

FINAL EVALUATION REPORT

“Providing safe, confidential, life-saving multi-sectoral prevention and response services to gender based violence in the most vulnerable areas of the Gaza Strip”
funded by AECID, implemented by Alianza por la Solidaridad
(31 December 2014 – 30 June 2016)

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ACRONYMS

AECID	Spanish Agency for International Cooperation and Development
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CFTA	Culture and Free Thought Association - Gaza
FGD	Focus Group Discussion
GBV	Gender Based Violence
GBVIMS	Gender Based Violence Information Management System
HQ	Headquarter level
HRBA	Human Rights Based Approach
HRs	Human Rights
HWC	Health Work Committees
IMS	Information Management System
INGOs	International Non-Governmental Organizations
LF	Logical Framework
M&E	Monitoring and Evaluation
MoE	Ministry of Education
MoH	Ministry of Health
MoSA	Ministry of Social Affairs
MoWA	Ministry of Women Affairs
NGO	Non-Governmental Organization
OCHA	Office for the Coordination of Humanitarian Affairs (UN System)
oPt	occupied Palestinian territories
PNA	Palestinian National Authority
SRH	Sexual and Reproductive Health
SRHRs	Sexual and Reproductive Health Rights
ToC	Theory of Change
UHCW	Union of Health Work Committees - Gaza
UNDP	United Nation Development Programme
UNFPA	United Nations Population Fund
UNRWA	United Nations Relief and Works Agency
UN WOMEN	United Nations Entity for Gender Equality and the Empowerment of Women
WATC	Women's Affairs Technical Committee - Gaza
WHO	World Health Organization

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EXECUTIVE SUMMARY

This report concerns the **Final Evaluation** of the project **“Providing safe, confidential, life-saving multi-sectorial prevention and response services to gender based violence in the most vulnerable areas of the Gaza Strip”**. The project is funded by AECID (2014/PRYC/000813) and implemented by Alianza por la Solidaridad (ALIANZA) in partnership with Union of Health Work Committees (UHCW), Women Affairs Technical Committee (WATC), and Culture of Free of Thought Association (CFTA) (31st December 2014 - 30th June 2016).

The **project aimed at** making available GBV protection services in 15 communities in the ARA (*Access Restricted Area*) of the Gaza Strip, by piloting a multi-sectorial, holistic response model (‘one-stop centre’) - based on the standardization of services, the accreditation and standardization of care protocols and referrals (*SOPs*) and the introduction of a the figure of the Case Manager - in three Health Centres managed by UHCW and CFTA. In addition, the project aimed, through awareness sessions delivered by UHCW, CFTA and WATC, at reaching out and linking women and men in the targeted communities to the GBV response services. Finally, through data collection within the communities (GBV Risk Assessment) and through the GBVIMS within the health centres, the project aimed at generating new data about GBV in the Gaza Strip, to be utilized for advocacy action at national and international level.

The **evaluation** has been carried out against the following understanding of GBV within humanitarian contexts. It is widely recognized that GBV-related risks, due to *“attitudes, beliefs, norms and structures that promote and/or condone gender-based discrimination and unequal power”*¹, are exacerbated during humanitarian crisis. Even if for long time the humanitarian sector has focused on addressing sexual violence in conflict —for instance the use of rape or other forms of sexual violence as a weapon of war, because of its immediate and potentially life-threatening health consequences, there is an increased recognition that one has also to focus on other types of GBV in humanitarian/recovery settings characterised by *“increased militarization, lack of community and State protections, displacement, scarcity of essential resources, disruption of community services, changing cultural and gender norms, disrupted relationships and weakened infrastructure”*.² Furthermore, it is increasingly recognised, that also in humanitarian settings, there is the need of *“not only working to meet the immediate needs of the affected populations, but also implementing strategies—as early as possible in any humanitarian action—that promote long-term social and cultural change towards gender equality”*³.

In the context of Gaza protracted humanitarian crisis, women are highly exposed to GBV, which needs to be promptly tackled through the provision of GBV protection services. Paramount, however, taken into account the protracted dimension of the humanitarian crisis, and the more structural roots of GBV, these response services have to become: a) solidly established on the ground, while at the same time, b) able to tackle social and cultural roots, and c) attempt to modify the policies and practices framework of the main service providers (e.g. MoH, MoSA etc.) who have a stake on GBV.

Evaluation data were collected through desk review and qualitative fieldwork in Gaza. Fieldwork was carried out in Palestine in October 2016, with the support of Fidaa Al-Araj, who supported the evaluator in translating and analysing of FGDs, interviews and relevant documents.

The main findings of the evaluation are:

Relevance: The project is relevant to all its main stakeholders: it responds to the needs of GBV survivors, and community women and men affected by the humanitarian crisis in Gaza, as identified

¹ IASC Inter-Agency Standing Committee. 2015. *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing risk, promoting resilience and aiding recovery*.

² Ibidem

³ Ibidem

by themselves and also by main reports and studies on GBV in Gaza and it is aligned to partners' interests and strategic plans

Effectiveness: Overall the project succeeded in achieving the expected outcomes and Alianza and partners were successfully able to manage the obstacles met during implementation. In particular:

- *Specific Objective: Protection of 15 communities in the ARA ("Access Restricted Areas") of Gaza Strip by providing response services to the Gender Based Violence (GBV) was also achieved. By the end of the project the improved pilot model of multi-sectoral response was completely adopted in the 3 centres. An increased number of GBV cases were detected and followed-up through improved GBV response service. Overall, beneficiaries felt more protected thanks to the availability of the GBV protection services. However, many of them signalled that only reaching economic independence they would be able to leave abusive situations. Finally, thanks to partners' advocacy activities within the Protection Cluster, the project managed to engage other Gaza health providers, including the MoH, MoSA and MoWA, in the discussion about GBV services.*
-
- *Result 1 - Improved the access, and the confidential and multi-sectoral (quality of the) response to GBV in the target communities was achieved thanks to a) the elaboration, piloting and adoption of GBV Case Management SOPs; b) capacity building to Case Management staff; c) equipment, disposable and medication for the health centres. GBV survivors reported satisfaction about the quality of the GBV services received.*
- *Result 2 - Men and women from 15 ARA communities are aware of GBV as an issue of protection was also achieved, especially in the case of community women and CBOs. The project provided information about GBV services to about 50% of the total population of the 15 targeted ARA. Fewer men took part into awareness activities, and there were difficulties with Mukhtars. Youth community leaders, nevertheless, seem to be very promising and worth focusing on in future projects. Overall, all the participants to the awareness sessions reported being more aware about GBV and the existence of GBV services.*
- *Result 3 - Implemented the system to collect information about GBV in order to have an impact at the national/international level, has been met as a homogenous system of data collection was developed in a participatory way by CFTA and UHWC staff and NRC experts (GBVIMS - including forms for data collection and related SOPs for confidentiality etc., in line with international standards). Through data collected, Alianza and partners, were able to feed into data by the Protection Cluster on GBV services in Palestine and provide important technical advice on the overall GBV information system for the oPt. In addition, the project has produced a GBV Risk Assessment for six specific areas, which has generated 2 related advocacy fact-sheets on GBV in North and Middle Gaza Strip.*

Efficiency: Overall the project was soundly managed from a financial point of view. The 'support' costs, sustained by Alianza during the project period, only 18% of the total expenditure (which is very reasonable amount) vs. 82% spent directly on the project; expenditure is distributed proportionally to the needs and tasks of each local partner and proportionally to the importance and the needs of the different Results. The cost per beneficiary, whether calculated in terms of service availability, GBV survivors follow-up, outreach and advocacy activities, seems reasonable, but it is not possible to compare them with similar costs sustained for similar activities by other organizations.

Furthermore, AECID funding allowed to cover a variety of costs – from transportation costs for GBV survivors, outreach activities and home-visits, staff and capacity building for staff, provision of technical expertise – which together with Alianza's strong supervision and coordination role, created the conditions for the creation of high quality 'one-stop' multi-sectoral GBV response services, while making them known and accessible within the ARA communities, and at the same advocating for the expansion of similar services within the Gaza Strip and the oPt.

Alignment: The project is aligned with international and national instruments for prevention of GBV, in particular with the Inter Agency Standing Committee, Guidelines for GBV in Humanitarian Action 2015 and with the PNA's 'National Strategy to Combat Violence Against Women 2011-2019'.

Consistency: The different project activities and strategies of the project successfully complemented each other. Gender equality and HR principles were mainstreamed in training and awareness activities and materials. Awareness sessions and advocacy actions strongly contributed to link GBV survivors, community women and men to the GBV response services. Mechanisms for coordination and exchange among project partners, and with other stakeholders (Protection Cluster), were clear and effective; overall partners, believed that this was one of the most successful aspect of the project.

Appropriation/Ownership: All partners took actively part in the design of the project and of project activities during all the phases of the project, also thanks to Alianza's coordination role. Overall, partners – especially at field level - showed a strong ownership for the multi-sectoral approach to GBV services piloted in the project. The SOPs for the Health Centres' GBV services were actively prepared and piloted by UHWC and CFTA's staff and adopted within the clinics. As already mentioned, all partners considered this a very positive aspect of this project.

Connectivity (Link Relief to Development/Sustainability): The connection between relief and development (see Chapter 2), together with social and cultural sustainability, and institutional and financial sustainability, has been highly taken into consideration by Alianza and partners when designing the project. Cultural and social sustainability were guaranteed by all partners by building a maintaining communication channels and relations of trust with the targeted communities. Nevertheless, one of the partners, UHWC, was not been able to identify effective strategies to guarantee institutional and financial sustainability.

It needs to be added that, at times, donors also contribute to this situation by: a) not always prioritizing GBV in their humanitarian strategies (AECID is an exception in this regard); b) by funding, in humanitarian contexts, only short-term projects, which do not always take into consideration the roots and the long-term consequences of a humanitarian crisis as the one in Gaza.

Participation: Overall, the project was managed with the strong involvement of the beneficiaries and of other Gaza and international stakeholders (Protection Cluster). Beneficiaries' views were taken into consideration took in consideration through the partners and their field team in charge of the provision of services. Furthermore, they had a substantial say especially on issues such as the choice of the topics for the awareness sessions or in planning of recreational activities. The cooperation that Alianza and partners established with the Protection Cluster was quite intense, and lead to the finalization of the SOPs which are ready to be adopted by all the organizations involved.

Coverage: The outreach of the most vulnerable women living in remote areas of the Gaza Strip, was a priority within this project. The main physical and financial obstacles preventing women to reach GBV services were analysed and tackled through specific outreach measure such as home-visits, including awareness and detection sessions during home-visits, and reimbursement of transportation costs to reach the health centre. Social and cultural obstacles were tackled thanks to the provision of multi-sectoral services that guarantee confidentiality to women.

Theory Of Change: The project did not make explicit its Theory of Change nor it was supported by a robust project Risk Analysis. However the 'implicit' ToC was coherent and realistic and the obstacles met during project implementation were properly managed.

Measurability: The Indicators, the data collected and the reporting (within AECID Excel format) were overall good, but some aspects of the Monitoring and reporting system could be improved.

The main recommendations emerging from this evaluation are:

On the basis of our findings, the overall main recommendation is that of continuing the delivery of GBV services, through 'one-stop-centres' within health facilities, considered a privileged entry point for GBV survivors, and whenever possible to extend the model to other health facilities, as this type of

services are extremely **relevant** to the needs of the female – and male – population in the Gaza Strip. It should also be explored the possibility of **targeting** women in cities, as they might be suffering from more isolation than women in marginalized rural areas.

Furthermore, it is recommended to continue adopting implementation strategies which have proved extremely successful with various project stakeholders, such as **outreach measures** for vulnerable beneficiaries, especially GBV survivors, **participatory trainings and coaching** with GBV response services' staff and **engagement with other national and international stakeholders** within the Protection Cluster.

The project was **efficiently** managed, but, in the future, it would be interesting to collect information about costs sustained by other organizations for the same services (service availability, GBV survivors follow-up, outreach and advocacy activities). This activity could be for example carried out within the Protection Cluster, so to have a shared baseline for the cost of this type of services.

In order to increase effectiveness of the services for GBV survivors, the inclusion of **income generating activities and cash assistance** should also be considered (as actually Alianza is doing in the currently implemented project). While doing so, it should also be considered that loans are risky because women are not strong enough to return them), to be able to support women in leaving abusive situations.

In order to increase and maintain the **capacity of the staff**, and thus the quality of the GBV response services, yearly refresher trainings and coaching to Case Management staff in the health centres and continue exchange/learning occasions for them should be provided.

As we discussed, one of the major downfalls of the project, was the discontinuation of UHWC 'one-stop-centres' and the loss of the majority of the involved staff. This impacted on **effectiveness, on ownership, and on connectivity (linking relief to development/sustainability)**. To obviate to this in future projects it is recommended:

- that partners identify a fundraising strategy able to render GBV services sustainable - and to recover as soon as possible and maintain in place the GBV services suspended by UHWC
- that the donor community will consider: a) prioritizing GBV in their humanitarian strategies and b) incorporating, in their humanitarian funding strategy for Gaza, also longer-term projects able to respond to the chronic character of Gaza humanitarian crisis.

It is strongly advised to introduce **ToC and Risk Analysis** as planning and monitoring tools in future projects. The monitoring and reporting system could also be improved by being more specific and appropriate about the relation between Indicators and outcomes, by being more precise in terms of beneficiaries (new and 'old' GBV survivors, trainees and beneficiaries of awareness sessions etc.) by introducing more qualitative indicators and by improving measurement of increased knowledge and improved skills and practices,.

Chapter 1) EVALUATION BACKGROUND

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Alianza is an organization with a strong focus on women’s rights, gender issues and GBV¹. In 2013, it² had implemented also in the oPt, the AECID funded *‘Regional Program on sexual and reproductive rights of Palestinian, Jordanian and Lebanese women in a position of vulnerability’*, which had a strong GBV element, and whose Gaza component was implemented in partnership with UHCW and WATC.

The project analysed in this report, built on the experience of the 2013 regional programme, and **aimed at** making available GBV protection services in 15 communities in the ARA (*Access Restricted Area*) of the Gaza Strip, by piloting a multi-sectorial, holistic response model (‘one-stop centre’) - based on the standardization of services, the accreditation and standardization of care protocols and referrals (*SOPs*) and the introduction of the figure of the Case Manager - in three Health Centres managed by UHCW and CFTA. In addition, the project aimed, through awareness sessions delivered by UHCW, CFTA and WATC, at reaching out and linking women and men in the targeted communities to the GBV response services. Finally, through data collection within the communities (GBV Risk Assessment) and through the GBVIMS within the health centres, the project aimed at generating new data about GBV in the Gaza Strip, to be utilized for advocacy action at national and international level.

The project has been followed by another AECID funded project, under implementation at the moment of this evaluation *“Integrated protection response for women at risk of GBV and GBV survivors, in the most vulnerable communities of the Gaza Strip”*, which is implemented in partnership with UHCW and CFTA, and includes an economic empowerment component for GBV survivors.

The purpose of this evaluation, as defined in the ToR, is that of *“establishing recommendations and draw lessons learned in order to improve the quality and impact of future interventions, paying special attention to the degree of achievement of the expected results, the implementation of the model of multi sectorial response to GBV in the Gaza Strip, coordination, quality, relevance, impact of the collective processes carried out together with the design, implementation and monitoring of the intervention as a whole”*.

ANNEX 1 – EVALUATION TOR

Chapter 2) GAZA, A CHRONIC HUMANITARIAN CRISIS AND GBV: THE ‘CONCRETE’ AND THE ‘CONCEPTUAL’ FRAMEWORK

Gender Based Violence is treated in different ways within the development and the humanitarian sectors. When tackled as a development matter, GBV is often seen as rooted structural society issues (patriarchy), which require long-term solutions focusing on change of knowledge, behaviours and attitudes. In Palestine, the work on GBV has for many years been characterized by this approach. As Nisreen Alami, Gender Advisor for the Humanitarian Country Team (UN Women / OCHA / Protection Cluster) points out: *“Within the development sector, the scale of investment on awareness etc. is excessive and there is no focus on GBV service provision. Women start understanding that they are suffering violence but then they do not know where to go. UNFPA has done a mapping of all projects*

¹ Alianza por la Solidaridad, Memoria de Actividades 2014 and Memoria de Actividades 2015.

² At that time their name was ‘Solidaridad Internacional’.

on GBV³ and it has emerged that only a very small percentage of them focuses on protection and service provision. This is a problem.” (Nisreen Alami, UN Women/ OCHA).

It is widely recognized that GBV-related risks, due to “attitudes, beliefs, norms and structures that promote and/or condone gender-based discrimination and unequal power”⁴, are exacerbated during humanitarian crisis.

Even if for long time the humanitarian sector has focused on addressing sexual violence in conflict — for instance the use of rape or other forms of sexual violence as a weapon of war, because of its immediate and potentially life-threatening health consequences, there is an increased recognition that one has also to focus on other types of GBV in humanitarian/recovery settings characterised by “increased militarization, lack of community and State protections, displacement, scarcity of essential resources, disruption of community services, changing cultural and gender norms, disrupted relationships and weakened infrastructure”⁵.

Furthermore, it is increasingly recognised, that also in humanitarian settings, there is the need of “not only working to meet the immediate needs of the affected populations, but also implementing strategies—as early as possible in any humanitarian action—that promote long-term social and cultural change towards gender equality”⁶.

This understanding of GBV in humanitarian settings seems especially relevant to the **Gaza situation**.

As a number of studies have pointed out in Gaza, GBV is a structural issue, with social and cultural roots, exacerbated by unemployment, displacement, war and factional violence.

In 2011, PCBS carried out a Survey on diverse forms of violence affecting Palestinians – violence by Israeli occupation, violence in the public sphere and domestic violence. Among the findings it emerged that 51% of ever-married women in the Gaza Strip were exposed to one form of violence by their husbands during the 12 months preceding the survey. Among those women, the rate of those who were exposed to psychological violence at least once was 76.4%, 88.3% were exposed to economic abuse violence, 78.9% were exposed to social violence, 34.8% were exposed to physical violence, and 14.9% were exposed to sexual violence - showing how GBV is a quite strongly rooted phenomena. To this, it needs to be added that Palestine does not offer to women survivors of GBV a protected environment: the Palestinian penal code does offer mitigation measures to perpetrators of ‘honor’ killing; it does not envisage protection measures for women survivors of domestic violence, and, together with the informal legal system (Mukhtars etc.) encourages women to go back to the environment where perpetrators are.⁷

A study produced in the context of this project by Alianza por la Solidaridad, in cooperation with ActionAid⁸, states that after the 2014 Israeli ‘Operation Protective Edge’ women highlighted “an increase of violence ... particularly for women whose families were displaced”. At the same time, “Israel’s long-standing policies of creating a state of systematic non-development and fragmentation has enormous effects on the economic situation and related stresses. (...) husband’s stresses from to

³ UNFPA, 2015, Results of the mapping of GBV interventions in Palestine: Analytical paper - <http://www.unfpa.ps/resources/file/publications/Analytical%20Paper%20on%20results%20of%20the%20mapping%20of%20GBV%20interventions%20in%20Palestine,%202015.pdf>

⁴ IASC Inter-Agency Standing Committee. 2015. *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing risk, promoting resilience and aiding recovery*.

⁵ Ibidem

⁶ Ibidem

⁷ *Violence Against Women In The Gaza Strip After The Israeli Military Operation Protective Edge 2014*, Prepared By Catherine Müller And Laila Barhoum, commissioned by Alianza por la Solidaridad (Aps) and Actionaid (Aa), October, 2015

⁸ Ibidem

feelings of potential inadequacy and of not being able to fulfil one's full potential are related to higher incidents of physical domestic violence".

A UNFPA GBV assessment completed after the conflict in Gaza in October 2014 found that women and girls – especially IDPs living in shelters or other overcrowded accommodations – were especially vulnerable to family separation, greater exposure to gender based violence, domestic violence and sexual harassment, family disputes and limited access to basic services⁹.

In this context of protracted humanitarian crisis, **women are highly exposed to GBV**, which needs to be promptly tackled through the provision of **GBV protection services**. Paramount, however, taken into account the **protracted** dimension of the humanitarian crisis, and the more **structural roots** of GBV, these response services have to become: a) solidly **established on the ground**, while at the same time, b) able to tackle **social and cultural roots**, and c) attempt to modify the **policies and practices** framework of the main service providers (e.g. MoH, MoSA etc.) who have a stake on GBV.

On the basis of this understanding, the system of UN and non-governmental organizations – together with relevant national actors such as NGOs and Ministries – have, in the recent years, established a framework for working on GBV in Palestine. On the one hand, GBV actions in **development** sector, are coordinated by the GBV Working Group within the Gender Task Force (lead by UN Women with focal points in various UN agencies). In this case the focus of programming is more on changing awareness, behaviours of society at large and also about modifying laws, policies and institutional practices. On the other hand, the **Protection Cluster** (coordinate by UNHCR) coordinates actions on GBV within **the humanitarian sector**. The focus, in this case, is on the most vulnerable women at risk of GBV, and the response is in terms of GBV multi-sectoral services provision (health, psychosocial, legal or economic support services), through the involvement of relevant governmental and non-governmental service providers. In this framework, awareness activities are seen mainly as tool for linking communities and GBV survivors to the GBV response services.

To use the words of Nisreen Alami *"GBV work in a humanitarian perspective is about needs and services. It is about expanding the services...It is also about increasing capacity, increasing awareness, but always in relation to services"*, without forgetting the roots of GBV and the long-term consequences of a humanitarian crisis.

Finally, as also made explicit in Alianza's proposal, work on GBV in a humanitarian context, has to take into account:

- the humanitarian principles and human rights especially concerning the protection of women and children in humanitarian settings as defined by International Humanitarian Law and Human Rights convention and standards (ICRC, CRC, CEDAW etc.);
- the good practices for humanitarian work, in terms of processes (holistic and participatory methodologies etc.) and interventions (protection of women and children), as defined in International standards and guidelines (OCHA Guidelines, HAP and Sphere Standards, ICRC etc.);
- the good practices for gender and GBV work in humanitarian settings, in terms of processes (holistic and participatory methodologies etc. etc.) and interventions (protection of women and children from GBV), as defined in international standards and guidelines (IASC GBV Guidelines and Gender Handbook).

It is against this understanding of GBV in humanitarian contexts, that we evaluated the project implemented by Alianza and partners in the Gaza Strip.

⁹ CFTA & UNFPA, October 2014, Protection in the windward. Conditions and Rights of Internally Displaced Women and Girls during the latest Israeli military operation in the Gaza Strip

Chapter 3) METHODOLOGY

3.1 EVALUATION QUESTIONS AND INDICATORS

Evaluation questions have been clearly set in the ToR of this assignment and they concern nine evaluation criteria: Relevance, Effectiveness, Efficiency, Alignment, Consistency, Appropriation, Connectivity, Participation and Coverage. The analysis of the Theory of Change, and an extra criteria, Measurability, have been added by the evaluator.

Qualitative and quantitative Indicators have, thus, been developed, for each of the evaluation questions. For the analysis of the project **Effectiveness**, the indicators included in the project proposal and monitoring plan have also been incorporated.

ANNEX 2 - EVALUATION MATRIX

It is important to mention, that while writing this report, we deleted some evaluation Indicators that resulted to be redundant.

3.2 EVALUATION TOOLS

Data related to the Evaluation Indicators were collected through a Desk Review of the main project documents and relevant reports (Gaza humanitarian crisis, GBV in Gaza, guidelines for GBV work in humanitarian settings etc.) and through FGDs and interviews, during one week of fieldwork in Gaza.

Desk Review

The Desk Review has focused on: a) literature about guiding principles of GBV work in humanitarian settings; b) information and reports about GBV in the Gaza context; c) main project documents.

ANNEX 3 – LIST OF REVIEWED DOCUMENTS

FGDs and Interviews with project, partners, rights-holders, community members other national and international stakeholders

On the basis of the evaluation matrix, questionnaires have been developed for the following project stakeholders:

- Project partners executive staff (Alianza, UHWC, CFTA, WATC + NRC)
- Project partners field staff (Alianza, UHWC, CFTA, WATC + NRC)
- Beneficiaries of GBV services
- Community women and men (beneficiaries of awareness sessions)
- Community leaders
- Other stakeholders (CBOs, national and international stakeholders etc.)

ANNEX 4 - QUESTIONNAIRES MATRIX

3.3 FIELDWORK

Fieldwork was carried out in Palestine in October 2016, with the support of Fidaa Al-Araj, and according to the following schedule:

Table 1 - Fieldwork schedule

DAY	ACTIVITY	PARTICIPANTS
GAZA		
Sunday 2 October	FGD CBOs + community facilitators – WATC	12 (8 women + 4 men)
	Meeting with Nadia Abu-Nahla – Executive Director – WATC	1
	Meeting with Hala Rizi – project Coordinator – WATC	1
Monday 3 October	Meeting with Jehan Al Aklouk Project Manager and Roula Jouda - Project Coordinator – UHWC	2
	Meeting with the GBV services staff – UHWC	9 (7 women + 2 men) including psychologists/Case Managers, social workers, nurses and lawyers
	FGD with GBV survivors (from Jabalia and Bet Hanoun) – UHWC	10 women
Tuesday 4 October	Meeting with Dr. Tayseer Al-Sultan– Executive Director UHWC	1
	FGD with men who attended workshops about GBV (Bet Hanoun) – UHWC	4 men
	FGD with women who attended workshops about GBV (Jabalia) – UHWC	15 women
Wednesday 5 October	Meeting with Feryal Thabet- Director and Salwa Sheral Admin Assistant of CFTA-WHC	2
	FGD with GBV services staff – CFTA-WHC	5 (women) Including social worker/Case Manager, psychologist, nurse, lawyer, pharmacist
	FGD with GBV survivors – CFTA-WHC	10 women
	FGD with community men participants on awareness sessions on GBV - CFTA-WHC	8 men
	FGD with community women participants on awareness sessions on GBV – CFTA-WHC	14 women
Thursday 6 October	Meeting with Amira Mohana (Protection Cluster -GBV SWG / ex-NRC)	1
JERUSALEM		
Friday 14 October	Meeting Nisreen Alami - Gender Advisor for Humanitarian Country Team (UN WOMEN / OCHA / Protection Cluster)	1
Remotely (Skype)		
13 September	Preliminary interview - Marta Gil – Project Manager – Alianza por la Solidaridad	1
5 October	Fieldwork Debriefing - Marta Gil – Project Manager - Alianza por la Solidaridad	
31 October	Interview with Raquel Pérez Palacios – Project Manager – AECID	1

In total we were able to talk to around 100 people involved in the project.

Executive, management and field staff of ALIANZA and partners (UHWC, CFTA and WATC – but also NRC staff that was in charge of carrying out the staff trainings) were interviewed during fieldwork. These interviews/FGDs allowed gathering not only information and in-detail picture about project activities, strengths and weaknesses, but also about management and coordination practices, MEAL system, capacity building received etc.

GBV survivors and community members, were interviewed during FGDs – and individual interviews - to gather information about; b) the relevance of the project to their needs and rights: c) on the quality of the services they were provided with; d) the way they understand their rights and are empowered to achieve them; e) the changes – positive and negative – created by the program; f) the major strengths, weakness and obstacles met in the achievement of the project objectives.

Also, AECID and UN Women/OCHA/ Protection Cluster were interviewed to gather further information about the general context, coordination and alignment of the project with main strategy documents and plans for Gaza and about favouring and blocking factors to the achievement of project objectives.

3.4 FIELDWORK ETHICAL GUIDELINES

Confidentiality and ‘do no harm’ considerations were considered paramount when carrying out interviews and FGDs. In particular, men and women were asked their consensus before starting the interview and informed that they were able to refuse answering any question and withdraw at any moment- They were also explained that confidentiality was guaranteed as no information provided would be trackable to the name of the person who gave it. The Assessment Team took no pictures of the participants during any of these events.

3.5 DATA ANALYSIS

Data analysis was carried out through the triangulation of desk review information and primary data collected through qualitative methods during fieldwork.

Chapter 4) MAIN FINDINGS

This chapter presents the main evaluation findings related to the evaluation criteria and related Indicators:

1. Relevance
2. Effectiveness
3. Efficiency
4. Alignment
5. Consistency
6. Appropriation/ownership (by partners)
7. Connectivity (link relief to development)
8. Participation (of beneficiaries)
9. Coverage (intersectionality)
10. Theory of Change
11. Measurability

4.1. RELEVANCE

4.1.1 The intervention addresses humanitarian priorities and needs of the rights-holders as identified by main reports by UN and non-UN agencies - including the Protection Cluster Strategic Response Plan (HPC 2014)

GBV is one of the humanitarian priorities in Gaza both as recognised by a number of studies and reports and by the Protection Cluster itself.

OCHA “Strategic Response Plan 2015 – oPt” recognizes GBV among its main protection concerns¹⁰, and thus part of one of its two Strategic Objectives: *“Enhance protection by promoting respect for IHL and IHRL, pursuing of accountability, and preventing and mitigating the impact of violations.”*

The Protection Cluster coordinates the strategy against GBV within the humanitarian sector in Palestine, and especially in Gaza. The “Protection Cluster Strategic Response Plan for 2015” includes a specific focus on GBV, on its structural – internal and external - roots¹¹, while focusing on the provision of protection services for GBV survivors. *“In order to address the specific needs of survivors of gender-based violence (GBV) within the humanitarian context, the Protection Cluster will increase risk mitigation measures and enhance the provision of multi-sectoral services, including psychosocial support, legal assistance, and access to health services, particularly medical emergency response, and referral to safe and confidential specialized services.”* Four Indicators are set by the Protection Cluster to monitor its achievements on GBV in 2015:

- # of GBV victims and survivors in Gaza who access safe and confidential legal assistance.
- # of women, men, girls and boys in vulnerable communities who benefit from awareness-raising sessions on GBV risks and information on services available.
- # of service providers that document GBV cases according to safe and ethical standards.
- # of organizations that provide safe and confidential psychosocial support to GBV survivors.

OCHA “Humanitarian Response Plan 2016 - oPt” makes Protection central to its strategy, by focusing on the most vulnerable, and prioritizes – among the others – GBV survivors. *“In order to address the specific needs of survivors of GBV within the humanitarian context, the cluster will support awareness raising and activities designed to reduce risk, will enhance the provision of multi-sectoral services including psychosocial support and legal aid and support access to emergency medical care with particular attention to ensuring referral to safe and confidential specialized services”.*

AECID, donor of this project, includes among its three Strategic Objectives for its development plan for 2015-2017 in Palestine *“Promover los derechos de las mujeres y la igualdad de género”*, (formal and actual gender equality, and women’s empowerment) with a special emphasis on *“acciones en materia de lucha contra la violencia de género”*. In particular, AECID aims at achieving the following Result: *Mecanismos de prevención y respuesta a la violencia de género más eficaces, con especial incidencia en el fortalecimiento de los sistemas legales y sociales de protección y atención integral a las víctimas*, in cooperation with Palestinian women’s rights organizations and relevant ministries (MoH, MoSA, MoE, MOWA etc.).

AECID reserves to establish a humanitarian plan on the basis of actual needs of the population: *“priorizando la intervención a favor de poblaciones especialmente vulnerables, protección a víctimas y*

¹⁰ *“Protection concerns are at the core of the crisis in the oPt due to the insufficient respect for the rights of Palestinian civilians in accordance with international humanitarian law (IHL) and human rights law (IHRL) by all sides. These concerns are the main drivers of humanitarian vulnerabilities in the oPt. Palestinian women, men, girls and boys in the oPt face threats to life, liberty and security (including physical and mental violence, presence of ERWs, settler violence, and Gender Based Violence (GBV)), destruction or damage to homes and other property, forced displacement, land seizure and restrictions on freedom of movement and on access to essential services, natural resources and markets. In addition, women and girls face a number of gender specific protection constraints related to their access to justice through Palestinian duty bearers as well as the Israeli occupation authorities. Widows, especially female heads of household also face issues regarding housing, land, property and inheritance rights, especially newly widowed female heads of households whose security of tenure and inheritance rights to children may be thrown into question after the death of the husband. Further, the psychosocial well-being of children, adolescents and families continues to deteriorate and is eroding individual and community coping mechanisms and resilience. (OCHA “Strategic Response Plan 2015 – oPt”)*

¹¹ Social restrictions and absence of recourse channels by Palestinian duty bearers with regard to their social rights (e.g. early marriage, divorce), economic rights (access to livelihoods, economic opportunity and inheritance rights), and physical protection (GBV and sexual harassment) together with violations of IHL and human rights by Israeli authorities and absence of recourse channels. (“Protection Cluster Strategic Response Plan for 2015”)

*protección del espacio humanitario e incorporando, cuando así tenga lugar, el enfoque VARD (vinculación entre ayuda, rehabilitación y desarrollo) como forma de mejorar la coherencia de actuaciones y el establecimiento de sinergias entre los diversos instrumentos y modalidades de ayuda”.*¹²

4.1.2 The intervention addresses humanitarian priorities and needs of the rights-holders as identified by rights-holders themselves

As emerged during the FGDs, the project implemented by Alianza and partners, respond to the needs of the rights-holders as identified by themselves. In fact, both women and men we met during fieldwork, on the one hand, recognize that GBV is an important issue in their communities and in their households, and that this is exasperated by the current humanitarian crisis (war, closure, unemployment), and on the other hand, understand that they need external support to solve the issue.

The effects of the war are not really over. I have a boy, he was 6 months old during the war, and he is still reacting when he hears a strong noise” (woman, GBV survivor, UHWC)

I am living in a caravan. Living in the caravan is very hard. Very hot in summer and very cold in winter. I have an injured child, and reconstruction is not happening. I live in fear of the winter...” (woman, GBV survivor, UHWC)

I know the centre since long time. But I came for the first time after the war, because I attended some outreach sessions on GBV and women’s rights. I came because I need psychosocial sessions, especially as my home has been demolished twice. I am in need of these services. (woman GBV survivor, CFTA)

I attend awareness session on GBV and counselling services, I have a problem at home, because men are very stressed because there is unemployment and they are always at home. (woman GBV survivor, CFTA)

My husband is normally very clam, but now because of the situation, he is more stressed, and I am exposed to violence because of this. And my daughter was very good at school, but I had to marry her at 16, because of the economic situation, and now she is not happy. And I am getting depressed because of this and I need help.” (Woman GBV survivor, UHWC)

“The main thing is that everybody is in need for such (awareness) sessions. Not only women. Everybody need help.” (Young man, UHWC)

“I needed counselling – I could not face these things alone” (Young man, UHWC)

“Especially after the last war we [men] realized we were in need of psychosocial support. But there is need to increase the outreach of this type of projects, because there are so many issues in our society” (Man, CFTA)

Yes there is need for such things. Psychosocial support is needed. Supporting women is needed in Gaza. (Woman, beneficiary of awareness sessions, UHWC)

4.1.3 The intervention addresses needs and interests of partner local organizations as identified by the organizations themselves

¹² AECID, Marco de Asociación País, Palestina-España (2015-2017)

All local partners - WATC, CFTA and UHWC - have an interest and previous experience in GBV, even if they put a different emphasis on it, depending on their programmatic focus and previous experience. This difference in emphasis and skills among the partner organizations has, on the one hand determined, the role of the organizations in the project, and, on the other hand, has also influenced project understanding and implementation method and results.

WATC is a women's rights organization whose mission statement says: *"We endeavour to build women's grassroots committees and mobilize their energies to advocate for the rights of Palestinian women and monitor commitment with such rights in a manner consistent with national references and international covenants"*. And among its five strategic objectives, the first is: *"Protection of Women against all Forms of Violence and Social Marginalization including Occupation's Violence"*, Two of the three long-term results linked to this strategic objective, WATC has: *"Ensure women access to appropriate quality services in all governorates"* and *"Palestinian legislation prohibits all forms of violence and social marginalization"*.¹³

CFTA is a large HRB community-development organization based in Khan Younis that has among its strategic goals, the empowerment of women, and especially those who *'have experienced or at risk' of Gender Based Violence*.¹⁴ The Women Health Centre in Al-Bureij was created from the start *"as a way to enter the community' not just for medical purposes"*¹⁵, and especially with the awareness that health centres are for women the main entry points to report and get support on issues related to GBV. Finally, during the last humanitarian crisis (Pillar of Defence), CFTA together with UNFPA, and well-trained CFTA youth volunteers, carried out a study on GBV in shelters.¹⁶

The project analysed in this evaluation has been for CFTA a way to provide continuity to existing GBV services, while improving their quality thanks to the introduction of a more holistic approach in line with international standards.

UHCW is *"a leading Palestinian knowledge-based community healthcare organization, contributing to community empowerment in healthcare and promoting the comprehensive healthcare concept in the Gaza Strip"*. (Strategic vision) and aims at achieving to objective through three programs, the first focusing on capacity development of the organization the second on provision of health care services, and the third on *"Community Health Communication and Advocacy"*. In this last program, one of the objectives is about community empowerment about health rights, and has one specific output on GBV (Output 3.3.1: *Community target groups offered safe, confidential, lifesaving multi-sectorial prevention and response services to GBV in the most vulnerable areas of Gaza Strip*), while other two objectives relate more generally to women and men's overall well-being and self-confidence¹⁷.

¹³ WATC, Annual Report 2015.

¹⁴ CFTA, Strategic Plan 2016-2021: ***"Result 2.3: The mental and physical wellbeing of women and girls - including those with disabilities - is improved as well as their knowledge of their rights, particularly for those who have experienced or are at risk of GBV."*** CFTA will continue to work with women girls and men at the WHC. The women will have access to a safe place where they can enjoy comprehensive and holistic package of Sexual and Reproductive Health services, counseling and empowering activities. Girls and women at risk will get the opportunity to learn about services available and referral mechanisms, survivals of GBV will be supported and empowered through group support, Women's Rights awareness sessions and capacity building for income generating activities. Also men will be included in women's rights awareness sessions. As for children's and youth's programs, also the WHC increase its focus on the inclusion of women with disabilities also aiming at identifying resources for making the 2nd floor of the center (counseling services) accessible".

¹⁵ UN agency, CFTA's long term partner in Gaza – from *"External Review of the Culture and Free Thought Association (CFTA) Khan Younis, Gaza Strip, oPt"* July 2015, by L.Maritano.

¹⁶ CFTA & UNFPA, October 2014, Protection in the windward. Conditions and Rights of Internally Displaced Women and Girls during the latest Israeli military operation in the Gaza Strip

¹⁷ UHWC, Annual Report 2015; UHWC, Strategy 2016-2018.

In 2013, UHWC partnered with Alianza (then Solidaridad Internacional) in a *"Regional Program on sexual and reproductive rights of Palestinian, Jordanian and Lebanese women in a position of vulnerability"* which had a significant focus on health services as entry points for GBV survivors.

Conclusions and Recommendations (Relevance)

The project is relevant to all its main stakeholders: it responds to the needs of GBV survivors, and community women and men affected by the humanitarian crisis in Gaza, as identified by themselves and also by main reports and studies on GBV in Gaza and it is aligned to partners' interests and strategic plans.

The main recommendation is that of continuing the delivery of GBV services, through 'one-stop-centres' within health facilities, considered a privileged entry point for GBV survivors, and whenever possible to extend the model to other health facilities, as this type of services are extremely relevant to the needs of the female – and male – population in the Gaza Strip.

4.2 EFFECTIVENESS

4.2.1 The implementation process has been clear and fluid and obstacles and risks, which could have affected the achievement of the Objectives/Results, have been consistently managed.

The project, who was supposed to last 15 months, started with four months delay on the planned start-up date, as for internal organizational issues, Alianza had not been able to hire a project coordinator and funds were transferred to the field four months later. During the remaining 11 months and thanks to a no-cost extension of 3 months - the implementing team managed, however, to complete the planned activities, and as we discuss in this report, to achieve most of the expected results in, in some cases, even to go beyond them.

Other obstacles emerged during implementation risked to hamper the achievement of the results, but were properly managed. The main one was the opposition of more traditional leaders within the communities. This did not allow to fully engage community leaders on the project, as initially hoped; nevertheless, the implementing teams – WATC, UHWC and CFTA - also thanks to strong community tights built in many years of community work, managed to maintain good relations with them and to avoid stronger opposition. Another risk was the opposition of the Gaza authorities on such a delicate theme such as GBV. Contrary to all the expectations, all the main stakeholders of the project (Alianza, CFTA, WATC, UHWC, NRC), also active members of the Protection Cluster, managed to engage the MoH on the proposal of adopting the GBV SOPs within their health facilities in Gaza.

4.2.2 The project succeeded in achieving Objective and Results

In this section, we analyse the achievement of the project outcomes, according to the project Log Frame and its Indicators. Nevertheless, we have added a few mainly qualitative Indicators (added IOV), to better complete the analysis of project effectiveness.

Specific Objective: Protection of 15 communities in the ARA ("Access Restricted Areas") of Gaza Strip by providing response services to the Gender Based Violence (GBV)

- **IOV 1.** Number of **GBV survivors** in ARA communities that access in a safe way, and receive appropriate and confidential multi-sectorial response services

BASELINE: 0 (GBV services were already provided at baseline by CFTA but not through a multi-sectoral approach)

TARGET: not mentioned

According to the data available (partners reports) around:

- 17.848 women accessed SRHRs where medical and non-medical staff was also trained for GBV detection;
- 5.421 GBV survivors were newly detected through outreach activities and SRH consultations;
- 2.985 of the detected GBV survivors, were provided with further psychological and/or legal consultations and follow-up

Table 2 - Number of GBV cases detected and followed-up during the project period

	CFTA (1 centre)	UHCW (2 centres)
Number of SRH consultations during project period	6581 SRH consultations provided	11267 SRH consultations provided
Number of GBV cases detected thanks to multi-sectoral GBV services during the project period	352 GBV cases detected thanks to outreach etc. 898 GBV cases detected through SRH consultations Total: 1250	291 GBV cases detected thanks to outreach etc. 3880 GBV cases detected through SRH consultations Total: 4171
Number of GBV cases who were registered through multi-sectoral GBV services during the project period	58 GBV cases signed the official GBV form 672 signed counselling form ¹⁸	20 GBV cases signed the official GBV form 1392 signed counselling form
Total number of GBV cases followed up through multi-sectoral GBV services during the project period	1024 GBV cases received psychological and legal assistance. 226 GBV survivors detected not willing to access to individual sessions were channelled to awareness sessions.	1961 GBV cases received psychological and legal assistance 560 GBV survivors detected not willing to access to individual sessions were channelled to awareness sessions where they received collective support and information + get peer-to-peer support. 907 benefited from home visits awareness sessions The remaining ones received SRH services only but were detected as GBV cases, although they did not want to access to more services, as some of them may not want to recognize the GBV situation.

¹⁸ While the formal 'GBV form' explicitly mentions GBV, the 'counselling form' has not mention of GBV. UHCW and CFTA GBV staff, in cooperation with NRC, devised the counselling form during the process of the developing the SOPs (see below in the report), in order to meet the confidentiality and protection needs of GBV survivors who did not want to sign the GBV form for fear of stigma, family repercussions etc.. It responds to the need of monitoring the GBV cases, it does collect important data, but does not mention GBV.

Number of GBV cases referred to other organizations during the project period	Referred cases: - 52 cases to Palestinian Centre for Human Rights (legal support) - 19 cases to Gaza Mental Health Project (psychological/psychiatric support)	Referred cases: - 18 cases to PCHR (legal support) - 6 cases to GMHP (psychological/psychiatric support)
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CFTA staff, whose Women Health Centre was already providing GBV response services, signalled a “high increase” of GBV cases managed, “due to:

- *outreach awareness sessions in marginalized areas, who brought new women to seek for help at the centre;*
 - *home-visits;*
 - *provision of transportation for women”.*
- **IOV 2.** At the end of the project, the improved pilot model of multi sectorial response for providing services to the ARA zones is completely adopted and is working in the 3 centres
BASELINE: 0
TARGET: The improved pilot model of multi sectorial response for providing services to the ARA zones is completely adopted and is working in the 3 centres

This Indicator was fully achieved during implementation: the GBV and multi-sectoral response services were made available during the project in all the three centres (1 CFTA Women Health centre and 2 UHWC Primary Health Care centres).

The project provided equipment (laptops, LCD, printer, furniture for meeting room, and GBV room), disposables and medications to the UHWC Health Centre in Bet Hanoun. In the follow up of this project, already started and funded by AECID, an Ultrasound has been purchased for improving both SRHSs and GBV detection services within the UHWC centre.

in addition, a meeting room and a room for psychosocial/legal consultation were identified within the centre, to guarantee privacy for GBV cases. Both UHWC and CFTA adopted the SOPs for GBV Case Management in their health centres and improved the organization of the physical spaces to better guarantee confidentiality. Partners’ staff – Case Manager/Psychologist, Lawyer, Social Worker and medical staff (Gynaecologist, Nurses) - were trained on the multi-response model and best practices to deal with GBV survivors (see Result 1).

- **IOV 3.** At least 3 notes about GBV in Gaza as a contribution to the different reports and documents prepared by the Protection Cluster
BASELINE: 0
TARGET: 3 notes about GBV in Gaza as a contribution to the different reports and documents prepared by the Protection Cluster

Alianza circulated and presented the GBV data deriving from the GBV Risk Assessment (carried out by WATC in North and Middle Gaza) and also data collected by CFTA and UHWC GBV response services (see also Result 3 and Appropriation/Ownership), to the main three bodies coordinating humanitarian and development work on GBV in Palestine:

- Protection Cluster, including presentation to donors and contribution to the Humanitarian Response Plan 2017;
- GBV Working group;
- Gender Task Force

Furthermore, together with OCHA and other actors in the Protection Cluster, Alianza advocated for maintaining GBV as a humanitarian priority in the country and in favour of the introduction of GBV SOPs, infrastructure and staff, within MoH medical facilities. The process is now in stall because of the political difficulties within the Gaza Strip, but it has informally achieved the positive result of involving medical authorities in Gaza in the debate on GBV.

Finally, Alianza had the chance to disseminate information about GBV in Gaza, data obtained with the project and lessons learned through the monitoring of intervention of the project in 4 conferences in Spain:

- 1 Seminar organized by UNRWA Spain in International University of Seville in October 2015
- 1 Seminar organized by UNRWA Spain in Casa Árabe, Madrid, October 2015
- Gender Conference organized by AECID, Madrid, October 2015
- 1 Seminar organized by Universidad Rey Juan Carlos, Madrid, November 2016

Also WATC, took part in the Gender Conference in Madrid (October 2015), organized by AECID, thus, contributing to the international advocacy together with Alianza.

- **ADDED IOV** - Community women and GBV survivors from 15 communities in the ARA report feeling more protected from GBV thanks to the services provided by the project (GBV centres + awareness).

GBV survivors and community members (many of the GBV survivors, were actually community members who attended the awareness sessions) have expressed an overall sense of protection, wellbeing and empowerment as a result of the GBV services provided in three centres. In this regard, many of them shared their stories of improvement:

I got married 31 years ago, at 18, through an exchange marriage, with my cousin. I lived with my mother in law and suffered all kinds of her violence: isolation, no food, they used to lock me in my room. I remained because my parents didn't want me back home with the kids. Now my husband has a relationship with another woman and brings her home. Here they give me psycho-social support, legal support etc. and I go back empowered. My husband stopped beating me up, but he is still bringing women home. (GBV survivor, CFTA)

I attended the awareness sessions on GBV and I started coming for the counselling service. Men are very stressed because they do not work, and are always at home. The male psychologist came for a home-visit. Now he goes for counselling with the same psychologist and he is improving. (GBV survivor, CFTA)

He used not to take into consideration the children. He used to beat me up in front of my children. Now we talk more and we discuss matters more privately. (GBV survivor, CFTA)

The sense of protection provided by the centres was strongly felt also by the women who utilized UHWC's GBV services:

I had a problem, and I needed people to help me. So I came here. I built a relationship with the Case Manager, and the lawyer supported me. (GBV survivor, UHWC)

I used to come for counselling with the psychologist. I learnt how to react in certain situation. We had a problem with my daughter's husband. They referred him to the psychiatrist, and now 70% of the problem iss solved. (GBV survivor, UHWC)

The sense of protection provided by the services, was also noticed by a young male volunteer in one of the UHWC centres:

I observed a big change in the centre. Before this project it was hard to find women coming to the community centre, but when the activities started, you would find more women and young girls - after 11 a.m. it was full of women also to seek the services of the project. A big feeling of security was created by the project. Initially they were going to awareness sessions, then later attended individual sessions. (Male youth volunteer, UHWC)

In many cases, however, they point out that economic independence would be part of the solution. In fact, many women are not able to leave the marital home, as they do not have place to go no money to support themselves and the children.

It is a problem to leave, when you have kids. It is a problem being divorced woman. If parents do not want to take her back with her kids, because they have not the means to support them all, what she can do? (GBV survivor, CFTA)

We all would like to get jobs out of the house regardless we are married or not... to support our families, the education of our children, to support ourselves... (GBV survivor, UHWC)

Even psychosocial support and the other services without economic empowerment are not sufficient... (GBV survivor, UHWC)

Lack of money, lack of balance (GBV survivor, UHWC)

I hope there will be a new project with an economic empowerment component... (GBV survivor, UHWC)

It is important to point out that Alianza took this recommendation into consideration. In the project that has followed - “Integrated protection response for women at risk of GBV and GBV survivors, in the most vulnerable communities of the Gaza Strip” - also funded by AECID, an economic component (capacity building and loans to open a small business) is being piloted with 16 GBV survivors, beneficiaries of CFTA and UHWC’s GBV response services.

R1: Improved the access, and the confidential and multi-sectoral (quality of the) response to GBV in the target communities.

- **IOV R.1.1.** IOV.R1.1. Number of service providers trained for implementing an appropriate and confidential response to GBV.

BASELINE: 0

TARGET: 15 staff members of service providers (CFTA and UHWC))

By the end of the project 3 full GBV Case Management teams (each one made of 1 psychologist, 1 lawyer, 2 social worker and 2 health focal points – among whom, the Case Managers were identified: the psychologists in the case of UHWC and the social worker in case of CFTA) were fully trained on GBV Case Management system.

The training was responsibility of NRC – GBV Department - with whom Alianza had a Memorandum of Understanding. The MoU envisaged a cycle of capacity building activities both on GBV and child protection (this last, NRC in cooperation with UNICEF), including the development of Standard Operating procedures both for CP and GBV, to be implemented with

women's and health centres in Gaza - as part of Alianza effort in favour of strengthened Child and GBV Protection System within the humanitarian context.

Because of this 'overlapping' of themese (Child Protection and GBV) the first training was found to focus too much on violence against children, and less on GBV. Corrective measures were immediately taken: the focus of the capacity building for UHWC and CFTA's staff shifted to GBV, participatory meetings to design GBV Case Management SOPs and formats and coaching for their implementation were included.

In addition, WATC provided GBV legal advocacy training to lawyers and case managers working in UHWC and CFTA health centres.

Table 3 - Training/coaching provided

	Quarter – Topic	CFTA staff	UHWC staff (2 centres)
Training provided by NRC			
SOPs and GBV Case Management system	2 nd - case management of GBV cases - child abuse, violence against children, child protection, referral pathways, and GBV	6 -1 project coordinator, 2 case managers, 2 psychologist, 1 social worker	3 -1 project coordinator and 2 case manager
	3 rd - GBV + sexual violence against children	7- 1 project coordinator, 2 case managers, 2 social workers, 2 psychologists	13 - project coordinator , 4 social workers , 2 nurses , 2 doctors , 2 psychologists/ 2 case managers
	4 th – review of GBV Case Management forms + identification of referral pathway (coaching)	2 - Case Managers	2 - Case Managers/psychologists
	5 th – Case Management and Case Management forms (coaching)	2 - Case Managers	8 - 4 social workers, 2 psychologists/2 case managers
Training for medical staff (GBV detection and referral)	5 th - SOPs on identification and referral	4 - Health GBV focal points - 2 nurses, 2 gynaecologists	6 - 2 doctors, 4 nurses
Coaching sessions	3 rd -4 th -5 th Support in relation to complex cases management; forms development; SOP development; development of safety plans, guidelines for referral to medical services; GBV survivors' interview skills, etc.	6	13
Training provided by WATC			
GBV legal advocacy training	5 th - GBV legal advocacy	3 – 2 lawyers, 1 case manager	4 - 2 lawyers , 2 psychologists/case managers

- **IOV.R.1.2.** At the end of the project, at least 75% of the trained staff have improved substantially their capacities to supply services according to the established protocol
BASELINE: 0

TARGET: At the end of the project, at least 75% of the trained staff have improved substantially their capacities to supply services according to the established protocol.

According to NRC capacity building coordinators (NRC quarterly reports) significant improvement in the GBV actors capacity to provide survivor centered services to GBV survivors.

Overall UHWC and CFTA staff met during fieldwork, expressed satisfaction for the whole capacity building process, including the ability to correct the direction (move focus from violence against children to GBV), and also the participatory/coaching character that the capacity building sessions took during the second part of project implementation.

Furthermore, they really appreciated the results of the trainings, in terms of improvement of their skills in dealing with GBV survivors, especially in relation to the development and the introduction of the Case Management system. It is impressive, the sense ownership for what they learnt, expressed by CFTA staff in charge of GBV cases:

I have been working in the Women Health Centre, on GBV cases, but now I realize that our services were not complete. We did not have means to cover all the needs. Now, the Case Management provides us with a better way of managing the case: it is holistic, it focuses on protection, it includes referral in the centre or outside, we have forms (CFTA, member of staff)

For example, before, when a case was identified by doctor and nurse), I did my best effort but without guidance, we were doing it spontaneously: "if you want you can go to psychologist or social worker" but many did not understand what would help her. Now, when a case is identified, we MUST refer, we MUST follow-up. We take her to all the services, we fill a form – which is more formal, we make sure she goes to the sessions. We provide a more effective follow-up and we have more tangible results" (CFTA, member of staff)

Also, for very bad cases, such as sexual harassment in the family that results in pregnancy, now we built relations with the Safe Home, and we manage to be able to follow her up also when she is there. (CFTA, member of staff)

Another new thing is that if there are minors involved, we have to notify the Police and MoSA and other organizations who provide protection. If she is over 18, she has the choice to notify others. Violence against children is followed up by UNICEF – since four years they have focal points in MoSA, in the Police etc., there is a child protection network. For all cases, we have to notify the directors of the centre before going on with these cases. (CFTA, member of staff)

As a psychologist, I learned that coordinating with other staff - social worker, lawyer – is more effective. Also knowing that I can refer to the Gaza Community Mental Health programme is good (CFTA, member of staff)

For me, as a nurse, the most important thing I learned is where my role ends and when I have to refer. Before she did not know where to stop. Also medically speaking we learned how to deal medically with sexual harassment cases – technical issues etc. Also, in terms of legal procedures, about doctors and forensic testimony – that your GBV detection is legal only if certain procedures are followed. So we learnt the procedures. (CFTA, member of staff)

The project really introduced the concept of protection. Before the concept of protection was limited to the follow-up of the cases in the centre, limited to working hours. After the training, I understood that the case is my responsibility, even if she is referred outside, even

out of the working hours. It made clearer that this is protection. Protection is my responsibility for the whole day. Now it is a matter of principle. (CFTA, member of staff)

UHCW staff mentioned similar things, about the success of the capacity building program and the introduction of the Case Management system

For me as a lawyer, the training on referral protocols, on how to follow up with other service providers, and the training on Case Management, on how to fill the files, and also the legal advocacy training, on what skills you need to identify GBV cases, how to legally protect yourself as GBV service provider, how to provide protection with GBV victims, these were all very useful things. (UHCW, member of staff)

The Case Managements training, for me, as Case Manager, was very useful. It was very extensive: what are the mechanisms for case management, for referral etc. Then we were trained on the SOPs, on how to fill the case management forms. This was all with NRC. With WATC, we had advocacy training on gender and GBV. (UHCW, member of staff)

- **IOV.R.1.3.** At the end of the project, the 70% of women - that have participated in the awareness and detection sessions in the target communities - know and also have the access to the available response services

BASELINE: 0% at Beit Hanoun (first time implementing GBV response in Beit Hanoun) 40% at Jabalia

TARGET: At the end of the project, the 70% of women - that have participated in the awareness and detection sessions in the target communities - know and have the access to the available response services.

All the three partners – CFTA, UHCW and WATC - provided awareness sessions through various modalities: community meetings, home-visits, and sessions in the clinics. They all provided information about existing services. A useful leaflet was prepared by WATC with all the necessary information to seek for help, taken from the SOPs “Referral Path”.

CFTA and WATC focused on issues such as: domestic violence, life skills, familial communication, solving problems, gender, negotiations skills, women rights, and inheritance, but also relevant SRH topics. The community sessions provided by UHCW included many SRH topics (such as breast feeding, breast cancer detection, depression etc.). However, during the visits, more GBV related topics were discussed: early marriage, inheritance, domestic violence, psychological pressure, divorce and its implications, legal protection for battered women, GBV, violence based on customs and traditions.

In total, CFTA and UHCW provided SRH and GBV awareness – and, during home-visits, GBV detection - sessions to around 19.000 beneficiaries (of which around 16.500 were women).

Table 4 - Number of participants to the awareness and detection sessions

	CFTA		UHCW		WATC		TOTAL	
	F	M	F	M	F	M	F	M
Community Awareness Sessions	10.171	1.228	929 (women: 725; female youth: 204)	463 (men: 315; male youth: 148)	1.001	138	12.101	1.829
Home-visits' Awareness Sessions	3417	407	907	110			4.324	517
				TOTAL			16.425	2.346

It is thus possible to say, that all these beneficiaries became informed about the availability of GBV response services in the three centres involved in the project, and also about other services through the Gaza Strip.

It has not really been possible to track how many of the women who attended the awareness sessions, accessed the GBV response services. According to CFTA, however, 80% of the GBV cases followed up in their centres became aware of their services through the awareness sessions.

UHCW did not monitor this data, rather they included in the overall satisfaction questionnaire about reproductive health services, distributed at the waiting area of the gynaecology and obstetric clinic ,a question about the modality they became informed about their services it emerged that only 10% of them knew it thanks to the awareness sessions, however more than 50% of them knew it by word of mouth:

- **Through their sister/friend/neighbour 51.73%**
- *Through visiting the UHCW website 18.24%*
- **Through awareness sessions 10.16%**
- *Through radio 8.31%*
- *Through collective home awareness visits 7.16%*
- *Through other organizations 3.93%*
- *other 0.46%*
- **ADDED IOV** - GBV survivors from 15 communities in the ARA, report satisfaction with the quality of the GBV services provided (information and awareness provided, 'one-stop', holistic and multi-sectoral, confidentiality etc.)

The introduction of the 'one-stop' centers, with their multi-sectoral approach, was the main achievement of the project. This is strongly reflected by the GBV survivors who accessed the CFTA services, and expressed a high level of satisfaction for the holistic services received:

I used to come here for awareness sessions, on GBV, family planning etc. Then I got married and I stopped coming: one year ago she came for lawyer because I want to divorce and I want to get alimony. So I came back again. The lawyer referred me to the Case Manager because I was depressed and I had consultations with the psychologist and the social worker. They advised me and I even got a short job opportunity. Now I am empowered. They referred me to a lawyer outside but CFTA lawyer and Case Manager follow up my case even if referred outside. They integrated me in recreational activities and in the young leadership programme. I consider this place as a home. There is also the added value of reintegrating

GBV victims in society with relationship with other orgs that can help us to have opportunities for work etc. (GBV survivor, CFTA)

There is always referral to other staff of the centre – or outside when needed and constant follow-up. They phone us up, they come for home visits. (GBV survivor, CFTA)

GBV survivors who attended UHWC services, also expressed satisfaction for the holistic services received:

I am a GBV victim. My husband beats me up, he is addicted, he takes the mobile phones away from me. He keeps all the money for him. I was married at 19, I have been married for 21 years. I attempted suicide many times. My life is very hard. I seek and got support from the psychologist and the lawyer. He did not change... but I have changed... I found someone with whom to share, and she advised me on how to behave (GBV survivor, UHWC)

R2: Men and women from 15 ARA communities are aware of GBV as an issue of protection.

- **IOV.R.2.1.** At the end of the project, at least 30% of women, men and children from the vulnerable communities have participated in the awareness sessions and have increased their knowledge about GBV
BASELINE: 0 (Total population of the 15 ARA; 44.449 habitants)
- **TARGET:** 30% of the population of the ARA communities (=13.334 habitants), women men and children from the vulnerable communities have participated in the awareness sessions and have increased their knowledge about GBV

As we have described above, in total, CFTA, UHWC and WATC provided awareness sessions to around 19.000 beneficiaries (of which around 16.500 were women). If we take into account that the total population of 15 ARA is around 44.500 people¹⁹, we can say that the project has managed through the awareness sessions to reach around 40/50% of the total population. During the FGDs carried out for this evaluation, it emerged that the majority of participants who had attended the awareness sessions, were aware about various types of GBV, of GBV consequences on women, children (child protection) and family as a whole (both men and women), that protection from GBV is a right, and about the existence of GBV response services.

Now I realize that verbal violence is violence. When someone continuously tells you: "You are stupid, you are lazy, you always make mistakes", now I realize that this is a problem, that this is violence and that I have the right to break the marriage. (Woman, awareness sessions, UHWC)

¹⁹ According to an estimate by the partners:

Gaza Strip Area	ARA Community	Population
BEIT HANOUN	Al Joura, Al Boura, Shurab St. , Al Banat St, Al Sikka St	7.597
	Ezbet Beit Hanoun	2.409
JABALIA	Jabalia Al Balad	13.240
	Al Atatra	1.208
	Al Salateen	2.329
	Ezbet Abed Rabu	3.056
AL BURAIJ	Al Maghasi	1.191
	Al Buraij Camp	10.217
	Al Nussierat Dair Albalah	3.202
	total	44.449

About early marriage, now I understand that is not a correct choice because of the high rate of divorce. The same for GBV, now I realize that violence is a problem – especially with children. Negotiate, talk, dialogue – no violence. (Woman, awareness sessions, UHWC)

Problem of early marriage is still a problem... people believe that waiting that they go to University, they will get too old... But now I refuse to marry my girls in early age even if someone comes and he is too good to refuse... (Woman, awareness sessions, UHWC)

If a girl suffers, for example, from harassment, she would not say this to anybody. But now, I know that now she does not have to be silent anymore. (Woman, awareness sessions, UHWC)

Now I realize that certain depression can last for very long time and that one needs to seek professional help as it will not go away alone. (Woman, awareness sessions, UHWC)

Main key to change, in case of my husband, has been the children. He did not think about the fact he was harming the kids, now he understands this. Socially, one of our kids had serious problem. Now my husband controls himself more, and I do the same. Now we avoid to escalate. Both of us, we changed, in our children's best interest. (GBV survivor, CFTA)

A similar increase in GBV awareness, can be noticed among the men who attended the awareness sessions, and, in some cases, were also followed-up through psychological and psychosocial individual counselling.

"When I first heard 'gender' he thought it was dangerous. Now after the awareness session, I think that these concepts are very useful and OK. Now I am sending my wife to attend the sessions – before I was scared" (Young man, UHWC)

Before when his sister wanted to say something he would shut her up > afterwards started to change his attitude – I should be more understanding with her and the kids (Young male beneficiary of awareness sessions, UHWC)

it is very important to keep this kind of projects because: a) this project introduced the concept legal protection in a society where women never considered to discuss their issues with a lawyer. Now women are aware that they can – it gave them empowerment to speak up about problems and rights and seek for legal help; b) it introduced the gender justice concept. I am married, I have sisters – I can see that change is happening, even if at the start; c) it started creating a new tradition in a very conservative society (...) we need to introduce new concepts – Rights, Gender, Law, Justice – we need to defend them... this is how change happens...For example, many times, the Mukhtar, when there is a marriage conflict, they put the wife back with her husband even if the husband is an addict, is violent etc. So also Mukhtars should be replaced by the Law. (Young male beneficiary of awareness sessions, UHWC)

When asked what they were the main learning from the awareness sessions, men in the CFTA Women Health Centre listed, listed the following issues:

- *How to deal in the family*
- *Stop violence against children*
- *Start dealing with wife better and not as a slave*
- *Be more respectful towards everybody*
- *Acceptance of other people*

- *Health issues*
 - *Addiction issues and how to deal with it*
 - *How to improve family relations*
- **IOV.R.2.2** At the end of the project, 30% of the community based organizations have improved their knowledge about GBV, and they have participated in the awareness organized campaign and actions
BASELINE: 0
TARGET: At the end of the project, 30% of the based organizations have improved their knowledge about GBV, and they have participated in the awareness organized campaign and actions.

WATC, a women's rights organization, was in charge of providing capacity on GBV detection tools to CBOs in the areas targeted by the project.

By the end of the project WATC targeted 10 CBOs and 15 facilitators from their organizations, preparing and sharing with them tools on GBV and GBV risk assessment. They carried out a total of 43 sessions on GBV (including early marriage, inheritance rights, legal issues related to GBV, etc.) targeting 1001 women and 138 men, which were also at the basis of the 'GBV Risk Assessment' report prepared by WATC (see also Result 2 IOV R.2.1). In addition, the 10 CBOs took actively part in the 16 days campaign against GBV, in cooperation with CFTA, and the Amal and Wesal coalitions.

The facilitators were chosen on the basis of their previous experience on women's rights and GBV, thus, as they mentioned, most of them already had the necessary tools. Each one of them submitted its program to WATC, and workshops were organized to provide feedback and integrate – with common language and new information – the GBV materials. As some of them pointed out, the strong point of this project, is not only the fact that provides GBV awareness sessions, as this was done also in other projects, but the fact that links up communities with GBV response services.

The added value of this project, is that makes women aware of where to find GBV response services (CBO facilitator, WATC)

The good point of this project is the strong relationship with the GBV response services provided by the partner organizations, so it is possible for us to refer women for medical checks also legal clinics inside the medical centres (CBO facilitator, WATC)

The added value of this project, is that when I work with women on GBV and other issues come up, such as violence against children, I can refer them address through networking for referral etc. It complements what WATC normally does. (CBO facilitator, WATC)

The '16 Days of Activism Against GBV' activities (25 November – 12 December 2016) were coordinated by WATC and CFTA, together with Wesal and Amal coalitions, the CBOs trained by WATC and other organizations working on GBV within the Protection Cluster. This included an open-day festival targeting the GBV survivors of CFTA and UHWC clinics and their families and friends (art exhibition, Dabka etc.). Women's turnout to the festival was high, and for many of them the festival represented a rare occasion for recreational activities. In addition, one radio episode on GBV was prepared and broadcast. WATC also organized activities for the International Women's Day (8th of March 2016): the information leaflet on GBV was printed and distributed in the targeted communities and 2 additional radio programs on GBV were broadcast.

- **IOV.R.2.3.** At the end of the project, at least 40% of the community representatives (leaders) target are aware of the risks of GBV already identified by the community.

BASELINE: 0

TARGET: At the end of the project, at least 40% of representatives in the target communities are aware of the risks of GBV already identified by the community.

As part of their community advocacy activities, WATC was supposed to establish cooperative relations with community leaders (Mukhtars) in the targeted ARA. This was not an easy task, as it was very difficult to treat such a delicate topic with them. Nevertheless, WATC managed to obtain the participation of 10 community leaders to the presentation of the “GBV Risk Assessment” results.

During the evaluation fieldwork, it wasn’t possible to meet but with one Mukhtar, because of the refusal of other Mukhtars to take part into the evaluation meetings. This gives an idea of the obstacles one can meet in trying to reach out community – often religious – leaders. It is our understanding that only 8 Mukhtars, from the targeted areas, were involved and showed some support for the project objectives and actions. Of these, only the Mukhtar from Bet Hanoun came to our meeting. From the things he told us, we could grasp some of the resistance that there can be among male traditional community leaders when discussing issues such as GBV:

Any project for women’s rights is encouraged because in harmony with ethics and Islam. Islam gave women rights that before. were denied (...) Before Islam, they tradition said that if you have a girl you can bury her alive in the ground. The first thing that Islam did was to forbid this practice. Also, polygamy before Islam was limitless; Islam put a limit of 4 wives. Instead, for example, the Gospel of Paul discriminates against women, he blames the original sin on women, while in Islam Satan is blamed. Traditions and social norms taken from Islam are supportive for women. (...) And there are Western things that we cannot accept. All these new western conventions supporting women’s rights, they are not designed for our culture. For example, homosexuals have rights in international conventions, but this is not accepted here. Also the equality issue is not accepted. There cannot be full equality. OK equal respect, OK equal access to [Sharia] inheritance rights, OK respecting the marriage contract and that women protect their rights there. But women must comply with the dressing code of our society. I am against Beijing and CEDAW, there are too many things I do not agree with. (...) Any project that does not put poison in the honey is OK. The projects are OK. But they must not go too far!” (Mukhtar, Bet Hanoun)

Nevertheless, it also emerged that there are youth leaders on whom it would be worth establishing relations, because of their openness to change:

Mukhtars believe that women are less than men by nature etc. But these are very old things. I do not believe in this. Women can be leaders, a single good girl can lead a crowd of men. But some people are distant from these new things because it decreases their authority. When they feel that young people start changing, they feel that their authority is being taken away. For example, Mukhtars say that conflict start because men are unemployed; the reality is that men today marry girls with money, not because they love them but because they have money. And then they want to control them. And here is where the problem starts. Also elderly people say that legal solutions are in conflict with religion, thus one has to go through traditional solutions. But I believe that this is not correct. (youth leader, Bet Hanoun)

R3: Implemented the system to collect information about GBV in order to have an impact at the national/international level.

- **IOV.R.3.1.** The 3 UHWC and CFTA centres count with a system to collect information in a homogenous and confidential way, following international standards. (Gender-based Violence Information Management System (GBVIMS) developed, introduced and in place)
BASELINE: Both UHWC and CFTA have an information system in place but need strengthening to include GBV specific information according to international standards.
TARGET: At the end of the project, UHWC and CFTA counts with a homogeneous and confidential system to collect information according to international standards in 2 Centres

A homogenous system of data collection has been developed in a participatory way by CFTA and UHWC staff and NRC experts (including forms for data collection and related SOPs for confidentiality etc., in line with international standards).

The system has been piloted within CFTA and UHWC health centres. While in case of UHWC it still needs to be fully computerized, in case of CFTA the GBV system has been integrated within the internal information management system of CFTA, utilized also in the Women Health Centre.

In regard to the GBVIMS, it is important to highlight that Alianza has been providing, within the Protection Cluster, technical advice on the configuration of the first online GBV data collection system in the whole oPt, which has been working since January 2016. And that this was the first time that GBV forms were devised and utilized, that staff was trained to use them and that GBV SOPs were piloted in health centres in Gaza.

- **IOV.R.3.2.** At the end of the project, at least 2 products (position and informed notes) have been elaborated jointly and spread into the community.
BASELINE: 0
TARGET: 2 fact sheets + 2 Women Voice Magazine WATC / 1 press release by CFTA

The Indicator was met, as during project implementation, WATC produced the following materials:

- Two fact sheets presenting the GBV data for the areas investigated by the GBV Risk Assessment Analysis . One covered the North of the Gaza Strip (Gaza City, Jabalia and Bet Hanoun), the other the Middle Areas (Johor ed-Dik and al-Maghazi).
 - Three issues (October 2015, December 2015 and March 2016) of the “Women’s Voices Magazine”, specialized on women’s rights issues and regularly published by WATC in Arabic. The issues included articles and reports on GBV and overall violence against women, also prepared thanks to the data of the GBV Risk Assessment.
 - Information leaflet on GBV and GBV services. Distributed at community level.
- **ADDED IOV** - Data collected through M&E system (GBVIMS) is analysed and utilized in advocacy activities nationally and internationally

As we have mentioned just above (but see also below Appropriation/ownership), thanks to the GBVIMS, Alianza and partners, were able to analyse the data collected about GBV cases in their clinics, and feed into an overall presentation by the Protection Cluster on GBV services in Palestine (June 2016) (cfr. Also Specific Objective – IOV 3). Furthermore, as already described, Alianza has been providing technical advice on the configuration of the first online GBV data collection system in the whole oPt.

In addition, as we have described just above, the project has produced a GBV Risk Assessment for six specific areas, which has generated 2 related fact-sheets on GBV in North and Middle Gaza Strip.

These materials available to Alianza and other organizations to advocate about GBV in Gaza and Palestine, either in public events (e.g. the 16 days campaign) or in institutional contexts (e.g. Protection Cluster, MoWA, MoH, conferences in Spain etc.) (see Specific Objective – IOV3).

Conclusions and Recommendations (Effectiveness)

To summarize what discussed in this Effectiveness section:

- *Result 1 - Improved the access, and the confidential and multi-sectoral (quality of the) response to GBV in the target communities* was achieved thanks to a) the elaboration, piloting and adoption of GBV Case Management SOPs; b) capacity building to Case Management staff; c) equipment, disposable and medication for the health centres. GBV survivors reported satisfaction about the quality of the GBV services received.
- *Result 2 - Men and women from 15 ARA communities are aware of GBV as an issue of protection* was also achieved, especially in the case of community women and CBOs. The project provided information about GBV services to about 50% of the total population of the 15 targeted ARA. Fewer men took part into awareness activities, and there were difficulties with Mukhtars. Youth community leaders, nevertheless, seem to be very promising and worth focusing on in future projects. Overall, all the participants to the awareness sessions reported being more aware about GBV and the existence of GBV services.
- *Result 3 - Implemented the system to collect information about GBV in order to have an impact at the national/international level*, has been met as a homogenous system of data collection was developed in a participatory way by CFTA and UHWC staff and NRC experts (GBVIMS - including forms for data collection and related SOPs for confidentiality etc., in line with international standards). Through data collected, Alianza and partners, were able to feed into data by the Protection Cluster on GBV services in Palestine and provide important technical advice on the overall GBV information system for the oPt. In addition, the project has produced a GBV Risk Assessment for six specific areas, which has generated 2 related advocacy fact-sheets on GBV in North and Middle Gaza Strip.
- *Specific Objective: Protection of 15 communities in the ARA ("Access Restricted Areas") of Gaza Strip by providing response services to the Gender Based Violence (GBV)* was also achieved. By the end of the project the improved pilot model of multi-sectoral response was completely adopted in the 3 centres. An increased number of GBV cases were detected and followed-up through improved GBV response service. Overall, beneficiaries felt more protected thanks to the availability of the GBV protection services. However, many of them signalled that only reaching economic independence they would be able to leave abusive situations. Finally, thanks to partners' advocacy activities within the Protection Cluster, the project managed to engage other Gaza health providers, including the MoH, MoSA and MoWA, in the discussion about GBV services.

The main recommendations to increase the effectiveness of future similar projects are:

- Include an economic component in GBV projects (as already done by Alianza in the new project funded by AECID) in order to help women to leave abusive situations. Consider income generating activities and/or cash assistance. Loans are risky because it is difficult for women to return them.

- Provide yearly refresher trainings and coaching to Case Management staff in the health centres and continue creating exchange/learning occasions for them.

4.3 EFFICIENCY

4.3.1 The intervention's inputs have been properly converted into outputs and results

This analysis takes into account AECID Guidelines in identifying direct and indirect costs. Namely that Indirect costs amount to 12% of the Direct costs and they do not need to be documented.

Overall we can say that the intervention was soundly managed from a financial point of view. The total budget amounted to **468.394 Euro**, including the 12% indirect costs. The total expenditure was **468.656 Euro** (difference due to exchange-rate variations)

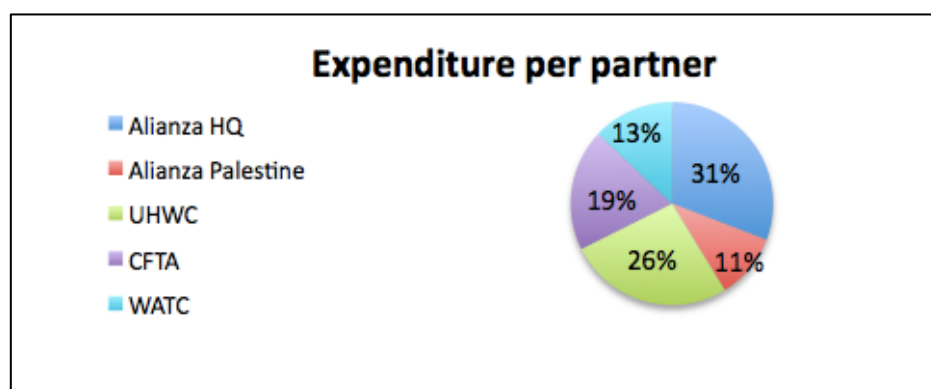
For more detailed calculations see: **ANNEX 5 – EFFICIENCY ANALYSIS**

a) Expenditure per partner and per Direct/Support costs

Table 5 - Expenditure per partner

	Expenditure per partner	% of total cost
Alianza HQ	144.576	31%
Alianza Palestine	48.862	11%
UHWC	123.415	26%
CFTA	91.000	19%
WATC	60.798	13%

Chart 1 – Expenditure per partner



From the analysis of **expenditure per partner**, it emerges that the budget has been distributed proportionally to the needs and tasks of each local partner: 26% to UHWC, in charge of GBV services (including staff, home visits, transportation for beneficiaries and awareness sessions) in two different health centres and also in need of setting up the spaces in one of the centres; 19% to CFTA in charge of one of the GBV services (including staff, home visits, transportation for beneficiaries and awareness sessions); 13% to WATC in charge of the GBV Risk Assessment, awareness' sessions and production of advocacy materials.

It needs to be pointed out that 42% of the costs of the project were sustained by Alianza, both HQ and Palestine Office, which is quite a big amount. However, if we look at them in more detail, we can see that the cost sustained by Alianza at HQ and field level cover for the large part (57%), direct project costs:

- 19%, Capacity Building Program, Audit and Evaluation
- 38% Project Management costs in Palestine (including social security, per diem and travel costs in/to/from Palestine)

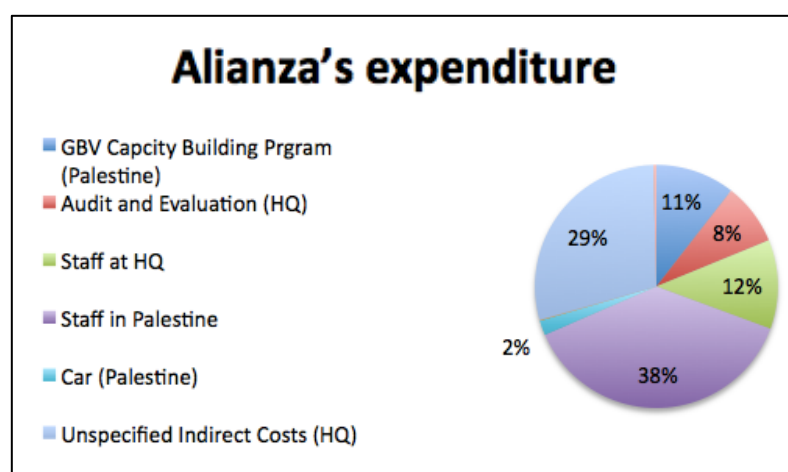
and for the rest (43%) they cover, what we can define more 'support' costs (HQ staff, admin costs, car):

- 12%, cost of salaries at HQ level
- 29% unspecified administrative costs (in line with AECID) guidelines
- 2% car's costs.

Table 6 – Alianza's Expenditure

Overall Alianza		% of total Alianza's expenditure
GBV Capacity Building Program (Palestine)	20.411	11
Audit and Evaluation (HQ)	15.950	8
Staff at HQ	22.950	12
Staff in Palestine	73.186	38
Car (Palestine)	3.777	2
Stationary (Palestine)	177	0
Unspecified Indirect Costs (HQ)	56.207	29

Chart 2 – Alianza's Expenditure



If we look at the **'support' costs**, sustained by Alianza during the project period, within the framework of the total project's costs, it emerges that they constitute **only 18% of the total expenditure** (which is very reasonable amount) vs. **82% spent directly on the project**.

Table 7 – Direct and Support costs

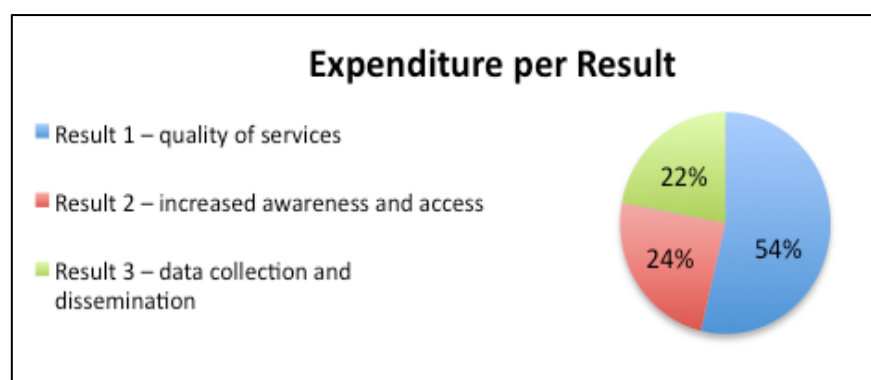
Direct Project costs		% of total expenditure
UHWC	123.415	
CFTA	91.000	
WATC	60.798	
Alianza	109.546	
	384.760	82%
Support costs		
Alianza (including 12% admin costs)	83.892	18%

b) Expenditure per Result

Table 8 – Expenditure per Result

	Expenditure per Result	% of total cost
Result 1 – quality of services	251.896	54%
Result 2 – increased awareness and access	113.223	24%
Result 3 – data collection and dissemination	103.537	22%

Chart 3 – Expenditure per Result



The expenditure per Result was calculated including all the indirect costs (12%) recognised by AECID, and also all the management and coordination costs sustained during the project period. The expenditure was done without relevant changes to the planned costs, and proportionally to the importance of the different Results.

c) Expenditure per beneficiary

Table 9 - Expenditure per beneficiary

Total project cost	Cost of multi-sectoral GBV services (Result 1)	Cost of awareness and access (Result 2)	Cost of data collection and dissemination (Result 3)
468.656	251.896	113.223	103.537
Total population of the 15 ARA targeted by the project	Number of GBV survivors provided with services	Number of community members reached	Production of research, fact sheets, women magazine, etc.
44.500	<ul style="list-style-type: none"> 5.421 GBV survivors were newly detected through outreach activities and SRH consultations; 2.985 of the detected GBV survivors, were provided with further psychological and/or legal consultations and follow-up 	19.000	<p>Estimated total: 15.000/20.000 people</p> <p>Fact sheets: 300 copies: Women Voice Magazine : 3000 copies (1.000 x 3) edited, printed and disseminated among local communities, and local and international orgs 5 radio episodes about GBV and women's rights > 7.500 listeners 16 Days of the Campaign and advocacy material produced (flags, stickers, poster, SMS) reached approximately 11.000 people</p>
Cost of service availability for each resident of the ARA	Services cost for GBV survivor	Awareness cost per awareness beneficiary	Data collection and dissemination cost per person reached
11	<p>46 if we consider all those detected</p> <p>84 if we consider only those who received follow-up</p>	6	5,5

The expenditure per beneficiary was calculated including all the indirect costs (12%) recognised by AECID, and also all the management and coordination costs sustained during the project period.

Overall, taking into account the project has benefited and will benefit the whole population of the targeted ARA communities, the project has had an acceptable cost (11 Euro per person). The cost of the services for GBV survivor identified and registered within the project amount to 50-80 Euro per person, depending if we consider all those detected or only those who were provided follow-up. If we take into account that the awareness sessions had the aim of sensitizing but also informing people of existing GBV services, we can say that this was obtained for about half of the population of the targeted areas (19.000 people) with a cost of around 6 Euro per person reached. Finally in relation to the production of advocacy data and material, we can estimate that it managed to reach around 15.000/20.000 people, for a cost of around 5,5 Euro per person.

No baseline of other organizations – or other projects – providing the same services are available. However, in future actions, it would be interesting to compare these costs per beneficiary with same costs sustained by other organizations/projects.

4.3.2 Human and material resources have been sufficient and no major staff/material gaps have been registered during project implementation

Both human and material resources made available for the project were considered sufficient by all the three partners.

Particularly appreciated was the money made available for transportation, a) to carry out outreach activities (reaching ARA communities for GBV Risk Assessment, for community awareness sessions, for home-visits) and b) for beneficiaries, to be able to reach out the centres.

We are very satisfied about the introduction of the holistic approach to GBV response. Even if money was not huge it was sufficient and comfortable. It included transportation costs, equipment, money for recreational events, not only for basic staff and basic activities. Covering transportation costs was very convenient, not only for women to access the services, but also for awareness sessions, home visits etc. (Executive staff, CFTA-WHC)

Covering transportation costs was very good. The transportation provided to women, who, after the awareness sessions, were able to come to the centre. This was very successful. Many who wanted to know more about centre, came to the centre. Also the possibility if doing many home-visits was very good – and there was money to give to women for refreshments, so that they can invite other women to their homes. (Executive staff, UHWC)

Usually, we work with CBOs volunteers. But this time, the facilitators involved in the 'GBV Risk Assessment' were also given some payment. (Executive Staff, WATC)

4.3.3 Alianza and partners have the needed capacities - especially in terms of humanitarian response in the health sector, community empowerment, gender and women's rights, awareness and sensitization about GBV prevention - to achieve the intervention's results/objectives

CFTA, UHWC and WATC were identified as project partners thanks to their capacity and experience, which were seen as integrating each other. CFTA had already medical and non-medical staff working on GBV detection and support, but, as discussed above, they were trained, together with new staff, on GBV Case Management and improved the quality of their work. UHWC, a consolidated community based health service providers in the Gaza Strip, who had already taken part in previous projects on GBV, made available its staff and hired new people. Also in this case, they were provided Case Management capacity building and obtained good results. WATC also had skills in Women's Rights and GBV and a large base of CBOs and volunteers, who were mobilized for the project.

4.3.4 The intervention has sufficiently supported - through experts, trainings and information/educational materials - the capacity building of Alianza and partners in relation to standardization of models (holistic, SOPs, Case Manager etc.), incorporation of international standards to collection and data analysis on GBV (GBVIMS)

As discussed in the section on Effectiveness (Result 1), CFTA and UHWC staff were very satisfied for the capacity building received from NRC and reported that it had produced substantial changes in their way of dealing with GBV cases. The participatory approach in the design of the Case Management SOPs and forms was especially appreciated. Same thing can be said for the coaching during implementation of SOPs and forms (see next Indicator).

4.3.5 The organizations have established a communication, coordination and learning mechanism that allows them to complement and strengthen each other in the achievement of the results and objectives

The participatory / coaching character taken by the capacity building program provided by NRC (shared preparation of SOPs), but also the many coordination meetings called by APS, were very much appreciated by partner organization and considered very fruitful in terms of exchange and learning (exchange of information on service providers, exchange of awareness material, reciprocal referral, identification of referral partners, common participation into the Protection Cluster, cooperation for GBV advocacy campaigns etc.).

We had quarterly meetings at executive level, All admin staff and directors. At field level all the trainings for the staff were done including both CFTA and UHWC staff. We built good relations; we keep calling each other, which thing facilitated the implementation of the project. Also we refer cases to each other. We built a strong partnership that is not competitive, we complete each other. (CFTA Executive staff)

The cooperation with, CFTA, WATC, Palestinian Centre for Human Rights and Gaza Mental Health Program was very good. (UHWC Executive staff)

The collective efforts of the partners, which allowed to put in place quality services while advocating against GBV and linking people to the services, had an important impact on the number of women attending the one-stop multi-sectoral centers run by CFTA and UHWC.

Conclusions and Recommendations (Efficiency)

Overall the project was soundly managed from a financial point of view. The 'support' costs, sustained by Alianza during the project period, only 18% of the total expenditure (which is very reasonable amount) vs. 82% spent directly on the project; expenditure is distributed proportionally to the needs and tasks of each local partner and proportionally to the importance and the needs of the different Results. The cost per beneficiary, whether calculated in terms of service availability, GBV survivors follow-up, outreach and advocacy activities, seems reasonable, even if the future it would be interesting to collect information about costs sustained by other organizations for the same services.

Furthermore, AECID funding allowed to cover a variety of costs – from transportation costs for GBV survivors, outreach activities and home-visits, staff and capacity building for staff, provision of technical expertise – which together with Alianza's strong supervision and coordination role, created the conditions for the creation of high quality 'one-stop' multi-sectoral GBV response services, while making them known and accessible within the ARA communities, and at the same advocating for the expansion of similar services within the Gaza Strip and the oPt.

4.4 ALIGNMENT

4.4.1 The proposed objectives and results are in line with the Strategic Development Plan of Palestine and especially the National Strategy to Combat Violence Against Women 2011-2019

The PNA's 'National Strategy to Combat Violence Against Women 2011-2019', includes seven main strategic objectives, and among these we find two Objectives, to which Alianza's project is aligned and contributes:

- Strategic Objective 3 – Improve social protection and social support offered to women victims of violence

- Strategic Objective 4 - Improve health services in dealing with cases of VAW

4.4.2 The project is in line with international (IASC etc.) and, above all, national instruments for prevention and protection of GBV (National Strategy to Combat Violence Against Women 2011-2019)

The SOPs and forms for GBV Case Management produced during this project, are part of the wider “Inter-agency Standard Operating Procedures for Prevention of and Response to Gender-Based Violence and Child Protection in Gaza – Palestine”. These were developed by the Standard Operating Procedures Technical Working Group (SOPs TWG) under the umbrella of the Child Protection and GBV sub-Working Groups. The SOPs TWG was led by NRC and composed of the Ministry of Social Affairs, UNICEF, UNFPA, Tamer Institute, Ma’an, SoS, and Alianza por la Solidaridad, through of extensive consultations with national and international stakeholders involving over 49 ministries, institutions and organizations, which have also endorsed the SOPs.

The GBV SOPs elaborated during the project were adapted from and in line with the Inter Agency Standing Committee, Guidelines for GBV in Humanitarian Action 2015 and other relevant guidelines, also thanks to the substantial feedback provided by Alianza, UHWC and CFTA.

Conclusions and Recommendations (Alignment)

The project is aligned with international and national instruments for prevention of GBV, in particular with the Inter Agency Standing Committee, Guidelines for GBV in Humanitarian Action 2015 and with the PNA’s ‘National Strategy to Combat Violence Against Women 2011-2019’. No major recommendations on this.

4.5 CONSISTENCY

4.5.1 Training activities, on gender, women's rights, GBV and multi-sectoral approach, are designed for and delivered both to women and men staff, taking into account their specific needs and, rights, opportunities but also possible points of resistance (e.g. materials and sessions delivery is clear, simple but exhaustive, gender and HR sensitive while at the same time culturally sensitive etc.)

As already discussed, capacity building of UHWC and CFTA’s health clinics staff included frontal training sessions, but also participatory development of Case Management SOPs and forms, and coaching. The staff who attended the trainings were in majority women – two social workers (UHWC) and one psychologist (CFTA) were male.

The SOPs elaborated are gender sensitive and always include reference to work to be done with men and boys. The training material included sections on how to work with men that are exercising violence against women and NRC provide specific coaching sessions for the male staff as well.

4.5.2 Training materials incorporate all the main elements of the gender approach and the HRBA in relation to GBV and multi-sectoral approach

The elaborated GBV Case Management SOPs, which are the main result of the capacity building provided to UHWC and CFTA staff, incorporates reference to international conventions and standards and gender / GBV related definitions, focus on specific needs/rights of women, focus on women's protection, promote holistic multi-sectoral services and a participatory approach towards women, men, boys and girls and take into account intersectionality (disability etc.)

4.5.3 The training strategies, including materials, methodology, staff skills, etc. facilitating the acquisition and application of knowledge on the part of the participant

As already mentioned, the capacity building strategy included frontal training sessions, but also participatory development of Case Management SOPs and forms, and coaching, which encouraged partners staff, both to test the SOPs during their daily work, and to provide feedback on the SOPs themselves, based on their daily professional experience. This was very much appreciated by partners' staff.

4.5.4 Awareness activities, on gender, women's rights, GBV and multi-sectoral approach, are designed for and delivered both to women and men, taking into account their specific needs and, rights, opportunities but also possible points of resistance (e.g. materials and sessions delivery is clear, simple but exhaustive, gender and HR sensitive while at the same time culturally sensitive etc.)

Awareness activities were overall targeted to specific groups of beneficiaries (e.g. women, men, mixed - graduates - housewives - unemployed - different age groups – Mukhtars). As we have seen the awareness sessions targeted a total of 19.000 beneficiaries, of which around 15.500 were women and 3.500 men).

Their gender, background and level of knowledge were taken into consideration when delivering the awareness sessions. Beneficiaries were always asked to choose the topics they wanted to hear about. The way of delivering the awareness sessions could vary, depending on the group (circle sessions, working groups, lecture with feedback from audience, etc.). Home-visit sessions, targeted to both individual and groups of women, and/or to family members, including male family members, and tailored to their specific needs, were considered very effective both by female and male beneficiaries, and by the staff.

Usually we have separate groups – for men and women. For example, I talk to women for the first 15 mins and I ask them what is the main concern in this area for example if inheritance, or early marriage and I talk about that” (community facilitator, WATC)

For the awareness sessions, the topics covered came from the women themselves: sexual harassment, social problems, personal status law etc. (field staff, UHWC)

“For example, sessions on inheritance are with mixed groups of men and women.” (community facilitator, WATC)

After the trainings, some female students contacted me for more trainings etc. – for more knowledge. Many went to WATC to get more trainings. Some men asked to be volunteers in the project. (community facilitator, WATC)

Home-visits awareness sessions are very good: it allows to reach very marginalized areas, one gets a better idea about the beneficiaries, women spread the word and invite other women, so the communities become aware. There is a stronger link between women and centres. (field staff, UHWC)

It needs to be added that also offering services to both women and men, and having male staff in the GBV Case Management team, able to deal with men (male perpetrators of GBV and male beneficiaries of awareness sessions), was considered an added value of the project.

One very important thing to say is that it is a women centre, but they tell women that they can come with their husband (male beneficiary, CFTA)

My wife used to come to the centre. I was very violent, shouting all the time. One day I was very surprised because the psychologist, a man, called me and convinced me to come for the awareness sessions. I went twice and I did not go on the third session. They came to see what had happened. I was very pleasantly surprised – thus they cared about me. So I started to come and I became friend with the team. Now things are better with my wife. (male beneficiary, CFTA)

In the end I am here because the psychologist and social worker, both men, kept trying and trying and trying and in the end they managed to convince me. (male beneficiary, CFTA)

Male social workers are important because a) they are a support in the dynamic of the team, they accompanying women staff to home visits in situations that could trigger violent male reactions; b) and for talking to men about GBV: it is easier for male beneficiaries to hear advice from a man, it is more effective. (field staff, UHWC)

Men social workers can work with men as perpetrators of violence. They can dig out and discuss men's problems. They provide them with the support needed social support to recognize that they have problems and then start to change the mentality. (field staff, UHWC)

Some topics are very delicate for women; it is very hard for them to talk about certain things with men. For example, Tramadol addiction... men are not comfortable to talk about this with women... (field staff, UHWC)

4.5.5 Awareness materials incorporate all the main elements of the gender approach and the HRBA in relation to GBV and multi-sectoral approach

We have not been able to see the training materials, as each person delivering the training has its own material. However, all awareness material was approved by the organization in charge of awareness sessions.

From the topic treated by the different organizations, we can say that while WATC's approach was more Women's Rights oriented, CFTA focused more on GBV and related issues (linking health and women's rights), and UHWC adopted a health-oriented approach focusing more on Sexual Reproductive Health and Rights.

Overall, however, during fieldwork, the facilitators of the awareness sessions showed a good understanding of HR and gender equality principles, GBV standards, together with ownership for a holistic and participatory approach.

We refer to CEDAW, Human Rights etc. Equality word is used! of course!!!! I know that in other Middle Eastern countries this word is hard to use, but here in Palestine the Human Rights context is much more developed ... (community facilitator, WATC)

When we talk about gender, the main message that we send is that roles of men and women can be changed. They are not holy concepts... they are changeable... (community facilitator, WATC)

When we talk about GBV, the main message is that GBV is not acceptable. Many women think it is normal and men have the right to do it. (community facilitator, WATC)

Also, GBV is not only physical violence. There are also psychological, economic violence. Denying rights. Many women think it is normal, men's rights to do this. We also make women to seek justice, go to judicial system – to seek rights legally not only through services. (community facilitator, WATC)

4.5.6 The protocols of attention and referral (SOPs, Standard Operational Procedures) developed in the context of the intervention have been adopted by the organisations institutionally

The formal approval and endorsement of the the 'Inter-agency Standard Operating Procedures for Prevention of and Response to Gender-Based Violence and Child Protection in Gaza – Palestine', by the Ministry of Health, was stopped by the intervention of the Gaza Ministry of Interior. For this reason, there is also no official endorsement by relevant organizations. Nevertheless, both UHWC and CFTA have trained staff and follow the SOPs in their facilities.

4.5.7 Project strategies (staff training / SOPs / centres organization / awareness / campaigning) included in the intervention were complementary and mutually strengthening

The different activities and strategies adopted in the project effectively complemented each other. The awareness sessions – also delivered through home-visits – and the advocacy campaigns contributed to the GBV Risk Assessment, created more aware communities, and also lead both women and men to the GBV services. The capacity building provided to the services' staff not only improved the effectiveness and the quality of the GBV services, but also contributed to the development of the Case Management SOPs; and the SOPs were endorsed by other organizations, thus contributing to the whole GBV protection system in the Gaza Strip. The GBV Risk Assessment and data collected from the services provided evidence about GBV situation in Gaza, which was presented and utilized in the Protection Cluster.

4.5.8 Mechanisms for coordination and exchange with other stakeholders, decision-makers and interventions nationally and internationally is clarified and in place

The partner organizations worked in strict connection, especially at the level of GBV Case Management staff, through meetings, exchanges, and common participation to the capacity building activities, including the development and the piloting of the SOPs. This constituted an important learning mechanism for all the staff involved, together with coaching during

All the organizations involved in the project – Alianza, UHWC, CFTA-WHC, WATC – were active within the Protection Cluster-GBV sub-working group thus establishing productive relations with other organizations involved in the development of the SOPs (NRC, Ministry of Social Affairs, UNICEF, UNFPA, Tamer Institute, Ma'an, SoS) and thus potential new partnerships.

This collective effort about the SOPs is being now targeted towards the Ministerial level (MoH, MoSA, MoWA, MoI etc.).

Conclusions and Recommendations (Consistency)

The different project activities and strategies of the project successfully complemented each other. Gender equality and HR principles were mainstreamed in training and awareness activities and materials. Awareness sessions and advocacy actions strongly contributed to link GBV survivors,

community women and men to the GBV response services. Mechanisms for coordination and exchange among project partners, and with other stakeholders (Protection Cluster), were clear and effective; overall partners, believed that this was one of the most successful aspect of the project.

No major recommendations on this point.

4.6 APPROPRIATION / OWNERSHIP

4.6.1 The local organizations have incorporated the multi sectoral response model (holistic 'one-stop-centres') according to international standards, including elaboration of the protocol of attention and referral (SOPs, Standard Operational Procedures) and introduction of the Case Manager and of the Gender-based Violence Information Management System (GBVIMS) in their health centres

CFTA and UHWC have endorsed and committed to the 'Inter-agency Standard Operating Procedures for Prevention of and Response to Gender-Based Violence and Child Protection in Gaza – Palestine' (SOPs) elaborated through this project. A Case Management Team capacitated for the task was created in all the three health centres. CFTA and UHWC staff participated in the elaboration of and introduced the SOPs within their health centres (see Effectiveness - Result 1). The GBV/consultation forms are being filled by the staff, and are being introduced within the computerized GBVIMS (even if UHWC computerized system is not completed yet).

4.6.2 The local partners are able to describe, and express satisfaction for, their participation in the design, management and monitoring of the intervention

Partners expressed overall satisfaction for their participation to all the phases of the Project Cycle.

Alianza had a pivotal role in the project as the lead coordinator, catalyst, gender/GBV technical advisor, etc. thanks to its added value of being a gender expert organization and to its strong partnership with UHWC, WATC and CFTA.

The project was designed during a two-day workshop with all the partners involved. For Alianza, UHWC and WATC, the project was the continuation of the previous project on SRHRs and GBV previously implemented together in 2013 ("*Regional Program on sexual and reproductive rights of Palestinian, Jordanian and Lebanese women in a position of vulnerability*"). CFTA had never partnered with Alianza before, but extensive contacts and relations existed before in relation to GBV issues. For these reasons, the identification of project's objectives and expected results happened through a smooth participatory process.

The meetings among each other and with Alianza, to discuss, exchange, improve and solve problems, were frequent (see Consistency). Recommendations made by partners to Alianza were taken seriously. For example the initial dissatisfaction for the training provided by NRC as it was too focused on child protection (see Effectiveness – Result 1), was promptly picked-up by Alianza that asked NRC to increase the focus on GBV, and to make it very concrete and responding to the concrete needs of local organizations in their GBV work. This changed of track also led to the fruitful decision of making the whole capacity building process more participatory, and created to the creation of Case Management forms that can be easily and effectively utilized in the health centres.

All the partners were involved in the preparation and piloting of the GBVIMS (Case Management forms), which is the main monitoring tools for the GBV response services provided in the three health centres targeted by the project (see Specific Objective and Result 3). In addition, partners provided to Alianza quarterly reports about the achievement of the main project Indicators (see below on Measurability).

4.6.3 The implementing partners show full understanding and sharing of the intervention's action lines aimed at the introduction of a single and homogeneous response model for GBV according to international standards, based on “one-stop centres” that allow women survivors accessing services with a holistic approach and preserving confidentiality

As discussed in other parts of this report (Effectiveness-Result 1, above in this section), partners, were strongly engaged in the introduction and piloting of the Case Management model in their clinics (GBV Case Management teams in the clinics were involved in elaboration and piloting of the SOPs). GBV Case Management teams also expressed satisfaction for the results obtained with GBV survivors thanks to the introduction of this model.

4.6.4 The implementing partners have been pro-active - during project implementation to introduce corrective measures when needed to achieve the expected results (examples)

As mentioned various times, partners were very pro-active in many phases of the project, also through introducing corrective measures to the project. For example, in asking to increase the focus of the capacity building program on GBV or when taking part in the development and piloting of the SOPs and GBV forms, which required the writing and testing of various versions.

Conclusions and Recommendations (Appropriation/Ownership)

All partners took actively part in the design of the project and of project activities during all the phases of the project, also thanks to Alianza's coordination role. Overall, partners – especially at field level - showed a strong ownership for the multi-sectoral approach to GBV services piloted in the project. The SOPs for the Health Centres' GBV services were actively prepared and piloted by UHWC and CFTA's staff and adopted within the clinics. As already mentioned, this was considered by all partners a very positive aspect of this project.

No major recommendations on this point.

4.7 CONNECTIVITY (LINK RELIEF TO DEVELOPMENT/SUSTIANABILITY)

4.7.1 The project has been adapted to the Emergency phase and to the rehabilitation phase in the Gaza Strip through appropriate design and implementation strategies

The project was implemented under the humanitarian umbrella, one year after the 2014 aggression. For this reason, it had to deal with longer-term humanitarian consequences of the aggression, in terms of GBV, rather than with the immediate effects. As we have described in previous sections of this report (Chapter 2 and Chapter 3-Relevance), both studies on the region and beneficiaries themselves, recognize the link between the aggression, its long-term consequences – death and injuries, displacement, living in overcrowded households, unemployment etc. – and high rates of distress, depression and violence, especially domestic violence.

Bearing this in mind, project implementers have decided to target heavily affected areas, on the especially affected Gaza border with Israel, heavily targeted during the war and site of 15 ARA communities.

In fact, the project has definitely responded to the very strong needs of these communities, especially by linking women, men, GBV survivors and perpetrators of violence to the GBV services. These needs are also highlighted by the 2 fact-sheets deriving from the GBV Risk Assessment.

Nevertheless, we would also like to highlight some interesting observations made during the FGD with WATC community facilitators, who suggest that women even more exposed to GBV might be found in other contexts:

The ARA are heavily targeted by NGOs etc. There is less work done in the city. In terms of GBV, also the city is a marginalized area. Violence in the city is very high. The extended family is somehow protection – in the city women are alone and nobody knows what happens. (community facilitator, WATC)

Overall we found a quite high level of awareness among the women in marginalized areas, because many NGOs work there. But we found total lack of awareness among graduates. There is less awareness among students than among women in marginalized areas (community facilitator, WATC)

4.7.2 The humanitarian response activities - as they were designed and then implemented - were able to 'link relief to development' by taking into account the deeper implications of GBV, such as its socio-cultural root causes and the need of long-term sustainable processes of change

The activities were **designed** by taking into account the link between relief and development, so important in a context of chronic humanitarian crisis. On the one hand, the project focused on provision of – quality, multi-sectoral – response services for GBV survivors, in areas very badly hit by the war. On the other hand, the project a) challenged social and cultural assumptions through awareness sessions, while at the same time, b) aimed at making the provision of these services structural and long-term within these communities - through SOPs introduction and staff training but also through advocacy actions towards other service providers (MoH, Mol etc.).

Nevertheless, the project did not always manage to make the provision of the services structural and long-lasting. In fact, UHWC substantially, discontinued its GBV multi-sectoral services in its two clinics in Jabalia and Bet Hanoun (the 2 lawyers left, of the 2 psychologists and the 2 social-workers, only 1 psychologist and 1 social workers remained and are now over-stretched and dedicated to other tasks), throwing the beneficiaries in a state of high discomfort.

She used to come for counselling with the psychologist. I learnt how to react in certain situation. We had a problem with my daughter's husband. They referred him to the psychiatrist, and 70% of the problem was solved. But now it is all stopped. If the psychologist were still there the problem would be completely solved. But now we still have problems and I do not know how to do. I am totally afraid of going back to the worse... (GBV survivor, UHWC)

My situation is a disaster. My children have Post-Traumatic Stress Disorder after the war... bed wetting... fear... Our house was partially demolished. We used to receive psychosocial support throughout the project, also my children. My husband is unable to work and he is always at home, he is very violent. I want to receive home visits for me, my children and my husband. Without that we'll go back to same situation. (GBV survivor, UHWC)

We still have some services but not the full team. I started with a psychologist and built a relationship, but now she is no longer here. Continuity is important. The team members are the link with the centre, but they are no longer here (Woman, GBV survivor, UHWC)

The same is for me. I used to follow-up with case manager, but she is no longer here. I am not comfortable to start again with someone else. (Woman, GBV survivor, UHWC)

The disruption brought by the discontinuation of the newly introduced system, was pointed out also by the remaining UHWC staff:

When the project was going on, I used to open a case file, fill the data, to send her to the gynaecologist for a medical check-up; then, gynaecologist and midwife would give them individual awareness sessions, then if she accepted she was sent to the psychologist, then the psychologist decides if she would need legal assistance etc. It was very effective. But now we went back to old system. (UHWC, member of staff)

Now the social worker manages GBV cases, but cannot deal with them with full team – before cases were discussed with the team – now it is just her effort. (UHWC, member of staff)

Now we have fewer cases. When there was the Case Manager, she had the authority to manage the cases. Now she does not have the authority. Also, the Case Management needs to have a full team but now we no longer have the full team. (UHWC, member of staff)

The Case Management system was much more effective. It was more a holistic assessment > identifies medical, social, psychological and legal needs. (UHWC, member of staff)

This is probably due to a mix of reasons. First of all, Gaza service delivery depend almost totally on humanitarian funding, but on the one hand, humanitarian/cooperation funds have fallen down in the last years strongly impacting on Palestine and on Gaza protracted crisis, while on the other hand, humanitarian donors do not always prioritize GBV in their funding strategies. AECID in one of the few donors who prioritizes GBV in Palestine. Thus it was especially difficult for HWC to identify funding for the continuation of GBV services provision. Nevertheless, additional reasons might also be that : a) UHWC, is mainly a health provider and tend to prioritize health services; b) UHWC, does not have fundraising strategy that guarantees the continuity of funding on this type of projects.

CFTA, on the other hand, managed to maintain the GBV services, after the end of funding. This was probably possible because: a) GBV is one of the main – if not the main - priority of the CFTA Women Health Centre; b) CFTA has fundraising strategy, for its programme, which allows continuation of activities even without specific funding for it. In particular, CFTA spreads the same positions and the same activities, across different projects, so that if one funding is discontinued, the other is not, which thing allows to maintain the continuation of the activities, at times, with a slight decrease in staff's time availability.

4.7.3 The institutional sustainability of the intervention has been ensured, especially thanks to increased partners' capacity and appropriation of the project approach

The institutional sustainability was supposed to be ensured in 2 ways: a) by introducing and adopting Standard Operating Procedures and b) by increasing the capacity of the staff in dealing with GBV survivors. This was definitely achieved in the case of CFTA, but not in the case of UHWC.

As we have just described, UHWC suspended most of the services provided during the project, thus discontinuing the model introduced thanks to the SOPs, and also losing the staff who had been trained, as most of them now are working in other positions within other organizations.

4.7.4 The financial sustainability of the intervention has been ensured thanks to specific organizational strategies

Financial sustainability depends on organizations' fundraising strategies, and it is strongly influenced and limited by donors' policies, especially in the humanitarian context. As described in the section above, humanitarian funding is always limited by short-deadlines, which do not well fit with the chronic character of the Gaza crisis. Nevertheless, organizations have always the freedom to prioritize and improve their fundraising policies.

In the case of this project, while UHWC fundraising strategy, very much project-focused, has not been able to guarantee financial sustainability to the project, at the same time, CFTA strategy to focus on funding their 'programme' through a multiplicity of donors, has proved more effective in providing financial sustainability to GBV multi-sectoral response services. UHWC Executive staff, however, suggest that the responsibility is not only of the NGOs but also of the donors:

Also donors have responsibility in giving funding for longer term... but funding is for short-term.... This needs to be solved... (Executive staff, UHWC)

4.7.5 Social and cultural sustainability of the intervention has been ensured especially thanks to rights holders' increased, knowledge, awareness, empowerment, ability to access GBV multi-sectoral services

Social and cultural sustainability was built by UHWC, CFTA, and WATC by building strong channels of communication and trust with the targeted communities. Of course, this relationship of trust with the communities was not created only through this project. Both UHWC and CFTA have been working for many years within the communities and the health centres involved in the project, and they are overall appreciated for the overall quality of the health services they provide. While WATC has been for many years working on gender issues, women's rights and GBV, with the CBOs present in the targeted areas.

This project, however, concerned also the discussion of delicate themes, which could have raised strong community opposition. This was handled by responding to communities' needs and through outreach awareness activities, and by providing strong follow-up of GBV survivors. Good relations, even if not cooperative, were maintained with Mukhtars.

Conclusions and Recommendations (Connectivity)

The connection between relief and development (see Chapter 2), together with social and cultural sustainability, and institutional and financial sustainability, has been highly taken into consideration by Alianza and partners when designing the project. Cultural and social sustainability were guaranteed by all partners by building a maintaining communication channels and relations of trust with the targeted communities. Nevertheless, one of the partners, UHWC, was not been able to identify effective strategies to guarantee institutional and financial sustainability.

It needs to be added that, at times, donors also contribute to this situation by: a) not always prioritizing GBV in their humanitarian strategies (AECID is an exception in this regard); b) by funding, in humanitarian contexts, only short-term projects, which do not always take into consideration the roots and the long-term consequences of a humanitarian crisis as the one in Gaza.

While we recommend that UHWC should identify strategies to recover as soon as possible the multi-sectoral GBV services in its clinics, we would like to recommend to the donor community to consider prioritizing GBV in their humanitarian funding strategy for Gaza, and to fund also longer-term projects able to respond to the chronic character of Gaza humanitarian crisis.

4.8 PARTICIPATION

4.8.1 The rights-holders are able to describe, and express satisfaction for, their participation in the design, management, monitoring and evaluation of the intervention

Women and GBV survivors of the targeted community were consulted during the GBV risk assessment (and also had been consulted in a previous Alianza/Actionaid's study on GBV in Gaza²⁰) to identify their needs and priorities, and obstacles they have in reaching out GBV protection services (see Relevance). Their views were also taken into consideration took in consideration their views through the partners and their field team in charge of the provision of services.

Furthermore, they had a substantial say especially on issues such as the choice of the topics for the awareness sessions (Result 2) or in planning of recreational activities (CFTA). Furthermore, both CFTA and UHWC, regularly distribute satisfaction questionnaires on the overall reproductive services provided in their health centres. Satisfaction questionnaires were also distributed during the awareness sessions.

300 fact sheets and 3000 copies of Women Voice Magazine were distributed also in communities, community centres, hospitals, local organizations, and to international organizations, forums and working groups in country (UN agencies).

4.8.2 The (non-partner) organizations that have a stake in the project are able to describe, and express satisfaction for, their involvement in the intervention

Members of the Protection Cluster (e.g. the Gender Advisor for Humanitarian Country Team), expressed high appreciation for the cooperation with Alianza and partners within the Protection Cluster, especially concerning the development of the SOPs, but also in relation to the production of data about GBV in Gaza (Study on Violence 2014; GBV Risk Assessment; monitoring data from GBVIMS).

4.8.3 Decisions made through the participatory process - with rights-holders and other stakeholder organizations - have been implemented during the Project implementation

As already described, the cooperation that Alianza and partners established with the Protection Cluster was quite intense, and lead to the finalization of the SOPs, which are ready to be adopted by all the organizations involved. Beneficiaries were mainly consulted in relation to specific issues of direct interest for them (see above in this section).

Conclusions and Recommendations (Participation)

Overall, the project was managed with the strong involvement of the beneficiaries and of other Gaza and international stakeholders (Protection Cluster). Beneficiaries' views were taken into consideration took in consideration through the partners and their field team in charge of the provision of services. Furthermore, they had a substantial say especially on issues such as the choice of the topics for the awareness sessions or in planning of recreational activities. The cooperation that Alianza and partners established with the Protection Cluster was quite intense, and lead to the finalization of the SOPs which are ready to be adopted by all the organizations involved.

No major recommendations on this point.

²⁰ *Violence Against Women In The Gaza Strip After The Israeli Military Operation Protective Edge 2014*, Prepared By Catherine Müller And Laila Barhoum, commissioned by Alianza por la Solidaridad (Aps) and Actionaid (Aa), October, 2015

4.9 COVERAGE

4.9.1 Risk analysis of physical, financial, social and cultural barriers met by rights-holders in and adopted during project implementation

Barriers that affect GBV survivors' access to services were analysed in the study commissioned by Alianza and Actionaid "Violence Against Women In The Gaza Strip After The Israeli Military Operation Protective Edge 2014"²¹, which informed the elaboration of this project. In particular:

- Women living in more remote areas were not well-enough covered, and high transportation costs at times impeded women from accessing services. It was thus suggested to: a) provide transportation or money for transportation could be provided; b) take the awareness sessions closer to beneficiaries, through the support of local organizations. These measures were adopted in the project. Actually, as we have already discussed, to facilitate outreach, also home-visits were included in the project.
- Social and cultural barriers were identified in male relatives and or mothers in law who can hamper women's mobility and also in the stigma associated with going to certain services. For this reason, the study suggested a number of measures, which were adopted within the project: a) maintaining the health centres as essential entry point for GBV survivors, who often are only allowed to leave their home to visit health centres; b) providing in a 'one-stop-centre' all the needed GBV services (health, psychological, psycho-social, legal etc.); c) by building a relationship of trust with communities responding to community requests and needs and (see Result 2); c) by maintaining good relations with Mukhtars (see Result 2).

4.9.2 Mechanisms to improve right holders' access to project services have been included in project design and utilized during project implementation

On the basis of the above vulnerabilities in terms of access, Alianza and partners designed mechanisms to improve the outreach of the most vulnerable women and men within the 15 Access Restricted Area targeted by the project.

In order to tackle access obstacles imposed by social and cultural, physical and financial barriers, CFTA and UHWC adopted: a) awareness sessions in remote places (including in beneficiaries' homes); b) home-visits, included some money given to women to buy refreshment for the sessions organized in their homes; c) reimbursement for public transportation costs to reach the clinic. In addition, UHWC also offered, to the women attending the awareness sessions, free of charge health checks.

These mechanisms were extremely appreciated by the beneficiaries, both women and men, and were considered essential, one hand, to make people recognizing the problems they have and deciding to access services, and on the other hand, as part of the continuous follow-up provided by the centres:

"My husband beats me-up a lot. We have a child with brain cells damage. This situation is very hard to cope with. It often results in conflict and violence. Once the counsellor came for a home-visit and other times they helped me with the transportation fees. It was helpful because they came to my home, as I am always busy with my sick child." (woman, GBV survivor, UHWC)

"My wife has been coming to the health centre for many years. And recently she started to come also with my daughter, as she has Post Traumatic Stress Disorder after the war. Then a

²¹ prepared By Catherine Müller And Laila Barhoum, October, 2015

psychologist came for a home-visit and asked to sit with me. Only then I started to realize how useful it was, and I also started coming to the centre". (man, CFTA WHC)

"It is very important to cover transportation, otherwise I would not be able to come" (woman GBV survivor, CFTA-WHC)

"The project provided lots of awareness sessions, home-visits, the follow-up was very strong" (woman GBV survivor, UHWC)

4.9.3 Coverage of the most vulnerable groups in 15 communities in the ARA ("Access Restricted Areas") has been guaranteed through specific outreach measures (examples)

As just described above, specific outreach measures were put in place, which were considered very important by the beneficiaries. Nevertheless, as a main suggests on the FGD at the CFTA Women Health Centre, the need for this type of projects is still huge, and outreach activities should be increased to involve more and more people in need:

"There is the need to increase the outreach of this type of projects. I want to stress the importance of the outreach. There is the need to make more awareness sessions in public. The needs are very high but they are hardly covered. The answer is to push on the outreach. There are many people out there who need help but they do not recognize it. Through the awareness sessions they will recognize that they need help, and then they will seek for help" (man, CFTA Women Health Centre)

Conclusions and Recommendations (Coverage)

The outreach of the most vulnerable women living in remote areas of the Gaza Strip, was a priority within this project. The main physical and financial obstacles preventing women to reach GBV services were analysed and tackled through specific outreach measure such as home-visits, including awareness and detection sessions during home-visits, and reimbursement of transportation costs to reach the health centre. Social and cultural obstacles were tackled thanks to the provision of multi-sectoral services that guarantee confidentiality to women.

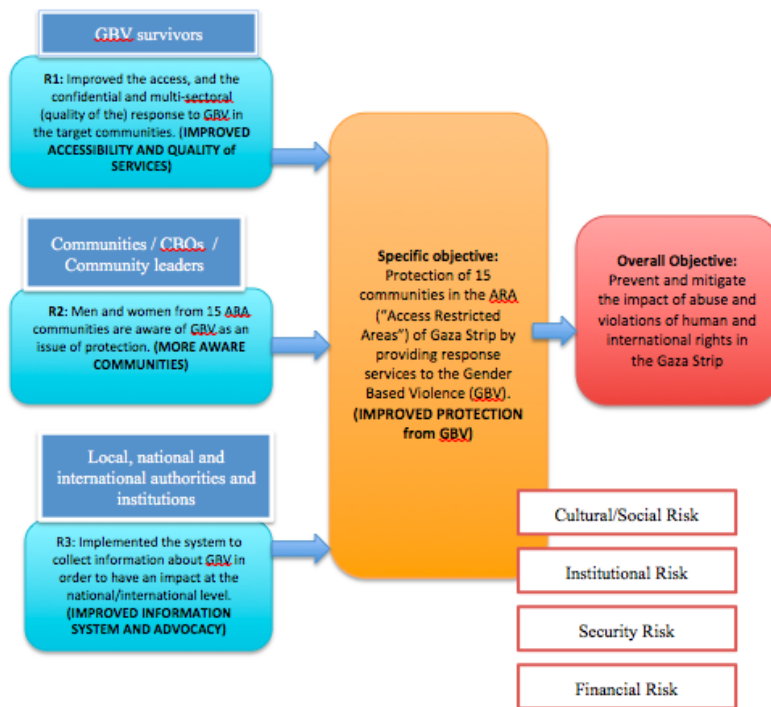
No major recommendations on this point, except that of considering the success of this kind of outreach measures in the design of future projects.

4.10 THEORY OF CHANGE

4.10.1 The intervention's Theory of Change is coherent and all major risks/gaps that could have hampered the achievement of the Objectives/Results were taken into account in the design phase

The project did not have an explicit Theory of Change included in the proposal text. However, we have attempted to render explicit the implicit ToC contained in the project LF and this is:

Chart 4 – ToC of the project



The project had the objective of increasing protection from GBV in 15 especially vulnerable communities in the Gaza Strip, by working at various levels: with CBOs and community based (health) service providers; with communities and women rights-holders; and with local, national and international duty-bearers. Intermediate outcomes included: a) increasing the access and the quality GBV response services, for GBV survivors, by introducing a GBV multi-sectoral services ; b) increasing community’s awareness about GBV and GBV protection services, by improving the outreach system (community information and awareness sessions); c) improving the system to collect data on GBV, in order to be able to advocate with other relevant national and international stakeholders, for the extension of GBV multi-sectoral response services to other health service providers in the Gaza Strip.

This – implicit - ToC is coherent and realistic and in line with a HRBA (with its focus on rights-holders, civil society actors and duty bearers and promoting a holistic response to GBV). Furthermore, by focusing on protection services provision, but also by tackling more structural issues (community attitudes and institutional policies and practices), successfully links relief to development, and is in line with the understanding of GBV in the context of the protracted humanitarian crisis of the Gaza Strip, as developed by main international actors (see Chapter 2; Relevance).

It needs to be mentioned, however, that Alianza’s proposal did not include a thorough analysis of the risks and of the risk management strategies that might have occurred, during project implementation, at the level of its various expected outcomes. It only briefly mentioned the following risks:

- Result 1 (GBV services): *The security situation in the ARA in Gaza does not get worse.*
- Result 2 (community awareness): *There is no opposition from community leaders. The security situation allows the implementation of awareness activities in the selected community.*

- Result 3 (GBV data collection): *Security situation. People from the community are available to provide information.*

Despite the lack of a strong analysis of the Risks, as we have seen Alianza and partners managed to implement the project without many obstacles, which however were successfully managed (see also: Effectiveness and Coverage).

Conclusions and Recommendations (Theory of Change)

The project did not make explicit its Theory of Change nor it was supported by a robust project Risk Analysis. Even if this was not an obstacle for the implementation of this project, it is strongly advised to introduce ToC and Risk Analysis as planning and monitoring tools in future projects.

4.11 MEASURABILITY

4.11.1 Results are formulated coherently with the ToC

As just described, the formulation of the ToC and thus of Objective and the Results, was clear and coherent.

4.11.2 Indicators are formulated and monitoring data are collected and presented coherently with the results

The Indicators, the data collected and the reporting (within AECID Excel format) were overall good, but some aspects of the Monitoring and reporting system could be improved.

Table 10 – Problematic aspects in monitoring and reporting system

INDICATOR (AS FORMULATED IN ALIANZA LF)	PROBLEMATIC ASPECTS
Specific objective: Protection of 15 communities in the ARA ("Access Restricted Areas") of Gaza Strip by providing response services to the Gender Based Violence (GBV)	
<i>IOV 1. Number of GBV survivors in ARA communities that access in a safe way, and receive appropriate and confidential multi-sectorial response services</i>	<p>It is not always or straightforward to distinguish among new GBV cases detected, 'new' GBV survivors who access the services and are followed-up, 'total' GBV survivors followed-up (newly registered and registered before the project), number of consultations for GBV survivors number of referred cases (distinguish per reason and organization) during project period.</p> <p>Baseline and targets should be clarified</p> <p>There are no qualitative indicators about GBV survivors sense of protection</p>
<i>IOV 2. At the end of the project, the improved pilot model of multi sectorial response for providing services to the ARA zones is completely adopted and is working in the 3 centres</i>	OK
<i>IOV 3. At least 3 notes about GBV in Gaza as a contribution to the different reports and</i>	OK

documents prepared by the Protection Cluster	
R1: Improved the access , and the confidential and multi-sectoral (quality of the) response to GBV in the target communities.	
<i>IOV.R1.1. Number of service providers trained for implementing an appropriate and confidential response to GBV.</i>	<p>It is not clear if 'service providers' refers to organizations or members of staff (we assume it is 'members of staff')</p> <p>It is not possible to distinguish between:</p> <ul style="list-style-type: none"> • number of trainees (each trainee might have received more than one training) - number of training sessions received by each trainee
<i>IOV.R.1.2. At the end of the project, at least 75% of the trained staff have improved substantially their capacities to supply services according to the established protocol</i>	<p>It is not possible to distinguish between:</p> <ul style="list-style-type: none"> - immediate learning, - change in skills and practices <p>For the immediate learning the evaluation system is based on descriptive activity reports by the trainers and it is not clear the pre/post-test system utilized.</p> <p>Qualitative indicators could be introduced for measuring changes in skills and practices.</p>
<i>IOV.R.1.3. At the end of the project, 70% of the women - who have participated in the awareness and detection sessions in the targeted communities - know about and also have the access to the available response services</i>	The quantitative part (70%) of this Indicator would be measurable only through a quantitative survey. It would be better not to have this type of Indicator if no resources are available for quantitative studies or systematic collection of pre- and post-test results during awareness sessions. Indicators without such quantitative measure would be more appropriate.
R2: Men and women from 15 ARA communities are aware of GBV as an issue of protection.	
<i>IOV.R.2.1. At the end of the project, at least 30% of women, men and children from the vulnerable communities have participated in the awareness sessions and have increased their knowledge about GBV</i>	As for IOV.R.1.3.
<i>IOV.R.2.2 At the end of the project, 30% of the community based organizations have improved their knowledge about GBV, and they have participated in the awareness organized campaign and actions</i>	<p>'It is not possible to distinguish among:</p> <ul style="list-style-type: none"> - number of CBOs - total number of trainees - and number of trainees per CBO - number of trainings/training sessions - number of trainings/training sessions received by each trainee <p>For increased knowledge, as for IOV.R.1.2.</p> <ul style="list-style-type: none"> -
<i>IOV.R.2.3. At the end of the project, at least 40% of the community representatives (leaders) target are aware of the risks of GBV already identified by the community.</i>	OK
R3: Implemented the system to collect information about GBV in order to have an impact at the national/international level.	
<i>IOV.R.3.1. The 3 UHWC and CFTA centers have in place a system to collect information in a homogenous and confidential way, following international standards.</i>	OK.

<i>IOV.R.3.2. At the end of the project, at least 2 products (position and informed notes) have been elaborated jointly and spread into the community.</i>	OK
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4.11.3 Human resources for monitoring are sufficient

UHCW and CFTA count with 1 M&E officer each. However, for confidentiality and safety concerns when dealing with GBV survivors, the health, PSS and legal staff in charge of the different services in the multi-sectoral response deals with the collection and analysis of the GBV data cases and share the information, without of course, disclosing any information with the M&E officer of the respective organization. The figure/role of the GBV case manager developed in the project is essential on the improvement of the monitoring and the centralization of the proper collection and follow-up of each GBV case documented.

Both UHCW and CFTA's Case Management teams, however, report they require further more capacity building in monitoring and more development on the GBV case manager role on this.

4.11.4 Monitoring data collection and analysis routinely carried out and informs project implementation

As we have seen, thanks to the forms developed as part of the SOPs, data collection and monitoring of GBV cases is routinely carried out. Furthermore, both organizations regularly collect information about attendees of awareness sessions.

4.11.5 LF and M&E is developed jointly and understood by all project stakeholders

Both the project LF and the monitoring plan were designed jointly by Alianza and partners during the project design two-day meeting and in following meetings.

Conclusions and Recommendations (Measurability)

M&E was probably not among the strongest component within this project. Indicators and data collected were not always coherent with the Results. In the following table we analyse the various Indicators, and we suggest ways to improve their formulation and related data collection:

Table 11 – Suggestions for improving the monitoring and reporting system

INDICATOR (AS FORMULATED IN ALIANZA LF)	SUGGESTIONS FOR IMPROVING INDICATORS AND DATA COLLECTION
Specific objective: Protection of 15 communities in the ARA ("Access Restricted Areas") of Gaza Strip by providing response services to the Gender Based Violence (GBV)	
<i>IOV 1. Number of GBV survivors in ARA communities that access in a safe way, and receive appropriate and confidential multi-sectorial response services</i>	Distinguish among: <ul style="list-style-type: none"> • new GBV cases detected in the project period (distinguish: through SRH consultations, other); • 'new' GBV survivors who access the services and are followed-up in the project period; • 'total' GBV survivors followed-up (newly registered and registered before the project) during the project period; • number of consultations for GBV survivors (distinguish: psychological, health, legal, husband/family involvement etc.) during project period. • number of referred cases (distinguish per reason and organization) during project period.

	<p>Clarify baseline and target</p> <p>Include qualitative indicator: <i>Community women and GBV survivors from 15 communities in the ARA report feeling more protected from GBV thanks to the services provided by the project</i></p>
IOV 2. At the end of the project, the improved pilot model of multi sectorial response for providing services to the ARA zones is completely adopted and is working in the 3 centres	OK
IOV 3. At least 3 notes about GBV in Gaza as a contribution to the different reports and documents prepared by the Protection Cluster	OK
R1: Improved the access, and the confidential and multi-sectoral (quality of the) response to GBV in the target communities.	
IOV.R1.1. Number of service providers trained for implementing an appropriate and confidential response to GBV.	<p>'Staff' of service providers – should be specified.</p> <p>Distinguish between:</p> <ul style="list-style-type: none"> - number of trainees (each trainee might have received more than one training) - number of training sessions received by each trainee
IOV.R.1.2. At the end of the project, at least 75% of the trained staff have improved substantially their capacities to supply services according to the established protocol	<p>Distinguish between:</p> <ul style="list-style-type: none"> - immediate learning, measurable through pre and post results. A uniform system should be elaborated for measuring improvement in pre/post tests. - change in skills and practices, measurable by introducing a qualitative Indicator such as: <i>At the end of the project, the majority of the staff are able to make examples of how substantially their capacities to supply services according to the established protocol have improved</i>
IOV.R.1.3. At the end of the project, the 70% of women - that have participated in the awareness and detection sessions in the target communities - know and also have the access to the available response services	<p>Replace with more qualitative Indicator: <i>The majority of community women who took part into awareness and detection sessions in the ARA, report that they feeling more able to access GBV protection services and explain why.</i></p>
R2: Men and women from 15 ARA communities are aware of GBV as an issue of protection.	
IOV.R.2.1. At the end of the project, at least 30% of women, men and children from the vulnerable communities have participated in the awareness sessions and have increased their knowledge about GBV	<p>Replace with more qualitative Indicator: <i>The majority of community women who took part into awareness and detection sessions in the ARA, report that their knowledge about GBV has increased.</i></p>
IOV.R.2.2 At the end of the project, 30% of the community based organizations have improved their knowledge about GBV, and they have participated in the awareness organized campaign and actions	<p>'Staff' of community based organizations – should be specified.</p> <p>Distinguish among:</p> <ul style="list-style-type: none"> - number of CBOs - total number of trainees - and number of trainees per CBO - number of trainings/training sessions - number of trainings/training sessions received by each trainee <p>For increased knowledge, distinguish between:</p> <ul style="list-style-type: none"> - immediate learning, measurable through pre and post

	<p>results. A uniform system should be elaborated for measuring improvement in pre/post tests.</p> <ul style="list-style-type: none"> - change in skills and practices, measurable by introducing a qualitative Indicator such as: <i>At the end of the project, the majority of the CBOs members report that their knowledge about GBV has increased and that they actively took part in awareness/advocacy campaign on GBV</i>
<i>IOV.R.2.3. At the end of the project, at least 40% of the community representatives (leaders) target are aware of the risks of GBV already identified by the community.</i>	OK
R3: Implemented the system to collect information about GBV in order to have an impact at the national/international level.	
<i>IOV.R.3.1. The 3 UHWC and CFTA centers have in place a system to collect information in a homogenous and confidential way, following international standards.</i>	OK.
<i>IOV.R.3.2. At the end of the project, at least 2 products (position and informed notes) have been elaborated jointly and spread into the community.</i>	OK. But one might want to add a further Indicator: <i>Data collected through M&E system is analysed and utilized in advocacy activities nationally (and internationally)</i>

Chapter 5) CONCLUSIONS AND RECOMMENDATIONS

The main findings of the evaluation are:

Relevance: The project is relevant to all its main stakeholders: it responds to the needs of GBV survivors, and community women and men affected by the humanitarian crisis in Gaza, as identified by themselves and also by main reports and studies on GBV in Gaza and it is aligned to partners' interests and strategic plans

Effectiveness: Overall the project succeeded in achieving the expected outcomes and Alianza and partners were successfully able to manage the obstacles met during implementation. In particular:

- *Specific Objective: Protection of 15 communities in the ARA ("Access Restricted Areas") of Gaza Strip by providing response services to the Gender Based Violence (GBV) was also achieved. By the end of the project the improved pilot model of multi-sectoral response was completely adopted in the 3 centres. An increased number of GBV cases were detected and followed-up through improved GBV response service. Overall, beneficiaries felt more protected thanks to the availability of the GBV protection services. However, many of them signalled that only reaching economic independence they would be able to leave abusive situations. Finally, thanks to partners' advocacy activities within the Protection Cluster, the project managed to engage other Gaza health providers, including the MoH, MoSA and MoWA, in the discussion about GBV services.*
-
- *Result 1 - Improved the access, and the confidential and multi-sectoral (quality of the) response to GBV in the target communities was achieved thanks to a) the elaboration, piloting and adoption of GBV Case Management SOPs; b) capacity building to Case Management staff; c) equipment, disposable and medication for the health centres. GBV survivors reported satisfaction about the quality of the GBV services received.*
- *Result 2 - Men and women from 15 ARA communities are aware of GBV as an issue of protection was also achieved, especially in the case of community women and CBOs. The*

project provided information about GBV services to about 50% of the total population of the 15 targeted ARA. Fewer men took part into awareness activities, and there were difficulties with Mukhtars. Youth community leaders, nevertheless, seem to be very promising and worth focusing on in future projects. Overall, all the participants to the awareness sessions reported being more aware about GBV and the existence of GBV services.

- *Result 3 - Implemented the system to collect information about GBV in order to have an impact at the national/international level*, has been met as a homogenous system of data collection was developed in a participatory way by CFTA and UHWC staff and NRC experts (GBVIMS - including forms for data collection and related SOPs for confidentiality etc., in line with international standards). Through data collected, Alianza and partners, were able to feed into data by the Protection Cluster on GBV services in Palestine and provide important technical advice on the overall GBV information system for the oPt. In addition, the project has produced a GBV Risk Assessment for six specific areas, which has generated 2 related advocacy fact-sheets on GBV in North and Middle Gaza Strip.

Efficiency: Overall the project was soundly managed from a financial point of view. The ‘support’ costs, sustained by Alianza during the project period, only 18% of the total expenditure (which is very reasonable amount) vs. 82% spent directly on the project; expenditure is distributed proportionally to the needs and tasks of each local partner and proportionally to the importance and the needs of the different Results. The cost per beneficiary, whether calculated in terms of service availability, GBV survivors follow-up, outreach and advocacy activities, seems reasonable, but it is not possible to compare them with similar costs sustained for similar activities by other organizations.

Furthermore, AECID funding allowed to cover a variety of costs – from transportation costs for GBV survivors, outreach activities and home-visits, staff and capacity building for staff, provision of technical expertise – which together with Alianza’s strong supervision and coordination role, created the conditions for the creation of high quality ‘one-stop’ multi-sectoral GBV response services, while making them known and accessible within the ARA communities, and at the same advocating for the expansion of similar services within the Gaza Strip and the oPt.

Alignment: The project is aligned with international and national instruments for prevention of GBV, in particular with the Inter Agency Standing Committee, Guidelines for GBV in Humanitarian Action 2015 and with the PNA’s ‘National Strategy to Combat Violence Against Women 2011-2019’.

Consistency: The different project activities and strategies of the project successfully complemented each other. Gender equality and HR principles were mainstreamed in training and awareness activities and materials. Awareness sessions and advocacy actions strongly contributed to link GBV survivors, community women and men to the GBV response services. Mechanisms for coordination and exchange among project partners, and with other stakeholders (Protection Cluster), were clear and effective; overall partners, believed that this was one of the most successful aspect of the project.

Appropriation/Ownership: All partners took actively part in the design of the project and of project activities during all the phases of the project, also thanks to Alianza’s coordination role. Overall, partners – especially at field level - showed a strong ownership for the multi-sectoral approach to GBV services piloted in the project. The SOPs for the Health Centres’ GBV services were actively prepared and piloted by UHWC and CFTA’s staff and adopted within the clinics. As already mentioned, all partners considered this a very positive aspect of this project.

Connectivity (Link Relief to Development/Sustainability): The connection between relief and development (see Chapter 2), together with social and cultural sustainability, and institutional and financial sustainability, has been highly taken into consideration by Alianza and partners when designing the project. Cultural and social sustainability were guaranteed by all partners by building a maintaining communication channels and relations of trust with the targeted communities.

Nevertheless, one of the partners, UHWC, was not been able to identify effective strategies to guarantee institutional and financial sustainability.

It needs to be added that, at times, donors also contribute to this situation by: a) not always prioritizing GBV in their humanitarian strategies (AECID is an exception in this regard); b) by funding, in humanitarian contexts, only short-term projects, which do not always take into consideration the roots and the long-term consequences of a humanitarian crisis as the one in Gaza.

Participation: Overall, the project was managed with the strong involvement of the beneficiaries and of other Gaza and international stakeholders (Protection Cluster). Beneficiaries' views were taken into consideration took in consideration through the partners and their field team in charge of the provision of services. Furthermore, they had a substantial say especially on issues such as the choice of the topics for the awareness sessions or in planning of recreational activities. The cooperation that Alianza and partners established with the Protection Cluster was quite intense, and lead to the finalization of the SOPs which are ready to be adopted by all the organizations involved.

Coverage: The outreach of the most vulnerable women living in remote areas of the Gaza Strip, was a priority within this project. The main physical and financial obstacles preventing women to reach GBV services were analysed and tackled through specific outreach measure such as home-visits, including awareness and detection sessions during home-visits, and reimbursement of transportation costs to reach the health centre. Social and cultural obstacles were tackled thanks to the provision of multi-sectoral services that guarantee confidentiality to women.

Theory Of Change: The project did not make explicit its Theory of Change nor it was supported by a robust project Risk Analysis. However the 'implicit' ToC was coherent and realistic and the obstacles met during project implementation were properly managed.

Measurability: The Indicators, the data collected and the reporting (within AECID Excel format) were overall good, but some aspects of the Monitoring and reporting system could be improved.

The main recommendations emerging from this evaluation are:

On the basis of our findings, the overall main recommendation is that of continuing the delivery of GBV services, through 'one-stop-centres' within health facilities, considered a privileged entry point for GBV survivors, and whenever possible to extend the model to other health facilities, as this type of services are extremely **relevant** to the needs of the female – and male – population in the Gaza Strip. It should also be explored the possibility of **targeting** women in cities, as they might be suffering from more isolation than women in marginalized rural areas.

Furthermore, it is recommended to continue adopting implementation strategies which have proved extremely successful with various project stakeholders, such as **outreach measures** for vulnerable beneficiaries, especially GBV survivors, **participatory trainings and coaching** with GBV response services' staff and **engagement with other national and international stakeholders** within the Protection Cluster.

The project was **efficiently** managed, but, in the future, it would be interesting to collect information about costs sustained by other organizations for the same services (service availability, GBV survivors follow-up, outreach and advocacy activities). This activity could be for example carried out within the Protection Cluster, so to have a shared baseline for the cost of this type of services.

In order to increase effectiveness of the services for GBV survivors, the inclusion of **income generating activities and cash assistance** should also be considered (as actually Alianza is doing in the currently implemented project). While doing so, it should also be considered that loans are risky

because women are not strong enough to return them), to be able to support women in leaving abusive situations.

In order to increase and maintain the **capacity of the staff**, and thus the quality of the GBV response services, yearly refresher trainings and coaching to Case Management staff in the health centres and continue exchange/learning occasions for them should be provided.

As we discussed, one of the major downfalls of the project, was the discontinuation of UHWC 'one-stop-centres' and the loss of the majority of the involved staff. This impacted on **effectiveness, on ownership, and on connectivity (linking relief to development/sustainability)**. To obviate to this in future projects it is recommended:

- that partners identify a fundraising strategy able to render GBV services sustainable - and to recover as soon as possible and maintain in place the GBV services suspended by UHWC
- that the donor community will consider: a) prioritizing GBV in their humanitarian strategies and b) incorporating, in their humanitarian funding strategy for Gaza, also longer-term projects able to respond to the chronic character of Gaza humanitarian crisis.

It is strongly advised to introduce **ToC and Risk Analysis** as planning and monitoring tools in future projects. The monitoring and reporting system could also be improved by being more specific and appropriate about the relation between Indicators and outcomes, by being more precise in terms of beneficiaries (new and 'old' GBV survivors, trainees and beneficiaries of awareness sessions etc.) by introducing more qualitative indicators and by improving measurement of increased knowledge and improved skills and practices.

ANNEXES

- ANNEX 1 – TOR
- ANNEX 2 - EVALUATION MATRIX
- ANNEX 3 – LIST OF CONSULTED DOCUMENTS
- ANNEX 4 – QUESTIONNAIRES MATRIXES
- ANNEX 5 – EFFICIENCY ANALYSIS