



EVALUATION OF IMPLEMENTATION OF 2005 IASC GUIDELINES FOR GENDER-BASED VIOLENCE INTERVENTIONS IN HUMANITARIAN SETTINGS IN THE SYRIA CRISIS RESPONSE



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EXECUTIVE SUMMARY

The Inter-Agency Standing Committee (IASC) Guidelines for Gender-based Violence Interventions in Humanitarian Settings: Focusing on Prevention of and Response to Sexual Violence in Emergencies (IASC GBV Guidelines 2005) state that all humanitarian actors must act under the assumption that gender-based violence (GBV) is occurring and constitutes a life-threatening protection issue, regardless of the existence of evidence. Moreover, the IASC GBV Guidelines require humanitarian actors across all sectors to respond to and prevent GBV.

Assessment reports from United Nations agencies, along with a range of NGOs, have repeatedly highlighted risks facing refugee women and girls. A report published by the International Rescue Committee (IRC) (2014) entitled, *Are We Listening? Acting on Our Commitments to Women and Girls Affected by the Syrian Conflict*, highlighted a significant gap between policy and practice of GBV prevention and response in humanitarian operations responding to the Syrian crisis.

As per a recommendation from this report, in 2015 The United Nations Population Fund (UNFPA) and the United Nations High Commission for Refugees (UNHCR), in cooperation with the United Nations Children's Fund (UNICEF), the International Rescue Committee and the International Medical Corps conducted an evaluation of the humanitarian system's response to GBV within the context of the Syrian crisis.

The purpose of the evaluation was to examine the extent to which the humanitarian community has implemented the 2005 IASC GBV Guidelines on GBV prevention and response and ensure that such learning informs and improves the effective implementation of similar guidance in both the immediate and longer term future. The outcomes of the evaluation will be used to improve future GBV programming and to inform the regional roll out and implementation process of the 2015 revised IASC GBV Guidelines (Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing Risk, Promoting Resilience and Aiding Recovery).

The evaluation conducted in the Kurdistan Region of Iraq (KR-I), Jordan, Lebanon and Northern Syria focused on evaluating two humanitarian sectors in each country as prioritised by the countries' GBV/sexual and gender-based violence (SGBV) sub-cluster/working groups. The Health, Shelter, Water, Sanitation and Hygiene (WASH) sectors were evaluated through semi-structured in-depth interviews with respondents representing donor institutions, local and international humanitarian organisations programming in the selected sectors as well as focus group discussions (FGDs) with women, girls, men and boys. The evaluation also included a desk review of key strategic planning and funding documents guiding interventions across the selected sectors.

There were five overarching findings identified through the evaluation:

FINDING 1:

THE IASC GUIDELINES FOR THE PREVENTION OF AND RESPONSE TO GBV (FORTHWITH REFERENCED AS THE GBV GUIDELINES) ARE NOT WELL KNOWN AND ARE NOT BEING USED IN PROGRAMMING PRACTICE.

The evaluation demonstrated that the majority of key informants had general information about the GBV Guidelines. Most knew that the GBV Guidelines existed and assumed that they had, at some point, influenced other guiding documents (primarily Sphere¹ standards, internal organisational guidelines and policies, cluster strategies) they reference in their daily work. Sector actors exhibited a good awareness level of women's and girls' increased vulnerability to GBV during a humanitarian crisis and consistently acknowledged the importance of addressing GBV. However, the majority of sector actors were not familiar with the minimum standards of GBV prevention and response that constitute the responsibility of their respective sectors according to IASC GBV Guidelines. The majority of organisations across sectors evaluated did not use the GBV Guidelines in programme assessment, design, development, implementation or evaluation. These actors preferred to draw on their own internal guidance (global cluster guides, technical guidelines, protection handbooks, guidelines on project development, frameworks, protocols and training manuals) and Sphere guidance (standards, key actions, key indicators and guidance notes)².

Among donors, knowledge of the Guidelines was broad but use extremely limited, with a preference for use of internal donor guidance and policy documents³.

FINDING 2:

THE STANDARDS IN THE GBV GUIDELINES ARE NOT INCORPORATED CONSISTENTLY IN ORGANISATIONAL OR SECTOR-SPECIFIC STRATEGIC DOCUMENTS AND STANDARDS.

The minimum standards for GBV prevention and response outlined in the GBV Guidelines are not incorporated consistently in regional and country-specific strategic documents (e.g. regional response plans (RRPs)) which outline sector technical and strategic priorities, objectives and indicators. The extent of incorporation of minimum standards into strategic plans was lower in the Shelter and WASH sectors than the Health sector. Some actors assume that if general protection measures are incorporated into programming, GBV issues will be covered automatically, further leading to the inconsistent application of standards. Furthermore, adherence to minimum standards also varied in implementation according to location, whereby generally higher implementation was referenced in well-established camp settings compared to urban settings and the informal tented settlements (ITS). This difference was justified by respondents as being due to the fact that 2005 IASC GBV Guidelines are geared towards camp settings and were seen as lacking clear and relevant guidance for operations in urban areas and ITS.

1. Sphere Project, *Humanitarian Charter and Minimum Standards in Disaster Response*, 2011. <http://www.sphereproject.org/handbook/>, last accessed September 1, 2015.

2. Many of these documents may have drawn from the GBV guidelines, but no one interviewed knew.

3. Documents that describe donor institutions' vision of the desired state of affairs in specific areas and preferred ways to achieve it. E.g. USAID/OFDA *Guidance for Protection and Code of Conduct Requirements*.

It is important to note that the evaluation revealed a number of good practices implemented across the three sectors contributing towards GBV prevention and response. However, overall organisations tended to implement GBV standards haphazardly rather than incorporate the full range of minimum standards of GBV prevention and response in a comprehensive, consistent and strategically guided way.

FINDING 3:

SECTORS ARE NOT HELD ACCOUNTABLE FOR FAILING TO INCORPORATE THE GBV RESPONSE AND PREVENTION MINIMUM STANDARDS OUTLINED IN THE GBV GUIDELINES.

Existing mechanisms of accountability are weak and do not provide a clear and comprehensive framework for holding sector coordinators and member organisations accountable to ensuring minimum standards of GBV prevention and response are integrated throughout programming and form an integral part of sector strategies and objectives. The desk review of strategic documents (RRPs, strategic response plans (SRPs)) highlights that over the span of the response, country overviews, which preface sector-specific strategies in annual strategic documents, increasingly articulate protection risks, including GBV, and appeal for multi-sector responses. However, the desk review revealed that the WASH, Shelter and to a lesser extent Health sector strategies in the RRP and SRPs do not include a comprehensive sex and age-specific assessment of needs, tailored and sector-specific designed activities,

and related indicators to prevent and respond to GBV as part of their sector strategy. The evaluation mirrors the desk review revealing partial or no implementation of the minimum standards in practice. It also highlights a lack of accountability, as there have been no instances in which sectors were held accountable for failing to incorporate the minimum standards.

Amongst donors, the evaluation found a certain level of commitment to GBV minimum standards. Donor respondents mentioned their calls for proposals issued listed requirements to include GBV-related standards, and that both the eligibility of submissions and the decision to allocate funding did take into consideration the articulation of GBV-related standards. However, although some donors require a stated commitment to comply with GBV minimum standards, accountability mechanisms for evaluating whether GBV commitments are fulfilled once funding is granted are not enforced. Based on the consultations with donors, no partner has been penalised in any form for failing to incorporate required GBV prevention and response measures into their work.

FINDING 4:

SECTORS EXPECT AND ASSUME THAT SGBV WORKING GROUPS/ GBV SUB-CLUSTERS ARE EXCLUSIVELY RESPONSIBLE FOR SENSITISATION, MONITORING AND IMPLEMENTATION OF THE GBV GUIDELINES.

The evaluation found that the onus for many actions related to the GBV Guidelines – including training, information dissemination,

mainstreaming and even implementation – fell on the SGBV working groups/ GBV sub-cluster. The Health, Shelter and WASH sector actors often expected the SGBV working groups/ GBV sub-clusters to provide *both* leadership in introducing GBV elements into other sectors, *and* the actual implementation of GBV-related measures within those sectors' programmes. While the evaluation revealed several examples of good practices involving successful coordination between the evaluated sectors and the SGBV working groups/GBV sub-clusters, overall the Health, Shelter and WASH sectors did not exhibit sufficient levels of leadership in introducing measures to prevent and respond to GBV within their sector. The finding is supported by the IASC operational peer reviews (OPRs)⁴ conducted in Iraq and Syria in May and June of 2015.

FINDING 5:

SECTORS RARELY INCLUDE, ENGAGE WITH OR HOLD THEMSELVES ACCOUNTABLE TO WOMEN AND GIRLS IN A MEANINGFUL, CONSISTENT AND ROUTINE MANNER.

Many Health, Shelter and WASH organisations initiate consultations with refugee women and girls. Some conduct these consultations regularly and the evaluation identified several examples when productive and timely consultations with refugee women and girls helped organisations make appropriate adjustments to their services. However, these consultations are mostly ad-hoc and rarely followed up with a report back to the women and girls' beneficiaries on why their input

was or was not incorporated into practice. This is substantiated by findings from the May 2015 IASC Iraq and Syria OPRs. Female FGD participants related that in urban areas, in ITs and some camps, the channels of communication are sometimes monopolised by a certain group/category among the refugee community, typically community leaders and power-holders who are always men with connections. As women are often excluded from opportunities to serve in community leadership structures, they are marginalised and silenced in discussions and decision-making. When women and girls are consulted, it is typically on an ad-hoc basis and their level of inclusion depends completely on the level of priority that individual agencies and actors place on the minimum standards to consult with women and girls generally and separately from men and boys.



4. IASC Operational Peer Review: Response to the Crisis in Syria, 15 July 2015, p21; IASC Operational Peer Review: Response to the Crisis in Iraq, 8 July 2015, p17.

LIST OF ABBREVIATIONS

CMR	Clinical management of rape
CP	Child protection
FGD	Focus group discussion
GBV	Gender-based violence
GBV AOR	Gender-based violence area of responsibility
GBV SC	Gender-based violence sub-cluster
GENCAP	Gender standby capacity project
HC	Humanitarian coordinator
HCT	Humanitarian country teams
HWG	Health working group
IASC	Inter-Agency Standing Committee
ICWG	Inter-cluster working group
IDPS	Internally displaced persons
IMC	International Medical Corps
IRC	International Rescue Committee
ISCCG	Inter-sector cluster coordination group
ISWG	Inter-sector working group
ITS	Informal tented settlement
KII	Key informant interview

KR-I	Kurdistan Region of Iraq
MISP	Minimum initial service package
NGO	Non-governmental organisation
OPR	Operational peer review
PHC	Primary health centre
REG	Regional emergency GBV advisor
RH	Reproductive health
RRP	Regional response plan
3RP	Refugee resilience response plan
SGB	Sexual and gender-based violence
SGBV SWG	Sexual and gender-based violence sub-working group
SOP	Standard operating procedures
SRP	Strategic response plan
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations International Children's Emergency Fund
UNFPA	United Nations Population Fund
UNOCHA	United Nations Office for the Coordination of Humanitarian Affairs
VAWG	Violence against women and girls
WASH	Water, sanitation and hygiene sector

STUDY BACKGROUND

The Inter-Agency Standing Committee (IASC) Guidelines for Gender-based Violence Interventions in Humanitarian Settings: Focusing on Prevention of and Response to Sexual Violence in Emergencies (IASC GBV Guidelines 2005) state that all humanitarian actors must act under the assumption that gender-based violence (GBV) is occurring and constitutes a life-threatening protection issue, regardless of the existence of evidence. Moreover, the IASC GBV Guidelines require humanitarian actors across all sectors to respond to and prevent GBV.

In the summer of 2015, the Syrian crisis crossed another tragic milestone: the number of Syrians seeking refuge in neighbouring countries reached four million. Some 98 per cent of refugees are hosted in four countries of the region: Iraq, Jordan, Lebanon and Turkey. Now, five years into the crisis, the meagre resources possessed by refugees are running out. Fear of deportation and a ban on legal work add to social, cultural and economic constraints, generating the situation of institutionalised precarity.⁵ Assessments conducted by UN agencies and international and local NGOs repeatedly demonstrated heightened risks of GBV for women and girls impacted by the Syrian crisis. Sexual exploitation, harassment and early marriage were identified among the primary threats faced by refugee women and girls.⁶

“ PLEASE, TELL THEM, EXPLAIN TO OUR PARENTS, THAT WE DO NOT WANT TO GET MARRIED, WE ARE CHILDREN. WE WANT TO STUDY IN SCHOOL. ”

FGD with girls, Syrian refugee community, Lebanon.

A report published by the International Rescue Committee (IRC) in 2014 entitled, *Are We Listening? Acting on Our Commitments to Women and Girls Affected by the Syrian Conflict*, highlighted a significant gap between policy and practice of GBV prevention and response in humanitarian operations responding to the Syrian crisis.

As per a recommendation in this report, in 2015, The United Nations Population Fund (UNFPA) and the United Nations High Commission for Refugees (UNHCR), in cooperation with the United Nations Children’s Fund (UNICEF), the IRC and the International Medical Corps (IMC) formed a steering committee to lead the evaluation of the humanitarian system’s response to GBV within the context of the Syrian crisis to date. The steering committee formed the backbone of the evaluation – providing technical guidance and expertise throughout the evaluation.

5. Hannah Lewis, Peter Dwyer, Stuart Hodgkinson and Louise Waite, *Precarious Lives: Forced Labor, Exploitation and Asylum*, (2015) pp35-37

6. *Are We Listening? Acting on Our Commitments to Women and Girls Affected by the Syrian Conflict*, (September 2014), IRC; *Findings from the Inter-Agency Child Protection and Gender-Based Violence Assessment in the Zaatari Refugee Camp, 2013*, Child Protection and Gender-Based Violence Sub-Working Group Jordan; *Sexual and Gender Based Violence. Syrian Refugees in Jordan*. SGBV SWG briefing note, March 2014.

METHODOLOGY

THE PURPOSE OF THE EVALUATION

The purpose of the evaluation was to examine the humanitarian community's implementation of global guidance on GBV prevention and response and ensure that such learning informs and improves the effective implementation of similar guidance in both the immediate and longer-term future. The outcomes of the evaluation will be used to improve future sector-specific programming and coordination mindful of preventing and mitigating GBV, and to inform the regional roll out and implementation process of the IASC GBV Guidelines revised in 2015 (Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing Risk, Promoting Resilience and Aiding Recovery).⁷

The 2005 IASC GBV Guidelines were used as a benchmark, representing the global guidance on GBV prevention and response available to sectors during the timeframe the evaluation covers. The GBV Guidelines envision GBV prevention and response as a multi-sector effort and emphasise the importance of shared responsibility of all humanitarian sectors for implementing the minimum standards. The evaluation examined to what extent the reality of humanitarian action in the Syrian crisis reflected this vision.

OBJECTIVES

The evaluation had the following objectives:

- To evaluate the extent to which the IASC GBV Guidelines⁸ were referred to and used in assessment and selection, design, monitoring and evaluation of programmes across humanitarian sectors;
- To identify the bottlenecks and the facilitating factors in implementation of the 2005 IASC GBV Guidelines in the Syria situation in order to directly inform the roll out and implementation process for the 2015 Guidelines;
- To examine the extent to which sectors were held accountable for adhering to the 2005 Guidelines (e.g. whether any actions were taken if sectors did not adhere to the guidelines);
- To determine whether donors referred to and used the 2005 IASC GBV Guidelines to decide on funding allocations in specific sectors and how.

7. The 2015 revised Guidelines aim to assist humanitarian actors and communities affected by armed conflict, natural disasters and other humanitarian emergencies to coordinate, plan, implement, monitor and evaluate essential actions for the prevention and mitigation of GBV across all sectors of humanitarian response.

8. Inter-Agency Standing Committee's *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing Risk, Promoting Resilience and Aiding Recovery, IASC (2005)*.

KEY EVALUATION QUESTIONS

In line with the purpose and objectives, the evaluation framework identified the following key evaluation questions:

- Are the minimum standards of GBV prevention and response (as outlined in the 2005 Guidelines) incorporated in programmes across three humanitarian sectors (Shelter, Health and WASH)⁹? To what extent were the 2005 Guidelines referred to and used in assessment and selection, design, monitoring and evaluation of programmes across the three humanitarian sectors?
- Which challenges and facilitating factors inform the implementation of the 2005 Guidelines across three humanitarian sectors?
- Which sectors were held accountable for adhering to the 2005 Guidelines?
- How do donors use the 2005 Guidelines in determining funding allocations in specific sectors?

THE PARAMETERS OF THE EVALUATION

The evaluation process started in March 2015 with the selection of the country operations by the steering committee, based on feasibility, access and demonstrated interest from the operations' GBV working groups. Selection of operations equally acknowledged the diversity within the Syria response across populations of concern, length of established coordination mechanisms, and therefore diversity of response modalities (i.e. remote programming in Northern Syria for internally displaced persons (IDPs) versus refugee programming in Lebanon).

9. The sectors identified: Health, WASH and Shelter were chosen based on recommendations by the GBV/SGBV sub-cluster/working groups in each country.

Two humanitarian sectors per country were selected to be evaluated by the GBV/SGBV sub-cluster/working groups in each country. The data collection targeted camp and non-camp settings, with a primary focus on non-camp settings, where 85 per cent of Syrian refugees reside.

Country	Shelter	Health	Wash
Lebanon	✓	✓	
Northern Syria		✓	✓
Kurdistan Region of Iraq		✓	✓
Jordan	✓	✓	

Table 1 - Sectors examined by the evaluation, per country

The evaluation framework which determined the central evaluation questions and defined the parameters of the evaluation was developed by the lead evaluator and approved by the steering committee. As part of the framework, specific data collection tools were developed per sector: Key informant questionnaires for each sector/cluster, donor questionnaire, focus group discussion (FGD) guides for women, girls, boys and men and the guidelines for data collection. Separate FGDs were conducted with refugee women, girls, boys and men in camp and non-camp settings.

The evaluation sample size was outlined in the evaluation framework based on which key informants were suggested by the lead evaluator, the steering committee and by the GBV WGs and cluster/sectors in each country.

Focus group participants were invited by camp management for discussions held in camps, and by GBV SWG members and/or sector actors for those held in urban areas.

DATA COLLECTION

The field evaluations took place in May, June and July 2015 and covered five days of data collection in each country. Data collection conducted in Turkey covered only the key informants involved in humanitarian assistance in Northern Syria, while in Jordan, Lebanon and Iraq the process involved FGDs with women, girls, boys and men. Data collection in Jordan and Lebanon was conducted by the lead evaluator, and in Turkey and the Kurdistan Region of Iraq by the GBV area of responsibility's regional emergency GBV advisors (REGA).



The table below details per country geographical coverage of the data collection and the number of key informant interviews and FGDs conducted in each country.

Country	Geographical coverage	Key informant interviews	Who was interviewed	Focus group discussions	Who participated
Jordan	Amman, Irbid governorate, Azraq refugee camp	22	Sector/cluster co-leads, sector actors, protection sector actors, SGBV sub-working group/taskforce members, and government actors. Gender standby capacity project (GenCap) advisers were interviewed in some countries.	8	Separate FGDs were conducted in camp and non-camp settings for: <ul style="list-style-type: none"> ● Women (age group: 20+); ● Girls (age group: 12-19); ● Boys (age group: 7-19); ● Men (age group: 20+).
Lebanon	Beirut, Bekaa and the North	17		7	
Turkey (for Northern Syria)	Antakya, Gaziantep	25		-	
Kurdistan Region of Iraq	Erbil city, Koya town and Domiz refugee camp	8		8	

Table 2- Geographical coverage, key informant interviews and focus group discussions.

LIMITATIONS

DATA ANALYSIS

Data from FGDs, key informant interviews, observations made during the site visits, sector reports and assessments was triangulated to produce the findings. Key informant questionnaires included a tool dedicated to measuring the extent of incorporation of the minimum standards of GBV prevention and response by respective sectors. The tool assigned scores for the implementation of each key action recommended by the GBV Guidelines. In the course of the data analysis, the performance of each sector was evaluated based on the scores. The process is described in greater detail in the evaluation framework (Annexe II). The evaluator also used theme-based content analysis to extract, compare and interpret information provided by the respondents through interviews and FGDs.

DESK REVIEW

The evaluation included a desk review conducted by the VAWG helpdesk¹⁰. The help desk research report being part of the overall evaluation synchronised its methodology with the key evaluation questions. The review explored the extent to which GBV interventions were explicitly mainstreamed into the three evaluated humanitarian sectors (Health, Shelter and WASH) in the regional appeals for the Syria crisis response. The findings generated by the desk review supported the findings of the evaluation.

The evaluation was conducted in four country operations, however, due to time and financial constraints, focused on a limited number of sectors (two) per country. The Health sector was evaluated in all countries; the Shelter sector was evaluated in Jordan and Lebanon; and the WASH sector was evaluated in the operations for Northern Syria and the Kurdistan Region of Iraq (KR-I). As a result, the findings are not necessarily representative of all sectors within a country, nor across the region. In addition, field evaluations were limited to five days per country and were conducted by three different evaluators due to logistical and time constraints. The steering committee addressed these limitations by developing a uniform set of tools to guide each evaluator in key informant interviews (KII) and FGDs. Moreover, because the evaluation in KR-I and Lebanon overlapped with Ramadan, the limited number of working hours impacted participant availability. Lastly, due to logistical and security constraints, no FGDs were held in Northern Syria.

10. The VAWG helpdesk is funded by the UK Department for International Development, contracted through the Inclusive Societies Department. Helpdesk reports are designed to provide a brief overview of the key issues and expert thinking on VAWG issues.

KEY FINDINGS

There were five overarching findings identified through the evaluation. Additional sector-specific findings are provided in a separate section.

FINDING 1:

THE IASC GUIDELINES FOR THE PREVENTION OF AND RESPONSE TO GBV (FORTHWITH REFERENCED AS THE GBV GUIDELINES) ARE NOT WELL KNOWN AND ARE NOT BEING USED IN PROGRAMMING PRACTICE.

The evaluation demonstrated that the majority of key informants had general information about the GBV Guidelines. Most knew that the GBV Guidelines existed and *assumed* that they had, at some point, influenced other guiding documents (primarily Sphere¹¹ standards, internal organisational guidelines and policies, cluster strategies) they reference in their daily work. Although the key informants did not refer to the GBV Guidelines while describing their understanding of GBV in a humanitarian crisis, their interviews exhibited high sensitivity towards the topic and supported the main principles of GBV prevention and response, as envisioned in the Guidelines. For example, key informants consistently acknowledged the importance of addressing GBV, and frequently stated that the risk of GBV for women and girls was exacerbated by humanitarian crisis and heightened their vulnerability as refugees or displaced persons.

Respondents in all sectors tended to perceive GBV as a life-threatening protection issue and stated that GBV was a sensitive topic, underreported due to cultural, social and economic barriers.

While respondents articulated overall GBV risks present in humanitarian settings the evaluation revealed that the majority of Shelter and WASH sector actors were not familiar with the specific minimum standards of GBV prevention and response that constitute the responsibility of their respective sectors outlined by the IASC GBV Guidelines. Respondents from the Health sector exhibited a higher level of awareness of the sector-specific GBV prevention and response standards. However, the majority of organisations across all evaluated sectors did not use the GBV Guidelines in programme assessment, design, implementation or evaluation. Organisations preferred to draw on their own internal guidance (global cluster guides, technical guidelines, protection handbooks, guidelines on project development, frameworks, protocols and training manuals) and Sphere guidance (standards, key actions, key indicators and guidance notes)¹². Among donors, knowledge of the Guidelines was broad but use extremely limited, with a preference for use of internal donor guidance and policy documents where in some cases GBV was mainstreamed.¹³

12. Many of these documents may have drawn from the GBV guidelines, but no one interviewed knew.

13. Documents that describe donor institutions' vision of the desired state of affairs in specific areas and preferred ways to achieve it. E.g. USAID/OFDA, *Guidance for Protection and Code of Conduct Requirements*.

FINDING 2:

THE GBV GUIDELINES ARE NOT INCORPORATED CONSISTENTLY IN ORGANISATIONAL OR SECTOR-SPECIFIC STRATEGIC DOCUMENTS AND STANDARDS.

“WHEN IT COMES TO GBV WE TRY TO DO OUR BEST, BUT WE DO IT INTUITIVELY.”

*A Shelter sector actor,
field office, Lebanon.*

The minimum standards for GBV prevention and response outlined in the GBV Guidelines are not incorporated consistently in regional and country-specific strategic documents (e.g. regional response plans (RRPs)) which outline sector technical and strategic priorities, objectives and indicators. The extent of incorporation of minimum standards into strategic plans was lower in the Shelter and WASH sectors than the Health sector. Some actors assume that if general protection measures are incorporated into programming, GBV issues will be covered automatically, further leading to the inconsistent application of standards. Furthermore, adherence to minimum standards also varied in implementation according to location, whereby generally higher implementation was referenced in well-established camp settings compared to urban settings and the informal tented settlements (ITS). This difference was justified by sectors as being due to the fact that 2005 IASC GBV Guidelines are geared towards camp settings and were seen as lacking clear

and relevant guidance for operations in urban areas and ITS.

It is important to note that the evaluation revealed a number of good practices implemented across the three sectors contributing towards GBV prevention and response. However, overall sector actors tend to implement GBV standards haphazardly rather than the range of minimum standards of GBV prevention and response in a comprehensive and consistent way.

FINDING 3:

SECTORS ARE NOT HELD ACCOUNTABLE FOR FAILING TO INCORPORATE GBV RESPONSE AND PREVENTION MINIMUM STANDARDS OUTLINED IN THE GBV GUIDELINES.

“WE SEND THE DOCUMENTS TO THEM AND THEY INCLUDE GBV ELEMENTS. WE ARE NOT GBV EXPERTS.”

*A Shelter actor, Jordan,
on the interactions with field GBV actors.*

Existing mechanisms of accountability are weak and do not provide a clear and comprehensive framework for holding sector coordinators and member organisations accountable to ensuring minimum standards of GBV prevention and response are integrated throughout programming.

The minimum standards of GBV prevention and response were not referenced or consistently used in the evaluation and monitoring frameworks employed by sector programmes.

The desk review of strategic documents (RRPs, Syria strategic response plan) highlights that over the span of the response, country overviews, which preface sector-specific strategies in annual strategic documents, increasingly articulate protection risks, including GBV, and appeal for multi-sector responses. However, the desk review reveals that the Shelter, WASH, and to a lesser extent Health sector strategies in the RRP or strategic response plan (SRPs), do not include a comprehensive sex and age-specific assessment of needs, tailored and sector-specific activities, and related indicators to prevent and respond to GBV as part of their sector strategy. The evaluation mirrors the desk review revealing partial or no implementation of the minimum standards in practice. It also highlights a lack of accountability, as there have been no instances in which sectors were held accountable for failing to incorporate the minimum standards. Although the evaluation revealed numerous examples of little or no implementation of these standards, *no instances* were identified of sectors being held accountable.

“ IF THE PROPOSAL DOES NOT INCLUDE A SECTION DESCRIBING HOW IT ADDRESSES GBV WE WILL NOT FUND IT. ”

A key informant from a donor institution.

Amongst donors, the evaluation found a certain level of commitment to GBV minimum standards. Donor respondents mentioned their calls for proposals issued listed requirements to include GBV-related standards, and that both the eligibility of submissions and the decision to allocate funding did take into consideration the articulation or not of GBV-related standards.

However, although some donors require a stated commitment to comply with GBV minimum standards, accountability mechanisms for evaluating whether GBV commitments are fulfilled once funding is granted are not enforced. Based on the consultations with donors, no partner has been penalised in any form for failing to incorporate required GBV prevention and response measures into their work. However, it is important to emphasise that the majority of key informants representing donor institutions expressed interest in engaging in an open and constructive discussion of donors' role in strengthening the accountability of sectors in implementing the new IASC GBV Guidelines.



FINDING 4:

SECTORS EXPECT AND ASSUME THAT SGBV WORKING GROUPS/ GBV SUB-CLUSTERS ARE EXCLUSIVELY RESPONSIBLE FOR SENSITISATION, MONITORING AND IMPLEMENTATION OF THE GBV GUIDELINES.

“ WE ARE IN CHARGE OF THE TECHNICAL SIDE, IT IS UP TO GBV (WORKING) GROUP TO MAKE SURE THAT ALL GUIDELINES ARE IN PLACE TO PROTECT WOMEN. ”

A sector actor, Lebanon.

The evaluation found that the onus for many actions related to the GBV Guidelines – including training, information dissemination, mainstreaming and even implementation – fell on the SGBV working groups/GBV sub-cluster. The Health, Shelter and WASH sector actors often expected the SGBV working groups/GBV sub-clusters to provide both leadership in introducing GBV elements into other sectors, and the actual implementation of GBV-related measures within those sectors’ programmes.

Many key informants related that the issues pertaining to the implementation of the IASC GBV Guidelines were never raised or discussed at sector working group meetings and considered GBV-related programme elements to be outside of the expertise of the sector actors.

Interestingly, “silo” identity¹⁴ was applied by many sector actors to the GBV working groups, which by its mandate is supposed to act as a coordinating mechanism. The tendency was pronounced in the Shelter and WASH sectors, while the Health sector exhibited a certain level of agency in implementing the Guidelines. The evaluation identified some actors’ assumptions that if general protection measures were incorporated into programming, GBV concerns/issues would be covered automatically.

The evaluation did reveal several examples of good practices involving successful coordination between the evaluated sectors and the SGBV working groups/GBV sub-clusters aiming to strengthen the incorporation of the minimum standards of GBV prevention and response. However, overall the Health, Shelter and WASH sectors did not exhibit sufficient levels of leadership in introducing measures to prevent and respond to GBV within their sector. The finding is supported by the IASC operational peer reviews (OPRs)¹⁵ conducted in Iraq and Syria in May and June of 2015.

“ WE SEND THE DOCUMENTS TO THEM AND THEY INCLUDE GBV ELEMENTS. WE ARE NOT GBV EXPERTS ”

A Shelter actor, Jordan, on the interactions with field GBV actors.

14. This observation echoes the concern regarding the “silo approach of the global humanitarian system” identified by the IASC Operational Peer Review: Response to the Crisis in Iraq, 8 July 2015, p7.

15. IASC Operational Peer Review: Response to the Crisis in Syria, 15 July 2015, p21; IASC Operational Peer Review: Response to the Crisis in Iraq, 8 July 2015, p17.

FINDING 5:

SECTORS RARELY INCLUDE, ENGAGE WITH OR HOLD THEMSELVES ACCOUNTABLE TO WOMEN AND GIRLS IN A MEANINGFUL, CONSISTENT AND ROUTINE MANNER.

Many Health, Shelter and WASH organisations initiate consultations with refugee women and girls. Some conduct these consultations regularly, and the evaluation identified several examples when productive and timely consultations with refugee women and girls helped organisations to make appropriate adjustments to their services. However, the repeated concern expressed by women and girls in the FGDs was that these consultations are rarely followed up by sector actors reporting back to the beneficiaries on why their input was or was not incorporated into practice. This is substantiated by findings from the May 2015 IASC Iraq and Syria OPRs. The beneficiaries were also often frustrated with the absence of the mechanisms for establishing a two-way flow of information, raising issues and requesting accountability. The evaluation found that consultations are for the most part ad-hoc and rarely followed up on by reporting back to the women and girls' beneficiaries on why their input was or was not incorporated into practice.

Female FGD participants related that in urban areas, in ITS and some camps, the channels of communication are sometimes monopolised by a certain group/category among the refugee community, typically community leaders and power-holders who are always men with connections. As women are often excluded from opportunities to serve in community leadership structures, they are marginalised and silenced in discussions and decision-making.

“

THERE ARE WOMEN IN OUR COMMUNITY, WHO SPEND THE ENTIRE DAY VISITING THE OFFICES OF INTERNATIONAL ORGANISATIONS, AND THEY ARE LUCKY IF THEY RECEIVE ANY HELP AT ALL BY THE END OF THE DAY. I DO NOT HAVE TIME FOR THAT. I HAVE TO WORK TO SUPPORT MY CHILDREN. ”

A female FGD participant, Lebanon.

When women and girls are consulted, it is typically on an ad-hoc basis and their level of inclusion depends completely on the level of priority that individual agencies and actors place on the minimum standards to consult with women and girls generally and separately from men and boys. Focus group participants spoke of being often frustrated with the absence of a mechanism establishing a two-way flow of information, raising issues and requesting accountability.

It is important to note that the evaluation identified several situations when productive and timely consultations with refugee women helped WASH and Shelter sector actors to make appropriate adjustments to the site layout, location of WASH facilities and the content of hygiene kits distributed to women and girls.

“

THEY DECIDE EVERYTHING HERE, AND THOSE WHO VISIT ONLY LISTEN TO THEM. ”

An FGD participant on how the power-holders in her community monopolise the channels of communication with humanitarian actors.

GOOD PRACTICES

The evaluation identified a number of good practices implemented by Health, Shelter and WASH organisations. These practices present efficient and creative ways in which GBV prevention and response is being integrated in Health, Shelter and WASH sector responses to the Syrian crisis. These examples should be replicated and expanded.

- ✔ Strongly designed and regularly conducted safety audits by GBV actors in cooperation with WASH, Shelter and other sectors enables gaps to be identified and addressed jointly and with the participation of affected populations, as was the case in KR-I, Jordan and Lebanon.
- ✔ Joint inter-cluster strategies such as the Northern Syria health/GBV strategy ensures greater incorporation of key actions that should be addressed by the health sector to enhance shared responsibility and accountability.
- ✔ Well-established standard operating procedures (SOPs) for response and prevention of GBV that are developed with (and outline the responsibilities of) all sectors clearly, facilitated the implementation of key actions to address GBV. Regular training on the SOPs for all new humanitarian staff and refresher training available monthly ensured key actions were regularly known and, more importantly implemented, in Jordan.
- ✔ Reproductive health services well integrated into the primary health care system facilitates the availability, access, confidentiality and quality of the clinical care for survivors of sexual violence as demonstrated in Jordan and Lebanon.
- ✔ Establishing the inter-agency GBV information management system allowed for joint analysis of where reported incidents of GBV were perpetrated and supported the Shelter sector in being able to take key actions to address GBV in Jordan and Lebanon.
- ✔ Good example of coordination and productive communication with the beneficiaries: Shelter actors and GBV working group members in Jordan joined forces to implement safe site planning of two camps. In the process, consultations with women and girls were conducted and necessary adjustments were made. In April 2014, WASH facilities for women and men, previously placed next to each other, were relocated to ensure more privacy, separate male/female sleeping quarters were introduced in the camps' waiting areas and a new policy for the distribution of non-food items was implemented.
- ✔ Good practice of supporting beneficiaries in rearranging shelter site for better safety: in Zaatari camp (Jordan) the site-related safety measures were partly introduced by the refugees themselves, through the formation of 'family blocks' (several caravans forming a small neighbourhood), with the assistance provided by the Shelter actors. Safety audits indicated that, as a result of these measures, refugee women and girls felt safer and better represented.
- ✔ The problem of the plastic sheets distributed in ITs in Lebanon provides a clear example of sector standards ignoring the minimum standards of GBV prevention. The plastic sheets provided to refugees are transparent and thus, when used as tent walls fail to provide necessary privacy. The issue was raised and emphasised by a Shelter actor and the evaluator witnessed the problem during one of her site visits in Lebanon. The situation carries especially strong risks for any women or girl alone in the tent but the shelter and GBV sectors are working closely to address this.

SECTOR-SPECIFIC FINDINGS

SHELTER SECTOR: JORDAN AND LEBANON

The majority of respondents from the Shelter sector knew about the existence of the GBV Guidelines, their general purpose, and articulated the fundamental principles stated in the IASC GBV Guidelines. However, they did not possess a detailed knowledge about the key interventions outlined in the Guidelines for their specific sector. About 20 per cent of respondents, mainly based in field offices, confused the GBV Guidelines with other tools (often training materials) containing general description of the nature, root causes and consequences of gender-based violence.

The evaluation established that, overall, Shelter sector organisations did not use the GBV Guidelines¹⁶ in programme development, implementation, monitoring and evaluation. Some believed that general protection measures already included in the programmes were sufficient to address GBV-related risks. Others communicated that they tried to incorporate measures to address the risk of GBV for women and girls, but did so “intuitively”.

Respondents repeatedly brought up sector-specific guiding documents (such as sector

strategies, technical guidelines and Sphere standards) as the primary sources shaping the design and implementation of programmes. Many respondents did not know whether these regulations were synchronised with the GBV Guidelines, some believed they were not. It is important to emphasise that the examination of strategic documents (six RRP, country plans for Jordan and Lebanon and refugee resilience response plans (3RPs) in the violence against women and girls (VAWG) helpdesk review established that the sections covering the Shelter sector did not include a single GBV-related indicator.¹⁷ The examination of Sphere standards demonstrated that the Shelter design and site planning section only makes marginal reference to GBV Guidelines.¹⁸ The examination of the technical guidelines did not reveal any references to GBV Guidelines or to GBV overall.

The key interventions designed to ensure the minimum standards of GBV prevention and response expected from the Shelter sector are outlined in the 2005 GBV Guidelines (Chapter 3) and are described in more detail (as necessary standards and practices) in the respective action sheet. In its minimum prevention and response section, the GBV Guidelines recommend four key interventions for the Shelter and site planning sector:

16. The technical guidelines are the guidelines developed by Shelter working groups in each country and used by the sector actors in finishing accommodation, conducting assistance through various cash modalities, building small shelter units etc. For examples of the technical guidelines, please see country Shelter WG sections on the Syria Regional Refugee Response Inter-Agency Information Sharing Portal, <http://data.unhcr.org/syrianrefugees/regional.php> (last accessed on 10 September 2015).

17. Sansani, I (2015) GBV Mainstreaming in Syria Crisis, VAWG helpdesk research report number 85, London, UK: VAWG Helpdesk, p16

18. Sphere Project, Humanitarian Charter and Minimum Standards of Humanitarian Response handbook, <http://www.spherehandbook.org>, chapter “Shelter and site planning” (last accessed on 23 August 2015).

“7.1. Implement safe site planning and shelter programmes; 7.2. Ensure that survivors/victims of sexual violence have safe shelter; 7.3. Implement safe fuel collection strategies; 7.4. Provide sanitary materials to women and girls.”

Out of the four key interventions, the one relating to safe fuel collection was not relevant for the context of the sites examined by this evaluation. For the remaining three interventions, key informant interviews and focus group discussions with the beneficiaries indicated partial incorporation. It is important to note that the key informants did not describe the actions as recommended by the IASC GBV Guidelines, since they very rarely had a detailed knowledge of the Guidelines.

Out of 10 key actions recommended by the Guidelines, only three were consistently incorporated into the sector activities. More specifically, these actions were:

- The partners coordinated and shared information with each other regarding the safety of refugees' accommodation,
- Conducted referrals of GBV victims/survivors in accordance with protocol,
- Consulted with women about their needs and concerns regarding the provision of safe accommodation.

However, one of the three key actions, “consulting with women on the needs and concerns regarding safe accommodation”, was consistently implemented only in camp settings.

In urban settings, only some actors consistently consulted with women. In the informal tented settlements in Lebanon, women were rarely consulted and actors reported difficulties in accessing sites and female beneficiaries.

Furthermore, the evaluation found that the key actions categorised as “GBV response” were more consistently incorporated by the Shelter sector's interventions compared to those categorised as “GBV prevention” actions. The majority of key informants reported that Shelter actors were aware of the referral pathways for GBV survivors, were trained to refer survivors to services in a confidential and timely manner and knew about the importance of respecting the choices and wishes of survivors. There was a good level of awareness and capacity due to the training on the SOP, prepared by GBV working groups.¹⁹

Mitigation measures such as ensuring lighting layout, design of individual shelters, communal centres set at or near the sites of residence, participation of women in the shelter committees were not consistently implemented in many urban areas and mostly not implemented in the informal tented settlements, where the Shelter actors frequently did not have control over the sites and detailed guidance on the implementation of the minimum standards. Some respondents working outside camps in both Lebanon and Jordan expressed concern over the lack of “relevant guidance” on addressing the GBV-related risks. They related that the key actions envisioned by the IASC Guidelines for the

19. The Inter-Agency emergency standard operating procedures for prevention of and response to gender-based violence and child protection in Jordan was developed under the umbrella of the National Council for Family Affairs (NCFA), the child protection and GBV sub-working groups. The development of the SOP was led by the SOP taskforce composed of Save the Children, UNHCR, UNICEF, UNFPA and NCFA.

Shelter sector were geared towards a camp environment and often did not provide detailed guidance for implementing the minimum standards of GBV prevention and response in urban areas or the ITS. This observation is supported by the evaluation findings, in that the extent to which the minimum standards were incorporated was higher in camp settings than in off-camp settings where the majority of refugees reside but where shelter actors feel they have less control over the planning of sites and application of humanitarian standards.

The following specific challenges were identified as hampering the incorporation of the IASC GBV Guidelines in Shelter sector operations:

- **GBV training undertaken by Shelter actors does not provide clear guidance on implementing the minimum standards of GBV prevention and response, as outlined in the IASC GBV Guidelines.** The trainings mentioned by the key informants provided by the SGBV working groups covered basic information about GBV and did not focus on the IASC GBV Guidelines or on specific sectors. The trainings were not intended for that purpose and therefore did not address the challenges in implementing the minimum standards of GBV prevention and response relevant for the daily work conducted by the sector staff nor post-training follow-up activities that involved Shelter actors suggesting changes in sectoral/organisational standards and practices.
- **Shelter actors more often than respondents from other sectors assumed that as long as general protection measures are followed GBV prevention is addressed.**
- **Shelter actors more often than respondents from WASH and Health assumed that the introduction of GBV-related minimum standards should be left to the “experts” (i.e. GBV actors).**
- **GBV prevention and response standards are not sufficiently reflected in the approach Shelter sector organisations use in providing targeted assistance.** Several respondents related that they use specific standards for determining the recipients of targeted assistance. However, the respondents could not point to a clear procedure ensuring that categories vulnerable to GBV (except for the female heads of households) and GBV survivors are included in the prioritised groups. With increasing importance of targeted assistance, this gap generates a significant challenge for the implementation of the minimum standards envisioned by the Guidelines.

SHELTER SECTOR: GOOD PRACTICES

The evaluation identified a number of good practices implemented by Shelter sector actors in Jordan and Lebanon. These practices present efficient and creative ways in which GBV prevention and response measures are being integrated into the Shelter sector's response to the Syrian crisis. These are practices that should be expanded and replicated.

- ✔ A good practice implemented by a Shelter actor in urban areas consisted of ensuring female staff members assess the renovations in sub-standard accommodation. Some key informants related that women were more open to discussing privacy-related concerns with female staff. A Shelter actor in Jordan uses a similar approach for the team specifically tasked with making home visits to inquire about social pressures and needs around housing.
- ✔ Mobile "safe spaces" are provided by a Shelter actor in Lebanon to provide women and girls from ITSs with some access to sexual and gender-based violence (SGBV)-related services. The "safe spaces" are located in mobile caravans and are stationed near ITSs on particular days of the week to allow women and girls access to recreational activities, psychosocial support and GBV referrals. In Lebanon, the use of the social development centres (run by the Ministry of Social Affairs) provided a good solution for "safe space" type assistance to women and girls in urban areas.
- ✔ A Shelter actor working in cash-for-rent and other rent-based modalities in Jordan's urban areas uses a lease agreement form that requires husband and wife to be co-signatories. This prevents situations where women and children are expelled of the house by a family member who signed the lease. The same organisation introduced basic legal education sessions to refugees entering rental agreements to also mitigate exploitation by landlords.
- ✔ Drawing on new technological means helps shelter organisations to provide efficient solutions when left face-to-face with challenges not covered by the Guidelines. For example, in 2015 public lighting was still absent in the Azraq refugee camp and interrupted for several months in the Zaatari camp (Jordan). Shelter working group and GBV working group members suggested and implemented the distribution and use of solar lamps. A similar approach was used in ITSs in the North of Lebanon, where two solar lamps were distributed to each household to ensure that women would also be able to use the lights.
- ✔ In Lebanon, a shelter organisation working in ITSs offers assistance in home improvements to refugee women.
- ✔ Strongly designed and regularly conducted safety audits by GBV actors in cooperation with Shelter actors and other sectors enables gaps to be identified and addressed in KR-I, Jordan and Lebanon.

HEALTH SECTOR/CLUSTER: JORDAN, LEBANON, KURDISTAN REGION OF IRAQ AND NORTHERN SYRIA

The interviews with key informants demonstrated that in Jordan, Lebanon and Northern Syria, Health sector actors most often knew about the GBV Guidelines, were familiar with their purpose and basic principles and exhibited good knowledge of key interventions recommended for their sector. The situation in the Kurdistan region of Iraq (KR-I) was different: Two out of the four health partners interviewed were not familiar with the GBV Guidelines. In all countries, the respondents mentioned training as the main source of their knowledge regarding the GBV Guidelines.

Despite the high level of awareness about the GBV Guidelines, key informants rarely used the Guidelines in the development, implementation, monitoring and evaluation of programmes. Overall, the health actors stressed that GBV Guidelines were only used as a secondary source.

**“ WE INCORPORATE GBV
CONCEPTS, RATHER THAN
GBV GUIDELINES. ”**

A health sector actor, Jordan.

The respondents most often mentioned three sources they drew on while considering GBV-related programmatic components:

Internal organisational/agency guidelines, Sphere standards and GBV standard operating procedures (in Jordan and Lebanon). However, it is important to note that the influence of the Guidelines was somewhat present, albeit indirectly. For example, Sphere standards for health included a reference to GBV Guidelines. As to the guidance produced by specific organisations and agencies, some respondents pointed at the International Rescue Committee’s (IRC’s) GBV Emergency Response and Preparedness: Participant Handbook (2011) as an example of a guiding text that closely incorporated GBV Guidelines²⁰. Many respondents emphasised that GBV Guidelines shared the objectives and main concepts with the guidance developed by their respective agencies/organisations.

The key interventions necessary to ensure the minimum standards of GBV prevention and response expected from the Health sector are presented in the 2005 GBV Guidelines (Chapter 3) and described in more details (as necessary standards and practices) in the respective action sheets in the health and community services section. Key interventions for Health sector activities are: “8.1. Ensure women’s access to basic health services; 8.2. Provide sexual violence-related health services; 8.3. Provide community-based psychological and social support for survivors/victims.” The evaluation demonstrated that health sector activities across four countries included some interventions that matched one of the three categories.

20. The handbook has a subsection dedicated to the IASC GBV Guidelines. Detailed references to the key interventions advised by GBV Guidelines (including the implementation of the MISP) are also made in the handbook’s GBV Emergency Preparedness Model and the section on Health Response. Please see GBV Emergency Response and Preparedness: Participant Handbook, IRC, 2011, p18, p43, pp49-50 gbvresponders.org

However, the GBV minimum standards were not implemented in their entirety, but rather as a patchwork of useful practices emerging periodically alongside the general public health-related effort. The detailed guidance on the key interventions in the Health sector is presented within the key action sheets (8.1-8.3) section of the IASC GBV Guidelines.

The analysis of data collected through the key informants and focus group participants demonstrated that out of 10 key actions recommended by the IASC GBV Guidelines, five were introduced at various sites:

- Developing the protocol on the clinical management of rape for GBV survivors;
- Implementing the minimum initial service package (MISP);
- Taking steps to secure the accessibility of services to refugee women and girls;
- Conducting “coordinated situational analysis of health services in targeted communities”;
- Training healthcare staff on confidentiality.

It is worth specifying that hospitals and medical staff apply some minimum standards of GBV prevention, based largely on common sense and national medical expertise and background. For example, reproductive health services for women are provided including antenatal care, postnatal care, family planning, safe birth delivery, Caesarean-Section, post exposure prophylaxis EP and the MISP thanks to UNICEF and UNFPA.

Overall, the higher level of incorporation of the minimum GBV prevention and response standards in the Health sector, compared to Shelter and WASH, matches the higher visibility of GBV response activities and indicators in the Health sector strategic planning section in RRP. This demonstrates that Health sector actors are more accountable to GBV standards than the Shelter and WASH sectors.²¹

The evaluation identified several challenges that hampered the incorporation of the IASC GBV Guidelines in Health sector operations.

Synchronising GBV Guidelines and national policies

proved challenging in some contexts. National policies/laws on mandatory reporting of sexual violence in Jordan, Turkey and Iraq for instance, do not allow healthcare professionals to respect the confidentiality and choices of GBV survivors, as they are mandated by law to report any known case to authorities. This makes it very difficult for Health actors to implement the respective key action, as outlined in the IASC GBV Guidelines. Post-rape kits content and its compliance to national policy was listed by some respondents in Jordan as a constraint in delivering relevant care to the survivors of sexual violence. Some believed that the legal restrictions in the use of emergency contraception affected women’s ability to make choices concerning their reproductive health.

21. *The Helpdesk Research Report established that the “inclusion of SGBV as a priority response area...has improved and remained relatively consistent in the Health sector in Jordan, but requires greater commitment in Health interventions in Iraq, Lebanon and Northern Syria”.*

A lack of female doctors (particularly willing or allowed to work in camps) was reported as a challenge by some key informants in Jordan. The situation was particularly challenging in the early days of the Zaatari camp, where safety was a major concern. Since then, the safety level has increased, but finding female healthcare staff in general and particularly for night shifts is still not easy and is a product of wider gender inequalities in the country. Health actors are currently addressing the issue by training more female doctors and nurses but this prevents health services in the meantime from ensuring the availability of female staff at all times as per the guidelines.

Training the healthcare staff on assisting GBV survivors was described by several key informants in Lebanon and Jordan as challenging. Management in healthcare facilities did not always look favourably on letting doctors undertake GBV-related training, as it is not a requirement outlined in national policies and at times regarded as an unnecessary distraction rather than an integral part of a healthcare providers' duty of care. In Northern Syria, external challenges preventing doctors from crossing into Turkey for training purposes and security conditions not permitting trainers to enter Syria have prevented Northern Syria from adequately training medical providers in clinical care for GBV survivors.

Moving away from minimum initial service package (MISP) implementation for reproductive health, although supported by many sector actors and the regional public health and nutrition strategy²², concerned some respondents. They believed that it would generate challenges in providing lifesaving assistance (for example, the distribution of clean delivery kits) to women and girls deprived of the access to public or private healthcare facilities.



22. *Regional public health and nutrition strategy, 2014-2015, UNHCR, p8*

HEALTH SECTOR: GOOD PRACTICES

The evaluation identified a number of good practices implemented by Health sector actors across the Kurdistan Region of Iraq (KR-I), Jordan, Lebanon and Northern Syria. These practices present efficient and creative ways in which GBV prevention and response measures are being integrated by the Health sector's response to the Syrian crisis. These are practices that should be expanded and replicated.

- ✔ The development and launch of the GBV action plan for the Health sector in Jordan. The process started in the second half of 2014 and brought together GBV WG and health WG members. The action plan listed key interventions, necessary resources and tools, and assigned the parties responsible for implementation. Proposed interventions aimed to strengthen the incorporation of GBV prevention and response at all stages of programme cycle in the health sector.
- ✔ Good practice of coordinated effort in Northern Syria: Health sector and GBV actors put together a joint strategic note that represented a roadmap for collaboration on the clinical management of rape and clinical support for GBV survivors (protocols are currently being drafted). The strategy also includes a monitoring plan.
- ✔ To ensure that female health staff would be able to attend trainings, the gender-based violence sub-cluster (GBV SC) paid for a babysitter to look after the children while the women attended the training.
- ✔ Health actors in Jordan and Lebanon organised mobile clinics to reach out to refugee women and girls in remote areas. Staff at mobile clinics were trained to provide referrals for survivors of GBV.
- ✔ Health actors in Jordan and Lebanon created community-based volunteer networks to distribute reproductive health kits, conduct awareness sessions on RH, GBV and early marriage and provide initial psychosocial support and referrals for GBV survivors.
- ✔ One health actor in Lebanon provides sexual violence-related health services through special GBV teams in public health centres (PHCs). A similar service is delivered in the healthcare facility, operated by a health actor in an urban area in Jordan.
- ✔ A facility in Jordan, run by a Health sector actor, hosts both health services and social services for sexual violence survivors in the same building, thus assisting survivors in reintegrating into society, in line with the key action recommended by the IASC GBV Guidelines.
- ✔ Health sector actors in Lebanon and Jordan conducted awareness sessions with men and women separately, spreading information on the negative impact of early marriage. They mobilised the help of midwives in waiting areas of PHC facilities and community health volunteers (male and female). Health sessions in schools were introduced to explain to students and teachers the negative effect of early marriage.

WASH SECTOR/CLUSTER:

KURDISTAN REGION OF IRAQ AND NORTHERN SYRIA.

The data collected in Northern Syria suggests a high level of awareness about the GBV Guidelines among WASH sector actors: all key informants were aware of the GBV Guidelines and affirmed that the Guidelines were referenced in strategic documents (country strategies, plans etc.). This high level of awareness might have been facilitated by the reference to GBV Guidelines made in the terms of reference of the Southern Turkey gender-based violence sub-cluster (Syria). In KR-I, the situation was drastically different: only one out of three key informants were familiar with the Guidelines.

The evaluation data suggests that the key informants did not use the GBV Guidelines in the development, implementation, monitoring and evaluation of programmes. The level of awareness regarding the use of the Guidelines at an organisational level was rather low among the key informants in KR-I. They did not know if their respective organisations ever specifically referenced the Guidelines in strategic documents, during implementation, or during monitoring and evaluation of programmes. In Northern Syria, many sector actors had no capacity to use the Guidelines: all trainings planned for Syrian humanitarian actors were cancelled due to movement restrictions and bans on cross-border activities.

The GBV Guidelines recommend one key intervention (“5.1. Implement safe water/sanitation programmes”) designed to ensure the minimum standards of GBV prevention and response expected from the WASH sector. The intervention is presented in Chapter 3 and described in more details (as minimum standards) in the respective action sheet²³. Overall, the WASH sector did not incorporate the minimum standards of GBV prevention and response in a comprehensive and consistent manner. Only two out of 10 key actions were consistently implemented by the sector actors (“Hand pumps and water carrying containers are designed (or adapted) for the use of women and children” and “Women are informed about the maintenance and use of WASH facilities”). Data from Northern Syria suggests that some key actions (such as keeping refugee women and girls informed about the use and maintenance of WASH facilities, or the use of adapted water containers) were implemented by all sector actors in camps. However, the situation outside of camps is unclear. In Iraq, two out of three sector actors reported implementing the key actions only partially. Similar to the attitude present among Shelter actors in Jordan and Lebanon, some key informants in KR-I assumed that by adhering to Sphere Standards they incorporated the minimum standards for GBV prevention.

The examination of Sphere standards for the WASH sector demonstrated that they overlap with some of the sector-specific minimum standards outlined in the GBV Guidelines.

23. GBV Guidelines, Chapter 4, section 7, pp 47-48

However, they do not consistently focus on women and girls as a group specifically vulnerable to GBV and unequal treatment. The Sphere standards for WASH contain a reference to the WASH section (“Gender and water, sanitation and hygiene in emergencies”) of the IASC gender handbook entitled *Different needs, Equal Opportunities (2006)*.²⁴

Along with the challenges common for all sectors (featured in the key findings), the evaluation identified some specific challenges impeding the implementation of the IASC GBV Guidelines by WASH actors in KR-I and Northern Syria.

High staff turnover in KR-I makes it particularly hard to maintain the necessary capacity level among the employees. The majority of the respondents did not know about the key

interventions envisioned by the GBV Guidelines for the WASH sector and were not trained to implement them.

Maintaining gender balanced representation in the community-based structures, in Northern Syria constitutes a significant challenge. Equal involvement of women and men in hygiene promotional activities and gender balanced representation on the WASH committees and among hygiene volunteers was hard to sustain due to cultural limitations on women’s mobility in the public space.

Clusters were only recently formed within the Northern Syrian humanitarian response. In this context, sector actors were yet to develop coordination in the incorporation of the minimum standards of GBV prevention and response.

24. Sphere Project. *Humanitarian Charter and Minimum Standards of Humanitarian Response handbook*, <http://www.spherehandbook.org/en/how-to-use-this-chapter-1/> (last accessed on 23 August 2015).

WASH SECTOR: GOOD PRACTICES

The evaluation identified several good practices implemented by WASH sector actors in the Kurdistan Region of Iraq and Northern Syria. These practices present efficient and creative ways in which GBV prevention and response measures are being integrated by the WASH sector response to the Syrian crisis. These are practices that should be expanded and replicated.

- ✔ In Northern Syria, a WASH sector actor mobilised female and male volunteers from the communities to make home visits in order to disseminate information on safe and hygienic use and care of WASH facilities.
- ✔ In Northern Syria, a WASH sector actor organised a series of informational sessions on hygiene in local mosques. Given a central part of hygiene rules in the Muslim cultural code of conduct, presenting the information in the mosques was culturally appropriate and allowed the actor to reach out to the community in a culturally sensitive way.
- ✔ In KR-I a WASH sector actor conducted community-based consultations, which had a positive impact on the successful distribution of culturally appropriate hygiene kits. Consultations with refugee women and girls revealed that the hygiene kits should contain different sizes of sanitary pads and include an additional antibacterial soap instead of toilet paper.
- ✔ In KR-I, WASH actors maintain a database of outcomes of the safety audits and related response across 59 camps.

CONCLUSION

Despite many good practices identified amongst Health, Shelter and WASH sector actors in implementing GBV prevention measures, the level of the incorporation of 2005 IASC GBV Guidelines in the Kurdistan Region of Iraq, Jordan, Lebanon and Northern Syria was not sufficiently intentional across the three evaluated sectors to mitigate the risks of gender-based violence as per standards examined in the evaluation. While fully acknowledging the complexity and scale of the Syrian crisis and common and country-specific contextual challenges, the evaluation has found significant gaps in the comprehensive, consistent and strategically guided implementation of the IASC GBV Guidelines by the Health, Shelter and WASH sectors, highlighting differences in the level of incorporation among countries, sectors and organisations within the sectors.

The data collected from the key informant interviews and FGDs across three humanitarian sectors (Shelter, Health and WASH) in four countries (Jordan, Lebanon, Northern Syria and KR-I), as well as the desk review of strategic documents, suggests that the gaps

in the sectors' incorporation of the IASC GBV Guidelines primarily stem from: the low level of detailed knowledge about sector-specific minimum standards of GBV prevention and response among sector actors; failure to consistently incorporate the Guidelines into sector-specific coordination strategic documents and institutionalised standards; weakness or lack of accountability mechanisms to ensure the implementation of the Guidelines as a key responsibility of all humanitarian sectors; insufficiency of detailed guidance on implementing standards in urban areas and ITSs in the 2005 Guidelines; lack of consistent and meaningful two-way communication among sector actors and beneficiaries (specifically refugee women and girls).

The evaluation has informed the subsequent detailed recommendations for addressing the identified gaps and ensuring that the new 2015 IASC GBV Guidelines are incorporated in a comprehensive and consistent way by all sectors to effectively mitigate, prevent and respond to gender-based violence within the Syrian humanitarian response.

RECOMMENDATIONS

HUMANITARIAN COORDINATORS (HC) AND REFUGEE COORDINATORS SHOULD:

1. Remind all members of humanitarian country teams (HCT) and inter-cluster/inter-sector working groups (ICWG/ISWG) that all clusters and sectors have a responsibility to integrate GBV risk reduction in their strategies and proposals.
2. Require regular monitoring updates during HCT/ICWG/ISWG meetings on actions taken to prevent, mitigate and respond to GBV.

HUMANITARIAN COUNTRY TEAMS (HCT) AND INTER CLUSTER/INTER SECTOR WORKING GROUPS (ICWG/ISWG) / INTER SECTOR CLUSTER COORDINATION GROUP (ISCCG) SHOULD:

1. Instruct and support all cluster/sector lead agencies to facilitate joint, multi-sector workshops on the IASC GBV Guidelines for national and field-level staff within 90 days of the release of this report.
2. Require each cluster and sector to incorporate and adhere to the IASC GBV Guidelines throughout each phase of the humanitarian programme cycle, including assessments, project design, implementation, and monitoring and evaluation; and incorporate GBV prevention and mitigation strategies into cluster/sector policies, standards and guidelines.
3. Regularly discuss GBV risks and risk reduction responses in inter-cluster/sector meetings, highlighting opportunities for joint cluster/sector approaches to prevent, mitigate and respond to GBV.
4. Develop and implement an accountability framework for affected populations so that agencies and sectors engage women and girls in a meaningful, systematic, and consistent manner, and report back to community groups about the results of the groups' input.
5. Seek resources, with support from the HC by the end of 2015, for developing the IASC GBV Guidelines implementation monitoring plan for 2016 as well as to conduct a follow-up real-time evaluation on the implementation of the new IASC GBV guidelines in each country within 18 months.

CLUSTER/SECTOR LEADS (INCLUDING WHOLE OF SYRIA ACTORS) SHOULD:

1. Incorporate questions related to risks of GBV in their respective sector assessments as required by the new IASC GBV Guidelines, with the support of the SGBV WG/ GBV sub-cluster, in order to ensure that GBV needs are known and addressed in sectoral planning, funding appeals such as regional response plans and strategic response plans, as well as all programming.²⁶

26. Questions should be vetted with GBV WG members prior to inclusion in assessments in order to ensure they are targeted in an appropriate and sensitive manner to ascertain specific GBV-related risks without causing harm to survivors.

2. Identify GBV risk reduction priorities based on sector assessments and findings from GBV and other protection-related assessments to inform ongoing project implementation.
3. Ensure that GBV prevention and mitigation actions are included in cluster/sector strategies.
4. Integrate relevant, contextualised indicators from the IASC GBV Guidelines into regular cluster/sector monitoring activities and share reports with GBV coordination mechanisms, HCT/ ICWG/ ISCCG and other stakeholders.
5. Designate a focal point (FP) responsible for monitoring and reporting on each sector's implementation of the sectoral strategy, including through regular attendance and information sharing at S/GBV WG/SC meetings.
6. Advise agencies within their respective clusters/sectors on GBV risk reduction efforts and offer specific recommendations to agencies which fail to comply with IASC GBV Guidelines.
7. Ensure that all agencies within their respective clusters/sectors disseminate, channel resources towards, and train staff on a regular basis to adequately implement the IASC GBV Guidelines.

DONORS SHOULD:

1. Require that funding proposals from all sectors outline specific GBV risk reduction activities and include indicators suggested in the revised IASC GBV guidelines.
2. Request updates to be included in reporting requirements and monitoring and evaluation plans.
3. Hold accountable any partners who fail to adhere to and implement the GBV Guidelines, including through the implementation of a programme improvement plan as well as restrictions on future funding opportunities if partners fail to meet requirements.

GBV SUB-CLUSTER/SGBV WORKING GROUPS SHOULD:

1. Provide ongoing support to cluster/sector staff on meeting their responsibilities outlined in the IASC GBV Guidelines. For example, ensure GBV specialists and GBV surge capacity (as far as possible) are available to support the HC, the Office for the Coordination of Humanitarian Affairs (OCHA) and cluster/sector to integrate the Guidelines' recommendations.
2. Lead on raising awareness of the IASC GBV Guidelines in country. For example, use all opportunities to introduce the revised IASC GBV guidelines; present the Guidelines to sector/clusters/ ISCCG/ ISWG/ICWG; identify Guidelines champions at all levels of decision-makers and programmers.
3. Conduct training on the Guidelines.
4. Continue conducting safety audits and encourage clusters/sectors to implement and follow up on the recommendations of the safety audit.

ALL HUMANITARIAN ACTORS SHOULD:

1. Ensure regular, consistent and systematic conversations – safely and ethically – with women and girls separate from men and boys, as well as regular feedback loops to share what specific actions were taken to respond to their unique and specific needs.
2. Raise awareness and advocate for the uptake of the IASC GBV Guidelines by all international, national and local partners involved in humanitarian response.

COUNTRY-SPECIFIC RECOMMENDATIONS²⁷**LEBANON AND JORDAN**

- Each sector involved in the evaluation should organise a presentation on the evaluation findings and recommendations to be followed by an orientation provided at the inter-sector level;
- Maintain continuous cooperation among all sectors to ensure adherence to the minimum standards of GBV prevention and response, as outlined in the 2015 IASC GBV Guidelines;
- Request the regional steering committee to support an orientation session on the evaluation findings and recommendations for the Jordan and Lebanon humanitarian country teams hosted in Beirut;
- Advocate for the inclusion of a specific GBV output(s) and indicator(s) section in activity info along with the guidance note for all sectors to support the integration of GBV measures in sector strategic objectives and to inform progress on achieving GBV mitigation and prevention objectives;
- Each sector should assign a focal point, responsible for leading the process and monitoring the progress on proposed actions.

IRAQ (WHOLE OF IRAQ)

- As part of the humanitarian response plan development process, propose the creation of a GBV marker (a GBV equivalent of the IASC gender marker tool) in three sectors (Shelter, Health and WASH), with support from UNHCR;
- Run an orientation session on the evaluation findings, recommendations and the rollout of the revised Guidelines at the inter-sector level by the end of 2015;
- Review the indicators suggested in the 2015 IASC GBV Guidelines (cover at least two sectors). Introduce the indicators for possible inclusion in activity info (possibility to produce dedicated GBV dashboards).

NORTHERN SYRIA

- Review the indicators in the sector strategies in line with the evaluation recommendations and new IASC GBV Guidelines;
- Strengthen the advocacy on the minimum standards of GBV prevention and response targeting donors and humanitarian actors.

27. These specific recommendations were identified by the GBV, Health, WASH and Shelter sector/clusters during the dissemination workshop in Amman, Jordan, 13 September 2015.

ANNEX

EVALUATION FRAMEWORK AND DATA COLLECTION GUIDELINES

EVALUATION FRAMEWORK

PURPOSE OF THE EVALUATION

To examine the humanitarian community's implementation of global guidance on **GBV prevention and response** and ensure that such learning informs and improves the effective implementation of similar Guidance in the both the immediate and longer term future.

OBJECTIVES OF THE EVALUATION

- To **evaluate the extent** to which the 2005 IASC GBV Guidelines²⁸ were referred to and used in assessment and selection, design, monitoring and evaluation of programmes across humanitarian sectors;
- To **identify the challenges and the facilitating factors** in implementation of the IASC GBV Guidelines in the Syria situation in order to directly inform the roll out and implementation process for the 2015 GBV Guidelines;
- To **examine the extent to which sectors were held accountable** for adhering to the IASC GBV Guidelines; (e.g. Whether any action was taken if sectors did not adhere to the Guidelines)
- To determine whether **donors referred to and used the Guidelines** to decide on funding allocations in specific sectors and how.

28. IASC Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing Risk, Promoting Resilience and Aiding Recovery (2005)

CENTRAL EVALUATION QUESTIONS

- Are the minimum standards of GBV prevention and response (as outlined in the 2005 Guidelines) incorporated in programmes across three humanitarian sectors (WASH, Health and Shelter)?
- To what extent the 2005 Guidelines were referred to and used in assessment and selection, design, monitoring and evaluation of programmes across three humanitarian sectors?
- Which challenges and the facilitating factors inform the implementation of the 2005 Guidelines across three humanitarian sectors?
- Which sectors were held accountable for adhering to the 2005 IASC GBV Guidelines?
- How donors used the Guidelines in determining funding allocations in specific sectors?

BORDERS (SCOPE) OF THE EVALUATION

Current evaluation does not measure organisational performance or the rate of GBV. The evaluation focuses on assessing the extent of implementation of the global guidance on GBV prevention and response across three selected sectors (WASH, Health, Shelter) of humanitarian effort targeting Syrian refugees in Northern Syria, the Kurdistan Region of Iraq, Lebanon and Jordan. The evaluation also aims to identify challenges and facilitating factors as well as the role of the key donors in the process.

2005 IASC GBV Guidelines are used in the current evaluation as a benchmark, representing the global guidance on GBV prevention and response.

Although the evaluation will generate some information on other responses to GBV, its scope does not cover the study of various ways in which humanitarian effort deals with the problem of GBV.

In terms of historical record covered, the evaluation will go back at least two years.

BENCHMARK

The performance of respective sectors will be compared against the minimum standards outlined in the IASC GBV Guidelines.

INDICATORS

- Extent of incorporation per sector
- Key actions meeting “success” or “partial success” criteria out of all key actions reviewed per sector
- Challenges identified per sector
- Facilitating factors identified per sector
- Actions taken if sectors did not adhere to the guidelines (non-quantifiable indicator)
- Share of donors referring to IASC GBV Guidelines and/or using the Guidelines among all donors interviewed.

METHODOLOGY

Data collection through face-to-face semi-structured interviews with key informants, FGDs in camp and non-camp settings, document review and site visits.

Criteria standards: Minimum standards of GBV prevention and response as outlined in 2005 Guidelines represent the criteria standard.

Measure of success: Full incorporation of the Guideline represents “success”; failure to incorporate Guidelines represents “failure”. Partial incorporation represents “partial success”.

For measurement instructions, please, see guidelines for data collection.

SOURCES OF THE EVALUATION DATA

Written sources: country reports, programme documents, country strategies, assessments, safety audits, meeting protocols.

Oral sources: face-to-face interviews (semi-structured), FGDs
Observation (site visits)

GUIDELINES FOR DATA COLLECTION

Measuring the extent of incorporation of the 2005 Guidelines in assessment and selection, design, monitoring and evaluation of programmes across three humanitarian sectors in selected sites.

The task will require triangulation of qualitative data with numerical indicators collected through the key actions section of the questionnaire. The key action list presents the main framework for measuring the extent of incorporation. Questions, examining the incorporation of the key actions, are included as a separate section in every questionnaire.

The main set of questions in this section corresponds to the **key actions proposed in the 2005 IASC GBV Guidelines** as necessary for ensuring the minimum standards of GBV prevention and response.

In the **key informant questionnaires (for WASH/Health/Shelter sectors)** there are 10 main questions written in bold font and marked by red arrow bullet point. Please assign the value of 1 for each positive response (“yes”), and 0 for each negative response. If the respondent answered “no” to all 10 main questions (sum of all answers equals 0) we will consider it a failure to incorporate the minimum standards of GBV prevention and response. If the respondent answered “yes” to all 10 questions (scored 10) this will be considered a complete incorporation of the minimum standards. Scores between 1 and 9 designate “partial incorporation”. Please mark the score for each interview and include this data in the report.

Sometimes, the respondent will answer sub-questions (written in bold, no red arrow bullet point) in a way that will reveal that the answer given to the main question is inaccurate and does not reflect the real situation. Please mark scores for each sub-question in the same way as you did for key questions and if over 50 per cent are negative (“no”) make a note of it in the report. The discrepancy between general response and the responses to specific questions is very important and should not be overlooked.

REFERRAL TO AND USE OF 2005 GUIDELINES:

The data is generated by questions in sections 3-6 of the questionnaires designed for the WASH, Shelter and Health sectors. The questionnaire includes open ended as well as closed questions. Wherever the question requires a “yes/no” answer, please mark the respondent’s answer, then move to the follow-up questions. The questionnaire contains instructions on the order of questions and follow-up questions.

TERMINOLOGY:

Please, take into consideration that terminology may change from organisation to organisation and do your best to match the terms used in the questionnaire to the terms used by the respondents. Please ask for clarifications if necessary.

IDENTIFYING CHALLENGES AND FACILITATING FACTORS:

Section 8 contains specific questions regarding the challenges and facilitating factors. However, asking about the reasons behind the lack of the compliance to the minimum standards of GBV prevention and response is very important and should be done consistently every time such a lack is revealed.

Whether the answer is “yes” or “no”, please, ask the respondent to elaborate. If respondent wishes to add explanations, please always provide this opportunity. Encouraging the respondents to explain the reasons for the lack of adherence to 2005 IASC GBV Guidelines is crucially important.

ACCOUNTABILITY:

Please encourage the key informants to explain what happens if the recipient fails to incorporate the minimum standards of GBV prevention and response.

THE ROLE OF DONORS IN SUPPORTING THE USE OF 2005 GBV GUIDELINES

Please use the separate donor questionnaire to interview the representatives of the donor organisations. Once again, encouraging the respondents to explain the reasons for the lack of adherence to 2005 GBV IASC GBV Guidelines is crucially important. **Whether the answer is “yes” or “no”, please ask the respondent to elaborate. If respondent wishes to add explanations, please always provide this opportunity.**

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