely to be much higher.
displacement increases the risk of GBV, with 87% of incidents reported up to the second quarter of 2015 occurring after arrival in Lebanon. Child mothers, early married girls, unaccompanied girls and adolescents, women and girls with a disability and female single heads of households, especially girls, are most at risk. Since 2014, almost nine out of ten reported survivors have been women and girls, and one in four cases involve (girl) children.\textsuperscript{48}

Overcrowding and lack of privacy in shared living accommodation heightens risks of GBV. FGD participants said that stressed husbands and wives also beat their children. Diminishing savings and scarce economic opportunities coupled with the high costs of accommodation and associated living expenses are associated with negative coping mechanisms including early marriage, child labour and survival sex. As the refugee situation continues, increasing levels of tension between host and refugee populations increases fear of harassment of Syrian girls by Lebanese males.

Some women are taking on more responsibility for household decisions having been displaced... ‘playing the role of men and women at the same time’ - having to deal with household decisions which men would have taken care of in Syria or supporting their families financially (in cases where men are absent or have been disabled). FGD participants are divided on whether this has been positive: while the women find dealing with foreign men ‘embarrassing’, they also feel empowered and are ‘discovering themselves’. However, in one FGD, a story was related about the case of a women (not present) who had been prosperous in Syrian, but the the husband is now disabled and the wife is taking more responsibility. In this case, the husband was over-stressed so he hit her very badly.\textsuperscript{49}

MoSA is the ministry responsible for GBV. While MoSA is hampered by inadequate human and financial resources, the long-standing relationship with UNICEF, a trusted partner, has been an important factor facilitating development and agreement of the MoSA National Plan to Safeguard Children and Women (‘the National Plan’), signed in October 2014.\textsuperscript{50} The National Plan provides an important framework under which GBV programming and protocols\textsuperscript{51} have been established, ensuring that services are available for all vulnerable groups, including refugees. However, the Lebanon Crisis Response Plan (see 3.2.3 below) remains the highest framework for GBV Programming.

### 3.2.3 General and GBV-specific Humanitarian Response

Despite initial reticence to recognise and engage with the emergency response, the GoL Crisis Cell is now the highest national authority for international response partners. The Lebanon Crisis Response Plan (LCRP) outlines the national coordination structures, with MoSA overseeing the Government’s response.\textsuperscript{52} The LCRP steering committee is co-chaired by MoSA and the UN Resident Coordinator/Humanitarian Coordinator (RC/HC), and includes Crisis Cell ministries, donors, and UN, national and international NGO partners. LCRP activities are coordinated by line ministries through Sectoral Steering Committees and

\textsuperscript{48} Draft Strategic Response Plans (SRP) for sectors, 2016.
\textsuperscript{49} FGD with adult women
\textsuperscript{50} The National Plan aims to provide high quality protection services to the most vulnerable young girls, boys, women and their caregivers in Lebanon. It will focus on strengthening existing capacity of MoSA at central and regional levels to provide integrated social services, as well as the capacities of associated civil societies and community based structures. The National Plan will initially cover 57 localities where MoSA social development centres (SDCs) are located. (UNICEF media release, Oct 1 2014)
\textsuperscript{51} In addition to these protocols, inter-agency standard operating procedures (SOPs) mentioned below were an inter-agency effort in which MoSA participated and eventually endorsed. (CP team)
\textsuperscript{52} The LCRP is the Lebanon chapter of the Regional Refugee and Resilience Plan 2015-2016 (3RP) led by UNHCR and UNDP. As a nationally-owned version of the 3RP, it is tailored to respond to the specific needs of Lebanon – its de facto refugees, communities and institutions - within the on-going regional crisis. (LCRP 2015-2016)
Sector Working Groups supported by specialised agencies, donors, UN/NGO partners as well as Lebanese civil society and the private sector.53

MoSA co-chairs the Protection Steering Group (PSG) with UNHCR. As part of the PSG, the SGBV Task Force was established in 2012. The GBVIMS was introduced in 2012, emergency Standard Operating Procedures (SOPs) were drafted and endorsed in 2014, trainings delivered, a strategic action plan developed and a plan to engage other sectors commenced.54 UNICEF, UNHCR and UNFPA co-chaired the SGBV Task Force until December 2015. UNICEF also supported MoSA to co-lead the SGBV sector through the recruitment of a national MoSA based GBV Coordinator. Since 2016, UNICEF exited the coordination of the SGBV Task Force, with UNHCR, UNFPA and MoSA remaining as co-chairs. However, UNICEF is still deeply involved in strategic discussions and still sitting at the Thematic Working Groups such as Clinical Management of Rape (CMR), Gender-based Violence Information Management System (GBVIMS), and Case Management.

International funding for the Syria crisis has been generous, particularly since the massive influx of refugees into Europe started in 2015. Regionally, the Regional Refugee and Resilience Plan 2016-2017 in response to the Syria Crisis (3RP) is a joint appeal by over 200 partners55 for USD5.78 billion.56 At the donor conference for the Syrian crisis (London, February 2016), USD10 billion was pledged. Funding for the response in Lebanon is channelled through the UN and INGOs, not through the GoL.

3.3 UNICEF GBV Programme57

UNICEF was the only UN agency working in Lebanon during the civil war and scaled up enormously when the Level 3 (L3) emergency was declared in January 2013. Pre-emergency the Lebanon CO (LCO) had eighteen staff in total. Now there are around 170.58 During the L3 emergency UNICEF has invested the most resources – financial and human – of all UN and other international agencies in Lebanon, with a

53 LCRP, 2015-2016
54 Lebanon COAR 2012
55 Governments, UN agencies, inter-governmental organizations and NGOs.
56 3RP strategic directions emphasize strong national leadership, enhanced accountability, a regional protection framework operationalized and protection principles mainstreamed across all sectors, a focus on resilience, investing in livelihoods and economic opportunity for both refugees and host communities, education opportunities in line with No Lost Generation and an inclusive and innovative response. (3RP, p7)
57 This section of the report provides a descriptive overview of the GBVIE programme being implemented by the LCO. Analysis and findings are discussed in section 4 of the report.
58 Lebanon COAR, 2015
presence in Beirut and in four field offices. The CO budget has increased by a factor of 10 times since January 2013, with a total of USD700 million over the past 3 years.

In early 2013, UNICEF led a multi-sectoral vulnerability assessment exercise, and together with the Information Management Unit of the Prime Minister’s Office, produced a Vulnerability Map identifying those locations in which the most vulnerable Lebanese (living on under $4 per day), and highest concentrations of registered refugees were living, supporting targeting of the response to the most vulnerable populations in all communities. The assessments and maps (updated throughout the response⁵⁹) have been used throughout the emergency response by the GoL and all UN agencies, and have informed UNICEF’s ‘convergence’ approach to the response. Multiple services, including GBViE prevention and response services, have been delivered to vulnerable host and refugee communities through public ‘gateways’. Gateways include MoSA-run Social Development Centres (SDCs), Primary Health Care Centres (PHCs), community centres, municipal buildings, schools, hospitals and mosques/religious buildings. The use of one community facility to delivery multiple services by UNICEF has reduced the number of locations beneficiaries need to attend to receive services, and increased efficiency in terms of delivery costs.

The 2016 UNICEF Humanitarian Refugee Response Plan (HRRP)⁶⁰ continues and deepens this comprehensive approach, with activities addressing prevention and response to GBV as well as engagement at systems level and systematic capacity development of government and civil society, and a new focus in the CPD on evidence gathering to support more effective monitoring and stronger advocacy on CP and GBV.

3.3.1 GBViE Specific Programmes
Pre-emergency the CP section consisted of the Chief and one national staff member, with no dedicated GBV programme. However, with the identification of GBV as a particular problem with the influx of refugees, a GBViE Specialist was recruited in January 2013. The current GBV team consists of the GBViE Specialist and a GBV officer in Beirut as well as CP/GBV staff in each of the four field offices, who have been responsible for both programming and coordination.⁶¹ Despite not being a regional office priority in the emergency response,⁶² GBViE has been a priority for LCO and has been strongly supported by the Chief, CP and the Deputy Representative throughout the emergency response.

Under the current HRRP, the GBViE Outcome is framed under three outputs:
Output 1.1 Communities are actively engaged in addressing vulnerabilities and building resilience
Output 1.2 Increased capacity of Government and Civil Society actors to respond
Output 1.3 Improved engagement with social welfare and justice systems

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⁵⁹ UNICEF conducted another comprehensive community-level vulnerability assessment early in 2016, again covering all population cohorts, with the results further refining the geographic targeting per sector.
⁶⁰ UNICEF Annual Plan aligned with the LCRP
⁶¹ South Lebanon, Bekaa, Tripoli and Akaar
⁶² MENARO priorities for the response were education, WASH, immunisation, winterisation and PSS.
Safe Spaces
UNICEF has developed a standard integrated package of GBViE services\(^{63}\) to be implemented by all IPs in safe spaces, established in different gateways including Social Development Centres (SDCs), Community Centres, Municipalities, Informal Settlements, Primary Health Centres (PHCs) and Palestinian Camps. Services, which target girls and women as a priority aim to empower them to support each other and include age-appropriate psycho-social support (PSS); life-skills courses; recreation activities; skills/vocational development; accessing safe and multi-sectoral GBViE response services through case management services and referral to specialized services\(^{64}\); information on reproductive health, coping strategies, hygiene promotion and women's rights. Child care is provided by trained assistants. A number of IPs deliver both CP and GBV programmes at the same location. Within the scope of the MoSA National Plan to Safeguard Women and Children, and with the objective of strengthening the response SDCs that are the cornerstone of MoSA’s response to the Syria crisis in Lebanon and provide basic services to vulnerable host populations, UNICEF is implementing static and mobile safe spaces in 36 SDCs (including 8 pilot safe spaces), with support from UNICEF partners to provide a minimum package of services to vulnerable adolescent girls and women from host and refugee communities for prevention and response to GBV, as well as community based structured PSS for their children. For remote areas where there is no CMR service in the hospital, on-call doctors are available to attend the safe spaces if there is a need.

To reach vulnerable Lebanese and refugee women and girls scattered through host communities, mobile safe spaces were established in 2015 where they can meet regularly and access the same package of services as in the static safe spaces. Services are provided for a minimum of six months.

A number of tools have been developed to address adolescent-specific needs since the start of the crisis. In 2013, UNICEF supported the Citadel of Protection toolkit, which has been endorsed by the CP and GBV sectors, and the My Safety My Wellbeing tool, developed by IRC. Most recently, a curriculum is being developed for adolescents (up to 17 years) which includes conflict resolution, communication skills, stress and anger management, sports for development, human and child rights, technical skills (use of computers), language classes and literacy. This curriculum is aimed at equipping adolescent girls and boys with knowledge and skills to reduce, prevent and respond to GBV, increase their confidence and build resilience.\(^{65}\) Adolescent girls and boys attend courses at the same time, together or separately, depending on the sensitivity of the session.

Two IPs (DRC and ABAAD) are working to engage men and boys to raise awareness of GBV as a problem and catalyse a positive shift in social attitudes to equal gender roles to bring about a reduction in violence against women and girls. Men are also targeted through sports gatherings which include discussions on aspects of GBV. Case management for boy survivors is also provided.

Dignity Kits
Dignity kits have been used strategically as incentives to women and girls to attend information briefings on services available through safe spaces, and are also distributed when they enroll. Community feedback was sought to ensure that the contents of kits are appropriate and relevant to the needs. Standard contents of dignity kits distributed by the LCO and IPs include: 1 pack Sanitary towels, disposable/PAC-30

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\(^{63}\) The GBViE Specialist has developed a checklist with guidance/standards on how to establish, manage and run static and mobile safe spaces, and what services should be offered. These services include legal, medical PSS including case management and access to specialised services

\(^{64}\) Referral services include mental health, medical, safety/shelter, legal counselling on issues such as child custody, alimony, divorce and court representation. (KII with MoSA staff).

\(^{65}\) UNICEF Factsheet, September 2015
with wings; 1 pack women’s underwear (3 pieces of different sizes); 1 bar antibacterial soap; 1 solar flashlight; 1 pack 20 wet wipes; 1 headband/headscarf; 1 cotton/polyester overcoat standard size for spring and 1 for winter; 3 pairs of socks; 1 multipurpose cloth; 1 fabric bag; 1 packing carton.

Shelters
In Lebanon, safe shelters are scarce. UNICEF is funding the Midway House as one of three pilot shelters\(^66\) to model immediate provision of protection services to refugees and host community women and girls and their dependents. It provides emergency shelter to women and girls at risk and to GBV survivors in life threatening situations, who can access specialised services and safe accommodation while they identify a longer term option.

Community mobilisation
UNICEF is working on raising awareness of girls, boys and caregivers on the impact of early marriage on girls’ health and reproductive health, domestic violence, psychosocial wellbeing, access to education, and access to resources and opportunities in the longer term through a series of culturally sensitive information, education and communication (IEC) materials developed with participation of communities.\(^67\)

Community mobilisation has been a focus of the GBViE programme from early in the response. Community volunteers are trained to reach out within their communities and encourage other women, girls and other people at risk to access GBViE services in gateways. Attendees of the different courses in safe spaces are encouraged to set up ‘committees’ for ongoing peer support and out-reach into their communities. The committees can choose their specific mandates and activities as long as they address CP and GBV.

Since 2013, UNICEF has been piloting a programme to combat GBV, engaging a group of well respected Muslim clerics. The clerics are trained on basic CP and GBV concepts and the risks relating to early marriage. In partnership with UNICEF, Friday messages have been prepared and delivered by male religious leaders on DV, child marriage and sexual harassment to raise awareness and support for attitude/behaviour change. A female religious leader has delivered sermons and led FGDs on child marriage and other issues with women and girls.

One IP engages with communities through ‘theatre of the oppressed’. Targeting communities with high levels of child marriage, they initiate community debates working closely with community leaders and other key individuals, such as mothers-in-law.

A GBV animated video on Child Marriage was developed in 2014 in consultation with girls, boys, as well as male and female caregivers and used at awareness raising session, followed by discussion groups facilitated by trained outreach volunteers and social workers. Supplementing the video, posters and leaflets with key messages on the Child Marriage were printed and distributed through the outreach volunteers at awareness raising sessions.

– Images from the video

\(^{66}\) The other two shelters are funded by UNHCR and Caritas

\(^{67}\) Materials include short animated videos on child marriage and sexual and reproductive health and rights. (UNICEF Factsheet September 2015)
**Capacity Strengthening for Multi-sectoral Response**

Systematic strengthening of government and civil society capacities has been an integral part of the LCO response, including for GBViE, from the start of 2013. In community gateways and SDCs, both IP and MoSA staff, are trained on GBV awareness and referral pathways. UNICEF has trained over 200 social workers on the national SOPs for case management and also seconded a GBV coordinator to MoSA during 2015.\(^{68}\)

No medical facility in Lebanon was equipped to provide CMR treatment before the crisis, and doctors were not trained in CMR. To ensure provision of medical services for survivors of sexual violence, UNICEF has supported CMR training to medical staff (doctors, nurses, midwives) in seventeen medical facilities throughout Lebanon. Nurses and midwives are also trained on referral pathways, GBV concepts, and issues related to early marriage to support prevention as well as response to GBV. In addition to the medical staff, whole of facility training on GBV awareness has also been conducted in these PHCs to ensure that survivors are treated appropriately by all staff. UNICEF is supporting the Ministry of Public Health (MoPH) to institutionalize this training to ensure its continuation once current emergency funding stops.

In addition to conducting training directly, UNICEF has developed materials together with IPs, and equipped them to conduct trainings for government staff and other civil society partners. (See Annex 5 for list and brief overview of GBV programme tools developed by UNICEF Lebanon since 2013).

**Evidence generation**

In addition to programme monitoring and reporting, UNICEF co-chairs the GBVIMS Task Force which currently collects and analyses data from eight partners.

In 2013, UNICEF conducted a study on the impact of violence on men and boys, both as victims and as witnesses. The UNICEF Regional Office is leading a study during 2016 on child marriage, including analysing root causes. The LCO will support this study.

For the new CPD (2017-2020), the importance of generating evidence to demonstrate results of the programmes is highlighted, as a standalone output.

**3.3.2 Integrated GBViE Programming**

**Child Protection**

There is a high degree of integration between the CP and GBViE programmes. GBViE and CP components are delivered as different components of the same courses offered in safe spaces to children, adolescents and adult caregivers.

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\(^{68}\) COAR 2015
Through the National Plan the CP team is strengthening capacities of Lebanese authorities at central and provincial levels, civil society and in community based structures to deliver CP, GBViE and family support services, including primary health care to vulnerable Lebanese and Syrian refugees. Financially and technically UNICEF is assisting in immediate deployment of additional social work professionals centrally and locally. 57 social workers have been recruited and deployed to 26 SDCs across Lebanon.

**Health and Nutrition**
UNICEF has trained over 250 health and education workers on the safe identification and referral of GBV/CP cases. Training in mental health and PSS in the Ministry of Public Health (MoPH) has also been conducted, with one doctor being trained as the focal point. One year’s salary is being covered for this position. Medical staff have been, and continue to be trained on GBV concepts, referral pathways, child marriage and reproductive health.

In addition to the whole of facility training on CMR (described above), the health and nutrition section ensures that 26 hospitals in Lebanon are supplied with obstetric, midwifery kits and surgical kits to support service provision to rape survivors.

**WASH**
The first training for WASH actors in field offices was conducted in February 2013, by IRC as part of their first PCA with UNICEF. This training on GBV concepts and detection and referral pathways has been continued. However, there has been no systematic integration of GBV across the WASH response, with the exception of a few GBV ‘messages’ included in the CP section of training given to hygiene promoters, including the need for women to accompany young girls to the latrines, the importance of having locks on the inside of latrines and that refugees do not have to pay for emergency WASH facilities, or accept abuse to use them.

**Education**
Education workers have been trained on safe identification and referral of GBV/CP cases (see above). UNICEF leads the education sector response in Lebanon and has supported the Ministry of Education and Higher Education (MEHE) with other partners to develop the Reaching all Children with Education (RACE) programme, which aims to meet acute and immediate needs of Syrian refugee and vulnerable Lebanese children by providing formal and informal education in safe and protective environments. RACE 2 has just been finalized, and includes some CP elements, but doesn’t highlight GBV specific awareness/knowledge of referral pathways for teachers. Until 2016, MEHE had put a political block on integrating GBV into education programming but this has now been removed, opening the way for greater integration.

Regionally, Child Protection is one of three core pillars of the “No Lost Generation” initiative, started in 2013. The initiative recognises the risk of early marriage and physical and sexual violence, and objectives include the provision of (i) quality, community based CP including PSS; (ii) provision of specialised CP services and (iii) strengthening national formal CP systems, including legal and policy frameworks. However, GBViE specific elements are not currently prioritised.

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69 COAR 2015
70 KII with UNICEF sector staff
71 KII, CP team
72 [http://nolostgeneration.org/about](http://nolostgeneration.org/about)
One UNICEF supported CP officer is now working in the MEHE, providing another entry point for stronger integration of protection issues. Other possible entry points will be identified by the current feasibility study for a cash transfer programme, which is looking at the feasibility of cash transfers to parents for encouraging their children, particularly girls, to remain in education.

3.3.3 Programme Funding
In 2015, of a total CO budget of US$150 million, funding for the CP section was US$26.2 million, of which 30% (US$7,326,500) is allocated to GBViE programming. In CO annual reports, CP and GBViE funding is not disaggregated, but in the 2016 HRRP and new CPD, GBViE programming has dedicated resources which will be tracked separately against proposals and internal indicators.

<table>
<thead>
<tr>
<th>Donor</th>
<th>Child Protection</th>
</tr>
</thead>
<tbody>
<tr>
<td>USA (State) BPRM</td>
<td>7,333,293</td>
</tr>
<tr>
<td>Canada</td>
<td>5,296,443</td>
</tr>
<tr>
<td>European Commission</td>
<td>4,614,423</td>
</tr>
<tr>
<td>Germany</td>
<td>3,513,961</td>
</tr>
<tr>
<td>Netherlands</td>
<td>2,116,402</td>
</tr>
<tr>
<td>The United Kingdom</td>
<td>1,657,995</td>
</tr>
<tr>
<td>Netherlands Committee for UNICEF</td>
<td>567,281</td>
</tr>
<tr>
<td>Kuwait</td>
<td>421,052</td>
</tr>
<tr>
<td>Spain</td>
<td>326,797</td>
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<tr>
<td>German Committee for UNICEF</td>
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<tr>
<td>Japan Committee for UNICEF</td>
<td>100,000</td>
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<tr>
<td>Canadian Committee for UNICEF</td>
<td>8,166</td>
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<tr>
<td>Italian Committee for UNICEF</td>
<td>7,615</td>
</tr>
<tr>
<td>Grand Total</td>
<td>26,246,695</td>
</tr>
</tbody>
</table>

The largest donors for GBViE are the EU, UK Aid and USAID/BPRM. The NatCom for the Netherlands gives 100% of its funding for GBViE, and the funding from the EU and the Netherlands is earmarked for GBViE, but otherwise, funding is unearmarked.

4 EVALUATION FINDINGS
The section on evaluation findings addresses the evaluation questions related to the respective evaluation criteria in the ToR and Inception Report.

4.1 Relevance
Alignment of UNICEF programming with assessed needs of beneficiaries (which may change over time), good GBViE programme practice and relevant UNICEF strategies and policies.

Alignment of GBViE programme with key GBV strategies/guidance
The Lebanon GBV programme is aligned with the UNICEF Strategic Plan, the Equity Approach, and the UNICEF Gender Action Plan (GAP), although this alignment has not been made explicit in programme documents. The UNICEF GBViE response is also aligned with national response plans. The LCRP is based

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73 The 2015 budget was 111%, which the CO interprets as a high level of satisfaction with their programme from donors. (KII with senior CO staff and CP section)
74 UNICEF GBV Factsheet, September 2015.
75 The GAP is not well known within the CO and has not influenced the programme or priorities, despite the fact that the GBViE programme is aligned with two of the four targeted priorities (on children marriage and GBViE).
on multiple interagency assessments within a GoL-led and UN-supported process\textsuperscript{76} and those sectors which are led by UNICEF, (WASH, Education and CP including GBViE) have been strongly influenced by UNICEF, so that the HRRP is an extraction of UNICEF’s components within the LCRP.

There is a high degree of alignment of GBViE programme interventions with the recommended actions in the Minimum Actions during immediate response to a crisis and Expanded GBV prevention and response in the Resource Pack (see below) are addressed in the programme. With the exception of risk mitigation across all sectors, all the actions are being comprehensively addressed, and there are plans to scale up multi-sectoral services and prevention initiatives.\textsuperscript{77}

<table>
<thead>
<tr>
<th>Minimum actions during immediate response to a crisis</th>
<th>Expanded GBV prevention and response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Effective coordination of humanitarian action to address GBV.</td>
<td>1. Effective coordination of GBV-related humanitarian and recovery action.</td>
</tr>
<tr>
<td>2. GBV risk mitigation across clusters and sectors in line with IASC Guidelines.</td>
<td>2. GBV risk mitigation across clusters and sectors in line with IASC Guidelines.</td>
</tr>
<tr>
<td>3. Age-appropriate clinical and crisis care for sexual assault.</td>
<td>3. Strengthening coordinated multi-sectoral care and support systems and services.</td>
</tr>
<tr>
<td>4. Safe spaces for women and girls.</td>
<td>4. Ongoing protection interventions to reduce vulnerability.</td>
</tr>
<tr>
<td>5. Dignity kits.</td>
<td>5. Primary prevention initiatives to empower girls and women, address harmful attitudes and social norms and legislative and policy interventions. This includes testing and scaling up prevention initiatives.</td>
</tr>
</tbody>
</table>

The LCO has not had an explicit Theory of Change (ToC) for GBViE programming and there is no Regional GBViE ToC for MENA, although there has been an explicit logic to the programme since its inception. In addition, the GBViE specific programme is largely aligned with the UNICEF corporate ToC developed as part of this evaluation. All ‘core roles’ within the corporate ToC have been explicitly addressed, namely (i) strengthening humanitarian action on GBV; (ii) supporting the State and other duty-bearers to uphold responsibilities to address GBV; and (iii) supporting civil society to address GBV. Associated actions and strategic interventions have all been addressed effectively to some degree, and some, extremely effectively.

As part of the developing the new CPD (2017-2020) a ToC has been developed through an extensive consultation process with all stakeholders including the GoL.

Alignment with assessed needs
The results of periodic vulnerability assessments and other data (including the GBVIMS) have informed GBViE programme priorities and implementation strategies. GBViE specific assessments were conducted in 2012 among Syrian women and girls in Lebanon, and in February/March 2014 among adolescent girls when a gap in programming for adolescents was noted.\textsuperscript{78} The results of this assessment are informing the adolescent-focused curriculum for programming in safe spaces.

\textsuperscript{76} The LCRP vulnerability framework incorporates human vulnerability (informed by the vulnerability assessment of Syrian Refugees 2014; 2015 Multi-Sectoral Needs Assessment Phase I Survey; National Poverty Targeting Programme and other assessments); Geographic vulnerability and Systemic Vulnerability

\textsuperscript{77} See under respective findings sections below for evaluation of different programme elements in detail.

\textsuperscript{78} An evaluation of PSS in April 2014 also informed GBViE programming.
The mobile safe spaces model was developed to reach refugee women and girls settled throughout the country, who had limited access to the static safe spaces. The provision of services two days per week for six months was based on data collected among host communities. 150,000 women and girls have been reached through the mobile safe spaces by UNICEF and IPs. This adaptation by which safe space services are provided to women and girls in hard to reach communities, within a cultural context (particularly for Syrian refugees) in which female mobility is severely constrained, is both innovative and highly effective.

Integration of GBV risk reduction across all sectors
While the LCO has prioritised convergence of multiple sectors delivering services in one location, and the CO project approval committee requires that projects should be discussed with other sectors before being approved, integration of GBViE risk reduction approaches/activities across all UNICEF sectors has not been systematically prioritised or championed by senior LCO staff, and has been limited. The health and nutrition section ensure provision of CMR supplies to 26 medical facilities; medical staff and school counsellors have been trained on GBViE concepts, awareness and referral pathways. Training of WASH staff in field offices has been conducted since the start of the crisis. However, there is very limited ownership of responsibility by sections other than the CP section to integrate GBV systematically throughout their response in line with the 2005 and 2015 IASC GBViE Guidelines.

The Youth section of LCO was (re-)established in early 2016, and is focussing on three areas: (i) system building at policy level; (ii) skills building, vocational training; and (iii) Syrian refugee engagement and empowerment. Given that the youth age group is a core target for the GBV programme, there are multiple entry points which can be exploited to integrate GBV systematically across the youth programme. This integration will be facilitated by those IPs which implement both CP/GBV and youth programmes.

Human Rights Based Approach
A human rights based approach (HRBA) is inherent in raising awareness of, and responding appropriately to, GBViE, as well as being at the heart of the UNICEF-led vulnerability mapping exercise which has informed the targeting of all vulnerable cohorts in the most vulnerable localities. The prioritisation of addressing relatively high levels of early marriage is closely linked with the rights of children and women. Capacity strengthening for civil society and government employees involves building their understanding as duty bearers to prevent and respond to GBV. Throughout the emergency response UNICEF has supported the GoL as duty bearers to fulfil their obligations in relation to all women and children.

79 Increasing Access, Increasing Healing: Mobile approach to GBV Service Provision and Community Mobilization in Lebanon, IRC
80 In line with detailed guidance provided in the 2005 Guidelines for Gender-based Violence Interventions in Humanitarian Settings and the 2015 IASC GBViE Guidelines for Integrating Gender-based Violence Interventions in Humanitarian Response.
81 This finding is aligned with the broader evaluation of the humanitarian system's response to GBV as part of the Syrian response in Kurdistan Region of Iraq (KR-I), Jordan, Lebanon and Northern Syria. This evaluation assessed knowledge and use of the IASC Guidelines for the Prevention and Response to GBV, 2005 in two sectors in each area. Findings included that the 2005 GBViE Guidelines are not well known and are not being used in programming or strategic documents and guidelines. Evaluation of Implementation of 2005 IASC Guidelines for Gender-based Violence Interventions in Humanitarian Settings in the Syrian Crisis Response, 2015
82 The GBViE-related messaging in WASH hygiene promoters' training manuals was reportedly the result of one WASH staff member’s efforts working with the GBViE Specialist.
83 Youth is defined within this sector mandate as 14-25 to avoid overlap with CP or other sections.
84 The National Plan demonstrates the increased acknowledgement by the CP and Women’s Unit of MoSA of their role in the provision of GBV among other services, through the strengthened GBV services provided in SDCs.
4.2 Effectiveness

The extent to which the programme/activity is achieving or is likely to achieve its stated purposes, on the basis of outputs delivered.

Improved access to services for GBV survivors

The LCO is perceived by other international and national agencies and the GoL to be effective in terms of developing and implementing GBVIE programming, with strong technical skills, resources and human capacity. Given the low levels of GBVIE awareness and service provision in January 2013, the UNICEF GBVIE programme has made impressive progress. LCO senior management consider that the GBV team is ‘phenomenal’.

The LCO had no GBV programme before January 2013, so there is no baseline against which to measure improvement in GBV survivor’s access to life-saving, multi-sectoral services. However, during 2015, 162,198 individuals, mostly women and girls at risk or survivors of GBV, accessed mobile and static safe spaces; up from 28,852 in 2013.85 Whereas there were very limited GBV services before the L3 emergency, in 2015, UNICEF Lebanon with MoSA provided services through 36 SDCs as well as in informal settlements, collective shelters, municipalities and community based organizations and specialist CMR services were available at 17 medical facilities. As the detailed figures of UNICEF Lebanon GBV results against LCRP targets (see 4.5 on coverage below) demonstrate, the LCO has exceeded the targets for individuals accessing safe spaces, numbers of community members sensitised on GBV and referral pathways, and the total numbers of women and girls at risk involved in socio-economic activities. In some cases, by a huge margin, demonstrating the reach of the programme which far exceeds that planned for some activities, demonstrating that beneficiaries find the services and programming relevant and useful as well as accessible.

The use of dignity kits as incentives has been effective, according to IPs, in attracting women and girls to attend information briefings on services available at safe spaces, and to enrol in safe spaces activities. For women who are not used to acknowledging or receiving support for their own needs (such as stress and violence), and whose household resources are too limited to spend on feminine hygiene and other personal items, having an actual ‘take away’ from the meetings provides a stronger incentive than just hearing about services which are available. Distribution of the dignity kits through safe spaces has increased women and girls’ access to services, as male decision makers are more inclined to let females in their households attend safe spaces when kits are distributed as incentives. Between 2013 and 2015, a total of 67,650 dignity kits were procured by UNICEF.86 In 2015, 10,500 were distributed (7,500 by the CP team87 and 3,000 by Field Operations).

Adult women in one FGD felt that UNICEF/IPs should be more transparent on exactly what services are being offered at safe spaces. For these women, their first priority is livelihoods while what is on offer are services relating to GBVIE, and they felt this was not always made clear in the initial information sharing sessions. This comment should be interpreted in the light of the recent, drastic cuts in humanitarian assistance by WFP and UNHCR, mentioned by several of the FGD participants. This has seriously worsened the economic situations of many of the refugees and raised even higher their desires for some way to generate income. However, given the legal situation re refugees working in Lebanon, income generating programming is not a possibility and the socio-economic empowerment activities which are offered by four IPs in UNICEF supported gateways are aimed at enhancing women and girls’ psycho-social wellbeing.

85 COAR 2013, draft 2015 COAR
87 The 2015 target for the CP team was 5,000. (CP/GBV HRRP results framework, 2015)
**Timeliness of UNICEF response**
By expanding GBViE services in safe spaces already established in gateways, UNICEF has been able to scale up GBViE rapidly. During 2015, UNICEF’s service provision for GBV and CP covered 80% of the GBV sector targets, which themselves were double the targets for 2014, demonstrating that services have been significantly scaled up year on year of the response.  

**UNICEF contribution to preventing and mitigating GBV risks**
The effectiveness of UNICEF programmes in mitigating GBViE risks relates, in part, to their ability to address root causes and contributing factors of specific types of GBV in different contexts. In order to try and reduce levels of child marriage and prevent GBV incidents, UNICEF and partners sensitized 150,914 community members on the risks associated with child marriage and other harmful traditional practices during 2015, and PSS sessions include raising awareness for girls and women of their human rights, and equipping them with alternative ways to deal with ongoing stress and tension related to their circumstances. However, the legal ban on refugees working seriously limits attempts to address the economic hardship faced by many families which are a key contributing factor to early marriage and increase household stress which contributes to GBV. Economic empowerment programming (knitting, sewing, soap-making, make up, etc.) has been introduced in response to requests from women and girls attending safe spaces to enhance their wellbeing, and professional kits are provided to participants so they can work within their homes if they wish to. During 2015, socio-economic empowerment activities were accessed by 1,196 women and girls in UNICEF safe spaces (nearly double the target for 2015 which was 650 individuals). In the context, these activities make a very limited - if any - contribution to household finances which is outside the control of UNICEF but is a serious consideration in terms of reducing incidence of GBV due to economic stress.

As well as the challenges which exist to being able to target key contributing factors and root causes of GBV, demonstrating programme effectiveness in preventing and mitigating risks is hampered by gaps in collection of meaningful data on the results of the programmes against these objectives, rather than data on the delivery of services. (See below for further discussion on data collection and use).

The most significant gap in the GBViE programme in terms of preventing and mitigating GBV risks, is the limited degree of integration with other sections. Despite efforts by the GBViE Specialist, a lack of systematic championing of integrated programming between sectors (as opposed to geographic convergence), combined with the UNICEF-wide tendency to siloed programming between sectors in a high-pressure, L3 response, has meant that entry points for integrating GBViE elements in education, youth, WASH programmes have not been fully exploited, representing missed opportunities for mitigating

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88 Reported in the Lebanon COAR, 2015 (draft).
89 Adult women in two FGD groups spoke of the direct relationship between taking decisions to marry their teenage daughters and the need for household income for rent and food as well as to protect them from harassment
90 Draft 2015 COAR
91 FGD adult women in Tripoli said that, following discussions in safe spaces about early marriage and the results on adolescent brides in terms of their education ending and physical challenges of motherhood while they are still growing, they are well aware that early marriage has negative repercussions on their daughters, but in the absence of other ways of making money to pay rents and meet basic needs, they have very little choice. On the other hand, one adult FGD female participant said she now regretted marrying two of her daughters young and felt that they are now the victims of her choices.
92 Lebanon COAR, 2015 (draft) and UNICEF SitRep: Syria Crisis, 2015 Humanitarian Results
GBV risks. For example, there is currently no integration of GBV within the youth programme, which is a significant gap given the significant risks to adolescent girls of child marriage, of other forms of GBV to which they are currently exposed and also the importance of engaging adolescent boys as agents of change. However, it should be noted that efforts to engage with the education sector were hampered by structural constraints for CP engagement with the MEHE, but that the recent placing of a CP officer within MEHE as part of RACE 2 should strengthen engagement on GBV as well as CP with education. Similarly, the relatively recent re-institution of a separate youth team and youth programme has meant that it has been limited in scope to date, but there are opportunities for greater integration going forward.

Capturing and disseminating programme results
The LCO GBViE programme objectives are clear and specific. In UNICEF’s Rolling Work Plan with MoSA, and the HRRP (2016) detailed outcomes, outputs and activities are stated with targets, timeframes, and indicators at each results level. Information on delivery of activities and outputs is relatively easy to collect, measure and report on. However, while outcome indicators are included in these plans, demonstrating progress on higher level results in terms of increased protection from/prevention of GBV is much more challenging.

The LCO has developed sophisticated systems of data gathering, using a number of different monitoring and reporting tools including Equitrack, and ActivityInfo. However, the emphasis is on collection of numerical data and much less on systematic qualitative feedback from those accessing services. The CP team are keenly aware of the gap between the strong programming which exists and a lack of documented evidence of programme results, particularly for women. Beyond safety audits, the CP team consider that periodic assessments of emotional/psycho-social wellbeing and perceptions of safety are needed to establish a baseline, and from that to measure whether women and girls feel, and objectively are, safer, and GBV risks are being minimized as result of the programming being implemented. (As noted below, tools are currently being developed by SGBV TF to address this gap).

Some measure of the perceived value of programmes can be gauged by levels of engagement and beneficiary feedback. The CP team estimates that 300 new people were attending safe spaces each day indicating a high degree of satisfaction with services; and all female FDG participants (adult women and adolescent girls) valued the safe spaces as places they could meet safely, feel validated and supported, and where they are supported to discuss and find more constructive and less violent ways within their families to deal with the highly stressful situations in which they are living. One adolescent girl said that coming to the safe space made her “feel my soul is back to my body”. Other adolescent girls reported getting up early on days when they attended services so they could go to the the service centres where “all the stress goes out of me”. One success factor in terms of attracting this number of participants has been that, after initial community reluctance to allow women and girls to attend safe spaces and questions about what would be offered in them, by encouraging women and girls to attend safe spaces with young

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93 The contrast between the success of the convergence approach and the lack of integrated programming between sections was noted by senior CO staff.
94 UNICEF Lebanon CP and GBV Rolling Work Plan for 2015-2016 with MoSA
95 An online partner tracking and monitoring tool which enables the LCO to have all partnership-related information in one repository, to map partnerships, and to aggregate planned results, progress and budgets.
96 UNICEF, UNHCR and other humanitarian partners input data (partners use tablets and smart phones to input real time data and facilitate data analysis) into a unified reporting system for high frequency indicators disaggregated by location, sex and population group. Partners receive training on the technical aspects of using ActivityInfo and report on 309 indicators in the first week of each month.
97 Violence from husbands, fathers and brothers to girls and wives, but also violence from parents to children. (FGD discussions)
children (U6) has really increased accessibility of the programmes as husbands allow women to come to accompany children. Services are provided separately at the safe spaces for women, girls and male children U6. In addition, the CFS also serve boys and girls aged between 6-12 years. Their appreciation of the services provided in safe spaces notwithstanding, some FDG participants (adult women) reported feeling uncomfortable accessing services in GoL SDCs, given the tensions between Lebanese and Syrian communities. While aware of these tensions, the CP team consider that the focus on supporting MoSA to provide GBV services is key in the long term, so that – once present levels of humanitarian funding have reduced (anticipated in the next funding round) – GoL capacities and service provision will already be established in government facilities and is therefore much more likely to be sustained than if it were only being provided in non-government facilities.

The CP team are aware that they are not systematically documenting and sharing the innovative and best practice programming which the CP/GBViE team is developing and implementing. (Despite having a ‘flagship programme’, the centrality of GBViE to UNICEF’s emergency response is not universally understood within the LCO. Some staff still see GBV as UNFPA’s responsibility.) This gap is the rationale for including a specific outcome on evidence gathering in the CP programme of the new CPD. Linked with this, the CP team is aware that one of the current gaps in the programme is systematic communication within and outside the CO of what GBViE initiatives are being implemented, and the results of these. An evaluation of the whole CP programme during 2016 is planned which will address some of these gaps.

During 2016, the LCO is prioritising the collection of more data from communities through FGD and survivor feedback forms which should go someway to bridging this gap. During the final workshop, there was some discussion on whether strengths and difficulties questionnaire (SDQ) based pre- and post-assessments of 25 questions measuring emotional, social, behavioural wellbeing of children could be adapted to measure results of GBViE programming more systematically. The CP team have also contacted UNICEF HQ and the Population Council and other expert institutions to see if they could advise on how to measure and demonstrate GBViE programme effectiveness, to date with little result. However, the LCO is developing new tools at country level which will contribute to being able to measure programme effectiveness.

In addition to UNICEF data collection and analysis tools, the SGBV Task Force is developing a monitoring and evaluation (M&E) tool, to which the LCO has provided substantial inputs, which aims to provide organizations with common practical M&E tools for the SGBV LCRP indicators. These will increase the harmonization and accuracy of reporting against indicators by partner NGOs and UN agencies. The M&E tool will facilitate better documentation and analysis on the services being provided, as well as identifying gaps, which – in turn - will inform to resource allocation to meet needs more effectively. The toolkit focuses particularly on outcome and output related measurements. Currently, quantitative data is being reported accurately and targets are being reached, however there is little reporting on outcomes. The toolkit will address this gap by providing guidance on four particular indicators:

- Empowerment of women and adolescent girls participating in SGBV activities
- Change in knowledge of trained SGBV actors and non-SGBV actors
- Change in knowledge and attitudes of trained community leaders
- Safety audit outcomes and collective action

The tool will be finalized by mid-July 2016 by when roll-out and testing of the tool should begin.
As demonstrating higher level results for GBV programming is a general challenge, and not restricted to Lebanon, the development of both LCO and SGBV Task Force M&E tools is very positive. Once the tools are tested and proven, they could well have great relevance for other countries and regions.

**Leadership contribution**
Support by CO leadership has been a significant success factor, as well as early identification of GBV as a key element of UNICEF’s humanitarian response. Since his arrival in January 2013, the Deputy Representative has been an active supporter of the programme, and the combination of the Deputy Representative, the Chief CP and the GBViE Specialist – who have all been in post since January 2013 - has been very productive. The relatively newly arrived Representative is also supportive of the GBV programme, affirming that its scope and level of funding will not be reduced as a result of no longer co-chairing the SGBV Task Force. Technical support has also been provided on request from HQ, with two missions by the GBViE Specialist, CPS New York, most recently in January 2015 to support the drafting of the new CPD. In December 2012, before the L3 emergency was declared, the GBV AoR Rapid Response Team member for MENA conducted a mission to Lebanon. However, since her departure, there has been no GBV Specialist at the RO. This is perceived as a real gap by the CP team, as UNHCR and UNFPA both have GBV Specialists in the RO (Amman), and UNICEF has not been represented when partners meet to discuss interagency GBV strategies, responses and priorities at regional level.

**Innovative Approaches**
Innovative programme approaches include the mobile safe spaces and working with religious leaders as opinion formers/influences to promote practices which reduce risks of GBV.

Recognising that training doctors in CMR would not ensure that survivors of sexual violence were treated appropriately by all staff at medical facilities offering CMR services, whole-of-facility training is conducted by UNICEF and IPs with medical staff trained in the clinical management of rape and other staff in appropriate, survivor-centred approaches. This approach is described in greater detail as one of the good practice case studies for Lebanon.

### 4.3 Sustainability / Connectedness
*To what extent emergency response activities take into account and support a longer-term approach, including in connection with UNICEF’s regular development programming.*

**Linking emergency and longer-term programming**
From the start of the emergency, UNICEF Lebanon’s approach has focused on linking the emergency response with longer term programming across all sectors, including GBViE, through a number of strategies including a focused approach on building national capacity and community mobilisation. This approach has been facilitated by the high levels of funding, and flexibility afforded by most of the funds being unearmarked.

From the start of the response, based on findings of the initial and subsequent multi-sector vulnerability assessments which identified the most vulnerable locations, the response has targeted both vulnerable

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98 For the duration of this funding cycle while the LCO programme is fully funded.
99 In addition to the lack of a GBViE Advisor at MENARO, there is currently no Gender Advisor although one has been identified and will take up her post shortly.
100 Since the evaluation mission, MENARO has begun recruitment for a GBViE Specialist to be based in Jordan.
101 The LCO is aware that the current high level of humanitarian funding will not be maintained, and is focused on leaving something better behind, particularly by strengthening the public sector. The real test of sustainability will be whether the GoL is prepared to allocate their own funding to GBV.
Lebanese and Syrian refugee communities, who access the same services in the gateways in the identified most vulnerable locations. As well as being aligned with the Equity Approach, this focus has enabled UNICEF to take advantage of the crisis-related window of opportunity to prioritise GBV programming, allowing awareness to be raised, and systems and capacities built, which can form the foundation of longer-term GBV programming.

Building national capacity
Since early 2013 LCO has prioritised building GoL capacity as part of establishing broad based response and prevention services. Within the National Plan, MoSA’s role is as a regulator, facilitating rather than directly providing GBV and CP services, and the capacity strengthening of SDC staff is aimed at strengthening technical and community engagement skills, to ensure that, communities will be served over the long term by MoSA staff who understand the needs and appropriate responses of those at risk and survivors of GBV; even if the level of PSS and other services fluctuates because of funding. While the National Plan was only signed at the end of 2014, this focus on capacity development is well appreciated by MoSA, and in many SDCs, centre managers welcome the support to strengthen staff capacities (both through UNICEF funded recruitment of social workers and through staff training) as well as the broadening of services which are provided through the SDCs in terms of services/activities directly implemented by UNICEF IPs working through the SDCs.

Emphasising a dual track approach (building capacity of both GoL and civil society), UNICEF has also focused on strengthening local NGO capacity. One way in which this is being done is by including training of LNGOs in INGO Programme Cooperation Agreements (PCAs), with the objective of upgrading local skills to take over roles currently performed by INGOs in a designated period of time. (This is good practice, providing timescales are realistic enough for sufficient training for local partners to ensure that they are capacitated to assume programme management and delivery responsibilities.)

UNICEF’s strategy that all IPs deliver both CP and GBVIE programmes in safe spaces is aimed at expanding the capacity of LNGOs, so that when the levels of emergency funding start to fall, (which is likely to be the case in the next funding round), there will be a broader base of local actors able to delivering basic GBV prevention and referral programming. While this is expedient given the shortage of local NGOs with GBV expertise, specialist service delivery will still be critical.

The current National Plan has been extended until the end of 2016, and UNICEF and MoSA are currently in process of reviewing the lessons learned and developed a second phase, 4-year National Plan which will become the overarching framework for work on CP and GBV. National Plan 2 will be expanded to include support to and integrate relevant roles of other ministries which address CP and GBV. This is a strong vote of confidence in the current National Plan and how it has already strengthened and expanded GBV and CP interventions in Lebanon.

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102 This has been a CO priority for all sectors, not only GBV/CP.
103 The concept of community mobilization is not well understood in Lebanon according to the CP team, as the prevailing model is highly privatized given a poorly functioning state. So time will be needed to build these skills and approaches.
104 One of the limitations of working with the GoL is that, even when laws are passed, many of them do not include implementation plans. The 2014 law on DV, while a major break through when it was passed, has lots of gaps. However, it is the opinion of the CP team that, given the stalemate in government, this there is no way in which new laws can be passed, or this existing law amended at the present time despite on-going advocacy by civil society. Given this situation, UNICEF Lebanon has made a tactical decision to support the development of the MoSA/UNICEF National Plan, which they can see is an ‘imperfect instrument’, but one which can be implemented within the constraints of current administrative and financial rules and government regulations. (Final workshop discussion)
Community mobilisation
Community mobilisation, with the aim of supporting long-term change, has been a focus since the early days of the response, and has been addressed by several approaches. Community volunteers are trained by IPs to reach out within their communities. Attendees of the different courses in safe spaces are encouraged to set up ‘Committees’ for ongoing peer support and out-reach into their communities. The committees can choose their specific mandates and activities as long as they address CP and GBV. Each committee has a budget of approximately $50 per month which can be spent monthly or saved for community events. The goal is lasting change in community attitudes to GBV with a corresponding decrease in prevalence of GBV. As a measure of success observed by the evaluation team in terms of course participants continuing as committee members, the SDC in Bakhoun where the GBV programme is being implemented by the Danish Refugee Committee estimates that, on average, of a course of 20 participants, 7-10 will choose to form a committee. Existing committees have engaged in community mobilisation and awareness raising on GBV; referring cases for case management support and hosting an information session on early marriage. This committee prepared the material and arrangements for the event, purchased souvenirs and hosted the event with DRC support.

In addition to committees and with the aim of fostering community self-help and creating better protective environments for girls and women, Family Support Networks are also being established to link formal and informal actors working to address GBV with other stakeholders in their communities, with the SDC playing a regulatory role.

Social norms
To date, there has been some focus in the programme on addressing prevailing social norms which contribute to current levels of GBV through the work with religious leaders in the South and North of Lebanon and also with caregivers and through Committees including those who have completed safe space courses. At this point of the response, with the focus moving towards transition to a more development-oriented programming, the CP team is expanding and strengthening the social norms component in the forthcoming CPD. The new UNICEF Communities Cares programme is one of the models being considered as a model for the next programme cycle to addressing underlying social norms which contribute to current levels of GBV.

4.4 Coordination
The extent/nature of UNICEF CO programming contribution to realizing GBV-sector strategies/plans/priorities and how UNICEF has added value to/been affected by the GBV sector response within the CO and across the response as a whole.

UNICEF’s added value to GBV Sector
From end 2012 until December 2015, UNICEF co-chaired the Task Force with UNHCR and UNFPA at national level and, with UNHCR, in four provinces. UNICEF is supporting MoSA to co-lead the SGBV sector through the recruitment of a national MoSA based GBV Coordinator. UNICEF also co-chairs the GBVIMS Task Force, and is a member of the CMR Working Group.

105 This programme is based on the SASA! Model developed in East Africa and has been adapted for UNICEF by the GPS in New York.
106 Tripoli + 5 (T5), Akkar, Bekaa, and South (GBV Sectoral Dashboard, Midyear June 2015)
In December 2015, UNICEF agreed, as part of a re-organization of leadership of all the sectors, to step down from co-chairing the SGBV Task Force, nationally and at field level. The evaluation team were informed by senior LCO staff, that this decision might be re-visited at the mid year interagency review and that it would not affect the priority which the LCO places on the GBViE programme or the 30% of CP sector funding which is to be maintained through the CPD 2017-2020. It was argued that time previously spent on coordination (double hatting for field and Beirut based CP/GBV staff) can now be invested in programming according to the Representative; and UNICEF will ‘lead from behind’ in GBViE, as they have been doing for the past few years in the education sector. CP, including GBV, will continue to be a CO priority for LCO even when the L3 emergency is no longer in place, and UNICEF’s very strong relationship with MoSA means that UNICEF will continue to influence and support the nationally led GBV programming and structures. However, not being co-lead means no longer been seen as the GBV sector lead, or being part of final sector coordination decision-making.

It is noteworthy that partners interviewed by the evaluation team unanimously advocated for UNICEF’s continuing leadership within the SGBV Task Force. Reasons given for this were that UNICEF has the largest GBV programme in Lebanon, has a uniquely strong and trusted relationship with the government, and is in place before, during and after emergency response due to UNICEF’s dual humanitarian and development mandates is recognised as being a key contributor to sustaining GBV services which have been initiated during the emergency response. This change has been seen by some partners as a de-prioritization by UNICEF of their GBV programme. One partner considered that “UNICEF is better placed to be leading GBV than other agencies: UNHCR is more focused on protection or community services, but UNICEF brings specialist GBV officers on board, so is not as broad and is therefore much better.” As discussed in the final workshop, coordination for GBV programming is different from that of other sectors, as a strong GBV response is dependent on effective coordination with those sectors and services to which survivors are referred: health, legal, justice and shelter actors. This is different from coordination within sectors focused on reducing duplication and ensuring quality programming.

Among sector partners, UNICEF is seen as a lead advocate and champion of GBViE prevention and response given the funding available to UNICEF and the influence the agency has with the GoL. UNICEF has led the way on GBViE programming in the response in Lebanon, in terms of the size value of the programming and by co-chairing of the national and field level coordination mechanisms since the SGBV Task Force was established.

UNICEF has contributed to overall sector knowledge and good practice through developing a number of standard courses and programmes for safe spaces and capacity strengthening with IPs.

**GBVIMS**
As co-chair of the GBVIMS, UNICEF provides leadership on collection of data on the incidence and nature of GBV and is considered a key partner in them implementation of the GBVIMS. From its inception in 2013, the IMS has expanded from four data sets to 14. Data is collated at national level and used to inform

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108 As part of the arrangement, UNICEF now is sole lead for Education and WASH Task Forces.
109 Also, that if UNHCR asked UNICEF to take back lead of the SGBV Task Force, they would do so with immediate effect, although this is not anticipated. (Final workshop discussion)
110 UNICEF will continue to implement a significantly larger programme than other international actors, (in terms of funding and scope), and will continue to be the primary advocate/influence on the GoL in terms of GBViE programming.
111 Discussions in final evaluation workshop, Feb 22nd 2016
112 KII, INGO partner
113 Interestingly, while GBV is seen as part of CP within the LCO, outside they are often perceived as separate sectors, with UNICEF playing a lead role in both.
programming, advocacy and fundraising. Data from the GBVIMS has demonstrated that the most prevalent type of violence being reported by women is DV.

In Lebanon, only six data gathering organisations are currently contributing data on types and incidence of GBV to the GBVIMS. The limited number of partners is seen by some parties, including the GoL, as the system being underutilised and ‘rather closed’. By contrast, other partners consider this as a strategy for ensuring quality oversight.

Internal UNICEF coordination
In terms of coordination within LCO across different sectors, some partners noted that there was room for greater coordination between UNICEF sectors particularly between programmes focused on reducing violence, eg GBViE and violence in schools. Some partners saw the current limited coordination between these programmes as an under-exploited opportunity by UNICEF to maximise potential synergies which is recognised by the CP team and now that the political block on integrating GBV more fully into education programming has been lifted, are planning to maximise opportunities for integration.

4.5 Coverage
The extent of UNICEF’s programming reach (geographic and numerical) compared with the needs of those at risk of or affected by GBV as assessed by UNICEF and/or the GBV sector as a whole.

According to the SGBV Task Force Dashboard in June 2015, the GBV sector was delivering legal, psycho-social and mental health support in 54 facilities in the 251 most vulnerable localities identified in the LCRP which include 87% of refugees and 67% of deprived Lebanese, according to the vulnerability mapping undertaken at the end of 2014. UNICEF supported programmes in 36 SDCs as well as in other gateways in 2015, with the number of SDCs in which CP/GBViE services are to be delivered rising to the National Plan target of 57 SDCs during 2016. CMR is now available in seventeen medical facilities in throughout the country.

In addition to Beirut, CP/GBV staff are posted in four of the field offices supporting service provision across the country. During 2015, UNICEF, working with MoSA and civil society partners (NGOs) reached:

- More than 600,000 children/women at risk and in need of GBV and CP services, which represented 80% of the inter-agency GBV target of those to be reached (720,000) in 251 priority localities;
- 178,500 individuals accessed GBV services through the static safe spaces (the LCRP target for 2015 was 32,000, so services were provided to over 5x the target number);
- 113 service providers as part of the UNICEF programme delivered case management services (of a LCRP target for GBV of 250 service providers);
- 147,789 children and caregivers who received structured and specialized case management and other response services aimed at survivors of violence, exploitation and abuse, including rehabilitation and reintegration of children at risk or formerly associated with armed groups;
- 131,557 children and caregivers who were supported with PSS;
- UNICEF developed CP/GBV life-skills tools for adolescent girls, and 23,163 adolescent girls attended life-skills courses in gateways, well in excess of the 2015 target of 17,500 adolescents;
- 1,569 women and girls accessed socio-economic empowerment activities in safe spaces; more than double the LCO target for 2015 of 600 individuals;
- 157,874 community members who were sensitized on GBV and referral pathways as part of the UNICEF GBV programme (nearly 32 times the 2015 target in the LCRP of 5,000);

114 Figures taken from the CO Annual Report for 2015 and a snapshot of the dashboard relating to UNICEF GBV Results against LCRP Targets, 2015, provided by the CP team.
15 health facilities providing quality care for sexual and GBV survivors (meeting the LCRP target was 15)

286 civil servants in MoSA, MEHE and MoPH were trained on safe identification and referral training.

Mobile safe spaces have extended the coverage for hard-to-reach communities, and 150,000 additional girls and women have been reached through mobile safe spaces.

The LCO is aware that GBV is not restricted to the poorest areas of Lebanon, and that services need to be extended to other areas of the country. A multi-sector household survey is currently being conducted by MoSA and UNICEF to capture data on those areas not targeted as one of the 251 most vulnerable locations which will be used to inform future programming.

One group of women/girls who are not currently being reached are women with disabilities, particularly mental disabilities or mental health issues, who are often not included in referral pathways to specific services, including the UNICEF supported Midway House shelter.

4.6 Efficiency
Measure of outputs versus inputs in terms of having appropriate levels of financial and human resource capacity in place, both within UNICEF and via implementing partners, and how well these have been used to generate outputs.

Funding levels
UNICEF’s delivery of programming to 80% of the GBV sector target for 2014-2015 indicates that (i) the programme budget was commensurate with needs identified by the sector, and (ii) the CP team has been able to use the money it was allocated efficiently to deliver the programme.

Human capacity
In terms of appropriate levels of human resources, the decision to have a dedicated GBVIE Specialist and a National Child Protection Officer focusing on GBV in Beirut, with CP/GBV staff members in four of the field offices, has been a critical success factor in the effective development and delivery of the programme. In the evaluation team’s opinion, it would not have been possible to develop and implement such a comprehensive programme in three years without the technical and management leadership provided by the GBVIE Specialist supported by colleagues in each of the field offices to ensure coordination and programming.

Partnerships
Partnerships are at the core of UNICEF service delivery and the relationships between UNICEF and IPs are key to efficient delivery of programmes. Universally among those interviewed for this evaluation, UNICEF is considered a technically strong and supportive partner, and is “greatly appreciated” and “essential and successful” both for UNICEF’s organisational capacity and the collaborative approach of the GBV staff. However, a number of challenges were highlighted by local and international partners. It should be noted that, while the evaluation team were told of these challenges in the context of this evaluation, they are structural challenges which are common to UNICEF partnerships across all sectors. The team consider that they are important to include here in the light of their impact on GBV programming, while recognising that, as structural/procedural challenges, it will take a response by UNICEF as a whole to address these satisfactorily. Challenges discussed related to:

- Delayed agreement/signing of PCAs compromises the ability of IPs to continue services and retain their skilled staff when there are months between the end of one PCA and the next being signed, and funding released;

115 Quotes from KIIs with INGO partners.
Signing shorter than annual PCAs supports IPs to focus on delivering the programmes rather than writing renewal applications. This observation needs to be seen within the context that, to date, UNICEF is the only UN Agency giving 1 year PCAs (rather than 3 months). However, given the imperative for GBV programming to be implemented over the long term to have any effective results, even if UNICEF is following better practice than other agencies it is still worth noting, understanding, and attempting to address the challenges this causes IPs. It should also be noted that the LCO is planning to draw up multiyear PCAs with some partners.

Defining beneficiary targets in terms of numbers of first time attendees to safe spaces. This emphasis on attracting first time attendees to reach targets for beneficiaries served was felt by some IPs to be a discouragement to re-enroll existing participants for follow up courses, while good practice for GBV programmes includes building long-term relationships of trust between service providers and those at risk/survivors. However, the CP team consider that some IPs are not historically used to reporting against quantitative targets and their views reflect accommodation to a new way of working. Given the importance of being able to demonstrate effectiveness of programming, the evaluation team feel that strong monitoring is in keeping with good programming, and that targets could be set both to encourage repeat participation in courses and also to reach out to new beneficiaries to access the services. 116

Delays in delivering dignity kits (as noted above, this is a procurement issue, not under the control of the CP team but it does affect the programme);117

Frequent sudden, unanticipated and urgent information requests requiring partners to divert from programming;

Unnecessary (according to IPs) and urgent meetings being called118 and multiple requests for field visits made, including for high profile visitors including celebrity ambassadors and donors.119

The GoL, and particularly MoSA, has significant limitations in absorbing and using funds effectively, and its recruitment processes can be very slow, which has meant that a number of social workers to be hired under of the National Plan, to work alongside IPs in the SDCs, are not yet in place. This reduces programme efficiency, particularly as IPs have capacitating social workers as one of their PCA deliverables. However, given the long term benefits of building national resilience and longer-term systems for GBV programmes, this reduction of short-term efficiency needs to be balanced against the longer-term benefits of investing in a sustainable programme.

Value for Money
In terms of value for money, the LCO policy of delivering multi-sector services through gateways is efficient in terms of programme delivery costs for UNICEF, with IPs delivering both CP and GBViE programmes together. In terms of value for money, UNICEF Lebanon has been tracking unit costs for GBViE and CPIE programming: for example, the cost for ‘a caregiver to be provided with quality information’ was US$78 in 2013 and US$32 in mid-2015.

116 KII with IPs, and final workshop discussion
117 For one IP, delivery was delayed by 5 months which has considerable impact when dignity kits are used as incentives to attract people to meetings to inform them on services available under the PCA.
118 One meeting was apparently called with 7 minutes’ notice! Visits require significant preparation, visitors are quite often late and/or come with body guards and convoys which can compromise the levels of trust which IPs have worked hard to build with beneficiaries. On occasion, these visits have resulted in the landlords raising refugee families’ rents because landlords consider that ‘they must be wealthy to be associated with high profile visitors, or have been given money by UNICEF’. (KII with INGO partner).
119 KII with IP
5 PROTECTION OF SEXUAL EXPLOITATION AND ABUSE (PSEA)

During 2013, 80 UNICEF staff were trained on Protection from Sexual Exploitation and Abuse (PSEA), and national and field focal points were identified. During 2014, a further 71 staff were trained on PSEA. UNICEF is a member of the PSEA network in Lebanon.

PSEA has been included in the induction package of training for newly recruited staff to LCO but this is not systematically conducted. All Partnerships include a COC that partners sign (which includes provisions on PSEA and Child Labour), to which the SG bulletin is attached. UNICEF also conducts trainings for partners (and for the sector) on PSEA – in 2016, 6 training workshops on PSEA were organized in partnership with IRC.

As indicated above, the evaluation team found that a number of staff interviewed who have not received training and are, therefore, not well aware of how to respond should they be party to allegations of SEA. No such allegations have been made to the knowledge of LCO staff to date.

It has been agreed, at the inter-agency level, that one community complaint mechanism will be set to ensure harmonization between all agencies, but this has not yet been done.

6 GOOD PRACTICE CASE STUDIES

To follow:
1 Engagement with religious leaders
2 Whole of facility CMR training

7 CONCLUSIONS

Successes

17. The Child Protection team in the Lebanon Country Office (CO) initiated and achieved a very significant expansion of the UNICEF GBViE programme following the declaration of a level 3 (L3) emergency for the Syria crisis in January 2013.

18. The GBViE specific interventions in Lebanon are relevant to the needs of beneficiaries and is consistent with the UNICEF Strategic Plan, the UNICEF Gender Action Plan (GAP) (despite this not being well known in the CO) and the newly developed corporate Theory of Change for GBViE. They are also consistent with much of the draft GBViE Programme Resource Pack, which sets out UNICEF’s good practice programming for GBViE specific programming.

19. From its inception, the GBViE programme has included service provision, prevention and capacity strengthening of national partners. This comprehensive approach addresses immediate needs of survivors and those at risk, while promoting sustainable approaches to GBV prevention and response.

20. The development of a standard programme for all implementing partners (IPs) to implement in safe spaces as a minimum, together with the policy of expanding the numbers of IPs delivering GBV programming, has ensured that basic GBV programming has been made available to vulnerable women and girls throughout Lebanon, with additional specialist response services being available to communities through referrals to facilities/NGOs offering those services.
21. The twin-track approach adopted throughout the GBViE response of supporting and building capacity of both government and civil society promotes the development of a broad base from which to support on-going expansion of GBV programming, notwithstanding the capacity constraints of the GoL, and the risk that government capacity may not increase significantly over the course of the new country programme.

22. The successful agreement, and current implementation, of the Ministry of Social Affairs (MoSA) National Plan to Safeguard Women and Children represents a major policy achievement; and UNICEF’s influence in its development demonstrates the close and productive relationship which the agency has with the GoL, and how it is using its influence to address GBViE.

23. UNICEF and its partners have developed a number of innovative approaches contributing to overall effectiveness of the programme, including the whole of facility clinical management of rape (CMR) training, engagement with religious leaders as champions and mobile safe spaces.

24. Success factors contributing to the Lebanon Country Office (LCO’s) ability to support quality GBV interventions include:
   - Recruitment of a dedicated, capable GBViE Specialist and National Officer level B who have been in post from the start of the L3 response. These staff positions will be continued into the new Country Programme Document (CPD) as part of a discrete GBV team;
   - Strong support by the Deputy Representative and Chief, Child Protection (CP), despite GBViE not being a UNICEF Middle East North Africa (MENA) regional priority for the Syria crisis response;
   - UNICEF having an established relationship of trust with the GoL, backed by funds available to implement programming;
   - The UNICEF response overall has been very well supported by donors throughout, which has allowed significant resources to be devoted to GBViE. Funds are being channelled through international agencies rather than to the GoL, which has strengthened UNICEF’s influence in shaping the humanitarian response. UNICEF has received by far the largest proportion of GBViE funding of any agency in Lebanon, demonstrating the high level of donor trust in the UNICEF Lebanon CO.
   - Availability in Lebanon of strong international and local non-government organisation partners with experience in GBViE programming;
   - The use of gateways as entry points for convergent multi-sector service provision which has reduced the stigma which would be attached to accessing dedicated GBViE services. The spaces are generally considered safe by women and girls and their male relatives.

25. The planned strengthening of social norms programming within the new CPD is highly appropriate for this stage of the GBViE response.

26. The LCO plans to conduct four evaluations over the next year, one of which will be of the whole CP programme. The findings from this report should inform that evaluation.

27. The LCO is fully aware that levels of funding are likely to be significantly reduced in the next few years. The CP team and the rest of the LCO is clear that the current GBViE programme includes a focus on leaving a significantly stronger system of service provision and real changes in attitudes towards the acceptability of GBV and its incidence in Lebanon among all communities. This goal will underlie the transition to non-crisis GBV programming.
**Gaps/Challenges**

28. The principle shortcoming of the programme is a lack of systematic integration of GBViE activities/approaches across all programme sections with the exception of the CP section. There are examples of cooperation between GBV and other sectors, such as the the CMR-related activities under Health and Nutrition; but while the GBV Programme has supported GBV training with other sections (sometimes in response to their requests), there is a lack of ownership among other sections on taking responsibility to integrate GBV risk mitigation routinely across their programmes. Given UNICEF’

29. Despite economic hardship being a key contributor to child marriage and increased levels of other types of GBViE, the GoL ban on refugees working has meant that economic strengthening needs of women and girls accessing safe spaces are not being met. Although existing socio-economic activities offer opportunities for social support, they do not address the severe economic hardship of many refugee households, a point of concern repeatedly raised by focus group participants. The GBV Unit has been coordinating with the LCO Social Cohesion and Livelihoods sector to strategize about how this area can be tackled, which is imperative to addressing a key contributing factor to GBV among Syrian refugees.120

30. UNICEF Lebanon is using relatively sophisticated information management and programme monitoring systems, including Equitrack and ActivityInfo. However, it remains a challenge to demonstrate programme results (beyond delivery of activities) in terms of levels of enhanced protection of children and women from GBV and changes in their wellbeing through GBViE service delivery. The CP team is aware of this and has sought help from external institutes and UNICEF HQ to develop/adapt tools.

31. UNICEF Lebanon is highly valued as a partner. However, some administrative practices are challenging for Implementing Partners. These include the numbers and frequency of programme changes and demands for additional information, and the emphasis on reaching targets for first-time beneficiaries reached which, several partners consider, do not support quality programming. (These practices are common to UNICEF as a whole and not specific to the GBV programme).

32. UNICEF’s withdrawal from co-chairing the SGBV Task Force has caused real concern to partners, (which the evaluation team shares). There is a perception that this change will negatively impact the sector, given that UNICEF has the largest GBV programme and considerable influence with the GoL.

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120 Of potential relevance to addressing the issue of refugee livelihoods, the LCRP includes provision for a livelihoods response with a MoSA-led Livelihoods Strategy, which it might be possible for UNICEF to explore further. The LCRP states: “The livelihood response will deliver, in full accordance with Lebanese labour laws and regulations, rapid-impact job creation initiatives targeting vulnerable groups, MSMEs, small farmers, and invest in the skills of young people and adolescents based on the Making Markets Work for the Poor (M4P) approach. It will also promote national economic and social safety-net reforms, an SME strategy, social protection reforms, and a MoSA-led National Livelihoods Strategy. Under the auspices of this strategy further creative solutions around livelihoods for de facto refugees from Syria will be explored during Phase I of the LCRP, through a consultative approach between with Ministry of Social Affairs, Ministry of Economy and Trade, Ministry of Foreign Affairs, Ministry of Labour, other line ministries, response partners and international experts.” (p23) Which suggests that there will be space for UNICEF to work with the MoSA and other ministries to augment livelihoods opportunities for refugees and poorer Lebanese.
RECOMMENDATIONS

Recommendation 1: Strengthen integration of GBViE activities/approaches across all UNICEF sectors in line with 2015 IASC GBViE Guidelines recommendations, including in the new CPD.

d. All UNICEF sectors adopt appropriate recommendations for each part of the programme cycle from 2015 IASC GBViE Guidelines, with one indicator per sector to be monitored regularly, and Chiefs of Sections take personal responsibility for ensuring that these are systematically integrated across their programming.121

e. Ensure that all technical sections are briefed and helped to understand the relevant sections of the GBViE Guidelines to help improve understanding across the office that practical achievable solutions to reducing GBV risks are available, and will add value to existing programmes. This could take the form of a support mission from UNICEF HQ for an external expert to visit LCO, provide initial trainings on the revised IASC GBViE Guidelines, and develop a training plan for on-going and sustained integration of GBViE across all sections of the new LCO country programme.

f. As part of this integration, identify and use entry points strengthening GBViE components, eg WASH programme, RACE 2, Youth sections programmes and No Lost Generation for Education sector.

g. Identify a few GBV specific indicators for monthly review during Programme Group Meetings by LCO Senior Staff.

Lead Responsibility: Senior CO staff (Deputy Representative and Chiefs of Sections), sustained support from GBViE Specialist in CPS, PD, HQ; MENARO CP Advisor and LCO GBViE Specialist for introduction of the 2015 GBViE Guidelines122 as required

When: 2016, to ensure each sector takes GBViE into account in the new CPD.

Recommendation 2: Building on current best practice, and in the likely context of greatly reduced funding over the next few years, contextualise established models for transitioning from emergency to post-emergency GBV programming, with the aim of developing high impact programmes which are also taken to scale to address the level of need.

d. Service delivery: Taking the Government of Lebanon (GoL) ban on refugees working into account, consider additional creative ways (including within the MoSA Livelihoods Strategy) to support livelihoods and economic strengthening programmes as key contributors to reducing GBV.

e. Prevention: As planned, expand existing social norms programming, informed by assessments of the specifics relevant for different communities and age groups, to tackle the deep social attitudes underlying the many forms of GBV faced by women and girls.

f. Capacity strengthening: Continue to ensure a balance of NGO and GoL capacity strengthening going forward, with a particular emphasis on expanding support to civil society women’s groups who can be empowered to create and lead on social change within Lebanon.

Lead Responsibility: GBViE team, Chief CP

Recommendation 3: Maintain a distinct GBViE sub-team under the leadership of the GBViE Specialist in order to facilitate UNICEF’s leadership on GBV at the national level, and ensure GBV specialist capacity within UNICEF at the sub-national level.123

121 See respective sectors of the 2015 IASC GBViE Guidelines for suggested indicators
122 NB Lebanon has not been selected as a designated CO for rolling out the 2015 GBViE Guidelines under the Implementation Plan. However, UNICEF HQ have indicated that they will support the LCO in this process.
123 This recommendation has been formally endorsed under the new PBR for the new CPD starting 2017 with an enlarged dedicated GBV as a separate unit.
c. Maintain the position of GBViE Specialist in the new LCO CP structure,\textsuperscript{124} who will lead and have oversight over all aspects of the GBViE programme to ensure that the programme retains coherence across all interventions, (including prevention, service delivery, capacity development, social norms programming, justice and legal inputs).

d. Ensure sub-national offices have staff with GBV expertise as part of the transition from the immediate response to longer-term programming.

Lead responsibility: Chief, CP
When: Implementation of the CPD

**Recommendation 4:** Strengthen evidence base to demonstrate programme effectiveness and collate and disseminate good programme practice regionally and globally.

d. Dedicate capacity within and outside the CP team to document innovative and best practice programmes while the current staff with institutional memory (Deputy Representative, Chief CP and GBViE Specialist) remain in position.

*Lead responsibility:* Chief, CP to designate. Staff members to ensure dedicated time.
*When:* ASAP to capture the institutional memory of current staff

c. Disseminate collated good practice and innovative programmes within the country, regionally and globally so that other COs and partners can benefit. Proactively seek opportunities to share learning and successes from this flagship GBViE programme within MENARO and at HQ, and at workshops and learning events outside UNICEF. Proactively seek opportunities to share experience of this flagship GBViE programme, within Lebanon, regionally and globally.

*Lead responsibility:* CO Representative, CO Deputy Representative, Chief CP, GBViE Specialist.
*When:* Ongoing

f. Once developed and tested, share the new M&E and IM tools being developed for GBV by UNICEF and by the SGBV Task Force across UNICEF and more widely with partners, to address the general challenge of demonstrating effectiveness of GBViE programming in contributing to reduced risk of GBV and increased safety for those most at risk of GBV. As necessary, draw on support from HQ and MENARO, work with local and regional institutes, and build IP capacity on data collection, analysis and reporting as necessary to be able to report on outcome and impact level results.

*Lead responsibility:* GBViE team, CP Chief, SPPME team, MENARO CP Advisor, GBViE Specialist, CPS, HQ
*When:* Once tools are developed and have been tested and proven

**Recommendation 5:** While continuing to build LNGO capacity to deliver high quality programmes and enhance their management skills, as far as possible within existing UNICEF procedures/systems, take action to reduce unnecessary reporting and administrative demands and activities for partners:

h. Review targets to include existing course participants and also new participants. This will support longer-term relationships between service providers as well as seeking to engage new beneficiaries and expand the reach of programming.

i. Where possible, agree multi-year agreements for GBV services to allow partners the necessary time to establish trust with communities on issues pertaining to GBV, even if budgets can only be confirmed

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\textsuperscript{124} With the planned recruitment of additional staff being recruited who will engage with both CP and GBV programmes
year by year. Provide as much clarity as possible re PCA termination and try and eliminate contract gaps in renewals so that expertise is not lost.

j. Continue with capacity strengthening/mentoring of LNGOs by INGOs as part of a long-term plan for transition to national ownership, reviewing whether the transition time to handover is realistic for local NGOs to be fully competent to deal with survivors, case management and capacity strengthening for other service providers.

Lead responsibility: LCO Deputy Representative (responsible for LCO procedures/systems), Chief CP, GBViE Specialist, SPPME, Reporting and Partnership staff in LCO

When: Immediately and renewal of PCAs

Recommendation 6: Review current coordination arrangements of the SGBV125 Task Force, to ensure a continued, effective response at national and sub-national levels with current coordination arrangements, and consider whether UNICEF should take up co-chair again if current arrangements are compromising the strength of the programme.

Review nationally and at field level at mid year 2016, to ensure that interagency coordination at national and field levels continues to support effective GBViE response and revisit the decision to relinquish leadership if it is not.

Lead Responsibility: Representative, Deputy Representative

When: Mid 2016

Annex 1: Evaluation Questions

Relevance
1. To what extent is UNICEF GBVIE programming for care, support, protection, and risk reduction based on:
   a. assessed needs and data analysis? (Are the different needs of needs of women, adolescents, and children considered separately?)
   b. established good practice for GBVIE service provision, risk reduction and prevention? (Is UNICEF employing the most appropriate strategies to ensure further violence is reduced and survivors provided with appropriate services and support?)

2. To what extent has risk reduction been integrated into other UNICEF sector programmes?

3. To what extent do GBVIE programmes adapt to changing needs, and how well are the changing needs documented?

4. How well have views of survivors and other high risk groups (adolescent girls, women, children) been reflected in programme assessment, design, implementation and monitoring? (covers AAP)

5. Are programmes built on a clear Theory of Change for GBVIE programming? To what extent is this consistent with a corporate/regional Theory of Change and with UNICEF standards and guidelines expressed through the CCCs or elsewhere?)

6. To what extent has a HRBA been taken in design, implementation, and monitoring of GBViE programming?

Effectiveness
7. To what extent have UNICEF GBVIE programmes improved survivors’ access to quality, life-saving, multi-sectoral services for care and support?

8. How quickly has UNICEF been able to establish services at the scale required?

9. To what extent has the programme contributed to preventing and mitigating risks of GBV for women, adolescents and children?

10. Are programme objectives clear and specific for different GBViE areas of programming? How far have programme objectives been achieved / likely to be achieved?

11. Which have been the most/least effective programmes? Why?

12. How systematically have results been captured/used/learned from?

125 As UNICEF addresses GBV this is the term used throughout the report with the exception of the Sexual and Gender-based Violence (SGBV) Task Force
13. How and how effectively has 1) UNICEF leadership and 2) technical support from HQ, regional and country levels contributed to the effectiveness of UNICEF GBViE programming? Including ensuring that GBViE is included in the earliest response strategies and funding priorities?

**Connectedness and Sustainability**

14. How, and how effectively does UNICEF GBViE programme design and implementation link emergency programming with UNICEF’s longer-term programming to prevent and respond to GBV? Is UNICEF’s approach to GBViE built into its conceptualisation and implementation of sustainable resilience programming?

15. How effectively have partnerships with civil society and government been built to address planned GBViE outcomes?

16. How and to what extent has the capacity of local and national partners been strengthened through the programme?

17. To what extent has UNICEF’s internal and external advocacy contributed to improved GBV response and prevention? (Including clarifying UNICEF’s specific programme and leadership roles?)

**Coordination**

18. To what extent are programmes consistent with good practice (Resource Pack and revised GBViE Guidelines)?

19. Does/how does UNICEF add value to the GBViE response (through leadership, standard setting, coordination)?

**Coverage**

20. Are there any gaps in GBViE programming (specialised and integrated) in terms of geographical and demographic coverage? - how has UNICEF (a) identified the gaps and (b) taken action to close the gaps?

**Efficiency**

21. To what extent have UNICEF financial and human resource inputs been commensurate/adequate to the task of meeting GBV programming need?

22. To what extent have UNICEF inputs achieved value for money outputs?

**Annex 2: Interviews/Workshops participants**

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<tr>
<th>Name</th>
<th>Organization</th>
<th>Position</th>
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<tbody>
<tr>
<td>Tanya Chapuisat</td>
<td>UNICEF – Management</td>
<td>Representative</td>
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<tr>
<td>Luciano Calestini</td>
<td>UNICEF – Management</td>
<td>Deputy Representative</td>
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<tr>
<td>Anthony MacDonald</td>
<td>UNICEF – CP</td>
<td>Chief, Child Protection</td>
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<td>Yuko Osawa</td>
<td>UNICEF – CP</td>
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<td>Jihane Latrous</td>
<td>UNICEF – CP</td>
<td>GBViE Specialist</td>
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<td>Nithiaraj Sellappu</td>
<td>UNICEF – CP</td>
<td>CPiE Sector Coordinator</td>
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<td>Nisrine Tawily Najjar</td>
<td>UNICEF – CP</td>
<td>Programme Officer, GBV</td>
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<tr>
<td>Rania Zakha</td>
<td>UNICEF – Education</td>
<td>Education Specialist</td>
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<tr>
<td>Aurelia Ardito</td>
<td>UNICEF – Education</td>
<td>Education Specialist</td>
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<tr>
<td>Violet Speek-Warnery</td>
<td>UNICEF – Field Operations</td>
<td>Chief, Field Operations</td>
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<td>Carina McCabe</td>
<td>UNICEF – Health and Nutrition</td>
<td>Programme Manager</td>
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<td>Zeroual Azzedine</td>
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<td>Meri Poghososyan</td>
<td>UNICEF – SPPME</td>
<td>SPPME Specialist, and disability</td>
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<td>Hrayr Wannis</td>
<td>UNICEF – SPPME</td>
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<td>Rodolphe Ghossoub</td>
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<td>IM Officer</td>
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<td>Jacqueline Chu-Montell</td>
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<td>Reports Specialist</td>
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<td>Jens Grimm</td>
<td>UNICEF – Supply</td>
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<td>Oliver Thonet</td>
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<td>Daila Ktaiche</td>
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<td>Jorge Bica</td>
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<td>Dren Rexha</td>
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<td>Amal Obeid</td>
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<td>Selina Yamout</td>
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<td>Lorenza Trulli</td>
<td>UNHCR</td>
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<td>Aung Thu Win</td>
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<td>SGBV TF, IM Expert</td>
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<tr>
<td>Natalie Abboud</td>
<td>Government - MoSA</td>
<td>Social Worker, GBV focal point</td>
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<td>Faten Ghanem</td>
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<td>GBV Coordinator for National Plan</td>
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<td>Dolly Chami</td>
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<td>Director SDC, Jbeil</td>
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<td>Wafa Kanaan</td>
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<td>Carine Hazim</td>
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<td>Child Care Assistant</td>
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<td>Stephanie Diab</td>
<td>ABAAD</td>
<td>Community Outreach Mobiliser</td>
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<tr>
<td>Lesy Mina</td>
<td>ABAAD</td>
<td>Community Outreach Mobiliser</td>
<td>F</td>
</tr>
<tr>
<td>Zeina Yaghi</td>
<td>ABAAD</td>
<td>GBV Case Worker</td>
<td>F</td>
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<tr>
<td>Jessica Chouoair</td>
<td>ABAAD</td>
<td>PSS Social Worker</td>
<td>F</td>
</tr>
<tr>
<td>Eliana Aslan</td>
<td>KAF  A</td>
<td>Centre Supervisor, Adolescent friendly space</td>
<td>F</td>
</tr>
<tr>
<td>Salwa el Homsi</td>
<td>KAF  A</td>
<td>Communications Officer</td>
<td>F</td>
</tr>
<tr>
<td>(2 female staff, names not noted)</td>
<td>Akkar Network for Development</td>
<td>F</td>
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</tr>
<tr>
<td>Michel Dai</td>
<td>Lecovaw</td>
<td>Project Coordinator</td>
<td>M</td>
</tr>
<tr>
<td>Liliane Salloum</td>
<td>DRC</td>
<td>GBV Coordinator</td>
<td>F</td>
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<tr>
<td>Rita Michael</td>
<td>DRC</td>
<td>Protection Manager</td>
<td>F</td>
</tr>
<tr>
<td>Nada Hanna</td>
<td>Heartland Alliance</td>
<td>GBV Programme Manager</td>
<td>F</td>
</tr>
<tr>
<td>Nicole</td>
<td>Heartland Alliance</td>
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<tr>
<td>Sunia Palekar</td>
<td>IRC</td>
<td>Women's Protection and Empowerment Coordinator</td>
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<tr>
<td>Sandra</td>
<td>IRC</td>
<td>Women's Protection and Empowerment Manager</td>
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<tr>
<td>(3 members of centre team, names not noted)</td>
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<td></td>
<td>F</td>
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<tr>
<td>Lina Abirafeh</td>
<td>Lebanese American University</td>
<td>Director, Institute for Women’s Studies in the Arab World (IWSAW)</td>
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</tr>
<tr>
<td>Moufeeda Haidar</td>
<td>National Consultant</td>
<td>Trainer, Living Skills Programme, IWSAW</td>
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</tr>
<tr>
<td>Mohammad Yaghi</td>
<td>National Consultant</td>
<td>Area manager, Himaya (LNGO, North Bekaa)</td>
<td>M</td>
</tr>
</tbody>
</table>
## Annex 3: Mission Itinerary

<table>
<thead>
<tr>
<th>Time</th>
<th>Tuesday 16th</th>
<th>Wednesday 17th</th>
<th>Thursday 18th</th>
<th>Friday 19th</th>
<th>Monday 22nd</th>
</tr>
</thead>
<tbody>
<tr>
<td>9am</td>
<td>Training of national consultants</td>
<td>Meeting with Youth Section</td>
<td>Meeting with GBViE Specialist</td>
<td>Meeting with MoPH (Beirut)</td>
<td>Visit to KAFA (Bekaa)</td>
</tr>
<tr>
<td>10am</td>
<td></td>
<td>Meeting with Health &amp; Nutrition Section</td>
<td>Meeting with Education Section</td>
<td>Meeting with MoSA</td>
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<tr>
<td>11am</td>
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<td>Travel</td>
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<tr>
<td>11.30am</td>
<td>Meeting with Reports Officer</td>
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<tr>
<td>12pm</td>
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<tr>
<td>12.30pm</td>
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<tr>
<td>1pm</td>
<td>Meeting with Chief, CP</td>
<td>Meeting with UNHCR/UNFPA</td>
<td>Visit to SDC jbeil</td>
<td>Visit to Midway House</td>
<td>Visit to Lecorwaw Tripoli</td>
</tr>
<tr>
<td>2pm</td>
<td>Meeting with GBViE Specialist</td>
<td>Meeting with Comms Team</td>
<td>ABAAD</td>
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<tr>
<td>2.30pm</td>
<td>Meeting with Comms Team</td>
<td>Security Briefing</td>
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<tr>
<td>3pm</td>
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<tr>
<td>4pm</td>
<td>Meeting with GBViMS Coordinator (UNHCR)</td>
<td>Meeting with WASH Section</td>
<td>Meeting with Supply Section</td>
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<tr>
<td>4.30pm</td>
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<tr>
<td>5 pm</td>
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</tbody>
</table>
Annex 4: Bibliography

IASC Guidelines for Integrating Gender-based Violence in Humanitarian Action, 2015
Draft GBVIE Programme Resource Pack, CPS, UNICEF
UNICEF Lebanon Humanitarian Resilience and Response Plan 2016, Final
Lebanon Crisis Response Plan, Year Two, 2015-2016
2015-2016 Rolling Workplan between the Ministry of Social Affairs and UNICEF
Syria Regional Refugee and Resilience Plan (3RP), UNHCR/UNDP
My Safety, My Wellbeing: Adolescent Girls Targeted Initiative, IRC Lebanon
Emergency Rapid Assessment of Health Facilities for Survivors of Gender Based Violence (CMR assessments)
Syria: A Regional Crisis, The IRC Commission on Syrian Refugees, January 2013
The 4Ws in Lebanon: Who’s doing what, where and until when in Mental Health and Psychosocial Support, April 2015, MoPH with IMC, WHO and UNICEF
Mariage Précoce: Illusion où Réalité? Survey on the types of early marriage among Lebanese and Syrian refugees in Lebanon, Carole Alsharabati & Hala Soubraitani (no date)
Increasing Access, Increasing Healing: Mobile Approach to GBV Service Provision and Community Mobilisation in Lebanon, IRC (no date)
Sexual and Gender-based Violence Prevention and Response in Refugee Situations in the Middle East and North Africa, 2015, UNHCR
Institutional Learning on Tdh Engagement with Religious Leaders to Promote Child Protection and Combat GBV in the Context of the Syrian Crisis, Terre des Hommes
Are we Listening?: Acting on our commitments to women and girls affected by the Syrian conflict, September 2014, IRC
http://nolostgeneration.org/about
Inter-Agency Standard Operating Procedures (SOPs) for SGBV prevention and response in Lebanon (endorsed December 2014)
Inter-Agency Q&A on Humanitarian Assistance and Services in Lebanon (INQAL), Updated April 2015
IRC proposal: Support to emergency-affected women and children in Lebanon’s North, Bekaa and Mt Lebanon Governorates, 8 October 2013 – 8 October 2014
PCA with KAFA: Protecting children and adolescents from GBV (phase), 1 March 2015 – 1 March 2016
Project Document: Terre des Hommes
PCA with ABAAD: Ending GBV: Towards standardization and strengthening quality of services and direct response,
1 June 2015 – 31 May 2016

SGBV Taskforce (Protection Sector) Number of Partners per Caza/District, April – June 2015


UNICEF Factsheet on Child Marriage, September 2015

UNICEF Factsheet on GBV, September 2015

SGBV Sector, Quarterly Dashboard, Jan – Mar 2015

SGBV Task Force, Activities Map, January - April 2015

SGBV Sector, Mid-year Dashboard, June 2015

SGBV Sector, Dashboard, November 2015

UNICEF Syria Crisis, SitRep, 2015

Equality in Humanitarian Action: GBV UNICEF Intervention in 2015 in Gateways within most vulnerable locations, Data from ActivityInfo for January – December 2015


Increasing Access, Increasing Healing: Mobile approach to GBV Service Provision and Community Mobilization in Lebanon, IRC

Summary Results Matrix, Lebanon Country Programme Results 2010 – 2014
ANNEX 5: TOOLS DEVELOPED BY UNICEF LEBANON SINCE 2013

Child Protection Policy (2013) developed by UNICEF/KAFA
The policy was developed to serve as a reference and a code of conduct for all organizations implementing child protection activities as part of their emergency program in response to the Syrian crisis.

Citadel of Protection (2013) developed by KAFA/UNICEF
Facilitators’ manual on child protection and GBV in emergencies.
Contains 3 modules: children, adolescents, and caregivers’ modules.
Tools aims at:
- Raising awareness on sexual violence
- Raising awareness on GBV and Child marriage
- Equipping children with skills that help them protect themselves and protecting their bodies from all forms of violence

The caregivers’ module includes:
- Challenges faced by caregivers in emergencies
- Child rights
- Impact of violence on children
- Gender
- Role of caregivers in educating children on gender equality
- Sexual violence
- Child Marriage
- Risks faced by children during emergencies
- Coping with stress
The tool includes posters and a board game.

Child Marriage Video (2014) developed by UNICEF/ABAAD with funding from EU
A GBV animated video on Child Marriage was developed in 2014 in consultation with girls, boys, as well as male and female caregivers and used at awareness raising session, followed by discussion groups facilitated by trained outreach volunteers and social workers. Supplementing the video, posters and leaflets with key messages on the Child Marriage were printed and distributed through the outreach volunteers at awareness raising sessions.

- Images from the video

Parenting Skills Training Printed and adapted for Lebanon by IRC with support from UNICEF and AUSAid.
A facilitators’ manual that is used in working with caregivers to achieve the following objectives:

- To understand child development and the role that parents play in their child’s health development
- To learn about and understand principles of learning and child behaviour management
- To gain skills to help and support parents create nurturing, positive relationships with their children
- To learn how to consistently follow the Healing Families curriculum and implement the training sessions

**Translation of the Caring for Child Survivors’ of Sexual Violence Tool (2011) into Arabic**

A tool that includes information and analysis on current best practice and evidenced-based approaches to case management and psychosocial & mental health interventions; tailored health care and treatment for child survivors of sexual abuse; and considerations for improving multi-sector collaboration across child protection, gender-based violence (GBV) and health sectors.

In 2014, UNICEF supported the translation of the Global tool into Arabic.

**Animated video on SRHR targeting Adolescent Girls (2013)** developed by UNICEF/ABAAD with funding from the EU

[https://www.youtube.com/watch?v=7JTng_dOln0&list=PLyPaiAM6tjFj5peZqWJJF5e7XCbRrxVGr](https://www.youtube.com/watch?v=7JTng_dOln0&list=PLyPaiAM6tjFj5peZqWJJF5e7XCbRrxVGr)

Targeting adolescent on:

- Changes to their bodies as they grow
- Menstrual cycle and hygiene
- Pregnancy and risks of early pregnancy
- How to protect their body from diseases, including STIs
- Protection from sexual violence and know where and how to seek help