EVALUATION REPORT

INDEPENDENT COUNTRY PROGRAMME EVALUATION

LEBANON

2010 – 2014

Evaluation Office

New York
June 2014

EVALUATION TEAM

UNFPA EVALUATION OFFICE
Team Leader: Hicham Daoudi
Research Assistant: Olivia Roberts

EXPERTS
Reproductive Health: Isabelle Cazottes
Population and Development / Monitoring and Evaluation: Max Hennion
Gender Equality: Najwa Ksaifi

Country Programme Evaluation: Lebanon

Design and Printing: Print by Premier & More

FOREWORD

The independent Evaluation Office is pleased to present the results of the evaluation of the UNFPA third country programme for Lebanon.

The evaluation covered the country programme period 2010-2014. This period coincided with the outbreak of the Syrian crisis, which called for substantial changes in the objectives of the country programme, shortly after the beginning of its implementation. Current figures from UNHCR indicate that the number of registered refugees in Lebanon is now more than 1 million. The UNFPA country office in Lebanon has reallocated funds and resources within its annual workplans, in order to meet the objectives of the UNCT response to the Syrian crisis.

The Lebanon country office is facing challenges which are common to other countries of the region, which are also affected by the consequences of the Syrian crisis. This evaluation therefore provides relevant and useful lessons for other UNFPA country offices and for UNFPA partners operating in similar contexts, but also, more generally, for all actors involved in humanitarian operations.

The evaluation particularly emphasizes the importance of the responsiveness, which consists in the capacity of a country office to flexibly adapt the objectives of its programmes to emerging needs, to establish adequate partnerships and to adjust implementation channels accordingly.

The evaluation also highlights the need to accurately target and reach the most vulnerable, through timely and appropriate vulnerability profiling and needs assessment.

Another lesson learned is that attention needs to be paid to the particular sensitivity surrounding specific aspects of the UNFPA mandate, such as family planning and the fight against gender-based violence, when intervening in fragile contexts, with culturally and religiously diverse communities.

This evaluation complies with the requirements set in the independent Evaluation Office handbook on how to design and conduct a country programme evaluation, and furthers the efforts of the Evaluation Office towards more evidence-based reporting of the performance of UNFPA. Such efforts are visible in the establishment of systematic linkages between the findings of the report and their supporting facts and data, as displayed in annexes in general, and in the evaluation matrix, in particular.

I hope that this evaluation will be helpful in highlighting the UNFPA contribution to the development results of Lebanon, and that, in particular, it provides useful lessons for consideration in the preparation of the next UNFPA country programme for Lebanon and the UNCT response to the Syrian crisis.

Andrea E. Cook

Director, UNFPA independent Evaluation Office

ACKNOWLEDGEMENTS

The independent Evaluation Office would like to thank the evaluation team under the leadership of Hicham Daoudi, including: Max Hennion, expert for the population and development component and the analysis of the monitoring system; Isabelle Cazottes, expert for the reproductive health and rights component; Najwa Ksaifi, expert for the gender component; Olivia Roberts, research assistant.

The independent Evaluation Office has particular thanks to the Lebanon office country team, and, especially to the assistant representative, Asma Kurdahi, who played a key role in giving the evaluation team access to all the required programme documentation, facilitating contacts with key informants and supporting the team during their field mission.

The evaluation benefited from the guidance and support of all the members of the evaluation reference group, who accompanied the whole evaluation process and, in particular, provided invaluable comments to the evaluation report. The reference group was composed of: Ms. Amal Karaki, Senior Social Development Specialist, Council for Development and Reconstruction (CDR); Ms. Dolly Basil, Consultant, Partners for Development; Ms. Sherin Saadallah, Regional Desk Advisor for Arab States, UNFPA; Ms. Kaori Ishikawa, Programme Specialist, Gender and Partnerships, UNFPA Arab States Regional Office; Mr. Mohamed Afifi, Special Assistant to Regional Director, UNFPA Arab States Regional Office.

The evaluation team would like to express special thanks to all the stakeholders and beneficiaries who were consulted during the evaluation, giving freely of their time and opinions.

TABLE OF CONTENTS

LIST OF TABLES

GRAPHS

ANNEXES

The volume containing the Annexes is available on the webpage of the Evaluation Branch.

ABBREVIATIONS AND ACRONYMS

AMDD	Averting Maternal Death and Disability
ANC	Antenatal Care
ARC	Arab Resource Collective
ARCL	Armenian Relief Cross of Lebanon
ASRO	Arab States Regional Office
AWP	Annual Work Plan
AWPMT	Annual Work Plan monitoring tool
BCC	Behaviour Communication Change
CAS	Central Administration of Statistics
CAWTAR	Centre for Arab Women in Training and Research
CBO	Community-based Organization
CC	Component Coordinator
CCA	Common Country Assessment
CSA	Centre for Studies on Aging
CDR	Council for Development and Reconstruction
CEDAW	Committee on the Elimination of Discrimination against Women
CESCR	Committee on Economic, Social and Cultural Rights
CIPD	Conference on Integration of Population and Development
CO	UNFPA country office
COAR	Country Office Annual Report
COM	Council of Ministers
CP	Country Programme
CPAP	Country Programme Action Plan
CPD	Country Programme Document
CPR	Conflict Prevention and Recovery
CSO	Civil Society Organization
CUSFU	Centre Universitaire de Santé Familiale et Communautaire
DAC	Development Assistance Committee
DEX	Direct Execution (by UNFPA)
DFA	Department of Family Affairs
DGUP	Directorate General of Urban Planning
DHS	Demographic and Health Survey
DRP	Department of Research and Planning
ECOSOC	Economic and Social Council of the United Nations
ECRD	Educational Centre for Research and Development
EfC	Education for Change
EmONC	Emergency Obstetric and Newborn Care
FACE	Fund Authorization and Certificate of Expenditures
FBO	Faith-based Organization
FP	Family Planning
GBV	Gender-Based Violence
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
GFP	Gender focal point
GNI	Gross National Income

GoL	Government of Lebanon
GPRHCS	Global Programme to Enhance Reproductive Health Commodity Security
H4+	Harmonized Approach for Cash Transfer
HDI	Human Development Index
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HMIS	Health Management Information System
NHPC	National High Population Committee
HQ	Headquarters
HR	Human Resources
HRH	Human Resources for Health
IAWG	Inter-Agency Working Group
ICM	International Confederation of Midwives
ICPD	International Conference on Population and Development (The Cairo Conference)
ICPDPOA	International Conference on Population and Development Programme of Action
IEC	Information Education Communication
IMC	Inter-Ministerial Committee
IMTI	International Management and Training Institute
INGO	International Non-Governmental Organization
IOCC	International Orthodox Christian Charities
IP	Implementing Partner
IWSAW	Institute for Women's Studies in the Arab World
LAU	Lebanese American University
LEA	Lebanese Epidemiological Association
LECORVAW	Lebanese Council to Resist Violence against Women
LFPA	Lebanese Family Planning Association
LSOG	Lebanese Society for Obstetrics and Gynaecology
LTA	Long-Term Agreement
MARPS	Most at Risk Populations
MCH/MNCH	Maternal and Child Health/Maternal, New-born and Child Health
MD	Millennium Declaration
MDG	Millennium Development Goals
MDSR	Maternal Death Surveillance and Response
M&E	Monitoring and Evaluation
MEHE	Ministry of Education and Higher Education
MENA	Middle East and North Africa
MHTF	Maternal Health Thematic Fund
MMR	Maternal Mortality Rate
MICS	Multi Indicator Cluster Survey
MISP	Minimum Initial Service Package
MoF	Ministry of Finance
MoIM	Ministry of Interior and Municipalities
MoPH	Ministry of Public Health
MoSA	Ministry of Social Affairs

MoYS	Ministry of Youth and Sports
MoV	Means of Verification
MSM	Men who have sex with men
MTR	Mid-Term Review
MYFF	Multi-year Funding Framework
NAP	National AIDS Program
NCEA	National Commission for Elderly Affairs
NCLW	National Commission for Lebanese Women
NEPR	National Emergency and Reconstruction Program
NEX	National Execution
NGO	Non-Governmental Organization
NPMP	National Physical Master Plan
NPTP	National Poverty Targeting Program
NSDS	National Social Development Strategy of Lebanon
NSSS	National Social Security System
NSSF	National Social Security Fund
NTC	National Teaching Curriculum
OCHA	Office for the Coordination of Humanitarian Affairs
OECD	Organization for Economic Cooperation and Development
OHCR	Office of High Commissioner of Human Rights
OSD	Office for Social Development
PAPCHILD	Pan Arab Survey on Mother and Child
PAPFAM	Pan Arab Survey for Family Health
PCA	Programme Coordination and Assistance
P&D	Population and Development
PHC	Primary Health Care
PHCS	Public Health Care Centres
PHI	Public Housing Institution
PMTCT	Prevention of Mother-To-Child Transmission (of HIV during delivery)
PRSP	Poverty Reduction Strategy Paper
PTCC	Programme Technical Coordination Committee
PWD	Persons with Disability
RAMOS	Reproductive Age Mortality Survey
RBM	Results-based Management
RH	Reproductive Health
RHP	Reproductive Health Programme
RHCS	Reproductive Health Commodity Security
RHR	Reproductive Health and Rights
RO	Regional Office
SBAA	Standard Basic Assistance Agreement
SDCs	Social Development Centres
SDG	Service Delivery Guidelines
SDP	Service Delivery Points

SPR	Standard Progress Report
SPSS	Statistical Package for the Social Sciences
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infection
SWAp	Sector-Wide Approach
TBPE	Theatre Based Peer Education
TCC	Technical Consultative Committee
ToR	Terms of Reference
TOT	Training of Trainers
TWG	Technical Working Group
U5MR	Under Five Mortality Rate
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistance Framework
UNDG	United Nations Development Group
UNDP	United Nations Development Programme
UNEG	United Nations Evaluation Group
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNODC	United Nations Office of Drug Control
UNHCR	Office of the United Nations High Commissioner for Human Rights
UNRWA	United Nations Relief and Works Agency
UN WOMEN	United Nations Entity for Gender Equality and the Empowerment of Women
USJ	Saint Joseph University
VAW	Violence Against Women
WAD	World Aids Day
VCT	Voluntary Counseling and Testing
WHO	World Health Organization
YFS	Youth Friendly Services
Y-PEER	Youth-Peer to Peer

UNFPA INTERVENTIONS IN LEBANON VISITED DURING THE FIELD MISSION

Map 4282 United Nations
January 2010

Department of Field Support
Cartographic Section

KEY FACTS : LEBANON

FACT		SOURCE
Geographical location	Eastern shores of the Mediterranean Sea, between longitudes 33o 03’ 38’’ and 34o 04’ 35’’ North and latitudes 35o 06’ 22’’ and 36o 37’ 25’’ East.	Central Administration for Statistics
Land area	10,452 square kilometres	Central Administration for Statistics (Lebanon in figure 2008)
POPULATION		
Population	3,759,100	Central Administration for Statistics (Lebanon in figure 2008)
Urban Population Growth Rate	87.2 % (2010)	ESCWA MDGs
Population Growth Rate	(2005-2010) 0.83 %	ESCWA MDGs
GOVERNMENT		
Type of Government	Democratic Parliamentary Republic	Central Administration for Statistics (Lebanon in figure 2008)
Key Political Events/Dates	Independence 22 November 1943	Central Administration for Statistics (Lebanon in figure 2008)
Seats Held by Women in National Parliament	3.1 % (2012)	MDG (UNSD)
ECONOMY		
GDP per Capita (2011) PPP USD	12,900 base (2005)	UNDP website
GDP Growth Rate	2 % (2012)	http://www.indexmundi.com
Main Industries	Services, commerce, tourism	http://www.lebanonembassyus.org
SOCIAL INDICATORS		
Human Development Index	0.745	UNDP website (2012)
Human Development Index Rank by Gender	81 (2005)	UNDP website
Unemployment Rate	7.9 % (2004)	ESCWA MDGs
Life Expectancy at Birth (Years)	72.8 (2012)	UNDP website
Infant Mortality Rate 0-5 Years (per 1000 Live Births)	9.3 (2012)	UNDP MDGs
Maternal Mortality (Deaths of Women per 100000 Live Births)	25/100000 (2010)	

FACT		SOURCE
Health expenditure (percentage of GDP)	2.8 % (2010)	UNDP website
Births Attended by Skilled Health Personnel	98 % (2004)	MDG (UNSD)
Adolescent Fertility Rate (Births per 1000 Women Aged 15-19)	16.2 (2010)	UNDP website
Condom use to overall contraceptive use among currently married women 15-49 years old, percentage	9.2 % (1996)	PAPCHILD
Contraceptive prevalence among married women aged 15-49 years old, any method, percentage	58 % (2004)	PAPFAM
Unmet need for family planning (percentage of women in a relationship unable to access)	ND	
HIV prevalence rate – 15 to 49 years	0.1 (2009)	MDG (UNSD)
Adult literacy rate (percentage of population aged 15 and above)	90 % (2007)	UNESCO
Total net enrolment ratio in primary education, both sexes (percentage)	97.1 (2011)	MDG (UNSD)

MILLENNIUM DEVELOPMENT GOALS (MDGS): PROGRESS BY GOAL

Eradicate Extreme Poverty and Hunger	"very low hunger"	MDG Country Progress Snapshot (December 2013 update)
Achieve Universal Primary Education	97.1 % (2011)	MDG Country Progress Snapshot (December 2013 update)
Promote Gender Equality and Empower Women	Girls' enrollment=91 %, parity Women in wage employment = low share (2011) Seats in parliament =3.1 %, very low (2013)	MDG Country Progress Snapshot (December 2013 update)
Reduce Child Mortality	9.3 under five/1000=low (2012)	MDG Country Progress Snapshot (December 2013 update)
Improve Maternal Health	25/100,000 maternal deaths=low (2010)	MDG Country Progress Snapshot (December 2013 update)
Combat HIV/AIDS, Malaria and other Diseases	Tuberculosis: 1.5 deaths/100,000 =low (2011)	MDG Country Progress Snapshot (December 2013 update)
Ensure Environmental Sustainability	Forest Cover = 13.4%, Medium (2010) Using improved sanitation facility = 98%, high (2005) Urban living in slums=53.1%, very high (2005) Using improved drinking water source = 100%, high (2011)	MDG Country Progress Snapshot (December 2013 update)
Develop a Global Partnership for Development	Internet users = 52 %, very high (2012)	MDG Country Progress Snapshot (December 2013 update)

EXECUTIVE SUMMARY

CONTEXT

This report is the result of the evaluation of the UNFPA third country programme in Lebanon, covering the period 2010-2014.

The country programme has three components: (a) reproductive health and rights (allocated with USD 5.5 million), (b) population and development (allocated with USD 2.0 million); and (c) gender equality (allocated with USD 2.0 million).

OBJECTIVES AND SCOPE OF THE EVALUATION

The objectives of the evaluation were: (1) to provide an independent assessment of the relevance and performance of the UNFPA third country programme for Lebanon; (2) to provide an analysis of how UNFPA positioned itself to add value in an evolving national development context; (3) to draw key lessons from past and current cooperation with a view to providing useful recommendations for the next programming cycle.

The evaluation covered all activities (including soft aid activities) planned and/or implemented during the period 2010-2013 within each programme component.

As a complement to the assessment of the three programme components, the evaluation team also conducted an assessment of the programme monitoring and evaluation system.

METHODOLOGY

The evaluation was structured around two categories of criteria: (i) the evaluation criteria of relevance, effectiveness, efficiency and sustainability for the assessment of the three programme components; and (ii) the criteria of coordination and complementarity for the analysis of the strategic positioning of UNFPA in Lebanon.

The data collection tools used by the evaluation team throughout the evaluation consisted in: (i) a detailed review of all the documentation available regarding the country programme and the main national public policies; (ii) semi-structured interviews with main stakeholders (including implementing partners); (iii) focus group discussions with final beneficiaries.

Besides Beirut, four field visits were conducted, respectively in the cities of Akkar, Halba, Baalbek and Siblin.

Triangulation was ensured through systematic cross-checking of data and information sources on the one hand, and data collection tools, on the other hand. Specific attention has been paid to the formulation of evidence-based findings by rigorously relating all findings to the supporting facts and data displayed in annexes in general, and to the evaluation matrix in particular.

During the course of the evaluation, the evaluation team faced some methodological constraints, consisting mainly in information gaps in the programme documentation and in the limited availability of some stakeholders for in depth interviews. In the reproductive health and rights component, it was not possible to formally meet with representatives from the Ministry of Public Health, which posed a serious additional challenge. However, the evaluation team managed to a large extent to mitigate these constraints and limitations through the consultation of a wider range of informants.

MAIN FINDINGS

The objectives of the UNFPA 3rd country programme for Lebanon were based on an accurate understanding of the Lebanese context, both in terms of addressing the needs of the population and aligning with national priorities. After 2012, the UNFPA country office in Lebanon demonstrated good response capacity in adjusting its programme to the new context of the Syrian crisis.

In the area of reproductive health and rights, UNFPA has achieved tangible results with regard to the sensitization of young people on HIV/AIDS and some reproductive health issues. UNFPA also contributed to ensuring a sufficient and regular supply of reproductive health commodities in areas identified as receiving a high influx of Syrian refugees. Results were more limited with regard to improving the access of vulnerable groups to reproductive health services. UNFPA also faced challenges in seeking to reinforce reproductive health services at primary health care level.

In the field of population and development, UNFPA focused its interventions on the strengthening of the national policy framework on aging, and more particularly on the most vulnerable groups attending public and charitable institutions. The support of UNFPA proved instrumental for documenting the situation of this population group and for providing standards for an accreditation scheme for elderly institutions.

In the field of gender, UNFPA was successful in raising the technical capacity of the National Commission for Lebanese Women and related NGOs, thus contributing to increased advocacy efforts towards the Government with regard to women empowerment, gender equality and the fight against gender based violence.

In the implementation of the programme, UNFPA regular resources were made available in a timely manner, although with several reallocations within annual work plans in order to mitigate the effect of the late transfer of the financial contributions of the Government for critical activities. UNFPA was successful in raising significant external resources to respond to the consequences of the Syrian crisis.

UNFPA has made a key contribution to the coordination among UNCT members, especially through its participation in the working groups addressing the needs of Syrian refugees. UNFPA has also sought to achieve complementarity between its interventions and those of other UN agencies, although this could have benefitted from a more systematic approach.

MAIN CONCLUSIONS

The UNFPA 3rd country programme for Lebanon has been adequately designed with regard to the context of Lebanon and the needs of the population, based on the conduct of needs assessment and using a fruitful participatory approach.

UNFPA demonstrated a quick response capacity to the needs of Syrian refugees and contributed to strengthening reproductive health services in areas with high influx of refugees. However, the lack of a joint vulnerability profiling by the humanitarian community until the end of 2013 has **hampered the targeting of some interventions to the most vulnerable refugee groups.**

The implementation of the UNFPA 3rd country programme for Lebanon has been **hindered by the lack of national policy frameworks.**

UNFPA has built upon the Lebanese vibrant civil society to establish adapted implementation channels and select appropriate partners. Implementation modalities were adjusted to the need to strengthen the capacity of implementing partners.

Most interventions of UNFPA have been designed and implemented with a concern for sustainability. In many cases, institutionalized involvement of the civil society, notably in National Commissions, was instrumental. Grass-roots and emergency-orientated civil society organizations did not have the same potential for taking over UNFPA interventions.

MAIN RECOMMENDATIONS

UNFPA should continue adjusting its interventions based on the regular conduct of needs assessments and a participative approach. UNFPA should build upon this approach, in particular to seek to establish closer links with the grassroots level.

UNFPA should advocate among stakeholders for increased flexibility in order to address emerging critical issues and the prioritization of the most vulnerable groups among the Syrian refugees based upon assessments of the needs of different communities and settings. UNFPA should address simultaneously the needs of refugees and those of vulnerable groups among the host communities.

UNFPA should enhance the level and intensity of policy dialogue in the three areas covered by the country programme.

UNFPA should ensure that a sustainability plan is agreed upon with different stakeholders at the beginning of each project, together with a clear exit strategy. Implementing partners' capacity should be strengthened for the adoption of UNFPA supported interventions.

1 INTRODUCTION

1. 1 PURPOSE AND OBJECTIVES OF THE COUNTRY PROGRAMME EVALUATION

In accordance with decision 2009/18 of the UNFPA Executive Board, all programmes supported by the United Nations Population Fund, in particular country programmes, must be evaluated at least once during the programming cycle.[1] The final evaluation of the UNFPA 3rd Country Programme of Assistance to the Government of Lebanon (2010-2014) complies with this requirement. The key lessons from the evaluation will contribute to the preparation of the next UNFPA country programme.

The specific objectives of the evaluation are:

- to provide the UNFPA country office in Lebanon, national programme stakeholders, and a broader audience with an independent assessment of the relevance and performance of the UNFPA 3rd Country Programme of Assistance to the Government of Lebanon;
- to analyze how UNFPA has positioned itself strategically to add value in an evolving national development context;
- to draw key lessons from past and current cooperation and provide a set of clear and forward-looking options leading to strategic and actionable recommendations for the next country programme.

1.2 SCOPE OF THE EVALUATION

The evaluation focuses on all interventions planned or implemented by UNFPA in Lebanon for the period 2010-2013. The evaluation covers three programme components: i) reproductive health and rights, ii) population and development; and iii) gender equality.

As a complement to the assessment of the three programme components, the evaluation team also conducted an assessment of the country office monitoring and evaluation system.

[1] Decision 2009/18 8f, Executive Board, 2009.

2 METHODOLOGY

2.1 EVALUATION PROCESS

The evaluation, which took place from April 2013 to April 2014, was conducted in five phases:

i) The **preparatory phase** (March 2013) involved the development of the terms of reference for the evaluation, in collaboration with the UNFPA country office in Lebanon. A reference group (to monitor the evaluation) was formed, and the team of evaluators was recruited.

ii) During the **design phase** (April 2013), the evaluation team conducted a preliminary review of the available documentation. A set of evaluation questions was developed, and, based on them, a strategy for data collection during the field phase was developed.

iii) The **field phase** (6 - 24 May 2013) involved site visits in Lebanon by the evaluation team for data collection. A debriefing meeting was held with the UNFPA Lebanon country office at the end of the field phase, and preliminary results were presented by the evaluation team and validated with the country office team.

iv) The **synthesis phase** (June 2013 – April 2014) involved the finalization of evaluation findings and preparation of conclusions and recommendations and drafting of the final evaluation report.

v) During the **dissemination phase**, the final evaluation report will be shared with the UNFPA Lebanon country office and national stakeholders, and dissemination activities will be undertaken as determined with the country office. The final evaluation report will be reviewed for quality by an external reviewer, and a management response will be prepared by the country office.

FIgure 1 *Phases of the Evaluation Process*

1	**PREPARATORY PHASE**	Drafting the terms of reference Scoping mission Constitution of the reference group
2	**DESIGN PHASE**	Documentary review Drafting of the evalutation questions Elaboration of a data collection and analysis strategy for the field phase Production of a report design
3	**FIELD PHASE**	Data collection and analysis on the field Debriefing of the preliminary results of the evaluation (at the end of the field phase)
4	**REPORTING PHASE**	Production of the draft final report Stakeholders workshop to present the results of the evaluation Production of the final report
5	**DISSEMINATION & FOLLOW UP PHASE**	Quality review of the final evaluation report Publishing and dissemination of the final evaluation report Management Reponse (from UNFPA services) Follow up of the recommendations of the evaluation (one year later)

2.2 EVALUATION QUESTIONS

The evaluation is structured around the following evaluation criteria:

- four of the five standard OECD-DAC criteria: relevance, effectiveness, efficiency and sustainability[2];
- two additional criteria, specific to UNFPA, with a view to assessing the strategic positioning of UNFPA within the Lebanon United Nations Country Team (UNCT): coordination and complementarity.

Based on these evaluation criteria, the evaluation team proposed the following six evaluation questions, which guided data collection and analysis throughout the evaluation process:

EQ1 To what extent has the UNFPA 3rd country programme for Lebanon been able to: i) address the needs of the Lebanese population; ii) align with the priorities set by international and national policy frameworks as well as the UNFPA strategic plan and iii) respond to changes occurred in the national development context during its period of implementation?

EQ2 To what extent did UNFPA-supported interventions contribute (or are likely to contribute) to sustainably increase the access to and utilization of high-quality reproductive health services, particularly in underserved areas, with a focus on young people and vulnerable groups, including Syrian refugees?

EQ3 To what extent did UNFPA-supported interventions in the field of population and development contribute in a sustainable manner to a strengthened framework for the planning and implementation of national development policies and strategies?

EQ4 To what extent did UNFPA-supported interventions contribute, in a sustainable manner, to : i) the integration of gender equality and the human rights of women and adolescent girls in national laws, policies, strategies and plans ; ii) the improvement of the prevention and protection from, and response to, gender-based violence at the national level, in particular in a humanitarian context?

EQ5 To what extent has UNFPA made good use of its human, financial and technical resources in pursuing the achievement of the outcomes defined in the country programme?

EQ6 To what extent did the UNFPA country office contribute to the good functioning of coordination mechanisms and to an adequate division of tasks within the UN system?

The correspondence between evaluation questions and evaluation criteria is illustrated in Table 1.

The evaluation questions have been converted into information needs, presented in the evaluation matrix in Annex 4. The evaluation matrix presents in a synthetic manner the information collected and compiled for analysis, as well as the sources of information and the data collection tools used by the evaluators.

Table 1 *Coverage of Evaluation Criteria by Evaluation Questions*

	Relevance	Effectiveness	Efficiency	Sustainability	Coordination	Complementarity
EQ1	X					
EQ2		X		X		
EQ3		X		X		
EQ4		X		X		
EQ5			X			
EQ6					X	X

[2] The OECD-DAC evaluation criterion, impact, is not considered in UNFPA country programme evaluations, due to the nature of the interventions of the Fund, which can only be assessed in terms of contribution and not attribution.

2.3 METHODS AND TOOLS USED FOR DATA COLLECTION AND ANALYSIS

The volume of the 3rd cycle supported interventions allowed an integral coverage of the projects by the evaluation team.

The team utilized the following tools for data collection through the phases of the evaluation: desk review, semi-structured interviews, site visits, group discussions, and focus groups. Triangulation was ensured throughout the evaluation process by cross-checking sources of information.

During the design phase, the country office made key documentation available to the evaluation team, including all programming (CPAP, AWPs) and monitoring (SPRs, Annual Review minutes…) documents, UNFPA financial database (Atlas), and studies and reports related to programmes' implementation.[3] Additional documentation was obtained from UNFPA financial systems and internet searches.

During the field phase, evaluators engaged in semi-structured interviews with ministries concerned by UNFPA-supported interventions, a sample of implementing partners, and also complemented the initial documentary collection. The views of final beneficiaries were collected through focus groups and group interviews in and outside Beirut.

Semi-structured interviews were also conducted with country office staff and other agencies of the UN country team (UNCT). Interviews were conducted with other key stakeholders identified at design phase to obtain their views on the performance of UNFPA interventions and the achievement of the outcomes.

Five focus groups with beneficiaries were conducted during the field visits. Focus group discussions were used with groups of beneficiaries, partners or providers in order to review the implementation process and to assess their perceptions about the interventions and their outcomes.

Table 2 *Interviews and Focus Groups* [4]

	Reproductive Health	Gender	Population & Development	**Total**
Number of Interviewees				
UNFPA Staff	**4**	**7**	**1**	**12**
Ministries (MoSA, MoPH, CAS)	**4** [5]	**8**	**5**	**17**
Implementing partners	**24**	**14**	**1**	**39**
Other UN agencies	**4**	**5**	**2**	**11**
Number of Participants to Focus Groups Meetings				
Implementing partners	**8**	**5**	**0**	**13**
Beneficiaries	**12**	**18**	**10**	**40**
Health care providers	**7**	**8**	**0**	**15**

[3] The list of documents consulted is presented in the Bibliography in Annex 2.

[4] The list of people met during the field mission is presented in Annex 3.

[5] Two MoPH staff were interviewed as trainers of the MISP training. One former MoPH staff and one NAP staff were also interviewed. However none of them were interviewed as representatives of the MoPH.

The topics and participants of the focus group meetings were:

- Theatre Based Peer Education with 2 trainers and 8 students in Mabarrat School (1 meeting).
- Humanitarian response with Syrian Displaced Women and with participants of the MISP training (2 meetings).
- The P&D component of the country programme and related trainings conducted (2 meetings covering a representative sample of the beneficiaries of the trainings: MoSA central services on one side, and local heads of SDC from various areas of the country).

The field visits took place in the following cities (*see map on page ix*):

- Northern region: Akkar, Halba in order to visit two health facilities where Syrian refugees influx was high.
- Bekaa region: Baalbek in order to visit one of the pilot centre for the implementation of the Youth Friendly Services.
- Southern region: Siblin where a session of the MISP training was conducted.
- Beirut to visit centres organizing awareness sessions and distribution of dignity kits for Syrian refugees.

Briefing and debriefing meetings were held with the country office at the start and end of the field mission. The evaluation matrix, which corresponds to the factual basis of the findings, was shared with the country office after the field mission in order to preclude factual inaccuracies.

2.4 LIMITATIONS AND CONSTRAINTS

The evaluation team faced several limitations and constraints, which varied from one programme component to the other.

Reproductive Health and Rights

Not all the AWPs clearly detail all the interventions supported by UNFPA. Consequently, the evaluation team had to reconstruct with the project staff all the interventions from the beginning of the field phase.

At the time of the evaluation, a modelled estimate of Maternal Mortality Rates was published by WHO that did not correlate with the data obtained by the Ministry of Public Health (MoPH) through the Hospital-Based Reproductive Age Mortality Survey (RAMOS). After publication of the WHO estimates, the team was informed that the MoPH interrupted communications with UN agencies in Lebanon and, as a result, the evaluation team could not meet with MoPH representatives. This prevented the evaluation team from clarifying the position of MoPH with regards to their relationship with UNFPA under the current country programme, and from obtaining their views on future collaboration. In order to assess UNFPA achievements, the evaluators used documentation and interviews with other related stakeholders to gain insight on some issues, but discussion of the long-term perspectives for UNFPA relationship with MoPH was not possible.

In Baalbek, the time allocated to the focus group meetings with young people was not sufficient for in-depth discussion of their needs and the effects of UNFPA-supported interventions as, during the field visit, the evaluation team had to meet a large range of stakeholders including young people in a limited time. In order to fill this information gap, longer meetings were then held with the peer educators in order to explore the specific needs of young people.

Gender

Programme documentation was not available in a consolidated form which made it difficult for the evaluators to access relevant documents. However, the country office provided all information and documents as requested, and directed the evaluators to sources of information. Field visits were well prepared and organized.

Population and Development

Data collection was conducted as planned during the field mission. The main limitation was the difficulties to organize meetings with the Minister of Social Affairs (leading the the Government efforts with respect to the humanitarian response during the field work nor the MoSA Director General, position left vacant since 2003.

3 CONTEXT OF THE UNFPA THIRD COUNTRY PROGRAMME

3.1 POLITICAL AND SOCIO-ECONOMIC CONTEXT

Lebanon is a sectarian-based democracy in which power is divided among representatives of different religious sects and legislative decisions are made through a consensus decision-making process.[6] The distribution of power has been controversial and played a role triggering the civil war in 1975-1991, together with the Israeli conflict that devastated the country. The 1991 Taif agreement, which ended the civil war, moderately re-allocated power and aimed to address the country's sectarian structure, but the 2005 assassination of former Prime Minister Rafic Hariri, followed by the March 14 expulsion of Syrian troops from the country, resulted in further sectarian clashes. A redistribution of power was achieved with the 2008 Doha agreement whereby the Presidency's power was reduced, and the Prime Minister and speaker's enhanced.

Until now, however, there have been no significant efforts to restructure the government as stated in the Taif Agreement, and sectarian tensions in Lebanon have increased.

Lebanon's political stalemate arises against the background of a radically liberal system, which is not formally referred to as neo-conservative, but whose approach toward social and economic issues is similar. Public services such as electricity, water, social security do exist, yet, in effect, private organizations and religious groups provide most social services. For example, since the end of the civil war, the public school system has been increasingly abandoned by the population and 60 per cent of students are currently enrolled in private schools. Such circumstances have increased since 2005, when the Hariri assassination crippled many government activities, such as upgrading the electrical generating capacity, which currently provides only three-quarters of the power the country needs, resulting in regular and frequent power cuts, so those who are unable to purchase expensive generators may spend up to 12 hours a day without power. Corruption is also a common problem. In 2013, Transparency International ranked Lebanon 127th out of 177 countries, with "*business costs routinely include bribes and kickbacks*" and nepotism is reported to often be a key factor in job appointments among others.

In addition to these political, economic and social problems, there is the refugee situation. In 1948, tens of thousands of refugees came to Lebanon from Palestine to live in temporary camps set up and overseen by the United Nations Relief and Welfare Agency (UNRWA). Today, the twelve camps still exist and have turned into small cities, self-organised and still overseen by UNRWA. Lebanese law severely restricts Palestinians' access to jobs, education, as well as their right to travel, and denies them the right to own property. Their number amounts to 450,000 (UNRWA Lebanon Official site, 2013) but tens of thousands are in Lebanon without identity papers.

In May, 2012, 450,000 Syrian refugees had registered in Lebanon and according to UNHCR official database. However, the Lebanese government has decided not to open camps for them. Many Syrians have also entered Lebanon without registering, and it is estimated that over one million Syrians have entered Lebanon by 2013.[7] While the government has made efforts to provide assistance, such as providing free textbooks for students, much of the resettlement and charitable work has been carried out by humanitarian relief agencies including NGOs, INGOs and UN organizations. A further challenge is that Lebanon's crowded Palestinian refugee camps are now receiving Palestinian refugees previously based in Syria's refugee camps. Finally, the conflict with Israel will probably continue to play a major role in the political and social life in Lebanon and in the refugees' camps.

[6] The World Bank Group and Lebanon, a Country Study, September 2012

[7] Syria Regional Refugee Response, UNHCR 2013

3.2 SITUATION WITH REGARD TO REPRODUCTIVE HEALTH

Lebanon has registered significant improvements on reproductive health outcomes and indicators, as clearly shown in the results and findings of the Pan Arab Survey for Family Health (PAPFAM) conducted in 2004 (and disseminated in 2007), and Multi Indicator Custer Survey (MICS) 3 conducted in 2009. Significant improvement and progress towards MDG5, namely improving maternal health and in particular reducing maternal mortality ratio, can be observed as shown in table 3 below. MICS 2009, however, reported a decrease in contraceptive prevalence rate.

The PAPFAM survey indicated that, in 2004, 95.5 per cent of pregnant women received antenatal care. Use of antenatal care was found to be proportional to the education level of women and inversely proportional to the number of children per woman. PAPFAM data indicate that 92 per cent of all births are in hospitals (private and public) and only 2.4 per cent of births take place at home. The survey showed that postpartum care was not seen as routine care, as 83.7 per cent of women who did not seek postnatal care claimed that this was due to lack of need since they did not suffer from any complications and/or side effects as a result of giving birth.

The 2004 PAPFAM study further indicates that about 44 per cent of women in the 15-24 age group used a method of contraception, but the use of modern contraception methods has declined from 33 per cent in 1996 to 29 per cent in 2004. However, MICS 3 indicates a 44.8 per cent contraceptive use in 2009. In terms of family planning, 70 per cent of couples report that choice of contraceptive use was a joint decision, which shows considerable progress in terms of gender equality in decision-making in family planning.

In Lebanon, young people aged 10 to 24 years constitute around 30.1 per cent of the population[10], yet they have received the least attention in terms of health care and health services. Most health services are tailored to serve either children or the elderly, neglecting the particular needs of young people especially in terms of counseling, health risk reduction and health education. Most of the data available on youth health describe problems related to behavior, namely violence such as physical fight and bullying, unprotected sex, unhealthy diet, inactivity and smoking, or mental health (namely anxiety and addiction).

Table 3 *Progress of the Key Maternal Health Indicators in Lebanon*

	1990	1996	2000	2007	2009
Maternal mortality ratio (per 100 000 live births)	140 (1993)	107	NA	86	23[8]
Proportion of births attended by skilled health personnel (%)	NA	NA	96	98	-
Contraceptive prevalence rate – modern and traditional (%)	53 (1987–94)	61	63	74	53.7[9]
Antenatal care coverage (at least one visit) (%)	87.1	87	94	96	-

Source: Millennium Development Goals report Lebanon, 2007

[8] Ministry of Public Health RAMOS, 2012

[9] MICS 3, 2009

[10] MoSA, CAS, UNDP, The National Survey of Living Condition of Households, 2004

Many rural areas have recently-built public hospitals with modern equipment, but there is a shortage of qualified staff, including management. Retaining qualified health staff in public hospitals located in rural regions is difficult, owing in part to relatively low salary scales, and unappealing living conditions and career development opportunities.

Private practice is dominant in the health service delivery system and the large share of health care delivery is dominated by the private sector. In Lebanon, 80 per cent of the population uses private services.[11] In this context, WHO has supported the development of hospital performance indicators, both in the public and private sector, an initiative which is being reinforced and institutionalized as part of the revised accreditation system.[12] Furthermore the cost of health care in Lebanon, particularly secondary and tertiary care, is extremely high. In public hospitals, uninsured patients pay 5 per cent of costs, in comparison with 15 per cent in private hospitals, with the MoPH reimbursing the remainder.[13]

In May 2012, it was estimated that women and girls constituted over 60 per cent (around 15,000) of the total displaced Syrian refugee population in North Lebanon and Bekaa. Available data from rapid assessments and field visits conducted by UNFPA and UNHCR indicate that while the number of cases, such as antenatal care and deliveries, is increasing there is also a significant number of pregnant women who do not always seek antenatal care. Therefore these women risk encountering complications during pregnancy and delivery. In some cases, women are compelled to travel longer distances to reach hospitals for delivery rather than going to nearby hospitals. One of the reasons being that political sensitivities among different groups prevent women to access the closest health services. Sexually transmitted infections (STI) cases are also increasing among both host and displaced communities.[14]

[11] Walid Ammar MD, Ph.D, Ministry of Public Health, *Health Reform In Lebanon - Key Achievements at a Glance*, 2009

[12] WHO Lebanon, Country Cooperation Strategy for WHO and Lebanon 2010–2015, 2010

[13] Walid Ammar MD, Ph.D, Ministry of Public Health, *Health Reform In Lebanon - Key Achievements at a Glance*, 2009

[14] UNFPA, CERF Final Proposal, 29 May 2012

3.3 SITUATION WITH REGARD TO GENDER EQUALITY

Lebanon has registered significant improvements in Gender outcomes and indicators according to the goals of MDG5. Significant improvement and progress towards equal girls' enrolment in primary education, women's share in wage employment in the non-agricultural sector and women's equal representation in local elections and municipalities.[15]

Between 2004 to 2009, the status of women in Lebanon improved marginally[16] , with a Gender Inequality Index score of 0.440, placing it at 76th out of 146 countries[17]. Furthermore, Lebanon is ranked 118th in the 2011 Global Gender Gap Index.[18] Article Eight of the Lebanese Constitution and some laws provide equal social and economic rights for women but other laws and practices continue to undermine those rights.

From a political perspective, women's equality is limited in several ways, as illustrated by the 1997 ratification of CEDAW which contains a number of reservations.[19] These are related, for example, to the fact that Lebanese citizenship can only be inherited from the father. Furthermore the restrictions on women's rights imposed by various sects (such as the fact that Sunni girls/women cannot inherit), as well as the absence of civil marriage, limits the human rights of both men and women.

Although the influence and expertise of the National Commission for Lebanese Women (NCLW)[20] is increasing, and a number of gender-oriented NGOs such as KAFA (Enough Violence and Exploitation) have begun to have an impact on political decision-making, female members of the cabinet are rare, and in 2011 only four out of 128 members of parliament were women.

Dramatic social and economic inequalities persist. Access to pre-natal care and contraceptives has increased at reduced cost. Domestic violence remains an issue. While some form of domestic violence (including psychological, physical and emotional) is reported by 35 per cent of Lebanese women, economic abuse by husbands is also prevalent. Such discrimination include: "*1) preventing women from getting resources (like getting jobs or education), 2) keeping them from using resources they already have, 3) stealing their money or running up debts,*" which was reported by 12 per cent of women.[21]

The ratification of the National Plan of Action for Prevention and Protection Against Gender-based Violence and the 2011 changes in the law regarding so-called honour crimes, which prohibited "any crime of violence against women in the family because they are women" were certainly steps in the right direction.[22] Recently Lebanese women just had their first big victory: the joint parliamentary committees approved the Bill to protect women and families from domestic violence.

The situation for women displaced by the conflict in Syria is extremely difficult. In 2012, Syrian women and girls constituted over 60 per cent of the total displaced population in the North and the Bekaa.[23] Moreover, this situation forces some women and girls to take dramatic decisions to survive. Some are forced into prostitution by human traffickers and some are being forced to marry at an early age (i.e. 13-14 years old) in return for some financial aid, while others facing destitution are forced to resort to the practice on their own or even at the insistence of their husbands.

---

[15] MDG Country Program Snapshot: Lebanon, December, 2012.

[16] Khalaf, Mona, *Lebanon.* http://www.freedomhouse.org/sites/default/files/inline_images/Lebanon.pdf

[17] OECD Development Center

[18] http://genderindex.org/country/lebanon

[19] Situation of Gender-based Violence Against Women, 2012; 29.

[20] In line with the recommendations of the Beijing Conference, the Lebanese Council of Ministers approved, in 1996, the formation of a national committee for women's affairs, the National Committee for Lebanese Women (NCLW). The NCLW is the official national institution responsible for realizing women's advancement and gender equality in Lebanon.

[21] Jinan Usta, Nisrine N. Makarem and Rima R. Halib. *"Economic Abuse in Lebanon: Experiences and Perceptions."* Violence Against Women, 22 April 2013.

[22] Ibid, 23.

[23] Ibid.

3.4 SITUATION WITH REGARD TO POPULATION AND DEVELOPMENT

Population statistics are not comprehensive in Lebanon as the last national census was conducted in 1932 and the most recent large population-based survey took place in 2004.

Population dynamics in Lebanon have been notable in the last decades with a significant downturn in birth rate, fertility rate and a stabilized mortality rate. Life expectancy at birth has steadily increased since 1950 (55 years) to present (72.8 years), with Lebanon being one of the very first Arab countries to undergo demographic transition.

The changing shape of the population profile illustrates the significance of population dynamics in Lebanon during the last thirty years and projections for the next forty years.

Owing to the political events and crises of the last 20 years, very few national surveys targeting the living conditions of the poor or the deprived have been conducted before 2009 (except for some limited studies on disadvantaged groups in specific areas of Lebanon).

Notable and relatively recent exceptions are the two national surveys by the Ministry of Social Affairs and the Central Administration of Statistics supported by UNFPA (1998) and UNDP (2006) respectively. The surveys did not use strictly comparable methodologies, but they are largely consistent and compatible. These surveys have produced detailed information on national living conditions, including on the poor who are referred to as "deprived". Findings from both studies indicated an increase in the proportion of older adults in the population, from 4.9 per cent in 1970 to 7.52 per cent in 2004, with an estimated projection of 15.3 per cent in 2025 and 30 per cent in 2050. This trend will affect the total dependency ratio whereby the responsibility of the workforce would increasingly shift from support to children to the simultaneous support to both children and the elderly. [24]

In the absence of a national health information system and a reliable civil registration system, data on the health situation of vulnerable groups are mostly obtained from studies related to specific projects, such as the Pan Arab Survey on Mother and Child (PAPCHILD) and the Pan Arab Survey for Family Health (PAPFAM) undertaken in 1996 and 2004[25] respectively, as well as the MICS[26] 1 (1997), MICS 2 (2001) and MICS 3 (2005). Moreover, data on mortality, causes of deaths and morbidity are not available.

Nonetheless, numerous small-scale studies, usually limited to certain population groups and geographic areas, are available. However, it is often difficult to generalize the results of these studies to the population at large due to their lack of representation and reproducibility and, at times, the poor quality of the data.

The second UNFPA country programme (2005-2009) achieved significant results with regards to mainstreaming population data into development planning, notably with the assessment of the impact of the July 2006 war[27] on specific vulnerable populations (PAPFAM and related studies). Several surveys focused on poverty, single-parent families and the elderly were conducted in 2009-2010.[28] UNFPA support towards strengthening civil registration for improving data systems, for example, measuring mortality achieved only limited results. Earlier, another achievement of UNFPA cooperation in Lebanon was the support provided for the development of the national population policy (2001).

This post-war period demonstrated the need for strengthening key institutions and mechanisms for provision of overall guidance and advice on population dynamics, reproductive health and gender equality at national and sectorial levels.

[24] Country Profile: Older Population in Lebanon, Fact and Prospects, CSA and UNFPA, 2011

[25] www.pdslebanon.org

[26] Multiple Indicator Cluster Surveys

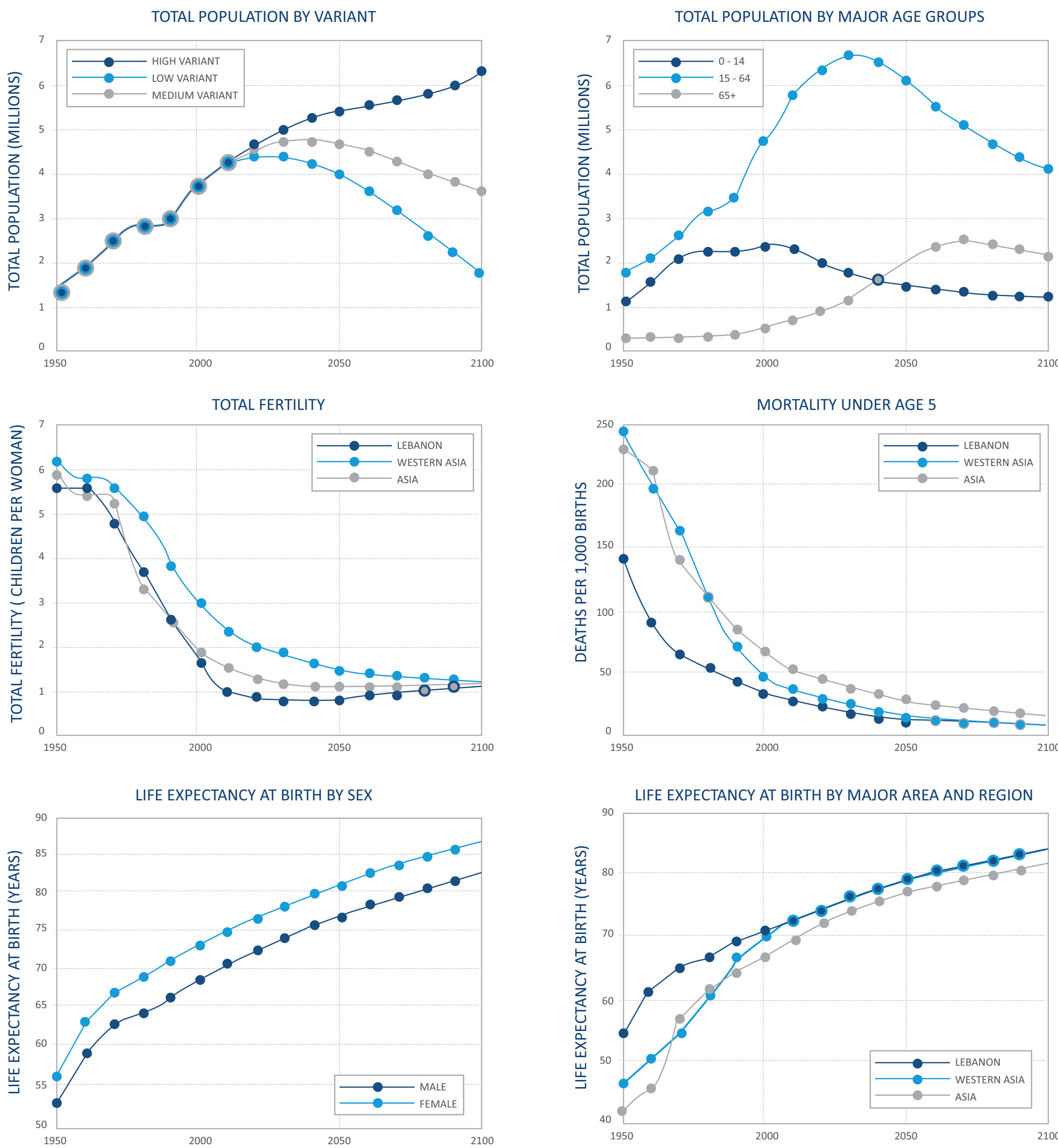
[27] www.pdslebanon.org

[28] Available on www.popdev-lebanon.org

Figure 2 *Evolution of the Lebanese Population by Age and Sex, 1950-2010 and Projection for 2050*

Source: ESCWA Lebanon demographic profile (http://www.escwa.un.org)

Figure 3 *Lebanon Demographic Country Profile*

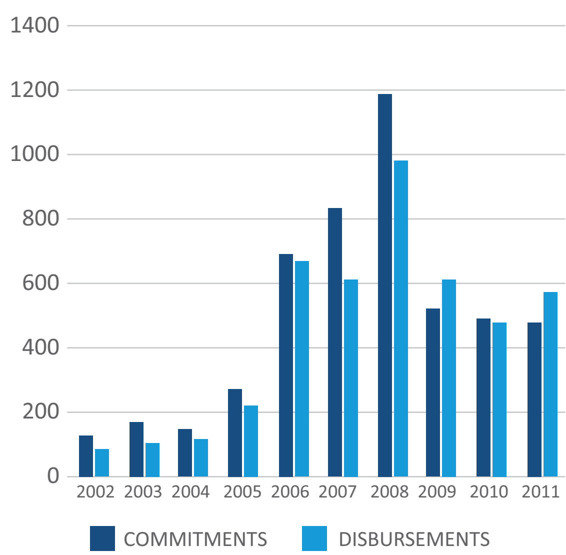


Source: ESCWA Lebanon demographic profile, 2014

3.5 DEVELOPMENT ASSISTANCE

Since the end of the civil war, foreign aid has played a significant role in the Lebanese economic and political context, including (but not limited to) the stabilization of macroeconomic policies, supporting various official institutional structures, and supporting civil society dynamics. This was a deliberate governmental decision, implemented through a series of international donor conferences (including Stockholm [2006], Paris II [2002], and III [2006] donor conferences), and began with raising funds to support post-war reconstruction efforts. Such initiatives started at the end of the prolonged civil war, more than twenty years ago, yet Lebanon is still dependent on substantial foreign aid and increasingly indebted (Lebanon external debt in May 2014 is USD 26 billion).[29]

Figure 4 *External Aid (2002-2011)*



Source: DAC-OECD 2013; Data is in current USD (million).

Net official development assistance and official aid received

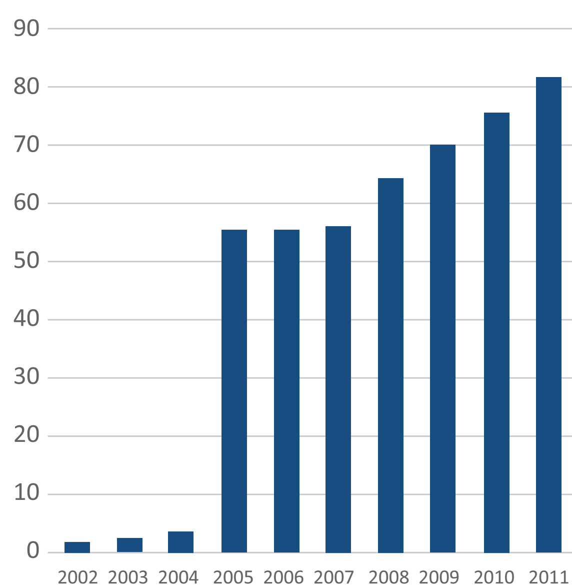
Net official development assistance and official aid[30] received in Lebanon was reported in 2010 at US Dollars (USD) 447,930,000.

According to the DAC-OECD Aid Database,[31] the flow of ODA to Lebanon increased after the 2006 war to a maximum commitment of USD 1.2 billion. Since then, the flow has stabilized to approximately USD 500 million annually. The level of disbursement slightly exceeds commitments due to delays in aid delivery (Figure 4).

Disbursement of ODA by UN agencies (Figure 5) in Lebanon has also increased steadily since the 2006 war.

The proportion of ODA disbursed by UN agencies varies annually from 20 to 46 per cent since 2006. The respective share for UNFPA is 0.3 to 0.4 per cent.[32]

Figure 5 *Disbursements by UN Agencies (2002-2011)*



Source: DAC-OECD 2013; Data is in current USD (million).

[29]TradingEconomics.com, sourced by Ministry of Finance, Lebanon

[30]Net official development assistance (ODA) consists of disbursements of grants and loans made on concessional terms by official agencies of the members of the Development Assistance Committee (DAC), by multilateral institutions, and by non-DAC countries to promote economic development and welfare in countries and territories in the DAC list of ODA recipients. ODA includes loans with a grant element of at least 25 per cent (calculated at a rate of discount of 10 per cent).

[31]www.stats.oecd.org

[32] Ibid.

3.6 UNFPA THIRD COUNTRY PROGRAMME IN LEBANON

3.6.1 Lessons learned from previous country programmes

The 2nd UNFPA country programme (CP) of assistance (2002-2006, extended until 2009) aimed at: (a) strengthening reproductive health services and information, particularly in underserved areas and within a primary health care context with special focus on young people; (b) supporting the integration of population dynamics and development in sectorial policies and strategies, with emphasis on data collection and advocacy.

The final evaluation of the 2nd country programme[33] identified three main areas where UNFPA was successful: i) its leadership in highlighting youth and women's health issues in Lebanon; ii) resource mobilization for its interventions, mainly from governmental sources; and iii) adapting the programme to recovery needs in the wake of the July 2006 War. UNFPA was also successful for mobilizing resources at the time of emergency. However, three general weaknesses appear in the UNFPA country programme (2002-2009): i) UNFPA has only limited success in transferring skills to the wider cadre of its governmental partners; ii) limited and ad'hoc coordination existed between UNFPA and government counterparts; iii) delays in delivery and implementation were commonplace in many of the UNFPA interventions affecting their efficiency.

Constraints to achieving the CP objectives identified by the previous evaluation were as follows:

- The political context was unstable, providing limited incentives for development or social breakthroughs;
- The slow transfer of funds from governmental counterparts significantly delayed programmes' implementation;
- The CP looked over-ambitious and not grounded on the capacity of implementing organisations, especially for governmental partners;
- Coordination and monitoring and evaluation mechanisms were loosely attended, hence hampering the progress of activities in several programmes. [34]

The evaluation concluded that UNFPA was: i) effective in mobilizing resources for its sub-programmes and interventions; ii) successful in adopting a coalition-building approach; iii) and interventions targeting specific and often excluded vulnerable groups (such as sex-workers) were appropriate and timely and reflected the position of UNFPA. The related recommendations were:

- UNFPA programmes implemented in collaboration with the Government should adopt an inclusive and integrated approach towards governmental departments and units, and shift from implementation to facilitation;
- UNFPA should continue its advocacy work and coalition-building approach in all programmes;
- UNFPA should assert the importance of monitoring and evaluation (M&E) among its counterparts. Making M&E an integral part of partnership, especially with government partners is critical;
- Coordination mechanisms should be established, especially between programmes sharing the same theme or CP objective;
- An emergency plan should be integrated in programme planning.

The main lessons learnt and recommendations from the second CP, as stated in the UNFPA Country Programme Action Plan (2010-2014), are the following:

[33] Evaluation of UNFPA Country Programme of Assistance 2002-2009 Lebanon; final report, April 2010

[34] Ibid

- Further capacity development on youth-friendly services is necessary, with a clear definition of a minimum package;
- Community sensitization for supporting youth participation and multi-sectorial interventions needs to be reinforced;
- Piloted interventions for young people, uniformed services, and vulnerable populations yielded innovative approaches;
- Special focus on addressing maternal mortality and morbidity while ensuring the buy-in and overall guidance and policy advice of the Ministry of Public Health is needed;
- Addressing specific reproductive health needs in emergency contexts is a challenge.

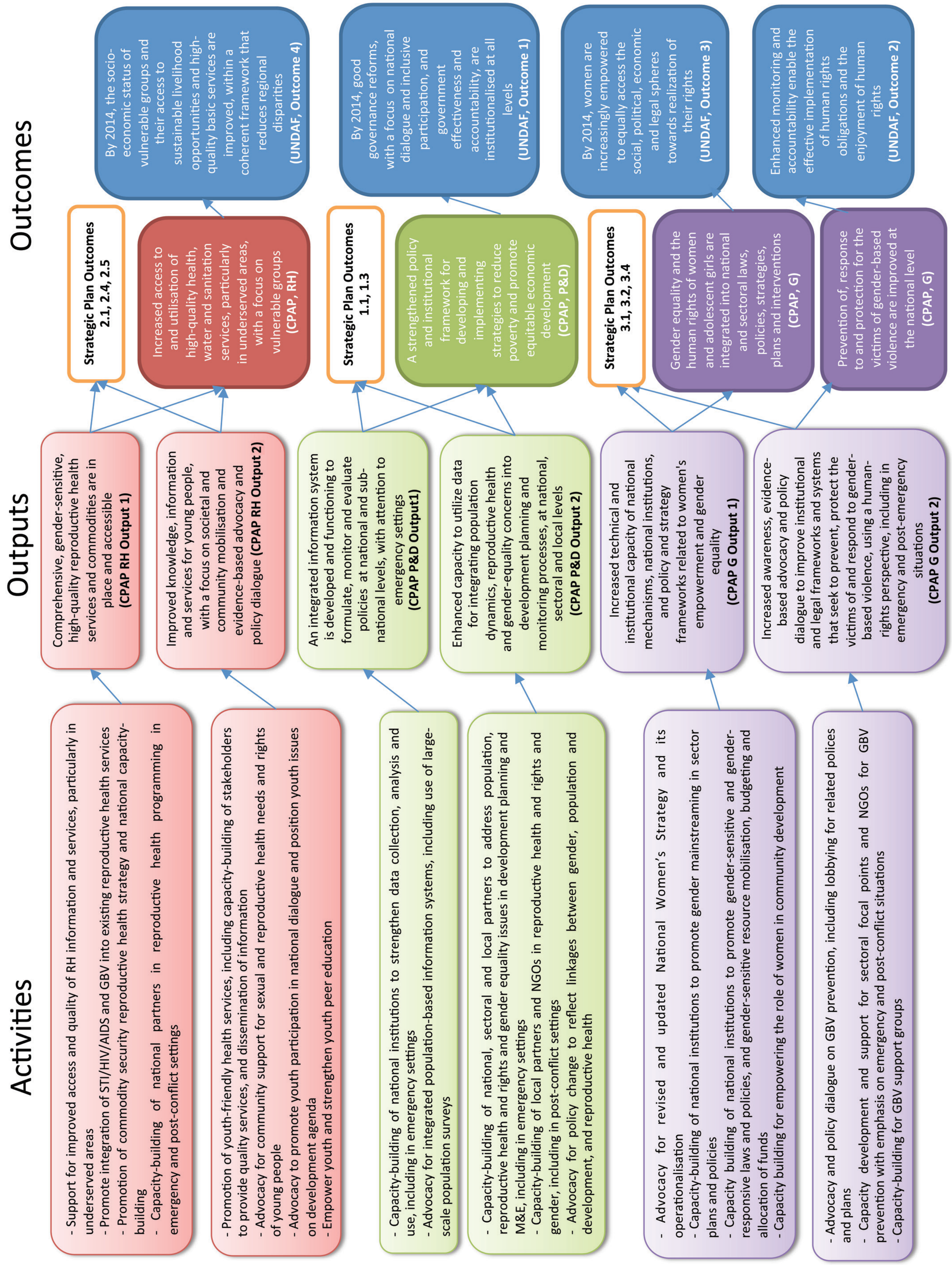
3.6.2 Intervention Logic of the UNFPA Third Country Programme

The UNFPA 3rd country programme for Lebanon (2010-2014) consists of three components: i) reproductive health and rights; ii) population and development; and iii) gender equality. The expected outcomes of interventions supported by UNFPA in its three country programme components are:

- increased access to, and utilization of high-quality health, water and sanitation services, particularly in underserved areas, with a focus on vulnerable groups;
- a strengthened policy and institutional framework for developing and implementing strategies to reduce poverty and promote equitable economic development;
- gender equality and the human rights of women and adolescent girls are integrated into national and sectorial laws, policies, strategies, plans and interventions;
- prevention of, response to, and protection for the victims of gender-based violence are improved at the national level.

The intervention logic, or theory of change, which illustrates the (assumed) logical links leading from the interventions supported by UNFPA to the expected outcomes of the country programme is presented in Figure 6 on the opposite page.

Figure 6 *Intervention Logic of the UNFPA Third Country Programme*



3.6.3 The financial structure of the country programme

The proposed UNFPA assistance, as stated in the Country Programme Document for the 3rd UNFPA country programme (2010-2014), was USD 10 million.

The annual breakdown is USD 2 million per year. Expenditures relating to the 2nd country programme were also budgeted during the reference period, owing to delayed transfer of government funds, for a total amount of USD 2.1 million.

The total disbursed funds for the 2010-2012 period was USD 5.8 million, with a quarter (USD 1.1 million) deriving from the 2nd country programme.[35]

The global disbursement ratio (combining the 2nd and 3rd country programmes) during the evaluation period (2010-2012) is 97.5 per cent. Taken in isolation, the disbursement ratio of the expenditures under the 3rd country programme is 96.2 per cent.

The respective shares of each component of the CPAP are shown in Figure 7. The gender component received the largest proportion of total expenditure, with 40 per cent of the total expenditures (2010-2012). Reproductive health received 33 per cent, and the population component received seven per cent. Management costs represented 20 per cent of total expenditure. For the 3rd country programme specifically, the proportion of expenditure for reproductive health increased to 48 per cent.

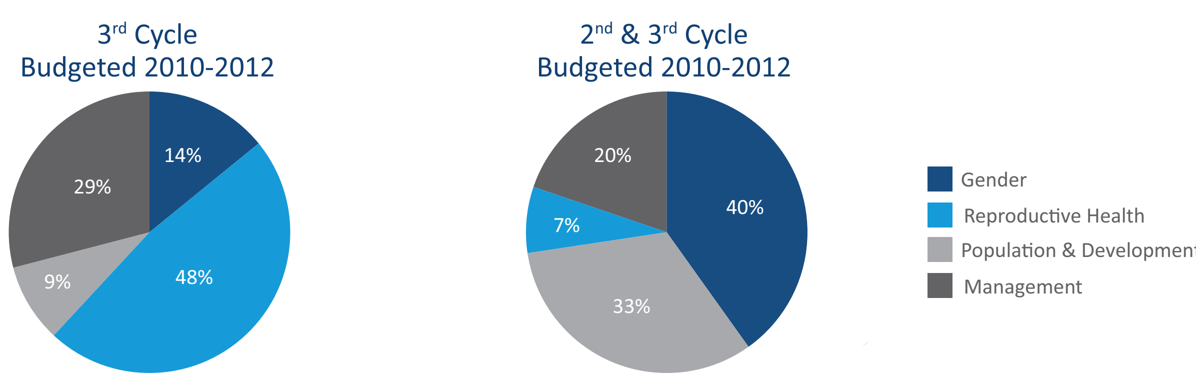
The financial support to reproductive health increased significantly over time, while the contribution to gender equality, population and development and management remained relatively consistent (Figure 8).

At outcome level, the pattern of expenditures of the 3rd country programme is shown in Table 4.

The majority of disbursement (79 per cent) was undertaken directly by the country office, while only 21 per cent of funds were disbursed by implementing partners (Table 5).

UNFPA regular resources represent 73 per cent of the CPAP spending between 2010 and 2012. Government resources account for 15 per cent and emergency funds for 12 per cent.

Figure 7 *UNFPA Third Country Programme Budget Distribution by Component 2010-2012*

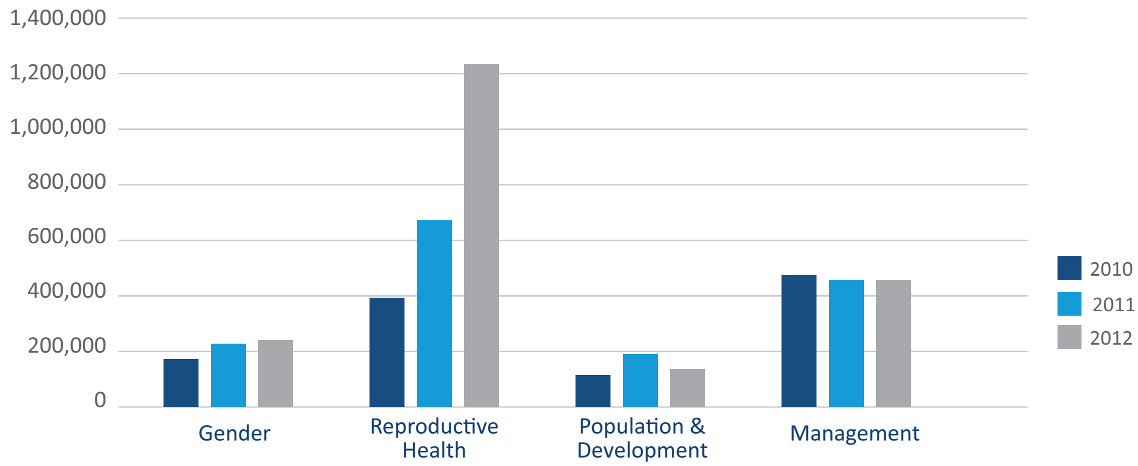


Source: Atlas[36], June 2013

[35] Most expenditure (97 per cent) for the 2nd country programme was related to the gender component due to the fact that 2010 was the final year for a gender project supported by extra budgetary funds in the context of the 2006 war.

[36] Atlas is an UNFPA enterprise resource planning system, for the recording and consolidation of information at global corporate level for all COs.

Figure 8 *UNFPA Third Country Programme Annual Disbursements by Component (in USD)*



Source: Atlas, June 2013

Table 4 *Disbursements by Component and Outcomes*

COMPONENT / OUTCOME	DISBURSED	PERCENTAGE
GENDER	**637,603**	**13.34**
3.1 Gender equality and women/young girls rights integrated into national planning	164,485	3.44
3.2 Gender equality, reproductive rights and empowerment of women/young girls promoted	473,118	9.90
REPRODUCTIVE HEALTH	**2,318,865**	**48.50**
2.1 RH integrated in public policies of development with monitoring	296,426	6.20
2.4 Demand, access and use of quality HIV/STI prevention services, especially for women, young people and vulnerable groups increased	816,052	17.07
2.5 Access of young people to SRH, HIV and gender violence prevention services	635,460	13.29
Emergency funds - Maternal and newborn health	570,928	11.94
POPULATION & DEVELOPMENT	**439,941**	**9.20**
1.1 Population dynamics and interlinkages with gender, RH and HIV/AIDS incorporated in policies	439,941	9.20
MANAGEMENT	**1,384,841**	**28.96**
Management	1,384,841	28.96
TOTAL	**4,781,250**	**100**

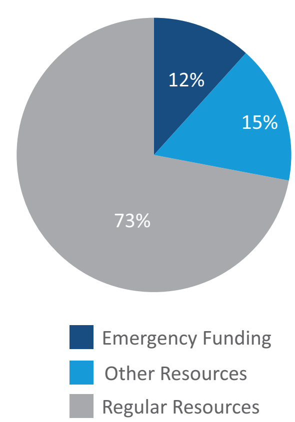
SOURCE: Atlas, June 2013

Table 5 *Disbursements by Implementer*

IMPLEMENTER	DISBURSED	PERCENTAGE
UN POPULATION FUND	**3,783,930**	**79**
St. Joseph University	271,674	6
Ministry of Social Affairs	229,241	5
MASAR Association	126,629	3
Educational Center for Research & Development	90,428	2
National Commission for Lebanese Women	81,065	2
National Commission for Lebanon	68,929	1
University of Balamand	53,977	1
Visual & Performing Arts Association	40,750	1
YMCA	34,454	1
TOTAL	**4,781,250**	**100**

Source: Atlas, June 2013

Figure 9 *Resources by Source*



Source: Atlas, June 2013

4 FINDINGS (RESPONSES TO EVALUATION QUESTIONS)

4.1 RELEVANCE

EQ1

To what extent was the UNFPA 3rd country programme for Lebanon able to: i) address the needs of the population; ii) align with the priorities set by relevant national policy frameworks as well as the UNFPA Strategic Plan and iii) respond to changes occurred in the national development context during its period of implementation?

SUMMARY

UNFPA programming was based on an accurate understanding of the Lebanon context and of the respective policy frameworks for the three programme components. UNFPA undertook various need assessments for vulnerable groups as well as capacity audits which have proven to be instrumental in adjusting the programme to Lebanon's specific opportunities and threats.

The CPAP is aligned with the UNDAF and duly takes into account national policy frameworks.

UNFPA responded to the call of the United Nations Resident Coordinator and followed the direction of the United Nations Country Team (UNCT) in responding to the Syrian crisis in early 2012. Rapid assessments in the most affected areas (North and Bekaa') ensured a proper adjustment of UNFPA programme to the needs of the refugees.

4.1.1 Attention to the needs of the population in the planning process, in particular those of vulnerable groups

UNFPA made a consistent utilization of studies in order to adjust the 3rd country programme to the needs of the population, targeting to the best possible extent the needs of vulnerable groups. Some of these analyses were conducted during the 2nd country programme which was significantly oriented towards knowledge generation. The 3rd country programme is consistent with the findings and recommendations of these studies. Further analyses were conducted at the beginning of the 3rd country programme to fine-tune the programme (the MoSA Units' Needs Assessment, 2010) or to proactively identify the RH needs of the Syrian refugees, specifically those of women and girls. Some programmes are a continuation of successful initiatives of the 2nd country programme interventions, while others are reflecting global initiatives (Y-Peers, for instance). In the case of the P&D component, there was a dramatic change in the planned interventions during the implementation of the programme, in response to a direct MoSA request to focus on a policy for the Elderly rather than statistics and M&E.

The interventions designed to achieve the first output of the **reproductive health (RH) component** of the programme -- i.e., "*Enhancing Ministry of Public Health (MoPH) capacities for providing quality RH services at primary and secondary care levels in Targeted Areas*", are in line with the priorities defined in the previous country programme to reinforce MoPH activities at primary health care level. In supporting the MoPH in its policy to focus upon the primary health care (PHC) level, UNFPA aims at reaching underserved members of the population. UNFPA focus on PHC centres contributed to targeting the most vulnerable members of the population, as these centres do not differentiate between insured and uninsured patients and only charge nominal fees.

Furthermore, in Lebanon where 80 per cent of the population uses private services, supporting public health services allows for targeting of vulnerable populations unable to access private services because of cost incurred.[37]

The vulnerability of the population as regards access to health services in some areas of Lebanon, particularly in Bekaa and in the North, is reported in a number of assessments.[38] The initial UNFPA plan to support outreach services responded to the identified discrepancies in coverage of public health services, including RH services, and problems of access to quality health services, especially in rural areas. The first UNFPA Annual Work Plans (AWPs) with MoPH targeted intervention areas located in the regions of Bekaa, South Lebanon, North Lebanon and Nabatie, which include the highest proportion of deprived households. [39]

UNFPA AWPs were also designed based on recommendations formulated in the *"Assessment of Linkages between Sexual and Reproductive Health and HIV"* [40] undertaken with the Ministry of Public Health and the National AIDS Control Program in 2010. Interventions were designed to reinforce the supply of RH commodities and to integrate SRH and HIV services within the Youth Friendly Service package piloted in collaboration with UNICEF (see details under J.C. 2.4 in Annex 4).

UNFPA AWPs under output 2, *'Improved knowledge, information and services for young people, with a focus on societal and community mobilization and evidence-based advocacy and policy dialogue'*, were based on national surveys such as the 2004 Pan Arab Survey for Family Health [41] and the 2011 Lebanon Global School-based Student Health Survey (GSHS).[42] Furthermore, a number of studies (conducted under the previous country programme) highlighting the needs of young people were used for the design of the 3rd country programme, including:

- Inventory of Knowledge, Attitude and Behaviour Studies Related to Sexual and Reproductive Health of Young Persons in the Arab States, 2004; [43]
- Knowledge, Perceptions and Practices of Young People in Borj Hammoud Community Regarding Reproductive Tract Infections: An Operation Research Reproductive Tract Infections among Young People, May 2006; [44]
- Two studies conducted on teachers' needs and on parents' opinion.[45]

These studies on youth reproductive health revealed that Lebanese youth are exposed to unsafe sexual practices leading to unplanned pregnancy, sexually transmitted infections (STIs) and abortion. These studies also reported other issues faced by youths, such as drug and alcohol use and violence.

In addition, UNFPA in collaboration with UNICEF and WHO led the undertaking of a Knowledge, Attitude, Behavior and Practices survey among young people on Reproductive and Sexual Health, STI/HIV/AIDS and Related High Risk Behaviors in 2010-2011. The quantitative component addressed university and secondary students whereas the qualitative part targeted youth with special needs and school dropouts.

[37]Walid Ammar MD, Ph.D, Ministry of Public Health, *Health Reform In Lebanon - Key Achievements at a glance*, 2009

[38]See Annex 4, Evaluation Matrix, Judgment Criteria 1.1

[39]United Nations, United Nations Resident Coordinator System in Lebanon. *Lebanon Common Country Assessment,* 2007

[40]United Nations Population Fund, American University of Beirut, Ministry of Public Health and the National AIDS Control Program, *Assessment of Linkages between Sexual and Reproductive Health and HIV in Lebanon*, April 2010.

[41]The Pan Arab Project for Family Health Lebanon Health Survey 2004

[42]Ministry of Public Health, CDC, WHO. *Global School-based Student Health Survey,* Lebanon

[43]Rima Afifi Soweid, Talar Manayan, Inventory of Knowledge, *Attitude & Behaviour Studies Related To Sexual And Reproductive Health Of Young Persons In The Arab States*, 2004

[44]Mary Arevian, Anna Bernadette Chadarevian, Zana El Roueiheb, *Knowledge, Perceptions and Practices of Young People in Borj Hammoud Community Regarding Reproductive Tract Infections: An Operation Research Reproductive Tract Infections among Young People*, May 2006

[45]Studies in Arabic language

Topics discussed during UNFPA peer education interventions were initially defined by the regional Y-PEER approach supported by UNFPA and mainly focused on HIV/AIDS-related messages. Later, topics such as drug addiction and early marriage were added to the subjects to be covered by Y-PEER network interventions. The latter was selected to address the needs of the Syrian young people targeted in interventions planned for 2012. The needs expressed by young people during the focus group discussions conducted during the evaluation depended upon their age. Younger people (13-14 years old) expressed interest in subjects like addiction to drugs or smoking. Although these topics are important and relate to life skills, they tend to obscure reproductive health issues. As a result, RH issues have not often been prioritised despite UNFPA mandate. Older youth were interested in topics such as relationships with parents, reproductive health and maternal health issues that were not all addressed through the Y-PEER approach. During the second country programme, two studies were undertaken regarding youth-friendly services (YFS), notably to evaluate the needs, interests, and barriers to using the services. [46] UNFPA, in collaboration with UNICEF, planned to support the development and the implementation of a YFS package aimed at fulfilling the issues and gaps identified in these studies.

An "*Assessment of Reproductive Health and Gender-Based Violence among Displaced Syrian Women in Lebanon"* [47] was undertaken from June to August 2012 by UNFPA in partnership with Yale University, to assess the reproductive health needs and the GBV situation among the displaced Syrian women and girls. UNFPA utilised some of the recommendations from the assessment in designing its interventions in response to the Syrian crisis. [48]

UNFPA-supported distribution of RH kits[49] responded to the need for reinforcement of RH services in health facilities that were identified as having high attendance by Syrian refugees in the North, Bekaa, South, Beirut and Mount Lebanon. These target facilities had been identified in collaboration with partners involved in the Syrian crisis health response, such as United Nations High Commissioner for Refugees (UNHCR) and International Medical Corps (IMC).

Additionally to RH kits, UNFPA distributed dignity kits containing items allowing women to maintain proper hygiene. These dignity kits were distributed to Syrian women refugees through NGOs.[50] In general, the content of the dignity kits responded well to the needs of the refugees, particularly those living in temporary structures or camps (e.g., women living under tents in the Bekaa Valley) and complemented the kits provided by other organisations. However, given the heterogeneity of the refugee population, the dignity kits did not meet the expectations of all groups. For example, in Beirut, where refugees generally due to their socio economic status, have access to more resources than in other locations, some women considered the content of the kits as too basic, and not fully addressing their needs. [51]

---

[46] Nancy Maroun, Hyam Kahi, Natalie Chemaly, Hala ElKahi, and Elie A. Akl, *Needs Assessment for a University-based Youth Clinic in Beirut, Lebanon: A Mixed Quantitative and Qualitative Study*, The Open Public Health Journal, 2013, 6, 21-30

[47] Usta Jinan, Masterson Amelia Reese, *Assessment of Reproductive Health and Gender-Based Violence among Displaced Syrian Women in Lebanon*, UNFPA and Yale School of Public Health, 2012

[48] See Annex 4 Evaluation Matrix, Judgment Criteria 1.1

[49] Standard emergency reproductive health kits containing small equipment and drugs were procured such as oral and injectable contraception, IUD insertion, suture, clinical delivery assistance, rape treatment and STIs treatment

[50] Dignity kits contain sanitary napkins, wet wipes, bath towel, women head scarf, women underwear and women's long-sleeved t-shirt

[51] See Annex 4 Evaluation Matrix, Judgment Criteria 1.1

The population and development (P&D) component of the 2nd country programme produced extensive analyses of population dynamics, including vulnerable groups and conditions regarding reproductive health and gender equality, by financing the following surveys:

- Disability in Lebanon: Vulnerability assessment of the disabled (May 2007);
- Female Headship in Lebanon. Vulnerability Assessment of Female heads of households (June 2007);
- Experiences, needs, vulnerabilities and resources of older adults (November 2007);
- Preparedness and Responsiveness of Lebanese NGOs, Social clubs and clinics in the provision of services to seniors in Lebanon (November 2007);
- Assessment of the responsiveness and readiness of Social Development Centres (SDCs) and MoSA-supported NGOS and Institutions (November 2007).

The data and analyses partially filled a gap in information that had existed for several decades, as the last general population census dates back to 1932. Attempts were made to update the census but failed due to the reluctance of the government and political parties to undertake an exercise that could affect the fragile balance between religious groups and communities.

In addition to limited data on general population and vulnerable groups, UNFPA identified shortcomings that hampered further integration of P&D into monitoring and evaluation during the 2nd country programme. The final evaluation of the 2nd country programme corroborated analyses shared by UNFPA country office, based on their experience of implementation and confirmed by MoSA staff interviewed by the evaluation team, that there had been high turnover of relevant ministers (1.5 years tenure as an average), lack of continuity in policy ownership due to personalized leadership and political polarization, and human resources shortages (70 per cent of the management positions were vacant or 'acting', including that of the Director General of MOSA).

A needs assessment funded under the first AWP for the P&D component of the 3rd country programme was conducted by MoSA in 2010. Within the same AWP, integration of P&D into development planning and monitoring was initiated; several training sessions on development planning and result-based monitoring were planned for MoSA central units and SDCs.

In 2011, a new MoSA Minister was appointed, who requested UNFPA to focus on aging issues rather than continuing the widespread approach of integrating P&D in development planning. This strategic shift was consistent with the identification of the elders as one of the most vulnerable groups in Lebanon, as demonstrated by the 2007 surveys, and subsequent studies (notably by the Centre for Studies on Aging, supported by UNFPA). Poor conditions of care in some institutions for the elderly had also been reported several times in the media. These observations were confirmed both by MoSA staff and SDCs heads who participated in the focus groups of the present evaluation.

The strategic shift was also consistent with the results of MoSA needs assessment. Since the shortcomings in integrating P&D were beyond the capacity of UNFPA funding and operational capacity under the P&D component, a dedicated project management unit was established. The evaluation team was able to check that the organisational and financial issues reported in 2010 aggravated further.

In terms of supporting the aging policy, UNFPA focused on: i) generating knowledge on the living conditions of the elderly, ii) setting norms and standards for elderly institutions and iii) enhancing capacities of MoSA to adequately address aging needs and priorities at advocacy, planning and programming levels. In Lebanon, apart from a few private/commercial institutions, most elderly institutions are charitable organizations for deprived old persons lacking family support; Lebanese cultural background impose that even physically dependent elders to stay within the family. Most of the patients of charitable and MoSA/MPH institutions are widowed women without any family ties.

The target group for UNFPA-supported interventions is relatively small and an on-going survey supported by NCEA identified 4,000 patients whose typology is still to be defined. The extent to which this figure may grow is not yet estimated, yet all demographic and economic trends concur on a steady increase in the next ten years. Lebanon was the first among Arab countries to undergo the demographic transition: decreased mortality rate, decreased fertility and the related adjustment period when higher age groups will grow without the necessary resources among the active population. In Lebanon, the phenomenon is likely to induce dramatic situations owing to the poor fiscal policy and lack of mechanisms in place for care of the elderly.

Within the framework of the gender component of its 3rd country programme with Lebanon, and in response to emerging national priorities, UNFPA targeted different population groups, especially Syrian refugees and women victims of violence. UNFPA interventions clearly strive to meet the needs of underserved populations (among which women and girls are considered as the most vulnerable)[52] in addition to youth (adolescent boys and girls) as mandated in UNFPA directives.[53] Rural and marginalized areas, especially the poorer and underserved areas in Akkar, Tripoli and the Palestinian camps, have been especially targeted by UNFPA. The selection of target groups to be supported was based on the findings of several needs assessments and studies[54] which led to the development of the Country Programme Action Plan (CPAP, 2010).

It is noteworthy that UNFPA was responsive to emerging national priorities, quickly adapting interventions, supported by human and financial resources, in response to a UNCT call for support to host communities in early 2012. UNFPA designed its interventions (based on an assessment conducted in June 2012) focused mainly on GBV and providing RH kits to medical centres, training health providers, and distributing dignity kits to the refugee population. By end of 2012, UNFPA reached 23,081 refugees (incl. 1,595 men), exceeding its initial plan to reach 16,000 refugees.

While the efforts of the country office to align UNFPA humanitarian interventions with the local and national needs were well noted, they were limited in terms of coordination among humanitarian agencies and adequate consultation with local communities necessary to ensure that the assistance keep on responding to the beneficiaries' (evolving) needs.

UNFPA addresses youth through the integration of reproductive and sexual health in the curriculum as well as through the Youth Empowerment-Let's Talk Campaign in association with the NGO Masar, implemented in collaboration with the National AIDS Program and the Y-PEER network.

UNFPA thus addressed the Youth needs, involving them in various interventions. UNFPA was also involved by the civil society organizations and Lebanese government (represented through the Ministry of Youth and Sports) in the elaboration

[52] UNDAF 2010-2014, CCA Lebanon 2007.

[53] Gender at the Heart of the ICPD - The UNFPA Strategic Framework on Gender Mainstreaming and Women's Empowerment 2008-2013 (revised).

[54] GBV Research, Resources and Training Materials in Lebanon, Education for Change, 2008 ; Review of GBV in Lebanon Executive Summary, Prepared by Education for Change,2011 ; An Assessment of Reproductive Health and Gender-Based Violence among Displaced Syrian Women in Lebanon, UNFPA, 2012 ; Situation Analysis of Gender-based Violence in Lebanon, 2012

of a National Youth Policy and, with the support of UNESCO, the creation of a Youth Forum. The development of the National Youth Policy in 2012, which is a key development and the first of its kind in Lebanon, provides the relevant stakeholders[55] with a practical and user-friendly tool for their work with the youth. However, while this Policy is very comprehensive and covers a wide spectrum of issues, the concept of 'youth' remains gender-blind and does not highlight the specific needs of female youth.

In 2011, UNFPA, along with UNICEF and WHO, and in partnership with the Ministries of Public Health and of Education and Higher Education, completed the national youth behavioral survey, which still has to be translated into programmatic interventions, baseline indicators, and evidence for setting national priorities[56].

UNFPA, with the University of Saint Joseph (USJ), is assisting selected pilot service delivery points in underserved regions of the country (Mazaraa, Burj Hammoud, Tyre, Baalbeck, and Rashaya) to provide youth-friendly services (YFS) to young people, including Sexual and Reproductive Health (SRH). UNFPA published a training manual on Youth Friendly Services and child protection and, in collaboration with USJ and ECRD[57], provided access to comprehensive youth-friendly service packages, with a view to decreasing high-risk behaviors, preventing and protecting from gender-based violence, as well as promoting peace culture and conflict prevention.

4.1.2 Consistency of the components of the programme with the UNDAF, relevant national policies and strategies, and the UNFPA Strategic Plan

The 3rd country programme is loosely connected to the UNDAF beyond the overarching priorities, with the exception of the reproductive health component. It was difficult to reconstruct clear links with the global framework for RH and P&D. Consistency was stronger for gender and some aspects of RH, in particular youth programmes. The flexibility demonstrated by the CPAP allowed alignment with national priorities rather than national policies, in particular for the RH focus on primary health care. The gender component is strongly aligned to the related national policy while, on the other hand, the P&D component of the CPAP does not reflect a specific national policy (with MoSA or MoPH) nor a clearly expressed demand from MoSA. The political instability during the last decade, as well as the concentration of decision-making power at ministerial level was not fully supportive to joint programming. Significant adjustments were introduced in AWPs to facilitate the achievement of country programme objectives.

The RH Component of the CPAP is generally aligned with the UNDAF. In particular, the CPAP output related to young people "Improved knowledge, information and services for young people, with a focus on societal and community mobilization and evidence-based advocacy and policy dialogue" is aligned with the UNDAF output. The UNDAF output related to enhanced capacity of government institutions to develop health policies[58] is not clearly reflected in the CPAP. Whereas the CPAP seeks to strengthen the quality and performances of the RH services and their integration in the Primary Health Care (PHC) system, it does not refer to policy development. Only the CPAP output indicators refer to policy dialogue and production of policy briefs related to young people including health.

[55] Minister of Councils, Parliament, NGOs, Private Sector, Municipalities, General Directorates, Universities and Schools, Religious Institutions, Experts, Media and Youth.

[56] Knowledge, Attitude, Behavior and Practices survey among young people on Reproductive and Sexual Health, STI/HIV/AIDS and Related High Risk Behaviors, UNFPA, UNICEF, and WHO, 2010-2011

[57] In charge of the theater based peer education UNFPA

[58] United Nations, United Nations Development Assistance Framework 2010-2014

The CPAP is consistent with the UNFPA Strategic Plan but some of the selected strategies are not appropriate in the national context. In a country such as Lebanon, where 98% of the deliveries take place with skilled attendants and Emergency Obstetric and Neonatal Care (EmONC) services are in place, planning to increase the mass of skilled attendants or to develop comprehensive services for maternal or neonatal emergencies is not fully relevant.[59] The focus on underserved areas through planning the development of outreach services is more appropriate. Overall, the CPAP remains very broad and aims at covering a large number of thematic areas without clear priorities.

The design of the AWPs is more in tune with the reality of Lebanon with interventions better tailored to the national context. UNFPA seeks to develop national capacities through its support to the institutionalisation of youth-friendly services as well as the integration of reproductive health, gender and life skills in the school curriculum.

UNFPA planned to support the integration of reproductive health at primary health care level. This is in line with the MoPH role and complements the national initiatives to '*Achieve Better Health and Work toward ensuring coverage to all through strengthening its regulatory role',* as well as with the latest Health Strategy proposing to strengthen primary health care services. UNFPA, based on the recognition that the MoPH needs the institutional capacity to exercise an effective regulatory role (particularly in the ongoing accreditation system), also planned to support the development or revision of protocols, quality assurance tools, and standards. However, support to the ministry to ensure that reproductive health standards are sufficiently integrated in the regulatory system was not specifically planned.[60]

The reproductive health concept remains vague in the recently developed National Strategy for Women in Lebanon[61] developed with the support of UNFPA. The youth policy[62] refers to reproductive and sexual health of young people and all the concerned stakeholders endorsed the policy without opposing the mention of sexual health. This can be considered as an important progress. Early marriage is also mentioned in the youth policy. However both strategies do not refer to specific issues critical in the Lebanese context such as family planning. Although such topics are sensitive and difficult to discuss especially with young people, this was a missed opportunity to promote these issues and advocate further for reproductive health.

UNFPA used a consultative approach with the MoPH to define the approach to promote the utilization of reproductive health services in underserved areas (Result 1 of the CPAP).[63] However, as seen above, the CPAP and the AWPs do not sufficiently reflect the role of UNFPA in supporting the accreditation process for RH-related interventions.

Ongoing dialogue was maintained with the Ministry of Education and Higher Education (MEHE) and the Educational Centre for Research and Development (ECRD) as regards to the integration of the Life skills and RH curriculum in the school manuals. UNFPA provided support which was valued by its counterparts, although MEHE representatives were not aware of some of the extracurricular interventions, for instance about the piloting of Theatre-Based Peer Education (TBPE) in public schools.

[59] See CPAP Result 1 'Comprehensive, gender-sensitive, high-quality reproductive health services and commodities are in place and accessible'

[60] See Annex 4, Evaluation Matrix, Judgment Criteria 1.2

[61] National Commission for Lebanese Women and the United Nations for Population Fund, National Strategy for Women in Lebanon, 2011-2021

[62] UNICEF, SIDA, Youth Forum for Youth Policy. Policy for Youth in Lebanon," 2012

[63] 'Comprehensive, gender-sensitive, high-quality reproductive health services and commodities are in place and accessible'

The UNDAF outcome 1 with which UNFPA P&D component is associated is too broad to provide a framework for implementation. The P&D component is anchored to the very large UNDAF outcome 1 on governance ("*By 2014, good governance reforms, with a focus on national dialogue and inclusive participation, and government effectiveness and accountability, are institutionalized at all levels*"). None of the terms of this outcome can be directly linked to the UNFPA P&D strategy in Lebanon. A relatively artificial link was established by setting "*Effective and accountable governance of state institutions and public administrations is improved*" as the CPAP P&D outcome, which is far too ambitious when compared to the expected outputs:

- **Output PD1:** An integrated information system is developed and functioning to formulate, monitor and evaluate policies at national and sub-national levels, with attention to emergency settings;
- **Output PD2:** Enhanced capacity to utilize data for integrating population dynamics, reproductive health and gender-equality concerns into development planning and monitoring processes at national, sectorial and local levels.

This result framework is consistent with the ICPD[64] goals and explicitly targets national capacity development. This lack of contextualization was not sought by the CO, based on 2nd programme country programme final evaluation, but alignment prevailed during consultation with the regional office. The assessment of MoSA needs and capacity regarding P&D[65] was not available at that time.

The CPAP and the UNDAF are coherent with UNFPA contribution to a joint programme supporting the Statistic Master Plan implementation with the objective of developing a functional integrated system of information, with special emphasis on data disaggregation according to sex, region and other factors. Based on a joint assessment of the UN agencies, the weakness of the national statistical system was highlighted as a shared concern.

The elaboration of the National Social Development Strategy was an on-going process (supported by UNDP) when the CPAP was formulated. Coherence with MoSA sector policy framework is not presented and the strategies of the two P&D outputs are not clearly related to the lack of social policy, peculiar to the Lebanese context. An activity such as the "*Development of normative guidelines for local planning to address priority population issues including in emergency settings*" could apply anywhere and hardly in Lebanon. Even the existing Social Policy document (led by UNDP and few line ministries) does not mirror all social challenges and priorities in the country including on women and youth. For example, accreditation standards of public and private social "undertakings" are privileged upon comprehensive policy frameworks advocated by the UN agencies in general, and UNFPA in particular.

In 2011, the new MoSA Minister requested UNFPA to focus on aging rather than continuing a widespread approach of integrating P&D in development planning. The support to aging is consistent with the national priorities as i) expressed by the Minister of MoSA, ii) presented in the National Social Development Strategy document (2011, based on an UNFPA input), iii) materialized in the National Committee for Elderly Affairs (NCEA), chaired by MoSA Minister, with the Technical Secretariat being held by the Department of Family Affairs (DFA), the main UNFPA partner in MoSA. As a result, the AWPs 2011 and 2012 were adjusted accordingly. There were no consultation on the shift to aging issues, yet it was assumed that the fact that NCEA and DFA reflected a grassroots demand.

The link between this reorientation and UNFPA mandate can be found in the 5th outcome of the

[64] Report of the International Conference on Population and Development, Cairo, 5-13 September 1994; pp. 15-16

[65] Lebanon, Ministry of Social Affairs and United Nations Population Fund, Assessment of the Ministry of Social Affairs Units' Capacities and Needs, 2011

2008-2011 Strategic Plan: "*Emerging population issues — especially migration, urbanization, changing age structures (transition to adulthood/ aging)* and population and the environment — incorporated in global, regional and national development agendas". In this regards, the plan supports the Madrid International Plan of Action on Aging, a reference for CSA policy briefs funded under P&D AWPs.

An integrated approach to gender inequalities requires recognition that "*in many societies, cultural beliefs and perceptions are at the root of gender inequalities, and that gender equality and women's empowerment cannot be achieved unless they, too, are rooted within cultures.*"[66] Central to such activity is the acknowledgement of the role of men and boys in initiating and supporting change. The UNFPA 2008 Strategic Plan refers to the development of "*an enabling socio-cultural environment that is conducive to male participation.*"[67] UNFPA document "*Gender at the Heart of ICPD"* emphasizes the importance of *"working on issues of masculinity and partner[ing] with men and boys to promote gender equality.*"[68]

The country office aligned its interventions with the global UNFPA approach to gender equality and empowerment as articulated in a number of UNFPA documents, including the third goal of the 2008-2011 Strategic Plan, which was extended with revisions and which reflects the lessons learned from the 2008-2009 Capacity Assessment.[69] UNFPA interventions on gender equality within the Lebanon CPAP are based on four key policy-to-practice instruments for Gender Equality Strategic Focus (Beijing Platform for Action, CEDAW, MDG's declaration, and UNSCR 1325).[70]

Several policy directives of UNFPA called for specific programmes for men and youth groups and started to address specific issues such as masculinity (the 1994 ICPD, Strategic Plan 2008, *Gender at the Heart of ICPD*). UNFPA took into account most of the report's recommendations such as increasing services to women who are survivors of GBV and promoting a hotline. The recommendation to create men's support groups was not followed up on by the UNCT. (Assessment of Reproductive Health and Gender-Based Violence among Displaced Syrian Women in Lebanon, UNFPA, 2012)[71].

There is, however, one pioneer programme addressing specifically men in the UNFPA Lebanon CPAP. This programme implemented by KAFA, an NGO supported by UNFPA, which engaged in awareness-raising efforts with the Lebanese Internal Security Forces.[72]

The gender component of the CPAP, including its two outputs on capacity development and GBV, is aligned with the UNDAF outcome 3 on Gender, and translated into the three outputs related to capacity development, advocacy on human rights of women and girls, and GBV, especially in emergency settings. The CPAP is also aligned with the MDG Goal 3 on gender equality and women empowerment mainly on equal girls' enrolment in primary schools and on women's equal representation in national parliaments.

The goals of the gender component of the UNFPA country programme for Lebanon (2010-2014) were aligned with the National Social Development Strategy of Lebanon 2011, mainly in strengthening social protection, improving opportunities for equitable and safe employment, achieving better

[66] Ibid.

[67] Strategic Plan 2008, 19.

[68] Gender at the Heart of ICPD: The UNFPA Strategic Framework on Gender Mainstreaming and Women's Empowerment 2008-2013 (Revised), 11.

[69] Ibid, 6

[70] Evaluation of UNFPA's Country Programme of Assistance 2002-2009 Lebanon, Consultation and Research Institute, April, 2010

[71] See Annex 4 EQ1, judgment criteria 1.1

[72] Individual Interviews: UNPFA GBV Focal Point, May 8th. KAFA May 9th. ISF Coordinator of ISF GBV Project May 15th, Training session May 17th KAFA Lawyer KAFA trainer, with two ISF Trainers,25 ISF trainees group interview.

health, etc.[73] UNFPA Lebanon country programme is also aligned with the National Women's Strategy (2011)[74] and Action Plan (2013)[75] which clearly incorporated the human rights of women and adolescents girls, particularly their reproductive rights as priority areas. Additionally, gender mainstreaming is one of the main areas of intervention in the National Women's Strategy.

The CPAP further addressed priority issues, including the need for government and society to establish broader commitments to gender equality, through a number of legal and political steps in support of women's rights and gender equality[76] within UNFPA focus on capacity development (outputs GEN1 and GEN 2 of the CPAP). The NCLW has drafted thirteen laws, five of which have been ratified and eight others were under discussion at the time of this evaluation. These laws address a wide range of gender-related subjects, including inheritance and maternity leave for government employees. One of the important draft laws currently under discussion is the right for Lebanese women to request citizenship to their foreign husbands and children. UNFPA supported a thorough review of the status of women in the Lebanese legislation by NCLW as well as supported the advocacy efforts on the nationality law and the protection of women from domestic violence led by NCLW and the National Coalition to End Violence respectively.

4.1.3 Adequacy of the country office response to changes in the national context and, in particular, to the consequences of the Syrian crisis

UNFPA demonstrated a strong capacity to activate its emergency response mechanisms in the Syrian crisis, following the UNCT decision in 2012. Three-quarters of the funds needed were collected, and interventions were implemented by an ad-hoc response team. A needs assessment report was rapidly issued 2012, and interventions in the field of RH and gender were adjusted accordingly. As already mentioned, UNFPA also showed flexibility in the field of P&D, by way of responding to the demand of MoSA for a specific focus on the aging policy.

In early 2012, in order to respond to the reproductive health needs of the Syrian refugees (in particular women and girls), UNFPA Lebanon activated its emergency response mechanism based on its preparedness plan (developed in 2011) and formed a response team[77] to undertake the logistical aspects and field coordination of the humanitarian response. The response of UNFPA was based on a UNCT Interagency Humanitarian Contingency Plan, within which UNFPA coordinates all GBV-SRH-and youth-related interventions with relevant humanitarian relief agencies. As such UNFPA co-chairs the GBV sub-working group, chairs the RH sub-working group and has the lead role in coordinating youth-related response and interventions.[78]

In August 2012, UNFPA provided technical and financial support to conduct an *"Assessment of Reproductive Health and Gender-Based Violence among Displaced Syrian Women in Lebanon"*.[79] This assessment has generated for the first time essential findings on RH and GBV and has been used to design the interventions to respond to the Syrian crisis by the different partners including UNFPA. UNFPA also used this assessment in order to mobilise resources from donors.

[73] The National Social Development Strategy of Lebanon. MoSA-2011

[74] National Women's Strategy. National Commission on Women, 2011

[75] Action Plan, National Commission on Women, 2013.

[76] The National Social Development Strategy of Lebanon (2011)

[77] The response team was formed among UNFPA country office staff, and a vacant post was filled to focus on logistical support for an initial 6 months, and a field coordinator was recruited.

[78] UNFPA Lebanon Humanitarian Contingency and Preparedness Plan, 2012-2013

[79] Assessment of Reproductive Health and Gender-Based Violence among Displaced Syrian Women in Lebanon, UNFPA, 2012.

UNFPA country office mobilised additional funding for the humanitarian response operations through coordination with the UNFPA Regional Office and the Humanitarian Response Branch (HRB). UNFPA participation in and contribution to the various Regional Response Plans and in the preparation of a proposal for the Central Emergency Response Fund (CERF) also helped to mobilize additional funds. The initial assistance under CERF proposal was planned for the North and the Bekaa but it was extended to South Lebanon due to the influx of Syrian refugees in these areas from July 2012 to the end of December 2012.

Under the CERF funding, UNFPA supported different interventions[80] with the aim of providing displaced women and young girls with emergency reproductive health services as follows:

- Distribution of RH kits in health centres where the Syrian population influx was the highest. The health centres were selected in collaboration with UNHCR and the International Medical Corps (IMC);
- Support for a series of MISP training sessions between January and December 2012 in partnership with the Lebanese Society for Obstetrics and Gynaecology as well as the Ministry of Public Health;
- Awareness sessions about reproductive health and GBV were conducted for Syrian women and women from host communities in the different areas accompanied by the distribution of dignity kits;
- Clinical management of rape and GBV, disseminating key messages/material on STI/HIV;
- Youth Peer education was undertaken with out-of-school young Syrians, Iraqis, Palestinians and host communities.

UNFPA addressed the needs of Syrian refugees, especially in North Lebanon and the Bekaa Valley, reaching 23,081 refugees (exceeding its initial target of 16,000 refugees). These interventions aimed at ensuring that reproductive health services are available to Syrian women at primary health care level and at raising awareness on reproductive health and GBV issues.

While the UNFPA CO efforts in aligning their humanitarian interventions with the local and national needs were well recognized, however there remains room for improvement, especially due to the rapidly changing political and security situation. Despite UNFPA efforts, there is not enough consultation between humanitarian agencies and the local health centres to ensure that assistance is fully in line with the needs of the beneficiaries.

The increased involvement of UNFPA in humanitarian assistance due to the Syrian crisis has not been to the detriment of regular activities. Although country office staff were involved in providing humanitarian assistance, they also ensured that regular programme activities were carried out with the respective implementing partners as initially planned. However, some of the government partners in the MoPH and MoSA were not always available for regular activities because they were involved in the humanitarian response.

In the P&D component, 2011 and 2012 AWPs marked a strategic shift from the CPAP. This shift responded to an explicit request of the Minister of Social Affairs, rather than a change in the national context. Although this change did not stem from new emerging needs, it appeared to be justified by two convergent UNFPA-funded surveys[81] on the conditions for the elderly in public and private institutions. The shift from UNFPA support for integrating the P&D dimension in MoSA statistics to supporting the elaboration of the aging policy was progressive, as shown in Table 6.

[80] Resident/Humanitarian Coordinator Report, 2012 on the use of CERF funds, Lebanon.

[81] See Annex 4, Evaluation Matrix, Judgment Criteria 3.1

This shift in focus is important and does correspond to the initial objectives of the CPAP. A revised CPAP results framework was expected from the mid-term review[82] finalized in 2012 but has not materialized yet, since, at the time of this evaluation, the review had not yet been approved by the government.

Table 6 *P&D AWPs Content 2010, 2011 and 2012*

2010	2011	2012
1 Project support	**1 Project support**	**1 Project support**
1.1 Equipment 1.2 Project personnel 1.3 Unexpected miscellaneous	1.1 Equipment 1.2 Project personnel 1.3 Unexpected miscellaneous	1.1 Equipment 1.2 Project personnel 1.3 Unexpected miscellaneous
2 Enhance Canacitv of MOSA DFA and DRP in RBM and integration of PD in local planning	**2 Enhance MOSA, DFA & DRP capacities in integrating population in development plans both centrally and peripherally**	**2 Enhance MOSA/NCEA capacities in integrating population in development plans both centrally and peripherally**
2.1 Conduct assessment of MOSA DFA and DRP 2.2 Conduct training (1 in 2010) for DFA and DRP on RBM 2.3 Conduct training (1 in 2010) for DFA & DRP staff on priority thematic areas 2.4 Conduct training for DFA and DRP (1 in 2010) on local development 2.5 Conduct sensitization meetings with MOSA units 2.6 Support MOSA staff in study tours/events 2.7 Procure EDP equipment for DFA and DRP	2.1 Conduct training for OFA, ORP, SDCs on RBM, priority thematic areas, local development and others 2.2 Conduct sensitization and cornmunity mobilization meetings 2.3 Support MOSA employees in study tours 2.4 Procure EDP equipment and software for DFA and DRP, SDCs 2.5 Conduct mapping of selected local communities 2.6 Support in planning interventions at local level	2.1 Conduct a series of trainings (x8) for DFA, DRP, SDCs on local development, project mgmt, planning and communication, fund raising, integration, monitoring and others 2.2 Conduct pilot training of trainers (x 1) on comprehensive care & rights of elderly 2.3 Hold workshops (x 2-3) with NCEA members to follow up on assessment 2.4 Conduct pilot training on implementation of standards (x 1)
3 Enhance local capacities of MOSA/SDC, NGOs and municipalities in local planning of PD issues	**3 Increase visibilitv in support of policy dialogue on aging**	**3 Generate knowledge base to support policies on aging**
3.1 Conduct 9 meetings (for community mobilization, dissemination of results) 3.2 Conduct mapping of selected local communities 3.3 Conduct training (6) on local planning for MOSA SDC	3.1 Advocacy events in relation to aging 3.2 Generation of knowledge base on aging related issues	3.1 Undertake feasibility study on sample elderly institutions to determine needs, cost and time frame for implementing standards 3.2 Undertake legal review study (draft laws and addressing laws impacting elderly in comparison to other countries in the region) 3.3 Develop manual/guidelines for implementing standards for elderly institutions 3.4 Develop training package on comprehensive care & rights of elderly 3.5 Conduct needed research on aging
4 Increase MOSA and proiect visibility	**4 Increasing MOSA capacity in integrating aging issues in national development plans**	**4 Strengthen MOSA leadership role in lntegrating Aging Issues in National Development Plans**
4.1 Develop, produce and disseminate material (Launching of CD/ guide for elderly services, Workshop on report on elderly services, printing of CSA report)	4.1 Conduct assessment of NCEA and its TS including mapping of similar countries experiences 4.2 Support participation of NCEA members in study tours/events 4.3 Support work on developing standards for institutions catering for the elderly	4.1 Organize high level national technical meeting towards a framework for developing capacities to plan aging strategy for Lebanon 4.2 Support participation of NCEA members in development study tours/events 4.3 Hold technical meeting to discuss final draft standards with elderly institutions 4.4 Hold advocacy/Lobbying meetings (x 4-5) sensitize targeted stakeholders (parliamentarians, media, academicians, etc) about understanding priority matters based on research review, etc.
5 Undertake project audit	**5 Undertake project audit**	**5 Undertake project audit**
	6 Support WPO 7 Billion campaign	

Source: UNFPA P&D AWPs, 2010. 2011, 2012

[82] Report On Mid--Term Review Of The UNFPA 2010--2011 Program implementation, September 2012

4.2
EFFECTIVENESS AND SUSTAINABILITY IN THE REPRODUCTIVE HEALTH AND RIGHTS COMPONENT

EQ2
To what extent did UNFPA-supported interventions contribute (or are likely to contribute) to sustainably increase the access to and utilization of high-quality reproductive health services, particularly in underserved areas, with a focus on young people and vulnerable groups, including Syrian refugees?

SUMMARY
During the 3rd country programme, the contribution of UNFPA in the area of reproductive health has been noticeable as regards to the sensitization of young people around STIs/HIV/AIDS and some reproductive health issues. UNFPA efforts have contributed to the progress of the integration of reproductive health and life skills education in the school curricula and in extracurricular activities. UNFPA support to the development and the piloting of a Youth-Friendly Services package through the involvement of a large variety of partners is an adequate prerequisite to its acceptance. A sensitization campaign and sessions through Y-PEER education remain more anecdotal and have little potential to produce any noticeable effects both in terms of delivery of key messages and in terms of coverage. Despite previous collaboration with the MoPH that was fruitful during earlier country programmes, UNFPA could not reinforce the reproductive health services further at primary health care level. An exception, however, is the support for a regular supply of contraceptive commodities and reproductive health commodities in areas identified as receiving a high influx of Syrian displaced populations and the conduction of MISP training.

4.2.1 Profile of the Reproductive Health and Rights Component

In the CPAP 2010 – 2014, the intended outcome of the reproductive health and rights component was stated as '*Increased access to and utilization of high-quality health services, particularly in underserved areas, with a focus on vulnerable groups.*'

Under the first output for the RH component of the CPAP, "Comprehensive, gender-sensitive, high-quality reproductive health services and commodities are in place and accessible", the project "Enhancing MoPH national capacities for providing quality RH services at primary and secondary care levels in Targeted Areas" was designed in consultation with the Ministry of Public Health (MoPH) as implementing partner.

The approach adopted in the 3rd country programme was a continuation of the previous cooperation with the MoPH, although the implementation modalities changed between the two cycles. During the 2nd country programme, implementation was under the responsibility of a Management Unit within the Ministry, with staff dedicated to the project. It is to be noted that the Management Unit supported by UNFPA under the 2nd country programme was fully absorbed by the MoPH structure under the 3rd country programme.

During the 3rd country programme, the AWP was signed by the MoPH and implementation was the direct responsibility of the Ministry. In 2010, no activity took place as the CPAP was signed at the end of May 2010 and discussions between UNFPA and the MoPH continued on the nature of their collaboration and the content of the AWPs. The project was signed in early 2011, outlining the following interventions as included in the AWP:

- Enhance capacities of service providers on comprehensive RH package at PHC and secondary care level in target areas;
- Enhance MoPH capacities for developing and operationalizing reproductive health (RH)

commodity security;

- Strengthen hospital capacity in training programme on outreach;
- Generate evidence and knowledge in RH;
- Develop and pilot and RH monitoring system in targeted area.

Despite the fact that a number of interventions were planned under the AWP signed with the MoPH, the only interventions implemented were the procurement of contraceptives and of RH commodities, as well as the MISP training undertaken in collaboration with the Lebanese Society of Obstetrics and Gynaecology (LSOG).

Following the change of government in 2011, the new Public Health Minister did not approve the different planned interventions despite the continuous support of the Director General who was in place during the previous country programme. As a result, the national financial contribution was not released.[83] In 2011, the procurement of contraceptives was made possible thanks to funds coming from interests accrued on the Ministry's contribution bank account.

The 2012 signed Annual Work Plan (AWP) outlined the following interventions:

- Procurement of essential RH drugs and contraceptives to ensure no stock-outs at the PHC level;
- Initiate preparation and framework for the development, implementation and institutionalization of the outreach training programmes;
- Conduct a rapid situation analysis of all RH-related strategies, programmes, initiatives, funding, etc.

In 2012, contraceptives and reproductive health commodities were purchased with additional funding from UNFPA emergency funds to support the needs of the Syrian displaced population. The RH situation analysis was initiated and a consultant was hired for this purpose.

In 2013, no AWP was signed with the MoPH. The relationships of the MoPH and the UN agencies deteriorated and were interrupted because of a disagreement on Maternal Mortality Rates (MMR). WHO published MMR figures stemming from a modeled estimate of Maternal Mortality Rates that did not coincide with the data obtained by the MoPH through Hospital-Based Reproductive Age Mortality Survey (RAMOS).[84] As UNFPA – at headquarter level - is one of the UN Agencies involved in the modeling process at global level, it was included amongst the UN agencies that the Ministry ceased relationships. This happened during the field phase of the evaluation mission.[85]

Under the first intended RH output (i.e., output RH1 of the CPAP), new projects were designed to respond to the Syrian crisis in 2012. "Awareness Campaign: Improving Syrian displaced and local women knowledge and referral on SRH/GBV" was signed with the Young Men's Christian Association (YMCA) and a broader AWP was designed to be implemented by UNFPA in partnership with other NGOs. In this AWP, the following interventions were planned and undertaken with UNFPA Emergency Funds, Central Emergency Response Fund (CERF) and UNFPA Lebanon CO funds:

- Enhancing capacities on RH/MISP, GBV, mental health;
- Procurement, distribution of commodities (including warehousing and transportation);

[83] In 2011 the AWP mentioned a contribution of the government of USD 372,000 (Trust Fund) against UNFPA's contribution of USD 75,000.

[84] Salim Adib, MD, DrPH, Maternal Mortality Ratio In Lebanon In 2008: A Hospital-Based Reproductive Age Mortality Survey (RAMOS), 2010

[85] It should be noted however that following consultation and advocacy with MoPH in late 2013 and early 2014, UNFPA succeeded in reinvigorating this partnership and an AWP was discussed with the Director General and signed in early April 2014.

- Data collection and analysis;
- Youth engagement;
- Personnel recruitment
- Communication and visibility.

In early 2013, UNFPA collaborated with the YMCA to raise the awareness of the host communities on SRH/GBV.

Under the second intended output of the RH component (i.e., output RH2 of the CPAP), "Improved knowledge, information and services for young people, with a focus on societal and community mobilization and evidence-based advocacy and policy dialogue", five different projects were designed:

- Y-PEER Project;
- Capacity development for integrating theatre-based peer education in education sector;
- Youth empowerment - Let's Talk;
- Enhancing Educational Centre for Research and Development (ECRD) capacities on Integration of "Life Skills RH Education" Public Teaching Curriculum;
- Expanding RH in school-based extra-curricular education.

With regards to the Y-PEER project, the following interventions were planned in 2010:

- Developing capacity of existing peers in project development and management, advocacy and negotiation skills as well as risk behaviors (substance abuse);
- Developing capacities of new youth groups in peer education (Palestinians and most at risk populations - MARP);
- Enhancing capacity of NGO in mainstreaming implementing and expanding peer to peer using different tools and approaches (including TBPE);
- Increasing visibility of Y-PEER interventions through various events;
- Developing a M&E system tailored for Y-PEER approach.

The capacity development interventions were conducted, with the exception of the training planned to target the most at risk populations (MARP) due to the lack of expertise of the Y-PEER network in this area.

The number of Y-PEERs increased following three trainings on HIV/AIDS conducted by the Lebanon Family Planning Association (LFPA) and Jeunesse Contre La Drogue (JCD). Following the training, 100 outreach sessions were conducted which reached 2000 young people. Advocacy events were also organised, such as World Aids Day.[86]

In 2011, the AWP included the following interventions:

- Developing capacity (of new and existing peers and NGOs) on strengthening and adapting peer to peer approach to emerging issues priorities (GBV, humanitarians settings, human rights);
- Increased advocacy;
- Support to develop relevant standards, normative tools and national strategies (National Youth Policy, HIV/AIDS action plan, eligibility standards);
- Increasing visibility of Y-PEER interventions through various events;
- Activate youth-friendly services;
- Developing a M&E system tailored for Y-PEER approach.

[86] See Annex 4, Evaluation Matrix, Judgment Criteria 2.4

UNFPA youth programming included the involvement of young people. The Y-PEER network was used as a resource network by the other UN agencies (e.g., UNHCR to work with young Iraqi refugees). The capacity of Y-PEER was developed in terms of gender equality and gender-based violence issues through various trainings. The Y-PEER network took part in International Days and events celebrations[87] and issued six-monthly newsletters to increase its visibility. A handbook on HIV/AIDS prevention and a documentary were prepared.

In 2012 and within the context of the humanitarian response, the Y-PEER network was involved in providing information among the young Syrian refugees in collaboration with the University of Balamand (UOB) and supported by UNFPA on:

- Enhancing capacity of Y-PEER (training module on stress management);
- Generating knowledge and data on youth;
- Conducting outreach activities and events.

Young people affiliated to NGOs attended a sub-regional Training of Trainers in Peer Education on SRH, Empowerment and Life Skills for Young People in Humanitarian Settings.[88] Peer education interventions took place aimed at raising awareness among young refugees through NGOs that received support costs and were supervised by UOB.[89]

An AWP was signed in 2010 with the Visual and Performing Arts Association (VAPA) in order to enhance its capacity and the capacities of four private schools on **Theatre-Based Peer Education (TBPE)**, as well as to develop learning and visibility tools. The VAPA and the Y-PEER network, as well as teachers and students of the four beneficiary schools, participated in a TBPE training.[90] A manual and a documentary were produced.[91] The TBPE activities were continued under the AWP signed with ECRD in 2012.

In 2011, UNFPA signed an AWP with the MASAR Association[92] in order to develop youth capacity in terms of advocacy, and to implement outreach and advocacy events, called the "**Youth empowerment - Let's Talk**" campaign. Two training workshops and a national media campaign were organized.[93]

From 2010 to 2013, AWPs were signed with the ECRD for the introduction of **Life Skills RH education** in public teaching curricula through the development of the cycle 1 and cycle 2 scholastic books. As part of the same AWP, UNFPA started strengthening the teachers' capacity in TBPE techniques and introducing TBPE in public schools from 2011. All interventions were undertaken, but the integration of the curriculum is a very slow process and has only reached cycle 1.

UNFPA signed an AWP in 2011 and in 2012 with the Saint Joseph University to **expand reproductive health in extracurricular activities in schools**. Interventions included a consensus building on tools to be used, capacity development, adaptation or production of tools, and generation of evidence (through pre and post test). A university course was developed on life skills and reproductive health.[94] As part of the same AWPs, a Youth-Friendly Services package was developed, a manual produced and the capacity of stakeholders developed.

The budget allocated to the programme during the period under evaluation was USD 2.4 million. Disbursement increased regularly from USD 0.4 million in 2010 (starting in June) to USD 1.2 in 2012. The disbursement ratio is 98 per cent (Figure 10).

---

[87] Ibid

[88] See Annex 4, Evaluation Matrix, Judgment Criteria 2.4

[89] Ibid

[90] See Annex 4, Evaluation Matrix, Judgment Criteria 2.4

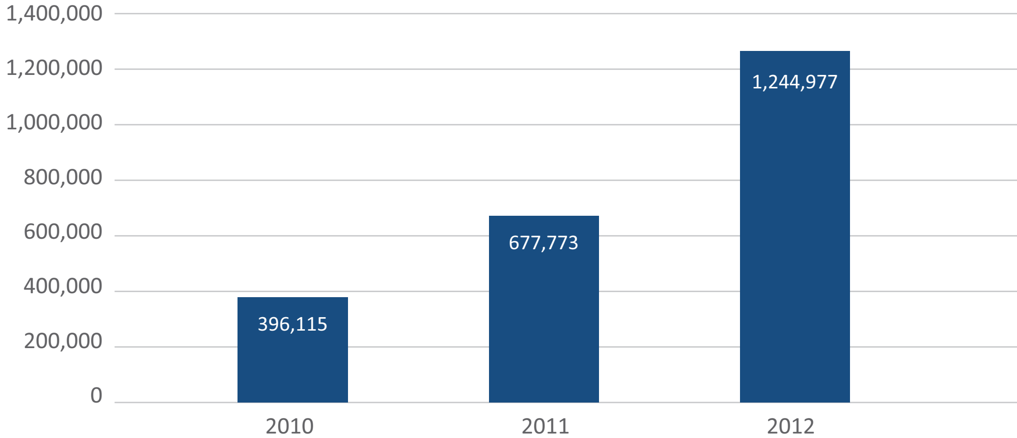
[91] Y-PEER Lebanon and Visual Arts and Performing Association (VAPA): Theatre Based Peer Education at school - Training Manual, 2011

[92] Organisation with 10 years' experience in advocating for national youth policies in Lebanon

[93] See Annex 4, Evaluation Matrix, Judgment Criteria 2.4

[94] Ibid

Figure 10 *RH Component: Annual AWP Budget (2010 - 2012)*



Source: Atlas

Table 7 *RH Progammes and Disbursements*

COMPONENT / OUTPUT / PROGRAMME	2010		2011		2012		TOTAL	
	Disbursements	Percent	Disbursements	Percent	Disbursements	Percent	Disbursements	Percent
Comprehensive, gender-sensitive, high-quality reproductive health services and commodities are in place and accesible (2.1)	-	0	210,222	31	657,132	53	**867,354**	**37**
LBN3R11A: Enhancing MOPH capacities in Rep/ Enhancing national capacities for providing quality RH services at primary and secondary care levels in Targeted Areas	-	0	210,222	31	86,204	7	**296,426**	**13**
LBN3U207: An Awareness Campaign: Improving Syrian displaced and local women knowledge and referral on SRH/GBV	-	0	-	0	570,928	46	**570,928**	**25**
Improved knowledge, information and services for young people, with a focus on societal and community mobilisation and evidence-based advocacy and policy dialogue (2.2)	396,115	100	467,551	69	587,846	47	**1,451,512**	**63**
LBN3R41A: Capacity develpment and expansion of (Y-PEER)	263,387	66	168,717	25	206,419	17	**638,523**	**28**
LBN3R41B: Capacity development for integrating theatre based peer education in education sector	45,300	11	-	0	-	0	**45,300**	**2**
LBN3R41C: Youth empowerment let's talk	-	0	126,629	19	5,600	0	**132,229**	**6**
LBN3R51A: Enhancing ECRD's capacities on Integration of "Life Skills RH Education" Public Teaching Curriculum	87,428	22	72,705	11	90,598	7	**250,731**	**11**
LBN3R51B: Expanding RH in school-based extra-curricular education	-	0	99,499	15	285,229	23	**384,728**	**17**
Total	**396,115**	**100%**	**677,773**	**100%**	**1,244,977**	**100%**	**2,318,865**	**100%**

Source: Atlas

4.2.2 Availability and accessibility of comprehensive, gender-sensitive, high-quality reproductive health services, especially in underserved areas, with a focus on young people and vulnerable groups

During the 3rd country programme, UNFPA was able to contribute to ensuring that primary health care centres have sufficient supplies of reproductive health commodities. Political changes led to challenging relationships with the MoPH. As a result, the contribution of UNFPA to the harmonization of the normative tools and to improving access by vulnerable groups to high quality RH services (as originally planned) was limited.

During its 2nd country programme (2002-2006 extended to 2009), UNFPA contributed to strengthening and integrating reproductive health at primary health care level (PHC) through the PHC centres network of the MoPH.[95] UNFPA efforts were in line with the policy of the MoPH to reinforce the Primary Health Care Centres. UNFPA also supported the assessment of linkages between SRH and HIV and also contributed to the integration between SRH and HIV services. However, this remains an on-going effort and the RH-related protocols are not yet entirely harmonized across the country.[96]

During the first three years of the 3rd country programme (2010-2014), most of the planned interventions could not be implemented because of reduced collaboration with the MoPH which led to a delayed release of the MoPH financial contribution and to the absence of human resources allocated to implement the agreed interventions.[97] This weakened cooperation with the MoPH did not allow UNFPA to continue advocating for the integration of the essential reproductive health services package into the normative tools and referral systems of the Ministry.

Difficulties in the collaboration between UNFPA and the MoPH can be explained by the following factors:

- The nature of the collaboration between UNFPA and the MoPH changed under the 3rd country programme. During the 2nd country programme, UNFPA was supporting the salaries of the MoPH staff involved in the RH project (using the MoPH financial contribution) and these UNFPA-supported staff were directly implementing the project interventions. The 3rd programme was designed differently as it sought to support health sector reform. The project staff recruited by the MoPH during the 2nd programme cycle were fully absorbed by MoPH (through the Civil Servant Council) and became fully responsible for project implementation. This implies transfer of know-how as well as some degree of buy-in by the government. However, the transition to this new approach whereby MoPH staff was no longer supported by UNFPA besides technical support might have led to a decreased interest from the MoPH. [98]
- The commitment of MoPH to reproductive health was not as strong following political changes in the government, and reorganization in the MoPH leading to lower support for reproductive health.[99] Nevertheless the issue of reducing maternal mortality remained high on the agenda of the MoPH.
- Under the previous programme, concerned UN agencies (UNFPA, WHO) had been actively striving for the development of a reproductive health strategy. However, because of the sensitivity surrounding RH issues in Lebanon but also unclear health policy, no agreement could be reached on a strategy that would satisfy all the parties. The absence of such a strategy is a hindering factor to the harmonization of

[95] Evaluation Matrix, Judgment Criteria 2.1

[96] Interviews with development partners, implementing partners and UNFPA CO

[97] See Annex 4, Evaluation Matrix, Judgment Criteria 2.1

[98] Ibid

[99] Evaluation Matrix, Judgment Criteria 2.1

reproductive health protocols. A reproductive health policy would have allowed laying the basis for future regulations and for building a common understanding among all partners.[100]

- Despite the consultative process with MoPH for designing the 3rd country programme, the MoPH considers that its needs as regards the accreditation scheme of health services were not properly addressed.[101] On the other hand, the accreditation process has not specifically integrated reproductive health; UNFPA has not sufficiently geared its efforts towards ensuring that reproductive health is integrated in this ongoing process.[102]

UNFPA had planned to support the development of gender sensitive outreach services with a view to targeting vulnerable groups. It was planned that UNFPA support would include the development of services providers' capacity in conducting outreach services. UNFPA could not carry out these interventions forward because of weaker collaboration with MoPH. [103]

The only interventions that were undertaken in collaboration with the MoPH were: i) the procurement of contraceptives and RH commodities in 2011 and 2012;[104] ii) the implementation of MISP training under the humanitarian interventions[105] in 2012; and iii) in early 2013, the initiation of a situation analysis of reproductive health in Lebanon which is still on-going.

The rationale for undertaking a RH situation analysis is to review all the reproductive health efforts, to analyze the policy development as well as the bottlenecks and gaps encountered during the implementation of RH interventions. It is planned that all the stakeholders will be involved to draw key recommendations in terms of policy, programme, monitoring (with a particular focus on RH indicators), coordination, and sustainability. Such undertaking is a positive move as it has the potential to be used as an advocacy tool and to promote reproductive health in the political agenda provided it gives clear directions for reproductive health in Lebanon and that it is adhered to by the various key stakeholders.

Advocacy and promotion activities on maternal, neonatal, family planning and sexual and reproductive health were carried out, such as the 7 Billion Day campaign celebration in 2011 in 17 maternity hospitals or the roundtable on "Media Approach to Women Health Issues" to improve media coverage on women's health issues and rights organized in October 2011, with the Lebanese Society for Obstetrics and Gynecology (LSOG).[106] These types of interventions contributed to advocacy for maternal health but their scope is limited as they are punctual and only address a small range of stakeholders; overall, they have been insufficient to put reproductive health higher on the national agenda.

4.2.3 Status of the reproductive health commodity security system

UNFPA has contributed to supporting the MoPH to ensure a sufficient supply of contraceptive commodities. However, it did not contribute to developing and operationalizing a reproductive health (RH) commodity security system despite its initiative to involve MoPH representatives in related capacity development interventions. So far, the availability of contraceptives in the primary health care system has been generally adequate, including in facilities responding to the emergency situation, but it is unclear whether family planning commodities will be sufficient in the future.

---

[100] Ibid

[101] See Annex 4, Evaluation Matrix, Judgment Criteria 2.1, Interviews with stakeholders

[102] See Annex 4, Evaluation Matrix, Judgment Criteria 2.1, Interviews with stakeholders

[103] See Annex 4, Evaluation Matrix, Judgment Criteria 2.1

[104] See section 4.2.3

[105] see section 4.2.4

[106] See Annex 4, Evaluation Matrix, Judgment Criteria 2.1

In Lebanon, the private sector is the main source of contraceptive methods for 81 per cent of the population and only 6.6 per cent obtain contraceptive methods from the public sector (hospital or health centres), which serves the poorest segment of the population.[107] In 2011 and 2012, in the primary health care network of the government, 95 per cent of the Service Delivery Points (SDPs) offered three or more modern contraceptive methods and no SDPs experienced stock-out in the last six months.[108] The facilities receiving a high influx of refugees, and visited during the evaluation,[109] had not experienced stock-outs.

Despite the support of UNFPA to the RH programme (until 2009), mechanisms for the monitoring of contraceptive commodities availability and stock-outs are not in place.[110] This issue was discussed with MoPH, and the development of a reproductive health commodity security (RHCS) system was included in the 2011 AWP. Two MoPH representatives attended a regional training in Cairo on commodity security in 2012. However, no system could be developed and the contraceptive commodities forecasts are still based on consumption. This can be partly explained by the current relationships with MoPH which was not conducive to a constructive dialogue and to a strong interest for reproductive health. As a result, UNFPA could not promote the development of a RHCS system.[111]

In 2010, UNFPA did not procure contraceptives for the MoPH since there was no request for contraceptives from the government. In 2011, contraceptives were procured by UNFPA mainly with government funds,[112] this allowed ensuring sufficient supply as no stock out were reported in PHC Centres. [113] In 2012, three sources of funds were mobilized for procuring contraceptives: government, UNFPA regular resources and emergency funds (CERF). Emergency funds aimed at responding to the increased demand for family planning methods from the Syrian refugees in addition to the contraceptives supplied by some of the reproductive health kits. By mid-2013, the MoPH nevertheless requested UNFPA to continue procuring contraceptive and RH commodities and in view of the increased influx of Syrians fleeing to Lebanon for safe haven.

4.2.4 Availability of high-quality reproductive health services in humanitarian settings

UNFPA is recognized as a key partner for reproductive health in emergencies and assumed a coordination role during the response to the Syrian crisis. It has contributed to strengthening the provision of reproductive health services in the areas where the health care system faces a high influx of Syrian refugees through providing RH commodity supplies, capacity development of health care providers and awareness raising among women and youth. However, the collaboration of UNFPA with the MoPH was more limited, as it does not reflect fully the potential contribution of UNFPA.

In the Emergency Health Contingency Plan developed by the MoPH in 2012, UNFPA is considered as one of the partners in the health response to emergencies under the MoPH leadership. In this Plan UNFPA role is related to the activation of the Reproductive Health sub-cluster and to possible source of supplies. Nevertheless, the role of UNFPA in the field of reproductive health does not appear as prominently in the plan compared to the more significant role played by other UN agencies in the field of health. Although

[107] The Central Administration of Statistics, The Pan Arab Project for Family Health. *Lebanon Family Health Survey, Principal Report, 2006*

[108] UNFPA, Country Office Annual Report 2012

[109] MoSA SDC Baalbeck, Machha PHCC, MoSA SDC Halba

[110] United Nations Population Fund, *Country Office Annual Report 2011*

[111] UNFPA CO

[112] This was possible due to the remaining interests of previous Ministry's contribution

[113] See Annex 4, Evaluation Matrix, Judgment Criteria 2.2

UNFPA resources and capacities are limited the plan does not reflect fully what UNFPA can contribute, for instance in terms of RH training. [114]

At the beginning of the response to the Syrian crisis, the health response was coordinated by UNHCR and WHO; UNFPA was one of the partners involved. The government was not engaged until the end of 2012 and the role of the governmental facilities in providing support to Syrian refugees was not well defined despite the plan cited above.[115]

From the last quarter of 2012, a RH sub-working group was created after the health working group and relevant partners acknowledged that reproductive health interventions were not sufficiently coordinated in the context of the Syrian crisis. The RH sub-group is chaired by UNFPA and co-chaired by International Orthodox Christian Charities (IOCC). As the chair of the RH sub-group, UNFPA plays the role of coordinator and has been convening monthly meetings since February 2013. It helped creating linkages between the MoPH and the RH sub-working group, representing all the humanitarian relief agencies working on RH. MoPH representatives started attending the RH subgroup from April 2013, which facilitated the coordination of interventions between the different actors and the MoPH, for instance as regards to the selection of health facilities serving Syrian refugees. It also allowed for a better alignment of interventions with MoPH policies in the context of the response to the Syrian crisis.[116]

Capacity development interventions were supported by UNFPA with a view to developing the capacity of health care providers in humanitarian crisis setting. UNFPA started introducing the **Minimum Initial Service Package** (MISP) in Lebanon after a training of trainers which took place in Cairo in 2009. This core group of trainers, formed of MoPH and NGO representatives, adapted the MISP training materials to the situation of Lebanon following the regional training.[117]

In 2012, four MISP 3-day training sessions were conducted, one in the North (15 participants) and in three in different locations of the Bekaa region (52 participants).[118] These trainings were organized through cooperation with the MoPH and the Lebanese Society for Obstetrics and Gynaecology (LSOG) and targeted doctors, social workers, midwives and nurses from service delivery points pertaining to the MoPH, Ministry of Social Affairs and NGOs as well as referral centres. The service delivery points (SDP) were selected on the basis of the influx of Syrian displaced families, their capacity to offer free SRH services to Syrian displaced women and girls, and the existence of a referral system between these SDPs and selected hospitals to ensure continuum of care and safe delivery.

MISP training sessions were also organized for health care providers working in Primary Health Care Centres ran by the United Nations Relief and Works Agency for Palestine Refugees (UNRWA) and Palestinian Red Crescent society hospitals in 2013.

Some of the training participants met during the evaluation expressed their interest in topics covered during the training, such as counselling and issues related to Gender Based Violence that would help them to deal with HIV cases and violence in the future. They also learned about referral channels for such cases as well as the use of the reproductive health kits.[119]

The MISP training was planned and is useful for reinforcing existing knowledge on RH in emergency as well as raising the awareness of service providers on issues such as violence but stakeholders recognize that it requires further adaptation to be

[114] Ministry of Public Health Lebanon, Emergency Health Contingency Plan, Draft, Revised 2012

[115] Ibid

[116] See Annex 4, Evaluation Matrix, Judgment Criteria 2.3

[117] Ibid

[118] Data provided by the UNFPA country office

[119] FGD MISP trainees in Annex

fully appropriate to the context of Lebanon.[120] In interviews with stakeholders, it was noted that this approach was limited to awareness raising, and that it did not provide opportunities to develop comprehensive strategies to address RH issues in emergency settings.[121] Most of the services are provided within the health system network which does not always provide the necessary flexibility to undertake prevention or protection activities. Furthermore, there is no provision for follow-up or support once service providers have been trained, neither from UNFPA nor from the government. Even though follow-up is challenging in emergency situation the lack of support mechanisms limits the effects of the MISP training.

Besides MISP training, another area of capacity development supported by UNFPA and other partners in collaboration with the Lebanese Society of Obstetrics and Gynaecology (LSOG) concerns the sensitization of health professionals on the **clinical management of rape.** In 2012, 45 health professionals (nurses, midwives and physicians) in the Bekaa and North regions were sensitized on the issue of sexual violence and on the clinical management of rape protocols and treatment based on WHO guidelines. The introduction of this type of training is fraught with challenges as, because of the sensitivity of the issue, health professionals are not all ready to be involved in such case management and patients do not systematically come forward when they are victims of violence. The fact that there is no national protocol for rape case management in Lebanon has led to difficulties for the health authorities to adopt a training module introduced during the Syrian crisis. Nevertheless the various persons interviewed during the evaluation mentioned that the involvement of several humanitarian actors in this intervention would progressively facilitate its acceptation.[122]

The support of UNFPA in the context of the Syrian crisis led to an additional supply of contraceptives through the MoPH network (CERF funding),[123] the supply of reproductive health kits and awareness sessions conducted for women among the refugees and the host communities as well as among young people. This types of support resulted in an increased access to reproductive health services and information among the Syrian displaced population.

UNFPA provided **79 reproductive health kits** to all the identified health units until the evaluation field phase. Most of the kits aimed at providing oral and injectable contraception, IUD insertion and STI treatment. The distribution of the reproductive health kits was done with a view to responding to the increase in demand for reproductive health services in the service delivery points serving both the local women and the Syrian displaced women.[124] The selection of the facilities was based on discussions with UNHCR and the International Medical Corps (IMC), field visits to service delivery points, which were meant to assess the availability of reproductive health commodities (family planning, STI treatment), as well as the RH needs identified by the service delivery points themselves.[125] The rape treatment kits were distributed to health facilities selected by the different partners where health care providers had been trained. It is unclear whether the selection of these facilities was based on information regarding rape incidence as most cases are not reported. The trained service providers met during the evaluation reported that they did not handle any rape cases and thus did not use the kit as victims do not seek support. Little compiled information is available concerning the use of the rape treatment kits.

Most of the kits were distributed during the last quarter of 2012 and the first quarter of 2013, in

[120] Evaluation Matrix, Judgment Criteria 2.3. Interview with partners.

[121] Ibid

[122] See Annex 4, Evaluation Matrix, Judgment Criteria 2.3

[123] See paragraph 4.2.3

[124] Resident / Humanitarian Coordinator, Report 2012 on the Use of Cerf Funds Lebanon

[125] Interview of UNFPA staff

health units in North Lebanon, Bekaa, Beirut, Mount Lebanon, and South Lebanon, as well as in UNRWA Primary Health Care centres and Palestinian Red Crescent society hospitals in the regions hosting Palestinians camps (Beirut, South and North Lebanon). The kits were supplied to MoSA Social Development Centres, to Primary Health Care centres, clinics and hospitals of the MoPH network (some run by NGOs).

The reproductive health kits provided sufficient equipment and commodities to respond to the increased attendance at the health facilities by the Syrian displaced population. To date, the visited facilities had not faced any shortages of drugs and contraceptives although the increasing influx of refugees may lead to the incapacity of the facilities to respond to the growing demand.[126] In 2012, most of the kits were funded through CERF funding, and the continuity of funding was unsure for 2013 through different funding sources.

The reproductive health kits contain a fixed number of drugs, equipment and contraceptives based on an international standard basis and not on consumption basis, which may lead to wastage if some of the drugs are provided in too high quantity compared to needs and if they are not used before the expiration date. A system allowing to monitor the consumption of the drugs, contraceptives and consumables that are included in the kits was introduced by UNFPA among all the partners, which may prevent the waste inherent to the kit system used so far.

UNFPA also supported interventions aiming at providing **information about reproductive health issues** and the availability of RH services for the displaced population. UNFPA collaborated with the Young Men's Christian Association (YMCA) in the last quarter of 2012 in order to conduct awareness sessions on reproductive health and GBV in 4 regions: North, Beirut, Bekaa and South. A total of 121 awareness sessions were conducted by 45 trained educators for 3175 Syrian displaced women and girls and women from the local communities. Sessions addressed topics such as nutrition during pregnancy, safe pregnancy, pre-term birth, post natal care, modern family planning, reproductive tract infections and sexually transmitted infections and prevention and response to GBV.[127] These topics were selected based on the findings of the RH/GBV assessment supported by UNFPA in 2012, and on the priority issues suggested by the health working group. These sessions were an opportunity to provide information on free services as well as on the process of registration with UNHCR.[128] Pamphlets and brochures on prenatal care, STIs and GBV were distributed during the sessions.

YMCA trained the educators who were either community health workers (nurses or midwives) or social workers in 41 centres (PHC, SDC or NGO). The educators were motivated and qualified on the content and have adopted appropriate interactive methodologies to conduct the awareness sessions.[129]

Most participants received messages on only one particular subject as they attended one single session. Any increase in knowledge as a result of the awareness session was assessed through pre and post-tests conducted by the facilitators. Overall, the tests showed an average increase in knowledge of 27 per cent to reach 98 per cent, particularly on specific topics such as family planning and GBV. Little increase was found on issues such as safe motherhood and STIs as initial knowledge was higher.[130] Progress reports do not spell out the differences between locations as data regarding knowledge increase are aggregated for all areas of intervention.[131]

[126] Field interview

[127] See Annex 4, Evaluation Matrix, Judgment Criteria 2.3

[128] Interview with IP, YMCA Standard Progress Report 2012.

[129] Ibid

[130] SPR 2012

[131] SPR 2012

As reported by different interviewees, the level of initial knowledge of Syrian women refugees varies according to the different locations, their place of residence and their socio economic status. In the Bekaa and North regions, refugees often come from rural areas, whereas refugees residing in Beirut come mostly from cities. For women refugees coming from an urban setting, and with a higher educational level, the awareness sessions provided only little new knowledge.[132] This raises the issue of the importance to appropriately target the groups having greater information needs by the implementing partners despite the operational difficulties related to the emergency situation.

For instance, the assessment highlighted the importance to raise awareness on modern family planning methods among the groups of refugees with lower education levels, particularly in North and Bekaa regions.[133] It is unclear whether this topic, which has been acknowledged as culturally sensitive among strict religious groups, has been prioritized during the awareness sessions undertaken with these groups. The analysis of the documents[134] indicates that topics for the different awareness sessions were selected randomly, without taking into consideration the specific needs of refugees. This is shown by the fact that topics changed for each session conducted by PHC centres conducted.

One of the motivations[135] for joining the awareness sessions was to receive a **dignity kit** (six months' supply of basic hygiene items).[136] Dignity kits were distributed to 3,000 women following awareness sessions by YMCA. Another 8,316 dignity kits, funded through the Central Emergency Response Fund (CERF), were distributed by UNFPA through five other organizations.[137]

In some areas, such as in the North or Bekaa regions where about half of the kits was distributed, the content of the kit was appropriate, responded to urgent needs and was appreciated by the recipients. This was the case for the groups of refugees living under tents or in overcrowded accommodations or among poor socio-economic groups. In other areas to a lesser extent, where refugees were better integrated in the Lebanese society or had some source of income, like in Beirut, such type of kits did not fully address the expectations of the refugees[138]. [139] Given the inadequacy of available resources for addressing the needs of the displaced population targeting interventions towards the groups with greatest needs is essential. Also, in emergency situation, since flexibility in adapting the kit content to the specificities of the groups is hardly feasible and would be costly, appropriate targeting is important. Such targeting however has faced little attention so far in planning the response to the Syrian Crisis probably due to the lack of sufficiently specific information regarding the status of the different groups of refugees and the continuous evolution of the crisis.[140] On the other hand little follow up information is available regarding the appropriateness of the kits once they have been distributed.

Awareness-raising interventions among young refugees were initiated following the participation of eight young people affiliated to five Lebanese NGOs in the "Y-PEER Sub Regional Training of Trainers (ToT) in Peer Education on SRH, Empowerment and Life Skills for Young People in Humanitarian Settings" that took place in Amman, Jordan in July 2012. Their participation was supported by UNFPA with a view to addressing the needs and priorities of young people in

[132] Interview with IP and with beneficiaries

[133] Needs assessment, IP interviews, development partners, focus group discussions

[134] Data provided by IPs

[135] Interview with IP, beneficiaries

[136] See content in section 4.1.1

[137] Amel, World Vision International, Islamic Relief, IOCC and Makhzoumi.

[138] SPR 2102, Interview with beneficiaries, with IP

[139] See Annex 4, Evaluation Matrix, Judgment Criteria 2.3

[140] A vulnerability mapping has been undertaken in the second half of 2013, this then allowed targeting interventions more specifically.

humanitarian settings. Following the training, the participants prepared action plans to be supported by UNFPA to develop the capacity of the young people to conduct awareness sessions with young Syrian, Palestinian, and Iraqi refugees using a peer-to-peer approach. The trained trainers from four NGOs (five were initially planned)[141] undertook awareness sessions in 2012, reaching 712 young people aged 15 to 25 years (Syrians, Palestinians, Iraqis and host communities). In support of the awareness-raising sessions, a series of leaflets were distributed. The awareness-raising interventions among young people covered topics related to HIV/AIDS, Sexually Transmitted Infections (STIs), Gender Based Violence (GBV), early marriage and prenatal care. A training module on stress management was developed but young people were not able to conduct stress management sessions on their own due to lack of capacity.[142]

Peer educators and the NGOs to which they were affiliated faced difficulties during the implementation of the awareness sessions, such as the lack of security in some areas such as Tripoli or in the Palestinian camps, or the sensitivity of the topics (e.g., early marriage, STIs, and HIV/AIDS). Additionally, the smooth implementation of the awareness sessions was hindered by the fact that the young refugees had to work to fulfil their family basic needs or because of high transportation costs to reach the location of the sessions.

4.2.5 Availability of information and services for young people

UNFPA has launched a large range of interventions aimed at making information available for young people in the education system and in the communities through the Y-PEER network and the Let’s Talk campaign. Supporting the integration of the gender-sensitive reproductive health and life skills curriculum contributed to the institutionalization of reproductive health within the education system. However, the delays in the process of integration did not allow for a timely operationalization. Consequently, UNFPA initiated extra-curricular activities (interactive CD and Theatre-Based Peer Education) to introduce RH in schools through other channels than the formal curriculum. Youth-friendly health services protocols have been developed, and service providers trained in pilot service delivery points are still not fully operational since preparatory activities such as advocacy are still ongoing. All these approaches are appropriate means to reach young people, yet constraints linked to the cultural context hampered the delivery of clear messages. The lack of continuity in some extracurricular undertakings hindered clear demonstration of results and their institutionalization in the long term.

UNFPA and UNICEF elaborated a joint programme to operationalize the **Youth-friendly health services (YFS)** package following a UNFPA pilot project implemented by the Armenian Relief Cross of Lebanon (ARCL) during the previous country programme. In 2009, UNFPA conducted an assessment in five service delivery points (SDPs) concerning the availability and gaps in services, outreach, resources, commodities and infrastructure which served as a basis for discussion with the SDPs’ directors and health service providers on a YFS minimum package.[143]

[141] One NGO withdrew because of the security situation

[142] Standard Progress Report 2012

[143] See Annex 4, Evaluation Matrix, Judgment Criteria 2.4

The youth-friendly services concept supported by UNFPA is comprehensive and includes treatment, referral, counselling; it also addresses reproductive and mental health as well as social related issues. Furthermore, it includes sensitisation sessions on reproductive health-related topics and life-skills[144] using interactive methods as well as the promotion of YFS by young educators to their peers.

UNFPA selected the Centre Universitaire de Santé Familiale et Communautaire (CUSFC) at Saint Joseph University as implementing partner (IP) based on its experience in the provision of YFS to university students as well as to young people from the surrounding communities. The CUSFC collaborated closely with MoPH and MoSA to adapt the YFS training module and to operationalize the provision of YFS in these five health service delivery points. A consultative committee composed of CUSFC, MoSA, MoPH, UNFPA and UNICEF was formed and met several times in 2012 but could not address all the issues related to the operationalisation of the YFS package due to several challenges, such as:

- Delays in the provision of feedback by the committee members on various documents and tools (i.e., training manual for service providers, policy brief);
- MoSA was nominated by the Lebanese government as the official authority in charge of leading the humanitarian response to the Syrian crises and was no longer available to actively participate in the committee;
- Ensuring the continuous commitment of the MoPH decision makers has proved difficult.

In 2012, nineteen service providers (physicians, midwives, nurses as well as social workers) were trained on the YSF concept.[145] Seventeen young people were also trained as peer educators.[146] At the time of the evaluation, young people had not started using the YFS since preparatory activities such as awareness-raising sessions and promotion of the services were still ongoing. The health educators usually reach young people in schools or in the SDPs to conduct awareness-raising sessions. The topics are adapted according to the local culture and health educators are cautious regarding the use of sensitive words and in approaching sensitive issues. While it is possible to talk about HIV/AIDs prevention with young people, it is difficult to talk about early pregnancy among young non-married women. Abstinence and being faithful are the main messages as regards to protection while in some communities, use of condom as a mean of protection is being promoted. Early marriage was discussed in the North but not in Baalbeck where it is less prevalent. Information regarding the services available to young people is also provided.

Although five SDPs were initially part of the project, by the end of 2012, only four SDPs were still involved because of several constraints such as commitment of the staff, capacities, security, and change in SDPs management.[147] In 2013, as part of the UNFPA-UNICEF joint programme, three additional MoPH-affiliated health facilities have been selected and another three remained to be selected by MoSA to launch the YFS approach.

A Management Information System for monitoring the services is being developed but the first trial indicated that the system is quite complicated and it is currently being revised.[148] The extent to which this Management Information System is integrated in the SDPs information system is unclear.

In 2004, UNFPA started supporting the development of the **"Life skills reproductive health education curriculum from a gender perspective"**

[144] Including the promotion of the USJ info-santé website

[145] The YFS training package covers the following topics: 1) Youth friendly services, 2) Communication and partnership; 3) Adolescence and puberty; 4) Behaviors and problems that affect negatively the health of adolescence; 5) Life skills and 6) Child protection and youth civic engagement.

[146] See Evaluation Matrix, Judgment Criteria 2.4

[147] Ibid.

[148] UNFPA, UNICEF, Narrative Progress Report 15 May – December 31, 2012

("the curriculum") in collaboration with the Ministry of Education and Higher Education (MEHE) through the Educational Centre for Research and Development (ECRD). The curriculum was issued and approved by all stakeholders in 2009. The process involved all stakeholders from different religious confessions and is well-documented and is as an example of best practice. The process is perceived by the partners "to have created an enabling environment where discussions around RH issues", "to be a major accomplishment given the circumstances (cultural norms, conservative atmosphere) in the country" and as "having built relationships between stakeholders".[149] Also the partners acknowledged facilitating elements such as the fact that the curriculum is available in Arabic and that school health education department helps to link curricular to extracurricular activities in the schools.[150]

Following the issuance of the curriculum, UNFPA continued supporting MEHE and the ECRD[151] for the integration of the curriculum within the sciences, civic education and language disciplines, which is part of the overall review of the National Curriculum by the ECRD. The curriculum has so far been integrated within the first two scholastic years of the first cycle. The integration of the curriculum in the scholastic books will start concomitantly for the second and of the 3rd country programme but the committee in charge of integration foresees that the curriculum will only be integrated at all levels of the education system by 2020. The process is extremely slow and is hampered by constraints inherent to the system, despite appropriate support from UNFPA.[152]

UNFPA support is crucial since it ensures that the concept is clear among all the school book writers (who are not all familiar with the life skills and RH concepts) and all appropriate activities are included. A consultant was hired with UNFPA support in order to support the school book writers for the integration process and to design adequate reproductive health and life skills education methodologies. Reference books specific to the RH and Life Skills concepts were prepared in 2012 and provided clear and documented references to the school book writers and to the teachers.[153]

Whereas the development and the integration of the curriculum are essential for the introduction of reproductive health in the education system, concerns remain that the curriculum, because it had to be developed through a broad consensus, provides limited exposure to SRH issues (sexual health in particular). According to some of the stakeholders, the use of non-controversial words leads to the distortion of the messages and, as such, the curriculum may not be sufficiently comprehensive. This concern is less acute in private schools since the teaching content can be more flexible.

Taking into account the duration of the process necessary for the integration of the curriculum, UNFPA opted for the introduction of reproductive health in extra-curricular sessions through training school health educators and teachers, introducing an interactive CD ROM and through theatre-based peer education.

The UNFPA initiative **Theatre-Based Peer Education (TBPE)** stemmed from a regional initiative, and two trainers from the Visual and Performing Art Association (VAPA) attended a training of trainers (TOT) in Cairo in 2010. These two trainers trained 12 Y-PEER and VAPA members in TBPE techniques. In 2010, UNFPA, in collaboration with VAPA, worked with health educators in four private schools selected to address multi-religious culture of Lebanon.[154] As planned, a total of 68 students aged

---

[149] Rima Afifi Soweid, Report on consultancy for developing an evaluation framework for the education in education sector, 2012

[150] Ibid.

[151] Co- financing (earmarked) contribution agreement between the government of Lebanon (ECRD) and UNFPA, ATLAS code LBN3R51A.

[152] See Annex 4, Evaluation Matrix, Judgment Criteria 2.4

[153] Reference books in Arabic

[154] Two schools from Al Mabarrat Association, the Lebanese Evangelical School and Zahrat Al Ihsan School

15 to 19 years and ten teachers were trained on the TBPE techniques. As a result, in each selected school, theatrical scenes were organised around a selected topic. Messages and learning objectives were developed by the students with the help of the facilitators. Selected topics were related to HIV, drugs, peer pressure, violence and smoking. In one of the school visited during the evaluation, 60 students had attended the performance and could benefit from the messages disseminated during the play. Performances are followed by interactive discussions on the selected topic to reinforce the messages. This requires strong facilitation skills but the Y PEER facilitators were not sufficiently equipped with these types of skills and a trained person was needed (often a UNFPA staff member). It is estimated that 600 students attended the shows in the four pilot private schools and were thus exposed to the information shared during the show.[155]

The extent to which the learning objectives were achieved was assessed through pre- and post-test questionnaires. These showed an increase in knowledge on some issues (e.g., the cost of the HIV test) but little increase in knowledge and attitude in some other issues on drug related issues or even violence. They also revealed at times, a wrong perception of some messages.[156] Some of the questions asked during the pre and post-test were not clear.[157] The effort of undertaking impact analysis of such intervention should be noted, but unfortunately data analysis is often not clear and conclusive. This raises the question about the early planning and the quality of the assessment of the interventions. Positive outcomes of the TBPE approach in private schools should be highlighted. The students (both among the performers and the audience) said that they enjoyed and were interested by the shows. The student performers said that the process helped to build their confidence, to learn tolerance, compassion and civil responsibility, how to communicate, as well as to break the traditional hierarchy between teachers and students.[158] On the other hand, the time allocated for the activity did not allow sufficient in-depth discussions on the selected topic(s).[159]

In 2011, one training manual for Theatre Based Peer Education at school [160] was developed and proved to be a useful tool. UNFPA supported the ECRD to start TBPE in four public schools. A series of three workshops (SRH, TBPE techniques and facilitation skills) were conducted to develop the capacities of a core group of 12 trainers from the ECRD Continuous Training Program (CTP), the School Health Programme at the Ministry of Education and Higher Education (MEHE), and Mabarrat Educational Institution. The analysis of the pre and post-tests in public schools highlighted that facilitation of the interactive sessions with the audience is sometimes not sufficient, therefore some messages were only partially grasped. It was reported that 300 students attended the performance undertaken in the four schools involved that is less, in average, than in private schools.[161]

---

[155] See Annex 4, Evaluation Matrix, Judgment Criteria 2.4

[156] For instance the responses 'true' increased between the pre and post test to the following statement 'Violence can be a solution to deal with some issues'

[157] UNFPA, VAPA, Y-PEER, Theater Based Peer Education Initiative: Impact Analysis, 2010

[158] Rima Afifi Soweid, Michel Khoury, Saja Michel, Theatre Based Peer Education to Promoting Responsible Healthy Behaviors among School students: Understanding Facilitators and Barriers and Possible Alternatives, 2013

[159] Discussion with IP and beneficiaries, Standard Progress Report 2010

[160] Y-PEER Lebanon and Visual Arts and Performing Association (VAPA): Theatre Based Peer Education at school - Training Manual, 2011

[161] Report in Arabic

Although the TBPE approach triggered interest in the public sector, it proved to be challenging as it requires a flexible approach which is not always possible in the public administration. When introducing such approaches, follow-up and coaching is necessary to sustain teacher's commitment. The Continuous Training Programme (CTP) was not in a position to ensure this as its role is confined to the training of teachers. The intervention in the public sector was less successful than in the private sector as it depends on the commitment of teachers and the support of the school principals. It was noted that prior information and advocacy with the schools authorities is key as to ensure that it is part of the overburdened school schedules.

In both private and public schools, the topics of some theatrical scenes was not always linked to the UNFPA mandate but rather responded to the interest of the students such as smoking or road accidents.

As a whole, it was felt that the TBPE approach had a real potential as a tool to introduce new subjects if sufficient time is allocated for TBPE activities, facilitation skills are developed adequately and when it is part of an overall strategy linking various extracurricular activities to the curricular activities. The support role of the school principal has also proved crucial. With few exceptions parents were not involved although this appeared to be an important factor for success as recognised by the stakeholders.[162] The lack of continuity in supporting the approach did not make it possible to institutionalise the activity. One year experience cannot be considered to be sufficient to develop capacities, contextualize the approach and develop ownership for such an innovative approach.

UNFPA partnered with the Department of Continuous Training at the Faculty of Educational Sciences - University Saint Joseph (USJ) to **develop the reproductive health education capacities of school health educators**. Seventeen school health educators attended training workshops in 2011 and 2012. They developed a plan to carry out awareness activities in their respective schools and conducted activities accordingly. They were coached under the supervision of USJ. Health educators expressed the usefulness of such activities for both educators and students to disseminate SRH information in schools in innovative ways.[163]

In 2012, the USJ Department of Continuous Training designed, with UNFPA support, **a university course** to be conducted in 2013 to develop the reproductive health education capacities of teachers and school health educators, school nurses and physicians. The content of the training workshop is based on the curriculum and introduces several broader concepts, including participatory methodologies, project planning and ethical issues. The 40 hour course comprises theoretical lectures and tutored personal work in schools.

As of 2011, University Saint Joseph oversaw the development of a set of tools to be used in **school extracurricular activities** i.e., the USJ info website, the interactive SRH CD Rom and the "Sohhti wa Salamati Game". The first step was to obtain a national consensus on these tools. They were presented to decision-makers at the levels of communities, school principals, school health coordinators/educators as well as parents associations and even young adolescents. The content of the SRH CD Rom was reviewed to assess whether it was in line with the "Gender Sensitive Life-Skills RH Education Curriculum". Specifically,

[162] See Annex 4, Evaluation Matrix, Judgment Criteria 2.4

[163] Ibid

the Life Skills part was added as it was missing in the initial version. The opinion of school students regarding their needs for educational tools in RH education was also assessed. In 2012, the CD was introduced as a pilot in 17 schools throughout the country. The impact of the SRH CD Rom on students was assessed in 2013 through a pre and post-test and through focus group discussions. [164] All tools have been approved by the MEHE.[165] The introduction of extracurricular activities has helped to maintain reproductive health momentum in the education system.

In 2008, UNFPA started supporting the Lebanon **Y-PEER network** with regional funding for Y-PEER initiatives. An initial core group of 17 focal points (boys and girls), belonging to ten Lebanese NGOs, were trained on peer education, advocacy, and theatre-based education both regionally and in country.

In 2010, the Y-PEER network expanded to include 85 new members totalling 175 peer educators in the different regions of the country. Two NGOs[166] conducted three peer education workshops for young people on: (a) advocacy for HIV/AIDS and youth-friendly RH services; (b) peer education techniques; (c) substance abuse. Subsequently, around 100 outreach sessions (using movies, games and role play) were conducted whereby 2000 young people were reached.[167] Assessments showed some increase in knowledge about the HIV transmission routes, but also misconceptions on how young people can protect themselves and on attitudes that can stigmatise People Living with HIV (PLHIV).

It was noted that the lack of follow-up and regular contact with the Y-PEERs in rural areas make them less active than those living in the surroundings of Beirut, where many events take place such as international day celebrations which Beirut Y-PEERs are involved in. The commitment of NGOs to support the Y-PEER network has decreased and the number of outreach sessions supported by NGOs has decreased over the years except when supported by a grant.[168]

In 2010, on the occasion of World AIDS Day, Y-PEER Lebanon organized a two-day HIV/AIDS awareness-raising event among ten high school students under the patronage of H.E Minister of Public Health, in partnership with the National AIDS Control Program. The Y-PEER network, with the support of UNFPA, became visible in the media during the celebration of events such as the World AIDS Day, the International Youth Day and the “Let’s Talk” Campaign in 2011.

In 2011, Masar was selected as an implementing partner (IP) for the project ‘Enhancing Youth Institutional Capacity on Advocacy’ through the Let’s Talk campaign funded by H&M. Two workshops on advocacy and social media were conducted for young people. The campaign used the following media: advocacy booklets, billboards featuring celebrities, TV and radio programmes, newspapers, magazines and concerts to raise awareness about HIV/AIDS. Some of the TV spots could not be broadcast because of insufficient coordination with MoPH and NAP. In order to assess the effects of the campaign, an opinion poll was conducted by IPSOS with UNFPA support in all the regions of Lebanon. The main findings were that the young people were encouraged to speak about HIV, but only around 30 per cent could recall the main messages on HIV/ AIDS and only 20 per cent of the sample was aware of any Voluntary Counselling and Testing (VCT) centre for HIV/AIDS.[169] The results as regards to the effects of the Let’s Talk campaign remain unclear. Partners

[164] The results had not been analyzed at the time of the evaluation

[165] SPR 2011, 2012

[166] The Lebanon Family Planning Association and Jeunesse Contre La Drogue

[167] In Beirut, South, North, Mount Lebanon and selected Palestinian camps

[168] Interview with IP and UNFPA CO

[169] Ipsos. Let’s Talk – Post-Campaign Evaluation. 2011 (PowerPoint)

recognised that programming a campaign to cover the whole country had a more diluted impact among young people than a more focused action in a specific area.[170]

In 2011, the Y-PEERs acted as a resource network for UNFPA and other UN agencies for developing the capacities of young Iraqi refugees (supported by UNHCR). As a result, a team of 35 young Iraqi refugees conducted 20 outreach sessions related to HIV/AIDS prevention in two months under Y-PEER supervision. Selected Y-PEERs were trained on gender and gender-based violence issues, and acted as outreach facilitators in the north within the context of the MDG-F project[171] supported by UNFPA.

UNFPA and the Y-PEER network, in collaboration with the National AIDS Programme (NAP), developed A Peer Educators' Handbook to STI/HIV/AIDS Prevention.[172] The handbook is considered as a reference at national level for peer educators and provides information regarding modes of transmission and prevention, testing, treatment, stigma and discrimination.

In 2012, UNFPA had a direct agreement with Masar to train and support four local youth NGOs[173] from remote areas on advocacy and awareness-raising within the context of the Let's Talk Campaign. Eleven young people (three girls and eight boys) were trained on how to design and implement an advocacy campaign targeting local leaders and parents including the selection of messages. Young people developed their own work plans targeting their peers aged 14 -19 years as well as leaders and parents. The campaign consisted of awareness-raising, development of culturally sensitive material, use of social media on topics such as sexual education, drugs, reproductive health and youth against fighting (in Tripoli area).[174] The objectives of this intervention were achieved despite the security situation which caused delays during the implementation.

As a whole, it can be highlighted that the main focus for Y-PEER education was HIV/AIDS/STI prevention. Reproductive health issues were covered at a far less extend even though issues as GBV and early marriage were introduced at a later stage. Still messages did not mention pregnancy prevention which is considered as a sensitive issue in many communities. UNFPA supported interventions hardly refer to family planning methods and its partners did not find a way to discuss these issues with young people.

The Y-PEER network has been involved in different interventions (for instance in the Youth Friendly Services) with a view of integration in the overall programme. Nevertheless the planning remains ad hoc with isolated interventions based on the Y-PEER annual review recommendations. The Y-PEER project lacks a longer-term and holistic strategy that would allow increased effect and better synergies.

In terms of capacity development, the main trend is that the individuals belonging to the network greatly benefitted from the interventions due to their large exposure to various training and meetings (including at regional level), facilitation and presence in advocacy events but this outcome cannot be extended to young people outside the network.

UNFPA has been **advocating for young people**-related issues through several channels, and with different effects, as described below:

- In 2010, UNFPA supported the final review process of the national youth policy. It promoted the integration of the peer to peer approach in the policy's vision and priority areas.
- The Let's Talk campaign was used as an advocacy tool targeting different levels -- i.e.,

[170] SPR 2011

[171] See details in paragraph 4.4.2

[172] UNFPA and Y-PEER Lebanon: A Peer Educators' Handbook to STI/HIV/AIDS Prevention, 2011

[173] Zibkeen, Tripoli, Saida, and Qaa (Siddikine was part of the training but collaboration was stopped before starting the implementation)

[174] The number of beneficiaries was not reported.

at the national level with MoPH decision-makers, with a larger audience through events celebration with celebrities, TV and radio programmes and with local leaders in remote areas through the Y-PEER education in these areas. These activities highlighted HIV/AIDS-related issues although some activities had limited effects, as seen above.

- A documentary and an awareness-raising brochure were produced in order to promote TBPE in school. This type of advocacy tool has the potential to introduce an innovative approach in the education system.

- With UNFPA support, the Y-PEER network published newsletters in 2010 and 2011 highlighting the achievements of the network. The newsletters were disseminated to UNFPA and Y-PEER partners. The newsletters provide a showcase of the network activities but their advocacy effect for youth and reproductive health has not been measured.

4.2.6 Contribution of UNFPA-supported interventions to sustainable effects in the field of Reproductive Health and Rights

UNFPA has contributed to put reproductive health on the agenda in both the health and the education systems. However the uneven relationships with the MoPH may jeopardize the sustainable effects of the initial efforts within the health system. Sensitization to, and advocacy on HIV/AIDS among young people has been broad enough to sustain the interest of the different stakeholders. However the lack of continuity of some of the interventions does not allow to properly assess their effects and their appropriateness with a view to promote such interventions in the long term.

The collaboration with MoPH in the previous cycle has led to some continuity thanks to the mechanisms put in place by UNFPA -- e.g., procurement of commodities, which led to secure contraceptives in the Services Delivery Points of the MoPH PHC network. The MoPH showed some ownership for the MISP training,[175] but could not allocate sufficient resources to ensure its sustainability and replicability on a larger scale. On the other hand, the lack of interest from the MoPH for the other planned interventions indicates that the type of collaboration proposed by UNFPA does not respond to the needs and expectations of the MoPH.

The future of the collaboration between UNFPA and the MoPH is undermined by the uncertainty about their relationships although recent efforts towards resuming cooperation have been initiated and led to an agreement for restarting the partnership in early 2014. Constructive collaboration is a key factor for UNFPA influencing role as to improve the access and utilization of reproductive health services for vulnerable groups.

The fact that the Gender Sensitive Life-Skills RH Education Curriculum[176] has been approved by the Ministry of Education and Higher Education (MEHE) is a positive sign towards the sustainability of the reproductive health education in the education system. This is furthermore obvious that it is currently used as a reference document by a number of partners.[177] Similarly, the fact that the integration of the curriculum in school manuals is being supported by UNFPA[178]provides some assurance that reproductive health and life skills education, once integrated, will be included within the public school system. However, it appeared that a constant support to the integration process is needed to ensure that RH and life skills will be sufficiently present in the school manuals. The documentation of the process undertaken by

[175] See details in section 4.2.2

[176] Life skills reproductive Health education curriculum from a gender perspective

[177] See Annex 4, Evaluation Matrix, Judgment Criteria 2.4

[178] Ibid

UNFPA and the Centre for Educational Research and Development on the elaboration of the curriculum highlights the lessons learnt and can be used for undertaking of similar approaches in the future.[179]

Institutionalising extracurricular activities in public schools is challenging since the education system lacks the flexibility required to integrate new activities. Although there is a real potential for initiating activities such as theatre based education, the allocated one year was not sufficient to demonstrate its effects. The timeframe was also too short to adequately involve all the partners.

The Y-PEER network approach created an environment where the voice of youth can be heard, which contributed to the development of the Youth policy as well as to the involvement of young people in the national dialogue. The capacity of individuals in the network has been developed, but this capacity-building outcome hardly extends to other individuals outside the network. Overtime the turnover of a number of Y-PEERs (who travelled or started new jobs or university studies) has become a major constraint since they are less available than in previous years, while the network relied a lot on them. The continuity of the activities of the network remains a challenge because of this turnover, the decreasing commitment[180]and the attrition rate of young peer educators. [181]

Without UNFPA support, the future of the network remains uncertain. After the regional funding stopped in 2011, UNFPA has streamlined Y-PEERs activities in other interventions such as TBPE or YFS. UNFPA facilitated the preparation of a plan to expand within the Scouts organizations as a means to sustain the peer to peer approach. Preparations took place for collaboration, including advocacy meetings with the Scouts administrative committee. However, this plan did not succeed since the Scout agenda was different from the Y-PEER network to reach an agreement and the prospects for collaboration were put to an end. Some degree of continuity lies in the use of the peer-to-peer approach in other interventions targeting young people, such as the TBPE or the YFS.[182] These interventions build upon the lessons learnt and the skills developed during the Y-PEER network previous experiences.

A number of manuals, guidelines and reference guides have been developed thanks to UNFPA support, many of them in Arabic:

- the Gender Sensitive Life-Skills RH Education Curriculum,
- the theoretical concepts of life skills and reproductive health education,
- the Peer Educators' Handbook to STI/HIV/AIDS Prevention,
- the Training manual for Theatre Based Peer Education at School.

These documents provide elements of sustainability since the different stakeholders can use them as references in their undertakings. On one hand they provide the accurate information and on the other hand they propose a sound methodology.

[179] UNFPA and Centre for Educational Research and Development: Gender-Sensitive Life Skills Reproductive Health Curriculum Development: A Best Practice Documentation, 2010

[180] See Annex 4, Evaluation Matrix, Judgment Criteria 2.4

[181] The extent of decrease in number is not known as no data are available on the remaining active Y-PEERs.

[182] Ibid

4.3 EFFECTIVENESS AND SUSTAINABILITY IN THE POPULATION AND DEVELOPMENT COMPONENT

EQ3

To what extent did UNFPA supported interventions in the field of population and development contribute in a sustainable manner to a strengthened framework for the planning and implementation of national development policies and strategies?

SUMMARY

Under the P&D component of its country programme, UNFPA focused its interventions on the strengthening of the national policy framework on aging, and more particularly on the most vulnerable groups attending public and charitable institutions. UNFPA support was instrumental for documenting the situation of this population group and for providing standards for an elderly institutions' accreditation scheme, a direction strongly owned by the Ministry of Social Affairs. This support, implemented through the National Committee for the Elderly Affairs under MoSA presidency, provided with the required inputs though not endorsed by the Committee due to the lengthy decision-making of the government.

Many initially foreseen interventions were postponed – and some abandoned – due to important delays in the government's financial contribution to the programme. The following step in elaborating the aging policy – a pilot with two voluntary institutions – was starting at the time of this evaluation, with more than one year of delay. In spite of these setbacks during implementation, ownership by the MoSA as well as the civil society remained strong due to the incremental and inclusive process pushed through by UNFPA, hence ensuring a high potential of sustainability.

4.3.1 Profile of the Population and Development Component

The outcome of the Population and Development component for the UNFPA 3rd country programme in Lebanon was: "Effective and accountable governance of state institutions and public administrations is improved". The P&D strategy was structured around the following CPAP outputs:

- **Output PD1**
  An integrated information system is developed and functioning to formulate, monitor and evaluate policies at national and sub-national levels, with attention to emergency settings;

- **Output PD2**
  Enhanced capacity to utilize data for integrating population dynamics, reproductive health and gender-equality concerns into development planning and monitoring processes at national, sectorial and local levels.

During the 3rd country programme, only one project was implemented under the P&D component: "Enhancing MoSA's Capacities on Integrating Population Dimensions in Development", implemented through a project management unit already active during the 2nd country programme with a focus on developing the integration of population data into development planning (then under the name of P&D Strategy project).

The project's AWPs refer to output PD2. Output PD1 was not addressed by a dedicated UNFPA project. Based on a joint assessment of the UN agencies, the weakness of the national statistical system was pinpointed as a shared concern, calling for joint action. It was agreed under UNDAF to conduct a joint programme involving all UN agencies to support the development of a functional integrated system of information (i.e., UNFPA output PD1), with special emphasis on data disaggregation according to sex, region and other factors. UNFPA resources were allocated to this initiative for an amount of USD 1 million, to be engaged after finalization and endorsement of the Statistic Master Plan. However, the joint programme did not materialise.

The programme aiming to enhance MoSA capacities[183] is co-financed by the government, whose contributions are transferred to a dedicated trust fund. The UNFPA contributes 40% of the financing.

The transfer of MoSA financial contribution to the dedicated trust fund was challenged by large delays and the mapping, training and advocacy activities were consequently postponed. In 2011, the MoSA Minister changed and requested UNFPA to focus on aging, rather than carrying on a widespread approach consisting in integrating P&D in development planning. The MoSA Units assessment supported this view.

The initial 2011 AWP started to take into account this reorientation while maintaining the integration of P&D into development planning. It is only with the 2012 AWP interventions that the aging policy became the only core priority with the following interventions:

- Capacity and institutional development on several priority areas including on aging (i.e., for MoSA units/NCEA and SCDs, including pilot training, and possible NGOs/institutions)

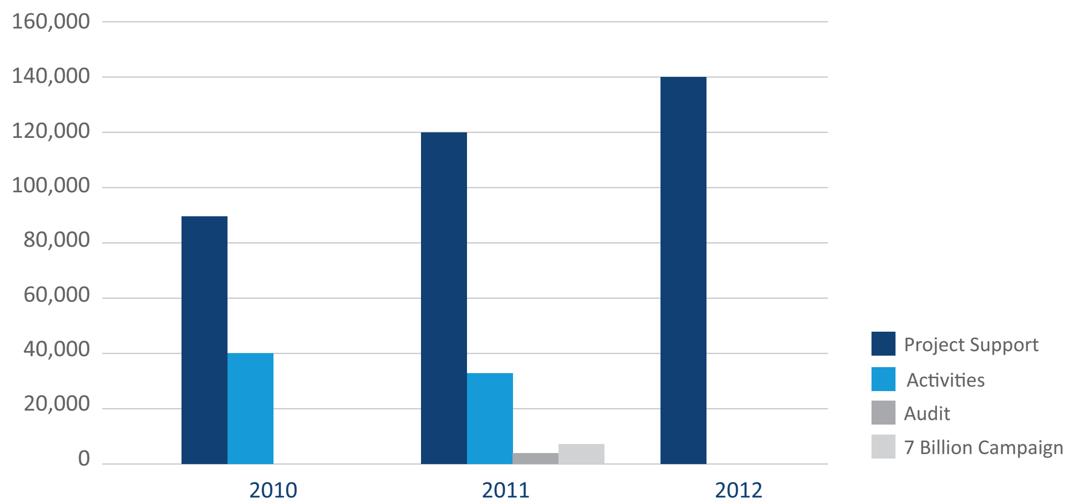
- Generation of evidence and knowledge for better addressing older people priorities (i.e., training material/package, operation/legal research, guidelines for implementation of elderly care standards, policy briefs, etc.)

[183] The project's initial 2010 AWP refers to the following activities: i) Conducting assessment of the MoSA Units capacities and needs; ii) Conducting mapping of 3 communities; iii) Enhancing capacities of MoSA Units and Service Delivery points in Results Based Management, strategic thinking and planning, thematic areas, etc.; and iv) Supporting advocacy efforts for promoting local planning and implementation.

- Advocacy activities on aging priorities (i.e., for informing policy, advancing legislation, developing a framework for aging strategy, disseminating research findings, etc.)

The budget allocated to the programme over the reference period was of USD 616,015, roughly equally distributed along the three AWPs.

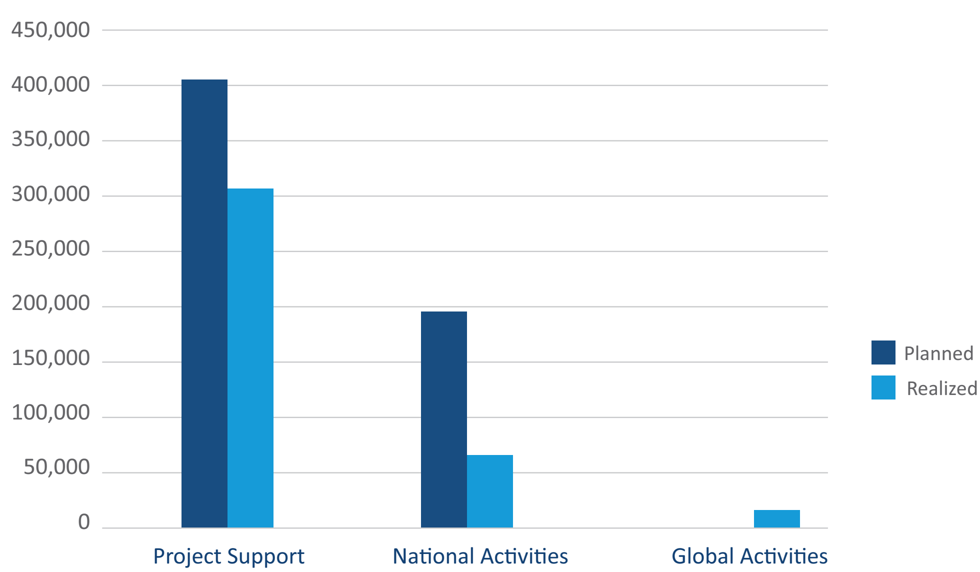
Figure 11 *P&D Component: Annual AWP Budget Distribution*



Source: Atlas

The disbursement rate of the programme and hence the component was 100% over the 2010-2012 period for the 3rd country programme AWPs. The ratio stayed even over the years.

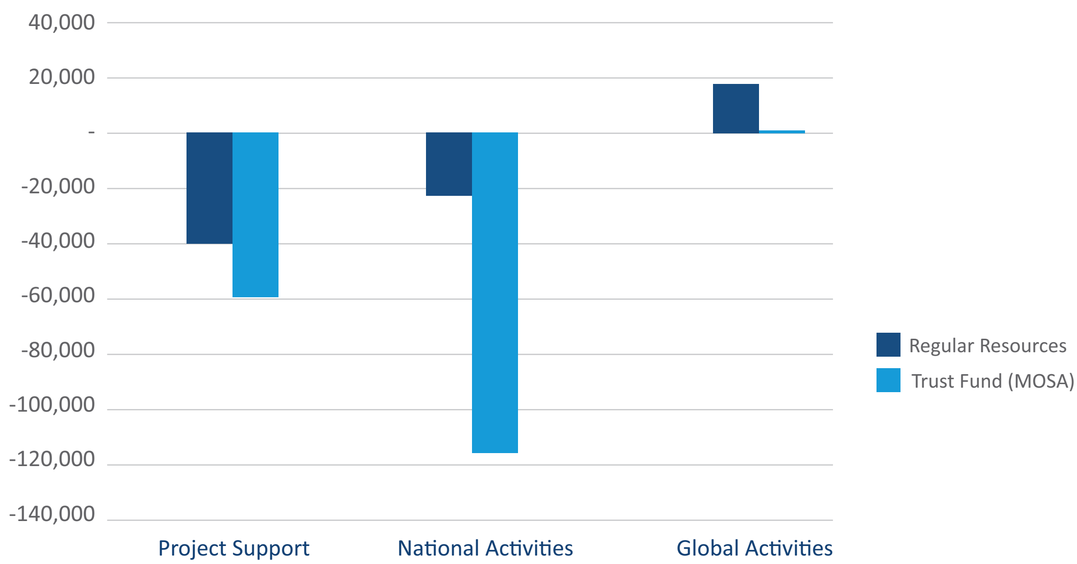
Figure 12 *P&D Component: Budget Realization by Type of Intervention*



Source: Atlas

The CO revised repeatedly AWPs during their implementation, progressively shifting regular resources to key interventions to adjust to the delayed payment of the government's financial contribution to the trust fund (see the M&E assessment section for details). Therefore AWPs do not provide an adequate means of assessment of the effective implementation of the planned interventions and related budget. For the P&D component, the Standard Progress reports are reflecting programmes' achievements, which were relatively limited, as illustrated below. The programme interventions (capacity building, knowledge generation) were more affected than the P&D project unit.

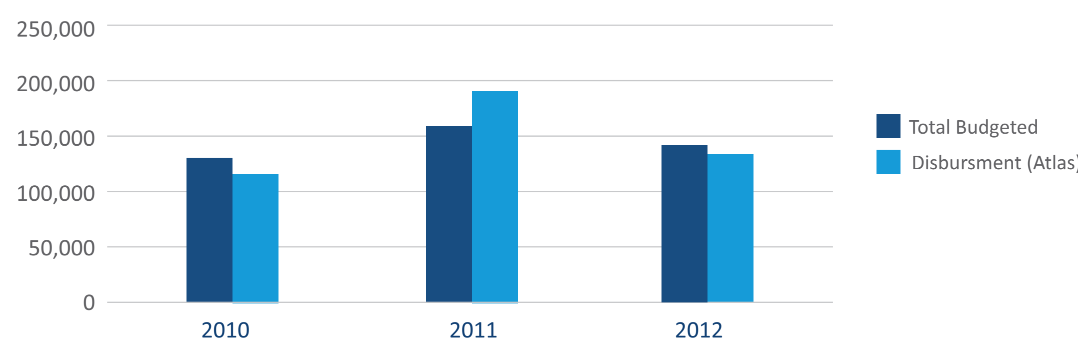
Figure 13 *P&D Component: Change in Budget by Source of Funding*



Source: Atlas, June 2013

This weakness in implementing planned interventions is linked to the lengthiness in mobilizing government funding, mainly dedicated to implement interventions under the component.

Figure 14 *P&D Component: Commitments (AWPs) and Expenditures (Atlas)*



Source: Atlas, June 2013

4.3.2 Contribution to the development of a functional integrated information system for formulation, monitoring and evaluation of national and sectorial policies

Developing a functional integrated information system for MoSA and MoPH, as foreseen in the CPAP, did not meet a demand from both ministries. The discrepancy with MoSA needs and capacity was further assessed in 2011. In 2010, the MoSA minister requested UNFPA to focus on the formulation of an elderly policy by contributing to knowledge generation, and assisting the National Committee on Elderly Affairs.

Under the AWP 2010, interventions were aimed at contributing to the 2nd P&D output "Enhanced capacity to utilize data for integrating population dynamics, reproductive health and gender-equality concerns into development planning and monitoring processes at national, sectorial and local levels" with the following interventions: assessment of MoSA units' capacity and needs, result-based management training, advocacy for promoting local planning and implementation. The link with the CPAP outputs weakened in AWPs 2011 and 2012, when an increased focus was placed on the improvement of the conditions of the vulnerable elderly in institutions.

Under the 3rd country programme, and in strong contrast with previous country programmes, UNFPA departed from large-scale population surveys. Under the UNDAF preparation process, the UN agencies had agreed that the lack of statistical data (on population, infrastructures, services, etc.) was a major impediment for implementing and monitoring programmes. Based on the draft document issued by the government with the support of the World Bank, a joint programme was identified by the UNDAF, with notably a USD 1 million contribution from UNFPA. The initiative was meant to support the operationalization of the Statistics Master Plan. The joint programme did not materialize because: i) the Prime Minister who was supporting the initiative was dismissed, ii) the comments of UNFPA on the draft version of the master plan (as regards data disaggregation and ICPD goals' coverage) – as well as other agencies' comments - were not taken into account, iii) the statistical task force under the UNDAF did not pursue the matter and iv) it seemed that the World Bank would be pursuing it with the Government. In junction with the above, the UN task force did not agree to finance the technical assistance required by CAS for elaborating the Action Plan of the Master Plan, eventually financed by the World Bank. CAS received also an assistance through the joint UNDP/CDR MDGs Framework project. The Statistics Master Plan is yet not endorsed by the Council of Ministers.

UNFPA did not find another satisfactory way to contribute to develop a functional integrated information system for the formulation, monitoring and evaluation of national and sectorial policies. The 2nd country programme has already demonstrated that both MoSA and MoPH are not prioritizing the development of an information system, further confirmed by the needs assessment of MoSA[184] conducted by UNFPA in 2010.

Most of the interventions planned under AWP 2010 have been postponed, waiting for the conclusions and recommendations of MoSA needs assessment. The report[185] concluded that: i) the political, economic, and social circumstances of the country have a negative impact on the work performance of the directly concerned departments in integrating the population dimension; ii) there was an absence of a strategy or an overall comprehensive vision to define the role of the ministry and its entities regarding the issue of the population integration in development and social programs; iii) existence of overlaps and conflicts of roles and functions resulting from the presence of similar entities in terms of functions and roles within the Ministry itself, or overlapping and conflicting

[184] Integrating the population dimension in development policies and programs - Assessment of the Ministry of Social Affairs Units' Capacities and Needs; February 2011

[185] See Evaluation Matrix, Annex 4, Judgment criteria 1.2

roles and functions between governmental units inside the ministry and outside it; and finally iv) important human resources challenges. There were many vacancies in the ministry personnel when compared with the actual number of staff members. These vacancies reached 70 per cent, including the post of the Director-General – who has a mobilizing, coordinating, administrative and decisive role - in addition to a large number of department heads. The situation was worsened by the lack of qualifications of the management staff, even after the UNFPA 2nd CP P&D project.

The recommendations of the MOSA Unit's Needs Assessment cover the areas of governance and institutional organization beyond MoSA, development of the institutional structure that supports the integration process, development of a clear mechanism for integration process, and human resource development and capacity-building. The scope of these recommendations exceeds the UNFPA objectives and means available for the P&D component under the 3rd Country programme.

The interviews with MoSA staff confirmed that the organization is exclusively focused on implementing existing social schemes, with limited interest in statistics beyond administrative routine. The Planning and Statistics Service, focal point for integrating population data, is staffed by only one person with neither adequate qualification nor resources.

Late 2010, UNFPA received a request from the new MoSA Minister to **re-focus its P&D interventions on the aging policy**. Considering the results of MoSA needs assessment, the CO agreed to reorient the interventions planned under the AWP 2010 towards "Strengthening MOSA Capacities in Advocating for Aging Issues on national agenda and Development Plans." This reorientation was consistent with the output 1 of the P&D component of the CPAP "An integrated information system is developed and functioning to formulate, monitor and evaluate policies at national and sub-national levels, with attention to emergency settings."

UNFPA support was targeted at the National Committee for Elderly Affairs (NCEA), in charge of the elaboration of an aging policy, through:

- Studies on the conditions for the elderly in the public and private institutions;
- Policy briefs;
- Appraisal of an accreditation scheme for the same institutions, including buildings, equipment and staff standards;
- Trainings on result-based monitoring and project appraisal for MoSA staff in the central administration as well as SDCs.

Knowledge generation activities were financed under the 2011 and 2012 AWPs, based on the assessment of the lack of data on the fate of the elderly in Lebanon overall, and on their daily living in particular. In 2011, the overall picture was presented in the country profile[186] elaborated by the Centre for Studies on Aging (CSA) which is comprehensive (demographic trends, social and economic conditions, structural support channels, etc.) and well documented. The living conditions of the old people are further analyzed in detail by the so-called Aldaleel survey[187], comparing the situation of 1,500 residents of 28 SDCs in Mount Liban, with a sample of 700 older adults not attending these SDCs.

These two UNFPA-financed studies improved significantly the knowledge on the conditions for the elderly in institutions, with alarming results on every aspect of the provided services: overcrowding, understaffing, unqualified staff, degraded buildings and lack of equipment. The most affected institutions are the charitable ones, yet expensive institutions do not abide to international standards either. The studies

[186] Country Profile: Older Population in Lebanon, Fact and Prospects, CSA and UNFPA, 2011

[187] "A preliminary assessment of activities of daily living among the elderly", 2012

pinpointed the fact that due to socio-cultural factors most of the population living in institutions are widowed women.

UNFPA contributed significantly to improving the knowledge base on the fate of old people living in institutions, and supported the dissemination of the availed information to the media. UNFPA initiatives were recently complemented by NCEA on-going initiatives, notably a large study covering all elderly institutions in Lebanon.

4.3.3 Contribution to the integration of population dynamics, reproductive health and gender equality into development planning at various levels

UNFPA has focused its interventions on elaborating an accreditation scheme for elderly institutions, a major milestone for setting an aging policy in Lebanon. The UNFPA study on accreditation standards was approved by the NCEA (chaired by the MoSA minister) and, at the time of this evaluation, the pilot phase was about to be launched with UNFPA support. UNFPA has therefore significantly contributed to elaborate Lebanon's aging policy. However, many issues are still unaddressed, notably budgets allocated to social policies at large, and to the aging policy, in particular.

Focused on MoSA only, output 2 of the P&D component (*Enhanced capacity to utilize data for integrating population dynamics, reproductive health and gender-equality concerns into development planning and monitoring processes at national, sectorial and local levels*) was ambitious considering i) the Lebanese context of lack of planning due to the transitional nature of the government, ii) the 2nd country programme's achievements, and iii) the USD 1 million allocated but unspent for the Statistical Master Plan.

UNFPA contributed to the National Social Development Strategy[188] issued in 2011 with UNDP support. It assumed responsibility for elaborating the section on the elderly (pp. 39-40), which proposes a comprehensive action plan. This action plan provides a suitable – albeit brief - policy framework and stands as an outstanding contribution of UNFPA with regards to the objectives stated in AWPs.

The AWP 2010 budget (USD 103,940 with USD 78,500 from regular resources) was for its main share dedicated to running the P&D project unit (84%), with general administrative and logistic functions. Besides the MoSA needs assessment analyzed above, one training on result-based monitoring with the Department of Family Affairs and SDCs' head was also foreseen. This training session was delayed by 6 months due to the late financial transfer from the government and the request by MoSA minister to wait for the results of the needs assessment of MoSA units. The content was adjusted to the re-orientation of UNFPA P&D component towards supporting the aging policy, keeping the results-based monitoring as the central theme. The session gathered 25 participants, half of which were MoSA social workers in the central administration, the other half being heads of SDCs coming from all regions.

A second training session was organized in 2012 (on AWP 2011), with a focus on project appraisal based on the logical framework methodology, with the same audience. The theme was selected after consulting with MoSA staff. The content was adjusted to the aging policy through the topics chosen for the case studies and the group works. This session was highly appreciated.[189] The training focusing on project evaluation is one of many trainings on programme/projects conceptualization, implementation, monitoring, evaluation, advocacy and fund raising, all taking

[188] Republic of Lebanon, Ministry of Social Affairs, National Social Development Strategy of Lebanon, 2011.

[189] From the two focus groups held with participants.

aging as case study. These are interlinked and provide SDC and NCEA staff with the capacity gaps identified for a better integration of aging in development. A third training session on fund raising, a pressing concern for SDCs, is planned in AWP 2012.

After the 2010 AWP, integration of population dynamics was focused on aging, with limited links with RH and gender. UNFPA support to elderly policy formulation comprises a study on accreditation standards for institutions caring for the elderly and policy briefs[190].

The main initiative of UNFPA in contributing to build a strategic and operational framework for improving the situation of the elderly was to hire a consultant to define the accreditation standards that should apply country-wide to institutions for the elderly, both public and private. The study was launched in 2011 and was still on-going at the time of this evaluation.

For each proposed standard (ex. *"The organization provides and maintains a safe and comfortable environment consistent with elders' care needs"),* the report specifies related elements of performance that operationalize the standard itself[191] (including for instance *"Elevators must be present in all floors of the institutions. The entrance to the elevator must be at least 0.80 meter in width and the elevator control must be located at a height of 1.30 meters"*).

After a halt of almost one year, activities resumed in October 2012 with a workshop under the auspice of the NCEA, to which professionals participated. The delay is largely related to the participative approach adopted jointly by the CO and MoSA and the lengthy decision-making process within MoSA owing to: i) the highly centralized decision making and ii) the recurrent transitional nature of the government (elections are postponed due to the Syrian crisis). [192] The report was finalized in April 2013, after several other rounds of consultation, and is not yet formally approved by the NCEA.

UNFPA agreed with MoSA to capitalize on this first study by financing the elaboration of an Action Plan for setting the elderly institutions' accreditation scheme, including operational guidelines -- i.e., translation of the previously agreed relatively general standards in detailed technical standards.

Another intended output of the 2012 workshop was the launch of a pilot phase with volunteer institutions in order to get a clear picture of standards' feasibility and of the cost involved. Two private institutions volunteered. The start of the pilot phase is conditional on the issuing of the above mentioned operational guidelines, expected to be completed in June 2013.

At best, the endorsement of the accreditation scheme should not intervene before two years. The approval process will follow several steps: approval of detailed standards, completion of the rehabilitation works for the two volunteer institutions, and assessment of the financial feasibility of proposed standards. The time line is a threat for UNFPA contribution to the elaboration of the aging policy in Lebanon. Political instability and high level of power centralization have been demonstrated to be a major risk factor for developing a long-term support, in the P&D area as well as in its other areas of UNFPA intervention. Moreover, the UNFPA strategy does not foresee significant quick-wins that would maintain the reform momentum. Last, the exposure of the general public to UNFPA advocacy for the elderly is limited.[193]

[190] See Evaluation Matrix, Annex 4, Judgment criteria 3.3

[191] Ibid.

[192] Interviews with CO staff, UN agencies and press releases.

[193] Interview with CSA, P&D project, MoSA staff; P&D focus groups.

UNFPA financed three policy briefs developed by CSA: "*Older People in Lebanon, Voices of the Caregivers*;"[194] "*Pensions: A Right Long Overdue for the Older Citizens*"[195] and *"Regional ICPD and MIPAA Review on Aging in the Arab World: A Mapping Tool."*[196]

UNFPA communicated broadly for the launching of the policy briefs, contributing to the sensitization of the media and the general public to the issues raised. The extent to which these publications impacted upon the policy makers is hard to assess as decision making is highly centralized (at cabinet level) in Lebanon and it was not possible to meet with the minister during the field mission. The Head of the Department of Family Affairs (DFA) did not acknowledge a significant contribution of the policy briefs to the elderly policy development but has mostly management responsibilities, with no involvement in policy making. DFA is far more concerned by operationalizing its regulatory attributions than revisiting the policy and regulatory framework.

The studies released by UNFPA in 2011 and 2012 contributed to the involvement of the Minister as the chairman of the NCEA. The Minister is said to have strongly supported quick progress in setting the accreditation scheme for elderly institutions during the NCEA meeting in May 2013.[197]

4.3.4 Mechanisms for the integration of population data in national and sectorial development planning

Despite the continuous commitment of UNFPA for an inclusive elderly policy formulation, the accreditation scheme is still not endorsed by MoSA and its recurrent cost for public finances not estimated.

To date, the aging strategy has not attracted budgetary resources supplementing UNFPA support. The Minister expressed his commitment to setting an aging policy framework during NCEA meetings. The long process of going through a pilot phase still does not require additional financial contribution from the government budget: pilot institutions volunteered and, as private undertaking, will invest their own resources.

Government resources will be needed when the regulatory framework is endorsed, making it compulsory for public and private institutions to upgrade facilities, equipment and staff qualifications. For the time being, the financial issue was not fully appraised. The government intends[198] to raise donors' contributions for financing the elderly's institutions upgrading scheme associated to the new standards. If successful, this initiative would cover part of the investment costs. Higher standards will increase recurrent costs, hence the need to increase of MoSA/MoPH indemnities to vulnerable people residing in institutions.

[194] CSA, Older People in Lebanon, Voices of the Caregivers, Policy Brief, Issue 1, November 2009.

[195] CSA, Pensions: A Right Long Overdue For The Older Citizens, Policy Brief, Issue 2, November 2009.

[196] CSA, Regional ICPD and MIPAA Review on Aging in the Arab World: A Mapping Tool, August 2012 (Arabic)

[197] Interview with members of the NCEA.

[198] Interviews with CO management.

To date, indemnities amount to USD 11 per person per day. The corresponding cost for the institutions in prevailing conditions[199] is USD 43. By increasing the standards, this cost will significantly increase (the daily fee in best commercial institutions in Lebanon is approximately USD 133, excluding medical examinations and drugs). In order to ensure the feasibility of the accreditation reform, assessing the capacity of the government to fund implied increase of indemnities is required. It was not undertaken yet.

The National Social Development Strategy spells out a comprehensive approach for the aging policy.[200] The objectives are the following:

- Supporting incubator families for the elderly;
- Adopting a unified pension system covering all the elderly in Lebanon;
- Developing the current health care system;
- Conducting research toward updating data on elderly;
- Investing the capacities of the elderly in community service;
- Building capacities and improving the quality of services provided to older persons in residential and day care institutions and through following the quality criteria set for this service;
- Rehabilitation of infrastructure in line with the requirements of older persons.

UNFPA support to the accreditation standards for elderly institutions is only one specific item of this aging agenda, likely the more sensitive for the general public following media reports on cases of abuse in some institutions.[201] Focusing on this issue provided UNFPA with a visibility that goes beyond its usual partners.[202]

Most of the activities implied by the objectives stated by the NSDS for aging would require significant extra budgetary resources, while the social development budget is already too low for implementing the existing social schemes.[203] SDCs budget and staff were continuously reduced during the last 10 years, driving the centres to develop fund raising and financing by local communities. Any significant change in the scope and nature of social development would call for a significant reform in public finance and overall development strategy.

[199] Interviews with NCEA experts and MoSA staff.

[200] See Evaluation Matrix, Annex 4, judgment criteria 3.4

[201] Interviews with CSA management.

[202] Ibid.

[203] Interviews with MoSA staff.

4.4 EFFECTIVENESS AND SUSTAINABILITY IN THE GENDER COMPONENT

EQ4

To what extent did UNFPA supported interventions contribute, in a sustainable manner, to: i) the integration of gender equality and the human rights of women and adolescent girls in national laws, policies, strategies and plans; ii) the improvement of the prevention and protection from, and response to, gender-based violence at the national level?

SUMMARY

The Gender component of the 3rd UNFPA programme is aligned with the Ministerial statements of 2008 and 2011 stressing the importance of strengthening women's participation and fulfilling equality between men and women. UNFPA supported activities on the assessments on priorities identified by line ministries.

At the policy level, UNFPA provides technical assistance mainly to the National Commission for Lebanese Women (NCLW) and related NGOs. Although Lebanon's formal commitment to CEDAW remains "with reservations," UNFPA also played an important role in developing the capacity and strengthening the role of the NCLW to lead the women-related laws and to mainstream gender. It has also supported government and civil society advocacy efforts in the struggle against GBV and gender inequities through activities including the development of materials, guidelines and tools as well as by supporting advocacy and outreach campaigns directed at a wide range of constituencies and stakeholders. These have included groups such as youth, journalists, health care providers and even Internal Security Forces.

The participatory approach and continuous coordination adopted throughout the GBV interventions between 2008 and 2013 had a positive impact on the relationships between UNFPA and its partners, as well as on the participation of the GBV stakeholders in the country office GBV issues and activities. UNFPA was also reactive in responding to emerging national priorities, and quickly adapting its interventions according to the circumstances.

4.4.1 Profile of the Gender Component

The gender component of the programme aims at: (a) promoting gender equality and the participation of women in sustainable development; and (b) strengthening the rule of law and protecting human rights. It also responds to the UNDAF Outcomes:

a. women are increasingly empowered to have equal access to social, political, economic and legal spheres, in order to realize their rights; and

b. enhanced monitoring and accountability enable the effective implementation of human rights obligations and the enjoyment of human rights.

The outcomes of the programme are:

- **Outcome 1** Gender equality and the human rights of women and adolescent girls are integrated into national and sectorial laws, policies, strategies, plans and interventions;
- **Outcome 2** Prevention of, response to and protection for the victims of gender-based violence are improved at the national level.

The outputs of the country programme are:

- **Output 1** Increased technical and institutional capacity of national mechanisms, national institutions, and policy and strategy frameworks related to women's empowerment and gender equality;
- **Output 2** Increased awareness, evidence-based advocacy and policy dialogue to improve institutional and legal frameworks and systems that seek to prevent, protect the victims of, and respond to gender-based violence, using a human-rights perspective, including in emergency and post-emergency situations.

UNFPA Projects for the 3rd country programme include the following:

- "*Enhancing the Capacity of the National Commission for Lebanese Women for Promoting Gender Mainstreaming in Sector Plans and Programmes (2010 - ongoing)*." The project aims at (a) Developing the action plan for the national strategy for women in Lebanon, and (b) Supporting advocacy activities for promoting the national strategy for women in Lebanon as well as finding of legal review studies.
- "*MDG-F Conflict Prevention and Peace Building (2009 - 2012)*" that aims at establishing women committees in targeted areas; Conducting assessment in targeted areas; Developing capacities of women in conflict resolution, participation, human rights…; Developing institutional capacities in GBV prevention, quality RH services, gender mainstreaming; and Mobilize/sensitize communities in support of women empowerment efforts and contribution in peace building.
- "*Improving Prevention of, Response to and Protection around Gender Based Violence at the National Level (2008 - 2013)*" that aims at the completion of four national studies on GBV as follows: Development of a GBV Lexicon in Arabic and English; Development and publishing of "TANSEEQ (Coordination) for Ending Gender Based Violence in Lebanon" newsletter; Contributing to and supporting the national coalition efforts for the issuance of a law on domestic violence, through participating in the 16 days of activism against Gender Based Violence 2010 (November 25- December 10) and specifically through supporting the production of TV spots and billboards.

Most of the interventions set out for achievement by UNFPA under the gender component of the programme have been achieved (see evaluation matrix; annex 4). However the following is to be noted:

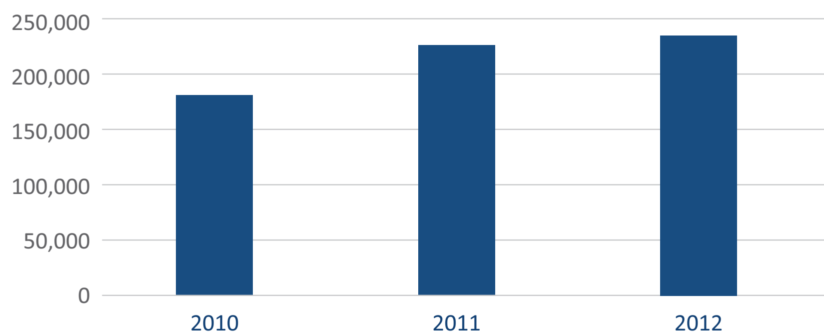
- **At the policy level,** UNFPA has provided technical assistance to the National Commission for Lebanese Women (NCLW) and to related NGOs to coordinate with related decision makers for advocating the mainstreaming of gender issues onto the Government's agenda. The aim was also to ensure that these institutions are able to promote by themselves policies which are gender-sensitive and gender responsive.

- **At the middle level**, UNFPA training programmes through the Project "Improving Prevention of, Response to and Protection around Gender Based Violence at the National Level (2008-2013)" also targeted intermediate groups such as social/health service providers, policemen, journalists, to raise their awareness on gender issues. Simultaneously, UNFPA has supported active NGOs by developing (in accordance with the GBV national plan of action (POA) and 2010 AWP), four GBV studies through these studies, UNFPA used a mechanism considered to be a good practice. A Steering Committee of the GBV Action Plan, which is supported by UNFPA and headed by MoSA, is considered a breakthrough as it brings together all actors involved in GBV and whose joint efforts are reflected in the CEDAW report; it also provides guidance to the GBV training programmes. Accordingly, many GBV training programmes and services (RH, sexual health, CLCs etc.) have been developed, with UNFPA IPs. In addition, normative tools on GBV, "Tanseeq" GBV Newsletter, Lexicon, website-theatre Peer based education and games, etc. have also been developed and utilized.

- **At the grassroots level**, projects have been directly implemented in a number of impoverished regions, focusing for the most part on Women and Youth in Akkar, Baalbek and the Palestinian camps. Additionally, and using the CERF funds, UNFPA was able to support 20 health centers in the Bekaa and the North and 2 centers in the South.

The budget allocated to the programme over the reference period was of USD 713,000. Disbursements stayed relatively even over the three years. The disbursement ratio is 89%.

Figure 15 *Gender Component: Annual AWP Budget Distribution*



Source: Atlas, June 2013

Table 8 *Gender Component Disbursements 2010 - 2012*

COMPONENT / OUTPUT / PROGRAMME	2010		2011		2012		TOTAL	
	Disbursements	Percent	Disbursements	Percent	Disbursements	Percent	Disbursements	Percent
Increased technical and institutional capacity of national mechanisms, national institutions, and policy and strategy frameworks related to women's empowerment and gender equality (3.1) AND Increased awareness, evidence-based advocacy and policy dialogue to improve institutional and legal frameworks and systems that seek to prevent, protect the victims of and respond to gender-based violence, using a human-rights perspective, including in emergency and post-emergency situations (3.2)	104,232	58	173,883	76	195,002	85%	**473,118**	**74%**
LBN3G21A: Gender in conflict prevention/ MDG-F Conflict Prevention and Peace Building	104,232	58	173,883	76	195,002	85%	**473,118**	**74%**
Increased technical and institutional capacity of national mechanisms, national institutions, and policy and strategy frameworks related to women's empowerment and gender equality (3.1) AS STATED IN AWP	75,432	42	53,656	24	35,397	15%	**164,485**	**26%**
LBN3G11A: Enhancing NCLW capacities for promoting gender mainstreaming in sector plans and programmes (national and periphery)	75,432	42	53,656	24	35,397	15	**164,485**	**26%**
Total	**179,664**	**100%**	**227,539**	**100%**	**230,400**	**100%**	**637,603**	**100%**

Source: Atlas, June 2013

4.4.2 Contribution to the technical capacity of national institutions and NGOs related to women empowerment and gender equality

UNFPA was successful in strengthening the technical capacity of the NCLW and of different NGOs in issues related to gender equality and women empowerment through its various interventions implemented under the 3rd country programme. UNFPA worked with women committees, and strengthened the links between NCLW and grassroots NGOs.

UNFPA supported the NCLW in strengthening women committees through different interventions, and was successful in providing support to women networks established by the UNFPA in 2006. The aim was to institutionalize the formed women committees, which afterwards developed into NGOs in Ghaziyeh Ras Baalbeck and in the municipality of Aytaroun committees.

UNFPA was successful in helping the NCLW to adopt a holistic approach towards gender equality in line with international recommendations and guidelines.[204] UNFPA helped the NCLW in strengthening its linkages with NGOs and committees at the grassroots level through the implementation of the WEPASS project. [205]

In addition, UNFPA succeeded in establishing and strengthening the capacities of women committees/Local NGOs in North Lebanon[206] to promote participation and civic empowerment, and to support conflict resolution, GBV prevention, quality RH services, and gender mainstreaming capacities.[207] This is evident in the interviews with women organizations members in Akkar who succeeded in obtaining the small grants following a capacity development programme and thus implemented awareness raising programs within their respective communities. Evidence of the success was manifested by the interviews in Akkar, as well as with the UNFPA staff and the MDG-F Evaluation Report.

Through newly acquired capacities according to individual interviews[208], the committees established by UNFPA were able to mobilize communities in support of women empowerment efforts, outreach activities for youth and production of best practices.[209] Two Interviews with the Heads of Women Local NGO Committees revealed that they were trained, among others, on: i) the elaboration of project proposals (four NGOs were awarded UNFPA grants to implement locally a number of important community-based initiatives, such as conducting awareness raising sessions on GBV and early marriage for the community); ii) the finalization of a needs assessment that culminated in the elaboration of a "Family Protection Awareness Raising" programme reaching more than 100 participants-men and women; iii) developing and distributing user-friendly materials about early marriage.[210]

UNFPA Lebanon also provided technical assistance for the assessment regarding their role and functions supported the **functioning of gender focal points (GFP) in national institutions,** through its project "Enhancing the Capacity of the National Commission for Lebanese Women for Promoting Gender Mainstreaming in Sector Plans and Programmes"; the NCLW is now following up on the implementation of a capacity-development plan for the Gender Focal Points. However, as elaborated by several studies on the functioning of the GFP system in national institutions, the '*establishment of focal points in the various*

[204] Evaluation of UNFPA 's country programme of assistance 2002-2009, Lebanon, Consultation and Research Institute, April 2010

[205] Individual Interviews with members of UN Gender Working Group

[206] See Annex 4 Evaluation Matrix EQ4 JC4.1

[207] MDG-F joint UN programme (LBN3G21A) "Conflict Prevention and Peace Building in North Lebanon" 2010-2012

[208] Individual interviews with two heads of women committees, NGOs and the project Director of MDG-F

[209] Standard Progress report of the project director of MDG-F Project (LBN3G21A)" Conflict Prevention and Peace Building in North Lebanon" MDG-F

[210] Individual Interviews with the heads of the two Local Women NGOs in the North of Lebanon

ministries and public institutions did not prove to be a successful endeavor;"[211] this was reiterated by focal point representatives who indicated that the experience was an "*outright failure*."[212] The main reasons were: no empowerment by government policy, limited political commitment, minimal human and financial resources, no participatory approach and poor degree of communication. The NCLW is now following up on the implementation of a capacity-development plan for the Gender Focal Points and building on the recommendations of the GFP study conducted in 2011[213].

The UNDAF Gender Working Group (GWG) commissioned a study at the request of the NCLW[214], which aimed at providing a comprehensive needs assessment on the status, capacity and training needs and gaps of the GFPs, and identified various difficulties encountered by the GFPs. The failure of the GFP system was a result of the lack of political commitment, limited access to decision making, and limited involvement of the focal points in gender equality and women's empowerment.[215] GFPs, usually at a less senior positioning, face a lot of constraints, most importantly the lack of empowerment, the absence of any decision making capacities and the lack of a clear government policy on their role. In addition, available human and financial resources are minimal, and organizational settings do not allow for a participatory approach to make decisions on reform.

Within the same context, UNFPA invested in **building the capacity of NCLW members,** as an institutional and capacity-building advocate by clarifying its strategic vision and role, through training on strategic thinking, priority settings, and result based management. UNFPA support also focused on enhancing the capacities of the NCLW to advocate for mainstreaming gender concepts and dimensions in sector plans and programmes at national and regional levels. UNFPA also supported in revising and elaborating the National Women Strategy and its Action Plan with all the parties concerned (noteworthy that UNFPA was the engine behind the elaboration of the strategy and the action plan). In addition, UNFPA Lebanon implemented training for the administrative cadre of NCLW to strengthen its internal control framework for improved execution and accountability.[216]

NCLW holds frequent meetings which are attended by members of various NGOs and line ministries. These meetings are devoted to topics such as the validation of the action plan of the women's strategy. They were conducted in a participatory manner with a clear methodological direction which includes key activities, indicators, main actors, and indicative resources. The commitment of NCLW members was well noted in various discussions with their partners, and these positive assessments were echoed during the field visits and expressed by the various NGOs and ministerial officials (mostly MoSA). One NGO official commented that "*for the first time, we feel fully engaged in the validation of the Action Plan.*" [217] In addition, the NCLW works closely with the Parliamentary L'Enfant et la femme Committee coordinates with the University Saint Joseph dispensary supports women for economic empowerment, and mainly coordinates with MoSA and its Social Development Centres.

[211] Mona Khalaf "*The Lebanese national women machinery Where does it stand?" Institute for Women's Studies in the Arab World, Lebanese American University of Beirut. 31 January 2005*

[212] El-Khoury, 2004

[213] "*Needs Assessment for Gender Focal Points in Line –Ministries and Other Public Institutions"*, Marguerite El-Helou, June 02, 2011

[214] Ibid.

[215] UNFPA and SPR

[216] Standard Progress Report 2011.

[217] See Annex 4 Evaluation Matrix EQ4 JC4.2

Notwithstanding the efforts highlighted above, UN agencies working with the NCLW strongly expressed[218] the need for increased training of NCLW employees on gender concepts and gender mainstreaming, as well as coordination with NGOs and line ministries.

NCLW continues to enjoy an excellent relationship with the UNFPA.[219] The NCLW acknowledges that the technical support provided by UNFPA has been crucial in furthering the capacity of the NCLW to address women's empowerment and gender equality issues in Lebanon.[220]

4.4.3 Contribution to the institutionalization of gender-sensitive and responsive policies, strategies and laws

UNFPA was successful in elaborating studies and supporting the drafting of laws in support of women's legal status, taking into consideration socio-cultural dimensions and legal issues to address gender inequalities and the rights of women and girls. UNFPA was also successful in supporting advocacy efforts with government and through civil society organizations. However, serious gaps continue to exist in the legal framework and related practices for the physical protection of women.

With UNFPA support, the **National Women's Strategy** was validated, endorsed and operationalized in 2012. The validation of the National Women's Strategy (2011-2021) was the main objective of the project "Enhancing the Capacity of the National Commission for Lebanese Women for Promoting Gender Mainstreaming in Sector Plans and Programs." UNFPA supported the elaboration and validation of the National Women's Strategy using a multi-disciplinary and participatory approach, through organizing a workshop with the participation of the Government and line ministries (March 2011). The National Women's Strategic Priorities and Framework were revised, elaborated, and agreed upon to be mainstreamed into national sectorial strategies and action plans.[221] UNFPA was successful in incorporating important themes into the revised/updated national women strategy, including the rights of women and adolescents girls, particularly reproductive rights.[222] Similarly, UNFPA incorporated gender mainstreaming as one of the main areas of intervention in the national women's strategy. More so, UNFPA advocated for the inclusion of "Women and Girls in Conflict" as one key objective of the Strategy and in view of the repetitive crisis that Lebanon has faced (and still is facing) in the past 30 years.

Additionally, UNFPA advocated, along with the NCLW, for the adoption and endorsement of the National Strategy by the Council of Ministers and which was realized in 2012. NCLW, with the support of UNFPA, also worked with MoSA[223] hand in hand to to support national institutions and civil society to upgrade, adapt and operationalize the National Women's Strategy and its Action Plan within the different sectors, including education, health, political participation. UNFPA and the NCLW organized meetings with local NGOs and regional officials to generate support for the National Strategy. In addition, UNFPA through on going seminars and workshops played a major coordinating role between NCLW and MOSA to promote all of the above mentioned issues.

Following the elaboration of the National Women's Strategy, UNFPA provided technical assistance to the NCLW for the finalization of the Action Plan, and supported efforts to advocate for the Action Plan to ensure the buy-in of, and endorsement by all concerned actors. UNFPA supported the NCLW in

[218] Individual interview with a member of the UN GWG

[219] Individual interview with UNFPA staff member

[220] NCLW Field Visit, May 19, 2013

[221] Standard Progress Report 2011

[222] Individual interviews with members of the UNGWG

[223] Individual interview with the head of women department in MOSA

organizing a series of advocacy activities (meetings, workshops, and national events) with civil society organizations, senior officials and decision-makers (in line ministries, academics and the media, etc.). The validation of the Action Plan took place in April 2013. The effort succeeded in gathering a wide pool of representatives from around 70 groups and organizations (NGOs, ministries, public administrators, international development agencies including the UN, academic institutions, etc.). The elaboration of the Action Plan was an excellent step towards the operationalization of the National Women's Strategy and helped to overcome the weaknesses of the strategy which is an achievement supported by UNFPA. This success was echoed by all Government and NGOs representatives interviewed during the evaluation mission.

UNFPA is also supporting the NCLW in 2013 to develop web-based software which will encompass all the elements of the Action Plan, that will be used to compile input by all concerned stakeholders on the contribution to the action plan and will generate yearly analytical reports on the progress made towards its implementation and which will also be considered as important input for the national CEDAW reports.

UNFPA plans to continue its support to the NCLW to strengthen its advocacy and strategic capacities, for the full implementation of the Action Plan of the National Women's Strategy and its follow-up. UNFPA also intends to support the Gender Focal Points for increased advocacy in support to the implementation of the Action Plan.

UNFPA was successful in furthering efforts for increasing women's legal status in Lebanon, through its support to advocacy efforts for the ratification of the nationality law led by NCLW through lobbying with political parties, parliamentarians, and religious institutions, and youth participation, and held meetings to draft an advocacy campaign.[224] UNFPA also supported several legal review studies to examine the status of women in Lebanese legislations, including the draft laws on the protection of women which have been used as a reference tool for legal efforts. UNFPA also supported the NCLW in conducting a situation assessment and analysis to clarify socio-cultural dimensions and human rights issues related to gender inequality and gender-based violence, and to identify and address legal and social constraints to establishing protective systems.[225]

Several findings of the studies were taken on board, and UNFPA and other related NGOs took steps to address men's opinions and needs. The NGO KAFA supported by UNFPA which engaged in awareness raising efforts with the Internal Security Forces,[226] is a pioneer model for addressing men. In addition, all UNFPA's work on Gender including GBV aim at engaging men in support of the gender equality and women empowerment interventions. These efforts are major success, however they need to continue and spread widely to reach more segments of men. Especially in reproductive health services where the services are not male-oriented and centers do not take into consideration the suitable opening hours for men, who make up the majority of the working population.

UNFPA supported reporting instruments, including the CEDAW reporting. Although in 1997 Lebanon ratified the CEDAW, it did so with reservations on articles 9/2, 16/1 and 29/1[227], which protected, to some extent, men's physical control over women as well as their priority in citizenship matters. While the CEDAW committee praised Lebanon for having integrated services for GBV survivors into primary care health clinics, it expressed concerns about the continuation of domestic violence and

---

[224] Standard Progress Report, 2012

[225] Ibid

[226] Individual Interviews: UNPFA GBV Focal Point, May 8th. KAFA May 9th. ISF Coordinator of ISF GBV Project May 15th, Training session May 17th KAFA Lawyer KAFA trainer, with two ISF Trainers, 25 ISF trainees group interview.

[227] Art. 9/2, regarding equal rights for men and women about citizenship for children; Art. 16/1, committing states to apply proper measures to eliminate discrimination in marriage and family relations; Art. 29/1, concerning the ways dispute is resolves.

the absence of a comprehensive approach among NGOs. UNFPA also supported the elaboration of the CEDAW report in GBV and RH related policies, programmes, interventions and in sex disaggregated data collection and analysis.[228]

UNFPA supported the coordination efforts with CSOs on advocacy for new laws, especially the national coalition for the protection of women from family violence. This support helped draw attention to the GBV issue through development of a law on protection of women from family violence. After a series of advocacy events and policy interventions, the draft law was endorsed by the cabinet on April 2, 2010 and is under approval by Parliament. In response to pressure from religious leaders, some members of the parliamentarian committee called for amendments in the law, which would result in passing a law that would be weak and will not remedy the fight against family violence. A campaign opposing the endorsement of the law was launched in 2011 by a small group of women NGOs in North Lebanon, backed by conservative religious institutions. So far Joint Parliamentary Committees approved the Bill to protect women and families from domestic violence. On April 1, 2014, the Parliament approved the law, however with major amendments which weakened the said law.

UNFPA was successful in providing a comprehensive package on GBV that helped support the efforts of the NCLW and NGOs. This package included i) advocacy efforts to support GBV, and media campaign; ii) GBV studies, resource and training materials, surveys, tools and guidelines; iii) and capacity development of NGOs, the Internal Security Forces (ISF), and Social/health service providers; and iv) coordination among stakeholders in planning, programming, and advocacy efforts on GBV.[229]

4.4.4 Contribution to increased awareness on GBV and improved legal frameworks and institutional capacity, in particular in emergency situations

UNFPA was successful in increasing awareness on GBV, including through programming, capacity development, and improved legal instruments. UNFPA support targeted a wider range of stakeholders, governmental and non-governmental.

The UNFPA programme supported the capacities of the national institutions and NGOs, and addressed the issue of coordination among key ministries and NGOs, making use of the existing active civil society in Lebanon. The implementation by UNFPA of the Gender Based Violence (GBV) programme involved the establishment of a network composed of NGOs, women groups, academic institutions, ministries, parliamentarians, UN partners and experts concerned with GBV. With support from UNFPA, the NCLW succeeded in building on these networks for further elaborating GBV into a full-fledged national programme with a 2-year national action plan.[230]

UNFPA supported NGO programming on GBV, including through: i) developing tools and guidelines for rehabilitation and reintegration interventions of GBV survivors; ii) supporting initiatives implemented by NGOs[231] targeting GBV survivors and victims and iii) conducting needs assessment of the community centres, followed by training of health providers.

[228] Standard Progress Report,2011

[229] Evaluation Matrix EQ4 JC4.3

[230] Evaluation of UNFPA 's country programme of assistance 2002-2009, Lebanon, consultation and Research Institute, April 2010

[231] Najdeh Association, Caritas Lebanon Migrants Center, Community Maryam and Martha, Congregation of our Lady of Charity of the Good Shepherd, Kafa Violence & Exploitation, The Lebanese Council to resist Violence against Women, The Lebanese Women Democratic Gathering, Mission de vie and Young Women Christian Association

UNFPA also succeeded in supporting the NCLW and related NGOs and Line Ministries in building a solid methodological approach for GBV, through the elaboration and dissemination of studies on GBV[232] to different stakeholders, as well as the elaboration and translation to Arabic of common definitions of GBV. The studies generated evidence that was used for GBV policy recommendations. The dissemination of evidence based studies, standards and tools contributed to a greater extent to the advocacy efforts in favor of a better GBV prevention and response[233]. Together with civil society organizations, international organizations, governmental institutions, academic institutions, experts, activists and media, UNFPA has helped draw attention to the GBV issue.

Although delays in their production and distribution proved frustrating,[234] people appreciated these documents whose results helped partners in consolidating GBV programmes.[235] The Steering Committee of the GBV Action Plan, which is supported by UNFPA and headed by MoSA, represented by almost all GBV actors is a real breakthrough among the GBV actors.

UNFPA was successful in advocacy and policy dialogue on GBV with key stakeholders based on a social media strategy that was developed and launched during the fourth quarter of 2012. UNFPA supported campaigns; media training;[236] GBV websites[237]; social media; and training of eight media persons and 24 graduate journalism students from the Lebanese University. The strategy was based on the findings and recommendations of the "*Assessment of Media Coverage of GBV in Lebanon*," carried out by UNFPA in collaboration with the Lebanese Council to Resist Violence against Women (LECORVAW), which stressed the vital role of media in fighting GBV.[238] A key initiative by UNFPA is its support to the advocacy campaign by NGOs and national institutions on the law on domestic violence "16 days of activism against Gender Based Violence" in 2010 and 2011. Through the engagement of the media in fighting GBV, UNFPA succeeded in raising the visibility of the issue of GBV as a human rights violation, and forming lobby groups to push policy makers to legislate against it.[239]

UNFPA also supported capacity development of NGOs through its GBV training programme with MoSA, which targets NGO social health workers that are in contact with the most deprived communities. The curriculum of the training programme is based on the UNFPA-designed Manual (*Dalil Houqouq Insaniya*) that is now used by all trainers. [240] Trained trainers were supported in implementing training activities for community members, which was also be coupled with coaching and monitoring, especially in underserved remote areas. In addition, social health providers and humanitarian workers (trained on GBV assistance)[241] were involved in awareness campaigns, such as the *white ribbon* campaign.[242]

[232] Situation Analysis in Gender Based Violence in Lebanon, 2012; Assessment of Media Coverage of GBV issues in Lebanon, 2013; Review of Gender Based Violence Research in Lebanon, 2012; Review of Gender Based Violence Resource and Training Material in Lebanon, 2013.

[233] See Annex 4 Evaluation Matrix, EQ4. JC4.3

[234] UNFPA GBV Report

[235] Individual interviews with NGOs and MoSA

[236] Individual interview with UNFPA

[237] www.infosantejeunes.usj.edu.lb

[238] Assessment of Media Coverage of GBV in Lebanon by the Lebanese Council to Resist Violence against Women, 2012

[239] See Annex 4 Evaluation Matrix EQ4 JC4.3

[240] Ibid

[241] HRSC-5

[242] Individual interview with the head of Lebanese Council to Resist Violence Against Women

UNFPA, through KAFA, also supported the training of the Internal Security Forces (ISF)). During a field visit to the training site, the six chapter training curriculum that was piloted and tested with nineteen officers was used during the training. The feedback on the training was positive regarding the organization of sessions, facilitators, methodology and approach used. Two additional advanced training programmes were conducted with other ISF members, including on handling cases of VAW (ToT workshop for ISF officers), establishing women friendly spaces at ISF stations showed a lot of progress on the GBV issue in the program with the ISF. In addition and through other awareness raising programmes, UNFPA used the Y-Peer for youth network to disseminate issues related to GBV.

4.4.5 Contribution of UNFPA supported interventions to sustainable effects in the field of gender equality and empowerment of women

It is likely that some of the initiatives of the UNFPA in gender equality and empowerment of women will continue beyond termination of the 3rd country programme, while other programmes will not be able to. Nevertheless, only in some cases, exit strategies were developed. UNFPA worked with women's committees that were established under an earlier supported project (WEPASS project) to support their institutionalization as registered NGOs.

UNFPA was successful in working with academia to institutionalize piloted training on GBV through including it in the curriculum (e.g. the course on GBV is being considered to be included by the Lebanese American University as a required course for graduate journalism students, and the Curriculum on Reproductive Health and Life Skills (see RH section) will be integrated in the schools as a manual for teachers).

The efforts of UNFPA's initiatives in capacity development is well sustained and supported specially to the NCLW in better understanding their roles and responsibilities, the partner NGOs and academia in integrating the gender perspective in all of their activities, the GBV Steering Committee who is now institutionalized in MoSA, and to the pilot GBV training programme targeting the Internal Security Forces (ISF) who is being institutionalized as part of the mandatory ISF Training Institute.

An exit strategy was built into some projects, whereas some others could have better benefited from a much clearer exit strategy. The project in support of KAFA with the Internal Security Forces (ISF) and the project related to the GBV media project of the white ribbon have clear processes for an exit strategy. On the other hand, the MDGF project, for example, contained no exit strategy as it was developed to respond to a crisis and required an emergency response that makes it difficult then to be able to design an exit strategy.

UNFPA made another major effort towards sustainability regarding the project's handover process: UNFPA ensured that not only information, trained expertise and relevant experiences, equipment and furniture were provided at the end of the project to the executing parties, but also the methodological processes related to all materials, documentaries, summary of studies, pamphlets, newsletters and tools developed during project implementation.

Ownership of the project is the utmost indicator of its success. It is the pillar of sustainability and is often a product of a participatory approach in planning and execution. Although the evaluation of the second cycle noted the varying degrees of participation mechanisms, there did not seem to be a strong sense of ownership or commitment. In the 3rd country programme, the situation improved as the UNFPA through is way collaboration with the governmental and non-governmental organizations increased their sense of ownership.

4.5 EFFICIENCY

EQ5

To what extent has UNFPA made good use of its human, financial and technical resources in pursuing the achievement of the outcomes defined in the country programme?

SUMMARY

UNFPA regular resources were available in a timely manner. However, they had to be reallocated within AWPs to mitigate the effect of late transfers of government's financial contribution on critical activities. Delays at design stage negatively impacted several interventions, in particular with fragile IPs.

UNFPA raised significant resources from the government for CPAP interventions and donors to respond to the Syrian crisis.

UNFPA proactively supported implementing partners in minimizing the constraints of its administrative and financial procedures.

4.5.1 Allocation and timeliness of resources for planned UNFPA support to beneficiaries

UNFPA regular resources were utilized without severe delays for all interventions. Some minor delays were claimed by a few IPs, yet could be due to a limited capacity on their side to adjust to unavoidable administrative constraints for assistance delivery. Delays were mainly caused by lengthy decision-making at ministry level – for CPAP, AWPs and the mid-term review. The high disbursement rate over the reference period indicates that resources were received by IPs to the level planned.

UNFPA resources were readily available for the implementation of interventions once they were approved. However, the 3rd country programme suffered from consistent delays related to governmental instability during the reference period, the high level of centralization of decision-making in some ministries, and recurrent budgetary shortages.

Finalizing and approving all 2010 AWPs was delayed by six months because of turn-over in the Lebanese cabinet after elections and the transition phase following as elections occurred during the design process of the UNFPA country programme. It took some time to agree on the new programme framework and related strategic approaches. Signing the CPAP between UNFPA and CDR did not occur before May 26, 2010. Such delays presented a major challenge to IPs charged with implementing a one year plan over a period of a six months period or less. Some of the 2011 AWPs were signed two months late, owing to a late start of the design process.

Within the RH component, the UNFPA-UNICEF joint programme to operationalize the Youth Friendly Services package (YFS)[243] was supposed to start in early January 2012. However, the implementation was delayed as the programmatic revision and contractual arrangements to finalize the JP with UNICEF took some time. Despite this delay, the

[243] See details in paragraph 4.2.5

implementing partner succeeded in completing the interventions included in the AWP (related to advocacy, capacity development, assessment of needs, and development of material). Similarly, the one-year interventions agreed under the AWP LBN3R51B with FHS/USJ were implemented over a 6-month period. This shows that the planning process does not start early enough to allow the implementing partners to timely start the interventions and that a number of administrative constraints (for both UNFPA and its IPs) are not taken into consideration.[244]

The P&D component faced serious concerns in undertaking planned interventions due to the delayed transfer of government funds. The delay was not caused by a lack of commitment from MoSA. In fact, the resources were duly and timely earmarked by MoSA and then transmitted to the Ministry of Finance who postponed transfers for months (e.g., early 2012 commitments were transferred only in late April 2013).[245]

Table 9 below compiled from AWPs and SPRs, indicates the ratio of realization of the P&D programme during the reference period was 65 per cent. The changes unequally affected implementation of interventions (76% of realization) and running cost of the programme management unit (33%).

This situation reflects the financing structure of the programme, with most of the national resources allocated to interventions, which is a sound design. The operational issues were mitigated by the CO to the possible extent, by re-allocating regular resources to urgent interventions that were not initially to be financed by UNFPA. The leeway was however limited but was instrumental in some cases.[246] The main recipient of regular resources in the P&D component was the P&D project unit (90%) for its running costs.

For the Gender component, mainly regular resources were utilized. Most projects were implemented in a timely manner. Projects faced some delays in finalizing consultancies and needs assessments, delay of the finalization of the National Women's Strategy (owing to the pace of the internal validation), lack of interest in technical training activities among NCLW members, weak coordination among collaborating agencies and the unstable political situation in the country. Security situation sometimes limited access to the targeted community and the tense political situation in general in the country affected implementation especially in Tripoli, still facing some security incidents, as well as the situation in Palestinian camps and more specifically Bared Camp.

Table 9 *P&D - Changes in Source of Funding at Cluster Level (in USD) (2010 - 2012)*

	PLANNED		FINAL		CHANGE		
	RR	TF	RR	TF	RR	TF	Total
Project support	202,151	205,651	162,258	147,120	-39,893	-58,531	-98,424
National Activities	89,000	113,500	67,018	-	-21,982	-113,500	-135,482
Global Activities	-	-	18,345	392	18,345	392	18,737
Sub-total	291,151	319,151	247,621	147,512	-43,530	-171,639	-215,169

Source: AWPs 2010, 2011, 2012; RR for regular resources and TF for Trust Fund (i.e. government contribution)

[244] See Evaluation Matrix, Annex 4, judgment criteria 5.1

[245] Ibid.

[246] Interviews of CO and P&D project staff

4.5.2 Leverage effect of resources provided by UNFPA on external contributions

The leverage of UNFPA regular resources on external financial contributions varied according to the programme components considered and the Ministries in charge. MoSA was particularly responsive for the P&D component - once redirected towards support for aging policy – by contributing up to 60 per cent of the budget. The same applies to gender, although on a more limited scale (15%). UNFPA was successful in collecting funds for addressing the Syrian crisis' refugees. In Lebanon, the vibrant civil society contributed by mobilizing volunteers and activists.

The partnership built with the Government, and the relative flexibility demonstrated during the programming and the implementation of the 3rd country programme, allowed the UNFPA to raise significant additional resources. Government resources account for 15% of the CPAP overall, and 60% for the P&D component where partnership has been particularly flexible. MoSA contribution was of USD 68,284 allocated to activities and USD 289,194 through supporting P&D project staff salaries.

For the P&D component, the UNFPA funds did not attract additional financial resources from institutional partners. A significant contribution in time and dedication of the Lebanese civil society can be however noticed.[247]This "invisible" leverage applies to the other components of the CPAP. The momentum given by the UNFPA involvement on behalf of old peoples' care is progressively triggering new initiatives through the NCEA members in particular.[248]

The partnership with MoPH, however, serves as a counterexample. UNFPA has been assisting the Ministry of Public Health for the procurement of contraceptives using the MoPH financial contribution. Traditionally the MoPH has received support from the UN agencies in order to procure health-related commodities. In the initial AWPs, the contribution of the Ministry of Public Health was supposed to cover the review of Standards Delivery Guidelines (SDGs) and the integration of RH, Voluntary Counselling and Testing (VCT) and GBV into the SDGs as well as the training of the revised SDGs and on outreach guidelines developed by UNFPA. So far the MoPH has not provided this type of contribution. As seen above in paragraph 4.2.2, the AWPs signed with the Ministry of Public Health were revised and foreseen contribution amounts were revised mainly because the MoPH could not release the funds during the year of implementation. In 2011, UNFPA contributed the amount that was planned initially.[249]

The Syrian crisis and the positioning of the UNFPA on its core mandate in emergency situations increased the leverage during the 3rd Country programme. The emergency funds represent 12% of the CPAP budget. In May 2012, the mobilization of funds for humanitarian interventions through the Central Emergency Response Fund (CERF) and regional emergency funding allowed a response to take place in the last quarter of the year. In 2013, UNFPA managed to secure additional funds from the CERF, the Bureau of Population, Refugees and Migration of the US Department of State, the Government of Germany and the Kuwaiti Fund.

Table 10 *P&D - Sources of Funding for the Third Country Programme (in USD) 2010 - 2012*

	RR	RF	TF	Total	%
Project support	194,103	-	289,194	483,297	78 %
Activities	42,844	4,000	68,284	115,128	19 %
Audit	-	-	3,500	3,500	1 %
7 billion campaign	7,045	-	7,045	14,090	2 %
Sub-total	243,992	4,000	368,023	616,015	100 %
Percentage	40 %	1 %	60 %		
Total	**$616,015**				

Source: AWPs 2010, 2011, 2012

[247] See Evaluation Matrix, Annex 4, judgment criteria 5.1

[248] See Evaluation Matrix, Annex 4, judgment criteria 5.2

[249] Ibid

4.5.3 Effects of the administrative and financial procedures and the mix of implementation modalities on the programme execution

Issues in implementing UNFPA procedures were identified at an early stage of the 3rd country programme, also taking from experience. Micro assessments and audits were undertaken for identifying specific issues and related capacity or knowledge shortcomings. On this basis, training sessions were conducted in 2012 that improved programmes' implementation. The P&D component was managed by an experienced project management unit and did not face any particular issue with UNFPA administrative and financial procedures.

UNFPA worked with a variety of IPs, including the Government institutions (Ministry Social Affairs, the Ministry of Education and Higher Education (MEHE), and the NCLW) ; civil society organizations such as KAFA, MASAR, VAPA, etc. as well as academia such as Saint Joseph University, LAU and AUB. Implementing partners were selected carefully based on their comparative experiences and the interventions foreseen for implementation. UNFPA followed a thorough process to select its partners. The assessment looked at staff, experience in working with development partners, interactive methods, usual target audience. Similarly, the selection of partners for the humanitarian interventions was done in a thorough manner, through assessments based on different pre-defined criteria, e.g., coverage area, logistics capabilities, human resources, experience, etc.[250]

UNFPA CO often works with the same resource persons or organizations for different tasks. Often it appeared that UNFPA selected the same resource persons for different interventions as they proved to be valuable resources. On the one hand, this approach builds on recognized expertise, yet it prevents the CO from extending its range of partners and from broadening its way of thinking. The NGO Masar was initially selected based on its 10 years long experience in advocating for national youth policies in Lebanon in the frame of the "Youth Advocacy Process" (YAP) initiative under the Y-PEER network AWP (LBN3R41A). It was then selected as an IP for the *Let's talk campaign* in 2011 and a contractual agreement in 2012 for training and support to Youth NGO.

A period of adjustment was required by IPs entering into partnership with UNFPA. UNFPA financial and, to a lesser extent, the administrative procedures, proved to be hard to manage for IPs that are mainly civil society organizations.

The limited time and dedication of voluntary workers and activists to administrative and reporting tasks was initially an issue. The CO identified this issue and other IP weaknesses during micro-assessments and NEX audits. The continuous relation built with IPs by CO and well-targeted training sessions on UNFPA procedural requirements helped overcome difficulties. The trainings were organized relatively late in the implementation of the programme, with the majority in 2012. Reporting improved in most of the cases, although it lacks regularity for some IPs.[251]

The coordination with UNFPA is perceived as helpful but the time for planning and preparing interventions was insufficient, notably for RH IPs. As part of the partnership, UNFPA facilitates the preparation of Terms of reference and action plans with its partners. This helped clarifying their tasks and a smooth implementation with few exceptions. The AWP monitoring mechanisms required by UNFPA are found easy to use and not too cumbersome.[252] IPs acknowledged that UNFPA was present when needed during the implementation and that it followed-up all the details of the project. UNFPA CO staff members were prompt in their response to issues arising in field operations, particularly during the humanitarian response. IPs recognized that the provided technical support was

[250] UNFPA, *Distribution survey matrix,* 2013

[251] See Evaluation Matrix, Annex 4, judgment criteria 5.3

[252] IP interviews

instrumental in achieving the overall objectives of the project despite challenges.

The IPs and stakeholders met by the evaluation team did not mention specifically issues regarding the CO administrative and financial procedures for implementation. Most of the IPs interviewed were completely satisfied with the partnership with UNFPA, and the technical advice they received during the implementation of interventions.[253]

In the case of the P&D project unit, the staff was already familiar with UNFPA procedures from the experience acquired during the 2nd country programme. Interventions were implemented without delay.

UNFPA oriented the staff of IPs facing reporting issues on UNFPA financial procedures. This training was found useful for the IPs staff to gain new skills and to work out the financial details of the UNFPA grant appropriately. The technical support provided to Masar (NGO implementing partner) included attending an introductory workshop on the campaign in ASRO; a workshop on financial reporting; in addition to ongoing planning and follow up meetings.[254] Some other IPs reported that the financial reporting was complicated and required the involvement of a lot of human resources, despite the training and coaching sessions provided by the UNFPA CO.[255] *"The financial management from both USJ and the UNFPA is demanding and time consuming, requiring tremendous paper work and official forms. The coordinator of the project had to juggle between two different financial systems to meet the requirements and finance the activities."*[256]

4.6 STRATEGIC POSITIONING OF UNFPA WITHIN THE UN SYSTEM

EQ6

To what extent did the UNFPA country office contribute to the good functioning of coordination mechanisms and to an adequate division of tasks within the UN system?

SUMMARY

UNFPA makes a key contribution to the coordination among UNCT members by taking part in – and sometimes chairing – several working groups. This contribution is particularly visible in the reproductive health and the gender components, especially in the groups and sub-groups addressing the needs of Syrian refugees. Beyond coordination, UNFPA has also sought to achieve complementarity between its interventions and those of other UNCT members, as exemplified by the successful partnership between UNFPA and UNICEF in the joint programme on Youth Friendly Services. However, the seeking for synergies and complementarity has not been done in a systematic manner, and, in some instances, overlaps were found between UNFPA interventions and those of other UN agencies.

---

[253] See Evaluation Matrix, Annex 4, judgment criteria 5.3

[254] Ibid

[255] United Nations Population Fund, *Report on Mid-Term Review of the UNFPA 2010-2011 Program Implementation*, September 2012, Interview with implementing partners

[256] SPR 2011

4.6.1 Contribution of the UNFPA country office to UNCT working groups and joint initiatives

UNFPA plays a crucial role in the coordination mechanisms of the UNCT in Lebanon, thanks to its active participation, sometimes with a leading role, in several UN working groups.

As far as the RH component is concerned, and within the humanitarian context, UNFPA takes part in the Health Working Group, chaired by WHO, and which meets on a monthly basis. UNFPA is also an active member of the UN theme group on HIV-AIDS and of the Joint UN Team on AIDS (JUNTA). It also takes part in the UN Youth task force, chaired by UNICEF. In April 2012, in order to better address the needs of Syrian refugees, a reproductive health subgroup was created within the Health Working Group. UNFPA chairs this subgroup, which is co-chaired by International Orthodox Christian Charities (IOCC). In the RH subgroup, UNFPA plays a crucial role in facilitating the sharing of information and knowledge on RH issues among partners and in liaising with the MoPH when necessary. Meetings of the RH sub-working group within the context of the humanitarian operation have allowed an improved harmonization of RH related interventions. [257]

In the field of Population and Development, UNFPA took part in the UN technical working group on statistics (created in 2010), which was meant to support the Central Administrative Statistics (CAS) office in finalizing a Statistical Master Plan and to ensure its operationalization by elaborating a corresponding action plan. The lack of political commitment in the finalization of the Statistical Master Plan has led the working group on statistics to progressively withdraw from the initiative. [258]

In the field of gender, UNFPA chairs the UNDAF Gender Working Group (GWG) since 2010. As the chair, UNFPA has been organizing regular meetings of all UN gender focal points. GWG members are appreciative of the role played by UNFPA in terms of expertise and knowledge sharing on gender initiatives. The GWG has led to an improved collaboration among UN agencies in the field of gender, with fruitful joint initiatives such as the gender focal points needs assessment study, commissioned by the GWG in 2011, at the request of the National Commission for Lebanese Women (NCLW).[259] UNFPA also co-chairs, with UNICEF, the sub-working group on sexual gender based violence (SGBV), which was created after the beginning of the Syrian crisis. Within this sub-working group, UNFPA has supported the assessment and roll-out of the GBV information management system (GBVIMS) and conducted two GBVIMS trainings for decision makers and focal points, resulting in a stronger inter-agency effort in the field of GBV, as exemplified by the development of a joint plan of action on GBV.[260]

4.6.2 Contribution of the UNFPA country office to the division of tasks among the UNCT

UNFPA has sought to generate complementarity and synergies between its interventions and those of other UN agencies, although UNFPA has also sought to achieve complementarity between its interventions and those of other UN agencies, although this could have benefitted from a more systematic approach.

In the field of RH, UNFPA has achieved complementarity between its interventions and those of UNICEF. The joint programme on Youth Friendly Services (YFS), which started in 2011,

[257] See Annex 4, Evaluation Matrix, Judgement Criterion 6.1

[258] Ibid.

[259] Ibid.

[260] Ibid.

is a good example of partnership, building upon the complementarity of the mandates of the two agencies.[261] Based on the initial YFS package developed by UNFPA within the framework of its second country programme, UNFPA and UNICEF have joined their efforts to operationalize the YFS, while ensuring that the UNICEF child protection mandate was included in the YFS package, as a complement to reproductive health and life skills aspects. The collaboration between UNFPA and WHO also led to examples of synergies and complementarities, as in the case of a training on Clinical Management of Rape, for which WHO provided technical assistance to develop the curriculum, while UNFPA supported the implementation of the training based on this curriculum. In a few instances, however, overlaps and/or missed opportunities for synergies were noted, as was the case for the extra-curricular health education in schools. Both UNFPA and WHO provided support to the development of two distinct interactive CDs on reproductive health and life skills education for young people. Although the target groups were different (in terms of age), the topics addressed by the two agencies were very close (dealing respectively with reproductive health and HIV/AIDS), yet they did not coordinate their interventions which were conducted in parallel. [262]

In the field of P&D, similar overlaps were noted in the interventions of UNFPA and WHO. Both agencies have indeed respectively financed several policy briefs, issued by the Center for Studies on Aging (CSA), the content of which was partially overlapping. It appears that the two agencies did not proactively coordinate their support to the CSA, thus missing an opportunity to generate synergies and to strengthen their advocacy work with regard to aging.[263]

In the field of gender, complementarity of interventions among the UNCT was ensured within the Gender Working Group, chaired by UNFPA. UNFPA developed and implemented several joint initiatives with other UN agencies such as: WHO, UNICEF, UNODC, UNDP, UNESCO and ILO. These joint initiatives related to capacity development, development of standards, guidelines and tools, as well as policy dialogue and advocacy work on gender.[264]

[261] See Annex 4, Evaluation Matrix, Judgement Criteria 2.4 and 6.2

[262] See Annex 4, Evaluation Matrix, Judgement Criterion 6.2

[263] Ibid.

[264] Ibid.

5 ANALYSIS OF THE COUNTRY PROGRAMME M&E SYSTEM

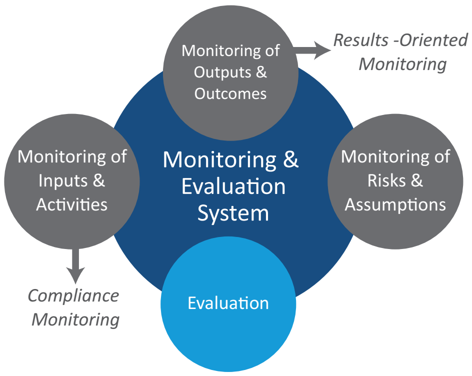
The M&E system aims at measuring progress towards inputs, activities, outputs and outcomes as planned in the country programme. The monitoring of inputs and activities refers to the day-to-day monitoring tasks carried out by programme officers at CO, in particular: budgets and expenditure follow-up; supervision of activities implementation. The monitoring and evaluation of outputs and outcomes is also directly associated with the country programme contribution to the UNDAF. Finally, the M&E system also encompasses the monitoring of risks and assumptions which directly relate to the country context. [265]

The monitoring of risks and assumptions is another important level to be covered. Following the current Strategic Plan, the improvement of risks management is one of the elements to take into account to strengthen results based management.

The evaluation component corresponds to the evaluation function within the country office and encompasses the process of planning, conducting and using the results of evaluation exercises.

An effective M&E system is therefore both a cornerstone and a precondition for fulfilling UNFPA corporate strategy towards: i) strengthening results-based management, ii) putting in place a culture of measurement of results, iii) using evidence of results to inform decision-making, and iv) improving measurability to ensure accountability of results, and v) strengthening national M&E systems.

Figure 16 *Monitoring & Evaluation System*



Objectives and methodology of the analysis of the M&E system

The assessment of the M&E system is meant to:

- Provide a snapshot of the type of M&E system in place including a brief description of the features of the system;
- Assess the quality of the M&E system and its features, in particular, the quality of the CPAP indicators, as the backbone for result-oriented monitoring;
- Assess UNFPA support to capacity building and/or strengthening of the national M&E systems and management for results;
- Provide a series of practical and actionable recommendations on how to improve the M&E system in the country office.

The analysis assesses i) the quality of the M&E system and its features, in particular, the quality of the CPAP indicators, as the backbone for result-oriented monitoring, and ii) UNFPA support to capacity building and/or strengthening of the national M&E systems and management for results. It eventually provides a set of practical and actionable recommendations on how to improve the M&E system in the country office.

The assessment of the M&E system covers the same period as the evaluation of the country programme, i.e., 2010-2014.

For the assessment of the CO M&E system, the data collection methods utilized consisted in documentation review (UNDAF, CPAP, AWP monitoring framework and evaluation plans) and semi-structured interviews, firstly with CO staff as well as with IPs counterparts. The Chair and Vice Chair of the UNDAF M&E Working Group were also met. The methodology for data collection is presented in Annex 10.

[265] UNFPA Guide "Assessing the country office monitoring and evaluation system"

Although the monitoring and the evaluation functions are closely related within the country office system, they are of a different nature and were assessed separately.

The overall assessment of the country office monitoring and evaluation system was undertaken also through the two dedicated tools set in the UNFPA Evaluation Office handbook on "How to design and conduct a country programme evaluation"[266]:

- The M&E system assessment grid (tool 15) assesses the degree of development and quality of the country office M&E system, namely: i) the type of M&E system in place in the country office; ii) the degree of development of the four components of the system, including their quality and their main weaknesses.

- The CPAP indicators quality assessment grid (tool 16) is an instrument enabling the assessment of the quality of output and outcomes indicators against a set of eight criteria and sub-criteria.

Monitoring of inputs and activities

The monitoring of inputs and activities refers to the day-to-day monitoring tasks carried out by programme officers at CO, in particular: budgets and expenditure follow-up; supervision of activities implementation. Actions undertaken under this component correspond to compliance monitoring, i.e., monitoring tasks performed by all UNFPA staff as an integral part of their job description.

In Lebanon, inputs and activities are closely monitored and are by far the most common understanding of monitoring among CO staff. Hence, all monitoring tools, even some that are in principle geared towards result-based monitoring e.g. CPAP Planning and Tracking Tool and annual reviews, are used for activity-based monitoring.

Budget and expenditures are followed up by IPs and the staff in charge of Atlas in the CO. The 2012 CO audit[267] was positive with regard to financial management – apart from an issue on VAT that does not impact on the follow-up of programme expenditures. The financial management appeared as relatively flexible i.e. AWPs being changed several times in a year (up to 10 times for the P&D programme in 2011). At activity level, the initially planned budget can be exceeded by taking from other budget lines without changing the result level. Many of these changes are linked to late payment of the government's financial contribution. This high level of flexibility definitely improves effectiveness in programmes' implementation but does not allow result-based monitoring as the link between objectives and resources can be significantly altered during implementation.

Supervision activities take the main share of the CO staff tasks in terms of monitoring and reporting on programme interventions. The main supervision tool is the Standard Progress Report (SPR), which was elaborated by the IPs until 2012; starting from 2013, the CO took over on IPs for preparing SPRs as per M&E guidelines whereas the IPs report on quarterly progress along with the financial reporting tools (e.g. FACE). Progress reports give a good picture of the achievements and of the constraints faced at activity level. However, their quality of reporting was uneven, according to familiarity with UNFPA templates, capacity, and inclination for routine administrative tasks. They were however useful to the present country evaluation for stating the context and the interventions undertaken.

The main usual source for the monitoring of UNFPA inputs and activities are the annual reviews. In Lebanon, the recourse to this process was minimal: only implemented for the RH component, and for only three IPs in 2012 (one only in 2010). IPs

[266] Results of both tools are presented in Annex 5 and 6 respectively.

[267] Division For Oversight Services, Audit of the UNFPA country office in Lebanon - Final Report, No LBN-101, 8 February 2013

integration into the process of annual planning is underdeveloped.

The Field Visit Mission (FVM) reports are another usual source of information on programmes' activities and results. They are framed by a dedicated template and the occasions for filling it clearly stipulated by the management. However, programme managers found it difficult to clearly distinguish between routine coordination meetings (not requiring a specific reporting) and a "field visit" reporting, targeted on critical meetings. The concentration of IPs and partners in Beirut itself contributed to make the distinction uneasy. Unless for activities supervised periodically outside the capital, FVM reports were completed for only a small number of important meetings. The completion of FVM reports by CO staff was uneven and was not strongly scrutinized by the management. The resulting knowledge generated is relatively thin i.e. for the P&D component, only three FVM reports of unsatisfactory substance.

Monitoring of outputs and outcomes

The monitoring of outputs and outcomes is closely associated to results-oriented monitoring, which, in turn, is an essential part of results-based management.

Based on the UNDAF, the CO designed a result-based monitoring framework for the CPAP that was approved at the regional and central levels of UNFPA. The ministries (MoSA, MoPH) and the Civil Society Organizations were associated in the design of the result framework for the CPAP. They endorsed the resulting objectives, indicators and targets, organized in a matrix: the CPAP Planning and Tracking Tool.

The matrix[268] defines, for each of the three UNFPA components and, in each, successively for UNDAF outcomes, CP outcomes and outputs:

- Results (from UNDAF/CPAP)
- Indicators (3-4 per output as an average)
- Means of Verification
- Responsible party
- Baseline value
- Target value
- Achievement (of target value)

The overall architecture of the matrix is well anchored in the UNDAF and CPAP lists of outcomes and outputs, taking as well into consideration national priorities. Outcomes and outputs all together are informed by 49 indicators.

Applying Tool 15 of the UNFPA Evaluation Handbook[269], approximately two-thirds of the indicators are clearly formulated (65%) and relevant (69%) but only one-third (37%) can be assessed as specific i.e. properly targeted on the result that they intend to measure. Actually, almost all indicators are process or activity indicators rather than output and outcome ones, for instance:

- At least two national and sectorial plans and strategic frames articulating gender equality and the human rights of women and girls
- At least three ministries or administrations allocating budgets for gender-related activities
- At least four ministries or administrations applying methods and tools of gender mainstreaming
- Prerogatives and mandate for women's mechanisms and gender focal points submitted for validation
- At least four evidence-based national debates conducted on identified priorities related to gender equality and the human rights of women and girls

[268] Presented in Annex 9

[269] Presented in Annex 10

The set of indicators is not operational. If most of them (82%) do have a baseline and an end line, the targets were identified only for 6% of them. However owing the focus on process rather than results, the baseline and the target are generally identified in a binary manner, for instance:

- System not functional / functional
- Comprehensive services not developed / Service package for RH in humanitarian developed and piloted
- Less than 85% capable of identifying / Capacity development program developed

The fact that the indicators initially were not SMART made it difficult to use them to measure outputs and outcomes, providing limited incentive for the staff to devote time to M&E.

The means of verification as well as the results themselves are not informed for all indicators: The CO understood the weaknesses of the tracking tool too late i.e. after formal approval of the framework by both the Regional Office and the government, and is now waiting for the formal approval by the government of the mid-term review to revise the whole framework.

Resources allocated to the M&E system

The M&E functions are assumed by the Assistant Rep in the absence of an M&E officer. Unless some AWPs that budgeted for a few audits, the specific tasks that would have informed the CPAP result framework are not budgeted. The CO staff is overwhelmed by administrative and management routine, with limited incentives from the management for M&E tasks and limited training.

An evaluation plan has not been developed and the only one foreseen (on integrating RH into curricula) was finally abandoned. UNFPA relies only on the country programme mid-term reviews and final evaluations for feedbacks on its results in Lebanon. Symptomatically, the terms of reference of the mid-term review, elaborated by the CO, are the ones of an extended monitoring, kept largely activity-based rather than result-oriented.

Monitoring of assumptions and risks

Following developments of aspects identified in the risks and assumptions section of the CPAP is another important tool ensuring safer implementation of activities and achievement of expected results. Following the current UNFPA Strategic Plan, the improvement of risks management is one of the elements to take into account to strengthen results-based management.

In the UNFPA 3rd country programme for Lebanon, the analysis of assumptions and risks underlying the CPAP was presented neither in the main text nor in any document shared by the CO with the evaluation team. The CO confirmed that assumptions and risks were not formally analyzed and set in perspective with CPAP objectives. The staff demonstrated a good understanding of risks associated with the implementation of interventions but did not formalize them during the programming process.

Integration of evaluations in the monitoring and evaluation system

The evaluation component corresponds to the evaluation function within the country office and encompasses the process of planning, conducting and using the results of evaluation exercises. In the case of the Lebanon CO, finalizing the CPAP and its result framework was not associated with designing an evaluation plan. The CO set internally the following two criteria for launching an evaluation: i) a degree of implementation that allowed results to arise, and ii) specific issues faced in implementing interventions. The second criteria has little to see with evaluation has such and illustrate the exclusive focus of the CO on activity-based management.

These criteria were satisfied only for the RH component's programme on integrating RH into curricula with the Ministry of Education, which faced issues in implementing activities. A significant budget (USD 25,000) was allocated for hiring a local consultant. A retreat was organized with CO staff, the line ministry and other stakeholders for designing the evaluation's terms of reference. During this one-day meeting, the consultation agreed that an evaluation might not be needed at this stage given that all the concerns related to implementation and sustainability were discussed and unanimously agreed upon. The main issue for the CO being settled, the evaluation was cancelled.

This case as well as the lack of an evaluation plan demonstrate the priority given by the CO on activity-based management over the accountability role of the M&E system, particularly of its evaluation component. This feature was confirmed by the interviews held with CO staff.

Strengthening of national partners capacities

UNFPA during the 3rd country programme's implementation did not undertake activities to directly strengthen the capacities of the national partners in M&E. Annual trainings were limited to programme and financial monitoring organized by the office on NEX (see section 4.5.3.) and attended by all IPs (finance and programme). However, some of these trainings had positive consequences in terms of M&E capacities (elaboration of logical frameworks, design of SMART performance indicators,…).

Two training sessions were organized under the P&D component for a group of 25 participants from MoSA, half from central services (social assistants) and half from SDCs (heads) of various cities. Those two sessions (one in 2011 and the other in 2012) were focused on project appraisal and proposal writing that increased the understanding of the participants on the causal chain between inputs and outcomes.

Besides these trainings, the CO staff provided the IPs with a constant support for activity-based monitoring, notably through the annual Standard Progress Reports. They conveyed the need for monitoring/evaluating the results of trainings organized by each of the IPs by supporting pre and post evaluations of the participants. The sustainability of the learning was not tested mainly because catching the public after several months is hindered by the turnover among the target groups (for programmes intended for youth or refugees in particular).

6 CONCLUSIONS

6.1 GLOBAL CONCLUSIONS

CONCLUSION 1 (C1)

The UNFPA 3rd country programme for Lebanon has been adequately designed with regard to the context of Lebanon and the needs of the population, based on the conduct of needs assessments and using a fruitful participatory and inclusive approach.

ORIGIN EQ1
ASSOCIATED RECOMMENDATION R1

The strategy of UNFPA in Lebanon is aligned with the overall mandate of the organization
The focus of UNFPA on primary health care and on young people's health was adequate within the context of Lebanon. Focusing on primary health care was in line with the policy of the Ministry of Public Health. Such a focus contributes to reaching the vulnerable groups of the population who are the users of public health services. Targeting Lebanese young people as well as young refugees proved relevant with regard to their specific needs in terms of reproductive health, although UNFPA was not in a position to address all the RH needs because of restrictions due to a sensitive cultural context.

In the gender component of its programme, the country office made specific efforts to meet the needs of underserved populations, with a particular emphasis on women and girls and the population of rural and marginalized areas.

The support to the elaboration and operationalization of the aging policy in the framework of the P&D component was a relevant strategic choice. This orientation took stock of: i) the poor conditions offered to generally vulnerable widowed women living in institutions for the elderly; and ii) the growing concern of the Lebanese Government, fueled by recent media coverage. The demand-driven approach adopted by UNFPA to adjust its interventions within the P&D component led to rewarding results in terms of advocacy and visibility.

A systematic utilization of need assessments
To inform the planning of the 3rd country programme, the country office has undertaken various needs assessments, particularly as regards the reproductive health needs of young people and Syrian refugees. In the P&D component, the country office reoriented its strategy towards the support of Minister of Social Affairs (MoSA) policy on aging, based upon the results of a needs assessment performed by the Ministry.

A participative and inclusive process
In several instances, UNFPA implemented a very participative and inclusive approach to ensure the buy-in from a large range of stakeholders, as was the case for the introduction of reproductive health education in the education sector or for the development of the Youth Friendly Services (YFS) package.

This approach proved equally successful in the support to the National Commission for Elderly Affairs (NCEA). The active participation of members of the NCEA and staff from the MoSA made possible the on-going adjustment of activities and the identification of new ones.

The validation workshop for the national women strategy and its action plan was also conducted in a participatory manner, with a clear methodological direction which includes strategic outcomes, key interventions, indicators and main actors. This exemplifies the increasing ability of the National Commission for Lebanese Women to act as an advisory platform for NGOs as well as line ministries.

CONCLUSION 2 (C2)

UNFPA demonstrated a quick response capacity to the needs of Syrian refugees and contributed to strengthening reproductive health services in areas with high influx of refugees. However, the lack of a joint vulnerability profiling by the humanitarian community until late 2013 has hampered the targetting of some UNFPA interventions to the most vulnerable groups, in particular those relating to awareness-raising sessions and the distribution of dignity kits. In the humanitarian field, UNFPA also contributed to improved coordination and complementarity among UN agencies.

ORIGIN EQ1, EQ2, EQ4, EQ6
ASSOCIATED RECOMMENDATION R2

A proven capacity to respond rapidly to emergencies

The country office has reacted swiftly in response to the new context created by the Syrian crisis. It initiated a study aiming at assessing the reproductive health needs of the Syrian displaced women and conducted it in collaboration with other actors. The country office mobilized sufficient human resources as well as the necessary logistics to ensure the supply of reproductive health commodities.

However, considering the scale of the crisis and the continuing influx of refugees, the stakeholders involved in the response to the Syrian crisis had not managed to map and to prioritize the most vulnerable groups. Furthermore, the fact that the Syrian displaced populations are dispersed geographically, live in a variety of settings, and have diverse needs (depending upon their socio-economic, cultural and religious background) has rendered the definition of a suitable response a challenging exercise. In the absence of a joint vulnerability profiling by the humanitarian community, UNFPA has limited ability to reach the most vulnerable refugee groups and tailor its interventions to their specific needs, even when guided by the results of the various assessments, the advice of the various sector working groups, the directives of the Government, and the Regional Response Plan framework. A vulnerability community mapping was eventually completed in the second half of 2013 only.

An active role in improving coordination in emergency settings

Initially, the humanitarian response suffered from limited coordination among UN agencies, especially when identifying needs and planning interventions. In this context, UNFPA interventions in the area of reproductive health have contributed to complementing the efforts of all the partners through the provision of commodities and the improvement of the response capacity of the health care providers. UNFPA was also able to implement gender-based interventions for Syrian refugees (distribution of dignity kits, financial support, improving mobility, awareness-raising, etc.).

The UNFPA Humanitarian Contingency Preparedness plan highlighted the role of the organization in coordinating GBV/SRH and youth-related activities in a humanitarian crisis setting. The role played by UNFPA in the reproductive health and gender working groups meetings led to an increased coordination among all parties involved in RH and gender issues.

CONCLUSION 3 (C3)

The implementation of the UNFPA 3rd country programme for Lebanon has been hindered by the lack of national policy frameworks.

ORIGIN EQ2, EQ3, EQ4

ASSOCIATED RECOMMENDATION R3

The absence of a national reproductive health policy in Lebanon, mainly due to a lack of consensus among the stakeholders, led to a vacuum in terms of harmonization of reproductive health standards. This in turn has made it impossible to lay the foundations for the definition of accreditation standards specific to reproductive health. Ultimately, the absence of a policy hindered the capacity of partners to keep reproductive health issues high on the national agenda and has decreased the ownership by the Ministry of Public Health (MoPH) of RH interventions supported by UNFPA.

UNFPA has successfully supported the NCLW and other partners in the development of national gender-related policies. However, it is difficult for UNFPA to respond fully to the needs of the Lebanese population in the field of gender in the absence of the broader framework of a national population policy.

In the field of population and development, the policy framework on aging remains limited to a brief list of key priorities contained in the National Social Development Strategy adopted in 2011. The priorities were defined with UNFPA support, yet they do not amount to a fully-fledged public policy nor a road map for its elaboration.

CONCLUSION 4 (C4)

UNFPA has built upon the Lebanese vibrant civil society to establish adapted implementation channels and select appropriate partners. Implementation modalities were adjusted to the need to strengthen the capacity of implementing partners (IPs). However, the shift from direct financial support to interventions financed through the Ministries proved challenging.

ORIGIN EQ5

ASSOCIATED RECOMMENDATION R4

UNFPA country office has adopted strict procedures to select its implementing partners among civil society organizations. This rigor has helped mobilize the necessary level of expertise as well as adequate implementing capability for programme execution. In its partnership with ministries (MoSA and MoPH), the shift from project management units to intervention-based financing has hindered the implementation of the country programme. There has been resistance from staff in central public administrations (IPs) that were no longer granted additional remuneration to assist in implementing jointly-agreed interventions supported by UNFPA.

UNFPA provided technical assistance and supported capacity development interventions to empower the NCLW and gender focal points (GFPs) to implement the Action Plan of the national women strategy. However, these efforts were constrained by the limited decision-making authority and financial capacity of gender focal points. UNFPA also continues to play a crucial role in connecting the NCLW with UN gender focal points in the various UN agencies (UNDP and UNHCR), through the mechanism of the UNDAF Gender Working Group, as well as with other relevant ministries.

CONCLUSION 5 (C5)

Most interventions of UNFPA have been designed and implemented with a concern for sustainability. In many cases, institutionalized involvement of the civil society, notably in National Commissions, was instrumental. Grass-roots and emergency-orientated CSOs did not have the same potential for taking over UNFPA inteventions.

ORIGIN EQ2, EQ3, EQ4
ASSOCIATED RECOMMENDATION R4

UNFPA was successful in ensuring the sustainability of most of its interventions, as was the case with its work on GBV with academia, the ISF and NGOs. The approval of the Gender Sensitive Life-Skills RH Education Curriculum by the Ministry of Education and Higher Education (MEHE) and the fact that it is currently being integrated in school manuals is a positive sign towards the sustainability of the reproductive health education in the education system. Also, providing direct support to active national commissions involving civil society, like NCEA and NCLW, provides valuable guarantees for sustainability.

However, in some instances, the absence of a carefully planned exit strategy has hindered the continuation of activities beyond the termination of UNFPA projects; this was the case with the creation of women committees, which did not remain active after UNFPA support ended. Furthermore, the absence of a longer term comprehensive strategy while designing the approaches led to a succession of pilot initiatives implemented with different partners that were not carried out long enough to demonstrate their effectiveness. The fact that UNFPA ended its support to some of the extracurricular activities after one year did not confer sufficient time for adequately piloting them and for its partners to possibly adopt these innovative approaches.

6.2 PROGRAMMATIC LEVEL

Reproductive Health

CONCLUSION 6 (C6)

UNFPA contribution to quality reproductive health services has been limited to support for the procurement of reproductive health commodities. UNFPA support to Youth Friendly Services is still in its piloting phase and its expansion is dependent upon additional support.

ORIGIN EQ2
ASSOCIATED RECOMMENDATION R5

UNFPA has had a limited effect upon the availability of quality reproductive health services for vulnerable groups due to a difficult collaboration with the Ministry of Public Health. The only achievement so far consists in the uninterrupted supply of contraceptive methods in the MoPH Primary Health Care (PHC) centres serving vulnerable groups, including Syrian displaced population, as a prolonged effect of the collaboration initiated under the 2nd country programme. However, the uneven collaboration with the MoPH may jeopardize the availability of contraceptives in the PHC network and in this context the recent resumption of relationships is a positive signal.[270] UNFPA support to the reproductive health situation analysis in Lebanon has the potential to stimulate dialogue and revive the collaboration with the Ministry of Public Health.

The development and implementation of the Youth Friendly Services package in pilot service delivery points has the potential to provide quality reproductive health services to young people. UNFPA in collaboration with UNICEF has started supporting this approach that will require additional time and support to demonstrate whether such a model can be adopted at a larger scale.

[270] The partnership has been resumed as of April 2014.

CONCLUSION 7 (C7)

UNFPA has contributed to provide improved access to reproductive health services to Syrian women refugees. However, awareness-raising interventions have not been sufficiently targeted to women who need them most. This is probably one of the factors limiting the potential for strengthening the demand for family planning within these particular groups.

ORIGIN EQ2
ASSOCIATED RECOMMENDATION R6

From the onset of the Syrian crisis, UNFPA interventions resulted in the increased access to reproductive health services by Syrian displaced women at primary health care level, in particular through increased supplies of commodities and particularly family planning methods.

However, the demand for family planning services remains low. This can partly be explained by the fact that awareness activities have not systematically targeted the women most in need of information, particularly in communities with high rates of pregnancies and where cultural barriers to accessing family planning services are strong.

CONCLUSION 8 (C8)

UNFPA has adopted appropriate channels with a view to improving the reproductive health knowledge of young people. Interventions have contributed to the integration of reproductive health, life skills and gender in the school curriculum. However, on-going efforts to introduce reproductive health in extracurricular activities have not yet been sufficient to reach the institutionalization phase. Sensitization efforts among young people in the community mainly aimed at HIV/AIDS while overlooking broader reproductive health issues.

ORIGIN EQ2
ASSOCIATED RECOMMENDATION R7

The methodologies and approaches adopted by the country office to provide information to young people within the education sector are well adapted to the context and are appreciated by its partners. They have contributed to the institutionalization of reproductive health life skills in mainstream education in spite of delays in the integration of the curriculum. As far as extracurricular activities are concerned, the institutionalization stage has not been reached yet because of the too limited time devoted to the piloting phase so far. Additional advocacy and further support are still required to achieve integration of the extracurricular activities in the education system, including at community level with parents and local leaders.

Numerous awareness raising interventions were supported by UNFPA outside the education system although their actual coverage is difficult to assess. However, these interventions were characterized by a greater emphasis on communication methods rather than on the content of messages. Young people's needs in terms of information are broad in nature and UNFPA endeavored to address a large scope of information needs. However, interventions mainly focused on HIV/AIDS and have not always prioritized other reproductive health issues that UNFPA seeks to promote globally among this age group. This can be explained by the cautious approach taken by UNFPA when developing messages to ensure that those messages are appropriate within the cultural context of Lebanon.

Population and Development

CONCLUSION 9 (C9)

UNFPA has provided the National Commission for Elderly Affairs (NCEA) and the Ministry of Social Affairs (MoSA) with a detailed set of standards that will contribute to improving the conditions of the elderly living in institutions, mostly vulnerable widows. However, the cost and financial feasibility of accreditation for all institutions are currently not addressed, placing the accreditation scheme at risk.

ORIGIN EQ3
ASSOCIATED RECOMMENDATION R8

The UNFPA study on accreditation standards for institutions for elderly people was a valuable first step towards improving the conditions of those living in institutions, mainly vulnerable widows. These standards will allow the NCEA and MoSA to initiate a pilot phase with two volunteer private pilot institutions. The accreditation scheme for public as well as private and charitable institutions is owned by authorities and stakeholders and is thus likely to be endorsed soon.

However insufficient attention has been paid to the challenge of the overall social policy, limiting fiscal revenue and consequently the ability of the public services to act for vulnerable groups, in particular the aging women. The decision to develop an accreditation scheme common to private, charitable and public institutions for the elderly may face a public resources shortage for social policy at large, and for the elderly in particular. Whilst the accreditation scheme was successful for hospitals, institutions for elderly people cannot afford the cost of increased standards.

The financial issue has not yet been addressed in elaborating the aging policy framework; the latter might soon appear unrealistic given the context of Lebanon, marked by the absence of funds required for the rehabilitation of buildings and equipment, to hire specialized staff, to subsidize the most vulnerable, and finally, to set up a decent pension system.

CONCLUSION 10 (C10)
The integration of population dynamics into the planning and monitoring of sectorial policies remains a challenge.

ORIGIN EQ3
ASSOCIATED RECOMMENDATION R9

The support of UNFPA to the statistical system did not materialize in Lebanon because of abrupt shifts in government priorities. The USD 1 million budgeted for the elaboration and operationalizing of the Statistical Master Plan was unused due to variation in prioritization of public registration and administrative statistics in the revised government agenda in 2010. The focus of the CPAP on mainstreaming population dynamics into MoSA and MEHE planning and M&E systems was abandoned in 2010 in order to respond to a direct request from MoSA to redirect UNFPA support towards the elaboration of an aging policy.

Gender Equality

CONCLUSION 11 (C11)
Despite efforts to mainstream gender into public policies, the government is not fully committed and equipped to integrate gender into their policies and action plans. All UN agencies including UNFPA continue to engage with the related governmental bodies to do so.

ORIGIN EQ4
ASSOCIATED RECOMMENDATION R4, R10

UNFPA was successful in supporting the NCLW in elaborating the Action Plan of the National Women Strategy. Regarding mainstreaming gender into the National Youth Policy, UNFPA continues its efforts to reflect gender in a clear actionable plan with concrete interventions. However, it is to be noted that the national social development plan was elaborated by UNDP with the consultants alone, at the request of MOSA. UNFPA was not able to reflect women and gender priorities in the social strategy. Other national policies remain largely ‘gender-blind’.

CONCLUSION 12 (C12)
UNFPA was successful in addressing GBV issues with a comprehensive support package including: revision of laws, development of materials, training, awareness raising, coordination and networking of most actors working on GBV in the country.

ORIGIN EQ4
ASSOCIATED RECOMMENDATION R11

UNFPA has played a major role in networking and coordination through its gender based violence interventions, which involved the establishment of a network of NGOs, women's groups, academic institutions, youth peers, ministries, parliamentarians, journalists, the Internal Security Forces (ISF), UN partners and related experts concerned with GBV. This strategy of networking has contributed to consolidating efforts, avoiding duplication and raising awareness. In addition, UNFPA has developed several strategies, (social media, research, distribution of materials, and trainings) and has developed capacities in various ministries which should ensure the continuation of activities beyond termination of UNFPA supported projects.

CONCLUSION 13 (C13)

Gender mainstreaming is not fully achieved in the programming of UNFPA and coordination on gender issues remains insufficiently developed within the three components of the country programme.

ORIGIN EQ4

ASSOCIATED RECOMMENDATION R12

UNFPA has not designed its gender-related interventions to target men specifically. An integrated approach to dealing with gender inequalities is required to further acknowledge the role of men in initiating and supporting change.

Although UNFPA country office staff (RH and GBV) meet regularly, there is insufficient collaboration between GBV, RH, and communication staff on the programming and implementation levels on gender-related issues, including in humanitarian interventions. This coordination mechanism needs to be strengthened through joint activities, field visits, workshops etc. All UNFPA staff also expressed the need for more training on gender issues and gender mainstreaming.

UNFPA has developed a participatory approach for facilitating research and studies, and has a well-defined mechanism to disseminate corresponding findings. The mechanism includes among others sharing terms of reference for researchers with all related partners, sharing research methodology, presenting preliminary findings to all related stakeholders, distributing draft reports for comments to the specialized related expert group, publication and dissemination of the study to all concerned people. This mechanism created a solid knowledge basis for UNFPA partners in the field. However, when the results of studies reveal issues or failures, as was the case for the situational analysis which revealed the weaknesses of the gender focal points network, corrective actions were not always addressed by related UN, non-governmental or national organizations.

Monitoring and Evaluation

CONCLUSION 14 (C14)

The results-oriented monitoring system designed by the country office was eventually not implemented. The focus on management and activity-based monitoring is however somewhat justified by the flexibility required in the implementation of interventions in Lebanon, in a context of frequent shifts in the priorities of the Government and emergencies such as the Syrian crisis.

ORIGIN M & E ASSESSMENT

ASSOCIATED RECOMMENDATION R13

The monitoring of the UNFPA country programme has been mainly focused on activities. It relies on a set of indicators which are insufficiently specific and measurable, and which are often associated with unrealistic target levels, rendering it difficult to inform and update the CPAP results framework.

Besides the issue of the quality of indicators, a context characterized by political and regional instability also accounts for the absence of an actual result-oriented monitoring system. The humanitarian response to the Syrian crisis, as well as the necessity to adapt flexibly to changes in the priorities and demands of the Government are indeed additional challenges to the design of a monitoring system.

Standard result-based monitoring tools were utilized but at the cost of relatively far reaching interpretation towards activity-based monitoring. AWPs were adjusted several times during the year, up to 6 times for the P&D component. Interventions are changing according to co-funding actually released by the government; regular resources are progressively re-allocated to priority actions. Standard Progress Reports are therefore activity-based, not results-based as the initial framework was continuously adjusted.

To a certain extent, these adjustments imposed by contextual factors are contributing to country office performance but they prevent accountability on expected short-term outcomes.

7 RECOMMENDATIONS

7.1 GLOBAL RECOMMENDATIONS

RECOMMENDATION 1 (R1)

UNFPA should continue adjusting its interventions based on the regular conduct of needs assessments and a participative approach. UNFPA should build upon this approach to seek to establish closer links with the grassroots level.

PRIORITY LEVEL MEDIUM
ADDRESSEE UNFPA COUNTRY OFFICE
ORIGIN C1

OPERATIONAL IMPLICATIONS

- Continue to pursue positively evaluated strategic options:
  - Focus on vulnerable populations and young people through advocating for their reproductive health needs, defining priorities and continuing to support strategies aiming at improving the access of these particular groups to reproductive health services.
  - Support the NCLW in strengthening its advocacy and strategic and execution capacities, for the full implementation of the Action Plan of the National women strategy and its follow-up.
  - Support initiatives that strengthen the linkages between NCLW and grassroots NGOs and activists on gender-related issues.
  - Support the NCEA to adopt an aging policy for Lebanon, with the same main focus on institutions for the elderly, mostly vulnerable widowed women.
- Increase advocacy work :
  - With ministers and members of parliament to strengthen the mandate and financing of the NCLW and the gender focal points system to enable it to address specific high-priority issues, such as Gender Based Violence (GBV).
  - For enlarging the membership of the NCEA towards professionals – and representatives of the final beneficiaries.
- Support innovative and feasible initiatives for widening the dissemination of the results of UNFPA studies, targeting decision-makers, CSOs and eventually the general public.

RECOMMENDATION 2 (R2)

UNFPA should advocate among stakeholders for increased flexibility in order to address emerging critical issues and the prioritization of the most vulnerable groups among the Syrian refugees based upon assessments of the needs of different communities and settings. UNFPA should address simultaneously the needs of refugees and those of vulnerable groups among the host communities.

PRIORITY LEVEL HIGH
ADDRESSEE UNFPA COUNTRY OFFICE
ORIGIN C2

OPERATIONAL IMPLICATIONS

- Continue, in collaboration with the other intervening agencies, the mapping process of Syrian displaced groups including the assessment of vulnerability of the different groups.
- Prioritize the most vulnerable groups based upon continuous assessments and target support to specifically address the reproductive health needs of these particular groups.
- Collaborate with other UN agencies to be more flexible in responding to emerging needs and changes of the target population (e.g. to address issues such as the temporary marriages of Syrian refugees; host community concerns, employability issues between hosting and refugees, etc.).
  - Coordinate with ILO, UNHCR and other UN agencies to provide services simultaneously to both the Syrian refugees and the Lebanese host communities e.g. by providing specific job opportunities in a more organized labor force.
  - Encourage other UN agencies to meet regularly at manager level to discuss all emerging issues resulting from the field and to create a unified UN system approach to respond to the crisis.
- Address the emerging issues of survival sex and arranged temporary marriages. This should include advocacy campaigns organized by all NGOs aiming to uncover these issues and address them

with immediate interventions in order to support women and families.

RECOMMENDATION 3 (R3)

Enhance the level and intensity of policy dialogue in the three areas covered by the country programme.

PRIORITY LEVEL MEDIUM
ADDRESSEE UNFPA COUNTRY OFFICE
ORIGIN C3

OPERATIONAL IMPLICATIONS

- Intensify advocacy efforts in order to maintain a high profile for reproductive health on the national agenda through highlighting the needs of vulnerable groups and young people.
- Advocate for and strengthen reproductive health within the ongoing accreditation process of health facilities undertaken by the MoPH through reviewing standards with a view to improving the access of vulnerable groups and young people to RH services.
- Continue advocating with the government and national partners to maintain gender issues high on the national agenda through a consultative manner bringing together relevant ministries, government (NCLW) and non-government institutions.
- Promote the reactivation of the National High Population Committee (NHPC) to support the implementation of population policies, including the translation of policies into implementable programmes, with clear division of roles among national stakeholders.
    - Provide technical assistance to the NHPC, including in terms of research and development, and awareness-raising.
- Maintain the focus on aging policy while widening its scope to enhance feasibility and sustainability while identifying other aspects of the aging policy stated in the NSDS that are consistent with the UNFPA mandate.
    - In parallel, focus explicitly on cases of hardship and abuse for women residents of the elderly institutions; increase media coverage while systematically providing perspective with wider issues (pensions, social safety nets, gender).
    - Support pilot accreditation cases of elderly institutions, provided that (i) pilots are not conducted only in wealthier institutions and (ii) the above wider issues are mainstreamed in the pilot cases.

RECOMMENDATION 4 (R4)

UNFPA should ensure that a sustainability plan is agreed upon with different stakeholders at the beginning of each project, togther with a clear exit strategy. Implementing partners' capacity should be strengthened for the adoption of UNFPA supported interventions.

PRIORITY LEVEL MEDIUM
ADDRESSEE UNFPA COUNTRY OFFICE
ORIGIN C4, C5, C11

OPERATIONAL IMPLICATIONS

- Exit strategies must have tangible components to build capacity of beneficiaries from the onset: conducting specific training workshops on understanding exit strategies, having monthly discussions, etc. in order to involve the beneficiaries to fully understand and implement the exit strategy with the organization.
    - In considering exit strategies for interventions in areas of conflict, UNFPA needs to ascertain the real impact of supported interventions and establish flexible mechanisms in order not to cut off its support prior to a thorough examination of the context of the intervention.
    - UNFPA should conclude the progressive exit strategy from the P&D project unit for the next country programme by transferring it to MoSA; Consider selecting CSOs as IPs for the interventions of the P&D component.
- Continue to strengthen links with related ministries, administrations, commissions and councils (Labor, Public Health, Social Affairs, Education and Higher

Education, Central Administration of Statistics, CDR, civil society organization/NGOs and NCLW).

- Advocate, with all related UN agencies and national partners on the important role of gender focal points and conduct a comprehensive needs assessment (status, capacity and training needs and gaps), followed by the implementation of capacity development initiatives.
- UNFPA needs to further develop a post-training monitoring mechanism to build on the lessons learnt and to create new training programmes accordingly.
- Elaborate and implement with related partners an innovative training programme to specifically address the NCLW staff in order to raise their interest in and recognition of the value of work on budgeting and auditing issues for their work.

7.2 PROGRAMMATIC LEVEL

Reproductive Health

RECOMMENDATION 5 (R5)

UNFPA country office should use the outcomes of the reproductive health situation analysis in order to reinforce dialogue with the Ministry of Public Health, explore possible areas of collaboration and set clear priorities for UNFPA support in response to the changing context and expressed needs.

PRIORITY LEVEL HIGH
ADDRESSEE UNFPA COUNTRY OFFICE
ORIGIN C6

OPERATIONAL IMPLICATIONS

- Ensure that the currently undertaken reproductive health situation analysis provides a comprehensive analysis of the reproductive health context including bottlenecks and gaps with regards to vulnerable groups.
- Support the prioritization of the RH needs of the vulnerable groups including young people involving all stakeholders and particularly the national partners.
- Ensure that the concerned stakeholders are involved in developing collaborative strategies to address the identified needs whereby responsibilities and commitments are clearly defined. As such, the collaboration with the MoPH should be revisited and redefined based upon a comprehensive analysis of the changing context.

RECOMMENDATION 6 (R6)

Within a context of limited resources, and given the uncertainty with regards to the evolution of the Syrian crisis, UNFPA should refocus its humanitarian response on the needs of the most vulnerable groups.

PRIORITY LEVEL HIGH
ADDRESSEE UNFPA COUNTRY OFFICE
ORIGIN C7

OPERATIONAL IMPLICATIONS

- Advocate for ensuring that most vulnerable groups of Syrian refugees are identified and mapped and their needs specifically assessed and prioritized based upon clearly defined criteria.
- Based on continuous assessments, support implementing partners to target the vulnerable groups (e.g. those with low education level and economic status) as regards awareness sessions and the distribution of dignity kits.
- Increase coordination efforts with the various partners and the MoPH with a view to designing a detailed plan aiming at supporting the selected health facilities to respond to increasing demand for reproductive health services from the continuous influx of refugees.
    - Assist the review of referral pathways at the time of childbirth and in case of complications during pregnancy and delivery.

- Strengthen advocacy efforts among all the stakeholders (UN agencies, NGOs and MoPH) to ensure that the most vulnerable pregnant refugee women have access to free obstetric care.

- UNFPA should strengthen its monitoring mechanisms in order to adjust the supply of reproductive health commodities based on needs rather than systematically distributing reproductive health kits to each selected facilities.

RECOMMENDATION 7 (R7)

UNFPA should define a long term and comprehensive strategy in order to streamline interventions aiming at introducing reproductive health in the education system while conducting targeted sensitization interventions with high potential impact.

PRIORITY LEVEL HIGH
ADDRESSEE UNFPA COUNTRY OFFICE
ORIGIN C8

OPERATIONAL IMPLICATIONS

- Review the outcomes of the assessment of all the different approaches that were undertaken so far to sensitize young people and to introduce reproductive health education in schools and define their potential for impact.

- Facilitate the design of a long term and comprehensive reproductive health and life skills education strategy based upon the assessment of the different approaches with all the concerned stakeholders.

- Continue to explore the various options to convey messages to young people that are culturally acceptable while providing clear information on a reproductive health issues.

Population and Development

RECOMMENDATION 8 (R8)

UNFPA should engage in advocacy efforts to ensure that the financial implications of the accreditation scheme for institutions for elderly people are adequately addressed.

PRIORITY LEVEL MEDIUM
ADDRESSEE UNFPA COUNTRY OFFICE
ORIGIN C9

OPERATIONAL IMPLICATIONS

- Engage in a scoping study on the investment cost of a rehabilitation programme of institutions for the elderly and on recurrent costs entailed by the revised standards (prioritizing public and charitable organizations);

- Undertake a feasibility study of increasing public funding of social schemes related to the aging policy: such as increased indemnities to vulnerable people living in institutions and pensions;

- Advocate beyond government circles (including donors and Lebanese CSOs) for the adjustment of available resources to the needs of decent living conditions for all in elderly institutions.

RECOMMENDATION 9 (R9)

UNFPA should reallocate the budget initially targeted on the Statistical Master Plan to other lines of activities.

PRIORITY LEVEL HIGH
ADDRESSEE UNFPA COUNTRY OFFICE
ORIGIN C10

OPERATIONAL IMPLICATIONS

- Address this issue in consultation both with the Government of Lebanon and with other UN agencies (UNDP, UNICEF) and the World Bank.

Gender Equality

RECOMMENDATION 10 (R10)

UNFPA should work with national counterparts for the mainstreaming and operationalization of gender issues in relevant national policies.

PRIORITY LEVEL MEDIUM
ADDRESSEE UNFPA COUNTRY OFFICE
ORIGIN C11

OPERATIONAL IMPLICATIONS

- Utilizing its excellent relationship with national counterparts and other UN agencies, UNFPA should increase the provision of expertise and technical assistance to the government in order to mainstream gender into national policies, development frameworks and laws.

- UNFPA should continue its advocacy efforts to operationalize the National Women Strategy and its Action Plan, including on gender mainstreaming.

- UNFPA should develop mechanisms for operationalizing the “gender mainstreaming” component that exists in the Social Development Strategy by translating it to concrete interventions and action plans.

- UNFPA should also continue to target adolescents and youth—of both genders—as agents for change.

RECOMMENDATION 11 (R11)

UNFPA should build on its work in GBV and continue to move the platform and agenda forward for increased impact and continuity, while holistically addressing gender-based violence through the support to reproductive health services and the enactment and the enforcement of policies and laws.

PRIORITY LEVEL HIGH
ADDRESSEE UNFPA COUNTRY OFFICE
ORIGIN C12

OPERATIONAL IMPLICATIONS

- UNFPA should continue its efforts on networking for GBV and reach out to all segments of society such as workers, employers, lawyers, etc.
    - Efforts should continue to consolidate UNFPA's networking role
    - The use of various media streams should continue
- A particular focus should be made on innovative approaches to reach people in places where confessional structures are strongly influential, who are among the most needy. To do this, UNFPA should continue to focus on its role as a neutral development agency addressing humanitarian needs.
- The need for innovative programmes to attract men to use reproductive health services and to address GBV awareness raising sessions should be addressed.

RECOMMENDATION 12 (R12)

UNFPA should make more efforts in integrating gender mainstreaming in all interventions of the country programme.

PRIORITY LEVEL MEDIUM
ADDRESSEE UNFPA COUNTRY OFFICE
ORIGIN 13

OPERATIONAL IMPLICATIONS

- When dealing with gender issues, UNFPA needs to continue to adopt a holistic approach, including men, so that men and women are both considered when working both at the policy and the grassroots levels.
- UNFPA should improve the gender mainstreaming dimension of the country programme by using specific tools, sensitizing on basic gender concepts, and better reflecting aspects of gender mainstreaming in reporting.
    - UNFPA should have a participatory and open dialogue approach with community leaders to understand how to tackle issues of gender and integrate their approaches in Y-Peer interventions.
    - UNFPA should develop research and project ideas specifically targeting men, as well as programmes with the aim to include men as both beneficiaries and allies in gender programmes.
- There is a crucial need for effective coordination and collaboration between UNFPA GBV, RH, and Communication staff for further joint work in the field.
    - UNFPA should ensure ongoing training for all UNFPA staff in gender mainstreaming, including the corporate course on "Integrating Gender, Human Rights and Culture". The training should be extended to members of the UN Gender Working Group and other partners.

Monitoring and Evaluation

RECOMMENDATION 13 (R13)

With the opportunity of the future approval of the MTR and the next CPAP, the M&E framework must be fully revised. The various tools dedicated to result-based monitoring should be re-engineered. The staff should be trained accordingly. The evaluation plan should be defined and ring-fenced.

PRIORITY LEVEL MEDIUM
ADDRESSEE UNFPA COUNTRY OFFICE
ORIGIN C14

OPERATIONAL IMPLICATIONS

- CPAP M&E framework should be revisited after MTR approval, anticipating upon the next CPAP; baseline and targets updated; resulting matrix regularly updated and annually commented;
- Revisions of AWPs should be limited to one or two maximum during implementation in order to allow results-oriented monitoring, with outcome indicators refined or added to each AWP;
- Content of standard progress reports should be revised (extended to achievements at outcome level and related SWOT analysis) and IPs trained and followed-up for compliance; annual reviews should be strengthened and systematized for all IPs, likely during a shared event covered by local media in order to increase visibility and advocacy;
- The M&E focal point should organize a monthly meeting dedicated to reviewing the M&E results until this is routinely dealt with by UNFPA staff and the IPs.

UNFPA – Because everyone counts

United Nations Population Fund
Evaluation Office
605 Third Avenue
New York, NY 10158 U.S.A.

http://www.unfpa.org/evaluation