Evaluation of the UNFPA response to the Syria crisis (2011-2018)

IRAQ COUNTRY NOTE

UNFPA Evaluation Office
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Acronyms

3RP	The Regional Refugee and Resilience Plan
ANC	Ante-natal care
ASRO	Arab States Regional Office
BEmOC	Basic Emergency Obstetric Care
BRHA	Board of Relief and Humanity Affairs
CDO	Civil Development Organization
CEmOC	Comprehensive Emergency Obstetric Care
CEFM	Child, Early and Forced Marriage
CLA	Cluster Lead Agency
CMR	Clinical Management of Rape
CO	Country Office
CPAP	Country Programme Action Plan
CPD	Country Programme Document
CSO	Civil Society Organisation
DCVAW	Directorate for Combatting Violence Against Women
DoH	Directorate of Health
EmOC	Emergency Obstetric Care
FGD	Focus group discussion
GBV	Gender-based violence
GBV AoR	Gender-based Violence Area of Responsibility
GBViE	Gender-based Violence in Emergencies
GBVIMS	Gender-based Violence Information Management System
GoI	Government of Iraq
GoS	Government of Syria
HCT	Humanitarian Country Team
HNO	Humanitarian Needs Overview
HQ	Headquarters
HRBA	Human-Rights Based Approach
HRP	Humanitarian Response Plan
IASC	Inter-Agency Standing Committee
IAWG	Inter-Agency Working Group
IM	Information Management
IMC	International Medical Corps
INGO	International Non-Governmental Organisation
IOM	International Organisation for Migration
IPV	Intimate partner violence
IRC	International Rescue Committee
ISG	International Solutions Group
ISIS	Islamic State of Iraq and Syria
ISP	Information sharing protocols
JCC	Joint Coordination Center
KRG	Kurdistan Regional Government
KRI	Kurdistan Region of Iraq
LGBT	Lesbian, Gay, Bisexual and Transgender
M&E	Monitoring and evaluation
MDGs	Millennium development goals
MISP	Minimum Initial Services Package
MMR	Maternal Mortality Rate
MNH	Maternal and new born health

MoH	Ministry of Health
MoI	Ministry of Interior
MOLSA	Ministry of Labor and Social Affairs
OCHA	Office for the Coordination of Humanitarian Affairs
PHC	Primary Healthcare Centre
PLWHA	People living with HIV and AIDS
PSEA	Prevention of Sexual Exploitation and Abuse
PNC	Post Natal care
PoA	Programme of Action
PwD	People with Disabilities
RC/HC	Resident Coordinator / Humanitarian Coordinator
RfP	Request for Proposals
RH	Reproductive Health
RO	Regional Office
SC	Sub Cluster
SDGs	Sustainable Development Goals
SGBV	Sexual and Gender-based violence
SOP	Standard Operating Procedures
SRH	Sexual and Reproductive Health
SRHiE	Sexual and Reproductive Health in Emergencies
SRHR	Sexual and Reproductive Health Rights
SSG	Strategic Steering Group
TFR	Total Fertility Rate
ToC	Theory of Change
ToT	Training of Trainers
UNDAF	United Nations Development Assistance Framework
UNCT	United Nations Country Team
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children Fund
WG	Working Group
WGSS	Women and Girl's Safe Space
WHO	World Health Organisation
WoS	Whole of Syria

Executive Summary

Since 2011 the ongoing and escalating crisis in Syria has had a profound effect across the region. By the end of 2017 13.1 million Syrian women, men, girls and boys were in need of humanitarian assistance, 6.1 million within Syria and seven million in surrounding countries. Close to three million people inside of Syria are in besieged and hard-to-reach areas, exposed to grave protection violations.[1] Iraq hosts approximately 250,000 Syrian refugees, with 97% of them within the Kurdistan Region of Iraq (KRI), 36% within nine refugee camps (in the KRI), the remainder within host communities.

Since 2011, the United Nations Population Fund (UNFPA) has been responding to the escalating crisis in Iraq – both the initial refugee response and encompassing the substantial humanitarian crisis brought on by the invasion of the Islamic State of Iraq and Syria (ISIS) into Iraq from 2014 to the current day. This crisis led to the displacement of over three million Iraqis across a wide swathe of the country, with the majority within the northern half.

Since the start of the Syrian crisis the UNFPA Iraq Country Office (CO) budget for refugee response has increased from $900,000 in 2012 to $1.9 million in 2017 (the budget for the response to the Internally Displaced Persons (IDP) crisis is substantially higher at approximately $50 million in 2017). The refugee response and IDP response programmes are run as two complementary programmes with some implementation, geographic and administrative overlap. To the extent possible, this evaluation report focuses on the UNFPA response to the Syrian refugee crisis within Iraq, and not the response to the Iraqi Internally Displaced Persons crisis.

UNFPA Iraq's refugee response concentrates on:

- Service Delivery: Sexual and Reproductive Health (SRH) Clinics (camp-based and mobile), Women and Girl's Safe Spaces (WGSS) and Youth Centres;
- Supplies: Maternity, Hygiene/Dignity Kits, Reproductive Health (RH) commodities;
- Capacity Building: On Clinical Management of Rape (CMR), Minimum Initial Service Packages (MISP), Emergency Maternal and Obstetric Care (EMOC), Psychosocial Support (PSS), Coordination and Standard Operating Procedures (SOPs);
- Empowerment: Skills Building and awareness raising.

UNFPA supports services in eight (of nine) camps specifically for Syrian refugees (that host 36% of refugees in Iraq), and also supports host community facilities – shared by refugees and IDPs.

The Iraq country office was re-established in 2011, moving from Amman, with the main office in Baghdad and a sub-office in Erbil (from where all refugee and IDP programming is administered) and further sub-offices in Sulaymaniyah (which has one refugee camp) and Dahuk (which has four refugee camps) governorates.

Findings

Relevance

1. To date, the refugee response has been relevant to the RH, Gender-Based Violence (GBV) and youth needs of Syrian refugees.

2. The assessments of needs that have taken place have been on the basis of comprehensive and ongoing interactions between UNFPA and refugees, communities, civil society, government and the humanitarian system.

3. The refugee response has been aligned with humanitarian principles of humanity, impartiality, neutrality and independence, and with international humanitarian law, international human rights law, and international refugee law.

4. While UNFPA was slow to start operations in response to the Syrian Refugee crisis in Iraq in 2011/2012, this was a reflection of both the prevailing sentiment among all stakeholders in Iraq (and the wider region), and of UNFPA's small capacity in-country at the time. While the UNFPA response has adapted over time to meet the changing circumstances and needs of Syrian refugee women and girls, much of the work is reflective of the current acute SRH and GBV needs and less so on worsening refugee household economic and resource constraints that are increasing vulnerability to adverse health and GBV outcomes.

5. UNFPA's assessment, management and coordination mechanisms in-country and linked to the wider regional response are adequate to ensure flexible and adaptive programming in line with needs and mandate.

6. UNFPA has effectively based its response on its comparative advantage in SRH and GBV expertise across refugee response programming.

Coverage

7. UNFPA's refugee response is focused on the areas with the highest *concentration* of Syrian refugees, i.e. 8 of the 9 dedicated refugee camps in the KRI, although they constitute only 36% of the refugee population in Iraq. Outside the camps, populations are distributed throughout the KRI (which has 97% of the countrywide refugees) and UNFPA is supporting these populations through support to dedicated activities (outreach, clinics, women's spaces) and through its support to IDPs within the KRI. This is an appropriate and effective targeting strategy.

[1] [1] UNOCHA; Also WoS HNO 2018

8. Focusing resources on refugee camps targets the most vulnerable refugees overall – as those within host communities typically have their own resources to rely upon. However, difficult economic circumstances in Iraq have resulted in depletion of resources, increasing vulnerability among refugees within host communities – some of which are now seeking to enter camps.

9. UNFPA-supported programming has limited focus on people with disabilities or other marginalised groups such as female-headed households.

Coordination

10. UNFPA is actively coordinating and leading GBV responses via the Erbil Sub-cluster (with IDP and refugee responsibilities) and Working Groups in Dahuk, Sulaymaniyah and Erbil, with particular focus on refugee issues at governorate Working Group (WG) level, although human resource gaps led to challenges in 2017/early 2018, and with the cessation of Norwegian Refugee Committee's (NRC) GBV programming UNFPA was the sole lead for some time, proving an additional coordination burden on staff.

11. RH coordination is integrated into the Health Cluster at national level and ad-hoc at subnational level, but functions well despite the ongoing and worsening resource limitations.

12. There is limited youth coordination as there is no Working Group. However, UNFPA has integrated coordination of youth programming effectively into GBV and SRH activities.

13. Although primarily (though not exclusively) related to the IDP response, UNFPA is taking a proactive role in the Protection from Sexual Exploitation and Abuse (PSEA) response mechanism (via the PSEA Taskforce). However, effective modalities of PSEA coordination are still being determined, with little clarity on responsibilities/functions, limited engagement of different stakeholders, and overall limited technical capacity to effectively address PSEA.

Coherence

14. Strategic plans for the IDP/refugee response promote SRH and GBV as life-saving, with UNFPA exercising a presence at the UN Country Team (UNCT) level. UNFPA also supports programming and engagement with the Government on GBV and SRH.

15. UNFPA's work demonstrates alignment with UNFPA's global mandate, the 3RP, Country Programme Plan (CPP), government priorities and international norms.

16. UNFPA is an active GBV Sub-Cluster lead, with good alignment of priorities, although as it is responsible for the majority of GBV funding and activities in the Iraq refugee response, this leads to a lack of diversity of voices.

Connectedness

17. UNFPA is committed to supporting government priorities and systems.

18. The substantial, and worsening, resource constraints that Iraq faces challenges integrating resilience and long-term development into refugee responses.

Efficiency

19. Resources for the Iraqi refugee response were efficiently mobilised via Headquarters (HQ) and the Amman Hub and continue to support programming, though a lack of multi-year funding is an ongoing challenge.

20. Strict disaggregation or separation of funding between IDPs and Refugees is burdensome, but donors have been flexible regarding complementary implementation, reflecting the realities on the ground.

21. Human and commodity resource procurement has been adequate, with greater delegation of authority to the CO proving useful.

22. UNFPA Iraq has progressively developed the quantity and quality of its systems and capacity for generation of evidence and data for communications, marketing and fundraising to a high standard, but outcome/impact data is still lacking.

23. UNFPA's partnership strategy is well grounded in the specific context of available implementing partners focussing on a capacity-building model that is building long-term sustainability of services for refugees as well as overall civil society within the KRI.

24. UNFPA maintains effective and appropriate partnerships with sister UN agencies.

Effectiveness

25. UNFPA has been, and continues to be, a key player in the delivery of quality SRH and GBV services for women, girls & youth in KRI refugee camps and host communities. However, specific, quantifiable outcomes of these important interventions cannot reliably be determined due to a lack of data.

26. While UNFPA's focus on building awareness of the dangers of early marriage is positive, there was little evidence of the effectiveness of this, and indeed economic constraints may be resulting in increases, particularly among population subgroups.

27. The modalities of operation – via a mix of civil society and government partnerships, promotes comprehensive and quality services.

28. While UNFPA has ensured coverage of SRH and GBV services among refugee populations, needs are increasing as resources diminish, thus it is not clear whether SRH and GBV risks are reducing and/or norms have changed.

Conclusions

A. UNFPA's refugee response programme, despite constituting only 5% of its overall humanitarian (refugee and IDP) portfolio in funding terms, is appropriately integrated with its IDP programming. This is true both for UNFPA supported direct programming and for UNFPA coordination responsibilities across SRH and GBV. UNFPA is managing this integration well, with no obvious major gaps in coverage for refugees, despite the much more sizable IDP response.

B. The refugee response operates closely with the Government of the KRI on the basis of a robust relationship with a high degree of direct support for government service provision, in the light of chronic resource constraints. This integration with government services is beneficial in terms of avoiding parallel systems and building long-term resilience and sustainability. However, the resource constraints, and the needs, are unlikely to diminish in the short term, and indeed international donor support for Iraq may well reduce in the coming years with the cessation of internal conflict. State services may find themselves increasingly constrained, leading to further shortages and resulting increasing demands on UNFPA as a provider of last resort.

C. UNFPA's partnership modalities with four main national NGO partners to implement GBV and youth services within camp settings has proven successful in terms of the depth and breadth of the services provided, and also in terms of the development of civil society within northern Iraq. While capacity-building of these partners is an ongoing process, they are largely satisfied with the relationship and partnership between themselves and UNFPA.

D. The refugee response was slow to start at the beginning of the crisis, due largely to a widespread underestimation of the scale and length of the crisis by all stakeholders. However, UNFPA has increased the scale of its work over the duration of the crisis and has embedded robust systems and learned from the lessons of the early years. However, systems insufficiently track outcome/impact data to adequately demonstrate the results of UNFPA's work.

E. UNFPA has largely held closely to its organisational mandate within Iraq, although there are opportunities to reflect on this and refocus, for example with respect to the introduction of men's spaces/men's centres in camps – arguably a departure from best practice in GBV prevention, and with respect to UNFPA's role on the PSEA Task Force.

F. UNFPA's leadership of the GBV Sub-Cluster/WGs and RH Working Group has received mixed reviews by other members and stakeholders. While variations in human resource capacity/availability over the course of the entire response period led to occasional challenges within these groups, UNFPA has consistently sought to address the challenges by filling coordination roles and ensure increasingly smooth coordination and leadership year-on-year.

G. Despite efforts to boost human resources, double/triple hatting is a notable feature of work in Iraq, to the extent of becoming normalised. Such a practice absorbs any reserve human resources capacity within the CO and has exacerbated coordination bottlenecks due to staff absences or turnover.

H. The programming and services that UNFPA supports play a vital role in maintaining the health and welfare of refugees in northern Iraq. While the KRI government's policy of welcoming Syrian refugees, and the social cohesion within the KRI that facilitates their integration into Kurdish society, has played an important part in underpinning their welfare within Iraq, UNFPA, via its partners, has provided a range of services, particularly for those refugees in camps (and hence the most economically vulnerable).

I. Despite UNFPA's good performance relative to its size and resources, limitations in services still exist. In terms of SRH, pre and post-natal care in some of the camps (particularly those located some distance from urban centres). Further, Government of KRI resource constraints are resulting in limitations in availability of medications/supplies.

J. Worsening economic conditions in Iraq and insufficiently comprehensive livelihoods support (for which sister UN agencies bear more responsibility than UNFPA) means that income generating opportunities for refugees are increasingly limited. This has a clear link to GBV.

Suggestions for Recommendations

A. The poor economic environment in the KRI is leading to chronic public service provision shortages and increasing poverty among refugees, many of which have depleted their economic reserves and run the risk of engaging in negative coping strategies. UNFPA should prepare for this eventuality and increasing calls as the provider of last resort for SRH and GBV services. A potential strategy may be the use of health vouchers for emergency cases to private healthcare providers or working with other agencies for cash supports and development of resource-poor strategies.

B. UNFPA Iraq should seek to deepen its engagement with the root causes of GBV, potentially via additional non-governmental organisation (NGO) partnerships. A limited amount of livelihoods work supported among camp inhabitants does not appear to have had significant economic benefits. Economic hardship was the most significant development issue noted amongst interviewees for this research. Economic deprivation impacts GBV incidence and the ability to access alternative sources of healthcare in the face of public service shortages.

C. UNFPA should reinforce development of human resources capacity. From an internal perspective, extensive double-hatting and over-reliance on short term surge staffing for long term issues leads to gaps and tensions both within UNFPA and with partners. From an external perspective, attrition among implementing partners means that new incumbents require capacity building on a range of technical skills.

D. UNFPA should continue its handover of programming responsibilities to national NGOs and building their capacity to implement effectively, including administratively. National NGO partners researched as part of the research demonstrated good capacity and institutional experience, and this should be reinforced, particularly with respect to issues of national registration. Further, additional investment in monitoring/evaluation systems is required to adequately track and report on outcomes of programme inputs among the refugee population.

E. The current focus of support to camp settings vs host community settings has worked well for UNFPA. However, the deteriorating economic environment is resulting in host community refugees seeking to enter or return to camps as their resources become exhausted and they wish to avail of free services within the camps. If UNFPA seeks to support the government strategy of encouraging refugees to remain within host communities, then a review the targeting of resources should be undertaken.

F. UNFPA Iraq should keep WGSS focussed on women and girls, in line with its mandate and global best practices on GBV programming.

G. Inasmuch as PSEA is equally relevant to Syrian refugees in Iraq as it is to Iraq IDPs, UNFPA should engage more deeply engage with PSEA issues in Iraq in line with its mandate – notably ensuring that survivor-centred protocols, approaches and mechanisms be established and embedded. This should include information sharing protocols, skills/training in specialist areas such as dealing with children, and appropriate mechanisms for authority and independence of the PSEA Taskforce. UNFPA should advocate for responsibility for the PSEA Taskforce to lie directly under the Resident Coordinator (RC) as designated in the Secretary General's (SG) bulletin (and are not within UNFPA's mandate). The GBV Sub-Cluster can then engage with the Task Force in supporting survivor care (potentially with an MOU around this). Guidance from UNFPA HQ, the PSEA Network and the planned PSEA Network hubs in Damascus and Amman could prove valuable in the Iraqi context in terms of technical inputs and alignment with global guidance.

H. People with disabilities should be actively addressed by UNFPA's partners in camp settings, specifically with respect to the SRH needs of young people and their increased vulnerability to GBV.

I. UNFPA should seek to leverage its data collection and management systems to track outcome/impact data to adequately demonstrate the results of its work.

Introduction

Since 2011 the ongoing and escalating crisis in Syria has had a profound effect across the region. By the end of 2017 13.1 million Syrian women, men, girls and boys were in need of humanitarian assistance, 6.1 million within Syria and 7 million in surrounding countries. Close to 3 million people inside of Syria are in besieged and hard-to-reach areas, exposed to grave protection violations.[2] Over half of the population of Syria has been forced from their homes, and many people have been displaced multiple times. Parties to the conflict act with impunity, committing violations of international humanitarian and human rights law.[3]

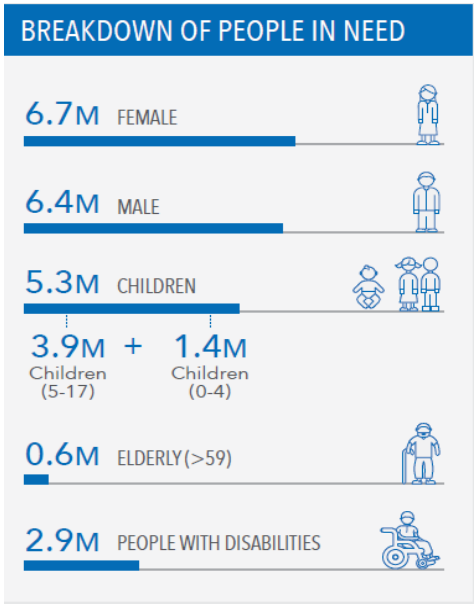


Figure 1: PiN (Source: HNO 2018)

The United Nations Population Fund has been responding to the escalating crisis since 2011. In 2013, UNFPA established a regional response hub to allow a more effective UNFPA representation at the different humanitarian coordination forums, increase the effectiveness and visibility of humanitarian response activities, and enhance resource mobilisation efforts.

In 2014, the Whole of Syria (WoS) approach was introduced across the United Nations. This response is an effort to ensure a coordinated humanitarian response to all people in need in Syria, using all relevant response modalities in accordance with relevant UN Security Council Resolutions. The relevant Security Council Resolutions include UNSCR 2139 (2014), 2165 (2014), 2258 (2015) and 2322 (2016) which, amongst other things, provided the framework for cross-border operations from hubs in Jordan and Turkey, attempting to reach those areas outside of Government of Syria (GoS) control that could not be reached from Damascus.

In addition to the cross-border work, and operations from Damascus within Syria, there is a Regional Refugee & Resilience Plan (commonly referred to as the 3RP) which attempts to harmonise protection and assistance to Syrian refugees in neighbouring countries (Egypt, Iraq, Jordan, Lebanon, and Turkey). In addition to the overall 3RP there are country-specific 3RP chapters.

The primary purpose of this evaluation of UNFPA's Regional Syria Crisis Response is to assess the contribution of UNFPA to the Syria humanitarian crisis response. A secondary purpose is to generate findings and lessons that will be of value across UNFPA, and for other stakeholders. The evaluation is both summative and formative. The more summative aspect of this evaluation is to ensure accountability at all levels: to the individuals and communities receiving assistance and protection within the UNFPA Response; to partner countries; and to donors. The more formative and forward-looking aspects of this evaluation will identify good practice, key lessons learnt, and generate recommendations for the continued UNFPA Response.

This country note provides the findings, conclusions, and recommendations for the Iraq-specific portion of the evaluation.

[2] UNOCHA; Also WoS HNO 2018
[3] Ibid

Methodology

Both qualitative and quantitative data and evidence has been collected through a range of methodologies including a desk review of documentation, key informant interviews, and community-based focus group discussions.

The evaluation research was conducted in accordance with the UN Evaluation Group (UNEG) *Norms and Standards for Evaluations*, the UNEG *Ethical Guidelines for Evaluations*, the UNFPA *Country Programme Evaluation Handbook*, and the World Health Organisation (WHO) *Ethical and safety recommendations for researching, documenting and monitoring sexual violence in emergencies*, and with adherence to the following principles:

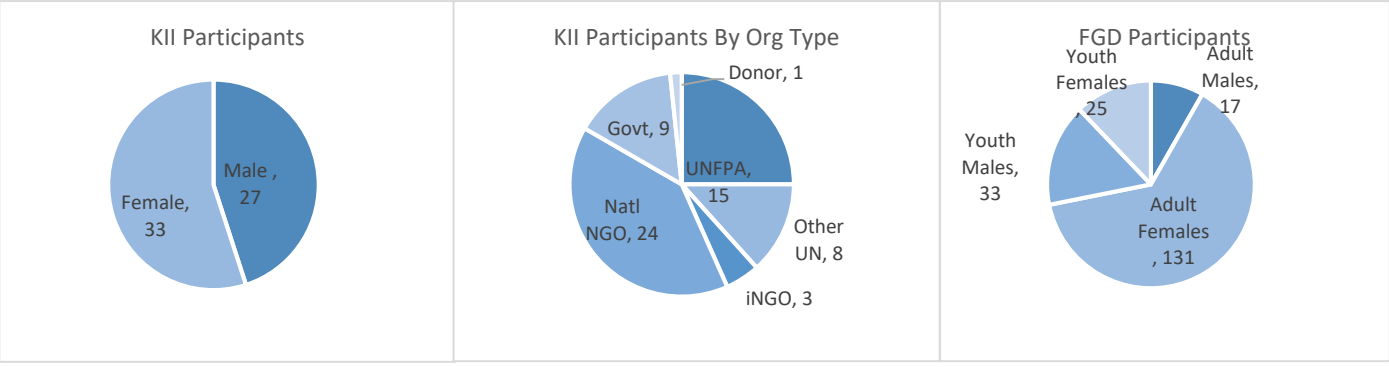
- ***Consultation*** with, and participation by, key stakeholders;
- ***Methodological rigor*** to ensure that the most appropriate sources of evidence for answering the evaluation questions re used in a technically appropriate manner;
- ***Technical expertise and expert knowledge*** to ensure that the assignment benefits from knowledge and experience in the fields of gender-based violence in emergencies (GBViE) and sexual and reproductive health in emergencies (SRHiE);
- ***Independence*** to ensure that the findings stand solely on an impartial and objective analysis of the evidence.

The Iraq Country Mission was undertaken by Brian O' Callaghan, evaluation supervisor, and Jeanne Ward, evaluation specialist, and took place between 30th April and 10th May 2018.

For the UNFPA Iraq CO research, the evaluation team conducted a total of 46 key informant interviews (KIIs) with 59 participants (32 female participants, 27 male), together with visits to UNFPA-supported WGSS, Youth Centres and SRH centres/clinics in six of the eight refugee camps supported by UNFPA in Iraq.

The research team undertook 17 focus group discussion (FGDs) with over two hundred Syrian refugees (male and female) in the refugee camps and visited 13 facilities supported by UNPFA inside and outside camps. A full list of key informant interviewees can be found in Annex I. A schedule of the mission can be found in Annex II.

Refugee Camps Visited		
Dahuk	**Erbil**	**Sulaymaniyah**
Domiz 1	Darashakran	Arbat
Domiz 2	Basirman	
Gawilan		



Background

The Republic of Iraq is an upper middle-income country[4] in the Middle East, bordered by Turkey to the north, Iran to the east, Kuwait to the southeast, Saudi Arabia to the south, Jordan to the southwest and Syria to the west.

Carved from the Ottoman Empire in 1918 under the Sykes-Picot Agreement, Iraq was formed as a state in 1920 (when it joined the League of Nations), and was ruled by a Hashemite monarchy until 1958, when a coup d'état led to successive military governments, culminating in the Ba'athist government of Saddam Hussein. Hussein ruled Iraq from 1979 until 2003, when the invasion by the United States and its allies overthrew his administration. An interim US-led administration was replaced by an elected government in 2005, with elections in 2014 leading to the appointment of current Prime Minister Haider Al-Abadi.

Since the fall of the Saddam Hussein regime in 2003, Iraq has undergone a prolonged period of internal political and social instability that has led to significant insecurity and displacement of populations. High population growth (particularly in urban areas), escalating pressure on services and employment opportunities, poor environmental and resource management and the ongoing internal violence has generated significant challenges to poverty reduction, gender equality, and universal access to reproductive health services and information, both in rural and urban areas. The violence and political instability at national and sub-national levels in the years leading up to 2011 led to over 1.6 million internally displaced people, and a further two million Iraqis seeking refuge outside Iraq[5] .

The commencement of the conflict in Syria in 2011 exacerbated instability within Iraq, with armed groups representing Shia and Sunni factions in increasing conflict with each other. In 2014, Sunni insurgents belonging to the Islamic State of Iraq and Syria (ISIS) staged successful attacks on large swathes of Iraq, seizing control of major cities such as Mosul, Fallujah and Tikrit. This dramatically increased the level of internal displacement within the country, particularly given the egregious and widespread human rights abuses that characterised ISIS rule.

Ongoing military responses to ISIS by the Iraqi army resulted in the progressive liberation of territory from ISIS control through from 2015 onwards, with Iraqi Prime Minister Haider al-Abadi declaring final victory over ISIS on 9 December 2017.[6]

The ongoing conflict in Syria and the massive displacement caused by the ISIS incursions have resulted in 248,092 registered Syrian refugees in Iraq as of March 2018[7] with an additional 3,317,698 Iraqis displaced and 3,511,602 IDP returnees.[8]

[4] World Bank categorisation - http://www.worldbank.org/en/country/iraq
[5] UNFPA Country Programme Action Plan 2011-2014
[6] https://www.bbc.com/news/world-middle-east-42291985
[7] UNHCR Iraq Factsheet, March 2018, see here
[8] Ibid

The table below presents a 2017 breakdown of Syrian refugees across the surrounding countries. Iraq hosts approximately 4.6% of the total Syrian refugee population, though its substantially higher IDP population has heavily influenced provision of support and availability of services.

Country	Registered Syrian refugees (01/12/2017)[1]	Total estimated number of Syrians[2]	Projected registered Syrian refugees by Dec 2018[3]	Members of impacted communities (direct beneficiaries) in 2018[4]	Projected registered Syrian refugees by Dec 2019	Members of impacted communities (direct beneficiaries) in 2019
Egypt	126,027	500,000	131,000	368,300	126,000	368,300
Iraq	246,592	246,592	245,000	158,110	240,000	158,110
Jordan	655,056	1,380,000	602,000	520,000	560,000	520,000
Lebanon[5]	1,001,051	1,500,000	1,000,000	1,005,000	1,000,000	TBC
Turkey	3,320,814	3,320,814	3,303,113	1,800,000	3,303,113	1,800,000
Total	**5,379,644**	**6,947,406**	**5,311,217**	**3,851,410**	**5,259,217**	

Iraq Country Statistics[9]

2017 Population:	38.3 million
Population under 10-24:	31%
Population aged 65 and older:	3%
Maternal Mortality Ratio (MMR):	50 per 100,000 live births
Births attended by skilled personnel:	91%
Adolescent birth rate (age 15-19):	82 per 1,000
Total Fertility Rate (TFR):	4.3
Contraceptive Prevalence Rate (CPR):	56% (all methods) 43% (modern methods)

Iraq ranks in the "Medium Human Development" range in the Human Development Index placement (2016 ranking 121 out of 188 countries – down from #118 in 2010).[10] Despite extensive oil resources (fifth largest global reserves[11]) the last 15 years has been characterised by ongoing conflict and enormous instability, most recently with the influx of Syrian refugees and the huge internal displacements from the ISIS-related conflict (itself an outcome of the Syria conflict). The vast majority (97%) of Syrian refugees in Iraq are located in the KRI (as are almost 30% of IDPs).[12] Of these, approximately 64% live outside camps.[13] More recently, the Iraq context has been characterised by decreasing availability of international funding due to the defeat of ISIS, as many international organisations scale back operations, and shortages of funding available to the KRG as a result of its internal disputes with the Federal Government of Iraq.[14]

Since the Gulf War of 1990–1991, when Iraq invaded and annexed Kuwait resulting in the military intervention of the US-led forces, Iraq's Kurds established their own autonomous region (the Kurdistan Region of Iraq – KRI) in the northeast of the country. Successive moves by the Kurdish Regional Government (KRG) to exert increased levels of autonomy and independence, culminating in a KRI-wide referendum on independence in September 2017 (during which 93% of voters voted for independence)[15], have led to tensions between the Federal Government and the KRG. The 2017 referendum was not recognised by the Iraqi Federal Government (nor by many other countries) and led to a travel and economic embargo of the KRI by the Federal Government, via closure of Kurdish airspace to international flights (reopened since April 2018) and reduction/suspension of federal funding.

[9] Statistics (2017) from UNFPA State of the World's Population, https://www.unfpa.org/data/world-population/IQ.
[10] http://hdr.undp.org/en/2016-report.
[11] OPEC Share of World Crude Oil Reserves, OPEC, 2015
[12] Iraq 2018 Humanitarian Response Plan
[13] UNFPA data
[14] UNFPA, other UN agency, and implementing partner key informants.
[15] Kurdistan Independent High Elections and Referendum Commission, 2017. See here.

United Nations operations in Iraq are governed by a United Nations Development Assistance Framework (UNDAF). The most recent UNDAF covers the period 2015-2019, with the previous version from 2011-2014. The earlier UNDAF focused on assistance to improve governance and human rights, economic growth, environmental management, access to services, investment in human capital and empowerment of women, youth and children.[16] However, the most recent UNDAF noted that the expected trajectory articulated in the earlier version of "post-conflict transition…has not materialized", despite Iraq's substantial resources. Thus, the 2015-2019 UNDAF focuses on the twin outcomes of improvements to national and sub-national institutions; and addressing acute participation and vulnerability gaps.[17]

Iraq has its own chapter of the 3RP which notes that as 97% of the refugee population is located in the KRI, the coordination structure is located at the KRI level and not replicated nationally. However, the 3RP states that the response is implemented under the overall leadership of the Government of Iraq, the Kurdistan Regional Government, and UN Agencies, in close coordination with the donor community.[18]

Most of the Syrian refugee population in Iraq fled violence in 2012 and 2013, and nine camps exclusively for refugees have been established by the KRG. The KRG implements a relatively benign protection policy towards refugees (the overwhelming majority of which are of Kurdish ethnicity), providing them residency permits, freedom of movement and the right to work. At the time of research, 36% of refugees were located within the nine camps, but increasingly challenging economic circumstances due to the persistently poor socioeconomic situation and reduced livelihood opportunities has negatively impacted refugee self-reliance and sparked an increase in the number of refugees seeking relocation to camps, whose absorption capacity is limited.[19] Movements of refugees take place at the Iraqi/Syrian border, with 7-8,000 returnees (to Syria) reported annually in 2016 and 2017, though over the same time period almost 50,000 Syrians were recorded as moving into Iraq (over 30,000 of which were readmissions).[20]

[16] United Nations Development Assistance Framework for Iraq 2011-2014
[17] United Nations Development Assistance Framework: Iraq, 2015-2019
[18] Iraq Chapter 3RP 2018-2019.
[19] Ibid.
[20] Ibid.

UNFPA Iraq Country Office

UNFPA began its assistance to Iraq in 1971, via a range of population and family planning projects. These interventions were suspended in 1991 under the UN sanctions regime and resumed in 1995 with a set of major humanitarian interventions focusing on SRH and FP services. During the relief phase of the 2003 crisis, UNFPA distributed pre-positioned relief supplies including reproductive health kits, and provided medical supplies and equipment. In August 2003, UNFPA conducted an assessment of SRH needs in Iraq and since 2004, UNFPA supported reproductive health, gender-based violence and youth development interventions countrywide, in accordance with its mandate.[21]

Subsequent to the 2003 bombing of the UN premises in Baghdad, the UNFPA office was based in Amman, Jordan, with a limited Iraq presence. From 2011, however, UNFPA increased its presence year-on-year, in accordance with the 2011-2014 Country Programme Document (CPD), which indicated a gradual UNFPA move to Baghdad, with a sub-office in the city of Erbil, capital of the KRI.

UNFPA's first Country Programme Action Plan (CPAP) for Iraq covered the period 2011-2014, and thus its development predated and did not anticipate the Syrian conflict. It focused on the priorities within the 2011-2015 UNDAF, with an associated budget of US$30 million for the five-year programme period, articulated within the 2011-2014 Country Programme Plan.[22] Due to the emerging protracted nature of the Syrian refugee crisis, the 2011-2014 CPD was extended in 2014 for one year, and in 2015 a new CPD for 2016-2019 was published, with significant attention to the ongoing crisis and the likelihood of it extending for the foreseeable future. Specific areas of focus articulated in the CPD are:

- Focus on SRH/GBV service preparedness plans in the event of escalation of the crisis;
- Capacity strengthening of maternity centres, referrals from camp clinics to outside maternity centres and to the tertiary SRH facilities;
- Strengthening/supporting capacity of health provider accountability & quality of care standards;
- Targeting young vulnerable people;
- Recognize and support the role of NGOs in filling humanitarian service delivery gaps, and standardise of their services, particularly for GBV;
- Address host community needs;
- Strengthening referral systems and state institutions to support to GBV survivors.[23]

Since the start of the Syrian crisis and the advent of the IDP crisis, the Iraq CO budget has increased substantially from $900,000 in 2012/2013 to $44 million in 2017[24]. This combines the IDP and Syrian refugee programming – management of both strands is combined. When disaggregated, the humanitarian refugee response programme is proportionately more modest, with Syrian refugee-specific programme funding increasing from $900,000 in 2013 and varying between $1.3 and $2 million between 2014 and 2017 - approximately 5% of the overall programme size. Funding streams for refugee activities (by donor) are presented in the table below.

Donor	2013	2014	2015	2016	2017
Kuwait	$506,000	$43,000	$0	$0	$0
OCHA	$275,000	$826,000	$157,400	$0	$0
USA	$134,000	$1,090,000	$700,000	$1,260,000	$450,000
Denmark	$0	$0	$426,000	$0	$0
Japan	$0	$0	$0	$200,000	$150,000
Norway	$0	$0	$0	$0	$200,000
Sweden	$0	$0	$0	$0	$1,100,000
Total	**$915,000**	**$1,959,000**	**$1,283,400**	**$1,460,000**	**$1,900,000**

[21] UNFPA Country Programme Action Plan, 2011-2015
[22] UNFPA Country Programme Document, 2011-2015
[23] Ibid.
[24] ATLAS data, 2014-2017

UNFPA provides support to eight of the nine Syrian refugee camps within the KRI, with additional support provided directly to government partners who operate facilities and deliver services within and outside camps. In addition to government partners, UNFPA currently has four direct national NGO implementing partners running WGSS and youth centres.

In addition to the Erbil office, UNFPA has sub-offices in Dahuk and Sulaymaniyah, with a total in-country staff presence of 53 people as of mid-2018.

UNFPA has supported some limited cross-border operations that operate through the Peshkhabour border crossing via a partnership with NGO Un Ponte Per (UPP). However, due to difficulties accessing cross-border such operations are ad-hoc and were not being implemented at the time of research, nor does UPP have a permanent presence in Iraq.

The management modality of the UNFPA Iraq country programme whereby refugee and IDP programming are mingled (outside refugee-specific or IDP-specific camps) is a reflection of the dynamics of refugees and IDPs within Iraq, particularly with respect to those within host communities. In this context, refugees can utilise the services available to IDPs, and service providers do not implement a uniform policy of disaggregating users by refugee/IDP status. While such a modality eliminates complex data collection management across, incomplete disaggregation of programme activities and outcomes to focus on refugees only is a limitation of this research.

The evaluation team has sought to mitigate this by emphasising qualitative findings that have either a bearing exclusively on refugees or on IDPs *and* refugees and limiting quantitative findings to refugees only. The evaluation team wishes to emphasise, however, that the findings of this Country Note focuses to the extent possible on UNFPA's refugee response, rather than the wider (and much more substantial) IDP response.

Findings

Evaluation Question 1: Relevance / Appropriateness

To what extent have the specific defined outputs and outcomes of the UNFPA Syria Crisis Response [hereafter referred to as the UNFPA Response] been based on identified actual needs of Syrians within Whole of Syria and within the 3RP countries?

Associated Assumptions:

1. UNFPA Response has been based on needs of Syrian refugee women, girls, and young people identified at community, sub-national, and national level.
2. UNFPA Response is based on coherent and comprehensive gender and inclusion analysis.
3. UNFPA Response is based on clear human rights-based approaches and aligned with humanitarian principles of humanity, impartiality, neutrality and independence, and with International Humanitarian Law (IHL), International Human Rights Law (IHRL), and International Refugee Law (IRL).

FINDINGS

1. To date, the refugee response has been relevant to the SRH, GBV and youth needs of Syrian refugees.
2. The assessments of needs that have taken place have been on the basis of comprehensive and ongoing interactions between UNFPA and refugees, communities, civil society, government and the humanitarian system.
3. The refugee response has been aligned with humanitarian principles of humanity, impartiality, neutrality and independence, and with international humanitarian law, international human rights law, and international refugee law.

To date, the refugee response has been relevant to the SRH, GBV and youth needs of Syrian refugees.

UNFPA's humanitarian response to the Syria refugee crisis started in 2011/2012 under the umbrella of a government-led and UN-supported response. In 2013, Iraq established two refugee camps to accommodate the influx of refugees: (1) Al-Obaidy Camp in Al Qaim, Anbar governorate, hosting approximately 2,900 individuals, and (2) Domiz Camp, in Dahuk governorate, with over 50,000 individuals (against an initial capacity to host 20,000 people). The reopening of the border with Iraq by the KRG in August 2013 resulted in an influx of a further 47,000 Syrians in less than a month. The KRG, the UN Humanitarian Country Team (HCT) and partner NGOs established five new camps and temporary transit facilities in Erbil and Sulaymaniyah governorates, further working to augment life-saving interventions. By the end of August 2013, there were 170,000 Syrian refugees in the North of Iraq.[25]

Given UNFPA's small presence in Iraq in 2011, and constraints around funding in the 2011-2014 period (key informants noted that pre-2014, Iraq was not viewed as a priority for Syrian response-related funding due to the small number of refugees as compared to surrounding countries). Thus, initial activities were limited and the response was "slow to start"[26]. The initial response in 2011/2012 focused on quick-impact projects such as distribution of RH kits, and MISP trainings outside Iraq for Camp management, Directorate of Health (DoH) staff, Medical NGO staff.

UNFPA established relations from the outset with the relevant Directorates of Health in each governorate with refugee populations on resource provision and capacity building for service providers.[27] Determination of needs was done on the basis of a process of consultation with

[25] Resident Coordinator/Humanitarian Coordinator Report on the use of CERF Funds, Iraq, 2013
[26] UNFPA Key Informant
[27] UNFPA key informants.

government and NGO counterparts, and directly on the basis of needs assessments and consultations with refugees and affected populations (see next finding).

Subsequent to the ISIS invasion of 2014, the enormous IDP movement resulted in substantially increased needs and overall available resources. However, UNFPA's modalities of operation did not substantially change, with the focus still on UNFPA's core mandate. The core approach of UNFPA has been to support and complement government-provided services and priorities, while emphasising UNFPA's mandate and model of operation and work via strong national CSO partners.[28]

The specific models utilised by UNFPA are: direct support to government-run SRH centres via staff salary payments and provision of crucial supplies; funding of NGO-operated WGSS and Youth Centres inside camps/Women's Community Spaces outside camps. The WGSS and youth centres in camps, implemented by national NGO partners, provide a range of services, including:

- Referrals to SRH services (maternal health, family planning information and commodities);
- Information on SRH services – leaflets and other information, education, and communication (IEC) materials on subjects related to antenatal care, postnatal care, neonatal care, nutrition during pregnancy etc.);
- Psychosocial support (PSS) services, for GBV survivors and more generally;
- Women and youth economic empowerment activities;[29]
- Social, recreational and educational activities for young people.

The WGSS and youth centres are staffed by social workers, psychologists, translators, outreach and support staff, and volunteers frequently from the Syrian camp inhabitants, who undertake outreach among refugee host communities and provide information to Syrian women and girls about the services available through the spaces/centres.

The assessments of needs that have taken place have been on the basis of comprehensive and ongoing interactions between UNFPA and refugees, communities, civil society, government and the humanitarian system.

UNFPA has, since the beginning of its response to the crisis (2011/2012), sought to root all programming in timely, comprehensive and iterative research among affected populations. For example, at the beginning of the crisis (2011/2012), UNFPA conducted GBV safety audits to gauge emerging GBV risks – assembling teams within affected communities to visit refugees directly and determine their needs.[30]

Examples of subsequent needs assessments reported by UNFPA are:

- Focus Group Discussions in Kawaragoesk and Darashakran camps (2013), with women, men, boys and girls on knowledge, attitude and practice on SGBV;
- Safety Audits in Basirma, Kawaragoesk, Darashakran camps (2013) to determine the potential SGBV risks to women and girls;

[28] UNFPA key informants
[29] UNFPA and implementing partner key informants.
[30] Ibid

- Monitoring of vulnerable groups among of women and girls, with complementary SGBV awareness strategies and SRH needs;
- Major UNFPA GBV assessment (2016) inside and outside camps across the KRI and integrating of findings via the GBV coordinator/GBV specialists in each governate into UNFPA work plans.
- External GBV survivors assessment (ongoing as of mid-2018) to assess quality of services, accessibility of services, and overall perceptions of beneficiaries. This will be used to guide ongoing programming.
- Ongoing monthly feedback via field staff and partners from users of WGSS' and SRH clinics. Personal testimonies collected are used for reporting and guiding programming.

Further, UNFPA informants report ongoing strong relationships and frequent day-to-day interactions with government counterparts at all levels as well as the coordination mechanisms (Protection Cluster, GBV Sub-Cluster/WG, RH WG) established for the overall humanitarian crisis response. These reports have been substantially corroborated by UNFPA partners and other stakeholders, and UNFPA's prominent role and presence in camp context in particular has been directly observed. This emphasis on maintaining close and frequent contact with partners and stakeholders, particularly via UNFPA focal points for individual implementing partners, has supported the ongoing relevance of UNFPA's work.

The refugee response has been aligned with humanitarian principles of humanity, impartiality, neutrality and independence, and with international humanitarian law, international human rights law, and international refugee law.

UNFPA's refugee response is, per UNFPA's organisational mandate and the 3RP, aligned with humanitarian principles of humanity, impartiality, neutrality and independence, and with international humanitarian law, international human rights law, and international refugee law.

However, UNFPA is bound by its partnership with the Governments of Iraq (regional and federal) and thus must work within the framework of Iraq's existing legislation covering humanitarian, human rights and refugee issues.

The Iraqi Constitution (2005) provides a robust framework for gender equality. It guarantees equality to all and prohibits discrimination based on gender (Article 14), prohibits all forms of violence in private and public spaces (Article 29) and forbids forced labour, slavery, sex trade and trafficking (Article 37). However, national legislation contains several gaps that create challenges for legal protection of GBV survivors, e.g. the Iraqi Penal Code continues to allow reduced sentences for "honour" crimes, lenient punishments if the accused has "honourable motives," perpetuating impunity and silence among survivors.[31] Within the KRI, legislation is better aligned with international norms, including a Domestic Violence Law from 2011, and a five-year national strategy (which has now expired) to combat violence against women.[32] While UNFPA informants report advocacy efforts with the KRI government on issues such as women's rights[33], and inputs (acknowledged by KRI government interviewees) to strategies such as the (KRI) National Strategy to Confront Violence Against Women, the ongoing legislative lacunae present challenges for UNFPA which is bound to operate within the existing legal framework in Iraq.[34]

[31] Iraq GBV Sub-Cluster Strategy, 2016
[32] National Strategy to Confront Violence against Women In Kurdistan 2012 -2016, KRG, 2012
[33] UNFPA key informants,
[34] UNFPA key informant

The Baghdad Ministry of Displacement & Migration has limited engagement on issues related to protection or health and is more focused on registration and tracking of IDPs/Refugees.[35]

Further, Iraq lacks a consistent and comprehensive refugee policy or law, leading to ad-hoc treatment of refugees by authorities, and risks of repatriation or refoulement, particularly those who return to Iraq after prematurely attempting to return to Syria, or who move to different areas within Iraq.[36]

> *In the absence of a uniform refugee policy framework in Iraq, or more specifically in the KRI, refugees face different standards of treatment and ad hoc policy changes affecting the realisation of their rights*
>
> *(3RP – Iraq Chapter, 2018)*

These issues present challenges to UNFPA Iraq in seeking to exercise its mandate and provide services for the protection and welfare of refugees – those who are unable to exercise their rights under international human rights law due to gaps in Iraq's legislative framework may also be unable to avail of services provided by UNFPA via its partners.

[35] UNFPA key informant

[36] 3RP Regional Refugee and Resilience Plan 2018-2019, Iraq Chapter

Evaluation Question 2: Adapted relevance over time

To what extent is UNFPA using all evidence, sources of data, and triangulation of data to able to adapt its strategies and programmes over time to respond to rapidly changing (and deteriorating) situations, in order to address the greatest need and to leverage the greatest change?

Associated Assumptions:

4. The UNFPA response reacts flexibly to rapidly changing situations (of displacement, besiegement, movement) based on overall UN and UNFPA-specific information;
5. UNFPA have systematic mechanisms for adapting interventions based on shifting needs and in line with humanitarian principles;
6. The UNFPA response is based on its comparative strengths with relation to other actors for SRH, GBV and youth.

FINDINGS

4. While UNFPA was slow to start operations in response to the Syrian refugee crisis in Iraq in 2011/2012, this was a reflection of both the prevailing sentiment among all stakeholders in Iraq (and the wider region), and of UNFPA's limited capacity in-country at the time. While the UNFPA response has adapted over time to meet the changing circumstances and needs of Syrian refugee women and girls, much of the work is reflective of the current acute SRH and GBV needs and less so on worsening refugee household economic and resource constraints that are increasing vulnerability to adverse health and GBV outcomes.
5. UNFPA's assessment, management and coordination mechanisms in-country and linked to the wider regional response are adequate to ensure flexible and adaptive programming in line with needs and its mandate.
6. UNFPA has effectively based its response on its comparative advantage in SRH and GBV expertise across refugee response programming.

While UNFPA was slow to start operations in response to the crisis in 2011/2012, this was a reflection of both the prevailing sentiment among all stakeholders in Iraq (and the wider region), and of UNFPA's limited capacity in-country at the time. While the UNFPA response has adapted over time to meet the changing circumstances and needs of Syrian refugee women and girls, much of the work is reflective of the current acute needs and less so on anticipating worsening economic and resource constraints.

As discussed above (under Finding 1), UNFPA's limited presence within Iraq in 2011, coupled with the widespread anticipation that the Syria crisis was limited in its extent and duration, led to a gradual ramping up of activities throughout 2011 to 2013. However, as more resources became available, UNFPA's activities focused increasingly on the areas of greatest need. Further, the dynamic nature of the crisis in Iraq – a significant contributing factor being the IDP movements resulting from the ISIS incursions – has been well negotiated by UNFPA, with most stakeholders highlighting how UNFPA has adapted programming to respond to changes in needs identified via a range of feedback mechanisms.

Stakeholders cited an example of how UNFPA adapted programming since 2013 to include an increased youth component in its SRH and GBV work. Earlier in the refugee response, UNFPA focused resources on supporting SRH services in camps and communities (via NGOs and government). To deepen engagement in SRH and GBV, however, UNFPA recognised that it was essential to include youth in programming activities – of further importance due to the increasing recognition of the long-term nature of the crisis and that young Syrians in Iraq would be spending many of their formative years in refugee camps. Thus, UNFPA adapted programming to increase the focus on youth. Other brief examples noted by external stakeholders of how UNFPA has adapted over time are:

- UNFPA's willingness to undertake commodity distributions on the basis of need, rather than insistence on prior registrations (for new refugees and IDPs);

- Subsequent to the ISIS takeover of Mosul, UNFPA established contact with the Dahuk DoH to set up a survivor's centre for care (medical, PSS, legal, advocacy) for survivors of ISIS and (more recently) Syrian refugees - *"they were there for us";*[37]
- A realisation that coordination and effective programming is challenging with multiple centralised decision-makers. Early in the response all decisions were made at central level in coordination with the KRG Ministry of Labor and Social Affairs (MOLSA). As the crisis response expanded, UNFPA decentralised operational management to governorate level, which reduced bureaucracy and speeded programme response times;
- Although a substantial focus of UNFPA is on the eight supported refugee camps, 64% of refugees are located in host communities. While UNFPA conducts specific outreach activities to reach these refugees (mobile clinics, non-camp WGSS'), they also seek to avoid a 'silo' approach with their IDP and refugee initiatives by making IDP facilities in host communities available to refugees;
- Financial and administrative flexibility in response to changing needs (a challenge when donor funds may be on the basis of a specific proposal of activities) has been ensured by close contact with donors to either reallocate specific budget lines or requests additional funding for emerging needs;
- An 'open door' policy with respect to UNFPA's implementing partners – cited almost unanimously by national partners as a positive feature of UNFPA's programming, allowing a two-way exchange of up-to-date information on actual needs and capacity-building/technical support as and when necessary.

However, the ongoing deterioration of the economic environment within Iraq[38], and in northern Iraq in particular, is leading to increases in risks of GBV and negative coping strategies such as early marriage among refugee populations – these issues were raised in most FGDs with women in the refugee camps, and also noted by several groups of adult and young men. Further, the limitations on donor resources that are increasingly being experienced in Iraq[39] are negatively impacting the quantity and quality of service delivery by UNFPA's partners – some SRH staff and camp inhabitants noted shortages of supplies and medications among service providers in camps (necessitating purchase from private providers outside camps)[40], and reductions in the extent or duration of training activities (notably livelihoods trainings)[41]. Some international organisations are reducing or even terminating their presence in Iraq (e.g. NRC has ceased GBV activity in Iraq[42]) and the projected level of humanitarian donor funding for Iraq for 2018 is less than 50% than that of 2017.[43] The scaling back of interventions by international actors is unlikely to be compensated for by significant increases in service provision by the KRG, which has significant resource shortfalls of its own (see Introduction to this report), so there is a need for contingency planning for these likely dynamics.

UNFPA has implemented a policy of extensive and ongoing capacity building among partners (in areas such as administration, M&E/information management, proposal development etc.) to go some way to prepare them for this inevitable shortfall in resources, although the key national NGO partners noted this as an area that requires ongoing attention.

[37] Dahuk Directorate of Health Key Informant

[38] E.g. decreasing availability of international funding post-defeat of ISIS, as international organisations scale back operations, and shortages of funding available to the KRG as a result of its internal disputes with the Federal Government of Iraq.

[39] Reported by UNFPA, other UN agency and donor key informants.

[40] Key informants in refugee camp SRH clinic; refugee FGD participants.

[41] Ibid

[42] A global decision not to continue GBV programming in a number of countries, rather than any reason specifically related to Iraq

[43] $1.44bn reported to the OCHA Financial Tracking System in 2017; $587m reported by Q3, 2018.

UNFPA's assessment, management and coordination mechanisms in-country and linked to the wider regional response are adequate to ensure flexible and adaptive programming in line with needs and its mandate.

UNFPA has progressively developed its assessment, management and coordination mechanisms at all levels over the course of the refugee response in order to tailor programming to ensure needs are met in a flexible and effective manner. Examples of UNFPA's performance reviewed by the evaluation team vis à vis these mechanisms at different levels are as follows:

- Field/community/camp level
    - Safety audits conducted by implementing partners twice per year in camp settings to establish that services and facilities are compliant with good protection practice;[44]
    - UNFPA's close work with other protection and health actors to ensure GBV is considered part of life saving programming;
    - Use of supported facilities and systems (Safe Spaces, Youth Centres) as sources of robust and timely information on needs and outcomes, also permitting integration of GBV, SRH and youth action and targeting activities appropriately.
- Governorate level
    - Daily contact with implementing partners and government stakeholders (BRHA in Dahuk, JCC in Erbil and Sulaymaniyah) to ensure prompt feedback on programming and needs;[45]
    - Leadership and representation on the GBV Sub-Cluster/WG and RH working group on a regular (monthly) basis to share emerging issues among members, target programming interventions and avoid duplication of activities;
    - Good awareness and exercising of UNFPA's mandate as provider of last resort, thus ensuring specific gaps are promptly addressed. E.g. Médecins Sans Frontières ceased direct operations in Dahuk governorate in 2017 so UNFPA took over their operations.
- Country level
    - Joint assessments (as part of the GBV Sub-Cluster to contribute to the annual Humanitarian Needs Overview (HNO);
    - Ad-hoc assessments (such as the 2018 Survivor's Survey) that complement existing strategic needs assessment tools;
    - A strategic focus on working with and supporting existing systems (notably government health infrastructure) to avoid duplication and build resilience;
    - Stakeholders (including GBV Sub-Cluster members) noted that UNFPA is an active and dynamic leader of the GBV Sub-Cluster and the RH WG.

The research also highlighted emerging areas of need where UNFPA should proactively focus attention. Many cases attending SRH clinics in camps (including deliveries) are referred to public hospitals, but such public services are deteriorating in response to the shortage of resources in the KRI, with long delays, user fees or unavailability of medications forcing refugees to seek assistance at private hospitals (assuming they have the resources to access these). A strike among healthcare staff in public hospitals in Sulaymaniyah Governorate in 2018 (due to the non-payment of salaries) meant that UNFPA, as provider of last resort, had to negotiate with private health providers to fill the gaps for immediate SRH cases. This resource squeeze is major issue identified by almost all health actors interviewed. The crisis has disproportionately affected IDPs/refugees as they do not have the same community-based social safety nets that can facilitate the process of negotiating the public and private

[44] International NGO key informant, UNFPA informants
[45] Government key informants

healthcare systems, thus further deterioration in the economic situation may result in UNFPA being called on as provider of last resort more frequently.

UNFPA has effectively based its response on its comparative advantage in SRH and GBV expertise across refugee response programming.

Evidence from key informants and community members indicates that UNFPA holds to its mandate within its programming and has sought to leverage its position to build effective and robust relationships with public health providers within and outside camps. UNFPA's work in camps (via SRH clinics, WGSS and youth centres) is the most visible aspect of the refugee response work, but UNFPA also supports KRG health services directly through provision of direct resources (supporting salaries of medical staff) to government and NGO partners and support to non-camp services such as mobile clinics, women's community spaces (the non-camp equivalent of WGSS) and a women's survivor's centre in Dahuk city.

Over time, UNFPA has sought to focus more and more on host communities to integrate GBV, SRH and youth in health worker training, encourage implementing partner coordination and information-sharing to help coordination in contexts where partners were working in the same locations. In the early years of the crisis, and again with the spike in needs post-2014 demand was increasing rapidly so UNFPA focused on meeting the minimum level of services. As programming matured, UNFPA leveraged its experience and embedded system to duplicate service provision and modalities efficiently.

> *In terms of service provision, [UNFPA] are definitely an important player, and key in both GBV and RH*
>
> *UN key informant*

As a corollary to UNFPA's ongoing processes to establish needs, many requests for assistance relate to gaps that are not necessarily core to UNFPA's mandate (such as infrastructure or non SRH-related commodities). UNFPA staff are aware of this and noted ongoing efforts to respond to needs that are within UNFPA's mandate. An example of this is the 2018 CMR training of trainers (ongoing at the time of the evaluation research) that will meet a significant need for this among SRH clinic staff – approximately 50% of the SRH clinic staff interviewed for the evaluation research had not received such training – partially due to ongoing staff rotation within SRH clinics but addressing a key need that has existed for some time.

The technical expertise of UNFPA in SRH and GBV was noted by key informants among implementing partners and government stakeholders, many of which have limited experience in humanitarian systems and architecture and required significant coaching and mentoring in this area – both on commencement of their relationship with UNFPA and on an ongoing basis, due to attrition of staff.[46]

[46] NGO key informants

Evaluation Question 3: Coverage

To what extent did UNFPA interventions reach the population groups with greatest need for sexual and reproductive health and gender-based violence services, in particular the most vulnerable and marginalised?

Associated Assumptions:

7. The UNFPA response systematically reaches all geographical areas in which women, girls and youth are in need and in line with humanitarian principles;

8. The UNFPA response systematically reaches all demographic populations of vulnerability and marginalisation (i.e. women, girls, and youth with disabilities, those of ethnic, religious or national minority status; Lesbian/Gay/Bisexual/Trans (LGBT) populations etc.).

FINDINGS

7. UNFPA's refugee response is focused on the areas with the highest *concentration* of Syrian refugees, i.e. 8 of the 9 dedicated refugee camps in the KRI, although they constitute only 36% of the refugee population in Iraq. Outside the camps, populations are distributed throughout the KRI (which has 97% of the countrywide refugees) and UNFPA is supporting these populations through support to dedicated activities (outreach, clinics, women's spaces) and through its support to IDPs within the KRI. This is an appropriate and effective targeting strategy.

8. Focusing resources on refugee camps targets the most vulnerable refugees overall – as those within host communities typically have their own resources to rely upon. However, the difficult economic circumstances within Iraq have resulted in depletion of many resources, increasing vulnerability among refugees within host communities – some of which are now seeking to enter camps.

9. UNFPA-supported programming has limited focus on people with disabilities or other marginalised groups such as female-headed households.

UNFPA's refugee response is focused on the areas with the highest concentration of Syrian refugees, i.e. 8 of the 9 dedicated refugee camps in the KRI, although they constitute only 36% of the refugee population in Iraq. Outside the camps, populations are distributed throughout the KRI (which has 97% of the countrywide refugees) and UNFPA is supporting these populations through support to dedicated activities (outreach, clinics, women's spaces) and through its support to IDPs within the KRI. This is an appropriate and effective targeting strategy.

UNFPA has pursued a strategy of targeting most of its resources to eight of the nine refugee camps[47] within the KRI. By doing so, it is specifically focusing its resources on refugees, with minimal dilution of resources among host communities and IDP populations.[48] Given that the camp-based population in the 2011-2013 period represented 50% of the refugee population in Iraq[49] and at the time of research 36%, UNFPA has also sought to extend coverage of SRH and GBV services to refugees within host communities through support to primary healthcare centres (PHCs) in non-camp settings with a high presence of refugees.[50] UNFPA reported challenges initially convincing people to seek services, and sought to replicate the WGSS model within communities (in 2012 they implemented 5 WGSS in areas populated by refugees) which were used to conduct awareness-raising linked to GBV prevention, provide orientation to women on the services available in PHCs, embed referral systems among PHC staff, and provide PSS and social activities/trainings. UNFPA reporting indicates good success in reaching the higher concentrations of host community refugees, most of which were located in two or three areas around Erbil.

[47] The ninth camp, Akre, has only 1,158 inhabitants – less than 2% of the total camp-based refugee population.

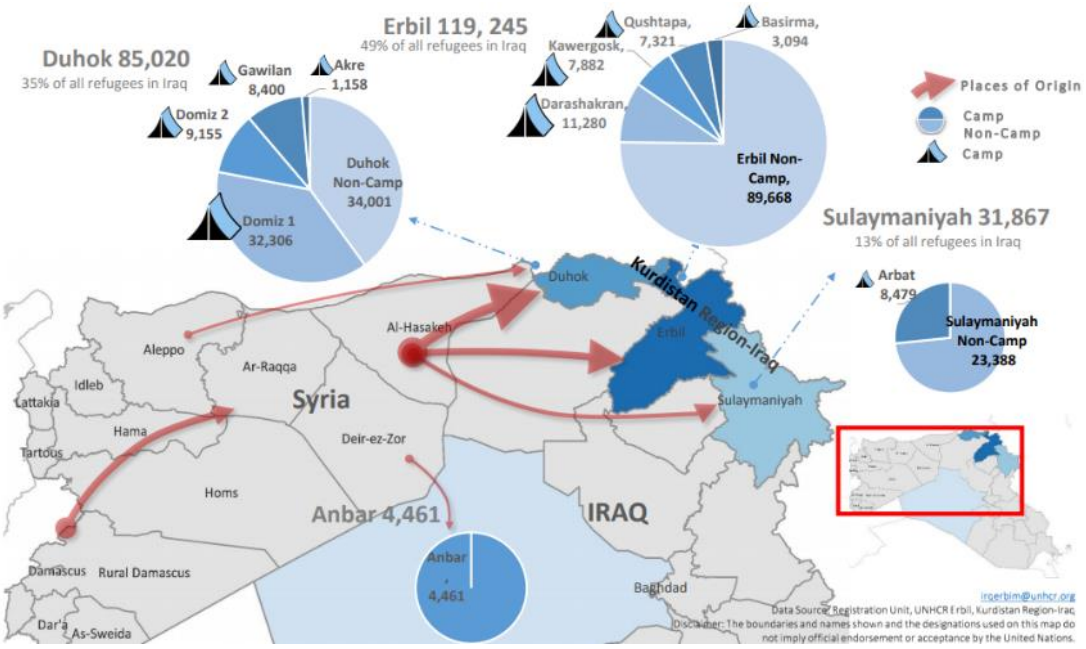
[48] UNFPA, government key informants.

[49] UNFPA key informant

[50] The 3% who are outside the KRG are in south & central Iraq and were reported by UNFPA and UNHCR to be exclusively living on their own resources and not in significant need.

Overall the GBV community has been able to expand programming to gain access to support to survivors. That's a big win and a credit to UNFPA.

iNGO key informant



3RP Breakdown of Syrian Refugees in Iraq, August 2017[51]

In general, the consensus among key informants is that UNFPA has implemented the correct mix of camp-based and host community-based services. Service mapping reports from stakeholders indicate that coverage within the KRI is quite comprehensive, within the constraints of the available resources.

Further, UNFPA-supported facilities and programming for IDPs located within host communities or camp settings is also available to refugees many Syrians are living in collective towns where IDPs are located.[52] While specific numbers of refugees vs. IDPs taking advantage of services are not tracked, anecdotal evidence from key informants indicates that such programming complements and supports the dedicated refugee services. A challenge to further work in host communities is that data on the numbers of refugees in host communities is sourced from the KRG but UNFPA considers this unreliable[53] – even refugee registration data is questionable – and delayed. UNFPA reports two years of advocacy and capacity-building with the KRG on the need to register all refugees, but the lacuna between needs and capacity still remains.[54]

Focusing resources on refugee camps targets the most vulnerable refugees overall – as those within host communities typically have their own resources to rely upon. However, the difficult economic circumstances within Iraq have resulted in depletion of many resources, increasing vulnerability among refugees within host communities – some of which are now seeking to enter camps.

UNFPA's rationale for primary focus of support on refugee camps was that the most vulnerable families with the fewest independent resources would seek entry there. Testimony of key informants and inhabitants of the camps themselves support the validity of this rationale.

However, the ongoing economic constraints are raising concerns among stakeholders that people in host communities are increasing in vulnerability as they are depleting their reserves and do not have sufficient social and community support to sustain themselves effectively but cannot gain access to

[51] https://data2.unhcr.org/en/documents/download/59159
[52] UNFPA key informants
[53] ibid
[54] ibid

camps. While NGO partners note ad-hoc exceptions for very vulnerable families, stakeholders noted that the government does not want to increase camp sizes or populations. In Sulaymaniyah Governorate, one informant noted 90-100 families who requested camp access but were refused.[55]

Stakeholders noted that some refugees are moving to other locations in Iraq, back to Syria, or to third counties (including European countries), but other refugees are returning back from Syria after an attempt to return. The increasing vulnerability due to economic constraints was cited by stakeholders at all level involved in the evaluation research.

UNFPA-supported programming has limited focus on people with disabilities or other marginalised groups such as female-headed households.

With respect to provision for people with disabilities (9% of Syrian households in Iraq report living with a mental or physical disability – likely an underestimate[56]), the UNFPA-supported WGSS and youth centres vary in terms of accessibility. Centres are located within refugee camps, which in many cases lack disability-friendly access. While UNFPA and partners are aware of the presence of disability among the refugee populations, and are inclusive of all people, there are no specific and proactive efforts to include them in services, such as outreach counselling and providing transportation for those with disabilities to facilitate access to services.[57]

UNPFA does not disaggregate data in terms of disability or have any 3RP programmatic indicators related to disability.[58]

A second vulnerable group that presents opportunities for further work is that of female-headed households, highlighted within the 2016 GBV Sub-Cluster strategy, particularly in relation to economic vulnerability.[59] The evaluation research within the refugee camps supports this, and respondents noted that individual female-headed households can suffer discrimination and prejudice if the absent male is suspected of having been associated with ISIS – to the extent of families being ejected from the camps.[60]

The current WoS GBV Sub-Cluster work plan includes a specific WoS strategy for adolescent girls[61], and a focus on women and girls with disabilities, with specific indicators included within work planning and monitoring and reporting around this. Adoption of this by the Iraq CO could facilitate improved programming in relation to working with people with disabilities.

UNFPA is also in the process of supporting the initiation of men's spaces/men's centres in four camps.[62] While this is in response to requests from community members and may be an opportunity to address some of the root causes of GBV, such initiatives may not be in alignment with UNFPA's global mandate on women and girls and the resources may be better focused on addressing some of the underlying contributory factors to GBV, such as livelihoods, through linking to and supporting agencies that have specific demonstrated skills in this area.

Finally, a vulnerable group of potential concern highlighted by informants in camp settings is that of Syrian 'gypsies' (*Nawar*) who retain traditional lifestyles and self-segregate within camps. Informants noted that they have high levels of early marriage and are resistant to interventions related to GBV or SRH, with male household members acting as gatekeepers with respect to outreach activities.[63]

[55] NGO key informant
[56] 3RP Iraq Chapter, 2018
[57] UNFPA and implementing partner key informants.
[58] UNFPA key informants.
[59] Iraq GBV Sub-Cluster Strategy for 2016
[60] Implementing partner key informants, camp inhabitants
[61] https://www.humanitarianresponse.info/en/operations/whole-of-syria/document/whole-syria-adolescent-girl-strategy
[62] UNFPA and implementing partner key informants
[63] Implementing partner, RH Centre key informants

Evaluation Question 4: Coordination

To what extent has UNFPA's formal leadership of the GBV AoR (at international, hub, and country levels) and informal leadership of RH WGs and youth WGs (at hub and country levels) contributed to an improved SRH, GBV, and youth-inclusive response?

Associated Assumptions:

9. UNFPA's support to and use of coordination within the GBV AoR at global level and the GBV Sub-Clusters at Hub and Country level has resulted in improved effectiveness of GBV programming in the Syria response: Overall GBV response under UNFPA direction through leadership if the GBV SC is based on needs of women, girls, and young people identified at community, sub-national, and national level and is based on coherent and comprehensive gender and inclusion analysis and Human Rights-Based Analysis (HRBA);
10. UNFPA's support to and use of coordination within the RH WG at Hub and country level has resulted in improved effectiveness of SRH programming in the Syria response: Overall SRH response under UNFPA direction through leadership of the RH WG is based on needs of women, girls, and young people identified at community, sub-national, and national level and is based on coherent and comprehensive gender and inclusion analysis and HRBA;
11. UNFPA's support to and use of coordination within the Youth WG at country level has resulted in improved effectiveness of youth engagement and empowerment programming in the Syria response.

FINDINGS

11. UNFPA is actively coordinating and leading GBV responses via the Erbil GBV Sub-Cluster (with IDP and refugee responsibilities) and Working Groups in Dahuk, Sulaymaniyah and Erbil, with particular focus on refugee issues at governorate Working Group level, although human resource gaps led to challenges in 2017/early 2018, notably with the cessation of NRC's GBV programming and transfer of co-chair to IMC.
12. RH coordination is integrated into the Health Cluster at national level and ad-hoc at subnational level, but functions well despite the ongoing and worsening resource limitations.
13. There is limited youth coordination as there is no Working Group. However, UNFPA has integrated coordination of youth programming effectively into GBV and SRH activities.
14. Although primarily (though not exclusively) related to the IDP response, UNFPA is taking a proactive role in the PSEA response mechanism (via the PSEA Taskforce). However, effective modalities of PSEA coordination are still being determined, with lack of clarity on responsibilities/functions, limited engagement of different stakeholders, and overall limited technical capacity to effectively address PSEA.

UNFPA is actively coordinating and leading GBV responses via the GBV Sub-Cluster and Working Groups, although human resource gaps led to challenges in 2017/early 2018, and with the cessation of NRC's GBV programming UNFPA was the sole lead for some time, proving an additional coordination burden on staff.

The overall refugee/IDP response in Iraq is characterised by a functioning cluster system[64], with robust engagement by stakeholders at UN, national NGO, international NGO and government stakeholders at both Sub-cluster (KRI-level) and Working Group (governorate) levels. Early in the refugee response, the UNFPA-led GBV coordination focused on establishment of referral pathways, SOPs and appointment of GBV focal points within agencies, but has become increasingly more sophisticated since 2014 and the IDP response.

Stakeholders who participated in the research presented some mixed perspectives on the process, outputs and outcomes of the GBV coordination over the course of the past several years[65] - one

[64] Although UNFPA established the GBV WG in 2013, the cluster system in Iraq was formalised with the L3 emergency declaration in August 2014

[65] Implementing partners, UNFPA, NGO and donor informants

government stakeholder expressed that coordination between operational agencies (UN and NGO) could be improved for better service mapping and avoidance of duplication. This may be reflective of the high turnover among coordination staff within different agencies (one informant noted themselves being the fifth such coordinator for their agency within one year). The exit of some agencies from the GBV sector (notably NRC's exit from GBV programming in Iraq – a former co-chair of the GBV Sub-Cluster – now taken on by IMC) increases the burden of coordination on the remaining agencies, and limited capacity among government counterparts to co-chair at subnational levels (leading to mixed reports on the quality of coordination at camp level[66]) to drive coordination mechanisms where appropriate is a further challenge.

UNFPA has, however, sought to develop and embed coordination at multiple levels – for example the funding of a GBV specialist position with its implementing partner in Dahuk (Harikar). In 2018 in particular, stakeholders noted that UNFPA has worked to alleviate previous concerns of other GBV Sub-Cluster members around dominating decision-making – due in part to the rapidly-changing dynamics that the conflict with ISIS and their expulsion from Mosul generated, and also as UNFPA is perceived as being responsible for the majority ("90%"[67]) of GBV funding and activities, leading to understandable challenges to having a diverse range of opinions and approaches represented in the coordination forums.

Implementing partners noted that coordination mechanisms operate more smoothly and effectively at governorate level than at national/KRI level, again due mostly due to the rotation of staff over the course of the duration of the crisis, and the withdrawal of agencies from direct GBV-related work. The presence of UNFPA sub-offices in Dahuk and Sulaymaniyah, in particular, was noted as facilitating regular, active and engaged GBV WG meetings with co-chairing by national stakeholders.

Historically, double and triple-hatting of GBV staff in UNFPA placed a particular burden on coordination mechanisms, but challenges related to this noted by respondents appear to be actively addressed by all coordination actors through recruitment of dedicated coordination staff.

A final concern noted by evaluators is the ongoing shifting of attention between IDPs and refugees[68] as the dynamics of conflict and displacement evolved between 2014 and the current time. Given the scale of the IDP crisis, attention to refugees risks being minimised. Successive versions of the Iraq HRP note under each cluster operational response plan a summary of representative measures for refugees but notes that the substantive refugee response is covered under the 3RP.[69] Interviewees noted this separation between refugees and IDPs but were generally positive that at coordination level (e.g. at cluster or Sub-cluster /working group level) that activities are coordinated well between the two groups. Further, the heightened focus on IDPs in 2017 because of the defeat of ISIS is anticipated to diminish in 2018/2019 with a refocus on the 3RP.[70]

RH coordination is integrated into the Health Cluster at national level and ad-hoc at subnational level, but functions well despite the ongoing and worsening resource limitations

Initial (i.e. 2012/2013) considerations of supporting an independent sub-working group among SRH actors were rejected in favour of keeping SRH coordination within the Health Cluster at the KRI level. A sub-working group has been established in Dahuk and a more formal WG established in Baghdad (primarily concerned with IDP issues), but not in Erbil and Sulaymaniyah, where the Health Cluster covers SRH. SRH meetings are undertaken informally on an ad hoc basis in the backdrop of the Health Cluster meetings[71] with the goal being integration of SRH as part of primary health care, and under the leadership of UNFPA and government counterparts (e.g. the DoH's in each governorate other than

[66] Implementing partner key informants
[67] iNGO key informant
[68] UNFPA key informants
[69] See 2018 HRP Executive Summary, pg 3 footnote
[70] UNFPA key informant
[71] Ibid

Erbil). Key informants expressed that this strategy has worked well in terms of mainstreaming SRH within other healthcare services and ensuring resources for SRH, although ensuring refugee considerations are not overshadowed by IDPs requires ongoing attention.[72]

On establishment of a refugee camp, the SRH clinics were established within the PHC unit, so women who attended for non-RH services (such as vaccinations) could also avail of SRH care with minimal risk of stigma or interference.

UNFPA partnered with WHO in provision of SRH components (approximately 25% of services for SRH) within every PHC established and considers the model to be best practice in the Iraq context and has been applied in a variety of refugee and IDP contexts.

As of the time of research, UNFPA was undertaking facility assessments, family planning service assessment (whether/why family planning needs are/are not met, key challenges), and planning to establish a review of "near-miss" cases (what was done, how was it done, what should have been done differently).

Overall, respondents expressed that the SRH meetings (as part of the Health Cluster or independently) provide good opportunities for updating stakeholders and avoiding duplication/identifying gaps and occasional donor opportunities presented. An informant presented a positive example of how in early 2018 an international NGO, faced with resource limitations, concluded SRH services in two (IDP) camps in Erbil. UNFPA was informed via the Cluster/subgroup and provided mobile medical teams to cover the gaps, in keeping with its mandate.

There is limited youth coordination as there is no Working Group. However, UNFPA has integrated coordination of youth programming effectively into GBV and SRH activities.

Similar to the SRH coordination, no formally constituted Working Group for youth exists within the Iraq humanitarian coordination mechanism. Informants noted that initial plans to establish a Youth WG early in the response did not materialise as most actors in the youth sector felt that the cross-cutting nature of youth work was better served by remaining within other sectors/clusters.[73] UNFPA considers youth as an important element but this is more on building resilience rather than response and immediate needs.

An Adolescent Girls Taskforce was set up in March 2016 comprising of UN agencies, GBV and child protection NGOs[74] working with girls. The taskforce was established as a short-term forum to complement the previous work of the child marriage taskforce (noted above) and other ongoing initiatives. UNFPA and IMC co-chair the taskforce and meet monthly. It focuses on:

- Identifying issues and concerns affecting adolescent girls.
- Recommending and developing programming responses to address needs.
- Field testing tools and resources developed.

In 2016 the Taskforce undertook an assessment of over 100 adolescent IDP and refugee girls. With support from the Government of Norway, the findings of assessment were used to produce a toolkit for implementing agencies designed to empower adolescent girls from IDP, refugee and host communities to address key issues on life skills, SRH, GBV and financial education.

[72] WHO key informant
[73] WHO informant
[74] UNICEF, UNFPA, UNHCR, NRC, IMC, Al Massala, ACTED, WRO, IRC, GBV and Child Protection sub clusters

Although UNFPA is taking a proactive role in the PSEA response mechanism (via the PSEA Taskforce), effective modalities of PSEA coordination are still being determined, with lack of clarity on responsibilities/functions/mandate, limited engagement of different stakeholders, and overall limited technical capacity to effectively address PSEA.

The impetus for more proactive policies, procedures and initiatives to address Sexual Exploitation and Abuse (SEA) was reinvigorated in 2016, under the previous Humanitarian Coordinator (HC) for Iraq. An Iraqi PSEA Taskforce was convened subsequent to this under the co-lead of UNFPA and WFP[75]. Given the *programmatic* distinction between PSEA and GBV work, many GBV stakeholders in Iraq interviewed for this research, while noting considerable activity on individual case management, expressed concerns around UNFPA co-chairing the Taskforce - an activity not within its mandate - in that the distinction between PSEA and GBV programming might not be recognised by many non-experts. Further, non-protection agencies might consider that PSEA is 'the responsibility' of UNFPA, whereas in fact it is the responsibility of all agencies[76], and establishment and functioning of the network / taskforce is the responsibility of the RC/HC's office. Thus, informants cited concerns that UNFPA's mandate may be diluted by acting on a perceived obligation to engage on PSEA more than other agencies, and that other agencies may not take required action on PSEA themselves. The GBV SC produced a briefing note for stakeholders in 2016 that clearly lays out some of the parameters around PSEA in line with best practice and recommendations for institutionalising these practices.[77]

Importantly, state armed actors' perpetration of SEA, per the SG's bulletin[78] is not under the remit of the PSEA Task Force and putting it under the Task Force creates real problems in terms of transparency, safety and accountability.

Also, concerns were expressed by several informants around potential protection violations by officials investigating alleged SEA[79] without adequate survivor-centred protocols.[80]

While addressing PSEA in Iraq (from whatever source) is an important issue, and UNFPA's willingness to advocate for this at all levels (including SEA committed by armed actors) is positive and addressing a widely-agreed need, informants noted valid concerns around ensuring that survivor-centred protocols, approaches and mechanisms be established and embedded. Responsibility for the PSEA Taskforce should lie directly under the RC as designated in the SG's bulletin.[81] The GBV SC can then engage with the Task Force in supporting survivor care (potentially with an MOU to ensure understanding of the discrete admin/management mechanisms, targets, and responsibilities of the Task Force and the coordination mechanism). Global guidance from the PSEA Network and the planned PSEA Network hubs in Damascus and Amman could prove valuable in the Iraqi context. Also, the issue of armed state actors engaging in SEA should not be within the PSEA Taskforce remit.[82]

[75] UNICEF informant
[76] UNFPA, UN sister agency and NGO informants
[77] Iraq GBV Sub-Cluster Brief, Protection from Sexual Exploitation and Abuse (PSEA), 2016
[78] ST/SGB/2003/13
[79] Non UN-related, but in camp settings, so under UN-mediated protection mechanisms
[80] Protection stakeholder informant
[81] ST/SGB/2003/13 section 4
[82] UNFPA key informant, ST/SGB/2003/13 section 2.1

Evaluation Question 5: Coherence

To what extent is the UNFPA Response aligned with: (i) the priorities of the wider humanitarian system (as set out in successive HRPs and 3RPs); (ii) UNFPA strategic frameworks; (iii) UNEG gender equality principles; (iv) national-level host Government prioritisation; and (iv) strategic interventions of other UN agencies.

Associated Assumptions:

12. UNFPA is institutionally engaged with, and drives focus on SRH and GBV, at UNCT, HCT and Strategic Steering Group (SSG) levels in all response countries;
13. UNFPA Response is aligned with:
    a. UNFPA global mandate and global humanitarian strategy;
    b. UNFPA Regional Office strategies;
    c. UNFPA CO strategies;
    d. National-level host government prioritisation (SAR, Turkey, Lebanon, Iraq, Jordan);
    e. International normative frameworks;
    f. UN global development strategies (MDGs, SDGs).
14. The UNFPA response is aligned to the priorities decided in Cluster Forum; specifically:
    a. The GBV AoR;
    b. The Global RH Coordination Forum (currently Inter-Agency Working Group)

FINDINGS

15. Strategic plans for the IDP/refugee response promote SRH and GBV as life-saving, with UNFPA exercising a presence at the UNCT level. UNFPA also supports programming and engagement with the government on GBV and SRH.
16. UNFPA's work demonstrates alignment with UNFPA's global mandate, the 3RP, CPP/CPAP, government priorities and international norms.
17. UNFPA is an active GBV Sub-Cluster lead, with good alignment of priorities, although as it is responsible for the majority of GBV funding and activities in the Iraq refugee response, this leads to a lack of diversity of voices.

Strategic plans for the IDP/refugee response promote SRH and GBV as life-saving, with UNFPA exercising a presence at the UNCT level. UNFPA also supports programming and engagement with the government on GBV and SRH

UNFPA, as with other UN agencies in Iraq, supports the government in its efforts to respond to the refugee (and IDP) crisis. For refugees, the geographical focus of the refugee work is in northern Iraq, with the UNCT sitting in Baghdad, leading to a potential disconnect. However, respondents across the board highlighted UNFPA's lead role on SRH and GBV with different government agencies (Ministry/Directorates of Health, DCVAW, High Council for Women's Affairs and MOLSA, specifically noting UNFPA's presence at all government partnership and intra-UN interactions of substance.[83]

Further, UNFPA is also a pilot country for the Real-Time Accountability Partnership on GBV, (RTAP), which seeks to highlight the lifesaving nature of GBV work. This initiative commenced in Iraq in February 2018, so at the time of research was still gathering momentum, with the appointment of a national focal point and delegation of external technical assistance in May 2018. Given that the duration of the RTAP pilot is one year, however, timely progress on implementation is warranted now that human resources are in place.

[83] Government, implementing partners, iNGO, donor, UN agency, key informants.

UNFPA's work demonstrates alignment with UNFPA's global mandate, the 3RP, CPP/CPAP, Government priorities and international norms.

Planning processes within Iraq for humanitarian programming by UNFPA and partners are clear – the 3RP, HNO, HRP, and are used by UNFPA as the basis for work planning. Different cluster leads collectively and iteratively determine their individual objectives carefully, with the resulting plans being noted by stakeholders as practical and useful, also aligned with UNFPA's global mandate (via its global strategy) and national priorities.[84] UNFPA Iraq's perspective is that the latest strategic plans for Iraq's humanitarian response (the HRP and 3RP) are the most valued and up-to-date reflection of a dynamically changing environment so have greatest value in designing strategies and work planning.[85]

Integration of international standards into SOPs, protocols, case management guidelines etc. has been an ongoing feature of UNFPA's work[86], with standardised referral pathways, an information-sharing protocol (ISP) (for the GBV Information Management System) and regular service mapping for whole of Iraq, and the KRI specifically. Capacity building on international standards is supported by various actors on an ongoing basis, for example UNFPA-supported training-of-trainers on CMR taking place in Iraq at the time of evaluation research.[87] GBV stakeholders did note ongoing concerns around the issue of mandatory reporting of rape requirements within Iraq.[88]

Many stakeholders noted that UNFPA and its implementing partners undertake good coordination with the appropriate government departments (DoH, DCVAW), which ensures that government priorities are met and UNFPA's work towards its mandate is easily facilitated.

Government stakeholders noted that UNFPA and other partners are aligned with the goals of the central government. Despite frequently changing needs and resources UNFPA has been noted to be flexible and works in concert with the government. [89]

UNFPA is an active GBV Sub-Cluster lead, with good alignment of priorities, although as it is responsible for the majority of GBV funding and activities in the Iraq refugee response, this leads to a lack of diversity of voices.

The cluster system was established in Iraq in 2014, with an interagency coordination mechanism directly linked to the 3RP (UNHCR is the convenor). Stakeholders interviewed agreed that UNFPA's work through the GBV Sub-Cluster/WG mechanism has indeed promoted GBV as life-saving.[90]

In some instances, to avoid doubling of coordination mechanisms, IDP/Refugee issues are coordinated jointly. For example, health does not have a specific refugee working group - refugee issues are instead discussed via the health cluster/WG, a system largely acceptable to stakeholders interviewed.

As noted above, UNFPA's responsibility for the majority of GBV funding and activities leads to stakeholder concerns around having a more diverse range of opinions and approaches represented on coordination forums that multiple senior stakeholders would bring, but interviewees were substantially positive regarding the role UNFPA plays in this regard.

[84] UNFPA key informants
[85] ibid
[86] UNFPA, implementing partner key informants
[87] ibid
[88] iNGO key informants, also noted in UNFPA's *GBV Assessment in Conflict Affected Governorates in Iraq*, 2016
[89] Government key informants
[90] For example, the 2016 Iraq GBV Sub-Cluster Strategy refers to GBV-related work as lifesaving across multiple services

Evaluation Question 6: Connectedness

To what extent does the UNFPA Response promote the humanitarian-development nexus?

Associated Assumptions:

15. UNFPA is working towards long-term development goals with regards to resilience of refugees when they return to Syria;
16. UNFPA is seeking to integrate in-country humanitarian response with long-term development goals.

FINDINGS

18. UNFPA is committed to supporting government priorities and systems.
19. The substantial, and worsening, resource constraints that Iraq faces challenges integrating resilience and long-term development into refugee responses.

A significant feature of the overall humanitarian response in Iraq has been the many unanticipated changes that have been seen – the initial refugee crisis was not expected to last as long as it has, and the ISIS invasion and consequent IDP crisis was unexpected in terms of its scale and intensity.

However, many interviewees, particularly government stakeholders, noted that plans for longer term development are now being refined and operationalised. KRG representatives were of the opinion that up to 50% of the refugees will stay within the KRI for 10 years or more, with many, particularly minorities, not feeling sufficiently safe to consider returning. Refugees are generally welcome within the KRI, and are, in theory, entitled to the same rights and entitlements as Iraqis.[91]

Some interviewees noted some discrimination within KRI, but not substantially, and not to the same extent as IDPs. The concerns around ISIS sympathisers within the IDPs coming to the KRI mean that IDPs have more difficulty traveling within the KRI. All inhabitants of the KRI require a residency card in order traverse security checkpoints within the KRI. Syrian Refugees can reportedly obtain residency cards more easily, thus they have greater opportunities to integrate within the population.[92] These findings are largely corroborated by the inhabitants of the camps with whom the evaluators met.

UNFPA is committed to supporting government priorities and systems

> *UNFPA is a development agency, you cannot escape that… I will be here after the crisis wearing a different hat…*
>
> *UNFPA Key Informant*

Government stakeholders noted that UNFPA and other partners are in line with the goals of the central government. Despite frequently changing needs and resources they unanimously attested to UNFPA's flexibility and work in concert with the government.[93]

However, these stakeholders also noted the need for additional commitment towards the handover strategy, specifically a resource plan in place to sustain services for the coming years, with an acknowledgement that there will be a need to establish long-term facilities for the long-term refugees.

An example cited by informants is the need to reorganise the SRH units and survivors centres to permit the government to continue to take over and develop them. For example, the UNFPA-supported survivor centre in Dahuk

[91] Government key informants
[92] Government, implementing partner key informants
[93] Government key informants

has the opportunity to become a centre of excellence in GBV case management that offers training and capacity building resources that can be leveraged for other regions.

The substantial, and worsening, resource constraints that Iraq faces challenges integrating resilience and long-term development into refugee responses

Almost all stakeholders interviewed noted the overwhelming constraint of resources with respect to long-term development. While UNFPA is coordinating closely with ministries, handing over facilities, building capacities, with national partner NGOs remaining in the loop for implementation[94], the government priority to have refugees (and IDPs) leave camps is not likely to be the best solution given the ongoing crisis in Syria and the extensive destruction of homes and infrastructure that are contributing to a protracted refugee and displacement crisis. Indeed, as discussed above, interviewees noted an increase in demand for places in camps due to the increasing levels of poverty among refugees in host communities.

The most significant impediment to longer-term development is the lack of government resources and high unemployment rate region-wide – government interviewees put the real rate at approximately 30%[95]. The resources constraints that the KRG is experiencing due to its discord with the Federal Government has severely impacted the KRG's ability to sustainably manage the facilities supported by UNFPA at the time of research – as an example, several SRH clinics within camp settings noted substantial supplies/medications shortages that are the responsibility of the government to meet.

Further, competition for employment puts refugees (and IDPs) in a more disadvantaged position than the general population. Refugees in camps that are more distant from population centres (e.g. Darashakran Camp or Gawilan Camp) noted that they are at a particular disadvantage, due to the time and expense involved in traveling to a city to seek or engage in employment. Camp inhabitants also noted difficulties in obtaining approvals from (government) camp management to engage in in-camp entrepreneurial activities, which they perceived as part of a strategy to discourage establishment of long-term systems or social environments within the camps themselves.[96]

[94] UNFPA key informants

[95] The World Bank (2018) puts the unemployment rate in governorates affected by ISIS at 21.6% - double that of other governorates

[96] FGD participants, various refugee camps

Note: Evaluation Question 7 relates explicitly to the Hub.

Evaluation Question 8: Efficiency

To what extent does UNFPA make good use of its human, financial and technical resources and maximise the efficiency of specific humanitarian/Syria response systems and processes?

Associated Assumptions:

20. UNFPA has maximised efficiency through a series of humanitarian fast-track and support mechanisms for human and financial resources, such as:
a. Fast-track protocols, policies and procedures (FTP);
b. Surge
c. Commodity procurement (particularly dignity kits and RH kits);
d. Emergency Fund
21. UNFPA has maximised leverage of humanitarian funding – donor, multi-year, and pooled funding – for the response and matched OR and RR appropriately for office sustainability.

FINDINGS

20. Resources for the Iraqi refugee response were efficiently mobilised via HQ and Amman Hub and continue to support programming, though a lack of multi-year funding is an ongoing challenge.
21. Strict disaggregation or separation of funding between IDPs and refugees is burdensome, but donors have been flexible regarding complementary implementation, reflecting the realities on the ground.
22. Human and commodity resource procurement has been adequate, with greater delegation of authority to the CO proving useful.
23. UNFPA Iraq has progressively developed the quantity and quality of its systems and capacity for generation of evidence and data for communications, marketing and fundraising to a high standard but outcome/impact data is still lacking

Resources for the Iraqi refugee response were efficiently mobilised via HQ and Amman Hub, and continue to support programming, though a lack of multi-year funding is an ongoing challenge

UNFPA's refugee response in Iraq has been characterised by a mix of donors and sources of funding. Initially funding came from the pooled funding/CERF, with progressive reliance on a range of donors. In the 2012-2014 period, the CO relied on a limited number of donors for refugee programming (Kuwait, BPRM and OCHA), with the Amman Hub making a positive contribution to fundraising due to the Hub's presence where many donors were located. [97]

The Arab States Regional Office (ASRO) in Cairo was small and limited in capacity to contribute to the Syria crisis in the early years, so the majority of fundraising came via the CO and Hub. From the 2014-2015 period to the time of the research, the substantial IDP crisis has come to dominate the UNFPA response, and UNFPA has relied on a wider range of donors, particularly since cessation of US Bureau of Population, Refugees and Migration (BPRM) funding for UNFPA since 2017.

Many key informants noted, however, that the limited availability of multi-year funding has imposed limitations on UNFPA's (and other implementer's) capacity to focus on medium to longer-term programming, particularly with a view to coherence of programming with long-term development and building of resilience.

…The absence of multi-year funding made us stretch ourselves... It made it harder, because we were also worried and preoccupied about closing down. This is common problem across all agencies.

[97] UNFPA informant

"The interventions … are very short term. I don't see these interventions as very viable for beneficiaries for any long-term benefit."

"UNFPA is still stuck in short-term mode when it needs to build more long-term strategies."

UNFPA, iNGO Key Informants

Strict disaggregation or separation of funding between IDPs and refugees is burdensome, but donors have been flexible regarding complementary implementation, reflecting the realities on the ground

One of the complex features of the Iraq humanitarian crisis is the double nature of the IDP/refugee crisis. While individual initiatives can focus on one or the other of these sub groups within Iraq, particularly in the context of the refugee camps (which are specific to either IDPs or refugees, in host-communities, IDPs and refugees may be located within the same area. For the sake of practicality, UNFPA does not insist that facilities or services are exclusive to any such group within a given host community, and thus refugees can take advantage of facilities that are supported for IDPs and vice-versa. This could potentially be a challenge with respect to disaggregation of data in health facilities, as service providers do not collect data on the IDP or refugee status of the patient – and indeed to do so might invite discrimination or stigma – but donors are not insistent on such disaggregation, which is a positive aspect of UNFPA's programming.[98]

Similarly with respect to administrative arrangements, strict disaggregation of funding per IDP and refugee budget lines can frequently prove challenging, particularly when a given donor supports programming for both groups, but UNFPA has demonstrated technical capacity and systems (see Finding 20 above for evidence related to this), and donor confidence in both[99] ensure that these challenges are met effectively and efficiently.[100]

Human and commodity resource procurement has been adequate, with greater delegation of authority to the CO proving useful

Stakeholders interviewed noted that the deployment of human and physical resources (commodities) in Iraq was indeed assisted by the FTP and surge mechanisms over the course of the crisis. UNFPA senior management staff (and stakeholders in other agencies such as UNHCR) report that the high workload and the working environment in Iraq proved a challenge in terms of high staff turnover (with a high reliance on surge recruitment contributing to this).[101] Interviewees noted that the process might have been facilitated by greater authority on the part of the CO to hire staff, but in the case of the Iraq CO most hiring of international staff was/is controlled and managed by HQ, with a recommendation for more flexible procedures in future humanitarian responses, which is particularly important in sensitive and technical areas such as GBV programming. Such a delegation of authority was applied in the case of procurement (with purchase authorisations raised from US$30,000 to US$100,000), which is reported to greatly facilitate procurement.[102]

UNFPA Iraq has progressively developed the quantity and quality of its systems and capacity for generation of evidence and data for communications, marketing and fundraising to a high standard, but outcome/impact data is still lacking

Data on UNFPA's programming was, in the initial years of the response, limited, due to rapid scaling up of activities and constraints on human resources and capacities among implementing partners. However, the evaluation team have noted the increasing sophistication of UNFPA's data collection

[98] UNFPA key informant
[99] Donor key informant
[100] UNFPA key informant
[101] ibid
[102] Ibid

and management systems over time, with the current systems being well embedded within UNFPA and partners. Examples of currently operational data systems managed by UNFPA include:

- The UNFPA global ATLAS grant management system (operational since 2014);
- The Global Programming System (GPS) electronic workplan management tool which is a comprehensive administrative database;
- The GBVIMS, which UNFPA administers;
- ActivityInfo – an M&E software for humanitarian information management.

These systems are managed by the Iraq CO's M&E/IMS data specialist, who is responsible for overall management of the systems, but also communication of the data requirements to partners and training of partners on data collection and inputting. Typically, partner capacity and engagement with technical tools such as the above is limited and can lead to friction between the fund manager and implementing partner. However, in the case of the UNFPA implementing partners for the refugee response, the evaluation team noted that capacities were high, as evidenced by partner abilities' to successfully engage with UNFPA's reporting systems. Partners reported that UNFPA has invested considerable resources in building them, even to the extent of (partially) funding reporting/data management positions among implementing partners.[103]

As a result, while not exclusively so, most partners (including national NGO partners) were positive regarding both the level of outreach and availability of UNFPA to assist them in their reporting/data management requirements, and their confidence in using the systems. Further, most partners interviewed for the research noted their understanding and appreciation for the ultimate need for such systems and stated that they were able to take advantage of the systems themselves to ensure a two-way flow of information.[104]

These systems, however, are recent in their implementation (i.e. 2017/2018) and have limited or no historical data from the outset of UNFPA's humanitarian programming in Iraq. Further, the data collected and reported on is substantially limited to output/activity or financial data only. Outcome/impact data that can be used to demonstrate quantitative progress of UNFPA's programming is largely absent, as are baselines that can be used as a point of comparison.

[103] Implementing partner key informants
[104] Ibid

Evaluation Question 9: Partnerships

To what extent does UNFPA leverage strategic partnerships within its Response?

Associated Assumptions:

22. UNFPA maximises strategic partnerships to leverage comparative strengths of different agencies / actors and promotes humanitarian principles across partnerships;
23. UNFPA has used evidence and data to highlight key needs through a communications, marketing, and fundraising strategy.

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24. UNFPA's partnership strategy is well grounded in the specific context of available implementing partners focussing on a capacity-building model that is building long-term sustainability of services for refugees as well as overall civil society within the KRI.
25. UNFPA maintains effective and appropriate partnerships with sister UN agencies.

UNFPA's partnership strategy is well grounded in the specific context of available implementing partners focussing on a capacity-building model that is building long-term sustainability of services for refugees as well as overall civil society within the KRI

> *No micromanaging, we work like partners. They are practical and are people you can sit with and discuss any matter. They listen and are accommodating. Few compare to them.*
>
> *iNGO Implementing Partner*

UNFPA supports programming and coordination within and outside the refugee camps within the KRI, via government partners that undertake coordination functions, operate facilities and deliver services, one international NGO and four direct national NGO implementing partners running WGSS and youth centres, as follows:

- Al Messalah (Erbil Governorate)
- CDO (Sulaymaniyah Governorate)
- Harikar (Dahuk Governorate)
- KRG Directorates of Health (DoH) in Dahuk, Erbil and Sulaymaniyah Governorates;
- KRG Directorate for Combatting Violence Against Women (DCVAW);
- Board of Relief and Humanity Affairs (BRHA), Dahuk;
- Joint Crisis Coordination Centers for refugees in Dahuk, Erbil and Sulaymaniyah Governorates
- KRG MOLSA (primarily IDPs, but have the mandate for protection in KRI);
- IMC.

UNFPA has implemented a strategy of working with national NGOs and government since the beginning of its response and since 2013/2014 of transitioning much of its support from international NGOs (IMC, IRC, NRC) to government or CSO partners, and has aimed to achieve the appropriate mix of partnerships across different sectors. Testimony of informants to this research across different sectors (government, civil society) is that this strategy has been successfully implemented and continues to be an effective model as civil society in Iraq grows in technical capacity, with the depth and quality of partnerships increasing closer to the field level.[105]

Since 2011/2012, there has been a changing mix of capacities among different partners as the dynamics of different sectors changes. In the early years of the refugee response, the government (KRG) sector was well-resourced, but the drain on resources resulting from the conflict with ISIS and the disputes with the Federal Government have progressively eroded capacities and service delivery, with KRG increasingly competing with other sectors for scarce resources, and even staff shortages as personnel leave hitherto sought-after government positions for better-paid private sector work.[106]

[105] UNFPA key informants

[106] Government and implementing partner key informants

Conversely, the civil society sector in Iraq, and in the KRI in particular, was nascent and emerging in the 2011-2012 period, with few established national NGOs, particularly with humanitarian experience. The humanitarian response of the past seven years, however, has resulted in increases in the pool of available national NGOs and their capacities. The quality of work undertaken by these national NGOs was acknowledged by almost all stakeholders, and UNFPA has built long-term relationships with several high-quality NGO partners[107], all of which were interviewed for this research and attested to the value (in terms of transfer of resources, capacity-building and technical support) they placed on the partnership with UNFPA. Indeed, the importance of partnerships between government and national NGOs was acknowledged by government stakeholders in the context of both benefitting the population and in terms of the efficient and accountable use of resources.[108]

An advantage in partnerships with national NGOs (particularly for GBV) is their understanding of the local context and their ability to engage with refugees and IDPs. Such NGOs also have close working relationships with their government counterpart (e.g. Directorates of Health) so there is little difficulty in obtaining various permissions and agreements. Further, such partnerships result in cost savings in terms of logistics in comparison to similar partnerships with international NGOs.[109]

National NGO partners also face challenges similar to government partners, however. The limited pool of available resources means that NGOs compete for funding in areas that may not reflect their core competencies, and the inevitable reductions in international resources in the coming years are unlikely to be matched by increases in nationally (i.e. government) available resources for some time.

Further, scaling back of activities by many international organisations follows a pattern of nationalisation of many positions within these organisations – frequently drawing on the pool of experienced national NGO staff, thus leading to a 'brain-drain' that several national NGO partners noted as an ongoing challenge to ensuring quality work.[110] It creates an ongoing need for investments in the capacity and skills of partner staff, particularly with respect to the complex management and data requirements of UNFPA partnerships outlined above.

A final potential challenge to civil society partnerships within the KRI is increasingly strict registration requirements for national NGOs deriving from the federal government. While not currently a barrier to operations for organisations, it is a factor that may impact the legality or availability of partnerships in the future, a contingency worthy of note in future strategic planning.

UNFPA maintains effective and appropriate partnerships with sister UN agencies

UNFPA Iraq's operations are characterised by robust collaboration between UN agencies, specifically with UNHCR and UNICEF. As an example, UNFPA at the time of the research was working with UNICEF on a GBV programme funded by Norway – 50% of this earmarked for refugees. some UNHCR protection actors noted occasionally strained relationships, but all stakeholders highlighted seeking to establish effective and productive working relationships.

Via the cluster system, the relevant UN agencies work together to ensure no duplication of services or programming and that each adds value in their area of comparative advantage and mandate. The only challenges noted are human resource gaps – regular turnover of (all) UN agency staff results in gaps in communication or in coverage of key positions (particularly technical roles such as within the Sub-Cluster, GBVIMS management etc). Once positions are filled and incumbents familiarise themselves with the context, the roles and their counterparts in other agencies, these issues ease.

[107] Such as NGOs Harikar, CDO, Zihan and Al Mesalah – see Evaluation Question 9, Partnerships, for more detail
[108] Government key informant.
[109] UNFPA and Donor key informants
[110] Implementing partner key informants.

Evaluation Question 10: Effectiveness

10a: To what extent does the UNPFA response contribute to access to quality SRH and GBV services as life-saving interventions for women, girls, and youth in the Syria Arab Republic;
10b: To what extent does the UNFPA response contribute to access to quality SRH and GBV services as life-saving interventions for Syrian refugee and host community women, girls, and youth in Turkey, Lebanon, Jordan, and Iraq.

Associated Assumptions:

24. UNFPA programming outputs contribute to the following outcomes articulated in the reconstructed ToC:[111]
    a. Syrian women, adolescents and youth access quality integrated SRH and GBV services:
    b. Syrian women, adolescents and youth benefit from prevention, risk reduction and social norm change programming and are empowered to demand their rights;
    c. Humanitarian community is accountable for SRH & GBV interventions mainstreamed across the overall humanitarian response.
25. UNFPA programming outputs contribute to the following outcomes articulated in the reconstructed ToC:
    a. Syrian refugee women, adolescents and youth, and affected host communities in surrounding countries access quality integrated SRH & GBV services:
    b. Syrian refugee women, adolescents and youth, and affected host communities in surrounding countries benefit from prevention, risk reduction and social norm change programming and are empowered to demand rights;
    c. Humanitarian community is accountable for SRH & GBV interventions mainstreamed across the overall humanitarian response.

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26. UNFPA has been, and continues to be, a key player in the delivery of quality SRH and GBV services for women, girls and youth within refugee camps and host communities in the KRI. However, specific, quantifiable outcomes of these important interventions cannot reliably be determined due to a lack of data.
27. Although quantitative data on the outcomes of activities is lacking, stakeholder feedback indicates that the modalities of operation – via a mix of CSO and government partnerships, promotes comprehensive and quality services.
28. While UNFPA's focus on building awareness of the dangers of early marriage (i.e. on adolescents) is positive, there was little evidence of the effectiveness of this, and indeed economic constraints may be resulting in increases, particularly among population subgroups.
29. While UNFPA has ensured coverage of SRH and GBV services among refugee populations, the needs are increasing as resources are diminishing, thus it is not clear whether SRH and GBV risks are reducing and/or norms have changed.

UNFPA has been, and continues to be, a key player in the delivery of quality SRH and GBV services for women, girls and youth within refugee camps and host communities in the KRI. However, specific, quantifiable outcomes of these important interventions cannot reliably be determined due to a lack of data

Accessing Quality Services

Since the onset of the refugee crisis, and through the IDP crisis, UNFPA has provided a range of direct and indirect support to government and NGO stakeholders providing services in eight of the nine Syrian refugee camps within the KRI. The provision of MISP training and SRH, dignity, and hygiene kits

[111] see Annex IV

contributed to increasing the quality of the services provided by government and NGO service providers for SRH and for GBV.

As of November 2017, UNFPA has supported facilities (camp-based WGSS, SRH clinics and youth centres, women's community spaces, mobile clinics and a survivor's centre) and provided SRH services to 726,000 refugees and IDPs and GBV services to over 588,000 IDPs and refugees. UNFPA tracking mechanisms do not specifically disaggregate refugees and IDPs, particularly within host communities where both groups overlap, but on a camp basis alone, UNFPA has supported SRH and GBV services to approximately 43,000 women and girls (approximately 48% of refugees in camps).[112] Dignity kits and hygiene kits have continued to be provided through WGSS as a tangible attraction to encourage women to access WGSS facilities.

Working through the DoH, UNFPA is providing direct support for salaries and in building the capacities of staff through ongoing trainings such as CMR to ensure complete SRH and GBV service provision coverage in camps. A good practice in specific camp settings has been the use of Syrian medical staff to provide SRH services where available. While this has led to some dissatisfaction among government stakeholders[113], research respondents noted that it has proven popular among Syrian refugees, and facilitated access to SRH services by women.[114]

However, a quantitative determination of the *effectiveness* of the activities supported that reach the above population in terms of outcomes on specific indicators (such as incidence of child marriage, cases of GBV etc.) is not possible given the lack of systematic quantitative data. Indeed, this gap has been noted by a previous evaluation (of the UNFPA 2011-2014 CPAP) which noted that its work was *"limited by deficiencies in monitoring mechanisms and lack of relevant data. Although the original plan included defined outcomes and outputs and indicators, the mechanisms for achieving these, the tools to measure them, and the timeline for measurement was not clear leading to a loss of opportunity to collect relevant and critical supportive data"*.[115]

Evidence from FGDs with youth in camp settings and interviews with implementing agency staff support the conclusion that UNFPA-supported youth centres are effective in reaching youth with key health and GBV-related messages, as well as providing them a valuable social outlet and opportunities to build skills during their formative years. UNFPA's Y-PEER (youth peer to peer education), supported by the Adolescent Girls Toolkit, is a means of transferring the benefits of youth engagement to a wider circle of youth, and in ameliorating some of the negative consequences for youth of life as a refugee.

Throughout the course of its humanitarian response in Iraq UNFPA has conducted early marriage assessments and awareness-raising campaigns for camp and non-camp inhabitants, though in the absence of detailed tracking of outcomes (rather than activities/outputs), it is not possible to determine the results of these activities, i.e. are they resulting in changes to behaviours. Other WGSS activities include early marriage/GBV prevention messages and counselling and information, education, and communication materials for safe delivery, antenatal care, postnatal care, contraception, and nutrition during pregnancy. Further, UNFPA continues to seeks evidence to drive programming for the future, for example ongoing research among survivors of GBV and assessments on the prevalence of early marriage in order to formulate its programme strategies.

[112] 3RP 4Ws Fact Sheet, November 2017 – numbers are extrapolated from totals based on camp populations as a % of total refugees in Iraq.
[113] Government key informant
[114] UNFPA, implementing partner, RH clinic staff key informants
[115] Iraq Country Programme 2011 – 2014 Evaluation Report; February 2015

Humanitarian community is accountable for SRH and GBV mainstreamed across the overall humanitarian response

In Iraq the KRG has led the refugee response as 97% of refugees are located within the KRI. The KRG has a relatively progressive policy environment with respect to SRH and GBV (see finding 3), though the resource constraints which it currently faces mean that it is heavily dependent on the support of UN agencies such as UNFPA and is focused on meeting minimum SRH/GBV services requirements via its limited resources. Overall, however, it is responsive to UNFPA's position of SRH and GBV being understood as life-saving priority humanitarian interventions[116].

The modalities of operation – via a mix of CSO and government partnerships, promotes comprehensive and quality services

As in other Syria response countries, the evolution of the WGSS model is widely recognised as successful, as is the of the priority accorded by stakeholders to SRH and GBV in the refugee response. Testimony of stakeholders (NGO, government and camp inhabitants) supports the conclusion that UNFPA's approach to partnerships – a mix of government and NGO partners (discussed in detail under Evaluation Question 9) has proven effective in reaching refugees with services, ensuring mechanisms for feedback and thus tailoring of services, and building long-term durability of services and institutions. However, there are some limitations in the depth and coverage of the resources themselves (discussed further below), so ongoing reflection and perhaps reframing of modalities on the basis of beneficiary feedback is warranted.

While UNFPA's focus on building awareness of the dangers of early marriage (i.e. on adolescents) is positive, there was little evidence of the effectiveness of this, and indeed economic constraints may be resulting in increases, particularly among population subgroups.

Through careful focus on adolescents via its youth programming, UNFPA has conducted early and ongoing work on mitigating the vulnerabilities of adolescents to GBV such as early marriage, rates of which in the KRI are among the highest in the middle east (24%).[117] Examples of interventions include:

- Awareness campaigns in all camps of the dangers and illegality of early marriage;
- Coordination with different stakeholders to create and implement an integrated strategy on early marriage via the KRI Child Marriage Taskforce
- Support (via the Taskforce) to the production of a key 2015 study of early marriage in the KRI *Inter-Agency Guidance Note: Prevention of and Response to Child Marriage* and an associated fact sheet;
- Ongoing support to the KRG via the High Council of Women Affairs which has implemented public awareness campaigns on the dangers of early marriage;
- Ongoing work (with ASRO) on a survey of child marriage among Syrian refugees in KRG to be completed in July 2018.

Despite UNFPA's work in the area, however, limited evidence was viewed by the evaluators as to the effectiveness of campaigns and interventions – some (though not all) informants at refugee camp level noted that early marriage may indeed be on the increase as a coping strategy as economic circumstances worsen. While awareness of the negative consequences and the illegal nature of early

[116] Various government key informants

[117] Inter-Agency Child Protection Assessment Erbil, Sulaymaniyah and Duhok Governorates Kurdistan Region of Iraq, July & August 2014

marriage were widely exhibited by interviewees, such awareness does not necessarily translate into changes in attitudes or practices. Indeed, some informants cited the dangers of a "spill-over effect", i.e. an increase in tolerance of early marriage within Iraqi citizens of the KRI due to the higher prevalence among Syrian refugees.[118] There are opportunities for UNFPA to deepen its engagement with this issue and seek to address the fundamental drivers of early marriage, for example in economic/livelihood support via additional NGO partnerships.

While UNFPA has ensured coverage of SRH and GBV services among refugee populations, the needs are increasing as resources are diminishing, thus it is not clear whether SRH and GBV risks are reducing and/or norms have changed

The evaluation team recorded testimony from implementing agencies, government partners and refugee community members of the effectiveness of UNFPA-supported programming in reaching vulnerable refugee populations. However, monitoring of initiatives is undertaken solely on the basis of activities and outputs, with little or no evidence of historic systematic monitoring of outcomes, so the results of UNFPA's activities can only be determined with reference to the above qualitative feedback from stakeholders provided for this evaluation research. Indeed, many stakeholders noted *challenges* to achieving overall net positive outcomes of such interventions – improved SRH, reduced incidence of GBV etc. A common theme of feedback from staff in SRH centres, WGSS and directly from refugees themselves was that of challenges related to increasing economic hardship within the KRI, and concerns that interventions supported by UNFPA are focused on survivor support (via WGSS) but insufficiently address the underlying causes of poor health and GBV through social norm changes and other prevention strategies. Many refugees articulated how their increasing hardship has led to some of the following negative outcomes:

- An inability to access appropriate healthcare due to poor public health services provision – essential for referrals from camps SRH clinics in (including a reliance on private health providers);
- Increasing frustration and poor psychosocial/mental health among family members, particularly men and boys, who cannot access employment;
- Increasing negative coping strategies such as early marriage for economic reasons;
- Increased levels of domestic violence within families.

While stakeholders report that UNFPA's work has led to increased awareness of the importance of SRH and the negative consequences of GBV and early marriage, changes in actual norms and practices among refugees are, anecdotally, not following suit to the same extent.[119] The UNFPA-supported research on early marriage and GBV survivor testimonies underway at the time of the research should prove useful in assessing the extent to which norms and attitudes/practices have changed within Iraq, and so direct future programming directions. It seems clear, however, that a focus on economic empowerment/livelihoods creation among refugees would be a useful complement to UNFPA's support to SRH and GBV services, to help address some of the underlying determinants of poor SRH and GBV.

[118] PHC staff, NGO key informants, FGD participants
[119] Ibid

Conclusions

A. UNFPA's refugee response programme is appropriately integrated with its IDP programming. This is true both for UNFPA supported direct programming and for UNFPA coordination responsibilities across SRH and GBV. UNFPA is managing this integration well, with no obvious major gaps in coverage for refugees, despite the much more sizable IDP response.

B. The refugee response operates closely with the government of the KRI on the basis of a robust relationship with a high degree of direct support for government service provision, in the light of chronic resource constraints. This integration with government services is beneficial in terms of avoiding parallel systems and building long-term resilience and sustainability. However, the resource constraints, and the needs, are unlikely to diminish in the short term, and indeed international donor support for Iraq may well reduce in the coming years with the cessation of internal conflict. State services – already at breaking point - may find themselves increasingly constrained, leading to further shortages and resulting increasing demands on UNFPA as a provider of last resort.

C. UNFPA's partnership modalities with four main national NGO partners to implement GBV and youth services within camp settings has proven successful in terms of the depth and breadth of the services provided, and also in terms of the development of civil society within northern Iraq. While capacity-building of these partners is an ongoing process, they are largely satisfied with the relationship and partnership between themselves and UNFPA.

D. The refugee response was slow to start at the beginning of the crisis, due largely to a widespread underestimation of the scale and length of the crisis by all stakeholders. However, UNFPA has increased the scale of its work over the duration of the crisis and has embedded robust systems and learned from the lessons of the early years. However, systems insufficiently track outcome/impact data to adequately demonstrate the results of UNFPA's work.

E. UNFPA has largely held closely to its organisational mandate within Iraq, although there are opportunities to reflect on this and refocus, for example with respect to the introduction of men's spaces/men's centres in camps – arguably a departure from best GBV practice.

F. UNFPA's leadership of the GBV Sub-Cluster/WGs and RH Working Group has received mixed reviews by other members and stakeholders. While variations in human resource capacity/ availability over the course of the entire response period led to occasional challenges within these groups (and double/triple hatting is a notable feature of work in Iraq), UNFPA has consistently sought to address the challenges and ensure increasingly smooth coordination and leadership year-on-year.

G. Despite efforts to boost human resources, double/triple hatting is a notable feature of work in Iraq, to the extent of becoming normalised. Such a practice absorbs any reserve human resources capacity within the CO and has exacerbated coordination bottlenecks due to staff absences or turnover.

H. The programming and services that UNFPA supports play a vital role in maintaining the health and welfare of refugees in northern Iraq. While the KRG's policy of welcoming Syrian refugees, and the social cohesion within the KRI that facilitates their integration into Kurdish society, has played an important part in underpinning their welfare within Iraq, UNFPA, via its partners, has effectively and efficiently provided a range of services, particularly for those refugees in camps (and hence the most economically vulnerable).

I. Despite UNFPA's good performance relative to its size and resources, limitations in services still exist. In terms of SRH, pre and post-natal care in some of the camps (particularly those located some distance from urban centres). Further, government of KRI resource constraints are resulting in limitations in availability of medications/supplies.

J. Worsening economic conditions in Iraq and insufficiently comprehensive livelihoods support (for which sister UN agencies bear more responsibility than UNFPA) means that income generating opportunities for refugees are increasingly limited. This has a clear link to GBV.

Suggestions for Recommendations

A. The poor economic environment in the KRI is leading to chronic public service provision shortages and increasing poverty among refugees, many of which have depleted their economic reserves and run the risk of engaging in negative coping strategies. UNFPA should prepare for this eventuality and increasing calls as the provider of last resort for SRH and GBV services. A potential strategy may be the use of health vouchers for emergency cases to private healthcare providers or working with other agencies for cash supports and development of resource-poor strategies.

B. UNFPA Iraq should seek to deepen its engagement with the root causes of GBV. A limited amount of livelihoods work supported among camp inhabitants does not appear to have had significant economic benefits. Economic hardship was the most significant development issue noted amongst interviewees for this research. Economic deprivation impacts GBV incidence and the ability to access alternative sources of healthcare in the face of public service shortages.

C. UNFPA should reinforce development of human resources capacity. From an internal perspective, extensive double-hatting and over-reliance on short term surge staffing for long term issues leads to gaps and tensions both within UNFPA and with partners. From an external perspective, attrition among implementing partners means that new incumbents require capacity building on a range of technical skills.

D. UNFPA should continue its handover of programming responsibilities to national NGOs and building their capacity to implement effectively, including administratively. National NGO partners interviewed as part of the research demonstrated good capacity and institutional experience, and this should be reinforced, particularly with respect to issues of national registration.

E. The current focus of support to camp settings vs host community settings has worked well for UNFPA. However, the deteriorating economic environment is resulting in host community refugees seeking to enter or return to camps as their resources become exhausted and they wish to avail of free services within the camps. If UNFPA seeks to support the government strategy of encouraging refugees to remain within host communities, then a review the targeting of resources should be undertaken.

F. UNFPA Iraq should keep WGSS focussed on women and girls, in line with its mandate and global best practices on GBV programming.

G. Inasmuch as PSEA is equally relevant to Syrian refugees in Iraq as it is to Iraq IDPs, UNFPA should engage more deeply with PSEA issues in Iraq *in line with its mandate* – notably ensuring that survivor-centred protocols, approaches and mechanisms be established and embedded. This should include information sharing protocols, skills/training in specialist areas such as dealing with children, and appropriate mechanisms for authority and independence of the PSEA Taskforce. UNFPA should advocate for responsibility for the PSEA Taskforce to lie directly under the RC as designated in the SG's bulletin (i.e. not within UNFPA's mandate). The GBV SC can then engage with the Task Force in supporting survivor care (potentially with an MOU around this). Guidance from UNFPA HQ, the PSEA Network and the planned PSEA Network hubs in Damascus and Amman could prove valuable in the Iraqi context in terms of technical inputs and alignment with global practice.

H. People with disabilities should be actively addressed by UNFPA's partners in camp settings, specifically with respect to the SRH needs of young people and their increased vulnerability to GBV.

I. UNFPA should seek to leverage its data collection and management systems to track outcome/impact data to adequately demonstrate the results of its work.

Annex I: List of Key Informants

Name	Title	Agency	Office	Country	Gender
Angela	GBV Programme Manager	IMC	Erbil	Iraq	f
Diana	Project Manager	Al Masalah	Erbil	Iraq	f
Nasreen Muhmmed	Social Worker	Al Masalah	Basirma Camp	Iraq	f
Rana Asalis Ahmed; Nezha Ali Omer; Rokstan Suliman	Volunteers	Al Masalah	Basirma Camp	Iraq	f
Dr. Wail	Health Cluster Coordinator	WHO	Erbil	Iraq	m
Elizabeth Hughess	GBV Programme Manager	IRC	Erbil	Iraq	f
Various	4 Programme Staff, Women's Social Space,	Harikar	Gawilan	Iraq	f
Sana (case manager), Nisha (social worker), Layla (social worker)	4 Programme Staff, Women's Social Space,	Harikar	Domiz 1	Iraq	f
Neshwa	Project Manager	CDO	Barika	Iraq	f
N/a	Data Entry (part time)	CDO	Barika	Iraq	f
Florence Adiyo	Co-coordinator GBV Subcluser	IMC	Erbil	Iraq	f
Gertrude Mubiru	Head of Office, GBV specialist	UNFPA	Duhok	Iraq	f
Ivana Chapcakova	GBV Specialist	UNICEF	Erbil	Iraq	f
Chiman Salih	Head of Relations	JCCC	Suly	Iraq	f
Mr Payma	Camp Manager, Barika	JCCC	Suly	Iraq	m
Lt Aram Aroshi	Head of Office	DCVAW	Duhok	Iraq	m
Mohammed Kirkuklizada	Youth Analyst	UNFPA	Erbil	Iraq	m
salwa musa	Communications Specialist	UNFPA	Erbil	Iraq	f
layla Hransnica	Senior Operations Manager	UNHCR	Erbil	Iraq	f
Nizar Al Muhyedin	Asst Programme Officer	UNHCR	erbil	Iraq	m
Emese Kantor	Protection Officer, SGBV	UNHCR	Erbil	Iraq	f
Rebaz Lak	Assistant Public Health Officer	UNHCR	Erbil	Iraq	m
Katarzyna Kot Majewska	Protection Cluster Lead at KRI level	UNHCR	Erbil	Iraq	f
Mohammed Khan	Proteciton Cluster Lead at National level	UNHCR	Erbil	Iraq	m
Florence Mahiya	GBV Specialist	Harikar	Dahuk	Iraq	f
Azhee Amin	GBV Programme Analyst	UNFPA	Erbil	Iraq	f
Ali Zedan	GBV Programme Analyst	UNFPA	Erbil	Iraq	m
Various	Idrees, Layla, Dr. Rosheen & Mr. Baravan, Programme staff, BRHA (Board of Relief and Humanities Affairs)	BRHA	Dahuk	Iraq	2f, 2m
Various	Bahtyar Ahmed Gen Director, Nashwakan PM, Dira Project Coordinator – Tablo Reporting	CDO	Sulaymaniyah	Iraq	2f, 2m
Dr Nezar Ismet Teyip	Head of Department	Directorate of Health	Dahuk	Iraq	m
Dr Haydar Al-Tawela	Program Analyst, RH	UNFPA	Erbil		m
Kara Agha	Hum Programme analyst - GBV, RH and Youth	UNFPA	Sulaymaniyah		f
Lionel Laforgue	GBV Coordinator	UNFPA	Erbil		m
Murad Ahmad	Finance Officer	UNFPA	Erbil		m
Nestor Owomuhangi	Deputy Representative	UNFPA	Erbil		m

Nicia El Dannawi	UNFPA GBVSC Coordinator	UNFPA	Erbil		f
Saleh	Executive Officer	Harikar	Dahuk		m
Various	Kawa (PM), Qasim (Chairman), Mumtaz (Finance)	Zihan	Erbil		m
Various	9 programme staff - youth center - Domiz 1	Harikar	Dahuk		4m, 5f
Sameer, Seepal	Programme Analysts	UNFPA	Dahuk		1f, 1m
Lana, Shaheen	Programme Coordinator, Outreach Worker	Al Masalah	Erbil		2f
Dr Omer Habib	Head of Sub-Office/Programme Specialist	UNFPA	Sulaymaniyah		m
Dr Roshgar	Focal Point	Directorate of Health	Sulaymaniyah		f
Matthew Totilo	Refugee and IDP Affairs coordinator	BPRM	Erbil		m
Alisher Ayunov	M&E Specialist	UNFPA	Erbil		m

Annex II: Master List of Key Informant Interview Questions

Introduction – to all:
Introduce interviewer; introduce evaluation; ensure interviewee is clear that confidentiality will be maintained and we will not be attributing any particular comment to any particular individual within the report.

Q1 – Please can you tell me a little bit about your role and how your work relates to UNFPA's Response.

Relevance – how well does the UNFPA Response address the stated needs of people, and how well does it align to humanitarian principles and a human rights approach?
Q2 – How well do you think the UNFPA response addresses stated needs of individuals and communities. How do you know this? Evidence?
Q3 – How has the UNFPA response included gender and inclusion analysis? Evidence?
Q4 – How does the UNFPA response adhere to humanitarian principles, and IHL / IRL? Evidence?
Q5 – How has UNFPA directed or supported the overall SRH response to be based on identified needs? Evidence?
Q6 – How has UNFPA directed or supported the overall GBV response to be based on identified needs? Evidence?

Relevance – how well has the UNFPA Response adapted since 2011 based on changing needs and priorities?
Q7 – How has the UNFPA response adapted to changing needs and priorities of people? How do you know this? Evidence?
Q8 – How has the UNFPA response built upon UNFPA's comparative strengths compared to other actors? How do you know this? Evidence?
Q9 – Is there evidence that the UNFPA response has adapted over time based on its comparative strengths compared to other (changing) actors? Evidence?

Coverage – how well has UNFPA reached those with greatest need – geographically and demographically?
Q10 – How well has the UNFPA response reached those most in need – geographically? Evidence?
Q11 – How well has the UNFPA response reached those most in need – demographically? Evidence? – (ask specifically about adolescent girls, people with disabilities, LGBT populations).

Coordination – how well has UNFPA led, directed, supported coordination mechanisms for SRH and GBV?
Q12 – How has UNFPA led and supported the RH WG? Evidence?
Q13 – How has UNFPA led and supported the GBV SC? Evidence?
Q14 – How has UNFPA led and supported the youth WG? Evidence?

Coherence – alignment with UNCT / HCT / Government / UNFPA HQ, RO, CO strategies, national government strategies, SC and WG strategies, and normative frameworks
Q15 – How does UNFPA drive focus on SRH and GBV at UNCT and HCT levels? Evidence?
Q16 –How does the UNFPA response align with global UNFPA strategy? Evidence?
Q17 – How does the UNFPA response align with EECARO / ASRO strategies? Evidence?
Q18 – How does the UNFPA response align with the CPD? Evidence?
Q19 – How does the UNFPA response align national Government prioritisation? Evidence?
Q20 – How does the UNFPA response align with MISP and with GBV guidance?
Q21 – How does the UNFPA response align with RH WG / GBV SC strategies? Evidence?

Connectedness – humanitarian-development nexus
Q22 – How does the UNFPA response promote resilience, sustainability, and working towards the humanitarian-development continuum? Evidence?

Efficiency – Hub and other aspects (Fast-Track Procedures (FTP), surge, commodity supply, multi-year funding) and partnerships
Q23 – How has the Hub contributed to the UNFPA response? What are the benefits? What challenges have there been?
Q24 – How have FTP been used? What are the benefits? What challenges have there been?
Q25 – Has surge been used? What were the benefits? What challenges have there been?

Q26 – How has commodity procurement (i.e. dignity kits, and RH kits) contributed to the overall response? What are the benefits? What challenges have there been?
Q27 – What impact has multi-year funding opportunities had on the UNFPA response?
Q28 – How has UNFPA used partnerships strategically? Evidence?

Effectiveness – outcomes across WoS and regional refugee and resilience response
Q29 – How effectively has UNFPA; provided quality MNH, SRH, GBV, and HIV services inside SAR, increased the capacity of Syrian providers, integrated SRH and GBV into life-saving structures, and used robust data to inform programming? Evidence?
Q30 –How effectively has UNFPA: provided quality MNH, SRH, GBV and HIV services to refugee and host community populations in the regional response, increased the capacity of local providers, integrated SRH and GBV into life-saving structures, and used robust data to inform programming? Evidence?

Notes:
Questions are not defined as a formalised interview process with all questions being asked in order. The key informant interview is a semi-structured process with the questions providing
Evaluation Team Members should select questions as per relevant to specific KII, grouped as:

- UNFPA Global Colleagues
- UNFPA Regional Colleagues
- UNFPA Hub / Country Colleagues
- Other UN Agency Global Colleagues
- Other UN Agency Regional Colleagues
- Other UN Agency Hub / Country Colleagues
- NGO Global Colleagues
- Implementing Partner Country Colleagues
- Other NGO Country Colleagues
- CSO Colleagues
- Government Partners
- Donor Partners
- Academic Partners

Annex III: Schedule

	Tuesday 01 May	Wednesday 02 May		Thursday 03 May		Sunday 06 May	Monday 07 May	Tuesday 08 May	Wednesday 09 May		Thursday 10 May	
		Brian	Jeanne	Brian	Jeanne				Brian	Jeanne	**Brian**	**Jeanne**
0700-0900					Dr. Wail, WHO at WHO office 8:15 - 9:00	0700 - depart for Dahuk (BOC+JW)		0700 - depart for Suly		Elizabeth Hughes		
0900-1000			Nestor UNFPA - BOC		Layla UNHCR Senior Ops 9:00 - 10:00 at UNHCR office						Tolio, Matthew A (BPRM) US consulate	
1000-1100				Dr. Shahwan Erbil DOH		UNFPA Sub-Office, Dahuk		UNFPA Suly Sub-Office			Benaflawa Women's center	
1100-1200						DoH, Dahuk						
1200-1300				UNFPA IP FP Ali Zedan GBV Program Analysts		BRHA, Dahuk	Gawilan Camp, Dahuk		Drashakran (KIIs with Al-Messale GBV, and RH Zhian- RH focal points) FGD with GBV and RH groups)	Basirma camp GBV Women Center		
1300-1400			Nestor UNFPA -BOC	UNFPA IP FP Azhee GBV Program Analysts	Ivana UNICEF GBV 13:00-14:00	Domiz 1 Camp		Arbat Camp (KIIs, FGDs)				
1400-1500	Briefing with UNFPA	UNFPA comms	UNFPA Finance - BOC	Nicia ElDannawi, GBV Sub-Cluster Coordinator	Florence SC Co-coord IMC 2.15-3 JW IMC office	Domiz 2 camp						
1500-1600		unfpa yotuh analyst		1515-1615 Lionel Laforgue, GBV Coord UNFPA	Angela IMC		Return to Erbil	Return to Erbil			debrief	debrief
1600-1700		unfpa m\&e	Dr, Haydar 15:30 - 16:30 UNFPA office	1615-1715 Saeed UNFPA RH Coord UNFPA-JW						Katarzyna Kot-Majewska, Refugee focal point Protection Cluster at UNHCR office	debrief	debrief

Annex IV: Reconstructed Theory of Change