Endline Study: UNRWA Gender-Based Violence Prevention Framework

Final Report

Prepared for //
Gender Section, UNRWA HQ

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Acronyms

ABAAD	Resource Centre for Gender Equality
CG	Commissioner General
CMR	Clinical Management of Rape
CSOs	Civil Society Organisations
FGD	Focus group discussions
FO	Field Office
GBV	Gender Based Violence
GBViE	GBV in Emergencies
GFO	Gaza Field Office
HQ	Headquarters
IASC	Inter-Agency Standing Committee
ICIP	Infrastructure and Camp Improvement programme
JFO	Jordan Field Office
LFO	Lebanon Field Office
M&E	Monitoring and Evaluation
MSF	Médecins Sans Frontières
MTS	Mid-Term Strategy
NRC	Norwegian Refugee Council
RBM	Results-based management
RSS	Relief and Social Services
SEA	Sexual Exploitation and Abuse
SFO	Syria Field Office
SOP	Standard Operating Procedure
USD	US Dollars
UNFPA	United Nations United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations International Children's Emergency Fund
UNRWA	United Nations Relief and Works Agency for Palestine Refugees in the Near East
WBFO	West Bank Field Office
WHO	World Health Organisation

Executive Summary

This report explores the extent to which UNRWA has been able to incorporate a GBV prevention component into Phase 2 of its "Building Safety" project. It assesses progress according to the 2016 baseline and UNRWA's GBV Prevention Framework Theory of Change. It seeks to provide forward looking recommendations to support the Agency as it transitions to its next phase of GBV prevention work, following on from the project's close.

Methodology and evidence base

The report builds on: 28 face to face interviews and 27 focus group discussions with a purposive sample of key informants from UNRWA field offices; an online survey of 170 staff; interviews with 21 UNRWA partners; eight focus group discussions with 80 UNRWA beneficiaries in Jordan, West Bank and Gaza; document review, including monitoring data, progress and annual reports; and a face to face validation workshop with staff members involved in the project from each of the five field offices and HQ.

Key findings

Key Finding 1: Overall, UNRWA has taken some important steps to mainstream GBV prevention across its work on gender based violence. These attempts are to be lauded as GBV prevention is a notoriously difficult area of work. It requires a deep challenging of existing cultural norms, norms in which staff are themselves often embedded. In this context, staff were facing compounding challenges including: the specific socio-economic and cultural context in the region which makes prevention work particularly complex; the conflict in Syria; the ongoing blockade in Gaza; the implications of the United States cutting its contribution of USD 300 million to the Agency and high turnover of key staff.

Key Finding 2: Staff awareness, knowledge and understanding regarding GBV prevention have been improved to some extent and to varying degrees but a response focus still dominates and cultural factors remain barriers for some staff. Further investment and focus will be required to ensure a systematic integration of a GBV prevention lens across UNRWA's work.

- **Evidence shows an improved awareness among staff about GBV prevention work.** Understanding of the distinction between GBV response and prevention has increased from 68% of staff being completely clear about the distinction at baseline to 79% at endline. Staff are also more familiar with GBV prevention work- an increase from 50% to 69% at endline. The focus remains, however, on awareness raising rather than more strategic and transformative attitudinal or behavioural change.

- **Staff attitudes to prevention work have increased to some extent but cultural issues remain a barrier for some.** The perceived relevance of prevention work has not changed between baseline and endline, with 65% of staff believing that GBV prevention is *fully relevant* to their work and 73% believing that it is *fully relevant* to UNRWA's mandate. There has, however, been an increase from 67% to 74% of staff completely agreeing that GBV prevention is *essential to the success* of their work. Data from focus groups and interviews show that cultural barriers for some staff remain. Differences between UNRWA's beliefs and those of staff; staff reluctance to intervene in domestic or personal affairs and; the dominant culture, religious beliefs and practices and conservative gender roles were highlighted during focus group discussions and interviews as ongoing barriers, as they were in the baseline study.

- **The majority of staff attention continues to be focused on response**, with interviewees in Lebanon and Jordan estimating that 80% of GBV work is dedicated to response and 20% to prevention and other field offices sharing a similar breakdown. Staff report that they are better able to identify GBV cases and are more confident in responding to them based on the training they have received, with confidence levels increasing from 56% to 65% between the baseline and endline.
- **Staff are feeling more insecure and unsafe to carry out work on GBV.** There has been a 20% increase in perception of risks to staff well-being since the baseline. This perception has led to a reluctance of staff to refer in fear that this will make life more difficult, not only for survivors but also for themselves. While this fear does not necessarily correlate to reported incidences against staff, this risk is an important challenge for the Agency to address as it invests more in GBV work.

Key finding 3: The mainstreaming approach has enhanced the sustainability of the prevention element of the project. The targeting of existing frontline staff, the adoption of a multi-sectoral approach and the integration of a prevention approach across the suite of "Building Safety" products has maximised staff reach, improved value for money and gone some way to ensuring that capacity building efforts are retained by UNRWA.

Key finding 4: While perception among staff of leadership engagement has improved- from 33% of staff strongly agreeing that there is strong leadership for GBV prevention to 48% at endline- there remain important gaps in terms of leadership. These include the need to ring-fence regular funds or source project funding to address GBV prevention and response, gaps in middle management leadership across the organisation in terms of support and prioritisation work, and the need to improve the knowledge, attitudes and practice of some managers.

Key finding 5: There is a clear recognition from UNRWA and its partners of the Agency's comparative advantage in GBV prevention, in terms of its reach and embeddedness in Palestine refugee communities; the quality of services provided compared with host governments in some cases; the ownership that UNRWA can provide to GBV prevention work given that its staff are also part of communities; its multi-sector approach bringing together health, education and RSS; and staff capacity and commitment, as well as intimate knowledge of the working context. The percentage of survey respondents who completely agree that UNRWA is uniquely placed to work successfully on GBV prevention has remained stable between the two surveys (69% at baseline and 70% at endline). Some important partnerships have been built up with a combination of national government institutions, community based organisations, international NGOs and other UN agencies. A more systematic approach to these moving forward will allow UNRWA to leverage resources most effectively to deliver prevention work.

Key finding 6: The evidence shows that while prevalence remains high there have been some shifts in knowledge and attitudes at community level regarding GBV awareness, particularly amongst women. This is a fundamental step in prevention. Communities in all five field offices are perceived by staff to being more open to discussing GBV, and beneficiaries who participated in the end-line study coincide in that their thinking around GBV has shifted and issues are now more openly discussed than they were in the past.

Key finding 7: UNRWA investment in developing a GBV learning culture has paid dividends but systems for monitoring results need strengthening and resources allocated are still seen as inadequate. There has been an increase between baseline and endline from 14% to 35% of respondents who completely agree that monitoring data is available to strengthen prevention work; and there is also an increase in staff reporting that they completely agree that they

use M&E data to improve their work from 25% to 41%. The change in these percentages is positive but they nonetheless remain low and staff report that there continue to be gaps in the use of data for decision-making, feedback and analysis to inform practices, as well as in the harmonisation of data across programmes.

Conclusion and recommendations: There is much for UNRWA to build on, including many good practices from each of the field offices. GBV prevention should not be seen as an after-thought or a bureaucratic hurdle but a requirement of an everyday staff practice that seeks to ensure that the rights of all Palestinian refugees are met across all UNRWA services.

With the project coming to a close there is a real risk that gains are not consolidated and scaled up. As part of the transition planning, it will be important to continue to build on the mainstreaming approach to GBV prevention, whilst also establishing clear ownership of gender and GBV work and clear reporting lines between programmes and across the Agency. The RSS reform provides a critical opportunity for UNRWA to ensure that GBV prevention work is coordinated and mainstreamed in a holistic manner across UNRWA programmes.

Key recommendations are as follows:

Recommendation 1: Establish specific funding for GBV prevention and response work going forward.

Recommendation 2: Establish clear ownership of gender and GBV work with clear and consistent reporting lines between programmes and across the Agency.

Recommendation 3: Ensure sustainability and consolidation of training provided by offering refresher and specialised training to staff, and by prioritising the training of newly recruited staff.

Recommendation 4: Strengthen middle-management leadership for GBV.

Recommendation 5: Put in place mechanisms for continuing work on on-the-job coaching and learning by doing, including with the support of supervisory staff, to ensure that knowledge gained through training is translated into practice.

Recommendation 6: Strengthen UNRWA's data practices, including consolidation of data across departments, and its capacity to undertake gender analysis to feed into planning and decision-making.

Recommendation 7: Enhance mechanisms for protection of staff from risks faced in their communities for engaging with GBV and in terms of duty of care.

Recommendation 8: Develop a systematic approach to partnerships.

Recommendation 9: Improve beneficiary targeting on GBV prevention to more systematically include men and community leaders, as well as moving from awareness to attitudinal change.

1. Introduction

1.1 Report structure

This report sets out the findings from the endline study of UNRWA's GBV prevention work undertaken in February and March 2019.

The objective of this endline study has been to provide an evidence-based understanding of UNRWA's trajectory in incorporating the prevention component into Phase 2 (2017-19) of the 'Building Safety' GBV project across the Agency. Findings from the endline study have allowed the consultancy team to identify and corroborate change against the findings of the 2016 baseline study on UNRWA's GBV prevention work, to provide an account of change over time and to trace UNRWA's contribution to that change through its GBV prevention work.

Findings from the endline study are the basis for recommendations provided at the end of this report in view of the 'Building Safety' project coming to an end in May 2019 and the transition plan being developed for the next phase of GBV work in the Agency. These recommendations are focused on ensuring that GBV prevention work undertaken so far can be taken forward, consolidated and built upon. While the focus of the study has been on GBV prevention, many of the findings resonate with the Agency's wider work on GBV and the impact of the 'Building Safety' project.

This report includes the following sections:

- A summary of UNRWA's context, the scope of Phase 2 of the 'Building Safety' project and the GBV/ GBV Prevention key products put in place since 2016, when this consultancy started;
- An outline of the endline study methodology and any limitations encountered;
- Findings from the endline study based on the document review, results from the online survey, field visits to Amman HQ, Jordan (JFO), Lebanon (LFO), Gaza (GFO) and the West Bank (WBFO), and remote engagement with the Syria Field Office (SFO);
- Conclusions and recommendations for going forward as the 'Building Safety' project comes to a close.

1.2 UNRWA's context

Key to understanding the impact of, and the challenges regarding UNRWA's work on GBV prevention is to understand the context in which the work is taking place. Key contextual elements that have had an impact on the rolling out and implementation of the 'Building Safety' project in terms of the timelines, quality of and capacity to deliver the project include:

- **The conflict in Syria** has been ongoing for eight years with significant displacements of the population including Palestine refugees there. As a result, UNRWA staff and communities have been displaced; some areas were besieged for nearly seven years — including some Palestine refugee camps; and there are Palestine refugees from Syria who fled to neighbouring countries. This situation has impacted the way in which UNRWA has been able to or constrained from providing services - for example having no access to besieged areas it was unable to reach its beneficiaries there, and given internal

displacement within Syria, it had to provide services in shelter settings. In addition, with the noted increase in GBV cases in emergencies, there has been a predominant focus on response and less capacity for engaging in prevention.

- **In Gaza**, the ongoing blockade creates a significant challenge for UNRWA in many aspects of its work with what staff refer to as an 'ongoing cycle of violence' where a whole society is perceived as traumatised and perpetually on the brink of an emergency. The protracted humanitarian crisis and its impact on gender and family dynamics has exacerbated GBV in all its forms, including sexual violence, intimate partner violence and child marriage. Levels of GBV are also thought to be aggravated by the economic situation, which has worsened over the timeframe of the 'Building Safety' project. This situation has repercussions on UNRWA's GBV workload.

- **Cultural factors** are unanimously recognised as the main challenge for UNRWA to work on GBV. Traditional social and cultural values held by communities (and by UNRWA staff who are members of those communities), as well as the attitudes of leaders (e.g. religious leaders and Popular Committees) are seen to pose considerable challenges for GBV response as well as GBV prevention.

- **Funding cuts** following the United States' decision to cut its contribution of USD 300 million in January 2018. This funding gap threatened UNRWA's ability to provide basic services to Palestine refugee beneficiaries, impacted on staffing numbers and on the prioritisation of services, including GBV and GBV prevention. Staff strikes against the financial crisis and job losses have also led to disruptions to services throughout the project, with offices closed for as long as three months at a time. Funding cuts have led to a prioritisation of core services: education, health, RSS. GBV is not considered to be a core service. In the absence of robust research on the prevalence of different forms of GBV, it is difficult to make the point that this may be a needed core service for women and girls in the community.

- **The structure of GBV prevention and response activities** in each field office (FO) has to some extent evolved organically and according to context, and different structures have been established to deliver work on GBV response and prevention across FOs. For instance, in the West Bank, GBV has been over most of the 'Building Safety' project coordinated through the health department but has recently moved to RSS. In Gaza, it was coordinated at first by the Gender Initiative, then by RSS and Protection with support from the now defunct Community Mental Health project. In Syria, it sits in RSS. Whilst these different structures may have been contextually relevant to each FO, they create a challenge in coordination and consistency across the Agency given the number of different actors engaged. In LFO and JFO, GBV coordination is within the Protection and Neutrality units. The upcoming RSS reform will create some uniformity across fields with specialised area supervisor social workers with overall responsibility for GBV case management and high-risk cases in each field, although the reform has is still underway. The lines of communication and coordination between RSS and other programmes as the 'Building Safety' project comes to a close are not yet fully established and create uncertainty on where GBV will sit and who will be accountable for it.

- **High turnover of staff** has been a challenge in all FOs. Staff turnover has signified a loss of GBV and GBV prevention skills and practices; and it creates a need for the provision of training to new staff, which cannot always be fulfilled or provided in a timely manner. The HQ 'Building Safety' Project Coordinator has changed several times over the course of the project, which has led to a perceived lack of continuity and consistency in the delivery of the project. At the same time, the Head of the Gender Section was seconded for a period of

six months to the Dignity is Priceless Fundraising Campaign resulting in a discontinuity of project leadership.

- **There has been a renewed focus on prevention of Sexual Abuse and Exploitation (SEA)** from donors, across the UN and within UNRWA which has led to an increase in profile of SEA, the development of new staff circulars and codes of conduct and staff training on SEA. There is a clear recognition within UNRWA of the interlinkages between GBV and SEA and the renewed focus on SEA has made clearer accountabilities and responsibilities for reporting and preventing SEA across UNRWA (staff to staff SEA as well as staff to community SEA), which is seen as positive for GBV work more generally.

1.3 The 'Building Safety' project

The 'Building Safety: Mainstreaming GBV Interventions into Emergency Preparedness, Prevention and Response' project has consisted of two phases. Phase 1 (2015-2017) focused on capacity building to enhance UNRWA capacity to integrate GBV response, prevention and mitigation in its emergency response. This was done through the development of capacity building products aligned with international guidelines and adapted to the Agency's context.

Building on phase 1, phase 2 (2017-2019) aimed to enhance the institutionalization of addressing GBV in field and programme work, ensuring quality control, improving accountability and involving communities in GBV mitigation and protection from GBV. Through field- and programme-led initiatives, this stream of work thus aimed to enhance accountability around the mainstreaming of GBV.

Key outputs of the 'Building Safety' project[1]

Phase 1: Establishing a common understanding

- GBV Prevention Framework roll-out
- Guidelines on GBV Mitigation in Emergencies
- E-learning course on GBV in Emergencies (GBViE)
- GBV Training Package on Enhancing Understanding of Gender-Based Violence
- Community engagement (mostly through awareness raising campaigns)

Phase 2: From knowledge to practice

- Roll-out of capacity building plans (including roll out of training packages) [2]
- On-the-job coaching and pilot mentoring programme for UNRWA staff working on GBV
- GBV Competency Framework with priority focus on three key areas of competencies: the application of the survivor-centred approach; communication and counselling skills; and strengthening of supervision of specialised GBV staff
- Development and roll-out of M&E tools (pre- and post-questionnaires linked to Training Package and e-learning; tools contained in the GBV Prevention Framework)

[1] UNRWA (2019a)
[2] The number of staff trained in 2018 is 2,419. The total number of staff trained along the lifetime of the 'Building Safety' project is still to be compiled.

- Community engagement (through community structures, piloting of self-protection mechanisms in two FOs, and six TV spots[3] entitled tackling gender and GBV related issues)

2. Methodology

The endline study was grounded in an enquiry matrix (see Annex 1). The enquiry matrix is broadly the same as the one employed for the baseline study that IOD PARC undertook in 2016, with refinements introduced to capture change over time in relation to the development and roll out of the GBV Prevention Framework. The data collection tools, which included an online survey, interviews and focus group discussions, were developed in line with the enquiry matrix.

The use of the enquiry matrix framed the data collection and analysis processes and enabled the consultancy team to triangulate evidence to generate the findings presented in the report, and to systematise how common threads or themes are supported by evidence.

2.1 Overview of data collection process

Interviews and focus groups discussions

The consultancy team conducted 28 semi-structured interviews and 27 focus group discussions with a purposive sample[4] of UNRWA staff in Lebanon, West Bank, Gaza, Jordan, Syria and HQ in February and March 2019. Remote interviews were conducted with Syria FO staff. Interviewees were selected based upon the request of the consulting team to have broad coverage of the sectors engaged in GBV work and staff at different levels of seniority. The purpose of these interviews and focus groups was to obtain details of UNRWA staff's knowledge, attitudes and understanding of GBV prevention and the wider context of GBV prevention practices and to identify changes related to the roll out of the GBV Prevention Framework.

The team also conducted 21 interviews with external stakeholders with whom UNRWA works on GBV. The purpose of these meetings was to gain an understanding of the broader context of UNRWA's work, identify examples of good practice and UNRWA's comparative advantage, as well as examine UNRWA's trajectory in widening its partnership approach to address GBV.

During field visits, the consulting team also conducted eight focus group discussions with 80 UNRWA beneficiaries in Jordan, West Bank and Gaza to ascertain how beneficiaries perceive and understand the issue of GBV, their awareness of GBV services from UNRWA or other providers, challenges in addressing GBV and changes they have observed over the past four years when the 'Building Safety' project was being implemented.

Online survey

The online survey was rolled out to ensure broad engagement with UNRWA staff who are working on GBV or will potentially engage in GBV work in the future. The purpose of the survey was to gauge

[3] The TV spots series is entitled *Dukkanet Abu Al-Muhandisah Lina*, which translates as *The Shop of Engineer Lina's Father*.
[4] A purposive sample is "a type of nonprobability sample. The main objective of a purposive sample is to produce a sample that can be logically assumed to be representative of the population. This is often accomplished by applying expert knowledge of the population to select in a non-random manner a sample of elements that represents a cross-section of the population" (Lavrakas, 2008).

information around staff attitudes and culture, knowledge and skills on GBV prevention work and on UNRWA practice regarding GBV Prevention, as well as to use this as an opportunity to identify examples of good practice or of common weaknesses and challenges.

The endline survey was sent to 421 staff in the five FOs and HQ at different levels of seniority including through the management team, covering all UNRWA Programmes and also including staff from Protection, Communications, Security, Strategic Partnerships Division, and Legal Affairs. The overall response rate was of 40%,[5] with highest response rates for West Bank and Syria (see Table 1 below).

Table 1: Survey responses per location

Field Office	Number of names received	Number of respondents	% response rate
HQ	64	31	48%
Gaza	95	18	19%
Jordan	105	31	30%
Lebanon	34	9	26%
Syria	42	25	60%
West Bank	81	54	67%
Total	421	170	40%

The team employed a purposive sample that included respondents who had been invited to participate in the baseline study, as well as additional staff in relevant job positions that have since joined UNRWA as new recruits or who have replaced staff that retired or left the organisation. The purposive sample was selected in consultation with the UNRWA Gender Section.

There were 60% female respondents and 40% male respondents. Most survey responses were received from Education staff (29%), Relief and Social Services (21%) and Health (12%). The lowest number of respondents were from Safety and Security, Communications and Emergency. This is probably reflective of the size of the organizational entity in UNRWA and also their role in GBV, which means there was a good cross-section of respondents.

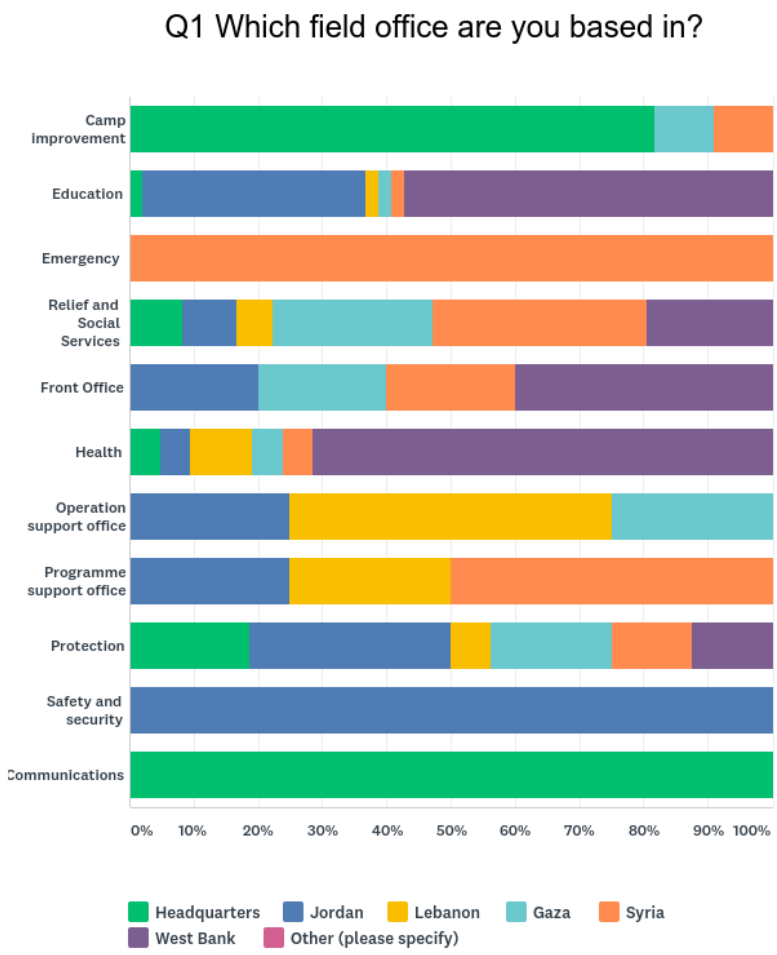
However, when examining responses by department and field office there are some noticeable divergences. In Jordan, 17 responses were from the Education department, followed by five from Protection. In Lebanon, most responses came from the Health and RSS departments (two responses each), and one from Education. In Gaza half of responses came from RSS (nine responses) followed by Protection (three responses). In Syria, 12 responses were received from RSS, and three from Emergency — these two being the highest. In the West Bank, 28 responses were from the Education sector, and 15 from Health. At HQ level, the highest number of responses were received from Camp Improvement (nine responses).

This could reflect, to some extent, the inconsistent structures regarding GBV prevention and response work from one field to the next. However, divergences in department participation do not necessarily correspond to where GBV sits for the various FOs. Responses from Syria are consistent with GBV and GBV prevention falling under RSS. In Jordan, GBV falls under Protection and is implemented by the

[5] Survey response rates are typically between 10% and 30%. The higher than average response rate for this survey likely reflects the targeted approach (purposeful rather than random sample) to reach respondents.

Health and Education sectors; responses from the Education sector are higher than Health, which is consistent with Education being the largest programme in Jordan. However, in the West Bank GBV work falls under RSS (previously Health) but the Education sector registers a higher level of responses. The Gaza and Lebanon response rates in percentage terms are rather low, with some sectors only having two or three respondents. It is not possible to infer reasons for these divergences. Figure 1 below provides a breakdown of responses received per field office and sector programme/ support services.

Figure 1: Responses per field office and sector programme/ support service



Document review

Documentation relevant to the endline study was provided by FOs and HQ. This included documents that have been developed since the baseline study, as well as monitoring data, progress and annual reports, and relevant tools employed for GBV and GBV prevention work (see Annex 3 for References). The team reviewed documents in line with the enquiry matrix and evidence from these documents was drawn to triangulate findings from interviews, FGDs and the online survey.

Validation workshop in Amman

Following the submission of the draft endline study report, the findings from the endline study were presented to relevant UNRWA staff (Gender Section, those involved in implementing the 'Building

Safety' project, GBV Focal Points, etc.) in a workshop in Amman in April 2019. This workshop was an opportunity to gather stakeholder feedback on the findings presented, serving to both validate them and to feed into discussions for UNRWA's transition plan for the 'Building Safety' project as it comes to an end.

2.2 Limitations

The team faced some limitations that affected data collection and analysis for the endline study.

- In terms of the **online survey**, we received low numbers of responses from Lebanon and Gaza and it is not possible to undertake conclusive analysis based on these responses of specific sectors, for example, or the experience of the FO as a whole. In order to mitigate this limitation, the team has triangulated against interview and document review findings.
- Respondents in Syria who were in remote locations reported having **difficulty in accessing the survey** due to slow or unavailable internet connection. Suggestions were made by the team to respondents who raised concerns, but these technical difficulties could have impacted the response rate for Syria.
- Interviews and focus group discussions with SFO were **conducted remotely** as it was not possible for the team to travel to Syria for the endline study. Even though interviews and focus group discussions in person are preferable for such an enquiry, participation and organisation of the remote enquiry with SFO was comprehensive and there are no noted repercussions related to remote engagement other than not having been able to conduct FGDs with UNRWA beneficiaries there.
- The fact that a **purposive sample was used** may influence both the response rates and the types of responses received as the staff chosen within the sample were predominantly those already working on GBV response or prevention and therefore more likely to have been trained or be aware of approaches to GBV prevention. Therefore, responses and response rates may be more positive than had the survey been deployed to a random sample of respondents or to all staff in the organisation. The number of respondents per programme and support services is included in the table below:

Table 2: Responses by programme or support service

Programme/ support service	Number of respondents	Percentage (%)
Education	49	32.03
Relief and Social Services	36	23.53
Health	21	13.73
Protection	16	10.46
Camp Improvement	11	7.19
Emergency	3	1.96
Operation Support Office	4	2.61
Programme Support Office	4	2.61
Front Office	5	3.27
Safety and Security	1	0.65
Communications	3	1.96
Total	**153**	**100**

3. Detailed findings

3.1 Staff knowledge, experience and learning preferences related to GBV

3.1.1 General knowledge about GBV prevention in UNRWA

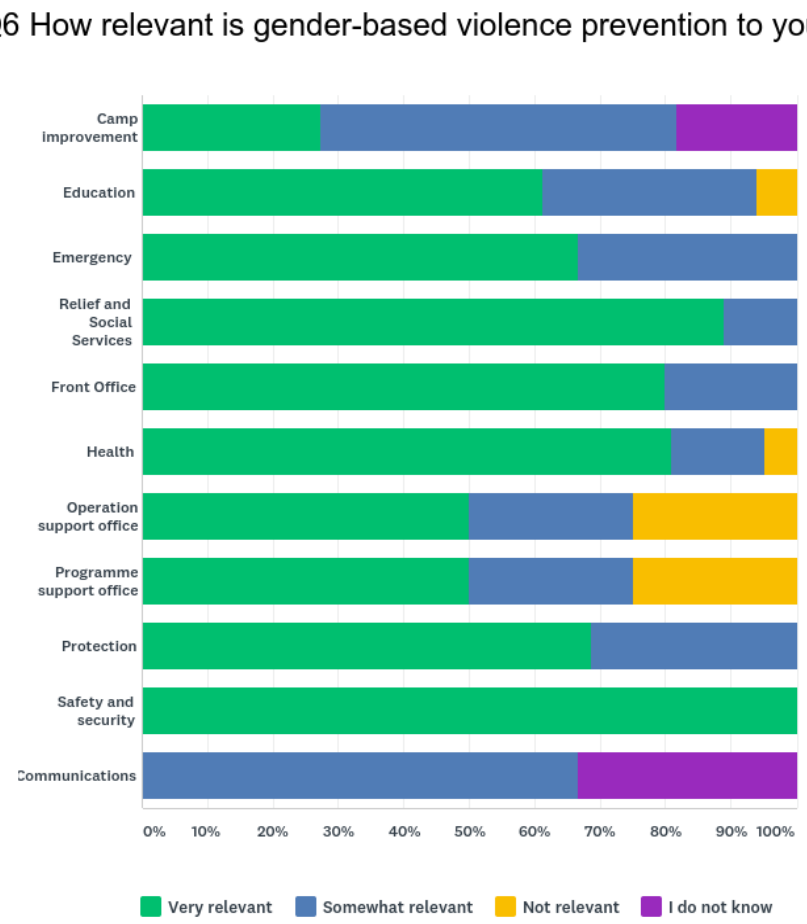
Frontline staff were able to differentiate between response and prevention. Interviews with all FOs suggests that most of UNRWA's work continues to predominantly focus on GBV response rather than prevention. Interviewees in Lebanon and Jordan estimated that 80% of GBV work is dedicated to response and 20% to prevention. Similar perceptions were shared by Gaza and West Bank FOs, and Syria highlighted that due to the crisis their work had also been mostly focused on response. The work that has been done on prevention and the ability to distinguish between prevention and response is attributed to the 'Building Safety' project; and there is a recognition that in order to tackle GBV there is a need to continue to build on and expand GBV prevention work.

Survey responses suggest that there is greater clarity about the difference between responding to and preventing GBV compared to baseline results; 79 percent of respondents completely agree with the statement *I am clear about the difference between responding to and preventing GBV* (compared to 68% in the baseline). There is also an increase in responses completely agreeing to being knowledgeable of who the main actors working on GBV prevention within and outside UNRWA are with an increase of 13% (internal) and 10% (external), respectively, between the baseline and endline. Discussions with staff during interviews reinforces the survey findings that they are better able to differentiate between what constitutes response and what pertains to prevention. Nonetheless, in terms of prevention most of the focus is on awareness raising rather than on attitudinal or behaviour change. For example, puppet shows aimed at children are becoming increasingly used, for instance in Syria and Jordan. Frontline staff in the health sector also recount addressing concerns of child marriage in health clinics with patients. Nonetheless, there is also evidence of other types of prevention activities being rolled out more recently. In Jordan too, there has been work done by UNRWA on the self-protection methodology, as well as Safety Walks and the Absence Tool to detect child marriage risk for girls. For the most part, these tools have been rolled out in the education sector in schools. In Lebanon, Women's Committees provide safe spaces and identify people at risk of GBV.

The perceived relevance of GBV prevention to the work of staff who participated in the survey has not changed between baseline and endline, with those considering it as very relevant remaining at 65%, and 28-29% for somewhat relevant. Figure 2 below provides endline survey responses disaggregated by sector for programmes and by support services. Figure 2 illustrates that RSS is the programme area where most respondents find GBV prevention very relevant to their work.

What has shifted between baseline and endline is the familiarity of respondents with UNRWA's GBV prevention work: those reporting being very familiar have increased from 50 to 69%. When disaggregated by field, all FOs range between 67 and 80% for being very familiar with GBV prevention work, whereas for HQ this figure is 35%, with most responses (52%) reporting being somewhat familiar.

Figure 2: Relevance of GBV prevention work by programme sectors and support services



Familiarity with tools and guidelines

Responses to the endline survey suggest that staff have greater familiarity with GBV prevention tools and sources of information than in the baseline, particularly for thematic specific knowledge, UNRWA's website and information from GBV Focal Points, as shown below in Table 3. Nonetheless, there is a decrease of nearly 16% (55% baseline to 39% endline) in the use of UNRWA publications and/ or guidelines. Qualitative responses to the survey refer to UNRWA's regulatory framework, UNRWA's Gender Strategy, the UNRWA GBV Prevention Framework, UN policies, IASC GBV Guidelines as key reference documents.

The interviews conducted at field level suggest that there is familiarity with some GBV prevention tools, and there is widespread recognition of training such as the UNRWA GBV Training Package and the GBViE e-learning course, which is consistent with the survey responses received. These are deemed to have been very useful and they are highly regarded, including their pre- and post-test tools. However, these training tools are not necessarily focused on prevention. Staff are familiar with the GBV Prevention Framework and use some of its tools, but it is not generally cited as the main resource for staff or a document that they regularly refer to (with a few exceptions).

Table 3: Tools and sources of information on GBV prevention

Q13. What tools and/or sources of information do you use to support your knowledge of GBV prevention issues in your work?	Baseline	Endline	Difference
Thematic specific knowledge centre (for example a specialised online platform, a library, etc.) inside or outside UNRWA. Please specify	24.89%	51.76%	26.87%
UNRWA's intranet	39.56%	42.35%	2.79%
UNRWA's website	28.89%	56.47%	27.58%
UNRWA's publications and/or guidelines	55.11%	39.41%	-15.70%
UNRWA's Gender Focal Point(s) or advisers	49.78%	78.82%	29.04%
Other's publications and/or guidelines	36.89%	70.59%	33.70%
Other	12.00%	37.65%	25.65%

3.1.2 Skill and proficiency on key gender mainstreaming processes applied to GBV prevention

There is an increased perception among staff of gender mainstreaming into programmes and departments, particularly for frontline staff and senior management – although interviewees noted gaps remaining in relation to middle-management (e.g. some Chiefs of individual programmes at Field office level). This was attributed by stakeholders in part to the fact that these leadership positions are occupied in higher numbers by men. Nonetheless, this greater level of awareness on the part of staff of gender mainstreaming of GBV prevention is in line with the GBV Prevention Framework Theory of Change, which identified this element as an area of influence for UNRWA (see Theory of Change in Figure 3 below).

Survey responses regarding the mainstreaming of gender have improved from the baseline to the endline study; those who completely agree that gender has been adequately mainstreamed into operations has increased by 16% for policy, 13% for administrative instructions and for directives by 21%. Nonetheless, the lack of core funding for gender within UNRWA and the project-based nature of much of its GBV work poses important challenges, as is discussed below.

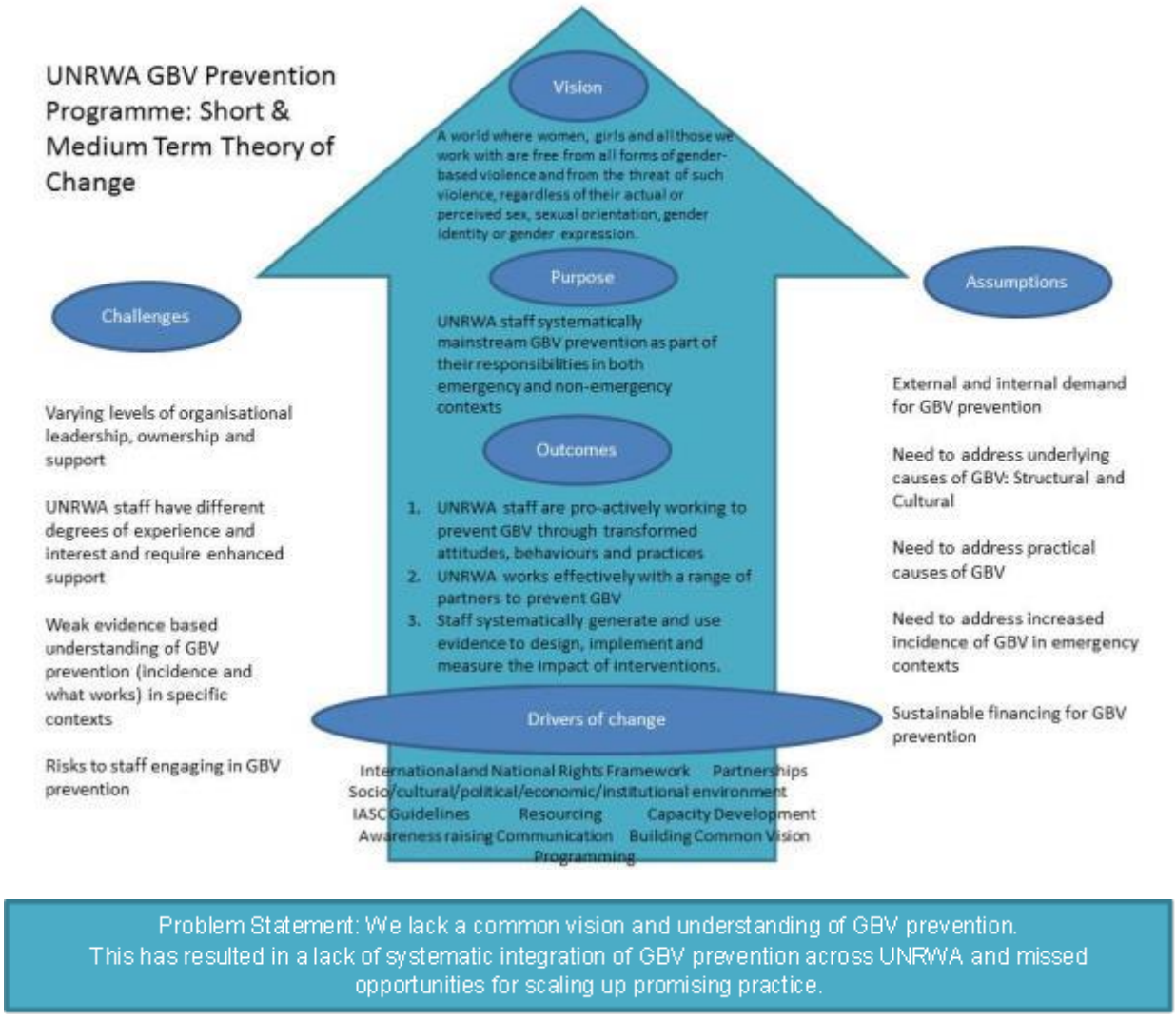
In terms of practice related to gender mainstreaming, all field offices collect sex-disaggregated data, although analysis of this data remains limited. Gender analysis in the design of interventions is conducted in some cases but not systematically, or required, as part of design. Reasons for the lack of gender analysis include gaps in capacity to undertake this analysis and limited use of monitoring data by the various sectors at frontline level. Nonetheless, at FO level there is some evidence of data being used, for example, to feed into LFO's Annual Protection Audit and related recommendations.

In terms of staff's self-reported confidence in being able to identify groups at risk of GBV, there has been an increase from 56 to 64% between the baseline and endline. Staff in all fields report that the number of GBV cases recorded has increased which corroborates reporting on GBV indicators in the RBM. Frontline staff in health, education and RSS across fields do note that they feel better equipped to identify GBV cases, and this is seen as a contribution of the 'Building Safety' project.

During the life of the project, LFO Health Front-line staff have received training in GBV, including a mechanism for referral to clinical management of rape (CMR). This has resulted in a dramatic increase of GBV cases identified by the Health Programme; from 4 in 2016 to 69 in 2018. Consequently, this has led to an increase in the access of survivors to basic services. Contrastingly, in Gaza, the number of reported GBV cases has also increased although stakeholders were unsure

whether to attribute this to increased reporting, increased detection of cases or a deterioration of the context in Gaza leading to higher GBV prevalence.

Figure 3: UNRWA GBV Prevention Theory of Change



3.1.3 Preferred learning styles

Interviews provided overwhelmingly positive feedback about the training received through the 'Building Safety' project: the GBV Training Package and the GBViE e-learning course. There was general consensus across FOs that trainings had contributed to a shift in knowledge and reflection from UNRWA staff on what constitutes GBV, and how they can work to prevent it, identify cases at risk, and also analyse their own working environment to recognise GBV in the work place and for them as members of refugee communities.

Staff interviewed often suggested that they prefer and enjoy trainings that are face-to-face and that allow for interaction with colleagues in their FO as well as between FOs. Even though they commended the GBViE course and its modular nature, they also highlighted that online courses can be isolating if they are not followed up by interaction and discussions. Survey results suggest that

face-to-face trainings are the preferred learning method for most respondents, increasing from 69% at baseline to 85% in the endline survey.

Another learning style that was preferable for staff was on-the-job leaning and learning by doing in order to ensure that the knowledge acquired through training courses is being appropriately applied. For example, the roll-out of the SOPs in LFO for 202 Primary Health Clinic staff used a two-phased approach which combined trainings with individual/ small group coaching (on-the-job learning) which took place in the April-June 2018 period and was well received by staff. However, due to delays in the project, the coaching aspect of the 'Building Safety' project had not been fully rolled out across all field offices by the time this endline study took place and it is not possible to fully ascertain its impact across FOs on staff knowledge and practice.

There is consensus that the training provided to frontline staff is not recognised as part of their workload by their supervisors, and there is therefore limited understanding and/ or support from supervisors, as well as a gap in the latter's knowledge and capacity to follow up on GBV work and ensure the application of training. The identification of supervision skills as a priority in the GBV Competency Framework is a positive step in this regard, as is the piloting of on-the-job coaching; support of staff in their practice is an identified gap that requires attention in going forward.

In addition, there were several suggestions for learning exchanges with other UN agencies, such as UNHCR and UNFPA; between FOs in a more systematic and regular manner than is currently the case; and with other countries to learn from their experiences in addressing and preventing GBV. Furthermore, there is interest in learning being further tailored to sectors beyond what is covered in existing training, with several FOs highlighting a gap in training on the provision of psychosocial support services at frontline level.

3.2 Personal attitudes and organisational culture related to GBV

3.2.1 Personal attitudes towards GBV

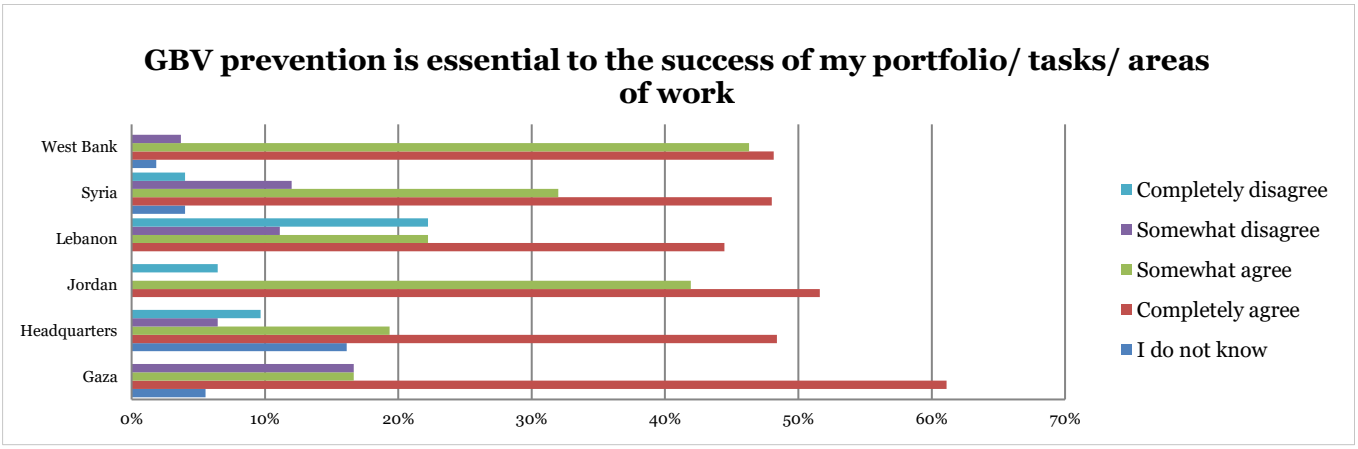
There has long been a recognition from UNRWA of the importance staff attitudes towards GBV can have on its work with '*UNWRA staff are pro-actively working to prevent GBV through transformed attitudes, behaviours and practices*' identified as one of the key intended outcomes in the UNRWA GBV prevention Theory of Change (see Figure 3 above). The GBV prevention baseline study found that there were often disparities between UNRWA's institutional position on GBV, which most staff recognised as being one of 'zero tolerance', and the position of many individual staff and their own cultural attitudes and values as members of the communities they live and work in. This meant that the institutional position was not being realised in practice.

Whilst changes in staff attitudes regarding GBV were not quantified in the baseline or endline survey, interviews reveal anecdotally that there have been some improvements in staff attitudes towards GBV over the course of the 'Building Safety' project. This was thought to be in part due to the trainings provided by the 'Building Safety' project and the contribution they had in influencing staff understandings of GBV; and partly to the emphasis placed recently by UNRWA on the prevention, reporting and consequences of SEA across the Agency in the form of staff circulars, messaging from UNRWA leadership and in trainings that have been disseminated.

The percentage of staff finding that *Preventing gender-based violence is fully relevant to UNRWA's mandate* and *Relevance of GBV prevention to my work* has remained consistent between the baseline and endline (72.5-73% and 65%, respectively, for both surveys). When asked the extent to which GBV prevention is essential to the success of their work, an increased number of staff

'completely agreed' rising from 67% to 74%. Disaggregated by field office, these numbers are quite different, though (see Figure 4 below). The highest percentage of staff completely agreeing was in Gaza (89%), followed by Syria (80%) with the lowest in Jordan (65%). For Gaza and Syria, this high percentage is likely due to the prioritisation from UNRWA of GBV in emergencies.

Figure 4: GBV prevention in relation to staff portfolio/ tasks/ area of work



The baseline study found that training on GBV in UNRWA has historically focused on technical definitions of GBV, on the referral system and on the identification of GBV cases with little evidence that UNRWA had made concerted efforts to change or challenge the attitudes and behaviours of its staff regarding GBV through trainings. However, the GBV Training Package and accompanying pre- and post-tests for staff developed under the 'Building Safety' project are thought to have helped address. The training and tests include sections where staff can answer regarding their attitudes; and these are then discussed as part of a facilitated group discussion. One staff member in the West Bank reported having delivered the training, and in a group discussion some staff answered that it was acceptable to abuse a woman if she was dressed a certain way. This led on to a facilitated discussion amongst staff where they discussed this viewpoint in light of the training they received and by the end of the training the staff reported understanding why their attitude was problematic.

The cultural context in which UNRWA works and the attitudes of staff were highlighted as challenges facing UNRWA in mainstreaming GBV prevention, including differences between UNRWA's beliefs and the beliefs of staff; reluctance to intervene in domestic or personal affairs; the dominant culture; religious beliefs and practices; and conservative gender roles. These challenges were also highlighted in the baseline study. There remain some worrying examples of staff attitudes to gender and GBV which could affect the Agency's work, although it is not possible to say how prevalent these are from the data collected during the endline study process as these were not specifically measured by the endline study. Examples given in the West Bank were that some health staff are reluctant to provide emergency contraceptives to women, even in cases where they have been victims of violence. Another was given in Gaza regarding the refusal of admittance of married girls to schools as it was thought they would be a corrupting influence on unmarried girls; this was also highlighted in Lebanon. There were also some staff members in interviews who argued that culture (in Gaza) should be decided upon by Gazans and that it was inappropriate for UNRWA to impose Western ideologies of rights onto its FOs – this view was also voiced in Jordan. In Lebanon, scepticism of the possibility of a woman being raped against her will was expressed during an interview. These examples suggest that additional work is needed to change staff attitudes in what pertains to GBV and gender norms/roles.

Interviews with staff revealed, as in the baseline study, a clear preference for UNRWA staff to intervene in GBV cases through community-based, such as Family Protection Committees, rather than formal/legal mechanisms. This was thought in part to be linked to (lack of) trust and perception

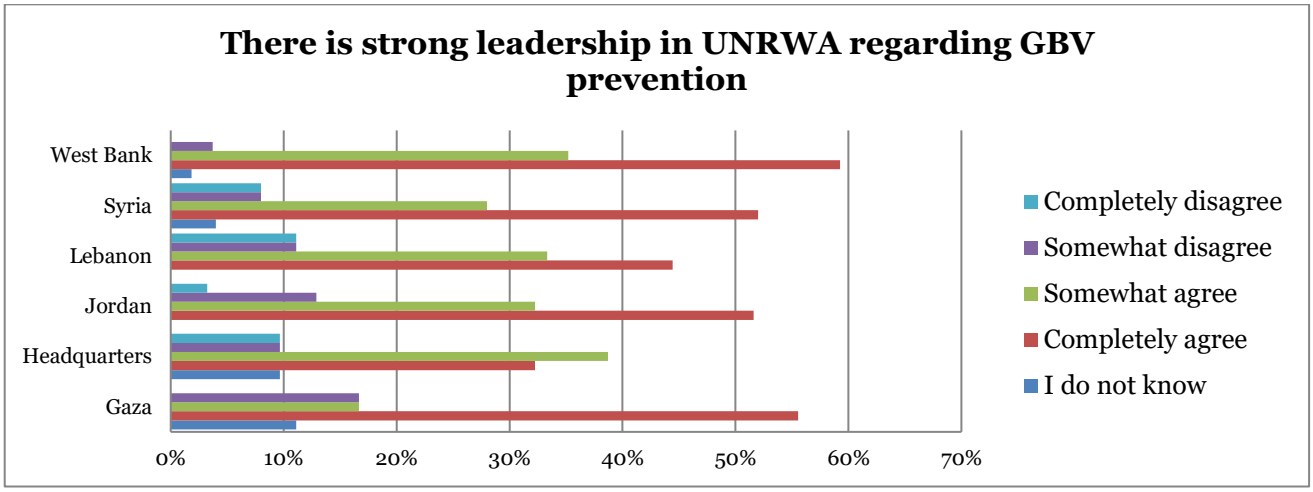
of the national systems and the potential risk to staff of raising cases to a legal level. In many cases, these community mechanisms were perceived by staff to be a culturally appropriate response and most appropriate in ensuring the safety and security of the survivor and their access to services. This was particularly noted to be the case in examples of sexual violence, where it was felt that if a girl was a survivor and this became known to the wider community through the intervention of police (or even of UNRWA), it could potentially ruin her chances of continuing in education as well as future prospects.

Informal mechanisms were also seen as preferable for dealing with staff to staff SEA within UNRWA as a workplace by some interviewees. It was noted that if there was a possibility for pursuing informal mechanisms, UNRWA staff were more likely to report abuse and harassment by colleagues as this may have lesser repercussions for them as members of their communities. Whilst this is concerning with regards to staff to staff SEA, it was also noted that even where suggestions had been made for informal mechanisms to be enabled, the Agency had rejected these across the board and continually emphasised that established procedures ought to be followed for reporting SEA at the workplace.

3.2.2 Organisational culture around GBV in UNRWA

In what concerns leadership and prioritisation of GBV work, there appears to have been a significant improvement in perceptions around the strength of leadership since the baseline survey; this has risen from 33% of respondents in the baseline survey strongly agreeing that there is *Strong Leadership in UNRWA regarding GBV Prevention* to 48% in the endline. This is particularly thought to be the case in terms of leadership at the highest levels of the organisation. There has been a focus from UNRWA leadership regarding SEA as a form of GBV and the expectations, responsibilities and behaviours demanded of staff related to this and the Commissioner General has become a visible gender champion. Whilst this increase in focus cannot be attributed specifically to the 'Building Safety' Project, the project has enabled UNRWA to embed process, guidance and protocols within the organisation which are supportive of these leadership messages.

Figure 5: UNRWA leadership on GBV prevention



It is interesting to note that when disaggregated by FO, there are some differences in perceptions of UNRWA organisational leadership on GBV according to the endline survey. For example, the highest percentage of respondents who 'Completely agree' was 55% from Jordan, with the lowest, 44% in

Gaza, Lebanon and the West Bank. The highest percentage of 'Completely' or 'Somewhat disagree' responses was in Lebanon with 33%.

Differences in perceptions of leadership are prevalent not just between field offices but at different levels of the organisation. Whilst perceptions of leadership have improved over the course of the 'Building Safety' project, there remain disparities in leadership and commitment between senior and middle management. This was noted for example by staff in West Bank who highlighted the strong commitment that was perceived to address GBV from the Director of Operations in each Field Office but that this was less the case from Programme Chiefs or Area Chiefs at a field office level as some Chiefs had been reluctant to prioritise staff attending GBV training. Staff also noted differences in some fields between the level of leadership between the different programme areas.

Staff in interviews also questioned the extent to which levels of leadership were linked to gender parity in leadership, as most leadership posts in UNRWA are occupied by men, despite the organisation having a gender parity action plan. The 'Building Safety' project has focused its efforts on frontline staff, whilst few leadership staff interviewed reported having had sufficient training themselves on GBV. This raises the question of both their ability to effectively supervise staff working on these issues and whether this is an area for UNRWA to prioritise going forward.

3.3 Challenges and best solutions

3.3.1 Capacity and resources for GBV prevention

Human and financial resources

While there is a perception that leadership for GBV has increased in UNRWA, this was not seen as being sufficiently in line with financial and human resources allocated to GBV. The percentage of staff who completely agree that UNRWA devotes sufficient human (19-29%) and financial resources (16-21%) to work effectively on GBV prevention has increased between baseline and endline.

The 'Building Safety' project has been appreciated by staff for having provided UNRWA with resources to strengthen its approach to addressing GBV. However, many staff in interviews highlighted the lack of institutional resources allocated from UNRWA's programme budget to GBV. With GBV being an institutional priority, it is noted that further resources should be allocated from the programme budget rather than GBV being addressed through projects. In addition, there is a lack of institutionally funded posts, which is a concern as the 'Building Safety' project comes to a close. As in the baseline study, the lack of human resources devoted to GBV was highlighted as an important challenge by a number of participants who mentioned high work load, lack of or limited time allocated for gender tasks in job descriptions, and inadequate support of senior management to undertake work on GBV prevention (see findings on leadership above). Interviews conducted predominantly suggest that work on GBV often comes down to the commitment of individuals. GBV Focal Points, for example, wear many hats with multiple responsibilities and some report they struggle to find time to prioritise GBV.

In terms of accountability for GBV work, there have been improvements in perceptions of accountability in the endline survey results compared to the baseline; with *UNRWA staff are held accountable* increasing from 17% completely agree to 36% and *UNRWA management is held accountable for informing, guiding, and supporting the introduction of GBV aspects effectively into its work* increasing from 15% 'Strongly agree' to 36%. However, staff reported that given the different structures and management of GBV activities across fields, there is a sense that no one department or programme owns and leads on GBV; and that there is a lack of clear coordination mechanism or

consistency in terms of reporting lines, links between programme areas, and roles and responsibilities. Only 35% completely agreed that roles and responsibilities to mainstream GBV prevention are clear in UNRWA. In Jordan, for example, where RSS is no longer dealing with GBV cases in an integrated manner with the Health and Education programmes, there is a felt gap in staff being able to follow up on cases or to bridge between the family sphere and that of health and education service provision.

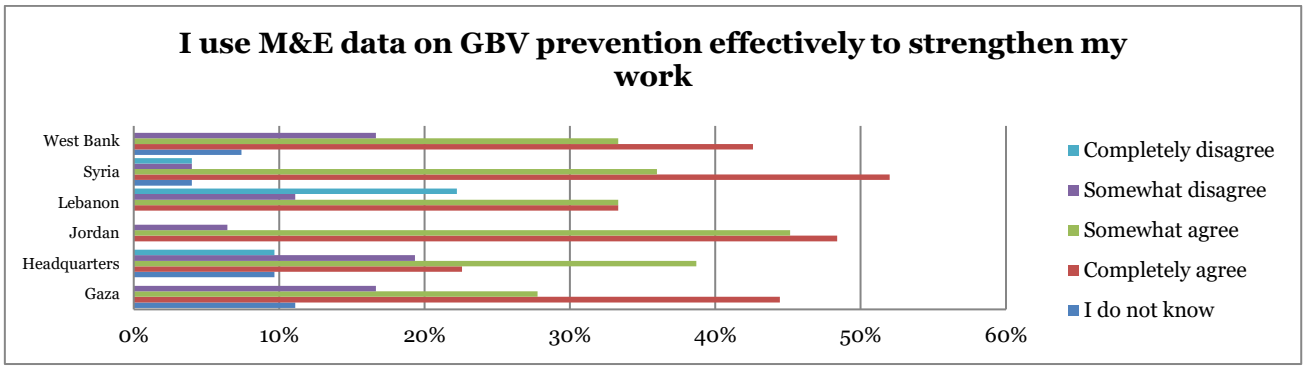
Institutional learning culture

In regards to the learning culture of what works for GBV prevention to inform design of interventions and decision-making, the baseline study identified that there were weaknesses in UNRWA's approach to evaluation generally, and no recognised practice of evaluating results and using evaluation to inform, plan and design GBV prevention work. UNRWA's evaluation function has been largely underfunded and deprioritised during the funding crisis, with limited formal learning and reflection opportunities. The endline survey indicates staff perceptions have improved in this regard, with the percentage of staff completely agreeing that *there is a strong culture of learning about what GBV prevention activities work in UNRWA* increasing from 20% to 35%, although this still is low. Staff in interviews highlighted the lack of structured institutional learning opportunities between programmes and between field offices and noted that these have been further restricted in the current austerity context as staff had been unable to travel for workshops. Learning culture seems to be somewhat ad hoc and anecdotal rather than a systematic practice across the organisation or in FOs.

The percentage of respondents who completely agree that M&E data is available to strengthen UNRWA's GBV prevention work has increased substantially over the course of the 'Building Safety' project from 14% to 35%. As with learning culture figures, though, this is not very high, and these perceptions are not mirrored in interviews. Staff report that there remain gaps in the use of data for decision-making and in regular feedback and critique/ analysis of data. For example, staff described that data is gathered on GBV cases but that there is not someone in every field who looks across the data and determines that if an increased number of cases are noted in one area, that prevention activities should be targeted there. In addition, there are also instances of monitoring systems, such as ActivityInfo which have improved case management and the reporting of results, that are not used by all fields and/ or all departments (e.g. in Jordan, RSS does not use ActivityInfo and they have opted out of the GBV Focal Point system). These differences mean that it is not possible for the Agency to easily consolidate and aggregate its data.

The percentage of staff who completely agree regarding using M&E data on GBV prevention to improve their work has increased from 25% to 41% between the baseline and endline, which could still be improved. Nonetheless, these figures show variations when they are explored by sector programmes and support services across the agency. For example, across the Agency 49% of respondents in Education, 53% in RSS and 62% in Health completely agree with this statement. Percentages are lower in Protection and support services, noting that responses for these categories are smaller (ranging from one to five responses) and inferences cannot be made based on them.

Figure 6: Use of M&E data in GBV prevention work by programme sector and support services



There are also some gaps noted by staff in terms of feedback loops. For example, if a case is referred by Education to Health or RSS, the provision of feedback on the case is not systematic and it may sometimes depend on the individual initiative of staff members. Staff report that M&E data is shared with HQ and interrogated for outliers but that there is also no feedback on the data in terms of trend analysis. There remain gaps in learning from evaluation and research; one case in point directly relevant to this endline study relates our finding that there remain gaps in working more with men and community leaders, which were identified in the baseline study as areas in need of strengthening.

Whilst these findings indicate there is still some way to go for UNRWA to strengthen the gathering, sharing, analysing and dissemination of evidence and learning to support its GBV work, it is clear that UNRWA has invested in developing M&E tools for its GBV work through the 'Building Safety' project. Of note are the efforts to measure the impact of training, community awareness and of embedding data on the number of GBV case in the MTS and its institutional reporting.

Staff in interviews highlighted the lack of structured learning opportunities between programmes and between field offices and highlighted that these have been further restricted in the current austerity context as staff had been unable to travel for workshops.

Staff safety and security when dealing with GBV

The risk to staff in responding to and preventing GBV is seen as a great challenge for UNRWA in terms of staff safety and security and the potential risks they face in intervening in GBV cases. This challenge was also highlighted in the baseline study, as outlined in the table below, with all perceived risk areas registering an increase between baseline and endline of staff feeling more insecure and unsafe to carry out work on GBV. This increase represents a worrying development at a time when the Agency has invested more in its GBV work. The study confirms data from DSRM which shows in particular that frontline staff are more at risk of threats, with social workers around eight times more likely to face an incident than other staff. Beyond identifying GBV cases, frontline staff report feeling they can do little to help survivors and are not fully aware of services available (inside and outside UNRWA) for GBV survivors. Consequently, there is a reluctance to refer in fear that the assistance will make life more difficult for survivors and for themselves.

Table 4: Comparison of baseline and endline perceived risks of UNRWA staff engaging in GBV work

Do you think there are risks of UNRWA engaging in GBV prevention work in terms of:	Baseline	Endline	Difference
Security?	36.89%	52.35%	15.46%
Protection?	44.44%	58.24%	13.80%
Cultural context?	43.56%	65.29%	21.73%
UNRWA's legal status/immunity?	22.22%	33.53%	11.31%
Staff well-being?	47.56%	67.65%	20.09%
Workload prioritisation?	36.00%	51.18%	15.18%
Other	6.22%	7.06%	0.84%
Do you think there are risks of UNRWA engaging in GBV prevention work in terms of:	**Baseline**	**Endline**	**Difference**
Security?	36.89%	52.35%	15.46%
Protection?	44.44%	58.24%	13.80%
Cultural context?	43.56%	65.29%	21.73%
UNRWA's legal status/immunity?	22.22%	33.53%	11.31%
Staff well-being?	47.56%	67.65%	20.09%
Workload prioritisation?	36.00%	51.18%	15.18%
Other	6.22%	7.06%	0.84%
Do you think there are risks of UNRWA engaging in GBV prevention work in terms of:	**Baseline**	**Endline**	**Difference**
Security?	36.89%	52.35%	15.46%
Protection?	44.44%	58.24%	13.80%
Cultural context?	43.56%	65.29%	21.73%
UNRWA's legal status/immunity?	22.22%	33.53%	11.31%
Staff well-being?	47.56%	67.65%	20.09%
Workload prioritisation?	36.00%	51.18%	15.18%
Other	6.22%	7.06%	0.84%

This perception of increased risk may be linked to the current institutional context in UNRWA where staff are reportedly generally more strained given their operational contexts and also the impact of the funding crisis. However, it is important to note that the perception of staff risk does not necessarily correlate to actual recorded incidences against staff addressing GBV cases. For example, in JFO, there were no threats reported by staff with regards to GBV prevention work and one threat reported by a staff member with regards to a particular reported GBV case the staff member was responding to.

UNRWA has put in place some mechanisms to remove frontline staff from directly dealing with GBV cases where threats exist and have conducted security trainings for those staff involved. However, the fact that UNRWA staff belong to the communities they provide services to does not always allow them to be shielded from the reactions of those affected by reporting of GBV – both on the survivor and perpetrator sides. UNRWA staff regularly cited receiving threats from family members or from their connections for example in the police or government. Even though it is not possible to quantify these threats from interviews, risk is a predominant concern of staff.

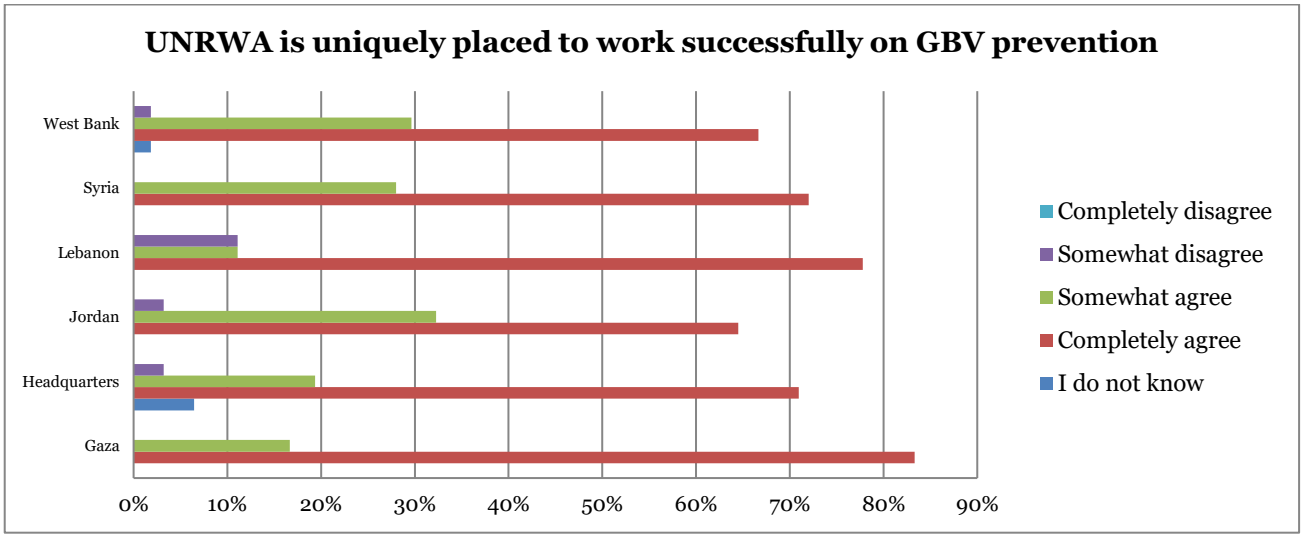
Similarly, in the baseline there were concerns around the extent to which UNRWA enacts its duty of care to staff (e.g. legal protection, immunity) and difficult cases where this had been experienced reported. This concern was also voiced during the endline study process. There is anecdotal evidence of supervisors advising frontline staff not to refer cases to the legal system as they will not be able to testify in a court of law; in part the preference for informal mechanisms of resolving issues and disputes is attributable to this kind of gap in the provision of duty of care to staff.

3.3.2 Comparative advantage and partnerships

UNRWA staff as well as partners interviewed for the endline study overwhelmingly agree that the Agency is uniquely placed to work successfully on GBV prevention. Several reasons are given for this: the organisation's reach and embeddedness in Palestine refugee communities; the quality of services provided (e.g. in education) compared with host governments in some cases; the ownership that UNRWA can provide to GBV prevention work given that its staff are also part of communities; its multi-sector approach bringing together health, education and RSS; and staff capacity and commitment, as well as intimate knowledge of the working context. No other organisation in the context of the UNRWA fields of operations brings together all these advantages. In addition, its targeting of women, men, boys and girls is seen as a strong comparative advantage.

These views were complemented by similar perceptions in the endline survey. The percentage of respondents who completely agree that UNRWA is uniquely placed to work successfully on GBV prevention has remained relativity stable between the two surveys (69% at baseline and 70% at endline). These perceptions provide a clear indication of staff ownership and recognition of mandate to work on GBV prevention. Figure 7 below provides details of disaggregated figures for each of the field offices.

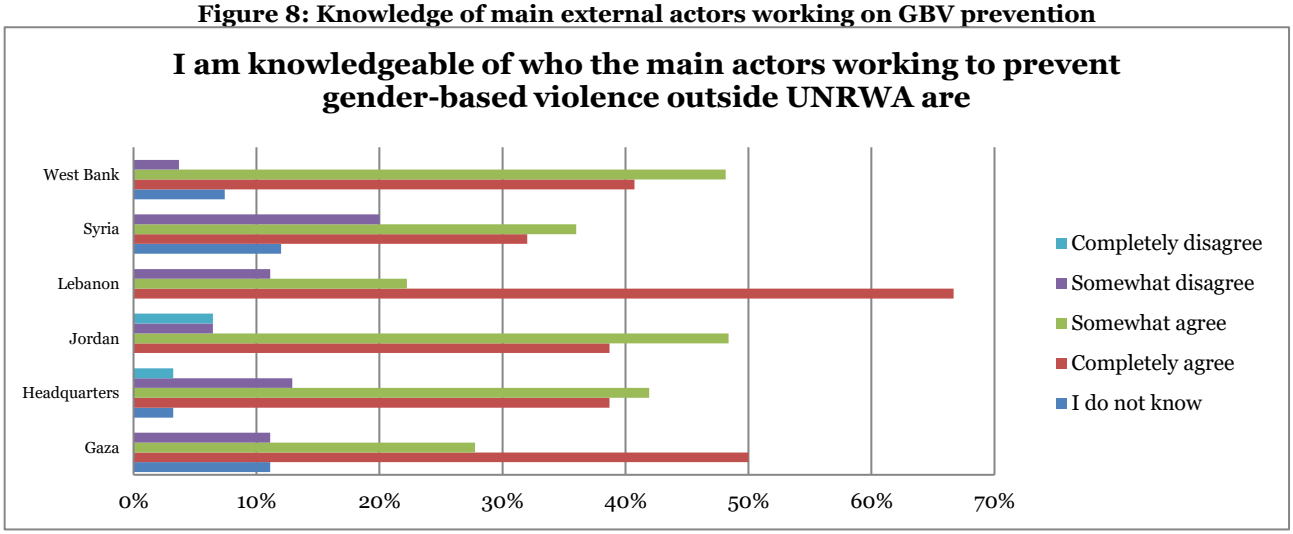
Figure 7: UNRWA's comparative advantage to work on GBV prevention



UNRWA has established partnerships with relevant actors in each of its fields, taking part in GBV technical working groups, clusters where relevant, and through referral pathways. Counterparts are usually a combination of national government institutions and CSOs, international NGOs and other UN agencies. For example:

- In LFO: Partnerships are mostly with UN Family, particularly with UNHCR and UNFPA. There is an active UN GBV Task Force (chaired by UNHCR and UNFPA) that works on very relevant outputs like the Lebanon Crisis Response Plan. The Task Force also harmonizes the quality of services in the referral system. Partnerships with civil society, particularly ABAAD, which supports the women' committees and works on harmful masculinity.
- In Gaza: Partnerships with civil society partners including the Gaza Mental Health Project, Aisha Association for Women and Child Protection, as well as with INGOs (NRC, MSF) and other UN agencies (UNFPA, UNWOMEN).

Figure 8: Knowledge of main external actors working on GBV prevention



There are some divergences between FOs in how partners perceive UNRWA. In the West Bank and Gaza there are some concerns that UNRWA can do more to share information with the broader sector. UNRWA is also seen to be somewhat bureaucratic and slow to respond partners. In Gaza there was some additional frustration expressed by partners that UNRWA had not signed up to the national referral pathways but instead had developed its own SOPs, in part due to UNRWA's no-contact policy with the de-facto government.

In Syria, Jordan and Lebanon, partners' perceptions of UNRWA are more positive. In Syria, there are strong working relations with NGOs and charitable organisations such as the *Good Shepherd Sisters* and *Dar Al-Mahabbeh* for referrals to women's shelters. There are also relevant exchanges and interaction with other UN agencies such as UNHCR, WHO and UNICEF, and national and international NGOs such as the Syrian Arab Red Crescent Society, Danish Refugee Council and SOS. Other relevant counterparts include *Maktab Al-Wifaq Al-Usari*, who are responsible for referrals to other stakeholders, Development Committees (*Lijan Al-Tanmiah)* for interactions with CSOs, and the Refugee Organisation, which facilitate liaison with government where necessary. All of these partnerships were understood to be highly functional and positive with main limitations revolving around capacity to absorb volume of cases and/ or incapacity to reach beneficiaries due to the crisis particularly in Syria.

In Jordan, there is a noted shift in partnerships due to referrals being removed from frontline to FO level, in part to address perceived threats to the safety of staff when dealing with GBV cases. Relevant organisations and counterparts include Nour Al-Hussein Foundation, and Jordan River Foundation. There are partnerships with UNICEF through Makani Centres; in the case of Talbiyeh camp working relations between the UNRWA GBV Focal Points and Makani Centre counterparts are strong and highly cooperative.

In Lebanon, partnerships with service providers are dependent on whether these accept Palestinians. In the UN family, the UN GBV Task Force, co-chaired by UNHCR and UNICEF, is active in harmonising the quality of services in the referral system as part of the Lebanon Crisis Response Plan. In what concerns civil society, ABAAD is seen as a key partner in supporting the Women's Committees, and they have played a key role in setting up and coaching the 13 existing Women's Committees.

3.4 The wider context and its relation to UNRWA's GBV interventions

3.4.1 Community understanding of UNRWA's GBV interventions

From the perspective of UNRWA staff, there is a noted shift in communities' understanding of GBV across all five FOs. Staff and communities highlighted that, whereas it was difficult for community members to come forward and speak about GBV in the past, during the lifetime of the 'Building Safety' project community members have become familiarised with GBV and are more aware of how to prevent it.

For example, Women Committees in Lebanon as well as interviewees in the West Bank consistently highlighted that men are more inclined to accept that violence towards women and men at home is GBV; and women are more aware of their right to mobility and economic autonomy. This is also the case in Jordan, where communities are said to be more aware of their options for legal action, as well as women increasingly coming forward to report cases of domestic abuse or instances of sexual harassment or abuse of their children to school counsellors. In the West Bank, willingness to speak more openly about GBV is linked to the family health approach implemented by UNRWA there. In Syria, which was an emergency/ crisis context throughout the period of implementation of the project, women have become more aware of their rights particularly in relation to civil status issues as well as cash and food distribution; women are said to come forward to report when men are claiming this assistance on their behalf, which was not the case in the past. In addition, in shelter settings UNRWA staff noted an increase in men coming forward to report GBV. In Gaza, there is a perception that communities are more aware of GBV as it is discussed more in the media, and that women are more aware of and likely to pursue their legal rights, for example around inheritance. Most beneficiaries interviewed in Lebanon, Jordan, West Bank and Gaza[6] do highlight that there has been a change for instance in recognising the various types of GBV. They also coincide with the perceptions of UNRWA staff that communities are more willing to speak about GBV than they were in the past.

Nonetheless, beneficiaries highlighted that there remain important obstacles to overcome. In Lebanon, there is uneven community awareness and understanding of UNRWA's GBV work and GBV more generally, and divergences are seen to be dependent on location both in terms of camps and whether communities are rural or urban. In Jordan, whereas UNRWA staff report increased community acceptance of speaking about GBV, FGDs with beneficiaries highlight that interactions at social and family/ personal level have not substantially changed and that change is rather at the individual level of knowledge and awareness about GBV with limited influence on other family and community members who have not participated in awareness raising events.

Women who have taken part in awareness raising sessions in Women Programme Centres in Jordan or through CBO partners in Gaza note that the awareness raising sessions have been helpful for managing their domestic spheres, but they have not necessarily helped them change the attitudes of their partners and they continue to be exposed to violence and abuse. Other women recount trying to share their learning from awareness raising sessions with the wider community only to be dismissed for 'speaking nonsense', or for not being in a position to challenge local customs just because they attended an UNRWA event that tried to instil so-called 'Western' ideas in participants.

Many of the GBV prevention activities across field offices have targeted women, which whilst raising awareness, has not served to change the attitudes and behaviours of men who are most frequently the perpetrators. Even boys who took part in FGDs highlight that they feel unable to share with their

[6] No FGDs were conducted with beneficiaries in Syria as the inquiry with SFO was conducted remotely.

families the content of awareness raising sessions because they fear not being taken seriously; for those who did try to intervene in specific situation (e.g. to convince their parents against child marriage of their sisters) they were not taken into account.

Child marriage is in fact highlighted across field offices as particularly problematic and indicative of the resistance of communities to engage with GBV prevention. Child marriage is often seen as a coping mechanism for families who have socio-economic difficulties, particularly in emergency settings. In Syria, UNRWA staff recounted stories of some teenage girls emerging from besieged areas who had been married (and widowed) multiple times and who had several unregistered children. In Jordan, some cases of child marriage are detected by UNRWA health staff when pregnant girls attend clinics; and schools are using a tool for girls to report on their classmates' absences as a way to identify child marriage risk cases. Across field offices girls are often married to older men and communities suggest that in many cases they end up divorcing (examples cited include partners' substance abuse as well as GBV as causes for divorce, as well as age difference), and once they are divorced their families refuse to take them back.

Efforts to raise community awareness on child marriage, though, are said to face significant resistance despite the consequences of child marriage being known and visible to communities. There are some cases where UNRWA interventions have led to change in parents' attitudes; examples were highlighted by staff in Lebanon, Syria and Jordan. Nonetheless, UNRWA staff are sometimes reluctant to intervene where this can lead to further repercussions (e.g. UNRWA interventions leading to girls being kept at home and withdrawn from school to avoid them from being influenced by school counsellors).

The focus of staff interviewed on child marriage, however, does not necessarily mean that this is the most prevalent type of GBV in UNRWA communities, and stories related by staff underline the even-greater resistance to reporting domestic violence and sexual abuse. Staff highlight that it is more acceptable to speak about child marriage than it is about other types of GBV. Frontline staff in health, education and RSS note that community members come to them to report cases of sexual abuse and domestic violence but backtrack from these being formally referred because they anticipate that they will face repercussions, and so prefer the use of community approaches. Community members are particularly reluctant to be referred if cases are likely to end up in the justice system of the host country; anecdotal evidence suggests that survivors fear for their safety if they are required to testify against family or community members. Community members who participated in FGDs noted cases where survivors were attacked or killed for taking rape cases to court.

In all field offices there is a recognition that most work has been with women, and girls and boys in school settings. Work with men on GBV prevention, however, continues to be insufficient. There are different reasons identified for this, including that activities and events organised by UNRWA on GBV prevention happen when men are at work, and at times when they could potentially attend, they often do not show up. Therefore, the problem is seen to be due to the timing of activities and events. Nonetheless, there is also a lack of engagement from men in communities. This gap is highlighted by both community members who engaged in FGDs and UNRWA staff interviewed for the endline study.

Another factor highlighted in discussion with UNRWA staff is that thousands of people have been reached over the course of the 'Building Safety' project through different kinds of awareness raising but that much of this awareness raising has been with women and focused on raising awareness of people's rights regarding GBV and services available to survivors. Given limited engagement with men and with community leaders, little of the GBV prevention work has attempted to challenge the gender inequalities and norms which underpin GBV, and to create attitudinal change among potential perpetrators.

There are some anecdotal examples of UNRWA approaches that have worked well for engaging with men. These include organising events during evenings and weekends, working with couples on GBV prevention awareness raising, as well as providing an incentive for attending events in the form of a meal or covering of transport to and from the venue (although this is seen as helpful for both men and women attendants, not only men). In Syria, because UNRWA staff were providing services in refugee shelters targeting of men for awareness raising happened in that setting as a captive audience - although now that shelters have closed it is unclear how systematic targeting of men will happen.

3.4.2 Contributing and hindering factors relevant to GBV prevention work with beneficiary communities

One important contributing factor relevant to GBV prevention work in UNRWA is the multi-sector approach. This was highlighted as relevant across the five field offices, and it greatly facilitated interaction between UNRWA programmes. Where this link was removed, for instance in Jordan with RSS withdrawing from the GBV Focal Point network, the effects were strongly felt. For example, where cases were detected by education and health, these could not be referred without survivors' consent, but neither could they be brought to the attention of RSS colleagues so they could support these cases through home visits (with the exception of child protection incidents).

In the West Bank and Gaza, the targeting of work to abusers as well as survivors is seen as highly relevant and important in ensuring the effectiveness of GBV prevention work although there has been limited design and delivery of activities to address this. There has also been limited targeting of UNRWA GBV prevention activities with men and community leaders, but where this has happened it is considered an important contributing element.

In Lebanon, Women's Committees are highly valuable and recognised as an important element in ensuring the success of UNRWA's GBV work. However, they voiced challenges related to them having a triple role in their communities: reproductive, productive and community roles, which places a huge burden on their time and leads to high turnover of engagement. To tackle this, they proposed the inclusion of leisure activities in their work plans as well as some form of legitimation of their work (e.g. a volunteer contract or certificate).

In Syria, the emergency situation and the localisation of UNRWA work in shelters until recently provided a contributing factor to engaging the community on GBV in a holistic manner as whole families were sharing the same space.

There are also important hindering factors to GBV prevention work with beneficiary communities, which are both internal and external to UNRWA. As mentioned above, there is a perception across field offices that GBV work is an intrusion on culture and traditions. This is particularly pronounced where communities are smaller and/ or located in rural settings; and in terms of the appropriateness of engaging community leaders (e.g. religious leaders and Popular Committees). An added difficulty in these contexts is that UNRWA staff are generally also community members, and their role as staff members is seen to conflict with social expectations. It is even more difficult to get involved if the perpetrator is an UNRWA staff member.

Host country systems are in some instances not seen to support UNRWA's work to combat GBV. Community members as well as UNRWA staff highlighted this as a serious limitation for survivors to access justice. In Lebanon, for instance, family law is governed along confessional lines and marriage is permitted before the age of 18; and there is limited protection against GBV in the application of the national legal framework - despite a recent repeal by Parliament of Article 522 of the Penal Code that allowed rapists to avoid prosecuting if they married the victims. In addition, refugee camps in

Lebanon have developed a parallel justice system where conflicts and crimes are dealt with by Popular Committees rather than the Lebanese police or justice system.[7]

In Syria, even though there are shelters run by national NGOs and CBOs, the government does not provide protection services; and the legal minimum age for marriage has only recently been raised to 18. Judges until recently could approve girl marriages from 13 years of age.[8] In Jordan, GBV cases get referred to the Family Protection Unit, and there are laws for protection from domestic violence (no.15 of 2017) and rape other than a spouse (Article 292 of the Penal Law Code of 1960). However, marital rape is not criminalised and gender inequalities remain in relation to sexual harassment and honour crimes as well as minimum age for marriage - this is set to 18 years of age but judges have the discretion to consent to marriages of minors 15 years or older.[9] In Palestine there is no domestic violence legislation, marital rape is not criminalised, and the minimum age for marriage in the West Bank is 16 for girls and 17 for boys, and 17 for girls and 18 for boys in the Gaza Strip - although ages can be lower if a judge allows it with parental consent.[10] In the West Bank and Gaza, the provisions of the penal code contain discriminatory provisions for women in relation to rape, adultery, and sexual violence committed in marriage. For example, if women are not able to provide evidence of force, threats and/or deception to support rape claims, they risk being criminalised for adultery. These contextual elements place constraining factors on the extent to which UNRWA's GBV interventions can be successful and effective.

It is also a significant challenge for UNRWA working to support GBV survivors in and between West Bank and the Gaza Strip, in terms of differences in laws, structures, roles, authority of line ministries, and services, and the lack of national coordination. The Palestinian legislative framework is fragmented as it falls under four different jurisdictions (Israeli, Jordanian, Egyptian and Palestinian) depending on geographic location. Whilst line ministries based in Ramallah technically cover the Gaza Strip as well, the staff and structures are in effect different due to the general lack of movement between the two areas and strict control by the de facto government in the Gaza Strip.

In Gaza, the political situation, volatility, and lack of a functioning government is seen as a key factor inhibiting UNRWA from working within national systems, with a perception from many interviewees that the de facto government in Gaza has actively worked to discourage the protection and advancement of women's rights through actions such as restricting women's rights to paid employment. Whilst there is one government shelter run by the Ministry of Social Affairs in Gaza, interviewees referred to it as prison-like and UNRWA staff would only refer women to it as a last resort. Interviewees also report a lack of gender-sensitivity in the police as another key challenge to engaging with formal systems in Gaza. There are also challenges reported in terms of coordination with the national system; that cases reported can get 'lost' and that once cases are referred in this way, UNRWA staff lose oversight and can no longer support cases or ensure survivors of quality support. The lack of oversight once cases are referred is also a challenge highlighted by the Jordan FO.

[7] LCRP (2019), UNDP (2018b)
[8] UNDP (2018d)
[9] UNDP (2018a)
[10] UNDP (2018c)

4. Conclusions and Recommendations

4.1 Conclusions on UNRWA's GBV Prevention trajectory (2016-2019)

The GBV Prevention Framework Theory of Change (see Figure 3) focuses on three outcomes: (1) transformed staff attitudes, behaviours and practices; (2) effective partnership work with other stakeholders; and (3) use of evidence to design and implement interventions and measure impact. These three outcomes were envisaged to lead to mainstreaming of GBV prevention in UNRWA through a focus on staff. The Theory of Change is key for contextualising the conclusions below.

Institutional arrangements and environment

Evidence gathered for this endline study suggests that the 'Building Safety' project has been successful in laying important foundations for UNRWA's GBV work going forward. Whilst 'Building Safety' has been a project, rather than supported by the programme budget, it has been delivered in such a way as to enhance the potential sustainability of potential results. This is clear in a number of key aspects; the project's targeting of existing frontline staff who will remain in post after the project ends has meant that the training, knowledge and experience gained over the course of the project will remain within the organisation. Secondly, the targeting of staff across all UNRWA programmes has facilitated a multi-sectoral approach, which is recognised as good practice and means that GBV is not siloed as an issue within a single programme. The project has also been particularly successful in putting together key products, such as the GBV Prevention Framework, the GBViE e-learning course, and the GBV Training Package; and in starting to roll these out across its five FOs.

However, there remain some areas to address going forward for the organisation to fully sustain project results. Whilst GBV prevention and response has received high attention across the Agency from the organisation's leadership and is recognised as a significant issue facing the refugee population, this attention, given the UNRWA's financial context, has not yet manifested itself in the form of long-term programme budget support. If preventing and responding to GBV is to remain an institutional priority, UNRWA will need to source additional long-term funding going forward to support GBV activities, ensure ongoing training is delivered and that existing gains in attitudes, knowledge and practice are built upon.

In a similar vein, the organisation will need to think through its transition plan institutional arrangements regarding GBV prevention and response going forward. Across the organisation and FOs, as the 'Building Safety' project comes to a close, there are no specific institutional posts designated to GBV prevention and response. GBV is currently the responsibility of a number of different actors, varying from FO to FO. However, there is a sense that no one department or programme owns and leads on GBV; and that there is a lack of clear coordination mechanism or consistency in terms of reporting lines, feedback loops, links between programme areas, and roles and responsibilities. The RSS reform is expected to help address some of these gaps in terms of allocating clear responsibility for the case management of high risk GBV cases going forward. However, there are other aspects of GBV prevention and response beyond case management which will need to be addressed in the transition plan, with clear linkages, lines of communication and coordination between programmes as well as clarity of responsibility for low- and medium- risk cases, and how these will be defined, identified and addressed going forward.

Leadership

The endline study finds that the perception amongst staff of UNRWA's leadership to address and prioritise GBV has increased over the last three years, in part due to the 'Building Safety' project, and

in part due to the wider context currently around SEA. The endline study finds though that there remain gaps. Increased organisational leadership has not meant the securing of ongoing funds to address GBV prevention and response, and there remain gaps in middle-management leadership across the organisation in terms of support and prioritisation of GBV work at this level, and in the knowledge, attitudes and practice of some managers regarding GBV.

Staff safety and security in addressing GBV

There remain significant concerns from UNRWA staff, which have increased according to the survey, regarding their safety and security to work on GBV prevention and response and perceived gaps in the agency's duty of care towards staff in this regard. Consequently, UNRWA staff relate a strong preference for pursuing community mechanisms for handling GBV cases which are seen as more palatable to the community and potentially less harmful to survivors, as well as safer for staff. Despite these increases in concerns from staff around safety and security when working on GBV, it is important to note that these concerns are not supported by increases in actual incidences of threats/ violence reported by staff. The agency has put in place mechanisms to remove frontline staff from directly dealing with GBV cases where threats exist and has conducted security trainings for those staff involved. However, the fact that UNRWA staff belong to the communities they provide services to means there may remain reluctance to formally report these incidences. Similarly, in regard to SEA, there remains a reluctance for staff to report SEA experience in the workplace for fear of reprisals both from colleagues as well as in the wider community to which they belong.

Staff attitudes, knowledge and practice

Whilst UNRWA's focus on GBV work remains largely on response rather than prevention, the endline study suggests that there is greater awareness among staff about the distinction between GBV response and GBV prevention. UNRWA staff report the greatest shift in thinking, handling and recognition of GBV cases, and reflection on their personal and professional spheres, as well as willingness to discuss GBV issues more openly than was the case in the past. These changes have been brought about in the investment of the 'Building Safety' project and the training component for which positive feedback was provided. However, changes in relation to staff attitudes as a result of the training received are harder to evidence and examples of negative attitudes to GBV (and gender) persist.

The endline study finds that the training modalities used for the 'Building Safety' project have supported increases in staff understanding and knowledge of GBV. Whereas previously training on GBV was often short, theory-based courses, staff appreciated the new in-depth training package which included many practical examples as to how the learning from training could be applied to their work. There remains a gap though in how the impact of training is monitored and followed-up; as the training has focused on frontline staff, many supervisors and management are inadequately equipped to ensure that knowledge gains from training lead to improved practice.

There is an overall concern that the end of the 'Building Safety' project could jeopardise progress made so far. There has been concentration of training in the last year of the project. The delay in the rolling out of training and on-the-job coaching until the past year has not allowed enough time for its consolidation in practice, but it has contributed to a sense of momentum. The GBV transition plan following the end of the 'Building Safety' project in May 2019, as well as the result of the RSS reform, will be key in ensuring that momentum is not lost, and that progress can continue to be built on and identified gaps duly addressed.

Institutional learning culture

The endline study finds that while there remain weaknesses in UNRWA's approach to evaluation generally (due to the underfunding and de-prioritisation of evaluation during the funding crisis,),

staff perceptions of a learning culture on what works for GBV have improved. However, a lack of structured institutional learning opportunities between programmes and between field offices remains and a learning culture seems to be somewhat ad hoc and anecdotal rather than a systematic practice across the organisation or in FOs.

There remain gaps as well in the use of data for decision-making and in regular feedback and critique/ analysis of data, in feedback loops, learning from evaluations being translated into practice and challenges for the Agency to easily consolidate and aggregate its data given the difference in reporting across FOs. Whilst this indicates there is still improvement needed to enhance learning, monitoring and evaluation of GBV work, it is clear that UNRWA has invested in developing M&E tools for its GBV work through the 'Building Safety' project and that these provide a mechanism for UNRWA to further analyse and learn about the difference it is making and improvements needed going forward.

UNRWA GBV partnerships

There is a clear recognition from UNRWA and its partners of the Agency's comparative advantage in addressing GBV in terms of its reach and embeddedness in Palestine refugee communities; the quality of services provided (e.g. in education) compared with host governments in some cases; the ownership that UNRWA can provide to GBV prevention work given that its staff are also part of communities; its multi-sector approach bringing together health, education and RSS; and staff capacity and commitment, as well as intimate knowledge of the working context.

Whilst not an explicit focus of the 'Building Safety' project, there is evidence that UNRWA has worked to establish partnerships with relevant actors in each of its fields and to share and learn from relevant technical expertise. However there remain some gaps in partnership approaches; there does not appear to be a systematic approach to partnerships across fields and referral pathways for GBV cases to partners are not consistently set out or applied. There is a perception from some partners that UNRWA can do more to share information with the broader sector and to integrate, align or work with broader referral pathways in place for GBV cases. In the context of the 'Building Safety' project coming to an end, a more systematic approach to partnerships which allows UNRWA to leverage existing resources to most effectively meet GBV case needs and deliver effective prevention work will be needed.

Community understanding of GBV

The endline study finds that there have been some shifts in knowledge and attitudes at community level, regarding GBV awareness. Communities in all five FOs are perceived by staff to being more open to discussing GBV, and beneficiaries who participated in the endline study coincide in that their thinking around GBV has shifted and issues are now more openly discussed than they were in the past. However, there remains more to be done as examples of harmful attitudes and behaviours are still reported as being highly prevalent.

The bulk of prevention work however has taken place through awareness raising activities. Other approaches such as the school absence tool, self-protection methodology, safety walks, TV spots and Women's Committees are noted as being helpful for facilitating GBV prevention work with communities, but they have not been as widely used as awareness raising sessions and campaigns. Targeting has been mostly of women, and girls and boys through the education sector with more limited engagement with men and community leaders. There is evidence that this awareness raising has led to an increase in women's understanding of GBV, their rights and in their accessing of services. However, little of the GBV prevention activity has targeted men, who pose the most resistance to the work of UNRWA staff and of community members engaged in GBV work and are the most frequent perpetrators, and there has been insufficient focus on attitudinal and behaviour change.

4.2 Recommendations for going forward

Recommendation 1: Establish specific funding for GBV prevention and response work going forward.

Recognising the current organisational funding context in UNRWA, it may not be easy to ensure the allocation of designated programme budget resources to be allocated to GBV. Nevertheless, UNRWA should investigate options for continued project funding to build upon the success the 'Building Safety' project as part of transition planning, as well as establish how existing institutional resources can be used to ensure the products (training, guidance) developed under 'Building Safety' become embedded in institutional practice rather than 'project' tools.

Recommendation 2: Establish clear ownership of gender and GBV work with clear and consistent reporting lines between programmes and across the Agency.

Whilst the multi-sectoral aspects of the 'Building Safety' project are to be commended, it will be important as the 'Building Safety' project comes to an end to ensure as part of the transition clear lines of ownership, accountability, responsibility and communication regarding GBV work, including in relation to RSS reform. Important elements to define include how GBV work will be coordinated across sectors; who will hold responsibility for low- and medium-risk cases; how will learning be consolidated and shared across the organisation; and where analysis and oversight of data trends in each FO will sit.

Recommendation 3: Ensure sustainability and consolidation of training provided by offering refresher and specialised training to staff, and by prioritising the training of newly recruited staff.

Training offered to UNRWA staff under the 'Building Safety' project is widely recognised as having contributed to improved knowledge and understanding of GBV and practices for identifying and addressing GBV cases in the Agency. Given UNRWA's multi-sectoral approach and turnover of staff, it is important that relevant GBV training is made compulsory for all staff who will work on GBV as part of their induction process in the Agency, or as soon as they take up their post if they are assuming a new position within UNRWA. Refresher and specialised training should also be offered to staff to ensure continuity and further development of knowledge and gained skills.

Recommendation 4: Strengthen middle-management leadership for GBV.

Whilst high-level leadership has strengthened over the course of the 'Building Safety' project, there remain gaps in terms of middle-management leadership, prioritisation and support to GBV. There are also gaps in the extent to which middle-management are themselves are adequately trained to supervise and support frontline staff working on GBV. As part of the transition plan, UNRWA should roll out existing training resources developed under 'Building Safety' to middle-management and implement necessary Competency Framework criteria for managers to support and supervise staff working on GBV prevention and response.

Recommendation 5: Put in place mechanisms for continuing work on on-the-job coaching and learning by doing, including with the support of supervisory staff, to ensure that knowledge gained through training is translated into practice.

The 'Building Safety' project has been successful in targeting frontline staff mainly through training. There is a felt gap in supervisory staff being able to support those who have received relevant GBV training to further advance their knowledge and consolidate relevant practices. The on-the-job coaching function should be institutionalised as part of supervisory staff responsibilities – building on Recommendation 4 that middle-management themselves are targeted for relevant GBV training.

Recommendation 6: Strengthen UNRWA's data practices, including consolidation of data across departments, and its capacity to undertake gender analysis to feed into planning and decision-making.

UNRWA collects relevant data on GBV cases. In order to better utilise data to feed into intervention designs, gender analysis, targeting, learning and decision-making, UNRWA needs to standardise its data practices to allow better consolidation across programme sectors. In addition, the transition plan should incorporate provisions for deciding on who owns data collected across the Agency and who would be responsible for undertaking analysis of this data.

Recommendation 7: Enhance mechanisms for protection of staff from risks faced in their communities for engaging with GBV and in terms of duty of care.

Concerns voiced by staff in relation to the risks they face for engaging in GBV work are on two fronts: internally in UNRWA, and externally in relation to (their) communities. At the internal level, UNRWA should continue in its efforts to embed a culture whereby staff feel safe to come forward and report, ensuring that survivors are not blamed, and that confidentiality is guaranteed. At the community level, community engagement should incorporate relevant sensitisation on the importance of reporting for preventing and addressing GBV cases as part of existing awareness raising.

Recommendation 8: Develop a systematic approach to partnerships.

Whilst has UNRWA has partners it engages with on its GBV work, there does not appear to be a systematic approach to partnership across the organisation and there are unclear feedback mechanisms, referral pathways and accountabilities in some partnerships. As part of the transition plan, UNRWA should develop a more systematic approach to partnerships. The aim of this would be to leverage and complement existing resources to most effectively meet GBV case needs and deliver effective prevention work, as well as ensure clear lines of accountability, information sharing and referral pathways.

Recommendation 9: Improve beneficiary targeting on GBV prevention to more systematically include men and community leaders, as well as moving from awareness to attitudinal change.

Both the baseline and endline study have found that UNRWA's GBV work predominantly targets girls and boys (in an education setting) and women (through 16 Days of Activism events, mother to mother groups, former Women's Programme Centres and so forth). Most of these activities are also primarily focused on awareness raising of rights and services. To substantially contribute to GBV prevention (i.e. stopping it happening in the first place), UNRWA needs to work with perpetrators (frequently men) on changing and addressing attitudes and behaviours and challenging the social norms which lead to GBV in the first place.

Annex 1: Enquiry Matrix

AREAS OF ENQUIRY: What we want to find out	Focus areas	Inquiry questions	Stakeholder targeted and method of engagement
THE WIDER CONTEXT: WE WANT TO HAVE AN UNDERSTANDING OF GBV INTERVENTIONS, THE CONTRIBUTING FACTORS THAT ARE RELEVANT TO GBV PREVENTION WORK WITH BENEFICIARY COMMUNITIES, AND THE GBV INTERVENTIONS OF OTHER ACTORS IN THE CAMPS AND IN THE COUNTRIES WHERE UNRWA HAS A PRESENCE			
Community understanding of UNRWA's GBV interventions	Extent to which UNRWA beneficiary communities are aware of UNRWA's GBV interventions. Gaps and opportunities identified by beneficiary communities where more could be done on prevention. Understanding how beneficiary attitudes and beliefs to GBV have changed over the life of the project Understanding whether awareness of/access to GBV services has improved over the life of the project	Do you know where to go for GBV services? Has people's awareness of available services improved over the last 3 years? Are you aware of how to access GBV services through UNRWA (e.g. referral system)? How are GBV services available affected by the context (e.g. in emergency/crises)? Are you aware of your GBV-related legal rights? Has people's awareness of their rights improved over the last 3 years? Where do community members/ refugees turn for help with GBV problems? How do emergency/crises contexts affect this?	UNRWA beneficiary communities (FGDs)

		Where do you gain your knowledge on GBV issues (e.g. media, school, neighbours, and community groups)? Have you taken part in any UNRWA organised activities on GBV/prevention? (E.g. awareness raising, 16 Days of activism events.) What difference do you think those events/trainings have made to people's attitudes and behaviours towards GBV in your communities? Over the last 3 years, what changes have you noticed in terms of GBV in your community (prevalence, attitudes, media coverage)? Over the last 3 years, do you think access/quality of GBV services has improved for your community? Are more people pursuing GBV cases?	
Contributing factors relevant to GBV prevention work with beneficiary communities and/ or other beneficiary groups in the countries where UNRWA has a presence	Opportunities for developing GBV prevention further Understanding of contextual limitations common to UNRWA and other actors	What are the challenges in addressing GBV (culture, resources, emergency? context)? Has there been any improvement/ change in these over the last 3 years? What are UNRWA's areas of	UNRWA beneficiary communities (FGDs) UNRWA partners (key informant interviews) Other relevant stakeholders

	Understanding of contextual limitations specific to UNRWA Understanding challenges in preventing GBV and how these are being addressed	strength/weakness in responding to GBV? And GBV prevention specifically? Are these same weaknesses prevalent/the same in emergencies/crises? Are these strengths/weaknesses the same/ different for other actors? Are there particular GBV prevention interventions that work well? In emergency/crisis contexts? What has been UNRWA's strongest contribution to GBV response/ prevention over the last 3 years? And in emergency/crises contexts?	(key informant interviews)
GBV interventions of other actors targeting UNRWA beneficiaries and/ or other beneficiary groups in the countries where UNRWA has a presence	Types of GBV interventions by other actors Types of GBV prevention interventions of other actors Identification of gaps and opportunities in UNRWA's approach to GBV interventions	What is/has been UNRWA's comparative advantage in GBV prevention relative to other actors? Does UNRWA have a comparative advantage in GBV prevention relative to other actors in emergencies/crises? Over the last 3 years, which other actors have been addressing GBV (in your community etc.? What are other actors doing that UNRWA is not? What have been the areas of overlap/synergy between UNRWA and	UNRWA beneficiary communities (FGDs) UNRWA partners (key informant interviews) Other relevant stakeholders (key informant interviews)

		other actors for GBV prevention work over the last 3 years?	
KNOWLEDGE/EXPERIENCE AND LEARNING PREFERENCES OF UNRWA STAFF IN RELATION WITH GBV PREVENTION.			
General knowledge about GBV prevention in UNRWA	Changes/improvements in: Knowledge and use of policies and UNRWA commitments on GBV prevention Knowledge of existing guidelines and other tools Knowledge and interactions with key actors working on GBV prevention (inside and outside UNRWA) Improvements in knowledge and interactions with the actions on GBV prevention taken by UNRWA in their field offices	What does GBV prevention work comprise of in your context? How does this change in emergencies/crises? Do you feel that you and colleagues have a common understanding of GBV prevention? Has this improved/changed over the course of the 'Building Safety' project? How does GBV prevention fit with your wider/other responses to GBV? Has this improved/changed over the course of the 'Building Safety' project? Do you feel you have appropriate/adequate training in GBV prevention? And GB prevention in emergencies/crises? Has this improved/changed over the course of the 'Building Safety' project? Are you aware of UNRWA's GBV prevention documentation/guidance? Has your awareness/use of these increased over the last 3 years?	UNRWA staff: Frontline, middle-management and senior level (survey and key informant interviews).

		What are your other guidelines of reference for GBV prevention? And GBV prevention in emergencies? Which stakeholders do you interact with regarding GBV prevention work inside UNRWA? Which external stakeholders? Has this changed over the last 3 years?	
Skill and proficiency on key gender mainstreaming processes applied to GBV prevention work	Changes/improvement in: Gender analysis in the different areas of work Collection and analysis of sex disaggregated data Identification of at-risk groups Gender responsive monitoring Training/capacity development for gender equality in each thematic area Gender-sensitive communications Inclusion of gender into administrative/operations documents (ToRs, vacancy announcements, action plans, reports, etc.)	How are gender considerations integrated into your area of work? Has this changed/improved over the course of the 'Building Safety' project? Do you collect gender-sensitive data? How is this data collected? How is it analysed? How is this undertaken in emergencies/crises? How have your ways of collecting/analysing gender-sensitive data changed over the course of the 'Building Safety' project? How are groups at risk of GBV identified? How is this undertaken in emergencies/crises? Has this changed/improved over the course of the 'Building Safety' project? Do you have monitoring tools that are gender-responsive? Are these suitable for use in emergencies/crises? Has this	UNRWA staff: Frontline, middle-management and senior level (survey and key informant interviews).

	Inclusion of gender into policies, administrative instructions and other directives on finance/ procurement/IT/Human Resources/management services/security.	changed/improved over the course of the 'Building Safety' project? Are UNRWA communications on GBV prevention gender-sensitive? Has this changed/improved over the course of the 'Building Safety' project? Has gender been mainstreamed into: documentation/ operations/ policies/ administrative instructions/ directives? Do these consider gender in emergencies/crises? Has this changed/improved over the course of the 'Building Safety' project? Do you see gaps in the way gender has been integrated into documentation? And into practices? How is GBV prevention in emergencies/crises integrated into relevant documentation? Has this changed/improved over the course of the 'Building Safety' project?	
Preferred learning styles	Trusted sources on GBV information (inside/outside UNRWA) Most appropriate ways to increase capacities on GBV in UNRWA (face-to-face training and courses; self-paced online courses; detailed	What sources/types of information do you use for GBV information inside UNRWA? And from other sources? What kinds of activities have been most helpful for learning about GBV prevention so far? What activities have	UNRWA staff: Frontline, middle-management and senior level (survey and key informant interviews).

	assignments; coaching; on-the-job/learning by doing)	been least helpful?	
PERSONAL ATTITUDES AND ORGANISATIONAL CULTURE AROUND GBV IN UNRWA			
Personal attitudes towards GBV (trends)	Changers/improvements in: Extent to which the issue is felt to be unacceptable; possible difference in different groups	Is it appropriate and/or feasible for UNRWA to undertake GBV prevention work? And in emergency/crisis situations? Is there increased acceptance amongst communities/staff of UNRWA engaging in GBV prevention work? Do you personally feel equipped/ trained to implement GBV prevention activities? And in emergency/crisis situations? Has this changed/improved over the course of the 'Building Safety' project? Are there any risks (to UNRWA staff, communities, people affected by violence) of UNRWA engaging in GBV prevention work? And in emergency/crisis situations? Has this changed/improved over the course of the 'Building Safety' project?	UNRWA staff: Frontline, middle-management and senior level (survey and key informant interviews).
Organisational culture (s) in their working unit regarding GBV	Changes/improvements in: Accountability to address GBV	Does your unit have specific organisational procedures to follow on GBV prevention? Any specific to	UNRWA staff: Frontline, middle-management and senior level (survey and key

	prevention How relevant is GBV perceived to be for the work of the department/unit?	emergency/crises? Has this changed/improved over the course of the 'Building Safety' project? Are these procedures followed? If not, why not? Is GBV prevention prioritised as part of your portfolio/ area of work? Has this changed/improved over the course of the 'Building Safety' project?	informant interviews).
PRACTICE NEEDS, PROBLEMS AND BARRIERS TO INCLUDE GBV PREVENTION EFFECTIVELY IN PROGRAMME DELIVERY OF UNRWA; BEST SOLUTIONS TO CO-ORDINATE, PLAN, IMPLEMENT, MONITOR AND EVALUATE ESSENTIAL ACTIONS FOR THE PREVENTION OF GBV.			
Analysis of capacity and resources to implement GBV prevention programmes within UNRWA	Changes/improvements to: Analysis of the proportion of UNRWA financial resources devoted to GBV Clarity of roles and responsibilities so that mainstreaming GBV is not left only to gender advisers Quality of capacity building of staff on GBV Staff accountability for their performance mainstreaming GBV issues Accountability of management for informing, guiding, supporting and	Is there a combination of gender-specific staff to provide guidance and progress, and a strong and committed leadership at the management level? Has this changed/improved over the course of the 'Building Safety' project?	UNRWA staff: Frontline, middle-management and senior level (baseline survey and key informant interviews).

	rewarding staff who introduce GBV aspects effectively into their work.		
Analysis of partnerships: grouping and analysis of the type and range of relationships established by UNRWA on GBV prevention	Changes/improvements to: Identification of main partnerships/alliances established by UNRWA on GBV prevention Quality of the relationships with partners. UNRWA's position among other players working on GBV prevention in MENA.	Who are UNRWA's partners for work on GBV? What is the nature of these partnerships? (i.e. strategic, implementation focused, funding, reciprocal support)? What has worked well in these partnerships? And if they haven't worked well, why not? Are there specific partnerships for addressing GBV in emergency/crises? Has this changed/improved over the course of the 'Building Safety' project?	UNRWA staff: Frontline, middle-management and senior level (survey and key informant interviews) UNRWA partners (key informant interviews).
Best solutions	Selection/catalogue of best practices and promising practices around GBV prevention (inside and outside UNRWA) Identification of priority areas for UNRWA to mainstream GBV prevention strategically.	What remain the priority areas for UNRWA to mainstream GBV prevention (e.g. communications, advocacy)? And specifically, in emergencies/crises?	UNRWA staff: Frontline, middle-management and senior level (baseline survey and key informant interviews) UNRWA partners (key informant interviews) Beneficiary communities (FGDs).

Annex 2: Baseline and endline survey responses

Q5. How relevant is gender to your work?	Baseline	Endline	Difference
Very Relevant	67.69%	72.94%	5.25%
Somewhat relevant	28.38%	21.18%	-7.20%
Not relevant	2.62%	5.29%	2.67%
I do not know	1.31%	0.59%	-0.72%

Q6. How relevant is Gender-Based Violence Prevention to your work?	Baseline	Endline	Difference
Very Relevant	65.02%	65.29%	0.27%
Somewhat relevant	29.15%	28.24%	-0.91%
Not relevant	4.04%	4.71%	0.67%
I do not know	1.79%	1.76%	-0.03%

Q7. How familiar are you with the GBV prevention work undertaken by UNRWA?	Baseline	Endline	Difference
Very familiar	50.00%	68.82%	18.82%
Somewhat familiar	43.75%	28.24%	-15.51%
Not familiar	5.80%	2.35%	-3.45%
I do not know	0.45%	0.59%	0.14%

Q8. How much do you agree or disagree with the following statements?			
At my work, I systematically gather and analyse gender sensitive information.	**Baseline**	**Endline**	**Difference**
I do not know	1.77%	3.53%	1.76%
Completely agree	48.67%	48.24%	-0.43%
Somewhat agree	42.04%	39.41%	-2.63%
Somewhat disagree	4.42%	5.88%	1.46%
Completely disagree	3.10%	2.94%	-0.16%
My colleagues and I (in my programme/department) are able to identify groups at risk of	**Baseline**	**Endline**	**Difference**

suffering gender-based violence.			
I do not know	1.32%	2.94%	1.62%
Completely agree	55.95%	63.53%	7.58%
Somewhat agree	34.36%	25.29%	-9.07%
Somewhat disagree	4.85%	5.29%	0.44%
Completely disagree	3.52%	2.94%	-0.58%
I systematically use gender sensitive monitoring tools.	**Baseline**	**Endline**	**Difference**
I do not know	4.89%	2.94%	-1.95%
Completely agree	26.22%	32.94%	6.72%
Somewhat agree	45.33%	44.12%	-1.21%
Somewhat disagree	21.33%	12.35%	-8.98%
Completely disagree	2.22%	7.65%	5.43%
I think gender has been adequately mainstreamed into operations in my programme/department	**Baseline**	**Endline**	**Difference**
I do not know	2.21%	1.76%	-0.45%
Completely agree	36.73%	52.94%	16.21%
Somewhat agree	45.13%	37.06%	-8.07%
Somewhat disagree	12.83%	5.88%	-6.95%
Completely disagree	3.10%	2.35%	-0.75%
I think gender has been adequately mainstreamed into policies in my programme/department	**Baseline**	**Endline**	**Difference**
I do not know	4.44%	2.94%	-1.50%
Completely agree	40.00%	52.94%	12.94%
Somewhat agree	44.00%	36.47%	-7.53%
Somewhat disagree	8.00%	6.47%	-1.53%
Completely disagree	3.56%	1.18%	-2.38%
I think gender has been adequately mainstreamed into administrative instructions/ directives in my programme/department	**Baseline**	**Endline**	**Difference**
I do not know	5.31%	2.94%	-2.37%
Completely agree	32.74%	53.53%	20.79%
Somewhat agree	47.35%	33.53%	-13.82%
Somewhat disagree	10.62%	8.82%	-1.80%
Completely disagree	3.98%	1.18%	-2.80%

Q9. How much do you agree or disagree with the following statements?			
Mainstreaming gender is relevant to UNRWA's mandate	**Baseline**	**Endline**	**Difference**
I do not know	6.22%	3.53%	-2.69%
Completely agree	68.89%	70.59%	1.70%
Somewhat agree	18.67%	17.06%	-1.61%
Somewhat disagree	5.33%	7.65%	2.32%
Completely disagree	0.89%	1.18%	0.29%
Mainstreaming gender improves UNRWA's services	**Baseline**	**Endline**	**Difference**
I do not know	0.89%	0.00%	-0.89%
Completely agree	85.33%	89.41%	4.08%
Somewhat agree	12.89%	10.59%	-2.30%
Somewhat disagree	0.89%	0.00%	-0.89%
Completely disagree	0.00%	0.00%	0.00%
Preventing gender-based violence is fully relevant to UNRWA's mandate	**Baseline**	**Endline**	**Difference**
I do not know	3.56%	4.12%	0.56%
Completely agree	72.44%	72.94%	0.50%
Somewhat agree	18.67%	16.47%	-2.20%
Somewhat disagree	4.89%	5.88%	0.99%
Completely disagree	0.44%	0.59%	0.15%
UNRWA can make a real impact preventing gender-based violence	**Baseline**	**Endline**	**Difference**
I do not know	1.33%	2.35%	1.02%
Completely agree	69.33%	75.29%	5.96%
Somewhat agree	27.56%	21.76%	-5.80%
Somewhat disagree	1.33%	0.59%	-0.74%
Completely disagree	0.44%	0.00%	-0.44%
There is strong leadership in UNRWA regarding GBV prevention	**Baseline**	**Endline**	**Difference**
I do not know	7.56%	3.53%	-4.03%
Completely agree	33.33%	48.24%	14.91%
Somewhat agree	44.89%	40.00%	-4.89%
Somewhat disagree	12.89%	6.47%	-6.42%
Completely disagree	1.33%	1.76%	0.43%

GBV prevention is essential to the success of my portfolio/tasks/areas of work	Baseline	Endline	Difference
I do not know	1.77%	1.18%	-0.59%
Completely agree	67.26%	74.12%	6.86%
Somewhat agree	26.11%	22.94%	-3.17%
Somewhat disagree	3.98%	1.18%	-2.80%
Completely disagree	0.88%	0.59%	-0.29%
Work on GBV prevention is a priority in emergency contexts	**Baseline**	**Endline**	**Difference**
I do not know	1.78%	1.18%	-0.60%
Completely agree	69.33%	74.12%	4.79%
Somewhat agree	24.00%	22.94%	-1.06%
Somewhat disagree	4.44%	1.18%	-3.26%
Completely disagree	0.44%	0.59%	0.15%
GBV prevention influences my everyday work	**Baseline**	**Endline**	**Difference**
I do not know	1.33%	3.53%	2.20%
Completely agree	39.82%	47.65%	7.83%
Somewhat agree	41.59%	35.29%	-6.30%
Somewhat disagree	12.39%	10.00%	-2.39%
Completely disagree	4.87%	3.53%	-1.34%
I think it is possible to understand the complex causes of gender-based violence	**Baseline**	**Endline**	**Difference**
I do not know	3.11%	1.76%	-1.35%
Completely agree	61.33%	67.06%	5.73%
Somewhat agree	32.00%	29.41%	-2.59%
Somewhat disagree	2.67%	1.76%	-0.91%
Completely disagree	0.89%	0.00%	-0.89%
UNRWA is uniquely placed to work successfully on GBV prevention	**Baseline**	**Endline**	**Difference**
I do not know	4.89%	2.35%	-2.54%
Completely agree	55.56%	70.00%	14.44%
Somewhat agree	33.78%	25.29%	-8.49%
Somewhat disagree	4.44%	2.35%	-2.09%
Completely disagree	1.33%	0.00%	-1.33%
I think it is possible to effectively prevent gender-based violence	**Baseline**	**Endline**	**Difference**

I do not know	2.21%	2.94%	0.73%
Completely agree	51.33%	53.53%	2.20%
Somewhat agree	41.15%	38.82%	-2.33%
Somewhat disagree	4.87%	4.12%	-0.75%
Completely disagree	0.44%	0.59%	0.15%

Q10. How much do you agree or disagree with the following statements?			
I am aware of UNRWA's strategy to mainstream Gender	**Baseline**	**Endline**	**Difference**
I do not know	3.11%	1.76%	-1.35%
Completely agree	47.56%	65.29%	17.73%
Somewhat agree	44.00%	28.82%	-15.18%
Somewhat disagree	5.33%	3.53%	-1.80%
Completely disagree	0.00%	0.59%	0.59%
I know who the relevant Gender Focal Points are for my work in UNRWA	**Baseline**	**Endline**	**Difference**
I do not know	3.54%	0.00%	-3.54%
Completely agree	61.95%	74.71%	12.76%
Somewhat agree	26.99%	20.59%	-6.40%
Somewhat disagree	5.75%	4.12%	-1.63%
Completely disagree	1.77%	0.59%	-1.18%
I am clear about the meaning of the term gender-based violence	**Baseline**	**Endline**	**Difference**
I do not know	0.44%	0.00%	-0.44%
Completely agree	83.56%	87.06%	3.50%
Somewhat agree	14.67%	10.59%	-4.08%
Somewhat disagree	1.33%	1.76%	0.43%
Completely disagree	0.00%	0.59%	0.59%
I understand fully how GBV prevention work leads to a reduction in the prevalence and effects of GBV	**Baseline**	**Endline**	**Difference**
I do not know	0.88%	0.00%	-0.88%
Completely agree	73.01%	82.35%	9.34%
Somewhat agree	23.45%	14.12%	-9.33%
Somewhat disagree	2.65%	2.94%	0.29%
Completely disagree	0.00%	0.69%	0.69%
I have a full understanding of what gender-based violence	**Baseline**	**Endline**	**Difference**

prevention comprises in my work			
I do not know	1.78%	0.59%	-1.19%
Completely agree	70.22%	77.06%	6.84%
Somewhat agree	25.33%	17.65%	-7.68%
Somewhat disagree	2.67%	3.53%	0.86%
Completely disagree	0.00%	1.18%	1.18%
I have a full understanding of the challenges of addressing gender-based violence in emergencies	**Baseline**	**Endline**	**Difference**
I do not know	1.77%	0.00%	-1.77%
Completely agree	62.83%	70.59%	7.76%
Somewhat agree	30.09%	25.29%	-4.80%
Somewhat disagree	5.31%	3.53%	-1.78%
Completely disagree	0.00%	0.59%	0.59%
I feel that there is a shared understanding of Gender-based violence protection between myself and my team	**Baseline**	**Endline**	**Difference**
I do not know	0.89%	1.76%	0.87%
Completely agree	49.78%	65.29%	15.51%
Somewhat agree	37.78%	29.41%	-8.37%
Somewhat disagree	10.67%	1.76%	-8.91%
Completely disagree	0.89%	1.76%	0.87%
I am clear about the difference between responding to gender-based violence and preventing gender-based violence	**Baseline**	**Endline**	**Difference**
I do not know	1.78%	1.76%	-0.02%
Completely agree	67.56%	78.82%	11.26%
Somewhat agree	27.11%	16.47%	-10.64%
Somewhat disagree	3.56%	2.94%	-0.62%
Completely disagree	0.00%	0.00%	0.00%
I have a full understanding of the impacts/consequences of not integrating gender-based violence into my area of work, including in emergencies	**Baseline**	**Endline**	**Difference**
I do not know	2.20%	1.18%	-1.02%
Completely agree	61.23%	74.12%	12.89%
Somewhat agree	31.72%	21.76%	-9.96%

Somewhat disagree	3.52%	2.35%	-1.17%
Completely disagree	1.32%	0.59%	-0.73%
I am knowledgeable of who the main actors working to prevent gender-based violence within UNRWA are	**Baseline**	**Endline**	**Difference**
I do not know	5.78%	1.76%	-4.02%
Completely agree	52.44%	65.88%	13.44%
Somewhat agree	33.33%	28.24%	-5.09%
Somewhat disagree	6.67%	3.53%	-3.14%
Completely disagree	1.78%	0.59%	-1.19%
I am knowledgeable of who the main actors working to prevent gender-based violence outside UNRWA are	**Baseline**	**Endline**	**Difference**
I do not know	8.44%	5.88%	-2.56%
Completely agree	30.67%	40.59%	9.92%
Somewhat agree	43.56%	41.76%	-1.80%
Somewhat disagree	13.78%	9.41%	-4.37%
Completely disagree	3.56%	2.35%	-1.21%
I know how to get support for gender analysis for my interventions when needed	**Baseline**	**Endline**	**Difference**
I do not know	4.44%	3.53%	-0.91%
Completely agree	44.44%	57.65%	13.21%
Somewhat agree	37.33%	32.94%	-4.39%
Somewhat disagree	11.11%	4.71%	-6.40%
Completely disagree	2.67%	1.18%	-1.49%
I undertake sound gender analysis to design my GBV prevention activities	**Baseline**	**Endline**	**Difference**
I do not know	7.11%	7.65%	0.54%
Completely agree	32.44%	45.88%	13.44%
Somewhat agree	43.56%	32.35%	-11.21%
Somewhat disagree	12.44%	10.00%	-2.44%
Completely disagree	4.44%	4.12%	-0.32%
I am well supported and supervised to undertake effective GBV prevention work	**Baseline**	**Endline**	**Difference**
I do not know	3.10%	5.29%	2.19%
Completely agree	34.51%	49.41%	14.90%

Somewhat agree	37.17%	33.53%	-3.64%
Somewhat disagree	16.81%	7.06%	-9.75%
Completely disagree	8.41%	4.71%	-3.70%
I have sufficient capacity and training to undertake GBV prevention work successfully	**Baseline**	**Endline**	**Difference**
I do not know	3.10%	4.71%	1.61%
Completely agree	34.96%	50.00%	15.04%
Somewhat agree	39.38%	31.76%	-7.62%
Somewhat disagree	16.37%	9.41%	-6.96%
Completely disagree	6.19%	4.12%	-2.07%
I use M&E data on GBV prevention effectively to strengthen my work	**Baseline**	**Endline**	**Difference**
I do not know	5.33%	6.47%	1.14%
Completely agree	24.89%	40.59%	15.70%
Somewhat agree	40.89%	35.88%	-5.01%
Somewhat disagree	20.44%	13.53%	-6.91%
Completely disagree	8.44%	3.53%	-4.91%

Q13. What tools and/or sources of information do you use to support your knowledge of GBV prevention issues in your work?	**Baseline**	**Endline**	**Difference**
Thematic specific knowledge centre (for example a specialised online platform, a library, etc.) inside or outside UNRWA. Please specify	24.89%	51.76%	26.87%
UNRWA's intranet	39.56%	42.35%	2.79%
UNRWA's website	28.89%	56.47%	27.58%
UNRWA's publications and/or guidelines	55.11%	39.41%	-15.70%
UNRWA's Gender Focal Point(s) or advisers	49.78%	78.82%	29.04%
Other's publications and/or guidelines	36.89%	70.59%	33.70%
Other	12.00%	37.65%	25.65%

Q14. What kinds of activities or trainings would you like to participate in to increase GBV prevention?	**Baseline**	**Endline**	**Difference**
Introduction to gender-based violence prevention	29.78%	28.82%	-0.96%

Gender based violence prevention in specific programming (health, education, protection, etc.)	55.56%	58.82%	3.26%
Gender based violence prevention in operations	36.00%	49.41%	13.41%
Gender based violence prevention in communications	35.11%	45.29%	10.18%
Gender based violence prevention in emergencies	63.11%	62.35%	-0.76%
UNRWA's GBV policies and strategies	50.22%	65.88%	15.66%
Other	7.56%	7.06%	-0.50%

Q16. What would be your preferred type of learning to increase capacities on GBV in UNRWA?	**Baseline**	**Endline**	**Difference**
Face-to-face training and courses	69.33%	84.71%	15.38%
Self-paced online courses	24.44%	30.59%	6.15%
Detailed assignments	14.22%	14.71%	0.49%
Coaching	45.33%	41.76%	-3.57%
On-the-job / learning by doing	56.44%	65.29%	8.85%
Other	2.67%	4.71%	2.04%

Q17. How much do you agree or disagree with the following statements?			
UNRWA devotes sufficient human resources to work effectively on GBV prevention	**Baseline**	**Endline**	**Difference**
I do not know	12.11%	4.12%	-7.99%
Completely agree	18.42%	29.41%	10.99%
Somewhat agree	37.89%	38.82%	0.93%
Somewhat disagree	24.21%	22.35%	-1.86%
Completely disagree	7.37%	5.29%	-2.08%
UNRWA devotes sufficient financial resources to work effectively on GBV prevention	**Baseline**	**Endline**	**Difference**
I do not know	13.83%	7.65%	-6.18%
Completely agree	15.96%	21.18%	5.22%
Somewhat agree	33.51%	33.53%	0.02%

Somewhat disagree	29.79%	31.76%	1.97%
Completely disagree	6.91%	5.88%	-1.03%
UNRWA GBV prevention activities are targeted towards the most vulnerable groups	**Baseline**	**Endline**	**Difference**
I do not know	13.30%	8.24%	-5.06%
Completely agree	27.13%	35.29%	8.16%
Somewhat agree	40.96%	41.76%	0.80%
Somewhat disagree	17.55%	11.76%	-5.79%
Completely disagree	1.06%	2.94%	1.88%
UNRWA GBV prevention activities engage the most appropriate stakeholders	**Baseline**	**Endline**	**Difference**
I do not know	15.26%	4.71%	-10.55%
Completely agree	26.32%	45.29%	18.97%
Somewhat agree	43.68%	38.24%	-5.44%
Somewhat disagree	14.21%	11.18%	-3.03%
Completely disagree	0.53%	0.59%	0.06%
UNRWA staff are held accountable for the work they do on GBV prevention	**Baseline**	**Endline**	**Difference**
I do not know	17.55%	10.00%	-7.55%
Completely agree	17.02%	35.88%	18.86%
Somewhat agree	32.98%	37.06%	4.08%
Somewhat disagree	25.53%	11.76%	-13.77%
Completely disagree	6.91%	5.29%	-1.62%
UNRWA management is held accountable for informing, guiding, and supporting the introduction of GBV aspects effectively into its work	**Baseline**	**Endline**	**Difference**
I do not know	21.28%	16.47%	-4.81%
Completely agree	14.89%	31.18%	16.29%
Somewhat agree	36.70%	34.71%	-1.99%
Somewhat disagree	20.74%	15.29%	-5.45%
Completely disagree	6.38%	2.35%	-4.03%
UNRWA interventions are based upon sound gender analysis	**Baseline**	**Endline**	**Difference**
I do not know	14.36%	9.52%	-4.84%
Completely agree	21.28%	38.10%	16.82%
Somewhat agree	43.62%	38.69%	-4.93%

Somewhat disagree	15.96%	12.50%	-3.46%
Completely disagree	4.79%	1.19%	-3.60%
UNRWA is able to successfully undertake GBV prevention work in emergencies	**Baseline**	**Endline**	**Difference**
I do not know	12.77%	9.47%	-3.30%
Completely agree	20.74%	42.01%	21.27%
Somewhat agree	44.68%	33.14%	-11.54%
Somewhat disagree	17.55%	13.61%	-3.94%
Completely disagree	4.26%	1.78%	-2.48%
M&E data is available to strengthen UNRWA's GBV prevention work	**Baseline**	**Endline**	**Difference**
I do not know	22.34%	13.53%	-8.81%
Completely agree	14.36%	35.29%	20.93%
Somewhat agree	41.49%	34.12%	-7.37%
Somewhat disagree	17.55%	15.88%	-1.67%
Completely disagree	4.26%	1.18%	-3.08%
There is a strong culture of learning about what GBV prevention activities work in UNRWA	**Baseline**	**Endline**	**Difference**
I do not know	8.51%	3.53%	-4.98%
Completely agree	19.68%	34.71%	15.03%
Somewhat agree	39.36%	42.35%	2.99%
Somewhat disagree	25.53%	16.47%	-9.06%
Completely disagree	6.91%	2.94%	-3.97%
Roles and responsibilities to mainstream GBV prevention are clear in UNRWA	**Baseline**	**Endline**	**Difference**
I do not know	8.95%	2.94%	-6.01%
Completely agree	18.42%	35.29%	16.87%
Somewhat agree	36.32%	41.18%	4.86%
Somewhat disagree	30.53%	20.00%	-10.53%
Completely disagree	5.79%	0.59%	-5.20%
UNRWA is a key player in the region/country regarding GBV	**Baseline**	**Endline**	**Difference**
I do not know	14.42%	6.51%	-7.91%
Completely agree	34.13%	47.93%	13.80%
Somewhat agree	32.69%	33.73%	1.04%
Somewhat disagree	16.83%	10.65%	-6.18%
Completely disagree	1.92%	1.18%	-0.74%

Q18. Do you receive information about GBV prevention work from?	Baseline	Endline	Difference
The Gender Unit?	51.56%	65.29%	13.73%
Your Field Office?	29.78%	42.94%	13.16%
UNRWA Senior Management?	18.67%	36.47%	17.80%
Other	16.89%	22.35%	5.46%

Q19. Is the information you receive:	Baseline	Endline	Difference
Irregular?	24.44%	13.53%	-10.91%
Somewhat Regular?	44.44%	42.94%	-1.50%
Very Regular?	13.33%	43.53%	30.20%
Blank	17.78%		-17.78%

Q20. Do you think there are risks of UNRWA engaging in GBV prevention work in terms of?	Baseline	Endline	Difference
Security?	36.89%	52.35%	15.46%
Protection?	44.44%	58.24%	13.80%
Cultural context?	43.56%	65.29%	21.73%
UNRWA's legal status/immunity?	22.22%	33.53%	11.31%
Staff well-being?	47.56%	67.65%	20.09%
Workload prioritisation?	36.00%	51.18%	15.18%
Other	6.22%	7.06%	0.84%

Annex 3 : References

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