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<td>Long Term Agreement</td>
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WGSS  Women and Girl’s Safe Space
WHO  World Health Organisation
WoS  Whole of Syria
Executive Summary

Since 2011, the ongoing and escalating crisis in Syria has had a profound effect across the region. By the end of 2017, 13.1 million Syrian women, men, girls and boys were in need of humanitarian assistance, 6.1 million within Syria and 7 million in surrounding countries. Close to 3 million people inside of Syria are in besieged and hard-to-reach areas, exposed to grave protection violations.¹ Over half of the population of Syria has been forced from their homes, and many people have been displaced multiple times. Parties to the conflict act with impunity, committing violations of international humanitarian and human rights law.²

The United Nations Population Fund (UNFPA) has been responding to the crisis since 2011 to the crisis. The UNFPA Syria Country Office (SCO) has expanded programming from advocacy and policy development with government partners to a focus on direct service delivery for Sexual and Reproductive Health (SRH) and Gender-based Violence (GBV) and youth programming through static and mobile services, continued partnership with key government ministries, capacity building, coordination for GBV, provision of supplies and Reproductive Health (RH) commodities¹ and promotion of GBV and SRH as necessary life-saving humanitarian interventions within the humanitarian response.

FINDINGS

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

² Ibid.
³ Within this report SRH (sexual and reproductive health) will be the terminology used with the exception of references specifically to Reproductive Health Kits (RH Kits) and the Reproductive Health Working Group (RH WG) which is the globally used terminology.
limited in respect of other aspects of inclusion such as disability.

10. UNFPA is providing consistent leadership of the GBV sub-sector with good collaboration and advocacy with the wider coordination mechanisms. While this has improved since 2016, there are gaps in technical support to partners and sub-national coverage due to limited human resources.

11. There is no dedicated SRH Working Group (WG) in Syria and UNFPA leadership on SRH has been weaker than for GBV.

12. There is no youth working group and youth issues are dealt with through the UN Youth Taskforce.

13. UNFPA is viewed as a strong voice within the United Nations Country Team (UNCT) and Humanitarian Country Team (HCT) advocating for the needs of women and girls and promoting GBV and SRH services as lifesaving.

14. Overall, UNFPA has a constructive relationship with relevant ministries and are supporting services, legislative reform, and policy engagement. However, there are notable tensions in aligning to national policies and legislation when they are not consistent with UNFPA mandate and GBV and SRH responsibilities.

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

16. Core resources allocated to the SCO were not commensurate to needs throughout the Syria crisis nor did they match other resources as they increased.

17. Although SCO has utilised Fast Track Procedures (FTP) since the start of the crisis, their capacity to expedite procurement and recruitment was impeded in the early years by insufficient resources, technical capacity, and a lack of flexibility in the application of procedures.

18. UNFPA has nurtured key strategic partnerships with government ministries and national NGO’s that has allowed for flexible responses to new crises while diversifying partnerships to enable greater coverage and expansion. Capacity of partners and the quality of services they deliver vary.

19. There is growing confidence among donors in UNFPA ability to deliver services, access hard-to-reach areas, and conduct due diligence with partners. This has translated into increased funding.

20. The UNFPA response in Syria has made significant contributions to improving access to and quality of GBV and SRH services for women, girls and youth. This is particularly evident in hard-to-reach areas and for the newly displaced populations though static services and mobile teams. UNFPA, like the wider humanitarian response, is restricted in effectiveness of delivery of services within Syria due to political, security, access, funding and partnership constraints.

21. Prevention, risk reduction and empowerment activities have been less of a focus but are an emerging priority for UNFPA.

22. GBV and SRH have been centrally positioned as lifesaving within the overall humanitarian response.

CONCLUSIONS

Key Conclusions for Syria:

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

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

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

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

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

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

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

Key Conclusions for the overall evaluation:

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

SUGGESTIONS FOR RECOMMENDATIONS

Key suggested recommendations at country level:

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

B. In recognition of the capacity gaps among partners and the demands to expand geographically in addition to transitioning from emergency responses, the SCO should:
   - Strengthen capacity building for IPs and develop a systematic strategy that goes beyond trainings, especially for new GBV partners. (i.e. on the job mentoring, using remote technology to support, field visits/exchanges etc.). Adopting a model where UNFPA partner with a strong international NGO to provide intensive capacity building or increasing SCO staffing so there are sufficient and experienced internal resources to dedicate to capacity building are options that should be explored. (Links to Conclusion B, C and G)
   - Review existing GBV and SRH integration including mobile responses to assess its overall functioning, effectiveness and identify any gaps or areas for improvement. This should enable UNFPA to further define guidelines for GBV and SRH integration during the acute and protracted phases as well as provide guidance for mobile teams to improve functioning and provide lessons learnt and good practices for application in other humanitarian settings. (Links to Conclusion A, B and C)

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

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

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

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

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

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

Key suggested recommendations for the overall evaluation:

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

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

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

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

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

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

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

The Syria Humanitarian Response Plan (HRP) provides the framework to respond to large-scale humanitarian and protection needs on the basis of the prioritization undertaken across sectors for both the cross-border work and operations from Damascus within Syria. In addition to this, there is a Regional Refugee & Resilience Plan (commonly referred to as the 3RP) which attempts to harmonise protection and assistance to Syrian refugees in neighbouring countries (Egypt, Iraq, Jordan, Lebanon, and Turkey).

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

The scope of the evaluation has three dimensions:

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

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5 Ibid.
(RH) and Gender-Based Violence (GBV) interventions (though also potentially other work with affected populations), and also its coordination role (via the RH Working Group and GBV Sub Clusters). Such interventions are articulated within the Syrian Humanitarian Response Plan(s) for the period, and include cross-border and Regional Refugee and Resilience Plan (3RP) programming;

- **Geographically:** Syria itself and neighbouring countries (Egypt, Iraq, Jordan, Lebanon and Turkey), including cross-border operations – notably across the sub-region. The evaluation is not intended to evaluate separately each country programme response;
- **Temporally:** The 2011-2017 period, which corresponds to the start of the conflict in Syria to the present day.

The primary intended users of the evaluation are:
1. UNFPA Country Offices (COs);
2. the UNFPA Syria Regional Response Hub (henceforth ‘the Hub’);
3. UNFPA Regional Offices (ROs) – the Arab States Regional Office (ASRO) and the Eastern Europe and Central Asia Regional Office (EECARO);
4. UNFPA Humanitarian and Fragile Contexts Branch (HFCB);
5. UNFPA Senior Management, including the Executive Board.

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

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

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

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

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

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

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

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6 [Online Survey for the Evaluation of the UNFPA Response to the Syria Crisis: Syria Country Research](#)
The online survey was administered in English or Arabic and 28 respondents completed it anonymously (10 in Arabic and 18 in English). Detailed analysis from this survey is included in Annex III. Respondents included UNFPA staff (32.1%), other UN staff (21.4%), National NGO (32.1%), (3.6%) International NGO, (7.2%) Government and external third party (UNFPA) (3.6%).

What is your organisational role in the Syria Humanitarian Response?

28 responses

Limitations of the research and mitigation measures

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

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

Syria

Prior to 2011, the Syrian Arab Republic (SAR) was a fast-growing, middle-income country with one of the highest growth rates in the world at 2.4% and the pre-conflict population was an estimated 20.7 million in 2010.7 Syria borders Turkey to the north, Iraq to the east, Jordan to the southeast, Israel to the southwest, and Lebanon and the Mediterranean Sea to the west. It is divided into 14 governorates, which are split into 65 districts and 281 subdistricts. Syria’s capital is Damascus, while Aleppo is the largest city. The humanitarian crisis started in 2011 as pro-democracy protests escalated rapidly into a multi-party conflict between Syrian government and a range of armed opposition groups. In 2014 the Islamic State of Iraq and Syria (ISIS) seized control of large parts Syria further escalating the crisis.8 Now in its seventh year, the Syrian conflict is unquestionably the worst humanitarian crisis of the twenty-first century with more than 50,000 dead, 1.2 million injured, 6.3 million internally displaced and 5.5 million refugees worldwide. Over 13.1 million people in Syria require humanitarian assistance with 5.6 million in acute need.9 The social and economic impacts of the conflict are also immense and the lack of sustained access to health care, education, housing, and food have exacerbated the impact of the conflict and pushed millions of people into unemployment and poverty.10

<table>
<thead>
<tr>
<th>2017 Syria Country Statistics 11,12</th>
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<tbody>
<tr>
<td>2017 Population:</td>
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<tr>
<td>Population under 10-24 (2017):</td>
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<tr>
<td>Population aged 65 and older, (2017):</td>
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<tr>
<td>Maternal Mortality Ratio (MMR) (2015):</td>
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<tr>
<td>Births attended by skilled personnel (2006 – 2016):</td>
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<tr>
<td>Adolescent birth rate (age 15-19) (2006 – 2015):</td>
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<tr>
<td>Total Fertility Rate (TFR) (2017):</td>
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<td>Contraceptive Prevalence Rate (CPR) (2017):</td>
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The complex and volatile nature of the conflict, with rapidly shifting frontlines and alliances, resultant insecurity, fighting and limited humanitarian access makes for an acutely challenging operating environment in Syria. Humanitarian access to large parts of the country steadily diminished since the start of the crisis in 2011, with a corresponding increase in humanitarian and protection needs. Until 2016 it was impossible to access large parts of the country from Damascus, due to large areas held by opposition groups and other restrictions placed on movement by the GoS including approvals needed for travel to many locations and insecurity. Adoption of SCR 2165 was followed by a succession of Resolutions renewing 2165: 2191 (December 2014), 2258 (December 2015), 2332 (December 2017) and finally, 2393 in December 2017, which authorises cross-border operations until 10 January 2019.13 The UN Resolutions allow for specific cross-border routes through Bab al-Salam and Ba al-Hawa from Turkey, Al-Ramtha from Jordan, and Al Yarubiyah from Iraq to deliver humanitarian assistance, including medical and surgical supplies, to people in need in Syria.14 The Whole of Syria (WoS) approach was introduced in 2014 to coordinate humanitarian responses for assistance provided cross

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8 https://www.acaps.org/country/syria/country-profile
10 World Bank (2018) The Toll of War: The Economic and Social Consequences of the Conflict in Syria
12 Data limitations render a precise and comprehensive decomposition of demographic changes impossible: conflict affects fertility rates and life expectancy alike.
13 See Annex V for detailed timeline on UNSC resolutions and evolution of cross border operations.
border from Jordan, Turkey and Iraq; assistance provided within Government-controlled areas of Syria and cross-line assistance provided from Damascus-based offices.

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

**Map of Syria with zones of control 2013**

*Government and Anti-government Held Areas as at January 14th 2013*

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{map_of_syria_2013}
\caption{Map of Syria with zones of control 2013.}
\end{figure}

\textbf{Data Sources:}
- Interpretation of General Areas: SHAPE
- Administration Boundaries: OCHA COD

Source: ACAPS\textsuperscript{17}

\textsuperscript{15} https://www.acaps.org/country/syria The GoS has been re-gaining control of large parts of the country since 2016 including Aleppo in 2016, Ar-Raqqa in 2017, and Eastern Ghouta and most recently Dara’a in 2018.


Map of Syria with zones of control 2015

Source: ACAPS (2015) \(^{18}\)

\(^{18}\) https://reliefweb.int/sites/reliefweb.int/files/resources/m-aoc_map_01may2015_snap.pdf
The first Syria Humanitarian Action Response Plan (SHARP) was developed in 2012 jointly with the GoS and raised 62% or $215.9 million of the $348.3 million requested for the response inside Syria. The situation was declared a Level 3 (L3) in January 2013 which changed the tone, scale and pace of the response including raising the profile of the crisis globally, creating the Emergency Response Fund (ERF) and resulting in some existing UN country leadership positions being replaced by individuals with more humanitarian expertise among a number of key agencies. The 2013 SHARP initially estimated a request of $519 million but this was revised up to $1.41 billion in mid-2013 to reach 6.8 million people in need. The revised request received $959.3 million of the total request. The 2014 SHARP increased the total number of people in need to 9.3 million and requested $2.26 billion in funding but only received $1.15 billion.

Source: [Al Jazeera](https://www.aljazeera.com/indepth/interactive/2015/05/syria-country-divided-150529144229467.html) (accessed 29 October 2018)

[https://fts.unocha.org/appeals/396/summary](https://fts.unocha.org/appeals/396/summary)


[https://fts.unocha.org/appeals/442/summary](https://fts.unocha.org/appeals/442/summary)
Prior to 2014 it was challenging (for all actors) to assess needs in many parts of Syria and no comprehensive inter-agency needs assessments were conducted from Damascus until late 2014 due to lack of support from the GoS and access/security constraints. In November 2014, the first comprehensive HNO was produced, combining areas accessible from GoS control and areas outside of GoS control and this informed the 2015 humanitarian plan for Syria. The SHARP evolved into the Syria Response Plan (SRP) in 2015, incorporating all aspects of the Syria response (including cross border operations) targeting 13.5 million with a $2.89 billion requirement that was only funded at 43% ($1.24). Subsequent Whole of Syria HRPs 2016-2018 have continued at these levels, increasing to $3.5 billion in 2018 targeting 13.1 million. Funding appeals have been chronically underfunded, often less than 50%, with humanitarian needs considerably eclipsing available resources.

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

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

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

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

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

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

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

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

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

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

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36 Financial data provided by SCO in July 2018.

37 All data provided by the SCO in August 2018.

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

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

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


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

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

44 TPMs are located in Derizor, Sweida, Latakia, Tartous, Hama, Aleppo and Homs.
Findings
Evaluation Question 1: Relevance / Appropriateness
To what extent have the specific defined outputs and outcomes of the UNFPA Syria Crisis Response [hereafter referred to as the UNFPA Response] been based on identified actual needs of Syrians within Whole of Syria and within the 3RP countries?

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

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

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

46 Security conditions and delays in getting approvals for missions hindered ability to carry out needs assessment and access to affected populations.
48 Data from multiple primary and secondary level sources including quantitative and qualitative interagency multi-sectoral needs assessments that use a common set of indicators was collected in 4,185 communities located in 254 sub-districts out of 272 sub-districts across the country. Additionally, data obtained through 117 FGDs, Client Satisfaction Surveys, expert FGDs, KIs and existing secondary literature was analysed and synthesised to provide an overview of GBV patterns, trends and risk factors, gaps in services by location to inform programming responses and advocacy.
49 UNFPA Key Informant
50 UN Key Informant.
UNFPA has been leading and supporting SRH assessments since the start of the crisis to inform programming responses. These include family planning and contraceptive use, quality of emergency obstetric care, assessing and evaluating the SRH vouchers. In 2016, UNFPA led a rapid assessment to evaluate SRH services provided by public and non-governmental institutions supported by UNFPA in 9 out of 14 governorates. The assessment enabled UNFPA and partners to identify gaps and served as a basis for designing interventions for integration with GBV.

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

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

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

51 UNFPA (2013:19) COAR “In 2014, UNFPA carried out five operational pieces of research aimed at assessing the effectiveness, efficiency and quality of interventions and focused on a) the implication of the crisis on RH professionals, b) assessment of the quality of EmOC at UNFPA-assisted facilities c) assessment of the services of UNFPA assisted mobile teams; d) the lessons learnt of the application of RH vouchers and d) assessment of the quality of PSS/PFA training sessions.”
53 UNFPA (2016) COAR.
54 UNFPA (2017) Draft Integrating GBV into RH services – Logical Framework. The strategy outlines actions to improve integration including improved information sharing, coordination and representation of SRH within GBV meetings as well as strengthening GBV referral systems for health services including CMR and providing trainings and developing protocols.
55 UNFPA and NGO Key Informants.
57 The Evaluator for Research & Economical Consultancy (EREC) (2017) Evaluation Study For Women and Girl Safe Space in Syria. The number of individual interviews carried out was 437. 24 FGDs were conducted with 182 participants: service providers (42) and clients (140).
58 EREC (2017:28) Evaluation Study For Women and Girl Safe Space in Syria. In terms of knowledge among those interviewed about the services provided in the safe spaces 88% responded that the safe spaces are a place to provide vocational training; life skills (67%); health services (41%); sports (37%); psychosocial support (PSS) sessions (35%); legal counselling (35%); recreational activities (29%); Awareness and counselling sessions for family and males (24%) and psychosocial support individual sessions (5%).
challenge due to restricted humanitarian access, fluctuating security along access routes, and the
difficulties in getting government travel authorisations to some locations. 60 This creates a situation
where much of the data collection must be done remotely. The difficulty in obtaining reliable data and
mitigating any politisisation of information is a challenge that was highlighted by many key
informants. 62 Available data on programming within the SCO from 2011 – 2014 is inconsistent and not
sex or age disaggregated due to insecurity and inaccessibility that limited data collection. Since 2015,
the SCO increased M&E staff from one to three to improve quality of data obtained from needs
assessments, monitoring and follow up with partners. Additionally, technical support from the
Information Management (IM) Specialist in the Hub, increased number of TPMs for field monitoring
and growing humanitarian access has facilitated improved data collection. A 2016 assessment of
UNFPA M&E systems commissioned by DFID awarded a compound attainment score of 90% (100%
representing an “ideal” M&E system) for UNFPA WoS M&E system noting “it is remarkable taking into
consideration the difficult working environment in which UNFPA is operating.”64

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

The UNFPA response is based on humanitarian principles and human rights-based approaches as far
as the operating context of the conflict allows. However, the successful application of these are
undermined by the continued grave violations of IHL and IHRL by parties to the conflict and the
constrained humanitarian space that limits the provision of supplies and services. All humanitarian
assistance provided by UNFPA is in line with IHL and humanitarian law and operates under the
framework of UNSCR 2139.67 UNFPA has regularly engaged in cross-line deliveries to hard-to-reach
and besieged areas advocating for humanitarian access and providing much needed humanitarian
assistance including supplies and medications when convoys can reach these areas with essential
supplies. 68,69 Humanitarian partners rely on being granted necessary approvals for access to besieged

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60 UNOCHA Syria HNO 2016 - 2018
61 For example, inaccurate information could be provided to direct humanitarian assistance to specific locations (based on
alliances to different parties to the conflict) that may not be in most need.
62 UN key informants.
63 UNFPA and NGO Key Informants.
64 Syria Independent Monitoring (2016:4) Assessment of the Monitoring and Evaluation Systems and Processes of DFID
Partners.
65 UN, Government and UNFPA Key Informants.
assistance, cease depriving civilians of food and medicine indispensable to their survival, and enable the rapid, safe and
unhindered evacuation of all civilians who wished to leave. It demanded that all parties respect the principle of medical
neutrality and facilitate free passage to all areas for medical personnel, equipment and transport.”
68 UNFPA (2017) Press release: UNFPA aid reaches Deir Ez-Zor City for the first time in three years
and newly accessible areas. However, these are often hindered or prevented from delivering supplies due to delays in approvals and denial of authorisations by the GoS.  

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

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

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

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


73 NGO and UN Key Informants.

74 UN Key Informants.

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

**Evaluation Question 2: Adapted relevance over time**

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

**Associated Assumptions:**

4. The UNFPA Response reacts flexibly to rapidly changing situations (of displacement, besiegement, movement) based on overall UN and UNFPA-specific information;

5. UNFPA have systematic mechanisms for adapting interventions based on shifting needs and in line with humanitarian principles;

6. The UNFPA Response is based on its comparative strengths with relation to other actors for SRH, GBV and youth.

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<th>FINDINGS</th>
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<tr>
<td><strong>4.</strong> During the initial years of the crisis UNFPA was slow to scale up and did not expand significantly until 2015. Since then, there has been continuous investment in human, technical and financial resources to address humanitarian needs in Syria.</td>
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<tr>
<td><strong>5.</strong> UNFPA has demonstrated growing capacity, flexibility, and adaptability by responding to new and emerging crises and displacements to become a front-line responder in Syria.</td>
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<tr>
<td><strong>6.</strong> UNFPA has successfully leveraged its comparative advantage on GBV and SRH and is taking on a leadership role on youth programming and population data within Syria.</td>
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<tr>
<td><strong>7.</strong> UNFPA has distanced itself from the interagency PSEA leadership role due to concerns on the compatibility of this with their GBV coordination leadership role.</td>
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**During the initial years of the crisis UNFPA was slow to scale up and did not expand significantly until 2015.** Since then, there has been continuous investment in human, technical and financial resources to address humanitarian needs in Syria. UNFPA were considerably delayed in shifting into emergency mode and developing adequate humanitarian response capacity and systems to meet the needs of the crisis.  

77 UNFPA, like many other agencies, underestimated the scale of the crisis in the early years. Although the overall humanitarian response progressed slowly in the beginning, the 2013 L3 declaration, adoption of UNSCR 2139 (and later UNSCR 2165 and 2191) and the establishment of the WoS structure to coordinate the response in 2014 provided the impetus for many UN agencies to accelerate the pace of their response.  

78 Evidence collected through this research indicates that the UNFPA response was impeded by a lack of human resources, humanitarian technical skills, funding, and clear response strategy until 2015.  

The SCO 2007-2011 Country Programme Document (CPD) primarily focused on policy, advocacy and legislative reform. From 2011 – 2015 programming was based on four one-year extensions prior to the development of the 2016-2017 CPD.  

80 During the early years of the crises, UNFPA focused on the provision SRH services including safe delivery through deployment of mobile teams, procurement of RH Kits and other medical items, training service providers on MISP and EmOC as well as integrating GBV services into SRH programming and mainstreaming youth.  

81, 82 From 2011 – 2014, UNFPA worked with the same 8-10 partners (many of whom were development partners) as in previous years with overall funding increasing from $5.08 million in 2011 to $10.5 million in 2014 (spiking to $13.44 million...
in 2013 following the L3 declaration). The 2016-2017 CPD marked a transition to humanitarian response with a clear focus on (a) improving access to high-quality reproductive health care; (b) scaling-up GBV prevention and response; and (c) supporting capacities to collect and use gender- and age- disaggregated data. GBV and SRH integration within mobile teams, health facilities and WGSS feature heavily as does youth mainstreaming. The new CPD coincided with increased humanitarian access from Damascus including to some areas that had previously been served by cross border programming. This amplified demand for services and drove subsequent expansion of the SCO and the wider humanitarian response.

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

<table>
<thead>
<tr>
<th>Year</th>
<th>Staffing</th>
<th>Funding</th>
<th>Partners</th>
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<tbody>
<tr>
<td>2011</td>
<td>24</td>
<td>$5.09 million</td>
<td>10</td>
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<tr>
<td>2014</td>
<td>28</td>
<td>$10.58 million</td>
<td>6</td>
</tr>
<tr>
<td>2017</td>
<td>56</td>
<td>$32.03 million</td>
<td>20</td>
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"Overall, yes, we need to give them credit, they are a small agency but despite the size, they do a lot, they are small but efficient."

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

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

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83 Funds from DFID, Office of U.S. Foreign Disaster Assistance (OFDA), OCHA, the Government of Australia and Italy accounted for much of this.
85 UN and UNFPA Key Informants.
86 From 2012-2015, three people held the position of UNFPA Representative until the current one was recruited in 2015.
87 UN, UNFPA and NGO Key Informants.
88 Developed from multiple sources of data provided by the SCO in July 2018.
89 Some were government counterparts working on development initiatives that were not supported after 2012. As such, IPs reduced to six in 2013 and 2014 before increasing in 2015 to 13.
90 UN Key Informant.
91 UN, UNFPA, donor and NGO Key Informants.
93 UN, UNFPA, donor and NGO Key Informants.
the SCO supports programming in 13 out of the 14 governorates (though limited and inconsistent in coverage and services in some locations) through 20 partners (increasing from 6 in 2014)\textsuperscript{94,95}. Key informants highlighted the challenge in balancing the need to respond to multiple competing acute crises in hard to reach areas while maintaining and expanding services in more protracted settings. One UNFPA interviewee noted that “once you agree with a donor on deliverables, suddenly you have to re-adjust a project to respond to new needs and locations. Overall, the donors are very understanding and flexible and don’t have an issue in adjusting the project to meet needs.”\textsuperscript{96}

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

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

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

\textsuperscript{94} UNFPA Key Informants.
\textsuperscript{95} http://pcss.syriadata.org/HubDashboards/PCSSInterventionsAgencies_2018.aspx
\textsuperscript{96} UNFPA Key Informant.
\textsuperscript{97} Donor, UNFPA and UN and NGO Key Informants.
\textsuperscript{99} Donor, UNFPA and UN Key Informants.
\textsuperscript{100} UNFPA(2017:5) COAR UNFPA mobile SRH/GBV teams provide a range of GBV and SRH services depending on the partner and focus on the team. Of the 39 mobile teams, 22 are providing GBV services and referrals and 17 provide integrated SRH and GBV services. Composition varied depending on the services offered by each team.
\textsuperscript{101} Mobile medical units support emergency response in hard-to-reach and newly accessible locations providing general consultations, integrated reproductive health services include family planning, antenatal care, ultrasound scans, micronutrient supplements, natural deliveries, postnatal care, treatment of reproductive tract infections and referral of high risk pregnancies and complicated deliveries to public health facilities. https://reliefweb.int/report/syrian-arab-republic/syria-east-ghouta-humanitarian-update-facts-and-figures-22-april-2018
\textsuperscript{102} EREC (2017:21) Evaluation Study for Reproductive Health Facilities.
\textsuperscript{103} UNFPA and NGO Key Informants.
\textsuperscript{104} UNFPA (2017:6) GBV WGSS Programmatic Annex (not published).
\textsuperscript{105} Donor, UNFPA and UN and NGO Key Informants.
evaluation found that while mobile services were identified as a useful and effective modality to cover large (often previously un-served) areas, follow up was weaker and risk of duplication of services higher. Additionally, some services like the provision of Intra Uterine Device (IUD) are only available through static services and this is one of the most common forms of contraception among those surveyed (44%). Levels of satisfaction among service users interviewed for the 2017 evaluation were lower for mobile services (81%) as compared to static clinics (95%). Based on a review of partner project documents, UNFPA mobile team guidance and interviews with key stakeholders, the evaluators noted a need to review the functioning, composition and coverage of mobile teams to ensure they provide harmonised and quality services and are able to transition beyond the acute emergency response.

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

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

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

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

28 responses

- Very well - UNFPA has adapted in response to changing circumstances
- Moderately well - UNFPA has adapted sometimes but not always or not enough
- Not well - UNFPA is slow to adapt
- Not at all - UNFPA has not adapted its approach on the basis of changing needs
- I do not know

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106 EREC (2017:33) Evaluation Study for Reproductive Health Facilities. The study included a sample of (358) client distributed by (32%) from the governorate of Al-Hasakeh, (23%) from Hama Governorate, (22%) from the governorate of Aleppo, and (9%) from Dara’a governorate, whereas (8%) from As-Sweida, and (6%) from Damascus Governorate.


108 Ibid.

109 UN, Donor, Government and NGO Key Informants.

110 UNFPA Key Informant.

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

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

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

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

112 UN, Donor, Government and NGO Key Informants.
113 UN, Donor, Government and NGO Key Informants.
115 UNFPA (2017) GBV WGSS Programmatic Annex (not published). This guidance also includes 1. Standards for WGSS 2017 of implementation; 2. Outreach Mobile teams; 3. Prevention of Sexual Exploitation and Abuse (PSEA) policy; 4. Verification tools for activity monitoring.; 5. GBV sub-sector membership requirement and benefits and is signed by partners as part of the contract with UNFPA.
117 UN, Donor, Government and NGO Key Informants.
118 UN Key Informants.
119 UNFPA, UN and Government Key Informants.
120 NGO Key Informant and https://www.facebook.com/SCS.Incubator/; https://www.facebook.com/scs.org.sy/
UNFPA work on adolescent girls is also creating new opportunities to leverage GBV, SRH and youth comparative strengths.

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

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

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121 UN, UNFPA, Government and NGO Key Informants.
122 IASC (2016:21) PSEA Community-Based Complaints Mechanism Global Standard Operating Procedures. “While the PSEA network should not be substituted by the Gender/GBV coordination mechanisms, the SEA referral pathway should provide a linkage between relevant assistance networks. It is important to ensure a common understanding of the core responsibilities of the PSEA in-country network and its relation to the GBV coordination mechanism, and a willingness to coordinate.”
123 UNFPA Key Informants.
124 UN Key Informants.
Evaluation Question 3: Coverage

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

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

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

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

Map of Cross-border Operations Turkey, Jordan and Iraq to Syria
Sector presence by district in June 2018

Source: UNOCHA June 2018

125 UNOCHA Whole of Syria HNO and HRP 2016 and 2017
126 UN and UNFPA Key Informants.
Challenges relating to coordination and sharing of information on geographical coverage by Amman and Gaziantep hubs with the SCO were highlighted as were related risks of duplication and/or gaps in services. 127 As illustrated in this diagram, 60% of humanitarian assistance was provided from within Syria and 40% through cross-border operations in 2017.128 By 2018, the SCO reported being able to access almost 80% of the country by supporting partners to provide services in 12 governorates (albeit inconsistently in some locations with ad-hoc/irregular access in others). 129,130,131 Modalities for humanitarian assistance vary and coverage is heavily influenced by partner capacity, funding and competing emergency responses. Selection of priority locations is undertaken in coordination with OCHA and based on the severity scales.132

“The needs are tremendous – new IDPs and newly accessible areas are emerging all the time and we cannot cover all the locations – we need to prioritise”.133

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

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

127 UNFPA Key Informants.
128 UNOCHA (2016:17) SAR HRP 2016 Summary of Humanitarian Response Plan Monitoring Report, January - December 2016 “74% of the reported response - in terms of the number of people reached - was delivered from inside Syria through a combination of regular programmes and crossline operations. The majority of the response from inside Syria comprised regular programming from Damascus, with UN regular programmes accounting for 53% and NGO regular programmes accounting for 10% of the overall response. Approximately 1% of the response was delivered through UN and NGO airdrops. 26% of the reported response was conducted through cross-border operations, of which 14% was delivered through UN cross-border convoys under UNSC 2139/2165/2258/2332, and 10 per cent delivered through NGO regular programmes. However, NGO cross-border assistance is estimated to be higher due to underreporting.”
129 UNFPA key informant interviews.
132 UNOCHA (2018:18) Syria HNO “In Syria, humanitarian responses are based on geographical prioritisation from the intersector severity categorization tool seeks to identify the areas across Syria where humanitarian needs are more acute, given a convergence of factors including: besiegement, displacement, exposure to hostilities, and limited access to basic goods and services.”
133 UNFPA Key Informant.
134 UN,UNFPA, Donor and NGO Key Informants.
135 UN,UNFPA and NGO Key Informants.
136 UNFPA COAR 2011-2014
resultant expansion in geographic coverage (discussed in more detail under Evaluation Question 9.) UNFPA GBV and SRH coverage are spread across the locations as illustrated below.\textsuperscript{137} Additionally, UNFPA partnership with the MoH through the provision of supplies, capacity building, and other support to over 900 MoH facilities has enabled them to contribute to a larger geographical response. This partnership preceded the crisis and has expanded since 2011.\textsuperscript{138}


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

“This strategy intends to strengthen and expand upon existing programming for adolescent girls in Syria, through the cross-border programming managed from Gaziantep, Turkey and from Jordan and those managed from Damascus, Syria”\textsuperscript{144}

\textsuperscript{137} SCO maps provided in July 2018. A limitation to these is that they do not differentiate stand-alone services or integrated or illustrate where youth programming is located.

\textsuperscript{138} UNFPA (2017) COAR

\textsuperscript{139} While not explicitly focused on the Palestinians or Iraqi refugees due to the presence of UNRWA and UNHCR, UNFPA does provide needs driven support as requested. For example, with supplies or through partner support for GBV and SRH services to Neirab camp in Aleppo.

\textsuperscript{140} UN,UNFPA, Donor, NGO and Government Key Informants.

\textsuperscript{141} UNFPA (2017:7) Listen, Engage and Empower: A strategy to address the needs of adolescent girls in the Whole of Syria

\textsuperscript{142} https://www.humanitarianresponse.info/en/operations/whole-of-syria/document/whole-syria-adolescent-girl-strategy

\textsuperscript{143} Data from SCO 2015 – 2018 beneficiaries. Girls accounted for 271,982 out of total 1,529,538 women, men, boys and girls targeted with GBV prevention and response services.

\textsuperscript{144} UNFPA (2017:7) WoS Adolescent Girls Strategy
UNFPA is increasingly working with youth and this has been identified as an opportunity for the SCO to integrate GBV and SRH awareness through youth interventions and develop youth friendly SRH and GBV friendly services. The need to integrate adolescent services within existing SRH services was highlighted as a gap that UNFPA is trying to address.\textsuperscript{145}

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

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

Results from survey respondents also correspond with this, specifically:

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

\textsuperscript{145} UNFPA Key Informant; UNFPA (2017:22) WoS Adolescent Girls Strategy “Objective 2: Promote adolescent girl friendly SRH services and specialised GBV services.”
\textsuperscript{146} UNOCHA (2018) HNO WoS.
\textsuperscript{147} UN, UNFPA, Donor, NGO and Government Key Informants.
\textsuperscript{148} UN and NGO Key Informants.
\textsuperscript{149} Voices 2017 and 2018.
Evaluation Question 4: Coordination

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

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

FINDINGS

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

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

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150 Sida I., et al (2016:24,31) Evaluation of OCHA response to the Syria crisis Within the WoS Coordination arrangements (see annex iv), sectors and clusters are used inter-changeably and “the cluster system has not been formally activated, but Syria has effectively followed this template using sectors. OCHA has played as close to a normal role as it was able, establishing an inter-sector role and providing support to the sectors. This has included significant information management support (based out of Amman), as well as linking this into the production of the response plan.”
151 UNFPA Key Informants.
152 UNFPA (2014) COAR
Key informants noted that since 2016 leadership of the GBV sub-sector has improved but highlighted that there has been a higher turnover of GBV Coordinators as compared to Child Protection or Protection. This coupled with the lack of sub-national GBV coordination staff constrains the overall functioning of the GBV sub-sector. Until 2017, there was only one national coordination forum managed out of Damascus by the GBV sub-sector coordinator. As the humanitarian response expanded geographically, sub-national coordination was increasingly required and for GBV this fell under the sub-national protection sector in 2017. In early 2018, two technical GBV working groups were established in coordination with the national GBV sub sector to coordinate responses in Homs and Aleppo supported by UNFPA national staff who are double hatting with programme responsibilities. More sub-national coordination mechanisms are likely to emerge in the future as the UN coordination structure continues to grow through sub-offices at the governorate level. While double hatting and lack of co-chairs at the sub-national level affect most sectors, stakeholders consulted noted that it was more pronounced for the UNFPA-led GBV sub-sector as they have less staff at national and sub-national levels to support coordination. UNFPA is currently finalising recruitment for a second international GBV Coordinator to support sub-national coordination and this should address some of these challenges.

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

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

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

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154 There are no NGO co-chairs for sectors/sub-sectors inside Syria.
155 UN Key Informants.
156 Currently in Qamisli there is a standing agenda item for GBV during the Protection sector meetings.
157 UN Key Informants.
158 UN Key Informants.
159 According to updates from the GBV sub-sector, this has increased to 35 in 2018.
160 WoS GBV A Dashboard
161 UNFPA AWPs 2017
162 PCSS Dashboard
163 UN, Donor and NGO Key Informants.
of the GBV sub-sector.\textsuperscript{164} UNHCR implements a capacity building programme with IMC to provide training, support and mentoring on GBV to their IPs. However, some key informants noted that different training materials were used by different training providers/ agencies.\textsuperscript{165}

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

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

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

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

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\textsuperscript{164} PCSS Dashboard

\textsuperscript{165} UN, UNFPA and NGO Key Informants.

\textsuperscript{166} \url{http://gbvims.com/wp/wp-content/uploads/GBVAOR-GBVIMSFactSheet1.pdf} The GBVIMS enables humanitarian actors to safely collect, store and analyse reported GBV incident data, and facilitate the safe and ethical sharing of this.

\textsuperscript{167} UN, UNFPA and NGO Key Informants.

\textsuperscript{168} UN Key Informants.

\textsuperscript{169} This could include the use of the GBV classification tools, GBV IMS intake form, incident recorder and ISP. If this is not possible, a number of agreed data points could be collected based on this but following all guidance, ethical and safety procedures that accompany the GBV IMS.

\textsuperscript{170} UNFPA Key Informants.

\textsuperscript{171} NGO Key Informant.

\textsuperscript{172} UN, UNFPA and NGO key informants.
There is no dedicated SRH working group (WG)\(^\text{173}\) in Syria and UNFPA leadership on SRH has been weaker than for GBV. SRH is included as a standing item during health sector meetings and UNFPA provide SRH updates. The SCO did not have a dedicated SRH Coordinator until 2018 and it was only in 2015 that a national SRH Officer was recruited to focus solely on SRH - including coordination and UNFPA programming. Prior to this SHR sat under the responsibility of an RH/Youth Officer.\(^\text{174}\) Although UNFPA lead the RH WG in Gaziantep, there is no WoS external SRH coordination function. SRH technical support to the SCO was provided mostly by ASRO, however, since a full-time SRH Coordinator was recruited in 2018, communication with the Gaziantep SRH Specialist has increased.\(^\text{175}\) The SCO SRH Coordinator is under a one-year contract supported through NORCAP surge.\(^\text{176}\) Findings from interviews with several key informants indicate that UNFPA prioritised GBV over SRH coordination and this is supported by the apparent lack of SRH technical support and dedicated SRH coordination staff within UNFPA Syria. Discussions between UNFPA and the health sector are on-going on whether to establish an SRH WG.\(^\text{177}\) Health partner feedback indicated that, overall, UNFPA was undertaking good coordination of SRH-related humanitarian programming in Syria despite the lack of a dedicated coordinator and WG.

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

“4) develop and expand appropriate inter-sector collaboration to increase availability of CMR services and the response to the needs of adolescent girls and child survivors of GBV”

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

“Gender mainstreaming efforts will continue throughout health programming and will include support for provision of care for survivors of GBV.”\(^\text{181}\)

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

\(^{173}\) SRHR is coordinated globally through the Inter-Agency Working Group (IAWG), sitting outside of the formalized IASC system, and at country-level is usually an informal working group established under the WHO-led Health Cluster rather than a formal global AoR/country-level sub-cluster. UNFPA has a clear IASC-mandated coordination and provider of last resort accountability for GBV as the cluster lead agency (CLA) for the GBV AoR. However, there is no formalized equivalent SRHR responsibility for UNFPA even though UNFPA normally adopt an informal leadership role of SRH in emergencies through the establishment of RH Working Groups under the WHO-led Health Cluster. However, UNFPA does have a leadership role to play on SRHR based on UNFPA’s own mandate.

\(^{174}\) UNFPA Key Informants.

\(^{175}\) UNFPA Key Informants.

\(^{176}\) UNFPA Key Informants.

\(^{177}\) UN and Government Key Informants.

\(^{178}\) UN Key Informants.


\(^{180}\) UNOCHA (2018:30) Whole of Syria HRP

\(^{181}\) UNOCHA (2018:61) Whole of Syria HRP

\(^{182}\) UN Key Informants.
health care. Despite the mandatory reporting, CMR (though not human immunodeficiency virus (HIV) post-exposure prophylaxis (PEP) antiretroviral (ARV)) is provided by some health professionals. Although CMR trainings have been provided by both UNFPA and UNHCR since 2012, these have not been well coordinated either in terms of materials used or advocacy with the GoS. Findings from this research indicate that advocacy efforts to address the provision of CMR require improved coordination between UNFPA and UNHCR and WHO and GOS.

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

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

184 UN Key Informants.

185 UNFPA and UN Key Informants.
Evaluation Question 5: Coherence

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

Associated Assumptions:

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

FINDINGS

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

UNFPA is viewed as a strong voice within the UNCT and HCT advocating for the needs of women and girls and promoting GBV and SRH services as lifesaving. Their participation within these fora and advocacy and leadership on GBV and SRH was highlighted as effective by respondents. UNFPA have been able to shape priorities in the Whole of Syria HRP, United Nations Development Assistance Framework (UNDAF), UN Strategic Framework (SF). Within the HRP, GBV is a priority issue. GBV was less visible at the start of the crisis, but since 2015, it has become increasingly recognised as a priority within humanitarian planning documents. GBV was scarcely referenced in the 2012 SHARP. Additionally, UNFPA is well represented across the UNSF outputs (see Evaluation Question 10 for more detail) and GBV and SRH needs are well articulated in the SF. Respondents overwhelmingly indicated that UNFPA have matched advocacy with actions, including the provision of supplies for convoys, assisting partners expand mobile services, and regularly participating in visits to newly accessible areas. UNFPA senior-level participation in joint advocacy with UNHCR and UNICEF on protection concerns is also considered valuable by protection partners and UN consulted. Some key informants stressed that the humanitarian response in Syria is more UN-driven than others given the limited presence of international NGOs which leads more advocacy falling to the UN and this creates tensions with the GoS. UNFPA were praised for their “very principled approaches when facing significant challenges.”

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186 UN, UNFPA, NGO and Donor Key Informants.
187 UNOCHA SHARP 2012, 2013
189 UN, UNFPA, NGO and Donor Key Informants.
190 UN Key Informants.
girl’s agenda and pushing GBV and increased visibility of these issues. A lot is related to the leadership in-country and there is an appetite for it within the UN country team. We all recognise that women and girls have been severely impacted by armed groups – there is a hunger for guidance and expertise and it’s nice to have good colleagues from UNFPA.”

The active participation of UNFPA within UN coordination mechanisms was emphasised by UN key informants including their role in championing the formation of the Youth Taskforce and Gender Working Group192 and their role in the UN Communication Group, PSEA in-country network, Programme Management Team, and Statistics Working Group. One respondent noted that “UNFPA has a very large voice for such a small agency”.193 Other highlighted the willingness of UNFPA to collaborate on joint programming and co-operate with other agencies.194 For example, since 2016, UNFPA partners have been working with WFP195 to assist the provision of additional food vouchers to pregnant and lactating mother following a referral or confirmation of pregnancy. Referrals are made from UNFPA supported health facilities to WFP distribution centres and vice versa and there is no monetary benefit to either agency from this.196

Overall, UNFPA has a constructive relationship with relevant ministries and are supporting services, legislative reform, and policy engagement. However, there are notable tensions in aligning to national policies and legislation when they are not consistent with UNFPA mandate and GBV and SRH responsibilities. UNFPA does a commendable job in maintaining robust partnerships with a variety of ministries and offices including the MoH, MoSAL, CBS, and SCFA that are critical in advancing UNFPA work in Syria. Respondents197 reported many examples of positive engagement including:

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

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

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

191 UN Key Informant.
192 UN Key Informants.
193 UN Key Informant.
194 UN Key Informants.
195 See link to the video describing the UNFPA WFP partnership, this was done in early 2017 and shows paper vouchers and the programme now uses electronic vouchers.
196 UN Key Informants.
197 UN, UNFPA, NGO and Donor Key Informants.
198 In 2014, MoSAL, with support from UNHCR, UNFPA and UNICEF, established in 2014 a Family Protection Unit (FPU) for the protection of women and children to strengthen all protection-related activities for women and children and revise all relevant Syrian laws that affect the provision of services for survivors of GBV including CRSV.
199 UNFPA Key Informants.
Damascus. As such, UNFPA no longer import HIV PEP. This legislation, medical practices and restrictions on HIV PEP are misaligned with UNFPA global mandate to ensure clinical care and creates a dichotomy between global GBV and SRH minimum standards and the reality of service provision in Syria. While work is on-going, progress is slow, and the impact is that post-rape care, including HIV PEP, is not available to survivors. Some of those consulted underlined the need for external support to provide good practice examples on legislative reform on mandatory reporting that could be presented to the GoS.  

200 Key Informant Interviews  
201 Government and UN Key Informants.
Evaluation Question 6: Connectedness
To what extent does the UNFPA Response promote the humanitarian-development nexus?

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

**FINDINGS**

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

UNFPA is committed to responding to new crises while pursuing opportunities to build resilience where possible. Where feasible and practical, UNFPA is trying to meet longer-term needs and link ongoing humanitarian assistance to resilience as much as donor priorities, and political and security constraints permit. Respondents noted that there is no clear plan on how the international community will engage with the GoS in the longer-term.202 One key informant noted that “…working with the government, it’s difficult to balance programming versus the systems strengthening work that leans towards government engagement.”203 Stakeholders concurred that even when there is a cessation to hostilities, the humanitarian crisis will persist and needs among the affected populations including the displaced and returnees will continue to magnify. The operating environment in Syria is characterised by continuous ‘emergencies within an emergency’ including Homs in 2015, Alepppo in 2016, Ar-Raqqa in 2017, and Eastern Ghouta in 2018.204 The ongoing fighting in Dara’a and looming battle for Idlib continues to focus efforts on life-saving humanitarian assistance.

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

Other examples of UNFPA engagement on resilience include promoting legislative reform related to Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), CMR, UNSCR 1325 and 2250.208 In 2017, UNFPA held a workshop with the SCFAP that led the GoS to withdraw its reservation to Article 2 of CEDAW that mandates states ratifying CEDAW to declare intent to repeal discriminatory provisions against women in their laws.

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202 UN and Donor Key Informants.
203 Donor Key Informant.
204 UN, UNFPA, Donor and NGO Key Informants.
205 UN and UNFPA Key Informants.
206 UNFPA-UNDP signed agreement for funding from the Government of Japan 15 April 2017
207 UNFPA and Government Key Informants.
208 UNFPA (2017) COAR
209 Syria has been a party signatory to the Convention on the Elimination of All Forms of Discrimination against Women since 2002, however it has made reservations to several articles of the Convention, in particular article 2, article 9(2) regarding women’s equal right with respect to the nationality of their children, article 15(4) regarding the freedom to choose their
However, despite these positive examples, deeper in-country engagement in systems strengthening is restricted by the on-going conflict, lack of resolution and transition plan agreed by parties to the conflict and endorsed by the international community.  

\[\text{Note: Evaluation Question 7 relates explicitly to the UNFPA Regional Response Hub.}\]

\[\text{210 UN, UNFPA and Donor Key Informants.}\]
Evaluation Question 8: Efficiency

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

Associated Assumptions:

20. UNFPA has maximised efficiency through a series of humanitarian fast-track and support mechanisms for human and financial resources, such as:
   a. Fast Track Policies and Procedures;
   b. Surge
   c. Commodity procurement (particularly dignity kits and RH kits);
   d. Emergency Fund

21. UNFPA has maximised leverage of humanitarian funding – donor, multi-year, and pooled funding – for the response and matched OR and RR appropriately for office sustainability.

FINDINGS

16. Core resources allocated to the SCO were not commensurate to needs throughout the Syria crisis nor did they match other resources as they increased.

17. Although SCO has utilised Fast Track Procedures (FTP) since the start of the crisis, their capacity to expedite procurement and recruitment was impeded in the early years by insufficient resources, technical capacity, and a lack of flexibility in the application of procedures.

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

While Other Resources (OR) has increased212, Regular Resources (RR) as a proportion of overall funds has reduced from 46% in 2011 to less 8% in 2017.213 The re-classification of the SCO from yellow to

211 UNFPA Key Informants.
212 While the overall 2014 expenditure was $10,578,681.04 [OR: $7,996,718.04; RR $2,581,963.00]. the SCO mobilised $12,179,534 in funding in 2014 with the remaining amounts utilised the following year.
213 Data provided by the SCO in July 2018. RR as a proportion of overall funds reduced from 46% in 2011; 51% in 2012; 26% in 2013: 24% in 2014: 15% in 2015:19% in 2016 to 0.08% in 2017.
orange within the UNFPA quadrant classification system\textsuperscript{214} was delayed, the business case was initially made in 2014 “to reclassify Syria in the orange quadrant to enable the CO to get more regular resources and focus also on capacity building” \textsuperscript{215,216}

![UNFPA Funding 2011-2017](image)

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

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

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

\textsuperscript{215} UNFPA (2014:5) COAR.

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

\textsuperscript{217} UNFPA (2012:23) COAR.

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

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

\textsuperscript{220} UNFPA Key Informants.
humanitarian assistance. Even now, with increased human resource capacity within supply chain, some international procurements take more than six months and local procurements often require waivers for each order which can be time consuming. To improve supply chain functioning, the SCO is working on Long Term Agreements (LTA) for locally procured pharmaceuticals that receive UNFPA approval/waivers rather than having to submit requests for each new purchase.

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

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

<table>
<thead>
<tr>
<th>Commodity Distributed</th>
<th>RH Kits Total</th>
<th>Dignity Kits Total</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>368</td>
<td>188,969</td>
<td>182,419</td>
<td>6,550</td>
</tr>
<tr>
<td>2015</td>
<td>384</td>
<td>219,755</td>
<td>193,996</td>
<td>25,759</td>
</tr>
<tr>
<td>2016</td>
<td>433</td>
<td>310,680</td>
<td>294,170</td>
<td>16,510</td>
</tr>
<tr>
<td>2017</td>
<td>271</td>
<td>462,259</td>
<td>441,757</td>
<td>20,502</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,456</strong></td>
<td><strong>1,181,663</strong></td>
<td><strong>1,112,342</strong></td>
<td><strong>69,321</strong></td>
</tr>
</tbody>
</table>

Source: UNFPA SCO 2018

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221 UNFPA Key Informants noted that until 2018, there were two staff in procurement and one in logistics and this was insufficient to support the growing operation. Part of the rationale for the increased investment in procurement was based on lessons learned from 2016 when UNFPA struggled to maintain supplies for emergency responses.

222 UNFPA Key Informants.

223 UNFPA (2015:31) UNFPA Fast Track Policies and Procedures “… local procurement of pharmaceuticals is only allowed under the following circumstances: The pharmaceuticals are WHO Prequalified; Where WHO PQ Prequalified pharmaceuticals are not available, the pharmaceuticals must be duly registered in the country of intended use. This is to ensure local procurement does not go against the National Regulation and Legislation and that the pharmaceuticals meet the acceptable National quality standards.”

224 UNFPA Key Informant.


226 The cost differential per kit is significant ($1,500 to $150 per kit without HIV PEP).

227 UNFPA Key Informants noted that contents of the kits were revised significantly based on 2017 consultations and seven different kits were created to meet different needs in winter, summer, for girls, pregnant and lactating women, and men.

228 Detailed data on UNFPA kit distribution was not available from the SCO prior to 2014.

229 Data provide by the SCO in August 2018.
“When we are organising humanitarian convoys, UNFPA contribute supplies – RH kits – UNFPA is always there in terms of readiness and quantity and we have not witnessed a situation where they have not been able to deliver” 230

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

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

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

There are on-going challenges in securing visas and this affects UNFPA ability to maintain existing staff235 and bring in new international staff and consultants. These bureaucratic obstacles are further exacerbated by delays in identifying and deploying surge staff. For example, during the Eastern Ghouta crisis in 2018, the SCO requested surge support for a Humanitarian Coordinator, but no suitable candidate was available on the roster, and when one was identified outside of the roster, they deployed after the acute phase passed due to delays in visa, identification and selection process. 236

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

230 UN Key Informant.
231 UNFPA (2014:5) COAR.
232 UNFPA (2013) COAR.
233 UNFPA and UN Key Informants.
234 UNFPA Key Informants.
235 During the evaluation, the visa for the one senior staff member was not renewed and the position had to be advertised to get a replacement. Some staff from other UN agencies also had the same experience and were working remotely.
236 UNFPA Key Informants.
237 UNFPA Key Informants.
A final issue related to efficiency is that the SCO is working with two programmatic cycles, one for Whole of Syria (WOS01) and one for the 8th Country Programme (SYR08) that do not have the same outcomes, outputs, indicators, targets or baselines. According to the SCO, considerable management of the reporting process is required to minimise the risk of double-reporting of results and report actual values for indicators due to difficulties separating fund contributions among activities. The SCO stakeholders highlighted that it is not always feasible to fund each IP or each facility from one single fund code or programmatic cycle and some are funded from both. The CO works very closely with IPs and the Hub to minimise the risk of duplication and improve accuracy in reporting, monitoring and tracking of expenditures.238

238 UNFPA Key Informants.
Evaluation Question 9: Partnerships

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

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

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

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

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

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

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

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

\textsuperscript{242} NGO Key Informants.
\textsuperscript{243} UN, UNFPA and NGO Key Informants.
\textsuperscript{244} UN and NGO Key Informants.
\textsuperscript{245} The GPS II allows IPs to submit Funding Authorization and Certificate of Expenditure (FACE) form to request cash advances, report on their use, request the reimbursement of expenses through an online platform.
\textsuperscript{246} NGO Key Informants.
\textsuperscript{247} Donor Key Informants.
\textsuperscript{248} Donor Key Informants.
\textsuperscript{249} UN Key Informants.
Evaluation Question 10: Effectiveness

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

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

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

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

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

²⁵⁰ see Annex VI
made substantial progress expanding geographic coverage that was facilitated by increased humanitarian access, funding and partnerships with IPs. Much of UNFPA programming has been focused on immediate lifesaving responses, including cross-line assistance, during the acute phase of the crises which can be difficult to measure.

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

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

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

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<td>588,928</td>
<td>134,183</td>
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<td>4,719,855</td>
<td>278,797</td>
<td>41,479</td>
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<tr>
<td>Total</td>
<td>9,107,704</td>
<td>8,243,997</td>
<td>572,071</td>
<td>106,148</td>
<td>185,486</td>
</tr>
</tbody>
</table>

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

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251 Evidence from interviews with key stakeholders including UN, NGO and donors and review of financial data, coverage of services and beneficiaries’ targets.
252 UNFPA COAR 2015-2017
253 Review of beneficiary data, impact assessments, evaluations and interviews with key stakeholders.
254 Evidence from interviews with key stakeholders and recent independent evaluations on GBV and SRH services in Syria.
255 This is taken from raw data provided by UNFPA that is available for beneficiaries by sector/partner and service.
256 Data provide by the SCO in August 2018.
257 Data provide by the SCO in August 2018.
258 From a total of 7,435,633 including 49,680 men and boys (based on data from SCO in August 2018)
259 http://www.ocha-sy.org/4wspresence.html
260 Data provide by the SCO in August 2018.
Additionally, out of the 12.3 million medical treatments provided by the health sector inside Syria in 2017, UNFPA SCO supported 4.63 million SRH services.

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

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

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

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

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

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261 http://www.ocha-sy.org/4wspresence.html
262 Data provide by the SCO in August 2018.
263 UNFPA, UN and NGO Key Informants.
266 UNFPA, UN and NGO Key Informants.
267 UNFPA COAR 2016 and 2017 and 2016-2017 CPD
268 UNFPA, UN and NGO Key Informants.
area for the SCO. As the situation evolves, UNFPA is concentrating more on skills building, vocational training and empowerment for women, girls and youth to improve resilience.²⁶⁹,²⁷⁰

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

Although SRH interventions (both integrated and standalone) are an essential part of the humanitarian response, GBV has been more visible than SRH within coordination and advocacy.²⁷² In part, this is related to the higher proportion of GBV staffing at the SCO and Hub (coordination and programme), presence and functioning of the GBV sub-sector and a high level of awareness among key stakeholders on GBV patterns and risks emanating from *Voices* and strong advocacy.²⁷³ This acknowledgment of GBV as a lifesaving priority has gained momentum since 2015²⁷⁴ and the 2018 Whole of Syria HRP makes specific commitment that:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Key suggested recommendations at the UNFPA Syria Country Office:

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

B. In recognition of the capacity gaps among partners and the demands to expand geographically in addition to transitioning from emergency responses, the SCO should:
   - Strengthen capacity building for IPs and develop a systematic strategy that goes beyond trainings, especially for new GBV partners. (i.e. on the job mentoring, using remote technology to support, field visits/exchanges etc.). Adopting a model where UNFPA partner with a strong international NGO to provide intensive capacity building or increasing SCO staffing so there are sufficient and experienced internal resources to dedicate to capacity building are options that should be explored. (Links to Conclusion B, C and G)
   - Review existing GBV and SRH integration including mobile responses to assess its overall functioning, effectiveness and identify any gaps or areas for improvement. This should enable UNFPA to further define guidelines for GBV and SRH integration during the acute and protracted phases as well as provide guidance for mobile teams to improve functioning and provide lessons learnt and good practices for application in other humanitarian settings. (Links to Conclusion A, B and C)

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

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

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

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

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

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

Key suggested recommendations for the overall evaluation:

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

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

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

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

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

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

### Relevance – how well does the UNFPA Response address the stated needs of people, and how well does it align to humanitarian principles and a human rights approach?

- **Q2** – How well do you think the UNFPA response addresses stated needs of individuals and communities. How do you know this? Evidence?
- **Q3** – How has the UNFPA response included gender and inclusion analysis? Evidence?
- **Q4** – How does the UNFPA response adhere to humanitarian principles, and IHL / IRL? Evidence?
- **Q5** – How has UNFPA directed or supported the overall SRH response to be based on identified needs? Evidence?
- **Q6** – How has UNFPA directed or supported the overall GBV response to be based on identified needs? Evidence?

### Relevance – how well has the UNFPA Response adapted since 2011 based on changing needs and priorities?

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

### Coverage – how well has UNFPA reached those with greatest need – geographically and demographically?

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

### Coordination – how well has UNFPA led, directed, supported coordination mechanisms for SRH and GBV?

- **Q12** – How has UNFPA led and supported the RH WG? Evidence?
- **Q13** – How has UNFPA led and supported the GBV SC? Evidence?
- **Q14** – How has UNFPA led and supported the youth WG? Evidence?

### Coherence – alignment with UNCT / HCT / Government / UNFPA HQ, RO, CO strategies, national government strategies, SC and WG strategies, and normative frameworks

- **Q15** – How does UNFPA drive focus on SRH and GBV at UNCT and HCT levels? Evidence?
- **Q16** – How does the UNFPA response align with global UNFPA strategy? Evidence?
- **Q17** – How does the UNFPA response align with EECARO / ASRO strategies? Evidence?
- **Q18** – How does the UNFPA response align with the CPD? Evidence?
- **Q19** – How does the UNFPA response align national Government prioritisation? Evidence?
- **Q20** – How does the UNFPA response align with MISP and with GBV guidance?
- **Q21** – How does the UNFPA response align with RH WG / GBV SC strategies? Evidence?

### Connectedness – humanitarian-development nexus

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

### Efficiency – Hub and other aspects (Fast-Track Procedures (FTP), surge, commodity supply, multi-year funding) and partnerships

- **Q23** – How has the Hub contributed to the UNFPA response? What are the benefits? What challenges have there been?
- **Q24** – How have FTP been used? What are the benefits? What challenges have there been?
Q25 – Has surge been used? What were the benefits? What challenges have there been?
Q26 – How has commodity procurement (i.e. dignity kits, and RH kits) contributed to the overall response? What are the benefits? What challenges have there been?
Q27 – What impact has multi-year funding opportunities had on the UNFPA response?
Q28 – How has UNFPA used partnerships strategically? Evidence?

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

Notes:
Questions are not defined as a formalised interview process with all questions being asked in order. The key informant interview is a semi-structured process with the questions providing
Evaluation Team Members should select questions as per relevant to specific KII, grouped as:
- UNFPA Global Colleagues
- UNFPA Regional Colleagues
- UNFPA Hub / Country Colleagues
- Other UN Agency Global Colleagues
- Other UN Agency Regional Colleagues
- Other UN Agency Hub / Country Colleagues
- NGO Global Colleagues
- Implementing Partner Country Colleagues
- Other NGO Country Colleagues
- CSO Colleagues
- Government Partners
- Donor Partners
- Academic Partners
Annex III: Survey Results

What is your organisational role in the Syria Humanitarian Response?
28 responses

1. How does your organisation's humanitarian work relate to UNFPA?
27 responses
2. How well do you think the UNFPA response addresses stated needs of individuals and communities? (Please indicate on the scale)

28 responses

- 60.7%: Very well - UNFPA address most or all needs related to its work
- 35.7%: Moderately well - many needs are met, but there are still many remaining
- 1.4%: Not well/not at all - most or all needs related to UNFPA's work are unmet
- 2.1%: I do not know

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

28 responses

- 50%: Very well - UNFPA has adapted in response to changing circumstances
- 42.9%: Moderately well - UNFPA has adapted sometimes but not always or not enough
- 2.1%: Not well - UNFPA is slow to adapt
- 2.1%: Not at all - UNFPA has not adapted its approach on the basis of changing needs
- 2.1%: I do not know
4. How well has UNFPA reached those most in need - geographically?
28 responses

- Very well - UNFPA works in geographical areas that are most in need
- Moderately well - UNFPA works in some needy locations but not all or...
- Not well - UNFPA works in few locations of greatest need
- Not at all - UNFPA does not reach areas where the need is greatest
- I do not know

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

- Very well - UNFPA has specifically focused on and reached adolescent girls
- Moderately well - UNFPA has some focus on girls, but not enough
- Not well - UNFPA does not focus specifically on these girls
- I do not know
5b. How well has UNFPA reached vulnerable people with disabilities?

28 responses

- 46.4%: Very well - UNFPA has specifically focused on and reached people with disabilities
- 32.1%: Moderately well - UNFPA has some focus on people with disabilities, but not enough
- 21.4%: Not well - UNFPA does not focus specifically on people with disabilities
- I do not know

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

27 responses

- 55.6%: Very well - UNFPA takes the lead and is very active in coordination and support
- 22.2%: Moderately well - UNFPA leads and supports the group, but should do more
- 18.5%: Not well - UNFPA shows little or no leadership or support in this group
- I do not know
7. How well has UNFPA led and supported the GBV Subcluster?
28 responses

- Very well - UNFPA takes the lead and is very active in coordination and support (57.1%)
- Moderately well - UNFPA leads and supports the group, but should do more (28.6%)
- Not well - UNFPA shows little or no leadership or support in this group (14.3%)
- I do not know (0%)

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

- Very well - UNFPA takes the lead and is very active in coordination and support (44.4%)
- Moderately well - UNFPA leads and supports the group, but should do more (29.6%)
- Not well - UNFPA shows little or no leadership or support in this group (18.5%)
- I do not know (6.5%)
9a. How well does the UNFPA response align with national Government priorities?
28 responses

9b. How well does the UNFPA response align with wider UNFPA priorities?
28 responses
9c. How well does the UNFPA response align with the humanitarian system and other UN agencies?
28 responses

- 67.9% Very well - all activities are in line with the humanitarian system and other UN agencies
- 28.6% Moderately well - most, but not all, activities are in line with the humanitarian system and other...
- 7.4% Not very well - some are in line with the humanitarian system and other...
- 4.6% Not at all - none of UNFPA’s activities are in line with the humanitarian system...
- 1.4% I do not know

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

- 48.1% Very well - UNFPA’s work always seeks to build resilience and long-term sustainability
- 29.6% Somewhat - long-term sustainability and resilience are taken into account...
- 14.8% Not well - long-term sustainability and resilience are only occasionally taken...
- 7.4% Not at all - UNFPA’s work is not sustainable nor building long-term r...
- 1.4% I do not know
11. Has UNFPA's distribution of commodities (Dignity kits, Reproductive Health kits) been a good use of resources?

28 responses

- 32.1% Definitely - commodity distributions supported by UNFPA reached those in significant need
- 14.3% Somewhat - distributions reach some in need, but not enough
- 22.2% Not at all - commodity distributions did not reach those who needed them or were not needed
- 53.6% I do not know

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

27 responses

- 44.4% Multi-year funding has significantly improved UNFPA’s response
- 29.6% Multi-year funding has had moderate positive impacts on UNFPA’s response
- 22.2% Multi-year funding has had little or no impact on UNFPA’s programming
- 14.3% I do not know
13. Has UNFPA used partnerships strategically?
28 responses

- **Definitely** - UNFPA's partnership choices have been strategic and added significant value to its response (64.3%)
- **Somewhat** - UNFPA's partnerships have added some value to its response (32.1%)
- **Not really** - UNFPA's partnerships have not been strategic nor added value to its response (3.5%)
- **I do not know** (0.7%)

14. How effectively has UNFPA provided quality services inside the Syrian Arab Republic?
15a. Has UNFPA increased the capacity of Syrian service providers?
28 responses

- 46.4% Capacity has STRONGLY increased due to UNFPA’s contributions
- 39.3% Capacity has increased MODERATELY due to UNFPA’s contributions
- 10.7% Capacity improvements due to UNFPA’s contributions are SMALL
- 1.1% UNFPA’s contributions have NOT led to any improved capacity
- 0% I do not know

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

- 53.6% Yes - UNFPA’s data collection and analysis has driven programming decisions
- 21.4% Somewhat - data collection/analysis drives some but not all programming decisions
- 17.9% Limited/Not at all - UNFPA rarely or never collects or uses data to drive programming decisions
- 0% I do not know
Annex IV: WoS Coordination Arrangements

COORDINATION ARRANGEMENTS FOR THE WHOLE OF SYRIA

HUB-LEVEL COORDINATION

Humanitarian Country Team or Humanitarian Liaison Group
Chair: Humanitarian Coordinator or DRHC
Members: Heads of key humanitarian organizations
- Agrees on common policies and response strategies
- Promotes adherence to principles, guidelines and policies
- Establishes clusters and designates cluster lead agencies
- Provides guidance to cluster lead agencies
- Activates resource mobilization mechanisms and advises on allocation of resources and common messaging

Inter-Cluster / Sector Coordination Team
Chaired by OCHA Head of Office Members: Cluster Coordinators, Cluster Coordinators and Advisors on specific issues as invited (e.g. Gender) as needed
- Leads inter-agency operational planning at Hub level
- Maintains overview of response and gaps
- Ensures cross-cutting issues are reflected in cluster plans
- Coordinates multi-cluster needs assessments
- Monitors cluster performance

IM Working Group (Information Management Working Group)
Coordinate and implement IM activities at hub level: information sharing, pooling of technical resources, needs identification, and other issues related to IM

WHOLE OF SYRIA COORDINATION

WoS Strategic Steering Group (SSG)
Co-Chairs: HC for Syria and RHC for Syria Crisis
Membership (from all hubs): HC for Jordan; Deputy RHC for Syria Crisis, 6 x UN agencies, 2 x NGOs, 2 INGO Coordination Forums; OCHA; Observers: ICRC, IFRC, SARC.
The SSG will advise the Syria HC and RHC on:
- Strategic response priorities and approaches for implementation
- Developing and implementing the SRP and associated needs identification, vulnerability framework, and prioritization
- Improving operational coordination arrangements
- Promoting adherence to humanitarian principles, IASC guidelines, and adopted WoS policies and strategies
- Improving and harmonizing WoS humanitarian access and protection strategies
- Improving humanitarian advocacy and resource mobilization for the Syria Crisis

WOS Inter-Sector/Cluster Coordination Group
Chaired by OCHA Syria Head of Office
Members: WoS Sector Focal Points/Coordinators & INGO Co-Focal Points; OCHA; Observer: Syria INGO Forum
- Provide technical support to WoS clusters / sectors on WoS strategic planning, information management, needs assessment and identification, and access in order to implement the WoS approach and the SRP as well as other decisions of the WoS SSG.
- Facilitate and support the establishment of a WoS inter-sector/cluster monitoring system.
- Provide technical or policy advice to the WoS SSG to support its decision-making throughout the Humanitarian Planning Cycle.
- Support operational coordination by ensuring effective de-confliction and gap filling
- Help identify core advocacy concerns emerging from the response and the identification of resource gaps impacting operational delivery

SMAIWG
(Syria Information Management and Assessment Working Group)
Coordinate and implement IM activities for the WoS related to data standards, compatibility, information sharing, pooling of technical resources, needs identification, etc.

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Annex V: Annex Timeline

2011:
March: Syrian Crisis begins
May: first refugee camp opened in Turkey
August: Sanctions imposed on GoS by EU and US

2012:
February: UNGA Resolution 66/253 condemns violence in Syria
June: Geneva Communiqué
December: more than 2 million displaced and 4 million in need

2013:
June: OHCHR report more than 93,000 killed to date
September: More than 2 million refugees in Jordan, Lebanon, Turkey, Iraq, and Egypt
December: 9.3 million in need

2014:
February: UNSCR 20139 and March: first convoy from Turkey
June: 10.8 million in need
July: UNSCR 2165 authorising cross-border operations
August: More than 190,000 killed to date
October: 3 million refugees in Jordan, Lebanon, Turkey, Iraq and Egypt
December: UNSCR 2191 authorising continued cross-border operations

2015:
July: 4 million refugees in Jordan, Lebanon, Turkey, Iraq and Egypt
September: 13.5 million in need
December: UNSCR 2258 renewing cross-border operations

2016:
March: EU-Turkey Statement
December: UNSCR 2332 renewing cross-border operations
December: 30 December a nationwide ceasefire comes into effect (not effective)

2017:
May: Iran, Russia and Turkey sign a memorandum for creation of de-escalation zones
(the UN is not a party to this)
December: UNSCR 2393 renewing cross-border operations until January 2019

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282 Taken from 2016 and 2018 Humanitarian Needs Overviews.
Annex VI: Reconstructed Theory of Change

**Impact:** Safety, wellbeing and resilience of women, adolescents and youth affected by the Syrian crisis improved

- SRH and GBV recognised as life-saving interventions
- GBV is recognised as a critical protection component
- SRH and GBV is understood to be a requirement for wellbeing & resilience

**Outcomes**
- Syrian women, adolescents, youth & affected host communities in surrounding countries access quality integrated SRH & GBV services
- Syrian & affected host community women, adolescents & youth benefit from prevention, risk reduction, and social norm change programming and are empowered to demand their rights
- Humanitarian community is accountable for SRH & GBV interventions mainstreamed across the overall humanitarian response

**Outputs**
- Improved host country policy environment for SRH and GBV in Syria and surrounding host countries
- Increased availability of integrated GBV and SRH services and information
- Improved Coordination of GBV, SRH and Youth Responses
- Improved capacity of local, national actors to provide quality SRH and GBV services
- Use of data for UNFPA programming, GBV SC / RH WG / Youths WG programming and for wider humanitarian evidence use

**Inputs**
- Advocacy & policy inputs with host governments, the humanitarian community and public
- Service Delivery—support to IPs, including commodity supply
- Coordination, Leadership & Partnerships
  - Internal
    - UNFPA Hub
  - External
    - GBV, RH, Youth coal mechanisms
- Capacity Building—support to IPs (CSO, NGO, Govt)
- Knowledge Management—Data provided by GBV coordination mechanisms (GBVIMS)
  - HNO, linking to HRP

**Assumptions**
- Adequate funding/resources, coordination mechanisms in place;
- Adequate UNFPA Influence with HCT / UNCT

**Barriers**
- Protracted nature of conflict—Displacements; Destruction of infrastructure; Loss of medical service providers; Poor Security & Access; SRH & GBV services not considered life-saving; Cultural issues

**Problem Statement**
Due to the ongoing and increasingly escalating conflict in Syria, Syrian women, adolescents and youth (both within Syria and displaced outside of Syria) have experienced a dramatic reduction in access to SRH services leading to increased mortality and morbidity whilst also experiencing a dramatic increase in the risks of GBV