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

SYRIA COUNTRY NOTE

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Acronyms

3RP	The Regional Refugee and Resilience Plan
4Ws	'Who does What, Where and When' Dashboard
ANC	Ante-natal care
ARV	Antiretroviral
ASRO	Arab States Regional Office
BEmOC	Basic Emergency Obstetric Care
CBS	Central Bureau of Statistics
CEFM	Child, Early and Forced Marriage
CEmOC	Comprehensive Emergency Obstetric Care
CLA	Cluster Lead Agency
CMR	Clinical Management of Rape
CO	Country Office
COAR	Country Office Annual Report
CPAP	Country Programme Action Plan
CPD	Country Programme Document
CSO	Civil Society Organisation
EECARO	Eastern Europe and Central Asia Regional Office
EmOC	Emergency Obstetric Care
ERF	Emergency Response Plan
ERP	Enterprise Resourcing Plan
FACE	Funding Authorisation and Certification of Expenditure
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
GPS II	Global Programme System II
GoS	Government of Syria
HACT	Harmonised Approach to Cash Transfers
HFCB	Humanitarian and Fragile Contexts Branch
HIV	Human Immunodeficiency Virus
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
IMC	International Medical Corps
IOM	International Organisation for Migration
IP	Implementing Partner
IPV	Intimate Partner violence
ISIS	Islamic State of Iraq and Syria
ISP	Information Sharing Protocols
IUD	Intra Uterine Device
L3	Level 3 (emergency)
LGBT	Lesbian, Gay, Bisexual and Transgender
LTA	Long Term Agreement

M&E	Monitoring and evaluation
MISP	Minimum Initial Services Package
MMR	Maternal Mortality Rate
MNH	Maternal and New Born Health
MoE	Ministry of Education
MoFA	Ministry of Foreign Affairs
MoH	Ministry of Health
MoJ	Ministry of Justice
MOSAL	Ministry of Social Affairs and Labour
OCHA	Office for the Coordination of Humanitarian Affairs
OR	Other Resources
PEP	Post-exposure Prophylaxis
PFA	Psychological First Aid
PHC	Primary Health Care
PNC	Post Natal care
PSEA	Protection against Sexual Exploitation and Abuse
PSB	Procurement and Supply Branch
POS	Programmes and Operations Support
PSS	Psychosocial Support
PwD	People with Disabilities
RC/HC	Resident Coordinator/Humanitarian Coordinator
RH	Reproductive Health
RO	Regional Office
RR	Regular Resources
SARC	Syrian Arab Red Crescent
SAFAP	Syrian Commission of Family Affairs and Population
SC	Sub Cluster
SCO	Syria Country Office
SCS	Syrian Computer Society
SDGs	Sustainable Development Goals
SFPA	Syrian Family Planning Association
SHARP	Syrian Humanitarian Assistance Response Plan
SOPs	Standard Operating Procedures
SRH	Sexual and Reproductive Health
SRHiE	Sexual and Reproductive Health in Emergencies
SRH	Sexual and Reproductive Health Rights
SSG	Strategic Steering Group
SWG	Sub-Working Group
TFR	Total Fertility Rate
ToC	Theory of Change
ToR	Terms of Reference
TPM	Third Party Monitoring
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistance Framework
UNEG	United Nations Evaluation Group
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children Fund
UNSF	United Nations Strategic Framework
WFP	World Food Programme
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] 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.[2]

The United Nations Population Fund (UNFPA) has been responding to the crisis since 2011 to the crisis. The UNFPA Syria Country Office (SCO) has expanded programming from advocacy and policy development with government partners to a focus on direct service delivery for Sexual and Reproductive Health (SRH) and Gender-based Violence (GBV) and youth programming through static and mobile services, continued partnership with key government ministries, capacity building, coordination for GBV, provision of supplies and Reproductive Health (RH) commodities[3] and promotion of GBV and SRH as necessary life-saving humanitarian interventions within the humanitarian response.

FINDINGS

1. The UNFPA response in Syria is relevant to the GBV and SRH needs of women and girls and based on regular needs assessments. Youth programming is an emerging area of focus.
2. UNFPA has developed tools and resources for remote data collection management that have improved the accuracy and reliability of information collected.
3. The UNFPA response is based on humanitarian principles and human rights-based approaches as far as the operating context of the conflict allows. However, the successful application of these are undermined by the continued grave violations of International Humanitarian Law (IHL) and International Human Rights Law (IHRL) by parties to the conflict and the constrained humanitarian space that limits the provision of supplies and services.
4. During the initial years of the crisis UNFPA was slow to scale up and did not expand significantly until 2015. Since then, there has been continuous investment in human, technical and financial resources to address humanitarian needs in Syria.
5. UNFPA has demonstrated growing capacity, flexibility, and adaptability by responding to new and emerging crises and displacements to become a front-line responder in Syria.
6. UNFPA has successfully leveraged it comparative advantage on GBV and SRH and is taking on a leadership role on youth and population data within Syria.
7. UNFPA has distanced itself from the interagency Protection against Sexual Exploitation and Abuse (PSEA) leadership role due to concerns on the compatibility of this with their GBV coordination leadership role.
8. Geographically, UNFPA is increasingly able to reach those in greatest need in Syria but this remains dependent on humanitarian access, government approvals, partner capacity, coverage and funding.
9. Demographically, UNFPA has a clear and targeted focus on women and girls with a growing youth portfolio but has been

[1] UNOCHA (2018) Whole of Syria (WoS) Humanitarian Needs Overview (HNO) 2018.
[2] Ibid.
[3] Within this report SRH (sexual and reproductive health) will be the terminology used with the exception of references specifically to Reproductive Health Kits (RH Kits) and the Reproductive Health Working Group (RH WG) which is the globally used terminology.

limited in respect of other aspects of inclusion such as disability.

10. UNFPA is providing consistent leadership of the GBV sub-sector with good collaboration and advocacy with the wider coordination mechanisms. While this has improved since 2016, there are gaps in technical support to partners and sub-national coverage due to limited human resources.
11. There is no dedicated SRH Working Group (WG) in Syria and UNFPA leadership on SRH has been weaker than for GBV.
12. There is no youth working group and youth issues are dealt with through the UN Youth Taskforce.
13. UNFPA is viewed as a strong voice within the United Nations Country Team (UNCT) and Humanitarian Country Team (HCT) advocating for the needs of women and girls and promoting GBV and SRH services as lifesaving.
14. Overall, UNFPA has a constructive relationship with relevant ministries and are supporting services, legislative reform, and policy engagement. However, there are notable tensions in aligning to national policies and legislation when they are not consistent with UNFPA mandate and GBV and SRH responsibilities.
15. UNFPA is committed to responding to new crises while pursuing opportunities to build resilience where possible.
16. Core resources allocated to the SCO were not commensurate to needs throughout the Syria crisis nor did they match other resources as they increased.
17. Although SCO has utilised Fast Track Procedures (FTP) since the start of the crisis, their capacity to expedite procurement and recruitment was impeded in the early years by insufficient resources, technical capacity, and a lack of flexibility in the application of procedures.
18. UNFPA has nurtured key strategic partnerships with government ministries and national NGO's that has allowed for flexible responses to new crises while diversifying partnerships to enable greater coverage and expansion. Capacity of partners and the quality of services they deliver vary.
19. There is growing confidence among donors in UNFPA ability to deliver services, access hard-to-reach areas, and conduct due diligence with partners. This has translated into increased funding.
20. The UNFPA response in Syria has made significant contributions to improving access to and quality of GBV and SRH services for women, girls and youth. This is particularly evident in hard-to-reach areas and for the newly displaced populations though static services and mobile teams. UNFPA, like the wider humanitarian response, is restricted in effectiveness of delivery of services within Syria due to political, security, access, funding and partnership constraints.
21. Prevention, risk reduction and empowerment activities have been less of a focus but are an emerging priority for UNFPA.
22. GBV and SRH have been centrally positioned as lifesaving within the overall humanitarian response.

CONCLUSIONS

Key Conclusions for Syria:

A. UNFPA has made substantial strides in expanding programming responses, field operations and presence outside of Damascus since 2015 and this is improving their overall response capacity. Overall, the current UNFPA response in Syria presents an interesting mix of stand-alone and integrated GBV and SRH services, youth programming, cross-line assistance, robust remote data management and remote support for programming as well supply capacity.

B. UNFPA responses in Syria are responsive to needs identified and are strongly aligned to the wider humanitarian response plans. The provision of integrated GBV and SRH services as well as stand-alone interventions builds on UNFPA strengths and provides an opportunity for learning. The integrated approach has

allowed for greater flexibility in modalities, broader coverage and increased services. However, it is important that integration does not narrow the scope of GBV responses to SRH only but allows adequate space for comprehensive GBV services including case management, Psychosocial Support (PSS), empowerment as well as prevention and risk reduction. As the situation stabilises in some locations, modalities for service delivery and approaches require further review.

C. Since 2015, the SCO has increased its capacity to respond to evolving needs and adapt interventions to the various realities including spontaneous returns, fresh displacements, newly accessible, and besieged areas. However, responding to these multiple and often simultaneous emergencies often takes attention and resources away from more stable locations. As more areas became accessible from Damascus, the SCO is under increasing pressure to disperse finite resources to even larger areas. There is a growing recognition within the SCO on the need to develop plans and strategies to guide responses beyond the acute emergency phase. Limited capacity of partners, growing geographic areas and burgeoning needs demand considerable technical and financial investment from UNFPA that needs be sustained. To the extent that humanitarian access, security, funding, and partner coverage allow, UNFPA has been proactive in getting services and supplies to those areas most in need. They have provided significant support for cross-line assistance and UNFPA supported partners are consistently among the first responders in newly accessible areas.

D. Youth is a critical and politically charged issue within Syria and UNFPA has been successful in positioning itself as a lead through the youth taskforce and partnership with the Government of Syria (GoS) and prising open a space for youth engagement. UNFPA is approaching this cautiously and linking youth programming to existing GBV and SRH services and connecting it to their global responsibilities on UN Security Council Resolution (UNSCR) 2250 and the Youth Compact. Greater efforts are required to solidify this space and create more opportunities for meaningful engagement with civil society on youth issues and address their underlying needs, vulnerabilities, risks and marginalisation. This could include establishing and inter-agency youth taskforce for coordination and advocacy and scaling up youth activities.

E. While there has been considerable investment in GBV coordination, at the Hub and SCO level, SRH coordination has been neglected and this has impacted the visibility and attention to SRH within the humanitarian response as evidenced by the lack of a dedicated SRH Working Group (WG) and absence of a dedicated SRH Coordinator until 2018.

F. UNFPA does a commendable job in maintaining partnerships with key government ministries and finding opportunities to engage in resilience and systems strengthening work to the extent that the political and funding limitations allow. The SCO has the unenviable task of finding the middle ground between responsibilities under the Whole of Syria (WoS) architecture and those that accompany UN agencies operating under a host government which can be at odds with each other. As the coverage from Gaziantep and Amman continue to decrease, this requires significant manoeuvring to advance UNFPA mandate in line with humanitarian principles.

G. UNFPA has increased their partnerships since 2015 and this has made considerable contributions to expanding services which demonstrate a six-fold increase in beneficiaries in 2017 as compared to 2015. UNFPA has been strategic in their selection of partners and modalities to maximise

coverage with available resources. However, high turnover of staff, continued geographical expansion that requires new partners, and the need to adapt approaches from acute emergency responses to protracted situations underscore the necessity to have a robust strategy to provide technical support to IPs that goes beyond training. Despite on-going efforts to further expand programming, the funding available (albeit increasing) within UNFPA and capacity of partners constrains growth.

Key Conclusions for the overall evaluation:

1. Insufficient investment in human, technical, financial and operational resources proportionate to the needs and scale of the crisis significantly impeded responses until 2015.The allocation of core resources were inadequate for the scale of the Syria crisis and were insufficient to support a) GBV and SRH coordination responsibilities b) operational expansion including human, technical, physical and other resources needed sustain increasing field offices c) stockpile supplies including pharmaceuticals and Reproductive Health (RH) kits. Low levels of core resources expose UNFPA to deviations in funding flows and they lack adequate cushioning to absorb any shocks. This was evident in shortfalls following the withdrawal of OFDA funding.

SUGGESTIONS FOR RECOMMENDATIONS

Key suggested recommendations at country level:

A. The SCO should review programming approaches and take stock of current and future needs. This should include a detailed capacity building strategy for IPs, greater economic empowerment components, skills building, resilience and recovery programming in addition to systems strengthening. UNFPA should continue to increase its focus on adolescent girls under the WoS Adolescent Girls Strategy and use this as an opportunity to capitalise on SRH, GBV and Youth expertise in Syria. Opportunities to develop innovative responses to address the demographic shifts caused by the conflict and promote transformative gender norms should be prioritised. (Links to Conclusion A, B, C and D)

B. In recognition of the capacity gaps among partners and the demands to expand geographically in addition to transitioning from emergency responses, the SCO should:
   - Strengthen capacity building for IPs and develop a systematic strategy that goes beyond trainings, especially for new GBV partners. (i.e. on the job mentoring, using remote technology to support, field visits/exchanges etc.). Adopting a model where UNFPA partner with a strong international NGO to provide intensive capacity building or increasing SCO staffing so there are sufficient and experienced internal resources to dedicate to capacity building are options that should be explored. (Links to Conclusion B, C and G)

   - Review existing GBV and SRH integration including mobile responses to assess its overall functioning, effectiveness and identify any gaps or areas for improvement. This should enable UNFPA to further define guidelines for GBV and SRH integration during the acute and protracted phases as well as provide guidance for mobile teams to improve functioning and provide lessons learnt and good practices for application in other humanitarian settings. (Links to Conclusion A, B and C)

C. To address the impasse on Clinical Management of Rape (CMR), UNFPA, in collaboration with the health sector, should utilise regional and headquarters (HQ) expertise to re-engage with the GoS to develop a strategy to make CMR

accessible in line with survivor centred principles. Additionally, they should expand health responses beyond CMR and increase services for health consequences of other forms of GBV. (Links to Conclusion B and E)

D. As part of the development of the new Country Programme Document (CPD), the SCO, with support from the regional office, should review staffing structures in line with expansion plans so that SCO can keep pace with the changing operating environment with sufficient technical, programmatic, and operational capacity. Operational and programmatic expansion needs to be matched with human, technical and operational resources required to support the continued growth. (Links to Conclusion G)

E. Conduct a review of UNFPA Syria to capture good practice and lessons learned from operations, programming and coordination that can be applied in other humanitarian responses to improve capacity and understanding on what is required to provide front-line responses. (Links to Conclusion A, C, G and overall Conclusion 1)

Key suggested recommendations for the UNFPA Syria Regional Hub and Regional Office (RO):

1. Taking into consideration the diminishing humanitarian responses from the Amman and Gaziantep hubs and increased coverage from Damascus, the SCO, the Hub and the RO's should develop realistic plans based on likely scenarios for the immediate future. This should include a detailed outline of resources required to support different scenarios, clarity roles and responsibilities for the SCO and the Hub and be aligned to the plans of the wider humanitarian response. (Links to Conclusion F and G)

2. UNFPA, through funding from core resources at the Hub or RO, should deploy a staff counsellor/Psychologist to support the SCO on a regular basis both in-person and remotely.

Key suggested recommendations for the overall evaluation:

1. As the SCO assumes greater responsibility for UNFPA responses within Syria, core resources need to be increased to enable them to adequately expand operations and programming proportional to needs. (Links to Conclusion G and overall Conclusion 1)

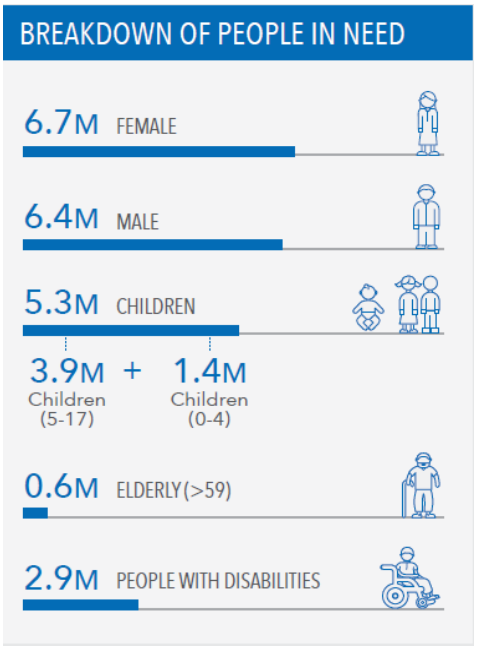
2. At the HQ level, UNFPA should clearly communicate to country offices their global position on PSEA and outline clear parameters for engaging with and supporting in-country efforts on PSEA including leadership of the PSEA mechanisms and networks.

3. UNFPA should develop institutional capacities and policies at the HQ level to ensure that staff counsellor/Psychologists are available to all staff especially those operating in high risk environments.

4. UNFPA should review technical, human and financial investment in GBV and SRH coordination responsibilities with a view to resourcing these positions and related coordination activities from core resources. This should facilitate the recruitment of experienced and dedicated GBV and SRH coordination staff on fixed term contracts that are not double hatting. (Links to Conclusion E)

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.[4] 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.[5]



Source: *Humanitarian Needs Overview (HNO) 2018 People in Need*

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

In 2014, the Whole of Syria (WoS) approach was introduced across the United Nations (UN). 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 interagency hubs in Jordan and Turkey, attempting to reach those areas outside of Government of Syria (GoS) control that cannot be reached from Damascus.

The Syria Humanitarian Response Plan (HRP) provides the framework to respond to large-scale humanitarian and protection needs on the basis of the prioritization undertaken across sectors for both the cross-border work and operations from Damascus within Syria. In addition to this, 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).

The primary purpose of the evaluation of UNFPA 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:

- *Thematically*: All UNFPA humanitarian interventions targeting populations affected by the conflict in Syria. This primarily incorporates both UNFPA directly-supported Reproductive Health

[4] UNOCHA (2018) Whole of Syria (WoS) Humanitarian Needs Overview (HNO) 2018.
[5] Ibid.

(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.

The primary intended users of the evaluation are:

1. UNFPA Country Offices (COs);
2. the UNFPA Syria Regional Response Hub (henceforth 'the Hub');
3. UNFPA Regional Offices (ROs) – the Arab States Regional Office (ASRO) and the Eastern Europe and Central Asia Regional Office (EECARO);
4. UNFPA Humanitarian and Fragile Contexts Branch (HFCB);
5. UNFPA Senior Management, including the Executive Board.

This country note provides findings from the remote research and conclusions pertaining to the UNFPA response in Syria and formulates specific suggestions for recommendations for the Syria Country Office (SCO) and for UNFPA at the regional and headquarters (HQ) level.

Methodology

Both qualitative and quantitative data and evidence have been collected through a range of methods and tools, including a desk review of documentation, key informant interviews (KII) conducted remotely, and an online survey.[6]

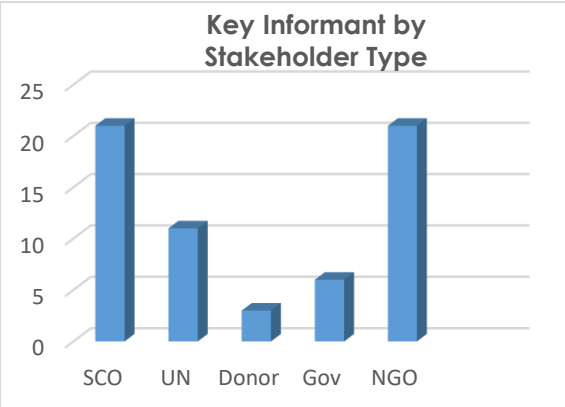
The evaluation was conducted in accordance with the United Nations Evaluation Group (UNEG) *Norms and Standards for Evaluations*, the UNEG *Ethical Guidelines for Evaluations*, the UNFPA *Country Programme Evaluation Handbook*, and the WHO *Ethical and safety recommendations for researching, documenting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

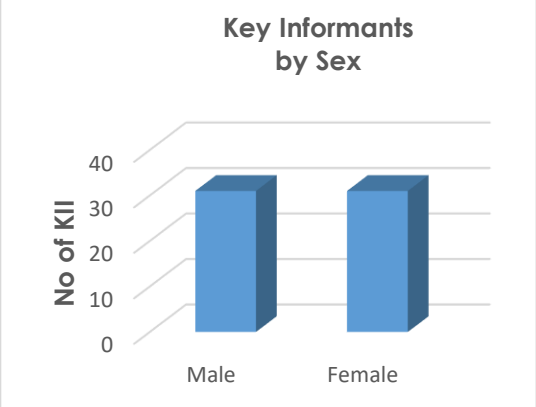
- ***Consultation*** with, and participation by, key stakeholders;
- ***Methodological rigor*** to ensure that the most appropriate sources of evidence for answering the evaluation questions are used in a technically appropriate manner;
- ***Technical expertise and expert knowledge*** to ensure that 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.

Data collection for the SCO was carried out from 25 June - 13 July 2018 by two independent consultants contracted by UNFPA, Sinéad Murray and Rula Al Sadi. It was not possible to secure visa approvals for the consultants to travel to Syria therefore all primary and secondary data collection was undertaken remotely using the following tools:

- **Document Review** of reports, proposals, plans and strategies related to UNFPA-supported humanitarian programme activities and coordination;
- **Key Informant Interviews** with UNFPA, UN, donors, government, international Non-Governmental Organisations (NGO) and national NGO representatives which explored, in depth, important areas related to overall humanitarian programme planning and implementation;
- **Online Survey for Key Informants** with 19 questions aligned to the 10 evaluation questions administered in Arabic or English to capture quantitative data.

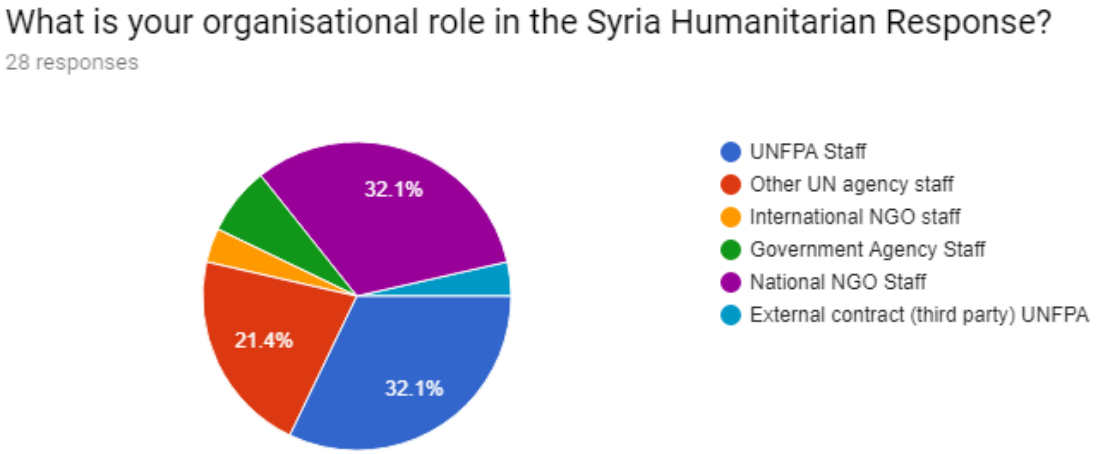
Key informant interviews were conducted in English or Arabic depending on the preference of the interviewee. In total 62 stakeholders (31 female and 31 male) were interviewed (20 in Arabic and 42 in English). Twenty-one UNFPA SCO staff, 11 UN agency representatives, three donors, six government and 21 NGO stakeholders were interviewed. A list of key informants is included in Annex I.





[6] Online Survey for the Evaluation of the UNFPA Response to the Syria Crisis: Syria Country Research

The online survey was administered in English or Arabic and 28 respondents completed it anonymously (10 in Arabic and 18 in English). Detailed analysis from this survey is included in Annex III. Respondents included UNFPA staff (32.1%), other UN staff (21.4%), National NGO (32.1%), (3.6%) International NGO, (7.2%) Government and external third party (UNFPA) (3.6%).



Limitations of the research and mitigation measures

The Syria data collection was hampered by the inability of the consultants to conduct a research mission to Syria. The absence of in-person interviews, site visits, observations, or FGDs with women, men, boys and girls constrained the quantity and quality of primary data and the evaluators' ability to triangulate some of the information presented in this country note. Several strategies were developed to mitigate the impact of this including increasing the number of key informants to ensure as diverse as possible views and insights were represented, implementation of an online survey to further triangulate information from key informants and evidence from the document review. Recent evaluations, reviews and assessments conducted independently and through the SCO form part of the document review. The lack of available quantitative data against targets at the results and outcome levels was a limitation to assessing programmatic results of the UNFPA SCO response (see Evaluation Question 10 Effectiveness). Available data was triangulated with qualitative information from key informant interviews and secondary sources.

Limitations	Mitigation Measures
Remote interviews only and no in-person interviews.	Obtain direct feedback from diverse groups of stakeholders (62 in total).
Lack of site visits and observations of services.	Cover all programming locations remotely with KIIs and triangulation of findings from different sources to increase robustness/accuracy.
No Focus Group Discussions (FGDs) or direct discussions with beneficiaries or field staff.	KIIs conducted in English (42) and Arabic (20) to reach more stakeholders. Online survey to collect additional data to triangulate information.
	Extensive document review including recent evaluations on SRH and GBV conducted in Syria in 2017.

Background

Syria

Prior to 2011, the Syrian Arab Republic (SAR) was a fast-growing, middle-income country with one of the highest growth rates in the world at 2.4% and the pre-conflict population was an estimated 20.7 million in 2010.[7] Syria borders Turkey to the north, Iraq to the east, Jordan to the southeast, Israel to the southwest, and Lebanon and the Mediterranean Sea to the west. It is divided into 14 governorates, which are split into 65 districts and 281 subdistricts. Syria's capital is Damascus, while Aleppo is the largest city. The humanitarian crisis started in 2011 as pro-democracy protests escalated rapidly into a multi-party conflict between Syrian government and a range of armed opposition groups. In 2014 the Islamic State of Iraq and Syria (ISIS) seized control of large parts Syria further escalating the crisis.[8] Now in its seventh year, the Syrian conflict is unquestionably the worst humanitarian crisis of the twenty-first century with more than 500,000 dead, 1.2 million injured, 6.3 million internally displaced and 5.5 million refugees worldwide. Over 13.1 million people in Syria require humanitarian assistance with 5.6 million in acute need.[9] The social and economic impacts of the conflict are also immense and the lack of sustained access to health care, education, housing, and food have exacerbated the impact of the conflict and pushed millions of people into unemployment and poverty.[10]

2017 Syria Country Statistics [11,12]	
2017 Population:	18.3 million
Population under 10-24 (2017):	34%
Population aged 65 and older, (2017):	4%
Maternal Mortality Ratio (MMR) (2015):	68 per 100,000 live births
Births attended by skilled personnel (2006 – 2016) :	96%
Adolescent birth rate (age 15-19) (2006 – 2015):	54 per 1,000
Total Fertility Rate (TFR) (2017):	2.9
Contraceptive Prevalence Rate (CPR) (2017):	58% (all methods) 44% (modern methods)

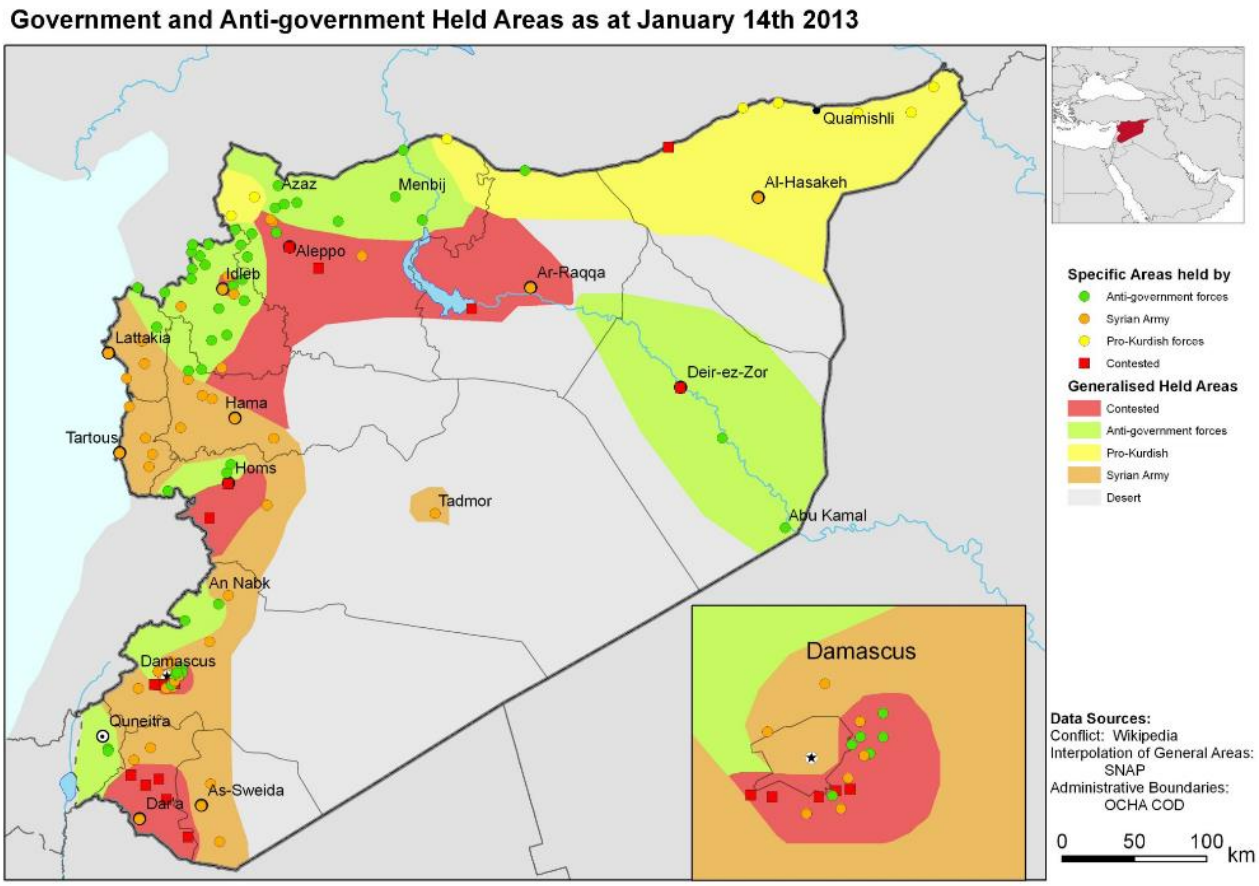
The complex and volatile nature of the conflict, with rapidly shifting frontlines and alliances, resultant insecurity, fighting and limited humanitarian access makes for an acutely challenging operating environment in Syria. Humanitarian access to large parts of the country steadily diminished since the start of the crisis in 2011, with a corresponding increase in humanitarian and protection needs. Until 2016 it was impossible to access large parts of the country from Damascus, due to large areas held by opposition groups and other restrictions placed on movement by the GoS including approvals needed for travel to many locations and insecurity. Adoption of SCR 2165 was followed by a succession of Resolutions renewing 2165: 2191 (December 2014), 2258 (December 2015), 2332 (December 2017) and finally, 2393 in December 2017, which authorises cross-border operations until 10 January 2019.[13] The UN Resolutions allow for specific cross-border routes through Bab al-Salam and Ba al-Hawa from Turkey, Al-Ramtha from Jordan, and Al Yarubiyah from Iraq to deliver humanitarian assistance, including medical and surgical supplies, to people in need in Syria.[14] The Whole of Syria (WoS) approach was introduced in 2014 to coordinate humanitarian responses for assistance provided cross

[7] World Development Indicators (2010) https://data.worldbank.org/country/syrian-arab-republic
[8] https://www.acaps.org/country/syria/country-profile
[9] UNOCHA (2018) Whole of Syria Humanitarian Response Plan (HRP)
[10] World Bank (201&) The Toll of War: The Economic and Social Consequences of the Conflict in Syria
[11] UNFPA (2017) from State of the World's Population, https://www.unfpa.org/data/world-population/SY
[12] Data limitations render a precise and comprehensive decomposition of demographic changes impossible: conflict affects fertility rates and life expectancy alike.
[13] See Annex V for detailed timeline on UNSC resolutions and evolution of cross border operations.
[14] https://reliefweb.int/sites/reliefweb.int/files/resources/cnv_syr_xb_regional_sep2017_171017_en.pdf

border from Jordan, Turkey and Iraq; assistance provided within Government-controlled areas of Syria and cross-line assistance provided from Damascus-based offices.

From 2016 onwards many parts of Syria were re-taken by GoS[15] and this improved humanitarian access from Damascus to other parts of Syria that were previously inaccessible or served from cross-border interventions.[16] Below are maps of 2013 and 2015 control by different groups as compared to 2018.

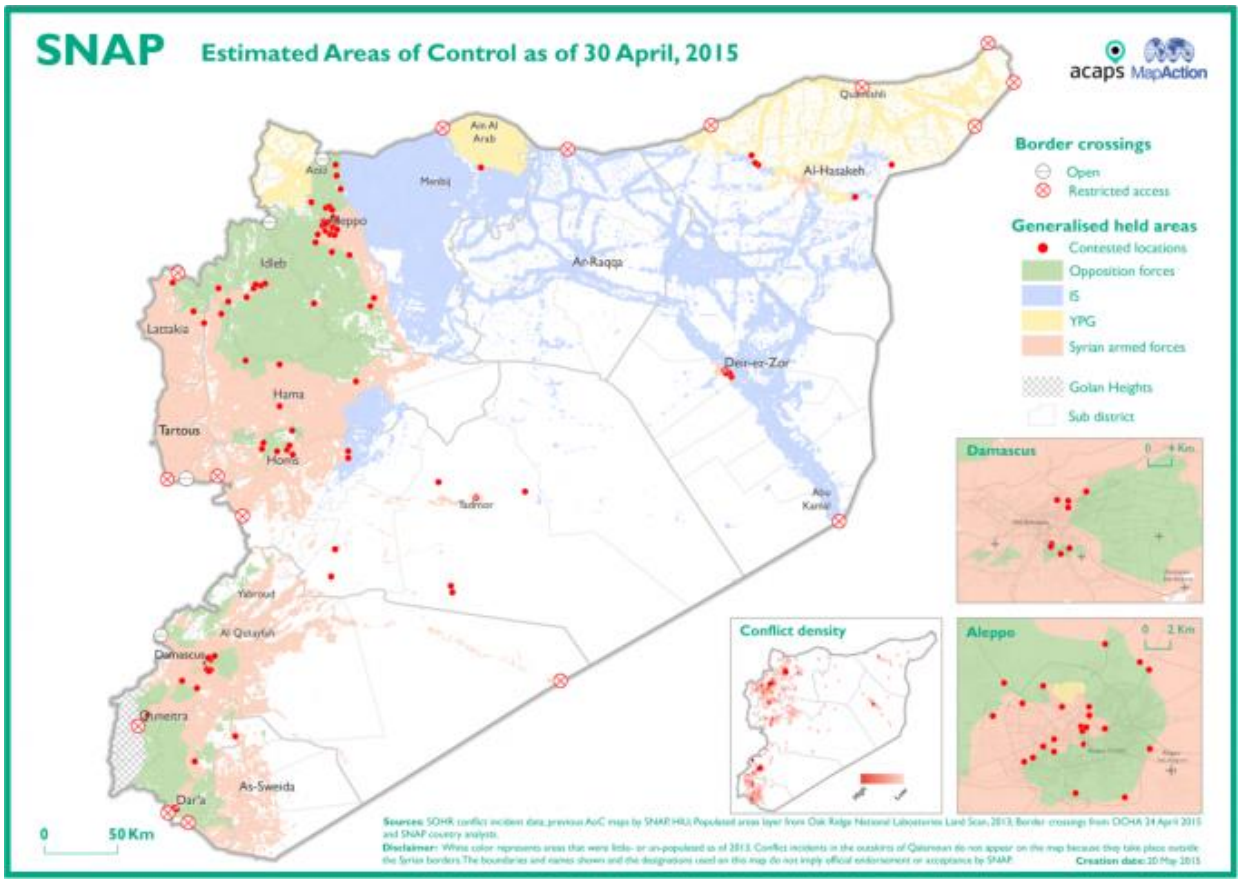
Map of Syria with zones of control 2013



Source: ACAPS[17]

[15] https://www.acaps.org/country/syria The GoS has been re-gaining control of large parts of the country since 2016 including Aleppo in 2016, Ar-Raqqa in 2017, and Eastern Ghouta and most recently Dara'a in 2018.
[16] UNOCHA (2016:17) SAR HRP 2016 Summary of Humanitarian Response Plan Monitoring Report, January - December 2016
[17] Map Action (2013) Regional Analysis Syria - 28 January 2013 https://reliefweb.int/map/syrian-arab-republic/regional-analysis-syria-28-january-2013

Map of Syria with zones of control 2015



Source: ACAPS (2015)[18]

[18] https://reliefweb.int/sites/reliefweb.int/files/resources/m-aoc_map_01may2015_snap.pdf

Map of Syria with zones of control 2018

Source: Al Jazeera (accessed 29 October 2018) [19]

The first Syria Humanitarian Action Response Plan (SHARP) was developed in 2012 jointly with the GoS and raised 62% or $215.9 million of the $348.3 million[20] requested for the response inside Syria. The situation was declared a Level 3 (L3) in January 2013 which changed the tone, scale and pace of the response including raising the profile of the crisis globally, creating the Emergency Response Fund (ERF) and resulting in some existing UN country leadership positions been replaced by individuals with more humanitarian expertise among a number of key agencies.[21] The 2013 SHARP initially estimated a request of $519 million but this was revised up to $1.41 billion in mid-2013 to reach 6.8 million people in need. The revised request received $959.3 million of the total request. [22] The 2014 SHARP increased the total number of people in need to 9.3 million and requested $2.26 billion in funding but only received $1.15 billion.[23]

[19] https://www.aljazeera.com/indepth/interactive/2015/05/syria-country-divided-150529144229467.html
[20] https://fts.unocha.org/appeals/396/summary
[21] Sida I., Trombetta L., and Panero V., (2016) Evaluation of OCHA response to the Syria crisis
[22] https://fts.unocha.org/appeals/421/summary
[23] https://fts.unocha.org/appeals/442/summary

Prior to 2014 it was challenging (for all actors) to assess needs in many parts of Syria and no comprehensive inter-agency needs assessments were conducted from Damascus until late 2014 due to lack of support from the GoS and access/security constraints. In November 2014, the first comprehensive HNO was produced, combining areas accessible from GoS control and areas outside of GoS control and this informed the 2015 humanitarian plan for Syria.[24] The SHARP evolved into the Syria Response Plan (SRP) in 2015, incorporating all aspects of the Syria response (including cross border operations) targeting 13.5 million with a $2.89 billion requirement that was only funded at 43% ($1.24).[25] Subsequent Whole of Syria HRPs 2016-2018 have continued at these levels, increasing to $3.5 billion in 2018 targeting 13.1 million.[26] Funding appeals have been chronically underfunded, often less than 50%, with humanitarian needs considerably eclipsing available resources. [27]

Although rates of return are increasing in some locations with an estimated 721,647[28] people returning to their areas of origin in 2017, there is still ongoing large-scale displacement. Despite a reduction in UN-declared besieged locations[29], violence and insecurity continue in many areas, with an average rate of 6,550 people displaced each day. According to the 2018 HRP, there are 2.98 million people living in hard-to-reach areas including 419,000 in UN-declared besieged areas. [30] The needs of people in these locations continue to be exceptionally severe due to the lack of access to basic commodities, services or humanitarian assistance. Humanitarian responses are further undermined by the limited presence of international NGOs, low capacity of national NGOs, funding, and gaps in geographic coverage. Due to the massive numbers and the geographical spread of the population in need, the provision of humanitarian assistance prioritises geographic areas where people face highest severity of needs and where access to basic goods and services is most limited. [31]

Even in accessible areas, quality and quantity of services are inadequate to meet the needs. [32] During the initial years of the crisis, all assistance was channelled through the Syrian Arab Red Crescent (SARC) and a small number of national NGOs. This has since relaxed, and the GoS have permitted increasing numbers of national organisations (121 in 2017) to respond, but the presence and coverage of international NGOs (16 in 2017) remains limited and the humanitarian response is implemented primarily by national NGOs.[33] In 2017, 57.55% of humanitarian assistance was implemented by SARC and national NGOs, 23.13% of humanitarian assistance was provided by the UN, 17% by the GoS and 1.89% implemented by international NGOs.[34]

[24] Sida I., et al (2016:39) Evaluation of OCHA response to the Syria crisis
[25] https://fts.unocha.org/appeals/461/summary
[26] UNOCHA (2018) Whole of Syria HRP
[27] https://fts.unocha.org/appeals/442/summary
[28] UNOCHA (2018) Whole of Syria HRP
[29] UNOCHA (2017:6) Whole of Syria Humanitarian Needs Overview (HNO) "Besieged area is an area surrounded by armed actors with the sustained effect that humanitarian assistance cannot regularly enter, and civilians, the sick and wounded cannot regularly exit."
[30] UNOCHA (2018) Whole of Syria HRP
[31] UNOCHA (2018:6) Whole of Syria HRP *"Objective 1: Provide life-saving humanitarian assistance to the most vulnerable people with emphasis on those in areas with a high severity of needs"*
[32] UNOCHA (2018) Whole of Syria HNO
[33] In 2017, there were 16 international NGO's and 121 national NGOs implementing humanitarian activities based within Syria. http://www.ocha-sy.org/4wspresence.html
[34] In 2017, 23.13% of humanitarian assistance was provided by the UN; 24.89% SARC; 32.66% national NGOs; 1.89% International NGO's and 17% GoS. http://www.ocha-sy.org/4wspresence.html

UNFPA Syria Country Office

UNFPA began operations in Syria in 1971 and, until the outbreak of the conflict in 2011, predominately focused on policy and advocacy work.[35] Since the start of the Syrian crisis, the SCO budget has increased from $5.03 million (in 2011) to $32 million in 2017[36] and staffing has increased from 24 in 2011 to 56 in 2017. Additionally, UNFPA contracted 17 third-party monitoring (TPM) staff in 2017 bringing total staffing to 73 in 2017.[37, 38]

Until 2015, UNFPA worked predominantly with a pool of 8-10 partners including government ministries, but this expanded to 20 in 2017 due to increased availability of funding, partners and humanitarian access from Damascus. These cover a range of GBV and SRH interventions and, since 2016, youth programmes. The SCO response is focused on:

- **Service Delivery:** Women and Girls Safe Spaces (WGSS), Health Clinics, Youth Centres/spaces and SRH/GBV mobile teams;
- **Supplies**: Hygiene/Dignity Kits, RH kits and SRH commodities;[39]
- **Capacity Building**: Trainings on Minimum Initial Services Package (MISP)[40], Maternal and Neonatal Health (MNH). Family Planning, GBV, Referrals, Case Management, Clinical Management of Rape (CMR) and support for curriculum, guidelines and strategy development;
- **Empowerment:** Life skills, business development, youth led initiatives and vocational training;
- **Awareness Raising:** Peer to Peer on GBV, SRH and Youth, interactive theatres and campaigns.

Currently, UNFPA, through its government and non-government partners, is supporting:

- 35 WGSS, 39 GBV/SRH mobile teams;
- 65 mobile medical units;
- 55 health facilities;
- (partial support to) 912 Ministry of Health (MoH) facilities and two hospitals with the Ministry of Higher Education (MoHE)
- and 16 youth friendly spaces. [41]

GBV services via the WGSS and mobile teams include GBV case management, psychosocial support (PSS), skills building, vocational training, referrals for health and legal assistance. SRH services include a range of family planning; prevention, treatment and care for STIs; MNH including Basic Emergency Obstetric Care (BEmOC), Comprehensive Obstetric Care (CEmOC), Ante Natal Care (ANC), Post Natal Care (PNC); health education and counselling and early cancer detection.

Since 2016, UNFPA programming, coverage and funding has expanded substantially and currently SCO support services in 13 out of the 14 governorates [42,43] (excluding Idlib under opposition control). The SCO has increased its physical footprint from one office in Damascus to two sub-offices in Homs and Aleppo and a field presence (via UNFPA staff in sub-offices or TPM staff[44]) in 8 out of 14 governorates.

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[35] https://www.unfpa.org/data/transparency-portal/unfpa-syrian-arab-republic

[36] Financial data provided by SCO in July 2018.

[37] All data provided by the SCO in August 2018.

[38] UNFPA contracts TPMs to implement monitoring and programming activities and has 30 staff recruited as TPMs in 2018 (increased from 17 in 2017) filling a range of positions from field coordinators to RH/GBV or Youth assistants. This mechanism allows for greater flexibility and mobility as they do not operate under UN travel and security regulations.

[39] Within this report SRH (sexual and reproductive health) will be the terminology used with the exception of references specifically to Reproductive Health Kits (RH Kits) and the Reproductive Health Working Group (RH WG) which is the globally used terminology.

[40] 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).

[41] UNFPA (2017) Country Annual Office Report (COAR)

[42] 4 W's and Services are provided in Aleppo, Al-Hasakeh, Ar-Raqqa, As-Sweida, Damascus, Dara'a, Deir-ez-Zor, Hama, Homs, Lattakia, Rural Damascus, Tartous and in parts of Quneitra.

[43] UNFPA (2017) Annual Work Plan (AWP) with SFPA included programming in 10 out of 14 governorates (Aleppo, Hasakeh, Sweida, Damascus, Dara'a, Hama, Latattakia, Tartous and Rural Damascus)

[44] TPMs are located in Derizor, Sweida, Latakia, Tartous, Hama, Aleepo and Homs.

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. The UNFPA response in Syria is relevant to the GBV and SRH needs of women and girls and based on regular needs assessments. Youth programming is an emerging area of focus.
2. UNFPA has developed tools and resources for remote data collection and management that have improved the accuracy and reliability of information collected.
3. The UNFPA response is based on humanitarian principles and human rights-based approaches as far as the operating context of the conflict allows. However, the successful application of these are undermined by the continued grave violations of IHL and IHRL by parties to the conflict and the constrained humanitarian space that limits the provision of supplies and services.

The UNFPA response in Syria is relevant to the GBV and SRH needs of women and girls and based on regular needs assessments. Youth programming is an emerging area of focus. UNFPA has developed programming responses based on identified needs. A sentinel example of this: '*Voices from Syria: Assessment Findings of the Humanitarian Needs Overview'* (commonly referred to as the *Voices* Report) was first developed in 2015 and has been improved upon in 2016 and 2017.[45] Prior to this, assessments were restricted by the GoS[46],, particularly those related to protection, until the first comprehensive HNO was conducted in 2014.[47] As such, few GBV programming responses were informed by broad based needs assessments. Since 2015, the geographical coverage of the GBV needs assessment has widened annually, and by 2018, it included data from all 14 governorates[48] with much of the data provided from partners operating under the SCO. [49] Stakeholders within and outside Syria have noted that *Voices* is highly regarded as a robust evidence base to inform programming.[50] Key issues identified from the *Voices* in recent years have driven GBV programming priorities including the development of the adolescent girls' strategy to respond to the specific needs and vulnerabilities of adolescent girls and growing efforts to address intimate partner violence (IPV).

[45] UNFPA (2018) '*Voices from Syria: Assessment Findings of the Humanitarian Needs Overview'*

[46] Security conditions and delays in getting approvals for missions hindered ability to carry out needs assessment and access to affected populations.

[47] Sida I., et al (2016:39) Evaluation of OCHA response to the Syria crisis

[48] Data from multiple primary and secondary level sources including quantitative and qualitative interagency multi-sectoral needs assessments that use a common set of indicators was collected in 4,185 communities located in 254 sub-districts out of 272 sub-districts across the country. Additionally, data obtained through 117 FGDs, Client Satisfaction Surveys, expert FGDs, KIIs and existing secondary literature was analysed and synthesised to provide an overview of GBV patterns, trends and risk factors, gaps in services by location to inform programming responses and advocacy.

[49] UNFPA Key Informant

[50] UN Key Informant.

UNFPA has been leading and supporting SRH assessments[51] since the start of the crisis to inform programming responses. These include family planning and contraceptive use, quality of emergency obstetric care, assessing and evaluating the SRH vouchers.[52] In 2016, UNFPA led a rapid assessment to evaluate SRH services provided by public and non-governmental institutions supported by UNFPA in 9 out of 14 governorates. The assessment enabled UNFPA and partners to identify gaps and served as a basis for designing interventions for integration with GBV. [53]

In 2016 UNFPA developed a strategy to integrate SRH into GBV services *"to contribute in reducing the stigma related to GBV by improving access to the physical & psychosocial support for both survivors and persons of concern."*[54] The strategy outlines actions to improve integration including improved information sharing, coordination and representation of SRHR within GBV meetings as well as strengthening GBV referral systems for health services including CMR and providing trainings and developing protocols. Overall, many key informants were positive on this integration of services to expand coverage, reduce stigma and ensure that SRH and GBV services are available. [55] While UNFPA continues to support stand-alone GBV and SRH interventions as well as integrated service, since 2017, UNFPA partners have been increasingly implementing integrated responses with GBV and SRH services[56] However, findings from an independent WGSS evaluation[57] conducted in 2017 indicated tension over resources between SRH and GBV services in some safe spaces when they were shared and a lack of knowledge among some clients on the services offered at the safe spaces particularly GBV services.[58] Findings from the 2017 evaluation identified the need to review the division of spaces, roles and responsibilities between GBV and SRH; promote a systematic understanding among partners on the concept of 'safe spaces'; and ensure quality of services are not compromised by integration.

In 2016 the SCO supported a national youth assessment and UNFPA-supported youth programming is based on this. [59] The assessment also forms the basis for a two-year national youth strategy with the GoS and the UN Youth Taskforce led by UNFPA and UNICEF partnership with UNICEF which focuses on employment, heath, education, protection and engagement. There has been a positive trend within SCO for increased youth programming and an increased focus on youth as a priority target group.

UNFPA has developed tools and resources for remote data collection and management that have improved the accuracy and reliability of information collected. Collecting accurate information is a

[51] UNFPA (2013:19) COAR *"In 2014, UNFPA carried out five operational pieces of research aimed at assessing the effectiveness, efficiency and quality of interventions and focused on a) the implication of the crisis on RH professionals, b) assessment of the quality of EmOC at UNFPA- assisted facilities c) assessment of the services of UNFPA assisted mobile teams; d) the lessons learnt of the application of RH vouchers and d) assessment of the quality of PSS/PFA training sessions."*

[52] UNFPA (2012) Reproductive Health Vouchers: Improving Women's Access to Emergency Obstetric Care in the Violence Affected Areas in Syria; UNFPA (2014) Lessons Learnt from the Application of RH Vouchers.

[53] UNFPA (2016) COAR.

[54] UNFPA (2017) Draft Integrating GBV into RH services – Logical Framework. The strategy outlines actions to improve integration including improved information sharing, coordination and representation of SRH within GBV meetings as well as strengthening GBV referral systems for health services including CMR and providing trainings and developing protocols.

[55] UNFPA and NGO Key Informants.

[56] Review of IP AWPs 2015-2017 showed increases in GBV/SRH integration.

[57] The Evaluator for Research & Economical Consultancy (EREC) (2017) Evaluation Study For Women and Girl Safe Space in Syria. The number of individual interviews carried out was 437. 24 FGDs were conducted with 182 participants: service providers (42) and clients (140).

[58] EREC (2017:28) Evaluation Study For Women and Girl Safe Space in Syria. In terms of knowledge among those interviewed about the services provided in the safe spaces 88% responded that the safe spaces are a place to provide vocational training; life skills (67%);health services (41%); sports (37%); psychosocial support (PSS) sessions (35%); legal counselling (35%); recreational activities (29%); Awareness and counselling sessions for family and males (24%) and psychosocial support individual sessions (5%).

[59] In 2016 UNFPA took on leadership role under the UNFPA (and ICRC)-led Compact for Young People in Humanitarian Action to address youth needs in humanitarian settings .https://www.unfpa.org/sites/default/files/event-pdf/CompactforYoungPeopleinHumanitarianAction-FINAL_EDITED_VERSION.pdf.

challenge due to restricted humanitarian access, fluctuating security along access routes, and the difficulties in getting government travel authorisations to some locations. [60] This creates a situation where much of the data collection must be done remotely. The difficulty in obtaining reliable data and mitigating any politicisation of information[61] is a challenge that was highlighted by many key informants. [62] Available data on programming within the SCO from 2011 – 2014 is inconsistent and not sex or age disaggregated due to insecurity and inaccessibility that limited data collection. Since 2015, the SCO increased M&E staff from one to three to improve quality of data obtained from needs assessments, monitoring and follow up with partners. Additionally, technical support from the Information Management (IM) Specialist in the Hub[63], increased number of TPMs for field monitoring and growing humanitarian access has facilitated improved data collection. A 2016 assessment of UNFPA M&E systems commissioned by DFID awarded a compound attainment score of 90% (100% representing an "ideal" M&E system) for UNFPA WoS M&E system noting *"it is remarkable taking into consideration the difficult working environment in which UNFPA is operating."*[64]

UNFPA are providing technical support to the Population Data Taskforce with OCHA and also coordinates the Technical Working Group on data at the developmental level that is making significant contributions to improving the availability of data in Syria. Data collection, analysis and dissemination has been challenging in Syria and national population data is out of date and based on last census conducted in 2004. To address challenges in population statistics (which underpin accurate needs assessments), UNFPA has been providing support to the GoS 2017 Social Demographic Survey (SDS) through collaboration with the Central Bureau of Statistics (CBS). In 2018, the CBS shared updated figures based on recent surveys. This will be a key planning document for the GoS and UN in Syria.[65] Several interviewees noted that UNFPA has been a strong advocate for the use of Sex and Age Disaggregated Data (SADD) in Syria. "*Supporting capacities to collect and use gender- and age-disaggregated data for tailoring response and recovery programming*" is a focus of the 2016-2017 Country Programme Document (CPD).[66]

The UNFPA response is based on humanitarian principles and human rights-based approaches as far as the operating context of the conflict allows. However, the successful application of these are undermined by the continued grave violations of IHL and IHRL by parties to the conflict and the constrained humanitarian space that limits the provision of supplies and services. All humanitarian assistance provided by UNFPA is in line with IHL and humanitarian law and operates under the framework of UNSCR 2139.[67] UNFPA has regularly engaged in cross-line deliveries to hard-to-reach and besieged areas advocating for humanitarian access and providing much needed humanitarian assistance including supplies and medications when convoys can reach these areas with essential supplies. [68,69] Humanitarian partners rely on being granted necessary approvals for access to besieged

[60] UNOCHA Syria HNO 2016 - 2018

[61] For example, inaccurate information could be provided to direct humanitarian assistance to specific locations (based on alliances to different parties to the conflict) that may not be in most need.

[62] UN key informants.

[63] UNFPA and NGO Key Informants.

[64] Syria Independent Monitoring (2016:4) Assessment of the Monitoring and Evaluation Systems and Processes of DFID Partners.

[65] UN, Government and UNFPA Key Informants.

[66] UNFPA (2016:4) Country Programme Document for the Syria Arab Republic 2016-2017.

[67] http://unscr.com/en/resolutions/doc/2139 UNSCR 2139 (2014) *"demanded that all parties allow delivery of humanitarian assistance, cease depriving civilians of food and medicine indispensable to their survival, and enable the rapid, safe and unhindered evacuation of all civilians who wished to leave. It demanded that all parties respect the principle of medical neutrality and facilitate free passage to all areas for medical personnel, equipment and transport."*

[68] UNFPA (2017) Press release: UNFPA aid reaches Deir Ez-Zor City for the first time in three years https://www.unfpa.org/news/unfpa-aid-reaches-deir-ez-zor-city-first-time-three-years

[69] UNOCHA (2017) Summary of Humanitarian Response Plan End of Year Report Jan-Dec 2017

and newly accessible areas. However, these are often hindered or prevented from delivering supplies due to delays in approvals and denial of authorisations by the GoS. [70]

As of mid-2018, the Syrian government forces were in the process of re-taking control of Dara'a after five weeks of heavy fighting that resulted in mass displacements, civilian casualties and restrictions freedom of movement. Humanitarian partners based in Damascus had still not been granted the necessary approvals to access the affected areas, and there were no guarantees for the safety of cross-border humanitarian actors to continue to address humanitarian needs in accordance with UNSCR 2165 and 2191. [71] Despite the severe humanitarian needs, the UN (including UNFPA) continues *"to advocate for regular and sustained access to provide assistance and protection services to all people in need across all affected areas."* [72] This example serves to illustrate the extremely challenging and restrictive operating environment for all humanitarian actors. However, UNFPA assisted partners were able to provide some limited services in accessible areas of Dara'a governate from Damascus.[73] Many research respondents noted that UNFPA were active in advocating for humanitarian principles while simultaneously trying to ensure the provision of services. [74]

Further, UNFPA through the GBV sub-sector and jointly with Protection Sector and Child Protection sub-sector has supported the development of advocacy documents related to freedom of movement, civilian nature of sites in Eastern Ghouta and Ar-Raqqa and well as developing Standard Operating Procedures (SOPs) for screenings and advocating for unconditional and sustained humanitarian access to hard to reach[75] and besieged areas.[76]

[70] https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/2017_syria_pmr_overview.pdf *"Denial of authorization to operate, the delay in providing facilitation letters and the removal of critical medical supplies has limited the quantity and quality of supplies delivered through cross-line inter-agency convoys. In 2017 only 27% (275,571) of those people targeted under the UN inter-agency convoy plans were actually reached between January to December."* This accounted for 11% of humanitarian assistance from the Damascus hub and it accounted for 7.4% of overall assistance from Gaziantep and Amman cross-border.

[71] In July and December 2014, the UNSC adopted two additional resolutions – 2165 and 2191 – which, among other things, authorized UN aid operations into Syria from neighbouring countries without requiring the consent of the Syrian government.

[72] UNOCHA (2018) Syrian Arab Republic: Dara'a, Quneitra, Sweida Situation Report No. 4 As of 26 July 2018.

[73] NGO and UN Key Informants.

[74] UN Key Informants.

[75] UNOCHA (2017:6) HNO "Hard-to-reach (HTR) area an area not regularly accessible to humanitarian actors for the purpose of sustained humanitarian programming due to the denial of access, the continual need to secure access, or due to restrictions such as active conflict, multiple security checkpoints or failure of the authorities to provide timely approval. Some areas within the hard-to-reach category are subject to specific access constraints because they are militarily encircled. These areas are physically surrounded by single or multiple armed actors, with the effect of constraining access for both supplies and people to and from the area, such that sustained humanitarian programming is not possible."

[76] http://www.globalprotectioncluster.org/en/field-support/field-protection-clusters/countries/syria.html

Evaluation Question 2: Adapted relevance over time

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

Associated Assumptions:

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

FINDINGS

4. During the initial years of the crisis UNFPA was slow to scale up and did not expand significantly until 2015. Since then, there has been continuous investment in human, technical and financial resources to address humanitarian needs in Syria.
5. UNFPA has demonstrated growing capacity, flexibility, and adaptability by responding to new and emerging crises and displacements to become a front-line responder in Syria.
6. UNFPA has successfully leveraged it comparative advantage on GBV and SRH and is taking on a leadership role on youth programming and population data within Syria.
7. UNFPA has distanced itself from the interagency PSEA leadership role due to concerns on the compatibility of this with their GBV coordination leadership role

During the initial years of the crisis UNFPA was slow to scale up and did not expand significantly until 2015. Since then, there has been continuous investment in human, technical and financial resources to address humanitarian needs in Syria. UNFPA were considerably delayed in shifting into emergency mode and developing adequate humanitarian response capacity and systems to meet the needs of the crisis.[77] UNFPA, like many other agencies, underestimated the scale of the crisis in the early years. Although the overall humanitarian response progressed slowly in the beginning, the 2013 L3 declaration, adoption of UNSCR 2139 (and later UNSCR 2165 and 2191) and the establishment of the WoS structure to coordinate the response in 2014 provided the impetus for many UN agencies to accelerate the pace of their response.[78] Evidence collected through this research indicates that the UNFPA response was impeded by a lack of human resources, humanitarian technical skills, funding, and clear response strategy until 2015. [79]

The SCO 2007-2011 Country Programme Document (CPD) primarily focused on policy, advocacy and legislative reform. From 2011 – 2015 programming was based on four one-year extensions prior to the development of the 2016-2017 CPD.[80] During the early years of the crises, UNFPA focused on the provision SRH services including safe delivery through deployment of mobile teams, procurement of RH Kits and other medical items, training service providers on MISP and EmOC as well as integrating GBV services into SRH programming and mainstreaming youth. [81, 82] From 2011 – 2014, UNFPA worked with the same 8-10 partners (many of whom were development partners) as in previous years with overall funding increasing from $5.08 million in 2011 to $10.5 million in 2014 (spiking to $13.44 million

[77] UNFPA, UN, Donor, Government and NGO Key Informants.
[78] Sida l et al (2016) Evaluation of OCHA response to the Syria crisis
[79] UNFPA, UN and NGO Key Informants.
[80] The CPD was developed for the period 2007-2011. When the crisis started, the CPD was extended on a yearly basis until end of 2015. This was not a UNFPA decision but was due to the fact that the CPDs need to be aligned with the UNDAF and this was repeatedly extended,
[81] UNFPA Key Informants.
[82] UNFPA 2011-2013 COAR

in 2013 following the L3 declaration).[83] The 2016-2017 CPD marked a transition to humanitarian response with a clear focus on (a) improving access to high-quality reproductive health care; (b) scaling-up GBV prevention and response; and (c) supporting capacities to collect and use gender- and age- disaggregated data. GBV and SRH integration within mobile teams, health facilities and WGSS feature heavily as does youth mainstreaming.[84] The new CPD coincided with increased humanitarian access from Damascus including to some areas that had previously been served by cross border programming. This amplified demand for services and drove subsequent expansion of the SCO and the wider humanitarian response. [85]

Many stakeholders consulted during the research indicated that this growing humanitarian response capacity was also related to new senior management[86] in the SCO from 2015 that provided a level of stability and leadership required for expansion.[87] At the same time, staffing and implementing partners increased and funding grew with an expanded donor portfolio.

Table 1: Changes in UNFPA staffing, funding and partners 2011 – 2017[88]

Year	2011	2014	2017
Staffing	24	28	56
Funding	$5.09 million	$10.58 million	$32.03 million
Partners	10[89]	6	20
Office/Field Presence	1	2 (Homs and Aleppo)	3 offices/sub-offices and field presence in 8 governorates

Source: *UNFPA SCO July 2018*

"Overall, yes, we need to give them credit, they are a small agency but despite the size, they do a lot, they are small but efficient." [90]

However, those interviewed consistently highlighted that the relative size of UNFPA and funding (while increasing) continues to be a major impediment to UNFPA ability to scale up responses commensurate to needs. [91]

UNFPA has demonstrated growing capacity, flexibility, and adaptability by responding to new and emerging crises and displacements to become a front-line responder in Syria. Since 2015, the SCO interventions are increasingly responsive to the rapidly changing environment and emerging humanitarian needs, fluctuating access, partner capacity and available resources. This is evidenced by the consistent participation of UNFPA in cross-line assistance and increasing coverage of mobile teams and mobile medical units (39 mobile teams and 65 mobile medical units by the end of 2017) providing services in hard to reach areas and newly accessible areas.[92, 93] The situation continues to evolve, and

[83] Funds from DFID, Office of U.S. Foreign Disaster Assistance (OFDA), OCHA, the Government of Australia and Italy accounted for much of this.
[84] UNFPA (2016:4) Country Programme Document for the Syrian Arab Republic 2016-2017.
[85] UN and UNFPA Key Informants.
[86] From 2012-2015, three people held the position of UNFPA Representative until the current one was recruited in 2015.
[87] UN, UNFPA and NGO Key Informants.
[88] Developed from multiple sources of data provided by the SCO in July 2018.
[89] Some were government counterparts working on development initiatives that were not supported after 2012. As such, IPs reduced to six in 2013 and 2014 before increasing in 2015 to 13.
[90] UN Key Informant.
[91] UN, UNFPA, donor and NGO Key Informants.
[92] UNFPA (2017) COAR; UNOCHA (2018) Syria: East Ghouta - Humanitarian Update, Facts and Figures - 22 April 2018; and (2017) EREC Evaluation Study for Reproductive Health Facilities.
[93] UN, UNFPA, donor and NGO Key Informants.

the SCO supports programming in 13 out of the 14 governorates (though limited and inconsistent in coverage and services in some locations) through 20 partners (increasing from 6 in 2014)[94,95] Key informants highlighted the challenge in balancing the need to respond to multiple competing acute crises in hard to reach areas while maintaining and expanding services in more protracted settings. One UNFPA interviewee noted that *"once you agree with a donor on deliverables, suddenly you have to re-adjust a project to respond to new needs and locations. Overall, the donors are very understanding and flexible and don't have an issue in adjusting the project to meet needs."*[96]

Several donors, UN and NGO stakeholders commended the adeptness of the SCO in shifting resources and adapting modalities to respond to this environment. For example, in Eastern Ghouta and more recently in Dara'a, UNFPA assisted partners re-deployed their mobile teams to provide GBV and SRH services based on humanitarian needs.[97] Many are funded through partners like SARC and Syrian Family Planning Association (SFPA) that have national coverage and can quickly respond to newly accessible areas using resources funded under existing agreements with UNFPA. In the context of Syria, this was identified as critical to enable a fast response as new projects and partners are subject to an extensive approval process with Ministry of Social Affairs and Labour (MoSAL) and Ministry of Foreign Affairs (MOFA) that can take some months depending on the project, partner, and location. Having partners pre-positioned to respond provides a level of flexibility and responsiveness that is essential.

UNFPA staff and partners regularly participate in convoys to besieged and hard-to-reach areas providing reproductive health kits, dignity kits, pharmaceuticals and medicines as part of the inter-agency delivery of cross-line assistance.[98] Many of those interviewed indicated that these interventions (mobile teams and convoys) have led UNFPA to be seen as a *'front-line responder'* in Syria.[99]

By the end of 2017, UNFPA was supporting 39 mobile teams[100] (17 SRH/GBV mobile teams and 22 GBV teams) and 65 mobile medical units[101] run by partners providing SRH and/or GBV services in hard to reach areas and newly accessible areas.[102,] The composition of mobile teams varies and can include a combination of gynaecologist, nurse, midwife, psychologist and social worker/case workers depending on the partner, donor and location. [103,104] Feedback from interviewees on mobile teams was positive but some highlighted variance in capacity among partners and concerns on the coverage and quality of mobile services. Given the large geographical areas that are covered by mobile teams, the existing number of teams are insufficient to meet the needs of affected populations. [105] The 2017 SRH

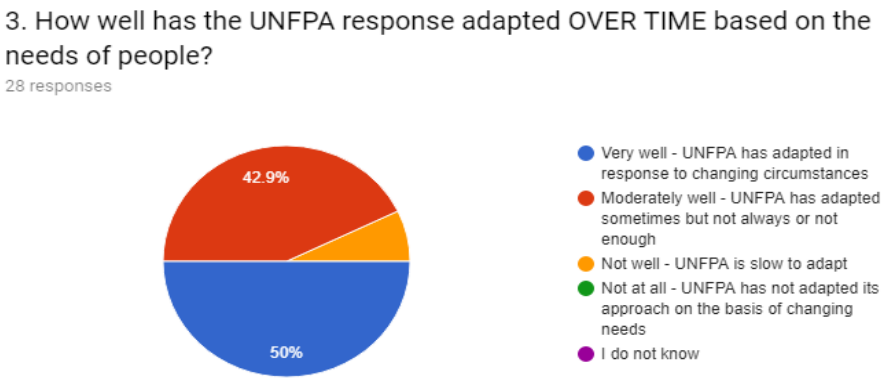
[94] UNFPA Key Informants.
[95] http://pcss.syriadata.org/HubDashboards/PCSSInterventionsAgencies_2018.aspx
[96] UNFPA Key Informant.
[97] Donor, UNFPA and UN and NGO Key Informants.
[98] https://www.unfpa.org/news/unfpa-aid-reaches-deir-ez-zor-city-first-time-three-years
[99] Donor, UNFPA and UN Key Informants.
[100] UNFPA(2017:5) COAR UNFPA mobile SRH/GBV teams provide a range of GBV and SRH services depending on the partner and focus on the team. Of the 39 mobile teams, 22 are providing GBV services and referrals and 17 provide integrated SRH and GBV services. Composition varied depending on the services offered by each team.
[101] Mobile medical units support emergency response in hard-to-reach and newly accessible locations providing general consultations, integrated reproductive health services include family planning, antenatal care, ultrasound scans, micronutrient supplements, natural deliveries, postnatal care, treatment of reproductive tract infections and referral of high risk pregnancies and complicated deliveries to public health facilities. https://reliefweb.int/report/syrian-arab-republic/syria-east-ghouta-humanitarian-update-facts-and-figures-22-april-2018
[102] EREC (2017:21) Evaluation Study for Reproductive Health Facilities.
[103] UNFPA and NGO Key Informants.
[104] UNFPA (2017:6) GBV WGSS Programmatic Annex (not published).
[105] Donor, UNFPA and UN and NGO Key Informants.

evaluation[106] found that while mobile services were identified as a useful and effective modality to cover large (often previously un-served) areas, follow up was weaker and risk of duplication of services higher. Additionally, some services like the provision of Intra Uterine Device (IUD) are only available through static services and this is one of the most common forms of contraception among those surveyed (44%).[107] Levels of satisfaction among service users interviewed for the 2017 evaluation were lower for mobile services (81%) as compared to static clinics (95%).[108] Based on a review of partner project documents, UNFPA mobile team guidance and interviews with key stakeholders[109], the evaluators noted a need to review the functioning, composition and coverage of mobile teams to ensure they provide harmonised and quality services and are able to transition beyond the acute emergency response.

While UNFPA has been providing MISP trainings on an on-going basis since 2011, the high staff turnover among partners, increased geographical coverage and new staff providing services in newly accessible areas necessitates further support.[110] In 2017 UNFPA hired a full-time consultant to review the capacity of SRH partners (government and NGOs) and develop and deliver a targeted capacity building intervention. This included trainings on MISP and CMR, on the job mentoring and follow up through in-person and remote support. Some research respondents questioned if MISP was the most appropriate resource for Syria where more comprehensive care is available in some locations and recommended it be updated and further contextualised. [111]

Overall, findings outlined above demonstrate the flexibility of UNFPA programming to address new and emerging needs. However, UNFPA operational systems are reportedly not commensurate with this programming flexibility, leading to tensions among stakeholders and inefficiencies (discussed in more detail under Evaluation Question 8).

In line with this, survey respondents' responses were positive in terms of UNFPA adaptability over time with most (92.8%) indicating that UNFPA adapted moderately or very well. Additionally, 60.7% of survey participants felt that UNFPA addressed most or all needs related to its work while 35.7% responded they did it moderately well with many, but not all, needs being met.



[106] EREC (2017:33) Evaluation Study for Reproductive Health Facilities. The study included a sample of (358) client distributed by (32%) from the governorate of Al-Hasakeh, (23%) from Hama Governorate, (22%) from the governorate of Aleppo, and (9%) from Dara'a governorate, whereas (8%) from As-Sweida, and (6%) from Damascus Governorate.
[107] EREC (2017:31) Evaluation Study for Reproductive Health Facilities.
[108] Ibid.
[109] UN, Donor, Government and NGO Key Informants.
[110] UNFPA Key Informant.
[111] Government and NGO Key Informants.

UNFPA has successfully leveraged its comparative advantage on GBV and SRH and is taking on a leadership role on youth programming and population data within Syria. All stakeholders consulted expressed positive feedback on UNFPA SRH and GBV work in Syria[112] UNFPA have successfully leveraged the space, linkages and technical capacity to emerge as the lead agency on GBV and SRH. During this research, UNFPA was consistently identified as the "go-to" agency on women and girls with integrated GBV/SRH approaches and mobile teams, advocacy efforts and technical guidance identified as key strengths. [113] This is aided by strong technical support on GBV from the Hub. The Hub has developed numerous resources and tools and many of these are utilised in Syria including the Adolescent Girl Strategy and media trainings for journalists.[114] However, the SCO GBV WGSS Programmatic annex[115] provides partners with an overview of WGSS standards but these are not directly linked to the UNFPA Safe Space Guidance [116] and it is unclear if additional support using this guidance is provided to partners. While gaps were identified by key informants in relation to CMR (discussed in more detail under Evaluation Questions 4, 5 and 6), overall, respondents concurred that UNFPA has worked well to position women and girls at the centre of the response within Syria drawing on their regional and global expertise. [117]

In line with UNFPA global mandate, their GBV and SRH programmes primarily target women and girls and engage with men and boys through community outreach and awareness raising on GBV prevention. Working with men and boys (up to 25 years) is increasingly done through UNFPA supported youth programming, and its integration with SRH and GBV including peer-to-peer, outreach and awareness raising and interactive theatre. While not discussed extensively during the research, some respondents stressed the need for UNFPA in Syria to more clearly articulate how (or if) they work with men and boys.[118]

The evaluators noted an absence of Sexual (S) and Rights (R) in the SRHR terminology in use in UNFPA programming in Syria. RH is the default term used to describe any SRHR work by UNFPA or any health actor. There is limited focus on the 'sexual' or 'rights' components in programming, coordination or policy dialogue. Few key informants used the term SRHR and most focused on RH needs and responses.[119] This limits opportunity to promote UNFPA global SRHR mandate and advance its uptake in policy and programming.

The emerging youth focus within the SCO demonstrates their responsiveness to the particular youth needs in Syria. From the start of the crisis, UNFPA has mainstreamed youth into existing GBV and SRH programming and it has become dedicated programmatic focus since 2016. UNFPA currently work with 10 partners on youth programming increasing from two partners in 2016. Some interventions build on existing GBV and SRH programmes while others are stand-alone youth interventions. One innovative partnership with Syrian Computer Society (SCS) addresses the ICT vacuum by building computer programming skills, robotics and includes a youth business incubator.[120] As part of this, a computer programme was developed for safe digital communication targeting adolescent girls.

[112] UN, Donor, Government and NGO Key Informants.
[113] UN, Donor, Government and NGO Key Informants.
[114] UNFPA (2016) Best practices in reporting on GBV A training manual for Journalists reporting on GBV Women and girls safe space; UNFPA 2(015) Reporting on GBV: A Journalist Handbook
115 UNFPA (2017) GBV WGSS Programmatic Annex (not published). This guidance also includes 1. Standards for WGSS 2017 of implementation; 2. Outreach Mobile teams; 3. Prevention of Sexual Exploitation and Abuse (PSEA) policy; 4. Verification tools for activity monitoring.; 5. GBV sub-sector membership requirement and benefits and is signed by partners as part of the contract with UNFPA.
[116] UNFPA (2015) Women and Girl Safe Spaces: A Guidance Note based on Lessons Learned from the Syria Crisis.
[117] UN, Donor, Government and NGO Key Informants.
[118] UN Key Informants.
[119] UNFPA, UN and Government Key Informants.
[120] NGO Key Informant and https://www.facebook.com/SCS.Incubator/; https://www.facebook.com/scs.org.sy/

UNFPA work on adolescent girls is also creating new opportunities to leverage GBV, SRH and youth comparative strengths.

UNFPA has also leveraged its comparative strength in population data within the humanitarian and developmental contexts supporting the Population Task Force and other technical working groups on data with needs assessments, surveys and other initiatives. [121]

UNFPA has distanced itself from the interagency PSEA leadership role due to concerns on the compatibility of this with the GBV coordination leadership role. In 2017, UNFPA, at the request of the Humanitarian Coordinator (HC), supported the establishment of the PSEA in-country network which was subsequently co-chaired (with UNHCR) by the UNFPA Inter-Agency GBV sub-sector Coordinator until mid-2018. Start-up support included developing Terms of Reference, identifying agency level PSEA focal points, and drafting a community-based complaints mechanism. In 2018, UNFPA stepped down from the leadership of this and continues to participate as a member only. The SCO respondents articulated a clear need to maintain segregation between GBV and PSEA and ensure that interagency PSEA leadership is viewed as a HC/RC responsibility (whilst recognising the need to ensure PSEA procedures are firmly in place within UNFPA. The Inter-Agency Standing Committee (IASC) PSEA guidelines outline that PSEA coordination should be distinct from GBV coordination with complementary but differing mandates, accountabilities, composition and responsibilities.[122] However, some SCO respondents highlighted the lack of corporate guidance from UNFPA on PSEA coordination responsibilities and the inconsistent uptake of the PSEA leadership role in different countries that led them to initially assume the co-chair position.[123] While SCO stakeholders were clear on their reasons for withdrawing from the interagency PSEA leadership function, some external interviewees were unclear and perceived it to be related to UNFPA resources/capacity gaps rather than for policy/conceptual reasons. [124]

[121] UN, UNFPA, Government and NGO Key Informants.

[122] IASC (2016:21) PSEA Community-Based Complaints Mechanism Global Standard Operating Procedures. "While the PSEA network should not be substituted by the Gender/GBV coordination mechanisms, the SEA referral pathway should provide a linkage between relevant assistance networks. It is important to ensure a common understanding of the core responsibilities of the PSEA in-country network and its relation to the GBV coordination mechanism, and a willingness to coordinate."

[123] UNFPA Key Informants.

[124] UN Key Informants.

Evaluation Question 3: Coverage

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

Associated Assumptions:

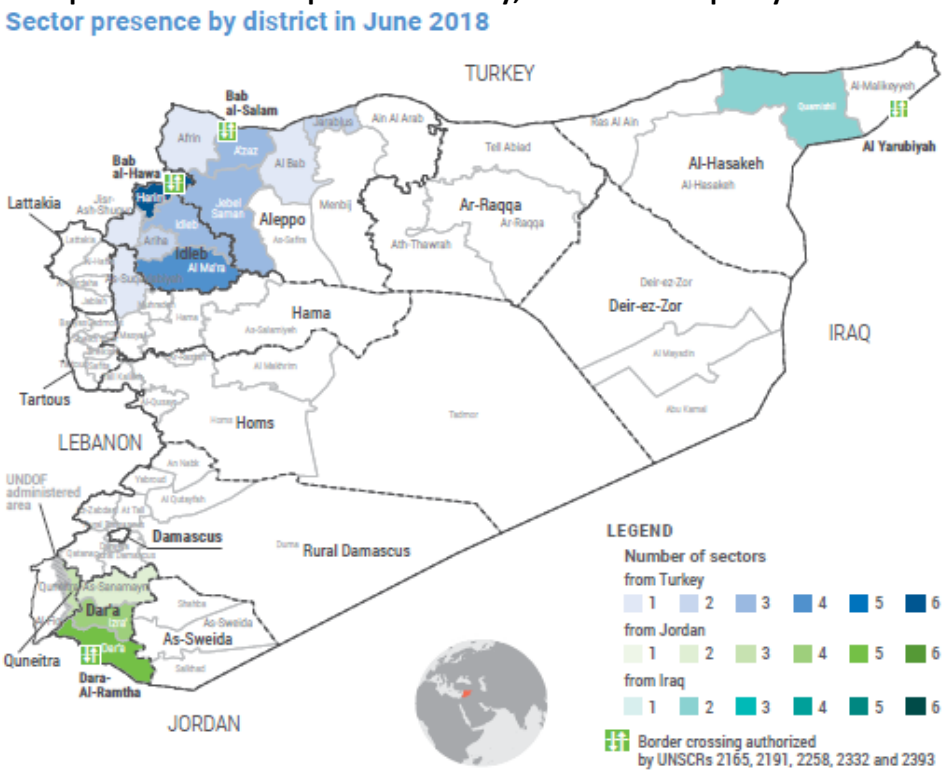
7. The UNFPA Response systematically reaches all geographical areas in which women, girls and youth are in need and in line with humanitarian principles;
8. The UNFPA Response systematically reaches all demographic populations of vulnerability and marginalisation (i.e. women, girls, and youth with disabilities, those of ethnic, religious or national minority status; Lesbian/Gay/Bisexual/Trans (LGBT) populations etc.).

FINDINGS

8. Geographically, UNFPA is increasingly able to reach those in greatest need in Syria but this remains dependent on humanitarian access, government approvals, partner capacity, coverage and funding.
9. Demographically, UNFPA has a clear and targeted focus on women and girls with a growing youth portfolio but has been limited in respect of other aspects of inclusion such as disability.

Geographically, UNFPA is increasingly able to reach those in greatest need in Syria but this remains dependent on humanitarian access, government approvals, partner capacity, coverage and funding. Until 2016, large parts of the country were not accessible from Damascus, severely curtailing the response from the SCO. [125] Since then, there has been a shift in control of large areas of Syria that are now (July 2018) under the control of the GoS that has resulted in increased coverage by the SCO as humanitarian access from Gaziantep and Amman hubs has been diminishing. [126]

Map of Cross-border Operations Turkey, Jordan and Iraq to Syria

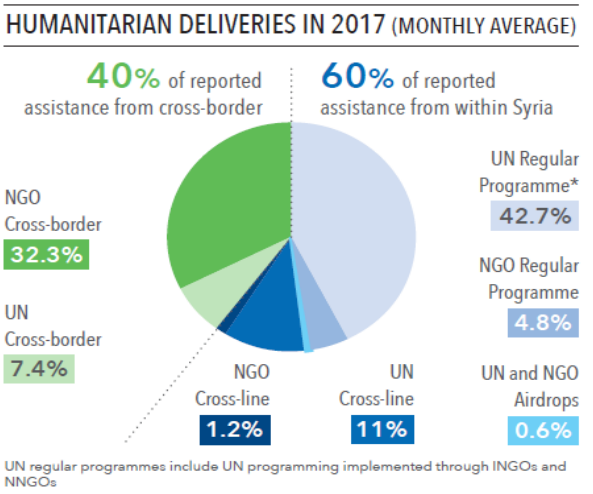


Source: *UNOCHA June 2018*

[125] UNOCHA Whole of Syria HNO and HRP 2016 and 2017

[126] UN and UNFPA Key Informants.

Challenges relating to coordination and sharing of information on geographical coverage by Amman and Gaziantep hubs with the SCO were highlighted as were related risks of duplication and/or gaps in services. [127] As illustrated in this diagram, 60% of humanitarian assistance was provided from within Syria and 40% through cross-border operations in 2017.[128] By 2018, the SCO reported being able to access almost 80% of the country by supporting partners to provide services in 12 governorates (albeit inconsistently in some locations with ad-hoc/irregular access in others). [129,130,131] Modalities for humanitarian assistance vary and coverage is heavily influenced by partner capacity, funding and competing emergency responses. Selection of priority locations is undertaken in coordination with OCHA and based on the severity scales.[132]



Source: *UNOCHA December 2017*

"The needs are tremendous – new IDPs and newly accessible areas are emerging all the time and we cannot cover all the locations – we need to prioritise" [133]

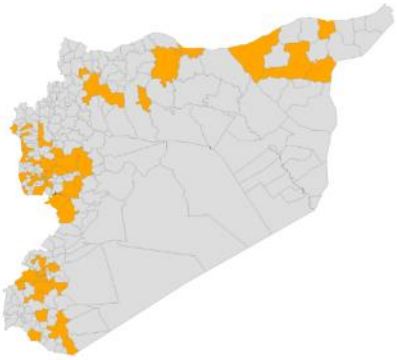
Numerous stakeholders stated that inconsistent humanitarian access and competing needs in different areas require a constant revision and flexibility in approaches. They agreed that UNFPA has good presence in newly accessible areas including Eastern Ghouta and most recently Dara'a and partnerships with SARC and SFP facilitate this due to their national presence. Responding to needs in new locations often means resources and teams are diverted from existing sites.[134] While UNFPA has increased coverage through partner assisted mobile teams, some stakeholder expressed concerns on quality and a recognised need to transition these to static services.[135]

Until 2015, UNFPA partnered predominately with the MoH, MoHE, MoSAL, SARC, SFPA and SCFAP for the provision of GBV and SRH services.[136] The number of UNFPA IPs increased to 20 in 2017 with

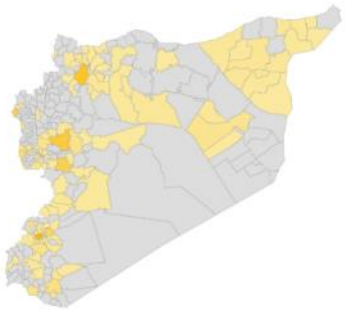
[127] UNFPA Key Informants.
[128] UNOCHA (2016:17) SAR HRP 2016 Summary of Humanitarian Response Plan Monitoring Report, January - December 2016 "74% of the reported response - in terms of the number of people reached - was delivered from inside Syria through a combination of regular programmes and crossline operations. The majority of the response from inside Syria comprised regular programming from Damascus, with UN regular programmes accounting for 53% and NGO regular programmes accounting for 10% of the overall response. Approximately 1% of the response was delivered through UN and NGO airdrops. 26% of the reported response was conducted through cross-border operations, of which 14% was delivered through UN cross-border convoys under UNSC 2139/2165/2258/2332, and 10 per cent delivered through NGO regular programmes. However, NGO cross-border assistance is estimated to be higher due to underreporting."
[129] UNFPA key informant interviews.
[130] http://pcss.syriadata.org/HubDashboards/PCSSInterventions_Governorate_2018.aspx GBV services in 12 governorates including Aleppo, Al-Hasakeh, Ar-Raqqa, As-Sweida, Damascus, Dara'a, Deir-ez-Zor, Hama, Homs, Lattakia, Rural Damascus and Tartous.
[131] http://www.ocha-sy.org/4wsresponse2018.html
[132] UNOCHA (2018:18) Syria HNO "In Syria, humanitarian responses are based on geographical prioritisation from the inter-sector severity categorization tool seeks to identify the areas across Syria where humanitarian needs are more acute, given a convergence of factors including: besiegement, displacement, exposure to hostilities, and limited access to basic goods and services."
[133] UNFPA Key Informant.
[134] UN,UNFPA, Donor and NGO Key Informants.
[135] UN,UNFPA and NGO Key Informants.
[136] UNFPA COAR 2011-2014

resultant expansion in geographic coverage (discussed in more detail under Evaluation Question 9.) UNFPA GBV and SRH coverage are spread across the locations as illustrated below.[137] Additionally, UNFPA partnership with the MoH through the provision of supplies, capacity building, and other support to over 900 MoH facilities has enabled them to contribute to a larger geographical response. This partnership preceded the crisis and has expanded since 2011. [138]

UNFPA GBV Coverage 2017



UNFPA SRH coverage 2017



Source: *UNFPA SCO July 2018*

Demographically, UNFPA has a clear and targeted focus on women and girls with a growing youth portfolio but has been limited in respect of other aspects of inclusion such as disability. The focus and prioritisation on Syrian women, girls and youth[139] is a positive reflection of UNFPA global mandate. Stakeholders consulted stressed UNFPA commitment to working with these groups.[140] Evidence from *Voices* in 2017 highlighted that *"while women and girls were at high risk of GBV, certain groups were perceived to be at higher risk than others. Adolescent girls were perceived to be at higher risk of sexual violence, child marriage, and sexual exploitation through the form of serial temporary marriages."* [141] This led SRH, GBV and Youth Specialists working on the WoS response to develop a joint strategy addressing the specific needs of adolescent girls and this is used to guide UNFPA work on adolescent girls in Syria.[142] The WoS GBV Strategy also articulates UNFPA focus on women and girls and since 2017 there has been increasing attention to adolescent girls in the SCO. While the adolescent girl's strategy identifies adolescent girls— defined as girls aged 10-19 years – it was unclear from this research if UNFPA partners were consistently targeting girls aged 10-14 years with GBV and SRH interventions in their programming. Between 2015-2017, girls under 18 years accounted for 18% of total GBV beneficiaries. [143]

> *"This strategy intends to strengthen and expand upon existing programming for adolescent girls in Syria, through the cross-border programming managed from Gaziantep, Turkey and from Jordan and those managed from Damascus, Syria"*[144]

[137] SCO maps provided in July 2018. A limitation to these is that they do not differentiate stand-alone services or integrated or illustrate where youth programming is located.
[138] UNFPA (2017) COAR
[139] While not explicitly focused on the Palestinians or Iraqi refugees due to the presence of UNRWA and UNHCR, UNFPA does provide needs driven support as requested. For example, with supplies or through partner support for GBV and SRH services to Neirab camp in Aleppo.
[140] UN,UNFPA, Donor, NGO and Government Key Informants.
[141] UNFPA (2017:7) Listen, Engage and Empower: A strategy to address the needs of adolescent girls in the Whole of Syria
[142] https://www.humanitarianresponse.info/en/operations/whole-of-syria/document/whole-syria-adolescent-girl-strategy
[143] Data from SCO 2015 – 2018 beneficiaries. Girls accounted for 271,982 out of total 1,529,538 women, men, boys and girls targeted with GBV prevention and response services.
[144] UNFPA (2017:7) WoS Adolescent Girls Strategy

UNFPA is increasingly working with youth and this has been identified as an opportunity for the SCO integrate GBV and SRH awareness through youth interventions and develop youth friendly SRH and GBV friendly services. The need to integrate adolescent services within existing SRH services was highlighted as a gap that UNFPA is trying to address.[145]

Despite the estimated 2.9 million[146] people with disabilities, the evaluation saw little evidence of a focus on people with disabilities (PwD) and support to disability-friendly services. Increased vulnerability to GBV related to disability has been highlighted in successive HNOs but responses remain limited and respondents noted that few health facilities or WGSS were disability-friendly. [147]

The evaluators noted evidence of gaps in the provision of care to child survivors of GBV. Care for child survivors is a joint responsibility of GBV and Child Protection actors. Key informants noted that many UNFPA GBV partners lack specialised skills to provide care to child survivors (particularly those under 14 years) and existing Child Protection partners do not have good capacity or knowledge on GBV. [148] Risks of GBV, in particular early and forced marriage, sexual violence, sexual exploitation and abuse are reportedly high[149] and require further responses.

Results from survey respondents also correspond with this, specifically:

- Over 50% of respondents felt that that UNFPA has some, but not enough, focus on girls, while 46.6% responded that UNFPA has specifically focused on and reached adolescent girls.
- For disabilities, 46.4% of respondents felt that UNFPA has some, but not enough, focus on people with disabilities and were performing moderately well with 32.1% responding responded that UNFPA does not focus specifically on people with disabilities. The remaining 21.4% did not know what UNFPA were doing in relation to disability.

[145] UNFPA Key Informant; UNFPA (2017:22) WoS Adolescent Girls Strategy "Objective 2: Promote adolescent girl friendly SRH services and specialised GBV services."
[146] UNOCHA (2018) HNO WoS.
[147] UN,UNFPA, Donor, NGO and Government Key Informants.
[148] UN and NGO Key Informants.
[149] *Voices* 2017 and 2018.

Evaluation Question 4: Coordination

To what extent has UNFPA formal leadership of the GBV Area of Responsibility (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 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 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 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

10. UNFPA is providing consistent leadership of the GBV sub-sector with good collaboration and advocacy with the wider coordination mechanisms. While this has improved since 2016, there are gaps in technical support to partners and sub-national coverage due to limited human resources.
11. There is no dedicated SRH working group (WG) in Syria and UNFPA leadership on SRH has been weaker than for GBV.
12. There is no youth working group and youth issues are dealt with through the UN Youth Taskforce.

UNFPA is providing consistent leadership of the GBV sub-sector[150] with good collaboration and advocacy with the wider coordination mechanisms. While this has improved since 2016, there are gaps in technical support to partners and sub-national coverage due to limited human resources. The GBV sub-sector was set up in Syria in 2014 and currently has an Inter-Agency GBV sub-sector Coordinator and national IM assistant. The GBV sub-sector coordinator is double hatting with national and sub-national coordination responsibilities (and acting as the alternate UNFPA PSEA focal point). The IM assistant is also currently double-hatting with UNFPA M&E duties but is predominantly focused on sub-sector IM responsibilities.[151]. Prior to 2014, the SCO did not have any dedicated GBV staff and was relying on ad-hoc support from the regional GBV Advisor during short missions from 2012- 2014.[152] In 2015 the SCO recruited an international GBV Specialist and this position assumed responsibility for both interagency coordination and programming until a dedicated GBV sub-sector Coordinator was hired in 2016. Technical support was provided through the GBV Specialist and IM Specialist based in the Hub and was reportedly highly beneficial, especially when there were gaps in full time staff. Support from the Hub also made significant contributions to building robust IM systems and remote monitoring capacity. [153]

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[150] Sida I., et al (2016:24,31) Evaluation of OCHA response to the Syria crisis Within the WoS Coordination arrangements (see annex iv), sectors and clusters are used inter-changeably and "*the cluster system has not been formally activated, but Syria has effectively followed this template using sectors. OCHA has played as close to a normal role as it was able, establishing an inter-sector role and providing support to the sectors. This has included significant information management support (based out of Amman), as well as linking this into the production of the response plan."*

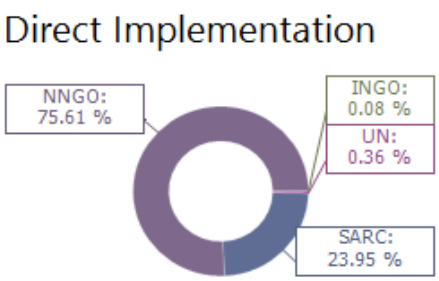
[151] UNFPA Key Informants.

[152] UNFPA (2014) COAR

[153] Key Informants and Syria Independent Monitoring (2016) Assessment of the Monitoring and Evaluation Systems and Processes of DFID Partners.

Key informants noted that since 2016 leadership of the GBV sub-sector has improved but highlighted that there has been a higher turnover of GBV Coordinators as compared to Child Protection or Protection. This coupled with the lack of sub-national GBV coordination staff[154] constrains the overall functioning of the GBV sub-sector.[155] Until 2017, there was only one national coordination forum managed out of Damascus by the GBV sub-sector coordinator. As the humanitarian response expanded geographically, sub-national coordination was increasingly required and for GBV this fell under the sub-national protection sector in 2017. In early 2018, two technical GBV working groups were established in coordination with the national GBV sub sector to coordinate responses in Homs and Aleppo supported by UNFPA national staff who are double hatting with programme responsibilities. More sub-national coordination mechanisms are likely to emerge in the future as the UN coordination structure continues to grow through sub-offices at the governorate level.[156] While double hatting and lack of co-chairs at the sub-national level affect most sectors, stakeholders consulted noted that it was more pronounced for the UNFPA-led GBV sub-sector as they have less staff at national and sub-national levels to support coordination.[157] UNFPA is currently finalising recruitment for a second international GBV Coordinator to support sub-national coordination and this should address some of these challenges.

UNFPA reports that contingency planning forms a significant part of the work of the GBV sub-sector work as does advocacy. The positive collaboration and coordinated advocacy between GBV, Child Protection and Protection coordinators who are a *'united front'* was identified as a notable strength of UNFPA Syria programme by many key informants.[158]



In 2017, there were 23 members [159,160] in the GBV sub-sector, of which 12 are UNFPA-funded IPs.[161] Few international NGOs work on GBV (only one in 2017) [162] and though the number of national organisations is increasing due to growing demands for services, gaps in quality and coverage remain. The need for intensive and sustained capacity building especially as the responses expand was apparent from this research.[163]

Source: *PCSS Dashboard*

The GBV sub-sector has a Terms of Reference (ToR), a workplan, and capacity building strategy that is linked to the GBV WoS Strategy. Interviewees voiced some frustration vis à vis delays finalising the SOPs, referral pathways, and the Information Sharing Protocol (ISP). There is a capacity building/training plan for the GBV sub-sector that includes trainings using global resources on case management, care for survivors, the GBV Guidelines and resources produced by the Hub including the media trainings for journalists. Taking into consideration the considerable role of UNFPA in supporting GBV actors in Syria, it can be difficult to disaggregate the contributions of UNFPA from other actors. In 2018, the UN (primarily UNHCR and UNFPA) provided 98.29% amount of funding to the members

[154] There are no NGO co-chairs for sectors/sub-sectors inside Syria.
[155] UN Key Informants.
[156] Currently in Qamisli there is a standing agenda item for GBV during the Protection sector meetings.
[157] UN Key Informants.
[158] UN Key Informants.
[159] According to updates from the GBV sub-sector, this has increased to 35 in 2018.
[160] WoS GBV A Dashboard
[161] UNFPA AWPs 2017
[162] PCSS Dashboard
[163] UN, Donor and NGO Key Informants.

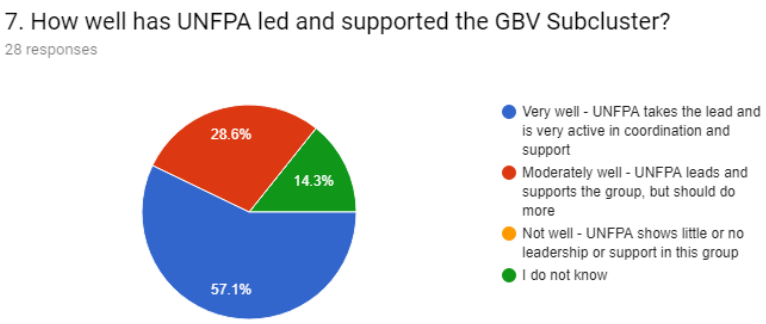
of the GBV sub-sector.[164] UNHCR implements a capacity building programme with IMC to provide training, support and mentoring on GBV to their IPs. However, some key informants noted that different training materials were used by different training providers/agencies. [165]

The GBV Information Management System (IMS)[166] has not been rolled out in Syria. GBV partners do not use a standardised IMS system with a variety of tools used by different partners.[167] Some interviewees noted that GoS approvals be needed for a GBV IMS rollout. [168] However, considering the necessity for safe, confidential and harmonised systems for GBV data, there are opportunities to engage with the Global GBV IMS Steering Committee to review current systems and introduce a basic model to roll out the GBV IMS tools.[169] These can be adapted to any challenges presented by GoS approvals needed, insecurity, remote technical support and access issues and could accompany the Inter-Agency Gender-based Violence Case Management Resource Package which is used in Syria.

Some key informants noted that '*Voices*' can create tensions between the GBV sub-sector and the GoS, in part related to it been a WoS product that contains findings from areas not under their control. The need for additional time to liaise with the GoS to secure approvals to conduct assessments including review tools, findings and recommendations was highlighted. These are necessary to avoid resistance from the GoS and obtain necessary approvals to conduct research in government-controlled areas that contributes to *Voices.* However, this but can lead to delays with timelines set by the WoS GBV AoR and cause friction between them and the Syria GBV sub-sector.[170]

The GBV sub-sector is working across sectors to promote GBV risk mitigation and integration in the humanitarian response In 2017, they organised trainings on the GBV Guidelines and developed sector specific checklists for GBV risk mitigation. [171] Data to measure progress on this is limited but interviewees that participated in trainings noted that they contributed to improved awareness on GBV risk mitigation among other sectors in Syria. [172]

With regard to GBV coordination, 57.1% of survey respondents felt that UNFPA was performing very well and that UNFPA takes the lead and is very active in coordination. This triangulates well with the qualitative interview findings of the research and, although not unanimous, the lower level of respondents who felt UNFPA should do more (28.6%) is evidence of strong coordination by UNFPA.



[164] PCSS Dashboard
[165] UN, UNFPA and NGO Key Informants.
[166] http://gbvims.com/wp/wp-content/uploads/GBVAOR-GBVIMSFactSheet1.pdf The GBVIMS enables humanitarian actors to safely collect, store and analyse reported GBV incident data, and facilitate the safe and ethical sharing of this.
[167] UN, UNFPA and NGO Key Informants.
[168] UN Key Informants.
[169] This could include the use of the GBV classification tools, GBV IMS intake form, incident recorder and ISP. If this is not possible, a number of agreed data points could be collected based on this but following all guidance, ethical and safety procedures that accompany the GBV IMS.
[170] UNFPA Key Informants.
[171] NGO Key Informant.
[172] UN, UNFPA and NGO key informants.

There is no dedicated SRH working group (WG)[173] in Syria and UNFPA leadership on SRH has been weaker than for GBV. SRH is included as a standing item during health sector meetings and UNFPA provide SRH updates. The SCO did not have a dedicated SRH Coordinator until 2018 and it was only in 2015 that a national SRH officer was recruited to focus solely on SRH - including coordination and UNFPA programming. Prior to this SHR sat under the responsibility of an RH/Youth Officer.[174] Although UNFPA lead the RH WG in Gaziantep, there is no WoS external SRH coordination function. SRH technical support to the SCO was provided mostly by ASRO, however, since a full-time SRH Coordinator was recruited in 2018, communication with the Gaziantep SRH Specialist has increased.[175] The SCO SRH Coordinator is under a one-year contract supported through NORCAP surge.[176] Findings from interviews with several key informants indicate that UNFPA prioritised GBV over SRH coordination and this is supported by the apparent lack of SRH technical support and dedicated SRH coordination staff within UNFPA Syria. Discussions between UNFPA and the health sector are on-going on whether to establish an SRH WG.[177] Health partner feedback indicated that, overall, UNFPA was undertaking good coordination of SRH-related humanitarian programming in Syria despite the lack of a dedicated coordinator and WG.

Linkages with the Health Sector and the GBV sub-sector are reportedly strong, in part related to UNFPA leadership role on GBV and SRH.[178] Coordination between the Health Sector and GBV sub-sector occurs mainly through the UNFPA SRH Coordinator rather than directly with the Health Sector. Health responses tend to focus primarily on CMR (in part due to its inclusion in MISP) and do not focus on the health consequences of Intimate Partner Violence (IPV) even though GBV needs assessments consistently identify IPV and early and forced marriage as serious and life-threatening issues.[179] Trainings on CMR are under the GBV sub-sector plan and CMR is an activity under GBV in the HRP:

> "*4) develop and expand appropriate inter-sector collaboration to increase availability of CMR services and the response to the needs of adolescent girls and child survivors of GBV*" [180]

CMR does not feature explicitly within the 2017 health component of the Whole of Syria HRP but GBV mainstreaming and response is referenced as a part of the overall response strategy:

> *"Gender mainstreaming efforts will continue throughout health programming and will include support for provision of care for survivors of GBV."* [181]

However, the health sector does have an indicator in the 4 W related to CMR: *# of facilities providing CMR*. [182] In Syria, health professionals providing post-rape care are mandated to report cases to the police if survivors access health care and this is a barrier to both providing and accessing lifesaving

[173] SRHR is coordinated globally through the Inter-Agency Working Group (IAWG), sitting outside of the formalized IASC system, and at country-level is usually an informal working group established under the WHO-led Health Cluster rather than a formal global AoR/country-level sub-cluster. UNFPA has a clear IASC-mandated coordination and provider of last resort accountability for GBV as the cluster lead agency (CLA) for the GBV AoR. However, there is no formalized equivalent SRHR responsibility for UNFPA even though UNFPA normally adopt an informal leadership role of SRH in emergencies through the establishment of RH Working Groups under the WHO-led Health Cluster. However, UNFPA does have a leadership role to play on SRHR based on UNFPA's own mandate.
[174] UNFPA Key Informants.
[175] UNFPA Key Informants.
[176] UNFPA Key Informants.
[177] UN and Government Key Informants.
[178] UN Key Informants.
[179] UNFPA (2018) '*Voices from Syria: Assessment Findings of the Humanitarian Needs Overview'*
[180] UNOCHA (2018:30) Whole of Syria HRP
[181] UNOCHA (2018:61) Whole of Syria HRP
[182] UN Key Informants.

health care. Despite the mandatory reporting, CMR (though not human immunodeficiency virus (HIV) post-exposure prophylaxis (PEP) antiretroviral (ARV))[183] is provided by some health professionals. Although CMR trainings have been provided by both UNFPA and UNHCR since 2012, these have not been well coordinated either in terms of materials used or advocacy with the GoS. [184] Findings from this research indicate that advocacy efforts to address the provision of CMR require improved coordination between UNFPA and UNHCR and WHO and GOS.

There is no youth working group and youth issues are addressed through the UN Youth Taskforce. While there is no inter-agency WG, youth programming is supported through the UN Youth Taskforce co-led by UNICEF and UNFPA that was established in 2016. This does not include any NGOs and youth engagement with the GoS is directed by a two-year National Youth Strategy between GoS and the UN. Respondents indicated that the youth strategy and UN taskforce are nascent steps to support broader coordination on youth issues and have been successful in opening up the space to the extent possible.[185] This includes celebrations to commemorate International Youth Day in 2017 that were undertaken with support from the GoS. Additional work is required by UNFPA to accelerate engagement with youth in Syria to facilitate more meaningful coordination and information sharing.

[183] Tenofovir (TDF) + lamivudine (3TC) are recommended as the preferred backbone regimen for PEP among adults and adolescents, and atazanavir/ritonavir (ATV/r) is the recommended third drug. Tenofovir (TDF) + lamivudine (3TC) are recommended as the preferred backbone regimen for PEP among adults and adolescents, and atazanavir/ritonavir (ATV/r) is the recommended third drug. This is based on the 2014 updated guidance from WHO. http://iawg.net/wp-content/uploads/2016/11/Updated-PEP-guidance-RH-Kit-3-Oct-2016.pdf

[184] UN Key Informants.

[185] UNFPA and UN Key Informants.

Evaluation Question 5: Coherence

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

Associated Assumptions:

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

FINDINGS

13. UNFPA is viewed as a strong voice within the UNCT and HCT advocating for the needs of women and girls and promoting GBV and SRH services as lifesaving.
14. Overall, UNFPA has a constructive relationship with relevant ministries and are supporting services, legislative reform, and policy engagement. However, there are notable tensions in aligning to national policies and legislation when they are not consistent with UNFPA mandate and GBV and SRH responsibilities.

UNFPA is viewed as a strong voice within the UNCT and HCT advocating for the needs of women and girls and promoting GBV and SRH services as lifesaving. Their participation within these fora and advocacy and leadership on GBV and SRH was highlighted as effective by respondents.[186] UNFPA have been able to shape priorities in the Whole of Syria HRP, United Nations Development Assistance Framework (UNDAF), UN Strategic Framework (SF). Within the HRP, GBV is a priority issue. GBV was less visible at the start of the crisis, but since 2015, it has become increasingly recognised as a priority within humanitarian planning documents. GBV was scarcely referenced in the 2012 SHARP.[187] Additionally, UNFPA is well represented across the UNSF outputs (see Evaluation Question 10 for more detail) and GBV and SRH needs are well articulated in the SF.[188]

Respondents overwhelmingly indicated that UNFPA have matched advocacy with actions, including the provision of supplies for convoys, assisting partners expand mobile services, and regularly participating in visits to newly accessible areas.[189] UNFPA senior-level participation in joint advocacy with UNHCR and UNICEF on protection concerns is also considered valuable by protection partners and UN consulted. Some key informants stressed that the humanitarian response in Syria is more UN-driven than others given the limited presence of international NGOs which leads more advocacy falling to the UN and this creates tensions with the GoS. UNFPA were praised for their *"very principled approaches when facing significant challenges."*[190] *"They are dynamic and pushing the women and*

[186] UN, UNFPA, NGO and Donor Key Informants.
[187] UNOCHA SHARP 2012, 2013
[188] UN (2016) Strategic Framework for Cooperation between the Government of the Syrian Arab Republic and the United Nations 2016-2017
[189] UN, UNFPA, NGO and Donor Key Informants.
[190] UN Key Informants.

girl's agenda and pushing GBV and increased visibility of these issues. A lot is related to the leadership in-country and there is an appetite for it within the UN country team. We all recognise that women and girls have been severely impacted by armed groups – there is a hunger for guidance and expertise and it's nice to have good colleagues from UNFPA." [191]

The active participation of UNFPA within UN coordination mechanisms was emphasised by UN key informants including their role in championing the formation of the Youth Taskforce and Gender Working Group[192] and their role in the UN Communication Group, PSEA in-country network, Programme Management Team, and Statistics Working Group. One respondent noted that *"UNFPA has a very large voice for such a small agency"*.[193] Other highlighted the willingness of UNFPA to collaborate on joint programming and co-operate with other agencies.[194] For example, since 2016, UNFPA partners have been working with WFP[195] to assist the provision of additional food vouchers to pregnant and lactating mother following a referral or confirmation of pregnancy. Referrals are made from UNFPA supported health facilities to WFP distribution centres and vice versa and there is no monetary benefit to either agency from this. [196]

Overall, UNFPA has a constructive relationship with relevant ministries and are supporting services, legislative reform, and policy engagement. However, there are notable tensions in aligning to national policies and legislation when they are not consistent with UNFPA mandate and GBV and SRH responsibilities. UNFPA does a commendable job in maintaining robust partnerships with a variety of ministries and offices including the MoH, MoSAL, CBS, and SCFA that are critical in advancing UNFPA work in Syria. Respondents[197] reported many examples of positive engagement including:

- The establishment of one safe shelter in Rural Damascus through support to the Family Protection Unit (FPU)[198] under the SCFAP;
- Capacity building efforts with the CBS including support for the Social and Demographic Study;
- Development of the National Midwifery Curriculum and National Youth Framework;
- Working with the MoH to develop a National Women's Health Strategy which offers an opportunity to integrate CMR and adolescent health services.

Despite this favourable relationship, there are substantial challenges in removing obstacles to the provision of CMR in Syria. As outlined above, health professionals are mandated to report to the police if they provide CMR regardless of whether the survivor wishes to or not. UNFPA has been working with the MoH to develop a CMR manual and has also been engaged in policy dialogue with the GoS. UNFPA held a workshop in 2017 with the SCFAP with representatives from MoH and Ministry of Justice (MoJ) to discuss mandatory reporting requirements and exemptions and there was consensus to address these legislative barriers. However, due to changes in senior level staffing within the MoJ, no action was taken in 2017 and the process must now be re-started with the new MoJ leadership. [199]

The provision of CMR is further complicated by the fact that the GoS do not approve the distribution HIV PEP in RH Kit 3 to NGO partners and it can only be accessed at a dedicated MoH facility in

[191] UN Key Informant.
[192] UN Key Informants.
[193] UN Key Informant.
[194] UN Key Informants.
[195] See link to the video describing the UNFPA WFP partnership, this was done in early 2017 and shows paper vouchers and the programme now uses electronic vouchers.
[196] UN Key Informants.
[197] UN, UNFPA, NGO and Donor Key Informants.
[198] In 2014, MoSAL, with support from UNHCR, UNFPA and UNICEF, established in 2014 a Family Protection Unit (FPU) for the protection of women and children to strengthen all protection-related activities for women and children and revise all relevant Syrian laws that affect the provision of services for survivors of GBV including CRSV.
[199] UNFPA Key Informants.

Damascus. As such, UNFPA no longer import HIV PEP.[200] This legislation, medical practices and restrictions on HIV PEP are misaligned with UNFPA global mandate to ensure clinical care and creates a dichotomy between global GBV and SRH minimum standards and the reality of service provision in Syria. While work is on-going, progress is slow, and the impact is that post-rape care, including HIV PEP, is not available to survivors. Some of those consulted underlined the need for external support to provide good practice examples on legislative reform on mandatory reporting that could be presented to the GoS. [201]

[200] Key Informant Interviews
[201] Government and UN Key Informants.

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

15. UNFPA is committed to responding to new crises while pursuing opportunities to build resilience where possible.

UNFPA is committed to responding to new crises while pursuing opportunities to build resilience where possible. Where feasible and practical, UNFPA is trying to meet longer-term needs and link ongoing humanitarian assistance to resilience as much as donor priorities, and political and security constraints permit. Respondents noted that there is no clear plan on how the international community will engage with the GoS in the longer-term.[202] One key informant noted that *"...working with the government, it's difficult to balance programming versus the systems strengthening work that leans towards government engagement."*[203] Stakeholders concurred that even when there is a cessation to hostilities, the humanitarian crisis will persist and needs among the affected populations including the displaced and returnees will continue to magnify. The operating environment in Syria is characterised by continuous *'emergencies within an emergency'* including Homs in 2015, Aleppo in 2016, Ar-Raqqa in 2017, and Eastern Ghouta in 2018.[204] The ongoing fighting in Dara'a and looming battle for Idlib continues to focus efforts on life-saving humanitarian assistance.

While much of UNFPA funding and programming is humanitarian focused, the SCO interviewees were cognisant of the necessity to transition from emergency interventions to more resilience programming.[205] For example, UNFPA has invested in developing and improving the skills of midwives since the beginning of the crisis through training and provision of RH Kit 2 for clean delivery. To compensate for the loss of qualified maternal health care providers, UNFPA undertook an initiative in 2017 (under a joint UN programme with UNDP) to improve the quality of obstetric care by enhancing technical skills and accreditation of midwifes and nurses in partnership with the MoH to increase the cadre of skilled professionals.[206] UNFPA is also working closely with MoH and MoSAL through capacity building, supplies, and resource development including developing a national curriculum on Mental Health and Psychosocial Support Services (MHPSS) and training social workers and psychologists. [207]

Other examples of UNFPA engagement on resilience include promoting legislative reform related to Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), CMR, UNSCR 1325 and 2250.[208] In 2017, UNFPA held a workshop with the SCFAP that led the GoS to withdraw its reservation to Article 2[209] of CEDAW that mandates states ratifying CEDAW to declare intent to repeal discriminatory provisions against women in their laws.

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[202] UN and Donor Key Informants.
[203] Donor Key Informant.
[204] UN, UNFPA, Donor and NGO Key Informants.
[205] UN and UNFPA Key Informants.
[206] UNFPA-UNDP signed agreement for funding from the Government of Japan 15 April 2017
[207] UNFPA and Government Key Informants.
[208] UNFPA (2017) COAR
[209] Syria has been a party signatory to the Convention on the Elimination of All Forms of Discrimination against Women since 2002, however it has made reservations to several articles of the Convention, in particular article 2, article 9(2) regarding women's equal right with respect to the nationality of their children, article 15(4) regarding the freedom to choose their

However, despite these positive examples, deeper in-country engagement in systems strengthening is restricted by the on-going conflict, lack of resolution and transition plan agreed by parties to the conflict and endorsed by the international community. [210]

Note: Evaluation Question 7 relates explicitly to the UNFPA Regional Response Hub.

residence and domicile, article 16(1) (c-d-f-g) regarding the same rights and responsibilities during marriage and at its dissolution in terms of guardianship, wardship, trusteeship and adoption, article 16(2) regarding the legal effect of the betrothal and the marriage of a child due to their conflict with the provisions of Islamic Sharia law, as well as article 29(1) regarding arbitration between states in the event of a dispute. https://euromedrights.org/wp-content/uploads/2017/11/Factsheet_VAW_Syria_EN_Nov2017.pdf

[210] UN, UNFPA and Donor Key Informants.

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?

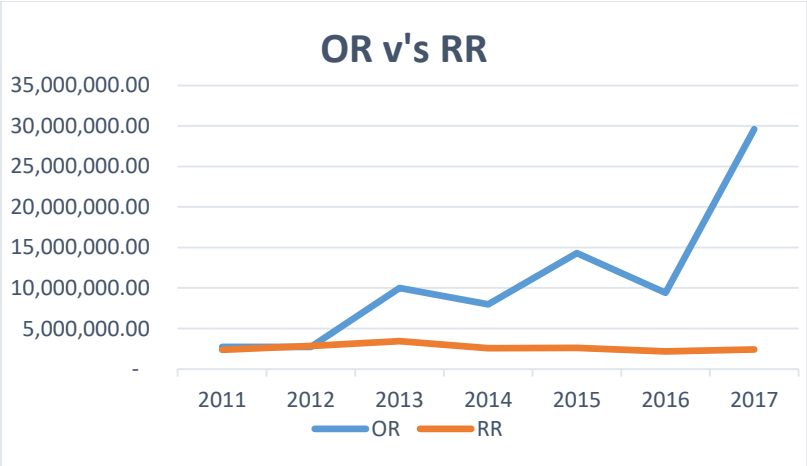
Associated Assumptions:

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

16. Core resources allocated to the SCO were not commensurate to needs throughout the Syria crisis nor did they match other resources as they increased.
17. Although SCO has utilised Fast Track Procedures (FTP) since the start of the crisis, their capacity to expedite procurement and recruitment was impeded in the early years by insufficient resources, technical capacity, and a lack of flexibility in the application of procedures.

Core resources allocated to the SCO were not commensurate to needs throughout the Syria crisis nor did they match other resources as they increased. During the initial two years, SCO struggled to secure funding, relying heavily on OCHA funding until 2013 when the funding portfolio increased with the addition of DFID, ECHO and OFDA supported by Hub led resource mobilisation. This funding was pivotal for the SCO to develop programming to meet the growing humanitarian needs and the multi-year funding enabled further expansion. The addition of the Programme and Operations Support (POS) unit in 2015 reportedly brought much needed in-country capacity on resource mobilisation and grant management. [211]



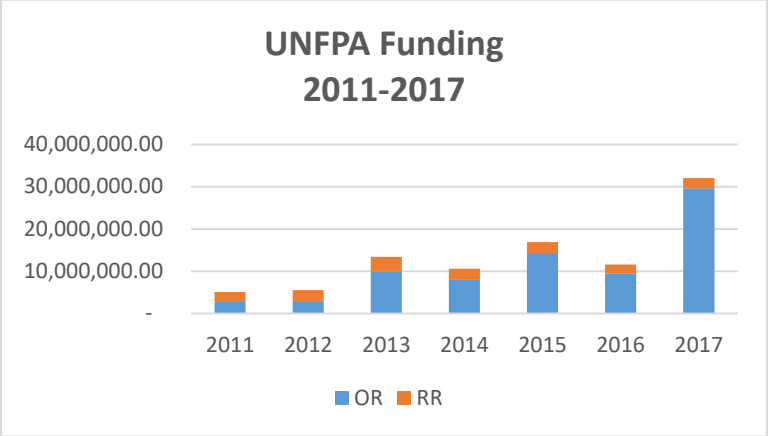
While Other Resources (OR) has increased[212], Regular Resources (RR) as a proportion of overall funds has reduced from 46% in 2011 to less 8% in 2017.[213] The re-classification of the SCO from yellow to

[211] UNFPA Key Informants.

[212] While the overall 2014 expenditure was $10,578,681.04 [OR: $7,996,718.04; RR $2,581,963.00]. the SCO mobilised $12,179,534 in funding in 2014 with the remaining amounts utilised the following year.

[213] Data provided by the SCO in July 2018. RR as a proportion of overall funds reduced from 46% in 2011; 51% in 2012; 26% in 2013: 24% in 2014: 15% in 2015:19% in 2016 to 0.08% in 2017.

orange within the UNFPA quadrant classification system[214] was delayed, the business case was initially made in 2014 *"to reclassify Syria in the orange quadrant to enable the CO to get more regular resources and focus also on capacity building"* [215,216]



Although SCO has utilised Fast Track Procedures (FTP) since the start of the crisis, their capacity to expedite procurement and recruitment was impeded in the early years by insufficient resources, technical capacity, and a lack of flexibility in the application of procedures. The FTPs were activated for the SCO in 2012 and were recently extended until November 2018 and have been used consistently during this timeframe. During the initial phase of the emergency, there was a lack of knowledge on how to apply FTPs, an insufficient number of operations personnel with adequate humanitarian experience and FTPs were utilised to their potential. [217, 218]

FTPs[219] are designed to facilitate faster responses through greater delegation of authority and flexibility in the standard policies and procedures. The application of FTPs offer – amongst other things – an opportunity for increased speed for commodity procurements during emergencies. However, knowledge of how to apply these to facilitate swifter procurements, especially internationally, is essential. Respondents noted that this lack of experience among existing staff in the early years combined with the international sanctions; the approvals needed from MOFA to import many commodities including pharmaceuticals; and the exemptions and waivers required by UNFPA resulted in significant procurement delays. [220] This negatively impacted the SCO's ability to deliver

[214] UNFPA (2018) Strategic Plan, 2018-2021 Annex 4 Business model outlines the quadrant classification system in UNFPA that divides countries of operation into four colour coded categories (Red; Orange; Yellow and Pink) with red indicating high risk and greatest needs. Country financing and modes of engagement are driven by this coding including whether countries can work on advocacy and policy dialogue; capacity development; knowledge management; partnerships and coordination; and service delivery.

[215] UNFPA (2014:5) COAR.

[216] UNFPA (2018:16) Meta-analysis of the engagement of UNFPA in highly vulnerable contexts. UNFPA Evaluation Office *"UNFPA gives priority and allocate a higher share of regular resources (approximately 60 per cent)to countries with a combination of (i) highest need and low or lower-middle level ability to finance their programme; and (ii) high need and low ability to finance (red quadrant)."*

[217] UNFPA (2012:23) COAR.

[218] Efforts to conduct a staff review were delayed until 2014 that impacted recruitment of new positions and visa constraints for international staff further aggravated the situation.

[219] UNFPA (2015:5) "The Fast Track Procedures (FTPs) are a set of procedures that offer UNFPA country offices in special situations greater delegation of authority and flexibility in specific programme and operational areas for a time-bound period… Except during a Level 3 crisis where the response capacity of the country office is severely compromised requiring global wide response, and where activation of FTPs is automatic, activation must be requested by country offices and approved by the DED Management.."

[220] UNFPA Key Informants.

humanitarian assistance. Even now, with increased human resource capacity[221] within supply chain, some international procurements take more than six months and local procurements often require waivers for each order which can be time consuming. [222] To improve supply chain functioning, the SCO is working on Long Term Agreements (LTA) for locally procured pharmaceuticals[223] that receive UNFPA approval/waivers rather than having to submit requests for each new purchase. [224]

RH kits are prepacked with the agreed contents of each kit and this has created some difficulties importing them into Syria recently. The GoS has imposed restrictions on imports from Turkey. In 2018, a shipment of supplies including RH kits were detained by customs as there were items produced in Turkey in the kits. An auxiliary issue related to the contents of the RH kits is the inclusion of HIV PEP in RH kit 3 that is not permitted to be distributed in Syria outside of MoH facilities. These cannot simply be removed from the kit as kits are pre-packaged and follow global guidelines[225] As such, the SCO worked closely with the UNFPA Procurement Services Branch (PSB) to order the contents without HIV PEP.[226] Within Syria, the MoH policy only permits HIV PEP to be provided in selected MoH selected facilities and in two hospitals in Damascus and Aleppo and cases requiring testing and treatments need to be referred to these facilities.

There are local LTAs for dignity kits that are purchased locally and regularly reviewed based on extensive consultation with women and girls and men.[227] IPs involved in kit distributions provided positive feedback and highlighted that UNFPA are responsive to concerns raised on content quality or appropriateness. The dignity kits and the RH kits are critical supplies for the inter-agency convoys. UNFPA distribution of kits has increased substantially since 2014.[228]

Table 2: RH and Dignity kit distributions 2014 -2017

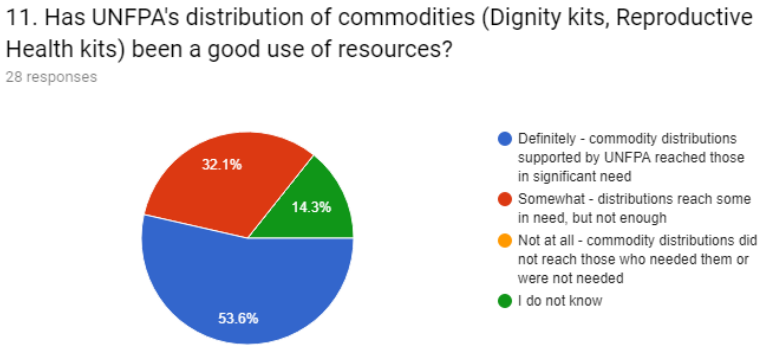
Commodities distributed	RH Kits Total	Dignity Kits Total	Female	Male
2014	368	188,969	182,419	6,550
2015	384	219,755	193,996	25,759
2016	433	310,680	294,170	16,510
2017	271	462,259	441,757	20,502
Total	**1,456**	**1,181,663**	**1,112,342**	**69,321**

Source: *UNFPA SCO 2018*[229]

[221] UNFPA Key Informants noted that until 2018, there were two staff in procurement and one in logistics and this was insufficient to support the growing operation. Part of the rationale for the increased investment in procurement was based on lessons learned from 2016 when UNFPA struggled to maintain supplies for emergency responses.
[222] UNFPA Key Informants.
[223] UNFPA (2015:31) UNFPA Fast Track Policies and Procedures " … local procurement of pharmaceuticals is only allowed under the following circumstances: The pharmaceuticals are WHO Prequalified; Where WHO PQ Prequalified pharmaceuticals are not available, the pharmaceuticals must be duly registered in the country of intended use. This is to ensure local procurement does not go against the National Regulation and Legislation and that the pharmaceuticals meet the acceptable National quality standards."
[224] UNFPA Key Informant.
[225] UNFPA (2014:20) Reproductive Health Kits Management Guidelines for Field Offices "*UNFPA has no mandate to modify the contents of the Inter Agency RH kits"* Kits are based on agreed specification from the IAWG and WHO guidelines and cannot be altered. https://www.unfpa.org/sites/default/files/resource-pdf/RH_KIT_GUIDELINES_EN.pdf
[226] The cost differential per kit is significant ($1,500 to $150 per kit without HIV PEP).
[227] UNFPA Key Informants noted that contents of the kits were revised significantly based on 2017 consultations and seven different kits were created to meet different needs in winter, summer, for girls, pregnant and lactating women, and men.
[228] Detailed data on UNFPA kit distribution was not available from the SCO prior to 2014.
[229] Data provide by the SCO in August 2018.

"When we are organising humanitarian convoys, UNFPA contribute supplies – RH kits – UNFPA is always there in terms of readiness and quantity and we have not witnessed a situation where they have not been able to deliver" [230]

The data from survey respondents concur with qualitative information from key informants with 53.6% of respondents agreeing that UNFPA commodity distributions supported those most in need with 32.1% responding that commodities reach some in need but not all.



FTPs were also applied to staffing to expedite recruitment but there were significant delays due to postponements in conducting a HR review. This was originally planned for 2012 but was delayed until 2014 and new positions for fixed term national and international staff were pending until it was completed.[231] As such, existing staff had humanitarian responsibilities added to existing tasks.[232] Between 2011 and 2014, UNFPA staffing only increased from 24 to 28 before expanding to 40 staff in 2015 and 56 in 2017. Some respondents noted an over-reliance on short term staff and surge and felt that this high turnover negatively impacted UNFPA ability to respond. Many stakeholders consulted emphasised the need for UNFPA to have *experienced, competent and dedicated* GBV and SRH coordination staff on fixed term contracts that are not double-hatting with programmatic responsibilities.[233] As the operating context continues to evolve, the evaluation team notes a need to review the current staffing structures to ensure it is adequate and *'fit for purpose'* [234] now and in the coming years to allow the SCO to keep pace with the changing environment.

There are on-going challenges in securing visas and this affects UNFPA ability to maintain existing staff[235] and bring in new international staff and consultants. These bureaucratic obstacles are further exacerbated by delays in identifying and deploying surge staff. For example, during the Eastern Ghouta crisis in 2018, the SCO requested surge support for a Humanitarian Coordinator, but no suitable candidate was available on the roster, and when one was identified outside of the roster, they deployed after the acute phase passed due to delays in visa, identification and selection process. [236]

Staff care and well-being was identified by some SCO interviewees as a significant gap by SCO interviewees considering the highly stressful environment staff operate in. Other UN agencies either have dedicated Staff Counsellors or have Arabic speaking Psychologists that visit regularly. [237]One SCO interviewee noted that *" a staff counsellor needs to be put in place for staff. We're working in a hard situation and don't have anyone to support…….we need to have them outside the office."*

[230] UN Key Informant.
[231] UNFPA (2014:5) COAR.
[232] UNFPA (2013) COAR.
[233] UNFPA and UN Key Informants.
[234] UNFPA Key Informants.
[235] During the evaluation, the visa for the one senior staff member was not renewed and the position had to be advertised to get a replacement. Some staff from other UN agencies also had the same experience and were working remotely.
[236] UNFPA Key Informants.
[237] UNFPA Key Informants.

A final issue related to efficiency is that the SCO is working with two programmatic cycles, one for Whole of Syria (WOS01) and one for the 8th Country Programme (SYR08) that do not have the same outcomes, outputs, indicators, targets or baselines. According to the SCO, considerable management of the reporting process is required to minimise the risk of double-reporting of results and report actual values for indicators due to difficulties separating fund contributions among activities. The SCO stakeholders highlighted that it is not always feasible to fund each IP or each facility from one single fund code or programmatic cycle and some are funded from both. The CO works very closely with IPs and the Hub to minimise the risk of duplication and improve accuracy in reporting, monitoring and tracking of expenditures.[238]

[238] UNFPA Key Informants.

Evaluation Question 9: Partnerships

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

Associated Assumptions:

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

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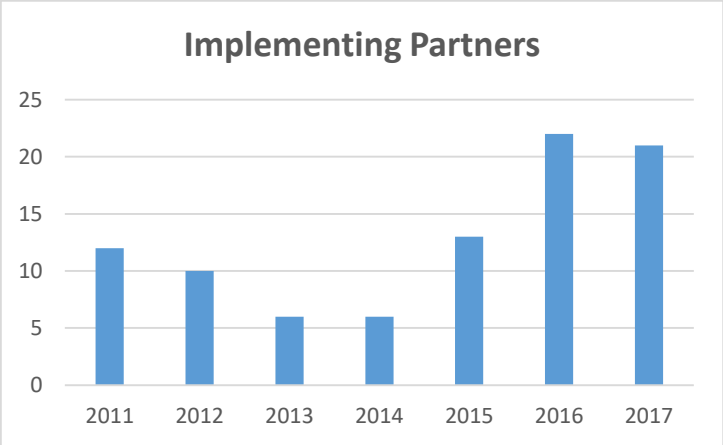
18. UNFPA has nurtured key strategic partnerships with government ministries and national NGO's that has allowed for flexible responses to new crises while diversifying partnerships to enable greater coverage and expansion. Capacity of partners and the quality of services they deliver vary.
19. There is growing confidence among donors in UNFPA ability to deliver services, access hard-to-reach areas, and conduct due diligence with partners. This has translated into increased funding.

UNFPA has nurtured key strategic partnerships with government ministries and national NGOs that has allowed for flexible responses to new crises while diversifying partnerships to enable greater coverage and expansion. Capacity of partners and the quality of services they deliver vary. UNFPA in Syria was consistently referred to as '*strong and collaborative'* by NGOs, UN and donors consulted. Overall, IPs were positive about their relationship with UNFPA and valued the partnership, capacity building, funding, flexibility and support – particularly for M&E. [239] UNFPA increased the number of IPs from 10 in 2011 to 20 in 2017. By 2013, UNFPA had reduced to six partners[240] working mainly on the humanitarian response (MoH, MoSAL, SARC, SFPA. SCFAP and MoHE) and this continued with some additions until 2015 when IPs increased to 13 then to 20 in 2017. Overall, this is a positive development that has enabled UNFPA to reach more locations and affected communities with services.



SARC and SFPCA have been two of the largest IPs since 2011 and their national coverage, in addition to SARCs lead on the humanitarian response in Syria, has enabled UNFPA to maximise coverage and facilitated emergency response capacity. UNFPA has been expanding its youth programming from two partners in 2016 to 10 in 2018 (of whom eight were existing GBV or SRH partners). Many research respondents stated that strong relationships with MoH, CBS and the SCFAP were well utilised by UNFPA.[241] In line with the qualitative findings, 64.3% of respondents to the online survey indicated that UNFPA partnership choices have been strategic and added *significant* value to its response while the remaining 32.1% felt that UNFPA partnerships added *some* value to its response.

[239] Government and NGO Key Informants.
[240] Reduction was related to the suspension of much of non-humanitarian work.
[241] UN, UNFPA, Government, Donor and NGO Key Informants.

Given the fluidity of the conflict, it is evident that a high degree of programming and partnership flexibility is required - another area where IPs expressed positive opinions about UNFPA willingness to modify projects when new needs arise. IPs consulted also noted that they valued regular meetings, planning, support on reporting, M&E and technical trainings for SRH, GBV and youth. [242] Restrictions on travel due to insecurity, access and need for government approvals limit in-person UNFPA visits, creating difficulties in assessing needs, quality of services, providing capacity building, and conducting regular monitoring. The SCO has developed remote management systems with support from the Hub and are regularly in contact with partners over Skype or WhatsApp to provide remote support. However, respondents highlighted that more intensive technical capacity building is needed to improve the quality of services.[243] Follow up with GBV partners on data collection and information management was reported to be strong by stakeholders[244] with the WoS GBV Dashboard and the Syria Protection and Community Services Sector (PCSS) PCSS Dashboard derived from this data.

Some IPs voiced frustration on the duration of the project approval processes within UNFPA and then the additional approvals that are required by MoFA that can delay start-up, though, they acknowledged that the latter was outside of UNFPA control. Insufficient funding to meet needs was identified as a challenge by some IPs though they noted that UNFPA funding has been increasing since 2015 (see Evaluation Question 8 Efficiency). The introduction of the Global Programme System (GPS) II[245], UNFPA electronic workplan management tool in quarter two of 2018, has created some confusion among partners partly as it is new and online. [246] However, training and on the job support is being provided by the SCO to all IPs to mitigate challenges.

There is growing confidence among donors in UNFPA ability to deliver services, access hard-to-reach areas, and conduct due diligence with partners. This has translated into increased funding. Donors consulted were unanimous in their praise for UNFPA work in Syria and they consider UNFPA a valued partner.[247] Strong data management and monitoring mechanisms at the WoS level from the Hub and at the SCO-level were highlighted as strengths and the SCO is regarded as proactive, transparent, and technically sound. Growing levels of funding and the donor portfolio is testament to donor confidence in UNFPA at both the Hub level and the SCO level which has been increasing its role in resource mobilisation. [248] UNFPA is also viewed as an important partner for UN joint programming and UN multi-partner trust funds. [249] Regular meetings, transparent sharing of information and needs assessments like the *Voices* report, along with regular impact assessments and evaluations were all identified as factors that build confidence in UNFPA as do the efficient utilisation of funds and good performance.

[242] NGO Key Informants.
[243] UN, UNFPA and NGO Key Informants.
[244] UN and NGO Key Informants.
[245] The GPS II allows IPs to submit Funding Authorization and Certificate of Expenditure (FACE) form to request cash advances, report on their use, request the reimbursement of expenses through an online platform.
[246] NGO Key Informants.
[247] Donor Key Informants.
[248] Donor Key Informants.
[249] UN Key Informants.

Evaluation Question 10: Effectiveness

10a: To what extent does the UNFPA 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 Theory of Change (ToC):[250]
    a. Syrian women, adolescents and youth access quality integrated SRH and GBV services:
    b. Syrian women, adolescents and youth benefit from prevention, risk reduction and social norm change programming and are empowered to demand their rights;
    c. Humanitarian community is accountable for SRH & GBV interventions mainstreamed across the overall humanitarian response.
25. UNFPA programming outputs contribute to the following outcomes articulated in the reconstructed ToC:
    a. Syrian refugee women, adolescents and youth, and affected host communities in surrounding countries access quality integrated SRH & GBV services:
    b. Syrian refugee women, adolescents and youth, and affected host communities in surrounding countries benefit from prevention, risk reduction and social norm change programming and are empowered to demand rights;
    c. Humanitarian community is accountable for SRH & GBV interventions mainstreamed across the overall humanitarian response.

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20. The UNFPA response in Syria has made significant contributions to improving access to and quality of GBV and SRH services for women, girls and youth. This is particularly evident in hard-to-reach areas and for the newly displaced populations though static services and mobile teams. UNFPA, like the wider humanitarian response, is restricted in effectiveness of delivery of services within Syria due to political, security, access, funding and partnership constraints.
21. Prevention, risk reduction and empowerment activities have been less of a focus but are an emerging priority for UNFPA.
22. GBV and SRH have been centrally positioned as lifesaving within the overall humanitarian response.

UNFPA has partially achieved the outcomes as articulated in the reconstructed ToC in relation to (a) women, girls and youth in Syria 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.

The UNFPA response in Syria has made significant contributions to improving access to and quality of GBV and SRH services for women, girls and youth. This is particularly evident in hard-to-reach areas and for the newly displaced populations though static services and mobile teams. UNFPA, like the wider humanitarian response, is restricted in effectiveness of delivery of services within Syria due to political, security, access, funding and partnership constraints. UNFPA has utilised available resources, service delivery modalities, and leveraged partnerships to advance the delivery of SRH and GBV services in locations where there is greatest need that are accessible. This is done in coordination with the HCT and based on detailed needs assessments and severity scales. Since 2016, UNFPA has

[250] see Annex VI

made substantial progress expanding geographic coverage that was facilitated by increased humanitarian access, funding and partnerships with IPs.[251] Much of UNFPA programming has been focused on immediate lifesaving responses, including cross-line assistance, during the acute phase of the crises which can be difficult to measure. [252]

Overall, evidence collected through this research[253] indicates that UNFPA has improved access to SRH and GBV services in targeted locations, using static services and mobile teams in parallel to investing in partner capacity building efforts, developing guidelines and strategies and advocacy.[254] The lack of available quantitative data against targets at the outcome levels is a significant limitation to assessing the programmatic results of the UNFPA SCO response. Output level data was provided for 2015-2017 but comparable data is lacking for the period 2011-2014. Available data was triangulated with qualitative information from key informant interviews and secondary sources. Data from 2015 – 2017 outlined below illustrates an increasing number of beneficiaries accessing services. [255] These include

- GBV services via the WGSS and mobile teams including GBV case management, psychosocial support (PSS), skills building, vocational training and referrals for health and legal assistance.
- SRH services including family planning; prevention, treatment and care for STIs; MNH including BEmOC, CEmOC, ANC, PNC; health education and counselling and early cancer detection.
- Youth services including peace building, interactive theatre, adolescent SRH, vocational training and peer education.

In addition to direct services, dignity kits were provided to 1,181,663 between 2014-2017.[256]

Table 3: UNFPA beneficiaries 2015 -2017

SCO	Total	Women	Girls	Boys	Men
2015	815,665	588,928	134,183	32,890	59,664
2016	3,084,691	2,863,948	159,091	31,779	29,873
2017	5,207,348	4,719,855	278,797	41,479	95,949
Total	9,107,704	8,243,997	572,071	106,148	185,486

Source: *UNFPA SCO 2018*[257]

The above data demonstrates significant increases in beneficiaries accessing UNFPA supported GBV and SRH services from 2015 – 2017 increasing more than six-fold from 2015 to 2017 corresponding to geographical expansion, increased funding and partnerships. These output level results exceeded the targets set in the 2016-2017 CPD. For example, the SRH target of number of women receiving SRH services was 1 million and the numbers reached were 7.38 million women and girls.[258] For GBV, there was a target related to number of facilities providing PSS with a target of 14 from a baseline of 6. By 2018, 35 WGSS, and 39 GBV/SRH mobile teams were providing PSS. The 2017 Whole of Syria HRP had a target of 1.13 million reached with GBV services and the Damascus led GBV sub-sector partners reached 1.21 million[259] of which a total of 432,033[260] were supported by UNFPA SCO programming.

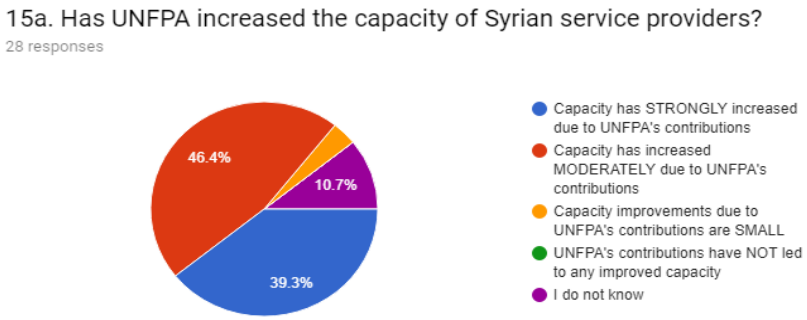
[251] Evidence from interviews with key stakeholders including UN, NGO and donors and review of financial data, coverage of services and beneficiaries' targets.
[252] UNFPA COAR 2015-2017
[253] Review of beneficiary data, impact assessments, evaluations and interviews with key stakeholders.
[254] Evidence from interviews with key stakeholders and recent independent evaluations on GBV and SRH services in Syria.
[255] This is taken from raw data provided by UNFPA that is available for beneficiaries by sector/partner and service.
[256] Data provide by the SCO in August 2018.
[257] Data provide by the SCO in August 2018.
[258] From a total of 7,435,633 including 49,680 men and boys (based on data from SCO in August 2018)
[259] http://www.ocha-sy.org/4wspresence.html
[260] Data provide by the SCO in August 2018.

Additionally, out of the 12.3 million[261] medical treatments provided by the health sector inside Syria in 2017, UNFPA SCO supported 4.63 million[262] SRH services.

UNFPA has demonstrated flexible and innovative approaches in programming including promoting GBV and SRH integration, using mobile teams, youth programming and rolling out the adolescent girls' strategy. Capacity building for partners is an area of increasing focus to improve and harmonise the quality of services and transition these beyond emergency responses. Based on findings from this research, it was identified as a priority as the SCO response progresses. [263]

Overall satisfaction with assessed services among beneficiaries was reviewed as part of two evaluations in 2017, with 90% of clients who received services at the SRH clinics being *satisfied* or *very satisfied* about the services with variance across static clinics (95%) and mobile teams (81%).[264] For WGSS, overall satisfaction on services in the safe spaces (91%) between *very satisfied* and *satisfied*.[265]

Survey data also reinforces this with 85.7% of survey respondents reporting that UNFPA had strongly or moderately improved the capacity of Syrian service providers.



Prevention, risk reduction and empowerment activities have been less of a focus but are an emerging priority for UNFPA. For GBV and SRH, the provision of immediate response services has taken precedence and there has been less focus on prevention or risk mitigation. Since 2016, UNFPA has been supported more work on prevention and risk reduction through the distribution of dignity kits, trainings on the GBV Guidelines, community outreach and awareness raising, and skills building. [266,267]. Community outreach and awareness raising on GBV prevention and risk mitigation is becoming a larger component of UNFPA partners approaches. [268] Between 2015-2017, 543,395 men, women, boys and girls out of the overall 9,107,704 beneficiaries participated in awareness raising and outreach with annual increments from 134,010 in 2015 to 165,535 in 2016 to 243,850 in 2017. Given the overall increase in utilisation of services, awareness raising and outreach activities were successful in facilitating access to services.

Youth programming which includes a range of educational activities, campaigns, interactive theatre, skills building and peer to peer learning reached more than 142,533 young people and is a growing

[261] http://www.ocha-sy.org/4wspresence.html
[262] Data provide by the SCO in August 2018.
[263] UNFPA, UN and NGO Key Informants.
[264] EREC (2017:33) Evaluation Study for Reproductive Health Facilities.
[265] EREC (2017:47) Evaluation Study For Women and Girl Safe Space in Syria.
[266] UNFPA, UN and NGO Key Informants.
[267] UNFPA COAR 2016 and 2017 and 2016-2017 CPD
[268] UNFPA, UN and NGO Key Informants.

area for the SCO. As the situation evolves, UNFPA is concentrating more on skills building, vocational training and empowerment for women, girls and youth to improve resilience. [269,270]

GBV and SRH have been centrally positioned as lifesaving within the overall humanitarian response in Syria. Strong leadership and advocacy from UNFPA have been instrumental in promoting the acceptance of GBV and SRH as front-line components of the humanitarian response. The confluence of senior level support, improved humanitarian access, technical skills and resources that were underpinned by strong needs assessments like *Voices* solidified this. [271]

Although SRH interventions (both integrated and standalone) are an essential part of the humanitarian response, GBV has been more visible than SRH within coordination and advocacy. [272] In part, this is related to the higher proportion of GBV staffing at the SCO and Hub (coordination and programme), presence and functioning of the GBV sub-sector and a high level of awareness among key stakeholders on GBV patterns and risks emanating from *Voices* and strong advocacy.[273] This acknowledgment of GBV as a lifesaving priority has gained momentum since 2015[274] and the 2018 Whole of Syria HRP makes specific commitment that:

> *"Project review and prioritization will ensure gender considerations are taken into account, including through the use of the IASC Gender Marker and the IASC GBV guidelines"*[275]*.*

During the early years of the crises, UNFPA focused on the provision SRH including safe delivery services, training of service providers on MISP and emergency obstetric care. [276] [277] GBV became more of a focus as the crisis evolved and scaled up significantly from 2014 onwards both as standalone and through integration with SRH. GBV and SRH emergency teams are included as part of the immediate response to people living in UN-declared besieged and hard-to-reach areas.[278] The UNSF also makes commitments to addressing GBV and SRH needs of women and girls.[279]

Findings from this research indicate that advocacy by UNFPA with the HCT and GoS to address protection concerns affecting women and girls has made considerable contributions to increasing awareness on GBV as a critical priority and entrenched it across the humanitarian response. [280]

[269] UNFPA Key Informants.
[270] Donor proposals 2017-2018
[271] UN, UNFPA, Government, Donor and NGO Key Informants.
[272] UN, UNFPA, Government, Donor and NGO Key Informants.
[273] UN, UNFPA, Government and Donor Key Informants.
[274] UNOCHA Whole of Syria HNO 2015-2018 and SAR HRP 2016-2016
[275] UNOCHA (2018:18) Whole of Syria HRP
[276] UNFPA Key Informants.
[277] UNFPA 2011-2013 COAR
[278] UNOCHA (2018:14) Whole of Syria HRP
[279] UN (2016) Strategic Framework for Cooperation between the Government of the Syrian Arab Republic and the United Nations 2016-2017 "Output 2.1: People have equitable access to quality health and nutrition services with a focus on vulnerable groups." and "Output 3.2: Social and economic needs of the most vulnerable groups are identified and addressed"
[280] UN, UNFPA, Government, Donor and NGO Key Informants.

Key Conclusions

Key conclusions are split between conclusions for the SCO and conclusions to be considered more broadly across UNFPA.

Key conclusions for the **UNFPA Syria Country Office** cut across Findings for Evaluation Questions 1 (Key Conclusion B); Evaluation Question 2 and 3 (Key Conclusion C); Evaluation Question 4 (Key Conclusion D and E); Evaluation Question 5 and 6 (Key Conclusion F); Evaluation Questions 8 and 9 (Key Conclusion G); and Evaluation Question 10 (Key Conclusion A and G).

A. UNFPA has made substantial strides in expanding programming responses, field operations and presence outside of Damascus since 2015 and this is improving their overall response capacity. Overall, the current UNFPA response in Syria presents an interesting mix of stand-alone and integrated GBV and SRH services, youth programming, cross-line assistance, robust remote data management and remote support for programming as well supply capacity.

B. UNFPA responses in Syria are responsive to needs identified and are strongly aligned to the wider humanitarian response plans. The provision of integrated GBV and SRH services as well as stand-alone interventions builds on UNFPA strengths and provides an opportunity for learning. The integrated approach has allowed for greater flexibility in modalities, broader coverage and increased services. However, it is important that integration does not narrow the scope of GBV responses to SRH only but allows adequate space for comprehensive GBV services including case management, PSS, empowerment as well as prevention and risk reduction. As the situation stabilises in some locations, modalities for service delivery and approaches require further review.

C. Since 2015, the SCO has increased its capacity to respond to evolving needs and adapt interventions to the various realities including spontaneous returns, fresh displacements, newly accessible, and besieged areas. However, responding to these multiple and often simultaneous emergencies often takes attention and resources away from more stable locations. As more areas became accessible from Damascus, the SCO is under increasing pressure to disperse finite resources to even larger areas. There is a growing recognition within the SCO on the need to develop plans and strategies to guide responses beyond the acute emergency phase. Limited capacity of partners, growing geographic areas and burgeoning needs demand considerable technical and financial investment from UNFPA that needs be sustained. To the extent that humanitarian access, security, funding, and partner coverage allow, UNFPA has been proactive in getting services and supplies to those areas most in need. They have provided significant support for cross-line assistance and UNFPA supported partners are consistently among the first responders in newly accessible areas.

D. Youth is a critical and politically charged issue within Syria and UNFPA has been successful in positioning itself as a lead through the youth taskforce and partnership with the GoS and prising open a space for youth engagement. UNFPA is approaching this cautiously and linking youth programming to existing GBV and SRH services and connecting it to their global responsibilities on UNSCR 2250 and the Youth Compact. Greater efforts are required to solidify this space and create more opportunities for meaningful engagement with civil society on youth issues and address their underlying needs, vulnerabilities, risks and marginalisation. This could include establishing and inter-agency youth taskforce for coordination and advocacy and scaling up youth activities.

E. While there has been considerable investment in GBV coordination, at the Hub and SCO level, SRH coordination has been neglected and this has impacted the visibility and attention to SRH within

the humanitarian response as evidenced by the lack of a dedicated SRH WG and absence of a dedicated SRH Coordinator until 2018.

F. UNFPA does a commendable job in maintaining partnerships with key government ministries and finding opportunities to engage in resilience and systems strengthening work to the extent that the political and funding limitations allow. The SCO has the unenviable task of finding the middle ground between responsibilities under the WoS architecture and those that accompany UN agencies operating under a host government which can be at odds with each other. As the coverage from Gaziantep and Amman continue to decrease, this requires significant manoeuvring to advance UNFPA mandate in line with humanitarian principles.

G. UNFPA has increased their partnerships since 2015 and this has made considerable contributions to expanding services which demonstrate a six-fold increase in beneficiaries in 2017 as compared to 2015. UNFPA has been strategic in their selection of partners and modalities to maximise coverage with available resources. However, high turnover of staff, continued geographical expansion that requires new partners, and the need to adapt approaches from acute emergency responses to protracted situations underscore the necessity to have a robust strategy to provide technical support to IPs that goes beyond training. Despite on-going efforts to further expand programming, the funding available (albeit increasing) within UNFPA and capacity of partners constrains growth.

One key conclusion for **UNFPA global consideration** emerging from the Syria research which requires reflection at a corporate level.

1. Insufficient investment in human, technical, financial and operational resources proportionate to the needs and scale of the crisis significantly impeded responses until 2015.The allocation of core resources were inadequate for the scale of the Syria crisis and were insufficient to support a) GBV and SRH coordination responsibilities b) operational expansion including human, technical, physical and other resources needed sustain increasing field offices c) stockpile supplies including pharmaceuticals and RH kits. Low levels of core resources expose UNFPA to deviations in funding flows and they lack adequate cushioning to absorb any shocks. This was evident in shortfalls following the withdrawal of OFDA funding.

Suggestions for Recommendations

Key suggested recommendations at the **UNFPA Syria Country Office:**

A. The SCO should review programming approaches and take stock of current and future needs. This should include a detailed capacity building strategy for IPs, greater economic empowerment components, skills building, resilience and recovery programming in addition to systems strengthening. UNFPA should continue to increase its focus on adolescent girls under the WoS Adolescent Girls Strategy and use this as an opportunity to capitalise on SRH, GBV and Youth expertise in Syria. Opportunities to develop innovative responses to address the demographic shifts caused by the conflict and promote transformative gender norms should be prioritised. (Links to Conclusion A, B, C and D)

B. In recognition of the capacity gaps among partners and the demands to expand geographically in addition to transitioning from emergency responses, the SCO should:
   - Strengthen capacity building for IPs and develop a systematic strategy that goes beyond trainings, especially for new GBV partners. (i.e. on the job mentoring, using remote technology to support, field visits/exchanges etc.). Adopting a model where UNFPA partner with a strong international NGO to provide intensive capacity building or increasing SCO staffing so there are sufficient and experienced internal resources to dedicate to capacity building are options that should be explored. (Links to Conclusion B, C and G)

   - Review existing GBV and SRH integration including mobile responses to assess its overall functioning, effectiveness and identify any gaps or areas for improvement. This should enable UNFPA to further define guidelines for GBV and SRH integration during the acute and protracted phases as well as provide guidance for mobile teams to improve functioning and provide lessons learnt and good practices for application in other humanitarian settings. (Links to Conclusion A, B and C)

C. To address the impasse on CMR, UNFPA, in collaboration with the health sector, should utilise regional and HQ expertise to re-engage with the GoS to develop a strategy to make CMR accessible in line with survivor centred principles. Additionally, they should expand health responses beyond CMR and increase services for health consequences of other forms of GBV. (Links to Conclusion B and E)

D. As part of the development of the new CPD, the SCO, with support from the regional office, should review staffing structures in line with expansion plans so that SCO can keep pace with the changing operating environment with sufficient technical, programmatic, and operational capacity. Operational and programmatic expansion needs to be matched with human, technical and operational resources required to support the continued growth. (Links to Conclusion G)

E. Conduct a review of UNFPA Syria to capture good practice and lessons learned from operations, programming and coordination that can be applied in other humanitarian responses to improve capacity and understanding on what is required to provide front-line responses. (Links to Conclusion A, C, G and overall Conclusion 1)

Key suggested recommendations for the **UNFPA Regional Hub and Regional Office**:

1. Taking into consideration the diminishing humanitarian responses from the Amman and Gaziantep hubs and increased coverage from Damascus, the SCO, the Hub and the RO's should develop realistic plans based on likely scenarios for the immediate future. This should include a

detailed outline of resources required to support different scenarios, clarity roles and responsibilities for the SCO and the Hub and be aligned to the plans of the wider humanitarian response. (Links to Conclusion F and G)

2. UNFPA, through funding from core resources at the Hub or RO, should deploy a staff counsellor/Psychologist to support the SCO on a regular basis both in-person and remotely.

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

1. As the SCO assumes greater responsibility for UNFPA responses within Syria, core resources need to be increased to enable them to adequately expand operations and programming proportional to needs. (Links to Conclusion G and overall Conclusion 1)

2. At the HQ level, UNFPA should clearly communicate to country offices their global position on PSEA and outline clear parameters for engaging with and supporting in-country efforts on PSEA including leadership of the PSEA mechanisms and networks.

3. UNFPA should develop institutional capacities and policies at the HQ level to ensure that staff counsellor/Psychologists are available to all staff especially those operating in high risk environments.

4. UNFPA should review technical, human and financial investment in GBV and SRH coordination responsibilities with a view to resourcing these positions and related coordination activities from core resources. This should facilitate the recruitment of experienced and dedicated GBV and SRH coordination staff on fixed term contracts that are not double hatting. (Links to Conclusion E)

Annex I: List of Key Informants

No.	Name	Title	Agency	Office	Country	Gender
1	Francesca Paola Crabu	GBV Coordinator/GBV Sub Sector coordinator	UNFPA	Damascus	Syria	F
2	Hala Al-Khair	RH officer	UNFPA	Damascus	Syria	F
3	Yamameh Esmaiel	M&E Analyst	UNFPA	Damascus	Syria	F
4	Khaldoun Al Assad	Head of Aleppo sub-office	UNFPA	Aleppo	Syria	M
5	Dr Victor Ngange	RH Coordinator	UNFPA	Damascus	Syria	M
6	Huda Kaakeh	GBV Programme Analyst	UNFPA	Aleppo	Syria	F
7	Widad Babikir	GBV Specialist	UNFPA	Damascus	Syria	F
8	Omar Ballan	Assistant Rep	UNFPA	Damascus	Syria	M
9	Mohammed Zaza	M&E Analyst	UNFPA	Damascus	Syria	M
10	Dr. Rewa Dahamn	Health Officer	UNHCR	Damascus	Syria	F
11	Pilar Gonzalez Rams	Protection Officer	UNFPA	Damascus	Syria	F
12	Francois Landiech	Humanitarian Affairs Officer	SIDA	Beirut	Lebanon	M
13	Lara Babbie	First Secretary	Canada	Beirut	Lebanon	F
14	Elisabetta Brumat	Protection Sector Coordinator	UNHCR	Damascus	Syria	F
15	Chamith Fernando	Deputy Representative	UN Habitat	Damascus	Syria	M
16	George Qitini	Director	Syrian Enterprise Business Centre	Damascus	Syria	M
17	Dr. Lama Moakeaa	Coordinator	Syrian Family Planning Association	Damascus	Syria	F
18	Julien Buha Collette	Technical Assistant	ECHO	Beirut	Lebanon	M
19	Akiko Suzaki	Deputy Country Director	UNDP	Damascus	Syria	F
20	Azret Kalmycov	Health Sector Coordinator	WHO	Damascus	Syria	M
21	Khawla Akel	Head of Office/GBV Specialist	UNFPA	Homs	Syria	F
22	Dr Yasser Joha	RH Trainer/Consultant	UNFPA	Damascus	Syria	M
23	Antria Spyridou	MHPSS Coordinator	IMC	Damascus	Syria	F
24	Sara Maliki	GBV subsector IM	UNFPA	Damascus	Syria	F
25	Rania Hadra	Head of the UN Coordination Support Office	RCO	Damascus	Syria	F
26	Kehkashan Beenish Khan	Child Protection sub-sector Cordinator	UNICEF	Damascus	Syria	F
27	Fadwa Murad	Director	Syrian Computer Society	Damascus	Syria	F
28	Dr. Hassan Khansa	Medical Services Advisor	AKF	Hama	Syria	M
29	Dr. Reem Dahman	Head of RH Department	MoH	Damascus	Syria	F
30	Kristele Younes	Head of Office	UNOCHA	Damascus	Syria	F
31	Alessandra Dentice	Deputy Representative	UNICEF	Damascus	Syria	F
32	Massimo Diana	Representative	UNFPA	Damascus	Syria	M
33	Wesam Naser	Operations Manager	UNFPA	Damascus	Syria	M
34	Nada Naja	Youth and RH Specialist	UNFPA	Damascus	Syria	F
35	Radu Adrian Tirlea	Procurement Analyst	UNFPA	Damascus	Syria	M

36	Dr. Iman Bahnasi	Child Survival & Development	UNICEF	Damascus	Syria	F
37	Mahmound ALKawsa	International Cooperations Manager	MOSA	Damascus	Syria	M
38	Mateen Shaheen	Former Deputy Rep	UNFPA	Damascus	Syria	M
39	Mona Shaikh	Head of Nutrition	WFP	Damascus	Syria	F
40	Marta Perez del Pulgar	Deputy Representative	UNFPA	Damascus	Syria	F
41	Grace Hauranieh	Head of POS Unit	UNFPA	Damascus	Syria	F
42	Garik Hayrapetyan	International Programme Manager	UNFPA	Damascus	Syria	M
43	Mr. Ammar Ghazali	Director of Developmental Media Dep	Ministry of Information	Damascus	Syria	M
44	Waddah Rakkad	Director of Policies	Syrian Commission for Family Affairs and Population	Damascus	Syria	M
45	Nour Hamouri	Director of Technical Cooperation	Central Bureau of Statistics	Damascus	Syria	F
46	Yahia Joumaa	Director of Planning and International Cooperation	Central Bureau of Statistics	Damascus	Syria	M
47	Eng. Mamoun Muty	Head of Board	Al Bir Association Hama	Hama City	Syria	M
48	Mr. Ibrahim Al Kahlidi	Head of Board	Al Bir Association Qamishly	Qamishly /Hassakeh	Syria	M
49	Fadia Addeh	Head of Organization	Pan Armenian Charitable Association(PACA)	Qamishly /Hama	Syria	F
50	Awad Al Haro	Head of Board	Al Ihsan Charitable Association	Qamishly /Hassakeh	Syria	M
51	Saeed Khider	Head of Board	Al Yamamah Association	Hassakeh	Syria	M
52	Fadi Jresh	Director-General/Senior Programs Manager	Greek Orthodox Patriarchate	Damascus	Syria	M
53	Ghader Qara Bolad	Project Coordinator	Aoun for Relief and Developments	Homs	Syria	M
54	Alaa mahdi	Project coordinator	Al Tamayoz	Damascus	Syria	F
55	Samer Alfaqeer	Project Manager	SSSD	Damascus	Syria	M
56	Roi Mosally	Executive Director	SSSD	Damascus	Syria	M
57	Wassim Mando	Project FP	Aoun	Homs	Syria	M
58	Yara Rostum	Project Manager	Al- Batoul	Tartus	Syria	F
59	Mohammed Osama Al-jaber	Chairman	Masyaf Charitable Association (MSF)	Mesyaf	Syria	M
60	Hussein Alkash	Project Manager	Al Bir and Al-Ihsan Charitable Association in Ras Alain (BICA)	AlHasakeh	Syria	M
61	Jouma Azzi	Project Manager	BICA	AlHasakeh	Syria	F
62	Susan Kassam	Deputy Head of Board	Nour Foundation for Relief and Development (NFRD)	Damascus	Syria	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 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 comparative strengths compared to other actors? How do you know this? Evidence?
Q9 – Is there evidence that the UNFPA response has adapted over time based on its comparative strengths compared to other (changing) actors? Evidence?

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

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

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

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

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

Q25 – Has surge been used? What were the benefits? What challenges have there been?
Q26 – How has commodity procurement (i.e. dignity kits, and RH kits) contributed to the overall response? What are the benefits? What challenges have there been?
Q27 – What impact has multi-year funding opportunities had on the UNFPA response?
Q28 – How has UNFPA used partnerships strategically? Evidence?

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

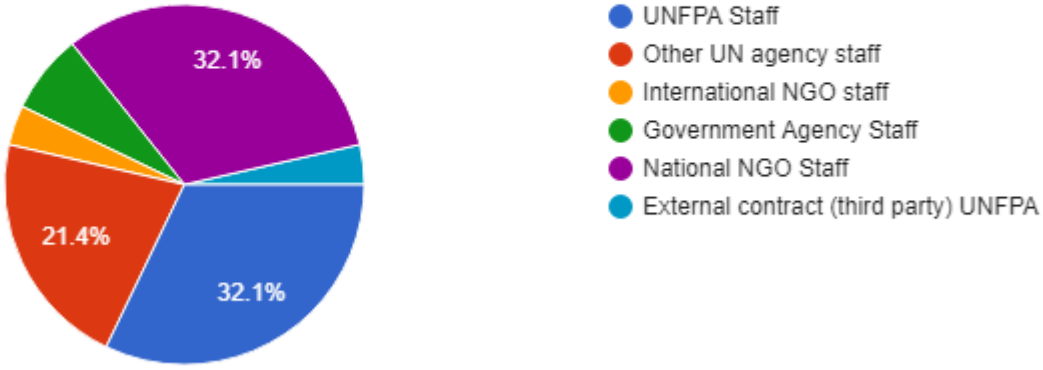
Notes:
Questions are not defined as a formalised interview process with all questions being asked in order. The key informant interview is a semi-structured process with the questions providing
Evaluation Team Members should select questions as per relevant to specific KII, grouped as:

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

Annex III: Survey Results

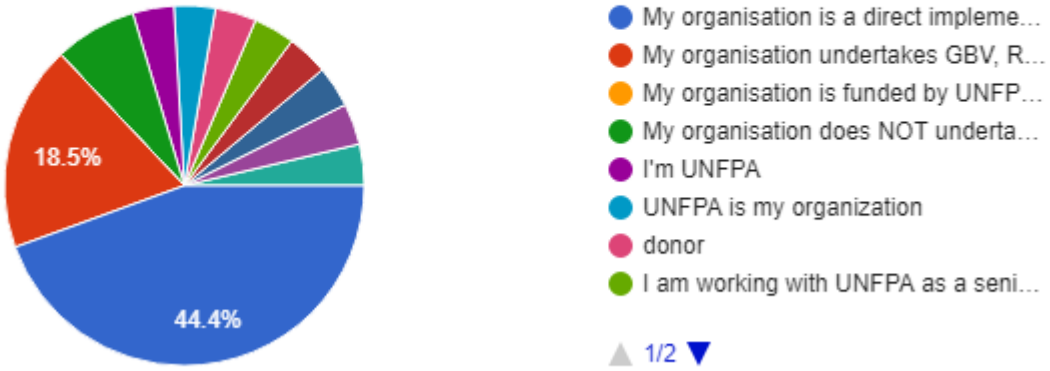
What is your organisational role in the Syria Humanitarian Response?

28 responses



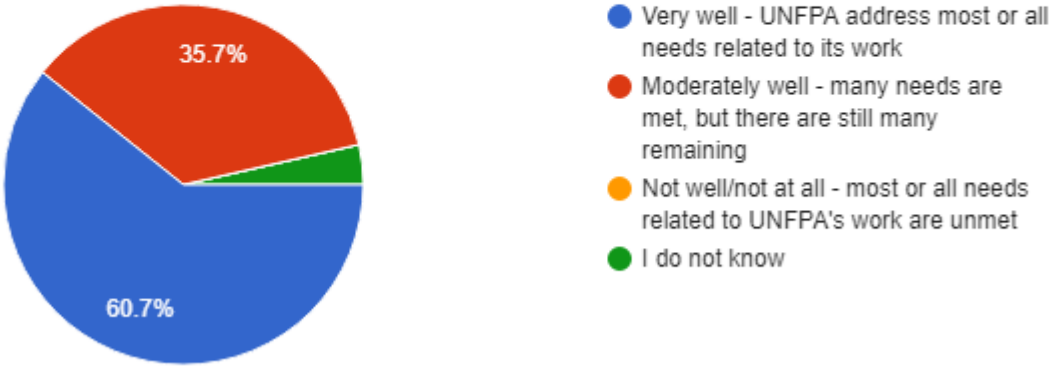
1. How does your organisation's humanitarian work relate to UNFPA?

27 responses



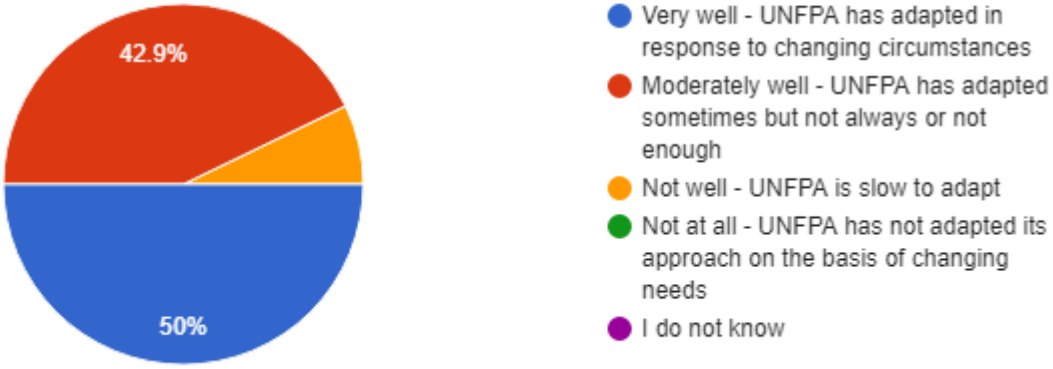
2. How well do you think the UNFPA response addresses stated needs of individuals and communities? (Please indicate on the scale)

28 responses



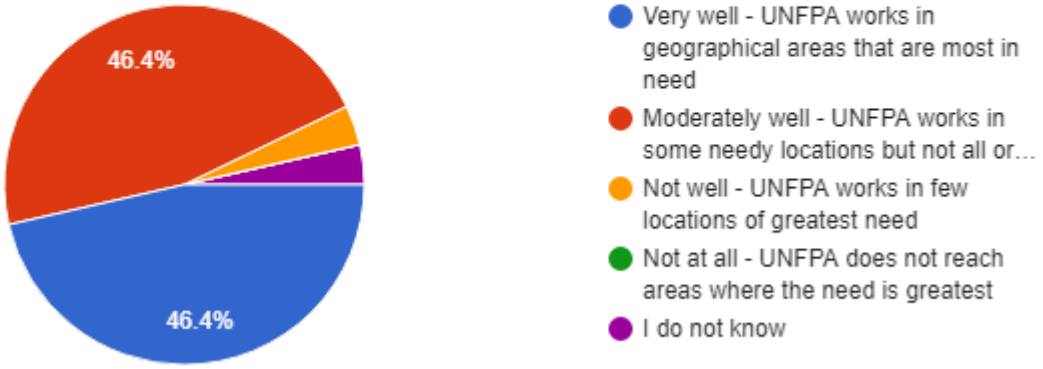
3. How well has the UNFPA response adapted OVER TIME based on the needs of people?

28 responses



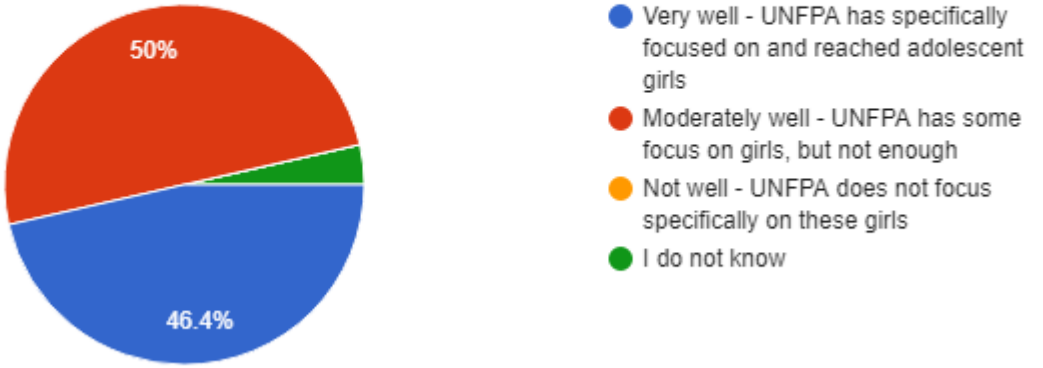
4. How well has UNFPA reached those most in need – geographically?

28 responses



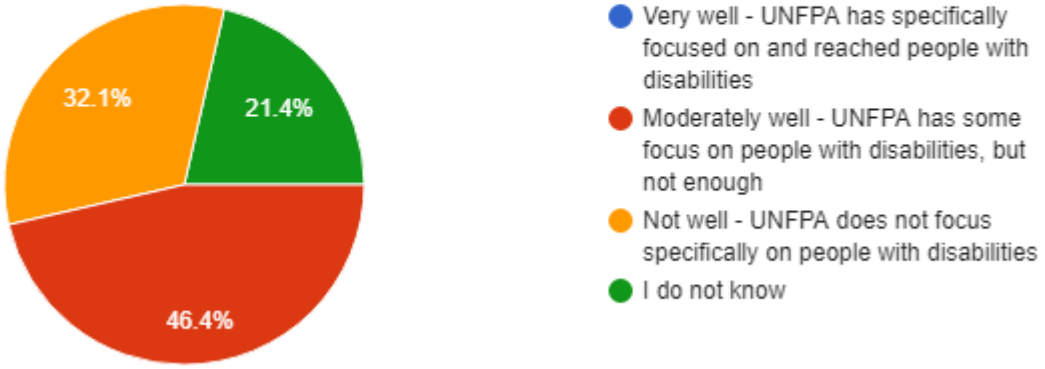
5a. How well has UNFPA reached vulnerable adolescent girls?

28 responses



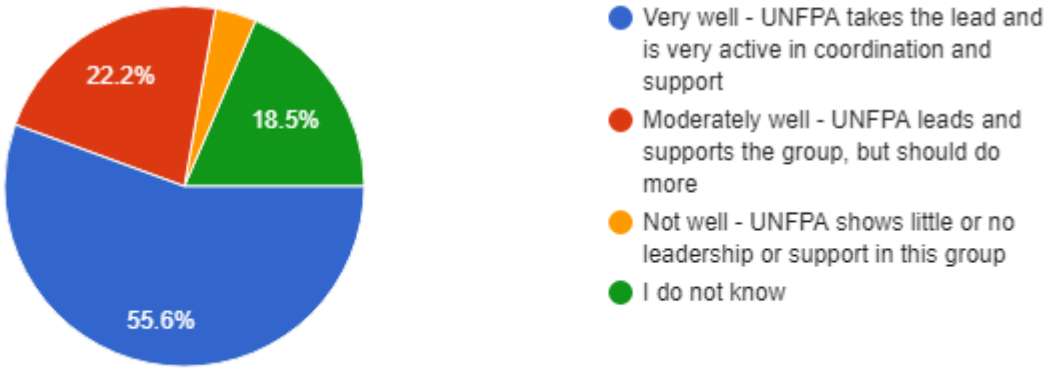
5b. How well has UNFPA reached vulnerable people with disabilities?

28 responses



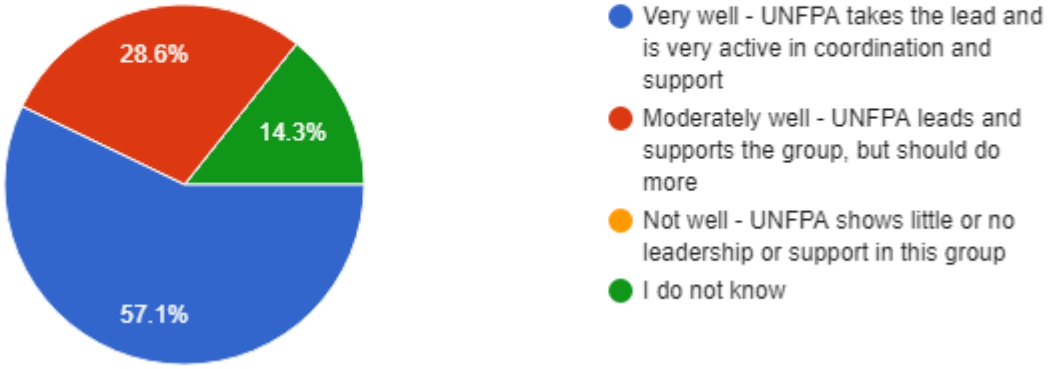
6. How well has UNFPA led and supported the Reproductive Health Working Group?

27 responses



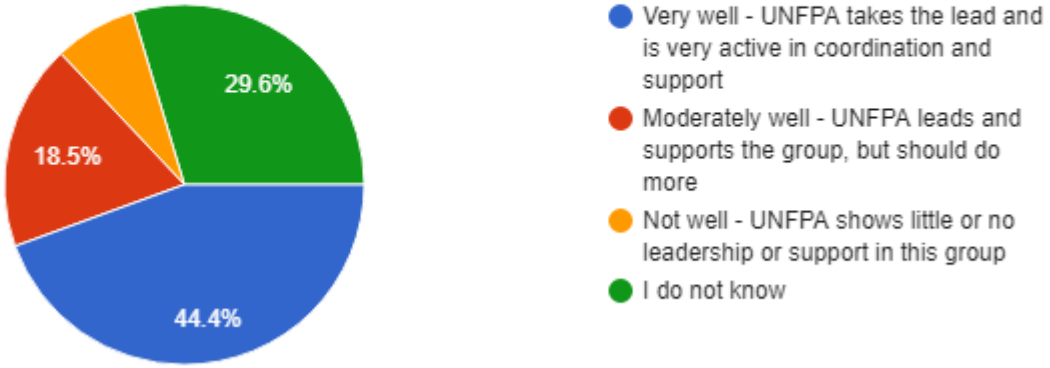
7. How well has UNFPA led and supported the GBV Subcluster?

28 responses



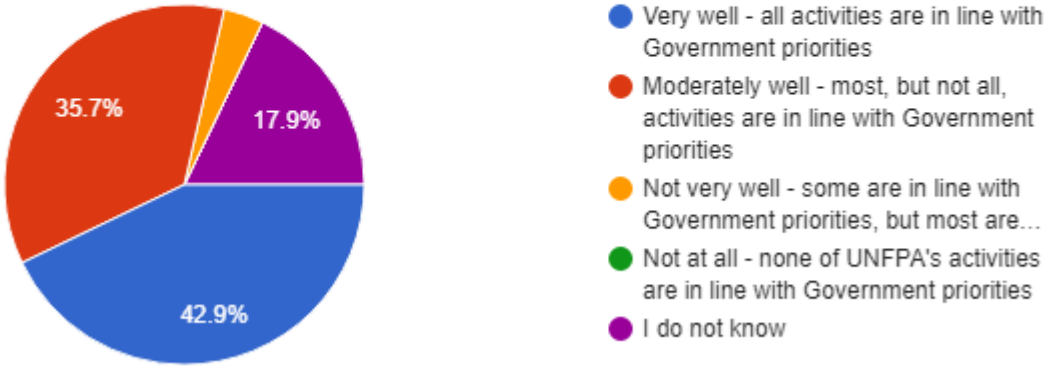
8. How well has UNFPA led and supported the Youth Working Group?

27 responses



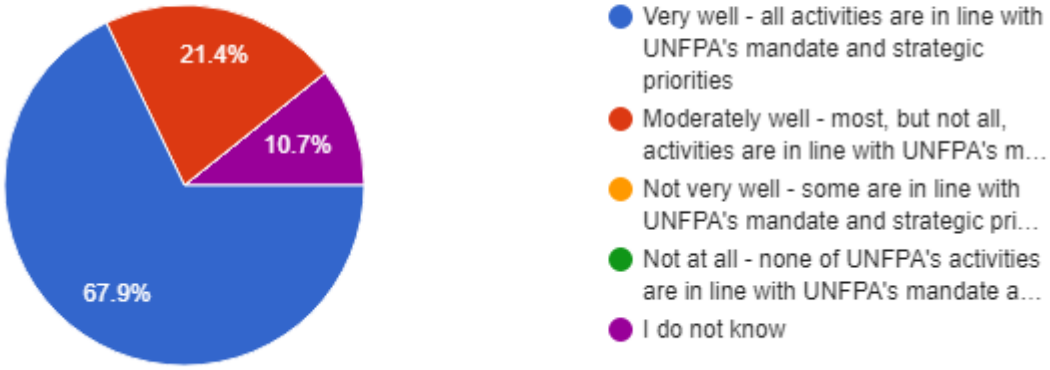
9a. How well does the UNFPA response align with national Government priorities?

28 responses



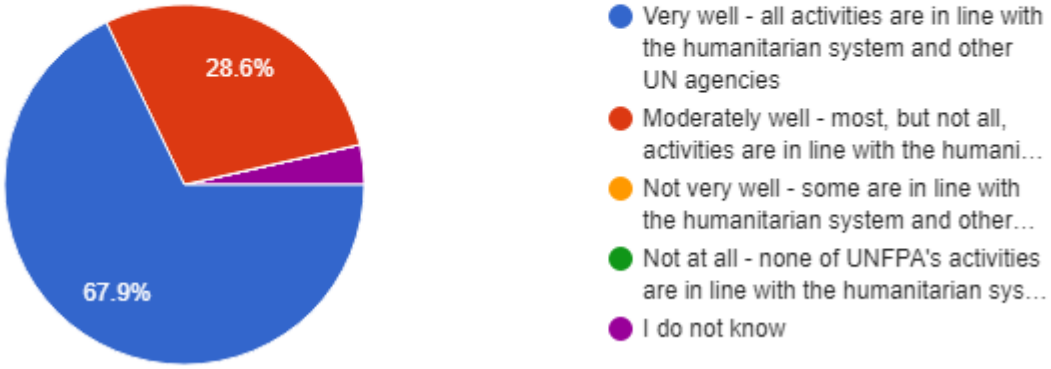
9b. How well does the UNFPA response align with wider UNFPA priorities?

28 responses



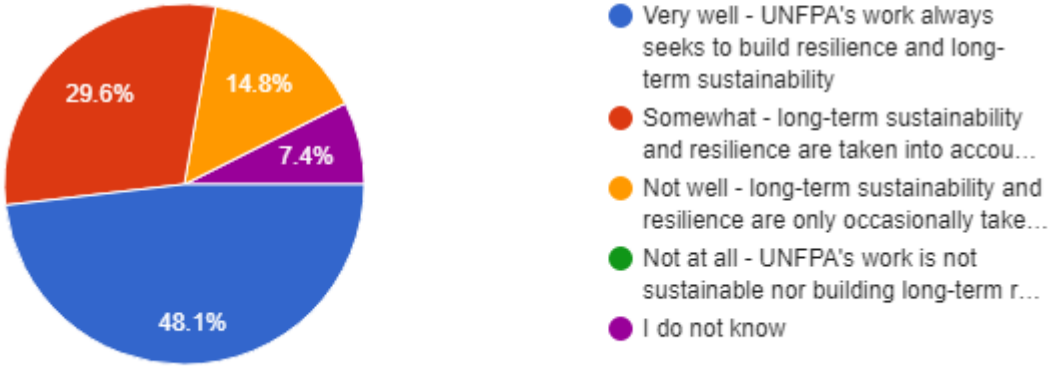
9c. How well does the UNFPA response align with the humanitarian system and other UN agencies?

28 responses



10. How well does the UNFPA response promote resilience, sustainability, and working towards the humanitarian-development continuum?

27 responses

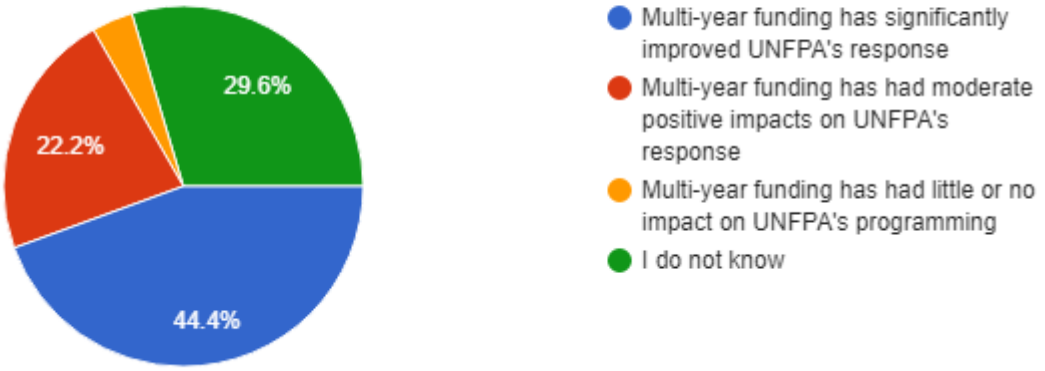


11. Has UNFPA's distribution of commodities (Dignity kits, Reproductive Health kits) been a good use of resources?

28 responses

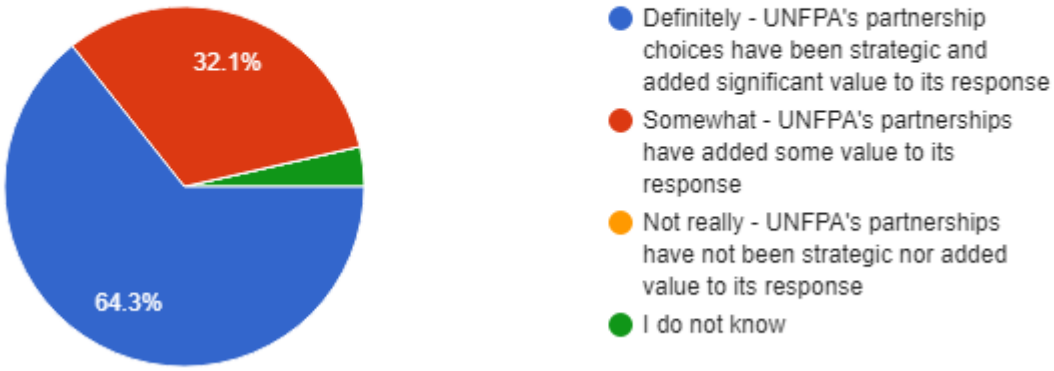
12. Has multi-year funding affected UNFPA's humanitarian response?

27 responses

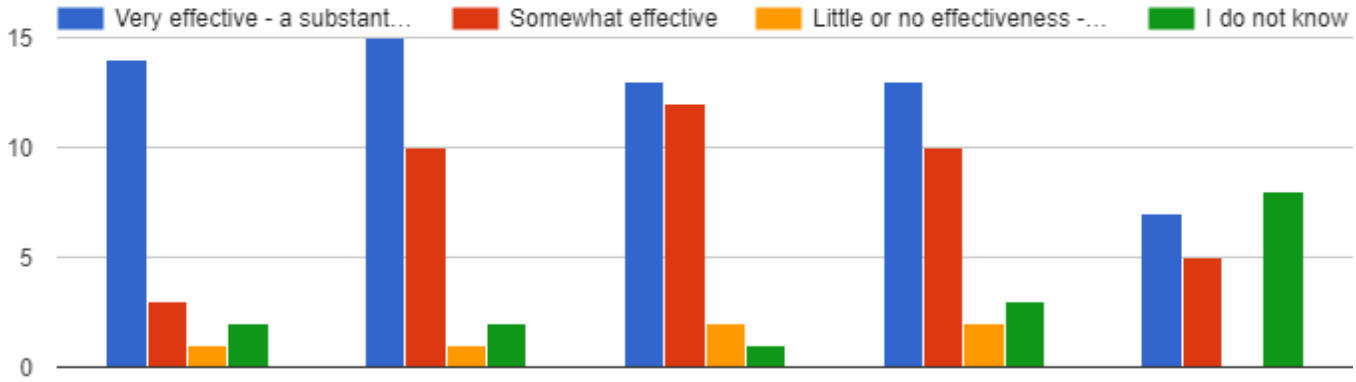


13. Has UNFPA used partnerships strategically?

28 responses

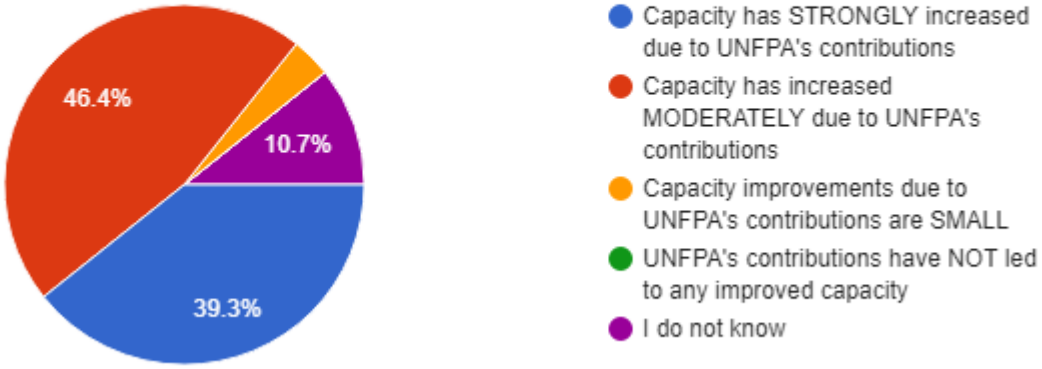


14. How effectively has UNFPA provided quality services inside the Syrian Arab Republic?



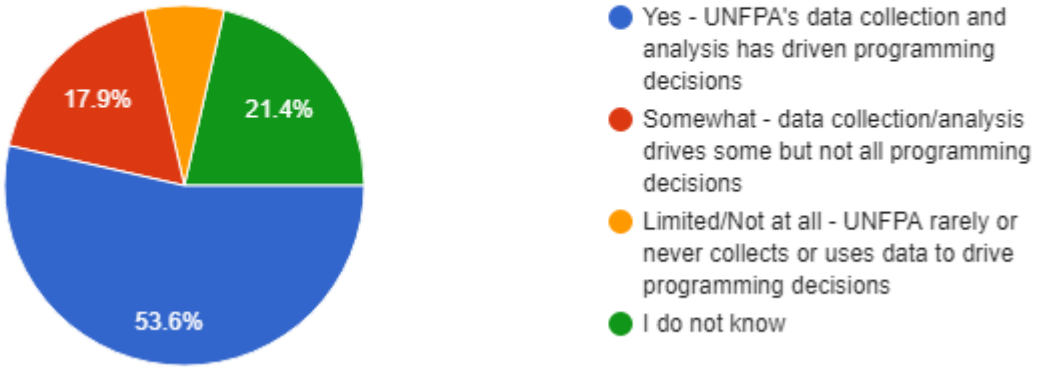
15a. Has UNFPA increased the capacity of Syrian service providers?

28 responses

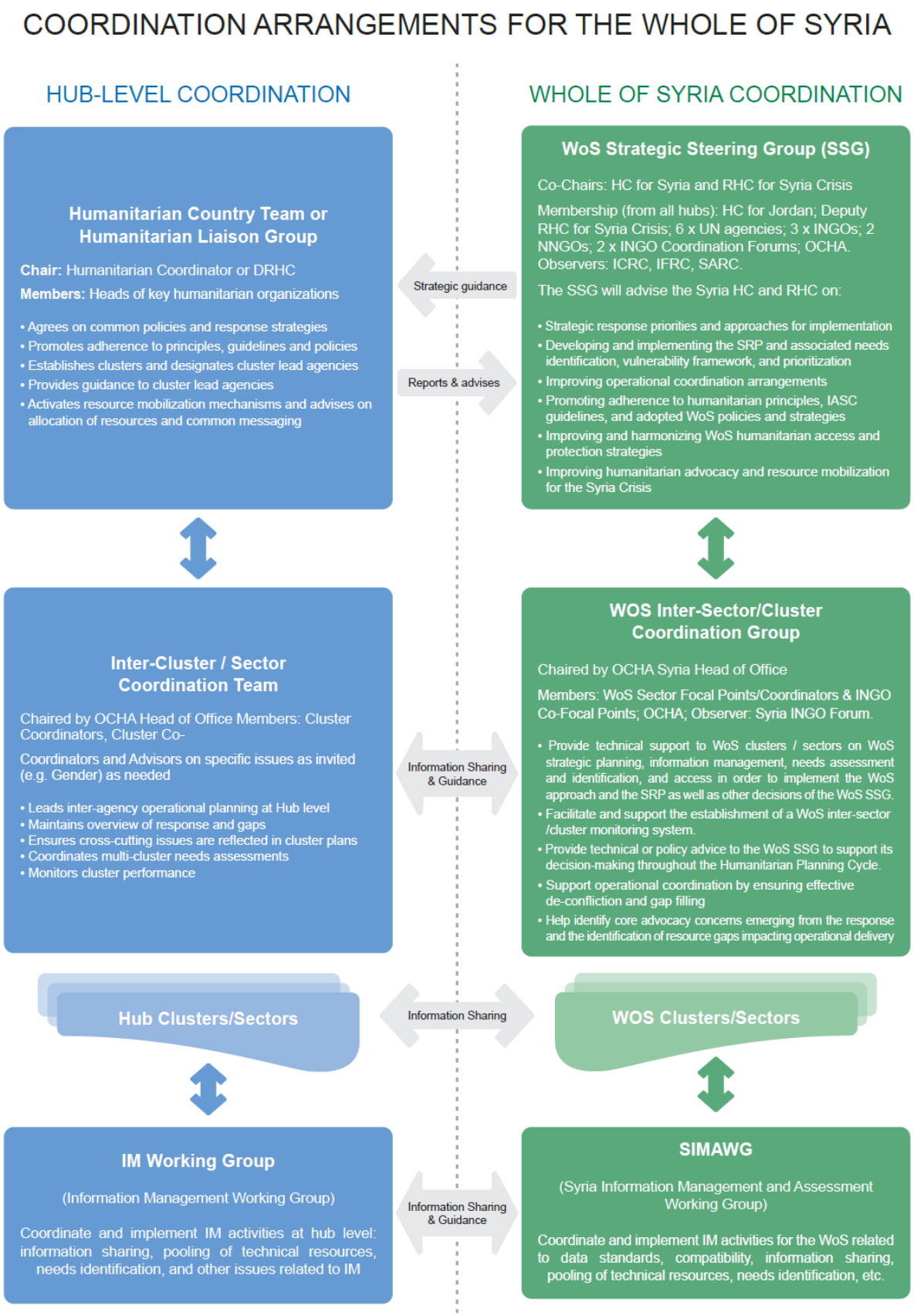


15b. Has UNFPA used robust data to inform programming?

28 responses

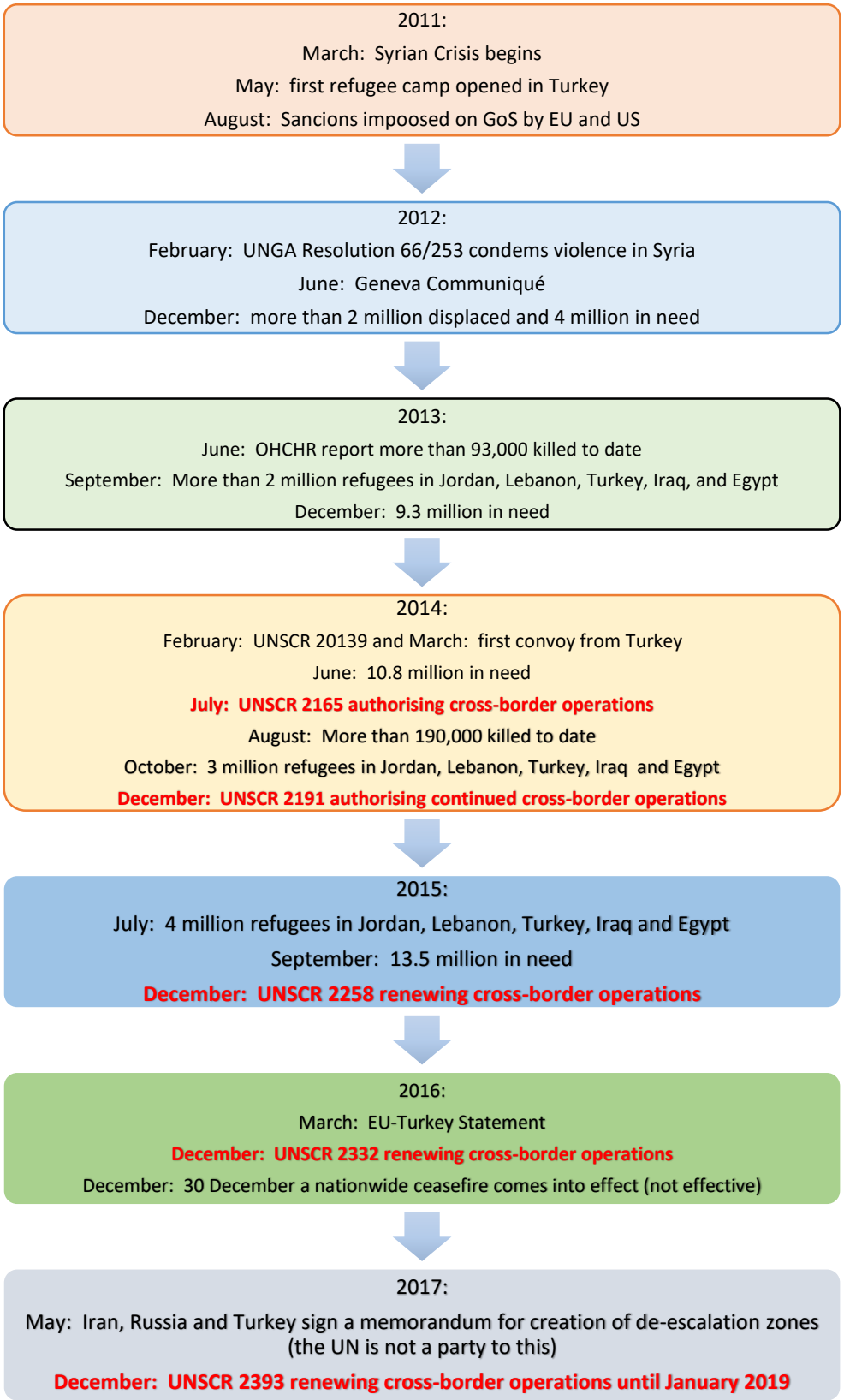


Annex IV: WoS Coordination Arrangements[281]



[281] Sida I., et al (2016:24 Evaluation of OCHA response to the Syria crisis

Annex V: Annex Timeline[282]



[282] Taken from 2016 and 2018 Humanitarian Needs Overviews.

Annex VI: Reconstructed Theory of Change