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## List of Acronyms

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<th>Acronym</th>
<th>Description</th>
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<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<tr>
<td>ALSO</td>
<td>Advanced Life Support in Obstetrics</td>
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<td>APR</td>
<td>Annual Program Review</td>
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<td>AWP</td>
<td>Annual Work Plan</td>
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<tr>
<td>BCC</td>
<td>Behavioral Change Communication</td>
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<td>BTN</td>
<td>Beyond the Numbers</td>
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<td>CBO</td>
<td>Community Based Organization</td>
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<td>CBS</td>
<td>Central Bureau of Statistics</td>
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<td>CCA</td>
<td>Common Country Assessment</td>
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<tr>
<td>CEDAW</td>
<td>Convention on the Elimination of all forms of Discrimination Against Women</td>
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<td>CEMD</td>
<td>Confidential Enquiry into Maternal Deaths</td>
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<td>CO</td>
<td>Country Office</td>
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<td>CP</td>
<td>Country Programme</td>
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<td>CPAP</td>
<td>Country Programme Action Plan</td>
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<td>CPAP/PTT</td>
<td>CPAP Planning and Tracking Tool</td>
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<td>CPR</td>
<td>Contraceptive prevalence rate</td>
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<td>CRC</td>
<td>Convention on the Rights of the Child</td>
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<td>EmOC</td>
<td>Emergency Obstetric care</td>
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<td>Food and Agriculture Organization</td>
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<td>FGD</td>
<td>Focus Group Discussion</td>
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<td>Gender Based Violence</td>
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<td>Gross Domestic Product</td>
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<td>HIV</td>
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<td>HIV/V</td>
<td>HIV /Voluntary confidential counseling and testing</td>
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<td>ICPF</td>
<td>International Conference on Population and Development</td>
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<td>ICPD/PoA</td>
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<td>ICPD @15</td>
<td>ICPD after 15 Years</td>
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<td>ICU</td>
<td>Intensive Care Unit</td>
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<td>IUD</td>
<td>Intra Uterine Device</td>
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<tr>
<td>Acronym</td>
<td>Description</td>
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<td>IYY</td>
<td>International Youth Year</td>
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<td>KAP</td>
<td>Knowledge, Attitudes and Practice</td>
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<td>IMR</td>
<td>Infant Mortality Rate</td>
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<td>IOM</td>
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<td>JCI</td>
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<td>MAAR</td>
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<td>MARY</td>
<td>Most At-Risk Populations</td>
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<td>MCH</td>
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<td>MDs</td>
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<td>MDGs</td>
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<td>Monitoring and Evaluation</td>
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<td>National Development Plan</td>
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<td>National Execution Guideline</td>
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<td>Non Governmental Organization</td>
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<td>NPC/TAC</td>
<td>NPC Technical Advisory Committee</td>
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<td>National Plan for Protection of Women</td>
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<td>National Social Aid Fund</td>
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<td>Obstetrics and Gynecology (Association)</td>
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<td>Objective Structured Clinical Exams</td>
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<td>Pan Arab Project for Family Health</td>
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<td>Population &amp; Development</td>
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<td>Provider Initiated Testing and Counseling</td>
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<td>PLWHA</td>
<td>People Living With HIV Aids</td>
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<td>PoA</td>
<td>Program of Action</td>
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<td>Pop</td>
<td>Population</td>
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<td>PTT</td>
<td>CPAP Planning and Tracking Tool</td>
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<td>RBM</td>
<td>Result Based Management</td>
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<td>RH</td>
<td>Reproductive Health</td>
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<td>Acronym</td>
<td>Full Form</td>
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<td>RH/RR</td>
<td>Reproductive Health/ Reproductive Rights</td>
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<td>RHTC</td>
<td>RH Technical Committee</td>
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<td>RTI</td>
<td>Reproductive Tract Infection</td>
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<td>RYU</td>
<td>Revolutionary Youth Union</td>
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<td>SAOG</td>
<td>Syrian Association for Obstetricians and Gynecologists’</td>
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<td>SARA</td>
<td>Status Assessment and Response Analysis of HIV/AIDS</td>
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<td>SARC</td>
<td>Syrian Arab Red Crescent</td>
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<td>SBAA</td>
<td>Standard Basic Assistance Agreement</td>
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<td>SCFA</td>
<td>Syrian Commission for Family Affairs</td>
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<td>SFPA</td>
<td>Syrian Family Planning Association</td>
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<td>SPC</td>
<td>State Planning Commission</td>
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<td>SRH</td>
<td>Sexual Reproductive Health</td>
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<td>SSPR</td>
<td>State of Syria Population Report</td>
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<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<td>TBPE</td>
<td>Theatre Based Peer Education</td>
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<tr>
<td>TFR</td>
<td>Total Fertility Rate</td>
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<td>TOT</td>
<td>Training Of Trainers</td>
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<td>TS</td>
<td>Technical Secretariat</td>
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<td>TV/R</td>
<td>Television and Radio</td>
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<td>UN</td>
<td>United Nations</td>
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<td>UNAIDS</td>
<td>United Nations Programme on HIV/AIDS</td>
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<td>UNDAF</td>
<td>United Nations Development Assistance Framework</td>
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<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
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<td>UNESCO</td>
<td>United Nations Educational, Scientific, and Cultural Organization</td>
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<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<tr>
<td>UNFPA/CP</td>
<td>UNFPA Country Program</td>
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<tr>
<td>UNHCR</td>
<td>United Nations High Commissioner for Refugees</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children Fund</td>
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<tr>
<td>UNIFEM</td>
<td>United Nations Development Fund for Women</td>
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<tr>
<td>VAW</td>
<td>Violence Against Women</td>
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<tr>
<td>VCCT</td>
<td>Voluntary Confidential Counseling Testing</td>
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<tr>
<td>WB</td>
<td>World Bank</td>
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<tr>
<td>WFP</td>
<td>World Food Programme</td>
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<td>WGU</td>
<td>Women’s General Union</td>
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<td>WHO</td>
<td>World Health Organization</td>
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<tr>
<td>YPEER</td>
<td>Youth Peer</td>
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Executive Summary

The UNFPA Country Programme (CP) for 2007-2011 reflects the priorities the Government, as well as those of the United Nations Development Assistance Framework (UNDAF), and the strategic direction of UNFPA. The CP cycle is harmonized with other United Nations agencies in the Syrian Arab Republic. It was developed through an intensive consultative process with the Government and development partners. It contributes to three UNDAF Outcomes: (1) Inter and intra regional disparities related to access and quality of health, education and other basic social services reduced with a focus on the Eastern, North and Badia regions and other disadvantaged areas; (2) Efficiency and accountability of governance structures at central and local levels strengthened by, government, civil society and the private sector, towards sustainable development; and (3) Risk and impact of natural and manmade disasters is reduced.

At the level of provision of services, the CP focus on the North-Eastern governorates, while interventions in areas such as advocacy, policy dialogue and capacity building will be undertaken at the national level.

The purpose of the evaluation is to conduct an end of programme cycle for 2007-2011 to assess the achievement of the programme results, the facilitating and constraining factors, and to compile lessons learned so as to inform development of the next CP. However, because of timing the process will be only limited to the period up to 2010.

Excellent preparatory steps, the clarity of the overall and specific objectives for the CP evaluation and the sincere collaboration, at all levels, were among the factors that facilitated and supported the evaluation process and reduced the effect of the constraining factors. This included the delay in recruiting the evaluators, the limited allocated time for completing the process and the relevant logistical problems, the insufficient understanding, among some partners, of the result-based approach and the need for having a timely set of smart indicators. In addition, obtaining reliable, timely and well defined data represented a problem for some areas, especially RH activities. These limitations were related to sample size, timing of data collection, result analysis and finally obtaining solid feedback.

Overall conclusions:
Assessment of progress towards the goals and priorities of the CP and the results achieved up to 2010, indicated that the proposed outputs were effectively and efficiently responding to the Country’s needs. The Government demonstrated very high level commitment to population and development issues through securing strategic reports, studies as well as other related initiatives and high-level statements and articles in print and other media, which in turn supported the CP and enhanced progress towards the realization of the specifies results. This was reflected in the increase of the Government Trust Fund contribution to the current cycle of assistance (2007-2011) from 15 % to 50 %, as well as being committed to increase the Government contribution to the procurement of contraceptives from the central health budget by annual allocations of $700,000 totaling to $2,800,000 for the whole cycle.

At the national level, evidences are showing that the Syrian Arab Republic has made tangible progress towards achievements of the MDGs, however, the results of various surveys and studies revealed that some areas across the country and mostly
concentrated in the North-Eastern region significantly lag behind others in terms of the population and development variables, including reproductive health (RH) indicators. In addition, it is noted that the Syrian Arab Republic has been witnessing stagnated or slow fertility decline reached 3.5 in 2009 compared to 3.58 in 2004 and 3.6 in 2006, as well as a very slow increase in the utilization of modern contraceptives.

UNFPA and partners have effectively utilized survey and research results and regional/international expertise to build the program; annual program and mid-term reviews have collected lessons. However, more resources placed toward in-depth monitoring at district and community level would help to investigate issues and propose local solutions. Viable long term investments include strengthening the overall monitoring system, the Beyond the Numbers process to study maternal mortality and the youth outreach activities which aim to affect KAP for RH among youth peer groups. In addition, more integration of activities and components and coordination with other agencies would help to improve efficiency and effectiveness.

1. Reproductive Health Component

UNFPA and partners have made significant progress since 2007 in strengthening all supported aspects of the Reproductive Health (RH) Component, supported by the high level commitment of the Government to ensure reaching the health outcomes of the NDP and to achieve the MDGs. However, impacting the national fertility rate, maternal mortality ratio, infant mortality rates and knowledge, attitudes and practices requires stronger strategic planning and coordination to reach the Vulnerable Groups. Stronger advocacy and support is needed to help the national health care system to meet challenges in management of human resources and data analysis.

The CP design contained major strategic components for development and has evolved since 2007 on broad-based participation and a locally driven agenda. Local capacities have been tapped as training resources and community mobilization to promote community awareness, as well as more work is needed to increase numbers using the RH public health clinics and to coordinate with the private sector to help ensure high quality RH services, since 69% of Syrian citizens use private clinics and only 25.5% use public health facilities.

The cross cutting areas that have been identified for greater attention include: a) strengthening an evidence-based and integrated planning approach based on RBM principles. CPAP planning should select indicators for which continuous data is available to ensure that activities are contributing to impact through in-depth analysis indicating the extent of coverage achieved against the investment being made; b) easing administrative hurdles to promote efficiency through harmonizing fiscal dates used by both MoH (Trust Fund) and UNFPA. Moreover, experts and trainers need to be identified and secured expeditiously to ensure timely implementation of relevant activities, and securing high quality equipment; and, c) strengthening commitment for sustainability through reaching the most Vulnerable Groups as well as coordinating all stakeholders’ efforts to advocate for solutions to the very difficult and long term problems that are observed.
The specific evaluation issues that were covered in assessing the RH performance of the CP include:

1. Functionality of mechanisms for systematic improvement of Emergency Obstetric Care (EmOC)

**Relevance and Sustainability.** capacity development activities, including training and Beyond the Numbers confidential inquiry into causes of maternal mortality, based on several studies, emphasized the importance of the referral system to flag possible complications. The planned Beyond the Numbers approach is considered critical to the sustainability of the strategy to reduce maternal and neonatal mortality. It could be particularly beneficial to bring community members into the process and to permit a greater understanding of the problems faced by women in the communities. Reducing the MMR, that has dropped significantly to 52/100,000 in 2009 with predicted decline to 32/100,000 in 2015, requires increasing the ratio of births attended by skilled health personnel, and to continue coping with geographical disparities, especially in the Eastern region. Home deliveries have decreased from 44.9% in 2002 to 19.4% in 2009. If continued on the same track, it is possible for Syria to achieve MDG 4 and 5.

**Effectiveness and Efficiency.** Mechanisms for supporting systematic improvement of EmOC largely consisted of training, provision of equipment and supplies, supporting protocol acceptance, and promoting community awareness. The mixture of options has been effective to addressing needs for better clinical skills, improvements in the maternal care system and strengthening the referral system. Training relevant to safe motherhood including EmOC, antenatal care, RH concepts and newborn resuscitation have reached more than 3,900 medical staff. However, one of the major challenges is staffing the rural clinics with midwives, and ensuring that Vulnerable Groups are included in all efforts to improve services and raise awareness. Maternal mortality data is very difficult to collect due to lack of a surveillance system and cases of failure to list the cause of death on death certificates and the inefficiency of the registration system, particularly in rural areas. Thus far, 43 senior health professionals from 14 governorates have been trained on Beyond the Numbers that should become part of the surveillance systems in support of generating qualitative evidence. The RH Technical Committee (RHTC) is responsible for providing advice to the MoH RH Department; however, members have expressed a desire to operate more effectively.

2. Effectiveness of RH clinical protocols focusing on family planning, antenatal care and emergency obstetric care in support of better utilization of the services

**Relevance and Sustainability.** Nationally approved clinical protocols and guidelines are critical for antenatal care, family planning and EmOC and only those on Family Planning (FP) existed in 2009. The CP addressed the needs for post-natal guidelines along with the antenatal guidelines but the RH postnatal services need to be promoted. Only 27% of post-partum women in Syria use postnatal services and this should be taken up in the next CPAP. Visits to clinics indicated that nutritional guidance provided to pregnant women is extremely minimal and that nutrition counseling guidance is important to be included in the antenatal and postnatal guidelines. EmOC and Family Planning protocols have been adopted and are in circulation and being trained. Antenatal/postnatal guidelines are under revision and should be available next year.
A major sustainability challenge in promoting clinical protocols is including the private practice in standard setting and usage, and these protocols and guidelines also need to be followed up by the MoH in regular monitoring visits.

**Effectiveness and Efficiency.** Systematic improvements in the performance of RH components continued through training, provision of equipment and supplies and upgrading facilities, although some were delayed/ cancelled due to problems with locating appropriate trainers. As of 2010, 50% of midwives have been trained in the FP guidelines and the remainder will be trained next year. Training of physicians and midwives went ahead in 2008 using the standards that were already in place. High level of satisfaction with the training was indicated by various groups. However, some prevailing challenges include, the need for better ventilation in the RH and FP clinics, means to include men in the FP awareness raising, need to ensure the protocols are unified in terms of standards as well as being interconnected, and need to heighten coordination and collaboration with the private sector.

3. **Availability and access to RH services (e.g. Antenatal care, Family Planning and Early Detection of Breast and Cervical Cancers)**

**Relevance and Sustainability.** The HHS (2009) showed that the use of contraceptives has improved, unmet needs for women of reproductive age were reduced, adolescent births were substantially reduced, and antenatal coverage care has increased. However, geographical disparities within Syria still represent a major challenge and focus should be on increasing access to RH services particularly in disadvantaged areas. A number of issues are of concern in terms of sustainability, including MoH staffing and limitations of clinic based services. The HHS, which is the most recent source of data indicate:

- **Contraceptive Prevalence Rate (CPR)** among Syrians indicates that 53.9% of women aged 15-49 years are using, with 37.5% using modern contraceptives and 16.4% using traditional contraceptives, which is below the CPAP level of 58.3% as per the Multiple Indicator Cluster (MICS) Survey, 2006, with 42.3% modern methods. However, the use of family planning methods has increased from 46.6% in 2002 to 53.9% in 2009. The governorates with the lowest usage of contraceptive rates among married women 15-49 include Deir-ez-Zor (by far the lowest with 17%) followed by Dara’a (40.2%) and Quinetra (40.8%). According to this data, the CPR fell in Deir-ez-Zor from 37.8% (MICS 2006) to 17% which is surprising as this was a targeted governorate for RH activities. Al-Rakka and Aleppo rates are 46.4 and 46.5 respectively. The CPR in Al-Rakka was 33.7% in the 2006 MICS and thus has improved considerably. Contraceptives can be purchased through pharmacies and private practices. The CPAP target for the CPR was 65% for all methods and 49% for modern methods (which was ambitious) and it seems likely that this goal will not be attained by the end of 2011.

Although fertility rate is a key concern of the government is not considered an outcome indicator yet a stagnated or slow fertility decline is noticeable, where the total fertility rate is still well above 3 and was 3.58 in 2004 and 3.6 in 2009. Some major reasons for weak demand for or fluctuating use of contraceptives include: Traditional and deeply felt desire for a large number of children; and Male opposition to use of contraceptives.
• **Proportion of births attended by skilled health personnel.** The 2006 MICS reported that approximately 93% of births were attended by skilled health personnel with the lowest level in Al-Hasakeh where the figure was only 80.3%, while the HHS reports that the percentage of deliveries in health institutions during the five years preceding the survey reached 78.2%, with a greater increase in urban areas (83.4%) than rural areas (72.1%).

• **Percentage of women with one or more antenatal visits during pregnancy.** The CPAP baseline was taken from the MICS (2006) which indicated the percentage of women using antenatal services is 85.3%. The MoH Statistical report indicated that the average number of antenatal care visits was 2.7 and the lowest average number of visits was reported in Deir-ez-Zor at 1.5. According to the HHS, the percentage of women who were provided antenatal care in the last live birth during five years preceding the survey reached 87%. However, the percentage decreases with a higher birth order, 94.6% with the first child declining to 74.5% by the seventh birth. The CPAP PTT does not specify a target percentage for increase but an increase is desired in Deir-ez-Zor, Al-Rakka and Al-Hasakeh. Increases are noted in both Al-Rakka (80.6 to 85.6) and Al-Hasakeh (82.7 to 86) while the percentage in Deir-ez-Zor has decreased from 81.7 to 78.2%.

**Effectiveness and Efficiency.** The number of health services offering at least three RH services increased through the program. Other achievements included equipping natural birth centers with qualified cadre and necessary equipment; training and provision of guidelines; adopting RH information systems of Iran, Egypt and Oman; improvement of early cancer detection centers; supporting RH research in governorates; promotion of RH messages through TV and radio; strengthening RH skills of 1,000 private doctors; and integrating RH into support for Iraqi refugees. Effective tools to increase usage include: public awareness campaigns, follow-up by medical staff on women in the community, maintaining modern equipment such as ultrasound and colposcopy technology as well as the mammogram and pap smear analyses, clinic renovations, and improvements in sanitation.

**RH Training.** Training has largely been evaluated only at the first level using the Kirkpatrick model, employing before and after tests and a course satisfaction questionnaire. The MoH keeps records of these results from training courses but does not systematically follow up on results. In 2008, UNFPA created an enabling environment for enhancing monitoring/ measuring of effectiveness and impact of trainings for midwives according to Kirkpatrick's evaluation model. It was also proposed to opt for Objective Structured Clinical Exams (O.S.C.E) as an effective method of evaluation of knowledge and clinical skills. Issues in training include: limited flexibility of trainer doctors due to demands on their time, need for better training facilities and manikins, and need to promote higher standards for training through more rigorous evaluation and follow-up.

4. **Validity of strategies and approaches for the HIV VCCT domain**

**Relevance and Sustainability.** Support to the Voluntary Confidential Counseling and Testing (VCCT) Services is part of the support to the National AIDS Program (NAP) of the MoH. The new leadership for NAP is moving forward the implementation of
the national strategy. Although HIV/AIDS prevalence is low, risk factors are increasing, thus the challenge is to maintain the low prevalence rate and to promote effective detection mechanisms. UNFPA supported studies such as the SARA report, the UNGASS report and a mapping study on high risk groups, which have provided insights into the best investments for preventing and detecting HIV and STIs and for follow-up on cases.

**Effectiveness and Results.** The VCCT’s services are integrated within National AIDS Programme laboratory services and some connections are being made to the primary and maternal health facilities. National VCCT protocols have been developed, endorsed and applied in full. UNFPA has equipped 12 of (25 national) VCCT centers and they are applying adopted protocols and guidelines in the three program governorates (Al-Rakka – Al-Hasakeh – Deir-ez-Zor) including the central VCCT in Damascus and in Idleb. However, a national indicator on HIV/AIDS is needed to guide the program on the CPAP/PTT. UNFPA’s program has addressed several concerns in the UNGASS report. Including more of the Vulnerable Groups in the services as soon as possible would enhance the effectiveness of the program. Challenges in that respect include securing privacy, serious stigma affecting People Living with HIV/AIDS (PLWHA) among medical personnel and this impedes their successful support and treatment. UNFPA has conducted some training with physicians on the PLWHA issues. Additionally, the number of VCCTs needs to be increased nationally but to be cost effective, services may need to come out of the clinic to meet the public.

5. **Relevance of approaches to reach out to youth with RH STI/HIV/AIDS messages**

**Relevance and Sustainability.** Targeting youth with RH messages is important as of 2008; there were slightly more than four million Syrians between the ages of 15-24, accounting for 21% of the population. The 10th National Development Plan (NDP) for 2006-2010 places an emphasis on developing the potential of young people. UNFPA with the Syrian Commission for Family Affairs (SCFA) is articulating a National Strategy for Young People. UNFPA supports youth centers (Youth Development Units) and Adolescent Health Centers in the three program governorates. Youth activities form a cross-cutting approach, some activities falling under Population and Development and some under RH.

Most NGOs and networks collaborating with UNFPA are largely well established and have several streams of funding and support. Government commitment to address issues of youth is very strong and will contribute to sustainable gains in influencing youth behaviors. However social pressures negatively influencing youth behavior may be gaining in strength, thus concerted and coordinated efforts are particularly needed at this time.

**Effectiveness, Results.** Quantities study of youth empowerment and social mobilization showed that 75% of the surveyed sample is aware of the HIV/AIDS as a result of media campaigns. The HHS indicates that 82% of women who have ever been married aged 15-49 years have knowledge about HIV/AIDS. Knowledge in this group regarding other STI/STDs varied with the type from 21-57%. This may be seen to be an improvement, however evidence of changes in behavior including increased use of services, should also be included in the output indicator.
The youth outreach program is casting a wide net to include capacity development for numerous actors as evidenced by activities undertaken in 2010. The partnerships have expanded to include more than 12 national counterparts. A variety of social media and techniques are used such as theatre, peer education and public campaigns. Plans are in place to center some activities on juveniles and youth at risk. Messages on RH are incorporated in a wide variety of capacity development activities undertaken in 2010.

Youth volunteers are highly committed to developing their capacities in communication, and planning and implementing programs, tackling social and environmental issues and strengthening youth networks. However, both partner management and youth volunteers need more capacity to be results-oriented keeping the overall outcomes, outputs and indicators in mind as they plan, implement and discuss their programs. There is a need to ensure quality control and dissemination of up-to-date information and approaches to sexual behavior realities that fall out of the mainstream in Syria, such as homosexuality, drug use and MARPs.

Youth interviewed noted achievements such as referrals of possible STI cases to RH centers for testing; Drugs and Doping campaigns resulting in more youths seeking services; reduction in marriages between relatives; and a high rate of successful communication through public media activities. The strategic partnership with the Office of the First Lady for the youth narratives has resulted in recording of solid evidence on youth perceptions to support future programming efforts which was an unexpectedly significant positive effect.

**Efficiency.** Strengthening M&E and coordination would help improve efficiency. With a relatively small budget, the youth component is able to accomplish many activities by using volunteers and networks, however, efficiency may be lost if results are not more carefully monitored and documented and implementation does not proceed systematically toward achievement of program outcomes and changes in indicators. The Youth Theme Coordination Group consists of UNICEF, UNFPA (co-chairs) – UNRWA, UNDP, ILO, IOM, FAO, WHO, WFP, UNIFEM, UNAIDS, and UNESCO. A mapping exercise revealed overlaps and duplications. The challenges for all agencies are measuring impact and developing indicators. It is clear to interviewees that better coordination would lead to improved efficiency in reaching outcomes.

6. Value-added role of the local YPEER volunteers in launching small scale projects on healthy lifestyle and HIV/AIDS awareness raising

**Relevance and Sustainability.** The YPEER, Youth Peer Education Network, is touted as an efficient and effective means of promoting youth participation in sexual and reproductive health issues. As of 2007, YPEER linked more than 5,000 members from 36 countries.

**Effectiveness and Results.** Half of YPEER’s activities are implemented by Syrian Arab Red Crescent (SARC) and the other half by YPEER. YPEER’s value added is demonstrated in the wide range of activities the group is able to carry out and in particular, TOTs which enable others to carry forth the training. It is estimated that the YPEER activities have influenced 1,000 youth in 2009 and 2010, judging by proxy
indicators, such as numbers of flyers distributed. The YPEER volunteers have built capacity of more than 60 SARC staff and volunteers on community health and participation in 3 Governorates. The Anti-Doping campaign was implemented by MoH and YPEER and ultimately 32,000 flyers will be distributed.

Discussions with stakeholders during the evaluation visits to the governorates indicated that the peer education was very effective. In a focus group discussion with YPEER, the youth felt that their value added was in keeping the benefits of being a network rather than an NGO, and thus able to operate more independently. Topics that are presented/discussed either in training or in activities are not followed-up on to see what the impact has been. Efficiency concerns are similar to those mentioned in the section on Strategic Objective 5 on youth.

2. Population and Development Component

The PD component of the UNFPA/CP (2007-2011) contributed significantly to achieving the specified outcomes and outputs as was documented throughout the evaluation process. However, specific attention is needed to sustain the high-level of commitment already noticeable and to ensure that plans at local levels are fully integrating population, RH, gender and youth issues, as well as to enhance the utilization of survey and in-depth studies carried out. Moreover, the M&E framework requires further work for defining the indicators and plan for providing relevant reliable data for their estimation.

**Strategic Alignment and Relevance:**
The 10th National Development Plan (2006-2010), which is also MDG-based, as well as the UN Development Assistance Framework (UNDAF) for the period 2007-2011, confirm the relevance of the PD component outputs to national priorities. They provide clear evidence to the responsiveness of the CP/CPAP to national directions, strategies and objectives adopted by the Government and supported by donors. Besides it takes into account the need to enhance the ability of individuals and organizations and systems to promote the implementation of the goals and objectives of the ICPD and its PoA, as well as progressing toward full realization of the MDGs.

**Efficiency and Effectiveness:**

1) Expanding Policy Dialogue and raising commitment to Population, RH, Gender and Youth Issues:
The DP components efficiently and effectively adopted several strategies that were instrumental in furthering commitment to the ICPD/PoA and toward expanding policy dialogue, including: a) Preparation of a preliminary M&E framework for NDP, to assess progress and although it was fully operational it created momentum in support of the process; b) Supporting the preparation and launching of the first report on “The State of the Population in Syria (2008)”; c) Preparation and dissemination of ICPD@15 progress report, which also emphasize the interlinkages between the ICPD/PoA and the MDGs, as well as its costing; d) Preparation of National population policy and the integration of population dimension within the context of the 11th NDP; e) Incorporating youth rights and needs into policies at various levels, capitalizing on the demographic dividend. Moreover, promoting youth empowerment and participation as well as providing “space” for them, through various initiatives carried out by: Youth Agenda, SHABAB, and Trust for Development as well as other
conventional organizations, to engage youth in evidence-based policy dialogue based on youth socio-cultural perceptions, views and future perspectives leading to enhanced capacity building within the context of the National Youth Agenda Framework; and, f) Reformulation of Governorate plans. The e strategies prove to be efficient and effective in reaching the goals, and significantly contributing to the realization of national priorities.

The adopted strategies were effective and efficient in expanding policy dialogue, on solid evidence-base, and accordingly enhancing commitment among various influential decision makers and increasing support among the public at large.

2) Enhancing Commitment of Parliamentarian to Population, RH, Gender and Youth Issues:
The CP introduced some effective and efficient innovative activities to involve Parliamentarians in the debates about population issues and to ensure their support for population concerns, RH, gender and youth issues as well as realizing the specified national goals and objectives within the NDP. These include: a) Policy dialogue sessions for Parliament and youth based on recent data, in 2009 and 2010; following their training by experts of the SCFA; b) Arrange for Parliament-NGOs dialogue to debate gaps in existing legislations in support of women empowerment; c) Field visits for Parliamentarians to program sites related to household poverty reduction, humanitarians sites providing health services, RH/FP services as well as some NGOs sites, youth voluntary counseling and battered women shelters, to gain their support for such issues; d) Expanding evidence based policy dialogue to four Parliamentarian committees (Environment and Population activities, Services, Constitutions and Guidance Committees) as well as members of other committees; and, e) Review communication strategy and action plan addressing population, RH, gender and youth issues from cultural lens; and, f) assess the current status of early marriage.

The feedback obtained from meeting Parliamentarians, headed by the Chairman of the Financial Committee and attended by members from various committees, emphasized the importance of these activities and their efficient approach in providing them with important information about various population issues and their interlinkages with development. These furthered their contribution to Parliamentary debates and the integration of population issues.

3) Utilization of Census and Survey Results for in Depth-Studies &Strategic Reports:
A total of 11 in-depth studies and reports were produced throughout the period 2007-2010 based on the various data collection activities carried out with support from UNFPA. Although different in type, coverage and the level of analysis, the evidences produced contributed to the specification of the national goals and priorities as well as informed the process for identifying relevant strategies. The SSPR is a testimony to the process to integrate information, from various sources, to undertake an in-depth situation analysis that also elaborated the findings and informed decision-makers about the efficiency and effectiveness of the current policies in achieving national goals.

4) Fielding Surveys and the utilization of their findings for programming purposes:
Three key surveys (HHS, youth and Household Domestic Violence) were implemented during the UNFPA/CP cycle 2007-2011. These provided assessment for
the validity of current strategies and programmes as well as the progress towards national development priorities and goals. The list include the HHS, the youth survey and the GBV survey, which provided indicators about the current situation and evidences about potential abilities to reach national goals as well as other goals committed for within the context of ICPD/PoA and MDGs. In addition, small scale surveys and studies, with specific objectives, led also to re-visiting the planned program for specific issues such as the survey for Juvenile centers.

Although these surveys were highly efficient and effective in informing decision-makers and planners, its sustainability represents a challenge that requires building capacity for in-depth analysis of the findings and its translation into policy-action and programmes. The collaboration of various development agencies in the implementation of the HHS is an example of the strategic alignment with National Development Plan and UNDAF. It creates opportunities for strengthening and promoting further analysis of the data and their utilization for improving policy intervention and programming.

Cross Cutting Issues within the population and development theme include: a) Capacity building programmes involving various stakeholders (SPC, SCFA and CBS), which were instrumental in supporting progress towards the successful implementation of key interventions of the UNFPA/CP 2007-2011. The content of such programmes stems from national priorities and they were building on broad-base participation at both central and local levels. The trainings for the staff of the State Planning Commission, Central Bureau of Statistics and directorates of health & education focuses on the inter-linkages of population and development variables, at the central and governorate levels. The main purpose was to support the current situation analysis related to the next national development plan for 2011-2015.

Special attention was devoted to building the capacity of the Central Bureau of Statistics (CBS) as the lead agency for quality data collection, analysis and dissemination. Its training needs in statistics were assessed as well as the process aims to review the policy for statistical information, including the role of the Central Bureau of Statistics as the primary producer and coordinator of the official statistics in the country in line with the internationally accepted standards.

The manual providing key concepts used in population and social statistics, for media professionals is breaking the barriers among various disciplines and contributing to the process of establishing a consensus about the terminology used by various sources. It also shows the importance of the close cooperation between stakeholders (CBS and the Ministry of Information) with the support of UNFPA.

3. Gender Component:
The main issues covered are concerned with the implementation of the gender/GBV related surveys as well as use of surveys’ data for programming purposes, the extent of community-based and non-governmental organizations role and media entities in promoting gender/RH issues, coordination and their full-fledged acceptance by local communities, and assess facilitating and constraining factors as well as challenges on the way to establishing GBV Observatory and National Gender Coordination Group. In addition, within the context of health and community mobilization, efforts were directed to up-scale MDGs, through targeting the poorest villages in the North Eastern Region, and to develop a joint gender communication strategy.
1. Establishing Gender Knowledge Base:
Reliable and timely information about gender related issues is considered important to identify intervention and for using the resources/inputs in a cost-effective manner. It provides evidences for advocacy and informing the content and priorities of strategic development framework. To this end, the CP supported the quantitative survey and qualitative study on domestic violence, as well as enhanced mainstreaming efforts to ensure the integration of gender issues in the design of all other initiatives. Moreover, the programme worked on building the capacity of institutions that are engaged in the design, analysis, dissemination and utilization of findings.
The household domestic violence survey and the attached qualitative studies, under the auspices of the Syrian Commission for Family Affairs (SCFA), provided evidences that were used for informing the gender related priorities of the 11th National Development Plan for 2011-2015, as well as identifying priorities for the forthcoming UNFPA country programme (2012-2016). Moreover, the SCFA with UNFPA support conducted an in-depth study on gender related legal frameworks and CEDAW implementation.
The wide utilization of the survey finding demonstrates its effectiveness for evidence-based policy dialogue and advocacy in support of gender issues. This was also strengthened through the various inputs that were carried throughout the period 2007-2010. Key among these inputs were: a) Evidence-driven national workshops on Household Domestic Violence (GBV, 2009), and gender and women’s empowerment, early marriage (2010) for the parliamentarians; b) Orientation workshops conducted for the staff of the Ministry of Social Affairs and Labour (MOSAL), NGOs, media professionals and community leaders on RH/GBV concepts; c) Gender Manual to serve mainstreaming efforts during the national development planning processes; d) National assessment of juvenile centres in Syria where gender issues were integrated and a manual for service providers was designed; e) Mainstreaming gender issues in the joint project on establishing National Social Aid Fund (NSAF’), which was launched jointly with UNDP and MOSAL and Labour in 2007 and is still being implemented and was extended to 2011.
In total, some 730,000 families have got registered for assistance and 550,000 met the criteria for assistance. The main purpose is to ensure that most vulnerable households/ultra-poor can benefit from this initiative. In particular, the NSAF is expected to provide cash assistance to aged people, persons with disabilities, divorced and separated women, single female heads of households, orphans up to 15 years of age and families of prisoners. It is worth noting that generating gender specific evidence through the mapping exercises secured mainstreaming gender issues and aspects, especially the importance of addressing the needs of disadvantaged women, is relevant to the purpose of the programme component as well as the national priorities and UNDAF.
Besides, other surveys carried out within the context of the other programme components also contributed to securing evidences about gender-related concerns and issues. Key among these is: a) The Youth survey/studies (2007/08), b) The 2009 HHS; The Household Income and Expenditure Survey (2007/08) which integrated questions on women’s status and decision-making power.
Ensuring the sustainability of gender-related data and indicators was also given due attention within the CP where technical support on establishing a consolidated structure and working mechanisms of the Gender and Children Statistics Unit at the Central Bureau of Statistics, to secure the flow of systematic gender data.
2. **Strengthening outreach capacity:**
Establish a strong culturally sensitive community outreach component with multi-sectoral coordination mechanisms, involving local government entities, CBOs and NGOs. Community mobilization and media campaigns, which were designed and successfully conducted in 7 governorates and 60 villages throughout 2008-2010, have reached out more than 100,000 people with gender, RH and GBV sensitization messages. Successful community mobilization campaigns and culturally sensitive approach gained commitment and support of the local authorities and community leaders to the campaigns and gender and RH issues. Such programmes were initially launched in the three north-eastern governorates- Deir-ez-Zor, Al-Hasakeh and Al-Rakka and later expanded to other governorates, namely Aleppo, Idlib, Homs and Lattakia based on the government request that confirmed the success of the selected interventions and approaches.

In 2010, UNFPA community mobilization model was adopted by the Syrian State Planning Commission (SPC) as a national programme and integrated within the 11th 5-Year NDP with the subsequent resource allocation, which witnesses the sustainability of this initiative. It can also be considered as an unexpected positive result. This materialized as a result of opting for and implementation of the planned interventions, which worked well for effectiveness within the available resources.

The Gender component contribution also involved capacity building support to NGOs in Al-Rakka, Deir-ez-Zor and Aleppo on establishing and managing counselling centres for violence against women and their families as well as scaling up violence prevention mechanisms. UNFPA also secured the inclusion of GBV in-service training of health service providers and integration of GBV related services in Halbouni Clinic.

3. **Integrated Community Development for up-scaling the MDGs:**
Within the context of community mobilization, 9 ministries and 7 UN Organizations, including UNFPA, launched a joint project to promote the achievement of the MDGs at local level. Based on the concept paper developed by UNFPA, the project targeted the poorest villages in the North Eastern Region.

4. **Strengthening gender coordination and protection mechanisms:**
The programme component was proactive, efficient and effective in securing multi-sectoral coordination and protection mechanisms and initiatives for gender mainstreaming as follows: a) setting up a steering/coordination group for the gender component, a national gender coordination committee was established by the SCFA in 2009 on the basis of a concept note developed by UNFPA which can be considered as a breakthrough achievement. This was re-launched in 2010 to lead and operationalize the functional responsibilities of the coordination mechanism; b) National gender mainstreaming manual to guide gender mainstreaming efforts of the gender coordination committee. The manual is considered as a practical tool for mainstreaming gender in national policies and development frameworks, which witnesses the relevance of the programme interventions.

The mutually reinforcing nature of these two interventions is a good demonstration of the efficiency and effectiveness of the specific programme components initiatives.
towards producing the desired outputs:

- Establishing Family Protection Units (FPU) in 2008 under the SCFA, which embrace women’s refuges as well. (The SCFA initiative of setting up women’s refuges within the FPU is a response and commitment to the need of combating domestic violence and at a larger context tackling GBV issues in the country. It expressed the willingness and commitment of government to combat any sort of violence against women and children in Syria.)
- National GBV Observatory was established in 2010, which will be linked, upon its full functionality, to the FPU. Besides facilitating the work of these two initiatives the Gender component also put out tangible efforts towards introducing the principles and concept of establishing counseling centers for victims of GBV in selected NGOs in Al-Rakka Deir-ez-Zor and Aleppo in 2010.

One of the key challenges faced by the Gender programme component was related to securing timely and quality technical assistance. It is worth mentioning that the UNFPA humanitarian component managed to include GBV in-service training of health service providers and integrate GBV related services in Halbouni Clinic, which can be replicated within the development component. However, there is still room for awareness raising and capacity building on the concept of gender at the grassroots level. This requires simplified awareness raising and training materials.

5. Gender Communication Strategy:
Developed in collaboration between the MOI and SCFA (with UNFPA support). The strategy was based on the quantitative and qualitative research on domestic violence and previous experience in carrying out such exercise in 2008-2009 concerning family planning and maternal health that was followed by three waves of media campaigns.

KEY RECOMMENDATIONS
Based on the detailed assessment of progress toward achieving the specified objectives of the CP 2007-2010, for various thematic areas, and the lessons learned throughout the in-depth analysis, a set of key recommendations are presented which will be also detailed in the section for recommendations.

Reproductive Health
1. Devote more resources to strengthening access to and availability of Family Planning services by strengthening quality assurance mechanisms including the contraceptive logistics management system within Family Planning services and promoting the demand side of FP through well targeted BCC and by implementing more activities directly in/with communities prioritizing rural and poverty-stricken areas and the Vulnerable Groups.
2. Continue to strengthen utilization of community resources effectively, e.g. leaders, youth, and volunteers to pass RH messages to both males and females.
3. Strengthen an evidence-based and integrated planning approach, aiming for collecting evidence that activities are working toward sustainable KAP changes and that components are integrated to the degree possible.
4. Strengthen coordination and collaboration among components in the MoH and UNFPA and with other agencies and assistance providers, developing stronger collective efforts toward improving key indicators. Promote public-private sector partnerships especially for capacity building and standard setting.

5. Advocate for solutions to long-term constraints to sustainability in the health system support for RH, providing motivation and support for medical staff in rural clinics and for routine monitoring by the MoH to help improve services in rural and disadvantaged areas.

6. Help ease administrative barriers to timely funding and implementation, timely securing of consultants and trainer, and provision of quality equipment and supplies.

Population and Development

1. National Population Policy: Develop the overall policy framework to highlight the main goals and objectives of the Country concerning population and other related matters. The document should be given priority for its finalization as an integral part of the 11th NDP.

2. Develop responsive plans to population issues, RH, gender and youth, at central and local levels, with clear specified goals and objectives, especially all stakeholders that are playing an effective role in supporting the national programmes and advocacy.

3. Strengthen coordination among various partners working with youth as well as enhancing institutional and community capacity for promoting youth empowerment and participation.

4. Finalize the development of a comprehensive, integrated and well-designed M&E framework, and relevant databases including DevInfo, to assess progress towards achieving national goals.

5. Further involvement of parliamentarians in policy dialogue and advocacy for population and sustainable development issues as well as actively participating in monitoring and evaluating progress within Parliamentarian debates.

6. Strengthen the management and content of the National data base, with special emphasis on quality, timeliness and identification of priority emerging topics to be covered within the strategy (disability, aging…). This includes key elements such as: National Statistical Strategy, assessment of data quality, and the 2014 census.

7. Support efforts for capacity development, within a comprehensive framework and adopting modalities that integrates formal training and on the job activities.

8. Production of user-friendly materials for various partners, especially media professional, elaborating the main findings of various national data sources and in-depth studies, to expand their participation in policy dialogue and advocacy.
Gender

1. Use evidences to advocate for developing a national gender strategy and multi-sectoral action plan in support of operationalization of the related objectives of the 11th National Development Plan;

2. Continue addressing the needs of disadvantaged women (divorced and separated women, single female heads of households) in the framework of the NSAF;

3. Enhancing the content of the gender mainstreaming manual based on the findings of the Survey and Study on Domestic Violence.

4. A comprehensive output for Gender programme component need to be developed to bypass the limitation of the current program, only to addressing GBV. This would focus on strengthening gender mainstreaming in policies, institutional frameworks as well as conducting a comprehensive thematic assessment of community mobilization and media campaigns on gender, RH and youth issues.

5. Scaling advocacy and behavior change communication as cross-cutting issues in the other programme components, based on good practices and lessons learned generated from component’s communication and community mobilization.

6. Upscale youth involvement in community mobilization and media campaigns on addressing gender and GBV issues through leveraging the potentials of the Revolutionary Youth Union, National Union of Syrian Students, Junior Chamber International, NGO “SHABAB’ and YPEER network.

7. Provide support to the SCFA and MOI in their efforts to form a national team of gender experts and media professionals on the concept of gender, gender equity and equality principles.

8. Establish partnership with the Ministry of AWQAF, Women General Union, Ministry of Education (gender and school curriculum) and National Union of Syrian Students in order to further expand gender/GBV response and scale up culturally sensitive aspects in the framework of the next cycle of assistance along with the SCFA, MOSAL and MOI.
**Introduction:**
The UNFPA Country Programme (CP) for 2007-2001 reflects the priorities of the Government as stated in the five-year 10\textsuperscript{th} National Development Plan, as well as those of the Common Country Assessment (CCA), the United Nations Development Assistance Framework (UNDAF), and the strategic directions of UNFPA. The CP cycle is harmonized with other United Nations agencies in the Syrian Arab Republic (SAR).

The UNFPA CP developed through an intensive consultative process with the Government and development partners, including UN sister agencies, was designed to contribute to three UNDAF Outcomes: (1) Inter and intra regional disparities related to access and quality of health, education and other basic social services reduced with a focus on the Eastern, North and Badia regions and other disadvantaged areas; (2) Efficiency and accountability of governance structures at central and local levels strengthened by, government, civil society and the private sector, towards sustainable development; and (3) Risk and impact of natural and manmade disasters is reduced.

The focus of the CP interventions, especially at the level of the provision of services, will be on the North-Eastern governorates, interventions at the national level in areas such as advocacy, policy dialogue and capacity building will be undertaken.

**UNFPA/CPAP Outcomes and Outputs:**

The specified outcomes and outputs for the CP 2007- 2011, for the three components are:

**Outcome 1** “Increased access to and utilization of comprehensive quality reproductive health services and information, including family planning, with a special focus on the Eastern, Northern and Badia regions and other disadvantaged areas” responds to UNDAF Outcomes 1 and 3 as stated above. By focusing on ensuring increased access and utilization of quality reproductive health services and information, this outcome contributes to the Multi Year Funding Framework (MYFF) Outcome 2 related to increasing access to comprehensive RH services. Two outputs will contribute to this CP outcome.

The **outputs of the Reproductive Health components are:**

**Output 1**: Increased availability of comprehensive, integrated, quality reproductive health services and information, including family planning and emergency obstetric care in selected underserved areas.

**Output 2**: Increased availability of reproductive and sexual health information, and counseling services for young people, with a special focus on the prevention of HIV/AIDS and STIs among population at risk.

**Outcome 2** “National, sectoral and local policies take into account population dynamics, reproductive health and gender issues, in the context of poverty reduction, development and the MDGs”, responds to UNDAF Outcome 2. This outcome will
contribute to the Multi Year Funding Framework (MYFF) outcome 5, which states that national, sub-national and sectoral policies, plans and strategies take into account population and development linkages. To this end, the two related outputs for the Population and Development components are specified:

**Output 3:** Enhanced national capacity for integrating population, gender and reproductive health issues into national, sectoral and local plans.

**Output 4:** Strengthened national capacity for generation, analysis, dissemination and utilization of disaggregated data, including supporting research for policy decision-making.

**Outcome 3** “Policies and institutional mechanisms for improving the legal status of women, eliminating gender based violence, promoting women’s and girl’s rights and increasing gender equity in decision making strengthened” responds to UNDAF Outcome 2. This outcome will contribute to the Multi Year Funding Framework (MYFF) Outcome 6, which states that institutional mechanisms and socio-cultural practices promote and protect the rights of women and girls and advance gender equity.

One output linked to this CP outcome states:

**Output 5:** Strengthened institutional capacity of government and NGOs in integrating gender based violence in national plans and strategies

**Previous Monitoring Reviews:**

In order to review the extent of progress in the implementation of the CP components, generate lessons learned and identify the way forward, UNFPA/CO, State Planning Commission and all the implementing partners conducted annual programme reviews (APR) in 2007 and 2008. The APRs reviewed facilitating and constraining factors as well as programme management and coordination issues, which resulted in clear-cut and strategic recommendations. As a result of the APRs the CPAP Planning and Tracking Tool (CPAP/PTT) was equipped with the necessary data and targets and a common consensus was reached on monitoring and evaluation (M & E) activities, which were incorporated in the framework of the CPAP M & E Calendar.

UNFPA CP Mid-Term Review (MTR) was conducted in December 2009 and also built on the body of data and recommendations of the APRs. Further to the Country Office consultations with the State Planning Commission, both conventional/ or “expert driven” and participatory approach were opted for throughout the MTR process. It resulted in the following sets of recommendations:

1) **Sustainable institutional and human resource development:** a) high quality technical assistance for integration of population, RH, gender and youth issues in development policies & plans as well as their implementation, monitoring and evaluation; b) gender & culturally sensitive behavior change communication; c) high quality technical assistance for further up scaling RH management & services; d) promoting holistic approach to young people development & participation; and, e) emergency preparedness and response.
2) **Securing further and greater contributions to the National Development Plan:** a) further expansion of the programme focus to the North-Eastern governorates; b) strengthening technical & programme management capacity; c) linking development and humanitarian efforts; d) promoting national execution modality, financial accountability and accountability for results further; e) fostering different levels of strategic partnership, including in support of youth empowerment and participation; and, f) addressing youth empowerment and participation in a holistic manner.

3) **Up scaling monitoring and a strong focus on evaluation:** a) strengthening the role of the programme components’ steering committees; b) continuous monitoring of performance indicators and targets, including annual targets; c) updating the monitoring and evaluation calendar; d) establishing annual performance targets; e) advanced planning for data analysis and review; f) confirming the programme evaluation plan; and, g) conducting baseline data quality assessment for the next cycle of assistance.

Based on the assessment of recent indicators, the main focus of the CP Evaluation will be on the CP relevance, efficiency, effectiveness and strategic alignment with the way towards addressing challenges and building on opportunities, which serve the purpose of strategic positioning over the new cycle of assistance. The CP Evaluation is also expected to take into account the quality of M & E over the current cycle of assistance.

**COUNTRY PROGRAMME EVALUATION (2007-2011)**

The purpose of the evaluation is to conduct an end of programme cycle evaluation to assess the achievement of the programme results, the facilitating and constraining factors, and to compile lessons learned so as to inform development of the next CP cycle. The timing of the CP Evaluation is to respond to UNFPA Evaluation Guidelines requesting that the end of country programme cycle evaluation is to be conducted in the programme penultimate year. The evaluation will be utilization-focused and provides credible information on the CP relevance, efficiency, effectiveness and strategic alignment to support decision-making by the programme management and national counterparts for further programme improvement and strategic positioning over the new cycle of assistance.

**A) EVALUATION SCOPE**

The scope of the Evaluation embraces the CP for the period 2007-2010, which was designed to focus on the Eastern, North and Badia regions and other disadvantaged areas.

**B) OVERALL EVALUATION OBJECTIVES**

1) To evaluate the extent of the outputs achievement on the basis of the CPAP PTT baselines and targets and the degree of the outputs contribution to the attainment of the CP outcomes with a special focus on unanticipated positive results;
2) To evaluate the CP achievements in terms of capacity building relying on the following conditions: a) broad-based participation and a locally driven agenda; b) leveraging local capacities; c) ongoing learning and adaptation; d) long-term investments; and, d) integration of activities at various levels to address complex problems;
3) To assess the CP efficiency and relevance, including the CP performance in terms of prioritization of and focusing on interventions with evidence of effectiveness and evidence-informed assessment of needs;
4) To assess quality of the CP M & E with the main focus on quality of indicators, baselines and targets as well as evidences of using knowledge and the CP monitoring/reviews information systematically;
5) To evaluate the CP strategic alignment with the National Development Plan (NDP) for 2006-2010 and UNDAF.

C) SPECIFIC EVALUATION OBJECTIVES (Evaluation Methodology Framework– Annex I)

To assess: 1) functionality of mechanisms for systematic improvement of the emergency obstetric care (EmOC); 2) effectiveness of the clinical protocols on FP, antenatal care and EmOC in better provision/utilization of the services; 3) validity and effectiveness of the RH programme component’s approaches and strategies in support of increasing the availability of and access to at least three RH services; 4) validity of the current strategies and approaches in HIV/VCCT domain; 5) relevance of the current approaches and strategies in reaching out youth with RH STIs/HIV/AIDS messages; 6) the value added role of the local YPEER volunteers in launching small scale projects on healthy life style and HIV/AIDS related awareness raising initiatives; 7) effectiveness of the population and development (PD) programme component’s approaches and strategies in raising the commitment of parliamentarians to population, reproductive health, gender and youth issues; 8) quality and extent of utilization of the census and survey data for producing in-depth research studies and strategic reports; 9) efficiency and effectiveness of the implementation of the surveys as well as use of surveys’ data for programming purposes; 10) the extent of NGOs/CBOs’ role, coordination and their full-fledged acceptance by the local communities; 11) facilitating and constraining factors as well as challenges on the way to establishing GBV Observatory.

D) EVALUATION METHODOLOGY

The evaluation methodology will embrace the following: overarching evaluation objectives/question, specific evaluation objectives/questions, performance indicators, data source, evaluation design, sampling plan, data collection instruments, and data analysis plan. Data collection methods will include reviewing available documentation interviews with key contacts, focus group discussions with key informants and field visits.

The CP Evaluation related processes was carried out in slightly more than 13 weeks, starting on the 29th of September and ending on the 31st of December and embrace the following stages (CP Evaluation Roadmap – Annex 2). The exercise took place in three stages:

The preparatory stage 1: consultants/external evaluators conducted an in-depth desk review of the relevant materials i.e. strategic reports, reviews and thematic assessments. This process included standard progress reports, technical mission reports, training reports, needs assessments/studies, clinical protocols, media coverage of the launching campaigns and various reports, CP Action Plan Planning and Tracking Tool, CP Mid-Term Review and CP Monitoring and Evaluation Calendar. Based on this review and the specific evaluation objectives and questions, the
evaluators for various components drew up inception reports demonstrating the proposed evaluation design, methodology, implementation plan, (there was no national expert) including the division of labour, deliverables, and schedules/deadlines.

**Stage 2: Country mission of selected external evaluators focused on data collection, validation and analysis, through key informant interviews, as well as meetings with beneficiaries, including primary and secondary stakeholders.** Several meetings were held with key informants and a number of focus group discussions were also conducted. Specifically, this process included:

a) Interviews with key informants including: UNFPA Staff, Staff of the Reproductive Health Department in Damascus, Deir-ez-Zor, Aleppo and Idleb governorates, the National AIDS Programme of the Ministry of Health and MoH Logistical Department, Syrian Family Planning Association, Syrian Arab Red Crescent, Ob/Gyn Association, SPC and SCFA Staff;

b) Focus group discussions covering various groups: RH Technical Group of the MoH, Doctors, Midwives and technicians who received training through the UNFPA programme, NGOs conducting Youth related Programmes, Youth center volunteers of the Syrian Arab Red Crescent in Damascus and in Deir-ez-Zor and YPEER Volunteers. Moreover, meetings with the Director of planning, at various levels, were held to discuss the integration of the population dimension into planning. This also covered the staff of CBS, SPC, SCFA and M&E offices, who contributed to the discussion.

c) Specifically for RH, visits were undertaken to the governorates of Deir-ez-Zor, Aleppo and Idleb in addition to the Damascus area. Nine PHC centers, (no hospitals) were visited as well as one VCCT center in Damascus.

d) Review of the outputs of the national statistical system as well as the MoH statistics and facility service data (selected health facilities). The data collection program was arranged in advance by the UNFPA office but the evaluators were able to determine who to interview in various areas (especially for health facilities and planning departments). Various approaches were also used to ensure bias reduction, including triangulation, where all findings are checked (using three or more sources) to mitigate bias.

**Stage 3: Report Preparation**

The evaluators prepared a draft evaluation report for the various program components which was submitted for review. This includes:

a) Submission of the first draft thematic evaluation reports, by the consultants, and its subsequent distribution to the Evaluation Management Committee (EMC)/partners for peer-reviewing, comments and feedback.;

b) Resubmission of the revised draft incorporating comments and feedback, to finalize the CP evaluation report;

c) Present the main findings to the CP evaluation meeting with all the concerned partners and dissemination of the Evaluation Report;

d) Securing proper use of the evaluation findings for further programme improvement and strategic positioning over the new cycle of assistance. In this context, the Evaluation Managers will provide general comments to the evaluation
results as well as specific response and actions to be taken against each evaluation recommendations.

In line with the UNFPA evaluation policy of strengthening national evaluation capacity by using participatory and inclusive approaches and by supporting national-led evaluations, the Evaluation Management Committee (EMC, Annex 3) was established. It is jointly chaired by the representative of the CPAP Government Coordinating Authority (State Planning Commission) and UNFPA Representative. In addition, it includes representatives of programme component managers (Ministry of Health, Syrian Commission for Family Affairs), as well as other implementing partners, UN sister Agencies and various stakeholders. The EMC was in charge of: a) endorsing TOR; b) selecting and debriefing Evaluation Team/Evaluators; c) organizing technical support; d) approving inception report and final evaluation budget; e) monitoring progress and quality of evaluation activities; f) reviewing and commenting on drafts; g) approving evaluation reports; h) disseminating and following up to evaluation findings; i) assessing performance. At the same time, the UNFPA Representative and the International Programme Specialist, acted as the CP evaluation managers, responsible for: a) convening, coordinating and supporting the Committee’s meetings; b) leading the development of various TORs and the management response; c) managing the CP Evaluation budget and ensuring logistical and administrative support; d) coordinating with ASRO; e) facilitating access to background documents; and, f) uploading evaluation TOR and final report into UNFPA central repository.

Evaluation Methodology Constraint:

Although the evaluation process was highly facilitated and supported by various stakeholders, the following constraints were experienced:

1. **Time constraints.** Allocated time for the assessment of performance concerning thematic areas was affected by the limited span for the finalization of the overall process. Specifically for the RH component, the evaluation involved inquiry into six questions involving three major elements of the UNFPA program including reproductive health, voluntary HIV/AIDS testing and youth and community outreach. These programs compose over 70% of the program budget. The time to look carefully into the issues was limited compared to the scope of the evaluation. Due to the time limitations, the evaluation relied on the Mid Term Review and Annual Reviews as a basis for investigation into the program from 2007-2009. The evaluator used documentation and consulted closely with UNFPA and Ministry of Health staff. The evaluator was still receiving documents and program analysis from UNFPA on 17th December which was important to the analysis and these needed to be woven into the report.

2. **Limited result analysis.** Although RBM tools were employed to develop the CPAP, the log frames evolved with the Annual Work Plans and outputs/outcomes were largely limited to the implementation of the activities rather than the outcomes and results. This was clearly noticeable for various components and specifically, the MoH data analysis was limited and/or difficult to obtain since there is no surveillance system in the health sector in Syria. The evaluators thus reported on data that was available.
3. **Sample size limitations.** In that respect, it should be noted that no hospitals were visited and some of the planned interviewees could not be visited due to time limitations. The time to meet external stakeholders was limited compared to the scope of the evaluation and a larger sample would have enriched the findings, particularly of other UN and donor agencies, and more governorate and district level RH staff. However, for RH the evaluator was able to use secondary sources along with interviews to triangulate findings.

4. **Limitations on overall and thematic preliminary briefing feedback.** Several factors including the scheduling of the missions as well as specific conditions (the snowstorm in Damascus, health status,) led to limiting the discussion of the final briefing to the RH component, and even for this, the attendance was limited to a few UNFPA staff and the MoH and other partners were not able to attend.

**E) Evaluation Team**
The Evaluation Team, in charge of conducting the evaluation for various thematic areas, included a consultant for each of the UNFPA components (RH, PD and Gender) covered by the country programme, and taking into consideration the proposed evaluation methodology, including data analysis. The selection process was based on having a strong experience in planning and evaluation, sound knowledge of development environment and excellent analytical and communication skills.

The **Team included:**

1. Mr. Hussein A. Sayed, Team Leader and PD Component Evaluation;
2. Ms. Sheila Reed, RH Component Evaluation;

**Findings and Conclusions:**
The UNFPA CP developed through an intensive consultative process with the Government and development partners, including UN sister agencies within the context of UNDAF program, was designed to contribute to three UNDAF Outcomes: (1) Inter and intra regional disparities related to access and quality of health, education and other basic social services reduced with a focus on the Eastern, North and Badia regions and other disadvantaged areas; (2) Efficiency and accountability of governance structures at central and local levels strengthened by, government, civil society and the private sector, towards sustainable development; and (3) Risk and impact of natural and manmade disasters is reduced.

Assessment of progress towards the goals and priorities of the CP and the results achieved up to 2010, indicated that the proposed outputs were effectively and efficiently responding to the Country’s needs. Their identification was based on a solid situation analysis that covered population dynamics and interlinkages with sustainable development as well as identified gaps and areas for inventions.
Throughout the current programme cycle the Government demonstrated very high level commitment to population and development issues through securing strategic reports, studies as well as other related initiatives and high-level statements and articles in print and other media, which in turn supported the CP and enhanced progress towards the realization of the specifies results.

The strategic alignment between the Government and UNFPA resulted in the increase of the Government Trust Fund contribution to the current cycle of assistance (2007-2011) from 15 % to 50 %. In addition, the Government is committed to the procurement of contraceptives from the central health budget with the annual allocations of $700,000 totaling to $2,800,000 for the whole cycle.

At the national level, evidences are showing that the Syrian Arab Republic has made tangible progress towards achievements of the MDGs, however, the results of various surveys and studies revealed that some areas across the country and mostly concentrated in the North-Eastern region significantly lag behind others in terms of the population and development variables, including reproductive health (RH) indicators. In addition, it is noted that the Syrian Arab Republic has been witnessing stagnated or slow fertility decline where the total fertility rate was expected to constitute 3.16 during the period of 2005-2010 while it reached 3.5 in 2009 compared to 3.58 in 2004 and 3.6 in 2006, as well as a very slow increase in the utilization of modern contraceptives

This overall assessment is based on the detailed evaluation for the three UNFPA programme areas; RH, PD and Gender as will be presented in the following sections.

**Reproductive Health Component:**

This section is structured around the six Specific Objectives of the RH evaluation component as specified on the TOR.

**Strategic Alignment of the Country Program (CP) with the National Five Year Plan and UNDAF:**

The UNFPA Country Programme (CP) for 2007-2011 reflects the priorities of the Common Country Assessment (CCA), the United Nations Development Assistance Framework (UNDAF), and the strategic direction of UNFPA as well as the National Five Year Development Plan. This was confirmed by the Mid-Term review (2009). The CP cycle is harmonized with other United Nations agencies in the Syrian Arab Republic. However, it is noted that the indicators and goals, used by the UNDAF and the SAR, are not always in alignment, nor are the data sources for their determination.

**Overall RH Conclusions**
UNFPA and Partners have made significant progress since 2007 in strengthening all supported aspects of the Reproductive Health Component. All RH clinics visited by the evaluator have experienced increases in users due to improved skills of medical staff, better management and cleanliness of the clinics, more and improved equipment and infrastructure and public outreach. RH clinic users and staff all noted increases in public awareness due to multiple media and community-based campaigns. “Beyond the Numbers” is in process and is being considered an important initiative to study causes of maternal mortality. Youth counselors note increases in attendance at youth centers and more youth volunteers. The community mobilization campaign pilot projects in five communities offer a means to successfully promote RH, using community leaders and volunteers.

All program efforts are supported by the high level commitment of the Government of the Syrian Arab Republic to strengthen the national response in support of the health outcomes of the National Development Plan and to achieve the MDGs. However, impacting the national fertility rate, maternal mortality ratio, and infant mortality rates requires stronger strategic planning in order to promote the desired knowledge, attitudes and practices (KAP) particularly of those who are not adequately covered or affected by RH public and private health services and public RH media/outreach messages. These include the rural populations, youth, the poor, illiterate, migrating groups, groups with high risk sexual and health related behavior (Most at Risk Populations, MARP) and those who desire to have more than three children. Linkages around community outreach and mobilization need to be strengthened within UNFPA, and among UNFPA and its Partners and other organizations working in RH, and importantly in coordination with the private RH practices.

The national health care system faces human resources and data management issues that will impact any assistance support and constrain progress toward the desired and sustainable outcomes. This includes transfers of staff, difficulties in staffing and ensuring well trained staff in rural centers, constraints to supervision and monitoring including transport to the districts, and the collection and reliability of data from RH clinics and other health care providers.

With its partners, UNFPA’s program design has contained major strategic components for development and has evolved since 2007 to strengthen these aspects. Some examples are given below.

a) Broad-based participation and a locally driven agenda – The MoH relies on the governorates to conduct needs assessments and propose actions to be addressed at central, governorate and district levels. This approach allows variations in needs among governorates to be considered, however, it was noted by several interviewees that the quality of assessments and strength of workplans may vary with the ability of the governorate MoH staff to plan and strategize. In order to strengthen governorate and district planning, it may be feasible for governorates to share strategies and approaches, particularly by governorates that demonstrate results effectively. One example might be the Aleppo MoH RH departments’ training initiatives and plans to evaluate the impact of the training in the workplace using the Kirkpatrick model.

RH training initiatives are aiming to cover a majority of RH clinics in the country (total number is 1700) and the youth and community mobilization activities will be
spread to more areas. It will be important to extend ownership of training activities to the district level particularly the areas with higher mortality and fertility rates.

b) **Leveraging local capacities** – Most training courses are taught by national professionals and the national training pool for RH has been expanded through the use of TOTs, for example for physicians and for youth through the YPEER TOTs. More inclusion of midwives as trainers is needed. The community mobilization activities have helped to tap the capacity of local NGOs and community members for use in communicating key RH messages. More work is needed with the private sector to help ensure high quality RH information and to use private sector resources to reach underserved and vulnerable populations.

c) **Ongoing learning and adaptation** – UNFPA and the MoH have effectively utilized survey results as a basis for building the program and have annually adapted activities through the workplan. Annual program reviews collect good practices, lessons and recommendations and a Mid-term review was held in 2009. More resources placed toward in-depth monitoring and evaluation at district and community level would help to investigate issues and propose local solutions. More sharing of lessons would be beneficial among other organizations supporting RH and related activities undertaken by members of coordination groups for RH and youth activities.

d) **Long-term investments** - The program has supported and reported results of research consistently and has brought in international experts or sponsored some study trips to help raise national capacity. The use of the Beyond the Numbers approach will provide reliable data on which to base maternal health activities. A major long term investment is the youth component of the program which aims to affect KAP for RH among youth peer groups.

e) **Integration of activities at various levels to address complex problems** – UNFPA’s program contains activities targeted at various population groups and uses a variety of inputs such as training, provision of supplies, research and a number of communication methods. More integration of activities and components would help to improve efficiency and effectiveness.

**Cross-cutting Issues**

The following cross cutting areas have been identified for further strengthening.

1. **Strengthening an evidence-based and integrated planning approach.** In developing the Country Programme and CPAP, UNFPA uses RBM principles in accordance with the UN/UNFPA RBM procedures and guidelines. According to the M&E requirements the CO conducts annual programme reviews in 2007 and 2008 and the mid-term programme review was conducted in 2009 with concrete lessons learned and strategic recommendations. As a result, the CPAP Programme Tracking Tool was revised as well as the M&E Calendars. The ongoing CP Evaluation reflects also the commitment of the CO to the M&E principles and evidence/result-based planning.

Recent regional consultations (with the engagement of the MoH) confirmed the need for identifying and reaching a common consensus on potential areas of UNFPA support to the country specific surveillance action plan which aims at establishing and
further strengthening the maternal, perinatal and neonatal health surveillance system in the country. This is a major step forward which will take some time to implement.

The CPAP logical framework identifies two major levels of targets, the overall CP targets and the annual targets. In themselves, some overall CP targets are somewhat problematic because they cannot be tracked through any consistent and reliable sources of data. The fertility rate is relevant but has not been included and some of the program targets could be more specific, measurable, achievable, relevant and time-bound (SMART). There is no indicator for cervical or breast cancer detection.

Most annual targets aim for completion of planned activities which cannot be considered to be results in themselves. It is assumed that the results of such activities will ultimately appear as changes in the overall targets but this assumption is not always correct. This evaluation contends that an intermediary step in assessing results is needed so that stakeholders can see whether the activities can be expected to ultimately affect the overall CP targets based on evidence that they are working or whether a change in strategy is required. An example would be assuming that contraceptive inputs to clinics will result in an increased Contraceptive Prevalence Rate, when in fact the supply at present in clinics exceeds the demand.

Discussions with UNFPA staff and partners indicate that the main focus tends to be on completion of activities rather than results or outcomes that may lead to results. In order to achieve the overall results, the key to results-based management is gauging the impact of activities on the KAP needed to move the larger indicators in the right direction in a systematic fashion. Coverage of vulnerable population groups needs to be a key concern in all planning. Evidence of the impact of activities is critical to assessing whether an activity is worth a continuing investment.

Integration among components is also essential to efficient use of resources. Planning tends to be clustered into components which may make planning easier but tends to foster vertical management. The community mobilization activity is an example of where all components have the potential to come together, yet the planning did not adequately include the Ministry of Health or the UNFPA youth component.

Therefore the following is advised:

- Provide training in results-based planning to partners (some staff at the MoH have received such training from WHO) including the youth groups to affect their thinking as they plan and implement their activities.
- Create targets or sub-targets that indicate progress in KAP in target groups, such as follow-up on training activities using the Kirkpatrick model and impact of training not only on the trainee but on the client groups.
- Request reporting from partners and among UNFPA staff on outcomes gauged from mini-surveys, focus group discussions and monitoring visits.
- Ensure that all UNFPA staff and partners participate in the RBM exercises so that the outcomes are clear and seem attainable to all staff and partners and that targets and indicators are unified.

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1 Donald L. Kirkpatrick, “Evaluating Training Programs”, 1994. The four levels of Kirkpatrick's evaluation model essentially measure: 1) reaction of the student; 2) the resulting increase in knowledge or capability; 3) the extent of application, 4) results on the work or development environment.
• Vet the outcomes and targets of all components with partners so that the ultimate
targets of UNFPA and Partners in Syria are well known to all and so people can
more effectively brainstorm how to connect the components in reality. The idea of
connection should permeate all activities and these include tying together all
components in the RH such as EmOC, antenatal and FP with each other and with
the youth and community mobilization components.
• Steer presentations by partners to focus on outcomes and results from their work
as well as lessons and good practices and help them to share their successes and
why things worked based on evidence.

2. **Easing administrative hurdles to promote efficiency.** Many interviewees
mentioned the need to address these issues which affect program implementation.
• **Timing of funds allocation and receipt** – The MoH (Trust Fund) and UNFPA use
different fiscal years and releases of funds occur at different times, resulting in the
past in delays of up to three months in start up of program implementation. The
organizations have somewhat adapted to this reality but more accurate timing is
needed to allow programs to proceed. Activities that use Trust Funds should not
be programmed to begin until May.
• **Identification of consultants and trainers** – Several training activities have been
delayed or cancelled due to administrative issues in securing international
consultants and/or difficulty of locating qualified and available national
consultants. Most training activities using national trainers have proceeded on a
timely basis and national sources should be used when possible. However,
international expertise is often needed and processes to secure experts’ services
should be streamlined.
• **Equipment and supply quality** – Medical staff in clinics visited noted that some
UNFPA equipment was not of high quality, for example examination tables and
speculums. UNFPA has rectified some of the quality issues in the past few years
by using local purchase when possible, however, it should be noted that lower
quality equipment will need to be replaced earlier.
• **Strengthening commitment for sustainability.** The success of the program in
reaching the most at-risk populations will depend on the dedicated efforts of all
stakeholders. Some of the greatest constraints to promoting maternal health will
require feasible solutions, for example, to motivate midwives to serve in
disadvantaged areas, and to ensure that MoH staff has the motivation and the fuel
to reach rural clinic to help them improve their services. UNFPA and the MoH
RH department in coordination with the RH Technical Committee should
advocate for solutions to these very difficult and long term problems.

**Specific Objectives Evaluation:**

**Specific Objective 1:** Assess functionality of mechanisms for systematic
improvement of Emergency Obstetric Care (EmOC)
Relevance and Sustainability

UNFPA and the MoH have planned capacity development activities including training and “Beyond the Numbers” studies of the causes of maternal mortality, based on issues in EmOC that were identified in several studies. These included the following.

A study published in 2009 focused on deaths among women aged 15–49 reported to the national civil register for 2003 were investigated through home interviews. Verbal autopsies were used to ascertain the cause of death among pregnancy related maternal deaths, and causes and preventability of deaths were assessed by a panel of doctors. Direct medical causes accounted for 88%, and haemorrhage was the main cause of death (65%). Sixty nine deaths (54%) occurred during labour or delivery. Poor clinical skills and lack of clinical competency were behind 54% of maternal deaths. Ninety one percent of maternal deaths were preventable. The study concluded that the causes of maternal death in Syria and their contributing factors reflected serious defects in the quality of maternal care that need to be urgently rectified.

The UNFPA/MoH “Needs Assessment of eastern Governorates’ Primary and Referral Level Health Care Facilities with a Focus on Reproductive Health Care” (2006), includes many conclusions which are still relevant:

- Further actions are needed to address the main causes of maternal death, which are known to be hemorrhage (65%), hypertensive disease (11%), thrombo-embolism (10%), anesthesia (9%) and sepsis (5%)
- The 2006 study indicated that only obstetricians were allowed to perform the six signal functions, including administration of drugs, blood transfusions and c-sections, related to addressing the causes of obstetric complications. As of 2010, midwives and supervising MDs may administer life saving drugs such as magnesium sulfate and oxitoxiccs, anticonvulsants and antibiotics, but blood transfusions and c-sections are referred to hospitals.

The referral system from the antenatal centers to flag possible complications during pregnancy and from the normal delivery centers for emergency or critical care during delivery is important to save lives. However, the 2006 study notes that antenatal care is underutilized and thus emergencies must often be addressed through the normal birthing centers and hospitals. Since post-natal care is only utilized by 27% of the population, post-delivery issues such as sepsis may occur without proper post delivery monitoring.

Research was conducted on near miss cases from the years 2006-2007 at Damascus Maternity University Hospital, Syria 2005-2007 in a hospital in Damascus. This study concluded that hypertensive disorders (52%) and hemorrhages (34%) were the top causes of near-misses. Late pregnancy hemorrhage was the leading cause of

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maternal mortality (60%) while sepsis had the highest mortality index (7.4%). Most cases (93%) were referred in critical conditions from other facilities; namely traditional birth attendants’ homes (67%), primary (5%) and secondary (10%) healthcare units and private practices (11%). Around 26% of near-miss cases were admitted to Intensive Care Units (ICU). The study concluded that near-miss analyses provide valuable information on obstetric care and highlighted the need to improve antenatal care which would help early identification of high risk pregnancies. It also emphasizes the importance of both: developing protocols to prevent/manage post-partum hemorrhage and training health care professionals to manage infrequent but fatal conditions like sepsis. An urgent review of the referral system and the EmOC in Syria was highly recommended.

**Beyond the Numbers.** In 2009, the World Health Organization (WHO) published a consensus on maternal near-miss definition, (“a woman who nearly died but survived a complication that occurred during pregnancy, childbirth or within 42 days of termination of pregnancy”) and set a criteria for cases identification. High-quality care can prevent many maternal deaths. In order to understand how this care should be organized and delivered, much more needs to be known about the underlying and root factors leading to maternal death, which also lies behind the philosophy of **Beyond the Numbers.** Therefore, the **Beyond the Numbers** methodology was introduced by the Ministry of Health in 2009 with the technical support of UNFPA.

The **Beyond the Numbers** approach is considered by the majority of interviewees to be critical to the relevance and sustainability of a strategy to strengthen EmOC and reduce maternal and neonatal mortality. This approach has been used in many countries and consists typically of the following processes: 1) community based reviews (verbal autopsy); 2) facility-based review; 3) confidential inquiries; 4) “near miss” reviews and 5) clinical audit. In Syria, the step to conduct the verbal autopsy or community based assessment is planned but not yet implemented due to the unavailability of consultants. It could be particularly beneficial to bring community members into the process and to permit a greater understanding by the committee of the problems faced by women in the communities.

**Results**

**Maternal mortality indicators.** The maternal mortality ratio (MMR) in Syria has dropped significantly (58/100,000 live births as per WHO website, 2006 data). A presentation by the government in 2010 concerning the health situation in Syria notes that maternal mortality has decreased from 71/100,000 in 1999 to 52/100,000 in 2009 with predicted decline to 32/100,000 in 2015 and mentions that 90% of the deaths were preventable in 2005. In terms of progress toward the **MDG Target Number 5 by 2015** (Reduce by three quarters the maternal mortality ratio since 2000); the 2010 MDG Syria report notes that there is a substantial improvement in reducing the MMR at the national level. Increasing the ratio of births attended by skilled health personnel has taken place, in spite of continuing geographical disparities on the regional level especially in the Eastern region. Home deliveries have decreased from 44.9% in 2002 to 19.4% in 2009. The 2010 MDG Syria report attests that by continuing its efforts, it is possible for Syria to achieve MDG 5.

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5 MDG report summary on UNDP website (note: this website does not list UNFPA as a resource)
Infant (less than one year of age) mortality indicators. Infant mortality has declined slowly in recent years, from 18.2/1000 in 2002 to 17.9/1000 in 2009. The child mortality rate has increased from 20.2/1000 in 2002 to 21.4/1000 in 2009 (SAR data) and 68% of the deaths are due to newborn mortality. Therefore improving the quality of EmOC is relevant to preventing infant mortality.

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<tr>
<th>Baseline</th>
<th>Changes</th>
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<tbody>
<tr>
<td>Maternal Mortality Ratio</td>
<td>58/100,000 2009 (SAR)</td>
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<tr>
<td>58/100,000; Maximum Regional disparity: 81 in Al-Rakka; (UNDAF - date-before 2007)</td>
<td>46/100,000 (20-100)</td>
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<td>67/100,000 (39-108) 2000</td>
<td>UN Group estimate 2008</td>
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<tr>
<td>Lancet: Gates Foundation 2008</td>
<td>50/100,000 (28-84)</td>
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<tr>
<td>Infant Mortality Rate</td>
<td>17.9/1000 2009 (SAR)</td>
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<tr>
<td>17.1/1000; Maximum Regional disparity: 19.56 in Al-Hasakeh (UNDAF)</td>
<td>(SAR goal – 12 by 2015; UNDAF goal: 26.75 by 2015)</td>
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<td>2002 – 18.9/1000 (SAR)</td>
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Effectiveness and Efficiency

Mechanisms for supporting systematic improvement of Emergency Obstetric Care. Mechanisms used have largely consisted of training, provision of equipment and supplies, and supporting protocol acceptance. The EmOC clinical protocols were adopted in 2007 from “Advanced Life Support in Obstetrics” (ALSO) (see next section under Specific Objective 2 for more details) and promoting community awareness. Interviewees indicated that the mixture of options has been effective to addressing needs for better clinical skills, improvements in the maternal care system and strengthening the referral system. (These activities have been spread across the first three strategic objectives, including development and use of clinical protocols and strengthening the RHs.)

The following annual targets were reached:

2007. a) In the context of development of Emergency Obstetric Care (EmOC) clinical protocols and guidelines a book entitled "Advanced Life Support in Obstetrics" (ALSO), was translated and adopted by the Ministry of Health; b) Provision of RH-related equipment and supplies

2008. a) Antenatal care research and assessment of EmOC services; b) Upgrading skills and capacity of health providers in provision of basic and comprehensive EmOC though trainings on the newly adopted EmOC clinical protocols and guidelines; c) Creating an enabling environment and mechanisms to promote upgrading midwifery services through a contract with Jordan University Hospital for improving the knowledge and skills of the nursing and midwifery staff in antenatal, postnatal, and EmOC; d) Provision of RH related equipment and kits to all normal delivery centers, including those in the north-eastern governorates; one ambulance
was secured for one delivery centre in Al-Hasakeh; e) Increasing community awareness on EmOC and increasing demand for services at the three selected provinces. EmOC brochure on pregnancy related risk factors was designed by the RH technical committee, issued and distributed among all the concerned health facilities.

**2009.** a) first national workshop on the "Beyond the Numbers" concept was held in December; b) second national workshop on ALSO was conducted in October 2009; c) a regional expert was deployed to Al-Hasakeh and Al-Rakka governorates to provide on the job training in midwifery services; d) Numerous capacity building activities aimed at enhancing knowledge and skills of health service providers in the provision of antenatal care, emergency obstetric care, newborn resuscitation, early detection of cervical and breast cancer were conducted; e) conducting a training on RH programme management; f) MoH released clinical protocols/guidelines on antenatal and postnatal care; g) UNFPA procured the necessary medical equipment/teaching aids and audio visuals and two ambulances.

In 2010, the Annual Work Plan called for (and extent of achievement) the following:

<table>
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<tr>
<th>Output 1: Increased availability of comprehensive, integrated, quality reproductive health services and information, including family planning and emergency obstetric care in selected underserved areas</th>
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<tbody>
<tr>
<td>1. Proportion of women having obstetric complications correctly identified or referred at the three selected provinces.</td>
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<tr>
<td>2. Percentage of selected service delivery points offering at least three reproductive health services complying with upgraded clinical practice protocols and guidelines and quality services.</td>
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<tr>
<th>Strengthening emergency obstetric care (EmOC) system</th>
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<tbody>
<tr>
<td>Comments</td>
</tr>
<tr>
<td>Intervention needed couldn't be done</td>
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<tr>
<td>In order to prevent a duplication with the community mobilization</td>
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<td>The data is available but the printing has postponed to next year</td>
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<tr>
<th>Enhancing quality of safe motherhood services, including antenatal and postnatal care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comments</td>
</tr>
<tr>
<td>The expert was not</td>
</tr>
<tr>
<td>Available this year</td>
</tr>
<tr>
<td>--------------------</td>
</tr>
<tr>
<td>YES</td>
</tr>
<tr>
<td>YES</td>
</tr>
<tr>
<td>YES</td>
</tr>
<tr>
<td>YES</td>
</tr>
<tr>
<td>YES</td>
</tr>
<tr>
<td>YES</td>
</tr>
<tr>
<td>On going</td>
</tr>
<tr>
<td>NO</td>
</tr>
<tr>
<td>NO</td>
</tr>
<tr>
<td>NO</td>
</tr>
<tr>
<td>YES</td>
</tr>
<tr>
<td>YES</td>
</tr>
<tr>
<td>YES</td>
</tr>
<tr>
<td>YES</td>
</tr>
<tr>
<td>Improving the existing screening systems of early detection of cervical and breast cancer</td>
</tr>
<tr>
<td>YES</td>
</tr>
<tr>
<td>YES</td>
</tr>
<tr>
<td>Clinic staff note increase</td>
</tr>
<tr>
<td>in awareness, self exams and mammograms</td>
</tr>
<tr>
<td>----------------------------------------</td>
</tr>
<tr>
<td>The place where the training should be conducted is under construction</td>
</tr>
<tr>
<td>YES</td>
</tr>
<tr>
<td>YES</td>
</tr>
<tr>
<td>YES</td>
</tr>
</tbody>
</table>

### Supporting RH Research Activities

<table>
<thead>
<tr>
<th>It is about Menopausal and we still work on it.</th>
<th>On going</th>
<th>One research about one of the RH components</th>
</tr>
</thead>
<tbody>
<tr>
<td>The suggested researchers need to be modified and written in a better way</td>
<td>NO</td>
<td>Three operational researches in three different governorates.</td>
</tr>
<tr>
<td>Not been reported</td>
<td>Training courses on RH components, according to the LOU</td>
<td></td>
</tr>
<tr>
<td>YES</td>
<td>Continuous monitoring of the clinics through regular field visits</td>
<td></td>
</tr>
<tr>
<td>YES</td>
<td>Seminars on the use of Ultrasound to monitor pregnancy development</td>
<td></td>
</tr>
<tr>
<td>YES</td>
<td>Workshops on two different RH issues in Palmyra and Deir-Ez-Zor</td>
<td></td>
</tr>
</tbody>
</table>

### Securing high quality FP services and commodities

<table>
<thead>
<tr>
<th>The capacity of UNFPA office in Oman was very limited</th>
<th>NO</th>
<th>Study tour for senior health managers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guidelines well appreciated by clinic staff</td>
<td>YES</td>
<td>Printing of the newly prepared comprehensive FP guidelines</td>
</tr>
<tr>
<td>Clinic staff note increase in awareness, self exams and mammograms</td>
<td>YES</td>
<td>TOT training on the use of protocols/guidelines</td>
</tr>
<tr>
<td>YES</td>
<td>Refresher courses on FP (on the job training) according to the newly prepared guidelines</td>
<td></td>
</tr>
<tr>
<td>Due to administrative changes</td>
<td>NO</td>
<td>Training sessions on counseling and communication skills</td>
</tr>
<tr>
<td>YES</td>
<td>Ensuring provision of needed quantities of contraceptive supplies to all the health centers</td>
<td></td>
</tr>
</tbody>
</table>

### Strengthening the existing national logistic system and management of information system in support of reproductive health commodity security

<p>| YES | Training on RH/MIS software in all governorates |
| YES | Providing RH logistics/MIS with IT and office equipment |
| But the beneficiaries | YES | Study tour for MIS staff to |</p>
<table>
<thead>
<tr>
<th>turned into heads of RH in different governorates</th>
<th>Jordan or Oman</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>Printing of forms and registers used for provision of RH services at RH clinics</td>
</tr>
<tr>
<td>YES</td>
<td>Conducting monitoring visits to the North-East Area.</td>
</tr>
<tr>
<td>YES</td>
<td>Meetings for heads of RH sections.</td>
</tr>
<tr>
<td>YES</td>
<td>Meetings for RH supervision groups at the province level</td>
</tr>
<tr>
<td>YES</td>
<td>Conduct regular field monitoring visits to the primary health care facilities by the MOH staff</td>
</tr>
<tr>
<td>YES</td>
<td>Field visits conducted at the province level to the selected health districts</td>
</tr>
</tbody>
</table>

**Increasing community awareness of RH issues**

| NO                                              | Production and distribution of one educational booklet to the newly married couples. |
|YES                                              | Educational seminars in the selected governorates |
|YES                                              | Improving of media methods in the reproductive health domain |
|YES                                              | Weekly educational contests on the reproductive health issues through television and radio |
|YES                                              | Support quarterly meetings of the media network |
Training. As shown in the chart below, training over the past four years has reached less than half of medical personnel in the country. However, training to safe motherhood including EmOC, antenatal care, RH concepts and newborn resuscitation have reached more than 3,900 medical staff.

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Number of people who have been trained</th>
<th>Name of course – 2007-2010</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>88 obstetricians - 70 midwives</td>
<td>Advanced Life Support in Obstetrics</td>
</tr>
<tr>
<td>47%</td>
<td>960 midwives</td>
<td>RH concept and components</td>
</tr>
<tr>
<td>49%</td>
<td>1000 midwives</td>
<td>Antenatal care (refreshing courses)</td>
</tr>
<tr>
<td></td>
<td>780 physicians</td>
<td>RH concept</td>
</tr>
<tr>
<td></td>
<td>975 physicians and midwives</td>
<td>Newborn resuscitation</td>
</tr>
<tr>
<td></td>
<td>30 technicians</td>
<td>Pap smear diagnostic techniques</td>
</tr>
<tr>
<td></td>
<td>52 technicians</td>
<td>Pap smear diagnostic techniques (refreshing courses)</td>
</tr>
<tr>
<td>31%</td>
<td>640 midwives</td>
<td>Early detection of cervical and breast cancer</td>
</tr>
<tr>
<td></td>
<td>20 obstetricians-Gyn</td>
<td>Principles of cervical colposcopy</td>
</tr>
<tr>
<td>In each governorate one person at least has been trained</td>
<td>25 physicians</td>
<td>Operational Research in Reproductive Health</td>
</tr>
<tr>
<td>24%</td>
<td>500 midwives certified</td>
<td>IUD insertion</td>
</tr>
<tr>
<td>52%</td>
<td>1080 midwives</td>
<td>Family planning</td>
</tr>
<tr>
<td></td>
<td>160 midwives and physicians</td>
<td>Counseling and communication skills</td>
</tr>
<tr>
<td></td>
<td>20 physicians/head of RH division</td>
<td>Program management</td>
</tr>
<tr>
<td>Half of 2 major maternity hospitals staff</td>
<td></td>
<td>Infection control</td>
</tr>
<tr>
<td></td>
<td>50 obstetricians</td>
<td>Beyond the numbers</td>
</tr>
<tr>
<td></td>
<td>20 physicians</td>
<td>Mammography</td>
</tr>
</tbody>
</table>

Interviewees for this evaluation provided the following comments on progress achieved in the past several years.

- Midwives are much more confident in carrying out their duties related to EmOC due to training and refresher courses and are capable of carrying out infant resuscitation and administration of emergency medications such as magnesium sulfate.
- The number of referrals is increasing due to the awareness of the need to program potential complex deliveries to the hospital beforehand and to use ambulances to transport women who encounter complications during delivery which cannot be handled in the normal birthing centers to the hospital.
Patients in the clinics feel welcomed and well cared for by the staff and well informed about their options.

Ambulances provided by UNFPA are being used effectively to transport emergency cases.

**Challenges in strengthening EmOC**

One of the major challenges is staffing the rural clinics with midwives and means of transportation. Generally the midwives come from other areas and stay in the clinics over a period of two to three days to ensure 24 hour coverage. However, the difficulties in motivating the midwives to take on this posting include their reticence to stay in the rural areas and the fact that many of them also have private practices which they do not wish to leave. Other issues are securing transport and care for their children. The effectiveness of EmOC in terms of reducing national maternal and infant mortality is likely to depend on ensuring that vulnerable groups are included in all efforts to improve services and raise awareness. Over 19% of births are still carried out in homes.

**Issues in collecting maternal and neonatal mortality data in Syria:** The Ministry of Health RH Department has noted that maternal mortality data is very difficult to collect due to lack of a surveillance system and cases of failure to list the cause of death on death certificates particularly in rural areas, in addition to the inefficiency of the registration process in such areas. The MoH now requires daily tallies of deaths from the public health sector along with details on causes of death. Nevertheless, this action does not promote details on the associated risk factors. A number of studies have been undertaken including those mentioned above and a study on “Main Causes of Maternal Mortality”, partially supported by UNFPA in 2005, but the data needs to be verified and consolidated in order to promote well targeted programs.

WHO sponsored a regional “Consultative Meeting for Strengthening Maternal, Perinatal and Neonatal Health Surveillance Systems in the Eastern Mediterranean Region” (Beirut, 28-30 October, 2010) which featured presentations of good practices and issues in surveillance in countries around the region. Conclusions included the following:

- Continuing discrepancies in maternal and neonatal health data at the country, regional and global levels lead to uncertainty and inadequate response to maternal and neonatal health needs.

- Insufficient reporting, surveillance and information systems and poor quality of available data, jeopardize national efforts aiming at improving maternal and neonatal health

- Poor utilization of already available data in decision making and planning is hampering efforts for improving maternal and neonatal health and is resulting in inefficient use of already scarce resources.

**Results Based Planning for the Improvement of the EmOC.** A number of organizations will provide support for the establishment of a surveillance system in Syria which supports the vision of the government to: “Establish a surveillance system of maternal and newborn health at all levels”. Until this system is established,
likely to be a few years into the future, studies, compilation of data from the clinics around the country and sampling surveys are the main means of evidence for making decisions on where to place resources for EmOC. It is therefore critical that adequate resources are devoted to ensuring that the data analysis is based on valid data and enough skilled personnel are available to analyze it.

According to the SAR, the following data is available from the normal delivery centers: a) Numbers of births (Mulipara and Primipara), Number of referral cases, and Causes for referral and Status of mother when she discharges from health center.

The following data is available at the health center level:
• The number of pregnant women who visited the health centre
• The average number of visits for pregnant women
• The percentage of high-risk pregnancies between women newly enrolled to the center
• The percentage of high-risk pregnancies on the total visits
• The percentage of high-risk pregnancies according to causes (medical history – gynecological.)
• The percentage of referrals cases among beneficiaries of antenatal care services

Analysis was requested from the MoH for this evaluation; however, data could not be expeditiously validated and analyzed. It is recommended that a comprehensive data analysis on indicators relevant to the program takes place early in 2011 and well before the end of the CPAP cycle.

Beyond the Numbers (BTN). UNFPA has compiled a report on the progress thus far.
1) In December 2009 and October 2010, 43 senior health professionals from 14 governorates and members of the RH Technical Committee attended training and brainstorming processes and reached a common consensus on the practical steps of the Beyond the Numbers approaches.
2) The WHO Regional Consultative Meeting, mentioned above, confirmed that the Beyond the Numbers approaches should become part of the surveillance systems in support of generating qualitative evidence. During this meeting it was noted that the following countries succeeded in establishing or are on the way to setting up confidential enquiries into maternal deaths: UK, the Netherlands, France, South Africa, Moldova, Kazakhstan, Syria and Tajikistan.

Challenges faced in the BTN included: a) Legal and technical challenges related to the implementation of the surveys of severe morbidity (near misses). It might take some time to secure the necessary high-level endorsement/a decree; b) There is a need to reach a common consensus among all the stakeholders involved in the provision of maternal health care in Syria on the working aspects and framework of a committee on confidential enquiries into maternal deaths at the national and regional levels and c) Involvement of the private sector service providers.

UNFPA and Partners worked to address the challenges by: a) trying to secure the commitment of the Primary Health Care/RH Department of the Ministry of Health to operationalize the agreed upon approaches which would facilitate the high-level endorsement process, and possibly, potential involvement of other government bodies, including Ministry of Higher Education, Ministry of Justice as well as the
Syrian Society of Obstetricians and Gynecologists and private sector entities; b) building on the current achievements of UNFPA in securing technical support to the national initiative in introducing the **Beyond the Numbers** approaches, namely confidential enquiries into maternal deaths and “near-miss” case reviews, which should become part of the maternal, perinatal and neonatal health surveillance system; and c) facilitating inter-country/regional cooperation and knowledge sharing in support of establishing/strengthening public-private health sector partnership (e.g. benefiting from the American University of Beirut Medical Center expertise/experiential knowledge National Collaborative Perinatal and Neonatal Network).

In 2010, the Confidential Enquiry into Maternal Deaths (CEMD) committees have not yet been formed as MDs have not all been trained in the BTN approach. It is thought that the MDs need the training before they will commit to serving on the committees. Also the “Maternal deaths in the Community” training did not take place due to non-availability of international experts.

The next steps in the process include the following:
1. Gain commitment of the MoH Primary Health Care Department and RH Unit to secure the MoH decree;
2. Explore opportunities of potential involvement of other partners and government bodies, including Ministry of Higher Education along with its hospitals, Syrian Society of Obstetricians and Gynecologists and private sector entities would further enforce the operationalization process;
3. Conduct follow-up consensus building workshops (in addition to the second national workshop conducted in October 2010);
4. Reach a common consensus on near-miss case definitions in the context of prevailing local health problems and the availability of services.

**RH and CEMD Technical Committees.** The RH Technical Committee (RHTC) is composed of eminent physicians in the country serving in public and private practice and in academic settings. The RHTC is responsible for providing advice to the MoH RH Department and signing off on MoH RH activities and products such as protocols. Members of the group may also be commissioned separately for special activities such as developing guidelines.

In order to ensure systematic improvement, a national technical committee was established in 24 June 2007 (according to the decree No 4180 issued by his Excellency Minister of Health). The committee included the following members in addition to the project coordinator and directors:
- Head of OBS/Gyn Department at Damascus Maternity Hospital - University of Damascus
- Member of OBS/Gyn Department at Damascus Maternity Hospital - University of Damascus.
- Member of community medicine department – University of Damascus
- Head of Obs/Gyn Association
- Head of Al-Zahrawi Hospital –Ministry of Health.

In a focus group discussion for the evaluation, RHTC members expressed frustration regarding their TOR and further investigation revealed that there are actually two
versions of the TOR which are slightly different. Some members felt that the potential of the group was not being realized and that they could perhaps operate more effectively. The RHTC members also said they required a greater information flow from the RH department. The group members are all extremely busy and it is difficult to get them together, they do not meet as often as they are supposed to and this delays some decisions for the RH program. The situation with the RHTC is typical since most MDs have private practices in addition to their daily jobs and are strained for time. In this regard, the operation of the CEMD committees may be similarly constrained and this should be anticipated and measures put into place to promote efficiency. It was tentatively agreed by the RHTC members that a one day retreat could be beneficial to motivate and help the group to improve its effectiveness.

**Conclusions for EmOC**
- Interviewees confirmed the relevance of the support which is expected to lead to sustainable approaches for reducing maternal and infant mortality. The combination of mechanisms aimed to improve the EmOC, such as equipment and supplies, training, and initiation of “Beyond the Numbers approach” has been effective in building capacity, and improving emergency response and the referral system for high risk pregnancies.
- (Also a conclusion under Specific Objective 3) The health system is improving but still weak in connecting/integrating the various components of RH which contribute to prevention/reducing need for EmOC by reducing home deliveries, promoting birth spacing and healthy pregnancies and births. Antenatal care, family planning and post-natal care (which is largely missing) should be connected more firmly to normal birthing and EmOC. The connection to youth RH awareness and service provision is also weak but improving. The connections to the community are improving but require much more effort to achieve the reduction of obstetric complications and maternal and infant mortality.
- Lack of a surveillance system makes it difficult to assess impact on maternal and infant mortality but the planned actions to develop one should help to clarify results. Data recording at district level is manual and possibly subject to difficulties in collection and analysis but this information is crucial to showing improvements over time and for making decisions on placement of resources. The results of project inputs need to be tracked more carefully using surveys and periodic assessments.
- Process deliverables could have been more efficient if consultants are available on a timely basis, deliverables are programmed on time, and the RH Technical Committee meets regularly.

**Specific Objective 2: Assess effectiveness of RH clinical protocols focusing on family planning, antenatal care and emergency obstetric care in support of better utilization of the services**

**Relevance**
The 2006 UNFPA/MoH “Needs Assessment of eastern Governorates’ Primary and Referral Level Health Care Facilities with a Focus on Reproductive Health Care” recommended “developing, pre-testing and introducing clinical protocols on EmOC and post-natal care at the referral level hospitals and delivery centers”. The CPAP mentions the importance of adherence to nationally approved clinical protocols and
guidelines for antenatal care, family planning and EmOC. Of the needed guidelines, only those on family planning existed in 2009 but they required updating. Therefore, program outputs to secure the guidelines were extremely relevant.

It is noted that the CP addressed the needs for post-natal guidelines along with the antenatal guidelines but the RH services lack a postnatal aspect. However, the MoH is indicating its availability although not promoted. During the five-year preceding the HHS, only 27% of post-partum women in Syria use postnatal services and further analysis of the HHS findings would allow full understanding of the reasons for such low level. This need should be taken up in the next CPAP along with the establishment/promotion of postnatal services. Providing support for post-natal services falls within UNFPA’s mandate and does not fall within the mandate of UNICEF, for example.

Visits to clinics indicated that nutritional guidance provided to pregnant women is extremely minimal and that nutrition counseling guidance is important to be included in the antenatal and postnatal guidelines. There is ample opportunity to include nutritional advice in counseling sessions and development of simple guidelines can be undertaken in-country and annexed to the national antenatal and postnatal protocols. The MoH and UNFPA provide ferrous sulfate and folic acid supplements for pregnant women and the dispensing of these tablets would offer an opportunity for further nutritional counseling. Nutrition guidelines should take into account the importance of good nutrition to the health of the mother and baby, including appropriate calories, protein supplementation and essential nutrients for a healthy pregnancy. Ante/postnatal care related information, education and communication materials (including those related to lactation) should also embrace the local context and promote national food sources that are high in protein and essential nutrients, and provide advice on the cheapest option to supplement the women’s diet.

The use of private health care services is growing in Syria and many physicians and midwives operate their own private practices in addition to their daily jobs which may be in the public domain. Private services are preferred by some citizens for reasons of privacy and comfort and a belief among some that paying for services ensures better quality. A major challenge in promoting clinical protocols is including the private practice in standard setting and usage. While the private health care services are obligated to use national standards, there is no means of enforcement, for example, there is no history of lawsuits for malpractice as there is in many countries. The WHO is assisting Syria to develop a public health law in coordination with the Ministry of Health legal department.

The Society of the OBSs/Gyn was engaged in the program to help strengthen cooperation with the private sector. A number of seminars were conducted for members of the society and society members contributed to trainings.

Effectiveness and Efficiency

Program outputs were somewhat delayed and a few had to be cancelled, reducing efficiency, mainly due to problems with locating appropriate trainers. The Mid-Term Review and Annual reports mention the following activities.
2007: a) The EmOC clinical protocols were translated in 2007 from “Advanced Life Support in Obstetrics” (ALSO). The training on the guidelines by the Juzoor Foundation in was rescheduled to 2008 due to delays in getting visas for international trainers. (The guidelines were not widely adopted until 2009.) b) Two activities were designed in 2007 for upgrading midwifery services to be held at Dar'a National Maternity Hospital but no suitable trainers could be located; c) Three seminars were conducted for members of the OBS/Gyn including early detection of cervical cancer and importance of a national strategy for conducting pap smears; early diagnostic of fetal diseases; and antenatal care. In addition, the OBS/Gyn annual conference included recent RH scientific findings.

2008: a) Planned training on ALSO by the Juzoor Foundation had to be cancelled but was conducted by national experts for 24 participants; b) Upgrading skills and capacity of health providers in provision of basic and comprehensive EmOC though trainings on the newly adopted EmOC clinical protocols and guidelines;

2009: a) Systematic improvements in the performance of RH components continued through training, provision of equipment and supplies and upgrading facilities; b) The second national workshop on ALSO was conducted in October 2009 with the involvement of the consultants of the King Saud bin Abdul Aziz University for Health Sciences. The event resulted in the adoption of the national guidelines. c) Numerous capacity building activities aimed at enhancing knowledge and skills of health service providers in the provision of antenatal care, emergency obstetric care, newborn resuscitation, early detection of cervical and breast cancer were conducted; e) A resuscitation reference was translated into Arabic.

Development of antenatal and postnatal guidelines: In 2008, the antenatal and postnatal guidelines were developed by an international expert using WHO guidelines. However in 2009, the RH Technical Committee reviewed them and found them impractical. The audit and simplification of these guidelines was pushed to 2010.

Development of national Family Planning Guidelines and Protocols: Deployment of a regional expert who developed the first national FP guidelines/protocols, which was based on the four World Health Organization's cornerstones of family planning guidance, namely the Medical Eligibility Criteria for Contraceptive Use, the Selected Practice Recommendations for Contraceptive Use, FP Global Handbook and Decision-Making Tool for FP Clients and Providers. The technical expert conducted a workshop with the participation of the national experts and other concerned parties around the main outcome and recommendations of the mission.

As of 2010, 50% of the midwives have been trained in the FP guidelines and the remainder will be trained in 2011. The FP guidelines are available in the full training book form to the trainees. The planned pocket-guide was considered not practical as medical staff generally do not like to refer to a book while with a patient, so the WHO FP reference “wheel” will be distributed instead, which is planned for the near future.
It is important to note that although the protocol and guideline development process met with some delays, training of physicians and midwives went ahead in 2008 using the standards and guidelines that were already in place. This was critical to improve the KAP of medical staff as soon as possible. UNFPA and MoH staff members believe that careful vetting of the standards is necessary to gain acceptance from the majority of practitioners, although it took longer than planned.

Interviewees mentioned the following **impact of the accepted protocols** (EmOC and Family Planning):

- Midwives trained in the Family Planning guidelines reported a high level of satisfaction with the training and with the FP guideline publication.
- Midwives trained in FP said they were more confident in carrying out procedures, for example, the placement of IUDs.
- Doctors and midwives who received counseling training felt that they were better able to guide patients to make decisions about contraceptives and to make them feel that their privacy was important.
- In some clinics, those who were trained came back to their work places and trained other staff and shared the guidelines among them.
- The availability of brochures to be given to the public is helpful to promote KAP in family planning standards.

Some **challenges** mentioned by interviewees and in the annual reports include:

- Ventilation is a problem in the RH and FP service rooms. This was noticed in at least two FP facilities visited. In the summer, when it is hot, there is no air conditioning and this makes the patient and midwife very uncomfortable when placing IUDs, for example. Often the sterilizer is in the same room so that sanitized instruments are handy but this adds to the heat and discomfort. In one of these locations in Deir-ez-Zor governorate, UNFPA had renovated the counseling room and examination room, which had significantly increased satisfaction of both patients and staff, but the ventilation had not been improved.
- Despite the positive effects of training and FP inputs on the provision of services, men often control women’s access to birth control and cases were reported where women had IUD’s inserted and came back to have them removed as per their husband’s request.
- MoH staff in Aleppo mentioned the need to streamline the protocols and ensure that they are unified in terms of standards and not contradictory as well as being interconnected.
- In addition to the involvement of the OBS/Gyn Association, more progress needs to be made on coordination and collaboration with the private sector.

**Sustainability**

There are two major intertwined issues with sustainability and both related to professionalism and compliance.

1. **The standards found in the guidelines and protocols need to be followed up by the MoH.** Sustainability can be promoted if there are measures in place to judge compliance with the standards. These would include regular supervisory visits to facilities using the checklists established by the MoH and follow-up on the monitoring results. The constraints to regular monitoring by the MoH seem to be
mainly related to the need for greater motivation to visit the remote areas or crowded clinics where compliance with standards may be more difficult and this includes need for support for transportation costs.

It would also be important that procedures are visible to clients that is placed on the wall or given out on an information sheet. Procedures for sanitation and infection control were noted in one clinic, handwritten on a large poster but this was not the case in other clinics.

2. The private sector should confirm acceptance of the standards and guidelines and ensure compliance in their private practices. The program inputs to vet the guideline and promote their approval through the medical community followed by training of medical personnel should contribute to sustainable outcomes and since many midwives and physicians have private practices, they may be likely to use the guidelines in their own practices as well.

Conclusions for Effectiveness of RH Clinical Protocols

- The RH clinical protocol approach is relevant; however, the challenge is to enforce the standards in the private sector, which would enhance sustainability. The successful adoption of protocols requires supervision and monitoring to ensure compliance - constraints include need for transportation support; Unification of protocols between components services needs to be ensured

- Antenatal protocols will be rolled out next year. The FP protocols have been used in training by UNFPA/MoH and JICA. Partnerships with regional entities were useful for adaptation of the EmOC (ALSO).

- The nutritional aspects of both antenatal and post natal care need to be secured; however, taking into account the need for postnatal care, the related protocols, should be developed.

- The process of capacity development could have been more efficient; it was constrained by loss of time for implementation due to administrative procedures causing delays in study tours abroad, moving events into the next year, etc.

Specific Objective 3: Availability and access to RH services (e.g. Antenatal care, Family Planning and Early Detection of Breast and Cervical Cancers)

The MDG Target 2 aims to achieve universal access to reproductive health. The Syria MDG report 2010 mentions that nationally, the use of contraceptives has improved, unmet needs for women of reproductive age were reduced, adolescent births were substantially reduced, and antenatal coverage care has increased. However, the latter two rates are still below the prevailing level in a large number of Arab countries and developing countries in general. Moreover geographical disparities within Syria still represent a major challenge. Thus focus on increasing access to RH services is particularly relevant especially in disadvantaged areas.
Results

The CPAP Outcome 1 aimed to “increase access to and utilization of comprehensive quality reproductive health services and information, including family planning, with a special focus on the Eastern, Northern and Badia regions and other disadvantaged areas”. The Outcome Indicators are:
1. Contraceptive prevalence rate (CPR)
2. Proportion of births attended by skilled health personnel
3. Percentage of women with one or more antenatal visits during pregnancy
4. Proportion of young people aged 15-34 demonstrating correct knowledge of RH issues including family planning, HIV/AIDS/STIs

It is noted that there are no indicators on cervical and breast cancer detection and follow-up and these baselines and indicators should be included in the next CPAP.

A survey undertaken by the SAR, the League of Arab States, UNICEF, UNFPA, WHO and the Pan Arab Project for Family Health, called the Household Health Survey (HHS), required three years to complete and was published in 2010. It was published in two parts, one on Syrian respondents and one on Iraqi refugee respondents. The HHS offers data on marriage, fertility and family planning as well as maternal health.

1. The contraceptive prevalence rate⁶ in Syria noted on the CPAP is 58.3% as per the Multiple Indicator Cluster Survey (MICS), 2006, with 42.3% modern methods. The Household Health Survey (HHS) among Syrians indicates a somewhat lower usage rate of 53.9% among women aged 15-49 years, with 37.5% using modern contraceptives and 16.4% using traditional contraceptive methods. In either case, the use of family planning methods has increased from 46.6% in 2002 (as per SAR presentation, which seems to not be broken down into traditional and modern) to 53.9% in 2009.

Contraceptive methods include condoms, female and male sterilization, injectable and oral hormones, intrauterine devices, diaphragms, spermicides and natural family planning, as well as lactational amenorrhoea (lack of menstruation during breastfeeding) where it is cited as a method. UNFPA cites modern methods in Syria as modern spacing methods, pills, IUD or condom.

The governorates with the lowest usage of contraceptive rates among married women 15-49 include Deir-ez-Zor (by far the lowest with 17%) followed by Dar'a (40.2%) and Qunetira (40.8%). The targeted governorates in the UNFPA/MoH program are the East and North governorates and the Badia (eastern desert regions), which includes Deir-ez-Zor, however, Dar'a and Qunetira are in the southern area. According to this data, the CPR fell in Deir-ez-Zor from 37.8% (MICS 2006) to 17% which is surprising as this was a targeted governorate for RH activities. However, no

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⁶ WHO defines the contraceptive prevalence rate (CPR) as the percentage of women between 15-49 years who are practising, or whose sexual partners are practising, any form of contraception. The indicator is useful in tracking progress towards health, sex and poverty goals. It also serves as a proxy measure of access to reproductive health services that are essential for meeting many of the MDGs, especially the child and maternal mortality and HIV/AIDS goals. Statistics on contraception prevalence rates are based primarily on data reported by women, mainly because contraception is more easily measured in this way. In some countries the denominator is married women only, as (reported) sexual activity outside of marriage is considered rare
available data yet on the prevalence of modern methods by Governorates to assess real progress.

Al-Rakka and Aleppo rates are 46.4 % and 46.5 % respectively. The CPR in Al-Rakka was 33.7% in the 2006 MICS and thus has improved considerably. There are likely to be parts of urban areas which fall in the lower ranges due to the presence of most at risk groups (MARPs) in terms of reproductive health behavior. It is possible that contraceptive usage is higher than survey results would indicate as contraceptives can be purchased through pharmacies and private practices and some users such as males and unmarried people may be largely unaccounted for in the data.

It is noted that the fertility rate is not used as an outcome indicator yet reducing the fertility rate is a key concern of the government. There is a stagnated or slow fertility decline where the total fertility rate is still well above 3 and was 3.58 in 2004, and 3.6 in the HHS 2009. The mean fertility rate among Iraqi refugees as noted by the HHS is 2.6 for women 15-49 and total fertility rate of 1.7 in the past three years. The Mid Term Review has suggested that causes of the slow fertility decline requires a more specific study on the demand side of the family planning in order to best target resources. Due to lack of a recent analysis on this issue, assumptions can be made that the Family Planning activities have not progressed as hoped to address causes of fertility. Other possible reasons for the reported fertility rates may be statistical errors due, for example, to difficulty in fixing population numbers because of internal and in- and out- migration.

The CPAP target for the CPR was 65% for all methods and 49% for modern methods and it seems likely that this goal was too much ambitious and will not be attained (statistically) by the end of 2011. UNFPA provides contraceptives for the MoH clinics and all clinics visited reported adequate supplies of contraceptives. One of the factors behind the stagnation may be linked to the progress of the Family Planning Programme, which might have outpaced the increase in people’s demand for fertility control. Socio-economic and cultural, including gender factors are very important to take into account while designing further family planning interventions, which should not only focus on the supply side, but also the demand side of quality family planning care. It is also essential to focus on the quality aspects of the supply side. UNFPA’s Contraceptives Agreement signed with the Government in 2006 included annual payments of US $700,000 totaling to US $2,800,000 for the four-year period. However, based on the demands for the modern contraceptives the total amount of the utilized resources only reached US$ 1,851,235 for the period of 2007-2010.

Some major reasons for weak demand for or fluctuating use of contraceptives as expressed by interviewees in this evaluation (and indicated in previous studies) include:

- **Traditional and deeply felt desire for a large number of children** – Women in rural areas in particular are encouraged by their spouses and families to produce large numbers of children, and high fertility rates are a source of prestige and satisfaction. Modern youth also express a desire for more than two children (the average number desired is four). The Syrian Household Health Survey (2010, data collected from 2008-2010) indicates that 4.2 is the average number of desired children among Syrian women interviewed while it is 3.2 among Iraqi refugees
interviewed. Responses among youth interviewed in one focus group for the evaluation indicated that (urban, well-educated) young women preferred to have 3-4 children while young men preferred to have one or two.

- **Male attitudes** – Due to desire to have large numbers of children, males may actively oppose use of contraceptives. Nurses and midwives in several clinics described situations where a woman has had to return to the clinic to have IUDs removed due to opposition by their spouses.

<table>
<thead>
<tr>
<th>Baseline</th>
<th>Changes</th>
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<tbody>
<tr>
<td><strong>Contraceptive Prevalence Rate</strong>&lt;br&gt;58.3% / 42.3% modern methods (2006 MICS) (youth not surveyed?)</td>
<td><strong>Contraceptive Prevalence Rate</strong>&lt;br&gt;53.9% (GovSAR) 2009</td>
</tr>
<tr>
<td><strong>Unmet needs study</strong> (2006) 64.2% usage</td>
<td><strong>UNDAF goal:</strong> 55% modern methods among married couples by 2015; <strong>SAR goal = 60% by 2015</strong></td>
</tr>
<tr>
<td><strong>Women with unmet needs = 14%</strong></td>
<td><strong>Fertility Rate</strong>&lt;br&gt;3.5&lt;br&gt;2009 (SAR and HH)</td>
</tr>
<tr>
<td><strong>(there is no UNDAF goal; SAR goal not stated)</strong></td>
<td><strong>Use of Antenatal Services</strong>&lt;br&gt;87.7% (HH survey for five years prior)</td>
</tr>
<tr>
<td><strong>84% (2006) MDG Report</strong> 2010</td>
<td><strong>CPAP Goal unclear on PTT, SAR goal – 99% by 2015</strong></td>
</tr>
</tbody>
</table>

2. **Proportion of births attended by skilled health personnel.** The 2006 MICS reported that approximately 93% of births were attended by skilled health personnel with the lowest level in Al-Hasakeh where the figure was only 80.3%. Based on the HHS report the percentage of deliveries attended by skilled health personnel is about 96.2% while the percentage of deliveries in health institutions during the five years preceding the survey reached 78.2%, with a greater increase in urban areas (83.4%) than rural areas (72.1%). (However, skilled personnel may work outside of institutions so these figures may be misleading.) The SAR data reports that home deliveries still constitute a relatively large proportion of the total deliveries (20%).

3. **Percentage of women with one or more antenatal visits during pregnancy.** The CPAP baseline was taken from the MICS (2006) which indicated the percentage of women using antenatal services is 85.3%. The MoH Statistical report indicated that the average number of antenatal care visits was 2.7 and the lowest average number of visits was reported in Deir-ez-Zor at 1.5. According to the HHS, the percentage of women who were provided antenatal care in the last live birth during five years preceding the survey reached 87.0%. However, the percentage decreases with a higher birth order, 94.6% with the first child declining to 74.5% by the seventh birth.
The CPAP PTT does not specify a target percentage for increase but an increase is desired in Deir-ez-Zor, Al-Rakka and Al-Hasakeh. Increases are noted during the CPAP in both Al-Rakka (80.6 to 85.6%) and Al-Hasakeh (82.7 to 86%) while the percentage in Deir-ez-Zor has decreased from 81.7 to 78.2%.

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**Experience of Two Women in Normal Delivery and RH Clinics**

The evaluator interviewed a woman who had just given birth in the Al Kisraa normal delivery clinic located in a low income rural area. She was 20 years old and had just delivered her fourth child, having married at age 14. Her husband works in Lebanon for most of the year. She was accompanied by two aunts, one having 16 children, one with six and her mother who had five children. Her first two children were born in Damascus and her second two children had been born in the local normal birthing clinics. She praised the excellence of the midwifery skills and expressed complete confidence that the midwives would ensure that if she had any complications in delivery they would address them successfully and she would be taken to a hospital immediately by ambulance if necessary. She intended to use birth spacing in the future through the RH clinic Family Planning services. She and her aunts mentioned that male attitudes are a major barrier to women using birth control.

In Aleppo, the Jamal Abdel Nasser health clinic which serves a lower income area, a client who was interviewed privately had lost her first two children when giving birth at home, the newborns could not be revived by the birth attendants. She then had her next two children using a private doctor and her next four children using the public normal delivery clinics, resulting in six live births. She was very satisfied with the services as they are free and she has seen the services improve over the years. She was in the clinic for a pap smear and had learned that these tests were important through her association with the clinic midwives through antenatal care and also through information that was available in her community.

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**Effectiveness and Efficiency**

The CPAP Output indicators relevant to availability and access to RH services are as follows:
1. Number of health service points offering at least three RH services (antenatal care, FP, RH conditions).
2. Proportion of health facilities (normal delivery points, and health centers) providing quality RH services in accordance with the established protocols on FP, antenatal care and EmOC. (Discussed under specific objective 2)
3. Mechanisms to ensure systematic improvement in the performance of different components of EmOC. (Discussed under specific objective 1)
4. Percentage of health service points providing at least three modern FP services
As mentioned in the Mid-Term Review, annual targets generally do not match overall CP targets; therefore progress toward the outputs is difficult to follow. The baseline number of health services offering at least three RH services was 1378 out of 1700: Ar-Raqqa 38/54, Hassakeh 69/78, Der-ez-Zor 81/86, and the target was 1,400. Due to the inputs to the clinics, such as training, supplies and equipment, the target was likely to be reached. The baseline for the CPAP was 84.33% facilities which offered 3 types of modern contraception. As mentioned above, usage of contraceptive stocks is less than desired.

The following are among the numerous achievements, noted in the Mid-Term Review (from 2007 to 2009) since the start of the CPAP 7. Please see charts under Specific Objective 1 for activities accomplished in 2010 and Training achievements.

a) Strengthening emergency obstetric care system (EmOC): Obstetric services were identified in 6 areas in the eastern region, emergency obstetrical cadre of doctors and midwives is partly available and functional all over the country, specialized emergency obstetric care guide is available for trainers and 11 natural birth centers are operational with qualified cadre and necessary equipments.

b) Enhancing the quality of safe motherhood services at health centers: 2800 doctors and midwives of health care and natural birth centers were trained for safe motherhood and postnatal services, RH services’ supervisors at governorate level are qualified in fields of training, quality of services and RH management, an Arabic guide about infant care is under development, maternal mortalities are monitored (MM beyond figures), Midwives technical and administrative services at Al-Hasakeh, Qamishly and Al-Rakka hospitals improved, an international midwives’ guideline was made available in Arabic for schools and hospitals, and infrastructure of six health care centers in the eastern region were improved.

c) Strengthening family Planning services: RH information systems of Iran, Egypt and Oman were adopted in the Syrian system, National family planning guideline is in the process of printing, 1200 midwives were trained to provide FP services, 160 doctors and midwives were trained in the area of communication and counseling, FP tools and publications are available in health care centers, 123 centers for RH (Contraceptives) were added to providers list, developed computerized system is in use in governorates and districts warehouses and information system operators are trained.

d) Improving the existing early detection of cervical and breast cancer screening system: cervical cancer detection centers are equipped with qualified technicians, cervical cancer detection services providers are available in 400 centers, 50% of breast cancer detection services are done through trained specialists.

e) Supporting RH research activities: at least one trained researcher is available in each governorate and RH researches are adopted to mitigate problems facing services’ provision.
f) Developing a specific and culturally sensitive communication strategy: the community is more aware about RH issues by means of TV&R competitions and informative press messages. Informative RH publications are available in service provision points and a network of journalists promote RH issues.

g) Strengthening partnership with NGOs and private sector: 1000 private doctors developed their skills and knowledge in the field of RH and staff of FPA clinics were through continuous training.

h) Integrating RH/RRs into relief operations and emergency programmes: within the humanitarian component dealing with the Iraqi refugees the following RH activities were recorded in the review period: In cooperation with MoH, 59 health centers in Iraqis concentration areas were equipped with medical equipments and materials including emergency health pack, In collaboration with UNHCR and SARC, RH clinic of UNHCR headquarter was supported, with support of SARC mobile RH clinics were provided, Syrian Family Planning Association and Alraee AlSaleh Monster supported the provision of personal hygiene packs and finally, the Syrian Association of Development and Health Enhancement supported the provision of awareness campaigns, training of health care providers and personal hygiene packs.

It was noted by the Mid-Term Review that some of the key activities stipulated in the CPAP7 document were not attained such as: supporting the provision of RTIs/STIs services and supporting provision of RH services to moving communities.

**Usage of the Public Health Clinics:** An expressed goal of the MoH and UNFPA is to increase usage of the public clinics. According to the HHS 2009, the percentage of women ages 15-49 using private doctors services (67.4%) far exceed those using public services (18.2%). According to some midwives who work in both the public health and the private sector, there is no valid quality-related reason why people prefer the private practices, as professionally the public sector offers equally high quality; the main reasons seem to be privacy related to personal information and personal space and treatment, and belief that paying for the service means a better service.

In terms of what has worked to increase usage, the following was noted:

- Public awareness campaigns were noted to have helped. It was observed in one clinic that large numbers of people come in during the vaccination campaigns, which are widely advertised, and this could be capitalized upon and women urged to use the RH service during the same visit.
- In most clinics visited, medical staff tries to follow-up with women who do not show up for their antenatal visits or for follow-up on test results, by locating and communicating with them in the community.
- The reasons women attend the public clinic have to do with their confidence in the medical staff as well as the equipment in the clinic, the ultrasound and colposcopy technology is important to have, (some of the equipment in some clinics are not the most modern, being between 5-10 years old), as well as the mammogram and pap smear analyses.
- Renovations offer value added due to promoting a high degree of satisfaction for both clients and staff, improvements in sanitation, and according to staff being one reason for increase in use of the clinic.
- Some medical staff uses their own computers to collect data and keep records on their clients; it was thought that the larger clinics should be equipped with computers to promote more efficient data collection.

**RH Capacity Development**

Training has largely been evaluated only at the first level using the Kirkpatrick model, employing before and after tests and a course satisfaction questionnaire. The MoH keeps records of these results from training courses (a sample of course evaluation analysis was requested but this was not forthcoming) but it needs to be systematically followed up based on solid results, at the 3 month, 6 month and 1 year outcomes.

In 2008, UNFPA Syria explored opportunities of creating an enabling environment and ensuring innovative capacity building approaches and mechanisms in support of upgrading midwifery services and enhancing monitoring/measuring of effectiveness and impact of trainings for midwives according to Kirkpatrick's evaluation model. A regional expert was deployed to the North-Eastern and Western governorates of the country: 1) to conduct a rapid assessment of training needs previous capacity building initiatives and the related methods of clinical exams; and 2) to provide on the job training in midwifery services, which was seen as an innovative approach in building capacity of midwives.

The results of the initial assessment demonstrated that that extent of the knowledge transfer i.e. practical application and outcome of the acquired knowledge from training initiatives for midwives were not up to the desired standards and required a more innovative approach of training and evaluation of midwifery practices vs. traditional training activities.

In 2009, the regional expert was deployed to Al-Hasakeh and Al-Rakka governorates to provide on-the- job training in midwifery services, which was seen as an effective approach in building capacity of midwives and worthy of replication vs. traditional short-term trainings outside their duty stations/clinics.

It was also proposed to opt for Objective Structured Clinical Exams (O.S.C.E) as an effective method of evaluation of knowledge and clinical skills, which is more comprehensive, systematic and objective and provides a uniform basis for assessment of theoretical knowledge and clinical/practical skills of midwives working in hospital settings. As it is known O.S.C.E. involves a circuit of short stations, in which each candidate is examined on a one-to-one basis with an examiner and simulated patients.

**What worked well?** As a result of the implementation of the above strategies the following have been secured:
- On-the- job trainings for midwives and the use of O.S.C.E for measuring the strengths and weaknesses of the midwifery education/training programmes with the subsequent recommendation for further enhancement;
- Guidelines/policy document in support of upgrading midwifery services for the initial application in Tartous governorate (a clinic);
A plan for upgrading midwifery services, including a system for establishing a Continuous Education Unit at the hospital level;

Job descriptions for the concerned health staff working in obstetrics wards.

The evaluation interviewed three medical doctors who were trainers in Aleppo governorate. The issues that were raised included:

- The doctors are limited in their flexibility to conduct training due to their need to be on call for medical emergencies and deliveries both in their public and private practices, even though they try to cover for each other, thus they need more support and incentives to take the extra time and effort.
- The training facilities need more user friendly inputs such as proper seating arrangements, good projection equipment and screens and more modern and quantity of manikins that the trainees use to practice on (this has been a recurring request for a number of years, as per the Annual reports).
- The head of the RH department in Aleppo has advocated for high quality of training and is a champion in this respect who is able to motivate doctors and midwives to give their time to training and her example should be communicated to other governorates. Training evaluation will be expanded to include the extent of application in the work environment as per the Kirkpatrick model.

Conclusions for access to RH services

- Training, equipment and supplies, BCC and infrastructure improvement have been effective in promoting RH services and increasing capacity and satisfaction of users and staff, Indicators show decrease in CPR, stagnant Fertility and discrete potential increase in HIV/AIDS. The FP services require a focused effort to improve usage and results.

- Inefficiencies include poor quality and delays of some equipment and supplies provided by UNFPA, resolved partly by local purchase; contraceptives, drugs and supplements supply is efficient (Also a conclusion under Specific Objective 1). The health system is improving but still weak in connecting/integrating the various components of RH which contribute to prevention/reducing need for EmOC by reducing home deliveries, promoting birth spacing and healthy pregnancies and births. Antenatal care, family planning and post-natal care (which is largely missing) should be connected more firmly to normal birthing and EmOC. The connection to youth RH awareness and service provision is also weak but improving. The connections to the community are improving but require much more effort to achieve the reduction of obstetric complications and maternal and infant mortality.

- The program design and inputs are relevant. Relevancy, effectiveness, efficiency and sustainability would be increased by reaching families with KAP barriers to use of FP services through outreach and the community mobilization models, linking the services, more efficient means of data collection and analysis, better planning for results, better coordination with other RH supporting organizations and less transfer of trained MoH staff.
**Specific Objective 4: Validity of strategies and approaches for the HIV VCCT domain**

**Relevance and Sustainability**

Support to the Voluntary Confidential Counseling and Testing Services are part of the support to the National AIDS Program (NAP) of the Ministry of Health. The Government demonstrates a high level of commitment to maintain the low prevalence rate of HIV in the country and to strengthen the national response in support of the health outcomes of the National Development Plan. Integration of HIV/AIDS prevention, care and treatment in the 10th Five Year National Development Plan (2006-2010) was achieved with the support of UNFPA. The NAP office has played the most important role in the HIV/AIDS response to date. However, frequent turnover in leadership and staffing/productivity issues may have prevented it from delivering its full potential given the level of experience accumulated since its inception in 1987 (short- to medium-term). The NAP now has new leadership and is moving forward on implementation of the national strategy.

Most recent estimates provided by the NAP indicate that the HIV virus may be spreading with some speed. It reveals that the total number of accumulated HIV/AIDS cases in Syria reached 519 in the first quarter of 2008. The sources show that about 85% of HIV infected people are under 39 years of age, 34% of cases are among young people aged 15-24, and the male/female ratio is 3:1. The modes of transmission are: sexual 83%, contaminated blood/blood products 10% (sources indicate that infection through blood transfusion took place before 1992, of which some outside the country), intravenous drug injections 4%, and, mother to child transmission 3%.

Although HIV/AIDS prevalence is low, there is a growing concern about the risk factors that make Syria susceptible to a predictable increase, including patterns of drug use, in particular injecting drug use (IDU), socio-economic disparities in key indicators, such as unemployment and access to social services, and limited access to information and prevention services, due to social and cultural barriers. Thus the challenge faced is to maintain low prevalence rate and also to increase effective detection mechanisms.

The VCCT’s services are integrated within National AIDS Programme laboratory services, but not within the primary health care and maternal health facilities. There are 14 VCCT sites operated by the Ministry of Health, 10 by the Syria Family Planning Association (SFPA) and 1 by the Red Crescent. UNFPA in its efforts to strengthen this system has been investing in the NAP and health service providers, through supporting training activities including fielding a study tour to Belgrade Center for Students Health and VCT Center. This activity resulted in developing the National VCCT protocols, ensuring confidentiality and privacy. The protocols were further reviewed in light of the new practice of Provider Initiated Testing and Counseling (PITC) supported with training of the NAP staff. However, it is to be noted that HIV testing is not only voluntary but there is a mandatory testing, which can have a negative impact on encouraging voluntary testing and overall prevention efforts.
Assessments: UNFPA supported studies such as the SARA report, the UNGASS report and a mapping study on high risk groups, which have provided insights into the best investments for preventing and detecting HIV and STIs and for follow-up on cases.

The SARA report (HIV/AIDS Situation Analysis and Risk Assessment) of January 2009 warns of increasing higher risk conditions that may increase transmission. The overall cultural context does not create an enabling environment for preventive measures such as promoting condom use. Populations at risk remain understudied and are scarcely covered by preventive programs. Relatively little is known about the prevalence of HIV and STI’s in the high risk populations.

The UN General Assembly Special Session on HIV/AIDS (UNGASS) reported on the period January 2008 to December 2009 in Syria. The study recommends targeted action oriented prevention such as condom distribution and clean needle exchange programs.

Mapping studies conducted in late 2010 on MSM, FSW and Prisoners revealed some important information regarding the KAP of the MARPs and provided suggestions for the best way to proceed with program development and potential partners.

Effectiveness and Results

Results Summary statement – All targets for the VCCTs have been accomplished. UNFPA has equipped 12 VCCT centers and they are applying adopted protocols and guidelines in the three programme governorates (Al-Rakka – Al-Hasakeh – Deir-ez-Zor) including the central VCCT in Damascus and in Idleb. There should be a national indicator on HIV/AIDS which guides the program on the CPAP/PTT. UNFPA’s program has addressed several concerns in the UNGASS report, such as support to a national strategic plan, support to civil society organizations for prevention and response, support to M&E systems, and mapping activities on the MARP. The report noted the need for support to the PLWHA and expansion of the VCCT clinics nationwide. To be more effective, the VCCTs need to seek and include more of the Vulnerable Groups in the services as soon as possible.

Support to the VCCTs fall under CPAP Output 2: Increased availability of reproductive and sexual health information and counseling services for young people with a special focus on the prevention of HIV/AIDS and STIs among the population at risk.

Key Activity: Strengthening VCCT services and support to the NAP of the MoH.

The following accomplishments are noted:
- Setting quality standards by development of the national protocol of VCCT, promoting adoption of the standards and providing training
- Assessment of the performance of the national VCCT centers (2009)
- Study tours to Bulgaria and Tunisia
- Increasing linkages with NGOs and SARC to testing services
• Assessments of needs and provision of supplies and testing kits to VCCT centers

**Key Activity:** Creating demand through culturally sensitive communication strategy including comprehensive BCC initiatives

• National guidelines concerning youth education about HIV/AIDS and journalist guidelines about HIV/AIDS were published and distributed
• Increasing the media bases for coverage of HIV/AIDS activities
• The SARA study on populations at high risk is completed to contribute to the National Strategic Plan

The 2010 accomplishments included:

1. Building the capacities of 18 MOH/NAP staff on M&E, in terms of principles of M&E especially in light of the current national efforts in developing a national AIDS monitoring and evaluation (M&E) plan, the of barriers to proper M&E and approaches to overcome such barriers, overview of the various stages of M&E based on activity/project phase, the importance of including M&E in the planning process and the linkage between both and the overview of the five stages of evaluation.
2. Building the capacities of 15 MOH/NAP staff on Mapping of high risk groups (FSWs and MSM), where 250 questionnaires were filled among these groups.
3. Building the capacities of 40 SFPA Midwives/Counselors on VCCT services and skills, which are provided in the 19 SFPA clinics nationwide and the provision of 1000 Rapid Test Kits.
4. Improving the HIV/AIDS testing services through the provision of CD4/CD8 kits to the main MOH Laboratory in Damascus.
5. Improving the VCCT services of the MOH through the provision of 6000 Rapid Test kits, training of staff on VCCT (PICT approach) and the support to the main HIV/AIDS testing center in Damascus (Electronic Queue System) which was launched by the Minister of Health and UNFPA to improve the efficiency and the confidentiality of the services.
6. Production of two TV spots by MOI and MoH on (HIV/AIDS) with the participation of the most Syrian Artists to help in advocating for VCCT services and HIV/AIDS prevention. The spots will be shown regular on Syrian satellite TV channels (public and private).

The evaluator visited one contagious disease testing center "Professional Centre for Diagnosing Infectious Diseases (Zablatani)" and one VCCT center in Damascus. The attendance at the VCCT has declined slightly from 2009-2010. The center serves approximately 200 people per year; case detection in 2010 was approximately 20. Some accomplishments include:

• Several measures to further protect privacy have been put into place including the queue system which calls people to the testing area by number
• Information campaigns seem to result in increases in clinic usage but usage tends to also be seasonal
• All the protocols are in place and training has been very useful for improving quality.
Some of the issues in effectiveness include the following:

- Even though confidentiality is part of the concept, some people do not have a high degree of confidence in the privacy aspect. This is because once people agree to be tested and counseled, they develop a relationship with the staff and some then feel that it is no longer private; the data concerning their case is recorded and used for informational and statistical purposes and some become suspicious that their identity will become known.

- People who wish to protect their identities generally seek testing in private practice and many go to Lebanon.

- There is a serious stigma affecting People Living with HIV/AIDS among medical personnel and this impedes their successful support and treatment, some special services have been set up for PLWHA including dentists who only work on this target group.

Although more focus has been advised in the CPAP and the Mid-Term Review on addressing RTI and STIs, the STD testing center at the VCCT clinic has been discontinued as it was expensive to maintain and testing can be done elsewhere. The 2010 activities included development of STI protocol for the RH clinics.

The major challenge for impacting the rate of testing and counseling is the need to seek out the high risk populations and these tend to be people who are hard to attract or will not come into a clinic setting. The Vulnerable Groups mentioned by the VCCT staff in Damascus include: ages 16-25, females, illiterates, drug users, sex workers (artists), MSMs, very poor, and migrants. The VCCT and other entities with similar mandates need to reach out to the communities and offer something like mobile testing. (The SARA report mentions a large number of groups that may be vulnerable to HIV: female sex workers (FSW), heterosexual men with multiple sexual partners, men who have sex with men (MSM), young people, injecting drug users (IDU), truck drivers, sailors, prisoners and refugees.)

The above findings support the UNGASS (2010) finding (page 14): “Findings from testing conducted at these VCT centers do not reveal a high case detection rate. Furthermore, there is little evidence on what roles exactly these centers play in providing support for PLHIV or their attempts to target/attract MARPs.”

**Efficiency**

Although no cost comparison is available to other testing and counseling methods, the cost of supporting the centers is said to be expensive. Based on the assessment above, UNFPA should determine whether support to the VCCT’s is the most cost effective means of detection and service to positive cases, and whether the services can be extended further into the communities to be more effective in prevention and detection.

**Conclusions for VCCT Strategies**

- Equipment, supplies, counseling and BCC are effective as are approaches designed to protect privacy and encourage testing; Operational and sound VCCT system and protocol supported opportunities to deal with HIV/AIDS; Issues include level of trust and stigmas in society and follow-up treatment for PLWHA.
- The VCCT needs to be more efficient in serving high risk (MARP) or missed groups such as ages 16-25, females, illiterates, drug users, sex workers (artists), MSMs, very poor, and migrants
- Relevancy would be increased by closer linkages between the RH and HIV/AIDS departments within the MoH and more community outreach; Sustainability is promoted by high government commitment to prevention and the National AIDS Committee, and the NSP.

**Specific Objective 5: Relevance of approaches to reach out to youth with RH STI/HIV/AIDS messages**

**Relevance and Sustainability**

The importance of targeting youth with RH messages cannot be understated. Studies mentioned in the previous section underscore the need for targeting youth as a high risk population in itself and taking strong measures to reach the most at risk groups among youth. In Syria, young people aged 10-24 represent 36.3 percent of the total population. As of 2008, there were slightly more than four million Syrians between the ages of 15-24, accounting for 21 percent of the population (CBS, 2009). This proportion of young people suggests the need for development initiatives that are specially focused on the young. Investing in young people to develop their full potential will reap long-term dividends and contribute to the sustainable development of the country. As a result, the 10th National Development Plan (NDP) for 2006-2010, with the support of UNFPA, places increased emphasis on young people’s development, participation in development and empowerment.

UNFPA has been supporting the Syrian Commission for Family Affairs (SCFA) in taking the steps to articulate a National Strategy for Young People, the objectives of which will be realized within the overall national development framework. UNFPA is supporting Youth centers (Youth Development units) and Adolescent Health Centers in the three programme governorates, to provide a comprehensive, life skills-based education. UNFPA support is focusing on working on building the national capacity for delivering quality youth friendly education, information and counseling services, adapted to local and cultural context, and enriching libraries with essential literature on youth development, reproductive health and HIV/AIDS, supporting outreach activities and provision of EDP equipment in these centers.

These efforts are complemented through supporting the establishment of an effective national peer education network (see next section on YPEER); through expanding the partnership with and building capacity of youth organizations and NGOs active in this field; which will be further supported with peer education training materials adapted to local/social context, and using Behaviour Change Communication (BCC) interventions. The support will also empower young people to actively participate in creating innovative entertaining and ways to reach their peers with information and educational messages such as Theatre-Based Education and outreach activities and awareness raising campaigns.

The NGOs and networks collaborating with UNFPA are largely well established and have several streams of funding and support. Government commitment to address
issues of youth is very strong and will contribute to sustainable gains in influencing youth behaviors. It is noted; however, by interviewees that social pressures negatively influencing youth behavior may be gaining in strength, thus concerted and coordinated efforts are particularly needed at this time.

Effectiveness/Results

The output indicator is: Proportion of young people aged 15-34 demonstrating correct knowledge of RH issues including family planning, HIV/AIDS/STIs. The CPAP goal is to increase youth awareness by 10%; however, the available data does not match the indicator. The data of the quantities study of youth empowerment and social mobilization showed that 75% of the surveyed sample is aware of the HIV/AIDS as a result of media campaigns. (This was found in the Mid-Term review, but no source or what they are aware of.)

The HHS 2009 indicates that 82% of women who have ever been married aged 15-49 years have knowledge about HIV/AIDS. Knowledge in this group regarding other STI/STDs varied with the type from 21- 57%. This may be seen to be an improvement, however evidence of changes in behavior including increased use of services, should also be included in the output indicator.

The relevant outcomes are:

SP Outcomes 4 and 5 concerned with demand, access to and utilization of quality HIV and STI prevention services, especially for women, young people, and other vulnerable groups, as well as access of young people to SRH, HIV and gender-based violence prevention services, and gender-sensitive life skills-based SRH education.

<table>
<thead>
<tr>
<th>Baseline</th>
<th>Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>UNGASS indicator - % of age 15-24 who can identify modes/methods</td>
<td>82% of never married women 15-49 have knowledge about preventing AIDS (HH survey)</td>
</tr>
<tr>
<td>(UNICEF/MOH women’s survey 2006) heard of HIV/AIDS = 78%; modes of transmission – 7.9% other KAP surveys 2006</td>
<td>Youth survey (2008) 76.3% knew about HIV AIDS while one out of ten (9.9%) showed knowledge of syphilis for instance (CPAP goal – to increase youth awareness on AIDS by 10%)</td>
</tr>
<tr>
<td>Most data 2005-6</td>
<td></td>
</tr>
<tr>
<td>HIV/AIDS prevalence 552 cases of HIV from 1987 to 2008 (216 of which were AIDS cases)</td>
<td>Discrete increase; Vulnerable Groups are understudied and tested (SARA, 2009)</td>
</tr>
<tr>
<td>PLWHA 2007, the total number of people living with HIV was 182</td>
<td></td>
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</tbody>
</table>

Assessments: As described in the previous section, UNFPA has supported or contributed to the SARA, UNGASS and Vulnerable Groups mapping studies and has modified the youth programs according to recent findings and recommendations. Assessments of the needs for youth have been undertaken in 2008.
The following achievements were noted from 2007-2009:

- Alliances were reinforced and expanded with NGOs, peer leaders, faith based organizations and community mobilization. Partners included the Ministry of the Interior, Syrian Family Planning Association, the Revolutionary Youth Union (RYU), Syria Trust/SHABAB and JCI.
- The RYU ran in-depth workshops on youth in relation to work, communication, family relations, demographic distribution, health and gender
- SCFA conducted a joint training program with the Tunisian Arab Centre for Training and Research (Kawthar) to build training capacity from various youth zones (40 participants) which will then support the governorate committees for RH training and awareness raising.

The youth outreach program is casting a wide net to include capacity development for numerous actors as evidenced by activities undertaken in 2010. The partnerships have expanded to include more than 12 national counterparts. A variety of social media and techniques are used such as theatre, peer education and public campaigns. Plans are in place to center some activities on juveniles and youth at risk:

1. Building the capacities of 300 health staff on Adolescent health issues and life skills issues and supporting the main AH central center in Damascus and equipping the training hall for future training sessions.
2. Building the capacities of 40 Juveniles center staff on Reproductive health issues and STIs/HIV/AIDS in particular, based on the findings of (Juveniles Centers Assessment Report) which was launched in 2010.
3. Building the capacities of 600 members of RYU in (14 governorates) on STIs/HIV/AIDS
4. Building the capacities of 60 school teachers in three Governorates on STIs/HIV/AIDS issues in cooperation with the MOE and SFPA.
5. Training for SFPA members (youth centers) in 19 SFPA clinics on STIs/HIV/AIDS and also issues related to (hormones and doping).
6. Training for more than 100 NUSS members during NUSS voluntary camps on STIs/HIV/AIDS
7. Training for more than 50 labor union members on STIS/HIV/AIDS
8. Improving the medical services provided by youth volunteers during NUSS voluntary camps (which is providing free quality medical services to outreach people in slum areas) through the provision of (1) Medical Caravan equipped with RH and Gynecological clinic.

Messages on RH are incorporated in a wide variety of capacity development activities undertaken in 2010:

- Support the FL technical team (Youth agenda) to conduct the “Public narrative” sessions to more than 1400 young people nationwide to tackle issues related to their value, role models, their story, their understanding and expressing their citizenship, their recommendations to improve their reality, which helps draw a picture of the future for young people in Syria.
- Building the capacities of 15 young people from (SHABAB project - business awareness (Syria Trust) to address issues related to (Edutainment): on how
important for young people to know themselves and improve their skills to succeed in life, lacking of awareness amongst youth and its negative effects and the influence of the local community on youth choices and future.

- Building the capacities of 72 public secondary school students on (Junior Chamber International Syria) public speaking skills (to prepare them to enter the business world through developing their awareness of business and their key skills).
- Building the capacities of more than 100 secondary public school students (SHABAB project - Know about Business) where volunteers train the students on project management concepts for two days.
- Building the capacities of (50) young people with impaired vision on (computer skills) - (Junior Chamber International Syria), to increase their opportunities to find jobs.
- Prepare a practical training manual for services providers working in Juveniles Center (Ministry of Labor and Social Affairs).

The evaluator conducted or participated in several focus groups with partners and youth volunteers. The following observations are noted:

- Youth volunteers are highly committed to developing their capacities in communication, and planning and implementing programs, tackling social and environmental issues and strengthening youth networks.
- Both partner management and youth volunteers need more capacity to be results-oriented keeping the overall outcomes, outputs and indicators in mind as they plan, implement and discuss their programs. Their manner of discussion presents activities as if they are end-achievements. Youth volunteers interviewed were not able to consistently explain the mandate and objectives of UNFPA or the outcome and output indicators for the country program.
- Some mis-information was noted in one focus group and stressed the need to ensure quality control and dissemination of up-to-date information and approaches to sexual behavior realities that are not traditional in Syria. Youth counselors may need stronger steering in order to address complex social issues related to homosexuality, drug use and MARPs.

Achievements noted by youth volunteers included the following:

- They are able to refer possible STI cases to RH centers for testing
- The Drugs and Doping campaigns resulted in more youths seeking services
- They gauge success in numbers of repeat visits and whether counseled people have changed their KAP over time, this information is recorded in files
- Marriages between relatives had decreased because of information imparted through the center
- An effective way for people to get the most information is through public media activities.

The youth recommended the following:

- More connections with civil society would help to support their ideas generated through the counseling and peer interaction
- They need more and longer workshops to share experiences and get in-depth knowledge
Public projects such as interactive theatre productions should be financially supported.
More rural targeting is required to achieve results.
The UN agencies need to work more with the public schools.

More ways need to be found to locate and approach the people who do not come to counseling; it does not help to wait for them to come because they will not.

**Strategic Partnership with the Office of the First Lady Pays Off in Greater Youth Empowerment and Increased High Level Awareness**
UNFPA with the Technical Team of the Office of the First Lady supported a “Youth Narrative”, (one of the components of the National Youth Agenda Framework), involving 1400 youth in more than 156 sessions. The objective was to secure an enabling environment where youth can articulate their stories, connect to other youth and have a catalytic effect on promoting cultural changes. The idea was based on addressing the assessed situation of youth: some youth do not value higher education, there are unacceptably high unemployment and school drop-out rates; youth are not taking initiatives for their future and have limited engagement in society.

The targeted groups were: 1) Youth from poor families and slum areas - 30 meetings; 2) Youth volunteers - 16 meetings; 3) Students from schools and universities (within three age groups - 15-18, 19-24, 25-30) – 110 meetings. The challenges included getting youth from different backgrounds and locations to talk about their environment-related issues and to avoid getting bogged down in negative perspectives.

The result of this process is that solid evidence on youth socio-cultural perceptions are in place in support of further youth strategizing and programming efforts. As a side effect of the process UNFPA has been touted as an honest development broker of youth issues and more support is being sought from UNFPA for the youth agenda for linking research and advocacy, networking using YPEER methodology and strengthening community work.

**Efficiency**

Strengthening M&E and coordination would help improve efficiency. With a relatively small budget, the youth component is able to accomplish many activities by using volunteers and networks and to have a ripple effect in the areas and sectors in which they work. However, in aiming for an increasing number of youth-oriented partners and activities, efficiency may be lost if results are not more carefully monitored and implementation does not proceed systematically toward achievement of program outcomes and changes in indicators. It is noted that the results are not well documented in the past Annual Reports, although the 2010 report should have strengthened input. Lessons and good practices can be quickly lost if not noted soon after activities take place. Perhaps the partners are already doing this; a good practice/lessons learned event once or twice a year among partners would ensure that mutual learning is recorded for the future. UNFPA will make use of a new guideline has been released by YPEER and USAID on “Evidence-based Guidelines for Youth Peer Education”.
The Youth Theme Coordination Group consists of UNICEF, UNFPA (co-chairs) – UNWRA, UNDP, ILO, IOM, FAO, WHO, WFP, UNIFEM, (non-resident) UNAIDS, and UNESCO (HIV, Education, MDGs). A mapping exercise was conducted and overlaps and duplications were found among programs and activities; among all there are 22 national partners working on youth issues. These partners do not attend the coordination meetings but will be invited next year.

The challenges for all agencies are measuring impact and developing indicators. All are dependent on ministry records and the MICS for tracking indicators. In August 2011 there should be fresh data from MICS 4 and a survey on youth attitudes being planned by UNFPA and UNICEF. The newly developed indicators for the UNFPA CPAP 8 should be in harmony with the data that is being collected and with indicators other agencies are using to improve collective impact.

There are indications that the UNDAF does not have the appropriate clout to unite the programs and that what is needed is a tangible and sound joint program. There is currently one shared by a few agencies (UNFPA, UNICEF, UNDP and UNHCR) that address juvenile issues. It is clear to interviewees that better coordination would lead to improved efficiency in reaching outcomes.

Conclusions for Relevance of Youth Approaches

- The project has effectively contributed to increase in HIV/AIDS awareness but more evidence on improvement in RH and STI awareness is needed; the SARA and mapping data and the NSP should help improve effectiveness;
- Building partnerships with NGOs working with youth offers what appeals to youth, but the program needs to be more effectively monitored, recording lessons and good practices, and documented in a cross-cutting program perspective (with Gender and PD)
- A stronger results-based approach and more collaboration among NGOs and other actors would contribute to efficiency given the large numbers of groups/activities involved and need for coverage of the Vulnerable Groups and to help prioritize the most effective/efficient means of BCC
- The youth-based approach is relevant to national goals, although it needs to be ensured that NGOs are imparting up-to-date information reliably.
- Government commitment promotes sustainability. Most NGOs have volunteers who seem highly committed and they seek various sources of support.

Specific Objective 6: Value-added role of the local YPEER volunteers in launching small scale projects on healthy lifestyle and HIV/AIDS awareness raising

Relevance and Sustainability

The following information from the Y-PEER website provides adequate rationale for using this resource in Syria. Y-PEER is the Youth Peer Education Network and is a groundbreaking and comprehensive youth-to-youth initiative pioneered by UNFPA. Y-PEER is a network of more than 500 non-profit organizations and governmental institutions; its membership includes thousands of young people who work in the many areas surrounding adolescent sexual and reproductive health. Y-PEER is an
efficient and effective means of promoting youth participation in sexual and reproductive health issues. To this end, it builds partnerships between young people and adults by advocating for:

- National youth development strategies
- Increased access to information, knowledge, and services on sexual and reproductive health
- Sharing lessons learned across borders and between cultures
- Standards of practice and improved training resources for peer educators
- Strengthening the knowledge base of peer educators and trainers of trainers
- Y-PEER Country Networks are designed by and for young people.

Members of Y-PEER include young people, active peer educators, trainers and youth advocates for adolescent sexual and reproductive health. They contribute to and benefit from the resource materials, tools, training programmes and campaigns provided by the Y-PEER website, electronic communications, and face-to-face meetings. As of 2007, Y-PEER linked more than 5,000 members from 36 countries. The network continues to grow as more young people and organizations join.

**Effectiveness and Results**

The YPEER has operated since 2009, however, the Mid-Term Review did not comment on this initiative. YPEER’s activities fall under the AWP SYR7R51A, half of it to be implemented by SARC and the other half by YPEERs. UNFPA made an agreement with SARC to adopt the YPEER methodology; most of the YPEER volunteers have served as SARC volunteers.

YPEER’s value added is demonstrated in the wide range of activities the group is able to carry out and in particular, TOTs which enable others to carry forth the training. It is estimated that the YPEER activities have influenced 1,000 youth judging by the numbers trained and flyers distributed.

The activities carried out for 2010 include the following.

- Building the capacities of more than 60 SARC on community health and participation in 3 Governorates.
- Conducting two YPEER/PE training in March and September 2010, each training had more than 20 participants from different youth NGOs and Popular Unions
- Conducting the YPEER/TOT for 22 young people from different youth NGOs and Popular Unions, the TOT resulted in having new 10 YPEERs TOT.
- Conducting two Month of activism to strengthen the partnership between SFPA and YPEER (in March and November 2010, the sessions covered many issues related to social media, Healthy diet, Environment & Climate change, SRH, Peer pressure, Business related skills, Youth & Music, Recycling and Edutainment..)
- Conducting two YPEER Theatre Based Peer Education (TBPE) trainings where two shows took place with participation of more than 100 young people, the shows covered issues related to climate change, drugs and VAW.
- Conducting Art and Graffiti workshop (self development & health) for YPEER members and young people. The work was shown during the launch of the IYY.

Results regarding advocacy and policy dialogue
The first partnership between MOH and YPEER was regarding the “Anti Doping campaign” among young people during the World Cup 2010 - distribution of more than 7000 flyers in Damascus – MOH and YPEER. The MOH has adopted the idea and requested the printing of 25000 additional flyers to be distributed in 2011 among all health centres in Syria.

Launch of the YPEER Syria website www.ypeer-syria.org on 10/10/2010. The interactive website is fully designed and developed by Y-PEERs, it is composed of many features for young people:

- 10 days of activism (1-12 December 2010) it will cover WAD and the UNFPA MDGs Regional Exhibition (Youth in the Arab States).
- Production of (3) documentaries (TBPE, Doping, Graffiti) are used as advocacy and training tools.
- YPEER Syria activism and highly recognized participation during the launch of the International Year of Youth in August 2010.
- YPEER Syria participation in World Youth Conference (Mexico 2010).

Discussions with stakeholders during the evaluation visits to the governorates indicated that the peer education was very effective. In a focus group discussion with YPEER, the youth felt that their value added was in keeping the benefits of being a network rather than an NGO, and thus able to operate more independently.

Challenges that are faced include the following.

- YPEER conducted a TOT for SARC and the candidates were not well selected and only 2 ended up using the training; YPEER had no control over the candidates or conditions of the training so it is disappointing when the training is not effectively used but lessons were learned and recorded from this experience.
- Youth assistance to Iraqi refugees is very limited in some cases to only vocational training support.
- The Anti-Doping Campaign, although making progress, needs more research basis for strategies.
- Many of the topics that are presented/discussed either in training or in activities is not followed-up on to see what the impact has been.

Efficiency concerns are similar to those mentioned in the section on Strategic Objective 5 on youth.

**Conclusions for Value-Added Role of YPEER**

- This initiative holds promise for effectiveness through peer-to-peer education and training has been given for 60 NGO volunteers and awareness raising in 3 governorates; the YPEER needs to be expanded to include youth from poor areas
- As with the other youth-related initiatives this network although globally established and well known needs to be more results focused in Syria to improve efficiency and add an M&E component as per new UNFPA guideline
- The peer to peer concept is relevant and cohesive with national goals and the involvement of youth should provide short and long term dividends; sustainability will depend on continuing funding and strengthening of the approaches through results based monitoring and modifying BCC approaches to be more effective for changing youth KAP.
Population and Development Component:

The specified outcome for the PD component, within the Country Program Action Plan (CPAP 2007-2011), stated that “National, sectoral and local policies take into account population dynamics, reproductive health and gender issues, in the context of poverty reduction, development and the MDGs”. Generally, it aims to establish a common understanding of operational linkages between population, reproductive health, gender and poverty reduction to ensure that such issues are regularly taken into consideration in assessing progress toward achieving the MDGs and poverty reduction efforts. In turn, this would lead to increased budgetary resources for population policies and programmes, from various sides.

Contributing to the achievement of the specified PD outcome, the CPAP included two outputs that were formulated as follows:

The first PD Output reads “Enhanced national capacity for integrating population, gender and reproductive health issues into national, sectoral and local plans”.

Envisaged activities to attain such goal are elaborated within the CP to include:

a) Building capacity of key decision makers and planners in methods and techniques of integration of population issues including reproductive health and gender in development planning, monitoring and evaluation; b) Promoting awareness and understanding of parliamentarians, opinion and religious leaders, media and popular organizations on population, RH and gender issues including related successful practices; c) Strengthening capacity of concerned actors at various levels on linkages/synergies between population, RH, gender, poverty and development; d) Building capacity of parliamentarian groups in advocating for population, gender and RH issues; e) Supporting the establishment of a Technical Secretariat (TS) in the framework of the National Population Committee/Technical Advisory Committee (NPC/TAC) which will serve as a functional link between the above entities and other governmental and popular organizations; f) Strengthen capacity of the Higher Institute for Studies and Demographic Research; and, g) Supporting a communications strategy to effectively advocate and communicate for population, gender and RH issues.

The second PD Output was formulated as “Strengthened national capacity for generation, analysis, dissemination and utilization of disaggregated data, including supporting research for policy decision-making”.

Planned key activities to attain PD output 2 include the following: a) Strengthening national capacities in policy research to broaden evidence for advocacy & policy dialogue; b) Building capacity of national professionals in packaging research findings for policy and programmatic decisions; c) Providing technical support to national efforts in the analysis, dissemination and utilization of 2004 census data at the national, sectoral and sub-national levels; d) Support to on-the-job formal trainings in population studies/demography and providing fellowships for the demographic studies; and, e) Support to qualitative research to complement quantitative approach.
Overall Conclusions:
The outcome of the PD component, according to the Country Program Action Plan is to ensure that “National, sectoral and local policies take into account population dynamics, reproductive health and gender issues, in the context of poverty reduction, development and the MDGs”. It aims to establish a common understanding of operational linkages between these issues to ensure that they are regularly taken into consideration in assessing progress toward achieving the MDGs and poverty reduction efforts, as well as ensure allocating budgetary resources for population policies and programmes...

To this end, CPAP included two outputs that lend support to the effective achievement of the specified outcome. These are: a) Enhanced national capacity for integrating population, gender and reproductive health issues into national, sectoral and local plans; and, b) Strengthened national capacity for generation, analysis, dissemination and utilization of disaggregated data, including supporting research for policy decision-making.

The PD component of the UNFPA/CP (2007-2011) contributed significantly to achieving the specified outcome as was documented throughout the evaluation process.

Cross Cutting Issues:
Capacity building programmes, which involved various stakeholders of the DP component (SPC, SCFA and CBS), were instrumental in supporting progress towards the successful implementation of key interventions of the UNFPA/CP 2007-2011. The content of the organized programmes stems from national priorities that are covered within the CP activities and they were build on broad-base participation from all those involved in the implementation, at central and local levels.

The trainings for the staff of the State Planning Commission, Central Bureau of Statistics and Directorates of health & education focuses on the inter-linkages of population and development variables, at the central and governorate levels. The main purpose of the trainings was to support the current situation analysis related to the next national development plan for 2011-2015. Participants’ evaluation emphasized their importance and effectiveness in transferring knowledge-base and methodologies and accordingly furthering their abilities for undertaking planned activities.

Special attention was devoted to building the capacity of the Central Bureau of Statistics (CBS) as the lead agency for quality data collection, analysis and dissemination. Its training needs in statistics were assessed as well as the process aims to review the policy for statistical information, including the role of the Central Bureau of Statistics as the primary producer and coordinator of the official statistics in the country in line with the internationally accepted standards.

The manual providing key concepts used in population and social statistics, for media professionals is breaking the barriers among various disciplines and contributing to the process of establishing a consensus about the terminology used by various sources. It also shows the importance of the close cooperation between stakeholders (CBS and the Ministry of Information) with the support of UNFPA.
PD Component Relevance:
Examining both the 10th National Development Plan (2006-2010), which is also MDG-based, as well as the UN Development Assistance Framework (UNDAF) for the period 2007-2011, confirm the relevance of PD component outputs to national priorities. They provide clear evidence to the responsiveness of the CP/CPAP to national directions, strategies and objectives adopted by the Government and supported by donors. Besides it takes into account the need to enhance the ability of individuals and organizations and systems to promote the implementation of the goals and objectives of the ICPD and its PoA, as well as progressing toward full realization of the MDGs.

a) National Development Plan:

The national priorities highlighted in the 10th five-year Development Plan aimed at: a) improve governance, transparency, accountability and efficiency of public institutions and services, in the context of a social-market led and citizen-centered economy and society; b) To seek balanced population growth that matches development requirements; and, c) Activating women's role at both family and social levels and fostering their participation in all fields.

The 10th national five-year development plan devoted chapter 17 for population, RH and gender sector. It elaborated the current population problems and their socio-economic interlinkages and the need for integration the population dimension into all levels of development planning within the context of national population policy consistent with the ICPD/PoA as well as adopting the MDGs approach. The long-term objective for the plan is to establish a balance between the growing population demands and potential socio-economic development for Syria. Specific objectives included: a) integrated planning, follow-up and evaluation of population, RH and gender issues; b) strengthen integration of population dimension into policies and regular development planning; c) Reach high-level standards for reproductive health and rights; d) mobilize required resources to support population, RH and gender within development plans; and, e) pay due attention to population mobility and population redistribution within the context of balanced local development including regulating internal migration.

The sustained policy dialogue about population dynamics and their interlinkages to socio-economic development, culminated with the launching of the first ever report on the state of Syrian population as well as the stalling population situation, led to wider emphasis on population issues within the 11th five-year development plan. Although it is being considered a cross-cutting issue, the planned goals and objectives are becoming focused and operational. The plan calls for: a) controlling high-level population growth (approaching the last stage of the demographic transition); and, b) upgrading population characteristics and accordingly the level of human development and labor force. To this end, the proposed development plan would adopt strategies to reduce population growth through lower fertility levels and upgrading characteristics including education and health care, integrate population dimensions with all policies and strategies; expand women participation in social life, especially non-agriculture labor force. The plan is promoting the adopting a policy-package that would support
the achievement of the specified goals and these are adding evidences to the relevance of PD component outputs.

b) United Nations Development Assistance Framework 2007-2011:

National priorities were also echoed within UNDAF which consolidates the UN system efforts in contributing to the overall achievement of national goals and objectives, as specified within the National development Plans, and establishing a strategic alignment framework among all partners.

Accordingly, the UNFPA/CPAP, Population and Development outcome is designed to contribute to UNDAF outcome 2 concerning Governance that reads as follows “Efficiency and accountability of governance structures at central and local levels strengthened by governments, civil society and the private sector, towards sustainable development”. UNDAF sub-outcome 2, emphasized several important elements within the context of the UNFPA/CP, such as: a) policy and decision-making supported by quality information and analysis, especially taking into account population dynamics, reproductive health and gender and children’s issues, including introducing mechanisms for evidence-based policy making and resource allocations; b) empowered civil society involved in the development and implementation of public policies, planning and programmes; c) comprehensive Syrian child protection legislation and policies; and, d) strengthened institutional mechanisms and policies for improving the legal status of women, eliminating GBV, promoting women’s and girls’ rights and increasing gender equality.

The CP/CPAP also contributes to UNDAF outcome 3 covering basic social services “Inter and intra-regional, disparities related to access and quality of health, education and other basic social services reduced with a focus on the Northern, Eastern and Badia regions of the country and other disadvantaged areas”, which confirms interventions supporting progress toward achieving the MDGs.

For both outcomes UNFPA/CP collaborated with other UN organizations to expand access to information and to support a wide scale, ambitious plans for reliable data collection, dissemination and analysis of the findings, including related capacity building (at both central and local levels), aiming to strengthen policy formulation and the decision-making process as well as reinforcing accountability.

Besides being responsive to these UNDAF outcomes, the UNFPA/CP activities contributed to several breakthrough results that are being documented. Key among these are: a) Launch of the 1st state of Syria Population Report (SSPR); b) Syria submission of progress report on the implementation of CEDAW and CRC; c) ICPD@15 report; d) Beijing @15 Report; and, e) the 2010 MDGs report. Various initiatives concentrated on policy/strategy development and capacity building aiming to support national services delivery systems, especially health, based on key national studies and surveys that generated solid evidences for planning and policy formulation.

In sum, both national priorities and those adopted by all development partners, represented by UNDAF, as well as global priorities (ICPD/PoA and MDGs) are fully adopted by the UNFPA/CP for the years 2007-2011.
**Specific Objectives Evaluation:**

**First: Expanding Policy Dialogue and raising commitment to Population, RH, Gender and Youth Issues:**

Recognition of the central role of population issues within development planning process is clearly demonstrated in the formulation of various policy documents. This also culminated during the preparation period for the NDP, which exhibited high political commitment for integrating population variables, RH, young people's concerns and gender into NDP. The process need, however, to be expanded to other planning levels including sectoral as well as regional and local areas. However, the increasing resource allocations for population activities, reflecting high level commitment, was demonstrated by the growing contribution of the Syrian Arab Republic (SAR) to the UNFPA/CP reaching about US$2.8 million.

Besides the catalyst role played by UNFPA, during the preparation period for the NDP, the DP components efficiently and effectively adopted several strategies that were instrumental in furthering commitment to the ICPD/PoA and toward expanding policy dialogue, including: a) the preparation of the M&E framework for NDP; b) Supporting the preparation and launching of the first report on “The State of the Population in Syria (2008)” ; c) Preparation and dissemination of ICPD@15 progress report, which also emphasize the interlinkages between the ICPD/PoA and the MDGs, as well as its costing; d) Preparation of National population policy and the integration of population dimension within the context of the 11th NDP; e) Incorporating youth rights and needs into policies at various levels, capitalizing on the demographic dividend; and, f) Reformulation of Governorate plans. These strategies prove to be efficient and effective in reaching the goals, and significantly contributing to the realization of national priorities.

**Monitoring and Evaluation Framework:**

The 10th NDP provided a general framework for M&E performance for various sectors including population issues, RH, gender and youth. Chapter 27 of the plan elaborated the principles of the proposed M&E system to provide decision-makers with reliable information about the level of progress in the implementation of various projects, ensure cost-effectiveness, increase potential returns and define lessons learned that can be of use for future planning. The system would also lead to strengthen national statistical data bases, expand dissemination and transparency.

With the support of UNFPA, the SPC elaborated a logical framework matrix for monitoring and evaluating progress in the areas of population, RH, gender and youth. These efforts capitalized on a series of programs for building capacity of SPC, and other population related sectoral staff including health and education. These programmes covered the structure of the M&E system and the logical framework approach, the main criteria for selecting SMART indicators, the interlinkages between population dimension and socio-economic variables as well as identifying the relevant indicators.

The logical framework matrix elaborated: a) Specified goals within the overall CP; b) Specified strategies and policies; c) Planned interventions and activities; and, d)
Monitoring as well as evaluation indicators. Besides providing mechanisms for M&E progress at mid-term interval of the 10th development plan, the designed system was also instrumental in facilitating the preparation of national reports assessing progress for ICPD+15 and the 2010 MDGs in 2010.

At the same time, UNFPA collaborated with UNICEF and UNDP in assisting SPC to establish DevInfo database for providing indicators to monitor various population dynamic indicators as well as the full range of MDGs indicators. The system is to be maintained by SPC in collaboration with the Central Bureau of Statistics (CBS) which is responsible for updating the database according to the availability of recent sources and the decision of the steering committee. Mechanisms to enhance expand access to the established database and its regular timely update, need to be further developed and disseminated to ensure expanded utilization.

SPC efforts to shoulder the responsibility of undertaking all activities to develop the M&E system provide evidence to the “ownership” of such system and accordingly its sustainability for monitoring integrated population and development, especially with the growing interest in adopting a result-based management approach. The process contributed also to changing the concepts of monitoring from being merely depending on financial-based indicators to those measuring and evaluating progress against specified goals.

The growing concerns about population dynamics and their impact on development planning is becoming noticeable in recent years and is demonstrated by the commitment of the government to implement the ICPD/PoA as well as the MDGs, which led to widening the circle of policy dialogue and diversified topics being discussed. Availability and accessibility of reliable data/information, however, was important to ensure constructive policy dialogue based on evidence and the findings of well founded studies about the linkages between population and development.

To this end, the first ever report on the state of the Syrian population (2008) present an accurate analytical profile of the Country as well as its potential directions. It aims to strengthen the dialogue through increasing awareness of the current and future population challenges that would affect development efforts and consequently reflect on the quality of life. The overall understanding of the various population issues would certainly invites decision-maker and other groups to consider their integration into development process and to thoroughly assess the impact of population dynamics on various aspects of life. The main objective of the report was to enhance the debate about the population situation to become a public opinion issue that is on the agenda of the public at large.

Topics covered in the report falls within the context of four areas of concern including: a) Population size, growth, and geographical distribution; b) Population dynamics; c) Characteristics of the population; and, d) Population problem. The findings were elaborated by a team of national experts to ensure national “ownership” and sustainability (with the support of an international consultant). Various population and development issues were presented in three section including nine chapters. The key findings emphasized the high level of population growth leading to serious
increase in the size of the population which if continued to prevail will have serious consequences on various socio-economic developments planning in Syria. The report refers also to the imbalanced geographical-population distribution, to the unfavorable population characteristics, especially those related to human development, and to the possible advantages of the demographic window.

The annexed Economic Report takes the subject further by discussing the implications of the continuous population growth. It provides estimates for potential demand and the required financial resources needed for the years 2015 and 2025, based on the projected population size, covering some selected sectors including: education, health, petroleum, electricity, communication, water and the environment. It documents the implications of continuous high-level population growth on these sectors, which was highly efficient and effective in expanding the policy dialogue based on evidences.

The importance of the topic and the comprehensive nature of the analytical report highlighting the policy implications of population and development interlinkages are demonstrated throughout its launching. The Syrian Commission for Family Affairs (SCFA), with the support of UNFPA conducted a Forum on the State of Syria Population Report (SSPR) on April, 27, 2009. The event was patronized by HE the Prime Minister and was attended by 11 line ministers, heads and members of Parliament committees, 10 Governors and representatives of local authorities as well as representatives of religious entities, civil societies and UN organizations. Besides the PM emphasizes on the outcome of the report, he conveyed the message of HE the president of SAR “the President is looking forward to fruitful discussions, operational recommendations and results”.

The discussion throughout the Forum highlighted the main challenges as well as the proposed actions and recommendations that would enhance the opportunity for achieving the national population goals. Coverage by various types of media was intensified and led to growing discussion among the public at large.

The impact of this report and its contribution as a major source of inputs to the forthcoming 11th national development plan and Syria’s upcoming UNDAF, as well as its recommendations, championed by the President of SAR, was recognized the Executive Director of UNFPA in her statement to the 2010 June session of UNDP/UNFPA Executive Board.

Commitment to the recommendations of the SSPR is gaining momentum and the SCFA, with UNFPA support, is developing messages to advocate for their operationalization, with religious background. The findings would lend support to efforts aiming to develop national population policy action plan based on adopting the principles of strategic planning.

The catalyst role of the report and its success in furthering the policy dialogue about population situation stressed the need to sustain such activity and a decision was taken to prepare a report on the state of Syrian population every two year, with a special focus on one priority topic. With the support of UNFPA, the second SSPR is being currently prepared and aims to explore the impact of the potential “demographic window”. Knowledge of the expected time-frame of possible dividend for various
governorates as well as its implications would allow the development of relevant policies to maximize benefits.

**ICPD@15 Report**

The complementarities between the objectives of the ICPD/PoA and the MDGs provided the framework that was adopted to assess countries’ progress toward reaching the goals, within its specified time-frame. The report prepared by the SPC in May 2009, supported by UNFPA, contributed also to the growing debate about the population situation and its implications.

Besides elaborating population dynamics, it monitored progress toward achieving the objectives of the ICPD/PoA, within the context of MDGs, depending on the list of the agreed upon set of indicators. It provided an excellent opportunity for all stakeholders to realize the importance of integrating population dimension, RH, gender equality, empowerment of women and youth, for the achievement of MDGs and the national goals of the NDP. The report emphasized the mutual interaction between both the ICPD objectives and the MDGs and that their success reinforces each other progress.

The report paved the way for the successful incorporation of RH and gender dimensions in monitoring progress reports about the MDGs. It also documents efforts for building reliable information data base for monitoring and evaluation; define existing statistical gaps and areas for further actions to compensate for slow progress. It also highlighted the importance of assessing progress at regional and local levels since national estimates are masking the presence of differences in development levels by areas (governorates). Lessons learned and good practices about the interlinkages between population and development were presented. The findings and conclusions of the report provided also inputs to the SPC/UNDP 2010 report about progress in achieving the MDGS. Both reports contributed to the continued policy dialogue and the need for specific interventions to cope with the possible implications of the prevailing population dynamics.

**National Population Policy and the 11th NDP:**

Growing population concerns and the continuous policy dialogue about population and development interlinkages emphasized the need for having a national population policy documents that spell out national goals and specified strategies and policies for their achievements, especially with the government commitment toward reducing high-level population growth and the integration of population dimensions within various strategies and policies for socio-economic developments, which are the main two pillars for population strategies within the context of the 11th NDP. The national population policy documents would be annexed the five-year development plan to ensure that it is being taken into consideration of various sectoral and local plans.

To this end, the SCFA supported by UNFPA, initiated a wide-range consultative process, at various central and local levels, covering all governorates, to present updated reliable information about the current population situation and various possible scenarios for future directions. The process aim to establish consensus among decision-makers at various levels, intellectual groups and academics as well as the public at large, about the goals and objectives to be adopted and the required interventions for ensuring harmonization between population and development strategies.
Furthering the integration of population and development within the 11th NDP based on the lessons learned from the experiences of the previous plan, SPC undertook a full scale situation analysis to support the development of the forthcoming NDP 2011-2016. For this purpose, SPC supported by UNFPA, carried out a series of training sessions, at central and local levels, for their staff as well as those of CBS and directorates of health and education on the interlinkages of population and development. The training contributed to the possible list of indicators for monitoring poverty, health/RH and education.

**Incorporating Youth rights and needs into policy documents:**
UNFPA continued to support efforts for capacity development, expanding evidence-based policy dialogue and advocacy for youth issues. The preliminary step, however, was to strengthen the knowledge data base to provide evidence for guiding future directions. To this end, in collaboration with the SCFA, the youth survey was conducted in 2008 and five in-depth studies were undertaken to examine the various dimensions of youth issues including health, education, labor, gender and social participation. Besides the qualitative survey, the research included qualitative/in-depth studies that provided solid evidence as well as comprehensive disaggregated data on Syrian youth empowerment and participation in the various areas under consideration.

The launching of these findings and their discussion (2010), at various levels, scaled up advocacy and policy dialogue in support of youth empowerment and participation, which would eventually lead to the finalization of the national youth strategy. Key evidences in support of such result include: a) substantial policy dialogue between parliamentarians and youth in two governorates; b) The national campaign on the role of families and parents in promoting young people’s development; c) Extended policy dialogue during the launching event of five in-depth studies; d) Celebration of the International Year of Youth under the theme: Dialogue and Mutual Understanding; f) support the celebration the International Volunteers Day and the International Year of Volunteerism, which focused on the role of young people in achieving MDGs and addressing environmental concerns and issues. The process also enhanced the capacity of a core group of young people to engage in evidence-based dialogue to advocate for youth issues.

Similarly, the CP supported other activities that provide information about specific youth vulnerable groups such as Juveniles and young children (10-14), which would strengthen efforts to ensure the responsiveness of policies to the needs of such groups, mobilize resources and ensure coordination among various interested groups. The findings of the Juveniles Centers Assessment Report were shared with government bodies as well as local and international non-governmental organizations to draw their support.

In addition, capacity development for youth empowerment as well as addressing their special needs and concerns, were carried in collaboration with a group NGOs including: a) Youth Agenda; b) Syria trust/SHABAB project; c) Junior Chamber International Syria and, d) the Ministry of Social Affairs and Labor.
The adopted models strengthened youth empowerment and participation component of national policies and plans. It incorporated computer skills for youth with impaired vision, business awareness initiatives, training standards for juvenile centers service providers and youth communication/public speaking skills. Moreover, the process provided evidences on youth socio-cultural perceptions, views and future perspectives generated through the implementation of one of the capacity building components of the National Youth Agenda Framework, which is “Public Narrative” that allow youth to connect among themselves and to have the opportunity for culture change. This would provide evidence on youth socio-culture perceptions and support the development of customized youth strategies and programmes.

Reformulation of Governorates’ Investment Plans:
Mid-term monitoring and evaluation for the 10th NDP and the in-depth situation analysis of the population situation emphasized the need for their reformulation to ensure responsiveness to local population dynamics. In turn, this will also contribute to various efforts to reduce the development gap among various governorates. To this end, the SPC with support from UNFPA carried out a series of capacity building initiatives, focusing on mechanisms for preparing annual governmental budget based on population activities and needs. Overall, the capacity building initiatives elaborated approaches for the integration of population dimension/RH, into development planning at various levels. It also covered DevInfo, MDGS costing and population projection for planners. Additionally, in collaboration with UNDP, the training sessions provided participants with skills to prepare investment budget and procedures to define investment needs for various sectoral services including education, health, social support, culture and other infra-structure services. Accordingly, the population dimension is becoming the critical input for the distribution of allocations between governorates.

The outcome of this capacity building initiatives, at the central and local levels, confirm its efficient and effectiveness which was demonstrated through examining a sample of these plans and the supportive evidences provided by the staff of local planning departments for various sectors including health and education. The process increased the awareness of high-level local decision makers (Governors) about the importance of such integration for all planning activities and provided them with objective criteria for resource allocations, especially with the intention to further decentralization, as indicated by UNDAF.

Taking the population dimension into consideration affected budget allocations for various Governorates, between 2006 and 2010, as can be seen from the following table. It shows that the share of some Governorates increased such as Damascus Rural, Aleppo and Idleb while others received reduced allocations to match population requirements and the current level of per capita services.
### Budget Allocations by Governorates for Specified years
(In 1000 Syrian Lira)

<table>
<thead>
<tr>
<th>Governorates</th>
<th>% 2010</th>
<th>Allocations 2010</th>
<th>% 2006</th>
<th>Allocations 2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Damascus</td>
<td>3.70</td>
<td>1165</td>
<td>4.51</td>
<td>896</td>
</tr>
<tr>
<td>Damascus Rural</td>
<td>10.05</td>
<td>3161</td>
<td>8.50</td>
<td>1690</td>
</tr>
<tr>
<td>Homs</td>
<td>9.46</td>
<td>2975</td>
<td>10.24</td>
<td>2035</td>
</tr>
<tr>
<td>Hama</td>
<td>7.53</td>
<td>2368</td>
<td>7.12</td>
<td>1415</td>
</tr>
<tr>
<td>Aleppo</td>
<td>15.93</td>
<td>5011.5</td>
<td>12.68</td>
<td>2520</td>
</tr>
<tr>
<td>Idleb</td>
<td>7.19</td>
<td>2260</td>
<td>6.61</td>
<td>1314</td>
</tr>
<tr>
<td>Lattakia</td>
<td>6.51</td>
<td>2046.5</td>
<td>7.09</td>
<td>1410</td>
</tr>
<tr>
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<td>6.99</td>
<td>2199.6</td>
<td>8.15</td>
<td>1620</td>
</tr>
<tr>
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<td>6.60</td>
<td>2076.9</td>
<td>6.89</td>
<td>1370</td>
</tr>
<tr>
<td>Al-Hasakeh</td>
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<td>2390</td>
<td>8.35</td>
<td>1660</td>
</tr>
<tr>
<td>Al-Sweida</td>
<td>3.50</td>
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<td>4.04</td>
<td>803</td>
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<tr>
<td>Dar’a</td>
<td>6.17</td>
<td>1940.5</td>
<td>6.15</td>
<td>1222</td>
</tr>
<tr>
<td>Tartous</td>
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<td>6.24</td>
<td>1240</td>
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<tr>
<td>Qunetira</td>
<td>2.62</td>
<td>825</td>
<td>3.42</td>
<td>680</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>31450</td>
<td>100.0</td>
<td>19875</td>
</tr>
</tbody>
</table>

**Second: Enhancing Commitment of Parliamentarian to Population, RH, Gender and Youth Issues:**
Commitments toward population issues is not only limited to government bodies but it is extended to parliamentarians who demonstrated their concerns about population dynamics and their interlinkages with development. The partnership between the Syrian Parliament and UNFPA expanded their involvement in evidence based policy dialogue and their commitment to the ICPD/PoA and MDGs. The project activities are expanded to four Parliamentarian Committees (Environment and Population activities, Services, Constitution and Guidance) as well as members of other committees.
The UNFPA/CPAP introduces some effective and efficient innovative activities to ensure the involvement of Parliamentarians in the debate of population issues and ensure their support to population concerns, RH, gender and youth issues as well as realizing the specified national goals and objectives within the NDP. These included: a) Policy dialogue sessions for Parliament and youth based on recent data; b) Arrange for Parliament-NGOs dialogue to debate gaps in existing legislations in support of women empowerment; c) Field visits for Parliamentarians to program sites related to household poverty reduction, humanitarians sites providing health services, RH/FP services as well as some NGOs sites, youth voluntary counseling and battered women shelters, to gain their support for such issues; d) expanding evidence based policy dialogue to four Parliamentarian committees, especially budgeting; e) Review communication strategy and action plan addressing population, RH, gender and youth issues from cultural lens; and, f) Assess the current status of early marriage.

In addition, UNFPA activities included orientation and knowledge sharing workshop sessions on various population dimensions including the interlinkages between population RH, gender, youth from one side and development, on the other side. Special sessions were organized on the occasion of launching the SSPR, the ICPC@15 report, HIV/AIDS Situation Assessment and Response Analysis, Youth Survey including the five in-depth studies (Youth & Gender, Youth & Health, Youth & Societal Participation, Youth & Education, Youth & Labor) as well as discussing the findings of the Gender Based Violence (GBV) survey, the relevant issues, the legislative framework and highlighting interlinkages with early marriage of woman as one of the causes for GBV, and Further promoting services for maternal and children health in collaboration with the MOH and NGOs engaged in such activities. Overall, these activities were effective in strengthening the commitment and support of Parliamentarians to population, RH, gender and youth issues. Is also allowed various groups, especially youth, to have evidence based advocacy, and to voice their concerns on various different population issues related to health, gender, societal participation, education and employment, at both central and governorate levels.

The feedback obtained from a meeting with Parliamentarians, headed by the Chairman of the Financial Committee and attended by members from various committees, emphasized the importance of these activities and their efficient approach in providing them with important information about various population issues and their interlinkages with development which furthered their contribution to Parliamentary debates. They expressed interest in the continuation of these initiatives in the future. Besides participation in debating the state of the Syrian population, some indicated intentions to support relevant legislative interventions to cope with the current situation and the need to intensify efforts to change the existing culture to accommodate the norm of small family size, preferably based on two children.

It should also be noted that these debates led the Syrian Parliament to present a draft law concerning the rights and responsibilities of the people living with HIV/AIDS which is being currently discussed with different committees of the Parliament before its adoption.

Besides knowledge sharing and briefings, some members of the Parliament, especially newly elected, were exposed to the experiences of other similar forum at the regional
and international levels. UNFPA supported the participation of representative from Syria to Parliamentarian forums for the Arab region as well as the global Parliamentarian meetings.

**Third: Utilization of Census and Survey Results for in Depth-Studies &Strategic Reports:**
The Government recognized the importance of having timely updated data for effective planning, supporting the decision-making process as well as monitoring and evaluating progress toward realizing national goals and honoring its commitment to ICPD/PoA and MDGs, at various levels. To this end, the CBS is entrusted with collecting, processing, analyzing and disseminating data for national, sub-national and sectoral and sectoral levels. In addition, other Ministries including Health, Interior/Civil Registration, Education and Environment provide flow data relevant to their functions. These were technically and financially supported by UNFPA, throughout previous program cycles, to strengthen the national integrated statistical system.

Recent supported activities included the 2002 PAPFAM survey, the 2004 census, the Rapid Assessment Research in 2005, and the youth survey, confirming that improvement of the institutional capacity for data collection is noticeable, although it needs to be continued. However, the apparent gap remained in the area of promoting wider and effective accessibility of available data to further their utilization and effective integration of population issues, RH, gender and youth in development planning at both central and local levels.

To enhance effective utilization of existing data, UNFPA supported undertaking further analysis for the 2004 census covering important population issues including marriage, fertility, population projection and internal migration. These were providing in-depth analysis of the specific phenomena under consideration; however, they should have been fully coordinated to ensure extensive utilization of their findings, especially for future population projection.

Further in-depth studies, based on data collection initiatives supported by UNFPA, provided also evidences for re-visiting the current strategies. These include:

- The Syrian rapid assessment research which provided inputs for specifying priorities and target areas for intervention;

- The youth survey, in addition to the five qualitative in-depth studies, was instrumental in providing a detailed profile for youth empowerment and participation; as well as informed decision-makers about future directions and strategies;

- GBV survey which provided detailed information about the level and type of Physical, Psychological, sexual and Symbolic Violence. It succeeded in establishing a solid evidence base for advocacy and informing content and priorities of the 11th NDP as well other initiatives.

- The integration of RH and gender into the Household Income and Expenditure Survey questionnaire (HIES 2008/2009). Analysis of the main findings related to RH/gender and interlinkages with poverty would lead to
assess the level, structure and trends of economic well-being of the households and provide data to support the evaluation of social and economic policies;

- GBV and quality of life survey, for Iraqis in Syria, produced evidences in support of advocacy and resource motivation to address GBV concerns and psychosocial needs for Iraqis.

Besides contributing to the preparation of various reports through being responsible for providing the main required statistics (SSPR, ICPD@15, …), CBS was mandated to field various surveys in close consultation with SPC, the MOH, and the SCFA.

The most resent one, was the 2009 Household Health Survey (HHS) that was supported by UNFPA, UNICEF, WHO and the League for Arab States (LAS/PAPFAM), adopting the methodologies and tools of the Pan Arab Project for Family Health and the Multiple Indicator Cluster Survey. It produced and disseminated the preliminary report providing updated data and indicators about population issues including household characteristics, marriage, fertility and family planning as well as maternal health, child health and survival. The main report, coordinated by CBS, is about to be completed and disseminated to all stakeholders. This large scale survey (24883 Syrian households and 2959 Iraqi refugee households residing in Syria), secured baseline data for the 11th National Development Plan (2011-2015), UNDAF (2012-2016) and the Humanitarian Response Plan for 2011.

The findings of these studies/reports and their recommendations are instrumental in assessing the effectiveness and efficiency of current policies and provides evidence-based conclusions that lead to a strategic review of the currently formulated policies. The SSPR is a clear example of such process that is leading to adopting new strategies aiming to target areas experiencing low progress toward reaching national population goals and requires further action to fully integrate population issues with development planning.

The effectiveness of this HHS and the key to its success resulted from the high-level government commitment to the unified survey and close coordination of such government bodies as State Planning Commission, Central Bureau of Statistics, Ministry of Health and Syrian Commission for Family Affairs.

Similarly, the strategy to improve the situation in the least-developed villages, through the initiative for the comprehensive mapping of ultra-poor villages, included providing technical assistance in support of data collection (carried out with the support of CBS). The process was a joint initiative with the Ministry of Social Affairs and Labor, UNDP and UNICEF, with the participation of community leaders.

The challenge, however, is to ensure ownership and wide use of data by various stakeholders, furthering analysis and use of the findings for policy dialogue and advocacy as well as packaging survey data in a simple format for parliamentarians, planners, NGOs, media professionals and other stakeholders. This would promote the sustainability of the process which is currently affected by the need to expand the capacity and skills for quality in-depth analysis on regular basis.

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In sum, a total of 11 in-depth studies and reports were produced throughout the period 2007-2010 based on the various data collection activities carried out with support from UNFPA. Although different in type, coverage and the level of analysis, the evidences produced contributed to the specification of the national goals and priorities as well as informed the process for identifying relevant strategies. The SSPR is a testimony to the process to integrate information, from various sources, to undertake an in-depth situation analysis that also elaborated the findings and informed decision-makers about the efficiency and effectiveness of the current policies in achieving national goals.

**Fourth: Fielding Surveys and the utilization of their findings for programming purposes:**

Three key surveys were implemented during the UNFPA/CP cycle 2007-2011 that provided detailed information to assess the validity of current strategies and programmes as well as the progress towards national development priorities and goals. These are the HHS, the youth survey and the GBV survey, which provided indicators about the current situation and evidences about potential abilities to reach national goals as well as other goals committed for within the context of ICPD/PoA and MDGs. In addition, small scale surveys and studies, with specific objectives, led also to re-visiting the planned program for specific issues such as the survey for Juvenile centers.

The final outcomes and conclusions of the SSPR concerning the population situation as well as the evidences recently obtained from the Household Health Survey promoted a comprehensive assessment of the population dynamics and the current adopted policies and strategies. It also emphasized the importance of having a National Population Policy as well as policies for population related issues such as youth and women.

The HHS portrayed the demographic and socioeconomic characteristics of the population showing its young nature (37.1% under age 15), the universality of marriage, the low level of women participation in the labor force (among those 15+, only 14.3% females compared to 68.8% males), and the high level of literacy although with clear gender differentials (% illiterate among females 19.9 compared to 8.8% for males). In addition, it provided information about the dwelling characteristics indicating that dwelling ownership is about 90%, and the majority of these dwelling have access to an improved source of drinking water (89.7%), used improved sanitation (98.6%), and the universal use of electricity in all urban and rural areas, which are indicators for progress towards realizing some of the MDGs.

Concerning population dynamics and growth, the survey provided indicators for marriage, fertility and family planning. Contrary to the national goal of controlling population growth, it confirms the stalling fertility levels (3.5 children per woman) and the slow progress in the utilization of modern FP methods (37.5 % of married woman in reproductive age with wide-range differentials by governorates), during the past recent years. This prevailing conditions, especially with the mean number of desired children surpassing the actual number (4.2 children per woman) and the high percentage of currently married woman aged 15-49 years who want to have more children (40 %), lead to the conclusion that potential continuous increase in population size, with its all implications is anticipated. It emphasizes the need for a
serious consideration of the current strategies, which is being translated into adopting a targeting approach, focusing on the areas showing high-level fertility and unfavorable population characteristics.

The targeting program that is included within the 11th five-year National Development plan (2011-2015), aim to reach a balance between population growth and sustainable socioeconomic development, with special emphasis on achieving increasing growth rates, coping with poverty and unemployment as well as enhancing health conditions and reducing marginalized groups. It also aims to reduce the gap between various governorates of Syria, taking into account the prevailing local conditions and characteristics within such areas. The program is to be piloted in selected area of Dar'a Governorate and to later scaled-up based on the lessons learned from the exercise.

Similarly, the HHS provided information about maternal care covering antenatal care, assistance at delivery, postnatal care, reproductive morbidity, sexual transmitted diseases (STDs) as weee as child health and survival including breastfeeding, immunization, child diseases, child mortality, and nutritional status. The findings support other independent evidences indicating that Syria have already achieved significant progress in reducing maternal and child mortality and that the country is most probably reaching the specified MDGs goals in that respect. Current programmes need to sustain and confirm such trend and to work on increasing the percentage of children aged 12-23 months fully immunized which was about 76.3%, according to HHS results.

The policy dialogue and the extensive debates based on the evidences resulting from both the youth and GBV surveys led to the identification national priorities and goals that need to be elaborated within the context of National strategies that was drafted and are being now under discussion for its finalization and translation into intervention programmes.

Although these surveys were highly efficient and effective in informing decision-makers and planners about the current levels of progress, the existing gaps and areas for further interventions, its sustainability represents a challenge that requires building capacity for in-depth analysis of the findings and its translation into policy-action and programmes. However, the collaboration of various development agencies in the implementation of the HHS is an example of the strategic alignment with National Development Plan and UNDAF. Such collaboration creates the opportunity for strengthening and promoting further analysis of the data and its utilization for improving policy intervention and programming.

**Cross Cutting Issues:**
Building capacity and the role of communication channels are part and parcel of the activities of the above mentioned four specific objectives as well as all stakeholders of the population and development component.

**Capacity Development:**
The CP aims to build capacity of decision makers and planners in the use of data for planning purposes, monitoring and evaluation and mainstreaming of population, RH,
gender and youth issues in the national, sectoral and local plans and policies. At the same time, the CP is focusing on building capacity and enhancing the skills of the staff of the organizations concerned with the collection, analysis and dissemination of data. This includes research design and execution as well as relevant methodologies for quality analysis to provide evidence-based information for development efforts, especially focusing on population and sustainable development interlinkages. In addition, the process is to be extended to the academic education of demography that will provide qualified human resources.

Capacity building programmes, which involved various stakeholders of the DP component (SPC, SCFA and CBS), were instrumental in supporting progress towards the successful implementation of key interventions of the UNFPA/CP 2007-2011. The content of the organized programmes stems from national priorities that are covered within the CP activities and they were build on broad-base participation from all those involved in the implementation, at central and local levels. It also included building capacity through support two staff members of the SPC to obtain diploma in population from the Cairo Demographic Center.

Although several training programmes were carried out by SPC, as the main national counterpart for building capacity activities, participation included members from other organizations to create common understanding and skills for talking complex problems, through the integration of various activities at various levels. The expected returns for such programmes lead overall reduction of the cost of the planned intervention, especially since the majority is covered by available local capacities.

The trainings for the staff of the State Planning Commission, Central Bureau of Statistics and directorates of health & education are a good example of the adopted modalities for building capacity. It focuses on the inter-linkages of population and development variables at the central and governorate levels. The main purpose of the trainings was to support the current situation analysis related to the next national development plan for 2011-2015. One of the outcomes of this training was a list of draft indicators related to poverty, health, including RH and education;

Participants’ evaluation emphasizes the importance of such programmes and their effectiveness in transferring knowledge-base and methodologies and accordingly furthering their staff abilities for undertaking planned activities. This can be seen from the following table presenting the key training programme, carried out at the local level, and participants’ assessment.
<table>
<thead>
<tr>
<th>Topic</th>
<th>No. Participants</th>
<th>year</th>
<th>Place</th>
<th>Evaluation (% answering very good)</th>
<th>objectives</th>
<th>Training Methods</th>
<th>Sufficient Time</th>
<th>Trainer</th>
<th>Overall</th>
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<td>66</td>
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<td>48</td>
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<td>Integration of pop. Issues in local plans</td>
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<td>Integration of pop. Issues in local plans</td>
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<td>Responsive Investment Budget to Pop. Needs</td>
<td></td>
<td>2010</td>
<td>Al-Sweida</td>
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<td>2010</td>
<td>Tartous</td>
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<td>67</td>
<td>6</td>
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</table>

Overall, percentages of participant’s evaluation of the training session as very good fluctuated between 35 and 88%, and it is noticeable that in most cases the balance reported the following level specified as “good”, which is a clear indicator of the effectiveness of the training. The Governorates investment plans that were prepared upon the knowledge and skills given to the participants are clearly indicating how population dimension are being taken into account leading to a different mechanism for resources allocations between various governorates. The FGD with the directors of planning for the Northern Governorates and the local sectoral planning department confirmed the benefits of such approach and the importance of having objective criteria for resource allocations. They also indicated that the approach led to strengthen their position, within the decision-making circle of the governorate, which would strategically support their efforts for integrating population issues into local development planning.

Other training sessions were also carried out to facilitate the implementation of some planned activities and to ensure their effectiveness. These include:

- Review of procedures and methodologies for the formulation of the national population strategy action plan;
- Capacity building initiatives for MDGs costing which led to the preparation of the first national health sector MDG costing report. This was carried out at both central and governorates' level;
- On the job training, through technical assistance, in support of the youth survey and in-depth studies.

Special attention was devoted to building the capacity of the Central Bureau of Statistics (CBS) as the lead agency for quality data collection, analysis and dissemination. UNFPA fielded a technical assistance mission for the assessment of the training needs in statistics as well as to review the policy for statistical information, including the role of the Central Bureau of Statistics as the primary producer and coordinator of the official statistics in the country in line with the internationally accepted standards. In addition, specific attention was given to strengthening the role and working mechanisms of the Gender and Children Statistics Unit at the office, further activities, supported by UNFPA, include:

- Examine and analysis of constraining factors affecting the quality of vital statistics data and their differences by various sources;
- Enhancing the capacity of CBS to undertake various data collection activities such as time-use which would provide gender–related information as well as the envisaged disability survey;
- Expanding the interaction between users and producers of gender statistics;
- Strengthening capacity of concerned CBS staff for the analysis of data;
- Support technical capacity of staff through scholarships as well as ensure exposure to various successful experiences in the region (Morocco);
- Establishing data base system within the context of Oracle and conducting training for It Directorate concerning population and social data. This also included exposure to the experience of Egypt in that respect.

In sum, the impact of capacity development is considered a long-term investment that would affect the performance of various stakeholders and increase potentials for progressing towards achieving the national goals and priorities. The sustainability of such activities is challenged by the possible mobility of the trainees, the need for continuous capacity building as well as increasing the number of participants and adopting modalities that integrate training sessions with special programmes for on-the-job training.

**Communications and Advocacy:**

One of the main outcomes of the PD activities is to provide quality information concerning population issues and their interlinkages to sustainable development planning. These are evidence-based information that is being used for extensive policy dialogue and advocacy for national goals and priorities, within the context of the National Development plan. The comprehensive and reliable analytical knowledge base that are obtained from different sources would enhance community ownership and allow the formulation of a culturally-sensitive communication strategy on population issues, RH, gender and youth.

The challenge in this case is to strengthen the coordination among various components of the country programme and to make better use of the comparative advantages of various stakeholders. Such process would strengthen strategic alliances.
and partnership at the local level as well as ensure better coordination with international agencies contributing to the full implementation of the CP.

The media is playing an effective role that need to be harmonized through the utilization of the same concepts and definitions. Within that context, the manual providing key concepts used in population and social statistics, for media personnel is breaking the barriers and contributing to the process of establishing a consensus about the terminology used by various sources. It also shows the importance of the close cooperation between stakeholders (CBS and the Ministry of Information) with the support of UNFPA.

**Gender Component:**

The component evaluation covers three basic questions concerned with the implementation of the gender/GBV related surveys as well as use of surveys’ data for programming purposes, the extent of community-based and non-governmental organizations role and media entities in promoting gender/RH issues, coordination and their full-fledged acceptance by local communities, and assess facilitating and constraining factors as well as challenges on the way to establishing GBV Observatory and National Gender Coordination Group. In addition, within the context of health and community mobilization efforts we are directed to up-scale MDGs, through targeting the poorest villages in the North Eastern Region, and to develop a joint gender communication strategy.

**Establishing Gender Knowledge Base:**

Availability of reliable timely information about gender related issues is considered a priority to guide further intervention and for using the resources/inputs in a cost-effective manner. It provides evidences for advocacy and informing the content and priorities of strategic development framework. The Gender programme component supported undertaking the quantitative survey and qualitative study on domestic violence. It is to be noted that the mainstreaming efforts of the Gender programme component stakeholders ensured the integration of gender issues in the design of other studies/surveys and all other initiatives aiming to generate evidences. Moreover, the programme worked on building the capacity of institutions that are engaged in the design, analysis, dissemination and utilization of findings.

The first national quantitative survey on household domestic violence, initiated in 2008 and fielded in 2009 was followed by a qualitative research in 2010 under the auspices of the Syrian Commission for Family Affairs (SCFA). The survey successfully provided evidences that were used for informing the gender related priorities of the 11th National Development Plan for 2011-2015, and accordingly these will be also used in identifying the priorities for the forthcoming UNFPA country programme (2012-2016). Moreover, the SCFA with UNFPA support conducted an in-depth study on gender related legal frameworks and CEDAW implementation.

The wide utilization of the survey finding demonstrates its effectiveness for evidence-based policy dialogue and advocacy in support of gender issues. This was also
strengthened through the various inputs that were carried throughout the period 2007-2010. These inputs were instrumental in paving the way to reach the planned results:

- Evidence-driven national workshops on Household Domestic Violence (GBV, 2009) and early marriage (2010) for the parliamentarians was conducted with the tangible inputs of the concerned national NGOs, including Association for Women's Role Development and Women General Union;

- Evidence-based workshops on gender and women’s empowerment for the parliamentarians in the context of the National Development Plan;

- Orientation workshops were conducted for the staff of the Ministry of Social Affairs and Labour (MOSAL), NGOs, media professionals and community leaders on RH/GBV concepts;

- National Gender Mainstreaming Manual was designed, to serve gender mainstreaming efforts during the national development planning processes;

- A national assessment of juvenile centres in Syria was completed and disseminated in 2010. Gender issues were integrated in the assessment’s questionnaires followed by designing a manual for service providers;

- UNFPA succeeded in mainstreaming gender issues in the joint project on establishing National Social Aid Fund (NSAF)’, which was launched jointly with UNDP and MOSAL and Labour in 2007 and is still being implemented. In this context, UNFPA incorporated gender issues in questionnaires of a comprehensive mapping of ultra-poor in 2007 and provided further support in data collection, developing M & E system and communication strategy in 2008-2010. The project was extended to 2011.

In total, some 730,000 families have got registered for assistance and 550,000 met the criteria for assistance. The main purpose is to ensure that most vulnerable households/ultra-poor can benefit from this initiative. In particular, the NSAF is expected to provide cash assistance to aged people, persons with disabilities, divorced and separated women, single female heads of households, orphans up to 15 years of age and families of prisoners.

It is worth noting that generating gender specific evidence through the mapping exercises secured mainstreaming gender issues and aspects, especially the importance of addressing the needs of disadvantaged women, is relevant to the purpose of the programme component as well as the national priorities and UNDAF.

Besides, other surveys carried out within the context of the other programme components also contributed to securing evidences about gender-related concerns and issues. Key among these is:

- The Youth survey/studies (2007/08) provided solid evidence in terms of comprehensive & disaggregated quantitative and qualitative data on Syrian
Youth and Gender in addition to youth societal participation, education, health and employment.

- The 2009 Household and Health survey secured evidence on gender related concerns and issues;
- The Household Income and Expenditure Survey (2007/08) also integrated questions on women’s status and decision-making power.

Ensuring the sustainability of gender-related data and indicators was also given due attention within the CP where technical support on establishing a consolidated structure and working mechanisms of the Gender and Children Statistics Unit at the Central Bureau of Statistics, to secure the flow of systematic gender data.

**Strengthening outreach capacity:**

The Gender programme component succeeded in establishing a strong culturally sensitive community outreach component with multi-sectoral coordination mechanisms, which involves local government entities, CBOs and NGOs.

Community mobilization and media campaigns, which were designed and successfully conducted in 7 governorates and 60 villages throughout 2008-2010, have reached out more than 100,000 people with gender, RH and GBV sensitization messages. Successful community mobilization campaigns and culturally sensitive approach gained commitment and support of the local authorities and community leaders to the campaigns and gender and RH issues.

It is worth noting that the community mobilization and media campaigns were initially launched in the three north-eastern governorates- Deir-ez-Zor, Al-Hasakeh and Al-Rakka and further expanded to other governorates, namely Aleppo, Idleb, Homs and Lattakia based on the government request that confirmed the success of the selected interventions and approaches.

In 2010, UNFPA community mobilization model was adopted by the Syrian State Planning Commission (SPC) as a national programme and integrated within the 11th 5-Year NDP with the subsequent resource allocation, which witnesses the sustainability of this initiative. It can also be considered as an unexpected positive result.

The above achievements materialized as a result of opting for and implementation of the following interventions, which worked well for effectiveness within the available resources.

The Gender component contribution also involved capacity building support to NGOs in Al-Rakka, Deir-ez-Zor and Aleppo on establishing and managing counselling centres for violence against women and their families as well as scaling up violence prevention mechanisms. UNFPA also secured the inclusion of GBV in-service training of health service providers and integration of GBV related services in Halbouni Clinic.
Integrated Community Development for up-scaling the MDGs:
Within the context of community mobilization, 9 ministries and 7 UN Organizations, including UNFPA, launched a joint project to promote the achievement of the MDGs at local level. Based on the concept paper developed by UNFPA, the project targeted the poorest villages in the North Eastern Region.

Strengthening gender coordination and protection mechanisms:
The programme component was proactive, efficient and effective in securing multi-sectoral coordination and protection mechanisms and initiatives for gender mainstreaming as follows:

1. Further to the recommendations of the 2008 Annual Program Review on setting up a steering/coordination group for the gender component, a national gender coordination committee was established by the SCFA in 2009 on the basis of a concept note developed by UNFPA. This can be considered as a breakthrough achievement.

The national gender coordination committee was re-launched in 2010 with the renewed commitment of the SCFA and other stakeholders to lead and operationalize the functional responsibilities of the coordination mechanism as follows: a) secure capacity building support to members of the Group; b) promote information and knowledge sharing; c) strengthen the gender focal points system within government and non-governmental organizations; d) provide technical support and advise to sectoral ministries in support of gender mainstreaming; and, e) mainstream gender in the national development frameworks.

2. Gender Communication Strategy that was developed in collaboration between the MOI and SCFA (with UNFPA support). The strategy was based on the quantitative and qualitative research on domestic violence and previous experience in carrying out such exercise in 2008-2009 concerning family planning and maternal health that was followed by three waves of media campaigns.

3. National gender mainstreaming manual developed within the Gender programme component (involving a regional expert and a national consultant) is expected to guide gender mainstreaming efforts of the gender coordination committee. In this context, the manual is considered as a practical tool for mainstreaming gender in national policies and development frameworks, which witnesses the relevance of the programme interventions.

The mutually reinforcing nature of the two interventions given above is a good demonstration of the efficiency and effectiveness of the specific programme components initiatives towards producing the desired output.

4. In 2008, the SCFA initiated the process of establishing Family Protection Units (FPU), which is under way. UNFPA provided the necessary support to the process of establishing FPU which embrace women’s refuges as well. (The SCFA initiative of setting up women’s refuges within the FPU is a
response and commitment to the need of combating domestic violence and at a larger context tackling GBV issues in the country. The effort itself expressed the willingness and commitment of government to combat any sort of violence against women and children in Syria.)

5. **National GBV Observatory** was established in 2010, which will be linked, upon its full functionality, to the FPU:

- With respect to establishing FPU and GBV observatory, the Gender programme component provided the necessary technical support, which includes preparation of the women refuge’s terms of reference, protocols for partner agencies, referral procedures, provision of equipment for the observatory, and assessment of the training needs.

- The programme component facilitated study tours to Morocco and Tunisia so that the Syrian Commission for Family Affairs could get acquainted with and build on the Moroccan and Tunisian experience in addressing gender/GBV issues through establishing protection mechanisms and systems.

- The programme component also provided technical assistance to the SCFA to conduct a desk review on gender related legal frameworks and analytical study on CEDAW implementation at the national and local levels.

- In addition to the GBV (House Domestic Violence) related initiatives at the central level, the Gender component also put out tangible efforts towards introducing the principles and concept of establishing counseling centers for victims of GBV in selected NGOs in Al-Rakka Deir-ez-Zor and Aleppo in 2010.

One of the key challenges faced by the Gender programme component was related to securing timely and **quality technical assistance**.

It is worth mentioning that the UNFPA humanitarian component managed to include GBV in-service training of health service providers and integrate GBV related services in Halbouni Clinic, which can be replicated within the development component. However, there is still room for awareness raising and capacity building on the concept of gender at the grassroots level. This requires simplified awareness raising and training materials.

**Gender Communication Strategy:**
Developed in collaboration between the MOI and SCFA (with UNFPA support): The strategy was based on the quantitative and qualitative research on domestic violence and previous experience in carrying out such exercise in 2008-2009 concerning family planning and maternal health that was followed by three waves of media campaigns.
Lessons Learned

Commitment translated into actions and resources allocations (human and financial) as well adopting a solid framework for following up and monitoring progress are key issues for the success of planned programme interventions within the various components of the UNFPA/CP. This was clearly noticeable in the last year of current NDP and for the preparation of the 11th NDP (2011-2016) where allocations for population issues were secured.

Active coordination between various CP components’ inventions is instrumental for progressing towards achieving the planned outputs and maximizing results. The coordination among various national counterparts and UN agencies lend support to the success of the overall process.

Specifically, lessons learned for each component are presented;

Reproductive Health

1. Situations of Women

- Some women and neonatal who die due to complications related to pregnancy and birth may not be receiving adequate health care or tracking from public or private sources and may be unable to reach emergency services in time due to distance from them or logistical issues (e.g. availability of transport).

2. Reproductive Services

- Conditions of work and distance from city centers make staffing difficult for rural clinics - special effort is required to ensure adequate midwives/staff in rural clinics for antenatal care, outreach, and referrals.
- Supervision and monitoring in governorates and districts are vital to ensure high quality of EmOC services and support needs to be provided for transportation and fuel and other supporting costs.
- Committees of physicians or midwives have numerous commitments and special advocacy efforts are needed to motivate and support their involvement; they require a strong information flow from the MoH.
- Special efforts are required to ensure that high-risk pregnancies are identified and linked to services; Community support may be vital to protect them.
- Improvement of infrastructure and higher quality of medical equipment has a positive effect on demand and quality of services.

3. Capacity Development

- Beyond the numbers approaches should become part and parcel of national maternal, perinatal and neonatal health surveillance system, which would serve the purpose of sustainability
• The success of TOT training depends on the commitment of the organization being trained to use the trained staff and funds are wasted if this commitment is not secured.
• Training requires a varied approach (long/short-term; repetition; on-the-job, practical/theoretical) as opposed to a traditional approach, and local implementation.
• Long term experts working with the national team have a positive impact in improving skills and services.
• International consultants can make substantial contributions particularly in RH technical topics.
• Training is more effective when conducted locally; refresher courses are important motivators; TOTs have a multiplier effect and more are needed to create a cadre, especially of midwives.

4. Policy decisions

• It is essential to ensure high-level endorsement process i.e. the Ministry of Health (MoH) decree in support of a full-fledged operationalization of confidential enquiries into maternal deaths and near-miss case reviews.

5. Administration

• Forward planning and anticipation of delays can keep objectives on track and avoid need for reprogramming funds and activities. All activities which come under the Trust Fund should be scheduled for April-May.

6. Communications/networking

• Numbers of VCCT service users fluctuate with intensity of public messages and seasonally so more effort is required to consistently maintain and increase numbers.
• Regular inclusion of RH and HIV/AIDS within community mobilization programs helped to network to other efforts for widening awareness.
• Building partnership with NGOs, especially working with youth, improved successful planned interventions and enhances awareness.
• Any campaign such as the anti-Doping campaign requires a good research base to be effective and strong monitoring.
• Strong community-based strategies are required to counter pressures to have many children.

Population and Development

1. Relevance of the UNFPA/CP with national goals and priorities and the Country’s commitment, foster community ownership of the program objectives, including support to population issues, RH, gender and youth.
2. Furthering commitment is instrumental for the successful implementation of program activities. Policy dialogue and extensive debates among all concerned partners, using reliable evidences, as well as linking with NDP, at all levels, are key strategies in that respect.

3. Widening the circle of policy dialogue to involve decision-makers at various levels, Parliamentarians and community leaders in advocacy would be reflected on the performance of the CP and improves coordination.

4. Expand the CP stakeholders to secure the participation of religious leaders in support of development and population issues.

5. Monitoring and evaluation plans, with the specified set of indicators, should be part of the design stage to ensure consistency, the standardization of the concepts and agreed-upon methodologies.

6. Creating the culture of result-base management would enhance the process for developing programmes for intervention as well as contribute to the proper implementation of the M&E framework.

7. National reports such as ICPD@15, 2010 MDGs and the State of the Syrian Population report provides comprehensive tool to measure progress and at the same time indicated commitment to the global initiatives (ICPD/PoA and MDGs).

8. The presence of an endorsed national population policy and other related documents (such as women and youth policies/strategies) is a priority to inform decision makers as well as the public at large, of the goals and objectives concerning this issues and foster support to them.

9. The formulation of governorates responsive development plans to population issues operationalize the integration process, strengthen local planners and provide objective criteria for the allocation of resources.

10. Parliamentarians can be effective and influential in debating various population-related issues based on quality and reliable evidences.

11. Expanding utilization of quality data and research findings is essential for broadening policy dialogue and informing goals and priorities as well as develop relevant advocacy plans.

12. Linking surveys and studies to the time table of major strategic planning and programming processes (National Development plan) as well as reporting and monitoring activities (State of the Syrian Population Report, ICPD@15, MDGs report), enhance utilization of the findings.

13. Capacity building is a long-term investment that should be expanded based on actual needs and careful assessment of previous sessions. It should adopt modalities that enhance dependence on local capacities and integrate both formal training sessions with special programmes for on-the-job training.
14. The availability of solid timely updated knowledge base as well as packaging the findings of various surveys and studies in a user-friendly format for media professionals, increase their utilization and lead to wider policy dialogue and advocacy.

**Gender**

1. Surveys and studies provide data to close the gaps and enrich major national analytical processes, strategic planning exercises as well as reporting and monitoring initiatives. This is key to success of advocacy, policy dialogue and gender mainstreaming efforts (such as national state of population report, ICPD and MDG reports & etc.);

2. Packaging findings of surveys and studies in a simple and user-friendly format for policy and decision makers, community leaders and media professionals is considered as an effective way of dissemination of data for gaining support and commitment;

3. While mainstreaming gender issues in the other programme components is a very positive development, the role of the Gender programme component should have been expanded to:
   a) Serve as a repository of knowledge base (generated within surveys and studies of the other programme components) and
   b) Move to the forefront of advocacy and policy dialogue promoting gender equity, equality and women’s empowerment.

4. Taking into account socio-cultural aspects, promoting community ownership and applying culturally sensitive approach in women’s empowerment turned out the key factors behind gaining the support of local communities to community mobilization campaigns, the subsequent replication/expansion and adoption as a national programme;

5. Creativity aspects of community mobilization and media campaigns on gender, GBV (Household domestic violence), maternal health, family planning and youth issues and concerns included theatre sketches and TV spots ‘fraught with drama’, which can work better in terms of sensitization of the intended audience rather than just “lecturing” and “preaching” types of communication;

6. Even though the communication/media group, which was established within the Gender programme component, played a key role in the overall coordination of behavior change communication/media campaigns on gender, maternal health and family planning issues, mainstreaming behavior change communication interventions across all the programme components is considered as the best approach in mobilizing national expertise for analyzing and informing the content of media materials;

7. In the context of the cross-cutting nature of advocacy and behavior change
communication, intersectoral collaboration is considered as the key factor to achieving the related communication objectives in terms of capacity building, outreach and tailoring communication messages to the needs of the intended audience.
(e.g. Statistical and HIV/AIDS manuals for media professionals were designed in close cooperation of the Central Bureau of Statistics, National AIDS Programme and Ministry of Information (MOI) or community mobilization teams comprised of CBOs/NGOs and various sectoral directorates).

8. Establishing the overall multi-sectoral gender coordination mechanisms vs. just the programme component steering committee with limited/specific functions is seen as a key factor that ensures the programme sustainability;

9. Efficient and effective GBV protection mechanism requires concerted efforts at all levels from central down to the community and grass-root levels, which in their turn, can set up specific models;

10. Mixed technical assistance initiative when a regional expert works hand-in-hand with a national expert serves the purpose of sustainable national capacity development, which is worth replicating;

11. Figuring out which intervention is critical in terms of reinforcing another intervention or creating a good ground for implementing another intervention is a key to operational efficiency and effectiveness (e.g. gender mainstreaming manual in support of the functions of the gender coordination committee or the linkage between GBV observatory and FPU);

**RECOMMENDATIONS**

**Reproductive Health**

**Key Recommendation 1:** Devote more resources to strengthening access to and availability of Family Planning services by strengthening quality assurance mechanisms including the contraceptive logistics management system within Family Planning services and promoting the demand side of FP through well targeted BCC and by implementing more activities directly in/with communities prioritizing rural and poverty-stricken areas and the Vulnerable Groups.

**Key Recommendation 2:** Continue to strengthen utilization of community resources effectively, e.g. leaders, youth, and volunteers to pass RH messages to both males and females

**Key Recommendation 3:** Strengthen an evidence-based and integrated planning approach, aiming for collecting evidence that activities are working toward sustainable KAP changes and that components are integrated to the degree possible
Key Recommendation 4: Strengthen coordination and collaboration among components in the MoH and UNFPA and with other agencies and assistance providers, developing stronger collective efforts toward improving key indicators. Promote public-private sector partnerships especially for capacity building and standard setting.

Key Recommendation 5: Advocate for solutions to long-term constraints to sustainability in the health system support for RH, providing motivation and support for medical staff in rural clinics and for routine monitoring by the MoH to help improve services in rural and disadvantaged areas.

Key Recommendation 6: Help ease administrative barriers to timely funding and implementation, timely securing of consultants and trainer, and provision of quality equipment and supplies.

Detailed Suggestions and Recommendations

1. Systematic improvement of Emergency Obstetric Care (EmOC)

- Increase support for normal delivery centers which are hubs for referral to hospitals for comprehensive EmOC
- Promote linkages of RH staff with community-based groups as well as linking midwifery services with antenatal and postnatal care and community support
- Consider including the "Beyond the Numbers" community-based reviews (verbal autopsies) in the project
- Provide support for the RH Technical Committee to review its TOR and agree on their roles as well as the modalities of work that can lead to achieving its objectives
- Promote the development of the maternal mortality and neonatal surveillance systems as soon as possible.

2. Effectiveness of RH clinical protocols

- Effectively work with the Ob/Gyn Association and other channels to strengthen cooperation with the private sector
- Promote MoH postnatal services as soon as possible and add nutritional counseling guidelines to antenatal/postnatal guidelines and procedures
- Reduce administrative hurdles for program and funding approvals and advocate for monitoring support such as for fuel and transport.

3. Availability and access to RH services

- Focus on improving Family Planning services, disseminating FP guidelines; Employ greater use of outreach, word of mouth, mobile clinics, youth networks and community mobilization to reach males
- Continue to upgrade (particularly rural) facilities and equipment and work steadily to improve data collection
- Link RH services efficiently (and with vaccination events) so women use more than one service with each visit
- Create models/pilots to illustrate good practices such as for RH community outreach (with possible home visits)
4. **Approaches for the HIV/VCCT Domain**

- Enhance linkages between VCCT staff and services, community organizations and youth projects to cover needs of the those previously missed and the Vulnerable Groups and to capture information on them.
- Promote closer integration of the NAP and the RH services within the MoH and continue to extend the information linkages between the VCCT services with the RH clinics.

5. **Relevance of Youth Approaches**

- Advocate for institutionalization of results based planning aiming for KAP gains (as per SARA findings); expand to 2-4 levels of the Kirkpatrick model for training evaluation.
- Develop strategies to reach the most Vulnerable Groups.
- Ensure an effective mechanism for planning and connecting the components of the youth-related activities to each other and to all other components.
- Add more Family Planning aspects to the NGO youth activities and relate them to national goals.

6. **Value-Added Role of YPEER**

- Systematically expand the YPEER network, by training young people and showing them the benefits of the YPEER network, experience and influence in the community.
- Demonstrate to NGO partners and YPEER network advantages of using results planning aiming for longer term KAP gains and do planning together with united objectives, outputs and indicators.
- Ensure that training and awareness raising is based on sufficient research and expertise.

**Population and Development**

1. Developing the overall policy framework clearly highlighting the main goals and objectives of the Country concerning population and other related matters. Priority should be given to the finalization of the National Population Policy which is considered an integrated part of the 11th NDP.

2. Expand and upgrade the process of developing responsive plans to population issues, RH, gender and youth, at central and local levels, with clear specified goals and objectives.

3. Strengthen coordination among various partners working with youth as well as enhancing institutional and community capacity for promoting youth empowerment and participation.

4. Expand ownership for the population issues, RH, gender and youth, to all stakeholders that can play an effective role in supporting the national programmes and advocacy. This should include the Ministry of Awqaf.
5. Finalize the Development of a comprehensive, integrated and well-designed M&E framework, to assess progress towards achieving national goals, based on a clearly defined set of SMART indicators.

6. Support efforts to expand knowledge and utilization of DevInfo, at various levels, and develop operational procedures to activate the role of different partners for updating and dissemination.

7. Further involvement of parliamentarians in policy dialogue and advocacy for population and sustainable development issues as well as actively participating in monitoring and evaluating progress within Parliamentarian debates.

8. Strengthen the management and content of the National data base, with special emphasis on quality, timeliness and identification of priority emerging topics to be covered within the strategy (disability, aging…). This include:
   - Contribute to various efforts aiming to develop a National Statistical Strategy in line with well established framework including institutional and human resources;
   - Establishing a mechanism to assess the validity and consistency of statistical data, from various sources;
   - Support comprehensive data collection activities, the 2014 census, with emphasis on quality, timely dissemination of findings, accessibility and intensive utilization of results (CBS);
   - Contribute to the support for the planned large-scale survey on youth, condition to the provision of required additional information and to update the current one that would lead to the finalization of a youth strategy.

9. Support efforts for capacity development, within a comprehensive framework and adopting modalities that integrates formal training and on the job activities.

10. Production of user-friendly materials for various partners, especially media professional, elaborating the main findings of various national data sources and in-depth studies, to expand their participation in policy dialogue and advocacy.

**Gender**

1. Use evidences to advocate for developing a national gender strategy and multi-sectoral action plan in support of operationalization of the related objectives of the 11th National Development Plan;

2. Continue addressing the needs of disadvantaged women (divorced and separated women, single female heads of households) in the framework of the NSAF;

3. Analyze and reconsider behavior change communication interventions and materials, including media spots on domestic violence based on the findings of the Survey and Study.

4. Enhancing the content of the gender mainstreaming manual (*designed in the framework of the Gender programme component*) based on findings of the Survey
and Study on Domestic Violence.

5. A comprehensive output for Gender programme component, based on the current needs and in conformity with the six key pillars of the UNFPA Gender Strategy Framework, need to be developed to bypass the limitation of the current program, only to addressing GBV. This would result in focusing on strengthening gender mainstreaming in policies, institutional frameworks as well as conducting a comprehensive thematic assessment of community mobilization and media campaigns on gender, RH and youth issues.

6. Build on the good practices and lessons learned generated from the Gender programme component’s communication and community mobilization initiatives, while up scaling advocacy and behavior change communication as cross-cutting issues in the other programme components.

7. Upscale youth involvement in community mobilization and media campaigns on addressing gender and GBV issues through leveraging the potentials of the Revolutionary Youth Union, National Union of Syrian Students, Junior Chamber International, NGO “SHABAB’ and YPEER network.

8. Provide support to the SCFA and MOI in their efforts to form a national team of gender experts and media professionals with the subsequent capacity building support to the team members, including training of trainers on the concept of gender, gender equity and equality principles.

9. Provide further support to the SCFA in its capacity as the chair of the gender coordination committee and operationalization of the committee’s terms of reference.

10. Support establishing gender “clearing house”/library for reports, bulletins, publications, and other information in support of further gender mainstreaming efforts.

11. Establish partnership with the Ministry of AWQAF, Women General Union, Ministry of Education (gender and school curriculum) and National Union of Syrian Students in order to further expand gender/GBV response and scale up culturally sensitive aspects in the framework of the next cycle of assistance along with the SCFA, MOSAL and MOI.

12. Provide support to GBV protection mechanisms at the central and local levels.

13. Establish clear-cut criteria for regional and national consultancy, and whenever feasible and essential, continue arranging mixed technical assistance missions with regional experts supporting national experts.
ANNEXES
## ANNEX I (SYRIAN ARAB REPUBLIC) - EVALUATION METHODOLOGY FRAMEWORK

<table>
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<th>Objective</th>
<th>Specific Questions</th>
<th>Performance Indicator</th>
<th>Data Source</th>
<th>Evaluation Design</th>
<th>Sampling Plan</th>
<th>Data Collection Instruments</th>
<th>Data Analysis Plan</th>
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<tbody>
<tr>
<td>Assess functionality of mechanisms for systematic improvement of the emergency obstetric care (EmOC)</td>
<td>Were the mechanisms conducive to the efforts aimed at improving EmOC?</td>
<td>Mechanisms to ensure systematic improvement in the performance of different components of EmOC are in place</td>
<td>Interviews and focus group discussions with the RH Department and RH Technical Group of the Ministry of Health</td>
<td>-</td>
<td>-</td>
<td>Questionnaire for the interviews and focus group discussions</td>
<td>Analysis of questionnaire responses and minutes of focus group discussion</td>
</tr>
<tr>
<td>Assess effectiveness of the clinical protocols on FP, antenatal care and EmOC in better provision /utilization of the services</td>
<td>Did the introduction and use of the RH related protocols contribute to scaling up the quality of care?</td>
<td>Proportion of health facilities (normal delivery points, and health centers) providing quality RH services in accordance with the established protocols on FP, antenatal care and EmOC</td>
<td>RH Department and RH Technical Group of the Ministry of Health; Facility service data/ selected health facilities</td>
<td>-</td>
<td>-</td>
<td>Concise questionnaire for health professionals</td>
<td>Analysis of questionnaire responses</td>
</tr>
<tr>
<td>Assess validity and effectiveness of the RH programme component’s approaches and strategies in support of increasing the availability of and access to at least three RH services</td>
<td>Did the RH programme component interventions result in increasing the number of health facilities providing at least three RH services?</td>
<td>Number of health service points offering at least three RH services (antenatal care, FP, RH conditions)</td>
<td>MoH statistics</td>
<td>-</td>
<td>Random sampling of health facilities</td>
<td>Concise field visit questionnaire</td>
<td>Analysis of questionnaire responses</td>
</tr>
<tr>
<td>Assess validity of the current strategies and approaches in HIV VCCT domain</td>
<td>What were the key achievements in the VCCT domain?</td>
<td>Number of HIV VCCT centers equipped to apply national adapted protocols and Facility service</td>
<td>National AIDS Programme of the MoH; Facility service</td>
<td>-</td>
<td>Random sampling of health facilities</td>
<td>Concise field visit questionnaire</td>
<td>Analysis of questionnaire responses</td>
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<tr>
<td>Objective</td>
<td>Specific Questions</td>
<td>Performance Indicator</td>
<td>Data Source</td>
<td>Evaluation Design</td>
<td>Sampling Plan</td>
<td>Data Collection Instruments</td>
<td>Data Analysis Plan</td>
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<tr>
<td>Assess relevance of the current approaches and strategies in reaching out youth with RH STIs/HIV/AIDS messages</td>
<td>Were there any unexpected positive results?</td>
<td>Number of Youth Centers providing RH, including STIs/HIV/AIDS information</td>
<td>National AIDS Programme of the MoH; Youth centres’ data; Various reports</td>
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<td></td>
<td>Did the programme component identify innovative and efficient ways and means of reaching out youth with RH STIs/HIV/AIDS messages?</td>
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<tr>
<td>Assess effectiveness the PD programme component’s approaches and strategies in raising the commitment of parliamentarians to population, reproductive health, gender and youth issues</td>
<td>Did the PD programme component adopt innovative approaches to engage parliamentarians in population advocacy and programmes?</td>
<td>Number of newly elected parliamentarians oriented on population and development issues and engaged in the related activities.</td>
<td>Interviews with key informants; Media coverage of the parliamentarians’ activities</td>
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<td>Assess the extent and quality of utilization of the census and survey data for producing in-depth research studies and</td>
<td>Did the findings of in-depth research studies and population reports bring about specific</td>
<td>Number of in-depth research studies and reports (including SSPR) related to</td>
<td>Interviews with key informants; Media coverage of the parliamentarians’ activities</td>
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<tr>
<td>strategic reports</td>
<td>strategic policy and programme related decisions and actions? What is the total amount of resources earmarked to population, including reproductive health interventions?</td>
<td>population and development, including youth issues produced and disseminated</td>
<td>Print and other media.</td>
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<td>Assess efficiency and effectiveness of the implementation of the surveys as well as use of surveys’ data for programming purposes</td>
<td>Did surveys provide adequate evidence concerning progress towards national development priorities and goals?</td>
<td>Number of surveys related to population and development</td>
<td>Interviews with key informants</td>
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<tr>
<td>Assess efficiency and effectiveness of the implementation of the surveys as well as use of surveys’ data for programming purposes</td>
<td>Were the surveys’ findings produced and used in a timely manner? Were the surveys’ findings produced and used in a timely manner?</td>
<td>Quantitative and qualitative research studies on Gender/GBV are in place</td>
<td>Interviews with key informants</td>
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<td>Assess the extent of NGOs/CBOs’ role, coordination and their full-fledged acceptance by the local communities</td>
<td>Did the UNFPA supported NGOs/CBOs integrate into the local communities? Were there any unexpected positive results as a result if UNFPA support to</td>
<td>Number of NGOs, local communities and women’s groups actively promoting gender issues, women’s empowerment and addressing GBV</td>
<td>Interviews with key informants, namely NGOs/CBOs staff and community members</td>
<td>-</td>
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<td>Concise questionnaires</td>
<td>Analysis of responses</td>
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<tr>
<td>NGOs/CBOs?</td>
<td>Assess facilitating and constraining factors as well as challenges on the way to establishing the GBV Observatory</td>
<td>Did the programme component take into account and address the multi-sectoral nature of the process of establishing the GBV Observatory?</td>
<td>GBV Observatory is in place</td>
<td>Interviews with key informants, including the concerned staff of the sectoral entities</td>
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# ANNEX 2 - EVALUATION ROADMAP (SYRIAN ARAB REPUBLIC)

<table>
<thead>
<tr>
<th>EVALUATION ACTIVITIES</th>
<th>August 25 - September 23</th>
<th>September 23 - October 8</th>
<th>October 10 - November 9</th>
<th>November 16 - November 30</th>
<th>December 1 - December 8</th>
<th>December 15</th>
<th>December 16 - 25</th>
<th>RESPONSIBLE PARTY/SUPPORT</th>
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<tr>
<td>1. Formal communication with the State Planning Commission on the establishment of the CP Evaluation Management Committee (August 25)</td>
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<td>2. Submission of the CP Evaluation ToR to the ASRO M &amp; E Advisor (August 29) and State Planning Commission (September 5)</td>
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<td>3. Securing CVs (September 20) and organizing a meeting of the CP Evaluation Management Committee (September 23) to select external evaluators on the basis of the ToR requirements.</td>
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<td>CP Evaluation Managers ASRO M &amp; Advisor</td>
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<td>4. Consultancy arrangements (September 23 – October 4) and desk review of relevant materials i.e. reviews and thematic assessment exercise by the evaluators and ASRO M &amp; E Advisor and submission of an inception report (October 4 - October 8)</td>
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<td>CP Evaluation Managers External Evaluator ASRO M &amp; Advisor</td>
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<td>5. Country mission of external evaluators, including one day workshop with stakeholders on the 3rd or 4th of November (ASRO M &amp; E Advisor can join the Evaluation Team over the last week of the consultancy and also attend one day stakeholder workshop)</td>
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<td>CP Evaluation Management Committee CP Evaluation Managers ASRO M &amp; Advisor</td>
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<td>6. Submission of a first draft of the CP Evaluation Report (November 15) with the subsequent distribution of the draft to Evaluation Management Committee/partners for peer-reviewing and securing final comments and feedback (in order to finalize comments to the first draft the CP Evaluation Report the CO will arrange a meeting of the Evaluation Management Committee on the 30th of November)</td>
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<td>7.</td>
<td>Resubmission of a draft that has incorporated comments and feedback on the first draft. Arranging a meeting of the Management Committee on the 8th of December.</td>
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<td>CP Evaluation Management Committee</td>
<td>CP Evaluation Managers ASRO M &amp; Advisor</td>
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<td>8.</td>
<td>Finalizing CP Evaluation Report</td>
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<td>CP Evaluation Management Committee</td>
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<td>9.</td>
<td>CP Evaluation Meeting at the State Planning Commission</td>
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<td>CP Evaluation Management Committee</td>
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<td>10.</td>
<td>Uploading the CP Evaluation Report into the UNFPA central document repository, and announcing on the UNFPA M&amp;E Community of Practice</td>
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<td>CP Evaluation Managers</td>
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Annex 3: Evaluation Management Committee (EMC)

**Government:**

- Mr. Rifaát Hijazi, Director of Human Development Department, State Planning Commission
- Dr. Mazen Khadra, Director of Primary Health Care, Ministry of Health
- Ms. Doha Khaddam, Gender Section Coordinator in the SCFA

**UNFPA:**

- Dr. Bakhtior Kadirov, Programme Specialist

ANNEX 4: Persons Consulted

**Reproductive Health**

**Key Informants**

1. Saner Tarek Adel, MD Head of Boutstan Al Kaser Health Center, Aleppo
2. Etab Altakee, Programme Officer, Gender and Communication, UNFPA
3. Nabeel Al Ashram, MD, Head of District, Deir-ez-Zor
4. Hussein Asaad, MD, Head of Sarayeb Sihi Health Center, Idleb
5. Ammar Awas, MD, Head of Al Rishdiyeh Health Center, Deir-ez-Zor
6. Rana Ayzra, MD, Voluntary Counseling and Testing Unit, Damascus
7. Reem Bajari, Assistant Project Officer, Reproductive Health Component, UNFPA
8. Kousai Barbandi, MD, Head of Reproductive Health, Ministry of Health, Deir-ez-Zor Governorate
9. Reem Dahman, MD, Head of Reproductive Health Department, Ministry of Health
10. Rafifi Ghareeb, MD, Head of Aljamiyat Altadribi Health Center, Aleppo
11. Asma Habel, Reproductive Health Project Assistant, Reproductive Health Department, Ministry of Health
12. Liqaa Hallak, MD, Head of Reproductive Health, Ministry of Health, Aleppo Governorate
13. Wael Hatahet, Project Officer, Reproductive Health Component, UNFPA
14. Bakhtior Kadirov, Program Specialist, UNFPA
15. Mohamed Kanawati, Program Officer, Youth Program, UNICEF, Damascus
16. Mouhamad Kassas, MD, Head of Abou Touhour Normal Delivery Center, Idleb
17. Jamal Khamis, National AIDS Program, Ministry of Health
18. Hala Khayer, MD, Head of Infectious Diseases Department, Ministry of Health
19. Makiko Komasawa, Chief Advisor, Health System, Project for Strengthening Reproductive Health in Syria, JICA, Aleppo
20. Sanna Mihsen, MD, Head of Reproductive Health, Ministry of Health, Idleb Governorate
21. Ibrahim Najjar, MD, Head of Jamal Abd Al Nasser Health Center, Aleppo
22. Mamdouh Nesli, MD, Manager of National AIDS Programme, Damascus Directorate of Health, Head of the center for detection and treatment of infectious and contractible diseases
23. Rafah Trefi, Programme Officer, Population and Development, UNFPA

Focus Groups

1. Youth Group meeting:
   - Youth Agenda (Najwa Kallas)
   - Ministry of Labour and Social Affairs - (Ulfat Said)
   - Syria Trust for Development – research department (Majd Haddad)
   - Syrian Commission for Family Affairs (Karim Halaweh)
   - Junior Chamber International (Nada Assaad)
   - MOH – Adolescents Health programme (Hajaj Sharee)
   - Syria Trust for Development – SHABAB project (Hanadi Jawish)
   - Syrian Family Planning Association (Anas Habib)
   - Syrian Arab Red Crescent (Ramez Rawas)
   - Youth Commission for Volunteerism (Koutaiba Abo Shaer)
   - National Union of Syrian Students (Omar Aroub)
   - Revolutionary Youth Union – Ghazi Bakour

2. Syrian Family Planning Association, Youth Volunteers, Hajar Aswad, Damascus (15)
3. MoH Medical Staff, Health Care Center, Zouheir Hubi, Damascus, Physicians and Midwives (5) Cytology lab
4. MoH Medical Staff, Hai Al –Zouhour Clinic, Damascus, Mammography Technician, Physicians and Midwives (6)
5. Reproductive Health Technical Committee: Dr. Reem Dahman; Dr. Hyam Bashour; Dr. Salah Alsheika; Dr. Bashar Alkurdi; Dr. Mohamed Smadi; Dr. Redwan fayumi
6. Syrian Family Planning Association, Youth Volunteers, Deir-ez-Zor (20+)
7. Al Rishdiyeh Center, Deir-ez-Zor, Physicians and midwives (11)
8. Al Kisraa Normal Delivery Center, Deir-ez-Zor, Midwives (7) Physicians (3) Clients (3)
9. Jamal Abdel Nasser Health Centre, Aleppo, (number of beneficiaries annually = 54,000, number of RH among them = 7,200) Physician and Midwives interviewed (3) Client (1)
10. Aljamiiyat Altadribi Health Center, Aleppo (number of beneficiaries annually = 15,156, RH among them = 1,944) Physicians (3) Midwives (10)
11. Boustan Al Kaser Health Center, Aleppo (number of beneficiaries annually = 108,000 among them 3,600 RH) Physicians and midwives and mammography and pharmacy laboratory staff interviewed (8)
12. Medical Training Team, Aleppo (Dr. Ali Asfour, Dr. Ahmad Kadib Alban and Dr. Waleed Kabalawi)
13. Sarayeb Sihi Health Center, Idleb (number of beneficiaries annually = 72,000 among them 2,500 RH, Midwives interviewed (2)
14. Abou Touhour Normal Delivery Center, Idleb, (number of deliveries annually = 500) Midwives interviewed (2)

Population and Development

أولاً: مكتب الإحصاء المركزي

المنصب                          الاسم

مدير المكتب المركزي للاحصاء     د. شفيق عربش
مدير الإحصاءات السكانية والاجتماعية د. علي رستم
مدير التخطيط والتعاون الفني شامل بدران
معاون مدير التخطيط - مدير المشروع م. يحيى جمعة
مدير الحاسب الآلي إيمان مبيض
عاملة في مديرية الحاسب الآلي شهناز كريم
عامل في مديرية الحاسب الآلي شاهر طربين
عامل في مديرية الحاسب الآلي راتب زيدان
معاون مدير الحاسب الآلي فهمي الفاعوري
عاملة في مديرية الحاسب الآلي إيمان النحام
عاملة في مديرية الإحصاءات السكانية عزة بهلولي
مدير مركز التدريب الإحصائي في دمشق رغدة خطاب
عاملة في مديرية الحاسب الآلي ريم الشماع
عاملة في مديرية الحاسب الآلي رانيا المنقل
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الهيئة السورية لشؤون الأسرة

- رئيس الهيئة: د. إنصاف حمد
- مستشار: د. أكرم القش
- مدير البحوث: د. كريم أبو حلوة
- منشئ محور النوع الاجتماعي: أ. ضحى خدام
- منشئ ملف السكان: أ. وضاح الركاد
- باحثة: أ. الهام الصافي

رئاسة مجلس الوزراء

- لينا الفيسي: مكتب المتابعة
- حسين إبراهيم: مكتب دعم القرار

صندوق الأمم المتحدة للطفولة:

- مساعد مدير المكتب القطري: أ. مارك لويسيت
- مديرة برامج: أ. زينب سليم

نوع الاجتماعي

الهيئة السورية لشؤون الأسرة

- ضحى خدام
- عضو مجلس إدارة الهيئة السورية لشؤون الأسرة: د. هيام بشور
- جامعة دمشق: د. إسعاف حمد
- جامعة دمشق: د. حسام السعد
- جامعة دمشق: د. كندة الشماط
- د. نجوى قصاب حسن: خبيرة في قضايا النوع الاجتماعي
- غادة الأحمد: خبيرة إعلامية في قضايا النوع الاجتماعي
- إلهام صافي: مشروع النوع الاجتماعي في الهيئة السورية لشؤون الأسرة

صندوق الأمم المتحدة المتحدة للسكان

- رفاة طريفى: مسئولة برامج السكان والتنمية
- راية شكر: مسئولة برامج الشباب
Annex 5: Documents Consulted

First: Reproductive Health

- Reproductive Health, Annual Work plans and Reports (State Planning Commission, Ministry of Health, UNFPA), 2006
- The 10th Five Year Plan 2006-2010; GoSAR; Chapter One the Five Year Plan approach, 2007
- Annual Work Plan 2007 (no budget)
- CPAP Annex VI – The Five Year Monitoring Calendar (Was this updated?)
- Final Report 2007 (describes activities and research results, some feedback on training; constraints and difficulties, facilitating factors and lessons learned and budgetary note on pages 15-17)
- CPAP Project Tracking Tool, 2008
- RH Project Annual Report 2008 (constraints and difficulties, facilitating factors and lessons learned and budgetary note on pages 15-17), 2009
- Annual Work Plan 2009 (Family Planning) (Partner is MoH and activities: C, F, G): Totally Gov. funded? ($854, 827)
- Maternal Health Annual Work Plan 2009 (Partners: Syrian Family Planning and the OB/Gyn Association: CPAP activities – A, B, D, H, I, and J (the difference between this and the Annual Work plan are the activities and the partners) (same funding situation as Family Planning)
- RH Project Annual Report 2009 (improved analysis by activity and forward looking recommendations;
- CPAP Mid-Term Review 2009
- CPAP Project Tracking Tool, 2009
- Comprehensive Training Report on Advanced Life Support in Obstetrics (ALSO) Provider Course, October 2009, UNFPA and Center for Continuing Medical and Health Education
  “Support midwifery program in nursing school &in the maternity wards at the national hospitals at the north eastern governorates. Phase 1”; Prepared by: Dr Najwa Karout (Short-term Consultant) May to July 2009.
- “National Workshop on Beyond the Numbers”; December 2009; Report by external consultant, Professor James Drife
• Annex III – UNFPA CP MTR Strategic Report, 2010

• Annual Work Plan 2010 (file name is Family Planning) (Partners – MoH, coordination – State Planning Commission) CPAP Activities, C, F and G

• “Beyond the Numbers Initiative to address maternal death and disability” - a summary of good practices and challenges (2010)

• Maternal Health Annual Work Plan 2010, CPAP activities – A, B, D, H, I, and J (the difference between this and the Annual Work plan are the activities and the partners) Budget = similar to 2009 - $834,459.


• “National Workshop on Beyond the Numbers”, October 2010, Professor James Drife

Undated

• Annex I – CP Updated Evaluation Methodology Framework

• TORs for the RH National Technical Committee (2 versions)

Presentations and Studies (Government of Syrian Arab Republic, UNFPA)

• “The Health Situation in Syria”, GoSAR, PowerPoint presentation, no date on the pres, but includes 2009 data, comparative data

• “Needs Assessment of Eastern Governorates’ Primary and Referral Level Health Care Facilities with a Focus on reproductive Health Care”, September 19, 2006.

CP Evaluation

• TOR – Country Program evaluation

• TOR – RH Component Country Program evaluation

• RH Concept Note for the CP Evaluation

• Concept note – Youth Component, 2010

• Report Sample Format

• Tentative Programme

• Annex I – CP Updated Evaluation Methodology Framework

Other Sources

• MDG report summary on UNDP website


• UNFPA, BEYOND THE NUMBERS INITIATIVE TO ADDRESS MATERNAL DEATH AND DISABILITY

Second: Population and Development


• MID-TERM REVIEW, UNFPA COUNTRY PROGRAMME, 2007-2011.

• Follow-up and Monitoring Matrix for the 10th Five-year Development Planning, 2006-2010 (Arabic).

• COAR, APR, for Population and Development projects, 2009 and 2010.

• UNFPA, Syria, Concept Note: Population and development component, CP Evaluation 2007-2011.


• CPAP Monitoring and Evaluation Calendar, UNFPA CP, Syria 2007-2011.

• CPAP Planning and Tracking Tool, UNFPA/CP 2007-2011, Syria, Cycle 7.

• Household Health Survey (2009), Preliminary Report, English.

• Brief Summary on the Process for the Preparation of the State of Syria Population Report (SSPR), SCFA/UNFPA.


Statement of Thoraya Ahmed Obaid, UNFPA Executive Director, 2010 Annual Session UNDP/UNFPA Executive Board, June 2010, Geneva.


Youth Component: Concept Note, UNFPA/CP 2007-2011


القرير الوطني الثالث للاهداف التنمية للCAF بالأغلبية في الجمهورية العربية السورية (2010). هيئة تخطيط الدولة وبرنامج الأمم المتحدة.

مشروع دعم الإستراتيجية الوطنية للشباب في سوريا (2010). دراسات تحليلية معمقة، الهيئة السورية لشؤون الأسرة وصندوق الأمم المتحدة للسكان.


تحليل الوضع الراهن لقطاعات التنمية الإنسانية (2009). للجهيز لخطة التنمية الخمسية 11، هيئة تخطيط الدولة، إدارة التنمية البشرية.

ألفش، محمد إكرام (2010). مقترح المخطط الأول لموضوع صياغة السياسة السكانية في سورية، الهيئة السورية لشؤون الأسرة.

تقرير جلسات العمل الحوارية للجان الفرعية للسكان في المحافظات السورية (2010). الهيئة السورية لشؤون الأسرة.


Third: Gender

- COAR, APR, MTR, Gender component briefs prepared by the NPPP on Gender and Communication for evaluation purpose.

- UNFPA Communication Strategy on Family Planning and Maternal Health in the Eastern Region

- NGOs assessment report prepared for NGOS in the Eastern Region

- Training package for NGOs: 7 training manuals on RH, Gender (2), Management Skills (2), Communication skills, Life Skills, ToT

- Juvenile Centers assessment report

- Review brief report and presentation related to quantitative report and Qualitative study on National Domestic Violence Survey

- Advocacy materials related to the three Media Campaign: “ماما بخير. كلنا بخير” which includes; 4 T.V spots, 12 Radio spots, 12 Public figures video messages, notebooks with printed messages inside,

- Review advocacy materials, initiatives, and reports related to “Community Mobilization Project’, which includes: T.V spots, Interactive Theater sketches, local publication materials, community dialogues and open discussion and lectures covering: PDS, RH, Gender, AND Youth issues

- Review related materials of UNFPA- UN two joint projects under Gender component: MDG Up-Scaling project, (community development), and Social Aid Fund.

- Review draft 20 T.V spots prepared under Gender component, addressing, maternal health, youth and PDS issues with special focus on Gender, and GBV related issues.

- Review mission reports, under Gender and communication component

- Review MoMs related to the national Communication Committee, and Gender coordination committee

- Gender Program Component Evaluator, TOR, CP Evaluation 2007-2011


EVALUATION OF UNFPA COUNTRY PROGRAMME FOR 2007-2011
TERMS OF REFERENCE FOR THE EVALUATION TEAM
SYRIAN ARAB REPUBLIC

I. BACKGROUND

The UNFPA Country Programme (CP) for 2007-2001 reflects the priorities of the Common Country Assessment (CCA), the United Nations Development Assistance Framework (UNDAF), and the strategic direction of UNFPA. The CP cycle is harmonized with other United Nations agencies in the Syrian Arab Republic.
The UNFPA CP developed through an intensive consultative process with the Government and development partners, including UN sister agencies was designed to contribute to three UNDAF Outcomes: (1) Inter and intra regional disparities related to access and quality of health, education and other basic social services reduced with a focus on the Eastern, North and Badia regions and other disadvantaged areas; (2) Efficiency and accountability of governance structures at central and local levels strengthened by, government, civil society and the private sector, towards sustainable development; and (3) Risk and impact of natural and manmade disasters is reduced.

In order to review the extent of progress in the implementation of the CP components, generate lessons learned and identify the way forward, UNFPA CO, State Planning Commission and all the implementing partners conducted annual programme reviews (APR) in 2007 and 2008. The APRs reviewed facilitating and constraining factors as well as programme management and coordination issues, which resulted in clear-cut and strategic recommendations. As a result of the APRs the CPAP Planning and Tracking Tool (CPAP PTT) was equipped with the necessary data and targets and a common consensus was reached on monitoring and evaluation (M & E) activities, which were incorporated in the framework of the CPAP M & E Calendar.

UNFPA CP Mid-Term Review (MTR) was conducted in December 2009 and also built on the body of data and recommendations of the APRs. Further to the Country Office consultations with the State Planning Commission, both conventional/ or “expert driven” and participatory approach were opted for the MTR process. The MTR came up with the following sets of recommendations:

1) Sustainable institutional and human resource development: a) high quality technical assistance for integration of population, RH, gender and youth issues in development policies & plans as well as their implementation, monitoring and evaluation; b) gender & culturally sensitive behavior change communication; c) high quality technical assistance for further upscaling RH management & services; d) promoting holistic approach to young people development & participation; e) emergency preparedness and response.

2) Securing further and greater contributions to the National Development Plan: a) further expansion of the programme focus to the north-eastern governorates; b) strengthening technical & programme management capacity; c) linking development and humanitarian efforts; d) promoting national execution modality, financial accountability and accountability for results further; e) fostering different levels of strategic partnership, including in support of youth empowerment and participation; f) addressing youth empowerment and participation in a holistic manner

3) Upscaling monitoring and a strong focus on evaluation: a) strengthening the role of the programme components’ steering committees; b) continuous monitoring of performance indicators and targets, including annual targets; c) updating the monitoring and evaluation calendar; d) establishing annual performance targets; e) advanced planning for data analysis and review; f) confirming the programme evaluation plan; g) conducting baseline data quality assessment for the next cycle of assistance.

It is to be noted that the current cycle of assistance was overshadowed and marked by a demonstration of the very high level commitment of the Government to population and development issues through securing strategic reports, studies as well as other related initiatives and high-level statements and articles in print and other media. Although, Syrian Arab Republic has made tangible progress towards achievements of the MDGs, the results of various surveys and studies revealed that some areas across the country and mostly concentrated in the north-eastern region significantly lag behind others in terms of the population and development variables, including reproductive health (RH) indicators. Syrian Arab Republic has been witnessing stagnated or slow fertility decline where the total fertility rate was expected to constitute 3.16 during the period of 2005-2010 and constituted 3.45 in 2007 and 3.58 in 2004.

Thus, the main focus of the CP Evaluation will be on the CP relevance, efficiency, effectiveness and strategic alignment on the way towards addressing challenges and building on opportunities, which serve the purpose of strategic positioning over the new cycle of assistance. The CP Evaluation is also expected to take into account the quality of M & E over the current cycle of assistance.

II. PURPOSE OF THE EVALUATION

The purpose of the evaluation is to conduct an end of programme cycle evaluation to assess the achievement of the programme results, the facilitating and constraining factors, and to compile lessons learned so as to inform development of the next CP. The CP Evaluation has been envisaged at this
point in time, since in accordance with the UNFPA Evaluation Guidelines the end of country programme cycle evaluations are expected to be conducted in the programme penultimate year. The evaluation will be utilization-focused and expected to provide credible information on the CP relevance, efficiency, effectiveness and strategic alignment to support decision-making by the programme management and national counterparts for further programme improvement and strategic positioning over the new cycle of assistance.

III. EVALUATION SCOPE

The scope of the Evaluation embraces the CP for 2007-2010, which was designed to focus on the Eastern, North and Badia regions and other disadvantaged areas.

A. OVERALL EVALUATION OBJECTIVES

1) To evaluate the extent of the outputs achievement on the basis of the CPAP PTT baselines and targets and the degree of the outputs contribution to the attainment of the CP outcomes with a special focus on unanticipated positive results;
2) To evaluate the CP achievements in terms of capacity building relying on the following conditions: a) broad-based participation and a locally driven agenda; b) leveraging local capacities; c) ongoing learning and adaptation; d) long-term investments; & d) integration of activities at various levels to address complex problems;
3) To assess the CP efficiency and relevance, including the CP performance in terms of prioritization of and focusing on interventions with evidence of effectiveness and evidence-informed assessment of needs;
4) To assess quality of the CP M & E with the main focus on quality of indicators, baselines and targets as well as evidences of using knowledge and the CP monitoring/reviews information systematically;
5) To evaluate the CP strategic alignment with the National Development Plan (NDP) for 2006-2010 and UNDAF.

B. SPECIFIC EVALUATION OBJECTIVES (Evaluation Methodology Framework–Annex I)

To assess: 1) functionality of mechanisms for systematic improvement of the emergency obstetric care (EmOC); 2) effectiveness of the clinical protocols on FP, antenatal care and EmOC in better provision /utilization of the services; 3) validity and effectiveness of the RH programme component’s approaches and strategies in support of increasing the availability of and access to at least three RH services; 4) validity of the current strategies and approaches in HIV VCCT domain; 5) relevance of the current approaches and strategies in reaching out youth with RH STIs/HIV/AIDS messages; 6) the value added role of the local YPEER volunteers in launching small scale projects on healthy life style and HIV/AIDS related awareness raising initiatives; 7) effectiveness the population and development (PD) programme component’s approaches and strategies in raising the commitment of parliamentarians to population, reproductive health, gender and youth issues; 8) quality and extent of utilization of the census and survey data for producing in-depth research studies and strategic reports; 9) efficiency and effectiveness of the implementation of the surveys as well as use of surveys’ data for programming purposes; 10) the extent of NGOs/CBOs’ role, coordination and their full-fledged acceptance by the local communities; 11) facilitating and constraining factors as well as challenges on the way to establishing GBV Observatory.

IV. EVALUATION QUESTIONS

A. OVERALL EVALUATION QUESTIONS

1) Effectiveness
   Outputs: to what extent have envisaged outputs been achieved? What is the quality of the outputs?
   Data on indicators: have data been collected on the indicators of achievement? Do they provide adequate evidence regarding achievement of programme outputs and contribution to the outcomes?
   Gender: what were the achievements in terms of promoting gender equity and equality?
   Capacity building: what were the achievements in terms of capacity building?
2) Efficiency
Costs: did the actual or expected outputs justify the costs incurred?  

Duplications: did programme activities overlap and duplicate other similar interventions in the context of the programme components?  

Alternative options: are there more efficient ways and means of delivering more and better outputs with the available inputs?  

3) Relevance:  
Are current strategies and approaches across three program components still valid or should they be reformulated for the new cycle of assistance?  

4) Sustainability  
Have programme activities been integrated into current practices of national counterparts’ institutions and/or the target population? What is the total amount of resources earmarked to population, including reproductive health interventions?  

5) Unanticipated results  
Were there any unexpected positive results of the CP? Can they be further enhanced to achieve the desired impact?  

6) Strategic alignment  
Have UNFPA pivotal roles in the implementation of capacity development to support the use of data been well reflected in the UNDAF and supported the NDP’s priorities?  

B. SPECIFIC EVALUATION QUESTIONS (Evaluation Methodology Framework – Annex I)  

1) Were the mechanisms conducive to the efforts aimed at improving EmOC?  
2) Did the introduction and use of the RH related protocols contribute to scaling up the quality of care?  
3) Did the RH programme component interventions result in increasing the number of health facilities providing at least three RH services?  
4) What were the key achievements in the VCCT domain?  
5) Did the programme component identify innovative and efficient ways and means of reaching out youth with RH STIs/HIV/AIDS messages?  
6) Did YPEER volunteers succeed in initiating and introducing innovative projects aiming at promoting awareness on healthy life style and HIV/AIDS?  
7) Did the PD programme component adopt innovative approaches to engage parliamentarians in population advocacy and programmes?  
8) Did the findings of in-depth research studies and population reports bring about specific strategic policy and programme related decisions and actions?  
9) What is the total amount of resources earmarked to population, including reproductive health interventions?  
10) Did surveys provide adequate evidence concerning progress towards national development priorities and goals?  
11) Were the surveys’ findings produced and used in a timely manner? Did the UNFPA supported NGOs/CBOs integrate into the local communities?  
12) Did the programme component take into account and address the multi-sectoral nature of the process of establishing GBV Observatory?  

V. EVALUATION METHODOLOGY  
The evaluation methodology will embrace the following: overarching evaluation objectives/ question, specific evaluation objectives/questions, performance indicators, data source, evaluation design, sampling plan, data collection instruments, and data analysis plan. Data collection methods will include reviewing available documentation interviews with key contacts, focus group discussions with key informants and field visits.  

It is envisaged that the CP Evaluation related processes will take slightly more than 12 weeks, starting on the 29th of September and ending on the 25th of December and embrace the following stages (CP Evaluation Roadmap – Annex II):  

1) During the preparatory stage the consultants/external evaluators are expected to conduct desk review of the relevant materials i.e. strategic reports, reviews and thematic assessments;  
2) Country mission of the external evaluators will focus on data collection, validation and analysis, including through key informant interviews and meetings with beneficiaries, primary and secondary stakeholders;  
3) a) Submission of the first draft of the CP evaluation report by the consultants with the subsequent distribution of the draft to Evaluation Management Committee/partners for peer-reviewing and securing comments and feedback.; b) Resubmission of a draft that has
incorporated comments and feedback on the first draft; c) Submission of final CP evaluation report;
4) CP evaluation meeting with all the concerned partners and dissemination of the Evaluation Report;
5) Securing proper use of the evaluation findings for further programme improvement and strategic positioning over the new cycle of assistance. In this context, it is to be noted that the Evaluation Managers will provide general comments to the evaluation results and specific response and actions to be taken against each evaluation recommendations.

In line with the UNFPA evaluation policy of strengthening national evaluation capacity by using participatory and inclusive approaches and by supporting national-led evaluations, a management structure will be established, which will envisage the participation of the CPAP Government Coordinating Authority (State Planning Commission), programme component managers (Ministry of Health, Syrian Commission for Family Affairs and State Planning Commission), implementing partners and various stakeholders.

VI. EVALUATION PRODUCTS

The Evaluation Team is expected to secure the following deliverables:

1) **Inception report** (showing the proposed evaluation design, methodology, implementation plan, including the division of labor, deliverables, and deadlines) - **15 pages** (5 page for each programme component);

2) **Debriefing report** at the end of field work covering summary of work covered in the field, and preliminary findings (two-page evaluation brief & a presentation for one day stakeholder workshop);

3) **Evaluation report** – Initially, the Evaluation Team will prepare and submit a draft to the Evaluation Managers who will route the initial draft for peer-reviewing. In the second iteration, the Evaluation Team is expected to re-submit a draft that has incorporated the comments on the first draft. The Evaluation Manager shares the second draft with the designated M&E adviser and with the Evaluation Management Committee. After sharing the second draft, the Committee is convened to prepare comments and to guide the evaluators on finalization of the report (40-45 pages).

VII. IMPLEMENTATION ARRANGEMENTS

1) **Evaluation Team** will be in charge of conducting the evaluation. The Evaluation Team will be comprised of a consultant for each of the UNFPA mandate areas (RH, PD and Gender). The country mission of the international evaluators focusing on RH and Gender programme components will be supported by national experts.

   **Experience and competencies required:** One of the evaluators will be recruited as the team leader who is expected to be experienced in the UNFPA type of evaluations and should have strong evaluation methodology background. S/He should possess recognized expertise in evaluation and strong track record of innovative leadership in conducting evaluations, and proven ability to produce demonstrable results. With respect to the evaluation team members they should have strong expertise in planning and evaluation, sound knowledge of development environment and excellent analytical and communication skills.

2) **Evaluation Management Committee** will be chaired by a representative of the State Planning Commission and UNFPA Representative and also include representatives of programme component managers, implementing partners and UN sister Agencies. The CP Evaluation Management Committee will be in charge of: a) endorsing TOR; b) selecting and debriefing Evaluation Team/Evaluators; c) organizing technical support; d) approving inception report and final evaluation budget; e) monitoring progress and quality of evaluation activities; f) reviewing and commenting on drafts; g) approving evaluation reports; h) disseminating and following up to evaluation findings; i) assessing performance and approving payments to evaluators.
2) **Evaluation Managers** – UNFPA Representative and International Programme Specialist. The CP evaluation managers will be responsible for: 

* a) convening, coordinating and supporting the Committee’s meetings; 
* b) leading development of the TOR and the management response; 
* c) managing the CP Evaluation budget and ensuring logistical and administrative support; 
* d) coordinating with ASRO; 
* e) facilitating access to background documents; 
* f) uploading evaluation TOR and final report into UNFPA central repository.

**VIII. TIMEFRAME**

The envisaged country mission of the evaluators: **November 23 – December 6 2010.** ASRO M & E Advisor can join the Evaluation Team over the last week of the consultancy and also attend one day stakeholder workshop.

**IX. ETHICAL CONSIDERATIONS**

The whole evaluation process will be governed by the principles of the United Nations Evaluation Group’s ethical guidelines, which have been drawn up with reference to relevant texts, principal among them the UN Norms and Standards for Evaluation. All those engaged in designing, conducting and managing evaluation activities should aspire to conduct high quality work guided by professional standards and ethical and moral principles, as the integrity of evaluation is dependent on the ethical conduct of key actors in the evaluation process.

**X. EVALUATION BUDGET**

Consultancy fees are payable according to normal terms of payment and subject to receipt of Certification for Payment form, including the Evaluation Committee and Evaluation Managers’ certification of satisfactory performance. The UNFPA CO will provide for international consultants with a round-trip air ticket (between originating city and duty station) plus the payment of the appropriate per diem by means of the applicable DSA at United Nations established rates.

**XI. ANNEXES**

I) Evaluation Methodology Framework

II) CP Evaluation Roadmap

III) CP Mid-Term Review Report

IV) List of annual work plans

V) CPAP PTT

VI) CPAP M & E Calendar

VII) Other background documents and reports