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

LEBANON COUNTRY NOTE

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Acronyms

3RP	The Regional Refugee and Resilience Plan
ANC	Ante-natal care
ASRO	Arab States Regional Office
AUBMC	American University of Beirut Medical Centre
BEmOC	Basic Emergency Obstetric Care
CEmOC	Comprehensive Emergency Obstetric Care
CEDAW	Convention on the Elimination of Discrimination Against Women
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
CPR	Contraceptive Prevalence Rate
CSO	Civil Society Organisation
DRC	Danish Refugee Council
DV	Domestic Violence
EECARO	Eastern Europe and Central Asia Regional Office
EmOC	Emergency Obstetric Care
FGD	Focus group discussion
FP	Family Planning
FTP	Fast Track Procedures
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
GoL	Government of Lebanon
GoS	Government of Syria
HC/RC	Humanitarian Coordinator/Resident Coordinator
HCT	Humanitarian Country Team
HFCB	Humanitarian and Fragile Contexts Branch
HI	Humanity & Inclusion (previously Handicap International)
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
ICPD	International Conference on Population and Development
IEC	Information, Education and Communication
IHL	International Humanitarian Law
IHRL	International Human Rights Law
IM	Information Management
IMC	International Medical Corps
IMS	Information Management System
INGO	International Non-Governmental Organization
IOM	International Organization for Migration
IPV	Intimate partner violence
IRC	International Rescue Committee

IRL	International Refugee Law
ISG	International Solutions Group
ISIS	Islamic State of Iraq and Syria
ISP	Information sharing protocols
ISWG	Inter Sector Working Group
IUD	Intra-uterine Device
IAWG	Inter-agency Working Group for Reproductive Health
IWSAW	Institute for Women's Studies in the Arab World
KII	Key Informant Interview
LCO	Lebanon Country Office
LCRP	Lebanon Crisis Response Plan
LGBT	Lesbian, Gay, Bisexual and Transgender
M&E	Monitoring and Evaluation
MDGs	Millennium Development Goals
MISP	Minimum Initial Services Package
MMR	Maternal Mortality Rate
MMU	Mobile Medical Unit
MNH	Maternal and New-born Health
MoSA	Ministry of Social Affairs
MoPH	Ministry of Public Health
MoI	Ministry of Interior
MRR	Map of Risks and Resources
NGO	Non-governmental Organization
OCHA	Office for the Coordination of Humanitarian Affairs
OR	Other Resources
OR	Operational Review
PHCC	Primary Health Care Centres
PLWHA	People living with HIV and AIDS
PSEA	Protection from Sexual Exploitation and Abuse
PSS	Psychosocial Support
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
SCR	Security Council Resolution
SDC	Social Development Centre
SDGs	Sustainable Development Goals
SGBV	Sexual and Gender-based violence
SGBV TF	Sexual and Gender-based Violence Task Force
SRH	Sexual and Reproductive Health
SRHiE	Sexual and Reproductive Health in Emergencies
SRHR	Sexual and Reproductive Health Rights
SRD	Syrian Relief and Development
SWG	Sub-Working Group
RR	Regular Resources
TFR	Total Fertility Rate
ToC	Theory of Change

UN	United Nations
UNDAF	United Nations Development Assistance Framework
UNDCS	United Nations Development Cooperation Strategy
UNDP	United Nations Development Programme
UNCT	United Nations Country Team
UNHCT	United Nations Humanitarian Country Team
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children Fund
UNRWA	United Nations Relief and Works Agency for Palestinian Refugees
UNSF	United Nations Strategic Framework
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 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.[1]

Lebanon currently has the highest per capita concentration of refugees worldwide. With a Lebanese population of 4.2 million living in Lebanon, the country also hosts just over 1 million registered Syrian refugees, and an estimated additional half million who are unregistered. Lebanon also hosts approximately 6,000 Iraqi refugees, and an estimated 174,000 Palestinian refugees.

Since 2011, the United Nations Population Fund (UNFPA) has been responding to the escalating crisis. The UNFPA Lebanon Country Office (LCO) has expanded programming from policy development with government partners, to a focus on direct service delivery through support to non-governmental organization (NGO) partners, capacity building, coordination for gender-based violence (GBV) and sexual and reproductive health (SRH), promotion of GBV and RH as necessary life-saving humanitarian interventions within the wider humanitarian community, and continued partnership with government counterparts.

FINDINGS

1. UNFPA's support to SRH service delivery is relevant to the needs of the affected population. The services are based on assessed and stated needs of the affected populations. UNFPA have used a variety of entry points and methods for ensuring refugee access to quality SRH services. Clients report these services to be of generally high quality.
2. UNFPA's support to GBV-related systems and services, empowerment activities, and peer-to-peer outreach are relevant to the needs of women and girls. More recently, in alignment with the Sexual and Gender-based Violence (SGBV) Task Force workplan, UNFPA has added outreach targeting men and boys. It is not clear the extent to which this outreach focuses on social norms change related to GBV.
3. The integrated youth programming offers an opportunity to scale up attention to an underserved demographic in humanitarian response, particularly adolescent girls.
4. LCO and its partners have incorporated gender and inclusion considerations into programming, with an acknowledged lack of focus on people with disabilities, for which LCO, along with the SGBV Task Force, aims to improve, starting with improved collection of disability-disaggregated data.
5. UNFPA's tools and guidance reflect human-rights based approaches.
6. Although UNFPA struggled to find footing in the early stages of humanitarian response, shifts in approach following the 2013 Country Programme Evaluation meant that UNFPA prioritised collecting and using data in order to improve their capacity to identify and meet critical needs in the refugee response. As a result, UNFPA is notable within the United Nations (UN) community for its ability to ground its interventions in empirical analysis.

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

7. UNFPA has clearly and effectively based its response on its comparative strengths in delivering SRH and GBV programming, with its youth programming focused on peer-to-peer activities integrated into SRH and GBV programmes.

8. Despite these important contributions, the relatively small scale of UNFPA's response was noted by UN and donor stakeholders as limiting UNFPA's ability to react flexibly to changing needs associated with the Syria crisis.

9. Geographically, UNFPA has made advances in ensuring coverage across many locations in Lebanon, particularly through its commodities distribution and capacity-building efforts.

10. UNFPA has used interagency vulnerability criteria and service mapping to prioritise areas with limited services and critical funding gaps, implementing an integrated approach that supports national partners in order to capitalise on limited resources for the broadest reach, and through Mobile Medical Units (MMUs) in the hardest-to-access locations. .

11. Demographically, UNFPA's prioritisation of women and girls is clearly aligned with their mandate. However, programmes may not be effectively serving younger adolescent girls (in the 10-14 year-old range). There is no specialised programming for people with disabilities, nor for LGBTI populations.

12. UNFPA facilitates coordination of the RH Working Group, the Clinical Management of Rape (CMR) Task Force, and the SGBV Task Force. All coordination mechanisms are informed by actions plan. The SGBV Task Force and the RH Working Group have strong engagement of multiple partners and are considered important mechanisms for improving response to women and girls affected by the Syria crisis. The recent action plan development by the CMR Task Force holds promise to improve that area of intervention.

13. UNFPA's engagement in SRH and GBV coordination, as well as its close working relationship with government partners, has facilitated its leadership on SRH and GBV response in the Syria crisis. However, UNFPA's presence at other UN fora (e.g. the United Nations Country Team--UNCT and United Nations Humanitarian Country Team--UNHCT) is less visible.

14. UNFPA's response is aligned with global, regional and national mandates and priorities, and in particular, helps to shape the Lebanon Crisis Response Plan (LCRP).

15. The UNFPA Lebanon programme is aligned with international normative standards, including priorities and guidance emanating from the GBV AoR and the global RH coordination forum (Inter-agency Working Group for Reproductive Health--IAWG).

16. UNFPA has increasingly integrated attention to development goals in their in-country humanitarian response.

17. UNFPA has undertaken some activities that focus on facilitating refugee resilience when they return to Syria.

18. UNFPA has maximised efficiency in some areas by, for example, streamlining commodities procurement and distribution. Other approaches, such as an over-reliance on surge, have undermined UNFPA's efficiency.

19. UNFPA at corporate level has insufficiently supported LCO with core resources relevant to the size and scale of the country (humanitarian) response .

20. UNFPA is generally viewed as a very good partner. However, some UNFPA IPs have been significantly affected by delays in funding that have contributed to slow start-up and halt to existing programmes that is particularly unsuitable in humanitarian response.

21. UNFPA has used joint partnership agreements to facilitate programming.

22. UNFPA support has significantly contributed to access to quality integrated SRH and GBV services.
23. UNFPA support has contributed to social norm change programming for refugee and host communities in Lebanon related to SRH and GBV but the impact of these efforts on behavior change is unclear.
24. UNPFA support has contributed significantly to the humanitarian community being accountable for recognising SRH and GBV as life-saving interventions.

CONCLUSIONS

Key Conclusions for Lebanon

A. Although its' operations are relatively small, UNFPA has had an outsized impact due in part to its strong relationships with government and UN partners. At the same time, its staffing limitations have compromised UNFPA's ability to utilise existing funds as efficiently and effectively as possible, as well as to generate new funding in order to improve its ability to meet beneficiary needs.

B. Coverage (geographically) of SRH and GBV services has been facilitated largely through provision of equipment, supplies and training. Support to the delivery of direct services is still limited. This is particularly a concern for GBV programming given the marked decrease in funding from UNICEF to GBV programming and the related expectation by sister agencies that UNFPA scale up programming. UNFPA's integrated SRH/GBV approach has allowed a higher level of GBV services to be offered than would have happened without GBV services being provided under the umbrella of 'SRH.' Coverage (demographically) is likely underserving young adolescent girls (age 10-14), as well as people with disabilities and the LGBTI community.

C. Following several initial years of instability in coordination leadership resulting from a reliance on short-term contracts and surge capacity, UNFPA's leadership of RH and GBV coordination functions has been very strong in recent years,. This current stability has been due to the presence of longer-term staff with solid technical capacity. However, the GBV coordinator is still not on a fixed-term contract. Double-hatting continues to be a challenge. [See *Conclusion 2* for UNFPA global consideration below for more information].

D. Given its strong relationships with government partners, UNFPA has been particularly well-equipped to support interventions that bridge the humanitarian to development continuum. Although perhaps not initially the case, the majority of its interventions currently support system strengthening and capacity building: in this way, UNFPA has "found its footing" in approaches that are aligned with the resilience focus of the LCRP. Provision of CMR is a particular area requiring increased government leadership for sustainability.

E. LCO's partnership strategy for GBV programming has been influenced in part by its limited access to funds, resulting in a focus on supporting small local NGOs through capacity building,

prioritising underserved locations in Lebanon. While this approach shows some promise, it also presents challenges given UNFPA's low number of staff and lack of field presence.

F. Many elements of UNFPA's programming in Lebanon have been effective in improving humanitarian response in terms of supporting improved access to RH supplies and services in PHCCs and select non-government sites, as well as to GBV case management for GBV . However, it is not yet clear whether the humanitarian response is having a measurable impact on several key intervention areas, including the fertility rate of Syrians in Lebanon, or in terms of reducing exposure of Syrian women and girls to different forms of GBV, particularly intimate partner violence and child marriage. While UNFPA has contributed considerably to research on SRH, GBV and, to a lesser extent, youth, it has not focused on impact measurement.

Key Conclusions for the overall evaluation:

A. UNFPA core, corporate investment with regular resources has not been commensurate with the size and scale of the Lebanon response for agency leadership and programming responsibilities.

B. UNFPA core, corporate investment with regular resources has not been commensurate with the size and scale of the Lebanon response for coordination responsibilities.

SUGGESTIONS FOR RECOMMENDATIONS

Key suggested recommendations at country level

A. UNFPA Lebanon should continue with and solidify provision of integrated SRH and GBV services. Even (and perhaps most especially) at a time of reductions in humanitarian funding, UNFPA should continue to capitalise on strategies such as support to government and local NGOs to improve quality and reach of sustainable programmes that support the humanitarian/development nexus.

B. To this end, UNFPA should consider developing, as part of its capacity building of local partners, more comprehensive and targeted strategies for improving oversight of local partners through direct field monitoring and other mechanisms of support.

C. In reference to specific gaps in programming areas, UNFPA should prioritise actions to scale up national capacity in the provision of CMR, including mechanisms for transferring oversight of CMR to the government in the line with the CMR strategy.

D. UNFPA should review its access to young adolescent girls and address coverage gaps.

E. UNFPA should improve collection of disaggregated data on working with people with disabilities as a first step in improving services for that underserved group.

F. UNFPA should consider how its SRH programming can more effectively serve the needs of the LGBTI community.

G. UNFPA should continue its investments in research, but with greater focus on examining outcomes related to key programming areas, such as uptake of family planning (FP); impact of early marriage awareness-raising; impact of men and boys peer-to-peer programming; etc.

H. UNFPA Lebanon should advocate with UNFPA Headquarters for stronger support with coordination functions (recognising that donors are often unwilling to support this through project funding, and thus core funding through regular resources is required) so that coordinators are not required to double hat and are recruited on fixed-term contracts. Recognise the commitment UNFPA itself has made to this within the UNFPA GBV Minimum Standards (p.80).

I. With staff realignment, UNFPA LCO should focus on becoming fully "fit for purpose", including by:

i. monitoring and reducing problems in partnership funding and oversight;

ii. improving communications with donors in order to establish more reliable funding streams;

iii. continuing to support office and programmatic capacity to reduce the humanitarian/development divide;

iv. scaling up presence and participation in humanitarian leadership fora.

*Key suggested recommendations for the **overall evaluation**:*

1. UNFPA should urgently review its corporate commitment to humanitarian operations with a view to:

(a) Understanding and fully committing to guideline percentage parameters between Regular Resources (RR) and Other Resources (OR). UNFPA's corporate commitment to connectedness and longer-term sustainable, impactful programming cannot be achieved with Country Offices (COs) that must transition from a 49 percent RR for country programme (2011) to a 8 ½ percent RR (2017) country programme as LCO has done.

(b) Understanding and addressing systemic limitations to addressing core staffing needs that contribute to COs inability to respond rapidly and flexibly to emergencies.

(c) Understanding and fully committing to coordination responsibilities with a clear corporate commitment to discharging those responsibilities in line with other cluster lead agencies, thus ensuring GBV and SRH receive an equal opportunity for visibility, attention, and funding as other sectors.

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]

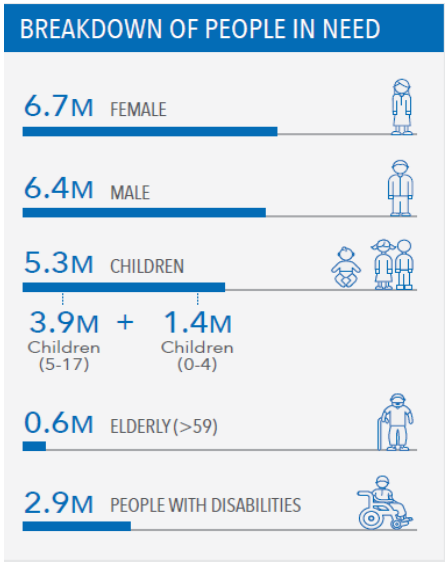


Figure 1: PiN (Source: HNO

The United Nations Population Fund (UNFPA) has been responding to the escalating crisis since 2011. In 2013, UNFPA established a regional response hub in Amman, Jordan 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 mobilization 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, for example the Lebanon Crisis Response Plan (LCRP). [4]

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.

The scope of the evaluation has three dimensions:

[2] UNOCHA; Also WoS HNO 2018

[3] Ibid

[4] The Lebanon Crisis Response Plan (LCRP) is the Lebanon Chapter of the Regional Refugee and Resilience Plan (3RP). The current iteration of the LCRP is 2017-2020, updated in 2018. Since the start of the Syria crisis, there have been 6 Syria Response Plans (2012, 2013 Syria Humanitarian Assistance Response Plans and 2014, 2015, 2016, and 2017 Humanitarian Response Plans) and two 3 Regional Refugee and Resilience Plans (2015-2016, 2016-2017).

- *Thematically:* All UNFPA humanitarian interventions targeting populations affected by the conflict in Syria. This primarily incorporates both UNFPA's directly-supported Reproductive Health (RH) and Gender-Based Violence (GBV) interventions (though also potentially other work with affected populations), and also its coordination role (via the RH Working Group and GBV Sub Clusters). Such interventions are articulated within the Syrian Humanitarian Response Plan(s) for the period, and include cross-border and Regional Refugee and Resilience Plan (3RP) programming;
- *Geographically:* Syria itself and neighbouring countries (Egypt, Iraq, Jordan, Lebanon and Turkey), including cross-border operations – notably across the sub-region. The evaluation is not intended to evaluate separately each country programme response;
- *Temporally*: The 2011-2017 period, which corresponds to the start of the conflict in Syria to the present day.[5]

The primary intended users of the evaluation are:

(a) UNFPA Country Offices (COs);
(b) the UNFPA Syria Regional Response Hub (henceforth 'the Hub');
(c) UNFPA Regional Offices (ROs) – the Arab States Regional Office (ASRO) and the Eastern Europe and Central Asia Regional Office (EECARO);
(d) UNFPA Humanitarian and Fragile Contexts Branch (HFCB);
(e) UNFPA Senior Management, including the Executive Board

This country note provides the findings, conclusions, and recommendations for the Lebanon-specific evaluation.

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.

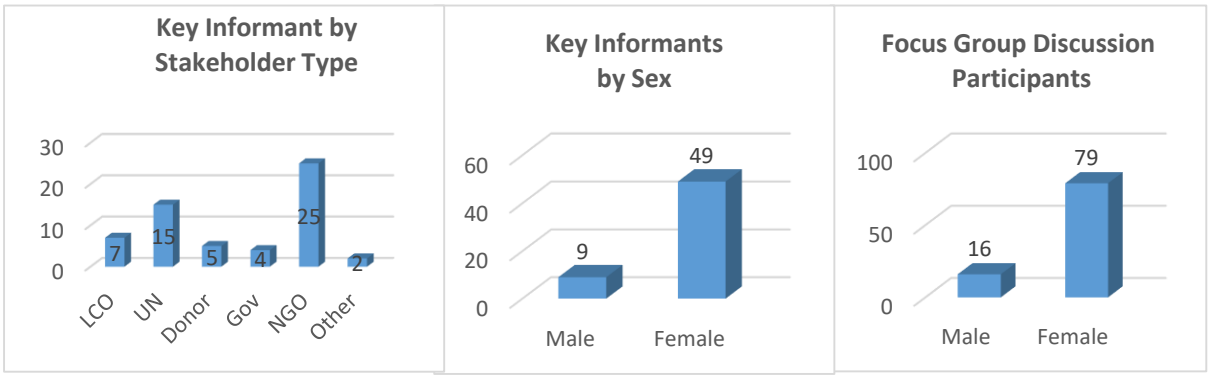
The evaluation was conducted in accordance with the UNEG *Norms and Standards for Evaluations*, the UNEG *Ethical Guidelines for Evaluations*, the UNFPA *Country Programme Evaluation Handbook*, and the WHO *Ethical and safety recommendations for researching, documenting and monitoring sexual violence 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 Lebanon Country Mission was undertaken by Jeanne Ward and Sinéad Murray, Evaluation Specialists, between 16th and 27th April 2018.

[5] An independent country programme evaluation was conducted for UNFPA in Lebanon covering programming from 2010-2013. This evaluation builds on those findings.

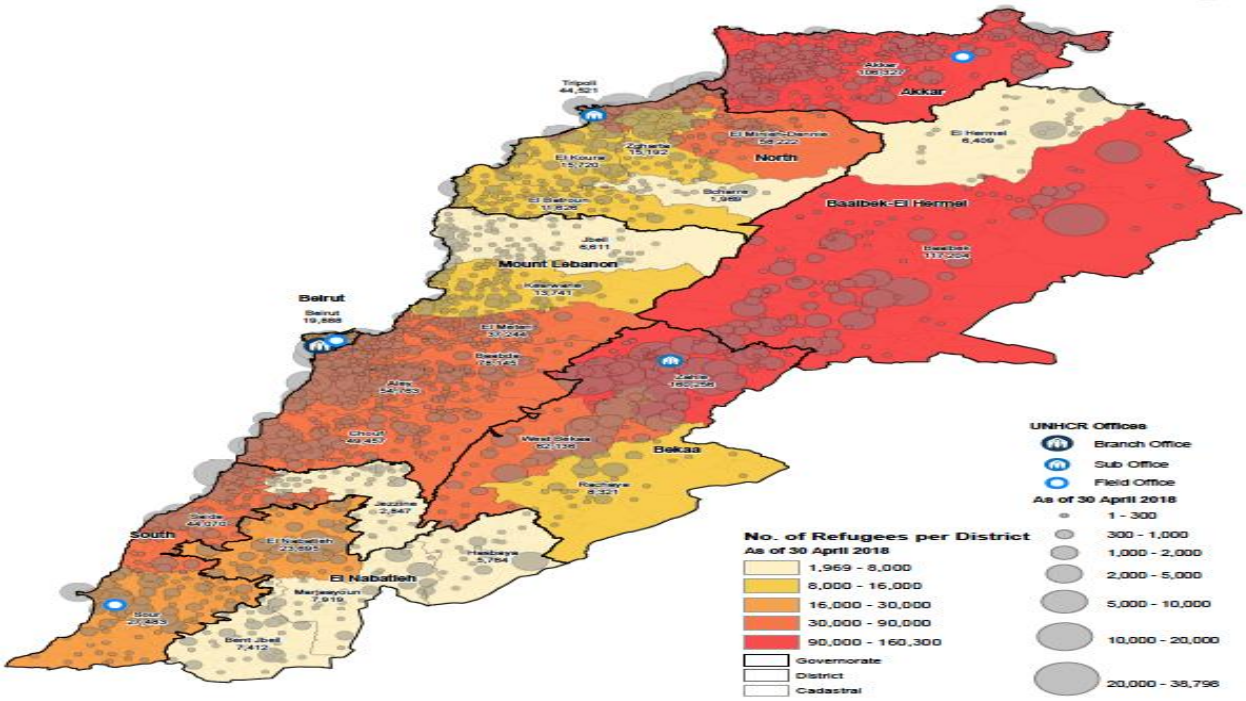
For the UNFPA Lebanon Country Office (LCO) country visit, a total of 58 key informant interviews were conducted (with 49 female and 9 male participants), together with visits to seven UNFPA-supported service delivery points, including a mobile medical unit (MMU), primary health care centers (PHCCs) and Women and Girls' Safe Spaces (WGSS) in the North, South and Bekaa. Eleven focus group discussions (FGDs) were held with 16 adolescent and adult males and 79 adolescent and adult females. A full list of key informant interviewees can be found in Annex I. A schedule of the mission can be found in Annex II.



Background

Lebanon

Lebanon is an upper middle-income country[6], ranking 76/188 on the 2016 Human Development Index With the Mediterranean Sea defining its western border, Syria to its north and east, and Israel to the south, Lebanon is comprised of four provinces: Bekaa, South, North and Mount Lebanon.



https://data2.unhcr.org/en/documents/download/63757

[6] World Bank categorisation - https://data.worldbank.org/country/lebanon

Lebanon currently has the highest per capita concentration of refugees worldwide. With a Lebanese population of 4.2 million living in Lebanon, the country also hosts just over 1 million registered Syrian refugees, and an estimated additional half million who are unregistered. Lebanon also hosts approximately 6,000 Iraqi refugees, and an estimated 174,00 Palestinian refugees. In line with the Government of Lebanon's (GoL) "no camp" policy, there are no formal UNHCR-run refugee camps.[7] An estimated 82 percent of refugees live among host communities in 1,700 locations across the country, many of which are among the poorest areas in Lebanon. The remaining refugees live in informal collective and tented settlements.[8]

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**	

Fifty-two percent of Syrian refugees are women and girls. The total fertility rate among Syrian refugee females was estimated in 2016 between 3.4 to 3.7 children per woman with a relatively higher rate among younger groups—and significantly higher overall than the national rate (see table below). Child marriage (i.e. marriage below the age of 18) of girls and early pregnancy is evidently on the rise, among some Syria communities in Lebanon double that of child marriage and early pregnancy rates in Syria, prior to the war.[9] Although contraceptives are generally made available at all supported PHC through UNFPA, a study in 2017 showed that around 15.3 percent and 38.8 percent of male and female respondents respectively had at least one unplanned pregnancy, while around 75 percent and 50 percent of male and female respondents respectively reported not using any contraceptive method because they want more children.[10]

Lebanon Country Statistics[11]

Population:	**6.1 million**
Population aged 10-24:	**26%**
Population aged 65 and older:	**9%**
Maternal Mortality Ratio (MMR):	**15 per 100,000 live births (2015)**
Births attended by skilled personnel:	**N/A**
Adolescent birth rate (age 15-19):	**N/A**
Total Fertility Rate (TFR):	**1.7 (2017)**
Contraceptive Prevalence Rate (CPR):	**62% all methods)**
	46% (modern methods)

[7] https://reliefweb.int/sites/reliefweb.int/files/resources/lebanon_syrian_crisis_en.pdf
[8] UNHCR (2015) "Refugees from Syria: Lebanon", available from: https://data.unhcr.org/syrianrefugees/download.php?id=8649
[9] Universite Saint Joseph, July 2015, *Early Marriage: Illusion or Reality?*
[10] UNFPA (n.d.) Multi-Country Response to Syrian Crises: Syria, Iraq, Jordan, Lebanon, Turkey, Report to the donor.
[11] Statistics (2017) from UNFPA State of the World's Population, https://www.unfpa.org/data/world-population/LB

Separation from families, tensions with host community, limited access to support and overcrowded living conditions also increase risks of gender-based violence (GBV) for girls and women. Lebanon's residency policy (including extensive application paperwork and high fees) makes it difficult for Syrians to maintain legal status, restricting refugees' access to work, education, and healthcare, and further contributing to risks of sexual exploitation and abuse. According to Human Rights Watch, an estimated 80 percent of Syrians in Lebanon now lack legal residency and risk detention for unlawful presence in the country.[12]

Initially reluctant to engage in or recognise the severity of the refugee crisis, the government of Lebanon has taken an increasingly significant role in facilitating humanitarian response. The Government of Lebanon's Crisis Cell is the highest national authority for international partners supporting the crisis response inside Lebanon, including through the LCRP. The Ministry of Social Affairs is mandated by the Crisis Cell to oversee the Government's humanitarian response in Lebanon. An LCRP steering committee is co-chaired by the Minister of Social Affairs and the United Nations Resident Coordinator/Humanitarian Coordinator (RC/HC), and includes participation of Crisis Cell ministries, humanitarian and stabilisation partners across the UN, national and international NGOs, and donors.[13]

Since 2017, the response to the Syrian crisis has been guided by a revised LCRP (updated again for 2018), jointly developed by the humanitarian partners and the GoL and covering a multi-year period up to 2020. It provides an integrated humanitarian and stabilisation framework, aimed at tackling Lebanon's challenges holistically, taking into account the vulnerability of all people affected by the crisis.[14] The response seeks to ensure protection and provide immediate assistance to the displaced population from Syria, the host community, the Palestinian refugees in Lebanon and from Syria, while at the same time strengthening the capacity of national and local service delivery systems to expand access to, and increase quality of basic services for all. It also seeks to reinforce and improve Lebanon's economic, social and environmental stability.

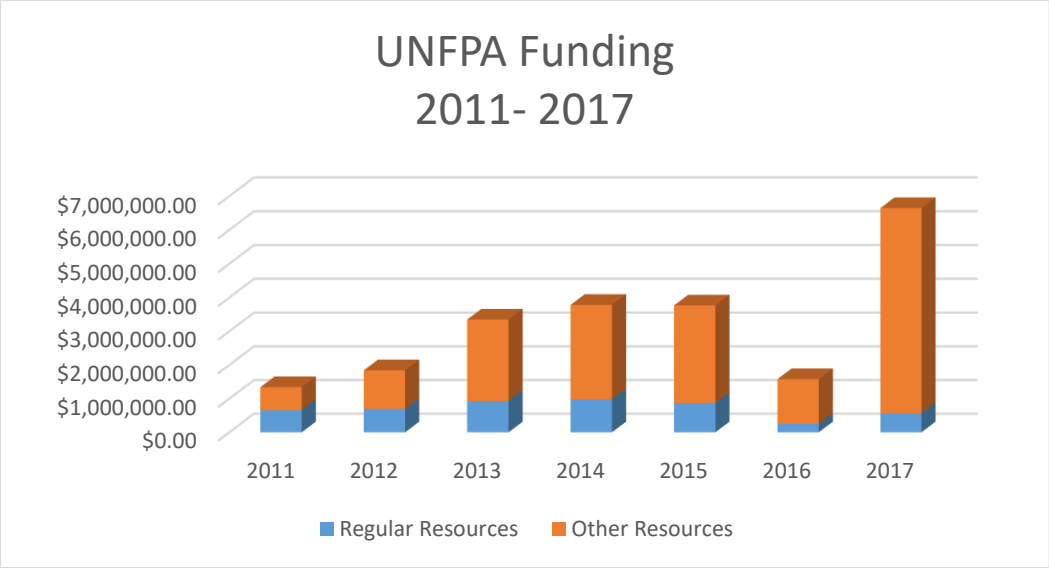
UNFPA Lebanon Country Office

UNFPA started work in Lebanon in 1993 under the umbrella of the United Nations Development Programme (UNDP). From 1993 until the start of the Syria crisis in 2011, LCO remained a small development-oriented entity, initially with two staff members that, by 2011, had scaled up to seven. Work focused on supporting the Government of Lebanon (GoL) in policy development and undertaking advocacy initiatives. In response to the Syria crisis, staffing increased to 16 by 2017, and with approval of a realignment in November 2017 is anticipated to expand to 22 in 2018/2019. The office has never had Country Representative, and is instead managed by an Assistant Representative/Head of Office, with the HC/RC as the designated Representative. In 2011, the office had five NGO and government implementing partners (IPs); it currently has 26 IPs. Approximately 50 percent of funding was from regular resources (RR) in 2011, whereas in 2017, only 8.5 percent of funding was from regular resources. With the exception of a downturn in 2016, funding has increased, most markedly in 2017, to 6.6 million USD per annum, due primarily to increased funding to UNFPA's GBV programming.

[12] In February 2017 Lebanon waived residency fees for some Syrians in Lebanon. https://www.hrw.org/world-report/2018/country-chapters/lebanon

[13] LCRP 2015-2016.

[14] Even before the eruption of the Syrian conflict in March 2011, Lebanon was grappling with a depleted infrastructure and inadequate public services. Over the last seven years, Lebanon's public finances, service delivery, and the environment have further deteriorated, with the crisis worsening poverty incidence among Lebanese as well as widening income inequality. The World Bank estimates that as a result of the Syrian crisis, some 200,000 additional Lebanese have been pushed into poverty, adding to an existing 1 million poor. http://www.worldbank.org/en/country/lebanon/overview



In addition to the expansion of LCO in terms of resources – financial and human – the Syria crisis has also necessitated a change in programming modalities. Since the start of the Syria crisis in 2011 UNFPA Lebanon has expanded programme entry points: from existing policy development and advocacy with Government partners to working across all four UNFPA modes of engagement, addressing:

- **SRH and GBV service delivery** through international and national non-governmental organisations (NGO) partners;
- **community-based awareness raising** on SRH and GBV;
- **supply chain** management and delivery;
- **capacity building** of SRH and GBV partners, including in data/knowledge management;
- **advocacy** on GBV and RH as necessary life-saving humanitarian interventions within the wider humanitarian community; and
- continued **partnership** with Government counterparts.

UNFPA also supports humanitarian coordination as the co-lead of SGBV Task Force, the CMR Task Force, and the SRH Working Group.

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 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. UNFPA's support to SRH service delivery is relevant to the needs of the affected population. The services are based on assessed and stated needs of the affected populations. UNFPA has used a variety of entry points and methods for ensuring refugee access to quality SRH services. Clients report these services to be of generally high quality.
2. UNFPA's support to GBV-related systems and services, empowerment activities, and peer-to-peer outreach are relevant to the needs of women and girls. More recently, in alignment with the SGBV Task Force workplan, UNFPA has added outreach targeting men and boys. It is not clear the extent to which this outreach focuses on social norms change related to GBV.
3. The integrated youth programming offers an opportunity to scale up attention to an underserved demographic in humanitarian response, particularly adolescent girls.
4. LCO and its partners have incorporated gender and inclusion considerations into programming, with an acknowledged lack of focus on people with disabilities, for which LCO, along with the SGBV Task Force, aims to improve, starting with improved collection of disability-disaggregated data.
5. UNFPA's tools and guidance reflect human-rights based approaches.

UNFPA's support to SRH service delivery is relevant to the needs of the affected population. The services are based on assessed and stated needs of the affected populations. UNFPA has used a variety of entry points and methods for ensuring refugee access to quality SRH services. Clients report these services to be of generally high quality. Starting from a RH assessment in 2012 which informed UNFPA's initial advocacy on the need to scale up SRH programming within health systems, the SRH services have been and continue to be based on assessments and stated needs of the affected populations.

In the early years of the emergency, refugees faced significant challenges accessing health care in the costly and fragmented health care system in Lebanon. UNFPA has strategically employed a variety of entry points and methods for improving refugee access to quality SRH services. For example, UNFPA has worked closely with MoPH to improve access to and utilization of Primary Health Care Centers (PHCCs) by reducing consultation fees, increasing availability of physicians, ensuring availability of essential drugs and supplies including reproductive health supplies, providing centers with essential equipment, and capacity building on various issues.[15] UNFPA provides direct funding for physicians and midwives in select PHCCS and mobile medical units (MMUs) offering ante- and post-natal care, family planning (FP), and basic gynaecological services. UNFPA also funds MMUs to provide RH services to more isolated refugee communities, such as those living in informal tented settlements.

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In a study of unmet RH needs of Syrian refugees undertaken by UNFPA in 2016, it was noted by key service delivery informants that the numbers of patients seeking RH and FP services had more than doubled since the onset of the Syrian crisis, and that the proportion of Syrians accessing services is higher than that of the Lebanese.[16] Clients interviewed in focus group discussions as part of the Lebanon country visit consistently noted the quality of services, as well as appreciation for being able to access free gynaecological and family planning services, as captured by one focus group discussant: "For us, this service unloaded a big burden."

In response to the high rate of Syrian births in Lebanon[17]—an issue which has placed pressure on public health facilities and reportedly increased tensions between some Lebanese and refugee communities-- UNFPA sought to accelerate FP programmes. For example, in 2014 UNFPA supported thirteen training workshops on family planning counseling which were undertaken in four regions to assist in establishing common understanding of FP counseling and redress the lack of a national MOPH policy on FP counseling. [18] Prior to planning the workshop, UNFPA interviewed Syrian women as well as service providers, and subsequent to the workshop UNFPA conducted a rapid analysis of the trainings in order to identify areas for improvement.[19] UNFPA continues to support the development of RH learning and awareness-raising materials for use in centres as well as in peer-to-peer outreach targeting refugees and host communities, developing the tools based on consultations with the affected communities.

UNFPA's support to GBV-related systems and services, empowerment activities, and peer-to-peer outreach are relevant to the needs of women and girls. As with its SRH interventions, UNFPA has adopted a variety of modalities to facilitate GBV response, risk mitigation and prevention, based on assessed needs and according to priorities identified by the SGBV Task Force linked to global best practices. Prior to the emergency, few GBV services existed in the Lebanon. UNFPA and partners have therefore focused on building systems to support safe and ethical response, undertaking capacity development across various levels, including development of training tools and their implementation through, for example, training of social workers in the Ministry of Social Affairs' (MOSA) Social Development Centres (SDCs) across Lebanon on case management; health care providers working in hospitals and PHCCs as well as medical students on GBV basics and CMR; media personnel on ethics; and law enforcement on communication, referrals, and safety.

UNFPA, in collaboration with UNHCR, has also led in the oversight and expansion of the GBV Information Management System (GBVIMS) among GBV partners by co-funding a GBVIMS coordinator and oversight of development of GBVIMS protocols and guidelines.[20] The GBVIMS shows that the large majority of GBV cases seen by IPs involve physical violence—mostly within the family/home. GBV-specific services supported by UNFPA to meet the needs of women and children affected by family violence include psychosocial support through individual counselling and support groups; legal

[16] UNFPA, 2016. Assessment of Unmet Needs and Projecting Family Planning Needs for Syrian Refugees in Lebanon.

[17] The Syrian fertility rate was relatively high prior to the crisi, at 5.2% in 2010. Syrian Center for Policy Research, 2016. *Forced Dispersion: A Demographic Report on Human Status in Syria*.

[18] UNFPA LCO, August 2015 . Rapid Analysis of Family Planning Counseling Training.

[19] In an example of findings, Syrian refugees were less likely to ask for FP services than Lebanese and more Syrian refugees than Lebanese women required the husband's consent for FP. See UNFPA LCO, August 2015 . Rapid Analysis of Family Planning Counseling Training.

[20] The Gender-Based Violence Information Management System (**GBVIMS**) is a multi-faceted initiative that enables humanitarian actors responding to incidents of GBV to effectively and safely collect, store, analyse and share data reported by GBV survivors. GBVIMS is the standard GBV Information Management System that is promoted globally through the GBV Area of Responsibility (AoR). It was introduced in Lebanon by UNFPA, UNHCR and UNICEF in 2012 and is currently used by 6 international and 2 local organizations. GBVIMS meetings are held with partners on a monthly basis to discuss findings and trends. Lebanon has been chosen as a rollout country for GBVIMS + (known as Primero). Several INGOs are engaged in the pilot, using the process to test the system and fix bugs before it is rolled out to other partners.

assistance on Law 293 on family violence, custody issues, birth certificate, etc; and referral for additional specialised services such as specialised case management, mental health, shelter and CMR.

UNFPA supports direct service delivery by funding five centres to provide GBV-specific services (two are Women and Girls Safe Spaces, and three are community health centres). Given the exceedingly low level of rights enjoyed by the majority of Syrian refugee women and girls[21], an overarching and fundamental aspect of the GBV work in the WGSS and the integrated health centres focuses on women's empowerment through skills development--including life skills, cottage livelihood skills (e.g. chocolate-making, hair dressing), financial management, etc.—with training programmes including peer-to-peer education. This skills development has a socialising function, and also serves as an opportunity to help women and girls gain trust in service providers in order to improve comfort around reporting GBV-related incidents or concerns to identified social workers to receive immediate support and referral. Repeatedly during the country visit, women refugees acknowledged the value of peer-to-peer learning, but expressed concerns about the fact that the number of sessions were too few to 1) learn an actual skill[22]; and 2) did not facilitate livelihoods, which is a considerable challenge for refugees in Lebanon.[23]

More recently, in alignment with the SGBV Task Force 2017 workplan and based on a determination that GBV programming should seek to engage more males in the community, UNFPA conducted a mapping of male engagement programming. It also added outreach targeting men and boys to its GBV portfolio by developing male engagement peer-to-peer training tools that focus on gender equality, GBV and FP , which have been rolled out by trained male outreach workers through ten UNFPA implementing partners (IPs).

The integrated youth programming offers an opportunity to scale up attention to an underserved demographic, particularly adolescent girls. UNFPA supported a ground-breaking *Situation Analysis of Youth in Lebanon Affected by the Syrian Crisis* (2014), and since 2014 has supported the integration of youth spaces in existing community centres and has facilitated capacity building of service providers and youth peer-to-peer outreach trainers with an emphasis on RH and early marriage. Women and girls interviewed during the evaluation perceive that the outreach on early marriage has helped girls to stay in school and improved communication among family members on the negative effect of child marriage.[24] In 2016 UNFPA mapped youth interventions and actors in the humanitarian response as

[21] Syria is categorized under "low human development" in the global Gender Development Index, http://hdr.undp.org/en/composite/GDI

[22] This is consistent with UNFPA's own monitoring of the peer-to-peer education programming focused on the elements of family planning and early marriage, captured in the report on *Monitoring and Evaluation framework of targeted UNFPA supported interventions (2017-2019: Prevention/mitigation of Early Marriage and increasing access and utilization to reproductive health and Family Planning services among Syrian refugees in Lebanon.* Peer educators originally provided four training sessions for a group of 20 participants, which has now been cut to three, an issue that was raised in almost all the FGDs undertaken for the evaluation.

[23] This is consistent with UNFPA's 2016 evaluation of a UNFPA-funded project led by Intersos, *Women Empowerment, A Livelihood Supported Initiative*. Restrictions on refugees' right to work have created severe economic challenges for Syrian refugees, while at the same time limiting the extent to which skills development programmes such as those offered in the safe spaces can actually contribute to women's livelihoods. Although these restrictions have been lifted somewhat by the GoL in the last two years, allowing refugees to engage in certain types of work, the GBV community has not widely addressed economic strengthening of refugees, despite economic hardship being a key contributor to girl marriage.

[24] As noted previously, however, data suggest that early marriage has been on the rise among the Syria population compared to rates of early marriage in Syria prior to the conflict. UNFPA conducted a baseline survey on early marriage in Bekaa, *The Prevalence of Early Marriage and Its Determinants Among Syrian Girls and Women* (2015), which produced interesting findings and related programming recommendations linked to correlates to early marriage such education levels and poverty. To date, however, there has been no population-based evaluation of the impact of efforts to reduce early marriage among Syrian refugees in Lebanon, beyond anecdotal reports from project beneficiaries and some analysis of marriage registration (not necessarily a good indicator).

well as compiled resource material on adolescent and youth programming. UNFPA is currently supporting the development of a "youth incubator" project that will focus on developing youth's digital and entrepreneurial skills and linking them with economic opportunities, with the aim of empowering them and improving livelihoods.

LCO and its partners have incorporated gender and inclusion considerations into programming, with an acknowledged lack of focus on people with disabilities, for which LCO, along with the SGBV Task Force, aims to redress, starting with improved collection of disability-disaggregated data. UNFPA aligns its programming with the gender marker—and supports other humanitarian and development partners to do the same through the SGBV Task Force and the Gender Working Group.[25] 'Gender equality and women's empowerment' is one of three core outcomes of UNFPA's Country Programme Document 2017-2020 for Lebanon and aims to strengthen national capacity to promote and ensure reproductive rights, gender equality, and the prevention of GBV.

UNFPA's tools and guidance reflect human-rights based approaches. UNFPA's tools and guidance reflect human-rights based approaches. In one recent example, UNFPA has been working with the Lebanese Order of Midwives (LOM) in support of a protocol for FP that meets human rights standards including freedom from discrimination, coercion and violence. The protocol was piloted with in 2017 and is being rolled out in 2018.[26]

Further, UNFPA's Country Programme Document 2017-2020 explicitly references international agreements and guidance the reflect and reinforce UNFPA's commitment to human rights, including the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), the Sustainable Development Goals, the Amman Youth Declaration, and Security Council Resolutions on Women, Peace and Security. In relation to international human rights law international humanitarian law and international refugee law, UNFPA's programming implicitly adheres to global standards. Operations targeting Syrian refugees in Lebanon fall under the overall leadership of UNHCR and as such, are assumed to be compliant with international refugee law and international human rights law.

[25] The Gender Working Group is focused primarily on development action rather than humanitarian response.
[26] UNFPA COAR, 2017

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

6. Although UNFPA struggled to find footing in the early stages of humanitarian response, shifts in approach following the 2013 Country Programme Evaluation meant that UNFPA prioritised collecting and using data in order to improve their capacity to identify and meet critical needs in the refugee response. As a result, UNFPA is notable within the UN community for its ability to ground its interventions in empirical analysis.
7. UNFPA has clearly and effectively based its response on its comparative strengths in delivering SRH and GBV programming, with its youth programming focused on peer-to-peer activities integrated into SRH and GBV programmes.
8. Despite these important contributions, the relatively small scale of UNFPA's response was noted by UN and donor stakeholders as limiting UNFPA's ability to react flexibly to changing needs associated with the Syria crisis.

Although UNFPA struggled to find footing in the early stages of the humanitarian response, shifts in approach following the 2013 Country Programme Evaluation meant that UNFPA prioritised collecting and using data in order to improve their capacity to identify and meet critical needs in the refugee response. As a result, UNFPA is notable within the UN community for its ability to ground its interventions in empirical analysis.

A UNFPA Lebanon key informant observed that despite a preparedness-planning exercise that was undertaken just prior to the escalation of the Syrian refugee crisis, the LCO was not fully prepared for the scale of the crisis[27], nor for how to position itself within the larger humanitarian architecture in order to establish and build upon UNFPA's value-add as a leader in SRH and GBV. Although UNFPA regional and headquarters offices provided important initial financial and technical support and oversight, which ensured UNFPA's ability to meet basic responsibilities for distribution of RH supplies and dignity kits (with, for example 25,320 male condoms and 22,422 dignity kits distributed in 2012)[28], they did not ensure sufficient assistance to manage the political shifts necessary to become a significant humanitarian partner in Lebanon in the early stages (i.e. the first two years) of humanitarian response. In 2011 and 2012, UNFPA's annual budget was under 2 million USD and continued to focus more on development action. In 2012 no services were supported to address GBV among the Syrian population, and only 3465 women accessed RH care and 1750 men accessed STI treatment supported by UNFPA (as compared to an estimated 144,000 men and women who accessed RH services supported by UNFPA in 2017).[29]

[27] The preparedness planning was a learning exercise not specific to or in anticipation of the Syria conflict, but nevertheless proved timely given the subsequent rapid escalation of the war in Syria.
[28] Data provided by UNFPA LCO summary analysis.
[29] Data provided by UNFPA LCO summary analysis.

As described by one stakeholder, the fact that there was no UNFPA Representative in Lebanon at the onset of the crisis (with the responsibility therefore delegated to the Lebanon RC/HC, as is the standard protocol) presented challenges in terms of UNFPA's ability "to take a seat at the table"[30], a challenge one UN key informant felt was exacerbated by leadership tensions between the RC/HC and UNHCR. UNFPA's response was also affected by a variety of other external factors, including the absence of a unified government response to the crisis; a failure in the early days of the crisis to undertake adequate vulnerability assessments to identify those most in need; a tendency, according to one interviewee, of donors to focus on "hardware" responses, such as food and shelter; and the development by UNHCR and its IPs of a parallel health response for refugees.[31]

However, the fact that UNFPA had been in the country for almost two decades at the time of the onset of the crisis meant, according to one donor and at least three UN interviewees, that UNFPA had a particularly keen understanding of the context and ability to operate within it, if primarily from the development side. UNFPA was well-respected by MOSA, MOPH and other public institutions, so that as the government scaled up its attention to the refugee response and the response itself expanded to include a broader profile of needs, UNFPA had an important role to play in terms of advocating for attention to SRH and GBV and ensuring attention to needs was embedded in existing service delivery structures, with standards contextualised to the setting. A good example of this is in UNFPA's contextualisation of the MISP, where it was deemed more efficient to procure medications in bulk, and integrate relevant MISP supplies into MOPH's system, rather than purchase standard kits that had supplies that were not relevant to Lebanon (e.g. the female condom, which had no uptake).

UNFPA's role as a key stakeholder in SRH and GBV became even more pronounced after UNFPA's Country Programme Evaluation (June 2014), which highlighted—among other recommendations--the need for regular needs assessments. In response to that recommendation, the LCO has become a leader in collecting data on SRH and GBV, including needs and impact assessments, service mapping, rapid evaluations, exit interviews with beneficiaries, etc. One UNFPA key informant shared the sense that UNFPA has, particularly within the last two years, "found its footing" in the refugee response. Some examples of UNFPA-led assessments and other research conducted over the last several years include:

For SRH:

- Rapid Assessment Of UNFPA/IRC Joint Initiative (2015)
- Needs Assessment Of Maternity Ward And Neonatal Intensive Care Unit Of Rafic Hariri Public Hospital (2015)
- Assessment Of Referral Mechanism – Primary To Secondary Health Care Including Emergency Obstetrics And Neonatal Care (2016)
- Assessing Clinical Management Of Rape (CMR) Services At Health Facilities In Lebanon (2016)
- Rapid Analysis Of Family Planning Counselling Trainings (2015)
- Assessing Unmet Needs And Projecting Family Planning Needs For Syrian Refugees In Lebanon (2016)
- Multi-Year Strategic Framework For Expanding Voluntary Family Planning Services In Lebanon With Emphasis On Displaced Populations (2017)

For GBV (in addition to products supported through the SGBV Task Force):

- Assessment of SGBV Referral Pathway Information Dissemination and Women Empowerment (2014)

[30] UN KII.

[31] This last point was raised by a heath sector key informant, who described it as a significant misstep in the early health response.

- Evaluation of Women Empowerment and Livelihood Supported Initiative (2015)
- Rapid Assessment of Women Safe Spaces (2015)
- Assessing Effectiveness of Gender/GBV Interventions in Baalbeck (2015)
- Gender Based Violence Against Women and Girls Displaced by the Syrian Conflict in South Lebanon and North Jordan: Scope of Violence and Health Correlates (2015)
- The Prevalence of Early Marriage and Its Key Determinants Among Syrian Refugee Girls/Women (2016)
- Summary Findings - Focus Group Discussions With Women In Dairy Sector (2106)
- Desk Review and Analysis of Guidance, Tools And Practices Related to the Engagement of Men and Boys (With a Special Focus on Male Youth) Against Violence Against Women And Girls (2017)
- Rapid Assessment for UNFPA on Dignity Kits (2017)

In relation to these assessments and other research, UNFPA has striven to adjust its programming. For example, UNFPA undertook a national situation analysis that identified critical gaps in relation to the supply of reproductive health (RH) commodities, which in turn led to the development of an RH commodity security strategy. A UNFPA-supported CMR assessment and consultative meetings allowed the development of a national 2017 action plan aimed at tackling systemic gaps in CMR service provision.[32] The study on early marriage—considered a key reference tool both for its methodology and its findings--informed the development of training tools on early marriage targeting parents and youth, as well as a national campaign to increase the minimum legal age of marriage to 18 years old. UNFPA's study on unmet FP needs showed low attendance to postpartum and family planning services for both Lebanese and Syrian populations, which resulted in the development in 2017 of a multi-year national strategic framework aimed at improving FP services.

Where relevant to these assessment process, inputs are solicited directly from affected populations, often through FGDs. UNFPA uses this and other beneficiary feedback—such as informal discussion with beneficiaries as part of periodic monitoring of implementing partners--to inform improvements in SRH and GBV interventions. In one example, better understanding of the need for improved communications between FP service providers and beneficiaries has resulted in improvements in FP training materials, as well as emphasis on training support to midwives. In another example, UNFPA's interviews with and survey of youth across all regions in Lebanon as part of its national youth study contributed to the development of a UNFPA-led national peer-to-peer youth education project.[33] In the observation of one health colleagues, UNFPA since 2011 has transitioned from commodities distribution to "more targeted inventions focused on needs."[34]

UNFPA's research has also made important contributions to improving the relevance of the work of the wider humanitarian community. For example, the desk review and analysis related to male engagement resulted in recommendations that have been endorsed and prioritised by the SGBV Task Force. UNFPA research and data analysis has also made an important contribution to filling the gap around monitoring quality of care in GBV through their leadership in the development of the "sense maker" tool, that facilitates measurement of impact of GBV interventions (with includes engagement with the affected population on quality of care), which GBV partners have described as a "huge" contribution.[35] Moving forward, UNFPA intends to rely less on specialised studies, and more on integrated monitoring such as the sense maker tool, as well as through external tools such as the Map

[32] UNFPA, Annual Dashboard 1 January – 31 December 2016.
[33] http://www.unfpa.org.lb/documents/situation-analysis-of-the-youth-in-lebanon-affecte.aspx
[34] UN KII.
[35] UN KII.

of Risks and Resources (MRR)—an inter-sector needs assessment conducted regularly at the municipal level.

UNFPA has clearly and effectively based its response on its comparative strengths in delivering SRH and GBV programming, with its youth programming focused on peer-to-peer activities integrated into SRH and GBV programmes. Donor, UN, government and I/NGO stakeholders interviewed during the country visit recognise alike UNFPA's contribution to SRH and GBV. As one illustration of its evolving improvements in efforts to address SRH, in 2015 UNFPA started to work with the government in documenting maternal mortality in hospitals, adding documentation of infant mortality in 2016**.** In 2017 a unified reporting tool was developed by UNFPA and MOPH to further improve data collection and reporting on the RH indicators related to the LCRP 2017 – 2020. As of the time of evaluation research, UNFPA is working with MOPH to develop systems to monitor morbidity and mortality of home deliveries.

From the beginning of the crisis, UNFPA assumed its co-leadership role in GBV coordination (see Evaluation Question 4, below) and has over time scaled up its programming such that capacity building of local implementing partners on GBV is a significant component of UNFPA's GBV portfolio, with the effect of UNFPA reaching twice as many women and girls through case management from 2016 to 2017 (from 1832 served in 2016, to 3775 served in 2017).[36]

While its youth programming is currently limited to integrating peer-to-peer learning activities within existing SRH and GBV projects, UNFPA is leading the articulation of an action plan for meeting the needs of Lebanese and Syrian youth. Addressing youth is a core outcome of the UNFPA LCO Country Programme Document 2017-2020.

Despite these important contributions, the relatively small scale of UNFPA's response was noted by UN and donor stakeholders as limiting UNFPA's ability to react flexibly to changing needs associated with the crisis. Overall, UNFPA funding for the Syria crisis response in Lebanon has been lower than even that of major INGOs (e.g. IMC, IRC), with the annual programming budget remaining below 4 million per annum until 2017, when an infusion of funds to support GBV programming increased the budget to 6.6 million. In the words of one UN key informant, "this [funding] is the basis for meeting needs."[37] A donor key informant noted that while UNFPA is accorded the respect of a UN agency, "they operate more like an INGO."

A related issue is that UNFPA LCO is able to support relatively few staff, both in their own offices, as well as in the ministries and PHCs (e.g. two national health staff placed in the ministries and/or PHCCs in 2018, compared to UNICEF's 133 staff, and UNHCR's 40[38]), impacting their ability to expand activities and programmes. In order to increase staff numbers, and as part of the realignment of the CPD with the Strategic Plan 2014-2017, UNFPA requested additional fixed term appointments in 2014. Due to delays at headquarters and at the regional level, the realignment was only approved in November 2017. This, along with understandable concerns about opening posts with only short-term humanitarian funding, has meant that UNFPA has been operating largely with surge and service contract holders, including short-term consultants. Some positions have remained unfilled (e.g. a communications post and a youth specialist) since 2016, and other positions have been filled largely by surge and service contract holders, which has contributed to high turnover of staff who move on as they are seeking more permanent positions. On the other hand, where staff have stayed for several or more years, this has made a significant difference in terms of developing and refining UNFPA's SRH and GBV programmes.

[36] Data provided by UNFPA LCO summary analysis.
[37] UN KII.
[38] https://data2.unhcr.org/en/documents/download/63985 pg 6.

One UN key informant noted about UNFPA that "I haven't seen any corporate involvement in the country." The interviewee contrasted this with some other UN agencies, which appear to be more engaged with and supported by their corporate entity, and questioned whether the lower budget (and profile) of UNFPA relative to other UN agencies in Lebanon could be a function of this.

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

9. Geographically, UNFPA has made advances in ensuring coverage across many locations in Lebanon, particularly through its commodities distribution and capacity-building efforts.
10. UNFPA has used interagency vulnerability criteria and service mapping to prioritise areas with limited services and critical funding gaps, implementing an integrated approach that supports national partners in order to capitalise on limited resources for the broadest reach, and through MMUs in the hardest-to-access locations.
11. Demographically, UNFPA's prioritisation of women and girls is clearly aligned with their mandate. However, programmes may not be effectively serving younger adolescent girls (in the 10-14 year-old range). There is no specialised programming for people with disabilities, nor for LGBTI populations.

Geographically, UNFPA has made advances in ensuring coverage across many locations in Lebanon, particularly through its commodities distribution and capacity-building efforts. Lebanon presents particular challenges in humanitarian response because refugees are scattered across more than three thousand locations. UNFPA has achieved national coverage through its capacity-building efforts for social workers and health care providers, as well as its community-based programming including volunteer outreach and peer-to-peer training. In 2016 and 2017, through funding from Saudi Arabia, UNFPA procured medical equipment and supplies as well as RH commodities for 160 PHCCs and 26 Governmental hospitals. It is estimated that this equipment may benefit 1.5 to 2 million persons in Lebanon—both Lebanese and refugees.[39] UNFPA also supports commodities distribution to 215 MOPH PHCCs, as well as an additional 70-80 dispensaries not in the MOPH network. UNFPA is still working to scale up capacity on CMR in PHCC's, with currently only a third trained to do so. Even so, UNFPA has otherwise sought to improve the reach of CMR by supporting CMR consultation groups in 4 regions; these groups come together once a month to identify challenges and brainstorm solutions on systems improvements. UNFPA, alongside UNICEF, is supporting the development of a mobile phone app to provide generalised information to programme beneficiaries and health care providers on CMR treatment and referral.

UNFPA has used interagency vulnerability criteria and service mapping to prioritise areas with limited services and critical funding gaps, implementing an integrated approach that supports national partners in order to capitalise on limited resources for the broadest reach, and through MMUs in the hardest-to-access locations. UNFPA's 2014 Independent Country Evaluation recommended that operations should "seek to establish links with the grassroots level." UNFPA's strategy for support to GBV programming has worked to implement this recommendation via small grants to a number of national NGOs. As noted previously, there was little recognition of GBV within Lebanon pre-crisis and service provision for GBV was very limited, with most services concentrated in and around Beirut. Two main civil society organisations addressed intimate partner violence (IPV) and

[39] Data provided by UNFPA LCO summary analysis.

other forms of DV as part of a broader focus on women's equality programming. As an important step in enhancing a national network of civil society providers, UNFPA seeks to identify promising NGOs already working in underserved areas that can be further supported to scale up GBV interventions. Two UN stakeholders noted that this is a 'promising' approach, though expressed concerns about UNFPA's ability to support capacity building of lower-skilled organisations given UNFPA's lack of field presence.[40]

Another concern relates to the fact that only six UNFPA partners have the capacity to provide safe and ethical GBV case management: DRC (and its IPs) in the South; Amel Association and Intersos in Bekaa; HAI in Akkar; and two KAFA centers in Mt. Lebanon. Given the significant reductions in funding to UNICEF for GBV service delivery, there is increasing pressure from the GBV community for UNFPA to scale up more rapidly in order to fill anticipated gaps.[41] UNFPA is already trying to capitalise on an integrated approach (three of the five dedicated GBV service delivery points are within PHCCs) to support greater attention to GBV, and the question was raised by UN and I/NGO key informants as to whether these efforts to scale up GBV services should be expanded in order to fill the gaps in other programmes that are losing funding.

UNFPA has also supported MMUs through their IPs. In one example from Makassad, their MMU conducts field visits three time per week to provide general as well as gynaecological services along with free medications.

Demographically, UNFPA's prioritisation of women and girls is clearly aligned with their mandate. However, programmes may not be effectively serving younger adolescent girls (in the 10-14 year-old range). There is no specialised programming for people with disabilities, nor for LGBTI populations. Because UNFPA's integrated youth programming has a strong RH component, their target group is generally 15-24. While a few IPs may work with girls age 12-15, this is not the standard. The result is that younger adolescent girls, from 10-14, are a largely missed demographic in these youth programmes.[42] Even with older youth, targeted programming is limited compared to UNFPA's SRH and GBV interventions, despite significant gaps in youth health.[43] There is the intent to change this in the future: UNFPA is leading the articulation of an action plan for national youth policy. Addressing youth is a core outcome of the Country Programme Document 2017-2020 for Lebanon.[44]

UNFPA has acknowledged that people with disabilities are also underserved; as noted previously, there is no specialized programming for people with disabilities. UNFPA organised workshops at the beginning of the year with partners to discuss disability inclusion, and have since included a target in project reporting for an IP in Bekaa that is related to "the number of people reached with referrals."[45] Even so, at the time of research UNFPA was not disaggregating data by types of disabilities or other

[40] UN KIIs.

[41] According to a GBVIMS update, during the last quarter of 2017, the sector faced a sudden funding shortfall, which caused interruption and reduction of GBV programmes across the country, including case management services to survivors, such that organizations could no longer identify and support new cases (with limited exceptions for high risk ones), but could only provide support to open – ongoing cases. This resulted in a 60% decrease of survivors reporting incidents of GBV in quarter four of 2017, as compared to quarter three. GBV coordination partners re-shifted budgets, to bridge gaps in an attempt to ensure funding is available for life-saving case management services for open and on-going cases. Nevertheless, this indicates the potentially dire consequences of reduced case management programming.

[42] Other GBV partners have done considerable work with adolescent girls, including developing and implementing an adolescent girls toolkit that has been rolled out regionally. UNICEF works with younger adolescent girls, but their programming is diminishing, making it even more important for UNFPA to develop strategies to better meet the needs of this age group.

[43] See the Global school health survey in Lebanon, http://www.who.int/ncds/surveillance/gshs/Lebanon_2017_GSHS_FS.pdf

[44] UNFPA had a pilot with MOPH, MOE and MOSA on providing youth friendly services in 11 PHCs that trained health care providers but the project ended in 2009. This year MOPH agreed to restart services in these PHCs with retraining.

[45] UNFPA KII.

parameters, nor is data collection about numbers of beneficiaries with disabilities widespread across projects. This is an area upon which UNFPA intends to focus further in 2018-2019.

Further, UNFPA is not focusing specifically on the needs of the LGBTI community, including people at risk of HIV. There are few NGOs providing support to the LGBTI community. While there is a national AIDS programme serving people with or at risk of HIV, there is no provision for HIV rapid testing at the PHCs. Condoms are available in PHCs, but these may not be the most convenient or effective distribution point for target groups. UNFPA is planning an RH rights needs assessment in 2018 to inform improved response to the LGBTI community.

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

12. UNFPA facilitates coordination of the RH Working Group, the CMR Task Force, and the SGBV Task Force. All coordination mechanisms are informed by actions plan. The SGBV Task Force and the RH Working Group have strong engagement of multiple partners and are considered important mechanisms for improving response to women and girls affected by the Syria crisis. The recent action plan development by the CMR Task Force holds promise to improve that area of intervention. UNFPA coordinators continue to double-hat, contrary to recognized good practice.

UNFPA facilitates coordination of the RH Working Group, the CMR Task Force, and the SGBV Task Force.[46] The SGBV Task Force and the RH Working Group have active engagement of multiple partners and are considered important mechanisms for improving response to women and girls affected by the Syria crisis by UN and implementing partners.[47] Facilitating coordination was one of the first and most critical activities that UNFPA undertook from the earliest stages of the emergency.

The **SGBV Task Force** is noted for its very strong capacity, organisation and influence. It stands as a model globally for productive collaboration amongst the GBV leads in Lebanon (UNHCR, UNFPA and UNICEF) together with the government (MoSA).[48] Initially, however, UNFPA's support to the GBV Task Force was not ideal, insofar as coordinators were on short-term surge posts until 2014, which contributed to problems of continuity of support. The coordinator in position as of mid-2018 has been in the post for four years. Although the funding UNFPA receives for its GBV programming is significantly less than its sister agencies—which may to some extent affect its leadership capacity--it engages in programming strategically to support the implementation of the SGBV Task Force action

[46] These are for refugee response. As noted previously, UNFPA also leads the Gender Working Group focused on development action.

[47] There are six core functions of cluster coordination as outlined in the Cluster Coordination Reference Module (IASC, 2015) which include informing HCT/UNCT strategic direction ('informing' meaning contributing to, and influencing), supporting robust and unified advocacy, supporting service delivery, supporting capacity building, information management, and monitoring,

[48] In other research undertaken in Lebanon on GBV, the SGBV Task Force has been noted as a strong entity (e.g. an evaluation undertaken by UNICEF in 2015; a GBV assessment undertaken by the Swiss Development Cooperation in 2016). UN key informants reconfirmed the utility of the coordination mechanism during the country review.

plan in accordance with UNFPA capacity and mandate.[49] In the last year, particularly, UNFPA has stepped in to address urgent gaps identified by the Task Force.

Some concerns, however, have been expressed around UNFPA's support to the coordinator position. The current coordinator has been on a temporary contract for four years. Moreover, challenges were noted linked to double-hatting of the GBV coordinator, who also has responsibility for overseeing UNFPA's GBV programmes. Although broadly understood to negatively impact capacity for coordination[50], this concern will not be resolved through the organigram realignment because the GBV fixed term post will continue to be responsible for both coordination and programmes. Adding to this, the national UNFPA GBV coordinator does not participate in national-level coordination due to lack of time, which was felt by one key information to have a negative impact on programmes because of her lack of participation in information-sharing among the wider GBV community. Lack of field presence means that UNFPA does not regularly participate in sub-national SGBV coordination mechanisms; however, there is good reporting from those mechanisms up to the national SGBV Task Force.

The **RH Working Group** and the **CMR Task Force** are overseen by the same UNFPA SRH staff person, who is thus double-hatting in a coordination role and with UNFPA programming. The RH Working Group has made significant strides in accountability of and support to MOPH (the de facto co-lead) particularly through the rollout of the RH Guidelines and in terms of facilitating reporting on service delivery--although delays were noted by one key informant on completion by the working group of the family planning counselling curriculum for midwives. Even so, the RH coordination is described by one key informant as "very direct, very action-oriented", with another key informant suggesting that the coordination was "perfect."[51] However, the CMR Task Force is reportedly "less strong", struggling with efforts to scale up CMR services, including ensuring timely delivery of RH Kit 3 supplies, to PHCCs.[52] In addition, few international NGOs are working on CMR, which has meant a relatively lower level of participation, and even some of those who are working on CMR do not regularly participate in meetings.[53] However, recent action plan development by the CMR Task Force holds promise to improve programming. Coordination between the GBV and CMR Task Forces would reportedly benefit from strengthening to improve collaboration of partners as well as to ensure consistently safe, ethical and timely CMR response, including tracking of PHC trainings and provision of relevant CMR (RH Kit 3) commodities.[54]

[49] According to key informants, UNFPA is in third place as an appealing agency for GBV, but the differentials between UNFPA and the other two lead agencies, UNHCR and UNICEF, are significant. In 2017, for example, UNICEF received approximately 11 million for GBV programming in Lebanon.

[50] See, for example, guidance in the GBV Coordination Handbook, www.aor.com

[51] UN and INGO KIIs.

[52] UN KII.

[53] UN KII.

[54] WHO noted they have a universal health project though the World Bank that will be piloted in 71 PHCs, for which they want to upgrade packages to include GBV.

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 (v) 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 IAWG)

FINDINGS

13. UNFPA's engagement in SRH and GBV coordination, as well as its close working relationship with government partners, has facilitated its leadership on SRH and GBV response in the Syria crisis. However, UNFPA's presence at other UN fora (e.g. the UNCT and UNHCT) is less visible.
14. UNFPA's response is aligned with global, regional and national mandates and priorities, and in particular, helps to shape the Lebanon Crisis Response Plan.
15. The UNFPA Lebanon programme is aligned with international normative standards, including priorities and guidance emanating from the GBV AoR and the global RH coordination forum (IAWG).

UNFPA's engagement in SRH and GBV coordination, as well as its close working relationship with government partners, has facilitated its leadership on SRH and GBV response in the Syria crisis. However, UNFPA's presence at other UN fora (e.g. the UNCT and UNHCT) is less visible. As noted above, UNFPA's leadership of coordination mechanisms for SRH and GBV is generally considered quite strong. UNFPA is a key partner in developing sector strategies and action plans and in leading/supporting their implementation. One UN colleague noted: "I see UNFPA quite active and vocal in making sure that violence and RH get the necessary attention and funding --I find them present, vocal, quite easy to collaborate with." UNFPA's robust partnership with MOPH, in particular, as well as with MOSA, has meant that UNFPA is in a strong position to advocate for sector priorities and to support implementation of those priorities (e.g. with regard to MOPH reigniting attention to youth health in pilot PHCC's). For GBV, it was noted by a UN key informant that UNFPA has, in recent years, both supported and facilitated evolving priorities within the larger GBV community. For example, the SGBV Task Force annual work plan for 2015-2016 focused on supporting service delivery; in 2016-2017, the focus was more on reflecting on how GBV partners work with local partners; considering efforts to scale up access to justice; working with men and boys; facilitating GBV mainstreaming. UNFPA's GBV priorities have, in many way, mirrored those of the larger GBV community.

At the same time, at least three key UN informants noted that UNFPA does not contribute substantially to broader policy discussions and decisions with the UNHCT. UNFPA has been described by one UN interviewee as more of a "project or programme implementor"; another surmised that UNFPA may have a more vocal presence within UNSF planning—as a development partner--than the UNHCT, as this is reportedly a forum that is more open and where smaller agencies can take more of

a leadership role. A possible explanation offered by another UN interviewee for UNFPA's limited contributions in the UNHCT was that "the coordination structures are vast, and you have to make priorities." One UN key informant noted that the UNFPA Head of Office "had to push" to be included in the UN senior management team (SMT) meetings, raising the importance of her inclusion first with the RC/HC and then, after receiving no response, with the regional office. This same informant suggested that UNFPA LCO would have benefitted from greater support from the regional office and headquarters in this regard, and that, once she was successfully integrated into the SMT, "there was no issue" about the value and legitimacy of her participation.

UNFPA's response is aligned with global, regional and national mandates and priorities, and in particular, helps to shape the Lebanon Crisis Response Plan.[55] UNFPA not only aligns with national legislative and policy frameworks, it helps to create them (e.g. through advocacy for the ratification of the Domestic Violence law, development of the National Women's Strategy, work on SCR 1325, the new aging portfolio, etc.). UNFPA both guides and supports the health strategy for the MOPH, operationalising their support through an annual work planning process described by MOPH as very useful and collaborative. UNFPA engages directly with government on drafting commitments for the LCRP under both the humanitarian and resilience pillars, which are aligned with UNFPA's CPD 2016 and 2017-2020 and UNFPA's global Strategic Plan. The UNFPA Lebanon programme is also aligned with the UNFPA Second Generation Humanitarian Strategy, conceived in 2012, which emphasises strengthening UNFPA's accountability for advocating for, delivering results on, and coordinating SRH and GBV activities and interventions in emergencies. The Second Generation Humanitarian Strategy has a focus on UNFPA's core mandate, including capacity-building and advocacy for MISP, maternal and newborn health (MNH), access to family planning, GBV prevention and response, and services for youth. All of these outputs and outcomes are included within UNFPA Lebanon refugee response (recognising that greater attention to youth is a priority area for increased attention in the 2017-2020 CPD).

The UNFPA Lebanon programme is largely aligned with international normative standards, including priorities and guidance emanating from the GBV AoR and the global RH coordination forum (IAWG). UNFPA's RH guidance reflects and reinforces global human rights and technical standards, as does other training and programming interventions, with adjustments such as in the MISP that are aligned to an upper middle-income country, and to the cultural context (e.g. in terms of FP supplies).[56] However, some interviewees noted that this contextualisation may limit attention to some key areas; for example, two key informants felt there was limited attention in Lebanon to the "sexual" in "SRH", particularly in terms of support to youth and to LGBTI groups, possibly because of cultural sensitivity around sexual rights. Even when Issues of sexual health and sexuality are be considered in programming, they may not be addressed overtly due to cultural sensitivities.

For GBV, UNFPA took over the global cluster lead agency (CLA) role for the GBV Area of Responsibility (AoR) in 2017.[57] In addition, UNFPA has produced its own 2017 GBV Minimum Standards for GBV in Emergencies.[58] This guidance consists of 18 standards organised as foundational standards, mitigation, prevention, and response standards, and coordination and operational standards and exists currently as an aspirational comprehensive framework for UNFPA GBViE programming. UNFPA Lebanon is largely aligned with both global GBV normative frameworks and UNFPA's own minimum

[55] The Lebanon Crisis Response Plan (LCRP) is the Lebanon Chapter of the Regional Refugee and Resilience Plan (3RP). Since the start of the Syria crisis, there have been 6 Syria Response Plans (2012, 2013 Syria Humanitarian Assistance Response Plans and 2014, 2015, 2016, and 2017 Humanitarian Response Plans) and two 3 Regional Refugee and Resilience Plans (2015-2016, 2016-2017).

[56] MISP is the fundamental core of global standards for SRH in emergencies, under the authority of the Inter-Agency Working Group on Reproductive Health in Crises (IAWG).

[57] Until 2017 the GBV AoR was co-led by UNFPA and UNICEF. In 2017 a transition has taken place to sole leadership by UNFPA

[58] Minimum Standards for Prevention and Response to Gender-Based Violence in Emergencies, UNFPA, 2017

standards for GBV response. For the last two years UNFPA LCO, through the SGBV Task Force, has also supported the dissemination of the Inter-agency Standing Committee's *Guidelines for Integrating Gender-based Violence Interventions in Humanitarian Action* (IASC GBV Guidelines) to sector programmers in Lebanon; this tool constitutes the leading guidance on GBV mainstreaming globally.

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

16. UNFPA has increasingly integrated attention to development goals in their in-country humanitarian response.
17. UNFPA has undertaken some activities that focus on facilitating refugee resilience when they return to Syria.

UNFPA has increasingly integrated attention to development goals in their in-country humanitarian response. Several key informants noted that UNFPA's initial humanitarian response did not link to its development action—there was a separate humanitarian coordinator in the office, which may have served to reinforce divisions between humanitarian and development work.[59] Divisions may also have been a function of UNFPA striving to retain some of its focus on programming and relationships with the government ministries and institutions that preceded the Syria response, including some of the youth work and work with aged.[60] Aside from these internal drivers, shortcomings of UNFPA to address the humanitarian/development nexus was also likely influenced by UNHCR's leadership, including their emergency focus and caution around engaging in discussion about, or planning for, stabilization and resilience.

However, UNFPA LCO no longer works in humanitarian and development silos, but rather through an integrated approach--one that has accelerated in the last several years not only as a practical response to human resource challenges within the UNFPA office, but also as the wider humanitarian community has undertaken efforts to support stabilization, and the GoL has become more engaged in linking development with humanitarian action in line with the LCRP's focus on resilience for both the refugees and the Lebanese. UNFPA's work with the GoL has been described as "stellar"[61], illustrating an unusually strong capacity to work across different stakeholders—UN/INGOs/NGOs and the government--in order to generate mutually beneficial outcomes. A key informant noted that UNFPA has a particular ability to work "in between spaces" in national systems in order to more efficiently advance priorities.[62] The results are largely very positive, illustrated by the example of how the MCH package is now embedded in Lebanon's universal health care standards.

Moreover, UNFPA's programmatic approaches strongly reflect an appreciation of the humanitarian-development nexus, particularly in terms of its efforts at nationwide systems-building for sustainability (e.g. commodity security strategies, procurement, etc.); and its focus—especially in its GBV programming—on capacity building of local partners.[63] This is notwithstanding the challenges of

[59] UN KIIs.

[60] It proved difficult for UNFPA to continue to access funds for this work because resources were being diverted to the crisis; however, as already noted, UNFPA's work in this area is now becoming reenergized, through an approach that embraces attention to both refugees and Lebanese.

[61] Donor KII.

[62] Donor KII.

[63] This approach is in line with one of the key recommendations that emerged by UNFPA's Independent Country Programme Evaluation: "UNFPA should ensure that a sustainability plan is agreed upon with different stakeholders at the beginning of each project, together with a clear exit strategy. Implementing partners' capacity should be strengthened for the adoption of UNFPA supported interventions."

capacity building local partners that UNFPA faces because of their lack of field presence, which UNFPA has addressed through several strategies, such as assigning staff liaisons to different local partners, as well as supporting the twinning of INGOs and NGOs. UNFPA's partnership with UNDP on working on the Rule of Law is also an important investment in establishing longer-term protections for GBV survivors and those at risk.[64] However, issues remain in terms of short-term funding for IPs as well as relatively low levels of coverage due to UNFPA's limited funding to service delivery for both SRH and GBV.

UNFPA has undertaken some activities that focus on facilitating refugee resilience when they return to Syria. UNFPA's peer-to-peer learning is one example of empowering Syrian refugees to engage in leadership activities that will benefit them when and if they return to Syria, as is its other community outreach activities aimed at increasing knowledge and awareness of refugees around SRH and GBV rights.

[64] While global good practice in GBV programming recognizes that efforts to promote access to justice should not be a priority in the early stages of an emergency, the Lebanon GBVIMS has identified that survivors continue to be reluctant to accept referrals to legal services for a variety of reasons, including lack of trust in the capacity of the legal sector, and this may be impacting their decision to access other services such as PSS.

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 Policies and Procedures;
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

18. UNFPA has maximised efficiency in some areas by, for example, streamlining commodities procurement and distribution. Other approaches, such as an over-reliance on surge, have undermined UNFPA's efficiency.
19. UNFPA at corporate level has insufficiently supported LCO with core resources relevant to the size and scale of the country (humanitarian) response.

UNFPA has maximised efficiency in some areas by, for example, streamlining commodities procurement and distribution. Other approaches, such as an over-reliance on surge, have undermined UNFPA's efficiency. In the early stages of the emergency, UNFPA distributed pre-packaged commodities to clinics, which included supplies that they might not use (e.g. female condoms, not a preferred form of contraception among Syrian refugees or Lebanese). In order to enhance efficiency, UNFPA developed a list of commodities that was shared with clinics in advance so they could identify the commodities they needed. UNFPA also streamlined reporting from the PHCC's, using that data to inform annual work planning with the MOPH. Dignity kits have similarly been adapted to the needs of women and girls based on assessments by the GBV partners, and according to two UN key informants distribution is generally quite reliable. Although there were some delays previously in the replenishment of CMR supplies, this has improved, and will continue to improve in line with the implementation of the CMR strategy to support government management of CMR supplies and services.

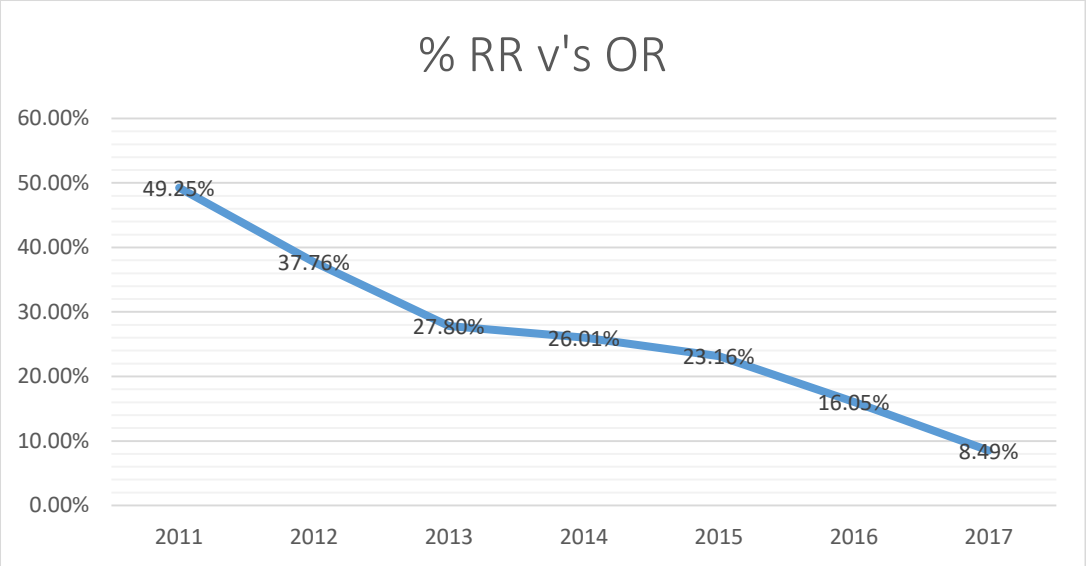
Some other strategies to maximise efficiency have not been as effective, particularly in relation to human resources. For example, UNFPA's stop-gap reliance on surge capacity for programme positions, as well as on short-term consultants, has limited the extent to which UNFPA has been able to promote consistency and stability in its programming. Delays in recruitment, high staff turnover and temporary contracts have also had an impact on UNFPA relationships with IPs and donors. Staff are reportedly over-burdened; one example is that there is one person in the office who oversees all operations, including finance, human resources, and logistics. In 2017, the CO was "operating with barely the minimum required staff."[65] The absence of sufficient human resource staff raises concerns about UNFPA LCO's capacity to manage its PSEA responsibilities, as well as other human resource

[65] COAR 2017.

issues such as staff concerns/complaints, contracts, etc.[66] According to one donor, staffing limitations have compromised UNFPA's ability to utilise existing funds as efficiently as possible (e.g. resulting in programming delays), noting that they "are not a demanding donor, but even then UNFPA can't meet our [reporting] needs."[67] UNFPA colleagues also noted that staffing issues have affected its ability to generate new funding, not only because staff are busy, but also because of the absence of a communications officer who can develop reports and other communications materials to share with prospective donors.[68]

UNFPA at corporate level has insufficiently supported LCO with core resources relevant to the size and scale of the country programme. In the first two years of the emergency, UNFPA headquarters led funding mobilisation, which was subsequently picked up by the Hub. By 2016, UNFPA LCO was largely responsible for generating its own funding, a considerable responsibility to undertake given the already limited number of staff. This challenge with fundraising was exacerbated by LCO's inability to fill the communications position because of struggles with finding someone to take the position as a consultant at the same time there were delays in the approval of the realignment to allow the communication post to be fixed term.

Until 2017, annual funding was below US$4 million, with an upsurge in funding in 2017 to more than $6 million due largely to new GBV grants from Canada and the Swedes. Over this period core resources have declined markedly. The below figure shows the UNFPA LCO budget of regular resources (core resources provided through UNFPA) since the humanitarian response.[69]



Donor (project) funding is occasionally unearmarked, but generally is much more likely to be restricted to specific project activities in specific (donor-driven) locations, with limited opportunity for either increasing office management, systems, M&E and general operations or for providing services based on a clear independent assessment of needs rather than donor criteria. One donor key informant noted that UNFPA's staffing shortfalls have contributed to UNFPA's struggles to "get fit for function":

[66] There are two PSEA focal points in the office responsible for following up on UNFPA HQ, ASRO, and UNCT PSEA-related responsibilities, including the UNCT action plan. One is the operations manager, whose responsibilities are already extensive, and the other is a programme staff person on a junior professional officer (JPO) contract.
[67] Donor KII.
[68] UNFPA KIIs.
[69] Based on financial data provided by LCO.

"the agency has a huge mandate and could do so much but are limited by staffing to expand based on needs."

Lack of core resources for longer-term positions (which are usually not fundable under donor resources) are the major factor in the LCO overuse of surge support. As mentioned previously, some of these human resource challenges have been due to UNFPA corporate/systemic rigidity in terms of CO organigrams, coupled with regional and headquarters delays in approval of the LCO realignment. Even with the approval of the CPD 2017-2020 staffing structure in November 2017, the problem of double-hatting for coordination will remain.

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.

FINDINGS

20. UNFPA is generally viewed as a very good partner. However, some UNFPA IPs have been significantly affected by delays in funding that have contributed to slow start-up and halt to existing programmes that is particularly unsuitable in humanitarian response.
21. UNFPA has used joint partnership agreements to facilitate programming.

UNFPA is generally viewed as a very good partner. However, some UNFPA IPs have been significantly affected by delays in funding that have contributed to slow start-up and halts to existing programmes that is particularly unsuitable in humanitarian response. As noted above, UNFPA's relationship with the government was observed by many key informants, including government personnel, to be very strong. At least four national partners interviewed—those who tend to be less affected by delays in funding given the small amount of support they receive—also praised UNFPA as a high-quality partner, characterizing UNFPA as one the more responsive and supportive UN donors, and in the words of one NGO key informant, "a true partner", with another noting "they are very good, very cooperative." In one example of the support provided to partners aimed at assisting them to raise their quality standards and/or to be able to promote/implement an integrated GBV-SRH approach, UNFPA has assessed their capacity development needs and developed jointly/implemented a capacity development plan under each agreement. Partners interviewed who had received this support were appreciative of this type of capacity-building approach, specifically mentioning the value of operational training, annual work plan review, and quarterly meetings of partners contributing to the same project to enhance information-sharing about good practices and lessons learned.[70]

Training sessions on NEX-Financial management were conducted and delivered for all IPs and programme staff (new and existing), and the training materials were shared with IPs after the training. Even so, three NGOs interviewed during the country visit requested additional guidance on financial reporting and. They also requested additional information about developing proposals, noting delays in proposal approval due to back-and-forth on budgets and what can be included in them. There continue to be concerns about the number of reports requested by UNFPA, particularly among the smaller organisations that—like UNFPA—have limited operations/financial management capacity. Several partners—especially the larger ones--expressed significant frustration over delays in approvals and signing agreements, even for critical gaps, which in two instances have resulted in the suspension of programming in areas that have limited or no alternative GBV or SRH services, with one partner noting that the agreement with UNFPA "is the most difficult arrangement we have--hands down, nothing else comes close."[71] One partner also expressed frustrations about requests for programme reports at the same time as the arrival of the first tranche of funding.

UNFPA has used joint partnership agreements to facilitate programming. UNFPA has a notably strong partnership with UNHCR and UNICEF through the SGBV Task Force, recognized not only by the coordination leads, but also by key informants from the UN and INGO. To support shared priorities of

[70] COAR, 2017.
[71] KII, implementing partner

the SGBV Task Force (e.g. the GBVIMS oversight and the roll-out of the IASC GBV Guidelines), UNFPA has undertaken joint implementation with UNHCR and UNICEF through UN-to-UN agreements. In fact, since 2012 UNFPA has received funding from sister agencies through 8-9 UN-to-UN agreements on joint interventions focused on research, capacity development, policy formation, and standards development. This practice has contributed to improved coordination, increased funds available for implementation and raised the level of trust and understanding among agencies. UNFPA is currently engaged in a joint project with UNDP and UN Women on the rule of law related to GBV, and with UNICEF on a national youth policy.

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:[72]
    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.

FINDINGS

22. UNFPA support has significantly contributed to access to quality integrated SRH and GBV services.
23. UNFPA support has contributed to social norms programming for refugee and host communities in Lebanon related to SRH and GBV but the impact of these efforts on behavior change is unclear.
24. UNPFA support has contributed significantly to the humanitarian community being accountable for recognising SRH and GBV as life-saving interventions.

UNFPA has partially achieved the outcomes as articulated in the reconstructed ToC in relation to (a) women, girls and youth in Lebanon accessing quality integrated SRH and GBV services; (b) women, girls, and youth benefiting from prevention, risk reduction, and social norm change programming; and (c) the humanitarian community being accountable for recognising SRH and GBV as life-saving interventions, insofar as:

UNFPA support has contributed significantly to access to quality integrated SRH and GBV services. In spite of UNFPA's relatively small country programme as compared to its sister UN agencies, it has employed a variety of modalities to support the delivery of quality integrated programming nationally, resulting in significant improvements in access to services: In 2012 only 3465 women accessed RH care and 1750 men accessed STI treatment supported by UNFPA, whereas an estimated 144,000 men and women accessed RH services supported by UNFPA in 2017.[73]

In 2016 and 2017, through funding from Saudi Arabia, UNFPA procured medical equipment and supplies for 160 PHCCs and 26 Governmental hospitals. It is estimated that this equipment may benefit 1.5 to 2 million persons in Lebanon—both Lebanese and refugees.[74] According to a UNHCR 2016

[72] See Annex III
[73] Data provided by UNFPA LCO summary analysis.
[74] Data provided by UNFPA LCO summary analysis.

Heath Access and Utilization Survey among Syrian refugees in Lebanon, 70 percent of refugee women of reproductive age (15-49 years old) who were pregnant in the past two years reported accessing antenatal care, with 73 percent reporting three or more visits, while 53 percent reported more than four visits.[75] In a study undertaken by UNFPA in the same year, it was noted by key informants that the numbers of patients seeking RH and FP services has more than doubled since the onset of the Syrian crisis, and that the proportion of Syrians accessing services is higher than that of the Lebanese.[76] Clients interviewed as part of the evaluation consistently noted the quality of services, as well as appreciation for being able to access free gynaecological and family planning services, as captured by one focus group discussant: "For us, this service unloaded a big burden."

UNFPA support to the provision of commodities has included RH kits, specific RH drugs, and contraceptives to 214 PHCCs of the MOPH, in addition to approximately 70 NGO-supported centres, ensuring for the first time widespread availability of RH supplies across Lebanon for both refugees and Lebanese. UNFPA has further equipped a select number of CMR-trained facilities with post-rape equipment and supplies (e.g. the RH kit 3), although delivery and replenishment of expired kits has not always been timely,[77] and uptake of CMR services appears to be quite limited.[78] UNFPA also supplies drugs for STIs, but lab tests, which are expensive, are not subsidised. There has reportedly been improved uptake of contraceptives in supported health centres, with IUDs and pills the preferred methods.[79]

UNFPA has led in the procurement and distribution of dignity kits, a process which UN and INGO stakeholders interviewed during the country visits agree has generally been reliable and efficient, with occasional delays in resupply. In addition to easing a financial burden, these dignity kits serve as an incentive for women to participate in empowerment and life skills activities. In 2017, UNFPA distributed 17,000 dignity kits.

Support to local implementing partners on GBV is now a major component of UNFPA's GBV portfolio, with the effect of UNFPA reaching twice as many women and girls through case management from 2016 to 2017 (from 1832 served in 2016, to 3775 served in 2017).[80] However, UNFPA's empowerment activities for women and girls, while widely appreciated by beneficiaries, generate some frustration linked to their limited impact on livelihoods.

UNFPA support has contributed to social norms programming for refugee and host communities in Lebanon related to SRH and GBV but the impact of these efforts on behavior change is unclear.

[75] UNHCR, 2016. Health access and utilization survey among Syrian refugees in Lebanon, https://data2.unhcr.org/en/documents/details/52301

[76] UNFPA, 2016. Assessment of Unmet Needs and Projecting Family Planning Needs for Syrian Refugees in Lebanon.

[77] Distribution of the RH Kit 3 is overseen by UNFPA, whereas all other distributions are overseen by MOPH. UNFPA has acknowledged challenges in managing these supplies separately. It is anticipated that the government will assume distribution at some point, but until then IMC is tasked, through the CMR Task Force, with monitoring RH kit 3 supplies for replenishment.

[78] While efforts by the SGBV and CMR task forces to roll out CMR training, GBV actors acknowledge that service providers require more support to ensure quality of care. To date there has been very limited self-referral for CMR. It is unclear whether this is because people do not know about availability of services, or because of stigma in seeking medical care or quality of services. There is currently no monitoring or reporting system through MoPH to better understand service delivery gaps and needs related to CMR and this is currently done through UNFPA supported programming.

[79] UNFPA and MOPH, 2016. *Assessing Unmet Needs and Projecting Family Planning Need for Syrian Refugees in Lebanon.* Interestingly, one key informant noted that government priorities were related to the availability of family planning supplies, but they are unsure about the extent to which the increased supply has been met with increased demand. At the moment, condoms are only available at pharmacies. IUDs and pills are more often used, according the interviewee, because women get them themselves; however, these supplies requires FP counselling, including with males, as men often make decisions on FP.

[80] Data provided by UNFPA LCO summary analysis.

UNFPA has made contributions to longer-term social norm change through its community outreach and peer-to-peer learning—with evidence of impact largely from anecdotal reports rather than impact evaluations.

Awareness-raising has been a component of SRH programming since 2012, and GBV programming since 2013, with SRH awareness-raising reaching an estimated 45,000 Syrian males and females, and GBV awareness raising around 60,000 males and females (with approximately half reached in 2017 alone due to an increase in funding for peer-to-peer learning). For many women interviewed during the country visit, peer-to-peer learning was their first formal exposure to RH issues and has helped them understand, for example, the value of birth spacing and the availability of different forms of contraceptives.[81] However, it is unclear the extent to which this learning has resulted in behaviour change, particularly regarding family planning. According to the 2017 *Multi-year Strategic Framework Expanding Voluntary Family Planning Services in Lebanon With Emphasis on Displaced Populations,* fertility rates remain high among refugees; the strategy indicates, that

> In the case of Syrian women in displacement this is extremely critical in order to overcome the range of structural and incidental elements of resistance and to bring about a favorable attitude and a positive change of behavior regarding family planning.[82]

UNFPA's attention to early marriage as well as to youth SRH are further important entry points for social norm change. UNFPA has translated its messaging into accessible IEC materials for widespread distribution and in the last year broadened its base of partners engaged in community-based awareness activities considerably, with the result of reaching approximately 30,00 females and males with GBV awareness raising. Women and girls interviewed during the country visit perceived that the outreach on early marriage has helped girls to stay in school and improved communication among family members on the negative effect of child marriage.[83] However, data has yet to be collected on the reduced prevalence of early marriage linked to programmes.

With regard to the male peer-to-peer activities, women participating in focus group discussion as part of the country visit noted that this outreach has been beneficial insofar as helping men to understand the value of family planning: "It's a great idea… men didn't believe women before, and now when they have a male trainer they listen to him."[84] While the male peer-to-peer trainers interviewed for the evaluation appreciated the value of the work, it was not clear the extent to which trainers who were interviewed have embraced and/or understood their responsibilities for addressing the specific element around social norms change related to GBV. Instead, a number of male peer-to-peer trainers implied that the main focus of their work was more linked to support—such as skills training--for males in the community. While UNFPA's support to men and boys is in line with priorities identified by the SGBV Task Force, it is not clear the extent to which this approach is meeting its objective of focusing on social norm change related to GBV and SRH.

UNPFA support has contributed significantly to the humanitarian community being accountable for recognising SRH and GBV as life-saving interventions. UNFPA's very positive relationships with the

[81] Focus group discussion, adult women, North, South and Bekaa

[82] 2017 Strategic Framework, p 7.

[83] As noted previously, however, data suggest that early marriage has been on the rise among the Syria population compared to rates of early marriage in Syria prior to the conflict. UNFPA conducted a baseline survey on early marriage in Bekaa, *The Prevalence of Early Marriage and Its Determinants Among Syrian Girls and Women* (2015), which produced interesting findings and related programming recommendations linked to correlates to early marriage such education levels and poverty. To date, however, there has been no population-based evaluation of the impact of efforts to reduce early marriage among Syrian refugees in Lebanon, beyond anecdotal reports from project beneficiaries and some analysis of marriage registration (not necessarily a good indicator).

[84] Female FGD participant.

GoL has had a significant influence—even in a time of government instability—on the GoL's improved response to SRH and GBV, including in terms of working with the government to draft relevant sections of the LCRP and other national strategies, such as the recent *Multi-year Strategic Framework Expanding Voluntary Family Planning Services in Lebanon With Emphasis on Displaced Populations,* as well as the youth action plan and updated national youth policy. UNFPA's guidance regularly emphasizes reproductive rights, including in its tools development, such as the RH Guidelines.

Its strong coordination leadership has also had a major impact in improving humanitarian response to SRH and GBV. For example, as a result of the UNFPA-supported rollout of the IASC GBV Guidelines, action plans aiming at enhancing GBV mainstreaming capacity were developed and endorsed by each humanitarian sector (including by line Ministries). Those sectoral action plans have been integrated in the 2018 LCRP and constitute the basis of the action plans to be monitored by the sectors in 2018.[85]

Its commitment to research over the last several years, including sex and age-disgreggated data (where relevant), has not only impacted the value of its own programming but has also been a service to the wider humanitarian community in terms of better understanding of needs and approaches to addressing SRH and GBV in humanitarian action. However, as yet this research has not focused significantly on understanding impact of the interventions.

[85] UNFPA LCO 2017 Annual Report.

Conclusions

Key conclusions for the **UNFPA Lebanon Country Office** cut across Findings for Evaluation Questions 1, 5 and 8 (Key Conclusion A); Evaluation Question 3 (Key Conclusion B); Evaluation Question 4 (Key Conclusion C); Evaluation Question 6 (Key Conclusion D); Evaluation Questions 8 and 9 (Key Conclusion E); and Evaluation Question 10 (Key Conclusion F).

A. Although its' operations are relatively small, UNFPA has had an outsized impact due in part to its strong relationships with government and UN partners. At the same time, its staffing limitations have compromised UNFPA's ability to utilise existing funds as efficiently and effectively as possible, as well as to generate new funding in order to improve its ability to meet beneficiary needs.

B. Coverage (geographically) of SRH and GBV services has been facilitated largely through provision of equipment, supplies and training. Support to the delivery of direct services is still limited. This is particularly a concern for GBV programming given the marked decrease in funding from UNICEF to GBV programming and the related expectation by sister agencies that UNFPA scale up programming. UNFPA's integrated SRH/GBV approach has allowed a higher level of GBV services to be offered than would have happened without GBV services being provided under the umbrella of 'SRH.' Coverage (demographically) is likely underserving young adolescent girls (age 10-14), as well as people with disabilities and the LGBTI community.

C. Following several initial years of instability in coordination leadership resulting from a reliance on short-term contracts and surge capacity, UNFPA's leadership of RH and GBV coordination functions has been very strong in recent years,. This current stability has been due to the presence of longer-term staff with solid technical capacity. However, the GBV coordinator is still not on a fixed-term contract. Double-hatting continues to be a challenge. [See *Conclusion 2* for UNFPA global consideration below for more information].

D. Given its strong relationships with government partners, UNFPA has been particularly well-equipped to support interventions that bridge the humanitarian to development continuum. Although perhaps not initially the case, the majority of its interventions currently support system strengthening and capacity building: in this way, UNFPA has "found its footing" in approaches that are aligned with the resilience focus of the LCRP. Provision of CMR is a particular area requiring increased government leadership for sustainability.

E. LCO's partnership strategy for GBV programming has been influenced in part by its limited access to funds, resulting in a focus on supporting small local NGOs through capacity building, prioritising underserved locations in Lebanon. While this approach shows some promise, it also presents challenges given UNFPA's low number of staff and lack of field presence.

F. Many elements of UNFPA's programming in Lebanon have been effective in improving humanitarian response in terms of supporting improved access to RH supplies and services in PHCCs and select non-government sites, as well as to GBV case management for GBV . However, it is not yet clear whether the humanitarian response is having a measurable impact on several key intervention areas, including the fertility rate of Syrians in Lebanon, or in terms of reducing exposure of Syrian women and girls to different forms of GBV, particularly intimate partner

violence and child marriage. While UNFPA has contributed considerably to research on SRH, GBV and, to a lesser extent, youth, it has not focused on impact measurement.

Two key conclusions for **UNFPA global consideration i**nclude themes emerging from the Lebanon evaluation visit which require reflection at a more corporate level.

1. UNFPA core, corporate investment with regular resources has not been commensurate with the size and scale of the Lebanon response for agency leadership and programming responsibilities.

Overall investment of core funding (regular resources – RR) vs reliance on donor project funding (other resources – OR):

In 2011 UNFPA Lebanon operated under a budget of US$659,647 in Regular Resources (RR) and US$679,829 in Other Resources (OR). This was a total budget of 1,339,477, with 49 percent of it being RR – core funding that can be used to ensure adequate expenditure on systems and operational support to programming.

By 2017 UNFPA Jordan operated under a total budget of US$6,645,848, of which US$6,081,409 was Other Resources (OR) – representing 92 percent of the overall budget. Other Resources represent donor funding which is usually ear-marked for specific programming projects, and restricted in use in terms of programming and operational vs programming costs.

This change in resourcing modalities has resulted in a country office highly reliant on temporary short-term contract project staff, and without corporate support to sustainable systems and staff in place to ensure connectedness, drive coverage to relevance of needs, discharge coordination responsibilities with the provision of dedicated coordinators, etc.

This lack of investment in regular resources is not the only challenge in terms of corporate investment; UNFPA regional office and headquarters also did not adequately assess and devise strategies for management support in the early days of the emergency in a way that could have enhanced LCO response to the crisis and establish them as a larger voice in humanitarian response. To add to this, UNFPA regional office and headquarters were slow to approve the realignment, which—given the systemic challenges in adjusting CO organigrams—has had a major impact in LCO's ability to respond flexibly to the crisis.

2. UNFPA core, corporate investment with regular resources has not been commensurate with the size and scale of the Lebanon response for coordination responsibilities.

UNFPA has had, since 2017, a formal responsibility under IASC for GBV coordination. Whilst the Lebanon refugee response is managed under UNHCR and not as a clusterised response under OCHA / IASC protocols, the sectoral accountabilities held by UN Cluster Lead Agencies (CLA) remain relevant.

UNFPA falls short of other CLA in terms of not resourcing dedicated Sub-Cluster (SC) /Sub-Working Group (SWG) positions. Many other clusters – including the Child Protection Sub-Cluster under UNICEF, will often have P4 or P5 dedicated coordinators. When UNFPA fails to 'keep up' and provides double-hatting and/or lower level staff grades to GBV SC or SWG roles, it means that the GBV coordination forum has much less authority and influence within the humanitarian response; generally receiving less allocation of funding from pooled funding sources and less weight within inter-cluster coordination forum.

Coordination work is time-intensive. It is possible to do basic coordination (to identify gaps and duplications in geographical areas) as a part-time role. However, genuine coordination – identifying

and eliminating gaps and duplication; ensuring consistency of quality of services; capacity-building of partners; developing robust strategies with inputs from a range of different organisations providing GBV services and programmes from different perspectives (health, human rights, education, social protection, and gender equality); representing the GBV community at all inter-cluster forums, and ensuring adequate respect for GBV, adequate resourcing for GBV from pooled funding, and adequate coverage of GBV in HNOs and HRPs; and developing advocacy strategies so all diverse GBV partners advocate with one voice – is *not* a part-time role and requires a dedicated staff member with the requisite skills and experience. A dedicated Information Management position is also worthwhile.

UNFPA does not have an equivalent formal responsibility for Reproductive Health coordination (with RH Working Groups usually being established voluntarily under the Health Cluster, as opposed to the official standing of the global GBV AoR). However, UNFPA is the global lead agency for SRH and therefore should take SRH coordination responsibilities just as seriously, with all aspects highlighted above for GBV being as pertinent to SRH.

Suggestions for Recommendations

*Key suggested recommendations at **country level (**all recommendations are for UNFPA Lebanon)*

A. UNFPA Lebanon should continue with and solidify provision of integrated SRH and GBV services. Even (and perhaps most especially) at a time of reductions in humanitarian funding, UNFPA should continue to capitalise on strategies such as support to government and local NGOs to improve quality and reach of sustainable programmes that support the humanitarian/development nexus.

B. To this end, UNFPA should consider developing, as part of its capacity building of local partners, more comprehensive and targeted strategies for improving oversight of local partners through direct field monitoring and other mechanisms of support.

C. In reference to specific gaps in programming areas, UNFPA should prioritise actions to scale up national capacity in the provision of CMR, including mechanisms for transferring oversight of CMR to the government in the line with the CMR strategy.

D. UNFPA should review its access to young adolescent girls and address coverage gaps.

E. UNFPA should improve collection of disaggregated data on working with people with disabilities as a first step in improving services for that underserved group.

F. UNFPA should consider how its SRH programming can more effectively serve the needs of the LGBTI community.

G. UNFPA should continue its investments in research, but with greater focus on examining outcomes related to key programming areas, such as uptake of family planning; impact of early marriage awareness-raising; impact of men and boys peer-to-peer programming; etc.

H. UNFPA Lebanon should advocate with UNFPA Headquarters for stronger support with coordination functions (recognising that donors are often unwilling to support this through project funding, and thus core funding through regular resources is required) so that coordinators are not required to double hat and are recruited on fixed-term contracts. Recognise the commitment UNFPA itself has made to this within the UNFPA GBV Minimum Standards (p.80).

I. With staff realignment, UNFPA LCO should focus on becoming fully "fit for purpose", including by:
   i. monitoring and reducing problems in partnership funding and oversight;
   ii. improving communications with donors in order to establish more reliable funding streams;
   iii. continuing to support office and programmatic capacity to reduce the humanitarian/development divide;
   iv. scaling up presence and participation in humanitarian leadership fora.

*Key suggested recommendations for the **overall evaluation**:*

1. UNFPA should urgently review its corporate commitment to humanitarian operations with a view to:
(a) Understanding and fully committing to guideline percentage parameters between Regular Resources (RR) and Other Resources (OR). UNFPA's corporate commitment to connectedness and longer-term sustainable, impactful programming cannot be achieved with Country Offices (COs) that

must transition from a 49 percent RR for country programme (2011) to a 8 ½ percent RR (2017) country programme as LCO has done.
(b) Understanding and addressing systemic limitations to addressing core staffing needs that contribute to COs inability to respond rapidly and flexibly to emergencies.

(c) Understanding and fully committing to coordination responsibilities with a clear corporate commitment to discharging those responsibilities in line with other cluster lead agencies, thus ensuring GBV and SRH receive an equal opportunity for visibility, attention, and funding as other sectors.

Annex I: List of Key Informants

	Name	Title	Agency	Office	Sex
1	Hala Abou Farhat	Interagency Health Coordinator	UNHCR	Beirut	F
2	Aly Khan Rajani	Head of Development Section	GAC Canadian Embassy	Beirut	M
3	Alissar Rady	National Professional Officer, Head technical team	WHO	Beirut	F
4	Wafa Kanaan	Primary Health Centre, Chief Central Coordinator	Ministry of Public Health	Beirut	F
5	Bahia Sleiman	Director of the National Program For Reproductive Health	Ministry of Social Affairs	Beirut	F
6	Rania Zattari	Head of Makassed Communal Healthcare Bureau	Makassed	Beirut	F
7	Dima Bou Daher	Project Coordinator	Makassed	Beirut	F
8	Muna El Jabi	Project Supervisor	Makassed	Beirut	F
9	Manal Kassem	GBV Coordinator	IMC	Beirut	F
10	Hagop Kouyoumijian	Coordination Officer	RCO	Beirut	M
11	Bjorn Betzler	Area Manager, Bekaa Valley&South Lebanon	DRC	South	M
12	Gaelle Kibranian	Governance Programme Officer	UNDP	Beirut	F
13	Manar Sarsam	Admin and Finance Associate	UNFPA	Beirut	F
14	Dana Dib	GBV IMS Coordinator	UNFPA	Beirut	F
15	Anne France White	Humanitarian Affairs Officer	OCHA	Beirut	F
16	Gwyn Lewis	Deputy Director Programmes	UNRWA	Beirut	F
17	Toni-Anne Vinell Stewart	GBV Coordinator	UNRWA	Beirut	F
18	Celine Moyroud	Country Director	UNDP	Beirut	F
19	Margunn Indrebo	Inter-agency Coordinator	UNDP	Beirut	F
20	Saad Abou Chahime	Project Coordinator	Intersos	Bekaa	M
21	Olivia Spilli	Programme Director	Intersos	Bekaa	F
22	Nawal Mdallaly	Director	Sawa Association for Development	Bekaa	F
23	Jad Youssef Hussein Chouman	Programe Manager	Nabad	Bekaa	M
24	Nada Hanna	GBV Programme Manager	HAI	North	F
25	Tracey Khoury	GBV Programme Officer	HAI	North	F
26	Dr. Jinan Usta	UNFPA SRH and GBV Consultant	Independent	Beirut	F
27	Rita Chemaly	Projects Manager	NCLW	Beirut	F
28	Chantal Bou Akl	Project Coordinator	NCLW	Beirut	F
29	Jihane Latrous	Child Protection and GBV Specialist	UNICEF	Beirut	F
30	Violet	Dep Rep	UNICEF	Beirut	F
31	Amal Obeid	Adolescent and Youth Programme Specialist, Youth Programme	UNICEF	Beirut	F
32	Saja Michaem	Founder and Director	Abaad	Beirut	F
33	Zoya Rouhana	Director	KAFA	Beirut	F
34	Philippe Lazzarini	Representative	UNRC&UNDP	Beirut	M

35	Raymond Tarabay	Humanitarian Affairs and Economic Development	German Embassy	Beirut	M
36	Christian Kirchen	Humanitarian Affairs and Economic Development	German Embassy	Beirut	F
37	Youssef Boutros	Refugee Program Specialist	US Embassy	Beirut	M
38	Sabrina Aubert	Premiere Secretary	French Embassy	Beirut	F
39	Myriam Sfeir	Associate Director	IWSAW	Beirut	F
40	Cecilia Chami	Program's Director	LFPADE	South	F
41	Mohammed Walid	RH/HIV Program Specialist	UNFPA	Beirut	M
42	Noushig Etyemezian	GBV Coordinator	UNFPA	Beirut	F
43	Christelle Mousallem	RH programme manager	UNFPA	Beirut	F
44	Asma Kurdahi	Head of Office	UNFPA	Beirut	F
45	Alexia Nisen	GBV Specialist	UNFPA	Beirut	F
46	Hiba Hamza	Program Coordinator	NABAA	South	F
47	Hiba Kassir		Amel	Bekaa	F
48	Raghida Younes	Head of Centers	Amel	Bekaa	F
49	Israa Ammar	Social Worker	Amel	Bekaa	F
50	Hiba Kchour	Project Coordinator (HQ)	Amel	Bekaa	F
51	Salima Hamoud	Social Worker	Amel	Bekaa	F
52	Amani Al Ammar	Mid Wife	Amel	Bekaa	F
53	Lora Makhlouf	Intern	Amel	Bekaa	F
54	Claire Pillier	Intern	Amel	Bekaa	F
55	Carol Sparks	Intersector Coordinator	UNHCR	Beirut	F
56	Dr. Gabriel Riedner	Representative	WHO	Beirut	F
57	Iman Khalil	Health Coordinator	IMC	Beirut	F
58	Lorenza Trulli	GBV Inter Sector Coordinator	UNHCR	Beirut	F

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 (ie 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

Monday *April 16, 2018*

Time	Name	Title	Organization	Contact	Location
8:00-10:00	Meeting at UNFPA/ scheduling				
11:00-12:00	Aly-Khan Rajani	Head of Development Section	Canadian Embasy	Phone: (+961) 71 534 646 Email: alykhan.rajani@international.gc.ca	43, Jal el-Dib Highway/43 Autoroute Jal el Dib
12:00-1:00	Note: Around 40 min. needed to reach Beirut- half an hour lunch No time for another interview before 2:00				
1:00-2:00					
2:00-3:00	Hala Abou Farhat	Interagency Health Coordinator	UNCHR	Phone: 03183067 Email: aboufarh@unhcr.org	Nicolas Ibrahim Sursock St.Jnah, UNHCR S&K building
3:45-4:45	Lorenza Trulli	GBV	UNCHR	Phone: 76421570 Email: trulli@unhcr.org	Nicolas Ibrahim Sursock St.Jnah, UNHCR S&K building
4:30-5:00					

Tuesday

April 17, 2018

Time	Name	Title	Organization	Contact	Location
8:15-9:15	Alissar Rady	National Professional Officer, Head technical team	WHO	Mob: 00 961 70111735 Email: radya@who.int	Museum Square, Glass Building, 4th floor
10:00-11:00	Wafa Kanaan	MoPH Primary Health Centre, Chief Central Coordinator	MoPH (Ministry of Public Health)	Mob.:70982290 Email: wafakan@hotmail.com	Primary Healthcare Department Jnah, MoPH bldg., 2nd Floor
12:00-1:00	Bahia Sleiman Mohamad Waleed	Director of the National Program For Reproductive Health RH/HIV Program Specialist	MoSA (Ministry of Social Affairs) UNFPA	Mob.: 03184401 Email: bahiasleiman@hotmail.com	Badaro UNFPA Office
1:00-2:00	Noushig Etyemezian	GBV Coordinator	UNFPA		UNFPA Office
2:00-3:00	Christelle Mousallem		UNFPA		UNFPA Office
3:00-4:00	Asma Kurdanhi	Head of Office	UNFPA		UNFPA Office
4:00-5:00					

Wednesday

April 18, 2018

Time	Name	Title	Organziation	Contact	Location
9:00-10:00	Jihane Latrous		Unicef	Mob.: 70996620 Email: jlatrous@unicef.org	Sama Beirut, Sodeco, 4th floor
10:00-11:00					
11:00-12:00	Amal Obeid	Adolescent and Youth Programme Specialist, Youth Programme	Unicef	aobeid@unicef.org	Sama Beirut, Sodeco, 4th floor
11:30-12:30	Rania Zaatari	Head of Makassed Communal Healthcare Bureau	Makassed	Phone: 01636666 Email: raniazaatari@hotmail.com	Beirut
	Dima Bou Daher	Project Coordinator			
	Muna El Jabi	Project Supervisor			
12:30-2:00	Field visit- Makassed				
12:30-1:00	Lunch				
1:30-2:30	Ghida Anani	Founder and Director	Abaad	Mob.: 03663052 Email: ghida.anani@abaadmena.org	51 Bustani Street, Sector 5, Najjar Building, Furn Chebbak
3:00-4:00	Zoya Rouhana	Director	KAFA	Zoya.rouhana@kafa.org.lb	43, Badaro Street, Beydoun Bldg, 1st Floor PO BOX: 116-5042
4:00-5:00					

Thursday

April 19, 2018

Time	Name	Title	Organization	Contact	Location
9:00-10:00	Dr. Faisal Kak*		Lebanese Society Obstetrics and Gynocology	Email: fk01@aub.edu.lb	UNFPA Office
10:00-11:00	Manal Kassem	GBV Coordinator	IMC	Mob.: 71878481 Email:mkassem@internationalmedicalcorps.org	UNFPA Office
	Iman Khalil*	Health Coordinator	IMC	Email: ikhalil@internationalmedicalcorps.org	UNFPA Office
11:00-12:00	Manar Sarsam	Admin/Finance Assistant	UNFPA		UNFPA office
12:00-1:00					
1:00-2:00	Hagop Kouyoumijian	Coordination Officer	RCO	+961 70 894024 Email: kouyoumdjian@un.org	UNFPA Office, level 2
1:30-2:30	Philippe Lazzarini	Representative	UNRC&UNDP		
2:00-3:00	Bjorn Betzler	Area Manager, Bekaa Valley&South Lebanon	Danish Refugee Council (DRC)	Mob.:70 996 653 Email: am.bekaa@drclebanon.dk	UNFPA Office
3:00-4:00	Tanya Chapuisat	Representative	UNICEF	tchapuisat@unicef.org	UNICEF Office-Sodeco
4:15-5:15	Gaelle Kibranian	Governance Programme Officer	UNDP	Mob.: 03830282 Email:gaelle.kibranian@undp.org	UNFPA Bldg., 4th floor, room 409

*Was Iman Khalil in the meeting?
Interview with Dr. Faysal Kak did not take place

Friday

April 20, 2018

Time	Name	Title	Organization	Contact	Location
9:30 – 10:30	Asma Kurdahi	Head of Office	UNFPA		
1:00-2:00	Carol Sparks	Interagency Coordinator	UNHCR	sparks@unhcr.org	Lea Bldg., 2nd floor, UNHCR, Jnah
2:00-3:00	Nayla Doughane	Présidente Ordre des sages-femmes du Liban Directrice Honoraire Ecole de sages-femmes Université Saint-Joseph	Lebanese Mid. Wives	nayladoughane@hotmail.com	UNFPA Office
3:00-4:00	Anne France White(on behalf of Natalie Fustier)	Deputy Head of Office	OCHA	white5@un.org	UNFPA Bldg. 3rd floor, meeting room

Monday

April 23, 2018

Time	Name	Title	Organization	Contact	Location
	Leave at 9:30- share details of who will be attending the meeting				
11:00-12:00	– Raymond Tarabay – Christian Kirchen	Humanitarian Affairs and Economic Development	Embassy of the Federal Republic of Germany	wz-11@beir.auswaertiges-amt.de wz-3@beir.auswaertiges-amt.de	Centre Freeway, Regent Park Tower, Barbar Abou Jawdeh St.,Dekwaneh, 2703 Metn
12:00-1:00	Reach US embassy + lunch				
1:00-2:00	Youssef Boutros	Refugee Program Specialist	US Embassy	BoutrosY@state.gov	The Village Dbayeh, Lina's café, Dbayeh

2:00-3:00					
3:00-4:00	Sabrina Aubert	Premiere Secretary	French Embassy	sabrina.aubert@diplomatie.gouv.fr	Damascus Street - Facing St. Joseph University
4:45-5:45	Myriam Sfeir	Associate Director	IWSAW	Myriam.sfeir@lau.edu.lb	Hamra

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Time	Name	Title	Organization	Contact	Location
11:00– 12:00	Gwyn Lewis	Deputy Director (Programmes),	UNRWA	C.MOUSSA@unrwa.org	Bir-Hassan Area, facing Sports City and just before the Ministry of Health.
	Toni-Anne Vinell Stewart	GBV Coordinator			
1:00-2:00	Karolina Lindholm Billing	Deputy Representative (Protection)	UNHCR	nehme@unhcr.org lindholm@unhcr.org	UNHCR, S&K building, Jnah
3:30-4:30	Celine Moyroud	Country Director	UNDP	Celine.moyroud@undp.org	UNDP Office, 4th floor
4:30-5:30	Margunn Indrebo	Senior Inter-agency Coordinator	UNDP	margunn.indreboe@undp.org	L4 Meeting room, UNDP

Tuesday

April 24, 2018

Time	Name	Title	Organization	Contact	Location
7:30 am	Need to depart from UNFPA Office				
9:00 – 10:00	Olivia Spilli	Program Coordinator	INTERSOS	programme.coordinator.lebanon@intersos.org 71-698222	INTERSOS Bekaa office Sawan Bldg 1st - Floor Ksara - Zahle - Bekaa GPS coordinates: 33.8244184,35.8889484
	Saad Abou Chahime	Project Coordinator			

10:30 – 12:30	INTERSOS – Focus Group Discussion in Al Marj				
1:30-2:30	Nawal Mdallaly	Director	Sawa Association for Development	03030267	Delora, Chtoura* - Next to Starbuck – facing McDonalds
3:00-4:00	Jad Youssef	Programs Manager	Nabad	81222073	Rayak – Ali nahri – Wazir Street / Central Bekaa - Lebanon

*Please note that Delora is a hotel and has a café/restaurant. It is on Chtoura highway, the organization's center is currently busy with the elections.

Time	Name	Title	Organization	Contact	Location
8:30 – 9:30	Alexia Nisen		UNFPA	alexiaunfpa@gmail.com	UNFPA Office
10:00-11:00	Dr. Gabriel Riedner		WHO		Museum Square, the Lebanese University building (glass bldg..), 4th floor

Wednesday

April 25, 2018

Time	Name	Title	Organization	Contact	Location
7:30 am	Need to depart from UNFPA Office				
9:30 – 10:30	Cecilia Chami	Program's Director	LFPADE	cchami@lfpa.org.lb	Tyre - Deir Kanoun Nahr – Main Road – 1st floor – next to the cemetery
10:30 – 11:30	LFPADE – Focus Group Discussion				
12:30 – 1:30	Hiba Hamza	Program Coordinator	NABAA	h.hamzi@nabaa-lb.org	Saida – Saray Street – Abdel Majid Bazzi Bldg. 1st floor (next to Banque Du Liban)
1:30 – 2:30	NABAA – Focus Group Discussion				
4:00 – 5:00	Alexia Nisen		UNFPA	alexiaunfpa@gmail.com	UNFPA Office
6:00 – 7:00	Dr. Jinan Usta	Consultant with UNFPA		ju00@aub.edu.lb	Cairo street (descent leading to

					AUBMC main entrance), Marignan center, third floor

Time	Name	Title	Organization	Contact	Location
6:30 am	Need to depart from UNFPA Office				
9:30 – 10:30	Nada Hanna	GBV Program Manager	HAI	nhanna@heartlandalliance.org	
10:30 – 12:30	HAI – Focus Group Discussion				

Thursday

April 26, 2018

Time	Name	Title	Organization	Contact	Location
7:30	Need to depart from UNFPA Office				
9:30 – 10:30	Hiba Kassir		AMEL	Fadila.ghandour@hotmail.com	Mashghara PHC
	Raghida Younes	Head of Centers			
	Israa Ammar	Social Worker			
	Hiba Kchour	Project Coordinator (HQ)			
	Salima Hamoud	Social Worker			
	Amani Al Ammar	Mid Wife			
	Lora Makhlouf	Interns at Amel			
	Claire Pillier				
10:30 – 12:30	AMEL – Focus Group Discussion				

Time	Name	Title	Organization	Contact	Location
7:30	Need to depart from UNFPA Office				
9:00 – 10:00	Rita Chemaly Chantal Bou Akl	Projects Development Consultant	NCLW	Rita.chemaly@nclw.org.lb	Lebanon, Baabda, Damascus Road, Facing Toyota Company, Center no. 3176, 2nd floor

Friday April 27- Debriefing at UNFPA office

Annex IV: Reconstructed Theory of Change