GENDER BASED VIOLENCE (GBV) COORDINATION IN EMERGENCIES

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Declaration

I, Philomena Raftery, confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

Signed: 

Date: 25/04/2023

ABSTRACT

BACKGROUND

Considered a global health crisis and human rights violation, addressing GBV remains a fundamental challenge in emergencies. GBV coordination is an essential element of every emergency response, ensuring that survivors have access to safe services and prevention and mitigation actions reduce GBV. As global commitment to addressing GBV intensifies, this thesis explored what influences effective GBV coordination during emergencies, to identify opportunities for strengthening systems in protracted and complex crises, using Lebanon as a case study.

METHODS

I conducted a qualitative study using a scoping review, remote in-depth interviews (38), document review, and meeting observations (7). Data collection with stakeholders involved in Lebanon's response (2012-2022), spanned a two-year period (Oct 2019 - May 2022) and was analysed using framework analysis.

FINDINGS

Findings are presented in three manuscripts which build on each other. A scoping review of GBV coordination in emergencies, summarises the global literature and presents an evidence informed framework for effective GBV coordination. Despite enhanced global commitments in recent years, findings indicate that GBV remains under-resourced with minimal progress on localization. GBV risk mitigation was compromised by weak accountability systems, and GBV prevention frequently deprioritised in emergencies. The second manuscript illustrates how the protracted emergency in Lebanon was a transformative force for GBV, promoting the establishment and expansion of GBV coordination and services nationwide. However, over-reliance on international leadership and funding, alongside limited government commitments to institutionalising systems, compromised sustainability. Findings emphasise the importance of dedicated, experienced coordinators who promote trust and collaboration with notable successes in advancing localization through mutually beneficial partnerships. GBV information management systems strengthened coordination, supporting funding mobilization and service delivery. The third manuscript examines Lebanon's compounded crises from 2019-2022 and underscores the need to adapt coordination efforts to evolving contexts and to promote a government-led response. Findings reveal that GBV coordination adapted well to the changing context, but service delivery by local actors was challenged by the multiple crises, and the expanding vulnerable populations required increased, multiyear funding.

CONCLUSION

As the first of its kind, this study contributes to the evidence-base on GBV coordination, distilling several transferrable lessons. Findings demonstrate that effective coordination ensures GBV is

adequately addressed in emergencies, improving emergency responses for women and girls. Recommendations to strengthen GBV coordination include funding and deploying dedicated GBV coordinators across all types of emergencies, and investing in GBV risk mitigation, data management systems, localization and prevention, through multiyear funding. Furthermore, the study highlights the need for dedicated attention to GBV coordination in public health emergencies.

DRPH INTEGRATING STATEMENT

Since I began my Doctorate of Public Health (DrPH) in October 2016, I have broadened my knowledge, understanding and expertise in global health and have matured as a global health professional, researcher and policy advisor. When I embarked upon this DrPH journey, I had experience in the area of microbiology and biomedical science research and in the implementation of public health systems in low-income countries but did not have the theoretical or practical knowledge or skills to design and conduct qualitative research. I also did not fully appreciate the importance of evidence-based global health policy or the process by which research can influence policy, nor did I have significant training in leadership and management as a public health practitioner. Upon finalising my Doctorate, I am certainly better equipped to assume management and leadership roles in global health organizations, to critically appraise, design and execute research studies and to use research to inform public health policy. I have also developed expertise and knowledge in a new technical area, GBV coordination, which has become a new passion for me.

For the initial three months of my DrPH, I studied full-time in London to undertake the two mandatory courses, Understanding Leadership and Management in Organizations (ULMO) and Evidence-Based Policy and Practice (EBPHP). The ULMO course gave me an understanding of strategic and change management, as well as leadership and decision making in organizations. Through the ULMO course, I learned how to conduct a strategic analysis of an organization, using a variety of tools which I had the opportunity to apply in the course assignment (which I conducted on the World Health Organization (WHO) country office, Liberia, post-Ebola) and in several strategic planning exercises which I have led or contributed to in my work with WHO since. The EBPHP course helped me to understand the relationship between research, policy and practice. I learned how to critically evaluate public health studies, to conduct a systematic review, and to write policy briefs based on evidence. I have used these skills several times since, in my academic research, consultancy work with the international diagnostic centre at LSHTM and in my professional career with WHO. I addition, I employed the skills I learned conducting the systematic review, to systematically search, organize and extract data and critically evaluate papers for my thesis scoping review and in my Organizational Policy Analysis (OPA) literature review.

The ULMO and EBPHP courses prepared me with the skills and tools I needed to complete my OPA, which I conducted at the UK Public Health rapid support team (UK-PHRST) entitled: *"An arranged marriage: Exploration of the partnership functioning and collaborative advantage of the UK-PHRST"* (1). For my OPA, I explored the partnership functioning of the UK-PHRST, analysing how it impacted

delivery of the organizational objectives. The UK-PHRST is a partnership between Public Health England and an academic consortium, led by LSHTM, which was established in the aftermath of the 2013-16 Ebola epidemic, to address critical gaps in outbreak response, operational research, and capacity building, illuminated during the epidemic. My study explored the design, establishment and early experiences of the UK-PHRST as one of the first bodies of its kind globally, examining key governance decisions which enabled them to address their complex mission. I employed a qualitative approach and constructed a conceptual framework to gather and analyse data. I utilised several tools from the ULMO module to design data collection tools, and to analyse data, including stakeholder analysis and SWOT analysis which allowed me to situate the UK-PHRST within the broader policy context of global outbreak preparedness and response. Following completion of the OPA, I also developed two manuscripts which have been published in peer-reviewed journals and presented the findings at two global health conferences in 2021. I immensely enjoyed conducting the research for my OPA and am very proud of the two publications which emerged from the report published in 2021 (available at: https://rdcu.be/coeYy and https://doi.org/10.1093/heapol/czab150) (2, 3). Because I had been working with WHO during the Ebola response in Liberia, and this was my area of technical expertise, I already had a broad understanding of outbreak responses which I believe helped me to build rapport with my interview informants, encouraging openness. This was my first experience of conducting a qualitative study and it taught me the data collection and analysis skills which I applied in my thesis. While conducting my OPA, I also enrolled in an array of additional courses available through LSHTM and was grateful to be based in London during that time, where I could conduct interviews in-person, while continuing my learning through workshops and lectures.

My DrPH thesis integrated both the coursework learning and the experience I gained through my OPA research. I had initially planned to study laboratory coordination during public health emergencies which would have built upon my professional expertise and been more connected to my OPA topic. However, during my time in London, when I had to opportunity to engage with, and learn from, experts in different areas of Global Health, I could not deny my deepening interested in humanitarian crisis and Gender based violence (GBV). Therefore, in 2018, I switched thesis topics, departments and supervisors to research GBV in emergencies. This certainly complicated and likely delayed my DrPH journey, but I believe gave me a new skill set and expertise in a different technical area, one that I believe will be important throughout my career. In March 2018, I enrolled in the researching GBV short course at LSHTM and participated in the GBViE course in July 2019 which helped me to design my study. On first glance, the thesis topic was essentially different from the

OPA with the only link being study design and data collection and analysis methods. However, I found that many themes important for partnerships in outbreak responses were also relevant for GBV coordination in emergencies. I also saw many parallels between my work with WHO on outbreak response and GBV coordination in emergencies. I believe that understanding the factors that influence effective coordination is important to build strong coordination systems in challenging and complex emergency setting, regardless of the technical area, and I am already utilising some of the learnings from my thesis in my professional work. Furthermore, the thesis component of my DrPH programme required me to design from scratch and conduct a research study in a technical area and context I did not have previous knowledge or experience, which was both challenging and rewarding in equal measure.

In summary, this thesis consolidates and galvanises the knowledge and learning I have acquired throughout my DrPH journey. During each stage, I integrated and built upon what I had learned in the previous stage and also incorporated the experience I was gaining in my professional career. While completing this programme as a part-time student while working full-time was immensely challenging at times, I believe that it greatly contributed to my development as a global health professional. I was able to learn the theory of leadership, management, and public health policy through the programme and my research, while simultaneously applying it in my real-life profession as a global health expert working with WHO. Coming from a biomedical science background I have come to appreciate the importance of qualitative research to inform public health policy and practice. I have integrated these competencies into my skill set as a global health professional which I will draw on throughout my professional career. My experience also taught me to construct conceptual frameworks, and to refine research findings into publishable manuscripts, critical skills for a global health professional. I am confident that I have created a portfolio of work that successfully integrates research, public health policy and leadership, three components that are essential in my professional career as a global health practitioner. Finally, during this journey, I had the privilege of collaborating with experts in the fields of humanitarian and public health emergency responses who will continue to inspire and support me as I embark on my next steps in my professional career.

ACKNOWLEDGMENTS

There are many people who have guided and supported me throughout this DrPH journey.

Firstly, this thesis is dedicated to all the GBV experts and humanitarians in Lebanon and beyond who contributed to this research. They have deepened my admiration for women's strength in the face of adversity, demonstrated the importance of upholding human rights regardless of the circumstances, and heightened my commitment to our collective endeavour for gender equality. I am deeply appreciative to the GBV coordination task force in Lebanon, particularly Erica Talentino, UNFPA GBV Coordinator and Afaf Khalil, MOSA Protection coordinator, for their support for this project, their guidance on refining the objectives and insightful input and feedback on the findings. I offer my sincere gratitude to all the informants who participated in the study. Individuals with extremely busy schedules took the time to be interviewed and contribute their views and perspectives while dealing with multiple challenges in their personal and professional lives. I hope this thesis does justice to the richness of the experiences they shared and that the findings will provide something valuable and beneficial in return.

I extend my sincerest gratitude to my team of distinguished supervisors and advisors for their guidance throughout my DrPH journey. I was fortunate to have had the support of three supervisors over the course of my DrPH thesis, each of which provided unique, complementary, perspectives which have shaped this thesis and have been an invaluable support. In particular Jennifer Palmer and Mazeda Hossain from whom I learned a huge amount through their mentorship and guidance during conceptualisation of the study and throughout data collection, analysis and writing. From the first conversation I had with Mazeda, she was supportive of my switch to this topic for my thesis and guided me through my DrPH review. I am grateful for her encouragement without which I may have gone down a very different path. Jen's discerning coaching and insightful feedback left a great impression on me, and I believe it has helped me become a better researcher and writer. She motivated me to constantly strive for a deeper understanding of the data and to position my findings within the broader study context, abilities that will prove invaluable in my future profession. A particular thanks to Ligia Kiss, who stepped in as my lead supervisor while Jen was on maternity leave and guided me across the finish line with her positive encouragement and thoughtful feedback.

A very special thanks to Jinan Usta who acted as my collaborator in Lebanon and supported me to obtain local ethics approval. I had the pleasure to meet Jinan in Lebanon in 2022 and to get a tour of

the amazing and historical AUB grounds. Jinan helped to deepen my knowledge of the Lebanese context and the challenges the Lebanese population have been facing and I greatly value her insightful feedback on my case study findings.

I would also like to thank my advisory team of Natasha Howard and Diane Duclos. Natasha provided invaluable guidance during writing of the scoping review for which I remain very grateful. I am thankful to Diane who provided helpful feedback at various stages of this process including on the original thesis proposal and methods chapter.

Throughout my DrPH journey, I greatly appreciated and relied on the camaraderie and diverse knowledge of my DrPH cohort. I learned as much from my classmates in our discussions and experience sharing as I did from our lecturers. They provided many useful words of wisdom, shared challenges and solutions and were always there to celebrate successes via whattsapp messages or in-person catch-ups when we found ourselves in the same location. Based on their calibre, I believe we can be optimistic about the future of global health. They will remain steadfast friends and colleagues throughout my career and life.

Much gratitude to my WHO and partner colleagues who tolerated my busy schedule over the past few years, particularly through the last three extremely busy years of the COVID-19 pandemic. I really appreciate their encouragement and support while I juggled competing priorities of work and DrPH, especially my team in Türkiye since 2021.

Finally, thanks to my family in Ireland, and my wonderful friends all over the world, who encouraged and supported me throughout this journey and, most importantly, readily distracted me with cups of tea and glasses of wine when needed. I am very grateful to have such wonderful people in my life.

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LIST OF ACRONYMS AND ABBREVIATIONS

AoR	Area of Responsibility
AUB	American University Beirut
CEDAW	Convention on the Elimination of all Forms of Discrimination Against Women
CMR	Clinical Management of Rape
CSO	Civil Society Organizations
Call to Action	Call to Action on Protection from GBV in Emergencies
DRC	Danish Refugee Council
ERP	Emergency response plan
GBV	Gender Based Violence
GBViE	Gender-based violence (in emergencies)
GBVIMS	Gender Based Violence Information Management System
IASC	Inter-Agency Standing Committee
ICC	Inter-Cluster Coordination
IDP	Internally displaced person
IMC	International Medical Corps
INGO	International non-governmental organization
IPV	Intimate Partner Violence
IRC	International Rescue Committee
ITS	Informal Tented Settlement
LAF	Lebanese Armed Forces
LAU/AIW	Lebanese American University / The Arab Institute for Women
LCRP	Lebanon Country Response Plan
LGBTIQ+	Lesbian, gay, bisexual, transgender, intersex, queer, +
MHPSS	Mental health and psychosocial support
MISP	Minimum Initial Services Package
M&E	Monitoring and Evaluation
MOPH	Ministry of Public Health
MOSA	Ministry of Social Affairs
NCLW	National Commission for Lebanese Women
NGO	Non-governmental organization
PEP	Post-exposure prophylaxis
PSEA	Protection from Sexual Exploitation and Abuse
PSS	Psycho-Social Support

PRIMERO	Protection Related Information Management System
RRP	Refugee response plan
SDC	Social Development Centre
SOPs	Standard Operating Procedures
UN	United Nations
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UN OCHA	United Nations Office for the Coordination of Humanitarian Affairs
VASYR	Vulnerability Assessment of Syrian Refugees
WGSS	Women and girls safe space(s)
WFP	World Food Programme
WHO	World Health Organization
WRC	Women's Refugee Commission

CHAPTER 1: INTRODUCTION TO THE THESIS

In this introductory chapter I introduce the research topic, outline the research rationale and guiding framework, aims and objectives, explain the study timeline and funding and discuss my motivation for undertaking the research. I end the chapter by briefly describing the thesis overview.

GBV IN HUMANITARIAN AND PUBLIC HEALTH EMERGENCIES

Gender-based violence (GBV) is a widespread human rights violation with serious public health, social and economic consequences for countries and societies, which is insufficiently addressed in many contexts (4). GBV is rooted in systematic gender inequality, and is exacerbated by patriarchal and socio-cultural norms, or discriminatory laws, that undermine women's rights (4, 5). The Inter-Agency Standing Committee (IASC) defines GBV as "an umbrella term for any harmful act that is perpetrated against a person's will, and that is based on socially ascribed (gender) differences between males and females" (6) (p.5). GBV is generally divided across four domains – sexual, physical, emotional and psychological, and economic violence. In emergencies, GBV can take many forms including sexual abuse or harassment, intimate partner violence (IPV), trafficking, forced/early marriage, and harmful traditional practices such as female genital mutilation (FGM), honour killings and widow inheritance, among others (7, 8). While GBV can affect all genders, globally women and girls are disproportionately affected and are the focus of this research. In this study, GBV is synonymous with the term violence against women and girls (VAWG) and sexual and gender-based violence (SGBV). I did not include protection from sexual exploitation and abuse (PSEA) in this study, as this is a unique area of work dealing with the exploitation of affected populations by humanitarian responders and while often linked with GBV, requires a different focus.

Globally, one in every three women is believed to have experienced physical and/or sexual IPV or non-partner sexual violence in their lifetime (9, 10). Intimate partner violence accounts for up to 38% of all female murders, while non-partner sexual violence is reported by 6% of women (9, 11). Situations of displacement, humanitarian and public health emergencies create environments which can intensify GBV risk, and compromise family and societal protection systems (12). Still, GBV remains systematically under-reported in all contexts, due to various factors including stigma and shame faced by survivors; risks of retaliation, such as femicide including honour killing; further violence and harm to survivors and their loved ones; and shortages or lack of trust in quality, survivor centred services (11, 13, 14). The prevalence of GBV in conflict and humanitarian settings is poorly understood, and prevalence data are difficult to collect during emergencies (15, 16). Vu et al. estimate that one in five refugee or displaced women have experienced sexual violence (17). In

camps for displaced people, existing data suggests that IPV is more prevalent than non-partner sexual assault and sexual violence is frequently employed as a tactic of war (8, 18-20). For example, a study in war-torn South Sudan, demonstrated that 50-65% of women had experienced either physical or sexual violence from a partner or non-partner in their lifetimes, while one third of women had been sexually assaulted by someone other than a partner (21). At least half of women and girls living in camps had experienced IPV and outside of camp settings that rose to 60-75% (21). Additionally, during public health emergencies, such as the COVID-19 pandemic, GBV-related risks can increase, including IPV, child marriage, and exploitation (22-25). Where decreased rates were noted during the COVID-19 pandemic, this was attributed to underreporting, as survivors are unable to report or seek help during lockdowns (26). In some studies, increased severity or new types of IPV were also noted, such as cyberviolence and online harassment (26).

As a global health issue, GBV can have severe and long-term consequences on the health and psychological well-being of survivors (7). The consequences for women who have experienced IPV are wide ranging. These include physical injuries, depression, alcohol use disorders, miscarriage, abortion, preterm birth, sexually transmitted infections, and increased risk of acquiring HIV. Specifically, 42% of IPV survivors report physical injury, while the likelihood of depression and alcohol use disorders is doubled (9). Moreover, the risk of miscarriage is 16% higher, and the probability of having an abortion is twice as high compared to those who have not experienced IPV. Additionally, survivors of IPV are 41% more likely to have a preterm birth and 1.5 times more likely to have a sexually transmitted infection (9). Finally, in some contexts, they face an increased risk of HIV acquisition (9). Survivors of sexual violence can be disowned by their families, and in some societies, forced to marry their perpetrators (27).

Emergencies and humanitarian settings can also perpetuate negative coping mechanisms such as forced/child marriage and economic violence through denial of basic resources (28). Forced or child marriage is a violation of human rights that encompasses any type of marriage, either formal or informal, in which one or both parties involved are under the age of 18 and/or did not provide free and full consent (29). The consequences of child marriage can be serious, including increased risk of IPV and high risk for complicated pregnancies and deliveries as well as neonatal death and stillbirth (29). Furthermore, it can remove girls from formal education systems, compromising their future potential (29, 30).

STUDY RATIONALE AND GUIDING FRAMEWORK

Despite increased GBV risks in emergencies, addressing GBV is not always prioritized in responses, which requires a range of actors working together on GBV response, risk mitigation and prevention programming (31). GBV response refers to the provision of life-saving services for survivors following exposure to GBV; GBV risk mitigation involves a range of activities that identify GBV risks across all sectors of a humanitarian response and implement actions to reduce those risks and; GBV prevention includes tailored programming that prevents GBV from occurring in a particular setting (32). Therefore, GBV coordination is essential to ensure that adequate and appropriate GBV services are available and accessible to survivors, and that women and girls are protected from GBV (33). International GBV stakeholders have emphasised the critical need for coordinated action to address GBV, both internationally, and at country level (4, 12, 34, 35). In the foreword of the GBV coordination handbook (2019) Dr. Natalia Kanem, Executive Director of the United Nations population fund (UNFPA), describes why GBV coordination matters: "*The protection and safety of women and girls can be achieved only through coordinated, collective and sustained action. . . Only through effective coordination can we bridge any gaps, address persistent challenges and make progress against common objectives. . . Now, more than ever, we must strengthen our knowledge and skills for GBV coordination.*" pvii (33).

Despite the growing body of evidence on what works to respond to and prevent GBV in emergencies (16, 21, 36), although GBV coordination is recognised as a vital to addressing GBV, it is rarely researched. My hypothesis was that by investigating the coordination of GBV during an emergency response, I could analyse the factors that impact effective coordination, thus enhancing our comprehension of this issue, which can subsequently be utilized to improve GBV coordination across all categories of emergencies. This research aimed to contribute to the limited evidence base on GBV coordination in emergencies and Figure 1 below presents the thesis guiding conceptual framework.

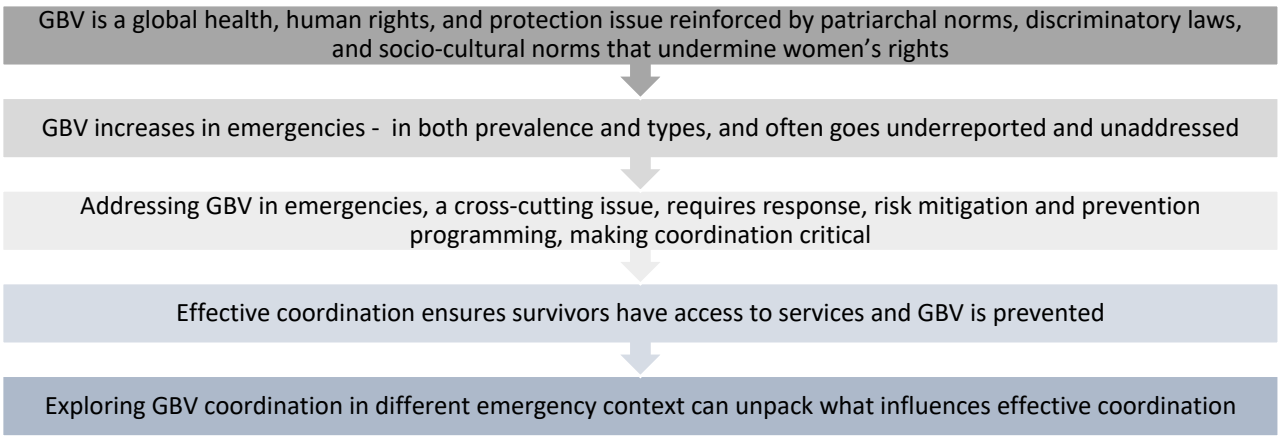

Figure 1: Thesis guiding conceptual framework and hypothesis.

Research aim and objectives

Aim

This thesis aims to explore what influences effective GBV coordination during emergencies and to identify opportunities for strengthening GBV coordination in these settings, using Lebanon's protracted and complex crises as a case study.

Objectives

1. To review, summarise and synthesize the evidence on GBV coordination in humanitarian and public health emergencies and identify facilitators and barriers influencing its effectiveness.
2. To explore the evolution of GBV coordination in Lebanon's humanitarian response throughout the protracted crisis from 2012-2022.
3. To examine the effectiveness of GBV coordination in the context of Lebanon's compounded emergencies from 2019-2022 and explore its future direction.

Study design

As a Doctorate of Public Health (DrPH) thesis, this study seeks to advance academic knowledge and produce practical lessons for global health policy and practice. I present a summary of the objectives, research questions, corresponding data collection methods and sampling strategies, below in Table 1 and detailed methods are presented in chapter 4.

This thesis took a qualitative approach to answering the objectives, with the main methods employed being a scoping review, in-depth interviews, document review and observations. I chose qualitative methods as they allowed me to engage more deeply with the topic, and for policy-relevant findings and reflections to emerge. Qualitative methods helped to unravel experiences, perceptions, and practices of the study participants, addressing the how, what and why different aspects of coordination were important for addressing GBV in emergencies (37-39). Qualitative research is particularly suitable for studying emergency responses, which are inherently complex situations that involve multiple actors, systems, contexts, and populations. This approach allows for a comprehensive exploration of the perspectives and experiences of those involved. By examining how different stakeholders interpret and experience the same events, qualitative research can help to uncover the reasons for conflicting views (40). By employing a qualitative approach, examples of good practice and recommendations for future actions emerged, allowing the final product of the research to be practical, as a DrPH thesis is intended to be.

I began the study with a scoping review of the available literature, through which I developed and presented an evidence-based framework for effective GBV coordination, identified facilitators and barriers to effective GBV coordination and made a series of recommendations to strengthen GBV coordination in emergencies. I continued with a qualitative case study of GBV coordination in Lebanon's complex humanitarian emergency. Case studies involve researching a phenomenon within its context and typically comprise a combination of data collection methods such as interviews, observations and document analysis (39). I applied the framework for effective GBV coordination, developed in my scoping review, to highlight key findings which influenced the effectiveness of GBV coordination throughout the 10-year Syrian refugee crisis response in Lebanon. I then delved deeper into GBV coordination in Lebanon's compounded crises, including the COVID-19 public health emergency and the national economic emergency, highlighting transferrable lessons applicable in complex humanitarian settings, which can inform policy and practice.

Study Write-Up and Dissemination of findings

In addition to this LSHTM DrPH thesis document, I submitted three peer-reviewed articles from my research to address each of my objectives and to ensure that the findings are made available and disseminated to the broader humanitarian and academic community. The first, which was published in June 2022, was the scoping literature review on GBV coordination in humanitarian and public health emergencies, which was well received by the GBV community globally (available at: https://conflictandhealth.biomedcentral.com/articles/10.1186/s13031-022-00471-z). The second and third papers of my thesis present the findings and recommendations stemming from my research conducted in Lebanon, which are consistent with objectives 2 and 3. Objective 2 delved into the development of GBV coordination within Lebanon's humanitarian response during the extended crisis from 2012-2022. Meanwhile, objective 3 scrutinized the efficiency of GBV coordination in the midst of Lebanon's compounded emergencies from 2019-2022. These were submitted to open access journals in November 2022 and were still under review in April 2023. All published work will be shared with participants of the research study, the GBV coordination taskforce in Lebanon, the GBV community of practice and my networks for broader dissemination. I will also develop policy briefs for key stakeholders based on the findings, which can be disseminated by the GBV task force and humanitarian actors in Lebanon. Additionally, I have already presented preliminary findings of this study at the doctoral workshop of the SOLIWAY (Solidarite internationale mode d'emploi(s)) global conference in November 2021, the LSHTM 16-days of activism in December 2021, and at a monthly GBV task force meeting in July 2022. I plan to present my findings at relevant conferences and GBV forums internationally in 2023.

Table 1: Overview of study objectives, research questions, data collection methods, and sampling strategy

OBJECTIVE	RESEARCH QUESTIONS	DATA COLLECTION METHODS	SAMPLING STRATEGY
1. To review, summarise and synthesize the evidence on GBV coordination in humanitarian and public health emergencies and identify facilitators and barriers influencing its effectiveness	a) What evidence exists on GBV coordination in humanitarian and public health emergencies? b) What are the facilitators and barriers influencing the effectiveness of GBV coordination? c) What themes are important to design a conceptual framework to understand and analyse GBV coordination?	Scoping literature review	Peer reviewed literature, organizational evaluations and reports and grey literature
2. To explore the evolution of GBV coordination in Lebanon's humanitarian response throughout the protracted crisis from 2012-2022, using a case study	a) Describe and map the evolution of GBV coordination under the humanitarian response in Lebanon using the six themes outlined in the framework for effective coordination. b) What were the key milestones, events and innovations influencing GBV coordination and in the broader policy context as the situation evolved through the protracted crisis? c) How did GBV coordination influence service delivery at field-level? d) What were the facilitators and barriers to effective GBV coordination in Lebanon? e) What lessons and recommendations can be extracted to strengthen GBV coordination across emergency settings?	Remote In-depth Interviews (IDI) Document Review	Purposeful sampling for IDIs IDIs included GBV coordinators & experts at Global, National and Field level, humanitarian staff from other sectors and Government
3. To examine the effectiveness of GBV coordination in the context of Lebanon's compounded emergencies from 2019-2022 and explore its future direction	a) How have the compounded crises in Lebanon impacted the effectiveness of coordination architecture? b) How did the GBV task force adapt to the multiple layers of crises, including the 2019 social and political unrest, the COVID-19 pandemic and the national economic emergency? c) How have the compounded crises affected coordination dynamics and legitimacy of different actors, including government, donors and national and local actors? d) What recommendations can be made on the future direction of coordination in Lebanon? e) What lessons can be applied to GBV coordination in other complex crises?	Remote IDI and group Interviews Document Review Remote meeting observations	Purposeful sampling for IDI's and Group Interviews IDIs and Group IDI's included GBV coordinators & experts at Global, National and Field level, humanitarian staff from other sectors and Government Meeting observation – National GBV task force meetings

Abbreviations: GBV: Gender-Based Violence; IDI: In-Depth Interview

RESEARCHER SELF-POSITIONING AND MOTIVATION FOR UNDERTAKING THE RESEARCH

My educational background and experience is primarily in infectious disease and public health and I have 20 years of experience working in national and international health systems. Since 2015, I have been working with WHO supporting developing countries in Africa, Asia and Europe to respond to outbreaks and to strengthen laboratory systems to respond to public health emergencies. My rationale for pursuing a DrPH, and not a laboratory-based PhD focussing on an infectious diseases, was to gain a broader experience in global health. My experience during various public health emergencies, including the West Africa Ebola epidemic, Tuberculosis, Lassa Fever, Influenza outbreaks, and most recently the COVID-19 pandemic, highlighted to me the critical importance of effective coordination during emergencies. An integral part of my role with WHO is to coordinate strategic partnerships and promote collaboration among diverse stakeholders. I, therefore, recognize coordination as vital for ensuring efficient, effective and sustainable interventions in emergency settings. I believe that understanding and documenting the factors that influence effective coordination is important to build strong coordination systems. In addition, during the Ebola response in Liberia, I was a key stakeholder in the incident management system and it struck me how little attention was given to GBV during coordination meetings and throughout the response in general, despite it being highly conducive context for GBV. I realised the obvious need for better evidence to inform GBV interventions in public health emergencies.

I had initially planned to research laboratory coordination during public health emergencies for my thesis, however, during the first year of my Doctorate (2016-17), which I spent in London, I became increasingly interested in humanitarian crisis and the fundamental challenge of addressing GBV in these settings. Following a meeting hosted by the GBV centre at LSHTM in 2017, I met with one of my current supervisors, and began exploring the possibility of switching my thesis topic to GBV. After several iterations, I arrived at a proposal to explore GBV coordination in Lebanon's humanitarian response and began the arduous but exciting process of switching departments, changing supervisors and deepening my knowledge and expertise on the topic. I believed that studying GBV in humanitarian response would allow me to contribute to this under researched area while broadening my global health knowledge and expertise.

My political motivation for conducting research on GBV coordination in Lebanon's humanitarian response, was rooted in a desire to promote gender equality and human rights globally. I was interested in exploring how GBV is addressed in emergency contexts, particularly in a country like Lebanon where the issue is pervasive. Additionally, I was motivated by a desire to interrogate

patriarchal structures and systems that perpetuate GBV, and to advocate for the empowerment of women and marginalized communities. I am passionate about gender equality, womens leadership and the global struggle against GBV and this research reflects my commitment to promoting social justice and equity, and a recognition of the important role that research and advocacy play in advancing these goals.

In 2018, I participated in the LSHTM short course on “Researching GBV: methods and meaning” which helped me to streamline my thesis proposal. In July 2019, I was privileged to be chosen to participate in the excellent GBV in emergencies (GBViE) course, run by International Medical Corps (IMC), which augmented my knowledge and understanding of addressing GBV and gave me skills which I applied during my thesis data collection. This also gave me a recognised certification in GBViE, helped to build connections and contacts in the area and opened up future opportunities. As a follow up to this course I participated in a Global GBV community of practice, where a huge amount of information, research and expertise is shared amongst GBV coordinators and experts across the world. In addition, I had the opportunity to enrol in a mentorship programme, and because the organisers knew that I was conducting my research in Lebanon, I was matched with the UNFPA GBV coordinator there. This relationship proved to be extremely fortuitous and helpful, as I embarked on the process of data collection in Lebanon. Erica Tolendo, UNFPA GBV coordinator in Lebanon from 2020-2022, was encouraging and supportive of my study and provided opportunities for me to present my research proposal to the GBV task force in Lebanon before commencing data collection. Unfortunately, Erica departed Lebanon just before I travelled there in 2022, so we didn't get the opportunity to meet in person, however we have continued our mentorship relationship.

In addition, because of my thesis research I have become increasingly involved in gender mainstreaming within WHO. I am now an active member of WHO’s global task force for mainstreaming gender in health emergencies. In both Türkiye and Cambodia, I acted as gender focal point for the WHO country office, promoting gender mainstreaming across our work. While I may not fully transition to work solely on GBV, I am quite sure that I will carry this expertise throughout my career and it will serve me in every position that I assume, especially as I progress to management and leadership positions. I believe that having leaders in global health who have expertise in gender and GBV, is critical to ensure that GBV is prioritized and adequately addressed in all emergencies. While WHO have been doing important work on GBV for many years, this has not been well integrated into our work on health emergencies. With that initiation of the global taskforce, this is changing, and I hope to be part of the team catalysing that change. I believe that

my unique combination of expertise in public health emergencies and GBV coordination make me a valuable change agent.

My rationale for choosing Lebanon as my study context was partly ideological and partly practical. For many years the Middle East has fascinated me. I have travelled a lot in the region and spent time in Egypt, Jordan, Palestine, Israel and surrounding countries in my 20s and 30s. Since 2016, I knew that I wanted to do my research on the Syrian crisis response. Lebanon seemed like a good option as it was central to the response, was heavily affected by the crisis. I therefore purposely designed my research with the intention of spending time in Lebanon and learning more about the geopolitics and culture of the region from, at the time, what was a stable country in the region. The more I got to know about Lebanon, the more it fascinated me. The first time I visited Beirut was in 2016 as a tourist and it was a vibrant city. I didn't get a chance to return until 2022 and the change was palatable. While that trip was extremely helpful for me to add depth and context to my research findings, it felt extremely sad to see how the country had deteriorated socially and economically in such a short period. It also reinforced my decision to focus my research on Lebanon and amplified my interest in the country.

While interacting with my research participants, I was aware of my privileged position as an educated, white, Irish woman with the backing of my academic institute and professional experience. As someone who was not viewed as an expert on GBV nor had worked in the Lebanese context before, my position as an "outsider" meant that I did not have a vested interest or agenda, which could have been viewed positively. This may have helped in gaining the trust of my informants as I did not have any affiliation with any organization, allowing for openness and authentic and nuanced responses during interviews. Although I was working with WHO in other contexts throughout the period of data collection, I did not primarily present myself as a WHO or UN staff member when approaching potential participants, rather as a DrPH candidate at LSHTM. In some cases, more frequently when interviewing international UN and INGO staff working on the response, I Informed them of my position with WHO and I believe this may have helped to build rapport and mutual respect in our interactions.

English is my mother tongue and I have intermediate-level French proficiency, but I do not speak Arabic. Since I did not have funding to hire a research team to support data collection, I collected all data in English myself. This limitation likely hindered my access to certain actors at the field level who only spoke Arabic or French, including local and government actors. My introductory emails

inviting people to participate were in English, and the introduction of my research at GBV sub-sector meetings was also conducted in English. I acknowledge that this restricted my ability to reach those who only spoke Arabic or French, such as community organizations, refugee-led organizations, or Syrian refugees working on the response.

Study Timeline

This study spanned several years and took longer to complete than originally anticipated, with both positive and negative consequences. Figure 2 below presents the timeline for my DrPH Thesis. Several reasons explain the delays experienced.

The impact of the 2019 political and social unrest and the COVID-19 pandemic in Lebanon resulted in review of my local ethics application taking over one year, with approval eventually obtained in February 2021. I conceived and designed this study in 2018 and passed my DrPH review in May 2019, after which I received LSHTM ethics approval in September. I began data collection in October 2019, conducting interviews with international GBV experts who had worked in Lebanon throughout the Syria crisis, but were no longer based there. However, data collection stalled in Nov 2019 due to challenges with receiving local ethics approval. I was eventually able to begin data collection in Lebanon in February 2021, the initial phase of which continued until November, followed by a follow-up phase in May 2022, when I had the opportunity to travel to Lebanon.

Additionally, the part-time nature of my studies limited the time I could allocate to my thesis. Since 2018, I have been working full time with the WHO Health emergencies program (WHE) in three different countries, including throughout the COVID-19 pandemic. In early 2020, I moved from Sierra Leone to Cambodia and throughout 2020-21, I played a key coordinating role in the COVID-19 pandemic response which increased my workload significantly, prompting me to take an interruption of studies for several months in 2020.

While these delays were frustrating on several levels there were also some positive repercussions. Because data was collected over a long period of time, and the context in Lebanon changed drastically from 2019 to 2022, I was able to explore GBV coordination within the changing context of the compounded crisis, which is reflected in chapter seven of this thesis.

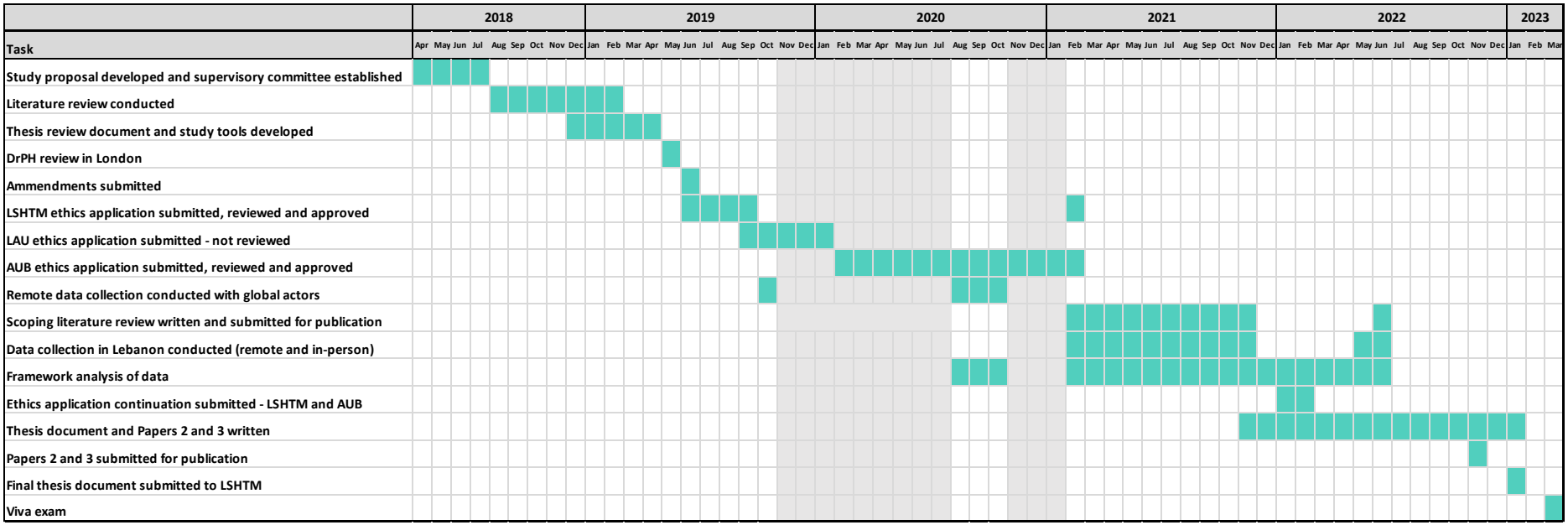

Figure 2: Timeline for DrPH Thesis. The DrPH was completed as a part-time student. The light grey shaded area represents interruption of studies.

STUDY FUNDING

My research was self-directed and mostly self-funded. I was grateful to have been awarded a traveling scholarship (£5,000) from LSHTM to cover some of the costs for my thesis fieldwork. This covered costs for travelling to Lebanon in May 2022 to conduct a data verification meeting and transcription of interviews. The budget for my thesis fieldwork and travelling scholarship is presented in Annex 1.

THESIS OVERVIEW

The thesis is broken into eight chapters. Following this introduction, chapter two locates this research within the broader literature on humanitarian and GBV coordination. It provides an introduction to the humanitarian architecture, and a review of the existing research on humanitarian coordination relevant to this study and introduces GBV coordination in emergencies. Chapter three introduces the case study context, Lebanon. It briefly outlines the history and political context of Lebanon, describes the evolution of the Syrian refugee crisis and the recent compounded crises and introduces GBV in the Lebanese context. Chapter four presents the theoretical and conceptual frameworks grounding the research, the methodology for my primary data collection and analysis, and ethical considerations.

The next three chapters present the study findings. Chapter five presents the first of three results papers, a scoping review of GBV coordination in humanitarian and public health emergencies, which describes advances in the GBV policy context and the overall architecture for GBV coordination in emergencies, summarises the literature and presents an evidence informed framework for effective GBV coordination. Chapter six presents results paper two which explores the evolution of GBV coordination in Lebanon's humanitarian crisis using the framework for effective GBV coordination to analyse and discuss the findings. Chapter seven is the last of the three results papers, which examines GBV coordination in Lebanon's compounded crises and unpacks its future direction.

In the final chapter, I consolidate this thesis, synthesise the main findings and discuss the key contributions of the study. This chapter also reflects on the strengths and limitations of the research and the ethical considerations. Finally, I present the practical and policy contributions of this research along with recommendations for humanitarian practitioners, policy makers and researchers, both in Lebanon and globally

CHAPTER 2: BACKGROUND AND LITERATURE

This chapter sets the scene for the thesis by situating the research within the broader literature on humanitarian coordination. It is divided into three parts.

The first part of the chapter provides an overview of humanitarian coordination. It starts with introducing common definitions of 'humanitarian crises', coordination, and humanitarian coordination and answering what coordination is and why is it important. It goes on to describe the humanitarian architecture, documenting key shifts in the policy context in recent years aiming to make coordination more effective.

Part two presents a brief literature review of existing research on humanitarian coordination which informed this study. Part three focuses on GBV coordination in emergencies. It describes advances in the GBV policy context. A more detailed overview of the architecture and a review of the existing literature on GBV coordination in emergencies will be presented in chapter five, as the first results paper, so will not be covered here.

HUMANITARIAN COORDINATION

WHAT CONSTITUTES AN "EMERGENCY"?

A humanitarian crisis is defined as "*a singular event or a series of events that are threatening in terms of health, safety or well-being of a community or large group of people. It may be an internal or external conflict and usually occurs throughout a large land area*" (41). Humanitarian crises fall broadly into three categories: natural disasters, armed conflicts and disease outbreaks. In this study the term "*emergencies*" covers armed conflict or natural disaster, involving population displacement, and public health emergencies.

Protracted crisis are "*situations in which a significant portion of a population is facing a heightened risk of death, disease, and breakdown of their livelihoods, over a long period of time*" (42). UNHCR defines a protracted refugee situation as one in which "*25,000 or more refugees from the same nationality have been in exile for five consecutive years or more in a given asylum country*" (43). Protracted crises require humanitarian actors to meet both immediate and longer-term needs of populations (42).

Where protracted crises span several years, governments and economies can be weakened causing the development of fragile states and an increase in complex emergencies (44). The Inter-Agency

Standing Committee defines a complex emergency as *"a humanitarian crisis in a country, region or society where there is total or considerable breakdown of authority resulting from internal or external conflict, which requires an international response that goes beyond the mandate or capacity of any single agency, and/or the ongoing United Nations country program"* and which requires significant political and management coordination (44) (p.2).

WHAT IS COORDINATION AND WHY IS IT IMPORTANT IN EMERGENCIES?

In the realm of international humanitarianism, there is a general consensus that coordination is necessary, but there is no shared understanding of what it means, how it can be attained, or how much it should be prioritized (45-47). Coordination is commonly believed to improve efficiency by avoiding duplication and promoting synergistic outcomes (48). It provides direction and motivation, helps to integrate diverse functions, ensures optimum use of resources, promotes efficiency by helping to achieve timely objectives and encourages team spirit improving inter-personal relationships (48). Previous research suggests that coordination involves deciding the necessary level of coordination and then working to build relationships, knowledge, and understanding to reach the agreed-upon objectives (48, 49). Facilitators of coordination include mutual support and trust, recognizing diversity, and openly sharing information (48). Ensuring the buy-in of stakeholders to avoid tensions between the priorities of the collective initiative and an individual's organization is also critical and building a shared culture supports a sense of joint ownership of working arrangements and results achieved (48). Coordination barriers include complexity, mission uncertainty, and significant differences in power and resources among stakeholders (49). In addition, differences in organizational agendas, mandates, timelines, programming approaches, and expected outcomes, as well as differences in culture, language, and communication systems, can impede coordination, especially in complex emergency settings (49).

The stated aim of humanitarian coordination is to enhance the effectiveness of a response by improving predictability, accountability and partnership (50). Effectiveness refers to "*the degree to which humanitarian operations meet their stated objectives, in a timely manner and at an acceptable level of quality"*; Efficiency is "*the degree to which humanitarian outputs are produced for the lowest possible amount of inputs*" and; Impact is "*the degree to which humanitarian action produces (intentionally or unintentionally) positive longer-term outcomes for the people and societies receiving support*" (51) p.31.

A clear definition of the concept of crisis or humanitarian coordination has not been agreed (47, 52). Below I present some of the definitions proposed in the literature and present my own definition to guide this study. Although this thesis is not an effectiveness study, throughout this thesis I have chosen to use the terminology 'effective coordination', to align with existing definitions of coordination, in which the concept of effectiveness is integral, and global research on improving humanitarian coordination, which will be summarized in the next section.

The Google Online English Dictionary describes coordination as "*the organization of the different elements of a complex body or activity so as to enable them to work together effectively*", which is extracted from the Oxford English Dictionary (53). In this definition, the concept of effectiveness is integral to coordination.

Campbell et al. proposed that coordination involves *"an iterative process of gradually building trust, understanding and working relationships"* (49) p.7. This definition focuses more on the interpersonal aspects necessary to make coordination work.

In studies on humanitarian coordination, Saavendra et al. designate coordination as "*the overarching term to encompass these different relationships, all of which are different ways and degrees of organization, to enable some type of coordinated activity*" (54) (p.19). This definition attempts to combine both the inter-personal and the operational aspects, which I believe to be more representative.

The New Zealand State Services Commission defines coordination as "*the sharing of information, resources and responsibilities to achieve a particular outcome*" and present the Factors for Successful Coordination Framework which I discuss in chapter four of this thesis (48) (p.7).

Reflecting on these previous definitions, I have combined several of the concepts to propose a more holistic definition of coordination, which will guide my research:

> *"Coordination is the driving force which organises a group of individuals/organizations to achieve common objectives, fosters trust, motivation and interpersonal relationships, ensures efficient use of resources (funds, staff, time etc), and promotes collaboration and synergy".*

Efforts to improve the Humanitarian Architecture

Effective coordination is particularly important in emergency contexts. In recent years, the diversity of organizations in the humanitarian sector has expanded, and the complexity and duration of responses has increased, multiplying the potential for confusion, conflict and duplication (46). Coordination in emergencies can be complicated by diverse response stakeholders mandates, leadership, policies and missions, all speaking a variety of languages (46). To address these challenges, efforts have been made to improve coordination effectiveness by transforming the global humanitarian landscape (46). The United Nations Office for the Coordination of Humanitarian Affairs (UN OCHA) was established in 1991, as the lead UN agency responsible for coordinating humanitarian actors and ensuring coherent emergency responses (55, 56). Shortly after in 1992, the IASC was established by UN General Assembly Resolution 48/57 as the primary system for inter-agency humanitarian coordination (57). Following the Darfur crisis in Sudan, the Humanitarian reform process formally established the Cluster system in 2005, and this remains a key mechanism for humanitarian coordination (58-60).

The Cluster system, which includes eleven Clusters and four cross-cutting issues, provides a platform for governments, UN agencies, and NGOs to work together to improve capacity, organization, coordination, leadership, and accountability within the different sectors at the global and country level, thus enhancing the effectiveness of humanitarian responses (61-63). The specific cluster and sub-cluster structures implemented depend on the needs in the particular context (64). Generally, the humanitarian country team (HCT), led by the humanitarian coordinator (HC) works alongside the national government to coordinate the efforts of humanitarian organization's (UN and non-UN) (64). The Clusters build on pre-existing coordination mechanisms and support national systems, while working in partnership with national governments. In 2011, the IASC deemed coordination one of the three pillars of the Transformative Agenda, alongside stronger UN leadership, and improved accountability and since then significant investments have been made to improve coordination effectiveness (46, 65). In refugees settings, the United Nations High Commission for refugees (UNHCR) coordinates different sectors (rather than Clusters) under the “Refugee Coordination Model” (66).

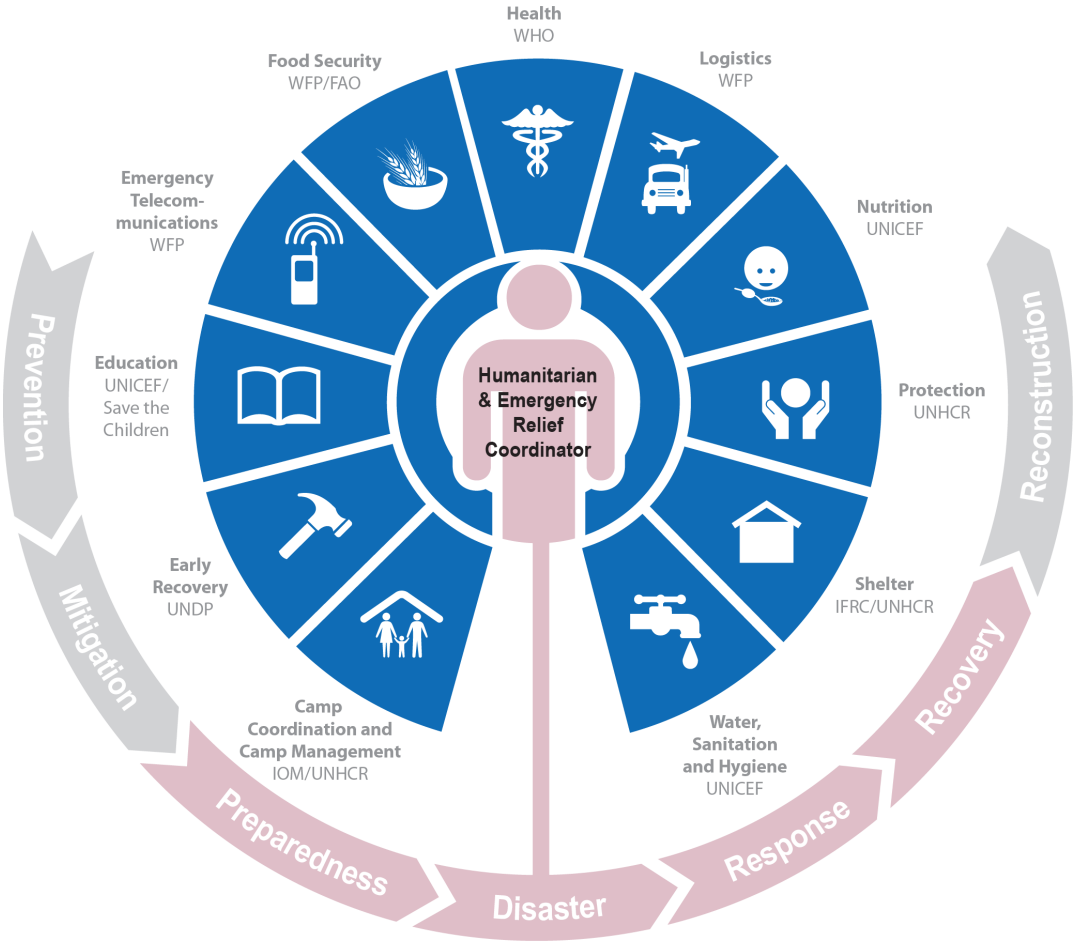

Figure 3: Humanitarian Clusters and Lead Agencies (OCHA, 2019) (55)

Research on improving the effectiveness of Humanitarian coordination

In this section, I describe the results of a brief review of the body of literature on improving the effectiveness of humanitarian coordination. While most research does not focus on the GBV sector specifically, within which there are many peculiarities related to coordination, the findings offered a theoretical background to ground my understanding of humanitarian coordination and offered some valuable insights on coordination in emergencies which informed my study tools and data analysis. Much of the most relevant research has been conducted by the Active Learning Network for Accountability and Performance in Humanitarian Action (ANLAP) (45, 46, 67). In addition, several other publications and evaluations have examined how effective the humanitarian system is in different context, the majority of which focussed on the cluster approach (52, 63, 64, 68, 69). Key topics explored in the literature, which informed this study included: the overall design of humanitarian coordination and decision-making, resourcing coordination, the role of national governments and of national civil society organization's (CSOs), inter-cluster and subnational levels of coordination and information management (45, 46, 67).

As with any complex system, the context in which the humanitarian system operates has an impact on how it behaves, functions, and adapts to the environment (70, 71). The term "context" encompasses a range of factors such as stakeholders, policies, practices, cultural and social norms, and media, among others. Research published by ALNAP emphasizes the importance of developing coordination mechanisms that are tailored to the specific context and that can adjust to the changing circumstances of a crisis, which I found particularly pertinent in my exploration of Lebanon's protracted and compounded crises (46). The research recommends that coordination systems be designed to suit the particular context, incorporate existing government and civil society coordination mechanisms, and be flexible enough to accommodate contextual diversity (46). Additionally, it suggests that continually monitoring the context and outcomes would help improve the response's effectiveness (46). For example, evaluations of the West Africa Ebola crisis 2014-16 suggested that a Cluster system may have been more effective than the UNMEER (UN Mission for Emergency Ebola Response)-led system, and when the Clusters were finally introduced in Liberia, the response improved (72, 73). In Iraq, the cluster system coordinating the IDP response, in parallel to the UNHCR-led system for refugees, made coordination complex and confusing, reducing coordination effectiveness (74). The response to the Haiti earthquake was hindered by a lack of coordination and resources, despite it being described as the worst natural disaster in modern history (75). Comes et al. explored two case studies, the response to Typhoon Haiyan in the Philippines and the Syria Crisis, and illustrated how the lack of reliable coordination structures resulted in reactive decision-making driven by individual and local leadership, rather than organizational mandates, joint standards, and norms (76). This led to continuous revisions of processes and structures, with mandates and aims adapted based on new insights, changes in information, and rivalry among humanitarian organizations (76). Hence, mapping and assessing coordination structures in protracted crises and complex emergencies could aid in improving systems over time (77).

Furthermore, evidence suggests that a lack of coordination between organizations providing health services during public health emergencies can cause complications in the provision of essential services (78). Lotfi et al. identified five models of coordination for delivering health services during humanitarian crises, with the Cluster approach being the most commonly used and showing some evidence of improving coordination, particularly for sexual and reproductive health services (78). However, the study noted a need for further research to assess the effectiveness and efficiency of these models. Akl et al. conducted a systematic review that found coordination between health service providers can improve health system inputs, and management/directive coordination

models like the cluster model can increase access to health services (79). But there was no evidence that coordination through common representation and framework coordination was effective, and the evidence quality was low. The study highlights the limitations in the research field in crisis settings, including the lack of clear guidelines or standards on how to conduct and report studies in this field, and the scarcity of funding (79). The study proposes that policymakers and stakeholders apply the limited evidence to address coordination dysfunctions during humanitarian crises, including duplication of activities and inequitable distribution of aid (79).

When designing a coordination structure, it is crucial to consider the capacity and role of national governments in coordinating the response, particularly in protracted crises like Lebanon's (46, 67). According to the legal framework and UNHCR's coordination model, national governments are responsible for leading the coordination of humanitarian assistance in their countries (54, 66). However, research indicates that national governments are often marginalised by the humanitarian system, and their role is disputed in many humanitarian responses (67, 80, 81). International actors sometimes question the independence and impartially of government-led coordination and governments in-turn can be suspicious of, and frustrated by, international organizations, which can be perceived to be ‘over-resourced, unaccountable, and donor-driven' (82) p.11. Moreover, governments may use coordination mechanisms to advance their political agenda (80, 81). In some situations, however, governments may lack sufficient capacity to lead or even participate in humanitarian response coordination (46, 83). Nevertheless, existing research strongly suggests that failing to coordinate with national governments can undermine national sovereignty and be disconnected with development agendas, which can hamper long-term recovery (46).

In humanitarian responses, vertical coordination refers to the process of coordinating humanitarian efforts across different levels, including national, sub-national, and local levels, and ensuring that such interventions are properly integrated into the existing national systems (84). On the other hand, horizontal coordination refers to the coordination between humanitarian organizations operating at the same level and within the same sector, such as between different NGOs or UN agencies (84). Vertical coordination is essential for ensuring that humanitarian efforts are in line with national and local government policies, as well as for facilitating access to affected populations and coordinating the allocation of resources (85). It is also crucial for ensuring that humanitarian efforts are sustainable and integrated into long-term development plans (85). Vertical, or top-down coordination, can pose significant challenges, particularly in contexts where the state is weak or non-existent and vulnerable populations rely on community-led efforts and local NGOs to provide

essential services (86). In such settings, local NGOs may lack the resources or expertise to fully address the needs of affected communities, while community-led efforts may struggle to access the necessary funding or support to sustain their activities over the long term (86).

Humanitarian coordination, in practice, often involves horizontal coordination between various actors, including local NGOs and community-led efforts. Horizontal coordination, is important for avoiding duplication of efforts, sharing information and resources, and enhancing the overall effectiveness of the humanitarian response (85). It helps to ensure that each organization is working towards the same objectives and that there is a clear division of labour between organizations. Stephenson proposed that since the UN cluster system lacks a powerful central authority, coordination should be accomplished through enhanced cooperation and the consensus building (87). This approach also recognizes the importance of engaging with and supporting local communities, who are often the first responders in times of crisis. According to the ODI, effective coordination in humanitarian response demands authentic partnership and collaboration among international, national, and local actors, founded on mutual respect, trust, and shared objectives (88). Both types of coordination are necessary for effective humanitarian responses and are often interrelated. This study mainly focuses on horizontal coordination.

Effective coordination requires access to adequate resources, including having appropriate people in coordination roles with dedicated time for coordination tasks (46). Previous research has highlighted several challenges to achieving this, including difficulty recruiting and retaining individuals in coordination roles, lack of local actors in coordination positions and insufficient experience or training of coordinators (46). In emergencies, coordination roles often experienced high turnover, causing interruption and inconsistency and coordinators were often expected to perform other roles in addition to coordination (46, 89). Gaps in predictable leadership were also noted in Cluster evaluations, attributed to a lack of impartiality of lead agencies alongside high turnover rates of Cluster coordinators and insufficient training and experience (68, 69). According to the GBV coordination handbook, as coordinators are responsible for representing all sector members and their agendas, not just their own agency, they should be dedicated to inter-agency coordination, however this can be challenged by the lack of resources allocated to coordination (33, 90). Ruesch et al. caution against the cluster lead agency taking on dual roles of coordinator and active operator and demonstrate that the ambiguity created by the cluster lead's dual role can lead to a lack of swift trust and hinder resource utilization (91). This is particularly problematic when the cluster lead is seen as prioritizing its own organisational agenda over the aims of the cluster (91).

Previous research on crisis coordination has emphasized the significance of establishing positive coordination dynamics, which involves creating mutual trust among organizations to enable effective non-directive, voluntary coordination systems (46). Trust has been recognized as a crucial factor for effective coordination and partnerships and has been shown to have a positive correlation with team performance, satisfaction, and commitment (52, 92, 93). Stephenson posits that trust is a crucial element for achieving coordination, and different forms of inter-organizational interaction can lead to varying levels of trust (87). Rather than bemoaning the lack of top-down coordination mechanisms, he suggests that humanitarian organizations could benefit from fostering organizational cultures that promote improved inter-organizational trust and cooperation, with improved outcomes for their beneficiaries (87). Moreover, Campbell et al. suggest that hierarchical coordination structures are insufficient for addressing coordination challenges, and incentives should be established to encourage agencies to coordinate (49). Crisis coordination mechanisms should also integrate the use of tools and analysis to build relationships and foster understanding (49). Therefore, coordinators need to possess skills and qualities that enable them to establish trust and collaboration among organizations and individuals. The Core Competencies for GBV Specialists is intended to support the GBV AoR in strengthening the GBV workforce by outlining a set of core competencies, including professional and behavioral competencies related to coordination roles (90). These competencies include facilitating a collaborative environment among colleagues and stakeholders to promote effective coordination, exhibiting empathy and positive interpersonal skills, including cultural competence, fostering effective and productive communication among stakeholders, demonstrating good judgement and decision-making skills, and effectively negotiating and advocating with a variety of actors, including leading strategic planning and mobilizing funds (90).

Several studies have identified sub-national coordination and Inter-Cluster Coordination (ICC) as areas requiring attention and improvement (45, 46, 64, 68, 69). Sub-national coordination was found to be under-resourced, lacked clarity on mandates, roles, and responsibilities in relation to national coordination mechanisms and had limited communication with national level in most responses (45, 46). Yet research has highlighted important benefits of investing in subnational coordination, including more rapid and relevant decision making, resulting from a better understanding of context, and greater participation of operational actors, especially civil society organization's (CSOs) (46, 94). Campbell et al. recommend that decision-making authority should be devolved to field level but strong, supportive linkages need to be maintained with national/HQ level (49). Challenges for ICC included weak trust and communication among country Clusters, unclear roles and mechanisms for

that communication and lack of clarity on responsibility for ICC and cross-cutting issues, which have particular implications for GBV risk mitigation (45, 46). Ensuring clear roles and decision-making procedures within the coordination architecture and having strong communicating mechanisms within and between different elements, were highlighted as critical for effective coordination (46).

There is now increased recognition of the important role national and local civil society can play in humanitarian crises and the need to increase their participation and influence, particularly pertinent for inclusion of women-led organization's in addressing GBV (46, 67, 89, 95). Previous research highlights that local actors possess the advantage of a deep understanding the context and needs of affected communities and are frequently best placed to provide culturally appropriate and effective interventions (88). However, research has shown that international humanitarian coordination mechanisms often marginalise or disregard existing local networks (46, 54). Barriers to engagement of national and local actors can include language, financial, and logistic constraints and a lack of understanding of how the humanitarian coordination architecture works, and how or why they should participate (46). Furthermore, in conflict or sectarian contexts, international actors may perceive national or local NGOs as lacking impartiality (46). Conversely, local organizations have accused international actors of imposing standardized coordination mechanisms without adequately incorporating local actors or recognizing their contextual knowledge (96). Cluster evaluations too, noted barriers to inclusive partnership alongside insufficient efforts to enhance accountability to affected populations, as significant shortcomings (69). Altay and Labonte's case study of the Haiti earthquake reports that coordination failed because international players dominated the response while ignoring local organizations and their knowledge (75).

The Call to Action on protection from GBV in emergencies (Call to Action) recognises local organizations, particularly women's organizations, as critical stakeholders in effective humanitarian response and promotes their engagement, participation and leadership (4). In addition, the GBV AoR Strategy 2018–2020 sought to facilitate the active participation of local organizations as well as national governments in GBV coordination (35). To support implementation of this strategy the GBV AoR created a global localization task team and commissioned a multi-country study which highlighted several barriers and gaps to GBV localization across emergency settings, including insufficient funding allocation, and barriers to assuming leadership roles and to engaging in coordination mechanisms (95). Campbell et al. conclude that the sustained effectiveness of coordination mechanisms ultimately depends on national capacity (49).

Finally, the theme of information management (IM) emerged as a critical element of effective coordination and alongside strong communication is vital for coordination mechanisms to function optimally, allowing informed and timely decision making (46). Comes et al. suggest that having sufficient information systems is crucial, especially at the beginning of a response (76). As capacity is increased, more and better information becomes available, and to fully benefit from this decision-makers need to look beyond their own information and coordination networks and monitor the environment to identify emerging trends and adjust their decisions accordingly (76). Challenges include, the collection of information that donors and agency leadership want, rather than practically actionable data and information, reluctance to share information between organizations, and incompatible tools and approaches across agencies limiting comparison (46). Collecting data and sharing information on GBV is vital to enable planning for context-appropriate GBV interventions, however, this can be extremely challenging in emergencies, especially for sensitive topics such as GBV (97).

In the next section I introduce policies and structures relevant for GBV coordination in emergencies.

Gender-based violence (GBV) coordination in Emergencies

In the past three decades, international awareness and commitment to addressing GBV in emergencies have been steadily increasing. The Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW), ratified by 189 states, is a landmark international treaty adopted in 1979 by the UN General Assembly, devoted to the elimination of all forms of gender-based discrimination and to realizing gender equality (98). Following this, the 1993 UN Declaration on the Elimination of Violence against Women provided the first international framework for action on addressing GBV (99). In the 1990s, the magnitude and visibility of sexual violence perpetrated against women in the former Yugoslavia and Rwandan conflicts, heightened attention and response by the international community prompting implementation of the first GBV programmes in refugee camps in western Tanzania (100). Subsequently, in 1997, GBV was recognised as a 'public health issue' by the General Assembly of WHO, and over the past 20 years, the UN Security Council has promoted the Women, Peace, and Security agenda (101-103).

Establishment of the United Nations (UN)-led international cluster system in 2005 provided a standardised structure for implementing GBV coordination mechanisms in humanitarian emergencies and in 2006, the GBV Area of Responsibility (AoR) was founded as the global forum for GBV coordination, under the Protection cluster (104). GBV Coordination structures in emergencies

are described in detail in Chapter 5. In 2013, launch of the multi-stakeholder global Call to Action on Protecting Women and Girls in Emergencies (Call to Action), commanded unprecedented attention, funding and high-level commitment from global actors, and placed the issue of GBV on the international agenda in a way that had not been previously witnessed (4, 105). Call to Action partners reported significant advancements in global and field-level coordination in 2018, including improvements in global leadership, rapid activation of field-level GBV coordination and enhanced local leadership of coordination (106). In addition, GBV services are part of the minimum initial service package (MISP) in emergencies which is promoted by global institutions (107). Other initiatives which have attracted new resources and leadership include the United Kingdom's (UK's) Preventing Sexual Violence in Conflict Initiative (PSVI) (2012-present) and the United States' Safe from the Start programme (2013-present) and the UK Government's "What Works" to Prevent Violence against Women and Girls in Conflict and Humanitarian Crises programme launched in 2014, which aims to generate evidence to improve GBV programming (36, 105).

Despite this progress, GBV coordination faces many challenges in emergencies. A 2021 gap analysis of GBV in humanitarian settings, highlighted several areas across GBV response, risk mitigation and prevention which required attention, many of which are important for GBV coordination and will be discussed further throughout the results chapters of this thesis (31). In addition, lack of trust between actors, competition between agencies for funding, and tensions between organizational priorities and those of the coordination system, can limit collaboration (108). Prioritization and integration of GBV by other sectors depend on GBV being considered essential by humanitarian leadership and actors but, despite responsibilities outlined in the 2015 GBV guidelines, many barriers remain. Furthermore, responses to displaced populations in urban environments create unique GBV risks and challenges compared with camp-based settings and studies suggest that response policies, programs, and strategies developed for camp-based responses, require reformulation to reflect the nuances and complexities of urban settings (109).

Furthermore, during public health emergencies, such as epidemics and pandemics, survivors access to life-saving GBV services can be restricted or curtailed due to the redirection of healthcare services towards the outbreak response. (22). The COVID-19 pandemic has presented significant challenges in terms of accessing critical medical and psychosocial GBV services due to the implementation of public health and social measures (PHSMs), staff shortages, resource constraints, and lockdowns (23, 110). Other essential support services such as women's shelters, crisis centres, hotlines, legal aid, and psychosocial support services were also reduced and studies noted that some shelters were

refusing new admissions without negative COVID-19 tests, to avoid viral transmission (111). In addition, lockdown measures and lack of privacy restricted women's ability to access remote support (24). In 2020, Call to Action partners urged governments and humanitarian stakeholders to ensure the safety of women and girls during the COVID-19 response, which included the inclusion of a GBV objective within the Global Humanitarian Response Plan (28). Call to Action partners emphasized the need for GBV services to be officially recognized as essential for the COVID-19 response, staff equipped to provide services safely, and data on reported cases collected in a disaggregated manner (28, 111). They also recommended that GBV services be adapted and expanded to address heightened GBV risks, ensure accessibility, and encourage the use of technology and telemedicine to safely support GBV survivors (28, 112). Crucially, stakeholders urged actors to improve GBV coordination, including the allocation of specific GBV funding, an increase in direct funding to local women's organizations, meaningful participation of women in planning, program design, and decision-making, and clear communication with women and girls about the availability of services (22, 28).

In the next chapter I describe the study context and highlight key political, social and economic events which are important to ground the later findings on GBV coordination.

CHAPTER 3: STUDY SETTING – LEBANON

Chapter three introduces the case study context and is divided into two parts. The first section describes the political, cultural and operational factors which make the complex Lebanese context so unique. I begin with an introduction to Lebanon's history and politics, followed by a brief description of the Syrian refugee crisis response, including the policy context for refugees. Finally, I describe Lebanon's recent compounded crises, which have changed Lebanon dramatically in the past two years.

The second part focuses on GBV in Lebanon. I summarise the evidence on GBV prevalence among Lebanese's and Syrian Refugees and present the GBV policy context in the country before providing a brief introduction to GBV coordination in Lebanon.

LEBANON'S HISTORY AND POLITICS

Lebanon's current state can be traced back through its history of conflict and emergencies and the complex political system which emerged. Below I summarise events which shaped the country's path, to what has recently been referred to as a failed state (113-115). According to the definition presented in the previous chapter, Lebanon can be classified as a complex emergency, as it displays "*considerable breakdown of authority resulting from external conflict, which requires an international response that goes beyond the mandate or capacity of any single agency, and/or the ongoing United Nations country program".*

Following independence from France in 1943, power sharing between Lebanon's 18 religious sects was entrenched by allocating political power along confessional lines on the basis of the 1932 census, with the President, a Maronite Christian; the Speaker of the Parliament, a Shi'a Muslim; and the Prime Minister, a Sunni Muslim (101). After a period of economic stability in the 1950's and 60's, Lebanon's civil war (1975-1990), devastated the country both politically and economically, leaving a population of stateless Palestinian refugees in its aftermath (116). The 1989 Tai'f Accord, which ended the civil war, redistributed parliamentary seats equally between Christians and Muslims and embedded sectarianism as an integral component of Lebanon's political system (117). In 1991, all militias except Iranian-backed Hezbollah were disbanded, and the Lebanese Armed Forces rebuilt as Lebanon's only major non-sectarian institution (118). In subsequent years, Lebanon experienced several crises which threatened its political, economic and security stability including the assassination of Prime Minister Rafiq Hariri in 2005, the Israeli military intervention in July–August 2006, and the global financial crisis (2008/2009) (119). Hezbollah has become the most influential

political organization in Lebanon and is believed to operate largely without accountability, controlling the border with Syria and the Port of Beirut (114). The Free Patriotic Movement, a Maronite Christian party, founded by the current President, Michel Aoun (2016-present), formed the March 8 Alliance with Hezbollah, and in the 2018 elections controlled a majority of 72 of the 128 seats (114). In recent years Lebanon has faced a crisis of governance with extended power vacuums, multiple different governments from 2011-2022, and extended periods with caretaker governments (116).

Consistent financial and economic mismanagement along with corruption and a culture of impunity among the political elite, have placed Lebanon third on the global list of most indebted countries (120-122). Following the civil war, tourism, foreign aid, and large donations from Gulf Arab states supported Lebanon to rebuild but reduced in response to Iran's rising influence via Hezbollah (114, 122). Remittances from the millions of Lebanese diaspora living abroad provided a major income source, but decreased after 2011 due to the Syrian war and political instability across the middle east (119). Most political parties follow sectarian lines and clientelism and patronage are a "*powerful structural force to keep the Lebanese in their sectarian place*" (122) p.14. With high inequality and persistent poverty, 1% of Lebanese richest citizens hold 25% of national income, and 10% of the population control 55% of wealth (119, 122). According to economic commentators, the Lebanese economy had been in recession and facing severe challenges prior to 2011, due to low growth rates, heavy dependence on imports, and relatively high unemployment (119, 122).

In Lebanon, the government's limited and often inadequate role in providing public services widely recognized and has been documented in numerous reports and studies (123, 124). Political instability and economic crises, including a weak state and a history of sectarian conflict, have hindered the government's ability to provide essential services and basic services such as electricity, water, and waste management are frequently disrupted or unavailable, leaving residents to rely on private alternatives. According to a World Bank report, public service provision in Lebanon is characterized by fragmentation, duplication, and inefficiency, resulting in poor quality and coverage (123). The public healthcare system is underfunded, and according to a WHO report, healthcare in Lebanon is primarily delivered through the private sector, with only a small percentage of the population covered by public health insurance (124). Many Lebanese citizens, particularly those with low income, face financial obstacles to access healthcare services and medications due to their high cost (124). Moreover, other social welfare services, such as education and housing, also struggle with inadequate resources and poor infrastructure leaving them heavily reliant on private providers,

with limited government support. As a result, these services are often inaccessible or unaffordable for many Lebanese citizens, resulting in a two-tiered system with high levels of inequality and social exclusion (125). In recent years, the Lebanese government has faced increasing criticism for its failure to address these issues, and there is a growing demand for more effective and accountable public services. The government's failure to provide adequate public services has led to widespread protests and calls for reform and has diminished its credibility and legitimacy in the public opinion (125).

In 2011, the Syrian crisis erupted causing a massive refugee influx to neighbouring Lebanon, requiring a major humanitarian response. The crisis further destabilised the social, economic, and political situation in Lebanon, severely challenging infrastructure and public services, and is considered one of the most difficult challenges that Lebanon has faced in its complex history (116, 126, 127). Below, I summarize key issues in the evolution of the response to the Syrian refugee influx in Lebanon, which will be further explored in Chapter 6.

Lebanon and The Syrian Refugee Crisis

Hosting the world's highest number of refugees per capita, and the fourth largest refugee population globally in 2022, an estimated 1.5 million Syrian refugees continue to reside in a country of 4 million Lebanese, with women accounting for >50% of the refugee population (43, 127, 128). The first Syrian refugees crossed the border into the north of Lebanon in 2011 and over the subsequent two years, refugee numbers rose from 5,000 in 2011, to 800,000 by the end of 2013. In 2012, Lebanon’s Inter-Ministerial Committee was established to manage the refugee crisis, however for the initial years, the Lebanese government did not play a leading role (47). Internal divisions between political parties who supported the Syrian regime and those allied with the Syrian opposition, and a stance of “dissociation” from the crisis, compromised management of the crisis response (47). Therefore, UNHCR led the response in Lebanon alongside INGOs and other UN agencies, under a series of regional response plans (RRP) that covered the countries most affected by the Syrian refugee influx (Türkiye, Jordan, and Lebanon) (47, 56). As the crisis prolonged, the government played a more prominent role, and in 2015, led development of the multiyear Lebanon Crisis Response Plan (LCRP) jointly with UN agencies and international and national partners (56). The LCRP coordination structure was established, which included inter-agency units with sectors jointly led by UNHCR, a sector-specific agency, and a national ministry and an inter-sector coordination unit co-led by UNHCR and United Nations Development Project (UNDP), including all NGOs and UN agencies (56, 127, 129-131) (Annex 2). At the local level, MOSA played an important

coordination role through a nationwide network of social development centres (SDCs), which provided various social services, and were expanded to serve host and refugees communities (56).

The response faced many challenges including weak coordination between international actors, the national government, and (in)formal local authorities, the lack of a national response strategy, weak capacities of local authorities, interagency tensions between UN agencies and ineffective intersectoral coordination, in the early days (47, 56, 116, 129). Despite several UN and INGOs having an existing presence in Lebanon, they failed to expand rapidly enough to meet the need during the initial years (116). The scale of the crisis also challenged UNHCR who was coordinating all sectors and within four years, had expanded from one office in Beirut with an operating budget of four million dollars, to five offices distributed across the country, with an operating budget of $322 million (116, 132). In the early years, ad hoc and short-term funding prevented effective coordination and strategic planning and some authors accused UN and INGOs of being more concerned with competing for funding than designing and implementing an effective response (47). From 2015, the LCRP promoted a more comprehensive and integrated approach through medium-term, multi-year planning serving equal numbers of vulnerable Lebanese's and refugees, to meet the increasing needs of host communities (47, 131, 133). Despite an increase of international humanitarian funding from less than $20 million in 2011 to $1 billion in 2015, and an increase in funding requested through the LCRP from 2.1 billion in 2015, to 2.67 billion in 2020, approximately 50% shortfalls continued throughout the protracted crisis (116, 126, 133). From 2015-21, Lebanon had received US$8.2 billion in support under the LCRP (133). In 2022, to meet expanding needs, the request increased to 3.2 billion, 229 million for protection, including GBV. In 2018, the LCRP introduced the importance of having 'un-earmarked funding' and a gradual shift toward direct cash-based assistance to refugees occurred, promoting unconditional and multipurpose cash assistance to give refugees autonomy while positively impacting the local economy (127).

The situation of Palestinian refugees in the country, influenced policies implemented by the government to manage the Syrian refugee response, which became increasingly hostile (116). Lebanon has not signed the 1951 Refugee Convention, or the 1967 Protocol, limiting legal protections for refugees and complicating UNHCRs protection mandate (56, 134). The government refused to establish official refugee camps, and prevented refugees from seeking employment beyond three sectors, agriculture, construction and domestic work (116, 119, 130). The labour participation rate among Syrian refugees in 2021 was 47%, of which only 9% were women (128). In 2015, the government suspended registration of refugees by UNHCR and made it increasingly

complicated for Syrians to maintain legal residency, which, at 200 USD, most refugees could not afford (116, 135). Legal recognition of temporary residence was also denied, as was registration of Syrian refugee births, resulting in statelessness of Syrian children born in Lebanon (116, 126). The lack of legal residency affected multiple domains of Syrian refugees' lives including protection, housing, livelihoods, education and health, and unregistered Syrians faced barriers in accessing services and were vulnerable to detention and extortion (119). Subsequently, other registration certifications, including marriage, divorce, death, legal guardianship over children, and inheritance rights were complicated (119). Although the Government announced a waiver of legal residency and overstay fees in 2017 to simplify processes and increase access, and streamlined birth registration and other civil documentation processes, rates remained low (128, 133).

By 2016 when the Syrian regime began to dominate the conflict in Syria, Lebanese politicians intensified calls for refugee return and various state and non-state actors proposed return plans, contrary to the principle of non-refoulment (118). In addition, political divisions inside Syria extended into Lebanon with increasingly polarized communities and security incidents which intensified refugee-host tensions (47, 126). This required instituting a cross cutting social cohesion group in the response structure, and in 2017 a system for monitoring intercommunal relations across the country was established (127). Perceptions amongst Lebanese that Syrians were prioritised in aid allocation was considered unfair to poor Lebanese, causing a deterioration of intercommunal relations in many localities (133). Additionally, several municipalities imposed illegal curfews on refugees, marking them a threat to the Lebanese community and informal security actors, such as the Shawishes in Lebanon's ITS, exploited the precarious living conditions of refugees, especially women-led households (136). Refugees are often scapegoated, especially by certain political factions, and blamed for the recent economic crisis in Lebanon (119, 122). However, analysists suggest that the corrupt sectarian political system, alongside the government's failure to deliver political and economic reforms, had put Lebanon on the road to economic collapse even prior to the Syrian refugee influx (120, 122, 137, 138).

LEBANON'S DECENT INTO A NATIONWIDE ECONOMIC CRISIS

Since 2019, Lebanon has been dealing with multiple compounding crises which have plunged the country into a nationwide economic emergency. Key events are summarised below and explored in more detail in Chapter 7.

In October 2019, mass protests against the Hezbollah-dominated government erupted in Lebanon demanding urgent governance and institutional reforms, political accountability, and an end to corruption and economic mismanagement (24, 139). This led to the resignation of Prime Minister Saad Hariri in October who was replaced in January 2020 by Hassan Diab. Meanwhile, inflow of foreign exchange stopped, dollars were withdrawn from Lebanon and savings were reduced to a fraction of their original value. All but essential functions of government offices halted, banks closed, the government defaulted on its foreign debt and the currency devalued by 90% (113).

Soon after, the first COVID-19 cases were detected in Lebanon in February 2020 and intermittent lockdowns and PHSMs worsened the situation and exposed long-standing challenges within the chronically under-resourced and overstretched public health system (139-141). In March, MOPH launched the Coronavirus Disease 2019 National Health Strategic Preparedness and Response Plan with support from WHO to manage the pandemic response (142). Refugees living in ITS were particularly vulnerable to COVID-19 due to poor access to healthcare and water and sanitation facilities, alongside crowded living conditions and movement restrictions which created access barriers for humanitarian actors proving support (119, 143).

Compounding the situation, on 4 August 2020 a massive explosion at Beirut's Port devasted large areas of the city, resulting in over 215 deaths and 6,000 injuries (144-146). The explosion damaged health facilities, with three of the major hospitals in Beirut closed, while others functioned at reduced capacity (147). Furthermore, reports have indicated an increase in mental health conditions amongst those affected, with PTSD rates reaching 67% in individuals close to the blast and up to 37% in the general population (141). In the absence of a government-led response, several initiatives emerged in response to the blast which will be explained in Chapter 7.

Throughout 2020-21, Lebanon descended further into a nationwide economic crisis the details of which will be elaborated in chapter 7 (115). In the severe economic contraction, usually associated with conflict or war, Lebanon's GDP fell drastically in 2021 to approximately US$20.5 billion (113, 115). In an effort to avoid state failure, donors are providing assistance to maintain critical institutions and infrastructure, and providing direct assistance to the population to support livelihoods and prevent a severe humanitarian crisis (114). The multiple crises have exacerbated social instability and deepened refugee-host tensions. Meanwhile, the Lebanese Armed Forces (LAF), one of Lebanon's only non-sectarian institutions are overstretched and underpaid, threatening a decline of the security situation in Lebanon (114, 148).

Below I summarise GBV prevalence, policies and coordination in Lebanon to ground the case study on GBV coordination.

GBV IN LEBANON

GBV PREVALENCE IN LEBANON

Official GBV prevalence data is not available for Lebanon (24, 134). However, social and cultural norms condone violence against women and research suggests that approximately 10% of Syrian refugees and 6% of Lebanese believe that a man is justified in hitting or beating his wife (149). Amongst Syrian refugee women in Lebanon, IPV, sexual violence, exploitation, and forced and early marriage are the most commonly reported GBV incidents and although these were also reported in Syria before the crisis, displacement and, more recently, the economic crisis appears to be exacerbating risks (127, 150-152). A 2014 study among Syrian women displaced to Lebanon reported that >30% experienced conflict-related violence and non-partner sexual violence (3.1%), with 28% suffering from physical injury and 68% from psychological consequences (153). Of those, only 35% sought medical care, and 9.2% psychosocial support, citing insufficient resources, lack of awareness, and other reasons (153). According to a 2015 study conducted among Syrian refugee women in South Lebanon, approx. 9% of Syrian women experienced physical and sexual violence, and 26% emotional violence, with multiple health and psychosocial implications (154). Furthermore, patriarchal socio-cultural values, lack of trust in service providers, fear of stigma and retaliation, lack of legal residence and fear of refoulement deterred women and girls from disclosing GBV or seeking support services in Lebanon (24, 152, 155, 156). In addition, rises in child marriage have been noted, which is often used as a harmful coping mechanism to prevent GBV, sexual harassment or to decrease financial burden on the family (27, 29, 127, 154, 157). In 2018, 29% of 15 to 19-year-old Syrian refugee girls were reported married, in contrast to 11.6% in Syrian prior to the crisis, however this had decreased to 20% in 2021 (128). 2021 rates varied across different regions with the highest rate in the South at 34% (128). Reports have indicated that families marry girls to wealthy Syrian or Lebanese men to meet accommodation costs and in some cases, girls are exploited within short-term contractual marriages (29, 152). Moreover, 46% of girls ages 15–24 are forced to leave formal education after marrying, due to the traditional gender and social norms (128, 158). More recently, the compounded crises in Lebanon have increased GBV risks and survivors have faced challenges in accessing services and legal support amid the COVID-19 pandemic and economic crisis (120, 128, 133, 140, 159).

GBV POLICY CONTEXT IN LEBANON

Although there is a vibrant civil society working on gender issues in Lebanon, as of 2021, it ranks 132 out of 156 countries in the World Economic Forum Global Gender Gap, due to weak political representation (5%), low rates of economic participation, the sectarian legal system and patriarchal socio-cultural norms (24, 160, 161). Lebanon's 18 religious sects have 15 different personal status laws which govern issues such as marriage, divorce and inheritance, and are applied by religious courts which treat women unequally (101).

Recent years have seen increased involvement of Lebanese's government institutions in efforts to address GBV, including MOSA, MOPH, Ministry of Justice, and the Ministry of Interior and Municipalities (Annex 3 maps stakeholders involved in the GBV space in the humanitarian response and government in Lebanon) (24). Three main institutions within the government are important to note. The National Commission for Lebanese Women (NCLW), founded in 1996, is the National Women Machinery whose mandate includes coordination, policy formulation and analysis, legal reform and the monitoring progress on gender equality, including CEDAW reporting (101). NCLW developed the National Action Plan 2017-2019 with support from UNFPA, which complemented the National Strategy for Women in Lebanon 2011-2021 (24). Within the Department of Family Affairs at MOSA, the Department of Women's Affairs works alongside NCLW and with support from UNICEF, developed a 7-year Strategic Plan on Child Protection and GBV (24). In addition, the National Technical Task Force to End GBV against Women and Children (NTTF), established in 2012 and co-chaired by MOSA and ABAAD (National NGO), aims to identify national GBV priorities and develop action plans to address GBV (24). In 2016, Lebanon established an Office of the Minister of State for Women's Affairs (OMSWA), whose mandate included promoting women's participation in governance and addressing GBV. OMSWA developed the National Strategy for Gender Equality (2017-2030) and alongside NCLW were responsible for coordinating stakeholders and ensuring implementation of the strategy (134). However, in 2019, OMSWA became the Ministry of State for Economic Empowerment of Women and Youth, and reportedly no longer works on GBV issues (24). Although NCLW allocate a small proportion of its annual budget to address GBV and gender inequality, overall budget allocation by government to GBV has been minimal (24).

In parallel, for the past two decades, Lebanon's civil society have been making consistent progress towards addressing GBV and gender equality in Lebanon, although major gaps still remain (24, 101, 134). In August 2011, the Parliament annulled Article 562 which reduced the sentence of family members who committed "honour kilings", however, there are reports of this practice continuing

(24). In 2014, the parliament passed Law 293 on the Protection of Women and Family Members Against Domestic Violence which although is intended to protect all women in Lebanon, excludes unregistered refugee women who are unable to access the justice system (134). In December 2016, the Lebanese parliament abolished the Penal Code Article 522, the "rape law," which meant that rapists escaped punishment if they married their victim (134). In addition, the Coalition Women for Politics, a coordination mechanism led by NCLW with CSOs, was established in 2016 to advocate for a quota system (30%) in parliament, however, despite the head of the NCLW being the daughter of the President, to date they have not been successful. Furthermore, marital rape is not illegal in Lebanon, abortion is only permitted where the woman's life is threatened and women are not permitted to give their nationality to their children or a foreign spouse (24). Finally, Lebanon's civil law does not define a minimum age for marriage meaning it is governed by religious courts which set the age based on personal status laws and the majority of religious sects permit girls under the age of 18 to marry (24, 132, 134). Since 2017, five draft bills have been presented to parliament to set the legal minimum age of marriage at 18, but have met resistance from several parliament representatives and are still pending endorsement (24, 134, 161).

GBV Coordination in Lebanon's Emergencies

Under the LCRP, the National GBV task force was established in 2012 by UNHCR, co-led by UNFPA and MOSA, providing overall technical support to the GBV sector in Lebanon (132, 134). In addition, the UN Gender Working Group, co-led by UNFPA and UN Women, promotes gender equality and coordinates gender mainstreaming (162). Other coordination groups relevant to GBV include the Protection and Child Protection working groups, the Clinical Management of Rape (CMR) working group, and the Mental Health and Psychosocial Support (MHPSS) task force. International donors including United Nations agencies, the Canadian International Development Agency (CIDA), the European Union (EU), France, Italy the Netherlands, as well as partners in the United States and Canada, provide financial support for programmes and initiatives (Annex 3)(24).

Several national NGOs in Lebanon work to address GBV. ABAAD Resource Centre for Gender Equality and KAFA Violence & Exploitation are probably the most well-known national Lebanese NGOs and internationally recognised. Alongside these two, the Lebanese Council to Resist Violence Against Women (LECORVAW), Helem, Lebanese Women Democratic Gathering (RDFL), and Makhzoumi Foundation among others provide various support services to GBV survivors, conduct research, and advocate for policy change. Local organizations such as Basmeh & Zeitooneh, Akkar Network for Development (AND), Fe-Male, MENA Organization for Services, Advocacy, Integration and Capacity

building (MOSAIC) also work to address GBV through service provision and support to communities. Additionally, academic institutions such as The Arab Institute for Women (AiW) at The Lebanese American University and American University Beirut conduct research on GBV and advocate for policy change. Annex 3 provides details and characteristics of stakeholders involved in the GBV space in the humanitarian response and government in Lebanon.

This study builds on previous evaluations and reports published by UN and NGOs on addressing GBV in Lebanon. Prior to the crisis, a situational analysis conducted in 2010 identified a lack of coordination among government actors and civil society, as well as a small number of NGOs providing services to GBV survivors (101). Within the problematic legal framework and the culture of impunity on GBV, they recognised that integrating GBV in the national agenda was the only way to reduce GBV (101). Subsequently, in 2017, the EU funded a Gender Analysis which noted many encouraging achievements since 2010, including legal reforms, the expansion of services and increased numbers of NGOs and CSO working to address GBV (134). The report recommended the GBV task force under the LCRP to provide the basis for long-term coordination of actors working on GBV in Lebanon and another 2016 study partly attributed success to having strong, dedicated coordinators with dedicated funding for coordination activities (134, 150). They also pushed for joint coordination between OMSWA, MOSA and NCLW, clarification on the role and mandate of each institute in terms of GBV, and improved coordination between all stakeholders, including CSOs (134).

A UNHCR evaluation of their GBV program in Lebanon covering the period of 2016-2018 concluded that the response had adapted to the changing context and ensured a coherent approach across the sector, enabled by sustained funding and strong coordination (132). Findings suggested that UNHCR Lebanon had supported the appropriateness and accessibility of GBV services and had built on local capacity in MOSA SDCs, partnerships with national NGOs and had used monitoring data to adapt activities and services to respond to identified needs, such as Lesbian, gay, bisexual, transgender, intersex, queer, + (LGBTIQ+) and adolescent girls (132). A 2020 report by the Irish consortium for GBV supported many of the previous findings and concluded that sustainability and national government ownership were major concerns (156). They underlined the important role of national and local organizations, who had expanded or emerged to meet the needs of the refugee influx, and encouraged increased investment to promote national ownership and system strengthening (156). An evaluation of GBV and SRH services within the Syria response, which included Lebanon, published by UNFPA in 2020, reinforced the important role of strong GBV coordination led by dedicated long-

term GBV coordinators in driving progress on addressing GBV (23). The report noted the positive impact of multi-year funding, although increased needs generated by the COVID-19 pandemic raised concerns (23). In 2020, ABAAD and UNFPA mapped GBV program services and policies in Lebanon in 2020 and reinforced the significant progress made over the past ten years on reforming the legal framework, expanding survivor-centered GBV services, and engaging government actors and ministries in the GBV space in Lebanon (24).

In summary, Lebanon's protracted emergency response (2012-22) provides a unique and interesting context in which to study GBV coordination and can offer several important insights on effective GBV coordination, which will be further elaborated in chapter 6 and 7. In the next chapter I present the methods used in the case study followed by the three results chapters.

CHAPTER 4: METHODOLOGY AND THEORETICAL FRAMEWORKS

This chapter describes the study methods. The first part of the chapter presents the theoretical and conceptual frameworks grounding this research, explaining how literature on GBV coordination and humanitarian coordination informed the study design and data analysis. Part two describes primary data collection methods, followed by data management and analysis in part three. Methods have also been described in each of the results Chapters 5, 6 and 7, but primary data collection methods are described in greater detail in this section. Finally, I discuss ethical considerations.

THEORETICAL AND CONCEPTUAL FRAMEWORKS

Frameworks assist researchers to organize and plan research questions, data collection, and analysis and support to make assumptions explicit, identify and test hypotheses, and calibrate models against real data (163). Based on the literature, I developed conceptual frameworks to guide the creation of data collection tools and data analysis for my case study. The process of building the conceptual frameworks to guide my research analysis was based on the literature review I conducted for my DrPH review, updated during development of the scoping review and was continually refined throughout the study. I considered several frameworks and theories and incorporated concepts from several of these in my study tools and final analysis. Throughout the research analysis, I continued to develop the frameworks using the systematic approach described by Maxwell, comprised of four elements; experiential knowledge, prior theory and research, pilot and exploratory studies and thought experiments (164).

FACTORS FOR SUCCESSFUL COORDINATION FRAMEWORK

The first framework I considered to guide my research was the Factors for Successful Coordination Framework (Figure 4) which was developed by the New Zealand state services commission to improve coordination among government agencies (48). This framework identifies nine success factors that are consistently recognized in the literature and groups under three separate but interrelated and mutually-reinforcing dimensions: mandate, systems and behaviours (48). The Mandate dimension includes leadership, stakeholder buy-in, and shared outcomes, while the Systems dimension encompasses governance and accountability, resources, and performance measurement. The Behaviours dimension incorporates right representation, skills and competencies, organizational cultures, and shared values and cultures. The authors suggest that ensuring these factors are present can support agencies to coordinate more effectively towards achieving success through collaboration (48).

While this framework included many important concepts, themes and dimensions for understanding coordination more broadly, it was not specific for humanitarian or emergency settings and did not fully represent all of the elements important for GBV coordination in emergencies. Therefore, while the theories informing this framework were important to ground my background knowledge about coordination dynamics and development of my study tools, I decided against using it as my main analytical framework.

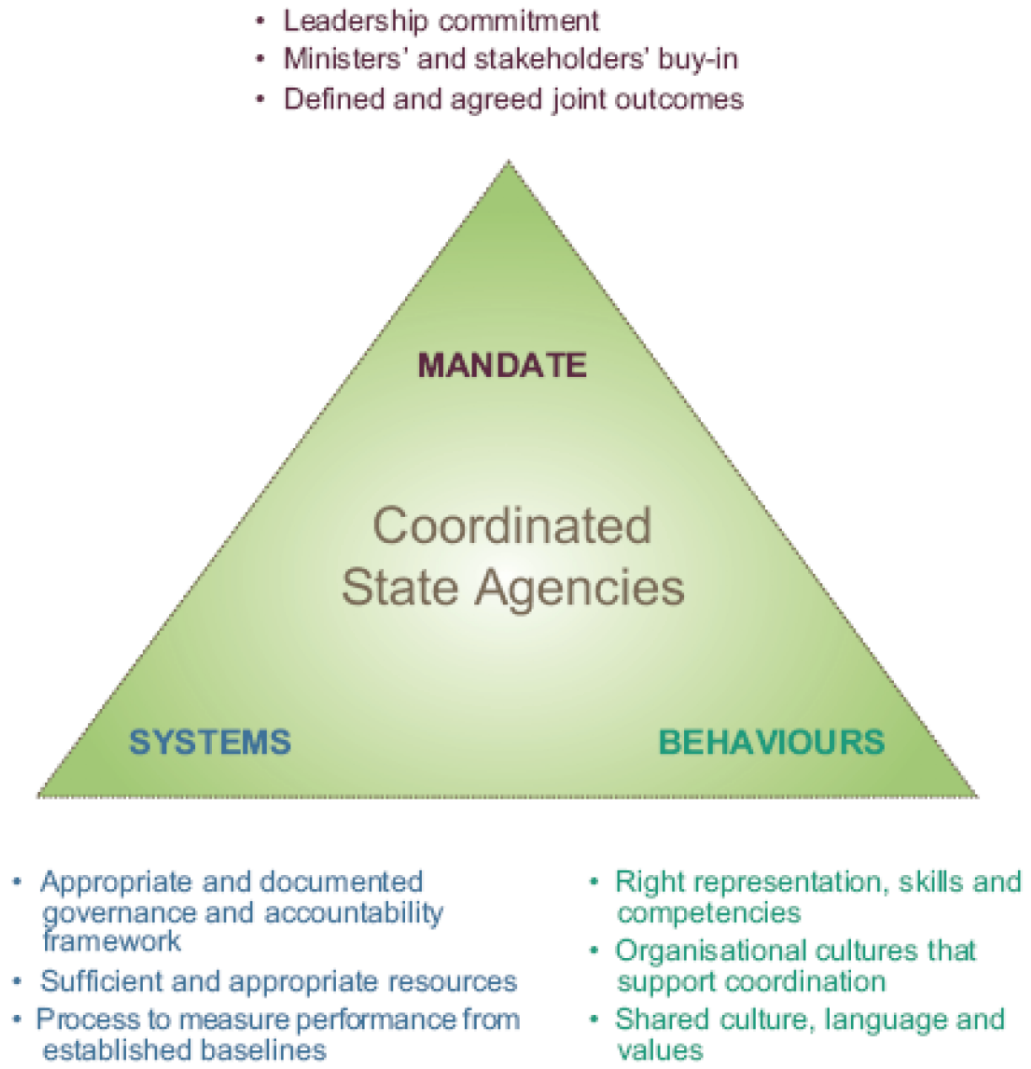

Figure 4: Factors for Successful Coordination Framework (New Zealand state services commission) **(48)**

LITERATURE ON GBV COORDINATION INFORMING THE CONCEPTUAL FRAMEWORKS FOR GBV COORDINATION

In terms of theoretical lenses, the study draws concepts from the Factors for Successful Coordination Framework and key topics explored in research on improving humanitarian coordination described in Chapter 2. In addition, descriptions of GBV coordination in the GBV

coordination handbook and concepts included in the Call to action roadmaps were integrated, as described below (12, 33, 34).

Improving GBV coordination is a key goal of the Call to Action and in the Call to Action Roadmap 2015 and 2021, outcome two is focused on the humanitarian architecture, promoting effective and accountable interagency GBV leadership and coordination (4, 12, 34). The 2021-25 roadmap states that "*effective coordination within the GBV sector, and between other relevant actors and the GBV sector, ensures action and accountability to prevent and respond to GBV at all levels of the response*" (34) p.14. Themes outlined in the Call to Action roadmap 2021-25 include GBV sector coordination at global and field levels, coordination between GBV, PSEA, and gender equality actors, coordination on risk mitigation, integration of GBV, localization, resources and advocacy (34). The priority actions within outcome two include establishing a timely and effective GBV coordination mechanism at the field level, institutionalizing inter-sectoral GBV coordination, and dedicating qualified staff to meaningfully engage with gender and GBV (34). In addition, Chapter 4 of the GBV handbook outlines the steps involved in implementing a GBV sub-cluster, which include: launching an emergency coordination group, encouraging inclusive membership, developing terms of reference and working groups, implementing integration of GBV interventions into other sectors, implementing information management and the GBVIMS, linking national and sub-national coordination groups and ensuring sustainability of GBV coordination (33). Further, the IASC requires six generic core functions of clusters at country level and are outlined in the GBV coordination handbook, to: support service delivery, inform strategic decision-making, plan and implement cluster strategies, monitor and evaluate performance, build national capacity in preparedness and contingency planning and support robust advocacy (58).

Based on key themes included in the Call to Action roadmap 2021-25, the GBV handbook and literature outlined in Chapter 2, I developed a framework for GBV coordination and refined this through the scoping review, arriving at what I have termed the *"Framework for effective GBV coordination"* presented in Chapter 5. Through an iterative process, the framework was refined via a scoping review to identify the six key dimensions and elements within each dimension that frequently emerged in the literature. This conceptual framework was then utilized to guide data collection and analysis to explore Objective two of the study, which aimed to investigate the evolution of GBV coordination in Lebanon's humanitarian response from 2012-2022, albeit with some modifications. Although the six key dimensions were maintained in Chapter 6, the elements within each dimension were applied more flexibly. To address Objective three of the study, which

aimed to examine the effectiveness of GBV coordination within Lebanon's compounded emergencies from 2019-2022, I built upon previous research on improving humanitarian coordination as presented in Chapter 2. By exploring six key themes related to the complex crisis in Lebanon, namely effectiveness of humanitarian coordination, context-relevant and adaptable coordination mechanisms, resourcing coordination, the government's role and legitimacy, the participation and influence of national and local CSOs, and information management, I aimed to gain a deeper understanding of GBV coordination within Lebanon's compounded crises.

SCOPING LITERATURE REVIEW

The methods used to conduct the scoping review are described in detail in Chapter 5.

PRIMARY DATA COLLECTION

Following a desk-based scoping literature review, fieldwork was conducted remotely over a two-year period and involved primary research using mixed qualitative methods of document review, observations, and in-depth interviews (IDIs) as data collection methods. My approach of using mixed qualitative methods enabled triangulation of data to ensure depth of understanding about the GBV coordination mechanism in Lebanon.

IN-DEPTH INTERVIEWS (IDI) AND GROUP INTERVIEWS

A total of 38 interviews were completed for this research. IDIs were used to address objectives 2 and 3, providing perceptions and reflections on the past, present and future functioning of the GBV coordination mechanism in Lebanon. I used IDIs because they provide participants an opportunity to express views based on their own experiences and enabled me to understand the issues from different interviewees' perspectives and to contrast differing views (39). All IDI's was conducted remotely via videoconference (Zoom), due to physical distancing precautions and travel restrictions implemented to combat the COVID-19 pandemic. Green & Thorogood caution that IDIs provide subjective descriptions of issues and at times may not fully represent what actually occurs, therefore meeting observations and document analysis were used to corroborate sources (39). Semi-structured interview guides were developed (Annex 4) to explore the key topics presented in my conceptual frameworks. The guides were piloted and revised prior to data collection. One group interview (two individuals from the same organization) was conducted as requested by the participants; otherwise, individual interviews were preferred. The group interview process followed the same process as individual interviews, using the same topic guide and informed consent process for each individual.

Sampling Strategy

Purposeful sampling (Figure 5) was used to gain a broad range of information-rich cases from a diverse range of actors and organizations on the topic, enabling in-depth study over the 10 years of the humanitarian response in Lebanon. I used a pragmatic approach to determining sample size balancing the need to achieve saturation with practicalities of time and resources (39). I recruited participants by email using the email script in Annex 5. Snowball sampling through interviews and meeting observations was used to augment the list of potential informants ensuring that key individuals were included.

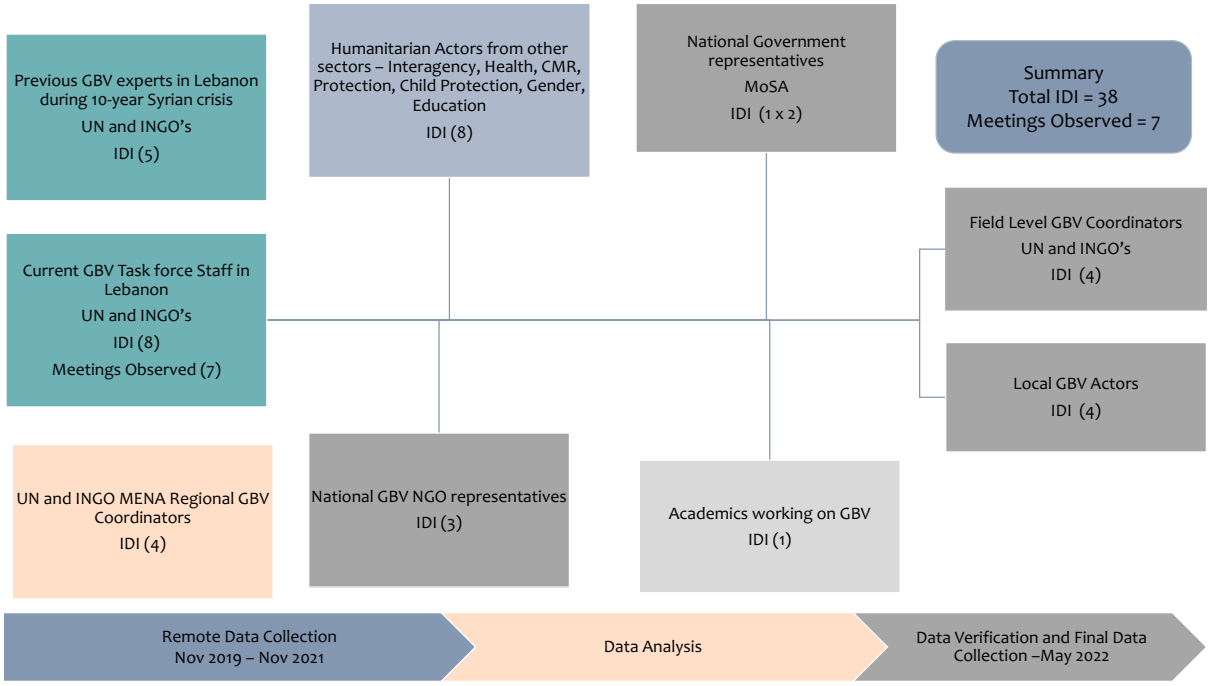

Figure 5: Sampling strategy for in-depth interviews and meeting observations

Table 3 below details interviewee characteristics. I interviewed actors who were involved in the GBV coordination task force in Lebanon over ten years, from 2012-2022. This included current and past members of the GBV task force and international and national GBV coordinators and experts from UN agencies and INGO's in Lebanon and at Regional (Middle East and North Africa) level working on the Syrian crisis response. In addition, I engaged key individuals from sectors closely connected to GBV, including protection, child protection, CMR task force, health, education, gender and the interagency coordination unit. I invited government actors in MOSA, NCLW and MOPH to provide perspectives on the role of government in the GBV coordination system. Unfortunately, only MOSA agreed to participate, limiting Government perspectives. National NGO's who were part of the task force and working on GBV in Lebanon and academics researching GBV and gender were also included as key informants to understand their involvement in, and perception of, GBV coordination.

I also invited donors funding GBV coordination and programmes but did not receive a response. In addition, field level staff, at two UNHCR field sites (North and Beirut and Mount Lebanon), and local organizations working on GBV were engaged as key informants to examine the impact of GBV coordination on field-level implementation and service delivery. I conducted follow-up interviews and informal discussions when clarifications or additional questions were required. Unfortunately, as data collection was conducted remotely, I did not have access to smaller CSOs or refugee-led organizations working at the field level. All interviewees were comfortable in English, and language translation was not necessary. Interviews were audio recorded and augmented by taking field notes.

Table 3: Characteristics of interview participants

CATEGORY OF STAKEHOLDER/ACTOR	TYPE OF ORGANIZATION	NO. OF PARTICIPANTS
GLOBAL GBV ACTORS WHO WORKED IN LEBANON DURING SYRIAN CRISIS	UN	3
	International NGO	2
REGIONAL MENA GBV COORDINATORS	UN	3
	International NGO	1
CURRENT NATIONAL GBV TASK FORCE LEBANON, INCLUDING GBVIMS	UN organizations	4
	International NGO's	4
	National Organizations	3
SUB-NATIONAL GBV COORDINATORS	UN	3
	INGO	1
	Local Organizations	4
MOSA GBV REPRESENTATIVE	Government	1
GBV ACTOR IN LEBANON	Academic	1
HEALTH SECTOR AND CMR COORDINATORS	UN	3
PROTECTION AND CHILD PROTECTION COORDINATOR		2
UN COORDINATORS OF OTHER SECTORS - INTERAGENCY COORDINATION UNIT, GENDER, EDUCATION	UN	3
TOTAL INTERVIEWEES		**38**

MEETING OBSERVATION

Attending organizational meetings can provide invaluable insights on organizations and groups and I attended seven national GBV coordination task force meetings remotely as a participant observer (39). Observational data is assumed to produce the most valid data on social behaviour and can significantly augment qualitative studies by providing validation of what participants claim they do (39). The observations focussed on understanding the participation and roles of different stakeholders, information shared and priorities discussed as well as contextual challenges and relationships between key stakeholders involved in the GBV task force. During the observations, I wrote notes using the observation guide (Annex 4) and expanded those notes following meetings (165). During subsequent interviews, I included questions to gain clarity on some of the aspects observed and also conducted informal follow-up discussions with GBV coordinators. Because of the

remote nature of data collection, I was unable to observe field level task force meetings or meetings of other sectors which integrate GBV risk mitigation, as originally planned.

Field notes

Fieldnotes provide subtle and complex understandings of meanings observed by the researcher during interviews and observations (165). Documenting these processes as they occur, helps to limit distortions of memory in recalling events and to allow deeper reflection and understanding of experiences, helping to build new insight and understanding (165). I took field notes during and directly following each interview and meeting observed and integrated data and insights in my overall analysis.

DOCUMENT REVIEW AND ANALYSIS

In this study, documents provided important background and context over the ten years of the response, helped to track changes and developments, helped to verify findings from other sources and were used as reliable sources of past events (166). Documents included in the analysis were identified through internet searches, in emails shared within the GBV task force, and during interviews and discussions with stakeholders in Lebanon and globally. I was added to the GBV task force mailing list which was helpful to understand the types of information and documents shared. This also facilitated access to meeting minutes, presentations given during task force meetings and documents shared among the task force that were not in the public domain. In addition, during interviews, I requested informants to share any relevant documents or any documents referred to during the interview. Table 4 displays the documents analysed for Objectives 2 and 3, which include policy documents, strategic plans, guidelines, reports, meeting minutes, and other relevant materials. Objective 2 aimed to investigate the evolution of GBV coordination in Lebanon's humanitarian response during the protracted crisis spanning from 2012-2022, while Objective 3 focused on examining the effectiveness of GBV coordination in the context of Lebanon's compounded emergencies between 2019 and 2022.

Table 4: Documents included in the analysis

AUTHOR, YEAR	STUDY	OBJECTIVE 2	OBJECTIVE 3
CAWTAR, 2012 (101)	Situation Analysis of Gender Based Violence in Lebanon	x	
INTERNATIONAL RESCUE COMMITTEE, 2012 (152)	Syrian Women & Girls: Fleeing death, facing ongoing threats and humiliation	x	
UNFPA, UNHCR, IRC, UNICEF, IMC, 2015 (167)	Evaluation of Implementation of 2005 IASC Guidelines for Gender-based Violence Interventions in Humanitarian Settings in the Syria Crisis response	x	
WOMENS REFUGEE COUNCIL, 2016 (150)	The Call to Action on Protection from Gender-based Violence in Emergencies: Field-level Implementation Urgently Required	x	
KELLEY, 2017 (116)	Responding to a Refugee Influx: Lessons from Lebanon	x	
CARRERAS E., 2017 (134)	"Gender Analysis in Lebanon" Situation Analysis report	x	
LILLESTON ET AL., 2018 (168)	Evaluation of a mobile approach to gender-based violence service delivery among Syrian refugees in Lebanon	x	
HANLEY, 2018 (132)	Evaluation of UNHCR prevention and response to SGBV in the refugee population in Lebanon (2016–2018)	x	
IRISH CONSORTIUM ON GBV, 2019 (156)	Responding and Empowering GBV Services in Lebanon in Response to the Syrian Crisis	x	x
UNFPA, 2020 (23)	Evolution of gender-based violence and sexual and reproductive health services within the Syria crisis response 2017–2020	x	x
ABAAD & UNFPA, 2020 (24)	Mapping gender-based violence programmes, services, and policies in Lebanon	x	x
GOVERNMENT OF LEBANON AND UNITED NATIONS, 2015	Lebanon Crisis Response Plan 2015- 2017	x	
GOVERNMENT OF LEBANON AND UNITED NATIONS, 2017	Lebanon Crisis Response Plan 2017- 2020	x	
GOVERNMENT OF LEBANON AND UNITED NATIONS, 2018 (127)	Lebanon Crisis Response Plan 2017- 2020 (2018 update)	x	
GOVERNMENT OF LEBANON AND UNITED NATIONS, 2021 (133)	Lebanon Crisis Response Plan 2017- 2021 (2021 update)	x	x
GOVERNMENT OF LEBANON AND UNITED NATIONS, 2022 (131)	Lebanon Crisis Response Plan 2022-2023	x	x
	Lebanon Crisis Response Plan compendium	x	
OCHA, HUMANITARIAN COUNTRY TEAM AND PARTNERS, 2021 (159)	Emergency response plan Lebanon 2021-2022	x	x
UN WOMEN, UNHCR, UNICEF, ABAAD, CARE, DRC, IRC, INTERSOS, 2020 (169)	Joint Assessment: Impact of COVID-19 on the SGBV Situation in Lebanon		x

AUTHOR, YEAR	STUDY	OBJECTIVE 2	OBJECTIVE 3
INTER-AGENCY SGBV TASK FORCE LEBANON, 2021 (170)	The Impact of Lebanon's Fuel and Electricity Crisis on Sexual- and Gender-Based Violence Programming		x
UN WOMEN, UNFPA, 2020 (171)	Violence against women in the time of COVID-19, Lebanon 2020		x
UN WOMEN, 2021 (145)	A rapid gender analysis of the August 2020 Beirut explosion: An intersectional examination		x
UNFPA, 2020 (172)	COVID-19 / UNFPA best practices and lessons learned in humanitarian operations in the Arab region		x
INTER-AGENCY SGBV TASK FORCE LEBANON, 2021	GBV task force Meeting minutes April 2022 – November 2022	x	x
GBVIMS LEBANON, 2022 (158)	Gender-Based Violence Information Management System Analysis of an increase in GBV incidents against children Quarter 3—2021		x

Table five below summarises the data contributing to each of the two objectives of the case study, including details on the time period covered, numbers of IDI, GBV task force meetings observed and documents reviewed, as well as the period of data collection and analysis method and framework used.

Table 5: Data collection contributing to each objective

	OBJECTIVE 2	OBJECTIVE 3
AFFECTED POPULATION TARGETED BY GBV COORDINATION	Syrian refugees in Lebanon and host population	Lebanese people, Syrian refugees, other refugees and migrants living in Lebanon
TIME PERIOD COVERED	2012-2022	2019-2022
NUMBERS OF IN-DEPTH INTERVIEW	38	29
INTERVIEW PARTICIPANTS	UN, INGO, Academic, Government, Local and National Actors currently working in Lebanon or having worked in Lebanon from 2012-22	UN, INGO, Academic, Government, Local and National Actors currently working in Lebanon
GBV TASK FORCE MEETINGS OBSERVED	0	7
DOCUMENTS REVIEWED	19	13
PERIOD OF DATA COLLECTION	Oct 2019 - May 2022 (Interruption from Nov 2019 – July 2020 and Nov 2020 – Feb 2021)	Feb 2021 – May 2022
ANALYSIS METHOD USED	Framework analysis	Framework analysis
FRAMEWORK USED	Framework for effective coordination	Research on improving Humanitarian coordination

DATA MANAGEMENT, ANALYSIS AND VERIFICATION

DATA MANAGEMENT

I designed, coordinated and implemented all research activities myself, including conducting IDIs meeting observations, document analysis and recording of field notes as well as the data management, analysis, interpretation and writing. This direct involvement in all aspects of the study meant that I approached analysis with prior knowledge of the data and key issues which supported with data familiarisation, one of the critical steps in the qualitative data analysis (173).

DATA ANALYSIS

My analytical approach involved framework analysis, adapted from Gale et al. (174), based on my thesis conceptual frameworks described above. The Framework method is a tool for supporting analysis of interview data and documents as it provides a systematic model for managing and mapping the data, allowing the researcher to generate themes by comparing data from different cases and sources (174). The thematic coding matrix creates a structured overview of summarised data (174). Analysis was iterative, and I analysed data and refined the approach throughout data collection, including emerging themes and apply working theories to future interviews. I remained flexible and adaptable throughout the research analysis in order to allow themes to emerge and to generate rich and nuanced interpretations that explored the complexity of the issues emerging (174).

Framework analysis involved the following key steps:

Transcription

Transcription of the interview recordings was conducted by a transcription service rev.com and quality assured by checking against the audio. Interview transcripts were anonymised after transcription by replacing the participants name with the unique interview code (described below) assigned, ensuring that the participant could not be identified by the transcript.

Data immersion and familiarization

The step involved repeated reading of the interview notes and transcripts, observation notes and field notes. As I was directly involved in all study activities, familiarisation with data began during the data collection process (175). Following each interview, I reflected on the fieldnotes and transcripts and revised the topic guides to include emerging themes or ideas. Before each new interview, I reviewed my topic guide and highlighted the areas I wanted to focus on with the particular interviewee, depending on their position and expertise.

Coding, and applying and charting data into an analytical framework

Based on the study frameworks and reflection and analysis of the initial five interviews, I developed a coding framework of themes and codes but this did not blind the analysis to ignore other emerging themes. I then tested those codes against my data to determine if additional codes were required. I adapted my conceptual framework to account for any emerging themes or codes, and then collected additional data. The process of coding allowed me to generate additional codes beyond the frameworks, as they emerged through data analysis. I continually refined the coding framework, adding emerging themes as I conducted additional interviews. As a result, this iterative process allowed me to synthesise emerging themes and develop a comprehensive understanding of GBV coordination in Lebanon. I coded all interview transcripts, observation and field notes and several documents using NVivo 12 software (176).

Interpreting the data

To develop a write-up for each theme, I explored relationships between themes and connections with the broader literature to develop interpretations of the findings and create an overarching story. At this stage, I also reflected on how all themes fitted together to address the research questions, and on relationships between themes to establish explanations of the findings. I maintained a research journal, where I recorded reflexive notes, impressions of the different cases and data, reminders of follow-up questions and documents to access and thoughts about analysis throughout the process, and discussed these with my supervisory team and GBV coordinators in Lebanon (174).

DATA VERIFICATION

In May 2022, I travelled to Lebanon to conduct a data verification workshop with members of the GBV task force and key informants who participated in the research. During the meeting I presented my preliminary research findings and provided a forum for stakeholders (18 individuals, in-person and online) to give feedback on the accuracy and completeness of findings. This field trip allowed me to collect additional data and to fill gaps in my existing analysis and provided an opportunity to reflect on my findings in collaboration with key members of the GBV task force, some of whom had worked on the response since 2012, ensuring that my interpretations were validated and any gaps or uncertainties clarified. Additionally, following the data verification meetings and integration of final data analysis, I presented my findings to the broader GBV coordination task force in Lebanon during a monthly meeting, and received constructive feedback. Following the meeting, I shared my presentation and draft paper abstracts with participants for additional comments and feedback.

Ethical Considerations

For this study, I received ethical approval from the London School of Hygiene and Tropical Medicine Observational / Interventions Research Ethics Committee (Project ID: 16208) in September 2019 and the institutional review board of the American University Beirut (Protocol Number: SBS-2020-0067) in February 2021. Several issues were considered to ensure that this research upheld the highest ethics standards, which I will discuss below alongside the actions I took to pro-actively address ethical issues as they arose.

Local ethical approval

The process of obtaining local ethics approval was fraught with delays and challenges which I had to navigate. In advance of submitting an application, in 2019, I developed connections with the Executive Director of the Arab Institute for Women (AiW) at the Lebanese American University (LAU) who agreed to facilitate the application process and access to their network of partners working on GBV in Lebanon. Directly after receiving LSHTM ethics approval in September 2019, I submitted an application to LAU. However, after five months it became clear that the application would not be processed due to staff shortages caused by the social and political unrest in Lebanon. I then approached Dr. Jinan Usta, at the American University Beirut (AUB), who agreed to support my local ethics application and to act as Co-PI in Lebanon. Dr Jinan Usta has significant experience in research on GBV in Lebanon and AUB is a highly reputable University based in Beirut with established links and collaborations with LSHTM. I submitted an ethics application in February 2020 but experienced further delays with obtaining approval due to COVID-19 pandemic and the compounded emergencies in Lebanon. The application also required multiple reviews and resubmissions, including an AUB requirement to switch data collection to remote due to the COVID-19 pandemic, all of which took considerable time and effort. In addition, a collaboration agreement was developed and signed between LSHTM and AUB as part of the local ethics application. The application was eventually approved in February 2021. Subsequently, an amendment was submitted to, and approved by, LSHTM to align with the final AUB ethics approval. In February 2022, I also submitted study continuation reviews to both universities.

Building trust, rapport and maintaining confidentiality

As I was studying a relatively small population of policy actors who could be potentially identifiable to each other and other stakeholders, building trust, rapport and maintaining confidentiality was important. Prior to conducting the research, I developed several connections in Lebanon with individuals involved in GBV coordination who confirmed their interest in participating in the

research, including UNHCR and UNFPA GBV coordinators, the Director of ABAAD, one of the biggest National GBV NGOs in Lebanon and academics at LAU and AUB conduction research on GBV. My initial research proposal was reviewed by the GBV task force who provided valuable input, facilitated by the UNHCR GBV coordinator at the time, which assisted me to finetune my objectives. Review and discussion with key GBV experts in Lebanon during definition of study objectives and the study design stage in 2018, was important for me to ensure that the research could have a practical application and relevance for the GBV task force in Lebanon. From the design stage, they were supportive of my research, viewing it as relevant, meaningful and useful.

My GBViE mentor, and the UNFPA GBV coordinator in Lebanon in 2020-22, was a key facilitator for my study. Before I began data collection in February 2021, she provided an opportunity for me to present my research proposal to the GBV task force core group during which I got buy-in from different stakeholders on the value of the research and their willingness to participate. This reflected the interest of UNFPA and their mandate to support evidence generation on GBV. Another key facilitator was the MOSA GBV coordinator whose support may have encouraged engagement of key stakeholders in interviews. During this meeting, one UN GBV expert voiced concerns about the timing of my research on coordination in Lebanon, perhaps signifying some sensitivities around coordination at the time. This perspective was not shared by others within the task force however, which included international, national and local actors, who were all supportive of the research and indicated their willingness to participate. Regular calls during 2021 with my mentor supported to validate and augment the interpretation of my findings as I collected and analysed data and facilitated access to key stakeholders. In addition, the UNFPA and MOSA GBV coordinators helped to arrange the data verification meeting in May 2022 during which I received very positive and helpful feedback and in July 2022, gave me an opportunity to present my findings to the GBV task force.

From the beginning, my position as an “outsider” not being a GBV “expert” nor ever having worked in the Lebanese’s context meant that I was not viewed as someone with a vested interest or agenda. Positively, this may have helped in gaining trust of my informants as I did not have any affiliation with any organization, which was likely to have supported openness and authentic and nuanced responses during interviews. Many of my interviews lasted longer than one hour, suggesting that interviewees felt comfortable sharing information, experiences and insights with me.

During interviews, to encourage informants to be open and candid about their opinions and experiences I endeavoured to guarantee anonymity and maintain confidentiality and obtained

written or verbal informed consent. To ensure that the identities of those interviewed or observed remained anonymous and information provided remained confidential, I assigned anonymous codes to informants and interview records. I created a list of interviewees names and emails and assigned a unique, individual code to each one. This document was stored separately from the raw data and I did not use participants names or identifiers when storing the recordings, transcripts or any raw data, in the thesis or in any publications. I was the only person with access to raw data or with a copy of the original recordings and transcripts. The list of identifiers and corresponding codes were stored separately on a different computer, also password protected, limiting access to myself as lead researcher. The interviews always began by introducing the purpose of the study and sharing a participant information sheet (Annex 6) and only took place after the interviewee had agreed to participate and signed the informed consent form (Annex 7) or provided verbal consent. As a more robust way of gaining consent, where possible I obtained written consent using the approved consent forms. However, when this was not possible or where participants were not comfortable with providing written consent for any reason, verbal consent sufficed (1 informant). Participants could decline to answer any questions that they are not comfortable answering or to stop the interview at any stage and all information remained confidential. This safeguarding protocol, intended to support and protect participants, did not need to be initiated at any stage.

For meeting observations, I only attended meetings that I was invited to attend and observe by the host. The host/chair of the meeting informed participants of my presence at the initial meeting and that I was conducting observation for a research study. For subsequent meetings, I always signed the electronic attendance sheet notifying participants of my presence. Because all of the meetings were large meetings (>10 people), individual written consent was not possible. I did not record the meetings but took notes according to the observation guide (Annex 4).

PROVISION FOR PSYCHOSOCIAL SUPPORT SERVICES

Prior to conducting interviews with participants in Lebanon, I had made provisions to refer any participants showing distress during the interview to psychosocial support services. Given that the study population were GBV coordinators, GBV experts and employees of organizations working on the humanitarian response and *not* GBV survivors, the risk of them needing psychosocial support as a result of participating in this research was extremely low. All interviews took place remotely via zoom and no participants expressed distress at any stage during the interview. The majority of organizations working on GBV in Lebanon already had psychosocial support services available for staff members if necessary. My co-PI in Lebanon had confirmed that in the unlikely event that

participants required psychosocial support because of their participation in this research, psychosocial support services were available and the informant would be referred to services run by three organization's, including: IMC, ABAAD and KAFA.

REFLEXIVITY

Reflexivity is an important concept in qualitative research and influences the generalisability, replicability and scientific rigour of the methods (177). Although numerous definitions exist, most converge on the general understanding of: *"a process that challenges the researcher to explicitly examine how his or her research agenda and assumptions, subject location(s), personal beliefs, and emotions enter into their research"* (178) p.212. Essentially, reflexivity involves turning the investigative lens on the researcher and helps to examine how the researcher's individual position affects the methods applied, questions asked, data collected and interpretations of the findings (175, 179). Reflexivity recognises that the researcher plays an active role as a participant in the knowledge production process rather than simply being an outsider-observer (177).

I acknowledged that I held a privileged position, as an educated, Irish, white woman with the backing of my academic institute and professional experience, while interacting with my research participants. As debates on the localization of research, global health, and humanitarian action gain traction, I attempted to be reflexive of how my position may have influenced the reflections of some of my informants or my analysis and interpretation of the findings. I was particularly conscious of this during the data verification meeting where I met Lebanese's local actors who took the time to engage in my research while they were all struggling professionally and personally in the difficult economic circumstances. One government participant even travelled from Tripoli, in North Lebanon, to participate in-person, for which I was very grateful.

Throughout the data collection and analysis, I sought to remain reflexive by critically reflecting on the research itself (39). As recommended by Green and Thorogood, I considered the broader political and social context to unpack my assumptions and to identify ways in which the context may have shaped my research findings (39). Also, I considered my role in generating and analysing the data, particularly in managing and accounting for any personal bias I had on the topic based on my gender, cultural and social background, views and opinions (39). This involved taking note of issues observed or noted from the interview and taking time to reflect on my interpretation of issues or events, while questioning whether my personal biases or position influenced those aspects. During data collection the fact that I had neither worked on GBV or in Lebanon before, meant that I asked

probing questions, and did not jump to conclusions based on experience, which I believe resulted in a more nuanced understanding. It may have also allowed me to recognise issues that appeared obvious to an outsider, but those embedded within the system may have been unaware of.

ACCESS TO INFORMANTS, REPRESENTATION OF DIFFERENT VOICES AND DATA VERIFICATION

Amid drives for localization of humanitarian aid and research and insistence in academia on co-production, I endeavoured to balance the voices of local and national actors with those of international stakeholders. However, my position as an outsider and the remote nature of data collection, may have negatively affected accessibility and selection of study participants, representation of different voices and the understanding of the study setting which may have, to some extent, influenced data collection and interpretation of the study findings. In addition, lack of familiarity with some of the gate keepers or authorities and inability to meet people in person, worsened by the fact that I was not in Lebanon, made it difficult to access actors at field sites.

If it had been possible for me to conduct data collection in Lebanon, there would have been several other opportunities that I could have explored. Firstly, I would have conducted meeting observation at national and field level in person which I believe would have expanded my reach in terms of interview participants. This would have also provided an opportunity to have informal discussions following meetings which would have deepened my understanding of the context and of coordination dynamics. An interesting opportunity would have been to conduct observational studies, such as shadowing coordinators, to validate the information obtained through interviews and gain a better understanding of their day-to-day work and interactions. However, due to the remote nature of data collection caused by COVID-19, this was not feasible. Furthermore, conducting an observational study would have required a different level of ethics approval and organizational approvals from UN, and other organizations and would have been time and space limited to observing one or two coordinators as opposed to the entire duration of the study. In addition, I would have liked to visit women's safe spaces, shelters, social development centers (SDC), and health facilities providing CMR, to gather observational data and insights on the reality on the ground. Unfortunately, it was not possible to visit such places due to the remote nature of data collection. The opportunity to visit one SDC was explored during a trip to Lebanon, however, it was closed due to the week before the election, and many government staff were not working. Lastly, if I were able to be in Lebanon, I would have liked to visit local organizations' offices and meet people in person in their own settings to gain a better understanding of how they had developed and expanded throughout the crisis and how this had affected them.

Due to a lack of funding, I was unable to offer compensation for the time or effort of my collaborators or informants, nor was I able to hire a research team to support data collection. Consequently, I had to collect all data by myself in English, which restricted access to some individuals who only spoke Arabic. This language barrier may have contributed to the limited participation of government actors. Furthermore, my initial email invitations and presentation of my research at GBV task force meetings were conducted in English, which further hindered my ability to engage with those who solely spoke Arabic, including refugee-led organizations and Syrian refugees involved in the response. However, as a requirement for obtaining local ethics approval from AUB, all research instruments were translated into Arabic, enabling me to communicate with potential interviewees in Arabic, if required. Moreover, AUB would have provided translation services for conducting interviews in Arabic as part of the collaboration, however this resource was not utilised.

Data verification was an important and useful component of this study, which compensated to some degree for the remote nature of data collection. This exercise helped to ensure that research findings were accurate, practical and useful for the GBV task force in Lebanon and gave task force members the opportunity to comment on preliminary findings and to gather additional data. This meeting also attracted participants who had not engaged in interviews but were interested in the findings and who also provided some interesting and insightful reflections on GBV coordination and on the accurateness of my findings. For example, UNHCR coordinators attended along with participants from local feminist organizations who had not engaged in interviews, which gave them an opportunity to contribute to data and research findings. This experience also deepened my understanding of the Lebanese's context which was particularly important in the rapidly evolving and multiple layers of crises.

Data management

Interviews were recorded on my laptop which automatically synced to my personal iCloud storage and later transferred into an external hard drive for secure storage, all of which are password protected, limiting access. Hard copies of data were not used or stored anywhere as all documents and raw data were stored as electronic versions on my devices. Following completion and write-up of the study data will be stored for five years securely and confidentially.

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RESEARCH PAPER COVER SHEET

Please note that a cover sheet must be completed for each research paper included within a thesis.

SECTION A – Student Details

Student ID Number	1603924	**Title**	Ms
First Name(s)	Philomena		
Surname/Family Name	Raftery		
Thesis Title	Gender based violence (GBV) coordination in emergencies		
Primary Supervisor	Dr Ligia Kiss		

If the Research Paper has previously been published please complete Section B, if not please move to Section C.

SECTION B – Paper already published

Where was the work published?	Conflict and Health		
When was the work published?	June 2022		
If the work was published prior to registration for your research degree, give a brief rationale for its inclusion			
Have you retained the copyright for the work?*	**Yes**	Was the work subject to academic peer review?	**Yes**

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Where is the work intended to be published?	
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Stage of publication	Choose an item.

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For multi-authored work, give full details of your role in the research included in the paper and in the preparation of the paper. (Attach a further sheet if necessary)	

SECTION E

Student Signature	[redacted]
Date	05/01/2022

Supervisor Signature	[redacted]
Date	10/01/2023

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Conflict and Health

RESEARCH Open Access

Gender-based violence (GBV) coordination in humanitarian and public health emergencies: a scoping review

Philomena Raftery[1*], Natasha Howard[1,2], Jennifer Palmer[1] and Mazeda Hossain[1,3]

Abstract

Background: Gender-based violence (GBV) is a global health, human rights, and protection issue, which can increase during emergencies. GBV coordination is an essential component of every humanitarian response, ensuring that, from the earliest phases of a crisis, accessible and safe services are available and prevention and mitigation mechanisms are implemented to reduce GBV. We sought to address the limited evidence on GBV coordination, by reviewing literature on GBV coordination in emergencies, identifying facilitators and barriers influencing effectiveness.

Methods: We conducted a scoping review on GBV coordination in emergencies from 1990 to 2020. Studies explicitly discussing GBV coordination in humanitarian, natural disaster and public health emergencies, in low or middle-income countries, were included. Using thematic analysis, we developed a six-topic framework to synthesise evidence on effective GBV coordination and present recommendations for strengthening GBV coordination in emergencies.

Findings: We included 28 of 964 sources identified, covering 30 different emergency settings across 22 countries. Sources spanned emergency settings, with minimal evidence in public health emergencies and none focussed solely on GBV coordination. Several sources suggested that timely establishment of GBV coordination mechanisms, led by dedicated, experienced coordinators, increased funding and strengthened service provision. GBV risk mitigation was compromised by weak commitment across sectors, poor accountability systems, and limited engagement of affected women. Inclusive GBV coordination, involving national and local actors is vital but engagement efforts have been inadequate and localisation funding targets not yet achieved. Implementation of the GBV Information Management System has reinforced coordination, funding allocation and service provision. While specialist GBV services remain insufficient, emergencies can present opportunities for expansion. Sustainability and long-term impact are compromised by over-reliance on international leadership and funding, weak commitment by governments, and limited attention to GBV prevention.

Conclusion: Despite enhanced global commitments to addressing GBV in recent years, it remains consistently under-prioritised and under-resourced. Recommendations to strengthen GBV coordination in emergencies include: funding dedicated GBV coordination positions across all types of emergencies, building the global GBV coordination workforce, expanding inclusion of national actors and investing in GBV risk mitigation and prevention through

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Abstract

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Conclusion

Despite enhanced global commitments to addressing GBV in recent years, it remains consistently under-prioritised and under-resourced. Recommendations to strengthen GBV coordination in emergencies include funding dedicated GBV coordination positions across all types of emergencies, building the global GBV coordination workforce, expanding inclusion of national actors and investing

in GBV risk mitigation and prevention through multiyear funding. The evidence-based framework for effective GBV coordination presented here, can guide further research in diverse emergencies.

INTRODUCTION

EVOLUTION OF GENDER-BASED VIOLENCE (GBV) COORDINATION IN EMERGENCIES

Gender-based violence (GBV) is a global health, human rights, and protection issue, which often goes underreported and unaddressed (4). The Inter-Agency Standing Committee (IASC) defines GBV as *"an umbrella term for any harmful act that is perpetrated against a person's will, and that is based on socially ascribed (ie. gender) differences between males and females"* p.5 (180). Humanitarian emergencies, which are becoming increasingly complex and protracted (20, 45), can perpetuate GBV, as vulnerabilities and risks increase and family and community protections are stretched or collapse (12). During emergencies, coordination between UN agencies, national governments, international, national and local organizations, within the established humanitarian coordination architecture, ensures that responses are effectively delivered (181). Through collaborative efforts that optimally use available resources and capacities, effective coordination identifies and meets priority needs, addresses gaps and reduces duplication (33, 35). GBV coordination is an essential component of the humanitarian response, which ensures that from the earliest phases of a crisis, accessible and safe services are available to survivors and that prevention and mitigation mechanisms are put in place to reduce incidents of GBV (33). Despite expanded international attention and growing evidence on GBV response, risk mitigation and prevention in emergencies, GBV coordination, while recognised as a vital to addressing GBV, is rarely explored systematically. This study aimed to fill this gap by synthesising the research evidence on GBV coordination in emergencies, identifying facilitators and barriers to effective coordination.

Deeply entrenched in gender inequality, GBV is often reinforced by patriarchal norms, discriminatory laws, and socio-cultural norms that undermine women's rights (4, 5). GBV takes many forms in humanitarian settings, with estimates that one in five refugee or displaced women experience sexual violence (17). In camp settings for displaced people, intimate partner violence (IPV) is often the most common reported form of GBV (8, 18, 19). Public health emergencies such as epidemics and pandemics also increase GBV-related risks and limit access of survivors to services, due to lockdowns and staff and resource constraints (22, 23).

GBV coordination in humanitarian emergencies falls within the protection cluster in the United Nations (UN)-led international humanitarian cluster system adopted in 2005 (104), with the GBV Area of Responsibility (AoR), led by UNFPA, acting as the global forum for GBV coordination, since 2006 (33). The GBV AoR leads GBV coordination in non-refugee emergencies (35), while in refugee contexts, UNHCR takes the lead under the refugee coordination model, often in collaboration with

UNFPA (33, 66, 182). At the country-level, GBV coordination ensures a multi-sectorial and multi-level response for survivors, including Health, Mental Health and Psychosocial Support (MHPSS), Legal aid, and Livelihoods (33). The Gender-Based Violence Information Management System (GBVIMS) enables GBV service providers to safely and ethically collect, store, analyse, and share data related to reported GBV incidents which informs coordination and programming (13). National and field-level coordination mechanisms often have different, but complementary functions (33).

Addressing GBV requires a broad multi-sectorial, interagency approach, therefore, successful GBV coordination, depends on a wide variety of actors collaborating to achieve safe, ethical and comprehensive GBV programming (33). GBV coordination promotes a shared understanding of GBV amongst humanitarian, national and local actors, ensuring that GBV minimum standards and guiding principles are known and that GBV is prioritized by response leadership, donors and actors (33). Crucially, the 2015 guidelines state that all humanitarian actors must act under the assumption that GBV is occurring, regardless of the existence of evidence and outline responsibilities and actions to be taken by each sector to identify and mitigate GBV risks (180). The GBV sector is closely linked with the work of the larger Protection sector, and also with the other areas of responsibility within the Protection sector, particularly child protection (33, 104). Close coordination with the Health cluster, is required for implementation of the Minimal Initial Service Package (MISP), which provides guidance on sexual and reproductive health (SRH) and GBV service provision in emergencies, and Clinical Management of Rape (CMR) services (33, 107). MHPSS responsibilities are usually attached to the Health or Protection clusters or addressed within a cross-sectoral working group (33). Other sectors with specific GBV risk mitigation responsibilities include WASH, Shelter, Education and Livelihoods. Systemic gender inequality is recognized as a root cause of GBV, therefore, gender equality programming is critical and Protection against Sexual Exploitation and Abuse (PSEA) is also often closely linked to GBV coordination (33, 104). The cross-cutting nature of GBV programming can make coordination of diverse actors operating within complex, emergency contexts challenging, which can compromise GBV survivors' access to services (8).

GBV Policy context Advances

International attention and commitment to addressing GBV in emergencies has rapidly expanded in recent years (105). The UN Security Council has adopted seven ground-breaking resolutions which frame the Women, Peace, and Security agenda over the past two decades (102, 103). GBV funding flows and accountability mechanisms increased considerably following the 2013 multi-stakeholder global Call to Action on protection from GBV in emergencies which mobilized attention and high-

level commitment from global actors and donors (4, 105). Call to Action partners launched five-year road maps in 2015 and 2021, with outcome two, focused on the humanitarian architecture, promoting effective and accountable inter-agency GBV leadership and coordination (12, 34). Several international best practice standards, guidelines, training resources and technical tools to support GBV coordination in emergencies have also been developed (105) including the 2015 guidelines for Integrating GBV interventions in humanitarian action (183); the 2010 handbook (updated in 2019) for coordinating GBV interventions in emergencies (33, 104); a 2014 set of core competencies considered necessary for effective GBV prevention and response programming and inter-agency coordination (90); and a 2020 set of minimum standards for GBV programming in emergencies (184). At the operational level, in 2014 creation of GBV AoR Regional Emergency GBV Advisor (REGA) roles for deployment in Level three emergencies, was a successful follow-up to these global-level investments. GBV is a now a core component of UNHCR's protection mandate and GBV and gender equality are priority areas in UN Humanitarian Coordinators' Terms of Reference.

Within this rapidly evolving context, understanding what influences effective GBV coordination in different contexts is critical. While several systematic reviews investigate GBV prevention and response in humanitarian settings, literature exploring GBV coordination is limited. This review aimed to examine literature on GBV coordination in humanitarian and public health emergencies to identify facilitators and barriers to effective GBV coordination and to draw out lessons for strengthening GBV coordination in emergencies.

METHODS

STUDY DESIGN

We conducted a scoping review from October 2020 to January 2021 using Arksey & O'Malley's five-stage approach (185, 186). The term "emergencies" refers to situations of armed conflict or natural disaster, involving population displacement, or public health emergencies such as outbreaks, epidemics or pandemics (187).

RESEARCH QUESTION

Our research question was intentionally broad to capture a range of sources (185): 'What is the existing evidence on GBV coordination in emergencies, including facilitators and barriers influencing its effectiveness?'

IDENTIFYING POTENTIAL SOURCES

We initially searched six databases (i.e. Web of Science, Scopus, Pubmed, Medline, EMBASE, Global Health systematically using search terms related to three concepts: (a) humanitarian response/crisis/emergency; (b) emergency response coordination; and (c) gender-based violence/GBV (Additional File 1: Box 1 Search strategy). Secondly, we searched 12 relevant websites purposively (i.e. GBV AoR, OCHA, UNHCR, UNFPA, UN Women, UNICEF, WHO, International Rescue Committee [IRC], CARE, Women's Refugee Council, ALNAP, Interagency working group on reproductive health in crises (IAWG)) using 'GBV coordination' and related search terms. Finally, we searched reference lists for additional relevant sources.

SELECTING SOURCES

We screened potential sources by title and abstract and the remainder by full text against eligibility criteria (Table 1). We included humanitarian, natural disaster and public health emergency settings in low or middle-income countries including emergency onset, relief and recovery phases. We included any affected populations (e.g., refugees, service providers, emergency responders, policy professionals), any study design (e.g., qualitative, quantitative, evaluation), published from 1990-2021 in English. We only included sources explicitly discussing GBV coordination and excluded those reporting interventions or approaches to GBV prevention and response that did not explicitly discuss GBV coordination. Conference abstracts, training materials, social media, media, and guidance and policy documents were excluded.

CHARTING AND SYNTHESIS

We kept the definition and scope of GBV coordination broad to capture a range of data. We extracted data using the six elements outlined in the Call to Action roadmap outcome two, i.e. GBV Sector coordination; coordination between GBV, PSEA, and gender equality; coordination on risk mitigation; integration of GBV; localization; resources and advocacy (34). We synthesised data on each topic then used an iterative approach, informed by Ritchie & Spencer's framework method (188), and the coordination functions outlined in the GBV coordination handbook (33), to develop six synthesised themes: (i) Implementing a GBV sub-cluster; (ii) GBV prioritisation, advocacy and access to resources; (iii) GBV risk mitigation and integration; (iv) GBV localization; (v) GBV data and information management; and (vi) GBV coordination to support service delivery. We used thematic analysis to identify and summarise data on facilitators and barriers to effective GBV coordination within each theme.

Table 1. Eligibility criteria

CATEGORY	*INCLUSION CRITERIA*	*EXCLUSION CRITERIA*
CONTEXT	• Humanitarian and public health emergency settings including relief, and recovery phases	• Other settings • Pre-emergency, non-emergency settings e.g. preparedness
TOPIC	• Studies explicitly mentioning GBV coordination and containing information pertaining to at least one of the key topics of GBV coordination identified as: Implementing a GBV sector; GBV prioritisation, advocacy and access to resources; GBV risk mitigation and integration; GBV localization; GBV data and information management; and (GBV coordination to support service delivery.	• Studies that did not explicitly mention GBV coordination • Reviews or evaluations of individual GBV response or prevention interventions or approaches • Other topics
SOURCE TYPE	• Research articles • Systematic/scoping reviews • Technical reports with a research component • Organizational reports • Evaluations	• Conference abstracts covering material in a publication • Training materials • Individual/household case studies. • Protocols, methods description only • Social media/media, audio/video • Guidance and policy documents
STUDY DESIGN	• All study designs	• No research component/entirely theoretical
PARTICIPANTS/ POPULATION	• Staff of UN, international and national organizations working on GBV in emergency settings, GBV service providers and affected populations in emergency and humanitarian settings.	• Populations in non-emergency/non-humanitarian settings
PUBLICATION YEAR	• 1990 – January 2021	• Pre-1990
LANGUAGE	• English	• Other languages with no English abstract

RESULTS

SOURCE CHARACTERISTICS

We included 28 sources of 964 identified (i.e. 896 from databases, 25 from websites, 43 from reference lists). Figure 1 presents the PRISMA flow diagram and Table 2 provides characteristics of included sources. All studies were conducted and published between 2008-2020. Most (23) included frontline 'field-level' perspectives covering 30 different emergency settings across 22 countries. (i.e. 12 Middle East and North Africa region - primarily the Syrian refugee crisis (10/12), 12 sub-Saharan Africa, six Asia-Pacific region, four Americas, 10 multi-country, 5 global-level), although none focussed solely on GBV coordination. Three sources discussed public health emergencies (i.e. 2013-

16 West Africa Ebola epidemic, 2012 cholera outbreak in Haiti, COVID-19 within the Syrian refugee crisis), five covered natural disasters (i.e. Pakistan floods, Ethiopia drought, Indonesia tsunami, Nepal earthquake), and the remainder involved humanitarian settings at various stages of crisis. Less than half (11) were peer-reviewed articles and 17 were organization reports, evaluations or non-peer reviewed research, three of which were independent evaluations.

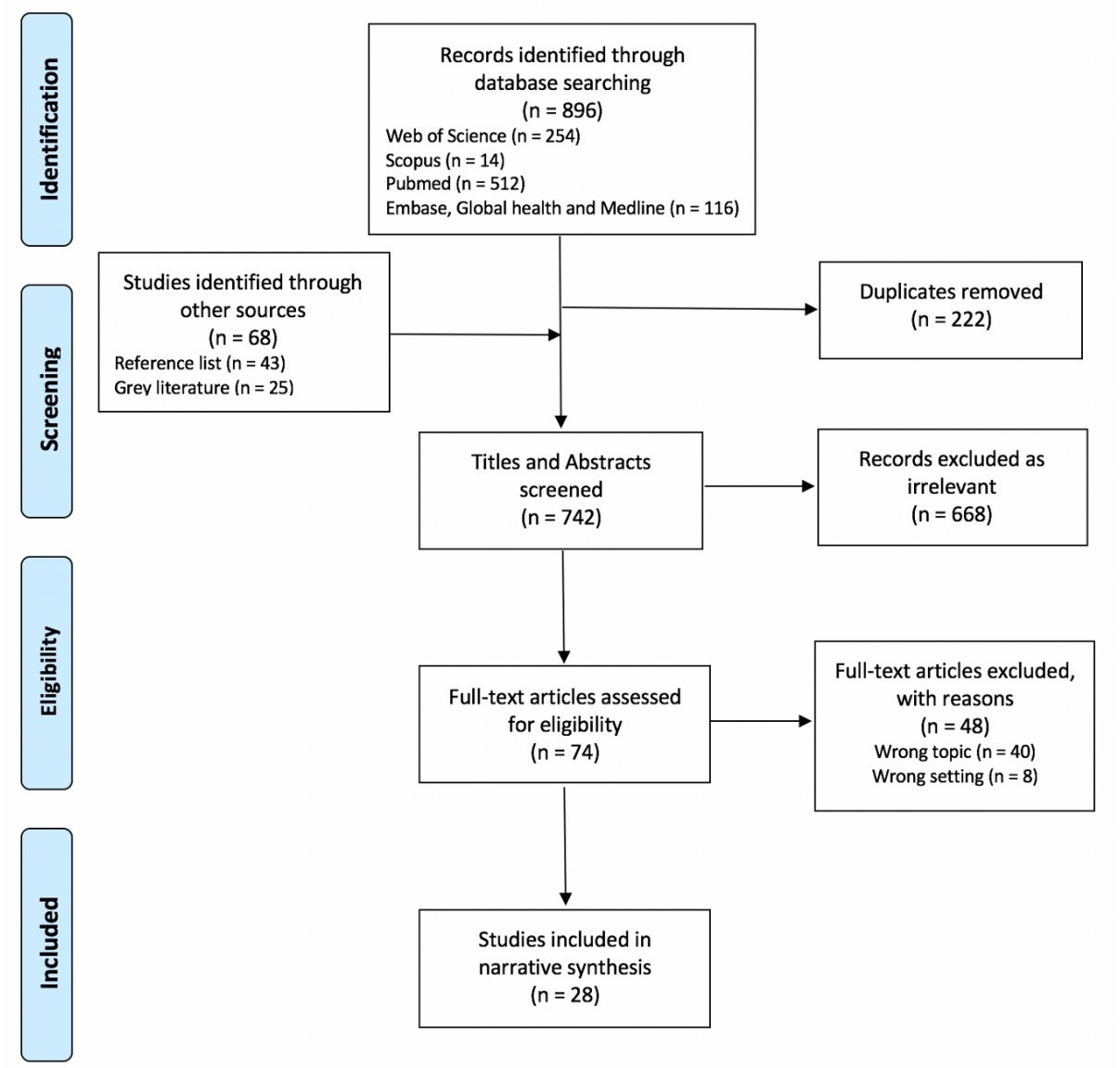

Figure 1. PRISMA flow diagram.

Table 2: Source characteristics, including: author, year published, study design, population, country context and GBV coordination topic covered for each source

AUTHOR, YEAR	STUDY DESIGN	POPULATION	COUNTRY	EMERGENCY CONTEXT	FRAMEWORK FOR EFFECTIVE GBV COORDINATION THEME COVERED					
					IMPLEMENTING A GBV SUB-CLUSTER	PRIORITISATION, ADVOCACY AND ACCESS TO RESOURCES	GBV RISK MITIGATION, AND INTEGRATION	GBV LOCALIZATION	DATA AND INFORMATION MANAGEMENT	COORDINATION TO SUPPORT SERVICE DELIVERY
AMIRI, 2020 (189)	Systematic literature review	Syrian refugees Women & Girls	Jordan	Syrian refugee crisis	x					x
CHYNOWETH, 2008 (190)	Original research, qualitative	Iraqi refugees Women & Girls	Jordan	Iraqi refugee crisis	x					x
DAVOREN, 2012 (191)	Original research, qualitative	Women & Girls	Haiti	Post-earthquake IDP setting & cholera outbreak	x	x	x			x
GBV AOR LOCALIZATION TASK TEAM, 2019 (95)	Report using mixed-methods approach, employing both qualitative and quantitative methods	Refugees and IDPs Women & Girls	Iraq Nigeria South Sudan, Whole of Syria Turkey Hub	Internal & Syrian crisis migrant, refugee, IDP Internal Conflict & IDP Internal Conflict & IDPs Syrian crisis IDP remote	x	x		x		x
KRAUSE, 2015 (192)	Original research, qualitative	Syrian refugee Women & Girls	Jordan	Syrian refugee crisis	x		x			x
HANLEY, 2018 (132)	Evaluation using mixed quantitative methods	Refugees Women & Girls	Lebanon	Syrian refugee crisis	x	x	x	x	x	x
HANLEY, 2019 (13)	A synthesis of key findings from evaluations of UNHCR approaches to GBV in humanitarian crises 2016-18	Refugees Women & Girls	Global		x	x	x	x	x	x
HENTTONEN, 2008 (193)	Original research, mixed qualitative and quantitative methods	Refugees / GBV survivors / Female Adult	Northern Uganda	2006 Internal Conflict & IDPs	x	x	x			x
HORN, 2010 (18)	Original research, qualitative	Displaced populations / Female Adult	Kenya	Kakuma refugee camp	x		x			x

AUTHOR, YEAR	STUDY DESIGN	POPULATION	COUNTRY	EMERGENCY CONTEXT	FRAMEWORK FOR EFFECTIVE GBV COORDINATION THEME COVERED					
					IMPLEMENTING A GBV SUB-CLUSTER	PRIORITISATION, ADVOCACY AND ACCESS TO RESOURCES	GBV RISK MITIGATION, AND INTEGRATION	GBV LOCALIZATION	DATA AND INFORMATION MANAGEMENT	COORDINATION TO SUPPORT SERVICE DELIVERY
INTERNATIONAL RESCUE COMMITTEE, 2012 (152)	Rapid assessment report using qualitative methods	Syrian refugee Women & Girls	Lebanon	Syrian refugee crisis	x					x
INTERNATIONAL RESCUE COMMITTEE, 2013 (194)	Discussion paper using document review	IDPs, Refugees Women & Girls	Haiti Pakistan Kenya and Democratic Republic of Congo (DRC)	2010 post-earthquake 2010 Floods 2011 Somali Refugees fleeing famine in Dadaab refugee camp 2012 Internal Conflict & IDPs	x	x	x			x
INTERNATIONAL RESCUE COMMITTEE, 2015 (74)	Discussion paper using document review	IDP, Refugees and national population Women & Girls	Central African Republic (CAR) South Sudan Iraq Sierra Leone	2013 Internal Conflict & IDPs 2013-15 Internal Conflict & IDPs 2014 Islamic state Conflict & IDPs 2013-16 Ebola outbreak	x	x	x	x		x
INTERNATIONAL RESCUE COMMITTEE, 2017 (105)	Report using desk review and key informant interviews	Refugees and IDPs Women & Girls	Global		x	x		x		x
INTERNATIONAL RESCUE COMMITTEE, 2020 (108)	Report using mixed qualitative and quantitative methods	Refugees and IDPs Women & Girls	Global			x		x		
INTERNATIONAL SOLUTIONS GROUP, 2014 (195)	Independent evaluation commissioned by UNFPA using qualitative methods	Global level and country level International and national organizations responding to emergencies	Global and country level Kenya DRC and Colombia	 Dadaab refugee camp Internal Conflict & IDPs Internal Conflict & IDPs	x	x			x	x
IRISH CONSORTIUM	Report using qualitative methods	Syrian Refugees Women & Girls	Lebanon	Syrian refugee crisis	x	x		x		x

AUTHOR, YEAR	STUDY DESIGN	POPULATION	COUNTRY	EMERGENCY CONTEXT	FRAMEWORK FOR EFFECTIVE GBV COORDINATION THEME COVERED					
					IMPLEMENTING A GBV SUB-CLUSTER	PRIORITISATION, ADVOCACY AND ACCESS TO RESOURCES	GBV RISK MITIGATION, AND INTEGRATION	GBV LOCALIZATION	DATA AND INFORMATION MANAGEMENT	COORDINATION TO SUPPORT SERVICE DELIVERY
ON GBV, 2019 (156)										
LANDEGGER, 2011 (63)	Original research, qualitative	Displaced populations / Female Adult	Northern Uganda	Internal Conflict & IDPs	x	x	x		x	x
MYERS, 2018 (196)	Original research, qualitative	Post-earthquake IDP setting Women & Girls	Nepal	Post-earthquake IDPs	x		x			x
ONYANGO, 2013 (197)	Review of five assessments	Humanitarian settings Refugee and IDP Women & Girls	Pakistan Chad Indonesia Kenya and Haiti	2003 Afghan refuges 2004 Sudanese refugees from Darfur 2005 Tsunami IDPs 2008 Post-election Violence IDPs 2011 Earthquake	x		x			x
ROBBERS, 2017 (198)	Systematic literature review	Refugees Women & Girls	Global		x		x			x
ROTHKEGEL, 2008 (14)	Evaluation using primarily qualitative methods	Refugees Women & Girls	Tanzania DRC Yemen Nepal and Georgia	Refugees Returnees Urban populations Bhutan refugees Chechen and Kits refugees & IDPs	x	x	x	x	x	x
STEETS, 2010 (64)	Independent evaluation using qualitative methods	Refugees and IDPs	Northern Uganda	Internal Conflict & IDPs	x		x	x		x
UNFPA, UNHCR, IRC, UNICEF, IMC, 2015 (167)	Evaluation using qualitative methods	Syrian Refugees Women & Girls	Jordan Lebanon Turkey Iraq	Syrian refugee crisis	x		x			
UNFPA, 2020 (23)	Evaluation using qualitative methods	Syrian Refugees Women & Girls	Cross border operations into Syria from Turkey Jordan Lebanon and Iraq	Syrian refugee crisis	x	x	x	x	x	x

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					IMPLEMENTING A GBV SUB-CLUSTER	PRIORITISATION, ADVOCACY AND ACCESS TO RESOURCES	GBV RISK MITIGATION, AND INTEGRATION	GBV LOCALIZATION	DATA AND INFORMATION MANAGEMENT	COORDINATION TO SUPPORT SERVICE DELIVERY
UNICEF, 2016 (155)	Evaluation using qualitative and quantitative methods	Refugees and IDPs Women & Girls	CAR Jordan Lebanon Nepal Pakistan Somalia South Sudan DRC	Internal Conflict & IDPs Syrian refugee crisis Syrian refugee crisis Post-earthquake Floods/earthquake Internal Conflict & IDPs Internal Conflict & IDPs Internal Conflict & IDPs	x	x	x	x	x	x
WAYTE, 2008 (199)	Original research, qualitative	Conflict IDP setting Women & Girls	Timor-Leste	Internal Conflict & IDPs	x					x
WOMENS REFUGEE COUNCIL, 2016 (150)	Evaluation using qualitative methods	Refugees and IDPs Women & Girls	Lebanon Tanzania Ethiopia	Syrian refugee crisis Burundi refugees Drought	x	x	x	x	x	x
WOMENS REFUGEE COUNCIL, 2019 (200)	Report using document review	Refugees and IDPs Women & Girls	Global		x	x	x	x		x

Overview of GBV Coordination

To visualise the complex matrix of agencies, relationships, and mechanisms constituting GBV coordination, we developed a graphic overview of GBV coordination from global to frontline level (Figure 2) based on descriptions of GBV coordination in the GBV coordination handbook and guidance documents (33, 104).

Thematic analysis

Table 3 presents facilitators and barriers to effective GBV coordination identified through the scoping review, Figure 3 presents an evidence-based framework of themes influencing effective GBV coordination, and evidence supporting each theme is summarised below.

Implementing a GBV sub-cluster

All 28 sources included reflections on implementing a GBV sub-cluster. Timely GBV sub-cluster activation, with dedicated GBV coordinators and funding were noted as critical for effective GBV coordination. However, over-reliance on international funding, technical support and leadership, compromised sustainability.

Timely and clear GBV sub-cluster activation and MISP implementation

Several sources noted a growing awareness and commitment to addressing GBV early in humanitarian response (189, 190, 192, 196, 199, 201). UNICEF in 2016, reported implementing rapid GBV responses following declarations of Level 3 emergencies in Lebanon, Jordan, South Sudan, and Nepal (155). In Nepal, strong MISP coordination was driven by committed leadership from the Ministry of Health, leveraging existing relationships between government, international non-governmental organization's (INGOs), UN agencies, and national actors, resulting in the rapid establishment of GBV coordination and a GBV referral pathway (196). Uganda's protracted humanitarian emergency was one of the first pilots of the Humanitarian Cluster Approach in 2006 and was praised by humanitarian actors and GBV specialists for improving GBV coordination (63). The Uganda GBV sub-cluster reduced duplication, enhanced GBV services quality, defined a standardized referral pathway, developed a system for collecting GBV data, and formed a consortium to implement common trainings and mobilise funds (63, 64). The establishment of sub-national or decentralised coordination structures which complement national level functions was also deemed beneficial in several settings. In Lebanon and Northern Uganda, for example, UNHCR and UNFPA had decentralised coordination and delegated authority to field offices, allowing them to better adapt the response to the local context and engage more operational local actors (63, 132).

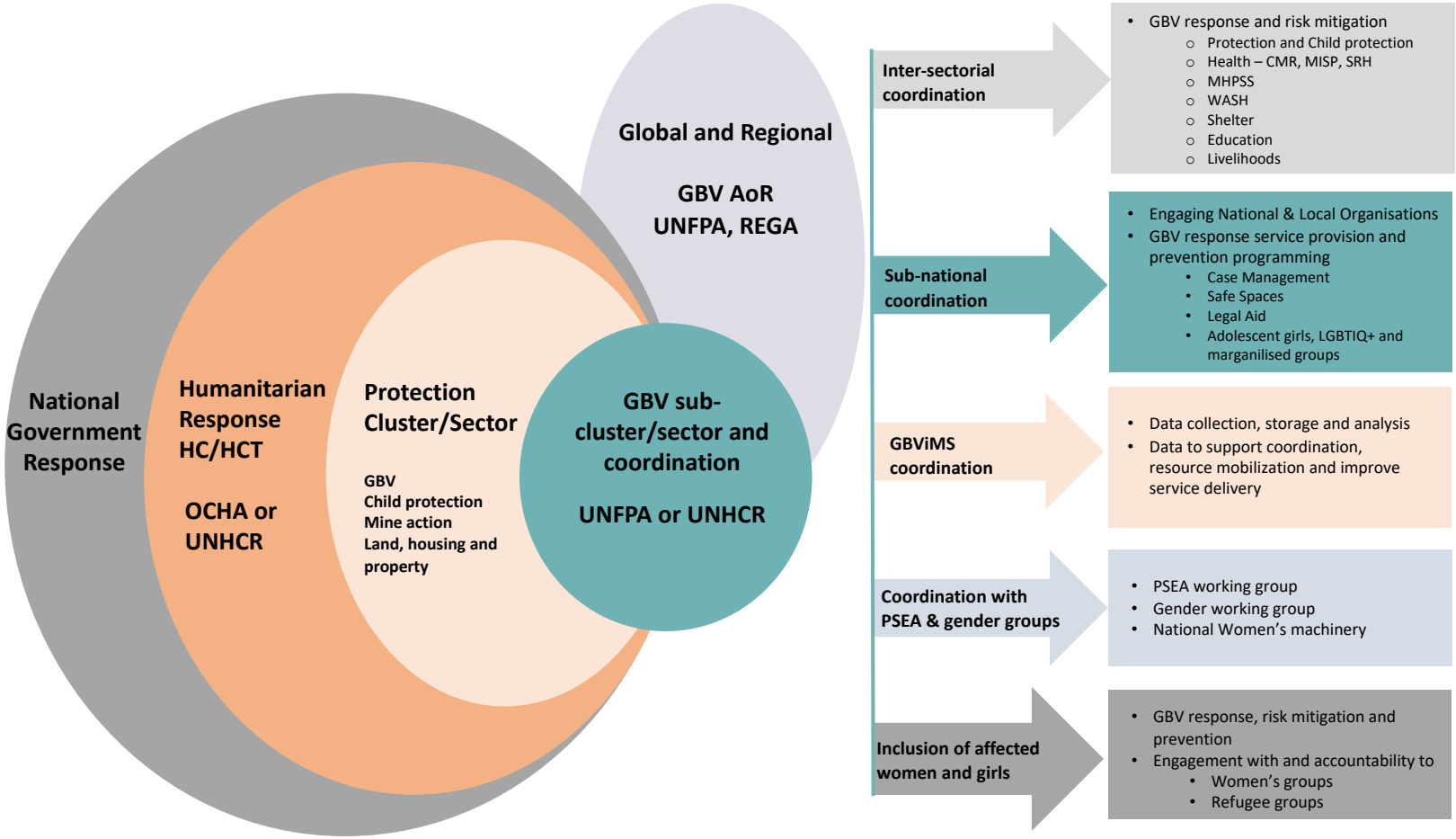

Figure 2. Graphic overview of GBV coordination from global to frontline level

GBV AoR = GBV Area of Responsibility; UNFPA = United Nations Population Fund; REGA = Regional Emergency Gender Based Violence Advisor; UNHCR = United Nations High Commissioner for Refugees; OCHA = Office for coordination of humanitarian affairs; HC/HCT = Humanitarian coordinator/ Humanitarian country team; PSEA = Prevention of sexual exploitation and abuse; CMR = Clinical management of rape; MISP = Minimum initial service package; SRH = Sexual and reproductive health; LGBTIQ+ = Lesbian, Gay, Bisexual, Trans and gender diverse, Intersex, Queer and questioning.

Table 3. Facilitators and barriers to effective GBV coordination identified through the scoping review

GBV COORDINATION FRAMEWORK THEME	FACILITATORS	BARRIERS
IMPLEMENTING A GBV SUB-CLUSTER	1. Timely GBV sub-cluster activation and MISP implementation	1. Late or non-activation of a GBV coordination mechanism and MISP implementation
	2. Designated interagency GBV coordinators and funding	2. Late or short-term deployment of coordinators
		3. Limited government engagement compromised sustainability
PRIORITISATION, ADVOCACY AND ACCESS TO RESOURCES	3. Increased high-level commitments to combatting GBV	4. Insufficient and inconsistent GBV funding allocation
RISK MITIGATION AND INTEGRATION	4. Roll-out of GBV guidelines enhanced efforts to integrate GBV risk mitigation	5. Low commitment and accountability on GBV risk mitigation across sectors
		6. Non-compliance to GBV guidelines exacerbates GBV risks
LOCALIZATION	5. Long-term capacity building, mentoring and partnerships with UN agencies and INGOs and mentoring of local and national NGOs	7. Minimal progress on funding allocation to support the localization agenda
		8. Lack of global good practice standards to guide localization efforts
		9. Exploitative and unequal partnerships
		10. Language and cultural barriers to local and national NGOs engaging in coordination mechanisms
DATA AND INFORMATION MANAGEMENT	6. Adoption of Gender-Based Violence Information Management System	11. Donors requests for GBV prevalence data delay funding hampering implementation
COORDINATION TO SUPPORT SERVICE DELIVERY	7. Emergencies present opportunities for expanding and contextually-adapting GBV services	12. Insufficient specialist GBV services and trained staff
		13. Limited investment in GBV prevention programming for long-term impact

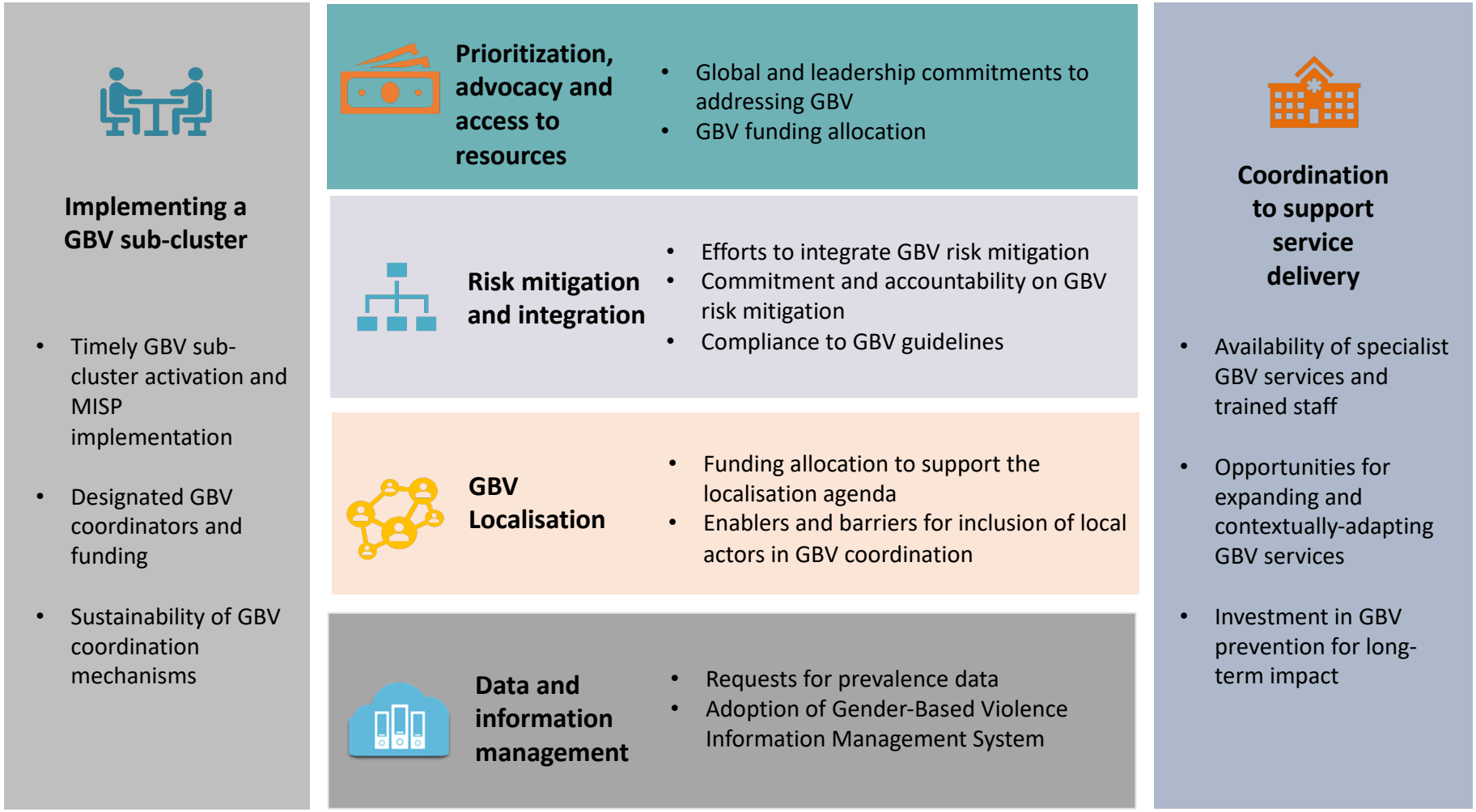

Figure 3. Evidence-based framework of themes influencing effective GBV coordination.

Conversely, late or non-activation of a GBV coordination mechanism and MISP implementation compromised GBV service delivery. For example, the GBV sub-cluster in Pakistan's 2010 emergency, was established almost two months after emergency declaration (194), in 2014 in Iraq was activated seven months after emergency onset, and not at all in Sierra Leone during the 2013-16 Ebola epidemic (74). With no GBV coordination mechanism in place in Sierra Leone, and limited funding, GBV actors were unable to address gaps left by the overwhelmed health sector, leaving GBV survivors without critical services (74), pointing to an important gap in GBV coordination in public health emergencies. Minimal coordination and lack of adherence to international standards in 2011, hindered refugee access to appropriate GBV services at the start of the Syrian refugee crisis, in Lebanon (152). Weak MISP coordination in Jordan in 2007, impacted GBV response, although improvements were noted during the Syrian refugee response (190, 192, 197). Nevertheless, coordination in urban settings was weaker than camp coordination because dispersed refugees were less visible (189, 192). In Timor-Leste 2006 response, an interagency MISP coordinator was not appointed, with GBV response leadership and advocacy consequently lacking (199) and in Indonesia lack of coordination hindered MISP implementation (197). Complex UN coordination systems in Iraq in 2014, with the cluster system activated for IDPs in parallel to the UNHCR-led system for refugees, complicated GBV response work, leading some to criticise GBV coordination as 'confusing' or 'inefficient' (74).

Designated GBV coordinators and funding

Strong coordinators with good leadership qualities and dedicated time and funding for coordination were highlighted as critical facilitators for effective GBV coordination. In Lebanon, national coordination was considered strong, attributed to having dedicated coordinators with allocated budgets (132, 150). In Northern Uganda, introduction of resourced GBV coordinators at national, regional, and district levels, chosen for their "good leadership qualities", was also deemed a successful coordination facilitator (63). In the Syria response, strong GBV coordination and contextual understanding, facilitated effective use of limited resources and improved trust and accountability among stakeholders, improving GBV service delivery (23). In 2016, UNICEF noted that successful implementation of GBV programming in multiple settings was enabled by deployment of GBV specialists for an extended period (155), and in South Sudan, deployment of GBV AoR regional emergency GBV advisors (REGAs) to inform development of the 2015 humanitarian response plan, increased funding allocated to GBV (74). Furthermore, in settings where GVBIMS had been most successful, strong and committed coordinators had facilitated analysis and reflection on data (195). However, recurrent challenges were noted across responses related to human resources, including

GBV expertise often being deployed late in a response and rapid staff turnover, creating gaps and inconsistencies (13, 14, 69, 74, 150, 155, 194). Additionally, sources indicated that GBV coordinators were often junior, short-term and expected to fulfil roles beyond coordination, diluting their focus (45, 95, 132). Moreover, lack of GBV expertise in senior management positions prevented prioritization of GBV within humanitarian response plans (108).

Sustainability of GBV coordination

In many settings, GBV coordination relied on international donor funding, technical support and leadership, with limited ownership of government, compromising sustainability. In Northern Uganda, for example, concerns were raised about government ownership of GBV activities, political commitment to GBV, and capacity to sustain GBV coordination and service delivery (63). In the Haitian post-earthquake and cholera epidemic emergencies, the GBV sub-cluster was criticised for not working more effectively with the Women's Ministry in the early stages (191). GBV programming through the humanitarian response plan in Lebanon created a parallel system and there was a need to strengthen support for government leadership in GBV coordination (156), and both GBV coordination and services remained reliant on international funding (132, 150).

Prioritisation, advocacy and access to resources

Seventeen sources noted prioritisation, advocacy and access to resources as critical for GBV coordination at global and frontline levels (13, 14, 23, 63, 74, 95, 105, 108, 132, 150, 155, 156, 191, 193-195, 200). While in recent years, high-level commitments to addressing GBV in emergencies have encouraged investments, GBV is still not systematically prioritised and funding remains insufficient and inconsistent across settings.

Increased commitments to addressing GBV

Since 2013, the Call to Action has promoted senior leaders in donor and implementing agencies to prioritise GBV, galvanising collective action, accountability, and investments (105). Following the World Humanitarian Summit in 2016, initiatives such as the *Grand Bargain* and *New Way of Working* focused on increasing multi-year, collaborative, and flexible funding and planning, moving towards longer-term GBV strategies (202, 203). A 2017 global report on the impact of the Call to Action noted that non-governmental organization's (NGOs) were increasingly accessing multi-year GBV funding and donors were playing a role in ensuring that funding was channelled through the country response plans and that GBV is addressed within funding proposals (105). Support from senior leadership within UNHCR and UNICEF was reported as a key factor in prioritising GBV in Lebanon,

Jordan, Somalia, and South Sudan, demonstrating the importance of leadership and advocacy in harnessing resources (132, 150, 155). A multi-country source noted that implementation of the Call to Action Road Map strengthened humanitarian GBV responses in Lebanon and Ethiopia (150).

Despite this progress, humanitarian leadership and sectoral actors on the ground, overwhelmed with competing priorities, often dismiss GBV as non-essential, particularly in acute emergency stages (105, 183, 194). Lack of GBV technical capacity in country, particularly at the onset of an emergency, when funding priorities are being agreed, can mean GBV is not prioritised, and limits investment in GBV throughout the emergency (155). Donors can accentuate this by not allocating specific funding for GBV as a life-saving intervention (108). Sources described significant delays by humanitarian leadership in Iraq and Sierra Leone in including GBV analysis in emergency reporting (74). In Haiti's 2010 earthquake and cholera emergency responses, weak coordination was blamed for GBV not being included among high-level priorities, and inadequate adherence to international standards by humanitarian responders (191).

Insufficient and inconsistent GBV funding allocation

GBV funding is insufficient and inconsistent across settings and is often subsumed within protection sector budgets, making it difficult to track specific GBV investments (13, 108, 193). One study reported that according to the office for humanitarian affairs (OCHA) financial tracking service, between 2016 and 2018, GBV only accounted for 0.12% of all humanitarian funding (108). Another noted that donors and common funding pools did not consistently fund GBV during emergencies (74). For example, 2014 humanitarian response plans for Central African Republic, South Sudan, and Iraq, only fulfilled 5.2%, 20.9%, and 5.5% of GBV funding requests, respectively (74). In the 2015 South Sudan response in Ethiopia, only 2% of the budget was allocated to GBV (13) and out of $1.4 billion funding requested following the 2010 Haiti earthquake, only $5 million (0.3%) was allocated for GBV programs (194). Conversely, in Lebanon, OCHA prioritized GBV in its call for proposals, resulting in overall funding for the sector reaching 38%, though this remained insufficient compared with the needs (13, 132, 150). In Dadaab refugee camp in 2011, one year after famine declaration, reported cases of GBV increased by a third, while GBV funding was cut in half (74). Although UNFPA reported being able to scale to meet growing needs in the Syrian crisis response through successful advocacy for non-earmarked predictable, multi-year funding, they struggled to increase budgets to meet expanding GBV needs due to COVID-19 (23).

Risk mitigation and integration

Nineteen sources highlighted the importance of GBV risk mitigation and cross-sector coordination in emergency responses (13, 14, 18, 23, 63, 64, 74, 132, 150, 155, 167, 191-194, 196-198, 200). Efforts to integrate GBV risk mitigation in humanitarian settings are compromised by weak commitment and accountability across sectors, and this non-compliance exacerbates GBV risks for women and girls.

Enhanced efforts to integrate GBV risk mitigation

Since 2016, when UNICEF noted a lack of systematic integration of GBV risk mitigation by clusters/sectors, the roll-out of the GBV guidelines has played a critical role in increasing commitments to GBV risk mitigation, with several good practices emerging (155). By establishing a focal points network in Jordan and in Lebanon, UNHCR managed to integrate GBV risk mitigation into other sectors (13, 132). GBV coordination in Lebanon used mentorship to introduce the GBV guidelines to five priority sectors as part of the roll-out of the guidelines in 2017, and facilitated intersectoral engagement to identify livelihood solutions for GBV survivors, despite limited employment options (132, 150). In Tanzania, GBV coordinators had contextually adapted risk mitigation strategies, resulting in GBV being well integrated in water, sanitation and hygiene (WASH) and shelter sectors (150). In several settings, involvement of GBV coordinators in assessments by shelter and WASH sectors, led to GBV risk mitigation measures such as locks and more secure tents (13, 132, 150). UNFPA supported GBV service providers to integrate cash assistance as part of case management for Syrian refugee GBV survivors, though this was inadequate to address increased economic vulnerabilities during the COVID-19 pandemic (23).

Low commitment and accountability on GBV risk mitigation

Studies noted low levels of commitment to GBV minimum standards, limited understanding of how to operationalise the 2015 IASC GBV Guidelines, and weak accountability mechanisms to donors, humanitarian leadership, and beneficiaries, as well as weak linkages between gender equality and GBV in humanitarian action (167, 200). Recurrent challenges to integrating risk mitigation included: lack of knowledge and understanding on GBV risk mitigation; lack of clarity on staff roles in risk mitigation and assumptions that this was GBV experts' responsibility; insufficient training on responsibilities, tools, and resources to support implementation; cultural barriers and biases among humanitarian actors; and limited incentives to address GBV on top of existing workloads (13, 63). Additionally, overwhelmed GBV focal points lacked capacity to effectively lead inter-agency coordination, and simultaneously integrate GBV risk mitigation (14). An inter-agency evaluation of

IASC GBV guidelines implementation in Jordan, Lebanon, Turkey and Iraq found mixed understanding about GBV risk among relevant staff and although donors were aware of the GBV guidelines, they rarely used them (167). In Central African Republic and South Sudan, a general failure among sectors to integrate essential GBV risk reduction into emergency programming, reflected non-compliance with the GBV guidelines and absence of political will to address GBV (74). Despite good progress in Lebanon, weak accountability mechanisms and follow-up, meant trainings did not necessarily translate into action within sector responses (132). Furthermore, engaging refugee women in the design, management, and leadership of GBV risk mitigation measures appeared limited across setting, and accountability to affected women and girls minimal (14, 18, 167). Humanitarian sectors responding to the Syrian conflict in 2015, rarely included meaningful or consistent accountability to refugees (167). In Kenya's Kakuma camp, refugee women found humanitarian GBV responses unhelpful, and continued employing their own systems for addressing GBV in their community (18, 198).

Non-compliance to GBV guidelines exacerbates GBV risks

Non-compliance of response actors to their responsibilities within the GBV guidelines exacerbated GBV risks for women and girls. One study noted minimum GBV risk reduction was overlooked during the Sierra Leone Ebola crisis, with cases and suspected cases not separated by sex in facilities, and few treatment centres able to treat pregnant women, resulting in denial of care and some women giving birth and dying on the street (74). Lack of safe congregation spaces, lighting, or locks on toilets, tents, and showers increased GBV risks in displacement settlements (74). In South Sudan, sexual violence risk factors included inadequate lighting, non-lockable, non sex-segregated toilets and showers, tents that unzipped from outside, and overcrowding (197). MISP studies too, found multisectoral failures in essential GBV risk mitigation reporting that women felt unsafe using toilets at night in camps in Jordan and Nepal (192, 196). Evaluations in Tanzania, Bangladesh and Brazil noted limited attention to ensuring safe access to shelter, firewood, and WASH facilities (13) and in South Sudan, women and girls were attacked and abducted while collecting firewood, water, and food (74). In both Kenya and Haiti, lack of basic supplies and income increased vulnerability to transactional sex (191, 197).

Localization

Thirteen sources explored issues of GBV localization and inclusion of local actors in GBV coordination (13, 14, 23, 64, 74, 95, 105, 108, 132, 150, 155, 156, 191, 200). Despite significant global policy commitments, in practice, GBV localization has been minimal, with little international funding

channelled to local organizations and several barriers and enablers were identified for local actors engaging in UN-led GBV coordination mechanisms.

Minimal progress on funding allocation to support the localization agenda

In 2019, findings showed minimal GBV localization in three of four contexts studied (i.e. Iraq, Nigeria, South Sudan), with only Turkey reporting high perceived localization, which was necessitated by the lack of access of international organizations in Syrian cross-border operations (95). Women-led local organizations were rarely allocated sufficient funding despite being recognised in policy commitments as key partners in GBV prevention and response, and little funding had been channelled to local organizations in general (e.g. just 0.4% of global GBV humanitarian assistance in 2015 and 0.3% in 2016) (74, 95, 200). Without long-term, flexible, multi-year funding, local GBV organizations struggled to obtain independent funding, upgrade their internal management systems, or build reporting and accountability mechanisms, perpetuating the cycle (23, 108). One study highlighted the lack of global good practice standards to guide localization efforts, which weakened implementation (95).

Barriers and enablers for engagement of local actors in UN-led GBV coordination mechanisms

Several sources noted cultural, linguistic and logistical barriers for local and national NGOs engaging in humanitarian coordination mechanisms, including meetings not being held in appropriate languages to facilitate participation (64, 150, 191). In Haiti, for example, GBV coordination was criticised for holding meetings in English or French rather than Kreyol, thus excluding grassroots NGOs (191). Exploitative partnerships included practices such as staff poaching and unequal pay for local actors versus UN or INGO staff, weakening technical expertise of local actors (95). Challenges cited by humanitarian actors in working with local women's rights organizations included their insufficient existing funding, capacity and ability to show impact, but also ideological concerns that such organizations were inherently 'political' and therefore inappropriate for engagement in impartial humanitarian GBV projects (108). Several sources also cited patriarchal biases among international and national humanitarian actors as a major barrier to humanitarian actors working in partnership with women's organizations (95, 105).

Nevertheless, some positive examples of engagement were highlighted. For example, in Lebanon, Jordan and South Sudan, UN organizations invested in capacity-building partnerships with local GBV actors, involving ongoing mentoring, which was seen as practical and sustainable (132, 155). In Lebanon, local organizations expanded their geographical and services coverage rapidly as refugee

numbers grew, by partnering with government, UN, and INGOs (156). Using a system-building approach to implement long-term capacity building plans that strengthened government and civil society, UNICEF helped to create sustainable country-based GBV technical capacity in Lebanon and Jordan (155).

Data and information management

Eight sources noted data and information management as influencing effective coordination (13, 14, 23, 63, 132, 150, 155, 195). Although requests for GBV prevalence data can delay funding and hamper progress, significant improvements have been noted since implementation of the GBVIMS, leading to enhanced coordination, funding allocation, service provision, and advocacy in many settings.

Requests for prevalence data

GBV coordinators are frequently asked for "evidence" of GBV in the early days of a crisis, particularly in funding discussions. A 2016 multi-country study in Ethiopia, Tanzania and Lebanon, reported that donors and humanitarian leaderships' need for 'evidence' of GBV prevalence was a fundamental challenge and when donors failed to earmark GBV funding at the beginning of a crisis, frontline implementation was delayed (150).

Adoption of Gender-Based Violence Information Management System

A 2014 global evaluation noted that implementation of the GBVIMS had contributed to effective and safe collection, storage, analysis and ethical sharing of GBV data at country level (195). Service providers were analysing and using GBV data for donor reports and fundraising, to identify gaps, better target and improve programmes, and enhance GBV coordination (195). For example, analysis of time and location of GBV incidents in all camps in Dadaab refugee camp was used to enhance camp safety and reduce GBV risks (195). GBVIMS was successfully implemented in Lebanon, Jordan and Iraq, allowing partners to track trends and target interventions, e.g. for child marriage in Lebanon (23). UNFPA or UNHCR-hosted GBVIMS coordinators in Lebanon, Iraq, and Jordan, provided regular trend analyses that enhanced advocacy, coordination, and service provision (23). Effective country-level rollout of GBVIMS was facilitated by strong technical support, country level ownership, a phased approach, strong and dedicated coordinators and existing interagency coordination (195). Nevertheless, data management challenges were noted across settings, including varied reporting capacity, accuracy of data, and sharing restrictions that impacted quality and effectiveness (13, 23, 155). Poor data management in Uganda in 2015 and Tanzania in 2018, meant that data could not be used for planning (13) and national partners in Central African Republic used GBVIMS but lacked

data collection expertise (155). Engagement of national government by UN agencies was recommended to sustain GBVIMS, particularly as countries transitioned to recovery phases (195).

Coordination to support service delivery

Twenty-six sources included reflections on the importance of GBV coordination to support service provision (13, 14, 18, 23, 63, 64, 74, 95, 105, 132, 150, 152, 155, 156, 189-200). Although specialist GBV services remain insufficient across emergency settings, emergencies can present opportunities for expanding and contextually-adapting services.

Insufficient specialist GBV services and trained staff

Many specialist GBV services, such as CMR and MHPSS, were insufficient across settings and lack of trained staff hampered services delivery in many contexts. In Central African Republic , Uganda, South Sudan, Iraq, and Sierra Leone, establishment of essential GBV services was hindered by insufficient availability prior to the crisis, slow deployment of GBV experts, limited funding, and sometimes weak advocacy for GBV prioritisation (74, 155, 193). In Pakistan, humanitarian actors did not prioritise GBV services during 2010 floods, deeming them inappropriate given strict traditional gender norms (194). During Sierra Leone's Ebola epidemic, GBV services provided through the public health system were severely disrupted, and although GBV cases increased, specialist services remained inadequate (74). CMR was only partially available during Nepal's earthquake response, with gaps in availability of HIV prophylaxis and qualified staff (196) and in Jordan, access to CMR for Syrian refugees was limited by lack of emergency contraception, HIV prophylaxis, trained staff and a national protocol (189, 192). In Ethiopia and Bangladesh, specialist GBV services were sometimes available for refugees but inadequate for IDPs and host communities (13, 150). Specialist GBV services in Tanzania were short-term without sufficient follow up and limited shelters for GBV survivors in Lebanon, resulted in women returning to abusive partners (132, 150). Lack of trained and qualified staff to deliver GBV services and limited female staff to treat women according to their cultural beliefs was an issue in several settings (189, 193, 197). In Northern Syria, security challenges prevented doctors from crossing into Turkey for training and trainers from entering Syria, resulting in a lack of adequately trained medical providers for GBV survivors (167). Importantly, lack of access to legal services prevented survivors from disclosing GBV incidents and in several settings, adolescent girls were at heightened risk for many forms of GBV, but rarely received tailored GBV interventions (95, 155, 193).

Emergencies present opportunities for expanding and contextually adapting GBV services

In Central African Republic, Jordan, Lebanon, Uganda, Somalia, and South Sudan, humanitarian GBV responses expanded GBV services provision and access, especially CMR, MHPSS, safe spaces, and community outreach (132, 155, 156, 193). In Northern Uganda, the GBV sub-cluster enhanced GBV services quality through common approaches to provider training, monitoring, and standards and enhanced GBV information and services resulted in increased numbers of survivors seeking care (63, 64, 193). GBVIMS in several settings helped to identify gaps in service provision and advocate for services (195). Structured volunteer networks developed from refugee and host communities, in some settings, helped to improve community knowledge of GBV, services availability, referrals, and to monitor trends and an urban refugee women's network in Turkey helped strengthen confidence among refugees and improve understanding of their rights (13). In addition, UNHCR adapted services in Lebanon to reach dispersed urban populations through mobile outreach volunteers and innovative communication strategies (13, 132). To improve participation and reduce stigma related to accessing GBV services in Somalia, South Sudan, Lebanon, Jordan, and Nepal, GBV-related activities were implemented in women and girls safe spaces, defined as a space which ensures the physical and emotional safety of women and girls (155, 204). CMR training in Lebanon, was conducted with all staff at health facilities, not just medical staff, to ensure that survivors were uniformly treated in a survivor-centred manner (155). In Georgia, UNHCR culturally adapted psychosocial services through group activities, building support networks, promoting skills building and economic empowerment (14). Training, mentoring and support was provided to local NGOs in South Sudan, without previous GBV experience, to increase the number of organizations qualified to provide MHPSS, awareness raising, and referral of survivors (155). UNHCR improved coordination with government and NGOs in Tanzania, to establish more effective legal services for survivors (14). In the Syrian response, GBV interventions were adapted to the COVID-19 pandemic to maintain access to services through mobile and online modalities (23).

GBV prevention for long-term impact

GBV prevention programming is essential for long-term impact but often deprioritised in emergencies. Long-term GBV reduction requires addressing root causes, namely gender inequality and unequal power relations, and is often seen as too complex and long-term to implement in emergency contexts (95, 105). In several settings, GBV response dominated GBV prevention because humanitarian agencies prioritised life-saving services, highlighting the need for increased investment in GBV prevention to address the root causes of GBV (13, 23, 63). UNHCR community-based prevention activities showed promise but were small scale (13). For example, 84% of women and

adolescent girls participating in empowerment activities in Lebanon reported a greater sense of empowerment (13, 132). More agencies reported exploring prevention or gender equality issues in protracted crisis contexts. For example within the protracted Syria response a progressive shift from service delivery, to risk mitigation, to prevention initiatives challenging harmful social norms, was enabled by multi-year, predictable funding (23). Robbers et al. noted that the active involvement of female refugees in the design, planning and implementation of sexual violence preventative measures, increased empowerment and ownership of programmes and helped to transform harmful gender norms (198). In 2019, the Women's refugee council raised concerns about the increasing separation of work on GBV and gender equality in the humanitarian system, representing a missed opportunity for GBV prevention (200).

DISCUSSION

To our knowledge, this review is the first to explore GBV coordination in emergencies and revealed the near absence of academic literature systematically examining the effectiveness of GBV coordination. However, by maintaining a broad inclusion criteria and analysis framework, we were able to synthesise relevant findings for policy, practice, and research. Included sources spanned 2008 to 2020, and while the global policy context has evolved significantly in this period with many notable advancements, our findings highlight several remaining barriers to effective coordination, some of which have also been noted by a 2021 gap analysis on GBV in humanitarian settings (31). This review makes several important contributions including (i) a graphic overview of GBV coordination from global to frontline levels; (ii) an evidence-informed framework on facilitators and barriers to effective GBV coordination; and (iii) recommendations for strengthening GBV coordination in emergencies and for further research on this important topic (Table 4).

The overview of GBV coordination graphic highlights the complex network of organizations and actors involved in addressing GBV in emergencies. The UNFPA-led GBV AoR take the lead in non-refugee settings and have developed comprehensive guidance, standards and toolkits for application in the cluster system, in addition to providing training and technical support (35). Coordination in refugee settings, however, is led by UNHCR, and it is not clear from the available literature, if GBV AoR guidance and tools are applied systematically in refugee settings or if technical support is provided. In addition, much guidance relates to traditional camp settings, but increasingly refugees and IDPs live in urban and peri-urban contexts, creating additional context-specific GBV risks and access challenges that deserve attention (205). Furthermore, our review demonstrates a gap in awareness to GBV coordination in public health emergencies, when coordination is under the World

Health Organization (WHO). Although it is widely accepted that risk factors for GBV are magnified during infectious disease outbreaks, only three sources presented reflections on GBV coordination challenges in outbreaks (22). Further research is needed to learn from and adapt innovative GBV coordination mechanisms and service provision approaches implemented during the COVID-19 pandemic.

Findings indicated major improvements in GBV coordination in emergencies, attributed to rapid activation of coordination mechanisms and organizational investments in building and deploying GBV coordination experts (106). Deploying GBV specialists early, strengthened coordination, donor confidence, GBV prioritisation and funding allocation across settings. Thus, ensuring funding for dedicated, experienced, long-term GBV coordinators should be promoted in all kinds of emergencies, including public health. WHO is augmenting efforts to address GBV in health emergencies, including through the deployment of GBV advisors at regional, global and country-level and to newly graded health emergencies, which deserves further investment and expansion (206, 207). While the concepts of strong coordinators and good leadership qualities appeared to be important for effective GBV coordination, more research is needed to understand and characterise these terms in the context of GBV.

Major gaps remain between global GBV policy commitments and funding allocations with a lack of prioritisation, commitment and accountability across the humanitarian sector. GBV is consistently de-prioritised, with less than 1% of humanitarian funding allocated to the GBV sector over the past five years (31). Our findings emphasised the importance of adequate GBV funding and human resources, alongside multi-year, flexible funding for protracted emergencies (31, 45, 203). Still, existing humanitarian financing systems are unaligned with the needs, with short-term, inflexible funding, limiting deployment of long-term, senior GBV coordinators, inclusion of local actors, and investment in GBV risk mitigation and prevention. In the context of the COVID-19 pandemic, increased multi-year and flexible funding is critical to meet increasing and emerging GBV needs (23).

Significant benefits of investing in subnational coordination include faster and more contextually-relevant decision-making and greater participation by local actors - particularly civil society – to advance the localization agenda but requires strengthening in emergencies (45, 46, 67, 69, 94, 208). Despite global commitments to GBV localization, progress has been slow and uneven, with little evidence suggesting local actors have been meaningfully included in GBV coordination efforts or received adequate funding (95, 105). Local actors have greater understanding of context, are

embedded in the affected populations, and with language and cultural knowledge, can navigate complex socio-political dynamics more easily, yet global targets to increase local organizations' funding, from under 3% to 25% by 2020, have not been achieved (95, 105, 203). Security, movement restrictions and access concerns in many emergencies, including COVID-19 restrictions, underscore the need for investment in local GBV technical capacity-building (105, 209-211). Good examples from Syrian refugee responses in Lebanon, Jordan, and Turkey could be used as case studies. Inclusion of women-led organizations, and women from affected communities, is similarly crucial, to address GBV prevention and risk mitigation in culturally appropriate ways (31, 105). Challenges of funding access, inequitable power dynamics and patriarchal attitudes within the humanitarian sector require targeted attention at global and country levels (31).

Limited commitment to GBV risk mitigation across sectors suggested stronger inter-sectorial engagement and enhanced inter-agency accountability systems are needed to improve multi-sectoral resourcing and attention (45, 64, 69). The humanitarian system has made some progress integrating GBV risk mitigation since 2016, with the roll-out of the revised IASC GBV Guidelines in multiple countries, and initiatives such as the Real-Time Accountability Partnership (212). Still, risk mitigation activities are often seen as under the remit of the GBV sector, rather than integrated across all sectors (31). As non-GBV specialists may not have the required expertise to mitigate GBV risks, deploying GBV risk mitigation specialists with dedicated time and funding could help sectors to meet their responsibilities using a mentorship approach (31). Donors too can improve systems by requiring that GBV risk mitigation activities be included and budgeted in all funding proposals, with monitoring, evaluation, and follow-up on reporting. In addition, GBV guidelines are not systematically integrated in public health emergencies and more efforts are needed to ensure that public health responders understand and address their responsibilities. Furthermore, inclusion of, and accountability to, affected populations in development and monitoring of risk mitigation measures requires investment (31).

Collecting and sharing GBV information is both extremely challenging and important in emergencies. Despite global guidance, our review highlighted that donor requests for 'evidence' of GBV remains a consistent challenge, delaying funding allocation and GBV responses (33, 150). Furthermore, unethical practices such as donors requiring access to individual survivor information can put survivors at increased risk (31). The implementation of GBVIMS since 2008 has provided notable improvements, with innovative digital platforms rolled out across multiple contexts, which could be duplicated elsewhere. Importantly for GBV coordination, GBVIMS helps to inform programmatic

decision-making for service providers and inter-agency working groups, improve donor reporting and fundraising, and strengthen advocacy efforts (195).

Effective GBV coordination ensures comprehensive multi-sectorial, survivor-centred services, strong referral mechanisms, and collaborative, culturally-appropriate programming. However, our review highlighted significant gaps in both availability of services and access of survivors across emergency settings. Stigma, shame and lack of appropriately trained staff are common barriers to survivors accessing GBV services, and practical guidance on approaching these culturally-sensitive issues within GBV coordination structures is needed (13, 14). Although significant efforts have been made to improve coordination and programming strategies between the GBV and child protection sub-sectors, including the Child and Adolescent Survivors Initiative, adolescent girls are still often overlooked in GBV programming (31). In addition, our review highlights a lack of evidence on how the coordination system accounts for the needs of specific groups such as people with disabilities, LGBTIQ+. While GBV prevention is essential for long-term impact, it is rarely prioritised in emergency responses, but multi-year, predictable funding, especially in protracted crisis, can encourage investment in culturally-appropriate prevention programming (31, 213). Linkages between gender equality and GBV require strengthening and investments are required in translating the increasing empirical evidence about 'what works' to prevent GBV in humanitarian settings (31, 200).

In settings without existing GBV coordination mechanisms, emergencies can provide an opportunity to introduce GBV coordination and expand services (33). Particularly in protracted emergencies where humanitarian actors are required to support both immediate and longer-term needs, GBV coordination and services have been embedded and expanded in several settings. Nevertheless, advances in GBV coordination are not routinely sustained and built upon, with GBV coordination and service delivery often dependent on international funding and leadership, coupled with weak government commitments to institutionalising services and systems (155). In settings with pre-existing GBV coordination structures, merging emergency GBV coordination into government and civil-society structures is recommended, however, in reality, implementation is often challenging (33, 35, 46, 67, 80, 81). Finally, GBV coordination efforts should be contextually nuanced and build on existing government, and civil society networks to improve both effectiveness and sustainability (46, 96).

LIMITATIONS

This study has several limitations and should be interpreted accordingly. Firstly, we only included sources within our search and language capacity, and it is possible that other relevant sources were inaccessible due to search terms or unavailable electronically. Second, only the first author searched and selected sources, however, discussion and oversight of other authors minimised bias. Finally, sources were not excluded on evidence quality, allowing inclusion of a broader range of data from peer-reviewed and grey literature.

CONCLUSIONS

While GBV coordination is increasingly recognised as vital to global efforts to respond to, mitigate and prevent GBV, it is rarely researched, demonstrated by the lack of peer-reviewed sources, with literature on GBV coordination during public health emergencies particularly scant. Recommendations to strengthen GBV coordination include to, increase multi-year and flexible funding for GBV across emergencies, fund dedicated GBV coordination positions in all emergencies, build the global GBV coordination workforce including for deployment in public health emergencies, strengthen subnational coordination mechanisms, expand inclusion and leadership of national and local actors and channel more funding to these organizations. In addition, guidance and tools developed by GBV AoR should be adapted for application in refugee settings and public health emergencies and investment in context appropriate GBV risk mitigation and prevention should be promoted through multiyear planning and funding, especially in protracted emergencies. We present a series of recommendations (Table 4) to improve effectiveness of GBV coordination across emergency settings. The evidence-based framework for effective GBV coordination presented above, can help guide further research to explore effective GBV coordination in diverse emergencies.

Table 4. Recommendations to enhance effectiveness of GBV coordination in diverse emergency settings

DIMENSION OF GBV COORDINATION FRAMEWORK	RECOMMENDATIONS	TARGET GROUPS
IMPLEMENTING A GBV SUB-CLUSTER	1. Ensure funding of dedicated long-term GBV positions at frontline, national, and global levels, including during public health emergencies	Donors, international & national GBV actors
	2. Adapt guidance and tools developed by GBV AoR for application in refugee and public health emergencies	GBV AoR, UNHCR and WHO
	3. Improve inter-sectorial engagement by deploying interagency coordinators early	Donors, international & national GBV actors
	4. Adapt coordination efforts to context to improve both effectiveness and sustainability	GBV AoR and UNHCR
	5. Research GBV coordination in diverse humanitarian and public health emergencies to provide more robust evidence on what influences effective GBV coordination in diverse settings	Researchers and donors
	6. Conduct research to understand strong leadership and effective coordination in the context of GBV	GBV AoR and Researchers
PRIORITISATION, ADVOCACY AND ACCESS TO RESOURCES	7. Increase multi-year and flexible funding, especially in protracted emergencies	Donors and International GBV actors
	8. Proactively address patriarchy, and power imbalances which limit GBV prioritization and involvement of women-led organization's in coordination	Donors, international & national humanitarian actors
RISK MITIGATION AND INTEGRATION	9. Improve integration of risk mitigation across sectors through dedicated GBV specialists focused on supporting multi-sectorial integration and accountability	Donors, international & national GBV actors
	10. Improve engagement with beneficiaries to identify GBV risks, adapt services and promote bidirectional communication and accountability on mitigating risks	Donors, international & national GBV actors
	11. Mandate that GBV risk mitigation activities be included and budgeted in all funding proposals, with monitoring and evaluation	Donors, international & national GBV actors
	12. Train public health responders on GBV risk mitigation	WHO and GBV AoR
LOCALIZATION	13. Strengthen subnational coordination mechanisms that engage and facilitate the leadership of local actors	Donors, international & national GBV actors
	14. Invest in partnerships to build both GBV technical capacity of frontline actors and to strengthen management systems to receive international funding	Donors, UN & international GBV actors
	15. Increase funding allocations to national and local organizations	Donors, UN & international GBV actors
DATA AND INFORMATION MANAGEMENT	16. Limit requests for GBV prevalence data which delay funding allocation hampering GBV responses	Donors and humanitarian leadership
	17. Continue to improve the GBVIMS platforms and translate innovations across contexts	GBV AoR and Researchers
COORDINATION TO SUPPORT SERVICE DELIVERY	18. Strengthen evidence on how GBV coordination addresses the needs of marginalised groups (eg. adolescent girls, boys, LGBTIQ+)	GBV AoR and Researchers
	19. Increase investment in context appropriate GBV prevention programming, especially in protracted emergencies, through multiyear planning and funding	Donors, GBV AoR and UNHCR
	20. Develop practical guidance on approaching culturally sensitive issues such as shame, stigma and social norms within GBV programming, including on training health care workers	GBV AoR

CHAPTER 6: EVOLUTION OF GENDER-BASED VIOLENCE (GBV) COORDINATION IN A PROTRACTED HUMANITARIAN EMERGENCY: A QUALITATIVE CASE STUDY OF LEBANON FROM 2012-2022

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Thesis Title	Gender based violence (GBV) coordination in emergencies		
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Stage of publication	**Submitted**

SECTION D – Multi-authored work

For multi-authored work, give full details of your role in the research included in the paper and in the preparation of the paper. (Attach a further sheet if necessary)	I, PR conceived, designed and coordinated the study, with inputs from MH and JP. I, PR designed study tools, collected and analysed data, drafted the manuscript, revised all versions and wrote the final draft. JP, JU and MH contributed to interpretation of findings. All authors provided critical review and approved the final version for submission.

SECTION E

Student Signature	[redacted]
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Date	10/01/2023

Abstract

Background

Rooted in systematic gender inequality, gender-based violence (GBV) remains a global health and human rights challenge, often exacerbated in emergencies. Effective GBV coordination ensures that in emergencies GBV services are available to survivors, and prevention and mitigation mechanisms are implemented to reduce GBV. We explored the evolution of GBV coordination in Lebanon's protracted Syrian refugee crisis (2012-2022), reflecting on key milestones as it matured through multiple phases of crisis. We propose recommendations to strengthen GBV coordination across protracted emergencies.

Methods

We reviewed policy documents and conducted 38 remote in-depth interviews with GBV and humanitarian stakeholders involved in the response in Lebanon from 2012-2022. We used a previously published framework for effective GBV coordination to analyse and present our findings.

Results

Lebanon's GBV coordination system was established to deal with the refugee crisis, but overtime, evolved to become the national coordination mechanism for GBV actors. Our findings suggest that effective GBV coordination developed among UN, international, national and local actors since 2012, while Government co-leadership and engagement with refugee-led organizations, has been hampered by a volatile and restrictive policy context. GBV coordinators successfully forged trusting relationships, facilitating cohesive coordination within a complex sectarian context. Dedicated and experienced interagency coordinators were considered a key asset which strengthened prioritisation and funding allocation, reinforced by GBV data analysis. Stakeholders cautioned however, that an over-reliance on international leadership and funding alongside limited government commitments to institutionalising coordination and services threatened sustainability. Influential national and local actors were highly valued for providing contextual understanding and benefited from capacity building and increased funding, advancing localization. Overall, from a low base in 2012, essential GBV services were established nationwide. However, lack of an interagency strategy on GBV risk mitigation and prevention compromised impact.

Conclusion

Our findings illustrate the transformative effect that the humanitarian response has had on addressing GBV in Lebanon, facilitated by effective coordination. Such protracted crisis, present opportunities to expand services, introduce innovative approaches, institutionalize coordination and advance localization. We reinforce the importance of investing in dedicated GBV coordinators,

allocating multiyear GBV funding and enhancing attention to GBV risk mitigation and prevention in emergencies.

INTRODUCTION

GBV COORDINATION IN EMERGENCIES

Gender-based violence (GBV) is a human rights violation with broad global health and protection implications, rooted in systematic gender inequality (4, 5, 12, 20, 45, 214, 215). Considered a complex and politically sensitive issue in many contexts, GBV can be exacerbated in emergencies. Addressing GBV in emergencies, requires effective coordination across multiple United Nations (UN), government, international and national organizations, to ensure that accessible and safe services (including health, psychosocial, legal, and socio-economic) can be delivered to survivors and that prevention and mitigation measures are implemented to reduce GBV (33). Within the humanitarian architecture, the GBV Area of Responsibility (AoR), led by United Nations Population Fund (UNFPA) provides global coordination on GBV and at the country level, leads GBV coordination in non-refugee emergencies, while United Nations High Commissioner for Refugees (UNHCR) coordinates in refugee settings, often alongside UNFPA (33, 35, 182). GBV and child protection are sub-sectors of the Protection sector and are closely linked (33, 104). GBV actors work closely with the Health sector to ensure that clinical management of rape (CMR) and mental health and psychosocial support (MHPSS) are available to survivors (33, 107).

Over the past decade, global attention, funding and high-level commitment to addressing GBV in emergencies has increased, galvanised by the 2013 Call to Action on protection from GBV in emergencies (4, 105). Additionally, in recent years, several international standards, guidelines, and technical tools have been developed to strengthen GBV coordination in emergencies (105, 184). These include the revamped 2019 handbook for coordinating GBV interventions in emergencies, the 2015 guidelines for integrating GBV actions in humanitarian responses, under which all sectors have responsibilities to mitigate GBV risks and core competencies for GBV coordinators published in 2014 (6, 33, 104, 183). Despite this progress, GBV is historically under-prioritised and underfunded in emergency responses and GBV coordination is rarely researched in operational contexts, leaving a gap in evidence on what influences its effectiveness (89). To address this gap, here we investigated GBV coordination in Lebanon's protracted emergency (2012-2022).

LEBANON AND THE SYRIAN REFUGEE CRISIS

The Syrian crisis, which began in 2011, resulted in a massive refugee influx to neighbouring Lebanon, requiring a huge international humanitarian response. The crisis exacerbated the economic, political, and social instability of Lebanon placing unprecedented strain on infrastructure and public services (116, 126, 127). Since 2015, Lebanon has hosted the world's highest number of refugees per capita

and in 2022, an estimated 1.5 million Syrian refugees, more than 257,000 Palestinians and 100,000 migrant workers lived in a country of approx. 4 million Lebanese (43, 126, 128, 131, 216).

During the initial years of the crisis, the Lebanese government did not play a prominent role in the response and a government "policy of no policy", is widely believed to have compromised effective national management of the Syrian refugee influx (47). Within this national leadership vacuum, UNHCR coordinated the response in Lebanon during the initial years, alongside international non-governmental organizations (INGOs) and other UN agencies under a series of UNHCR-led regional response plans (RRPs) (47, 56). The magnitude of the refugee influx challenged humanitarian organizations who struggled to expand to meet the needs, and coordination across government ministries and UN agencies faced many difficulties (116). In the absence of national policies, decision making often devolved to local authorities, who were leading operational responses, but lacked capacity, and humanitarian actors had to navigate various levels of government with sometimes conflicting political agendas (47, 56, 116). Tensions also existed between UN agencies themselves, and reports indicated ambiguity on the role of Office for the Coordination of Humanitarian Affairs (OCHA) in Lebanon, and struggles for leadership and power between UNHCR, OCHA, and United Nations Development Project (UNDP) (129). Furthermore, the scale of the crisis raised concerns that UNHCR was too dominant in coordinating all sectors, rather than relinquishing leadership to UN agencies and partners who had a comparative advantage in certain sectors (116). Within the protection sector, the National GBV task force was established in 2012 by UNHCR to coordinate GBV actors in Lebanon (132, 134). In 2013, field-level coordination was established across four regions: Bekaa, South, Beirut and Mount Lebanon, and North, to improve coordination at the sub-national level (56).

As the crisis protracted, the government assumed greater leadership and in 2015, the Ministry of Social Affairs (MOSA), designated by the Government to coordinate the response, led development of the Lebanon Crisis Response Plan (LCRP) (56). This MOSA-led, multi-year plan, with UNHCR and UNDP as co-chairs, reflected a shift in the response approach, to address medium-term recovery and development issues in addition to providing humanitarian assistance (47, 127, 131, 184). The coordination structure included interagency units, with sectors jointly led by UNHCR, a national ministry and a sector-specific agency, and an inter-sector coordination unit led by UNHCR and UNDP, which included all NGOs and UN agencies (Annex 2) (56). Articulation of the response strategy from 2015, was more inclusive of host communities serving equal numbers (1.5 million) of refugees and Lebanese communities who were affected by the crisis, allowing the needs and reality of the context

to inform the response (47). The third edition of the LCRP comprised a two-year plan covering 2022-2023, as the successor of the 2015-2016 and 2017-2021 plans. Although, funding requested through the LCRP increased from 2.1 billion in 2015, to 2.67 billion in 2020, persistent underfunding continued throughout the protracted crisis with shortfalls averaging 50% annually (116, 126, 133).

As Lebanon has not signed the 1951 Refugee Convention, legal protections for refugees are limited and over the protracted crisis, refugee policies became increasingly hostile (119, 134). The first official policy on the Syrian refugee influx was announced in October 2014, with key objectives of preventing integration, encouraging return to Syria, addressing growing security concerns and protecting the Lebanese workforce and economy (47). The government labelled refugees as "displaced", and continuously reiterated that Lebanon was not an ultimate destination, asylum, or resettlement country for Syrian refugees, which many interpreted as the government obfuscating responsibility (126, 130). Refusal to designate official refugee camps, fearing a repeat of the situation with Palestinian refugees, meant that refugees were dispersed in informal tented settlements (ITS), and among the urban population, often in overcrowded and sub-standard housing, across 1,700 localities (27, 116, 126, 128). In 2015, as the number of registered Syrian refugees exceeded one million, the government suspended UNHCR registration of refugees, made it increasingly difficult for Syrians to maintain legal residency, and refused to recognise temporary residence and birth registration (116, 135). These policies made addressing the protection, health and development needs of refugees challenging, hindered their access to services, and exposed them to arrest, detention, and exploitation (27, 116, 126, 215). This also complicated refugee outreach, accessibility, and registration with the municipalities and made it difficult to reach women and girls with information on GBV services (56). Furthermore, refugees were restricted to employment in three sectors - agriculture, construction and domestic work, and those who acquired a legal work permit lost their right to access humanitarian assistance (119). As the crisis became increasingly protracted, and the political and economic situation in Lebanon deteriorated, political attention and debate on the return of Syrian refugees heightened, alongside rises in host-refugee tension (132, 217).

Since their arrival in Lebanon, Syrian refugees have been progressively marginalized, living in evermore precarious circumstances and becoming increasingly reliant on aid (119, 127, 128). By the end of 2021, 90% of Syrian refugees were living below the poverty line, 57% of Syrian refugee families lived in overcrowded or sub-standard shelters, and 94% of refugee households had difficulty acquiring food, causing them to resort to negative coping mechanisms, such as survival sex, child

marriage and child labour, with profound impacts on the protection of Syrian women and girls (47, 128). There is no official data on the prevalence of GBV in Lebanon (24, 134). A 2012 assessment conducted among Syria refugees in Lebanon, reported sexual violence as the most common form of GBV experienced while in Syria, and intimate partner violence (IPV), early marriage and survival sex had increased among women and adolescent girls since arriving in Lebanon (152). A 2015 study reported that 26%, 9.2% and 8.7% of Syrian refugee women experienced emotional, physical, and sexual violence, respectively, with many women reporting exposure to multiple types of violence, the health impacts of which included miscarriages, sexually transmitted infection and mental health implications (154).

More broadly, Lebanon's confessionalism political system which divides power across the 18 sects in the country, while intended to minimize sectarian conflict, is often blamed for entrenching gender inequalities, masking pervasive corruption and compromising effective governance (113-115, 126, 218). During the period 2012-2022, Lebanon had multiple changes in government and faced long periods with caretaker or no functioning government, when policy decision making halted (113-116). Since 2019, a series of internal crises, including social unrest, the COVID-19 pandemic, and the Beirut port explosion, have caused the political and economic situation in the country to deteriorate, resulting in a nationwide economic emergency affecting Lebanese and refugees alike. In response to this new phase of crisis, humanitarian coordination has been reformulated yet again, with the launch of an emergency response plan (ERP) by OCHA, to provide short-term humanitarian assistance to vulnerable groups to complement the LCRP, in parallel to the COVID-19 response and the Beirut blast response (159).

Lebanon provides an interesting emergency context in which to study GBV coordination for several reasons. Firstly, the protracted emergency response (2012-22) cycled through multiple phases, during which the humanitarian response matured and systems evolved, offering several insights. Secondly, government prominence and policies fluctuated, and changing mandates and power dynamics between different stakeholders influenced how the response was governed and coordinated throughout the decade. Thirdly, the restrictive refugee policies implemented, the dispersed refugee population, and a weak legal framework to protect women and girls from GBV, created a context conducive to GBV risks, which GBV stakeholders had to navigate. Furthermore, prior to the Syrian refugee crisis, other research noted weak coordination between government and civil society GBV actors in Lebanon (101, 152). However, significant progress was noted in more recent studies, spurred by investments made through the humanitarian response (23, 24, 132, 134,

156). Finally, Lebanon's crisis has been a described as a laboratory for innovative approaches, which can offer several insights (132). In this study we explored the evolution of GBV coordination in Lebanon's protracted emergency (2012-2022), reflecting on the processes and dynamics of establishing the system, as well as key milestones, successes and challenges as it matured through multiple phases of crisis over the decade. We draw out globally relevant recommendations to strengthen GBV coordination in protracted emergencies.

METHODS

STUDY DESIGN AND CONCEPTUAL FRAMEWORK

We conducted a case study using in-depth interviews (IDI) and document review over a two-year period (2019-2022), to explore GBV coordination throughout the crisis in Lebanon (2012-2022). To inform interview topic guides and our analysis we used previously published framework for effective GBV coordination, developed through a scoping review of global literature, including six key themes: (i) Implementing a GBV sub-sector; (ii) GBV prioritisation and resources; (iii) GBV risk mitigation; (iv) localization; (v) GBV information management; and (vi) GBV coordination to support service delivery (89).

SAMPLING

To understand the evolution of the humanitarian response, we reviewed relevant policy documents and conducted 38 remote in-depth interviews with stakeholders involved in GBV coordination and the humanitarian response in Lebanon and in the region from 2012 to 2022, selected by purposive sampling (219). Informants were contacted by email and snowball sampling was used to expand reach. Key informants compromised of GBV experts from the Ministry of social affairs (MOSA) (1), UN agencies (13), INGOs (8), national and local organization's (7), academia (1) and UN coordinators of other related sectors (interagency, health, gender working group, CMR, protection, child protection and education) (8). We reviewed websites and databases for key policy documents (Table 4, Methods). We mapped the key stakeholders involved in the GBV sector within the humanitarian response in Lebanon and relevant government institutions (Annex 3).

DATA COLLECTION AND FRAMEWORK ANALYSIS

In-depth interviews followed topic guides (Annex 4) which were edited following each interview to include questions on emerging themes. Interviews were digitally recorded before transcription and analysis. Key documents including policy documents, strategic response plans, GBV evaluations and reports on the response in Lebanon and meeting minutes, were included in the framework analysis

and helped to track changes and developments over the 10-year period and to verify findings from interviews (166). Framework analysis (188) was used to analyse data using NVivo 11 (176). Data from interviews and documents was coded within the six key themes of the conceptual framework using framework analysis. We allowed flexibility for emerging themes to surface and maintained a critical perspective on influential political and contextual factors.

A data verification workshop was conducted in Beirut in 2022, with GBV task force members and key informants of the study (18 in-person and online), some of whom had worked on the response since 2012. This provided an opportunity to collectively reflect on the preliminary findings, ensuring that interpretations were validated and any gaps or uncertainties in the data were clarified. By triangulating data from different sources we ensured that findings were corroborated and data gaps addressed. We reached saturation on several key themes, which we describe below.

RESULTS

We present the findings across the six themes for effective GBV coordination outlined above, highlighting important milestones, challenges and lessons. Figure 1 below presents a timeline of key milestones for GBV coordination in Lebanon, against unfolding events in the broader policy and response context.

Overall, all of our informants believed that an effective coordination system had evolved in Lebanon from 2012-22. The task force had to navigate complex political and contextual factors, to forge trusting relationships and build a collaborative and cohesive system, which facilitated funding allocation, localization and service expansion. As one UN actor put it:

> *"Having been working in a dozen countries since I set up the GBV coordination in 2012, I can tell you that this is the best coordination I have ever seen"*

Nevertheless, our findings highlighted several gaps and challenges, including over-reliance on international funding, weak government commitment to institutionalising coordination and services, barriers to GBV risk mitigation, insufficient investment in GBV prevention and the absence of refugee representation.

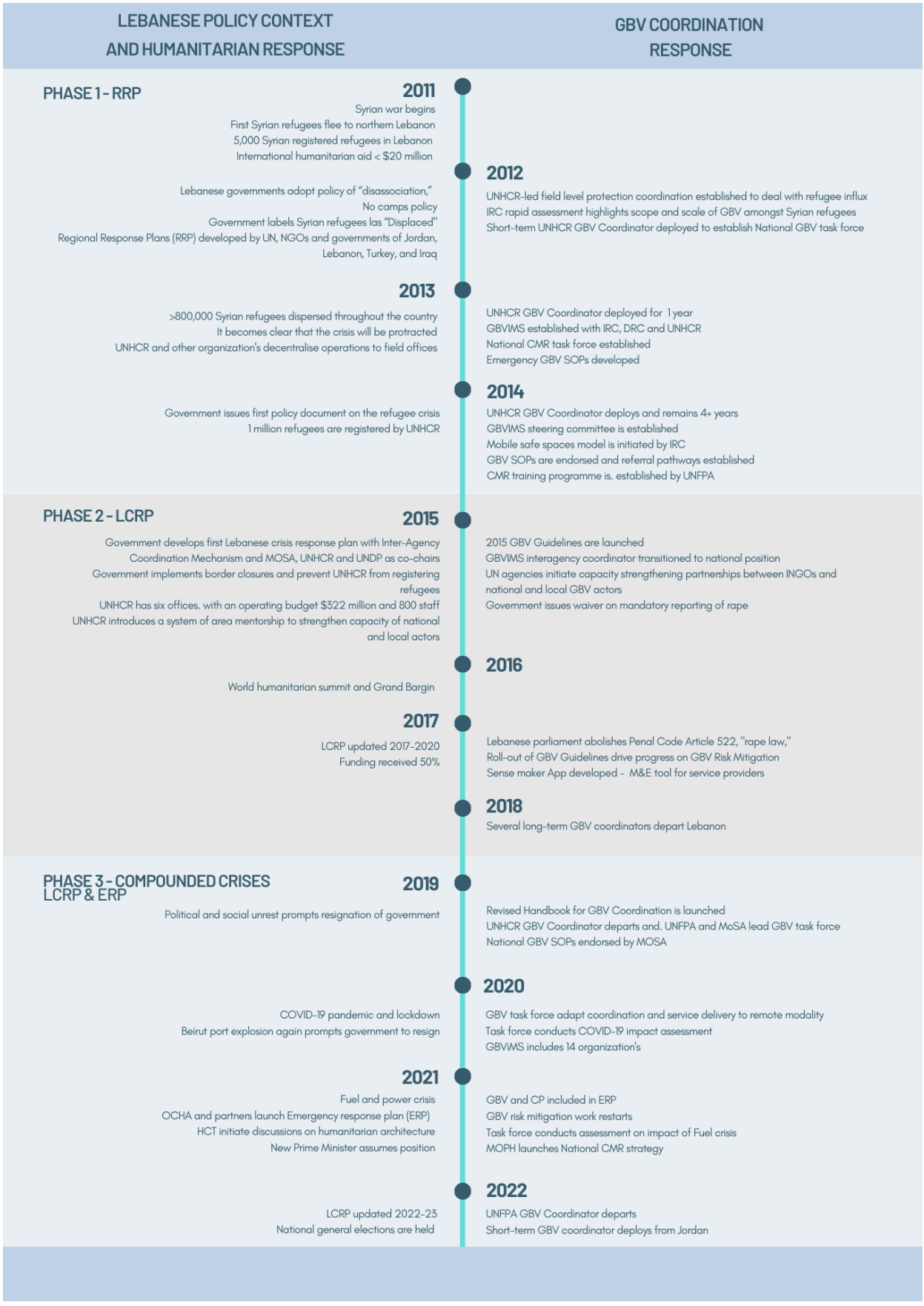

Figure 1: Timeline of key milestones for GBV coordination in Lebanon, against the backdrop of the policy context and broader humanitarian response through the protracted crisis

The timeline is split into three phases with key stakeholders, response strategies and milestones highlighted for each phase. Phase 1 (2012-2014) covers the initial emergency stage, which required establishing the GBV task force and services and can be characterised by weak government leadership and prominence of UNHCR and INGOs. Phase two covered a more stable period in the response, characterised by stronger government leadership under the LCRP, availability of multiyear funding, when the GBV task force, led by long-term coordinators, initiated capacity building of national and local actors and implemented several innovations which advanced GBV coordination and services. Phase three covered the compounded crises 2019-22, including the October 2019 revolution, the COVID-19 pandemic and the Beirut blast, the fuel and power crisis and multiple changes of government, all culminating in a national economic crisis. This phase was characterised by rising GBV risks and expanding vulnerable populations, which required adapting to remote coordination and services provision and operating within multiple response frameworks.
CMR: Clinical Management of Rape, CP: Child Protection, CSO: Civil Society Organization's, DRC: Danish Refugee Council, ERP: Emergency response plan, GBV: Gender Based Violence, GBVIMS: Gender Based Violence Information Management System, IMC: International Medical Corps, INGO: International non-governmental organization, LCRP: Lebanon Country Response Plan, M&E: Monitoring and Evaluation, MOSA: Ministry of Social Affairs, NGO: Non-governmental organization, OCHA: Office for the Coordination of Humanitarian Affairs, RRP: Refugee response plan, SDC: Social Development Centre, SOPs: Standard Operating Procedures, UN: United Nations, UNDP: United Nations Development Programme, UNFPA: United Nations Population Fund, UNHCR: United Nations High Commissioner for Refugees, UNICEF: United Nations Children's Fund.

IMPLEMENTING THE GBV SUB-SECTOR

The establishment of an internationally-led GBV coordination mechanism within the humanitarian response in 2012 was driven by multiple factors (101, 134). Firstly, the lack of centralised GBV coordination unit within the government, compounded by weak government leadership and a national response strategy in the early years of the crisis, prevented government coordination of the GBV sector. Although several government institutions were mandated to provide leadership on GBV and gender in Lebanon, including the National Commission for Lebanese Women (NCLW), and the Department of Women's Affairs, within MOSA, (Annex 3), coordination among GBV actors was weak and efforts to address GBV prior to 2012, had been mostly led by national CSOs (24, 101, 134). In this context, all interviewees perceived that there was limited awareness and attention to GBV within the government, and a lack of expertise on how to address it. The Lebanese government was commonly regarded as a patriarchal administration, within which matters relating to GBV were left to the governance of religious sects. As one government actor explained*:*

> *"I think before the crisis, we had a limited number of NGOs working on gender. And even our understanding of GBV was very limited. . . . it's [gender] still something we are still trying to explore as a state and as a government. I know that in terms of regulations and law, . . . that countered or reject GBV... We're not so much advanced on that."*

Secondly, entrenched sectarian divisions undermined efforts to establish a cohesive national response which complicated humanitarian and GBV coordination including government leadership, as one UN GBV coordinator described:

> *"I had hoped that we would be there to support the national system. To a certain extent it was the case, but the Lebanese society is also highly divided. You had so much tension*

between the different sects and political parties, that it also undermined whatever the national authorities could do.. . . we could feel within the government, some tensions among the more progressive and the less progressive, and everything went back to the belonging to one sect or another."

The country's 18 religious sects have 15 different personal status laws, leading to unequal treatment of women by religious courts. These sectarian divisions have created tensions among different political parties and hindered collaboration among GBV actors, making coordination difficult. One local actor described how sectarianism, entrenched in the Lebanese's society, was in direct opposition to the very idea of coordination:

"how polarized the landscape is in Lebanon, the GBV actors specifically aren't that many and they're very territorial. There isn't a lot of collaboration. So, coordination even on a good day is not in the Lebanese psyche, unfortunately. It just doesn't feature as part of something we do well."

Thirdly, the scale of the crisis overwhelmed government, national and local actors, who had previously focused on the Lebanese population and had limited capacity and funding, preventing them from rapidly expanding to serve the refugee influx. Furthermore, nobody expected the Syrian refugees to stay long-term, least of all the government, who avoided establishing a more formal response, as one UN GBV expert described:

"Very soon we were overwhelmed with refugees, and we said, Okay, that's the biggest crisis of all times. What do we do? How do we manage that? . . . And they arrive and they run out of the savings and there was no improvement, it was getting worse, everyone was starting to say, okay, . . .it's going to last. . . so the discussions [UNHCR had] with the government of Lebanon saying, "you know, this informal settlement, as much as they are informal, you need to take more accountability. We need to set up a bit more services" "

In this context, the first UNHCR coordinator established the national GBV task force at the end of 2012, and initially this was largely dominated by UN agencies and INGO's, including UNHCR, UNFPA, United Nations Children's Fund (UNICEF), Danish Refugee Council (DRC), International Medical Corps. (IMC), and International Rescue Committee (IRC) (Figure 1: Phase 1). The rapid assessment conducted by IRC in 2012 was instrumental in highlighting the scale and scope of GBV Syrian women and girls had faced in Syria and the lack of services available in Lebanon, which galvanized support for GBV within UNHCR and across humanitarian leadership (152). Senior leadership support for GBV meant investments were made in experienced coordination positions, who in turn mobilized additional funding to sustain positions and expand programming.

> *"Positions were well-funded and it was not even a topic of discussion. So we were very lucky in this regard . . having somebody different for GBV coordination at National level, having a co-lead, having a national GBVIMS coordinator. All that was luxury that I would never see again, I think." (UN GBV Coordinator)*

In January 2013, a second UNHCR coordinator deployed for one year, and embarked on the process of expanding the task force taking a bottom-up approach, by identifying allies in the GBV space. Recognizing the existing GBV capacity in the country, the coordinator made conscious efforts to engage national and local organizations in the GBV task force which gradually expanded and was open to all organizations working on GBV. This inclusive approach was important for forging collaborations and trusting relationships, setting the foundation for later successes.

> *"I could hear from some Lebanese colleagues from UNHCR that . . it was a very international driven response. So, I started to develop some personal connections, basically, I heard about first LECORVAW . . . then there was KAFA and ABAAD, and so I will always remember at that time, so she [ABAAD Director] had an office that was outside of Beirut, and so I would go and she would be alone in her office and just explaining to me the history of women's organizations in Lebanon." (*UNHCR GBV coordinator)

As the task force expanded, it transformed into a national GBV sub-cluster under the Protection Sector Working Group, reflecting the shift towards localization, integration, and strengthening of government coordination mechanisms. National NGOs were recognized as key stakeholders, providing contextual understanding and helping to identify national organizations and soon became influential voices in coordination meetings. As the number of participating agencies expanded, a core GBV coordination group was formed within the task force, to lead strategic planning, guidance development and ensure inclusive decision-making. This group was comprised of MOSA, four UN agencies (UNFPA and UNHCR, UNICEF and one elected UN member), four INGOs, and four national NGOs, drawn from organizations with GBV technical expertise and capacity to actively participate, with membership updated annually through an election process.

Reflecting the broader response context, government leadership improved overtime, and from 2015, a GBV coordinator position was created within the LCRP unit in MOSA and funded by UN agencies. However, due to long vacancies in the position at several stages of the crisis (sometimes for two years), and limited expertise on GBV, representation remained inconsistent for most of the response which limited joint coordination (132). Therefore, although MOSA formally acted as co-chair since 2015, most informants described their representation as superficial or "fake" until 2020,

which was challenging when it came to endorsement of response strategies, as described by one UN GBV coordinator:

> *"But in GBV they [MOSA] were also the actual line ministry [Government Ministry responsible for GBV] and we couldn't have anyone who could really ensure that whatever was described in our strategy was actually agreed and endorsed at the level of their ministries that was a bit difficult."*

Following a two-year vacuum (2018-20), a GBV and protection expert was hired by MOSA in 2020 and had been actively co-leading the task force, which was highly appreciated by all informants. This role covered protection, child protection and GBV which facilitated coordination across the three sub-sectors, but limited the time and attention allocated to GBV alone. Government representation, however, remained superficial at sub-national level, which was broadly attributed to a general lack of GBV expertise and limited local capacity, mirroring challenges across the response.

The tension between UN actors being outspoken on issues which directly challenged government policies, and the need to maintain relationships, also played out in Lebanon where sensitive government policies were often not directly contested. For example, engaging government in discussions on early marriage, which was governed by sectarian religious courts, was met with a lot of resistance.

> *"And the fact that when we were working Hezbollah was also part of the government. That also didn't help because they had a very strong position on early marriage to the extent where they accused UNFPA, after a very powerful campaign against early marriage, of undermining the concept of family in Lebanon." (UN GBV Coordinator)*

Equally, topics which challenged government policies such as the 2015 border closures, were off limits. In the early days, Lesbian, gay, bisexual, transgender, intersex, queer, + (LGBTIQ+) issues, could not be discussed openly in meetings or directly referred to in documents, although the task force made some progress on acceptance of these issues overtime.

Informants believed that dedicated interagency GBV coordinators, not strictly affiliated to UNHCR or other UN agency, was a major strength of GBV coordination in Lebanon, building trust amongst stakeholders and improving effectiveness of the response. In addition, the response attracted experienced staff who stayed long-term which helped to forge relationships and collaboration within the task force. Informants described how the interagency coordinators, with interpersonal skills that built credibility, trust and mutual solidarity among stakeholders, created collaborative and inclusive spaces, facilitating effective coordination.

> *"both of them had very strong field experience as service providers, so both of them actually worked for many years within INGOs and in leading GBV programming and service provision at field level in different context. So they brought all of that amazing expertise. . . in addition to personalities that were very engaging, very humble in their approach, especially in engaging local partners. So it never felt patronizing, on the contrary, always felt anyone is welcome to engage and contribute and so I think that made the GBV coordination quite successful at national level." (National GBV actor)*

In the GBV sector, the initial four-header leadership between MOSA, UNHCR, UNFPA and UNICEF, moved to MOSA, UNHCR and UNFPA from 2017, when at the global level UNICEF relinquished co-leadership of the GBV sector. In addition, four sub-national GBV working groups were led by UNHCR GBV field officers since 2013 with some co-led by INGOs, such as DRC in the North and IRC in Bekka, which strengthened accountability and transparency. Field level working groups facilitated coordination close to service delivery, decentralised decision-making, promoted engagement of local organizations, ensured geographical coverage of services, and coordinated work within regional strategic plans which linked to the national GBV LCRP priorities, creating a harmonized system. Local actors highlighted how sub-national coordination supported them to better meet the needs of beneficiaries, as one local actor put it:

> *"They [local actors] knew that if you want to implement a project . . . you have to go to the SGBV working group because they would make your work easier."*

While national GBV coordinators were 100% dedicated to coordination, those at field level had to cover multiple positions, which research findings suggest compromises successful coordination (45). One UN field coordinator highlighted the value of having dedicated coordination positions:

> *"I do really think that, even if you're tasked to do other things, if you have to do coordination, that should be the main focus of your work. . . when you see how active and responsive the national task force coordinators are . . . you see the incredible impact that their work and dedication has on the sector. . . because you have someone who's accountable, committed, following up on the details, ensuring inter-sector coordination and ensuring interagency coordination, responding to the trends, setting a strategy and setting a tone for the group. That then, trickles down to the field."*

Since 2019 (Figure 1: Phase 3), participants concurred that the Lebanese context had further deteriorated, requiring the humanitarian and GBV coordination mechanisms to adapt to multiple crises within an increasingly challenging operating context, with little hope for improvement as demonstrated by the following quotes from National actors:

"having to adjust to the multi-layered and multi-complex crisis. We have to expand at some moment really very fast, and we need to adjust our operational model accordingly, and also the burnout for the team . . . and then shifting totally to everything remote, which was brand new for us. Even remote management. I had to adjust and adapt and learn in order to be able to continue providing services"

"So it's like we're in a deep tunnel that I honestly don't see a light. I just see that the more time passes, the worse it's going to become, and the least we can do. It's like a survival mode."

Parallel, complementary response frameworks created a complex humanitarian coordination architecture which stakeholders had to navigate. Positively, coordination was integrated under the established LCRP interagency coordination unit and the GBV task force remained the main coordination mechanism for GBV actors. The task force was valued by its members, for having effectively adapted to the evolving context, including working remotely during the COVID-19 lockdowns, maintaining emergency GBV services, assessing the compounding crises' impact on programming and adjusting accordingly and harmonising guidance, tools and approaches across the country. Mutual solidarity and strong relationships built over the preceding years had supported the GBV response to the compounded crises, however, was threatened by remote working modalities and higher turnover of coordinators in recent years.

The influx of international organization's to Lebanon was described by our informants as a transformational force, eliciting more attention to, and increased acceptance of, issues related to GBV, both within government and across civil society. Our Lebanese informants agreed that work on GBV had significantly progressed over the past decade, and largely attributed this to the effect of the humanitarian coordination, which enticed actors to collaborate, and the presence of GBV actors who promoted international standards, as one MOSA representative explained:

"So I think they [UN and INGOs] brought with them so many new concepts, so many new terminology. . . with the support of the international organizations working in Lebanon within the response to the Syrian crisis. I think progress was achieved."

Despite this progress, all informants, including MOSA, acknowledged the complete reliance on international funding and lack of a centralized coordination unit within the government, doubting that coordination would be successful institutionalized anytime soon. Some informants believed that MOSA representatives within the government LCRP coordination unit, were separated from core government Ministries, which limited their power in decision making and raised concerns about institutionalizing coordination.

> *"There is a team overseeing the LCRP, which is detached from the operational team of the ministry. . . So it's not the most effective to be honest. . . . especially if you want to talk about sustainability and how do you hand it over, hand it over to whom?"* (UN Coordinator)

Government informants, however, stressed that the LCRP was endorsed by the Prime Minister, and implemented under the direct supervision of the Minister of Social Affairs, with LCRP government staff embedded within government ministries.

GBV Prioritization and Resources

Although GBV funding allocation changed through different phases of the crisis, in general informants agreed that because the Syrian crisis was a high-profile emergency, the GBV sector in Lebanon had been well funded, although compared to the needs, this remained insufficient. Still in the early days GBV coordinators recalled having to fight to mainstream GBV in policy discourses and information going to donors and government to ensure that GBV was high on the agenda. They organized specific donor briefings to highlight GBV issues in 2013, which mobilized the first GBV earmarked funding allowing them to invest in programming. Within the LCRP annual GBV priorities were defined and advocacy with international donors to mobilize funding for the GBV sector was an important function of GBV coordination. GBV coordinators used several approaches to influence donors, including, engaging them in field trips to affected populations in the early years, inviting them to attend task force meetings and more recently coordinating annual donor briefings across the protection sector.

The LCRP funding request for GBV hovered at around 1.3% of overall funding, increasing from $27.7 million in 2015 to 35 million through 2017-2021 and consistently achieved over 50% of requested funding (>60% in 2021), which compared well to other sectors. In recent years, funding allocated to the GBV sector was apportioned equally between international and national actors and was inclusive to all GBV actors as long as projects aligned with agreed LCRP priorities. Nevertheless, informants raised concerns about drops in funding, particularly pronounced in 2017-18, which affected availability of some life-saving services, including women's and girls safe spaces (WGSS), that remained completely reliant on international funding (23, 132, 156). As a result of the compounded crisis since 2019, including the COVID-19 pandemic, hyper-inflation and the national economic emergency, which expanded GBV risks and funding needs, the sector funding request had increased by 20%, to 42 million in 2022.

Informants highlighted several unique aspects of the funding landscape in Lebanon. Access to multi-year funding in recent years facilitated longer-term planning and a level of sustainability which allowed actors to build trust with communities' overtime, ultimately improving uptake of services. Additionally, the ability to mobilize funding for implementing interagency initiatives increased collaboration across the sector and improved credibility with donors and other sectors in the response, as described by one UN GBV coordinator.

> *"The impact it [funding for interagency initiatives] had, on the way we have been working, on the credibility we were having, on our interactions with donors. That was really something that I would definitely recommend." (UN GBV Coordinator)*

For example, UNICEF UNHCR and UNFPA pooled funding for the GBVIMS coordinator position, and UNICEF funded the use of GBVIMS for 2022 while UNFPA paid for trainings. A case management toolkit was developed as an interagency funded initiative, as was, RESPONSE, a GBV referral mobile application (24).

GBV RISK MITIGATION AND INTEGRATION

In response to the findings of a 2015 evaluation of the 2005 IASC guidelines in the Syria crisis response, the revised 2015 GBV guidelines, were rolled out in Lebanon in 2017, which was seen as an opportunity to attract funding and promote multi-sectorial accountability on GBV risk mitigation (167). Each sector had a responsibility to implement the guidelines and received training and support from the GBV task force, which laid the groundwork for developing tailored actions to mitigate GBV risks in their sectors. UNICEF hired a consultant to support efforts, implementing a series of 19 GBV risk mitigation trainings across prioritized sectors, reaching 334 individuals in 2017, and supporting development of action plans for each sector (132). Some sectors were more willing to engage than others, but overall, the initiative was reported to have strengthened inter-sectorial coordination, driving progress on risk mitigation. Senior level support was also highlighted as critical for ensuring success of the rollout. Interest from WFP, for example, was attributed to commitment from headquarters to mainstream GBV at country offices. Ultimately, however, lack of accountability mechanisms and systematic follow-up, along with competing sector priorities, limited the impact of the initiative.

> *"So at the beginning they were very much motivated. During the training they were very active, but all of them were very reluctant to add indicators to work on a rigid action plan, which they can integrate into their annual action plan. . . . Everybody was responsive at the level of the training. After the training, nobody was responsive." (National GBV consultant)*

Informants also noted multiple repetition of GBV risk mitigation trainings throughout the protracted crisis, which due to high staff turnover, had limited long-term impact. In 2021, this work was again being revived, 10 years into the crisis, with five prioritized sectors; health, shelter, education, WASH, and livelihoods, employing a focal point system to work directly with sector partners, similar to the system implemented earlier in the response. Reflecting on this, several task force members recognized the need to systematize efforts at an interagency level and to take a more strategic and long-term approach to risk mitigation including encouraging donors to make this a pre-requisite when funding initiatives.

> *"If donors would insist on having GBV mainstreamed in all the other sectors, since the beginning from the proposal. If organizations had a person really dedicated to review proposals, review assessments and have GBV mainstreamed, that would solve the problem." (INGO GBV actor)*

Informants believed that the UNHCR interagency unit had created an environment conducive for inter-sectoral coordination and provided a space for relationship building among sector coordinators which helped to progress GBV risk mitigation. Several achievements on GBV mainstreaming within protection, child protection, livelihoods, assistance, WASH and shelter sectors were highlighted previously and reiterated by our informants (132). GBV coordinators participated in CMR task force meetings, health sector working groups, the gender working group, led by UN women and co-led the PSEA task force (132). The LCRP recognizes that addressing GBV is a collective responsibility and in the most recent iteration, GBV is integrated across all sectors as a key crosscutting initiative (127, 131).

Nevertheless, informants recognized that stronger interagency efforts were needed to improve meaningful participation and engagement with refugee women and girls. While recognised as critical by informants, engaging with, and ensuring accountability to, Syrian refugees, was especially challenging in Lebanon with the large and dispersed populations. Locating and accessing refugees outside of camp settings, especially with sensitive GBV information, was challenging. In addition, lack of legal residence prevented women refugees from reporting incidents and seeking care, for fear of deportation or retaliation (24).

> *"I mean the absence of camp impacted a lot. . . the fact that the refugees were widespread everywhere and mixed with the Lebanese was really challenging . . . they are everywhere, they are nowhere. To disseminate information was really a nightmare. And when the information is sensitive even more". (UN GBV Coordinator)*

In the early days, GBV coordinators made efforts to engage with Syrian refugee women through focus group discussions and informal gatherings to understand the issues they faced:

> *"We did a couple of joint missions to look at the informal settlements, to have discussions with women and . . . we just picked up really precarious living conditions and distress" (UN GBV Coordinator)*

Outreach volunteers formed a key component of the UNHCR GBV approach to increase community understanding of GBV, awareness on availability of services and referrals and to build relationships with communities (132). UNHCR undertook annual participatory assessment to consult with refugees regarding their needs, priorities and trends, which included GBV survivors and marginalized populations (132). However, other than a survey which was conducted among beneficiaries of case management services in 2019, participants of the data verification meeting in 2022, recognised that at the interagency level, efforts had been insufficient, supporting previous finding from 2018 (132).

LOCALIZATION

*S*ignificant investments were made by UN agencies and INGOs to strengthen the capacity of national and local Lebanese organizations throughout the crisis which informants believed contributed towards developing sustainable GBV capacity in the country. In 2015, UNHCR introduced a mentoring system which involved UN agencies funding INGOs, who sub-contracted local GBV organizations as implementing partners under three-year contracts. This provided stable funding for local actors to provide GBV services, while also participating in capacity development programs to build internal management and financial accountability systems, after which they could be eligible to receive UN funding with the ultimate aim of them replacing the INGOs in service provision. Local actors credited their membership in the GBV task force for allowing them to evolve and expand as organizations.

> *"Back in 2011, we had six staff. This is overall. Now, we have more than 25. . . . The more the organization is growing, the more the donors are more demanding for policies and procedures, especially human resources and financial procedures. This is something we did achieve. We now have a policy and procedure for HR and for the financial policies. We also created policies related to fraud, to the inventory, to the procurement. Recently, also we designed our PSEA policy. This all helped us transition from a very small NGO to a middle-sized NGO." (Local GBV actor)*

Notably, several national NGOs, such as ABAAD and KAFA, capitalised on partnerships, opportunities and funding created by the humanitarian system, to showcase their expertise and build visibility and reputations on the international stage.

Major efforts too, were made to enhance the role of NGOs in the leadership and coordination of the response in Lebanon and the LCRP reinforces the principles of a localized response (131). Their influence and contribution in the task force were highly valued by international GBV coordinators, providing contextual understanding and access to remote populations. Nevertheless, sectarian division between national and local actors created coordination challenges, slowing down some initiatives, with high sensitivities around mandates and visibilities and historical tensions coming to the fore. Some national actors furthermore, challenged international actors on their added value in a country with such a strong civil society. As one UN GBV coordinator explained:

> *"Coordination was not always easy. there was a lot of tensions among them that were pre-existing the crisis or crystallized during the crisis for question of funds or question of visibility or whatever. . . . the value that they would bring on the table was also incomparable basically because they had the knowledge of the working context, a capacity of how to treat of the most remote or reluctant communities that was unique. So it was really a win-win strategy that we adopted. . . . . also requesting us to bring an added value . . . challenging credibility of every single one of us."*

GBV task force members who attended the data verification meeting in 2022, however, recognised that more efforts were needed at the coordination level to map out and engage smaller CSOs, and refugee-led organization's in coordination, a gap previously noted (47, 132).

Nevertheless, several practices were highlighted which hampered true localization in Lebanon. For example, one local actor described incidents of staff poaching from national to INGOs having invested heavily in building staff capacity only to have them offered higher pay and leave. By restricting salary scales for local actors to lower levels than for INGOs, working for local organizations was less attractive.

> *"we faced several challenges with a couple of INGOs where we would train the staff and we invest in our staff, then they [INGOs] come and offer them more and take them. . . for a field officer, they will not approve more than $800. But they [INGOs] offer for the same position $1200. So, we were like, what about the localization? And what about all this talk you're saying we want to include local organizations and want to build capacities, you're not building capacities, you're actually setting us back. . . they restrict it." (Local GBV actor)*

Informants also emphasized the need to improve accountability and auditing of local actors, citing incidents where local actors negotiated specific salaries with donors, but in reality, paid lower salaries to staff. Furthermore, coordination meeting language varied depending on the region and phase of crisis. While during the early phase, field coordinators reported conducting meetings in

Arabic to encourage engagement of local actors, more recently meetings at two field sites included in the study, were conducted in English without translation, which was likely a barrier for CSOs.

GBV Data and Information Management

The GBVIMS system in Lebanon was considered an integral part of GBV coordination and was valued immensely by informants, however, sustainability was a concern. Implementation of GBVIMS in 2013 was described as a gamechanger by GBV coordinators, which once established provided a safe and ethical way to gather data and analyze trends, reinforcing coordination decisions. Having a dedicated, interagency, GBVIMS coordinator, and the GBVIMS steering committee established in 2014, were highlighted as major advantages in Lebanon compared with other contexts. Initially established with three organizations, IRC, DRC and UNHCR, GBVIMS gradually expanded using a stepwise approach, and by 2020 comprised seven international and seven national and local actors. In 2015, Lebanon was chosen as a pilot country to roll out the GBVIMS primero, an innovative system containing both GBV and Child Protection information management platforms. Although the GBVIMS coordinator had been transitioned to a national interagency position, both the coordination and the GBVIMS system itself were dependent upon international funding. Ideally the system would be institutionalised within a government body, however, informants did not believe that was feasible in the current circumstances, and without GBVIMS, the task force would have been severely compromised. Nevertheless, to initiate engagement of the government and to build awareness on safe and ethical GBV data sharing, in 2019, the steering committee and GBV task force conducted a one-day training on GBV data management for government actors from across ministries. This was considered the first step in a move towards eventually institutionalisation.

GBVIMS data analysis was used to develop thematic reports on topical issues, to inform programming decisions and service coverage and to mobilize funding, thereby reinforcing GBV coordination. Thematic reports were circulated widely amongst GBV actors and other sectors to ensure that data was used optimally to inform and influence interventions across the humanitarian response. GBVIMS data was often the first source of data used in information products produced by the task force including dashboards, situational updates and strategic planning documents. In addition, an information sharing protocol was agreed with agencies which upheld safe and ethical data management procedures (132). Organizations used trends and data from the reports produced by the GBVIMS steering committee to draft funding proposals, for example. This holistic approach to use of GBV data had a major advantage when, for example, in 2017, Lebanon faced a funding cut and data over the following few months showed a decrease in reported incidents of GBV. Following

a thorough analysis of available data from multiple sources, the steering committee concluded that because of funding cuts, many organizations had to suspend their case management services so caseloads decreased. This enabled the steering committee to draft a report highlighting the importance of financial tracking alongside GBVIMS data analysis.

COORDINATION TO SUPPORT SERVICE DELIVERY

The GBV task force was commended for significantly enhancing and contextually adapting GBV services across the country over the decade of crisis, however, services remained reliant on international funding and while some efforts had been made towards institutionalizing these, government ownership remained weak, threatening overall sustainability. Our informants reiterated previous findings that GBV services had been dramatically expanded with improved coverage, availability, accessibility and quality, even in remote areas, although gaps still persisted (132, 156). Over the past decade, the GBV task force produced high quality tools to support agencies' service provision, which were actively taken up by GBV actors at national and field level (24, 132). Informants believed that without the GBV task force, the nationwide system existing in 2022, would not have been achieved. As one local actor described:

> *"If you go to remote areas like Baalbek, Aakkar, all those really remote areas of the country, you'll see there was no GBV service delivery. And I have witnessed in my career, lot of women unfortunately passing away simply because there was no kind of support being provided to those women. So today, if you go ... Due to this advocacy, coordination work, having field coordination structure, you can see that you have today, GBV service delivery, almost all the governates all the remote areas like border areas and so on. And that's really perfect."* (Local GBV actor).

Despite huge investments, because all funding was still provided through international channels, and the role of government in both funding and service delivery was limited, informants had little hope that services could be institutionalized. While a comprehensive mapping of services was beyond the scope of this study, we reflect on two important services below, CMR and case management, to demonstrate the impact of coordination on the evolution of these services in Lebanon.

Despite CMR services being largely unavailable at the beginning of the response, services were introduced and expanded across the country and the national CMR strategy evolved over the decade, with increasing ownership of the government. According to our informants, prior to the Syrian crisis, due to the sociocultural context and norms around sexual violence, hospitals did not provide CMR services, medical schools did not include CMR within their curriculums and doctors and

nurses were not routinely trained to treat GBV survivors. The 2012 assessment shone a light on the lack of available CMR services in Lebanon (152), prompting significant investments in expanding CMR services, led initially by IRC and later coordinated by MOPH and UNFPA, within the national CMR task force. Initial efforts to ensure availability meant sustainability was not considered from the beginning, resulting in 47 facilities being trained using tools adapted to the Lebanese context (132). As one UN coordinator described:

> *"And the results were dramatic, dramatic, dramatic, dramatic. . . IRC decided to immediately come and open their first women centers. I think it took them two weeks to arrive as the result were that bad. And they started to have everything that was not sustainable. They were having gynecologists on call that were paid privately. I mean we did everything that normally you're not supposed to do because there was nothing to build on. So, the whole response at the beginning was completely unsustainable and was really there to do the basic life-saving, as simple as that."*

In the initial years, mandatory reporting of GBV cases by health care providers compromised survivor-centred CMR, placing survivors at increased risk. Following advocacy by the GBV task force, a waiver was approved by the government in 2015, which allowed health care workers to circumvent this legislation. CMR training was provided to all staff at health facilities, to ensure that survivors were treated in a survivor-centred manner throughout the facilities (155). However, with limited resources and staff to support facilities, MOPH oversight was weak compromising the quality of services, which prompted MOPH to rationalize services in recent years. In 2019, MOPH and UNICEF developed a national CMR strategy which prioritized 10 MOPH supported facilities. Since 2012, cost for CMR treatment for Syrian refugees was supported by UNHCR, however, Lebanese women and girls had to pay for services (24, 132). The national CMR strategy launched in 2021, addressed issues of financing CMR services in government facilities, advocating for financial coverage for the Lebanese population and for a dedicated budget within MOPH (220).

GBV case management services, considered a life-saving intervention for GBV survivors, were radically expanded to deal with the complex cases in Lebanon and several models for service delivery emerged to better suit the context. A dedicated national case management working group endorsed a harmonized strategy, which defined a standardized package of services, developed inter-agency SOPs and established minimum standards in relation to case worker and case load and static and mobile safe spaces. Capacity building of case management service providers evolved dramatically throughout the years, resulting in a sophisticated coaching program for GBV case

managers, implemented by IRC and funded by UNHCR (132). Innovations such as mobile safe spaces, were implemented in public spaces to expand outreach and access for dispersed Syrian refugee and host populations (168). Although not recommended in every context, in Lebanon this was a way for women and girls to reclaim public spaces which were often only accessed by men and boys, thereby also addressing some of the root causes of gender inequality. Social development centers (SDCs) overseen by MOSA, provided social services to communities in Lebanon prior to the crisis, and UNICEF and UNHCR supported INGOs and local actors to provide case management at more than 50 SDC's around Lebanon through long-term five year plans (132). These SDCs acted as hubs where women and girls could receive information, seek support, and be referred for GBV services and was seen as a way to institutionalized services to government run facilities. However, several challenges emerged when working with government which informants felt limited the long-term impact of the initiative, including poor work ethics, rooted in insufficient renumeration of government staff, especially pronounced more recently, due to the economic crisis.

> *"I don't want to say it was a catastrophic experience because ... Let's say it did not go so well because of the culture of the governmental staff or the SDC staff. First of all, the working hours. Second, even if you trained them, they would still act based upon what they see right. For example, if we're talking about confidential information, they wouldn't mind sharing it. . . . Third, it's sadly, some of the employees if they work over-time might ask for payments which the government do not provide. The agreement is that we had to provide the extra working hours fees. Which would also be challenging as they would say on the time sheet that they did attend, and in fact they did not." (Local GBV actor)*

The nature of the crisis, the restrictive refugee policies being implemented by the government, and the fact that minimal services existed at the start of the crisis, meant that a strong focus remained on GBV response for several years, at the detriment of investment in GBV prevention programming. Although emergency SOPs were developed at the end of in 2012, it took until Dec 2014 to have GBV SOPs endorsed by the task force and fully functional referral pathways in place across all regions that were well disseminated and known by GBV actors and other sectors (221).

> *"Yeah, so I have to confess that due to the profile of the crisis, we remain for really long, probably too long focused on having a response that was decent. I mean in 2012 I still remember there was nothing, not even a gynecologist who had an idea on what to do with a woman who had been raped. Really, we started from zero." (INGO GBV coordinator)*

Transitioning to prevention programming, was challenged by the need to continually justify funding to maintain response services and a cohesive, interagency prevention strategy was never developed.

Although several innovative, context-appropriate, GBV prevention initiatives had been developed in Lebanon, and even exported to other countries such as Jordan, for example “I'm Here, I'm Strong” and “KOUDAR”, most informants agreed that there had been insufficient attention to GBV prevention over the decade.

DISCUSSION

Global awareness of, and dedication to, addressing GBV in emergencies, has expanded in recent years and we have seen this play out through Lebanon's protracted crisis, during which the GBV response matured and coordination systems evolved, offering several important insights. To the best of our knowledge, this is the first study to interrogate what influences effectiveness of GBV coordination in a protracted emergency context. Our findings demonstrate the importance of effective GBV coordination in addressing GBV in such settings as the driving force that directs programming, mobilizes funding, encourages collaboration and requires leadership, commitment, and sustained investment. Our findings indicate that an effective GBV coordination system had evolved among UN, international, national and local actors in Lebanon since 2012, while engagement with the Lebanese Government and refugee-led organizations had been hampered by an everchanging and challenging policy context (46, 67, 181). Below we reflect on the findings of our case study on GBV coordination in Lebanon’s protracted crisis and draw out global recommendations (Table 1) to strengthen GBV coordination across protracted emergencies.

Although the GBV coordination system was established to deal with a refugee influx, and there was limited availability of GBV response capacity before the Syria response, overtime it evolved to become the main coordination mechanism in the country for GBV actors, galvanising efforts to address GBV with potential for instituting long-term change. GBV coordinators successfully forged relationships across diverse political and sectarian groups to create a cohesive and effective coordination structure within a fractured and complex sectarian context. The Syrian crisis created opportunities to advocate for, and build capacity on GBV, across government institutions, and to improve collaboration and commitment to addressing GBV in Lebanon (24, 156). Despite UN efforts, MOSAs leadership of the GBV task force remained inconsistent for most of the response, but they assumed a more prominent role since 2020. Although the government co-led approach had several limitations, including sectarian divisions and hierarchical structures which slowed progress, having to adapt to constantly changing governments and boundaries placed on politically sensitive discussions, it was critical to set the foundation for sustainability.

Table 1: Recommendations for strengthening GBV coordination across emergency contexts

THEMATIC AREA	RECOMMENDATIONS FOR OTHER EMERGENCY CONTEXTS
IMPLEMENTING A GBV SUB-SECTOR	Design coordination mechanisms to suit the context and to build on existing government and civil society networks
	Invest in capacity building and funding for dedicated long-term GBV positions at national and sub-national levels from the onset of emergencies
	Adopt interagency coordination mechanisms to share leadership roles and dedicate interagency coordinators, particularly in protracted emergencies
	Strengthen subnational coordination mechanisms that engage and encourage leadership of local actors and inclusion of refugee-led organizations
	Implement approaches to strengthen the linkage between national and sub-national coordination, learning from Lebanon
	Consider establishing an elected core team of technical experts to support strategic planning and priority-setting
	Consolidate context-specific tools and guidance at coordination level to create a central repository
	Conduct research on GBV coordination in diverse operational settings, including humanitarian and public health emergencies, to provide evidence on factors influencing effective GBV coordination
	Conduct research to explore qualities, skills and competencies of effective GBV coordinators in different contexts
PRIORITIZATION AND ACCESS TO RESOURCES	Increase multi-year GBV funding, planning and programming, especially in protracted emergencies
	Promote mobilization of interagency funding for coordination positions and implementation of interagency initiatives
	Ensure funding is channelled through national response plans with priorities agreed through consensus building within GBV coordination platforms
RISK MITIGATION	Improve GBV risk mitigation across sectors through training dedicated GBV specialists to work with sectors during planning stages
	Improve commitment of leadership and systems for accountability on GBV risk mitigation across all sectors through, donor mandating, support from GBV risk mitigation experts during planning and integration of GBV indicators in sector plans
	Improve engagement with affected populations to identify and mitigate GBV risk
LOCALIZATION	Provide incentives for local actors and refugee-led organization to engage in GBV coordination including capacity building and funding opportunities, through mutually beneficial partnerships
	Document and share successes and lessons learned on GBV localization, with focused case studies, including from Lebanon
DATA AND INFORMATION MANAGEMENT	Invest in interagency GBVIMS coordinators with appropriate skills, deployed across emergency settings and build national capacities
COORDINATION FOR SERVICE DELIVERY	Learn from and adopt methods to expand and institutionalize services from Lebanon considering sustainability from emergency onset
	Institutionalize GBV services in government-run facilitates where possible (eg.SDCs)
	Increase investment in GBV prevention through multi-year funding from the early stages of emergencies, especially in protracted emergencies

In parallel, noteworthy progress has been made over the past 10 years on reforming the legal framework in Lebanon, including; Law 293 on the Protection of Women and Family Members Against Domestic Violence passed in 2014 (134) abolishment of the Penal Code Article 522, the "rape law," which allowed rapists to evade punishment if they married the survivor, in 2016 (134); and since 2017 five draft bills have been presented to parliament to set the legal minimum age of marriage at 18, but are yet to be endorsed (134, 161). While much of this success can be attributed to a vibrant civil society, the presence of international actors, who promoted international standards was recognized as a driving force for change in Lebanon (24).

Although there is still no centralised government GBV coordination unit, the GBV task force can provide the foundation for institutionalizing coordination. Clarity is required on the mandates and roles of NCLW and the National Technical Task Force to End GBV against Women and Children (NTTF), which was established in 2012, and more efforts are needed to promote their leadership roles in the GBV space (24, 134). The National GBV Standard Operating Procedures, which were launched in 2019, are expected to improve coordination, data collection and service provision in Lebanon, and should be operationalised (24). The role of local government actors in sub-national coordination, and provision at SDCs, also requires strengthening. Ultimately, however, a national budget allocation for GBV is required for national systems to fully subsume GBV coordination and services, which is unlikely the current economic circumstances (23, 24).

Effective coordination requires leadership commitment and investments and partially depends on having suitable individuals in coordination roles (46). Dedicated, experienced, interagency, long-term, coordinators were a fundamental aspect of the success of the coordination in Lebanon and strengthened donor confidence, GBV prioritisation and funding allocation (132, 150). They facilitated a harmonised response where strategic priorities were clearly defined and limited resources used effectively (23). Collaborative GBV coordinators at both national and subnational level elicited trust and solidarity among stakeholders and advocated to keep GBV high on the agenda, which is often challenged by high staff turnover and competing priorities in emergencies (132). Forming a GBV core group of experts, with membership balanced between UN, INGO, national and local actors, who could lead strategic decisions, was highlighted as an important lesson which could be replicated elsewhere. In addition, a dedicated interagency GBVIMS coordinator with the skills to perform data analysis to inform coordination decisions, was considered a precedent in effective coordination. GBVIMS supported programming decisions and service provision, and strengthened advocacy and fundraising efforts (195). In Lebanon's protracted and multi-layered crises, and across emergency

settings, donors must continue to fund these critical international GBV coordinator positions, and UN and INGOs must invest in building the GBV coordination workforce to ensure that dedicated, experienced, GBV coordinators are deployed from emergency onset (23).

Protracted crisis, like Syria, are the new normal, and in the absence of political or livelihood solutions for refugees, demand for long-term assistance increases, which requires multiyear funding, planning and programming (23, 31, 45, 203, 222). Challenges of GBV prioritisation and insufficient and inconsistent funding allocation in emergencies, highlighted by a recent scoping review, were not reflected in Lebanon (150). The GBV task force was well-funded compared with many settings, perhaps signifying enhanced global commitment to combatting GBV, and the LCRP framework created space for predictable and multi-year planning and funding appeals, which facilitated several important advantages (116). The LCRP was effective in guiding priorities at national and field level and creating a unified system providing strong incentives for actors to coordinate (23, 127). Nevertheless, funding remained insufficient, and drops in funding through the protracted crisis compromised some services sustainability, such as WGSSs. Recommendation made at the 2016 World Humanitarian Summit, to limit earmarking, provide adequate multi-year funding and harmonize reporting requirements should be promoted in Lebanon and across emergencies (116, 223).

While the interagency mechanism in Lebanon created an environment conducive for inter-sectoral coordination, repeated efforts to integrate risk mitigation failed to create lasting impact compounded by lack of coherent long-term strategy (132). Despite the common misconception that the GBV sector is responsible for GBV risk mitigation, providing mentorship and support to sectors during the roll-out of the GBV guidelines had some impact and could be replicated elsewhere. This remained insufficient however, in the absence of sector accountability mechanisms, underscoring the need for improved multi-sectoral resourcing and attention from donors and humanitarian actors (23, 31, 167). Recent research highlighted multisectoral coordination, close collaboration with GBV specialists to design GBV risk mitigation activities, monitoring frameworks and tools, and ensuring buy-in on GBV risk mitigation amongst leadership, as promising practices for promoting GBV risk mitigation, which our findings supported (214). Building a workforce of GBV risk mitigation experts who can work directly with sectors at programme design stage may contribute to addressing these challenges and donors should require GBV risk mitigation to be integrated in funding proposals for all sectors (167). We also recommend to articulate an inter-sectorial strategy on GBV risk mitigation

in Lebanon and support recommendations to improve engagement with affected women and girls to identify and reduce GBV risks (132).

The Syria crisis elevated the role of NGOs and local women's organizations in the GBV space in Lebanon (156). Significant efforts were made by the GBV task force to engage these actors in coordination and to extend relationships across diverse sectarian groups (156). National and local Lebanese organizations capitalised on opportunities for capacity building and increased funding allocation, by engaging in the GBV task force at national and field level, advancing the localization agenda. The inclusive, collaborative approach adopted, created an environment where national and local actors influenced GBV coordination, were highly valued by UN coordinators and embraced opportunities to build international visibility. Mutually beneficial multi-year partnerships with UN and INGOs, enabled local actors to upgrade internal management and accountability systems, making them eligible to directly receive international funding (23, 108). With reports of 50% of GBV funding channelled to national and local organizations in Lebanon, this surpassed global localization targets and contrasted with recent global findings (95, 105, 203). Reserved spaces for national and local actors in the coordination core group ensured that they are involved in decision making and leadership, which is critical for long-term impact (46, 156). This transferrable approach to building sustainable GBV technical capacity could be replicated elsewhere. Additionally, establishing subnational coordination enabled more contextually-relevant programming and improved engagement of local actors who are closer to affected communities (46, 94). Enhanced efforts were needed, however, to effectively engage smaller CSOs and refugee-led organizations, a gap previously highlighted and made more difficult by the restrictions placed on refugee employment in Lebanon (23, 45, 47, 64, 108). Furthermore, staff poaching from local organization's to UN and INGOs and restricting salary scales for local actors, in some cases hampered localization (95). Across emergency settings, participation of national and local actors in GBV coordination can be enhanced by building mutually beneficial partnership, which experience from Lebanon could help to inform (156).

The protracted crisis has served as a catalyst for considerably enhancing essential GBV service provision in Lebanon (156). Overall, from a low base in 2012, Lebanon's protracted crisis provided an opportunity to introduce, expand and adapt GBV services across the country, however, integration into national systems remained a challenge (23, 24, 132). Approaches from Lebanon to improve coverage and uptake of GBV services such as deployment of mobile safe spaces, and building local capacity in SDCs affiliated with government, could be adapted for use elsewhere, building a body of knowledge on GBV programming approaches in protracted and urban crisis (23, 24, 132). Our

findings underline the important role of effective GBV coordination in developing and adapting tools appropriate to the context and ensuring a harmonised approach to service delivery (13, 14, 132, 151, 154, 215). In line with global recommendations, our findings reinforce the need for more attention and multi-year funding in Lebanon for context appropriate GBV prevention programming (23, 31). We support recommendations, to develop an interagency prevention strategy which would assist to mobilise and sustain multi-year funding to support long-term change in Lebanon (132).

LIMITATIONS

Due to COVID-19 pandemic restrictions, data collection was conducted remotely, which limited access to key informants, especially those at field level, government actors, CSOs and refugee-led organizations. In addition, some informants were describing events from several years back which may have caused issues of recall. Difficulties contacting key individuals, including past UN coordinators, some government actors and donors, meant those perspectives are not fully represented.

CONCLUSION

The Syrian crisis has been a transformative force on addressing GBV in Lebanon, presenting opportunities to institutionalise coordination and services. Experience from Lebanon's complex and protracted crisis demonstrates the influence of the political and social context on GBV coordination, underlining the importance of integrating civil society networks and ensuring government co-led coordination to set the foundation for sustainability. Protracted crisis like Lebanon's offer opportunities to expand, contextually adapt and even to institutionalize GBV services, to advance localization and to introduce innovative approaches to service provisions and coordination. Our findings reinforce the importance of investing in risk mitigation and GBV prevention programming from crisis onset. More research is needed to explore the future direction of GBV coordination in Lebanon in the context of the recent compounded crises which could threaten these achievements.

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Thesis Title	Gender based violence (GBV) coordination in emergencies		
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SECTION D – Multi-authored work

For multi-authored work, give full details of your role in the research included in the paper and in the preparation of the paper. (Attach a further sheet if necessary)	I, PR conceived, designed and coordinated the study, with inputs from MH and JP. I, PR designed study tools, collected and analysed data, drafted the manuscript, revised all versions and wrote the final draft. JP, LK, JU and MH contributed to interpretation of findings. All authors provided critical review and approved the final version for submission.

SECTION E

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Date	05/01/2022

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Date	10/01/2023

Abstract

Background

Lebanon is dealing with multiple compounded crises (2019-2022). Progressive economic collapse caused by political and social instability, the COVID-19 pandemic, and the Beirut Port explosion, alongside the ten-year Syrian refugee crisis, have resulted in a nationwide economic emergency. Within the humanitarian response, the Gender-based violence (GBV) task force has effectively coordinated the sector since 2012. The compounded crisis, however, created new challenges, offering a unique opportunity to explore GBV coordination, as it adapted to respond to the multiple crises, highlighting lessons for other complex emergencies.

Methods

We conducted remote in-depth interviews (29), reviewed key policy documents and observed GBV task force meetings (7). We analysed and presented our findings across three key themes: Effect on coordination architecture and perceived effectiveness; Context-relevant and adaptable coordination; and Stakeholders legitimacy and power.

Results

Parallel frameworks developed to address the multiple crisis, created a complex humanitarian architecture within an increasingly challenging operating context, with some perceived inefficiencies. Positively, coordination was integrated under the established Government-UN interagency system and the GBV task force maintained sector coordination. The task force was commended for effectively adapting to the evolving context, including working remotely, maintaining essential GBV services, assessing the compounding crises' impact on programming and adjusting accordingly and harmonising guidance, tools and approaches. The importance of a government co-led response was reinforced by both UN and government actors and marginalising the government criticised for compromising sustainability. The role of local actors had become increasingly important but more difficult, with the impact of the economic crisis and remote modalities, challenging service delivery. Donors were encouraged to increase flexible, multiyear funding for GBV coordination and services to allow organizations to adapt to the volatile context.

Conclusion

Experience from Lebanon suggest that Government leadership of coordination should be supported; localization supports crisis response; and GBV service delivery during public health emergencies requires effective national, sub-national and intersectoral coordination. Innovative guidelines and models implemented during the pandemic, should be evaluated and consolidated to generate future lessons. In Lebanon, we recommend a review of the humanitarian architecture to support the evolving context, ensuring women-led organizations are at the forefront of recovery efforts.

INTRODUCTION

Since 2019, Lebanon has faced multiple compounded crises. The progressive collapse of the economy brought on by political and social instability, the Coronavirus-19 (COVID-19) pandemic, and the Beirut Port explosion, on top of the ten-year Syrian refugee crisis, have plunged the country into a nationwide emergency. Such complex humanitarian emergencies can perpetuate gender-based violence (GBV), a critical global health and human rights challenge (4, 5, 12, 20, 45). In emergencies, effective GBV coordination ensures that GBV response services (including health, psychosocial, legal, and socio-economic) are available to survivors and that GBV is reduced (33). In Lebanon, a GBV coordination system was originally established in 2012 to deal with the influx of Syrian refugees and had evolved and expanded to address the broader impact of the Syrian crisis in the country. However, the compounded crisis created new challenges for GBV coordination and service delivery. In this paper, we explore GBV coordination in Lebanon through the multiple crises (2019-22), as it flexed to meet the expanding GBV needs, while adapting to overcome the particular challenges of each crisis. We highlight recommendations for strengthening GBV coordination in complex emergencies.

LEBANON'S DESCENT INTO NATIONWIDE CRISIS

The Syrian crisis which began in 2011 has had a profound economic, environmental and social impact on Lebanon (116, 126, 127). By 2022, an estimated 1.5 million Syrian refugees remain displaced in Lebanon, accounting for nearly a quarter of the total population (43, 128). Because official refugee camps were not established for Syrian refugees, they are dispersed across informal tented settlements, and among the urban population (27, 116, 128, 134). In 2015, the Lebanese's government tightened refugee policies, restricting registration of newly arrived refugees, preventing those registered from seeking employment, and made it increasingly difficult for Syrians to maintain legal residency, with unregistered Syrians facing obstacles in accessing services and vulnerable to detention and extortion (27, 116, 126, 135). Despite more recent efforts to simplify legal residency processes and increase access, the registration rate was still only 31% in 2021 and only 16% of Syrians aged 15 years and above had legal residency in 2021 (128, 133). In addition, increasing host-refugee tensions and security incidents have occurred in recent years, alongside an overstretched and underpaid Lebanese Armed Forces (LAF), causing fears of a breakdown of peace (114, 126).

Corruption and consistent financial and economic mismanagement have left Lebanon the third most indebted country in the world (120, 121). Although the refugee crisis is often blamed for the economic crisis, analysists propose that the sectarian political system, alongside the government's

failure to deliver political and economic reforms, had placed Lebanon on the road to economic collapse long before the Syrian refugee crisis (120, 122, 137, 138). In October 2019, widespread protests began, demanding political and institutional reforms to reduce corruption, and to replace the Hezbollah dominated government (139). In parallel, the government defaulted on its foreign debt and the currency devalued by 90% (113, 114). The COVID-19 pandemic hit Lebanon during this vulnerable time and intermittent lockdowns and mitigation measures, worsened the situation, challenging the already overburdened and under-resourced public health system (139, 140). Compounding the already dire situation, a massive explosion at Beirut's Port on 4 August 2020 devasted areas of the city, caused more than 215 deaths and over 6,000 injuries, as well as displacing more than 300,000 people, including 81,000 women of reproductive age and 48,000 adolescents (144-146). Estimated costs to Beirut's infrastructure were around USD 3.1 billion, while the impact on the economy estimated at approx. USD 920 million (224).

Throughout 2020-21, Lebanon descended further into a nationwide economic and financial crisis which the World Bank has ranked in the top 10 most severe global crises since the nineteenth century (115). Hyperinflation, which was estimated to average 145% in 2021, has pushed food prices up by 400% (113, 159). Caretaker administrations have led Lebanon for most of the last three years, and after a 13-month vacuum following government collapse in the wake of the Beirut blast, a new Prime Minister assumed the role in September 2021, but the Lebanese political elite have delayed reforms that could compromise their hold on power (113, 114). Meanwhile, international donors, distrustful of the Lebanese government, have withheld a much needed bailout (114). Hezbollah, who have built tactical alliances with several of the country's leaders, including President Michel Aoun, have resisted transparent investigation of the cause of the Beirut Blast, which has further deepened divisions, as the public call for accountability and justice (114, 225). National elections in May 2022, saw Hezbollah's seats in parliament reduced and 13 independent candidates elected, altering the balance of power in parliament, with some hope for political reform, but by the end of 2022 a cabinet had yet to be formed (226, 227).

A once middle income country, the majority of the population are now deprived of adequate access to basic services which were mostly privatised, including healthcare, education, water and electricity (139, 159). By September 2021, estimates suggest that 82% of the Lebanese population (3 million people) were living in multidimensional poverty, and 89% of Syrian refugee families in extreme poverty (128, 228). Throughout 2021, Lebanon experienced severe fuel and electricity shortages, which caused nationwide electricity blackouts, rendering marginalized groups even more vulnerable

(170). In parallel, the government gradually ended its fuel subsidy program, causing the cost of fuel to drastically increase (170). Supplies of drugs and medicine subsidized by the government were also limited and hospitals struggled to maintain critical services, while responding to the COVID-19 pandemic (120, 139). Some hospitals shut down or closed wards, which was further exacerbated by a failure to pay healthcare workers causing many, including doctors and nurses, to immigrate (141). In 2021, rent costs for all shelter types increased by 18%, and eviction threats and evictions rose, particularly for refugees living in urban areas (128, 133, 159).

The compounded crises in Lebanon have disproportionately affected women and GBV rates have intensified (229). Many low-income families have been pushed into extreme poverty, and prolonged periods of isolation during COVID-19 lockdowns, and the economic stresses, have increased GBV risks (120, 128, 133, 140, 159). In 2020, calls to emergency hotlines increased significantly in both number and severity, compared with the same period in 2019 (230). Female migrant workers, subjected to the sponsorship (Kafala) system, faced high rates of unemployment, food and shelter insecurity, leaving them reliant on basic humanitarian support and highly vulnerable to GBV and exploitation (159, 231, 232). There are also increasing reports of transactional sex, particularly affecting low-income women, with significant mental health consequences (231, 233). Increases in child marriage have been reported among Syrian refugees in some areas of Lebanon, exacerbated by the prolonged school closures due to COVID-19 in 2020-21 (29, 158, 234). New risks emerged, including online harassment and cyberstalking and some reports indicate that GBV against LGBTQ individuals has increased (24).

GBV COORDINATION IN LEBANON'S EMERGENCIES

Since 2015, the Ministry of Social Affairs (MOSA) has coordinated the humanitarian response to Lebanon's Syrian refugee crisis, under the Lebanese Crisis Response Plan (LCRP). The LCRP is a multi-year plan between the Government, the United Nations (UN) and international and national partners, which provides humanitarian assistance in parallel to addressing medium-term recovery and development issues (127, 133). Under the LCRP, the GBV task force, established in 2012, co-led by MOSA, United Nations High Commission for Refugees (UNHCR) and United Nations Population Fund (UNFPA), coordinates the GBV sector in Lebanon (132, 134). Initially established to deal with a refugee influx, the GBV task force had evolved to become the main coordination mechanism in the country for GBV actors and had significantly enhanced systems and services for addressing GBV throughout the protracted crisis (220). In parallel, significant progress has been made on reforming the legal framework over the past decade with a vibrant civil society promoting change. In 2014, the

parliament passed Law 293 on the protection of women and family members against domestic violence and in December 2016, abolished the penal code article 522, the "rape law," which allowed rapists to evade punishment if they married the survivor, and in January 2021, the first law on sexual harassment was published by the parliament (134). Many gaps remain however including weak female participation in parliament (5%) and the sectarian legal system which does not define a minimum age for marriage and within which, women do not enjoy equal rights (24, 161).

In this paper we explore how the humanitarian coordination architecture and the GBV task force adapted to respond to the multiple compounded crises, examining how this affected coordination dynamics and perceived effectiveness, as well as legitimacy and power of UN, national and government stakeholders. We propose lessons relevant to GBV coordination in other complex crises.

METHODS

STUDY DESIGN AND CONCEPTUAL FRAMEWORK

We conducted a case study over a 16-month period (2021-2022), to explore GBV coordination throughout the compounded crisis in Lebanon (2019-2022). We addressed the following research questions: 1. How have the compounded crises impacted the humanitarian and GBV coordination architecture and its perceived effectiveness? 2. How did the GBV task force adapt to the multiple layers of crises? and 3. How have the compounded crises affected coordination dynamics and legitimacy and power of different stakeholders? We built on previous research on improving humanitarian coordination (46).

SAMPLING

We use mixed qualitative methods including document review (13), meeting observations (7), and 29 remote in-depth interviews with a range of GBV and humanitarian stakeholders selected by purposive sampling (219). Informants were contacted by email and snowball sampling was used to expand reach. Key informants comprised GBV experts from MOSA (1), UN agencies (4), INGOs (5), sub-national coordinators (4), national and local organization's (7), academia (1) and UN coordinators of other related sectors/working groups (interagency, health, Clinical Management of Rape (CMR), gender, protection, child protection and education) (8).

DATA COLLECTION AND ANALYSIS

Interviews were conducted using semi-structured interview topic guides (Annex 4) and were digitally recorded before transcription and analysis. Applying an iterative process, we edited topic guides

following each interview to include questions on emerging themes in subsequent interviews. Documents relating to GBV coordination and the humanitarian response were included in the framework analysis, comprising policy documents, strategic plans, guidelines, reports and meeting minutes, among others (Methods, Table 4). Seven national level GBV coordination meetings were attended as a participant observer to gain a deeper understanding of coordination dynamics and roles of stakeholders. A data verification workshop was conducted in Beirut in May 2022, which provided a forum to reflect on preliminary findings in collaboration with key members of the GBV task force, ensuring that interpretations were validated and any gaps or uncertainties in the data were clarified.

Framework analysis (188) using the three research questions outlined above, was used to analyse data using Nvivo 11 (176). Data from multiple sources were validated and triangulated, thereby increasing the validity and reliability of the results.

RESULTS

We present our findings across our three research themes. Figure 1 below presents the various crises in Lebanon and the issues associated with the specific events in the timeline which affected GBV coordination and service provision.

EFFECT OF THE COMPOUNDED CRISES ON THE COORDINATION ARCHITECTURE AND ITS PERCEIVED EFFECTIVENESS

Since 2019, the Lebanese context had changed drastically, requiring the humanitarian and GBV task force to adapt to multiple crises within an increasingly challenging operating context. Parallel frameworks, developed to respond to the multiple crisis, intended to be complementary and mutually reinforcing, created a complex humanitarian architecture, with some inefficiency and duplication. As one interagency UN coordinator described:

> *"In a very small country with a huge number of actors. And in some ways, I think there is lot to learn and draw because things have evolved to, often, a very high technical specification. However, the coordination landscape . . . then becomes incredibly messy because you've got so many different people. . . different mandates, different global politics being played out at the country level"*

Importantly, coordination across all frameworks had been integrated at the sector level under the established LCRP interagency system and the focus had now shifted to strengthening coordination. Therefore, the GBV task force remained the principal coordination mechanism for the GBV sector in Lebanon and informants believed that the effective GBV coordination mechanism, which had been

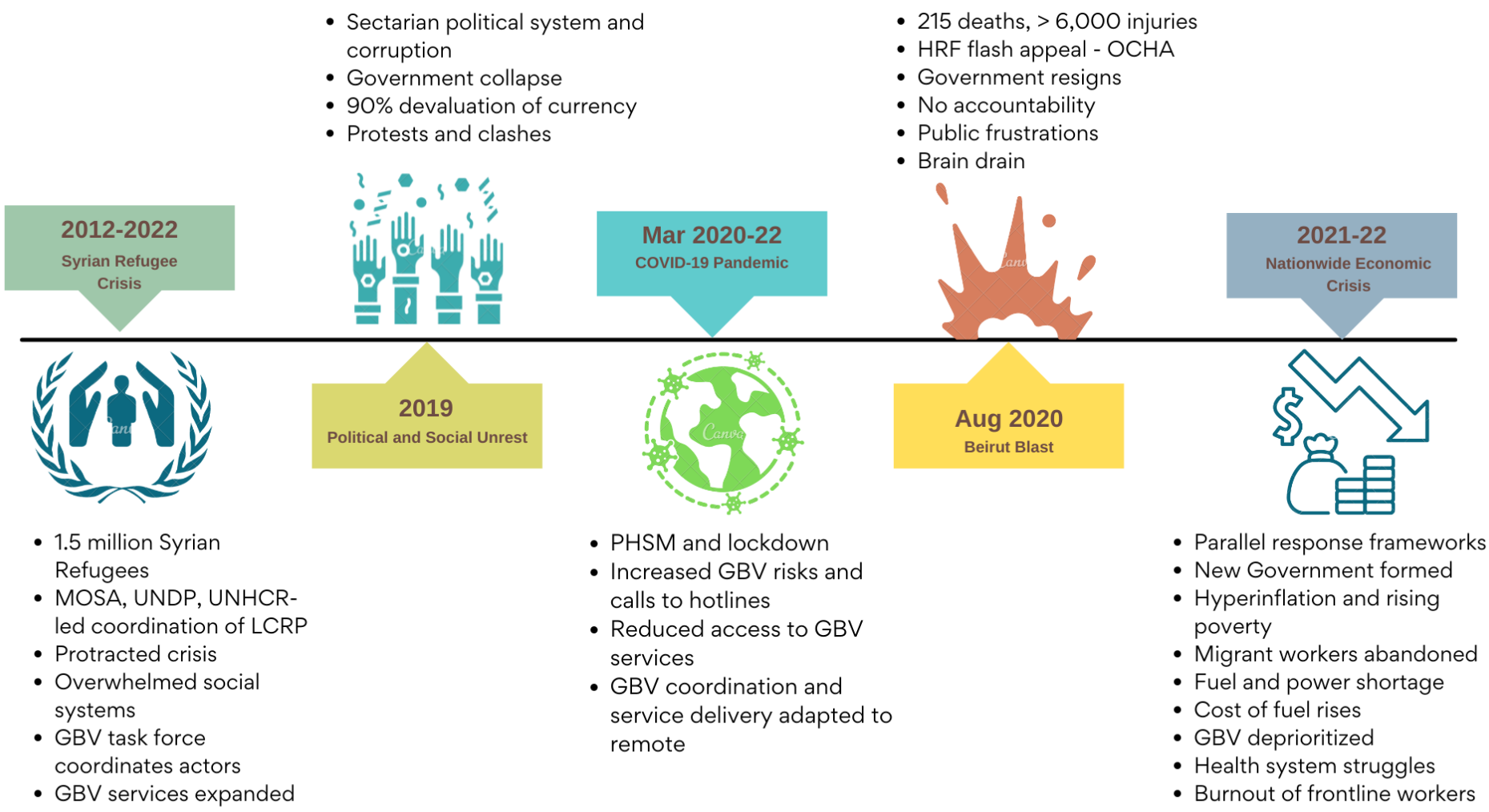

Figure 1: Lebanon's compounded crises and key issues emerging within each crisis which affected GBV coordination and service provision.

built throughout the protracted crisis, had enabled them to adapt to the changing context since 2019. The national GBV task force was officially co-led by MOSA, alongside UNHCR and UNFPA, however, the UNHCR GBV coordinator had departed Lebanon in October 2019, and a replacement was only recruited in Dec 2022, meaning MOSA and UNFPA co-led the task force.

By 2022, several humanitarian response frameworks, were operating in parallel in Lebanon (Figure 2). The third edition LCRP covering 2022-2023, remained the main framework to address the impact of the Syria crisis in Lebanon, and according to our informants, still accounted for more than 87% of humanitarian funding (131). Throughout 2020-21, the public health response to the COVID-19 pandemic had been coordinated by the Ministry of Public Health (MOPH) and the World Health Organization (WHO), under the COVID-19 Health Strategic Preparedness and Response Plan (142). In the absence of a government response to the Blast, the United Nations Office for the Coordination of Humanitarian Affairs (OCHA) took the lead, and initial proposals to establish a cluster system were rejected in favour of using the existing sub-national coordination under the LCRP in Beirut and Mount Lebanon. A Flash Appeal Response of USD 33.4 million, was launched by OCHA under the Humanitarian response fund to provide immediate lifesaving and recovery needs following the blast (235). GBV actors' applications for Lebanon's Humanitarian Fund focused on four areas of work: service delivery, emergency protection cash, support to existing midway houses and safe shelters, and community engagement around GBV risk mitigation. Five GBV projects were funded, three from national NGOs and two from INGOs.

Subsequently, in August 2021, the Humanitarian Coordinator and the Humanitarian Country Team, with the support of OCHA, the UN and NGOs, developed a 12-month multi-sectoral Emergency Response Plan (ERP), to provide short-term assistance to the most vulnerable Lebanese, Palestinians from Lebanon and Migrant workers not covered under the LCRP, and incorporated continued response to the COVID-19 pandemic (159). Although UNHCR reportedly resisted inclusion of a protection sector within the ERP in 2021, to avoid duplication with the LCRP, following strong advocacy of the task force coordinators, Child Protection and GBV sectors were incorporated. Overall funding allocated to the Protection Sector within the ERP, including GBV and CP, was approximately three million which was not considered a substantial amount and according to informants, by May 2022, the implementation rate was low. Informants agreed that this had created a complex environment and that the LCRP should have been adapted earlier and a parallel structure should not have been set up for the COVID-19 and Blast responses. Additionally, reporting had to be

conducted against the different individual frameworks for different funding streams which introduced some duplication and inefficiency.

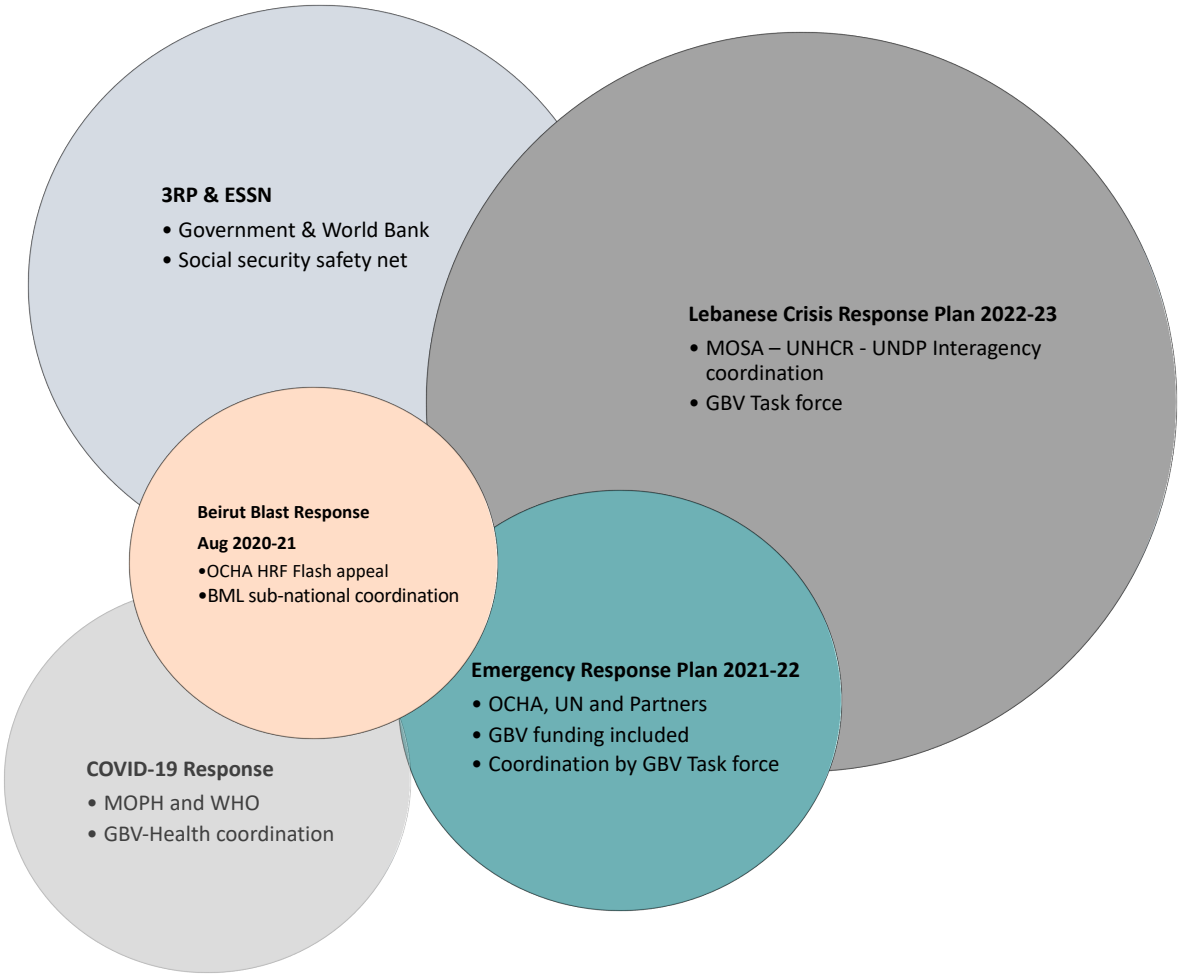

Figure 2: Overview of Lebanon's complex parallel response frameworks. Size of circles loosely indicates proportion of total funding for the humanitarian response in Lebanon.

In parallel, the World Bank, UN, and the EU, in coordination with civil society, the Lebanese government, and international partners, implemented the 'Reform, Recovery and Reconstruction Framework' (3RF)(USD 2.5 billion), to provide a comprehensive response to the Blast, providing immediate humanitarian assistance alongside funding for medium-term recovery and reconstruction (236). In 2021, a government led, World Bank supported (US$246 million), three-year Emergency Crisis and COVID-19 Response Social Safety Net Project (ESSN), was established to provide basic assistance to 786,000 vulnerable Lebanese impacted by the socio-economic crisis and to support development of a comprehensive national social safety net system (237, 238). In addition, following

several years of negotiations, the International Monetary Fund (IMF) reached an agreement with Lebanon in April 2022, for four-year funding (3 billion) with full approval pending government reforms, which was considered vital for Lebanon to begin recovery from the economic crisis (114).

Our informants expressed differing perceptions of the effectiveness of the overall humanitarian architecture. According to some informants, Lebanon had shifted from a country responding to a refugee crisis, to a country dealing with a nationwide crisis, which needed to be reflected in the way the humanitarian architecture was structured. They suggested that a more integrated, holistic approach would be more effective, to encompass the nationwide expanding needs, as one UN actor described:

> *"We cannot keep having things detached. . . especially that Lebanon is no longer just the recipient of a crisis, of a Syrian refugee influx of people, but it's a country of crisis. So I would think that now it's time to move to a different framework that includes the whole of Lebanon framework, and specifically for sustainability purposes. . . For the way forward, definitely to not have it led with the stamp of UNHCR/refugees. But yes, a multi-cluster of different agencies with different mandates. . . now the needs are equally there. Lebanese and Syrians, they suffer the same. . ."*

However, any change would require repositioning the role of several organization's and redistributing power across different UN agencies, including OCHA and UNHCR. Given the nationwide economic crisis, a more comprehensive role had been proposed for OCHA under the framework of a humanitarian response plan (HRF). According to our informants, however, following two years of negotiations, the proposal for a HRF had been rejected, as the causes of the crises were rooted in poor governance, which required government reforms. As one UN Coordinator put it:

> *"we've been fighting about this for two years, we just need to get on and deliver. And there wasn't an agreement about an HRP, no one is pushing for that now, so let's just try and focus on delivering the frameworks that we've got, try and streamline coordination"*

Reaching consensus between the perspectives of different UN organizations was challenging, with politics and agency interests contributing to the fractured approach, which some informants felt compromised effective coordination. However, several UN and government informants agreed that while a significant refugee population existed in Lebanon, UNHCR would play a leadership role under the LCRP.

> *"So basically, what we're seeing in Lebanon is the competition between the new framework that OCHA is pushing for, and the existing framework, which is LCRP, which is UNHCR led and really focusing on refugees. Honestly, I would say that LCRP will remain the biggest response*

because you cannot just overlook the presence of 1.5 million refugees in Lebanon. . . I don't think that the framework will be anything else but refugees focused. Even if they try to push for a more integrated approach." (Government actor)

Ensuring Context-relevant and adaptable GBV coordination mechanism

The compounded crisis had challenged coordination dynamics and the GBV task force had to flex and adapt in response to the changing context throughout the multiple crisis, including the COVID-19 pandemic, Beirut blast, national economic emergency, and fuel and power crisis. According to our informants, experienced, interagency GBV coordinators, had successfully forged relationships across diverse stakeholders and built a culture of trust and mutual solidarity which provided strong incentives for actors to voluntarily coordinate throughout the protracted Syrian crisis, and were leveraged to adapt to the multiple crises (46). Several local actors highlighted the resilience and adaptability of organizations, which helped them to navigate the multiple challenges since 2019. By example, national actors commended their speed and commitment during the Beirut blast response, despite being personally affected:

"Beirut blast happened on a Tuesday. . . And I remember on Thursday, we had our first meeting, noting that most of the people that were sitting in that meeting, helping coordinate, had their homes broken, shattered...We were that fast." (National GBV actor)

However, in recent years the challenging context was resulting in higher staff turnover, with many of the long-term GBV coordinators departing Lebanon, leaving gaps in leadership with loss of institutional and contextual knowledge and compromising relationships built. In addition, because meetings were conducted remotely over the past two years, in-person interactions were infrequent, which limited relationship building and informal coordination, which previous research noted was important (77). Remote meetings continued on a monthly basis with approx. 30+ members consistently attending throughout 2021-22, including UN, INGO, national and local organizations, researchers and donors. Coordinators were, however, conscious of the difficulties of ensuring engagement when conducting meetings remotely and compensated through frequent emails, surveys and bilateral communications.

The GBV coordination taskforce was commended by informants for quickly adapting coordination and service delivery to remote mechanisms from the beginning of the COVID-19 pandemic and for effective coordination between the Health, Protection and GBV sectors in response to the public health emergency. The task force developed guidelines for GBV response and risk mitigation during COVID-19, a training manual for health care workers to provide remote services to GBV survivors

and delivered trainings on provision of remote case management. Adapting service delivery to remote became the priority for the task force in 2020, and a range of innovative approaches for service delivery were implemented by GBV actors including an emergency hotline through which women and girls could reach security forces, support by local actors to develop safety plans and credit to call the hotline, and provision of group psychosocial support via WhatsApp using a mixed approach of chats, voice messages and live calls. Fear of contracting COVID-19 at public hospitals, which doubled as COVID-19 treatment centres, prevented some survivors from seeking care for CMR and the task force intervened to provide alternative solutions or referral for CMR to INGOs and UNFPA supported MOPH to assess CMR facilities to ensure continuity of care (144, 172). At the beginning of the pandemic challenges were faced by GBV survivors requiring negative tests before being admitted to safe shelters, as well as limited capacity for survivors at safe shelters (24). To circumvent these challenges GBV and health partners allocated funding for testing GBV survivors and COVID-19 testing costs for GBV survivors were incorporated in the 2021 ERP which further reduced barriers. At the end of 2020, the task force launched a survey among members on the impact of COVID-19 on GBV programming, followed by a stocktaking event in which they reflected on 2020 and used lessons learned to plan for 2021.

Sub-national coordinators across the four field sites in Lebanon supported the operation response, and credited the proactive, and responsive approach of the national task force in providing harmonized guidance and tools which supported actors at the field level to adapt to remote modalities and respond to the pandemic.

> *"there was a lot of adaptiveness and responsiveness. Like how can we adapt to provide safe remote services. how can we provide safe remote psychosocial support. And the task force was actively looking for tools, adapting or developing tools trying to harmonize and provide guidance. So that actors on the ground were not running around trying to figure out what the solution was, allowing them to respond in a safe and effective way ensuring the minimum standards were adhered to. There was a lot coming out from the task force during that period that really helped us to adapt to the pandemic." (UNHCR Field coordinator)*

The interface between the national and the field level coordination mechanisms were strengthened by a number of mechanisms implemented by the task force including; having clear and complementary roles and responsibilities; field coordinators attending national meetings which kept them informed on the GBV strategy and priorities; national coordinators attending sub-national meetings to communicate national-level priorities; and guidelines and tools adapted to context at national level and disseminated to all stakeholders ensuring harmonization across all regions of the

country. More recently national GBV coordinators held six-weekly meetings with all field coordinators which provided a forum to share experiences and lessons across regions and was highly valued, as described by one UN field coordinator.

> *"Super useful!.. that's what I find is the strength of this forum is it's coordination, but is also really a place to share experience, and share knowledge, and share lessons learned, and that's how we're building our expertise as a sector, because we have these spaces, and then when we can do that across regions, it even adds more value to that."*

Although a strong network of GBV services and a comprehensive referral system had been built up through the 10-year Syrian crisis (132, 156), the recent compounded crises and expanding target populations, generated additional layers of complexity and new challenges to delivering services, which the GBV task force needed to overcome. Compounding COVID-19 conditions, implementation of activities and communication with affected communities was hampered by shortages of electricity, fuel and internet connection in Lebanon, since many survivors did not have access to smartphones, phone credit or internet. The remote modality was a barrier for some cases and providing MHPSS services over the phone was difficult for both beneficiaries and case workers. Furthermore, loss of human capital, particularly skilled and educated Lebanese, including doctors and psychiatrists, presented challenges for survivors requiring access to specialised services. For example, for the Lesbian, gay, bisexual, transgender, intersex, queer, + (LGBTIQ+) community, especially those undergoing sex reassignment surgery, the availability of endocrinologists and psychiatrists who were willing to support this community had shrunk, leaving them resorting to dangerous practises such as taking hormones without prescription. Our informants commended the task forces at national and sub-national level for being creative and flexible to ensure service delivery continued and that high-risk cases could receive in-person services where possible, as described by one field coordinator:

> *"we had the COVID 19 pandemic, intersecting with the fuel and electricity crisis, and so how can you provide remote services to individuals who can't charge their phones, for example, because they don't have electricity? So just dealing with those very practical, operational challenges in terms of creating a space, where, at the national and subnational level, we were really focusing a lot . . on sharing knowledge and experience." (UN Field coordinator)*

Because of challenges with transportation and the fear of contracting COVID-19, some beneficiaries actually preferred remote modalities and several informants reported that engaging particular groups, such members of the LGBTIQ+ community, had been enabled by the anonymity provided.

Informants credited an effective GBV information management system (GBVIMS), with a dedicated interagency coordinator, for supporting the GBV task force to assess the impact of the compounded crises and adapt GBV coordination and services accordingly. GBVIMS reinforced coordination, with data to advocate for funding, develop policy briefs, inform programming and service coverage. Positive examples included, a multi-stakeholder 2020 assessment on the impact of COVID-19 on GBV and gender and COVID-19 policy briefs, which were issued throughout the public health crisis and the economic crisis. The 2020 assessment demonstrated an increase in domestic violence and in parallel a decrease in reporting incidents of GBV, highlighting that during lockdowns women were more exposed to violence as they were locked in with the perpetrators, but couldn't report incidents or seek care (169). The GBV task force recommended that key sectors integrated GBV risk mitigation and that GBV actors work with different sectors, such as health, justice, shelters and livelihoods, to ensure that survivor-centred response services were available and adapted for COVID-19 conditions. To complement the assessment, the GBVIMS steering committee closely monitored pre-COVID and during COVID-19 routine data, triangulating data sources, to inform a report on the impact of COVID-19 on GBV survivors, in particular focusing on minority groups such as LGBTIQ+. In addition, the National Commission for Lebanese Women (NCLW), UN Women, UNFPA, UNHCR interagency coordination unit and WHO partnered to provide periodic, Lebanon specific, gender and COVID-19 policy briefs throughout 2020-21 (239). These included key recommendations for policymakers and practitioners to support a more gender equitable response and were disseminated across the humanitarian sector highlighting key issues related to GBV and gender. In 2021, GBVIMS data showed and increased in GBV case among children from nine to 13%, with forced marriage, psychological or emotional abuse and sexual assault most commonly reported (158). In response, the GBVIMS steering committee issued a report which made a series of recommendations on safeguarding at-risk populations and responding to the needs of adolescent girls and child survivors including improved coordination across the protection sector and strengthened programming focused on adolescent girls (157, 158).

In the context of the national economic emergency, as the population of vulnerable Lebanese increased, more funding flexibility was needed to meet the expanding needs. Throughout 2020-2021, the Lebanese currency devaluation and fluctuating exchange rates increasingly affected the prices of delivering services. As GBV partners were reporting increased cost, the GBV task force increased the sector funding request for 2022 by 20%, compared with previous years. Additionally, several informants raised frustrations about donor driven agendas and the lack of unrestricted and flexible funding, which especially limited local and national organizations. Furthermore, informants

noted that donors and agencies allocated funding in line with their mandates, at the exclusion of certain vulnerable populations, who were left without access to life-saving services. One local actor, for example, reported difficulties mobilizing funding to support the LGBTIQ+ community.

In this context, GBV actors struggled to engage women and girls in traditional GBV services, when they were unable to meet their basic needs and cash assistance became increasingly important for GBV survivors but raised several additional difficulties which GBV coordinators and local actors had to navigate. UNFPA Lebanon piloted cash assistance integrated within GBV case management services which had a positive impact on mitigating further risk of GBV and supported survivors' access to a comprehensive GBV services (240). A 2022 report demonstrated that for 85% of beneficiaries the assistance significantly mitigated their immediate exposure to GBV incidents and for 82% the assistance enabled or encouraged them to access GBV response services (240). However, the deteriorating economic situation and hyperinflation led to a reduction in the emergency cash transfer value, and the scale of assistance remained insufficient. Although funding was provided in dollars, donor conditions required assistance to be provided to beneficiaries in Lebanese pounds, and the currency's devaluation meant beneficiaries were only receiving a fraction of that expected, as described by one local GBV actor:

> *"we have these conditions that come from the donors. We are providing cash assistance in dollars, but we have to give it to the beneficiaries in Lebanese pounds and because of the devaluation of the lira what they are receiving is peanuts and then they call us and they say you know you're paid to give us money in dollars but what we get it's not even covering the transport to come and pick it up and then go to the bank."*

While the pilot program offered cash assistance for up to six months, simultaneously partners worked with survivors on medium to long term livelihoods plans, although informants recognised that this was difficult to achieve in such short timeframes.

COORDINATION DYNAMICS AND STAKEHOLDERS LEGITIMACY AND POWER

Several years of political instability coupled with perceived corruption within government had resulted in a weakened legitimacy and capacity of the Lebanese government to coordinate the response. Donors lack of trust in government to initiate reforms meant that they were reluctant to channel funding through the government and their exclusion from the ERP was considered a result of this. Informants also believed that the government were not taking decisions to benefit the Lebanese people but rather to pacify foreign agendas. The Government were largely absent from the blast response, which was attributed to their chronic lack of preparedness for a disaster of such

magnitude, however, others blamed Hezbollah's alleged involvement and their resistance to investigating the cause, eliciting strong criticism from our informants:

> *"There's no worse example than how the government responded to the blast. There's no accountability, there's no interest in what had happened, there is no commitment to the population. . . it's horrible. So, for me, if you can't see beyond your petty sectarian issues for that, then you never will. . . if the blast wasn't a moment to drop all that rubbish and say, 'You know what, we need to really start thinking collectively. We're in this together. This has been a massive mess. Let's commit to never having it happen again. Let's clean up.' Well, no, it didn't happen. And I think that's appalling." (Local GBV actor)*

Overall, GBV actors expressed their deep frustration with the political system, which was underpinned by patriarchy and corruption, and without addressing the systemic root causes, informants did not believe that any real change could be achieved in Lebanon.

> *"Our politicians all need to be taken out and dumped in the sea and overhaul completely. Because as long as we continue to recycle the same old men with the same old ideas, we are the classic example of a patriarchal [system]" (National GBV actor)*

Despite having to adapt to constantly changing governments, chronic corruption and weakened legitimacy of the Government, both UN and government actors emphasised the importance of ensuring Government-led coordination under the LCRP interagency and intersectoral unit, to ensure protection of refugees in the country. Having a dedicated forum for engagement with government actors on GBV and protection, with dedicated funding, allowed humanitarian actors to influence government policies and was seen as critical, as described by one UN actor:

> *"Because I personally am convinced on this point and I think it does underpin the whole raison d'être of the LCRP, that by maintaining this co-led response, this is one of the key ways in which we are protecting the protection space for refugees here. . . that's the space that we actually use to negotiate the decisions that are being made and try to prevent harm in terms of governmental policy decisions that would be harmful to refugees."* (UN coordinator)

Furthermore, marginalising and excluding government from coordination and decision making, such as from ERP planning, was criticised by government actors who suggested that this further compromised sustainability and impact of the assistance being delivered:

> *"You can never, never, marginalize the government when working in a country. First of all, you're working under their authority and you're working under their jurisdiction. Secondly if you're working as a humanitarian actor to ensure sustainability because you're not going to stay here forever, you need to ensure coordination with the government. So even if you don't*

want to channel funds through government you still need to coordinate and engage the government in decision making. . . And I think this is a bad practice, and this will never help with sustainability and never help with the efficiency of the programs." (Government actor)

Informants recognized that government actors maintained contextual knowledge and experience, and high turnover of humanitarian actors made government leadership of the humanitarian response ever more critical. Furthermore, the LCRP reiterates the need to reinforce Government leadership *(131).* Despite Government absence from the ERP and Blast response, MOSAs co-leadership of the GBV task force, where issues were discussed and decisions made, meant they were still engaged at the coordination level.

Positively, since 2020, MOSA's protection coordinator within the LCRP played a leading role in GBV task force meetings, evident through meeting observations, and acted as liaison between the task force and MOSA to facilitate government review and approval of key decisions and documents, and to provide government perspectives during GBV task force discussions. However, competing demands of the compounded crises meant that issues such as GBV, gender equality and prevention of sexual exploitation and abuse (PSEA) were being deprioritized within government too.

At the local Government level, progress made throughout the crisis on institutionalizing GBV services within government run social development centers (SDCs), was also being threatened in the challenging operating context. Although dependent upon international funding, SDCs were overseen by MOSA and supported by UN, INGOs and local actors, acting as hubs where women and girls could receive information, seek support, and be referred for GBV services (156). In recent years however, SDCs were operating at much reduced capacity, because of challenges of government staff payment and lack of fuel and power, as described by one local actor:

"They make effort to be involved and they try to be present, but because sometimes they go two, three months without pay. And now with a market fluctuation, they get paid in Lebanese pound, which is basically nothing in comparison to the prices at the market. So, you feel that they are no longer devoted, they're not really convinced that they can make a difference." (Local GBV actor)

CMR services at public hospitals too, were being compromised. For example, Lebanon Rafiq Hararri Hospital in Beirut which was an important a hub for vulnerable populations to access free medical care, was a designated COVID-19 treatment facility and not operating at full capacity, leaving a major gap in CMR service provision. Widespread cynicism regarding government interest in

assuming responsibility in the current context is captured well in one local actor's response about transitioning GBV services to the government: *"Maybe in another life."*

Consequently, since 2019, the role of national and local actors had become increasingly important but evermore challenging. Highly influential within the GBV task force at both national and sub-national level, their contextual understanding and trusting relationship's with communities, became increasing important during COVID-19 lockdowns. For example, in response to the rise in child marriages in the North, GBV actors intensified efforts to reach adolescent girls by piloting remote PSS activities for adolescent girls in Akkar and Bekaa and mobilized outreach volunteers to support access to remote sessions. In addition, ensuring that national NGOs played leadership roles within the GBV task force was considered more important than ever as Lebanon faced the multiple crises. As one local actor explained:

> *"We need to make sure that local NGOs are also in the leadership position, not only supporting in the decision making, . . and make sure that out of these NGOs, we really have those strong feminist organizations at the forefront."*

Through capacity building efforts over the past decade, a gradual evolution had occurred, to a semi-sustainable system, where UN agencies directly funded national and local NGOs to provide GBV services, working closely with communities. The majority of local actors acknowledged the significant and successful investments made by UN and INGOs since 2012, however, one local actor questioned their commitment to transition service implementation to local actors, suggesting that it was a way to justify their presence in Lebanon, and to maintain control of funding.

> *""Well, you guys have been building our capacities for the last five years. So, if we don't know how to do this, that's shame on you. . . And I'm saying, "But that's your aim, your aim is to transition to local NGO, then local NGO to transition to governmental entities. That's why we're working in close coordination with the Social Development Center of Ministry of Social Affairs." To my understanding, that's the whole goal of partnership"* (Local GBV actor)

UN actors too recognized the need to review the impact of localization efforts adopted over the 10 years, so that lessons could be learned an approaches adapted, including engaging more smaller civil society actors and refugee-led organizations, which was a key point raised during the data verification meeting.

National and local actors were personally affected by the multiple crises and the GBV task force at National and sub-national level recognised the importance of supporting staff wellbeing in the

difficult context. As one local actor described: *"The economic crisis has just destroyed everybody's lives."* Local actors were experiencing high rates of staff burnout and the compounded crises were making it increasingly difficult for them to continue GBV service provision. The GBV task force were commended across the humanitarian response for assessing the impact of the situation on frontline workers and highlighting this with donors and other stakeholders. Results of an assessment conducted by the GBV task force in August 2021, to evaluate the impact of the crises on GBV service providers, indicated a significant impact on GBV service delivery, with 27% of providers reporting their organization's capacity to provide services was severely impacted, with 96% reporting that the crises were impacting beneficiaries ability to reach GBV services (170). Local providers implemented adaptive measures to ensure the continuity of GBV services, with 28% of organizations increasing support for staff and beneficiary's communication costs and 24% increasing support for transportation. In addition, 94% indicated that the unstable operating context was impacting their and their colleagues' safety with some informants reporting thefts and threats to their organization's and personnel. Some organizations were providing staff with psychosocial support, 67% of organization either had a dedicated counsellor or provided ad hoc services or referrals, while 18% of organizations lacked the funding to provide PSS services (170). The task force had used the 2021 16 Days of Activism, as an opportunity to raise awareness on the increasing GBV risks, expanding vulnerable populations, and the importance of continuing to prioritize and fund the GBV sector, with a focus on front-line service providers and the additional stressors they faced during the compounded crises.

Both UN and local GBV actors agreed that efforts at women's empowerment were futile in the current context, compromising long term change, and informants feared that progress made over the past decade would now be reversed, as described by a local actor:

> *"No one cares anymore about human rights in Lebanon. All they care about is the political crisis and the economic crisis. People used to be more encouraged to access our centres and benefit from awareness sessions. They wanted to increase their knowledge about women's rights, GBV, gender roles, how to have a more equal society, but this is all changing."*

Despite the difficult circumstances one local actor demonstrated their commitment to upholding human rights:

> *"Never give up. I think no one should ever give up. We live in a country with so many variables and so many negative changes all the time, but still we are trying to do our best. Human rights are rights."*

DISCUSSION

Lebanon's compounded crises offered a unique setting from which many lessons on GBV coordination in complex emergencies can be drawn. Since 2019, the continued decline of socioeconomic circumstances, caused by the multiple crises and government inaction, have intensified the vulnerability of both refugees and Lebanese populations, increasing GBV risks. Humanitarian response has been repeatedly reformulated to adapt to the COVID-19 pandemic, the Beirut blast and the economic crisis, which have complicated GBV coordination and service delivery, requiring innovative approaches. Within this context, effective GBV coordination was critical to provide lifesaving services and protect women and girls from GBV. In this paper, we explored evolution of the humanitarian architecture since 2019, examined how the GBV task force responded and adapted to the multiple crises and its effect on coordination effectiveness and the role of different stakeholders. Below we discuss our findings in relation to existing literature on effective humanitarian coordination and make recommendations for sustaining and strengthening GBV coordination in Lebanon's compounded crises and other complex emergencies.

Although the humanitarian coordination established under the LCRP in Lebanon had matured throughout the Syrian crisis, working in partnership with government and national organizations, the compounded crises since 2019 have challenged these structures to further evolve (46). Conflicting organizational agendas and national and global politics have played out in Lebanon's sectarian context over the past three years, resulting in a complex network of response frameworks which stakeholders had to navigate (47, 116, 129). Constructively, coordination was streamlined and integrated within the established interagency coordination under the LCRP and the GBV task force remained the principal coordination mechanisms for GBV actors in Lebanon. Experience from Lebanon’s compounded crises underlines the need for coordination systems to be designed to fit the context while being flexible to adapt and evolve as the context changes (45, 46, 67, 181). To ensure that the current mechanisms are most appropriate for the evolving context in Lebanon, we recommend a comprehensive mapping of the humanitarian architecture to rationalize and clarify the roles of different organizations, in line with Knox and Campbell’s recommendation (46). Furthermore, contextual understanding of local CSOs is critical to inform design of coordination in such a complex, politically unstable, and continually evolving context and local women’s organizations should be engaged in co-design. Donors should fund this review and any modifications required (46).

Globally, the COVID-19 pandemic posed major challenges for GBV coordination and service delivery and in Lebanon this was further compounded by the severe economic crisis, and the devastation caused by the Beirut blast. During public health crisis such as the COVID-19 pandemic, comprehensive and specialised GBV programmes are essential and life-saving and services should not be deprioritised in the context of PHSMs (22, 23). Yet, despite rises in calls to emergency GBV hotlines, increasing prevalence and intensity of GBV, reduced access to GBV services was noted in several settings, as lifesaving health services dedicated to women and girls were repurposed to respond to COVID-19 or compromised by lockdowns, staff shortages, and resource constraints (23, 230). Ensuring that GBV was addressed during the compounded emergencies in Lebanon, was enabled by effective national and sub-national GBV coordination and inter-sectoral coordination with Health, Protection, Child Protection and other sectors. To address challenges, the GBV task force developed contextualised guidance for service providers, supported adaptation of services and revision of referral pathways to ensure that GBV services were available to survivors and promoted a harmonised response across the country, in line with global recommendations (28, 112). Additionally, GBVIMS provided critical data to assess and adapt services, coordination and programming throughout the multiple crises. While providing remote services presented several challenges for service providers, it also created a space for innovation to emerge and in some cases for marginalized populations, such as LGBTIQ+, even improved service access. Some of these innovations could be continued or even expanded post COVID-19 and may be helpful as Lebanon deals with the national cholera outbreak declared in October 2022 (156). Globally, new guidelines and coordination and programming models developed and piloted during the COVID-19 pandemic, should be evaluated and harmonised with lessons consolidated and integrated to future public health emergencies (31).

While Lebanon’s GBV response has been relatively well funded and prioritized by the donor community, the sector remains almost completely reliant on international funding. Considering GBV needs have increased drastically, increased predictable, multi-year funding is required in the context of Lebanon's compounded crises, currency devaluation, and increasing operational costs (231). Furthermore, fragmented response frameworks, donor driven agendas and strict organizational mandates, created multiple and complicated reporting requirements which especially burdened local actors, and left some populations without lifesaving GBV services (132). Moving away from donor driven agendas which our findings noted can be unaligned with the needs on the ground and providing non earmarked, flexible, funding would allow organizations to adapt to the extremely volatile context (170). Donors should simplify reporting requirements, track GBV-specific

investments within protection sector budgets, and disaggregate funding allocations across GBV response, risk mitigation and prevention programming, information which is currently unavailable within the LCRP (13, 31, 108, 193). Amid concerns that humanitarian funding and services may be scaled down as a result of the global health COVID-19 crisis causing budget deficits in donor countries, and with heightened attention to the war in Ukraine, it is critical to maintain attention and funding for GBV coordination and services in Lebanon and across complex emergency settings (114, 170, 233).

In recent years cash assistance has provided much needed support for GBV survivors in Lebanon, however, the impact is undermined by the economic challenges, lack of livelihood options and restrictive refugee policies that trap refugees in a cycle of aid-dependency. In Lebanon, refugees right to work is severely restricted, often resulting in deepening poverty and exacerbating negative coping mechanisms, such as child marriage and survival sex, and limits refugees capacity to contribute to the humanitarian response and recovery (156). The GBV task force should consider implementing longer-term cash assistance taking into account rising inflation and the dollarization of services to better serve survivors, helping to mitigate the risks of harmful coping mechanisms (23). Targeted integration efforts are required for Syrian refugees to contribute to the economic recovery in Lebanon. Furthermore, GBV prevention, including women's economic empowerment, requires long term investment and the multiple layers of crisis in Lebanon are threatening progress made in recent years, warranting intensified funding and attention (13, 132).

Despite international donors' distrust of the Lebanese government, in a context where politicians have scapegoated Syrians and sectarian clashes are on the increase, our findings highlight the importance of maintaining the government co-led humanitarian response, which provided a platform for humanitarian actors to influence Government policy decisions (114). Although Government leadership of GBV coordination had improved since 2020, sustainability remained a key challenge in the deteriorating economic context, where GBV and gender issues were being deprioritised. In addition, weak engagement of government actors at field level due to the challenging operating context compromised availability and sustainability of GBV services at SDCs and CMR at public hospitals (132). While humanitarian assistance can alleviate suffering, it cannot address the root causes of complex emergencies such as Lebanon's, which exacerbate GBV. Rather, this requires governance and institutional reform alongside regional and international solutions for Lebanon's recover, including delivery of support from the IMF (114, 120, 237). Following the

national election in May 2022, a government is yet to be formed and a caretaker government with limited powers is expected until the end of 2022, meaning decisive action to address the urgent economic, and humanitarian needs will be further delayed, increasing the vulnerability of women and girls (226, 227).

Weak government, erosion of state institutions and the exodus of high-skilled professionals have made the role of national and local civil society actors in sustaining GBV services and coordination ever more important, underlining the need to advance localization. The experience in Lebanon demonstrated that investing in building partnerships and strengthening local capacity paid off, as they were the ones who continued service delivery throughout the compounded crises, enabled by strong coordination at both national and sub-national level. Approaches implemented to strengthen the interface between national and sub-national coordination in Lebanon, could be replicated elsewhere (132). Mutual solidarity and trust was high amongst task force members, with strong relationships built over the past decade, which supported the response, however, remote working modalities and higher turnover of coordinators in recent years created challenges. Although in 2018 UNHCR recommended to continue their investment in interagency GBV coordinators, this key position had been vacant since 2019 and was only filled in late 2022 (132). The potential for more coordination roles to be transitioned to national and local organizations, could address the issue of longevity in Lebanon and other protracted emergencies (67). Continuing to channel funding to, and invest in, national and local organizations will be increasingly important to support recovery from Lebanon's compounded crises, especially in a context where donors restrict funding flows to government (114, 120, 170). Furthermore, increasing refugee-host tensions, security incidents between sectarian groups, movement restrictions and access barriers for international actors, including during the COVID-19 pandemic, underline the importance of local capacity-strengthening (105, 114, 209-211). Inclusion of refugees and refugee-led organization's in coordination should also be prioritised in Lebanon and learning from contexts with high perceived localization such as Syrian cross-border operations in Türkiye, could offer insights (95, 241). In addition, within a sectarian context with increasingly scarce resources, continued investment in building a culture of trust, solidarity and inclusiveness in GBV coordination will be beneficial (96, 114).

LIMITATIONS

Due to COVID-19 pandemic restrictions, data collection was conducted remotely, which limited engagement of civil society actors, donors and government actors. The range of informants

interviewed for this study is limited and does not reflect the full spectrum of humanitarian actors involved in the response.

CONCLUSION

To the best of our knowledge, this is the first study exploring GBV coordination in a complex compounded crisis and offers a series of transferrable lessons to strengthen GBV coordination across complex emergencies. The national GBV sub-sector in Lebanon offers an example of how coordination mechanisms can evolve and adapt over time to better respond to the changing needs of a crisis-affected population. Our findings suggest that Government leadership of coordination is critical to maintain protection space for vulnerable populations in complex emergencies; investing in capacity building of local actors pays off during crises as they are the ones embedded in their communities; service delivery is enabled by effective national and subnational coordination and a harmonized national approach; during public health emergencies strong coordination between health, GBV, Protection, Child Protection and gender actors is necessary to address specific GBV issues and; well-being of front-line staff should be considered in complex crises. In addition, our findings underline the importance of targeted programming for adolescent girls in Lebanon, especially considering their increased vulnerability to early marriage and exploitation in the economic circumstances (23). Now more than ever in Lebanon, humanitarian and development assistance needs to focus on maintaining and strengthening national systems and women-led organization's must be at the forefront of recovery efforts, creating a more equitable society (114).

CHAPTER 8: DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

This thesis addressed the evidence gap on GBV coordination, through a case study on Lebanon's protracted and complex emergency response. I have presented and discussed the detailed findings of the study in the preceding chapters five, six and seven. In this chapter, I consolidate the work presented in the thesis, synthesise and summarise key findings and reflect on their theoretical and practical implications. In addition, I discuss strengths, limitations and ethical considerations affecting the work including factors that influenced study design, data collection and interpretation. Finally, I present the study contributions to global health knowledge and practice and recommendations for future policy and practice, before ending with concluding remarks.

SUMMARY OF KEY FINDINGS

Considered a global health crisis and serious human rights violation, addressing GBV remains a fundamental challenge in emergencies requiring coordination and collaboration at global and field level. To the best of our knowledge, this is the first study that has been conducted on GBV coordination in an emergency response and the first to interrogate what influences effective GBV coordination in emergencies. The findings of this research are presented in three manuscripts that build upon each other, with the first a scoping review presenting an evidence-informed framework for effective GBV coordination. The arguments and themes raised in the scoping literature review, which grounds this thesis in the available global evidence, were further explored through the case study in Lebanon's complex, protracted crisis. The second manuscript, based on a case study in Lebanon, highlights the importance of dedicated and experienced coordinators, as well as collaboration and trust-building for advancing localization and strengthening coordination. The third manuscript focuses on adapting coordination to suit evolving contexts and promoting a government co-led response in a complex multi-crisis context. Additionally, these findings on GBV coordination reinforce several themes presented by other researchers who explored effectiveness of humanitarian coordination (45, 46, 67).

For several reasons outlined in Chapters 6 and 7, Lebanon provided a unique and interesting emergency context in which to study GBV coordination over a 10-year period. The initial years of the response, required forging relationships and alliances, establishing the GBV task force and services and was characterised by weak government engagement and prominence of UN and INGOs. This was followed by a more stable period, facilitated by improved government leadership, availability of multiyear funding, and long-term GBV coordinators, who championed innovation, service expansion and advanced localization. More recently, the multiple, compounded crises which culminated in a

national economic emergency, required adjusting to remote coordination and service provision and operating within multiple response frameworks. Common coordination issues witnessed across emergencies include strong presence of international actors, tensions between mandates of governments, civil society and other actors, limited resources and investments and challenges with sustainability of interventions, all of which played out in the Lebanese context.

Below I have synthesised and discussed the most important lessons from this research that show a degree of transferability to other contexts, which I critically reflect on throughout this chapter. Importantly, the majority of these lessons and insights can also be integrated into current and future crisis responses in Lebanon.

1. Effective coordination is the driving force and requires trained and competent coordinators

This research has clearly demonstrated the impact of effective GBV coordination which ensures that GBV is adequately addressed in emergencies, and services and programming are implemented at field level, improving responses. Admittedly, my decision to use the terminology 'effective coordination' throughout this thesis could be challenged by evaluation scientists and others. However, following reflection and discussions with my supervisory team, I chose to maintain the term 'effective coordination' throughout my analysis and interpretation as it was widely used in literature on humanitarian coordination and across GBV coordination policy and guidance documents, as presented in chapters 2 and 4. My interpretation of 'effective coordination' is presented in the six-dimension framework illustrated in chapter 5. My analysis in Lebanon reinforced the six dimensions, demonstrating that effective GBV coordination ensures the GBV is adequately prioritized and resourced, risk mitigation is integrated across the response, national and local actors are included in coordination mechanisms and allocated funding, GBV data and information systems are established and used to inform coordination and programming and finally, but perhaps, most importantly, appropriate and accessible GBV services and prevention programming are implemented at field level, ultimately improving the lives of affected women and girls.

Furthermore, my findings have reinforced the definition of coordination proposed by the research as: *"the driving force which organises a group of individuals/organizations to achieve common objectives, fosters trust, motivation and interpersonal relationships, ensures efficient use of resources, and promotes collaboration and synergy".* Further research should evaluate the applicability of this definition to technical areas beyond GBV, and its generalisability to broader

humanitarian coordination efforts. As suggested in the scoping review GBV coordination is necessary in all types of emergencies whether refugee crisis, cluster systems or public health emergencies and guidance should be expanded and harmonized to reflect the diversity of these settings.

Notably, my findings emphasise the importance of having appropriate people in coordination roles with the qualities, skills and competencies necessary to build positive coordination dynamics (46). A critical facilitator for effective GBV coordination highlighted in the scoping review was having dedicated, experienced and long-term coordinators with time and funding for coordination, which was heavily reinforced by the experience in Lebanon. Across settings, GBV coordinators, deployed from crisis onset, influenced GBV prioritization, funding allocation, establishment of data and information management systems, response service delivery and advancement of the localization agenda. In Lebanon, longer-term contracts allowed coordinators to build trust, understanding and forge mutually respectful relationships, which previous findings on humanitarian and crisis coordination found to be important (46, 49, 52). Not surprisingly, findings suggest that previous GBV program experience makes better coordinators too. Globally, there is a need to invest in building the workforce of GBV coordinators with experience in all types of emergencies. While the GBV coordination handbook and core competencies outline a set of skills and competencies required by GBV coordinators, more in-depth research is recommended to explore the qualities and skills required for effective GBV coordination, which can inform capacity building efforts (33, 90). In 2023, IMC are implementing a GBV Program Twin Volunteer where newly trained GBV experts can gain direct, hands-on field experience while shadowing and supporting experienced GBV program managers or coordinators, which is a worthwhile initiative and deserves expansion (personal communication).

2. Increased commitments to addressing GBV but funding models need to adapt

This research has underlined the importance of effective GBV coordination to ensure adequate prioritization and resourcing of GBV in emergencies. Although globally, attention to GBV has intensified in recent years, GBV funding remains insufficient and inconsistent, with less than 1% of global humanitarian funding allocated to the GBV sector from 2015-20 (31). Moreover, the short-term funding allocation mechanisms of most donor agencies prevents long-term sustainable capacity building and limits work on GBV prevention and longer-term change (56). Although support from donors and senior leadership was a key factor in prioritizing and funding GBV in Lebanon, strengthened by advocacy of GBV coordinators, GBV funding still only reached 1.3% of overall response funding and gaps persisted. More recently, the economic situation and COVID-19

pandemic had increased vulnerable populations and operational costs, requiring more flexible, predictable and long-term funding. This reinforces previous findings, that in rapidly evolving contexts, needs are frequently changing and funding must adapt accordingly (24, 47). In Lebanon, donors and international actors must continue to prioritise and fund GBV in the increasingly challenging context and to ensure that progress made on GBV over the past ten years is not reversed. Globally, in the post-pandemic global economic climate, funding for humanitarian emergencies may stagnate or decline and responders and policymakers will need to continually advocate for dedicated GBV funding in all emergency settings, at global and field level (31). Finally, the importance of UN, NGO and Government senior leadership understanding of, and support for, GBV cannot be understated in ensuring that GBV is adequately resourced at both global and field level in all emergencies and requires targeted sensitization efforts.

3. Coordination mechanisms should suit the context

A key findings of this research reinforced the influence of context on the establishment and implementation of GBV coordination. As previously noted in research on humanitarian coordination, context must be considered when designing systems and coordination mechanisms should be adapted to suit changing contexts (46). Coordination in the unique Lebanese context did not follow the standard UNHCR refugee coordination model and was adapted to suit the multi-layered protracted crises (242). The size and complexity of the response warranted introduction of the interagency system under the LCRP and subnational coordination which were not standard in UNHCR-led operations at the time (116). The interagency mechanism created a more effective system were leadership, decision making, and information was shared across organizations and interagency funding could be mobilised for coordination positions and implementation of interagency initiatives promoting stronger collaboration on GBV programming and service provision. Subnational coordination mechanisms, with dedicated GBV experts which encouraged engagement of local CSOs, was critical to improve service delivery and impact at field level. Efforts to strengthening the interface between national and subnational levels had created a harmonised approach across the country, while responding to particular contextual challenges in each region, and could be replicated elsewhere. Furthermore, the protracted emergency response (2012-22) cycled through multiple phases during which the response evolved and power and influence of key stakeholders changed. Competing mandates and agendas played out between different UN agencies and often negatively impacted the effectiveness of the response, underlining the importance of reviewing and adapting humanitarian coordination in evolving contexts (46).

Furthermore, this research demonstrated the influence of the political, social and cultural context on GBV coordination and the importance of considering these issues when establishing and implementing coordination. In Lebanon's sectarian political system, coordination was a balancing act where multiple stakeholders with conflicting political affiliations and organizational agendas sometimes challenged effective coordination. Cultural and social norms of both Syrians and host communities, alongside a weak legal framework to protect women and girls from GBV, and more recently the complex crises, created a context conducive to high levels of GBV occurring. Simultaneously, restrictive refugee policies including the no-camp policy, low rates of legal residency among Syrian refugees and lack of access to livelihood opportunities, compromised survivors access to services and complicated service provision (133). This range of complex challenges had to be tackled by the GBV coordination mechanism requiring a deep understanding of the context alongside effective coordination between multiple stakeholders and sectors of the response. As affected populations are now more frequently dispersed in host communities, urban settings or informal settlements, similar to Lebanon, innovative approaches implemented for GBV coordination and programming in Lebanon, could inform similar non-camp settings globally (243).

4. National governments should play a leading role in coordination and sustainability should be promoted

A key point emphasised by previous research and reinforced by this study is the important role that national governments play in leading and coordinating humanitarian assistance in a country (46, 54, 66). The findings from Lebanon clearly demonstrated that government engagement and their leadership of coordination was critical to provide a platform to negotiate the protection space for refugees in the country. However, the volatile refugee policy context and fluctuating government prominence throughout the ten years, sometimes cast doubts over the legitimacy, willingness and capability of the government to coordinate, issues noted in other settings too (67, 80, 81). Development of the ERP for example, excluded the government in an effort to reduce corruption and their absence from the blast response was hampered by Lebanon's multiple political, social, and economic crises (244). Notably, the most stable and productive period of the protracted response appeared to be from 2015 to 2019 when the government played a leadership role and the humanitarian response supported national systems through multi-year planning and funding. In the case of GBV coordination, following several years of inattention, the government's role in GBV was strengthened more recently which had a positive impact on coordination, highlighting the importance of having appropriate and dedicated experts in coordination roles within government too.

While major strides were made on raising awareness and commitment to addressing GBV across government, there is still no government body with full oversight of GBV issues or responsibility for coordination in Lebanon. Sustainability of coordination, GBVIMS and services were threatened by weak government commitment to funding and institutionalizing systems, overwhelmed and under-resourced public institutions and the compounded crises and deteriorating economic situation, where other priorities trumped GBV (242). Because of their experience co-leading the GBV task force, MOSA appear best placed to coordinate GBV actors in the future and collaboration between government institutions, including the NCLW and the NTTF, should be improved with roles and mandates clarified, promoting synergy (134). My findings present a noteworthy recommendation that in protracted crisis humanitarian actors should focus on strengthening national leadership and systems to generate sustainability and when the government are absent or marginalised, long-term impact can be compromised.

5. Emergencies can be harnessed as a catalyst for transformative change

The scoping review noted the potential for emergencies to be harnessed as an opportunity for establishing and expanding GBV coordination and services and this was certainly the case in Lebanon (89). From a base of weak coordination and limited availability of GBV services prior to the Syria response, throughout the protracted crisis an effective GBV coordination mechanism evolved to address multiple challenges and established comprehensive multi-sectorial, survivor-centred services, providing a strong foundation for a nationally-led system. However, as noted in other settings, GBV coordination and service delivery remained dependent on international funding, technical support and leadership, which was being worsened by the economic crisis.

Moreover, despite significant investments throughout the decade, several critical services remained insufficient, including specialised legal and mental health services, and services for marginalised populations such as adolescent girls and LGBTIQ+ (156, 233). The economic emergency was further challenging service delivery and increasing numbers of Lebanese health care professionals were emigrating, furthering the country's economic decline, with detrimental consequences for GBV survivors and marginalised populations (113, 133). In parallel, GBV risks and the severity and frequency of GBV, including femicide, was being exacerbated by the economic crisis (229). Since mid-2022, the increase of telecom tariffs by over 600% led to a decrease in calls to helplines, including GBV hotlines, which made it difficult for survivors to access remote GBV case management (245). Further exacerbating the situation, the judges' strike since August 2022 for better pay and working conditions in Lebanon made it impossible for authorities to process GBV charges,

compounding the pervasive culture of impunity in Lebanon (229, 246). Meanwhile, mental health needs had increased due to the COVID-19 pandemic, Beirut blast, and economic crisis, with Syrian refugees among the most vulnerable (233, 247). A 2021 global gap analysis highlighted the need for improved coordination between GBV and MHPSS sectors and to adapt trainings and guidance to the needs of GBV survivors, which should be promoted in Lebanon (31). In addition, rising prevalence of child marriage due to the compounded crises, and the severe psychological consequences, required more innovative approaches to addressing GBV in adolescent girls, and stronger coordination with child protection, MHPSS and education sectors (145, 157, 171).

Positively, the protracted emergency had acted as a catalyst for transformative change in Lebanon, creating a window of opportunity to reform the legal framework for women's rights over the past ten years (31). The current compounded crises could be leveraged to institute further change, by ensuring that women are in leadership positions and that gender equality is placed front and centre of Lebanon's recovery. Women's organizations should be funded and supported, ensuring access to economic opportunities and the tools and resources needed to engage at all levels of leadership and decision-making, to be a positive force in Lebanon's recovery (248).

6. A CONTEXT-SPECIFIC, STRATEGIC AND COORDINATED APPROACH TO ADDRESSING GBV IMPROVES IMPACT AT FIELD LEVEL

My scoping review and case study findings suggest that GBV response, risk mitigation and prevention efforts have a greater impact when coordinated within an interagency, strategic framework that adapts interventions to the local context. In Lebanon, when a more strategic and coordinated approach was taken to expanding response services, results were substantially better. At the beginning of the crisis, CMR was significantly expanded to meet the extreme needs of Syrian refugees but without considering sustainability, which ultimately compromised the quality of services. A CMR task force was established to coordinate efforts, however, it took until 2021 for the national CMR strategy to be endorsed and for services to be rationalised. In contrast, case management had a working group which collaboratively addressed key issues and developed localized guidance and training programmes to support case managers, resulting in a nationwide network of service providers, a strong referral pathway and a sophisticated coaching programme, which could inform other responses.

Globally, stronger commitment and accountability mechanisms are needed to GBV risk mitigation across response leadership and sectors alongside enhanced cross-sector coordination. Although

clear guidance and tools have been developed to support risk mitigation efforts, de-prioritisation by other sectors means they are inconsistently and inadequately implemented (31). In Lebanon a more strategic approach to risk mitigation could have reduced repetition and duplication of work over the years and created a longer lasting impact. The mentorship approach and focal point system applied in 2017 helped sectors to meet their responsibilities and this could be repeated in Lebanon and replicated in other settings. This research supports previous recommendations that donors should promote these efforts by mandating integration of GBV risk mitigation across all sector strategies from the design phase and affected populations and local women's organizations, embedded in their communities, should be integrated within response planning to mitigate GBV risks (31, 167).

Both the scoping review and the experience in Lebanon underlined the need for increased investment in GBV prevention in emergencies where GBV response services are traditionally prioritised over prevention programmes (13, 23, 31, 63). In protracted crises like Lebanon's, which make up the majority of emergencies, it has become increasingly possible to invest in prevention programming which require a longer-term approach to change social norms and shift male-female power dynamics, working across multiple levels of the socio-ecological framework (31, 249). Furthermore, multi-year and multisector, context-specific, GBV prevention strategies are needed, especially in protracted crises, which could be facilitated by improved coordination with gender working groups and other sectors (200). Adopting a coordinated, interagency, context-appropriate approach to prevention programming, from the early phase of the crisis, could have helped to drive these efforts in Lebanon. For example, women's economic empowerment, including long-term cash assistance, is key to GBV prevention, especially important in Lebanon's compounded crises, and requires effective multisector coordination (134). Additionally, child marriage in Lebanon, was found to be highly influenced by gender norms and consequent social expectations making efforts to design context-specific social and behavioural change interventions critical (157). Researching interventions that prevent GBV in adolescents in Lebanon could offer some important insights for other contexts.

7. Investment in localization reaps benefits, requires sustained efforts and should include affected populations

This research reinforced the growing body of evidence that recognises the important role national, local and CSOs play in humanitarian responses and the need to promote their participation and influence in coordination mechanisms (31, 46, 67, 89, 95). Although the scoping review noted minimal achievements on GBV localization across settings and several barriers for local actors

engaging in UN-led GBV coordination mechanisms, the experience in Lebanon demonstrated many successes (89). In contrast to global findings, national and local GBV organizations in Lebanon were core members of the GBV task force and allocated a significant proportion of multi-year funding. This had allowed them to upgrade their management systems, and access direct funding, which may have been more feasible in a context with a strong existing civil society, within a protracted crisis (95). Local organizations expanded geographical coverage of services to serve increasing refugee and host populations, through mutually beneficial partnerships with government, UN, and INGOs, creating national GBV technical capacity (132, 156). The impact of this was evident in recent years, when national and local actors, maintained services during the COVID-19 pandemic and in insecure areas. However, the compounded crises were presenting profound challenges for local actors to continue providing high-quality services and achievements were being threatened. Continuing to resources these actors will be integral to Lebanon's recovery in the coming years and I support the 2021 recommendations to develop and implement a specific localization plan for Lebanon ensuring that interventions are anchored within local communities to improve sustainability in the volatile context (242). At the global level, the "Building Local, Thinking Global" initiative aims to promote women's transformative leadership by supporting local and national networks to play leadership roles in addressing GBV (31, 250). Other notable efforts, including the Call to action and the GBV AoR localization team, deserve expansion, and experiences from Lebanon could help inform approaches in other settings (34, 95).

Despite Lebanon's successes, we argue that efforts cannot be considered true localization without integration of the affected population in coordination and implementation of the response. Exclusion of Syrian actors from the response has been a challenge since the beginning of the crisis in Lebanon with previous research accusing the UN coordination structure of marginalizing Syrian actors (47). Although they may be best placed to understand the context and design long-term and sustainable solutions for the response, lack of legal status presents major obstacles preventing Syrian organizations from registering and Syrians from obtaining work permits (47). Our study too noted insufficient efforts to integrate refugee-led organizations within the GBV sector which likely compromised response effectiveness and should be a lesson for other contexts. Preventing refugees from working keeps them stuck in poverty and precludes them from contributing in a real way to recovery of the country, which seems short sighted given the protracted nature of the crisis. In addition, there is consensus that the exodus of high-skilled Lebanese professionals is liable to undermine economic recovery efforts, making integration of Syrians more urgent (114, 119, 141). I support the recommendation for UN agencies to advocate with government to allow the registration

of Syrian organizations and for granting work permits to Syrians working on the response in Lebanon, especially now in the increasingly complex context (47). In Türkiye, for example, Syrian organizations are influential in the OCHA-led humanitarian coordination meetings and with the support of WHO, Syrian health care professionals, were successfully integrated into the system to provide health care services to refugees (47, 251). Proposals to institute innovative coordination mechanisms which incorporate Syrian actors including at the policy and decision-making levels, should be supported especially in the increasingly complex crises in Lebanon (47, 56, 158).

8. GBV COORDINATION IN PUBLIC HEALTH EMERGENCIES REQUIRES DEDICATED ATTENTION

A key finding of the scoping review was that literature on, and attention to, GBV coordination in public health emergencies is insufficient and although this study has gone some way towards addressing that, further research is urgently needed. GBV in public health emergencies has traditionally been neglected, however, we have seen major improvements throughout the COVID-19 pandemic, globally and in Lebanon, which should be documented (74, 172). New guidelines and innovative coordination and programming models which have been developed and piloted during the COVID-19 pandemic should be evaluated and standardised for use in future public health emergencies (31). WHO can play a leading role in ensuring that GBV is adequately addressed in public health emergencies and should convene a global consultation on GBV in public health emergencies to facilitate cross fertilization between countries and regions and to learn and integrate lessons from the COVID-19 response (252). Furthermore, GBV risk mitigation in public health emergencies remains weak or non-existent, public health responders are not necessarily aware of the GBV guidelines and intensified efforts are needed to ensure that they are systematically integrated across all emergencies (74). In Lebanon, guidelines and approaches designed and implemented during the COVID-19 pandemic could be adapted to respond to the emerging national cholera outbreak declared in October 2022 (156). Globally, further research is needed to examine GBV coordination during public health emergencies.

9. DATA AND INFORMATION MANAGEMENT ARE INTEGRAL COMPONENTS OF EFFECTIVE GBV COORDINATION SYSTEMS

This research supports previous findings that information management, data analysis and communication are integral components of effective GBV coordination systems and should be invested in (195). This was heavily reinforced by the experience in Lebanon where GBVIMS was considered a game changer once implemented and was used throughout the protracted crisis and compounded crisis to adapt and inform GBV coordination and programming. Previously, no standardized and coordinated information management system had existed in Lebanon and this can

provide the foundation for a national-led system in future, which is one aim of the National GBV SOPs (24). Stronger engagement of government by UN agencies will be needed to sustain and expand GBVIMS as Lebanon recovers (195). In addition, the scoping review noted that coordinators who analysed and reflected on data contributed to the success of GBVIMS, and this was a key advantage in Lebanon, where the position had been transitioned to a national staff increasing the chances of longevity (89). Nevertheless, while GBVIMS is an important source of data, it should not stand alone and needs to be triangulated with other data sources to provide a clear picture that can inform coordination decisions, as evidenced by the experience in Lebanon. Additionally, alternative data sources are needed for identifying GBV-related risks and priority mitigation activities (253). Furthermore, improved monitoring and evaluation methods to assess the effectiveness and impact of interventions are needed at the interagency GBV coordination level both in Lebanon and other settings.

10. A STRATEGIC RESEARCH AGENDA IS NEEDED ON GBV COORDINATION IN ALL TYPES OF EMERGENCIES

A strategic research agenda is recommended on GBV coordination in all types of emergencies which could be led by the GBV AoR and overseen by GBV coordination mechanisms in individual settings. In Lebanon the GBV task force acts as a gate keeper for GBV research. For this study, for example, I went through several layers of review by GBV coordinators and task force members, before beginning data collection and presented findings back to the task force. This could be considered a good practice to ensure that research findings are validated, useful and have practical implications in the study context. However, in contexts where there is conflict of interest or where research is controversial, independent research institutions should maintain oversight. A review of GBV research in Lebanon was carried out in 2010 which highlighted repetition and duplication of studies, attributed to poor publication mechanisms, disorganized funding and the absence of a central repository for GBV research (5). Considering the scope and depth of research that has been conducted on GBV over the past ten years in Lebanon, a repeat review would be beneficial and a central repository should be established. This could be replicated in other settings and at the global level.

STUDY STRENGTHS, LIMITATIONS AND ETHICAL CONSIDERATIONS

There were several strengths and limitations to this study which need to be considered in context and in relation to some of the ethical considerations presented in the methods chapter, which I discuss below.

As a Doctorate of Public Health (DrPH) thesis, this study aimed to contribute to academic evidence while also producing practically applicable recommendations for policy and practice, which I see as one of its strengths. I chose a qualitative research design because it was appropriate for studying humanitarian and public health emergency responses which are inherently complex. The qualitative approach enabled a more in-depth and nuanced exploration of GBV coordination, extracting examples of good practice and recommendations for future, allowing the research to be practical and future-orientated which a DrPH thesis is intended to be (37-39). Utilizing qualitative and mixed methods allowed for a comprehensive understanding of the GBV coordination, which could not have been achieved through quantitative data alone. To ensure that all available literature was included, I chose to conduct a scoping review instead of a systematic review, given the lack of existing data on GBV coordination. This approach had the added advantage of not excluding literature based on quality assessment. The goal of the scoping review was to provide an exhaustive summary of the literature on GBV coordination, and the research question was deliberately broad to capture a wide range of sources. A systematic review may not have been appropriate due to the lack of existing data and the stringent protocols for searching and abstracting, which may not have been suitable for this research. Furthermore, incorporating interview data with meeting observations and document review added depth to the analysis. Although the study was qualitative, and thus not statistically generalizable to the broader population, it has identified transferable findings that can be applied to other contexts. However, a limitation of the study was that I was the only individual responsible for coding and analysing the data.

The timeline which I was studying spanned 10 years from 2012 to 2022, which I believe was a major strength of my study but may have also introduced some limitations. I was able to explore the evolution of the response throughout the 10 years of the crisis as the context changed dramatically in that period allowing me to extract lessons for other protracted and complex crises. However, I experienced challenges accessing several relevant individuals who had already moved on to new positions. For example, several of the longer-term coordinators who had worked in Lebanon before 2018, were unable to participate in interviews. There were also potential issues of recall bias spanning the ten-year period for those who did participate.

Certainly, the availability of resources and funding played a significant role in shaping the study design. Given the limited resources available, including both material and personnel, the research needed to be feasible and practical. At the outset of the study, there was no external funding available, and I planned to finance the entire study personally, so cost was a consideration. Initially, I planned to spend a few months in Lebanon, but due to the COVID-19 pandemic, this was not

possible. I was fortunate to receive a traveling scholarship from LSHTM for £5000, which funded the transcription of all interviews and my travel to Lebanon in May 2022 for the data verification meeting.

The COVID-19 pandemic had quite a significant impact on how I implemented this study and also on the timeline required for data collection. This included both positive and negative consequences which I have outlined in the introductory chapter of this thesis, and further elaborate in the COVID-19 Impact Statement (Annex 8). Due to the COVID-19 pandemic travel restrictions and social distancing measures, all data collection, other than the data verification meeting, was conducted remotely.

Positively, the remote nature of my study provided me with the opportunity to collect data over an extended period of two years, allowing me to explore GBV coordination in the complex and compounded crisis in Lebanon while taking into account significant changes in the context from 2019 to 2022. This approach also enabled me to examine GBV coordination within the framework of a public health emergency within a humanitarian response, drawing on my areas of expertise.

While remote data collection allowed for longer and more in-depth interviews with a greater number of stakeholders, it did have limitations. For instance, it may have hindered access to key informants, particularly those working with local women's organizations or those who did not have access to video conferencing software. Additionally, the remote nature of data collection may have prevented me from building relationships and visiting field sites, which could have enriched my study with a more local focus. Despite these limitations, I used purposeful sampling to gather information-rich cases on GBV coordination in Lebanon over ten years, including stakeholders such as GBV coordinators and experts from UN agencies and INGOs, government actors, national NGOs, academics, and field-level UNHCR coordinators and local organizations. While smaller CSOs or refugee-led organizations at the field level were not included, this approach balanced the voices of local and national actors with those of international stakeholders. It is important to note that the remote nature of data collection may have limited my ability to engage with government actors who were unresponsive to emails and may have been more receptive to in-person meetings. Although I attempted to contact several government officials during my field trip to Lebanon, I was unsuccessful, which may have been further constrained by the national general elections scheduled for the end of that week.

Due to the remote nature of data collection, I was unable to observe GBV coordination meetings at field level and meetings within other sectors as initially planned. This was due to my inability to get the appropriate approvals, which would have been necessary for such observations. Observing GBV coordination meetings at field level would have provided me with better insight into coordination dynamics and the roles of different stakeholders. Additionally, it would have allowed me to contact more local organizations in the two field sites included in the study. The remote nature of meeting observation may have also limited my understanding of coordination dynamics, the roles of different stakeholders, and their levels of engagement in the task force. Furthermore, I was unable to have follow-up discussions with participants in-person following meetings, which would have helped me gain clarity on issues observed, or to engage certain actors in interviews. However, the remote meetings did provide me with the opportunity to observe more meetings over a longer period than I could have done in person. This enabled me to witness the response to the changing context and increasingly complex challenges, which formed the basis of my analysis in chapter five of this thesis.

I acknowledge that language limitations may have limited data collection and analysis of findings. Regarding the scoping review, it is important to note that the sources included were limited by my search parameters and language capabilities. It is possible that relevant sources may have been excluded due to search terms or lack of electronic availability. This was evidenced by a heavy focus of the research on the Middle East and the Syria response. In terms of data collection for the interviews, both email outreach and interviews were conducted in English. I recognise that this may have limited access to potential interviewees who only spoke Arabic. However, as part of the AUB local ethics approval process, all study tools were translated into Arabic, allowing for the possibility to reach out to potential interviewees in Arabic if needed. Additionally, through collaboration with AUB, translation services were available for conducting interviews in Arabic. It is important to note that the language barrier may have limited access to certain populations, particularly Syrian refugees and CSOs working at the local level who may not have been regularly engaged in the GBV task force meetings. Furthermore, not being able to attend field level coordination meetings, some of which were conducted in Arabic, may have limited access to potential non-English speaking interviewees. Therefore, the lack of access to individuals who may not have spoken English did hinder the ability to include a more diverse range of perspectives in the study.

The field trip and data verification meeting in Lebanon proved to be a significant strength of this study, ensuring the accuracy, practicality, and usefulness of research findings for the GBV task force in Lebanon. Through this trip, I was able to collect additional data that helped to fill gaps in my

existing analysis, and to review my findings in collaboration with key members of the GBV task force. This experience deepened my understanding of the rapidly evolving and compounded crises in Lebanon and allowed me to meet with my Lebanon co-PI, MOSA and UNFPA GBV coordinators, as well as some of the GBV task force in person, including local and national actors and field coordinators who had participated in the research. The meeting attracted attendees who did not participate in interviews but were interested in the findings and gave valuable insights. UNHCR field coordinators and local feminist organizations' representatives attended and contributed to data verification and research findings. This was a rewarding opportunity for me to express my gratitude for their inspiring work and the support and engagement they had shown during my study. It also gave me the chance to reiterate my ultimate objective for the research, which was to provide practical recommendations that could add value to their important work.

The humanitarian community in Lebanon have been described as "over-researched" so a key concern was that there may be research fatigue and individuals may be unwilling to participate in interviews. By engaging GBV Coordinators working for MOSA, UNHCR and UNFPA and key stakeholders in Lebanon at all stages of the research, I at least partially mitigated these risks. They helped to facilitate introductions, allowed access to meetings, added me to mailing lists and shared key documents. Nevertheless, engagement with government actors was very limited (to one individual).

In terms of reflexivity, my position in the UN may have influenced my framing and interpretation of data. However, during the research, I made an effort to maintain methodological and theoretical openness, which involved being explicit about the steps I took in producing and analysing the data, and accounting for the assumptions and theoretical starting points that shaped the study. I also developed a deep awareness of the political and cultural setting, including the changing circumstances in Lebanon, and the political and social systems that influenced the research findings. Although my UN background may have made it easier for me to engage other UN staff on an equal footing, I always used my LSHTM affiliation when conducting interviews or introducing myself during meetings to maintain neutrality. I learned a lot through conducting this research, and I am currently leveraging this knowledge in my work on the earthquake response in Turkiye. I believe that presenting myself as an outsider, rather than a GBV expert or someone embedded in the system, helped people to see me as an independent observer, allowing participants to be more open and honest in their assessments, perceptions, and opinions. One national actor even thanked me for

doing the research in Lebanon and commented that the findings would be really useful, especially given that I was an outsider, and that the research findings would be independent.

While the research itself did not consciously employ feminist theories, it inherently focused on a feminist topic - GBV. A feminist approach was applied to examining the qualities and skills required of GBV coordinators, which are often more centered on feminine values of empathy and collaboration, rather than masculine values of command and control. This highlights the need for further research on how gender influences leadership in humanitarian responses. Especially given that the broader humanitarian system is inherently patriarchal, with the majority of leaders being men. Furthermore, the majority of participants interviewed for the research were women, particularly Lebanese women who often spoke about the patriarchal system in Lebanon. By giving a voice to these women, especially those representing national and local actors, the research can be seen as taking a feminist approach.

Finally, I had to remain very flexible and adaptable to multiple changes to my research timeline and supervisory team throughout this study. I was a part-time student and was working full-time with WHO in challenging and busy contexts from 2018-2023, and I moved countries three times during the course of my thesis. Additionally, I changed topics, supervisors, and departments in 2018 all of which extended the timeline for my thesis (Figure 1).

Contributions to Global Health Knowledge and Practice

As a DrPH thesis, this research contributes to global health knowledge and practice in the field of GBV coordination, by advancing theory and understanding of what influences effective GBV coordination in emergencies and by proposing recommendations for future practice. This study has made several important original contributions to the evidence base for GBV coordination in emergencies.

Firstly, this research presents a clear finding that effective GBV coordination is critical in all emergencies and demonstrated the impact of that coordination on ensuring that GBV is adequately prioritised, resourced and addressed across responses, improving the lives of affected women and girls. The findings demonstrated the impact of effective coordination on the six dimensions of the framework for effective coordination and explored in-depth the factors which influence coordination effectiveness.

Secondly, I presented a clear definition of the concept of coordination which did not previously exist and have proven the validity of this definition through the findings of the research (47, 52). Furthermore, I propose that this definition can be applied to other cross-cutting issues in coordination of both humanitarian and public health emergencies.

I contributed the first scoping review of the global literature on GBV coordination which summarized and synthesized existing evidence, the findings of which I further expanded on in the Lebanese case study. Based on the literature reviewed, I developed an evidence-based framework for effective GBV coordination, which I tested and calibrated by applying it to comprehensively analyse GBV coordination in Lebanon. This framework can be leveraged and built upon to guide future research.

In addition, I designed a graphic representation of coordination from global to frontline levels based upon available guidance and the GBV coordination handbook to demonstrate the complex network of different stakeholders involved in GBV coordination which can be used in guidance and policy documents to aid understanding of GBV coordination across the humanitarian sector. I have also adapted this to the Lebanese context (Annex 9).

Through my Lebanese case study, I have developed two manuscripts which contribute to ongoing debates about the effectiveness of GBV coordination and the importance of addressing GBV in emergencies. This case study provided the first qualitative analysis of GBV coordination in an evolving and volatile operational context - the protracted Syrian crisis overlayed by complex compounded crisis and a global public health emergency, and presents important findings, reflections and recommendations.

Finally, I mapped key stakeholders involved in addressing GBV coordination in the Lebanese context, which can provide a useful reference for GBV actors in Lebanon and at Regional and Global level (Annex 3).

Recommendations for strengthening GBV coordination in emergencies

Recommendations specific to all three of the manuscripts have been presented in chapters 5, 6 and 7, but below I have synthesized the most important and transferrable, high-level recommendations including for strengthening GBV coordination in complex, protracted emergencies, in Lebanon, and for further research.

RECOMMENDATIONS FOR STRENGTHENING GBV COORDINATION IN COMPLEX AND PROTRACTED EMERGENCIES

1. GBV coordination must be prioritized and resourced in every emergency from the outset. This means both creating and deploying high-level, long-term, dedicated GBV coordination positions and funding coordination as a task in itself rather than something to be conducted on top of a technical role. Humanitarian leadership and responders need to be sensitized on the importance of addressing GBV to promote prioritization and resourcing.
2. Both the humanitarian and public health community should invest in building the workforce of GBV coordinators with specialized skills and training in response, risk mitigation and prevention and the necessary qualities and skills to drive effective coordination. A shadowing system could be established whereby newly trained GBV coordinators can be deployed alongside experienced coordinators to learn from them and build their expertise and knowledge creating a pool of experts available for deployment (similar to the recent initiative by IMC). Experienced and skilled coordinators should be deployed in every emergency, including public health emergencies, from the beginning of the response.
3. Coordination mechanisms in humanitarian and public health emergencies must be designed to suit the context in which they are implemented and be flexible to adapt as the context evolves. This means building on existing government, civil-society and affected-populations, formal and informal coordination mechanisms and making conscious efforts to engage and include all actors from the early stages, including refugee-led organization's and affected populations. Regular reviews should be conducted to ensure that coordination is most effective and appropriate, and any adaptations needed should be made, especially in evolving contexts. Roles of different stakeholders, including government actors, should be agreed and defined within a holistic framework to avoid conflict, confusion and duplication which can compromise the efficiency of the response. Communication between different levels of coordination and different sectors are also important issues to be clarified.
4. When introducing GBV coordination and services, sustainability should be considered from the start taking a long term, strategic approach which contributes to building national systems. Approaches from Lebanon to improve coverage and uptake of GBV services could be adapted for use in protracted and urban crisis.
5. GBV actors at global and field level should invest in GBV prevention especially in protracted emergencies, taking a multisectoral, strategic approach that is developed at the coordination level and adapted to the local context, integrating and building upon evidence from the “what works” initiative and other research findings (36).

6. The humanitarian system must strengthen accountability mechanisms across sectors on GBV risk mitigation, improve measurement of the impact of risk mitigation measures, and train and deploy experts in risk mitigation at the onset of crisis to ensure it is integrated in sector work plans from the early planning stage (253). Although GBV risk mitigation is the responsibility of all sectors, this risks it not being addressed from the design phase and I propose that this requires dedicated investment by deploying GBV risk mitigation experts, from the beginning of all responses, at least for some years until it becomes second nature within every humanitarian response.
7. Across emergency settings, increase the meaningful participation of national and local CSOs in GBV coordination by demonstrating the value of engaging in coordination and building mutually beneficial partnership, which experience from Lebanon could help to inform.
8. Better integration of affected populations in emergency responses is required, in both the design and implementation of coordination mechanisms and in the design and monitoring of programming. Affected population know best what would work in their particular culture and society and should be aware of and understand humanitarian coordination mechanisms, refugee representatives should be engaged in coordination mechanisms and affected populations should receive regular feedback on the impact of interventions.
9. Concerted efforts are needed (from WHO and others) to strengthen GBV coordination in public health emergencies to ensure that GBV is addressed across the response that services are available and considered essential and that risk mitigation is integrated in outbreak responses. While WHO have largely focused on their normative role in public health emergencies, the WHO health emergencies program aims to be more operational and experts in GBV coordination should be deployed to lead this work. These could be seconded from other organizations with existing expertise such as UNFPA or UNHCR, however in the long term WHO needs to develop a pool of experts on GBV coordination with specific training and expertise on GBV in public health emergencies.
10. WHO, GBV AoR and other organizations should convene a global consultation to generate lessons learned for GBV in public health emergencies during the COVID-19 pandemic and to consolidate and harmonise guidance and innovative approaches developed for future use.

Recommendations for strengthening GBV coordination in Lebanon

1. Institutionalize GBV coordination systems and create a centralized GBV coordination mechanism within government structures which is inclusive of all actors and supported by donors, UN agencies, INGOs, NGOs and local CSOs.

2. Ensure that women and women-led organizations including Syrian actors are at the forefront of Lebanon's recovery, creating the foundation for a more equitable gender inclusive society as Lebanon recovers. Promote women in leadership positions as agents of change for sustained growth and development in Lebanon.
3. Make efforts to better include Syrian actors and refugee-led organization's in GBV coordination. Conduct outreach to engage smaller local CSOs and refugee-led organization's in GBV coordination at field level.
4. Articulate an inter-sectorial strategy on GBV risk mitigation and improve engagement with affected women and girls to identify and reduce GBV risks.
5. Develop an interagency prevention strategy which would assist to mobilise and sustain multi-year funding to support long-term change.
6. Intensify efforts to prevent child marriage by promoting stronger coordination with child protection and education sectors. Invest in capacity building for GBV service provision for child survivors and promote joint activities to enhance case management and CMR services for child survivors. Strengthen programming targeting adolescent girls and design context-specific social and behavioural change interventions (158). Support parents to keep girls in school with free education, transportation, and meals, as formal education shields girls from early marriage and GBV (145, 231).
7. More funding and attention are urgently needed for GBV survivors to access MHPSS services and specialised mental health services and close collaboration with the Health Sector, the MHPSS Task Force, and the National Mental Health Programme is required in Lebanon. Contextually relevant interventions are required to reduce access barriers, including shame, stigma, social norms and logistical challenges (89).
8. Advocate for the importance of providing livelihood and employment opportunities for Syrian refugees, allowing them to contribute to the economic recovery of the country, and to reduce their vulnerability to GBV.
9. Repeat the GBV research review conducted in 2010 to capture the scope and depth of research conducted on GBV over the past ten years. Create a central repository with oversight by one of the leading academic institutes working on GBV, such as a AUB or AiW at LAU.

Recommendations for Further research on GBV coordination

1. Research GBV coordination across different operational context to build a body of evidence on what influences effective coordination including in cluster responses and those led by UNHCR,

WHO and other agencies. The framework for effective coordination presented in the scoping review could guide further research on this topic.

2. The GBV AoR and other stakeholders and partners should come together to create a strategic research agenda on GBV coordination, addressing historically under-represented areas, reducing duplication within and across settings and improving generalizability and transferability of findings.
3. Create a central repository for GBV-specific research in emergency settings at the global level, which can be drawn from and built upon in further studies.

CONCLUSIONS

At a time when there is growing global momentum to address GBV, this thesis aimed to better understand what influences effective GBV coordination during emergencies and identify opportunities for strengthening GBV coordination in these settings, using Lebanon's complex, protected crises as a case study. Humanitarian responses are uncertain, and volatile contexts which make coordination challenging so understanding the factors which influence effective coordination in such contexts is critical to improve humanitarian responses overall. This research clearly demonstrates the importance of effective GBV coordination, which ensures that GBV is adequately addressed in emergencies, and response services and prevention programming are implemented at the field level, ultimately improving humanitarian responses and impacting the lives of affected populations. The study explores key dimensions that influence GBV coordination effectiveness, identifies opportunities for enhancing them in parallel to strengthen coordination across emergencies, and demonstrates how effective GBV coordination in a protracted emergency can promote transformative change in a country. A noteworthy finding emphasises the need for more attention to, and evidence on, GBV coordination in public health emergencies. As the first of its kind, this study contributes to academic knowledge on GBV coordination, builds the evidence base, and produces practical lessons applicable to global health practice, both in Lebanon and globally.

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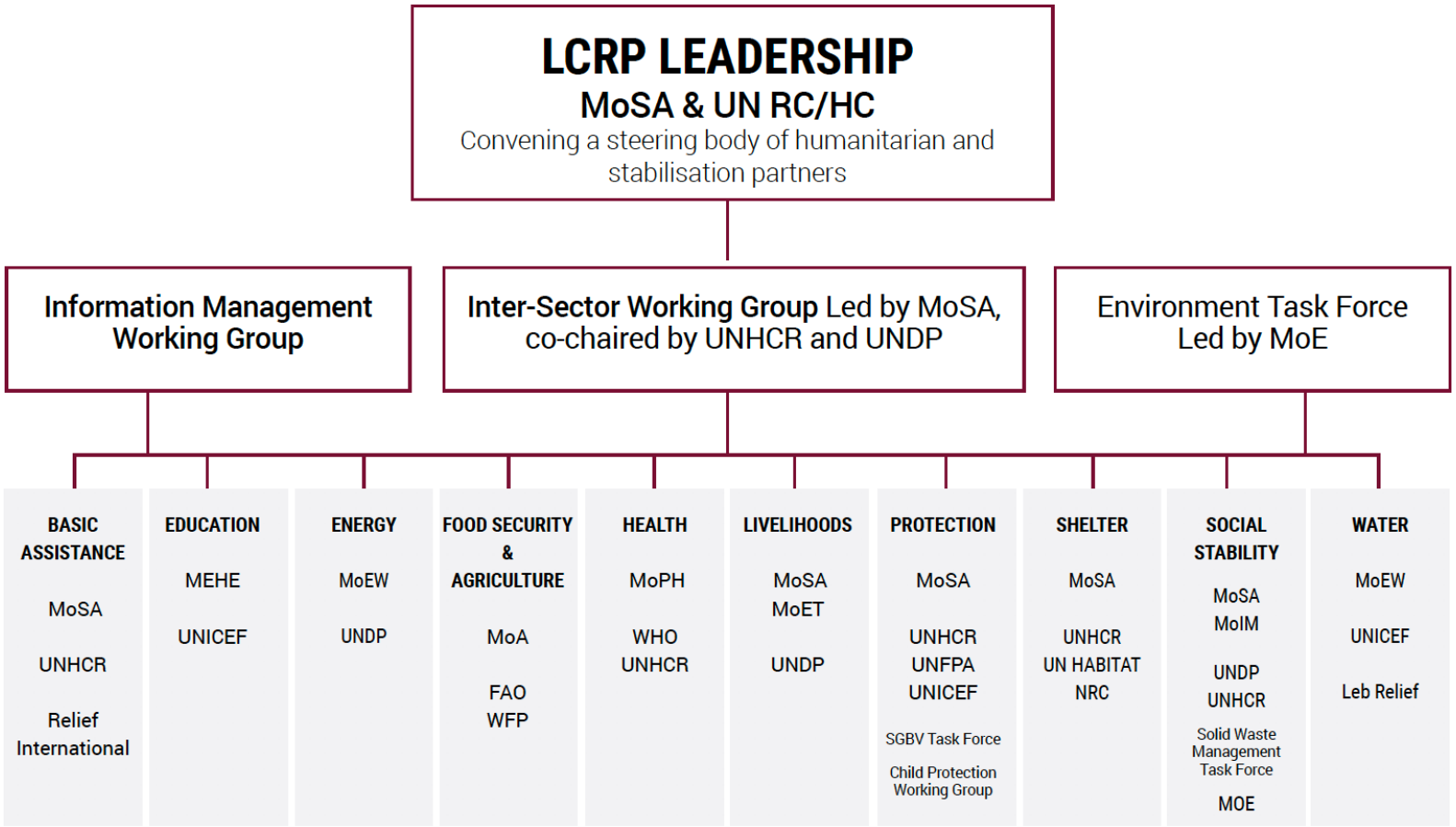
ANNEXES

ANNEX 1: BUDGET FOR THESIS FIELDWORK AND TRAVELLING SCHOLARSHIP

Thesis Project Budget						
Exploring the evolution of the gender-based violence (GBV) coordination system in Lebanon's humanitarian response						
Dates: July 2020 - May 2022						
Location: Beirut, Lebanon, Phnom Penh, Cambodiaand Ankara, Turkey						
Item	Units	GBP	Total GPB	**Travelling Scolarship**	**Actual Expenditure US**	Notes
Travel Expenses						
Airfare - Ankara - Beirut (return)	2	1500	3000	2000	685	
Taxi - to and from airports in Beirut and Ankara	2	500	1000		150	
Local Transport - taxis in Beirut	2	200	400		100	
Subtotal Travel			**4400**	**2000**	**935**	
Living Expenses						
Accomodation in Beirut	2	2000	4000	3000	1,400	Hotel 7 days (with security)
Room rental and coffee break for data verification meeting					300	At hotel
Food and drink in Lebanon during field trip					350	
Subtotal Accomodation			**4000**	**3000**	**2,050**	
Data Collection Expenses						
Research Assistant Salary (monthly)	2	500	1000		0	Includes conducting interviews in Arabic and translation as required
Translation of data collection tools for ethics application					300	Through Americal University Beirut
Ethics Application Fee	1	300	300		300	Through Americal University Beirut
Transcription Fees	40	60	2400		2,640	Based on 38 interviews lasting 30-90 mins each
Subtotal Data Collection			**3700**		**3,240**	
TOTAL		GPB	**12100**	**5000**	**6,225**	

ANNEX 2: THE LCRP COORDINATION STRUCTURE 2022



(LCRP, 2022-23) (131)

Abbreviations: *GBV: Gender Based Violence, LCRP: Lebanon Country Response Plan, MOSA: Ministry of Social Affairs, MoPH: Ministry of Public Health, MEHE: Ministry of Education and Higher Education, MoE: Ministry of Environment, MoA: Ministry of Agriculture, UN: United Nations, UNDP: United Nations Development Programme, UNFPA: United Nations Population Fund, UNHCR: United Nations High Commissioner for Refugees, UNICEF: United Nations Children's Fund, UN HABITAT: United Nations Human Settlement Programme, FAO: Food and Agriculture Organization, WFP: World Food Programme, WHO: World Health Organization,*

ANNEX 3: STAKEHOLDERS INVOLVED IN THE GBV SPACE IN THE HUMANITARIAN RESPONSE AND GOVERNMENT IN LEBANON*

CATEGORY OF STAKEHOLDER	ACTOR / ORGANIZATION	DESCRIPTION AND SUMMARY OF ROLE AND RESPONSIBILITIES IN THE GBV SECTOR
GOVERNMENT PUBLIC POLICYMAKING AND IMPLEMENTING BODIES	Ministry of Social Affairs (MOSA)	Founded in 1993 to provide social protection and assistance in Lebanon. Maintains oversight of the Lebanon Crisis Response Plan (LCRP) which governs the Syria crisis response. Established a Women Affairs Department and in 2008 appointed a gender focal point. Collaborates with UN agencies and civil society to implement several programs to promote women and provide services to GBV survivors. Operates Social Development Centres (SDCs) where GBV services are delivered.
	Ministry of Public Health (MOPH)	Founded in 1958 to govern and manage the health sector. Mandate includes norm-setting, regulatory, technical/advisory and financing functions. Appointed a gender focal point in 2009. Co-leads the Clinical management of rape (CMR) task force and led development of the National CMR strategy. MOPH administers primary healthcare centres (PHCs), provides all women with health and reproductive health services and GBV survivors can access specialized health services.
	National commission for Lebanese women (NCLW)	Founded in 1996 as the national mechanism for women's advancement and gender equality. Mandate includes national priority-setting, advocacy, policy formulation and analysis, legislative change, monitoring of women's status, and research and training. Chaired by the First Lady of Lebanon, Mrs. Claudine Aoun.
	Ministry of Justice (MoJ)	Mandate includes Human rights of women, addressing GBV, legislative reform, rule of law, coalition and lobbying, etc. Appointed a gender focal point in 2009 Outside Lebanon's regular court system sectarian courts have jurisdiction over personal status matters including marriage, divorce, inheritance etc. in their communities.
	Ministry of Education and Higher Education (MEHE)	Mandate includes education, gender equality, human rights of women, children and young people, reproductive health and rights through life cycle, sensitization, including on GBV.
	Ministry of Interior and Municipalities - Internal Security Forces (ISF)	Engages in partnerships with UN agencies, academic institutions, and local CSOs, including ABAAD, Caritas, and KAFA on GBV issues. Issued two mandatory service memos related to receiving and processing cases of domestic violence, sexual violence and/or human trafficking. GBV task force trained Internal Security Forces, judges and forensic doctors on GBV. As a result of task force advocacy, gender focal points have been appointed at police stations throughout Lebanon, a four-digit helpline for GBV reporting and referral was established, and investigation rooms specifically for GBV cases were allocated at stations. GBV task force trained legal advisors to help refugee women complete the complex registration process.
LEADERSHIP AND COORDINATION	Interagency coordination Unit	Governs the response to the Syrian refugee crisis under the LCRP, led by MOSA, UNHCR and UNDP.

CATEGORY OF STAKEHOLDER	ACTOR / ORGANIZATION	DESCRIPTION AND SUMMARY OF ROLE AND RESPONSIBILITIES IN THE GBV SECTOR
	The Sexual and Gender-Based Violence Taskforce (SGBV TF)	Co-led by MOSA, UNFPA and UNHCR, includes UN agencies and national and international NGOs working on GBV activities in Lebanon. Supports a comprehensive and coordinated approach to GBV, including response, risk mitigation and prevention.
	Clinical management of rape (CMR) Task force	Co-led by MOPH and UNFPA, comprises Health and GBV actors supporting access to CMR services. Developed the National CMR strategy, which was launched in 2021.
	GBVIMS steering committee	Led by interagency coordinator. Review GBVIMS data and produce quarterly reports. GBVIMS comprises 14 organization's in Lebanon.
	Protection and Child Protection (CP) Sectors	Both co-chaired by MOSA focal point. UNHCR co-chair protection and UNICEF CP. Work closely with GBV task force and stakeholders on many cross-cutting initiatives.
	UNHCR field office coordination	Decentralised model with four sub/field offices in the North, Bekaa, South and Beirut and Mount Lebanon, and a branch office in Beirut. GBV focal points in each field office coordinate inter-agency GBV working groups, manages local partnerships and UNHCR's internal GBV programming.
	UN OCHA	Mandate on coordination (covering financing, policy, and information management in humanitarian responses), but its role in Lebanon is vague and is outside the core governance structure for the LCRP. OCHA manages the Lebanon Humanitarian Fund, under the Emergency Response Plan developed in 2021, aligned with LCRP Under leadership of the Humanitarian Coordinator, ERP supports the most vulnerable in Lebanon.
	United Nations resident coordinator (UNRC)	UN system in Lebanon comprises 23 agencies, funds and programmes as well as a peacekeeping mission, a political mission and a regional commission. Covers peacekeeping, political, development, human rights and humanitarian work. Supports Lebanon to promote the country's long-term peace and security, development and human rights priorities.
UN AGENCIES WORKING ON GBV	United Nations High Commissioner for Refugees (UNHCR)	Field presence in Lebanon since 1963, but its work in-country was only formalised in 2003. Operates with the permission of the Lebanese government - ongoing challenges with its country mandate. Co-leads the LCRP interagency unit with MOSA and UNDP. Operates GBV programmes alongside partners. A dedicated GBV protection officer leads and coordinates GBV task force at inter-agency level. Position was vacant from 2019-22.
	United Nations Population Fund (UNFPA)	Co-leads the Interagency GBV Task Force with MOSA and UNHCR. UNFPA works in partnership with NGOs supporting GBV programming and services.
	United Nations Children's Fund (UNICEF)	Established in 1950, works to meet the needs of disadvantaged children in Lebanon. Co-leads the Interagency Child Protection and Education sector with MOSA and UNHCR. Works on prevention of and response to child protection violations and GBV.

CATEGORY OF STAKEHOLDER	ACTOR / ORGANIZATION	DESCRIPTION AND SUMMARY OF ROLE AND RESPONSIBILITIES IN THE GBV SECTOR
	United Nations development programme (UNDP)	Co-leads the LCRP (with UNHCR), to coordinate the humanitarian response to the Syria crisis. In partnership with Canada, ABAAD and ACTED, is piloting innovative interventions to integrate GBV prevention into women's economic participation programming.
	UN Women	Chair of the Gender Working Group (GWG), a strategic forum and advocacy platform for UN agencies and NGOs to promote gender equality and gender mainstreaming in humanitarian-development-peace actions Co-chair of the LGBTIQ Task Force, in partnership with UNFPA Coordinates gender equality and women's rights work as Chair of the Social Cohesion, Inclusion and Gender (SCIG) Sector of the Lebanon Reform, Recovery and Reconstruction Framework (3RF) Co-chair of the GBV and Child Protection Sector of the Emergency Response Plan (ERP) in partnership with UNFPA and UNICEF
	World Health Organization (WHO)	Co-lead health sector for the ERP and under LCRP Supports MOPH on the COVID-19 response.
	United Nations Relief and Works Agency (UNRWA)	Established to provide support to Palestinians displaced in 1948. Approx. 275,000 Palestinian refugees registered in Lebanon with UNRWA, living across 12 camps.
DONORS FUNDING GBV	International Monetary Fund (IMF)	Reached an agreement (3 billion) with Lebanon in April 2022, for a four-year extended fund facility with full approval pending government reforms.
	World Bank	Established the Lebanon Syria Crisis Trust Fund (LSCTF), a multi-donor trust fund designed to help mitigate the effects of the Syrian crisis. Providing funding (US$246 million) for a government led, three-year Emergency Crisis and COVID-19 Response Social Safety Net Project (ESSN), to provide cash transfers and access to social services to address the needs of vulnerable Lebanese impacted by the economic crisis and intended to support the development of a comprehensive national social safety net system.
	European Union (EU)	Operates the Regional Trust Fund in Response to the Syrian Crisis since 2014. Donated EUR 32.2m to support vulnerable Lebanese and Syrians impacted by the Beirut blast
	Canada	Provides Humanitarian aidin Lebanon to address the impact of the Syrian crisis. Funds GBV coordinator positions and services to respond to and prevent GBV. The Embassy of Canada to Lebanon works towards eliminating GBV through advocacy and programming.
INTERNATIONAL NON-GOVERNMENTAL ORGANIZATION'S WORKING ON GBV	International Rescue Committee (IRC)	Member of the GBV Task force, GBV Information Management System and the Clinical Management of Rape (CMR) task force. Recognized as a leader in humanitarian GBV prevention and response programming. Conducts research and partners with local and national organization's on GBV capacity building projects including case management coaching programme.

CATEGORY OF STAKEHOLDER	ACTOR / ORGANIZATION	DESCRIPTION AND SUMMARY OF ROLE AND RESPONSIBILITIES IN THE GBV SECTOR
	International Medical Corps (IMC)	Operating in Lebanon since 2006 with expanded programming since 2011 in Tripoli, Akkar, Beirut and Mount Lebanon, Bekaa and the South. Recognized as a leader in humanitarian GBV prevention and response programming. Member of the GBV Task force, GBV Information Management System and the Clinical Management of Rape (CMR) task force. Provides response services for GBV survivors - case management and psychosocial support services. Promotes GBV prevention, works with communities to address protection risks and combat harmful practices.
	The Danish Refugee Council (DRC)	Operating in Lebanon since 2004, responding to various humanitarian crises, working with Palestinian, Iraqi and Syrian refugees. Member of the GBV Task force and GBV Information Management System
	Intersos	Operating in Lebanon since 2006 and with funding from EU to support women in vulnerable situations in the North and South of the country. Provide psychosocial and financial assistance for survivors of GBV to gain independence, new skills, physical and mental health.
	Concern Worldwide	Operational in Lebanon since 2013. Responding to the Syrian refugee crisis and supporting local host communities in the Akkar and North governorates of Lebanon.
	Caritas Lebanon	Provides protection Services to Syrian and Iraqi refugees. Provides free legal services to access justice, psychosocial support, case management, community-based activities, GBV/LGBTI and CP services and assistance for a specific needs, elderly, women and children.
	Care International in Lebanon (CARE)	Operational in Lebanon since 2006 and responding to the Syrian Crisis since 2012 in Beirut, Mount Lebanon, Akkar, North Lebanon, South Lebanon, and the Beqaa Valley. Implements emergency and development projects on livelihood, food security, protection, gender, shelter, and WASH benefiting both host and refugee communities.
	Heartland Alliance International (HAI)	Provides services to vulnerable populations affected by the Syrian refugee crisis including women and girls, LGBTI individuals, and survivors of GBV, torture and trauma. Works on psychosocial support, violence prevention, livelihoods strengthening and social cohesion. Partners with local actors to build capacity on GBV.
NATIONAL NON-GOVERNMENTAL ORGANIZATION'S WORKING ON GBV	ABAAD Resource Centre for Gender Equality	One of the largest and well-known national organization that aims to achieve gender equality in the MENA region. Member of the GBV Task force since 2012 and the core group, GBV Information Management System and the Clinical Management of Rape (CMR) task force. Co-chair of the National Technical Task Force to End GBV against Women and Girls, alongside MOSA since 2012. Provides holistic protection and support services to GBV survivors, conducts research and advocates for policy change.

CATEGORY OF STAKEHOLDER	ACTOR / ORGANIZATION	DESCRIPTION AND SUMMARY OF ROLE AND RESPONSIBILITIES IN THE GBV SECTOR
	KAFA (enough) Violence & Exploitation	Established in 2005, non-governmental, non-profit, feminist, and secular organization. Aims to eliminate GBV and exploitation and to realize gender equality through: law reform, introduction of new laws and policies, public advocacy and social change, conducts research and training, and provides social, legal, and psychological support for women and children victims of violence. Member of the GBV Task force since 2012 and the core group, GBV Information Management System and the Clinical Management of Rape (CMR) task force.
	The Lebanese Council to Resist Violence Against Woman (LECORVAW)	Established in 1997 by a group of social activists, operating in Beirut since 1997 and in Tripoli since 1999. NGO working for the purpose of fighting and resisting all forms of GBV in Lebanon. Operates Listening and counselling centres in Beirut and Tripoli providing GBV survivors with free social, mental and legal services.
	Helem	Works to empower young LGBTIQ+ leaders and to create a community that leverages its diversity as strength. Resists arrests and reduces the harm caused by discrimination, empower through education and mobilize to change policies and practices denying full equality and reducing quality of life.
	Lebanese Women Democratic Gathering (RDFL)	Non-governmental women organization Promotes women's status, participation and empowerment, aiming to achieve full equality
	Makhzoumi Foundation	National, private, not-for-profit NGO, established in Lebanon in 1997 Provide CMR and Case Management for GBV survivors
CIVIL SOCIETY AND LOCAL ORGANIZATION'S WORKING ON GBV	Basmeh & Zeitooneh	Operational since September 2012 in areas with high concentrations of the most marginalized Syrian refugees. In February 2014 became an officially registered organization. Serves approx. 17,214 Syrian refugees, across community centers in Burj Al Barajneh, Tripoli, Nabaa and the Bekaa Valley.
	Lebanese Association for Self-Advocacy (LASA)	Since 2009, has been working in collaboration with local, regional and international NGOs on the implementation of the Convention on the Right of Persons with Disabilities
	Najdeh	Secular feminist organization founded in 1976 at the beginning of civil war and was registered in 1978 as an independent NGO. Works mainly with Palestinian refugee women and girls, and other poor communities who live in camps.
	Sawa for Development and Aid	CSO founded in December 2011 to respond to the arrival of the first Syrian refugees in North Lebanon. Grew to include individual activists, locals and internationals, who worked together to share knowledge and exchange experiences in order to support Syrians, internally displaced or refugees in neighbouring countries.
	Akkar Network For Development (AND)	Lebanese NGO works with civil society, local authorities and Akkar community to implement projects, including GBV, and ensure the creation of a development policy for Akkar.
	Fe-Male	Feminist CSO working with women and girls to eliminate injustice.

CATEGORY OF STAKEHOLDER	ACTOR / ORGANIZATION	DESCRIPTION AND SUMMARY OF ROLE AND RESPONSIBILITIES IN THE GBV SECTOR
		Building a young feminist movement, empowering agents of change, and campaigning against discriminatory norms and policies.
	MENA Organization for Services, Advocacy, Integration and Capacity building (MOSAIC)	Founded by LGBTIQ activists and legal and health experts, works with LGBTIQ individuals in Lebanon and beyond. Provides comprehensive services for LGBTIQ persons, research and advocate for policy reform, build knowledge and capacities, and combat homophobia.
	Women Now for Development Syrian Organization	Women`s organization established in Syria and now working within Lebanon. Operates through Centres for Women's empowerment, providing activities that serve as a safe space for women and girls. Offer a variety of services, including focused and specialised psychosocial support services, case management and other protection programmes and educational, vocational and leadership training to women.
	Tabitha	Local Lebanese CSO, registered in Beirut since 2016. Implementing a community-based protection program as well as projects with gender or child-focus in Beirut, Mt. Lebanon, and in Batroun, North governorates. Participates in local NGO coordination mechanism and UN-led coordination mechanism at governorate and national levels.
ACADEMIC INSTITUTIONS WORKING ON GBV	The Arab Institute for Women (AiW) at The Lebanese American University	A leading institution working for the advancement of women and the promotion of gender equality in the Arab world. Advancing gender equality and empowering women through a combination of education, research, development programs and outreach with a focus on issues affecting Arab women. Conducts and supports academic research on women in the Arab world, and partners with several organizations to deliver development programs to promote gender equality, empower women, and serve as a catalyst for policy change on women's rights.
	American University Beirut	Engaged in research and knowledge production on GBV to advocate for policy change, in addition to the provision of support to the government.

*This list is not exhaustive. Information was extracted from websites and various policy documents and publications and augmented with data gathered during interviews and meeting observations.

ANNEX 4: TOPIC GUIDES FOR IN-DEPTH SEMI-STRUCTURED INTERVIEWS AND STRUCTURED OBSERVATIONS

Qualitative Interview Guides

Objective: To gather information on the evolution of the Gender-based violence (GBV) coordination system in Lebanon's humanitarian response

The interview topic guides are structured as follows:

1. Individuals involved in development of the GBV Coordination Mechanism since 2011 - Evolution of the GBV Coordination mechanism
2. Individuals currently involved in GBV Coordination – UN and iNGO Humanitarian actors, Government, National NGO's, Research Institutes
3. Government and Humanitarian Actors in other sectors of the Response
4. National and Local Actors working on GBV and Gender issues

Introduction to participants:

Hello and thank you for your time. My name is Philomena Raftery and I am a DrPH candidate at the London School of Hygiene and Tropical Medicine and I am collecting information for a research project I am doing for my programme.

All the information and recordings collected for this research project will be kept confidential and I will not share it with anyone else. I will not use your name or job title in any reports from this study. However, I may use direct quotations in the reports and it is possible that people familiar with this setting may be able to identify you by role/type of organization. If you prefer to keep your answers fully anonymous, please let me know. None of the quotes will be attributed to you but if there is a risk that you could be identified by a quotation I will re-contact you to get additional consent to use the quote.

Please refrain from stating any sensitive information or any information that may identify specific incidents/individuals. All information discussed will be kept confidential and should not be disclosed to anyone.

Do you have any questions from the Information Sheet or Consent Form? About this research project?

Remember, you are free to decline to answer any of the questions or stop the interview at any time.

Topic Guide 1: Individuals involved in Development of the GBV Coordination Mechanism since 2012

Evolution of the GBV Coordination mechanism

I would like to start by asking you a few questions about how the GBV coordination system works in Lebanon.

1. Briefly describe your role and responsibilities within the GBV Coordination mechanism.
2. Can you describe the GBV coordination mechanism for the humanitarian response in Lebanon? Who are the main agencies and actors?
    a. Prompt: National and Field level, Inter-sectorial coordination, role of National Government, Key actors and stakeholders
    b. How was it initially set up and how has it changed over the course of the protracted crises?
3. What are the different levels of coordination – National, Field level and what are the different roles and responsibilities at each level?
    a. Who are the key players at each level?
4. Can you identify any key milestones and events which significantly influenced how the GBV coordination mechanism developed in Lebanon?
5. Can you think of any innovative solutions that were created to support GBV coordination?
6. How does this GBV coordination mechanism compare with or differ from those in other contexts where you have worked?
    1. Prompt: Urban response, Protracted crisis, no camp policies
7. Do you have any examples of policy decisions which influenced the GBV coordination mechanism over the course of the response? Prompt: Call to Action, Repeal of rape law and Grand Bargain

Context – Stakeholders

8. Who are the actors (local, national and international) and stakeholders working on GBV and involved in the coordination mechanism in Lebanon
    a. Can you identify "GBV champions" over the course of the response?
9. Who have been key leaders in the GBV response? How have they influenced the evolution of the GBV coordination mechanism in Lebanon? (national, international levels)
    a. What has been the role of the National Government in GBV humanitarian response in particular?
10. Who are the key external stakeholders? How does the GBV coordination mechanism interact with the Broader humanitarian response actors & other sectors and National Government
11. What, if any, do you see as external factors which may impact the success of the GBV coordination system?
    a. Prompt: Political will, Government and Humanitarian Policies, Donor priorities, Access to resources

Localization

12. What is the role of National NGO's, Local Actors and civil society in the GBV coordination mechanism in Lebanon?
13. What, if any, is the role of refugee committees and women's movement groups in the GBV coordination mechanism in Lebanon?

14. How were local organizations engaged in planning to ensure existing local strategies were strengthened and not undermined.
15. Were local organizations involved in assessments and needs/gap analysis and priority setting?
16. Working with local actors are they real partnerships or just cosmetic for funding purposes?
17. How do you support and build capacity of these local organizations?
18. What assessments were performed at early stages – was GBV considered in multi sector rapid needs assessments?
    a. Were local organizations involved in assessments and needs/gap analysis and priority setting?

Field-level Implementation - Tracer Services

19. What services were offered at beginning and how did that change over time?
20. Who is implementing which services? Names of organizations.
21. Was service mapping performed in early stages and regularly updated?
22. At what stage were SOP's and referral pathways developed?
23. How does or does not GBV coordination translate into field-level implementation?

Prioritization

24. Can you describe how the GBV response has been prioritized and mainstreamed within the Humanitarian response in Lebanon?
    a. What factors do you believe influenced how each humanitarian sector prioritised GBV response?
25. Describe the national GBV prevention and response policy context in Lebanon's humanitarian response?
    a. How do you think this influences, if at all, how GBV is prioritized and addressed in the Humanitarian response in Lebanon?
26. Describe the cultural context concerning GBV prevention and response in Lebanon at the national level. How do you think this may influence how GBV is prioritized and addressed in the humanitarian response?
        i. Prompt: cultural practices, social norms, harmful gender practices, human rights, women's rights, child rights

Integration and Mainstreaming

27. What are the key sectors the GBV coordinators work with? What does this work involve?
28. What influences how is GBV integrated and mainstreamed by other sectors?
29. How does the context - political discourse, policies, social and cultural norms - influence integration of GBV in the humanitarian coordination system in Lebanon?
    a. Please tell me about the roll-out of the 2015 GBV Guidelines. Has this affected how GBV is addressed in humanitarian response? If yes, how?
30. What have been barriers, if any, to GBV integration into humanitarian coordination system to date?
    a. How can these been overcome?

Political unrest and Beirut blast

31. How has the recent political unrest in Lebanon and the Beirut blast impacted your work?
32. How are coordination mechanisms being adapted in response to the emergencies?
    a. Has this negatively affected your work?

COVID-19 Pandemic

33. How has the covid pandemic impacted your work?
34. How are coordination mechanisms being adapted in response to the pandemic?
    a. Has this negatively affected your work?

Future Direction

35. Do you believe sustainability is being addressed in relation to the continuation of GBV programmes and coordination in the protracted crisis?
36. How do you think sustainability of GBV programs and coordination structures can be built in the protracted crisis?
    a. Probe: Resource allocation, Donor prioritization, Partnership with Local Actors
37. What if anything needs to change with the current system to ensure sustainability in the protracted crisis?
    a. What if anything already has changed?

Conclusion

38. What are the strengths, if any, of the existing GBV coordination model in the current protracted crisis?
39. What could improve the existing GBV coordination mechanism in Lebanon?
40. What important lessons could we learn and apply to other contexts?
41. Do you have anything else to add? Suggestions? Recommendations?
42. Are there other individuals or organizations you can suggest I speak with regarding the GBV coordination mechanism in Lebanon?

Topic Guide 2: Those currently involved in GBV Coordination – UN and iNGO Humanitarian actors, Government, National NGO's, Research Institutes

I would like to start by asking you a few questions about how the GBV coordination system works in Lebanon.

1. Briefly describe your role and responsibilities within the GBV Coordination mechanism.

Context – Stakeholders, Partnerships and Policy Context

2. Can you describe the GBV coordination mechanism for the humanitarian response in Lebanon? Who are the main agencies and actors?
3. What are the different levels of coordination – National, Field level and what are the different roles and responsibilities at each level?
    a. Who are the key players at each level?
4. Describe the GBV Policy Context in relation to the GBV coordination system in Lebanon
   Prompt: Key policies, guidelines, frameworks, Political will
5. What has been the role of the National Government in the response? In GBV in particular?
6. What is the role of each of the following the GBV coordination mechanism in Lebanon?
    a. National NGOs
    b. Local Actors
    c. Civil society
    d. community-based organizations
    e. refugee groups or women's groups
    f. political movement groups
7. What challenges does your organization experience operating in this context?
   Prompt: Urban context, protracted crisis, no-clusters
8. Would you describe the environment as enabling for innovation for GBV response?
9. What do you see as the external factors which may impact (barriers/enablers) the success of the GBV coordination?
10. How would you describe the leadership style used within the GBV Coordination mechanism?
    a. How do you think this influences the success of the coordination?
    b. How are priorities agreed?
    c. How are decisions made on GBV prioritization and integration?
    d. How are collective outcomes agreed and how often is strategic planning updated?
11. How does the GBV coordination mechanism in Lebanon compare or differ from other contexts in which you have worked?

Resources and information

12. Are GBV coordination resources sufficient in this protracted crisis?
    a. Funding?
    b. Technical resources?
    c. Human resources?
    d. Time?
13. Briefly describe how resources are mobilized and distributed within the GBV coordination system
14. What and how is GBV information is generated, managed and communicated? How?
15. How is information and evidence used to inform the functioning GBV coordination system and prioritization and integration of GBV programs?
16. Would you describe the flow of GBV coordination communication as bottom-up or top-down?

Localization

17. What is the role of National NGO's, Local Actors and civil society in the GBV coordination mechanism in Lebanon?
18. What, if any, is the role of refugee committees and women's movement groups in the GBV coordination mechanism in Lebanon?
19. How are local organizations engaged in planning to ensure existing local strategies were strengthened and not undermined.
20. Are local organizations involved in assessments and needs/gap analysis and priority setting?
21. Working with local actors are they real partnerships or just for funding purposes?
22. How do you support and build capacity of these local organizations?

Field-level Implementation - Tracer Services

23. What services are available at field level?
24. Who is implementing which services? Names of organizations.
25. How does or does not GBV coordination translate into field-level implementation?
26. What, if any, results of GBV coordination in field level implementation are you aware of?
    a. If yes, are there relevant reports or other documents you could share with me?

Prioritization and Integration

27. Would you say that GBV is prioritized within the broader humanitarian response and what factors influence this?
28. Who sets the GBV priorities within the GBV coordination mechanism and the wider Humanitarian response?
29. What strategies are being used to integrate and mainstream GBV within the Humanitarian response
    a. What frameworks and guidance do you use for integration of GBV and how are humanitarian actors held accountable?
    b. Please tell me about the roll-out of the 2015 GBV Guidelines. Has this affected how GBV is addressed in humanitarian response? If yes, how?

Behaviours

30. How would you describe the values and culture within the GBV coordination mechanism? Prompt: Trust, shared values
31. How would you describe how colleagues within the GBV coordination mechanism interact with one another?
    a. How would you describe the organizational culture of your organization?
    b. How would you say this fits with the culture of the GBV Coordination mechanism?
    c. In your role, do you every experience tension between competing priorities of the GBV Coordination mechanism and your own organization?
    d. How do you think this may or may not influence GBV coordination?
32. How would you describe the range of skills and competencies within the GBV Coordination mechanism?
    a. Are they adequate for the needs?

Political unrest and Beirut blast

33. How has the recent political unrest in Lebanon and the Beirut blast impacted your work?
34. How are coordination mechanisms being adapted in response to the emergencies?
    a. Has this negatively affected your work?

COVID-19 Pandemic

35. How has the covid pandemic impacted your work?

36. How are coordination mechanisms being adapted in response to the pandemic?
    a. Has this negatively affected your work?

Future Direction

37. Do you believe sustainability is being addressed in relation to the continuation of GBV programmes and coordination in the protracted crisis?
38. How do you think sustainability of GBV programs and coordination structures can be built in the protracted crisis?
    Probe: Resource allocation, Donor prioritization, Partnership with Local Actors
39. What if anything needs to change with the current system to ensure sustainability in the protracted crisis?
    a. What if anything already has changed?

Conclusion

40. What are the strengths, if any, of the existing GBV coordination model in the current protracted crisis?
41. What could improve the existing GBV coordination mechanism in Lebanon?
42. What important lessons could we learn and apply to other contexts?
43. Do you have anything else to add? Suggestions? Recommendations?
44. Are there other individuals or organizations you can suggest I speak with regarding the GBV coordination mechanism in Lebanon?

Topic Guide 3: Government, Donors. and Humanitarian Actors in other sectors of the Response

I would like to start by asking you a few questions about how the Humanitarian coordination system works in Lebanon.

1. Briefly describe your role and responsibilities within the Humanitarian Coordination mechanism.
    a. How long has your organization been working on the response in Lebanon?
    b. Briefly describe how your work has changed over the course of the response?
2. Can you describe the coordination mechanism for the humanitarian response in Lebanon? Who are the main agencies and actors?
3. What are the roles of the different organizations? National and Field level, Inter-sectorial coordination, role of National Government, Key actors and stakeholders
4. Briefly describe the governance structure of the Humanitarian response. How does GBV fit within this governance structure?

Prioritization and resources

5. Do you participate in the humanitarian coordination mechanism in Lebanon?
    a. When was the last time you attended a meeting?
6. Briefly describe your role and your involvement with the GBV coordination system.
    a. Describe your organizations relationship or involvement with the GBV coordination system.
7. How does your organization consider and address GBV as a priority in the response
    a. If not why not?
    b. If yes, please provide examples to demonstrate this
    c. What frameworks and guidance do you use for integration of GBV and how are humanitarian actors held accountable?
8. How does the GBV coordination mechanism in Lebanon compare or differ from other contexts in which you have worked?
9. Is GBV adequately funded compared with the overall response?
    a. How could this be improved?

Integration and Mainstreaming

10. What do you see as the external factors which may impact the success of the GBV coordination system in Lebanon?
    a. Probe: political, policy, access to resources
11. What are the contextual challenges of addressing GBV in the humanitarian response in Lebanon?
    a. Probe: Urban setting, protracted crisis

Localization

12. What is the role of National NGO's, Local Actors and civil society in the GBV coordination mechanism in Lebanon?
13. Are local organizations engaged in planning, assessments and needs/gap analysis and priority setting?
14. When working with local actors are they real partnerships or just cosmetic for funding purposes?
15. How do you support and build capacity of these local organizations?

Field-level Implementation - Tracer Services

16. What services does your organization provide?

17. Do you think coordination translates into results at field level for GBV response?
    a. If yes, do you have any examples you could tell me about?
    b. If no, why not?
18. What could be improved in terms of support to improve and sustain the delivery of integrated GBV services at the field level?

Political unrest and Beirut blast

19. How has the recent political unrest in Lebanon and the Beirut blast impacted your work?
20. How are coordination mechanisms being adapted in response to the emergencies?
    a. Has this negatively affected your work?

COVID-19 Pandemic

21. How has the covid pandemic impacted your work?
22. How are coordination mechanisms being adapted in response to the pandemic?
    a. Has this negatively affected your work?

Future Direction

23. Do you believe sustainability is being addressed in relation to the continuation of GBV programmes and coordination in the protracted crisis?
24. How do you think sustainability of GBV programs and coordination structures can be built in the protracted crisis?
    a. Probe: Resource allocation, Donor prioritization, Partnership with Local Actors
25. What if anything needs to change with the current system to ensure sustainability in the protracted crisis?
    a. What if anything already has changed?

Conclusion

26. What are the strengths, if any, of the existing GBV coordination model in the current protracted crisis?
27. What could improve the existing GBV coordination mechanism in Lebanon?
28. What important lessons could we learn and apply to other contexts?
29. Do you have anything else to add? Suggestions? Recommendations?
30. Are there other individuals or organizations you can suggest I speak with regarding the GBV coordination mechanism in Lebanon?

Topic Guide 4: National and Local Actors working on GBV and Gender issues in Lebanon

I would like to start by asking you a few questions about your work and how the GBV coordination system works in Lebanon.

1. Briefly describe your work and role in supporting the GBV and humanitarian response in Lebanon.
2. How long has your organization been working on the response in Lebanon?
3. Briefly describe how your work has evolved over the course of the response?
    a. Probe: Urban setting, protracted crisis

Context – Stakeholders, Partnerships and Policy Context

4. What support , if any, does your organization receive from the GBV coordination system?
5. What, if any, support do you receive in your role, from the GBV coordination system?
    a. Probe: Trainings, meetings, resources (technical, financial, human, logistical, operational, time)
6. If you receive support in your role from the GBV coordination system, what do you think of that support?
        i. Probe: positive versus negative aspects of that support
7. Have you partnered with any International agency or received funding for your work on GBV response?
    a. If so, in your opinion was this a real partnership or more cosmetic for funding purposes?
    b. How could this be improved?
8. What do you see as the external factors which may impact the success of the GBV coordination system in Lebanon?
    a. Probe: political, policy, access to resources
9. What are the contextual challenges of addressing GBV in the humanitarian response in Lebanon?
    a. Probe: Urban setting, protracted crisis
10. Do you work with the government, if so how do you find that relationship?

Localization

11. What is the role of National NGO's, Local Actors and civil society in the GBV coordination mechanism in Lebanon?
12. What, if any, is the role of refugee committees and women's movement groups in the GBV coordination mechanism in Lebanon?
13. Are local organizations engaged in planning, assessments and needs/gap analysis and priority setting?
14. When working with local actors are they real partnerships or just for funding purposes?
15. How do international actors support and build capacity of these local organizations?

Field-level Implementation - Tracer Services

16. Do you think coordination translates into results at field level for GBV response?
    a. If yes, do you have any examples you could tell me about?
    b. If no, why not?
17. What could be improved in terms of support to improve and sustain the delivery of integrated GBV services at the field level?

Prioritization

18. Do you participate in the humanitarian coordination mechanism in Lebanon?
    a. When was the last time you attended a meeting?
19. Briefly describe your role and your involvement with the GBV coordination system.

    a. Describe your organizations relationship or involvement with the GBV coordination system.
20. How does your organization consider and address GBV as a priority in the response

Political unrest and Beirut blast

21. How has the recent political unrest in Lebanon and the Beirut blast impacted your work?
22. How are coordination mechanisms being adapted in response to the emergencies?
    a. Has this negatively affected your work?

COVID-19 Pandemic

23. How has the covid pandemic impacted your work?
24. How are coordination mechanisms being adapted in response to the pandemic?
    a. Has this negatively affected your work?

Future Direction

25. Do you believe sustainability is being addressed in relation to the continuation of GBV programmes and coordination in the protracted crisis?
26. How do you think sustainability of GBV programs and coordination structures can be built in the protracted crisis?
    a. Probe: Resource allocation, Donor prioritization, Partnership with Local Actors
27. What if anything needs to change with the current system to ensure sustainability in the protracted crisis?
    a. What if anything already has changed?

Conclusion

28. What are the strengths, if any, of the existing GBV coordination model in the current protracted crisis?
29. What could improve the existing GBV coordination mechanism in Lebanon?
30. What important lessons could we learn and apply to other contexts?
31. Do you have anything else to add? Suggestions? Recommendations?
32. Are there other individuals or organizations you can suggest I speak with regarding the GBV coordination mechanism in Lebanon?

Topic Guide 5: Those involved in Global and Regional GBV Coordination

I would like to start by asking you a few questions about how the GBV coordination system works in the Region.

1. Briefly describe your role and responsibilities within the GBV Coordination mechanism.
2. Can you describe the GBV coordination mechanism for the humanitarian response in the MENA? Who are the main agencies and actors?
    a. How was it initially set up and how has it changed over the course of the protracted crises?
    b. Regional Coordination for WoS
3. What are the different levels of coordination – National, Field level and what are the different roles and responsibilities at each level?
    a. Who are the key players at each level?
4. How does each level coordinate and communicated with the other?
5. As Regional coordinator, do you work with Lebanon at all?
    a. What does this work involve?
    b. What impact do you think this has at a local level?
6. How does this GBV coordination mechanism compare with or differ from those in other contexts where you have worked?
        i. Prompt: Urban response, Protracted crisis, no camp policies
7. What has been the role of the National Government in GBV humanitarian response in particular?
8. What is the role of National NGO's, Local Actors and civil society in the GBV coordination mechanism?
9. Describe the impact of Global GBV initiatives such as the call to action and New way of working on country level
    a. Do you have any examples of policy decisions which influenced the GBV coordination mechanism over the course of the response? Prompt: Call to Action and Grand Bargain

Prioritization and Integration

10. Would you say that GBV is prioritized within the broader humanitarian response and what factors influence this?
    a. Prompt: Humanitarian organizational cultures
11. What strategies are being used to integrate and mainstream GBV within the Humanitarian response
12. Describe the cultural context concerning GBV prevention and response. How do you think this may influence how GBV is prioritized and addressed in the humanitarian response?
    a. Prompt: cultural practices, social norms
13. What information is generated, managed and communicated? How?
    a. How is information and evidence used to inform the functioning GBV coordination system and prioritization and integration of GBV programs?
    b. Would you describe the flow of GBV coordination communication as bottom-up or top-down?

Localization

14. What is the role of National NGO's, Local Actors and civil society in the GBV coordination mechanism in Lebanon?
15. In your experience working with local actors are they real partnerships?

Field-level Implementation - Tracer Services

16. What services are available at field level?
17. Who is implementing which services? Names of organizations.
18. How does or does not GBV coordination translate into field-level implementation?
19. What, if any, results of GBV coordination in field level implementation are you aware of?
    a. If yes, are there relevant reports or other documents you could share with me?

Resources and Future Direction

20. Are GBV coordination resources sufficient in this protracted crisis?
    a. Briefly describe how resources are mobilized and distributed within the GBV coordination system
    b. How can mechanisms be more sustainable? Probes: innovation, multi-year funding, ...
21. Is sustainability being addressed in the protracted crisis?
    a. If yes, how is it being addressed?
    b. Prompt: Strengthening collaborations and partnerships, Building partnerships with local and national actors and organizations, academic institutions for research
22. How do you think sustainable GBV programs and coordination structures can be built in the protracted crisis?
    a. Probe: Resource allocation, Donor prioritization, Partnership with Local Actors
23. What if anything needs to change with the current system to ensure GBV response sustainability in the protracted crisis?
    a. What if anything already has changed?

COVID-19 Pandemic

24. How has the covid pandemic impacted your work?
25. How are coordination mechanisms being adapted in response to the pandemic?
    a. Has this negatively affected your work?

Conclusion

26. What important lessons could we learn and apply to other contexts?
27. Do you have anything else to add? Suggestions? Recommendations?
28. Are there other individuals or organizations you can suggest I speak with regarding the GBV coordination mechanism in Lebanon?

Qualitative Observational Guide

Objective: To gather information on the evolution of the Gender-based violence (GBV) coordination system in Lebanon's humanitarian response

Introduction to participants (if possible):

Hello and thank you for your time. My name is Philomena Raftery and I am a DrPH candidate at the London School of Hygiene and Tropical Medicine and I am collecting information for a research project I am doing for my programme.

All the information and recordings collected for this research project will be kept confidential and I will not share it with anyone else. I will not use your name or job title in any reports from this study. However, I may use direct quotations in the reports and it is possible that people familiar with this setting may be able to identify you by role/type of organization. If you prefer to keep your answers fully anonymous, please let me know. None of the quotes will be attributed to you but if there is a risk that you could be identified by a quotation I will re-contact you to get additional consent to use the quote. If you refuse to be observed, I will stop taking notes during your participation in the meeting.

Please refrain from stating any sensitive information or any information that may identify specific incidents/individuals. All information discussed will be kept confidential and should not be disclosed to anyone. I will not record the meeting but I will make notes.

Do you have any questions from the Information Sheet or Consent Form? About this research project?
Remember, you are free to stop the observation at any time or to request that certain information be omitted from the observation field notes.

Title of Meeting being Observed: _____

Date: _____ **Time:** _____

Host Organizations: _____

Participant Organizations: _____

Key Discussions and Information shared

ITEM	*NOTES ON DISCUSSION OR OBSERVATION*
Key discussions/agenda points	
Information shared & flow	
Documents to review	
Coordination dynamics	
Key stakeholders	

GBV coordination discussions related to themes below

TOPIC / ISSUE	*NOTES ON DISCUSSION OR OBSERVATION*
Leadership	
Collaboration and partnerships	
Prioritization, resources and Funding	
Service delivery	
Risk mitigation	
Localization, role of national and local actors	
Data and information, GBVIMS	
Government involvement and sustainability	
Context - political discourse, policies, social and cultural norms	
GBV prevention	
Compounded crises	
COVID-19 pandemic	
Challenges experienced	
Solutions proposed	

ANNEX 5: EMAIL INVITATION SCRIPT FOR AMERICAN UNIVERSITY BEIRUT

AUB Social & Behavioral Sciences
INVITATION SCRIPT

Invitation to Participate in a Research Study

This notice is for an AUB-IRB Approved Research Study

for Dr._Jinan Usta_at AUB.

Family Medicine Department

It is not an Official Message from AUB

I am Doctorate of Public Health candidate studying (part-time) at London School. Of Hygiene and Tropical Medicine (LSHTM) and collaborating with American University Beirut (AUB) to collect data in Lebanon. I am inviting you to participate in my thesis research. The title of my study is "Exploring the evolution of the GBV coordination mechanism in Lebanon's humanitarian response".

I will be using Lebanon as a case study to look at what works and does not work for GBV coordination and how it impacts GBV service delivery. I am reaching out to you as someone who played a critical role in supporting the response so your experience and perspective would be invaluable.

Would you be willing to be interviewed as a participant for my research? If so, would you be available anytime over the coming weeks to do an interview via Zoom which would take approximately 45-60 minutes? If yes, please propose a date and time which would work for you, I will of course be flexible depending on your schedule.

I am attaching the participant information sheet and consent form for your information. You would be asked to review and sign the consent form prior to commencing the interview if you agree to participate. If you have any questions about this study, you may contact me on this email and my contact details are in my email signature below.

ANNEX 6: PARTICIPANT INFORMATION SHEETS

Participant Information Sheet – Interviews

I am a Doctor of Public Health (DrPH) research degree candidate at the London School of Hygiene and Tropical Medicine (LSHTM) and am collaborating with AUB. You are being invited to participate in a research project. Before you decide to take part, it is important for you to understand why the research is being done and what it will involve. Please ask me if there is anything that is not clear or if you would like more information.

Background:

This project forms the thesis component of my DrPH degree. The DrPH provides doctoral level training for future leaders in public health.

Study aim:

The aim of the study is to explore the Gender-based violence (GBV) Coordination mechanism for the humanitarian response in Lebanon. I will document how GBV was coordinated throughout the crisis. This will help to identify and recommend good and bad practice in GBV coordination and its impact on GBV work.

Study Objectives include:

1. To describe the GBV coordination mechanism for the humanitarian response in Lebanon and to explore how this evolved throughout the crisis
2. To look at what factors influence GBV coordination mechanism in Lebanon now and in the future
3. To identify good and bad policy and practice, and make recommendations for improving GBV coordination in other humanitarian settings

To do this, I will be interviewing approximately 40 individuals, including GBV coordinators, GBV programme managers, GBV and Humanitarian experts, policy makers, national field staff and other key stakeholders involved in GBV prevention and response in the humanitarian response in Lebanon. All interviews will be conducted remotely via zoom. I will be recruiting participants for the study through email and this will be approved as part of my ethics approval.

Your participation

Your participation in this study is entirely voluntary and is important to provide information on the GBV Coordination mechanism for the humanitarian response in Lebanon. The interview will last approximately 45 mins – 1 hour in a private setting where you are comfortable. If you agree, I would like to record the interview however if you do not agree to it being recorded, I will just take notes instead. You would be asked to review and sign the consent form prior to commencing the interview if you agree to participate.

How confidentiality will be ensured

All information and recordings collected in the research will be kept confidential and will not be shared with anyone else. Only the research team members will have access to the data. I will not use your name or job title when storing the data or in any reports or publications from this study. However, I may use direct quotations in the write-up and publications, and it is possible that people familiar with this setting may be able to identify you by role/type of organization. If you prefer to keep your answers fully anonymous, please let me know. Data will be monitored and may be audited by the IRB while assuring confidentiality.

What are the benefits?

The information collected in this interview can help to guide, plan and improve the coordination mechanism for the GBV response in Lebanon and other similar contexts. Although participating in this study is not directly beneficial to you, information gained from interviews will help to inform good practice in GBV coordination mechanisms in humanitarian response settings.

What are the risks?

This study involves minimal risk for you as a participant. You may decline to answer any questions that you are not comfortable answering. You may also decline to participate in the research project at any time. No statement made by you or information given will be held against you at any time. The information will remain confidential. You will not receive a financial or other type of reimbursement for taking part in the study. Refusal or withdrawal from the study will involve no loss of benefits to which you are otherwise entitled, nor will it affect your relationship with AUB/AUBMC or your organization.
A list of organizations that provide psychological support services in Lebanon, free to staff who do not have access to such services within their own organizations, is available. In the unlikely event that you require psychosocial support as a result of participating in this research, you will be referred (by the researcher or PI) for support to one of these services.

Ethical approval

This study will be approved by the LSHTM Research Ethics Committee and the AUB Research Ethics board (IRB). You may contact the AUB IRB in case of questions about rights or concerns about the study - irb@aub.edu.lb. You may contact the Principal Investigator at AUB, Dr. Jinan Usta, if you have any questions about the research study - ju00@aub.edu.lb.

Thank you for your time!

Participant Information Sheet – Meeting Observations

I am a Doctor of Public Health (DrPH) research degree candidate at the London School of Hygiene and Tropical Medicine (LSHTM) and am collaborating with AUB. You are being invited to participate in a research project. Before you decide to take part, it is important for you to understand why the research is being done and what it will involve. Please ask me if there is anything that is not clear or if you would like more information.

Background:

This project forms the thesis component of my DrPH degree. The DrPH provides doctoral level training for future leaders in public health.

Study aim:

The aim of the study is to explore the Gender-based violence (GBV) Coordination mechanism for the humanitarian response in Lebanon. I will document how GBV was coordinated throughout the crisis. This will help to identify and recommend good and bad practice in GBV coordination and its impact.

Study Objectives include:

4. To describe the GBV coordination mechanism for the humanitarian response in Lebanon and to explore how this evolved throughout the crisis
5. To look at what factors influence GBV coordination in Lebanon now and in the future
6. To identify good and bad policy and practice, and make recommendations for improving GBV coordination in other humanitarian settings

To do this, I will be conducting interviews remotely and also observing meetings via zoom. I will be recruiting participants for the study through email and this will be approved as part of my ethics approval. I intend to attend meetings for the GBV coordination and the humanitarian response at both national and field level. This will help me to understand the context and the stakeholders involved in GBV prevention and response in the humanitarian response in Lebanon. I will look at how GBV is addressed, prioritized and integrated in the response. I will also observe group interactions and discussions related to themes of leadership, collaboration, competition, communication, sharing of information, level of trust/distrust, power balance, learning and innovation. I will not make audio recordings of the meetings.

Your participation

Your participation in this study is entirely voluntary and is important to provide information on the GBV Coordination mechanism for the humanitarian response in Lebanon. If you agree, I would like to observe the meeting and take notes on my observations throughout. You may be asked to review and sign a consent form prior to commencing the meeting (in meetings with <10 participants) if you agree to participate. In meetings with >10 participants you will be ask to give verbal consent. If you refuse to be observed, I will stop taking notes during your participation in the meeting.

How confidentiality will be ensured

All information and notes collected in the research will be kept confidential and will not be shared with anyone else. I will not use names or job titles in any reports from this study. Only the research team members will have access to the data. Data will be monitored and may be audited by the IRB while assuring confidentiality.

What are the benefits?

The information collected in this study can help to guide, plan and improve the coordination mechanism for the GBV response in Lebanon and other similar contexts. Although participating in this study is not directly beneficial to you, information gained from observation of meetings will help to inform good practice in GBV coordination mechanisms in humanitarian response settings.

What are the risks?

This study involves minimal risk for you as a participant. You may decline to allow me to participate in the meeting at any time. No statement made by you or information given will be held against you at any time. The information will remain confidential. You will not receive a financial or other type of reimbursement for taking part in the study. Refusal or withdrawal from the study will involve no loss of benefits to which you are otherwise entitled, nor will it affect your relationship with AUB/AUBMC or your organization.

A list of organizations that provide psychological support services in Lebanon, free to staff who do not have access to such services within their own organizations, is available. In the unlikely event that you require psychosocial support as a result of participating in this research, you will be referred (by the researcher or PI) for support to one of these services.

Ethical approval

This study will be approved by the LSHTM Research Ethics Committee and the AUB Research Ethics board or IRB. You may contact the AUB IRB in case of questions about rights or concerns about the study - irb@aub.edu.lb. You may contact the Principal Investigator at AUB, Dr. Jinan Usta, if you have any questions about the research study - ju00@aub.edu.lb.

Thank you for your time!

ANNEX 7: CONSENT FORMS

CONSENT FORM – SEMI-STRUCTURED INTERVIEW

Title of Project: Exploring the evolution of the Gender-based violence (GBV) coordination system in Lebanon's humanitarian response

Principal Investigator and Local Advisor in Lebanon: Dr Jinan Usta, American University Beirut, Beirut, Lebanon.

E-mail: ju00@aub.edu.lb

Co-Investigator: Philomena Raftery, London School of Hygiene and Tropical Medicine, Keppel Street, London, UK.

Telephone and E-mail: Tel: +353834640877; Email: philomena.raftery@lshtm.ac.uk

I agree to take part in the study titled "Exploring the evolution of the Gender-based violence (GBV) coordination system in Lebanon's humanitarian response". I endorse the following by ticking the box against the entry.

I confirm that I have read, and that I understand, the Participant Information Sheet	
I understand that my participation is voluntary and that I can stop the interview at any time without giving a reason	
I understand that if I decide to stop the interview all data collected will be destroyed	
I agree to take part in the study	
I understand that recording the interview is optional. By ticking this box, I agree to have this interview recorded	
I understand that any quotations used in writing up the study findings will be used anonymously and I consent to this	
I give permission to be re-contacted for follow-up interview and clarification as necessary	

Participant **Researcher**

Name:_____ Name:_____

Signature:_____ Signature:_____

Date:_____ Date:_____

Consent to be obtained in two copies: 1 copy for participant; 1 for researcher.

CONSENT FORM – STRUCTURED OBSERVATION OF MEETINGS

Title of Project: Exploring the evolution of the Gender-based violence (GBV) coordination system in Lebanon's humanitarian response

Principal Investigator and Local Advisor in Lebanon: Dr Jinan Usta, American University Beirut, Beirut, Lebanon.

E-mail: ju00@aub.edu.lb

Co-Investigator: Philomena Raftery, London School of Hygiene and Tropical Medicine, Keppel Street, London, UK.

Telephone and E-mail: Tel: +353834640877; Email: philomena.raftery@lshtm.ac.uk

I agree to take part in the study titled "Exploring the evolution of the Gender-based violence (GBV) coordination system in Lebanon's humanitarian response". I endorse the following by ticking the box against the entry.

I confirm that I have read, and that I understand, the Participant Information Sheet	
I agree to allow the researcher to observe the meeting – (Insert Name and date of meeting)	
I understand that I can stop the researcher observations at any time without giving a reason or ask that certain information be omitted from the field notes and study	
By ticking this box, I agree to allow notes to be taken during the observation	
I understand that any quotations used in writing up the study findings will be used anonymously and I consent to this	
I give permission to be contacted for follow-up interview and clarification as necessary	

Participant **Researcher**

Name:_____ Name:_____

Signature:_____ Signature:_____

Date:_____ Date:_____

Consent to be obtained in two copies: 1 copy for participant; 1 for researcher.

ANNEX 8: COVID-19 IMPACT STATEMENT

Details on how disruption caused by COVID-19 has impacted the research
The COVID-19 pandemic had a significant impact on how I implemented this study and also on the timeline required for data collection with both positive and negative consequences which I summarize and reflect on here.

The process of obtaining local ethics approval was fraught with delays and challenges which I had to navigate. I submitted an ethics application to AUB in 2020 but experienced several delays with obtaining approval, due to COVID-19 pandemic and the compounded emergencies in Lebanon. The application required multiple reviews and resubmissions, including an AUB requirement to switch data collection to remote, due to the COVID-19 pandemic, all of which took considerable time and effort. The application was eventually approved in February 2021 and an amendment had to be submitted to LSHTM to align with the final AUB ethics approval. In February 2022, I also submitted study continuation reviews to both universities.

Due to the COVID-19 pandemic travel restrictions and social distancing measures, all data collection was conducted remotely. This likely limited access to key informants especially those working with local womens organizations at field level or those who did not speak English or have access to video conferencing software such as zoom. I believe that the remote nature of data collection also limited my access to government actors who were unresponsive to emails but may have been more responsive if I had been able to approach them in person. Although I attempted to contact several government officials during my field trip to Lebanon in 2022, I was still unable to get a response. This may also have been due to the fact that it was the week before the national general elections. Although I had initially planned to observe GBV coordination meetings at field level and meetings within other sectors this was not possible due to the remote nature of data collection and my inability to get the appropriate approvals to do so.

Positively, remote data collection also meant that the study could span a much longer period of time, two years, rather than limited to short field trips, as was initially planned. This also allowed me to study GBV coordination in a public health emergency within the context of a humanitarian response combining my two passions and areas of expertise.

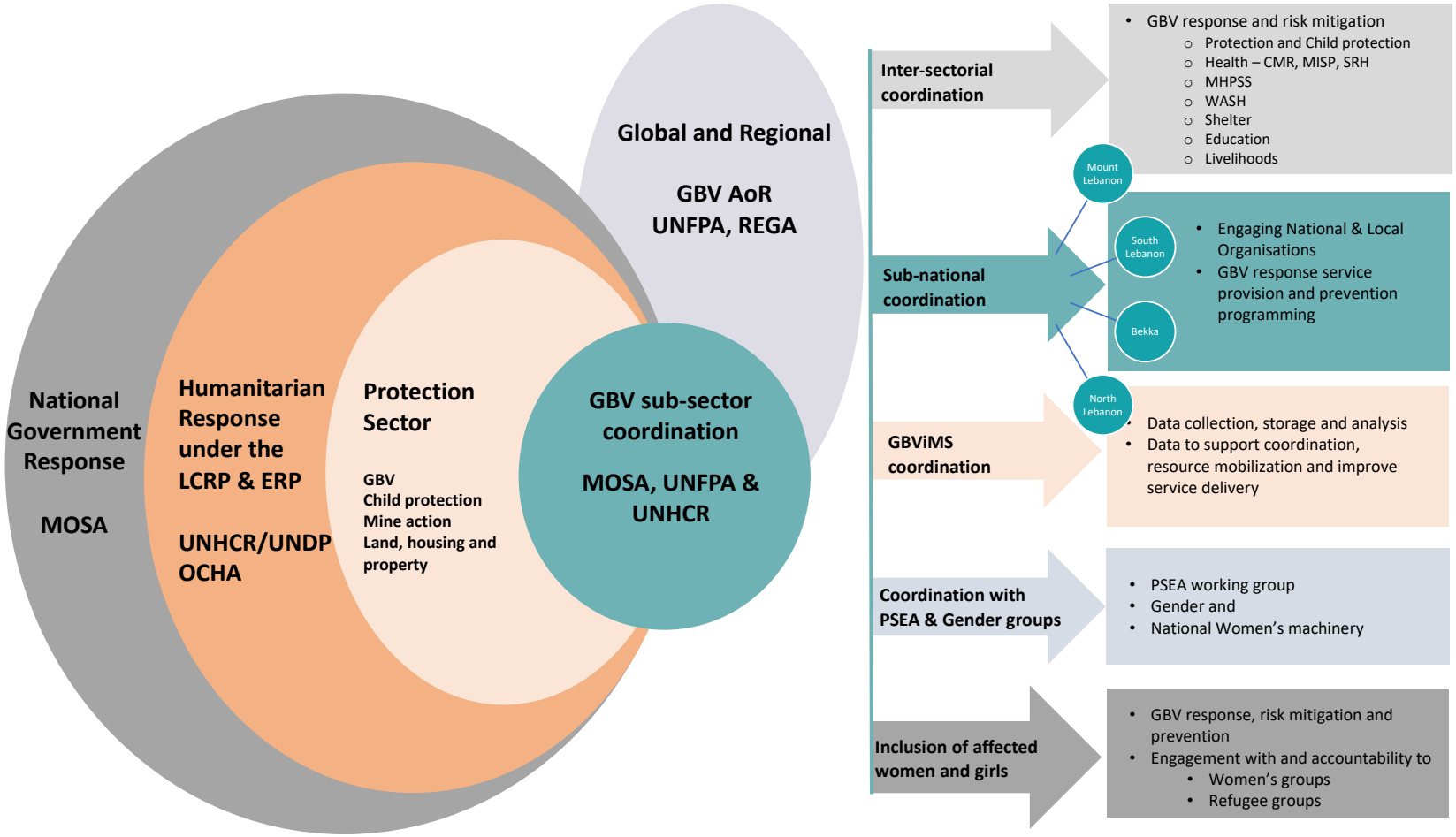
Description of how the planned work would have fitted within the thesis' narrative
The remote nature of meeting observation limited both my understanding of coordination dynamics, roles of different stakeholders and their levels of engagement in the task force. My ability to meet participants in-person following meetings to have follow-up discussions to gain clarity on issue observed or to engage certain actors in interviews was also limited by the remote nature of interactions. I believe that observing GBV coordination meetings at field level would have helped me to better understand coordination dynamics, roles of different stakeholders, and to contact more local organization's in the two field sites I included in the study.

Summary of any decisions / actions taken to mitigate for any work or data collection/analyses that were prevented by COVID-19
In early 2020, I moved from Sierra Leone to Cambodia and played a leading role in the COVID-19 response in Cambodia, which required long hours and was intensely stressful and prompted me to take an Interruption of studies for several months during 2020.

Before I began data collection in February 2021, my GBViE mentor, and the UNFPA GBV coordinator in Lebanon in 2020-21, provided an opportunity for me to present my research proposal to the GBV task force core group in Lebanon during which I got buy-in from different stakeholders on the value of the research and their willingness to participate.

Data verification proved to be an important part of this study to ensure that research findings were not only accurate but also practical and useful for the GBV task force in Lebanon, ensuring that I was providing some incentive and compensation for their greatly appreciated engagement. This experience also deepened my understanding of the Lebanese's context which was particularly important in the rapidly evolving and multiple layers of crises. In May 2022, I travelled to Lebanon to conduct a data verification workshop with the GBV task force and key informants who participated in the research. During the meeting I present my preliminary findings to the GBV task force and provided a forum for stakeholders to give feedback on the accuracy and completeness of my research findings. This field trip also allowed me to collect additional data and to fill gaps in my existing analysis and provided an opportunity to reflect on my findings in collaboration with key members of the GBV task force, some of whom had worked on the response since 2012, ensuring that my interpretations were validated and any gaps or uncertainties clarified. This field trip allowed me to meet with and get to know my Lebanon co-PI, the MOSA and UNFPA GBV coordinators and some of the GBV task force in person, including local and national actors and field coordinators who had participated in the research, which was very rewarding. It also gave people the opportunity to meet me and for me to express my deepest appreciation and gratitude for their incredible and inspiring work, and the support and engagement they had shown during my study. It also provided the opportunity to reiterate my ultimate objective for the research findings which was to provide practical recommendations that could add value to their work.

ANNEX 9: GRAPHIC REPRESENTATION OF THE GBV COORDINATION SYSTEM IN LEBANON



GBV AoR = GBV Area of Responsibility; UNFPA = United Nations Population Fund; REGA = Regional Emergency Gender Based Violence Advisor; UNHCR = United Nations High Commissioner for Refugees; OCHA = Office for coordination of humanitarian affairs; HC/HCT = Humanitarian coordinator/ Humanitarian country team; PSEA = Prevention of sexual exploitation and abuse; CMR = Clinical management of rape; MISP = Minimum initial service package; SRH = Sexual and reproductive health; LGBTIQ+ = Lesbian, Gay, Bisexual, Trans and gender diverse, Intersex, Queer and questioning.